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

- Important to have information on MA quality: One-third of beneficiaries enrolled in a model of care that should be an efficient, high-quality alternative to FFS
- However, under the current system:
  - Cannot adequately judge MA quality, and how MA plans compare to each other
  - Beneficiaries do not have good information about MA quality in their geographic area
  - Cannot adequately compare MA and FFS quality
- FFS quality incentive programs are budget neutral or produce savings; the QBP adds $6 billion dollars per year in program costs
- Over the past decade, the Commission has written extensively about the flaws with the current system and how it should be financed

The MA QBP has many flaws

OVERBUILT	• Too many measures: 45 measures, including process and insurance function measures
NOT WELL-IMPLEMENTED	• Unwarranted bonus payments and inaccurate/incomplete information on plan quality because of contract-level reporting and consolidations
CREATES UNCERTAINTY	• Plan uncertainty over eligibility for bonus payments (due to 4-star cliff and use of year-by-year tournament model)
INEQUITABLE	• Not clear that peer grouping mechanism is effective; plans serving high-needs populations not in bonus status
COSTLY TO THE PROGRAM	• Financed with additional program dollars, unlike most FFS quality incentive programs • 82 percent of enrollment in bonus-level contracts—unclear that the program identifies the highest-performing plans

The QBP is not well-implemented

- Contract-level reporting of quality is not consistent with the MedPAC 2010 recommendation: Reporting unit should be local market area
- Contract configurations bear no relation to the geography of health care
  - There are unusual area combinations in contract configurations, such as the Iowa-Hawaii contract
  - Three MA contracts have over one million enrollees across multiple states that are the legacy of contract consolidations
  - Quality for many measures based on a sample of 411 enrollees across diverse geographic areas and diverse populations

Contract consolidations exacerbate the problem

- Contract consolidation activity increased because of financial incentives—over 4 million enrollees moved to unwarranted bonus status
  - Companies allowed to use a contract with a bonus-level star rating to absorb contracts not in bonus status, with bonus rating applied to total enrollment
- In March 2018, the Commission recommended changes to consolidation policy to prevent unwarranted bonuses
- Subsequent legislative change makes strategy more difficult—no such activity for 2020

The Commission has long supported a budget-neutral quality incentive program

Commission support for budget-neutral approach over the years	
1999	Encouraged Medicare to institute rewards and penalties for health plans based on quality
2004	Recommended budget-neutral quality incentive program, financed by small withhold
2005	Reiterated support for quality pool financed by withhold of 1 to 2 percent of base payments
2009	Reiterated support for incentive program, adding that, after reform of benchmarks, if MA quality higher than FFS, MA could be paid more than 100 percent of FFS

A budget-neutral approach would have a limited effect on MA extra benefits

- Currently, substantial level of extra benefits
  - Average value of rebates in 2019 is at its highest historic level of $107 per month
- Reductions in payments to MA plans do not always have a commensurate reduction in extra benefits
  - Affordable Care Act benchmark reductions did not have the predicted effect of reductions in extra benefits
  - Analysis in June 2019 chapter shows that
    - Plans that newly achieved bonus status did not use the added money to provide extra benefits
    - Plans losing bonus status maintained their level of extra benefits

A budget-neutral approach would significantly reduce Medicare program costs

- Congressional Budget Office 2018 estimate of a budget-neutral bonus program: $94 billion in savings over 10 years
  - Savings to Part A Trust Fund over 10 years: About $40 billion
  - Savings to Part B: About $54 billion
    - Savings to taxpayers for the 75% financed by general revenues
    - Remaining 25% is savings to beneficiaries and states in reduced Part B premiums (more than $13 billion over the 10-year period)

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 measures
• Contract-level quality measurement is too broad and inconsistent	• Evaluate quality at the local market level
• Bonus targets are not prospectively set	• Measure quality against a scale that is known ahead of time
• Ineffective accounting for social risk factors	• Use peer grouping mechanism to account for differences in enrollee's social risk factors

Future goal: Compare FFS, MA plan and accountable care organizations (ACO) quality in local market area

Score small set of measures calculated at the local market level

- Patient-oriented, encourage coordination across providers, and promote change in the delivery system
- Use measures that are not unduly burdensome for providers/plans (e.g., largely calculated by CMS)
- Lack of complete encounter and clinical data limits the initial measure set for modeling the MA-VIP, but measure set should continue to evolve

Reporting unit: Measure quality of each MA organization within a local market area

Initial MA-VIP measure set

Domains	Ambulatory care sensitive (ACS) hospitalizations	Readmissions	Patient-reported outcomes composite	Patient/ enrollee experience composite
Measures	Risk-standardized rate of ASC hospitalizations per 1,000 enrollees	Risk-adjusted, unplanned readmissions rates across all conditions	Improved or maintained • Physical health status • Mental health status	7 core measures including: • Getting needed care • Care coordination • Rating of health plan
Data sources	Encounter data, MedPAR	Encounter data, MedPAR	Beneficiary-level Health Outcomes Survey (HOS) data	Beneficiary-level Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data

Competition at the market level

- MedPAC's hospital-VIP compared hospital quality distributed rewards and penalties on a national level
- However, the nature of the MA marketplace precludes national level competition
  - Plans can choose to enter and leave market areas, or choose not to participate in certain areas
  - Beneficiaries can and often do switch plans within their market area
- MA-VIP distributes rewards and penalties within each market area
  - Prevent market areas with persistent penalties or rewards for all plans

Evaluate MA-VIP in each local market area using peer grouping

- To account for social risk factors, apply peer grouping within each market area
  - For each parent organization in a market area, create two groups
    - Peer Group 1: Fully dual-eligible beneficiaries
    - Peer Group 2: Non-fully dual-eligible beneficiaries
- Anticipate that peer groups with more social risk factors likely would result in a greater reward per point increase in quality
- Grouping different populations a plan serves within a local market area likely will make payment adjustments more equitable compared with the existing QBP

Estimate of market areas with sufficient parent organization enrollment to be included in the MA-VIP

- Each reporting unit and peer group would need to meet minimum sample size requirements for each measure
- Each MedPAC market area would need 3 reporting units that meet minimum sample size requirements for each measure
  - To ensure adequate comparison and distribution of rewards and penalties
- 96 percent of MA enrollees are in MedPAC market areas with 3 parent organizations that meet minimum enrollment criteria
  - 721 MedPAC market areas (out of 1,230)

Scoring results and distributing quality rewards

- Score performance for each quality domain and peer group (where applicable) based on a national scale
  - Parent organizations have separate scores for each peer group
- Calculate reward pools for each peer group
  - Funded with a withhold of revenue for each group's enrollees
- Distribute rewards by peer group
  - Each reward is proportionate to the points achieved
  - All withheld payments are distributed within the market area

MA-VIP modeling: Next steps

- Due to limitations in current CAHPS and HOS data, the MA-VIP model sample includes:
  - 65 market areas, 87 parent organizations (284 reporting units)
  - About 41 percent of total MA enrollment
- Modeling results to discuss in January:
  - Performance to points scales
  - Distribution of points and reward amounts in each market
  - Plan information by whether achieved rewards or penalties

Discussion

- We are unable to assess MA quality in a meaningful way, beneficiaries lack good information about MA quality
- Yet, the current quality bonus program costs Medicare about $6 billion annually
- We would appreciate discussion and feedback on:
  - Structure of the MA-VIP
  - Considerations for modeling