

Ensuring Equity and Fairness in Medicare Advantage Quality Measurement

Background to the Issue

The Centers for Medicare & Medicaid Services (CMS) use various tools to ensure the Medicare Advantage (MA) program provides high-quality care to Medicare beneficiaries. One tool, the Medicare Health Outcomes Survey (HOS), has been used since 1998 and relies on beneficiary self-reported physical and mental health status. The stated goals of the HOS are to gather valid and reliable clinically meaningful data for targeting quality improvement activities and resources; monitoring health plan performance and rewarding top-performing health plans (via the Medicare Star Ratings program); helping people with Medicare make informed health care choices; and advancing the science of functional health outcomes measurement.ⁱ However, in its current design, the HOS does not support an accurate, or equitable approach to quality measurement for the increasingly diverse Medicare population. Action is required to address HOS equity limitations.

This brief, a collaboration between the SNP Alliance and ATI Advisory (ATI), outlines the limitations of the HOS for equitable quality measurement within the MA population, with a focus on Special Needs Plans (SNPs). SNPs are a type of MA plan created in 2003, designed to serve certain high-need Medicare beneficiaries. Currently, 5.1 million beneficiariesⁱⁱ are enrolled across the three types of SNPs: D-SNPs for individuals dually eligible for Medicare and Medicaid; I-SNPs for those who need an institutional level of care; and C-SNPs for individuals with severe or disabling chronic conditions.

To ensure MA quality measurement equitably reflects the demographics of the Medicare population, **Congress should require CMS to update its quality measurement approaches** (including the HOS) in the following ways:

1. Quality measures should be **adequately tested and validated on diverse populations** (e.g., physically and intellectually disabled, people with social risk factors such as unstable housing, those with degenerative chronic conditions or behavioral health complexity, people of advanced age or frailty, and those with low literacy) if those measures are to be used in quality measurement for these groups.

2. Survey questions should **meet current mandatory translation requirements** as is required for other MA public-facing documents (i.e., any non-English language that is the primary language of at least five percent of the individuals in a plan's service area).
3. Future use of the HOS **should incorporate changes that align with CMS health equity priorities**, through principles of equitable and fair measurement:
 - a. Survey questions should be **inclusive and culturally appropriate**.
 - b. Survey administration should be **representative and equitable**.
 - c. Survey results should **provide actionable insights** for improving quality among diverse populations.

The Health Outcomes Survey Within Medicare Advantage Quality Measurement

The HOS is administered yearly to a random sample of enrollees from each MA plan that has a minimum of 500 enrollees. Two years later, the baseline respondents are surveyed again as a follow-up measurement to see how their self-reported outcomes have changed, if at all, over the two-year period. The HOS contains specific questions on self-reported functional status, disability status, and conditions or diagnoses in addition to questions on enrollee demographics such as race, primary language, income and education level, marital status, living arrangements, and home ownership.

All MA and Part D plans, including SNPs, are evaluated annually on specific quality measures

through CMS's Medicare Star Ratings program. CMS created the Star Ratings program to provide quality and performance information on MA and Part D plans to Medicare beneficiaries to help inform their plan choices. Star Ratings are carefully watched by plans, advocates, and industry experts as ratings impact MA plans' reputations, marketing, enrollment, and revenue through performance bonuses and benchmark payment adjustments. In addition to plans regularly including Star Ratings performance on marketing and enrollment materials, ratings are provided on the Medicare Plan Finder. Medicare Plan Finder is a go-to resource to support beneficiaries as they assess their coverage options. Plans with five stars are identified with a special star icon on the Medicare Plan Finder while plans with summary ratings of 2.5 or lower are marked with a low performing icon.^{iv} For low-performing plans, CMS may disable the Medicare Plan Finder online enrollment function, thereby inhibiting new enrollment through the tool.

Key Facts about the Medicare HOS ⁱⁱⁱ

- The first patient-reported outcomes survey used in Medicare managed care, implemented in 1998
- Participation required for all MA contracts – annual random sample drawn from each plan with 500+ enrollees
- Administered via mail and phone (no online option)
- Administered in English, Spanish, Russian, and Chinese
- Can be completed via proxy if the intended respondent is unable to complete the survey

Star Ratings are calculated from a variety of different data sources, including surveys of enrollees such as the Medicare HOS, which was the first patient-reported outcomes measure used in Medicare managed care.^v There are six HOS-derived measures, three of which are temporarily on “Display Only” and three that are included in the 2023 Medicare Star Ratings program:^{1, vi}

- Improving or Maintaining Mental Health (MCS)*
- Improving or Maintaining Physical Health (PCS)*
- Monitoring Physical Activity
- Physical Functioning Activities of Daily Living (PFADL)*
- Reducing the Risk of Falling
- Improving Bladder Control

The MCS and PCS are composite measures calculated from twelve separate items contained within the HOS. These measures rely on the beneficiary’s response to these twelve items at baseline data collection and follow-up collection two years later.

Impact of COVID-19 on the HOS

In August 2021, CMS announced that the HOS MCS and PCS measure scores would not influence MA plans’ 2022 or 2023 Star Ratings due to “significant impacts” on the validity of the two measures caused by the COVID-19 public health emergency (PHE).^{vii} The remaining HOS-derived measures, which are cross-sectional and do not rely on longitudinal data collection, were not affected and continue to be used in Star Ratings calculations. CMS’s recognition of the inability of HOS to effectively control for contextual variables like those impacted by COVID-19 raises larger questions about the use of these longitudinal measures. Changes in mental and physical health status, particularly among low income, high social risk, vulnerable older adults, are often influenced by external factors – not only during the COVID-19 pandemic. Without having contextual information about the survey responses provided, the results may or may not be related to action or inaction by the services rendered by the health plan or the person’s providers.

¹ An asterisk (*) indicates measures that are currently on “Display Only.”

Fair and Equitable MA Quality Measurement as a Tool for Achieving CMS Health Equity Goals

In the recently released Framework for Health Equity 2022 – 2023, CMS testifies to its “unwavering commitment to advancing health equity.” CMS outlines expanded collection, reporting, and analysis of standardized data as a top priority. CMS has made significant strides over the past few years to standardize and expand data collection (e.g., requiring demographic and social need data from CMS demonstration model participants), enabling the creation of sophisticated analytical tools for targeting disparities and improving quality for Medicare beneficiaries.^{viii}

“CMS is committed to... assessing our programs and policies for unintended consequences and making concrete, actionable decisions about our policies, investments, and resource allocations.”

Our goals are to explicitly measure the impact of our policies on health equity, to develop sustainable solutions that close gaps in health and health care access, quality, and outcomes, and to invest in solutions that address health disparities.”

In line with its *Framework for Health Equity* goals, CMS has an opportunity to consider Medicare Star Ratings quality measurement approaches through the lens of equity and fairness and to address areas for improvement in the HOS to better meet stated goals and principles. HOS presents a key opportunity for putting the *Framework* into action in quality measurement for MA enrolled beneficiaries.

As shown in **Figure 1**, MA enrollees who respond to the HOS are not representative of the broader MA population, particularly the composition of those served by SNPs. HOS respondents are disproportionately white, English-speaking, and younger – skewed to a healthier and less diverse subset of Medicare beneficiaries.

Figure 1. Demographics of HOS Respondents, Medicare Advantage Enrollees (non-SNP) and SNP Enrollees²

 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 ADLs refer to Activities of Daily Living.

As shown, the HOS sample substantially underrepresents groups more vulnerable to health disparities. The lack of representation and inclusion impedes CMS’s stated goal of explicitly measuring the impact of its policies on health equity and investing in solutions that reduce health disparities. For MA quality measurement to play a role in CMS’s efforts to advance health equity, the data that inform quality measurement must be reliable and representative of all beneficiaries enrolled in MA plans. As the MA population, and particularly the SNP population (**Figure 2**) increases in diversity of race, ethnicity, language, and social risk factors, the HOS samples should reflect this diversity.

Figure 2. Demographics of Medicare Advantage Enrollees (non-SNP) and SNP Enrollees

Medicare Advantage Enrollee (non-SNP)	SNP Enrollee
13% Receive Help with 2+ ADLS	27% Receive Help with 2+ ADLS
12% Experience Serious Mental Illness	25% Experience Serious Mental Illness
15% No High School Diploma	39% No High School Diploma
20% Live in a Disadvantaged Area	47% Live in a Disadvantage Area

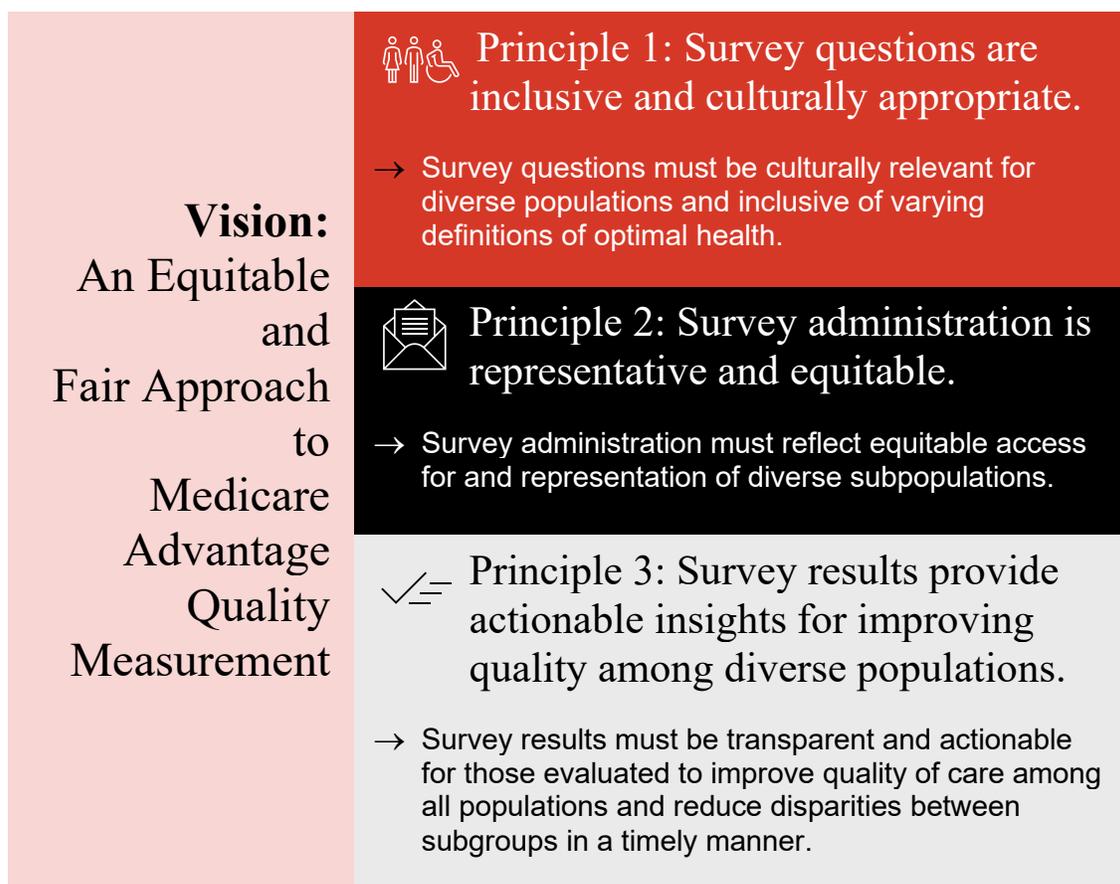
Medicare Advantage data from 2017-2019 MCBS.

Features of an Equitable and Fair Approach to Medicare Advantage Quality Measurement

In addition to underrepresentation, the HOS is not an equitable and fair approach to MA quality measurement due to limitations across the questions themselves, administration approaches, and the ability of results to be used in an actionable way to address disparities. An equitable and fair approach to MA quality measurement is one that leverages person-centered, validated, accessible, and reliable tools that enable timely, actionable, and transparent results. Tools must be appropriate and work for all beneficiaries, across race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, and changes in address and phone numbers over time. Three key underlying principles necessary for achieving this vision are shown in **Figure 3**.³

³ Concepts inspired by National Quality Forum’s [Principles for Core Set Measure Selection](#) (2021); graphic developed by ATI Advisory.

Figure 3. Underlying Principles for an Equitable and Fair Approach to Quality Measurement



KEY PRINCIPLE 1: SURVEY QUESTIONS ARE INCLUSIVE AND CULTURALLY APPROPRIATE.

Survey questions used to assess quality measurement for a given population should be validated for cultural relevancy and inclusivity of that population. The HOS, while used to assess self-reported health status among the diverse MA and SNP population, has not been validated on core subpopulations, including individuals with disabilities, people with social risk factors, those with degenerative chronic conditions or behavioral health complexity, people of advanced age or frailty, and those with low literacy. The Medical Outcomes Trust and Short Form-36 (MOS and Veterans SF-36) instruments from which the HOS was derived were developed for a veteran population in the late 1980s. As such, the demographics of respondents who served to validate HOS measures are considerably different from today's MA population, and even more so from today's SNP population (**Figure 4**).

Figure 4. Demographics of MOS and Veterans SF-36 Respondents Compared to Current Medicare Advantage (non-SNP) Enrollees and SNP Enrollees^{ix}

MOS and Veterans SF-36 Survey Respondents	10% Younger than 65	98% Male	19% Non-white	72% Married
Medicare Advantage Enrollee (non-SNP)	11% Younger than 65	44% Male	21% Black or Latinx	53% Married
SNP Enrollee	33% Younger than 65	36% Male	51% Black or Latinx	24% Married

MOS and Veterans SF-36 respondent data from Kazis et al., 2004. Medicare Advantage data from 2017-2020 MCBS.

As a result of the HOS’s original respondent population and lack of evolution with the changing demographics of Medicare beneficiaries, it includes survey items that are not culturally relevant – particularly to the SNP population. For example, to assess physical functioning, the HOS asks respondents how much they participate in moderate activities such as bowling or playing golf.^x As of 2019, only three percent of American recreational golfers were Black.^{xi} Including sports that are significantly more popular among white populations as two of the four exemplary activities used to assess physical functioning of Medicare beneficiaries is not inclusive. This is especially true for the SNP population, which is even more racially and ethnically diverse than the MA population generally. Fifty-two percent of SNP enrollees are Black or Latinx, while only 21% of non-SNP MA beneficiaries identify as such.⁴

“2. The following items are about activities you might do during a typical day. Does **your health now limit you** in these activities? If so, how much?”

a. **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf

- Yes, limited a lot
- Yes, limited a little
- No, not limited at all”

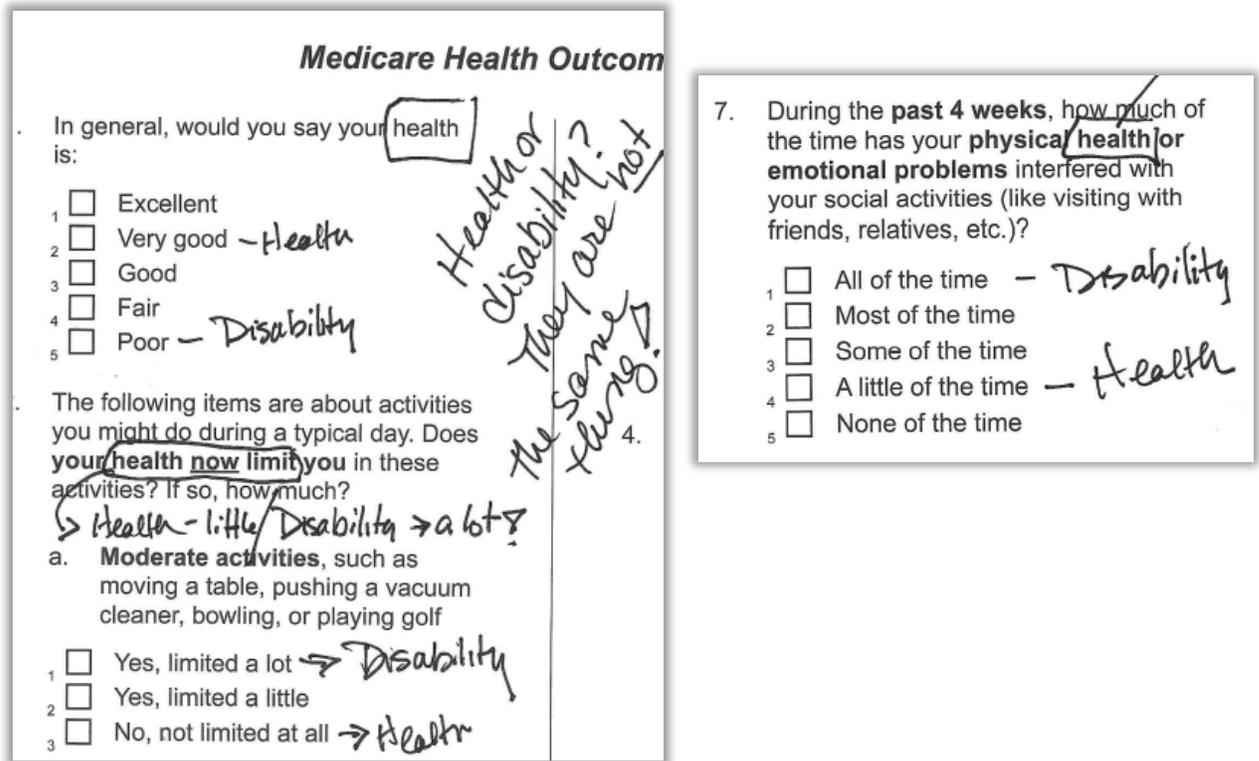
- The HOS English Questionnaire, 2022^{xii}

In addition to not including culturally accessible measures, the HOS also relies on several measures inappropriate for those with physical disabilities or frail older adults. It is unclear how an enrollee with substantial limitation in movement due to a physical disability should respond to the above item on moderate activities. These individuals may never have been able to move a table or push a vacuum cleaner. If the enrollee responds at both baseline and follow-up that they are “limited a lot” in completing these moderate activities, that enrollee will not reflect an “improvement” on the PCS, at no fault of the MA plan. This confusion of how to accurately answer the HOS questions as a disabled person is illustrated in **Figure 5**. This issue is salient for SNPs, given the significantly higher proportion of enrollees who receive help with activities of daily living (ADLs) compared to non-SNP MA plans (27 percent vs 13 percent, respectively).

⁴ ATI analysis of 2017-2019 MCBS data.

These are examples of how HOS is unaligned with CMS's goal in their *Framework for Health Equity* that all beneficiaries have "a fair and just opportunity to attain their optimal health."^{xiii}

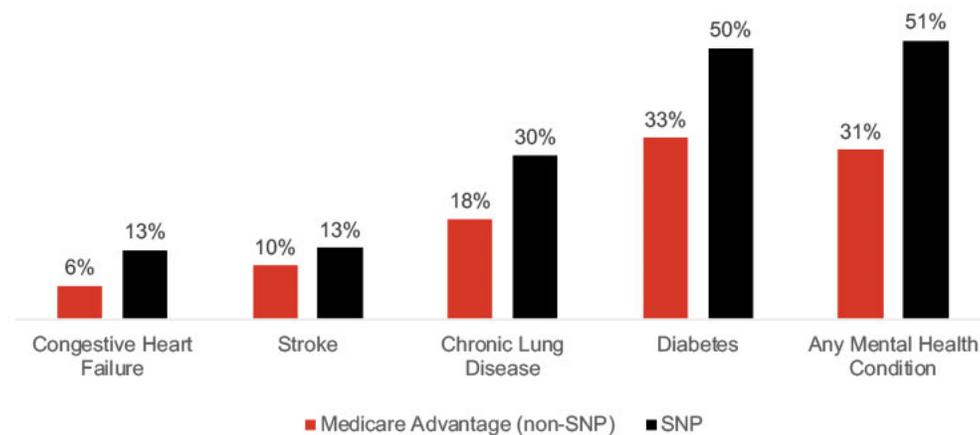
Figure 5. Screenshots of a SNP Beneficiary's Unsolicited Comments on the HOS



Relatedly, the HOS measurement does not fully address the likelihood of potential improvements or declines in health status when determining PCS and MCS scores. People with multiple chronic conditions and those with disabilities are less likely to improve in physical or mental health functioning over time. While the HOS does adjust for age and other demographic factors, it does not adjustment for disease severity. This lack of adjustment is more likely to impact SNP scores on the HOS, as SNP enrollees experience key physical and mental health conditions at higher rates than those in non-SNP MA plans (**Figure 6**). This issue is especially pertinent when considering degenerative neuromuscular diseases. The HOS does not collect information on neuromuscular diseases, such as multiple sclerosis (MS), amyotrophic lateral sclerosis (ALS), or Parkinson's disease. Such progressive diseases are inherently degenerative and will result in health status declines over time even if the best treatment is available.^{xiv} Disease progression is also highly variable for one person compared to another. The HOS methodology also does not adjust for life changes that may affect health status, like the loss of partner or housing insecurity. SNP enrollees, who are often dually eligible, are more likely to have high social risk vulnerabilities, such as housing, food, or transportation insecurity that may impact their HOS responses. Given these unaccounted-for factors, decline in health status over two years cannot be directly attributed to a health plan's actions.

Additionally, the HOS does not collect information on nor exclude beneficiaries receiving palliative care from the possible respondent pool. Palliative care programs focus on comfort care and individuals are highly unlikely to “improve” in health status over two years, as is measured by the MCS or PCS. A person-centered and non-discriminatory survey tool for measuring self-reported physical or mental health status should accommodate differing definitions of optimal health, contextual information from the respondent on factors advancing or impeding their health status, and respondent opportunity to indicate the health plan’s role in their care.

Figure 6. Prevalence of Physical and Mental Health Conditions by SNP Status



ATI analysis of 2017-2020 MCBS data.

Recommended Actions for HOS to Achieve Key Principle: Inclusive and Culturally Appropriate Survey Questions

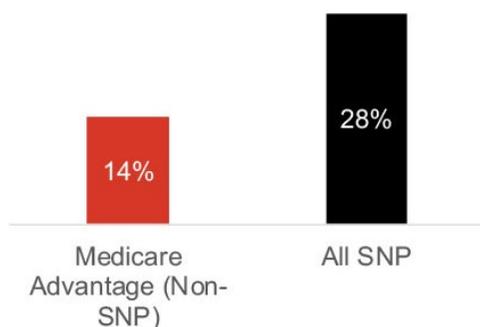
- Validate the current HOS items among diverse populations and consider beneficiary input on alternative wording of questions on the HOS with contextual information to ensure inclusivity of accessibility and meaningfulness to diverse populations.
 - Prioritize the validation of questions that generate the PCS and MCS composite measures.
- In lieu of MCS and PCS HOS measures, pursue alternative, validated, and widely used self-report measures that have been translated into many languages and been tested with diverse people, including those with functional limitations, disabilities, and degenerative chronic conditions (e.g., PROMIS Global Health, Dartmouth COOP Charts, etc.).⁵
- Exclude populations in palliative care or with degenerative conditions from potential HOS samples.

⁵ Other self-report measures of well-being in adults are compiled in [Linton, M-J, et al., 2016](#).

KEY PRINCIPLE 2: SURVEY ADMINISTRATION IS REPRESENTATIVE AND EQUITABLE.

To ensure equity, surveys should be administered in a way that allows any eligible respondent (or their proxy) to complete the survey, regardless of language, physical or intellectual disability, or communication method. Although the potential respondent pool is intended to be representative of the entire MA population, the limited language translations of the HOS and reliance on completion via mail or telephone restrict the participation of some Medicare beneficiaries, particularly those enrolled in SNPs. In 2022, the HOS was administered via mail and telephone in four languages: English, Spanish, Chinese, and Russian.^{6, xv} Considering that SNP beneficiaries are more likely than non-SNP MA beneficiaries to speak a language other than English at home (**Figure 7**), this is a substantial barrier to representation. More than four million Americans over the age of 65 speak a language other than English or Spanish, including about four percent who speak Indo-European languages, three percent who speak Asian and

Figure 7. Percent of Beneficiaries who Speak a Language Other Than English at Home by SNP Status



ATI analysis of 2017-2020 MCBS data.

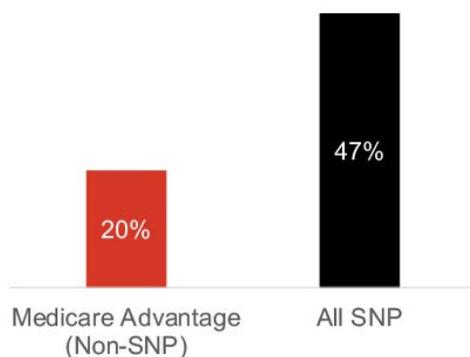
Pacific Island languages, and one percent who speak other languages.^{xvi} The most common languages spoken in the U.S. besides English and Spanish are Chinese, French, Tagalog, and Vietnamese.^{xvii} To be a representative survey tool for the MA population, the HOS should be available in any language that is the primary language for at least five percent of the individuals in a plan’s service area.⁷ Efforts to expand the non-English language availability of the HOS reflect a core element of the Health and Human Services Equity Action Plan, which emphasizes a focus “... on assessing the accessibility and quality of [HHS] language access efforts to improve agency capacity to serve individuals with limited English

proficiency.”^{xviii} Ensuring understanding of the HOS survey requires not only translating the wording of each question, but also ensuring that the meaning is as intended. Cultural differences impact the interpretation of words and questions.

⁶ Note that Russian is administered by mail only (not via telephone).

⁷ See 42 CFR § 422.2267(a)(2) for existing language standards for MA required materials and content.

Figure 8. Percent of Beneficiaries Living in the Top 25% Most Disadvantaged Counties by SNP Status



ATI analysis of 2017-2020 MCBS data.

The HOS also has no online administration component and relies solely on mail or telephone completion. The vast majority (82 percent) of MA beneficiaries complete the HOS by mail.^{xix} However, because completion by mail requires an address and housing stability over the two-year survey period, MA beneficiaries experiencing housing insecurity may be underrepresented among HOS respondents. Almost half of SNP beneficiaries live in highly socioeconomically deprived areas, potentially placing them at higher risk for housing insecurity (Figure 8). The significant majority of HOS respondents who complete the survey by mail also has implications for HOS scores

themselves; PCS and MCS scores have been found to be significantly worse (i.e., respondent indicates worse health) when the respondent completed the survey via mail compared to telephone.^{xx}

If an MA beneficiary in a plan's HOS respondent pool is unable to complete the HOS, a proxy can complete the survey on the beneficiary's behalf. However, the HOS does not require that the same proxy complete the survey at both data collection periods (baseline and follow-up), which can introduce potential bias into MCS and PCS measure results. If two different proxies complete the HOS, it is unlikely their responses will consistently reflect the beneficiary's health status given that different proxies will have different interpretations of the HOS measures and/or assess the beneficiary differently. Furthermore, in general, proxy respondents are less reliable reporters of health status than the respondent themselves.^{xxi} Proxy-reported outcome scores for mental and physical health have been found to be significantly lower than patient-reported outcome scores.^{xxii} Given their potential disability status, likely caregiver involvement, and demographic characteristics (e.g., non-English language speaking), SNP enrollees are more likely than non-SNP MA enrollees to rely on proxy completion of the HOS and therefore have this form of bias introduced into their survey results.

Recommended Actions for HOS to Achieve Key Principle: Representative and Equitable Survey Administration

- Establish pathways for non- English, Spanish, Chinese, or Russian speakers to complete the HOS. Possible pathways include:
 - Requiring translation and adaptation of the HOS questions into other languages that are the primary languages of at least five percent of the individuals in a plan's service area. Translations of the HOS should be tested to ensure comprehension and meaningfulness to each sub-group before being used.
 - Prioritize the translation of questions that generate the PCS and MCS composite measures.

- Identifying similar survey questions from other survey tools (e.g., PROMIS Global Health) that have already been translated into alternative languages and crosswalk HOS items to these alternative translated measures.
- Require survey administrators to introduce an online and smart phone accessible survey administration option. Determine how to improve access to beneficiaries who may experience housing instability and have insufficient Wi-Fi or broadband.
- Only allow proxy responses to inform PCS and MCS scores if the same proxy representative completes the survey at baseline and follow-up.

KEY PRINCIPLE 3: SURVEY RESULTS ARE ACTIONABLE IN A WAY THAT IMPROVES QUALITY AMONG DIVERSE POPULATIONS.

Quality measurement should be actionable, with health plan performance in the survey attributable to actions the plan took. Although HOS responses are used to evaluate health plans, when respondents answer questions about their physical and mental health status they often reflect on the progression of their condition(s) and/or on significant life changes (such as loss of a partner) rather than what their insurance plan has done or is able to do. The HOS includes no questions on the respondent's insurance company nor the communication

between the insurer and the respondent. The vague connection between survey results and the insurer's role impedes health plans' ability to implement informed changes to improve their PCS or MCS scores, and therefore the quality of their care and coverage, over time. Additionally, because the respondent sample is blinded from the health plan and survey results are not reported until more than two years after the initial measurement period, health plans are further inhibited from leveraging HOS results for actionable and timely quality improvement. The Agency for Healthcare Research and Quality's National Quality Strategy includes levers to achieve improved national health and quality of healthcare through transparent reporting and technical assistance activities. Several of these levers are currently not implemented for the HOS to allow for learning and diffusion of best practices across MA plans.^{xxiii}

Furthermore, research has shown that it is difficult to interpret self-reported measures of health, like those leveraged in the HOS, due to significant differences in responses depending on race, ethnicity, and gender.^{xxiv} Demographic differences in how self-report measures are interpreted and how health is self-evaluated limit the ability to make broad generalizations on the health of a population based solely on self-reports.

National Quality Strategy levers that should be applied to the HOS for improved quality of care:

- **Measurement and Feedback:** Provide Performance feedback to plans and providers to improve care.
- **Public Reporting:** Compare treatment results, costs and patient experience for consumers
- **Learning and Technical Assistance:** Foster learning environments that offer training, resources, tools, and guidance to help organizations achieve quality improvement goals
- **Innovation and Diffusion:** Foster innovation in health care quality improvement, and facilitate rapid adoption within and across organizations and communities

Recommended Actions for HOS to Achieve Key Principle: Actionable Survey Results

- Consider including additional questions on beneficiaries' communication, engagement, and/or experience with their health plan.
- Consider providing health plans with internal reports on their HOS performance following the initial data collection period (rather than more than two years later) that includes blinded demographic information on respondents (to the degree possible without breaking anonymity) like race, ethnicity, language, and age.
- Conduct longer-term, year-over-year analysis of PCS and MCS aggregate performance with 5-year trends, enrollment characteristics, and plan benchmarks in conjunction with a transparent platform for health plans to discuss this analysis, understand how performance may be associated with certain beneficiary characteristics, and guide quality improvement efforts.

Conclusion

Quality measurement that does not reflect the demographics or baseline physical accessibility of MA and SNP enrollees does a disservice to the people the Medicare program serves. Each year, thousands of beneficiaries dedicate time to filling out the HOS with the intention of informing plan efforts to ensure high-quality care. However, because of the limitations as described, the effort fails to represent the increasingly diverse MA and SNP population and does not adequately provide information for actionable and timely quality improvement.

Congress and CMS have an important and timely opportunity to address the shortcomings of the HOS and modernize it to better reflect and understand the changing Medicare population. As policymakers seek to assess programs and policies for unintended consequences and health equity impact, quality measurement should prioritize accessibility, inclusivity, and transparency. To that end, Congress should require that CMS update its quality measurement approaches (including the HOS). The CMS *Framework for Health Equity* can act as a powerful tool in achieving the vision for a more equitable and fair approach to quality measurement. Specifically, Congress should require the CMS address the following:

To ensure MA quality measurement equitably reflects the demographics of the Medicare population, **Congress should require CMS to update its quality measurement approaches** (including the HOS) in the following ways:

1. Quality measures should be **adequately tested and validated on diverse populations** (e.g., physically and intellectually disabled, people with social risk factors such as unstable housing, those with degenerative chronic conditions or behavioral health complexity, people of advanced age or frailty, and those with low literacy) if those measures are to be used in quality measurement for these groups.
2. Survey questions should **meet current mandatory translation requirements** as is required for other MA public-facing documents (i.e., any non-English language that is the primary language of at least five percent of any given state's Medicare population).
3. Future use of the HOS should **incorporate changes that align with CMS health equity priorities**, through principles of equitable and fair measurement:

- a. Survey questions should be **inclusive and culturally appropriate**.
 - i. Quality measures should be adequately tested and validated on diverse populations (e.g., physically and intellectually disabled, people with social risk factors, those with degenerative chronic conditions or behavioral health complexity, broad age groups, people with low literacy). In addition, alternative wording of HOS questions should be considered, to ensure inclusivity of and accessibility and meaningfulness to diverse populations. HOS could use alternative, validated, and widely used self-report measures that have already been translated into many languages and tested with diverse people with functional limitations, disabilities, and degenerative chronic conditions (e.g., [PROMIS Global Health](#), [Dartmouth COOP Charts](#), etc.).
 - ii. Quality measures evaluating health status improvement or decline over time should adjust for variables that might affect rate of decline and/or exclude individuals who have differing likelihoods of decline. Individuals in palliative care or with degenerative conditions should be excluded from potential HOS samples.
- b. Survey administration should be **representative and equitable**.
 - i. Survey questions should meet current mandatory translation requirements as is required for other MA public-facing documents (i.e., any non-English language that is the primary language of at least five percent of the individuals in a plan's service area). Non-English, Spanish, Chinese, or Russian speakers should have pathways to complete the HOS. This might include requiring translation of the HOS into other languages that are the primary languages of at least five percent of the Medicare population in a state. Translations of the HOS should be tested to ensure comprehension and meaningfulness to each sub-group before being used. HOS could use alternative, validated, and widely used self-report measures that have already been translated into many languages (e.g., [PROMIS Global Health](#)).
 - ii. Surveys should be accessible through a variety of formats to allow for respondent completion regardless of consistent phone or mail access. HOS administrators should be required to introduce an online and smart phone accessible survey administration option.
 - iii. To prevent significant proxy bias across two data collection periods, the HOS should allow or report on proxy responses only in instances where the same proxy representative completes the survey at baseline and follow-up.
- c. Survey results should **provide actionable insights** for improving quality among diverse populations.
 - i. Consider including additional questions on beneficiaries' communication, engagement, and/or experience with their health plans.
 - ii. Provide health plans with internal-use interim performance reports summarized by demographics such as race, ethnicity, language, and age, to allow for more real-time ability to address issues identified in the initial data collection period.
 - iii. Conduct longer-term, year-over-year analysis of PCS and MCS aggregate performance with 5-year trends, enrollment characteristics, and plan benchmarks in conjunction with a transparent platform for health plans to discuss this analysis,

understand how performance may be associated with certain beneficiary characteristics, and guide quality improvement efforts.

Taken together, the improvements listed above will allow for a quality measurement approach that is more reflective and inclusive of today's MA and SNP populations, provide a more accurate understanding of program quality, and help to advance more effective, efficient, and culturally appropriate care for the millions of Medicare beneficiaries enrolled in MA and SNP.

About This Work

ATI ADVISORY

ATI Advisory (ATI) is a research services and advisory firm, focused on improving the care experience and financing of care for individuals across Medicare, Medicaid, and long-term services and supports. ATI works with states, health plans, providers, associations, and philanthropic organizations to advance healthcare innovations and system efficiencies, and to improve equitable and appropriate access to care and programs.

SNP ALLIANCE

The SNP Alliance is a national non-profit leadership organization dedicated to improving policy and practice for serving high risk and complex needs individuals through Medicare Advantage Special Needs Plans (SNPs) and Medicare-Medicaid Plans (MMPs). The SNP Alliance's 26 health plan organization members serve over 2.8 million special needs individuals in 47 states and the District of Columbia.

Appendix: Methods

This analysis pulled from two data sources described below. the Health Outcomes Survey (HOS) Respondent data provides basic demographics on beneficiaries that fill out the HOS, while the Medicare Current Beneficiary Survey (MCBS) describes Special Needs Plan (SNP) and Medicare Advantage (MA) beneficiaries.

HOS RESPONDENT DATA

Data from CMS Medicare HOS Public Use Data Files (PUFs). ATI analyzed the follow-up respondents from cohort 22.

MEDICARE CURRENT BENEFICIARY SURVEY (MCBS)

The MCBS is a nationally representative sample of the Medicare population. The survey documents expenditures, payments, and health insurance coverage, while collecting critical data on demographic, social determinates of health, and experience with healthcare not available in other administrative data.

Pooled Study Design:

To enhance the sample size, the analysis leveraged years 2017-2020 of the MCBS. Some beneficiaries are surveyed multiple years in a row. A pooled design was used to modify the weight of the beneficiary to the average weight across their years in the survey, resulting in all individuals “appearing” once in the dataset.

Variable Definitions:

Activities of Daily Living (ADL): Six ADLs are defined in the MCBS: (1) eating, (2) bathing or showering, (3) dressing, (4) getting in and out of bed or a chair (transferring), (5) using the toilet, and (6) walking across the room. Respondents are coded as being impaired in an ADL at the “Help” level – that is, individuals who received assistance from another person to perform the activity—including assistance in physically doing the activity, instruction, supervision, and “standby” help. Alternately, the respondent does not perform the activity because of their health.

Area Deprivation Index: The national area deprivation index ranked census block groups by socioeconomic deprivation across factors like income, education, employment, and housing quality. This analysis estimated the percent of individuals whose primary residence is in the top quartile of most deprived census block groups. The area deprivation index is only available for years 2018-2020, so data was limited to those years and was appropriately weighted.

MA Enrollment: MA enrollment is defined as at least one month of coverage under MA during the study year, using Centers for Medicare and Medicaid Services (CMS)-derived variables that describe Medicare managed care membership. Beneficiaries were attributed to the MA plan they had been enrolled in the longest over the year.

SNP Enrollment: ATI cross walked the MA contract number and plan ID to the CMS' SNP Comprehensive Report file for January of each year from 2017-2020 to identify if the individual was enrolled in a SNP.

Serious Mental Illness: This definition differed depending on whether the Medicare beneficiary received the community or facility segment of the survey. Community respondents were tagged for serious mental illness if they confirmed diagnosis of a "Mental Disorder" or if they scored 3+, Major Depressive Disorder likely, on the Patient Health Questionnaire-2 (PHQ-2).

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