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United States Government Accountability Office
Washington, DC 20548

March 21, 2012

The Honorable Orrin G. Hatch
Ranking Member
Committee on Finance
United States Senate

Subject: *Medicare Advantage: Quality Bonus Payment Demonstration Undermined by High Estimated Costs and Design Shortcomings*

Dear Senator Hatch:

The Medicare Advantage (MA) program, an alternative to the original Medicare fee-for-service (FFS) program, provides health care coverage to Medicare beneficiaries through private health plans offered by organizations under contract with the Centers for Medicare & Medicaid Services (CMS). In 2011, about a quarter of all Medicare beneficiaries were enrolled in approximately 3,300 MA plans sponsored by 175 MA organizations. These organizations generally offer beneficiaries one or more plans to choose from—with different coverage, premiums, and cost sharing features—in the areas they serve. Also, MA plans may provide additional benefits not offered under Medicare FFS, such as reduced cost sharing or vision and dental care coverage. In 2010, Medicare payments to MA plans totaled about $115 billion, or roughly 25 percent of all Medicare spending for Part A and Part B.[1]

CMS determines the amount to pay an MA plan by comparing its bid—the MA plan's projected revenue requirements for providing the traditional Medicare benefit package to an average beneficiary—to a benchmark derived from the average amount of Medicare FFS spending in the plan's service area.[2] Most plans receive their bid amount plus a rebate based on the difference between their bid and their benchmark. The rebate must be used to reduce premiums, reduce cost sharing, or offer additional benefits. To help Medicare beneficiaries select an MA plan in their area, CMS rates MA contractors on a 5-star scale, with 5 stars indicating the highest

[1]Medicare Part A includes inpatient hospital, skilled nursing, and some home health services. Medicare Part B includes physicians' services, outpatient care, and durable medical equipment. MA plans must cover Medicare Part A and Part B benefits except hospice care.

[2]An MA plan's benchmark is the enrollment-weighted average of the maximum amount Medicare will pay in each county within the plan's service area.

quality.[3] Plans' overall star ratings indicate their performance relative to that of all other plans on about 50 measures of clinical quality, patient experience, and contractor performance.[4]

The 2010 Patient Protection and Affordable Care Act as amended (PPACA) aligned benchmarks more closely with Medicare FFS spending and provided incentives for plans to achieve high star ratings.[5] PPACA tied the new benchmarks to a percentage of average FFS spending in each county and caps them at the pre-PPACA level. The new benchmarks would be phased in from 2012 to 2017 by blending them with the old benchmarks. PPACA also tied MA payments to plans' star ratings in two ways. First, PPACA introduced differential rebates—varying from 50 to 70 percent—based on plans' star ratings.[6] Second, PPACA provided that plans with 4 or more stars receive a bonus that adds 1.5 percent to the PPACA portion of their blended benchmark in 2012, 3 percent in 2013, and 5 percent in 2014 and beyond.[7] CMS's Office of the Actuary (OACT) estimated that PPACA's payment reforms would reduce Medicare payments to MA plans by $145 billion over 9 years and would cause plans to offer less generous benefit packages.[8] OACT also projected that MA enrollment in 2017 would be half as much as it would have been in PPACA's absence.

Rather than implement PPACA's bonus structure, CMS announced in November 2010 that it would conduct a nationwide demonstration from 2012 through 2014 to test an alternative method for calculating and awarding bonuses. Compared with PPACA, the MA Quality Bonus Payment Demonstration extends the bonuses to plans with 3 or more stars, accelerates the phase-in of the bonuses for plans with 4 or more stars, and increases the size of the bonuses in 2012 and 2013. According to CMS, the goal of the demonstration is to test whether a scaled bonus structure would lead to larger and faster annual quality improvement for plans at various star rating levels compared with what would have occurred under PPACA.

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[3]Although multiple MA plans are typically included in a contract, CMS assigns star ratings at the contract level. As a result, every plan covered under the same contract receives the same star rating. According to CMS estimates, in 2012, about 9 percent of MA beneficiaries are in 5-star plans, about 20 percent are in 4-star and 4.5-star plans, and about 58 percent are in 3-star and 3.5-star plans. The remaining MA beneficiaries are in plans that have fewer than 3 stars or that do not have a star rating.

[4]CMS can revise the methodology for calculating star ratings and can also change the cut points for the levels of the measures that constitute the ratings. On December 20, 2011, CMS proposed changing the 2013 star rating methodology by adding four new measures and modifying seven current measures. It was beyond the scope of this report to assess the 5-star quality rating system.

[5]For purposes of this report, references to PPACA include the amendments made by the Health Care and Education Reconciliation Act of 2010. Pub. L. No. 111-148, §§ 3201-02, 124 Stat. 119, 442, 454 (2010). Pub. L. No. 111-152, § 1102, 124 Stat. 1029, 1040 (2010).

[6]Prior to 2012, if a plan's bid was less than the benchmark, the plan received a rebate equal to 75 percent of the difference between the bid and the benchmark. The new rebates will be phased in from 2012 through 2014. In 2012, the rebate equals the sum of two-thirds of the old rebate amount and one-third of the new rebate amount. In 2013, the rebate will equal the sum of one-third of the old rebate amount and two-thirds of the new rebate amount.

[7]New plans and plans with low enrollment are also eligible for bonus payments. The bonus percentages are doubled for plans in qualifying counties.

[8]See OACT, *Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Amended* (Baltimore, Md.: Apr. 22, 2010).

You asked us to review the cost and design of the MA Quality Bonus Payment Demonstration. In this report, we examined (1) cost estimates that have been developed for the demonstration; (2) the extent to which the demonstration conforms to the principles of budget neutrality; (3) how the demonstration compares in budgetary impact, size, and scope with other Medicare demonstrations; and (4) the extent to which the design of the demonstration will allow CMS to achieve its stated research goal. On November 18, 2011, we presented information on these objectives to committee staff (see enc. I). This report contains the results of our review and a recommendation that the Secretary of the Department of Health and Human Services (HHS) cancel the demonstration and allow the quality bonus payment system established by PPACA to take effect.

To examine cost estimates that have been developed for the demonstration, we obtained published and unpublished analyses and interviewed representatives from OACT and the Kaiser Family Foundation. We also conducted interviews with Medicare Payment Advisory Commission representatives and other health care researchers. To assess the extent to which the demonstration conforms to the principles of budget neutrality, we reviewed information on the budget neutrality policy for Medicare demonstrations and conducted interviews with officials from CMS and the Office of Management and Budget (OMB). To compare the demonstration's budgetary impact, size, and scope with those of other Medicare demonstrations, we reviewed OMB cost estimates published in the President's Budgets from fiscal years 1996 through 2012, as well as CMS documents. To assess the extent to which the design of the demonstration will allow CMS to achieve its goal, we reviewed CMS's announcements and evaluation plans as well as literature on evaluating Medicare demonstrations.

We conducted this performance audit from October 2011 to March 2012 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

In summary, we found the following:

- OACT has estimated that the MA Quality Bonus Payment Demonstration will cost $8.35 billion over 10 years, most of which will be paid to 3-star and 3.5-star plans. About $5.34 billion of OACT's cost estimate is attributed to quality bonus payments more generous than those prescribed in PPACA, specifically to (1) higher bonuses for 4-star and 5-star plans, (2) new bonuses for 3-star and 3.5-star plans, (3) applying bonuses to plans' entire blended benchmarks, and (4) allowing plans' benchmarks to exceed their pre-PPACA levels.[9] Most of the remaining projected demonstration spending stems from higher MA enrollment because the bonuses enable MA plans to offer beneficiaries more benefits or

[9]Under PPACA, about one-third of MA beneficiaries would be covered by contracts eligible for a bonus in 2012 and 2013. In contrast, under the demonstration, about 90 percent of MA beneficiaries will be covered by contracts eligible for a bonus in 2012 and 2013.

lower premiums. Taken together, the expanded bonuses and higher MA enrollment mainly benefit average performing plans—those receiving 3-star and 3.5-star ratings.[10] In addition, OACT estimated that the demonstration will offset more than one-third of the reduction in MA payments projected to occur under PPACA during the demonstration years. The largest annual offset will occur in 2012—71 percent—followed by 32 percent in 2013 and 16 percent in 2014.

- The MA Quality Bonus Payment Demonstration does not—and is not required by law to—conform to the principles of budget neutrality. OMB officials told us that they considered the costs of the demonstration in the context of other administrative actions in the Medicare program that are expected to generate savings. However, they did not confirm whether specific offsets were identified to account for the total costs of the demonstration.

- The MA Quality Bonus Payment Demonstration dwarfs all other Medicare demonstrations—both mandatory and discretionary—conducted since 1995 in its estimated budgetary impact and is larger in size and scope than many of them.[11] Our review of CMS and OMB data shows that the estimated budgetary impact of the demonstration, adjusted for inflation, is at least seven times larger than that of any other Medicare demonstration conducted since 1995 and is greater than the combined budgetary impact of all of those demonstrations. While the demonstration is similar in size and scope to some Part D demonstrations, it is unlike many Medicare pay-for-performance demonstrations in that it is implemented nationwide and allows all eligible plans or providers to participate.[12]

- The design of the demonstration precludes a credible evaluation of its effectiveness in achieving CMS's stated research goal—to test whether a scaled bonus structure leads to larger and faster annual quality improvement compared with what would have occurred under PPACA. Because of the timing of data collection—all of the performance data used to determine the 2012 bonus payments and nearly all of the data used to determine the 2013 bonus payments were collected before the demonstration's final specifications were published—the demonstration's incentives to improve quality can have a full impact only in 2014. In addition, the demonstration's bonus percentages are not continuously scaled—in 2014, plans with 4, 4.5, and 5 stars will all receive the same 5 percent bonus—and its bonus payments do not consistently offer better incentives than PPACA to achieve high star ratings in 2013 and 2014. Moreover, because the demonstration lacks a direct comparison group, it may not be possible to isolate

[10]An analysis by the Kaiser Family Foundation estimated that the total cost of the demonstration would be about $3 billion in 2012. The authors indicated that expanded bonus payments for 3-star and 3.5-star plans would account for a majority of the cost—about $2 billion. G. Jacobson, T. Neuman, A. Damico, and J. Huang, *Medicare Advantage Plan Star Ratings and Bonus Payments in 2012* (Washington, D.C.: Kaiser Family Foundation, November 2011).

[11]The estimated budgetary impact refers to the difference between the total costs of the demonstration and the total costs that would occur in its absence.

[12]The Medicare Part D program provides voluntary, outpatient prescription drug coverage for eligible individuals.

its effects, and any effects that are observed could be attributable, at least in part, to other MA payment and policy changes.

Conclusion

Estimated to cost more than $8 billion, the MA Quality Bonus Payment Demonstration offsets a significant portion of PPACA's MA payment reductions during its 3-year time frame. At the same time, the design shortcomings of the demonstration may undermine its ability to achieve CMS's stated research goal—to test whether a scaled bonus structure leads to larger and faster annual quality improvement compared with what would have occurred under PPACA. Rather than rewarding only high performing plans, most of the additional payments made under the demonstration will accrue to average performing plans. In addition, the demonstration's ability to test an alternative quality improvement incentive structure is compromised by its design. The reliance on predemonstration performance data, the absence of an appropriate comparison group of MA plans, and design features that are inconsistent with its research goal make it unlikely that the demonstration will produce meaningful results.

Recommendation for Executive Action

The Secretary of HHS should cancel the MA Quality Bonus Payment Demonstration and allow the MA quality bonus payment system established by PPACA to take effect. If, at a future date, the Secretary finds that this system does not adequately promote quality improvement, HHS should determine ways to modify the system, which could include conducting an appropriately designed demonstration.

Agency Comments and Our Evaluation

We obtained written comments on a draft of this report from HHS, which are reprinted in enclosure II. HHS did not concur with our recommendation to cancel the MA Quality Bonus Payment Demonstration and our finding regarding its design. After reviewing HHS's response, we determined that our recommendation is warranted and our finding is sound.

Regarding its disagreement with our recommendation, HHS contended that the MA quality bonus payment system established by PPACA would not provide an immediate incentive for many plans to improve the quality of care delivered to MA beneficiaries. It stated that the demonstration addresses this concern by providing quality improvement incentives for plans throughout the star ratings continuum. We found that bonuses paid in 2012 and 2013 under both PPACA and the demonstration would primarily reward past performance, with the demonstration doing so far more generously. Moreover, we found that PPACA's bonus structure in 2014 provides many plans better incentives than the demonstration to achieve higher star ratings. In fact, plans improving from 3.5 to 4 stars would generally receive a larger increase in their bonus payment under PPACA. Therefore, we maintain that HHS should implement and evaluate the MA quality bonus payment system established by PPACA before it considers ways to modify that system.

HHS also disagreed with our finding that the design features of the demonstration are inconsistent with CMS's research goal. The agency stated that the demonstration provides an incrementally larger quality bonus for each increase in a plan's star rating with the exception of bonuses to 4-star, 4.5-star, and 5-star plans in 2014. However, as we stated in our report, 4-star and 4.5-star plans receive the same bonus percentage as each other in all 3 years of the demonstration. Furthermore, we found that CMS's decision to provide all plans with a bonus at least as great as the one they would have received under PPACA results in a bonus structure that is not continuously scaled and, therefore, conflicts with its stated research goal of testing whether a scaled bonus structure leads to larger and faster annual quality improvement.

In addition, HHS disagreed with our finding that the timing of data collection precludes a credible evaluation of the demonstration. The agency noted that CMS's evaluation contractor will compare the impact of the demonstration—as measured by MA plans' 2012 and 2013 star ratings—to what would have occurred under PPACA—as shown in their 2014 star ratings. However, such a comparison fails to distinguish between predemonstration and demonstration performance. As we stated in our report, the 2012 star ratings were based on data collected almost entirely before the demonstration's final specifications were published in April 2011 and, therefore, cannot be used to measure the demonstration's impact. Moreover, this comparison confuses the chronological order of events by using the 2014 star ratings to represent what would have occurred under PPACA. The 2014 star ratings will be based on data collected during the demonstration and, therefore, will reflect the demonstration's incentives. The agency acknowledged this point in stating that improvements in plan quality during the demonstration would affect star ratings prior to the end of the demonstration in 2014, as well as in future years.

Finally, HHS disagreed with our finding that the demonstration lacks an appropriate comparison group. The agency stated that CMS's evaluation contractor will 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 cost contracts, Medicaid plans, and commercial plans. We do not believe that these plans constitute an appropriate comparison group because they may serve different populations, may follow different regulations and policies, and may have different incentives to improve quality.

HHS also provided technical comments that we incorporated as appropriate.

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As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the CMS Administrator and other interested congressional committees. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions regarding this report, please contact me at (202) 512-7114 or cosgrovej@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Individuals making key contributions to this report include Rosamond Katz, Assistant Director; Sandra George; David Grossman; and Eric Wedum.

Sincerely yours,

James C. Cosgrove
Director, Health Care

MEDICARE ADVANTAGE: Quality Bonus Payment Demonstration Undermined by High Estimated Costs and Design Shortcomings

Presentation to staff of the Senate Committee on Finance

November 18, 2011 (updated)

Introduction

- In 2008, the Centers for Medicare & Medicaid Services (CMS) implemented a 5-star quality rating system—with 5 stars indicating the highest quality—for Medicare Advantage (MA) plans as a tool to help beneficiaries make enrollment decisions.*
- This system assigns an overall star rating derived from measures of clinical quality, patient experience, and contract performance. CMS publishes MA plans' ratings on the Medicare website and uses them in its oversight of plans.
- The 2010 Patient Protection and Affordable Care Act as amended (PPACA) expanded the use of star ratings by requiring CMS to award bonus payments to MA plans with at least 4 stars beginning in 2012.

*CMS assigns a star rating for each MA contract rather than for individual plans. Contracts typically include multiple plans.

Introduction (cont.)

- In November 2010, CMS announced that it would conduct a nationwide demonstration from 2012 through 2014 to test an alternative method for calculating and awarding quality bonus payments to MA plans.
- CMS is conducting the demonstration under section 402(a)(1)(A) of the Social Security Amendments of 1967, as amended.*
- The MA Quality Bonus Payment Demonstration
  - extends the bonuses to plans with 3 and 3.5 stars,
  - accelerates the phase-in of the bonuses for plans with 4 or more stars, and
  - increases the size of the bonuses in 2012 and 2013 compared with PPACA.
- When the demonstration terminates at the end of 2014, MA plans will transition to the quality bonus payment system established by PPACA.

*This section allows CMS to test whether changes in Medicare payment methodologies increase the efficiency and economy of Medicare services through the creation of additional incentives without adversely affecting the quality of such services.

Introduction (cont.)

- CMS's stated research goal for the demonstration is to test whether a scaled bonus structure leads to larger and faster annual quality improvement for plans at various star rating levels compared with what would have occurred under PPACA.
- According to CMS, the demonstration was designed to reflect several principles, such as the following:
  - Providing a strong incentive for MA plans to improve performance at various star rating levels.
  - Creating a difference between the bonus payment percentages for 4-star and 5-star plans to test whether the difference moves plans to achieve 5-star ratings.
  - Ensuring that all plans will receive a bonus at least as great as the bonus they would have received under PPACA.

Objectives

This report examines

1. cost estimates that have been developed for the demonstration;
2. the extent to which the demonstration conforms to the principles of budget neutrality;
3. how the demonstration compares in budgetary impact, size, and scope with other Medicare demonstrations; and
4. the extent to which the design of the demonstration will allow CMS to achieve its stated research goal.

Scope and Methodology

- To examine cost estimates of the demonstration, we obtained published and unpublished analyses and interviewed representatives from CMS's Office of the Actuary (OACT) and the Kaiser Family Foundation. We also conducted interviews with Medicare Payment Advisory Commission representatives and other health care researchers.
- To assess the extent to which the demonstration conforms to the principles of budget neutrality, we reviewed information on the budget neutrality policy for Medicare demonstrations and conducted interviews with officials from CMS and the Office of Management and Budget (OMB).
- To compare the demonstration's budgetary impact, size, and scope with those of other Medicare demonstrations, we reviewed OMB cost estimates published in the President's Budgets from fiscal years 1996 through 2012, as well as CMS documents.
- To assess the extent to which the design of the demonstration will allow CMS to achieve its goal, we reviewed CMS's announcements and evaluation plans as well as literature on evaluating Medicare demonstrations.

Background

- In 2011, about a quarter of all Medicare beneficiaries were enrolled in approximately 3,300 MA plans included in 555 contracts. In 2010, MA payments totaled about $115 billion, or roughly 25 percent of all Medicare spending for Part A and Part B.*
- Since 2006, payments to each MA plan have been determined by the plan's bid—the projected cost of providing Medicare Part A and Part B benefits—and a benchmark—the maximum amount Medicare will pay for those benefits in the plan's service area.
  - If the plan's bid is higher than the benchmark, Medicare pays the plan its benchmark and enrollees pay the remainder in their monthly premium.
  - If the bid is lower than the benchmark, the plan receives its bid and a portion of the difference as a rebate, which must be used to reduce premiums, reduce cost sharing, or provide additional benefits, such as vision or dental coverage. Prior to 2012, this portion was set at 75 percent.

*Medicare Part A services include inpatient hospital, skilled nursing, and some home health services. Medicare Part B services include physicians' services, outpatient care, and durable medical equipment.

Background (cont.)

PPACA changed the way MA plan payments are set in the following ways:

1. *Tying benchmarks to projected county-level fee-for-service (FFS) spending.* From 2012 to 2017, benchmarks will be a blend of the pre-PPACA and PPACA amounts. The PPACA benchmark formula will be phased in over 2, 4, or 6 years depending on the difference between counties' pre-PPACA and PPACA amounts.
2. *Tying rebates to performance beginning in 2012.* By 2014, rebates will be set at
   - 70 percent for plans with 4.5 or 5 stars,
   - 65 percent for plans with 3.5 or 4 stars, and
   - 50 percent for all other plans.
3. *Establishing bonus payments for plans with 4 or more stars*. Bonuses will be phased in from 2012 through 2014 and will be applied only to the PPACA portion of the blended benchmark.

Background (cont.)

Quality Bonus Payment Characteristics under PPACA and the Demonstration

	PPACA	MA Quality Bonus Payment Demonstration
How many stars do MA plans need to be eligible for bonuses?	4 or more stars	3 or more stars
What portion of the benchmark are bonuses applied to?	Only the PPACA portion	The entire blended benchmark
May the blended benchmark exceed the pre-PPACA amount?	No	Yes
Are rebates tied to star ratings?	Yes	Yes
Are MA plans in qualifying counties eligible for double bonuses?	Yes	Yes
Are new MA plans eligible for bonuses?	Yes	Yes
Are MA plans with low enrollment eligible for bonuses?	Yes	Yes in 2012 and 2013

Source: GAO analysis of CMS information.

Notes: New MA plans are defined as those in a contract offered by a parent organization that has not had an MA contract in the previous 3 years. These plans lack sufficient data to calculate an overall star rating.

MA plans with low enrollment are defined as those in a contract that lacked a sufficient number of enrollees to reliably measure plan performance.

MA plans qualify for double bonuses in counties that meet three conditions: (1) have lower-than-average projected FFS county spending for 2012, (2) had at least 25 percent of beneficiaries residing in the county enrolled in an MA plan as of December 2009, and (3) were designated as large urban floor counties–those whose benchmarks are based on their being located in a Metropolitan Statistical Area with a population of more than 250,000 in 2004.

Background (cont.)

Quality Bonus Payment Percentages under PPACA and the Demonstration

Percentage of benchmark

	PPACA			MA Quality Bonus Payment Demonstration		
Overall star rating	**2012**	**2013**	**2014**	**2012**	**2013**	**2014**
5 stars	1.5	3	5	5	5	5
4 or 4.5 stars	1.5	3	5	4	4	5
3.5 stars	0	0	0	3.5	3.5	3.5
3 stars	0	0	0	3	3	3
Fewer than 3 stars	0	0	0	0	0	0
New plan	1.5	2.5	3.5	3	3	3.5
Low enrollment plan	*	*	*	3	3	**

Source: GAO analysis of CMS data.

Notes: Under PPACA, the bonus payment percentages would be applied only to the PPACA portion of the blended benchmark. Under the demonstration, the bonus percentages will be applied to the entire blended benchmark. Under both PPACA and the demonstration, MA plans in qualifying counties will be eligible for double bonuses.

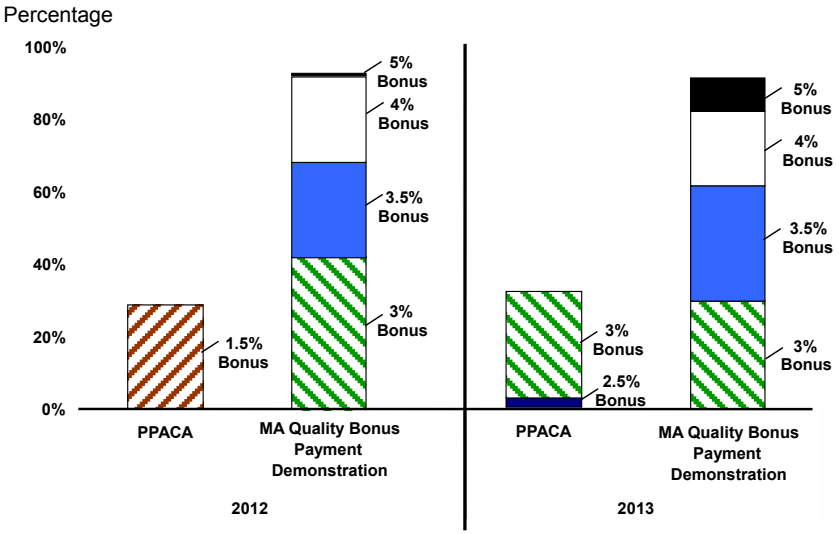
*In the final rule for MA program changes in 2012, CMS stated that low enrollment plans will qualify for bonuses in 2012 and subsequent years. However, CMS did not specify the bonus payment percentages for low enrollment plans.

**In the February 2012 call letter for the MA Quality Bonus Payment Demonstration, CMS did not specify the bonus payment percentages for low enrollment plans in 2014.

Background (cont.)

- Under PPACA, about one-third of MA enrollees would be covered by contracts eligible for a bonus in 2012 and 2013.
- In contrast, under the demonstration, about 90 percent of MA enrollees will be covered by contracts eligible for a bonus in 2012 and 2013.

Percentage of Enrollees in MA Contracts Eligible for Quality Bonus Payments under PPACA and the Demonstration, 2012 and 2013



Source: GAO analysis of CMS data.

Notes: The distribution of contracts is weighted by prior enrollment data and is subject to change if there are shifts in enrollment. MA plans in qualifying counties may receive double bonuses, which are not reflected in this chart. Low enrollment plans are included only in the distributions for the MA Quality Bonus Payment Demonstration.

Results

1. The current estimated cost for the MA Quality Bonus Payment Demonstration exceeds $8 billion, most of which is paid to 3-star and 3.5-star plans.
2. The MA Quality Bonus Payment Demonstration does not—and is not required by law to—conform to the principles of budget neutrality.
3. The MA Quality Bonus Payment Demonstration dwarfs all other Medicare demonstrations—both mandatory and discretionary—conducted since 1995 in its estimated budgetary impact and is larger in size and scope than many of them.
4. The design of the demonstration precludes a credible evaluation of its effectiveness in achieving CMS's stated research goal.

Finding 1

The current estimated cost for the MA Quality Bonus Payment Demonstration exceeds $8 billion, most of which is paid to 3-star and 3.5-star plans.

1: OACT's current estimate of the demonstration's cost over 10 years is over $8 billion, most of it occurring during 2012 to 2014*

- Most of the cost is concentrated in the 3 demonstration years. ▸ **$6.83 billion**
  - Higher bonuses for 4-star and 5-star plans, new bonuses for 3-star and 3.5-star plans, applying bonuses to plans' entire blended benchmarks, and allowing plans' benchmarks to exceed their pre-PPACA levels account for most of the cost in the demonstration years. $5.34 billion
  - Net cost of higher enrollment in MA as beneficiaries switch from FFS because bonuses enable plans to offer more benefits or lower premiums $1.49 billion
- The remaining cost is almost entirely due to continued higher enrollment in MA in the post-demonstration period.** ▸ **$1.52 billion**

Total 10-year cost (2012-2021) ▸ **$8.35 billion**

*The budgetary impact of the demonstration is in comparison to the implementation of PPACA.
**A small portion of the remaining cost, $40 million, stems from plans whose star ratings are assumed to increase as a result of the demonstration.

1: Bonuses for and additional enrollment in 3-star and 3.5-star plans will likely account for most of the cost of the demonstration

- Of the $5.34 billion of projected demonstration spending attributed to expanded bonuses, the majority is likely to go to 3-star and 3.5-star plans.
  - This result is due, in part, to a difference in the number of 4-star and 5-star plans in 2013 and 2014 assumed to exist under the demonstration and PPACA scenarios.
- Most of the remaining projected demonstration spending attributed to higher MA enrollment (both during and after the demonstration) is also likely to go to 3-star and 3.5-star plans.
  - OACT assumes that the additional MA enrollment stimulated by the demonstration will be distributed similarly to the current distribution of enrollees—which is concentrated among 3-star and 3.5-star plans.

1: Kaiser Family Foundation's estimate of the cost of the demonstration in 2012 exceeds that of OACT

Billions of dollars	Kaiser Family Foundation estimate*	OACT estimate
New bonus payments to 3-star and 3.5-star plans	$2.0**	$1.8**
Higher bonus payments to 4-star and 5-star plans	1.0	0.7
Net cost of FFS beneficiaries switching to MA plans	Not included***	0.2
Total	**$3.0**	**$2.7**

*G. Jacobson, T. Neuman, A. Damico, and J. Huang, *Medicare Advantage Plan Star Ratings and Bonus Payments in 2012* (Washington, D.C.: Kaiser Family Foundation, November 2011).

**Includes new plans and low enrollment plans.

***Kaiser's methodology holds constant other factors, such as changes in enrollment and plans' bids.

1: Estimated cost of the demonstration offsets a substantial portion of the MA payment reductions projected to result from PPACA during the demonstration years

- OACT estimates that the demonstration will offset a significant portion of PPACA's MA payment reductions in the demonstration years:
  - 71 percent in 2012
  - 32 percent in 2013
  - 16 percent in 2014
- Overall, OACT estimates that the demonstration will offset more than one-third of PPACA's projected reductions in MA payments during the demonstration years.

Finding 2

The MA Quality Bonus Payment Demonstration does not—and is not required by law to—conform to the principles of budget neutrality.

2: Although the demonstration is not budget neutral, OMB officials considered the cost of the demonstration in a programwide context

- Medicare demonstrations conducted under section 402(a)(1)(A) of the Social Security Amendments of 1967, as amended, are not required to be budget neutral—whereby the total costs of a demonstration cannot exceed the total costs in its absence—but OMB generally does require these demonstrations to be budget neutral.
- OMB officials told us that they considered the costs of the MA Quality Bonus Payment Demonstration in the context of other administrative actions in the Medicare program that are expected to generate savings, such as an adjustment to skilled nursing facility payment rates.
- However, OMB officials did not confirm whether specific offsets were identified to account for the total costs of the demonstration.

Finding 3

The MA Quality Bonus Payment Demonstration dwarfs all other Medicare demonstrations—both mandatory and discretionary—conducted since 1995 in its estimated budgetary impact and is larger in size and scope than many of them.

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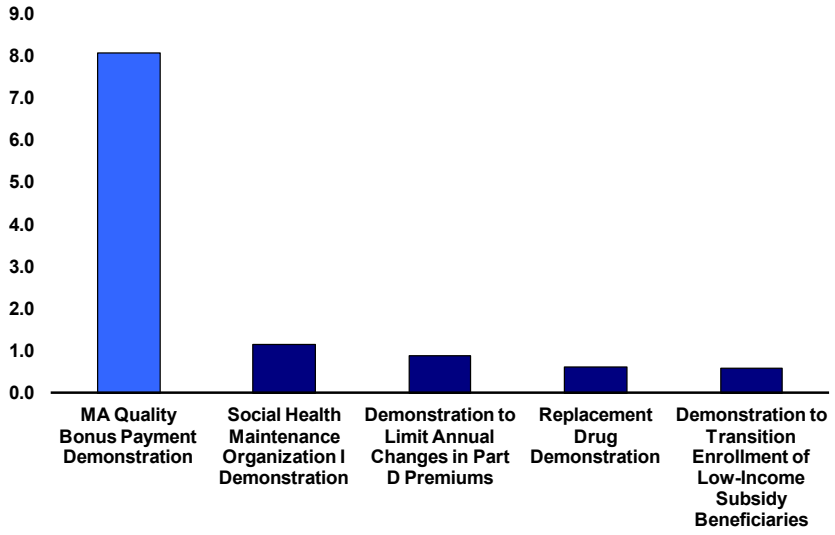
3: The MA Quality Bonus Payment Demonstration has the greatest estimated budgetary impact of any Medicare demonstration conducted since 1995

According to CMS and OMB cost estimates, the estimated budgetary impact of the MA Quality Bonus Payment Demonstration, adjusted for inflation, is

- at least seven times larger than any other Medicare demonstration conducted since 1995 and
- greater than the estimated budgetary impact of all other Medicare demonstrations conducted since 1995 combined.

Top Five Medicare Demonstrations by Estimated Budgetary Impact, 1995 to 2021

Outlays in billions of 2011 dollars



Source: GAO analysis of CMS and OMB data.

Notes: Estimated budgetary impact refers to the difference between the total costs of the demonstration and the total costs that would occur in its absence. Estimates shown are in constant 2011 dollars.

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3: The MA Quality Bonus Payment Demonstration is larger in size and scope than other Medicare pay-for-performance demonstrations

Unlike other Medicare pay-for-performance demonstrations, the MA Quality Bonus Payment Demonstration

- is implemented nationwide and
- allows all eligible plans or providers to participate.

Size and Scope of Medicare Pay-for-Performance Demonstrations

Demonstration name	Number of affected states	Number of participants
MA Quality Bonus Payment Demonstration	50	All MA plans
Premier Hospital Quality Incentive Demonstration	38	About 225 hospitals
End-Stage Renal Disease (ESRD) Disease Management Demonstration	13	3 providers
Physician Group Practice Demonstration	10	10 physician groups
Cancer Prevention and Treatment Demonstration for Ethnic and Racial Minorities	7	6 organizations
Care Management for High-Cost Beneficiaries Demonstration	7	6 care management organizations
Home Health Pay-for-Performance Demonstration	7	569 home health agencies
Health Care Quality Demonstration	5	3 organizations
Acute Care Episode Demonstration	4	5 organizations
Care Management Performance Demonstration	4	Almost 700 physician groups
Hospital Gainsharing Demonstration	2	2 hospitals
Physician Hospital Collaboration Demonstration	1	1 hospital consortium

Source: GAO analysis of CMS information.

3: However, the large size and scope of the MA Quality Bonus Payment Demonstration is similar to some Medicare Part D demonstrations*

Like the MA Quality Bonus Payment Demonstration, some Part D Demonstrations have

- been implemented nationwide and
- allowed all eligible plans to participate.

Size and Scope of the MA Quality Bonus Payment Demonstration Compared to Medicare Part D Demonstrations

Demonstration name	Number of affected states	Eligible participants
MA Quality Bonus Payment Demonstration	50	All MA plans
Demonstration to Limit Annual Changes in Part D Premiums	50	All Part D plans
Demonstration to Revise the Part D Low-Income Benchmark Calculation	50	All Part D plans
Demonstration to Transition Enrollment of Low Income Subsidy Beneficiaries	50	All Part D plans

Source: GAO analysis of CMS information.

*The Medicare Part D program provides voluntary, outpatient prescription drug coverage for eligible individuals.

Finding 4

The design of the MA Quality Bonus Payment Demonstration precludes a credible evaluation of its effectiveness in achieving CMS's stated research goal.

GAO
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4: The timing of data collection limits the extent to which the demonstration's impact on quality improvement can be measured

- The timing of data collection for the measures constituting the star ratings will compromise an evaluation of the demonstration's impact on quality improvement in the first 2 years.
  - In 2012, bonus payments will be based on data collected entirely before the demonstration was announced in November 2010.
  - In 2013, bonus payments will be based on data collected almost entirely before the final specifications of the demonstration were announced in April 2011.
- Accordingly, 2014 is the only year for which plans can respond comprehensively to the demonstration's quality improvement incentives.

Data Collection Timeline for the Measures Constituting the 5-Star Quality Rating System

Demonstration year	Release date of applicable star ratings	Data collection period*
2012	November 10, 2010 (2011 ratings)	January 2009 – June 2010
2013	October 18, 2011 (2012 ratings)	January 2010 – June 2011
2014	Fall 2012 (2013 ratings)	To be determined**

Source: GAO analysis of CMS information.

*Data collection time frames for individual measures vary within this overall period.

**GAO assumes that the dates for the data collection period for 2013 star ratings will be similar to those of the 2 preceding years.

4: The demonstration's design is inconsistent with CMS's stated research goal

Research goal	Design features that conflict with research goal
Test whether a scaled bonus structure leads to larger and faster annual quality improvement for plans at various star rating levels compared with what would have occurred under PPACA	• The demonstration's bonus percentages are not continuously scaled. ▪ In 2012 and 2013, the size of the bonus percentage for 4-star and 4.5-star plans is the same—4 percent. ▪ In 2014, the size of the bonus percentage for 4-star, 4.5-star, and 5-star plans is the same—5 percent. • The demonstration's bonus percentages in 2013 and 2014 do not offer all plans better incentives than PPACA to achieve higher star ratings. ▪ Most plans improving from 3.5 to 4 stars would receive a larger increase in their bonus payment under PPACA.

4: Isolating the effects of the demonstration may not be possible

- Comparison groups are necessary to isolate the effects of a demonstration from other factors in an unbiased manner. However, the demonstration lacks a direct comparison group because all MA plans are participating.
- The effects of the demonstration may be explained, at least in part, by other MA payment and policy changes that may encourage plans to improve quality, such as the following:
  - PPACA's method of tying rebates to star ratings. For example, in 2014, PPACA rewards plans that improve from 3 to 3.5 stars with a 30 percent increase in their rebate amount and plans that improve from 4 to 4.5 stars with a 7.7 percent increase in their rebate amount.
  - CMS's proposed rule establishing procedures under which the agency may terminate contracts with MA plans that achieve fewer than 3 stars in 3 consecutive years.*
- CMS officials acknowledged that it will not be possible to isolate the effects of the demonstration from other MA payment and policy changes.

*CMS issued this proposed rule in October 2011. If finally adopted, this proposal is expected to take effect beginning in contract year 2013. Under this proposal, CMS could terminate MA contracts beginning in contract year 2015 based on their 2013, 2014, and 2015 star ratings.

Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES — OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

FEB 28 2012

James Cosgrove
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Mr. Cosgrove:

Attached are comments on the U.S. Government Accountability Office's (GAO) correspondence entitled, "Medicare Advantage: "Quality Bonus Payment Demonstration Undermined by High Estimated Costs and Design Shortcomings" (GAO-12-409R).

The Department appreciates the opportunity to review this draft section of the report prior to publication.

Sincerely,

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT CORRESPONDENCE ENTITLED, "MEDICARE ADVANTAGE: QUALITY BONUS DEMONSTRATION UNDERMINED BY HIGH ESTIMATED COSTS AND DESIGN SHORTCOMINGS" (GAO-12-409R)

GAO Recommendation

The Secretary of the Department of Health and Human Services (HHS) should cancel the MA Quality Bonus Payment Demonstration and allow the MA quality bonus payment system established by the 2010 Patient Protection and Affordable Care Act (PPACA) to take effect. If, at a future date, the Secretary finds that this system does not adequately promote quality improvement, HHS should determine ways to modify the system, which could include conducting an appropriately designed demonstration.

CMS Response

The Centers for Medicare & Medicaid (CMS) does not concur with the GAO's recommendation to cancel the QBP demonstration. We also disagree with GAO's findings regarding the design and evaluation of the demonstration.

CMS believes the demonstration supports our national strategy to improve the delivery of health care services, patient health outcomes, and population health. Absent this demonstration, we believe that many plans would not have an immediate incentive to improve the quality of care delivered to MA enrollees.

Current law provides the same bonus payment for 4 and 5 star plans; under the demonstration we use a scaled approach where 3-star, 3.5 star, 4 star, and 5-star plans are eligible for bonus payments. The QBP demonstration tests whether allowing plans with quality ratings below four stars to earn quality bonus payments will lead to more rapid and larger year-to-year quality improvements, resulting in increased efficiency and economy of care compared to the current law bonus structure. This is based on the premise that improved quality results in improved health outcomes, and thus in savings over time. The changes made under the demonstration provide financial incentives for quality improvement and reward improvement throughout the ratings continuum, rather than just in cases in which a rating improves from three to four stars.

CMS believes the design features of the demonstration are consistent with the overall goal of improving quality in the Medicare Advantage program and do not, as suggested by the GAO, preclude a credible evaluation of the demonstration. The demonstration provides an incrementally larger quality bonus for each increase in a plan's star rating. The only exceptions to this, as noted in the GAO report, are the bonuses for 4, 4.5 and 5 star plans in 2014, which will receive a uniform bonus of 5 percent per the statute. CMS included this feature in the demonstration in order to ensure that all plans receive a quality bonus that is at least as great as the quality bonus they would have received under the Affordable Care Act. Section 402 of the SSA Amendments of 1967 does not require that CMS test changes to all features of current law under a demonstration. As a result, we believe this design feature is consistent with the requirements of section 402.

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We also disagree with the conclusion that the timing of the data collection precludes a credible evaluation of the demonstration. CMS was aware of the lag between data collection and quality rating while designing this demonstration. It was never the agency's intent that positive outcomes of this demonstration occur only within the three year window of the alternative bonus payments. While the improvements in plans' quality during the demonstration will not translate immediately into higher star ratings, any improvements could have immediate benefits for enrollees and would affect star ratings prior to the end of the demonstration in 2014, as well as in future years.

CMS will conduct a comprehensive evaluation of the demonstration to determine whether quality improved as a result of the demonstration, in which domains improvement occurred, how improvements were accomplished, and how demonstration results might be replicated in the future. One task of the evaluation will be to examine the effect of the demonstration beyond the impact of the more limited quality bonus payments prescribed under current law. CMS' evaluation contractor will estimate the impact of the demonstration over and above current law in two ways. First, plan ratings for 2012 and 2013 will be compared with plan ratings for 2014; ratings for 2012-13 will determine bonus payments under the demonstration, whereas 2014 ratings will determine quality bonus payments for 2015 under provisions of current law. Second, year-to-year progress in plan ratings will be compared among plans with different baseline ratings, which will provide evidence of the impact of additional incentives attributable to the demonstration.

Because all MA plans will be part of the demonstration, the evaluator will look outside the MA program to identify suitable comparison groups. One comparison group consists of managed care plans contracting with Medicare under section 1876 cost contracts. Plans contracting with Medicare under section 1876 receive payments based on costs rather than risk-based capitation, and will not participate in the 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 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. A second potential 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 evaluator is exploring the suitability of using such data for comparison purposes. Considerations include the degree of overlap in quality measures and the costs of obtaining the data.

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