



Advising the Congress on Medicare issues

MIPPA MA payment report Simulations

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MedPAC report on MA payments

- Mandated by Section 169 of MIPPA
- Three main tasks
 1. evaluate CMS's measurement of county-level spending
 2. study the correlation between MA plan costs and county FFS Medicare spending
 3. **examine alternate payment approaches** and make recommendations as appropriate
- Report due March 2010

MedPAC view of private plans

- MedPAC has long supported private plans in Medicare
 - Plans have the flexibility to use care management techniques to improve care, unlike FFS
 - If paid appropriately, plans have incentives to be efficient
- MedPAC has been concerned about how plans are currently being paid, and the incentives that the payment system has created – e.g. lack of financial neutrality

MA payment system concerns

- Payments 14 percent above FFS
- Medicare subsidizing inefficient plans that are not designed to coordinate care and improve quality
- Subsidization is greater than value of enhanced benefits, e.g. each dollar of enhanced benefits in PFFS plans involves a \$3.26 Medicare program subsidy

Prior recommendation – June 2005

- The Congress should set the benchmarks that CMS uses to evaluate Medicare Advantage plan bids at 100 percent of the fee-for-service costs.

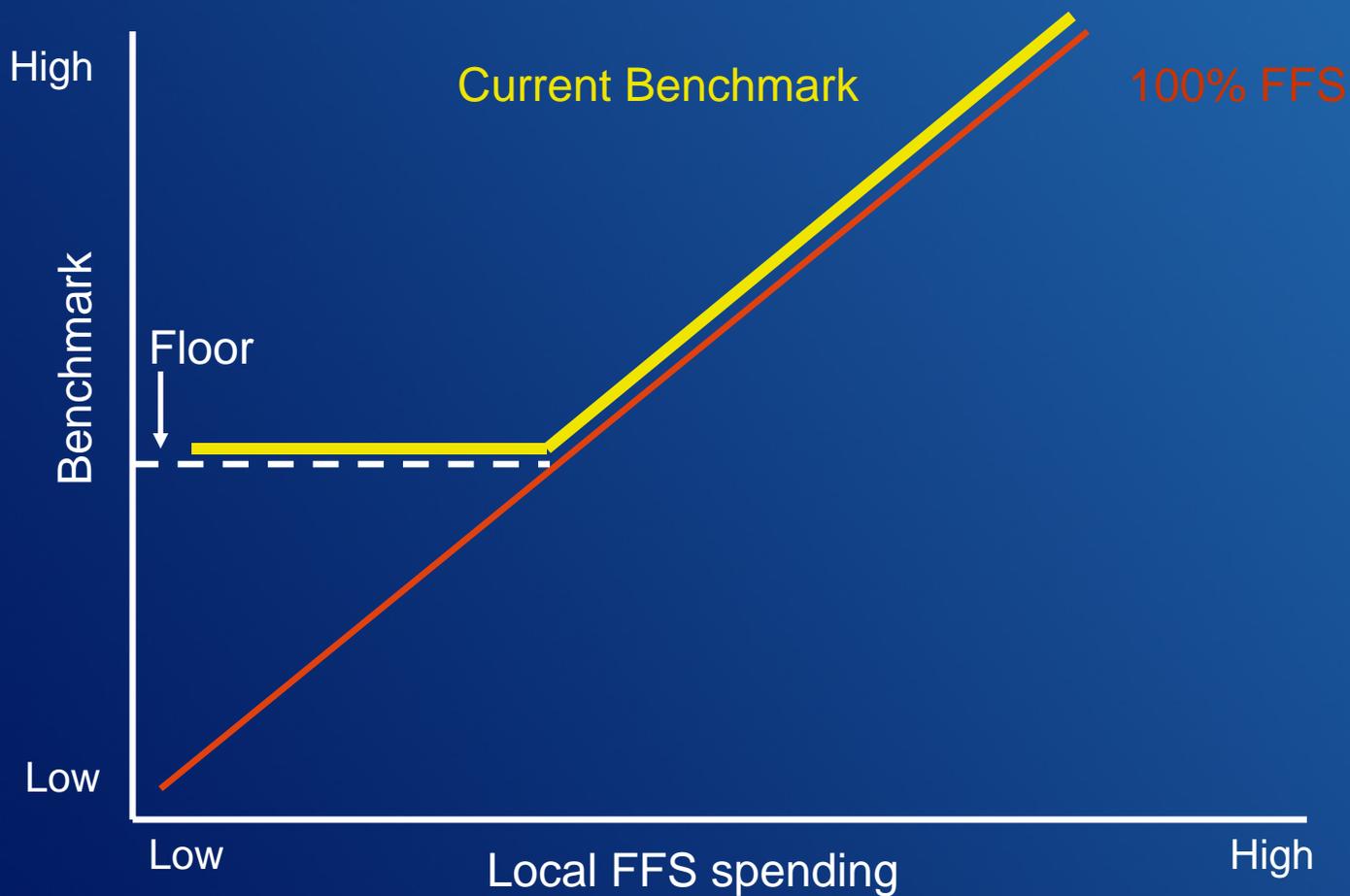
Alternate payment approaches

- Language asks us to examine policies other than payment based on FFS at county-level
- We've discussed some
 - Larger payment areas
 - Blend
- Today we'll simulate some other alternatives

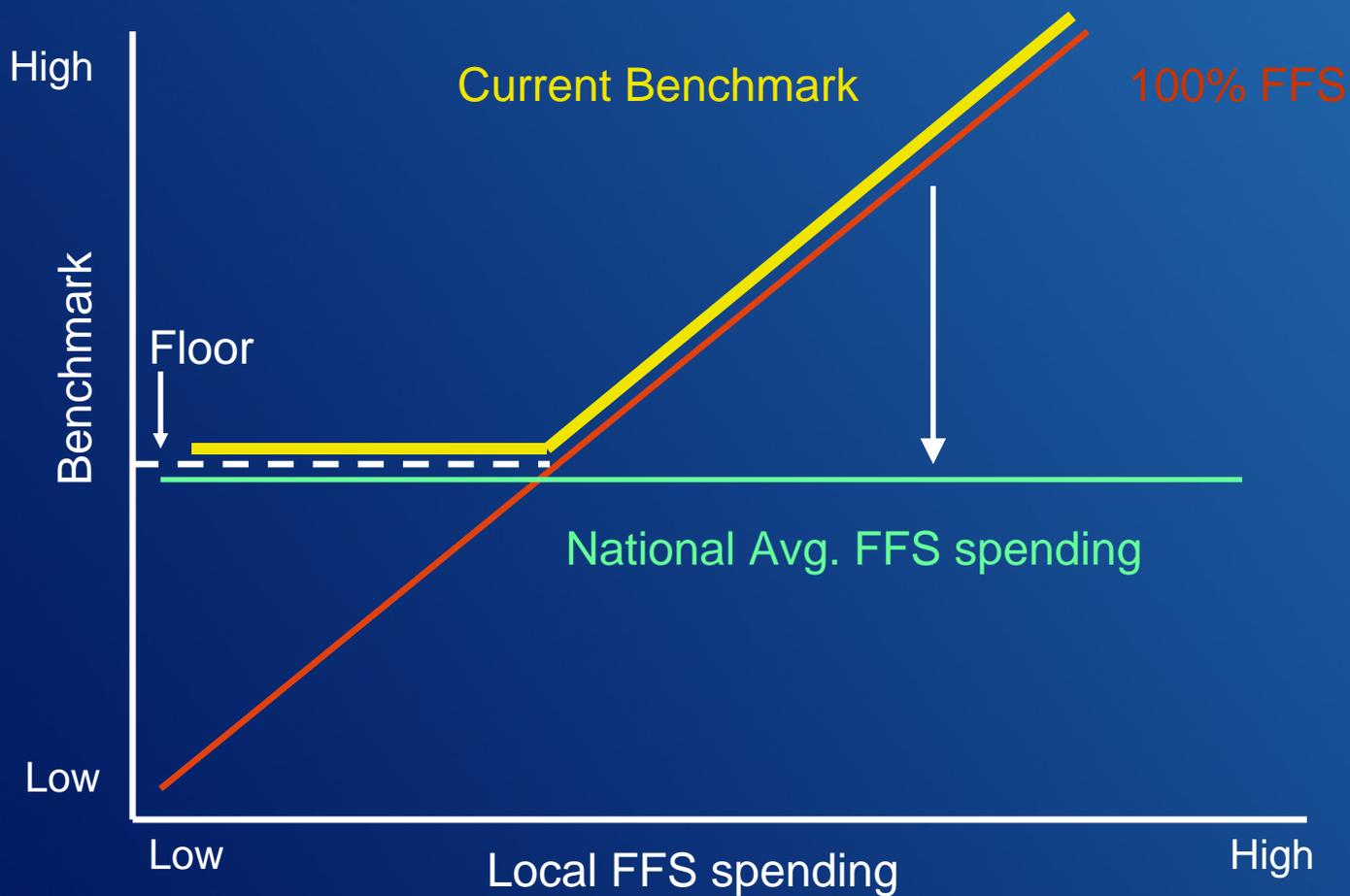
Alternatives simulated

- Current law
- 100% local FFS
- 100% national FFS
- National average FFS adjusted for local prices
- 75% local FFS / 25% national average FFS blend

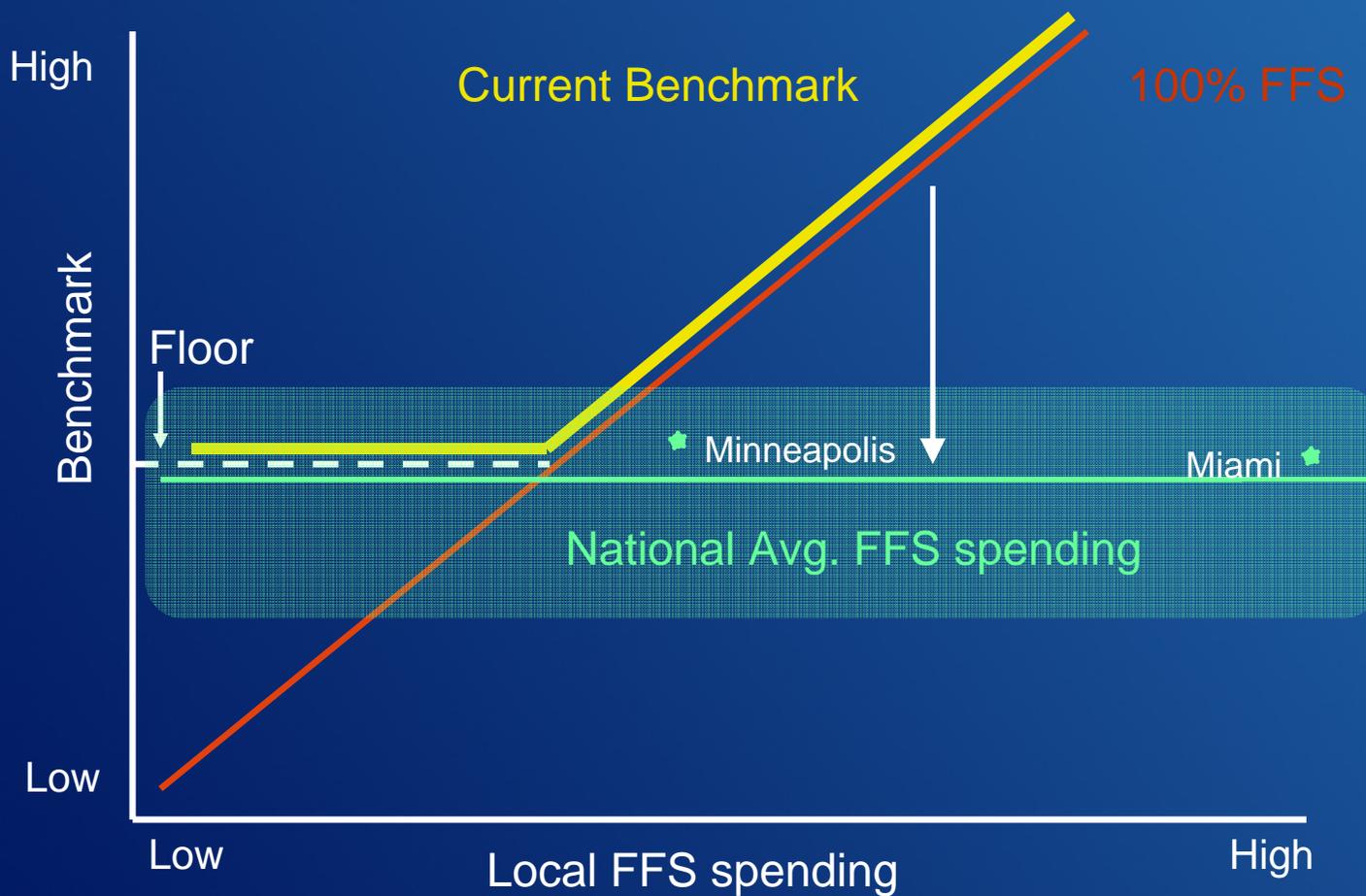
Current law benchmarks and local FFS spending



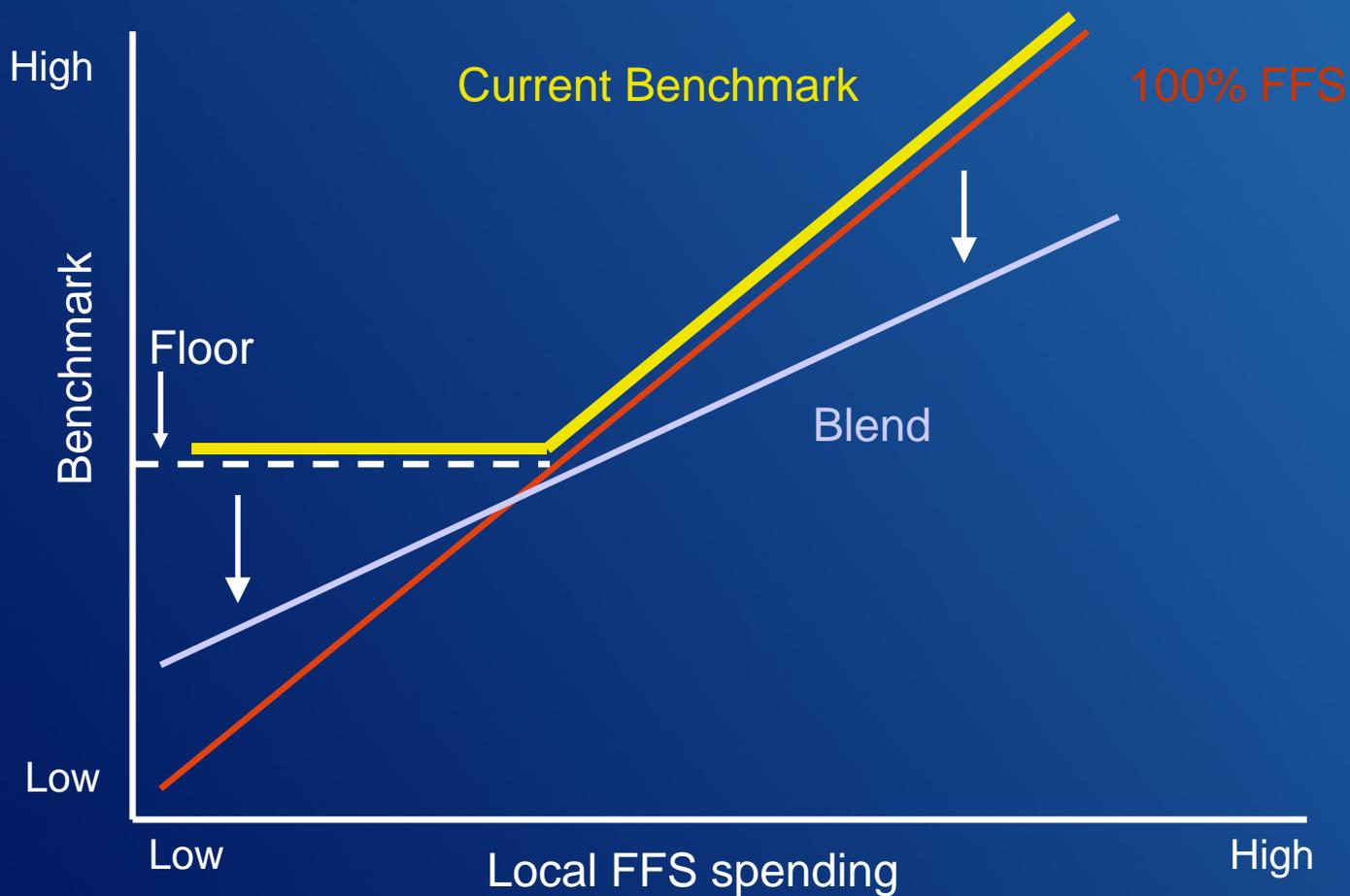
Current law benchmarks, local FFS spending, and National average FFS



Current law benchmarks, local FFS spending, and National average price-adjusted FFS



Current law benchmarks, local FFS spending, and local FFS/ national average FFS blend



Simulation rules for today

- Models based on 2009 plan bids
 - Including HMOs, local PPOs, regional PPOs, and PFFS plans
 - Excluding SNPs and employer-group plans because they are not available to all
- Assumes no change in plan bidding behavior

Medicare beneficiaries with plans bidding at or below benchmarks

Set benchmarks at:	0 plans	1 plan	2+ plans
Current benchmarks	0%	0%	100%
100% local FFS	19	12	70
100% national FFS	6	4	90
100% national FFS adj. for local prices	13	13	75
75% local / 25% national blend	13	12	75

Preliminary, subject to change

Medicare beneficiaries with no plans bidding at or below benchmarks

Set benchmarks at:	Total	Urban	Rural
Current benchmarks	0%	0%	0%
100% local FFS	19	15	31
100% national FFS	6	6	4
100% national FFS adj. for local prices	13	9	24
75% local / 25% national blend	13	10	22

Preliminary, subject to change

Other implications of alternatives

County	Current benchmark	100% Local FFS	100% natl. avg. FFS
Miami-Dade	\$1,238	\$1,213	\$720
Marathon, WI	\$741	\$599	\$720

Preliminary, subject to change

- Relative to local FFS, the national FFS and the blend alternatives:
 - Continue to encourage plans in low FFS spending areas where bids may be higher than local FFS
 - These tend to be areas dominated by PFFS
 - Discourage plans in areas where bids may be less than local FFS

Summary

- Caveat: assumes plan is unavailable if bid is above alternative benchmark
- All alternatives reduce average benchmarks to 100% of FFS spending and result in lower spending and reduced plan availability
- 100% local FFS benchmarks have the most impact on availability, 100% national average FFS benchmark the least
- Alternatives may have different effects on urban/rural areas
- Alternatives other than 100% local FFS continue to encourage inefficient plans

Further simulations Commissioners may want

- Plan-types?
- Larger payment areas?
- Other metrics?
- Benchmarks set by bids?
 - simulations based on current bids; may be of limited use because modeling plans' response to new benchmarks requires behavioral assumptions
- Other alternatives?

What should be the goals of the MA program?

- Ensure plan availability?
- Lower Medicare program spending?
- Improve quality?
- Other?