The Medicare Advantage program: Update on quality

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Summary from November meeting

- Enrollment in MA plans grew 5 percent in 2010 — about 24 percent of beneficiaries now enrolled in MA plans
- In 2011 MA plans available to 100% of Medicare beneficiaries—fewer PFFS choices than 2010
- In 2011 we estimate beneficiaries in MA will cost Medicare 110 percent of what Medicare would spend on the same beneficiaries under the FFS payment system
- MA payment rules will create **unintended** inter-county anomalies

Background on MA quality: The Commission has recommended changes

- Mandated report to the Congress dealt with two main areas:
  - Improving ways of measuring and reporting on quality in Medicare Advantage
  - Developing ways of comparing quality in MA to traditional FFS program
- The Commission has recommended that there be a pay-for-performance system to reward higher-quality plans

Recent and forthcoming changes in quality address some of the recommendations

- New measures under development for MA
- Forthcoming encounter data can be source of measures to compare MA with FFS
- Plan reporting of quality measures now on a more even footing for PPOs
- Congress enacted a quality bonus payment system for MA plans, beginning in 2012

Issues remain

- Still difficult to make quality comparisons across plan types and between MA and FFS
  - Many factors affect the performance of plans
  - Similarly, various factors need to be considered in using data to compare MA to FFS
- Current measures will be used to determine quality bonuses for 2012
- CMS will use demonstration authority to institute alternative program-wide system

Quality measurement systems in MA

System	Description
Healthcare Effectiveness Data and Information Set (HEDIS®)	• Plan reporting of process measures and "intermediate outcome" measures • Administered through NCQA; used for commercial, Medicaid and Children's Health Plans
Health Outcomes Survey (HOS)	• Yearly member survey on health status, and two-year changes in health status • Source of a number of HEDIS measures • A Medicare survey; VA uses a similar survey
Consumer Assessment of Healthcare Providers and Systems (CAHPS®)	• Beneficiary survey of perceptions of quality of care, ease of access to care, and health plan responsiveness • Also source of rates of flu and pneumonia vaccination for HEDIS • A product of AHRQ used in various sectors, including fee-for-service Medicare

HEDIS quality indicators show some improvement, with variation on many dimensions

- Nine out of 46 effectiveness of care measures improved over the past year for HMOs; other measures stable. (7 improved last year; one declined.)
- Continued variability on scores for specific measures
  - "Intermediate outcome" measures (such as control of blood pressure) show up to 5-fold difference in scores from plan to plan
- Variation across plan types similar to past trends
  - Newer HMOs have lower scores than established HMOs
  - Local PPO performance similar to HMOs
  - Small number of regional PPO (RPPO) plans as reporting entities, but tend to show poorer results

HOS results for most recent two–year period similar to past years

- Health Outcomes Survey results show little change in inter-plan differences from preceding years
- 21 of 268 plans "outliers"—outcomes worse or better than the overall average of expected results
  - No outliers for changes in physical health
  - In mental health, 8 plans better, 13 plans worse than all-plan average

Adjusted CAHPS results similar in MA and FFS

[preliminary results, subject to change]

- **Flu and pneumonia vaccination rates about the same in each sector**
  - Flu 65.5 in MA; 65.8 for FFS
  - Pneumonia 67.0 in MA; 66.0 for FFS
- **Various access to care measures similar: usually or always—**
  - Easy to get an appointment with a specialist (90.2 MA; 91.3 FFS)
  - Get care for an illness as soon as wanted (89.2 MA; 90.3 FFS)
  - Get appointment for routine care as soon as wanted (86.2 MA; 87.8 FFS)

Caution necessary in using CAHPS data to compare MA and FFS

- CAHPS results differ by geography as well as other factors
- CMS displays CAHPS comparisons between MA and FFS at Plan Finder (medicare.gov)
  - Geographic areas do not always match
  - For example, 3-state regional plan, with one CAHPS rate, is compared to 3 FFS results in 3 states

A plan's overall star rating is the average of individual measures

- MA-PD plans have 51 measures (36 Part C; 15 Part D)
- Each measure has a star distribution (1 to 5 stars)
- Overall C/D star rating (1 to 5 with ½ intervals) is average star rating for the 51 measures, with "integration factor"

One-third of current overall star rating based on contract performance measures

Source and distribution of measures that determine overall star rating

Type and source of measures	Measures for Part C rating: Number	Measures for Part C rating: As percent of Part C component	Measures for Part D component of MA-PDs: Number	Measures for Part D component of MA-PDs: As percent of Part D component	Measures for combined Part C and Part D: Number	Measures for combined Part C and Part D: As percent of total
Clinical quality						
HEDIS	15	42%			15	29%
Part D--clinical quality			2	13%	2	4
HOS	6	17			6	12
Patient experience, vaccination rates						
CAHPS	8	22			8	16
Part D--CAHPS			3	20	3	6
Administrative (contract performance)						
Part C	7	**19%**			7	**14%**
Part D			10	**67%**	10	**20%**
Total measures in each set	**36**		**15**		**51**	

Note: Figures may not sum due to rounding
Source: CMS description of star system

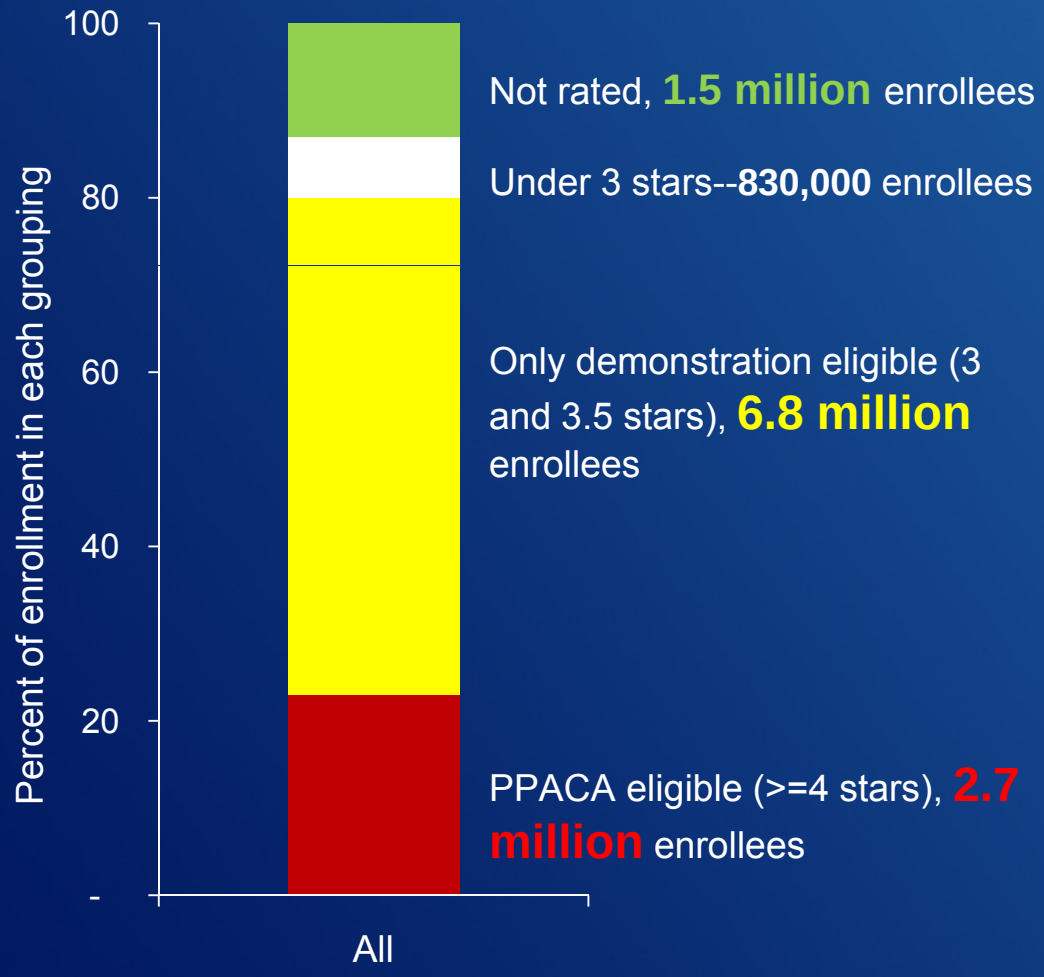
Other factors also increase weight of contract performance measures in overall star rating

- Before 2010, overall plan star rating was Part C only
- Because Part D measures are predominately contract performance measures, the weight of such measures increases in a combined rating system
- Star ratings also given to plans with missing measures
  - Allowance for missing measures can further increase the weight of contract performance measures as a component of the overall star rating

Quality bonus payments to MA plans begin in 2012

- PPACA enacted an MA bonus system based on a 5-star rating system
  - 4- and 5-star plans have benchmarks increased (phased in to maximum of 5%, or 10% in "qualifying counties")
  - Rebate levels reduced from 75% of bid-to-benchmark difference to 70% or 50% based on stars (phased in)
- CMS instead using a program-wide demonstration
  - 3-star ("average") plans, and above, eligible for bonuses 2012-2014
  - Rebate provision unchanged
- Star system is the current system, originally used for consumer information at medicare.gov

Lowering eligibility to 3 stars means plans covering 80% of enrollees eligible for bonuses



- 29% of HMO enrollment and 24% of local PPO enrollment in PPACA bonus plans; with demonstration, total of 88% of enrollees for each plan type in bonus plans
- 1% of PFFS enrollees in PPACA bonus plans; with demonstration, total of 49% of PFFS enrollment in bonus plans
- No RPPO enrollees in bonus plans under PPACA; 48% under demonstration

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Source: CMS enrollment data, November 2010, and CMS plan star data

Issues with use of program-wide demonstration authority for MA quality bonus program

- Not budget-neutral: cost of $1.3 billion compared to PPACA approach
- Questionable as to whether incentives will promote quality improvement more so than PPACA approach
- Demonstration authority intended to test innovations
- Commission has raised similar concerns before with the use of demonstration authority