

# Social HMO Consortium

## MEMORANDUM

To: Department of Health and Human Services  
Fr: Social HMO Consortium  
Re: Docket ID 2004S-0170  
MMA Section 1013: Priority Topics for Medicare, Medicaid and SCHIP Research  
Date: June 28, 2004

The Social HMO Consortium represents three health plans that have been participating in the first generation Social HMO demonstration program for 19 years and one plan that has operated a second-generation program for eight years (membership attached). We appreciate the opportunity to submit our recommendations on CMS research priorities for improving Medicare and Medicaid benefits. These recommendations are based on our collective experience in operating demonstration programs that target at-risk, frail and chronically ill Medicare beneficiaries, including those dually eligible for Medicaid.

### I. Background of Social HMO Demonstration

The Social HMO demonstration originally was authorized under the Deficit Reduction Act of 1984 and was expanded under the Omnibus Reconciliation Act of 1990. A primary goal of the first and second generation demonstrations has been to test financing and delivery systems that improve health care and related services for Medicare beneficiaries through enhanced screening and assessment, care coordination, and improved access to an expanded set of supplements to Medicare services from specified preventive and ancillary services to community-based care benefits such as adult day care, home care and supportive services, medical transportation, meals programs and other services that help beneficiaries remain independent in their homes. The first generation program has focused largely on preventing functional decline, helping people maintain independence in their homes, delaying or reducing costly nursing home placements and reducing fragmentation across the service continuum through care management. The second generation expanded the focus also to include the integration of a system-wide geriatric approach to care and enhanced linkages among chronic care case-management services and acute-care providers (Leutz, Ford et al. 2003).

### II. Recommendations on CMS Research Priorities

Our goal in submitting the research recommendations outlined below is to continue building upon the knowledge we have acquired regarding the needs of vulnerable Medicare beneficiaries and improving the way we finance and deliver services to meet these needs. We have divided our recommendations into five categories: Medicare payment, care coordination and expanded care services, the Medicare pharmacy benefit, best practices in geriatric care and benchmarking.

- A. **Medicare Payment:** The new CMS-HCC risk adjustment methodology and frailty adjusters represent a vast improvement over the original demographic payment model for Medicare managed care plans. This methodology, however, continues to overpredict risk for the lowest risk beneficiaries and underpredict risk for the highest risk population. Additional payment research is warranted to enhance payment accuracy and promote the development of managed care models for high-risk populations. Managed care payment systems offer the greatest

flexibility in matching individual beneficiary needs with appropriate care and services. Given the range of needs for high-risk beneficiaries and certain limitations on basic Medicare benefits, capitated payment systems, if appropriately risk adjusted, hold great promise for enhancing beneficiary outcomes.

1. **Risk adjustment.** Continue refining the CMS-HCC risk adjustment methods, including the frailty adjustment, to improve payment accuracy for the highest-risk populations.
  2. **Frailty factors.** Evaluate whether the inclusion of new frailty factors, such as those identified by Fried and others (e.g., generalized weakness, poor endurance, slow gait speed) could help explain unexplained variation in risk that is not accounted for by diagnostic and functional data to improve payment accuracy for high-risk Medicare beneficiaries. Also identify refinements to the Health Outcomes Survey and Medicare Current Beneficiary Survey to capture new frailty factors in FFS and managed care data.
  3. **Pharmacy risk adjustment.** Evaluate which diagnoses, conditions or combinations of conditions generate greatest drug use and costs and the adequacy of Medicare Advantage pharmacy risk adjustment relative to these costs.
  4. **Capitated payment.** Evaluate the effect of capitated payment methods on medical practice and outcomes for frail elderly, disabled and beneficiaries with comorbidities. Determine whether a capitated approach result in different practice patterns or care and treatment decisions and, if so, how these decisions affect health outcomes.
- B. **Care Coordination and Expanded Care Services:** CMS has administered a number of demonstrations and research projects related to care coordination and supportive services for Medicare and Medicaid beneficiaries. It would be useful to study the impact of these benefits on specific health outcomes and quality of life for Medicare beneficiaries.
1. **Institutionalization:** Study rates of admission to residential LTC, as measured by stays longer than 90 days, and/or ALOS (Fischer, Green et al. 2003). Include assisted living and foster care as categories. Examine the relationship to Medicaid spend down to determine if the availability of a coordinated community-based chronic care benefit reduces long-term institutional placements and/or lengths of stay and reduces Medicaid expenditures.
  2. **Impact on bad LTC outcomes:** Track frequency of (1) unmet need for ADL/IADL support, and (2) "bad things happening," e.g., not being able to drink when thirsty or to get to bathroom when needed (Allen and Mor 1997). It would be difficult for a plan without case management and/or HCBC benefits to affect these indicators, but a plan that had them should have an impact.
  3. **Caregiver stress, morbidity and mortality:** Measure caregiver stress re direct care and coordination. Stressful caregiving has been found to be related to spousal mortality (Schulz and Beach 1999).
- C. **Medicare pharmacy benefit:** The advent of a Medicare drug benefit will provide new data for evaluating clinical and economic outcomes related to pharmacy benefits.
1. **Polypharmacy outcomes.** Evaluate the relationship between polypharmacy and adverse outcomes for persons with multiple comorbidities. Are persons with multiple chronic

conditions at greater risk of adverse drug interactions and other medication errors as a result of taking multiple medications? Are certain drugs contraindicated or of lesser value for seniors? Are physicians and pharmacists appropriately trained on medication administration for frail seniors?

2. **Managed care enrollment and selection:** Evaluate the impact of the fee-for-service drug benefit on enrollment in Medicare Advantage plans. Does access to a fee-for-service benefit reduce beneficiary interest in managed care plans? Does it increase the risk of adverse selection for managed care plans by creating an incentive to enroll in managed care plans among beneficiaries with higher drug expenditures?
  3. **Health outcomes and spending.** Evaluate impact of the drug benefit on Medicare beneficiaries' health outcomes and the net impact on health care spending. That is, do improvements in health outcomes such as stabilization of acute conditions and reduction in hospital utilization offset the cost of drugs?
- D. **Best Practices in Geriatric Care:** The geriatric imperative facing our country demands that we identify effective clinical care for geriatric syndromes and chronic conditions. Upwards of two decades of targeted research on frail elders provides a valuable body of research for mining best practices.
1. **Evaluate the impact of geriatric influence on health outcomes.** Do geriatrically focused services reduce overall utilization and result in better health outcomes? Is a geriatric approach most effective for all beneficiaries or should these services be targeted to certain risk strata? Preliminary research at the Health Plan of Nevada suggests the need for a targeted approach. Further evaluation of geriatric medical practices is warranted.

Evidence from a preliminary study by Dr. Steven Phillips et al at the Health Plan of Nevada suggests that geriatric services are most effective for seniors at moderate risk for rehospitalization. A group of beneficiaries identified as moderate risk by PRA screening criteria were impaneled to two practices – one that only provides care for seniors and the other that includes multiple primary care providers with standard community-based practices. The study showed lower utilization of emergency room visits, hospital bed days and office visits for the geriatric only practice, greater use of skilled nursing days, home health referrals and domiciliary visits and overall cost savings of \$760 per member per year for the geriatric-only practice over the traditional primary care practice.

2. **Identify best practices in geriatric care .** CMS has conducted numerous demonstrations in the past two decades testing various financing and clinical approaches for improving care and outcomes for high-risk Medicare beneficiaries. The first generation and Social HMO models focused largely on approaches to prevent or delay nursing home placement. The second generation Social HMO and Evercare focused on geriatric approaches to aggressive primary care for community-based and institutional populations, respectively. Dual eligible demonstrations are exploring strategies for integrating Medicare and Medicaid financing and administration to simplify access to care and reduce administrative inefficiencies. Several care management and disease management programs are in various stages of testing. While CMS did not establish a consistent approach to the evaluation of these programs, there is much to be learned from a review of best practices identified through these demonstrations.

3. **Measurements for vulnerable elders:** Developing population based definitions and measures for high-risk Medicare beneficiaries remains an elusive science. Identifying population characteristics that help target vulnerable populations is critical to targeting appropriate clinical interventions, assuring accurate payment methods and effectively evaluating plan and provider performance.
  - a. **Evaluate and enhance clinical knowledge about the relationships among frailty, disability and comorbidities.** Research conducted by Dr. Linda Fried et al at Johns Hopkins University suggest that frailty, disability and comorbidities are distinct, but highly interdependent clinical entities (Fried, Ferrucci et al. 2004). They recommend improving our ability to distinguish among these entities, refining their definitions and criteria, developing standardized approaches to screening and risk adjustment and ongoing exploration of interventions to prevent onset and adverse outcomes for each condition. They suggest that, due to causal relationships and co-occurrence of these conditions, our ability to differentiate these conditions and target therapies will help enhance outcomes and potentially prevent one condition from causing or exacerbating another. Of special interest is (1) further evaluation of frailty indicators (e.g., generalized weakness, poor endurance, weight loss, low physical activity, slow gait speed) and the establishment of a generally accepted definition of frailty (e.g., a specified number of defined indicators); (2) evaluation of the accuracy of current risk adjustment methods, including the frailty adjuster, in predicting frailty-related risk and costs; and (3) evaluation of best practices for preventing or delaying the onset of frailty and disability (Fried et al, 2004).
  - b. **Evaluate geriatric care criteria:** Track how well plans meet ACOVE criteria for appropriate geriatric care for patients with chronic illness and complex care. The criteria, developed by the American College of Physicians Task Force on Aging, cover medical care and coordination (<http://www.acponline.org/sci-policy/acove>). Also (Shekelle, MacLean et al. 2001; Wenger and Shekelle 2001; Westropp 2002). Assess the value of expanding the criteria to include interventions related to LTC/community care.
  - c. **Evaluate impact of disability on enrollment and disenrollment patterns.** Track rates by functional status. New analyses of Social HMO data are showing that the disabled are an increasing percentage of new enrollees and that disabled are less likely to disenroll than non-disabled.

**E. Benchmarking:** The lack of standard data collection and reporting requirements has made it challenging to conduct comparative research on health outcomes, costs and cost-effectiveness and impact of clinical interventions under various financing and delivery methods. A starting point for such research is to obtain baseline data using standard measures such as inpatient and outpatient utilization. To fully evaluate the performance of specialty plans and providers, alternative measures are needed that assess plan performance in relation to the unique health problems and needs of high-risk populations.

1. **Hospital, skilled nursing facility and home health use:** Conduct comparative analysis of rates of admission, lengths of stay, total days/units among fee-for-service, Medicare Advantage plans and Medicare Advantage Special Needs Plans.

2. **Performance measures for high-risk beneficiaries:** Identify which population characteristics (e.g. demographics, diagnoses, functional impairments, frailty factors) should be used to produce a comparative analysis of cost and quality across specialty plans. Identify risk factors unique to high-risk beneficiaries. Develop an alternative performance evaluation system based on related measures.
3. **Interventions and costs for seniors vs. disabled Medicare beneficiaries.** Evaluate differences in the health care needs of over-65 seniors and under-65 disabled Medicare beneficiaries, including predominant diagnoses, services used, utilization levels and costs.

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If you have any questions, please feel free to contact Valerie Wilbur, Social HMO Policy Director (202-624-1508), Walter Leutz, Social HMO Research Director (781-736-3934) or any of the site directors listed in the attachment.

### **Endnotes**

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