The Impact of Payment Reform on Rural Medicare Advantage Enrollment and Quality

Leah M. Kemper, Timothy D. McBride, and Abigail R. Barker

Washington University in St. Louis and RUPRI Center for Rural Health Policy Analysis

Contact: Leah M. Kemper, Policy Analyst, Washington University in St. Louis, Brown School, 1 Brookings Drive, St. Louis, MO 63130, email: kemper@wustl.edu

Introduction

This project examines the implications of changes in Medicare Advantage (MA) payment implemented in the Patient Protection and Affordable Care Act of 2010 (ACA) and in the current Centers for Medicare and Medicaid (CMS) demonstration of quality-based bonus payments. In addition, MA plan quality in both rural and urban areas is studied to monitor the effects of the payment policies on quality improvement. This research also focuses on key issues including: how the changes to MA payment, including bonus payments linked to quality-based star ratings, impact the plans available to rural beneficiaries, the likely impact of these changes on enrollment in MA plans, and the differences in MA plan quality both regionally and in rural and urban areas.

Motivation

This analysis of MA data looks at enrollment and quality as a function of geography, while at the same time looking at the payment benchmark and the quality bonus payments received by the plans. This study generated results using both the parameters established by the ACA and the current CMS demonstration for quality based bonus payments. In 2010, the ACA authorized quality–based bonus payments to MA plans beginning in 2012. MA plans are given a star rating based on their scores on a number of performance measures and—beginning in 2012—received bonus payments for high quality. The ACA quality bonus payments were expanded by a CMS demonstration that dramatically increased the number of plans that were eligible to receive the bonus payments. The demonstration lowered the threshold required of the plans to receive the bonus payment (Figure 1). This analysis looks at the county-level data to determine the impact of the bonus payments by county on MA payment. In addition, the researchers looked for any changes (positive or negative) in the quality scores of the MA plans given that the bonus payment are incentives for quality improvement.

Figure 1. Medicare Advantage Quality Based Bonus Payments as a Function of the Star Ratings

Star Rating	MA Quality Bonus Payments							
	PPACA				PPACA as modified by CMS Demonstration			
	2012	2013	2014	2015	2012	2013	2014	2015
5 Stars	1.5%	3%	5%	5%	5%	5%	5%	5%
4 or 4.5 Stars	1.5%	3%	5%	5%	4%	4%	5%	5%
3.5 Stars	0	0	0	0	3.5%	3.5%	3.5%	0
3 Stars	0	0	0	0	3%	3%	3%	0
Fewer than 3 Stars	0	0	0	0	0	0	0	0

The expansion of the quality–based bonus payments, authorized by the CMS demonstration, are scheduled to end in 2014 and the bonus payments will then follow the parameters established by the ACA (Figure 1). Rural counties are more likely to lose their bonus payments because of their lower quality scores, on average ,compared to urban areas. This research measures the effect of the end of the demonstration on MA payment at the county level and monitors the changes in plan quality since the bonus payments went into effect. In addition, rural and urban MA quality is analyzed to detect differences in the star ratings and availability of MA plans in these areas.

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Data and Methods

The data are from CMS for 2010 and 2012. Files used include: Source Files detailing plan types, benefits and premiums by contract ID and plan ID; enrollment data by contract ID, plan ID, and county; Service Area files by contract ID and county; and quality scores by contract ID. Only plans offering Medicare Advantage with prescription drug coverage and non-employer plans were considered. Territories were excluded. Enrollment data below ten persons is censored, so we treated these values as equal to ten. Results were not sensitive to other choices of this value.

The method was to merge the data described above for both 2010 and 2012 separately, creating files that show, for each county, how many MA enrollees are in plans of various types, quality levels, and cost sharing. These data are merged with Urban Influence codes to determine urban or rural status of the county. Ultimately, the 2010 and 2012 files are also merged in order to track quality changes over time. Most of the descriptive results shown below are obtained directly from this file. To create the map showing payment changes due to quality-based methodology under the ACA, we use the more recent data only. We project how payment changes as the demonstration ends by calculating the bonus payment as well as adjusting the bidding rebate based upon the particular plan's most recent quality score, while factoring in the county-level changes to the benchmark calculation (i.e., the division of all counties into quartiles based upon their fee-for-service costs). This is then compared to the amount the plan would have earned in bonus payments and rebates, based upon star rating at the time, before the ACA implementation began.

Discussion and Implications

Overall, we find that, on average, MA quality in rural areas is lower than in urban areas, but this difference is a result of a difference in the composition of enrollment in the MA market—specifically in rural and urban areas (Figure 2). The bulk of enrollment in rural areas is concentrated in preferred provider organizations (PPO) plans, while the bulk of enrollment in urban areas is concentrated in health maintenance organization (HMO) plans. HMOs typically have higher quality scores than PPO plans resulting in higher overall quality scores in urban areas. This finding that the rural/urban quality differential exists because of a difference in the MA market composition suggests that the focus on quality improvement for MA plans should focus on the type of plan, not its location. What this also shows is that the same percentage of rural plans as urban (39% and 40%)—but a higher proportion of enrollees (31% vs. 24%)—are in plans with 3 or fewer stars (Figure 3), indicating that rural residents are more likely to enroll in lower quality plans. In addition, this research found that the quality of plans varies regionally across the country with the highest quality scores in the Northeast, West and the Upper-Midwest (Figure 3).

While many MA plans are currently benefitting from the demonstration program, nearly all counties will experience a reduction in their quality-based bonus payments with the conclusion of the demonstration program in 2014, if the quality scores remain the same, with some counties faring worse than others. There is significant variation in the amount of payment reduction the counties will experience, ranging from no reduction to over $400 per enrollee annually (Figure 6). However, the highest quality counties will continue to receive the same levels of bonus payments. Rural bonus payments will decline in many areas, but rural counties will not be as negatively impacted as many urban areas. Going forward we are identifying specific quality indicators that account for the bulk of the difference in quality among rural and urban plans, and we categorize these with regard to their implementation feasibility. Some of the reductions in MA payment that began with the ACA are offset by quality-based bonus payments. Rural areas have lower average quality ratings and less HMO enrollment; therefore, they won't benefit significantly from the ACA quality payments. As demonstration bonus payments end in 2014, and the transition to the new MA payment structure begins, these reductions in payment could have an impact on MA enrollment and plan availability going forward. In addition, the research showed that plans are improving their quality in both rural and urban areas (Figure 5), and that plans with lower quality scores tend to be leaving the MA program (since 2010) and those with higher quality scores are staying (Figure 7). The quality based bonus payments have significant cost, but they appear to be incentivizing the plans to improve quality, benefiting both rural and urban MA beneficiaries.

Results

Figure 2. Average MA plan quality star ratings by type of plan and location

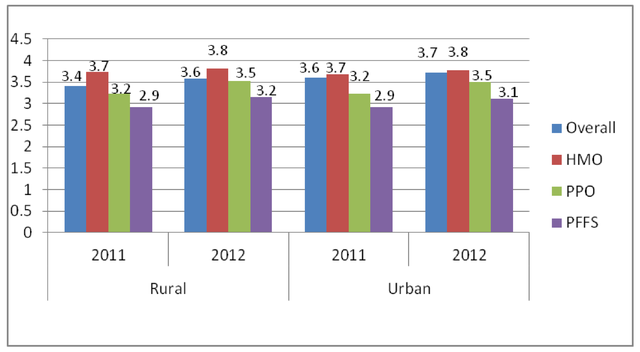

Figure 3. Distribution of Enrollment within MA Plans by Quality Star Ratings

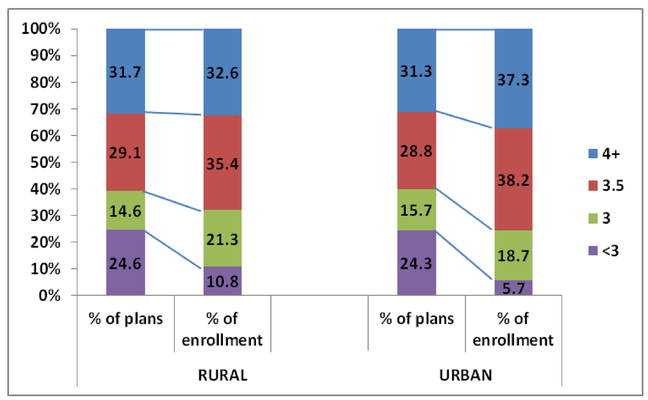

Figure 4. Average MA Plan Star Ratings by County, 2012

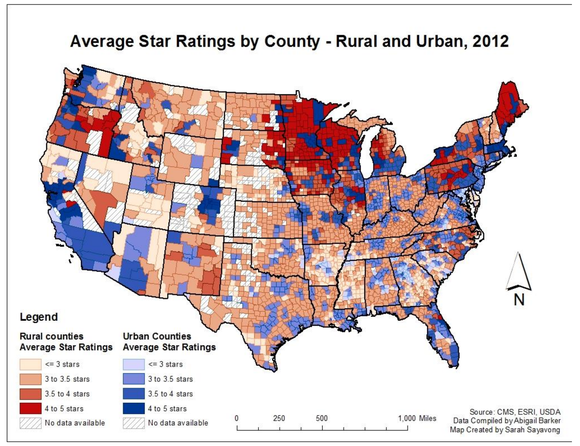

Figure 5. Percentages of MA Plans that Crossed a Quality Threshold from 2010-2012, Making them Eligible for Bonus Payments

	Rural			
	3 Stars	3.5 Stars	4 Stars	none
HMO	2%	16%	16%	67%
Local PPO	0%	12%	20%	68%
PFFS	0%	20%	0%	80%
Regional PPO	1%	47%	0%	52%
	Urban			
	3 Stars	3.5 Stars	4 Stars	none
HMO	2%	13%	16%	70%
Local PPO	1%	22%	15%	63%
PFFS	0%	8%	0%	92%
Regional PPO	0%	33%	0%	67%

Figure 6. Potential Change in MA bonus payments to plans, per enrollee, with the end of the CMS Demonstration in 2014

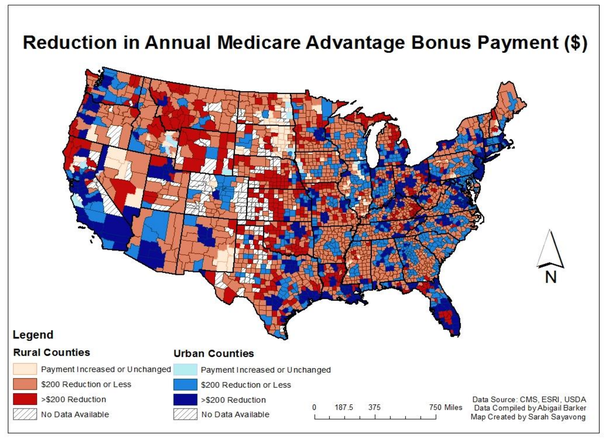

Figure 7. Average Star Ratings for MA plans that are Exiting, Continuing and Leaving the MA Program

	Data	Exiting Plans	Staying Plans	Entering Plans
Rural	2010 enrollment weights	3.16	3.37	--
	2012 quality scores, 2010 enrollment weights	--	3.51	--
	2012 quality scores, 2012 enrollment weights	--	3.56	3.73
Urban	2010 quality scores, 2010 enrollment weights	3.13	3.49	--
	2012 quality scores, 2010 enrollment weights	--	3.70	--
	2012 quality scores, 2012 enrollment weights	--	3.72	3.66