Medicare Advantage Enrollment and Quality: Impact on Payment Reform

Timothy D. McBride
Leah Kemper
Abigail Barker
Keith Mueller

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Washington University in St. Louis, Brown School
University of Iowa, RUPRI Center for Health Policy Analysis

Introduction

- Affordable Care Act (ACA) implements changes in payment for Medicare Advantage (MA) plans
  - Payment will be based in part on MA plan quality as well as current level of payment
  - Centers for Medicare and Medicaid (CMS) demonstration focused on effects of quality-based bonus payments on MA plans
- This study looks at MA plan quality by plan type (HMO, PPO, PFFS) across geography (urban, rural) and explores impacts of proposed payment changes
  - What is the status quo in terms of quality of MA plans?
  - How will the proposed policy change impact MA plans and recipients? Will it have the intended effect?

Background

- 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
  - Policy was to give plans a bonus payments for high quality starting in 2012 if their star rating was 4 stars or higher
- 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, since plans with three or more stars were given bonus payments (Figure 1)
  - Our analysis explores how many plans, and of what type fall into these thresholds

Medicare Advantage Quality Based Bonus Payments as a Function of Plan "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

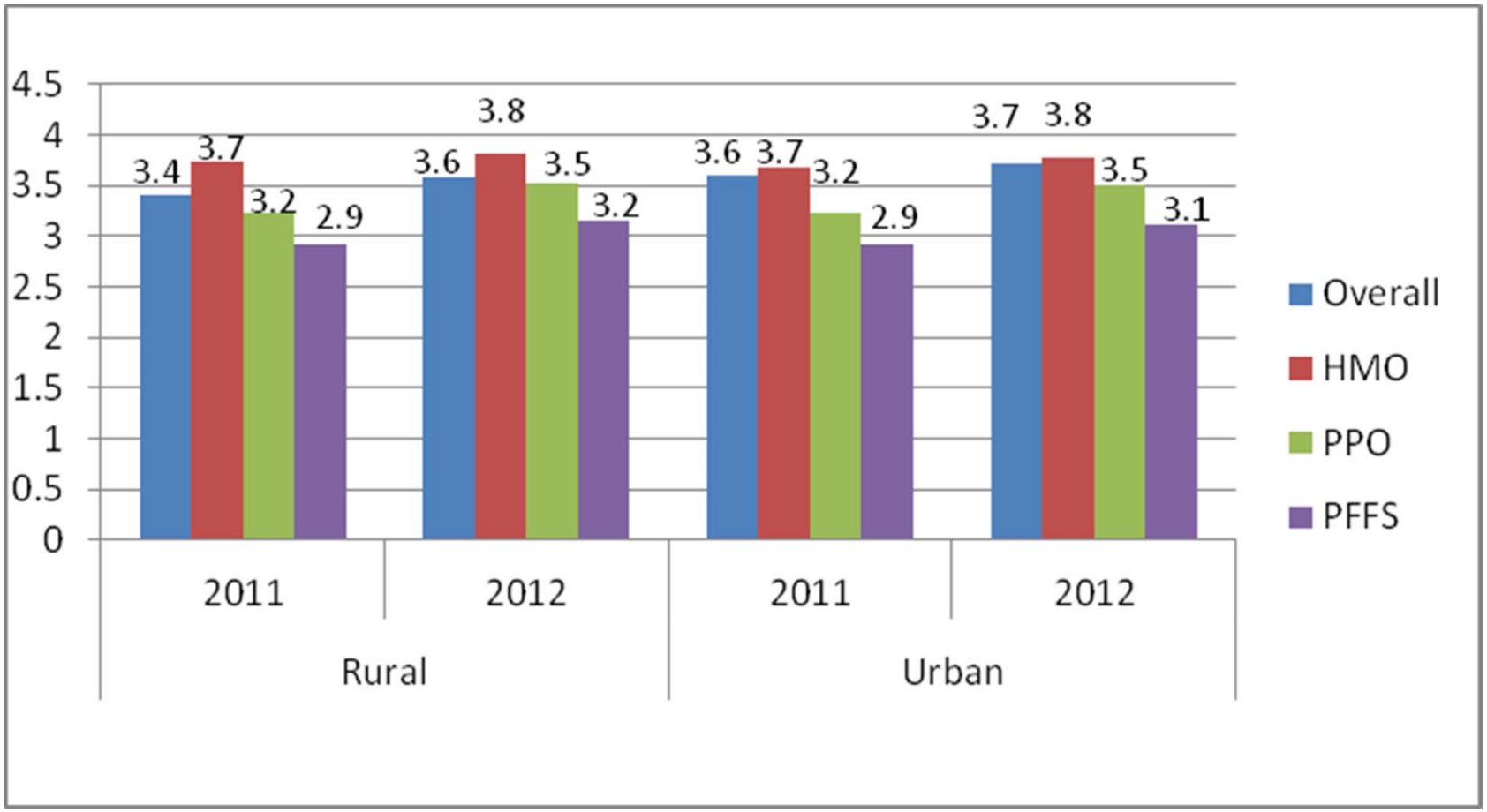
Data and Methods

- Source of data: Centers for Medicare & Medicaid Services (CMS), 2010, 2012
  - Source Files: plan types, benefits, premiums by contract ID and plan ID; enrollment by contract ID, plan ID, and county;
  - Service Area files by contract ID and county; and quality scores by contract ID.
  - Includes only plans offering MA with drug coverage and non-employer plans were considered.
  - Territories excluded; and 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.
- Methods:
  - Merged data for 2010, 2012 by county, Urban Influence codes to identify type of county
  - Weighted enrollment by plan types, quality levels, and cost sharing.
  - Projections of payment changes computed 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 as specified in ACA (i.e., the division of all counties into quartiles based upon their fee-for-service costs); compared to amount the plan would have earned in bonus payments and rebates, based upon star rating at the time, before the ACA implementation began.

Average MA plan quality star ratings by type of plan and location

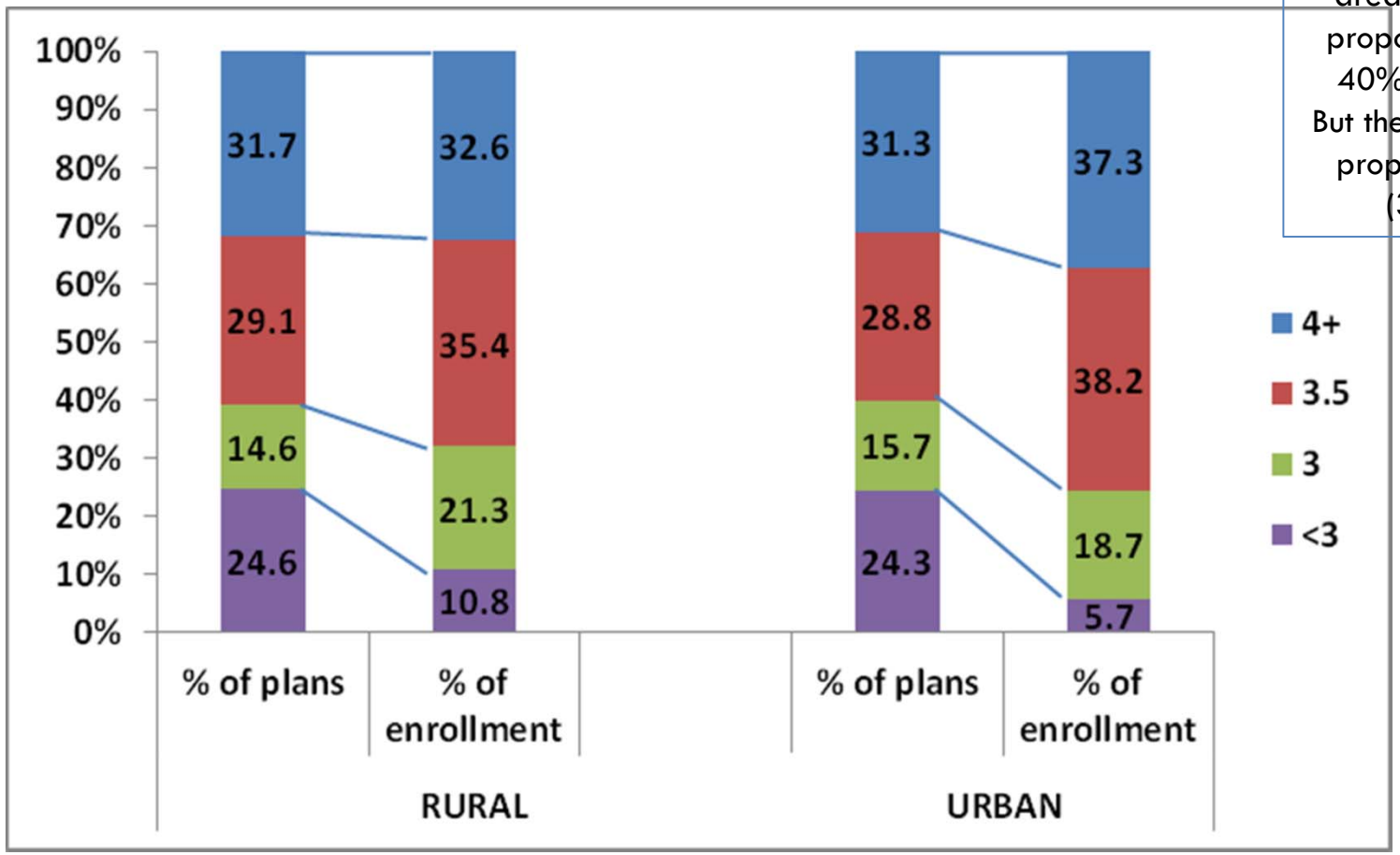
Overall Rural has lower quality, compared to urban in 2011 (3.4<3.6) and in 2012 (3.6<3.7)

However, note that rural HMO=urban HMO, rural PPO=urban PPO, rural PFFS=urban PFFS in both years

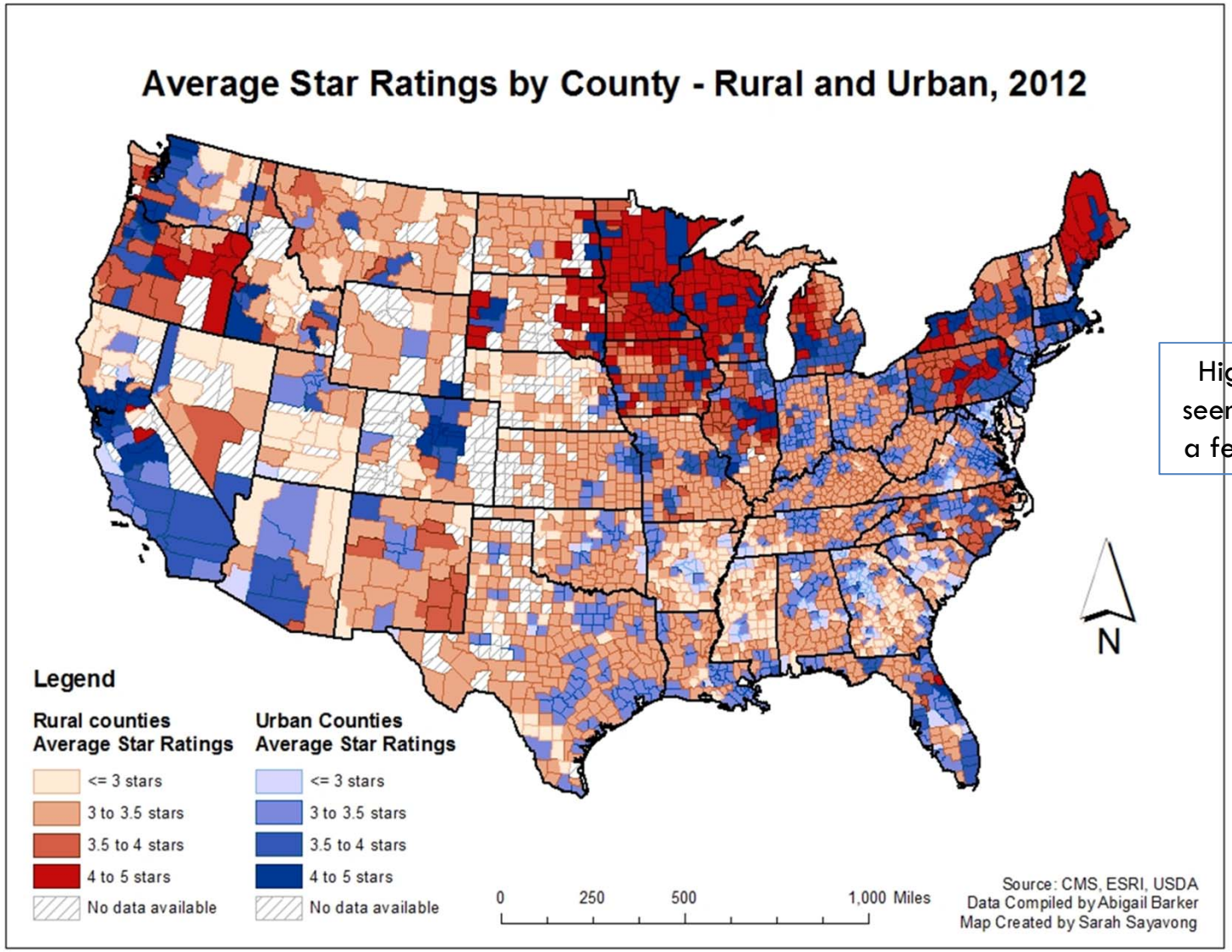


Distribution of enrollment within MA plans by quality star ratings

In both urban and rural areas, a relatively high proportion of plans (39-40%) have quality<4*
But these plans have lower proportion of enrollees (32% R, 24%U)

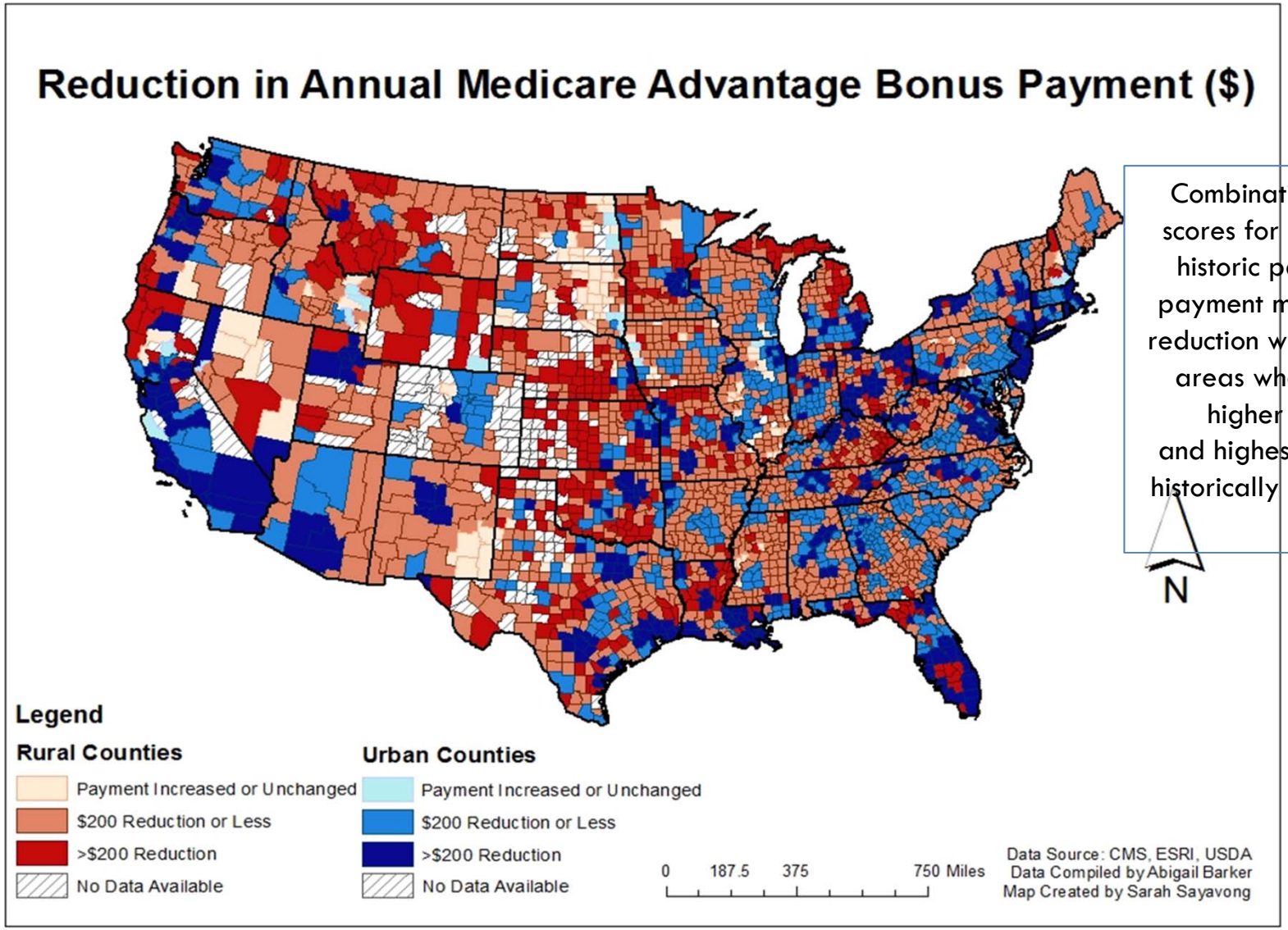


Average MA star ratings by County, 2012



Higher quality MA plans seem to be concentrated in a few areas of the country

Potential change in MA bonus payments to plans, per enrollee, after end of CMS demonstration, 2014



Combination of quality scores for MA plans and historic pattern of MA payment means payment reduction will be smaller in areas where quality is higher (e.g., WI), and highest in areas with historically high rates (e.g. FL)

Discussion and Implications

- MA quality does vary by location (urban v rural, and by are of the country)
  - However, overall MA quality in rural areas is lower than in urban areas, but difference is result of composition of enrollment; enrollment in rural areas is concentrated in PPOs while in urban areas enrollment is concentrated in HMOs
- This suggests that the focus on quality improvement should focus on the type of plan, not its location.
- Nearly all enrollees will experience a reduction in their quality-based bonus payments when demonstration concludes, if the quality scores remain the same
  - There is significant variation in the amount of payment reduction the counties will experience, ranging from no reduction to over $400 per enrollee annually
  - Research needs to focus on what accounts for the bulk of the difference in quality across plans and regions
  - While this result is preliminary, plans showed some slight improvement in quality in both rural and urban areas from 2011 to 2012, so the incentive payments may be having some effect

Average quality star ratings for continuing, exiting and entering MA plans

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

Exiting plans seem to have lower quality; entering plans higher quality

Percentage of MA plans that crossed a Quality threshold between 2010 and 2012, making plan 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%

There is some evidence bonus payments are creating incentive effects for PPOs and HMOs, stronger for plans where bonus is attainable;
Not for PFFS plans