

Local Fee-for-Service Medicare Spending Should Not be Used to Set MA Payments

Some in Congress have focused on the differences between Medicare Advantage (MA) and traditional fee-for-service (FFS) Medicare spending to claim that MA plans are “overpaid” and should be cut. Comparing traditional Medicare to MA is an “apples to oranges” comparison because it overlooks the geographic inequities in FFS Medicare and ignores the additional value – improved benefits, care coordination, quality improvement – that MA plans offer.

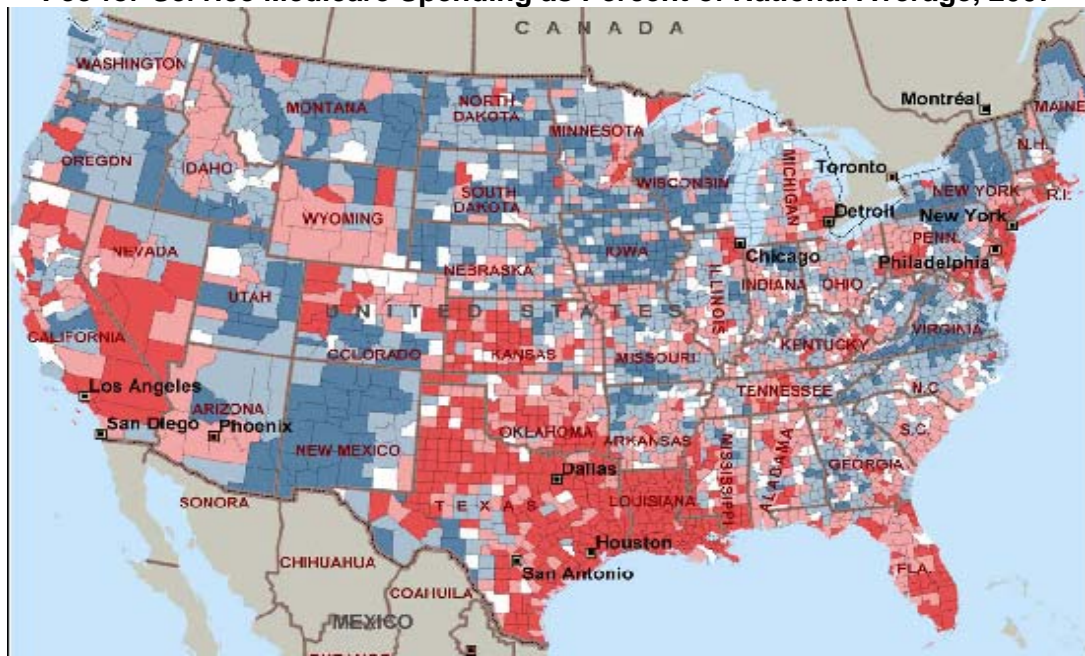
Issue: Local (county-level) FFS Medicare spending is an inappropriate benchmark for MA payments because it does not reflect actual plan costs. Basing MA rates at 100% of local FFS spending would translate into very different benefit packages and premiums for beneficiaries across the country. Local FFS spending is not an appropriate benchmark because:

- *Local FFS Medicare spending has large geographic variation across the country;*
- *Neighboring counties can have wide differences in Medicare spending; and*
- *FFS spending can have significant year-to-year swings in an area.*

Local FFS Medicare spending varies enormously across the country even though the FFS Medicare program is purchasing an identical benefit package everywhere. Basing MA payments on local FFS costs disadvantages low-cost areas. Beneficiaries in areas with low FFS spending, such as Iowa, Montana, Oregon, Western New York, Washington and New Mexico, would be particularly disadvantaged if MA payments were based on FFS costs.

- Even though the FFS Medicare benefit is identical for all beneficiaries, Medicare spends \$12,600 per beneficiary in Manassas, VA compared to only \$5,300 in Wibaux, Montana.¹
 - Medicare spends less than \$3,200 a year per beneficiary in Puerto Rico – one quarter of the highest cost areas.
 - Nationally, county-level FFS spending ranges from 68% above the national average to 30% below the national average.

Fee-for-Service Medicare Spending as Percent of National Average, 2007



■ 70-89% ■ 90-98% ■ 99-101% ■ 102-110% ■ 111-168%

¹ Analysis of CMS estimates of 2007 county-level FFS costs.

Neighboring counties can have wide differences in Medicare spending. Basing MA benchmarks on local FFS spending would lead to greater variation in benefit packages with very different premiums for neighboring beneficiaries.

- Traditional Medicare spends \$10,000 a year per beneficiary in Culberson, TX but only \$5,700 a year for a beneficiary in neighboring Loving, TX.
- FFS Medicare spends \$600 more per beneficiary in Nassau County than in Suffolk; both on Long Island, NY. Basing MA payments on county-level spending results in higher premiums for residents of Suffolk because of lower benchmarks; even though the MA delivery system is similar in both counties.

FFS Medicare spending can have significant year-to-year variation. Changes in enrollment and beneficiary health status can cause wide variation in year-to-year Medicare spending.

- Loving, TX demonstrates the extreme volatility of year-to-year changes in FFS spending. With a small number of beneficiaries, per capita spending increased 213% in 2003, dropped 43% in 2004 and increased by an enormous 237% in 2005².
- Gilpin, Colorado is another example of variation in local FFS spending. Medicare spending increased 85% in 2003, decreased 23% in 2004 and then increased by 45% in 2005.

FFS Medicare vs. Medicare Advantage is an “apples to oranges” comparison because they are very different programs.

- MA is a comprehensive benefit package that provides coordinated care, disease management and predictable cost sharing as well as quality reporting and improvement. Traditional Medicare, as a claims payment mechanism, does little to coordinate care for beneficiaries and does not require universal quality reporting.

FFS Medicare underpays providers in many areas, shifting costs to private plans.

- MedPAC found that Medicare pays less compared to private payers. MedPAC found that 2006 Medicare rates for physician services were only 81.3% of private insurer rates³. The underpayment may be particularly large in areas of the country with low FFS spending. An analysis in Washington State found that hospital cost-shifting from Medicare and Medicaid added \$490 to the annual cost of a private insurance policy in 2004 (Milliman, 2006).

There are many reasons for large variation in Medicare spending; some of which include:

- *Physician practice patterns.* While there may be some consistency on how to perform most medical procedures, there is substantial variation in practice patterns. For example, Medicare patients living in Nebraska undergo knee replacements at twice the rate of those in Rhode Island (10 in 1,000 vs. 5 in 1,000 respectively).⁴
- *Geography and provider supply.* There are also regional differences in both access and patient health seeking behavior due to geography. In rural areas where there is reduced access to providers, beneficiaries may seek less care.
- *Population size.* Some counties have so few Medicare beneficiaries that a change in health status of one or a few of them can skew Medicare spending in either direction. Loving, Texas, for example, has only 20 Medicare beneficiaries. A single person developing a serious illness such as congestive heart failure in a low population county can cause FFS spending to rise even when costs are averaged across multiple years.
- *Weather.* In areas of the country with longer seasons of bad and inclement weather, beneficiaries are less likely to seek optional care in times of bad weather.

² Analysis of CMS FFS claims data

³ MedPAC, Report to Congress, “Medicare Payment Policy” March 2008

⁴ Saul, Stephanie, “Need a Knee Replaced? Check Your ZIP Code,” NY Times, June 7, 2007