The relative cost of Medicare Advantage, Accountable Care Organizations, and fee-for-service Medicare

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MEDPAC

Review of last year's discussion

- 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
- Prior finding: No one model has the lowest program cost in all markets
- To allow models to compete on a level playing field, there is a need to synchronize payment models

Lowest program-cost model under current law

Markets ranked according to service use quartile	Number of markets (out of 78) where the lowest program cost model is: FFS	ACO	MA
All markets	28	31	19
Low-use quartile	9	10	1
Second quartile	7	8	4
Third quartile	10	6	4
High-use quartile	2	7	10

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.

Data are preliminary and subject to change

Recap of Commission's perspective on synchronizing MA with FFS

- 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

Most recent data on relative program cost for of MA, ACOs and FFS

Markets ranked by service use quartile	Program cost in 78 markets relative to FFS (markets weighted equally) ACOs/FFS	MA/FFS*
All markets	100%	105%
Low-use quartile	101	113
Second quartile	100	105
Third quartile	101	103
High-use quartile	98	98

* MA costs include the full adjustment for coding we discussed last month

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.

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Relative MA program cost under different benchmarks (with no change in bids)

Markets ranked by service use quartile	MA program cost relative to FFS in 78 markets: 2015 Law	2017 Law	100% FFS*
All markets	105%	102%	98%
Low-use quartile	113	111	99
Second quartile	105	101	98
Third quartile	103	102	98
High-use quartile	98	95	95

*100% of FFS is FFS without any increases in the benchmark for quality.
Note: MA plans exclude special needs plans and employer-based plans
Source: MedPAC analysis of ACO and MA plan bid data.

Will bids decline relative to FFS costs as benchmarks decline?

	2010	2011	**2012**	**2013**	**2014**	**2015**
Average benchmark /FFS cost	1.16	1.12	1.11	1.09	1.12	1.06
Average A/B bid /benchmark	0.88	0.87	0.86	0.85	0.86	0.86
Average A/B bid /FFS cost	1.02	0.97	0.95	0.93	0.96	0.92*

*Adjusted for coding differences this bid would be 95% of FFS for the basic A/B benefit

Note: The ratios of benchmarks over FFS are based on CMS data and do not include any additional coding adjustments beyond those in the CMS estimates. The bid is the payment for the basic A/B benefit and does not include payments for extra benefits. MA plans exclude special needs plans and employer-based plans.

Source: MedPAC MA plan bid data.

Data are preliminary and subject to change

What will be the effects of continuing to lower benchmarks?

- Some plans may continue to lower bids
  - Reduces taxpayer cost
  - Reduces beneficiary premiums
- At some point, plans will not be able to lower bids
- Plans may leave some MA markets where they cannot compete with FFS on price

MA plans ability to restrain bids depends on prices plans pay providers

- FFS prices serve as an MA price anchor
- Roughly 40 percent of the average plan's costs are for hospital care
- Commercial hospital rates are roughly 50 percent above costs and are more than 50 percent higher than rates paid by MA plans on average
- MA plan affordability in part depends on continuing to pay hospital prices that are substantially lower than commercial rates

Additional issues in synchronizing benchmarks: Quality

- MA and ACO quality adjustments are inconsistent
  - MA plans get higher benchmark if high quality
  - ACOs get lower shared savings if lower quality
- Possible approach: common adjustment for ACOs and MA:
  - e.g., 2% addition to benchmark if higher than FFS
  - e.g., 2% subtraction from benchmark if lower than FFS
  - If MA and ACOs have higher quality, may need a reduction in FFS rates to make it budget neutral

Other issues for synchronization

- 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?
- How should beneficiaries be encouraged to choose the most efficient model?

Discussion

- How to establish benchmarks to promote competition among models?
- What should be the Medicare program's objectives in setting benchmarks?
  - Current model:
    - Guarantee FFS for the part B premium in all markets?
    - Subsidize MA in low-use markets in order to have MA in almost all markets?
  - Least-costly model: guarantee either FFS or MA, which ever has the lower program cost?