SNP Alliance

The National Voice for Special Needs and Medicare-Medicaid Plans

A National Nonprofit Leadership Organization

Performance Evaluation Quality Leadership Group

Call: June 1, 2022

Focus on: Health Equity

Deborah Paone,
DrPH, SNP Alliance

- **Level-set on new Health Equity focus**
- **Discuss comments we provided to CMS**
- **Share SNPA plans' feedback on current status of Health Equity**

Health Equity is not "Everyone gets the same thing"

Equality means giving everyone the same thing, whereas equity means giving people what they need to reach their best health.

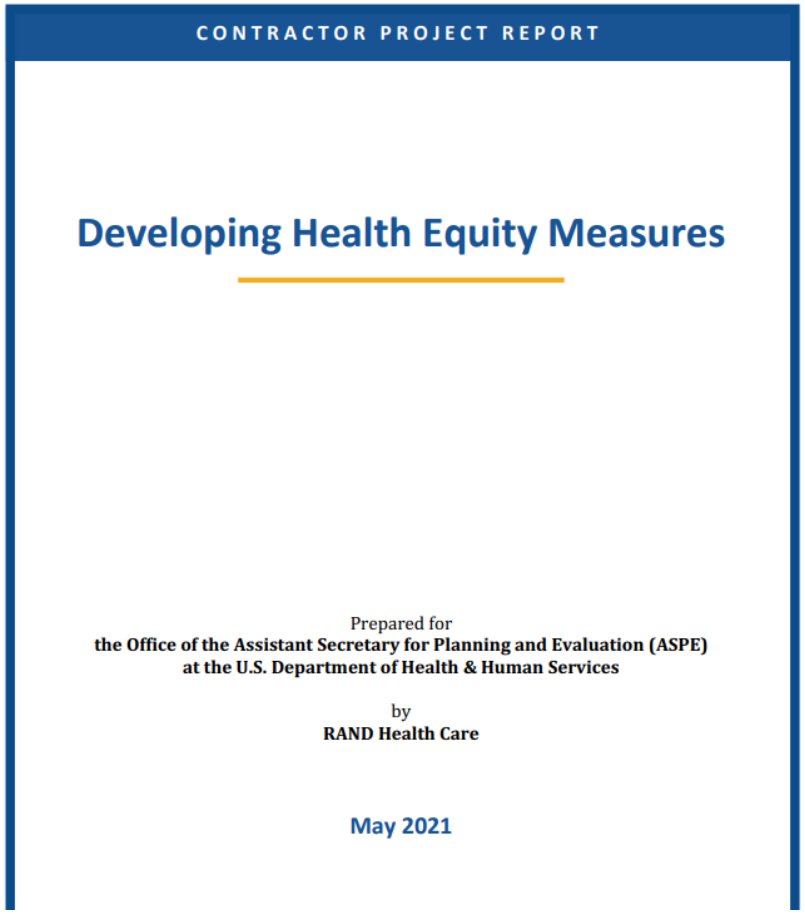
The different heights of the people represents the unequal distribution of the social determinants of health in society.

CMS Framework for Health Equity 2022–2032

[CMS Framework for Health Equity 2022–2032]

CDC Definition [Health Equity | CDC]

Health equity is achieved when every person has the opportunity to “attain his or her full health potential” and no one is “disadvantaged from achieving this potential because of social position or other socially determined circumstances.”



Based on input from RAND, ASPE, and the TEP, in this report RAND defines a health equity measurement approach as "an approach to illustrating or summarizing the extent to which the quality of health care provided by an organization contributes to reducing disparities in health and health care at the population level for those patients with greater social risk factor burden by improving the care and health of those patients."

Level-set on Health Equity Focus by CMS

CMS has been exploring ways to advance health equity such as:

- Expanding current stratified reporting efforts
  - Providing stratified data by disability, LIS/DE status through confidential reports in HPMS to MCOs and sponsors
- Developing a health equity index (HEI) that summarizes contract performance among those with social risk factors across multiple measures into a single score
  - Goal is to improve health equity by incentivizing to perform well among socially at-risk beneficiaries
  - Initial focus on LIS/DE status and disability
- Adding to the HRA requirement on SDOH risk factors
  - Potentially develop a measure focused on assessment of an array of enrollees' health-related social needs using a standardized screening tool
  - NCQA is developing a measure assessing screening and referral for unmet food, housing, and transportation needs

Health Equity Index - CMS

Health Equity Index (Part C and D) (p. 106 Advance Payment Notice CY2023) –

"CMS is developing a health equity index as a methodological enhancement to the Star Ratings that summarizes contract performance among those with SRFs across multiple measures into a single score. Disability and LIS/DE status would be included in the health equity score. CMS is considering other variables as well, such as the Area Deprivation Index.

The goal is to improve health equity by providing incentives for plans (contracts) to perform well for socially-at-risk beneficiaries.

The Health Equity Index would look at a subset of the Star Rating measures, such as measures included in CAI and CAHPS measures.

The distribution of performance for each measure would be separated into thirds and the top third would receive 1 point, the middle, 0, and the bottom -1"

SNP Alliance PE/Quality Group – Comments on the Advance Notice around Health Equity

SNP Alliance Comments: The SNP Alliance strongly supports health equity goals. We support development of a health equity index and approach. We see a connection between better understanding of social risk factors (and complexity characteristics) of an individual and understanding what barriers the person faces in achieving optimal health. From an individual-level understanding, this can inform macro-level change—to move toward achieving better health equity at a population level.

Special needs plans report many collaborative efforts with others in their communities to address deficits in housing, food, and other services.

SNP Alliance PE/Quality Group – Comments on the Advance Notice around Health Equity

SNP Alliance Comments: We would appreciate CMs providing additional information to guide analysis of the methods and potential impact/utility. We would like to understand the methodology of this Health Equity Index.

One concern is that the measure methodology (the variables within the model and the categorization of plans based on characteristics and proportion of enrollment) would not be sensitive enough to accurately assess plan performance nor divide/stratify the plans.

A second concern is around which measures are chosen. We recommend that CMS begin with the measures most directly under health plan control and test out the methodology. These could include:

- Rating of health plan
- Complaints about the health plan
- Members choosing to leave the plan

SNP Alliance PE/Quality Group – Comments on the Advance Notice around Health Equity

SNP Alliance Comments:

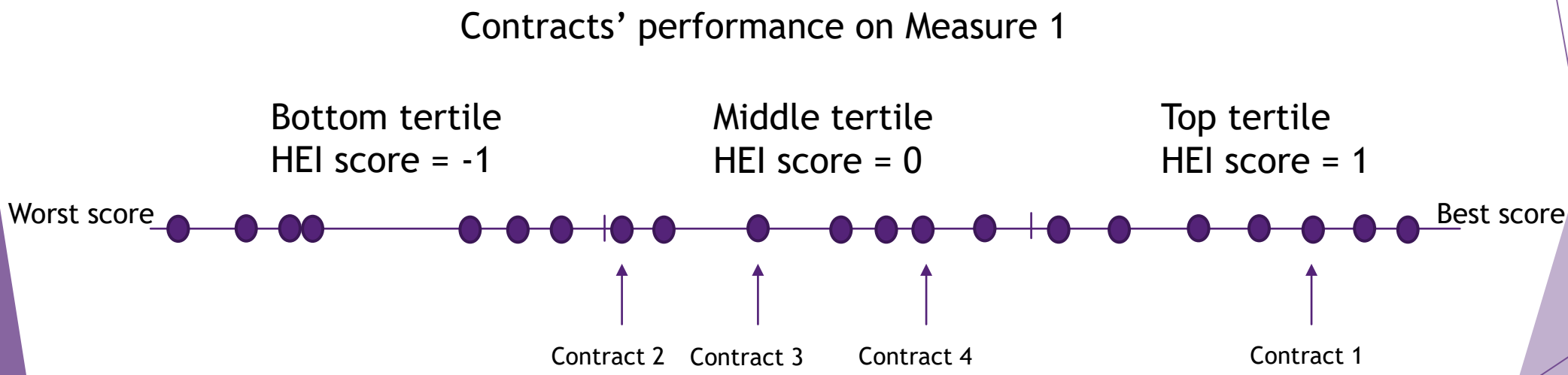
A third concern is around combining measure results into a single score – composite scores have the disadvantage of washing out high and low values or otherwise muddying clarity. Therefore, we lose key information around actual performance on each measure for the socially at-risk or other beneficiary groups.

How would the health equity index (HEI) work?

- Focus on a subset of Star Rating measures
- Contracts meeting denominator and reliability criteria for individual measures would be ranked by unrounded LIS/DE/disabled scores for each measure
  - Top tertile receives score of 1
  - Middle tertile receives score of 0
  - Bottom tertile receives score of -1
- Contracts receive a HEI score if they meet the inclusion criteria for at least 50% of measures included in the HEI
- LIS/DE/disabled scores on individual measures averaged across measures in HEI using Star Ratings measure weights
- Contract receives HEI reward if exceeds performance threshold and at least a certain percentage of contract's enrollees are LIS/DE or disabled

Simplified example of calculating HEI scores and rewards (assumes only 4 measures used)

- Contract performance among LIS/DE and disabled beneficiaries is compared to other contracts for each measure



SNP Alliance PE/Quality Group – Comments to NCQA on Stratification by Race & Ethnicity in HEDIS

SNP Alliance Comments: SNP Alliance is very supportive of advancing health equity and improving the utility of measurement results to understand special population groups and help guide improvement efforts. We support stratification but note some recommendations:

(1) Add Dual, Disabled, Low Income Status and Language to Race & Ethnicity as a variable for stratification (2) NCQA/CMS Transparency. Findings must be published and available. (3) R/E data is not routinely available or transmitted to health plans; CMS must provide these data prior to stratification.

(4) Select measures where there is evidence of disparities and where there is at least emerging effective practice to address such disparities.

(5) Effective practices require efforts across sectors—to impact outcomes and improve health equity. (6) Show trends – disparity gaps over time. (7) Information must have utility and be able to inform improvement. (8) If a beneficiary refuses SDOH screening or service/care, then this contextual information must be part of the evaluation.

PE/Quality Group – conducted a "Mini-survey" with 3 key Health Equity questions posed:

Q: Does your health plan evaluate health disparities/health equity? How? What is it doing? Is this specific to your SNP?

A: Some plans say "yes," some say "not at the SNP product level"

Those with multiple products said they are not doing so specifically for their SNP – more commonly for specific target groups such as separating out by race and ethnic group and assessing experience of care, screening rates for preventive screenings and care engagement and follow up for certain target conditions (e.g., Diabetes, Alcohol/substance treatment, Depression). All that commented said they compare the rates to the White population and baseline disparity gaps observed to see changes/trends over time.

Some plans mentioned analyzing health disparities also based on SES, and region of residence.

One plan mentioned first describing discrete subpopulations within their full Dual SNP, and examining experiences and considering variables "upstream" including SDOH factors. This allows the plan to get at root causes which might be driving the gaps and then develop initiatives that focus on these root causes.

PE/Quality Group – conducted a "Mini-survey" with 3 key Health Equity questions posed:

Q: Are you stratifying your quality measure results? If so, how (for example: by Race/ethnicity? Language? Dual status? Disabled status? Other?)

A: Most plans are stratifying or examining some of their quality measure results by some variables/sub-populations.

Plans often mentioned HEDIS measure data used when conducting stratification – one plan reported this has not shown much difference.

Examples of variables for stratification:

- Age
- Gender orientation
- Race, Ethnicity
- Language
- Income (LIS)
- Dual status
- Disability status
- Mental health diagnosis
- Homelessness status
- Product
- Provider network
- Zip code, county, other geographic unit

PE/Quality Group – conducted a "Mini-survey" with 3 key Health Equity questions posed:

Q: How do you know if you're making progress?

A: Plans most often mentioned that they do an annual review. They discussed an "annual population assessment" of some sort that informs the plan on additional design/redesign, targeting, intervention and quality improvement planning, and other strategies to address the gaps.

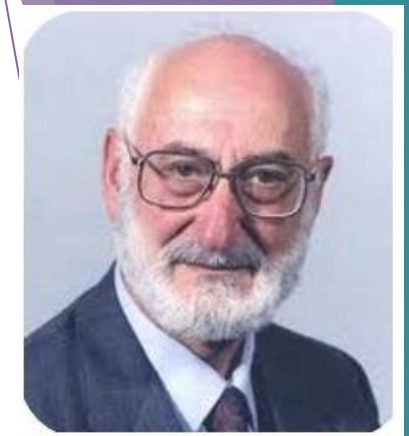
Some plans mentioned health equity dashboards and other tools to identify, target, monitor, and evaluate.

Some plans mentioned a formal QIP evaluation comparing performance metrics against historical data and targets, so that there is awareness within the enterprise of real improvement longitudinally and relative improvement vs. comparison groups and the general population.

We've identified several considerations for SNPs in measuring and addressing health equity

- **Who to focus on? – Defining the Groups** – There are many and diverse characteristics across SNP enrolled members on which plans could focus. Beneficiaries have multiple "vulnerabilities" – complex multiple chronic conditions, behavioral health needs, long term services and support needs, frailty, functional status – all important; Many options for which group to select .
- **What to measure? – Selecting meaningful, appropriate measures –** Target biggest gaps? Largest group? Once you decide – what measures/outcomes/disparities are the most important? To whom? There are practical considerations.
- **Where to get good data for analysis**? – Race, ethnicity data is not easily available; existing measurement data may not have the volume to support analysis
- **What is within health plan control/influence?**. Many things influence outcomes. What will the plan focus on? What it within its control or influence? Since racial, ethnic, language, cultural differences impact where, when, how, what care is delivered—how will these be taken into account in strategies/interventions. These differences require tailored approaches. Achieving optimal health outcomes requires resources and collaborative efforts across plan, provider, and community

The 5 “A’s” of Quality- *Address each of these to readjust the environment and tailor interventions to help people reach that “full health” potential and quality outcome being measured*



1. ***Availability*** – ***Is the service/care needed by the person*** (to reach the quality outcome being measured) ***in the community?*** (Is it there at all and if so, how widely available)
2. ***Accessibility*** – ***Is the service/care accessible to the person?*** (can the person get there, can they get in, hours/place/set-up – physical, technological, processes, for example, if functionally limited, is there assistance getting in the door, around within the facility, if tele/tech is required, does the person have access to the equipment needed?)
3. ***Affordability*** – ***Can the person afford the service/care?*** (not only financially, but in terms of what does it cost them in time away from work, time to get there, other direct and indirect costs of using the service).
4. ***Accommodation*** – ***Does the service accommodate the person? (***Has the service entity addressed how to accommodate differences arising from language, culture, literacy, education, health beliefs and other ethnic or racial considerations. Does the service accommodate people who cannot tolerate long wait times, are vision or hearing impaired, or other characteristics that need accommodation?)
5. ***Acceptability*** – ***Is this service acceptable to the person related to his/her/their primary health concerns and priorities***? (Is the provider and other aspects of the service acceptable to the person and does it take into account the preferences and values of the person?)

Source: Derived and adapted from work of Dr. A. Donabedian (1980, 1983, 1981) by D. Paone

Additional resources for HE and SDOH/SRS

Link:https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf

ASPE
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF HEALTH POLICY

REPORT
April 1, 2022
HP-2022-12

Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts

Amelia Whitman, Nancy De Lew, Andre Chappel, Victoria Aysola, Rachael Zuckerman, Benjamin D. Sommers

Summary and on the Horizon:

- Plans indicate they are at least annually looking at measure disparities. Based on this initial mini-survey, they may need to do more/devote more resources to this.
- CMS **will issue Health Equity Index Measure**- part of QBP program
- CMS– OMH continues **to issue quality measure results based on Race & Ethnicity –** shows disparities/gaps
- **NCQA is working on Health Equity measure concept**
- **NQF is working on Health Equity** (Deborah is on their TEP)
- If we **want to showcase SNPs** or if we want CMS (MMCO) **to understand and support best practices by SNPs *we need more detail.*** *Contact Deborah at the SNP Alliance dpaone@snpalliance.org and participate in PE calls.*

Further discussion and development:

-Participate in PE/Quality Leadership Monthly Call next one is June 8, 2022

-Engage in shared learning among SNPA plan members

-Respond to SNPA questions

-Participate in comment development

For more information:

Dr. Deborah Paone, Performance Evaluation Lead and Policy Consultant
dpaone@snpalliance.org