CHAPTER 12

The Medicare Advantage program: Status report

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Chapter summary

Each year the Commission provides a status report on the Medicare Advantage (MA) program. To monitor program performance, we examine MA enrollment trends, plan availability for the coming year, and payments for MA plan enrollees relative to spending for fee-for-service (FFS) Medicare beneficiaries. We also provide an update on current quality indicators in MA. In addition this year, we describe the changes in the MA payment system that are being phased in as a result of the Patient Protection and Affordable Care Act of 2010 (PPACA) and suggest a technical adjustment to the benchmark formula.

The MA program allows Medicare beneficiaries to receive benefits from private plans rather than from the traditional FFS Medicare program. The Commission supports private plans in the Medicare program; beneficiaries should be able to choose between the traditional FFS Medicare program and the alternative delivery systems that private plans can provide. Private plans have greater potential to innovate and to use care management techniques and, if paid appropriately, would have more incentive to do so.

Enrollment—In 2010, MA enrollment increased to 11.4 million beneficiaries (24 percent of all Medicare beneficiaries). Enrollment in HMO plans—the largest plan type—increased 7 percent. In a major pattern change between

In this chapter

2009 and 2010, enrollment in private FFS (PFFS) plans declined from about 2.4 million to about 1.7 million enrollees. PFFS plans made business decisions in anticipation of new network requirements for PFFS plans beginning in 2011 mandated by the Medicare Improvements for Patients and Providers Act of 2008. Some PFFS plans reduced offerings and some stated they would begin to transition their enrollment to network-based preferred provider organization (PPO) plans. Predictably, PPOs exhibited rapid growth in enrollment, with local PPO enrollment growing about 40 percent and enrollment in regional PPOs more than doubling between 2009 and 2010. The MA plan bid submissions to CMS project an increase in overall enrollment for 2011, with further movement from PFFS plans to PPOs and continued growth in HMOs.

Plan availability—In 2011, virtually all Medicare beneficiaries have access to an MA plan (0.4 percent do not), and 99 percent have access to a network-based coordinated care plan (CCP). Ninety percent of beneficiaries have access to an MA plan that includes Part D drug coverage and charges no premium (beyond the Medicare Part B premium). While some PFFS plan sponsors offer network PFFS plans in 2011, as noted above there are fewer PFFS plan options. As a result, fewer MA plan options are available in 2011 than in 2010, but beneficiaries can still choose from an average of 12 plan options in each county, including 8 CCPs.

Plan payments—PPACA changes to setting MA plan benchmarks will not be fully phased in until 2017. For 2011, benchmarks were frozen, and the freeze, combined with low growth in FFS Medicare spending, did not result in much change in our measures of benchmarks, plan bids, and Medicare MA payments relative to FFS spending. We estimate that 2011 MA benchmarks, bids, and payments will average 113 percent, 100 percent, and 110 percent of FFS spending, respectively. HMOs are the only plan type with average bids below FFS levels. All other plan types continued to bid above FFS levels on average. The new method of setting MA payment benchmarks may need some technical adjustments, particularly with respect to intercounty benchmark inequities.

Quality measures—For 2010, quality measures were stable with some improvement in clinical process measures over the preceding year, as measured by the Healthcare Effectiveness Data and Information Set. Looking at beneficiary survey information collected through the Consumer Assessment of Healthcare Providers and Systems, we find that, at an aggregate level, vaccination rates and measures of patient experience are comparable to the rates in FFS Medicare, but we are cautious in how we view this result because of variation by population and by geographic area. Measures of patient outcomes in MA are not significantly changed

from earlier years. There continues to be wide variation in quality indicators across plans and across populations in MA.

PPACA introduced a pay-for-performance program for MA that, beginning in 2012, would provide bonus payments to higher quality plans under a five-star rating system. The stars are based on measures of clinical quality, patients' reported care experience, and contract performance. Under the PPACA provisions, plans with four or more stars would have received quality bonuses. However, from 2012 through 2014, CMS is using demonstration authority to replace the PPACA bonus system with a program-wide demonstration that will incur higher program costs. Under the demonstration, plans will provide bonus payments to plans with as few as three stars, the level that CMS defines as average performance. ■

The Medicare Advantage (MA) program allows Medicare beneficiaries to receive benefits from private plans rather than from the traditional fee-for-service (FFS) program. The Commission supports private plans in the Medicare program, as they enable beneficiaries to choose between the FFS Medicare program and the alternative delivery systems that private plans can provide. Plans often have flexibility in payment methods, including the ability to negotiate unique methods with individual providers; care management techniques that fill potential gaps in care delivery (e.g., programs targeted at preventing avoidable hospital readmissions); and robust information systems that provide more timely feedback to providers. Plans can also reward beneficiaries for seeking care from more efficient providers and give them more predictable cost sharing, but plans often restrict the choice of providers.

By contrast, traditional FFS Medicare has lower administrative costs while offering beneficiaries an unconstrained choice of health care providers. Of course, traditional Medicare also has the potential to modify its payment methods over time to better reward value. Private plans and traditional FFS Medicare both have something to offer that might appeal to a segment of the Medicare population. Thus, we favor giving beneficiaries a financially neutral choice of Medicare private plans and FFS Medicare.

Providing a financially neutral choice means that the Medicare program should not send a strong financial signal to the beneficiary favoring MA over FFS, or vice-versa. Currently, Medicare spends more under the MA program for similar beneficiaries than it does under FFS. This higher spending results in extra benefits being provided by way of increased government outlays and beneficiary Part B premiums (including for those who are in traditional FFS Medicare) at a time when Medicare and its beneficiaries are under increasing financial stress. To encourage efficiency and innovation, MA plans need some degree of financial pressure, just as the Commission advocates for providers in the traditional FFS program. There is more than one way to achieve "financial neutrality" between Medicare and private plans. One method is to more tightly link payment to private plans to Medicare FFS costs in the same market. Alternatively, neutrality can be achieved through establishment of a defined contribution that is available for enrollment in either Medicare or a private plan. The latter approach has important implications that the Commission has not yet analyzed. Meanwhile, the Commission will monitor the effect of the changes mandated by the Patient Protection and Affordable Care Act of 2010 (PPACA) on plan payments and performance as well as progress toward financial neutrality.

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

Background

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

- ***Health maintenance organizations (HMOs) and local preferred provider organizations (PPOs)—*** These plans have provider networks and can use tools such as selective contracting and utilization management to coordinate and manage care. They can choose to serve individual counties and can vary their premiums and benefits across counties.
- ***Regional PPOs—***These plans are required to offer a uniform benefit package and premium across designated regions made up of one or more states. Regional PPOs have less extensive network requirements than local PPOs.
- ***Coordinated care plans (CCPs)—***This category includes all HMOs, local PPOs, and regional PPOs.
- ***Private FFS (PFFS) plans—***Before legislation effective 2011, PFFS plans typically did not have provider networks, making them less able than other plan types to coordinate care. They used Medicare FFS payment rates and had fewer quality reporting requirements. Under a requirement in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), in areas with two or more network MA plans, PFFS plans can be offered only if they have provider networks. PFFS plans are also now required to participate in quality reporting. Existing PFFS plans had to either withdraw or develop provider networks, which in effect would change them to PPOs or HMOs.

TABLE 12–1

Medicare Advantage enrollment grew in 2010

	MA enrollment (in millions)		Percent change	2010 MA enrollment as a share of total Medicare
	November 2009	November 2010		
Total	10.9	11.4	5%	24%
Urban	9.6	10.0	4	26
Rural	1.3	1.4	7	15
Plan type				
CCP	8.4	9.8	16	21
HMO	7.0	7.5	7	16
Local PPO	1.0	1.4	42	3
Regional PPO	0.4	0.9	98	2
PFFS	2.4	1.7	–32	3
Restricted availability plans included in totals above				
SNPs*	1.4	1.4	–2	3
Employer group*	1.9	2.0	4	4

Note: MA (Medicare Advantage), CCP (coordinated care plan), PPO (preferred provider organization), PFFS (private fee-for-service), SNPs (special needs plans). CCP includes HMO, local PPO, and regional PPO. Totals may not sum due to rounding.
* SNPs and employer-group plans have restricted availability and their enrollment is included in the statistics by plan type and location. They are presented separately to provide a more complete picture of the MA program.

Source: MedPAC analysis of CMS enrollment files.

Two additional plan classifications cut across plan types. First are special needs plans (SNPs), which offer benefit packages tailored to specific populations (i.e., beneficiaries who are dually eligible for Medicare and Medicaid, are institutionalized, or have a chronic condition). SNPs must be CCPs. Second are employer-group plans, which are available only to Medicare beneficiaries who are members of employer or union groups that contract with those plans. Employer-group plans may no longer be non-network PFFS plans. Both SNPs and employer-group plans are included in our plan data, with the exception of plan availability figures, as these plans are not available to all beneficiaries.

Plan payment rates are determined by the MA plan "bid" (the dollar amount the plan estimates will cover the Part A and Part B benefit for a beneficiary of average health status) and the payment area's "benchmark" (the maximum amount of Medicare payment set by law for an MA plan to provide Part A and Part B benefits). If a plan's bid is above the benchmark, then its MA payment rate is equal to the benchmark, and enrollees have to pay an additional premium equal to the difference. If a plan's bid is below the benchmark, then its payment rate is its bid plus 75 percent of the difference between the plan's bid and the benchmark. Because benchmarks are often set well above what it costs Medicare to provide benefits to similar beneficiaries in the FFS program, MA payment rates usually exceed FFS spending. In past reports, we examined why benchmarks are above FFS spending and what the ramifications are for the Medicare program. (Actual plan payments, as opposed to payment rates, are risk-adjusted. A more detailed description of the MA program payment system can be found at http://www.medpac.gov/documents/MedPAC_Payment_Basics_10_MA.pdf.)

Trends in enrollment, plan availability, and payment

Two pieces of enacted legislation have brought changes to the MA program for 2011. As noted, MIPPA requires PFFS plans to maintain provider networks in areas where there are already two or more MA plans with networks. While some PFFS plan sponsors offer network PFFS plans in 2011, many sponsors withdrew their PFFS plan options

(and some simultaneously expanded their PPO options). PPACA froze MA benchmarks for 2011 at 2010 levels. (PPACA also makes other changes, including benchmark reductions in future years, which are discussed below.)

Enrollment trends: Plan enrollment grew in 2010

From November 2009 to November 2010, enrollment in MA plans grew by about 5 percent, or one-half million enrollees, to 11.4 million beneficiaries, or 24 percent of all Medicare beneficiaries (Table 12-1).

Between 2009 and 2010, enrollment patterns differed in urban and rural areas. A larger share of urban Medicare beneficiaries were enrolled in MA (about 26 percent) than beneficiaries residing in rural counties (about 15 percent), even though plan enrollment grew at a faster rate in rural areas (about 7 percent) than in urban areas (about 4 percent). In 2010, 42 percent of rural MA enrollees were in PFFS plans (not shown in Table 12-1), compared with about 12 percent of urban enrollees.

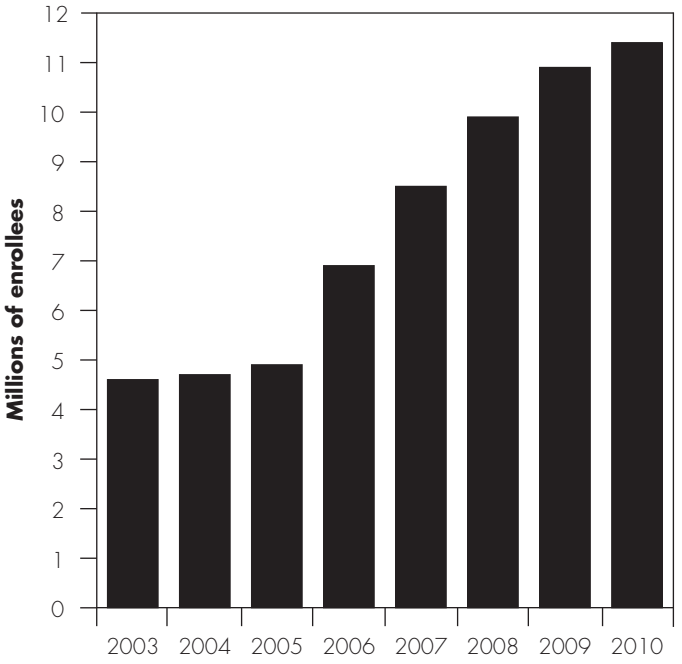
The percentage of Medicare beneficiaries enrolled in MA plans in 2010 varied widely by local area. In some metropolitan areas, less than 2 percent of Medicare beneficiaries were enrolled in MA plans, whereas in other areas, enrollment was 50 percent or more. (In Pittsburgh, PA, 60 percent of beneficiaries were enrolled in MA plans; in some areas of Puerto Rico, 70 percent of Medicare beneficiaries were enrolled.)

Among plan types, HMOs continued to enroll the most beneficiaries (7.5 million), with 16 percent of all Medicare beneficiaries in HMOs in 2010. PFFS enrollment shrank from about 2.4 million in 2009 to about 1.7 million enrollees in 2010, a decrease of about 700,000 enrollees. The decrease followed reduced PFFS plan offerings, as plans made business decisions to reduce their PFFS service areas in anticipation of MIPPA's network requirements for PFFS plans beginning in 2011. Some PFFS plans stated that they would begin to transition their enrollment to network plans. Indeed, PPOs exhibited rapid enrollment growth, with local PPO enrollment increasing about 40 percent and enrollment in regional PPOs more than doubling between 2009 and 2010. In 2010, SNP enrollment stayed at 1.4 million and employer-group enrollment grew about 5 percent to 2 million enrollees.

MA enrollment growth in 2010 continued a trend begun in 2003 (Figure 12-1). Enrollment more than doubled in the last five years. The 5 percent growth in 2010, however, was the lowest growth since 2005 and was down from 10 percent growth in 2009. We did not have 2011 enrollment information as of this report's publication, but plans projected overall enrollment growth in the 5 percent to 6 percent range for 2011.

FIGURE 12–1

Medicare Advantage enrollment, 2003–2010



Source: CMS monthly Medicare Advantage enrollment reports.

Plan availability for 2011

Every year, we base our plan availability and projected enrollment for the coming year on the bid data that plans submit to CMS. Access to MA plans remains high in 2011, with most Medicare beneficiaries having access to a large number of plans.

Overall access is stable

While almost all beneficiaries have had access to some type of MA plan since 2006, local CCP plans are more widely available in 2011 than in previous years (Table 12-2, p. 292). In 2011, 92 percent of Medicare beneficiaries have an HMO or local PPO plan operating in their county of residence, up from 91 percent in 2010 and 67 percent in 2005. Regional PPOs are available to 86 percent of beneficiaries in 2011, unchanged from 2010. In contrast, access to PFFS plans decreased between 2010 and 2011, from 100 percent to 63 percent of beneficiaries, consistent

TABLE 12–2

Access to Medicare Advantage plans remains high

	Percent of beneficiaries with access to MA plans by type						
Type of plan	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
All plan types*	84%	100%	100%	100%	100%	100%	100%
CCP							
HMO or local PPO	67	80	82	85	88	91	92
Regional PPO	N/A	87	87	87	91	86	86
PFFS	45	80	100	100	100	100	63
Zero-premium plans with Part D	N/A	73	86	88	94	85	90
Average number of MA plans open to all beneficiaries in a county	5	12	20	35	34	21	12

Note: MA (Medicare Advantage), CCP (coordinated care plan), PPO (preferred provider organization), N/A (not applicable), PFFS (private fee-for-service). These figures exclude special needs plans and employer-only plans. A zero-premium plan with Part D includes Part D coverage and has no premium beyond the Part B premium. Regional PPOs were created in 2006. Part D began in 2006.
*Statistics for medical savings account plans (MSAs) are not shown. Only two MSA plans are offered in 2011 (and only in New York and Pennsylvania). In 2010 there were only about 600 MSA enrollees.

Source: MedPAC analysis of plan bids to CMS, 2010

with MIPPA's network requirements for PFFS plans. Overall, virtually all Medicare beneficiaries have access to an MA plan (0.4 percent do not), and 99 percent have access to a CCP (not shown in Table 12-2).

Even lower access to PFFS plans might have been expected, as 13 percent of beneficiaries reside in counties without two or more network plans. Under MIPPA network requirements, PFFS plans must have a network in most of the counties they serve in 2011.

In 2011, 90 percent of Medicare beneficiaries have access to at least one MA plan that includes Part D drug coverage and charges no premium (beyond the Medicare Part B premium), compared with 85 percent in 2010.

The availability of SNPs (not shown in Table 12-2) has decreased slightly and varies by type of special needs population served. In 2011, 76 percent of beneficiaries reside in areas where SNPs serve beneficiaries who are dually eligible for Medicare and Medicaid (down from 79 percent in 2010), 47 percent live where SNPs serve institutionalized beneficiaries (down from 49 percent), and 46 percent live where SNPs serve beneficiaries with chronic conditions (down from 63 percent). Overall, 81 percent of beneficiaries reside in counties served by SNPs (in some cases, we could not identify which population a plan serves).

Although fewer than last year, a large number of plans remain available to beneficiaries

In most counties, a large number of MA plans are available to beneficiaries, although the number varies by county. For example, in Broward County, FL, beneficiaries can choose from 59 plans in 2011 (down from 69 in 2010). A few counties in the country have no plans (they represent 0.4 percent of the beneficiary population). On average, 12 plans are offered in each county in 2011, down from 21 plans in 2010.

There are two principal reasons for this decrease. The primary reason is the withdrawal of PFFS plans from many counties because of the network requirements in MIPPA. Although an average of five PFFS plans remain available in each county in 2011, an average of 13 PFFS plans were available in 2010. MIPPA requires that, by 2011, PFFS plans develop provider networks in areas where there are two or more network-based plans. (Some supporters of the provision believed there was no need to subsidize PFFS plans in areas where beneficiaries had other alternatives to Medicare FFS that held more promise to be able to provide care more efficiently.) In 2009, PFFS enrollment was about 22 percent of MA enrollment. Plan bids project that PFFS enrollment will fall to about 7 percent of MA enrollment in 2011. Because of the

TABLE 12–3

Payments exceed FFS spending for all plan types in 2011

	Percent of FFS spending in 2011		
Plan type	**Benchmarks**	**Bids**	**Payments**
All MA plans	113%	100%	110%
HMO	113	97	109
Local PPO	116	109	114
Regional PPO	110	104	110
PFFS	116	110	114
Restricted availability plans included in totals above			
SNP*	116	104	113
Employer groups*	114	108	112

Note: FFS (fee-for-service), MA (Medicare Advantage), PPO (preferred provider organization), PFFS (private fee-for-service), SNP (special needs plan). Benchmarks are the maximum Medicare program payments for MA plans. FFS spending by county is estimated using the 2010 MA rate book. Spending related to the double payment for indirect medical education payments made to teaching hospitals was removed. Totals may not sum due to rounding.
*SNPs and employer-group plans have restricted availability and their enrollment is included in the statistics by plan type. They are presented separately to provide a more complete picture of the MA program.

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

current round of PFFS plan withdrawals, many enrollees will need to join a different MA plan in 2011. CCPs are available to 99 percent of beneficiaries in 2011, and, as in 2010, an average of eight CCPs are still being offered in each county. Beneficiaries can also choose to obtain care through FFS Medicare.

The second reason for the decrease in MA plans is that CMS has made additional efforts to decrease the number of low-enrollment plans (CMS found a large number of plans with fewer than 10 enrollees) and duplicative plans. CMS defined a duplicative plan as one that did not offer meaningful differences from other plan choices. (In bidding guidance to plans, CMS defined a meaningful difference as $20 per month in cost sharing (Centers for Medicare & Medicaid Services 2010a).) Usually, such plans belonged to a family of plans from the same insurer with small differences among the benefit packages.

2011 benchmarks frozen at 2010 levels

Under PPACA, MA benchmarks for 2011 were set equal to the 2010 benchmarks for each county. Beginning in 2012, benchmarks will transition to a system in which each county's benchmark will be a certain percentage (ranging from 95 percent to 115 percent) of the average per capita Medicare FFS spending for the county's residents. The percentage will be based on the level of FFS spending for the county relative to spending for other counties. (The FFS spending estimates will be updated every three years or more frequently at CMS's discretion.)

The average benchmark by plan type will vary depending on the counties the plans serve and where they draw their enrollment. By law, certain counties were given higher benchmarks with the intent to increase plan availability. Local PPOs and PFFS plans tend to operate in counties with higher benchmarks relative to FFS than other plan types. SNPs have high benchmarks relative to FFS because a large share of total SNP enrollment is in Puerto Rico, where benchmarks have been very high relative to FFS (180 percent).

MA benchmarks, bids, and payments relative to Medicare FFS

We estimate that 2011 MA benchmarks, bids, and payments would average 113 percent, 100 percent, and 110 percent of FFS spending, respectively (Table 12-3). (Benchmarks, bids, and payments are weighted by plans' projected 2011 enrollment by county to estimate overall averages and averages by plan type.) Last year, we estimated that, for 2010 (assuming there was no sustainable growth rate reduction in Medicare physician payment rates during 2010), these figures would be 112 percent, 100 percent, and 109 percent, respectively. The benchmark freeze between 2010 and 2011, combined with low FFS growth between 2010 and 2011, resulted

in very little change in the ratios, even at the plan-type level. Given the level of precision of the estimate and the refinement of data, we view this as no change from 2010.

The ratio of MA plan payments to FFS spending varies by plan type, but the ratios for all plan types are substantially higher than 100 percent. In 2011, overall payments to plans average an estimated 110 percent of FFS spending. Many plans (about 37 percent of all plans bidding) bid to provide Part A and Part B benefits for less than what the FFS Medicare program would spend to provide these benefits. However, because the benchmarks are high relative to FFS spending, payments for enrollees in these plans usually exceed FFS spending. For example, HMOs, as a group, bid an average of 97 percent of FFS spending, yet payments for HMO enrollees are estimated to average 109 percent of FFS spending. Other plan types have average bids above FFS spending and, as a result, payments for PFFS and local PPO enrollees are estimated to be 114 percent of FFS spending.

We separately analyzed bids and payments to SNPs and employer-group plans, because their bidding behavior differs from that of other plan types. Payments to SNPs are estimated to average well above FFS spending because the plans tend to be located in areas that have high benchmarks relative to FFS, and their bids average more than FFS spending. Employer-group plans consistently bid higher than plans that are open to all Medicare beneficiaries. In aggregate, employer-group plan bids and payments are well above FFS spending. The dynamic of the bidding process for employer-group plans is more complicated than for other MA plans, because employer-group plans can negotiate specific benefits and premiums with employers after the Medicare bidding process is complete. Conceptually, the closer the bid is to the benchmark—that is, the maximum Medicare payment—the better it is for the plans and the employer, because a higher bid brings in more revenue from Medicare, potentially offsetting expenses that would have required a larger contribution from employers.

Trends in MA quality

In this section, we examine the level of, and trends in, the quality of care for beneficiaries enrolled in MA plans. We discuss the state of MA quality in the context of our past work on ways to improve quality measurement in MA and in the context of the pay-for-performance system, or quality bonus program, required under PPACA that will provide additional payments to plans that perform well on quality indicators.

Our analysis resulted in two general findings. First, MA plan quality, as reflected in the measures from the three main data sets of quality metrics, is stable relative to 2009, but there is wide variation in quality among plans. Some of the variation reflects differences in the way plans report certain measures. Our second general finding pertains to the CMS star rating system and the undue weight given to contract performance measures in determining a plan's overall star rating. This finding is of particular concern because the current overall star ratings will be used to determine quality bonus payments to plans for at least the immediate future. Although the bonus program does not begin until 2012, bonuses at that time will be determined based on the quality measures reported during the current reporting cycle. Bonus payments will be made in the form of increases to benchmark levels for qualifying plans. The quality measures currently reported have to be the basis for bonus payments, because 2012 benchmarks are fixed as of the announcement of MA rates for the year 2012 that will occur in April 2011 (the annual rate announcement date required by the statute). The Commission believes that outcome measures are better indicators of plan quality, and such measures (to the extent they are available) should be the most important factor in determining a plan's overall rating on quality.

In past work, we discussed two major issues in evaluating quality in MA: ways to improve the ability to measure quality in MA plans and how to compare quality of care in the MA sector with the FFS sector. In a mandated report to the Congress in 2010 dealing with these two issues, the Commission made a number of recommendations that would require several years to implement (Medicare Payment Advisory Commission 2010). CMS is making progress on some of the Commission's recommendations, and, in a recent proposed rule, stated its intention to pursue a direction that is consistent with our recommendations. Specifically, CMS is moving toward more outcome-oriented measures and is seeking to expand the number of measures targeted to Medicare beneficiaries and specific classes of beneficiaries, such as the frail elderly. CMS has stated its intent to place a "greater emphasis on demonstrable improvements in beneficiary access to care, beneficiary health status and outcomes, beneficiary satisfaction and engagement, prevention and management of chronic conditions as well as coordination across the

continuum of care" as well as seeking "to continually raise performance targets, so as to incentivize continual quality improvement across established metrics of performance and quality" (Centers for Medicare & Medicaid Services 2010b).

In terms of evaluating the current status of quality in MA, the salient points of the recommendations in the mandated report that are relevant to our examination of the current quality indicators include the following recommended actions:

- Additional measures of quality should be developed that are primarily outcome oriented, and the measures should be of sufficient scope to give a broad picture of the quality of care provided to Medicare enrollees in plans.
- All plans should be on an equal footing in the standards for reporting and measurement.
- Comparisons across plans, and between plans and the traditional FFS program, should be "apples to apples" comparisons. (For example, comparisons of one MA plan with another, and plan performance compared with quality in FFS Medicare, should be judged within the geographic area served by each plan; as we discuss below with regard to the use of medical record review, measures that are used to compare plans and to compare sectors should be uniform and consistent in their specifications and in the way they are determined and reported.)

With regard to progress made on these particular issues, CMS and the National Committee for Quality Assurance (NCQA) are working on developing new measures—including a hospital readmission measure—but did not introduce any new MA measures in the current reporting cycle. NCQA has noted that developing measures for the elderly presents special challenges—including lack of an evidence base for the elderly, who are often left out of clinical trials, "multiple comorbidities that confound treatment recommendations," and a small numbers issue for rare conditions or "newly incident" conditions (National Committee for Quality Assurance 2011).

CMS is proceeding with its intent to collect detailed encounter data from plans beginning in 2012, which could enable CMS to derive additional quality measures for plans, including measures that can be compared directly with measures determined from FFS claims (such as hospital readmissions, admission rates for ambulatory care sensitive conditions, potentially preventable emergency department visits, and mortality rates after a hospital stay (Medicare Payment Advisory Commission 2010)). With respect to the second point above, CMS put other plan types on a more even footing with HMO plans by allowing PPO and PFFS plans, at their option, to use medical record review as a basis for reporting certain measures, beginning with the current reporting cycle (as opposed to the prior policy of having non-HMO plans use only administrative records).

The third point—how to ensure comparability—involves geography as well as other factors. CMS currently makes comparisons by geographic area between FFS Medicare and health plans in measures that are collected through the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) beneficiary survey. A problem remains in that the health plan measures that are compared with FFS measures are not always area specific. The measures for health plans are reported at the MA contract level, while FFS measures are reported at the state level for 42 states or territories (and at a substate level otherwise). For example, when a Medicare beneficiary uses the medicare.gov Plan Finder website to compare available plans with FFS Medicare, a regional PPO covering three states has one flu vaccination rate reported across its three states (an enrollment-weighted average across the organization's three states). The FFS vaccination rates, on the other hand, are reported for the state where the Medicare beneficiary resides. At the other extreme, a local HMO that serves a very small, distinct geographic area has its rates compared with a statewide FFS average.

Comparability is also a concern as we look at plan performance on individual quality measures. We continue to see wide variation in results by plan type and great variation in plan scores among certain types of measures. Some of the variation reflects differences in the quality of care across plans and the greater ability of some plans to influence provider practices and to invest in the infrastructure that gives plans the ability to track quality indicators and undertake improvements. However, the data also suggest that the variation among plans may reflect other factors, including:

- differences in plan characteristics (e.g., newer HMO plans tend to have lower scores on quality measures than more established plans),
- the composition of plan enrollment (differences that we see in the proportion of Medicare beneficiaries

under age 65 in certain plan types may be a factor affecting quality indicators),

- the use of a good system of electronic medical records (a difference that appears to explain large differences in one new measure),
- the geographic area served by a plan (e.g., a plan may do well on quality indicators because of the attention to quality among the provider community in its area), and
- the reporting standards and definitions that apply to individual measures (in particular, the choices that plans can make in deciding how to report measures for which medical record review is an option).

The variation that we continue to see in performance reinforces the recommendations dealing with the need to improve comparability in measures within MA and to ensure comparability between measures that compare MA with FFS. Comparisons should be based on like measures that are compared within the same or like geographic areas. Recognizing differences across plans that materially affect certain measures may require adjusting current measures or introducing new measures that are neutral with respect to such differences.

From the three sources of quality indicators in MA, CMS will use a subset of measures to determine bonus payments as well as contract performance measures

In examining quality indicators for MA each year, we use three sources of data, which we describe briefly below (and which are described in greater detail in the online appendix (available at http://medpac.gov/chapters/Mar10_Ch06_APPENDIX.pdf) to Chapter 6 of the MIPPA-mandated report (Medicare Payment Advisory Commission 2010)). As we describe each data set, we also indicate the extent to which CMS will use measures from the data sets in determining star ratings that will be the basis of quality bonus payments as of 2012. (We discuss the star system in greater detail below.)

For MA–Prescription Drug (MA–PD) plans, there are 36 measures under Part C (the Medicare Part A and Part B benefit) and 15 unique Part D measures—for a total of 51 measures—that make up the overall star rating that will determine the quality bonus level, if any, and the rebate level of each plan. Each measure that CMS uses is equally weighted in determining stars. The distribution of measures that determine the cut points for each level of star ratings—that is, where a plan falls within the range of one to five possible stars—is a distribution that includes all reported rates by all plan types for each of the measures, with no weighting (e.g., by enrollment or otherwise, but with colorectal cancer screening not included in the star computation for PPOs).

The three data sources and the proportion of measures that each contributes to the star ratings are:

- The Healthcare Effectiveness Data and Information Set (HEDIS®) is a set of clinical process and intermediate outcome measures, maintained by NCQA, that health plans report to CMS; it is also used for commercial, Medicaid, and children's health plans.[1] HEDIS measures are based on administrative data, such as claims and encounter data, and often are supplemented with clinical data extracted from medical records. HEDIS also includes measures from the next two sources of data, which are beneficiary surveys.
  - The star rating system uses 21 HEDIS measures, including 6 measures included as HEDIS measures that come from the next two sources of data. In other words, most of the 36 Part C measures for MA plans are HEDIS measures.[2]
- The Consumer Assessment of Healthcare Providers and Systems for MA plans (CAHPS®–MA) is a beneficiary survey measuring beneficiary experience of care in terms of access to care and the rating of a health plan and its providers.[3] For MA, the CAHPS survey consists of questions in six domains: how well doctors communicate, getting care quickly, getting needed care without delays, health plan information and customer service, overall rating of health care quality, and overall rating of health plan quality. CAHPS is the source of HEDIS measures that track flu and pneumonia vaccination rates.
  - The MA star rating system uses eight CAHPS measures—the flu and pneumonia vaccination rates (which are also HEDIS measures)—and six measures of access to care and satisfaction with the beneficiary's health plan and its providers. In addition, Part D star measures (which apply to MA–PD plans) include three CAHPS measures.
- The Health Outcomes Survey (HOS) is a survey of self-reported health status among Medicare health plan enrollees. It is a source of seven HEDIS measures and is the basis for determining whether a health

plan's enrollees have had any improvement or decline in their health status over a two-year period. A plan is deemed to have better or poorer outcomes if the plan's results on the physical or mental health measures differ significantly from the national average across all plans.

- The star rating system uses measures of each plan's rate of improvement or maintenance of physical health (one measure) and mental health (one measure), as well as four of the seven HEDIS measures that are collected through the HOS survey (osteoporosis testing, management of urinary incontinence, advising patients on physical activity, and addressing the risk of falls).

In addition to the measures of clinical quality and patient experiences of care, the overall star rating includes 17 contract performance measures, of which 10 are Part D measures and 5 are Part C measures (with contract performance measures therefore making up one-third of the 51 measures that determine the overall star rating). Contract performance measures include measures of complaint and appeal rates, call center performance, and corrective action plans. The online appendix to this chapter (available at http://www.medpac.gov) lists all measures included in the star ratings.

Recent indicators of quality in MA plans are stable but many measures continue to show wide variation across plans

In the next sections, we discuss results from the three sets of quality indicators for the current reporting cycle. In general, we find little change from last year in HEDIS and HOS results and little difference between MA and FFS in CAHPS results. Underlying the overall results in HEDIS, we see wide variation across quality indicators among plans with respect to their performance on individual measures, wide variation by plan type, and variation by the nature of the enrolled population (e.g., whether an enrollee is in an employer-sponsored MA plan or benefit package). On HEDIS measures that each plan type reports from administrative data, there is generally little difference between HMO results and local PPO results. We continue to see poorer HEDIS results among newer HMO plans compared with older, more established plans. Very few regional PPOs and PFFS plans have reported HEDIS results, but among those that do report results, many measures show poorer results for these plan types. With CAHPS, we also see wide variation in results by plan type, for example, but little difference between MA overall and the FFS system in vaccination rates and several access-to-care measures. HOS results are similar to last year's results, which showed that a large majority of plans did not have extreme changes in the physical or mental health of their enrollees over the most recent two-year period.

Without changing the method of collecting and reporting data to address two concerns addressed in the MIPPA report—having all plans report on an equal footing and making comparisons at an appropriate geographic level—it is often difficult to draw conclusions about how plans are performing relative to each other and what MA plan results on certain measures mean compared with available measures in FFS (Medicare Payment Advisory Commission 2010).

HEDIS results show slight improvement, with HMOs and local PPOs performing at about the same level on many measures

We have traditionally examined performance among HMOs when evaluating the performance of the MA sector across the entire set of HEDIS measures. The other types of MA plans—PPOs and PFFS plans—could not be compared directly on all 46 measures because, in the case of PFFS plans, reporting has been optional (but will be required as of the next reporting cycle), and because, for PPO plans, certain measures (the 13 measures with a medical record review component) were not reported on the same basis as for HMOs.

Beginning with the current reporting cycle, PPOs are subject to the same standards as HMOs in that for the 13 measures that are hybrid measures—those that can include a medical record review component—both HMOs and PPOs can choose to report either on the basis of administrative records only (claims, encounters, electronic medical records) or by using a sample of medical records to supplement the administrative data. In addition, for one specific hybrid measure—colorectal cancer screening—PPOs are still precluded from using medical record review to report their HEDIS scores (but the measure, though reported for each plan at the medicare.gov Plan Finder website, is not used for computing a PPO's star rating (Centers for Medicare & Medicaid Services 2010c)). While HMOs and PPOs are now on an equal footing with respect to how they can report the hybrid measures other than colorectal cancer screening, the ability of each individual plan to choose one or the other method for reporting still means that it is not possible to compare results across plans. Standardizing the reporting

TABLE 12–4

MA HMO plans showed improvement in 9 of 46 HEDIS® effectiveness-of-care measures between the 2009 and 2010 reporting years

Measure and category	Type of measure	Component of star ratings?	Mean rate 2009	Mean rate 2010	Percent change, 2009–2010
Testing, screening exams					
HbA1c testing for diabetics	Hybrid	Yes	88.3%	89.6%	1.5%
Eye exams for diabetics	Hybrid	Yes	60.6	63.5	4.8
Glaucoma screening in older adults	Administrative	Yes	59.8	62.1	3.8
Drug use and monitoring drug use					
Monitoring ACE inhibitors or ARBs	Administrative	No	86.7	89.5	3.2
Monitoring digoxin	Administrative	No	90.4	92.0	1.8
Monitoring diuretics	Administrative	No	87.1	89.8	3.1
Total annual monitoring of patients on persistent medications	Administrative	Yes	86.3	89.1	3.2
Persistence of beta-blocker treatment after a heart attack*	Administrative	No	79.7	82.6	3.6
Bronchodilator pharmacotherapy management of COPD exacerbation*	Administrative	No	74.1	76.2	2.8

Note: MA (Medicare Advantage), HEDIS® (Healthcare Effectiveness Data and Information Set), HbA1c (hemoglobin A1c), ACE (angiotensin-converting enzyme), ARB (angiotensin receptor blocker), COPD (chronic obstructive pulmonary disease). Administrative measure reporting is based on claims, encounter data, drug data or electronic records. The rate is the percent of the population to whom the measure applies who obtain the service or meet the criteria. Change for each measure shown is statistically significant ($p < 0.05$).
*In each year, fewer than half of HMO plans reported the beta-blocker measure and about three-quarters of plans reported the bronchodilator measure. For each of the other measures shown, 96 percent or more of plans reported a HEDIS® score.

Source: MedPAC analysis of CMS HEDIS® public use files. http://www.cms.gov/MCRAdvPartDEnrolData/HEDIS/list.asp.

methodology would address that problem. (As we discuss in greater detail below, our analysis of the HEDIS results that local PPOs have reported for hybrid measures leads us to believe that, for this year at least—perhaps because it is the initial year of hybrid reporting—the local PPO hybrid results should not be considered reliable.)

Looking at Medicare HMO plans, for the most recent time period, HEDIS performance indicators show a slight improvement over last year's results.[4] Of the 46 effectiveness-of-care measures that Medicare plans report, 9 showed statistically significant improvement between the HEDIS 2009 and 2010 results (Table 12-4).[5] Four of the improved measures are in the family of measures that track the monitoring of drugs with persistent use (180 days or more of ambulatory medication therapy in the year), including the "total" measure, which is the sum of the numerators of four measures for particular drug categories, divided by the denominators for the four measures. Within this family of measures, only one drug category, the monitoring of anticonvulsants, showed no statistically significant change between 2009 and 2010. Another improved measure, persistence of beta blockers, is no longer used as a CMS star system measure because it applies to few plan enrollees; of the measures shown in Table 12-4, it is the one with the fewest number of plans reporting a result because many plans have too few instances of meeting the measure criteria to have a valid, reportable result.[6]

Measures that show the greatest variation across plans are among the most important measures—intermediate outcome measures

As we have noted in the past (Medicare Payment Advisory Commission 2008, Medicare Payment advisory Commission 2009, Medicare Payment Advisory Commission 2010), for many measures there is wide variation in plan performance. However, some measures show little variation. When a HEDIS measure has little variation and average scores are high, the measure can be withdrawn, as no further major improvement can be expected. For example, NCQA withdrew the measure of the provision of beta blockers after a heart attack—a measure that showed wide adherence across plans (and in the entire health care system). In the last year the measure was reported (the 2007 reporting year), Medicare HMOs

TABLE 12–5

Measures of intermediate outcomes show wide variation among HMO plans

Measure	Mean rate	Number of HMOs reporting (out of 297)	Ratio of 90th to 10th percentile of reported rates
Measure for which a lower rate is better			
Poor HbA1c control among diabetics	28.1%	294	4.71
Measures for which a higher rate is better			
Cholesterol level below 100 for diabetics	49.9	295	1.90
Blood pressure controlled for diabetics (<130/80)	33.1	290	2.12
Blood pressure controlled for diabetics (<140/90)	60.2	290	1.64
HbA1c controlled (<8.0%) for diabetics	63.6	293	1.85
Cholesterol controlled for patients with cardiovascular conditions (<100 LDL–C)	55.7	264	1.98
Total rate of control of high blood pressure for hypertensives	59.7	287	1.57

Note: HbA1c (hemoglobin A1c), LDL–C (low-density lipoprotein cholesterol). The rate is the percent of the population to whom the measure applies who obtain the service or meet the criteria.

Source: MedPAC analysis of CMS HEDIS® public use files. http://www.cms.gov/MCRAdvPartDEnrolData/HEDIS/list.asp.

had an average rate of 93.7 percent and commercial plans were at 97.7 percent for the beta blockers measure.

Many of the measures that show the smallest variation are among those that showed significant improvement in the most recent time period (and for which we might not expect to see further improvement). Of the 9 measures showing improvement among HMOs between 2009 and 2010, the 5 measures in Table 12-4 with mean 2010 rates above 89 have very little variation across HMO plans (with the ratio of the 90th to the 10th percentile of scores in the range of 1.1 to 1.16).

The measures with the greatest variation across plans include what are known as intermediate outcome measures—the measures that are perhaps the most important indicators of the quality of care that MA enrollees receive (Table 12-5). Each of these seven measures is a hybrid measure that can include medical record review as a component of the determination of a HEDIS score on such measures. When a plan can report either with administrative-only data or by using a review of a sample of medical records, it is difficult to compare results across plans without knowing the reporting method each plan has chosen. A plan may choose one or the other approach depending on which yields a higher score, or a plan may forgo medical record review if it is deemed too labor intensive and expensive (as in the case of a small plan). In the case of PPO plans, there may also be an issue with the plan's ability to obtain medical records from all sources of care an enrollee used, given that a member of a PPO plan can use providers that have no contractual relationship with the health plan. The results that local PPOs have reported for the intermediate outcome measures (such as control of blood pressure) have such a wide range across plans that they do not appear to be entirely credible, as we discuss in greater detail below.

Measures that are newly introduced in HEDIS also tend to show wide variation. The HEDIS measure for recording body mass index (BMI) is a measure that NCQA publicly reported for the first time this year for Medicare plans, but it was included in last year's CMS HEDIS data release. For the 290 HMOs reporting the BMI measure in the current round, the average share of members who have their BMI evaluated is 38.4 percent, and the ratio of the 90th to the 10th percentile for this measure is 14.5. Typically, new measures show relatively lower scores and high variation initially. In the case of BMI measurement—which has to be extracted from medical records—the variation can be illustrated by comparing two categories of MA HMOs: Kaiser plans and non-Kaiser plans. Among 11 Kaiser plans across the country, the average percentage of enrollees who have their BMI measured and recorded is 91.3 percent (with an average for this measure of 89.6 percent last year among nine Kaiser plans reporting the

TABLE 12–6

Among HEDIS® measures showing improved results for HMOs, and other selected measures, differences in mean rates exist based on the age of plans, 2010

Measure and category	Type of measure	Mean rate: Cost plans	Mean rate: HMO without cost plans	Mean rate: Established plans	Mean rate: New plans	Percentage difference between new and established plans
Colorectal cancer screening	Hybrid*	69.0%	53.9%	61.7%	46.2%	–25%
Diabetes care:						
HbA1c testing	Hybrid**	93.1	89.4	91.2	87.7	–4
Eye exams	Hybrid**	75.9	62.9	68.2	57.6	–16
Glaucoma screening in older adults	Administrative	73.2	61.5	66.6	56.2	–16
Annual monitoring of patients on persistent medications:						
ACE inhibitors or ARBs	Administrative	77.2	90.1	91.2	88.9	–3
Digoxin	Administrative	84.8	92.3	93.1	91.2	–2
Diuretics	Administrative	77.2	90.3	91.6	89.0	–3
Total rate	Administrative	77.2	89.6	91.0	88.2	–3
Bronchodilator use in pharmacotherapy management of COPD exacerbation	Administrative	79.3	76.1	77.4	74.2	–4

Note: HEDIS® (Healthcare Effectiveness Data and Information Set), HbA1c (hemoglobin A1c), ACE (angiotensin-converting enzyme), ARB (angiotensin receptor blocker), COPD (chronic obstructive pulmonary disease). Administrative measure reporting is based on claims, encounter data, drug data, or electronic records. The rate is the percent of the population to whom the measure applies who obtain the service or meet the criteria. Established plans are those with contracts dating from before 2005. New plans are those with contract start dates from January 2005 or later. Typical number of plans reporting are: cost plans (14 to 19 plans), HMO without cost plans (280 plans), established plans (134 to 141 plans), and new plans (140 to 159 plans).
* HMOs allowed to use medical record review.
** All plan types may use medical record review.

Source: MedPAC analysis of CMS HEDIS® public use files. http://www.cms.gov/MCRAdvPartDEnrolData/HEDIS/list.asp.

measure). The average for the remaining 279 reporting HMOs is 36.3 percent (with an average of 29.3 percent last year for 170 plans reporting).

A possible reason for the superior performance of Kaiser plans in the BMI measure is that the information necessary for reporting this measure is recorded in the Kaiser plans' electronic health record systems (the medical record that likely forms the basis of much of Kaiser's HEDIS reporting in many, if not all, of the organization's plans), thereby facilitating accurate reporting that is not as labor intensive as other means of obtaining medical record information. Thus, to some extent, the BMI measure results illustrate an issue that we have raised before, which is that some plans are better able than other plans to collect and report data, making it difficult to fully judge whether there are actual differences in performance among plans in the quality of care for certain measures.

Variation in HEDIS measures by plan type and by new versus old plans persists

As in the past, we find variation within the HMO sector of MA in quality measures. Older HMO plans (for this purpose, those with contracts beginning before 2005) show better results than newer HMO plans, as we show for selected measures (Table 12-6). As has historically been the case, cost-reimbursed plans as a class tend to have the highest average HEDIS scores.[7] For 26 of 46 measures, cost plans have average scores that are at least 10 percent better than the average of all other HMOs reporting HEDIS measures. Aside from one measure on alcohol and drug abuse, the only measures on which cost plans perform more poorly than other HMOs are the measures for monitoring the persistent use of medications. However, this result may be due to the optional nature of drug coverage under cost plans, which means that these plans

TABLE 12–7

For most HEDIS® administrative measures with differences, PPOs perform better than HMOs on average

Measure	Which plan type better?	HOS a source?	HMO		PPO	
			Mean rate	Number of plans reporting	Mean rate	Number of plans reporting
Breast cancer screening rate (total)	HMO	No	69.1%	291	66.1%	84
Osteoporosis management in women who had a fracture	HMO	No	20.7	194	18.1	50
Discussing fall risks (older adults)	HMO	Yes	31.4	274	30.0	76
Initiation and engagement of alcohol/drug dependence treatment	PPO	No	46.2	233	58.1	61
Disease modifying anti-rheumatic drug therapy in rheumatoid arthritis	PPO	No	72.3	216	76.9	62
Systemic corticosteroid pharmacotherapy management of COPD exacerbation	PPO	No	60.9	228	64.1	52
Discussing urinary incontinence (older adults)	PPO	Yes	57.2	246	58.8	78
Receiving urinary incontinence treatment (older adults)	PPO	Yes	35.5	247	37.7	78
Discussing physical activity (older adults)	PPO	Yes	51.4	274	54.8	81
Advising about physical activity (older adults)	PPO	Yes	46.9	275	48.2	81
Osteoporosis testing percent (older adults)	PPO	Yes	67.9	272	73.5	81

Note: HEDIS® (Healthcare Effectiveness Data and Information Set), PPO (preferred provider organization), HOS (Health Outcomes Survey), COPD (chronic obstructive pulmonary disease). The rate is the percent of the population to whom the measure applies who obtain the service or meet the criteria.

Source: MedPAC analysis of CMS HEDIS® public use files (http://www.cms.gov/MCRAdvPartDEnrolData/HEDIS/list.asp).

may not have full information on their members' drug use and services related to drugs.

With respect to local PPOs, for most measures other than the hybrid measures there are no statistically significant differences between the performance of HMOs and local PPOs. For many of the hybrid measures, we believe that anomalies in the data lessen the credibility of reported results for local PPOs.[8] For the measures that are based on administrative data or survey data, local PPO plans perform better than HMO plans on many measures (Table 12-7). For six of the measures collected through HOS that are included as HEDIS measures, there are significant differences between HMOs and local PPOs, but HMOs perform better than PPOs in only one case. As we discuss below, this difference may be because there are different populations in each of these plan types.

With respect to other plan types, it is difficult to generalize about PFFS plans because of the small number of reporting plans and because reporting is currently optional for these plans.

There are 13 MA regional PPO plans as of 2010, all of which reported some or all HEDIS measures in the last cycle. Although 13 is a small number of reporting entities compared with the nearly 300 reporting HMO plans, it is important to be able to track regional PPO performance because enrollment in such plans is increasing. To some extent, regional PPOs can be compared with local PPOs, though local PPOs are often associated with local HMO plans (and perform at a level similar to the associated plan). In comparing local PPO HEDIS results with those for regional PPOs, local PPOs have HEDIS scores that exceed regional PPO results by 10 percent or more for 12 measures, including seven hybrid measures (with four of the seven being intermediate outcome measures). Regional PPOs do better by more than 10 percent in one of the HEDIS measures of drug interactions that should be avoided.

Enrollment composition of a plan may affect HEDIS results

The MA plan types have differences in the types of beneficiaries who join their plans. As of December 2008,

TABLE 12–8

As of December 2008, regional PPOs have more beneficiaries entitled to Medicare on the basis of disability (under age 65) than other plan types while HMOs have more older enrollees

Age ranges	HMO	Local PPO	Regional PPO	PFFS
Under 40	1%	1%	1%	1%
40–64	10	11	17	11
65–75	48	57	57	55
76–80	18	14	13	16
81–85	13	10	8	11
86 or older	10	8	5	7

Note: PPO (preferred provider organization), PFFS (private fee-for-service).

Source: MedPAC analysis of CMS denominator file.

regional PPOs had a larger share of disabled enrollees than other plan types, and HMOs tended to enroll an older population, on average, than local PPOs.

Beneficiaries entitled to Medicare on the basis of disability (those under the age of 65) make up 24 percent of the FFS population, but only 16 percent of MA enrollees are entitled to Medicare on the basis of disability. Regional PPOs have the greatest share of beneficiaries under age 65 of any plan type (18 percent) and HMOs have the smallest share (11 percent) (Table 12-8). The larger proportion of disabled enrollees in regional PPOs may be a factor in explaining why these plans perform more poorly on some measures. It may be more difficult to coordinate care for the under-65 population in general, and people under age 65 include a greater share of individuals with mental disorders, which are the basis of their entitlement to Medicare. Similarly, local PPOs may have better scores on the HEDIS measures collected through HOS because of the make-up of their population.[9] Further work is necessary to understand why the under-65 population is less likely to enroll in MA plans (e.g., because of the large proportion of Medicare–Medicaid dual eligibles among the under-65 population), and to know whether population distribution differences explain some of the differences in quality measures for regional PPO plans.

CAHPS shows variation across plans and across populations

CAHPS is a survey instrument developed by the Agency for Healthcare Research and Quality that provides information on respondents' experiences with the health care system. CAHPS surveys cover a variety of settings, including surveys of MA enrollees and surveys of beneficiaries receiving care through the traditional FFS program. Because beneficiaries in the two sectors are surveyed with comparable questions, CAHPS has been used to compare beneficiary experiences in MA and FFS. CMS posts comparison information at the Plan Finder website of medicare.gov, and various studies have used CAHPS to compare the two sectors (Keenan et al. 2009).

This year, we compared the performance of MA plans with FFS Medicare on certain CAHPS measures. To be able to compare the two sectors at a national level, we have adjusted the CAHPS results to attempt to match geographic areas in the two sectors. We use state-level FFS results to arrive at a national rate for FFS to compare with the national MA rate. The FFS rates are adjusted by the state distribution of MA enrollment across the country. In that way, the FFS rate represents the FFS rate for the areas where MA plans enroll their members. After this adjustment, we find that vaccination rates are similar in MA and FFS, while pneumonia vaccination rates are slightly better in MA. We also see that measures of the ease of getting care and access to a specialist are similar, with FFS showing slightly higher rates of beneficiaries reporting that they usually or always can get an appointment with a specialist as well as care for an illness or for routine care as soon as they want it (Table 12-9).

Regional PPO plans have a statistically significantly lower rate for flu vaccination (61 percent) than other MA plan types, which range from 64 percent to 66 percent. Different populations in MA also have different rates of vaccination. Flu vaccination rates are higher for enrollees who have retiree coverage through their MA plan (employer-sponsored MA benefit packages)—many of whom are long-standing plan members and

have "aged in" to their plans on becoming eligible for Medicare. Vaccination rates are about 10 percent higher for employer-sponsored enrollees than for other types of enrollees.

To some extent, flu vaccination rates follow parallel geographic patterns in MA and FFS. The highest reported flu vaccination rate for any MA plan shown on the medicare.gov Plan Finder is 92.48 percent, for a continuing care retirement community in Maryland (which constitutes a special case of a "captive" population), followed by rates in the 82 percent to 86 percent range for plans in Hawaii, Minnesota, upstate New York, and Wisconsin. The highest FFS flu vaccination rates are in Hawaii and South Dakota (75 percent); rates greater than 70 percent are found in 15 states or areas, including Minnesota, upstate New York, and Wisconsin. However, flu vaccination rates in MA plans do not always mirror the rates in FFS. Cost-reimbursed HMO plans have very high flu vaccination rates, with 4 of 17 plans having rates of 80 percent or higher. Cost plan rates of flu vaccination exceed 70 percent in all cases except one, a cost plan in Minnesota. The Minnesota cost plan has a flu vaccination rate of 57 percent compared with the FFS rate for the state of 73 percent.

The variation that we see in CAHPS results below the aggregate level argue for a more refined approach to examining the CAHPS data. It may not be possible to make a statement about the relative performance of MA versus FFS at an aggregate level, and comparisons below the aggregate level should take into account geography as well as other factors that can explain the differences we see in looking more closely at the data—including differences that reveal plan efforts to promote prevention and improve access to care for plan enrollees.

TABLE 12–9

Overall, MA plans and FFS show similar 2010 CAHPS® results on many measures

Measure	Average MA	Average Adjusted FFS
Vaccination rates		
Flu	65.5%	65.8%
Pneumonia	67.0	66.0
Access to care measures:		
Members reporting "usually or always"		
Easy to get an appointment with a specialist	90.2	91.3
Get care for an illness as soon as wanted	89.2	90.3
Get routine care appointment as soon as wanted	86.2	87.8

Note: MA (Medicare Advantage), FFS (fee-for-service), CAHPS® (Consumer Assessment of Healthcare Providers and Systems). Adjusted refers to geographic adjustment of results in FFS to match the distribution by state of MA enrollment.

Source: MedPAC analysis of CAHPS® data.

Health Outcomes Survey again shows virtually no difference across plans but for star rating purposes CMS makes distinctions among plans

HOS is a survey of self-reported health status among Medicare health plan enrollees. It is the source of seven HEDIS measures and is also the basis of a determination of whether the health status of a health plan's enrollees has improved or declined over a two-year period. For each plan in the MA program, a randomly selected sample of enrollees who have been in the plan for at least six months are surveyed in a given year and resurveyed two years later to measure changes in their physical and mental health. Two-year change scores are calculated and beneficiaries' physical and mental health status is categorized as better, the same, or worse than expected according to a predictive model that takes 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 differ significantly from the national average across all plans.

The most recent HOS results, for the 2007–2009 cohort, show that none of the 268 plans with survey results was classified as an outlier in physical health status changes for its enrollees—that is, the physical health status changes were within expected ranges and not significantly different from the average across all plans (Table 12-10, p. 304). For mental health, 8 of the 268 plans showed better-than-expected improved mental health outcomes and 13 showed worse-than-expected mental health outcomes. The results have been similar over the past several years, but we note that the most recent cohort includes a much larger number of plans with HOS results—90 more than in the previous year.

The Commission has recommended that CMS examine the HOS survey and its use to determine whether there can be greater distinctions made across plans. Having

TABLE 12–10 **Medicare HOS performance measurement results show little change in recent years**

Cohort	Years	Total number of plans reporting	Mental health outcomes		Physical health outcomes	
			Better than expected	Worse than expected	Better than expected	Worse than expected
Cohort 8	2005–2007	154	9	4	0	0
Cohort 9	2006–2008	187	2	10	0	0
Cohort 10	2007–2009	268	8	13	0	0

Note: HOS (Health Outcomes Survey).

Source: CMS posting of HOS results. http://www.hosonline.org/surveys/hos/hosresults.aspx.

greater differentiation among plans on the measures of improvements in health would assist beneficiaries in comparing plans and would also make the survey of greater use to plans, in determining their performance, and to CMS as the agency that evaluates the performance of MA plans. (The evaluation of HOS is under way through a contract that CMS awarded to NCQA.)

While the overall HOS results posted on the HOS website do not show significant differences for most plans, the medicare.gov website does differentiate among plans in the star system (discussed in further detail below). The website shows that the percent of members reporting improved health (after risk adjustment) ranges from 57 percent to 75 percent for physical health and from 65 percent to 86 percent for mental health. On the basis of the relative distribution of these results, no plans received a 5-star rating in the measure for improving or maintaining mental health, and 66 of 255 plans with scores on the measure received the minimum 1-star rating. On the measure for improving or maintaining physical health, there were no 1-star plans; 99 of 255 rated plans received a 5-star rating; and 154 plans received a 4-star rating.

Originally a source of consumer information, CMS star ratings for overall plan quality and contract performance will be the basis of quality bonus payments

In 2008, CMS instituted a star rating system for MA plans and stand-alone drug plans. The star system was put in place as a tool for Medicare beneficiaries and their advisors to evaluate the relative quality of MA plans available in the person's area and, to the extent possible, provide a comparison of MA plans with FFS Medicare, consistent with requirements in the statute enacted in the Medicare Modernization Act of 2003. Specifically, Section 1851(d)(4) of the Social Security Act ("information comparing plan options") called for information to be provided on "plan quality and performance indicators for the benefits under the plan … including … disenrollment rates for Medicare enrollees … information on Medicare enrollee satisfaction … information on health outcomes, and … the recent record regarding compliance of the plan with requirements of this part (as determined by the Secretary)." Beginning in 2012, this star rating system will be the basis of quality bonus payments for MA plans.

For a plan's Part C coverage (Medicare Part A and Part B), the star rating combines selected measures from HEDIS, CAHPS, and HOS, along with certain contract performance measures to arrive at an overall composite star rating and star ratings for five components or domains (see the online appendix to this chapter at http://www.medpac.gov for the list of measures). Each of the 36 individual measures in Part C (e.g., each HEDIS measure) also receives a star rating. The overall star rating for a plan not offering drugs is the average of the 36 individual stars for individual measures, each equally weighted. For MA–PD plans, an additional 15 measures are added for Part D (of the 17 applicable to stand-alone drug plans, because the two Part D complaint tracking measures duplicate the MA complaint tracking measure). For the open enrollment period occurring at the end of 2010, CMS used a rating system that combines Part C results with star results for Part D—which include 15 unique measures for MA–PD plans—to arrive at

TABLE 12–11 **Of 51 measures for MA–PD star ratings, one-third are contract performance measures**

Type of measure or measure set	Category	Number of measures (equally weighted)	As a percent of 51 total Part C and Part D measures
HEDIS®	Clinical quality	15	29%
HOS*	Clinical quality, patient-reported results	6	12
CAHPS®			
Vaccine rates**	Clinical quality	2	4
Access to care and satisfaction measures	Patient experience	6	12
Part D			
Clinical quality	Clinical quality	2	4
CAHPS® access and satisfaction	Patient experience	3	6
Contract performance			
Part C	Contract performance	7	14
Part D	Contract performance	10	20
Totals by category			
Contract performance		17	33
Clinical quality measures		25	49
Patient experience measures		9	18

Note: MA–PD (Medicare Advantage–Prescription Drug [plan]), HEDIS® (Healthcare Effectiveness Data and Information Set), CAHPS® (Consumer Assessment of Healthcare Providers and Systems), HOS (Health Outcomes Survey). Numbers may not add due to rounding.
*Four of the HOS measures are used for HEDIS® but not included in that number.
**Used for HEDIS® but not included in that number.

Source: CMS analysis of star ratings data.

an overall plan star rating based on 51 measures. The results for each of the 51 measures are equally weighted in determining a plan's star ratings—for example, the HEDIS rate for osteoporosis management in women who had a fracture has a weight equal to the CAHPS measure of members' overall rating of a plan. (For this year, CMS was unable to include disenrollment rates as a factor in the star rating system.)

CMS assigns star ratings through algorithms comparing performance across plans. The overall star rating can include an integration factor, raising the overall rating by up to 0.4 point in the five-star system for plans that have consistently high performance across the individual measures. Plans are not necessarily penalized for not being able to report particular measures. Within each domain, a tolerance level is set for the number of measures that can be absent but that will still permit the plan to be assigned a star rating for the domain (Centers for Medicare & Medicaid Services 2010c).

The star results are posted at the medicare.gov website, where beneficiaries and other users can see overall star levels, domain star levels (groupings such as "managing chronic (long-term) conditions"), and individual measure star results as well as the values that each plan reports (such as actual HEDIS rates for a plan). For the CAHPS measures, the website compares plan results with FFS results in vaccination rates and other CAHPS patient experience measures.

Although many of the clinical quality measures are from the HEDIS set of 46 measures, not all HEDIS measures are used to determine star ratings. CMS uses 21 of the HEDIS measures, including two measures collected through CAHPS (flu and pneumonia vaccine rates) and 4 measures collected through HOS (Table 12-11). CMS has removed several HEDIS measures from the star rating system owing to small numbers and a lack of statistical reliability. The measures previously used but no longer included are depression medication management, mental

TABLE 12–12

As of November 2010, nearly a quarter of enrollees are in plans rated at four stars or higher

	All	HMO	Local PPO	Regional PPO	PFFS
Total enrollment	11,850,666	7,828,154	1,395,826	875,473	1,650,200
Percentage distribution of enrollment by number of stars					
5.0	1%	1%	0%	0%	0%
4.5	14	19	8	0	0
4.0	8	9	16	0	1
3.5	25	31	33	3	5
3.0	32	29	31	45	43
2.5	7	4	4	51	1
2.0	0.03	0.04	0	0	0
Not rated	13	7	8	1	49

Note: PPO (preferred provider organization), PFFS (private fee-for-service).

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

illness measures, and persistence of use of beta blockers after a heart attack. It appears that CMS is trying to narrow down the measures to those most appropriate and meaningful for the Medicare population (hence the number of HOS measures).

CMS defines a three-star rating as an average rating. As of November 2010, nearly half of MA enrollees are in plans with overall star ratings (Part C and Part D combined) of three or lower or not rated (Table 12-12). There is variation by plan type, with HMO members more likely to be in higher rated plans and regional PPOs having lower star ratings.

One aspect of the star rating system that creates concern is the degree to which star ratings are influenced by measures other than clinical quality measures. For the combined Part C and Part D ratings, 17 of the 51 measures (one-third) are contract performance measures, such as the length of time callers are placed on hold. Because a plan can have a star rating even if a number of measures are not reported or computed, it is theoretically possible to have a star rating with up to 61 percent of measures being contract performance measures (though measures that are found on audit to be materially biased or measures that a plan chooses not to report result in a one-star rating). For the 2011 contract year, the plan with the highest percentage of contract performance measures determining its star rating is a PFFS plan for which 54 percent of the reported measures are contract performance measures, with a star rating of 2.5. An additional 16 plans have a star rating based on 40 percent or more of the measures being contract performance measures. Among those 16 plans, 10 have 3 stars, 5 plans have 3.5 stars, and 1 plan has 2.5 stars.

We are not suggesting that contract performance measures are unimportant when judging a plan. Such measures are important, and rating plans based on those measures provides useful information to beneficiaries in choosing among plans. CMS, and plan enrollees, should be concerned if a plan performs well on clinical quality measures but shows consistently poor results in contract performance measures.

However, contract performance measures are of a different nature than clinical quality measures. The former type of measure is something that beneficiaries can more directly perceive and act on (e.g., by disenrolling from a plan or not recommending a plan to other beneficiaries—something that is also true of the CAHPS patient experience measures). As such, plans already have an incentive to ensure that they perform well on contract performance measures. In the case of clinical quality measures, beneficiaries are not likely to be aware of how successful a plan has been at achieving appropriate levels of quality and ensuring that appropriate care, including preventive care, is being rendered—either at the level of

an individual enrollee who is under treatment or across the entire enrolled population.

The concern is a question of balance between clinical quality measures and contract performance measures. Rather than having all measures weighted equally, there should be relative weighting so that, as a possible alternative, each contract performance measure carries only half as much weight as an individual clinical quality measure. In general, the relative weighting of the 51 MA–PD measures may need to be reexamined—for example, to potentially give more weight to clinical quality measures that have a greater impact on the quality of care of enrollees than other measures. (CMS recently indicated that it would examine the weighting issue and other issues related to the effectiveness of the star rating system (Bureau of National Affairs 2011).)

MA payment changes in PPACA

Four sets of changes will directly affect MA payments starting in 2012 (fully phased in by 2017):

- County benchmarks will ultimately be set at specified percentages of the per capita FFS Medicare expenditures for county residents.
- CMS will have clearer authority to correct for increased coding intensity in risk scores.
- Plans will be able to earn substantial quality bonuses.
- The proportion of benchmark-to-bid "savings" provided to the plans as rebates for enhanced benefits will be reduced and will be based on quality ratings.

On average, these changes were intended to reduce overall payments (to bring MA payments in line with average FFS spending), redistribute payments from high-spending counties to low-spending counties, and encourage plans to improve their quality.

New method for setting county benchmarks

PPACA changed the formula that sets MA benchmarks and fully phases in an overall reduction by 2017. Beginning in 2012, new benchmarks are phased in over two to six years, depending on how large a reduction is required as determined by FFS spending in each county. The counties are ranked in order of FFS spending. (They must be reranked at least every three years and at CMS's discretion could be reranked more frequently.) Beginning with the top quartile of counties (each quartile contains just under 800 counties) with respect to FFS spending, benchmarks will be set at 95 percent, 100 percent, 107.5 percent, and 115 percent of FFS spending, respectively. If the current county-level MA enrollment continues, the benchmarks in 2017 will average 101 percent of FFS (before addition of the 5 percent or 10 percent quality bonuses, as discussed in the PPACA quality section), down from the 2011 average of 113 percent of FFS.

There is an anomaly with the quartile model that is very likely to draw complaints from counties with lower benchmarks than other counties, even though their FFS spending is above the other counties' FFS spending. The final benchmarks resulting from the quartile formula show a "saw-tooth" pattern (Figure 12-2A, p. 308). The FFS spending range is considerably narrower for the middle two quartiles, and the concentration of FFS spending values is such that many counties will be near the boundaries between the quartiles. In many cases, a county on the low end of a higher spending quartile will end up with a substantially lower benchmark than a county on the high end of a lower spending quartile.

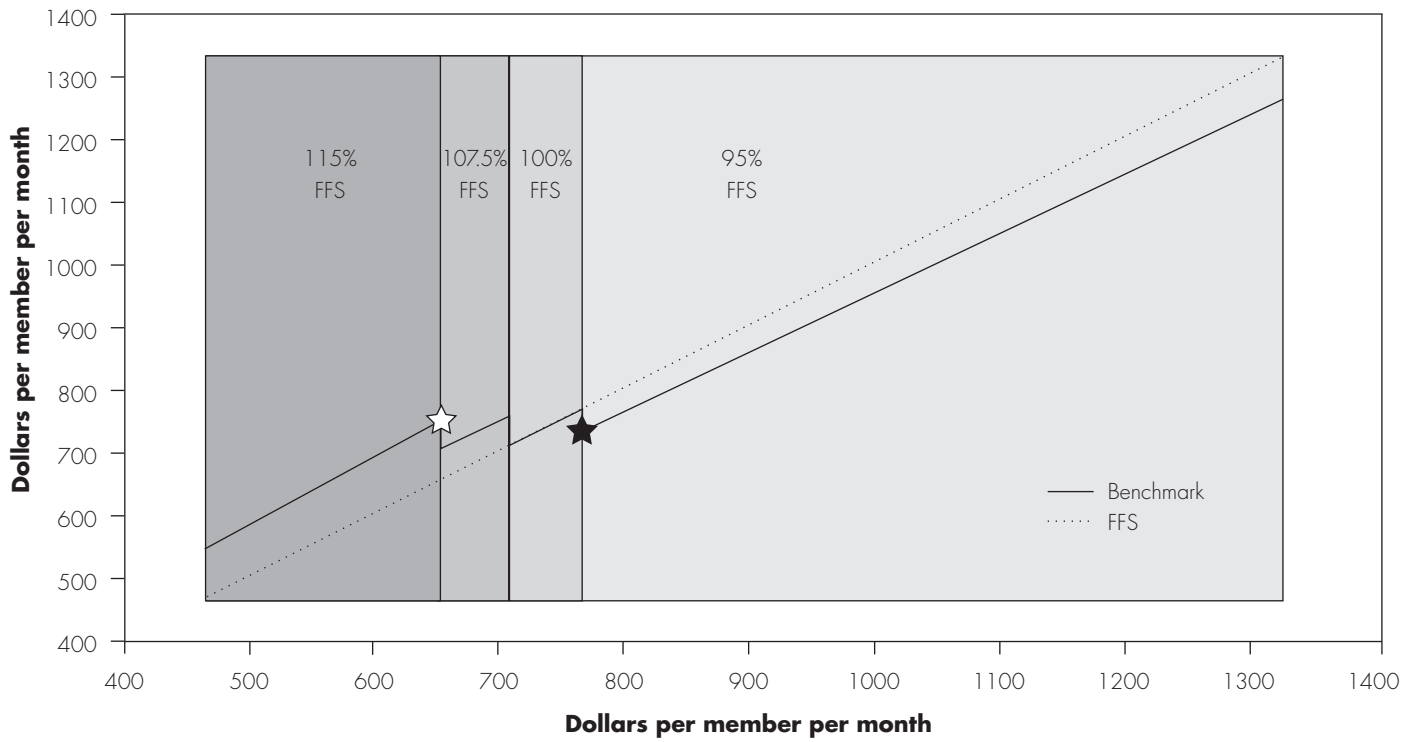
For example, the highest spending county in quartile 1 (represented by the light-colored star in Figure 12-2A) would have FFS spending of $657 per month and would have a benchmark of $756 (using 2010 FFS levels and 2017 benchmark rules). At the same time, the lowest spending county in quartile 4 (represented by the dark-colored star in Figure 12-2A) would have FFS spending of $767 and a benchmark of only $728. Therefore, a county with FFS spending $110 higher than another county could have a benchmark $28 lower than the other county (Table 12-13, p. 309).

The intercounty anomaly can be addressed by adding minimum or maximum conditions on benchmarks between quartiles. Under such an alternative, shown in Figure 12-2B, quartile 1 counties could not have a benchmark above a certain level ($706, to illustrate); quartile 2 counties could not have benchmarks above a slightly higher level; quartile 3 counties would keep their benchmarks at 100 percent of FFS; and quartile 4 counties could not have benchmarks cut below another level. The adjusted level changes could be calculated to be budget neutral. The result would be a benchmark-setting system in which no county would have a higher benchmark than another county with higher FFS spending.

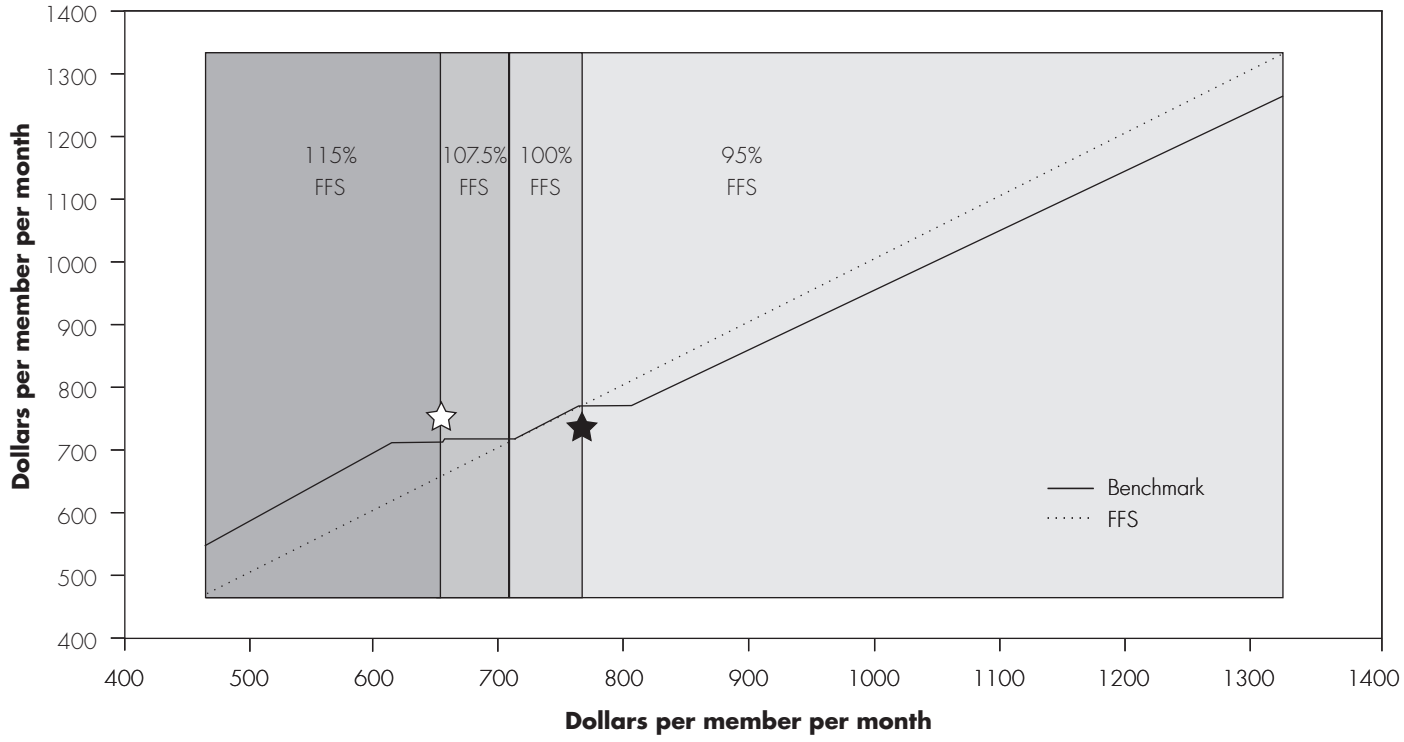
FIGURE 12–2

Graphic illustration of MA benchmarks in 2017

12-2A Current quartile formula



12-2B Alternative quartile formula



Note: MA (Medicare Advantage), FFS (fee-for-service). Amounts are given in 2010 dollars. The dollar amounts of the upper range of the first quartile and lower range of the fourth quartile for FFS and the benchmark (from Table 12-13) are shown as two starred points, each of which represents a theoretical county.

TABLE 12–13 **Tabular illustration of MA benchmarks in 2017**

	Quartile			
	1	2	3	4
Quartile FFS factor	115%	107.5%	100%	95%
FFS range	$469–**$657**	$657–$710	$710–$767	**$767**–$1,325
Benchmark range	$539–**$756**	$706–$763	$710–$767	**$728**–$1,260
Percentage of:				
Medicare beneficiaries	15%	19%	24%	42%
MA enrollees	16	18	22	44

Note: MA (Medicare Advantage), FFS (fee-for-service). Quartile FFS factor is the percentage by which FFS is multiplied to produce the benchmark. Amounts are given in 2010 dollars. The dollar amounts of the upper range of the first quartile and lower range of the fourth quartile for FFS and the benchmark (displayed in bold) denote the two starred points in Figure 12-2.

CMS will have clearer authority to correct for increased coding intensity in risk scores

Medicare payment to plans is calculated separately for each beneficiary as the plan's payment rate times the beneficiary's risk score. The risk scores are based on diagnoses attributed to the beneficiary during the year before the payment year. The diagnoses are reported to Medicare through claims for Medicare FFS beneficiaries or by the plans for MA enrollees. The risk-adjustment model, however, is currently calibrated only on FFS claims. The plans have an incentive to ensure that the providers serving the beneficiary recorded all diagnoses completely so as to receive accurate payment, while providers in FFS have no such incentive to code completely.

CMS has found that diagnoses for MA plan members have been growing more rapidly than the risk scores of FFS beneficiaries. (For 2011, plans project an average risk score of about 1.02. For 2009 they projected an average of 1.00.) Thus, as mandated by previous legislation, CMS has been making an across-the-board adjustment to the scores. Taking into account multiple years of coding differences, CMS reduced risk scores by 3.41 percent for 2010 and 2011. Under PPACA, CMS can continue to correct for the differences it finds without any restrictions for 2012 and 2013, but for 2014 and all future years PPACA specifies minimum reductions that CMS must make in the scores, although CMS has discretion to make larger reductions. The mandated reductions will end once CMS begins risk-modeling based on MA utilization rather than on the current FFS utilization in the model.

PPACA provisions specified that plans with an overall star rating of four or higher would receive a quality bonus; star levels determine rebates

PPACA established a system of quality bonuses for MA plans beginning in 2012, specifying only that it would be a five-star system based on the information collected under Section 1852(e) of the Social Security Act (which differs from the information reported under Section 1851(d)(4) of the Social Security Act—the original basis of the star system—in that there is no mention of the latter section's "recent record of program compliance," or what we refer to as contract performance measures). PPACA provided that plans with the highest quality ratings—four stars or higher in a five-star rating system—would have their county benchmark amounts increased by 1.5 percentage points in 2012, 3 percentage points in 2013, and 5 percentage points in 2014 and thereafter. High-quality plans operating in certain counties would be eligible for a doubling of the bonus amount. Plan rebates would also vary according to the number of stars a plan achieved.

The benchmark increase applies to the newly enacted benchmark portion of the total benchmark—that is, the portion set at a specified level of FFS in a county. By the time the bonus payments and new benchmarks are fully phased in, plans with benchmarks at 95 percent of FFS that have a four-star or better rating will have a post-bonus benchmark of 100 percent of FFS, for example. The additional bonus—a doubling of the bonus levels—would be available in "qualifying counties." Qualifying counties are those that were urban (metropolitan statistical area)

floor counties in 2004, had MA penetration of at least 25 percent as of December 2009, and have FFS expenditures in the county that are lower than the national average for the year the bonus level is being determined.

The star ratings used to provide information to beneficiaries enrolling in MA during the November–December 2010 open enrollment period will be the basis of bonus payments in 2012. In addition, CMS has announced that the star rating will be a combination of the Part C and Part D rating for MA–PD plans (regardless of the proportion of enrollees in the contract who have Part D coverage). A relatively small proportion of current MA enrollees—about 23 percent (Table 12-12, p. 306)—are in plans with star ratings of four or better, which would make them eligible for bonuses.

PPACA reduces rebate levels, and they will vary by star ratings

Star levels will also be a factor in determining rebate levels for plans with bids below their benchmarks. The current proportion of 75 percent of the bid-to-benchmark difference will be reduced, by 2014, to 70 percent for the highest rated plans and to 50 percent as the rebate proportion for the lowest rated plans.

CMS will replace the PPACA bonus system with a program-wide demonstration

On November 10, 2010, CMS announced a program-wide demonstration for the three-year period 2012–2014 whereby CMS would test an alternative approach to providing quality bonuses to MA plans. Under the CMS demonstration (applicable to all MA plans), plans with star ratings of three or higher will be eligible for a bonus of up to 3 percentage points in increased benchmark amounts. Extending quality bonuses to the vast majority of plans is likely to result in far greater program costs than the reward system enacted by PPACA. Using the 2010 ratings that will be the basis of 2012 bonuses, 80 percent of MA enrollees (as of November 2010) were in plans with three or more stars, while 7 percent were in plans with fewer than three stars and 13 percent were in plans that were not rated. The Office of Management and Budget estimates that the demonstration will result in additional program expenditures of $3 billion over the three-year period (Office of Management and Budget 2011). CMS has stated that the rationale for the demonstration is that it will promote greater improvement in quality among lower rated plans as well as among higher rated plans. Plans below the 4-star level will have an incentive for incremental improvement (e.g., a plan at 2.5 stars could improve to 3 stars and gain a bonus); because 5-star plans will receive larger bonuses than 4-star plans, 4-star plans will have an incentive to improve their performance (Rice 2011).

The Commission has a long-standing recommendation regarding CMS's overly broad use of demonstration authority, a recommendation made in 2006 in connection with a program to provide additional payments to oncologists. Later, with respect to two program-wide demonstrations under Part D, the Commission reiterated that "the Secretary should use … demonstration authority to test innovations in the delivery and quality of health care. Demonstrations should not be used as a mechanism to increase payments. … [The] demonstration authority is intended for smaller scale projects that help decision makers learn about innovations in financing and delivering Medicare services." Like the Part D demonstrations, the MA quality bonus payment demonstration is a program that "increases program spending at a time when Medicare already faces serious problems with cost control and long-term financing" (Medicare Payment Advisory Commission 2007).

While we have discussed some of our concerns about the star rating system, extending bonuses to three-star plans raises additional issues, in part because of the combining of Part C (the MA Part A and Part B program) and Part D scores and the degree to which contract performance measures can influence a plan's ratings. For example, CMS has instituted a new practice of highlighting, on the Plan Finder Tool at the medicare.gov website, those plans that have been poor performers for three consecutive years. Poor performance is defined as having health and/or drug plan summary ratings of 2.5 or less for three consecutive years. With the demonstration setting the bonus threshold at three stars, and with the combining of Part C and Part D measures (which did not occur in the three preceding years), there are nine of these poorly performing MA plans—with 72,000 enrollees—that have a three-star combined rating that makes them eligible for a quality bonus payment (if the plans maintain their contracts in 2012). While these plans have 3-star ratings using the combined Part C and Part D approach, their overall rating for just the Part C measures (excluding the Part D drug measures) is at 2.5 stars for this year.

The Commission has also noted that contract performance measures can be a large component of a plan's star ratings in some cases. Combining the Part C and Part D ratings adds more administrative measures as a proportion of

the total (because 10 of 15 of the Part D measures for MA drug plans are administrative, with 3 of the 15 being Part D CAHPS measures and two being clinical quality measures) and results in some rating anomalies. To cite one example, one plan has no reported results on the clinical quality of care other than those reported through CAHPS. For the CAHPS vaccination measures, this particular plan received a one-star rating in each measure, the lowest possible star rating, because of the low rate of immunizations. However, the plan received good ratings on other CAHPS measures and on the administrative measures that CMS tracks, resulting in an overall three-star rating and making the plan eligible for a bonus payment under the demonstration. (In the next reporting cycle, this particular plan is expected to have reportable clinical quality measures.)

Another concern with the current design of the quality bonus payment system is that it is oriented toward rewarding attainment and does not sufficiently reward improvement on quality indicators. When the Commission made its recommendation that MA include a pay-for-performance component, the system was envisioned as providing rewards both for attainment and for improvement (Medicare Payment Advisory Commission 2004); that is, plans that do well on quality indicators would be rewarded, but plans that improved over their past performance would also receive bonus payments. This approach addresses several issues, including the concern that a given plan's high level of performance, when compared with other plans across the country, may be a reflection of the performance of the provider community where the high-performing plan operates. Ideally, another basis on which to judge eligibility for quality bonus payments is in relation to the performance of FFS Medicare in the plan's service area once data are available to compare the two sectors (Medicare Payment Advisory Commission 2010). ■

Endnotes

1 HEDIS is a registered trademark of NCQA. HEDIS reporting also includes measures that are collected through the two beneficiary surveys. HEDIS results for flu vaccination rates, pneumonia vaccines, and smoking cessation advice are from the CAHPS survey, and HEDIS includes Health Outcomes Survey results for fall risk management, osteoporosis testing, management of urinary incontinence, and advice about physical activity.

2 The star system includes the HEDIS measure of access to primary doctor visits. It is not one of the measures we include in our analysis of the HEDIS results, which are based on "effectiveness-of-care" measures rather than access-to-care measures (in the same way that effectiveness-of-care measures are the basis for the evaluation of plan performance in NCQA's annual State of Health Care Quality report (National Committee for Quality Assurance 2010)).

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

4 We report HEDIS results based on the CMS public use files available at http://www.cms.gov/MCRAdvPartDEnrolData/HEDIS/list.asp#TopOfPage. Those files contain a classification of organizations by type (e.g., HMO vs. PPO). However, we use CMS contract report data (available at http://www.cms.gov/MCRAdvPartDEnrolData/MEC/list.asp#TopOfPage) to determine the plan type for each entity reporting HEDIS data. The HEDIS public use files contain some erroneous classifications.

5 The HEDIS results we report are simple averages across all plans. Such an approach shows the performance of plans across the country on the HEDIS measures. An alternative approach is to consider weighted averages, which says more about the quality of care rendered to the majority of enrollees in the MA sector. Weighting purely by enrollment, weighted-average HEDIS results for HMOs are higher than the simple average for 19 of the 46 effectiveness-of-care measures (more than 3 percent to 23 percent better), lower for 14 measures (4 percent to 14 percent lower than the simple average), and about the same for 13 measures (within 3 percent of the simple average). For local PPOs, 5 measures are more than 3 percent to 35 percent better, 33 are more than 3 percent to 29 percent worse, and for 8 measures the simple average is within 3 percent of the enrollment-weighted average. However, weighting purely by enrollment is not consistent with the design of HEDIS measures. A more appropriate weighting is by the denominators of the HEDIS measures—information that is not available to the Commission. For example, the nine HEDIS effectiveness-of-care measures for comprehensive diabetes care apply to Medicare beneficiaries of a plan who are diabetics and are 18 to 75 years old—not the universe of the enrolled Medicare population and not the universe of Medicare enrollees of a plan with diabetes (who would be of any age).

6 The measure for persistence of beta blockers applies to very few plan members, which, as we noted, is why it is not included as a measure in the star rating system—too few plans can report the measure, and when it is reportable it applies to a small number of people. To provide an idea of how small a number of beneficiaries the measure applies to, we note that data that CMS used to determine HEDIS-like measures in FFS (the Generating Medicare Physician Quality Measurement Results program) showed that, among the more than 30 million beneficiaries in FFS, there were 51,000 beneficiaries to whom this measure applied (0.2 percent of beneficiaries)—the number of beneficiaries who were hospitalized and discharged with a diagnosis of acute myocardial infarction. This value compares with a denominator of 8 million FFS beneficiaries for the HEDIS measure on monitoring of persistent medication use (the summary total measure). As discussed in the preceding note, the numbers also illustrate why, for many measures, a weighted average of HEDIS measures across plans would have to be weighted at the level of the individual measure using the number of beneficiaries to whom each measure applies in each plan; a weighting based on plan enrollment would not produce an accurate MA-wide result for many measures.

7 Cost-reimbursed plans technically are not MA plans in that they are governed by the provisions of Section 1876 of the Social Security Act, not the MA provisions of the law. All cost plans are HMOs, but members are not "locked in" to the plan. That is, enrollees are free to use FFS Medicare providers and the program will pay such providers. Profit is not an allowable cost under Section 1876 rules. It is possible that these plans may perform better on quality measures because the costs of setting up and maintaining quality monitoring systems would be allowed as reasonable costs.

8 The results that local PPOs have reported for the intermediate outcome measures of control of blood pressure, cholesterol, and blood sugar do not appear to be credible—perhaps because this year is the first year of such reporting for local PPOs. Looking at the details of those measures, we see, for example, that the comprehensive diabetes care measure for blood pressure below 140/90 has an average rate of 49.7 percent among local PPOs (compared with 60.2 percent across HMO plans). The 90th percentile of local PPO rates for this measure is 68.1 percent and the 10th percentile is 1.2 percent (compared with the HMO levels of 74.0 percent and

45.0 percent for the 90th and 10th percentiles, respectively). Of 93 local PPOs in the HEDIS data, 14 are not reporting a value for this measure, and 10 plans are reporting a value less than 1.5 percent, including 3 plans reporting a rate of 0 percent. Among HMOs, 290 of 297 plans are reporting a result, with only one plan at an extremely low level (at 0.62 percent, though this number may be erroneous in the HEDIS files, given that the plan showing this score has very high scores on other measures).

9 One reason measures collected through HOS are included as HEDIS measures is to address the concern that there are not enough measures tracking care rendered to the very old. However, as shown in Table 12-7 (p. 301), the differences between HMO results and local PPO results on the seven HOS measures may indicate that there are issues with how these measures are reported. In addition to having a younger distribution of enrollment, local PPOs tend to occupy a market niche as an alternative to medigap coverage among higher income beneficiaries and therefore they may attract different types of enrollees than HMOs—higher income, more highly educated beneficiaries with a history of good access to health care. Perhaps the HOS results should be adjusted before their use in HEDIS, following the CAHPS example. Before the CAHPS–MA results are used for public reporting and MA plan comparisons, the results are adjusted for response bias with respect to age, education, self-reported physical and mental health status, proxy status (whether the surveyed individual had help completing the survey), and Medicare–Medicaid dual-eligibility status (Medicare Payment Advisory Commission 2010). The HOS results for HEDIS do not have similar adjustments for factors that may affect a person's response. For example, the HEDIS osteoporosis testing measure from HOS is based on the person's answer to the question, "Have you ever had a bone density test to check for osteoporosis, sometimes thought of as 'brittle bones'? This test may have been done to your back, hip, wrist, heel or finger." (HOS survey instrument 2010). If there is an indication that a respondent has issues with recall, should the individual's self-report of whether he or she received a particular test be accepted at face value?

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