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MEDICARE ADVANTAGE

Quality Bonus Payment Demonstration Has Design Flaws and Raises Legal Concerns

Statement of

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Chairman Issa, Ranking Member Cummings, and Members of the Committee:

We appreciate the opportunity to participate in today's hearing on the Medicare Advantage (MA) Quality Bonus Payment Demonstration, which the Centers for Medicare & Medicaid Services (CMS) initiated rather than implementing the MA quality bonus payment program established in the Patient Protection and Affordable Care Act (PPACA).[1] Our testimony today discusses our March 2012 review of the 3-year demonstration's cost and design, as well as our July 2012 letter to the Secretary of Health and Human Services (HHS) regarding the agency's authority to conduct the demonstration.[2] Our March 2012 report concluded that the demonstration, with an estimated cost of over $8 billion over 10 years, is unlikely to produce meaningful results. It recommended that the Secretary of HHS cancel the demonstration and allow the MA quality bonus payment system established by PPACA to take effect. That review also gave rise to concerns about the agency's authority to conduct the demonstration under the Social Security Amendments of 1967.[3] In our July 2012 letter, we noted that the statute provides broad authority, but found that the agency has not established that the demonstration meets the criteria set forth in that statute.

Background

The 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 CMS. About a quarter of all Medicare beneficiaries are enrolled in an MA

[1]Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 3201-02, 124 Stat. 119, 442, 454 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1102, 124 Stat. 1029, 1040 (Mar. 30, 2010) (hereafter, "PPACA").

[2]*See* GAO, *Medicare Advantage: Quality Bonus Payment Demonstration Undermined by High Estimated Costs and Design Shortcomings,* GAO-12-409R (Washington, D.C.: Mar. 21, 2012) and *Medicare Advantage Quality Bonus Payment Demonstration*, B-323170, July 11, 2012.

[3]CMS conducted the MA Quality Bonus Payment Demonstration under section 402(a)(1)(A) of the Social Security Amendments of 1967, as amended. Pub. L. No. 90-248, § 402, 81 Stat. 821, 930-31 (Jan. 2, 1968), as amended by the Social Security Amendments of 1972, Pub. L. No. 92-603, § 222, 86 Stat. 1329, 1390-93 (Oct. 30, 1972) (both codified at 42 U.S.C. § 1395b-1) (hereafter, "section 402").

plan. MA plans may offer additional benefits not provided under Medicare FFS, such as reduced cost sharing or vision and dental coverage.

Effective January 1, 2012, PPACA requires CMS to provide quality bonus payments to MA plans that achieve 4, 4.5, or 5 stars on a 5-star quality rating system developed by CMS. In November 2010, CMS announced that it would waive the PPACA quality bonus provisions and instead determine quality bonus payments for 2012 through 2014 under a demonstration in which all MA plans would participate unless they affirmatively opt out. Compared with the quality bonus program established by PPACA, the demonstration provides larger bonuses earlier to more plans. Specifically, it extends quality bonuses to plans with 3 or more stars, accelerates the phase-in of the bonuses for plans with 4 or more stars, increases the size of the bonuses for plans with 4 or more stars in 2012 and 2013, and applies the quality bonus percentage to a plan's entire benchmark during the phase-in of PPACA's new MA plan payment methodology.[4] In announcing the demonstration, CMS stated that the demonstration's research goal 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. Under PPACA, about one-third of MA enrollees would be covered by MA contracts eligible for a bonus in 2012 and 2013. In contrast, under the demonstration, about 90 percent of enrollees will be covered by MA contracts eligible for a bonus in those 2 years. The demonstration ends on December 31, 2014, at which time CMS is expected to implement the quality bonus payment program that PPACA authorized.

[4]The "benchmark" is used to determine the maximum amount to pay an MA plan.

Table 1. Comparison of PPACA Quality Bonus Payment Percentages to Demonstration Quality Bonus Payment Percentages

	MA Quality Bonus Payments					
	PPACA			Demonstration		
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

Source: GAO analysis.

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

Section 402 of the Social Security Amendments of 1967, as amended, provides the Secretary of HHS with broad authority to undertake demonstration projects to test new Medicare payment methodologies.[5] Specifically, it authorizes the Secretary to conduct demonstration projects to determine whether changes in payment methods would increase the efficiency and economy of Medicare services through the creation of additional incentives, without adversely affecting quality. Accordingly, a demonstration under section 402 includes (1) changes in payment methods that create additional incentives toward increasing the efficiency and economy of Medicare services and (2) a determination of whether the changes in payment methods actually increase the efficiency and economy of such services. While a demonstration need not in fact result in increased efficiency and economy, it must meet these criteria.

[5]Section 402(a)(1)(A) authorizes the Secretary to develop and engage in experiments and demonstration projects "to determine whether, and if so which, changes in methods of payment or reimbursement for health care and services under health programs established by the Social Security Act … would have the effect of increasing the efficiency and economy of health services under such programs through the creation of additional incentives to these ends without adversely affecting the quality of such services." 42 U.S.C. § 1395b-1(a)(1)(A). Relatedly, section 402(b) authorizes the Secretary to waive Medicare payment requirements to carry out such demonstrations. 42 U.S.C. § 1395b-1(b).

MA Demonstration Characterized by High Estimated Costs and Large Scope

Our March 2012 review found that the CMS Office of the Actuary's (OACT) estimated cost of the demonstration exceeds $8 billion over 10 years. About $5.34 billion of this 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 benchmarks during the phase-in of PPACA's new payment methodology, and (4) allowing plans' benchmarks to exceed their pre-PPACA levels. Most of the remaining projected demonstration spending stems from higher MA enrollment because the bonuses enable MA plans to offer beneficiaries more benefits or lower premiums. Taken together, the expanded bonuses and higher enrollment mainly benefit average-performing plans—those receiving 3 and 3.5-star ratings. Also, while a reduction in MA payments was projected to occur as a result of PPACA's payment reforms, OACT estimated that the demonstration would offset more than one-third of these payment reductions projected for 2012 through 2014.

In addition, the 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.[6] Specifically, our review of CMS and Office of Management and Budget 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 these demonstrations. Moreover, 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 to participate.[7]

[6]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.

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

MA Demonstration Is Unlikely to Achieve Its Research Goal as Designed and Raises Legal Concerns

Our March 2012 report identified several shortcomings of the demonstration's design that preclude 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. Subsequently, in our July 2012 letter, we raised concerns about whether the demonstration meets the requirements of section 402 and, therefore, falls within the agency's authority.

Notably, the bonus payments are based largely on plan performance that predates the demonstration. 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. Therefore, we are concerned about the demonstration's ability to provide additional incentives to increase the efficiency and economy of Medicare services. In response to our inquiries on this issue, CMS acknowledged that payments in 2012 and 2013 reward plans for their past performance, but asserted that these payment changes are consistent with the requirements of section 402.

In addition, our March 2012 report found that the demonstration's design is inconsistent with CMS's stated research goal. First, the demonstration's bonus percentages are not continuously scaled. For example, in 2014, plans with 4, 4.5, and 5 stars will all receive the same bonus percentage. Second, the demonstration's bonus percentages in 2014 do not offer all plans better incentives than PPACA to achieve higher star ratings. In 2014, most plans improving from 3.5 to 4 stars would receive a larger increase in their bonus payment under PPACA. These features also call into question whether the demonstration includes additional incentives to increase the efficiency and economy of Medicare services. Notably, for highly-rated plans, CMS chose to revise the payment methodology for years in which the changes are unlikely to have any impact on plan quality, while making no changes from PPACA for the year in which changes could induce improved quality.

Furthermore, characteristics of the demonstration raise concerns about the agency's ability to determine whether the payment changes result in increased efficiency and economy, one of the criterion specified in the law. A determination of whether a change in payment methodology results in an increase in efficiency and economy involves a comparison of the effect of the payment methodology adopted under the demonstration

to the effect of the payment methods in place under current law. CMS will evaluate the impact of the demonstration using MA plans' 2012 and 2013 star ratings and what would have occurred under PPACA using their 2014 star ratings. However, because of the timing of data collection for plan star ratings, this evaluation approach appears far more likely to enable CMS to compare plan performance under the demonstration to plan performance under the law in effect prior to PPACA—not under current law. Moreover, because the demonstration lacks a direct comparison group, it may not be possible to isolate its effects, and any changes in quality observed could be attributable, at least in part, to other MA payment and policy modifications.

In closing, given the findings from our program review and legal analysis of the demonstration's characteristics, our recommendation to cancel the demonstration and allow the MA quality bonus payment system established by PPACA to take effect remains valid.

Chairman Issa, Ranking Member Cummings, and Members of the Committee, this completes our prepared statement. We would be happy to respond to any questions.

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James Cosgrove, PhD, is a Director in the Heath Care team at the U.S. Government Accountability Office (GAO). Mr. Cosgrove is responsible for GAO studies of health care financing and Medicare payment issues. In recent years, he has directed studies on a variety of Medicare payment reform and policy topics, including Medicare managed care, risk adjusted payments for health plans, physician fees, beneficiary access to physician services, bundling of health care services, home oxygen payment rates, the cost of implantable medical devices, and issues related to payments for the treatment of end-stage renal disease. Prior to joining GAO in 1989, Mr. Cosgrove taught economics at Marquette University. Mr. Cosgrove holds a PhD degree in economics from Boston College and a BA in economics and history from the University of Rhode Island.

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