STATEMENT OF

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ON

MEDICARE ADVANTAGE QUALITY BONUS DEMONSTRATION

BEFORE THE

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Testimony of Jonathan Blum, Acting Principal Deputy Administrator and Director, Center for Medicare, Centers for Medicare & Medicaid Services on the Medicare Advantage Quality Bonus Payment Demonstration

House Committee on Oversight and Government Reform

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Chairman Issa, Ranking Member Cummings, and the Members of the Committee, thank you for your interest regarding the Centers for Medicare & Medicaid Services' (CMS) efforts to strengthen quality for about 13 million Medicare Advantage (MA) enrollees through the Medicare Advantage Quality Bonus Payment (MA-QBP) demonstration.

Background

Under the MA program (also known as Medicare Part C), Medicare beneficiaries have the option of enrolling in a private health plan to receive medical care. Beneficiaries can also enroll in a Medicare Advantage Prescription Drug (MA-PD) plan to receive prescription drug benefits. CMS pays private organizations contracting under the program (MA organizations) a capitated monthly payment to provide all Part A and Part B services[1], and also Part D services[2] for the MA-PD plans. Today the MA program provides health insurance to about 13 million beneficiaries through private insurance health plans and enrollment continues to grow despite recent payment reductions mandated by the Affordable Care Act. Each per-person payment is based on a bid amount validated by CMS that reflects the plan's estimate of average costs to provide benefit coverage to enrollees, subject to an upper-payment limit (or benchmark). CMS risk-adjusts these payments to take into account the cost associated with treating individual beneficiaries based on health status.

Nearly 100 percent of Medicare beneficiaries enjoy access to a MA plan. Today, on average, there are 26 MA plans to choose from in each county. Since 2010 when the Affordable Care Act

[1] In general, Medicare Part A covers inpatient care in hospitals, inpatient care in a skilled nursing facility, hospice care services, home health care services, and inpatient care in a religious nonmedical health care institution. In general, Medicare Part B covers medically-necessary services such as doctors' services, outpatient care, durable medical equipment, home health services, and some preventive services.

[2] Medicare Part D is Medicare prescription drug coverage.

was passed, MA premiums on average have fallen 16 percent and enrollment has climbed by 17 percent to over 12.8 million beneficiaries in plan year 2012. We expect this enrollment growth to continue in 2013.

CMS is committed to making MA quality, performance, and other data widely available so beneficiaries can choose a plan that best meets their individual health care needs. Since 1997, organizations contracting under Part C have been required to collect and report the majority of the data that feed into the current Medicare Plan Rating system, and CMS has posted these data for beneficiaries and the public since 1999 as part of the earlier version of the Medicare Plan Finder Tool on www.medicare.gov.

CMS began to aggregate the measures into Plan Ratings for Part D and for MA in 2007 and 2008, respectively, with the majority of these measures remaining consistent over time[3]. CMS created the Medicare Plan Ratings to quantify the quality and performance of plans offering the MA and Medicare Prescription Drug (PDP) Benefits. The Plan Ratings are scored using a 5-star system, with 5 stars being the highest rating. In addition, thresholds for the majority of the measures were established in 2010 and have remained consistent since then[4], which ensures that plans are aware of the level of performance they must achieve to be rewarded with a high rating. The Medicare Plan Finder tool is intended to increase public confidence in choosing a plan by combining cost and coverage information with quality and performance information.

In 2012, MA plans were rated on how well they performed in five specific domains:

- Staying Healthy: Screenings, Tests and Vaccines (12 measures);
- Managing Chronic (Long-term) Conditions (13 measures);
- Ratings of Plan Responsiveness and Care (5 measures);

[3] For Part C, 30 of the 36 measures have been consistent or the same across the past three years (2010, 2011 and 2012 Plan Ratings). For 2010, there were 32 measures, 37 in 2011, and 36 in 2012. For Part D, 13 measures have been consistent across the past three years in the areas measured (2010-2012 Plan Ratings). For 2010 and 2011 Ratings, there were 19 Part D measures; for 2012, there were 17 measures.

[4] Of the 36 Part C measures, 28 had a pre-determined 4 star threshold for the 2012 Plan Ratings with 96 percent of them being consistent from the prior year. Of the 17 Part D measures, 9 had a pre-determined 3 or 4 star threshold for the 2012 Plan Ratings with 44 percent of them being the same from the prior year.

- Member Complaints, Problems Getting Services, and Choosing to Leave the Plan (3 measures); and
- Health Plan Customer Service (3 measures).

Star Ratings for MA plans that offer Part D benefits also include measures in four additional categories:

- Drug Plan Customer Service (5 measures);
- Member Complaints, Problems Getting Services, and Choosing to Leave the Plan (3 measures);
- Member Experience with Drug Plan (3 measures); and
- Drug Pricing and Patient Safety (6 measures).

The current Star Rating system for MA represents the best snapshot CMS has of the current quality of these plans. All clinical quality and patient experience measures used in the ratings have been developed, tested, and endorsed by multi-stakeholder organizations such as the National Quality Forum (NQF), National Committee for Quality Assurance (NCQA) and Pharmacy Quality Alliance (PQA), which incorporate substantive input from relevant stakeholders in these processes, including MA plans.

As described earlier, while Star Ratings have been available and in use since 2007, the Affordable Care Act expanded the use of Star Ratings, linking the ratings with payment, and requiring CMS to award bonus payments to MA plans with at least 4 stars beginning in 2012. Additionally, under these new Affordable Care Act provisions, qualifying plans (those with 4 or more stars) in qualifying counties (generally counties with low fee-for-service costs and MA penetration rates exceeding 25 percent) are eligible for double bonus payments. It is important to note that these bonus payments allow plans to invest in quality improvement. Organizations receiving bonuses can take the availability of these new resources into account in submitting their bids for Medicare Part A and B benefits, while still having a margin available to provide additional benefits to enrollees based on the difference between their bid and the higher benchmark amount produced by the bonuses.

Star Ratings and their Correlation to Enrollment Levels

While CMS has been stressing the many benefits for beneficiaries in choosing higher-quality health care, there are also early indications that better MA plan quality has a relationship to increased beneficiary enrollment for participating plans. According to CMS calculations of 2011 enrollment data, the Medicare Advantage Star Ratings Program demonstrated a strong association between improved Star Ratings and increased beneficiary enrollment in MA plans with higher ratings.

After controlling for beneficiary sociodemographic, clinical, and MA plan characteristics, CMS' analysis of internal data from 2011 has found that every "one star" increase in a plan's rating was associated with a more than 9 percentage point increase in enrollment for beneficiaries first enrolling in a MA plan. In 2011, among beneficiaries switching from one MA plan to another, the impact of a plan that had a "one star" increase in their rating was associated with a more than 4 percentage point increase in enrollment. These changes in enrollment show the impact that increased transparency and more information about plan quality has on beneficiaries' decisions to enroll and choose an MA plan. These results build on previous research demonstrating that patients consider quality information when choosing health plans[5,6], including MA plans[7]. Clearly, incentivizing plans to improve their quality with public reporting is a key driver to increasing enrollment in high quality MA plans.

The MA Quality Bonus Payment Demonstration

Building on the quality bonus payment provisions in the Affordable Care Act, CMS developed a Quality Bonus Payment (QBP) demonstration to further test whether stronger financial incentives and investments in quality plans will lead to more rapid increases in quality among MA plans. While the Affordable Care Act methodology provided for a new bonus payment to be awarded if a MA plan rating improved from 3 stars to 4 stars in 2012 and thereafter, under the current nationwide demonstration, there are financial incentives for MA plans to improve from 2

[5]Kolstad JT, Chernew ME. Quality and consumer decision making in the market for health insurance and health care services. *Medical Care Research and Revie*w. 2009;66(1 suppl):28S-52S.
[6] Faber M, Bosch M, Wollersheim H, Leatherman S, Grol R. Public reporting in health care: How do consumers use quality-of-care information?: A systematic revie*w. Med Car*e. 2009;47(1):1-8.
[7] Dafny L, Dranove D. Do report cards tell consumers anything they don't already know? The case of Medicare HMO*s. Rand J Eco*n. 2008;39(3):790-821.

to 3 stars, from 3 to 4 stars, and from 4 to 5 stars. With respect to the early years of the demonstration, this approach provides investments in plans that have quality ratings across a broader spectrum, as they have proven their ability to use resources effectively, and could be expected to improve quality more effectively. These incentives encourage, and the investments enable, quality improvement for a larger number of plans, positively affecting a larger number of beneficiaries. This demonstration is based on the premise that improved quality results in improved health outcomes, and thus savings over time from more effective and efficient delivery of needed health care. CMS fully supports this initiative and is committed to seeing the demonstration through its three-year duration. Without the demonstration, more than 262 plans serving the majority of MA enrollees would not have an immediate investment to maintain or improve the quality of care delivered to MA enrollees. In addition to providing resources for improved quality, the expanded bonuses provide incentives for still further improvement for plans with Star Ratings below 5 stars.

The QBP demonstration was created through a transparent and open process, providing stakeholders the opportunity to submit comments:

- On November 10, 2010, CMS released a proposed rule (CMS-4144-P) announcing a three-year MA-QBP demonstration program that would determine how quality bonus payments were made to MA organizations. Supplemental materials specified that MA organizations would receive such bonus payments on a sliding scale based on their quality Star Ratings, with the magnitude of the reward provided increasing with plan quality. The public had the opportunity to submit comments on this proposed rule.
- On February 18, 2011, CMS solicited comments on how to enhance the MA-QBP demonstration by publishing the Advance Notice of Methodological Changes for Calendar Year 2012 for MA Capitation Rates. In that advanced notice, CMS described in detail the payment methodology under which health plans would be eligible for QBPs based on the quality of care they provide to beneficiaries.
- On April 4, 2011, after receiving, reviewing, and responding to comments from the public and many stakeholders, CMS finalized its payment policies, including the methodology for applying QBPs, in the Announcement of Calendar Year 2012 MA Capitation Rates and MA and Part D Payment Policies.

The MA-QBP demonstration went into effect on January 1, 2012 and will terminate on December 31, 2014. When the 3-year demonstration is over, bonuses will be calculated according to the Affordable Care Act quality bonus structure. If under the MA-QBP demonstration, 3-star plans improve their quality scores and in turn their star ratings, then movement from 3 to 4 stars will provide a natural transition from the demonstration's bonus structure to the Affordable Care Act quality bonus structure in 2015.

Given the significant enrollment growth of the MA program in recent years, it is critical that we test concepts that encourage improved quality of care for Medicare beneficiaries who choose to enroll in MA plans. The MA-QBP demonstration supports improving the delivery of health care services, patient health outcomes, and population health. The demonstration reflects three principles: 1) all MA organizations would benefit from an improvement to their star rating, and should therefore have incentives to improve quality, so that they can provide better care at lower costs to Medicare beneficiaries; 2) MA organizations should be rewarded in increasing amounts for higher-quality performance along the continuum of fully achieving high quality care; and 3) MA organizations that are already at the 3-star level and above should have additional investments and incentives to invest heavily in activities to improve their quality even further.

The MA-QBP demonstration uses alternative payment methodologies to incentivize and invest in MA plans to pursue quality improvement through the Medicare Advantage Star Ratings program. The demonstration is testing whether providing payment incentives for higher quality and front-end investments result in greater savings from high-quality care over time. At the conclusion of the demonstration, the evaluation will determine whether quality improved because of the demonstration, in which domains improvement occurred, how improvement was accomplished, and how demonstration results might be replicated in the future.

CMS is committed to a thorough evaluation of the demonstration to inform future policy decisions. CMS' evaluation contractor will estimate the impact of the demonstration over and above the Affordable Care Act methodology by assessing year-to-year progress in plan ratings

among plans with different baseline ratings, which will provide evidence of the impact of additional incentives attributable to the demonstration.

For example, under the Affordable Care Act's structure, 5 star plans will receive the same quality bonus incentive payments as 4 star plans, but under the temporary demonstration in effect for 2012, 2013, and 2014, higher performing plans will receive a higher bonus. A significant shift of plans from 4 to 5 stars would suggest high-quality plans are motivated to improve further under the demonstration, thereby providing higher quality outcomes to beneficiaries and greater value to the Medicare program.

As a national demonstration, the sliding scale of quality bonus payments is available to all qualifying MA plans. As a result, all MA beneficiaries stand to benefit as plans strive to increase the quality of care that they provide. In addition, as part of the evaluation and analysis of this demonstration, CMS intends to determine the demonstration's impact on quality improvement by comparing MA plans' performance with that of non-MA plans—specifically, managed care plans contracting with Medicare under section 1876 of the Social Security Act cost contracts, Medicaid plans, and commercial plans. Plans contracting with Medicare under section 1876 receive payments based on costs rather than risk-based capitation, and will not participate in the MA-QBP demonstration. However, the Healthcare Effectiveness and Data Information Set (HEDIS), the Consumer Assessment of Healthcare Providers and Systems (CAHPS), and the Health Outcomes Survey (HOS) are reported under section 1876 cost contracts, and plan ratings are generated. In order to achieve a valid comparison, cost contract plans will be compared to a subset of MA plans matched on enrollment, geographic location, and profit status/ownership type. The second comparison group consists of plans participating in commercial and Medicaid CAHPS and HEDIS programs. Payments under commercial insurance and Medicaid contracts will not be affected by the demonstration and trends in quality derived from these data sources can be compared to trends in quality reported by MA plans.

The design of the demonstration is consistent with the overall goal of improving quality in the MA program and is expected to improve the delivery of health care services and patient health outcomes. The hypothesis of the demonstration is that it will result in increased efficiency and

economy of care in MA compared to the current law bonus structure, which will lead to increased savings over time.

Addressing Concerns about the Legal Authority of the MA-QBP Demonstration

Section 402 of the Social Security Amendments of 1967, 42 U.S.C. 1395b-1, is the authority for this Medicare payment demonstration. Subsection 1395b-1(a)(1)(A) authorizes HHS to develop and engage in "experiments and demonstration projects" to determine whether changes in methods of payment or reimbursement would increase the "efficiency and economy of (Medicare) health services…through the creation of additional incentives…without adversely affecting the quality of such services."

CMS has a long history of using section 402 authority during the last 40 years. Section 402 demonstration programs at CMS are designed, implemented, and overseen by the Center for Medicare and Medicaid Innovation (and its predecessor the Office of Research, Demonstrations, and Information) and the Center for Medicare. Demonstrations initially conducted under authority in section 402 were the foundation for many significant payment reforms in the Medicare program, including the original Medicare HMO risk-contracting program enacted in 1982 that formed the basis for Medicare Part C, the Inpatient Hospital Prospective Payment System (PPS), Skilled Nursing Facility PPS, Home Health PPS, Durable Medical Equipment Competitive Bidding, Medicare HMOs, Social HMOs, Medicare Preferred Provider Organizations (PPOs), and the Program of All-Inclusive Care for the Elderly (PACE), as well as the hospice benefit.

Below are more detailed examples of recent demonstrations that were national in scope and not budget neutral, which were conducted under section 402 authority:

- In 2007, CMS implemented the two-year demonstration, "Demonstration to Limit Annual Change in Part D Premiums," which affected the premiums for all Part D beneficiaries in all Part D plans. Under this demonstration, CMS delayed the implementation of a statutory calculation used to determine beneficiary premiums and Federal direct subsidy payments. Specifically, the demonstration allowed for a multi-year transition to a

weighting methodology required by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) that otherwise would have significantly increased Part D beneficiary premiums in 2007. The total cost of this demonstration was $830 million due to the increased Federal direct subsidy payments made in 2007 and 2008.

- Also in 2007, CMS implemented the "Demonstration to Transition Enrollment of Low-Income Subsidy (LIS) Beneficiaries." This nationwide demonstration delayed the implementation of a statutory calculation of regional premium subsidy amounts for low-income beneficiaries. The methodology required by the MMA would have significantly reduced the regional LIS premium benchmarks in 2007 and thus, the number of prescription drug plans with fully-subsidized beneficiary premiums. By increasing the regional LIS benchmarks in 2007 and 2008, this demonstration significantly reduced the number of LIS beneficiaries who were reassigned to a different Part D plan because their plan's premiums exceeded the low-income premium subsidy amount. The total cost of this demonstration was approximately $540 million due to the increased low-income premium subsidy amounts provided by the federal government.

CMS believes that the MA-QBP demonstration is consistent with the precedent established by the above demonstration projects, and disagrees with the Government Accountability Office's (GAO) recent letter suggesting that that there are questions regarding our legal authority for implementing the demonstration[8]. Specifically, CMS does not agree with GAO's conclusion that there are questions about whether this demonstration will allow the agency to determine whether changes in MA-QBP provide for more efficient and economical care without adversely effecting quality. While bonus payments in early years are providing resources for MA plans that have already proven to be of higher quality, as the Star Ratings are based on data collected before the demonstration was announced, the availability of these resources provide a new incentive for MA organizations offering such quality plans to take even further measures to improve quality, and in future years, potential new financial rewards for doing so.

[8] GAO B-323170, *Medicare Advantage Quality Bonus Payment Demonstration*. July 11, 2012. http://www.gao.gov/products/B-323170

Based on the plans CMS has in place to measure the success of the demonstration discussed above, CMS also disagrees with GAO that there are questions about our ability to measure the effectiveness of the demonstration.

For all these reasons, CMS stands by this demonstration as a key opportunity for all MA organizations to continually improve their plans' quality by using a market-based incentive system, while also being rewarded for that effort. Given the recent and dramatic growth in the number of beneficiaries choosing to enroll in the MA program, we believe it is imperative to test ways to encourage quality improvement through incentives and investments to best serve beneficiaries enrolling in Medicare private plans.

Conclusion

Thank you for your interest in the MA-QBP demonstration. I look forward to working together with you to maintain a strong MA program, where we ensure that MA plans are paid accurately and appropriately, and where our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices.

Jonathan Blum, Acting Principal Deputy Administrator and Director of the Center for Medicare at the Centers for Medicare and Medicaid Services (CMS), is responsible for overseeing the regulation and payment of Medicare fee-for service providers, privately-administered Medicare health plans, and the Medicare prescription drug program. The benefits pay for health care for approximately 45 million elderly and disabled Americans, with an annual budget in the hundreds of billions of dollars.

Over the course of his career, Jonathan has become an expert in the gamut of CMS programs. He served as an advisor to Senate Finance Committee members and its current chairman, Sen. Max Baucus, where he worked on prescription drug and Medicare Advantage policies during the development of the Medicare Modernization Act. He focused on Medicare as a program analyst at the White House Office of Management and Budget. Prior to joining CMS, Jonathan was a Vice President at Avalere Health, overseeing its Medicaid and Long-Term Care Practice.

Most recently, Jonathan served as a health policy advisor to the Obama-Biden Transition Team. He holds a Master's degree from the Kennedy School of Government and a BA from the University of Pennsylvania.