Center for Medicare & Medicaid Services
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

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On behalf of Health Alliance Plan and the Henry Ford Health System, I am pleased to respond to the Request for Information on differences in Medicare Advantage (MA) and Part D Star Rating Quality Measurements for Dual-Eligible versus Non-Dual-Eligible Enrollees. As a Medicare Advantage plan (46,587 total members) serving a large number of dual-eligible enrollees in the Detroit area, Health Alliance Plan has had a chance to directly observe the challenges that low-income individuals and their families face in doing what they need to do to have good glycemic or lipid control if diabetic, receive recommended cancer screenings, or avoid hospital readmission. In spite of excellent clinical quality of care, and in spite of the presence of active care coordination and social support service programs, plans serving a large share of dual-eligible enrollees can still have lower star ratings and miss opportunities for financial incentive payments.

A relationship between SES factors, particularly poverty, and health plan performance has been reported over the past 10-15 years.[i] A number of studies have demonstrated this relationship, in commercial HMOs[ii], in Medicare Advantage Plans[iii], and in Part D drug plans.[iv] Plans serving "vulnerable" member populations do worse, on average, on specific measures and in the MA "star rating" system than plans serving relatively affluent members.[v] The presence of this relationship is not in dispute; the key question seems to be whether the association reflects the influence of individual, household, or community dynamics outside the control of the health plan, or whether it reflects truly poorer quality of care. One would generally adjust for sociodemographic factors in the former case, but not in the latter.

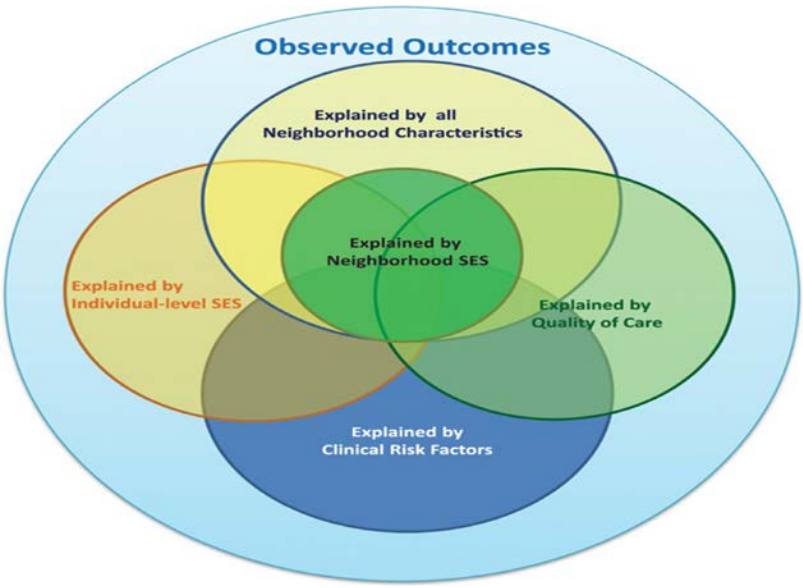
When the performance measures in question are outcome measures, one has some analytic leverage by examining process measures linked to the outcomes in question, in order to determine whether they also vary by member sociodemographic factors.[vi] If yes, the argument for "poor quality" is stronger, but still not yet compelling, as many process of care measures are also influenced by patient- and community-level sociodemographic factors and not just by plan- or provider-level quality of care.

For example, in diabetes measures, it has been observed regularly for at least the past 20 years[vii] that racial disparities in HbA1c control are observed even when there are no disparities in HbA1c testing or in other related process measures. One can still argue that some unmeasured aspects of

process quality are contributing to the disparities in outcome, but the consistency of the finding across many diverse settings and over time suggests strongly that factors other than quality of care are at work in producing the disparities in glycemic control.

One core concept underlying this entire discussion is the idea that most performance "measures", particularly outcome "measures", are reflections or indicators of quality of care, not direct, unambiguous measures of quality of care. The graphic below[viii] captures the idea well in the context of hospital readmission as a quality "measure".

Figure 1: Proposed model for contribution of individual-level and neighborhood factors in disease outcomes. SES indicates socioeconomic status



Readmissions are a function of quality of care, but also a function of a number of other things that are not quality of care, such as clinical risk measures and individual-level and neighborhood SES. If the goal of measurement is to have the clearest and most unbiased reflection of quality, then adjustment for factors other than quality that influence the measure seems like the right thing to do.

In practice, the distinction between quality of care and other influences as the reason for sociodemographic disparities is difficult to make. A plan serving a primarily minority, low-income, and non-English-speaking membership may have a lower "star rating" than one serving a largely affluent, majority membership because the clinical and other services provided to members under the plan's control are truly of lower quality, or because of the influence of individual, household, or community-level characteristics that have nothing to do with either what the plan itself does and what its contracted providers do. Poor outcomes could be the result of poor quality of care, or they could occur in spite of excellent quality of care.

Ashish Jha and Alan Zaslavsky have probably done the best and most thoughtful work in describing how the effects of quality and of other factors can be disentangled.[ix] A nice illustration is provided in their recent JAMA article[x], but the ideas have been around for quite some time, and have already been applied to the context of health plan performance measurement.[xi]

Basically, the important distinction they make is about within-plan and between-plan disparities. A simple version of their argument is that disparities (related to poverty, for instance) are observed consistently in a large number of plans, of various types, in a variety of different circumstances, then it is highly unlikely that those differences reflect quality of care. One would have to believe that all of the plans are doing the same thing(s) wrong, to the same degree, with the same measurable effect. In most circumstances, this is implausible. These are "within-plan" differences. On the other hand, if the disparities reflect largely "between-plan" differences, so that the members of the "disadvantaged" group(s) cluster together in plans in which ALL members seem to have lower scores, then it is more likely that disparities are a result of lower quality of care.

When this form of analysis has been applied to health plans, or to HEDIS measures at the individual physician level, the results to date have been largely consistent. The within-plan (or within-physician) effects are relatively large and significant; the between-plan (or between-physician) effects are relatively small – in a couple of examples, essentially non-existent.[xii]

This body of work, taken as a whole, clearly supports the concept of adjustment of Medicare Advantage "star ratings" on the basis of one or more sociodemographic factors. The available evidence suggests that within-plan factors are far more important than between-plan factors, so the observed effects of variables like poverty or minority status do NOT come as a result of poorer quality of care.

The recent National Quality Forum Expert Panel report[xiii] takes up these arguments in more detail and presents more comprehensive statistical analysis of the between- vs. within-unit issue. Their recommendations are clear, though, and we fully support them. When the effects of sociodemographic factors on performance measures do not seem to be primarily mediated by quality of care, adjustment is the right thing to do. The "between-within" approach to analysis currently provides the best way to determine whether quality is in the causal path or not.

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