

USC-BROOKINGS SCHAEFFER INITIATIVE FOR HEALTH POLICY

March 4, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services

Re: Advance Notice for Part C and Part D Payment Policies [CMS-2022-0021]

Dear Administrator Brooks-LaSure:

Thank you for the opportunity to comment on provisions of the 2023 Advance Notice of Methodological Changes for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (hereafter the advance notice). We applaud the emphasis being placed on improving quality measurement and exploring approaches to improving equity in the health care system. Our comments focus on two specific issues: (1) CMS' proposal to incorporate socioeconomic factors in the CMS-HCC risk adjustment model; and (2) the need to improve quality measurement related to substance use disorders in the MA program.

Using socioeconomic factors as predictors in the CMS-HCC risk adjustment model

The advance notice seeks comment on incorporating socioeconomic variables (e.g., enrollee ZIP code) into the CMS-HCC risk adjustment model. CMS suggests that this approach may help advance health equity, presumably by increasing risk scores for disadvantaged enrollees and thereby increasing MA plans' incentives to provide high-quality coverage to these enrollees.

However, there is good reason to believe that this approach would have the *opposite* of the intended effect. After accounting for the variables that are currently included in the CMS-HCC model (e.g., HCCs, age, and sex), Medicare enrollees living in low-income ZIP codes have lower spending, on average, than those living in higher-income ZIP codes.¹ Thus, including ZIP-code-level income in the risk adjustment model would tend to reduce risk scores for enrollees in low-income areas, weakening plans' incentives to appeal to these enrollees. While these findings are for ZIP-code-level income, they plausibly extend to other socioeconomic variables as well.

Importantly, these findings do not contradict evidence demonstrating that lower-income people tend to be in worse health.² Rather, they indicate that people of a given health status (as measured by the variables in the CMS-HCC model) who live in low-income areas use less health care than people of comparable health status who live in higher-income areas. There are many factors that may contribute to this pattern. Notably, people in low-income areas may have more difficulty accessing care, perhaps because fewer health care providers are located nearby, because they have lower levels of trust in the health care system, because they have less access to transportation, or because cost-sharing is a greater financial burden for people with lower incomes. MA plans' efforts to profit

¹ Savannah L. Bergquist et al., "Data Transformations to Improve the Performance of Health Plan Payment Methods," *Journal of Health Economics* 66 (July 1, 2019): 195–207, <https://doi.org/10.1016/j.jhealeco.2019.05.005>.

² See, e.g., Raj Chetty et al., "The Association Between Income and Life Expectancy in the United States, 2001-2014," *JAMA* 315, no. 16 (April 26, 2016): 1750–66, <https://doi.org/10.1001/jama.2016.4226>.

from this pattern by attracting more low-income enrollees may also be one reason that low-income enrollees disproportionately opt for Medicare Advantage over traditional Medicare.³

In light of this evidence, if CMS' objective is to improve health equity, adding socioeconomic variables to the risk adjustment model will often be counterproductive.⁴ This is an illustration of the more general point that improving the risk adjustment model's statistical performance will not always make risk adjustment more effective at improving market outcomes and, conversely, that making risk adjustment more effective at improving market outcomes will sometimes require making changes that worsen the model's statistical performance.

Different modifications to risk adjustment could potentially help CMS achieve its goals. CMS could consider increasing risk scores for the enrollees of interest on an ad hoc basis. Another strategy would be to make upward adjustments to the spending data used to fit the risk adjustment model for enrollees in the targeted group *in combination* with adding socioeconomic predictor variables.⁵ If implemented appropriately, this approach would increase the risk scores of the targeted group, as desired. We do not affirmatively recommend any specific approach here, but these are the types of approaches CMS would need to explore to achieve its goals.

Quality measurement and substance use disorders

We believe that CMS should rethink its overall approach to quality measurement in MA as it relates to substance use disorder (SUD) care. We are in the midst of an opioid epidemic as well as an emerging crisis in stimulant misuse and over 100,000 people lost their lives to drug overdoses during 2021. But the vast majority of people with SUDs get no treatment. The 2016 Report of the Surgeon General on Substance Use Disorders reported that just 10% of people with SUDs get any treatment for their condition.⁶ In the case of opioid use disorders (OUDs), only 20% of people with these conditions get treated.⁷ Of those that get treated, only 34% get treated with an intervention that is likely to work for them.⁸ Yet, despite evidence that health plans have often gone to great lengths to avoid enrollment by people with SUDs—including by limiting networks, erecting administrative barriers, and imposing high cost-sharing—the tools Medicare Advantage has in place to promote better treatment for SUDs are extremely limited.⁹ We recommend that CMS change its approach in two ways.

Develop additional MA quality measures related to SUD care

To start, CMS should develop additional MA quality measures related to SUD care. The single existing MA quality measure related to SUD care is the Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) measure, for which the advance notice proposes some minor technical changes. Broadly, the IET measures the percentage of people with a medical claim that includes a SUD diagnosis who

³ Gretchen Jacobson et al., "Medicare Advantage vs. Traditional Medicare: How Do Beneficiaries' Characteristics and Experiences Differ?" (Commonwealth Fund, October 14, 2021), <https://doi.org/10.26099/yxq0-1w42>.

⁴ A caveat is that if plan marketing efforts currently cause some enrollees who would be better off in traditional Medicare to opt for MA instead, then reducing MA plans' incentives to attract enrollees with socioeconomic disadvantages could, paradoxically, benefit these enrollees. Regardless, we presume that this would not be CMS' goal in making this change.

⁵ Bergquist et al., "Data Transformations to Improve the Performance of Health Plan Payment Methods."

⁶ Substance Abuse and Mental Health Services Administration (US) and Office of the Surgeon General (US), *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*, Reports of the Surgeon General (Washington (DC): US Department of Health and Human Services, 2016), <http://www.ncbi.nlm.nih.gov/books/NBK424857/>.

⁷ Carlos Blanco et al., "Probability and Predictors of Treatment-Seeking for Prescription Opioid Use Disorders: A National Study," *Drug and Alcohol Dependence* 131, no. 1 (July 1, 2013): 143–48, <https://doi.org/10.1016/j.drugalcdep.2012.12.013>.

⁸ National Academies of Sciences Medicine Engineering, and et al., *Medications for Opioid Use Disorder Save Lives* (National Academies Press, 2019).

⁹ Geruso M, TJ Layton, Selection in Health Insurance Markets and Its Policy Remedies, *Journal of Economic Perspectives* 32(4)t:23-50, 2017.

have a subsequent visit or interaction with the treatment system for that condition. For two reasons, this measure provides a very incomplete picture of MA plans' performance in connecting people with SUDs to care.

First, the IET misses people with SUDs who never use services and therefore do not receive a diagnosis, so a plan can perform very highly on the IET while failing to ensure that most people who need treatment receive it. Epidemiological survey evidence makes clear that this is likely a major problem.¹⁰ Second, the IET takes no account of whether the treatment that people receive is appropriate. In light of the high prevalence of interventions that are not supported by evidence of effectiveness, which was noted above, this is a serious limitation.

We recommend that CMS develop two new types of measures. First, CMS should develop measures that reflect the share of *all plan enrollees* (rather than just plan enrollees with documented SUDs) who are receiving SUD care. This measure's broader denominator would avoid the first key problem of the IET. While it would have its own downside of failing to adjust for differences in SUD prevalence across plans, we believe it would offer a useful complement to the IET while better approaches are developed. Second, CMS should consider developing measures for OUDs and possibly Alcohol Use Disorders that would only count evidence-based treatments such as Medication for Opioid Use Disorders in the measure numerator.

Incorporate SUD measures into the Star Rating system

Over the longer-term, we believe that CMS should seek to incorporate quality measures related to SUD care into the Star Rating system in order to strengthen MA plans' incentives to facilitate access to this care. We acknowledge that including these measures in the Star Rating program would dilute the weight placed on existing measures. However, given the magnitude of the deficiencies in SUD care, we believe that cost is worth bearing.

We also note that incorporating the existing IET into the Star Rating program is not advisable. Because of the limitations of the IET described above, attaching financial incentives to the IET would reward conduct that does not promote access to evidence-based treatment. In fact, it may cause plans to discourage enrollees from seeking out SUD diagnoses or encourage enrollees to use ineffective treatments. The new measures we describe above would avoid some of these problems, but they would also have the potential to create some unintended incentives, which would need to be carefully weighed. Nevertheless, we believe that developing SUD measures suitable for inclusion in the Star Rating program should be CMS' medium-term goal.

Thank you again for the opportunity to comment on the advance notice. If we can provide any additional information, please do not hesitate to contact us.

Sincerely,

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¹⁰ Bridget F. Grant et al., "Epidemiology of DSM-5 Drug Use Disorder: Results From the National Epidemiologic Survey on Alcohol and Related Conditions—III," *JAMA Psychiatry* 73, no. 1 (January 1, 2016): 39, <https://doi.org/10.1001/jamapsychiatry.2015.2132>.