From: Wintringham, Karen [mailto:Kwintrin@HAP.ORG]
Sent: Monday, October 17, 2011 9:43 AM
To: FN-OMB-OIRA-Submission
Subject: Comments on CMS-R-246 and CMS-10147

We appreciate the opportunity to comment on behalf of Health Alliance Plan (HAP) in Michigan. HAP is a 50-year old health plan that has served Medicare beneficiaries for more than 20 years and currently serves more than 44,000 members in Medicare Advantage plans.

We include comments on the proposed changes outlined in the Comment Request. In addition, we recommend there be some reconsideration of the entire set of questions. These were developed some time ago, and when there were not significant payments associated with the results. As the industry has developed these past few years and new products have been introduced, CAHPS has not necessarily adapted to the changes. Now that the results have much more significant meaning as a major determinant in payment to the plan under the Star rating system, it is even more important – to the plans , but, ultimately to the members because of the impact on their premiums – to reassess the appropriateness and effectiveness of the questions.

What we have found through our own testing of our own materials, is that beneficiaries really want us to get away from using any "industry speak", which we have worked hard to do. In re-reading the CAHPS questions it is our opinion that some terms not understood by many beneficiaries are used in the survey, such as "managing care" .

In addition, the response to the question is likely to differ depending on the product the beneficiary is in. For example, in an HMO or HMO-POS it is much more likely that the plan is involved in coordinating care – in the PPO it is more likely it's the physician. For questions 29, 30,and 31, for example, in an HMO the care coordination may have been handled by the plan, not the doctor's office, and especially for someone with multiple chronic conditions who is being helped by a plan's care management program.

Question 32 may be of casual interest, and plans can certainly go out and ask/encourage doctors to do this. But we question the value of offering after visit notes to all patients.

Questions 38 and 39 do not clearly identify what is being asked – are they trying to get to care that required prior authorization (understanding that term would mean little to the member) or care the member tries to get from the doctors or other providers associated with the health plan? There is an assumption here that members understand the nuance that we are not confident they do. By contrast the questions beginning at #40 are clearly services provided by the health plan.

In research with our members, one area of significant concern is about the complexity and lack of clarity of many of the documents they receive. When asked about specific documents, they tend to be most concerned about the ones with model language mandated by Medicare. So are the answers to these questions more a reflection of CMS' requirements or plan performance?

Is question 52 really measuring plan performance when so many aspects of what the plan can or cannot do are regulated?

In the PDP questionnaire, questions 8 and 9 may be somewhat unclear. Are they asking what the member's copays or coinsurance amounts are or are they asking what the total cost to the member will

be. The latter could vary for each pharmacy, as is not something a plan's customer service department should have to answer. The former, including where the member is in relation to the Coverage Gap, is something the Customer Service department should be able to answer. Without clarification, you might not be getting a response to what plans are expected to do.

#16 on the PDP questionnaire is a biased question. The answer to the appeal might have been entirely appropriate but the member doesn't like it. That is different from whether the process was handled appropriately, fairly, and timely.

We also are concerned with the growing length of the survey instrument and its potential result of decreased participation. Rather than continue to add questions, we recommend substitution: re-evaluate the effectiveness of additional questions and add new ones only as older ones are updated or removed. The vendor we use has confirmed the potential risk of alienation of subjects as the questionnaire grows. For 2011 only 368 of our HMO members responded, representing the views of approximately 40,000 members. When only general trends were derived from the survey the response rate mattered less then when the surveys influences significant payment potential to the health plans.

Finally, we would just like to add to the record an identification of the CAHPS survey payment requirements as one more element that differs from FFS to Medicare Advantage. Our understanding is that the Medicare Advantage plans have to pay for these surveys while the FFS community does not. Yet the Medicare Advantage community's payments are being reduced to payments relative to FFS. To the extent the Medicare Advantage plans face financial requirements beyond those in FFS, they should be added to the payment to result in as much of an "apples to apples" comparison as possible. This is yet another example that should be incorporated into such a comparison.

Thank you for the opportunity to comment on ways to make the CAHPS survey even more meaningful and useful in accomplishing the goals set out in the Comment Request. We believe the concept of the CAHPS survey is valuable, to beneficiaries, to plans, and to CMS. However, particularly with the evolution of the industry and product types and the increased importance now that the results are linked to plan payments, the survey deserves a re-look and fine tuning to ensure it is clearly asking questions that support the intended meaning. If any additional clarification is needed, feel free to contact us.

Respectfully submitted,

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