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Rural Medicare Advantage Plan Payment in 2015

Leah Kemper, MPH, Abigail R. Barker, PhD, Timothy D. McBride, PhD, and Keith Mueller, PhD

Purpose

Payment to Medicare Advantage (MA) plans was fundamentally altered in the Patient Protection and Affordable Care Act of 2010 (ACA). MA plans now operate under a new formula for county-level payment area benchmarks, and in 2012 began receiving quality-based bonus payments. The Medicare Advantage Quality Bonus Payment Demonstration expanded the bonus payments to most MA plans through 2014; however, with the end of the demonstration bonus payments has been reduced for intermediate quality MA plans. This brief examines the impact that these changes in MA baseline payment are having on MA plans and beneficiaries in rural and urban areas.

Key Data Findings

- Payments to plans in rural areas were 3.9 percent smaller under ACA payment policies in 2015 than they would have been in the absence of the ACA. For plans in urban areas, the payments were 8.8 percent smaller than they would have been. These figures were determined using hypothetical pre-ACA and actual ACA-mandated benchmarks for 2015.
- MA plans in rural areas received an average annual bonus payment of $326.77 per enrollee in 2014, but only $63.76 per enrollee in 2015, with the conclusion of the demonstration.
- In 2014, 92 percent of rural MA beneficiaries were in a plan that received quality-based bonus payments under the demonstration, while in March 2015, 56 percent of rural MA beneficiaries were in a plan that was eligible for quality-based bonus payments.

Introduction

The MA program allows Medicare beneficiaries to receive health insurance coverage from private health insurance plans rather than from traditional fee-for-service (FFS) Medicare. Enrollment in MA and other prepaid plans grew to over 16.6 million in March of 2015 (31.1 percent of all Medicare beneficiaries), including 2.1 million in rural counties (21.2 percent of rural Medicare beneficiaries). The ACA made substantial changes to the structure of MA payment that has reduced payment, on average, to MA plans in both rural and urban areas. Some of these changes in payment are based on quality scores received by the MA plans. Previous research has found that plans in which rural MA beneficiaries are enrolled have lower quality scores, on average, than those in which urban MA beneficiaries are enrolled.[1] Due to this difference, the impact that quality has on MA payment in rural areas should be examined.

Changes to MA Payment

Baseline MA Payment

Each county's MA plan payment is based on the bids submitted by the plans to provide coverage to Medicare beneficiaries in that county and on the county's benchmark, which is set by the MA program. Per the ACA, if the MA plan's bid is below the county's benchmark, the plan's payment is equal to the total of their bid plus a rebate of 50 to 70 percent of the difference between the plan's bid and the

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RUPRI RURAL POLICY RESEARCH INSTITUTE

RUPRI Center for Rural Health Policy Analysis,
University of Iowa College of Public Health,
Department of Health Management and Policy,
145 Riverside Dr., Iowa City, IA 52242-2007,
(319) 384-3830
http://www.public-health.uiowa.edu/rupri
E-mail: cph-rupri-inquiries@uiowa.edu

benchmark. The rebate percentage paid to the plan is based on the plan's star quality rating, and the percentage paid rises for higher quality plans. In the event that the MA plan's bid is above the benchmark, Medicare pays the benchmark rate.

The ACA created a quartile-based system to determine new MA benchmarks, replacing the previous benchmark formula[2] to reduce overall MA payments by setting benchmarks for plans as a percentage of historic FFS Medicare expenditures in a county. Under the new system, the nationwide average county-level FFS Medicare costs are ranked and divided into quartiles from highest to lowest. Benchmarks in counties within the highest quartile are set to 95 percent of their counties' FFS Medicare costs. Benchmarks for counties in the lower three cost quartiles are set to 100 percent, 107.5 percent and 115 percent of their counties' FFS costs, respectively. In addition, total MA payment is capped so that no plan receives a higher payment than its benchmark prior to the ACA implementation. These changes are being phased in over a period of six years that began in 2010 and will be fully implemented in 2016. In 2015, more than three-quarters of counties have benchmarks that have been fully phased in to the post-ACA level.[3]

Quality-Based Bonus Payments

MA plans may receive bonus payments based on the quality-based star rating of the plan. Quality scores used by the Centers for Medicare & Medicaid Services (CMS) are based on performance measures that are derived from administrative data as well as information 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).[4] MA plans are given an overall star rating based on their weighted average scores of a selection of individual performance measures obtained from the sources listed above. Medicare beneficiaries who are considering enrolling in an MA plan are given access to these star ratings as they make their choices.[5]

These 2015 star ratings, based on member experiences in 2013 and early 2014, determine the bonus payments that are awarded to MA plans for providing high quality care in 2015. The ACA requires plans to have a quality rating of 4 stars (out of 5 stars) or higher to be awarded a quality-based bonus payment. In addition, due to capping MA payment at pre-ACA levels, if a plan has a high star rating but its payment is already as high as the pre-ACA benchmark it will not receive an additional quality-based bonus payment. From 2012 through 2014, the Medicare Advantage Quality Bonus Payment Demonstration, developed by CMS, provided bonus payments to plans with star ratings below the threshold required by the ACA. As a result, most MA contracts received bonus payments until the demonstration concluded at the end of 2014. In addition to expanding the number of plans receiving bonus payments, the demonstration paid bonuses in 2012-2013 that were more generous than those set by the ACA (Table 1), and the implementation of the cap on payments to MA plans was delayed. The end of this demonstration, and a reversion to the ACA parameters, has decreased the number of plans receiving quality-based bonus payments and the average bonuses paid.

Table 1. Medicare Advantage Quality-Based Bonus Payments as a Function of Star Ratings

Star Rating	MA Quality Bonus Payments, (Additional Payment to Plans Awarded as a Percentage of the County-Level Benchmark)							
	ACA				ACA 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

Other Adjustments to Actual MA Payment

Other factors affect the actual payment to an MA plan, including risk model adjustments and adjustments for changes in coding trends. Data presented in this brief shows the payment to plans by county before these adjustments are made. CMS reported that the overall change in payment from 2014 to 2015 due to changes in benchmark calculations, including bonus payments, would be -7.8 percent.[6] While it is true that other program-wide adjustments (pertaining to the modification and decelerated implementation of risk adjustments) compensate for this reduction in the short run, leaving the total impact of all changes at +0.4 percent,[2] it is still important to analyze the benchmark reductions separately for two reasons. First, the offsets due to risk calculation methods will disappear once the new methods are fully phased in. Second, due to the ACA requirements regarding both benchmark determination and bonuses for high-quality plans, the reductions are likely to be experienced unevenly in rural and urban areas.

Effects of the Changes in MA Payment on Rural Areas

Baseline MA Payment

Changes made by the ACA to the payment area benchmark and quality-based bonus payments have had an effect on total MA payment in both rural and urban areas (Table 2). If the ACA changes in payment had not been made, then using 2014 cost and enrollment data, we would have observed an average plan reimbursement of $802.54 per month per rural enrollee and $882.86 per urban enrollee.[7] The changes to payment using the parameters from the ACA implementation result in 2014 payment values of $799.08 and $850.55, respectively. This represents a decrease of 0.4 percent for plans in rural areas and 3.7 percent in urban areas, including corrections for the new quality-based rebates and bonus payments. Urban counties are disproportionately represented in the highest-cost quartile of counties, with benchmarks newly anchored at 95 percent of FFS costs.

However, moving into 2015, the discontinuation of bonus payments for plans at 3 and 3.5 stars will disproportionately change payment to MA plans in rural areas; especially because total MA payment is capped at pre-ACA levels. In the right-most column of Table 2, 2015 ACA-mandated payments are compared to the hypothetical 2015 payment in the absence of ACA policies. Overall, payments to rural plans fall by 3.9 percent compared to 8.8 percent for urban plans.

Table 2. Monthly Medicare Advantage Payments under the ACA with Quality Adjustments

	Hypothetical Payment Using *Pre-ACA Benchmarks**		Payment under the ACA (2014 Includes Demonstration Bonus Payments)		Percent Change in 2015 Payment Relative to 2014 under ACA	Percent Change in Payment Relative to Pre-ACA Payment	
	2014	2015	2014	2015		2014	2015
Rural	$802.54	$769.85	$799.08	$739.91	-7.4%	-0.4%	-3.9%
Urban	$882.86	$859.49	$850.55	$783.49	-7.9%	-3.7%	-8.8%

*This is a hypothetical value in which benchmarks are derived using pre-ACA methods (without quartiles), the original bidding rebate of 75 percent is assumed, and no demonstration bonuses are awarded. The last pair of columns of percentages is calculated relative to these values.

Rural MA enrollees are impacted somewhat less than urban enrollees by the ACA changes because 41 percent of rural enrollees are in a county in the lowest FFS costs quartile (thus plans are receiving 115 percent of FFS costs as a benchmark), while only 15 percent are in a county in the highest FFS costs quartile (where they would receive 95 percent of FFS costs). In contrast, 16 percent of the urban enrollees are in a county in the lowest quartile, while 46 percent are in a county in the highest quartile.

Quality-Based Bonus Payments

Plans operating in rural areas have not benefitted as much as those in urban areas from the quality-based bonus payments due to their lower average quality star ratings and the fact that only urban counties are included in a special provision for double bonus payments.[8] However, rural areas have still received significant bonus payments. Under the demonstration, 92 percent of rural beneficiaries were in a plan qualified to receive a bonus payment based on its star rating, while in 2015, only 56 percent are in such a plan. Rural counties are also much more likely than urban counties to have benchmarks

capped in 2015 (at pre-ACA payment levels), either before or after quality-based bonuses are applied: 34 percent of rural beneficiaries in March 2015 were enrolled in plans whose benchmark (before the bonus) payment had been capped, making them ineligible to receive a bonus payment. An additional 31 percent were in plans whose bonus payments were capped. The corresponding numbers for urban enrollees were 3 percent and 18 percent, respectively. This higher rate of capping in rural areas is in part a result of rural counties falling into the higher quartiles for their benchmark payments. Further research needs to be done regarding this high rate of capping in rural counties as it could have a negative impact on incentivizing plan quality improvement in these areas.

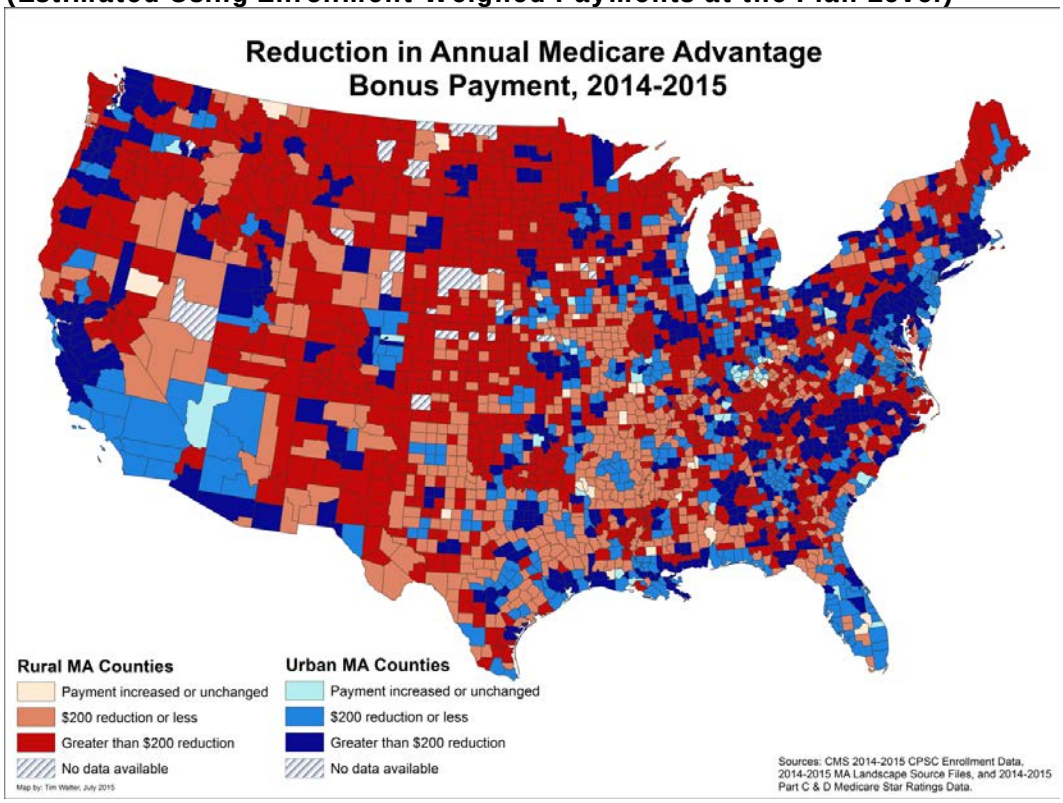
Using the ACA-defined parameters for bonus payments (after the conclusion of the demonstration), MA plans in rural areas received an average annual bonus payment of $318.96 per enrollee (MA plan bonus payments received by MA plans within a county are weighted and averaged) in 2014, and this figure drops to an average annual bonus payment of only $61.44 per enrollee in 2015 with the conclusion of the demonstration (Table 3). This reduction is a result of intermediate quality plans losing their bonus payments in 2015 and the capping of overall MA payment at pre-ACA payment levels, which made some plans ineligible for bonus payments. Urban areas have also experienced a dramatic reduction in bonus payments, moving from an average annual bonus payment of $405.43 per enrollee in 2014 to a payment of $184.49 in 2015.

Table 3. Annual Medicare Advantage Quality-Based Bonus Payments

	2014 Average (Demonstration) Bonus Payment	2015 Average (ACA) Bonus Payment	2014 Total Bonus Payments (in millions)	2015 Total Bonus Payments (in millions)
Rural	$318.96	$61.44	$406	$97
Urban	$405.43	$184.49	$4,274	$2,197

While average payment has been reduced overall at the county level, the amount of average plan payment reduction varies significantly across counties ranging from no reduction (those with star ratings 4 and above and not capped)[9] to over $200 per person annually (Figure 1).

Figure 1. County Level Reduction in Average Annual Medicare Advantage Bonus Payments, (Estimated Using Enrollment Weighed Payments at the Plan Level)



Discussion

MA plans in rural areas have experienced a reduction in baseline payment on average since the ACA went into effect in 2012, but less than in urban counties. This difference is due in large part to rural areas having lower fee-for-service Medicare costs prior to the implementation of the ACA and therefore MA plans receiving a larger percentage of these costs in the modified MA payment area benchmarks. MA enrollment in rural areas continues to grow; however, some research has shown an increase in cost-sharing for MA beneficiaries.[10] We will continue to monitor the impact of the ACA changes on MA payment area benchmarks and the end of the MA bonus payment demonstration on enrollment and plan offerings in rural areas.

MA plans operating in many rural areas do not have the same monetary incentives to improve quality as those in most urban areas because they are not eligible to receive the quality based bonus payments in 2015 and beyond due to both lower quality scores and/or payment caps. MA plans operating in rural areas have lower quality, on average, than plans in urban areas; therefore, rural beneficiaries could benefit from incentives for MA plans to improve quality. If the ACA quality-based bonus payments do not prove to be an effective tool in improving MA plan quality in rural areas, alternative rural-targeted incentives may need to be explored.

Notes

[1] Kemper, L., A Barker, T McBride, K Mueller. "*2012 Rural Medicare Advantage Quality Ratings and Bonus Payments*." RUPRI Center for Rural Health Policy Analysis, 2014-1. Available at http://www.public-health.uiowa.edu/rupri/publications/policybriefs/2014/Rural%20Medicare%20Advantage%20Quality%20Ratings.pdf

[2] For additional information regarding the changes see: *Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy*. March 2011. Retrieved at http://www.medpac.gov/documents/reports/mar11_entirereport.pdf?sfvrsn=0

[3] *Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy*. March 2015. Retrieved at http://www.medpac.gov/documents/reports/chapter-13-the-medicare-advantage-program-status-report-(march-2015-report).pdf?sfvrsn=0

[4] *Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy*. March 2013. Retrieved at http://www.medpac.gov/documents/Mar13_EntireReport.pdf .

[5] 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.

[6] The 7.8 percent reduction combines the 3.4 percent reduction attributed to the Medicare growth rate and the 4.4 percent reduction due to benchmark updates. See "*Fact Sheets: Strengthening Medicare Advantage*." May 2014. Retrieved at http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2014-Fact-sheets-items/2014-04-07.html

[7] Throughout the brief, we make assumptions about plans' bids that are consistent with Figure 13-2 in the Medicare Payment Advisory Commission report available at: http://www.medpac.gov/chapters/Mar14_Ch13.pdf. The methodology is a simulation in which we draw bids from the distributions implicitly given in that figure and average over the resulting plan payments to obtain the approximate values that form the basis for our results. When we know that a plan charges a premium, then bid information is not needed and we use the benchmark itself.

[8] *Medicare Advantage Plan Star Ratings and Bonus Payments in 2012*. Henry J. Kaiser Family Foundation. November 2011. This brief states that double bonus counties are required to have the following characteristics: 1) lower than average Medicare FFS costs, 2) a MA penetration rate of 25 percent or more as of December 2009, and 3) a designated urban floor benchmark in 2004. Due to the requirement that the county be designated as an urban floor benchmark in 2004, no rural counties receive double bonus payments.

[9] A few counties with very high quality plans and no cap will actually increase their bonus payments by moving to "double bonus" status in 2015.

[10] G. Jacobson, A. Damico, T. Neuman, M.Gold. "*Medicare Advantage 2015 Spotlight: Enrollment Market Update*." Henry J. Kaiser Family Foundation. June 2015. Retrieved at http://files.kff.org/attachment/issue-brief-medicare-advantage-2015-spotlight-enrollment-market-update