Frequently Asked Questions
Reporting of National Medicare Advantage Quality Scores by Race, Ethnicity and Gender

1. What is CMS announcing today?

CMS is announcing the release of two national level reports detailing the health care experiences and quality of care received by Medicare Advantage (MA) enrollees. One report presents data stratified by gender and the other presents data stratified by race and ethnicity within gender groups. These reports, which use the two most current years of pooled data from 2014 and 2015, are companion pieces to the November 2016 release of Medicare quality measures stratified by race and ethnicity. The release of these reports is timed to coincide with Minority Health Month in April. Each year at this time CMS plans to make additional reports available to the general public on the CMS OMH website.

2. Why is CMS displaying this information?

Despite advances in health care access, increases in spending, and improvements in quality over the last decade, there is well-documented evidence that members of racial and ethnic minority groups continue to experience worse health outcomes (2015 National Healthcare Quality and Disparities Report). To begin to comprehensively address and eliminate health disparities, it is first necessary to be able to measure and publicly report – in a standardized and systematic way – the nature and extent of these differences. Additionally, the IMPACT Act of 2014 requires the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) to examine the differential effect of a number of demographic variables, including race and ethnicity, on Medicare payment policy and the reporting of additional quality measures.

3. What do these data represent?

The data presented in one report indicate overall national differences in the care that is delivered to men and women MA enrollees overall. The data presented in the other report indicate overall national differences in care that is delivered to men and women MA enrollees who identify as Asian or Pacific Islander, Black/African American, Hispanic, or White.

4. How can MA contracts use this information to improve performance?

The data presented here focus on the analysis, reporting, display, and dissemination of existing quality measures aggregated at the national level, stratified by race and ethnicity within gender groups and by gender among MA enrollees. This information may be useful for targeting quality improvement activities and resources, monitoring health and drug plan performance, and advancing the development of culturally and linguistically appropriate quality improvement interventions and strategies.

5. Are these results included in the Part C and D Star Ratings Program?

NO. This effort is entirely separate from the Part C and D Star Ratings program. These scores are based on national level, pooled MA data and are not plan or contract specific. They are intended to be used to support health plan quality improvement and accountability but do not affect Star Ratings.

6. Do the data presented in this release suggest that CMS' socio-economic status (SES) adjustment of Part C and D Star Ratings should have been larger or whether CMS should NOT have adjusted for SES?

Following standard scoring practices, no adjustment is made to the HEDIS measures; CAHPS measures are case-mix adjusted for low income, dual eligibility, and other factors. These analyses examined gender, racial and ethnic differences in HEDIS and CAHPS scores overall. The HEDIS analyses did not include any measure of SES. As such these analyses do not directly inform the adjustment of HEDIS measures for SES. The proportion of Medicare beneficiaries with low SES does differ across racial and ethnic groups, as well as across other demographic subgroups. The descriptive data in this release do not suggest that adjustment of Part C and D Star Ratings for SES is inappropriate. Additionally, research conducted by the HHS ASPE found that adding indicators of race and ethnicity to SES adjustment models for HEDIS measures used in the Star Ratings had little effect on the coefficients used for adjustment by SES.

7. How is gender reported?

Gender is self-reported by Medicare beneficiaries on the CAHPS survey. For HEDIS, information on gender is gathered from administrative records.

8. How is race and ethnicity reported? Which racial and ethnic groups are included in the national disparities reports?

CAHPS measures are based on respondent self-reported race and ethnicity. For HEDIS, information on race and ethnicity is gathered from administrative records. For both the HEDIS and CAHPS measures, data are provided for women and men in four racial/ethnic groups: (1) Asians or Pacific Islanders (incudes Native Hawaiians), (2) Blacks, (3) Hispanics, and (4) Whites. Data are not presented for American Indians or Alaska Natives due to insufficient sample size to produce reliable estimates. Limitations in CMS administrative data as well as in the reporting of race and ethnicity data by health plans precluded us from reporting HEDIS measures for additional groups.

9. Why are there two separate national disparities reports? How are the two files different?

Both reports contain national data for care delivered during 2014 and 2015. The reports present national estimates for quality measures stratified by race and ethnicity within gender groups or by gender. The report presenting racial and ethnic group comparisons separately by gender includes information about the care given to members in each of four racial and ethnic groups: Asian/Pacific Islanders, Blacks/African Americans, Hispanics, and Whites. For the report showing gender comparisons in care, quality scores for national level MA data are shown for both women and men.

10. If the score for a particular racial or ethnic minority group is lower than the score for Whites, what does that mean?

At the national level, for patient experience measures (not including the flu immunization measure, which is a clinical care measure included in the Medicare CAHPS Survey), a lower score for a particular racial or ethnic minority group means that members of that particular racial or ethnic minority group reported worse experiences than Whites of the same gender after adjustment for other characteristics, such as age and education. Scores on clinical care measures, including the flu immunization measure,

are not adjusted for these other characteristics. At the national level, for clinical care measures, a lower score for a particular racial or ethnic minority group means that members of that particular racial or ethnic minority group received worse care than Whites of the same gender.