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Meeting topics

Motivation for addressing disparities in MA and Part D contract Star Ratings

Understanding the role of social risk factors in MA and Part D contract performance

Approaches to ensuring accurate performance measurement

TEP’s input on strategies to reduce disparities
Increased attention to reducing disparities in care

A large body of literature demonstrates:

- Disparities in quality of care and patient outcomes across an array of beneficiary characteristics, including social risk factors
- Social risk factors influence care seeking and health outcomes

Interest in assessing disparities

Focus on understanding the role of social risk factors in performance measurement
Not accounting for social risk factors in performance measurement could have unintended consequences

• Concentration of beneficiaries with social risk factors among some providers may affect their performance ratings in value-based payment programs (VBP) and, in turn, their payments

• VBP penalties or lack of VBP rewards may compromise the ability of providers who serve a high proportion of beneficiaries with social risk factors to deliver high quality care
  – Providers who serve a high proportion of beneficiaries with social risk factors tend to have fewer resources than other providers

• VBP can create incentives to avoid patients with social risk factors

• May lead beneficiaries to make suboptimal choices of providers
There are many potential reasons for disparities related to patient characteristics

<table>
<thead>
<tr>
<th>Out-of-pocket costs</th>
<th>Comorbidities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low health literacy</td>
<td>Disability*</td>
</tr>
<tr>
<td>Lack of transportation</td>
<td>Other characteristics</td>
</tr>
</tbody>
</table>

* Medicare Payment Advisory Commission, March 2015 Report to the Congress: Medicare Payment Policy
Providers also contribute to disparities in multiple ways

- Lower quality providers
- Poor communication
- Discrimination (active or passive)
- Structural racism
Organizations simultaneously considered the impact of social risk factors on performance measurement and VBP

**NASEM**

National Academies of Science, Engineering, and Medicine (NASEM) convened the Committee on Accounting for Socioeconomic Status in Medicare Payment Programs
- Commissioned by HHS Office of Assistant Secretary for Planning and Evaluation (ASPE)
- Asked to “provide input into whether socioeconomic status (SES) and other social risk factors could be accounted for in Medicare payment and quality programs”

**ASPE**

The HHS Office of the Assistant Secretary for Planning and Evaluation examined disparities related to social risk factors in Medicare VBP programs
Experts and policymakers are exploring the role of social risk factors in performance measurement and VBP

2014

- The National Quality Forum (NQF) releases draft report, *Risk Adjustment for Socioeconomic Status (SES) and Other Sociodemographic Factors* (April 2014)
- Considers risk adjustment on measure-by-measure basis

2015-2016

- The Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act): HHS to assess how to account for SES in value-based payment programs
- NASEM released a series of reports funded by ASPE

2016-2017

- NASEM released a series of reports funded by ASPE
- Since 2015, the NQF could consider whether measures appropriately accounted for social risk as part of its measure review (NQF social risk trials)

2018-present

- ASPE released 2nd report to Congress (June 2020)
What is a social risk factor?

NASEM

Committee developed criteria for what constitutes a social risk factor (SRF)

• Related to health care outcomes
• Are evident before health care is delivered
• Are not consequences of the quality of care
• Are not easily modified by health care providers

Social risk factors identified by NAM, ASPE, and CMS

- Socioeconomic position
  - dual eligibility
  - income
  - education-level

- Race/ethnicity/cultural context
  - race/ethnic group
  - country of origin
  - language spoken

- Gender/sexual orientation

- Social relationships
  - marital/partnership status

- Residential/community context
  - urban/rural residence
  - extent of neighborhood deprivation
  - adequacy of housing

Data readily available
Some data available

Social risk factors identified by NAM, ASPE, and CMS

- Socioeconomic position
  - wealth

- Race/ethnicity/cultural context
  - extent of acculturation

- Gender/sexual orientation
  - gender identity
  - sexual orientation

- Social relationships
  - living with others/alone
  - amount of social support

- Residential/community context
  - other environmental factors

Complementary strategies are needed to measure performance accurately and address disparities

Ensure accuracy of measurement

Increase awareness of disparities in performance

Strengthen payment incentives to reduce/eliminate disparities

Modify payments to providers to offset higher cost of delivering high quality care to those with social risk factors and provide other support
Complementary strategies are needed to measure performance accurately and address disparities

Ensure accuracy of measurement

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Strengthen payment incentives to reduce/eliminate disparities

Modify payments to providers to offset higher cost of delivering high quality care to those with social risk factors and provide other support
Strategy 1

- Direct adjustment (e.g., case-mix adjustment)
- Indirect adjustment that approximates case-mix adjustment
Strategy 2

Increase awareness of disparities in performance

- Report stratified measures of performance
- Assess performance among those with social risk factors
- Develop measures specific to those with social risk factors
- Disparity/equity index to reward equitable care
- Collect additional data to better identify/evaluate disparities
Strategy 3

• Reward performance improvement among those with social risk factors
• Assign higher weight to measures focusing on equity or performance among those with SRFs
• Determine rewards within strata/peer groups based on SRFs (MedPAC)

Strengthen payment incentives to reduce/eliminate disparities
Three strategies to identify and reduce disparities were highlighted in both ASPE reports to Congress

1. Measure and report quality for beneficiaries with social risk factors
2. Set high, fair quality standards for all beneficiaries
3. Reward and support better outcomes for beneficiaries with social risk factors
NASEM identified four approaches to account for social risk factors in measurement and VBP programs

1. **Stratified public reporting** by social risk factors at the level of designated “reporting units” (e.g., MA contracts)

2. **Adjustment of performance measures** to make provider quality estimates comparable

3. **Restructuring payment incentives** to reward improvement in quality or achievement of high-quality care for these patients

4. **Direct adjustment of payments** to providers who disproportionately serve patients with social risk factors

Lack of consensus about how to address disparities in value-based purchasing programs

- Desire to create incentives to deliver equitable care/achieve equitable outcomes
- Don’t want to unfairly disadvantage those serving beneficiaries with social risk factors
- Concern that adjustment for social risk factors masks disparities
Questions?
Meeting topics

Motivation for addressing disparities in MA and Part D contract Star Ratings

Understanding the role of social risk factors in MA and Part D contract performance

Approaches to ensuring accurate performance measurement

TEP's input on strategies to reduce disparities
CMS focuses on 2 social risk factors for MA and PDP Star Ratings

1. Dual eligibility for Medicare and Medicaid (DE) or receipt of Part D low-income subsidy (LIS)
   - Full or partial dual
   - DE or LIS at any point in year

2. Disability
   - Original reason for entitlement
MA contracts vary in their LIS/DE enrollment

- Average % LIS/DE is 36.0% (range: 1.4% -- 100%)
- Many contracts have a very low percentage of LIS/DE enrollees
- D-SNPs are 100% LIS/DE
Disabled enrollment in MA contracts is skewed

- Average % disabled is 29.2% (range: 2.2% -- 99.8%)
- Many contracts have a low percentage of disabled enrollees
- Few contracts have a very high percentage of disabled enrollees
LIS/DE and disabled enrollment in PDP contracts are skewed and lower on average than in MA contracts

Average: 14.1% LIS/DE
Range: 0.6% to 87.3%

Average: 15.3% disabled
Range: 3.6% to 42.0%
Approximately a third of MA beneficiaries are LIS/DE, disabled, or both.
Slightly higher Star Ratings among MA contracts with lower percentage of LIS/DE beneficiaries

- Few contracts that are more than 50% LIS/DE received 4.5 or 5 stars
Negative relationship between MA contracts’ percentage disabled beneficiaries and contract performance

- Very few contracts that are more than 50% disabled received 4.5 stars.
- None received 5 stars.
Negative relationships between performance and percentage of LIS/DE/disabled enrollees are stronger among PDP contracts than MA contracts.
Disparities can be broken into two parts

- Between-contract disparities
- Within-contract disparities

Total disparities
Disparities can be broken into two parts

Between-contract disparities

Beneficiaries with social risk factors are more often enrolled in lower-performing contracts
  • Reflect true differences in performance
  • Not appropriate for adjustment

Within-contract disparities

Total disparities
Disparities can be broken into two parts

- Between-contract disparities
- Within-contract disparities

Total disparities

They receive worse care within the same contract

- May mean unadjusted assessments of performance are mis-measured or biased in some contracts
- May be appropriate for adjustment
Disparities can be broken into two parts

- Between-contract disparities
- Within-contract disparities

Total disparities

Adjusting for within-contract disparities does NOT eliminate or mask between-contract disparities
Illustration of difference in types of disparity

<table>
<thead>
<tr>
<th>Contract</th>
<th>% of Low-SES Enrollees</th>
<th>Overall Average Performance</th>
<th>Low-SES Avg Performance</th>
<th>High-SES Avg Performance</th>
<th>Within-Contract Difference (Low SES - High SES)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>17.6%</td>
<td>84.9%</td>
<td>80.0%</td>
<td>86.0%</td>
<td>-6.0%</td>
</tr>
<tr>
<td>B</td>
<td>61.5%</td>
<td>51.5%</td>
<td>50.0%</td>
<td>54.0%</td>
<td>-4.0%</td>
</tr>
</tbody>
</table>

Between-contract disparities

Contract B has worse performance than contract A among both low-SES and high-SES groups

Within-contract disparities

Difference for low- vs. high-SES groups is -6% for contract A and -4% for contract B

Within-contract difference averages 5%
Within-contract disparities exist on many Star Rating measures for most of the social risk factors considered by ASPE.

- **Dually-enrolled/LIS**
  - Worse care: 16
  - Similar care: 2
  - Better care: 2

- **Low-income ZCTA**
  - Worse care: 12
  - Similar care: 4
  - Better care: 5

- **Black**
  - Worse care: 9
  - Similar care: 4
  - Better care: 6

- **Hispanic**
  - Worse care: 15
  - Similar care: 3
  - Better care: 12

- **Rural**
  - Worse care: 14
  - Similar care: 3
  - Better care: 2

- **Disabled**
  - Worse care: 2
  - Similar care: 3
  - Better care: 1

* Similar care means the odds ratio for a measure was not statistically significant at p<0.05; ASPE 2016
RAND’s work for CMS Star Ratings has focused on identifying and addressing LIS/DE and disability disparities

- Examine the extent to which disparities exist overall and within contracts
- Assess the consistency of within-contract disparities across contracts
- Develop an approach for addressing the measurement issue posed by consistent within-contract disparities across contracts
Across many measures there is a consistent negative within-contract LIS/DE disparity for MA contracts.
Measures consistently show a negative within-contract LIS/DE disparity for PDP contracts

- Part D medication adherence for diabetes medications
- Part D medication adherence for hypertension
- Part D medication adherence for cholesterol
- MTM program completion rate for CMR
- Statin use in persons with diabetes
Across many measures there is a negative within-contract disability disparity for MA contracts.
Measures consistently show a negative within-contract disability disparity for PDP contracts.
Questions?
Meeting topics

- Motivation for addressing disparities in MA and Part D contract Star Ratings
- Understanding the role of social risk factors in MA and Part D contract performance
- Approaches to ensuring accurate performance measurement
- TEP’s input on strategies to reduce disparities
Two approaches to ensuring accuracy of measurement of performance

Direct adjustment
Case-mix adjustment (CMA) for within contract disparities

Indirect adjustment
Categorical Adjustment Index (CAI)
CMA of individual measures

Direct adjustment

Analytic approach that accounts for differences in enrollee populations across contracts
Goal is more equitable comparisons (contract scores reflect expected performance if they all served the set of beneficiaries)
CMA accounts for differences in use of the range of survey response options
CMA of individual measures

- CMA encourages plans to serve vulnerable beneficiaries
  - Removes disincentives to avoid enrolling beneficiaries whose characteristics are associated with lower performance scores

- Characteristics included in case-mix adjustments are considered part of the measure specification
  - Measure developers determine whether to case-mix adjust measures

- Debate exists over which types of measures should be adjusted and whether adjustment masks the delivery of lower quality care
  - Some view stratified reporting as way to avoid masking performance differences and can be a complement to adjustment
CMA addresses mis-measurement (bias)

Differences in the characteristics of MA contracts’ enrollees can affect contract performance in ways that are outside the control of contracts and the providers in their network

- Not accounting for these differences in enrollee characteristics can lead to biased assessments of how well a contract is performing
CMA is used for multiple Star Ratings measures and some include measures of social risk

<table>
<thead>
<tr>
<th>Type of measure</th>
<th>Characteristics used in adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS); example measures include:</strong></td>
<td>Age, education, general health rating, mental health rating, proxy helped, proxy answered, dually eligible, low-income subsidy (LIS), Asian language</td>
</tr>
<tr>
<td>• Getting needed care</td>
<td></td>
</tr>
<tr>
<td>• Rating of drug plan</td>
<td></td>
</tr>
<tr>
<td><strong>Health Outcomes Survey</strong></td>
<td></td>
</tr>
<tr>
<td>• Maintaining and improving physical health</td>
<td>Age (linear), age 75+, age 85+, gender, age and gender interaction, married race/ethnicity, dually eligible, eligible for SSI, home owner, education, income</td>
</tr>
<tr>
<td>• Maintaining and improving mental health</td>
<td></td>
</tr>
<tr>
<td><strong>Plan all-cause readmissions</strong></td>
<td>Presence of surgeries, discharge, conditions, comorbidities, age, gender, base risk weight</td>
</tr>
</tbody>
</table>
Categorical Adjustment Index simulates the effect of case-mix adjustment

- Adjusts contracts’ overall and summary stars rather than scores on individual measures
- Adjusts for LIS/DE and disability
- Developed to address concerns that a high percentage of LIS/DE enrollees limited contracts’ ability to achieve high Star Ratings

Implemented starting with 2017 Star Ratings
Steps in constructing the CAI

1. Calculate contracts’ CMA-adjusted scores for selected measures
2. Convert CMA scores to stars using Star Rating thresholds
3. Calculate adjusted overall, summary, and unadjusted Star Ratings
4. Categorize contracts based on % LIS/DE and disabled enrollees
5. Compute mean difference between adjusted and unadjusted ratings
6. Collapse initial categories into final adjustment groups
7. Apply CAI values to contracts’ unrounded Star Ratings
Step 1: Calculate contracts’ CMA score for the measures selected for adjustment in the CAI

- Fit a logistic regression model for each measure included in the CAI to person-level data with:
  - Fixed effect for LIS/DE status
  - Fixed effect for disability status
  - Fixed effects for contracts, which enables the identification of average within-contract disparities

- Separate models for MA and PDP contracts
Step 2: Use Star Ratings thresholds to determine CMA measure stars

Contract's CMA breast cancer screening score = 79

Breast cancer screening thresholds:
- 1 star: <50
- 2 stars: >=50 - <66
- 3 stars: >=66 - <76
- 4 stars: >=76 - <83
- 5 stars: >=83

Contract's CMA breast cancer screening measure stars = 4
Step 3: Calculate unadjusted and adjusted overall and summary Star Ratings
Step 4: Contracts are placed into one of 50 categories based on their % LIS/DE and % disabled enrollees

<table>
<thead>
<tr>
<th>% LIS/DE Decile</th>
<th>Values of % LIS/DE</th>
<th>% Disability Quintile</th>
<th>Values of % Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>&gt;= 0.00 to &lt; 6.23</td>
<td>1</td>
<td>&gt;= 0.000 to &lt; 15.39</td>
</tr>
<tr>
<td>2</td>
<td>&gt;= 6.23 to &lt; 9.49</td>
<td>2</td>
<td>&gt;= 15.39 to &lt; 22.22</td>
</tr>
<tr>
<td>3</td>
<td>&gt;= 9.49 to &lt; 11.70</td>
<td>3</td>
<td>&gt;= 22.22 to &lt; 28.75</td>
</tr>
<tr>
<td>4</td>
<td>&gt;= 11.70 to &lt; 15.73</td>
<td>4</td>
<td>&gt;= 28.75 to &lt; 40.96</td>
</tr>
<tr>
<td>5</td>
<td>&gt;= 15.73 to &lt; 21.33</td>
<td>5</td>
<td>&gt;= 40.96 to &lt;= 100.00</td>
</tr>
<tr>
<td>6</td>
<td>&gt;= 21.33 to &lt; 30.24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>&gt;= 30.24 to &lt; 42.48</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>&gt;= 42.48 to &lt; 74.17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>&gt;= 74.17 to &lt; 100.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>&gt;= 100.00 to &lt;= 100.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2021 CAI
Step 4: Few MA contracts have high % LIS/DE and low % disabled enrollees and vice versa

<table>
<thead>
<tr>
<th>% disability quintile</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
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<td>2</td>
<td>1</td>
<td>3</td>
<td>16</td>
<td>21</td>
<td>34</td>
</tr>
</tbody>
</table>
Step 5: For each initial category, we calculate the mean case-mix adjusted and unadjusted stars and the difference

<table>
<thead>
<tr>
<th>% disability quintile</th>
<th>% LIS/DE decile</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>N</td>
<td>33</td>
</tr>
<tr>
<td>Mean Adjusted Star</td>
<td>4.273</td>
</tr>
<tr>
<td>Mean Unadjusted Star</td>
<td>4.302</td>
</tr>
<tr>
<td>Mean Difference</td>
<td>-0.029</td>
</tr>
<tr>
<td>(Adjusted - Unadjusted)</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>
Step 6: Combine categories to arrive at final groups

<table>
<thead>
<tr>
<th>% disability quintiles</th>
<th>% LIS/DE decile</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Mean Difference</td>
<td>67</td>
</tr>
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<td>(Adjusted - Unadjusted)</td>
<td>-0.044</td>
</tr>
<tr>
<td>2</td>
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<tr>
<td>Mean Difference</td>
<td>88</td>
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<tr>
<td>(Adjusted - Unadjusted)</td>
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<td>(Adjusted - Unadjusted)</td>
<td>-0.010</td>
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<td>Mean Difference</td>
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<tr>
<td>(Adjusted - Unadjusted)</td>
<td>0.060</td>
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</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>Mean % LIS/DE</th>
<th>Mean % Disabled</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (gray)</td>
<td>6.6</td>
<td>11.3</td>
</tr>
<tr>
<td>2 (pink)</td>
<td>15.7</td>
<td>17.6</td>
</tr>
<tr>
<td>3 (green)</td>
<td>19.8</td>
<td>27.0</td>
</tr>
<tr>
<td>4 (purple)</td>
<td>42.5</td>
<td>33.8</td>
</tr>
<tr>
<td>5 (blue)</td>
<td>81.4</td>
<td>46.5</td>
</tr>
<tr>
<td>6 (peach)</td>
<td>100</td>
<td>61.9</td>
</tr>
</tbody>
</table>
Step 7: Estimated Star Ratings unchanged for 89% of MA contracts when comparing unadjusted and CAI-adjusted overall stars for 2021

<table>
<thead>
<tr>
<th>Unadjusted Star</th>
<th>1</th>
<th>1.5</th>
<th>2</th>
<th>2.5</th>
<th>3</th>
<th>3.5</th>
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- 37 contracts (9.5%) ↑ half a star
- 7 contracts (1.8%) ↓ half a star
Contracts that benefit from CAI are almost all in top quartile of either LIS/DE or disabled (or both)
The CAI substantially increased the number of high percentage LIS/DE or disabled contracts that achieved at least 4 stars.
CAI benefits are focused on contracts that serve largest percentage of LIS/DE and disabled beneficiaries

- Identified consistent negative within contract disparities on many measures for LIS/DE and disability

- Contracts that serve a large percentage of LIS/DE and disabled beneficiaries rarely receive 4 or 5 stars

- CAI has little impact on most contracts, but benefits a substantial number of contracts with the largest percentage LIS/DE and disabled beneficiaries
CAI discussion questions for TEP

- Is the CAI beneficial to include in the Star Ratings?
  - MedPAC and ASPE have suggested rescinding it

- Does the CAI meet its intended goal of improving accuracy of measures of performance for MA and PDP contracts?

- Are there ways the CAI could be improved?
Meeting topics

Motivation for addressing disparities in MA and Part D contract Star Ratings

Understanding the role of social risk factors in MA and Part D contract performance

Approaches to ensuring accurate performance measurement

TEP’s input on strategies to reduce disparities

Strengthen payment incentives to reduce/eliminate disparities

Increase awareness of disparities in performance