
# Factors affecting variation in Medicare Advantage plan star ratings: Follow-up

Carlos Zarabozo

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MEDPAC

# The issue

- Medicare Advantage plans with high quality ratings in the star system receive bonuses
- Plans serving primarily low-income populations tend not to have high star ratings
  - Plans attribute this to the complex care needs and socioeconomic status of their enrollees
- CMS and MedPAC found an association between low star ratings and enrollees'
  - Low-income status
  - Disability status

# Follow-up issues on MA stars

- Important aspects of CMS findings
- Potential impact if star ratings adjusted
- Questions and issues raised by Commissioners
- Different approaches to address the problem

# Important aspects of CMS findings

- Small effect for small set of measures
  - "The research to date has provided scientific evidence that there exists an LIS/Dual/Disability effect for a small subset of the Star Ratings measures. The size of the effect is small in most cases and not consistently negative."
- Socio-economic status does not show significant effect when LIS/disability taken into account
  - "Little improvement in explanatory power of model when census block SES factors are included....Not sensitive to inclusion of census block group-level SES measures (education, income/poverty)."

Source: Centers for Medicare and Medicaid Services, *Examining the potential effects of socio-economic factors on star ratings*, September 8, 2015.

# What is meant by “small effect”?

| CMS median within-contract measure differences by population category for non-outlier contracts | | | | |
|---|---|---|---|---|
| | **Number of star measures examined** | **Large effect** | **Mid-range effects** | **Lowest effect, or better in LIS/disabled population** |
| Low-income effect | 16 | 1 measure | 7 measures | 8 measures |
| Disability status effect | 15 | 2 measures | 8 measures | 5 measures |

Note: Large effect is 8 percent difference in the rate for a given measure between the two populations (e.g., low-income versus non-low-income). Mid-range effect is 2 to 7 percent difference. Low effect is less than two percent; some measures are better for the low-income or disabled compared to non-low-income and aged.
Source: Centers for Medicare and Medicaid Services, *Examining the potential effects of socio-economic factors on star ratings*, September 8, 2015. Because data points for graphics were not provided in the CMS document, figures are estimated from bar charts.

# Effects at the contract level

- **Effects for disabled are small for most plans because disabled are a small share in each contract**
  - For example, if there is an 8 percent difference for a measure for a person with disability status, and disabled enrollees are 20 percent of the denominator for the measure, there is a 1.6 percent effect on the contract's overall measure result
- **Biggest effect among**
  - Special needs plans for dually eligible beneficiaries when contract is 100 percent SNP
  - Overlapping category of plans with high shares of enrollees under age 65 (81 percent of full dually eligible beneficiaries who are MA enrollees are in D-SNP plans)

# Commissioner discussion at September 2015 meeting

- Do specialized plans show better performance for their populations compared to non-specialized plans?
- Is it the stars or the dollars?
  - Level the playing field for whom?
  - Provide additional funds to plans with high shares of disadvantaged populations?

# Do specialized plans perform better than non-specialized plans?

- Two populations of concern are low-income beneficiaries and beneficiaries under the age of 65 (disabled)
- There are specialized plans for Medicare-Medicaid dually eligible beneficiaries (D-SNPs)
  - Many under-65 enrollees in D-SNPs: 45 percent of Medicare beneficiaries under 65 are dually eligible
- With some exceptions (plans with small enrollment), no plans specializing, per se, in care of the disabled
  - However, plans with high shares of under-65 enrollees would be expected to address the specific care needs of their enrolled population

# Do certain beneficiaries fare better in specialized plans?

| Beneficiary/plan category | Comparison |
|---|---|
| **Comparing special needs plans (D-SNPs) to non-SNPs** | |
| Aged full dually eligible beneficiaries | Specialized plans (D-SNPs) better |
| Full dual eligibles under age 65 (disabled) | Specialized (D-SNP) plans better, but not to same extent as among aged |
| **Comparing contracts based on their share of under-65 enrollment** | |
| Under 65 in D-SNPs | For their under-65 population, D-SNPs with higher shares of under-65 enrollment generally do not perform better than D-SNPs with lower shares of under-65 |
| Under 65 in non-SNP plans | For their under-65 population, non-SNPs with higher shares of under-65 enrollment do not perform better than those with lower shares of under-65 enrollment |

Note: Results preliminary and subject to change. Source: MedPAC analysis of 2012 MA quality data.

# The disabled as a category of focus: Leveling the playing field for beneficiaries

- On average, D-SNP results for full dually eligible beneficiaries better than among non-D-SNPs
- On average, plans with higher shares of enrollment of the under-65 do not have better results for under-65 enrollees
- Suggests that more attention should be paid to the under-65 population
  - Seek to level the playing field for the disabled population, reducing disparities in their quality of care

# The star system as a vehicle for addressing disparities for disabled

- Plans pay attention to measures in star ratings
- For most measures, majority of population to whom measure applies are aged
- Focus on disabled by including/heavily weighting certain measures (with need to add measures for disabled, as Commission recommended in 2010)

# Alternative interim methods for changing contract star ratings

- Weighting methodology, such as CMS's initial approach of down-weighting certain measures (or removing some measures)
- Improvement approach
  - Giving greater weight to existing improvement measure
  - Give more weight to improvement for measures showing disparities

# Alternative/additional approaches

- Designate funds to promote improvement among plans with highest shares of specific populations (on a budget-neutral basis, similar to Commission's recommendation on the role of Quality Improvement Organizations)
- Tailor benefit packages within plans to meet the needs of beneficiaries with disabilities (already the case for the dually eligible with D-SNPs)

# Basis for supporting an interim approach

- Impact of currently identified adjustments may be relatively small for most plans
- Stars have already been determined for 2017 bidding purposes (the “2016” stars released in the fall of 2015)
  - May be legal issue of statute not permitting two sets of stars (public reporting; for bonus)
- CMS and HHS continuing to examine the issue (IMPACT Act requirement)
- Consider degree of infrastructure changes needed (e.g., plan reporting) if only small effect

# Conclusion

- Comment on interim solutions
- Will continue to monitor work of CMS and Department of Health and Human Services