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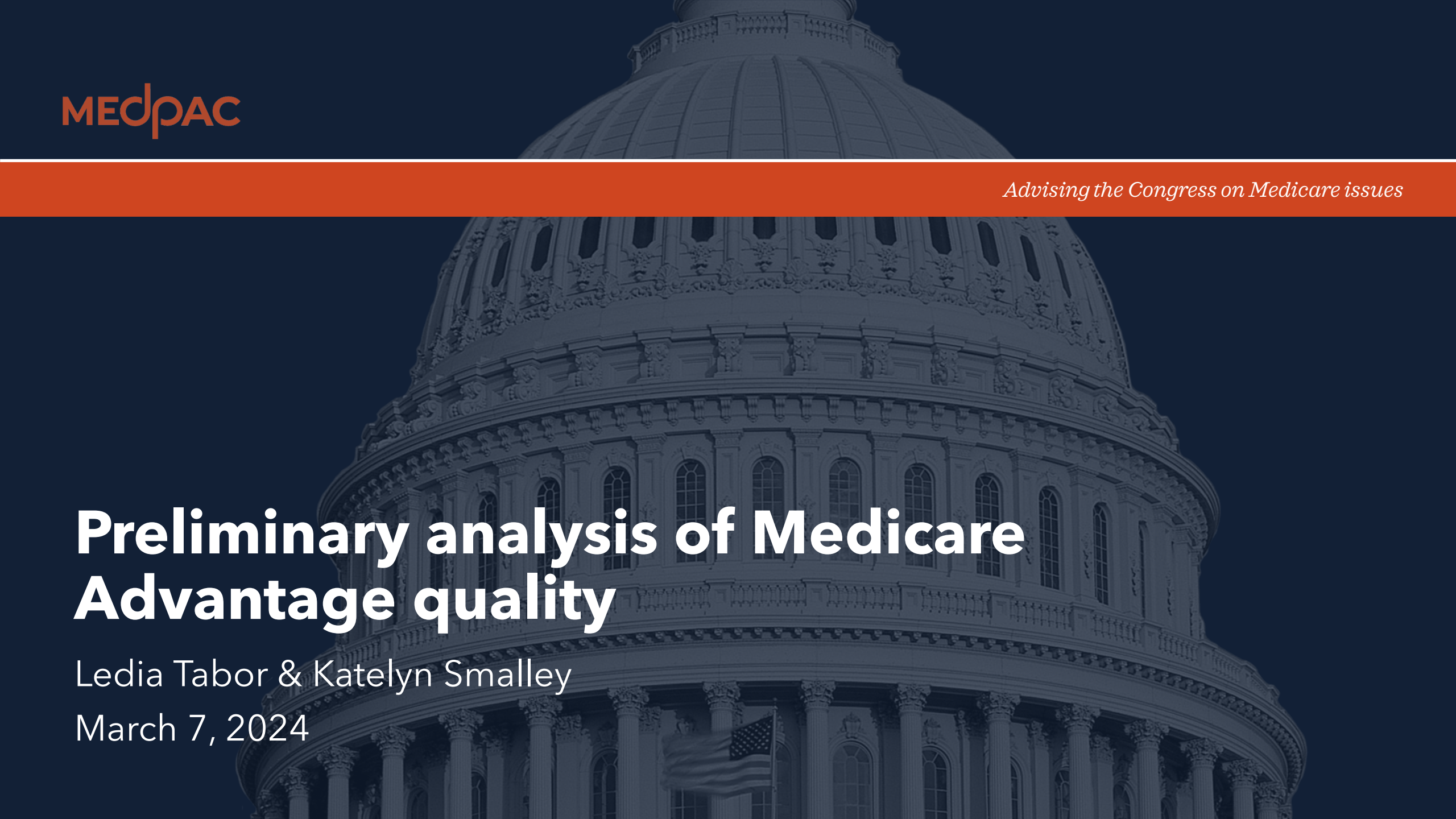

Preliminary analysis of Medicare Advantage quality

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Today's presentation

1. Background on Medicare Advantage (MA) quality
2. Commission's prior recommendations for MA quality
3. Preliminary analysis: Evaluating MA quality using a measure of ambulatory care–sensitive hospitalizations
4. Review of recent literature comparing MA and fee-for-service (FFS) quality
5. Methodological issues with MA and FFS comparisons
6. Discussion

Important to monitor MA quality

- Over half of beneficiaries are enrolled in MA, a model in which plans have greater incentives than FFS providers to deliver efficient care
- Important to monitor MA quality
  - Provide beneficiaries with good information for decision-making
  - Ensure that beneficiaries have access to high-quality health care
  - Reward high quality and drive quality improvement
- However, the Commission has determined that we cannot provide an accurate assessment using CMS's current data

Note: MA (Medicare Advantage).

MA quality is reported at the contract level, which can reflect many diverse health care markets

- Medicare currently uses over 100 MA quality measures
- CMS collects MA quality measure results on a contract-wide basis; CMS uses these results to determine a star rating for all plans under the contract
  - Largest MA contract (with 2.6 million enrollees):
    - Over 1,000 enrollees in each of 46 states
    - Over 20,000 enrollees in each of 30 states
- Commission has recommended that MA quality should be evaluated at the local market-area level (recommended in March 2010 and 2018, June 2020)

Note: MA (Medicare Advantage).

MA quality bonus program costly, not a good basis for judging quality

- The quality bonus program (QBP), which is based on the star ratings, accounts for at least $15 billion in MA payments annually, and it has serious flaws:
  - Large and geographically dispersed contracts
  - Too many measures, some based on small samples
  - Cannot be compared to FFS in local market
- QBP does not promote the use of high-value care, nor provide beneficiaries with meaningful information about local plan quality
- Commission recommended replacing the QBP with a value incentive program that would address its many flaws (June 2020)

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

Limitations in our ability to calculate MA quality at the local market-area level

- Data collected at the contract level
  - Some measures based on administrative data
  - Some measures use medical record data or surveys across a sample of the contract's enrollees
- Unable to validate the completeness of some MA encounter data

Note: MA (Medicare Advantage).

Preliminary analysis: Evaluating MA quality using a measure of ambulatory care–sensitive hospitalizations

Preliminary analysis of MA quality

- Calculated one outcome measure, risk-adjusted ambulatory care–sensitive (ACS) hospitalization rates, based on currently available encounter and administrative data
- Should be used in conjunction with other measures to comprehensively evaluate quality in the MA program
- Plan to do more analysis of MA quality in upcoming cycles

Note: MA (Medicare Advantage).

Risk-adjusted ACS hospitalization rates

- The Commission used the measure in our illustrative modeling of the MA value incentive program (June 2020)
- Population-based outcome measure
- Rates of inpatient and observation stays for certain ACS acute and chronic conditions
  - Takes into account clinical risk factors
- Conceptually, some events could have been prevented with timely, appropriate, high-quality care

Note: ACS (ambulatory care sensitive), MA (Medicare Advantage), FFS (fee-for-service).

ACS hospitalizations: Analytic approach

- Used 2021 MA encounter data supplemented with MA inpatient data reported in the MedPAR file
- Calculated risk-adjusted ACS hospitalization rates for various units of analysis
  - Across market areas *(consistent with the Commission's recommendations)*
  - Within market area (by parent organization)
  - By MA enrollee characteristics
  - By MA organization and plan characteristics

Note: ACS (ambulatory care sensitive), MA (Medicare Advantage), MedPAR (Medicare Provider Analysis and Review).

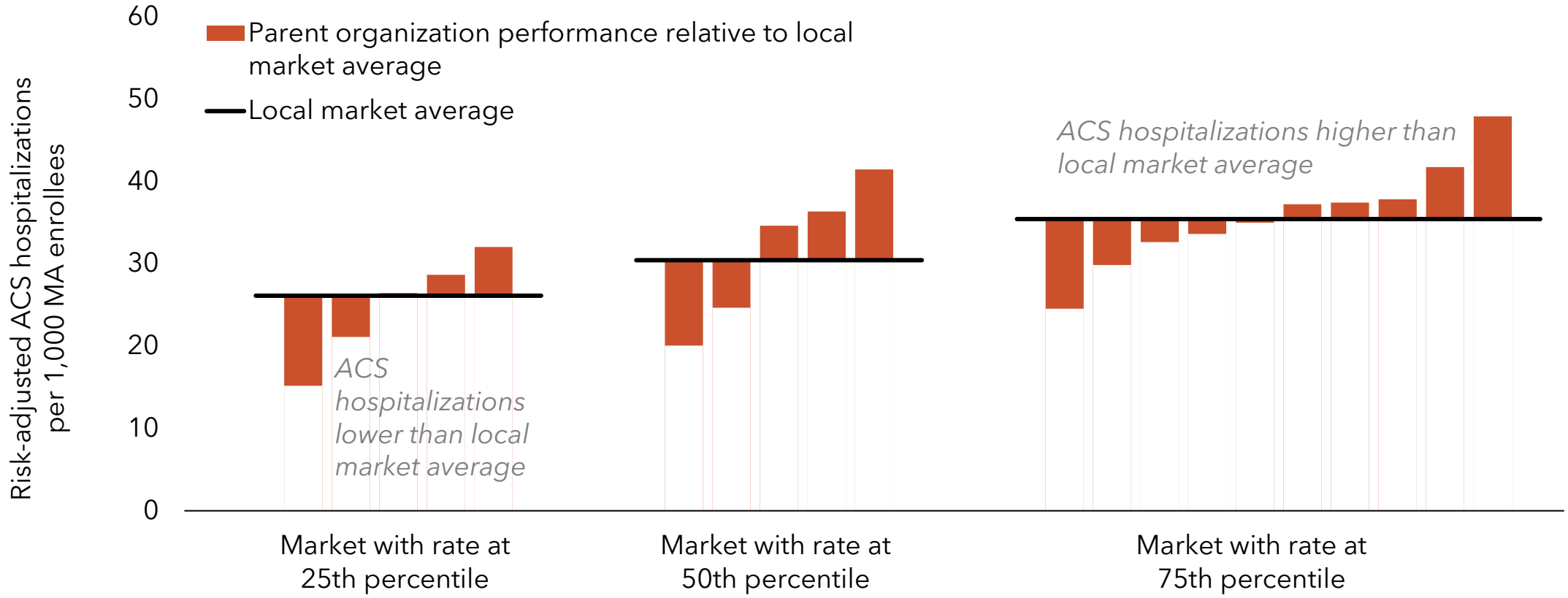
Risk-adjusted rates of ACS hospitalizations for MA enrollees varied across market areas, 2021

Risk-adjusted ACS hospitalization rates per 1,000 MA enrollees					
10th percentile (high performing)	25th percentile	50th percentile	75th percentile	90th percentile (low performing)	Ratio of 90th to 10th
22.4	26.1	30.4	35.4	41.7	**1.9**

Note: ACS (ambulatory care sensitive), MA (Medicare Advantage). Lower rates are better. We calculated the risk-adjusted rates of inpatient admissions and observation stays tied to a set of acute and chronic conditions per 1,000 MA enrollees in MedPAC market areas. Risk adjustment is based on beneficiary-level clinical factors including age, sex, and hierarchical condition categories. There are about 1,200 MedPAC market areas designed to reflect health care markets. The average population of MA enrollees in each market area is about 17,000 enrollees. We excluded any MedPAC market area with fewer than 150 MA enrollees.

Source: MedPAC analysis of 2021 MA encounter and MedPAR data.

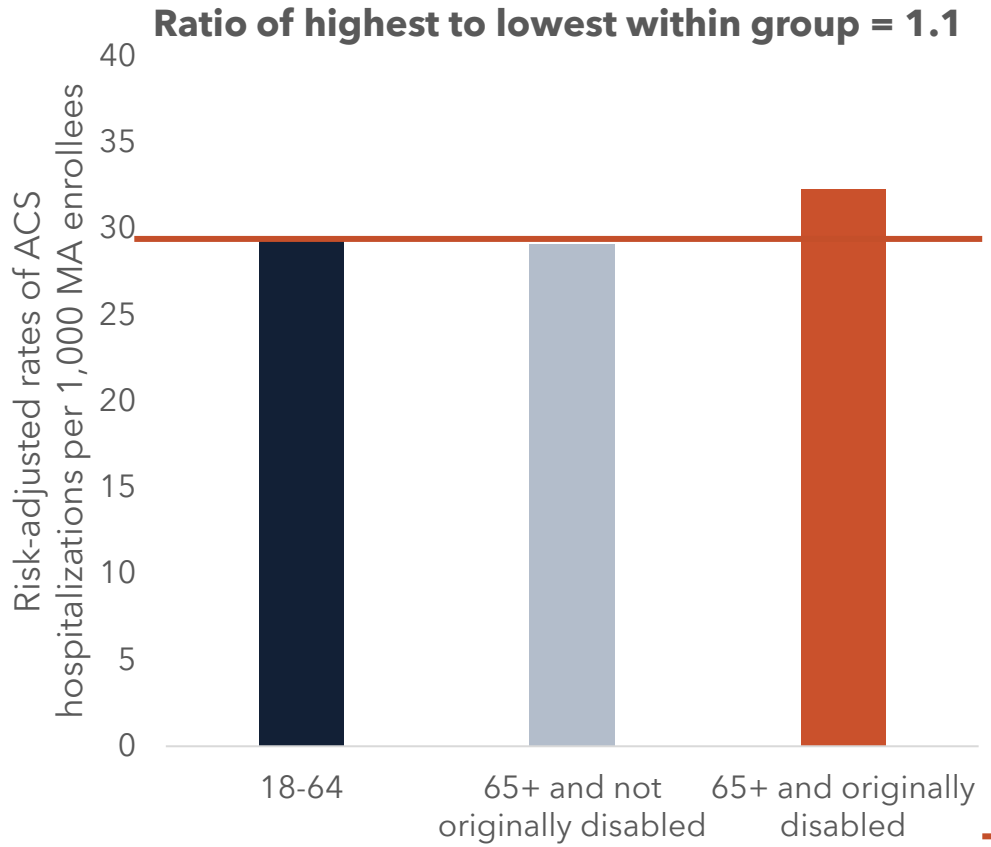
Risk-adjusted rates of ACS hospitalizations for MA organizations varied within market areas, 2021

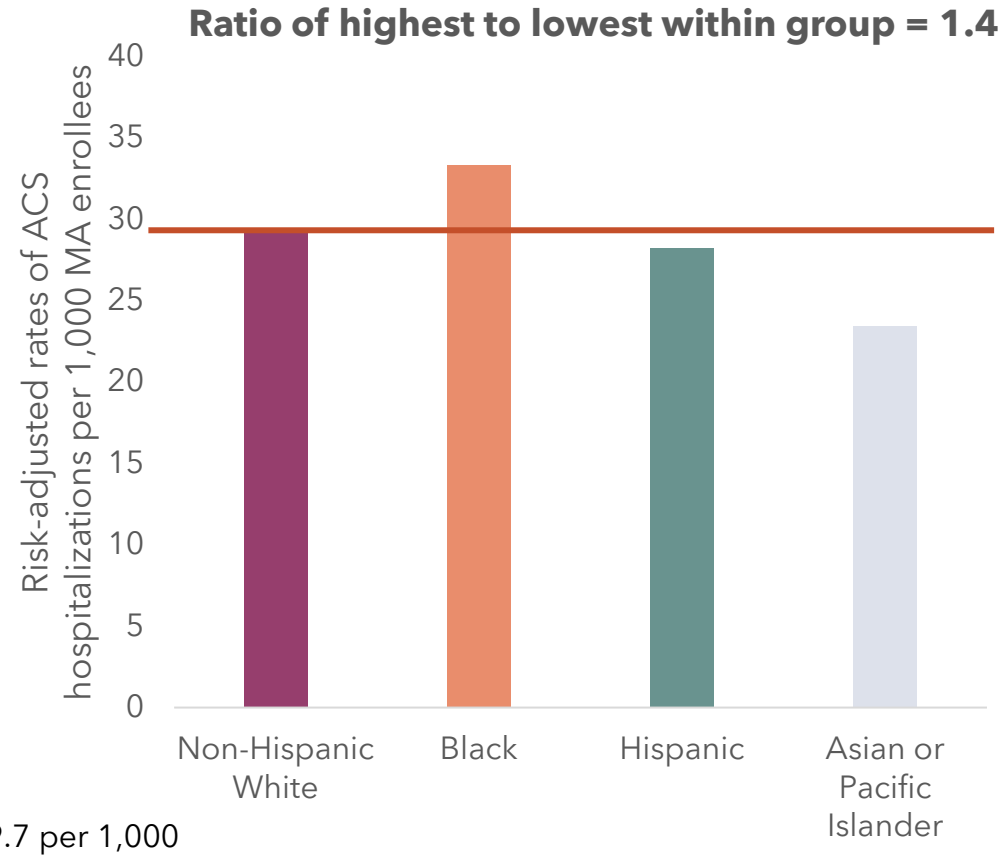


Note: ACS (ambulatory care sensitive), MA (Medicare Advantage). Lower rates are better. We calculated the risk-adjusted rates of inpatient admissions and observation stays tied to a set of acute and chronic conditions per 1,000 MA enrollees in MedPAC market areas. Risk adjustment is based on beneficiary-level clinical factors including age, sex, and hierarchical condition categories. There are about 1,200 MedPAC market areas designed to reflect health care markets, and this figure features the market areas at the 25th, 50th, and 75th percentiles of performance on risk-adjusted ACS hospitalization rates nationally. Parent organizations must have at least 150 eligible MA enrollees to be included in the figure. Enrollment of parent organization in these market areas ranged from 250 to 7,000 eligible MA enrollees.

Source: MedPAC analysis of 2021 MA encounter and MedPAR data.

Risk-adjusted rates of ACS hospitalizations for MA enrollees: Age/eligibility and race/ethnicity, 2021



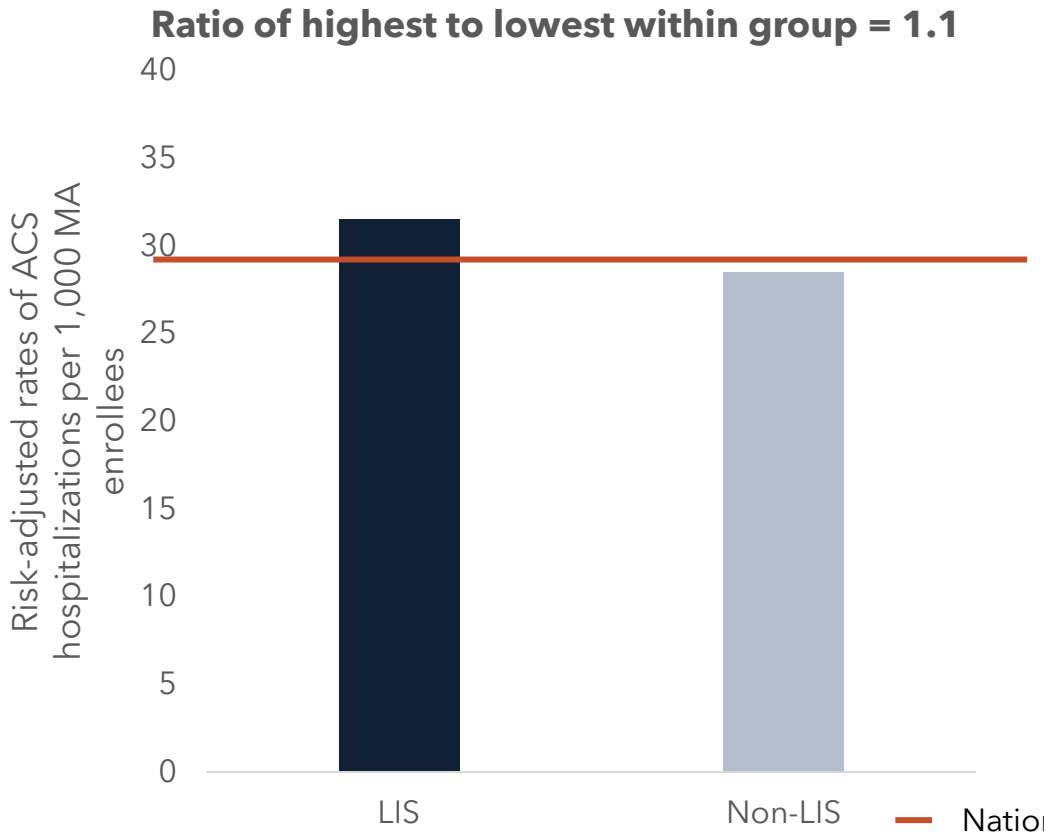


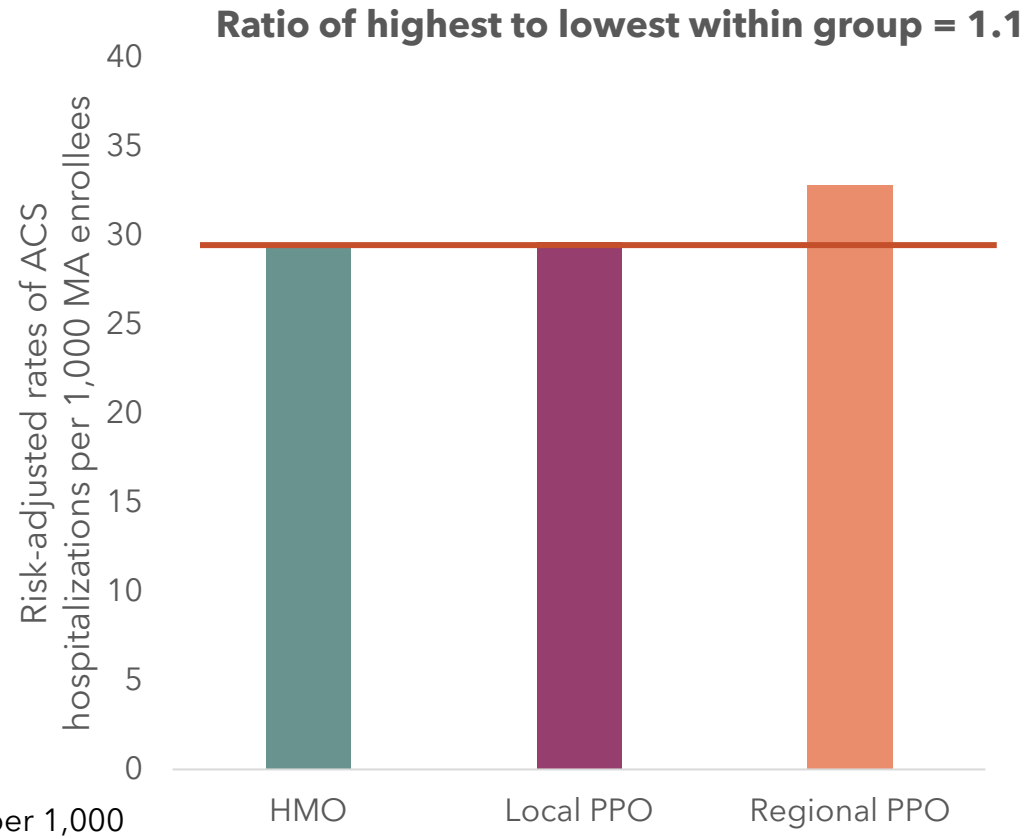
National average = 29.7 per 1,000

Note: ACS (ambulatory care sensitive), MA (Medicare Advantage). Lower rates are better. We calculated the risk-adjusted rates of inpatient admissions and observation stays tied to a set of acute and chronic conditions per 1,000 MA enrollees by groups of enrollees. Risk adjustment is based on beneficiary-level clinical factors including age, sex, and hierarchical condition categories. The ratios are the highest (worst) risk-adjusted ACS hospitalization rate per 1,000 MA enrollees rate divided by the lowest (best).

Source: MedPAC analysis of 2021 MA encounter and MedPAR data.

Risk-adjusted rates of ACS hospitalizations for MA enrollees: Income status and MA plan type, 2021





National average = 29.7 per 1,000

Note: ACS (ambulatory care-sensitive), MA (Medicare Advantage), LIS (low-income subsidy), HMO (health maintenance organization), PPO (preferred provider organization). Lower rates are better. We calculated the risk-adjusted rates of inpatient admissions and observation stays tied to a set of acute and chronic conditions per 1,000 MA enrollees by groups of enrollees. Risk adjustment is based on beneficiary-level clinical factors including age, sex, and hierarchical condition categories. The "LIS" group includes beneficiaries who receive full or partial Medicaid benefits and beneficiaries who do not qualify for Medicaid benefits in their state of residence but receive the Part D LIS, which provides premium and cost-sharing assistance to low-income beneficiaries enrolled in Part D. The ratios are the highest (worst) risk-adjusted ACS hospitalization rate per 1,000 MA enrollees rate divided by the lowest (best).

Source: MedPAC analysis of 2021 MA encounter and MedPAR data.

Risk-adjusted rates of ACS hospitalization for MA enrollees: Little to no difference within some groups

- Urban and rural residence
- Nonprofit and for-profit MA organizations
- Provider-sponsored and non-provider-sponsored organizations
- Restricted-availability plans (SNPs, employer group, conventional)

Note: ACS (ambulatory care sensitive), MA (Medicare Advantage), SNP (special needs plan). Lower risk-adjusted ACS hospitalization rates are better. We calculated the risk-adjusted rates of inpatient admissions and observation stays tied to a set of acute and chronic conditions per 1,000 MA enrollees for each subgroup. Risk adjustment is based on beneficiary-level clinical factors including age, sex, and hierarchical condition categories. The ratios are the highest (worst) risk-adjusted ACS hospitalization rate per 1,000 MA enrollees rate divided by the lowest (best).

Source: MedPAC analysis of 2021 MA encounter, MedPAR data, Managed Markets Insight and Technology Directory of Health Plans.

Comparing quality across MA and FFS

Systematic review of MA and FFS quality comparisons

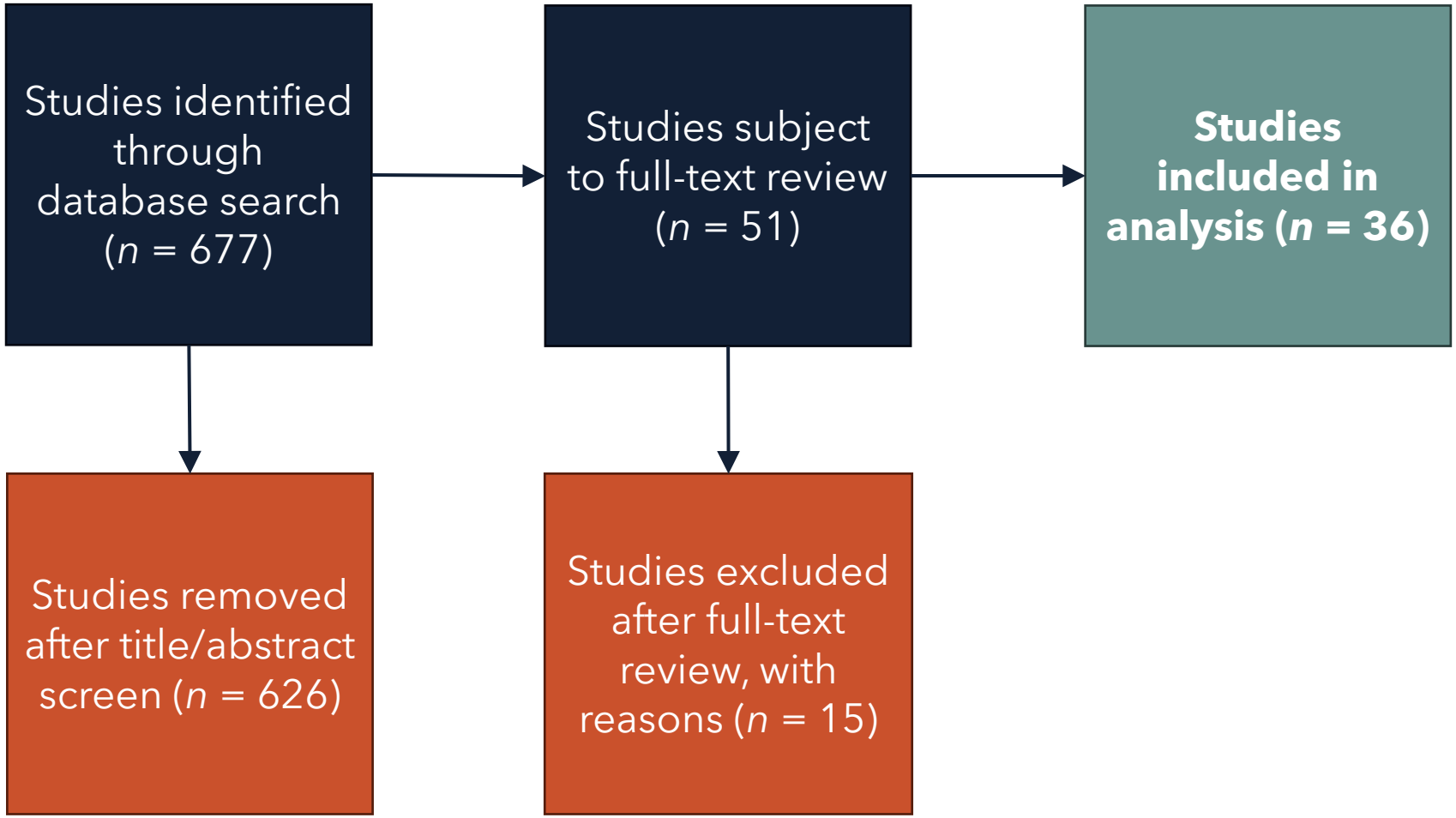
- Accurate and reliable comparisons of the quality of care in MA and FFS are challenging to make but are necessary for:
  - Beneficiary decision-making
  - Program monitoring
- Previously published reviews of quality in MA and FFS found:
  - Wide heterogeneity in study design, population, and research question
  - Mixed findings across a range of quality metrics
- We conducted a systematic literature review of MA and FFS quality comparisons published since 2020 (*n* = 36 studies)

Note: MA (Medicare Advantage), FFS (fee-for-service).
Source: Medicare Payment Advisory Commission 2023; Agarwal, Connolly et al. 2021; DuGoff, Tabak, et al. 2021; Ochieng and Fuglesten Biniek 2022.

Systematic review: Inclusion and exclusion criteria

Criterion	Inclusion	Exclusion
Year	2020–2023	Pre-2020
Publication type	Peer-reviewed academic literature; primary studies	Comment/viewpoint; policy brief; preprint
Participant	Medicare beneficiaries (including dual eligible) over age 65 and studies that include both aged and non-aged Medicare beneficiaries	Studies of Medicare beneficiaries limited to the under-65 population, providers, plan-level analyses
Intervention/ exposure	Enrollment in MA	Enrollment in commercial, employer-sponsored or marketplace plans, Medicaid only, uninsured
Comparator	FFS	Any other comparator, no comparator
Outcome	Quality of care, utilization of health care services (Part C), health outcomes, patient/enrollee experience	Cost, enrollee characteristics, (dis)enrollment, coverage, medication use (Part D), disparities across subgroups
Study design	Quasi-experimental/econometric designs; associational/observational cohort studies	Synthetic design; qualitative study; pilot/feasibility study; case study; randomized control trials of drug, medical procedure, or clinical process; cost-effectiveness analysis; systematic review/meta-analysis

Systematic review: Screening of articles for inclusion



Systematic review: Heterogeneous findings

Study populations

- Participant inclusion criteria varied by:
  - Geography
  - Health status
  - Dual-enrollment status
- MA enrollment criteria also differed:
  - Methods for ascertaining enrollment status
  - Length of enrollment

Quality measures

- Common measure types included:
  - Preventive care
  - Readmissions
  - Mortality
  - Surgical complications
- Several studies reported multiple measures

Data sources

- Studies used a variety of data types:
  - Surveys
  - CMS administrative data
  - State all-payer databases
  - Proprietary data
  - Disease registries
- Some studies linked data from multiple sources, especially to verify enrollment

Results

- Within each measure category, findings were mixed
- In studies reporting multiple outcomes, results did not consistently point to higher performance in one program than the other

Note: MA (Medicare Advantage).
Source: MedPAC analysis of published literature on MA and fee-for-service quality comparisons, 2020–2023.

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Source: MedPAC analysis of published literature on MA and FFS quality comparisons, 2020–2023.

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Source: MedPAC analysis of published literature on MA and FFS quality comparisons, 2020-2023.

Methodological challenges

- All comparisons of MA and FFS face 3 challenges that limit the reliability of findings:
  - Data comparability and completeness
  - Differences in coding intensity (both within MA and between MA and FFS)
  - Favorable selection in MA
- We urge caution in interpreting the findings of studies of this type as a signal of overall higher quality in either MA or FFS

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

Data comparability and completeness

- MedPAC has long been concerned about the completeness and accuracy of MA encounter data
  - Completeness varies by service type
  - Some, but not all, encounters can be supplemented or cross-validated with other data sources (e.g., MedPAR)
- Post-acute care data completeness may vary across MA and FFS
- Implications for accuracy of comparisons of utilization rates
- Triangulation of multiple data sources could reduce risks of bias

Note: MA (Medicare Advantage), MedPAR (Medicare Provider Analysis and Review), FFS (fee-for-service).

Differences in coding intensity

- Medicare's payments to MA plans are adjusted to reflect a beneficiary's expected spending, creating an incentive for MA plans to code more diagnoses than providers in FFS do
- Coding differences can lead to misunderstanding the reasons for observed differences on quality metrics
- Removing diagnoses obtained through HRAs and chart reviews could reduce the impact of coding intensity on quality results

Note: MA (Medicare Advantage), FFS (fee-for-service), HRA (health risk assessment).
Source: Medicare Payment Advisory Commission 2016; Medicare Payment Advisory Commission 2024 (forthcoming).

Favorable selection

- Beneficiaries who choose MA likely differ from those who choose FFS in important ways
  - This creates problems for comparisons between the programs when differences are unobservable and/or poorly understood
- Our June 2023 and March 2024 reports present evidence of favorable selection with respect to spending, but more work needs to be done to understand:
  - The mechanisms of selection in MA
  - Any implications of selection for quality, rather than spending

Note: MA (Medicare Advantage), FFS (fee-for-service).
Source: Medicare Payment Advisory Commission 2023; Medicare Payment Advisory Commission 2024 (forthcoming).

Discussion

- Questions?
- Feedback on these analyses
  - ACS hospitalizations
  - MA and FFS comparison
- Directions for future work on MA quality