MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, April 24, 2003
9:40 a.m.

COMMISSIONERS PRESENT:

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

AGENDA ITEM:
Comments on CMS's social HMO demonstration evaluation
-- Tim Greene, Scott Harrison

MR. GREENE: Good morning. I will be discussing developments in the long-running CMS demonstration of the social health maintenance organization.

The Commission is required to make recommendations on the future of the demonstration six months after CMS submits its final report on the demonstration. The CMS report was submitted to Congress on February 28th, so your report is due August 28th. This is the last scheduled public meeting that you're holding before the due date for the report.

I'll be discussing action by CMS dealing with the social HMO. Then I'll review key findings from the CMS evaluations of the demonstration. After discussing some principles you may wish to consider, I'll present two recommendations. I will conclude with a review of issues that arise in considering the social HMO that go beyond the scope of the current recommendations and report.

Briefly, what is the social HMO? We've discussed this before so I'll be brief. As you know, the S/HMO is a managed care model that seeks to integrate acute and long-term care. There are two types, one the first generation or S/HMO I model founded in the 1980s, which emphasizes case management. The second generation plan, established in 1996, that places an emphasis on geriatric care. All these plans are paid with an add-on payment 5.3 percent higher than county Medicare+Choice payment rates.

There are four plans in the country. They vary greatly in size. Though we talk about social HMOs as one entity, they're very different. The smallest, Kaiser in Portland, has 4,400 members and two others, SCAN in Long Beach and Health Plan in Nevada, each have almost 50,000 for a total of 113,000. The first three are the first generation plans founded in 1985 and HPN, the Nevada plan, is the sole second generation plan.

We turn now CMS actions, both originally and the more recent ones. The social HMO demonstration was started in 1985. CMS, then HCFA, followed up with an evaluation from 1985 through 1991 essentially, with results published in the early 1990s.

The BBA required the Secretary to submit two reports to Congress. The first was submitted in February, 2001. In included additional findings on the first generation plans and preliminary findings from the new evaluation by Mathematica Policy Research of the second generation plan. I'll be going over the evaluation findings in a moment.

The 2001 report recommended that the existing plans be converted to standard M+C plans and be paid under the same risk-adjustment approach used with M+C plans that had been introduced into M+C with a transition period.

The second report, sent to Congress this February, is the final evaluation report on the project. It does not include recommendations. It was always understood to be an evaluation

document and it was expected to involve recommendations.

However, in last month's annual notice of payment changes from Medicare+Choice, CMS proposed to bring S/HMOs on to risk-adjusted payment using the phase-in schedule that applies to all M+C plans. The notice proposed that the plans receive a special frailty adjustment in addition to the standard Medicare+Choice risk adjustment during the transition.

Over four years, the special S/HMO payment add-on would be gradually phased out. The frailty adjuster would be calculated at the plan level and would apply to all plan beneficiaries, and the payment adjustment would apply solely to the social HMOs had not to other M+C plans. I will now turn to the evaluation information.

The first evaluation found that the social HMO plans did not effectively integrate acute and long-term care. Coordination between case managers and physicians was particularly poorly developed. Since the final evaluation of the first generation plan, the Kaiser plan in Portland, the group model HMO had some success in integrating care. There was some evidence in the second evaluation that the second generation plans has successfully directed benefits to targeted members.

The first evaluation found mixed effects on service use with lower hospital use and higher nursing home use. And incidentally, the first evaluation was reflecting the health care system on the day of comparison with fee-for-service. The second evaluation compares the plan to M+C plans.

The final evaluation finds comparable results for the second generation plans. Measures of hospitalization show mixed and inconsistent results. For the overall plan population, though, there was noticeable effect on one very small subgroup. Too few enrollees were seen in long-term nursing facilities and it was impossible to evaluate an impact there, with is unfortunate because reduced nursing home use was one of the goals of the evaluation.

The plan has had mixed impacts on hospital use after the end of the CMS evaluation. Studies submitted by the S/HMOs to MedPAC found that in 1998 through 2000 discharges increased among beneficiaries enrolled in a network practice affiliated with the S/HMO, but decreased along members seen in S/HMO clinics. This suggests that a large part of the impact reflects the effect of a more tightly organized delivery system. And the findings are consistent with what was reported in the CMS evaluation.

The CMS evaluation also, the second evaluation provides a little information on the first generation plans. They went back and looked at CAHPS data on satisfaction and found that despite the fact that S/HMO plan members receive extra benefits, they were no more satisfied with their plan than were members of M+C plans.

As you may notice, many of these are service use input measures. The evaluation of the second generation plan was able to look at a number of outcome measures. That's what I'll focus on now.

The evaluation uses survey data on beneficiaries and other data and finds that there's no consistent impact on health

status, self-reported health status among plan members, with no consistent impact on physical, cognitive, emotional health and with the S/HMO performing better on some evaluation and the comparison M+C plan better on others.

In the overall sample there was no consistent impact on functional status. In 10 of 12 comparisons of activities of daily living, ADLs, there was no statistically significant difference between plan and comparison group than in 11 comparisons of IADLs. There was no consistent difference. There really does not appear to be a difference in impact on that important outcome measure in this frail population.

In general, the performance of the plan in delivering preventive services was good, better than fee-for-service, but comparable to an M+C plan, which suggests that the experience reflects often measured result with managed care plans doing better in prevention than fee-for-service but without distinct strengths or weaknesses among managed care plans.

The evaluation looked at treatment of specific chronic conditions and found mixed results, the S/HMO doing better in some, M+C plans better in others or no worse than others. The evaluators looked at potentially avoidable hospitalizations, which were taken to be indicators of -- the presence of an avoidable hospitalization was taken to be an indication of poor ambulatory care -- and found small mixed effects.

So on all of these outcome measures, we find modest --

DR. MILLER: Tim, I want to ask one thing. A lot of what went on here, for example in functional status, there would be something like 14 or 15 measures. There might be two in which the S/HMO populations did better on, one in which M+C populations did better on, and then the remainder, the 10 or 11 in which there was no statistical difference.

MR. GREENE: Right.

DR. MILLER: That was sort of the way things played inside the evaluation.

MR. GREENE: Absolutely.

MS. DePARLE: When you say no statistical difference, do you mean between M+C and S/HMO, not between that and fee-for-service.

MR. GREENE: No, the second generation is an M+C comparison, which is more appropriate in the current context.

MS. RAPHAEL: Tim, you said S/HMO I was compared to fee-for-service, but under satisfaction you say there's no difference versus M+C. Could you explain that?

MR. GREENE: That was the only new evaluation result from the just completed evaluation, that was applying to the S/HMO I. So the recent evaluation compares to M+C and that one finding on S/HMO I is from the recent evaluation.

DR. NELSON: Can I ask a quick question also related to the evaluation?

Tim, it was unclear to me whether, on page 11 and 12, where we have the bullets, that are prefaced by an analytic statement, whether or not that analytic statement was part of the bulleted paragraph or MPR's words, or CMS's interpretation, or our interpretation.

For example, on page 12, the third bullet says the S/HMO did

not consistently have lower rates of hospitalization for potentially avoidable, and so forth. And then becomes more precise and says that in 12 comparison with fee-for-service, S/HMO showed significantly lower rates in seven, higher in two, and no differences in three.

So the statement that sort of summarizes that, in a sense, represents a subjective analysis. And I want to know whether that analysis was ours or MPR's. It seems to me that if it's MPR's then we ought to state that. If it's our interpretation of those data, then that ought to be clear, too.

MR. GREENE: It's both. In some cases I'm restating MPR but the findings that they're summarizing are in front of me. I'm looking at it and looking at those comparisons and seeing -- what I'm here more likely calling small and mixed impacts, inconsistent, different signs, different magnitude in different samples.

DR. NELSON: Somebody is going to take objection with our characterization of the data on some of this, think. I'm willing to do that but I think we need to be able to defend it. It seems to me that if we're citing someone else's study, we ought to -- to the degree possible -- also cite their analytic conclusions on the data.

MR. GREENE: To distinguish, I think I'm reflecting their analytic conclusions, but if you want the association tighter, I can make that. But this is also my conclusion, as well.

DR. REISCHAUER: I don't, quite frankly, understand your point, Alan. The first sentence says does not have consistently lower. And to me, to have consistently lower, in all 12 cases it would have to be lower. And then just explain why it's not consistently lower, what the distribution looks like. That's a statement of fact, it's not a judgment by an analyst.

DR. NELSON: I guess it's a different way that your discipline would interpret that paragraph, as compared to mine.

DR. REISCHAUER: I forgot, you're part of an art, not a science.

[Laughter.]

DR. NELSON: I suspected if everybody agrees that that is true, but it sounds like seven out of 12 represents some level of evidence.

DR. REISCHAUER: Good enough for medicine?

DR. NELSON: Yes. If you need all 12 in order to make that kind of a statement, I guess that's true.

DR. NEWHOUSE: Actually, I think we're even giving the benefit of the doubt here because technically you should make a correction for multiple comparisons. Probably if you did that, two out of 12 would not be significant. So the idea being that if you look 12 times at random, you'll be more likely to find something significant at the 5 percent level than if you only look once.

MR. HACKBARTH: I have no problem with our staff drawing inferences from data. We do that regularly. It there's ambiguity about whether it's our conclusion or Mathematica's, I think that ought to be avoided. I think it ought to be consistent and clear, are we talking about our characterization

or theirs.

In any case, if I'm looking at the right place, in each case we actually cite the data afterwards. It's not like we're just making a subjective statement without then reporting the results. So let's just be consistent and clear about whose characterization this is. I personally can live with it either way. To me the important thing is the numbers that come afterwards anyhow.

Tim, do you want to pick up again with the presentation?

MR. GREENE: We turn now to several principles that you may wish to consider in preparing your recommendations. Medicare is a national program with a uniform benefit package for all beneficiaries. Extra benefits provided by the social HMOs are only available to a small number of beneficiaries in about a dozen counties in the country.

Second, certain plans should not be advantaged relative to other plans. The 5.3 percent add-on received by the social HMOs unfairly advantages them relative to others. We think this raises questions of equity across beneficiaries and across plans.

Second, we need to always remember the these plans are demonstrations. The federal government initiates demonstrations to identify promising techniques that then can be diffused elsewhere. The plans should be evaluated, at least in part, based on the effectiveness of the care they render.

Third, the Commission has previously recommended that the long-term capitation payments for frail beneficiaries should be based on their characteristics not on the type of plan in which they are enrolled. Or as we put it here, payment follows the person rather than being linked to the plan.

Our first recommendation addresses the S/HMOs and Medicare+Choice. It proposes that demonstration plans be converted to M+C plans. Under this recommendation, at the conclusion of the demonstration, on December 31st of this year, the end of this year, the Secretary would request that the existing four demonstration plans apply to participate in Medicare+Choice. They would become coordinated care plans in the M+C program.

When the existing plans become M+C plans after the end of the demo, they would not be required to continue to offer the expanded benefit package that they offer as demonstration plans. However, there would also no longer be a payment add-on, a 5.3 percent add-on, which was intended to compensate for the extra benefits.

The plans, as M+C plans, could of course continue to offer whatever benefits they wished, and could deal with the additional expense, if any, with savings elsewhere or with premiums charged to members.

During the transition, after the end of the demonstration, plans would be paid based entirely on CMS risk adjustment, M+C risk adjustment, with a frailty adjustment added on. As we understand the frailty adjustment, given existing data, it would have to be calculated at the plan level and it would then be applied to each beneficiary.

Under this, we're simply dealing with the period through

2007 when we foresee a frailty adjustment here as applying just to these former demonstration plans, not to M+C generally.

DR. MILLER: so just to summarize really quickly, the idea is they become like regular Medicare M+C plans, but for the period 2004 to 2007 they're paid 100 percent on a risk-adjusted basis plus the frailty adjuster. The notion being that that will track the kinds of populations that these plants are supposed to have. We note that the frailty adjuster is at the plan level and we're about to come to a recommendation that says in a perfect world, post-2007, that should be beneficiary-specific. But we recognize in the interim we get there.

DR. NEWHOUSE: Can you tell me what that means, plan level? Isn't that just an average of beneficiaries in the plan?

MR. GREENE: Not quite because this issue arises in the context of using survey data, functional status information that's not available for all plan members. It's currently collected by CMS in the Health Outcomes Survey for samples of members of all demonstration and M+C plans. The intent, CMS's intent currently is to use that data to calculate a plan average estimate of a frailty measure and then apply that on average to all plan members. It's not the perfect way of doing it but --

DR. NEWHOUSE: What's the pacing? I'm sorry to hog the floor here, but is this budget neutral or what? How is the frailty adjuster calibrated in terms of how much more money we pay for three ADLs versus two ADLs?

MR. GREENE: I don't know. I don't think its budget neutral. It wouldn't be budget neutral but the overall program is being implemented in budget neutral fashion, so I suppose is the feedback there. As far as I know.

DR. NEWHOUSE: How is the frailty adjuster set then? What's the conversion factor for the frailty adjuster?

MR. GREENE: We know it's been the frailty adjustment modeled and that CMS is ready to implement. We haven't seen the model.

DR. NEWHOUSE: I speak for myself, I'm a little bit reluctant to vote for this until I know more about what this is all about.

MR. HACKBARTH: Comments on that particular issue?

MR. SMITH: Tim, why doesn't the risk adjustment pick up frailty? What is it that means when need an additional frailty adjuster if we're using the M+C risk adjuster?

It sounds to me like an elaborate disguise for a transition payment, which may be entirely appropriate, sort of a phase out of the 5.3. But I don't understand, unless we think that the current risk adjustment apparatus misses frailty, in which case a frailty adjuster makes sense, which we know later.

MR. GREENE: It is basically an empirical finding. There's been a large body of work in the last five years by CMS and independent researchers that finds that for beneficiaries with multiple ADL limitations and other indications of frailty, the existing risk adjustment model underpays slightly, somewhat.

DR. MILLER: But we're going to come to our second recommendation which is going to address the frailty adjuster. And one of the fundamental questions is to evaluate both the need

for it and then the mechanism to tie it to the patient level. There is some indication that the risk adjustment, as it stands, falls short on this count. But on the second recommendation, we're trying to push that very question, which we're going to come to.

MR. SMITH: Mary and I were just talking about, if we know enough to apply the frailty adjuster in addition to the risk adjuster to the S/HMO population, why don't we know enough to apply it to the rest of the M+C population?

MR. GREENE: We'll get there.

MR. SMITH: If we do know enough to do that, why don't we recommend it?

MR. GREENE: The difficulty, which I'll touch on in future issues, pertaining to Medicare+Choice county rates, the rate book. When applying a risk adjustment or changing a risk adjustment method you need to adjust county rates to be consistent with the risk adjuster you're applying. We don't have the frailty data for counties that would allow that adjustment. It's a technical problem. It's a broad risk adjustment problem. But it does impinge on this particular case.

MR. HACKBARTH: So this wouldn't preclude it being ultimately adopted for the whole M+C population, but what you're saying is that the data necessary to do that do not exist at the point?

MR. GREENE: Yes.

MR. HACKBARTH: So it would be limited to this particular group.

DR. STOWERS: I'm just wondering, is the inference here that the frailty adjustment would bring about a certain set of benefits? Kind of looking at this from an access issue. The S/HMOs kind of had a certain set of objectives and benefits. Are we thinking that this is a way of spreading a particular set of benefits? So if an HMO later on or Medicare+Choice plan is going to be receiving these frailty adjustment or whatever we're going to call it, does that bring about a certain set of -- so we're getting rid of a certain set of benefits that goes along --

MR. HACKBARTH: The mandated benefits would be dropped. They would no longer be required to provide the additional S/HMO benefits, if you will. The idea, though, is that if they are, in fact, enrolling a frailer population, that they would get additional payments which would give them resources to use as they see fit to best care for this population.

DR. REISCHAUER: I have the question, Tim. When these things disappear or are transformed, do the individuals who are in them have the rights to Medigap purchase the same way as a plan disappearing from your area did? Because I would be reluctant not to have some kind of transition for existing participants if these folks have to go into the unadjusted Medigap market.

DR. HARRISON: We're pretty sure that they do have those same protections. We need to consult the law, but we're pretty sure they do.

DR. MILLER: First of all, on the frailty discussion, we have a second recommendation that addresses some of these issues.

And then in your presentation, don't you have some additional information on what their other options are?

MR. GREENE: I can go to that now.

MR. HACKBARTH: Why don't you go ahead to draft recommendation two, since it is on point, for the recent conversation.

MR. GREENE: Now turning to the recommendation that goes to risk adjustment for frail populations beyond the S/HMOs and after the period of the end of the transition after 2007. Under this recommendation the Secretary would continue working to improve risk adjustment for all M+C and specialized plans. But the goal would be to improve payment accuracy overall, not specifically to direct resources to any specific subset of beneficiaries.

CMS would continue research on payment adjustment for frail populations. After 2007, when risk adjustment is fully phased in for M+C, frailty adjusters would apply to all plans, not just demonstration plans or social HMOs.

Patient payments for frail beneficiaries would be based on their characteristics, not on the type of plan to which they belong. The frailty adjuster could either be part of the established risk adjustment system, it could be a tweak on the existing HCC model, or some other adjustment. Or it could be a free-standing frailty adjustment. This is not committing ourselves one way or another. It's simply saying improved payment accuracy and consider this particular population.

MR. HACKBARTH: Now why don't you go ahead also, Tim, and describe the options available for the beneficiaries?

MR. GREENE: We realize there's concern about the impact on beneficiaries of a change in the status of these demonstration plans. We Looked at options available for the beneficiaries in the four market areas in which they operate.

We found, looking at the current M+C data, that there are multiple plan options, other M+C plans, that beneficiaries could move to in all the four areas. These are metropolitan areas including New York, of course. In all cases, there's at least one plan that offers a drug benefit. And in three out of the four there is still a zero premium plan.

So beneficiaries could choose to stay with the former demonstration plans, which would be free to offer the expanded benefits they do now, or if they chose to move within the program, within managed care, they have reasonable options.

Turning now to Bob's point, we also considered the fee-for-service options. And this is what you were getting at, I think. There are established protections for beneficiaries who leave plans that withdraw from M+C. It's a legal question we haven't settled, whether these currently apply to those beneficiaries, but such beneficiaries are guaranteed access to selected Medigap plans. And in some cases, are protected -- in the case of New York, which is relevant here, by elaborate state protections that go beyond federal protections.

And we need to remember that this population, as all, also have in many cases employer-sponsored insurance options, Medicaid in a small way, and VA. We're not throwing these people out on the street when a plan is suddenly forced to close. That's not

the scenario we see in any way.

As I say, these plans may simply convert -- first, they're not closing. And second, they may not even change their benefit package. It's up to them.

MR. SMITH: We don't know the answer on Medigap?

MR. GREENE: No, certain.

MR. SMITH: Shouldn't we incorporate that, that the Secretary shouldn't proceed until --

DR. NEWHOUSE: Staff and the audience thinks we're certain.

MR. SMITH: Staff and the audience thinks we're certain.

DR. BERNSTEIN: [off microphone] ...that use the term demonstrations and I think S/HMOs are specifically singled out, as if they had. And they have the same re-entry into the Medigap market as other people who have lost their plans.

MR. GREENE: I've seen references to demonstrations in the descriptive material. I haven't looked at the actual legal documents.

DR. NEWHOUSE: Glenn, I don't know how many people were on the Commission at that time, but in the past we had Lenny Gruenberg come -- and this is really responding to David and Mary's question.

And he, in my recollection, made a compelling case that the HCCs, or the frailty adjustment specifically adjusting for ADLs, would add importantly to explain variation in the HCCs. So there was -- definitely HCCs were missing something that ADLs were picking up.

Having said that, the then-commission backed away from doing anything with frailty adjustment. And the reasons, seem to me, to potentially apply here as well. The first was the point already raised, what was the conversion factor. There was no obviously ADL data element in the claims data. So there was no way to very readily set what you were going to pay for an ADL except through the survey data that were linked to the claims data, which is what's coming here.

Then there were questions about how many people were you going to have in any given plan? What was the reliability of the survey data? Maybe you can oversample here. But there were a couple of more things that were troubling, I thought.

One was that what was the reliability of the ADL determination, whether there were really two ADLs or three ADLs, for example, was somewhat in the eye of the beholder. And what accentuated that was that the difference in payment in the survey research sample was quite substantial as you incremented the number of ADLs.

In other words, there were some real cliffs in payment on ADLs which raised the issue at a minimum on the potential ADL creep.

Now having said all of that, it still remains that in the survey data, again where you're not paying on ADLs, so you're presumably getting an unbiased read of ADLs, the ADLs explain something that the HCCs don't.

But it seems to me there is a real dilemma here. As I hear this, I don't think we've given a sufficient weight to the potential downsides of frailty adjustment.

MR. HACKBARTH: The dilemma, I think, is that currently we have a payment system that pays extra dollars based on the categorization of the organization. If it wears the social HMO label, it qualifies for an additional 5.3 percent. The data, as I understand it, is that, in fact, the organizations are quite disparate. Some are enrolling frail --

DR. NEWHOUSE: All four of them.

MR. HACKBARTH: All four of them. And sometimes even within a single organization, like Health Plan Nevada, as I understood it, there's quite a significant difference in performance between the clinic-based piece of the organization versus the network based. There are differences across the demonstration sites in terms of the population that they enroll. As I understand it, the Kaiser site is clearly enrolling a frailer population. That's not necessarily true of other sites.

So the current approach is we pay 5.3 present more based on a label attached to the organization, regardless of the fact that they are quite different organizations and they enroll different patients. Focusing on the frailty adjuster option is an effort to say well, let's forget the label attached to these disparate organizations and have dollars follow patients. But as you point out, and I'm sure you're right, it's not as simple as it seems on the surface.

So that's the dilemma that we face, where do you want to make your mistakes? Dollars following patients with imperfect measures or paying for broad categories of organizations even though they're very different in their characteristics and performance?

DR. MILLER: I just want to say, this is talking about the period from 2004 to 2007. The second recommendation raises the question of should there be a frailty adjuster, and what should be the basis? And there's other methodologies that are not ADL-based. We had some conversations with a bunch of different parties involved in this. And there's actually one group working on a statistical adjustment to the risk adjustment model -- and I can't describe it here -- but it deals with details of the distribution, and it captures some of this, and would drive directly off of the risk adjustment model and would not work off of an ADL-type of model.

We're saying all of this needs to be looked at.

DR. NEWHOUSE: That seems unexceptionable, but the real issue is what happens in 2004, or what do we say about what we think should happen in 2004? And whether this is ready to be trotted out for S/HMO reimbursement or not.

DR. HARRISON: Can I say a little bit about the frailty adjuster? What CMS did was they took the MCBS and looked at ADL measures off the MCBS. So that's how they calibrated the model. They said that the other coefficients had to be the same as the general population, and they figured out what add-ons would be appropriate for frailty.

Now of course, they don't really think this is an awesome model, but for the interim they think that this could do the trick.

Now PACE programs will be paid based on this, as well. I'm

not sure what happens to them past 2007.

MR. GREENE: It's phased in.

DR. HARRISON: That was the notice that came out, the 45-day notice.

They've got special problems because they had very small sample sizes, as well. That's the way the model was created. It's not budget neutral. It's definitely an add-on for frailty.

MS. DePARLE: My point isn't specifically on risk adjustment, it's a broader point.

I guess, after reading the draft chapter and thinking about this and hearing our discussion today, I'm seeking some comfort here. I feel this is sort of a depressing discussion because a lot of effort was put into this by the various demonstration sites, the clinicians and others who were involved, the Congress, Senator Durenberger and others, the Agency, many agencies, Mathematica and others. And some of us at least believe in coordinated care models and think that's the hope for the future.

I was having a sidebar with Nick saying well, should we feel good that maybe we're already doing the best we can do? Or am I wrong that this is very depressing because it doesn't seem to show, even with prescription drugs and all the good things that you think people need, that we're making a lot of progress in care.

So help me out here.

DR. HARRISON: One thing that we learned was that Kaiser learned things from the demonstration and then actually applied them to their general population. So I think, in some cases, things have been learned and techniques have been learned and they may be used in general practice.

MR. HACKBARTH: Nancy-Ann, it's not unlike M+C as a whole. There are, frankly, good organizations and there are not so good organizations. There are organizations that do innovative things, that offer an outstanding level of quality, and there are those that I certainly wouldn't want any family member of mine enrolled in. I don't mean to imply in any way that these social HMO's are bad organizations but they have different results, different populations.

To me, the fundamental problem here is paying more for a label, as opposed to paying more for performance. I don't think, based on what we've seen thus far, there's anything special about this label that merits additional payment compared to other M+C organizations, some of which may be doing these things or other very good things.

I think paying for the label is inherently inequitable when you've got disparate organizations.

MS. DePARLE: I wholeheartedly agree, but I guess what I find concerning is I don't see, from the evaluations of this so far, and everything I've read, including the materials from the consortium and others, that it has made an appreciable difference, at least not of the magnitude that I would have hoped. That this kind of service delivery model that includes more care coordination and other kinds of services that we aren't offering, doesn't seem to produce a large effect on people's need for institutional care and other things that we don't want to

have to have them undergo and have Medicare pay for.

So that's what I find disheartening, and maybe we just don't have the model right. It's been going on almost 20 years. I'm' sure none of the original beneficiaries are even still around.

MR. DURENBERGER: Thank you very much.

I particularly appreciate the comments that I've heard so far this morning because, as always, I've learned from all of them. It's no secret, and I think I've mentioned it here before, that I have been sort of wedded to this program for 20-some years of it's existence. I certainly have a concern for the model, if you will, not necessarily for the plan but for the model.

I wasn't sure exactly how best to deal with this subject and, frankly, I visited with Bob Kane because I know Bob, and so forth.

And then across my desk, as across everybody else's desk, came this fax from Bob Newcomer. So I called up Sheila because I knew she wasn't going to be here today and she teaches twice a year apparently and this just happens to be her trip to Harvard. And because we were both involved in the beginning of this program, I asked her, in effect, what position she would be taking were she here today.

And her position, and my position, is sort of reflected, I think, best in this question which is, what should we -- not that we're wedded to four plans that serve only 112,000 Americans out of however many may be available. But really what is it that we should learn from the S/HMO II demonstration before we move the opportunity, as Nancy has said better than I could, to provide coordinated care for people who are frail, frail elderly, and so forth, before we move them into the workplace, whether it's M+C or some of these other alternatives?

It seems to me that Newcomer makes the argument, particularly I think it's at the top of the second or third page, that even though there were more than 20,000 treatment cases available, such a stratified analysis was not reported by MPR. I consider this to be a fundamental flaw in MPR's analysis and gross unfairness in the evaluation of the S/HMO model.

Then what he talks about, as you all know, is what do you have to do to change the culture of the organization in order to get the benefit of the coordinated care for all of the members?

It seems to me, that's the lesson that needs to be taken away from S/HMO II, and what these three evaluators seem to be saying to us, through Newcomer, is give us a little bit more time and eliminate the unfairness, allegedly, of the MPR evaluation. And perhaps we can help you understand what it is about this particular S/HMO II model that is adaptable, if you will, to other cultures of service delivery in other parts of the country.

That is one part of it from -- it answers your first question, which is how do we know the difference? And I think, in part, we do need to know that difference and whether it's the frailty adjuster issue which Joe's already talking about, or it's this that's important.

I agree with you that paying just for a label rather than for performance is inappropriate. But I think the issue here is not whether one plan gets 5 percent more than another plan for

allegedly doing the same thing, and we don't even know whether they do, but whether or not the 112,000 people who are currently enrolled in one or the other of these plans are getting better care?

We can debate the data as to whether or not the program is saving money by less hospitalization or something like that, but I don't know -- and I haven't heard in the 20 years that this program has been around -- that all the people that are in it are unhappy because they're less healthy or they're not getting something that they bargained for, or things like that.

So the other question that occurs to me is why are we spending so much time, so much effort at CMS? I know at OMB for 20 years -- it started with John Cogan and it's been there forever -- and in this commission, why are we spending so much time and effort over 5.3 percent on 112,000 people, unless it's going to lead us to a different approach for everyone in this country?

And I don't mean just M+C because I don't come from a part of the country where we've got any M+C. So it might be PACE or On Lok, or it might be something else in our part of the country. So my view is I'm not going to vote today to end or recommend that we end the S/HMO as of today unless some of the kinds of questions that have been raised here and by Newcomer's paper can be better answered. We can answer them three months from now or six months from now or a year from now. I just think we ought to do it.

MR. HACKBARTH: Does the S/HMO II have a frail population, a frailer-than-average population?

MR. GREENE: It appears not, based on the data, based on even the information we've gotten from the S/HMO consortium and from CMS. It's a large plan. It moved essentially all of its M+C plan into a new S/HMO, so it got a fairly representative body of people.

MR. HACKBARTH: So we're testing techniques of how to better manage a frail population in an organization that doesn't have one.

MR. GREENE: It has a typical proportion.

One point on what we'd be doing here, we're not closing plans, we're not telling them to close down. In fact, the way the recommendation is structured, they would be given the opportunity to offer what benefits they chose and would be getting a frailty adjustment during a transition that would compensate essentially for the 5 percent add-on. As currently estimated by CMS, the frailty adjustment would give these plans more than the 5 percent they'd be losing.

In other words, they would on average end up better off comparable M+C plans. So we would not order them to close. It would, at least as structured here, give them resources.

MR. HACKBARTH: Is there an existing S/HMO that does have a frail population?

MR. GREENE: Kaiser. Kaiser, clearly.

MR. HACKBARTH: So if we want to learn about how to best manage a frail population, given this universe of four sites, we have one that's been in existence how many years at Kaiser?

MR. GREENE: Since 1985.

MR. HACKBARTH: They've been working at this for 15 years, and actually have done a lot of very good work.

So I guess I'm troubled by the argument well, we've got to allow Health Plan Nevada, which doesn't have a frailer-than-average population, go on as a way to learn how to care for a frail population when we have one site, Kaiser, that's been doing it for 15 years and actually does have a frail population.

MR. GREENE: One lesson from the evaluation, the first evaluation, and Newcomer's findings, are that a group model HMO in Kaiser or the clinic's organized system of care at Nevada seems to work reasonably well. That is a consistent observation there. So we have learned something from this demonstration, as far as the frail go.

DR. REISCHAUER: This becomes more and more illuminating as little bits and pieces are fed to us here. I changed my mind on this from where I was when I read this the other night.

I want to say that I share very much Nancy-Ann's disappointment that what I would like to have thought would have had a very significant impact doesn't seem to have. And say to Dave that I don't find your case convincing simply because these are groups that came forward and volunteered, that thought about this a whole lot, brought in outside expertise, were well-meaning, and in the case of S/HMO II had the experience of S/HMO I to build on. And yet we don't seem to have a lot of positive results.

One has to ask yourself why continue to pay 5.3 percent. Now we're told oh, it's not going to be 5.3 percent, it's going to be a higher number. But we're going to change the label on it so we all feel comfortable, we'll call it a frailty adjustment. And then we'll take away the requirements that you provide any additional benefit.

It strikes me, I could almost go along with Dave simply because if we're going to give them the extra money, make them do the extra benefits. In a way, we're creating an even stranger situation.

Now it strikes me maybe for transition to preserve institutions, you might want to give the 5.3 declining over time for the individuals who were in the plan as of termination date. But even that's a little rocky as an argument, given what we've learned.

So I'm really left with a very uneasy feeling about the recommendations.

MR. HACKBARTH: Just a clarification. The frailty adjustment only means more dollars if, in fact, you have a frailer-than-average population, which is not true at all these sites.

DR. REISCHAUER: What you're really saying is that only Kaiser would get this adjustment.

DR. NEWHOUSE: They only have a tiny number of people. How can there be more total dollars? We've said there's more total dollars.

DR. MILLER: Relative to the 5 percent.

DR. HARRISON: Under the frailty adjuster. Now, there's

another set of things going on here. CMS, in its 45-day notice, said they were keeping risk adjustment, as a whole, budget neutral at least through 2004.

DR. NEWHOUSE: With or without this frailty?

DR. HARRISON: Not even thinking about the frailty, for all plans.

DR. NEWHOUSE: Frailty comes on top.

DR. HARRISON: Right. So if you do CMS's version of budget neutrality and you give a frailty adjuster, three of the four plans do better than other M+C plans, and one plan does worse than other M+C plans.

DR. MILLER: On net, the total dollars are less than 5 percent.

DR. HARRISON: At 100 percent, if everything was CMS's version of budget neutrality, it would be more than the 5.3. If it were fully implemented 100 percent. The simulations get tough and we can't promise that they won't move, but that's the way it looks right now.

MR. SMITH: I may be the only one who's totally confused now.

If you use the makeshift frailty adjuster, you're suggesting that the plans would get more total dollars than they do now, or they would get more than 5.3 percent additional dollars for each frail patient? Is Bob's description right? If you apply this at the plan -- the question is are total dollars going up during this transition period? Or is just some per capita --

DR. HARRISON: It's hard to know, but if CMS's version of budget neutrality were to hold during this, I believe they would get more than they current get.

MR. HACKBARTH: But that would be not because of the frailty adjustment --

DR. HARRISON: Because of the budget neutrality.

MR. HACKBARTH: -- necessary but because of how CMS is choosing to implement risk adjustment, which is quite independent of S/HMOs.

DR. HARRISON: If you compare them to other M+C plans.

DR. REISCHAUER: But that is going to happen anyway.

MR. HACKBARTH: If you think of it in terms of a baseline, you need to adjust the baseline for what would happened.

MR. SMITH: But that's going to happen.

MR. HACKBARTH: So the current law line, if you will, is revised upward because of what's happening with CMS's approach to risk adjustment for all of M+C.

MR. SMITH: The question that I think I am, and maybe others are wrestling with is, having done that, the baseline is the baseline. Would the additional payment beyond the M+C baseline be greater than 5.3 percent? If the answer is yes, then I end up with Bob, this is crazy.

MR. HACKBARTH: Do you understand the question? If you just look at the frailty piece alone, is that greater than or less than the 5.3?

DR. MILLER: I'm going to try and answer this. This is very confusing and the reason that you have another issue that's playing into this that doesn't have anything to do with S/HMOs,

which is that CMS's methods of implementing risk adjustment for all of the M+C plans has been decided to be "budget neutral," which is the dollars going to all M+C plans would not go down with the implementation of risk adjustment, although lots of indications are that given the mix of the patients, they should.

So when we say implement risk adjustment with a frailty adjuster, these plans will continue to do well in part because of that decision for all M+C plans.

MR. SMITH: But Mark, is that going to happen anyway?

DR. MILLER: That's correct.

MR. SMITH: So it's 5.3 percent of something.

DR. REISCHAUER: Assume Dave wins the vote and those go on, assume they're going to get a payment, that assumes that you abolish them, is the payment going to be higher?

DR. MILLER: That, I think, is the part -- and Scott, you can feel free to bail me out at any point, either way.

That's the part of the analysis that we aren't particularly able to disaggregate. However, here are the things we can tell you. Scott, feel free to correct any of this.

The frailty adjuster has very different effects on plans. Some plans, like Kaiser, will do well under the frailty adjuster because of their populations, for example, in Nevada. Because of this we know that this is some of the basis of the information that we know, that they don't have a frail population. So there will be a lot of variability in the plans.

To the extent that -- and I almost don't want to bring this up because it will just confuse things, but CMS had a transition, which was Bob's point, took the 5.3 down and took this risk adjustment plus frailty up. And this is what I want to be careful about. At 2004, when you're doing 30 percent of the risk adjustment at that point, the dollars would have been lower than the 5 percent that they would have gotten under the current arrangement. Is that correct, Scott?

DR. HARRISON: That's right.

DR. MILLER: I think that was what we were able to tease out of this. And because we said -- our proposal was to say look, they shouldn't get the 5 percent. Give them risk adjustment and the frailty adjuster on the assumption that they are supposed to be dealing with these populations. And we said do it all at once in 2004. It actually pushes the dollars above the 5 percent, I think is what we're concluding here.

Now what we could do here is to go, I think again Bob put this on the table, the notion to something where there's more of a transition.

MR. HACKBARTH: Within that. It's more dollars in the aggregate, but the dollars are redistributed. There are some organizations that would get substantially more, I think including Kaiser because of its population, and there are others that would get less than they're currently getting, again because of the population they're enrolling.

So even if in the aggregate it's more money, the dollars are redistributed based on the frailty and risk of the population.

Quickly, we're running out of time here, folks.

MR. FEEZOR: I will make mine very brief.

I guess, along with Bob and Nancy, I'm disappointed at the results. And given what we're going to be discussing a little bit later on, quality and performance and most of the dollars we're spending, I don't know that we're going to be able to afford a 20-year experience or R&D on other questions that we're going to be calling later on. So I guess I just would put this in perspective.

When I get confused by details, I try to go back to the general principles. And I Tim, going back to your slide about three slides back when you laid out principles, my recommendation would be that we reverse those three. That in fact, ultimately, as a long-term goal the payment should follow the person, which should in fact hold them accountable for the effectiveness, and then the equity, just as a thought.

MS. RAPHAEL: But I just want to be sure that somehow in this recommendation we capture a couple of things. First of all, I, like and Nancy and now Allen, just want to see what we can learn from this experiment because we all know that one of the main issues we have are trying to coordinate care for people with multiple chronic conditions. And we have to tackle that. And there's care management, disease management, S/HMOs and a number of other forays into trying to do that, most of which up until now have not had astonishingly spectacular results.

But I really believe we need to keep experimenting in this area. And I want to capture in whatever we do, whatever is we have learned from all of this. I was out at Kaiser and this has affected what they are doing organization-wide. So I think we need to take something positive from all of this.

So I just want to be sure that this doesn't in anyway dampen the need to keep experimenting in the future. In addition to which, I do agree with what Gruenberg's points are here, which is we need to work on this frailty adjusted. There is something else out there. We need to try to define it and capture it in some valid way. And I'd like to make sure that, as part of our futuristic recommendations, we capture those points.

MR. HACKBARTH: We're well over time.

DR. WOLTER: This may be naive, but it seems to me that in a world, if we had some appropriate measures of demographics and risks and some appropriate measures of the results we want to obtain, that the 5 percent would be paid if those results were obtained. Why wouldn't, going forward, we design this so that the money is paid when some measures of cost savings and quality are achieved?

I think that a fundamental flaw in this particular project.

MR. HACKBARTH: Since there does seem to be some real interest in this we'll do a little bit more. Go ahead, Ralph and then Joe.

MR. MULLER: While I share the general principle that the payment should follow the beneficiary, I think this 20 years of experimentation and the dying of all the dreams on that side of the table indicates that organizations make a difference. And it may not always just be a payment for a beneficiary that makes a difference.

Like the rest of you, I commend Kaiser for many of the

innovative things that they do. But the thought that Nick just shared of how one thinks about paying for results versus just for inputs but also thinking about that, certain institutions have worked at this in a very substantial way for a long period of time, and they make a difference, I think counteracts some of the sense that they just should go with the beneficiary, because obviously there's some magic ingredient that some organizations put in that allows the performance to be better.

So I think that is one thing we have to take into account as we go into case management and other such things that are the hopes of the future, that there is a difference in how institutions deliver care. So it perhaps can't just always be as neutral, just saying it should follow the beneficiary. We have to think about the settings in which people achieve success.

DR. NEWHOUSE: I'd actually like to see a different kind of recommendation following this discussion. Kaiser has 4,400 some-odd people in this demo. I mean, 5 percent can't be that decisive. I would either like to just get rid of the 5.3 percent on the grounds that Glenn said, or transition it if we must.

And then I think the second question is what do we do then about the frailty adjuster? I don't think there's been enough brought forward to convince me that the particular -- first of all, there's very sketchy details about what frailty adjuster we're talking about.

And second, that at least as I understand the state-of-the-art here, that is ready to actually be trotted out and used. I could be wrong about that, but I haven't heard that case made yet.

Although I agree, as I said before, with Carol that there is some ore to be mined here. I just don't know if this specific -- I'm not comfortable enough with the specifics of what we're doing here to vote for a recommendation.

So at least as this is stated, I would vote against it or I would want to amend it to say let's just take away the extra money and do research on how we would actually do a frailty adjustment. Or maybe we come back in the fall and, with some more details about what we really mean by paying on a frailty adjustment.

DR. NELSON: I'll be brief.

I'm going to try again on page 12, because I want to make sure that our report doesn't mischaracterize Mathematica's evaluation. I could rewrite this based on the date that are there. And since we presumably are judging these based on whether they improve quality.

I could rewrite it to say that instead of there was no strong evidence of superior quality, to say there was some evidence of superior quality.

The first bullet, the S/HMOs performed better on two measures of preventive services and worse on none.

The second one, there were higher rates of recommended physician visits for two conditions.

And the third bullet, that there were lower avoidable hospitalization rates in the majority of the conditions studied.

The way we've written it, if that's Mathematica's words,

then I'm comfortable. But if we are mischaracterizing their evaluation, I think we're vulnerable. That was my point.

MR. GREENE: We're consistent with Mathematica evaluation. Their take on these multiple varied findings is inconsistent results in one field after another and hospitalization is one specific case where we're echoing what they say.

DR. NELSON: If indeed our report says Mathematica concluded that, I'm comfortable.

DR. MILLER: This is a very narrow response to Joe, and I don't know whether we brought this out.

Do you understand that at least CMS feels ready and has made a proposal to implement the frailty adjuster at the plan level as part of their transition?

DR. NEWHOUSE: I heard that, but I'm just not familiar enough to say I agree with it because I haven't really seen what they're talking about.

MR. GREENE: CMS has made a certain amount of information available. They described their estimation approach, their frailty factors, and so on. They haven't published the literal model but it is there and ready to be implemented.

DR. REISCHAUER: Is the frailty adjustment whether you have more than the average M+C population? You get money if it's more, or you get money if you have any?

MR. GREENE: If you have any -- essentially it processes information on a sample of beneficiaries from the Health Outcomes Survey for the plan, counts the number of ADLs from the survey for each beneficiary, applies a parameter to that count and calculates an average payment impact.

DR. NEWHOUSE: The answer is yes to your question.

DR. REISCHAUER: You get money if you have one frail person, not if your fraction is more than --

MR. GREENE: No, there's no cutoff, but I imagine the impact would be minimal if you had very tiny numbers.

DR. HARRISON: If you had all people with no ADLs you actually would get a cut. Zero ADLs is a negative number. One to two is a positive number, and then those numbers get larger as you go up to five and six.

DR. REISCHAUER: What I'm saying is how fair is this, especially if it's budget neutral, to the other M+C plans if you're providing an extra payment to a plan that might have below average number of ADLs, a of fraction of total --

DR. HARRISON: As recall, and I don't have it here, I think that if you had an M+C average population, you'd get like 2 or 3 percent, but I'm not positive of that. I think that what you would end up getting.

MR. HACKBARTH: We need to at least try to bring this to a conclusion.

MR. DeBUSK: What kind of money are we talking about here?

MR. HACKBARTH: In terms of dollars?

MR. FEEZOR: 5 percent.

MR. DeBUSK: Of what?

MR. HACKBARTH: It's a 5.3 add-on relative to the M+C rates. This isn't about budget control. This is a pittance in terms of the amount of Medicare dollars involved.

DR. HARRISON: I think it's $40 million a year.

DR. REISCHAUER: Pete, the answer is less than the foregone earnings that we have used discussing this topic.

[Laughter.]

DR. MILLER: None of this conversation has been motivated by saving money. We are Congressionally mandated to comment on this report. We have to make recommendations about whether to continue this demonstration.

What we've been trying to communicate is the results have been mixed. We don't see a strong argument for continuing with the demonstration. These other discussions are about equity and measurement of frailty, and that's what got us into these other places.

MR. HACKBARTH: Let's put up draft recommendation one. Joe, as I understand what you're saying is --

DR. NEWHOUSE: My problems at the bottom.

MR. HACKBARTH: And you feel so uncertain about the legitimacy, the appropriateness of how this calculation is done, that you would be reluctant to have yourself endorse it, and perhaps the Commission as a whole.

DR. NEWHOUSE: I would normally give CMS the benefit of the doubt, but I haven't read the regs or the basis behind their recommendation. So I feel like I'm being pushed beyond where I want to be.

I don't want to vote against it for that reason, but as I say, there certainly have been problems in the past with this. I just don't know where we are right now.

MR. HACKBARTH: So if we say we don't know enough about this to endorse it, we can either say well, go ahead with it and express our reservations in the text, or we can say strip it out.

Obviously the consequence of taking it out is fewer dollars available, particularly for the organizations that have frail populations. And that has consequences for the organizations, as well as for the beneficiaries.

So it's a question, in my mind, of where do you want to make your mistake in the face of the uncertainty about the frailty adjustment?

DR. NEWHOUSE: What I'm concerned about is exactly -- I mean, implicit in some of the remarks. If we do it here, we'll be confronted with the other M+C organizations that have a frailer population saying we should have it, too. And that will be a very compelling case then.

I'm not sure we really, the technology is really there.

MR. SMITH: Which is not to call it what it isn't, to call it what it is, and provide for a transition payment above the M+C rate to the existing S/HMOs that would phase down by 2007, at which point we would hope there would be a reliable either frailty incorporated in general risk adjustment or an additional frailty adjuster which passes the test of credibility.

I think Bob suggested something like that quit a while ago.

It would not be fair to these plays to say we're going to take away the 5.3 percent cold turkey in one year. Let's recommend that we phase it out through the period until or in a way that is consistent with a period which will end with the risk

adjuster being in place and applied for all M+C.

MR. HACKBARTH: Let me just make sure I understand it and then I want to get a sense of the Commission as a whole.

So as opposed to trying to do this uncertain frailty adjustment, you would just say keep the 5.3 but phase it out over this period. Express support for the concept of a frailty adjustment that hopefully would be generally available in the period post-2007. Any clarification?

DR. MILLER: That's not inconsistent with the principles that we're using because the second recommendation was the frailty adjuster, if appropriate, for all plans at 2007, assuming they had the time to do the research.

MR. HACKBARTH: The big difference is not in the concept but in saying what the transitional tool is. This proposal uses the 5.3 as the transitional, as opposed to an uncertain frailty adjustment.

DR. WOLTER: Just for clarification, again does a frailty adjuster lead to an incentive to implement proven results? And then secondly, are there going to be frailty adjusters in the fee-for-service program. Is that on anybody's radar screen? Just for clarification, not for discussion, just for clarification.

MR. HACKBARTH: Let me take a stab at it and then maybe Joe can correct me if I'm wrong.

The frailty concept seems to apply more to when you're talking about a package of services and, as opposed to small bundles as we put it. So it wouldn't be a frailty adjuster, per se, for the fee-for-service program. In particular facets of it, we talked about better severity adjustment for inpatient hospital care and the like. But it's sort of a similar concept but different lingo.

DR. REISCHAUER: Payment for coordination.

MR. HACKBARTH: Payment for coordination is a demonstration idea.

So let me get back to the proposal that's on the table. So it's phase down the 5.3 percent and recommend, express support for the concept of a frailty adjustment to be generally available to all plans post-2007.

How many commissioners like that formulation?

What I'd like to do then is get the staff to draft up something that we can put on the screen. Do you have the technology here to do that? Then right before we adjourn for lunch we'll come back and vote on that recommendation.

Actually, I guess that's a combination of draft recommendation one and two here, so it would all be folded into one.

DR. NEWHOUSE: Maybe we keep two as it is and we just change one to the transition being done from 5.3.

MR. HACKBARTH: Yes.