

CHAPTER

3

**Update on the Medicare
Advantage program**

R E C O M M E N D A T I O N S

3-1 The Congress should require the Secretary to establish additional, tailored performance measures for special needs plans and evaluate their performance on those measures within three years.

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

3-2 The Secretary should furnish beneficiaries and their counselors with information on special needs plans that compares their benefits, other features, and performance with other Medicare Advantage plans and traditional Medicare.

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

3-3 The Congress should direct the Secretary to require chronic condition special needs plans to serve only beneficiaries with complex chronic conditions that influence many other aspects of health, have a high risk of hospitalization or other significant adverse health outcomes, and require specialized delivery systems.

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

3-4 The Congress should require dual-eligible special needs plans within three years to contract, either directly or indirectly, with states in their service areas to coordinate Medicaid benefits.

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

3-5 The Congress should require special needs plans to enroll at least 95 percent of their members from their target population.

.....
COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 1 • ABSENT 0

3-6 The Congress should eliminate dual-eligible and institutionalized beneficiaries' ability to enroll in Medicare Advantage plans, except special needs plans with state contracts, outside of open enrollment. They should also continue to be able to disenroll and return to fee-for-service at any time during the year.

(Note: This recommendation includes a two-word, technical correction that Commissioners voted on at their January meeting. That vote was 14 yes and 3 absent.)

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

3-7 The Congress should extend the authority for special needs plans that meet the conditions specified in Recommendations 3-1 through 3-6 for three years.

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

Update on the Medicare Advantage program

Chapter summary

The Commission supports private plans in the Medicare program. Medicare beneficiaries should have a choice between the fee-for-service (FFS) Medicare program and the alternative delivery systems that private plans can provide. Private plans may use care management techniques, and—if paid appropriately—they have the incentive to innovate. The Commission supports financial neutrality between payment rates for the FFS program and the Medicare Advantage (MA) program. Financial neutrality means that Medicare should pay the same amount, adjusting for risk, regardless of which option a beneficiary chooses. Neutrality is important to spur efficiency and innovation.

Looking at the MA program, we find that:

- At the end of 2007, about 20 percent of Medicare beneficiaries were enrolled in MA plans. All beneficiaries have access to an MA plan in 2008, with an average of 35 plans available in each county. In 2008, 85 percent of Medicare beneficiaries have a local HMO or preferred provider organization plan in their county and

In this chapter

- Update on MA plan enrollment, availability, and payment
- Medicare Advantage plan performance on quality measures
- Special needs plans

all beneficiaries have a private fee-for-service (PFFS) plan available. Enrollment data show rapid growth in private plans, but it comes mostly from two types of plans of concern to us—PFFS plans and special needs plans (SNPs).

- For 2008, MA plan bids for traditional Medicare services relative to Medicare FFS spending increased over the ratio we found for 2006, and costs for MA plans continue to exceed Medicare FFS expenditures. This added cost contributes to the worsening long-range financial sustainability of the Medicare program. MA payments are projected to be 113 percent of FFS expenditures for 2008. The MA program is now less efficient than the traditional program. That is, plan bids for the traditional Medicare benefit package are projected at 101 percent of FFS, while they were at 99 percent of FFS in 2006. However, one plan type—HMOs—continues to bid below FFS, with bids projected at 99 percent of FFS in 2008. Although we are comparing plans with FFS, the Commission does not view traditional FFS as a reasonable standard of efficiency. Indeed, many of the Commission’s past recommendations are designed to address flaws in FFS.
- Some quality measures show disappointing results. Commercial and Medicaid plans improved more in clinical measures over the past year than Medicare plans. New plans in Medicare—those entering the program in 2004 or later—show poorer performance than older plans on clinical indicators of quality. However, MA plans, including new plans, have high enrollee satisfaction.

We are concerned about the lack of comparable quality indicators for Medicare beneficiaries in the traditional Medicare FFS program, in particular the survey that measures changes in the health status of FFS beneficiaries. We also discuss the absence of quality measures for certain types of MA plans. Data on the health care MA plans provide are also lacking. These data would be useful for monitoring and learning from the MA program.

SNPs, created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, were designed to serve Medicare beneficiaries with special needs. These plans are allowed to limit enrollment to specific categories of beneficiaries. Recent legislation extended SNPs for another year, but a moratorium was imposed that prevents the formation of new plans or the expansion of current plans. The Commission has concluded that SNPs require further study to determine whether they provide value to the program. We recommend ways to improve SNPs as they continue to be evaluated. The current rule allowing dual-eligible beneficiaries to change plans each month has contributed to marketing abuses. Therefore, we recommend a change in enrollment rules so that beneficiaries may enroll in an MA plan only during the annual open enrollment and during defined special election periods.

SNPs must collect and report general MA plan quality measures, which are not designed to ensure that SNPs provide specialized care for their targeted populations. New and existing measures should form the basis for a rigorous evaluation to help inform a future decision about whether SNPs should become a permanent MA option.

The Congress should require the Secretary to establish additional, tailored performance measures for special needs plans and evaluate their performance on those measures within three years.

Recommendation 3-1

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

A lack of clear information is an impediment to beneficiaries' learning about and making an informed decision about joining a SNP, as well as to policymakers' ability to judge what benefits SNPs provide.

The Secretary should furnish beneficiaries and their counselors with information on special needs plans that compares their benefits, other features, and performance with other Medicare Advantage plans and traditional Medicare.

Recommendation 3-2

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

CMS has not explicitly defined which chronic conditions are appropriate for SNPs to target. Not all chronic condition SNPs are sufficiently specialized to

warrant targeted delivery systems and disease management strategies and the unique ability to limit enrollment to certain beneficiaries.

Recommendation 3-3

COMMISSIONER VOTES:

YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

The Congress should direct the Secretary to require chronic condition special needs plans to serve only beneficiaries with complex chronic conditions that influence many other aspects of health, have a high risk of hospitalization or other significant adverse health outcomes, and require specialized delivery systems.

Although they were intended to coordinate Medicare and Medicaid, dual-eligible SNPs are not required to coordinate benefits with Medicaid programs, and many operate without state contracts. Without a contract with states to cover Medicaid benefits, it is unclear that a dual-eligible SNP is different from a regular MA plan.

Recommendation 3-4

COMMISSIONER VOTES:

YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

The Congress should require dual-eligible special needs plans within three years to contract, either directly or indirectly, with states in their service areas to coordinate Medicaid benefits.

SNPs may apply to CMS for a waiver to enroll a disproportionate share of their targeted population. This means that the target population in the plan must be greater than the percentage that occurs nationally in the Medicare population. SNPs with waivers can select among enrollees who fall outside targeted populations based on unknown criteria.

Recommendation 3-5

COMMISSIONER VOTES:

YES 16 • NO 0 • NOT VOTING 1 • ABSENT 0

The Congress should require special needs plans to enroll at least 95 percent of their members from their target population.

Dual-eligible and institutionalized Medicare beneficiaries can enroll and disenroll from MA plans monthly. The provision may contribute to plan marketing abuses. This recommendation would still allow dual-eligible and

institutionalized beneficiaries to change plans during the open enrollment period and during special election periods triggered by life events, and to disenroll from a bad plan at any time.

Recommendation 3-6

The Congress should eliminate dual-eligible and institutionalized beneficiaries' ability to enroll in Medicare Advantage plans, except special needs plans with state contracts, outside of open enrollment. They should also continue to be able to disenroll and return to fee-for-service at any time during the year.

(Note: This recommendation includes a two-word, technical correction that Commissioners voted on at their January meeting. That vote was 14 yes and 3 absent.)

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

SNPs' authority to limit enrollment will expire December 2009. In light of SNPs' rapid growth in number and enrollment, we call for a rigorous evaluation to inform our decision about recommending them as a permanent MA option. ■

Recommendation 3-7

The Congress should extend the authority for special needs plans that meet the conditions specified in Recommendations 3-1 through 3-6 for three years.

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

Update on MA plan enrollment, availability, and payment

The Medicare Advantage (MA) program allows Medicare beneficiaries to receive Medicare benefits from private plans rather than from the traditional fee-for-service (FFS) program. MA enrollees may receive additional benefits beyond those offered under traditional Medicare. Medicare finances these additional benefits in most cases, though in some cases enrollees pay additional premiums for the extra benefits. Medicare pays plans a capitated rate for the 20 percent of beneficiaries enrolled in MA plans at the end of 2007.

Over the past year, the Commission has monitored the MA program as enrollment in private plans expands, new organizations enter the Medicare market, and different types of MA options gain market share. The Commission's earlier recommendations to the Congress on MA and the new recommendations in this chapter concerning special needs plans (SNPs) generally seek to promote an efficient, high-quality private health plan option in Medicare.

The Commission supports private plans in the Medicare program. Beneficiaries should be able to choose between the FFS Medicare program and the alternative delivery systems that private plans can provide. Private plans may use care management techniques, and—if paid appropriately—they have the incentive to innovate.

However, the Commission also supports financial neutrality between payment rates for the FFS program and the MA program. Financial neutrality means that the Medicare program should pay the same amount regardless of which Medicare option a beneficiary chooses. Neutrality is important to restore the original goal of having private plans in Medicare: to stimulate efficiency and innovation. Currently, the MA system increases government outlays and beneficiary premiums (including those who elect to remain in traditional Medicare) at a time when Medicare is under increasing financial stress.

This chapter contains several new recommendations for improving the program, and we reiterate our past recommendations. We are particularly concerned about private fee-for-service (PFFS) plans and SNPs. Our concerns with regard to SNPs are discussed in detail at the end of this chapter. Our concerns with PFFS plans arise because they are not coordinated care plans and do not operate on a level playing field with other plan types. They are the plan type with the highest enrollment growth since

2005. With one minor exception (a plan that has a hospital network), PFFS plans do not have provider networks, and they pay providers at Medicare rates—that is, they operate like traditional FFS. However, they are less efficient than the traditional FFS program; they bid 8 percent higher than FFS for the same benefit package. PFFS plans have fewer program requirements than coordinated care plans; the law exempts them from the quality reporting requirements applicable to other plan types. An additional concern is that PFFS plans and their brokers have been responsible for a large portion of the marketing abuses in the MA program, which have resulted in sanctions and fines from the Centers for Medicare & Medicaid Services (CMS), including a moratorium on marketing and sanctions and fines on brokers by the states (U.S. House of Representatives 2007).

Plan types

The MA program includes several plan types. CMS calls HMOs and preferred provider organizations (PPOs) coordinated care plans (CCPs), which have provider networks and various tools to coordinate and manage care. CMS divides PPOs into two categories—local and regional. Local PPOs can serve individual counties (as can HMOs), while regional PPOs are required to serve and offer a uniform benefit package across regions made up of one or more states. Local PPOs must meet more extensive network requirements than regional PPOs. The MA program also includes PFFS plans (and plans tied to medical savings accounts (MSAs)), which do not typically have provider networks and so have less ability to coordinate care.

Within a plan type, we sometimes make further distinctions. SNPs, described in detail later in this chapter, are also CCPs. All enrollment, bidding, and payment statistics presented in this chapter regarding CCPs include SNPs. We also sometimes distinguish employer-only plans, which are available only to employer or union groups and not to individual beneficiaries. The employer-only plans may be any plan type, and our statistics (except for the availability statistics because these plans are not available to all beneficiaries) include them.

Plan enrollment in 2007

Enrollment in MA plans grew by 18 percent, or 1.4 million enrollees, from November 2006 to November 2007 (Table 3-1, p. 244). Almost 9 million beneficiaries are now enrolled in private plans, comprising 20 percent of all Medicare beneficiaries.

**TABLE
3-1****Medicare Advantage enrollment has grown rapidly**

| | MA enrollment (in millions) | | Percent change | MA penetration, November 2007 |
|-----------|-----------------------------|---------------|----------------|-------------------------------|
| | November 2006 | November 2007 | | |
| Total | 7.5 | 8.9 | 18% | 20% |
| Plan type | | | | |
| CCP | 6.7 | 7.2 | 8 | 16 |
| PFFS | 0.8 | 1.7 | 101 | 4 |
| Rural | 0.8 | 1.2 | 44 | 11 |
| Urban | 6.7 | 7.7 | 15 | 23 |

Note: MA (Medicare Advantage), CCP (coordinated care plan), PFFS (private fee-for-service). Penetration is the percentage of all Medicare beneficiaries who are enrolled in plans. For rural and urban areas, the table shows the percentage of beneficiaries living in these areas who are enrolled in plans. CCPs include special needs plans; all categories include employer-only plans. Totals include about 400,000 enrollees in cost-reimbursed plans that are not MA plans. Totals may not sum due to rounding.

Source: MedPAC analysis of CMS enrollment files.

Enrollment patterns still differ in urban and rural areas. Between 2006 and 2007, plan enrollment grew about 44 percent in rural areas and about 15 percent in urban areas. Despite the strong enrollment growth in rural areas, about 23 percent of Medicare beneficiaries in urban counties and about 11 percent of rural beneficiaries are in MA plans.

While PFFS plans account for only 19 percent of MA plan enrollment, they accounted for about 60 percent of total enrollment growth from 2006 to 2007. There are now about 1.7 million PFFS enrollees (about 4 percent of all Medicare beneficiaries), more than doubling in the past year, and increasing by more than eightfold since December 2005 (not shown in table). Growth in enrollment in CCPs was a more modest 8 percent, or about a half million enrollees in the past year.

Rural enrollees are increasingly more likely to be in PFFS plans. More than half of rural plan enrollees are in PFFS plans (not shown in table), while only about 14 percent of urban enrollees are in PFFS plans. About 80 percent of the year's growth in rural enrollment was due to increased enrollment in PFFS plans.

For many CCP sponsors, the enrollment distribution has shifted to plans open only to employer groups and to SNPs. Total enrollment in CCPs that are open to all Medicare beneficiaries has remained flat over the last year. As of November 2007, a million enrollees are in SNPs and another million are in employer-only CCPs (300,000 are in employer-only PFFS plans).

Plan availability for 2008

Medicare beneficiaries will have more plans to choose from in 2008. Private plan alternatives to the FFS Medicare program are available to all beneficiaries, as has been the case since 2006 (Table 3-2). Despite relatively slower enrollment growth in the local CCP plans, more of these plans will be available in 2008. Eighty-five percent of Medicare beneficiaries will have a local HMO or PPO plan operating in their county of residence, up from 82 percent in 2007 and 67 percent in 2005. (Separately, 80 percent of beneficiaries will have an HMO available and 64 percent will have a local PPO available in 2008, up from 76 percent and 62 percent, respectively, in 2007.) PFFS plan availability increased in 2007 to virtually 100 percent of beneficiaries, and that situation continues into 2008.

Overall access to CCPs (not shown in table) will remain at 99 percent of beneficiaries in 2008, up from 98 percent in 2006. Access to regional PPOs remains unchanged from 2006 and 2007.

High-deductible plans linked to MSAs will be available to all Medicare beneficiaries outside Puerto Rico in 2008. MSAs were available for the first time in 2007 and they were in 38 states and the District of Columbia (77 percent of beneficiaries). In 2007, about 2,000 beneficiaries were enrolled in MSA plans. (See p. 250 of MedPAC's March 2007 report for a more detailed description of MSA plans (MedPAC 2007).)

**TABLE
3-2**

Access to Medicare Advantage plans remains high

| Type of plan | 2005 | 2006 | 2007 | 2008 |
|------------------------------------------------------------------|------|------|------|------|
| All | 84% | 100% | 100% | 100% |
| CCP | | | | |
| Local HMO or PPO | 67 | 80 | 82 | 85 |
| Regional PPO | N/A | 87 | 87 | 87 |
| Other plans | | | | |
| PFFS | 45 | 80 | 100 | 100 |
| MSA | 0 | 0 | 77 | 100 |
| Zero-premium plans with Part D | N/A | 73 | 86 | 88 |
| Average number of MA plans open to all beneficiaries in a county | 5 | 12 | 20 | 35 |

Note: CCP (coordinated care plan), PPO (preferred provider organization), N/A (not applicable), PFFS (private fee-for-service), MSA (medical savings account), MA (Medicare Advantage). Excludes special needs plans and employer-only plans. Regional PPOs were created in 2006.

Source: MedPAC analysis of MA/special needs plan landscape file. http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/01_Overview/Downloads/MA_SNP_Source_2008.zip.

Beneficiaries will have many more plan options to choose from in 2008 than in the past. Excluding SNPs and employer-only plans, an average of 35 plan options are offered in each county in 2008, compared with 20 plan options in 2007. The growth in the number of PFFS offerings accounts for the bulk of the increase. PFFS plans now account for more than three-quarters of all plan options open to all Medicare beneficiaries (not counting SNPs and employer-only plans that are open to only a subset of beneficiaries).

For 2008, the share of Medicare beneficiaries living in an area with a SNP will increase to 95 percent, up from 76 percent in 2007. The percentages of beneficiaries in SNP service areas are: 77 percent for dual-eligible, 54 percent for institutional, and 89 percent for chronic condition SNPs.

Access to plans with extra benefits has increased. In 2008, 88 percent of Medicare beneficiaries have access to at least one MA plan that includes Part D coverage and has no premium (beyond the Medicare Part B premium) for the combined coverage (and no additional premium for non-Medicare-covered benefits included in the benefit package), compared with 86 percent in 2006.

Determining Medicare payment for MA plans

Since 2006, plan bids have partially determined the Medicare payments they receive. Plans bid to offer Part

A and Part B coverage (Part D coverage is handled separately) to Medicare beneficiaries. The bid discussed here covers an average beneficiary with respect to health spending and includes plan administrative cost and profit. CMS bases the Medicare payment for a private plan on the relationship between its bid and benchmark.

The benchmark is an administratively determined bidding target. Legislation in 1997 established benchmarks in each county, which included a floor—a minimum amount below which no county benchmarks could go. By design, the floor rate exceeded FFS spending in many counties. It was established to attract plans to areas (mostly rural) with lower-than-average FFS spending. Legislation in 2000 established a second, higher “urban” floor, which applied only to counties in metropolitan areas with more than 250,000 residents. Also, no benchmark can be below per capita FFS spending in a county.

If a plan’s bid is above the benchmark, then the plan receives the benchmark and enrollees have to pay an additional premium that equals the difference. If a plan’s bid falls below the benchmark, the plan receives its bid. Plans that bid below the benchmark also receive payment from Medicare in the form of a “rebate,” defined by law as 75 percent of the difference between the plan’s bid and its benchmark. The plan must then return the rebate to its enrollees in the form of supplemental benefits, lower cost sharing, or lower premiums.

A more detailed description of the MA program payment system can be found on MedPAC's website: http://www.medpac.gov/documents/MedPAC_Payment_Basics_07_MA.pdf.

Payments to plans in 2008 and comparison with Medicare FFS spending

The Commission supports financial neutrality between payment rates for the FFS and the MA programs. Financial neutrality means that the Medicare program should pay the same amount, adjusting for the risk status of each beneficiary, regardless of which Medicare option a beneficiary chooses. Numerically, that means plans should be paid 100 percent of FFS spending, after adjusting for risk. Our analysis of plan benchmarks and MA payment levels shows that benchmarks and MA program payments continue to be well above FFS expenditures.

In our March 2007 Report to the Congress, the Commission found that 2006 program payments to MA plans were 112 percent of spending in Medicare's traditional FFS program (MedPAC 2007). The report also noted that MA benchmarks were 116 percent of FFS expenditures. In this section, we update the earlier analysis with new enrollment data for 2007, the 2008 benchmarks, and the 2008 plan bids. The new analysis shows similar, although higher, results, with MA payments projected at 113 percent of FFS spending and benchmarks at 118 percent of FFS spending (Table 3-3).¹ That means the Medicare program is paying about \$10 billion more for the 20 percent of beneficiaries enrolled in MA plans than if they remained in FFS Medicare.

We present some of the data with and without results for plans in Puerto Rico, where the MA market has some unusual characteristics. The statute set benchmarks in Puerto Rico effectively at 180 percent of FFS expenditures. Traditionally, we have reported our MA analyses including Puerto Rico; however, excluding Puerto Rico from the overall statistics in the updated analysis results in benchmarks of 116 percent (rather than 118 percent) of FFS and puts MA payments at 112 percent (rather than 113 percent) of FFS.²

The ratio of payments relative to FFS spending varies by the type of MA plan. While we have grouped HMOs and local (not regional) PPOs together into the local CCP category for enrollment and availability analyses, we report them separately for the bidding and payment analyses because they exhibit different bidding behavior. We also look at SNPs and employer-only plans, because

their bidding behavior differs from that of other types of plans.

Benchmarks differ from the overall average of 118 percent when plans draw enrollment from areas with higher or lower benchmarks, relative to FFS, than the average. Local PPOs draw more heavily (not shown in table) from urban floor counties (55 percent of their enrollment vs. 40 percent of all MA enrollees), and PFFS plans draw more heavily from rural floor counties (31 percent of PFFS enrollment vs. 10 percent of all MA enrollees).³ Therefore, local PPOs and PFFS plans have higher average benchmarks compared with FFS than other plan types.

We estimate that HMOs bid an average of 99 percent of FFS spending, while bids from other plan types average at least 103 percent of FFS spending. These bids, combined with benchmarks well above FFS, produce payments to plans that are well above FFS spending. These numbers suggest that HMOs can provide the same services for less than FFS and other plan types tend to charge more. HMOs have increased their bids from 97 percent of FFS in 2006 to 99 percent in 2008. Only PFFS plans have reduced their bids relative to FFS compared with 2006, probably because PFFS plans have expanded and are now available in all areas. As they expand, they draw enrollment from counties with benchmarks that are closer to FFS, so their bids are closer to FFS.

We project 2008 payment to plans will average 113 percent of FFS spending. HMOs and regional PPO payments are estimated to be 112 percent of FFS, while payments to PFFS and local PPOs will average at least 117 percent. These payment ratios are two points higher than we estimated for 2006, except for the PFFS plan ratio, which is two points lower.

While, on average, SNPs bid below FFS spending, payments to SNPs average 115 percent of FFS spending. It is most appropriate to compare the SNP numbers with those for HMOs, because 90 percent of SNP enrollees are in SNP HMOs. We also report SNPs with and without Puerto Rico because almost one-quarter of all 2007 SNP enrollees lived in Puerto Rico. Average SNP benchmarks, without Puerto Rico, are projected at 114 percent rather than 121 percent; SNP program payment levels would have been projected at 109 percent rather than 115 percent of FFS if Puerto Rico had been excluded. With or without Puerto Rico, SNPs bid lower relative to FFS than any other group of plans, partly because of the relatively low benchmark-to-FFS ratios of the areas outside of Puerto Rico where they tend to draw enrollment.

**TABLE
3-3**

Benchmarks, bids, and payments relative to FFS, by plan type for 2008

| | Enrollment November 2007 (in millions) | Payments relative to FFS expenditures, 2006 | Payments relative to FFS expenditures, 2008 | Bids relative to FFS expenditures, 2008 | Benchmarks relative to FFS expenditures, 2008 |
|-------------------------|-----------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------------------------|--------------------------------------------------------|------------------------------------------------------------------|
| All MA plans with bids | | | | | |
| Including Puerto Rico | 8.0 | 112% | 113% | 101% | 118% |
| Excluding Puerto Rico | 7.6 | 111 | 112 | 100 | 116 |
| Plan type | | | | | |
| HMO | 5.9 | 110 | 112 | 99 | 117 |
| Local PPO | 0.4 | 117 | 119 | 108 | 122 |
| Regional PPO | 0.2 | 110 | 112 | 103 | 115 |
| PFFS | 1.4 | 119 | 117 | 108 | 120 |
| SNP | | | | | |
| Including Puerto Rico | 1.0 | 118 | 115 | 97 | 121 |
| Excluding Puerto Rico | 0.8 | 111 | 109 | 94 | 114 |
| Beneficiary eligibility | | | | | |
| All in service areas | 6.7 | 112 | 113 | 99 | 118 |
| Employer groups only | 1.3 | 114 | 116 | 108 | 118 |

Note: FFS (fee-for-service), MA (Medicare Advantage), PPO (preferred provider organization), PFFS (private fee-for-service), SNP (special needs plan). Enrollment includes only plans that submitted a bid for 2008 and had the same plan ID in 2007. Benchmarks are the maximum Medicare program payments for MA plans.

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

Employer-only plans tended to bid higher (108 percent) than other plans and their payments averaged 116 percent of FFS spending. Although they are not displayed, we examined employer-only plans within each plan type and found that they consistently bid higher than plans open to all Medicare beneficiaries. Because these plans do not have to market to individuals, the Medicare bids may not be as competitive. Employer-only plans can negotiate with employers after the Medicare bidding process is complete, which may result in some employer costs being shifted into the Medicare bid and payment. An alternative explanation for the higher bids is that the retiree population has higher costs. Regardless of the cause for the higher bids, excluding the employer-only plans from our calculations would move the average MA bid down to 99 percent of FFS. We intend to investigate employer-only plans further.

Beginning in 2007, almost all MA plan payments were fully risk adjusted, after a lengthy phase-in. The transition to full risk adjustment may affect the bidding behavior of some plan types. SNPs expect to enroll less healthy people

than average and employer-only plans expect to enroll healthier people on average (as one might expect given the target populations). Plans are paid more for less healthy enrollees, and if plans can successfully manage care, they should be able to lower costs for these enrollees more than for healthy beneficiaries. The opposite may be true of employer-only plans. What plans do to manage care and how effective they are is unknown. In future work, we would like to investigate the relationship between risk adjustment and bidding behavior.

To examine plans' relative costs for different types of enrollees, we need to see plan data that include service use. Plans now submit only diagnosis data for the risk adjustment process and no longer provide encounter data to CMS that detail the services provided to each enrollee. (Under a prior risk-adjustment system, plans submitted inpatient hospital encounter data.) If CMS collected encounter data, it would help explain plans' relative costs for different types of enrollees and help determine best practices that other plans or the FFS system might want to adopt. It may also inform questions about the relationship

between Part D offerings and the use of other health services.

Efficiency in Medicare Advantage and extra benefits

Ideally, efficient plans can provide extra benefits. If a private plan used savings from covering hospital and physician care to provide low cost sharing or extra benefits, it would attract enrollees. Extra benefits could include reduced out-of-pocket costs and coverage of services not covered by Medicare, such as dental, hearing, and vision services and (most importantly before the advent of Part D) outpatient prescription drugs. Having plans compete with each other based on furnishing hospital and physician care at low cost and high quality would promote efficiency. In a system in which plan payments are appropriately risk-adjusted, a richer benefit package would generally signal that one plan was more efficient than a competing plan—and that a private plan offering extra benefits was more efficient than the traditional Medicare FFS program in the plan's market area.

We want to be clear that even though we use the FFS Medicare spending level as a measure of parity for the MA program, this should not be taken as a conclusion that the Commission believes that FFS Medicare is an efficient delivery system in most markets. In fact, much of our work is devoted to identifying inefficiencies in FFS Medicare and suggesting improvements in the program. However, good policy might argue that coordinated care systems found in many MA plans should always be able to be as efficient as FFS Medicare and in most cases should be more efficient. We would also like to note that some level of inefficiency is built into benchmarks based on FFS spending.

Our analysis finds that some plans are able to cover the same services in the traditional Medicare Part A and Part B benefit at a lower cost. As shown in Table 3-3 (p. 247), on average for 2008, HMO plans cover the same services for 99 percent of Medicare FFS expenditures. However, some plan types were much less efficient; for example, PFFS plan bids averaged 108 percent of FFS expenditures. Note that Medicare payments are higher than these bids because of the payment formula mentioned earlier.

Paying a plan more than FFS spending for delivering the same services is not an efficient use of Medicare funds, particularly if the payments do not result in improved quality of care. We are concerned that the average MA bid

for Medicare Part A and Part B services is above average FFS spending. This means that, on average, all extra services by the plan are funded by the Medicare program and not by plan efficiencies. In addition, a significant portion of the value of the extra benefits goes to fund plan administration and profits and not to services for beneficiaries.

The MA program as currently structured does not ensure that any added benefits are delivered as efficiently as possible. Many MA plans have demonstrably higher costs than traditional Medicare. Moreover, increasing MA payments in low-cost areas does little to reward the providers responsible for keeping down costs in those areas. A better approach would be to reward providers in low-cost areas through the FFS payment structure—or better yet, through innovative new payment systems.

The effects of high benchmarks

The Commission supports financial neutrality between payments in the traditional FFS program and MA program payments. Expressed in terms of the level of benchmarks for MA plans in the current bidding system, financial neutrality would mean that benchmarks should be set at 100 percent of Medicare FFS expenditures, as the Commission recommended. The Commission also recommended that the 25 percent difference between the benchmark amount and bids below 100 percent of the benchmark that is currently retained in the Trust Funds should be used to fund a pay-for-performance program in MA to spur improvements in quality.

Payment policy is a powerful signal of what we value. The original conception (in the 1980s) for private plans in Medicare was that private plans would be a mechanism for introducing innovation into the program while saving money for Medicare (they were paid 95 percent of FFS). To compete effectively with Medicare, private plans would be compelled to do things that traditional Medicare found difficult or that would be difficult to impose on all beneficiaries and providers—for example, selective contracting with efficient providers and effective management and coordination of care. By increasing payment to levels significantly above traditional Medicare, we have changed the signal we are sending to the market: Instead of efficiency-enhancing innovation, we are getting plans (private FFS) that are much like traditional Medicare, except at a higher cost.

The growth in less efficient plans heightens our concerns about equity issues that arise with MA vis-à-

vis the traditional Medicare program, about equity for beneficiaries and taxpayers, and about ensuring a level playing field among the different types of MA plans. The equity and efficiency issues are of particular concern when Medicare is not financially sustainable in the long run (described in depth in Chapter 1).

With MA benchmarks at their current levels, the MA program has higher costs than FFS Medicare. While some of the excess funds are used to finance extra benefits for MA enrollees, all beneficiaries (through their Part B premium) and all taxpayers (through general revenues) are paying for those benefits. Most Medicare beneficiaries are not MA enrollees, but all beneficiaries pay for benefits enjoyed by the 20 percent who are enrolled in MA plans. The current level of payments also distorts other elements of the program, such as the Part D benchmarks (as we discuss in Chapter 4) and rapid plan market entry as noted later in this chapter.

The high MA benchmarks allow plans to be less efficient than they would be if they faced the financial pressure of benchmarks closer to Medicare FFS levels. As the Commission has stated in the past, organizations are more likely to be efficient when they face financial pressure, and the Medicare program needs to exert consistent financial pressure on the FFS and MA programs, coupled with meaningful quality measurement and pay-for-performance programs, to maximize the value it receives for the dollars it is spending. These principles are embodied in our past recommendations on the MA program (see text box, p. 250). We strongly reiterate these recommendations in light of our concerns about the directions the MA program is taking.

Medicare Advantage plan performance on quality measures

Although many MA plans perform well on quality measures, we find that between 2005 and 2006, clinical process measures and intermediate outcomes measures in MA did not show the same rate of improvement as in commercial and Medicaid plans. Newer MA plans—those that began operating in 2004 or later—tend to score worse than older plans on clinical quality measures. In addition, a survey that tracks the physical and mental health of MA enrollees shows that, between 2004 and 2006, the large majority of plans showed outcomes within expected ranges, but plans were less likely to have improved the physical and mental health of their enrollees than in

earlier years. On the other hand, surveys of MA enrollees' satisfaction with their health plans and providers show that, on average, Medicare beneficiaries are satisfied with their access to care in MA and are happy with their providers. Medicare health plan enrollees report greater satisfaction with their care and with access to care than enrollees of commercial and Medicaid plans (AHRQ 2007a).

The Commission has stressed the importance of using quality indicators to compare MA plans with each other and with care provided in the traditional FFS Medicare program. We have recommended the establishment of a pay-for-performance program for MA plans. Because these recommendations have not been adopted, we are concerned about the inconsistencies we see in plan measures available and our inability to compare quality in MA with FFS. In particular, we would like to be able to compare changes in enrollee health status over time between the two parts of the Medicare program.

Available data on quality in MA and summary results

There are several sources of information on the performance of MA plans on quality measures. The information forms the basis of public reporting of plan performance. Regulators and purchasers use the data to monitor health plans and promote quality improvement, and health plans use the data in their own quality improvement activities.⁴ In this chapter, we review the most recent results from three data sources: the Health Outcomes Survey (HOS), the Healthcare Effectiveness Data and Information Set (HEDIS[®]), and the Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]). The most recent HOS data show results as of 2006. The most recent HEDIS data are also for 2006, and CAHPS data reflect Medicare beneficiary experiences during early 2007 and the end of 2006.

Not all MA plans participate in HOS and HEDIS. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) exempted PFFS plans and MSA plans from quality-reporting requirements. PPO plans report only on the services of network providers, as provided for in the MMA, and are not obligated to report on measures based on data extracted from medical records.

Our main conclusions and findings are that:

- Quality has not been improving in MA plans as fast as for other payers. We base this conclusion on the

Prior Medicare Advantage recommendations

Medicare Advantage (MA) recommendations from the June 2005 Report to the Congress are summarized below:

- The Commission recommended that the Congress eliminate the stabilization fund for regional preferred provider organizations (PPOs). Authorization of the fund was one of several provisions intended to promote development of regional PPOs. The fund was available in 2007 but was not used. Subsequent legislation has reduced the fund and made funds unavailable until the year 2013.
- The Commission recommended that the Congress clarify that regional plans should submit bids that are standardized for the region's MA-eligible population. Regional PPOs can have an advantage over local plans as a result of the MA bidding process. Because of the different method used to determine benchmarks for regional PPOs in relation to the method used for other plans, and because of the bidding approach used for regional plans, there can be distortions in competition between regional and local plans.
- The Commission recommended that the Congress remove the effect of payments for indirect medical education from the MA plan benchmarks. MA rates set at 100 percent of fee-for-service (FFS) include medical education payments, but Medicare makes separate indirect medical education payments to hospitals treating MA enrollees.
- The Commission recommended that the Congress set the benchmarks that CMS uses to evaluate MA plan bids at 100 percent of FFS costs. The Commission has consistently supported the concept of financial neutrality between payment rates for the FFS program and private plans. However, financial neutrality can be achieved gradually to minimize the impact on beneficiaries.
- The Commission believes that pay-for-performance should apply in MA to reward plans that provide higher quality care. The Commission recommended that the Congress redirect the amounts retained in the Trust Funds for bids below the benchmarks to a fund that would redistribute the savings back to MA plans based on quality measures.
- The Commission recommended that the Secretary calculate clinical measures for the FFS program that would permit CMS to compare the FFS program with MA plans. The Commission believes that more can be done to facilitate beneficiary choice and decision making by enabling a direct comparison between the quality of care in private plans and quality in the FFS system.

One recommendation became a provision of the Deficit Reduction Act, which specifies in statute the timeline for phasing out the hold-harmless policy that offsets the impact of risk adjustment on aggregate plan payments through 2010. ■

HEDIS results reported by the National Committee for Quality Assurance (NCQA) that compare 2006 performance with 2005 performance and compare Medicare plans with commercial plans. The HOS data also show that fewer MA plans have improved outcomes for their Medicare enrollees between 2004 and 2006 compared with earlier years.

- Newer plans—those that began their contracts in 2004 or later—have lower performance on clinical measures than older plans, as reflected in the most recent HEDIS scores. CAHPS data show that beneficiaries have the same level of satisfaction in new and old

plans, but they also show that vaccination rates are substantially lower in newer plans.

- There are differences in reporting requirements that make it difficult for us, CMS, or beneficiaries to compare plans. PFFS and MSA plans do not report HEDIS data because of a statutory exemption. HEDIS data for PPOs (local and regional) are not as complete as for HMO plans. Across all plan types, plans occasionally do not report on individual HEDIS measures. We also do not have sufficient data to compare clinical measures in MA with similar measures in the traditional FFS program.

**TABLE
3-4**

Recent Health Outcomes Survey measures show fewer plans improving health

| Survey year | | Number of plans | Physical health | | | Mental health | | |
|-------------|-----------|-----------------|-----------------|--------|-------|---------------|--------|-------|
| Initial | Follow-up | | As expected | Better | Worse | As expected | Better | Worse |
| 1998 | 2000 | 188 | 188 | 0 | 0 | 160 | 13 | 15 |
| 1999 | 2001 | 160 | 146 | 9 | 5 | 147 | 8 | 5 |
| 2000 | 2002 | 146 | 125 | 20 | 1 | 127 | 15 | 4 |
| 2001 | 2003 | 152 | 129 | 22 | 1 | 152 | 0 | 0 |
| 2002 | 2004 | 153 | 132 | 21 | 0 | 123 | 27 | 3 |
| 2003 | 2005 | 154 | 154 | 0 | 0 | 134 | 18 | 2 |
| 2004 | 2006 | 151 | 136 | 2 | 13 | 139 | 5 | 7 |

Source: Medicare Health Outcomes Survey website. <http://www.hosonline.org/surveys/hos/hosresults.aspx>.

Recent performance results for Medicare plans: The Medicare HOS

HOS is a longitudinal survey of self-reported health status among Medicare health plan enrollees that measures changes over a two-year period. For each plan in the MA program (other than PFFS and MSA plans), a randomly selected sample of enrollees who have been in the plan at least six months are surveyed in a given year and resurveyed two years later. Two-year change scores are calculated and beneficiaries’ physical and mental health status is categorized as better, the same, or worse than expected, based on a predictive model, taking into account risk-adjustment factors and death. When results are reported, a plan is deemed to have better or poorer outcomes if the plan’s results on the physical or mental health measures are significantly different from the national average change in health status across all plans.

The most recent HOS data show disappointing results (Table 3-4). For the enrollee cohort surveyed on its health status changes between 2004 and 2006—the most recent cohort surveyed—CMS reported that in 13 of 151 plans enrollees reported a worse-than-expected decline in physical health, 2 plans showed improved physical health among enrollees, 7 plans showed declining mental health, and 5 plans showed improved mental health. The remaining plans had results within the expected range. While in the most recent cohort only two plans had results for physical health that were better than expected, between 2000 and 2004, 20 or more plans, from a similar total number of plans, showed improved physical health outcomes. In five plans, the mental health of enrollees improved in the 2004–2006 cohort, yet all but one of the

earlier cohorts showed greater improvement in mental health.

Recent performance results for Medicare plans: HEDIS

MA plans have not shown the same rate of improvement in HEDIS results as commercial and Medicaid plans. For measures that can be compared over multiple years, in some cases there has been little improvement in Medicare plan scores over the past six years.⁵ There is also significant variation in scores across plans. Plans that began their Medicare contracts in 2004 or later tend to have lower scores than older plans. Not all plans are required to report on all measures, and plans may choose not to report a particular measure. Consequently, some plans report on very few measures, with newer plans less likely to report a full complement of measures. While there may be good reasons not to report a particular measure, it does raise questions about whether plans may not report measures when they show poor quality.

HEDIS measures and reporting of results NCQA developed HEDIS through a public–private partnership of various stakeholders that includes CMS. Development began in 1992, with new measures continually added over the years. Medicare plans have been required to report HEDIS data since 1997. However, the MMA exempted PFFS and MSA plans from HEDIS reporting requirements, and PPO plans are required to report only on the services of network providers. PPOs also are not obligated to report on measures based on data extracted from medical records.

**TABLE
3-5**

Many measures of Medicare Advantage performance are not improving

| HEDIS® measure (total number) | New measures or not comparable year to year | Change over time, 2005 to 2006 | | | Medicare performance relative to commercial plans | | | Medicare-only measure(s) |
|---------------------------------------------------|---------------------------------------------|--------------------------------|-------|------|---------------------------------------------------|-------|------|--------------------------|
| | | Better | Worse | Same | Better | Worse | Same | |
| Antidepressant medication management (3) | 0 | 1 | 1 | 1 | 0 | 3 | 0 | 0 |
| Beta-blocker treatment (2) | 0 | 1 | 0 | 1 | 0 | 2 | 0 | 0 |
| Comprehensive diabetes care (9) | 5 | 0 | 4 | 0 | 7 | 2 | 0 | 0 |
| Screenings not in diabetes category (4) | 2 | 1 | 1 | 0 | 2 | 1 | 0 | 1 |
| Monitoring persistent drug use in the elderly (5) | 5 | N/A | N/A | N/A | 5 | 0 | 0 | 0 |
| Use of high-risk drugs in the elderly (2) | 0 | 2 | 0 | 0 | N/A | N/A | N/A | 2 |
| Mental health treatment (2) | 0 | 0 | 2 | 0 | 0 | 2 | 0 | 0 |
| Alcohol/drug treatment (2) | 0 | 0 | 2 | 0 | 1 | 1 | 0 | 0 |
| Other measures (5) | 2 | 2 | 1 | 0 | 0 | 4 | 0 | 1 |

Note: HEDIS® (Healthcare Effectiveness Data and Information Set), N/A (not applicable). Four additional measures are Medicare-only measures that are new or not comparable to earlier years.

Source: National Committee for Quality Assurance 2007.

HEDIS generally provides information on process measures (e.g., the percentage of women ages 40–69 who had a mammogram to screen for breast cancer). HEDIS measures also include intermediate outcomes measures (e.g., low-density lipoprotein cholesterol below 100 for patients with cardiovascular conditions) as well as measures of customer service (e.g., the percentage of calls received by plan call centers during operating hours that were “abandoned by the caller before being answered by a live voice”).

In addition to the effectiveness-of-care measures and certain utilization data, HEDIS collects resource use data for six major chronic conditions, including diabetes, chronic obstructive pulmonary disease, and hypertension. Although we do not examine the data in this chapter, NCQA summarizes its findings on spending on diabetes care (the focus of this year’s resource use findings) by saying that “initial results suggest that there is no meaningful relationship between how much plans spend and the quality of care they deliver—in other words, getting more care isn’t the same thing as getting better care” (NCQA 2007).

NCQA publishes an annual *State of Health Care Quality* (SOHCQ) report showing the performance of three types of plans participating in HEDIS—commercial, Medicare,

and Medicaid plans. The report also tracks the level of change over time in plan performance measures and shows the degree of variability among plans in individual scores. For our analysis, we use the NCQA data of the SOHCQ report to compare Medicare plans with commercial plans and for a historical comparison of recent results with those in Commission reports from prior years. To compare HEDIS results for different MA plan types and categories, we use data from public use files (PUFs) provided by CMS. The CMS data show information for a larger number of plans than the NCQA data.⁶ The NCQA SOHCQ report data are simple averages of scores across plans rather than being averages across the number of plan enrollees. Our analysis is also based on simple averages across plans when averages are used.

Medicare HEDIS results compared with commercial and Medicaid plans Medicare performs better than commercial plans for about half of the HEDIS measures common to both sectors, with commercial plans better for the other half. A concern, however, is that Medicare plans are not improving their performance to the same extent as commercial and Medicaid plans. While commercial and Medicaid plans improved significantly between 2005 and 2006, in releasing the SOHCQ report for 2006, NCQA pointed to the lower level of improvement among Medicare plans and commented that the Medicare results

“highlight ... a need to refocus on quality improvement efforts in this key public program” (NCQA 2007).

NCQA reported that, between 2005 and 2006, Medicare plans improved on only 6 of 38 HEDIS effectiveness-of-care measures, compared with 30 of 44 measures for commercial plans and 34 of 43 measures for Medicaid plans that showed improvement.⁷ For 4 of the 13 measures for which Medicare plans showed no improvement, Medicare scores are better than commercial scores; in 9 of the 13 measures, they are worse.

NCQA adds new measures periodically, and the specification of some measures changes over time. In such cases, performance can be measured, but not improvement. Eight new measures are tracked for both Medicare and commercial plans: five measures of persistent drug use among the elderly and three new comprehensive diabetes care measures. For seven of the eight new measures, Medicare plans performed better than commercial plans. For six other measures that cannot be compared between 2005 and 2006 because of changed specifications, Medicare performed better than commercial plans in four cases. Four new measures of drug–disease interactions in the elderly track care for Medicare only (Table 3-5).

Past Medicare HEDIS results Although many of the measures used in earlier years have changed their specifications and cannot be compared across years, a comparison of historical rates on some measures shows that there has not been improvement in many Medicare HEDIS scores. The March 2004 Report to the Congress noted that diabetes care had improved and suggested that the improvement reflected the targeted efforts of CMS (and others) to improve diabetes care (MedPAC 2004). The 2004 report also highlighted the poor performance of plans on mental health measures, which continued to be the case in 2006. The rate of eye exams for diabetic patients is lower than it was in 2000. Cholesterol management and hemoglobin A1c control also show relatively poor performance compared with past results. However, there have been gains in management of antidepressant medication (Table 3-6).

Variation in 2006 HEDIS measures across plans On any given measure, HEDIS scores vary greatly among health plans, as indicated by the minimum, maximum, average, and median scores for selected measures (Table 3-7, p. 254). For example, the rate of hemoglobin A1c testing varies from about 34 percent to 98 percent, and eye exams for diabetics range from about 15 percent to 91 percent.

**TABLE
3-6**

Medicare HEDIS® measures show mixed results

| Measure | Change in rate, 2001 to 2006 |
|-----------------------------------------------------|------------------------------|
| Beta-blocker treatment after heart attack | Better |
| Cholesterol management: control | Worse |
| Comprehensive diabetes care: eye exams | Worse |
| Poor hemoglobin A1c control | Same |
| Antidepressant medication management: | |
| Acute phase | Better |
| Continuation phase | Better |
| Contacts | Worse |
| Follow-up after hospitalization for mental illness: | |
| Less than 7 days | Same |
| Less than 30 days | Worse |

Note: HEDIS® (Healthcare Effectiveness Data and Information Set).

Source: National Committee for Quality Assurance 2007.

HEDIS data reporting issues One concern in reviewing the HEDIS data is the frequency with which plans do not report their performance on certain measures. Plans do not report measures for a number of reasons. With some measures, for example, a plan may not have a sufficient number of enrollees to whom the measure applies (e.g., diabetics) to calculate a valid rate. In such a case, the plan reports the measure as not applicable. A plan, or CMS or NCQA, may determine that a reported measure is materially biased and is not valid (shown as NR, not reported). In addition, plans may choose not to report a measure even though the report would be valid (also shown as NR in plan reporting). Because NR can represent two possibilities—inability to report or a decision not to report—CMS is working with NCQA to have plans specify the nature of the nonreporting. CMS hopes to be able to obtain such information in the 2008 HEDIS reporting cycle (for experience in 2007). To the extent that nonreported measures reflect a plan’s preference not to report rather than legitimate methodological issues, the value of the reporting requirement is undermined.⁸

HMOs are far more likely than PPOs to report a greater number of measures. Almost two-thirds of HMOs report on 80 percent or more of the HEDIS measures, while more

**TABLE
3-7**

Variation in selected HEDIS® measures

| Measure | Minimum | Maximum | Average | Median |
|---------------------------------------------------------------------|---------|---------|---------|--------|
| Drugs to be avoided in the elderly | | | | |
| One prescription* | 0.1* | 61.1* | 23.0* | 22.9* |
| At least 2 prescriptions* | 0.0* | 37.9* | 6.0* | 5.4* |
| Potentially harmful drug-disease interactions in the elderly | | | | |
| Falls + tricyclic antidepressants, antipsychotics or sleep agents* | 0.0* | 55.4* | 14.8* | 13.7* |
| Dementia + tricyclic antidepressants or anticholinergic agents* | 0.0* | 66.0* | 24.7* | 23.8* |
| Renal failure + non-aspirin NSAIDs or COX-2 selective NSAIDs* | 0.0* | 57.0* | 9.3* | 7.8* |
| Total potentially harmful drug-disease interactions in the elderly* | 0.0* | 62.4* | 19.5* | 18.5* |
| Comprehensive diabetes care | | | | |
| Hemoglobin A1c testing | 33.8 | 97.8 | 86.3 | 88.1 |
| Poor hemoglobin bA1c control* | 5.6* | 100.0* | 31.2* | 25.4* |
| Eye exams | 15.1 | 91.2 | 60.3 | 61.1 |
| Lipid profile | 33.2 | 98.3 | 83.8 | 85.4 |
| Monitoring diabetic nephropathy | 53.8 | 98.5 | 85.2 | 85.7 |
| <100 LDL-C level | 0.0 | 82.6 | 44.8 | 47.4 |
| Good hemoglobin A1c control | 0.0 | 91.2 | 43.8 | 46.0 |
| Blood pressure controlled <130/80 | 0.0 | 52.3 | 29.8 | 29.9 |
| Blood pressure controlled <140/90 | 0.0 | 83.2 | 57.1 | 59.1 |
| Follow-up after hospitalization for mental illness | | | | |
| Visit within 7 days | 0.0 | 76.8 | 36.6 | 35.5 |
| Visit within 30 days | 0.0 | 92.4 | 55.9 | 57.1 |

Note: HEDIS® (Healthcare Effectiveness Data and Information Set), NSAID (nonsteroidal anti-inflammatory drug), LDL-C (low-density lipoprotein cholesterol). Values of zero are reported. Because invalid values are not to be reported, zero values are assumed to be correctly reported values for a plan.
* Indicates lower score is better for this measure.

Source: MedPAC analysis of CMS HEDIS® public use files.

than two-thirds of PPOs report on fewer than half of the HEDIS measures. Fewer than two-thirds of MA plans reported on 15 of the 42 HEDIS measures reported in the CMS files. Seventy-one plans—all of which are HMOs—reported on all measures. Twenty-eight local or regional PPOs reported on fewer than one-third of the measures. However, one local PPO reported on all measures for 2006 other than the two mental health follow-up measures. There are 59 local or regional PPO plans included in the 276 total, or 21 percent of all plans reporting, which contributes to the relatively high percentage of nonreporting of certain measures, given that PPOs are not obligated to report on measures that require extracting medical records (Figure 3-1).

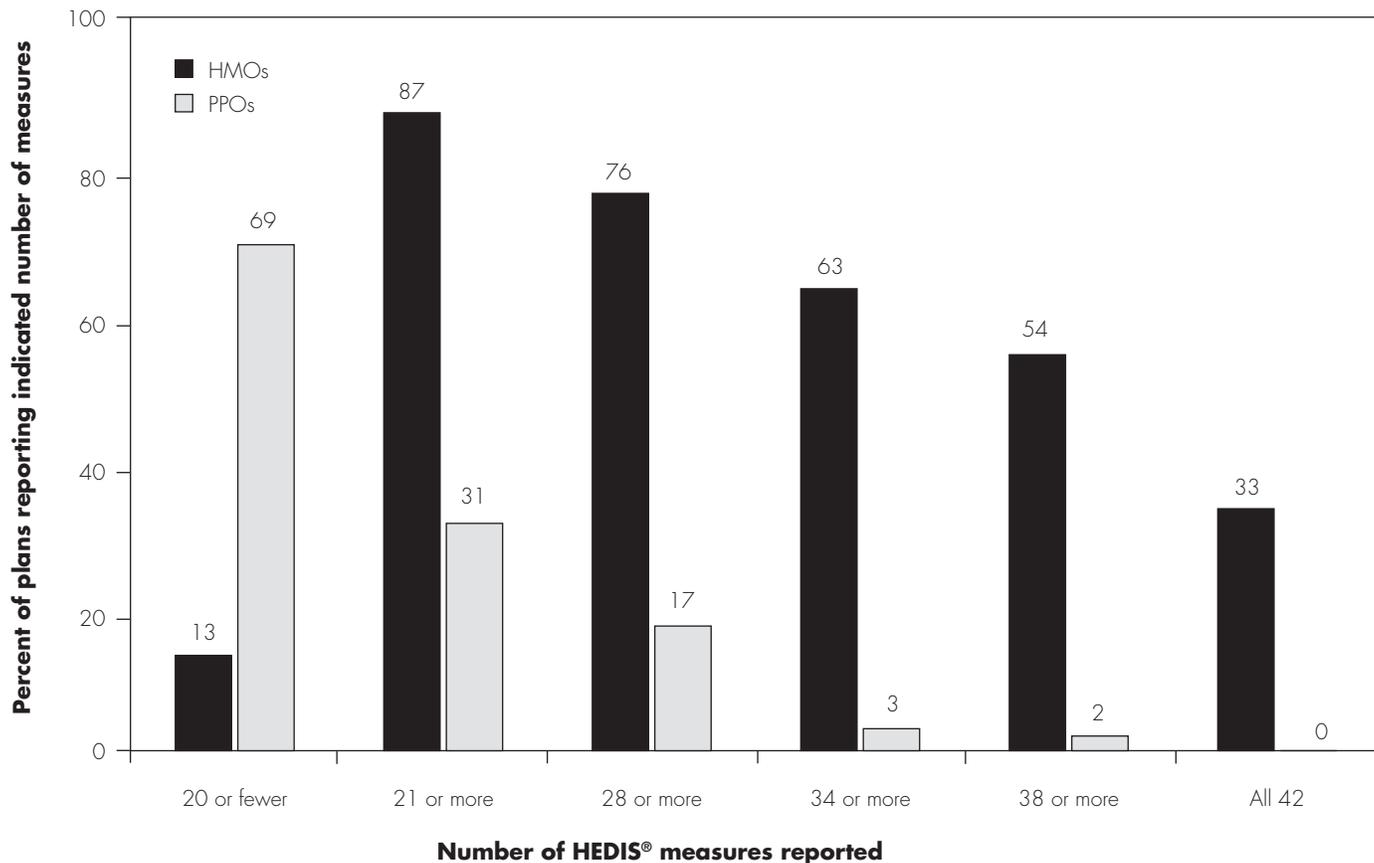
Variation in HEDIS results based on plan characteristics and the effect of new plans One issue NCQA raised when it released its 2007 SOHCQ report was whether

the generally poorer performance of Medicare plans was due to the number of new plans operating in MA. Looking only at plans that reported in both 2007 and 2006—that is, removing plans reporting for the first time in 2007—according to NCQA staff, the results of the SOHCQ report would have shown that Medicare plans had improved on 11 measures over the previous year, rather than on only 6 measures. On the basis of our analysis of the CMS HEDIS public use data, we have arrived at findings similar to those of NCQA about the effect of newer plans—that is, they tend to have lower HEDIS scores than older plans.

We have defined new plans as those that began their Medicare contracts on or after January 1, 2004 (versus plans that had been contractors before 2004—that is, before passage of the MMA).⁹ The plans are new in the sense that the contract is a new Medicare contract

FIGURE 3-1

HMOs report on more HEDIS® measures than PPOs



Note: HEDIS® (Healthcare Effectiveness Data and Information Set), PPO (preferred provider organization). Two private fee-for-service (PFFS) plans are not included in the totals. One of the PFFS plans does not report on any measures and the other reports on only one measure.

Source: MedPAC analysis of CMS HEDIS® public use files.

dating from 2004 or later. The organization holding a new contract may have extensive experience as an MA contractor in another area (dating back to well before 2004 in many cases) or with another type of MA product in the same area. About half the plans we are classifying as new in this analysis of HEDIS data are sponsored by national or regional chain organizations, or other types of organizations that have had extensive experience as MA contractors. Among the remaining plans, many have experience with reporting HEDIS data as Medicaid health plans or as commercial plans.

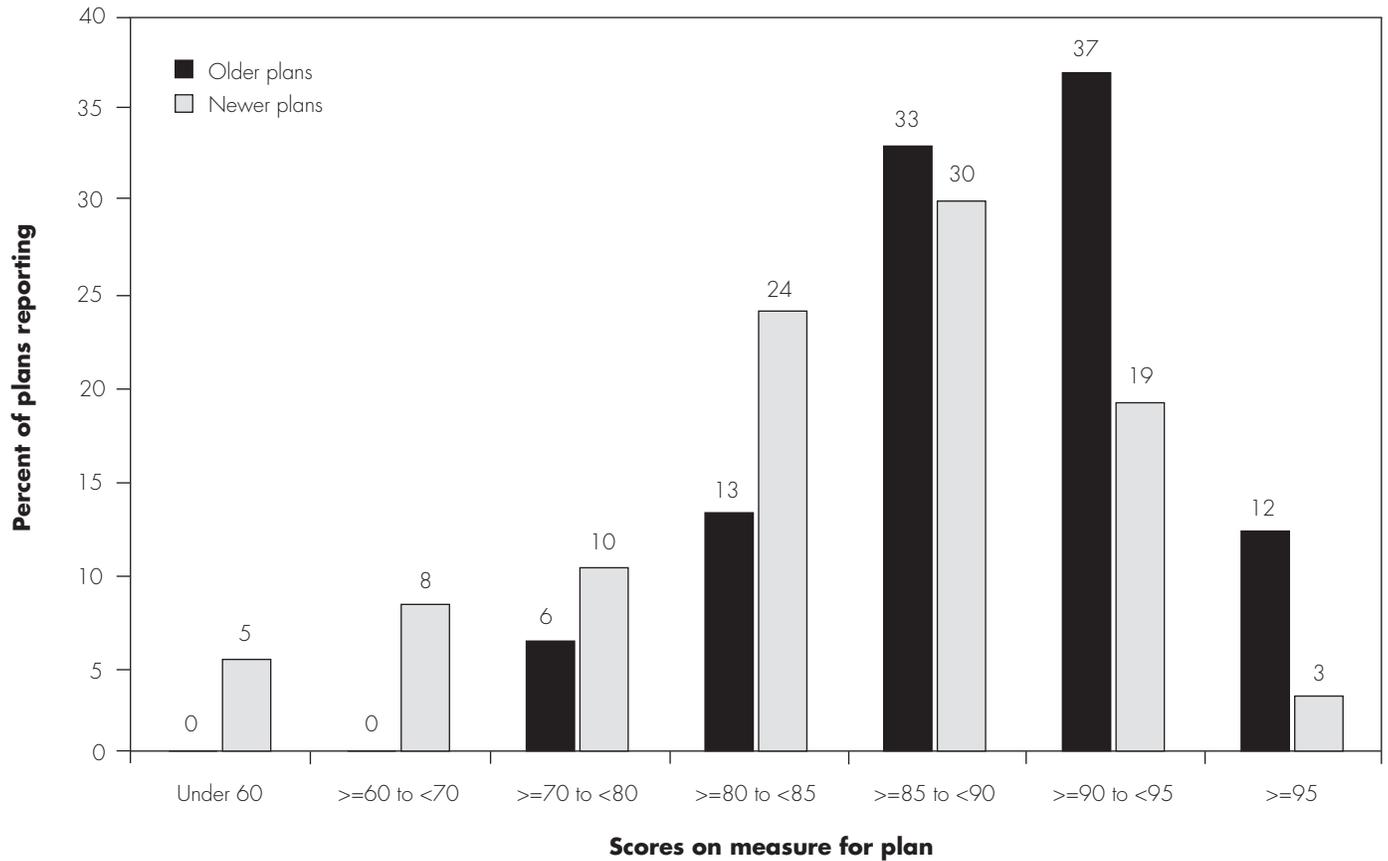
Although the differences are sometimes small for a given measure, there is a consistent pattern across the measures of newer plans having lower scores than older plans (Table

3-8, p. 256). One exception is in the area of management of antidepressant medication, where new plans had better scores. However, this conclusion is based on a very small portion, about 10 percent, of new plans reporting the measure (data not shown).

Using the measure for the rate of testing hemoglobin A1c for diabetics as an example of the variation in HEDIS scores across plans, we see systematically lower scores among newer plans (Figure 3-2, p. 256). The measure, in use since 1999, reports the percentage of plan members, ages 18 through 75, with diabetes type 1 and type 2 who were continuously enrolled during the measurement year and who had a hemoglobin A1c blood test (AHRQ 2007b). The difference between newer plans and older

**FIGURE
3-2**

Example of lower HEDIS® scores for newer plans: Hemoglobin A1c testing



Note: HEDIS® (Healthcare Effectiveness Data and Information Set). Older plans have Medicare contracts that began December 31, 2003 or earlier. There are 155 older plans. Newer plans have contracts that began January 1, 2004 or later. There are 121 newer plans.

Source: MedPAC analysis of CMS public use files.

**TABLE
3-8**

Medicare HEDIS® measures show mixed results

| Measure | New plans better | Old plans better |
|---------------------------------------------------|------------------|------------------|
| Monitoring for patients on persistent medications | 0 | 4 |
| Diabetes management | 0 | 9 |
| Drugs to be avoided in the elderly | 0 | 2 |

Note: HEDIS® (Healthcare Effectiveness Data and Information Set). Table includes effectiveness-of-care measures reported by at least 50 percent of both old and new plans (15 of 38 total measures of effectiveness of care). New plans began their Medicare contracts on or after January 1, 2004.

Source: MedPAC analysis of CMS HEDIS® public use files.

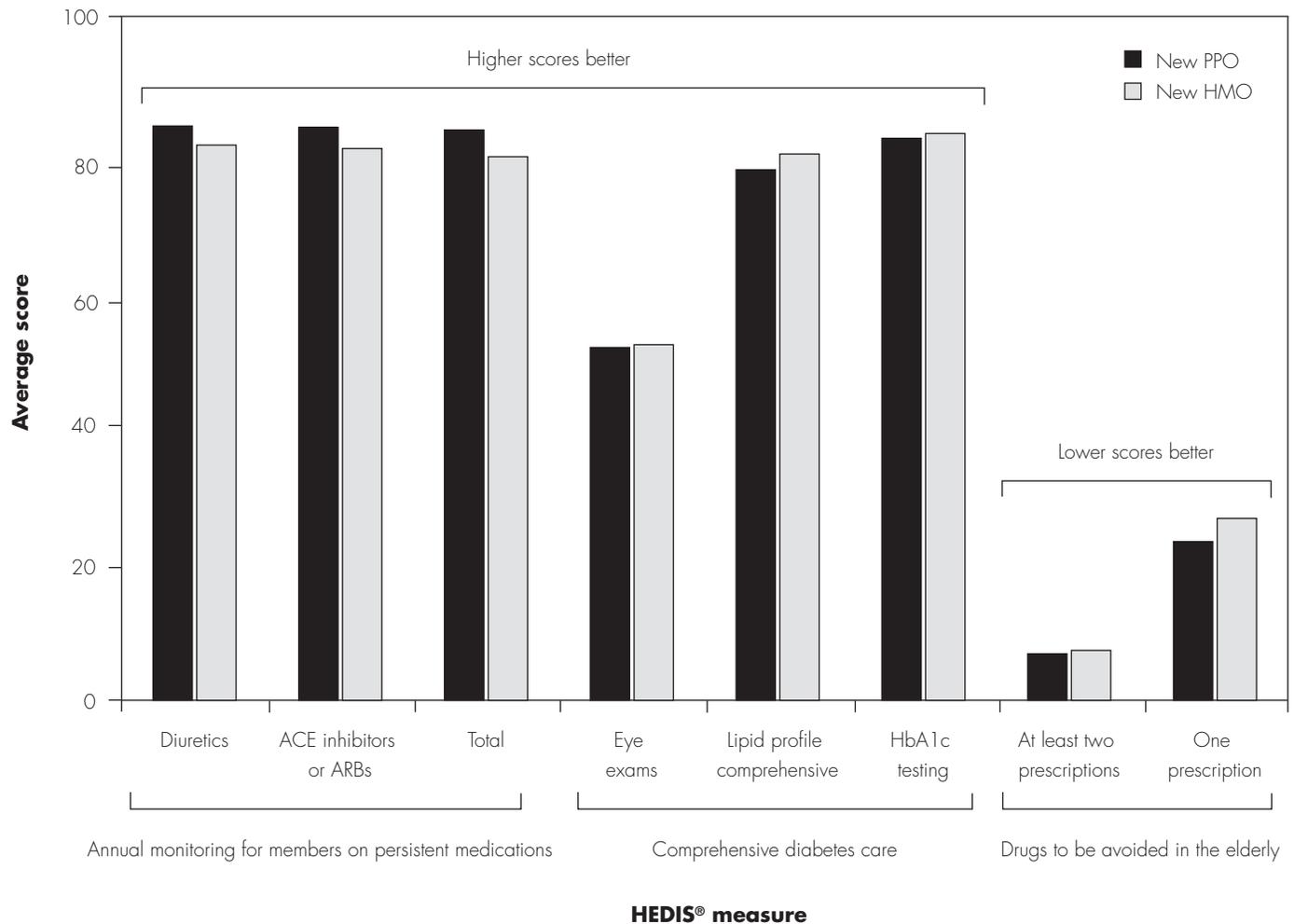
plans is likely not due to reporting issues: 98 percent of all plans reported on this measure.

For hemoglobin A1c testing, nearly half of all older plans have scores of 90 or better, compared with 22 percent of newer plans. Nearly half of newer plans have scores below 85. The scores of older plans are more concentrated in the higher numbers, while the scores of newer plans have a wider range and include scores under 70.

Enrollment in newer plans and possible causes of differences between new and old plans New plans in the HEDIS data set make up more than 40 percent of the total (121 of 276). However, enrollment in the new plans is relatively small. About 13 percent of enrollees are in the newer plans, with an average enrollment under

FIGURE 3-3

New PPO HEDIS® scores are better than new HMO scores on five out of eight measures



Note: PPO (preferred provider organization), HEDIS® (Healthcare Effectiveness Data and Information Set), ACE (angiotensin-converting enzyme), ARB (angiotensin receptor blocker), HbA1c (hemoglobin A1c). Measures displayed are those that are comparable among plan types. Results are for new plans only, defined as those that began their Medicare contracts on or after January 1, 2004.

Source: MedPAC analysis of CMS HEDIS® public use files.

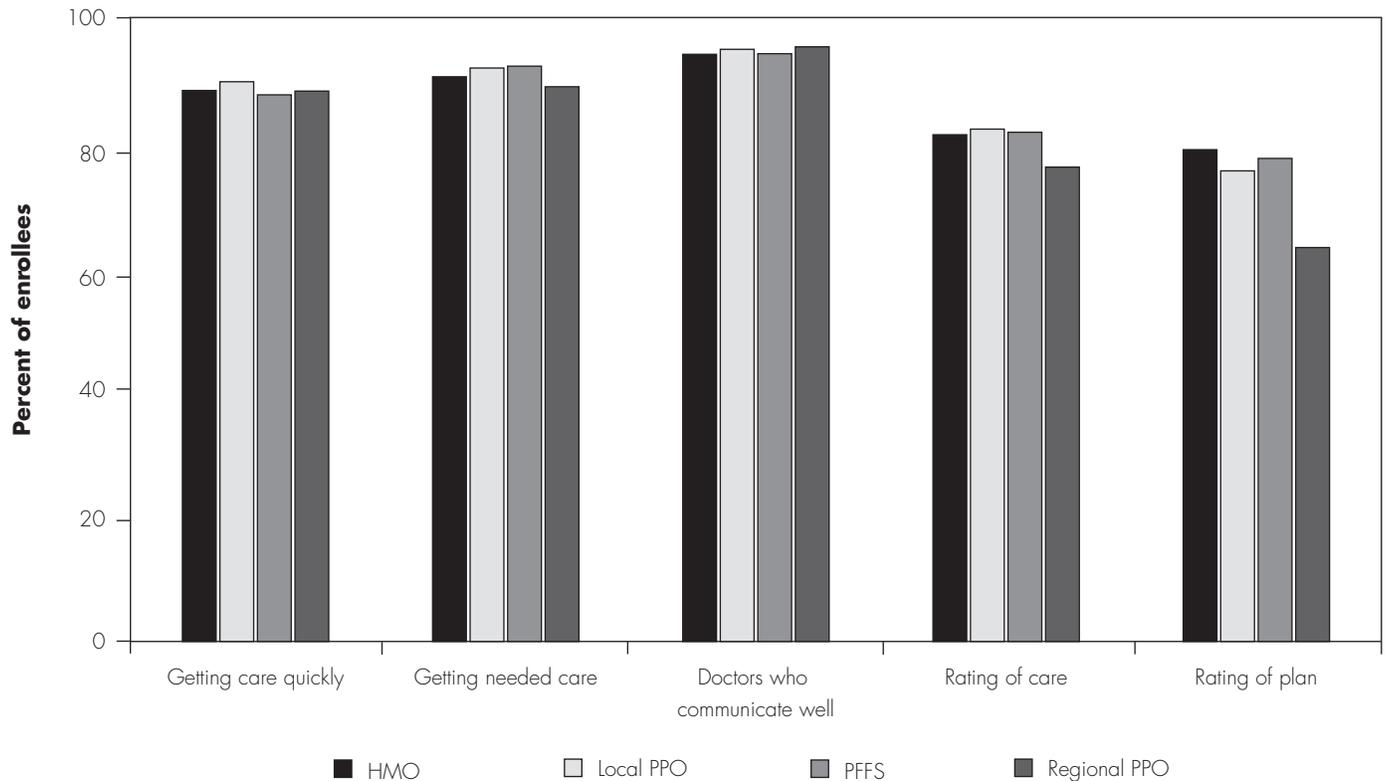
7,000, compared with 37,000 for older plans. The newer reporting plans are also more likely to be PPOs. The greatest growth in enrollment is in PFFS plans, which are not accountable for reporting on any of these measures.

The average enrollment in the different types of plans raises the question of whether smaller plans are likely to have lower HEDIS scores. This does not appear to be the case. Looking only at plans with fewer than 10,000 enrollees, we still see that newer small plans generally have lower HEDIS scores (data not shown).

Within the group of new plans, there is an almost even split between the number of PPOs and HMOs, with 47 PPOs and 55 HMOs.¹⁰ One might expect the relatively large percentage of PPOs among new plans to decrease the average scores for new plans because PPOs might have poorer HEDIS scores than more tightly managed plans, but that is not the case. HEDIS scores among new PPOs are often better than HEDIS scores for new HMOs. For measures reported on by at least 90 percent of new and old plans, the average scores of new PPOs are better than those of new HMOs in five of eight cases (Figure 3-3), although the differences are very small.

**FIGURE
3-4**

Enrollees give their Medicare Advantage plans high ratings for access to care and provider communication, but lower scores for overall care and overall rating of the plan, 2006-2007



Note: PPO (preferred provider organization), PFFS (private fee-for-service). Data for regional PPOs may not be representative of enrollee opinions because data are only available for plans representing 40 percent of enrollees. Data for cost-reimbursed HMOs excluded. The rating of care and rating of plan show beneficiaries giving a rating of 8, 9, or 10 on a 10-point scale. The remaining measures are composites, with the data showing beneficiaries stating that the description usually or always applied. Composite scores reflect a combination of questions on a particular topic.

Source: MedPAC analysis of CMS Consumer Assessment of Healthcare Providers and Systems® data.

To the extent that lower scores on quality measures may be due to a plan's status as a new, start-up organization, and scores can be expected to improve as the organization gains experience in data collection and reporting of HEDIS measures, CMS may wish to monitor more closely the new plans that show relatively poorer performance to ensure that scores improve as the plans gain experience. Another factor to consider is that variation in scores may occur within a given Medicare contractor at the plan level rather than at the contract level. Because HEDIS and CAHPS data are reported at a level of aggregation that includes different MA benefit packages and different geographic areas within the reporting unit, CMS may want to consider examining and reporting data at a lower level of aggregation than the contract level.

Recent performance results for Medicare plans: CAHPS

The CAHPS program provides information based on surveys of members' experiences with their health plan and with the providers in the health plan. The CAHPS domains consist of questions related to the following issues:

- getting care without long waits,
- getting care that is needed,
- having doctors who communicate well,
- overall rating of health care patients received, and
- overall rating of health plan.

The Agency for Healthcare Research and Quality (AHRQ) developed CAHPS. The Medicare health plan CAHPS survey was first fielded in 1997. In addition to consumer satisfaction results, CAHPS data are the source of some effectiveness-of-care measures, including the rate of flu shots and pneumonia vaccination. For reporting comparisons of one plan to another, CAHPS measures are adjusted for response bias with respect to age, education, self-reported physical and mental health status, proxy status, and Medicare and Medicaid dual-eligibility status.

The most recent CAHPS Medicare health plan survey, fielded in April through July of 2007, tracks member experiences over the preceding six months. For the 2007 reporting year, CAHPS data are reported at the Medicare contract level (the H-number or R-number level). Previously, the Medicare CAHPS reporting unit consisted of smaller geographic areas, or submarkets under a contract number. Reporting at the contract level makes CAHPS reporting consistent with reporting of HEDIS and HOS data in MA.

Completeness of CAHPS data for 2006–2007 MA plan enrollees participate in the CAHPS survey if the plan has at least one year of Medicare experience. Unlike HEDIS and HOS, CAHPS data include PFFS plans.¹¹ We have summary data for Medicare health plans, but they may not be representative for particular types of plans because of the age of the plan, the size of the survey samples, or other reasons that would cause CMS not to report data on particular plans. In particular, the data for regional PPOs and cost HMOs may not be representative of the entire group. Compared with MA HMO and PFFS plans, for which we have CAHPS data for 81 percent and 93 percent of plans, respectively, we have data for only 27 percent of regional PPOs and 54 percent of local PPOs.

CAHPS results for 2006–2007 In general, MA enrollees within all types of plans are satisfied with their access to care and doctors' communication. For the access-to-care categories of CAHPS, about 90 percent of enrollees report that they usually or always get needed care and they get the care on a timely basis. Ratings are even higher for the survey questions dealing with the ability of doctors to communicate well. Ratings are not quite as high in the categories of overall rating of health care that beneficiaries obtain through the plan. Overall plan ratings are also lower but still show high levels of satisfaction (Figure 3-4).

CAHPS results for Medicare plans compared with commercial and Medicaid plans Medicare enrollee satisfaction for the 2006–2007 CAHPS reporting period is higher than for commercial enrollees in each CAHPS category (Table 3-9, p. 260).

Flu shots and pneumococcal vaccinations CAHPS is the source of data for tracking vaccination rates among Medicare plan enrollees. The average rate of vaccination among MA enrollees was slightly lower than the national rate for the flu vaccine, and it was higher for the pneumococcal vaccine. The Centers for Disease Control and Prevention reported that, in the 2005–2006 flu season, 69.3 percent of Americans age 65 or older received a flu shot (CDC 2007); 63.7 percent had a pneumococcal vaccination in 2005 (CDC 2006). Across all Medicare plan types, 67.5 percent of enrollees received a flu vaccine and 65.6 percent received a pneumonia vaccine (data not shown). The rate varies by plan type—noting again that regional PPO data may not be representative of all plans within this category (Figure 3-5, p. 261). Within each plan type, the rates vary significantly across individual plans.

Comparing CAHPS results for new plans and old plans Unlike the HEDIS results, the CAHPS results do not show large differences in member satisfaction between older plans (pre-2004) and newer plans, except with respect to the overall rating of the plan. However, for the preventive services reported through CAHPS, newer plans performed worse than older plans (Table 3-10, p. 261).

Comparing quality in MA with the quality of care in FFS Medicare

All MA plans participate in CAHPS, including PFFS and MSA plans. There is also a CAHPS survey of Medicare beneficiaries in the traditional FFS program. The FFS CAHPS results can be used to compare beneficiaries' reported experiences in FFS with the experiences of MA enrollees for the domains CAHPS covers: access to medical care, impressions of the health plan (or the FFS program) and providers, and overall rating of the care beneficiaries receive. The FFS CAHPS survey was first fielded in 2000, and the latest results released were for 2004. The FFS CAHPS was fielded again in 2007 but results are not yet available. The 2004 Medicare FFS CAHPS results showed that FFS beneficiaries gave the traditional Medicare program ratings similar to those MA enrollees gave their plans, with Medicare FFS receiving slightly higher ratings in terms of getting needed care. Medicare FFS beneficiaries were more likely than MA

**TABLE
3-9**

CAHPS® enrollee satisfaction measures are higher for Medicare plans than commercial plans in 2006–2007

| Measure and plan type | Enrollee response | | |
|----------------------------------------|-------------------|---------|-------------------|
| | Always | Usually | Always or usually |
| Getting needed care composite | | | |
| Medicare | 63% | 27% | 90% |
| Adult commercial | 51 | 34 | 85 |
| Adult Medicaid | 47 | 27 | 74 |
| Child Medicaid | 52 | 18 | 70 |
| Getting care quickly composite | | | |
| Medicare | 66 | 22 | 88 |
| Adult commercial | 57 | 29 | 86 |
| Adult Medicaid | 53 | 25 | 78 |
| Child Medicaid | 71 | 12 | 83 |
| How well doctors communicate composite | | | |
| Medicare | 75 | 19 | 94 |
| Adult commercial | 70 | 22 | 92 |
| Adult Medicaid | 67 | 19 | 86 |
| Child Medicaid | 79 | 12 | 91 |

Note: CAHPS® (Consumer Assessment of Healthcare Providers and Systems). Composite scores reflect a combination of questions on a particular topic.

Source: Agency for Healthcare Research and Quality 2007a.

plan enrollees to give higher ratings for the quality of their health care and satisfaction with their health plan (RTI International and RAND 2005).

Another source of information comparing the experiences of MA enrollees and beneficiaries in FFS Medicare is the Medicare Current Beneficiary Survey (MCBS). MCBS data from 2005 show that beneficiaries in FFS and MA report similar trouble in getting access to care, getting needed care, and delaying care because of the cost (differences of 1 or 2 percentage points in each case). Higher proportions of FFS enrollees reported not having a usual source of care (2 percent in MA vs. 5 percent in FFS) or not having a usual doctor (8 percent in MA vs. 19 percent in FFS) (CMS 2007).

A HOS survey was administered in a pilot project to a national sample of FFS beneficiaries in 1998, with follow-up interviews in 2000. The FFS HOS survey has not continued beyond the initial pilot, and differences between outcomes in managed care for the 1998–2000 cohort and for the 1998–2000 FFS group have not been

analyzed.¹² A study that compared outcomes for the 2002–2004 HOS cohort (managed care enrollees) with a matched set of beneficiaries who completed the SF-12 survey as part of the FFS CAHPS survey found no significant difference between managed care enrollees and FFS beneficiaries at the national level in terms of the degree of change in mental or physical health. However, at the state level, a pattern emerged indicating that mental health outcomes were better in FFS Medicare (HSAG 2006).

Informing beneficiaries about MA performance measures

CMS has made it easier for beneficiaries to obtain information on the quality of care in MA plans. Until recently the only HEDIS scores beneficiaries could obtain easily in reviewing their plan options were scores for five measures: eye exams for diabetics, hemoglobin A1c control for diabetics, diabetics who received a lipid test, mammography rates, and receiving beta blockers after a heart attack. The measures were displayed as individual plan measures in bar graphs that included the national

average score for the measure and the average score for the measure in the state, along with scores for up to two additional plans that could be compared with the plan the beneficiary chose to examine. (The comparison among plans allows only three plans to be compared at a time. A beneficiary has to do multiple queries to look at more than three plans.)

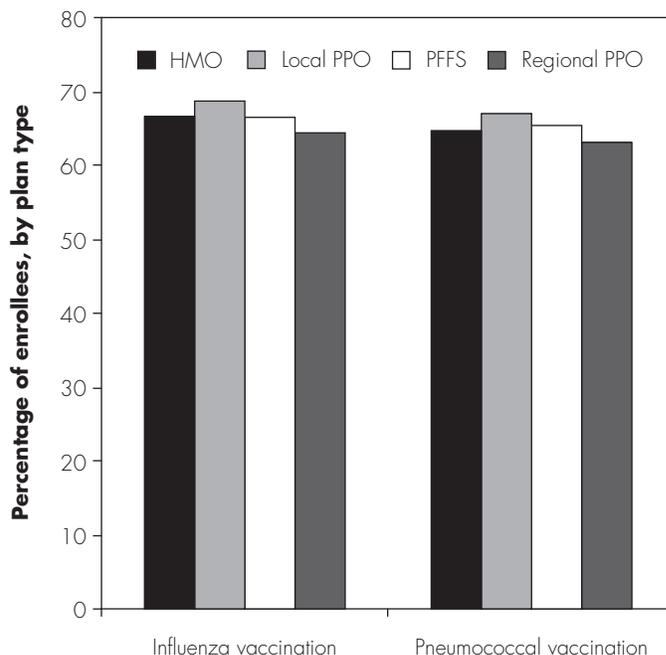
Beginning with the November–December 2007 open enrollment period, Medicare beneficiaries can obtain a much wider range of data from plans’ HEDIS reporting, though CMS has discontinued the display of national and state average scores. Using the Medicare Options Compare website, a beneficiary or other user can see plan scores for 20 HEDIS measures—about half of all the HEDIS measures in effectiveness of care (including the rates of flu and pneumonia vaccination, which are obtained from CAHPS, but which NCQA reports as part of its HEDIS reporting).

A beneficiary has a choice of seeing the actual HEDIS score or a star rating based on the score for each individual measure. The new star rating system is a five-star system for each HEDIS score that is based on the relative level of the plan score on the particular measure.

Conclusions on quality in MA

Medicare beneficiaries give high ratings to the care they receive through MA plans and express satisfaction with their providers and health plans. However, quality

FIGURE 3–5 Rates of influenza and pneumococcal vaccination varied among plans but were close to national average levels, 2006



Note: PPO (preferred provider organization), PFFS (private fee-for-service). Data for regional PPOs may not be representative of enrollee opinions because data are available only for plans representing 40 percent of enrollees. Data for cost-reimbursed HMOs excluded.

Source: MedPAC analysis of CMS Consumer Assessment of Healthcare Providers and Systems® summary data.

TABLE 3–10

Newer plans are similar to older plans on most CAHPS® measures, but worse on two measures, 2006–2007

| Measure | Average score | |
|------------------------------------------------------------|---------------|-----------|
| | Old plans | New plans |
| Getting care quickly composite (percent usually or always) | 89% | 89% |
| Getting needed care composite (percent usually or always) | 91 | 91 |
| Doctors who communicate well composite | 94 | 95 |
| Rating of care (percent rating 8, 9, or 10 out of 10) | 81 | 82 |
| Rating of plan (percent rating 8, 9, or 10 out of 10) | 81 | 77 |
| Preventive care measures | | |
| Flu vaccination rate (percent of enrollees) | 73 | 64 |
| Pneumonia vaccination rate (percent of enrollees) | 72 | 62 |

Note: CAHPS® (Consumer Assessment of Healthcare Providers and Systems). New plans are those that began their Medicare contracts on or after January 1, 2004. Composite scores reflect a combination of questions on a particular topic.

Source: MedPAC analysis of CMS CAHPS® summary data.

measures for clinical processes and intermediate outcomes in MA show disappointing results. Commercial and Medicaid plans show more improvement than Medicare plans in clinical measures over the past year. New plans in Medicare perform worse than older plans on clinical indicators of quality.

The Commission has recommended that the quality of care should be measured in both the MA and the FFS program so that beneficiaries can use quality as a factor when they choose between the two sectors. Beneficiaries can now judge differences in quality only between one MA plan and another without being able to compare MA quality with the quality of care in FFS Medicare (or in a given geographic area). Although the tools exist to measure and compare outcomes among FFS beneficiaries as well as MA enrollees—for example, the HOS—the Medicare program does not make such comparisons.

By statute, PFFS plans and MSA plans are exempt from the reporting requirement applicable to all other MA plans. In testimony before the Congress and in our June 2007 Report to the Congress, we called attention to this difference among plan types and have suggested that all MA plans should be subject to the same reporting requirements. We noted earlier that some plans are not reporting on required elements.

The other relevant point is that information on quality is a necessary component of pay-for-performance (P4P) programs. The Commission has noted that MA already has the type of quality data necessary for a P4P program, and the Commission has recommended that a portion of plan payments be used to fund a P4P program in MA. A P4P program would encourage plans to improve their performance and could help address our concerns about the relatively poorer performance of some MA plans on quality measures.

Special needs plans

The Congress created a new MA plan type known as a special needs plan in the MMA to provide a common framework for existing plans (in particular those operating under demonstration authority) for special needs beneficiaries and to expand beneficiaries' access to and choice among MA plans. Targeted populations include dual (Medicare and Medicaid) eligibles, the institutionalized, and beneficiaries with severe or disabling chronic conditions. SNPs function essentially like (and are paid the same as) any other MA plan but must also provide the

Part D drug benefit. Unlike other MA plans, however, they can limit their enrollment to their targeted populations—a provision that will lapse at the end of 2009, absent action by the Congress to extend the provision (see text box). If the Congress allows SNPs' authority to limit their enrollment to targeted populations to lapse, then existing SNPs could become regular MA plans and continue to serve their existing members, but they would need to accept enrollment from all eligible Medicare beneficiaries. A CMS evaluation that was due to the Congress in December 2007 will be based on early years of the program, so it may lack complete measures of SNPs' quality and other characteristics, and it will lack an evaluation of the experience of more recent entrants into the program.

There is an exception to SNPs' ability to limit their enrollment to targeted populations. They may apply to CMS for a waiver to enroll other beneficiaries as long as their membership includes a disproportionate percentage of their targeted population (greater than the percentage that occurs nationally in the Medicare population). This provision allows SNPs to select enrollees from among the nontarget population based on unknown criteria.

SNPs offer the potential to improve care coordination for dual eligibles and other special needs beneficiaries through unique benefit design and delivery systems. However, as described in MedPAC's June 2006 and June 2007 Reports to the Congress, we have concerns that SNPs have too little oversight to ensure that they fulfill this promise of coordinating care for special needs beneficiaries. SNPs, even dual-eligible SNPs, are not required to contract with states to provide Medicaid benefits. On the basis of site visits and discussions with experts, we do not see how dual-eligible SNPs that do not integrate Medicaid can fulfill the opportunity to coordinate the two programs. We also are unsure whether SNP designation is necessary to allow plans to furnish benefits targeted at people in institutions and with chronic conditions. CMS instructed SNPs to describe how they plan to meet their enrollees' special needs in their 2008 application, but CMS has not specified minimum expectations or established an enforcement mechanism. We are also concerned that since the creation of SNPs, CMS has consistently interpreted the SNP provision broadly and not established requirements to maximize the likelihood that all SNPs will focus on providing high-quality specialized care.

SNP types

The MMA authorized Medicare contracting with SNPs for three types of beneficiaries: dual eligibles, institutionalized

Medicare, Medicaid, and SCHIP Extension Act of 2007

Extension of authority for special needs plans (SNPs).

Extends the authority of SNPs to target enrollment to certain populations through 2009. Includes a moratorium on new plans and expanded service areas through December 31, 2009.

Access to Medicare reasonable cost contract plans.

Extends Section 1876 authority for cost contracts through December 31, 2009.

Adjustment to the MA stabilization fund. Removes \$1.5 billion from the stabilization fund for regional preferred provider organizations in 2012. ■

beneficiaries, and patients with severe chronic diseases or conditions.

Dual eligible

Dual-eligible SNPs are designed to serve dual-eligible beneficiaries, but they are not required to coordinate benefits with Medicaid programs, and many dual-eligible SNPs operate without any state contracts. They were intended, at least in part, to create a permanent home for various demonstrations to integrate Medicare and Medicaid in Massachusetts, Minnesota, and Wisconsin and to allow organizations in other states to implement similar programs. Dual-eligible beneficiaries can enroll in any type of SNP (if they meet the enrollment criteria) or other MA plan, not just dual-eligible SNPs.

Institutional

Institutional SNPs may enroll beneficiaries who reside or are expected to reside for 90 days or longer in a long-term care facility, including skilled nursing facilities, nursing homes, nursing facilities, intermediate care facilities for the mentally retarded, and inpatient psychiatric facilities. They may also enroll beneficiaries living in the community who require a level of care equivalent to that of beneficiaries in these facilities. With CMS approval, they may limit enrollment and marketing to select facilities within their geographic service area.

Chronic condition

Chronic condition SNPs are designed for beneficiaries with severe or disabling chronic conditions, which CMS has not explicitly defined. Because chronic condition SNPs are a new offering, CMS said it did not want to limit innovations. The agency instead said that it planned to evaluate proposed plans on a case-by-case basis,

considering appropriateness of the target population, clinical programs and expertise, and how the SNP will cover the full spectrum of the target population without discriminating against the sicker members. Currently, chronic condition SNPs serve beneficiaries with a variety of conditions, including cardiovascular disease, congestive heart failure, diabetes, chronic obstructive pulmonary disease, asthma, hypertension, coronary artery disease, osteoarthritis, mental illness, end-stage renal disease, and human immunodeficiency virus/acquired immunodeficiency syndrome. Some SNPs target multiple conditions that tend to occur together. CMS recently approved a chronic condition SNP for beneficiaries with high cholesterol as well as one for beneficiaries with Alzheimer's disease. At issue is whether all these conditions are sufficiently dominant to organize care around them.

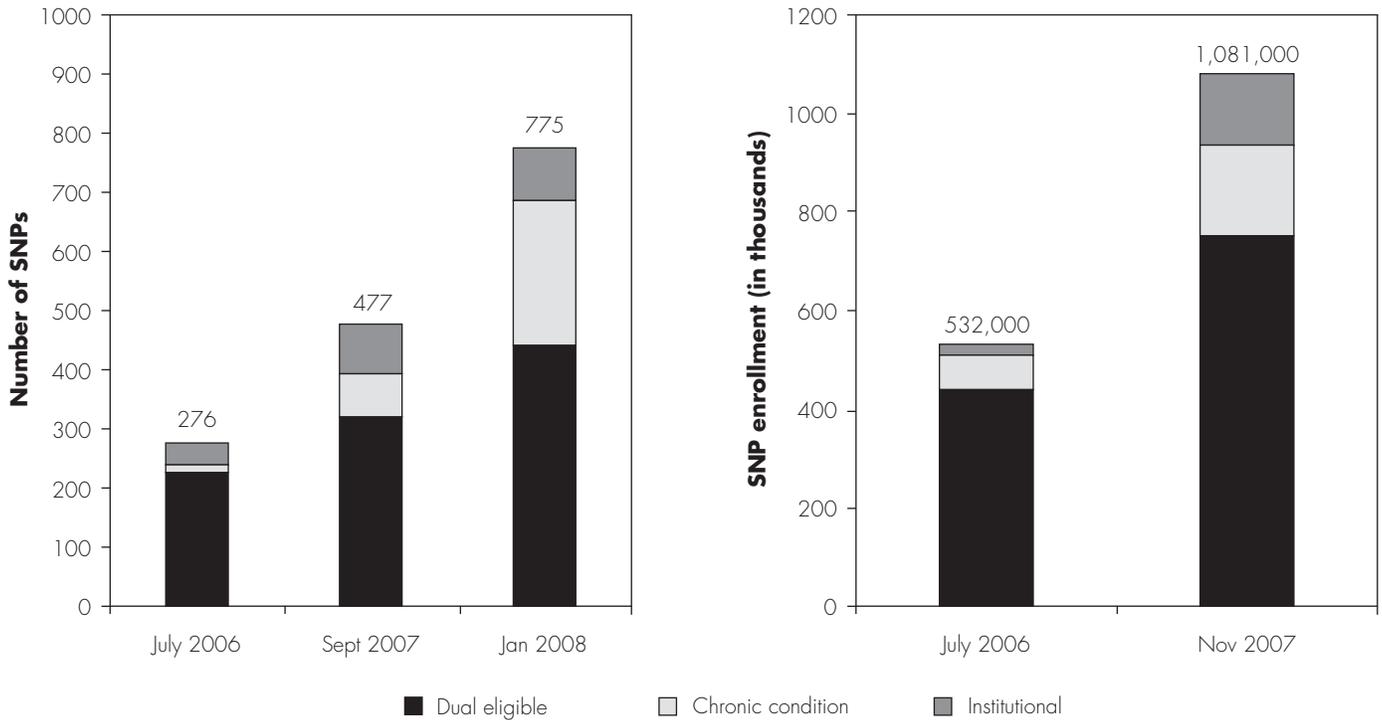
SNP availability and enrollment

The number of SNPs has grown rapidly since they were introduced, with just 11 SNPs in 2004, 125 in 2005, 276 in 2006, and 477 in 2007 (Figure 3-6, p. 264). In 2008, there are nearly 800 SNPs. Dual-eligible SNPs are still the most common type (57 percent of all SNPs), but chronic condition and institutional SNPs have grown to account for a larger share. Most beneficiaries (95 percent) live in an area served by a SNP. Eighty-nine percent of beneficiaries live in an area served by a chronic condition SNP, 77 percent in areas with dual-eligible SNPs, and 54 percent in areas with institutional SNPs.

Enrollment in SNPs by type is roughly proportional to the plans' availability. In July 2006, most SNP enrollment (83 percent) was in dual-eligible plans (Figure 3-6). Enrollment in chronic condition SNPs was almost entirely (98 percent) in a single plan in Puerto Rico, and

**FIGURE
3-6**

**The number of SNPs increased from 2006 to 2008,
and enrollment increased between 2006 and 2007**



Note: SNP (special needs plan).

Source: CMS special needs plans fact sheet and data summary, February 14, 2006; CMS SNP comprehensive reports, September and November 2007; CMS SNP Report for January 2008, November 2007; and CMS annual report by plan, July 26, 2006.

enrollment in institutional SNPs was mostly (88 percent) in Evercare plans offered by UnitedHealthcare. By November 2007, most SNP enrollment (70 percent) was still in dual-eligible plans. Enrollment in chronic condition SNPs increased partly because of the entrance of chronic condition SNPs structured as regional PPOs, offered by XLHealth, which attracted about 74,000 enrollees. Between July 2006 and November 2007, enrollment in institutional SNPs grew as a share of total SNP enrollment from 4 percent to 13 percent. Redefinition of the SCAN demonstration social HMO as an institutional SNP largely accounts for this growth.¹³ SCAN's approximately 90,000 enrollees account for 62 percent of institutional SNP enrollment.

What are our concerns about SNPs?

The Congress created SNPs to shift several existing specialized plans (primarily those operating under demonstration authority) to a more permanent status.

If the Congress allows their authority to limit their enrollment to targeted populations to lapse, then existing SNPs could become regular MA plans or be approved as demonstrations.¹⁴ Many observers have been surprised at how many organizations opted to offer SNPs under this new authority and how different some of these plans look compared with the demonstration models.

The transition to full risk adjustment may have contributed to rapid SNP growth.¹⁵ The new risk-adjustment model pays more appropriately than the previous model, thereby discouraging plan selection of healthier enrollees and making sicker beneficiaries more attractive to enroll than in the past. Nonetheless, the rapid, large growth in SNPs is surprising because they are paid the same as other MA plans. To the extent that they enroll beneficiaries who are less healthy, risk adjustment is the only difference in their payment and therefore may play a role in this growth. We plan to continue to monitor the risk-adjustment system.

Any improvements should apply to all MA plans and not just to SNPs.

We are concerned about the lack of Medicare requirements to target special populations to ensure that SNPs provide specialized care for their populations. We are also concerned that since the creation of SNPs, CMS has consistently interpreted the SNP provision broadly and not established requirements to maximize the likelihood that all SNPs would focus on providing high-quality specialized care. In short, we are concerned that there is a lack of accountability. This raises questions about the value of these plans to the Medicare program.

SNP recommendations

Whether to allow SNPs to continue to limit their enrollment to a target population comes down to whether they need to limit their enrollment to do something special or whether they do the same things as regular MA plans. A key motivation for creating SNPs still applies to allowing them to continue: providing a big umbrella to cover all special plans and demonstrations. If SNP authority were to cease, then some existing SNPs could change into regular MA plans and others could revert to or try to become demonstrations. CMS or the Congress would need to continually reapprove these types of demonstrations, and any new projects that hoped to build off the lessons learned would also have to become demonstrations.

The recommendations reflect our expectation that SNPs should provide specialized care for their enrollees that regular MA plans do not provide as efficiently or as effectively. SNPs may be able to tailor unique benefit packages that allow them to provide more efficient, higher quality care through specialization. However, some SNPs clearly do not meet this standard. SNPs are a type of MA plan and, as such, are subject to all the Commission's MA recommendations, including those on payment and quality (see text box, p. 250).

Quality, information, and accountability

We are concerned about the lack of Medicare requirements designed to ensure that SNPs provide specialized care for their targeted populations and SNPs' resulting lack of accountability to beneficiaries and the Medicare program. We are also concerned about problems eligible beneficiaries may have in accessing reliable information about SNPs.

All SNPs should be evaluated on some additional measures, while other measures should be specific to SNP

types—for example, SNPs for end-stage renal disease (ESRD) should be evaluated by the same measures as the ESRD demonstrations. All these measures, together with existing measures that compare SNPs with other MA plans, should form the basis for a rigorous evaluation to help inform a future decision about whether SNPs should become a permanent MA option. The performance measures should be established, plans' performance on them should be evaluated, and the Secretary should publicly report the results within a three-year period to inform future decisions about extending SNP authority.

Recommended performance measures should include quality, resource use, consumer satisfaction, and any other aspects the Secretary deems appropriate. Examples might include measures currently being developed by NCQA and CMS specifically for SNPs, HOS measures, and RAND's Assessing Care of Vulnerable Elders measures for health problems affecting seniors.

RECOMMENDATION 3-1

The Congress should require the Secretary to establish additional, tailored performance measures for special needs plans and evaluate their performance on those measures within three years.

RATIONALE 3-1

SNPs must measure and report the same quality measures as other MA plan types. If SNPs need to limit their enrollment to a target population to provide specialized care, then the quality of that specialized care should be assessed by appropriate measures.

IMPLICATIONS 3-1

Spending

- See Recommendation 3-7.

Beneficiaries and plans

- This recommendation is expected to improve the quality of care for beneficiaries.
- Plans will have the burden of reporting more information as a result of this recommendation.

After discussions with SNPs, states, and CMS, we have learned that lack of clear information is an impediment to beneficiaries' learning about and making an informed decision about joining a SNP. Because the CMS website template is structured to compare all MA plans consistently and CMS has not restructured the template to reflect SNP offerings, these plans are not described accurately. For example, the Medicare Compare website shows cost-

sharing requirements for dual-eligible SNPs that charge no enrollee cost sharing because it is paid by states through Medicaid. The comparative SNP information could be included on the Medicare Compare website—for example, as a drill-down option. Because most beneficiaries do not use the website, written comparative SNP information should be mailed to beneficiaries annually (similar to the regional Medicare+Choice guides that were included in *Medicare & You*).

RECOMMENDATION 3-2

The Secretary should furnish beneficiaries and their counselors with information on special needs plans that compares their benefits, other features, and performance with other Medicare Advantage plans and traditional Medicare.

RATIONALE 3-2

Both sources of information will assist beneficiaries and formal and informal beneficiary counselors to make informed decisions about the benefits SNPs offer.

IMPLICATIONS 3-2

Spending

- See Recommendation 3-7.

Beneficiaries and plans

- This recommendation should improve beneficiaries' ability to make informed choices about special needs plans.
- This recommendation should have minimal impact on plans.

Defining chronic condition SNPs

Chronic condition SNPs are designed for beneficiaries with severe chronic diseases or conditions, which CMS has not explicitly defined. We are concerned that the current standard is too loose; for example, CMS recently approved a SNP for beneficiaries with high cholesterol, a condition so common that all MA plans should be expected to manage it. Not all chronic condition SNPs are sufficiently specialized to warrant targeted delivery systems and disease management strategies and the unique ability to limit enrollment to certain beneficiaries.

Chronic condition SNPs should strive to integrate existing delivery systems, incorporating their enrollees' primary care and other responsible physicians. Plans should engage in activities to help to overcome the existing fragmentation in FFS Medicare. These care coordination

efforts could rely primarily on physicians to organize enrollees' care and services from multiple providers. Alternatively, they could use other care managers, such as disease management providers. Chapter 2 of MedPAC's June 2006 Report to the Congress discusses different care coordination models (MedPAC 2006).

We envision the narrower definition of chronic condition SNPs included in the recommendation going into effect soon. To refine the definition, the Secretary should convene a panel of clinicians and other experts to create a list of chronic conditions and criteria appropriate for chronic condition SNP designation. The list of chronic conditions and other criteria should be issued as a proposed rule with comment and final rule within a three-year period to inform future decisions about extending SNP authority. As part of the "other" criteria, the panel should identify the appropriate stage or severity for each condition for SNP designation.

RECOMMENDATION 3-3

The Congress should direct the Secretary to require chronic condition special needs plans to serve only beneficiaries with complex chronic conditions that influence many other aspects of health, have a high risk of hospitalization or other significant adverse health outcomes, and require specialized delivery systems.

RATIONALE 3-3

Chronic condition SNPs are too broadly defined. Not all chronic condition SNPs are sufficiently specialized to warrant targeted delivery systems and disease management strategies and the unique ability to limit enrollment to certain beneficiaries.

IMPLICATIONS 3-3

Spending

- See Recommendation 3-7.

Beneficiaries and plans

- This recommendation would help focus chronic condition SNPs on beneficiaries with appropriate chronic conditions.
- Some plans would either have to change their targeted conditions or cease to be SNPs; they could continue as MA plans, however.

Dual eligibles and states

Although they were intended to coordinate Medicare and Medicaid, dual-eligible SNPs are not required to

coordinate benefits with Medicaid programs, and many dual-eligible SNPs operate without state contracts. Without a contract with states to cover Medicaid benefits, it is unclear how a dual-eligible SNP would differ from a regular MA plan. Dual-eligible beneficiaries are too heterogeneous a group for a single clinical model to serve all of them. Instead, dual-eligible SNPs should be an integration model to coordinate financing and other aspects of Medicare and Medicaid.

Based on our discussions with SNPs that have a contract, it may reasonably take several years to establish one. Recommending that all dual-eligible SNPs should contract with states within three years means that by 2012 any new dual-eligible SNPs could begin operating only if they started with a contract in place. Contracts would not have to include capitation; states and SNPs may arrive at other payment arrangements and should coordinate other aspects, such as marketing, appeals, and enrollment. Ideally, contracts would cover long-term care, but we recognize that this may be more complicated than covering other benefits. Few SNPs with state contracts have taken risk for this high-cost service. Indirect contracts could be appropriate if states limit the number of managed care plans they will contract with and SNPs work out contracts with plans that have existing state contracts but may not be SNPs.

Some dual-eligible SNPs have succeeded in achieving greater coordination with states. In addition, by the end of 2008, 32 states will have Program of All-Inclusive Care for the Elderly (PACE) contracts that coordinate capitated Medicare and Medicaid payments. Although PACE is a different program, it shows that states will enter contracts and other collaborative agreements.

We welcome CMS's efforts to encourage greater state-SNP integration and would like CMS to do even more to facilitate collaboration between states and SNPs. It is unrealistic to expect or require all states to enter into partnership agreements with all entities that wish to offer dual-eligible SNPs. Not all states may see value in all plans, and they have a legitimate role in serving their dual-eligible beneficiaries in determining which plans they wish to contract with.

While pursuing contracts, dual-eligible SNPs should limit enrollees' out-of-pocket cost sharing to no more than Medicaid cost sharing. Medicare beneficiaries qualify for Medicaid support because they are poor. Cost sharing in Medicaid programs is low to ensure access to care. Plans should not raise cost sharing above these levels. To ensure

that SNPs are not given an unfair competitive advantage over other MA plans, their bids should be required to reflect actual negotiated provider payment rates and beneficiary cost sharing.

RECOMMENDATION 3-4

The Congress should require dual-eligible special needs plans within three years to contract, either directly or indirectly, with states in their service areas to coordinate Medicaid benefits.

RATIONALE 3-4

Without a contract with states to cover Medicaid benefits, it is unclear that a dual-eligible SNP would differ from a regular MA plan or offer any advantage to dual-eligible beneficiaries who join.

IMPLICATIONS 3-4

Spending

- See Recommendation 3-7.

Beneficiaries and plans

- Beneficiaries should receive greater coordination of their Medicare and Medicaid benefits.
- Some plans would be unable to contract with states and would have to cease to be SNPs; they could continue as MA plans, however.

Disproportionate share enrollment

Most SNPs limit their enrollment to their targeted special needs population. They may apply to CMS for a waiver to enroll other beneficiaries as long as their total membership includes a disproportionate percentage of their targeted population. According to CMS, the percentage of the target population in the plan must be greater than the percentage that occurs nationally in the Medicare population. We expect plans to report on their use of the waivers and explain which other beneficiaries they enrolled and why. We expect CMS to report this information, in addition to reporting the number of waivers it has granted, both annually and in its evaluation of SNPs to be completed within three years to inform future decisions about whether SNPs and waiver authority should continue.

RECOMMENDATION 3-5

The Congress should require special needs plans to enroll at least 95 percent of their members from their target population.

**TABLE
3-11**

MA election periods

| | Time frame | Eligibility |
|----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|
| Annual election period | November 15 through December 31 | All beneficiaries |
| Initial coverage election period | <p><i>Begins:</i> 3 months before entitlement to both Part A and Part B</p> <p><i>Ends on the later of:</i></p> <ol style="list-style-type: none"> 1. last day of the month preceding entitlement to both Part A and Part B, or 2. 3 months after the month of eligibility. | |
| Special election periods (SEPs) | <p><i>Begins:</i> defined trigger events, as listed in left-hand column below.</p> <p><i>Ends:</i> when the beneficiary elects a new MA plan or when the SEP time frame ends, whichever comes first.</p> | |
| Change in residence outside of the service area | <p>Permanent move:</p> <p><i>Begins:</i> the month prior to the beneficiary's move.</p> <p><i>Ends:</i> 2 months after the move.</p> <p>Temporary move:</p> <p><i>Begins:</i> beginning of the sixth month of being out of the area.</p> <p><i>Ends:</i> end of the eighth month.</p> | |
| MA plan's contract terminated | <p>MA plans must give notice of at least 60 calendar days.</p> <p><i>Begins:</i> 2 months before termination.</p> <p><i>Ends:</i> 1 month after the termination month.</p> | |
| Beneficiary demonstrates that the MA plan violated its contract, or the plan (or its agent) materially misrepresented the plan in marketing. | <p>Beneficiary may elect another MA plan or traditional Medicare during the last month of enrollment in the MA plan.</p> <p>CMS may process a retroactive disenrollment.</p> | |

Note: MA (Medicare Advantage), SNP (special needs plan). CMS may provide special election periods for other exceptional conditions. MA organizations are not required to open their MA plans for enrollment during an open enrollment period (OEP). However, MA organizations must accept valid requests for disenrollment from MA plans during the OEP since traditional Medicare is always open during an OEP. In addition, if an MA organization has more than one MA plan, the MA organization is not required to open each plan for enrollment during the same time frames. If an MA organization opens a plan during part of an OEP, it is not required to open the plan for the entire month; it may choose to open the plan for only part of the month.

Source: CMS, Medicare Managed Care Manual.

RATIONALE 3-5

The current disproportionate share standard is too liberal and untargeted. It allows SNPs with waivers to select among enrollees who fall outside targeted populations based on unknown criteria. The Commission encourages legitimate innovation in plan design but believes the current standard does not hold plans accountable for which enrollees they accept or reject.

IMPLICATIONS 3-5

Spending

- See Recommendation 3-7.

Beneficiaries and plans

- Because few SNPs have received a disproportionate enrollment waiver, relatively few beneficiaries would have to switch plans or return to FFS as a result of this recommendation. Changes now would avoid bigger effects in the future if more plans were granted a disproportionate share waiver.

**TABLE
3-11**

MA election periods (cont.)

| | Time frame | Eligibility |
|------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|
| Open enrollment for dual eligibles | <p><i>Begins:</i> when beneficiaries become dually eligible and exists as long as they receive Medicaid benefits.</p> <p>Beneficiaries who lose Medicaid eligibility have a 3-month period to make an election.</p> | Beneficiaries entitled to Medicare Part A and Part B and Medicaid |
| Open enrollment period (OEP) for MA | Beneficiaries may make one MA OEP election from January 1 through March 31 to join an MA plan, switch plans, or choose traditional Medicare coverage. Does not apply to Part D coverage (e.g., during the OEP traditional Medicare beneficiaries with no Part D coverage may not join an MA prescription drug plan, only an MA plan that does not include drug coverage). | All beneficiaries |
| Open enrollment for newly eligible individuals | <p><i>Begins:</i> the month of entitlement to both Part A and Part B</p> <p><i>Ends:</i> on the last day of the 3rd month of entitlement, or on December 31 of the same year, whichever occurs first</p> | Beneficiaries who become MA eligible during the year |
| Open enrollment period for institutionalized individuals (OEPI) | Eligible beneficiaries can make an unlimited number of MA elections during the OEPI, but plans are not required to be open for the OEPI. | Beneficiaries who move into, reside in, or move out of an institution (or for SNPs that are nursing-home certifiable, living in the community) |

Note: MA (Medicare Advantage), SNP (special needs plan). CMS may provide special election periods for other exceptional conditions. MA organizations are not required to open their MA plans for enrollment during an open enrollment period (OEP). However, MA organizations must accept valid requests for disenrollment from MA plans during the OEP since traditional Medicare is always open during an OEP. In addition, if an MA organization has more than one MA plan, the MA organization is not required to open each plan for enrollment during the same time frames. If an MA organization opens a plan during part of an OEP, it is not required to open the plan for the entire month; it may choose to open the plan for only part of the month.

Source: CMS, Medicare Managed Care Manual.

- Some plans would have to alter their enrollment or cease to be SNPs; they could continue as regular MA plans, however.

Open enrollment and special election periods

Special needs beneficiaries have more opportunities to join or switch MA plans outside of the open enrollment period than regular beneficiaries (Table 3-11). Beneficiaries going into, residing in, or leaving an institution have a continuous open enrollment period when they can join any open MA plan, which means they can change plans monthly. Dual eligibles have a special election period that begins when they become dually eligible and continues as long as they remain dually eligible, which means they too can change plans monthly. Individuals with severe or disabling chronic conditions have a special election

period to enroll in a SNP designed for beneficiaries with those conditions, which begins with diagnosis of the condition and ends upon enrollment in a SNP. CMS provides a special election period for those who are no longer eligible for a SNP, such as those who lose their Medicaid eligibility, to enable them to enroll in a regular MA plan. To address the problem of dual eligibles losing their Medicaid eligibility for short periods of time, CMS allows SNPs to keep these beneficiaries enrolled for up to 6 months (CMS 2006).

We are concerned about reports of marketing abuses. In 11 of a series of 13 focus groups that Commission staff conducted in 2007 on Part D issues, participants volunteered stories of inappropriate marketing. Sean Dilweg, the Wisconsin Commissioner of Insurance,

testified to the Subcommittee on Health of the House Committee on Ways and Means that states have consistently reported complaints of unethical, high-pressure sales tactics, such as door-to-door sales; sales agents improperly portraying that they were from Medicare or Social Security; mass enrollments and door-to-door sales at senior centers, nursing homes, or assisted living facilities; forged signatures on enrollment forms; and improper obtainment or use of personal information (Dilweg 2007).

One consequence is that these beneficiaries can find themselves enrolled in plans that charge them more cost sharing than under FFS. Another consequence is that these beneficiaries can enroll and disenroll from plans frequently, harming the continuity of care if their providers do not participate in each plan. We are also concerned about reports of marketing abuses from stand-alone prescription drug plans. If they enroll in one of these plans, dual eligibles are automatically disenrolled from their SNP or other MA plan. We encourage CMS to track and report the extent to which dual eligibles switch between plans (and FFS Medicare) during the year. Together with making changes to beneficiaries' ability to enroll in plans, we strongly urge CMS to consider increasing its oversight of plans' and brokers' marketing practices.

RECOMMENDATION 3-6

The Congress should eliminate dual-eligible and institutionalized beneficiaries' ability to enroll in Medicare Advantage plans, except special needs plans with state contracts, outside of open enrollment. They should also continue to be able to disenroll and return to fee-for-service at any time during the year.¹⁶

RATIONALE 3-6

Dual-eligible and institutionalized Medicare beneficiaries are allowed to enroll and disenroll from MA plans on a monthly basis. Presumably, they were exempted from lock-in to give them greater protection than other beneficiaries. However, the provision has had unintended consequences. This recommendation is designed to protect dual-eligible beneficiaries from marketing abuses from all types of MA plans. Dual-eligible and institutionalized beneficiaries could change plans during the open enrollment period and during special election periods triggered by life events (e.g., at the point they become eligible for Medicaid or enter a nursing home), and they could choose to disenroll from a plan at any time. We would provide an exception for SNPs with state contracts because states' enrollment periods can differ from

Medicare's and because states will oversee plans with which they have a relationship.

IMPLICATIONS 3-6

Spending

- See Recommendation 3-7.

Beneficiaries and plans

- This recommendation is designed to protect dual-eligible Medicare beneficiaries from plan marketing abuses.
- This should have a significant impact on plans; it may reduce plan enrollment.

Extension of SNP authority to limit enrollment

The authority for SNPs to limit enrollment is scheduled to expire December 2009. A CMS evaluation was due to the Congress in December 2007. Because most SNPs had been operating only for a year or two when the study was conducted, there may be insufficient quality and other data on which to evaluate them. In light of SNPs' rapid growth in number and enrollment, we want a rigorous evaluation upon which to base our decision before recommending that they be made a permanent MA option.

Plans should consider adopting a range of care coordination tools, such as care managers, individualized health plans, multidisciplinary teams, and electronic medical records. The Secretary should develop and implement quality measures that capture care coordination processes—for example, use of individualized health plans, medical record exchanges, and indicators of lack of care coordination such as emergency room use. New specialized measures must supplement existing measures that allow for the comparison between SNPs and other MA plans.

RECOMMENDATION 3-7

The Congress should extend the authority for special needs plans that meet the conditions specified in Recommendations 3-1 through 3-6 for three years.

RATIONALE 3-7

All SNP types have the potential to improve care; however, the current evaluation will not give us enough data to assess these plans. Additional quality indicators, state contracts, and narrower definitions of chronic diseases will improve oversight of these plans; we would like to re-evaluate them once they have an opportunity to meet

these criteria before deciding whether they should become a permanent MA option. The Secretary would need to implement all new rules, collect performance data from plans, evaluate their performance, and report the results within a three-year period to inform future decisions about extending SNP authority.

IMPLICATIONS 3 - 7

Spending

- No significant budgetary effect for 2009 and increases Medicare spending relative to current law by less than \$1 billion over five years

Beneficiaries and plans

- This recommendation would allow beneficiaries to continue to have access to SNPs during an additional evaluation period.
- This recommendation would allow providers additional time to be evaluated while continuing to operate SNPs. ■

Endnotes

- 1 We projected FFS spending by county using 2007 estimates in the 2007 MA rate book updated by the CMS estimate of growth in national spending for 2008. We discounted spending related to the double payment for indirect medical education payments made to teaching hospitals.
- 2 While we were able to isolate the influence of Puerto Rico on our ratios, we cannot isolate other geographic areas. Our ratios are built on data from plan service areas, so that a plan's ratio of payment to FFS is calculated over its entire service area and weighted by its enrollment from each county. We expect the ratios to vary based on the geography of each plan's service area, but many service areas are very broad and thus cannot be attributed to individual geographic areas. Plans that serve Puerto Rico, on the other hand, do not include mainland service areas in their bids.
- 3 Nonfloor counties' benchmarks average 112 percent of FFS spending. Floor counties have benchmarks that average 120 percent of FFS spending.
- 4 In discussing how CMS uses Healthcare Effectiveness Data and Information Set (HEDIS[®]) data in monitoring plans, CMS staff stated that the data are a component of contractor monitoring through a performance assessment system that is updated annually. The performance of plans is a factor in determining which plans are audited. For those with high scores on particular data elements, the audit requirements can be lessened. HEDIS scores were one of the factors used in deciding to terminate the contract of an MA plan in 2007 based on concerns about the quality of care the plan provided.
- 5 A score might not improve if it is particularly high to begin with. In most cases, this does not explain the lack of improvement in Medicare HEDIS scores. In comparing Medicare and commercial HEDIS scores on measures reported by both types of plans in 2006, for four measures Medicare scores exceeded commercial scores by 10 percent or more, but commercial scores exceeded Medicare scores by 10 percent or more for nine measures.
- 6 The NCQA report is based on a smaller proportion of Medicare health plans than the number that appear in the PUFs: NCQA included 211 plans (Medicare contracts), and the PUF files for 2006 (based on plan reports completed in 2007) contain data for 275 contracts, with one contract split into two market areas (for a total of 276 reporting units). The CMS HEDIS PUF files do not include all MA contractors for 2006. In 2006, there were 426 coordinated care plan contracts and 25 PFFS contracts. However, there is a minimum size requirement for MA organizations to report HEDIS measures. If an MA contract has at least 1,000 members as of July 1 of the measurement year (and is not otherwise exempt from reporting), the plan is subject to the HEDIS reporting requirements. At least 293 contracts met the minimum size requirements for 2006, and 3 contracts withdrew from the program at the end of 2006. Thus, the PUF files are relatively complete in their representation of Medicare plans in that they include reports from more than 90 percent of plans that were eligible for HEDIS reporting in 2006. However, not all measures are reported by all plans.

HEDIS and HOS data are reported at the Medicare contract level—the “H” or “R” number level. Multistate plans, such as the Humana regional plan contract number that covers 23 states (R5826), are considered a single “plan” for reporting HEDIS and CAHPS data. Reporting at the H or R level also means that data are reported for enrollees who may have very different benefit packages and cost-sharing structures in their MA “plans.” Some plans (benefit offerings), which are subsets of H and R numbers (and which are the organizational unit for plan bids and pricing), may not include Part D drug coverage or the H or R number will have benefit offerings with richer benefits or lower cost sharing. Reporting at the contract level also causes SNPs to be combined with other plans if an organization offers each type of plan under a single H or R number.
- 7 Medicare improved on six measures based on the final published version of the NCQA SOHCQ report for 2007 (showing 2006 results). Earlier versions of the report showed that Medicare improved on seven measures between 2005 and 2006.
- 8 CMS has indicated that when a plan does not report a HEDIS measure, CMS will “usually issue a request for the data, and [plans] ... comply as soon as they can.”
- 9 Plans that decided to enter into Medicare contracts because of the MMA provisions on payment and other provisions seeking to increase plan availability would have started their contracts in 2005 or toward the end of 2004 (the MMA was enacted in December 2003). In the HEDIS data we examined, there was only one plan with a contract that began on January 1, 2004. There were seven other contracts that began in 2004, dating from May 2004 or later.
- 10 There are also two PFFS plans represented in the CMS HEDIS PUF data, with only one of the plans reporting any measures at all. The only measure this PFFS reported was breast cancer screening rates.
- 11 MSA plan enrollees also participate in CAHPS, but the current data do not include any MSA plans. As in the case of HEDIS and HOS, cost-reimbursed HMOs participate in CAHPS. (Cost-reimbursed HMOs are paid under the

provisions of Section 1876 of the Social Security Act. They are not MA plans, and members are not “locked in” to the health plan; that is, they may receive Medicare-covered services through FFS providers.)

- 12 The CMS HOS staff told us that a forthcoming dissertation, expected to be completed in the fall of 2008, will compare the 1998–2000 managed care enrollees with FFS Medicare beneficiaries.
- 13 Another social HMO, Elderplan, Inc., of New York was also redefined as an institutional SNP and had 16,368 enrollees in November 2007.
- 14 There is no guarantee that any of the several hundred SNPs would be approved as demonstrations. Under Section 402(b) of the Social Security Amendments of 1967, CMS is

authorized to use demonstration authority to waive Medicare payment requirements. Since SNPs are paid the same as other MA plans, it may be especially difficult for them to be approved as demonstrations.

- 15 CMS phased in the hierarchical condition category risk-adjustment model, which uses age, sex, other demographic variables, and diagnoses, from 2004 through 2007. It predicts resource use better than the previous principal inpatient diagnosis cost group model, which did not include diagnoses (MedPAC 2004).
- 16 This recommendation includes a two-word, technical correction that Commissioners voted on at their January meeting. That vote was 14 yes and 3 absent.

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