SNP Alliance Position Statement

NOVEMBER 2017

Accounting for Beneficiary Characteristics (Social Determinants of Health, Disability Status, Functional Status) in MA Star Ratings

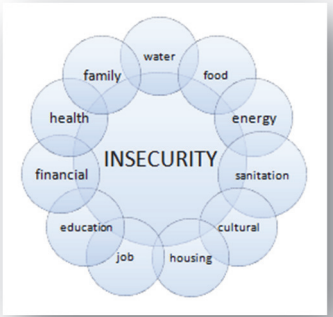
Background

In 2012, CMS began to implement the Medicare Advantage (MA) Star Rating system, providing quality incentive payments to health plans that obtain at least a 4-star rating under a 5-star 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 characteristics of the beneficiary population which may impact healthcare performance outcomes*. These include social determinant of health (SDOH) risk factors such as poverty, housing transience, low education level, living in a poor neighborhood, low health literacy, few social supports, and other beneficiary characteristics--such as poor functional status including cognitive impairment—which have been show to significantly impact health outcomes—*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).



Congress Requires HHS to Study Impact of SES in Medicare and the GAO to Study Functional Status

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) undertake studies on this population and the Medicare program at large. The 21st Century Cures Act requires the General Accounting Office (GAO) to study and report on how to accurately measure the functional status of MA beneficiaries and consider if including this factor in risk adjustment would improve the accuracy of quality measurement and payments. This is forthcoming.

ASPE Study, December 2016 - This seminal *Report to Congress* 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 of provider or plan behavior*. This was found across the board—for all Medicare programs (e.g., hospitals, clinics, plans, etc.). This report adds to a mounting body of evidence that low socioeconomic status, dual status, and disability status are recognized factors that impact health outcomes. For example, in 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.

Members of Congress have urged CMS to modify the Medicare 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 plan performance measurement should accurately reflect challenges in caring for low-income, chronically ill people. Congress has 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

In response, CMS modeled two adjustment methods in 2015. Unfortunately, the adjustment method developed and implemented in 2016 has proven ineffective, given its limited scope. In 2016 CMS 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 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 likewise negatively affected by their own Medicare quality rating system application for the same reason—serving low-income and vulnerable populations. Special Needs Plans (SNPs) 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, we urge Congress and CMS to support policy and regulatory action to:

1. ***Stratify Populations into High Dual/Low Dual Groups to Compare Quality Ratings for Similar Beneficiary Populations*** – Many reports suggest that stratification of populations into similar groups by using Dual-eligibility and Disability status as a proxy for social risk factors and other characteristics which increase vulnerability is warranted. This would increase understanding, accuracy, comparability, utility, and conclusions about measurement results.

2. ***Re-design the Medicare Star Ratings*** methods and measures, considering additional exceptions and exclusions for specific measures pertaining to specific special populations (e.g., end of life/palliative care, cognitively disabled).

3. ***Improve the effectiveness of the CAI*** by: adding additional Star measures into the calculation, incorporating additional factors in the CAI, adding one or more complexity of care and functional status factors into CAI. This will help move toward a measurement and payment system that is more equitable.

4. ***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.

5. ***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/Medicaid 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.

6. ***Provide Data Guidance and Technical Support*** - to improve data availability and standardization to obtain individual and community-level social risk factor information and use it to stratify, analyze, and report on beneficiary populations and quality measurement results. The Final Report of the *National Quality Forum Disparities Standing Committee* (July 2017) noted that data limitations and methodological issues significantly restrict the ability to make progress in adjusting individual quality measures to take into account social risk factors. Their work brings attention to the need for: data standardization and availability on social risk factors, refinement of risk adjustment models to be conducted and analyzed at the smallest (neighborhood) geographic level, and inclusion of community factors in models.