CHAPTER 1

Synchronizing Medicare policy across payment models

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Chapter summary

Historically, Medicare has had two payment models: traditional fee-for-service (FFS) and Medicare Advantage (MA). Traditional FFS pays for individual services according to the payment rates established by the program. By contrast, under MA, Medicare pays private plans capitated payment rates to provide the Part A and Part B benefit package. Starting in 2012, Medicare introduced a new payment model: the accountable care organization (ACO). Under the ACO model, a group of providers is accountable for the spending and quality of care for a group of beneficiaries attributed to them. The goal of the ACO program is to give groups of FFS providers incentives to reduce Medicare spending and improve quality, similar to the incentives under the MA program.

A major issue is that Medicare's payment rules and quality improvement incentives are different and inconsistent across the three payment models. There are various approaches to making those rules more consistent. From the program perspective, the Commission is examining how to synchronize policy across payment models with respect to spending benchmarks, risk adjustment, and quality measurement and will be examining how to synchronize regulatory oversight. The Commission is also interested in the beneficiary perspective on synchronizing policy across payment models, including how beneficiaries learn about the Medicare program, choose plans, and respond to financial incentives.

In this chapter

- Payment models under the current Medicare program
- Synchronizing benchmarks for ACOs and MA plans
- Additional considerations in synchronizing benchmarks
- Moving forward

This chapter represents the Commission's initial exploration of synchronizing Medicare policy across payment models and is not intended to be a definitive or comprehensive discussion. In this initial analysis, we focus on setting a common spending benchmark based on local FFS spending for MA plans and ACOs as a key element of synchronizing Medicare policy across payment models. Using an analysis of early results from the Pioneer ACOs, we illustrate that no one payment model is uniformly less costly than another model in all markets across the country. Which model is less costly and which ACOs and MA plans may want to enter the program would be sensitive to how benchmarks are set. To synchronize benchmarks, it is also necessary to address differences among the payment models in adjusting for risk, quality, and spending variations across areas. Detailed discussions of the issues related to risk adjustment and quality are included in Chapter 2 and Chapter 3 of this report. ■

Introduction

Under the current Medicare program, there are now three payment models through which beneficiaries can receive Medicare services: traditional fee-for-service (FFS), Medicare Advantage (MA), and accountable care organizations (ACOs). Traditional FFS pays for individual services according to the payment rates established by the program. By contrast, under MA, Medicare pays private plans a capitated payment rate to provide the Part A and Part B benefit package to plan enrollees.[1] In the ACO model (which started in 2012), a group of providers in an ACO is accountable for the spending and quality of care for a group of beneficiaries attributed to the ACO.

The Commission has for many years supported giving Medicare beneficiaries a choice between traditional FFS and private plans under MA. The original goals for private plans in Medicare were to provide a mechanism for introducing innovation into the program while constraining Medicare spending. Private plans have greater flexibility to develop innovative approaches to care and can more readily use care management tools and techniques than FFS. If private plans reduce spending and improve the quality of health care services, then Medicare beneficiaries' ability to choose between the traditional FFS and MA plans can lead to greater efficiency for the program. But MA plans are more likely to innovate if payment rates encourage them to do so. As the goals for private plans have shifted over time to include the goal of making MA plans available to all beneficiaries—even in markets where plans are not able to compete successfully with FFS based on cost—plan payments were increased above FFS levels. Higher payments have resulted in higher MA enrollment, but with some plans bringing little or no innovation to the program at higher costs. This situation is unfair to taxpayers and beneficiaries who subsidize the higher costs through higher program payments and higher Part B premiums.

In our June 2005 report, the Commission recommended setting the MA benchmarks at 100 percent of FFS costs, with differential payment for higher quality (Medicare Payment Advisory Commission 2005). That is, the Medicare program would pay the same amount for a beneficiary's enrollment in an MA plan, on average, as Medicare would expect to pay to cover the beneficiary in FFS Medicare. When the recommendation was made, the process for determining MA payments was not financially neutral relative to FFS cost. The administratively set benchmarks, against which the MA plans bid, were often well above the local cost of FFS Medicare. One way the system could be financially neutral was if the benchmarks were more reflective of the cost of FFS Medicare.

The Commission maintains that to encourage beneficiaries to choose the model that they perceive as having the highest value in terms of cost and quality, the Medicare program should pay the same on behalf of each beneficiary making the choice. The Medicare program could not subsidize one choice more than another and still be financially neutral with respect to the beneficiary's choice to remain in the FFS system or enroll in an MA plan.

In the current context of three payment models, we interpret the principle of financial neutrality to mean that the benchmarks would be equal across payment models. Equal benchmarks, however, do not mean equal payments because payments may be adjusted for quality and other factors. This definition of equal benchmarks represents a refinement of the earlier definition of equal program payments for FFS and MA. In this chapter, we examine this refined definition of financial neutrality and its implications.

Payment models under the current Medicare program

Under the current Medicare program, there are three payment models through which beneficiaries can receive Medicare services: traditional FFS, MA, and ACOs. Traditional FFS pays for individual services according to the rates established by payment systems for each sector of the FFS program. Although there is some value-based purchasing that ties payment rates to the quality of care provided, providers overall bear little risk under traditional FFS. By contrast, MA plans and ACOs are paid under different sets of rules.

The MA payment model

Under current law, MA plans are required to cover all Medicare Part A and Part B benefits except hospice. With some exceptions, all MA plans must also offer an option that includes the Part D drug benefit, although payments for the Part D benefit are handled separately.[2] Plans may supplement Medicare benefits by reducing cost-sharing requirements, providing coverage of non-Medicare benefits, enhancing the Part D drug benefit, or providing a rebate for all or part of the Part B or Part D premium.

TABLE 1–1

MA program payment

Bid versus benchmark	Program payment	Additional premium for enrollee above the standard Part B premium	Additional benefits for enrollee
Bid higher	Benchmark	Difference	None
Bid equal	Benchmark	None	None
Bid lower	Bid + (50%, 65%, or 70% of the difference, based on a plan's quality ranking)	None	Yes

Note: MA (Medicare Advantage).

For each county, CMS sets the MA benchmark.[3] An MA plan's payment from Medicare is based on how its bid compares with the local MA benchmark, which represents the maximum amount Medicare will pay to a plan in a given area on behalf of an MA enrollee. The plan's bid reflects its costs to provide the Part A and Part B benefit package for a beneficiary of average health status and includes plan administrative cost and profit. The local MA benchmark represents a bidding target and is set using statutory formulas and adjusted for the plan's quality ranking.[4] If a plan's bid is above the benchmark, then the plan receives a payment equal to the benchmark and the MA enrollees have to pay a premium—in addition to the Part B premium—that equals the difference between the bid and the benchmark. If a plan's bid is at the benchmark, then the payment equals the benchmark. If a plan's bid is below the benchmark, then the plan receives a payment equal to its bid plus a "rebate." As of 2014, the rebate is a fixed percentage—50 percent, 65 percent, or 70 percent, depending on a plan's quality ranking—of the difference between the plan's bid and benchmark. (Table 1-1 summarizes how MA payment relates to the plan bid and the MA benchmark.) Once the rebate dollars are determined, the plan must return the rebate to its enrollees in the form of supplemental benefits or lower premiums.[5] A more detailed description of the MA payment system can be found at http://www.medpac.gov/documents/MedPAC_Payment_Basics_13_MA.pdf.

The Pioneer ACO payment model

There are two models of ACOs: the Pioneer ACO and the Medicare Shared Savings Program (MSSP) ACO. In this chapter, we will be focusing on the Pioneer ACO due to earlier availability of data and the Pioneer ACO's faster movement toward full responsibility for the cost and quality of care. Similar to MA plans, the Pioneer ACOs will have full responsibility for the ACO beneficiaries' cost of care for Part A and Part B services starting in 2015. In contrast, the MSSP ACOs can operate in a bonus-only model for up to three years (no downside risk) and therefore initially have weaker incentives to control costs than Pioneer ACOs. Because the Pioneer ACOs are responsible for all costs—including services provided by non-ACO providers—they have a strong incentive to continually convince the beneficiary that the ACO's providers are providing the highest quality care. The beneficiaries in ACOs are all free to go to non-ACO providers if they feel those providers will provide better or more convenient care. The responsibility for the cost of care in such an open network is similar to MA preferred provider organization (PPO) plans; however, the Pioneer ACOs' accountability for the cost of care differs from MA PPO plans in three ways. First, MA plans are not responsible for hospice care or other services after a patient enters hospice; ACOs remain responsible for all care after patients enter hospice. The Commission has recommended that MA plans be given this responsibility in the future (Medicare Payment Advisory Commission 2014).[6] Second, about 90 percent of MA enrollees (as of March 2014) are in MA plans that include coverage for drugs (Part D coverage). Part D responsibility is currently not integrated into ACO benchmarks. Third, Pioneer ACOs have greater longitudinal responsibility for patients. Beneficiaries are prospectively assigned to the ACO if the beneficiary has historically used the ACO physicians for a plurality of their primary care visit, and the ACO is responsible for the beneficiary's costs for at least one full year after they are assigned to the ACO; that is, if the beneficiary becomes dissatisfied with the Pioneer ACO physicians and goes elsewhere, the Pioneer ACO is still responsible

Financial responsibility over time

Another issue for the synchronization of rules across payment models is the matter of financial responsibility over time. Pioneer ACOs remain responsible for their beneficiaries' Medicare spending for at least one year, even if those beneficiaries become dissatisfied and get their care outside of the ACO. Similarly, MA plans could be held accountable for some of the cost of beneficiaries who disenroll to FFS Medicare and have program spending above what would be expected. The Commission's past analysis suggests that MA beneficiaries who disenroll and return to FFS have 16 percent higher FFS spending than their risk score would suggest, and other research also suggests those who disenroll have high spending (Medicare Payment Advisory Commission 2012, Newhouse et al. 2012). If there were a desire to make financial responsibility over time consistent between ACOs and MA plans, there could be a policy change so that an MA plan's Medicare payments would be reduced if the average costs of beneficiaries who disenroll from the MA plan were significantly higher than would be expected based on their risk scores. ■

for the costs of care for at least one year. In contrast, if an MA patient becomes dissatisfied with the MA plan and leaves the plan, the MA plan is no longer responsible once the patient leaves. The implication is that the incentives for ensuring patient satisfaction in the Pioneer ACO program are very strong.

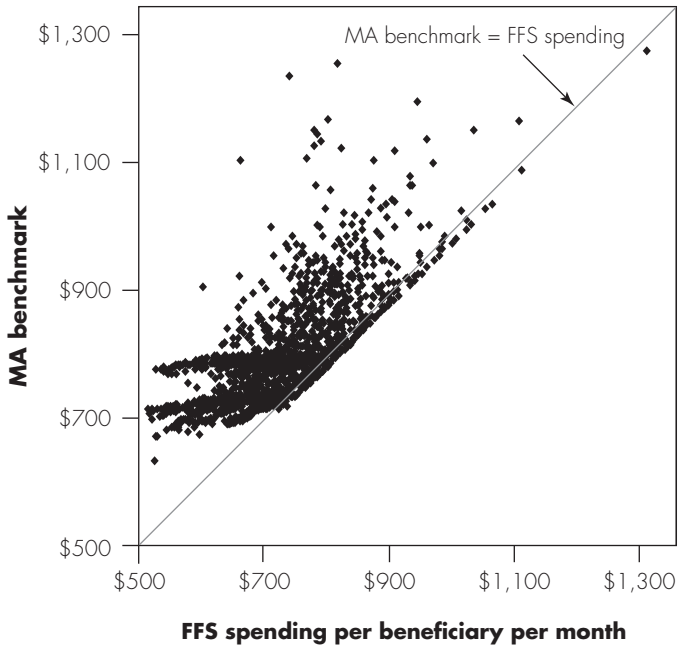
The mechanics of how ACOs are compensated also differ from MA plans. The MA plans enroll beneficiaries and then receive monthly capitated payments based on their benchmark and bids. The MA plans then pay providers and retain the difference between payments from the Medicare program and their payments to providers. The ACOs are different. Medicare directly pays providers FFS rates. The ACO then is paid shared savings based on the difference between what the program paid to providers and the ACO's benchmark. In the end, MA plans and Pioneer ACOs face similar financial incentives. However, ACOs avoid the extra cost of enrolling beneficiaries and paying claims, while MA plans face these extra overhead costs. Although there is a cost to enrollment and paying claims, the MA plans are the claims processing entity and can undertake utilization management activities such as requiring prior authorization for some services. The MA plans also have more flexibility to pay for innovative care delivery models that do not fit Medicare regulations and can direct beneficiaries to a limited network of providers. Thus, Pioneer ACOs have the advantage of lower overhead due to not paying claims and not having marketing costs, but the MA plans have the advantage of having more tools to control costs.

Unlike MA benchmarks, ACO benchmarks reflect historical FFS spending incurred by beneficiaries treated by the ACOs' physicians.[7] In 2015, the benchmark for Pioneer ACOs roughly represents the maximum spending level to be incurred by the ACO's beneficiaries, above which penalties are applied and below which savings are accrued and shared among the ACO's providers.[8] An ACO's target spending, or the benchmark, is calculated as follows. First, a subset of FFS beneficiaries is attributed to the ACO, based on its three years' claims history. (Unlike in MA plans, beneficiaries do not enroll in ACOs.) Second, an ACO's baseline spending is set equal to a weighted average of FFS spending for those beneficiaries over three years. Finally, the baseline spending is trended forward using the national growth rate in FFS spending.

At the end of each year, an ACO's actual spending is calculated as the sum of all FFS spending for the ACO's beneficiaries for the year, even if some of those beneficiaries get their care from non-ACO providers during the year (see text box). If the actual spending for the ACO's beneficiaries is below the benchmark, the difference is divided between the ACO and the Medicare program as shared savings. (The percentage of shared savings for the ACO ranges from 50 percent to 75 percent.) Under the first year of the Pioneer ACO program, some ACOs chose a two-sided risk arrangement (bonuses or penalties) and some chose a one-sided risk arrangement (bonuses only). In 2014 and all future years, the Pioneer ACOs face two-sided risk, where they are penalized for spending above the

FIGURE 1–1

FFS spending and MA benchmarks by county, 2012



Note: FFS (fee-for-service), MA (Medicare Advantage). FFS spending for 2012 is projected and excludes hospice, direct graduate medical education, and indirect medical education payments. FFS spending and MA benchmarks are standardized for a beneficiary of average health status. Data include U.S. counties only (not territories).

Source: MedPAC analysis of 2012 CMS MA bid data.

benchmark and receive shared savings when spending is below the benchmark.

As the brief descriptions of the payment rules for FFS, MA, and ACOs suggest, currently the Medicare program is likely to pay different amounts for similar beneficiaries across the three models. There are many reasons for this outcome, especially given the complexity of the payment rules. But one key factor is the difference in how the spending benchmark is set for MA plans and ACOs.

Relationship between FFS spending and MA benchmarks

MA benchmarks are set according to statutory formulas specified in the law, which include major changes introduced in the Patient Protection and Affordable Care Act of 2010 (PPACA). The PPACA provisions set county benchmarks for MA at specific percentages of FFS spending levels. Beginning in 2017, after a transition period from 2012 through 2016, a county benchmark will be at one of four quartile levels—95 percent, 100 percent, 107.5 percent, or 115 percent of the FFS rate projected for that county for the year—with the quartile assignment based on the relative FFS spending levels among counties during the preceding year.[9]

Figure 1-1 compares local FFS spending and MA benchmarks in 2012 at the county level.[10] Each point represents a county, with its FFS spending per beneficiary per month on the horizontal axis and its MA benchmark on the vertical axis. (There were a total of 3,144 counties in the United States in 2012.) The county-level FFS spending ranged roughly between $500 and $1,300, although the majority of counties were clustered between $600 and $800. Along the 45-degree line, the county-level FFS spending equals the MA benchmark. Figure 1-1 shows that the majority of counties were above the 45-degree line in 2012, with MA benchmarks above FFS spending. Counties with similar FFS average spending can have different MA benchmarks because 2012 is the first transition year for moving to benchmarks determined solely as a percentage of FFS, as provided for in PPACA.

Under current law, the MA benchmarks (before quality bonuses) are transitioning to those specified in PPACA. Figure 1-2 shows what MA benchmarks are likely to be by 2017 when PPACA benchmarks by quartile are in full effect. There are discrete changes at the boundaries of each quartile where benchmarks change from 115 percent to 107.5 percent, 107.5 percent to 100 percent, and 100 percent to 95 percent. Because the majority of counties had FFS spending between $600 and $800 in 2012 (shown in Figure 1-1), the FFS spending range for the two middle quartiles is small, between $646 and $751. In addition, Medicare beneficiaries are unevenly distributed across the county quartiles. For example, in 2012, 15 percent of Medicare beneficiaries were living in counties in the lowest FFS spending quartile compared with 44 percent in counties in the highest FFS spending quartile.

Relationship between FFS spending and ACO benchmarks

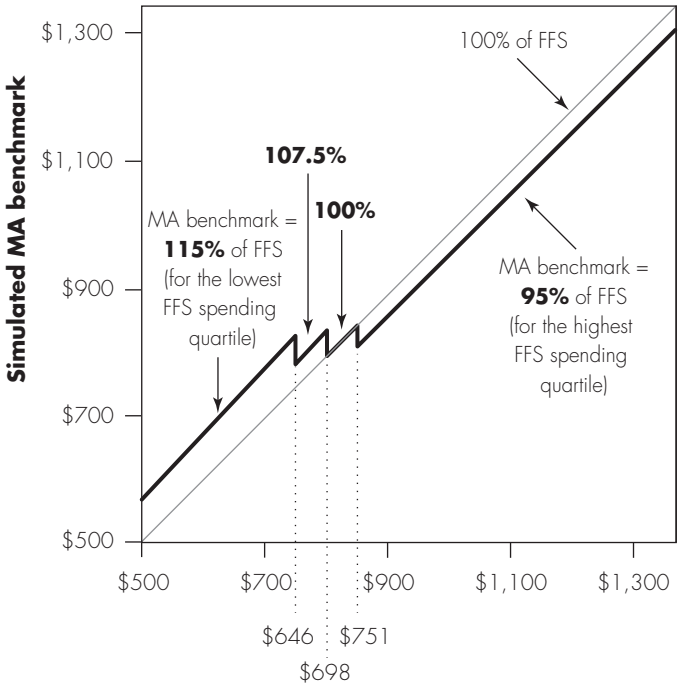
Pioneer ACO benchmarks are based on the historical Part A and Part B Medicare spending for individuals assigned to the ACO. These historical FFS spending numbers are trended forward to get the ACO's benchmark level of spending. By contrast, MA plans use county average

FFS spending trended forward by the CMS actuaries' projection of changes in spending for the forthcoming year (with rates announced in April of the preceding year). For these reasons, the FFS spending that is used to set MA benchmarks is not the same FFS spending used to set ACO benchmarks.

On average, the Pioneer ACOs' beneficiary-specific level of risk-adjusted spending in 2012 was slightly below the CMS actuaries' projected average FFS spending in the county. In other words, Pioneer ACO providers appeared to have slightly lower costs than average providers in 2012. However, that is only the average. Some ACOs have spending per beneficiary that is higher than we would expect given their beneficiaries' risk scores and average spending in their beneficiaries' counties of residence. Others have lower historical spending than would be predicted given their beneficiaries' risk scores and county of residence. As a result, some ACOs would do better if their benchmark were based on beneficiary-specific historical spending, and other ACOs would do better if their benchmark were based on the risk-adjusted average spending per beneficiary in the county.

In cases where the ACO's level of service use is similar to the average for its county, the ACO will have an easier time generating shared savings in markets where historical service use is relatively high. The 32 Pioneer ACOs are slightly more likely to be in markets with relatively high FFS spending. The quartile of counties with the highest spending contains 69 percent of the Pioneer ACOs, 74 percent of Pioneer ACO beneficiaries, and 44 percent of all Medicare beneficiaries.

FIGURE 1–2 **MA benchmarks specified in PPACA by county quartiles, 2012**



Note: MA (Medicare Advantage), PPACA (Patient Protection and Affordable Care Act of 2010), FFS (fee-for-service). PPACA provisions set county benchmarks for MA at specific percentages of FFS spending levels. Beginning in 2017, after a transition period from 2012 through 2016, a county benchmark will be at one of four quartile levels (95 percent, 100 percent, 107.5 percent, or 115 percent of the FFS rate projected for that county for the year) with the quartile assignment based on the relative FFS spending levels among counties during the preceding year. The ranges of FFS spending for the quartiles shown in the figure are based on the quartile assignment of the PPACA benchmarks by CMS for 2012. Data include U.S. counties only (not territories).

Source: MedPAC analysis of 2012 CMS MA bid data.

Synchronizing benchmarks for ACOs and MA plans

As a starting point for our analysis, we explore the concept of synchronized benchmarks by defining financial neutrality as setting the benchmark for ACOs and MA plans equal to spending in FFS—which we define to include both beneficiaries in traditional FFS and beneficiaries in ACOs. We include both populations in the benchmark because, as ACOs become more common, the population left in traditional FFS may become small and unrepresentative of the market. Conceptually, one might want to set the benchmark at the spending for a beneficiary served by the efficient health care delivery system, analogous to how the Commission looks at payments in the FFS settings relative to the efficient provider. However, we cannot estimate what that spending level is at this point. Eventually, it might be approximated as a function of MA bids, ACO spending, and spending in traditional FFS. For this chapter, we use local FFS as the starting point for the analysis. The Commission recommended setting MA benchmarks at local FFS in the past, and data on FFS spending are readily available.

The benchmark refers to the level of program spending that will trigger a potential bonus or penalty. For example, if spending in an ACO is materially below the benchmark,

the ACO would share in savings with Medicare. Similarly, if an MA plan bid is below the same benchmark, the MA plan would keep some of those savings through rebate dollars, which are used to fund the cost of extra benefits (including a profit margin and administrative expenses) or lower premiums to attract enrollees. By contrast, if ACO spending is above the benchmark, the ACO would be penalized by paying a share of the excess to Medicare. If the MA plan bid is above the same benchmark, it would become less attractive to beneficiaries because the beneficiary would need to pay the difference between the benchmark and the MA bid.

In this section, we illustrate that no one payment model (ACO, MA, or FFS) always yields the lowest program payments in all markets after benchmarks are synchronized to equal 100 percent of local FFS. In some cases, MA plans have lower program payments; in other cases, expected ACO or expected FFS spending would be lower. To illustrate the lack of dominance of one model, we simulate program spending for the three payment models under three different benchmark scenarios. The first scenario is based on the actual benchmarks for MA plans and ACOs in 2012; the second scenario is based on the synchronized benchmarks set equal to local FFS spending for both MA plans and ACOs; and the third uses MA benchmarks at the fully transitioned PPACA levels of 2017. We simulate the three scenarios to show that even after MA benchmarks are synchronized to FFS or moved to the levels mandated for 2017, no one payment model (ACO, MA, FFS) will uniformly have lower program spending than another model in all markets across the country.

The fundamental lesson from the simulations is that relative to FFS, MA and ACO spending varies by market. Driving volume to one model may not be desirable if that model is not always the best with respect to cost and quality. By setting benchmarks to be equal across each model, the models can compete in each market for beneficiaries. MA plans can compete for beneficiaries through the enrollment process, and ACOs can compete for beneficiaries by convincing their patients to continue using ACO primary care physicians. Policymakers may want a common benchmark to level the playing field and encourage beneficiaries to choose the model that will most efficiently give them the care and services that fit their individual preferences. However, whether there is a truly level playing field depends on several details in how overall financial neutrality across payment models is achieved.

Analysis of different benchmarks for ACOs and MA plans

Our simulation starts by showing how the current mix of benchmarks causes the relative Medicare program cost of the three payment models to vary across and within markets in 2012. Using data for 646,000 individuals assigned to Pioneer ACOs, we compared the expected FFS spending of these individuals with actual ACO program spending and simulated MA program spending. The simulated level of MA spending is what the Medicare program would have paid MA plans (including rebate dollars) if the 646,000 beneficiaries had chosen to join MA plans in proportion to each MA plan's current market share in each beneficiary's county of residence. The simulation uses three different sets of MA benchmarks: 2012 benchmarks, benchmarks synchronized to FFS, and 2017 benchmarks.

ACO spending was usually lower than MA simulated spending using 2012 MA benchmarks

As we have reported in the past, payments to Medicare Advantage plans in 2012 were higher on average than payments would have been under FFS (Medicare Payment Advisory Commission 2014). We modeled what MA payments would have been for the 646,000 beneficiaries assigned to Pioneer ACOs who live in markets where we have data on MA plan costs, including costs of MA HMO plans.[11] CMS estimated that the Medicare program would have spent an average of $11,662 per beneficiary on these 646,000 beneficiaries under the traditional FFS model (Centers for Medicare & Medicaid Services 2013).[12] Among the 31 ACOs, 18 had lower spending than expected FFS spending, and 13 had higher spending than expected. Random variation drives much of the spending variance on an individual ACO basis, but on average both the Center for Medicare and Medicaid Innovation (CMMI) and an independent review suggest modest savings from the Pioneer ACO model relative to expected traditional FFS spending (Centers for Medicare & Medicaid Services 2013, L & M Policy Research 2013).

We computed expected payments for MA plans using data from CMS that showed the spending per capita on the combined Part A and Part B benefit plus rebate-financed supplemental benefits by county. We assumed that the ACO populations would have joined MA plans in proportion to the rates that other individuals in their county joined in 2012. For example, if a particular HMO now has a 50 percent market share, we assume that the plan would continue to have a 50 percent market share

TABLE 1–2

Lowest program-spending model for 31 sets of beneficiaries aligned with Pioneer ACOs under three different benchmark systems

Method for setting MA benchmark	Cases for which expected traditional FFS spending would be the lowest	Cases for which ACO model would produce the lowest spending	Cases for which MA payments would have been lower than traditional FFS or actual ACO spending
2012 MA benchmarks	12	18	1
MA benchmarks set at 100% of average FFS spending plus a quality bonus	8	11	12
2017 MA benchmarks	7	10	14

Note: ACO (accountable care organization), MA (Medicare Advantage), FFS (fee-for-service). A total of 31 Pioneer ACO sites had MA HMO plans in their market and were evaluated.

Source: MedPAC analysis of CMS claims files and MA enrollment and county-level payment files.

after ACO beneficiaries shifted to MA plans. A more detailed description of the methods is in online Appendix 1-A, available at http://www.medpac.gov. For the 31 ACO markets with significant MA penetration in 2012, the MA payment rates were, on average, 5 percent higher than expected traditional FFS payments.[13] In contrast, in that year, payments for ACO beneficiaries' care were roughly 1.2 percent below expected FFS payments before paying out shared savings and were a net 0.7 percent lower than FFS after paying out shared savings bonuses.

When we compared estimated spending for each of the three payment models in the 31 areas we studied using 2012 MA benchmarks, we found that program spending was lowest in the ACO model in 18 of the 31 cases (Table 1-2, row 1). This finding is consistent with the aggregate ACO cost figures, external evaluations of the Pioneer ACO model, and findings from some private sector ACO evaluations. These analyses all point to ACOs, on average, reducing spending by a modest amount (1 percent to 3 percent) before bonuses were paid to the ACOs and saving 1 percent or less after paying out the shared savings bonuses (L & M Policy Research 2013, Song et al. 2012). Expected FFS spending was the lowest spending payment model in about one-third of the markets, possibly due to random variation, the lack of success of ACO activities in those markets due to FFS costs already being relatively low, or both. Simulated MA payment was the lowest spending payment model in only 1 of 31 markets. This result is generally because MA plans have benchmarks set by law that are above FFS rates, allowing them to bid above FFS costs, and consequently the plans receive payments above FFS levels. Even if the plans bid below FFS levels for the basic Part A/Part B benefit, the rebate dollars that are provided to the plan to fund extra benefits often result in payments above FFS rates.

No one model was uniformly less costly with MA benchmarks set equal to FFS

The second simulation we conducted was to evaluate how much payments for the 646,000 ACO beneficiaries would have been if they had been in MA plans and if the MA benchmarks were moved to 100 percent of FFS spending for the average beneficiary in each county. If MA benchmarks were set at the local FFS spending per beneficiary and bids remained constant, simulated MA plan payments would have been roughly 1 percent less expensive than FFS spending on average due to a decline in benchmarks resulting in a reduction in rebate dollars that are used to pay for supplemental benefits. Savings could be materially greater than 1 percent if bids declined when the benchmark declined. However, even if the base MA benchmark were set equal to FFS spending, MA plans could still cost more than FFS Medicare in some markets due to quality bonuses pushing payments above FFS rates.

In our simulation, we assumed county-level FFS rates were at the benchmark and the quality bonuses moved the benchmark up by 3 percent on average to 103 percent of

FFS spending. Given these assumptions, MA would be the lowest program-spending payment model in 12 of the 31 markets in our simulation (Table 1-2, row 2, p. 11). In eight other markets, FFS would have lower program payments than MA due to the MA quality bonus or to the particular group of patients attributed to ACOs having lower FFS costs than the average in their counties. In these eight cases, FFS would also cost less than ACOs due to random variation or a failure of some ACOs to lower spending. In the remaining 11 cases, ACOs would continue to generate savings larger than MA; this could happen in cases in which MA plans bid near the FFS benchmark and ACO program spending is below average FFS spending in the county.

We also examined how payments would change under the proposed 2017 benchmarks. In 2017, the benchmarks will range from 95 percent to 115 percent of FFS spending plus potential increases in the benchmarks for quality bonuses.[14] In this scenario, we would expect average payments to MA plans to be 3 percent lower than the average FFS program payments because, for most ACO markets, the new benchmark in 2017 will be 95 percent of FFS spending (100 percent of FFS spending with the quality bonus for qualifying plans) and some plans will bid below the benchmark. While MA is estimated to be the low-cost option in 14 of 31 markets under 2017 payment rules, there would still be some markets with benchmarks above 100 percent of local FFS spending (up to 115 percent plus quality bonuses) where program spending for MA would be more than for FFS or ACOs (Table 1-2, row 3, p. 11).

The main point of this simulation exercise is to show that no one payment model (MA, ACO, or pure FFS Medicare) would always be the low-cost model in all situations. The relative cost of the three models will depend on regional differences in care delivery, on the effectiveness of MA plans and ACOs in restraining cost growth, and on decisions regarding how quality bonuses and risk adjustment factor into the benchmarks.

Implications of synchronizing benchmarks for ACOs and MA plans

The simulations confirm what the Commission has said in the past: If more beneficiaries joined MA plans under 2012 payment rules, Medicare spending would increase because of high benchmarks. The level of the benchmark will determine the average relative costs across the three payment models. The second implication is that even under the proposed changes to the benchmarks that will take place in 2017, no one payment model will always result in the lowest Medicare program payments. This finding implies that efficiency can be gained by synchronizing the benchmarks to level the playing field. Beneficiaries then can choose the model that best serves their preferences, which could be going to an ACO-affiliated primary care physician, seeing an unaffiliated primary care physician, or joining an MA plan and using a physician in the MA network.

It is important to note that which ACOs are likely to be successful depends on how the ACO benchmark is determined and whether patients served by ACO primary care physicians historically have payments above or below the county average. For this reason, how to set ACO benchmarks is a policy question because it affects which ACOs will want to participate in the program.

On the one hand, setting benchmarks based on the ACO beneficiaries' past experience, as is now the case, should attract high-cost physician practices into the ACO program. This result would occur because, if ACOs are initially high cost relative to other providers in the county, they have room to improve compared with their own historical benchmark. High-cost ACOs would enter and hope to bring costs down to earn shared savings bonuses. The rationale for using a historically based benchmark is that ACOs could learn to reduce unnecessary services. If this rationale were correct, then FFS spending would decrease in the area (because ACO beneficiaries remain in FFS), and if MA benchmarks were set to local FFS spending, the MA benchmarks would eventually also decrease. ACOs with historically low costs relative to the local area would be less likely to enter the program because they would have difficulty improving under benchmarks derived from their own beneficiaries' past experience.

On the other hand, if benchmarks were set at the local FFS average, ACOs that were low cost to begin with would be more likely to enter the program. Those ACOs would have an easier time improving relative to a benchmark based on county average spending because they are low cost and would start with a per beneficiary cost below the local FFS average. The rationale for setting benchmarks at local FFS spending would be to reward low-cost ACOs and expect that they would attract patients and other providers to them over time. This approach would eventually lower not only FFS Medicare spending (because ACO beneficiaries remain in FFS), but also MA benchmarks, if those are set at local FFS spending. However, Medicare spending may increase in the short run because shared savings bonuses

would be paid to low-cost ACOs that were already treating beneficiaries at below average costs without reward.

If the eventual goal is to synchronize MA and ACO benchmarks, then the ACO benchmarks could be transitioned from using beneficiaries' historical costs toward using average costs of beneficiaries in the county. Eventually, ACO benchmarks would be based solely on average FFS spending in the county (FFS spending is defined to include both spending on beneficiaries in traditional FFS and spending on beneficiaries in ACOs). The movement toward prospective county-level benchmarks could be designed to be gradual enough to bring some high-spending physician groups into the ACO model while not discouraging low-spending ACOs from participating.

In addition to affecting which providers enter the ACO program, we have seen some evidence that benchmarks can affect who leaves the ACO program. While the sample size is limited to 31 ACOs, those ACOs that had benchmarks below expected local FFS costs in their county tended to leave the program at a higher rate than those that had benchmarks above local FFS costs. In other words, ACOs that were the relatively low-cost providers in their county were more likely to leave the Pioneer ACO program. (One way to potentially encourage more ACOs to stay in the program is to let ACOs share some of their savings with beneficiaries; this approach could increase beneficiaries' use of ACO providers relative to out-of-network providers. For example, further work could be done to evaluate ways to give beneficiaries assigned to ACOs lower cost sharing when they visit ACO-aligned physicians.)

Additional considerations in synchronizing benchmarks

As a general principle, payment policy may adjust for factors that affect the expected cost of Medicare benefits. For example, beneficiaries in worse health have higher spending because they have higher use of health care. Medicare payments should accurately reflect and adjust for differences in expected cost based on health status. Additionally, relative to some reference level, Medicare payments may adjust upward for higher quality of care. One way to account for those differences in a payment model is to adjust spending benchmarks for those factors. Therefore, synchronizing benchmarks would also need to address how to adjust benchmarks with respect to risk adjustment, quality measurement, and spending variations across markets. Detailed discussions of the issues related to risk adjustment and quality measurement are included in Chapter 2 and Chapter 3, respectively, of this report.

Risk adjustment

The purpose of risk adjustment is to adjust Medicare payments to accurately reflect how much each beneficiary would be expected to cost based on his or her health status. Without risk adjustment, health plans and providers at financial risk for patients' treatment costs will have financial incentives to avoid beneficiaries who are expected to cost more and seek out those who are expected to cost less. Under current rules, risk adjustment differs between MA plans and Pioneer ACOs.

MA plans receive monthly capitated payments for each enrollee, calculated by multiplying a base rate (which reflects the payment if an MA enrollee has the health status of the national average beneficiary) by a risk score (which indicates how costly the enrollee is expected to be relative to the national average beneficiary). Currently, the MA program uses the CMS–hierarchical condition category (CMS–HCC) model to risk adjust each MA payment. This model uses enrollees' demographics and medical conditions in a prior year collected into HCCs to predict their costliness.[15]

By contrast, Pioneer ACOs use prior spending for beneficiaries aligned with the ACO as the predictor of the beneficiary's costliness. In the Pioneer ACO model, the historical spending of beneficiaries attributed to the ACO is adjusted for spending growth based on their demographics. In other words, growth rates vary by demographic characteristics, such as age, sex, and eligibility for Medicaid.

If ACOs and MA plans are to move toward synchronized benchmarks, it may be reasonable for the risk-adjustment methods to converge as well. If payments are to become prospective, then the risk-adjustment method also would have to be prospective. The resulting method may be similar to the MA method of using prospectively determined risk scores for each beneficiary.

A current problem is that MA plan providers have an incentive to code MA patients more intensively, making it look as if MA patients' health has been declining more rapidly than similar patients in FFS. More intensive coding means higher payment rates for the MA plan (see Chapter 2 of this report). To limit potential distortions from more

intensive coding, a condition could be added that, for beneficiaries who stay in an MA plan for two years, MA payment rates would not increase faster than average just because the medical records suggest that the MA patients were getting sicker at a faster rate than unmanaged FFS patients. Any HCC risk scores that suggest that ACO or MA patients have health that is declining faster than expected would be reduced so the ACO or MA plan would not be rewarded for either intensive coding or poor quality care. The Pioneer ACOs (and MSSP ACOs) already have this limit on HCC growth; a similar approach could be applied to MA plans.[16]

Quality measurement

Quality measurement is an essential part of payment policy for MA plans and ACOs. Under current rules, MA plans are rewarded with a higher benchmark for higher quality, whereas ACOs are penalized by losing some of their shared savings if they do not meet quality benchmarks. In an MA plan, quality scores also are important signals for beneficiaries when choosing among plans, as well as being tied to bonuses. (The plan can get a bonus if it attains a specific level of overall quality. The bonus consists of a higher benchmark and allowing the plan to keep a larger share of the rebate. See the MA chapter in the March 2014 report to the Congress for details.) For ACOs, lower quality scores decrease the share of the savings that the ACO can keep. The quality protection in ACOs is that beneficiaries are free to choose other providers at any time if they feel that the care they are receiving is not of high enough quality. Thus, there is a certain asymmetry in the use of quality scores between MA plans and ACOs that will persist even if the payment benchmarks are more closely synchronized.[17]

To align quality measurement between MA plans and ACOs, the same set of population-based outcome measures could be used for both payment models because both MA plans and ACOs are accountable for a defined population. Bonuses or penalties for quality performance could also be similar. For example, MA plans with quality scores above the average for the area could receive higher payments than those with lower scores. Similarly, ACOs with quality scores above average could receive higher payments than ACOs with lower scores.

Concerning quality measurement for FFS Medicare, however, the Commission's current discussions distinguish between using population-based outcome measures for public reporting and making payment adjustments (see Chapter 3). For reporting purposes only, the same set of population-based quality measures would be used across all three payment models.

For the purpose of adjusting payments, however, there would be differences between FFS and the other two models. Traditional FFS would continue to use provider-based quality measures for payment adjustments because FFS providers have not explicitly agreed to be responsible for a population of beneficiaries. Provider-specific quality payments, such as reductions in payments for high readmission or infection rates at specific hospitals, would need to continue as under current law.[18] For the MA and ACO models, the population-based outcome measures reported for the FFS Medicare population—including both the population in traditional FFS and the population in ACOs—would be used as the reference level of quality to determine whether the MA plans and ACOs in the same local area would qualify for higher payments.[19] In other words, only the MA plans and ACOs that outperformed FFS Medicare on those quality measures would get higher payments. Furthermore, adjustments to payments in quality would be comparable between MA and ACO models.

Spending variations across markets

For discussion in this chapter, we assume a common benchmark for ACOs and MA plans based on local FFS spending levels. If the benchmark were set on national FFS spending levels, ACOs and MA plans could earn bonuses without any changes in practice patterns in low-cost areas. In addition, MA plans and ACOs would be less likely to enter high-cost areas, where they are needed most.

Under current law, MA benchmarks in high-spending counties will be reduced to 95 percent of local FFS spending. There are other possible policy options. One would be to move toward competitive bidding and base benchmarks for MA plans and ACOs on the result of the competitive bidding. MA and ACO benchmarks also could be set at a blend of the bids and traditional FFS spending. This option could encourage MA plans and ACOs to enter the market by retaining a level of potential profits for those eliminating excess use. Another option would be to have beneficiaries pay more if they elect to forgo lower cost options. (For a general discussion of who should pay for spending variations across markets, see online Appendix 1-B, available at http://www.medpac.gov.)

Regardless of whether and how the benchmarks are adjusted for spending variations across markets, defining a market consistently across the payment models is important to a synchronization policy. Currently, MA

benchmarks are at the county level. The Commission has recommended using larger geographical areas—metropolitan statistical areas (MSAs) and health service areas outside MSAs—to define payment areas in order to reduce year-to-year volatility in benchmarks and payment rates and to decrease differences between neighboring areas (Medicare Payment Advisory Commission 2005). Under the recommendation, MA plans would bid to serve the entire payment area. This approach, however, may be problematic for the ACO model. For example, if benchmarks were set based on average spending in an MSA, then physician groups serving low-cost areas within the MSA could join an ACO, whereas those serving high-cost areas within the MSA could decline to join an ACO. In other words, through their selection of providers, ACOs could indirectly define a market that is smaller and more favorable than a market for MA plans. Yet, allowing different definitions of a market between ACOs and MA plans seems inconsistent with the goal of synchronizing policy across all three payment models.

Moving forward

There are various approaches to synchronizing Medicare policy across payment models. This chapter represents the Commission's initial exploration and is not intended to be a definitive or comprehensive discussion. From the program perspective, approaches include considering spending benchmarks, risk adjustment, quality measurement, and regulatory oversight. From the beneficiary perspective, approaches include considering how beneficiaries learn about the Medicare program, choose plans, and respond to financial incentives. The Commission will continue to develop those approaches in the future.

Our discussions so far have focused on the Medicare program's perspective, specifically on how the program pays under each model. However, we also need to consider what the payment models look like from the beneficiary's perspective. For example, for the beneficiary, traditional FFS and ACOs look essentially the same. Under both models, beneficiaries get the same Medicare benefit package. In the case of an ACO, beneficiaries' provider history determines their attribution to an ACO. Although ACO providers can informally encourage beneficiaries to stay within the ACO, there are no rules preventing beneficiaries from going to other providers outside the ACO. In fact, since beneficiaries do not enroll in ACOs but rather are attributed to ACOs, some beneficiaries currently attributed to an ACO might not be aware of their inclusion in this payment and delivery arrangement.

By contrast, beneficiaries' experience in MA is different. First, they must enroll in an MA plan. Second, their benefits may vary across MA plans, such as different cost-sharing requirements and extra benefits if the plan bid is less than the MA benchmark. Finally, MA plans generally have a limited network of providers, a feature that contrasts with FFS Medicare and ACOs, where beneficiaries' choice of providers is unrestricted.

Consistent with the goal of encouraging beneficiaries to make cost-conscious choices about their health care, the Commission wants to better understand how beneficiaries actually make decisions and respond to financial incentives under Medicare. Currently, beneficiaries make choices regarding their options for Medicare coverage, such as choosing between traditional FFS and MA plans, in response to premiums and benefit designs. In general, their experience under the Medicare prescription drug benefit and MA suggests that some beneficiaries respond to financial incentives in choosing a plan, such as year-to-year changes in premiums and out-of-pocket spending. However, the decision-making process can impose nonmonetary and psychological costs, such as time and effort spent on researching plans. Moreover, beneficiaries find that the process of selecting or changing plans can be complicated and confusing. Given the perceived complexity associated with the process, the Commission recognizes that Medicare should make beneficiaries' decision making simpler and easier. For example, there are multiple ways of getting information, including in person, the 1-800-MEDICARE helpline, printed mailing, and online. Consistent presentation of information across channels may create choices that are easier to compare and could mitigate some of the costs in decision making.

From the program's perspective, the principle of financial neutrality is important in synchronizing Medicare policy across payment models. If the Medicare program provides a higher subsidy for one choice compared with another, the program would not be financially neutral with respect to the beneficiary's choice. However, if beneficiaries find it difficult to determine which payment model offers the highest value for them, or if they associate complexity with the process, the issue of how to design and communicate beneficiary incentives across payment models is also important. The Commission plans to examine what synchronized policy across payment models would look like from the beneficiary perspective. ■

Endnotes

1 The Part A and Part B benefit package in MA excludes hospice. In our March 2014 report, the Commission recommended including the Medicare hospice benefit in the MA benefits package beginning in 2016 (Medicare Payment Advisory Commission 2014).

2 In MA, private FFS plans have the option to offer Part D benefits, and Medicare medical savings account plans are not permitted to offer Part D coverage. All other plan types must offer at least one option with Part D coverage.

3 The local MA benchmark for a plan serving only one county is the county benchmark rate. Plans serving multiple counties would have a weighted benchmark based on the expected enrollment coming from each county. Regional PPO plans, another option within MA, bid in relation to regional benchmarks, which are set under a different methodology.

4 MA plans with a quality rating of 4 or higher (on a scale of 5) get a 5 percentage point increase in their benchmarks. In addition, MA plans with a quality rating of 4 or higher in 223 specified counties (based on their FFS spending, MA penetration rate in 2009, and urban floor status in 2004) get an additional increase of 5 percentage points in their benchmarks. For example, an MA plan with a quality rating of 4 in a county where the benchmark equals 95 percent of local FFS gets 100 percent of local FFS as its benchmark. In 2014, under the quality bonus program demonstration, MA plans with a quality rating of 3 or 3.5 also get higher benchmarks.

5 Part of the rebate dollars pays for the administrative cost and profit of those supplemental benefits other than reduction of the Part B premium or Part D premium.

6 Another difference is that beneficiaries with end-stage renal disease (ESRD) are not permitted to enroll in MA plans as new enrollees (but a beneficiary may remain enrolled in a plan after developing ESRD, and some MA special needs plans do enroll beneficiaries with ESRD). ACOs are responsible for the cost of care for beneficiaries with ESRD. The Commission has recommended doing away with the prohibition on MA enrollment of beneficiaries with ESRD (Medicare Payment Advisory Commission 2004).

7 The Pioneer ACOs originally tracked beneficiary-specific costs. However, starting in 2015, Pioneer ACOs will use a cross-sectional approach similar to the benchmarking in the MSSP program. Beneficiaries will still be prospectively assigned to the Pioneer ACOs, but the benchmark spending for those beneficiaries will be based on the risk-adjusted historical costs of patients (including decedents from prior years) served by ACO physicians, and those risk-adjusted costs will be trended forward to set the benchmarks.

8 In principle, spending above the benchmark would trigger penalties, and spending below the benchmark would trigger bonuses. But to account for the effect of random variation, there is a corridor of 1 or 2 percent around the benchmark where penalties and bonuses are not given. Quality is taken into account by varying the shared savings amount.

9 If a county changes its quartile position from one year to the next, then the percentage of the FFS amount determining the county benchmark will be the average of the two percentages in each of the different years.

10 FFS spending for 2012 is projected and excludes hospice, direct graduate medical education, and indirect medical education payments to make it comparable with the MA benchmarks, which exclude those categories of spending. Both FFS spending and MA benchmarks are standardized for a beneficiary of average health status.

11 There were initially 669,000 beneficiaries in Pioneer ACOs. We excluded beneficiaries who lived in counties not served by an HMO-model MA plan; these counties had only PPO options and relatively low enrollment. In these counties, there were so few MA beneficiaries, the bid data we have may not be good predictors of what bids would be if MA plan enrollment were expanded. As a result, our analysis is based on beneficiaries in 31 Pioneer ACOs.

12 This estimate uses the Pioneer benchmarks, which are based on historical spending for those beneficiaries and the national trend in FFS spending for 2012. This level of spending is higher than national average spending because beneficiaries are assigned to an ACO only if they have claims from that ACO's physicians over the three prior years. In other words, ACOs will not have new beneficiaries or beneficiaries without claims assigned to them. New (younger) beneficiaries and those who did not see a doctor (healthy beneficiaries) are less expensive. Not having any of these less expensive beneficiaries in the ACO results in higher than average costs per beneficiary. In addition, the ACOs tend to be in higher spending counties.

13 This difference between FFS and MA spending for these 31 sets of beneficiaries is similar to the average difference across the nation. In a nationwide examination of 2014 bids for all MA plans (excluding ESRD beneficiaries), MA spending was expected to be 6 percent higher than FFS (Medicare Payment Advisory Commission 2014).

14 Plans earning a quality bonus receive a 5 percentage point increase (or 10 percentage points in some counties) to their benchmark if they have a quality rating of 4 or higher in 2017. We assumed that 60 percent of enrollment would

qualify for the quality bonus in 2017, which is slightly higher than the 51 percent of enrollment that has 4 or more stars in 2014 (Medicare Payment Advisory Commission 2014). We expect an increase in those reaching 4 stars by 2017 due to historical trends and the fact that the incentive to move from 3 stars to 4 stars increases because the performance needed to achieve the bonus will shift from 3 stars to 4 stars by 2017. The results do not change materially if this assumption of 60 percent qualifying for bonuses is moved up or down. See online Appendix 1-A, available at http://www.medpac.gov, for details.

15 The 2013 model uses 70 HCCs, and the 2014 model uses 79 HCCs. See Chapter 2 of this report for a discussion of risk adjustment using the CMS–HCC model.

16 To address this issue, the MA program currently specifies a coding adjustment that reduces the risk score of all MA plans by a set percentage point amount each year. It does not differentiate by plan.

17 MA plans have penalties for lower quality in that rebate dollars are lower for lower quality plans, and CMS can terminate the contract of a plan that has persistently low quality.

18 Through 2017, ACO physicians are exempt from some quality programs, such as the value-based modifier for physician payments. This exemption holds for the provider's ACO and non-ACO patients.

19 This definition—including both traditional FFS and ACO populations in the FFS Medicare population—is consistent with that used for the spending benchmark.

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