ONLINE APPENDIXES

1

Synchronizing Medicare policy across payment models

ONLINE APPENDIX 1-A

Methodology

We compared the program cost of three payment models: traditional fee-for-service (FFS), Pioneer Accountable Care Organizations (ACOs), and Medicare Advantage (MA) plans. The Center for Medicare and Medicaid Innovation (CMMI) provided us with data on Medicare payments for serving the beneficiaries aligned with the Pioneer ACOs. CMMI also provided us with the FFS benchmark (projected FFS spending) that was used to evaluate ACO savings. The CMMI estimates of projected FFS spending and net savings were in aggregate similar to estimates by an outside consulting firm (L & M Policy Research 2013).

Our primary task was to estimate what Medicare would have spent on the Pioneer ACO population of beneficiaries if they had been in MA plans. Because our past research has shown differences in costs across MA plans and because rules governing MA plans will change, we projected costs under several different scenarios. We examined average MA program spending based on actual 2012 benchmarks and bids, what payments would have been if the benchmarks were 100 percent of FFS, and what payments would have been if benchmarks were set based on the rules scheduled to take effect in 2017. The units of analysis are the 31 groups of patients aligned with 31 Pioneer ACOs. In aggregate, these 31 groups represent 646,000 individuals.

To compute what Medicare would have paid MA plans if the ACO beneficiaries were enrolled in MA in 2012, we created a weighted average of the Part A and Part B (A/B) payment and rebate to MA plans in each county by plan type. CMS reports MA enrollment data at the plan level and at the county level. First, we merged files to create a file that included the plan's type (e.g., HMO, dual-eligible special needs plan, preferred provider organization) and county-level enrollment for each plan. To calculate the enrollment-weighted average A/B per member per month (PMPM) payment in each county, we multiplied the average A/B PMPM payment for each type of plan in a county by that type of MA plan's share of MA enrollees in that county. The basic payment rates for A/B benefits and rebate-financed benefits for those beneficiaries in each county who do not have end-stage renal disease (ESRD) are available from CMS at http://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/Plan-Payment-Data-Items/2012data.htmlhttp://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/Plan-Payment-Data-Items/2012data.html.[1] This process creates the enrollment-weighted average program payment to MA plans for A/B benefits for beneficiaries in each county. We calculated the enrollment-weighted PMPM rebate payment amount by the same method. This process gives us the expected MA payment for A/B services in the county (for a standardized beneficiary with a hierarchical condition category (HCC) score of 1) and the average expected program spending on rebate dollars per MA beneficiary in the county. We then computed the expected payments for individual beneficiaries in MA plans as follows.

Estimate 1: Medicare program cost if ACO beneficiaries had been in average MA plans

To estimate hypothetical MA payments for beneficiaries currently enrolled in the Pioneer ACO demonstration (the counterfactual), we made the following computations:

Total program payments = payments for A + B services + payments for rebate-financed benefits[2]

- Payments for A + B service = ((standardized average MA A/B payment[3] in the county) × (number of months alive and not in hospice in 2012) × (individual's HCC risk score)) + indirect medical education payments for the beneficiary's admissions (that would still be paid by FFS if the person joined MA) + FFS hospice payments for the beneficiaries (that would be paid by FFS if they joined MA)
- Payments for rebate-financed benefits = (average supplemental payments in the county) × (number of months alive in 2012)

The rebate-financed benefits reported are the average payments for extra benefits in MA plans. We did not adjust them for the risk score because ACO members tend to have higher risk scores than average and may have rebate-financed benefits that are lower as a percentage of total payments (but higher in total dollars). Not making this adjustment may have slightly understated the relative program spending for MA plans.

If a patient is enrolled in MA, then FFS Medicare (not the MA plan) continues to pay for hospice care and medical services after the person enters hospice. On average, for every $15 of hospice spending, FFS Medicare also pays an additional $1 for nonhospice FFS medical care provided to MA beneficiaries. Therefore, actual hospice claims data were multiplied by 16/15 to estimate the total FFS

spending once a person enters hospice. Because hospice use varies widely by region, we used the actual hospice use of ACO beneficiaries to estimate MA hospice use. If MA plans increased hospice use, that would slightly increase relative program spending for the MA program beyond our estimates because hospice costs are currently paid under the FFS Medicare program and are not part of the MA benefit.

Estimate 2: MA spending for ACO beneficiaries if the benchmark were 100 percent of FFS spending in a county and the quality bonus were allowed

In the past, discussions of payment neutrality across sectors have considered using 100 percent of FFS as the benchmark. In this model, we use 100 percent of a county's average FFS spending as the benchmark and account for quality bonuses. To compute what MA payments would be, we made the following computations:

Total payments = payments for A + B services + payments for rebate-financed benefits

- Payments for A + B services = ((lower of A/B bid or FFS spending[4] in the county) × (number of months alive and not in hospice in 2012) × (individual's HCC risk score)) + indirect medical education payments for the beneficiary's admissions (that would still be paid by FFS if the person joins MA) + FFS hospice payments for the beneficiaries (that would be paid by FFS if they join MA)
- Payments for supplemental services = (average supplemental payments in the county if the benchmark was lowered to 100 percent of FFS county spending) × (number of months alive in 2012)

The FFS spending reported by ACO patients in the Pioneer demonstration is similar to what would have been expected given their risk scores and location. We compared reported FFS spending by CMMI with the projected spending in the CMS rate book for 2012 ("Budget Neutral Credibility Blended FFS Rate" from the 2012 CMS rate book file available at http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Ratebooks-and-Supporting-Data-Items/2012Rates.html). We found that, after adjusting for indirect medical education and hospice spending, the projected aggregate FFS spending reported by CMMI for ACO beneficiaries is close to the projected spending if we had used the actuary's projections of 2012 spending. Therefore, the benchmark used on average for the ACOs was roughly equal to what the benchmark would have been for MA plans if the basic benchmark (not including quality bonuses) had been 100 percent of FFS.

Estimate 3: Medicare costs if all ACO beneficiaries had joined MA plans in 2012 and the benchmarks were lowered as they are projected to be by 2017

To compute what the Medicare program payments would have been in 2012 if the 2017 benchmark policy was in place, we did the following:

Beginning in 2017, a county benchmark will be at one of four quartile levels (95 percent, 100 percent, 107.5 percent, or 115 percent of the projected FFS spending for that county for the year) with the quartile assignment based on the relative FFS spending levels among counties during the preceding year. We made these adjustments to county-level FFS spending and then multiplied the result by the risk score to get the benchmark for the individual. The expected spending was then equal to the current bid (risk adjusted) plus 60 percent of the difference between the bid and the new benchmark (for bids below the new benchmark). The Medicare program rebate as a share of the differential (60 percent) is an average of what we expect the government's share of these costs to be in 2017. The range will be 50 percent to 70 percent, depending on the MA plan's quality score.

We also had to estimate how much of a quality bonus ACOs would receive when setting the benchmark. Under current law, MA plans will get a 5 percent quality bonus in 2017 if they are rated with 4 stars, 4.5 stars, or 5 stars. Currently, roughly half of MA enrollment is in plans that meet this criterion. In some low-spending areas, MA plans can also qualify for a double bonus (a 10 percentage point increase in their benchmark). We estimate an average bonus of 3 percent in the benchmark due to the quality bonus. If MA plans provided higher quality, spending would increase. If they had lower than average quality scores, spending would be lower.

A key question involves projecting what bids would be when benchmarks are lower. We assumed the bid would remain the same if it is below the new quality-adjusted benchmark using 2012 data and 2017 policy. However,

for cases in which the new benchmark is lower than the current bid (it often is for areas where the benchmark is being lowered to 95 percent of FFS), we lowered the amount Medicare paid to the new benchmark. It is possible that savings would be greater than our simulation shows if bids decreased to a level below the lowered 2017 benchmarks. However, it is also possible that some MA plans will drop out of the program if they cannot provide care for 95 percent of the projected FFS costs.

Risk score

We took the risk score from the Medicare risk-adjustment system and normalized the score so the average risk score equals 1. This calculation was also done for MA before payments are made.

Risk scores were not adjusted for the 3.41 percent MA coding adjustment that CMS made for MA patients in 2012. We did not make the MA coding adjustment to the FFS data because the claims data we have are for patients who were in the FFS system and are not subject to the more intensive coding associated with being in an MA plan. The implicit assumption we are making is that the risk scores would have increased by 3.41 percent on average if the beneficiaries had joined MA plans. CMS would have then reduced the risk score by 3.41 percent to account for more intensive coding of MA beneficiaries. ■

Endnotes

1 For traditional MA beneficiaries, CMS publishes county-level data on program spending for Part A and Part B benefits as well as for program spending for supplemental benefits. These data are not available for the beneficiaries on dialysis. Therefore, we need an alternative method for estimating the cost of the ESRD beneficiaries in our simulation of the MA counterfactual. We modeled MA payments for dialysis patients using the 2012 statewide ESRD benchmarks (published for dialysis patients, who are about 70 percent of beneficiaries with ESRD), each patient's dialysis risk score, and historical data on the relationship between MA bids and the benchmarks. This calculation yielded average program payments to MA plans of $6,900 per month per beneficiary on dialysis, which is essentially equal to average FFS costs. Only 1 percent of Pioneer ACO beneficiaries received dialysis (an x72 claim) in 2012; therefore, small changes in our methodology would not materially affect the simulation results. Under current law, the only MA beneficiaries on dialysis are those who were in an MA plan (as a Medicare or non-Medicare member) before being diagnosed with ESRD; FFS beneficiaries already diagnosed with ESRD must stay in FFS Medicare, with a few exceptions. As noted previously, the Commission has discussed changing this limitation (Medicare Payment Advisory Commission 2004).

2 It is mandated that the MA plan spend the rebate dollars on supplemental benefits.

3 The standardized average MA A/B payment is the average A/B payment for plans serving beneficiaries in the counties where ACO patients live. We assume that the ACO beneficiaries would have weighted purchases across the different MA plans equal to the distribution of purchases made by beneficiaries in the county where the ACO beneficiary lives. The average payment in the county reported by CMS for Medicare A/B benefits is standardized by dividing the payment by the patients' risk scores.

4 The average MA plan bid is modeled to be equal to the lower of the current bids or the average FFS spending in the county. From a program spending perspective, even if the bid was above FFS spending in the county, the program would pay only at the FFS level; the beneficiary would have to cover any additional MA cost.

References

L & M Policy Research. 2013. *Evaluation of CMMI accountable care organization initiatives.* Report prepared for the Centers for Medicare & Medicaid Services under contract HHSM–500–2011–0009i/HHSM–500–T0002. Washington, DC: L & M Policy Research.

Medicare Payment Advisory Commission. 2004. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

ONLINE APPENDIX 1-B

Who should be responsible for regional variation in costs?

TABLE 1–B1 **Who is responsible for variation in Medicare spending across regions and models?**

	Share of responsibility for variation in Medicare spending			
	Beneficiary		Medicare program	
Option for setting base beneficiary and program contributions[1]	**Risk (+/–) for variation in Medicare spending across regions**	**Share of cost associated with model choice**	**Risk (+/–) for variation in Medicare spending across regions**	**Share of cost associated with model choice**
Current Part B system: Fixed national Part B premium buys FFS	0%	0% if FFS chosen. Can share in benefit if MA chosen and MA bid < benchmark	100%	100% if FFS chosen. The Medicare program shares in savings or costs of MA[2]
Option 1 (local benchmark): Beneficiary pays a fixed Part B premium plus cost of choice above local benchmark	0%	100% of difference between the benchmark and the cost of the plan chosen	100%	0%
Option 2 (fixed percent contribution): Beneficiary pays fixed percent of the local benchmark plus any costs of a plan chosen above the benchmark	Fixed percent (e.g., 20% of the difference between average national and average local costs)	100% of difference between the benchmark and the cost of the plan chosen	Fixed percent (80%)	0%
Option 3 (national benchmark): Medicare pays a national base dollar amount (this approach is used in the Part D system)	100% of the difference between average national and average local costs	100% difference between the benchmark and the cost of the plan chosen	0%	0%

Note: FFS (fee-for-service), MA (Medicare Advantage).
[1] In all cases, we assume the government contribution will move up or down with respect to the individual's risk score.
[2] Currently, the Medicare program can pay more than FFS costs if the benchmark is above risk-adjusted FFS spending per beneficiary. The Medicare program can also share in savings if the benchmark is below FFS.

While annual allowed growth in spending for accountable care organizations (ACOs) or Medicare Advantage (MA) plans could be set at national levels, it is clear that the benchmark for the ACO or MA plan will likely have to be set on local spending. If it were set on national levels of spending, there would be ACOs and MA plans earning bonuses without any changes in practice patterns in low-cost areas. In addition, MA plans and ACOs would be less likely to form in high-cost areas, where they are needed most.

However, there is a related question of how a benchmark should be set with respect to the cost of Part B premiums paid by the beneficiary. A fundamental question in setting the Part B premium is whether the Part B premium should be set based on risk-adjusted local fee-for-service (FFS) spending per beneficiary or risk-adjusted national FFS spending per beneficiary. The answer to this question hinges on a value judgment regarding who should bear the cost (or savings) associated with regional variation in the cost of care. If the contribution from the Medicare program is a fixed national amount (adjusted only for

beneficiary risk), then the remainder would be paid by the beneficiary and the beneficiary would have to absorb the higher costs in high-cost regions and would have to pay less in low-cost regions. This approach is used in Part D. In contrast, if the benchmark is local, then the Medicare program absorbs any costs (or savings) associated with high (or low) spending in a region. This approach is currently used for setting Part B premiums. A related question is whether the beneficiary has to pay the marginal cost of choosing one model (e.g., MA plan X) over another model. Currently, if a beneficiary chooses an MA plan that costs more than FFS due to having a high benchmark, the Medicare program absorbs this cost. An alternative would be to have the beneficiary absorb the marginal cost or marginal savings of their choice. Table 1-B1 illustrates how the beneficiary and Medicare program's financial responsibility vary depending on how benchmarks are set and beneficiary premiums are set.

The lesson from Table 1-B1 is that the policy decision about how to set the Medicare program's contribution is fundamentally a decision between making regional variation in spending a factor that the beneficiary is responsible for versus having the Medicare program bear responsibility for the regional variation. In the case of Part D, where regional variation is small, the current rules have the Medicare program's contribution fixed at a national benchmark. The beneficiary absorbs the regional variation. For Part B, where regional variation in spending is large, the Medicare program fixes the beneficiaries' share of the Part B cost at a national Part B premium and the program absorbs regional variation (which on a national basis is roughly offsetting). Future policy discussions regarding beneficiary cost sharing will have to resolve the fundamental question of whether beneficiaries should be responsible for the average level of costs in the region where they choose to live, or the Medicare program should absorb the regional variation in those costs. ■