

Special Needs ————— Plan Alliance

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William N. Parham III
Director, Paperwork Reduction Staff
Office of Strategic, Operations, and Regulatory Affairs, Division of Regulations Development
Centers for Medicare and Medicaid Services, DHHS
Room C4-26-C05
7500 Security Blvd. 3
Baltimore, MD 21244-1850

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Dear Mr. Parham,

The Special Needs Plan Alliance (SNP Alliance) is a national, non-profit thought leadership organization addressing the needs of high-risk and high-cost complex care populations with chronic conditions through specialized managed care. The Alliance is the only organization exclusively representing Medicare Advantage Special Needs Plans – Dual SNPs (D-SNPs), Institutional SNPs (I-SNPs) and Chronic Condition SNPs (C-SNPs).

We represent approximately 65% of all SNPs. These plans have over 4 million beneficiaries enrolled across the country—totaling more than 55% of the national SNP and Medicare Medicaid Program demonstration enrollment. Our primary goals are to improve the quality of service and care outcomes for complex care populations with chronic conditions and to advance integration for those dually eligible for Medicare and Medicaid. The vast majority of all SNP enrollees, regardless of type of SNP, are dually eligible.

The SNP Alliance applauds the Administration’s focus on Medicare Advantage and complex care populations with chronic conditions. We look forward to a positive, solutions-oriented relationship with President Trump’s incoming leadership on these populations. As part of our dialogue, we will provide thoughtful input on how to best balance the need for government efficiency via payment policy with ensuring access to high quality care for America’s citizens with complex care needs through quality measurement.

We reviewed the PRA Notice and supporting statements as well as related materials pertaining to proposed changes in the Health Outcomes Survey instrument, including removing six items from the instrument.

www.snpanniance.org

OVERVIEW

We thank CMS for its' commitment to ensure that instruments used for quality measurement and performance evaluation are valid, reliable, accurate, fair, feasible, and have utility to promote improvement. We appreciate the interest in reducing beneficiary burden. We also look forward to the results from the current field testing of HOS around the use of items from PROMIS and the GAD-2 screen which may replace current HOS items.

It is time to re-examine the Health Outcomes Survey. Both the instrument and the methodology need to be revised to support its use by CMS as a source document for measures in the MA Quality measurement system. Unfortunately, proposed changes in this PRA Notice fall short of what is needed in terms of revising the Health Outcomes Survey.¹ Specifically concerns include:

- The small and unrepresentative sample (often less than 2% of the enrollment of the health plan)
- The low response rates to the HOS
- The lack of access to HOS among people who speak a language other than the three languages offered (in writing) and one additional language (verbal only)
- The lack of testing in ethnic populations
- The inability to determine source (positive or negative) of self-reported changes in health status
- The lack of attention to/data collection about several key medical and behavioral health conditions (e.g., self-reported neuromuscular diseases such as Parkinson's or ALS, Alzheimer's disease, or other immunological diseases, such as HIV/AIDs, or behavioral health conditions such as Substance Use Disorder)
- The lack of information about contextual issues when a respondent indicates a change in health status




The HOS limitations raise questions about the use of HOS-derived information to generate accurate results and therefore call into question the use of these data to measure performance.

The SNP Alliance recommends:

- ***Make Additional Revisions to the HOS Instrument and Methods*** - The SNP Alliance recommends additional revisions to the Health Outcomes Survey beyond those which have been proposed to improve access to the Medicare population. This would include increasing the sample size, ensuring that the respondent sample matches the characteristics of the enrollment of that plan, and ensuring that the instrument has been adequately tested and validated in a dually eligible, low-income, and disabled population.

¹ See the HOS White Paper at: <https://snpalliance.org/wp-content/uploads/2020/04/snpa-paone-hos-white-paper-final-dec-2018-1.pdf>

- **Remove Longitudinal Measures**—Because of the limitations with HOS, the data used to create the longitudinal measures *Improving or Maintaining Physical Health* and *Improving or Maintaining Mental Health*, is not sufficient. **The measures should be removed** for three reasons:
- (1) **Too small sample** - The sample size and composition are insufficient to accurately reflect the enrolled population at a contract level. A recent survey of special needs health plans indicated that the HOS sample often represented less than 2% of the enrolled population and was not reflective of their enrollment.
 - (2) **No contextual information** - without contextual information to understand the reasons why physical or mental health changes have been reported (up or down) CMS cannot attribute change in status to the health plan’s action or inaction—essentially, the scores are a “black box.” 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.
 - (3) **Information decay** - the two-year time period between measure points is too long for medically-complex people with high vulnerabilities, meaning that the opportunity for improvement has decayed by the time the plan receives measure results.
- **We recommend increasing the sample size and ensuring that the sample reflects the enrolled population of the contract.** The special needs population is significantly different from the general Medicare and the general Medicare Advantage population, with over 40% living alone (compared to 29%), 32% reporting memory difficulties (compared to 16%) and twice as many individuals in SNPs reporting having functional limitations. An analysis that the SNP Alliance did in 2023 with ATI Advisory² showed how different the demographic composition of the HOS respondent sample is from the characteristics of SNP enrollees. See below.

 HOS Respondent	 Medicare Advantage Enrollee (non-SNP)	 SNP Enrollee
79% White	75% White	45% White
10% Non-English Language Spoken at Home	14% Non-English Language Spoken at Home	28% Non-English Language Spoken at Home
0% Over Age 85	11% Over Age 85	9% Over Age 85

HOS respondent data from CMS Cohort 2022 follow-up HOS Respondents. Medicare Advantage data from 2017-2019 MCBS.

² [Ensuring-Equity-and-Fairness-in-Medicare-Advantage-Quality-Measurement_ExecSummary.pdf](#)

- ***We recommend re-testing HOS in a variety of contracts*** – When adapting the HOS survey and re-testing HOS, we strongly advise selecting contracts where over 80% of enrollment is dually eligible, disabled or low-income. 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 the wide range of characteristics within the Medicare population.
- ***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).***
 - adopt the language standards applied to health plans (15 of the most prevalent languages)
 - Adapt the HOS instrument through translation, cultural testing, and validity/reliability tests to afford access to all Medicare beneficiaries
- ***Conduct a 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 groups. Examining the survey as a whole and the response scale comprehension among 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.
- ***Full Transparency*** –In addition to reporting on sample size, CMS should report on language 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.
- ***PROXY Response*** – We strongly recommend that the item indicating if the person had a proxy respondent be added back into the instrument. 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.

SUMMARY

In summary, while we are encouraged by CMS' interest in reworking HOS, we recommend revisions beyond what has been proposed. Special Needs Plan (SNP) enrollees have complex care needs and multiple chronic conditions. Accurate, targeted measurement is critical to ensuring quality and efficiency of care.

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

Sincerely,



Mike Cheek, President & CEO
SNP Alliance



Deborah Paone, DrPH, MHSA, Performance
Evaluation Lead & Policy Consultant.
SNP Alliance