

Quality Incentives for Medicare+Choice Plans

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Abstract: The Medicare program should be a leader in national efforts to improve quality of care. This paper proposes a new system of quality bonuses for Medicare+Choice plans and lays out a framework of key issues and options to promote discussion about such an initiative.

The quality of care received by most Americans is often well below professional standards and the performance of top-quality healthcare plans, hospitals and physicians. These problems are particularly serious for patients with chronic conditions.¹ We believe that the Medicare program can—and should—have a national leadership role in improving the health system’s quality of care as soon as possible. The Medicare program’s \$250 billion of purchasing power, 40 million enrollees, program data, and professional expertise can bring more resources to bear on these quality problems than any other single actor. The Medicare program also has very large stakes in the improvement of healthcare quality, particularly for chronic illness, among both its present enrollees and under-65 populations.

Now is a good time to launch a major quality initiative based on the Medicare+Choice (M+C) health plans. The M+C plans have accountable management structures and there are now valid and well-accepted quality measures for the M+C plans that can be used to assess and reward their performance. There is thus an opportunity to improve care for Medicare’s M+C plan enrollees that does not yet exist in

Medicare’s traditional fee-for-service (FFS) program. A Medicare quality incentive initiative can build on and encourage private-sector payers’ efforts to make use of their health plans’ potential to improve quality and what is learned can be useful for Medicare FFS quality initiatives. Now, when Medicare budgets are under pressure and financing for M+C plans—and their future Medicare participation—are at issue, it is particularly timely to reassess the potential role of M+C health plans in Medicare’s future.

OVERVIEW

This paper outlines issues and options for designing a new system of quality bonuses for Medicare+Choice plans. The objectives of this initiative would be to improve quality of care for Medicare’s 40 million enrollees and to improve national health care quality.

Objectives for M+C Quality Incentives

- Improve quality of care for Medicare’s 40 million M+C and FFS enrollees
- Improve national health care quality, particularly for the chronically ill

If this initiative were successful, Medicare could benefit in five ways: higher quality of care for Medicare beneficiaries enrolled in M+C plans, stronger financing for high-quality M+C plans to encourage them to remain in the Medicare program, more enrollments in high-quality M+C plans, development of high-quality M+C plans as models of best practices that

can be adopted by the Medicare FFS program, and improved health of Medicare's enrollees. A successful initiative could improve national health care quality through national leadership in quality-based purchasing that built on and encouraged similar efforts by other purchasers; better quality of care, particularly for chronic illness, that will have spillover health benefits for under-65 population groups; advancing the business case for health plans and providers to improve quality; and accelerating learning about quality improvement.

The paper puts forward a framework of issues and options to promote discussion about how to design a Medicare quality incentive system to achieve these objectives. It does not offer specific recommendations. However, it does suggest approaches that use currently available data so Medicare can start this important initiative as soon as possible. Among the issues discussed are the following: (1) Should health plan quality bonuses be based on national excellence, market area leadership, or improvement from the prior year? (2) What quality measures should be used for assessing M+C plan performance? (3) How much should the quality incentives be? (4) How should the quality bonuses be financed? (5) Should Medicare or M+C plans share the quality bonuses with enrollees? (6) Will there be problems of adverse selection? (7) Should the QI/M+C initiative be integrated with other Medicare demonstrations and quality initiatives? (8) Should Medicare participate in private-sector quality purchasing?

ISSUES AND OPTIONS

What Outstanding Performance Should Be Rewarded?

Issue #1: Should health plan quality bonuses be based on national excellence, market area leadership, and/or a health plan's improvement?

What Outstanding Performance Should Be Rewarded?

- National excellence?
- Market area leadership?

A new system of Medicare quality awards could be targeted to health plans that provide excellent quality of care as judged by national quality standards. The leadership health plans that achieve these performance levels would offer national models, benchmarks and best practices for the rest of the Medicare program. Targeting quality bonuses to high performance levels would create incentives for other health plans to aim for these performance levels.

A strategy for targeting quality incentives could also offer rewards for regional or area leadership by M+C plans, even if these plans do not qualify for national performance awards. These awards could go to the "pacesetter" health plan that offered the best quality among Medicare M+C plans (and higher quality than Medicare FFS) in each area. The awards would provide incentives for health plans to offer Medicare enrollees better quality of care than was otherwise available, and they could

establish a competitive learning and performance dynamic among health plans competing for such leadership in every region. Making available regional leadership awards, as well as national performance awards, would recognize that it is easier for some plans than others to achieve national excellence because of underlying regional norms of care and area-to-area variations in Medicare's payment rates. A quality bonus system that included such regional awards might have more impact on improving quality of care in every region than a system that included only national awards.

A third option for providing quality incentives would be to reward M+C plans on the basis of improvements in their own quality scores from the previous year. The Medicare QISM (Quality Improvement System for Managed Care) regulations require quality improvement from M+C plans in projects of their selection, but do not require health plans to use comparable data or offer a quality bonus. A bonus system could include incentives for each M+C plan to improve on recognized standards of quality with comparable data.

Quality incentives offer ways for M+C plans to earn more and thus would strengthen the financial case for high-performing M+C plans to remain with the Medicare program and to grow their Medicare enrollments. Extending bonuses from national excellence to market area leadership would broaden the numbers of winners to include more jurisdictions, health plans, and supporters, and would broaden the potential

benefits. As a supplement to such national excellence and market leadership awards, awards for M+C plans that improved from their previous scores would share bonuses more widely among M+C plans, but also would dilute funds available for targeting the outstanding national and regional performers. In addition, they could result in a plan getting a quality bonus for improvements over a low base level, while a competing plan with higher performance did not get a bonus.

Quality Measures

Issue #2: What quality measures should be used for assessing M+C plan performance?

What Performance Measures Should Be Used?

- NCQA Medicare HMO ratings (* to ***)?
- CMS Medicare-specific measures for M+C plans?

There are two public rating systems for M+C plans that could be used for designing a quality bonus system: the National Committee on Quality Assurance (NCQA) summary ratings (* to ***) for Medicare HMOs and their Medicare enrollees; and the Medicare-specific measures of quality and consumer satisfaction (Medicare HEDIS and CAHPS) that are published by the Center for Medicare and Medicaid Services.²

The NCQA star ratings of HMOs now provide separate assessments for non-Medicare and for Medicare en-

rollees. They combine objective annual scores on selected HEDIS (Health Plan Employer Data and Information Set) and CAHPS (Consumer Assessment of Health Plans Survey) measures with NCQA's assessment of other aspects of performance from accreditation reviews that occur every three years (a **** rating is "Excellent"); about two-thirds of M+C plans are NCQA accredited.³ The CMS measures are also based on annual scores on selected HEDIS and CAHPS data. CMS reports these measures individually and does not combine them into an overall quality score for each plan. This reflects a CMS philosophy (as a public agency) that consumers should judge what aspects of performance are of most importance to them. The CMS measures would thus need to be weighted or averaged to determine an overall score for quality incentive bonuses. This score could be used for Medicare bonus calculations only rather than for public rankings.

In favor of using NCQA's star ratings are (1) they are already publicly available and would not require CMS to develop a separate scoring system and (2) Medicare use of NCQA ratings for quality bonuses could encourage purchasers and consumers to make more use of NCQA ratings as a national quality standard. In favor of using CMS measures for a quality incentive system are (1) CMS has data on all plans and (2) CMS could devise the weighting system to achieve agency objectives. Although CMS decisions will need to be made about developing an aggregate quality score, the individ-

ual measures are available and, like the NCQA star system, could be readily implemented. A CMS system would also allow more flexibility, as it would have the potential to set quality standards higher than NCQA, add quality and performance measures specific to the Medicare population and reflect HHS or congressional priorities for improved performance.

Quality Bonus Amount

Issue #3: How large a quality incentive should Medicare offer to high-performing M+C plans?

How Much Should the Quality Bonuses Be?

- 2% for national excellence awards?
- 1% for market area leadership?
- ___ for improvement?

A 2% quality bonus for national excellence could be a starting point for discussion of this issue. Although 2% is not a large amount (about \$120 per enrollee) in comparison to Medicare's average per capita payment (which is about \$6,000), it can amount to a significant incentive at the health plan level. For a health plan with 25,000 M+C enrollees, for example, a 2% quality bonus would amount to about \$3 million; a large health plan with 100,000 Medicare enrollees that achieved national excellence would earn a \$12 million bonus.

The design for the rest of the incentive structure needs to consider

how the other awards would relate to the national excellence bonuses and how far to spread limited funds. It would seem logical to reward best quality in a market area at a smaller amount than national excellence, e.g., 1% vs. 2%. If performance increases by a health plan from the prior year (which fell short of national excellence or area leadership) were also to be recognized, a smaller incentive would seem to be appropriate.

Financing

Issue #4: How should quality bonuses be financed?

How Should Quality Bonuses Be Financed?

- As add-ons to payments for M+C plans?
- As redistributions from payments for M+C plans?

Since the quality bonuses are an initiative to improve health care of Medicare beneficiaries, it is appropriate that they be financed from the Medicare trust funds rather than from general appropriations. Other Medicare quality-oriented activities are funded this way, e.g., the Quality Improvement Organizations, as are Medicare demonstration projects. An add-on financing strategy—that pays the quality bonuses as an additional amount beyond what would otherwise be paid to M+C plans—recognizes that the quality bonus payments are comparable to these other expenditures in quality improvement and research demonstrations.

If quality bonuses were financed as a redistribution of projected payments for M+C plans, either under current law or as the payment formula may be amended by this Congress, the mechanism used could be a withhold, e.g., .5%, from amounts that would otherwise be paid to the M+C plans. The bonus payments would then be paid, from this withheld amount, to plans that qualified for the bonus payments. This approach has the merit of not increasing Medicare's projected payments. It has the drawbacks of reducing the payments to most M+C plans at a time when their financial viability of remaining in the Medicare program is at issue, and the lowered payments could also make it more difficult for them to improve quality. Finally, the redistribution approach is likely to attract opposition from the potential losers, whereas an add-on strategy does not reduce payments and thus would not be subject to this opposition.

The federal budget expense of the bonus payments would depend on the structure of the incentives, the number of plans that met the performance standards, and the amounts each of these plans was owed. Among the design elements that could be used to manage federal budget costs are the size of awards (e.g., 1%, 1.5% or 2% for national excellence), raising the quality bar to include fewer plans (e.g., using CMS standards rather than NCQA ratings), and/or capping the total quality incentive that a M+C plan could receive.

Sharing of Quality Bonuses

Issue #5: Should Medicare or health plans share the quality bonuses with their enrollees?

Under current law, M+C plans are now required to share extra Medicare margins—above the margins earned for non-Medicare enrollees—in the form of extra benefits (the “adjusted community rate” [ACR] provision). Beginning in 2003, plans may also share these margins in the form of lower premiums. There are no comparable Medicare payment rules that limit hospital margins or direct their use.

Should Quality Bonuses Be Shared with Enrollees?

- Health plan’s choice?
- Health plan’s choice except higher margins than allowed under ACR tests must be shared with Medicare enrollees?
- Medicare shares bonuses with enrollees through lower Part B premiums?

The M+C plans would have more ways to benefit from a new quality incentive system if the M+C plans had flexibility in the use of the bonuses and could use them to increase their margins or reduce their losses, share savings with physicians and other health-care providers, fund innovative programs—or lower premiums and/or improve benefits. It is difficult to say one or another of these uses would be most advantageous for a plan and its beneficiaries, and trying to set new rules for a small amount (2% or less) of the M+C plan payment would run into

adding more regulations, reports, and potential oversight of bookkeeping. Arguably, one of the “bonuses” of a bonus could be the flexibility to use it at the plan’s discretion.

Medicare could also share bonuses with enrollees to provide a direct financial incentive for joining a high-quality health plan. Since Medicare Part B premiums are withheld from social security checks, these premiums can be adjusted administratively by CMS and the Social Security Administration.

Adverse Selection Concerns

Issue #6: Will quality bonuses adversely affect outstanding M+C plans by attracting higher-risk enrollees?

The quality bonuses are unlikely to adversely affect outstanding health plans by attracting higher-risk enrollees. NCQA and CMS quality measures that would be used for determining the bonuses are already publicly available, and top quality plans often use them in marketing. If there is a potential for adverse selection, a good bit of it has probably already occurred. (In fact, the quality bonuses might compensate for such selection.) What is being proposed is only higher payments for the plans that are highly rated by the NCQA or CMS measures. Health plans can make appropriate marketing use of their quality bonuses.

Work needs to proceed on the M+C risk adjustment system, which has already been mandated in statute,

and its timely implementation. Quality bonuses and risk adjusters can proceed on parallel tracks.

Integration with Medicare Demonstrations

Issue #7: Should quality bonuses be available for M+C plans and FFS providers that participate in Medicare payment demonstrations and quality initiatives?

Integration with Other Medicare Initiatives?

- Integrate quality bonuses with M+C payment demonstrations?
- Integrate quality bonuses with FFS quality initiatives?

In order to develop better payment arrangements for M+C plans, the Medicare program has started several demonstrations that involve innovative uses of financial incentives and risk-sharing. The eligibility of these plans for participation in the new quality bonuses would provide a way to test how well quality bonuses work in combination with other payment arrangements.

The Medicare program could develop a number of initiatives for improving quality of care in its FFS plan that are coordinated with an M+C quality bonus initiative. The provision for an M+C bonus payment based on an M+C plan's leadership in a local market, compared to other M+C plans and Medicare FFS (Issue #1) is one example of the kinds of strategy that could be extended to the FFS system. To facilitate such strategies,

it would be desirable to have comparable quality measures for both M+C and FFS plans, on a market area basis, so that Medicare beneficiaries are able to make informed choices and to reward quality initiatives by FFS providers. It may, however, be more difficult to implement this kind of reporting and bonus system in the Medicare FFS system than for M+C plans. For example, there are difficulties in deciding who the accountable entity is whose actions merit a quality bonus.

A second potential type of coordinated quality strategy would reward M+C plans for achieving the same kinds of improvements as are sought from FFS providers. For example, FFS Medicare could aim to increase the share of admissions to hospitals that have computerized prescription entry, or the share of admissions to hospitals that participate in error reduction and quality reporting initiatives. M+C plans could be given incentives to work toward such goals by including specific quality bonuses for achieving similar results for their enrollees.

A third potential type of Medicare-wide quality initiative would be to develop provider-level quality recognition and incentive systems. Indeed, Medicare has the potential for national leadership in such initiatives because of its large size and provider-level data. For example, physicians that do an outstanding job of providing quality of care to diabetic patients (based on measurable quality scores) could receive awards, recognition on CMS and patient group Web

sites, and quality bonuses. M+C plans that participated in these initiatives could receive quality bonuses based on their results for such targeted initiatives. If this approach is feasible, the combination of both FFS and M+C initiatives would make greater use of Medicare's full purchasing power.

Participation in Private-Sector Quality Purchasing

Issue #8: Should Medicare participate in private-sector quality purchasing arrangements?

Within the private sector, there are a number of business-led efforts to improve quality of care by providing higher payments to better quality health plans. Leaders in these efforts include General Motors, the Pacific Business Group on Health, General Electric, Minnesota's Business Health-Care Action Group, and others. Medicare may have much to gain from participating in such initiatives. The advantages of private-sector purchasing include flexibility, ability to innovate, a diversity of approaches, and additional enrollees and purchasing power (particularly in areas where M+C plans have a small market share). For the business community, Medicare participation could greatly increase their data, expertise, and market clout. For health plans, the collective effect of Medicare's M+C purchasing power, combined with such private-sector efforts, could sharply increase the business case for their own management initiatives and investments to improve quality of care. By participating in such purchasing

arrangements, the Medicare program and private-sector purchasers could complement each other's strengths and add the learning from these models to the experience of Medicare's own quality bonus system.

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ENDNOTES

1. Institute of Medicine, *Crossing the Quality Chasm* (Washington, D.C.: National Academy Press, 2001).
2. For more detail on NCQA ratings, see <http://www.NCQA.org>; for CMS ratings, see <http://www.CMS.gov>.
3. As of June 30, 2002, 94 of the 152 M+C plans were accredited by NCQA. Of those, 53 had earned a **** (Excellent) NCQA rating, and 37 had earned a *** (Commendable) NCQA rating.