NSCLC
National Senior Citizens Law Center

PROTECTING THE RIGHTS OF LOW-INCOME OLDER ADULTS

November 3, 2014

VIA ELECTRONIC SUBMISSION
PartCandDStarRatings@cms.hhs.gov

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244-8016

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 National Senior Citizens Law Center (NSCLC) is pleased to submit these comments on the request for information regarding the relationship between enrollment of individuals dually eligible for Medicare and Medicaid and lower MA and Part D quality measure scores.

The National Senior Citizens Law Center is a non-profit organization whose principal mission is to protect the rights of low-income older adults, especially women, people of color and other disadvantaged minorities. Ensuring access to Medicare programs and improvements in delivery of Medicare services, particularly to low income seniors, have been priority issues for our organization for decades.

As an advocacy organization, NSCLC does not collect and analyze data so we are unable to directly respond to the specific questions set out in the RFI. We do, however, want to raise some cautions based on our experience with low income beneficiaries and on the studies that have been done by others.

We have heard the drumbeat of claims by sponsors of low performing Medicare Advantage plans that the star rating system needs to be adjusted because the socioeconomic status of dual eligible members adversely affects the ability of plans with significant numbers of dual eligible to meet performance benchmarks. We appreciate that CMS is not taking these claims at face value but instead is asking for rigorous data to support these claims and further is asking for significantly more specificity as to which of the many measured items the plans claim are impacted.

We also very much appreciate and share the concern of CMS that, though there may be a correlation between socioeconomic status and lower star ratings, that correlation does not equate to causation and that, instead, low star ratings may simple reflect poor performance and failure to meet the needs of low income beneficiaries.

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Data Issues

There certainly are data to suggest that disadvantaged patients are more likely to receive poor care in the health system. For example, the 2012 National HealthCare Disparities Report released by the Agency for Healthcare Research and Quality (AHRQ) found that disadvantaged patients were more likely to receive poor quality care.[1] Similarly, the IOM Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care also found poorer care in its 2002 report regarding lower quality care for low income and minority patients.[2] The report found that several factors may lead to this trend, such as language and cultural barriers, potential provider bias, and the possibility that minorities are disproportionately enrolled in lower-cost health plans that place greater per-patient limits on healthcare expenditures and available services.[3]

This research suggests an overwhelming need for better care of low income and minority beneficiaries, a need that advocates see daily as they work with these individuals to help them access needed services. Addressing these health disparities is rightly a high priority for the Medicare program.

Though the data tell us that there are disparities in health care and that those disparities translate in poorer health outcomes, they do not support a conclusion that disadvantaged patients are the cause poor quality ratings. Rather the information simply shows that these individuals need better care.

We believe that more data will be helpful in understanding at a more granular level where disparities exist and how to address them. We appreciate that CMS is requesting such data from plans and we also hope that, over the longer run, data collection authorized by the IMPACT Act[4] will fill some of the current gaps and help inform future policy. We stress, however, that the primary goal of data collection should be finding information that helps providers and plans to erase health disparities, not to permit disparities to excuse or inferior care.

We appreciate that CMS also recognizes the limits of current data. We applaud CMS's thoughtful public comments objecting to the summary conclusions of a National Quality Forum

[1] Agency for Healthcare Research and Quality (AHRQ), available at http://www.ahrq.gov/research/findings/nhqrdr/nhdr12/highlights.html .
[2] IOM Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, available at https://www.iom.edu/~/media/Files/Report%20Files/2003/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care/Disparitieshcproviders8pgFINAL.pdf .
[3] Id.
[4] The Improving Medicare Post-Acute Care Transformation Act of 2014, signed into law October 6, 2014.

(NQF) report which, while acknowledging that there is a paucity of data, proposed risk adjustment based on socioeconomic status.[5]

Policy Concerns

Besides the lack of data to support a causal relationship between socioeconomic status and poor plan performance, we have other policy concerns about tampering with the basic structure of the star rating system.

First, quality stars are about whether care was delivered, about outcomes and about patient satisfaction. Whatever the reason, if a plan does not get a set percentage of its members vaccinated, it should not get stars as if it did. If members are unsatisfied with services, that failure to deliver member satisfaction should be reflected in stars. If blood pressure is not controlled, there should not be stars showing otherwise. The integrity and transparency of the star system must be preserved.

Second, CMS's current star ratings program appears to be leading to improvements in quality of care. A recent Avalere analysis of CMS quality data found that overall MA quality ratings are improving.[6] The report found that approximately 60 percent of MA enrollment is in four or five star plans, an increase from the 52 percent of MA enrollment in four or five star plans in 2014.[7] A 2014 Kaiser Family Foundation analysis of entering and exiting plans also found that as quality improves, Medicare beneficiaries will see fewer plans with average or below average ratings in 2015.[8] The star rating system should be allowed to work.

Third, there are many avenues for dealing with any documented challenges that plans face in serving low income and minority members. CMS can work with plans on best practices or can launch demonstrations to try specific approaches.[9] Addressing deficiencies, rather than adjusting quality measures, should not be the default response. The focus of CMS and plan

[5] NQF report, available at http://www.qualityforum.org/Publications/2014/08/Risk_Adjustment_for_Socioeconomic_Status_or_Other_Sociodemographic_Factors.aspx . See especially NQF Report at 40, "…SES-related data are not widely collected."

[6] Avalere Health Report, available at, http://www.avalerehealth.net/expertise/managed-care/insights/cms-report-shows-medicare-advantage-plan-performance-and-quality-continue-t

[7] Id.

[8] Kaiser report, pg 4, http://kff.org/medicare/issue-brief/whats-in-and-whats-out-medicare-advantage-market-entries-and-exits-for-2015/

[9] Some innovations in member engagement being tested in the dual eligible financial alignment demonstration may be appropriate for wider usage by Medicare Advantage plans. Best practices from high performing plans serving low income populations can also be replicated. See, e.g., Commonwealth issue 2012 May, Berenson et. al., page 5-6, available at, http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2012/may/1600_berenson_achieving_better_quality_care_low_income_v2.pdf .

response should be on developing ways to provide the needed services, not finding ways to compensate for failure to do so.

We also note that CMS already adjusts capitation rates to account for dual eligible status. While we have skepticism that further adjustment is needed, we would urge that, if CMS were to determine otherwise, any changes should not be tied to star ratings and associated pay-for-performance formulas, which should be left to be unadulterated by adjustments for beneficiary status.

Fourth, although we understand that there are concerns that plans may be discouraged from serving low income beneficiaries if they do not receive adequate incentives, we think the question is better framed from the viewpoint of the beneficiary. In our view, all beneficiaries deserve high quality care and, if a plan cannot figure out how to provide that care to all segments of its diverse membership, it should not be part of the Medicare system.[10] The star system is a critical tool for making that determination.

We very much appreciate the thoughtful approach that CMS is taking to these complex issues and we look forward to a continuing dialogue around the data that CMS can collect and the policy choices that the agency is considering.

Thank you for the opportunity to submit these comments.

Sincerely,

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[10] Further, it is important to remember that much of the Medicare population lives near the edge of economic insecurity. Nearly half of American seniors—48 percent—live on income less than two times the supplemental poverty threshold. Though socioeconomic status certainly accounts for some differences, it is a false dichotomy for plans to claim a great gulf between low income subsidy recipients and the rest of Medicare beneficiaries. See Elise Gould and David Cooper, "Financial Security of Elderly Americans at Risk: Proposed changes to Social Security and Medicare could make a majority of seniors 'economically vulnerable'"(Washington: Economic Policy Institute, 2013), available at http://www.epi.org/files/2013/EPI-economic-security-elderly-americans-risk.pdf .