Account for Social Disparities in MA-SNP Payment

SNP Alliance Issue Brief

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Background

In 2003, Congress established Special Needs Plans (SNPs) to improve quality and cost performance in serving special needs persons in the Medicare program, including persons who are dually eligible for Medicare and Medicaid, persons living in institutions or in the community with similar needs, and persons with serious and disabling chronic conditions. Today, SNPs serve nearly 1.8 million persons in Medicare.

Over the past 10 years, Congress has added a number of new program requirements to ensure SNP benefits and services are differentiated from traditional Medicare and Medicare Advantage. The SNP Alliance continues to advocate for policy chances that reflect the specialty care mandate of Congress. This includes accounting more fully for the unique needs of SNP enrollees in MA-SNP payment and oversight.

Recently, the SNP Alliance looked at the degree to which social factors, and not just medical conditions, determine health outcomes (such as quality and cost) and the degree to which these factors are accounted for in MA-SNP payment and oversight. Research concludes that social factors related to socioeconomic status (SES), as measured by income, education, and occupational status) are so important to health outcomes they are deemed "social determinants" of health.

Following are major findings[1] from the analysis and recommendations for policy improvement.

Epidemiological Findings

Income, education, and occupational status, or SES, are major determinants of health, as are a host of related factors, such as health literacy. They can dramatically affect health outcomes, including costs and a person's health status. For example:

1) Persons with lower SES tend to have worse health outcomes (e.g., more chronic illness and mortality) than persons with higher SES, even after controlling for other factors.
2) The SES and other aspects of a person's neighborhood, such as crime, access to fresh produce and exposure to pollution, can have a dramatic effect on health.
3) Persons with a long history of substance abuse, family abuse, or mental illness have higher rates of serious illness and related care complexities than individuals without these conditions.

Key social factors linked to SES also affect how individuals use health care, independent of the effects of benefits and services provided. For example:

1) Individuals with limited health literacy use less preventive care and have a lower level of health engagement.
2) Plans and providers treating people with low socioeconomic status and related factors are likely to achieve poorer outcomes in treating a given illness using the same methods as caring for persons without those complications.
3) In most cases, needed interventions for outreach and care coordination must be more intensive and are therefore more costly than for a general population.

Current MA-SNP Payment

Medicare payment methods for MA-SNPs do not adequately account for social determinants, known to independently affect health and costs. This is particularly concerning for plans serving a high percentage of poor, high-risk/high-need enrollees. For example:

1) The MA-HCC risk adjustment model does not include socioeconomic factors most closely associated with adverse health outcomes, as it only adjusts for costs associated with an enrollees "Medicaid status"
2) MA-SNP payment accounts for differences in biological factors that affect cost of care, such as age and sex, and for distinct illnesses, but the MA-HCC model does not account for "downstream" social factors associated with socioeconomic status that are known to affect health outcomes, such as health literacy.
3) Payment for MA plans, based on Medicare FFS payments, does not account for added outreach and coordination activities needed to adequately treat a population that is challenged by the complications of social determinants of health, as Medicare FFS does not reimburse for them.

Health effects of social determinants are prevalent among plans and providers serving a high percentage of beneficiaries who are homeless, have severe and persistent mental illness, have a history of substance abuse, and/or HIV-AIDS. In particular:

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[1] Findings are based on analysis conducted by Shawn Maree Bishop under contract with the SNP Alliance. A copy of the full report, entitled *A Framework for Paying for Social Determinants of Health in Medicare*, October 2013, can be provided on request to the SNP Alliance.

1) Persons who are homeless have a vast array of psycho-social-environment problems that complicate the ability of plans and providers to provide consistent care without an extensive investment in outreach.
2) Persons with severe and persistent mental illness often have a limited ability to manage their disease, and are therefore more difficult to treat than an individual with the same illness, (e.g. diabetes) in the general Medicare population.
3) Persons with a history of substance abuse tend to be less medically compliant, often have increasing complex medical conditions, and often require an increased level of hospital care.
4) The disabled and persons with HIV-AIDS experience social stigma that complicates care and increases costs beyond expected Medicare FFS costs.

While these social circumstances only apply to a small percentage of Medicare enrollees, relatively modest changes could make a significant difference in the ability of plans and providers to address the health and wellbeing of beneficiaries who face them.

Policy Options

At least four different payment approaches could be considered as vehicles to better reflect social determinants of health in Medicare payment. They include:

- Modify MA risk and FFS case-mix adjustment
- Modify pay-for-performance (P4P) programs
- Establish new adjustment to payments
- Establish a separate "add-on" payment

1. Modify MA risk and FFS case-mix adjustment. Current MA risk and FFS case-mix adjustment incorporate person-level demographic and health factors into their models (such as age, sex, diagnoses, and comorbidities). The models could be modified to include individual social factors known to affect health. Medicare could collect better income data to create a more robust income variable for MA risk adjustment. Information about educational attainment could be added to MA risk and FFS case-mix adjustment. Alternatively, the models could be modified to include new conditions and to interact with more conditions that are strongly linked to socioeconomic status. For example, substance abuse could be interacted with other medical conditions such as heart disease. CMS could also add or interact indicators of obesity.

Modify pay-for-performance (P4P) programs. Only a handful of P4P quality measures are case-mix adjusted to control for an individual-level factors that affect health. Education is often the only SES variable included when Medicare case-mix adjustment of quality measures is made. Expanding case-mix to more measures and adding income and other social indicators to case mix would more fully control for the individual-level factors that affect health. Without adequate case-mix adjustment, P4Pwill penalize providers and plans that treat populations with lower socioeconomic status and related conditions by reducing resources they have to deliver care.

3. Establish a separate payment. Separate payments have been established under FFS to achieve national policy goals. Even MA plans receive add-on payments in the form of rebates if their costs fall below benchmarks. Separate payments could be made to eliminate health effects of social disparities. Separate payments could be made to providers and plans that treat certain patients, e.g. people with low health literacy or homeless patients, or that provide care in certain neighborhoods where health disparities are perniciously high or where both health disparities and poor socioeconomic conditions exist.

4. Establish a new payment adjustment. Currently a small number of Medicare payment systems adjust rates beyond health risk or case-mix adjustment. (MA plans receive no adjustment beyond health risk adjustment.) For example, institutional rehabilitation facilities (IRFs) receive payment adjustments for the following reasons: 1) location in rural areas; 2) treatment of low-income patients; and 3) teaching status. Adjustments are a percentage increase of base rates per patient whereas separate payments are generally lump sum values.

Current payment for MA plan and FFS providers could be further adjusted to reflect higher costs of delivering care to certain beneficiaries or geographic areas with social conditions that negatively affect health. For example, an adjustment could be crated to increase payments for plans that serve "disparity areas." Or payment adjustments could be made retrospectively to cover demonstrated costs of specific interventions that have reduced health disparities linked to social disparities.

Conclusion

Frail, disabled, chronically ill persons are healthcare's most vulnerable, high-cost, and fast-growing service group. Some of these persons have social associated with poorer health that complicate care and increase costs. Current payment methods do not account for these added complexities and costs, and as a result, penalize SNPs and providers that specialize in populations with more prevalent social disparities. Congress should account for key social determinants of health in Medicare payment in order to reduce health disparities in Medicare and as a matter of compassion and social priority.

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