Eight extra words in the latest Advance Notice have the potential to drive big changes among Medicare Advantage (MA) plans.

Under the heading Part C and D Star Ratings and Future Measurement Concepts, the Centers for Medicare & Medicaid Services (CMS) states: "The Star Ratings support CMS' efforts to make the patient be the focus in all of our programs *and to create incentives to eliminate health disparities*." It's those last eight words in italics that could force health plans to reevaluate their approach to determining what really matters.

The added phrase suggests CMS may soon be increasing its expectations that MA plans take health equity seriously — and putting its money where its mouth is by rewarding the plans that demonstrate the highest performance in addition to providing the top care and experience.

CMS, which issued its latest Advance Notice on Feb. 2, will update with a final Rate Announcement by April 4. The agency solicited feedback on potential measurement concepts and methodological enhancements including:

- Plans to enhance current CMS efforts to report stratified Part C and D Star Ratings measures by social risk factors to help MA and Part D sponsors identify opportunities for improvement.
- Development of a Health Equity Index as an enhancement to the Part C and D Star Ratings program to summarize measure-level performance by social risk factors into a single score used in developing the overall or summary star rating for a contract.
- Development of a measure to assess whether plans are screening their enrollees for health-related social needs such as food, housing and transportation.
- How MA organizations are transforming care and driving quality through value-based models with providers to use in the potential development of a Part C Star Ratings measure.

Helen Kurre, naviHealth VP of Utilization Management, Operations and Quality, is pleased to see CMS returning to its pre-COVID-19 cycle of issuing its Advance Notice in February and its final rate notice in April. "Now we again have the opportunity to look at changes that are about the program and not a result of the COVID impact," she says.

MA Star Ratings and their impact today

Helen Kurre
VP of Utilization Management, Operations and Quality
naviHealth

Since CMS launched its 5-star rating system in 2008 to measure the performance of MA contracts, it has awarded about $6 billion a year in bonus payments based on those ratings, according to study results published June 11, 2021, by the JAMA Network.

Still, with a finite amount of money available to offer, not every health plan can earn the 4-star rating that unlocks the door to a quality bonus payment. And a plan can only guess what the 4-star threshold will be in a given year. For larger health plans, these bonuses can be worth tens of millions of dollars a year, and the unexpected loss of such a payment can be devastating to those that have factored them into their strategies, if not their budgets. It can force tough decisions that hurt membership or enrollees: Do we go from zero premium to a small premium? Cut back supplemental benefits? Increase our copays? Will we lose members?

An unintended side effect of the rating system has been the pressure on plans to drive their overall star rating, often at the expense of other performance measures that carry no weight. As a result, health plans may decide not to guide their interventions toward patients who are not going to help them meet their goals.

Meanwhile, dual-eligible health plans serving Black, Hispanic or lower socioeconomic status populations can feel the pinch. In customizing their benefits to better meet the needs of their patients — whether based on medical complexities, transportation barriers, language or other factors — they fall short of the 4-star rating that would bring them additional dollars and resources to help their members. Other MA plans, catering to memberships with a higher socioeconomic status, do not embed screenings and assessments to identify risk factors in their case management programs, allowing disadvantaged members to fall through the cracks.

Addressing the issues or gaps in the assessment

Despite the game-changing role that MA Star Ratings can play in the success of health plans, the degree to which they accurately represent the quality experience of patients across the racial and socioeconomic spectrum has been scrutinized for years.

CMS is scheduled to release the Final Rate by April 4 – but what role will the Health Equity Index play?

The previously mentioned JAMA Network investigation, a cross-sectional study of more than 1.5 million MA enrollees, sought to answer this question: “Do Medicare Advantage Star Ratings, which are generated using data from all enrollees in a plan, reflect the quality experience of racial/ethnic minorities and enrollees with low socioeconomic status (SES)?”

The study “found that simulated Star Ratings for persons with lower SES and Black and Hispanic enrollees were substantially lower than ratings for those with higher SES and White enrollees in the same contract.” Among its conclusions: “MA Star Ratings may need to be modified to explicitly consider and reward equity in care.”

Now, with CMS seemingly having expressed interest in 1) stratifying more MA quality measures by race/ethnicity and 2) including an equity index in Star Ratings, health plans would be wise to stay abreast of these and related developments. HEDIS, for example, recently included stratification in its measurement reporting for the first time, and other industry influencers could follow that widely used performance improvement tool.

Because the Advance Notice offers an opportunity to float and discuss concepts before they become a reality, certain measures in recent years have remained “on display” for a time but have never moved into the rule-making process and become codified. That has been the case with multiple measures aimed at combating the ongoing opioid crisis.

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This latest notice feels different to Kurre. “The concept proposal is pretty significant,” she says. “That they’re going to have some sort of measurement of the disparity is one piece of it, but the second piece is how they’re looking to apply it.”

The proposed Health Equity Index would replace the 0.0-to-0.4 reward factor, commonly used by health plans to push them above a 3.75 rating and get them into the 4 range. That the proposal has gotten to this point makes Kurre think it will go farther than the proposed opioid measures that remain on display.

The importance of applying equity to the MA Star Ratings equation

The health care industry’s continuing shift toward value-based models is increasing awareness among providers and payers of the need to treat the whole patient. That necessitates a sharper focus augmented by a rich data set that runs both deep and wide. Crucial to that focus are details about the economic conditions, access issues and other social determinants that contribute to the overall health of individuals as well as populations.

Equity is a crucial piece of the puzzle. The more the industry can do to highlight disparities and effectively confront them, the more care will improve. Fine-tuning the MA Star Ratings to produce a fuller, more accurate picture is an ongoing process; applying equity to the equation could lead to insights that galvanize much-needed change.

“Health care organizations are treasure troves of data. They have an opportunity to take a look at that data and understand the disparities within their own population,” Kurre says. “The first step is to understand the data and the disparities. The next step, which is the key, is creating appropriate interventions based on a root cause analysis of your particular population. For post-acute care providers and others caring for disadvantaged populations, it’s a matter of looking at: How might you plan differently? How can you better leverage caregiver support? Are there enough follow-up providers in your community who are like the population that you serve?”

The inclusion of those eight extra words in the Advance Notice holds exciting potential, Kurre says. “It’s definitely the right thing to do. It presents an opportunity for those health plans that care for disadvantaged and vulnerable populations to potentially have quality bonus payments more in arm’s reach than they ever have.”

Bonus payments can fund the creation of intervention programs that drive continued improvement. For a smaller health plan that cares for a niche membership — a dual-eligible, non-English-speaking population, for example — a several million dollar quality bonus payment could “help them create an intervention program that could truly make a difference.”

Click below to see how the “biggest disruption in health care delivery in modern history” means for Medicare Advantage.

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