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Challenges for Quality Measures on Seriously Ill Patients:

The Example of Medicare Advantage Plans' Performance

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Purpose

- Identify challenges in creating quality measures relevant to sub-populations
- Offer examples from Medicare Advantage
  - Patients' Switching out of MA Plans
  - Plan Members use lower Quality Providers
  - MA Plan Quality related to High Need Patient Outcomes
- A Modest Proposition to weight high need patients' outcomes more

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Challenges Creating Quality Measures for Sub-Populations

- Minimum Sample Size needed
- Clinically meaningful groups mean even smaller sample sizes
- Meaningful measures differ for high need
- Differences in preferences affect interpretation
- Patients' Choice and Switching Providers and Plans
- Accountability spans provider measures

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Medicare Advantage Plan Ratings

- 5 Star Plan rating is a composite of over 40 different parameters and types of quality measures from CAHPS to single chronic disease management;
- “Disenrollment rate” is 1 of many performance measures in MA Five-Star Composite
- Disenrollment alone has small effect on Star rating”. GAO Report 17-393.

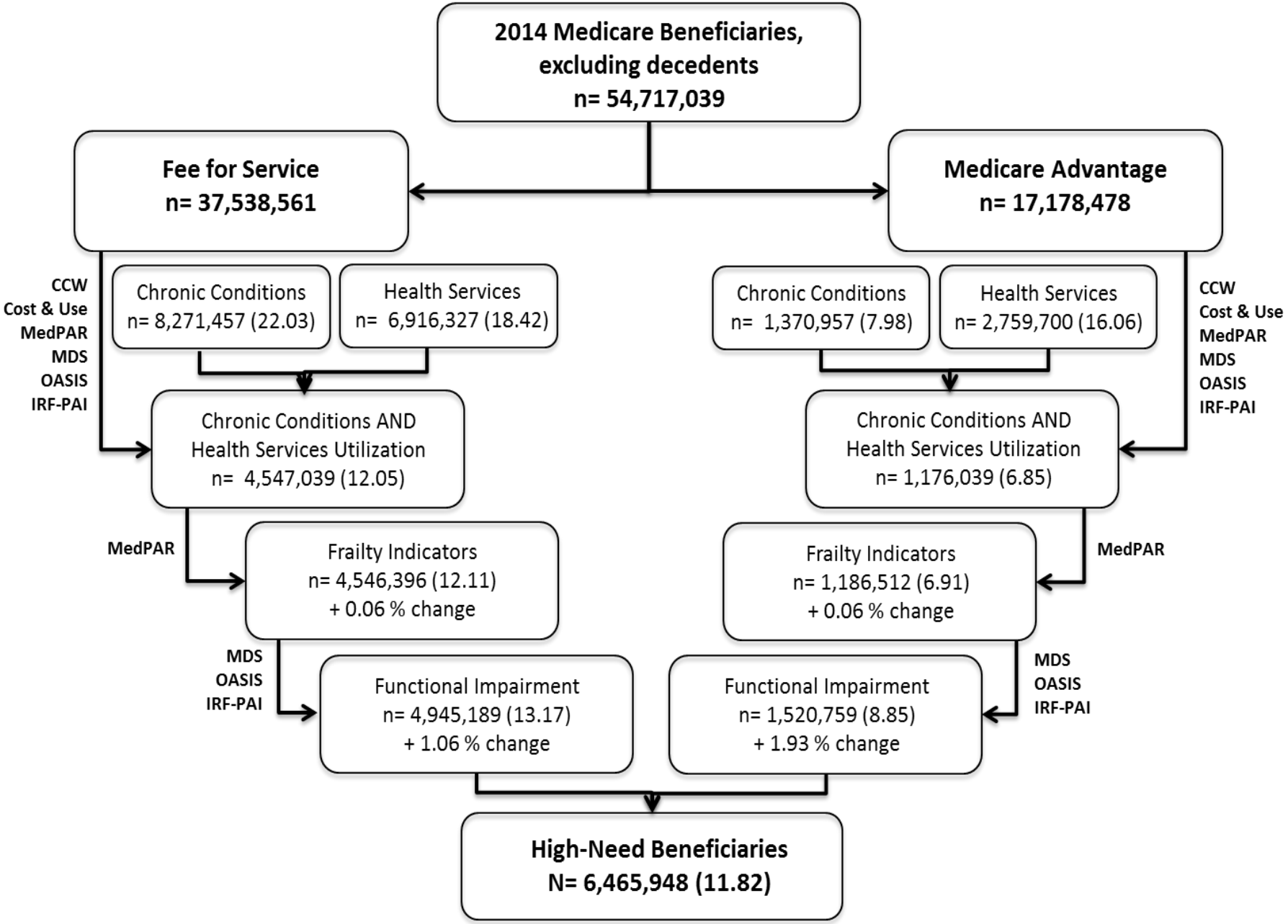
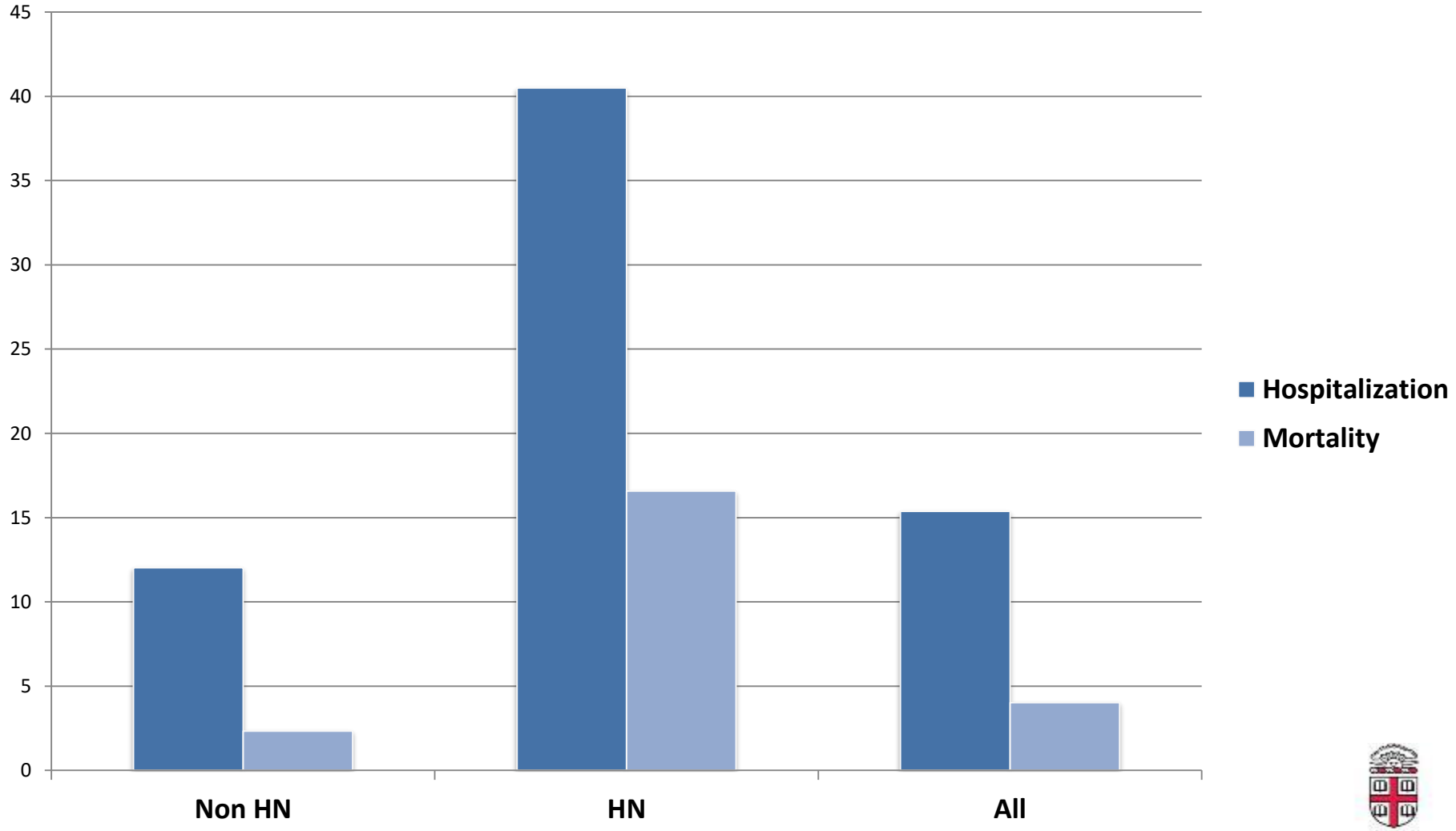


Figure 1: Stepwise Identification of High-Need Medicare Beneficiaries

Percentage of Medicare Beneficiaries Hospitalized / Deceased in 2015 by 2014 High Need Status



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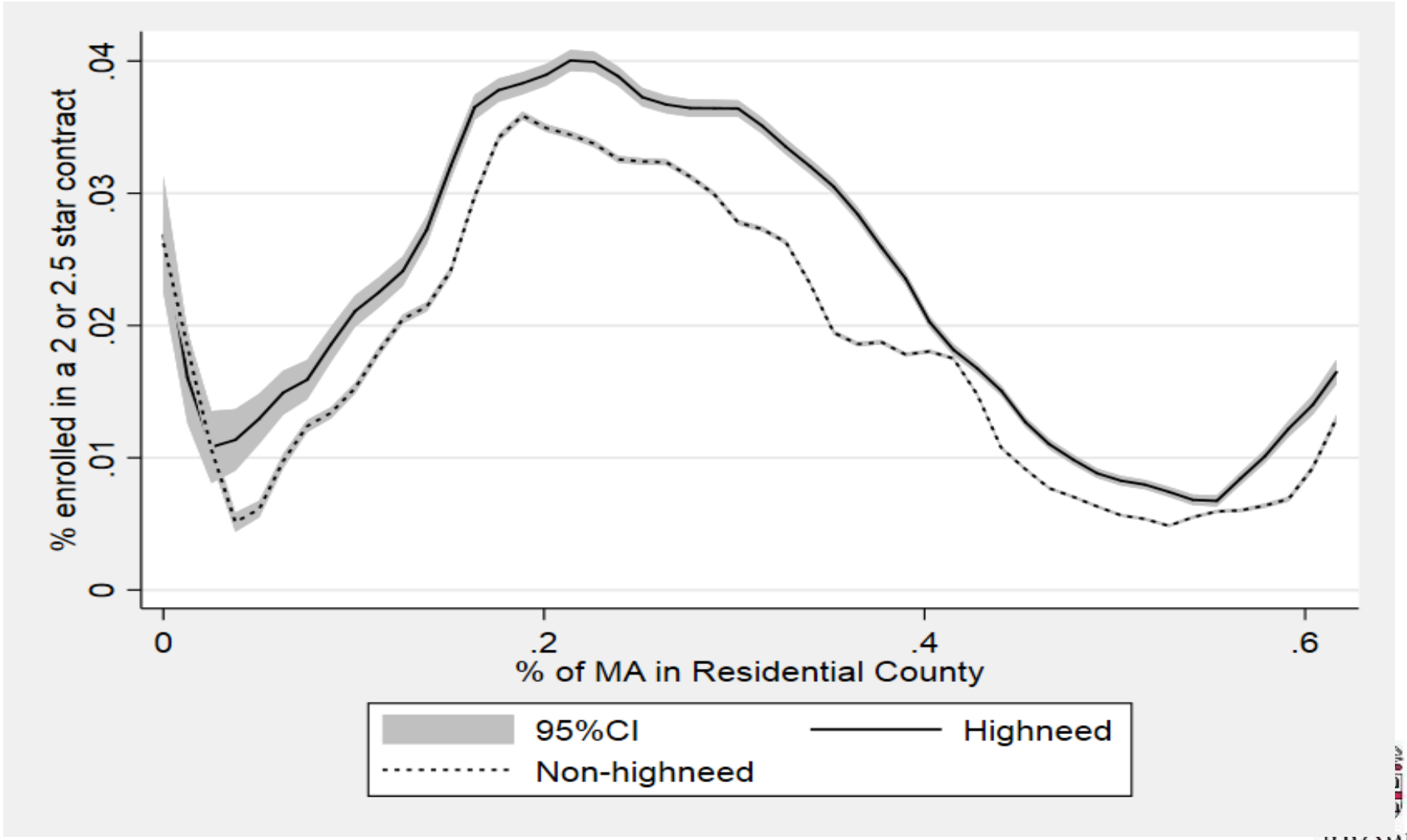
Percentage of High Need and Non-High Need Patients enrolled in low quality Medicare Advantage plans.



By Momotazur Rahman, Laura Keohane, Amal N. Trivedi, and Vincent Mor

High-Cost Patients Had Substantial Rates Of Leaving Medicare Advantage And Joining Traditional Medicare

DOI: 10.1377/hlthaff.2015.0272
HEALTH AFFAIRS 34,
NO. 10 (2015): 1675–1681

ABSTRACT **Medicare Advantage payment regulations include risk-adjusted capitated reimbursement, which was implemented to discourage favorable risk selection and encourage the retention of members who incur high costs. However, the extent to which risk-adjusted capitation has succeeded is not clear, especially for members using high-cost services not previously considered in assessments of risk selection. We examined the rates at which participants who used three high-cost services switched between Medicare Advantage and traditional Medicare. We found that the switching rate from 2010 to 2011 away from Medicare Advantage and to traditional Medicare exceeded the switching rate in the opposite direction for participants who used long-term nursing home care (17 percent versus 3 percent), short-term nursing home care (9 percent versus 4 percent), and home health care (8 percent versus 3 percent). These results were magnified among people who were enrolled in both Medicare and Medicaid. Our findings raise questions about the role of Medicare Advantage plans in serving high-cost patients with complex care needs, who account for a disproportionately high amount of total health care spending.**

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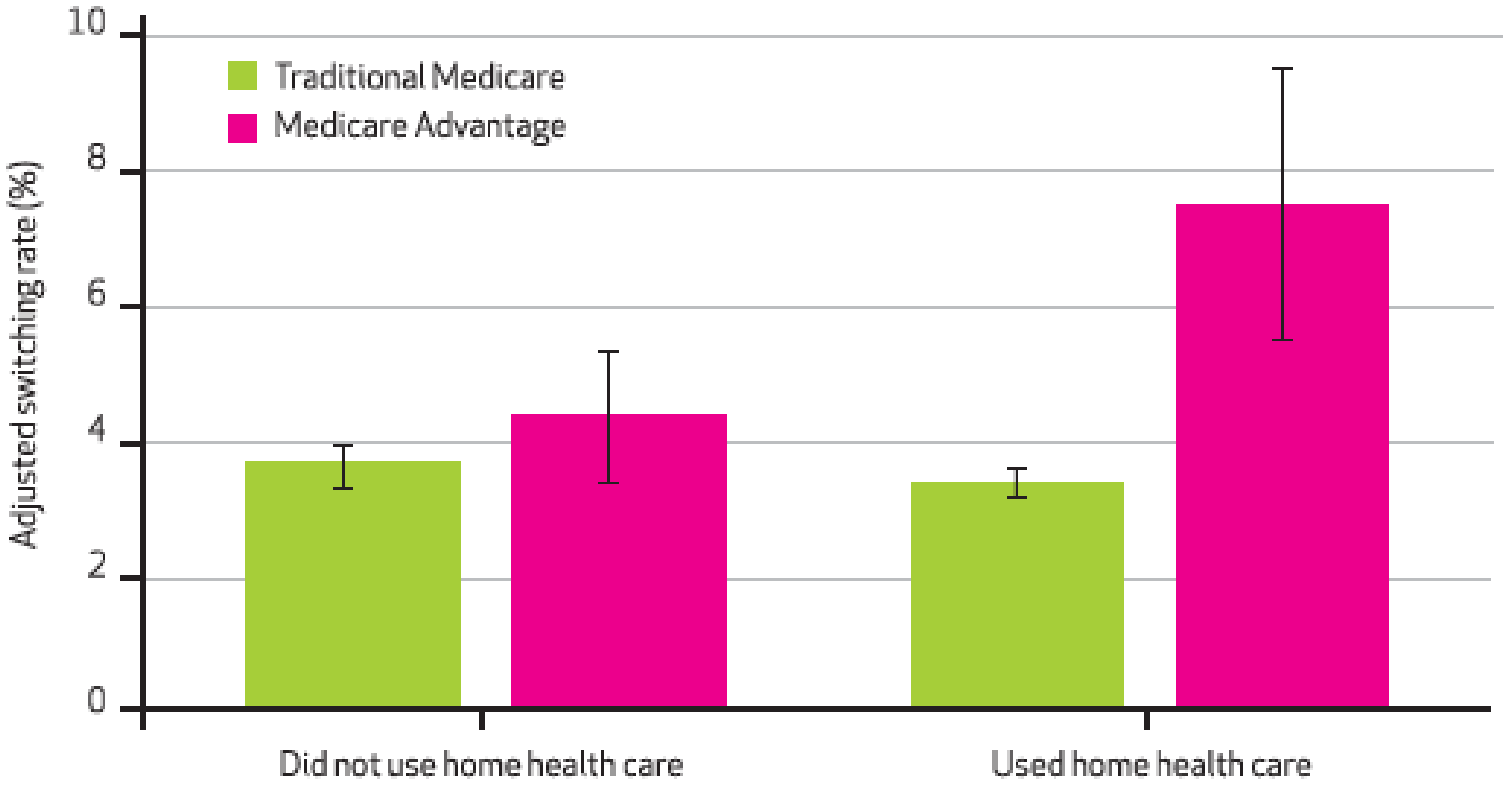
Amal N. Trivedi is an associate professor in the Department of Health Services, Policy, and Practice, School of Public Health, and in the Department of Medicine, both at Brown University. He also is a core investigator in the Center of Innovation in Long Term Services and Supports at the Providence Veterans Affairs Medical Center, in Rhode Island.

EXHIBIT 2

Beneficiaries' Adjusted Rates Of Switching In 2011 Between Medicare Advantage And Traditional Medicare, By Use Of Home Health Care In 2010



SOURCE Authors' analysis of data from the Medicare enrollment files, Minimum Data Set, Outcome and Assessment Information Set, Healthcare Effectiveness Data and Information Set, and Medicare claims. **NOTE** Rates and 95% confidence intervals (represented by the whiskers) were estimated using an ordinary least squares regression of switching onto age, sex, race, other types of care use, and state fixed effects.

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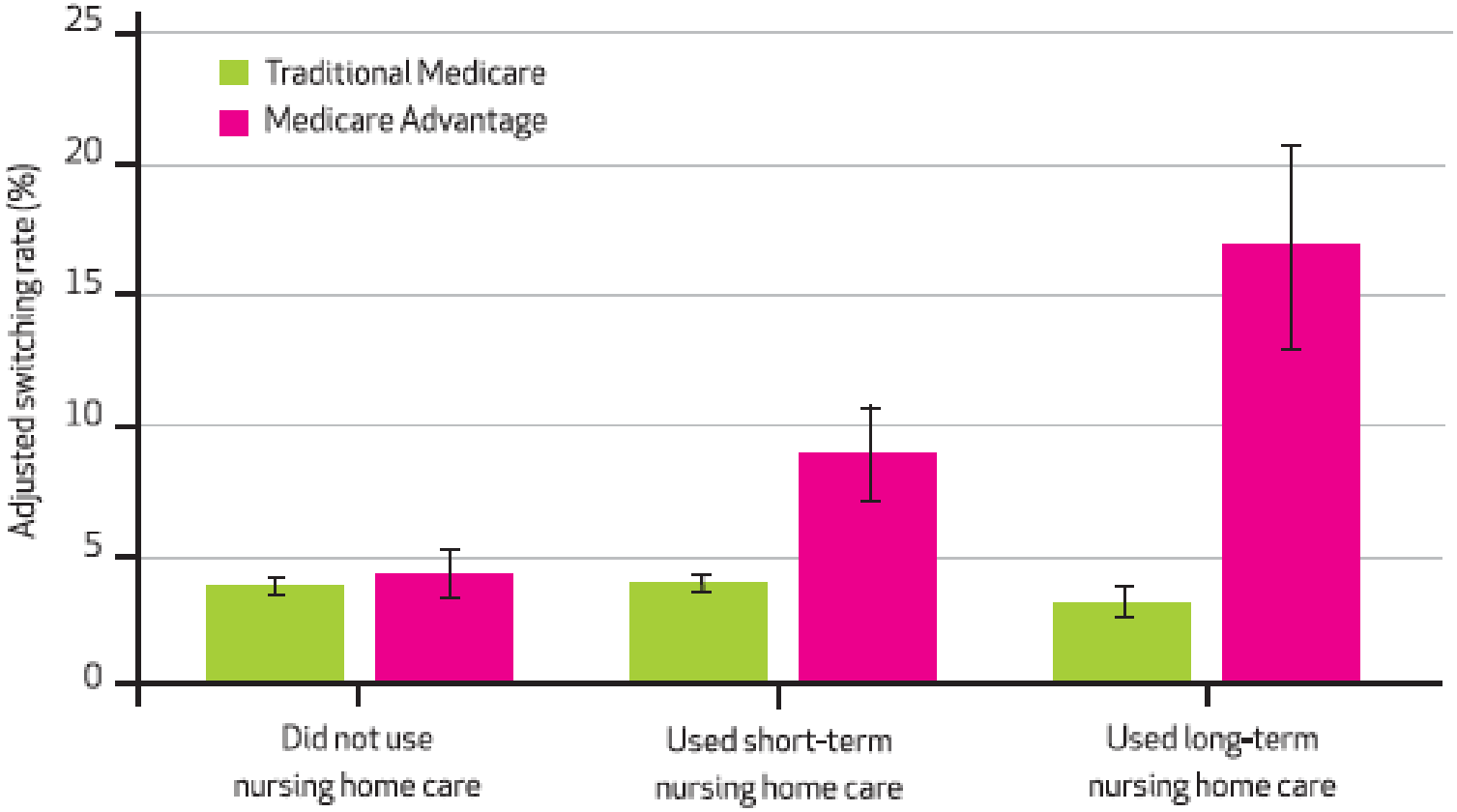
Beneficiaries' Adjusted Rates Of Switching In 2011 Between Medicare Advantage And Traditional Medicare, By Use Of Nursing Home Care In 2010



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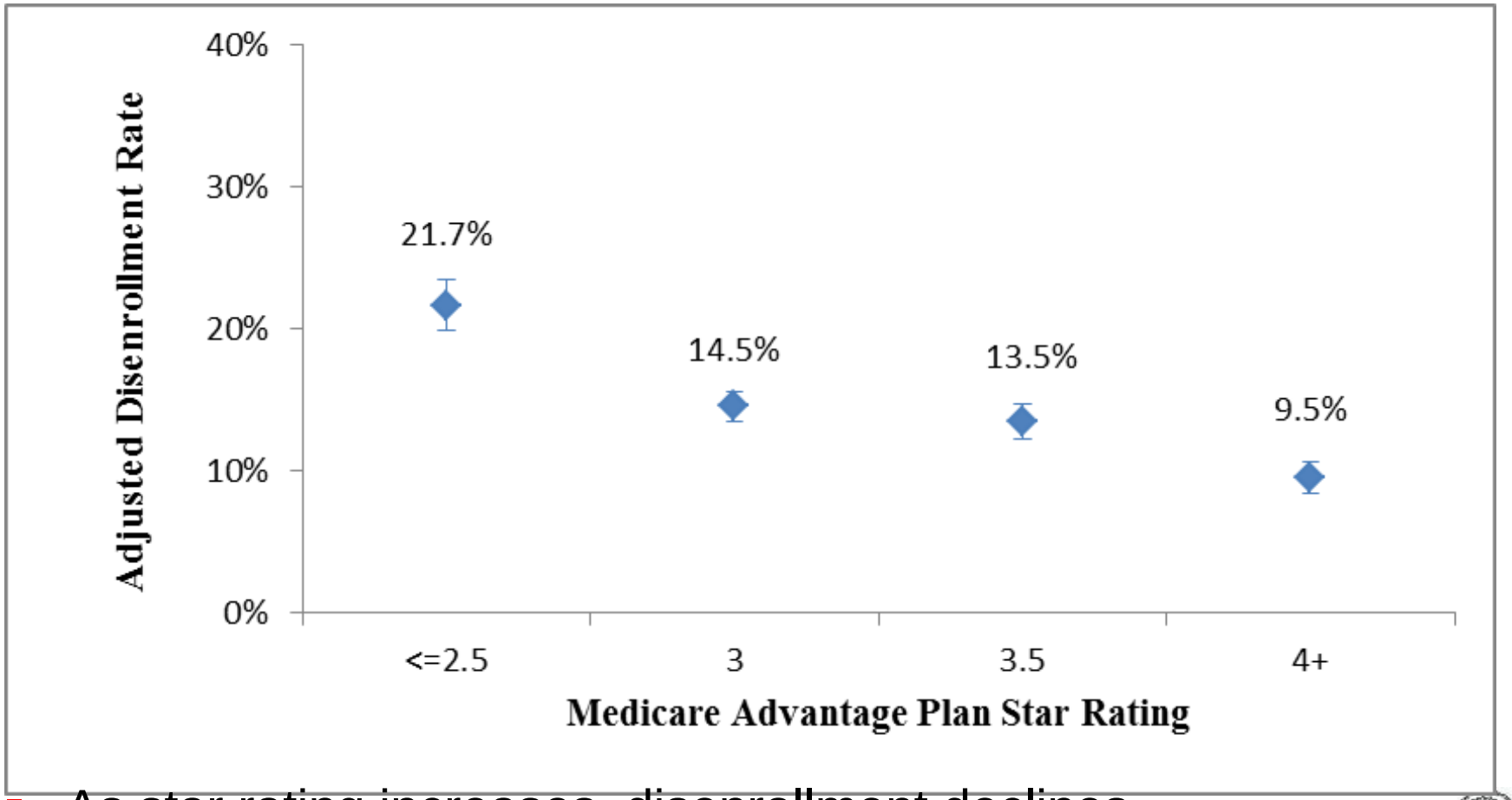
Adjusted Disenrollment Rates of New End-stage Renal Disease Patients by MA Plan Star Rating



- As star rating increases, disenrollment declines.

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High Need Patients Disenroll more frequently from MA

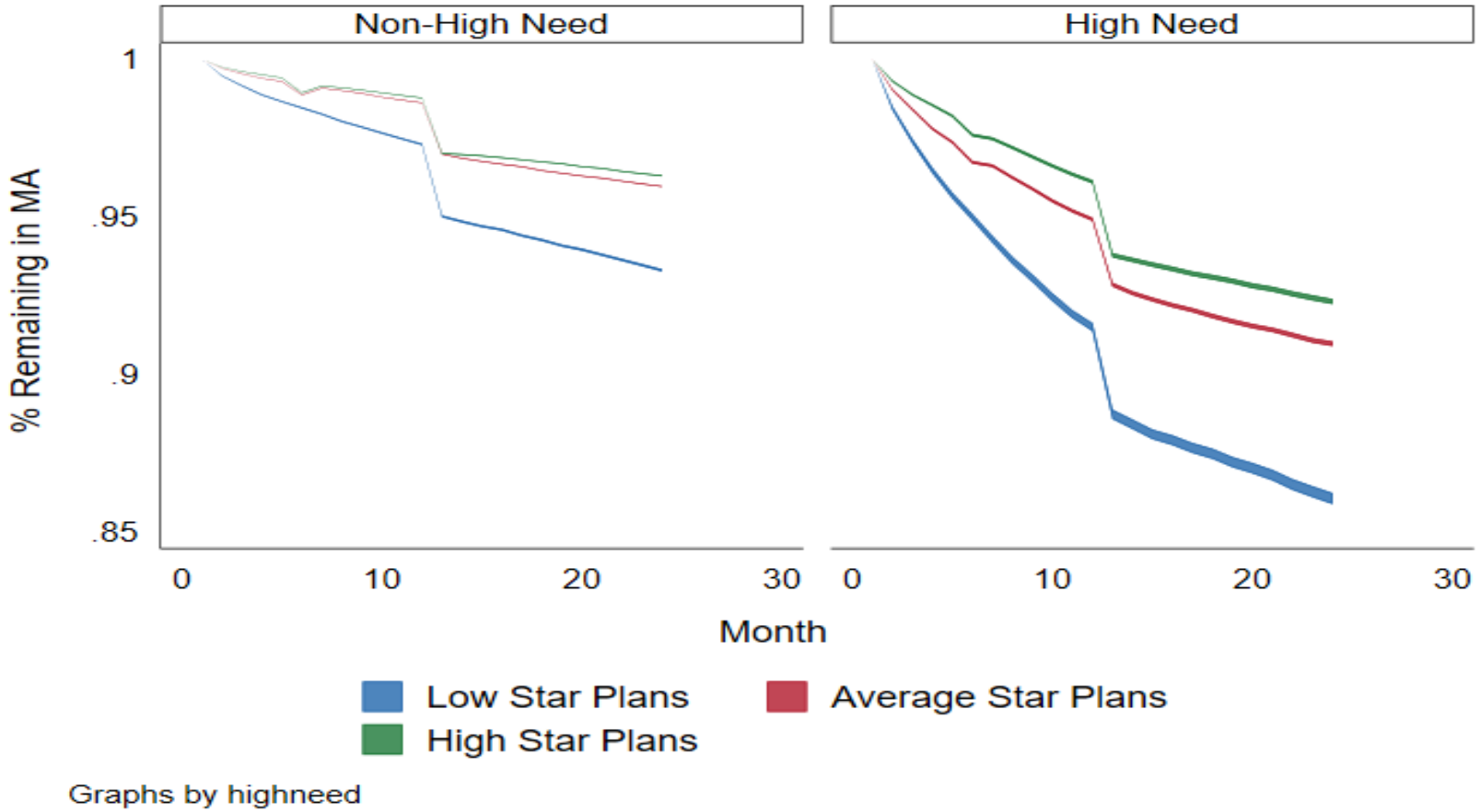
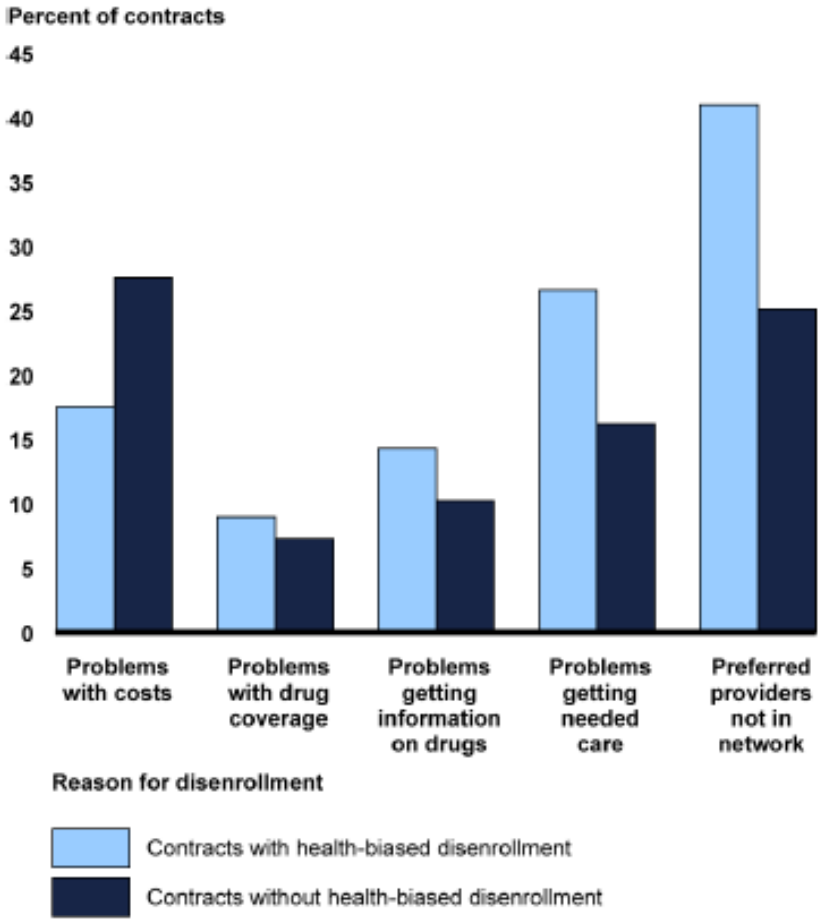


Figure 3: Disenrollment Reasons Survey Responses for the 126 Medicare Advantage Contracts with Relatively High Disenrollment Rates, 2014



Source: GAO review of Centers for Medicare & Medicaid Services's Disenrollment Reasons Survey reports. | GAO-17-393

Notes: This analysis includes the 126 contracts with 2014 disenrollment rates above the median rate of 10.6 percent among contracts in our study. We calculated odds ratios for each contract to determine the likelihood that beneficiaries in poor health had of disenrolling relative to those in better health. We used CMS data to identify beneficiaries in relatively poor health—those with projected spending at least twice as much as that for the average Medicare beneficiary. Contracts with odds ratios over 1.25 were designated as having health-biased disenrollment and contracts with odds ratios of 1.25 or less were considered to be without health-biased disenrollment.

Survey response rates varied by contract, and beneficiaries were able to select more than one reason for disenrolling from their contract. Reasons are composites of individual questions created by CMS. We analyzed those responses that CMS determined were reliable.

By David J. Meyers, Vincent Mor, and Momotazur Rahman

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Medicare Advantage Enrollees More Likely To Enter Lower-Quality Nursing Homes Compared To Fee-For-Service Enrollees

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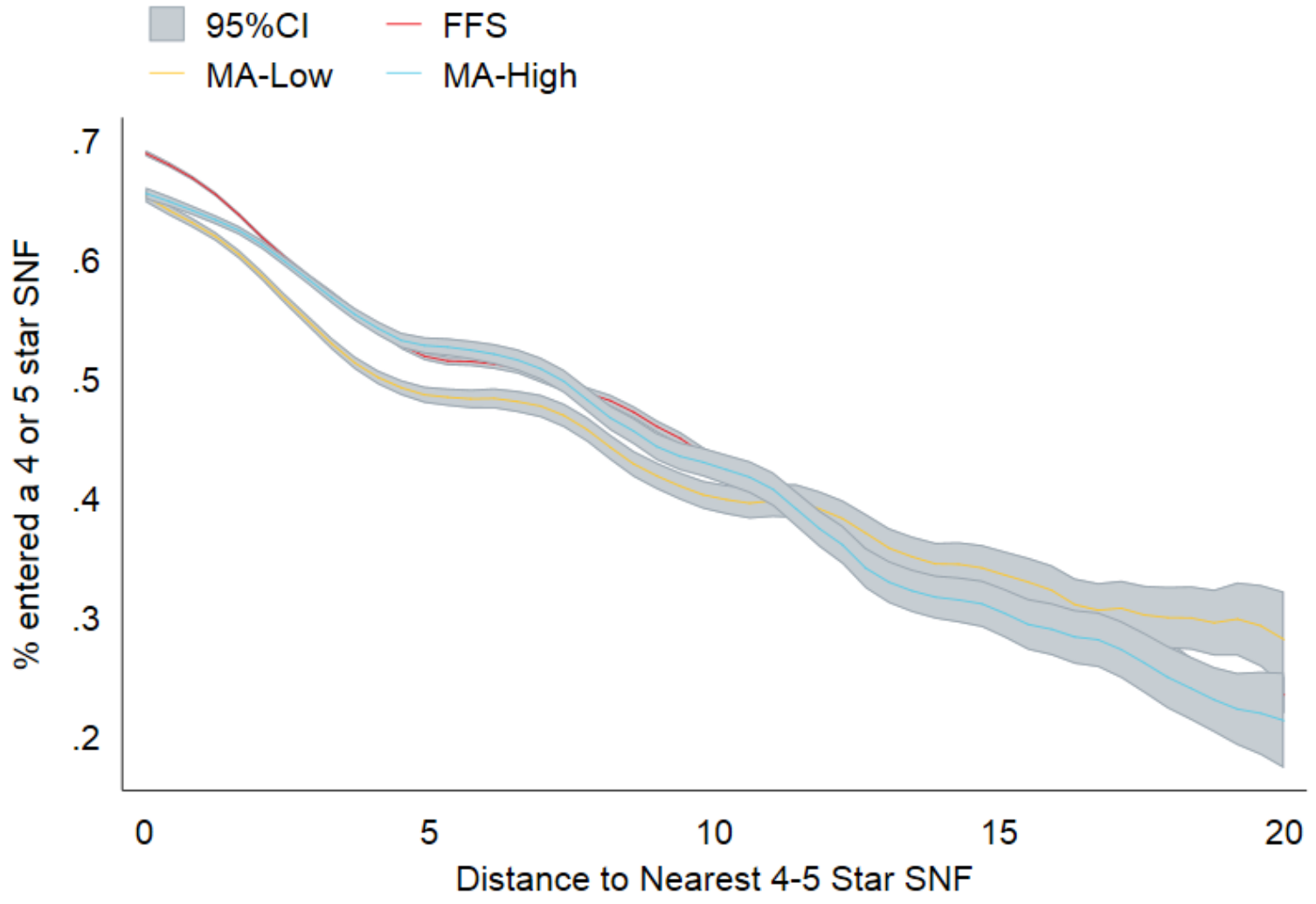
ABSTRACT **Unlike fee-for-service (FFS) Medicare, most Medicare Advantage (MA) plans have a preferred network of care providers that serve most of a plan's enrollees. Little is known about how the quality of care MA enrollees receive differs from that of FFS Medicare enrollees. This article evaluates the differences in the quality of skilled nursing facilities (SNFs) that Medicare Advantage and FFS beneficiaries entered in the period 2012–14. After we controlled for patients' clinical, demographic, and residential neighborhood effects, we found that FFS Medicare patients have substantially higher probabilities of entering higher-quality SNFs (those rated four or five stars by Nursing Home Compare) and those with lower readmission rates, compared to MA enrollees. The difference between MA and FFS Medicare SNF selections was less for enrollees in higher-quality MA plans than those in lower-quality plans, but Medicare Advantage still guided patients to lower-quality facilities.**

Medicare Advantage Enrollees from Poor Plans enter lower rated nursing homes



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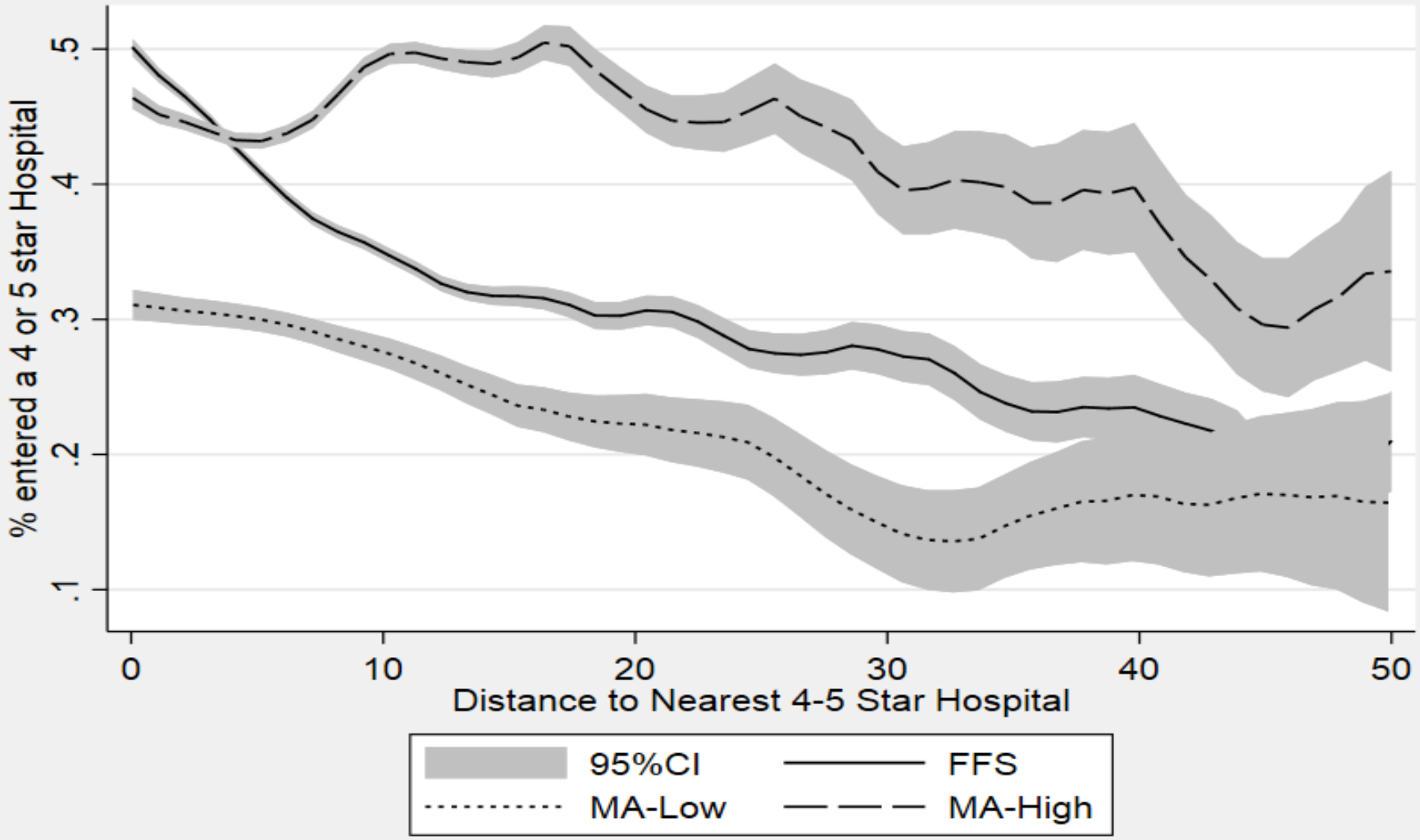
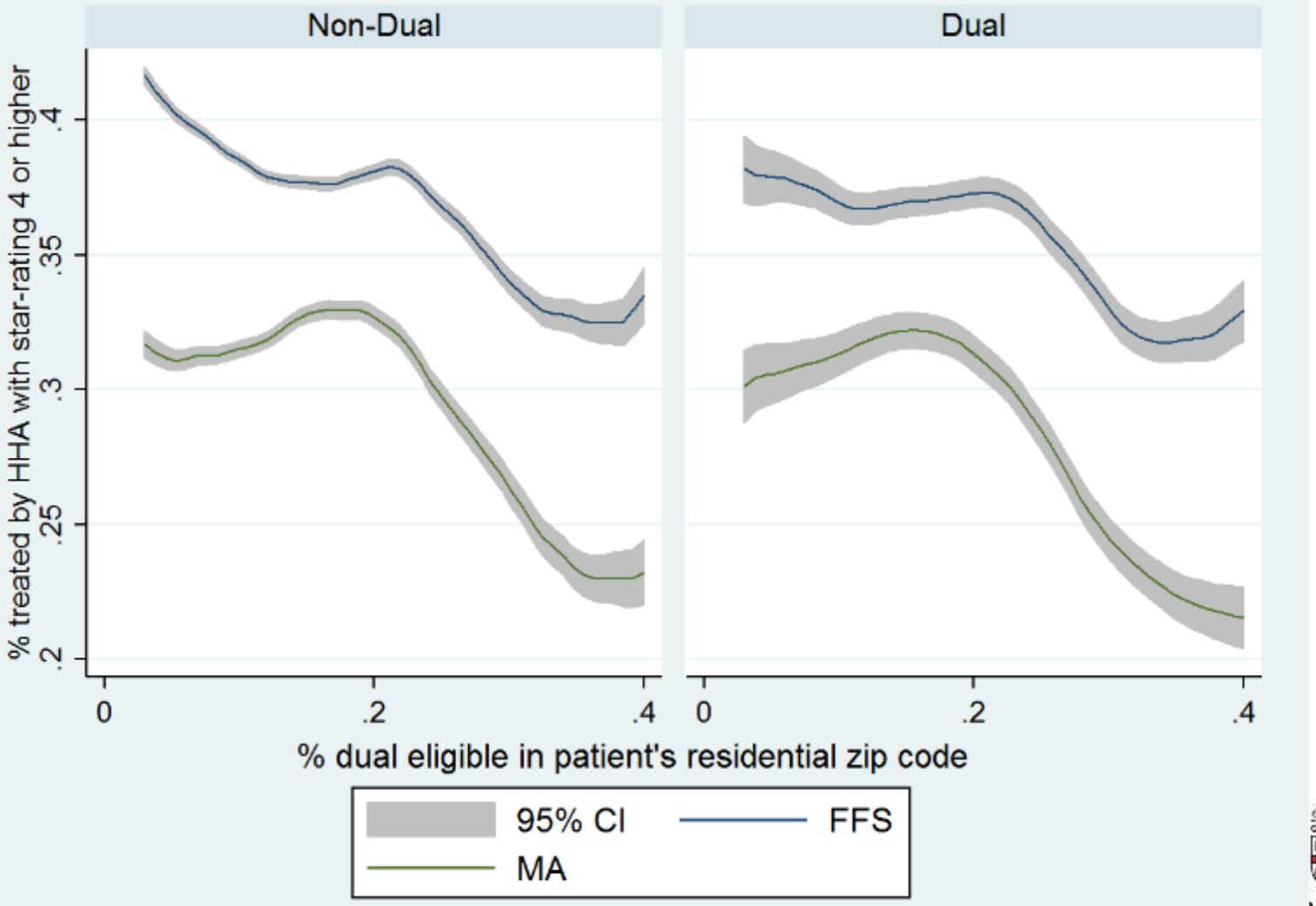
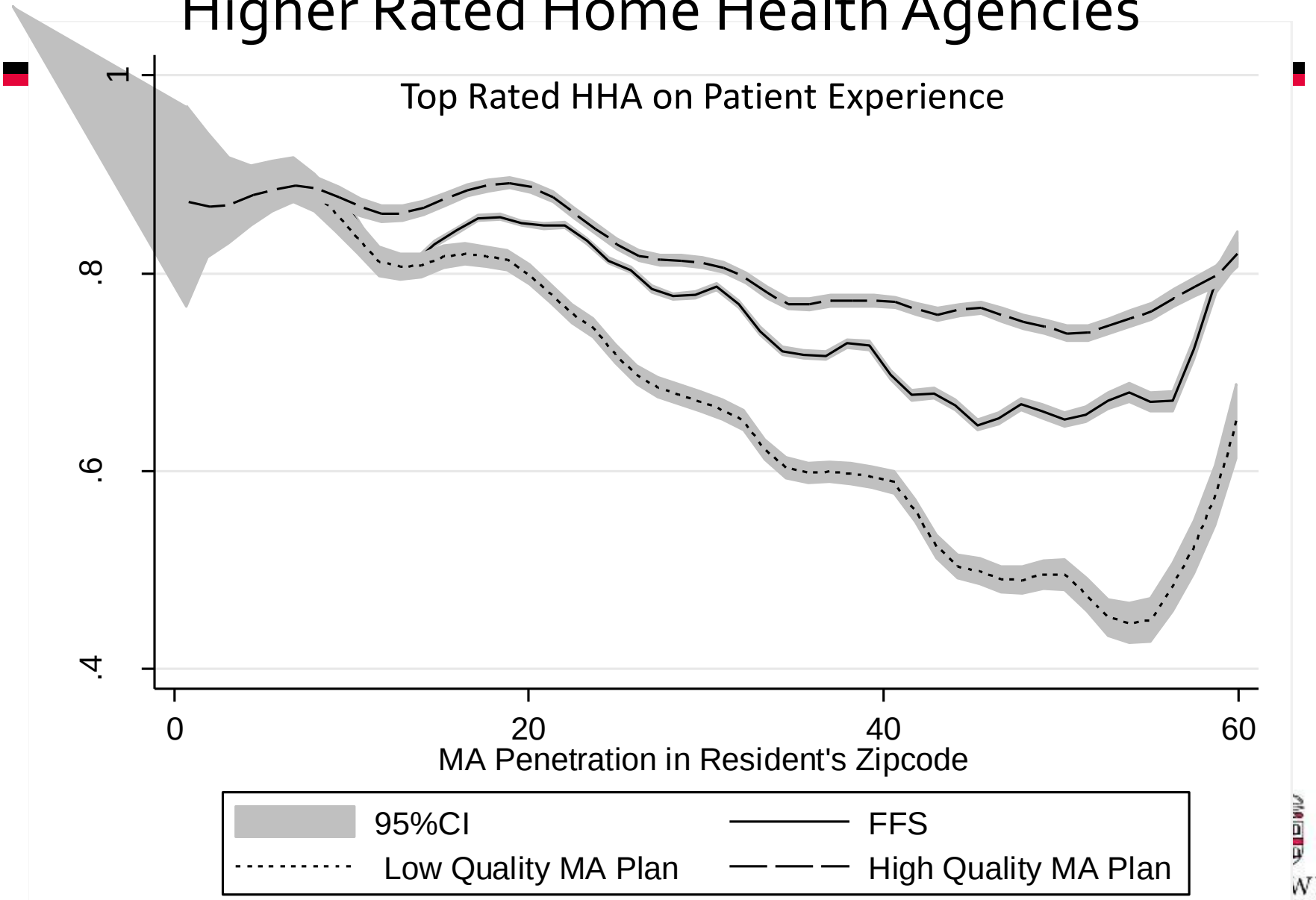
Non-Emergent Hospitalizations in High Quality Facilities by Plan Quality



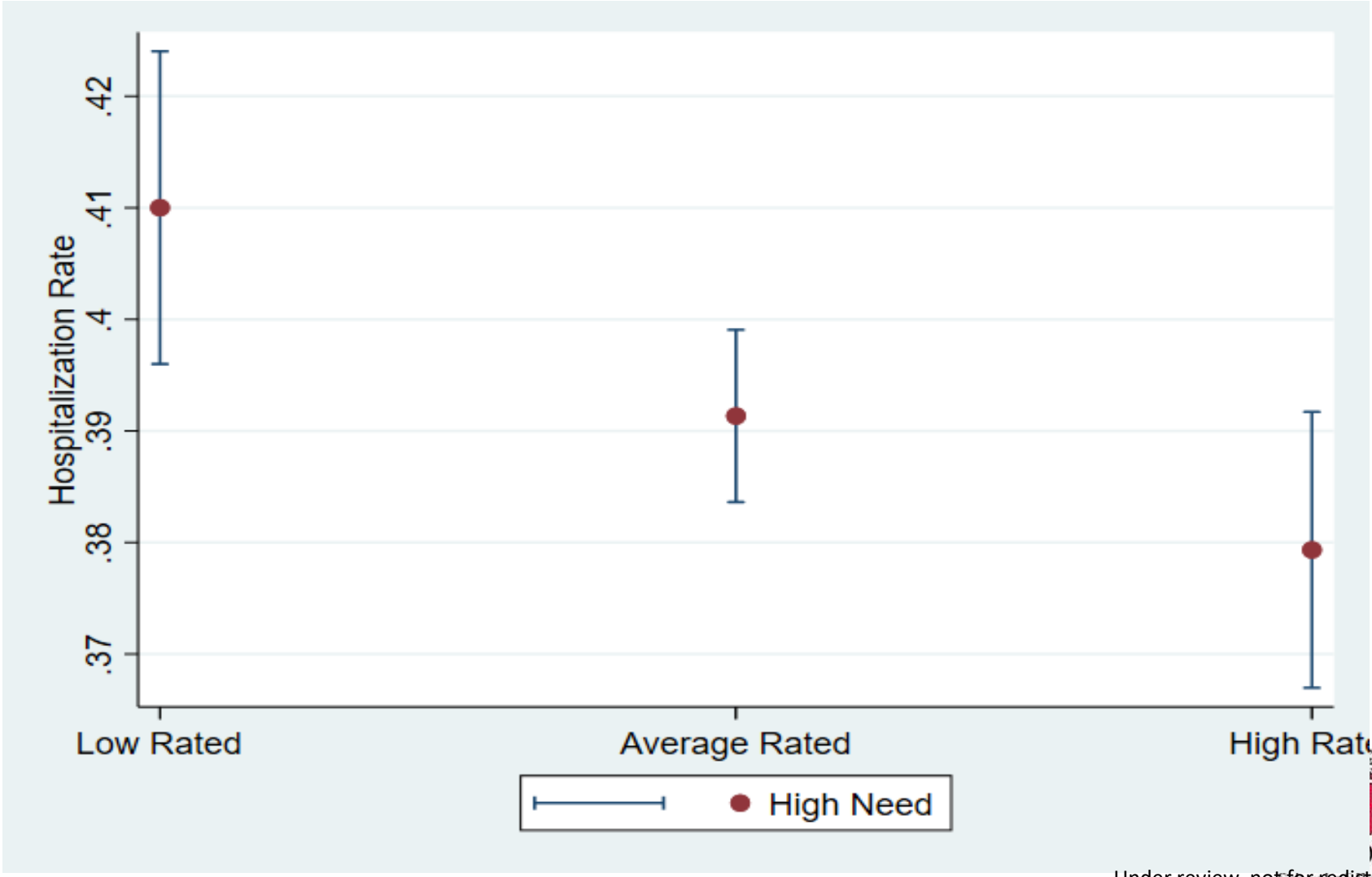
Medicare Advantage Enrollees enter lower rated home health agencies



Medicare Advantage Enrollees Treated by Higher Rated Home Health Agencies



High Need Patients in better plans have lower hospitalization rates



A Modest Proposition

- Alternative Payment Models Require Quality Metrics to Assure "Value"
- But, population composite measures not sensitive to high need patients' issues
- MA plans' payment weighted by case-mix, SO, weight quality measures more heavily based on high need patients