



DATE: July 27, 2020

TO: Nancy De Lew, Rachael Zuckerman, Lok Wong Samson, Wafa Tarazi, Susan Bogasky, Victoria Aysola, Scott Smith, and Steven Sheingold

RE: Report to Congress: *Social Risk Factors and Performance in Medicare's Value-Based Purchasing Program* (released July 2, 2020)

Dear ASPE Colleagues,

We have reviewed the Assistant Secretary for Planning and Evaluation (ASPE) 2nd Report to Congress: *Social Risk Factors and Performance in Medicare's Value-Based Purchasing Program* and have had two conference calls with special needs health plans in our Alliance to discuss our analysis and obtain their insights and responses.

The SNP Alliance would like to share our analysis and, if possible, obtain your response to several key issues as well as better understand the recommendations.

We appreciate the solid background research that you and colleagues from ASPE did to demonstrate that dual-eligible and functional status limitation (and social isolation) strongly impact health outcomes and quality measurement results under the Medicare program. We agree that dual-eligible status is a proxy for social determinant of health risks, and that function is a powerful predictor of poor outcomes for some measures - and not always captured. We also agree that there needs to be standardized language/definitions and measurement of social risk. We have always stated that poor quality should not be excused or risk-adjusted away.

However, we have concerns about the limitations of this report.

First, analysis is specific to provider data and does not include Medicare Advantage quality measurement data. ASPE's testing of risk adjustment factors were on hospital quality measure data and those of other providers, e.g., skilled nursing and home health care. We do not see any analysis on MA plans or MA measures. Without this, we are unclear how the recommendations on MA quality measurement were made—what analysis provides the information to do this? We are particularly puzzled by the recommendation to eliminate the Categorical Risk Adjustment Index without a replacement or a clear pathway to develop a better SDOH or other adjustment methods. We understood that Congress was very interested in guidance in how to adjust for risk factor differences in quality measurement and payment systems.

Early in the report, ASPE acknowledges that resource use and quality should be reported differently for those providers (and presumably plans) serving high proportions of dually-eligible individuals. The report acknowledges the challenges that providers (and presumably plans) have when serving a dually-eligible population—and the inequity of the current approach as these disproportionate share organizations are compared to providers/plans who serve more affluent individuals with a very different population profile. ASPE’s analysis (together with that of the National Academy of Sciences, Engineering, and Medicine in their five SES Reports) of the current quality measurement and value-based payment systems under Medicare demonstrate the inequities of these systems.

We appreciate that the ASPE researchers conducted key informant interviews with stakeholders and the insights gained from these. However, it appears that from these interviews, the team formed opinions about possible solutions and next steps.

The eight evaluation criteria generated by the team could have been vetted in some way e.g. by using a panel of experts through the Delphi Method, or conducting a meta-analysis of health policy research, or other qualitative method for validating these eight criteria. We don’t see that this was done.

The options offered as potential solutions or strategies, likewise, might have been vetted with experts and stakeholders, to provide feedback on the utility, feasibility, equity and other issues set forth in the report.

We don’t find any objective modeling on these options nor feedback from other experts or stakeholders to allow the research team to “score” the option as “low,” “moderate,” or “high” against the criteria. We also do not see much analysis on what it would take for the option to succeed—what resources, structures, or policies would have to be in place. We also do not find discussion on the limitations of the recommendations such as potential for harm. We do not find evidence that these solutions are actionable or can deliver what is suggested.

For example, in the discussion about possible solutions or steps forward, the report mentions the special supplemental benefits for the chronically ill (SSBCI) as a way that health plans could begin to address social risk and functional risk limitations. Yet, the report fails to acknowledge two major issues:

- 1) that Congress authorized SSBCI (and CMS has issued rules) with specific parameters for use of SSBCI—only for persons with chronic conditions that meet specific criteria and where health and function can be improved. CMS stated explicitly the SSBCI options "could not be used to solely address social determinants:"

- 2) that SSBCI benefits are voluntary and funded through rebates, such as quality rebates that are tied to the current Medicare MA quality system. ASPE neglected to realize or acknowledge that such extra benefits would have to be funded by quality bonuses. However, it is the current quality measurement system that has built-in inequities for those who disproportionately serve low income, dually eligible, and disabled individuals.

We are concerned about the potential for harm with some of these recommendations. For example, if the current Categorical Adjustment Index (CAI) for health plans that serve the dually eligible population goes away as recommended, the modest and interim “fix” developed by CMS to address social risk disproportionate share for MA plans—will be lost. We are very concerned that the small gains made over the last several years will evaporate, and it will be years before such plans are on par through a future replacement system which is not described in the ASPE report.

Another issue concerns peer grouping and stratification. While other expert committees and technical panels, such as with the National Academy of Science, Engineering, and Medicine and quality measurement organizations, such as the National Committee on Quality Assurance have endorsed peer grouping/stratification around quality measurement scoring and reporting in specific circumstances and under specific conditions, ASPE takes the opposite approach. In fact, with the recommendation, peer grouping and social risk categorical adjustment would be eliminated—even though the earlier analysis showed that such peer grouping for hospitals lessened penalties on disproportionate share safety-net hospitals.

This recommendation and several others seem that they would do harm. They would disadvantage those plans and providers who are committed to serving those with greatest social risks and complex needs. The necessary information and analysis to support some of the recommendations is not in this report, particularly pertaining to the Medicare Advantage Quality Measurement and Value-based Payment System. What is discussed does not provide evidence to support some of the conclusions or recommendations offered.

In summary, we are concerned that this report does not provide Congress or CMS with the information and analysis they need to address disparities with these high-risk populations, and the inequities in the current systems. We believe this is a missed opportunity.

Our commitment is to work with ASPE and other agencies in identifying best practices and policies to serve those at highest risk. Representing over 2.3 million beneficiaries who have special needs, social risk issues, and care complexity, the SNP Alliance member plans are committed to assisting Congress and government agencies to crafting a viable strategy for how to

"level the playing field" and to address these populations that now, more than ever, need outreach, care, and service that special needs plans and providers are committed to providing.

Thank you for the opportunity to share our response. We hope we can engage in further dialogue.

Sincerely,

A handwritten signature in cursive script that reads "Cheryl Phillips, MD".

Cheryl Phillips, MD
President & CEO
SNP Alliance

Cc: Deborah Paone, DrPH, MHSA
Performance Evaluation Lead, SNP Alliance