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)

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)

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

<table>
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<tr>
<th>Domain</th>
<th>Measures</th>
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| 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

Points achieved
9
8
7
6
5
4
3
2
1

Peer Group: Non full dual-eligible enrollees

Each circle represents one parent organization. The size of each circle is proportional to a parent organization’s enrollment in the market. The largest circle represents about 62,000 enrollees.

Market 1
(3 Parent Organizations)

Market 2
(7 Parent Organizations)

Market 3
(3 Parent Organizations)

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

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<tr>
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<td>3</td>
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<td>2</td>
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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: Most plans receive small payment adjustments

Based on reward pool funded by 2% of total payments to MA plans

- Fully-dual peer groups eligible beneficiaries
- All-other peer groups of parent organization in market area

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

Red bars represent parent organizations operating in 5 or more markets in our sample.

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.

**Share of enrollment in QBP bonus status, 2017**
- Full dually eligible enrollees: 54%
- Non-duals: 82%
- EGWP enrollees: 92%
- Under-65 enrollees: 67%

**Share of enrollment with positive net payment adjustment, MA-VIP 2017 modeling**
- Full dually eligible enrollees: 53%
- Non-duals: 57%
- EGWP enrollees: 62%
- Under-65 enrollees: 51%

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

<table>
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<th>All parent organizations</th>
<th>Number</th>
<th>Share of enrollment</th>
<th>Average enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>78</td>
<td>100%</td>
<td>89,000</td>
</tr>
<tr>
<td>Have positive MA-VIP net payment adjustment</td>
<td>40</td>
<td>38</td>
<td>66,000</td>
</tr>
<tr>
<td>Have negative MA-VIP net payment adjustment</td>
<td>38</td>
<td>62</td>
<td>113,000</td>
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- 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.

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

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