Written Testimony of

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Medicare Advantage Update

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Introduction

Chairman Roskam, Ranking Member Levin, and distinguished Members of the Subcommittee on Health, thank you for the opportunity to appear today to discuss the status of quality measures in Medicare Advantage plans.

As a professor of health sector management and policy, I teach and conduct research on the financing, organization, and delivery of the U.S. health care system, including the policies and programs that shape and define our fragmented system. I earned my Ph.D. in Health Services Organization and Policy from the University of Michigan in 2006. I have published two book chapters on Health and Health Care in Retirement (Medicare).[1,2] I have also published articles in the peer-reviewed academic literature on managed care in publicly financed health insurance programs, including outcomes assessment in managed care. I live and work in Miami-Dade County, Florida, where 65% of Medicare beneficiaries are enrolled in Medicare Advantage (MA) plans, one of the highest penetrations in the country.[3]

Quality Measurement

Quality measurement in health care spans measurement of structure, process, and outcomes,[4] as well as patient experience and access.[5] Ensuring quality of the structure of health care (hospitals, health systems, etc.) is largely overseen by accrediting organizations such as the Joint Commission. Structural measures assess, for example, whether the organization uses electronic health records, the ratio of providers to patients, or the proportion of board certified physicians.[6] Measures of process in health care abound, for a number of reasons. Process metrics are relatively easy to measure, they are consistent with national guidelines, and they represent the activities clinicians control the most directly (McGlynn).[7] Process measures track whether and how many times a service was provided for a targeted population, e.g. whether an eye exam was performed on a diabetic patient.

The majority of health care quality measures used for public reporting are process measures.[8] They can be informative to consumers about the care they can expect to receive. A limitation to process measures is that they may assess whether the provider prescribed a medication therapy, but not whether the patient filled the prescription, correctly took their medication, or if their outcomes improved due to the therapy. Although process measures play an important role in

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[1]Mortensen K, Villani J. Healthcare and Health Insurance in Retirement. In Wang M, editor: Oxford Handbook of Retirement. Oxford University Press. 2012.
[2]Mortensen K, Bloodworth R, Gaeta R. Health Insurance and Healthcare in Retirement. In Krauss Whitbourne, S., editor: The Encyclopedia of Adulthood and Aging. Wiley-Blackwell. December, 2015.
[3] Jacobson G, Damico A, Neuman T, Gold M. Medicare Advantage 2017 Spotlight: Enrollment Market Update. 2017. Kaiser Family Foundation.
[4] Donabedian A. Evaluating the Quality of Medical Care. *Milbank Quarterly*. 1966;44:Suppl:166-206.
[5] Centers for Medicare & Medicaid Services. Fact Sheet- 2017 Star Ratings.
[6] Agency for Healthcare Research and Quality. Types of Quality Measures.
[7] McGlynn E, et al. The Quality of Health Care Delivered to Adults in the United States. *New England Journal of Medicine*. 2003;348:2635-45.
[8] Agency for Healthcare Research and Quality. Types of Quality Measures.

quality measurement, members of this Committee, clinicians, administrators, and other stakeholders have concerns that the focus on process in the MA quality Star Ratings should be complemented with more of a focus on outcomes. This is the topic of my testimony today.

Outcome measures reflect the results of a process, and the impact of the health care service or intervention on the health status of patients.[9] Outcome measures provide insights into the quality of care provided, but can also be influenced by factors outside of the health care system, like patient compliance, socioeconomics, or social determinants of health.

Outcomes are in the definition of quality, as defined by the National Academies of Sciences, Engineering, and Medicine. "Quality is the degree to which health services for individuals and populations increase the likelihood of desired health *outcomes* and are consistent with current professional knowledge."[10] Outcomes are the quality and cost targets that health care providers seek to improve. Outcomes are the "gold standard" in quality measurement. Outcomes include mortality, readmission rates, surgical site infection rates, patient experience, ambulatory care sensitive (preventable) utilization, etc.[11] Some outcomes are more relevant for hospitals, while others are more relevant for health plans, while some pertain to both. Outcomes assessment is critical for assessing success in the pursuit of the Triple Aim: improve the patient experience of care, improve the health of populations, and reduce the per capita cost of health care.[12]

Measurement, and specifically outcomes assessment, in health care is important. It is increasingly so as the financing of health care in our system transitions from volume-based reimbursement to value-based reimbursement. Medicare is expected to see this transition occur more rapidly than most payers.[13]

Many providers and administrators feel there is an overabundance of measures. The National Quality Metrics Clearinghouse sponsored by the Agency for Healthcare Research and Quality (AHRQ) lists a total of almost 2,000 measures across five clinical categories (structure, process, outcome, access, and patient experience), with 244 clinical quality measures related to outcomes.[14] The proliferation of quality measures and quality reporting requirements have resulted in "measurement cacophony." Parsimonious and judicious use of measures should be encouraged. Some stakeholders argue the burden of a greater number of measures for MA plans is higher than any other value-based program, so they recommend reducing the number of measures, making them clinically meaningful outcome measures, and adjusting for

[9] Agency for Healthcare Research and Quality. Types of Quality Measures.
[10] National Academies of Sciences, Engineering, and Medicine. Crossing the Quality Chasm: The IOM Health Care Quality Initiative.
[11] Tinker A. The Top 7 Outcome Measures and 3 Measurement Essentials. HealthCatalyst.
[12] Berwick D, Nolan T, Whittington J. The Triple Aim: Care, Cost, and Quality. *Health Affairs*. 2008;27(3)759-69.
[13] Burwell S. Setting Value-Based Payment Goals- HHS Efforts to Improve U.S. Health Care. *New England Journal of Medicine*. 2015;372(10)897-8.
[14] This valuable clearinghouse at qualitymeasures.ahrq.gov will sunset on July 16, 2018 due to a lack of federal funding, a true blow to quality measurement in the United States.

socioeconomic status of beneficiaries.[15] This would substantially reduce the burden on providers without sacrificing quality.

Medicare Advantage Star Ratings

The MA program in 2017 included 185 organizations offering approximately 3,300 plan options, enrolling 19 million Medicare beneficiaries (33%), an enrollment increase of 71% since the passage of the ACA in 2010.[16] Medicare reimburses these private plans on a risk-adjusted, pre-determined per person rate rather than a fee-for-service (FFS) reimbursement.

The Centers for Medicare & Medicaid Services (CMS) implemented Star Ratings reflecting quality of care in MA contracts over 10 years ago, with a 3 star system. The intent of the ratings system was to provide accurate comparative information to Medicare beneficiaries about the quality of care they can expect to receive from the private health plans. The intent of the Star Rating system is to capture information on patient experience, clinical quality, and administrative quality of the plans. The Star Ratings span five broad categories: Outcomes, Intermediate Outcomes, Patient Experience, Access, and Process.[17]

MA plans that include Part D prescription drug coverage (MA-PD) are evaluated at the contract level (not the plan level) on up to 44 unique quality and performance measures. Half of the contracts in 2017 received 4 or more stars, and two-thirds (68%) of MA enrollees are in contracts with ratings of 4 or more stars in 2017.[18]

Star Ratings reflect value beyond informing the consumer's decision-making process. Beginning in 2012, MA plans are eligible to receive bonus payments if they achieve an overall rating of 4 stars or higher on CMS's 5 star rating system. The incentives for private MA plans are significantly different than they were in the Plus Choice plans and in the period before the Affordable Care Act. Quality bonuses in 2018 will add 4% to the average plan's base benchmark, and will add 3% to plan payments. Risk adjustments for higher enrollee risk also result in higher payments to the plan.

Current Measures Used in Star Ratings

Several of the measures in the MA program are consistent with CMS' Core Quality Measures.[19] CMS reports quality of MA plans with data derived from four sources:

1) The Healthcare Effectiveness Data and Information Set (HEDIS) is a data set of process and intermediate outcome measures from National Committee for Quality Assurance (NCQA).

2) The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

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[15] Anthem Public Policy Institute. Opportunities to Strengthen the Medicare Advantage Star Ratings Program. 2017.
[16] MedPAC March 2018 Report to Congress: Medicare Payment Policy.
[17] Centers for Medicare & Medicaid Services. Fact Sheet- 2017 Star Ratings.
[18] Jacobson G, Damico A, Neuman T, Gold M. Medicare Advantage 2017 Spotlight: Enrollment Market Update. 2017. Kaiser Family Foundation.
[19] Centers for Medicare & Medicaid Services. Core Measures.

3) The Health Outcomes Survey (HOS), a CMS survey of self-reported health outcomes

4) CMS administrative data.

Data from Anthem Public Policy Institute, illustrated in the chart below, suggest that the number of process measures (16) significantly exceeds the number of outcome measures (3) and intermediate outcome measures (6).

MA Star Rating Measure Type	2017 Measure Count	Percent of Total Measures	Weighted Measure Value*	Weighted Measure Percent of Total Weight
Process	16	36%	16	20%
Access	7	16%	10.5	13%
Experience	10	23%	15	19%
Intermediate Outcome	6	14%	18	23%
Outcome	3	7%	9	11%
Improvement	2	5%	10	13%

*Note this does not reflect that new measures all receive a weight of 1 their first year no matter their type.

Chart from the Anthem Public Policy Institute, available at: https://www.antheminc.com/cs/groups/wellpoint/documents/wlp_assets/d19n/mzmw/~edisp/pw_g330429.pdf

The process measures include screenings (mammography, colorectal cancer screening), flu vaccine receipt, measures of diabetes exams, etc. Intermediate outcomes reflect factors or a short-term result that contribute to an ultimate outcome. For example, diabetes patients with a controlled A1c (intermediate outcome measure C15 in the 2018 Star Ratings)is an intermediate outcome, as controlled blood glucose levels prevent diabetes complications. The three outcome measures include self-reported maintaining or improving physical health and mental health, and Plan all-cause readmissions. Intermediate outcomes include blood sugar controlled (diabetes), blood pressure controlled, etc. (The full list of 2018 Star Ratings in on the last page for reference.)

The MA Star Ratings have come under scrutiny for not including more outcomes measures, and there is a lack of confidence that the quality ratings reflect outcomes that matter.[20] Only 20% of the quality measures focus on outcomes or intermediate outcomes.[21] Progress on outcomes measurement has been slow, as the efforts are overwhelmingly led by specialty societies, although what matters are outcomes that encompass the whole cycle of care. The "let a thousand flowers bloom" approach has each organization reinventing the wheel, tweaking existing measures, or inventing ones of their own.[22] Health insurers are at the forefront of overhauling their quality improvement strategies to incorporate outcomes-based quality measures.[23] For

[20] Goozman, M. Does Medicare Advantage Measure Up? Modern Healthcare. 2017.
[21] Anthem Public Policy Institute. Opportunities to Strengthen the Medicare Advantage Star Ratings Program. 2017.
[22] Porter M, Larsson S, Lee T. Standardizing Patient Outcomes Measurement. *New England Journal of Medicine*. 2016;374:504-6.
[23] Castellucci, M. Health Insurers among Leaders in Using Outcome Measures. Modern Healthcare. 2018.

example, Blue Cross Blue Shield of Louisiana tracks potentially avoidable emergency department visits and medication adherence.

Lack of data availability has been a key barrier to more outcomes-based measures. Data quality issues arise largely due to poor data quality in a managed care setting, where insurers are reimbursed a capitated amount per person, lessening the need for strict documentation as the care provided is capitated. This is in stark opposition to a fee-for-service environment, where providers bill for each service rendered and thus have significant documentation.

Researchers have not had access to the claims data from MA plans.[24] This has prevented more claims-based outcomes measures, and has made comparisons between FFS and MA difficult. CMS Administrator Seema Verma announced in April 2018 that researchers will now be able to access MA claims data. This is a positive step forward for health services research and outcomes measurement.

Suggested Outcome Measures

A systematic approach to assess and incorporate more outcomes measures for the MA Star Ratings is essential. There are validated outcomes measures in use by a variety of stakeholders across the country and the world.

Experts recommend using outcome measures from the International Consortium for Health Outcomes Measurement (ICHOM). ICHOM has approved or is in the final stages of approval of more than 20 sets of measures covering 45% of disease burden in the United States.[25]

CMS can look to private insurers for outcome measures. Humana, a dominant player in the MA market, already assesses "Healthy Days" in the communities they serve, using the U.S Centers for Disease Control and Prevention (CDC) population health management tool that measures health related quality of life.[26] Seniors living in "Bold Goal" communities made improvements in physical and mental health, reducing their number of unhealthy days in 2017. This measure would incorporate the impact of MA plans' upcoming foray into offering food security and other health-related need factors for their enrollees.

Ambulatory Care Sensitive Conditions (ACSCs) or Preventable Visits, either in the inpatient[27] or emergency department[28] setting, are outcome measures that assess access to care in a community. ACSCs are conditions for which timely and effective outpatient care can help reduce

[24] Brennan N, Ornstein C, Frakt A. Time to Release Medicare Advantage Claims Data. *JAMA*. 2018;319(10):975-6.
[25] Porter M, Larsson S, Lee T. Standardizing Patient Outcomes Measurement. *New England Journal of Medicine*. 2016;374:504-6.
[26] Humana. Humana Releases its 2018 Bold Goal Progress Report.
[27] Hu T, Mortensen K. Mandatory Statewide Medicaid Managed Care in Florida and Hospitalizations for Ambulatory Care Sensitive Conditions. *Health Services Research*. 2018:53(1):293-311.
[28] Hu T, Mortensen K, Chen J. Medicaid Managed Care in Florida and Racial and Ethnic Disparities in Preventable Emergency Department Visits. *Medical Care*. 2018. In press.

the risks of hospitalization.[29] These are assessed readily with tools available by the Agency for Healthcare Research and Quality using their Prevention Quality Indicators (PQI) tool (qualityindicators.ahrq.gov). These are often measured using county population in the denominator, making this a meaningful measure relative to a beneficiary's geographic location. The release of MA claims data facilitates these types of outcome measures.

MedPAC members have expressed desire to see more Patient Reported Outcomes (PROs) or Patient Reported Outcome Measures (PROMs). CMS PROs are already incorporated into the new Merit-based Incentive Payment System (MIPS).

The Institute for Healthcare Improvement (IHI) has a variety of outcomes they recommend to measure population health and the Triple Aim. [30] These include Years of Potential Life Lost (YPLL), mortality amenable to health care, and Health Risk Assessment (HRA) scores. HRAs measure "How's your health?" A survey assesses "When you think about your health care, how much do you agree or disagree with this statement: I receive exactly what I want and need exactly when and how I want and need it?" A measure assessing likelihood to recommend the MA plan reflects patient experience of care. An experience of care outcome is average A1c level for population of patients with diabetes. A potential outcome reflecting access is number of days until 3rd next available appointment.[31]

An outcome that could spur interoperability (in an environment where about 75% of medical communications are conducted via fax)[32] would be to require laboratory results to be attached to the claim where appropriate, for accurate tracking of chronic illness.

Issues and Caveats

There has been an alarming trend in contract consolidations, where contracts performing below bonus star levels have consolidated with contracts achieving 4 or more stars for the purpose of obtaining bonus payments. Higher performing contracts absorbed 1.4 million enrollees by the end of 2017, triggering the scrutiny of MedPAC. Over 20% of MA enrollees have been absorbed into higher performing contracts since 2013, resulting in bonus payments that would not have been received in absence of the consolidation. This results in higher payments to these contracts than warranted, fostering inequity between FFS and MA. From a Star Rating perspective, this means a large number of enrollees are in contracts that appear to be high quality, but in reality are not. These contract consolidations occur across state lines.

MedPAC's issues with MA consolidations appear to be addressed in the Bipartisan Budget Act of 2018 (effective 2019), but should still be monitored. CMS' proposed new rules that will

[29] Billings J, et al. Impact of Socioeconomic Status on Hospital Use in New York City. *Health Affairs*. 1993;12(1)162-73.
[30] Stiefel M, Nolan K. A Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost. Institute for Healthcare Improvement. 2012.
[31] Institute for Healthcare Improvement. How to Improve: Science of Improvement: Establishing Measures.
[32] Kliff S. The Fax of Life: Why American Medicine Still Runs on Fax Machines. 2018. Vox.com

calculate a weighted average of Star Ratings across contracts that have been consolidated to more accurately reflect quality, and mitigate quality bonus payments that are not warranted.

Star Ratings are assessed at the contract level. Reporting measures at the contract level is not as informative as plan-level data. Several stakeholders have recommended reporting at the plan level when possible, and at the contract level when plan-level data are not complete (i.e. for plans with lower enrollment). There are numerous plans in any given contract, so plan-level data on quality are more meaningful than contract-level data. [33] MedPAC continues to urge Congress to use the geographic unit for quality reporting- the local health care market area.

There are procedural improvements that could be addressed in the Star Quality ranking process. Most quality incentive programs in Medicare announce and implement changes after a formal rule-making process with a 60-day comment period. Stakeholders have requested CMS provide a full comment period to weigh in on program changes such as new measures or score calculation methodology. Similarly, the Star Ratings is the only program whose measure set is not finalized before the data are collected. Stakeholders have concerns regarding the calculation of thresholds for the Star Rating cut off points. The cut points (threshold values to use to assign Star Ratings for individual measures) are determined annually, and after the data have been collected, rather than before the measurement period.[34] This results in an unclear, moving target for MA contracts.

Categorical Adjustment Index (CAI) adjustments were integrated to adjust for socioeconomic status of enrollees, but the adjustment has minimal impacts on Star Ratings (4% of MA plans had their star rating increased due to CAI in 2016).[35] Plans serving high need enrollees with low incomes, chronic illness, or disabilities show significantly lower performance on Star Ratings metrics.[36]

Recent adjustments in MA are allowing for more services related to health-related social needs. These services addressing major issues such as food insecurity and loneliness provide additional benefits likely to improve population health. This warrants broader outcomes measures to capture the effects of these investments, along the lines of CMS' Accountable Health Communities (AHCs). AHCs have measures to assess these outcomes. However, these benefits come with drawbacks, as advocates for choice and equity in Medicare have voiced concerns that these additional benefits, not available via FFS Medicare, bridge a divide in the access to services in the Medicare program.

Continuous quality improvement and innovating measurement to capture these improvements in individual and population health outcomes are essential for optimal health care. Stakeholders

[33] Johnson G, Lyon Z, Frakt A. Provider-Offered Medicare Advantage Plans: Recent Growth and Care Quality. *Health Affairs*. 2017;36(3):539-47.
[34] Anthem Public Policy Institute. Opportunities to Strengthen the Medicare Advantage Star Ratings Program. 2017.
[35] Teigland C, Donnelly P. The 2017 Medicare Star Ratings: How to Translate New CMS Data Into Future Successes. 2016.
[36] Teigland C, Donnelly P. The 2017 Medicare Star Ratings: How to Translate New CMS Data Into Future Successes. 2016.

including myself appreciate the Ways and Means Subcommittee on Health's attention to this critical matter.

Thank you.

2018 Part C & D Star Ratings Measures					
2018 ID	2017 ID	Measure	Primary Data Source	Improvement Measure	Weight
C01	C01	Breast Cancer Screening	HEDIS	Yes	1
C02	C02	Colorectal Cancer Screening	HEDIS	Yes	1
C03	C03	Annual Flu Vaccine	CAHPS	Yes	1
C04	C04	Improving or Maintaining Physical Health	HOS	No	3
C05	C05	Improving or Maintaining Mental Health	HOS	No	3
C06	C06	Monitoring Physical Activity	HEDIS / HOS	Yes	1
C07	C07	Adult BMI Assessment	HEDIS	Yes	1
C08	C08	Special Needs Plan (SNP) Care Management	Part C Plan Reporting	Yes	1
C09	C09	Care for Older Adults – Medication Review	HEDIS	Yes	1
C10	C10	Care for Older Adults – Functional Status Assessment	HEDIS	Yes	1
C11	C11	Care for Older Adults – Pain Assessment	HEDIS	Yes	1
C12	C12	Osteoporosis Management in Women who had a Fracture	HEDIS	Yes	1
C13	C13	Diabetes Care – Eye Exam	HEDIS	Yes	1
C14	C14	Diabetes Care – Kidney Disease Monitoring	HEDIS	Yes	1
C15	C15	Diabetes Care – Blood Sugar Controlled	HEDIS	Yes	3
C16	C16	Controlling Blood Pressure	HEDIS	Yes	3
C17	C17	Rheumatoid Arthritis Management	HEDIS	Yes	1
C18	C18	Reducing the Risk of Falling	HEDIS / HOS	Yes	1
C19	DMC22	Improving Bladder Control	HEDIS / HOS	No	1
C20	DMC23	Medication Reconciliation Post-Discharge	HEDIS	No	1
C21	C19	Plan All-Cause Readmissions	HEDIS	Yes	3
C22	C20	Getting Needed Care	CAHPS	Yes	1.5
C23	C21	Getting Appointments and Care Quickly	CAHPS	No	1.5
C24	C22	Customer Service	CAHPS	No	1.5
C25	C23	Rating of Health Care Quality	CAHPS	Yes	1.5
C26	C24	Rating of Health Plan	CAHPS	Yes	1.5
C27	C25	Care Coordination	CAHPS	No	1.5
C28	C26	Complaints about the Health Plan	Complaints Tracking Module (CTM)	Yes	1.5
C29	C27	Members Choosing to Leave the Plan	MBDSS	Yes	1.5
C30	C28	Beneficiary Access and Performance Problems	Compliance Activity Module (CAM)	No	1.5
C31	C29	Health Plan Quality Improvement	Star Ratings	No	5
C32	C30	Plan Makes Timely Decisions about Appeals	Independent Review Entity (IRE)	Yes	1.5
C33	C31	Reviewing Appeals Decisions	Independent Review Entity (IRE)	Yes	1.5
C34	C32	Call Center – Foreign Language Interpreter and TTY Availability	Call Center	Yes	1.5
D01	D01	Call Center – Foreign Language Interpreter and TTY Availability	Call Center	Yes	1.5
D02	D02	Appeals Auto–Forward	Independent Review Entity (IRE)	Yes	1.5
D03	D03	Appeals Upheld	Independent Review Entity (IRE)	Yes	1.5
D04	D04	Complaints about the Drug Plan	Complaints Tracking Module (CTM)	Yes	1.5
D05	D05	Members Choosing to Leave the Plan	MBDSS	Yes	1.5
D06	D06	Beneficiary Access and Performance Problems	Compliance Activity Module (CAM)	No	1.5
D07	D07	Drug Plan Quality Improvement	Star Ratings	No	5
D08	D08	Rating of Drug Plan	CAHPS	Yes	1.5
D09	D09	Getting Needed Prescription Drugs	CAHPS	Yes	1.5
D10	D10	MPF Price Accuracy	PDE data, MPF Pricing Files	No	1
D11	D12	Medication Adherence for Diabetes Medications	Prescription Drug Event (PDE) data	Yes	3*
D12	D13	Medication Adherence for Hypertension (RAS antagonists)	Prescription Drug Event (PDE) data	Yes	3*
D13	D14	Medication Adherence for Cholesterol (Statins)	Prescription Drug Event (PDE) data	Yes	3*
D14	D15	MTM Program Completion Rate for CMR	Part D Plan Reporting	Yes	1

* Note: for contracts whose service area only covers Puerto Rico, the weights for these measures will be zero in the summary and overall rating calculations and remain three for the improvement measure calculations.