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2012 Rural Medicare Advantage Quality Ratings and Bonus Payments

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Key Data Findings

- The average rural Medicare Advantage (MA) plan enrollee in 2012 experienced a quality rating of 3.60 stars (of a potential 5.0), compared with a rating of 3.71 stars experienced by urban enrollees.
- The measured rural-urban difference in the MA plan quality is a result of the difference in the composition of the enrollment and plan availability in MA markets, rather than differences between MA plans of the same type.
    - In general, rural Medicare beneficiaries often have limited MA plans available from which to choose, and typically have lower quality ratings than urban MA plans.
    - Rural MA beneficiaries are more likely to be enrolled in preferred provider organization (PPO) plans than in health maintenance organization (HMO) plans.
    - PPO plans have lower quality ratings on average than HMO plans.
    - HMO plans had the highest average quality rating at 3.83 and 3.78 stars, respectively, in rural and urban areas. PPO plans had lower quality ratings, at 3.52 and 3.50, respectively.
- In rural areas, 32% of the MA population is enrolled in a plan with a star rating of 4.0 or higher, and 92% are enrolled in a plan with a star rating of at least 3.0, as contrasted to urban enrollment of 36% and 94% respectively, making these plans eligible for quality based bonus payments.
- The quality rating of rural MA plans varies significantly across the country, with the highest quality ratings in rural areas in Minnesota, Iowa, Wisconsin, Oregon, Pennsylvania, and Maine.

Introduction

The MA program allows Medicare beneficiaries to receive benefits from private plans rather than from traditional fee-for-service Medicare. MA and other prepaid plan enrollment, including Cost and PACE plans,[1] increased to over 14.5 million as of March 2013 (28.2% of all Medicare beneficiaries), including 1.9 million rural enrollees (18.6% of rural Medicare beneficiaries).[2] The Patient Protection and Affordable Care Act of 2010 (ACA) established bonus payments to reward plans with high quality ratings (4 stars or higher) beginning in 2012. In addition, the Centers for Medicare and Medicaid Services (CMS) created a demonstration project that expanded the quality-based bonus payments to plans with lower quality ratings (3 stars or higher) from 2012 through 2014. This expansion of the quality based bonus payments made the majority of MA plans eligible to receive bonus payments, although higher quality plans receive higher payments. Thus, star ratings of MA plans are now both a tool for beneficiaries to use to compare plans and a source of additional payment for plans. On average, rural MA plans typically have lower quality ratings than urban plans resulting in lower quality based payments. This brief analyzes data to measure these differences in quality and payment and suggests reasons why quality ratings vary by geography.

Quality Star Ratings

CMS has been collecting quality ratings from MA plans for several years, using 37 performance measures across domains that include clinical outcomes, clinical process, patient experience, and access. Data are

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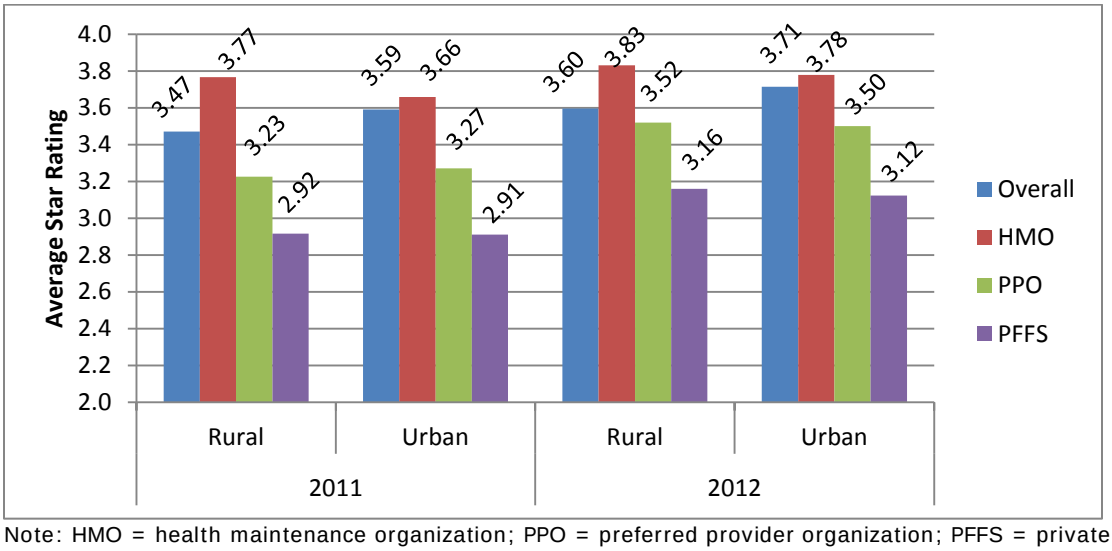
reported through administrative systems and are collected in three surveys: the Healthcare Effectiveness Data and Information Set (HEDIS), the Consumer Assessment of Healthcare Providers and Systems for MA plans (CAHPS-MA), and the Health Outcomes Survey (HOS).[3] MA plans report process and intermediate outcome measures to CMS using the HEDIS. Health plan members report on additional process measures, and self-reported health information is used to develop outcome measures to detect changes in the members' health using the HOS. The CAHPS-MA survey captures patient experiences regarding access to care while enrolled in the plans and rating of plan quality and quality of care offered by providers. Ratings from 1 to 5 stars for each indicator are weighted and then averaged to generate a final quality star rating for each plan. MA plans are given an overall star rating of either a whole or half star measure, such as 2.5, 3, 3.5, 4, 4.5 or 5 stars. Medicare beneficiaries can access these star ratings from a public web site to evaluate the plans before enrolling.[4]

This brief analyses data from CMS on all MA plans in the United States, linked to enrollment data for these plans that is housed at the RUPRI Center for Health Policy Analysis in an attempt to determine the difference in rural and urban MA plan quality and the resulting quality based bonus payments plans receive. MA plan payment was cut by the ACA and many plans have begun to receive quality based bonus payments that help to offset these cuts. Because this analysis is based on all MA plans available, the differences reported here are statistically significant (though in some cases the magnitude of the effects may be small, and in some situations the clinical significance of the difference may be negligible). Further research of detailed quality measures will help to explain the significance of these differences in quality scores.

Findings

In 2012, the average quality rating for MA plans in rural areas was lower than in urban areas, 3.60 and 3.71 stars, respectively (Figure 1). These ratings improved from 2011 scores of 3.47 and 3.59 stars, respectively.[5] Plans in which rural MA beneficiaries were enrolled showed greater quality improvement than plans in which urban beneficiaries were enrolled. Although all plan types improved their average quality ratings from 2011 to 2012, PPO plans showed the greatest improvement in both rural and urban areas.

Figure 1. Medicare Advantage Average Quality Star Ratings by Plan Type, 2011-2012



Note: HMO = health maintenance organization; PPO = preferred provider organization; PFFS = private fee-for-service.

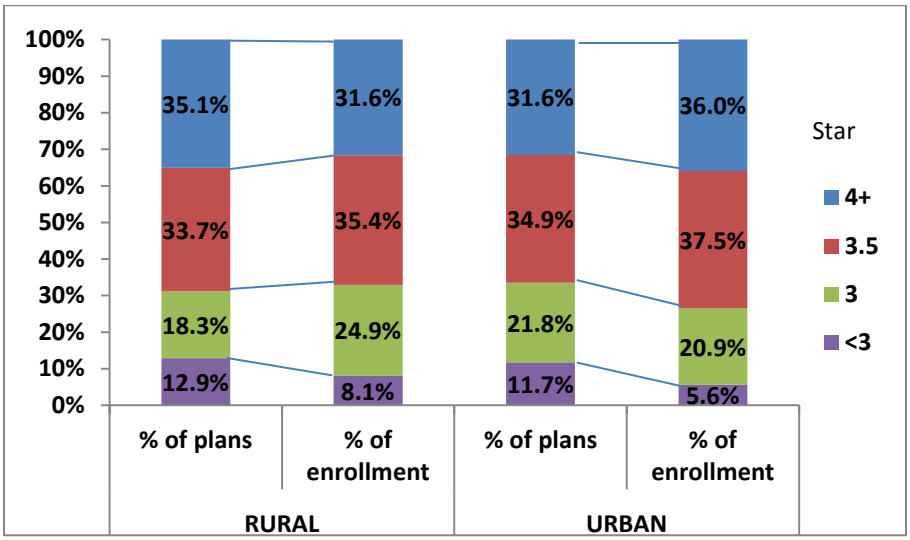
Quality ratings vary among MA plans by the type of plan, HMO, PPO and private fee-for-service (PFFS); however, the ratings within a plan type do not vary by location (urban vs. rural) of enrollee. On average, HMO plans have higher quality ratings than PPO or PFFS plans, regardless of location. HMOs have the highest quality ratings, averaging 3.83 and 3.78 stars in rural and urban areas in 2012. PPO plans have lower quality ratings, averaging 3.52 and 3.50 stars in rural and urban areas, respectively, in 2012, while PFFS plans have the lowest quality ratings, averaging 3.16 stars in rural areas and 3.12 stars in urban areas (Figure 1).

The measured rural-urban difference in access to MA plans rated 4.0 stars or higher (Figure 2) is a result of the difference in the composition of the types of MA plans in rural and urban MA markets, rather than differences between MA plans of the same type. HMO plans are more prevalent in urban areas than in rural areas, due in part to their historical presence in many urban areas and their ability to contract with providers in urban areas.[6] In contrast, PPO and PFFS plans have been more prevalent in rural areas.

However, in recent years, the majority of the enrollment in PFFS plans has shifted to PPO plans in rural areas.

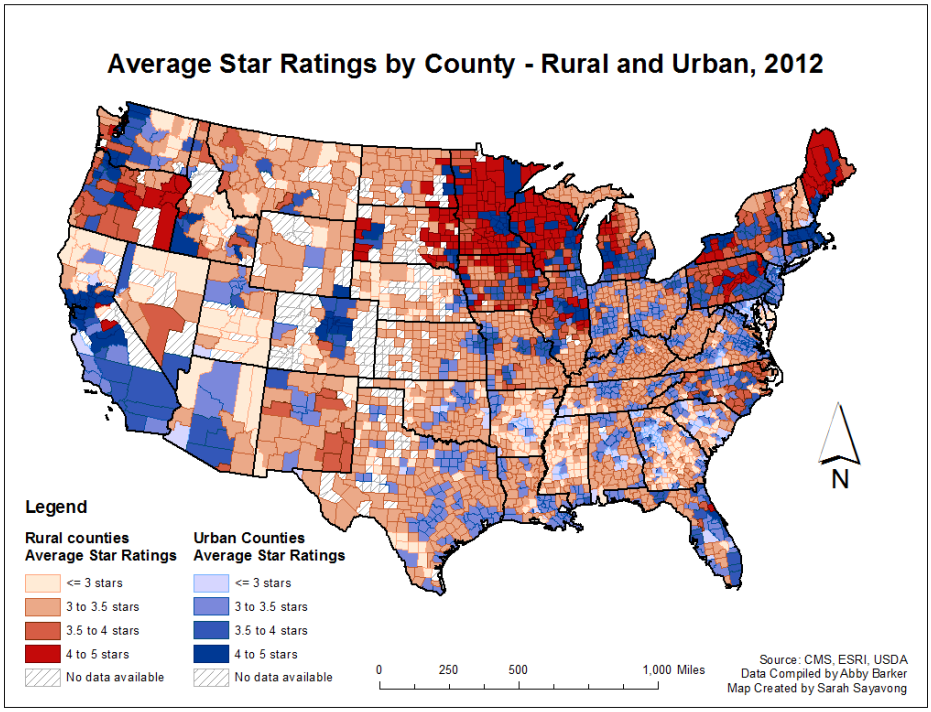
The ACA created quality-based bonus payments for MA plans with ratings of 4.0 stars or higher. Using this rating level as a dividing line, a higher proportion of urban MA enrollees (36.0% compared to 31.6% in rural areas) are enrolled in an MA plan that receives a bonus payment. However, nearly all MA enrollees both in rural areas (91.9%) and in urban areas (94.4%) are in plans with a quality rating of 3.0 stars or higher (Figure 2), qualifying them for bonus payments under the current demonstration program. Nearly one-half (49.8%) of rural HMO enrollment is in a plan with a 4.0-star or higher rating, while only 24.7% of rural PPO enrollment is in such a plan. The majority (73.6%) of rural PPO enrollment is in plans with an average quality rating of 3 or 3.5 stars. Many rural Medicare beneficiaries have limited access to MA plans and in some areas do not have an HMO option available to them, leaving them with PPO plans as their only option.

Figure 2. Percentage of Plans and Enrollment by MA Plan Star Rating and Location, 2012



The quality rating of rural MA plans varies significantly across the country, with the highest quality ratings in rural areas in Minnesota, Iowa, Wisconsin, Oregon, Pennsylvania, and Maine (Figure 3). MA beneficiaries in southern and some central midwestern rural areas are, in general, enrolled in MA plans with lower quality

Figure 3. Medicare Advantage Star Ratings by County



ratings. This difference is due, in part, to a lack of HMO penetration in rural areas, leaving the majority of rural Medicare beneficiaries enrolled in a PPO or PFFS plan and on average these plans have lower quality ratings as displayed above in Figure 1. Rural Medicare beneficiaries often have limited MA plans available from which to choose, limiting their access to high quality options.

Discussion

Overall, the quality rating of MA plans in rural areas is lower than in urban areas, a result of availability of, and enrollment in, different types of MA plans. Most rural enrollment is concentrated in PPO plans, while most urban enrollment is concentrated in HMO plans. HMOs typically have higher quality ratings than PPO plans, resulting in higher overall quality ratings in urban areas than in rural areas. HMO plans are more available in urban areas and tend to exercise more control over providers than PPO or PFFS plans. This control over providers may improve the quality ratings of the HMOs as they are more closely able to monitor and influence the actions of the providers that would affect their plans' quality rating. In addition, HMOs, by plan design, typically manage patient care more closely than either PPO or PFFS plans which could help to improve patient outcomes and thus improve quality ratings.[7] Despite their lower quality ratings, PPO plans improved their quality ratings from 2011 to 2012 in both rural and urban areas more rapidly than HMOs, narrowing the gap in quality ratings between plan types. The finding of a rural-urban quality differential because of a difference in MA market composition in these areas suggests that the focus on quality improvement for MA plans should be on the type of plan, not its location. PPOs must be the focus of quality improvement in rural areas because of their domination of the rural MA market, however due to the inherent differences in the design of HMO and PPO plans it may be a challenge for these plans to achieve the same quality scores of the more closely monitored HMO plans.

Bonus payments incentivize MA plans to improve their quality; however some plans are further from reaching the quality thresholds than others. Rural plans, on average, have lower quality ratings and are more likely to be further from reaching the 4.0 star thresholds. If the ACA policy awarding bonus payments to plans with quality ratings of 4.0 stars or higher is not amended, then enrollees in urban MA plans will likely benefit the most from the quality-based bonus payments going forward. MA plans are incentivized to maintain high quality ratings or take action to move their lower quality plans to the bonus level, especially in urban areas where this may seem more attainable. MA plans currently receiving quality-based bonus payments based on the CMS demonstration (ratings above 3.0 stars) would need to improve to a 4.0 rating by 2015 to maintain those bonus payments. Plans losing their quality-based bonus payments will experience the full effects of ACA-mandated payment reductions which began in 2012, with potential impacts on benefits and/or beneficiary cost sharing. These effects are more likely to occur in rural areas. Additional research is needed to determine the factors leading to quality differences between HMO and PPO plan types. Forthcoming work by the RUPRI Center will identify which metrics, used to compute the detailed quality scores, account for the differences in quality among plans.

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[1] PACE (Program of All-inclusive Care for the Elderly) is a Medicare and Medicaid program that helps people meet their health care needs in the community instead of going to a nursing home or other care facility. A Cost plan provides the full Medicare benefit package. Payment is based on the reasonable cost of providing services. Beneficiaries are not restricted to the HMO to receive covered Medicare services, i.e., services may be received through non-HMO sources and are reimbursed by Medicare intermediaries and carriers.

[2] RUPRI Center for Rural Health Policy Analysis, analysis of Centers for Medicare and Medicaid Services Medicare Advantage Enrollment Data.

[3] MedPac, Report to the Congress: Medicare Payment Policy. March 2013. Accessed at http://www.medpac.gov/documents/Mar13_EntireReport.pdf on April 30, 2013.

[4] MA star ratings are assigned to the plans at the contract level, as opposed to the plan level, so all plans within a contract will have the same quality star rating.

[5] These numbers are derived from data on all MA plans so they represent actual differences in average quality rather than estimated averages.

[6] Kemper, L., L Pollack, A Barker, T McBride, K Mueller. "Rural Medicare Advantage 2011: Enrollment Trends and Plan Characteristics." RUPRI Center for Rural Health Policy Analysis, P2011-9. Available at http://cph.uiowa.edu/rupri/publications/policypapers/NOV.MA%20Overview%20October%202011%20FINAL.pdf

[7] Gold, Marsha. "Medicare's private plans: a report card on Medicare Advantage." *Health Affairs*. 2009;28(1):w41–54.