Redesigning the Medicare Advantage quality bonus program: Initial modeling of a value incentive program

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Reform of the Medicare Advantage (MA) quality bonus program (QBP) is an urgent need

- One-third of beneficiaries are enrolled in MA—a model of care that should be an efficient, high-quality alternative to FFS
  - However, neither the Medicare program, nor Medicare beneficiaries, have good information on MA quality
- In the QBP 82 percent of MA enrollees are now in plans classified as high-quality, entitling such plans to Trust Fund and taxpayer-financed extra payments
  - Unlike the quality incentive programs of FFS Medicare, which are budget-neutral or produce savings, the QBP adds $6 billion dollars per year in program costs ($94 billion over 10 years)

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Source: MedPAC analysis of MA bid data and CMS monthly reports and plan rating reports; Congressional Budget Office (2018).

Addressing concerns about the QBP with a new MA value incentive program (MA-VIP)

Flaws with current QBP design	Redesigned MA-VIP
• Too many measures, not focused on outcomes and patient/enrollee experiences	• Score a small set of population-based measures
• Contract-level quality measurement is too broad and inconsistent	• Evaluate quality and distribute rewards and penalties at the local market level
• Ineffective accounting for social risk factors	• Use a peer grouping mechanism to account for differences in enrollees' social risk factors
• Bonus targets are not prospectively set	• Establish a system for predictably distributing rewards with no "cliff" effects
• Bonus financing is not budget-neutral	• Transition from current reward-only program financed by added dollars to budget-neutral system

Score a small set of population-based measures: Illustrative MA-VIP measure set

Domain	Measures
ACS hospital use	ACS hospitalizations* ACS emergency department visits
Readmissions	Rate of unplanned readmissions
Patient-reported outcomes	Improved or maintained physical health status* Improved or maintained mental health status*
Patient/enrollee experience	Getting needed care* Rating of health plan*
Staying healthy and managing long-term conditions	Breast cancer screening* Annual flu vaccine Colorectal cancer screening Controlling high blood pressure Diabetes: Hemoglobin A1c poor control

Note: ACS (ambulatory care sensitive)

* Scored in illustrative modeling

MA-VIP: Evaluate quality at the local market level

- Scores a plan's performance for beneficiaries they cover in a local market area
- Current contract-level quality measurement is too broad and inconsistent
- Market-level measure results are a more accurate picture of quality for beneficiaries and the program
- Illustrative MA-VIP reporting unit: Parent organization in MedPAC market areas

MA-VIP: Distribute rewards and penalties at the local market level

- MedPAC's hospital VIP distributed rewards and penalties nationally
- MA-VIP evaluates quality at the market area level, so distributes rewards and penalties at the local level
  - MA plans change where they offer plans each year
- Trade-off: Low-quality plans compared to national performance may receive rewards
- Benefit: Approach allows the best choices available to a beneficiary in a market to receive rewards

MA-VIP: Use a peer grouping mechanism to account for differences in social risk factors

- Stratify plan enrollment into groups of beneficiaries with similar social risk factors to determine payment adjustments
- Illustrative MA-VIP modeling: For each parent organization in a market area, stratify enrollment into 2 groups and calculate measure results
  - Peer Group 1: Fully dual-eligible beneficiaries
  - Peer Group 2: Non-fully dual-eligible beneficiaries

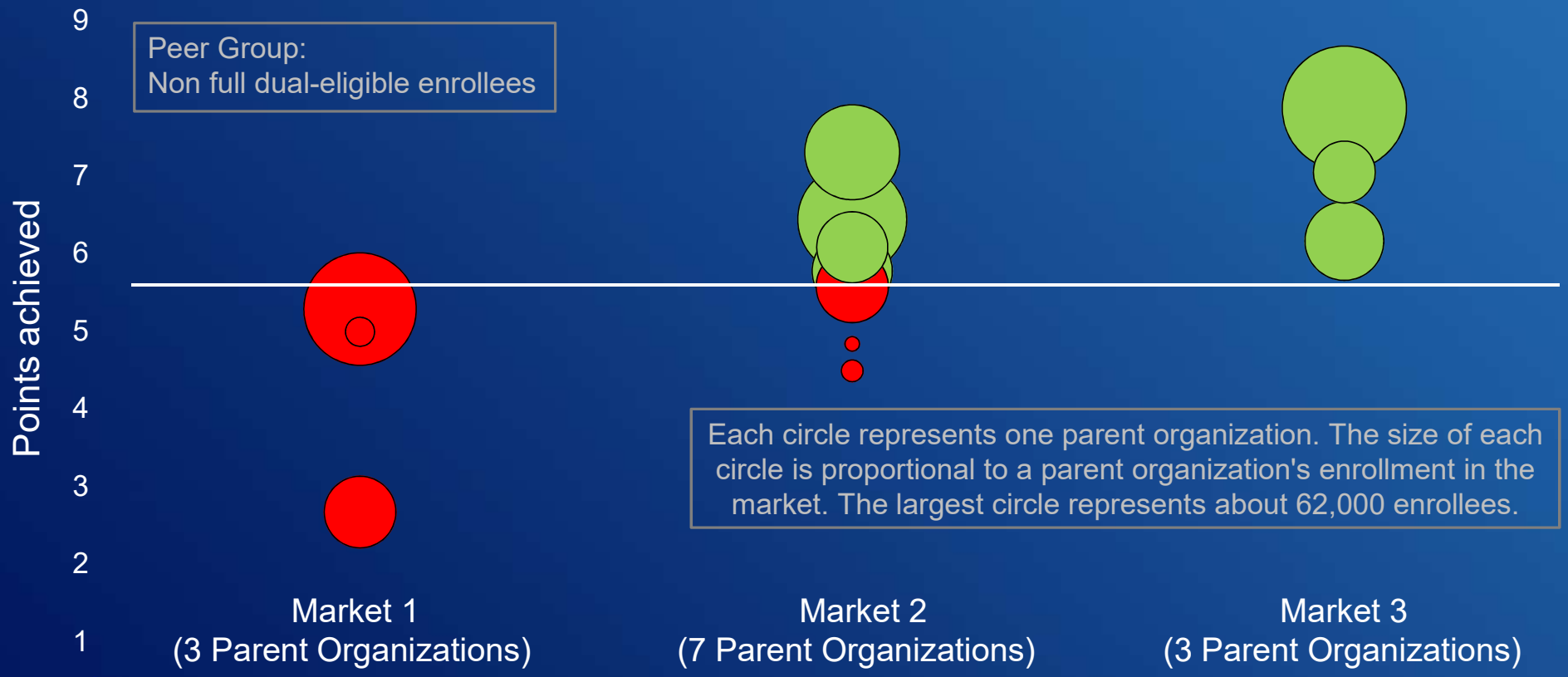
MA-VIP: Establish a system for predictably distributing rewards with no “cliff” effects

- Use a performance-to-points scale to convert measure results to a score which determines rewards and penalties
  - Prospectively set: Plans know how improvements impact rewards
  - Continuous: any change in measure results affects the size of any reward or penalty
- With market- level approach, plans will not initially know the payment multiplier which converts score to a payment adjustment
- Illustrative modeling: Scale set using national distribution of performance

Illustrative MA-VIP modeling: Sample

- Due to limitations in current survey data, the MA-VIP model sample includes:
  - 78 parent organizations in 61 market areas, 258 reporting units
  - About 39 percent of total MA enrollment
- Modeling results to discuss today:
  - Points achieved by parent organizations in example markets
  - Reward (positive adjustment) or penalty (negative adjustment) applied to overall plan payments

Illustrative MA-VIP modeling: National distribution of rewards and penalties in 3 example markets



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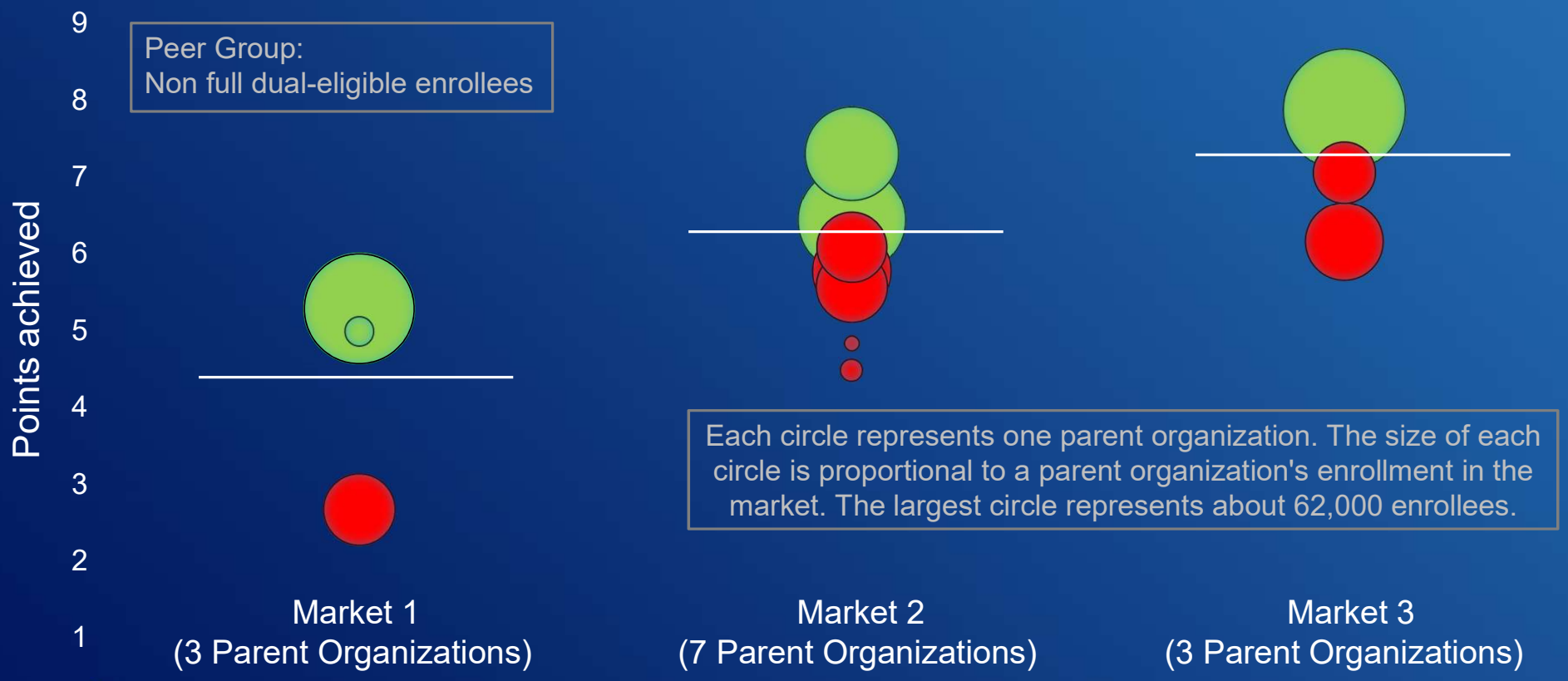
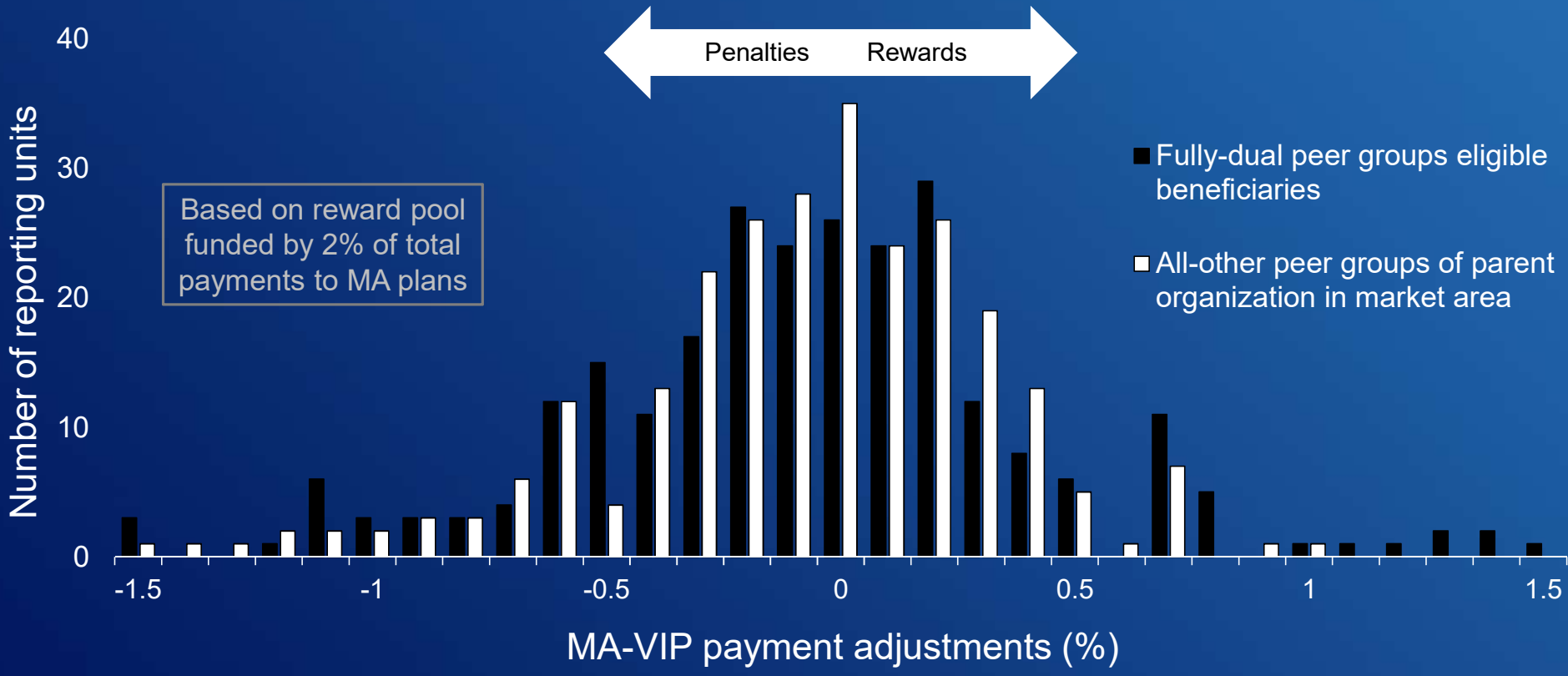
Source: MedPAC analysis of MA quality and payment data, 2015-2017. Note: Results are preliminary and subject to change.

Illustrative MA-VIP modeling: Local distribution of rewards and penalties in 3 example markets



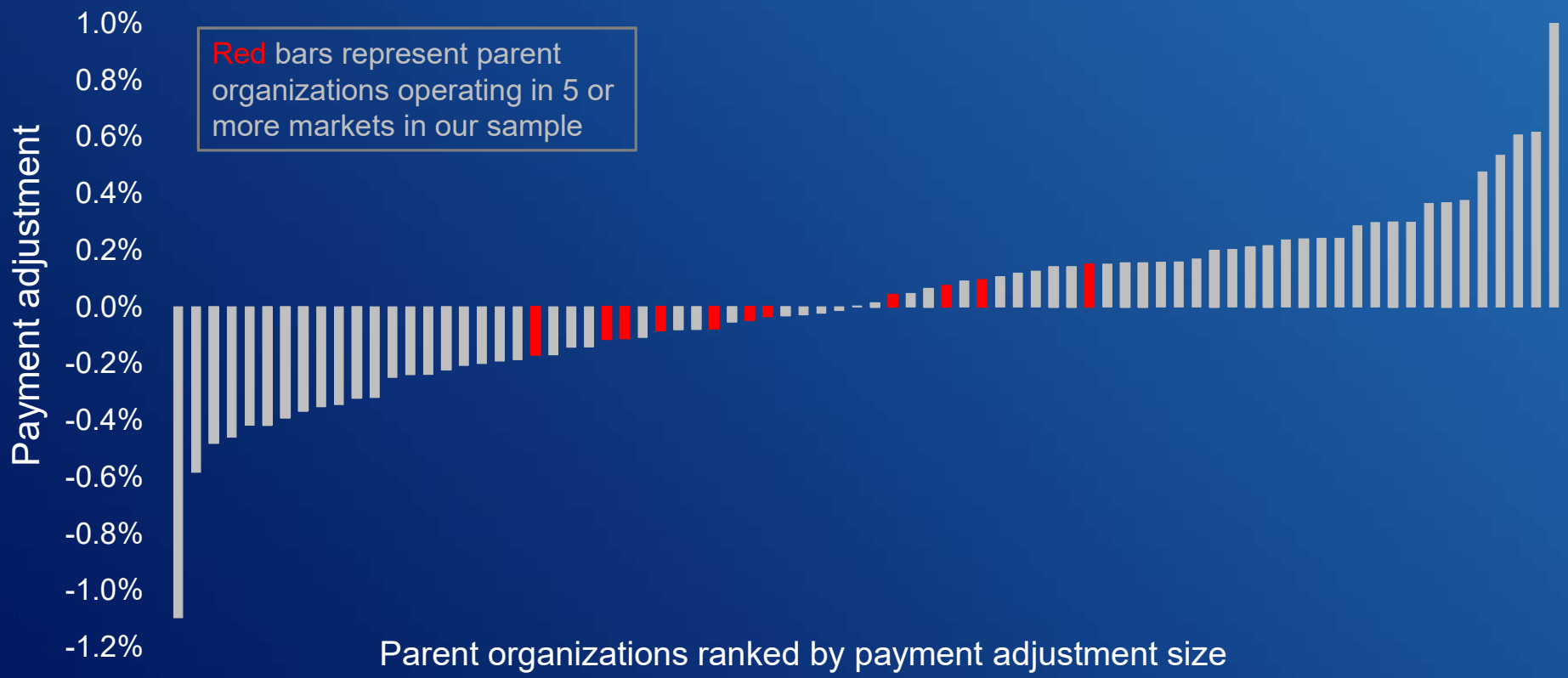
Source: MedPAC analysis of MA quality and payment data, 2015-2017. Note: Results are preliminary and subject to change.

Illustrative MA-VIP modeling: Most plans receive small payment adjustments



Source: MedPAC analysis of MA quality and payment data, 2015-2017. Note: Results are preliminary and subject to change.

Illustrative MA-VIP modeling: Payment adjustments by parent organization

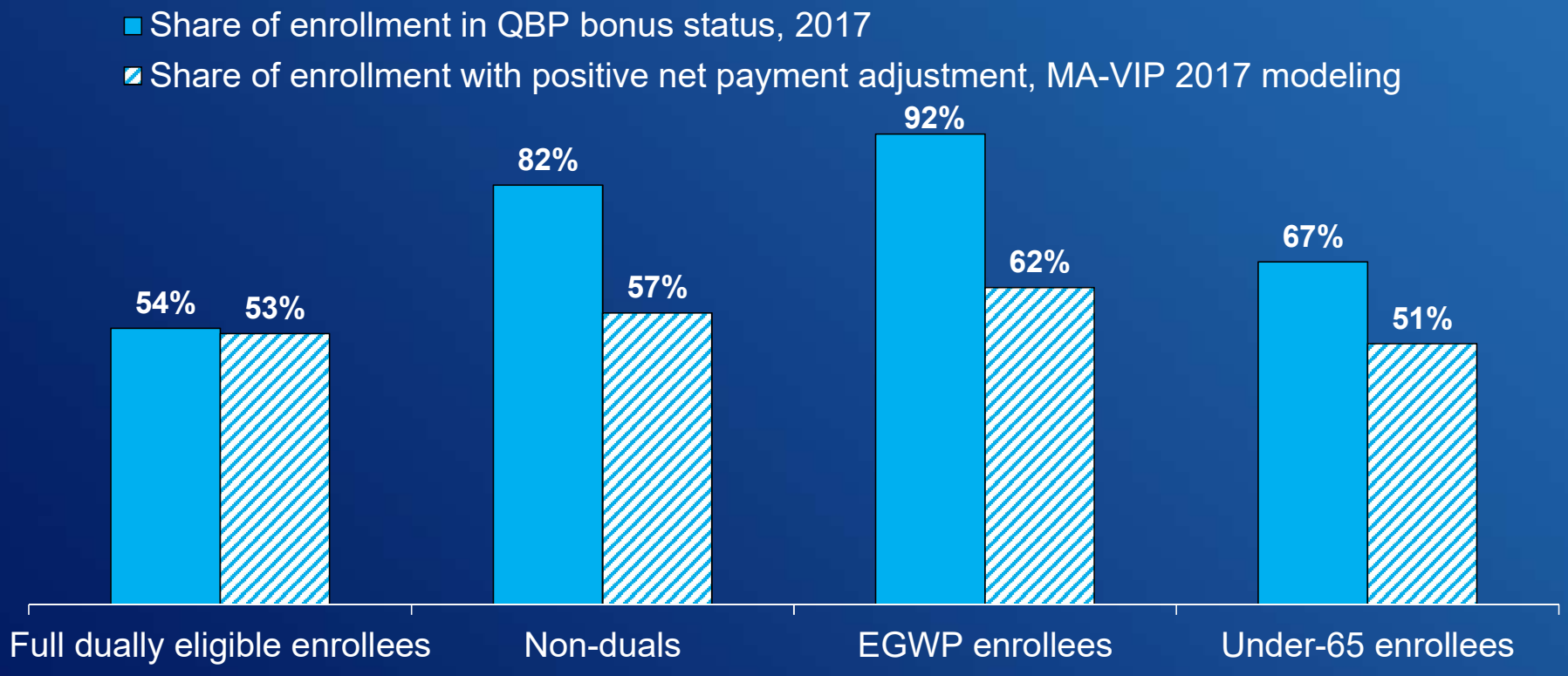


Source: MedPAC analysis of MA quality and payment data, 2015-2017. Note: Results are preliminary and subject to change.

How a budget-neutral MA-VIP affects plans and beneficiaries

- The set of plans receiving rewards changes
  - Narrows the disparity between plans with large share of full dually eligible beneficiaries versus others
  - Large organizations have less of an advantage under MA-VIP
  - Some plans not in QBP bonus status have positive net payment adjustments in MA-VIP—small regional (local) plans
- For beneficiaries, possible modest reductions in extra benefits

Compared to the QBP, the MA-VIP mitigates the disparity between full dually eligible beneficiaries and other populations



Source: MedPAC analysis of data on quality in 2017 and bid data for 2017.
Note: EGWP (employer-group waiver plan). Results are preliminary and subject to change.

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Larger plans do not have the same advantage in the MA-VIP compared to the QBP

	Number	Share of enrollment	Average enrollment
All parent organizations	**78**	**100%**	**89,000**
Have positive MA-VIP net payment adjustment	40	38	66,000
Have negative MA-VIP net payment adjustment	38	62	113,000

- About half of organizations have positive net financial results in MA-VIP, but a lower share of enrollees, and much smaller average enrollment compared to organizations with a negative net MA-VIP payment adjustment
- QBP benefits larger organizations—including those that have used contract consolidations to increase star ratings
  - In January 2020, 85 percent of enrollees in the 10 largest parent organizations are in bonus status, compared to 73 percent in other organizations

Source: MedPAC analysis of data on quality in 2017 and bid data for 2017.
Note: Results are preliminary and subject to change.

Many smaller organizations fare better in the MA-VIP than in the QBP

- For the organizations and markets we analyzed in our modeling, 20 parent organization received no 2017 QBP bonus payments in any of their markets
- Of the 20 parent organizations, 8 had positive MA-VIP net payment adjustments
- The eight were smaller organizations operating in single markets or a small number of markets

Source: MedPAC analysis of data on quality in 2017 and bid data for 2017.
Note: Results are preliminary and subject to change.

Budget-neutral MA-VIP yields large program savings with only modest changes to extra benefits

- QBP adds $6B in yearly program payments to MA plans ($94B over 10 years)
  - Average of $24 per enrollee per month
- In 2020, extra benefits average $121 per enrollee per month
- Our analysis of bid data suggests that a $24 reduction in revenue would reduce extra benefits by $6 to $17 per member per month
- Had budget neutral MA-VIP been implemented in 2020:
  - The value of extra benefits would fall from $121 to $104-$115
  - Similar to the 2019 level of $107

Source: Congressional Budget Office estimate of 10-year savings (CBO 2018). MedPAC analysis of MA bid data for June 2019 report to the Congress.
Note: Results are preliminary and subject to change.

Policy Option

- Replace the MA QBP with a value incentive program that:
  - Scores a small set of population-based measures
  - Evaluates quality and distributes rewards and penalties at the local market level
  - Uses a peer grouping mechanism to account for differences in enrollee social risk factors
  - Establishes a system for predictably distributing rewards with no "cliff" effects
  - Transitions from current reward-only program financed by added dollars to budget neutral system

QBP transition year	MA-VIP transition year	Full MA-VIP year
QBP/star scoring, half-size bonuses (2.5% & 5%)	MA-VIP scoring, half-size reward pools (e.g., 1%)	MA-VIP scoring, full-size reward pools (e.g., 2%)

Discussion

- We are unable to assess MA quality in a meaningful way; beneficiaries lack good information about MA quality
  - Yet, the QBP costs Medicare about $6 billion annually
- Modeling demonstrates feasibility of the MA-VIP design
- We would appreciate any feedback to support the development of a Commission recommendation