The SNP Alliance

A National Health Policy Group Initiative Working to Change Policy and Practice for High-Risk Beneficiaries

November 3, 2014

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Request for Information—Data on Differences in Medicare Advantage (MA) and Part D Star Rating Quality Measurements for Dual-Eligible versus Non-Dual-Eligible Enrollees

Dear Administrator Tavenner:

The SNP Alliance appreciates the opportunity to respond to CMS' request for information substantiating concerns that CMS' Star rating system does not adequately account for sociodemographic factors that affect the health care use and outcomes of Medicare beneficiaries. We commend CMS for reaching out to plans, providers and others through its RFI to gather information on this issue.

We strongly support paying for the performance of Medicare plans and for reporting Star ratings to inform consumer choice. Yet, the core issue of the RFI is one that we have been concerned about since the implementation of Stars. We have been particularly concerned that sociodemographic factors that independently affect health and healthcare outcomes are not adequately controlled for in the MA Star rating system. We firmly believe that without such accounting, the current MA Star rating system penalizes plans that enroll a large proportion of beneficiaries who are challenged by their sociodemographic circumstances, such as individuals who are dually eligible for Medicare and Medicaid.

Our response to this RFI draws largely from three sources: 1) a report written by Shawn Bishop in 2013 titled, *Building a Framework for Paying for Social Determinants of Health in Medicare*, that synthesizes long-standing research linking an individuals' socioeconomic status (SES) and related social factors to health care use and outcomes; 2) the National Quality Forum's recent report, *Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors*, and 3) extensive empirical analyses undertaken by Inovalon. The SNP Alliance commissioned the 2013 report by Shawn Bishop; is an active member of the National Quality Forum, and actively participates in NQF's Dual Eligible Beneficiaries Workgroup. Rich Bringewatt, Chair of the SNP Alliance, serves on the advisory committee for Inovalon's current follow-up study on dual-eligibility and quality outcomes.

Background

A large and growing body of research provides strong evidence that individuals' socioeconomic status (income, education, job status) and related social factors (health literacy, housing status, access to social supports, access to transportation, neighborhood characteristics, etc.) are directly related to health outcomes.[1] Collectively, these sociodemographic characteristics are so important to health outcomes that they are deemed "social determinants" of health. In addition to biological and clinical factors that affect outcomes, persons with low SES or who are impacted negatively by other sociodemographic factors have greater risk of poor outcomes. Dual-eligibles are characterized by lower SES and vulnerable to a variety of social circumstances and characteristics that lead to poorer outcomes in comparison to their non-dual counterparts.

The effects of sociodemographic factors on health care use and outcomes are of paramount importance to SNPs. D-SNPs exclusively serve dual-eligible beneficiaries. C-SNPs and I-SNPs also serve large proportions of duals, with some C-SNPs, most notably those specializing in care of persons with severe and persistent mental illness and persons with HIV/AIDS, affected by SES-related factors as much or more than many D-SNPs. Nearly 90% of all SNP enrollees are dual-eligibles, compared to 19% of Medicare beneficiaries overall and only 8% of beneficiaries enrolled in traditional Medicare Advantage plans. Dual-eligible beneficiaries face a myriad of challenges that have a direct impact on their health and healthcare outcomes. They also, in turn, have a direct impact on their plans' performance:

- Lower SES is linked to less use of preventive care, including screenings, vaccinations, and primary care;
- Lower educational and health literacy levels impact compliance and individuals' ability to adhere to prescribed treatments;
- Lack of transportation impedes access to health care services;
- Inadequate housing and lack of social support impede use of preventive and primary care;
- Higher levels of substance abuse and higher rates of obesity complicate chronic conditions and adherence to treatment;
- Neighborhood characteristics, e.g. higher crime and pollution levels, poorer access to nutritional food, lead to or complicate medical conditions and impede use of health care services.

Pathways that Affect Social Determinants of Health

A number of research studies have identified key pathways by which social determinants affect health outcomes. Bishop's paper summarizes pathways for three of the social determinants of concern to SNPs—health literacy, homelessness, and substance abuse—as shown in Table 1. The paper also summarizes some of the health system interventions that have been tried to help overcome health disparities stemming from social determinants.

Table 1: Health Effects of Literacy, Homelessness and Substance Abuse[2]

Social Determinant	Pathway	Outcomes	Intervention
Low Health Literacy	• Lowers patient engagement in health • Impairs function of patients and consumers in the health care system • Complicates	• High rates of missed appointments • High rates of ER use • Low rates of flu and pneumococcal vaccinations • Low rates of preventive screenings	• Longer office visits, more time with clinicians to deliver information and answer questions • Provider/plan outreach to monitor care • Simplified, yet accurate instructions post visit/admission • More frequent follow up care via phone, in-home,

[1] Bishop, Shawn M. *Building a Framework for Paying for Social Determinants of Health,* November 5, 2013.
[2] Ibid.

	communication between physicians and patients	• Low rates of comprehension of ER instructions • Less knowledge of chronic conditions, such as hypertension, diabetes, asthma and effects of smoking • Less consistent control of chronic conditions	and in office • Provider/plan knowledge of literacy level of patients • Cultural competency of provider/plan
Home-lessness	• Creates high risk for physical injury, substance abuse, mental health disorders • Impairs access to appropriate primary and preventive health care	• Higher acute care needs • Untreated mental health illness and substance abuse • Exacerbated chronic conditions • Physical stress related conditions • Conditions related to poor nutrition	• Full integration of physical and mental health services via care teams • Integrate substance abuse-related care (see below) • Coordination with community social services organizations • Cultural competency and racial sensitivity
Substance Abuse	• Deleterious effects on almost every system in the body • Creates higher risk for physical violence and risk	• Higher rates of hospital care • Causes or contributes to 70 other medical illnesses/conditions: -- Higher rates of heart disease, cancer, high blood pressure -- Higher rates of depression, anxiety, PTSD, bipolar disorder and schizophrenia • Co-occurs with wide range of medical and social conditions	• Long-term chronic disease management • Sustained coordination between physical and mental health providers • Medication and/or behavioral therapy • Intensive follow up after hospitalization or relapse • Lifelong monitoring and care

SNP Alliance Sociodemographic Goals and Concerns

Our collective goal is to mitigate and eliminate disparities in health outcomes, wherever possible. We believe health plans that provide coordinated, specialized care for SES vulnerable beneficiaries are best able to identify sociodemographic factors that adversely affect health and health outcomes and establish protocols for mitigating or eliminating their adverse effects. However, success requires MA payment and program policies as well as performance metrics that recognize the additional complications involved in caring for persons who are vulnerable to the influences of social demographic factors affecting their health

and health outcomes. Members that offer standard MA plans as well as D-SNPs have consistently reported it to be difficult if not impossible to achieve comparable star ratings for their D-SNPs and general MA plans without advancing more costly and targeted interventions. While a number of SNP Alliance members have achieved 4.0 and 4.5 star ratings, they also consistently report the need for more costly and targeted interventions, and are finding it increasingly difficult to maintain their high star rating, contrary to the experience of plans that do not treat a high proportion of enrollees with social and environmental care complexities. A failure to recognize these added care complexities provides inaccurate information to beneficiaries, penalizes plans that specialize in care of the most vulnerable, complex and costly Medicare beneficiaries, and puts some vulnerable beneficiaries in jeopardy of losing their plan of choice if it is eliminated from the Medicare program under CMS policy.

Our concerns are consistent with those put forth in the recent National Quality Forum (NQF) report, "Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors." This report is the product of an expert panel convened to make recommendations regarding risk adjustment of performance measures for individuals' socioeconomic and other sociodemographic characteristics. The panel recommended changing NQF's longstanding policy on risk adjustment for sociodemographic characteristics, with a specific recommendation that, "for comparative performance assessment, sociodemographic adjustment is appropriate if certain conditions are met, and further that, if a measure is adjusted for sociodemographic factors, it must be specified for stratification so that any disparities are made visible." In addition, the panel recommended the appointment of a Disparities Committee to monitor the impact of this significant change in NQF policy. The report observes, "In the context of public quality reporting and pay-for-performance, failing to account for the greater difficulty in achieving good outcomes in socially and economically disadvantaged populations could set up a series of adverse feedback loops that result in a 'downward spiral' of access and quality for those populations. The net effect could *worsen* rather than ameliorate healthcare disparities." As a result of the report, the NQF Board of Directors approved a trial period during which NQF's restriction on risk-adjusting performance measures for sociodemographic characteristics will be lifted and the impact of this change will be evaluated.

The SNP Alliance is particularly concerned about the outlook for plans and providers specializing in the care of lower income, higher risk individuals being penalized by pay-for-performance programs under pay-for-performance programs that do not take into account differences in individuals' SES/socio-demographic characteristics. We are hopeful that NQF's recommendations, together with the input that CMS receives in response to this RFI, will result in CMS' implementation of changes to the Star rating program that will take into account substantial differences across plans with respect to the socioeconomic and socio-demographic characteristics of their enrollees.

Inovalon Research Findings

We are pleased to be able to include in our response to CMS' RFI, a summary of the results of analyses undertaken by Inovalon. Inovalon, the SNP Alliance and its members have worked collaboratively for the past two years to examine how SNP and MA plans' performance on Star measures is impacted by the dual status of their enrollees as well as by specific sociodemographic factors. Inovalon will be responding directly to CMS' RFI and will address, in detail, the analytic methods employed in its research and its results. Here, we include a summary of Inovalon's findings and a discussion of their policy implications. Inovalon's recent analysis responds directly to CMS' request for comparison of the effects of dual eligible and non-dual eligible status on performance ratings at the beneficiary level, controlling for plan-related factors.

Inovalon's analysis provides strong evidence that "demonstrates dual eligible beneficiaries have significantly different clinical, demographic and socioeconomic profiles compared to non-dual MA members that result in worse performance on a majority of the measures evaluated."[3] To summarize, duals are much more likely than non-duals to be: disabled as the original reason for Medicare entitlement; younger, female, and/or ethnically/racially diverse; and more likely to have chronic conditions that impact

[3] An Investigation of Medicare Advantage Dual Eligible Member Level Performance on CMS Five-Star Quality Measures, Part 1: Member Level Analysis, Inovalon, October 2014.

other health outcomes including alcohol/drug/substance abuse, anxiety and bipolar/major depression. Further, they are more likely to live in areas designated as shortage areas for primary care physicians and mental health professionals; have more emergency room visits, hospitalizations and admissions; and are more likely to take 7 or more different medications. They are more likely to live in large urban neighborhoods with median incomes below $20,000, with more than 40 percent of the households being single-person three-fourths of the population living below the Federal Poverty Level (FPL). Relative to their non-dual counterparts, fewer of the people in dual-eligible individuals' neighborhoods are married and own their own home and more than 40 percent of the households are single-person. Consistent with research demonstrating which SES and related factors significantly impact health outcomes, Inovalon found that "dual eligible members perform significantly worse than non-dual beneficiaries on a majority of quality measures evaluated, supporting the recent calls to redefine some measures to account for the greater risk of experiencing poor outcomes, especially among dual members with certain clinical, SES and environmental characteristics."

To respond directly to CMS' request for comparison of dual vs. non-dual performance within plans, Inovalon analyzed data for approximately 2.2 million Medicare Advantage members enrolled in 81 contracts and 364 individual plans in 2013.[4] Inovalon undertook a multivariate analysis comparing dual vs. non-dual performance on 18 Star and Star display measures statistically controlling for plan benefit packages (PBPs) in order to determine if there is a "within" PBP effect of dual status on measure performance such that dual status affects measure performance independent of plan level characteristics. Inovalon found that, within PBPs, dual-eligible beneficiaries' performance on a variety of measures included in the Star rating program is significantly different from that of non-duals. The Star measures included in the analysis are listed in Table 1.

Table 1: Star Measures and Star Display Measures Included in Inovalon Analysis

Measure Acronym	Measure Name
Star Measures	
ART	Rheumatoid Arthritis Management
BPD	Diabetes Treatment
HRM	High Risk Medication
MA-C	Medication Adherence for Cholesterol (Statins)
MA-D	Medication Adherence for Diabetes Management
MA-H	Medication Adherence for Hypertension
OMW	Osteoporosis Management in Women who had a Fracture
PCR	Plan All-Cause Readmissions
Star Display Measures	
AAP	Access to Primary Care Doctor Visits
AMM	Antidepressant Medication Management
BCS	Breast Cancer Screening
DDI	Drug-Drug Interactions
IET-E	Engagement of Alcohol or other Drug Treatment
IET-I	Initiation of Alcohol or other Drug Treatment
PBH	Continuous Beta-Blocker Treatment
PCE-B	Pharmacotherapy Management of COPD Exacerbation-Bronchodilator
PCE-S	Pharmacotherapy Management of COPD Exacerbation-Systemic Corticosteroid
SPR	Testing to Confirm Chronic Obstructive Pulmonary Disease

Before controlling for PBP, duals were found to perform significantly worse on 10 of the 18 measures and 6 of the 8 current Star measures with scores for duals between 2% and 16% lower than for non-duals. The measures on which duals performed worse than non-duals were: AMM, ART, BCS, DDI, HRM, MA-C, MA-

[4] The Impact of Dual Eligible Populations on CMS Five-Star Quality Measures: Controlling for Plan (PBP) Characteristics, Inovalon, October 20, 2014.

D, MA-H, PCR and SPR. Duals outperformed non-duals on 5 of the 18 measures, BPD, IET-E, IET-I, PBH, and PCE, and there was no statistical difference between duals' and non-duals' performance for the remaining three: AAP, OMW and PCE-S.

The next step in Inovalon's analysis involved multivariate analyses in which Inovalon sought to determine if differences in Star measure outcomes between duals and non-duals persisted after controlling for PBP. In other words, within the same plan, did duals and non-duals perform differently which would suggest that these differences are due to differences in the characteristics of dual and non-dual members rather than differences in the plans. This finding was further reinforced by additional analyses in which Inovalon controlled for both PBP and the percentage of duals enrolled in the plan to test the hypothesis that members enrolled in plans serving larger proportions of dual-eligibles perform worse.

In its multivariate analyses, Inovalon found that duals performed significantly worse than non-duals on 6 measures (consistently across 3 statistical models and three different samples that included different numbers of PBPs based on their % dual membership (and on 7 measures in the two largest samples evaluated). These measures included: BCS, DDI, HRM, MA-H, OMW, SPR and PCR. It is particularly noteworthy that a statistically significant difference was found for Plan All-Cause Readmissions (PCR) as this is the only measure included in the analyses that is case-mix adjusted for differences in beneficiaries' clinical characteristics. Even after risk adjusting for beneficiaries' age, gender and HCC risk factors, significant differences were found between the performance of duals and non-duals within the same plan with duals at higher risk for readmission compared to non-dual members. Duals performed better on just three measures: AAP, PBH and PCE-B in the two largest samples. These findings persisted when controlling for both PBP and percent dual membership. Further, percent dual membership was often insignificant suggesting that members' performance was not influenced by the proportion of duals enrolled. When percent dual membership was significant, it often positively impacted performance suggesting that higher percent dual membership had a positive effect on members' performance.

Together, these multivariate results show that individuals' dual status impacts performance on a substantial number of Star measures, after controlling for PBP. We believe these statistically significant results strongly support the need for risk adjusting performance measures either for dual status or for sociodemographic factors for which dual status acts as a proxy. Dual status may be the best proxy in the immediate term as more data is collected on related factors. Factors that we believe might offer better control for sociodemographic effects are neighborhood characteristics on income and educational levels that are collected at the zip code level by the U.S. Bureau of Census.

Policy Recommendations

Based on the thoughtful evaluation and rationale by NQF, the highly significant findings from Inovalon's study of duals and quality performance measurement, as well as the robust evidence provided by scientific literature regarding the impact of sociodemographic factors on health and healthcare outcomes, it is imperative that CMS take immediate action to account for members' sociodemographic characteristics in performance ratings.

Without CMS action, Star ratings for plans serving dual eligibles have the unintended consequence of presenting consumers and the general public with an inaccurate picture of their performance relative to others plans, compromising their ability to retain members and attract prospective enrollees. Moreover, plans serving dual eligibles will be financially penalized if the impact reduces their ratings below 4 stars, making it even more difficult to address the needs of their high-risk/high-need enrollees—Medicare's most vulnerable, highest-cost and fastest growing service groups.

In taking this position, we want to be clear that our intent is not to lower the standard of quality for dual-eligibles by masking disparities in outcomes, nor are we advocating that payments for beneficiaries with special needs be made without an expectation that plans respond to these needs with targeted interventions. Our position is simply that MA payment, policies, and performance measurement should *support, not penalize* SNPs for targeting and serving poor, frail, disabled and chronically ill beneficiaries.

We recommend that CMS consider the following short-and long-term strategies to account for the impacts of social determinants of health on the Star rating system.

1) **Short-term**: For 2016 payment year, and until Star rating and bonus payment methods are risk adjusted to account for the impact of sociodemographic factors associated with lower health and healthcare outcome, CMS should:
    - Immediately publish all feedback from the RFI on Social Economic Status.
    - Remove the approximately ½ Star rating penalty (per Inovalon estimate) in quality bonus payments for plans serving a disproportionate number of dual eligible beneficiaries until sociodemographic factors are adequately addressed in performance metrics.
    - Add dual status to the set of factors used in adjusting for the "plan all cause readmission" measure and the "hospital all cause readmission" measure.
    - Advance a national demonstration program through CMMI to identify interventions most effective in mitigating or eliminating the adverse effects of sociodemographic influences on achieving preferred outcomes for an identified set of clinical conditions. Participating plans would need to demonstrate they specialize in care of SES-vulnerable beneficiaries. They would be compensated for the added costs of serving an SES-vulnerable populations through an add-on payment to their established MA benchmark and be required to use such compensation to support implementation of targeted interventions. An evaluation design would be established to identify SES-related best practices.
2) **Long-term**: CMS should modify the Star rating program to permanently account for the effects of social determinants of health. It should:
    - Stratify Star measures to create comparisons of plans based on comparable enrollment, including strata based on special needs individuals.
    - Work closely with NQF to establish performance evaluation methods that account for social demographic influences through a combination of risk adjustment and inclusion of new metrics in performance ratings that accurately account for the adverse effects of various factors on health and healthcare outcomes.
    - Include more interaction terms that are significantly associated with low socioeconomic status in the CMS-HCC model, such as substance abuse and/or obesity, in order to recognize the impact of social determinants of health in MA payment.

Next Steps: Targeting Interventions to Eliminate Disparities

It is imperative that we also advance evidence-based interventions to mitigate or eliminate the adverse effects of certain social demographic factors. This requires a better understanding of the ***specific*** clinical and sociodemographic factors that lead to poor performance.

Using an extensive data set made up of members' demographic and clinical information, and market area data that can be used to characterize members' sociodemographic status, it is our understanding that Inovalon will seek to identify those specific member-level characteristics that drive differences in measure performance and provide recommendations for plans to develop interventions to reduce or eliminate their adverse effects. For example, in the case of Antidepressant Medication Management (AMM), the overall performance gap between duals and non-duals is 14%, but the gap is even greater for specific subsets of duals, e.g. those with a diagnoses of alcohol/drug/substance abuse and those who use between 1 and 6 different medications a year. This type of information, together with targeted interventions, is what's needed to address disparities in performance over the long term. These interventions will require commitment and likely additional resources on the part of plans. At a minimum, plans with greater numbers of dual eligibles should not be disadvantaged financially through the Star ratings.

To properly address sociodemographic disparities, we believe it's important to understand more fully why duals perform worse than non-duals on the following measures:

- Breast Cancer Screening (BCS)
- Drug-Drug Interaction (DDI)
- High Risk Medication (HRM)
- Medication Adherence for Hypertension (MA-H)
- Osteoporosis Management in Women who had a Fracture (OMW)
- Testing to Confirm Chronic Obstructive Pulmonary Disease (SPR)
- Plan All-Cause Readmissions (PCR)

We also think it's important to look more closely as to why duals perform better than non-duals on the following measures:

- Access to Primary Care Doctor Visits (AAP)
- Continuous Beta-Blocker Treatment (PBH)
- Pharmacotherapy Management of COPD Exacerbation-Bronchodilator (PCE-B)

While we have some initial thoughts about what is driving these relationships, additional consideration of these issues is warranted before final conclusions are drawn and recommendations developed regarding potential interventions that could improve outcomes. As a result, our plan is to address this issue over the next few months and share our observations with CMS once it is complete.

In sum, we greatly appreciate CMS' interest in receiving input on the link between social determinants of health and MA Star measures. The RFI has come at a critical time: the full financial impacts of the Star rating system begin in 2015, as the national quality bonus demonstration expires. We believe it is imperative that CMS take immediate action to address the Star rating impact of sociodemographic characteristics that vary considerably between duals and non-duals and encourage development of evidence-based interventions to address disparities stemming from them. We believe CMS actions will improve the accuracy of MA performance measurement and remove the jeopardy plans otherwise face in serving high proportions of dual eligibles and addressing health disparities.

Sincerely,

Richard Bringewatt
President, NHPG
Chair, SNP Alliance