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

Carlos Zarabozo, Ledia Tabor, Andy Johnson

November 7, 2019
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

<table>
<thead>
<tr>
<th>Year</th>
<th>Commission Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>Encouraged Medicare to institute rewards and penalties for health plans based on quality</td>
</tr>
<tr>
<td>2004</td>
<td>Recommended budget-neutral quality incentive program, financed by small withhold</td>
</tr>
<tr>
<td>2005</td>
<td>Reiterated support for quality pool financed by withhold of 1 to 2 percent of base payments</td>
</tr>
<tr>
<td>2009</td>
<td>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</td>
</tr>
</tbody>
</table>
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)

<table>
<thead>
<tr>
<th>Flaws with current QBP design</th>
<th>Redesigned MA-VIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Too many measures, not focused on outcomes and patient/enrollee experiences</td>
<td>• Score a small set of measures</td>
</tr>
<tr>
<td>• Contract-level quality measurement is too broad and inconsistent</td>
<td>• Evaluate quality at the local market level</td>
</tr>
<tr>
<td>• Bonus targets are not prospectively set</td>
<td>• Measure quality against a scale that is known ahead of time</td>
</tr>
<tr>
<td>• Ineffective accounting for social risk factors</td>
<td>• Use peer grouping mechanism to account for differences in enrollee’s social risk factors</td>
</tr>
</tbody>
</table>

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

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