

CHAPTER

12

**The Medicare Advantage
program: Status report**

The Medicare Advantage program: Status report

Chapter summary

Each year the Commission provides a status report on the Medicare Advantage (MA) program. In 2011, the MA program included more than 3,400 plan options, enrolled more than 12 million beneficiaries, and paid MA plans about \$124 billion. To monitor program performance, we examine MA enrollment trends, plan availability for the coming year, and payments for MA plan enrollees relative to spending for fee-for-service (FFS) Medicare beneficiaries. We also provide an update on current quality indicators in MA.

The MA program 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, because they are paid a capitated rate rather than on a FFS basis, have greater incentives to innovate and to use care management techniques. However, to encourage efficiency and innovation, Medicare should place some degree of financial pressure on MA plans, just as the Commission has recommended for providers in the traditional FFS program.

Enrollment—In 2011, MA enrollment increased by 6 percent to 12.1 million beneficiaries (25 percent of all Medicare beneficiaries). Enrollment

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- Quality in MA plans

in HMO plans—the largest plan type—increased 6 percent. Enrollment in private FFS (PFFS) plans declined from about 1.7 million to about 0.6 million enrollees, continuing the decline from the previous year. New network requirements for PFFS plans began in 2011 (mandated by the Medicare Improvements for Patients and Providers Act of 2008). Beginning in 2010, many plan sponsors reduced PFFS offerings and transitioned their enrollment to network-based preferred provider organization (PPO) plans; others changed their PFFS offerings to network plans. Predictably, PPOs showed rapid growth in enrollment between 2010 and 2011, with local PPO enrollment growing about 65 percent and regional PPO enrollment growing about 34 percent. The MA plan bids submitted to CMS project an increase in overall enrollment for 2012, primarily in HMOs.

Plan availability—In 2012, virtually all Medicare beneficiaries have access to an MA plan (0.3 percent do not), and 99 percent have access to a network-based coordinated care plan (CCP). Eighty-eight 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). Beneficiaries are able to choose from an average of 12 MA plan options, including 8 CCPs in 2012.

Plan payments—For 2012, under the Patient Protection and Affordable Care Act of 2010 (PPACA), the base county benchmarks used to set plans' payment rates average approximately 3 percent less than the benchmarks for 2011. However, 93 percent of 2012 plan enrollment is projected to be in plans that will receive add-ons to their benchmarks through a CMS MA quality bonus demonstration program. These quality bonus add-ons will range from 3 percent to 10 percent in 2012, in effect substantially offsetting the PPACA benchmark reductions in legislation for 2012.

We estimate that 2012 MA benchmarks (including the quality bonuses), bids, and payments will average 112 percent, 98 percent, and 107 percent of FFS spending, respectively (assuming no sustainable growth rate reduction in Medicare physician payment rates during 2012). Last year, we estimated that, for 2011, these figures would be 113 percent, 100 percent, and 110 percent, respectively. The PPACA benchmark reductions, quality bonuses, and underestimates of FFS spending levels for 2012, combined with projected enrollment shifts into HMOs, resulted in some movement of projected MA payments toward FFS spending levels.

Quality measures—Overall, quality indicators for MA plans improved somewhat in 2011. A larger number of process measures and outcome measures showed improvement compared with past years, with differences by plan type. Local PPO plans had results similar to HMO plans on many measures but had lower results

on measures relying on extraction of information from medical records. Regional PPOs and PFFS plans generally had poorer results than other plan types. The health outcome survey of MA enrollees showed some improvement in outcomes, accompanied by a small number of plans showing worse than expected outcomes. Because quality indicators are now the basis of bonus payments, we expect to see continued improvement in measures, as plans pay closer attention to quality initiatives and seek to improve their documentation and record keeping.

As of 2012, MA plans with better performance on quality indicators will receive bonus payments in the form of increased benchmarks. Legislation authorized the bonus payments for plans meeting certain standards of performance, but CMS has used its demonstration authority to institute a program-wide system, across all MA plans, that provides bonuses to a far greater number of plans. The Commission has stated its concerns over the use of the demonstration authority in this manner—an authority intended to test innovations on a smaller scale—and the consequent added program costs. While the statutory provisions would have given bonuses to plans with about 25 percent of the projected MA enrollment for 2012, under CMS’s MA quality bonus demonstration, as we have noted, plan projections show that 93 percent of enrollees are expected to be in plans receiving bonuses, resulting in additional program costs estimated to be \$2.8 billion for 2012, compared with the \$200 million that would have been expended in bonus payments under the statute.

The 2012 bonuses will be based on CMS star ratings as of 2011. The star ratings include clinical process and outcome measures, patient experience measures, and contract performance measures. Recently released star ratings for 2012 will determine bonus amounts in the 2013 contract year. With the 2012 star rating methodology, CMS has made improvements by adding outcome measures and giving greater weight to outcomes and patient experience measures over process measures. ■

The Medicare Advantage (MA) program allows Medicare beneficiaries to receive benefits from private plans rather than from the traditional fee-for-service (FFS) program. In 2011, the MA program included more than 3,400 plan options, enrolled more than 12 million beneficiaries, and paid MA plans about \$124 billion. 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 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 beneficiaries 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. Traditional Medicare also has the potential to modify its payment methods over time to better reward value. To date, there has been limited application of care management in FFS Medicare. Because private plans and traditional FFS Medicare have structural aspects that appeal to different segments of the Medicare population, we favor providing a financially neutral choice between private MA plans and traditional FFS Medicare. Medicare's payment systems should not unduly favor one component of the program over the other.

While Medicare program payments should not unduly advantage MA over FFS, or vice versa, truly efficient MA plans may be able to capitalize on their administrative flexibility to provide a better value to beneficiaries who enroll in MA. Currently, much of the extra value that MA plans provide to their enrollees is due to the fact that Medicare spends more under the MA program than under FFS Medicare for similar beneficiaries. This higher spending results in extra benefits being provided by way of increased government outlays but with higher beneficiary Part B premiums (including for those who are in traditional FFS Medicare) at a time when Medicare and its beneficiaries are under increasing financial stress. To encourage efficiency and innovation, MA plans need to face some degree of financial pressure, just as the Commission has recommended for providers in the traditional FFS program. One method of achieving financial neutrality is to

link private plans' payments more closely to FFS Medicare costs in the same market. Alternatively, neutrality can be achieved by establishing a defined contribution that is available for enrollment in either FFS Medicare or an MA plan. The Commission will continue to monitor the effect of the changes mandated by the Patient Protection and Affordable Care Act of 2010 (PPACA) on plan payments and performance as well as progress toward financial neutrality.

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

Trends in enrollment, plan availability, and payment

In contrast to traditional FFS Medicare, MA enrolls beneficiaries in private health plans of several types. Plans are paid a fixed capitated rate per enrollee in contrast to FFS Medicare, which pays providers a predetermined fixed rate per service.

Types of MA plans

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

- *HMOs and local preferred provider organizations (PPOs)*—These plans have provider networks and can use tools such as selective contracting and utilization management to coordinate and manage care. They can choose individual counties to serve 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 more flexible network requirements than local PPOs.
- *Coordinated care plans (CCPs)*—This category includes all HMOs, local PPOs, and regional PPOs.
- *Private FFS (PFFS) plans*—Before 2011, PFFS plans typically did not have provider networks, making them less able than other plan types to coordinate

**TABLE
12-1**

Medicare Advantage enrollment grew in 2011

	MA enrollment (in millions)		Percent change in enrollment	2011 MA enrollment as a share of total Medicare
	November 2010	November 2011		
Total	11.4	12.1	6%	25%
Plan type				
CCP	9.8	11.5	18	24
HMO	7.5	8.0	7	16
Local PPO	1.4	2.3	65	5
Regional PPO	0.9	1.2	34	2
PFFS	1.7	0.6	-64	1
Restricted availability plans included in totals above				
SNPs*	1.4	1.4	4	3
Employer group*	2.0	2.2	9	4
Urban/rural				Share of Medicare in urban/rural areas
Urban	10.0	10.6	6	26
Rural	1.4	1.5	5	14

Note: MA (Medicare Advantage), CCP (coordinated care plan), PPO (preferred provider organization), PFFS (private fee-for-service), SNPs (special needs plans). CCP includes HMO, local PPO, and regional PPO plans. Totals may not 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.

care. They used Medicare FFS payment rates and had fewer quality reporting requirements. Given that PFFS plans generally lacked care coordination, had lower quality measures, paid Medicare FFS rates, and had higher administrative costs than traditional FFS Medicare, they were viewed as providing little value. In response, the Congress made changes in the law in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) so that, in areas with two or more network MA plans, PFFS plans can be offered only if they have provider networks. PFFS plans are also now required to participate in quality reporting. Existing PFFS plans had to either locate in areas with fewer than two network plans or develop provider networks themselves, which in effect would change them to become PPOs or HMOs or to operate as network-based PFFS plans.

Two additional plan classifications cut across plan types. First are special needs plans (SNPs), which offer benefit packages tailored to specific populations (i.e., beneficiaries who are dually eligible for Medicare and Medicaid, are

institutionalized, or have certain chronic conditions). SNPs must be CCPs. Second are employer group plans, which are available only to Medicare beneficiaries who are members of employer or union groups that contract with those plans. Employer group plans may no longer be 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.

How Medicare pays MA plans

Plan payment rates are determined by the MA plan bid (the dollar amount the plan estimates will cover the Part A and Part B benefit 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, its MA payment rate is equal to the benchmark, and enrollees have to pay a premium equal to the difference. If a plan's bid is below the benchmark, its payment rate is its bid plus a percentage (between 67 percent and 73 percent in 2012) 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.) In 2011, payments to MA plans totaled approximately \$124 billion. A more detailed description of the MA program payment system can be found at http://www.medpac.gov/documents/MedPAC_Payment_Basics_11_MA.pdf.

Enrollment trends: Plan enrollment grew in 2011

Between November 2010 and November 2011, enrollment in MA plans grew by about 6 percent, or 700,000 enrollees, to 12.1 million beneficiaries. About 25 percent of all Medicare beneficiaries were enrolled in MA plans in 2011 (Table 12-1).

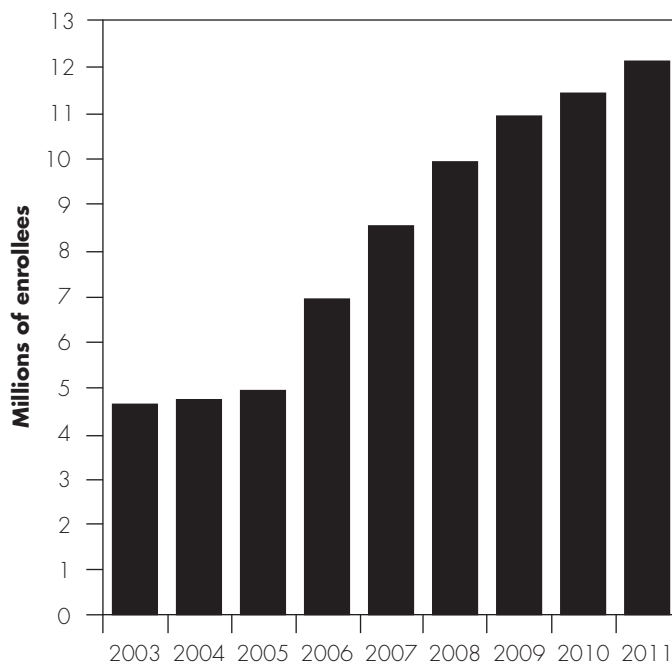
Enrollment patterns differ in urban and rural areas. A larger share of urban Medicare beneficiaries are enrolled in MA (about 26 percent) compared with beneficiaries residing in rural counties (about 14 percent). In 2011, 33 percent of rural MA enrollees were in HMO plans (not shown in Table 12-1) compared with about 71 percent of urban enrollees. At the same time, 17 percent of rural enrollees were in PFFS plans compared with 3 percent of urban enrollees.

The percentage of Medicare beneficiaries enrolled in MA plans in 2011 varied widely by local area. In some metropolitan areas, less than 1 percent of Medicare beneficiaries were enrolled in MA plans, whereas in other areas enrollment was 60 percent or more.

Among plan types, HMOs continued to enroll the most beneficiaries (8.0 million), with 16 percent of all Medicare beneficiaries in HMOs in 2011. Between 2010 and 2011, PFFS enrollment shrank from about 1.7 million to about 0.6 million enrollees. The decrease followed reduced PFFS plan offerings that resulted from MIPPA's network requirements for PFFS plans beginning in 2011. Some PFFS plans seemed to shift their enrollment to network plans. Between 2010 and 2011, PPOs exhibited rapid enrollment growth, with local PPO enrollment increasing about 65 percent and regional PPO enrollment increasing about 34 percent. In 2011, SNP enrollment stayed at 1.4 million and employer group enrollment grew about 9 percent to 2.2 million enrollees.

FIGURE 12-1

Medicare Advantage enrollment, 2003-2011



Source: CMS monthly Medicare Advantage enrollment reports.

MA enrollment growth in 2011 continued a trend begun in 2003 (Figure 12-1). Since 2006, enrollment has grown by about 75 percent. From 2010 to 2011, the enrollment growth rate increased from 5 percent to 6 percent. We did not have 2012 enrollment information as of this report's publication, but plans projected overall enrollment growth of 7 percent to 8 percent for 2012. Almost all the growth was projected to be in HMOs, while regional PPO and PFFS plans were projected to contract.

Plan availability for 2012

Every year, we base our plan availability and projected enrollment for the coming year on the bid data that plans submit to CMS. The data, especially over the past few years, have proved to reliably project availability and overall enrollment. Based on these data, we find that access to MA plans remains high in 2012, with most Medicare beneficiaries having access to a large number of plans. While almost all beneficiaries have had access to some type of MA plan since 2006, local CCP plans have become more widely available in the past few years (Table 12-2, p. 318). Ninety-three percent of Medicare

**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	2012
All plan types	84%	100%	100%	100%	100%	100%	100%	100%
CCP								
HMO or local PPO	67	80	82	85	88	91	92	93
Regional PPO	N/A	87	87	87	91	86	86	76
PFFS	45	80	100	100	100	100	63	60
Zero-premium plans with Part D	N/A	73	86	88	94	85	90	88
Average number of MA plans open to all beneficiaries in a county	5	12	20	35	34	21	12	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.

Source: MedPAC analysis of plan bids to CMS, 2011.

beneficiaries have an HMO or local PPO plan operating in their county of residence, up from 92 percent in 2011 and 67 percent in 2005. Regional PPOs are available to 76 percent of beneficiaries, down from 86 percent in 2011 due to the withdrawal of the only California regional PPO in 2012. Access to PFFS plans decreased between 2011 and 2012, from 63 percent to 60 percent of beneficiaries, consistent with MIPPA's network requirements for PFFS plans. Overall, virtually all Medicare beneficiaries have access to an MA plan (0.3 percent do not), and 99 percent have access to a CCP (not shown in Table 12-2).

In 2012, 88 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 90 percent in 2011.

The availability of SNPs has changed slightly and varies by the type of special needs population served (not shown in Table 12-2). In 2012, 78 percent of beneficiaries reside in areas where SNPs serve beneficiaries who are dually eligible for Medicare and Medicaid (up from 76 percent in 2011); 41 percent live where SNPs serve institutionalized beneficiaries (down from 47 percent in 2011); and 45 percent live where SNPs serve beneficiaries with chronic conditions (down from 46 percent in 2011). Overall, 83 percent of beneficiaries reside in counties served by at least one type of SNP.

In most counties, a large number of MA plans are available to beneficiaries, although the number varies by county. For example, in 2012, beneficiaries in Miami and New York City can choose from more than 50 plans. Some counties, representing 0.3 percent of the beneficiaries, have no MA plans available; however, many of these beneficiaries have the option of joining cost plans (another managed care option under Medicare).¹ On average, 12 plans including 8 CCPs are offered in each county in 2012, the same as in 2011.

2012 benchmarks, bids, and payments relative to FFS spending

We use the plan bid projections to compare projected MA spending with projected FFS spending on a like set of FFS beneficiaries. We calculate and present three sets of percentages: the percentage of the benchmarks relative to projected FFS spending, the percentage of the bids relative to projected FFS spending, and the resulting payments to MA plans relative to projected FFS spending. The benchmarks are set each April for the following year. The plans submit their bids in June and incorporate the recently released benchmarks. Thus, the plan bid submissions provide the information we use for the benchmarks, bids, and payments. The benchmarks reflect current law FFS spending estimates for 2012 at the time the benchmarks were published in April 2011.

**TABLE
12-3****Projected payments exceed FFS spending for all plan types in 2012****Percent of FFS spending in 2012**

Plan type	Benchmarks	Bids	Payments
All MA plans	112%	98%	107%
HMO	112	95	106
Local PPO	114	108	113
Regional PPO	107	100	105
PFFS	112	106	110
Restricted availability plans included in totals above			
SNP*	114	101	110
Employer groups*	114	108	113

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.

*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.

For 2012, the April 2011 current law estimates of FFS spending assumed that the sustainable growth rate (SGR) formula would be used to cut physician fee schedule rates by nearly 30 percent. However, we project 2012 FFS assuming a freeze rather than a reduction from the SGR. This results in total FFS spending of about 5 percent above what was expected when the benchmarks were set. This process does not reflect a change in our methods, as we make these adjustments each year, but the magnitude of the adjustment is larger this year.

We estimate that 2012 MA benchmarks, bids, and payments will average 112 percent, 98 percent, and 107 percent of FFS spending, respectively (Table 12-3). (Benchmarks, bids, and payments are weighted by plans' projected 2012 enrollment by county to estimate overall averages and averages by plan type.)

Last year, we estimated that, for 2011, these figures would be 113 percent, 100 percent, and 110 percent, respectively. The PPACA benchmark reductions, quality bonuses, and underestimates of FFS spending growth for 2012 when setting the benchmarks (described above), combined with projected enrollment shifts into HMOs, resulted in benchmarks and projected MA payments that are closer to FFS spending levels. With the exception of employer group plans, the payments for all plan types are projected to be closer to FFS spending levels in 2012 than they

were in 2011. Most notably, HMOs submitted bids that averaged 95 percent of FFS spending, although there is much variation in the relationships between individual plan bids and expected FFS spending.

MA benchmarks

Under PPACA, county benchmarks in 2012 are transitioning to a system in which each county's benchmark in 2017 is a certain percentage (ranging from 95 percent to 115 percent) of the average per capita FFS Medicare spending for the county's residents. (See the March 2011 report for details on PPACA benchmark changes.) The percentage is based on a county's level of FFS spending relative to spending for other counties. (The FFS spending estimates will be updated every three years or more frequently at CMS's discretion.)

For 2012, the base county benchmarks (before any quality bonuses are applied) average approximately 3 percent less than the benchmarks for 2011. However, for 2012, 93 percent of MA enrollees are projected to be in plans that will receive add-ons to their benchmarks through the PPACA quality provisions or the 2012–2014 CMS quality demonstration program. These quality bonus add-ons will range from 3 percent to 10 percent in 2012, in effect substantially offsetting the PPACA benchmark reductions in legislation for 2012.

Each plan's benchmark is based on the county benchmarks of its enrollees. Local PPOs tend to draw enrollment from counties with higher benchmarks relative to the counties' FFS spending than other plan types. SNPs also tend to have higher benchmarks relative to the counties' FFS spending, as a large share of total SNP enrollment is in Puerto Rico, where benchmarks have been set 80 percent higher than per capita FFS spending (as discussed in the June 2009 report (Medicare Payment Advisory Commission 2009)).

MA bids and payments for different plan types

The pre-quality benchmark reductions under PPACA may have encouraged plans to tighten costs and lower their bids for 2012. The average bid for 2012 is 98 percent of the projected FFS spending for similar beneficiaries, down from 100 percent in 2011. Many plans (about 46 percent of the nonemployer plans, up from 37 percent in 2011) bid to provide Part A and Part B benefits for less than what the FFS Medicare program would spend to provide these benefits. About 0.5 million beneficiaries, excluding those enrolled in SNPs and employer group MA plans, are projected to enroll in plans that bid lower than 75 percent of FFS spending. On the other hand, a similar number of beneficiaries are projected to enroll in plans that bid at least 117 percent of FFS spending.

Despite the fact that the plan bids average less than FFS spending, payments for enrollees in these plans usually exceed FFS spending because the benchmarks are high relative to FFS spending. For example, HMOs as a group bid an average of 95 percent of FFS spending, yet payments for HMO enrollees are estimated to average 106 percent of FFS spending because the benchmarks average 112 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 110 percent and 113 percent, respectively, of FFS spending (Table 12-3).

We analyzed bids and payments to SNPs and employer group plans separately, 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 spending, and their bids tend to be greater than FFS spending. Employer group plans consistently bid higher than plans that are open to all Medicare beneficiaries. These plans bid an average of 108 percent of FFS spending and are paid about 113 percent

of FFS, while nonemployer plans bid an average of 96 percent of FFS and are paid about 107 percent of FFS (not shown in Table 12-3). The dynamic of the bidding process for employer group plans is more complicated than for other MA plans, because employer group plans can negotiate benefit and premium particulars with employers after the Medicare bidding process is complete. Conceptually, the closer the bid is to the benchmark—that is, the maximum Medicare payment—the better it is for the plan and the employers, because a higher bid brings in more revenue from Medicare, potentially offsetting expenses that would have required a larger contribution from employers (or employees). On the other hand, nonemployer plans have an incentive to bid below the benchmark to obtain rebates they can use to finance extra benefits that, in turn, are used to attract increased enrollment.

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 2012, overall payments to plans average an estimated 107 percent of FFS spending, meaning that the Medicare program will pay approximately \$9 billion more for the MA enrollees than it would have paid to cover the same enrollees in FFS Medicare. (This figure includes the quality bonus payments discussed below.)

MA risk adjustment and coding intensity adjustment

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 plans have an incentive to ensure that the providers serving the beneficiary record all diagnoses completely in order to receive the maximum payment they may rightfully claim. Providers in FFS, who are paid per service rather than per beneficiary, do not have the same financial incentive to code beneficiaries' diagnoses so precisely. Thus, a beneficiary treated by providers who code for MA plans may have a higher risk score than if treated by providers billing FFS Medicare.

Experience supports the contention that MA plan enrollees have higher risk scores than otherwise similar FFS beneficiaries because of more complete coding. CMS

has found that diagnoses for MA plan members have been growing more rapidly than the risk scores of FFS beneficiaries. For 2012, plan bids project an average risk score of about 1.03 compared with 1.02 projected for 2011 and 1.00 for 2010. Thus, as mandated by the Deficit Reduction Act of 2005, CMS has been making an across-the-board adjustment to the scores. Taking into account multiple years of coding differences, CMS reduced risk scores by 3.41 percent from 2010 through 2012. Under PPACA, CMS can continue to correct for the differences it finds without any restrictions for 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 FFS utilization in the current model; however, CMS will be able to devise an adjustment to account for any difference between FFS and MA risk levels.

Quality in MA plans

In this section, we review the quality indicators in MA to determine

- whether plan quality has improved over time;
- how quality in MA differs from that in the traditional FFS program—to the extent that there are data that allow comparisons; and
- what differences exist in MA by plan type, plan characteristics, and plan enrollment, including a separate examination of SNPs.

We also examine the star rating methodology that CMS uses to determine which plans are eligible for quality bonus payments, the MA enrollment distribution by star ratings, and differences among plans in star ratings.

Our analysis of the quality of care among MA plans relies on the metrics that currently exist, which we describe below. We recognize, however, that the measurement of quality is multidimensional and involves intensive data collection efforts. As the Commission noted in its report on quality measurement in MA and FFS, there are many gaps in our knowledge of quality, and a long-term effort is required to fill those gaps, to improve the measurement of quality, and to have more measures of health outcomes (Medicare Payment Advisory Commission 2010b).

Quality measures and their data sources

We use three data sources to evaluate the quality of care in MA, each of which is described more fully in an online appendix to the March 2010 report (http://medpac.gov/chapters/Mar10_Ch06_APPENDIX.pdf):

- The Healthcare Effectiveness Data and Information Set (HEDIS[®]) includes a set of clinical quality measures that health plans report to CMS.² These measures are developed from several sources: administrative data, such as claims and encounter data; clinical data extracted from medical records; and two beneficiary surveys. HEDIS includes “process” measures, such as whether plans are monitoring blood glucose levels for diabetics, and “intermediate outcome” measures, such as whether diabetics are controlling their blood glucose levels.
- The Consumer Assessment of Healthcare Providers and Systems for MA plans (CAHPS[®]–MA) is a beneficiary survey producing “patient experience” measures. The survey asks plan enrollees to rate their access to care and satisfaction with their health plan and its providers.³ The CAHPS–MA 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. There is a separate CAHPS survey of patient experience measures among FFS beneficiaries. The CAHPS surveys thus allow a direct comparison of MA and traditional FFS Medicare.⁴
- 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 a major source of measures that apply to older Medicare beneficiaries. The HOS is the source of an overall outcome measure that gauges 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 its results on the physical or mental health measures are better or worse than expected and differ significantly from the national average across all plans.

HEDIS, CAHPS, and HOS are the principal data sources that inform the MA quality bonus payment

system newly instituted in 2012. In addition, CMS uses certain administrative data, along with Part D (drug plan) measures, to compute an overall plan rating that determines an MA plan's eligibility for and level of bonus payments and rebate dollars.

A new source of data on MA quality—detailed encounter data from plans—will be available for analysis sometime after 2012. Using encounter data, CMS can establish additional MA quality measures, including those that can be compared with FFS measures developed from claims data, 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 2010b). However, once collected, the encounter data would need to be evaluated and validated as a source of data on quality. Thus, we would not expect that encounter data could be used immediately as a data source for measuring quality.

Has plan quality improved over the past year?

Overall, we see some improvement in the quality indicators for MA plans. A larger number of HEDIS process measures and intermediate outcome measures show improvement compared with past years; the CAHPS–MA data show improvement from last year, with very similar CAHPS results for FFS; and the HOS survey shows some improvement in outcomes, accompanied by a small number of plans showing worse than expected outcomes. Because quality indicators are now the basis of bonus payments, we expect to see continued improvement in measures, as plans pay closer attention to quality initiatives and seek to improve their documentation and record keeping.

HEDIS results

We examine 45 HEDIS measures, which include all the effectiveness of care measures, as they are termed (such as the intermediate outcome measures and the clinical process measures), and several measures of access to care (such as the provision of alcohol and drug abuse treatment). The HEDIS results indicate that quality improved in HMOs and local PPOs between 2010 and 2011.⁵ Looking at plans that reported results in both 2010 and 2011 (“same store” results), HMOs improved on 14 of the 45 HEDIS measures we track, and local PPOs improved on 9 of the 45 measures. There was improvement among some important measures, with four of the six intermediate outcome measures improving

among HMOs or PPOs or both plan types (Table 12-4). Results for all other HEDIS measures remained stable between 2010 and 2011, measured on a same store basis, for both HMOs and local PPOs.

Of the 45 HEDIS measures, 16 are used as elements of the star rating system that determines plan quality bonuses. CMS now uses a weighted approach in the star rating system, with HEDIS intermediate outcome measures, for example, having a weight of 3, patient experience measures (such as members' ratings of the quality of their care) having a weight of 1.5, and other measures—such as HEDIS process measures—having a weight of 1. The weighted values, which include Part D measures, are averaged to determine an overall plan star rating.

Of the 14 HEDIS measures showing improvement among HMOs, 6 are elements in the star measurement system—meaning that HMOs reporting in both 2010 and 2011 improved in 6 of 16 star measures, including the intermediate outcome measure for members with hypertension who control their blood pressure (Table 12-4). As an intermediate outcome measure, this measure is one of the 5 Part C measures that has the maximum weight of 3 (with 5 Part D measures also having a weight of 3 within the overall plan rating that determines bonus payments for MA—prescription drug plans). For local PPOs, nine HEDIS measures show improvement among plans reporting in both 2010 and 2011, of which three are star rating system elements, including the intermediate outcome measure of cholesterol control among diabetics. In terms of the importance of some measures relative to others in judging plan quality, from the plans' perspective, measures that are included in the star ratings are important because they determine bonus payment amounts. Apart from the bonus issue, it is arguably the case that inclusion in the star rating system is an indication that a particular measure is important in that CMS exercises judgment in deciding which measures to include in the star rating system. For example, some measures are excluded from, or dropped from, the star rating system because they apply to a very small number of beneficiaries and are therefore of limited utility in evaluating quality over time and across plans.

As we have done in the past, we continue to examine HEDIS HMO results and PPO results separately. One reason for the separate evaluations is that, before the last two reporting cycles, HMOs reported on a different basis from other plan types for certain measures, the so-called hybrid measures. Such measures can be based exclusively or partially on documentation from a sample

**TABLE
12-4**

Plans show improvement between 2010 and 2011 on many measures, but HMOs and PPOs differ on hybrid measure results

	Weight for star rating, 2012 (if element of star ratings)	Which plan type(s) improved between 2010 and 2011^a	Average rate for all HMOs, 2011	Average rate for all local PPOs, 2011
HEDIS®: Hybrid measures that improved				
Intermediate outcome measures				
Blood pressure control among members with hypertension	3	HMOs	61.9	55.8
Blood pressure control among diabetics		HMOs; local PPOs	62.3	55.7
Cholesterol control among diabetics	3	Local PPOs	52.2	45.9
Blood glucose control among diabetics		Local PPOs	65.7	58.1
Other hybrid measures				
Recording of body mass index	1 ^b	HMOs; local PPOs	50.5	36.7
Colorectal cancer screening	1	HMOs	57.7	41.3 ^c
Monitoring nephropathy among diabetics	1	Local PPOs	89.2	87.3
HEDIS®: Nonhybrid measures that improved				
Treatment of chronic obstructive pulmonary disease (3 measures)	^d	HMOs (3 measures); local PPOs (2 measures)	34.0 66.6 78.3	36.4 70.2 76.0
Monitoring persistently used drugs (5 measures, including one total measure)	^e	HMOs (4 measures); local PPOs (1 measure)	90.7 93.1 90.9 68.2	90.9 92.7 91.3 69.5
			Total: 90.2	Total: 90.7
Glaucoma screening among older adults	1	HMOs	63.8	65.5
Persistence of beta blocker use after a heart attack		Local PPOs	83.1	83.6
Health Outcomes Survey measures that improved				
Advising patients on physical activity	1	HMOs	48.0	47.6
Managing the risk of falls	1	HMOs	60.5	55.1

Note: PPO (preferred provider organization), HEDIS® (Healthcare Effectiveness Data and Information Set). “Hybrid” measures are those that can include extraction of information from medical records or are exclusively based on medical record data. Nonhybrid measures are based exclusively on administrative records such as claims and encounter data. Each measure shown as improved had statistically significant improvement for the particular plan type between 2010 and 2011.

a. Includes only plans reporting in both years.

b. New for 2012.

c. Different reporting standard from HMOs.

d. One measure in stars in 2011, but none in 2012 stars.

e. Total measure in stars in 2011, but none in 2012 stars.

Source: MedPAC analysis of CMS HEDIS public use files.

of medical records, though for some hybrid measures HMOs could, at their option, report solely on the basis of administrative data, such as claims and encounter data. Until two years ago, non-HMO plans had to report hybrid measure results using only administrative records. Thus, for the 13 measures that are of this type—including all 6 intermediate outcome measures of HEDIS—HMOs and other plan types could not be directly compared.

Beginning in 2010, both HMOs and PPOs used the same reporting standards. Local PPOs did show improvement in many hybrid measures between 2010 and 2011. Some of the improvements likely reflect PPOs becoming better at using medical record information to report HEDIS results as of 2010, the first year PPOs were permitted to use medical record review to report results for these measures.

Although PPOs and other plan types can now use medical record information to report hybrid measures, there continue to be differences across plan types for the hybrid measures. Among the 45 HEDIS measures that we track, the cases with substantial differences in the 2011 HEDIS results between HMOs and local PPOs usually are measures that involve medical record review—as in the first five measures listed in Table 12-4. Other measures in Table 12-4 (p. 323) show that local PPO results are very similar to HMO results, and in some instances PPOs perform better than HMOs.

One possible reason for the HMO versus non-HMO differences to persist on hybrid measures, even into the second year of PPOs using medical record documentation for HEDIS reporting, is that HMO plans differ from non-HMO plans in their relationship with physicians who provide care to their members. Because members can use non-network providers in PPOs and PFFS plans, a plan may have difficulty gaining access to all of an individual's medical records to document information necessary for reporting hybrid HEDIS measures. Non-HMO plans may also have greater difficulty encouraging all physicians who see their members, particularly those who do not have contracts with plans, to undertake quality improvement activities, and improved documentation and coding, which could result in improved HEDIS results for the plan. At the same time, with local PPOs now showing improvement on many hybrid measures, PPOs appear to be overcoming problems they may have had in data collection and are becoming better at collecting and reporting HEDIS hybrid measures.

Table 12-4 (p. 323) indicates that HMOs reporting results in both 2010 and 2011 (same store results) showed statistically significant improvement on 14 of 45 HEDIS measures, compared with improvements on 9 measures in the preceding time period (using the same metric of plans reporting in each year of a 2-year period). The HEDIS measures showing statistically significant improvement include two measures of blood pressure control (for all hypertensives and among diabetics), rates of colorectal cancer screening and glaucoma screening, three measures of treatment of chronic obstructive pulmonary disease (COPD), four measures of the monitoring of persistently used drugs, and two measures collected through the HOS (providing advice on physical activity and managing the risk of falls). Another measure that improved is the recording of body mass index (BMI) in the medical record, which was a relatively new measure first reported publicly last year.

Local PPOs reporting in both 2010 and 2011 (same store results) showed statistically significant improvement on nine measures, several of which were among the HMO improved measures. These measures included two measures of COPD treatment, blood pressure control among diabetics, recording of BMI, and one measure of monitoring persistently used drugs. Local PPOs also improved on measures of cholesterol control and blood glucose control among diabetics, monitoring nephropathy among diabetics, and persistence of the use of beta blockers after a heart attack (which is, however, a measure reported by only 25 local PPOs in both 2010 and 2011).

While 14 of 45 measures improved for HMOs and 9 improved for PPOs, the remainder of the 45 HEDIS measures remained stable between 2010 and 2011 when compared on a “same store” basis. Measures that remain essentially unchanged include the intermediate outcome measures of cholesterol control among patients with cardiovascular conditions and a measure of blood glucose control among diabetics, the hybrid measures of eye exam rates for diabetics, cholesterol screening for diabetics and for members with cardiovascular conditions, and blood glucose testing among diabetics. Plans generally perform well on these measures, though the diabetic eye exam rate may be considered low at 65 percent for HMOs and 63 percent for local PPOs. Among other measures that remained stable, average breast cancer screening rates are at 69 percent among HMOs and 66 percent for local PPOs. There are six measures of the use of potentially harmful drugs or possible drug interactions. The rate of use of one potentially harmful drug among the elderly averages 22.1 percent among HMOs and 22.0 percent among local PPOs; the rate for the use of two such drugs is 5.1 percent for each plan category.

It is difficult to generalize about plan performance on certain HEDIS measures because of the small number of beneficiaries to whom the measures apply. CMS does not include such measures in the star rating system for bonus payments. For example, in the case of the measure on persistence of beta blockers after a heart attack, only 230 of 458 plans can report on this measure due to small numbers, compared with 457 of 458 reporting a rate for blood glucose monitoring among diabetics. Other measures of this nature are measures of follow-up care after an inpatient mental health stay, measures of antidepressant medication management, and measures of alcohol and drug abuse treatment. Recognizing the limitations on whether there can be generalizations about the results, the trend for these measures between 2008 and

**TABLE
12-5**

Most Health Outcomes Survey-based measures have had little change over time, and PPOs and newer HMOs often perform well on these measures

HEDIS® measures collected through the Health Outcomes Survey	HMOs reporting in each of 3 years			HMOs new in 2011	All PPOs, 2011
	2008	2010	2011		
Discussing urinary incontinence	57.7	57.0	58.1	62.9	58.6
Receiving urinary incontinence treatment	35.2	35.5	36.3	37.2	36.9
Discussing physical activity in older adults	51.2	51.7	53.2	52.9	54.3
Advising physical activity in older adults	46.0	46.7	48.2*	48.6	47.8
Discussing fall risk	29.2	29.8	31.2	40.9	31.6
Fall risk management	55.4	57.1	59.7*	67.2	55.9
Osteoporosis testing	65.9	70.4	71.9	62.3	73.9

Note: HOS (Health Outcomes Survey), PPO (preferred provider organization), HEDIS® (Healthcare Effectiveness Data and Information Set). "HMOs new in 2011" are HMOs reporting these measures in 2011 but not 2010. Numbers for each of the categories: HMOs reporting in each of 3 years (165 to 190 for each measure), HMOs new in 2011 (43 to 46), and all PPOs, 2011 (76 to 80). Rate is percent of applicable enrollees receiving the treatment (e.g., the percent of members age 65 or older reporting a urinary incontinence problem who discussed the issue with their caregiver).
*Indicates that for these plans the change in the measure between 2010 and 2011 was statistically significant (p < 0.05).

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

2011 shows declines for the alcohol and substance abuse measures and improvement for the inpatient mental health and the antidepressant medication management measures.

There are variations in performance across different categories of plans. Although newer HMOs (those with contracts begun in 2005 or later) tended to have lower HEDIS scores than older HMOs, for certain measures, including the measures of avoiding high-risk medications and drug interactions, newer HMOs had better scores. Newer HMOs also had better scores on the HEDIS measures collected through the HOS (Table 12-5), though there has been some improvement in the HOS-collected measures for HMOs reporting since 2008, with two measures showing statistically significant improvement among HMOs between 2010 and 2011 (advising older adults to engage in physical activity and managing the risk of falls).

The issue of access to medical records does not arise for the HEDIS measures that are collected directly from members through the two enrollee surveys, the HOS and CAHPS. Thus, while we see what are often large differences between HMOs and non-HMOs in hybrid HEDIS measures (Table 12-4, p. 323), for the HOS-collected measures, PPO results are similar to, and in two instances better than, HMO results (Table 12-5). For most of the seven HEDIS measures collected through the HOS,

PPO results are similar to HMO results. One characteristic of the HOS measures that may be problematic is that the HOS measures depend on beneficiary recall, and differences may exist among HMO and PPO beneficiary populations' relative cognitive abilities. (In part because of the reliance on beneficiary recall, CMS has withdrawn the osteoporosis testing measure from the star ratings, and the geriatric assessment measurement panel of the National Committee for Quality Assurance, which maintains the HEDIS measures, is exploring the development of an administrative measure to replace the measure collected through the self-reported responses of the HOS survey (Goldstein 2011).)

HOS overall health outcome results

As has been true over the past several years, HOS overall outcome results indicate that most plans have health outcomes within expected ranges that do not differ from the national average across plans (Table 12-6, p. 326). In last year's data, and in the two previous reporting cycles, there were no outlier plans on physical health changes. This year, 11 of 330 plans (3.3 percent) show improved physical health and 12 plans (3.6 percent) show declines in physical health outcomes. Most plans are within expected ranges on the mental and physical health outcome measures. For the 2007–2009 period, about 8 percent of plans were outliers by HOS standards, of which about 5 percent had worse than expected mental health outcomes.

**TABLE
12-6**

Medicare HOS performance measurement results show a small change in the most recent time period

Cohort	Years	Total number of plans reporting	Percent of plans with mental health outcomes:		Percent of plans with physical health outcomes:	
			Better than expected	Worse than expected	Better than expected	Worse than expected
Cohort 8	2005–2007	154	5.8%	2.6%	0%	0%
Cohort 9	2006–2008	187	1.1	5.3	0	0
Cohort 10	2007–2009	268	3.0	4.9	0	0
Cohort 11	2008–2010	330	3.3	3.9	3.3	3.6

Note: HOS (Health Outcomes Survey). Cohort is the group of beneficiaries surveyed and then resurveyed over the two-year time period shown.

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

In the 2008–2010 period, about 7 percent of plans were outliers in mental health outcomes, with slightly more than half of them showing worse than expected outcomes. In physical health, about 7 percent of plans were outliers, nearly evenly divided between those showing better and worse outcomes than expected.

Using the star rating system measures of improvement or decline in physical and mental health, we find that most outlier plans are relatively smaller. The average enrollment of all contracts having a star rating for the measures of health improvement or decline is about 66,000 compared with an average of about 16,000 among plans at either end of the star scale in this measure (i.e., outliers in improvement and outliers in declines). Three organizations are outliers that show declines in both mental and physical health, and three organizations appear in one category as improved and in the other as showing a decline—for example, showing improvement in mental health and declines in physical health.

Quality results for regional PPO and PFFS plans

In terms of number of reporting entities (without accounting for enrollment levels), very few regional PPOs and PFFS plans report HEDIS results, making it difficult to evaluate the performance of these types of plans or to determine how they compare with HMOs and local PPOs. In the 2011 HEDIS data, 17 PFFS plans and 13 regional PPOs reported results, compared with 314 HMOs and 114 local PPOs. Regional PPO averages are generally lower than local PPO average rates, but for 16 HEDIS measures regional PPO rates are within

3 percent of the local PPO average—including blood glucose and cholesterol testing measures, monitoring diabetic nephropathy, one of the COPD measures, and several measures in the monitoring of persistently used drugs and the avoidance of possibly harmful drugs and drug interactions. The greatest differences between regional and local PPO results were in 2 measures of blood glucose control for diabetics, colorectal cancer screening (a measure with a 10-year look-back period), 1 drug interaction measure, the use of spirometry testing in COPD assessment, and the measure of osteoporosis management in women with a fracture.

PFFS plans, which are not network plans and may have no contracted providers, have HEDIS rates that are generally lower than for local PPOs but have 10 measures (of the 45 measures we track) with rates similar to those for local PPOs—4 drug monitoring measures, breast cancer screening, osteoporosis management in women with a fracture, and 4 HEDIS measures among those with small numbers discussed above. The greatest differences between PFFS and local PPOs are in measures of blood pressure, blood glucose, or cholesterol control and in the recording of BMI.

Because of the small number of regional PPOs and PFFS plans, in order to evaluate improvement between 2010 and 2011, rather than comparing the averages of “same store” results between the two years for these plan types, we examined how individual plans performed on each of the 45 measures we track to determine how many plans improved, declined, or had results in which the 2010 and 2011 results did not show a statistically

**TABLE
12-7****HMOs and local PPOs had higher vaccination rates in 2011 than regional PPOs and PFFS**

Vaccination rates	HMO	Local PPO	Regional PPO	PFFS
Flu	69%	69%	66%*	64%*
Pneumonia	69	69	66*	65*

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

*Indicates rates where the difference is statistically significant: Flu rates for regional PPOs and PFFS differ from HMOs and PPOs; the regional PPO and PFFS pneumonia rates differ from those of HMOs and local PPOs but do not differ from each other.

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

significant difference. For regional PPO plans reporting in both 2010 and 2011, there were 4 measures (out of 45 tracked) in which the majority of plans showed improvement, including glaucoma screening, recording of BMI, colorectal cancer screening, and the total rate for monitoring of persistently used drugs (the total rate being a combination of several individual rates). Six of 12 regional PPOs declined in a measure of the use of high-risk medications in the elderly. For PFFS plans reporting in both 2010 and 2011, six of nine plans showed improved results for glaucoma screening, while the remaining three plans reporting this measure showed a decline in the rate. Four of seven plans showed improvement in the use of spirometry testing in the assessment and diagnosis of COPD. Three of nine PFFS plans declined in four drug monitoring measures and the blood glucose testing measure. On net, across the 38 HEDIS measures that can be assessed in this manner (out of 45 possible measures we track), regional PPOs and PFFS plans had little change in HEDIS results between 2010 and 2011.⁶

As for measures captured through the CAHPS-MA survey, we found that, similar to 2010 results, in 2011 regional PPO plans had a statistically significantly lower rate for flu vaccination (66 percent of enrollees) than HMOs and local PPOs (69 percent of enrollees), as did PFFS plans (64 percent of enrollees) (Table 12-7).

To the extent that we can evaluate their HOS performance, regional PPOs and PFFS plans performed relatively poorly in the HOS measures of improvement or decline in physical and mental health status. In the HOS-based star ratings for physical and mental health, 10 regional PPOs and 6 PFFS plans reported results. Four of the 10 regional PPOs were in the lowest quartile of scores for all plans. This number contrasts with 27 percent of local PPOs in the lowest quartile. Of the six PFFS plans reporting results,

half were in the lowest quartile of scores in the physical health measure and four of six were in the lowest quartile for mental health measures.

How do MA plans compare with FFS Medicare on quality measures?

Using the CAHPS surveys of MA enrollees and FFS beneficiaries to compare quality, we found little difference between MA and the FFS program in the surveys' results for vaccination rates and access to care measures (Table 12-8, p. 328). To compare the private plans and traditional program at a national level, we adjusted the CAHPS results to match the two programs' geographic areas. We used state-level FFS results to arrive at a national FFS rate. The FFS rates were adjusted to match the distribution across states of the MA plans in the CAHPS sample. After this adjustment, we found that vaccination rates were similar in MA and FFS, with slight improvement in both programs compared with last year's results. Last year, pneumonia vaccination rates were slightly better in MA, but for 2011 rates in the two sectors were very similar. Vaccination rates for both programs in 2011 were higher than they were in 2010, with a year-over-year difference that was statistically significant.

What variation in MA quality indicators exists among plans?

To summarize some of the differences across plans discussed above, we find that local PPO plans had results similar to HMO plans on many measures but had lower results on measures relying on extraction of information from medical records. We also find that regional PPOs and PFFS plans generally had poorer results than other plan types. In addition to these findings, we have examined differences in plans by population and plan type, as we have in the past (Medicare Payment Advisory Commission

**TABLE
12-8**

Overall, in 2011 MA plans and FFS continue to have similar CAHPS® results

CAHPS® measure	MA average		Adjusted FFS average	
	2010	2011	2010	2011
Vaccination rates				
Flu	66%	69%	66%	69%
Pneumonia	67	69	66	70
Access to care measures (<i>members reporting "usually or always"</i>)				
Easy to get an appointment with a specialist	90	92	91	92
Get care for an illness as soon as wanted	89	92	90	91
Get routine care appointment as soon as wanted	86	88	88	88

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.

2010b). As was the case in the preceding year, using CAHPS data, we find that flu vaccination rates were about 10 percent higher in 2011 for enrollees who have retiree coverage through their MA plan (employer-sponsored MA benefit packages). As was also true last year, there continue to be differences in the age distribution of enrollees across plan types, with regional PPOs having a greater share of enrollees under age 65 (19 percent as of December 2009) than other plan types (12 percent in HMOs). Although the HEDIS measures are not risk-adjusted and are not intended to be measures that should be risk-adjusted—that is, the measures should be valid across all age groups—the different age distribution may explain some of the results we see for regional PPOs.

Results for special needs plans

In this year’s report, we have attempted to examine the performance of SNPs in particular. Isolating results for SNPs as a separate category can be difficult because of the MA quality reporting mechanisms. A SNP is often a component of a larger entity consisting of SNP and non-SNP members. The larger entity reports aggregate HEDIS data across its entire membership—for example, the rate of breast cancer screening among all Medicare members—and we are unable to disaggregate such results solely for the SNP population. However, there are other direct and indirect ways to evaluate the performance of SNPs.

We can directly evaluate SNPs for the quality indicators collected through the CAHPS survey. The CAHPS data we

use are beneficiary-level data, and we can evaluate quality by assigning beneficiaries to their respective plan types (SNP or non-SNP and by type of SNP). Another source for direct evaluation of SNPs is the public reporting that CMS releases for a small subset of HEDIS measures that SNPs report, including SNPs that are part of larger entities that include non-SNP enrollment. Finally, as an indirect, or proxy, measure of SNP quality, we can compare organizations with a large proportion of SNP enrollees with organizations with few, or no, SNP enrollees.

Of the three types of SNPs—for dual-eligible enrollees, for chronically ill enrollees, and for enrollees in institutions—the flu and pneumonia vaccination rates among dual-eligible SNPs were the lowest among the three. The dual-eligible plans had flu vaccination rates of 64 percent (65 percent if Puerto Rico is excluded) while institutional and chronic care SNPs both had relatively higher flu vaccination rates of 73 percent. However, duals in MA SNPs have the same flu vaccination rates as duals in other MA plans, and their rates are about the same as the rate for duals in FFS Medicare.

SNPs separately report a set of 12 HEDIS measures to CMS so the results for such plans can be disaggregated from the results reported at the MA contract level (which may include SNPs and non-SNPs or multiple SNPs). SNPs also report certain measures that only SNPs are required to report: advance care planning (which includes advance directives, actionable medical orders, living wills,

a surrogate decision maker), functional status assessment, medication review, and pain screening—the last three of which are elements of the star rating system. CMS publishes results for some measures that SNPs report. For the SNP quality measures that CMS has posted to date (for three years, 2008–2010), we found that in general SNP performance was poorer than non-SNP performance, but there was wide variation across plans.

A proxy method of evaluating SNP quality is to examine the results at the MA contract level for plans that are primarily SNPs (defined as 75 percent or more of enrollment in SNP plans—which include 64 HMO contracts) versus those with little SNP enrollment (defined as 10 percent or less—which include 164 HMO contracts). Using this proxy method, we found that HMOs that are SNPs generally had lower HEDIS scores, except for the HOS measures on managing and discussing fall risks and managing urinary incontinence. SNPs point out that some of the HEDIS measures may not be the most appropriate measures for evaluating care rendered to individuals with multiple chronic conditions or other special needs. SNPs also suggest that the appropriate comparison is by population types within sectors—comparing, for example, HEDIS results for duals in SNPs with those of duals in non-SNP MA plans, though we do not have the person-level data to make such comparisons. We also note below that, although organizations with a higher proportion of SNP enrollment had lower star ratings in general, many organizations with a high proportion of SNP enrollment (or exclusively SNP enrollment) had relatively high star ratings.

Quality bonus program based on star ratings begins in 2012

Consistent with a recommendation that the Commission made for MA in 2004 (Medicare Payment Advisory Commission 2004) and consistent with the general direction of Medicare payment policy across FFS, the MA program now includes a system of bonus payments for high-performing plans.

Individual elements of the HEDIS, CAHPS, and HOS quality indicators are part of CMS's 5-star rating system for MA plans, as are certain contract administration factors. Each measure or factor is given a star rating, and scores on these elements are weighted (as described below) and averaged to arrive at an overall quality rating designated by 1 to 5 stars. Plans can receive a higher star rating after the averaging process, with an increase of 0.2 to 0.4 in the overall star rating, for high scores on the measures if they are consistently high across the range of measures.

The star ratings are made available to Medicare beneficiaries through the Plan Finder tool of the Medicare.gov website, and the ratings are the basis of MA quality bonus payments put in place as of 2012 by PPACA. New star ratings were posted for the open enrollment period of November–December 2011 for enrollments effective in 2012. However, because bonus payments determine the level of MA benchmarks for each plan, and because bids are due each April for the following contract year, the bids plans submitted in June of 2011 for the 2012 contract year had bonus amounts determined under the 2011 star ratings that were announced in the fall of 2010. Although 2012 bonus payments are based on the earlier 2011 star ratings (in which 3 plans had a 5-star rating), the provision that allows 5-star plans to enroll beneficiaries outside the annual open enrollment period is based on the most current star ratings—the 2012 ratings, in which 9 plans have a 5-star rating. For organizations with drug plans (MA–Prescription Drug plans), the bonus payments are based on the overall star rating, which includes both Part C (MA) measures and Part D measures.

In a 2011 report and in a comment letter to CMS, the Commission expressed concerns about the methodology of the CMS star rating system and concerns about a demonstration project that awards quality bonuses to a large majority of plans rather than the limited number of plans that would be eligible for such bonuses under the statute (Medicare Payment Advisory Commission 2011b, Medicare Payment Advisory Commission 2011c). In making additional program expenditures, limited Medicare dollars should go to truly high-performing plans, and beneficiaries should have a clear signal of quality differences among plans when making a decision at the point of enrollment. 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” (Medicare Payment Advisory Commission 2011c).

**TABLE
12-9**

The new star system gives greater weight to outcome measures

Category	2011		2012	
	Number of measures (equally weighted)	As percent of all measures	Total points assigned (measures given differing weights)	As percent of all measures by weights
I. Contract performance on Part C and Part D measures	17	33%	18.5	23%
II. CAHPS® patient experience measures and disenrollment rates (the latter for 2012 only)	9	18	12	15
III. Part C and Part D clinical quality measures	25	49	49	62
a. Outcome measures	7	28	31	63
b. Process measures	18	72	18	37

Note: CAHPS® (Consumer Assessment of Healthcare Providers and Systems).

Source: MedPAC analysis of CMS star rating documentation.

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). Under the statute, only plans with 4 stars or more (maximum of 5 stars) can receive a bonus. In contrast, CMS’s demonstration extends bonuses to plans at 3 stars or above, meaning that 80 percent of current enrollees are in plans that will receive bonuses, and plan projections show that 93 percent of enrollees will be in bonus plans this year—compared with a projected 25 percent of enrollees who will be in plans with 4 or more stars. The result is an additional cost to the Medicare program, which, on the basis of plan bids, we project to be \$2.8 billion for 2012 (in bonus payments beyond those called for in the statute, which would otherwise have totaled \$200 million in 2012).

With regard to the star rating methodology, CMS has addressed many of the Commission’s concerns by changing the system’s methodology for the 2012 ratings. The 2012 ratings were available for beneficiaries to use in the 2012 open enrollment period that occurred from October to November 2011. The 2012 ratings will be the basis for bonus payments in 2013. In its comment letter, the Commission noted that under the CMS demonstration, a bonus would be available to plans that CMS specifically identified as low-performing plans (indicated by an “icon” at the medicare.gov website that advised prospective

enrollees that the plan had a record of poor performance and beneficiaries should carefully weigh their decision to enroll in such a plan). CMS modified the standards for bonus payments so that any plan under sanctions automatically receives a 2.5-star rating, making the plan ineligible for bonus payments.

Another issue of concern was that the star rating system placed too much emphasis on contract performance (such as call center response time) rather than on measures of clinical quality and patient experience. In response, CMS has incorporated more outcome measures into the star rating system. For 2012, CMS is using a HEDIS measure for the first time that reports an all-cause hospital readmission rate for beneficiaries age 65 or older. Because it is a first-year measure, CMS assigns the measure a weight of 1, lower than other outcome measures, which are weighted at 3.⁷ In addition to adding more outcome measures, CMS has given greater weight to outcome and patient experience measures (Table 12-9). For example, the HOS measures of improvement or decline in physical and mental health have a weight of 3 points, CAHPS patient experience measures have a weight of 1.5 points, and HEDIS process measures have a weight of 1 point. These changes result in clinical quality measures constituting 62 percent of the weight of the measures in 2012 compared with 49 percent in 2011 and outcome measures constituting nearly two-thirds of the clinical quality measures compared with 28 percent in 2011.

In recommending pay-for-performance or quality bonus programs, the Commission has emphasized rewarding high levels of performance as well as improvement over time (Medicare Payment Advisory Commission 2004). Given that the star rating system incorporates elements from all three of the sources of quality indicators described above, it may appear that the star rating system can be used to answer the question of whether quality indicators have improved in MA from one year to another. However, the new weighting system, which is a major change in the star rating methodology, limits what can be concluded from year-over-year comparisons between 2010 and 2011. In addition, even when there is not a major change in the methodology for assigning stars, the following factors can produce changes from one year to another that limit the utility of the star ratings as a means of comparing overall MA quality from one year to another:

- CMS can change the measures to include for star rating purposes (e.g., by dropping some HEDIS measures and adding others, as illustrated in Table 12-4, p. 323).
- The cut points for stars given to individual measures can change based on the distribution of plan results (e.g., for the HEDIS breast cancer screening measure, the 5-star threshold was a rate of 82 percent or higher in 2011, while in 2012 the 5-star threshold is a lower rate, 80 percent).
- Because a plan can still obtain a star rating without reporting all measures (they can report as few as 51 percent of the measures), a change in a plan's star rating may be solely a consequence of the plan's performance on previously unreported measures.

CMS is examining ways to include improvement over time as a component of the star rating system, as indicated in the Agency's recent letter requesting comments on possible changes to the star rating system for the 2013 ratings (Centers for Medicare & Medicaid Services 2011).

Table 12-10 (p. 332) shows the star distribution of enrollment in November 2011 by plan type, using the 2011 star ratings and the 2012 star ratings. Even though the rating methodology changed between 2011 and 2012, the majority of plans' star ratings remained the same. When there were changes, most were half-star changes in one direction or the other (up or down in the overall star rating). Of the 383 plans rated in both years, the ratings of 10 contracts improved by 1 star; 4 contracts declined by 1 star; 1 contract declined by 1.5 stars; ratings for 73

contracts declined by 0.5 star; 87 contracts improved by 0.5 star; and ratings for 208 contracts were unchanged. In 2011, 3 plans had 5-star ratings, and in the 2012 star ratings, 9 plans have 5-star ratings.

Under the 2012 star ratings, more enrollees are in higher rated plans, which tend to be HMO plans. In both 2011 and 2012, only HMOs have 5-star ratings. This result is in part due to the lower level of performance of non-HMO plans on the intermediate outcome measures that are hybrid measures (as illustrated in Table 12-4, p. 323, and the discussion of that table). In the Part C star measures, there are 3 HEDIS intermediate outcome measures, with a total weight of 9. All HEDIS star measures, other than those from CAHPS or the HOS, have a total weight of 21.5 (out of an all-measure total of 52 Part C measures, on a weighted basis). The 3 HEDIS intermediate outcome measures are therefore 17 percent of all Part C weighted measures (9 of 52), and 42 percent of the HEDIS measures that contribute to star ratings (9 of 21.5) that are not from CAHPS or the HOS.

In both sets of star ratings in 2011 and 2012, local PPOs and HMOs are the highest rated plans, but in the 2011 ratings the proportion of PPO enrollees in plans with 4 or more stars, at 24 percent, was close to the HMO level of 29 percent. In the 2012 ratings, 36 percent of HMO enrollees are in plans with 4 or more stars, but only 14 percent of local PPO enrollees are in plans with 4 or more stars. This difference does not reflect a decline in the performance of local PPOs compared with HMOs, but instead it shows how the use of weighting, and the decisions on what measures to include in the star ratings, created a different distribution of higher rated plans across the different plan categories. The changes also affected regional PPOs and PFFS plans. In the 2012 ratings, enrollment in regional PPOs is almost entirely in 3-star plans, while in 2011 about half of the regional PPO enrollment was in 2.5-star plans. The PFFS distribution in the 2012 ratings is similar to what it was in 2011 (Table 12-10, p. 332).

We have also examined the star ratings by plan type and geography. Plans with higher SNP enrollment tend to have lower ratings in general, but many SNPs—those in Minnesota, Massachusetts, and Wisconsin—have relatively high star ratings. Older plans tend to have higher star ratings, and plans with a greater proportion of employer group enrollment tend to have higher star ratings. In the 2012 ratings, the average star rating for urban plans (with 50 percent or more urban enrollment)

**TABLE
12-10**

As of November 2011, almost a quarter of enrollees are in plans rated at 4 stars or higher, using the 2011 star ratings, with a higher proportion in such plans under the 2012 star ratings

Percentage distribution of enrollment

Number of stars	All	HMO	Local PPO	Regional PPO	PFFS
2011					
5.0	1%	1%	—	—	—
4.5	14	19	8%	—	—
4.0	8	9	16	—	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	—	—	—
Not rated	13	7	8	1	49
2012					
5.0	9%	14%	—	—	—
4.5	10	10	7%	—	—
4.0	9	12	7	—	—
3.5	32	34	50	2%	1%
3.0	27	19	26	92	34
2.5	9	10	7	3	12
2.0	0.3	0.3	0.1	—	—
Not rated	5	1	3	2	54

Note: PPO (preferred provider organization), PFFS (private fee-for-service). Enrollment includes cost-reimbursed plans that are not eligible for bonus payments but are given star ratings. “—” indicates no plans receiving the star rating displayed. Within the PFFS category for 2012, the 54 percent figure for “not rated” plans consists exclusively of plans that were too new to be rated.

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

was 3.34; the average star rating for nonurban plans (drawing the majority of their enrollment from areas not within a metropolitan statistical area) was higher, at 3.56. These results suggest that, despite concerns about the ability to form provider networks in rural areas, plans operating in these areas can perform at high levels. Similarly, SNPs can also perform at high levels, as indicated by the high star ratings among several such plans.

PPACA reduces rebate levels, which vary by star ratings

In 2014, 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 for

the lowest rated plans. In 2012, rebate levels will range from 63 percent to 72 percent of the bid-to-benchmark difference. The dollar distribution of rebates in 2012 is similar to that for 2011 (Table 12-11).

Concerns with the star ratings

One of our concerns with the current star rating system is the reporting unit to which the ratings apply. The geographic area to which a single rating applies may be extensive and may encompass many kinds of health care markets and provider networks. This situation is of special concern for PFFS plans spread over wide geographic areas, which are diminishing in number, but also for regional PPO plans, which cover wide geographic areas and have had significant growth in enrollment. We have pointed out that other plan types operating in large states—such as California, Texas, and Florida—with clearly defined,

differing market areas, also present a problem in assigning stars if the contract covers the entire state.⁸ In addition, the problem of a wide contract area extends to local plans (local PPOs and HMOs) in that HEDIS data and other quality data are reported at the contract level for an organization, but the geographic service area included within a local HMO or PPO contract may be extensive and can include multiple noncontiguous areas. For example, Humana’s Miami-based HMO contract, contract number H1036, operates in 22 counties in Florida but also includes in its authorized services three counties in Oregon (in the Portland area) and counties in North Carolina and Mississippi.⁹ Given that 97 percent of the organization’s enrollment is in Florida, the Humana star rating of 3.5 (2012 rating) may not be an accurate indicator of the performance of the Oregon plan or a fair comparison under CAHPS measures between the Oregon MA plan and FFS results in that area. Similarly, a UnitedHealthcare local PPO based in Indiana is offered in 19 counties in Indiana, but 83 percent of the enrollment under this contract is outside Indiana in counties where the PPO is authorized to enroll only employer group enrollees. The plan has enrollees in 48 other states, with the greatest proportion in Georgia (52 percent of non-Indiana enrollees). We suggest that CMS more closely examine the configuration of some

**TABLE
12-11**

**Rebate values by plan type
remain at about the same
level in 2012 as in 2011**

Plan type	2011	2012
HMOs	\$96	\$96
Local PPOs	35	34
Regional PPOs	41	42
PFFS	31	29
All	76	79

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

Source: MedPAC analysis of plan bids to CMS, 2011.

local contracts to determine whether the reporting units should be modified. We recognize that in many cases a problem of small numbers arises and a particular area cannot be evaluated. If there is a small numbers issue, there are alternative ways to evaluate quality (Medicare Payment Advisory Commission 2010b). ■

Endnotes

- 1 Cost plans are technically not MA plans. They do not submit bids but are paid their reasonable costs under provisions of section 1876 of the Social Security Act.
- 2 HEDIS® is a registered trademark of the National Committee for Quality Assurance.
- 3 CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.
- 4 We are aware of work that has been done comparing MA and FFS quality using other sources of data, including, for example, Brennan and Shepard (2010) and Cohen et al. (2012), and we are examining those studies.
- 5 In this chapter, we examine year-over-year changes in measures. Information on results for earlier years and trends over time for selected measures can be found in the Commission's June 2011 and June 2010 data books (Medicare Payment Advisory Commission 2010a, Medicare Payment Advisory Commission 2011a). Often, when a measure is introduced the results improve in the early years of the measure and plateau after a certain point—with some measures being withdrawn as not amenable to further improvement. For example, the recording of body mass index, a measure first publicly reported in 2010, increased from an average rate of 38.4 percent in 2010 to 51.7 percent in 2011 among HMOs reporting in both years.
- 6 As noted, this analysis was based on looking at the results for individual HEDIS measures by individual plan, among PFFS and regional PPO plans, and comparing the confidence intervals shown for 2010 results with those of 2011 results by plan and by measure.
- 7 CMS is using the HEDIS readmission measure for star rating purposes even though National Committee for Quality Assurance does not publicly report a new measure in the first year of use of the measure. We did note some anomalies in the readmission measures, which we have discussed with CMS, including whether there should be a minimum threshold of admissions for the readmission measure to be used (e.g., one plan with 5 stars had no admissions and therefore no readmissions). CMS reported that the intent was to have a minimum of 10 admissions before a star rating would be assigned. There also appear to have been issues with readmission rates for the under-65 population, but CMS has not included the under-65 readmission rates in the public release of HEDIS data, and they are not a component of the star rating system.
- 8 Kaiser of California reports separate results for Northern and Southern California for many quality measures. However, the star rating is assigned to the single Kaiser contract, H0524, and the individual Northern and Southern California measure rates are averaged to determine the measure rate for purposes of assigning stars to H0524.
- 9 In the early years of the Medicare HMO contracting program, it would not have been possible for a contract number to have a geographic configuration like that of the Florida organization. Contract numbers essentially represented rating areas for commercial rating purposes. If an HMO operated in a metropolitan area such as Washington, DC, for example, and the Washington premium structure differed from that of contiguous Northern Virginia counties, the entity would have had a regional component in Northern Virginia with different premiums. On contracting for Medicare enrollees, such an entity would have had two H numbers because the two areas were distinct rating areas, and the Medicare pricing and benefit package were determined through a comparison with the contractor's commercial rate structure. As various Medicare HMO contracting requirements were reduced or eliminated over time—such as the requirement that the Medicare area match the commercial area and the requirement that at least half of an organization's enrollment had to be non-Medicare/Medicaid enrollees—the connection between the H number and the service area and rating areas was lost. CMS subsequently encouraged the consolidation of H numbers within a state, as in the case of Kaiser, which previously had separate H numbers for Northern and Southern California.

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