Frequently Asked Questions
Reporting of National and Medicare Advantage Contract Level Quality Scores by Race and Ethnicity

1. What is CMS announcing today?

CMS is announcing the release of national level results for certain Medicare quality measures stratified by race and ethnicity for 2014, and Medicare Advantage (MA) contract level results stratified by race and ethnicity using the two most current years of pooled data (initial release combines 2013 and 2014). These reports will be available to the general public annually beginning with this release.

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 (2014 National Healthcare Quality and Disparities Report - http://www.ahrq.gov/research/findings/nhqrdr/index.html). 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. Section 4302 of the Affordable Care Act (adding section 3101 to the Public Health Service Act) requires the reporting and public posting of these data on HHS websites as well as other dissemination strategies.

3. What do these data represent?

The data presented indicate overall differences in the care that is delivered to Medicare beneficiaries who identify as Asian or Pacific Islander, Black/African American, Hispanic, or White. These are total differences, which include both within and between contract differences. That is, the differences include both differences between subgroups within a particular contract and differences that arise from varying quality levels across contracts for all enrollees.

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 by MA contract, stratified by race and ethnicity. This activity provides information that will 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 MA and Part D Star Ratings Program?

NO. This effort is entirely separate from the MA and Part D Star Ratings program. These scores are intended to be used for health and drug plan quality improvement and accountability purposes.

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

The data presented analyze HEDIS and CAHPS data as they are scored, with no adjustment to the HEDIS measures, and with CAHPS measures already case-mix adjusted for low income, dual eligibility, and other factors. These analyses examined racial/ethnic differences in HEDIS and CAHPS scores overall and by contract. 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/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 ASPE found that adding indicators of race/ethnicity to SES adjustment models for HEDIS measures used in the MA Star Ratings had little effect on the coefficients used for adjustment by SES.

7. Why are the data shown by contract, rather than by plan?

Data are shown by contract because CMS quality data are collected at the contract level.

8. Do these results affect MA contract payments?

NO. These results are not used for payment purposes of any sort. As required by the IMPACT Act of 2014, the HHS Office of the Assistant Secretary for Planning and Evaluation is examining the differential effect of a number of demographic variables, including race and ethnicity, on Medicare payment policy and the reporting of additional quality measures. Results are expected in 2017.

9. Why is my MA contract not listed on the page that shows scores for a particular racial/ethnic minority group?

We do not list MA contracts for which there is too little information to reliably report any of the measures of patient experience or clinical care for a particular racial and ethnic minority group. Having too little information to report does not mean that an MA contract did anything wrong, it means there is not enough information from the sample of members used for reporting at the time this report was generated.

10. Why are there two separate files that present MA contract level data? How are the two files different?

Both files contain information about the care that MA and Part D contracts gave to members in each of four racial and ethnic groups: Asian/Pacific Islanders, Blacks/African Americans, Hispanics, and Whites. The two data files contain the same information, but the information is organized differently in the "single-group" file than in the "multiple-group" file. The single-group file contains four separate tables, for members in each of four racial and ethnic groups. Each table describes how MA contracts differ in the care that they deliver to members who are Asian/Pacific Islander, Black/African American, Hispanic, or White. This file allows you to easily compare across MA contracts for a particular racial/ethnic group. The multiple-group file contains one table that shows contract by contract—how quality scores differ for each of the four racial and ethnic groups. This file allows you to compare across racial/ethnic groups by MA contract.

11. If the score for a particular racial/ethnic minority group is lower than the score for Whites for a MA contract, what does that mean?

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/ethnic minority group means that members of that contract who are members of a particular racial/ethnic minority group reported worse experiences than members of that MA contract who are White 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. On clinical care measures, a lower score for a particular racial/ethnic minority group means that members of the MA contract who are members of that particular racial/ethnic minority group received worse care than members of that contract who are White.

12. If a MA contract does not have a score for members who are in a particular racial/ethnic minority group, does that mean the MA contract doesn't have any or many members who are in that particular racial/ethnic minority group? Does it mean the MA contract has a low score for members who are in that particular racial/ethnic minority group?

If an MA contract does not have a score for a particular racial/ethnic group, it means that there are not enough data on the experiences of that group to permit reliable reporting of scores for that group. It does not mean that the MA contract provided poor care to members of that group, or that the MA contract did anything wrong.

13. Why are there so few Prescription Drug Plans (PDPs) with data for Asians/Pacific Islanders, Blacks/African Americans, and Hispanics?

In order to have a reliable report of experience with a MA contract we need information from at least 100 members. To have a reliable report of experience with a PDP, we need information from at least 200 members. We need more members to reliably measure quality differences between PDPs because those differences tend to be smaller and harder to measure. Few PDPs meet the sample size requirement for reporting on Asians/Pacific Islanders, Blacks/African Americans, and Hispanics.

14. Why are some scores reported with a footnote saying that the scores should be used with caution?

Scores with this footnote have low reliability (0.6 to 0.7 on a scale that ranges from 0 to 1), which means that they may not be a precise measure of a contract's performance. Reliability measures the extent to which a contract's score accurately measures the difference in the performance of that contract from other contracts. Scores with high reliability (greater than 0.7) are reported with no footnote. Scores with very low reliability (below 0.6) are not reported. Scores reported with a footnote have low but not very low reliability. They fall in a "gray area" between precise and imprecise, which is why users are urged to be cautious when interpreting the scores. Scores with lower reliability typically are those based on fewer members' experiences or involve measures for which it is harder to distinguish performance across MA contracts.

15. Why do the national data on disparities in patient experience and or clinical care contain information on American Indians and Alaska Natives but contract-level files do not?

No MA contracts meet the sample size requirements for reporting on the quality of care provided to American Indians and Alaska Natives. Thus, that group is excluded from the contract-level data files.

16. Why does my CAHPS vendor have a different score than what appears in these files?

Any difference in the racial/ethnic group scores provided by CMS and similar reports provided by your vendor may be due to differences in the application of CAHPS data cleaning rules, vendor differences in how scores are calculated, vendor differences in determination of an eligible survey, or vendor assignment of race and ethnicity.