

# **Medicare Advantage, Accountable Care Organizations, and Traditional Medicare: Synchronization or Collision?**

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## **I. Introduction**

Despite its size and immense influence over health care in America, Medicare today is no monolith. It is comprised of three distinct payment programs through which it provides services to beneficiaries: “traditional,” fee-for-service (FFS) Medicare; Medicare Advantage (MA); and the Medicare Shared Savings and Pioneer accountable care organizations (ACO) programs. These models, which strongly influence provider delivery arrangements and program costs, differ significantly along many dimensions important to beneficiaries and providers. In the wake of changes spurred by the Affordable Care Act (ACA)<sup>1</sup> and the evolution of the health care delivery system, all three are evolving rapidly and subject to regulation that will affect their interaction with each other. It is not clear whether their paths will eventually cross and, if so, whether they will link together or collide.

What is clear is that regulations affecting payment, quality, and delivery methods for each model will influence their success and interplay with each other. Navigating this dynamic terrain, Medicare’s overseers, the Centers for Medicare and Medicaid Services (CMS) and Congress, have choices to make. They may find useful guidance in a roadmap being developed by MedPAC, the independent agency that advises Congress on Medicare payment policies. That proposal, analyzed in this essay, would “synchronize” payment, quality and risk adjustment rules to assure a level playing field for the three payment options. Eliminating subsidies that tip the scale in favor of one model is an appropriate albeit tremendously complicated technical task as diverse regulations apply to the three models. However, this undertaking involves policy judgments that extend beyond making technical adjustments to payment rules. Further, achieving a completely neutral payment policy, to the extent that is even possible, will run afoul of a number of entrenched and often conflicting norms that underlie Medicare policy.

## **II. Medicare’s Three Payment Models**

### **A. Fee-for-Service (Traditional) Medicare**

Borrowing from the design of indemnity insurance plans offered by Blue Cross and Blue Shield at the time of its enactment, Medicare initially reimbursed hospitals for their “reasonable costs” and physicians for their “reasonable charges”<sup>2</sup> for all “medically necessary” care.<sup>3</sup> Although myriad adjustments have been made, including prospective payment for hospitals and other facility reimbursement and fee schedule payments for physician services, the fundamental structure of “traditional Medicare” under Parts A and B remains rooted in paying providers for the volume of services they provide, regardless of quality or outcomes. A near unanimous consensus among politicians and policy experts lays the blame for Medicare cost and related

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<sup>1</sup> See, e.g., Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3201, 124 Stat. 119, 442 (2010) (codified as amended in 42 U.S.C. § 1395w-23(j) (2012)).

<sup>2</sup> Social Security Amendments of 1965, Pub. L. No. 89-97, §§ 102a, 1814(b), 1832(a)(1), 1833, 79 Stat. 286, 291, 296, 302 (codified as amended in scattered sections of 42 U.S.C.).

<sup>3</sup> See *id.* § 1862(a)(1) (excluding medical care “not reasonable and necessary for the diagnosis or treatment of illness or injury”).

problems of quality and fragmentation in the delivery of care on the skewed incentives associated with FFS payment.<sup>4</sup> Equally problematic is the fact that because Medicare payment policy strongly influences commercial insurance, fee-for-service payment has long persisted in the private sector. Finally, the separation of physician and hospital payments promotes major inefficiencies. Not only are payment incentives for quality-improving coordination of care lacking, but hospitals are hamstrung in efforts to control costs because staff physicians, paid on a FFS basis even for practice in the hospital, have no financial incentives to make decisions that will reduce hospitals' costs. In some cases, the effects are especially perverse: physicians may be reimbursed at higher rates when employed by hospitals than when doing the same procedures as independent practitioners, thus giving hospitals a financial incentive to employ physicians and share the higher reimbursements with them.<sup>5</sup>

Attempts to improve upon the administered pricing mechanisms for provider reimbursement under Medicare have had at best mixed results. Inpatient prospective payment to hospitals has had some success in reducing the length of admissions, but has not discouraged use of expensive technologies and has resulted in cost shifting to private payers<sup>6</sup> and site shifting of Medicare-reimbursed procedures to other locations such as ambulatory care and physician offices.<sup>7</sup> Other reforms, such as the introduction of a fee schedule to rationalize physician payment and the attempt to control volume by a sustainable growth rate mechanism, have been abysmal failures.<sup>8</sup>

The Affordable Care Act initiated a large number of measures to address problems associated with FFS payment methodology. These include efforts to correct specific shortcomings of the physician fee schedule and other payment mechanisms. Other initiatives include pilot programs and demonstrations to test moving provider reimbursement, which is under traditional Medicare, from unit payments to global or bundled payments for services. For example, under the title "Improving Payment Accuracy,"<sup>9</sup> the Act directs the Secretary of HHS

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<sup>4</sup> Glenn Hackbarth, Chairman of MedPAC, concisely summarized the flaws of Medicare payment: "Care coordination is rare, specialist care is favored over primary care, quality of care is often poor, and costs are high and increasing at an unsustainable rate...[FFS] payment systems reward more care, and more complex care, without regard to the value of that care." *Reforming the Health Care Delivery System: Hearing Before the H. Comm. on Energy & Commerce*, 111th Cong. 1 (2009) (statement of Glenn M. Hackbarth, Chairman of the Medicare Payment Advisory Commission).

<sup>5</sup> Amanda Cassidy, *Health Policy Brief: Site-Neutral Payments*, HEALTH AFF. (July 24, 2014), [http://healthaffairs.org/healthpolicybriefs/brief\\_pdfs/healthpolicybrief\\_121.pdf](http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_121.pdf).

<sup>6</sup> See Allen Dobson et al., *The Cost-Shift Payment 'Hydraulic': Foundation, History, and Implication*, 25 HEALTH AFF. 22, 27 (2006); Austin B. Frakt, *How Much Do Hospitals Cost-Shift? A Review of the Evidence*, 89 MILBANK Q. 90 (2011); Uwe E. Reinhardt, *The Many Prices Paid to Providers and the Flawed Theory of Cost Shifting: Is It Time For a More Radical All-Payer System?*, 30 HEALTH AFF. 2125, 2127 (2011).

<sup>7</sup> See Nicholas Bagley, *Bedside Bureaucrats: Why Medicare Reform Hasn't Worked*, 101 GEO. L.J. 519, 541 (2013) (deeming prospective payment a "qualified failure" with modest effects on costs or how physicians practice medicine).

<sup>8</sup> See Thomas L. Greaney, *Controlling Medicare Costs: Moving Beyond Inept Administered Pricing and Ersatz Competition*, 6 ST. LOUIS J. HEALTH L. & POL'Y 229 (2013) [hereinafter Greaney, *Controlling Medicare Costs*] (discussing the failure to address collective action problems in the volume performance standard originally relied upon to control the amount of procedures and the political impediments undermining the sustainable growth rate mechanism). See also *Reviewing the Work Relative Values of Physician Fee Schedule Services*, in MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO CONGRESS: MEDICARE PAYMENT POLICY 133-50 (Mar. 2006) (explaining how CMS' reliance on the American Medical Association's Relative Value Update Committee, which is dominated by specialists, has caused the fee schedule to over-weight specialty procedures and undervalue primary care).

<sup>9</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 3131-602, 124 Stat. 119, 427-538 (2010).

to regularly review fee schedule rates, focusing especially on those with the fastest growth and strengthening the Secretary's ability to adjust rates found to be misvalued or inaccurate.<sup>10</sup> Also notable is a provision adding a "value-based payment modifier" to fee schedule payments under Part B.<sup>11</sup> Beginning in 2017, this adjustment will reward or penalize physicians based on the relative value of the care they provide using measures of adherence to recommended clinical processes.<sup>12</sup> The ACA also seeks to fill the void of quality oversight by adding new regulatory measures such as a penalty for hospitals ranking in the top twenty-fifth percentile for rates of hospital infections.<sup>13</sup>

In what is potentially the most far-reaching change, the Act initiates several programs designed to move away from the FFS concept. For example, the ACA requires the Secretary of HHS to establish, test, and evaluate a five-year pilot program "for integrated care during an episode of care . . . around a hospitalization in order to improve the coordination, quality, and efficiency of health care services,"<sup>14</sup> and further directs the Secretary to make a recommendation no later than January 1, 2016 as to whether to expand the pilot program.<sup>15</sup> CMS has begun to test four different "bundled" payment models in a three-year program that allow such payments to be made to physicians, hospitals, and post-acute care providers. Under bundled payment, a single payment is made for an "episode of care"—i.e., a defined set of services for treating a patient's medical condition or performing a major surgical procedure that are delivered by designated providers in specified health care settings and often time periods.<sup>16</sup> Other programs are also underway to develop payment modalities such as gainsharing and acute care bundling that encourage and reward integration of care.<sup>17</sup>

## **B. Medicare Advantage**

Although Congress has allowed private organizations to provide Medicare services to beneficiaries for over thirty years, Medicare managed care has proved something of a roller

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<sup>10</sup> *Id.* § 3134 ("Misvalued Codes Under the Physician Fee Schedule").

<sup>11</sup> See *Value-Based Payment Modifier*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html> (last visited Dec. 10, 2014).

<sup>12</sup> See Robert A. Berenson & Deborah R. Kaye, *Grading a Physician's Value—The Misapplication of Performance Measurement*, 369 NEW ENG. J. MED. 2079 (2013) (endorsing the concept of value based reimbursement but criticizing the measurements to be used in the program).

<sup>13</sup> Patient Protection and Affordable Care Act § 3008 (codified at 42 U.S.C. § 1395ww (2012)).

<sup>14</sup> *Id.* § 3023 (codified at 42 U.S.C. § 1395cc—4a (2012)).

<sup>15</sup> *Id.* See generally, Melanie Evans, *Interest Surges in Medicare Bundled Payment Initiative*, MODERN HEALTHCARE (July 31, 2014), <http://www.modernhealthcare.com/article/20140731/NEWS/307319832> (reporting CMS will add 4,100 providers to 2,400 already exploring use of bundled payments).

<sup>16</sup> Patient Protection and Affordable Care Act § 3023 (codified at 42 U.S.C. § 1395cc—4(c)(3)(C)) (2012). Under this program, CMS and providers set a target payment amount for a defined episode of care. Applicants propose the target price, which would be set by applying a discount to total costs for a similar episode of care as determined from historical data. Participants in these models are paid for their services under Medicare fee-for-service payments, but at a negotiated discount. At the end of the episode, the total payments would be compared with the target price.

<sup>17</sup> See *Innovation Models*, CTR. FOR MEDICARE & MEDICAID INNOVATION, <http://innovation.cms.gov/initiatives/index.html#views=models> (last visited Oct. 30, 2014) (providing descriptions of demonstrations underway at CMS including the Medicare Hospital Gainsharing demonstration, the Acute Care Episode (ACE) demonstration, and the Physician Hospital Collaboration Demonstration).

coaster ride. The Tax Equity and Financial Responsibility Act of 1982<sup>18</sup> authorized capitated payments to health maintenance organizations calculated at ninety-five percent of county fee-for-service expenditures under Part A and Part B. Born in the belief that private plans could be more efficient and innovative than traditional Medicare and the promise that significant savings would be shared with beneficiaries in the form of added benefits or reduced premiums, the program attracted health maintenance organizations (HMOs), which grew rapidly in limited areas of the country. Enthusiasm for managed care eventually dampened when it became apparent that the success of HMOs was in part attributable to their ability to enroll a disproportionately healthy cohort of beneficiaries.<sup>19</sup> Congress responded with the Balanced Budget Act of 1997, renaming the program Medicare+Choice, instituting a risk adjustment methodology that paid less to plans with relatively healthier enrollees, and severely limiting annual increases in program payments to plans.<sup>20</sup> The law proved to be an overreaction, as many plans, unable to earn profits, abandoned the program.<sup>21</sup>

In 2003, Congress again sharply reversed course, adopting the Medicare Modernization Act,<sup>22</sup> which once again renamed the program (Medicare Advantage) and provided significantly enhanced payments to attract greater participation by private plans. In addition, the new law added regional preferred provider organizations and private FFS plans to expand the availability of Medicare Advantage (MA) plans to previously unserved or underserved areas,<sup>23</sup> and adopted new bidding and risk sharing regulations. In the end, the law achieved its unstated but transparent goal of promoting managed care enrollment by overpaying private plans.<sup>24</sup> By 2009, MA plans were receiving payments in excess of 114% of FFS and some of the newly-configured MA plans were not even designed to provide integrated care.<sup>25</sup>

With passage of the Affordable Care Act (ACA) in 2010, Congress once again reversed course, cutting back substantially on overpayments to MA plans<sup>26</sup> and instituting a quality-based bonus program to reward plans demonstrating superior performance.<sup>27</sup> But in yet another mid-

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<sup>18</sup> 42 U.S.C. § 1395mm(a)(1)(C) (2006).

<sup>19</sup> MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO CONGRESS: MEDICARE PAYMENT POLICY (Mar. 2002).

<sup>20</sup> 42 U.S.C. §§ 1395w-23(a)(3), 1395w-23(c) (2006). *See generally* Marsha Gold, *Medicare+Choice: An Interim Report Card*, 20 HEALTH AFF. 120, 126 (2001) (cataloguing the shortcomings of the program following passage of the Balanced Budget Act of 1997).

<sup>21</sup> *See id.* at 126 (discussing the effects of the Balanced Budget Act of 1997 on Medicare managed care).

<sup>22</sup> Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-173, 117 Stat. 2066 (codified as amended 42 U.S.C. § 1395w-23 (2006)).

<sup>23</sup> *See* Marsha Gold, *Medicare's Private Plans: A Report Card on Medicare Advantage*, 28 HEALTH AFF. w41, w42 (2008). By 2008 all Medicare beneficiaries had multiple MA choices. *Id.*

<sup>24</sup> A corollary goal of undermining traditional Medicare can be seen in Speaker Newt Gingrich's justification for voucher plans that he hoped would make traditional Medicare "wither on the vine." *Gingrich on Medicare*, N.Y. TIMES (July 20, 1996), <http://www.nytimes.com/1996/07/20/us/politics-gingrich-on-medicare.html>; *see* Greaney, *Controlling Medicare Costs*, *supra* note 8, at 229.

<sup>25</sup> *See* Brian Biles et al., *Medicare Advantage in the Era of Health Reform: Progress in Leveling the Playing Field*, THE COMMONWEALTH FUND 5 (2011), <http://www.commonwealthfund.org/Publications/Issue-Briefs/2011/Mar/Medicare-Advantage.aspx>.

<sup>26</sup> The highest paid counties will bid against benchmarks set at 95% of FFS and the lowest at 115%, with the others in between, so that by 2017, CMS will set payments at a national average of 101% of FFS costs. *Medicare Advantage Fact Sheet*, KAISER FAM. FOUND., (2014), <http://kff.org/medicare/fact-sheet/medicare-advantage-fact-sheet/>.

<sup>27</sup> Plans that perform well on quality scores under the Star Rating program can offset some of the reduction with additional bonus payments. *See* Gretchen Jacobson et al., *Medicare Advantage Star Rating and Bonus Payments in 2012*, KAISER FAM. FOUND. (2011), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8257.pdf>.

course correction, the significant cuts in MA plan payments mandated by the ACA were substantially mitigated when the Obama administration initiated a demonstration program that allowed 90 percent of plans to receive bonuses and took other steps that ultimately gave back half of projected savings from cuts to MA plans.<sup>28</sup>

Although the MA payment model relies on plans submitting bids, the process diverges from a strictly competitive model in that payments to MA plans are determined by comparing each plan's bid to a statutorily determined local benchmark. Importantly, that benchmark is calculated based on the Part A and Part B fee-for-service spending in each county in which a plan proposes to operate. Plans bidding below the benchmark receive their bid plus a "rebate" equal to a fixed percentage—50 percent, 65 percent, or 70 percent, depending on the plan's quality rating—of the difference between the bid and the benchmark. Those bidding above the benchmark—a rare occurrence—receive the benchmark but must require that each plan enrollee pay a premium equal to the difference between the bid and the benchmark. Once the rebate amounts are determined, plans must return the rebates to their enrollees in the form of supplemental benefits or lower premiums. As noted above, the ACA made important adjustments to the bidding framework by lowering plan benchmarks to levels closer to the cost of enrollees in traditional Medicare in each county, setting relatively lower benchmarks in counties with high FFS Medicare costs, and setting relatively higher benchmarks in counties with lower FFS costs.<sup>29</sup> Nevertheless, because benchmarks continue to be based in part on historic spending and are subject to annual increases based on the growth in Medicare spending,<sup>30</sup> the bidding process does not encourage plans to compete as vigorously as one in which payments are based on the average of plans' bids.<sup>31</sup>

### C. Accountable Care Organizations

The most widely discussed (and in the **opinion of some, most promising**<sup>32</sup>) systemic reform contained in the ACA is the “Medicare Shared Savings Program” (MSSP), which is designed to test and spur the development of Accountable Care Organizations (ACOs).<sup>33</sup> The objectives of

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<sup>28</sup> JAMES COSGROVE & EDDA EMMANUELLI-PEREZ, U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-12-964T, MEDICARE ADVANTAGE: QUALITY BONUS PAYMENT DEMONSTRATION HAS DESIGN FLAWS AND RAISES LEGAL CONCERNS 4 (2012); see Meghan McCarthy, *Medicare Advantage and the 'Potomac Two-Step'*, MORNING CONSULT (Apr. 13, 2014), <http://themorningconsult.com/2014/04/medicare-advantage-and-the-potomac-two-step>.

<sup>29</sup> Under the revised bidding formula, benchmarks will be 95% of fee-for-service (FFS) costs per enrollee for the counties in the top quartile of FFS costs; 100% for countries in the second highest quartile; 107.5% for the third highest quartile and 115% for the bottom quartile. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3201, 24 Stat. 119, 442 (2010) (codified as amended in 42 U.S.C. §1395w-23(j)(2012)).

<sup>30</sup> See Robert A. Berenson, *From Politics to Policy: A New Payment Approach in Medicare Advantage*, 27 HEALTH AFF. w156, w160 (2008).

<sup>31</sup> See Greaney, *Controlling Medicare Costs*, *supra* note 8 (contending that “ersatz competition” in MA bidding lacks the requisite incentives to replicate competitive process). A provision in the Senate's version of the Affordable Care Act that was removed in the reconciliation required competitive bidding that set payments based on the average bid. See Austin Frakt, *Medicare Advantage Competitive Bidding: The Political Failure of a Good Idea*, KAISER HEALTH NEWS (Apr. 12, 2010), <http://www.kaiserhealthnews.org/Columns/2010/April/041210Frakt.aspx>.

<sup>32</sup> See e.g. Ezekiel J. Emanuel & Jeffrey B. Liebman, *The End of Health Insurance Companies*, N.Y Times Opinion Pages (Jan. 30, 2012)(predicting that ACOs will render commercial insurance obsolete by 2020)..

<sup>33</sup> As this article was going to press, CMS issued a Notice of Proposed Rule Making that proposes extensive revisions to the MSSP ACO regulations. The notice includes proposed changes to the financial performance tracks, waivers of certain FFS payment rules, a new beneficiary attestation process, and several alternative methodologies for establishing, updating and resetting ACO financial benchmarks. DEPT. OF HEALTH & HUMAN SERVS., CENTERS FOR MEDICARE AND MEDICAID SERVICES, MEDICARE SHARED SAVINGS PROGRAM: ACCOUNTABLE CARE

the program encompass fostering health systems capable of controlling costs and improving the quality of care, familiarly cited as the “triple aim”: “better care for individuals, better health for populations, and slower growth in costs through improvements in care”.<sup>34</sup> At bottom, the aspiration is to transform the delivery system by incentivizing diverse and fragmented providers to abandon their silos and instead offer services jointly.

The MSSP makes groups of providers that voluntarily meet certain quality criteria eligible to share in the cost savings they achieve for the Medicare program. To qualify, an ACO must agree to be accountable for the provision of all Part A and Part B services except hospice care for a defined group of Medicare beneficiaries, have sufficient participation of primary care physicians, have processes that promote evidence-based medicine, report on quality and costs, and be capable of coordinating care. Additionally, an ACO must be comprised of a group of providers and suppliers who have an established mechanism for joint decision making, and must be provider-driven: 75% of its participants must be providers. The law is flexible as to the composition of participating providers. ACOs may include practitioners (physicians, regardless of specialty; nurse practitioners; physician assistants; and clinical nurse specialists) in group practice arrangements, networks of practices, partnerships, or joint venture arrangements between hospitals and practitioners.<sup>35</sup>

ACOs qualify for an annual incentive bonus if they achieve a threshold level of savings for total per beneficiary spending under Medicare parts A and B for those beneficiaries “attributed” to the ACO. Attribution is a rather unique and controversial feature of Medicare ACOs. Medicare beneficiaries are attributed to the primary care doctor (and assigned to that doctor’s ACO) from whom they receive a plurality of their primary care services. Beneficiaries who have not recently had primary care services provided by a primary care physician are assigned to an ACO on the basis of the specialist physician or certain non-physician providers, including clinical nurse specialists and physician assistants from whom the beneficiary has received a plurality of primary care services. In addition, beneficiaries suffer no penalty or co-payment if they choose to be treated by a provider not affiliated with their ACO. Thus beneficiaries do not “enroll” in ACOs, have no incentive to be treated by ACO providers, and, although they receive notice of their attribution, are likely to have scant awareness of the ACO’s existence or practices.<sup>36</sup>

Provider payment is linked to savings associated with the ACO’s attributed beneficiaries. Medicare directly pays the ACO providers their FFS rates for those beneficiaries and also remits to the ACO any shared savings—the difference between the net FFS spending on all of its beneficiaries (including payments to non-ACO providers) and the ACO’s “benchmark”. Importantly, the ACO benchmark is based on a weighted three-year average of FFS spending for

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ORGANIZATIONS, NOTICE OF PROPOSED RULEMAKING,(DEC. 1, 2014).

[HTTP://WWW.OFR.GOV/OFRUPLOAD/OFRDATA/2014-28388\\_PI.PDF](http://www.OFR.GOV/OFRUPLOAD/OFRDATA/2014-28388_PI.PDF)

<sup>34</sup> See Donald M. Berwick, *Perspective: Launching Accountable Care Organizations—The Proposed Rule for the Medicare Shared Savings Program*, 364 NEW ENG. J. MED. 1 (2011) (purpose of ACOs is to achieve a triple aim: “better care for individuals, better health for populations, and slower growth in costs through improvements in care”).

<sup>35</sup> Center for Medicare & Medicaid Services, Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802 (Nov. 2, 2011).

<sup>36</sup> *Id.*

all beneficiaries attributed to the ACO.<sup>37</sup> Benchmarks are “trended forward” using national growth rates in Part A and B expenditures and are updated during ACOs’ three year cycle using a flat dollar amount based on national expenditure growth rates. Importantly, however, each ACO’s benchmark is reset for new 3 year agreement periods based on its assigned population. Hence, in order to receive shared savings, ACOs must “compete against themselves” in that they must continue to achieve cost savings based on their beneficiaries’ historical patterns. The amount of shared savings most ACOs in the MSSP<sup>38</sup> receive ranges from 50 to 75 percent (after the first 2 percent of savings) depending on the ACO’s score on a quality scale developed by CMS.<sup>39</sup>

The ACA also empowered CMS to establish a separate program for advanced ACOs able to assume capitated risk. Designed primarily for organizations that are already highly integrated and experienced in coordinating care for patients across care settings, the Pioneer program began in 2012 with thirty-two selected participants. Pioneer ACOs must “commit to entering outcomes-based contracts” with other purchasers (private health plans, state Medicaid agencies, and/or self-insured employers) such that the majority of the ACO’s total revenues (including revenues from Medicare) would be derived from such arrangements by the end of the second performance period in December 2013.<sup>40</sup> In the first two years, like the MSSP ACO model, the Pioneer Model tests a shared savings and shared losses payment arrangement; however, Pioneer ACOs are subject to higher levels of reward and risk. In year three of the program, those Pioneer ACOs that have shown savings over the first two years are eligible to move to a population-based payment model. Population-based payment is a per-beneficiary per month payment amount thus replacing FFS payments with a prospective monthly payment.

### III. Distinguishing the Three Models

The three payment models differ in many important respects relevant to devising synchronization policy discussed later in this article. This section first outlines the attributes that distinguish the models and the subsequent section highlights four dimensions of particular relevance to policy development.

First, Medicare applies distinct payment methodologies to each model. As shown in the following chart, provider payment under traditional FFS Medicare pays for individual services based on government-set prices. ACO providers are reimbursed using an identical methodology but receive a bonus or penalty depending on their ACO’s overall level of spending, which is

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<sup>37</sup> The baseline spending used for the benchmark is trended forward using the national growth rate in FFS spending. See *Synchronizing Medicare Policy Across Payment Models*, in MEDICARE PAYMENT ADVISORY COMM’N. REPORT TO THE CONGRESS: MEDICARE AND THE HEALTHCARE DELIVERY SYSTEM 1, 7 (June 2014) [hereinafter MedPAC, *Synchronizing Medicare Policy*].

<sup>38</sup> Higher shared savings are available to ACOs choosing to share downside risk under the MSSP (i.e. refund to CMS a portion of their excess costs if their spending exceeded the benchmark). However only 5 of 333 ACOs chose to do so. *Fast Facts – All Medicare Shared Savings Program and Medicare Pioneer ACOs*, CTRS. FOR MEDICARE & MEDICAID SERVS., 1 (2014), <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/PioneersMSSPCombinedFastFacts.pdf>.

<sup>39</sup> CMS employs 33 measures grouped into four domains: Patient/Caregiver Experience; Care Coordination and Patient Safety; Preventive Health; and At-Risk Population/Frail Elderly Health and assigns a performance score on each domain. See 76 Fed. Reg. 67,802 (2011). See also 42 C.F.R. § 425.500 (2012).

<sup>40</sup> *Pioneer Accountable Care Organization (ACO) Model Request for Application*, CTRS. FOR MEDICARE & MEDICAID SERVS., 13 (2011), <http://innovation.cms.gov/Files/x/Pioneer-ACO-Model-Request-For-Applications-document.pdf>.

measured against the historical FFS costs of their beneficiaries, and the ACO's performance on CMS quality measures. Medicare Advantage plans are paid a capitation amount determined by the difference between their bids and the FFS spending in the counties in which the plan operates subject to adjustment based on quality metrics. Each payment model is subject to regulatory controls though the nature and extent of those requirements differ significantly.

### Comparing the Three Payment Models

	<b>Traditional Fee-for-Service (FFS) Medicare</b>	<b>Accountable Care Organizations (ACOs)</b>	<b>Medicare Advantage (MA)</b>
<b>Medicare Program Payment</b>	<ul style="list-style-type: none"> <li>• Pays for individual services at set payment rates</li> </ul>	<ul style="list-style-type: none"> <li>• Pays for individual services at set payment rates (FFS)</li> <li>• Plus bonus payments/penalty based on spending &amp; quality targets</li> </ul>	<ul style="list-style-type: none"> <li>• Pays risk-adjusted capitation payments per enrollee</li> <li>• Based on MA benchmarks &amp; bids</li> <li>• Star Quality Bonus</li> </ul>
<b>Benefits and Requirements</b>	<ul style="list-style-type: none"> <li>• Medicare benefit package (Pt. A&amp;B)</li> <li>• Any participating provider</li> <li>• Beneficiaries buy supplemental coverage</li> </ul>	<ul style="list-style-type: none"> <li>• Same as under FFS</li> <li>• Beneficiaries "attributed" to ACOs</li> <li>• Providers informally encourage staying within the ACO</li> </ul>	<ul style="list-style-type: none"> <li>• Part A &amp; B</li> <li>• Extra benefits if the plan bid is less than the MA benchmark</li> <li>• Catastrophic coverage</li> <li>• Limited network of providers</li> <li>• Beneficiaries must enroll</li> </ul>

A second important distinction concerns the allocation of risk. No financial risk is assumed by providers under traditional Medicare. By contrast, MA plans are required to assume risk annually by virtue of accepting fixed capitated payment. ACOs under the MSSP may choose not to accept downside risk in the initial year of operation; in subsequent years they must accept risk as measured by their improved cost and quality performance over the previous year. The MSSP ACO model requires that risk be measured by the ACO's performance with respect to its own cohort of assigned beneficiaries. Risk is determined for MA plans based on their bids against a benchmark based on all beneficiaries in the counties in which they operate. Thus, in choosing in which models to participate, providers encounter significant differences in the amount of risk they must assume.



The three models also differ in the way they provide incentives to lower costs and who gets to share in savings achieved. Beneficiaries in MA plans share savings in the form of extra benefits or reduced premiums or cost-sharing, while plans presumably gain more business with lower costs as they are able to offer more attractive products in the MA market. By contrast, savings are distributed to ACOs. Under FFS, providers in low cost areas that achieve savings for the Medicare program receive no benefits although the beneficiaries they serve are indirectly rewarded in that services provided by low cost providers will entail lower co-payments.

Other differences among the payment models affect beneficiaries in important ways. For example benefits are not uniform across models. While beneficiaries are entitled to receive the identical package of Part A and Part B services from traditional Medicare, MA plans, and ACOs (with the exception of hospice benefits), MA plans that bid below their benchmarks are required to provide extra benefits and/or reduced premiums. In addition, MA plans must provide catastrophic coverage unavailable under traditional Medicare.<sup>41</sup> Although not required to provide specific additional benefits, ACOs must have in place a variety of quality assurance processes. Due to their responsibility for the full panoply of care, ACOs also need to have strong incentives to offer cost saving services that are not reimbursed under traditional Medicare such as social services, phone call assistance, and other support services

Finally, the models place different constraints on beneficiaries' choice of provider and on their ability to switch models. Under traditional Medicare, beneficiaries can receive services from any participating provider, which in most communities includes the vast majority of all hospitals and physicians. The same is true for beneficiaries attributed to ACOs; however, their providers have financial incentives to refer them to providers affiliated with their ACO. In addition, most MA plans are HMOs that limit access to out of network providers. However, some MA plans adopt a PPO or HMO POS model, which permits access to non-network providers. Beneficiaries must enroll or dis-enroll for MA plans during limited annual periods or under special circumstances such as a change in residence. Under the attribution process, beneficiaries make no election to participate in an ACO and, hence, have no restrictions on choice of providers. Beneficiaries receive notice of their attribution to an ACO and, although not allowed to opt out, may prohibit sharing of clinical data among ACO providers.

#### **IV. Dimensions for a Policy Framework**

As will be discussed in the following section, MedPAC has begun to investigate the desirability of “synchronizing” policies affecting the three models. Although the Commission is at an early stage in developing this concept, a core premise is that Medicare policy should adopt a position of “financial neutrality.” Explaining its rationale, MedPAC’s annual report states, “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

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<sup>41</sup> Medicare Advantage enrollees have a maximum out-of-pocket limit for all Medicare covered services of \$6,700 and “encouraged” by CMS to be no more than \$3,400. *Fact Sheets: Strengthening Medicare Advantage*, CTRS. FOR MEDICARE & MEDICAID SERVS. (2014), <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-04-07.html>; *see also*, *Medicare Advantage Spotlight*, KAISER FAM. FOUND. (2014), <http://kff.org/medicare/issue-brief/medicare-advantage-2014-spotlight-plan-availability-and-premiums/#LimitsOnOOPSpending>.

beneficiary making the choice.”<sup>42</sup> However, the heterogeneous characteristics of the three models and the policies embedded in them evince the daunting task the agency has undertaken. Synchronization will encounter a number of widely shared program objectives that may make achieving a “level playing field” an elusive goal. Below I discuss three important policy goals that will require careful balancing as payment reform proceeds.

### *Affording Beneficiaries Choice and a Range of Benefits*

A laudable feature of Medicare today is that it offers a range of options that serve the heterogeneous preferences of its beneficiaries. The three models provide differing mixes of choice and benefits. Traditional Medicare offers practically no formal limitations on choice of providers, while MA plans constrict choice to provider panels. ACOs are in an intermediate position, not formally limiting choice but operating in the background to steer patients to ACO providers. With respect to benefits, traditional Medicare offers the range of part A and B services. Yet, it fails to reimburse providers for so-called “non-medical” services and, thus, undervaluing certain primary care services like cognitive medicine may underprovide those services. By contrast, MA plans have incentives to provide add-on services. They are mandated to provide extra benefits or reduced premiums and catastrophic coverage unavailable in traditional Medicare, though their financial incentives may encourage under-provision of care. ACOs again occupy a middle position, having managed care incentives to provide cost-effective non-medical and coordinating care services, while also sharing incentives to underprovide care. Although developed over time in a rather haphazard fashion, the three payment models thus serve to provide choice and flexibility for a diverse population.

### *Limiting Subsidies and Disparate Payments*

Strong objections to “overpayment” or subsidies for private plans fueled cutbacks enacted under the Affordable Care Act. As discussed above, the Medicare Modernization Act enhanced payments to MA plans with the explicit goal of spurring enrollments. To the extent such payments exceeded the reimbursement that providers would have received under FFS plus compensation for providing additional services and assuming risk, CMS payments for MA plans is commonly seen as a subsidy for private plans.<sup>43</sup> Although less widely acknowledged, ACOs also benefit from the services provided by CMS in the form of billing assistance and assignment of beneficiaries. By contrast, MA plans must shoulder the costs associated with soliciting beneficiaries and servicing their accounts. Reforms aimed at attaining absolute financial neutrality would face the intractable task of untangling and harmonizing the levels of direct and indirect support the federal government supplies for participants in each payment model.

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<sup>42</sup> MedPAC, *Synchronizing Medicare Policy*, *supra* note 35, at 5.

<sup>43</sup> See e.g. *Eliminate Private Medicare Advantage Plan Subsidies*, NAT’L COMMITTEE TO PRESERVE SOCIAL SECURITY & MEDICARE (2009), <http://www.ncpssm.org/Document/ArticleID/754>. The extent of this subsidy must take into account differences in the product sold by MA plans. That is, because they provide extra benefits and more complete insurance, to some extent “extra” payments made to MA plans in the form of “rebates” compensate for those additional benefits. However extra benefits received by beneficiaries appears to be only a small proportion of the higher payments. See Steven D. Pizer et al., *Nothing for Something? Estimating Cost and Value for Beneficiaries from Recent Medicare Spending Increases on HMO Payments and Drug Benefit*, 9 J. INT’L HEALTH FIN. & ECON. 59 (2009) (finding only 14% of added spending on MA plans goes to consumers).

Another perceived anomaly is found in payment policies that provide disparate reimbursement and skew incentives for provider participation. For example, high cost providers are rewarded with the opportunity to share savings through ACOs because they can more readily cut costs to their attributed beneficiaries by eliminating the “low hanging fruit” of their cohort’s excess costs. By contrast, providers that have historically contained costs find it difficult to receive financial rewards for their cost effective practices. Adjustments to the benchmark applicable to ACOs would of course alter these incentives. However, the determination of whether to maintain incentives for both high cost and low cost providers to join ACOs is a judgment that will turn on policy-driven appraisals of the long term benefits of ACOs as a transformative payment model.

### *Reducing Payment Variations*

Decades of research has revealed that Medicare spending varies enormously across different regions of the country. Recent studies show variations in county-level FFS spending ranging from a high of \$1,300 per month to a low of \$500 per month, with most counties showing variations in the range of \$600-800 per month and with 44 percent of beneficiaries living in the highest spending quartile.<sup>44</sup> Because of the interaction of local FFS and payments to the other two models, local variations affect the distribution and costs of MA and ACO alternatives in local markets. For example, MA plans serving markets in which benchmarks were set higher than local FFS spending unsurprisingly tended to cost more than FFS. In low cost areas, this phenomenon might be justified as a necessary inducement for MA plan entry. Early evidence indicates that Pioneer ACOs tended to be located in higher FFS spending areas but historically have cost less than MA plans. However, these results are subject to important caveats. Changes in MA benchmarking will likely change the dynamics among the models as might proposed reforms of the MSSP ACO program and improvements in ACO capabilities as they mature and learn from successful models. Equally important, FFS payment reforms underway<sup>45</sup> have the potential to reduce payment variations and influence payments to the other models. Thus efforts at payment reform must entail educated guesses about the speed and extent of change in FFS payments.

In sum, payment reform take place against a backdrop of widely agreed upon policy objectives and other reforms well underway. Next, we consider how some of the norms that affect payment policy may complicate the task of synchronization.

## **V. The Challenge of Synchronizing Payment Policy**

### *A. Regulation: Benchmarks, Quality, and Risk Adjustment*

All three models are subject to extensive but divergent regulation. MedPAC’s initiative to synchronize policy across the models is rooted in several principles inherent in its responsibility to advise Congress on payments to private health plans and providers on issues

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<sup>44</sup> MedPAC, *Synchronizing Medicare Policy*, *supra* note 35, at 8. *See also* INST. OF MED., VARIATIONS IN HEALTH CARE SPENDING: TARGET DECISION MAKING, NOT GEOGRAPHY (2013) (reporting significant and persistent variations in spending).

<sup>45</sup> See notes 9-17 and accompanying text *supra*. ???

affecting quality, cost, and access.<sup>46</sup> One is “financial neutrality,” the belief that the Medicare program should not subsidize one model more than another.<sup>47</sup> A related concern is that beneficiaries’ choice of models should not be influenced by diverging payment policies, including rules governing quality and risk adjustment.<sup>48</sup>

A central consideration underlying the financial neutrality inquiry is the “benchmarks” used in payment policies for Medicare Advantage plans and ACOs. Defined as the “level of program spending that will trigger a bonus or penalty” in the two models, benchmarks are set according to statutory formulas that differ in several dimensions. For each ACO, the benchmark is the historical FFS spending *on its beneficiaries*, i.e. those attributed to it,<sup>49</sup> while MA plans bid against a benchmark based on *overall FFS spending* in the county in which the plan will operate.<sup>50</sup> Providers being reimbursed under administered (FFS) pricing of course face no benchmark.

In addition, payment to both MA plans and ACOs are adjusted based on quality standards that also differ in administration and measurement. MA plans are rewarded with a higher benchmark for attaining higher quality scores, while ACOs are penalized by reductions in their shared savings if they do not meet quality benchmarks. From the beneficiaries’ perspective, these distinctions have several implications. The quality scores for MA plans serve a dual purpose: first, as indicia of quality that helps beneficiaries select their plans, and second, as an enhancement of the plan’s value because greater rebates to plans must be passed along to beneficiaries in lower costs or enhanced benefits. In the case of ACOs, payment adjustments have only the indirect effect of creating incentives for better performance. Further complicating the picture is the fact that different metrics of quality metrics are used for adjusting payments to MA plan and ACOs.<sup>51</sup> Noting the shortcomings of existing quality measures<sup>52</sup> that rely

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<sup>46</sup> *About MedPAC*, MEDPAC, <http://www.medpac.gov/-about-medpac-> (last visited Oct. 30, 2014).

<sup>47</sup> MedPAC, *Synchronizing Medicare Policy*, *supra* note 35, at 5. MedPAC raised concerns about financial neutrality in its June 2005 Report, which questioned benchmarks for Medicare Advantage plans that exceeded 100%. *See The Medicare Advantage Program*, in MEDICARE PAYMENT ADVISORY COMM’N. REPORT TO THE CONGRESS: ISSUES IN A MODERNIZED MEDICARE PROGRAM 59, 79-80 (June 2005) [hereinafter MedPAC, *Medicare Advantage*].

<sup>48</sup> MedPAC, *Synchronizing Medicare Policy*, *supra* note 35, at 5.

<sup>49</sup> For MSSP ACOs, benchmarks are set on a historical cost spending under Parts A and B for its beneficiaries, a determination that is based on a retrospective “attribution” of beneficiaries to an ACO. Beneficiaries who received a plurality of their care from a primary care physician (or in some cases a non-physician or specialist) are attributed to that provider’s ACO. As a result, each ACO’s benchmark determining payment or penalty will be calculated using the three year historical costs, trended forward, for its beneficiaries. Because of uncertainties and inefficiencies associated with this process, MedPAC has recommended that CMS exercise its administrative authority to change to prospective attribution, as is done for ACOs in the Pioneer program. Letter from Glenn M. Hackbarth, Chairman, MedPAC, to Marilyn Tavenner, Adm’r, CMS 7-8 (June 16, 2014) (<http://www.medpac.gov/documents/comment-letters/comment-letter-to-cms-on-accountable-care-organizations-%28june-16-2014%29.pdf?sfvrsn=0>).

<sup>50</sup> Beginning in 2017, the county benchmark for MA plans will be set at four quartile levels—95 percent, 100 percent, 107.5 percent, or 115 percent of the FFS rate projected for that county for the year; quartiles will be based on the relative FFS spending levels among counties during the preceding year. MedPAC, *Synchronizing Medicare Policy*, *supra* note 35, at 8.

<sup>51</sup> *See* MedPAC, *Synchronizing Medicare Policy*, *supra* note 35, at 14 (recommending use of same population-based outcome measures for calculating bonuses and penalties for MA plans and ACOs).

<sup>52</sup> MedPAC’s principal criticisms of current quality measurement are that (1) it relies too heavily on clinical process measures that are “weakly correlated with health outcomes” and reinforces incentives to increase the volume of services, (2) it is administratively burdensome, and (3) it encourages providers to focus resources on processes being measured and neglect potentially important means for improving outcomes. *Measuring Quality of Care in Medicine*, in MEDICARE PAYMENT ADVISORY COMM’N. REPORT TO THE CONGRESS: MEDICARE AND THE HEALTHCARE DELIVERY SYSTEM 39, 41 (June 2014) [hereinafter MedPAC, *Measuring Quality*].

primarily on provider-based clinical processes rather than outcomes, MedPAC has proposed shifting to population-based outcome measures.<sup>53</sup> However, synchronizing such quality measurement for FFS payment poses an intractable problem because FFS providers do not belong to entities capable of coordinating care for a defined population and have not agreed to do so.<sup>54</sup>

The three payment models are subject to a third important form of regulation, risk adjustment. Risk adjustment plays a critical role in Medicare payment policy as it serves to counter the well-documented tendency of providers and payers that assume financial risk for the costs of treating beneficiaries to avoid beneficiaries expected to incur relatively high medical expenditures and to seek out those likely to have low costs.<sup>55</sup> Medicare adjusts the capitated payments to MA plans by calculating a risk score based on the demographic factors and medical history for each enrollee relative to the national average that it multiplies by the base rate payment for the plan. Payment to ACOs adjusts for risk based on the demographics alone calculated for all beneficiaries attributed to the ACO. MedPAC has indicated that synchronization may require reducing differences in the methods for risk adjustment and coding practices for all Medicare beneficiaries.<sup>56</sup>

## B. Synchronization and Financial Neutrality

As noted MedPAC has begun an investigation of whether and how regulation of the three payment models might be “synchronized.”<sup>57</sup> It has long advocated “financial neutrality” between MA and FFS payments, urging in 2005, for example, that overpayments to Medicare Advantage plans be curtailed and the MA benchmark be set at 100 percent of local FFS costs.<sup>58</sup> However, it has been careful to qualify its position on financial neutrality by stating that while benchmarks should be equal across payment models, “equal benchmarks... do not mean equal payments because payments may be adjusted for quality and other factors.”<sup>59</sup> Recent work by the MedPAC staff has involved simulation studies examining the relationship among the three models and comparing several benchmarks that may be used. It has concluded that no single payment model would always be the low-cost model in all situations. Instead, the relative cost of

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<sup>53</sup> *Id.* at 45-48.

<sup>54</sup> MedPAC therefore recommends continued reliance on provider-specific payment policies for FFS providers that control for quality deficiencies such as reductions in hospital payments for high readmissions or infection rates. *Id.* at 14.

<sup>55</sup> Reforms in Medicare’s risk adjustment system using the CMS-HCC model for adjusting payments for clinical diagnoses and demographic factors and instituting an enrollment lock in have achieved some success in reducing incentives for favorable selection. See J. Michael McWilliams, *New Risk-Adjustment System Was Associated with Reduced Favorable Selection in Medicare Advantage*, 31 HEALTH AFF. 2630 (2012). However, MedPAC has concluded that the HCC methodology “still substantially overpredicts the cost of the least costly beneficiaries and underpredicts the cost of the most costly beneficiaries” but was unable to find alternatives that performed better. *Improving Risk Adjustment in the Medicare Program*, in MEDICARE PAYMENT ADVISORY COMM’N. REPORT TO THE CONGRESS: MEDICARE AND THE HEALTHCARE DELIVERY SYSTEM 21, 32-33 (June 2014) [hereinafter MedPAC, *Improving Risk Adjustment*]. It is currently investigating administrative measures such as penalties for disenrollment of high cost beneficiaries. *Id.* at 33. See also U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-13-206, MEDICARE ADVANTAGE: SUBSTANTIAL EXCESS PAYMENTS UNDERSCORE NEED FOR CMS TO IMPROVE ACCURACY OF RISK SCORE ADJUSTMENTS (2013).

<sup>56</sup> MedPAC, *Synchronizing Medicare Policy*, *supra* note 35 at 13-14.

<sup>57</sup> See *supra* note 35 and accompanying text.

<sup>58</sup> MedPAC, *Medicare Advantage*, *supra* note 45, at 79.

<sup>59</sup> MedPAC, *Synchronizing Medicare Policy*, *supra* note 35, at 5.

the 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.”<sup>60</sup> This led MedPAC to conclude that “efficiency can be gained by synchronizing the benchmarks to level the playing field,” thus leaving it to beneficiaries’ choice of which model best suited their needs.<sup>61</sup>

However, the choice of a benchmark has important policy implications. For example, using local FFS spending as the benchmark for ACOs (as opposed to the current benchmark which consists of the historical spending for each ACO’s beneficiaries) would encourage ACOs comprised of low cost providers to enter the program. This is the opposite response seen under existing arrangements where high cost ACOs have the incentive to participate and low cost providers do not. However, as discussed below, using local FFS benchmarks will discourage participation of MA plans in low cost areas because of the difficulty of “beating” the locally determined capitation rate. By contrast, setting a benchmark based on a national average of FFS costs would perversely penalize beneficiaries in low spending areas, where costs are already low, by chilling the incentives facing MA plans and ACOs. Given the wide variation in spending in the country, any benchmark that is chosen will have significant effects on the incentives providers face and distributional consequences for beneficiaries. Finally, an underlying policy issue is whether the deeply flawed FFS spending serve as a benchmark. Benchmarks calculated on the basis of bidding experience or a calculation of an efficient level of spending would better serve program objectives by making each ACO’s success hinge on its ability to be cost efficient in relation to its local market.

### C. Divergent Background Norms

A more fundamental question remains. Why should Medicare policy pursue a level playing field at all? The myriad differences in the characteristics of the models discussed in the previous section reflect an amalgam of policies underlying those differences. These divergent norms, lurking in the background of Medicare payment policy, suggest that any attempt to level the playing field encounters a bumpy terrain of widely shared policy objectives that may prove impossible to reconcile.

*Integration and FFS Payment.* Virtually all policy analysts agree that a central failing of the American health care system is the absence of coordination among providers. Particular fault rests with traditional fee-for-service Medicare, which rewards providers for volume and ignores the potential benefits accruing from integration of services. Indeed, many sections of the ACA are designed to shift the focus of traditional Medicare by testing global and value-based payments and fostering new delivery arrangements.<sup>62</sup> In addition, Medicare payment policy decisions take on added importance because of their influence on the organization of delivery systems serving the commercial sector. Those who view it as an important objective of Medicare payment policy to move delivery in the direction of encouraging efficiency-enhancing

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<sup>60</sup> *Id.* at 12.

<sup>61</sup> *Id.*

<sup>62</sup> *See*, U.S. Dept. of Health and Human Services, Hospital Value-Based Purchasing Program [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Hospital\\_VBPurchasing\\_Fact\\_Sheet\\_ICN907664.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Hospital_VBPurchasing_Fact_Sheet_ICN907664.pdf); BARRY R. FURROW ET AL., HEALTH LAW 3D EDITION (Hornbook Series) §§. 8-16 – 8-17,

integration might well argue that the synchronization project should adjust the neutrality principal to encourage the proliferation of ACOs and Medicare Advantage plans.

*Equity and Regional Variation.* As discussed above, the variation in health care costs across regions of the country might cause significant variability in the availability and generosity of Medicare Advantage plans under synchronization.<sup>63</sup> For example, lowering the benchmark to (or below) fee-for-service levels might result in some areas being deprived of the extra benefits provided by MA plans.<sup>64</sup> Thus, from the consumers' standpoint, it would be inequitable if benchmark adjustment deprived some Medicare beneficiaries of the enhancements that come with MA enrollment. Likewise, providers find inequity in the imbalance of opportunity under certain payment arrangements. For example, ACOs have generally grown up in areas where high cost providers can more readily lower costs for their attributed beneficiaries and share in the savings they achieve. However, providers that have maintained lower costs in other regions without forming ACOs are not rewarded for their economizing efforts and are less likely to form ACOs. Were synchronization to set ACO benchmark at local FFS levels, it would address this perceived inequity but would give rise to criticism that benchmarks did not provide adequate incentives for participation of high cost providers. More generally, a related set of concerns focuses on the wide disparities in payment across regions. This view emphasizes the need to reduce inequity in the wide variation in Medicare spending across regions and advocates leveling federal provider reimbursements, though allowing for some differences based on some localized factors.

*Competition and Innovation.* Not widely appreciated is the interplay of Medicare payment policy and the competitiveness of provider markets in the commercial sector. Although administered pricing under Medicare does not differentiate among providers based on their market leverage, provider market competition has a significant effect on hospital Medicare margins. Examining the effect of hospital concentration on Medicare payments, MedPAC has found that high hospital margins on private-payer patients tend to induce more construction and higher hospital costs and that, "when non-Medicare margins are high, hospitals face less pressure to constrain costs, [and] costs rise."<sup>65</sup> These factors, MedPAC observes, explain the counterintuitive phenomenon that hospital Medicare margins tend to be low in markets in which concentration is highest, while margins are higher in more competitively structured markets.<sup>66</sup> Further, low "Medicare margins" attributable to expense preference behavior—the tendency of firms with market power to allow costs to increase<sup>67</sup>—by dominant hospitals may translate into

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<sup>63</sup> See Robert E. Moffit & Alyene Senger, *Progress in Medicare Advantage: Key Lessons for Medicare Reform*, HERITAGE FOUND. (Sept. 4, 2014), <http://www.heritage.org/research/reports/2014/09/progress-in-medicare-advantage-key-lessons-for-medicare-reform> (reducing the MA benchmarks as provided under the ACA may result in reduction in the number of plans around the country).

<sup>64</sup> As MedPAC Chairman Hackbarth characterized the argument, "People... in areas of the country where there are low fee-for-service costs are...not crazy by any stretch...what they're saying is that we pay equal taxes in Medicare...In some parts of the country, people are getting a whole lot more health care services for it than in other parts of the country." *Transcript of Medicare Payment Advisory Commission Public Meeting*, MEDICARE PAYMENT ADVISORY COMMISSION 93-94 (Mar. 7, 2014), [www.medpac.gov/documents/0314medpac\\_transcript.pdf](http://www.medpac.gov/documents/0314medpac_transcript.pdf).

<sup>65</sup> *Report to the Congress: Assessing Alternatives to the Sustainable Growth Rate System* xiv, MEDICARE PAYMENT ADVISORY COMMISSION (2009), [http://www.medpac.gov/documents/mar09\\_entirereport.pdf](http://www.medpac.gov/documents/mar09_entirereport.pdf).

<sup>66</sup> *Id.*; see also Stensland et al., *Private-Payer Profits Can Induce Negative Medicare Margins*, 29 HEALTH AFF. 1045, 1048-49 (2010).

<sup>67</sup> See Harvey Leibenstein, *Allocative Efficiency vs. X-Efficiency*, 56 AM. ECON. REV. 392 (1966).

higher Medicare costs because updates to hospital administered pricing under prospective payment are sensitive to these margins. Finally, as CMS noted in promulgating its Final Rule on ACOs, because monopolists face regulatory constraints in raising prices, they often reduce the quality or amount of inputs for their services.<sup>68</sup> In this way, inadequate competition in the private sector may lead to diminution in quality of care and access for Medicare beneficiaries. Hence Medicare payment policy encouraging formation of MA and ACOs serves to support the beneficial effects of the dynamic between Medicare and private markets.<sup>69</sup>

*Beneficiary Choice and Preserving Traditional Medicare.* The widespread support for traditional Medicare among the public and politicians suggests that payment reform will not encroach on the choice that option provides. In addition, traditional Medicare operates as an important constraint on cost increases in alternative models. Most obviously, the benchmarks for MA plans and ACOs limit the ability of dominant hospitals and physician groups to exercise their market power vis-a-vis Medicare. In markets with limited provider competition, the availability of traditional Medicare may also encourage somewhat more competitive bidding from MA plans and cost control from ACOs due to the freedom of choice afforded to beneficiaries by traditional Medicare. Further, MA plans' contract prices with hospitals are strongly influenced by FFS Medicare pricing. A MedPAC study demonstrated that MA plans pay hospitals the same, significantly discounted rates that FFS Medicare pays.<sup>70</sup> Hospitals have no alternative, higher paying alternatives because FFS rates are administratively determined, and regulations prohibit them from charging out of network rates for emergency services.

### III. Conclusion

The trajectory of the three payment models is anyone's guess. Some hazard predictions that all ACOs will eventually morph into MA plans; others suggest that MA plans cannot best traditional Medicare on cost, so in the absence of overly generous benchmarks, Medicare managed care will flounder; still others see payment reform of FFS Medicare inevitably pushing providers to integrate and eventually migrating to ACOs or MA plans. MedPAC's proposal to avoid subsidizing any model appropriately backs away from an explicit endorsement of any one model. However, its aspiration that regulators and Congress will endorse a truly level playing field is likely to be frustrated given the powerful norms that have driven Medicare policy in the past.

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<sup>68</sup> Center for Medicare & Medicaid Services, Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,806-961 (Nov. 2, 2011).

<sup>69</sup> Thomas L. Greaney, *Regulators as Market Makers: Accountable Care Organizations and Competition Policy*, 47 AZ. ST. L. J. 1 (2013).

<sup>70</sup> *Transcript of Medicare Payment Advisory Commission Public Meeting*, MEDICARE PAYMENT ADVISORY COMMISSION 93-94 (Nov. 1, 2014), <http://www.medpac.gov/documents/november-2012-meeting-transcript.pdf>.