

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

**Wednesday, January 14, 2004**  
**10:19 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  
JOHN W. ROWE, M.D.  
DAVID A. SMITH  
RAY A. STOWERS, D.O.  
MARY K. WAKEFIELD, Ph.D.  
NICHOLAS J. WOLTER, M.D.

**AGENDA ITEM:**

**Medicare+Choice payment policy -- Scott Harrison**

DR. HARRISON: The Medicare+Choice program has provided the majority of Medicare beneficiaries a choice of health care delivery systems through private plans. Past MedPAC recommendations have supported that choice and pushed for the choice to be financially neutral to the Medicare fee-for-service program.

Congress has just passed legislation establishing the Medicare Advantage Program for private plans in Medicare. However, much of that program will be based on the Medicare+Choice program. Thus, many of the same issues for M+C will continue to be relevant.

One of the issues we have focused on is setting M+C rates equal to what would be spent on enrollees by the Medicare program if they chose to remain in the traditional fee-for-service program. In the recent legislation, Congress chose to increase payment rates for 2004 and 2005 in order to bolster plans to they would remain in the program until 2006 when some competitive factors would influence rates.

Remember last year payment rates were the maximum of three prongs, a floor rate, blended local national rate, and a minimum 2 percent update. For 2004, a fourth prong is added, 100 percent of the county fee-for-service spending. MedPAC, of course, has been recommending that all county rates be set at that fourth prong. Adding the fourth prong and a few other adjustments, such as restoring IME spending to the rates, results in M+C rates growing faster relative to fee-for-service spending.

CMS will release the actual payment rates for 2004 this coming Friday but just to give you an idea, I've projected that M+C payments will average at least 107 percent of fee-for-service costs for demographically similar beneficiaries and that's compared with 104 percent the past year in 2003. Those ratios do not take into account any risk selection differences between the plans and the fee-for-service program, and that kind of difference will be discussed shortly.

However, given that Congress raised rates to encourage plan participation and that legislation has also given MedPAC several mandated studies involving broad issues surrounding Medicare Advantage plans, including a study due next year that will give the Commission an opportunity to re-examine financial neutrality. For the short run, including our report chapter and the draft recommendations we discuss today, we are focusing on other issues that are important for the current program and that will also be important in the long run.

I will present three draft recommendations. The first two arise from the new risk-adjustment system that has just been implemented. MedPAC has stated many times that risk adjustment is crucial if we are to pay private, risk-bearing plans properly. Risk-adjustment can be used to help creative financially neutral choices. CMS has made a choice in implementing the new risk-

adjustment system this year that has the effect of moving away from financial neutrality and the first draft recommendation would have CMS revert its position in future years.

The new risk-adjustment system also present an opportunity to expand plan choice to the ESRD population and the second draft recommendation would take advantage of that opportunity.

The final draft recommendation reflects an extension of the Commission's analysis of using payment incentives to improve quality of plan services.

CMS has implemented a new risk-adjusted system just earlier this month. It measures risk using demographics and diagnoses from inpatient, outpatient and physician settings from the previous year. It will greatly increase the accuracy of predicted fee-for-service costs for M+C enrollees. And in 2005 a special module will be added specifically for ESRD beneficiaries.

MedPAC has recommended that risk-adjustment systems be developed and used to pay plans fairly, both compared with other plans and with the traditional fee-for-service program. The new risk-adjustment system will increase the accuracy of payments, paying plans closer to the proportion of the expected costs of their actual enrollees.

Thus, plans should be paid fairly compared with competitor plans and should discourage plans from devoting resources attempting to attract a favorable selection of enrollees. However, all plans will be paid more than it would cost the traditional Medicare program to cover the same M+C enrollees because of an upward adjustment that CMS is making for all payment rates. CMS makes this adjustment to equalize total Medicare+Choice payments under the new system with what they would've been under the old demographic system. All plans, regardless of the actual effect that the risk scores would have on their payments, would benefit from the upward adjustment. This adjustment directly contradicts one of the prime reasons for risk adjustment which was to pay the same to cover a beneficiary whether the beneficiary enrolled in an M+C plan or chose to remain in the traditional fee-for-service plan.

CMS has publicly committed to this policy only through 2004. We do not know what the plan is for future years at this point.

Which leads us to draft recommendation number one. CMS should continue to risk-adjust payments with the new CMS HCC system but should not continue to increase payment rates to offset the overall payment impact of risk adjustment. Because at this point CMS's upward adjustment is not considered current law for 2005, eliminating it would not be considered a change to the current law and that's why we have no spending implications.

Medicare statute states that ESRD beneficiaries are ineligible to join Medicare+Choice plans. However, M+C enrollees who develop ESRD may stay in their current plans. And CMS has exempted ESRD beneficiaries who have had successful transplants from the prohibition, it deems them eligible to join plans. So at this point, the only ESRD beneficiaries deemed ineligible are those that are receiving dialysis.

Given that the Commission believes all beneficiaries should have equal access to managed care options, and that CMS has

developed and will implement a suitable risk-adjuster in 2005, and that we have seen no evidence that quality concerns are greater in managed care plans than in for the fee-for-service for ESRD beneficiaries, we present draft recommendation two, which reiterates a recommendation that we made in 2000. The Congress should allow beneficiaries with end-stage renal disease to enroll 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 fee-for-service providers who improve quality. MedPAC has recommended that Medicare pursue provider or plan payment differentials to improve quality.

Applying incentives at the health plan level serves several purposes. First, the health plan can use purchasing leverage and data analysis capability to encourage improvement by the providers with which it contracts.

Second, health plans can also address the problem of the lack of coordination and appropriate management of chronic services across settings with patients because they are responsible for all Medicare services.

Measuring quality at the plan level may help identify mechanisms for better coordination and thus imparting lessons and may turn out to be useful in the fee-for-service program, as well.

And to the extent that the plans approaches are successful, providers who treat beneficiaries both in the Medicare private plans and in the fee-for-service program may learn practices that improve the quality of care for the fee-for-service beneficiaries they treat as well.

In last June's report, we developed criteria for successful implementation of a financial incentive program. As we noted in June, Medicare+Choice plans meet all those criteria. Standard, credible performance measures are collected on all Medicare+Choice plans. Each year Medicare+choice plans report HEDIS data on specific clinical process measures, for example immunization and screening rates. And they complete a survey called CAHPS that reflects health plan member satisfaction with the plan's service provision. For example, enrollees perceived ability to obtain care in a timely manner.

Together these data comprise a widely accepted broad cross-section of plan quality and most of the measures in the data sets do not require risk adjustment and plans have developed a variety of strategies to improve upon their scores by working with providers and their networks.

Going back a little bit to where we were with Nancy, the goal of an incentives program should be to improve the care for as many beneficiaries as possible. Medicare could reward plans who meet a certain threshold on the relevant performance measure or plan to improve their scores or probably some combination.

In order to create incentives that would improve quality for many beneficiaries, most plans would need to feel that improvement goals were in reach. Thus, we would favor rewarding

a large share of plans. The incentives would be financed with a small proportion of total payments, as we just mentioned with dialysis.

What are some of the potential quality measures that could be used? MedPAC uses the quality goals outlined by the Institute of Medicine to determine the level of quality of care provided in any setting. Those are effectiveness, safety, patient centeredness, and timeliness.

As mentioned, Medicare plans already collect such data. These measures could be used in different ways to create the payment incentives. Several of individual CAHPS or HEDIS measures could be used to focus on particular problem areas. The specific measures could change over time to refocus plan efforts.

Individual measures could also be combined to create more comprehensive or composite measures. We don't really want to advocate any particular measures but it is important to include all managed care plans in the incentive system to maintain a level playing field between plan types and to reward those plans that invested in improving quality.

Incentive programs should thus use performance measures that all plans can collect. All plans, including PPOs and the private fee-for-service plans, report on 12 of the 18 HEDIS clinical quality measures and on all of the CAHPS measures.

However, for use in payment incentives programs, we might favor 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 clinical measures, and although they are publicly reported, the HEDIS measures do not tend to influence enrollment decisions. Payment incentives tied to clinical quality measures, however, do have the ability to reward strong plan performance on those measures.

In this draft recommendation MedPAC would not be recommending any particular formulation other than creating a reward pool from a small percentage of plan payments and redistributing it based on plans' performance attainment and improvement on quality measures. The draft recommendation reads the Congress should establish a quality incentive payment policy for all Medicare Advantage plans.

MR. HACKBARTH: For the benefit of our audience, although we are only considering recommendations for incentive payments in two areas this time around, M+C and ESRD, people should not infer from that that we think that's the end of the task. We see this as the beginning. We think this is a concept that should be broadly applied within the program.

We've chosen the two areas of M+C and dialysis because we think those are the two areas where we're most prepared to move ahead, for all the reasons that Scott and Nancy have described, consensus on measures and the like. But this is not as far as we think these concepts should be applied.

MS. ROSENBLATT: Are we going to discuss all three or one at a time? Do you want me to make comments on all three?

MR. HACKBARTH: Let's just do all three.

MS. ROSENBLATT: Scott, forgive me, I should know this. But

I'm getting confused about the years and what you're recommending. The 4.9 percent is going to apply to 2004 or 2005?

DR. HARRISON: [off microphone.] 2005, although that number may change.

MS. ROSENBLATT: And is your recommendation on not making this adjustment for financial neutrality, is that started in 2005 or are you saying we shouldn't do that in 2004?

DR. HARRISON: I think it's a little late to say that for 2004, so we're focusing on 2005.

MS. ROSENBLATT: I think that maybe I'm not the only one that might end up confused by the language. And maybe if you could include that.

DR. ROWE: So it's 2005?

DR. HARRISON: Yes.

MS. ROSENBLATT: So that's my comment on the first one.

On the second one, can you refresh my memory because I remember at previous meetings the advocates for ESRD patients have said don't do this. And I'm trying to remember why they've said that.

DR. HARRISON: I think it tended to be more from the dialysis facilities than from the groups.

MS. ROSENBLATT: No, I remember advocates.

MS. DePARLE: Alice is right. I met with the advocates a number of times. There was a study going on they wanted to see the results of before they were willing to say it was safe.

DR. HARRISON: And I think we reported the results of that study in June.

MS. DePARLE: I'm going back three or four years.

MS. ROSENBLATT: So the advocates would now say it's okay?

MS. DePARLE: Well, I haven't spoken with them. But what they said then was that they just were concerned that it might not be clinically safe for those patients and they wanted to see the results of this study.

MS. RAY: There was concern raised about the quality of dialysis care in managed care plans versus fee-for-service. CMS implemented a demo, started it back in the late '90s, '97, '98, finished in 2001. An evaluation was done on it. It included two plans, Kaiser and a plan in Florida, ultimately, Health Options.

The results of that showed that quality was either the same or better in the plans compared with fee-for-service on all the measures except one. The one where there was a difference was on rates of kidney transplantation. And that was with the Florida plan, which was the much smaller plan in the demo. And that was because of the distance from where the plan was to the nearest transplant facility.

But on all the other measures that they looked at -- and again, an outside group did the evaluation -- it was equal to or better.

MS. ROSENBLATT: On the third recommendation I'm still hung up on this, if it was the private sector you'd set up a liability. And I'm just wondering, you all may think I'm crazy, but this is the actuary in me speaking. Do we need some language, maybe not in the recommendation. bit in the text that

goes something like this: as the actuaries and the trustees project the long-range monetary obligations of the program, this quality incentive needs to be considered in the long-range financial projections. That it's not a zero number, that there actually needs to be money included in those projections.

DR. HARRISON: One way we had been thinking about this is you could end up paying on relative rates so that you pay for top X percent of beneficiaries in plans. You stack up all of the scores and pay for the top X percentage, so that you're sure the pot gets paid out. But that was also confusing to people. So we'll work on making it clear.

MS. BURKE: Alice, I would be concerned that that kind of instruction would be translated into new money and that's not, in fact, what's being discussed here. We're talking about a zero sum game. We're not talking about projecting an additional burden on the trust funds, that the actuaries in calculating long-term stability would consider.

MS. ROSENBLATT: I know, but we're not making a comment about budget neutrality. So if they don't include any kind of projection for this --

MS. BURKE: We could say that. I guess I understood when you say set aside 1 percent, that's of the existing pot, that is neutrality. That's not additive money. That's out of the base.

MS. ROSENBLATT: But we don't have that. In other words, I think where it exists right now is if ends up being a half percent, we would be okay with that.

MS. BURKE: That's not my point. My point is it's out of the base; i.e., neutral. Maybe we need to say that explicitly. Whether it's 20 percent set-aside or a 1 percent or a third of a percent, it is out of the base. It's not additive to the base. It's neutral to the base. Maybe we need to say that.

MR. HACKBARTH: And it's our expectation, as we discussed with the ESRD, that it will be paid out as opposed to used as a mechanism to reduce payments.

MS. ROSENBLATT: I'd be a lot more comfortable if we stated budget neutral.

DR. REISCHAUER: Scott, correct me if I'm wrong, because I want to make sure Alice understands this. A 4.9 percent across the board adjustment was made for 2004 to payments when the new risk adjustment procedures were introduced by an administrative action. We are recommending not just that when the next tranche of risk adjustment is introduced in 2004 that an administrative action is not taken to add another whatever percent to the payment, but that the payment made for 2004 disappears, as it will disappear unless the administration does something.

DR. HARRISON: It doesn't disappear in 2004, it disappears forward.

DR. REISCHAUER: But in 2005 it would disappear.

DR. HARRISON: Right.

DR. REISCHAUER: And there would be no adjustment so we would be back to where we recommended if be.

DR. HARRISON: This adjustment is not published in the base rates. This is done sort of off the books.

DR. ROWE: If we started at \$100 and we went to \$104.90 for

'04, what we would be recommending with this is we go back for '05 to \$100.

DR. REISCHAUER: Right.

DR. ROWE: I have comments on each of these. Let's start with the third one. Although I recognize there's a lot of concern among health plans on the quality issue, I believe in pay for performance and I think we're generally trying to go in that direction and I would support that recommendation.

As far as the end-stage renal disease -- and I recognize this is budget neutral, not new money and I would support that as well.

With respect to the end-stage renal disease, I'm not too concerned the advocacy groups, so-called advocacy groups who represent themselves as representing the best interests of the patients. We heard a lot from those groups about how it was really important to do bone marrow transplants for breast cancer patients. And I'd rather see what the data show, but unless the data indicate that there's something wrong with giving dialysis patients the option, I would support the recommendation. As I read it it's voluntary. It's not mandatory. So I don't understand why an advocacy group might -- and you know, you've seen one dialysis patient, you've seen one dialysis patient. They vary dramatically from healthy young people with polycystic kidney disease to elderly people with many diseases who would benefit disease management programs and other programs that might be in managed care plans.

So it would seem to me that we should let them make that decision. And we might say some stuff about that in the text about the variability of patients and the disease management programs, et cetera.

Now on the first one, a couple points. One is you started with the oft-quoted and sometimes striking statement, Scott, about the payment rates from M+C being, on average, 103 percent of fee-for-service unadjusted and 117 or 113 of whatever it is adjusted. I think it's fair, I liken this to the rural issue. It's a little bit like talking about the payments to all rural hospitals, including the critical access hospitals and the sole community resource hospitals where the rates were increased specifically in order to assure access.

You take those out, then you see that the rates for the rural hospitals don't look as high. The numbers you gave us include the floor counties, where by law the Medicare+Choice rates were increased above the fee-for-service rates in order to assure access to Medicare+Choice in the floor counties. So I just don't think that's quite fair. I think you should take those out.

You mentioned this in the text but in the presentation that's what we lead with and that's where everybody's starting point is. And everybody therefore says well, these plans are being "overpaid." And I think it's the same thing as with the rural hospitals. It should be apples and apples.

That said, I think we have to then try to figure out whether or not the difference between politics and policy, as a wise person told me recently, whether or not there was a policy reason

for holding the plans harmless during the transition or whether it wasn't based on policy. I wasn't there, thank God, but I guess the question is are we confident during the transition in the first implementation of the risk adjustment data and collection and analysis and implementation that something bad isn't going to happen? Presumably if there was a policy rationale, that was it, to wait until this thing is in place. Does everyone agreed that the data are what they are or are there uncertainties about it?

This is a something I don't know much about but other people do. So I'd like to hear something about our degree of confidence about the implementation of the risk adjustment.

DR. HARRISON: There is a transition built in. This year it's 30 percent based on the risk adjuster. Next year it goes to 50, then 75 and 100. So there is a transition.

DR. ROWE: [off microphone.] I understand the percent that's relative to the risk-adjusted data. I'm just questioning what do we know how that's likely to go?

DR. HARRISON: One of the problems is we don't know. There hasn't been a statement as to why this is being done and how long it would last. There hasn't been a public commitment on the part of the Department to know what their plans are.

DR. ROWE: We are taking a position contrary to what Congress has recommended and CMS has publicly said they're going to do; right?

DR. HARRISON: CMS has only said they're doing it for '04. That's why we have this problem.

MR. HACKBARTH: We are reiterating a long-standing MedPAC policy of neutrality, and that applies in the case of the floors and all of the other reasons that payments are elevated above fee-for-service levels. I'm not sure I followed your first point on why we ought to not include the floors in the calculation of the relationship between M+C payments and fee-for-service payments.

DR. ROWE: I didn't mean to imply that we shouldn't have included it. I was just trying to get to the point. I mean, if somebody comes up and says rural hospitals are paid more than urban hospitals why X percent, then somebody says wait a minute, that includes these special hospitals where there was limited access. And so they did that for a reason. And I think it's the same thing with respect to some of these floor four counties. So I'd just like that included in the conversation.

MR. HACKBARTH: So what we're doing here is we've increased the fee-for-service payments for rural providers, elevating the Medicare fee-for-service levels in the rural areas. And then we're saying on top of that we are going to add still more money for private plans. That's the policy that's in effect and that's the policy that we're taking issue with.

DR. REISCHAUER: But Jack is suggesting that the reason for the floors is to guarantee access for all Medicare patients to Medicare+Choice plans. And I think that was the original intent, but we have to remember that this system, in a sense, has run amuck when you go to Denver and you say that Denver County is a floor county. I mean, I do believe that there are

Medicare+Choice plans in Denver, at least there were when we were thinking of it as a site for an experimentation because there was so much competition in the area.

MS. BURKE: Just two questions on the actual text. At the very beginning of the document you briefly referenced the creation of the new Medicare Advantage, or whatever it's called. I wonder if some fuller explanation of how these differ from the Medicare+Choice, because you suggest that they're establishing a new program called MA, and that the MAs are similar based on the rules and payment structure in M+C, and M+C would become MAs.

For the ill-informed, some further explanation as to is there really a difference or what the critical differences are between what was and what will become might be helpful.

DR. HARRISON: I don't think there's really much of a difference except that they add the regional plans.

MS. BURKE: I think a little further explanation for people who haven't followed this closely might be useful.

The thing I think that might be helpful in terms of background information, the one chart that is not included is the number of plans currently in the program. You have the withdrawals and how many people they affected. You don't have the number of plans referenced, which the number of people is obviously more critical. But there's also nothing in here, even though you talk about the availability within certain areas, you don't ever anywhere talk about how many plans there actually are and how that has moved around, at least not in the document I saw.

And I just thought for a fact, that might be useful background to just have what the trends have been and the distribution among the types of plans. You referenced that in the content, in terms of how they have changed but an actual chart that says how many there are, how that's changed, and what the distribution is across the types of plans might be useful as background information.

MS. ROSENBLATT: Sheila, by plan do you mean entity or do you mean like if one company offers five plans it would be a count of five? Or would that be a count of one for one company?

MS. BURKE: It would be a count of five. I want to know how many plans are in play. If there are 5 million people enrolled, in how many plans are they enrolled?

MS. ROSENBLATT: I would ask, I think both might be helpful because you might offer five plans but nobody takes four of them.

MS. BURKE: [off microphone.] I can't look at this and say this many we talked about it. There's nothing that references how many there are, how that's changed and the nature against the types of plans.

DR. HARRISON: There's a problem with data in that we know the only numbers that have been consistent over the years have been the number of contracts which is really a very tough measure of what --

DR. MILLER: Scott, just using the same metric that we use to talk about plans dropping enrollment, we will use that same metric to talk about what plans are present and what the enrollment is.

DR. HARRISON: Yes, I have current information. It's going back that's tougher.

MS. BURKE: [off microphone] Whatever we have that's reliable in any way that is the least confusing, but it's an obvious question that arises in the text and there's no place where you actually figure out how many of whatever is in play. But that in terms of -- and also the explanation of [inaudible].

DR. NELSON: I agree with the recommendations and basic principles. My comments are more second level of detail.

I know we don't point out typos but occasionally there will be a clinical reference that I don't want to fall through the cracks and have us look clinically ignorant. So on page 13 it references hemoglobin levels for diabetes, and obviously mean hemoglobin Alc levels. And I point that out just so it won't somehow make it into the final report.

My main comment has to do with the administrative burden, the hassle that comes from abstracting information from records in PPOs or private fee-for-service. You point that out on page 14 and you point it out properly. But until we have an electronic health record, it's really important for everybody to recognize that simply rewarding these measures without considering the cost in time and money to collect the information and the fact that sometimes it's buried way down in the chart where it's hard to find, the point really needs to be borne in mind.

With respect to that, on table three, somebody makes an allocation of which of these HEDIS reporting data are applicable to private fee-for-service and PPOs and which ones aren't. And a number of those are arguable either way. For example: colorectal cancer screening might be applicable because you have colonoscopy and occult blood screening on administrative data sets.

DR. HARRISON: This table is actually from the Medicare managed care plan manual and this tells the plan what they're responsible for. So indeed, PPOs and private fee-for-service do report on the colorectal cancer screening. Now actually, that one turns out to be a new measure that they will have to start reporting this year. So these are decisions that CMS has made in administering the program.

DR. NELSON: Good. So that it doesn't become arguable and attributable to us in that argument, let's make sure that that's referenced.

DR. HARRISON: Let's make sure that that's clear.

MS. DePARLE: Sheila's question reminded me of a question I had when I read your materials. On page five you talk about the private fee-for-service plans and the reductions in those over the last couple of years. And I was curious as to what we think is going on there.

And then also you talk about the PPO demo. It doesn't say in here but the goals of that obviously were to expand access to these kind of plans. I can't tell from this whether any of those demos have gone into places where there were not already some sort of M+C options.

DR. HARRISON: The answer is some but not many.

MS. DePARLE: So how many?

DR. HARRISON: I did that a few months back. My recollection is -- I don't remember. I think it was single digits but I don't remember.

MR. HACKBARTH: Do you remember, Scott, the percentage of the PPO enrollees that were previously enrolled?

DR. HARRISON: Yes, that's in here.

MS. DePARLE: That's in here. That's 51 percent.

DR. HARRISON: There are some areas where there wasn't a Medicare HMO where a PPOs went.

MS. DePARLE: That's what I'm more interested in because if we want to get coverage of this in an option for beneficiaries, if not why not? Maybe Jack or others can answer, why are they still not going in there? Are there other things that we need to be doing?

And on private fee-for-service, I'm surprised that that seems to be declining and I'm interested in any insights you have about why that's happening.

DR. HARRISON: My impression is they see their history in an area. And if it doesn't look too good, they get out. New plans, but I'm saying the one plan tends to look at areas and see how they're doing.

MS. DePARLE: Loss ratios?

DR. HARRISON: I'm sure that's what they must doing.

DR. MILLER: [off microphone] Also no involvement.

DR. HARRISON: Well, their low enrollment sort of generally. They have a very vast area and a no area is their really large enrollment.

MS. DePARLE: Does it appear that there's any relationship between the PPO demo and the retrenchment of private fee-for-service? Because one could argue there's similarities in what those two kinds of offerings would be doing.

DR. HARRISON: I don't think so.

MS. ROSENBLATT: Scott, given Bob's comments, I need some additional clarification. It's been pointed out to me that there's report language in the Balanced Budget Refinement Act of 1999 which reads as follows: the parties to the agreement urge the Secretary to revise the regulations implementing the risk-adjuster so as to provide for more accurate payments without reducing overall Medicare+Choice payments.

I don't know what that means, and for how many years that was intended or whatever. I've just been given that one sentence sort of out of context.

DR. HARRISON: I'm glad you found it because I thought it was in BIPA. I couldn't find it last night. So it's BBRA?

DR. REISCHAUER: That sounds like report language. That isn't legislative language at all. So it's sort of like don't complain to me when I vote for this.

MS. ROSENBLATT: It was told to me that it was report language, yes.

DR. HARRISON: What happened was originally risk-adjustment was put in place. CBO, not knowing exactly what was going into place, was reluctant to say that there were any savings to it. So when it came back with a zero score, Congress looked at it and

said oh, so you mean it's budget neutral? And then they put budget neutral into the next report language. There were questions about what the actual intent were and there were two schools of thought about what the actual intent was.

DR. WOLTER: I'm quite supportive of the recommendation on the quality incentive, but a couple observations. In my review of the HEDIS criteria, I would say that's a pretty low bar in terms of specifically the clinical quality indicators. Particularly when you combine that with a recommendation of collecting only what all plans normally collect, you further even eliminate a couple of the clinical quality indicators.

Looking ahead beyond this year into next year, a few observations. I'm less optimistic than the chapter would suggest that health plans will be good at coordinating care because they're responsible for all Medicare services. They're responsible for payment of all Medicare services, but particularly plans that primarily have panels made up of independent practitioners may have less leverage than, for example, Kaiser Permanente or other staff model plans.

Also, I would note that some of those plans, Kaiser in particular, are making huge investments in clinical information systems which may allow us to have more immediate availability of the clinical quality indicators.

The other thing I would say is that actually in the fee-for-service system, CMS right now through the QIOs is measuring a more robust number of quality indicators than you would find in HEDIS. And in fact, in the recent law we now have .4 percent of Medicare payment actually tied to volunteer reporting of some of those.

So there's kind of a lot happening all at once right now and we might want to have our eye on how some of these things could be brought into alignment as we look at our quality agenda at MedPAC over the next year or two.

For example, since many providers are going to be capturing these measures anyway because of voluntary reporting or QIOs, perhaps plans should look at their quality agenda or we should be recommending HEDIS move to including some of those same measures so that over time we can compare plans with fee-for-service.

MR. DURENBERGER: First, I think this is an excellent piece of work and an excellent start on a subject that we're going to be deeply involved in, much more deeply involved in, in the future and so I thank the staff for that.

Secondly, I very much want to associate myself with Nick's remarks, and particularly that a plan is not a plan is not a plan. But take it another step farther and particularly my first question mark as I was going through this was in the very first paragraph. And I know the subject here is Medicare+Choice. It's not docs, but it says Medicare has a strong history of supporting private plans. The Commission strongly believes that beneficiaries should be given the choice of delivery systems that private plans can provide. Private plans have a greater flexibility to innovate, et cetera.

The implication is that you can't get a choice of delivery system except through a plan. At least that's one. And the

second one is that plans have some unique flexibility to innovate that provider groups in particular do not. And that's not true.

You can go to Nick's practice group. You can go to very large groups in North Dakota. You can go to groups in Minnesota, Wisconsin, all over the country, and you can find doctor groups who have done a lot of investment in innovation, a lot of investment in quality, and they haven't been rewarded for it because the Part B system doesn't have a mechanism for doing that.

So when we express ourselves in the context of treating fee-for-service equal with private plans, et cetera, I think we have to take it a step beyond that. And part of what Nick said relates to that and part of what I'm trying to say relative to this introduction language is also important to say.

That is that groups of physicians, groups of physicians and hospitals, systems like the one Nick runs, which is a hospital systems but it's basically run by a group of docs, but they run a hospital in a huge service area, have traditionally done a lot of the things that we are now turning nationally to Medicare+Choice plans to try to achieve.

And I think each time we try to say MedPAC supports this or that or we're fostering a particular approach, we really do need to reflect the fact that the system has failed, at least the payment system in the past, has failed to reward a lot of docs and doc groups in the fee-for-service system.

MR. HACKBARTH: I think that's an excellent point and we need to treat the language. The benefit of the M+C payment system is that it's a payment mechanism that maximizes the flexibility of clinicians, provider organizations to allocate resources new ways. Whereas, the traditional fee-for-service payment system with its silos can sometimes get in the way. Despite the fact that the fee-for-service payment system gets in the way, there are physician groups and provider organizations who do it anyhow. We ought to know that that does happen.

DR. REISCHAUER: I was just going to say, I think this involves more tweaking than restructuring. All you've said is that it's greater flexibility, not that the others don't have any flexibility. And what you probably want to say is on some dimensions, private plans have greater flexibility. And then the list of areas that you cited, some of those I think Dave right would say, hey, a good practice group in Minnesota can do that, too. But sort of the breadth of the benefit package, financial services, some things like that, the traditional fee-for-service system really doesn't offer any ability to experiment or provide flexibility.

MS. RAPHAEL: Just to build on Nick's point, I've recently been involved in a group working with Kaiser and Group Health and others looking at this care coordination and coordination across sites. And there's just a lot of road to travel here. And I would like to see looking at some outcomes that would measure, in fact, coordinating care across sites rather than again just what you do within each of the components of the providers that comprise the plan here. Because I think until we begin to measure this, we're not going to see movements even though plans

ostensibly have more of an incentive and they have control of the entire Medicare dollar.

And then the other point, I see this as a triangle with Congress, the plans, and the third angle has to do with CMS. I don't think we're going to succeed in this quality incentive area if CMS doesn't build an infrastructure and change some of how it looks at what it is responsible for.

I think we need to mention that in the text because I think often something is passed and then lo and behold we think about how is this all going to come to pass.

I think there are some elements going on now in CMS that can be built upon, but I think we need to make that point ultimately for this area, for the ESRD area, there has to be some attention paid to what's going to happen in CMS.

MR. MULLER: To go back to Scott, your first estimate I think when you started this, that you think that the plans will be now be paid roughly 107 percent of fee-for-service. Did I hear you correctly on that, Scott?

DR. HARRISON: Yes.

MR. MULLER: And where we have some evidence in the text that there's been some abatement in the dropping, or at least the dropping of M+C enrollment has dampened a bit, and in fact may have gone up by 1.5 or 2 percent in the last year or so; correct?

DR. HARRISON: Yes.

MR. MULLER: But if we have a payment plan in which we're 103, 105, 107 percent above fee-for-service, and we still don't have a major increase in enrollment, one of the questions I have is how much is it going to take to get enrollment back up? With a 7 percent premium already, and I know some of that 7 percent is perspective, but we've had more than 100 percent payment the last few years and we've only had modest increases.

What will it take to get -- insofar as there's a philosophical preference, at least as expressed in the most recent legislation, for getting more people into payment plans, whether it's flexibility or other kind of reasons that the authors of the bill wanted, it's still a fairly significant premium in light of all the payment pressures inside the program.

I don't know whether we or anybody is yet speculating as to what the increase might be. I remember when Mr. Scully first came in, he was looking to get M+C up to somewhere in the 30 or 40 percent range. And obviously it went the other way for a while, up to the recent abatement.

So I think one of the things we need to be looking at, and I don't think it's part of our mandate to speculate as to what it's going to take to get this kind of increase. But certainly the evidence has been that the payment increases have not brought the increase in participation that people are looking for.

MR. HACKBARTH: I'm not sure that there's any gain in our speculating about what the magic price might be. There are a lot of factors at work in the market here. I think a lot of Medicare beneficiaries were stung either personally or heard of other people who were stung by plan withdrawals. And it takes time for people to get over that. All of the bad publicity that managed care received in the 1990s, much of it if not most of it

unwarranted in my opinion, affects public perceptions and affects enrollment rates. Lord knows what the number is.

I think that's irrelevant. I think what's important is the principle of neutrality. I strongly believe, for a variety of reasons, that having this as an option for Medicare beneficiaries is very important. Jack gave us an illustration in the case of patients with ESRD about the potential gains of being in a private plan that has the flexibility to do some different things. I believe that's true not just for ESRD patients but for many other patients. I am a true believer.

Having said that, I think it's critically important that we be neutral. And I really don't care what the right price is --

MR. MULLER: You misread my -- I'm in favor of neutrality, too. We're paying a big premium to get people in that goes well beyond neutrality.

MR. HACKBARTH: Let's be neutral and let the chips fall where they may. The beneficiaries will make their choices. Personally, I take a long-term view of this. I think for a variety of reasons right now many Medicare beneficiaries are discouraged about private options. I think that will change in time. I hope it changes in time because I believe it will be good for them if the attitudes change.

DR. ROWE: Just one reaction. Those of us in this industry are delighted that you're a true believer, Glen. It sounds like you've drunk the Kool-Aid. It doesn't sound like you're willing to pay for it, but it does sound like you've drunk it.

[Laughter.]

DR. ROWE: I guess one thing I would say in response to Ralph's question is that I think one way to look at -- I don't know what the number is. That's not worth thinking about too much.

But it is worth thinking about the floor counties versus the others, or the rural areas versus the others. Because what happens is Medicare determines what the payment rate is for the providers and the health plans negotiate. And in areas in which there are thin networks, providers and hospitals, that drives up the rates that those providers can charge and you wind up with much higher than what the Medicare fee-for-service payments are.

So that's like a whole bunch and if the philosophy in Congress or CMS or in this room or wherever is we want everybody in America who's a Medicare beneficiary to try to access to a plan, that one of the things that drives the numbers up. It's those floor counties and the thin networks and the marketplace. And I think that's what Glen was referring to when he said there are a lot of market factors.

It's not a homogenous thing. It's very, very different in large urban areas where there are overlapping networks and Medicare payment rates are more or less similar to what the plans might pay the doctors.

So I think that's just one issue to consider.

MR. HACKBARTH: I think you're characterizing the reasons that people support these things accurately. I believe it is because they do think that everybody having access would be a good thing. And they think the price lever is one lever that we

can use to try to stabilize enrollment and broaden plan participation. I understand that. I respect that. But I do disagree with it. I think it's a mistake for the program.

We need to move ahead with our votes. Do you want to flash up our recommendations?

On draft recommendation one, all those opposed?

MR. FEEZOR: [off microphone.] Question, this is going to continue beyond 2004?

DR. MILLER: [off microphone] We're trying to capture that with a should not continue.

MR. SMITH: [off microphone] I was troubled by that language because it suggests there's another payment increase in the offing. But what Bob was saying is this payment should not continue. So I think we need to reword.

MR. HACKBARTH: Does people understand the intent here? All opposed? All in favor? Abstain?

Number two, all opposed? All in favor? Abstain?

Number three, all opposed? All in favor? Abstain?

Okay, thank you.

We'll now have a brief public comment period. Please, as usual, keep your comments very brief. And if someone ahead of you in line has made your comment already, please don't feel obliged to repeat it.