Advising the Congress on Medicare issues

Examining the Medicare Advantage quality bonus program

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MEDPAC

Today's presentation

- Brief summary of the Medicare Advantage (MA) quality bonus program (QBP)
- Review of contract configurations and consolidations as they affect the QBP in light of statutory change
- Other issues affecting QBP and possible solutions
- Moving towards budget neutrality in the MA QBP

The MA quality bonus program

- Instituted in 2012 by statute
- Overall star rating is weighted average of up to 46 measures
- Bonuses for rating at or above 4 stars on 5-star scale
  - Bonus increases plan benchmarks by 5 percent (10 percent in some areas)
- Overall star rating determines share of bid-under-benchmark difference to be applied to rebates (extra benefits for enrollees)—for example, 50 percent if below 3.5 stars
- Overall star rating and individual measure results posted at Health Plan Finder (Medicare.gov)
  - Updated in October for October-December annual election period
  - Stars that are the basis of bonus payments are from preceding year

Effects of contract configurations and consolidations

- Star ratings determined at MA contract level, often covering a wide geographic area
  - In 2018, about 40 percent of enrollees of MA HMOs and local PPOs are in contracts that include enrollees from non-contiguous states
- In last five years, more large contracts with wide geographic areas because of consolidations (contract mergers) to boost star ratings
  - With consolidation, the “consumed” contract acquires the star rating of the “surviving” contract
- Result: Unwarranted bonus payments, and even less likelihood that beneficiaries can rely on stars as indicators of plan quality in their area

Commission recommendations and recent legislation

- Commission's March 2018 report recommended
  1. Freezing quality reporting units at pre-consolidation configurations to prevent unwarranted bonuses, and
  2. Having all contracts report quality at the local market level (as previously recommended in 2010)
- Bipartisan Budget Act of 2018 partly addressed issue of unwarranted bonuses by requiring an averaging of quality results for consolidated contracts as of 2020
  - Can still result in unwarranted bonus payments under different consolidation strategies

Streamlining the MA measurement system

- The Commission's principles state that quality programs should use a small number of population-based outcome measures and patient experience measures
- A streamlined MA bonus system could exclude the current 17 process measures (and administrative measures, which would be monitored by compliance activities)
- Commission also advocates the use of claims-based measures, which in MA have their analog in encounter data
- Using outcome measures based on claims and encounters (when reliable encounter data become available) would have advantage of
  - Improved accuracy and uniformity
  - Comparability with FFS quality results
  - Reduced reporting burden for providers and plans

Cliff and plateau issue

- Cliff: Contracts with a rating below 3.75 stars (rounded to 4) do not receive bonuses
- Plateau: Limited incentives to achieve a rating above 4 stars:
  - Slightly higher rebate share (70 percent for 4.5 and 5 stars)
  - Ability of 5-star plan to accept enrollment on a year-round basis
  - 5-star rating highlighted on Medicare Plan Finder; advertising advantage
- Possible solution: A continuous scale for bonus payments, similar to the Commission's hospital value incentive program (HVIP) (June 2018)

Issues with the tournament model

- Each year CMS determines “cut points” for assigning measure results into the 5 star groups
- In a tournament model, even if overall quality declines, there will still be 5-star plans
- As contracts are added or dropped from the set of reporting entities (e.g., through consolidations), composition of 5 groups can shift, even with no appreciable change in quality
- Possible solution: Use a continuous scale to determine bonus payments; establish pre-set targets that promote improvement

Ensuring a level playing field in adjustments to star ratings

- CMS makes adjustments to a contract's overall star ratings based on the share of low-income enrollees and disabled enrollees to recognize systematic differences in measure results for these populations
- For 2019, 7 measures are adjusted, including one measure for which results are better for the low-income/disabled population
- Employer-group MA enrollees may also exhibit systematic differences in measure results
- Possible solutions: Make adjustments to overall star ratings based on share of employer-group enrollees, or exclude such enrollees from star calculations

Addressing narrow differences in measure results

- For some measures, such as CAHPS® patient experience measures, star cut points fall within a very narrow range

Measure	1 star	2 stars	3 stars	4 stars	5 stars
CAHPS customer service	< 88	>=88	>=89	>= 91	>= 92
Diabetes care, eye exams	< 47	>= 47	>= 59	>= 72	>= 81

Note: Star cut points for 2018 ratings, from CMS plan ratings data.

- For 2018, highest rate for CAHPS customer service was 96 and lowest 85
- Possible solution: Hold-harmless status for mid-range results (do not include in stars, or all rated 4); make distinction for highest- and lowest-performing plans (e.g., 5 stars and 1 star, respectively)

Issues with the MA hospital readmission measure

1. Risk adjustment: In contracts with substantial admissions, observed-to-expected readmission rates are higher for beneficiaries who die during the year (average 2x difference)
2. Plans rated based on small number of admissions
   - In 2018 stars, the one 1-star contract had 16 admissions, with 4 readmissions; many 5-star contracts had a small number of admissions

- Possible solutions:
  - Further examination of risk adjustment method (CMS and NCQA working on issue)
  - Exclude outliers

Moving towards budget neutrality in the QBP

- QBP payments raise benchmarks (including for benchmarks over 100 percent of FFS)
- Other Medicare quality programs are budget-neutral (bonuses and penalties), or save the program money (penalties only)

A budget-neutral quality program for MA

- In 1999, the Commission stated that Medicare should "look into developing a [quality monitoring] system that features rewards for exceptional performance in addition to penalties for substandard performance"
- Subsequently, the Commission was more specific, suggesting that a small portion of plan capitation payments should be withheld (such as 1 percent) and then distributed to higher-quality plans. Lower-quality plans would lose some or all of the withheld payments.

Medicare Payment Advisory Commission 1999, 2004

Discussion: Issues raised

Short- or medium-term solutions to:

- Too many measures
- Cliff and plateau
- Issues with tournament model
- Employer group plan enrollees as a separate population
- Narrow range of differences for some measures
- Issues with readmission measure

Further discussion

- Using a budget-neutral approach, withholding a small share of payments to be redistributed to highest-performing plans, consistent with the Commission's principles regarding reasonable equity between MA and FFS