



SNP Alliance Position Statement

MAY 2019

Social Determinants of Health and Complexity Factors Affect Special Population Quality Measurement: Issues & Recommendations

Special Needs Plans Described

Special needs plans (SNPs) are authorized and designed to meet unique needs of Medicare beneficiaries with high care and condition complexity. SNPs have additional requirements beyond general Medicare Advantage. For example, they conduct health risk assessments, submit a Model of Care, use tailored interdisciplinary care team and care management approaches, and coordinate an extensive service array within provider networks. Most of their beneficiaries are dually-eligible for Medicare and Medicaid.

Problem Statement

The SNP Alliance supports quality measurement to assess and improve care for Medicare beneficiaries. However, the current MA quality management system resulting in Stars Ratings *does not adequately take into account the underlying effect of characteristics of the beneficiary population which impact outcomes.* There is evidence that some of the Medicare Star *quality measures and methods used are not well-matched* to this complex and diverse population.

Three Priority Issues:

#1 Some Measures not Well-Matched- Some measures have not been adequately tested in the diverse, complex, and high SDOH groups and there is evidence they are not well-matched. The resulting scores (such as the PCS and MCS generated from the *Health Outcomes Survey*) may not provide useful information.

#2 Limited Methods & Adjustments – Methods to collect data and conduct adjustments have limitations which are more likely to negatively impact high Dual special needs populations

#3 No Stratification of Results – Because all types of plans are combined in one group (results are not separated into plan cohorts based on the populations characteristics of enrolled groups or by geographical area), inequities arise in how the Star ratings are

calculated and reported. Without stratification, the consumer may make inaccurate conclusions when they seek a health plan.

SDOH - Social determinant of health (SDOH) risk factors include poverty, housing instability, low education level, living in a poor neighborhood, lack of adequate food or transportation, or social isolation. These issues interact with mental health, chronic conditions, and physical and functional limitations which are characteristic of special needs populations.



SDOH risk factors affect what can be done, when, and how. Clinicians, behavioral health providers, nurses, social workers, and others working primarily with people who have significant social risk factors explain that, even when provision of medical care for conditions meets the highest standards of care or treatment guidelines, optimal health outcomes can be difficult to achieve.

BENEFICIARY SNAPSHOT:

“We have an average age of 82 years, 76% have a high school degree or less, 7% speak a language other than English, 72% are single, 85% live in a rural area, and 41% have an income of \$10,000/year or less.”

Expert Studies & Reports to Congress on SDOH/Duals

We have had ample study in the last five years. In the IMPACT Act of 2014, Congress recognized the potential effects of SDOH and dual eligible populations on the MA Star Ratings system by requesting studies on this population and the Medicare program at large.

RAND/CMS Study, 2015 - In September 2015 a RAND study commissioned by CMS found that a beneficiary's dual-eligible status significantly lowered outcomes on 12 of 16 Medicare Star Rating measures.

National Academies - In 2015 and 2016 the National Academies *Committee on Accounting for Socioeconomic Status in Medicare Value-based Payment Programs* conducted a thorough examination of socio-economic and social determinant of health risk factors. They discovered many impacted outcomes and should be taken into account in quality measurement and value-based payment. They released a series of 5 reports. See: [NASEM: SES-in-Medicare-Payment-Programs](#)

ASPE Study, December 2016 - This seminal *Report to Congress* found that dual beneficiary status was *the most significant predictor of poor health outcomes* as measured by the Medicare Star Ratings. Furthermore, dual status, low income status, and disability status, as well as specific SDOH factors examined impacted outcomes—*independent of provider or plan behavior*. This was found across the board—for all Medicare programs (e.g., hospitals, clinics, health plans, etc.). See: [ASPE.HHS - Report to Congress 2016](#)

HHS/ASPE/RAND Study 2018 – Another study under HHS and ASPE conducted by RAND in 2018 examined SDOH in Medicare Advantage and offered case examples of four exemplary health plans with best practice care strategies for complex chronic care populations—all four health plans featured are special needs plans and members of the SNP Alliance. See: [RAND SDOH MA 2018](#)

Additional Studies

SNP Alliance 2018 White Paper on HOS – Last year the SNP Alliance conducted a study on the *Health Outcomes Survey*—the instrument used to generate several measures in Medicare Stars. Findings provide compelling evidence indicating need for improvement. See: [HOS WHITE PAPER 2018](#)

Limitations include:

- *Diversity not fully Considered*
- *Instrument Limitations for People with Special Needs/SDOH*
- *Inadequate Methods and Administration*
- *Information Decay, Time Lag*
- *Proxy Bias*
- *Results Impacted by Characteristics of Enrollment*
- *Attribution, Context Issues*
- *Inadequate Models and Adjustments*
- *Analysis, Interpretation, and Reporting Cautions*

Ten options for improvement and recommendations were offered.

Response

Members of Congress have asked that the quality measurement and payment system better account for the clinical and socio-demographic risk factors that are out of a plan's control, arguing that MA plan performance measurement should accurately reflect challenges in caring for low-income, chronically ill people.

CMS Adopts CAI as Interim Adjustment - In response, CMS modeled two adjustment methods and implemented one (Categorical Adjustment Index or CAI) in 2016. Unfortunately, this has proven ineffective, given its scope and methodology. It has not corrected for the underlying characteristics of the populations in a robust way. In 2019 CMS signaled its intent to include additional measures in this adjustment in 2020.

No Minimum Standards

Currently, it is *the measure developer's responsibility* to determine if SDOH factors should be accounted for—if the methods, instruments, and specifications of their measure should be adjusted. There are no minimum guidelines for: (1) the sample size and composition (e.g., oversampling diverse groups), (2) the SDOH data set and sources, (3) appropriate risk adjustment testing/models, (4) specific analytic methods, or (5) reporting and disclosure of full findings. In their 2017 report the National Quality Forum Disparities Committee found substantial variability in measure development and testing for SDOH factors and attention to health equity in measurement. They also found little stratification of results by population subgroups. See: [NQF Disparities Final Report 2017](#)

Special Needs Plans' Responding to SDOH

Two recent surveys of health plans by the SNP Alliance (2017 and 2018 Annual Survey), found that many sources of information are being used to understand the social risk issues in their enrolled groups. These data are being collected, accessed, and reviewed to: better define needs, identify those most at risk, and initiate more proactive outreach to affected individuals.

The SNP Alliance Survey discovered plans are using multiple sources to locate social risk factor information on their members in order to proactively reach out, tailor care strategies and avoid negative outcomes.

Sources of SDOH information reported included:

- Health risk assessments (HRA)
- Internal care management records
- Member services information gathered through phone contact
- Claims data, encounter data, including ICD-10 “z” coded visits
- Member surveys
- Initial member enrollment forms
- Medical record information from providers
- External care management records
- State long-term services and supports data
- State Medicaid data
- American Community Survey data
- Census data
- County data, county health rankings
- Community (regional) health assessments

The SDOH and clinical factors have a much bigger impact for members with mental/behavioral health and dementia co-morbidities.

Once a set of risk factors are identified, this is combined with information about care complexity issues (medical, behavioral health issues). Plans then engage their own plan managers or delegated care coordinators to work together with others at the clinic, county, social service agencies, to work across primary, acute, long-term, rehab, home/community, and mental health settings and engage the person. The intent is for earlier identification, outreach, and

engagement of the individual to be proactive and marshal resources of all involved.

Collaboration & Partnerships

Special needs plans are working in partnership with others, including service providers and non-traditional sectors (e.g. housing, education), to address SDOH issues in their communities. In the 2017 *SNP Alliance Annual Member Survey*, a high number of health plans said they had a collaborative partnership underway addressing one or more social risk areas. Areas for partnership are shown below.

Area of Focus for Partnerships:

- Food insecurity/nutrition (71%)
- Transportation (57%)
- Social support (57%)
- Health Literacy (50%)
- Housing (36%)

Recommendations:

We now have *multiple independent studies* showing that social determinants of health, and specifically *dual status as a proxy*—significantly affects Medicare Star measure results. This, in turn, disproportionately negatively impacts health plans with high Dual/disabled/SDOH populations. Thus, plans who have these complex populations are less likely to look like top Star performers—even if they have implemented additional care outreach, service, and support strategies.

Thus, special needs plans and others such as safety net hospitals, low-income federally qualified health clinics (FQHCs), and other providers particularly serving these populations are likely to be negatively affected.

Given these findings and the analysis of independent researchers, we urge Congress and CMS to support policy and regulatory action to address the three priority issues raised:

1. ***Re-examine self-reported HOS surveys and methods*** for special needs groups, such as people with low education, linguistic diversity, SDOH risk factors, or significant condition complexity such as memory impairment, frailty, end-stage conditions (see the full White Paper for specifics).
2. ***Issue guidelines for Star measure developers and stewards*** to re-test their measures for effect of SDOH/SES factors, including dual status, disability status, and low-income status at the smallest neighborhood level geographic unit. Guidelines should specify a minimum sample size that includes oversampling of the Duals, a defined set of social risk factors to be tested, the accepted methods for design and analysis, and results should be reported separately between the Duals and non-Duals tests. All findings should be reported.
3. ***Stratify Populations into High Dual/Low Dual Groups to Compare Quality Ratings for Similar Beneficiary Populations*** –Using Dual-eligibility and Disability status as a proxy for social risk factors and other characteristics coupled with geographic reporting—stratify Star rating scores. This will provide essential information in understanding the results. Comparability of similar plans in terms of enrollment and geography will greatly enhance meaning around measurement results and provide the consumer with better information for decision-making.