CHAPTER 13

The Medicare Advantage program: Status report

RECOMMENDATIONS

13-1 The Congress should direct the Secretary to determine payments for employer group Medicare Advantage plans in a manner more consistent with the determination of payments for comparable nonemployer plans.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

13-2 The Congress should include the Medicare hospice benefit in the Medicare Advantage benefits package beginning in 2016.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

CHAPTER 13

The Medicare Advantage program: Status report

Chapter summary

Each year, the Commission provides a status report on the Medicare Advantage (MA) program. In 2013, the MA program included almost 3,600 plan options, enrolled more than 14.5 million beneficiaries (28 percent of all beneficiaries), and paid MA plans about $146 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 the traditional FFS Medicare program. The Commission supports the inclusion of private plans in the Medicare program; beneficiaries should be able to choose between the traditional FFS Medicare program and 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 all providers of care to improve efficiency and reduce Medicare program spending. For MA, the Commission recommended that payments be brought

In this chapter

- Trends in enrollment, plan availability, and payment
- Quality in the Medicare Advantage program
- Medicare Advantage and hospice
- Conclusion

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 has reduced the inequity between MA and FFS. As a result, over the past few years, plan bids have come down in relation to FFS spending while enrollment in MA continues to grow. The pressure of competitive bidding has led to either improved efficiency or lower margins that enable MA plans to continue to increase MA enrollment by offering benefit packages that beneficiaries find attractive. However, employer group plans do not demonstrate the same bidding behavior, bidding consistently higher than nonemployer plans. We believe that this difference results from employer group plans' lack of incentive to submit competitive bids. We have made a new recommendation to address this issue.

Previously, the Commission has 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, 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. More plans have achieved 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 to ensure the continued financial viability of the Medicare program.

***Enrollment*—**In 2013, MA enrollment increased by 9 percent to 14.5 million beneficiaries (28 percent of all Medicare beneficiaries). Enrollment in HMO plans—the largest plan type—increased 10 percent, to nearly 10 million enrollees. Local preferred provider organizations (PPOs) showed continued growth in enrollment between 2012 and 2013, with enrollment growing about 11 percent, to 3.3 million enrollees. Regional PPO enrollment increased about 16 percent, to 1.1 million enrollees. Enrollment in private FFS plans declined from about 500,000 to about 400,000 enrollees, continuing the expected decline resulting from legislative changes. The MA plan bids submitted to CMS project an increase in overall enrollment for 2014 of 3 percent to 5 percent, primarily in HMOs and local PPOs.

***Plan availability*—**In 2014, 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-four 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). In an average county, beneficiaries are able to choose from 10 MA plan options, including 8 CCPs in 2014.

***Plan payments*—**For 2014, the base county benchmarks used to set plans' payment rates are, on average, about 1 percent higher than the benchmarks for 2013. We estimate that 2014 MA benchmarks, bids, and payments (including the quality bonuses) will average 112 percent, 98 percent, and 106 percent of FFS spending, respectively. Based on an analysis of revised 2013 FFS spending numbers, we find that plans in 2014 have bid, and will be paid, about the same relative to FFS as in 2013.

***Quality measures*—**Comparing last year's quality indicators with the most current results, we see that the majority of measures remain stable, including intermediate outcome measures such as control of blood pressure among patients with hypertension. Also remaining stable or unchanged were patient experience measures from beneficiary surveys in which enrollees rate their health plans and their plans' providers in terms of ease of access to care, customer service, and the perceived level of care coordination. There was improvement in a number of indicators, including process measures such as cancer screenings, as well as hospital readmission rates and Part D drug adherence measures. As a result, the star ratings the MA program uses to determine quality bonuses improved for many plans.

***MA and hospice*—**Under current law, hospice is not included in the MA benefits package. When an MA enrollee elects hospice, the beneficiary typically remains in the MA plan, but hospice services are paid for by FFS Medicare. This carve-out of hospice from MA fragments financial responsibility and accountability for care for MA enrollees who elect hospice. We have made a new recommendation to include hospice in the MA benefits package. This step would give plans responsibility for the full continuum of care and promote integrated, coordinated care, consistent with the goals of the MA program. A hospice benefit in MA would also make it more feasible for plans to offer concurrent hospice and conventional care as a supplemental benefit if they wished to do so. It is the Commission's expectation that with the inclusion of hospice in the MA benefits package, plans would have an incentive to use the flexibility inherent in the MA program to develop and test innovative programs aimed at improving end-of-life care and care for patients with advanced illnesses more broadly (e.g., concurrent care or other approaches to provide flexibility in the hospice eligibility criteria, palliative care, and shared decision making). ■

Background

The Medicare Advantage (MA) program allows Medicare beneficiaries to receive benefits from private plans rather than the traditional fee-for-service (FFS) program. In 2013, the MA program included almost 3,600 plan options, enrolled more than 14.5 million beneficiaries (28 percent of all beneficiaries), and paid MA plans about $146 billion to cover Part A and Part B services. The Commission supports including private plans in the Medicare program because they allow beneficiaries to choose between FFS Medicare and 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 and offers beneficiaries an unconstrained choice of health care providers, but it lacks incentives to coordinate care and is limited in its ability to modify care delivery. 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 payments that would have been lower under FFS Medicare for similar beneficiaries. Thus, those benefits are financed by higher government spending and 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 within 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. Medicare pays plans a fixed capitated rate per enrollee rather than a fixed rate per service.

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. 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 did not have provider networks, making them less able than other plan types to coordinate care. They usually paid providers Medicare's FFS payment rates (instead of negotiated rates) and had fewer quality reporting

TABLE 13–1

Medicare Advantage enrollment grew in 2013

	MA enrollment (in millions)		Percent change in enrollment	2013 MA enrollment as a share of total Medicare
	November 2012	November 2013		
Total	13.3	14.5	9%	28%
Plan type				
CCP	12.8	14.2	11	27
HMO	8.8	9.7	10	19
Local PPO	3.0	3.3	11	6
Regional PPO	1.0	1.1	16	2
PFFS	0.5	0.4	–26	1
Restricted availability plans included in totals above				
SNPs*	1.6	1.9	18	4
Employer group*	2.4	2.6	9	5
Urban/rural				**MA enrollment as share of population**
Urban	11.6	12.7	9	30
Rural	1.7	1.9	12	18

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. Totals may not add due to rounding.
* 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.

requirements. Given that PFFS plans generally lacked care coordination, had lower quality measures than CCPs on the measures they reported, 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 into PPOs or HMOs, or they would 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. 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 since these plans are not available to all beneficiaries. (See the March 2013 report to the Congress for a full chapter on SNPs.)

How Medicare pays MA plans

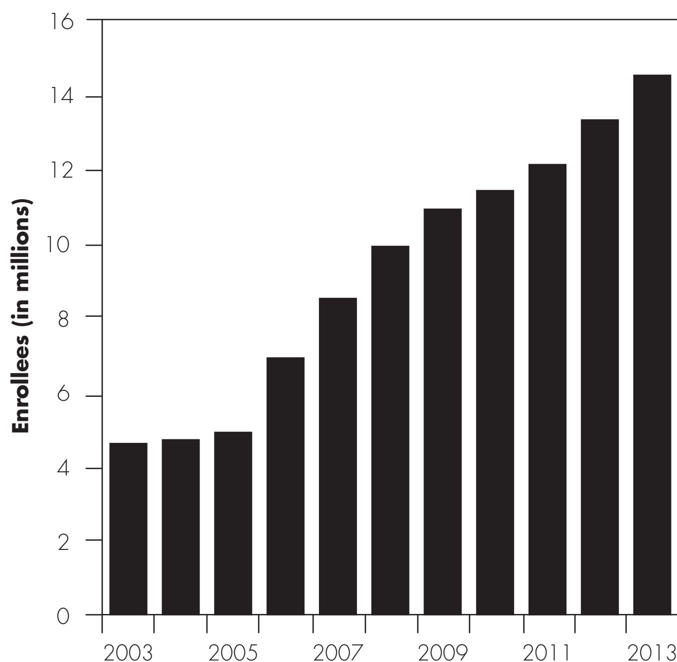
Plan payment rates are determined by the MA plan bid (the dollar amount the plan estimates will cover the Part A and Part B benefit package for a beneficiary of average health status) and the payment area's benchmark (the maximum amount of Medicare payment set by law for an MA plan to provide Part A 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 50 percent and 70 percent in 2014 and thereafter, 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 pay premiums to the plan for additional benefits). The payment amount above the bid is referred to as the rebate. The rebate must be used by the plan to provide additional benefits to the enrollees in the form of lower cost sharing, lower premiums, or supplemental benefits. A more detailed description of the MA program payment system can be found at http://www.medpac.gov/documents/MedPAC_Payment_Basics_13_MA.pdf.

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 2013, Part A and Part B payments to MA plans totaled approximately $146 billion.

FIGURE 13–1

Medicare Advantage enrollment, 2003–2013



Source: MedPAC analysis of CMS enrollment files.

Plan growth continued to outpace total Medicare beneficiary growth in 2013

Between November 2012 and November 2013, enrollment in MA plans grew by about 9 percent—or 1.2 million enrollees—to 14.5 million enrollees (compared with growth of about 4 percent in the same period for the total Medicare population). About 28 percent of all Medicare beneficiaries were enrolled in MA plans in 2013, up from 27 percent in 2012 (Table 13-1).

Among plan types, HMOs continued to enroll the most beneficiaries (9.7 million), with 19 percent of all Medicare beneficiaries in HMOs in 2013. Between 2012 and 2013, local PPOs exhibited continued growth in enrollment, which increased by about 11 percent. Regional PPO enrollment increased by about 16 percent, reversing a decline in the previous year. PFFS enrollment shrank from about 500,000 to about 400,000 enrollees, which was expected, given changes in the law. In 2013, SNP enrollment grew by 18 percent and employer group enrollment grew by 9 percent.

Enrollment patterns differ in urban and rural areas. A larger share of urban beneficiaries are enrolled in MA (about 30 percent) compared with beneficiaries residing in rural counties (about 18 percent). About one-third of rural MA enrollees were in HMO plans (not shown in Table 13-1) compared with about 72 percent of urban enrollees. At the same time, 10 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 2013 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).

Growth in MA enrollment in 2013 continued a trend begun in 2003 (Figure 13-1). Since 2003, enrollment has tripled. We did not have final 2014 enrollment information as of this report's publication, but plans projected overall enrollment growth of 3 percent to 5 percent for 2014. Most of the growth was projected to be in HMOs and local PPO plans, while regional PPO and PFFS plans were projected to contract.

TABLE 13–2

Access to Medicare Advantage plans remains high

Type of plan	Percent of beneficiaries with access to MA plans by type					
	2005	**2010**	**2011**	**2012**	**2013**	**2014**
Any MA plan	84%	100%	100%	100%	100%	100%
Local CCP	67	91	92	93	95	95
Regional PPO	N/A	86	86	76	71	71
PFFS	45	100	63	60	59	53
Zero-premium plans with drugs	N/A	85	90	88	86	84
Average number of choices	5	21	12	12	12	10

Note: MA (Medicare Advantage), CCP (coordinated care plan), PPO (preferred provider organization), N/A (not applicable), PFFS (private fee-for-service). CCP includes HMO, local PPO, and regional PPO plans. 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.

Plan availability for 2014

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 2014, with most Medicare beneficiaries having access to a large number of plans. While almost 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, the same as in 2013 and up from 67 percent in 2005. Regional PPOs are available to 71 percent of beneficiaries. Access to PFFS plans decreased between 2013 and 2014, from 59 percent to 53 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 2014, 84 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 86 percent in 2013.

The availability of SNPs has changed slightly and varies by the type of special needs population served (not shown in Table 13-2). In 2014, 82 percent of beneficiaries reside in areas where SNPs serve beneficiaries who are dually eligible for Medicare and Medicaid (the same as in 2013), 47 percent live where SNPs serve institutionalized beneficiaries (up from 46 percent in 2013), and 51 percent live where SNPs serve beneficiaries with chronic conditions (down from 55 percent in 2013). Overall, 86 percent of beneficiaries reside in counties served by at least one type of SNP.

In most counties, a large number of MA plans available to beneficiaries are offered by a more limited number of plan sponsors since most sponsors offer multiple plans. For example, beneficiaries in Miami, New York City, and some areas of Pennsylvania and Florida can choose from more than 40 plans in 2014. 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, 10 plans, including 8 CCPs, are offered in each county in 2014, down from 12 plans and 9 CCPs in 2013.[2] The decrease in plan choices from 2010 to 2014 was due to the reduction in PFFS and regional PPO plan choices.

2014 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

TABLE 13–3

Projected payments exceed FFS spending for all plan types in 2014

Plan type	Benchmarks*	Bids	Payments
	Percent of FFS spending in 2014		
All MA plans	112%	98%	106%
HMO	112	95	105
Local PPO	113	108	110
Regional PPO	109	102	106
PFFS	114	110	111
Restricted availability plans included in totals above			
SNP**	113	101	107
Employer groups**	112	107	109

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 and incorporate plan quality bonuses. We estimate FFS spending by county using the 2014 MA rate book. We removed spending related to the remaining double payment for indirect medical education payments made to teaching hospitals.
* Benchmarks include both statutory and demonstration bonuses.
** 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 fee-for-service expenditures.

their bids in June and incorporate the recently released benchmarks. Benchmarks reflect current law FFS spending estimates for 2014 made by CMS at the time the benchmarks were published in April 2013.

We estimate that 2014 MA benchmarks, bids, and payments will average 112 percent, 98 percent, and 106 percent of FFS spending, respectively (Table 13-3). (Benchmarks, bids, and payments are weighted by plans' projected 2014 enrollment by county to estimate overall averages and averages by plan type.)

Last year, we estimated that, for 2013, these figures would be 110 percent, 96 percent, and 104 percent, respectively. However, the estimates of 2013 FFS spending were too high last year. Therefore, our ratios were projected too low. Our finding based on the analysis of the new FFS spending numbers is that plans in 2014 have bid, and will be paid, about the same relative to FFS as in 2013.

MA benchmarks

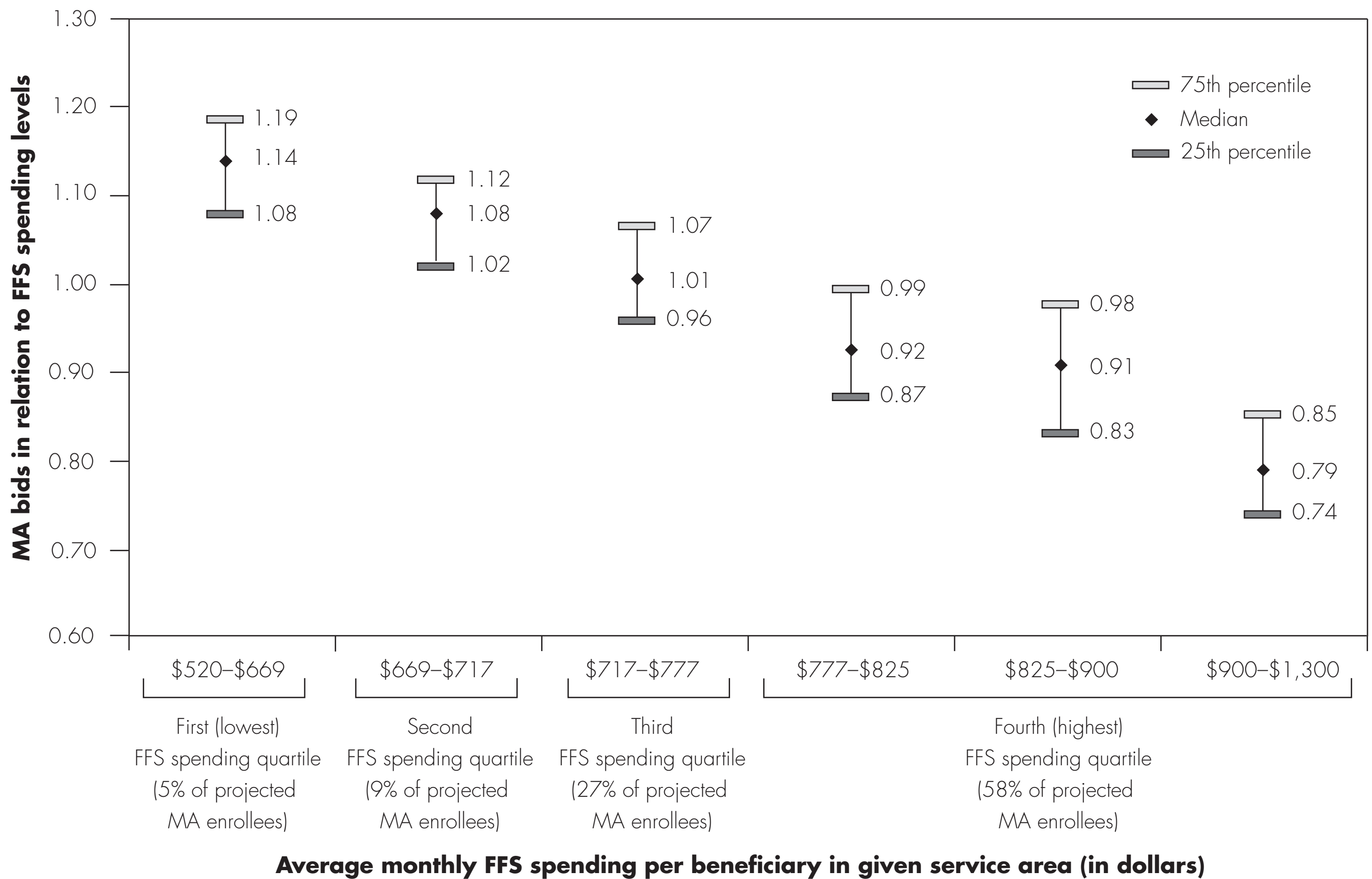
Under PPACA, county benchmarks in 2014 are transitioning to a system in which each county's benchmark in 2017 will be a certain percentage (ranging from 95 percent to 115 percent) of the average per capita FFS Medicare spending for the county's residents. Counties are ranked by average FFS spending; 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 the Commission's March 2011 report to the Congress for more details on PPACA benchmark changes.) In 2014, more than half of all counties have base benchmarks that have fully transitioned to the final PPACA levels. However, only 29 percent of all Medicare beneficiaries and only 22 percent of MA enrollees live in these fully transitioned counties. Overall, more than half of the base benchmark transition has occurred:

- In 2011, the last year before the PPACA transition and the inclusion of quality bonuses in MA benchmarks, plan benchmarks averaged 113 percent of FFS spending.
- In 2014, plan base benchmarks (excluding quality bonuses) averaged 106.5 percent of FFS.
- In 2017, fully transitioned base benchmarks (excluding quality bonuses) would average about 101.5 percent of FFS.

For 2014, the base county benchmarks (in nominal dollars and before any quality bonuses are applied) average approximately 1 percent higher than the benchmarks for 2013. However, for 2014, 95 percent of MA enrollees are

FIGURE 13–2

Medicare Advantage bids in relation to FFS spending levels, 2014



Note: FFS (fee-for-service), MA (Medicare Advantage). Percent of projected MA enrollees may not add to 100 due to rounding.

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

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 2014.

MA bids and payments for different plan types

The modest growth in the benchmarks over the past few years may have exerted fiscal pressure on MA plans and encouraged them to better control costs and restrain the growth in their bids. For 2014, bids increased by an average of 2 percent, and most plans will have to pay a new PPACA premium tax of about 2 percent in 2014. The average bid for 2014 is 98 percent of the projected FFS spending for similar beneficiaries. About 48 percent of nonemployer plans 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 52 percent of nonemployer MA enrollees in 2013. About 700,000 beneficiaries, excluding those enrolled in employer group MA plans, are projected to enroll in plans that bid lower than 75 percent of FFS spending, while a similar number of beneficiaries are projected to enroll in plans that bid at least 120 percent of FFS spending.

Figure 13-2, illustrating over 2,000 plan bids (employer group 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 for 2014. 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 120 plans and 800,000 projected enrollees, with about 76 percent of the plans and projected enrollment falling in the three groups between $717 and $900 of FFS spending per month.

Plans bid low (relative to FFS) in areas with relatively high FFS spending. When plans bid for service areas that average less than $777 in monthly FFS spending, they are likely to bid more than FFS (Figure 13-2). However, when plan service areas average more than $777 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-two percent of beneficiaries live in a county served by at least one plan that bid below the average FFS spending of its service area. While the bidding and payment patterns are reported here in averages, clearly there is much variation within these averages (Table 13-3, p. 331; Figure 13-2).

Although the plan bids average less than FFS spending, payments for enrollees in these plans usually exceed such spending because the benchmarks are high relative to FFS spending. For example, HMOs as a group bid an average of 95 percent of FFS spending, yet 2014 payments for HMO enrollees are estimated to average 105 percent of FFS spending because the benchmarks (including the quality bonuses) average 112 percent of FFS spending. Other plan types have average bids above FFS spending. As a result, payments for local PPO and PFFS enrollees are estimated to be 110 percent and 111 percent, respectively, of FFS spending (Table 13-3, p. 331).

We analyzed bids and payments to SNPs and employer group plans separately because these plans are available only to subpopulations of Medicare beneficiaries, and their bidding behavior differs from that of other plan types. Payments to SNPs and their bids tend to be slightly higher relative to FFS spending than general MA plans. SNP bids average 101 percent of FFS and payments are about 107 percent of FFS. The process for developing bids by employer group plans is different and is discussed in more detail later in this chapter.

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 2014, overall payments to plans will average an estimated 106 percent of FFS spending, meaning that the Medicare program will pay approximately $8 billion more for MA enrollees than it would have paid to cover the same enrollees in FFS Medicare. (This figure includes about $4.5 billion attributable to quality bonus payments, about two-thirds of which are due to a demonstration program that will end in 2014.)

Beginning in 2014, MA plans will be required to meet medical loss ratio (MLR) requirements. The primary requirement is that the plans must spend at least 85 percent of the premiums they collect (from both the Medicare program and beneficiaries) on medical expenses (as opposed to administrative costs and margins, or profits). If the plans do not meet this requirement, they will be required to refund a portion of the premiums they collected to the Medicare program. At this point, we could not determine whether the categorization of costs in the bids is the same as required in the law, but if the categorizations match, the average MA plan is close to meeting the MLR requirements. The average plan spends 84 percent of its total revenue on medical care, 11 percent on administrative functions, and maintains a 5 percent margin. HMO and local PPO bids projected average medical expenses of 85 percent of revenue.

Medicare Advantage employer group plans

While most MA plans are available to any Medicare beneficiary residing in a given area, some MA plans are available only to retirees whose Medicare coverage is supplemented by their former employer or union. These plans are called employer group plans. Such plans are usually offered through insurers and are marketed to groups formed by employers or unions rather than to individual beneficiaries. As of September 2013, about 2.6 million enrollees were in employer group plans, or about 18 percent of all MA enrollees (Table 13-4, p. 334).

For 2014, there are 1,042 employer group plan bids, of which 343 are essentially national bids that cover more than 3,000 counties. Those national bids contain about 58 percent of the projected enrollment in employer group MA plans. If the national plans are excluded, the employer group plan bids cover an average of 78 counties. By comparison, the 2,596 nonemployer plan bids cover an average of 16 counties. The average employer group plan is expected to enroll about 2,800 beneficiaries, while the average nonemployer plan is expected to enroll about 4,600 beneficiaries. To summarize the nature and reliability of the bids, employer group plans expect to enroll an average of fewer than 3 beneficiaries per county covered, while nonemployer plans expect to enroll almost 300 beneficiaries per county covered.

All else being equal, employer group plans consistently bid higher than plans that are open to all Medicare

TABLE 13–4

Comparison of employer group plans and nonemployer plans, 2013–2014

	Employer group plans	Nonemployer plans
MA enrollment, November 2013	2.6 million	11.9 million
Median ratio of bid to benchmark, 2014*	0.99	0.87
Average ratio of bid to benchmark, 2014*	0.95	0.86
Average ratio of MA bid to FFS spending for comparable beneficiaries, 2014	1.07	0.97
Average ratio of MA payment to FFS spending for comparable beneficiaries, 2014	1.09	1.06
Number of bids submitted to CMS for 2014	1,042	2,596
Average projected enrollment per county in covered area	3	288

Note: MA (Medicare Advantage), FFS (fee-for-service).
* Projected enrollee weighted.

Source: MedPAC analysis of data from CMS on plan bids, enrollment, benchmarks, and fee-for-service expenditures.

beneficiaries. The bidding process for employer group plans differs from other MA plans in that 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). In contrast, 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 competing this way. The employer plans have already ensured themselves of enrollment through negotiations with the employer groups; their bids appear to be set to maximize revenue. In fact, for 2014, the median employer plan (weighted by projected enrollment) has bid 99 percent of its benchmark.

Under the MA bidding process, the employer group MA plans tend to cost the Medicare program more than nonemployer plans would cost for the same enrollees because the employer group plans have less incentive to bid as far below the benchmark. The Part D drug plan bidding process differs in that, for the base (noncatastrophic) part of the Part D benefit, employer plans are paid based on the bids of nonemployer plans. In our view, using only the nonemployer plan bids would be a better way to set MA payments for employer group plans.

Because employer group plans usually cover very broad service areas, an option for setting plan payments would be to use the national average bid-to-benchmark ratio for nonemployer plans and apply that to employer group plans. In 2014, the average bid of nonemployer plans (weighted by projected enrollment) is 86 percent of their benchmarks. At the same time, employer group plans submitted bids that averaged 95 percent. (While the incentives are for the plans to bid 100 percent of the benchmarks, plans may not always have the actuarial evidence to support bids that high and still pass the CMS bid review, even though the employer group plans may get more latitude under the review process.) Under this option, employer group plans would have their "bids" set at 86 percent of their benchmarks. The employer group plans would be paid 86 percent of their benchmarks plus rebates based on their quality scores. There are alternative strategies for assigning a bid-to-benchmark ratio for employer group plans (e.g., weighting the ratio with employer group plan enrollment).

For the majority of employer group plan enrollees, who are in plans with national service areas, there would be no geographic concerns regarding setting the bids relative to the benchmarks. However, employer group plans might still feel some pressure to drop plans in geographic areas

where nonemployer plans tend to bid higher than average relative to the benchmarks. If this policy option had been in effect for 2014, MA employer plan payments would have been about one-half billion dollars lower.

RECOMMENDATION 13-1

The Congress should direct the Secretary to determine payments for employer group Medicare Advantage plans in a manner more consistent with the determination of payments for comparable nonemployer plans.

The implementation of this recommendation could use the national average bid-to-benchmark ratio for nonemployer plans and apply that ratio to employer group plans. However, alternatives to this approach are also possible.

IMPLICATIONS 13-1

Spending

- We would expect Medicare program spending to decrease. Under the specific option we discussed, spending would decrease between $250 million and $750 million over one year and between $1 billion and $5 billion over five years.

Plans

- Most employer group plans would be paid less by Medicare because of the lowering of Medicare subsidies. In response, plans could charge employers more, offer fewer supplemental benefits, make lower profits, or lower their costs.

Beneficiaries

- Some employer group plan enrollees might choose plans in the nonemployer market or move to FFS Medicare if employers dropped plans or increased charges to plan enrollees.

MA risk adjustment and coding intensity adjustment

Medicare calculates its payment to plans separately for each beneficiary, multiplying the plan's payment rate by the beneficiary's risk score. The risk scores are based on diagnoses that providers 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. 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 multiple years of coding differences, CMS reduced risk scores by 3.41 percent from 2010 through 2013. Under PPACA, CMS can continue to adjust for the differences it finds, but for 2014 and all future years, PPACA specifies minimum reductions, although CMS has discretion to make larger reductions. The Government Accountability Office (GAO) found that CMS should make larger reductions to fully account for the coding differences (Government Accountability Office 2012b). The American Taxpayer Relief Act of 2013 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 the Commission's March 2012 report to the Congress, we 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 2012). For 2014, CMS has chosen to reduce risk scores by 4.91 percent, the minimum reduction under current law. The law specifies that the minimum reduction rises by 0.25 percentage point each year until 2018, when it would reach 5.9 percent. The minimum reduction would remain 5.9 percent for 2019 and each subsequent year.

The 106 percent of the FFS payment figure projected for 2014 assumes that the risk-adjustment system and the CMS coding adjustment properly correct all health-risk differences between the FFS and MA populations. However, several studies (McWilliams et al. 2012, Medicare Payment Advisory Commission 2012, 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, 106 percent might understate the additional payments made for plan enrollees relative to Medicare FFS beneficiaries. At the same time, the payments include quality bonuses worth about 3 percent of payments. If there were no quality bonuses or favorable selection, plan enrollees in 2014 would receive about 103 percent of the funding that Medicare spends on similar FFS Medicare beneficiaries.

Quality in the Medicare Advantage program

Comparing last year's quality indicators with the most current results, the majority of measures remained stable, including intermediate outcome measures. Also remaining stable or unchanged were patient experience measures. There was improvement in a number of indicators, including process measures such as cancer screenings, as well as in hospital readmission rates and Part D drug adherence measures. As a result, plan star ratings, which are used to determine quality bonuses, improved for many plans.

Quality indicators in Medicare Advantage

For the most part, plan quality indicators have remained stable over the past year. Intermediate outcome measures (such as control of high blood pressure among plan enrollees with hypertension), patient experience measures (enrollees' perceived access to care and their rating of their plans and providers), and plan disenrollment rates were essentially unchanged over the past year. MA plan process measures and some clinical quality measures have improved. Hospital readmission results show improvement among all plan types, mirroring reduced readmissions in FFS Medicare during the same period. Part D clinical measures in MA prescription drug (MA–PD) plans also improved.

The quality indicators that we track come from four sources, the first three of which are described more fully in an online appendix to the March 2010 report to the Congress (http://medpac.gov/chapters/Mar10_Ch06_APPENDIX.pdf):

- The Healthcare Effectiveness Data and Information Set® (HEDIS®) measures, which health plans report to CMS, are the primary source of clinical process measures and intermediate outcome measures, including hospital readmission rates.
- The Consumer Assessment of Healthcare Providers and Systems for MA® (CAHPS®–MA), which is a health plan member survey, is the source of patient experience measures that include members' rating of access to care and satisfaction with a health plan and its providers.
- The Health Outcomes Survey (HOS), which is a survey of MA enrollees, is the source of some HEDIS measures and is used to determine whether a plan's enrollees have experienced improvement or decline in their physical and mental health.
- Measures that CMS reports through the star rating system include plan disenrollment rates and Part D clinical measures for MA–PD plans.

HEDIS results

The quality measures derived from HEDIS encompass clinical process measures, intermediate outcome measures, and hospital readmission rates. The most current HEDIS data (reported in June 2013) reflect care rendered in 2012. Table 13-5 provides a summary of year-over-year HEDIS results for the most recent two-year period, 2012 and 2013. The comparison is on a "same-store" basis, meaning that for each measure a plan has to have reported a result for a measure in each of the two years to be included in the analysis.

Over one-third of the HEDIS clinical process measures improved, but HEDIS outcome measures (other than hospital readmission rates) generally remained stable over the two-year period. However, one such measure declined among local PPOs (cholesterol control among patients with cardiovascular conditions).[3] For the hospital readmission measure, all plan types (HMOs, local and regional PPOs, and PFFS plans) showed improvement in the observed-to-expected ratio for rates of hospital readmissions, with those ratios declining between 2.4 percent (for PFFS plans) and 4.9 percent (for HMOs). In the same time period (2012), FFS Medicare also reduced readmission rates (Gerhardt et al. 2013).[4]

Though the differences are narrowing, differences in the HEDIS scores of HMOs and local PPOs persist—in both directions. HMOs perform better on measures that involve the extraction of medical record data (which include all the intermediate outcome measures of HEDIS), partly for reasons related to the change in rules for PPO reporting (Medicare Payment Advisory Commission 2013). However, PPOs perform better on 4 of the 42 HEDIS measures (specifically, initiation of alcohol and other drug dependence treatment, management of urinary incontinence, use of disease-modifying antirheumatic drug therapy in rheumatoid arthritis, and discussion of physical activity with older adult patients).

Between 2012 and 2013, measures that showed no change include six of seven HEDIS intermediate outcome measures: three blood pressure control measures, a second cholesterol control measure (in addition to the measure

TABLE 13–5

HEDIS® results for HMOs and local PPOs, 2012 and 2013 reporting

Measure categories	Specific measure(s)	Star status[a]	Plan performance
Measures that improved			
Patient health management	Hospital readmission rates Managing fall risks Discussing physical activity with patients[b] Advising physical activity[b]	✓ ✓ ✓	HMOs and PPOs improved
Screenings/tests	Colorectal cancer Glaucoma screenings Adult BMI recorded	✓ ✓ ✓	HMOs and PPOs improved
	Breast cancer screening	✓	HMOs improved; PPOs stable
Appropriate drug therapies	DMARD therapy for rheumatoid arthritis	✓	HMOs and PPOs improved
Medication management and monitoring	1 (of 4) specific drug–disease interaction monitoring measures		HMOs and PPOs improved
	Monitoring use of digoxin Total rate of monitoring drug-disease interactions in the elderly		HMOs improved; PPOs stable
Appropriate drug therapies	COPD treatment: Use of corticosteroids, use of bronchodilators		HMOs improved; PPOs stable
Medication adherence	Persistence of beta blocker use after heart attack		HMOs improved; PPOs stable
Measures generally remaining stable			
Intermediate outcome measures	Control of blood pressure Blood sugar and cholesterol among diabetics Cardiovascular conditions: cholesterol control Hypertension: control of blood pressure	✓ ✓ ✓ ✓	HMOs and PPOs stable[c]
Patient health management	Osteoporosis management Care for urinary incontinence Discussing fall risks	✓ ✓	HMOs and PPOs stable
Screenings/tests	Comprehensive diabetes care: eye exams Comprehensive diabetes care: kidney disease monitoring Comprehensive diabetes care: lipid profile Cardiovascular conditions: lipid profile Spirometry testing in COPD care	✓ ✓ ✓ ✓	HMOs and PPOs stable
Medication management and monitoring	Measures of monitoring patients on persistent medications		HMOs and PPOs stable[d]
Mental health	2 measures of follow-up after hospitalization		HMOs and PPOs stable
Alcohol or drug dependence treatment	Rate of initiation of treatment		HMOs and PPOs stable
Measures that declined			
Intermediate outcome measure	Cardiovascular conditions: cholesterol control	✓	PPOs declined; HMOs stable
Alcohol or drug dependence treatment	Rate of engagement in alcohol and other drug dependence treatment		HMOs declined; PPOs stable

Note: HEDIS® (Healthcare Effectiveness Data and Information Set®), PPO (preferred provider organization), BMI (body mass index), DMARD (disease-modifying antirheumatic drugs), COPD (chronic obstructive pulmonary disease). Data exclude cost-reimbursed HMO plans. Regional PPOs and private fee-for-service plans are not included because too few plans report HEDIS® data.
a. Indicates measure is used for star rating (which is the basis for bonus payments to plans).
b. Collected through the Health Outcomes Survey but reported as HEDIS measures.
c. One such measure declined among local PPOs.
d. One such measure declined among HMOs.

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

that declined among local PPOs), and two measures of control of hemoglobin A1c among diabetics.

There are also five HEDIS measures reported only by SNPs. Of those measures, four improved (advance care planning, medication review, functional status assessment, and pain management) and one remained stable (medication reconciliation postdischarge).

CAHPS results

Over the past year, the average rates for all the CAHPS patient experience measures were essentially unchanged from the preceding year.

The flu vaccine measure is also taken from CAHPS. In 2012, flu vaccination rates had statistically significant increases across all plan types other than regional PPOs. The lowest rate was among PFFS plans and regional PPOs (at 69 percent for each vs. 71 percent for HMOs and 72 percent for local PPOs).

The Health Outcomes Survey results

The HOS is the source of some of the survey-based measures that are included in HEDIS measures (such as whether a physician advised a person to undertake physical activity). The HOS is also the source of two outcome measures of whether a plan's enrollees report improvement or decline in physical health status or mental health status. Both of these measures showed improvement among MA plans between the most recent reporting period and the prior reporting period.

CMS also uses the HOS to determine whether health status changes in a given plan are markedly different from the average across all plans. As in past years, for the most recent two-year period of tracking changes in health status (2010 to 2012), fewer than 5 percent of plans had changes in their enrollees' mental or physical health status that differed significantly from the average across all plans.

Part D measures and contract performance measures

CMS gathers data from both MA and Part D for the purposes of program monitoring and for the star rating system. Part D measures in the overall star rating for MA–PD plans include three medication adherence measures (medications for diabetes, hypertension, and cholesterol). Plans improved on each of these measures.

Other measures in the star rating system include contract performance measures focusing on plans' customer service, appeals processing, and disenrollment, among others. Most of these measures showed improvement over the past year. In the most recent period, beneficiary access and performance problems were reduced and appeals processing improved. Disenrollment rates were stable between 2011 and 2012, with a weighted average at slightly under 11 percent in each year. However, disenrollment rates were highest among PFFS and regional PPO plans, averaging 14 percent.[5]

Comparison with FFS Medicare

We have little information on which to base a comparison of the MA quality indicators with the quality of care in FFS Medicare. However, studies show differences in use 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 in MA. One study, using data from one chronic care SNP, showed that the plan's diabetic enrollees had lower rates of emergency department use, 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 from 2003 to 2009 and differences in the frequency of certain procedures (e.g., MA HMOs had a greater frequency of coronary artery bypass graft surgery but fewer hip and knee replacements than FFS beneficiaries) (Landon et al. 2012). The authors used HEDIS utilization data reported by plans and included beneficiaries age 65 or over who had been members of a plan for the full 12 months of the year. After applying certain exclusions (such as excluding enrollees of SNPs), the study included data from 120 risk-based HMO plans in 2003 and 280 such plans in 2009. The authors matched the population with data from a 20 percent sample of beneficiaries in Medicare FFS. Using essentially the same design and scope as Landon and colleagues, over the same period, 2003 to 2009, Ayanian and colleagues found that MA HMO enrollees were more likely than beneficiaries in FFS Medicare to have received "appropriate breast cancer screening, diabetes care, and cholesterol testing for cardiovascular disease," though there were differences across plans, with more integrated, larger, older plans performing better (Ayanian et al. 2013). The research of Matlock and colleagues examined geographic variation in the frequency of certain interventional cardiac procedures, finding that "the degree of geographic variation in procedure rates was substantial among MA beneficiaries and was similar in magnitude to that observed among

Medicare FFS beneficiaries" (Matlock et al. 2013). The authors examined data for the years 2003 to 2007 for beneficiaries ages 65 to 99 in 32 hospital-referral regions that included 12 states. The data source for the MA beneficiaries was the research data submitted by 12 of 15 integrated delivery systems whose research divisions participated in the Cardiovascular Research Network of the National Heart, Lung, and Blood Institute. The data included nearly 900,000 MA enrollees and over 5 million Medicare FFS beneficiaries.

The star rating system and the quality bonus program

Since 2012, the MA program has included a pay-for-performance system that gives bonuses to higher performing plans. The bonuses take the form of an increase in plan benchmarks, and higher rated plans are able to use a higher percentage of the difference between bids and benchmarks for rebates, which finance extra benefits. Bonuses are based on a plan's overall rating, up to a maximum of five stars. Part D measures are included for plans that have Part D coverage (most MA plans). Performance on SNP-specific measures is a component of the star rating for sponsors of SNPs. Each element of the star rating is assigned a weight of 1 for process measures, 1.5 for patient experience and access measures, and 3 for outcome measures. New measures have a weight of 1 in their first year of use.

The highest rated plans (the 11 MA–PD plans and 3 MA-only plans that received 5-star ratings for 2014) can enroll beneficiaries outside of the annual election period.[6] Their status as high-rated plans is displayed at http://www.medicare.gov, while the lowest rated plans are also flagged, and beneficiaries are cautioned about choosing to enroll in a low-rated plan. The bonus payments to higher rated plans also make such plans more attractive to beneficiaries because of the plans' ability to offer more extra benefits than lower rated plans they may be competing with.

Under the statutory provision originally authorizing the bonus system, plans at or above a 4-star rating receive a bonus of 5 percent (or 10 percent in some counties); 4.5-star and 5-star plans have rebates that are 70 percent of the bid-to-benchmark difference (versus 65 percent or 50 percent for lower rated plans). From 2012 through 2014, CMS used a program-wide demonstration project to give bonuses to plans at the 3- and 3.5-star level. The Commission and the GAO have criticized the basis and design of the demonstration and its very high cost (Government Accountability Office 2012a, Government Accountability Office 2012b, Medicare Payment Advisory Commission 2013).

For the Part C (Medicare Part A and Part B benefits) component of the star ratings, 17 of the 36 star rating system measures are from HEDIS, and they represent 45 percent of the weighted value of all Part C measures. For MA–PD sponsors that operate SNPs (all of which are required to provide Part D drug coverage), HEDIS measures make up to 30 percent of the total weighted value of star rating measures in the quality bonus program (Table 13-6, p. 340). Outcome measures constitute the majority of the weight of the overall star rating and include HEDIS outcome measures (15.1 percent), HOS-based outcome measures (7.5 percent), and Part D outcome measures (22.6 percent)—for a total of 45.2 percent of the weighted value coming from outcome measures (this share includes the improvement measures for Part C and Part D that CMS computes). We would note that the Part D weighting, at one-third of the overall plan score, is almost three times greater than the proportion of expenditures for Part D within the MA–PD program, which is about 12 percent of MA–PD program expenditures. Although if beneficiary cost sharing is included, the Part D proportion would be higher than 12 percent. The greater weight given to Part D measures may be due to the greater availability of outcome measures from Part D data. The effect that particular measures have on the health of enrollees—to the extent that it is possible to quantify such a concept in relation to measures used to evaluate plans—may be a better basis for weighting the components of the star measurement system.

Star ratings and changes in the ratings

The elements and methodology of the star ratings have changed since the introduction of the star rating system. Greater weight is given to outcome measures, and a number of measures have been discontinued. Comparing the 2013 and 2014 star ratings components and methodology, the two years are very similar in the elements included and the "cut points" determining the assignment of stars for individual measures. There were no changes to the 4-star thresholds for each measure (which is an important threshold because it determines whether a plan is eligible for a quality bonus under the statutory provisions). Some measures had lower thresholds for a 5-star rating, and others had a higher cut point necessary to achieve a 5-star rating. In the main, the star ratings for each of the two years can be used to gauge whether a given plan has improved in its quality and contract performance over the past year.

TABLE 13–6

Measures included in the 2014 star ratings and their relative weight (continued next page)

	Weight	Share of total weight for non-SNP MA–PDs	Share of total weight for SNPs (all are MA–PDs)
All Part C		**66.7%**	**67.9%**
Outcome measures from HEDIS®			
Diabetes care – blood sugar controlled	3	15.1%	14.5%
Diabetes care – cholesterol controlled	3		
Controlling blood pressure (all members with hypertension)	3		
Plan all-cause readmissions	3		
Process measures from HEDIS			
Breast cancer screening	1	12.6	15.8
Colorectal cancer screening	1		
Cardiovascular care – cholesterol screening	1		
Diabetes care – cholesterol screening	1		
Glaucoma testing	1		
Adult BMI assessment	1		
Osteoporosis management in women who had a fracture	1		
Diabetes care – eye exam	1		
Diabetes care – kidney disease monitoring	1		
Rheumatoid arthritis management	1		
Care for older adults – medication review	1	SNP only	
Care for older adults – functional status assessment	1	SNP only	
Care for older adults – pain screening	1	SNP only	
Outcome measures from HOS (determined by CMS)			
Improving or maintaining physical health	3	7.5	7.3
Improving or maintaining mental health	3		
Process measures from HOS (reported through HEDIS)			
Monitoring physical activity	1	3.8	3.6
Improving bladder control	1		
Reducing the risk of falling	1		
Patient experience measures from CAHPS®			
Getting needed care	1.5	11.3	10.9
Getting appointments and care quickly	1.5		
Customer service	1.5		
Rating of health care quality	1.5		
Rating of health plan	1.5		
Care coordination	1.5		
Process measures from CAHPS			
Annual flu vaccine	1	1.3	1.2
Other measures for Part C			
Health plan quality improvement (outcome computed by CMS)	3	3.8	3.6
Complaints about the health plan	1.5	11.3	10.9
Beneficiary access and performance problems	1.5		
Members choosing to leave the plan (disenrollment rates)	1.5		
Plan makes timely decisions about appeals	1.5		
Reviewing appeals decisions	1.5		
Call center – foreign language interpreter and TTY availability	1.5		

Note: SNP (special needs plan), MA–PD (Medicare Advantage–Prescription Drug plan), HEDIS® (Healthcare Effectiveness Data and Information Set®), BMI (body mass index), HOS (Health Outcomes Survey), CAHPS® (Consumer Assessment of Healthcare Providers and Systems®), PPO (preferred provider organization), TTY (teletypewriter), RAS (renin angiotensin system). SNP measures are weighted in proportion to SNP membership in a given contract; a contract that is 100 percent SNP enrollment would have the full weighting shown in the table.

Source: MedPAC analysis of CMS star rating measures.

TABLE 13–6 Measures included in the 2014 star ratings and their relative weight (cont.)

	Weight	Share of total weight for non-SNP MA–PDs	Share of total weight for SNPs (all are MA–PDs)
All Part D		**33.3%**	**32.1%**
Outcome measures			
Drug plan quality improvement (computed by CMS)	3	22.6	21.8
High-risk medication	3		
Diabetes treatment (appropriate drug prescribing)	3		
Medication adherence for diabetes medications	3		
Medication adherence for hypertension (RAS antagonists)	3		
Medication adherence for cholesterol (statins)	3		
Patient experience measures from CAHPS			
Rating of drug plan	1.5	3.8	3.6
Getting needed prescription drugs	1.5		
Other measures for Part D			
Call center—foreign language interpreter and TTY availability	1.5	6.9	6.7
Appeals auto-forward (appropriate handling of appeals)	1.5		
Appeals upheld	1.5		
Medicare Plan Finder price accuracy	1		

Note: SNP (special needs plan), MA–PD (Medicare Advantage–Prescription Drug plan), HEDIS® (Healthcare Effectiveness Data and Information Set®), BMI (body mass index), HOS (Health Outcomes Survey), CAHPS® (Consumer Assessment of Healthcare Providers and Systems®), PPO (preferred provider organization), TTY (teletypewriter), RAS (renin angiotensin system). SNP measures are weighted in proportion to SNP membership in a given contract; a contract that is 100 percent SNP enrollment would have the full weighting shown in the table.

Source: MedPAC analysis of CMS star rating measures.

Comparing 2013 star results with 2014 results, a majority of beneficiaries are in plans with 2014 ratings that are at 4 stars or higher. Based on September 2013 enrollment, plans' improvement in their star ratings over the past year led to a majority of enrollees being in higher rated plans (Table 13-7, p. 342). These results reflect improvement primarily in Part D star-rated outcome measures, readmission rates, clinical process measures, contract performance measures, and CMS-computed Part C and Part D improvement measures (whereby CMS examines a collection of measures to evaluate whether the plan has shown improved results).

Variation in star ratings by plan type

As noted in CMS's 2014 star ratings fact sheet, plans with the highest star ratings have certain characteristics (Centers for Medicare & Medicaid Services 2013). Higher rated plans have been in the MA program longer and are more likely to be nonprofit.

There is also variation by plan type in the 2014 star ratings. For HMOs, the enrollment-weighted average is 3.93; for local PPOs, 3.85; for PFFS plans, 3.69; and for regional PPOs, 3.22. All of the 11 MA–PD plans rated at the maximum 5 stars in the 2014 ratings are HMOs (including one cost-reimbursed HMO). Among MA-only plans with a 5-star Part C rating, all 3 are cost-reimbursed HMOs; only 2 of 11 PFFS plans are rated 4 stars, with the remainder below that level; and 1 of 11 rated regional PPOs has a star rating of 4.5, and the rest are below 4 stars. SNPs tend to have lower star ratings, with an average of 3.19 stars. Among SNPs, the institutional SNPs have the highest enrollment-weighted average number or stars, at 3.51.[7] Plans with a larger proportion of employer group enrollees tend to have higher star ratings (4.39 for plans with employer group enrollment of 30 percent or more), in part because much of the enrollment is in more established plans that are not-for-profit organizations.

Medicare Advantage and hospice

The Medicare hospice benefit is carved out of—that is, not included in—the MA benefits package. MA enrollees who elect hospice remain in their MA plan, but FFS Medicare

TABLE 13–7

Distribution of enrollment by plan star ratings, 2013–2014

Star rating	Percentage distribution of enrollment 2013	2014
4.0, 4.5, 5.0[a]	36%	51%
3.0, 3.5[b]	59	48
Below 3.0 stars[c]	5	1

Note: Enrollment is for September 2013. Data exclude cost-reimbursed HMO plans, which are not eligible for bonuses. With cost plans included, 52 percent of enrollees would be in plans at 4 stars or higher.
a. Eligible for bonus under statutory provisions.
b. Eligible for bonus only under demonstration; not eligible in 2015.
c. Not eligible for bonus payments.

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

pays for their hospice services. Given that the Commission believes a goal of the MA program is to move away from fragmented payment arrangements and to provide an integrated, coordinated benefits package, the Commission is concerned that the hospice carve-out is inconsistent with this goal.

Background

The Medicare hospice benefit covers palliative and support services for beneficiaries with a life expectancy of six months or less. Beneficiaries who elect the Medicare hospice benefit agree to forgo Medicare coverage of conventional care for their terminal condition and related conditions. However, Medicare continues to cover items and services unrelated to the terminal illness. The hospice benefit is available to all beneficiaries who meet the eligibility criteria, whether in FFS Medicare or MA. Typically, MA enrollees who elect hospice remain in their MA plan but receive hospice services paid for by FFS Medicare. (For more detailed information on the hospice benefit, see this report's hospice chapter, Chapter 12).

The rationale for the hospice carve-out from Medicare managed care is not fully known, but the timing of the establishment of the hospice benefit and Medicare managed care plans may have been a contributing factor. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) first established the hospice benefit on a temporary basis (with a scheduled 1986 sunset date); the Omnibus Budget Reconciliation Act of 1985 made it permanent. TEFRA established full risk-bearing managed care plans as a permanent option within the Medicare program, with the first contracts beginning in 1985. According to a *Health Care Financing Review* article authored by CMS staff, hospice was initially excluded from the capitated payments to Medicare managed care plans because hospice use was small at that time and cost data were very limited (Riley and Herboldsheimer 2001). Many years later, the Balanced Budget Act of 1997 established in statute that hospice is carved out of the Medicare managed care benefits package. Although hospice is excluded from the MA benefits package, hospice services are now commonly covered by private insurance plans for the working-age population (based on our conversations with health plans, hospices, and their associations and our review of state essential health benefits benchmark plans).[8,9]

Beneficiaries enrolled in MA and FFS Medicare who receive hospice care are relatively similar in terms of hospice primary diagnosis (Table 13-8). In 2012, a slightly higher share of MA hospice users than FFS users (30 percent vs. 27 percent) had a primary diagnosis of cancer, while a slightly smaller share of MA hospice users (16 percent) had dementia or other neurological conditions, compared with FFS users (19 percent). Two other top hospice primary diagnoses—heart failure and debility/nonspecific signs and symptoms (e.g., adult failure to thrive)—had similar prevalence rates in the MA and FFS hospice populations.

TABLE 13–8

Comparison of FFS Medicare and MA hospice enrollees by primary hospice diagnosis, 2012

Primary hospice diagnosis	Percent of hospice patients FFS	MA
Cancer	27%	30%
Neurological conditions	19	16
Heart or other circulatory conditions	17	17
Debility or nonspecific signs/symptoms	17	17
COPD	5	6
Other	14	14

Note: FFS (fee-for-service), MA (Medicare Advantage), COPD (chronic obstructive pulmonary disease).

Source: MedPAC analysis of data from the denominator file and the 100 percent hospice claims standard analytic file from CMS.

TABLE 13–9

Comparison of hospice utilization between beneficiaries in FFS Medicare and MA

	FFS	MA
Number of hospice enrollees, 2011*	859,000	279,000
Medicare hospice payments (in billions), 2011*	$10.2	$3.5
Percent of decedents who used hospice, 2012**	45.6%	50.2%
Length of stay among decedents (in days), 2012**		
Average	90	83
10th percentile	2	3
25th percentile	5	6
50th percentile	18	18
75th percentile	82	77
90th percentile	251	234
Percent of hospice enrollees with a live discharge, 2010*	17%	17%

Note: FFS (fee-for-service), MA (Medicare Advantage). Length of stay is calculated for decedents who used hospice at the time of death or before death and reflects the total number of days the decedent hospice user was enrolled in the Medicare hospice benefit during his or her lifetime. Percent of hospice enrollees with a live discharge is based on the cohort of beneficiaries who first enrolled in hospice in 2010 followed through 2012. Cost-reimbursed plans are included in the MA data.
*MA status was measured in February of the reference year. Numbers exclude beneficiaries who were not alive in February or who had not yet enrolled in Medicare as of February of that year.
**MA status was measured as of the last month of life.

Source: MedPAC analysis of data from the denominator file, the Medicare Beneficiary Database, and the 100 percent hospice claims standard analytic file from CMS.

Compared with FFS beneficiaries, MA beneficiaries are somewhat more likely to use hospice at the end of life but slightly less likely to have very long stays. In 2012, 50.2 percent of MA decedents received hospice services compared with 45.6 percent of FFS decedents (Table 13-9). MA beneficiaries also had a somewhat shorter average length of stay (83 days) than FFS beneficiaries (90 days). The differences in hospice average length of stay between MA and FFS is largely the result of two phenomena: (1) MA has slightly more cancer patients (who tend to have short stays) and slightly fewer neurological patients (who tend to have long stays) compared with FFS, and (2) very long hospice stays tend to be slightly shorter in MA than in FFS for patients with neurological conditions or debility/nonspecific signs and symptoms. Live discharge rates are similar for MA and FFS hospice enrollees.

The hospice carve-out from MA

When a beneficiary in MA elects hospice, FFS Medicare becomes responsible for most services while the MA plan retains responsibility for certain services. The government payment to the MA plan is reduced to reflect the plan's limited financial responsibility for care. For hospice enrollees, the government pays the MA plan only the Part D payment and the rebate dollars that fund supplemental benefits; the plan no longer receives the Part A and B portion of the Medicare capitated payment. The beneficiary's premium payments do not change. The beneficiary continues to pay the Part B premium to the government and the Part C and Part D premiums, if any, to the plan.

The hospice carve-out from MA results in a complicated set of coverage rules for MA beneficiaries who elect hospice (Table 13-10, p. 344). The Medicare hospice benefit covers all services associated with the terminal condition or related conditions, and FFS Medicare pays the hospice provider a per diem rate for these services.[10] FFS Medicare also pays separately for any Part A or Part B services unrelated to the terminal condition, which the MA enrollee may obtain from any Medicare provider, not just those in the plan's network. MA–PD plans pay for any Part D drugs unrelated to the terminal condition. The MA plan is also responsible for any supplemental benefits offered by the plan (e.g., dental, hearing, or reduced cost sharing). For example, if the MA plan offers reduced cost sharing for some Part A or Part B services

TABLE 13–10

Coverage for MA–PD enrollees who elect hospice

	FFS Medicare covers	MA–PD covers
Before hospice enrollment		• All Part A, Part B, and Part D services, and any supplemental benefits
MA–PD enrollee elects hospice	• Hospice • Part A and Part B services unrelated to the terminal condition	• Part D drugs unrelated to terminal condition • Any supplemental benefits (e.g., reduced cost sharing)
MA–PD enrollee disenrolls from hospice	• Until the end of the month, all Part A and Part B services	• All Part D drugs • Any supplemental benefits (e.g., reduced cost sharing) • Beginning the next month after disenrollment, Part A and Part B services

Note: MA–PD (Medicare Advantage–Prescription Drug plan), FFS (fee-for-service).

Source: MedPAC analysis of Medicare coverage rules.

as a supplemental benefit, the plan must offer the reduced cost sharing to a hospice enrollee in certain circumstances (e.g., when the service is for a diagnosis unrelated to the terminal condition, is furnished by a network provider, and follows plan rules). In terms of coordination between the hospice provider and other providers furnishing services unrelated to the terminal condition, the hospice conditions of participation require the hospice to communicate and coordinate with unrelated providers.[11]

For beneficiaries who are discharged alive from hospice, financial responsibility for care continues to be split between FFS Medicare and the MA plan for an initial period of up to 30 days. From the day the beneficiary disenrolls from hospice until the end of the calendar month, FFS Medicare is responsible for all Part A and Part B services, and the MA–PD plan is responsible for Part D drugs and supplemental benefits. Beginning the first day of the next calendar month, the MA–PD plan receives its full capitation and becomes responsible for all Part A, Part B, and Part D services.

Overall, these coverage rules fragment financial responsibility and accountability for care. It is not uncommon for a hospice enrollee to receive Medicare services or drugs that are considered unrelated to the terminal condition paid outside of the Medicare hospice benefit. Analysis by a Commission contractor, Acumen LLC, found that about half of hospice patients in MA plans in 2012 received at least one Part A or Part B service or Part D drug during their hospice episode that was paid for outside the hospice benefit by FFS Medicare or an MA–PD plan.[12, 13] When this occurs, the hospice provider has responsibility for coordinating its care with the care furnished by other providers. However, under such circumstances, no one entity has overall financial responsibility or accountability for the patient's care, as would otherwise be the case for beneficiaries enrolled in MA plans. In the event that an MA enrollee is discharged alive from hospice, financial responsibility for care continues to be fragmented until the end of the calendar month. Of all MA beneficiaries who first elected hospice in 2010, 17 percent had a live discharge (either initiated by the beneficiary or the hospice).[14] How often beneficiaries go out of network and the extent to which plans are able to engage in care coordination or care management immediately after a live discharge is unknown.

Potential benefits of including hospice in MA

Including hospice in the MA benefits package has the potential to broaden the benefits package to reflect the full continuum of care. The current hospice carve-out from MA makes a plan's financial responsibility for end-of-life care uneven across beneficiaries. For beneficiaries who elect hospice care, the plan has limited financial responsibility for their care after hospice enrollment. In contrast, for beneficiaries with terminal conditions who do not enroll in hospice, the plan has full financial responsibility for care through the end of life.

If the purpose of MA is to give a health plan financial responsibility and accountability for managing its enrollees' care and for the plan to do so in an integrated, coordinated manner, it would make sense for the plan to have responsibility for the full continuum of care, including hospice. Broadening the bundle of services for which MA plans are accountable would give plans the incentive to consider the needs of their members more broadly and to provide coordinated, efficient care to meet those needs.

The hospice carve-out from MA is one example of a policy for which current Medicare program rules differ across platforms. Accountable care organizations (ACOs) have financial accountability for hospice because hospice expenditures are included within their shared savings benchmarks. This means that overall Medicare program expenditures for all services, including hospice care, for an ACO's beneficiaries are taken into account when determining whether an ACO does or does not receive a bonus (or a penalty in a two-sided risk model). In contrast, MA plans currently do not have any financial responsibility or accountability for hospice expenditures. Putting hospice within the MA benefits package would be a step toward synchronizing accountability across systems.

Further, including hospice in the MA benefits package and consolidating financial responsibility for the full continuum of care under the MA plan would give plans more incentives to develop innovative programs for patients with advanced illnesses both at the end of life and earlier in the disease progression. For example, the inclusion of hospice in the MA benefits package would make it more feasible for MA plans to offer concurrent hospice and conventional care as a supplemental benefit if they wished to do so.[15] Some stakeholders have asserted that the requirement that beneficiaries forgo conventional care as a condition of enrolling in hospice results in some beneficiaries' hesitation to enroll in hospice or only enrolling within the last few days of life. In the commercial managed care market for the working-age population, a few private insurers are experimenting with concurrent care (California HealthCare Foundation 2013, Spettell et al. 2009). Aetna has reported that its program for advanced illness in the working-age population, which permits concurrent hospice and conventional care, has led to increased hospice enrollment, reduced use of hospital and intensive care services, lower costs, and positive family feedback (Spettell et al. 2009). Whether concurrent care would have a similar effect in the Medicare population is not clear because the diagnosis and age profiles of the Medicare and working-age populations differ.[16] However, MA might be a logical place to test concurrent care within the Medicare program.[17] Aetna has noted that its utilization management approaches and its population's ease with these approaches may be a component of its success (Krakauer et al. 2009). MA plans bear financial risk for the benefits they provide, so the Medicare program would be protected financially if concurrent care were found to be associated with increased costs. Since it is up to MA plans to decide what, if any, supplemental benefits they wish to offer, plans could offer concurrent care as a supplemental benefit if they wished, but they would not be required to do so. Nonetheless, it is the Commission's expectation that with the inclusion of hospice in the MA benefits package, plans would have an incentive to use the flexibility inherent in the MA program to develop and test innovative programs aimed at improving end-of-life care and care for patients with advanced illnesses more broadly (e.g., concurrent care or other approaches to provide flexibility in the hospice eligibility criteria, palliative care, and shared decision making).

Including hospice in MA could also simplify some of the complex coverage issues concerning services related and unrelated to the terminal condition for MA enrollees. Currently, which party is financially responsible for the services a hospice enrollee receives depends on whether the services are related to the terminal condition. This is a medical determination that may not always be clear cut and can lead to confusing coverage rules for beneficiaries, hospice providers, and plans. Giving MA plans financial responsibility for all Medicare services for their members who enroll in hospice would lessen the need to precisely distinguish between services related and unrelated to the terminal condition for MA beneficiaries.[18]

Operationalizing the inclusion of hospice in MA

If hospice were included in the MA benefits package, it would be important to specify that MA plans must cover the full scope of the hospice benefit as defined in the Social Security Act. Doing so would ensure that an MA plan could not select among the services to cover within the scope of the hospice benefit. Instead, the MA plan would be required to cover the full scope of the benefit for eligible members who elect hospice. This would also ensure that important structural aspects of hospice care are required in MA. For example, as defined in the Social Security Act, hospice care under MA would need to be provided under a written plan of care established and periodically

reviewed by the patient's attending physician, the hospice medical director, and by the hospice interdisciplinary group (with the interdisciplinary group required to include a physician, registered nurse, social worker, and pastoral or other counselor). In addition, the more detailed requirements about what constitutes hospice care outlined in the Medicare hospice conditions of participation would be applicable to hospice care provided through MA since plans must contract with Medicare-certified providers who are required to abide by the Medicare conditions of participation for all patients.

Including hospice in the MA benefits package would necessitate recalculating MA plan payment rates. Plans' capitated payments would need to increase to account for the plans' increased financial responsibility for a broader set of Medicare services. If hospice services (as well as any Part A or Part B services unrelated to the terminal condition provided to hospice enrollees) were included in the MA capitation just like other Medicare services, this would increase the MA base payment rate since payment for these services would be spread across the payment rates for the entire MA population. MA risk scores would also need to be recalculated. Currently, the risk scores reflect the relative risk a beneficiary with certain characteristics has for Medicare expenditures excluding hospice.[19] The risk model would need to be revised to predict the relative risk of total Medicare expenditures including hospice. The combined effect of the increase to the base capitation rate and revisions to the risk model would be increased capitation payments to MA plans, with the increase being largest for patients with diagnoses and demographic characteristics associated with the highest average hospice spending per capita.

To facilitate monitoring of hospice services provided to MA enrollees, hospice should be included in the MA encounter data that plans submit, similar to what is done for other Medicare services. In general, the encounter data reported by plans are expected to include a level of detail similar to FFS claims. The FFS Medicare hospice claims data include rich detail on the number, type, and length of hospice visits received by beneficiaries. With MA encounter data, policymakers would be able to closely monitor the type and amount of hospice services received by beneficiaries in each MA plan and assess whether it differs from the extent of services provided to FFS beneficiaries. As we note in Chapter 12 on hospice, there may also be opportunities to use experience of care surveys or bereaved family member surveys to gauge satisfaction with care for Medicare patients with advanced illnesses across settings for both FFS and MA.

A majority of MA enrollees are in HMOs, which contract with a network of providers for their members' care. When beneficiaries enroll in such a plan, they agree to accept a more limited network of providers. In exchange, they receive certain additional benefits not covered by traditional Medicare, through an organization that also has the specific role of coordinating and managing their care. As with other Medicare services, these MA plans would be required to meet network adequacy standards to ensure that they have enough hospice providers in their network to meet the needs of their members. Marketing materials for these MA plans are also required to make clear that enrollees must obtain routine services (e.g., nonemergency services) from network providers, a point that may warrant special emphasis for hospice services given that beneficiaries may not be thinking about end-of-life care at the time they enroll in MA.

Some hospice industry representatives have expressed concern that including hospice in MA could limit access to hospice providers for beneficiaries with specific religious preferences. The hospice conditions of participation require that spiritual counseling be a core service offered by each hospice and that it be provided in accordance with the patient's and family's acceptance of this service and in a manner consistent with patient and family beliefs and desires.[20] However, if there were circumstances in which an MA plan's network hospice providers were unable to meet an individual's needs for spiritual counseling, general MA policy would give the plan the flexibility to authorize use of out-of-network hospices. When this need for flexibility occurs, plans typically pay non-network providers the FFS rate (out-of-network providers who accept an MA patient must agree to accept FFS rates as payment in full, though the plan and provider can negotiate an alternative payment arrangement).

RECOMMENDATION 13-2

The Congress should include the Medicare hospice benefit in the Medicare Advantage benefits package beginning in 2016.

RATIONALE 13-2

The carve-out of hospice from MA fragments financial responsibility and accountability for care for MA enrollees who elect hospice. Including hospice in the MA benefits package would give plans responsibility

for the full continuum of care, which would promote integrated, coordinated care, consistent with the goals of the MA program. With the inclusion of hospice in the MA benefits package, plans would have greater incentive to use the flexibility inherent in the MA program to develop and test innovative programs aimed at improving end-of-life care and improving care for patients with advanced illnesses more broadly. In addition, giving MA plans responsibility for hospice would be a step toward synchronizing accountability for hospice across Medicare platforms (MA, ACOs, and FFS). Because the Commission believes it is important to include hospice in the MA benefits package as soon as possible, we have recommended this change be made by 2016. We recognize that implementing this change, if it were enacted by the Congress, would require actions by CMS (to recalculate capitation rates and risk scores) and by plans and providers (to negotiate contracts), but we believe this change could be accomplished by 2016 under a tight time line.

IMPLICATIONS 13-2

Spending

- The effect on Medicare program spending is expected to be negligible, with the policy potentially resulting in a small cost or small savings. The estimated one-year and five-year effects on Medicare program spending fall into our smallest budget categories: cost or savings of less than $50 million over one year and less than $1 billion over five years.

Beneficiaries and providers

- MA enrollees could benefit from a more integrated, coordinated MA benefits package. Some plans may choose to provide concurrent hospice and conventional care or offer other supplemental benefits aimed at improving care for patients with advanced illnesses, which could expand options available to beneficiaries. We would not expect an adverse impact on beneficiaries' access to hospice care. As with other types of Medicare services, beneficiaries might be required to obtain services from a network provider, so they might have fewer hospice providers to choose from than they do under FFS Medicare. MA plans would have the option to charge nominal beneficiary cost sharing for hospice services, whereas under FFS Medicare, there is no cost sharing (with minor exceptions). If the experience with home health is any guide, MA plans may be unlikely to charge hospice cost sharing. Few MA plans require cost sharing for home health services from network providers.

  MA plans would be better positioned to manage and coordinate care for patients with advanced illnesses. If including hospice in MA led some plans to experiment with concurrent care or other approaches that seek to improve care for patients with advanced illnesses, hospice providers could have opportunities to participate in new models of care.

  Plans and hospices currently engage in private contracting for commercially insured individuals and incur administrative costs associated with that contracting. If hospice were included in MA, the breadth of those contracting activities would increase and plans and hospice providers would incur additional administrative costs associated with them.

Quality

- Including hospice in MA would reduce fragmentation of coverage, which would promote integrated, coordinated care. Furthermore, broadening MA plans' bundle of services to include the full continuum of end-of-life care could incentivize plans to focus more on efforts to improve quality and satisfaction with this care.

Delivery system reform

- Hospice is an area in which Medicare policy differs across delivery systems. Including hospice in MA would be a step toward synchronizing policies across the Medicare system (MA, ACOs, and FFS).

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 reducing payments from previous high levels such that the payment system is neutral—so that it 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 spending while MA enrollment continues to grow. With improved efficiency, MA plans are able to continue increasing MA enrollment by offering packages that beneficiaries find attractive.

Employer group plans bid higher than nonemployer plans, we believe, because of a lack of incentive for employer group plans to submit competitive bids. We have made a new recommendation to address this issue.

The hospice carve-out from MA fragments financial responsibility and accountability for care for MA enrollees who elect hospice. We have made a new recommendation to include hospice in the MA benefits package. This step would give plans financial responsibility for the full continuum of care and promote integrated, coordinated care, consistent with the goals of the MA program. It is the Commission's expectation that with the inclusion of hospice in the MA benefits package, plans would have an incentive to use the flexibility inherent in the MA program to develop and test innovative programs aimed at improving end-of-life care and care for patients with advanced illnesses more broadly. ■

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 The number of plan choices is not enrollment weighted. Because there are more plans in more populous counties, the weighted average by enrollment would be higher.

3 The difference in HEDIS results from one year to the next can reflect random variation, or "noise," in the data. Measures such as the level of cholesterol control—and similar "hybrid" measures in HEDIS that are reported based on a sampling of medical records—show more variation across plans than other types of measures that are based on administrative data (claims data or encounter data). For example, the measure that we report as showing a decline among local PPOs between 2012 and 2013 (cholesterol control among patients with cardiovascular conditions) varied from a minimum of 13.6 for local PPOs in 2013 to a maximum of 73.8, with a ratio between the 90th and 10th percentile of 1.6. In the preceding year, for the same local PPOs reporting in both years, the range was 26.8 to 85.2, with the same 90th-to-10th percentile ratio of 1.6 among the 95 plans. For 257 HMOs reporting in both years, the range for the measure was 1.5 to 86.3 in 2012 (with a 90th-to-10th percentile ratio of 1.7), and for 2013, the range was 6.8 to 86.3 (with a 90th-to-10th percentile ratio of 1.5). A companion measure that is based on administrative data—the measure of whether patients with cardiovascular disease have their cholesterol levels tested—does not show the same extent of variation. The 90th-to-10th percentile ratio in 2012 and 2013 ranged from 1.13 to 1.15 for both HMOs and local PPOs.

4 The HEDIS data for 2012 show an all-plan average readmission rate for all age groups of 13.7 percent. For FFS in 2012, Gerhardt and colleagues report a readmission rate of 18.4 percent for all age groups, which is a 3 percent decline from the "stable" trend from 2007 to 2011 (Gerhardt et al. 2013). Similar to the HEDIS approach, Gerhardt and colleagues use an all-cause 30-day readmission rate. However, MA readmission rates are computed only for enrollees who were plan members during the entire 12 months of the calendar year—thus leaving out beneficiaries who died during the course of the year, those who newly enrolled during the year, and those disenrolling during the year. The MA readmission rate of 13.7 percent for all age groups in all plans is therefore not directly comparable with the FFS rate that Gerhardt and colleagues report.

5 The disenrollment measure that CMS reports is "members choosing to leave the plan," which excludes "members who left their plan due to circumstances beyond their control (such as members who moved out of the service area, members affected by a contract service area reduction . . . [and] employer group members . . . also members in PBPs [plan benefit package plans] that were granted special enrollment exceptions. . . . The data for contracts with fewer than 1,000 enrollees are not reported in this measure" (Centers for Medicare & Medicaid Services 2013).

6 Star ratings are released to coincide with the October–December annual election period. The star ratings released in October 2013 are referred to as the 2014 star ratings (for enrollments effective in 2014). However, the level of any bonus payments and rebate percentages for each year are determined as part of the bidding process. For the 2014 contract year, bids submitted in June of 2013 used 2013 star ratings, released in October 2012, to determine bonus levels for the 2014 benefit packages. Thus, beneficiaries will be using more current (2014) quality ratings to see differences in quality across plans, but the variation in benefit packages that is due to star ratings is based on an earlier period's star ratings (2013 star ratings).

7 Because star ratings are determined at the contract level and SNPs are often benefit packages within larger contracts, to judge to what extent SNP status affects an organization's star ratings, we evaluate organizations in which 50 percent or more of their enrollment is in one of the three SNP categories. About half of dual-eligible enrollment in special needs plans (D–SNPs) (52 percent) and institutional special needs plans (I–SNPs) (48 percent) is in a contract in which the majority of enrollees are D–SNP or I–SNP enrollees. It is less common for chronic condition special needs plan enrollment to be the majority of a contract's enrollment.

8 Because the mortality rate is much higher in the elderly population than the working-age population, privately insured working patients make up a small share of all patients currently served by hospice providers. The Commission's analysis of data from the National Home and Hospice Care survey of 2007 found that about 9 percent of hospice discharges were of patients with private insurance.

9 The hospice benefits currently offered by private insurers to the working-age population vary in terms of what they cover. Some insurers offer a hospice benefit that mirrors the Medicare hospice benefit, while other insurers provide more limited benefits (e.g., limits on the number of days, total dollar amount, or type of hospice services covered).

10 An exception is payment for physician visits provided by the patient's hospice attending physician, which are paid separately by Medicare FFS.

11 The Medicare conditions of participation require hospice providers to conduct a comprehensive assessment of the patient's needs, including needs unrelated to the terminal condition, and to make referrals to appropriate health care professionals. Hospices are also required to provide for an ongoing sharing of information with other nonhospice health care providers furnishing services unrelated to the terminal illness. For example, in the 2008 CMS final rule implementing the conditions of participation, CMS stated that this requirement for information sharing "will ensure that hospices actively coordinate the care that they are providing with the care being furnished by other providers. The coordination will help hospices avoid a duplication of services as well as potentially dangerous drug prescribing and dosage problems. . . . When coordinating care with other providers, it is essential that hospices are aware of their role within the larger comprehensive plan of care, as well as any gaps in the comprehensive plan of care and the parties responsible for filling those gaps" (Centers for Medicare & Medicaid Services 2008).

12 This figure does not include physician visits provided by the hospice patient's attending physician (either those employed by the hospice or independent) that are billed as related to the terminal condition.

13 Part D drugs were the most common service unrelated to the terminal condition used. About 44 percent of MA beneficiaries who used hospice in 2012 had a Part D prescription dispensed during their hospice episode. The next most common services unrelated to the terminal condition were physician and supplier services, hospital outpatient services, and inpatient hospital services (about 24 percent, 9 percent, and 3 percent of MA hospice enrollees, respectively, received these services during their hospice episode).

14 There are a number of reasons a live discharge may occur. A beneficiary may revoke the hospice benefit (because of beneficiary or family choice, pursuing services not in the plan of care, quality of care, etc.) or the hospice may initiate a discharge because the beneficiary's condition is no longer considered terminal or for other reasons (e.g., beneficiary moves out of the service area or for cause).

15 Because the hospice carve-out results in the MA base capitation rate excluding payment for hospice and the MA capitated payment being reduced substantially when a beneficiary elects hospice, MA plans have little incentive to offer concurrent care as a supplemental benefit. Including hospice within the MA benefits package—which would consolidate financial responsibility for the full continuum of care under the MA plan, increase the MA base capitation rate to reflect plans' responsibility for hospice, and ensure that MA plans have contractual relationships with hospice providers serving their Medicare members—would make it more feasible for MA plans to offer concurrent care if they wished to do so.

16 Generally, working-age individuals with terminal illnesses are more likely to have cancer and to have shorter hospice stays than the Medicare population with terminal illnesses. Concurrent care may encourage younger people to use hospice more or for a longer time period, potentially avoiding costly acute care services at the end of life. By contrast, Medicare beneficiaries with terminal illnesses have a more diverse set of diagnoses (including neurological conditions, such as dementia, which tend to have longer hospice stays) and consequently, the cost of concurrent care may be more varied among Medicare beneficiaries.

17 A demonstration to test concurrent care in the FFS program was enacted by the Congress. The Patient Protection and Affordable Care Act of 2010 mandated a demonstration program of concurrent hospice and conventional care in 15 sites, but no funds were appropriated for the demonstration. However, CMS has indicated its intent to develop a demonstration to test the provision of palliative care and conventional care in the future, but no details have been released to date.

18 As noted in the appendix of Chapter 12 on hospice, data analyses by the Office of Inspector General and the Commission suggest that some of the services provided to hospice enrollees outside of hospice are likely related to the terminal condition and should be the financial responsibility of the hospice. Because financial responsibility for care provided to hospice enrollees is fragmented between the hospice, FFS, and Part D, no one entity has full responsibility to ensure that the correct entity has paid for the service. If hospice were included in MA, plans would have financial responsibility for all Medicare services for their members enrolled in hospice.

19 The average risk score for MA patients who use hospice in a year is substantially higher than for the MA population overall. For example, the 2011 risk score for MA beneficiaries who used hospice in 2011 averaged 2.5.

20 With respect to spiritual counseling, the hospice conditions of participation require that the hospice provide an assessment of the patient's and family's spiritual needs; provide spiritual counseling to meet these needs in accordance with the patient's and family's acceptance of this service, and in a manner consistent with patient and family beliefs and desires; make all reasonable efforts to facilitate visits by local clergy, pastoral counselors, or other individuals who can support the patient's spiritual needs to the best of its ability; and advise the patient and family of this service.

References

Ayanian, J. Z., B. E. Landon, A. M. Zaslavsky, et al. 2013. Medicare beneficiaries more likely to receive appropriate ambulatory services in HMOs than in traditional medicare. *Health Affairs* 32, no. 7 (July): 1228–1235.

California HealthCare Foundation. 2013. *A better benefit: Health plans try new approaches to end of life care.* Oakland: CHCF.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2013. *2014 Part C and D plan ratings.* Fact sheet. Baltimore, MD: CMS.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2008. Medicare and Medicaid programs; hospice conditions of participation. Final rule. *Federal Register* 73, no. 109: 32089–32220.

Cohen, R., J. Lemieux, J. Schoenborn, et al. 2012. Medicare Advantage chronic special needs plan boosted primary care, reduced hospital use among diabetes patients. *Health Affairs* 31, no. 1 (January): 110–119.

Gerhardt, G., A. Yemane, P. Hickman, et al. 2013. Data shows reduction in Medicare hospital readmission rates during 2012. *Medicare & Medicaid Research Review* 3, no. 2: E1–E12.

Government Accountability Office. 2012a. Letter to the Honorable Kathleen Sebelius, Secretary of Health and Human Services, regarding the Medicare advantage quality bonus payment demonstration. July 11.

Government Accountability Office. 2012b. *Medicare Advantage: Quality bonus payment demonstration undermined by high estimated costs and design shortcomings.* Washington, DC: GAO.

Krakauer, R., C. M. Spettell, L. Reisman, et al. 2009. Opportunities to improve the quality of care for advanced illness. *Health Affairs* 28, no. 5 (September–October): 1357–1359.

Landon, B. E., A. M. Zaslavsky, R. C. Saunders, et al. 2012. Analysis of Medicare Advantage HMOs compared with traditional Medicare shows lower use of many services during 2003–09. *Health Affairs* 31, no. 12 (December): 2609–2617.

Matlock, D. D., P. W. Groeneveld, S. Sidney, et al. 2013. Geographic variation in cardiovascular procedure use among Medicare fee-for-service vs Medicare Advantage beneficiaries. *Journal of the American Medical Association* 310, no. 2 (July 10): 155–162.

McWilliams, J. M., J. Hsu, and J. P. Newhouse. 2012. New risk-adjustment system was associated with reduced favorable selection in Medicare Advantage. *Health Affairs* 31, no. 12 (December): 2630–2640.

Medicare Payment Advisory Commission. 2013. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2012. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

Newhouse, J. P., M. Price, J. Huang, et al. 2012. Steps to reduce favorable risk selection in Medicare Advantage largely succeeded, boding well for health insurance exchanges. *Health Affairs* 31, no. 12 (December): 2618–2628.

Riley, G., and C. Herboldsheimer. 2001. Including hospice in Medicare capitation payments: Would it save money? *Health Care Financing Review* 23, no. 1 (Fall): 137–147.

Spettell, C. M., W. S. Rawlins, R. Krakauer, et al. 2009. A comprehensive case management program to improve palliative care. *Journal of Palliative Medicine* 12, no. 9 (September): 827–832.