

Double-Bonuses to Medicare Advantage Plans Do Not Increase Enrollment, Enhance Quality or Promote Equity

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Research Objective: Enrollment in Medicare Advantage (MA) – private plans for Medicare beneficiaries – has grown remarkably. Fueled by generous Medicare payments, MA offers attractive benefits and modest cost-sharing. Yet policymakers have argued that MA plans are overpaid and questioned its value. In response, the 2012 ACA cut MA payments while creating the Quality Bonus Program (QBP) in 2012. The QBP awards bonuses to plans with high star ratings (ranging 1–5, 5 being highest) based on clinical care, consumer satisfaction, and drug plan quality.

An unusual feature of the QBP is the delineation of “double-bonus” counties – larger population areas with high MA enrollment and low fee-for-service spending – where high-quality plans receive bonuses that are twice as large as plans with equivalent quality in non-double-bonus counties. Double bonuses are large, totaling \$2.3 billion in 2019. However, little is known about their impact on MA enrollment, quality, and equity.

Study Design: We used national data to test the association of double bonuses with MA enrollment, quality and equity from 2008 through 2018. First, using difference-in-differences (DID) analysis of enrollment in MA vs traditional Medicare, we compared MA enrollment in double-bonus and non-double-bonus counties, before and after double bonus eligibility. Second, using DID analysis of MA quality, we compared performance for 9 measures of quality consistently included in the QBP: breast cancer screening, 4 diabetes measures (e.g., A1c testing), 3 medication adherence measures (e.g., statins), and 1 rheumatoid arthritis management measure. Finally, we tested whether double bonuses were allocated equitably, comparing the probability of residing in a double-bonus county among Black versus White Medicare beneficiaries.

Population Studied: We evaluated MA enrollment using the 100% Medicare Beneficiary Summary File (544,356,215 beneficiary-years). We evaluated MA quality using 100% claims data for MA beneficiaries ages 50–74 using the largest commercial MA database in the United States (27,249,714 measure-beneficiary-years).

Principal Findings: In the pre-period (2008–2011), MA enrollment was 36% and 18% in double-bonus versus non-double-bonus counties, respectively. In DID models, double bonuses were not associated with changes in MA enrollment (DID, –1.9 percentage point [pp], 95% confidence interval [CI], –4.1, 0.3). In the pre-period, quality measures were achieved for 67.7% and 68.2% of MA beneficiaries in

double-bonus versus non-double-bonus counties, respectively. In DID models, double bonuses were not associated with changes in MA quality (DID, +2.2 pp, 95% CI, –1.6 to 6.1). Black beneficiaries were 5.8 pp (95% confidence interval [CI], –9.3, –2.3) less likely than White beneficiaries to reside in double-bonus counties, a relative difference of 24%.

Conclusions: In this national study of the MA double bonus policy, we report three main findings. First, double bonuses were not associated with MA enrollment. Second, double bonuses were not associated with MA quality performance. Finally, double bonuses were offered much less frequently to plans serving Black than White populations.

Implications for Policy or Practice: Our findings suggest that double bonuses are not an efficient or equitable mechanism for promoting enrollment or quality in MA. As MA expands, CMS should experiment with alternative strategies for improving value and equity in the program.

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Do Hospitals That Volunteer for Joint Replacement Bundled Payments Save More Money Than Those Required to Participate?

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Research Objective: Medicare has used both voluntary and mandatory programs to engage hospitals in joint replacement bundles. Starting in 2013, hospitals voluntarily joined the Bundled Payments for Care Improvement (BPCI) program. In 2016, Medicare randomly assigned hospitals in 67 of 196 metropolitan statistical areas (MSAs) to mandatory bundled payments under the Comprehensive Care for Joint Replacement (CJR) program. Because the CJR mandate applied to both hospitals with and without prior experience in BPCI, Medicare created the unique opportunity to compare performance between hospitals that voluntarily self-selected into bundled payments (i.e., chose to participate in BPCI prior to CJR) versus hospitals that did not (i.e., did not participate in BPCI prior to CJR).

Study Design: Our study leveraged the randomized design of CJR and compared CJR MSAs to non-CJR MSAs weighted by strata and using an intention-to-treat approach. We used 2011–2017 Medicare claims and generalized linear models with hospital fixed effects to conduct a difference-in-differences analysis evaluating patients in CJR-mandated markets undergoing joint replacement at hospitals with BPCI experience (*voluntary hospitals*) versus without BPCI experience (*mandatory hospitals*) prior to CJR. Like prior work, our comparison