Redesigning the Medicare Advantage quality bonus program

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MEDPAC

Today's presentation

- Review of concerns with the current Medicare Advantage (MA) quality bonus program (QBP)
- Redesign of the program to be consistent with the Commission's principles for quality measurement (June 2018)
- Review of financing issues
- Discuss plan for future modeling
- Seek your input on
  - Proposed measure set
  - Peer grouping mechanism
  - Budget-neutral financing

Purpose of the star rating system and bonus payments

- MA star rating system dates from before the bonus program, designed as vehicle to inform beneficiaries about MA quality
- PPACA: Star ratings to be used as basis for bonus payments
  - Higher benchmarks for higher-rated plans
  - Higher benchmarks may be used to give extra benefits to beneficiaries, attracting enrollees to bonus-level plans
    - Beneficiaries influenced more by premiums and benefits than quality star ratings in choosing MA plans
- Financed with additional (new) money per PPACA—currently $6 billion per year

Note: PPACA (Patient Protection and Affordable Care Act of 2010)

Star rating system not serving intended purpose of informing beneficiaries about quality

- Stars assigned at MA contract level
- Because contracts cover wide geographic areas and sometimes non-contiguous areas:
  - Stars no longer source of accurate information on quality for beneficiaries comparing plans in a given area
  - Stars not a good measure of MA quality because of geographic variation in quality

QBP (and underlying star rating system) not serving intended purpose of rewarding quality

- Because MA organizations have been allowed to consolidate contracts to boost star ratings:
  - Even more large contracts covering wide geographic areas (compounding the problem of inaccurate information)
  - Unwarranted bonus payments
- Commission made recommendation to address consolidations (2018); legislation partly addresses issue

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

Concerns with current QBP design	Redesigned MA-VIP
• Uses up to 46 measures, including process and insurance function measures • Unwarranted bonus payments through consolidation • Scores measure results using “tournament model;” targets not known in advance • Not clear that peer grouping mechanism is effective; plans serving high-needs populations not in bonus status	• Use small set of population-based outcome and patient experience measures • Evaluate quality at local level, not contract level • Score measure results using absolute performance targets • Use alternative peer grouping mechanism to convert performance to rewards and penalties

Overall goal: Allow comparison of FFS, MA plan and accountable care organizations (ACO) quality in local market area

MA-VIP: Small set of population-based measures

- Score a small-set of population-based outcome and patient experience measures that are patient-oriented, encourage coordination across providers, and promote change in the delivery system
- Use MA-VIP measures that are not unduly burdensome for providers (e.g., largely calculated or administered by CMS)
- Medicare and plans can use other measures, such as process and insurance function, to monitor plan performance and for public reporting

MA-VIP: Outcome and patient experience measure domains scored at the local level

- Readmissions
- Potentially preventable admissions
- Potentially preventable emergency department visits
- Patient experience (e.g., getting needed care, rating of health plan)
- Patient-reported outcomes: Improving or maintaining physical and mental health status

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

MA-VIP: Score measure results using absolute performance targets

- Current QBP uses a “tournament model” under which plans are scored relative to one another
  - Difficult for plans and providers to know how they will be judged
- MA-VIP would give rewards based on clear, absolute, and prospectively set performance targets
- MA-VIP would define a continuous performance-to-points scale

MA-VIP: Use peer grouping to convert performance to rewards and penalties

- Medicare should account for differences in plan's patient populations, including social risk factors, through payment and not by adjusting measure results
- Current QBP adjusts overall star ratings based on share of low-income and disabled enrollees, but plans with a higher proportion of low-income beneficiaries continue to have lower ratings
- MA-VIP would use an alternative peer grouping mechanism (stratification) to convert performance to rewards and penalties

MA-VIP: Peer grouping in local market areas

- MedPAC's hospital-VIP grouped hospitals on a national level by the share of fully dual-eligible beneficiaries they treated
- However, the nature of the MA marketplace precludes national level peer grouping
  - 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 would apply peer grouping within a market area
  - For each plan in a market area, create two groups
    - Peer Group 1: Fully dual-eligible beneficiaries
    - Peer Group 2: Non-fully dual-eligible beneficiaries

MA-VIP: Effect of peer grouping at the local level

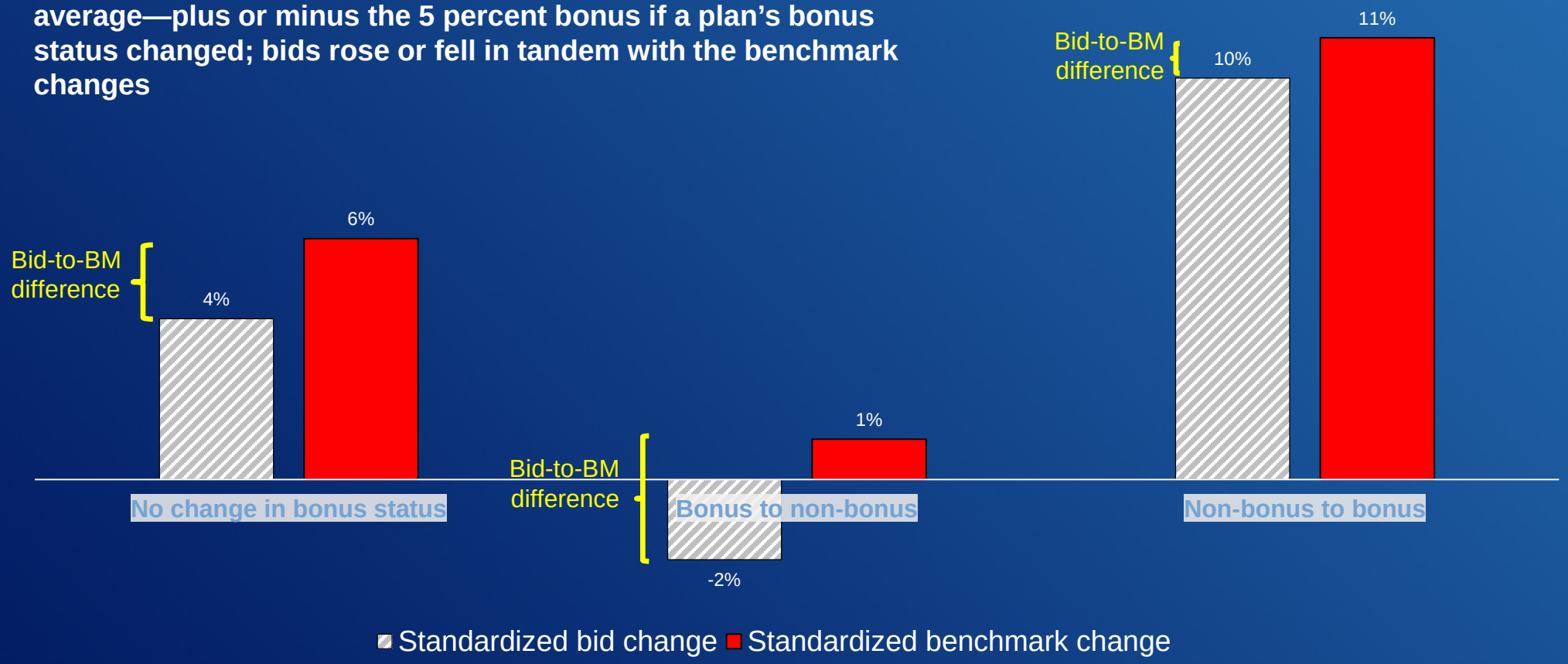
- Peer groups with more social risk factors likely would result in a higher reward for higher quality
- Grouping different populations a plan serves within a local area likely will make payment adjustments more equitable compared with the existing QBP
- MA-VIP would financially reward plans for efficiently providing high-quality care to beneficiaries

Financing: Applying budget neutrality to MA's quality payment program

- QBP financed with added dollars ($6 billion in 2018) in a reward-only system
- In contrast, all other Medicare quality incentive programs are budget neutral or involve penalties, with dollars carved out of the sector for bonuses and penalties
- FFS quality incentive programs exert financial pressure on providers; QBP does not
- Does the additional $6 billion produce value for beneficiaries?
  - Misconception regarding bonus payments: Plans **not required** to use all bonus dollars for extra benefits

Plans' bidding responds to changes in benchmarks

- **Between 2018 and 2019, benchmarks (BMs) rose by 6 percent on average—plus or minus the 5 percent bonus if a plan's bonus status changed; bids rose or fell in tandem with the benchmark changes**



Note: Bid-to-BM difference indicates how much of the benchmark increases will be used to provide extra benefits, including amounts financed not solely by increased program payments but also by plans (in the middle group) reducing their bids. Data are weighted by projected enrollment and exclude special needs plans.

Source: MedPAC analysis of 2019 MA bid data

Results preliminary; subject to change

Plans are not required to use all bonus dollars to finance extra benefits

	Bonus to non-bonus plans	Non-bonus to bonus plans
Beneficiary rebates from 2018-to-2019 payment/bid changes	**$ 21**	**$ 17**
Bid increase for Medicare benefit and its components	**$14**	**$83**
• Change in net medical expenses	30	59
• Change in administrative costs	(5)	(10)
• Change in margin	(10)	33

- **In 2019, plans losing bonus status gave enrollees a larger increase in their extra benefits ($21) than plans getting new added payments through bonuses ($17)**
- **A large share of the new money received by plans newly in bonus status was used to increase margins ($33—twice their rebate level), while plans leaving bonus status reduced their margins (by $10 per member per month)**

Note: Data are risk-adjusted figures weighted by projected enrollment and exclude special needs plans; figures may not add due to rounding

Source: MedPAC analysis of 2019 MA bid data

Results preliminary; subject to change

Summary: Issues with the current QBP and how they could be addressed by the MA-VIP

ISSUE IN QBP	HOW ADDRESSED IN A REDESIGNED SYSTEM
1. Uses 46 measures, including process and insurance function measures	1. Use small set of population-based outcome and patient experience measures
2. Unwarranted bonus payments through consolidations	2. Quality evaluated at local level, not contract level
3. Scores measure results using "tournament model"; targets not known in advance	3. Scores measure results using absolute performance targets
4. Not clear that peer grouping mechanism is effective; plans serving high-needs populations not in bonus status	4. Use alternative peer grouping mechanism (stratification) to convert performance to rewards and penalties
5. Financed with additional program dollars, unlike FFS quality incentive programs	5. Financing could be budget-neutral, with funds from a small percentage of payment from all plans

Next steps and discussion

- Plan to model the MA-VIP based on the Commission's feedback
  - Anticipate some issues with completeness of data
- Discussion
  - Feedback on design of the MA-VIP
    - Measure set
    - Peer grouping at the local market area level by population
    - Financing: Applying budget neutrality to MA's quality payment program