Synchronizing Medicare policy across payment models

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Outline of today’s presentation

- Review of previous presentations
- Design issues
- Additional issues
  - Policy design
  - Beneficiary decision-making
  - Coding adjustment
Review of January 2015 analysis

- No one model is always the low-spending model
  - MA and ACO program spending tends to be lower than FFS spending in high-service-use areas
  - FFS program spending tends to be lower than MA spending in many low-service-use markets
- By setting government contributions equal across models, beneficiaries will have an incentive to choose the model (e.g., FFS/MA) that efficiently serves their preferences
- The best choice may vary from market to market and vary from individual to individual within markets
## Relative program spending for MA, ACOs and FFS

Program cost in 78 markets relative to FFS (markets weighted equally)

<table>
<thead>
<tr>
<th>Markets ranked by service use quartile</th>
<th>ACOs/FFS</th>
<th>MA/FFS*</th>
</tr>
</thead>
<tbody>
<tr>
<td>All markets</td>
<td>100%</td>
<td>105%</td>
</tr>
<tr>
<td>Low-use quartile</td>
<td>101</td>
<td>113</td>
</tr>
<tr>
<td>Second quartile</td>
<td>100</td>
<td>105</td>
</tr>
<tr>
<td>Third quartile</td>
<td>101</td>
<td>103</td>
</tr>
<tr>
<td>High-use quartile</td>
<td>98</td>
<td>98</td>
</tr>
</tbody>
</table>

* Fully adjusted for coding.

Note: MA plans exclude special needs plans and employer-based plans. Relative costs refer to the most recent data available: 2012/2013 for ACOs and 2015 bid data for MA plans. Service use refers to historical service use from 2006 to 2008. Source: MedPAC analysis of ACO data and MA plan bid data.
**Review of March 2015 analysis**

<table>
<thead>
<tr>
<th></th>
<th>Portland, OR</th>
<th>Columbus, OH</th>
<th>Miami-Dade, FL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median MA plan bid</td>
<td>$703</td>
<td>$659</td>
<td>$743</td>
</tr>
<tr>
<td>Average FFS spending</td>
<td>$626</td>
<td>$722</td>
<td>$1,151</td>
</tr>
<tr>
<td>Difference between MA and FFS</td>
<td>$77</td>
<td>-$63</td>
<td>-$408</td>
</tr>
</tbody>
</table>

Note: FFS (fee-for-service), MA (Medicare Advantage).

**Assumptions in analysis:**
- FFS spending for 2015 and MA plan bids are per month per beneficiary and standardized for a beneficiary of average health status.
- Market areas consist of core-based statistical areas and health service areas in 50 states and the District of Columbia.
- FFS spending for 2015 is projected and excludes hospice, direct graduate medical education, and indirect medical education payments.
- MA plans bids are current bids for 2015 and exclude employer-sponsored plans, special needs plans, and private FFS plans. Also excluded are bids for plans not offered to at least half of the beneficiaries in a market area or those with fewer than 100 projected enrollees in a market area.
- Quality is constant among beneficiary choices.
- Number of Medicare beneficiaries and MA enrollees are as of January 2015.
Summary of illustrative examples

<table>
<thead>
<tr>
<th>Illustrative example</th>
<th>Portland, OR</th>
<th>Columbus, OH</th>
<th>Miami-Dade, FL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1) Nationally-set base premium pays for FFS Medicare in every market</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FFS premium</td>
<td>$101</td>
<td>$101</td>
<td>$101</td>
</tr>
<tr>
<td>MA premium</td>
<td>$178</td>
<td>$38</td>
<td>-$307</td>
</tr>
<tr>
<td>Federal contribution</td>
<td>$525</td>
<td>$621</td>
<td>$1,050</td>
</tr>
<tr>
<td><strong>2) Nationally-set base premium pays for either FFS Medicare or reference MA plan</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>whichever is lower cost—in each market</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FFS premium</td>
<td>$101</td>
<td>$164</td>
<td>$509</td>
</tr>
<tr>
<td>MA premium</td>
<td>$178</td>
<td>$101</td>
<td>$101</td>
</tr>
<tr>
<td>Federal contribution</td>
<td>$525</td>
<td>$558</td>
<td>$642</td>
</tr>
<tr>
<td><strong>3) Locally-set base premium pays for either FFS Medicare or reference MA plan</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>whichever is lower cost—in each market</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FFS premium</td>
<td>$84</td>
<td>$160</td>
<td>$562</td>
</tr>
<tr>
<td>MA premium</td>
<td>$161</td>
<td>$97</td>
<td>$154</td>
</tr>
<tr>
<td>Federal contribution</td>
<td>$542</td>
<td>$562</td>
<td>$589</td>
</tr>
</tbody>
</table>
Difference between average FFS spending and the median MA bid

Caveats to our analysis

- Assumed current plan availability and bids—plans will bid differently if rules change
- There is a distribution of MA plans available in a market area, not just FFS and a single MA plan
- Picked the median MA bid as the reference bid for illustration only
Design issues

- Policy context
  - No one payment model is uniformly less costly to the program in all markets
  - Create financial incentives for beneficiaries to choose efficient models

- Key design questions
  - National vs. local base premium
  - Which Medicare option the base premium pays for—FFS vs. “lower of”
  - Sharing of potential savings in program spending between the program and the beneficiary
Additional design issues

- Transition/ phase in
- All beneficiaries, or only newly eligible
- Low-income beneficiaries
- All market areas, or above certain threshold
Policy context for beneficiary decision-making

- Create financial incentives for beneficiaries to choose efficient models
- Need to consider how beneficiaries actually make decisions and respond to incentives
How beneficiaries make decisions

- Prefer to be able to choose their doctor, but willing to trade off for lower cost
- Beneficiaries get information from sources that are easy and convenient
  - Have more information available to them than before
  - Rely on “human” sources—family, friends, brokers, agents, etc.—to simplify information and decision-making
How beneficiaries make decisions (continued)

- Get overwhelmed by too many choices
  - Health insurance is complex
  - Too many choices can create regret
  - They use simplifying strategies

- Influenced by how choices are presented, described and framed
  - People are prone to systematic biases in decision-making
  - Program could design processes to minimize them
Coding adjustment

- To compare MA to FFS, accurate coding is necessary
- Coding also affects the measurement of quality
- Any coding differences across the three payment models would have to be addressed
Current coding adjustment in MA

- Demographic factors and diagnosis data determine a beneficiary’s risk score in FFS and MA, and payments for MA plans
- CMS uses FFS claims data to develop the model (determine relative expenditures)
- In MA there is more intensive coding of diagnoses
- CMS makes a coding adjustment in MA to produce accurate payments
Coding adjustment for synchronization

- If CMS uses current risk adjustment model, a coding adjustment would be necessary to ensure that MA bids are for a 1.0 risk score, and that ACO expenditures are for an average risk beneficiary.
- A coding adjustment may also be necessary in measuring quality—for measures that are risk-adjusted and for many that are not.
Design issues for discussion

- National vs. local base premium
- Which Medicare option the base premium pays for—FFS vs. “lower of”
- Sharing of potential savings in program spending between the program and the beneficiary
- Possible next steps