Synchronizing Medicare policy across payment models

David Glass, Scott Harrison, Julie Lee,
Jeff Stensland, and Carlos Zarabozo

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MEDPAC

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

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.

Data are preliminary and subject to change

Review of March 2015 analysis

	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

Note: FFS (fee-for-service), MA (Medicare Advantage).
Source: MedPAC analysis of MA plan bids for 2015 and MA enrollment data for January 2015.

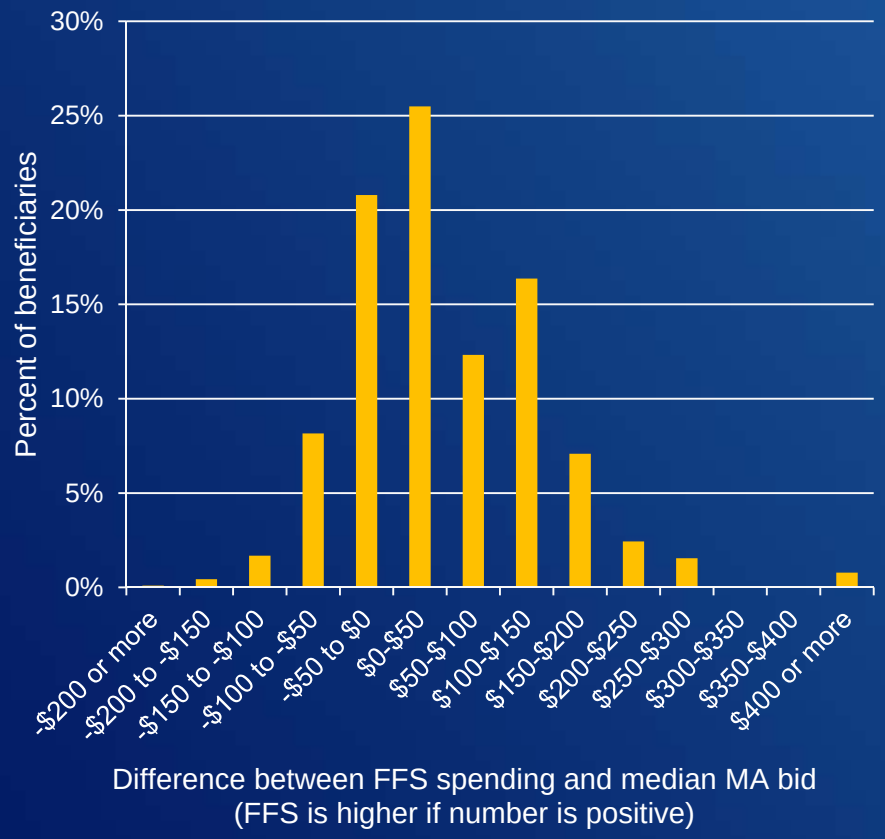
Assumptions in analysis:

- 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
1) Nationally-set base premium pays for FFS Medicare in every market			
FFS premium	$101	$101	$101
MA premium	$178	$38	-$307
Federal contribution	$525	$621	$1,050
2) Nationally-set base premium pays for either FFS Medicare or reference MA plan—whichever is lower cost—in each market			
FFS premium	$101	$164	$509
MA premium	$178	$101	$101
Federal contribution	$525	$558	$642
3) Locally-set base premium pays for either FFS Medicare or reference MA plan—whichever is lower cost—in each market			
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

- 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