Account for Social Disparities in MA-SNP Payment

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SNP Alliance Issue Brief

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 higher mortality) than persons with higher SES, even after controlling for other factors.
2) SES and other aspects of a person's neighborhood, such as crime, access to fresh produce and exposure to pollution, can have dramatic effects 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 lower levels of health engagement.
2) Plans and providers treating people with low SES and related factors are likely to achieve poorer outcomes in treating a given illness using the same methods as caring for persons without these complications.
3) In most cases, needed interventions for outreach and care coordination must be more intensive and, therefore, are 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) Although the MA-HCC risk adjustment model does include a risk factor for "Medicaid status," it is inadequate to account for the range of socioeconomic factors impacting health care costs and outcomes.
2) MA-SNP payment accounts for differences in biological factors that affect costs of care, such as age and sex, and for distinct illnesses, but the CMS-HCC model does not account for "downstream" social factors, such as health literacy, associated with SES factors known to affect health outcomes.
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 these activities.

Health effects of social determinants are prevalent among plans and providers serving a high percentage of beneficiaries who are homeless or have severe and persistent mental illness (SPMI), or 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 face a vast array of psycho-social-environmental challenges that complicate the ability of plans and providers to provide consistent care without extensive investments in outreach.
2) Persons with SPMI often have limited abilities to manage their diseases, and,therefore, are more difficult to treat than other individuals with the same illnesses (e.g. diabetes).
3) Persons with a history of substance abuse tend to be less medically compliant, and often have more complex medical conditions and require increased levels of hospital care.
4) Disabled individuals and persons with HIV-AIDS experience social stigmas that complicate care and increase costs beyond expected Medicare FFS costs.

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

Policy Options

At least four different payment approaches should be considered as possible means 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 models incorporate person-level demographic and health factors (such as age, sex, and diagnoses). These models could be modified to include individual social factors known to affect health care costs. For example, Medicare could collect better income data to create a more robust income variable for MA risk adjustment, and/or 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 also could 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 individual-level factors that affect health outcomes. Education is often the only SES variable included when Medicare quality measures are case-mix adjusted. Expanding case-mix adjustment to additional measures, and including income and other social indicators as adjustors would more fully control for the individual-level factors that affect health. Without adequate case-mix adjustment, P4P programs penalize providers and plans that treat populations with lower SES and related conditions by reducing the resources they have to deliver care.

3. Establish a separate payment. Separate payments have been established under FFS to achieve national policy goals. Consistent with this, separate payments also could be made to providers and plans to eliminate health effects of social disparities, e.g. for people with low health literacy or who are homeless, or to plans and providers 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 to base rates per patient whereas separate payments are generally lump sum values.

Payment amounts to MA plans and FFS providers could be further adjusted to reflect higher costs of delivering care to certain beneficiaries or in geographic areas where social conditions that negatively affect health are prevalent. For example, an adjustment could be created to increase payments for plans that serve "disparity areas." Or, payments could be adjusted retrospectively to cover demonstrated costs of specific interventions that have reduced health disparities linked to social determinants.

Conclusion

Frail, disabled, chronically ill persons are healthcare's most vulnerable, high-cost, and fast-growing service group. Some of these persons are impacted by social factors associated with poorer health that both 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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