Social Determinants of Health (SDOH) and COVID-19

American Institute of Healthcare Compliance
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Social Determinants of Health

Due to COVID-19’s rising numbers, especially amid communities and populations most vulnerable to racial and socioeconomic disparities, the Centers for Medicare & Medicaid Services (CMS) is again emphasizing the power of value-based reimbursement. CMS is calling for a renewed national commitment to value-based care based on Medicare claims data that provides an early snapshot of the impact of the coronavirus disease 2019 (COVID-19) pandemic on the Medicare population.

As stated on April 16, 2020 by the American Medical Association (AMA), “Marginalized and minoritized patients have and will suffer disproportionally during the COVID-19 crisis. All physicians treating COVID-19 patients are experiencing unprecedented stress, including PTSD and burnout. Minoritized and marginalized physicians may experience more acute distress given the compounding factors their patients are dealing with related to their physical and social well-being. In addition, they are facing the realities of these structural inequities in these health care systems as they are not able properly care for their medical staff or their patients during this crisis.”

Do we understand the data?

We need to proceed with caution when reviewing the explosion of new cases. It has been reported that an individual who has tested positive and has subsequently been tested again (perhaps many times) is NOT counted as 1 case, but reported as multiple cases (the number of times this person tested positive). This is falsely inflating the number of actual individuals infected with the virus.

Another situation where data may be skewed is when an individual testing positive is counted only once, but negative tests can be counted repeatedly if the same person got more than one test.

If we can rely on the data, it tends to demonstrate that older Americans and those with chronic health conditions are at the highest risk for COVID-19 and confirms long-understood disparities in health outcomes for racial and ethnic minority groups and among low-income populations.

Excerpt from the June 22, 2020 News Release from CMS: “The disparities in the data reflect longstanding challenges facing minority communities and low-income older adults, many of whom face structural challenges to their health that go far beyond what is traditionally considered ‘medical’,” said CMS Administrator Seema Verma. “Now more than ever, it is clear that our fee-for-service system is insufficient for the most vulnerable Americans because it limits payment to what goes on inside a doctor’s office. The transition to a value-based system has never been so urgent. When implemented effectively, it encourages clinicians to care for the whole person and address the social risk factors that are so critical for our beneficiaries’ quality of life.”

www.aihc-assn.org
The data released recently by CMS show that more than 325,000 Medicare beneficiaries had a diagnosis of COVID-19 between January 1 and May 16, 2020. This translates to 518 COVID-19 cases per 100,000 Medicare beneficiaries. The data also indicate that nearly 110,000 Medicare beneficiaries were hospitalized for COVID-19-related treatment, which equals 175 COVID-19 hospitalizations per 100,000 Medicare beneficiaries.

- Blacks were hospitalized with COVID-19 at a rate nearly four times higher than whites. The disparities presented in the snapshot go beyond race/ethnicity and suggest the impact of social determinants of health, particularly socio-economic status.

Other key data points:

- End-stage renal disease (ESRD) patients (individuals with chronic kidney disease undergoing dialysis) had the highest rate of hospitalization among all Medicare beneficiaries, with 1,341 hospitalizations per 100,000 beneficiaries. Patients with ESRD are also more likely to have chronic comorbidities associated with increased COVID-19 complications and hospitalization, such as diabetes and heart failure.

- The second highest rate was among beneficiaries enrolled in both Medicare and Medicaid (also known as “dual eligible”), with 473 hospitalizations per 100,000 beneficiaries.

- Among racial/ethnic groups, Blacks had the highest hospitalization rate, with 465 per 100,000. Hispanics had 258 hospitalizations per 100,000. Asians had 187 per 100,000 and whites had 123 per 100,000.

- Beneficiaries living in rural areas have fewer cases and were hospitalized at a lower rate than those living in urban/suburban areas (57 versus 205 hospitalizations per 100,000).

The data also shows that besides higher hospitalization rates, beneficiaries enrolled in both Medicaid and Medicare have a higher infection rate of COVID-19, with 1,406 cases per 100,000 beneficiaries. By comparison, the coronavirus infection rate for beneficiaries enrolled only in Medicare is 325 cases per 100,000. The rate of COVID-19 cases for dual eligible individuals is higher across all age, sex, and race/ethnicity groups.

CMS is encouraging states to double down on efforts to protect low income seniors and look at the data and determine what resources are available, both locally and federally, to improve this disparity of health outcomes. CMS has identified a range of operational opportunities for states to improve care for dually eligible individuals and a variety of models that states can participate in that focus on improving the quality and cost of care for individuals who are concurrently enrolled in Medicaid and Medicare.

Is value-based care achievable?

Although value-based payment is a solution for quality care, legal barriers like the Anti-Kickback Statute, the Stark Law, and the False Claims Act frustrate the program. Although these laws protect the public from fraudulent reimbursement and unfair referrals, physicians cannot comply with these laws when the language is difficult to understand. For instance, potential violators have safe-harbors, but are only granted it if they have strictly complied with the language of that safe-harbor. Not understanding the law
deters physicians from participating in value-based programs for fear of violating the law. One such complaint was the language of fair market value (“FMV”) under the Stark Law, which is crucial for any physician compensation arrangement. The American Medical Association (“AMA”) proposed that the definition of FMV be clarified. Others have asked that the Stark Law be eliminated altogether.

A step towards reform was seen last October though when CMS released its proposed new Stark Law to “provide greater certainty for...providers participating in value-based arrangements...and ease the compliance burden.” They have even proposed to clarify ambiguous definitions like FMV.

However, despite this announcement, no reform will be seen until next year. The CMS issued a notice this week extending the deadline to finalize the rules by one-year.

Resources

CMS June 22, 2020 News Release:

Medicare COVID-19 data:

FAQ on SDoH visit:

CMS Administrator Seema Verma Blog Article:

CDC Research on SDoH:
- [https://www.cdc.gov/socialdeterminants/index.htm](https://www.cdc.gov/socialdeterminants/index.htm)

CDC COVID-19 Surveillance – Understanding the Data

Law Review Article
- [https://scholarship.law.tamu.edu/lawreview/vol7/iss3/3/](https://scholarship.law.tamu.edu/lawreview/vol7/iss3/3/)

A Proposed Rule by the CMS

CMS Announcement

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