AUGUST 2003

REPORT TO THE CONGRESS

Social Health Maintenance Organization (S/HMO): Recommendations for the Future of the Demonstration

MEDPAC Medicare Payment Advisory Commission

Executive summary

The social health maintenance organization (S/HMO) demonstration tests a model of service delivery intended to integrate acute, chronic, and long-term care. It has operated since 1985 and been evaluated twice. The Secretary of Health and Human Services submitted the final report of his evaluation of the S/HMO to the Congress on February 28, 2003. The Balanced Budget Refinement Act of 1999 required MedPAC to submit recommendations regarding the project to the Congress no later than six months after the Secretary submits the final evaluation report. We have reviewed the evaluations and are submitting our recommendations on the future of the demonstration and on the issue of risk adjustment for frail beneficiaries.

Two evaluations found no conclusive evidence of positive effects on beneficiary health or functioning. They found that the demonstration did not consistently reduce hospital use or long-term nursing facility use or consistently deliver superior quality care. Any favorable effects on service use and use of preventive care were attributable to general characteristics of tightly organized managed care rather than to the features of the model being tested in the demonstration.

Our concern with equity for plans and beneficiaries leads us to conclude that all beneficiaries should be able to receive the same benefit package regardless of where they live and that certain plans should not be advantaged relative to other plans. Equity in payment and coverage policies requires that Medicare treat similar health plans and providers the same unless a payment differential is warranted based on the performance of an organization.

S/HMOs are currently paid more than regular Medicare+Choice (M+C) plans and are mandated to provide certain additional services. Since there is no clear evidence that S/HMOs improve outcomes or reduce costs, and since S/HMOs and Medicare+Choice plans enroll similar types of members, converting S/HMOs to Medicare+Choice and paying them as M+C plans is appropriate. At its April 2003 public meeting, the Commission agreed to recommend that plans participating in the S/HMO demonstration be converted to Medicare+Choice coordinated care plans on December 31, 2003.

Medicare makes risk-adjusted payments to Medicare+Choice plans to improve the accuracy of payments to plans that enroll a cross section of beneficiaries, but refinements may be needed for those plans that concentrate on certain types of enrollees. Thus, the Commission also recommends that the Secretary of Health and Human Services study payment adjustments for the frail population in the Medicare+Choice program.

Social health maintenance organization (S/HMO): recommendations for the future of the demonstration

RECOMMENDATIONS

1 The Commission recommends that, at the conclusion of the demonstration on December 31, 2003, the Secretary request that the existing social health maintenance organization (S/HMO) plans apply to participate in the Medicare+Choice program as coordinated care plans. The benefit mandate would end. During the transition period from 2004 through 2007, comprehensive risk adjustment applied to the S/HMO plans should be the same as for Medicare+Choice plans and the 5.3 percent would be phased out.

***YES: 15 • NO: 0 • NOT VOTING: 0 • ABSENT: 2**

2 The Secretary should consider making payment adjustments for frail populations. Options may include using administrative data, survey data, or statistical modifications to the CMS HCC risk-adjustment model. After 2007 the Secretary should set capitation payments for frail beneficiaries based on their characteristics, if frailty adjustment is found to be necessary. This adjuster could either be a component of the risk adjustment or a separate frailty adjuster.

***YES: 15 • NO: 0 • NOT VOTING: 0 • ABSENT: 2**

***COMMISSIONERS' VOTING RESULTS**

As the number of Medicare beneficiaries with multiple chronic conditions increases, policymakers have become interested in innovations in their care. Techniques of chronic care have advanced in recent years. In combination with changes in life style, use of preventive care, economic growth, and improved health care early in life, changes in medical technology and new medications for chronic conditions have contributed to reduced disability at older ages (Cutler 2001).

The Medicare program has long supported the development of new models of care and the spread of information on promising care techniques. Innovative approaches are tested in demonstrations that are intended to rigorously examine alternatives and identify options that promote quality care and are cost effective. When effective programs are identified and their features analyzed, the results are made available to encourage replication and adoption of proven techniques by other professionals in the field.

The social health maintenance organization (S/HMO) demonstration is an example of interest in new models of care. The first four plans under S/HMO I began in 1985. When the evaluation found that model did not have the desired result (DHHS 2003), a second generation model was developed. But the first model was allowed to continue as well. Only one S/HMO II plan was actually started, in 1996.

The Centers for Medicare & Medicaid Services (CMS) submitted the final evaluation report on the S/HMO demonstration in February 2003. It also announced its plans to bring S/HMOs on to risk-adjusted payment using the phase-in schedule mandated by the Benefits Improvement and Protection Act of 2000 (BIPA) for all Medicare+Choice (M+C) plans, with some modifications, as discussed below (CMS 2003a). The evaluation report provides the Congress and the Secretary an opportunity to decide whether the social health maintenance organization is an effective model of chronic care and to determine the lessons that the Medicare program can derive from the demonstration. The Balanced Budget Refinement Act of 1999 required MedPAC to submit recommendations regarding the project to the Congress no later than six months after the Secretary submitted the final evaluation report.

The Commission, in this report, reviews the experience with the S/HMO and considers the demonstration in the context of recent developments in chronic care and disease management. We begin with a description of the S/HMO model—what it does, how it is financed, and how it has evolved. We review both the policy context in which the model arose and the history of the two generations of the S/HMO model. We then detail results of the extensive evaluations of this long-running demonstration. Finally, we review the policy issues surrounding this model and, based on three principles that should guide further consideration of the future of the demonstration, recommend that S/HMOs be converted to Medicare+Choice plans on December 31, 2003.

The Social Health Maintenance Organization Model

The S/HMO is a managed care model that seeks to integrate acute and long-term care. The model includes two types of plans, S/HMO I and S/HMO II. The first generation S/HMO I model, founded in the 1980s, emphasizes case management. The second generation S/HMO II plan, established in 1996, emphasizes geriatric care and more comprehensive case management. All plans are paid rates that are 5.3 percent more than those paid to regular M+C plans in the same county and are required to

provide expanded benefits. Currently, four plans are in operation. The smallest, Kaiser in Portland, has 4,500 members, and Elderplan in New York has 12,000. Two other plans, SCAN in Long Beach and Health Plan of Nevada (HPN), each have approximately 50,000 for a total of around 115,000 (Table 1). The first three are the first generation plans founded in 1985 and HPN is the sole second generation plan.

TABLE 1

S/HMO Plans: December 1998 - July 2003

Plan	Market area	S/HMO model	Sponsor HMO model	Enrollment December 1998	Enrollment December 2002	Enrollment July 2003
Elderplan	Brooklyn, NY	I	IPA/Network	5,234	10,699	11,812
Senior Care Action Network (SCAN)	Long Beach, CA	I	IPA/Network	34,057	55,092	50,883
Kaiser North West	Portland, OR	I	Group	4,207	4,351	4,475
Health Plan of Nevada (HPN)	Las Vegas, NV	II	Staff and network	26,209	42,166	47,725
Total				69,707	112,308	114,895

Source: CMS Medicare managed care monthly report.

What S/HMOs provide

The S/HMO tests a model of service delivery and financing intended to furnish acute, chronic, and long-term care, along with the services deemed important to a smooth transition between these types of care. These services include care coordination and screening of enrollees to identify frail beneficiaries for whom use of community-based long-term care is expected to reduce the need for institutional care.

Depending on their health status, enrollees in S/HMOs can receive up to three types of benefits: basic Medicare, supplemental (such as prescription drugs and eyeglasses), and expanded care (such as personal care and homemaker services). All enrollees are entitled to basic and supplemental benefits. In the S/HMO I plans, only enrollees determined to be nursing home certifiable under their state's Medicaid standards may use the expanded care benefits, which include intermediate nursing care, homemaker and chore services, personal health aide care, medical transportation, adult day health care, respite care, and case management.

The S/HMO plans offer these services hoping to forestall or reduce the use of expensive medical—particularly institutional—care. For example, providing home and community-based care to some beneficiaries, it was hoped, would keep them from being admitted to a nursing home. Another feature of the S/HMO is the notion of integrating care delivery between acute and long-term care—that is, someone within the plan would track and coordinate all of these services to avoid duplication and to share information about the patient.

An early evaluation (Harrington et al. 1993), however, found that the S/HMO I plans did not effectively integrate acute and long-term care. Coordination between case managers (generally social workers) and physicians was poorly developed. Results on the use of institutional care were mixed. On the one hand, S/HMO members had higher nursing home costs; on the other hand, they had lower hospital costs than fee-for-service beneficiaries with similar medical conditions. The conclusion was that the first-generation sites had not achieved their objective of care integration with reduced institutional care use (DHHS 2003). Based on these findings, the Health Care Financing Administration (HCFA) developed a second-generation model.

One goal of the S/HMO II demonstration that differs from S/HMO I was to incorporate practices that geriatricians have developed into the operations of the plan. These practices include comprehensive geriatric assessment for certain patients, treatment of functional problems, and a team approach that brings together nurse practitioners, pharmacists, and other health care professionals. In S/HMO II, these benefits are not limited to those who are nursing home certifiable; they are also provided to all those identified as high-risk for needing nursing home care.

How S/HMOs are paid

Both types of S/HMO plans are paid on a capitation basis and both are paid 5.3 percent more than the Medicare+Choice county payment rates. This additional payment is meant to cover expanded benefits not covered by Medicare Part A or Part B. It is a holdover from the years when managed care payments were set to 95 percent of fee-for-service payments for a county—S/HMOs were to be paid 100 percent of these amounts.

Payments to S/HMO plans reflect the characteristics of their members, but the specific approach varies by the generation of the demonstration. First generation S/HMO plans use a variation on the demographic risk adjusters used for Medicare+Choice payments that incorporates a factor to reflect nursing home certifiable status. Payments for community residents who meet nursing home certifiable criteria are increased and payments for other community beneficiaries are reduced with the intent to make aggregate payments to each plan equal to payments using Medicare+Choice demographic factors. By contrast, the payment method for the second generation plan is based on results of a regression model. Payment reflects a member's sex, presence of ten chronic conditions, ability to perform three activities of daily living and one instrumental activity of daily living, self-reported general health rating, and ability to walk a quarter of a mile. CMS is dropping both payment methods and, starting in 2004, will phase in Medicare+Choice risk-adjusted payment and add a frailty adjustment as discussed in detail below.

Policy context: care for beneficiaries with chronic conditions

The Congress has long expressed concern for developing protocols in the Medicare program that both improve quality of care and reduce unnecessary expenditure. Since care for chronic conditions is an important concern, new models for approaching the issue have long been encouraged. This provides the context in which the S/HMO and other demonstration projects evolved.

The social health maintenance organization demonstration was started in 1985 and was an early experiment with approaches to care for elderly populations in need of care for chronic illnesses. At the time the demonstration was conceived, policymakers hoped that providing the enhanced benefits (e.g., community-based long-term care, personal health aide services) would lead to better outcomes and less use of institutional care. The S/HMO is now the longest running demonstration of care for the chronically ill.

CMS (formerly HCFA) has tested several other major approaches to chronic and long-term care since the beginning of Medicare. The first line of analysis was to see whether community-based long-term care (e.g., home health) would reduce the use of more expensive nursing home care. The On Lok demonstration, a test of a model of community-based long-term care which began in 1972, provided the basis for the Program of All-Inclusive Care for the Elderly (PACE) long-term care demonstration, now a permanent Medicare program. The National Long Term Care Channeling demonstration provided home and community-based care management between 1981 and 1985. Studies of the demonstration found that the intervention did not reduce cost.

Nevertheless, the Congress continued to express its concern over the value of care coordination for high-cost and vulnerable populations, specifically around questions of care management (e.g., disease management). The Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) mandated that HCFA sponsor demonstrations of case management services for beneficiaries with high-cost conditions. Three demonstration sites for beneficiaries in fee-for-service were chosen and operated from October 1993 through November 1995. An evaluation found no impact on Medicare spending or beneficiary self-care or symptom control. It attributed these results to lack of physician involvement in case management, lack of project focus, inadequate case manager expertise, and absence of financial incentives (Schore et al. 1999).

The Balanced Budget Act of 1997 (BBA) authorized the Secretary to conduct demonstration projects to evaluate methods, such as case management and other models of coordinated care, that improve the quality of care and reduce Medicare expenditures. It authorized a demonstration with at least nine sites for beneficiaries with chronic illnesses who receive care in fee-for-service Medicare. In 2001, CMS chose 15 sites for a pilot program providing disease and case management services. It sponsored a study of best practices in coordinated care. The BBA required a report to Congress on the demonstration at least two years after the April 2002 start of the demonstration and authorized the Secretary to act on demonstration findings.

CMS was mandated by BIPA in 2000 to conduct demonstrations of disease management in the fee-for-service beneficiary population. In response, CMS is reviewing proposals for a capitated disease management demonstration to test disease management techniques for frail and dual-eligible beneficiaries with chronic conditions. The demonstration is expected to start in January 2004.

Medicare managed care plans, although not demonstrations, have developed a variety of approaches to care management and expanded Medicare benefits. Most large Medicare managed care plans use some form of case management (National Chronic Care Consortium 1997). Many have offered a wide range of extra benefits, although the generosity has varied by geographic area and over time. In 1990, approximately one-third of plans offered outpatient drug benefits, increasing to one-half in 1995 (CMS 1990, 1995). Plans have reduced this coverage, with the proportion of enrollees in coordinated care plans with drugs in the lowest-cost plan declining from 84 percent in 1999 to 69 percent in 2003 (CMS 2003c). S/HMOs offer benefits similar to those of Medicare+Choice plans in their market areas (Table 2).

TABLE 2

Social health maintenance organization and Medicare+Choice benefits by market area

Characteristics	Kaiser Permanente Senior Advantage II	SCAN Health Plan	Elderplan	Health plan of Nevada
Number of Medicare+Choice plans	8	10	13	5
Premiums				
Medicare+Choice	$56/93	$0/60	$0/125	$0/88
S/HMO	196	0/30	0	0
Prescription drug coverage				
Number of Medicare+Choice plans offering benefit	1	10	12	4
S/HMO offers benefit	Yes	Yes	Yes	Yes
Generic drug copayment				
Medicare+Choice	$10	$8/10	$5/15	$10/15
S/HMO	10	10	10	10
Vision: coverage of eyeglasses and contact lenses				
Number of Medicare+Choice plans offering benefit	3	9	8	0
S/HMO offers benefit	Yes	Yes	Yes	No
Hearing aid benefits				
Number of Medicare+Choice plans offering benefit	2	3	8	0
S/HMO offers benefit	Yes	Yes	Yes	No

Note: S/HMO (social health maintenance organization). Medicare+Choice refers to all Medicare+Choice plans within a S/HMO market area, not including S/HMO.

Source: Medicare Compare, 2003, http://www.medicare.gov/MPHCompare/Home.asp/.

History of the S/HMO demonstration

The Deficit Reduction Act of 1984 mandated the S/HMO demonstration. The Congress extended the demonstration in 1987, 1990, 1993, 1997, 1999, and 2000. OBRA 1990 authorized extension and expansion of the first generation demonstration and mandated the development of new S/HMO sites differing from the S/HMO I plans. The BBA in 1997 required that the Secretary submit two reports to Congress. The first, submitted in February 2001, recommended ending the demonstration and moving the plans into the Medicare+Choice program. The second, sent to Congress in February 2003, is the final evaluation report on the project.

HCFA approved four S/HMO demonstration sites in 1985, of which three remain in operation. The four were Elderplan in Brooklyn, New York (now providing services there and in other counties in New York); Medicare Plus II (now Senior Advantage II), operated by Kaiser North West in Portland, Oregon; Senior Care Action Network (SCAN) in Long Beach, California; and Seniors Plus in Minneapolis, Minnesota. Seniors Plus closed in 1995. Based on negative findings of an evaluation conducted from 1985 to 1989, the Congress authorized the establishment of a second generation demonstration plan incorporating a new approach to care management. One second generation plan, operated by Health Plan of Nevada, was started in 1996. Five applicants received developmental grants to start S/HMO II model plans but chose not to establish them. The first generation sites were offered the opportunity to convert to the S/HMO II model. They chose to retain the older model of care after considering the requirements of the new model and the financial uncertainties associated with use of the new regression-based S/HMO II payment method.

Evaluating S/HMOS: Process and Results

Evaluation has been an integral part of the S/HMO demonstration since its inception. HCFA first evaluated S/HMO I sites in the 1980s. A second evaluation conducted for CMS —focused on the S/HMO II site —has also been completed. CMS reported preliminary findings of the second evaluation and additional findings on S/HMO I in 2001 and final results on S/HMO II in February 2003.

The first evaluation found that although the S/HMO I plans did indeed offer long-term care services, they did not develop well-coordinated systems of care with effective communication across acute and chronic medical benefits. The principal problem was that the projects did not establish good working relationships between physicians and case managers (Harrington et al. 1993). Physicians did not change their practice style and remained uninvolved with other participants in the delivery system.

Since the first evaluation, one S/HMO I plan, Kaiser North West in Portland Oregon (a group model HMO) has successfully integrated care. This plan has adopted several interdisciplinary team organization and numerous geriatric care techniques in the S/HMO and in its Medicare+Choice plan. The other S/HMO I plans have not made similar use of geriatric care techniques (DHHS 2003).

The 2001 Report to the Congress

The February 2001 Report to the Congress (DHHS 2001) included additional findings on the S/HMO I plans and preliminary findings from the evaluation of the S/HMO II plan. The evaluation estimated plan case-mix using a composite of measures—self-reported health status, mental and physical functioning, and the presence of a chronic condition. After adjustments were made for differences in enrollee age, sex, and Medicaid status—the factors used to determine payment in the S/HMO I demonstration—members in two of the plans did not appear to have greater frailty on these measures than members of Medicare+Choice plans. The exception was the Kaiser plan, which did enroll a more frail population.

The evaluation also examined member satisfaction in the S/HMO I plans. It used data on 10 measures of satisfaction from the Consumer Assessments of Health Plans Study (CAHPS) to compare responses of S/HMO members and members of area Medicare+Choice plans. The comparison showed that S/HMO enrollees are no more satisfied than members of Medicare+Choice plans even though they receive greater benefits.

The 2001 report also concluded that there was no consistent evidence of a positive effect of S/HMO II benefits on health or functional status and that the S/HMO II plan had small or statistically insignificant effects on service use. The report recommended that all existing S/HMOs be converted to standard Medicare+Choice plans. It recommended phasing out supplemental payments and phasing in the M+C risk-adjustment approach during a transition period.

The 2003 Report to the Congress

The February 2003 Report to the Congress (DHHS 2003) expanded on the research on the S/HMO II reported in 2001, but the findings did not differ substantially from those of the earlier report. The 2003 report does not include recommendations. It focuses on performance of S/HMO II regarding care coordination, service utilization, health and functional status, and quality of care.

Care coordination

The 2003 report presents some evidence that care coordination at the S/HMO II directed its expanded and supplemental benefits to targeted members. Fifteen percent of S/HMO II members and 47 percent of members who may have been eligible based on health status received comprehensive assessments. Care plans were prepared for 17 percent of members. Use of expanded and supplemental benefits was concentrated among those with an assessment or care plan. For example, 2.3 percent of all members received personal assistance services while 10.8 percent of those with an assessment or care plan received them. In general, members at high risk of hospitalization were significantly more likely to have had assessments and care plans and were more likely to receive both expanded and supplemental benefits (DHHS 2003).

Service use

Like the first evaluation, the final evaluation found mixed effects of S/HMO II on service use contrasted with a comparison Medicare+Choice plan:

- The S/HMO II did not consistently reduce the rate of hospitalization in the overall sample of S/HMO members. S/HMO members with no nursing home use followed for the full 22 months showed a 1.5 percent lower rate of hospitalization. Although this finding was statistically significant, analysis of a sample of S/HMO members followed less than 22 months due to disenrollment or death found a statistically significant 4.1 percent greater rate of hospitalization.

- S/HMO members with no nursing home use before the demonstration used more physician visits and had more home health use but did not use less hospital care compared to members of the comparison plan.

- The S/HMO substantially reduced the rate of hospitalization among community beneficiaries who had two or more hospitalizations in the prior year (the hospitalization risk group). Since S/HMO II benefits were targeted at higher risk beneficiaries, this greater impact was expected. However, the hospitalization risk group was very small. Although 27 percent of members were targeted and received either a special evaluation or extended services, only about 1 percent of S/HMO community members had two or more hospitalizations

- S/HMO members living in the community were more likely to be admitted to skilled nursing homes than was the case for M+C enrollees. Too few enrollees were admitted to custodial nursing care to assess whether the S/HMO affected their use rates. Inability to determine the S/HMO's effect on nursing home care is unfortunate, as one of the original goals of the demonstration was to reduce institutionalization.

A separate study of service use from 1998 to 2000 (after the end of the CMS evaluation) found that the S/HMO II plan had mixed impacts on hospital use (Newcomer et al. 2002). The number of hospital discharges decreased by 7 percent, and the number of hospital inpatient days by 1 percent, for patients seen in plan clinics (70 percent of S/HMO II members are in clinics and 30 percent are in less organized network medical practices). Hospital discharges increased 5 percent and inpatient days 17 percent for patients seen by plan network physicians, however. These findings suggest that more organized delivery systems control utilization better than less organized systems but do not necessarily demonstrate that the S/HMO II delivery model in and of itself is effective.

Health and functional status

One of the goals of S/HMO II is to maintain function of frail beneficiaries and slow the progression of disability. The 2003 report also examined data from a survey on health status, limitations in ADLs, and limitations in instrumental activities of daily living (IADLs) to determine whether the S/HMO slowed or reversed decline in health status or progression of disability. The plan surveys members with a Health and Functioning Assessment instrument to gather data for risk-adjusted payment and to identify members at risk of health care use or disability. The evaluation findings in this area were:

- The S/HMO did not consistently improve physical, cognitive, and emotional health of members in the overall S/HMO sample. The evaluation compared members of the S/HMO with a comparison group of members of a Medicare+Choice plan also operated by HPN. The S/HMO and the comparison plan differed in two of ten comparisons, with fewer S/HMO than Medicare+Choice members reporting improved general health but more reporting memory improved or unchanged.

- The S/HMO did not consistently improve performance of ADLs or IADLs by members in the overall S/HMO sample. In 10 of 12 ADL comparisons there were no differences between the S/HMO and the comparison group. In two ADL comparisons significantly fewer S/HMO members reported new or continuing difficulty eating. In 11 of 14 IADL comparisons there were no differences between the S/HMO and the comparison group. Fewer S/HMO members reported new difficulty with meal preparation, housework, or managing finances.

- The S/HMO did not consistently improve measures of physical, cognitive, and emotional health, ADL performance, and IADL performance across eight groups of S/HMO members considered at high risk of health problems or decline in functioning. The evaluation concluded that the limited number of apparently significant results were not statistically meaningful and could be attributable to chance when the 624 comparisons were made.

Quality of care

Another goal of the S/HMO model is to improve overall quality of care for all members. The evaluation, however, shows no strong evidence of superior quality of care for S/HMO II members:

- The S/HMO performed better than the comparison plan on two measures of preventive services use but was no different on two other measures. Consistent with other research on preventive service use in managed care, both the S/HMO and the comparison plan had greater preventive service use than traditional Medicare. In other analyses, Health Plan Employer Data and Information Set (HEDIS) data indicated no difference between S/HMO and area Medicare+Choice plans. These findings suggest that the performance of the S/HMO is associated with characteristics of managed care rather than with the unique features of the demonstration.

- S/HMO enrollees with chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF) had higher rates of recommended physician visits than those in the comparison plan. There was no difference in diabetes care. HEDIS data show that the S/HMO performs better than the comparison plan on some measures of diabetes and heart disease care and worse on others. In comparison with area Medicare+Choice plans, the S/HMO generally performs no better than and in some cases worse on these measures.

- S/HMO enrollees did not consistently have lower rates of hospitalization for potentially avoidable hospitalization conditions than the comparison Medicare+Choice plan, with a higher risk for pneumonia hospitalization and a lower risk for respiratory complications. In 12 comparisons with fee-for-service, the S/HMO showed significantly lower rates for 7 cases, higher rates for 2, and no significant difference for 3 cases.

The evaluation: the 2003 versus 2001 report

The 2003 evaluation report remedied several limitations of the 2001 report. The first report was conducted at an early stage of the demonstration and followed beneficiaries for only a year. Both the timing and the short period may have made it difficult to capture impacts on health status and functioning. Health Plan of Nevada, the HMO participating in the demonstration, maintained a comparison Medicare+Choice plan from the start of the evaluation period in July 1997 until April 1999. The closure of the comparison plan reduced the opportunity to find evidence of impacts. In addressing some of these problems, the 2003 report:

- studied the impact on functional status over twice as long and used twice as large a sample as that used in the 2001 study.
- analyzed service use data by following enrollees for 22 months, as compared with about one year for the 2001 analysis.[1]
- compensated for loss of the comparison group before the end of the demonstration by adding analysis of Medicare Current Beneficiary Survey data to the basic evaluation.
- analyzed an S/HMO sample that included more beneficiaries 85 and older, with COPD or CHF, or with low income.

Despite these refinements in the evaluation process, the 2003 effort produced essentially the same results as those reported in 2001.

Risk Adjustment

Medicare makes risk-adjusted payments to Medicare+Choice and demonstration plans to match payments to members' expected costs of care. This encourages plans to compete on the basis of the benefits and services they offer beneficiaries. Appropriate risk adjustment is important to counter incentives plans would otherwise have to avoid frail beneficiaries with higher costs.

[1] This period included the startup of the geriatric team and care coordination at the second generation plan (Newcomer et al. 2000).

Starting in 2004, CMS will begin phasing in a new risk adjustment system. It will use the CMS hierarchical condition category (HCC) model based on diagnoses from both hospital inpatient and ambulatory settings. This model is a better predictor of Medicare costs than the model currently in use, which uses only diagnoses collected from hospital stays.

Under the new risk adjustment system, CMS will use special models for several types of beneficiaries and plans. Beneficiaries residing in institutions and those on dialysis with ESRD (starting in 2005) are paid under models specially calibrated for them. CMS will risk adjust payments to PACE programs, S/HMOs, and other demonstration plans using a hybrid system that combines the CMS HCC model with additional adjusters based on ADLs. CMS will use Health Outcomes Survey (HOS) data to measure the risk of frail beneficiaries in S/HMO demonstration plans with plan-level risk adjusters.

CMS will introduce risk adjustment for the S/HMOs using a modified version of the phase-in schedule mandated by BIPA for all Medicare+Choice plans together with the frailty adjuster. Payment will be a blend of 90 percent of the old S/HMO payment method and 10 percent new risk-adjusted payment in 2004 (compared with a 70/30 old/new blend for Medicare+Choice plans that year). The risk-adjusted portion increases to 50 percent in 2005, 75 percent in 2006, and 100 percent in 2007. Each beneficiary's total risk score will equal the sum of the individual's risk adjustment score from the CMS-HCC model and the average frailty score for the plan based on the plan's HOS survey respondents. The total risk score is multiplied by the county rate to determine the risk-adjusted portion of payment.

Risk adjustment for specialty plans such as the S/HMO raises problems of data and measurement. The Commission is concerned with the accuracy of functional status data, the basis for the calibration, and the potential for changes in the coding of functional status that would inappropriately increase payments.[2] Risk adjustment using survey data or other information not available for all beneficiaries in a given county would require modification of Medicare+Choice county payment rates for consistent treatment of costs. Consequently, risk adjustment using functional status data cannot be used for all M+C plans even if they have a high share of frail enrollees. We address this in our discussion of issues for future consideration.

Some Medicare+Choice plans enroll significant numbers of beneficiaries with chronic conditions and limitations in ADLs. However, functional status information on ADLs and IADLs is not available for all members of plans. As a result, the frailty adjuster adopted by CMS for the S/HMO plans cannot be applied to all members of Medicare+Choice plans. Since HOS data are now available for samples of members of all Medicare+Choice plans, PACE organizations, and demonstration plans, it would be possible to calculate organization level frailty adjusters for all plans subject to Medicare+Choice risk adjustment. This approach is the only feasible option for functional status adjustment in light of current data and models.

[2] Beneficiaries report functional status data directly to CMS contractors. Plans do not collect or report these data, possibly mitigating any inappropriate change in coding.

Recommendations and Policy Issues

The social health maintenance organization is scheduled to end by December 31, 2004. CMS has announced that, in the absence of Congressional action, it intends to continue the demonstration with a risk-adjusted payment incorporating a frailty adjustment through 2004. As CMS considers options for the future of the demonstration, it will take into account the findings of the evaluations, experience with other demonstrations, and developments in Medicare+Choice risk adjustment.

To guide its consideration of the future of the S/HMO demonstration, the Commission has relied on three principles:

- Equity among beneficiaries. Medicare provides a national benefit package, regardless of what type health plan a beneficiary is in. Beneficiaries enrolled in Medicare+Choice obtain care from private health plans and receive Part A and Part B covered benefits. They may also receive other benefits, such as reduced cost-sharing requirements or some coverage for outpatient drugs or other products or services not covered by traditional Medicare for a premium paid by the beneficiary, employer, or former employer or from efficiencies in delivering Part A and Part B services, but the government does not pay for these or mandate that they be provided. All beneficiaries should have access to the same package of government financed benefits.

- Equity among health plans and providers. Medicare makes payments to cover the costs of a reasonably efficient provider with adjustments to reflect the local price level and to meet specific policy objectives. In general, payment is varied by service provided and by beneficiary characteristics rather than according to the plan or provider that supplies the service. Certain plans should not be advantaged relative to other plans.

- Capitation payments for frail beneficiaries. Payments should be based on beneficiaries' characteristics, not on the type of plan to which they belong. The Commission has previously recommended that payments follow the person and not depend on characteristics of the plan (MedPAC 1999).

The Commission has considered each of these principles in arriving at the recommendations that it adopted at its April 2003 public meeting listed below. Equal treatment of beneficiaries, equity for plans, using demonstrations to learn during limited periods of time, and payments that follow the person, not the plan, are all underlie our recommendations.

RECOMMENDATION 1

The Commission recommends that, at the conclusion of the demonstration on December 31, 2003, the Secretary request that the existing social health maintenance organization (S/HMO) plans apply to participate in the Medicare+Choice program as coordinated care plans. The benefit mandate would end. During the transition period from 2004 through 2007, comprehensive risk adjustment applied to the S/HMO plans should be the same as for Medicare+Choice plans and the 5.3 percent would be phased out.

In its concern for equal treatment of all beneficiaries, the Commission has considered the impact on beneficiaries of ending the demonstration. Members who choose to leave the former demonstration plans could enroll in another Medicare+Choice plan. All the markets in which the S/HMOs operate have multiple plan choices (Table 2). If available options stay as they are in 2003, beneficiaries could choose plans with outpatient drug coverage in all affected markets and zero premium plans in three of four areas. Beneficiaries who choose to return to fee-for-service Medicare would have the same protections as members of Medicare+Choice and demonstration plans that stop serving their area or go out of business. They would be guaranteed availability of Medigap plans A, B, C, and F. In states like New York and Nevada they would have additional protections under state law.

The Commission recommends that the demonstration end because certain plans should not be advantaged relative to other plans, and the 5.3 percent add-on received by S/HMO plans unfairly advantages these plans relative to others.[3] When the demonstration ends, the plans would not be required to offer the S/HMO expanded benefit package. They could, however, choose to continue to offer expanded benefits by realizing cost reductions or by charging members premiums for the expanded benefits.

The Commission does not believe as a general rule that the Congress should mandate a specific delivery system. This is particularly true in the case of S/HMOs, as there is scant evidence that these models have achieved their objectives. The S/HMO demonstration plans enroll members with health and functional status similar to beneficiaries enrolled in Medicare+Choice plans. To the extent that Medicare+Choice plans enroll frail members, the plans should be paid adequately to minimize incentives to avoid them or to stint on their care. The same adjustment would apply to payment for all plans.

[3] At the time of Commission action, the demonstration was scheduled to conclude on December 31, 2003. CMS subsequently extended it through December 31, 2004.

RECOMMENDATION 2

The Secretary should consider making payment adjustments for frail populations. Options may include using administrative data, survey data, or statistical modifications to the CMS HCC risk-adjustment model. After 2007 the Secretary should set capitation payments for frail beneficiaries based on their characteristics, if frailty adjustment is found to be necessary. This adjuster could either be a component of the risk adjustment or a separate frailty adjuster.

The risk-adjustment approach employed by CMS for all Medicare+Choice plans improves the accuracy of payments to plans that enroll a cross section of beneficiaries. In keeping with the principle of equity for plans, the Commission believes that CMS should continue examining methods to improve payment accuracy for high cost and frail populations. It should not apply a frailty adjuster to S/HMOs before it is ready for all plans.

CMS has proposed applying frailty risk adjustment to S/HMOs, PACE programs, and certain other demonstrations. It is considering the appropriate method for implementing frailty adjustment across the Medicare+Choice program. Many Medicare+Choice plans enroll beneficiaries with chronic conditions and limitations in ADLs. The Commission has recommended that, in the long term, the Secretary should set capitation payments for frail beneficiaries based on their characteristics, not on the type of plan to which they belong (MedPAC 1999).

Issues for future consideration

Medicare+Choice rates are based on 1997 county payment rates in effect before implementation of the BBA. Currently, new Medicare+Choice risk adjusters can only be implemented after rescaling the Medicare+Choice county rates to eliminate demographic adjustments built into the 1997 rates and incorporate county risk adjustment based on the new adjusters. These rules reduce the flexibility CMS has to introduce new risk adjusters such as those based on functional status data collected by survey. Since survey data are not currently available for all fee-for-service enrollees in every county, it is not possible to rescale county payment rates to make them consistent with survey-based risk adjusters. The Secretary may need to seek a technical correction to the statute from the Congress to allow an improved risk and frailty adjustment system to be implemented. CMS intends to collect functional status data on a sample of fee-for-service beneficiaries and may find that an adjustment to county payment rates is not necessary. In that case, a change to the statute may not be necessary.

The Congress could further improve payment accuracy by creating a level playing field by paying the same amount to plans as it spends in the fee-for-service program. The Congress should set payments to Medicare+Choice plans at 100 percent of per capita local fee-for-service spending, risk adjusted (MedPAC 2002).

In 2004, CMS will make risk adjustment budget neutral to the original demographic system for M+C plans. It estimates that, in the absence of budget neutrality, risk adjustment would reduce aggregate M+C payments (CMS 2003b). Payments to plans will be increased that year by a constant percentage (estimated at 16.3 percent when fully phased in) to keep aggregate M+C payments from declining. As a result, payments for beneficiaries enrolled in M+C plans will be higher than payments for fee-for-service beneficiaries of similar risk.

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APPENDIX

Commissioners' voting on recommendations

Commissioners' voting on recommendations

In the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000, the Congress required MedPAC to call for individual Commissioner votes on each recommendation, and to document the voting record in its report. The information below satisfies that mandate.

Recommendation 1

The Commission recommends that, at the conclusion of the demonstration on December 31, 2003, the Secretary request that the existing social health maintenance organization (S/HMO) plans apply to participate in the Medicare+Choice program as coordinated care plans. The benefit mandate would end. During the transition period from 2004 through 2007, comprehensive risk adjustment applied to the S/HMO plans should be the same as for Medicare+Choice plans and the 5.3 percent would be phased out.

Yes: *DeBusk, DeParle, Durenberger, Feezor, Hackbarth, Muller, Nelson, Newhouse, Raphael, Reischauer, Rosenblatt, Smith, Stowers, Wakefield, Wolter*
Absent: *Burke, Rowe*

Recommendation 2

The Secretary should consider making payment adjustments for frail populations. Options may include using administrative data, survey data, or statistical modifications to the CMS HCC risk-adjustment model. After 2007 the Secretary should set capitation payments for frail beneficiaries based on their characteristics, if frailty adjustment is found to be necessary. This adjuster could either be a component of the risk adjustment or a separate frailty adjuster.

Yes: *DeBusk, DeParle, Durenberger, Feezor, Hackbarth, Muller, Nelson, Newhouse, Raphael, Reischauer, Rosenblatt, Smith, Stowers, Wakefield, Wolter*
Absent: *Burke, Rowe*

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