

Special Needs ——— ————— Plan Alliance

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Dear Mr. Parham,

The Special Needs Plan Alliance (SNP Alliance) is a national non-profit leadership organization for Special Needs Plans and Medicare-Medicaid Plans. The SNP Alliance represents 26 health plan organizations with over 700 plan products, serving over 3.5 million enrolled beneficiaries (about 60% of all beneficiaries enrolled in SNPs).

A large proportion of the individuals enrolled in SNPs are dually eligible for both Medicare and Medicaid and have high social risk issues, including low literacy, housing instability, food insecurity, and lack of reliable transportation or telephone access. The SNP population also has greater racial and language diversity than the general Medicare population overall. Nationally, dually eligible individuals comprise about 11% of beneficiaries, but account for 30% of costs due to their condition and social risk complexity.

We reviewed the PRA Notice and Supporting Statements A and B as well as other materials issued in the FR pertaining to proposed changes in the Health Outcomes Survey (HOS) instrument. We base our comment development on calls held with special needs health plans, and re-examination of previous analysis. In preparing our comments, we also reviewed health plan responses over the last several years on items pertaining to the HOS in the SNP Alliance Annual Survey.

OVERVIEW

We applaud CMS' commitment to ensuring that instruments and quality measures used in the Medicare program are valid, reliable, accurate, fair, and have utility to promote improvement. We are encouraged by the willingness of CMS to re-examine the Health Outcomes Survey. We agree with the interest in revising the HOS instrument. We appreciate the interest in reducing beneficiary burden. We also look forward to the results from current field testing around proposed use of items from PROMIS and the GAD-2 screen which may replace current questions around functional status assessment and could add to the understanding of anxiety within the Medicare population and offer a web-based mode for data collection.

However, the proposed changes in this PRA Notice fall short of what is needed in terms of revising the Health Outcomes Survey. The SNP Alliance and other organizations have reviewed, analyzed, and previously reported on information that indicates the HOS instrument needs a more major overhaul. The methods of measurement and reporting utilizing HOS in the Medicare Advantage quality measurement program likewise need further changes in order for this to be used in a way that is fair, equitable, and appropriate. The HOS limitations raise questions about the use of HOS-derived information to generate accurate results and therefore call into question the ability to use these data to measure performance or to guide improvement.

- ***Further revisions to the Instrument*** - The SNP Alliance recommends additional revisions to the Health Outcomes Survey beyond those which have been proposed to increase the accuracy, utility and reliability of the items on the HOS and improve access to the Medicare population. This would include language access. We recommend CMS be held to the standard of offering HOS in the 15 most common languages spoken, as is required of health plans (§422.2267). See the HOS White Paper at: <https://snpalliance.org/wp-content/uploads/2020/04/snpa-paone-hos-white-paper-final-dec-2018-1.pdf>
- ***Attention to Proposed Analysis & Use*** –We urge caution about use of longitudinal measures generated from HOS for performance evaluation of a plan and for comparing plans at the contract level, for three reasons: (1) the methodology used results in sample size and composition which are insufficient to accurately reflect the enrolled population at a contract level, (2) without contextual information to understand the reasons why physical or mental health changes have been reported (up or down), we cannot attribute change in status to the health plan's action or inaction, (3) the time period between measure points, especially for medically complex and people with high social risk vulnerabilities is very long, meaning that the opportunity for improvement has substantially decayed by the time the plan receives measure results. See:

- **Diversity Analysis** - It is critical to conduct analysis of individuals who are non-White, dually eligible (a proxy for high social risk), and non-English speaking and compare them to individuals who do not have these characteristics. Sub-group analyses will reveal comprehension and other differences. This can be part of a larger effort around HOS to determine if diversity characteristics impact HOS responses. This will be an important step to examine accuracy, validity, feasibility, and utility issues in groups who have a different racial, ethnic, language, literacy, and economic profile than the Veteran population upon which HOS was developed. Proper inclusion of diverse populations in all aspects of development and testing is in keeping with the health equity goals espoused by CMS, and HHS.

RECOMMENDATIONS

- Ensure certain items are in the HOS to provide a more complete picture of the respondent's conditions and other characteristics, such as if a proxy responded.
- Adapt the HOS instrument through translation, cultural testing, and validity/reliability tests to afford access to all Medicare beneficiaries, and adopt the language standards applied to health plans.
- Increase the required sample size.
- Improve the diversity of the sample so that it reflects the diversity of the enrolled Medicare population for each contract.
- Capture contextual information from the beneficiary to better understand reported status around physical and mental health, and function.
- Address bias that can arise from the use of family or paid caregivers as proxy respondents.
- Address the issue around longitudinal measurement when applied to medically complex, high social risk individuals.
- Add a question at the end about dual eligible status which is frequently used as a proxy indicator for social risk issues.

Instrument Items - We have the following comments and recommendations for ensuring specific items are retained and/or expanded to improve understanding of the respondent's conditions, enhance clarity or meaning, and ensure accuracy in analyzing responses:

- **LIVES ALONE** - The item in HOS regarding whether the person "lives alone or with others" is an important characteristic, especially given substantial research and practice evidence of an increasing rate of social isolation and lack of family/care partner support

among older adults and those with physical disabilities. We strongly advise adding this question back into the instrument.

- **CONDITIONS** – The items where the individual indicates their conditions where “a doctor has told you that you had . . .” and “are you currently under treatment for” are important. These questions build the profile of the person which contributes to understanding their level of complexity. We strongly recommend including conditions that substantially impact a person’s daily function and prognosis—this is particularly important when considering longitudinal health status. Conditions that are necessary to include in HOS and that would provide important information related to interpreting other responses in the instrument include:
 - Colon, Lung, Breast Prostate Cancer – Recommend that each be listed separately rather than just “any cancer” –and include them all in one question which is posed: “Are you currently under treatment for any of the following” (check those that apply)
 - Stroke or Progressive Neuro-Muscular Condition such as ALS, MS, or CMT
 - Alzheimer’s disease or dementia
- **PROXY Response** – We strongly recommend that the item indicating if the person had a proxy respondent be retained. This is extremely important for understanding and comparing responses and it is standard practice to separate proxy respondents from self-directed responses. This is particularly important if the respondent was a paid professional caregiver.
- **Dual status** -We recommend adding a question at the end about dual eligible status which could be used as a proxy indicator for social risk issues.

Sample– The HOS sample size and composition are not adequate. We recommend that the sample size be substantially increased and diversified. This is especially important for longitudinal measures. In a recent survey of special needs health plans, they indicated that the follow-up HOS sample often represented less than 2% of their enrolled population and was not reflective of the diversity characteristics of their enrollment. For example, the following HOS sample sizes and proportion of total enrollment were calculated with data supplied by CMS:

Contract	HOS Follow up Sample Size	Total Contract Enrollment	% of enrollment
A	127	11,200	1.13%
B	124	16,450	.753%
C	155	35,183	.441%
D	111	34,276	.323%

These small and unrepresentative samples call into question calculations or interpretations derived from the data.

Complete Test - A true test of a survey instrument involves the question order, format, length, and total duration to complete--not just each individual item posed separately. Response rate is important, but comprehension of each item and the instrument as a whole (in the way that it is experienced by the respondent) is at least equally important. The response scales appearing in the HOS instrument may not be equally understood by different sub-population groups. Examining the survey as a whole and the response scale comprehension among diverse population sub-groups should be included in further testing, especially if CMS wishes to understand how comprehension and response may differ based on characteristics of the person completing the survey.

Contract Selection for Further Testing of HOS – When adapting the HOS survey for other populations, we strongly advise selecting contracts that include a high proportion of diverse beneficiaries, for example where over 80% of enrollment is dually eligible, disabled or low-income, and where contracts have a substantial enrollment of non-White, non-English speaking individuals. We also recommend selecting another set of contracts that predominately serve frail elderly, and a set of contracts that predominately serve people with high behavioral health needs and physical disabilities. The resulting sample will more accurately reflect a diverse range of characteristics within the Medicare population.

Context- HOS could be improved by allowing the respondent to provide some kind of *contextual information* about what has happened to them over the past two years, particularly for longitudinal measures. It could have checkboxes or Likert scale questions to provide insight from the individual about what impacts their health status. This would retain anonymity but could help plans know what was driving the health status changes reported.

Full Transparency – Researchers and CMS should report all results from qualitative and quantitative examination of HOS and make these available to the public. In addition to reporting on sample size, CMS should report on language, racial, and other characteristics of the final HOS respondent sample. This information is vital to inform future directions and is important to many stakeholders. Distribution should be complete and timely in keeping with transparency and accountability standards held by the U.S. government. We appreciate CMS' commitment to informing the general public and to providing in-depth information to subject matter experts working within health care, social services, academic, and other related fields.

Burden and Cost Estimates – The expected burden and costs via the hours and wages for conducting the survey may need reworking. A closer estimate of time to complete the full HOS

would be 40+ minutes for people with complex chronic conditions, frail individuals who experience survey fatigue more quickly, and those with low health literacy. These are characteristics more frequently observed among individuals enrolled in special needs plans. Health plans cover the cost of administering the HOS to their enrolled members, so it is important to have accurate time and salary estimates which reflect the prices they pay to the HOS survey vendors.

SUMMARY

In summary, while we are encouraged by CMS' interest in reworking HOS, we strongly support revisions to HOS beyond what has been proposed and recommend re-testing in diverse populations. Furthermore, the true costs may be higher than the estimates presented for special needs plans and their enrolled beneficiaries.

Thank you for the opportunity to comment. We welcome further discussion.

Sincerely,



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