The Impact of Social Risk Factors on Medicare Star Rating Performance

Differentiation in HEDIS® and Medication Adherence Performance

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For several years, the Centers for Medicare & Medicaid Services (CMS) has indicated they intend to reward Medicare Advantage Organizations (MAOs) that provide high-quality care to enrollees with social risk factors, or SRFs. With the release of the Contract Year 2024 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs Final Rule[1] on April 5, 2023, CMS has outlined changes in the Star Rating program that are intended to incentivize MAOs to focus on improving care for enrollees with social risk factors. These changes have the potential to substantially impact Star Ratings in 2027 and Medicare spending in 2028.

In the final rule, the MA Stars program was a particular focal point. CMS proposed several changes to both Part C and Part D individual measures and finalized the definition of a new Health Equity Index (HEI) score, which will begin impacting Star Ratings in 2027. The HEI aggregates contract performance among enrollees with SRFs across multiple Stars measures into a single score that can be compared across contracts. CMS has defined social risk factors to include those individuals who receive the low-income subsidy or are dually eligible for Medicare and Medicaid (LIS/DE) or have a disability. Contracts with a significant proportion of SRF enrollees and a positive HEI score will receive an HEI reward, which will increase their Overall Star Rating. The HEI reward will replace the current reward factor in the Star Rating program. For additional background on the HEI score and reward, refer to Appendix A.

CMS estimates this change will result in net savings to the Medicare Advantage program of $670 million in 2028 (based on 2027 Star Ratings) and savings of over $5.1 billion over the following 10 years. These savings estimates indicate many MAOs will see a decline in Star Ratings when the current reward factor is replaced by the HEI reward.

In addition to the HEI reward, the final rule also includes an update to the Part D medication adherence measures with the addition of an adjustment for socioeconomic disparity. The medication adherence measures will be risk-adjusted (also referred to as case-mix adjusted) for sociodemographic status (SDS). Although the details of the SDS model are unknown, they will likely be similar to the SRFs used for HEI determination. This change will take effect in the 2028 Star Ratings.

[1] https://public-inspection.federalregister.gov/2023-07115.pdf

Medicare Advantage Plan Members with Social Risk Factors Consistently Underperform in Key Quality Measures.

Wakely analyzed performance differences of Healthcare Effectiveness Data and Information Set [2] (HEDIS®) and Part D Medication Adherence measures for SRF compared to non-SRF individuals enrolled in Medicare Advantage (MA) plans. For this analysis, we used 2021 data from 38 Medicare Advantage contracts totaling over 600,000 members. Although the difference varies by Stars measure, one pattern is consistent: MA plans underperform on SRF members relative to non-SRF members. Table 1 summarizes the average difference in quality performance on these measures across all contracts. Note that the PCR measure is a "lower is better" measure, where a positive difference indicates worse performance. As such, members with social risk factors underperformed members without social risk factors for all of the measures below.

Table 1
Differences in Select Stars Measure Performance, SRF – non-SRF

Stars Measure	Differential
HEDIS	
Follow-Up After Emergency Department Visit for People with High-Risk Multiple Chronic Conditions (FMC)	-6%
Plan All-Cause Readmissions (PCR) [3]	2%
Medication Adherence	
Diabetes	-7%
Hypertension (RAS-Antagonists)	-8%
Cholesterol (Statins)	-8%

For this analysis, we selected a subset of HEI eligible measures with consideration of data limitations. We included administrative HEDIS Stars measures that use medical claims data as the primary source, do not rely on supplemental data sources such as laboratory and electronic health records, and only utilize claims data within the measurement year (no prior lookback period). Although CMS has not published the full list of Stars measures that will be included in the HEI score, current guidance indicates that all the measures in Table 1 will be included [4].

It is important to note that this difference varies widely between contracts, with some MA plans performing more similarly between SRF and non-SRF members. However, the majority of plans show a significant performance gap between these two groups.

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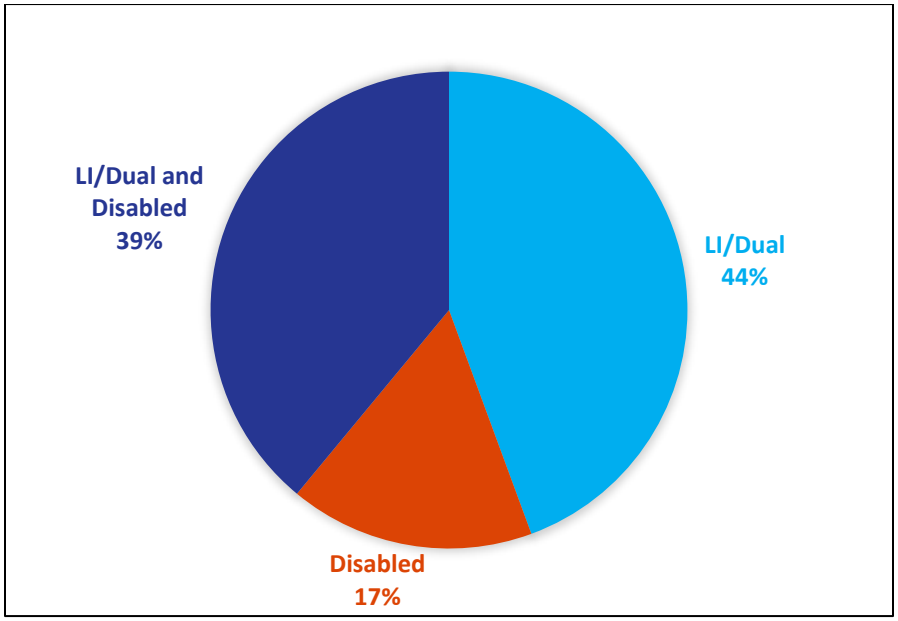
[2] The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA. Refer to Appendix B for applicable NCQA Copyright Notices and Disclaimers.
[3] Note that PCR is a "lower is better" measure – a positive difference indicates worse performance.
[4] CMS proposes to include all Star Ratings measures unless they meet one of these exclusions: the measure focuses on the plan or provider rather than the enrollee (e.g., call center measures), retired or display measures, SNP-only measures, or measures with less than 25% of contracts meeting the measurement criteria.

There is a Strong Correlation between Low-Income and Disabled Social Risk Factors.

As noted above, members with Social Risk Factors include those who are low-income (LI), dual eligible (Dual), or disabled. If a member receives any of these statuses at any point throughout the year, CMS will include them in the HEI. Our study determined that the LI/Dual and Disabled statuses are highly correlated, with 39% of SRF membership receiving both LI/Dual and disabled statuses. An additional 44% of members qualify due to solely having LI/Dual status, with the remaining 17% qualifying for having a disability only.

Chart 1
Composition of SRF Membership



Members with Multiple Social Risk Factors Perform Worse in Quality Metrics Than Members with Only One Qualifying Factor.

Although CMS treats all SRF members the same for purposes of the HEI, there is significant differentiation in quality performance of the cohorts within this group. Table 2 demonstrates the variation between cohorts relative to the average performance of SRF members in total.

Table 2
Variance in Select Stars Measure Performance, Relative to SRF Average

Stars Measure	LI/Dual	Disabled	LI/Dual and Disabled
Part C			
Follow-Up After Emergency Department Visit for People with High-Risk Multiple Chronic Conditions (FMC)	-1%	2%	0%
Plan All-Cause Readmissions (PCR)[5]	1%	-1%	0%
Medication Adherence			
Diabetes	2%	1%	-4%
Hypertension (RAS-Antagonists)	0%	4%	-3%
Cholesterol (Statins)	0%	4%	-3%

Members with both LI/Dual and disabled status perform significantly worse than the SRF average. Conversely, disabled-only members perform significantly better than the SRF average, particularly in the medication adherence measures.

Conclusion

CMS is implementing major changes to the Star Rating program over the next few years, with a clear focus on Health Equity. In addition, CMS has finalized other program changes that will bring new headwinds to plan Star Ratings, including the introduction of Tukey outlier deletion in 2024 and risk adjusting medication adherence measures for socio-economic status in 2028, which will likely depress performance in these measures for MAOs that do not have a significant portion of low-income or disabled membership. These changes will require plans to adjust in order to maintain current Star Ratings.

As CMS increases the Star Ratings focus on those with Social Risk Factors, it will be critical to improve quality performance for this population. In the past, MA plans could withstand some amount of relative underperformance in this population because CMS determined Star Ratings using the plan's performance in aggregate. With this change, CMS will now measure performance on the SRF population on its own in addition to aggregate plan performance. Underperformance on the SRF population, both within plan performance and in comparison to other MA contracts, will be a detriment to Overall Star Ratings. Plans must maintain or even increase their quality program investments targeting this population if they want to sustain historical Stars performance.

It will be increasingly important for MAOs to measure Stars performance for this population and model the anticipated impact on 2027 Overall Star Ratings. MAOs should be evaluating their performance on all measures for their SRF and non-SRF populations to better understand where gaps exist and how to begin closing such gaps. Plan performance in 2024 and 2025 will be used in the 2027 Star Ratings, which

[5] Note that PCR is a "lower is better" measure – a positive difference indicates worse performance.

further highlights the urgency for plans to implement initiatives such as case management, member outreach and provider engagement targeting the SRF population.

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Appendix A

Health Equity Index (HEI) Score

CMS will calculate measure-level scores for each contract for SRF enrollees. Not all Stars measures will be included; CMS will exclude operational measures such as appeals and customer service, Special-Needs Plans (SNPs) measures, measures where less than 25 percent of contracts receive a reliable score, and measures that are retired or moved to display status. The scoring methodology will use measure level scores from the most recent two measurement years to increase the number of contracts receiving a score and thus increase the number of measures where at least 25 percent of contracts have a reliable score.

The measure-level scores will roll up into the HEI score. This calculation closely resembles the methodology used to calculate the Part C and D improvement measures. Contract performance will be parsed into thirds, with the top third of contracts receiving +1 point, the middle third receiving 0 points, and the bottom third receiving -1 point. The weighted average of these points, weighted by the Stars measure weights, is the HEI score.

Health Equity Index (HEI) Reward

CMS proposed two different models for the HEI reward: tiered and non-tiered. With the Final Rule, they formalized the tiered model. To qualify for the HEI reward, a contract must have an HEI score above 0 and SRF enrollment above one-half (½) the median SRF percentage across all contracts. In CMS simulations using the 2020 and 2021 Star Ratings, the median SRF percentage was 41.645% for MA and Cost contracts.

Contracts falling below ½ the median will not be eligible for the HEI reward. Contracts between ½ the median and the median will receive an HEI reward between 0.0 and 0.2 on a linear scale, with a contract receiving 0 if the contract receives a score of 0 or less on the HEI and 0.2 if the contract receives a score of 1 on the HEI. Contracts above the median will receive an HEI reward between 0.0 and 0.4 on a linear scale, with a contract receiving 0 if the contract receives a score of 0 or less on the HEI and 0.4 if the contract receives a score of 1 on the HEI. The HEI reward is then added to the Overall Star Rating.

Appendix B

Methodology and Assumptions

Wakely used the licensed measure specifications for Healthcare Effectiveness Data and Information Set ("HEDIS®"), Volume 2 Technical Specifications, as published by the National Committee for Quality Assurance ("NCQA"). All HEDIS measures within this report are Wakely certified measures. Wakely also used the HEDIS Value Set Directories as released by NCQA. For this analysis, 2021 enrollment, medical, and pharmacy claims data were used to calculate HEDIS measures following the MY2022 technical specifications. No supplemental data, such as lab or vision, were included. Please find additional NCQA Copyright Notices and Disclaimers and NCQA Measure Adjustment and Certification Notices below.

Part D measures included in this report were calculated using the 2022 Measure Manual specifications published by the Pharmacy Quality Alliance (PQA).

For SRF identification, a low-income status or dual eligible beneficiary is defined as one who was full-or partial-benefit dually eligible or who received a low-income subsidy at any time during the measurement period. A disabled beneficiary is defined as one who had an original reason for entitlement code to the Medicare program (OREC) of one or three.

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