CHAPTER 13

The Medicare Advantage program: Status report

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Chapter summary

Each year the Commission provides a status report on the Medicare Advantage (MA) program. In 2012, the MA program included more than 3,600 plan options, enrolled more than 13 million beneficiaries, and paid MA plans about $136 billion. To monitor program performance, we examine MA enrollment trends, plan availability for the coming year, and payments for MA plan enrollees relative to spending for fee-for-service (FFS) Medicare beneficiaries. We also provide an update on current quality indicators in MA.

The MA program gives Medicare beneficiaries the option to receive benefits from private plans rather than from the traditional FFS Medicare program. The Commission supports private plans in the Medicare program; beneficiaries should be able to choose between the traditional FFS Medicare program and the alternative delivery systems that private plans can provide. Private plans, because they are paid a capitated rate rather than on an FFS basis, have greater incentives to innovate and use care management techniques.

The Commission has stressed the concept of imposing fiscal pressure on providers to improve efficiency and reduce Medicare program costs. For MA, the Commission recommended that payments be brought down from previous high levels and that they be set so that the payment system is neutral and does not favor either MA or the traditional FFS program. Recent legislation

In this chapter

has reduced the inequity between MA and FFS. As a result, we see evidence of improved efficiency in MA: As plan bids have come down in relation to FFS, enrollment in MA continues to grow. The improved efficiency of MA plans enables them to continue to increase MA enrollment by offering packages that beneficiaries find attractive.

The Commission has also recommended that pay-for-performance programs be instituted in Medicare to promote quality, with the expected added benefit of improving efficiency by reducing unnecessary program costs. The Congress instituted a quality bonus program for MA in the Patient Protection and Affordable Care Act of 2010 (PPACA), enacted in March 2010, with bonuses available beginning in 2012. Recent data on quality indicate that plans may be responding to the legislation by paying closer attention to quality measures, with better medical record validation and other documentation efforts as a contributing factor in improved performance for many plans. More plans have reached the level of quality ratings that would permit bonuses under the statutory provisions.

The Commission supports the concept of the quality bonus program as called for in the statute. Such a pay-for-performance system, combined with continuing fiscal pressure, will help ensure that a strong MA program will do its part in the urgent need to ensure the continued financial viability of the Medicare program. However, we are concerned that CMS has implemented the quality bonus program in a flawed manner at very high program costs not contemplated in the statute, using demonstration authority to pay bonuses to plans with low ratings and increasing bonus amounts for other plans above the level authorized in the statute.

Enrollment—Between 2011 and 2012, MA enrollment increased by 10 percent to 13.3 million beneficiaries (27 percent of all Medicare beneficiaries). Enrollment in HMO plans—the largest plan type—increased 10 percent to nearly 9 million enrollees. Local preferred provider organizations (PPOs) showed rapid growth, with enrollment growing about 30 percent, to 3 million enrollees. However, regional PPO enrollment decreased about 16 percent, to 1 million enrollees. Enrollment in private FFS plans also declined from about 0.6 million to about 0.5 million enrollees, continuing the expected decline resulting from legislative changes. The MA plan bids submitted to CMS project an increase in overall enrollment for 2013 of 8 percent to 10 percent, primarily in HMOs.

Plan availability—In 2013, virtually all Medicare beneficiaries have access to an MA plan (0.4 percent do not), and 99 percent have access to a network-based coordinated care plan (CCP), which includes HMOs and PPOs. Eighty-six percent of beneficiaries have access to an MA plan that includes Part D drug coverage and

charges no premium (beyond the Medicare Part B premium). Beneficiaries are able to choose from an average of 12 MA plan options, including 9 CCPs in 2013.

***Plan payments*—**For 2013, under PPACA, the base county benchmarks used to set plans' payment rates are, on average, roughly the same as the benchmarks for 2012. However, 93 percent of 2013 plan enrollment (similar to the percentage in 2012) is projected to be in plans that will receive add-ons to their benchmarks through a CMS MA quality bonus demonstration program. These quality bonus add-ons range from 3 percent to 10 percent in 2013.

We estimate that 2013 MA benchmarks, bids, and payments (including the quality bonuses) will average 110 percent, 96 percent, and 104 percent of FFS spending, respectively. Last year, we estimated that, for 2012, these figures would be 112 percent, 98 percent, and 107 percent, respectively. The PPACA benchmark reductions, underestimates of FFS spending levels for 2013, and projected enrollment shifts into HMOs, combined with offsetting quality bonuses, resulted in some movement of projected MA payments toward FFS spending levels.

***Quality measures*—**In the past year's quality results, MA plans improved in a number of process and intermediate outcome measures that they report to CMS, but there was little change in patient experience measures and measures used to determine whether there was overall improvement in the health status of plan enrollees. With respect to intermediate outcome measures, which are based on documentation from medical records, HMO results remained stable over the past year on most of those measures, while local PPOs have narrowed previously wide differences between the performance of PPO plans and HMOs. As a result of local PPOs' improved medical record validation and other documentation efforts in reporting the intermediate outcome measures, between 2012 and 2013 such plans were able to raise their CMS star ratings, which are the composite plan quality ratings that determine plan bonuses and the level of rebate dollars that plans can use to finance extra benefits. ■

The Medicare Advantage (MA) program allows Medicare beneficiaries to receive benefits from private plans rather than from the traditional fee-for-service (FFS) program. In 2012, the MA program included almost 3,600 plan options, enrolled more than 13 million beneficiaries, and paid MA plans about $136 billion to cover Part A and Part B services. The Commission supports private plans in the Medicare program, as they enable beneficiaries to choose between the FFS Medicare program and the alternative delivery systems that private plans can provide. Plans often have flexibility in payment methods, including the ability to negotiate with individual providers, care management techniques that fill potential gaps in care delivery (e.g., programs focused on preventing avoidable hospital readmissions), and robust information systems that provide more timely feedback to providers. Plans can also reward beneficiaries for seeking care from more efficient providers and give beneficiaries more predictable cost sharing, but plans often restrict the choice of providers.

By contrast, traditional FFS Medicare has lower administrative costs while offering beneficiaries an unconstrained choice of health care providers. Although traditional Medicare also has the potential to modify its payment methods over time to better reward value, more often than not, such alterations require changes in law; to date, application of care management in FFS Medicare has been limited. Because private plans and traditional FFS Medicare have structural aspects that appeal to different segments of the Medicare population, we favor providing a financially neutral choice between private MA plans and traditional FFS Medicare. Medicare's payment systems should not unduly favor one component of the program over the other.

Efficient MA plans may be able to capitalize on their administrative flexibility to provide better value to beneficiaries who enroll in their plans. However, some of the extra benefits that MA plans provide their enrollees result from the excess payments to plans that would have been lower under FFS Medicare for similar beneficiaries. This higher spending results in extra benefits being provided through increased government expenditures and also through higher beneficiary Part B premiums (including for those who are in traditional FFS Medicare) at a time when Medicare and its beneficiaries are under increasing financial stress. To encourage efficiency and innovation, MA plans need to face some degree of financial pressure, just as the Commission has recommended for providers in the traditional FFS program. One method of achieving financial neutrality is to link private plans' payments more closely to FFS Medicare costs in the same market. Alternatively, neutrality can be achieved by establishing a government contribution that is equally available for enrollment in either FFS Medicare or an MA plan. The Commission will continue to monitor the effect of the changes mandated by the Patient Protection and Affordable Care Act of 2010 (PPACA) on plan payments and performance as well as progress toward financial neutrality.

Each year, the Commission provides a status report on the MA program. To monitor program performance, we examine MA enrollment trends, plan availability for the coming year, and payments for MA plan enrollees relative to spending for FFS Medicare beneficiaries. We also provide an update on current quality indicators in MA.

Trends in enrollment, plan availability, and payment

In contrast to traditional FFS Medicare, MA enrolls beneficiaries in several types of private health plans. In contrast to FFS Medicare, which pays providers a predetermined fixed rate per service, plans are paid a fixed capitated rate per enrollee.

Types of MA plans

Our analysis of the MA program uses the most recent data available and reports results by plan type. The plan types are:

- ***HMOs and local preferred provider organizations (PPOs)—***These plans have provider networks and can use tools such as selective contracting and utilization management to coordinate and manage care and control service use (Landon et al. 2012). They can choose individual counties to serve and can vary their premiums and benefits across counties. These two plan types are classified as coordinated care plans (CCPs).

- ***Regional PPOs—***These plans are required to offer a uniform benefit package and premium across designated regions made up of one or more states. Regional PPOs have more flexible network requirements than local PPOs. Regional PPOs are also classified as CCPs.

- ***Private FFS (PFFS) plans—***PFFS plans are not classified as CCPs. Before 2011, PFFS plans typically

TABLE 13–1

Medicare Advantage enrollment grew in 2012

	MA enrollment (in millions)		Percent change in enrollment	2012 MA enrollment as a share of total Medicare
	November 2011	November 2012		
Total	12.1	13.3	10%	27%
Plan type				
CCP	11.5	12.8	11	26
HMO	8.0	8.8	10	17
Local PPO	2.3	3.0	30	6
Regional PPO	1.2	1.0	–16	2
PFFS	0.6	0.5	–12	1
Restricted availability plans included in totals above				
SNPs*	1.4	1.6	10	3
Employer group*	2.2	2.4	10	5
Urban/rural				MA enrollment as share of population
Urban	10.6	11.6	9	29
Rural	1.5	1.7	13	16

Note: MA (Medicare Advantage), CCP (coordinated care plan), PPO (preferred provider organization), PFFS (private fee-for-service), SNPs (special needs plans). CCP includes HMO, local PPO, and regional PPO plans.
* SNPs and employer group plans have restricted availability. Their enrollment is included in the statistics by plan type and location. We present them separately to provide a more complete picture of the MA program.

Source: MedPAC analysis of CMS enrollment files.

did not have provider networks, making them less able than other plan types to coordinate care. They usually used Medicare FFS payment rates and had fewer quality reporting requirements. Given that PFFS plans generally lacked care coordination, had lower quality measures than CCPs on those measures they did report, paid Medicare FFS rates, and had higher administrative costs than traditional FFS Medicare, they were viewed as providing little value. In response, the Medicare Improvements for Patients and Providers Act of 2008 required that, in areas with two or more network MA plans, PFFS plans can be offered only if they have provider networks. PFFS plans are also now required to participate in quality reporting. Existing PFFS plans had to either locate in areas with fewer than two network plans or develop provider networks themselves, which in effect would change them to become PPOs or HMOs or operate as network-based PFFS plans.

Two additional plan classifications cut across plan types. First are special needs plans (SNPs), which offer benefit packages tailored to specific populations (i.e., beneficiaries who are dually eligible for Medicare and Medicaid, are institutionalized, or have certain chronic conditions). SNPs must be CCPs. In Chapter 14 of this report, we make several recommendations related to SNPs. Second are employer group plans, which are available only to Medicare beneficiaries who are members of employer or union groups that contract with those plans. Employer group plans cannot be PFFS plans. Both SNPs and employer group plans are included in our plan data, with the exception of plan availability figures, as these plans are not available to all beneficiaries.

How Medicare pays MA plans

Plan payment rates are determined by the MA plan bid (the dollar amount the plan estimates will cover the Part A and Part B benefit package for a beneficiary of average health status) and the payment area's benchmark (the maximum amount of Medicare payment set by law for an MA plan to provide Part A and Part B benefits). Plans with higher quality ratings are rewarded with a higher

benchmark. If a plan's bid is above the benchmark, its MA payment rate is equal to the benchmark, and enrollees have to pay a premium equal to the difference. If a plan's bid is below the benchmark, its payment rate is its bid plus a percentage (between 58 percent and 72 percent in 2013, depending on a plan's quality ratings) of the difference between the plan's bid and the benchmark; the beneficiary pays no premium to the plan for the Part A and Part B benefits (but continues to be responsible for payment of the Medicare Part B premium and may still pay premiums to the plan for additional benefits). Because benchmarks are often set well above what it costs Medicare to provide benefits to similar beneficiaries in the FFS program, MA payment rates usually exceed FFS spending. In past reports, we examined why benchmarks are above FFS spending and what the ramifications are for the Medicare program. In 2012, Part A and Part B payments to MA plans totaled approximately $136 billion. A more detailed description of the MA program payment system can be found at http://www.medpac.gov/documents/MedPAC_Payment_Basics_12_MA.pdf.

Enrollment trends: Plan enrollment grew in 2012

Between November 2011 and November 2012, enrollment in MA plans grew by about 10 percent—or 1.2 million enrollees—to 13.3 million enrollees (compared with growth of about 4 percent in the same time period for the total Medicare population). About 27 percent of all Medicare beneficiaries were enrolled in MA plans in 2012 (Table 13-1).

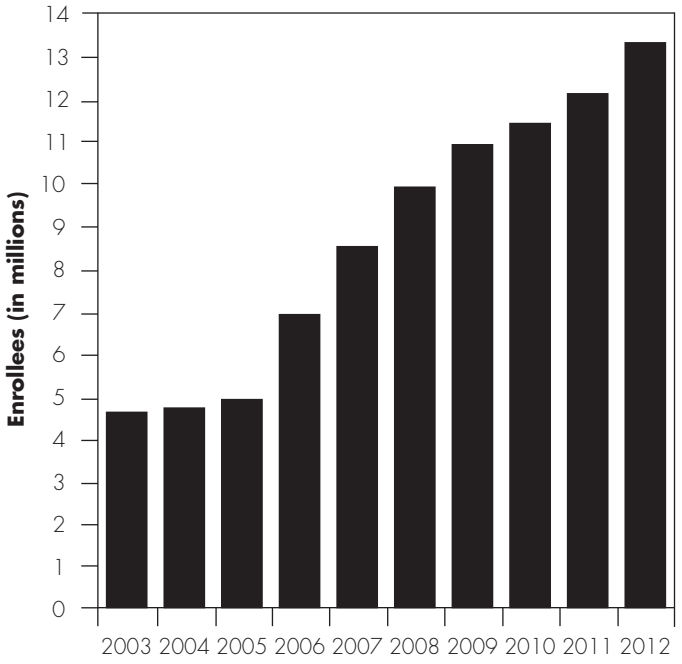
Enrollment patterns differ in urban and rural areas. A larger share of urban beneficiaries are enrolled in MA (about 29 percent) compared with beneficiaries residing in rural counties (about 16 percent). About a third of rural MA enrollees were in HMO plans (not shown in Table 13-1) compared with about 71 percent of urban enrollees. At the same time, 15 percent of rural enrollees were in PFFS plans compared with 2 percent of urban enrollees.

The percentage of Medicare beneficiaries enrolled in MA plans in 2012 varied widely geographically. In some metropolitan areas, less than 1 percent of Medicare beneficiaries were enrolled in MA plans, whereas in other areas enrollment was 60 percent or more (Pittsburgh, PA, Rochester, NY, and several areas in Puerto Rico).

Among plan types, HMOs continued to enroll the most beneficiaries (8.8 million), with 17 percent of all Medicare beneficiaries in HMOs in 2012. Between 2011 and 2012, local PPOs exhibited rapid growth in enrollment, which increased by about 30 percent. However, regional PPO enrollment decreased by about 16 percent. PFFS enrollment shrank from about 0.6 million to about 0.5 million enrollees. In 2012, SNP enrollment and employer group enrollment both grew by about 10 percent.

FIGURE 13–1

Medicare Advantage enrollment, 2003–2012



Source: MedPAC analysis of CMS enrollment files.

Growth in MA enrollment in 2012 continued a trend begun in 2003 (Figure 13-1). Since 2003, enrollment has almost tripled. From 2011 to 2012, enrollment growth rates increased from 6 percent to 10 percent. We did not have final 2013 enrollment information as of this report's publication, but plans projected overall enrollment growth of 8 percent to 10 percent for 2013. Most of the growth was projected to be in HMOs, with lower growth in PPO plans, while PFFS plans were projected to contract.

Plan availability for 2013

Every year, we assess plan availability and projected enrollment for the coming year based on the bid data that plans submit to CMS. We find that access to MA plans remains high in 2013, with most Medicare beneficiaries having access to a large number of plans. While almost

TABLE 13–2

Access to Medicare Advantage plans remains high

	Percent of beneficiaries with access to MA plans by type				
Type of plan	**2005**	**2010**	**2011**	**2012**	**2013**
All plan types	84%	100%	100%	100%	100%
Local CCP	67	91	92	93	95
Regional PPO	N/A	86	86	76	71
PFFS	45	100	63	60	59
Zero-premium plans with drugs	N/A	85	90	88	86
Average number of choices	5	21	12	12	12

Note: MA (Medicare Advantage), CCP (coordinated care plan), PPO (preferred provider organization), N/A (not applicable), PFFS (private fee-for-service). These figures exclude special needs plans and employer-only plans. A zero-premium plan with drugs includes Part D coverage and has no premium beyond the Part B premium. Regional PPOs were created in 2006. Part D began in 2006.

Source: MedPAC analysis of CMS bid data and population reports.

all beneficiaries have had access to some type of MA plan since 2006, local CCPs have become more widely available in the past few years (Table 13-2). Ninety-five percent of Medicare beneficiaries have an HMO or local PPO plan operating in their county of residence, up from 93 percent in 2012 and 67 percent in 2005. Regional PPOs are available to 71 percent of beneficiaries, down from 76 percent in 2012 due to withdrawal of the regional PPOs in Nevada and the seven-state region of the Great Plains for 2013. Access to PFFS plans decreased between 2012 and 2013, from 60 percent to 59 percent of beneficiaries. Overall, virtually all Medicare beneficiaries have access to an MA plan (0.4 percent do not), and 99 percent have access to a CCP (not shown in Table 13-2).

In 2013, 86 percent of Medicare beneficiaries have access to at least one MA plan that includes Part D drug coverage and charges no premium (beyond the Medicare Part B premium) compared with 88 percent in 2012.

The availability of SNPs has changed slightly and varies by the type of special needs population served (not shown in Table 13-2). In 2013, 82 percent of beneficiaries reside in areas where SNPs serve beneficiaries who are dually eligible for Medicare and Medicaid (up from 78 percent in 2012), 46 percent live in areas where SNPs serve institutionalized beneficiaries (up from 41 percent in 2012), and 55 percent live in areas where SNPs serve beneficiaries with chronic conditions (up from 45 percent in 2012). Overall, 85 percent of beneficiaries reside in counties served by at least one type of SNP.

In most counties, a large number of MA plans are available to beneficiaries. For example, beneficiaries in Miami, New York City, and some areas of Pennsylvania and Florida can choose from more than 40 plans in 2013. At the other end of the spectrum, some counties, representing 0.4 percent of beneficiaries, have no MA plans available; however, many of these beneficiaries have the option of joining cost plans (another managed care option under Medicare).[1] On average, 12 plans, including 9 CCPs, are offered in each county in 2013, the same total as in the previous 2 years, but up by 1 CCP over that time. The decrease in plan choices from 2010 to 2011 was due to the reduction in PFFS plan choices.

2013 benchmarks, bids, and payments relative to FFS spending

We use the plan bid projections to compare the Medicare program's projected MA spending with projected FFS spending on a like set of FFS beneficiaries. We calculate and present three sets of percentages: the benchmarks relative to projected FFS spending, the bids relative to projected FFS spending, and the resulting payments to MA plans relative to projected FFS spending. Benchmarks are set each April for the following year. Plans submit their bids in June and incorporate the recently released benchmarks. Benchmarks reflect current law FFS spending estimates for 2013 made by CMS at the time the benchmarks were published in April 2012. For 2013, the April 2012 current law estimates of FFS spending assumed that the sustainable growth rate (SGR) formula would cut

TABLE 13–3 **Projected payments exceed FFS spending for all plan types in 2013**

	Percent of FFS spending in 2013		
Plan type	**Benchmarks**	**Bids**	**Payments**
All MA plans	110%	96%	104%
HMO	110	92	103
Local PPO	111	107	108
Regional PPO	106	97	102
PFFS	110	105	107
Restricted availability plans included in totals above			
SNP*	111	96	105
Employer groups*	111	106	108

Note: FFS (fee-for-service), MA (Medicare Advantage), PPO (preferred provider organization), PFFS (private fee-for-service), SNP (special needs plan). Benchmarks are the maximum Medicare program payments for MA plans. We estimate FFS spending by county using the 2013 MA rate book. We removed spending related to the remaining double payment for indirect medical education payments made to teaching hospitals.
* SNPs and employer group plans have restricted availability and their enrollment is included in the statistics by plan type. We have broken them out separately to provide a more complete picture of the MA program.

Source: MedPAC analysis of data from CMS on plan bids, enrollment, benchmarks, and FFS expenditures.

physician fee schedule rates by about 30 percent. (CMS will not adjust the benchmarks for 2013 to correct for the change but will adjust the projections used for the 2014 benchmarks to account for the 2013 SGR change.) However, we project 2013 FFS spending based on a freeze in physician payment rates rather than a reduction from the SGR. This projection results in total FFS spending about 4 percent above what was expected when the benchmarks were set. This process does not reflect a change in our methods, as we make these adjustments each year, but the magnitude of the adjustment has been larger in the past two years because the current law scheduled SGR reduction (as of the April projection) was larger than it has been in the past.

We estimate that 2013 MA benchmarks, bids, and payments will average 110 percent, 96 percent, and 104 percent of FFS spending, respectively (Table 13-3). (Benchmarks, bids, and payments are weighted by plans' projected 2013 enrollment by county to estimate overall averages and averages by plan type.)

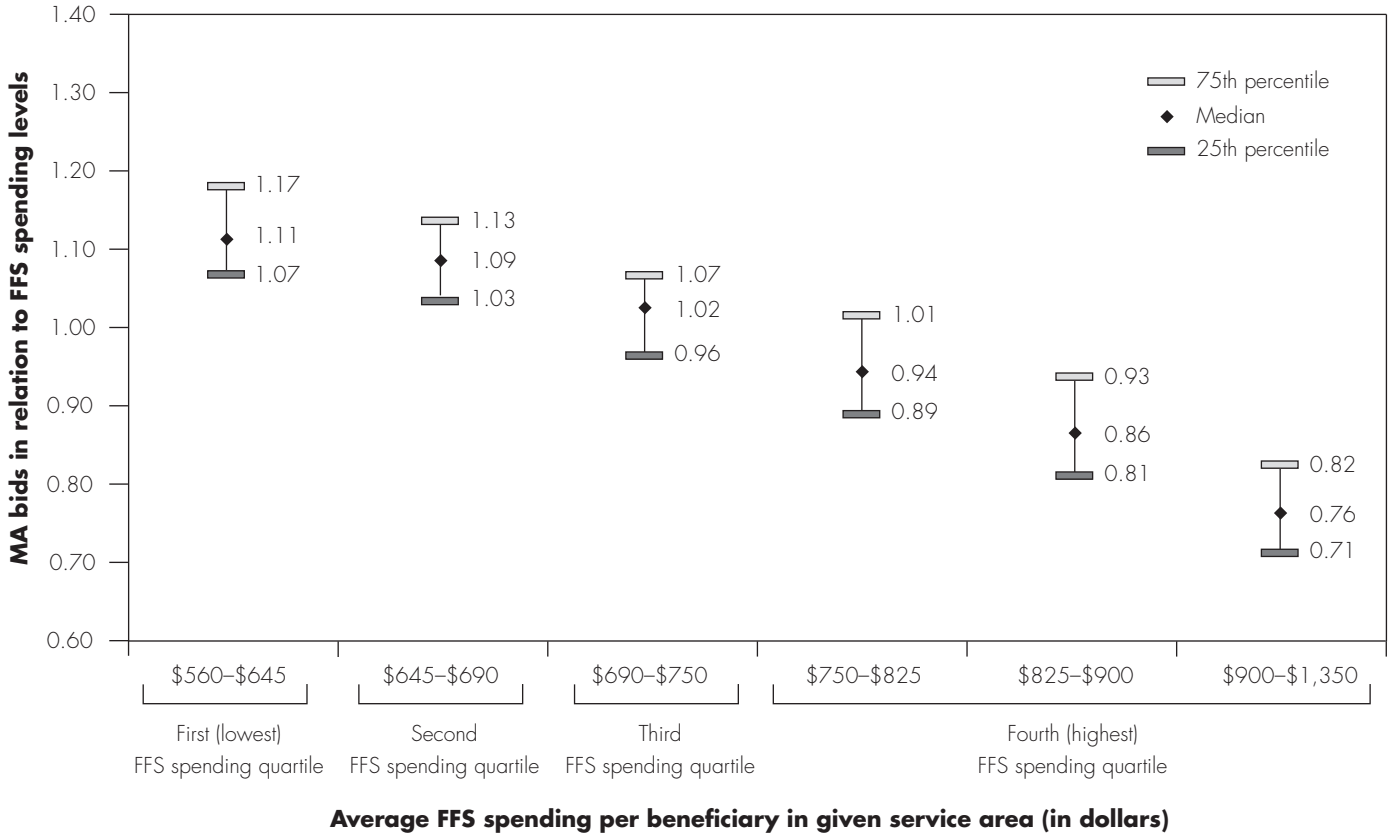
Last year, we estimated that, for 2012, these figures would be 112 percent, 98 percent, and 107 percent, respectively. The PPACA benchmark reductions, underestimates of FFS spending levels for 2013, and projected enrollment shifts into HMOs, combined with offsetting quality bonuses, resulted in some movement of projected MA payments toward FFS spending levels. Payments for all plan types are projected to be closer to FFS spending levels in 2013 than they were in 2012. Most notably, HMOs submitted bids that averaged 92 percent of FFS spending, although there is much variation in the relationships between individual plan bids and expected FFS spending.

MA benchmarks

Under PPACA, county benchmarks in 2013 are transitioning to a system in which each county's benchmark in 2017 will be a certain percentage (ranging from 95 percent to 115 percent) of the average per capita FFS Medicare spending for the county's residents. Counties are ranked by average FFS spending; the highest spending quartile of counties would have benchmarks set at 95 percent of local FFS spending and the lowest spending quartile would have benchmarks set at 115 percent of local FFS spending. The transition from old benchmarks will be complete by 2017. (See our March 2011 report for more details on PPACA benchmark changes.) In 2013, more than half of all counties will have base benchmarks that have fully transitioned to the final PPACA levels. However, only 29 percent of all Medicare beneficiaries and only 21 percent of MA enrollees live in these fully transitioned counties. If all the benchmarks had transitioned completely, average plan benchmarks would have been 3 percent lower.

FIGURE 13–2

Medicare Advantage bids in relation to FFS spending levels, 2013



Note: MA (Medicare Advantage), FFS (fee-for-service).

Source: MedPAC analysis of MA bid and FFS expenditure data from CMS.

For 2013, the base county benchmarks (in nominal dollars and before any quality bonuses are applied) average approximately the same as the benchmarks for 2012. However, for 2013, 93 percent of MA enrollees are projected to be in plans that will receive add-ons to their benchmarks through the PPACA quality provisions or the 2012 to 2014 CMS quality demonstration program. These quality bonus add-ons range from 3 percent to 10 percent in 2013.

MA bids and payments for different plan types

The lack of growth in the benchmarks may have exerted fiscal pressure on the plans and encouraged them to better control costs and lower their bids for 2013. The average bid for 2013 is 96 percent of the projected FFS spending for similar beneficiaries, down from 98 percent in 2012. About 56 percent of nonemployer plans (up from 46 percent in 2012) bid to provide Part A and Part B benefits for less than what the FFS Medicare program would spend to provide these benefits. These plans are projected to enroll 60 percent of nonemployer MA enrollees in 2013. About 0.8 million beneficiaries, excluding those enrolled in employer group MA plans, are projected to enroll in plans that bid lower than 75 percent of FFS spending. On the other hand, a similar number of beneficiaries are projected to enroll in plans that bid at least 115 percent of FFS spending.

Figure 13-2, illustrating over 2,000 plan bids (employer plans, SNPs, and plans in the territories were excluded), shows how plans bid relative to FFS for service areas with different ranges of FFS spending. The first three FFS spending ranges roughly correspond to the FFS ranges in the first three rate quartiles in the PPACA payment rules.

We broke the fourth quartile into the last three FFS ranges because about 40 percent of Medicare beneficiaries live in counties in the highest spending quartile. Each FFS range covers the bids of at least 140 plans and a half-million projected enrollees, with about 75 percent of the plans and projected enrollment falling in the three groups between $690 and $900 of FFS spending per month.

Figure 13-2 shows that plans bid low (relative to FFS) in areas with relatively high FFS spending. When plans bid for service areas that average less than $700 in monthly FFS spending, they are likely to bid more than FFS. However, when plan service areas average more than $750 per month in FFS spending, plans are likely to bid below (sometimes far below) the FFS level. This finding suggests that, geographically, plan costs do not vary as much as FFS spending. Ninety percent of beneficiaries live in a county served by at least one plan that bid below the average FFS spending of its service area. Although the bidding and payment patterns reported in Table 13-3 (p. 295) are averages, Figure 13-2 shows there is much variation behind these averages.

Despite the fact that the plan bids average less than FFS spending, payments for enrollees in these plans usually exceed FFS spending because the benchmarks are high relative to FFS spending. For example, HMOs as a group bid an average of 92 percent of FFS spending, yet 2013 payments for HMO enrollees are estimated to average 103 percent of FFS spending because the benchmarks (including the quality bonuses) average 110 percent of FFS spending.

Other plan types (aside from the regional PPOs) have average bids above FFS spending. As a result, payments for PFFS and local PPO enrollees are estimated to be 107 percent and 108 percent, respectively, of FFS spending (Table 13-3, p. 295).

We analyzed bids and payments to SNPs and employer group plans separately, because the plans are available only to subpopulations of Medicare beneficiaries, and bidding behavior differs from that of other plan types. Payments to SNPs and their bids tend to mirror general MA patterns relative to FFS spending. Employer group plans consistently bid higher than plans that are open to all Medicare beneficiaries. These plans bid an average of 106 percent of FFS spending and are paid about 108 percent of FFS, while nonemployer plans bid an average of 94 percent of FFS and are paid about 103 percent of FFS (not shown in Table 13-3). The dynamic of the bidding process for employer group plans is more complicated than for other MA plans because employer group plans can negotiate benefit and premium particulars with employers after the Medicare bidding process is complete. Conceptually, the closer the bid is to the benchmark—that is, the maximum Medicare payment—the better it is for the plan and the employers, because a higher bid brings in more revenue from Medicare, potentially offsetting expenses that would have required a larger contribution from employers (or employees). On the other hand, nonemployer plans have an incentive to bid below the benchmark to obtain rebates they can use to finance extra benefits that, in turn, are used to attract increased enrollment. In other words, the nonemployer plans are competing for enrollment through the value of the benefit packages their bids allow them to submit, while the employer plans are not.

The ratio of MA plan payments to FFS spending varies by plan type, but the ratios for all plan types are higher than 100 percent. In 2013, overall payments to plans average an estimated 104 percent of FFS spending, meaning that the Medicare program will pay approximately $6 billion more for MA enrollees than it would have paid to cover the same enrollees in FFS Medicare. (This figure includes about $4 billion attributable to quality bonus payments, about two-thirds of which are due to the demonstration program that will end in 2014.)

MA risk adjustment and coding intensity adjustment

Medicare payment to plans is calculated separately for each beneficiary as the plan's payment rate multiplied by the beneficiary's risk score. The risk scores are based on provider diagnoses attributed to the beneficiary during the year before the payment year. The diagnoses are reported to Medicare through claims for Medicare FFS beneficiaries or by the plans for MA enrollees. To receive the maximum payment they may rightfully claim, the plans have an incentive to ensure that the providers serving the beneficiary record all diagnoses completely.

Experience supports the contention that MA plan enrollees have higher risk scores than otherwise similar FFS beneficiaries because of more complete coding. CMS has found that risk scores for MA plan members have been growing more rapidly than risk scores for FFS beneficiaries. For 2013, plan bids project an average risk score of about 1.04 compared with 1.03 projected for 2012 and 1.02 for 2011. Thus, as mandated by the Deficit Reduction Act of 2005, CMS has been making an across-the-board adjustment to the scores. Taking into account

TABLE 13–4

Distribution of enrollment by plan ratings and plan type, November 2012 enrollment, 2012 star ratings

	Percentage distribution of enrollment				
Number of stars	**All plan types**	**HMO**	**Local PPO**	**Regional PPO**	**PFFS**
4.0, 4.5, 5.0[a]	27%	35%	13%	0%	<0.5%
3.0, 3.5[b]	61	53	77	93	34
Below 3.0 stars[c]	9	10	5	4	12
Not rated	4	1	6	2	55

Note: PPO (preferred provider organization), PFFS (private fee-for-service). Data exclude cost-reimbursed HMO plans, which do have star ratings but are not eligible for bonuses. Figures may not sum due to rounding.
a. Eligible for bonus under statutory provisions.
b. Eligible for bonus only under demonstration.
c. Not eligible for bonus payments.

Source: MedPAC analysis of CMS star ratings and enrollment data.

multiple years of coding differences, CMS reduced risk scores by 3.41 percent from 2010 through 2012. Under PPACA, CMS can continue to adjust for the differences it finds without any restrictions for 2013 (it has chosen to maintain the 3.41 percent adjustment), but for 2014 and all future years, PPACA specifies minimum reductions, although CMS has discretion to make larger reductions. The Government Accountability Office (GAO) had found that CMS should make larger reductions to fully account for the coding differences (Government Accountability Office 2012). The American Taxpayer Relief Act of 2012 increased the minimum reductions that CMS must make in the scores. The mandated reductions will end once CMS begins risk modeling based on MA utilization rather than on FFS utilization in the current model; however, CMS will be able to devise an adjustment to account for any difference between FFS and MA risk levels. In our March 2012 report, the Commission noted that a number of issues must be considered in deciding whether to use MA utilization as the basis for risk adjustment and how to go about designing such an alternative (Medicare Payment Advisory Commission 2012a).

The 104 percent of FFS payment figure projected for 2013 assumes that the risk-adjustment system and the CMS coding adjustment properly correct for all the health risk differences between the FFS and MA populations. However, several studies (McWilliams et al. 2012, Medicare Payment Advisory Commission 2012a, Newhouse et al. 2012) suggest that MA plans may enjoy some favorable selection (though less than in previous years) that the current risk-adjustment model does not capture. For this reason, 104 percent might understate the additional payments made for plan enrollees relative to Medicare FFS beneficiaries. On the other hand, the payments include quality bonuses worth about 3 percent of payments. If there were no quality bonuses or favorable selection, plan enrollees in 2013 would receive about 101 percent of the funding that Medicare spends on similar FFS Medicare beneficiaries.

Quality in MA plans

As of 2012, the MA program makes bonus payments to high-performing plans. CMS uses a 5-star rating system to develop composite plan quality ratings that determine bonus levels. The bonus takes the form of a higher benchmark for higher quality plans. Higher rated plans also are entitled to a higher level of rebates (the payments plans use to finance extra benefits if bids are below benchmarks). The highest rated plans, those with a 5-star overall rating, are permitted to enroll beneficiaries year-round rather than having to limit enrollment to the October to December open enrollment season.

In 2012, CMS used 37 Part C (MA) measures or factors to determine each plan's star rating, though additional measures are also collected and reported but not included in the star ratings. For organizations with drug plans (MA–Prescription Drug, or MA–PD plans), an additional 14

TABLE 13–5

Distribution of enrollment by plan ratings and plan type, November 2012 enrollment, 2013 star ratings

	Percentage distribution of enrollment				
Number of stars	**All plan types**	**HMO**	**Local PPO**	**Regional PPO**	**PFFS**
4.0, 4.5, 5.0[a]	36%	41%	35%	2%	<0.5%
3.0, 3.5[b]	56	52	57	95	70
Below 3.0 stars[c]	5	6	3	0	23
Not rated	2	1	5	3	7

Note: PPO (preferred provider organization), PFFS (private fee-for-service). Data exclude cost-reimbursed HMO plans, which do have star ratings but are not eligible for bonuses. Figures may not sum due to rounding.
a. Eligible for bonus under statutory provisions.
b. Eligible for bonus only under demonstration.
c. Not eligible for bonus payments.

Source: MedPAC analysis of CMS star ratings and enrollment data.

Part D measures or factors were components of the overall star rating.[2] Each of the 51 measures for an MA–PD plan is given a star rating on the 1–5 scale, with each of the 51 measures also given a relative weight (of 1, 1.5, or 3). The overall rating that determines the bonus level is the average of the weighted value of the individual stars given for each of the 51 measures.[3]

The Medicare statute requires that plans achieve at least a 4-star overall rating to receive bonus payments, with benchmarks increasing by 3 percent for plans at 4 stars or higher. However, under a CMS demonstration that began in 2012 and will continue through 2014, plans with an overall average rating of 3 stars or above receive bonus payments. Under the demonstration, bonus levels vary by star ratings and are at levels higher than under the statutory provisions. Plans at 5 stars have a 5 percent bonus; those at 4 and 4.5 stars have a 4 percent bonus; those at 3.5 stars have a bonus of 3.5 percent, and those at 3 stars have a 3 percent bonus. Because of the demonstration, nearly all plans received bonus payments in 2012. As of November 2012, only 13 percent of enrollees were in plans that had star ratings below bonus levels (9 percent below 3 stars) or that were not rated (4 percent) (Table 13-4). Under the more restrictive statutory provisions, only 27 percent of plan enrollment would have been in bonus-level plans (those with ratings of 4 stars or above). Because of this large difference in the criteria for plans to be eligible for quality bonus payments and the resulting misallocation of Medicare funds, the Commission has expressed serious concerns about the demonstration project, viewing it as overly broad use of CMS's demonstration authority (Medicare Payment Advisory Commission 2012b, Medicare Payment Advisory Commission 2011a). GAO also expressed its concerns about the demonstration and noted that CMS actuaries projected that the demonstration would result in added program costs in excess of $8 billion. GAO recommended that the demonstration be terminated immediately (Government Accountability Office 2012).

Each year, plans receive new star ratings that reflect plan performance based on measures collected in the most recent time period. New star ratings were posted for the open enrollment period of October to December 2012 for enrollments effective in 2013, giving beneficiaries more up-to-date information on plan quality (the star ratings we refer to as the 2013 ratings). The newer star ratings will be the basis of bonus payments in 2014, the last year of the demonstration. If the enrollment distribution in 2014 mirrors the distribution in November 2012, only 7 percent of enrollment will be in plans not eligible for quality bonus payments under the demonstration (Table 13-5). Under the statutory provisions, 63 percent of enrollment would be in plans with star ratings below bonus levels (3.5 or fewer stars).

Analysis of the differences in the star ratings between the two time periods gives a rough snapshot of the extent to which plan quality may have improved between 2012 and 2013 in the MA program.[4] The universe of plans is held constant, as is the enrollment, but the star ratings for each

plan are updated using the new 2013 ratings for the second table (Table 13-5). Although there were some changes in the measures that constitute the star rating system and the weights assigned to the measures, star criteria for the two years are quite comparable.[5] Thus, the change in the percentage of enrollees in plans rated 4 stars or higher indicates that plans improved their performance on the measures that determine the star ratings. In particular, while HMO plan results improved (with 4-star or higher enrollment rising from 35 percent to 41 percent), the most striking shift is in the local PPO category, in which a number of plans raised their star ratings. The proportion of local PPO enrollees in plans with 4 or more stars nearly tripled, rising from 13 percent using the 2012 star ratings to 35 percent with the 2013 ratings. Whereas the 2012 ratings indicated that HMOs had a clear advantage over local PPOs in their overall performance, the 2013 ratings show a narrowing of the differences between HMOs and local PPOs—reflecting improved results for local PPOs in what are classified as intermediate outcome measures.

In what follows, we examine in more detail the differences in plan performance between 2012 and 2013 by looking at individual components of the star rating system. We see that the Part C measures that account for the improvement among local PPOs are measures that health plans report to CMS, based on documentation from medical records, and more heavily weighted in the star rating system.

Components of the star rating system

The 50 measures in the star rating system capture information about plan performance on clinical process and outcome measures, patient experience measures as determined from surveys of beneficiaries, and plan performance in contract administration measures tracked by CMS.

In Part C, there are two sources of clinical process and outcome measures. Health plans report process and intermediate outcome measures to CMS using the Healthcare Effectiveness Data and Information Set® (HEDIS®).[6] Additional process measures are obtained through a member survey, the Health Outcomes Survey (HOS), which also collects self-reported health information that is used to develop an overall outcome measure to gauge whether a health plan's enrollees have had any improvement or decline in their physical and mental health status over a two-year period.

The Consumer Assessment of Healthcare Providers and Systems for MA (CAHPS®–MA)[7] is the source of patient experience measures whereby beneficiaries report on their access to care in plans and their rating of plan quality and the quality of care rendered by plan providers.[8]

An important consideration with respect to many of the HEDIS measures is that plans report results based on documentation extracted from medical records rather than administrative data such as claims, encounter data, and pharmacy data. For reporting these measures based on medical record review—referred to as the "hybrid" measures—plans use a random sample of medical records (for up to 411 patients) to determine the rate to report in HEDIS. For example, whether plan members diagnosed with hypertension are controlling their blood pressure is a hybrid measure that is based on a review of patient medical records. For some measures, plans can use administrative data or medical record sampling.

As noted above, the measures in the star ratings are not equally valued but are weighted by the type of measure. Individual star measures that are outcome measures or HEDIS intermediate outcome measures have a weight of 3, patient experience measures have a weight of 1.5, and process measures have a weight of 1. Contract administration measures that CMS classifies as "measures affecting access" have a weight of 1.5 and otherwise have a weight of 1. Examples of types of measures, their classification, and their weighting are included in Table 13-6.[9]

The star rating system gives greater weight to outcome and intermediate outcome measures, both by the higher weight given to each star for the individual measures and by the proportion of such weighted measures that go into the overall star rating for a plan. In 2012, 62 percent of the weighting for the 50 star measures was for clinical measures, including clinical process measures as well as outcome measures. For the 2013 ratings, 66 percent of the weighting is for clinical measures—of which two-thirds of the weight is for outcomes (such as improvement in physical health based on HOS results) or intermediate outcomes (such as control of blood sugar among diabetics). In the 2013 ratings, 16 percent of the weighting is for patient experience measures (about the same as in 2012), and 18 percent is for contract performance measures (down from 23 percent in 2012).

Cannot determine whether plan quality has improved over the past year

We cannot definitively say whether quality overall has improved in MA between 2011 and 2012 because various

TABLE 13–6 **Examples of measures included in the CMS star ratings and their sources and weighting**

Measure type (CMS classification) and name	Source of measure	Weight given to the star for this individual measure
Outcome measures		
Plan all-cause readmissions	Plans report via HEDIS®	3
Improving or maintaining physical health	Based on HOS member survey	3
Improving or maintaining mental health	Based on HOS member survey	3
Intermediate outcome measures		
Diabetes care – blood sugar controlled	Plans report via HEDIS	3
Diabetes care – cholesterol controlled	Plans report via HEDIS	3
Controlling blood pressure	Plans report via HEDIS	3
Patients' experience and complaints measures		
Overall rating of plan	CAHPS member survey	1.5
Members choosing to leave the plan (disenrollment rates)	CMS tracking	1.5
Measures capturing access		
Plan makes timely decisions about appeals	CMS tracking	1.5
Call center – foreign language interpreter and TTY/TDD availability	Plans report to CMS	1.5
Process measures		
Breast cancer screening	Plans report via HEDIS	1
Cardiovascular care – cholesterol screening	Plans report via HEDIS	1
Monitoring physical activity	Question in HOS member survey	1
Reducing the risk of falling	Question in HOS member survey	1
Enrollment timeliness	CMS tracking	1

Note: HEDIS® (Healthcare Effectiveness Data and Information Set®), HOS (Health Outcomes Survey), CAHPS® (Consumer Assessment of Healthcare Providers and Systems®), TTY/TDD (telecommunications device for the deaf/teletypewriter).

Source: Centers for Medicare & Medicaid Services 2012a.

factors need to be taken into account in evaluating 2012 results. Currently, we cannot distinguish whether the observed differences in plans' performance on the quality measures reflects distinct actions they are taking to improve quality or improved documentation and reporting practices. As we discuss below, we do see improvement in HEDIS process and intermediate outcome measures—that is, measures that may be more directly under the control of plans in terms of their ability to improve provider performance as well as to improve provider reporting and record keeping. However, we do not see a similar level of improvement in quality measures drawn from beneficiary surveys—the patient experience measures and measures of changes in health status over time.

Traditionally, to judge whether the quality of care in MA has improved from one year to the next, we examine HEDIS rates for plans that report a particular measure for each of the two years—using a "same store" concept to determine whether results show improvement, decline, or no statistically significant changes.[10] We compare measures for which the definitions, or specifications, have not changed materially between the two years. This approach helps to ensure that we are making a valid "apples-to-apples" comparison when attempting to determine whether the trend across MA is in the direction of improvement.

Certain factors affect the results of an analysis of changes in MA quality. For example, for newly introduced

measures, it is often the case that initial rates for the new element are low and subsequent rates show dramatic improvement. When the National Committee for Quality Assurance (NCQA) introduces a new HEDIS measure, the results for the first year the measure is used are not publicly reported; when CMS has included new outcome measures in the star rating system, the new measure is given a weight of 1 in the first year and 3 for subsequent years. This approach allows plans time to become familiar with the measure and make any reporting or other administrative changes to be able to accurately report the measure. Thus, if the measure results show improvement over time initially, it can be due to better record keeping and data collection, as well as better performance now that the process or outcome measure is being measured.[11]

Another factor to consider in evaluating recent HEDIS results is a change in reporting methodology that has occurred. In our yearly analysis of MA quality results, we have traditionally analyzed HMOs and PPOs separately because of a major difference between the two plan types in the specifications for hybrid measures. It was not until 2010 that PPOs were permitted to report hybrid measures using medical record review. Previously, PPO reporting of such measures was based exclusively on administrative records, while HMOs had the option of using medical record review (which generally resulted in higher rates). Because the new specifications for PPOs began in 2010, we did not view the extremely low 2010 results for PPOs as entirely credible for purposes of comparison with HMO hybrid measure results (see, for example, the June 2011 MedPAC data book, Table 4-7 (Medicare Payment Advisory Commission 2011b)). The improvement in PPO results on HEDIS hybrid measures over the past three years—including between 2011 and 2012—suggests that the improvement can be attributed in large part to better record keeping and data collection. PPOs changed from reporting based solely on administrative data for all HEDIS measures to instituting processes for medical record review and data extraction from a sample of medical records as a basis of reporting HEDIS hybrid measures.[12]

Finally, we expect the introduction of the star rating system to motivate plans to improve outcomes and their documentation, record keeping, and reporting systems for a pay-for-performance program tied to results on quality measures. NCQA staff recently published a commentary on whether the star rating system has improved quality in MA. Citing the improvement in HEDIS measures among Medicare plans between 2011 and 2012—a level of improvement not mirrored in the performance of commercial plans—the authors noted that "anecdotally, we are seeing that several plans that before paid minimal attention to their star scores are now aggressively working to improve" (Cotton et al. 2012). Plans will pay attention to both aspects of quality measurement—better documentation as well as efforts to improve the quality of medical care.

Comparing 2011 and 2012 results in quality indicators

Between 2011 and 2012, a number of HEDIS measures that MA plans report to CMS improved, but little change occurred in measures collected through member surveys—the patient experience measures of CAHPS, the HOS care measures, and the HOS-based determination of improvement or decline in enrollees' health status. For other star measures, on average, comparing all plans rated in both years, scores for three contract administration measures and disenrollment rates improved between 2011 and 2012. Measures reported exclusively by SNPs also improved.[13]

By plan type, local PPOs, as well as regional PPOs and PFFS plans, improved their scores on the HEDIS hybrid measures (those based on documentation from medical records).[14] For local PPOs reporting on the 45 HEDIS measures in both 2011 and 2012, 13 of the 45 measures had an improved average rate that was statistically significant, while 1 measure declined and the rest were unchanged. Of the 13 improved measures, 10 were hybrid measures (Table 13-7). For HMOs, the results for most of the hybrid measures remained unchanged over the past year. Thus, local PPOs are catching up with HMOs on these measures and have narrowed wide differences between the performance of PPO plans and HMOs (one hybrid measure—cholesterol control among patients with cardiovascular conditions—has a higher average rate for local PPOs, though the difference between HMOs and local PPOs is not statistically significant).

The shift in the star ratings for local PPOs between 2012 and 2013 that we have discussed (Table 13-4, p. 298, and Table 13-5, p. 299)—with more plans moving to the 4-star or higher level—is primarily due to the gains local PPOs have made in the hybrid measures, given their (appropriately) greater weight in the CMS star rating system. As shown in Table 13-7, local PPO rates improved for all three HEDIS intermediate outcome measures that are components of the star system, as did regional PPO rates for these measures (not shown in Table 13-7). The

TABLE 13–7

Between 2011 and 2012, local PPO plans improved on a number of HEDIS® hybrid measures, and PPO rates are now closer to HMO rates

Measure name	Weight for star rating (if element of star ratings)	PPO Mean (2011)	PPO Mean (2012)	PPO Percent change	HMO Mean (2011)	HMO Mean (2012)	HMO Percent change
Measures showing improvement among PPOs reporting in both years							
Hybrid measures							
Adult BMI assessment	1	36.5	63.6	74%	49.7	68.2*	37%
Colorectal cancer screening	1	41.3	55.4	34	57.0	60*	5
Poor blood glucose control among diabetics†	3	34.3	28.4	17	26.3	25.7	2
Control of cholesterol among patients with cardiovascular conditions		50.6	57.4	13	56.4	56.8	1
Control of cholesterol among diabetics	3	46.0	51.6	12	51.6	52.8	2
Controlling high blood pressure in members with hypertension	3	55.8	62.0	11	61.4	63.6*	4
Blood pressure control among diabetics		55.7	61.5	10	61.8	63	2
Blood glucose control among diabetics (< 8.0%)		58.2	63.5	9	65.3	65.9	1
Cholesterol screening for patients with cardiovascular conditions	1	87.0	88.4	2	88.5	89.1	1
Monitoring diabetic nephropathy	1	87.2	88.3	1	89.2	90*	1
Administrative-only measures							
Use of high-risk medications in the elderly—one prescription†		22.0	19.1	13%	22.3	18.6*	17%
Use of high-risk medications in the elderly—at least two prescriptions†		5.1	3.7	27	5.2	3.6*	31
Persistence of beta blocker use after a heart attack		83.4	87.2	5	83.0	87.8*	6
Measure that declined among PPOs reporting in both years							
Initiation of alcohol and other drug dependence treatment (administrative measure)		59.7	48.7	–18%	44.5	40.6*	–9%

Note: PPO (preferred provider organization), HEDIS® (Healthcare Effectiveness Data and Information Set®), BMI (body mass index). All listed PPO measures had statistically significant differences in average rates between 2011 and 2012 ($p < 0.05$).
*Indicates a statistically significant change for HMO results between the two years for plans reporting in both years.
†Lower rate is better.

Source: MedPAC analysis of CMS HEDIS public use files.

three measures (cholesterol and blood sugar control among diabetics and control of blood pressure among members with hypertension) make up about 20 percent of the overall weighting of the 36 Part C components of the stars. For the 10 other measures for which local PPOs improved between 2011 and 2012, 7 are hybrid measures. Four of the seven measures are included in the star rating system (but weighted at 1). The remaining 31 HEDIS measures for local PPOs were stable between 2011 and 2012.

Of the 13 measures that had statistically significant improvement for local PPOs reporting in both 2011 and 2012, 7 also had statistically significant improvement

TABLE 13–8

Plan performance on the hospital readmission measure was stable between 2011 and 2012 for HMOs and local PPOs

Plan type	Year	Number of admissions, age 65 or over (in thousands)	Observed rate of readmission	Expected rate of readmission	Observed-to-expected ratio
HMOs	2011	988	14.2%	15.7%	0.91
	2012	1,032	14.3	15.7	0.91
Local PPOs	2011	107	13.1	14.5	0.90
	2012	184	13.2	14.8	0.90
Regional PPOs	2011	50	15.2	14.9	1.02
	2012	122	14.9	15.3	0.97
PFFS	2011	120	13.3	14.7	0.91
	2012	27	14.2	15.0	0.94

Note: PPO (preferred provider organization), PFFS (private fee-for-service). Observed rates and expected rates are rounded; observed-to-expected ratio is computed on an unrounded basis, but the result reported in the table is rounded. Puerto Rico data are excluded.

Source: MedPAC analysis of CMS Healthcare Effectiveness Data and Information Set® public use files.

among HMOs reporting in both years (indicated with an asterisk in Table 13-7). HMOs also improved on the following measures (not shown in table), for a total of 14 out of 45 measures for which there was improvement for HMOs:

- two measures included in the star ratings, weighted at 1—osteoporosis management in women who had a fracture and glaucoma screening in older adults,
- three measures of avoidance of specific drug interactions,
- percent of older women tested for osteoporosis (a measure collected in HOS), and
- testing of blood glucose levels of diabetics.

Both local PPOs and HMOs showed statistically significant declines in a measure of treatment for alcohol and drug abuse, a measure not included in the star ratings. HMOs also had a statistically significant decline in the measure for management of urinary incontinence in older adults (a measure collected in HOS and also not in the star ratings). For HMOs, the remaining 30 HEDIS measures were stable between 2011 and 2012, including the 6 remaining intermediate outcome measures of control of blood pressure and cholesterol for diabetics and for beneficiaries with cardiovascular conditions and control of blood sugar levels for diabetics.

Regional PPOs and PFFS plans

As for plan types other than HMOs and local PPOs, the 2012 HEDIS data include 14 regional PPOs and 22 PFFS plan reporting, compared with 326 HMOs and 130 local PPOs reporting most measures. As in past years, PFFS plans and regional PPOs have lower average HEDIS scores than HMOs and local PPOs. This fact is reflected in the relatively poor performance of these plans in the star ratings (Table 13-5, p. 299). However, in terms of changes between 2011 and 2012, the trend for these plans is similar to the trend for local PPOs. That is, we see large gains in measures based on the extraction of information from medical records (assessment of body mass index and control of blood pressure and cholesterol among patients with diabetes or a cardiovascular condition) as well as in measures indicating reduced use of high-risk medications among the elderly.

Hospital readmission rates

Plan performance on hospital readmission rates, an important measure that has been reported in HEDIS for the past two years, remained stable between 2011 and 2012 for HMOs and local PPOs (Table 13-8). The

TABLE 13–9

Various factors associated with plan star ratings, including plan age and the extent of special needs plan enrollment

	Enrollment-weighted average star rating		Number of contracts	Enrollment, November 2012 (in thousands)
	2012	2013		
All plans rated in both years	3.54	3.69	412	12,604
By plan age				
Plans starting 2003 or earlier	3.79	3.90	129	6,810
Plans starting 2004 or later	3.25	3.45	283	5,794
By plan composition of enrollment				
Plans with 90 percent or higher SNP enrollment	3.09	3.12	52	448
Plans with 10 percent or less SNP enrollment	3.52	3.71	247	8,380

Note: SNP (special needs plan).

Source: MedPAC analysis of CMS star ratings and enrollment data.

admission-weighted ratio of observed-to-expected rates of readmission was unchanged for HMOs and for local PPOs. Although there were differences between 2011 and 2012 for regional PPOs and PFFS plans—with regional PPOs improving and PFFS results declining—the large shifts in enrollment in these two plan types (reflected in the number of admissions) may explain the year-to-year differences. Unlike HMOs and local PPOs, most PFFS and regional PPO plans cover very wide geographic areas. Particularly with PFFS plans, which have minimal care management, the difference in rates between the two years may reflect geographic differences across wide service areas.

Beneficiary survey results: CAHPS and HOS health status change results

Using the CAHPS results from the CMS star ratings report, we found little change between 2011 and 2012 in the measures from the beneficiary survey that asks about access to care in plans and rating of overall plan quality and the quality of care rendered by plan providers. The outcomes component of another survey, HOS, which measures two-year changes in self-reported health status, also showed little change in plan results between results posted in 2011 (for the 2008 to 2010 time period) and 2012 (for the 2009 to 2011 time period). As in previous years, about 90 percent of plans had HOS results within expected rates and not different from the national average rates of two-year changes in mental and physical health status across all plans.

MA plan performance on quality indicators varies by several plan characteristics

CMS has posted an analysis of the 2012 and 2013 stars and a map of the distribution of the 2013 star ratings (Centers for Medicare & Medicaid Services 2012a). The map shows that the highest rated plans are in the Northeast, the upper Midwest, and the Pacific Coast.[15] In general, beneficiaries in the South do not have access to plans rated 4 stars or higher, with the exceptions of Florida (a change from 2012) and North Carolina. Consistent with the Commission's past and current findings, CMS has noted that newer plans do not perform as well as more established plans in the star ratings (Table 13-9). CMS also noted that not-for-profit plans perform better than for-profit plans. We have found that SNPs, or plans with a high proportion of SNP enrollment, do not perform as well as other plans, a point we discuss in Chapter 14 of this report.

Comparison with FFS Medicare

We have little information on which to base a comparison of the MA quality indicators we discuss in this chapter with the quality of care in FFS Medicare. However, we can compare CAHPS results in MA with FFS results because beneficiaries in each of these sectors are surveyed. We found little difference between MA and the FFS program in the surveys' results for vaccination rates. MA rates of influenza vaccination were similar to the FFS rate.

TABLE 13–10

Plans report a single rate for HEDIS® measures that vary across the states with plan enrollment

Location of state	Rate for glaucoma screening measure	Star rating for individual measure based on state rate
Upper Midwest	60%	2 stars
Pacific Coast	64	3 stars
Mid-Atlantic	70	4 stars

Note: HEDIS® (Healthcare Effectiveness Data and Information Set®). The denominators for these measures include over 2,000 enrollees in each of the three state locations shown.

Source: MedPAC analysis of CMS HEDIS® person-level data.

There are studies showing differences in utilization of services among MA enrollees compared with FFS beneficiaries, which in some cases may be indicative of better access to appropriate care and better integration of care. One study showed that diabetics enrolled in a chronic care SNP had lower rates of emergency department utilization, more primary care visits, and lower hospital admission and readmission rates than the comparison group in FFS, though the differences narrowed after risk adjustment (Cohen et al. 2012). Another study also showed lower rates of hospital admissions and emergency use across MA HMO plans over the period 2003 to 2009 and differences in the frequency of certain procedures (e.g., MA HMOs had a greater frequency of coronary artery bypass graft surgeries but fewer hip and knee replacements than FFS beneficiaries) (Landon et al. 2012). Another study comparing hospital readmissions in FFS versus MA examined 2006 data for five states. The authors found that, after risk adjustment and controlling for self-selection in MA, enrollees in MA had a substantially higher likelihood of readmission (Friedman et al. 2012).

Concerns with the star ratings

CMS has addressed many of the Commission's concerns about the methodology for determining star ratings. Greater weight is being given to clinical process measures and patient experience measures than contract performance measures. Our March 2012 report discusses our concerns about the reporting unit to which the star ratings apply (Medicare Payment Advisory Commission 2012b). We noted that the geographic area to which a single star rating applies may be extensive and may encompass many kinds of health care markets and provider networks. The amalgamation of diverse areas affects both purposes of the star rating system—to provide beneficiaries with information about the quality of a health plan they are considering joining and to determine which plans are eligible for bonuses because they provide high-quality health care.

In addition to the number of plans operating in large, diverse states, there are at least 17 contracts serving noncontiguous states under one contract with substantial enrollment in the different states (including one regional contract covering more than one region). An example from one plan illustrates how different a star rating might be for each area if star ratings were determined at the appropriate geographic level. We compare person-level HEDIS data in the case of a contract that includes various states (13 of which have substantial plan enrollment at over 1,000 members in the state). The plan received a rating of 3 stars for the HEDIS glaucoma screening measure across its entire contract, but individual states would have received different ratings had the reporting unit been at the state level, as we illustrate with an example of three state locations (Table 13-10).

In last year's report, we suggested that CMS more closely examine the configuration of some contracts to determine whether the reporting units should be modified, given that even within a state there can be large geographic differences that affect the quality of care. We noted that in many cases—though not in the example provided—there could be a problem of small numbers of enrollees and therefore small sample sizes, a methodological problem that can be overcome in different ways, such as by pooling data for multiple years. Given the potential differences in quality measures, and given the known differences in MA benchmarks based on star ratings, including differences by area where certain counties are double-bonus counties, the cost burden associated with additional reporting or data manipulation is likely outweighed by the benefit to beneficiaries and, potentially, to program costs, by ensuring that reporting is done at the appropriate geographic level.

Conclusion

The Commission has stressed the concept of imposing fiscal pressure on providers to improve efficiency and reduce Medicare program costs. For MA, the Commission

recommended that payments be brought down from previous high levels and be set so that the payment system is neutral and does not favor either MA or the traditional FFS program. Recent legislation has taken the program closer to this point of equity between MA and FFS. As a result, we are seeing evidence of improved efficiency in MA as plan bids have come down in relation to FFS while enrollment in MA continues to grow. The improved efficiency of MA plans enables them to continue to increase MA enrollment by offering packages that beneficiaries find attractive.

The Commission has also recommended that pay-for-performance programs be instituted in Medicare to promote quality, with the expected added benefit of improving efficiency by reducing unnecessary program costs. The Congress instituted such a quality bonus program for MA. The initial results of the program indicate that more plans are achieving ratings that would qualify them for bonuses as called for in the statute. Plans are paying closer attention to the quality measures, with improved documentation and medical record validation as contributing factors in improved performance for many plans.

The Commission supports the concept of the quality bonus program as called for in the statute. Such a pay-for-performance system, combined with continuing fiscal pressure, will help ensure that a strong MA program will do its part in the urgent need to ensure the continued financial viability of the Medicare program. However, CMS has implemented the quality bonus program in a flawed manner at very high program costs not contemplated in the statute, using demonstration authority to pay bonuses to plans with low ratings and increasing bonus amounts for other plans above the level authorized in the statute. ■

Endnotes

1 Cost plans are technically not MA plans. They do not submit bids but are paid their reasonable costs under provisions of section 1876 of the Social Security Act.

2 As stated in CMS documentation of the star rating system, there are 49 unique measures for MA–PD plans. Two additional factors computed from those measures are new factors, one for Part C and one for Part D, that assign a star rating for whether a plan has improved or not. The improvement factor(s) may or may not be used for a particular plan in that a high-performing plan (4 stars or better) would not be penalized if including the improvement measure reduces the plan's overall star rating (on the assumption that the highest performing plans do not have as much room for improvement as lower performing plans). Part D has 18 total measures or factors, but only 14 are used for MA–PD ratings because 4 measures overlap with Part C. Three measures in Part C apply only to special needs plans (Centers for Medicare & Medicaid Services 2012a).

3 Plans can receive a higher star rating after the averaging process, with an increase of 0.2 to 0.4 in the overall star rating, for high scores on the measures if they are consistently high across the range of measures.

4 When we refer to ratings as pertaining to a particular year, it is the enrollment year for which the ratings are posted. For the 2013 ratings, beneficiaries are enrolling at the end of 2012 for a 2013 effective date. Plans reported measures such as Healthcare Effectiveness Data and Information Set (HEDIS®) in 2012 for the 2013 star ratings, but those measures reflect plan performance in 2011 on the HEDIS measures. Thus, there is a lag in reporting in that the star ratings for 2013, announced at the end of 2012, reflect performance in the preceding year (2011).

5 Measures are dropped and added from year to year. For example, a new measure for 2013 is a care coordination measure collected through the Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) beneficiary survey, which is a measure of the extent to which a beneficiary receives information from physicians about his or her care and help in managing care. A measure that was dropped from the star ratings (but that continues to be collected and reported) is the pneumonia vaccination measure, also collected through CAHPS, because of issues with beneficiary recall of whether they had ever received the vaccination (Centers for Medicare & Medicaid Services 2012b).

6 HEDIS® is a registered trademark of the National Committee for Quality Assurance.

7 CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

8 HEDIS, CAHPS, and HOS are described more fully in an online appendix to our March 2010 report (http://www.medpac.gov/chapters/Mar10_Ch06_APPENDIX.pdf).

9 How much of a difference there is in the star ratings between plans varies with each measure. For example, for the HEDIS breast screening measure, a 5-star rating is a rate of 83 percent or higher. A 4-star rating is between 74 percent and 83 percent, and a 3-star rating is between 64 percent and 73 percent. For the measure of cholesterol screening among diabetics, for which most plans achieve relatively high rates, the 5-star level is 90 percent or higher, and the differences at each of the star levels below 5 stars are narrower (in absolute percentage point differences) than the breast cancer screening measure. For the cholesterol measure, a 4-star rating is 85 percent to 89 percent and a 3-star rating is 81 percent to 84 percent (Centers for Medicare & Medicaid Services 2012b).

10 Technically, we are comparing average results across the universe of reporting plans and not a sample of plans. Therefore, use of the term "statistical significance" to characterize differences is not precisely correct. However, we use statistical significance as a guide to highlight larger differences. We also note that the underlying numbers each plan reports—that is, the reported HEDIS rate for each measure—are based on samples. We also note that some of the changes shown as statistically significant reflect a 1 percent or 2 percent change in the measure, which is a very small change over one year and may not be as meaningful as larger changes in other measures.

11 This effect can be seen in the results for the measure of assessment of body mass index (BMI)—whether a person's BMI was recorded in the medical record. The BMI measure is a relatively new measure first publicly reported in 2010. Among HMOs reporting over three years, the rate rose from 40.8 in 2010 to 54.0 in 2011 and 73.0 in 2012. As shown in Table 13-7, the measure had the greatest rate of increase of any improved measure between 2011 and 2012 among HMOs and local PPOs.

12 The following NCQA statement describes the basis of the original prohibition on PPO reporting based on the hybrid methodology: "Currently, HMO and POS plans report HEDIS using data from claims (administrative) and medical records, known as hybrid data collection. Because many PPOs have multi-state service areas, they may face some barriers to accessing medical records. Therefore, for 2008 and 2009 (the first years of PPO reporting), NCQA requires PPOs to

report HEDIS measures based on administrative data only. To assure that all PPOs are compared on equal grounds based on data collection methodologies, NCQA will not accept results based on hybrid data from PPOs." (National Committee for Quality Assurance. *PPO HEDIS Requirements for Health Plan Accreditation 2010 Products Update – Draft Changes, Appendix 4*. Washington, DC: 2009. (NCQA public comment document, obsolete after 4/1/09.))

13 Several HEDIS measures are reported only by SNPs, all of which are based on medical record documentation. All these measures showed statistically significant improvement in average rates between 2011 and 2012: medication review, functional status assessments, pain screening (the three measures included in the star rating system), advance care planning, and medication reconciliation postdischarge. The three SNP-only measures in the star rating system are a factor in determining the star rating of contracts that are exclusively SNP contracts; they are also factors for determining the star ratings of organizations that have both SNP and non-SNP members under one contract.

14 As we have noted, plans have the option of reporting hybrid measures using only administrative data, and an organization with good electronic medical records, for example, may choose to report a measure solely on the basis of administrative records. To cite an example, for the measure for colorectal cancer screening, which has a nine-year look-back period to determine whether a beneficiary had a colonoscopy, about 5 percent of plans appear to be reporting based on administrative data, according to an analysis of the confidence intervals for the reported results.

15 There is similar regional variation in health plan performance in the commercial sector (National Committee for Quality Assurance 2011).

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