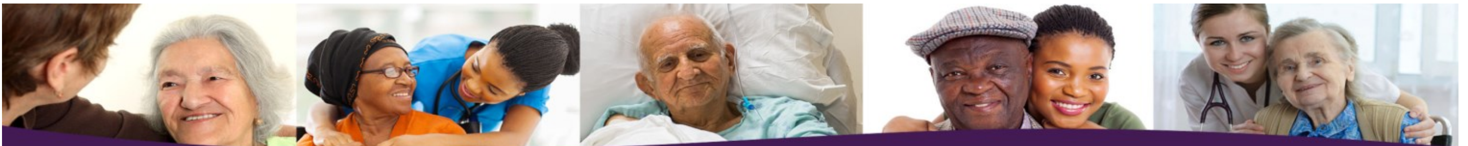

ASPE Report on Social Risk Factors - Summary related to Medicare Advantage Plans - Prepared for *SNP Alliance* Members – Working Document 2.21.2017

The Assistant Secretary for Planning and Evaluation (ASPE) published their "Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Payment Programs" in late December, 2016. The entire report can be found at: https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs. See also the Appendix to the report which has important detail for Medicare Advantage plans and can also be downloaded.

Their report clearly spells out the significant impact of social risk factors on quality ratings and value-based payment under Medicare across the board. It is very compelling. It validates the points SNP Alliance members have been making the last few years on the negative effect that having high-dual enrollment has on quality outcome ratings results under the Medicare Stars rating Quality Measurement System (QMS).

The SNP Alliance believes that CMS needs to pay attention to these findings. They need to move the QMS toward a population-based focus, recognizing that population characteristics affect individuals' health and care delivery. The duals and non-duals under Medicare exhibit significantly different characteristics, as this ASPE report clearly shows. Therefore the QMS that is focused on populations of general MA plans should not be applied across plans with very different enrollee populations. CMS should also create an environment where quality is compared for similar populations.

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EXECUTIVE SUMMARY of ASPE Report
The Executive Summary of this ASPE Report to Congress noted two main findings.

A. FINDING 1: Beneficiaries with social risk factors had worse outcomes on many quality measures, regardless of the providers they saw, and dual enrollment status was the most powerful predictor of poor outcomes.

Beneficiaries with social risk factors had poorer outcomes on many quality measures, including process measures (e.g., cancer screening), clinical outcome measures (e.g., diabetes control, readmissions), safety (e.g., infection rates), and patient experience measures (e.g., communication from doctors and nurses), as well as higher resource use (e.g., higher spending per hospital admission episode). This was true even when comparing beneficiaries at the same hospital, health plan, ACO, physician group, or facility. Dual enrollment (enrollment in both Medicare and Medicaid) was typically the most powerful predictor of poor performance among those social risk factors examined. For the most part, these findings persisted after risk adjustment, across care settings, measure types, and programs, and were moderate in size.

B. FINDING 2: Providers that disproportionately served beneficiaries with social risk factors tended to have worse performance on quality measures, even after accounting for their beneficiary mix.

Under all five value-based purchasing programs in which penalties are currently assessed, these providers experienced somewhat higher penalties than did providers serving fewer beneficiaries with social risk factors.

In every care setting examined, providers that disproportionately cared for beneficiaries with social risk factors tended to perform worse than their peers on quality measures. Some of these differences were driven by beneficiary mix, but some of the difference persisted even after adjusting for beneficiary characteristics. As a result, safety-net providers were more likely to face financial penalties across all five operational Medicare value-based purchasing programs in which penalties are assessed, including programs in the hospital, physician group, and dialysis facility settings. They were also less likely to receive bonuses in Medicare Advantage. The single exception was that ACOs with a high proportion of dually-enrolled beneficiaries were more likely to share in savings under the Medicare Shared Savings Program, despite slightly worse quality scores.

However, in every setting, be it hospital, health plan, ACO, physician group, or facility, there were some providers that served a high proportion of beneficiaries with social risk factors who achieved high levels of performance. This suggests that high performance is feasible, with the right strategies and supports.

Strategies and Considerations for Moving Ahead

ASPE outlined potential strategies across the board for moving ahead. All are based on the following 3-part strategy:

1. **Measure and Report Quality – for beneficiaries with social risk factors**
2. **Set High, Fair Quality Standards – for all beneficiaries**
3. **Reward and Support Better Outcomes – for beneficiaries with social risk factors**

From Section 3, Chapter 8 – Medicare Advantage
Regarding findings related to Medicare Advantage, including a review of the effects of social risk factors on quality measurement and bonus payments, as well as proposed strategies to address the inequities, see Section 3 of the report which begins on page 177. Chapter 8: "Medicare Advantage," begins on page 179 and poses the research questions posed and summary findings as follows:

Medicare Advantage (MA) - Research Questions

1. ***Is there a relationship between beneficiary social risk and performance on the metrics that comprise the Medicare Advantage Quality Star Rating program?***
2. ***Is there a relationship between contract social risk profile and performance on the metrics that comprise the program?***
3. ***Are contracts that serve a high proportion of beneficiaries with social risk factors less likely to receive bonuses under this program?***
4. ***What impact would policy options, including adjustment and stratification, have on contracts' performance and bonuses?***

Key Findings:

Underlying Relationships

- Dually-enrolled or low-income-subsidy, Black, and rural beneficiaries, beneficiaries living in low-income neighborhoods, and beneficiaries with disabilities experienced worse outcomes compared to other beneficiaries on many to most of the quality metrics included in the MA Quality Star Rating program. These differences were small to moderate in size, and largely driven by patient rather than contract factors. Hispanic beneficiaries had better outcomes on most measures.

Program Impact

- Contracts with a high proportion of beneficiaries with social risk factors generally did worse on overall quality scores, and were much less likely to receive quality bonus payments. However, a small number of contracts serving predominantly dually-enrolled / low-income subsidy-enrolled beneficiaries performed well on the quality measures overall.

Policy Simulations

- Adjusting for social risk at the measure level, either directly or using an index, led to small changes in performance scores for contracts overall, though there were small gains in high-dual contracts; changes were small because the differences in performance between dually-enrolled and non-dually-enrolled beneficiaries were small for some measures, and because only the patient-level clinical measures were adjusted, and no adjustments were applied to patient experience measures (because they are already adjusted for social risk) or contract-level measures.
- Up-weighting the improvement measure had a limited impact.
- Stratifying contracts by proportion dual led to changes in Star Ratings; using population grouping to stratify within contracts also led to changes in Star Ratings.
- Providing star adjustments for improvement or achievement in beneficiaries with social risk factors, or for equity, led to changes in Star Ratings.

Strategies and Considerations for Medicare Advantage Plans

The ASPE report poses "considerations" (options) under each of the three part strategy foci as follows (see page 180 of the full report). Note that those highlighted in yellow have more potential to clarify the extent of the inequities and/or address some of the inequities arising from the QMS in a substantive way.

SUMMARY OF STRATEGIES AND CONSIDERATIONS LANGUAGE FROM THE ASPE REPORT
STRATEGY 1: Measure and Report Quality for Beneficiaries with Social Risk Factors
CONSIDERATION 1: Consider enhancing data collection and developing statistical techniques to allow measurement and reporting of performance for beneficiaries with social risk factors, or for subgroups of plans (e.g., special needs plans) on key quality measures.
CONSIDERATION 2: Measure developers should develop measures that are meaningful for Medicare beneficiaries with disabilities, where many current measures do not apply.
CONSIDERATION 3: Consider developing and introducing a new measure or domain on Achieving Health Equity into the MA program to assess and reward health plan efforts to reduce health disparities.
CONSIDERATION 4: Prospectively monitor the financial impact of the MA program on providers disproportionately serving beneficiaries with social risk factors
STRATEGY 2: Set High, Fair Standards for All Beneficiaries
CONSIDERATION 1: A temporary adjustment index by contracts' dual and disability makeup should be used in the short term, as outlined in the 2017 Rate Announcement and Call Letter. The measures used in the current MA program should continue to be examined to determine if adjustment for social risk factors is appropriate.
CONSIDERATION 2: Program measures should be studied to determine whether differences in health status might underlie the observed relationships between social risk and performance, and whether better adjustment for health status might improve the ability to differentiate true differences in performance between providers.
STRATEGY 3: Reward and Support Better Outcomes for Beneficiaries with Social Risk Factors
CONSIDERATION 1: Consider providing targeted Star adjustments to reward contracts that achieve high quality or improve significantly for dually-enrolled beneficiaries.
CONSIDERATION 2: Consider using existing or new quality improvement programs to provide targeted technical assistance to contracts serving a high proportion of beneficiaries who are dually-enrolled or who have disabilities.
CONSIDERATION 3: Consider requiring that contracts serving dually-enrolled beneficiaries coordinate between Medicare and Medicaid. Barriers to integration of services between the two payers as well as barriers to spending flexibility for supplemental benefits for dually-enrolled beneficiaries should be minimized where feasible.
CONSIDERATION 4: Consider developing demonstrations or models focusing on care innovations that may help achieve better outcomes for beneficiaries with social risk factors.
CONSIDERATION 5: Consider further research to examine costs of caring for beneficiaries with social risk factors to determine whether current payments adequately account for differences in care needs.

SNP Alliance Positions and Analysis

The SNP Alliance has developed and refined its position on many of these issues raised in the ASPE report over several years. In brief, the following includes excerpts from position statements, comment letters, and other documents we have produced to share with CMS, external agencies with a focus on quality measurement and improvement, collaborative partners, states, reporters, advocacy organizations, and additional organizations in the health care sector. These positions provide a starting point in 2017.

2016 SNP Alliance Position Statements and Comment/Response Letters

Excerpts from SNP Alliance 2016Positon on *Social Determinants of Health*:

In April 2016, CMS finalized plans to adopt a Categorical Adjustment Index (CAI) in FY 2017 as an interim adjustment to Stars. The methodology accounts for selected SES factors on 6 of 47 measures, reporting to affect a total of 11 plans nationwide. The SNP Alliance supports this initial step but believes CMS must assume a larger and more expeditious leadership role.

Recommendation

The current Star Rating system penalizes plans that specialize in care of dual eligible persons. Congress should require CMS to:

1. *Include additional Star measures and additional data on SDOH and SES factors in the CAI and subsequent methods to more fully account for the impact on Star Ratings.*

2. *Implement a more meaningful plan to account for the social determinants of health on Star ratings to be implemented no later than FY 2018, beginning with adjustment of SDOH/SES factors for plan all-cause hospital readmission.*

3. *Define a standard set of scientifically sound criteria and transparent methods for use by measure developers/stewards in reviewing, evaluating and adjusting for the presence of SDOH/SES.*

4. *Re-examine the validity and reliability of self-reported survey data for persons who do not speak English, have low health literacy, or significant cognitive/memory impairment.*

Excerpts from SNP Alliance 2016 Position and Comment Letters re Quality Measurement including for MMPs:

The SNP Alliance believes that any measurement system for Medicare-Medicaid (beneficiaries/plans) should be based on the following principles:

1. *Measures reflect the dual population needs and characteristics.*
2. *Every beneficiary should be able to participate equally in the quality measurement process.*
3. *Social determinants of health risk factors are fully considered--minimum standards are set for measure developers and stewards for testing and adjustment.*
4. *Quality metrics may apply to FIDESNPs and other high dual plan types so that plans focusing on like populations are compared with each other consistently.*
5. *Fairness and attention to administrative burden is demonstrated.*
6. *There is a balance of process and outcome measures, with greater focus on outcomes that plans can impact.*
7. *There is value of aligning metrics across states, where possible, recognizing state's authority.*
8. *Reporting comparisons ensure match of like to like in terms of plans and populations enrolled.*

Excerpts from: *Challenges in Selected Issues in Quality Measurement for Dually-Eligible Beneficiaries Served by Managed Care Special Needs Plans* (September 2016):

It is time to revise and re-test the HOS and CAHPS instruments, the data collection and administration, the self-report measures, and survey methods to better accommodate dual beneficiaries' characteristics in quality measurement, and to risk-adjust based on population characteristics before comparing general MA plans to SNPs in quality performance.

<u>Single Instrument, Limited Translation</u> - The HOS and CAHPS surveys are currently used to assess beneficiary experience with health plans (as well as other aspects of care provided by clinics, hospitals, and other settings). The same instrument is used for the general Medicare Advantage population (non-duals) as for the duals in managed care. The instruments are only available in three translations: English, Spanish, and Chinese. Beneficiaries who do not speak or read in these languages may receive the survey instrument in the mail or receive a telephone call asking the person to participate, however explanatory material is not in their language.

Proxy survey responses are allowed, however the surveys are lengthy (more than 50 items) and the family member translating the survey would need to tolerate a three-way listen, interpret, and parrot response, which would extend the time to complete. Unfortunately, Medicare does not allow for any translation of the survey by health plan interpreters and does not provide the survey in other languages. This effectively shuts out participation by many non-English speaking individuals and those with limited English proficiency.

<u>Sampling Issues</u> - There are challenges in both HOS and CAHPS with sampling methodology. Beneficiaries are contacted by mailed survey and by phone. Given the characteristics of dually-eligible people who are more likely to be frail, experience behavioral and cognitive challenges, change residences, and have more limited access to communication technology, the HOS longitudinal design is especially challenging. Locating a dual individual after two years can be difficult, let alone taking into account the person's conditions which may impact response, such as if they have Alzheimer's disease or other dementias, or psychosocial and mental health issues.

CMS has noted that MA contracts tend to have either a very high percentage of duals and low-income individuals (e.g., SNPs) or a very low percentage. Given this, the sample of individuals from general Medicare Advantage plans are likely to be markedly different from the sample of individuals from Special Needs Plans. Any bias in responses arising from characteristics of the two populations (e.g., presence of social risk factors) would be embedded in the results. There is evidence of such bias in responses based on population characteristics. These known biases have not been adequately adjusted in the scoring, weighting, or composite ratings for quality measures. Therefore, comparison of the two groups on quality measures may not be methodologically sound. Such a serious issue must be taken into consideration when considering both quality measurement and value-based payment using these instruments and methods.

<u>Non-Response Bias</u> - A recent study of non-response bias in CAHPS among 695,197 Medicare beneficiaries found a 49% response rate, with Asians, African-Americans, and Hispanics responding at an adjusted rate that was 7 to 17 percentage points lower than Whites (p <.001 for each group). Older age was the strongest predictor of missing responses. African-Americans were most likely to break off of the telephone survey. The authors note that CMS administrative measures of race/ethnicity are primarily derived from SSA files and typically under-count certain ethnic groups. They posit that those with limited English proficiency may prefer phone vs. mail formats. Non-White and older beneficiaries especially those 85 and older consistently have low response rates and higher missing items and therefore may need oversampling.[i] Unfortunately, Medicare does not provide for oversampling of one ethnic or age sub-group over another.

Health plans find that the response rates with the final number of respondents for the HOS survey are extremely low (e.g., 60 to 80 members). Often less than 10% of membership is responding to the HOS survey and there is no adjustment based on member characteristics. This calls into question the conclusions and calculated ratings.

<u>Questions Do Not Match Population-</u> SNP Alliance health plans have reported challenges arising from the nature of the questions on physical, functional, and emotional health, particularly with the HOS survey as applied to the frail elderly and those who are in later stages of illness. Note, also, that physical, functional, and emotional health are often

interrelated and thus a lower score in one domain/measure is likely to also be reflected in another domain/measure. In addition, the emotional status questions do not take into account grief and loss, such as arising from the death of a spouse. Consistently there is a high proportion of widows and widowers among the enrolled SNP population, especially in the I-SNPs and in SNPs focusing on the senior population where average age can be 80+. Since the HOS survey is comparing that person's response to that same person's response two years ago, it is not surprising that the individual would report decline given medical and chronic conditions which are progressive and degenerative. For example:

- *"Does **your health <u>now</u> limit you** in these activities? Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf? Climbing several flights of stairs?"*
- *"Compared to **<u>one year ago</u>**, how would you rate your physical health now?"*
- *"**Compared to one year ago**, how would you rate your **emotional problems** (such as feeling anxious, depressed or irritable) in general now?"*

Beneficiaries' responses are compared over time. Decline in status is considered a marker of poor quality or care management. Note that if a person dies in the 2-year time period, this is considered poor performance by the plan. These HOS measures are considered "outcome" measures vs. process measures, and are thus heavily weighted at 3.0. This magnifies the impact on final quality scores for the plan.

<u>Need for Case-Mix Adjustment-</u> As early as 2001, CMS (then HCFA) was being advised to adjust CAHPS survey results for patient characteristics.[ii] Through case-mix modeling and other analysis methods researchers have found strong associations between SES/social risk factors and quality measurement outcomes.[iii] For example, a 2001 study using self-reported measures of health status, age, education, and proxy response found that there was regional variations in results (which varied substantially from year to year) and that there were some health plans where measure results were substantially impacted by the case-mix of their enrolled populations—where measurement results could be attributed to characteristics of the population rather than of the health plan.

In August 2014, the National Quality Forum (NQF) noted in its report Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors that, "There is a large body of evidence that various sociodemographic factors influence outcomes, and thus influence results on outcome performance measures." In the IMPACT Act of 2014, Congress recognized the potential effects of SES and dual eligible populations on the MA Star Ratings system by requesting the HHS Assistant Secretary for Planning and Evaluation to undertake studies on this population and the Medicare program at large [NOTE the ASPE Report published in December 2016 is the first part of these studies].

In September 2015, CMS released findings from a RAND study funded by DHHS. The research evaluated the effect of the Low Income Subsidy (LIS) and/or Dual Eligible (DE) status as well as the effect of disability status on Medicare Star Ratings. The design was to compare within plans rather than between plans, in order to take out differences that might arise from plan administration or other plan characteristics. This study found that a beneficiary's dual-eligible status significantly lowered outcomes on 12 of 16 Star Rating measures. It also found that disability status significantly lowered outcomes on 11 of 16 measures. [iv]

An Inovalon study found similar results.[v] Characteristics of dual-eligible enrollees explained 70% or more of the disparity in outcomes compared to non-dual eligible enrollees on five of eight measures. Significantly, dual-eligible status lowered performance on the "all cause hospital readmission" measure, the only Star Rating measure that is already adjusted for age, gender, and co-morbidities. Lastly, even after adjusting for dual status and other factors, living in poverty further increased likelihood of readmission.

In April 2016, CMS finalized plans to adopt a Categorical Adjustment Index (CAI) in FY 2017 as an interim adjustment to Stars. However, the methodology accounts for adjusting for only LIS, and disabled status, and on only 6 of 47 measures. Analysis projected this would affect only 11 plans nationwide—out of several hundred plans nationally. This limited adjustment will not address the fundamental problems in the current instruments, measures, methods, or comparability of results. Furthermore, it does not take into account other social risk factors that may have impact on outcomes. Responses from several SNPs have confirmed that the CAI adjustment had no effect on their quality ratings.

From: SNP Alliance Statement on *Guidelines to Measure Developers* (2016):

We urge CMS to set a minimum standard for measure developers and stewards to consistently test their measures – especially among the dual subpopulation groups who are not like the majority Medicare population and who represent the highest cost, most complex Medicare beneficiaries.

This will help ensure that the measure accurately captures actual experience and will reveal areas where risk adjustment is needed. This should include:

- *Sampling* **-** *minimum sample size and diversity of population, including low-income, non-English speaking, ethnically diverse, transient, and those with behavioral health conditions as comorbidities to physical conditions.*
- *Unit of Analysis* **-** *requirement to use small geographic areas as the unit of analysis (below the zip code level) as has been recommended in several robust studies showing variances are masked when only using zip code data.*
- *Variables Tested* **-** *requirement for a minimum set of variables to be included in the model that have been previously found to be associated with change in health outcome, including: low income or poverty status, living in a poverty neighborhood, single person household size, dual status, disability status, living in a primary care shortage area, living in a behavioral health care shortage area, limited English proficiency, and alcohol or substance dependency.*
- *Sound methods of administration* **-** *requirement that the measure stewards ensure that the survey methods and administration they recommend adequately accommodates low-income, transient, non-English speaking, and isolated dual beneficiaries. This is so that people who may experience housing instability, health literacy challenges, physical disabilities, cognitive or behavioral challenges, or have inadequate access to communication tools—have the opportunity to participate in the quality measurement process and that the methods of administration accommodate them.*
- *Transparency* **-** *requirement that the measure developer publish their scientific methods, data sources, and findings to provide a comprehensive technical report available allowing those in the field to replicate results.*
- *Dissemination* **-** *requirement that the measure developer provide a summary report for disclosure to the general public so that findings can be understood by the lay public.*

From: SNP Alliance Position on *Payment* June 2016

The SNP Alliance has long advocated adjusting payment based on a beneficiary's overall health conditions. However, studies show that plans specializing in high-cost populations like duals are financially disadvantaged by the current risk model's inability to fully account for the high medical costs involved in serving them. The current risk model

under-predicts costs for some high-risk conditions and for dual eligible beneficiaries as a group. Payment accuracy for every chronic condition is not always possible under the MA risk model, as most under- or over-payment for conditions within the model are generally averaged out for plans serving a relative normal distribution of Medicare beneficiaries. However, the lack of payment accuracy becomes problematic when a plan exclusively serves a high-cost population like duals, where an underpayment cannot be offset by an overpayment for a healthier population, like "non-duals." In fact, the current risk model creates perverse financial incentives to avoid enrolling high-cost beneficiaries.

The final CMS proposal will encourage plans to invest in specialized care and work with States in designing models that will improve beneficiaries' quality of care. Plans serving a population whose mix of beneficiaries is comparable to Medicare FFS will see little or no financial impact as the projected over and under adjustment to community risk scores will balance.

Recommendation

The SNP Alliance applauds CMS for finalizing this long awaited payment policy. As a next step in seeking to eliminate barriers to specialized care for important high-risk/high-need beneficiaries, the SNP Alliance recommends requiring CMS to study and improve the accuracy of the risk model for beneficiaries with Chronic Kidney Disease, diabetic neuropathy, Alzheimer's disease and related dementias, severe and persistent mental illness, ESRD, frailty, and beneficiaries receiving end-of-life care. There is evidence of adverse impact on plans that serve a disproportionate share of beneficiaries with these complex care conditions.

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[i] Klein, et al. (2011).

[ii] Zaslavsky, A., Zaborski, L., Ding, L., Shaul, J., Cioffi, M. and Cleary, P. (2001). Adjusting Performance Measures to Ensure Equitable Plan Comparisons, *Health Care Financing Review*. 22:3:109-126.

[iii] Inovalon (2015). *An Investigation of Medicare Advantage Dual Eligible Member-Level Performance on CMS Five-Star Quality Measures.*

[iv] *Examining the Potential Effects of Socioeconomic Factors on Star Ratings*, contract HHSM-500-2013-00283G. Centers for Medicare and Medicaid Services, September 8, 2015.

[v] Inovalon (2015). *An Investigation of Medicare Advantage Dual Eligible Member-Level Performance on CMS Five-Star Quality Measures.*