CHAPTER 4

Medicare+Choice payment and eligibility policy

RECOMMENDATIONS

4A CMS should continue to risk-adjust payments with the new CMS hierarchical condition category system, but should not continue to offset the impact of risk adjustment on overall payments in 2005 and subsequent years.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 1 • ABSENT 0

4B The Congress should allow all beneficiaries with end-stage renal disease to enroll in private plans.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 1 • ABSENT 0

4C The Congress should establish a quality incentive payment policy for all Medicare Advantage plans.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

CHAPTER 4

Medicare+Choice payment and eligibility policy

In this chapter

- Plan payments, availability, and enrollment
- Risk adjustment system and payments to M+C plans
- Using payment incentives to improve the quality of care in private plans

MedPAC has a 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 and that payment mechanisms should promote financial neutrality between private plans and the traditional program. Many of the same issues the Commission has raised about the M+C program will continue to pertain to the recently enacted Medicare Advantage program that will replace it. MedPAC identifies three improvements that could be made to the current and future programs: implementing risk adjustment so that it captures differences in health status between Medicare beneficiaries who enroll in private plans and those who stay in the fee-for-service program; allowing all beneficiaries with end-stage renal disease the choice of enrolling in private plans; and providing financial incentives to improve quality.

MedPAC has a 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. On some dimensions, private plans have a greater flexibility to innovate than the traditional Medicare fee-for-service (FFS) program as it currently operates. This ability to innovate, through financial incentives, care coordination, and other management techniques, gives private plans tools to improve the efficiency and quality of health care services delivered to Medicare beneficiaries. Currently, private plans participate in Medicare through the Medicare+Choice (M+C) program. The M+C program has provided the majority of Medicare beneficiaries a choice of delivery systems, and MedPAC has supported that choice.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) establishes a new program for private plans called Medicare Advantage (MA). The Congress created the MA program to expand the role of private plans in Medicare. Much of that new program will be based on the rules and payment structure in the M+C program. M+C plans will become known as local MA plans and will operate similarly as under the M+C program. (The MMA also authorizes regional MA plans.) Many of the same issues the Commission has raised about M+C will continue to pertain to MA.

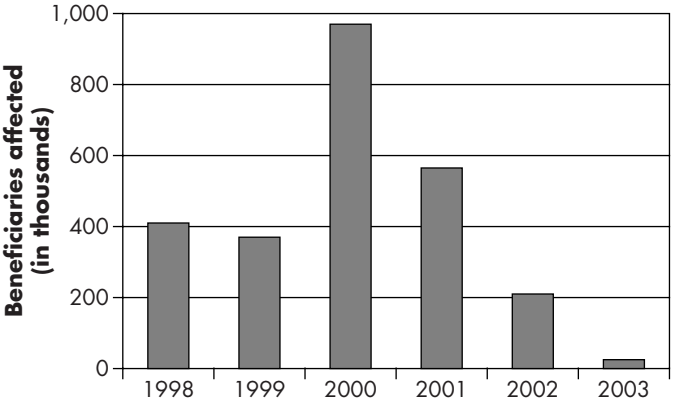
This chapter focuses on short-run issues that are important for the current program and will also be important in the long run. Specifically, this chapter discusses the current status of the M+C program, M+C payment compared with Medicare FFS spending, recommendations arising from CMS's implementation of a new risk adjustment system, and a recommendation on introducing payment incentives tied to the quality of services delivered by private plans. These discussions address the current M+C program rather than some of the broader payment issues in the MA program. The MMA has also mandated future MedPAC studies of payment and benefit design issues for MA plans. These studies will contain MedPAC analyses of features of the new program.

Plan payments, availability, and enrollment

Most Medicare beneficiaries enrolled in private plans that provide Medicare's Part A and Part B benefits are enrolled in M+C plans.[1] Under the M+C program, Medicare beneficiaries have the option of joining a private coordinated care plan (CCP), which receives payment from Medicare for providing all Medicare-covered services. Generally, members of M+C CCPs must use plan providers to get coverage for their care. These private plans are allowed to provide additional benefits and to charge beneficiaries an additional premium for them. However, if a plan's projected costs for Medicare benefits are lower than its Medicare payments, the plan is required by law to either return the difference to enrollees in the form of additional benefits (or lower premiums) or to contribute the money to a reserve fund for future use (few plans choose the latter option). In practice, beneficiaries have often been able to join these plans and have lower cost sharing and/or receive extra benefits at no additional premium.

After several years of declining enrollment and plan participation, the M+C program may have stabilized, although at lower levels than when the program peaked in 1999 to 2000. Plan withdrawals from the M+C program for 2004 are the least extensive of any year in the program's history and withdrawals have slowed considerably over the past few years (see Figure 4-1). Less than 1 percent (41,000) of M+C enrollees will lose their plan at the end of the year. Of those enrollees who will lose their M+C CCP, only about 1,000 are in areas where there are no other CCPs. Also, since the start of 2003, new plans have entered the program and other plans have expanded their service areas. As of December 2003, CMS listed 7 plan sponsors with pending applications into the

FIGURE 4-1 **Beneficiaries affected by plan withdrawals, 1998–2003**



Note: Data is based on year-end reporting.

Source: CMS fact sheet on Medicare+Choice, September 1, 2003, on cms.hhs.gov/media.

program and another 17 plan sponsors seeking service area expansions.

Access to CCPs

More Medicare beneficiaries will have access to an M+C CCP in 2004 than in 2003. At least 60 percent of beneficiaries will have access to an M+C CCP in 2004, up from 58 percent at the beginning of 2003. Enrollment in M+C CCPs increased by 1.5 percent between January 2003 and December 2003. About 12 percent of Medicare beneficiaries are currently enrolled in M+C CCP plans.

Although there are signs that the M+C program is stabilizing, availability and enrollment are considerably lower than levels just after the implementation of the M+C program, and extra benefits offered by the plans have eroded (Gold and Achman 2003). In 1998, 74 percent of beneficiaries had M+C CCPs available, and in 1999, about 16 percent of Medicare beneficiaries were enrolled in M+C plans. Trends in participation, enrollment, and benefits may change in response to higher payments under the MMA.

Access to private fee-for-service and preferred provider organization demonstration plans

Because many beneficiaries do not have access to M+C CCP plans, CMS has tried to expand choices in the M+C program by approving several private fee-for-service (PFFS) plans and preferred provider organization (PPO) demonstration plans, and by taking a number of actions to lessen the administrative burden on plans.

The PFFS option under the M+C program allows plans to offer Medicare benefits to enrollees without restriction to a network of providers. The PFFS plans reimburse providers on a fee-for-service basis using the same payment rates that apply in the traditional Medicare program. Other reimbursement strategies are permitted, but no plans have chosen to use them.

Insurers continue to show interest in the PFFS option, but enrollment has been low and plan participation has not been sustained. Although a fourth PFFS plan joined the M+C program this year, the largest plan is reducing its service area for the third consecutive year and is withdrawing from over 500 counties. Because enrollment is small in each county, this action affects only about 2,400 enrollees. As a result, only 31 percent of beneficiaries will have access to a PFFS in 2004, compared with 36 percent in 2003. However, CMS lists two PFFS plans as having new applications pending, so access to this type of plan may increase.

Another new option for some Medicare beneficiaries is enrollment in PPO demonstration plans. CMS initiated a demonstration of PPOs for Medicare beneficiaries in 2003. Although PPOs now represent the predominant form of insurance for the under-65 population, only three M+C organizations offered PPO plans in 2002. The demonstration is intended to attract PPOs to the M+C program by increasing payment and reducing some administrative requirements. Many PPOs signed up in response; organizations in the Medicare PPO demonstration offer 31 plans in 19 states. Approximately 11 million (more than 25 percent) Medicare-eligible residents live in the 206 counties in which PPO demonstration plans are available.

Plan entry was encouraged under the demonstration by modifying payment rates in two ways that have since been adopted to encourage entry into the MA program. In 2003, the payment rates for demonstration plans were set to the greater of the M+C rate or 99 percent of the county FFS spending. Another way of encouraging plan entry is to limit the risk for demonstration plans: CMS allowed plans to negotiate risk-sharing arrangements. All but five of the demonstration plans chose to enter into negotiated risk-sharing arrangements.

The PPO demonstration was intended to expand M+C options and stimulate new enrollment. However, while the PPO demonstration has offered many beneficiaries a new choice, for the most part, it has not provided an option to beneficiaries who do not already have other alternatives to Medicare FFS. Of the more than 11 million beneficiaries who have a PPO available, only about a half million do not already have a CCP available. Generally, demonstration plans are going into urban areas, but a couple of the plans are targeted to rural areas. As a result, about 600,000 rural beneficiaries will have access to PPOs, although 450,000 of them already have a CCP available.

MedPAC examined the prior managed care enrollment experience of beneficiaries enrolled in PPO demonstration plans, and found that very few were joining a Medicare managed care plan for the first time. In September 2003, 75,500 beneficiaries were enrolled in PPO demonstration plans. Only 13 percent of these enrollees had switched from FFS Medicare and had no prior experience in Medicare managed care plans. The other 87 percent (approximately 65,700) had been enrolled in M+C plans

before they enrolled in a PPO demonstration plan. Of these, 51,000 had been enrolled in plans operated by the same managed care organization that controlled the PPO plan in which they subsequently enrolled.

Plan availability varies by geographic area

Recent efforts have not yet resulted in substantial new enrollment in M+C plans (Table 4-1). Medicare legislation in 1997 established M+C payment rates which included a floor—a minimum amount below which no county rates could go. By design, the floor rate was above the FFS spending in many counties. It was established to attract plans to areas (mostly rural) that had lower-than-average FFS spending. Legislation in 2000 established a second, higher floor which applied only to counties in metropolitan areas which had more than 250,000 residents ("large-urban" areas). Despite the support of these floor-payment rates, no plans exist in some areas (particularly rural areas) of the country.

Beneficiaries living in floor counties (for this section we consider the determination of floor status to have been made before the MMA changed payment rules) are much less likely to have a coordinated care plan available than those beneficiaries living in nonfloor counties (Table 4-2). They are, however, more likely to have access to a private FFS plan. Those availability differences have narrowed, although a large portion of the changes is attributable to relatively high-payment counties shifting from nonfloor to floor status between 2003 and 2004, thereby decreasing the difference in average payment rates between the floor and nonfloor counties.

A similar pattern is evident for rural beneficiaries (most of whom live in counties with floor payment rates). Despite the overall increase in coordinated care plan availability, only 16 percent of rural beneficiaries have a plan available. Also, even though rural beneficiaries are more likely than beneficiaries in urban areas to have access to PFFS plans, virtually all of the loss in PFFS plan availability has occurred in rural areas.

Plan payments are higher than fee-for-service spending

MedPAC has used the concept of "financial neutrality" as a guiding principle for setting payment rates in the M+C program. Financial neutrality means that the Medicare program should be financially neutral as to whether a beneficiary chooses its FFS program or a private plan to provide coverage for the same benefits. A private plan may accrue higher administrative expenses or earn a reasonable profit, as long as it reduces spending on care to recoup those additional costs. If the program pays more

TABLE 4-1

Medicare+Choice plans and enrollment, by type of plan, 1997–2003

	Plans						
Type of plan	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**
CCP	307	346	309	266	179	155	151
PPO demonstrations	N/A	N/A	N/A	N/A	N/A	N/A	33
PFFS	N/A	N/A	0	1	1	2	4
Total	307	346	309	267	180	157	188
	Enrollment						
CCP	5,211,339	6,055,546	6,347,434	6,260,549	5,480,899	4,929,690	4,622,031
PPO demonstrations	N/A	N/A	N/A	N/A	N/A	N/A	79,223
PFFS	N/A	N/A	0	1,178	19,835	24,536	25,897
Total	5,211,339	6,055,546	6,347,434	6,261,727	5,500,734	4,954,226	4,727,151

Note: CCP (coordinated care plan), N/A (not applicable), PPO (preferred provider organization), PFFS (private fee-for-service). Plans are defined as contracts either under Medicare+Choice or its predecessor program.

Source: Medicare Managed Care Contract Plans Monthly Summary Report, December of each year, from CMS.

TABLE 4-2

Availability of Medicare+Choice coordinated care or private fee-for-service plans

	Percent of beneficiaries in Medicare		Percent of beneficiaries with plans available			
			M+C coordinated care plan		M+C private fee-for-service	
County characteristics	**2003**	**2004**	**2003**	**2004**	**2003**	**2004**
National	100%	100%	58%	60%	36%	31%
Payment rate						
Floor	55	63	40	46	50	37
Large urban floor	31	36	61	67	43	36
Other floor	23	27	12	17	58	39
Nonfloor	45	37	80	84	20	19
Rural	23	23	16	16	56	40
Urban	77	77	74	77	30	28

Note: M+C (Medicare+Choice). Totals may not sum due to rounding. 2004 numbers are before the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Source: MedPAC analysis of Geographic Service Area Report, September 2002 and November 2003, from CMS.

than FFS costs to plans, they will have less financial pressure to improve the delivery of care. Paying plans more than FFS cost to perform the same as FFS Medicare simply raises spending for the program. MedPAC has been steadfast in its position that financial pressure on FFS providers and plans is important in motivating them to improve productivity and efficiency.

Payment policy 1998–2004

Before the Balanced Budget Act of 1997 (BBA), payment rates for private plans were set at 95 percent of a county's per beneficiary spending under the traditional FFS program. The BBA instituted a new method for calculating payment rates for the M+C program that broke the direct link to county-level FFS spending. Under the BBA and two subsequent acts, rates were the highest of three formula prongs: fixed dollar amounts or "floors," a minimum guaranteed increase (2 percent) from prior year county rates, or a blend of local and national rates. The floor rates and the blended rates were updated using the rate of increase in national FFS spending.

As discussed, the two floor rates vary with the characteristics of a county. One floor rate is for counties in large urban areas, such as Portland, OR, and Minneapolis-St. Paul, MN. The other floor rate applies to all other counties. The floor rates for 2004 (pre-MMA) were $592 per month for large urban areas and $536 for all other areas. Most floor counties would have seen an increase of about 5 percent from 2003 to 2004.

Before the MMA changed the payment rules, updates for 2004 would have been low for nonfloor counties. For the fourth year in a row, and for the sixth time in the seven years since the BBA, all counties with payment rates above the floors (e.g. Los Angeles, New York, and Miami) would have gotten the minimum guaranteed increase for 2004. The minimum guaranteed increase would have been 2.2 percent for 2004, based on the legislated 2 percent, plus 0.2 percent to account for increased coverage responsibilities of plans because of national coverage determinations.

Note that as the floor rates increase faster than the 2 percent minimum increase, the floor component of the payment formula has determined the rate for more counties over time. For 2004 (pre-MMA), about 8 percent of Medicare beneficiaries were living in counties where the floor would have applied for the first time (Montgomery County, MD, and Denver, CO, are examples). Approximately 63 percent of Medicare beneficiaries and 40 percent of M+C CCP enrollees would have been in floor counties. In 1998, when there

TABLE 4-3

Plan payments are higher than fee-for-service spending, 2004

Payment rate for county	Pre-MMA		Under MMA	
	Average ratio in counties	Percent of enrollees	Average ratio in counties	Percent of enrollees
Total	103	100	107	100
Large urban floor	110	37	116	26
Other floor	113	3	123	3
Fee-for-service	N/A	N/A	102	40
Blend rate or minimum update	100	60	107	31

Note: MMA (Medicare Prescription Drug, Improvement, and Modernization Act of 2003), N/A (not applicable). Ratio is plan payment to fee-for-service spending. Includes all Medicare+Choice plans. Ratio is calculated based on demographic differences without regard to other health risk differences.

Source: MedPAC analysis of 2004 rate book from CMS.

was one national floor, only 12 percent of beneficiaries lived in floor counties. As recently as 2001, after the introduction of the large urban floor, 46 percent of Medicare beneficiaries lived in floor counties.

While the increases in M+C rates have been below growth in spending in the FFS Medicare program over the last several years, we estimate that for 2004 M+C plans would still have been paid, on average, at rates higher than per capita spending in the traditional FFS program, for a demographically comparable population. For 2004—again, before MMA—we estimate that across all counties, Medicare would have paid M+C plans an average of 103 percent of what it would cost to cover the current demographic mix of M+C enrollees under the traditional FFS Medicare program (Table 4-3). The payments above FFS spending were concentrated in the floor counties; Medicare would have paid 100 percent of average FFS spending in nonfloor counties, where 60 percent of enrollees live. By contrast, Medicare would have paid 110 percent of FFS spending for enrollees in floor counties in large urban areas and 113 percent of FFS spending in floor counties in other areas. These estimates assume that the average health risks of the M+C and traditional enrollees are the same, other than those differences accounted for by demographic characteristics. (The health risk differences will be described later in the section on risk adjustment.)

Payment policy 2004–2005

Congressional desire to increase the availability of and enrollment in Medicare private plans led to an increase in payment rates for plans in the MMA for at least 2004 and 2005. The MMA, effective March 2004, has altered the formula in several ways. The minimum update for 2004 is 6.3 percent, because it was set at the rate of projected national FFS spending growth for 2004 (now higher because of increased payments to FFS providers under MMA). The floor rates also increase, because of higher projected FFS spending growth, to $614 in large urban areas, and $555 in other areas. In addition there are more blended rates for 2004. Finally, beginning in March 2004, a fourth prong is added to the formula—100 percent of the county's per capita FFS spending. For the purposes of the fourth prong, FFS spending includes spending for indirect medical education (IME), even though the Medicare program will continue to pay IME to hospitals directly on behalf of M+C patients.

As a result of the MMA payment formula changes, many counties move from one payment category to another. Before MMA, 40 percent of M+C enrollees lived in floor counties, but only 29 percent live in counties that remain in the floor category. Some counties, such as Montgomery County, MD, had their rates in 2004 determined by a floor rate before the MMA, but now have their rates determined by the "100 percent of FFS" prong of the formula. Under the MMA, 40 percent of enrollees live in counties where the rates are determined by the "100 percent of FFS" prong and 31 percent are determined by either the blended rate prong or the minimum update prong.

For 2004 under the new MMA rates, we estimate that across all counties, Medicare is paying M+C plans an average of 107 percent of what it would cost to cover the current demographic mix of M+C enrollees under the

traditional fee-for-service Medicare program. That is, Medicare pays 116 percent of FFS spending for enrollees in floor counties in large urban areas, 123 percent of FFS spending in floor counties in other areas, and in nonfloor counties (counties where the blended rate, the minimum update rate, or the "100 percent of FFS" rate is higher than the floor rate) Medicare pays 104 percent of average FFS spending. Because of the additional payments made on behalf of M+C patients by the Medicare program directly to hospitals for IME, payments to plans in "100 percent of FFS" counties average 102 percent of the cost of covering demographically similar beneficiaries. As with the earlier estimates, these assume that the average health risks of the M+C and traditional enrollees are the same, other than those differences accounted for by demographic characteristics.

Risk adjustment system and payments to M+C plans

From the time plans were first paid based on capitation, the program has adjusted the capitation rates to reflect expected health care spending differences among plans based on the characteristics of their enrollees. This "risk adjustment" has been intended to pay plans appropriately for the health status of enrollees. Without accurate adjustments, two imbalances occur in the Medicare payment system:

- Payments are inequitable among competing plans. Plans that enroll healthier beneficiaries are paid the same as those that enroll sicker ones.
- Payments are inequitable between the FFS and private plan programs in the aggregate. If plans in general attract healthier-than-average beneficiaries, the Medicare program pays more than these same beneficiaries would cost in the FFS program.

The early form of risk adjustment ("demographic") was based on administrative data: enrollees' age, sex, and other demographic features, along with certain program features, such as whether beneficiaries were enrolled in Medicaid. Evaluation and other studies in the past found that this demographic risk adjustment system did not reflect expected spending differences among enrollees very well. As a result, Medicare paid inaccurately across plans, and paid more for plan enrollees than for similar enrollees in the FFS program.

In 1997, the Congress required the Secretary to improve the risk adjustment system. The improved system, based on health conditions and demographic features of enrollees, is to be phased in over time to allow plans to adjust to the expected change in payments. Based on the findings from the earlier studies, CMS and other analysts estimated that—on average—private plan enrollees are healthier than FFS beneficiaries. Thus with more accurate risk adjustment, aggregate payments to plans are expected to decrease. However, payments to individual plans might be higher or lower, depending on the health status of their enrollees. Further, as the payment system becomes more accurate, the financial penalties for enrolling sicker beneficiaries would lessen, so one might expect enrollment differences among plans and the FFS program to decrease. More accurate coding of diagnoses by plans would also narrow measured differences.

An issue with implementing the new risk adjustment system

In 2004, the Secretary is introducing a risk adjustment system to more accurately reflect expected differences in health spending than either the earlier demographic system or the current interim system, each described in the text box on page 212. According to the statutory transition schedule, 30 percent of the payment is to be adjusted using the new system and the remainder of the payment is to be adjusted using the current demographic system. Although this phase-in cushions plans from the risk adjustment's effects, it also allows for 70 percent of payments to be higher than they would be if the more accurate risk adjustment system were fully implemented. Following the phase-in schedule in the law, the new system would be fully implemented in 2007.

Even though the new system is phased in to prevent dramatic changes in payments, the Secretary further cushioned plans against the expected effect of risk adjustment. To prevent aggregate plan payments from decreasing as a result of the more sensitive risk adjustment system, CMS estimated the impact of the new system on aggregate plan payments and has restored the difference (CMS 2004). Some argue that authority for the increase derives from Congressional conference report language for the Balanced Budget Refinement Act of 1999 (U.S. House 1999). CMS has not yet indicated whether its policy of maintaining the aggregate amount of plan payment will continue in 2005 and beyond. The Commission is concerned that if it does, risk selection between the M+C program and the FFS program will not be addressed, and

Details of the new risk adjustment system

When CMS developed its new risk adjustment system based on hierarchical condition categories (HCCs), the agency found that the costliness of specific groups of beneficiaries differs substantially. In response, CMS developed distinct versions of the CMS-HCC for beneficiaries who

- live in the community and do not have end-stage renal disease (the "standard" population);
- have lived in institutions over the long term (at least 90 days);
- have end-stage renal disease (ESRD); or
- are frail and participate in special managed care programs for frail beneficiaries. These programs include the Program for All-Inclusive Care for the Elderly (PACE), social HMOs, the Minnesota disability health option, the Minnesota senior health option, and the Wisconsin partnership program.

CMS first developed the standard model and then created the models for the other populations, basing them on the standard model. The characteristics common to all of these models include:

- They use a beneficiary's demographic characteristics and diagnoses from hospital inpatient, hospital outpatient, and physician encounters to determine the beneficiary's expected costliness the next year.
- They organize beneficiaries' diagnoses into disease groups based on clinical attributes and treatment costs.
- CMS estimates the costliness associated with each demographic characteristic and each disease group. The agency determines expected costliness by summing the costliness associated with the beneficiary's demographics and disease groups.
- They are additive. Adding a diagnosis from a disease group to a beneficiary generally increases the beneficiary's expected costliness. However, the CMS-HCC has a few hierarchical sets of disease groups. If an enrollee has more than one disease group in one of these hierarchical sets, CMS will use only the most costly disease group to determine the enrollee's expected costliness.

CMS will determine an enrollee's risk score by dividing the enrollee's expected costliness by the costliness of the national average beneficiary in FFS Medicare. A risk score below 1.0 indicates that the enrollee's expected costs are lower than average. A score above 1.0 indicates that the enrollee's expected costs are higher than average. ■

payments for M+C enrollees will be systematically higher than if those same beneficiaries remained in the traditional Medicare program. Plans with adverse selection get paid accurately for their risk (relative to competitor plans) plus an extra amount that results from other plans' favorable selection.

A second-order issue is that MedPAC fears the adjustment may be higher than the true selection difference. This is expected both because plans are likely to code more accurately once their payments are based on diagnoses and because the plans will have less or no incentive to avoid beneficiaries with more costly conditions which, if these beneficiaries join plans, will raise plans' relative risk scores. If the estimated difference indeed proves too high (because M+C enrollees are more similar to those in the FFS population than projected), plans will continue to receive the higher rate adjustments, at least for that year. In sum, even if the estimate of the difference were perfect, plans would continue to benefit from the additional payment under CMS's current policy.

The Commission has recommended in the past that program payments for beneficiaries should be equal whether they are enrolled in private health plans or in traditional Medicare (MedPAC 2001). MedPAC and its predecessor Commissions have strongly supported adoption of more accurate risk adjustment as an important step towards achieving this goal of payment equity. Increasing plan payments (as CMS has done) to offset the effect of more accurate risk adjustment is inconsistent with the Commission's views on payment equity.

Looking toward a reformed Medicare system of competing plans that are at risk for health care service costs—both those that cover drugs only and those that cover all Medicare benefits—it is important for the program to employ tools like risk adjustment that accurately reflect differences in the expected health care spending of enrollees. This both protects the Medicare program and sets a level playing field among all types of plans.

RECOMMENDATION 4A

CMS should continue to risk-adjust payments with the new CMS hierarchical condition category system, but should not continue to offset the impact of risk adjustment on overall payments in 2005 and subsequent years.

RATIONALE 4A

MedPAC and its predecessor Commissions have strongly supported adoption of more accurate risk adjustment as an important step towards achieving the goal of payment equity between the Medicare FFS program and private plans in Medicare. Increasing plan payments to offset the effect of more accurate risk adjustment is inconsistent with the Commission's views on payment equity. CMS has not yet indicated whether its policy of maintaining the aggregate amount of plan payment will continue in 2005 and beyond. The Commission is concerned that if it does, risk selection between the M+C program and the FFS program will not be addressed, and payments for M+C enrollees will be systematically higher than if those same beneficiaries remained in the traditional Medicare program.

IMPLICATIONS 4A

Spending

- This recommendation should not affect Medicare benefit spending because current baseline spending does not assume the increase will occur after 2004.

Beneficiary and plan

- This recommendation should not affect beneficiaries or plans because current law does not assume the increase will occur after 2004.

Risk adjustment and end-stage renal disease patients on dialysis

Current law prohibits end-stage renal disease (ESRD) beneficiaries who are treated with dialysis from enrolling in M+C. However, beneficiaries who start in plans and later develop ESRD are allowed to remain in their plans.[2] The Congress based its decision in part on concerns that the payment method for ESRD does not effectively adjust payments for conditions that affect costliness (MedPAC 2000). Currently, Medicare pays M+C plans 95 percent of statewide per capita costs of caring for ESRD beneficiaries.

ESRD beneficiaries are, on average, very costly to treat compared with non-ESRD beneficiaries; moreover, the cost can vary widely. Plans therefore would take a large risk in covering ESRD beneficiaries unless the payment system is accurate. In 2005, however, CMS will replace the current payment system for dialysis patients, which is the statewide ESRD average cost adjusted only for age and sex, with a version of the new risk adjustment system that is designed specifically for ESRD beneficiaries receiving dialysis. The system is virtually the same for ESRD (those on dialysis) and non-ESRD beneficiaries, but the calculations are done separately, thereby increasing the accuracy for both groups of beneficiaries. Thus, for ESRD beneficiaries on dialysis, this model should perform much better than the current demographic system and payments to plans will more accurately reflect the costs of treating them.

All beneficiaries should be allowed the voluntary choice of plans so long as payment is accurate, so MedPAC has recommended that ESRD beneficiaries be allowed to enroll in plans once CMS has implemented adequate risk adjustment.[3] The evidence from a recent demonstration was that quality of care in M+C plans was good. In 2001, Medicare completed a three-year demonstration project testing the use of integrated acute and chronic care services and case management for ESRD beneficiaries enrolled in two M+C plans. The study evaluating the effectiveness of this demonstration showed that the quality of care and outcomes of most participants were equal to or better than those for ESRD patients enrolled in traditional Medicare. Many private plans offer care coordination and disease management services that may benefit ESRD beneficiaries, as they often have multiple chronic comorbidities such as diabetes, congestive heart failure, and hypertension.

RECOMMENDATION 4B

The Congress should allow all beneficiaries with end-stage renal disease to enroll in private plans.

RATIONALE 4B

All beneficiaries should be allowed the voluntary choice of plans so long as payment is accurate. In 2005, CMS will replace the current payment system for ESRD enrollees with a version of the new risk adjustment system

that should perform much better than the current demographic system and payments to plans will more accurately reflect the costs of treating them. A study evaluating a Medicare ESRD demonstration showed that the quality of care and outcomes of most plan participants were equal to or better than those for ESRD patients enrolled in traditional Medicare.

IMPLICATIONS 4B

Spending

- This recommendation should not affect Medicare benefit spending.

Beneficiary and plan

- ESRD beneficiaries will have the choice of private plans.
- There should be no significant impact on plans.

Using payment incentives to improve the quality of care in private plans

One of Medicare's most important goals is to ensure that beneficiaries have access to high-quality health care. Generally, the current payment system is neutral or negative toward quality and fails to financially reward plans or providers that improve quality. MedPAC has recommended that Medicare pursue provider or plan payment differentials to improve quality (MedPAC 2003). We are examining FFS providers (see Section 3E on dialysis) and expect to expand to other sectors as measurement sets improve.

The Commission recognizes that the ability to choose, collect data on, and make payments based on measures of quality varies in different settings. Private Medicare plans already report to CMS on a host of well-accepted quality measures. Plans vary in performance on the reported quality measures and room for improvement exists on almost all measures (see Chapter 2). Because plans are responsible for the whole spectrum of Medicare benefits, they have unique incentives to coordinate care among providers. To the extent that these incentives are successful, providers treating beneficiaries in both Medicare private plans and in the FFS program may learn practices that improve the quality of care for FFS beneficiaries as well. Also, measuring quality at the plan level may help identify effective mechanisms for better coordination, imparting lessons that may be useful in the FFS program.

This is not to say that private plans are the only groups able to innovate and improve their performance. FFS providers are sometimes organized so that they coordinate care across settings and improve quality. Under the current FFS payment system, however, it is difficult to recognize and financially reward these types of non-plan provider organizations. The Commission expects to identify these arrangements and consider payment and other approaches to stimulate innovative delivery systems in future work.

RECOMMENDATION 4C

The Congress should establish a quality incentive payment policy for all Medicare Advantage plans.

RATIONALE 4C

One of Medicare's most important goals is to ensure that beneficiaries have access to high-quality health care. Generally, the current payment system is neutral or negative toward quality and fails to financially reward plans or providers that improve quality. Private Medicare plans already report to CMS on a host of well-accepted quality measures. Payment incentives have the ability to improve the care of beneficiaries in MA plans.

IMPLICATIONS 4C

Spending

- This recommendation should not affect Medicare benefit spending because the Commission envisions that an incentive program would be implemented in a budget-neutral manner.

Beneficiary and plan

- Quality of care for enrollees in private plans would improve.
- Some plans could receive higher or lower payments based on their performance on quality measures. We believe this recommendation represents a minimal burden to plans because measures are already being reported.

It is feasible to implement quality incentive payments for Medicare managed care plans

The Commission prefers to apply quality payment incentives to all groups of providers and plans in Medicare, but many sectors lack the data structure necessary to support an effort immediately. Based on our analysis of private sector efforts, several criteria need to be met for incentive efforts to be effective:

- Well-accepted quality measures must be available.
- A standardized data collection method must exist.
- If risk adjustment is necessary, acceptable methods must be available.
- Plans or providers whose performance is measured must be able to improve.

The Medicare Advantage program (as well as facilities and physicians that care for beneficiaries on dialysis—see Section 3E) is an excellent sector for applying payment incentives to provide high-quality care because it meets, in whole or in part, all the criteria for successful implementation. Standardized, credible performance measures are collected on all M+C plans. Each year M+C plans collect data on specific clinical process measures (e.g., immunization and screening rates) and data that reflect health plan members' satisfaction with the plan's service provision (e.g., enrollees' perceived ability to obtain care in a timely manner). Together, these data constitute a widely accepted, broad cross section of plan quality. Most of the process measures in these data sets do not require risk adjustment, and CMS has developed risk adjusters for the satisfaction measures. Plans have developed a variety of strategies to improve their scores on these measures by working with providers in their networks.

Applying incentives at the health-plan level serves a dual purpose. First, the health plan can use purchasing leverage and data analysis capability to encourage improvement by the providers with which it contracts. Second, because they are responsible for all Medicare services, health plans can also address the problem of the lack of coordination and appropriate management of chronic conditions across settings. Measuring care at the health plan level may make it possible to identify effective mechanisms for better coordination not often possible through provider-specific efforts. For example, one group of M+C plans, the Alliance of Community Health Plans (ACHP), has proposed a mechanism for using payment incentives to improve quality.

What performance measures could be used?

MedPAC uses the quality goals outlined by the Institute of Medicine (IOM) to determine the level of quality care provided in any setting—effectiveness, safety, patient-centeredness, and timeliness. M+C plans already collect data on several of these aspects of quality. Therefore, if CMS bases its incentive program on those data, it would not place any added burden on plans. Plans annually report audited Health Plan Employer Data and Information Set (HEDIS) data on process measures, such as whether patients received certain preventive screenings and tests. Also, in the annual Consumer Assessment of Health Plans Survey (CAHPS), plans report data that reflect health plan members' assessments of the care they receive, their personal doctors and specialists, the plan's customer service, and whether they get the care they need in a timely manner (see Chapter 2 for more detail on HEDIS and CAHPS data). More measures are becoming available as HEDIS requirements for M+C plans are being expanded and as Medicare's Quality Improvement Organizations require data collection from Medicare providers.

These measures could be used in different ways to create payment incentives. Several individual measures might be used to focus on particular problem areas. The specific measures could change over time to refocus plan efforts. Other possibilities include combining individual measures to create more comprehensive, or "composite" measures. For example, CMS has calculated CAHPS composite measures from time to time to simplify plan comparisons on its website. In another instance a group of researchers found that they could group measures into four summary scores representing 1) care at the doctor's office, 2) customer service and access, 3) vaccinations, and 4) clinical quality measures (Zaslavsky et al. 2002).

The Commission recognizes that there is much work to be done on devising the most appropriate individual or composite measures. For use in payment incentive programs, however, MedPAC favors relying more heavily on the clinical measures of quality collected in HEDIS than on the consumer satisfaction measures in CAHPS. The Medicare payment system does not currently reward strong plan performance on the clinical measures, and although they are publicly reported, the HEDIS measures do not tend to influence enrollment decisions (Harris et al. 2002, Scanlon and Chernew 1999). Payment incentives tied to clinical quality measures, however, do have the ability to reward strong plan performance on those measures.

We recognize the value in consumer satisfaction data because it is a good way to measure progress toward the IOM quality goal of patient-centeredness. However, it is not as important to reward strong performance on those measures through payment incentives. By their nature, satisfaction measures derive from beneficiary perceptions,

and beneficiaries are generally free to act on their perceptions by staying in plans they like and leaving those they do not like. Although in some instances beneficiaries do not have alternative choices, in many cases the market already rewards plans for strong consumer satisfaction performance through increased enrollment.

Including all managed care plans in the incentive system maintains a level playing field between plan types and rewards those plans that invest in improving quality. Incentive programs should thus use performance measures that all plans can collect. Some, but not all, of the clinical quality measures are most accurately collected by abstracting medical records. Abstracting records is a resource-intensive process for all types of plans, but closed-panel managed care plans generally have better access to medical records than plans with wide or no networks (such as PPOs and PFFS plans) and those that allow beneficiaries to go out-of-network to receive covered services. In fact, CMS exempts PPOs and PFFS plans from reporting a small group of HEDIS measures that are collected only through record abstraction (Table 4-4). Therefore, it may be important, at least initially, to base incentives on quality measures currently collected on all types of plans.

TABLE 4-4

HEDIS measures for Medicare PFFS/PPO plans, 2004

	Whether measures are required		
HEDIS measures	**All**	**Some**	**None**
Breast cancer screening	X		
Controlling high blood pressure			X
Beta blocker treatment after heart attack			X
Cholesterol management after acute cardiovascular event		X	
Comprehensive diabetes care		X	
Follow-up after hospitalization for mental illness	X		
Antidepressant medication management		X	
Medicare health outcomes survey	X		
Management of urinary incontinence in older adults	X		

Note: HEDIS (Health Plan Employer Data and Information Set), PFFS (private fee-for-service), PPO (preferred provider organization). PPO plans include Medicare+Choice, PPOs and PPO demonstration programs.

Source: CMS Medicare Managed Care Manual, 2003.

What types of payment incentives could be used?

The goal of an incentives program should be to improve care for as many beneficiaries as possible. This goal provides guidance on how to distribute incentive payments.

Medicare could reward plans that meet a certain threshold on the relevant performance measure, plans that improve their scores, or some combination thereof. A combination would likely reach the most beneficiaries. Some issues to consider in the design of specific incentives include:

- **Threshold level**—If a threshold is set too high, some plans may decide that it is not reachable and not expend any effort to improve. If a threshold is set too low, plans may expect to reach it without any additional effort.
- **Improvement measure**—All plans have the potential to improve their scores, but if the improvement measure is not carefully designed, low-performing plans may have a better chance of showing greater improvement.
- **Number of plan awards**—Awards made to only a few plans would result in most plans getting lower base payments with less of a chance to get an award.
- **Size of awards**—The larger the awards, the more competition there is likely to be for them and the greater the improvement effort is likely to be. If awards are too small, plans may decide not to make the investment to improve quality.
- **Multiple dimensions**—Awards could be based on one score or be divided up so that plan eligibility would be based on different aspects of care. For example, a plan might receive an award for improving diabetic care, but might not qualify for an award for heart care.

An illustration

MedPAC is not recommending any specific implementation strategy for an incentive program and acknowledges that CMS would have work to do before it would be ready to administer any incentive program. MedPAC suggests creating a reward pool from a small percentage of current plan payments and redistributing it based on plans' performance attainment and improvement on quality indicators. The program should be budget neutral to the Medicare program, and CMS would need to

create a mechanism that ensures budget neutrality. For illustrative purposes (and mathematical simplification), assume an award fund equal to 1 percent of Medicare plan payments. If the incentives are to be reachable and the awards still be substantial enough for plans to compete, perhaps between one-fourth and one-half of plans would get awards. If one-fourth of plans got an award, the awards would be for an additional 4 percent of Medicare payments; if one-half got an award, they would be for a 2 percent bonus. In both cases, a plan that did not receive an incentive payment award would receive 1 percent lower Medicare payments than if there were no incentive program. It is the Commission's intention that all funds would be spent from the incentive fund promptly, and we believe that administrative mechanisms will make this feasible.

To motivate most plans to improve or maintain high quality, some awards could be based on the plan's attainment on performance measure scores, and other awards could go to plans with the greatest improvement over their prior year's score. The award pool would be split in some predetermined manner and a plan could win only one award. ■

Endnotes

1 For Medicare beneficiaries enrolled in private plans as active workers, Medicare acts as a secondary payer. Many other beneficiaries are enrolled in private plans that supplement Medicare (e.g., Medigap).

2 Effective June 2000, CMS permits ESRD beneficiaries with functioning kidney transplants to enroll in M+C if they meet all other eligibility criteria.

3 MedPAC also recommended that CMS establish a system for monitoring quality for ESRD services before allowing ESRD beneficiaries to join M+C plans. CMS already monitors the care of dialysis patients in its Clinical Performance Measures Project. This effort could be modified to provide quality information separately for patients in FFS and private plans.

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