Advising the Congress on Medicare issues

Synchronizing Medicare benchmarks across payment models

David Glass, Julie Lee, and Jeff Stensland

March 7, 2014

MEDPAC

Review of the Nov. 2013 presentation

- Policy context
  - There are different payment models in Medicare—FFS, MA, and ACOs
  - Payment rules are different across those models
  - They can result in different program payments for similar beneficiaries across those models
- Policy questions
  - How should different models relate to one another?
  - Does “synchronizing” mean financial neutrality across FFS and other models?
  - How to address spending variations within and across areas?

Outline of today's presentation

- Review current payment rules for FFS, MA and ACOs
- Explore financial neutrality: ACO and MA benchmarks = 100% local FFS spending
- Illustrative example based on data from Pioneer ACOs, FFS, and MA in 2012
- Additional issues

Rules under current law

	Traditional FFS Medicare	Accountable care organizations (ACOs)	Medicare Advantage (MA)
Medicare program	• Pays for individual services at set payment rates	• Pays for individual services at set payment rates (FFS) • Plus bonus payments/ penalty based on spending & quality targets	• Pays risk-adjusted capitation payments per enrollee • Based on MA benchmarks and plan bids
Beneficiaries	• Medicare benefit package • Any participating provider • Can have supplemental coverage	• Same as under FFS • Attributed to an ACO • Providers can informally encourage staying within the ACO	• Plan-specific benefits—get extra benefits if the plan bid is less than the MA benchmark • Limited network of providers or in-network incentives • Need to enroll

Commission's perspective on MA

- Private plans could offer efficiency and quality
- 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 recommended financial neutrality between MA and FFS

What does benchmark mean for MA?

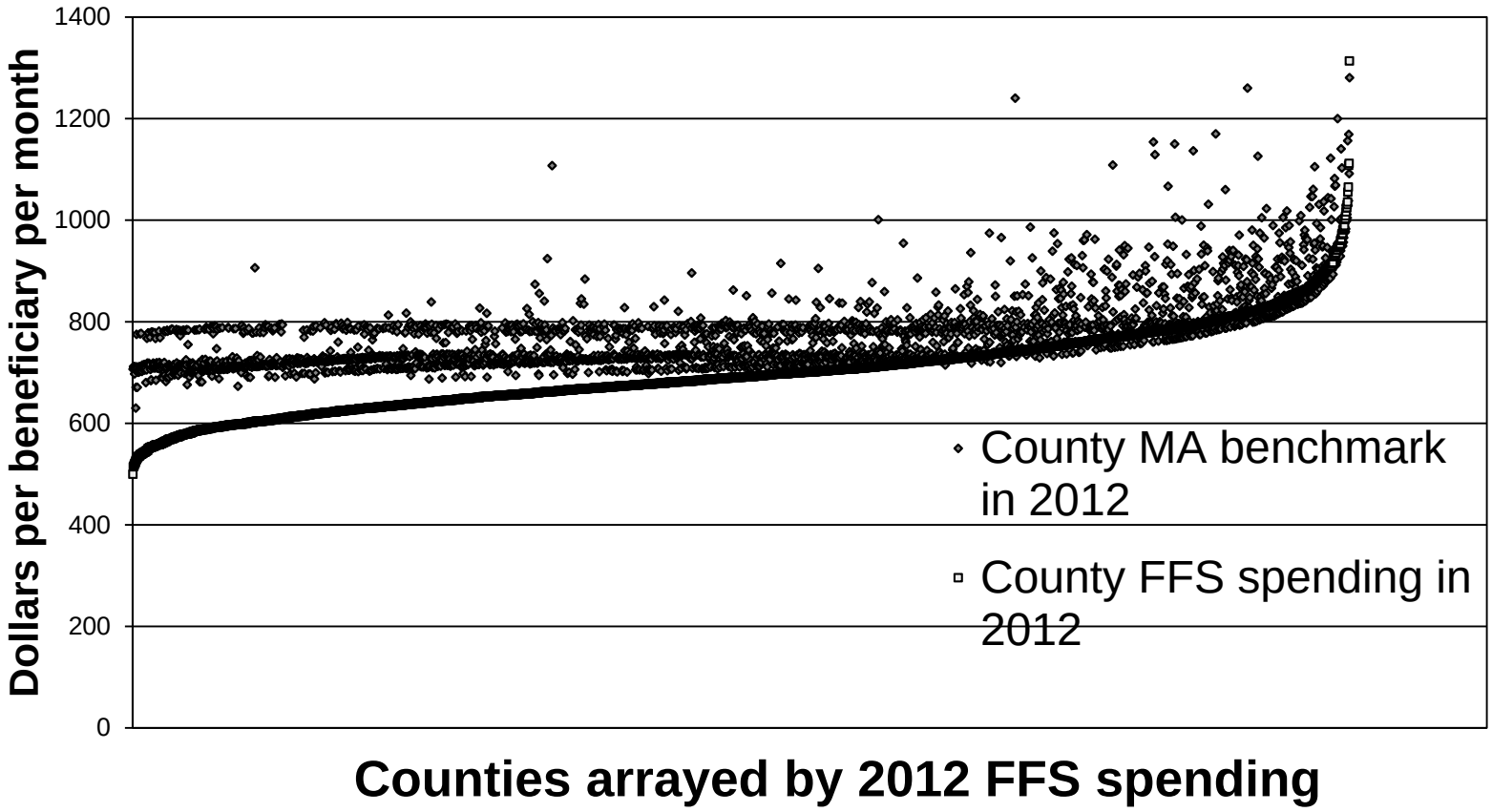
For MA the benchmark is the upper limit of payment

Bid vs benchmark	Program payment	Additional premium	Additional benefits
higher	benchmark	difference	none
equal	benchmark	none	none
lower	bid + (50, 65 or 70% of the difference)	none	yes

What does benchmark mean for ACOs?

- For ACOs the benchmark is the expected payment
- If spending is less than the benchmark:
  - shared savings between the program and ACO
  - total program payment (spending plus shared savings) lower than the benchmark
- If spending is greater than the benchmark:
  - shared loss (two-sided risk) or not (one-sided risk)
  - total program payment greater than the benchmark

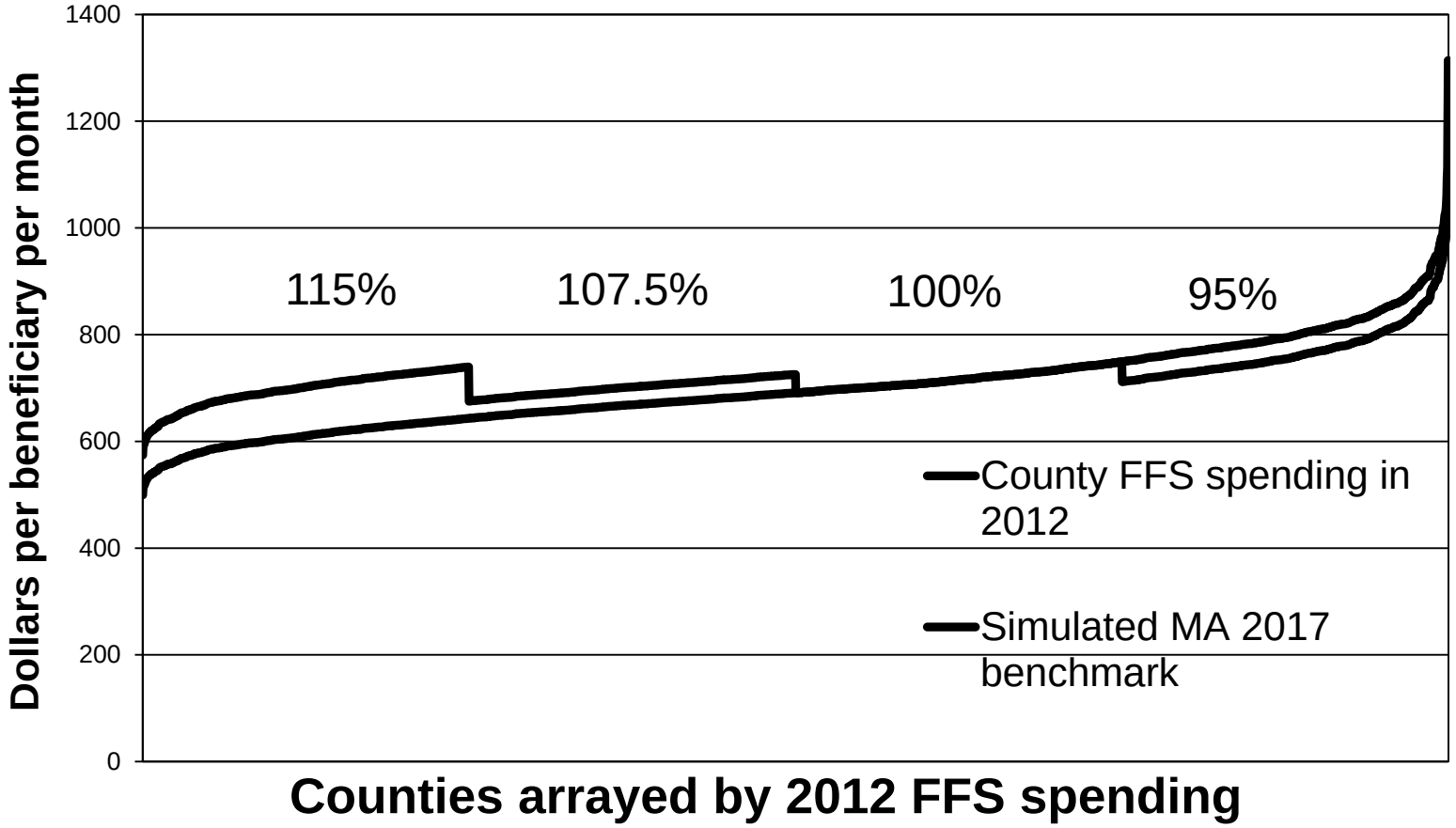
MA benchmarks higher than FFS spending in most counties, 2012



Note: FFS spending excludes hospice and most of IME.
Source: MedPAC analysis of 2012 CMS data

MEDPAC

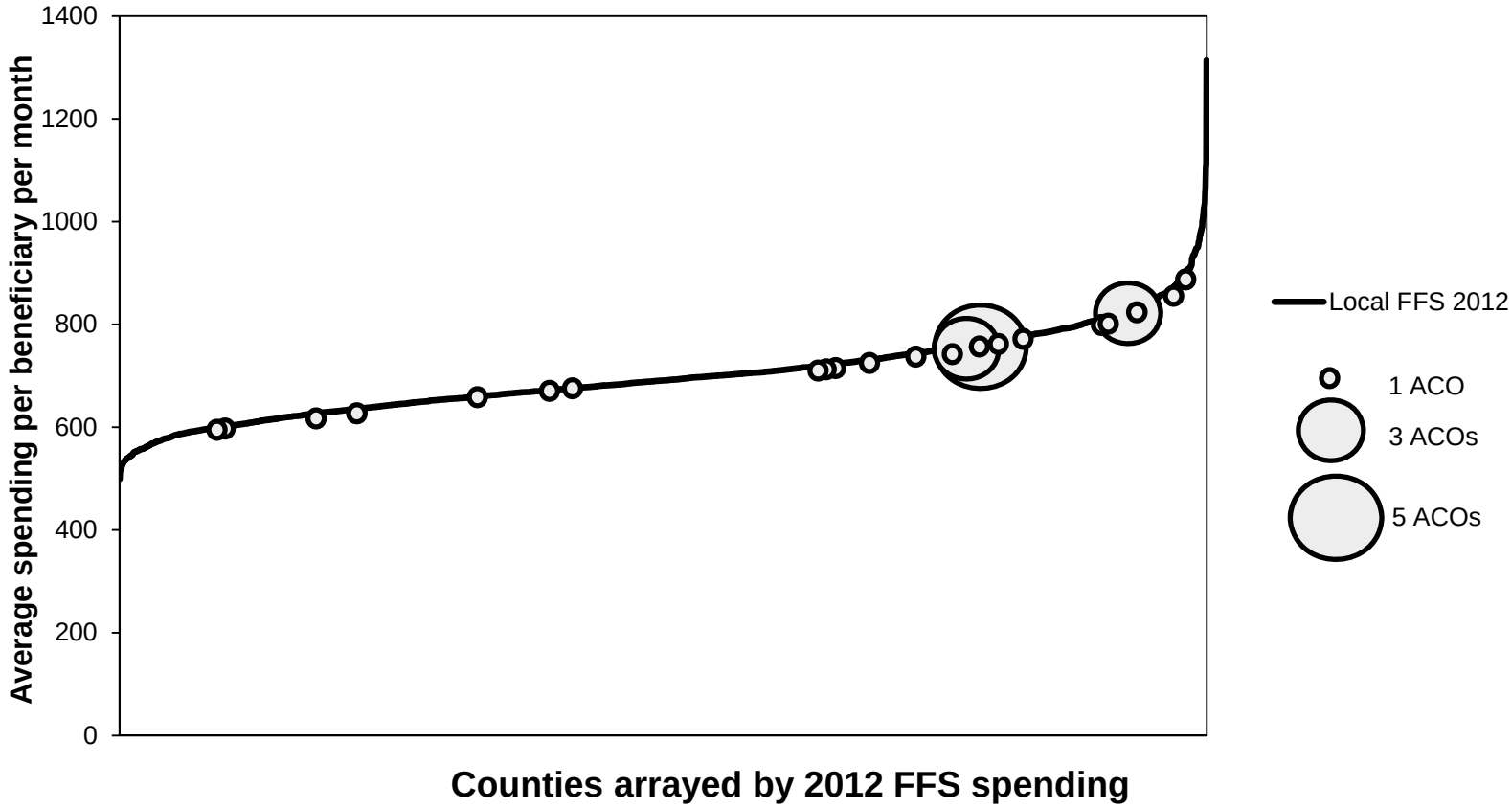
Simulated 2017 MA benchmarks



Note: For this illustrative example, simulated 2017 benchmark quartiles were calculated using 2012 FFS spending by county. In practice, the 2012 quartiles were determined using 2011 FFS spending, minus the 2011 IME phaseout.
Source: MedPAC analysis of 2012 FFS spending data from CMS

MEDPAC

Pioneer ACOs tend to locate in higher spending areas



Note: The total number of counties is 3,145. The total number of Pioneer ACOs was 32 in 2012. Nine subsequently have left the program. Only one county per ACO was used – the county where the ACO is headquartered. Some beneficiaries served by the ACO may not reside in the same county.
Source: MedPAC analysis of CMS data on FFS spending and on the location of ACOs

Simulation of relative program spending for ACO beneficiaries under three payment models (ACO, FFS, MA)

- ACO model = actual program spending for the ACO beneficiaries in 2012
- FFS model = ACO beneficiaries' 2011 FFS spending trended forward to 2012
- MA models = ACO beneficiaries' simulated spending had they joined MA in 2012
  - Scenario 1: used actual 2012 benchmarks
  - Scenario 2: used benchmarks set equal to expected 2012 FFS cost

No single payment model is lowest cost in all markets

	Count of markets where the lowest cost option was:		
	Traditional FFS	ACO FFS	MA
Using actual 2012 MA payment rates	11	15	5
If MA benchmarks were set at 100% of expected average FFS costs plus a 3% quality bonus	5	7	19

Note: A total of 31 Pioneer ACO sites had MA HMO plans in their market and were evaluated. We estimated the lowest cost option for these 31 sets of beneficiaries. We assumed that some MA plans would earn quality bonuses, and used an average quality bonus of 3% in our analysis.
Source: MedPAC analysis of CMS claims files, MA enrollment and county level payment files, as well as data from CMMI on expected FFS and actual ACO cost

Additional issues: Quality

- MA plans get higher benchmark if high quality
- ACOs get lower shared savings if lower quality
- Possible approach: common budget-neutral adjustment for ACOs and MA:
  - 2% addition to benchmark if high quality
  - 2% subtraction from benchmark if low quality

Additional issues: Risk adjustment

- ACO uses historical spending
- MA uses the CMS-HCC risk score
- Possible approach: Move ACO to prospective benchmark and use the CMS-HCC for risk adjustment

Additional issues: Financial responsibility over time

- Pioneer ACOs are responsible for costs, even if patients leave for other providers. This creates a strong incentive to keep high-cost beneficiaries satisfied and loyal to ACO providers
- MA plans have no financial responsibility for disenrollees
  - Less incentive to keep high-cost enrollees satisfied
  - Disenrolles tend to have high costs
- Possible approach: give MA plans an incentive similar to ACOs

Future issues for synchronization

- How do we address high-cost FFS areas?
  - Synchronize quality and cost objectives for FFS with ACOs and MA?
  - How much will ACOs reduce average FFS spending (and thus benchmarks) in these areas?
- How should we reward low-bid MA plans and low-cost ACOs?
  - Currently, if MA plans bid below the benchmark they must use the savings to add benefits
  - Use of ACO shared savings is not restricted
  - Should MA and ACO shared savings policies be more closely aligned?
  - Implications for beneficiaries

Discussion

- How to establish equal benchmarks for ACOs and MA?
- How to create comparable quality adjustments to MA and ACO benchmarks?
- Should we use CMS-HCC risk adjustment for ACOs?
- Should certain MA plans be penalized if an above-average share of high-cost beneficiaries leave those plans?