



*Advising the Congress on Medicare issues*

# Synchronizing Medicare policy across payment models

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# Outline of today's presentation

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

# Review of January 2015 analysis

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- 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

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

\* 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

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	Portland, OR	Columbus, OH	Miami-Dade, FL
Median MA plan bid	\$703	\$659	\$743
Average FFS spending	\$626	\$722	\$1,151
Difference between MA and FFS	\$77	-\$63	-\$408

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

Source: MedPAC analysis of MA plan bids for 2015 and MA enrollment data for January 2015.

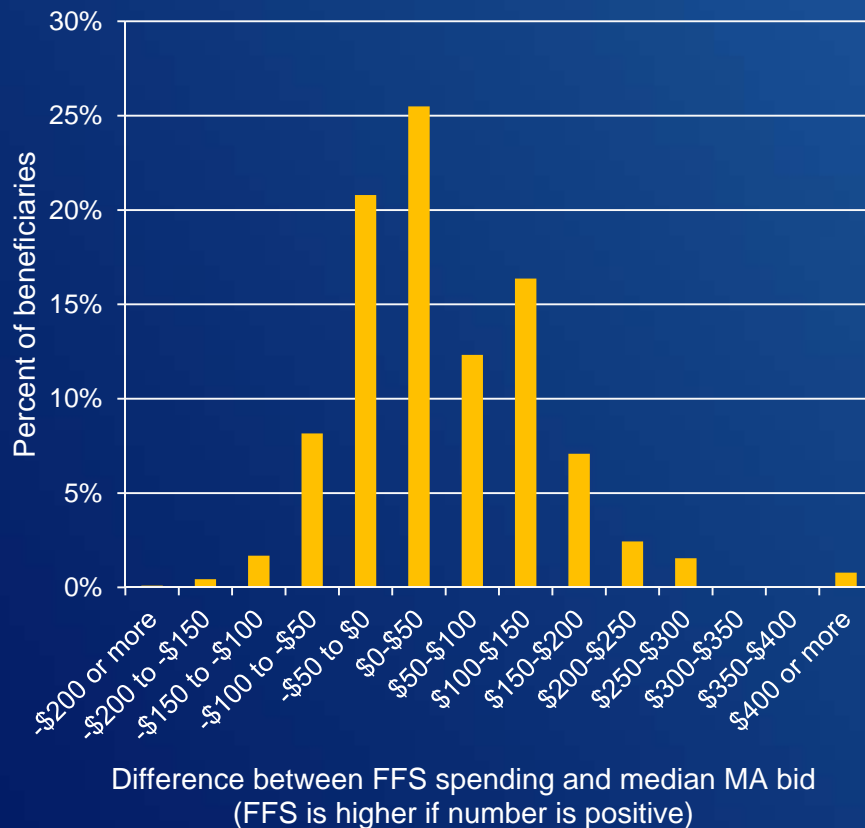
## Assumptions in analysis:

- 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

Illustrative example	Portland, OR	Columbus, OH	Miami-Dade, FL
<b>1) Nationally-set base premium pays for FFS Medicare in every market</b>			
FFS premium	\$101	\$101	\$101
MA premium	\$178	\$38	-\$307
Federal contribution	\$525	\$621	\$1,050
<b>2) Nationally-set base premium pays for either FFS Medicare or reference MA plan—whichever is lower cost—in each market</b>			
FFS premium	\$101	\$164	\$509
MA premium	\$178	\$101	\$101
Federal contribution	\$525	\$558	\$642
<b>3) Locally-set base premium pays for either FFS Medicare or reference MA plan—whichever is lower cost—in each market</b>			
FFS premium	\$84	\$160	\$562
MA premium	\$161	\$97	\$154
Federal contribution	\$542	\$562	\$589

# 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

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- 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

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- 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

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- 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

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- 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)

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- 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

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- 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

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- 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

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- 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

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- 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