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Francis J. Crosson, M.D., Chairman
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Andrew Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington DC, 20201

Dear Mr. Slavitt:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) memorandum entitled "Request for Comments: Enhancements to the Star Ratings for 2017 and Beyond" issued by the Medicare Drug Benefit and C & D Data Group on November 12, 2015. The memorandum proposes a number of possible changes to the Medicare Advantage (MA) star rating system, which may be included as proposals in the advance notice to be released in February of 2016. We appreciate your staff's ongoing efforts to administer and improve the quality measurement and payment systems for MA, particularly considering the competing demands on the agency.

The specific issue on which we wish to comment is how to take into account within-contract differences in MA plan performance when there is evidence that a difference in performance is due to the low-income status or disability status of plan enrollees. The research your agency has undertaken provides evidence of such differences, findings consistent with our own research. Both CMS and the Commission found that, for a limited subset of quality measures, there are systematic differences by population, though the differences are relatively small. And, for some measures, performance was actually better among low-income or disabled populations.

The memorandum notes that CMS is continuing to examine this issue. In the meantime the memorandum offers two possible interim approaches to address it. One approach is to use a Categorical Adjustment Index. As noted in the memorandum, this approach is similar to the case-mix adjustment methodology used to adjust MA patient experience measures, where there is an adjustment based on a contract's distribution of enrollment by age, education, income status, and other factors affecting beneficiaries' survey responses. The Categorical Adjustment Index approach would group MA contracts together, by deciles (for example), based on their share of the relevant populations (low-income, disabled). For each of these initial contract groupings, there would be a comparison between the overall or summary star rating determined under the current methodology, and an overall or summary star rating determined if there are adjustments made to measure results. The adjustment to the measure results would be based on a beneficiary-level regression model that determines the average within-contract difference in measure results for the

relevant populations. The initial grouping of contracts would then be combined (if appropriate) into final groups for adjustment purposes so as to group together contracts that had similar mean differences between adjusted and unadjusted summary or overall results. Once that final grouping is determined, each contract within the group would receive the same adjustment to its summary or overall star rating, and the adjusted star rating determines the contract's status for purposes of determining bonus payments.

The alternative proposal included in the memorandum is to use indirect standardization to derive adjusted results. Under indirect standardization, an all-contract average measure result for a subpopulation is computed, which becomes the expected result for the given subpopulation, and plans are rated based on the relationship between observed and expected results for their enrolled population.

We have two concerns regarding the indirect standardization approach. First, several of the measures for which CMS and the Commission found population-based differences are measures that are reported based on medical record sampling (generally 411 records per contract) or measures for which some contracts report results based on sampling while other contracts report based on the universe of enrollees to whom the measure applies (for example, results for all diabetics in a plan versus results for a sample of 411 diabetics). Two concerns arise. One is whether a sample of 411 records yields a sufficient number of records for a subpopulation within a contract to be able to determine a valid measure result for the subpopulation. For example, many contracts are likely to have only a very small number of beneficiaries under the age of 65 (disabled) who are low-income in a sample of 411. For some contracts, the subpopulation may be entirely missing from the 411 sample because the subpopulation is such a small share of the overall population.

Our second concern in indirect standardization is that, if all enrollees within a subpopulation are used to determine an all-contract expected rate, then undue weight would be given to contracts that report based on the universe of enrollees to whom the measure applied. For example, assume that there were only two MA contractors, each with 50,000 enrollees and a similar distribution of subpopulations. One contract reported results by subpopulation for its 10,000 diabetic enrollees while the other reported results for its subpopulation among a sample of 411 diabetics. Even though the contracts have the same number of enrollees and similar subpopulation shares, the former contract reports results for many more enrollees, and therefore represents a disproportionate amount of the results in the total universe that is used to calculate an all-contract expected rate.

In summary, given the agency's desire to implement an appropriate *interim* measure as it develops a more analytically rigorous long-term solution, we believe that of the two approaches discussed in the memorandum, the Categorical Index Adjustment is administratively less complicated but still addresses the concerns plans have raised. In addition, although in our recent October meeting the Commission did not formulate a recommendation on this issue, there was conceptual support for an approach similar to the proposed Categorical Index Adjustment. We would thus urge CMS to implement this approach as an interim measure rather than the indirect standardization approach.

MedPAC appreciates the opportunity to comment on the important policy proposals crafted by the CMS and its contractors. The Commission also values the ongoing cooperation and collaboration between MedPAC and CMS staff on technical policy issues. We look forward to continuing this productive relationship.

If you have any questions, or require clarification of our comments, please feel free to contact Mark E. Miller, the Commission's Executive Director.

Sincerely,

Francis J. Crosson, M.D.
Chairman