VIA ELECTRONIC SUBMISSION

November 3, 2014

Department of Health and Human Services
Centers for Medicare & Medicaid Services (CMS)

Re: Request for Information – Data on Differences in Medicare Advantage (MA) and Part D Star Rating Quality Measurements for Dual-Eligible versus Non-Dual Eligible Enrollees

The Medicare Rights Center (Medicare Rights) is pleased to respond to the Request for Information (RFI) regarding the relationship between higher enrollment of low-income beneficiaries in Medicare Advantage (MA) and Part D plans and lower Star Ratings scores for those plans. Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs and public policy initiatives.

For questions concerning these comments, please contact Stacy Sanders, Federal Policy Director, at ssanders@medicarerights.org or 202-637-0961 and Casey Schwarz, Policy and Client Services Counsel, at cschwarz@medicarerights.org or 212-204-6271. Thank you for the opportunity to comment.

Overview:

We are supportive of CMS' thoughtful inquiry into the relationship between sociodemographic (SDS) status and quality metrics. In particular, we are grateful that CMS is committed to a data-oriented review of the available evidence. We appreciate that some health plans may face challenges providing high-quality care to beneficiaries who are otherwise disadvantaged, and we are concerned by the suggestion that otherwise high-performing health plans may be deterred from serving dually eligible beneficiaries under the current Star Ratings program.

Yet, we are hesitant to suggest, as recommended in a recent National Quality Forum (NQF) report, that adjusting quality measures for SDS factors—like income, education, race and ethnicity—is an appropriate path forward, particularly given the absence of data which clearly demonstrates that some health plans are disadvantaged by the existing Star Ratings standards.[1]

Quality measurements are designed to reveal disparities in care between health plans, and to incite plans to make appropriate adjustments to minimize those disparities. We are concerned that creating different quality standards for SDS factors may mask these disparities and dis-incentivize plans from making changes that could improve quality for all enrollees. In particular, we ask CMS to carefully consider the following potential pitfalls as it evaluates whether SDS risk adjustment is appropriate for the Star Ratings program.

[1] The National Quality Forum (NQF) "Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors" (August 2014), available at: http://www.qualityforum.org/Publications/2014/08/Risk_Adjustment_for_Socioeconomic_Status_or_Other_Sociodemographic_Factors.aspx

First, SDS risk adjustment has the potential to mask existing disparities in care for low-income beneficiaries enrolled in plans that primarily serve disadvantaged populations, rather than expose and address these disparities. Simply adjusting away differences may perpetuate inequities. Second, SDS risk adjustment could create two divergent standards of care for health plans based on the wealth or poverty of the populations they serve. Adjusting scores for plans with significant proportions of low-income beneficiaries could, in effect, lower the bar. This type of adjustment may allow unequal quality standards for low-income patients versus wealthier patients.

Last, we are concerned that, the root cause of disparities in care is not likely to be addressed if the differences are concealed through adjustment in performance scores. For example, risk adjustment could raise performance status from "substandard" to "average" or from "average" to "good," without actually making any improvements in the quality of care. Given these concerns, we believe that any adjustments to quality standards must be directly responsive to measurable differences directly caused by the characteristics or circumstances of a particular subgroup and not general adjustments that risk masking the provision of lower-quality care and coverage to vulnerable populations.

Should CMS definitively conclude, based on an evidence-based review, that health plans that disproportionately serve low-income beneficiaries are disadvantaged by the current Star Ratings system, we ask that the agency consider a range of policy solutions, not limited to SDS risk adjustment of quality measures. Importantly, we encourage CMS to ensure that appropriate tools are used to encourage strong plans to enter and remain in the market to serve dually eligible or other low-income beneficiaries.

Below we detail existing data on care disparities among low-income populations, provide direct comment on the NQF report, comment on trends related to improving plan quality, and suggest the outlines of potential alternatives to risk adjusting quality measures based on SDS status, should such policies prove warranted. We are grateful that CMS is eager to improve the quality of care all patients receive, particularly among low-income populations. We applaud CMS for seeking data on this important issue, and generally urge CMS to approach changes to the Star Ratings program through SDS risk adjustment with caution.

Available Data on Sociodemographic Factors and Care Quality:

As acknowledged by CMS, the available evidence does not establish a causal link between disadvantaged populations and lower plan quality scores. Further, data that may support SDS adjustments to quality scores is weakened by methodological difficulties, including inconsistent reporting of the SDS factors examined. Indeed, some research shows that disadvantaged populations routinely receive substandard care. SDS adjustments to quality measures, then, risk masking true disparities in access to high-quality care.

Existing evidence suggests that disadvantaged patients may be more likely to receive poor quality care. The data do not, however, show that this substandard care is caused or precipitated by the actions or circumstances of patients. Instead, mechanisms within the control of a health plan, including differential treatment from network physicians and stereotyping, may be responsible for lower quality health services. For example, a 2012 Agency for Healthcare Research and Quality (AHRQ) report found that disadvantaged patients were more likely to receive poor quality care. According to AHRQ, "We find that racial and ethnic minorities and poor people often face more barriers to care and receive poorer quality of care when they can get it." [2]

[2] Agency for Healthcare Research and Quality (AHRQ), "2012 National Healthcares Disparity Report" (2012), available at http://www.ahrq.gov/research/findings/nhqrdr/nhdr12/highlights.html

Similarly, a 2002 Institute of Medicine (IOM) study found that low-income and minority patients received lower quality care.[3] The IOM attributed several factors to this trend, including language and cultural barriers, potential provider issues like bias, clinical uncertainty with regard to minority patients, and stereotyping. Notably, the IOM also suggested the possibility that minorities are disproportionately enrolled in lower-cost health plans that place more restrictions on accessing services.[4] As this research suggests, disadvantaged patients may disproportionately receive poorer quality care, but the potential causes are multiple.

A related concern is that data collection for SDS factors is quite limited.[5] The August 2014 NQF report referenced in CMS' RFI underscores this shortcoming by including a recommendation that strategies be developed to "identify a standard set of sociodemographic variables (patient and community-level) to be collected and made available for performance measurement and identifying disparities."[6] CMS' public comments to the NQF report also addressed these challenges and the likely costs involved in the standardized collection of socioeconomic (SES) and SDS data for patients. CMS writes, "…SES in particular can be difficult to measure, and typically requires multiple indicators, including employment status/history, income, and education level. It is difficult to collect social support data, given that reports of social support tend to be confounded with the individual's need for social support."[7]

Also, as noted above, we are unaware of data that demonstrates a causal link between disadvantaged patients and lower Star Ratings, or data that show that Star Ratings for disadvantaged people do not accurately reflect the quality of care received. Indeed, CMS' public comments to the NQF report reflect the existence of a correlation between low-income beneficiaries and poor-performing plans, as opposed to the existence of a causal relationship between dually eligible enrollees and poor plan performance. According to CMS, "Previous analyses have shown that in some cases patients with low SES do concentrate in providers, hospitals, and plans that provide lower quality of care to all patients, so adjusting for this patient characteristic could adjust away true differences in quality across plans." [8] And, as discussed above, even the variables used in collecting SDS data have yet to be determined and standardized.

In the absence of both data sets, it is unclear how causality could be established to support SDS risk adjustment of the Star Ratings program. Given this, we would be hesitant to endorse any changes to the Star Ratings program for SDS risk adjustment, particularly based on dual-status alone. Because of under-enrollment in low-income assistance programs, widely variable eligibility thresholds across states Medicaid programs, and great diversity within the dually eligible population, dual-status can only very roughly account for particular barriers to quality care that may impact specific populations.

Until a causal link between SDS and quality scores is definitively established, we urge CMS to work with health plans—including low-performers and high-quality plans—to develop strategies to remedy known disparities in the delivery of care for disadvantaged populations. CMS should require convincing data that has been rigorously collected and reviewed to support such a fundamental change in the Star Ratings standards by which beneficiaries evaluate plans and upon which bonus payments depend. For this reason, we enthusiastically support the expectations outlined in the RFI for the data submitted, including that it is comparable to a defined control group and that potentially confounding variables are excluded.

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[3] Institute of Medicine "IOM Report: Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care" (2002), available at https://www.iom.edu/~/media/Files/Report%20Files/2003/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care/Disparitieshcproviders8pgFINAL.pdf

[4] Ibid

[5] Agency for Healthcare Research and Quality (AHRQ), "2012 National Healthcares Disparity Report" (2012), available at http://www.ahrq.gov/research/findings/nhqrdr/nhdr12/highlights.html

[6] Ibid

[7] CMS Comments "Risk Adjusting for Sociodemographic Factors Draft Report" (April 14, 2014)

[8] Ibid

Response to the National Quality Forum (NQF) Report:

In the RFI, CMS cites the August 2014 report released by the NQF regarding risk adjustment for socioeconomic (SES) and sociodemographic (SDS) status, specifically studying performance measures used in accountability applications.[9] The NQF established Measure Evaluation Criteria expressly forbids using SES or SDS. Yet, the NQF 2014 recommendations reversed course on this issue, suggesting that in targeted circumstances and for specific measures it may be appropriate to risk adjust for SDS factors.[10]

In general, we concur with the comments to the NQF report submitted by the Consumer Purchaser Alliance (C-P Alliance), a collaboration of consumer, labor and employer groups. The C-P Alliance concludes:

> We are deeply worried that the proposed change in NQF risk adjustment criteria would obscure our ability to see differences in outcomes that correlate with sociodemographic factors. However, we are also concerned about the unintended consequences of using outcome measures in accountability strategies (payment and reporting) that could result in additional harm to disadvantaged populations by inappropriately penalizing providers working with these populations, reducing the resources available for such providers to improve care for these populations, or by inadvertently making it more difficult for disadvantaged patients to find willing providers and access to the care they need. Given these concerns, we propose thorough consideration of an approach in which the measures themselves are not risk adjusted for sociodemographic factors, but instead appropriate adjustments are made in the application of provider accountability strategies. This would enable us to continue to see the true extent of variations in outcomes for different populations.[11]

Similarly, The National Committee on Quality Assurance (NCQA) submitted public comments on the proposed change, and cites concerns about potential harm to low-income patients, stating that risk adjustment for SES "…would unfairly lock in lower expectations for the very populations that most need better quality."[12]

Also like the CP-Alliance, we remain unconvinced that the NQF report provides sufficient evidence to support its recommendations to apply SDS risk adjustments in some circumstances. In particular, the report lacks data establishing a causal relationship between SDS factors and poor healthcare unit (meaning hospital, health plan or clinician, etc.) quality. According to the CP-Alliance,

> …[t]he recommendation to risk-adjust for patient-level sociodemographic factors is not accompanied by sufficient evidence showing that the current policy is resulting in harm to disadvantaged patients. Further, the recommendations are not grounded in evidence that any of the proposed actions would prevent or preclude harm from occurring. This is inconsistent with NQF's standards of scientific acceptability."[13]

CMS, in its public comments on NQF's draft report, also expresses caution about the proposed change. CMS writes, "We are concerned, however, that the recommendation that is being made to risk adjust for sociodemographic factors is premature, given the lack of evidence that has been generated to warrant such a recommendation. Changing the criteria for NQF endorsement will have a sweeping impact, and should be based only on the strongest of evidence."[14]

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[9] The National Quality Forum (NQF) "Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors" (August 2014), available at: http://www.qualityforum.org/Publications/2014/08/Risk_Adjustment_for_Socioeconomic_Status_or_Other_Sociodemographic_Factors.aspx

[10] NQF, "Measure Evaluation Criteria," (accessed November 3, 2014), available at http://www.qualityforum.org/docs/measure_evaluation_criteria.aspx

[11] Consumer-Purchaser Alliance, "Public comments to Dr. Cassel re: Draft Report on Risk Adjustment for Sociodemographic Factors" (April 16, 2014), available at http://www.consumerpurchaser.org/files/RAletter.pdf

[12] NCQA, "Public comments to Christine Cassel," (April 16, 2014) available at http://www.ncqa.org/Portals/0/Public%20Policy/2014%20Comment%20Letters/NQF_SES_Comments_4-16-14.pdf

[13] Consumer-Purchaser Alliance, "Public comments to Dr. Cassel re: Draft Report on Risk Adjustment for Sociodemographic Factors" (April 16, 2014), available at http://www.consumerpurchaser.org/files/RAletter.pdf

[14] CMS Comments "Risk Adjusting for Sociodemographic Factors Draft Report" (April 14, 2014)

Quality Trends and Dually Eligible Beneficiaries

It is important note that CMS' current star ratings program appears to be leading to improvements in quality of care. Notably, a recent Avalere analysis of CMS quality data found that overall MA plan quality ratings are improving.[15] According to Avalere, approximately 60 percent of MA enrollment is in four or five star plans, an increase from the 52 percent of beneficiaries enrolled in four or five star plans in 2014.[16]

CMS' public comments on the NQF report also assert that high performing health units treating disadvantaged patients can provide high quality care, and that their existence undermines the need for risk adjustment. According to CMS, "Further, the argument that not risk adjusting has the effect of driving providers/insurers away from low SES patients is directly contradicted by the growth in D-SNPs (322 plans in 2012 with 1,303,408 enrolled; 353 plans in 2014 with 1,576,291 enrolled) as the Star Rating program has been implemented."[17]

We are concerned that SDS risk adjustment of quality scores could reverse this progress. In its comments to the NQF proposal, NCQA expresses concern that progress in quality improvement would be hindered by SDS risk adjustment. According to NCQA, "Risk adjustment for SES and sociodemographic factors at the measure level will impede our progress by artificially reducing variation in performance measurement, putting a filter over the bright light of transparency, and lowering the bar of accountability." [18]

The comments from CMS also reflect concerns that risk adjustment for SES/SDS could impact the integrity of quality measures. CMS writes, "[T]he quality gap between higher SES individuals and lower SES individuals may increase as a result of the proposed requirement [from NQF] to risk adjust outcome measures. CMS is concerned that this recommendation could be a setback to the goal of equity within the healthcare system."[19]

In analyzing the relationship between dually eligible status and quality performance, it is essential to examine successful programs treating large numbers of dually eligible and other low-income beneficiaries. We are encouraged that CMS requested information regarding the achievement of high-quality plans serving dually eligible beneficiaries, and how those results were obtained. We encourage CMS, to the extent permissible under other law, to share these strategies for success by developing best practices for plans serving dually eligible and other low-income beneficiaries.

Alternatives:

While we share CMS's concern that some high-quality health plans may be deterred from serving low-income beneficiaries under the existing quality framework, we remain skeptical that across-the-board adjustment of quality measurements for SDS factors is the appropriate solution. Should CMS determine, based on data that is rigorously collected and reviewed, that a causal link can be drawn between serving lower-income populations and having lower quality scores, we would encourage the agency to consider policy options beyond SDS risk adjustment.

For instance, the Medicare Payment Advisory Commission (MedPAC) presented an alternative to SDS risk adjustment in their June 2013 Report to Congress.[20] With respect to hospital readmission rates, MedPAC recommended using peer

[15] Mendelson, D., "Avalere Health Report: CMS Report Shows Medicare Advantage Plan Performance and Quality Continue to Improve" (October 14 2014) available at, http://www.avalerehealth.net/expertise/managed-care/insights/cms-report-shows-medicare-advantage-plan-performance-and-quality-continue-t.
[16] Ibid.
[17] CMS Comments "Risk Adjusting for Sociodemographic Factors Draft Report" (April 14, 2014)
[18] NCQA, "Public comments to Christine Cassel," (April 16, 2014) available at http://www.ncqa.org/Portals/0/Public%20Policy/2014%20Comment%20Letters/NQF_SES_Comments_4-16-14.pdf
[19] CMS Comments "Risk Adjusting for Sociodemographic Factors Draft Report" (April 14, 2014)
[20] MedPAC, "Report to Congress," (June 2013), available at: http://www.medpac.gov/documents/reports/jun13_entirereport.pdf?sfvrsn=0

group comparisons rather than risk adjustment. According to MedPAC, this would allow hospitals with similar proportions of low-income patients to be compared to each other rather than comparing them to all hospitals. We believe this concept might also be useful in comparing Medicare health plans that serve a disproportionate share of dually eligible or other low-income beneficiaries. Similarly, as CMS outlined in its comments to the NQF report, we believe solutions to this potential problem must include a conversation about payment, particularly given that health plan payment is already risk adjusted, including by condition and for low-income enrollees.[21] Alternate payment policies may be required to address the issue at hand.

Again, we must stress that the exploration of these solutions is only appropriate should CMS establish a causal link between the disproportionate enrollment of dually eligible beneficiaries and lower Star Ratings scores, based on clear evidence. We appreciate that CMS is approaching this issue from a data-based perspective, and we support the agency's desire to establish an evidence-based connection between SDS factors and quality measurement before proceeding with any adjustments to the Star Ratings system. Only through this careful approach can CMS ensure the highest quality care is accessible to the most vulnerable beneficiaries.

Thank you for the opportunity to respond.

[21] CMS Comments "Risk Adjusting for Sociodemographic Factors Draft Report" (April 14, 2014)