SNP Alliance Position Statement

MARCH 2017
Accounting for Social Determinants of Health in MA Star Ratings

Background

In 2012, CMS began to implement the Medicare Advantage (MA) Star Rating system, which makes quality incentive payments to plans that obtain at least a 4-star rating under a 5-star rating system. Higher payments are provided in the form of higher MA benchmarks in each county. A financial penalty comes in the form of lower benchmarks. Currently, plan ratings are based on 47 performance measures derived from HEDIS, CAHPS, and HOS instruments, and from CMS administrative and encounter data.

Position

The SNP Alliance supports quality measurement and pay-for-performance as tools to assess and improve care for Medicare beneficiaries.

However, the current MA quality rating system (QRS) *does not take into account the underlying effect of social determinants of health* (SDOH) on beneficiary health status. Social risk factors such as poverty, low education level, living in a poor neighborhood, low health literacy, and other beneficiary characteristic have been show to significantly impact health and health outcomes ratings — *independent of provider or health plan actions*.

In addition, there is strong evidence that the *quality measures and data collection methods chosen are not well-matched* to a diverse population with multiple chronic conditions, behavioral health issues, and who are dually-eligible for both Medicare and Medicaid (Duals).

Compelling Evidence that Dual/Low SES Contributes to Poorer Health Outcomes

RAND Study, September 2015 - CMS released findings from a RAND study showing that a beneficiary's dual-eligible status significantly lowered outcomes on 12 of 16 Star Rating measures. It also found that disability status significantly lowered outcomes on 11 of 16 measures.

Inovalon, 2015 - An Inovalon study found similar results in that characteristics of dual-eligible enrollees explained 70% or more of the disparity in outcomes compared to non-dual eligible enrollees on five of eight measures studied. Significantly, dual-eligible status lowered performance on the "all cause hospital readmission" measure, the only Star Rating measure that is already adjusted for age, gender, and co-morbidities— indicating that these adjustments were not sufficient to remove bias. Lastly, even after adjusting for dual status and other factors, living in poverty further increased likelihood of readmission.

National Quality Forum, August 2014 - The National Quality Forum (NQF) noted in its report *Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors* that, "There is a large body of evidence that various sociodemographic factors influence outcomes, and thus influence results on outcome performance measures."

Congress Requires HHS to Study Impact of SES in Medicare

In the IMPACT Act of 2014, Congress recognized the potential effects of SES and dual eligible populations on the MA Star Ratings system by requesting the HHS Assistant Secretary for Planning and Evaluation (ASPE) to undertake studies on this population and the Medicare program at large. The first of two of these reports was recently issued.

ASPE Study, December 2016 - This seminal study by ASPE, released in their Report to Congress in December of 2016, found that dual beneficiary status was *the most significant predictor of* poor health outcomes as measured by the Medicare Star Ratings.

Furthermore, dual status, low income status, and disability status, as well as other SDOH factors examined impacted outcomes—*independent from provider or plan behavior.*

This was found across the board—for all Medicare programs (e.g., hospitals, clinics, plans, etc.).

Congress Urges CMS to Modify Stars to Account for SES

In the 114th Congress, many members of Congress urged CMS to modify the Star Ratings system to better account for the clinical and socio-demographic risk factors that are out of a plan's control, arguing that MA performance measurement should accurately reflect the challenges in caring for low-income, chronically ill people. That bill (S. 2104) proposed increased funding for MA plans that are penalized with poor ratings because they enroll a high percentage of dual eligible or low-income persons.

CMS Adopts CAI Method as Interim Adjustment to Stars

CMS modeled two adjustment methods in 2015. Unfortunately, the adjustment method developed and implemented in 2016 has proven ineffective, as it was very limited in scope. Last year CMS finalized adopted the Categorical Adjustment Index (CAI) as an interim adjustment to Stars to try to take into account social determinant of health risk factors. The methodology they chose accounted for only a few factors and was only applied to 6 of 47 Star measures. Thus, the CAI adjustment had a very limited impact in moving any high dual plans Star ratings to the 4-star threshold. CAI affected only 19 plans nationwide out of several thousand.

Recommendation: Plenty of Study, Time to Act

We now have *multiple independent studies* showing that social determinants of health, and specifically *dual status as a proxy*—significantly affects Medicare Star measure results--and thus adversely impacts an health plan's ability to achieve excellence under the Star Rating system if that plan has a predominately dual-status beneficiary enrolled membership. The safety net hospitals, low-income federally qualified health center clinics, and other providers in the SNPs provider network are also negatively affected by their own Medicare quality rating system application.

Thus, the adverse effects of the current Medicare QMS are especially profound for Special Needs Plans (SNPs)—since these plans primarily focus on dual eligible beneficiaries and on beneficiaries who live in poverty, are frail and/or disabled, and have complex chronic illness as well as behavioral health issues.

Given these findings and the analysis of independent researchers, that the current Star Rating system penalizes plans that specialize in care of dual-eligible persons, we urge Congress to require CMS to:

1. *Re-design the Medicare Star Rating* methods and measures, beginning with providing special needs plans with additional exceptions and exclusions for their high dual enrollment beneficiary populations in the current system.

2. *Improve the effectiveness of the CAI* by: adding additional Star measures into the calculation, incorporating dual status and SDOH factors in the CAI to more fully account for the impact of such beneficiary characteristics on Star Ratings, add one or more complexity of care and functional status factors into CAI. This will help move toward a more adequate Medicare QMS and ensure that high dual health plans are not harmed.

3. *Issue guidelines for Star measure developers* and stewards to re-test their measures for effect of SDOH/SES factors, including dual status, disability status, and low-income status at the smallest neighborhood level geographic unit. Guidelines should specify a consistent minimum sample size that includes oversampling of the duals, a minimum set of social risk factors to be tested, and results should be reported separately between the duals and non-duals tests.

4. *Re-examine the validity and reliability of self-reported HOS and CAHPS survey*s for persons who do not speak English, have low health literacy, or significant cognitive/memory impairment (data from these surveys are used to calculate several of the Star measures). Currently, these survey tools and the methods do not fully accommodate Medicare dual status beneficiaries who often have social risk factors that affect their ability to participate in the survey and their understanding of the survey questions. This has the strong potential to impact the validity and accuracy of results.