MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, December 4, 2003
10:13 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
NANCY-ANN DePARLE
DAVID F. DURENBERGER
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Medicare+Choice payment policy
-- Scott Harrison, Dan Zabinski, Karen Milgate

MR. DURENBERGER: Scott, before you begin, would you just clarify for me, when you use the phrases in the beginning, private plans and delivery systems provide -- I'm just unclear exactly how that reads. Just so I don't have to ask it later on. You talk about doctors, hospitals, blah, blah, blah, all that sort of thing.

DR. HARRISON: You mean what the delivery system is?

MR. DURENBERGER: What are we talking about when we say --

MR. HACKBARTH: Where are you looking Dave, so we can all get on the same page?

MR. DURENBERGER: In just the basic language. He uses the language private plans provide delivery systems and I just need to understand what it is. It's probably so obvious...

* DR. HARRISON: That would include networks, care coordination, whatever techniques they're using to have care delivered that might be different than the fee-for-service.

MedPAC has a long history of supporting private plans in the Medicare program. The Commission strongly believes that beneficiaries should be given the choice of delivery systems that private plans can provide. Private plan, through financial incentives, care coordination, and other management techniques, have the potential to improve the efficiency and quality of health care services delivered to Medicare beneficiaries.

The current incarnation of privatize plans is the Medicare+Choice program. The Medicare+Choice program has provided the majority of Medicare beneficiaries a choice of delivery systems and MedPAC has supported that choice and pushed for the choice to be financially neutral to the Medicare fee-for-service program.

Congress has just passed legislation establishing a new Medicare Advantage program, however much of that program will be based on M+C plans. M+C plans will become known as Medicare Advantage and many of the same issues we have been addressing will continue to need addressing.

The reform bill has given MedPAC several mandated studies involving broad issues surrounding Medicare Advantage plans, including a study due in 18 months that will give us the opportunity to examine financial neutrality and payment area issues.

For the short run, including our work today, we are focusing on issues that are important for the current program as it transitions to the new program. And these issues, however,

will also be important for the long run.

Dan and I will present three draft recommendations today. The first two arise from the new risk adjustment system that will be implemented in January. MedPAC has stated many times that risk adjustment is crucial if we are to pay private risk bearing plans properly. This would include not only M+C plans but also drug plans and Medicare Advantage plans.

Risk adjustment can be used to help create financially neutral choices. CMS has made a choice in implementing the new risk adjustment system that has the effect of moving away from financial neutrality. And the first draft recommendation would have CMS reverse its decision.

The new risk adjustment system also presents an opportunity to expand plan choice to ESRD beneficiaries. And the second draft recommendation would take advantage of that opportunity.

The final draft recommendation reflects an extension of the Commission's analysis of using payment incentives to improve the quality of plan services. I will present that draft recommendation after Dan has finished presenting the first two.

DR. ZABINSKI: An important change facing plans in 2004 is that CMS will begin using a new system for risk adjusting their payments. A little bit of background on this thing is that the Agency has named the new risk adjuster the CMS-HCC. And this model measures an enrollee's risk, that is their expected costliness, using the demographics and conditions diagnosed during inpatient, outpatient, and physician encounters in the previous year. This model should be an improvement over the current risk adjuster, which uses only diagnosis from inpatient stays to evaluate enrollee's risks.

Probably the most important attribute of this new risk adjuster is it has the potential to substantially affect payments.

Today I'm going to focus on two key developments regarding the new risk adjustment system. The first key development is that in 2004 CMS will make proportional increases to all payments adjusted by the CMS-HCC. The purpose is to offset reduced payments that would otherwise occur under the CMS-HCC to make them budget neutral with a demographic adjuster that CMS currently uses in setting M+C payments.

Some argue that this policy is necessary to help stabilize Medicare+Choice and prevent plan withdrawals.

A second key development regarding the new risk adjustment system is that CMS has created a version of the CMS-HCC designed specifically to adjust payments for ESRD beneficiaries. These beneficiaries are currently barred from enrolling in Medicare+Choice, in part because the method currently used to risk adjust payments performed quite poorly.

But the new risk adjuster should do much better.

Over our next four slides, we present issues related to these two developments I just discussed and two related draft recommendations. First, I'll discuss concerns over CMS's decision to proportionally increase risk adjusted payments in 2004. Previously, the Commission has recommended that M+C payments should be risk adjusted and that payments should be financially neutral between the Medicare+Choice and traditional Medicare sectors.

And just to refresh your memory, financial neutrality means that on average payments should be equal in Medicare+Choice and traditional Medicare after accounting for differences in risk.

It's the job of risk adjustment to account for those differences in risk and put the M+C and fee-for-service sectors on a level playing field in terms of risk differences. But CMS's decision to proportionally increase risk adjustment payments in 2004 will have the adverse effect of moving us away from the concept of a level playing field and financial neutrality.

Another concern over CMS's decision to proportionally increase risk adjusted payments is that CMS may have overestimated how much the CMS-HCC will actually reduce payments. This is because the data that CMS used to estimate the impact of the CMS-HCC on payments came from a time when payments depended little on how providers in Medicare+Choice code enrollee's conditions. Consequently, providers may have under-reported conditions, making enrollees look healthier than they actually are. But providers will likely be more diligent when coding conditions --

MS. ROSENBLATT: Dan can I ask a clarifying question on that? That third billet, CMS may have overestimated, if I were to ask somebody at CMS why they did that, would this be their answer or are you guessing that this is their answer?

DR. HARRISON: Are you asking why they overestimated?

MS. ROSENBLATT: Why they're making the adjustment, the 4.9 percent? If I were to go to somebody at CMS and say why are you making the 4.9 percent adjustment, what would their answer be?

DR. ZABINSKI: I would say that it's to help stabilize the program. That's in their notice last March and they had the 45-day notice and then the final notice last spring. And that was in the notice, that the purpose was to stabilize the program.

MR. HACKBARTH: That's what I've heard personally from people in the administration as to why they think this is important.

DR. ROWE: [off microphone.] Because of this reason that the doctors or the hospitals in Medicare+Choice --

DR. REISCHAUER: No, it's that if they took the 4.9 percent

out of the system plans would drop out.

DR. ROWE: Can I ask you, just to clarify, what exactly -- on page five you say they want to put 4.9 percent in to make it budget neutral. Right? You said in 2004 CMS will increase the risk adjusted payments by -- and then the actual number is 4.9 percent -- to make them budget neutral with the demographic adjuster, right? That's what it says.

Now this one says increasing the risk adjusted payment moves us away from financial neutrality because you think it's too much. You think it's too much or you think that adjustment shouldn't be made at all because the adjustment theoretically moves us away -- I'm trying to figure out whether we're against any adjustment because it's inconsistent with the principle, or you think the numbers too big?

MR. HACKBARTH: They're two different benchmarks. One, when the administration, when CMS refers to budget neutrality, they're comparing the payments under the new system to what would have been spent under the old demographic system. So it's budget neutral relative to that. Plans get paid the same amount as they would have before --

DR. ROWE: [off microphone.] That's budget neutral longitudinally.

MR. HACKBARTH: The other reference point is are we paying the same amount that traditional fee-for-service Medicare would have paid for the same patients? That's the financial neutrality that MedPAC has focused on in the past. So there are two different benchmarks.

So a system that is budget neutral relative to the demographic adjustment is not neutral relative to what fee-for-service Medicare would have paid. What we are finding is based on these new risk adjustment measures that the enrolled population in private plans is healthier than in fee-for-service Medicare and their payment should be falling as a result of improved risk adjustment.

MS. ROSENBLATT: Can I ask one more clarifying question? Was there any reason why -- we went from demographic to PIP -- whatever it was called -- to the new thing. Why do they go budget neutral to demographic instead of the PIP one?

DR. ZABINSKI: I don't know.

DR. HARRISON: Actually, in '03, this year, they actually went budget neutral to demographic using the PIP-DCG. So there's a little bit of money this year that was given back, like .6 percent, something like that, to get from the current 90/10 blend of PIP-DCG back down to the demographic. So they've done it two years, '03 and '04.

DR. MILLER: Just the conceptual response to the question is that they were trying to maintain the dollars that the plans

were currently getting? Is that a fair response? Under the old risk adjustment system. the new risk adjustment system would have pulled their --

MS. ROSENBLATT: That's what I'm asking. It sounds like it didn't go to the 90/10, it went back to demographic. Or am I not understanding it?

DR. HARRISON: That's right, it's going back to the demographic, which I guess we sort of consider to be the old system.

MS. ROSENBLATT: It's as though anything beyond demographic never happened.

DR. HARRISON: Yes.

DR. MILLER: This is more of a sidebar. The other reason that people will give for this is that there are differences of opinion about how the legislation is interpreted. When the law was written, there are some who argue that this was the intent of the law and some who argue that this was not the intent of the law. So you have that overlay just to make it a little more confusing.

MR. HACKBARTH: Of course, what we want to do is bypass what is the correct legal interpretation of the existing law and not get involved in that at all but simply discuss what we think the appropriate policy should be for the program.

DR. ROWE: [off microphone.] I guess at this point we're at the point where we're looking at the recommendation, so I'll hold my question until then. But I want to ask it before we get to dialysis.

MR. HACKBARTH: So why don't you proceed.

DR. ZABINSKI: Now because of these issues regarding CMS's policy to proportionally increase the risk adjusted payments, we have developed this draft recommendation, that CMS should not continue to adjust payments under the CMS-HCC to make them budget neutral with the current demographic adjuster. This demographic would have no impact on program spending nor would it have an effect on beneficiaries or providers. And this is because there has not been action to increase risk adjusted payments in any way in 2005, which is the time when this recommendation would first apply.

DR. ROWE: What's not clear to me, and maybe -- I was at risk for understanding it a minute ago in the conversation but I think I need more help.

Let's get to the neutrality question of M+C versus traditional, which is the second version of neutrality.

MR. HACKBARTH: [off microphone.] Right, and the one that we focus on.

DR. ROWE: Congress or somebody raised the payments in the so-called floor counties, right? That was sort of done. And

that was done for whatever policy reason, access, choice, whatever it was.

When we're now comparing the payments in M+C versus traditional for the relative morbidity or risk associated with the population, are we taking out that extra payment that was added to the floor counties, so we're comparing apples to apples? Or are we including those extra dollars that were put in those floor counties because that was a separate policy issue that was done for a separate reason? So it seems to me we should take that out and then see how much are the M+C plans getting paid for the same patient? Is that clear?

MR. HACKBARTH: Yes, it is clear.

Just to clarify that record, we opposed the floor payments, as well, because they violated the neutrality principle and we thought they would be ineffectual at any rate. Now there's a second question of neutrality.

DR. ROWE: [off microphone.] But isn't that influencing our calculation?

MR. HACKBARTH: The staff have consistently given us two numbers. One which is the overpayment that results from the floors and that stuff, and then a second that is the additional overpayment attributable to the approach to phasing in risk adjustment, the budget neutrality provision of risk adjustment. So why don't you tell us again what those two distinct numbers are?

DR. ZABINSKI: The overpayment from the floors, et cetera, as Scott has estimated, is that the average payment rate is about 3 percent higher than what the average fee-for-service beneficiary costs.

DR. ROWE: If you take that out, then what is it?

DR. ZABINSKI: Then it's zero. Well, it would reduce the base payment rates by 3 percent, on average, if you take that out. Basically, if you set all base payment rates equal to focal fee-for-service spending, then the average base payment rate would go down by 3 percent.

DR. ROWE: So what you're saying then is we're currently paying plans 103 percent, but if we correct for whatever the reason was, floor payment thing, we're actually paying out 100 percent of fee-for-service?

DR. ZABINSKI: Right.

DR. ROWE: Because that's an important --

DR. HARRISON: That's for a demographically similar population.

MR. HACKBARTH: That's assuming there aren't any selection issues. The increment that would be attributable to using the current budget neutrality approach, if it's done through the full phase-in, is an additional increment of 16 percent.

DR. HARRISON: Let me talk about that number for just a second. The way that number was arrived at, CMS did a simulation. They said okay, we're going to pay you under the demographic system. You get X dollars. We're going to take your same patients that we have the data for. We're going to run them through the new system and find out what we're going to pay you. And it turns out you'd get 16.3 percent less. That's where that number came from. That includes the floors, right. That includes what would happen changing this one risk adjuster. So that's where that number comes from.

It may not always be appropriate to add or multiply that with the other differences because we do have some mathematical issues, but that's generally where we are.

MS. THOMAS: I think it's also important to point out that that number could change based on what plans actually enroll and how thoroughly they code diagnoses. So it's an order of magnitude number, -- not an absolute number that we should be focusing on.

MS. ROSENBLATT: If I could just, I have a lot of problems with that number because I don't understand what you mean by simulation. It's a much different number. You know, I think we've all been thinking that the selection impact, ever since the Rand study was done, was sort of the range of 5 to 7 percent. And now all of a sudden we're looking at a number like 16 percent.

Whenever something like that jumps in my world, there's usually a data problem.

So I am very concerned, when I read the stuff for this meeting, I was really concerned about how often we used that 60 percent. Because I'm worried that it's not even an appropriate order of magnitude, given that we've all been thinking about 5 to 7 percent for years now.

DR. HARRISON: We think that's right. We think the number will probably will come down. But one of the dangers of the policy is that that number is locked in as an add-on.

MR. SMITH: The 4.9.

DR. HARRISON: Right.

DR. MILLER: Just to be clear, first of all we agree with you and we're trying to not repeat that number as much. And you're right about the materials, and we have had a lot of discussions ongoing while we're doing this work. Your point is well taken. That's a CMS number. We think that CMS may estimate it.

However, if the policy were to be rolled forward, even if your mix of patients change, there still would have been an estimated 16 percent add-on to the payment because that percentage was basically built in.

The other point I would make is 6 percent, 16 percent, forget the number. It's the principle that I think we're really trying to focus on here.

DR. ROWE: Let me see if I can --

MS. RAPHAEL: I just want to see if I understand the recommendation, because I'm not sure that I do. And I'm going to restate it and tell me if I have this right.

We're saying CMS should adjust payments under this new system, the CMS-HCC system. That's the first thing. We're in favor of that. What we're not in favor of is adjusting payments under that system to make them budget neutral with the current system, which is based on demographic adjuster. Is that it?

DR. ZABINSKI: That's it.

DR. ROWE: Just to get the language straight, on page three, let me just read the first statement we have, because maybe not everybody is quite as into this is you guys, and then we'll read this statement. Page three.

Three draft recommendations. Number one, risk adjustment should support principle of financial neutrality. That's what it says. Recommendation: CMS should not continue to adjust payments -- dah, dah, dah -- to make them budget neutral with the current demographic adjuster.

I would suggest that unless you're really a cognoscenti, it does appear that those two statements are conflicting.

DR. MILLER: We will work on the words. That's fair.

MR. HACKBARTH: [off microphone.] This is helpful. The wording is delicate and we need to do a better job.

DR. ROWE: So what you're saying is you're in favor of budget neutrality, but not this budget neutrality.

DR. ZABINSKI: No, we're in favor of financial neutrality but not budget neutrality.

DR. ROWE: Are we talking about amortization or capital expense? What do you mean financial but not budget?

MR. HACKBARTH: Maybe a way to express it, maybe, is that what we're opposed to is holding plans harmless against the effect of the new risk adjustment. We think the new risk adjustment is as a good thing to do and we ought to pay according to its results as according to base payments based on the old demographic system.

DR. NEWHOUSE: [off microphone.] Maybe we should say what we should do.

DR. REISCHAUER: But we're only holding plans in the aggregate harmless when what we want to do is if the application of risk adjustment leads to an aggregate savings, that should rebound to the benefit of the program and not to the Medicare Advantage subset.

DR. ROWE: So are we talking about having the same amount

of money for the plans and redistributing them around the plans by virtue of some measure of the risk? Or are we talking about reducing the amount of money we would prefer, reduce the amount of money in the plans to make it more relevant to what's going on on the other side?

DR. NEWHOUSE: We're in favor of two.

DR. REISCHAUER: Number one is the policy.

DR. ROWE: And number one is the policy, right.

So we should change this language to say that?

DR. MILLER: We will redraft it.

DR. ROWE: And tell me about the difference between revenue and budget?

DR. ZABINSKI: We've made this financial neutrality recommendation a few years ago. Basically you want to pay the same for a beneficiary whether they're in fee-for-service or Medicare+Choice. In order to do that you need to risk adjust them properly. That's financial neutrality.

What the budget neutrality adjustment does is you initially risk adjust it and then you add an additional payment on top of it to make it budget neutral. So you're no longer going to be paying an equal amount in fee-for-service as in Medicare+Choice. You're going to be paying more in Medicare+Choice for that person.

DR. ROWE: [off microphone.] So you're mitigating the effect of the risk adjustment in this case because it turns out they're less risky. If the people in M+C were more risky, then they'd be getting more.

MR. SMITH: [off microphone.] Think of it as payment neutrality rather than budget neutrality.

DR. ROWE: [off microphone.] Right, but I think not everybody is going to understand the difference.

DR. ZABINSKI: I think this budget neutrality term has been unfortunate, but that's been the one that's been sort of used by the CMS.

MR. SMITH: Let me come back to Alice's question for a minute.

If the 16.3 is wrong, and we say in the text that it is wrong. We don't know what the right number is, but we know that it's wrong. But the 4.9 is law. So the closer the 16.3, Alice, gets to five or six or seven, the more distorting the 4.9 will be.

Of right number is say 7.3 percent instead of 16.3 percent. we are going to compensate the plans at a level that assumes that the 16.3 percent is the right number to reflect the healthier population in the plans. So the closer the number comes to your expectation, the more distorting the 4.9 percent gets.

MR. HACKBARTH: That's part of the problem, is locking into this number as the right number for the phase-in.

MS. ROSENBLATT: My concern is that somebody is going to read the way this is written now -- and I'm glad to hear it's going to change -- and say oh my god, plans are being overpaid by the 16 plus the three. There will be an assumption that plans are being overpaid by 19 percent. And I just look at reality that says a lot of plans have been withdrawing. If they were being overpaid by 19 percent, trust me, nobody would have withdrawn.

MR. HACKBARTH: That raises another issue that is still another source of confusion. Again, our consistent benchmark about appropriate payment is what would have been spent for the same patients under traditional fee-for-service. That is our guiding star in all of our recommendations in this area since I've been on the Commission.

That does not meet that the payments are adequate to cover the plans' costs or the plans are reaping large profits. That's a completely different issue that has to do with the cost structure of plans. In fact, having been in this world and worked for a plan trying to do this, I know what a disadvantage it is to have higher administrative costs, the marketing costs, and in the case of for-profit plans taxes and the like. So you're behind before you even start in this game.

So the plans' cost structure is a completely separate discussion that we've not taken up. We're talking talk about how payments compare to fee-for-service Medicare.

MS. ROSENBLATT: I agree with that and that was going to be the second part of my comment, Glenn, because there's an example in the paper that uses $100 and $84. And I think that example clouds that issue that you just bought up. I think it really makes it looks like the $100 is an adequate number and it's not.

MR. HACKBARTH: I think that's a good suggestion. In fact, it's something that Jack and I talked about on the phone. As we write this material, we need to draw out this distinction and address the issue of paying costs, not empirically try to measure it but just say that's a conceptually different issue and plans may have higher costs in some respects.

DR. ROWE: I had three things that I wanted to try to put into the conversation or the discussion part of the paper anyway, that I think address this and give people a fuller feeling for it. One of them is these inherent costs associated -- it's just a different design. That's fine. This is a voluntary program. Plans don't want to participant, they don't have to, as we've seen.

Secondly, is the assumption that the benefit package is the same. It's kind of an assumption, you're either getting this

benefit in M+C versus you're getting it in traditional. And the fact is that there are benefits in M+C that are not in traditional, preventive benefits, other kinds of disease management programs, et cetera. So we should at least recognize that.

The third is the payment from the point of view of the beneficiary because we're always comparing M+C to traditional but, in fact, in the real world it's M+C versus traditional plus Medigap because the beneficiary is paying the Medigap premium. Now a lot of those Medigap programs may disappear overnight with the pharmacy benefit, the expensive ones with the pharmacy benefit are probably not going to be --

DR. NEWHOUSE: [off microphone.] Only 8 percent of them have a drug benefit.

DR. ROWE: So I think that if you add those three things in the benefit may not be exactly the same because it's saying it's the same cost for the Medicare program kind of assumes that you're buying the same product at the same cost in these two pathways. And the plans would say well, we're not really giving the same product. We're giving a different product.

So if we throw that in, I think it enriches wherever we come out in the recommendation. It at least gives it a more fulsome discussion than that example, which I think doesn't do that.

DR. REISCHAUER: But the payment that the government is making is for a similar package of benefits. It's true that Medicare+Choice plans have a fuller package of benefits, and that's fine and that's good, but with respect to the calculations that Scott's doing, it's not relevant.

MR. SMITH: Scot, let me just check my arithmetic for a moment.

Given the MedPAC financial neutrality principle and the implications of the new legislation, is it right to say that in a floor county payments subsequent to the implementation of the legislation would be 7.9 percent higher than the financial neutrality principle would dictate? Can you add the three and the 4.9 together?

DR. HARRISON: Not exactly.

MR. HACKBARTH: Arithmetic in public is like making sausage in public, it's not a good thing.

DR. HARRISON: We've tried to do that because people keeping asking us to do that and I think we should stop because you really need to rebase things. These things are all based off of relative weights and everything. And when you throw different mixes of people from different counties in, things get very messy. The actuaries have to look at this stuff and when they redo things they need to think about the stuff, but it's

not as simple as just adding them.

MR. HACKBARTH: We need to quickly get to a conclusion here. Have we fully discussed recommendation one? I think so. Let's move on to recommendation two.

DR. ZABINSKI: Next I'd like to return to an issue I mentioned earlier, that ESRD beneficiaries currently are barred from enrolling in Medicare+Choice. The staff have identified three factors that support the notion of changing that policy and allowing ESRD beneficiaries full opportunity to enroll in private plans.

First, the new risk adjuster will pay plans more accurately for ESRD beneficiaries. Second, results from a demonstration program indicate that ESRD beneficiaries receive equal or better treatment in manage care. And finally, equity in Medicare+Choice requires that all beneficiaries should have full access to managed care settings.

That leads to this recommendation, that the Congress should allow beneficiaries with end-stage renal disease to enroll in private plans. This draft recommendation would have no spending impacts, but it might have a positive impact on ESRD beneficiaries who may get better coordinated care in managed care settings. Also, there would be do impact on providers except that dialysis providers would have to negotiate rates with private plans, rather than simply accepting Medicare payment rates.

MR. HACKBARTH: Comments or questions?

DR. NEWHOUSE: I'm in favor of this recommendation but I'm wondering if a skeptic might say if we observed the same selection we did in M+C, wouldn't this raise what the government was paying downstream if rates got based on fee-for-service? I'm going to the spending implications again.

DR. HARRISON: But this risk adjuster that we're using a specifically designed for ESRD beneficiaries with dialysis. They actually put them in a separate pool and estimated the model.

DR. NEWHOUSE: As I say, I'm fine with the recommendation but I think you have to then bring out that you're banking on risk adjustment to keep the spending implications at none. on.

DR. ZABINSKI: I want to fully understood understand what you're saying. Are you saying that even if we have this full risk adjuster, it might not do a perfect job?

MR. HACKBARTH: Within this class of patients there might be selection?

DR. NEWHOUSE: I'm not sure anybody else thinks HCC is the perfect risk adjuster and I would guess that you don't think the ESRD adjuster is the perfect risk adjuster.

MR. HACKBARTH: So within this class of patients with ESRD,

there may be selection with the healthier ones --

DR. NEWHOUSE: It's awfully strong to say there won't be.

MR. HACKBARTH: But I'm just trying to understand your point. And to the extent that there's selection within this category, there could be an increase --

DR. NEWHOUSE: We've got the composite rate where it is, but then what this would do, when we look at those payment-to-cost ratios that we looked at in the earlier section downstream, they would be headed down if there is selection against the traditional program and there would be pressure to raise that rate. That's the only point I'm...

DR. HARRISON: Joe, are you suggesting that we want to add something about it needs to be rebased now and then? Would that help?

DR. NEWHOUSE: I haven't thought that far ahead but maybe I would just add at this point that it's important that risk adjustment be implemented as part of this.

MR. HACKBARTH: Yes, acknowledge that in the accompanying text.

DR. REISCHAUER: Under undercurrent law, ESRD patients aren't allowed to sign up once they've been diagnosed. My understanding is if they develop symptoms while they're enrolled in a Medicare+Choice plans they can stay in a Medicare+Choice plans.

DR. ZABINSKI: Right.

DR. REISCHAUER: Which means that suddenly we'll be paying them, under this system, more. So by definition -- no?

DR. HARRISON: They're currently paid a state-wide average for ESRD beneficiaries.

DR. REISCHAUER: So we already adjust it?

DR. HARRISON: We already do pay for ESRD beneficiaries in plans but it's a state-wide rate, one state-wide rate.

DR. ZABINSKI: And it's not risk adjusted in any way.

DR. REISCHAUER: It's not a lot of people, I know that. And probably many of them switch out, if they were rolled. But I think we should mention in the chapter anyway what the current situation is.

The second thing is, not to tie this with the previous discussion we had, but we also, if we're going to go into a long discussion of paying for quality for dialysis patients, we might suggest that this would also apply to these plans.

DR. NEWHOUSE: That's our recommendation three.

MR. HACKBARTH: No, he's talking about plans that provide or take responsibly for dialysis care.

DR. NEWHOUSE: [off microphone.] That's sort of a subset.

DR. REISCHAUER: Right.

DR. ROWE: [off microphone.] As long as the things that

you're evaluating them on are things under their control.

DR. REISCHAUER: Same deal as the fee-for-service.

DR. NELSON: Do I understand right then, the end-stage renal disease patients enrolled in private plans would take with them the composite rate, the same reimbursement formula as they currently take to a dialysis unit? No?

DR. ZABINSKI: No.

DR. NELSON: I understand the risk adjustment. What accommodates the additional facility costs and all that kind of stuff that goes with an end-stage patient?

MR. HACKBARTH: It's a capitated rate.

DR. NELSON: And would be set by risk adjustment to take care of the facilities --

MR. HACKBARTH: It reflects the underlying Medicare payment structure and says Medicare costs like this for these patients with this category. And so there's an added -- as we've measured it -- an added increment of costs associated with this payment category. So then you take the base private plan rates, whatever they are, whatever they were calculated, and say you get a bump up of this amount for dialysis patients.

DR. NELSON: Thank you.

MR. HACKBARTH: Next recommendation?

DR. HARRISON: In our June report, the Commission supported tying financial incentives to quality for providers and plans. In that report we developed criteria for successful implementation of a financial incentive program. As we noted back in that June chapter, Medicare+Choice plans meet those criteria and this is really what Nancy had up.

Evidence-based measures are available. M+C plans already collect data that can be used to assess quality and not cause any added burden to the plans. Plans annually collect audited HEDIS data on process measures such as whether patients receive certain preventive screenings and some outcome measures, such as hemoglobin levels for diabetics and cholesterol control after an acute cardiovascular event.

In addition, plans participate annually in the Consumer Assessment of Health Plans Survey, known as CAHPS. The CAHPS data reflect health plan members assessments of the care they receive, their personal doctor and specialists, the plan's customer service, and whether they get the care they need in a timely fashion. While HEDIS and CAHPS scores have been improving, there are still plenty of room in the measures for further improvement.

You just really went over all this in the ESRD talk.

MR. HACKBARTH: As opposed to going over the same terrain, are there unique issues? Different issues raised by payments for quality in the area of private plans that we didn't touch on

in our ESRD discussion?

DR. NEWHOUSE: I wonder what we mean in the context of PPO plan, where the traditional issue has been we can't control things. I just raise it as a question.

DR. HARRISON: I believe the PPOs plans report most of the same HEDIS and CAHPS data. There may be a couple of exceptions in the HEDIS data.

DR. NEWHOUSE: So what the PPO plan, what we would want them to do would be to contract, limit their network in some fashion to providers that performed well on the HEDIS measures? Isn't that their only real instrument?

DR. HARRISON: Think it is as financial incentives or other ways of managing care.

MR. HACKBARTH: Currently aren't PPOs treated differently, in terms of expectations for quality improvement than the coordinated care plans?

DR. HARRISON: I believe they are different for quality improvement.

MR. HACKBARTH: I'm pretty sure that's true.

MS. MILGATE: The difference, as Scott said, is actually fairly minor, in terms of the HEDIS reporting. They have some exceptions for data that would need to come from medical records, for example, but there are a lot of HEDIS measures that are administrative data that they do report on. So there's some minor exceptions in reporting. And then the current M+C requirements also don't require them to show sustained quality improvement on the national project, which is something that the other plans have to show, the coordinated plans.

DR. NEWHOUSE: That's what I was thinking of but I thought that was because the PPO plans argued they didn't have the same degree of control.

MS. MILGATE: It was actually -- yes, that was a piece of it for the quality improvement exemption. But CMS still felt like it was possible for them to improve on some of the measures in HEDIS and it has caused some improvement in the HEDIS measures that the PPOs report on. And there are other ways that PPOs can do it other than limiting networks, that some of them have used. Like directly to the consumer to get a mammography, for example, or some other method. But it is a reasonable point that there are some differences between HMOs and PPOs.

MS. ROSENBLATT: Two things. One, to add to what Joe said, is private fee-for-service within this recommendation?

DR. HARRISON: Private fee-for-service, I believe, is still exempt from reporting and they're exempt from a few other things, too.

MS. ROSENBLATT: Say you're exempting it from here?

DR. HARRISON: I guess, at this point we would have to,

unless the law changes. I guess that's something for discussion. What would we want to do?

MR. HACKBARTH: I don't think we can hide behind what the law says. We're about recommending what the law should be. This different type of plan issue is just maddeningly complex. It's almost metaphysical, because we have these legalistic definitions of what organizations are, but in fact it's a real continuum and there are not clear lines distinguishing one from the other.

The conceptual distinction that exists in my mind, but it's not embodied in low, is some types of plans basically reflect a choice by the beneficiary to say I don't want somebody else making decisions for me about which provider I go to. I don't want somebody interfering in my physician/patient relationship. I'm a choice advocate.

And if that's the sort of arrangement we're talking about, as in the case of private fee-for-service, then holding them accountable for improvement and intervening is contrary to what the product exists for. It's contrary to the very purpose of it.

Whereas somebody that enrolls in a closed system has elected I'm going for a plan that's going to intervene in the provision of care on my behalf, and holding them accountable for how well they do that is entirely legitimate.

So that's the broad distinction that I think exists. But legalistically it isn't easy to put everybody into those two categories for purposes of incentive payment or mandates about quality reporting and improvement. So it's a sticky wicket.

MS. ROSENBLATT: I have one other issue that we sort of touched on when we were talking about the ESRD, which is where does the money come from for whatever we do on the incentive rate? Are you taking away or is it an add-on?

When health plans generally add a quality incentive, it's generally an add-on to what they are already paying providers. And if, for example, Wellpoint were to make a decision to pay a quality incentive, the minute we made that decision we'd have to put up a reserve for that and that money would be there.

My concern with the way the budget works is that it's not like there is a fund and the money is there. I just can't picture that and I'm just wondering if we need to address that.

DR. HARRISON: I think that's also a decision up for discussion.

DR. WOLTER: Glenn, I was just going to make the point you did, and it might be worth reflecting that in he body of the conversation, that there are some distinctions going on with these different types of plans in terms of the market forces that are driving choice, versus a plan that really is -- maybe

the expectation is out there that it will try to do more to coordinate care.

And then I would also say that we might want to recognize the fact that, at least as I look at some of what's happening in quality right now, much of the emphasis is on process measures of intervention which aren't captured by claims data. Many of the things you mentioned are. Some, such as the amount of time it takes for an antibiotic to be given when somebody's admitted with pneumonia, or is an antibiotic given within one hour of surgery, many of those data elements would not be well captured in administrative claims data.

And yet, they are becoming the focus some of our leaders in the quality movement in some of the areas where we can really improve quality outcomes and maybe improve cost at the same time.

So I don't know whether we want to get to that level of detail, but I think these are important distinctions and probably would be part of our discussion tomorrow on the quality chapter.

MR. HACKBARTH: Could you just briefly address, Scott, the data collection mechanism for the HEDIS measures? It isn't dependent or based exclusively on claims data.

DR. WOLTER: I assume plans could require other things, also.

DR. HARRISON: I don't believe -- I believe it's a survey that's often done.

MS. MILGATE: HEDIS is a mix of administrative data and medical record extraction. The two primary reporting tools are HEDIS and CAHPS. And CAHPS, of course, is a survey. And that goes to both PPOs and HMOs. I don't know actually if it's private fee-for-service, to tell you the truth. But it definitely goes to PPOs and HMOs. And then Medicare fee-for-service outside of Medicare+Choice.

HEDIS is a mix of administrative data as well as medical record abstraction. CMS just recently, for the last few years, have been doing an analysis of the parts of HEDIS that, in fact, don't work very well for PPOs. There were a few, and I'm not going to be able to tell you how many out of how many measures. But it was a fairly -- it wasn't more than maybe 10 percent of the measures that they didn't think PPOs should have to collect data on. And those were the ones that were medical record abstraction.

And those data go -- let's see, I'm thinking they go to NCQA. I'm not sure if they go directly to CMS or NCQA, but there's an audit process, is basically what I'm trying to get at. Maybe, Nancy-Ann, you could even fill us in.

But there's an audit process to make sure that those data

that are reported by the plan are accurate and that's an independent audit, and then the data become CMS data.

MR. HACKBARTH: That was the point that I wanted to get to. We're not talking about using claims data or administrative data exclusively. There are clinical data involved but there is an audit process in place, which I don't understand, but that there is one in place.

MS. MILGATE: I don't really know the details of it but I know that the CMS actually certifies --

MR. HACKBARTH: It's a pertinent question because here now we're talking about potentially adjusting payments based on data submitted by plans. And ordinarily we like the comfort of having some sort of a potential audit check on that accuracy.

MS. DePARLE: I do know something about that. When we first started collecting it in '97, we couldn't use it because we did an audit and it had not been audited before and it was pretty uniformly incorrect in the plan's favor. So we decided we couldn't report that data. So we went through a process with NCQA and the next year we had an independent audit.

And I don't even remember who the firm was that was being used. It doesn't matter, and they may use a different one now. But I think it's an important thing.

And the plans are very corporate in that process.

DR. REISCHAUER: I think NCQA now has an audit process, number one.

Number two, the Medicare+Choice HEDIS panel doesn't include all the questions that private plans. So it's a pretty truncated subset of the information that NCQA collects for just commercial plans.

DR. WOLTER: I'm wondering if it would be a reasonable request to get to some kind of a summary of what is collected in the combo of those two things? Or is it so voluminous it would be difficult to do?

MR. HACKBARTH: Absolutely. I think that's important to have.

DR. REISCHAUER: It's apt to be on the website, too.

MR. HACKBARTH: Any other questions or comments?

DR. WAKEFIELD: Sorry, Glenn, I think somebody answered this, but the answer was lost on me.

Does draft recommendation three apply to private fee-for-service or not?

DR. HARRISON: That's up for discussion. What do you think?

DR. WAKEFIELD: So you haven't dealt it in or out in your preparation?

MR. HACKBARTH: Do you have a preference? And if so, why?

DR. WAKEFIELD: What would be helpful to me is a little bit

of a better understanding of how it could be applied to that particular animal. You were talking about choice. Of course, a lot of areas that have fee-for-service, maybe they have private fee-for-service. They may not have any other M+C available to them.

So when we think about quality, ensuring quality for that beneficiary set, even though we're seeing some retraction, but I think your document said that there are some new private fee-for-service plans that have requested review by CMS to enter the program.

So if that's the case and we see new plans coming on deck, is this recommendation going to be applying to that enlarging family or not of plans? I don't have a sense of it because I don't exactly know how it would apply to that type of plan.

MR. HACKBARTH: Let us spend some time thinking through the issues a little bit for the January meeting and we'll come back with some ideas on that.