Assumptions

Social determinants of health (SDOH) are the conditions in which people are born, grow, live, work and age.[1]

1. SDOH adversely affect health and healthcare outcomes for all people, but particularly for poor Medicare beneficiaries.
2. Risk factors that are of particular importance are:
   - Socioeconomic position: Income, insurance, education, and occupation;
   - Race, ethnicity, and cultural context;
   - Gender and sexual orientation;
   - Social relationships, including social support;
   - Residential and community context, including neighborhood deprivation;
   - Health literacy (independent risk factor rather than social risk factor)[2]
3. Accounting for the influences of SDOH by MA plans in crafting care interventions and by CMS in crafting payment methods and performance evaluation metrics can significantly improve quality and cost outcomes for some of our most vulnerable population segments.

[1] World Health Organization, WHO Website, April 2017.

[2] Accounting for Social Risk Factors in Medicare Payment, National Academy of Science, Engineering, and Medicine, January 2017.

The Effects of SDOH on Health and Healthcare Outcomes is Well Established

1. **National Quality Forum (NQF), August 2014.** In NQF's report *Risk Adjustment for Socioeconomic Status or Other Socio-demographic Factors* found "*a large body of evidence* that various socio-demographic factors influence outcomes, and thus influence results on outcome performance measures."
2. **Medicare Payment Advisory Committee, March 2015**. MedPAC report notes that income, education, race and ethnicity, employment, community resources, and social support all play a major role in health.
3. **National Academy of Science, Engineering and Medicine (NASEM), Accounting for Social Risk Factors in Medicare Payment, 2016**: All other things being equal, the performance of a given health care system (in terms of quality, outcomes, and cost) can undoubtedly be affected by the social composition of the population it serves….Health literacy and social risk factors (SEP; race, ethnicity, and cultural context; gender; social relationships; and residential and community context) have been shown to influence health care use, costs, and health care outcomes in Medicare beneficiaries."

Addressing SDOH in Serving Duals in Particularly Important

1. **Costs are high**. The 20% of Medicare beneficiaries who are Medicaid eligible account for over 35% of Medicare costs. The 15% of Medicaid recipients who are Medicare eligible account for over 36% of Medicaid costs.[1] (These 10 million duals account for over $350 billion in annual federal/state costs.)
2. **Their problems are extensive**. 62% of Medicaid spending on Medicare beneficiaries is spent on long-term care services.[2] Nearly 50% of dually eligible persons 18-64 have a behavioral health problem compared with 14% of adults who are not dually eligible, and their annual expenditures were nearly twice as high as nonduals.[3] Nearly 75% of dually eligible beneficiaries have three or more chronic conditions.[4]
3. **Multiple risk factors affect their care.** 62% have no high-school diploma vs 20% for non-duals. Nearly 50% of duals live alone or in institutions.[5] Numerous other factors related to the culture of poverty affect cost and care outcomes.

[1,2,4,5] Issue Brief: Medicaid's Role for Medicare Beneficiaries, Kaiser Family Foundation, February 2017.

[3] The CBHQ Report, SAMHSA, Center for Behavioral Health and Quality, July 2014.

Why SDOH is Important to SNPs and MMPs

1. Over 2 million dually eligible beneficiaries are served by Special Needs Plans (SNPs); over 360,000 duals are served by Medicare-Medicaid Plans (MMPs).
2. SNPs serve over 20% of the total dually eligible population.
3. Over 85% of all SNP enrollees are dually eligible for Medicare and Medicaid.
4. Over two-thirds of the 3 million dual beneficiaries enrolled in all of Medicare Advantage (MA) are enrolled in SNPs.
5. Plans specializing in high-cost/high-risk care have extensive challenges not faced by other general MA plans.

Source: CMS Comprehensive SNP and MA Reports 2016.

Categorical Adjustment Index (CAI) Method as Interim Adjustment to Stars

1. According to CMS sponsored RAND Study, September 2015, a beneficiary's dual-eligible status significantly lowers outcomes on 12 of 16 Star Rating measures examined. Disability status lowered outcomes on 11 of 16 Star Rating measures.
2. CMS adjusted 6 of 47 Star measures through a method called the Categorical Adjustment Index (CAI) to account for within contract differences related to the presence of SDOH. The adjustment is based on a plan's percentage of low-income subsidy/dually eligible and disabled beneficiaries.
3. According to the CMS 2018 Call Letter and Advance Payment Notice, in 2018, of the nearly 500 Medicare Advantage contracts, 19 contracts will see their Star rating increase by ½ Star; 9 contracts will move from a 3.5 to a 4.0 Star rating.

Current Performance Evaluation Methods do not Fully Account for SDOH

- **Inovalon, 2015**. Characteristics of dual-eligible enrollees explained 70% or more of the disparity in outcomes compared to non-dually eligible enrollees on five of eight measures studied. Dual-eligible status lowered plan performance in the ‘all cause hospital readmission’ measure, that is already adjusted for age, gender, and co-morbidity.
- **ASPE Study, December 2016.** Found dual beneficiary status was *the most significant predictor of poor health outcomes* as measured by Medicare Star Ratings. Further, dual status, low income status, and disability status, as well as other SDH factors examined impacted outcomes—*independent from provider or plan behavior*…across the board—for all Medicare programs 9e.g. hospitals, clinics, plans, etc.

Key ASPE Research Findings

1. Beneficiaries with social risk factors had worse outcomes on many quality measures, regardless of the providers they saw. Dual enrollment status was the most powerful predictor of poor outcomes.
2. Providers (including plans) that disproportionately served beneficiaries with social risk factors tended to have worse performance on quality measures.
3. These providers experienced somewhat higher penalties than did providers serving fewer beneficiaries with social risk factors. They were also less likely to receive bonuses in Medicare Advantage.
4. ASPE could not determine why such patterns exist. Results may be due to a host of factors, including higher levels of medical risk, worse living environments, greater challenges in adherence and lifestyle, and/or bias or discrimination. Some of these factors are beyond providers' control, such as higher levels of medical risk and worse living environments. [1]

[1] ASPE Report: Social Risk Factors and Performance Under Value-Based Purchasing Programs, December 2016.

Key National Academy of Science, Engineering, and Medicine (NASEM) Findings

1. Healthcare providers (such as hospitals and physician groups) and health plans that serve greater shares of Medicare beneficiaries with social risk factors appear to produce worse health care outcomes on average compared to providers and plans that serve more advantaged patients.
2. They are more likely to score poorly on quality ratings, more likely to be penalized, and less likely to receive bonus payments.
3. Providers and plans can reduce the negative effects of social risk factors on health outcomes, but interventions to do so may require substantial effort, time, and costs.
4. Current Medicare Value-Based Purchasing generally does not account for social risk factors and thus disadvantages providers and plans that serve greater shares of patients with social risk factors.

[1] Accounting for Social Risk Factors in Medicare Payment, National Academy of Science, Engineering, and Medicine, January 2017.

NASEM Goals and Options

Goals

1. Reduce disparities in care, quality, and outcomes.
2. Provide quality improvement and efficient care delivery for all patients.
3. Create fair and accurate reporting of quality and outcome measures.
4. Compensate providers fairly.

NACEM Conclusion: Goals may be best achieved through payment based on performance, adjusted for social risk factors, combined with public reporting stratified by patient characteristics.

Options for Consideration

1. **Stratify public reporting**. *Example:* Show readmission rates separately for subgroups.
2. **Adjust performance measure scores**. *Example:* Add social risk factor indicators to current All Cause Readmission Rate.
3. **Direct adjustment of payment**. *Example:* Adjust plan payment to account for estimated additional costs.
4. **Restructure payment incentives.** *Example:* Pay differently based on high and low level of social risk factors.

[1] Accounting for Social Risk Factors in Medicare Payment, National Academy of Science, Engineering, and Medicine, January 2017.

SNP Alliance Recommendations

1. **Re-design the Medicare Star Rating Methods.** Additional exceptions and exclusions are needed to account for the effects of SDOH.
2. **Improve the effectiveness of CAI.** Add additional Star measures which incorporate dual status and SDOH factors. Add one or more measures to allow for complexity of care and functional status factors.
3. **Issue guidelines for Star measure developers.** Neither CMS nor NQF has provided guidance on testing for SDOF effects. There is wide variation in methods used. CMS would not let MA plans develop their own metrics and approach to performance measurement. Need minimum standards.
4. **Re-examine the validity and reliability of self-reported HOS and CAHPS surveys.** Must account more fully for non-English speaking beneficiaries; the presence of low health literacy; cognitive/memory impairment, etc.
5. **Other key considerations.** SDOH relationship to function and care complexity; accounting for disparities AND fairness; ensuring equal treatment regarding race and ethnicity while addressing the underlying influences of poverty; need short-term and long-term solution.

Guidance for Measure Stewards and Developers

1. Establish minimum sample size and diversity of subpopulations within sample.
2. Use small geographic areas as unit of analysis. Variances are masked when 5-digit ZIP code data is used.
3. Require minimum set of SDOH factors to be included in testing, for example, dual and disability status, living in poor neighborhoods, living alone, etc.
4. Ensure survey methods adequately accommodate the presence of low-income; diverse, non-English speaking beneficiaries; a limited use of cell phones, etc.
5. Require developers to publish methods, data sources, and findings. Provide summary of report to general public.

Targets for Specialty Care Intervention

1. Develop special programs for addressing health literacy, linguistics, and difficulty understanding health information.
2. Modify routine practice to account for cultural factors, interpreters for care management, scheduling of appointments, etc.
3. Implement new strategies to help find people without a telephone or permanent address.
4. Align medical and mental health services.
5. Create specialized supports for persons living alone; those with few social supports; and people who are lonely.
6. Coordinate efforts with public housing and transportation services.
7. Address history of trauma, adverse childhood events and violence/abuse.

Addressing SDOH requires a collaborative, community effort as well as a restructuring of traditional MA practices.

For Further Conversation

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