Redesigning the Medicare Advantage quality bonus program

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Reform of the Medicare Advantage (MA) quality bonus program (QBP) is urgently needed

- 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
- QBP uses broad contract-level quality results; contract consolidations have led to unwarranted bonus payments
- In the QBP plans that serve high-needs population are less likely to be classified as high-quality plans
- QBP adds $6 billion per year in program costs, unlike most FFS quality incentive programs

Many plans receive unwarranted quality bonus payments due to previous contract consolidations

- Many contacts consolidated between 2013 and 2018 to boost star ratings
- Majority of 2020 enrollees are in plans that have some level of consolidation
- Although incentives to consolidate have been addressed, legacy remains:
  - Increased program expenditures
  - Inaccurate consumer information on quality
  - Quality data not representative of performance in a local area
  - Unfair competitive advantage in a given market

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 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
• "Cliff" effect where only plans receiving a set rating receive bonuses	• Establish a system for distributing rewards with no "cliff" effects
• Bonus financing is through added program dollars, unlike most FFS quality incentive programs	• Distribute plan-financed rewards and penalties

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)

* Used 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
- Provides more accurate picture of market-level quality for beneficiaries and the program
- Illustrative MA-VIP reporting unit: Parent organization in local market areas

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

- Stratifies 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, enrollment stratified into two groups and measure results calculated
  - Peer group 1: Fully dual-eligible beneficiaries
  - Peer group 2: Non-fully dual-eligible beneficiaries

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

- Uses a performance-to-points scale to convert measure results to a score which determines rewards and penalties
  - Plans know that improvements impact rewards
  - Continuous scale, so any change in performance affects the size of the reward or penalty
- Illustrative modeling: Performance-to-points scale set using national distribution

MA-VIP: Distribute plan-financed rewards and penalties

- Finances rewards and penalties through a pool of dollars funded by a share of plan payments
  - Key change from current QBP: No bonus increase to plan benchmarks
- Pool of dollars could be distributed:
  - Within each local market, based on local market performance, or
  - Based on a blend of local and national performance

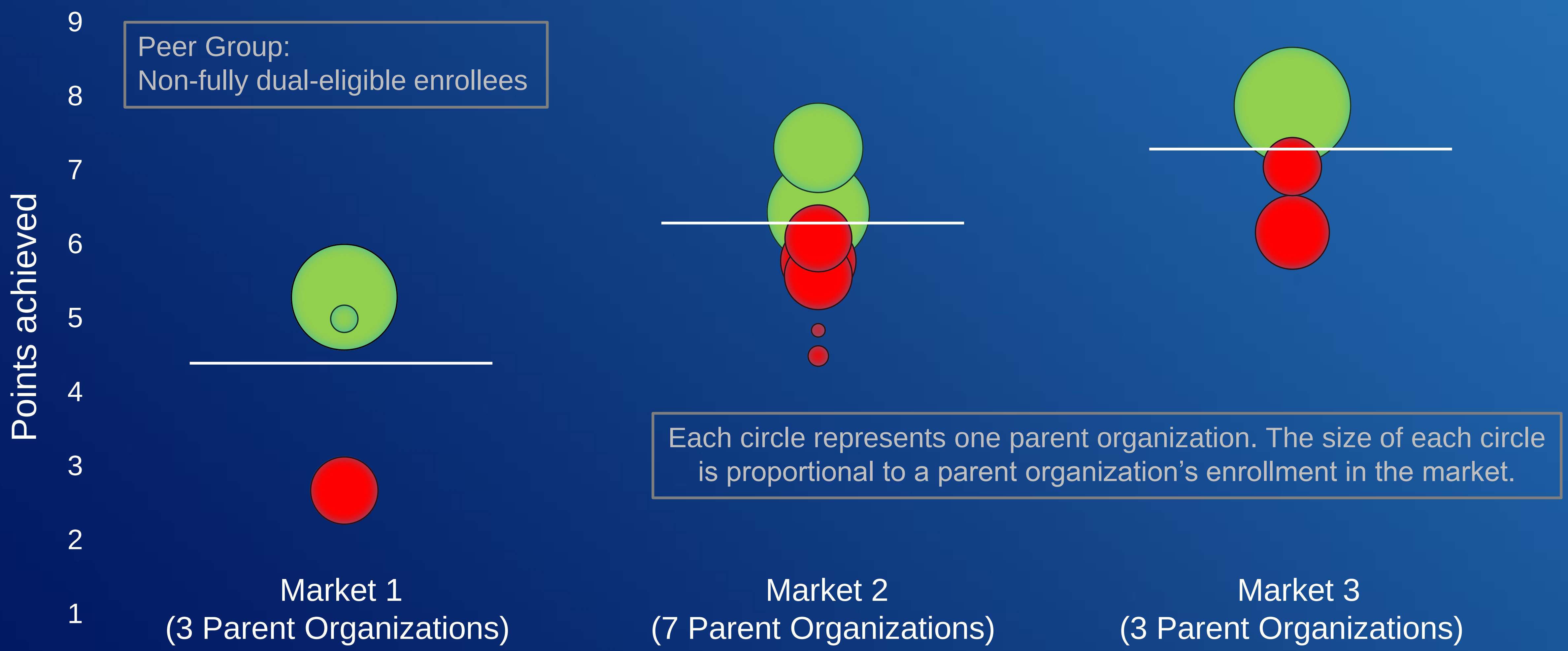
Approaches to distributing rewards and penalties

- Local approach: Equal rewards and penalties in each market
  - Accounts for varying local market conditions (e.g., safety net programs, infrastructure, social risk factors, provider organization)
  - *Would not* redistribute plan payments across markets, maintaining equal treatment of MA and FFS programs in each market
- Blended approach incorporates local and national distribution
  - National distribution holds plans accountable for local market conditions
  - National distribution *would* redistribute plan payments across markets, leading to markets with only rewards or only penalties
  - Blended approach: plans are held partially accountable for market conditions, some redistribution of plan payments across markets

Illustrative MA-VIP model: Sample

- Due to limitations in current survey data, the MA-VIP model sample:
  - Is based on local distribution of reward pools
  - Includes 78 parent organizations in 61 market areas, for a total of 258 reporting units
- Modeling results to discuss today:
  - Points achieved by parent organizations in example markets
  - Positive adjustments (rewards) and negative adjustments (penalties) applied to overall plan payments, zero percent adjustment means that plan payments are unaffected by quality performance

Illustrative MA-VIP model: Local distribution of rewards and penalties in three example markets



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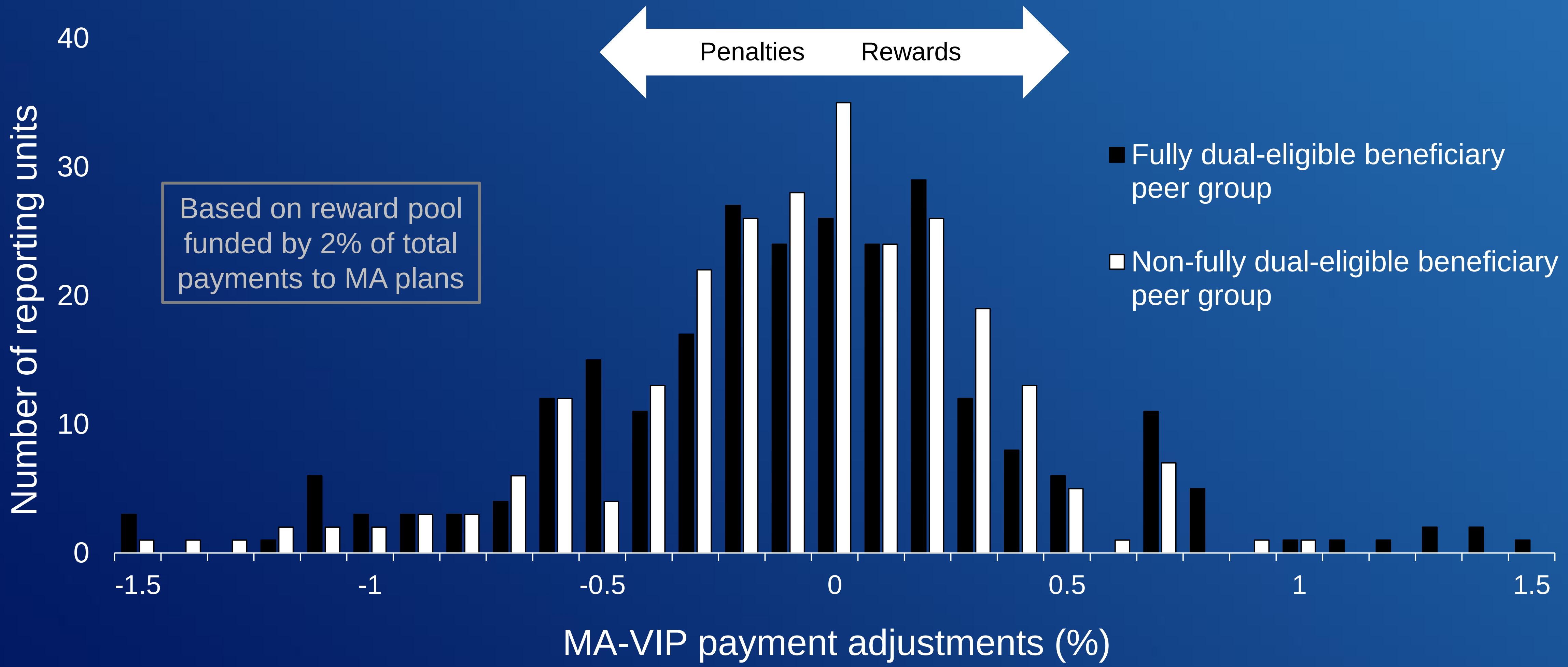
Source: MedPAC analysis of MA quality and payment data, 2015-2017. Note: Results are preliminary and subject to change.

Illustrative MA-VIP model: 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.

Impact of MA-VIP on plans compared to the QBP

- Narrows the payment disparity between plans with large shares of fully dual-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

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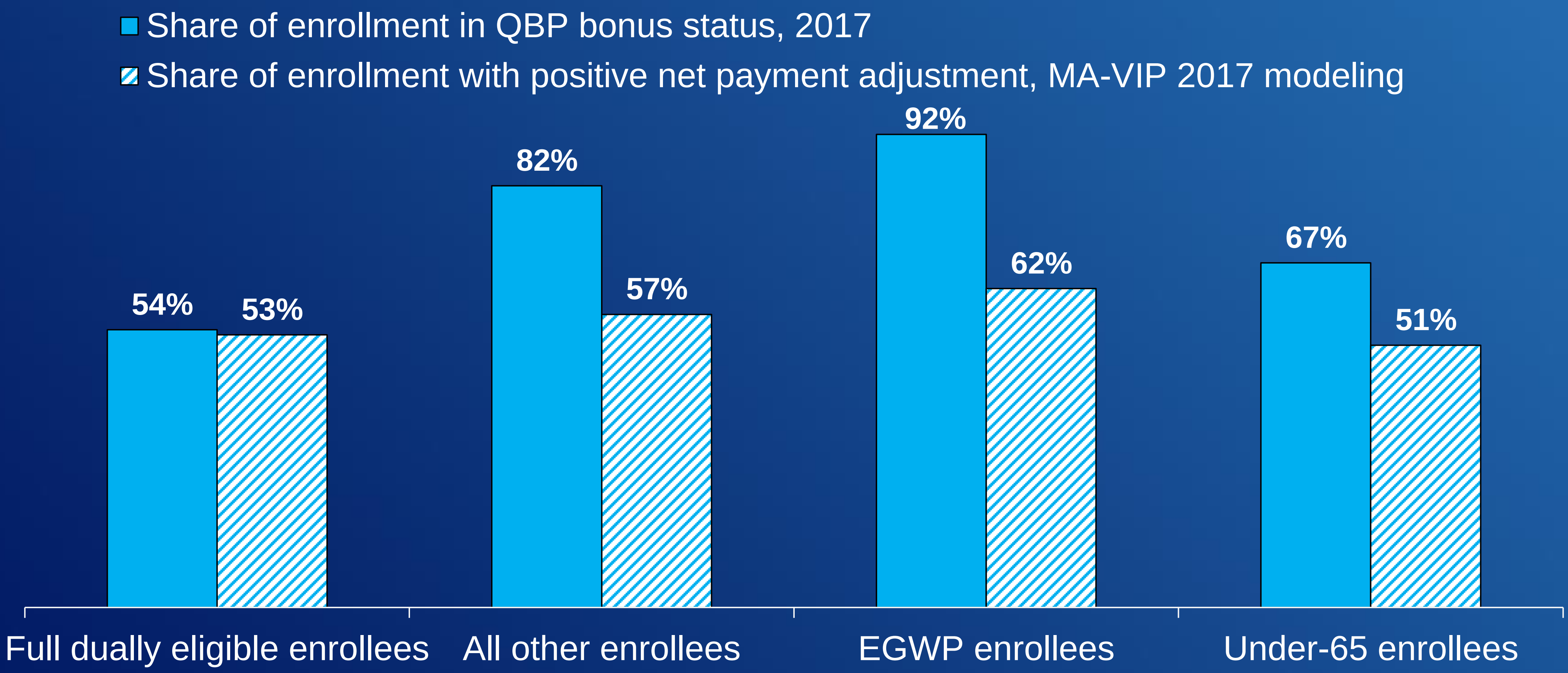
Compared to the QBP, the MA-VIP mitigates the payment disparity between full dually eligible beneficiaries and other populations



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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Smaller organizations in our model fare better in the MA-VIP than in the QBP

- 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
- Under MA-VIP, organizations receiving net rewards have lower enrollment on average than organizations with net penalties
- Our modeling included 20 parent organization that received no 2017 QBP bonus payments in any of their markets
  - Of these, 8 would receive net rewards under the MA-VIP
  - The 8 organizations were small and operating in single markets or a small number of markets