



Advising the Congress on Medicare issues

Report to the Congress on comparing quality in Medicare Advantage and traditional fee-for-service Medicare: work plan and discussion

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Legislative mandate (MIPPA section 168)

- Study of how quality performance and patient experience measures can be used to compare:
 - Medicare Advantage (MA) and traditional fee-for-service (FFS) Medicare
 - Differences among MA plans
- Address data collection and reporting methodology
- Address quality benchmarking issues
- Report due March 2010
- Implementation in 2011: CMS and plans to begin data collection and reporting

Background

- Uneven playing field between Medicare health plans and FFS is a long-standing issue
 - Health plans reporting on quality since 1997
 - FFS reporting has increased but still fragmentary
- In reports to the Congress, in testimony, and in recommendations, the Commission has supported leveling the playing field

Current situation

- Some data available on sector-to-sector comparisons
 - CAHPS (Consumer Assessment of Healthcare Providers and Systems)
 - MCBS (Medicare Current Beneficiary Survey)
 - Other data; published research
- Reporting of Medicare plan outcomes is population-based; FFS quality indicators generally are provider-specific
- Room for improvement in Medicare health plan quality reporting

Work plan

- Describe current data collection & reporting; benchmarking
- Evaluate effectiveness of current practices
- Explore ways to improve reporting of current data
 - Use of other data in quality comparisons (FFS claims)
 - Determine if major changes necessary, and evaluate burden and value
- Examine benchmarking changes in light of any reporting changes
- Consider role of new sources of data: MA encounter data, Part D (drug) data

Sources of information

- Commission's work on quality measurement, pay-for-performance (P4P)
- Review of health services research literature
- Consultation with stakeholders and experts
- Examination of best practices among other public and private purchasers

Issues to consider (1)

- How can the two sectors be compared?
 - *Measurement unit:* Health plan measures are population-based, most FFS measures are provider-based
 - *Geographic unit:* What is the appropriate geographic unit for comparison?
 - *Reporting:* Report by subpopulations so different types of beneficiaries can make meaningful comparisons?
- Issues also apply to MA plan comparisons

Issues to consider (2)

- Recognizing sources of variation in performance
 - Risk adjustment of measures
 - Demographic differences between plans and FFS Medicare, and among MA plans
- Using measures and benchmarks that are reliable, meaningful, and useful to varied audiences

Issues to consider (3)

- Weighing burden of data collection, performance reporting, and measure development on plans, providers, and CMS
- Identifying gaps in current measures