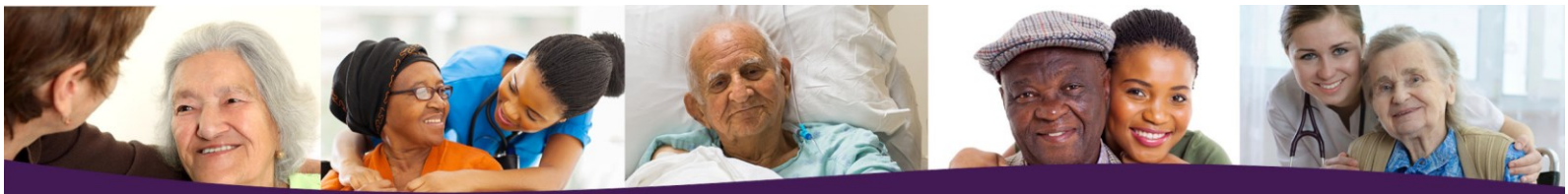

SNP Alliance Position Statement

JULY 2016

Proposed Guidelines for Measure Stewards and Developers to Test for SDOH/SES and Other Key Factors Affecting Health Care Outcomes

Special Needs Plans Described

SNPs are a subset of Medicare Advantage (MA) plans specifically authorized and designed to meet special care needs of Medicare beneficiaries. The plan types and subgroups include:

- ***Chronic condition SNPs*** (C-SNPs): serving persons with certain severe or disabling chronic conditions (e.g., HIV-AIDS, chronic heart failure, COPD, mental illness)
- ***Institutional SNPs*** (I-SNPs): serving persons residing in nursing homes or with comparable care needs in the community.
- ***Dual eligible SNPs*** (D-SNPs): serving persons covered by both Medicare and Medicaid.
- ***Fully Integrated Dual Eligible SNPs*** (FIDESNPs) and ***Medicare-Medicaid Plans*** (MMPs) – which are a specific type of D-SNP, providing both Medicare and Medicaid benefits, including long-term services and supports.

While SNPS are regulated, evaluated, and paid on the same basis as other MA plans, they are required to provide additional benefits and services to their target populations and to implement tailored care management according to unique Models of Care that serve every enrollee.

Quality Measures Background

Quality Ratings are Tied to Payment

In 2012, CMS began to implement the MA Star Rating system, which makes quality incentive payments to plans that obtain at least a 4-star rating under a 5-star rating system. Higher payments are provided in the form of higher MA benchmarks in each county. A financial penalty comes in the form of lower benchmarks. Currently, plan ratings are based on 47 performance measures derived from HEDIS, CAHPS, and HOS instruments, and from CMS administrative data.

Need for Recognition of Factors Affecting Health Outcomes

The SNP Alliance supports pay-for-performance as a tool to improve care for Medicare beneficiaries. However, the current system ignores the reality (exposed by research) that poverty, low levels of education, disability status, dual eligible status, and other social determinants of health (SDOH) effect outcomes. There is new evidence that socio-economic status of enrollees affects Star measure outcomes and thus adversely impacts a health plan's ability to achieve excellence under the Star Rating system.

Mounting Evidence Supports Need for Risk Adjustment

In September 2015, CMS released findings from a RAND study that provided scientific evidence that a beneficiary's dual-eligible status significantly lowered outcomes on 12 of 16 Star Rating measures. It also found that disability status significantly lowered outcomes on 11 of 16 measures. An Inovalon study found that characteristics of dual-eligible enrollees explained 70% or more of the disparity in outcomes compared to non-dual eligible enrollees on five of eight measures. Significantly, dual-eligible status lowered performance on the "all cause hospital readmission" measure, the only Star Rating measure that is already adjusted for age, gender, and co-morbidities—indicating that the current adjustment factors do not sufficiently capture the impact of SDOH (even after adjusting for dual status and other factors,).

Congress Urges CMS to Modify Stars to Account for SES

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

Problem Statement

CMS Agrees Risk Adjustment is Needed

Risk adjustment of healthcare outcomes measures is encouraged by CMS "because the existence of risk factors before or during healthcare encounters may contribute to different outcomes, independently of the quality of care received" (Source: CMS, *Blueprint for the CMS Measures Management System*, Version 12.0, May, 2016).

CMS Has Not Set Guidelines or Standards

CMS has stated that it is *the measure developer's responsibility* to determine if patient/individual SDOH factors should be accounted for to accurately compare plan performance. This agency also leaves it to the developers to determine *how to apply these factors in their measurement specification.*

While CMS offers guidance about attributes of risk adjustment models, there are no requirements for: (1) the sample size and definition (e.g., to include or even oversample among diverse patient groups to ensure statistical power to allow sub-population analysis), (2) a minimum data set and sources that accurately capture SDOH characteristics of patients, (3) a minimum set of SDOH variables to include in the risk adjustment testing/models—for example poverty status, (4) specific analytic methods to be used, or (5) disclosure in a way that is useful to researchers to replicate (validate) the work and also in a way that that is understood by the lay public.

Limited Scope

CMS guidance to measure developers and stewards only refers to selecting variables that are *clinically relevant*, where research has consistently shown that *social determinants of health*—such as income level/poverty status, dual eligible status, disability, living alone, housing transience, education level—may be equally important to achieving good health outcomes and should also be tested as risk adjustment factors in the models.

National Scientific Bodies Indicate Need for Adjustment

The National Quality Forum Technical Panel "strongly urges the field to develop and use sociodemographic-adjusted measures so that the data necessary to inform NQF's permanent policy in this area is generated." (*Risk Adjustment for Socioeconomic Status and other Sociodemographic* Factors, NQF Technical Report, August 15, 2014). This report identified potential risk factors that have the potential to impact health status and compromise quality results, including: poverty status, low health literacy, limited English proficiency, minimal social support, poor living conditions, and transportation limitations, among others. The NQF endorses both outcome and process performance measures.

The National Academies Committee on Accounting for Socioeconomic Status in Medicare Payment Programs' report entitled *Accounting for Social Risk Factors in Medicare Payment* (released July 13, 2016) provides a thorough examination of the social risk factors that could be used in quality measure systems and for measure testing/adjustment. The committee called for accounting for social risk factors in a way that "should neither mask low-quality care or health disparities nor reward poor performance." The committee developed a set of five criteria for selecting relevant social risk factors and noted that such factors should be "present at the start of care and not modifiable through provider actions."

Potential for Harm

The SNP Alliance believes the lack of guidance around minimum requirements for testing these and other attributes creates an environment where models and testing may not be sufficiently rigorous and could lead to faulty conclusions regarding the measure and its adequacy for application in the field with certain populations. Unadjusted measures used in the field could therefore yield inaccurate results about providers and plans who serve a disproportionate number of individuals with these characteristics. These quality ratings can influence consumer behavior and are tied to payment. This may inadvertently negatively impact providers and plans serving the most vulnerable population subgroups.

Solution

Creating (and making public) one consistent set of standards with minimum parameters for sample size, variables, data definitions, data sources, and methods for testing the measures, would provide critical guidance needed so that key stakeholders can be assured that the developers/stewards have performed risk adjustment evaluation with due diligence and used a sound approach, and so that there is full transparency to the public. We have therefore reviewed the literature and worked with those in the field to craft a set of parameters and make recommendations—for consideration by CMS.

Recommendation

We encourage CMS to set a **minimum standard** for measure developers and stewards to **consistently test** their measures—especially among the dual subpopulation groups who are not like the majority Medicare population and who represent the highest cost, most complex Medicare beneficiaries—to ensure that the measure accurately portrays experience in the intended area of focus, and to reveal areas where adjustment is needed.

This should include the follow requirements:

Sampling - a minimum sample size and diversity within the population used for testing that would include at a minimum younger disabled individuals (18-64) and older adults with multiple chronic conditions.

Unit of Analysis – utilize small geographic areas as units of analysis (below the 5-digit ZIP code level) when testing measures. Studies show that variances are masked when 5-digit ZIP code data (i.e., publicly available census data) is used, since these areas are too large and heterogeneous and thus mask true disparities. On the other hand, neighborhood-level data has been shown to be highly predictive of individuals' health outcomes.

Variables Tested - a minimum set of SDOH factors to be tested, building from the criteria offered by the National Academies Committee report. For the SNP population these would include: low income status, living in a poor neighborhood, single person household size, limited social support, low education level, and limited English proficiency. We note that association to health outcomes also has been empirically demonstrated with disability status and dual eligible status.

Accommodation and Sound Methods of Administration - the measure stewards ensure that the survey methods and administration adequately accommodates low-income, diverse, non-English speaking beneficiaries. Methods should not require beneficiaries to have cell phones, computers or Internet. Surveys should be appropriately translated and interpreter support should be available.

Transparency - the measure developers publish their scientific methods, data sources, and findings to provide a comprehensive technical report available to allow other scientists and analysts in the field to replicate results, as per standard scientific protocol.

Dissemination - the measure developers provide a summary report for disclosure to the general public so that findings can be understood by the lay public.