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United States Government Accountability Office
Washington, DC 20548

B-323170

July 11, 2012

The Honorable Kathleen Sebelius
Secretary of Health and Human Services

Subject: *Medicare Advantage Quality Bonus Payment Demonstration*

Dear Madam Secretary:

In response to a congressional request, GAO conducted an evaluation of the Department of Health and Human Services' (HHS) Medicare Advantage (MA) Quality Bonus Payment Demonstration (the "demonstration"), which HHS initiated under section 402(a)(1)(A) of the Social Security Amendments of 1967 as amended ("section 402"), in lieu of the Medicare Advantage quality bonus payment program Congress established under the Patient Protection and Affordable Care Act ("PPACA").[1] In March 2012, GAO reported that the demonstration's reliance on predemonstration performance data, the absence of an appropriate comparison group of MA plans, and the demonstration's design make it unlikely that the demonstration will produce meaningful results. These facts, in combination with the demonstration's $8 billion cost, resulted in our recommendation that HHS cancel the demonstration.[2] Our findings during the course of our evaluation of the demonstration also raised concerns about whether the demonstration falls within HHS's section 402 authority, and resulted in our solicitation, by letter of January 10, 2012, of the views of the General Counsel of HHS regarding this issue.[3] By letter of February 10, 2012, the Deputy Director of the Center for Medicare within the Centers for Medicare & Medicaid Services (CMS) responded to our inquiry.[4] CMS's

[1] Social Security Amendments of 1967, 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). 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).

[3] Throughout this letter, we refer to our inquiry as the January 2012 Letter.

[4] Throughout this letter, we refer to this response as the CMS Response.

response, however, does not explain how the MA Quality Bonus Payment Demonstration comports with its section 402 authority. To the contrary, as discussed in detail below, we remain concerned about the agency's legal authority to undertake the demonstration.

BACKGROUND

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 CMS. In 2011, about a quarter of all Medicare beneficiaries were enrolled in an MA 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. Under the law, in calendar year 2012, plans achieving such a rating are eligible to receive a 1.5 percent bonus; in 2013, they are eligible to receive a 3 percent bonus; and in 2014 and thereafter, they are eligible to receive a 5 percent bonus. In addition to establishing quality bonus payments, PPACA also aligns MA plan payment more closely with Medicare FFS spending and phases in this new payment methodology between 2012 and 2017. During this phase-in period, MA plans are eligible to receive quality bonus payments only on the portion of plan payment that is based on the new payment methodology.

On November 10, 2010, CMS released a proposed rule to implement PPACA's MA quality bonus program, among other PPACA provisions. In the proposed rule, CMS announced that "the rules for determining [quality bonus payments] set forth in [PPACA] and in these proposed regulations would be waived, and [quality bonus payments] would instead be determined under the terms . . . of [a] national quality bonus payment demonstration project." [5] Specifically, CMS announced it would determine quality bonus payments for 2012 through 2014 under a demonstration initiated under section 402(a)(1)(A), in which all MA plans would participate unless they affirmatively opt out. To our knowledge, no MA plans have elected to opt out, and, therefore, no plans are operating under the PPACA quality bonus payment provisions.

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[5] Medicare Program; Proposed Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2012 and Other Proposed Changes, 75 Fed. Reg. 71190, 71220 (Nov. 22, 2010); *see also* CMS, *Fact Sheet; Proposed Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2012 and Demonstration on Quality Bonus Payments,* Nov. 10, 2010 (on file with GAO). CMS affirmed this plan in its final CY 2012 MA rule and final CY 2012 Call Letter. Medicare Program; Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2012 and Other Changes, 76 Fed. Reg. 21432, 21487 (Apr. 15, 2011); CMS, *Announcement of Calendar Year 2012 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter,* Apr. 4, 2011.

Compared with the quality bonus program established by PPACA, the MA Quality Bonus Payment Demonstration 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 payment to a plan's entire payment amount during the phase-in of PPACA's new MA plan payment methodology. 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, which only provides bonuses to plans achieving 4 or more stars. The demonstration ends on December 31, 2014, at which time CMS intends to implement the quality bonus payment program that PPACA authorized.

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

Star Rating	MA Quality Bonus Payments					
	PPACA			Demonstration		
	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

DISCUSSION

To identify the extent of the Secretary's authority under section 402, we focus on the plain language of the statute. This approach to statutory interpretation is consistent with the Supreme Court's pronouncement that "the meaning of a statute must, in the first instance, be sought in the language in which the act is framed."[6] Moreover, we rely exclusively on the statute's text because the legislative history of section 402 provides limited insight into the particular criteria that a program must meet to qualify as a demonstration under the provision.[7] Similarly, while a few court cases discuss the Secretary's ability to waive specified sections of Title XVIII of the Social Security

[6] *Caminetti v. United States,* 242 U.S. 470, 485 (1917) (if the language of the statute "is plain, and if the law is within the constitutional authority of the law-making body which passed it, the sole function of the courts is to enforce it according to its terms"); *see also Carcieri v. Salazar,* 555 U.S. 379, 387 (2009) (stating that if a statute is clear and unambiguous, "we must apply the statute according to its terms").

[7] *See, e.g.,* H.R. Rep. No. 92-1605 (1972); S. Rep. No. 92-1230 (1972); H.R. Rep. 92-231 (1971); *see also* Staffs of S. Comm. on Finance and H. Comm. on Ways and Means, 90th Cong., Rep. on Summary of Social Security Amendments of 1967 (Comm. Print 1967) ("The Secretary of [HHS] is authorized to experiment with various methods of reimbursement to organizations, institutions, and physicians, on a voluntary basis, participating under medicare, medicaid, and the child health programs which offer incentives for keeping costs of the program down while maintaining quality of care.").

Act, which governs Medicare, they do not focus on the particular criteria that demonstrations initiated under section 402(a)(1)(A) must meet.[8]

Section 402 authorizes HHS to undertake demonstration projects to test new Medicare payment methodologies. Specifically, 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.[9]

Relatedly, section 402(b) authorizes the Secretary to waive Medicare payment requirements to carry out such demonstrations.

In light of the language of section 402(a)(1)(A), we consider two issues in analyzing the Secretary's authority to conduct the MA Quality Bonus Demonstration: (1) whether the demonstration's payment changes provide additional incentives to MA plans to increase efficiency and economy, and (2) whether the demonstration will enable the agency to determine if its changes in payment methods increase the efficiency and economy of Medicare services.

Whether the Demonstration Provides Additional Incentives to Increase Efficiency and Economy

In our March 2012 report, we found that the demonstration's incentives could have a full impact only in 2014, because all of the performance data used to determine the 2012 bonus payments and most of the data used to determine the 2013 bonus payments were collected before the demonstration's final specifications were published. We also found that, even in 2014, the demonstration's payment changes do not consistently offer better incentives than PPACA. In fact, in 2014, PPACA's bonus structure provides many plans better incentives than the demonstration to achieve higher star ratings. In our January 2012 Letter, we asked CMS to explain how, in light of these facts, the demonstration is consistent with section 402, which authorizes the agency to undertake demonstrations that create additional incentives to increase efficiency and economy of Medicare services. As described below, the CMS Response does not resolve our concerns about the demonstration's ability to provide such additional incentives and, therefore, how the demonstration satisfies this element of the statute.

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[8] We identified only one federal court decision addressing a demonstration initiated under the section 402(a)(1)(A) authority; however, the decision focuses on the Secretary's use of the section 402(b) waiver authority and not on the scope of section 402(a)(1)(A). *See Am. Academy of Ophthalmology, Inc. v. Sullivan*, 998 F.2d 377, 384 (6th Cir. 1993).

[9] 42 U.S.C. § 1395b-1(a)(1)(A).

Payment of Demonstration Bonuses in 2012 and 2013

For both 2012 and 2013, the MA Quality Bonus Payment Demonstration provides bonuses to MA plans based on star ratings derived from data collected before the demonstration's specifications were finalized in April 2011 (see Table 2 below). Specifically, quality bonus payments for 2012 will be based on plans' 2011 star ratings, which were derived from data collected between January 2009 and June 2010. Quality bonus payments for 2013 will be based on plans' 2012 star ratings and will be derived from data collected between January 2010 and June 2011. CMS announced its plans to initiate the demonstration in November 2010, and did not announce the demonstration's final specifications until April 2011—just a few months before the end of the 2012 plan rating data collection period.[10] Although CMS has not yet finalized the data collection period for MA plans' 2013 star ratings, which will be used to determine quality bonus payments for 2014, we assume—consistent with previous collection periods—that these ratings will be based on plan performance between January 2011 and June 2012. This time period encompasses the first 6 months of the demonstration and approximately 9 months prior to the start of the demonstration during which time the demonstration's final specifications were available.

In sum, in the first year of the demonstration, bonus payments will be based on data collected entirely before the demonstration was announced in November 2010. In the second year of the demonstration, bonus payments will be based on data collected almost entirely before the final specifications of demonstration were announced in April 2011. Calendar year 2014, therefore, is the only year in which bonus payments will be based primarily on plan performance under the demonstration's quality bonus payment methodology.

Table 2. Data Collection Timeline for MA Plan Quality Rating

Demonstration/PPACA Year	Star Rating Release Date	Data Collection Period
2012 (Demonstration Year 1)	November 10, 2010 (2011 ratings)	January 2009 – June 2010
2013 (Demonstration Year 2)	October 18, 2011 (2012 ratings)	January 2010 – June 2011
2014 (Demonstration Year 3)	Fall 2012 (2013 ratings)	January 2011 – June 2012 (estimated)
2015 (PPACA Year 1)	Fall 2013 (2014 ratings)	January 2012 – June 2013 (estimated)

In our January 2012 Letter, we asked CMS to explain how the demonstration's changes in payment methodology in 2012 and 2013 will provide MA plans additional incentives to increase efficiency or economy of Medicare services, given that these payments will be based on plan performance that predates the demonstration. In responding to our inquiry, CMS simply asserted, but did not explain how, the

[10] CMS, *Announcement of Calendar Year 2012 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter,* Apr. 4, 2011, at 25.

payment changes for 2012 and 2013 are consistent with section 402's requirements. Further, CMS acknowledged that payments in 2012 and 2013 reward plans for their past performance and, in this regard, do not provide incentives to increase efficiency or economy, stating that "[b]eginning in 2012, the demonstration provides a transition period during which plans can use additional bonus payments to improve the quality of care provided to beneficiaries . . . ." In other words, CMS intends to increase payments to plans in 2012 and 2013 on the assumption that plans will use these additional moneys to increase quality, as there is no requirement that plans improve or even attempt to improve quality in these years as a condition of receiving or retaining the payments made under the demonstration.

Further, although CMS stated its expectation that plans will use additional bonus payments to improve the quality of care provided to beneficiaries, it did not address the fact that current Medicare regulations preclude plans' ability to do so. In general, CMS determines the amount to pay an MA plan by comparing the plan's bid to a statutory benchmark amount. If the plan's bid is lower than the benchmark amount, the plan receives its bid plus a rebate based on the difference between its bid and the benchmark amount. If the plan qualifies for a quality bonus payment, CMS increases the benchmark amount by the applicable quality bonus percentage, which makes the difference between the plan's bid and benchmark amount greater and results in the provision of a higher rebate amount. Current rebate rules require plans to invest the rebates they receive (1) in the provision of supplemental health care benefits to beneficiaries, (2) in the payment of beneficiaries' premiums for prescription drug coverage, or (3) in the payment of beneficiaries' Medicare Part B premiums.[11] Investing in quality improvement is not a permissible use of rebate funds under CMS regulations; and CMS has not indicated that it is waiving this restriction to allow plans to use rebate funds for this purpose or how it plans to monitor such use. In fact, in the final 2012 call letter—the same call letter in which CMS announced the demonstration's final specifications—CMS stated that for 2012, MA organizations may use rebate dollars only for these three purposes.[12]

Payment of Demonstration Bonuses in 2014

Although plans may be able to respond comprehensively to the demonstration in 2014, for certain plans, even in 2014, the demonstration does not provide any additional incentives to increase efficiency and economy compared with PPACA. Specifically, in 2014, the size of the bonus percentage for MA plans attaining a 4-, 4.5-, or 5-star rating—5 percent—will be the same percentage for which they would have been eligible had CMS implemented the PPACA quality bonus provision. In our January 2012 letter, we asked CMS to explain how providing the same bonus percentage to 4-, 4.5-, and 5-star plans in the final year of the demonstration will provide plans additional incentives to increase the economy and efficiency of Medicare services. CMS stated that section 402 does not require it to test changes to all features of current law under the demonstration. However, it is the case that

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[11] 42 C.F.R. § 422.266(b) (2011).

[12] CMS, *Announcement of Calendar Year 2012 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter*, Apr. 4, 2011, at 25.

CMS has revised the payment methodology for these plans in 2012 and 2013—years in which these changes are unlikely to have any impact on plan quality because plan ratings are based on predemonstration data. In the only demonstration year in which payment changes could induce improved quality—2014—CMS has opted not to revise the payment methodology for these plans. As a result, the only plans for which, and the only year in which, the demonstration's payment changes may provide additional incentives to increase efficiency and economy is for 3-star and 3.5-star plans in 2014.[13] However, as noted in our March 2012 report, even in 2014, PPACA's bonus structure 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 than under the demonstration, which suggests that the demonstration may actually reduce incentives for these plans to improve quality.[14]

Whether the Agency Will Be Able to Determine If the Demonstration's Changes in MA Quality Bonus Payments Increase Efficiency and Economy without Reducing Quality

Our March 2012 report concluded that the demonstration's reliance on predemonstration performance data, the absence of an appropriate comparison group of MA plans, and design features that are inconsistent with the agency's goal of encouraging plans to improve quality make it unlikely that the demonstration will produce meaningful results. In our January 2012 Letter, we asked CMS to explain how, in light of these facts, the demonstration is consistent with section 402's grant of authority to engage in demonstration projects "to determine whether, and if so which, changes in methods of payment . . . would have the effect of increasing the efficiency and economy of health services." Specifically, we asked CMS to explain whether and, if so, how, the agency will be able to reach such a determination given that MA plans have no experience operating under PPACA's quality bonus structure, the demonstration lacks an MA plan control group, and the agency is implementing other MA payment and program changes that are likely to affect plan quality. The CMS Response, however, does not resolve our concerns that the agency is unlikely to be able to determine whether the demonstration's payment changes result in such increased economy or efficiency and, therefore, how the demonstration satisfies this element of the statute.

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[13] We note, however, that CMS has yet to announce the final methodology for calculating 2013 ratings, which will determine 2014 bonus payments, even though such ratings and payments will be based on plan performance between January 2011 and June 2012. In its 2013 call letter, CMS stated that "For the 2013 Plan Ratings, we are continuing to make enhancements to the current methodology" and described new measures under consideration for inclusion in the agency's 2013 star rating methodology. In light of the fact that plans are unaware of the final criteria against which they will be evaluated, it is unclear whether plans will be able to respond to the demonstration's incentives even in 2014. CMS, *Advance Notice of Methodological Changes for Calendar Year (CY) 2013 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2013 Call Letter*, Feb. 17, 2012, at 61.

[14] As described in Table 1, plans improving from 3.5 stars to 4 stars under the PPACA bonus structure would qualify for a 1.5 percent bonus payment, whereas such plans would qualify only for a .5 percent bonus payment under the demonstration.

Ability to Compare Plan Performance under the Demonstration to Plan Performance under Current Law

As discussed, section 402(a)(1)(A) authorizes the Secretary to revise Medicare payment methodologies to determine whether such changes increase the efficiency and economy of health services under the program. A determination of whether a change in payment methodology results in such an increase 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.

According to the CMS Letter, the contractor CMS has engaged to evaluate the demonstration will estimate the impact of the demonstration by comparing plan ratings for 2012 and 2013 with plan ratings for 2014, under the premise that ratings for 2012 and 2013 will determine quality bonus payments under the demonstration, whereas 2014 ratings will determine quality bonus payments for 2015 under provisions of current law. We are concerned, however, that because of the significant time lag between the collection of data upon which MA plans' star ratings are based and the issuance of plan star ratings (see Table 2 above), that comparing these 3 years of data is unlikely to yield a meaningful evaluation.

As described by CMS, the evaluation of the effects of the demonstration as compared to current law relies on data, and corresponding plan ratings, that reflect payment methods in place prior to PPACA and the payment methods in place under the demonstration. Specifically, the 2012 plan ratings were derived from plan performance that entirely predated the start of the demonstration. It is anticipated that the 2013 plan ratings will be derived from performance during the first 6 months of the demonstration and the 12 months immediately preceding the demonstration, and, therefore, also likely will reflect the demonstration's quality bonus payment methods rather than PPACA's payment methods. Lastly, it is expected that the 2014 plan ratings will be derived from plan performance occurring entirely during the demonstration period, and, therefore, likely will reflect the demonstration's, rather than PPACA's, quality bonus payment methods. As a result, the evaluation appears far more likely to enable the agency to compare plan performance under the demonstration to plan performance under the law in effect prior to PPACA rather than to plan performance under current law as contemplated by section 402.

With respect to the demonstration's lack of an MA plan control group, according to the CMS Response, CMS's evaluation contractor will identify comparison groups outside of the MA program, including, for example, plans contracting with Medicare under section 1876 cost contracts and plans participating in commercial and Medicaid CAHPS and HEDIS programs, which allow consumers to compare plan performance on select consumer and quality measures.[15] Although these programs might report quality-related information similar to that reported for MA plans, these

[15] CAHPS refers to the Consumer Assessment of Healthcare Providers and Systems. HEDIS refers to the Healthcare Effectiveness Data and Information Set. Section 1876 refers to the section of the Social Security Act that authorizes the operation of cost plans, which are Medicare managed care plans paid based on their reasonable costs incurred delivering Medicare-covered services.

plans may serve different populations, may follow different regulations and policies, and are not subject to the PPACA quality bonus provisions. The CMS Response does not explain how this type of comparison will enable the agency to determine whether the demonstration's changes in payment increase efficiency and economy compared to current law. CMS also stated that it plans to use modeling techniques to estimate how many and what percent of plans would have achieved each level of star rating under current law. However, because CMS did not provide details regarding these modeling techniques, we do not know whether or how they could yield a useful comparison.

Additional MA Plan Changes Likely to Affect Plan Quality

In addition to undertaking the MA Quality Bonus Payment Demonstration, CMS is also implementing other MA payment and policy changes that may have an independent effect on plan quality. In particular, section 3202 of PPACA revised applicable MA plan rebate percentages according to a plan's star ratings, such that the higher a plan's star ratings, the greater the rebate the plan is entitled to receive. Because a higher rebate percentage results in higher MA payments, PPACA's creation of scaled rebate percentages may have an independent effect on plan quality, as plans will be motivated to improve quality to obtain higher payments under this provision. In addition, under a final rule issued in April 2012, CMS now has the authority to terminate any MA plan that has failed to achieve, over a period of 3 years, at least a 3-star plan rating, giving MA plans an incentive to maintain or improve their star ratings.[16] Under this final rule, CMS may terminate MA contracts beginning in 2015 based on their 2013, 2014, and 2015 star ratings. Because all plans will participate in the demonstration and none will operate under the PPACA quality bonus payment provisions, we are concerned that CMS will be unable to isolate the demonstration's effects from these other payment and policy changes, a fact that CMS acknowledged in its response to us. In doing so, CMS stated that it will explore the relative roles of these other initiatives and trends on plan decision making. However, the agency did not explain how such an effort will enable it to effectively identify whether the demonstration's payment changes are responsible, and, if so, to what extent, for any improvements in plan quality, or economy and efficiency.

CONCLUSION

Section 402(a)(1)(A) provides the Secretary broad authority to modify methods of payment under Medicare to establish additional incentives to increase the economy and efficiency of services provided under the program by carrying out experiments and demonstration projects. This authority, however, is not unlimited. Although the payment changes tested under a particular demonstration need not actually result in increased efficiency or economy, demonstrations under which these payment changes are initiated must meet the criteria set forth in the statute, which include

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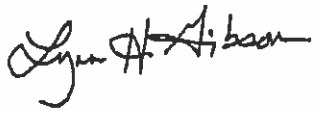
[16] Medicare Program; Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2013 and Other Changes, 77 Fed. Reg. 22072, 22107-08 (Apr. 12, 2012) (to be codified at 42 C.F.R. Parts 422 and 423).

providing additional incentives to MA plans to increase the efficiency and economy of Medicare services and enabling the agency to determine whether these changes in payment methods increase the efficiency and economy of Medicare services. However, CMS has not established that either of these elements is present in the MA Quality Bonus Payment Demonstration.

If you have any questions about this matter, please contact Edda Emmanuelli-Perez, Managing Associate General Counsel, at 202-512-2853.

Sincerely yours,



Lynn H. Gibson
General Counsel

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