CHAPTER 5

Managed care for frail Medicare beneficiaries: payment methods and program standards

RECOMMENDATIONS

5A The Secretary should study factors affecting the costs of care of frail beneficiaries and all other Medicare beneficiaries to determine if changes are needed to improve Medicare+Choice claims-based risk adjustment for frail beneficiaries. This study should identify data needed to support improvements in the Medicare+Choice risk adjustment system.

5B The Secretary should evaluate the use of partial capitation payment approaches for frail Medicare beneficiaries in specialized and Medicare+Choice plans.

5C The Secretary should postpone by at least one year the application of the interim Medicare+Choice risk adjustment system to specialized plans. Plans should be paid using existing payment methods until a risk adjustment or other payment system is developed that adequately pays for care for frail Medicare beneficiaries.

5D In the long term, the Secretary should set capitation payments for frail beneficiaries based on their characteristics, not of the type of plan to which they belong.

5E Performance measures for programs for frail Medicare beneficiaries should reflect the beneficiaries' health care needs and special practices for their care.

5F The Secretary should include special measures for evaluating and monitoring care for frail Medicare beneficiaries in the Medicare+Choice plan quality measurement and reporting requirements.

5G The Secretary should not now limit enrollment into the Program of All-Inclusive Care for the Elderly to a particular time of the year.

5H The Commission will await results from the Secretary's demonstration of for-profit entities in the Program of All-Inclusive Care for the Elderly before making a recommendation on allowing them to participate.

CHAPTER 5

Managed care for frail Medicare beneficiaries: payment methods and program standards

In this chapter

- Comparing programs for frail Medicare beneficiaries
- Medicare risk adjustment and specialized plans
- Program standards

The Medicare Payment Advisory Commission believes that payments and program standards should promote appropriate care of frail Medicare beneficiaries in all managed care programs. The risk-adjustment method HCFA will implement for Medicare+Choice does not appear to predict costs of frail beneficiaries' health care adequately, so it makes sense to delay its application to programs that specialize in caring for such people and to develop alternatives instead. HCFA should apply program standards developed for the Medicare+Choice program carefully to managed care programs for frail beneficiaries, considering the relevance of each standard to the beneficiaries the program serves.

Under the Program of All-Inclusive Care for the Elderly (PACE), Social Health Maintenance Organization (S/HMO), and EverCare demonstrations, the Health Care Financing Administration (HCFA) has explored innovations in the delivery of health care services for frail Medicare beneficiaries who need long-term, chronic, and acute care. All of these programs receive per-person monthly payment amounts from Medicare. HCFA is considering how to determine the monthly amount for the plans that participate in these programs. For 2000, it has decided to pay them under existing methods and not move them to the same system used under Medicare+Choice. The Secretary also is making important decisions about the future of these programs in 1999 and 2000. She will write regulations for the permanent PACE program, determine how to make the S/HMO demonstration a permanent option under Medicare+Choice, and decide whether to extend the EverCare demonstration. A critical question facing the Secretary is how to preserve valuable features of the specialized programs and, at the same time, establish program rules that do not favor one delivery system over another and that protect beneficiaries equally.

The Balanced Budget Act (BBA) of 1997 requires the Medicare Payment Advisory Commission (MedPAC) to make annual recommendations on both Medicare and Medicaid payment methods and amounts for PACE. The Commission also must comment on the appropriateness of allowing private for-profit entities to participate in PACE. MedPAC does not have any mandated responsibilities on the S/HMO or EverCare programs but may respond to the Secretary's report to the Congress on the future of the S/HMO demonstrations, scheduled to be completed in 1999.

This chapter has three main sections.

- The first section compares PACE, S/HMO, and EverCare with one another and with Medicare+Choice. The analysis finds that these programs share some characteristics but have different features. It also finds that frail Medicare beneficiaries may be enrolled in these programs or in Medicare+Choice plans. Further, plans participating in these programs sometimes are sponsored by organizations participating in Medicare+Choice. These overlaps in enrollees and participating organizations make a case for careful consideration of when payment methods and program standards should differ.
- The second section considers establishing Medicare payment rates for PACE, S/HMO, and EverCare and provides MedPAC's recommendations on the extent to which they should be calculated in the same way as payment rates under Medicare+Choice.
- The third section addresses which Medicare program standards for PACE, S/HMO, and EverCare should differ from those for Medicare+Choice. An analysis in this section finds some differences between the health care problems of beneficiaries targeted by specialized programs and those in the general Medicare population.

A discussion of setting payment rates from Medicaid for PACE participants is in Appendix B.

Comparing programs for frail Medicare beneficiaries

Although PACE, S/HMO, and EverCare all use managed care financing and case management tools to care for frail Medicare beneficiaries, the programs differ in several respects (see Table 5-1). This section compares PACE, S/HMO, and EverCare program objectives and evaluation findings. It concludes with a discussion of the overlap between programs for frail Medicare beneficiaries and Medicare+Choice, featuring a description of the differences and similarities among PACE, S/HMO, EverCare, and Medicare+Choice enrollees and the sponsors of plans that participate in these programs.

Overview of Programs

Before deciding whether the programs need to be treated differently from each other or from Medicare+Choice, one should consider what features of the programs are unique and whether the unique features are valuable. Only then can policymakers decide whether applying Medicare+Choice payment methods and performance standards across programs has the potential to undermine or enhance unique features of the programs. This section provides an overview of each program, including operational characteristics and, when available, evaluation findings. Neither the S/HMO II nor the EverCare demonstration has been evaluated yet.

Program of All-Inclusive Care for the Elderly: Using adult day health centers as a focal point in delivery of care

A primary objective of PACE is to delay or prevent use of hospital and nursing home care. The program provides a comprehensive range of preventive, primary, acute, and long-term care. PACE plans differ from most managed care plans in that all enrollees are frail and service delivery and coordination are centered on adult day health centers. Enrollees must be eligible for nursing home placement, based on state Medicaid criteria. The program usually requires enrollees to visit the centers often so that team members can assess their health and provide services as needed and families can have a break from care. Under the BBA, the Congress changed PACE from a demonstration to a permanent program under Medicare, and it granted states the option to offer PACE to their Medicaid enrollees.

TABLE 5-1

Selected features of PACE, S/HMO, and EverCare programs

Feature	PACE	S/HMO	EverCare
Program objectives	Integrate delivery and financing of primary, acute, and long-term care services for a frail elderly population.	Include community-based long-term care in an expanded managed care benefit package.	Provide better primary care to nursing home residents.
HCFA independent evaluation findings	Cost savings to Medicare, reduced use of institutional care.	Integration with primary care not successful; recommended changes led to S/HMO II.	None.
Payment methods	Base rate is Medicare+Choice rate. PACE gets base rate times 2.39 frailty adjuster for each enrollee.	Base rate is 100/95 x Medicare+Choice rate. S/HMO I gets adjuster for NHC enrollees and reduced adjusters for others. S/HMO II uses a multivariate formula.	Base rate is 93/95 x Medicare+Choice rate. EverCare gets institutionalized adjusters for each enrollee.
Benefits	All medical and long-term care benefits covered through pooled Medicare, Medicaid, and private capitation payments. Outpatient drugs are covered.	All Medicare benefits, expanded benefits, and long-term care benefits. Outpatient drugs are covered.	Similar packages to Medicare+Choice plans, but no outpatient drug coverage.
Eligibility requirements	Enrollees must meet state nursing home certifiability criteria and be age 55 or older.	Same requirements as Medicare+Choice, but beneficiaries under age 65 excluded from S/HMO I. S/HMOs initially limited participation of frail beneficiaries.	Nursing home residency.
Number of sites	25	3 S/HMO I, 1 S/HMO II	6 under demonstration, 3 Medicare+Choice subcontractors
Characteristics of sponsors	Most are freestanding, community-based provider entities; several sponsored by providers that own HMOs.	HMOs and long-term care providers	National HMO corporation—United HealthCare.
First year of operation	1971 (On Lok) 1990 (PACE)	1985 (S/HMO I) 1997 (S/HMO II)	1994

Note: PACE (Program of All-Inclusive Care for the Elderly), S/HMO (Social Health Maintenance Organization), BBA (Balanced Budget Act of 1997), NHC (nursing home-certifiable).

Source: MedPAC literature review.

Operational characteristics A multidisciplinary team of physicians, nurses, social workers, physical and occupational therapists, and others assesses enrollees' needs and develops treatment plans with patients and their families and provides much of enrollees' care. PACE plans cover a wide array of services, both medical and social, across care settings. Plans typically provide transportation, respite care, and meals in the adult day health centers and at home. Some sites also provide housing, although housing is financed separately from Medicare and Medicaid capitation. Though a PACE objective is to keep enrollees in the community, the program continues to pay for all services when participants must move into nursing homes. (In 1996, 6 percent of PACE enrollment days were spent in nursing homes.)

In addition to meeting state nursing home eligibility criteria, PACE participants must be at least 55 years old. Under the BBA, states re-evaluate annually whether PACE enrollees continue to meet state eligibility criteria, unless there is no reasonable expectation for improvement or significant change. Individuals who no longer meet the eligibility criteria must leave the program unless the evaluation finds that they are likely to meet the criteria again within six months. Although eligibility for Medicare and Medicaid is not required to join a PACE plan, most participants are covered by both programs. For these dual-eligible PACE enrollees, both Medicare and Medicaid make capitation payments that the plans pool to provide services.

PACE plans currently operate in 25 sites, with additional sites—known as "pre-PACE"—participating under Medicaid capitation only. The plans typically are small, with the largest site enrolling fewer than 1,000 participants. Several factors have kept the program relatively small:

- The program is available only to a subset of the Medicare population.
- PACE sites have high fixed costs. Sites are organized around one or

more buildings—adult day health centers—and salaried staff provide most services. Both of these features have made it harder for PACE plans to expand their capacity than if contracted providers had furnished most services in their own offices.

- Plans have limited budgets for generating referrals.
- The program requires that enrollees attend the adult day health center and use only the plan's providers. Some potential enrollees may find these rules unattractive. (Branch et al. 1995).
- Enrollment is expensive for beneficiaries without Medicaid coverage, who must pay the Medicaid capitation amount themselves as a premium.

Evaluation findings HCFA's evaluation contractor found that PACE had a mixed effect on outcomes (Burstein et al. 1996). Compared to people who applied to PACE but later declined to enroll, PACE enrollees had lower hospital and nursing home use and higher satisfaction. However, the PACE enrollees did not have lower mortality or improve function. Policymakers should view all of these findings with some caution, though, because the outcomes study did not control for the significant differences in health status between the two study groups (Irvin et al. 1997). Potential applicants for whom Medicare spending had been higher and who were closer to death were less likely to enroll in PACE.

Characteristics of enrollees A recent study found the average number of impairments in activities of daily living (ADLs) for all PACE enrollees was 3.9 out of a possible 5, with an average of 2.6 ADL impairments in the East Boston PACE site and 4.8 in the Columbia, South Carolina, site (Mukamel et al. 1998). Further, although some PACE enrollees improved over time (between 11 percent and 14 percent, depending on the time since enrollment), others deteriorated (between 8 percent and 13 percent) or died (between none and 13 percent) over 18 months.

First-generation Social Health Maintenance Organizations: Covering community-based long-term care benefits under Medicare

The first generation of the S/HMO (S/HMO I) program tests a model of service delivery and financing intended to integrate acute, chronic, and long-term care, and social services provided through capitated health maintenance organizations. One way to integrate services is through the benefit package. S/HMO I plans offer three types of benefits: basic Medicare, expanded benefits (such as prescription drugs and eyeglasses), and community-based long-term care (see Table 5-2). All enrollees are entitled to basic and expanded benefits. Only enrollees determined to be nursing home certifiable under their state's Medicaid standards are entitled to the long-term care benefits, which include intermediate nursing care, homemaker/chore services, personal health aides, medical transportation, adult day health care, respite care, and case management.

TABLE 5-2

Social Health Maintenance Organization site benefit summary: expanded long-term care services

Expanded long-term benefit	Kaiser Permanente Senior Advantage II	SCAN Health Plan	Elderplan
Overall spending cap	Annual maximum of $12,000 gross for home and community-based care, nursing facility, dentures, and other covered expanded care	No overall cap	Annual maximum of $7,800 gross and monthly maximum of $650 gross, including copayments
Home and community care	Pays 80%, up to $800/month; member pays 20% up to $200 per month ($1,000/month gross benefit)	Pays net after copayment to $625/month, $8.50/visit copayment for most services, $153/month out-of-pocket maximum	Pays balance after copayment, up to $650/month in gross costs; home care copayment is $12/visit; adult day care is $12/day
Nursing facility care (custodial/respite care)	Pays 80%, up to 14 days per period of confinement; 20% copayment	Covers up to 14 days per period of confinement; no copayment, but $7,500 lifetime limit	Covers 10 days lifetime for nonrespite stays and unlimited respite stays, subject to copayment and $7,800 annual cap

Note: All sites include in-home personal care and homemaker services, adult day care, in-home and institutional respite, short-term institutional stays, transportation to medical appointments, emergency response systems, foot care, and equipment and supplies. Some sites cover these separately, while others cover them within the expanded care benefit limits. Eligibility for long-term care benefits is based on functional status and need for supervision equivalent to state nursing home preadmission screening criteria.

Source: Social HMO Consortium, March 1999.

S/HMO I has been a demonstration since 1985. In the BBA, the Congress required the Secretary to submit a report in 1999 with a plan for integrating the S/HMO I demonstration into Medicare+Choice.

Operational characteristics The S/HMO I program controls enrollees' use of long-term care benefits. Plans determine continued eligibility for these benefits by reassessing enrollees' health and functional status every 90 days. Enrollees eligible for the long-term care benefits are limited to a maximum plan payment of $7,500 to $9,600 per year for these benefits, depending on the site; some sites also have lifetime limits on institutional benefits.

When S/HMO I was conceived, researchers were interested in finding out how pooling public and private funds to finance home and community-based services would affect the quality of life and use of institutional services. But two things have changed. First, researchers since have concluded that greater use of home health services generally does not lead to less use of hospital care (Neu and Harrison 1988). Second, the use of Medicare home health benefits—restricted when the S/HMO I was launched—has expanded greatly through the 1990s.

Another change since 1985 has been the growth in Medicare managed-care enrollment, with the concurrent provision of richer benefit packages at lower cost to beneficiaries. When the S/HMOs were first implemented, most Medicare HMOs (88 percent in 1988) charged premiums for their basic packages, and most (66 percent in 1988) did not cover prescription drugs (Brown et al. 1991). With greater competition among plans, coverage of prescription drugs with no premium has become the industry standard in many parts of the country.

Both S/HMOs and Medicare+Choice plans in their market areas currently offer similar expanded HMO benefits, but S/HMOs tend to provide broader coverage of prescription drugs (see Table 5-3). All market areas S/HMOs and Medicare+Choice plans serve have at least one plan offering a zero-premium

TABLE 5-3

Social Health Maintenance Organization site benefit summary: S/HMO and Medicare+Choice plans by S/HMO market area

Characteristics	Kaiser Permanente Senior Advantage II	SCAN Health Plan	Elderplan	Health Plan of Nevada
Number of Medicare+Choice plans in area	6	11	8	5
Medicare+Choice payment rate:				
Counties served by S/HMO				
Minimum	$382.37	$446.68	$733.87	$393.15
Maximum	$419.83	$647.70	$733.87	$530.04
Premiums				
Medicare+Choice				
Minimum	$0	$0	$0	$0
Maximum	$96	$50	$69	$70
S/HMO	$170	$0	$0	$0–$70.45
Prescription drugs				
Medicare+Choice				
Number offering benefit	2	11	7	4
Number with unlimited benefit	1	4	0	0
Average total limit	$600	$2,350	$700	$1,350
S/HMO	Unlimited	Unlimited	Unlimited	Unlimited
Generic drug copayment				
Medicare+Choice				
Minimum	$0	$0	$5	$4
Maximum	$0	$7	$10	$7
S/HMO				
Minimum	$5	$3.50	$5	$6
Maximum	$5	$3.50	$5	$7

continued

TABLE 5-3

Social Health Maintenance Organization site benefit summary: S/HMO and Medicare+Choice plans by S/HMO market area (continued)

Characteristics	Kaiser Permanente Senior Advantage II	SCAN Health Plan	Elderplan	Health Plan of Nevada
Vision				
Medicare+Choice				
Number covering eyeglasses, contacts, routine eye exams	6	11	7	3
S/HMO				
Covers eyeglasses, contacts, routine eye exams	Yes	Yes	Yes	Yes
Hearing aid benefits				
Medicare+Choice				
Average amount covered per period	$725	$250	$462.50	NA
Average period (years)	2	3	3	NA
S/HMO				
Amount covered per period	NA	$300	$600	NA
Period (years)	NA	2	3	NA
Foot care				
Medicare+Choice				
Number offering foot care beyond Medicare	0	5	5	2
S/HMO				
Offers foot care beyond Medicare	No	Yes	Yes	No
Nonemergency transportation				
Medicare+Choice				
Number offering nonemergency transportation to plan-approved location	2	2	2	1
S/HMO				
Offers nonemergency transportation to plan-approved location	NA	Yes	Yes	No

Note: Averages are for all benefit packages that Medicare+Choice plans offer within an S/HMO market area. Medicare+Choice payment rate is the total of 1999 Part A and Part B payment rates. NA (data not available). Medicare+Choice refers to all Medicare+Choice plans in area, excluding S/HMO. S/HMO (Social Health Maintenance Organization).

Source: Medicare Compare, January 1999 available at www.medicare.gov.

package, while three of the four S/HMOs offer zero-premium options. The exception (Kaiser Permanente Senior Advantage II) charges a high premium ($170), possibly because of its rich long-term care benefits or the low Medicare+Choice payment rates in the counties it serves. Most Medicare+Choice plans offer outpatient prescription drug coverage, although most cap their coverage at an annual maximum. In contrast, all S/HMOs have unlimited prescription drug coverage (although their copayments for generic drugs are generally not the lowest in their areas). S/HMOs offer richer hearing aid and nonemergency transportation benefits. Coverage of Medicare post-acute services is similar in S/HMOs and Medicare+Choice plans.[1]

In addition to providing expanded benefits and community long-term care, S/HMOs include a case-management component. S/HMO case managers emphasize community-based services and attempt to coordinate institutional and noninstitutional care.

1 The Medicare Compare data do not include enough responses from plans to compare the frequency with which plans offer coverage for skilled nursing facility stays of over 100 days.

Evaluation findings HCFA first evaluated S/HMO I in the 1980s, and a second evaluation is under way. The earlier evaluation found that although S/HMO I successfully offered long-term care services, it did not develop a well-coordinated system of care with acute and chronic medical benefits (Harrington et al. 1993). The principal problem was that S/HMO I projects did not establish successful working relationships between physicians and case managers. Physicians did not change their practice style and remained uninvolved with other participants in the delivery system. Even by the end of the evaluation period, many physicians were unaware of the S/HMO long-term care benefit package. However, case managers successfully managed long-term care resources, with no more than 2 percent of enrollees exhausting their long-term care benefits at any site.

The evaluation found that S/HMO I had mixed effects on outcomes. Researchers found no difference in case-mix standardized mortality rates between the S/HMOs and traditional Medicare. Although the less healthy enrollees were more likely to survive from one period to the next in traditional Medicare, the S/HMOs were somewhat more successful than the traditional program in helping less healthy survivors to return to active life.

The evaluation also found that S/HMO enrollees without functional impairments were more satisfied with their coverage and care than comparable beneficiaries in the traditional program. Enrollees with impairments were less satisfied than either unimpaired S/HMO enrollees or impaired beneficiaries in the traditional program (Newcomer et al. 1994). Other studies report a mix of findings on satisfaction. Some have similar results; others found that S/HMOs were able to satisfy their continuing members and that the S/HMOs' enrollees were as satisfied with their coverage as Medicare beneficiaries in traditional Medicare.

Characteristics of enrollees By design, S/HMOs enroll beneficiaries with and without disabilities. S/HMO I plans initially were allowed to limit the share of enrollees who were nursing home certifiable and would use long-term care benefits, but the plans since have chosen to drop these limits. Medicare beneficiaries younger than age 65 have not been permitted to enroll in S/HMO I plans but are enrolled in S/HMO II. In early 1999, the percentage of enrollees considered nursing home certifiable in the three S/HMO I plans were as follows: Elderplan, 20 percent; Kaiser, 23 percent; and SCAN, 15 percent.

Second-generation Social Health Maintenance Organizations: Focusing on models of geriatric care

The Congress mandated the second-generation S/HMO demonstration in 1990. It is similar to the S/HMO I demonstration in many regards, but it is supposed to improve services, financing methods, and benefit design. HCFA chose six organizations to participate in the second-generation program, but only one, Health Plan of Nevada, has become active. By late 1998, three sites had decided not to develop SHMO II plans, and two others were continuing discussions with HCFA to settle unresolved questions.

One goal of the newer demonstration is to develop S/HMO plans distinct from conventional risk HMOs because they incorporate practices that geriatricians developed into the operations of the plans. 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. Case management is not limited to those eligible for long-term care benefits; it is also provided to those with high-risk conditions, evidence of impending disability, or a risk of disability.

EverCare: providing better primary care to nursing home residents

EverCare is a recent demonstration program (started in 1994) that enrolls permanent nursing home residents into managed care. The demonstration builds on the EverCare company's experience subcontracting with Medicare HMOs to provide medical care for enrollees living in nursing homes.

Unlike PACE and S/HMO, EverCare does not expand the Medicare benefit package significantly; instead, the primary focus is to provide more Medicare-covered outpatient services. EverCare assigns a physician and nurse practitioner to nursing home residents to provide primary care in the nursing home. These providers have expertise in caring for geriatric patients and are to coordinate enrollees' care by developing a treatment plan, providing routine and emergency visits, arranging for specialist visits, communicating with enrollees' families, and overseeing any hospital care. The program provides these services to reduce residents' use of hospital and emergency room care. The demonstration also is intended to improve the quality of care and health outcomes and to develop practice guidelines.

Operational characteristics Although EverCare does not cover such services as prescription drugs or long-term nursing home care, the program does use the flexibility of a capitation payment to shift services among settings. EverCare sometimes increases payment rates to physicians above the Medicare amounts to encourage visits, and it also reimburses physicians for care planning and family conferences. EverCare must pay for skilled nursing care, a Medicare benefit, but plans do not require enrollees to have a three-day hospital stay to use this benefit. The plans have developed a payment scheme for nursing home "intensive service days," used when the homes care for patients who otherwise would have been transferred to a hospital.

EverCare markets to residents of nursing homes through the homes. This practice allows the program to enroll enough patients so that nurse practitioners can spend significant time in the homes. The program prefers to enroll patients of nursing homes where a small number of physicians provides most of the services and is receptive to the EverCare philosophy of care (Kane and Huck 1998). It also prefers to enroll patients living in nursing homes that provide skilled care, so that the program can use these services to substitute for hospital stays.

Characteristics of enrollees All EverCare enrollees are permanent nursing home residents. According to EverCare data, enrollees have an average of four to five impairments in ADLs, and about 80 percent of enrollees have dementia.

Comparing enrollees in programs for frail Medicare beneficiaries with those in Medicare+Choice

The populations overlap in the managed care programs for frail Medicare beneficiaries and in Medicare's main managed care program (formerly known as the risk contracting, or risk program, and called Medicare+Choice starting in 1999). Risk plans (participants in the risk program) enroll some beneficiaries with characteristics similar to those who enroll in specialized programs. PACE and EverCare are open only to beneficiaries who need long-term care. Recognizing the overlap among programs, policymakers will need to strike a balance between recognizing differences among programs and giving all managed care plans the same strong incentives to provide quality health care to frail beneficiaries.

Health plans participating in the Medicare+Choice program enroll beneficiaries who have functional disabilities and those who live in nursing homes (though they tend to enroll relatively fewer frail beneficiaries than the traditional program). In 1996, about 11 percent of Medicare risk plan enrollees needed help with at least one ADL (MedPAC 1998). The same year, risk plans enrolled 4 percent of all Medicare beneficiaries living in institutions and about 9 percent of all Medicare beneficiaries who reported functional disabilities. To care for these enrollees, some plans use many of the same tools featured in PACE, S/HMO, and EverCare, such as case management, care from nurse practitioners, and enhanced benefit packages (Pacala et al. 1995, Reuben et al. 1999).

Differences in enrollees' characteristics among programs

In the aggregate, enrollees in the three programs for frail Medicare beneficiaries are older and have higher mortality rates than those in Medicare risk plans. Differences are most apparent among PACE and EverCare enrollees (see Table 5-4). The population in the S/HMOs is similar to that of traditional Medicare. S/HMO enrollees are slightly older, are slightly more likely to be eligible for both Medicare and Medicaid, and have marginally higher mortality rates than risk plan enrollees. PACE enrollees, by contrast, are significantly older than either S/HMO or risk enrollees, are almost all dually eligible for Medicaid and Medicare, and have much higher mortality rates in each age group, probably indicating a higher burden of illness. EverCare enrollees are the oldest population and are the most likely to die; they are less likely than PACE enrollees to be eligible for Medicaid.

Each of the three programs enrolls beneficiaries with functional impairments, but the severity of these impairments varies by program and by state.

Many beneficiaries move from program to program

Each program attracts enrollees who were in a risk plan at some point after becoming eligible for Medicare, but relatively few enrollees in the demonstration programs disenroll and later join Medicare risk plans. Of the three programs, S/HMO enrollees are most likely to have been in a risk plan; 70 percent of all S/HMO enrollees have been in a risk plan at some time, with some enrollees moving back and forth between S/HMO plans and risk plans several times (see Table 5-5).

Comparing sponsors of plans in programs for frail beneficiaries with those in Medicare+Choice

Some of the programs for frail Medicare beneficiaries have sites sponsored by risk plans, making the need for careful design of payment methods and program standards all the more important. It is entirely appropriate for managed care plans to develop innovative care management techniques for a targeted population through a demonstration or under the Medicare+Choice program. However, to the extent that the same entities participate in multiple programs with different payment methods or program standards, the potential exists for exploiting the differences. For example, if the Secretary designed a payment system for specialized programs that paid more for a beneficiary in a S/HMO than for the same beneficiary in a Medicare+Choice plan, an organization with both a S/HMO and a Medicare+Choice contract would have a strong incentive to enroll that beneficiary in the S/HMO to receive a higher payment.

Of the four operational S/HMO sites, two—Kaiser Permanente Northwest and Health Plan of Nevada—are sponsored by HMOs that also contract with Medicare under the Medicare+Choice program. Three of the 21 PACE plans operating in February 1999 were offered by health systems that also had a Medicare HMO. EverCare is a subsidiary of United HealthCare, a major managed care company with multiple Medicare+Choice contracts. EverCare operates demonstration sites and subcontracts with Medicare+Choice plans in several cities.

TABLE 5-4

Selected demographic information on enrollees in Medicare programs for frail Medicare beneficiaries, 1997

Category	PACE	S/HMO	EverCare	Risk	Traditional Medicare program
Number of enrollees (in thousands)	4	59	7	5,900	31,800
Annual increase in enrollees (1994–97)	22.9%	44.4%	257.5%	33.3%	0.6%
Age (distribution in percent):					
<65	4%	6%	1%	12%	17%
65–74	24	49	12	54	44
75–84	40	35	37	28	29
85+	33	10	50	7	10
Enrollees with Medicaid eligibility	96%	5–6%	70–75%	5%	16%
Mortality rate by age					
<65	10%	2%	22%	2%	3%
65–74	12	3	21	2	3
75–84	14	6	30	5	7
85+	18	15	36	13	17

Note: PACE (Program of All-Inclusive Care for the Elderly), S/HMO (Social Health Maintenance Organization).

Source: MedPAC analysis of data from the HCFA Group Health Plan Master and Denominator files and programs.

Medicare risk adjustment and specialized plans

The BBA mandated that HCFA develop a new system of risk adjustment for Medicare+Choice plans. Risk adjustment makes Medicare payments to plans more accurately reflect predictable differences in plan health care spending on behalf of enrollees. Risk-adjusted payments are more equitable across plans and allow resources to follow the people who will need the most care.

Risk adjustment increases payments for beneficiaries whose health would lead to predictably higher spending by plans in which they are enrolled. This reduces incentives for plans to avoid enrolling them or to encourage them to disenroll. Risk adjustment should lead to less risk selection (enrollment of relatively healthy beneficiaries) and encourage plans to compete on the basis of how effectively they manage care rather than on how successfully they attract favorable risks.

MedPAC has considered whether HCFA should use methods developed for Medicare+Choice to pay plans participating in programs for frail Medicare beneficiaries. In general, the Commission believes that Medicare's capitation payments should follow beneficiaries into any managed-care plan they select, regardless of its special features. This policy would give all plans incentives to provide good care for frail beneficiaries and would encourage innovation in care for beneficiaries with functional disabilities.

MedPAC also recognizes, however, that the risk adjustment methods planned for use in 2000 for Medicare+Choice and considered for use in 2004 are inadequate predictors of the cost of care for frail Medicare beneficiaries.

Health plans such as those in Medicare+Choice generally serve a wide cross-section of beneficiaries and may be able to offset low payments for the care of some enrollees with higher payments for the care of others. Conversely, programs designed to serve frail Medicare beneficiaries have limited opportunities to average payments to meet the high costs of care these beneficiaries may require. For this reason, the Commission supports the Secretary's decision to exclude PACE, S/HMO, and EverCare temporarily from the risk adjustment methods being introduced for

TABLE 5-5

Medicare beneficiaries' enrollment in multiple managed care programs at some time

Program	Number of beneficiaries	Percentage in program
PACE	6,864	
PACE only	5,871	86%
PACE and risk	993	14
S/HMO	98,016	
S/HMO only	29,026	30%
S/HMO and risk	68,990	70
EverCare	9,673	
EverCare only	8,709	90%
EverCare and risk	964	10

Note: PACE (Program of All-inclusive Care for the Elderly), S/HMO (Social Health Maintenance Organization). Number of beneficiaries counts all beneficiaries ever enrolled in the programs. EverCare data are for demonstration sites only.

Source: MedPAC analysis of Group Health Plan Master file from the Health Care Financing Administration, April 1998.

Medicare+Choice in 2000. We believe that the Secretary should study the differences between frail and other Medicare beneficiaries to understand the factors affecting costs of care. This examination would help her determine whether changes are needed to improve Medicare+Choice claims-based risk adjustment for frail beneficiaries. If an improved adjuster is developed, the Secretary should use it for all frail beneficiaries. The Commission realizes that data limitations may require applying such an adjuster only to specialized plans in the short run and to all Medicare+Choice plans later.

We encourage the Secretary to consider information about functional status of beneficiaries with information about diagnoses and service use for characterizing, managing, and paying for care. State Medicaid programs already use information about functional status to determine nursing home eligibility, and Medicare will use this information for payments to skilled nursing facilities and home health agencies. We believe the Secretary should encourage plans to begin collecting such data, with encounter data, routinely.

This section reviews information on the performance of available risk adjustment methods when applied to frail beneficiaries in the community and in institutions. It discusses implementation issues such as data availability, reliability, and manipulation of information to increase payment (also called gaming); presents evidence on cost-effectiveness and risk selection in specialized plans for frail beneficiaries; and includes background information on current Medicare payment methods for PACE, S/HMOs, and EverCare.

Risk adjustment alternatives

Specialized plans differ from Medicare+Choice plans in several ways that, in combination, may justify special payment methods for beneficiaries in these plans:

- Specialized plans enroll disproportionate numbers of certain frail Medicare beneficiaries.
- Care for the beneficiaries enrolled may be significantly more expensive than for average Medicare+Choice plan enrollees.
- Specialized plans offer distinctive services of value to Medicare beneficiaries but costly to plans.
- Risk adjustments planned for Medicare+Choice do not accurately match payments to costs for the care of frail Medicare beneficiaries.

Risk adjustment methods generally use information from one or more years to forecast expected costs in the subsequent year. Such methods are intended to yield payment rates that match the expected costs of care for beneficiaries in different health status categories.

Several risk adjustment models might be used with frail Medicare beneficiaries. They vary in design, data requirements, performance, gameability, and other features. The most promising are diagnostic models based on claims data and functional and health status models based on data from clinical records or surveys.

Claims-based models use diagnostic information from claims or similar data submitted by providers to estimate the expected costs of enrollees. Models such as principal inpatient diagnostic cost groups (PIP–DCG) and hierarchical coexisting conditions (HCC) use reported diagnoses to classify patients by risk category. The models use information on the relative costliness of caring for patients in different diagnostic categories to estimate future resource use.

Other models use information on patients' functional status and self-reported health status to forecast resource use. Functional status information can be collected from either clinical records or by survey, and self-reported health status data can be collected by survey only. Functional status models use measures of impairment, generally reflecting performance of ADLs or instrumental activities of daily living (IADLs). ADL limitations indicate difficulty, or a need for help, in activities necessary for basic physical functioning, such as bathing or dressing, whereas IADL impairments

reflect difficulty or need for help in activities required for functioning, such as housework or managing money. Health status models use information such as respondents' assessments of their own health (for example, poor, fair, good, very good, or excellent, compared with others, of the same age) or information from a survey instrument such as the Short Form 36 (SF-36). The SF-36 is a questionnaire that collects information on persistent or recurring physical, social, and emotional dysfunction, as well as attitudes and concerns about health and efficacy of medical care (Ware and Sherbourne 1992).

Performance of models applied to all beneficiaries

Research indicates that claims-based models provide better overall explanatory power than models based on self-reported health status or functional status measures alone for the general population. The PIP-DCGs, which HCFA plans to use for Medicare+Choice risk adjustment from 2000 through 2003, perform relatively well overall, but they underestimate costs for beneficiaries with disabilities (see Table 5-6).[2] HCCs, which HCFA may use for risk adjustment starting in 2004, perform better for these groups but still underestimate costs. Adding variables measuring functional status and self-reported health status improves the performance of both PIP-DCGs and HCCs for beneficiaries with disabilities.

The performance of claims-based models varies by subgroup. The PIP-DCGs significantly overestimate costs of care for people who have no difficulty with ADLs and underestimate costs of care for people who have difficulty with one or more ADLs, with underestimates of almost 30 percent for people who have difficulty with five or six ADLs. HCCs have similar, but much smaller, predictive errors—no more than 15 percent for people who have difficulty with three or four ADLs and a lower percentage for those who have difficulty with five or six ADLs.

Risk adjustment under Medicare+Choice will use a modification of the PIP-DCG method.[3] This modified PIP-DCG system still underpays—by as much as 39 percent—for beneficiaries with spending in the top 5 percent and by as much as 11 percent for those with any chronic condition (HCFA 1999a). The modified PIP-DCG model's predictions are essentially the same as the basic PIP-DCG model for all ADL groups except for elderly needing help with three or more ADLs. For these beneficiaries, predictions improve modestly from an underestimate of 30 percent to an underestimate of 23 percent (Table 5-6 and Pope et al. 1999).

Adding health and functional status to risk adjustment models improves the predictive ability of claims-based models for beneficiaries with disabilities. Adding health and functional status information gives models that accurately forecast spending for all beneficiaries who have difficulty with ADLs and for elderly needing help with three or more ADLs.

TABLE 5-6

Predictive ratios for alternative risk adjustment models by validation subgroup

Validation groups	PIP-DCG	PIP-DCG and health and functional status	HCC	HCC and health and functional status
Institutional status				
Non-institutionalized	1.01	0.99	0.99	0.98
Institutionalized	0.88	1.16**	1.12	1.27***
Functional status				
5-6 ADLs	0.72***	1.06	0.88*	1.08
3-4 ADLs	0.74***	0.94	0.85*	0.95
1-2 ADLs	0.85***	1.03	0.90**	1.03
IADLs only	1.06	0.97	1.04	0.96
None	1.30***	0.98	1.16***	0.98
Elderly helped with 3+ ADLs	0.70***	0.96	0.88*	1.00

Note: Predictive ratio is the ratio of spending predicted by the model to actual spending. (A predictive ratio closer to 1.00 indicates better prediction.) Predictive ratios of each group normalized by dividing by the predictive ratio of the overall sample. ADL (activity of daily living), IADL (instrumental activity of daily living). PIP-DCG (principal inpatient diagnostic cost group). HCC (hierarchical coexisting conditions).
*** Predictive ratio is significantly different from1 at the .01 level.
** Predictive ratio is significantly different from 1 at the .05 level.
* Predictive ratio is significantly different from 1 at the .10 level.
Data are 1992 (Round 4) and 1993 (Round 7) Medicare Current Beneficiary Survey.

Source: Pope GC, Adamache KW, Walsh EG, Khandker RK. Evaluating alternative risk adjusters for Medicare. Waltham (MA), Center for Health Economics Research. Report to the Health Care Financing Administration under cooperative agreement no. 17-C-90316/1-02. 1998

2 Table 5-6 presents predictive ratios (ratios of predicted to actual spending, normalized by dividing by the model's ratio for the entire sample), for selected risk adjustment models and demographic groups. The table indicates those ratios for which the difference from one is statistically significant.

3 The base payment amount is paid for diagnoses that represent minor or transitory diseases or disorders, are rarely the main cause of an inpatient stay, or are classified by HCFA as "vague or ambiguous." It is also paid for diagnoses reported as a result of a short hospital stay (one day or less). Adjustments are included for aged beneficiaries originally entitled by disability, for Medicaid enrollment in any single month during the diagnosis year, and for working-aged status (HCFA 1999a).

Performance of models applied to institutionalized beneficiaries

Models perform differently for institutionalized and for all beneficiaries. Models including demographic characteristics underpredict spending for the institutionalized while SF-36-type and functional status models overpredict it (Pope et al. 1998).

PIP-DCGs and HCCs predict payments well for the institutionalized. Adding health and functional status to these models leads to overpredicting payments for the institutionalized (see Table 5-6).

HCFA presented analyses in 1997 indicating that the adjuster for institutional status used in the adjusted average per capita cost (AAPCC) payment system was higher than warranted by current data, so the agency proposed to reduce the adjuster. After passage of the BBA, the agency concluded that provisions of the new law and planned implementation of risk adjustment in 2000 made it inappropriate to change the AAPCC payment factors.

HCFA will phase out the adjuster for institutional status with the introduction of the new Medicare+Choice risk adjustment system. The agency notes that though total Medicare spending for beneficiaries in skilled nursing facilities is relatively high, spending for those in other long-term care facilities (nursing homes, intermediate care facilities for the mentally retarded, and mental health facilities) is not (HCFA 1999a). The modified PIP-DCGs scheduled for use with Medicare+Choice would pay accurately for the care of institutionalized beneficiaries such as those served by EverCare (Pope et al. 1999).

Industry representatives have raised concerns that the data used to test the modified PIP-DCG system in predicting the costs of institutionalized beneficiaries are flawed because they do not capture the full spending experience of nursing home residents. Further, they demonstrate that the costs to Medicare of an institutionalized beneficiary vary significantly over the course of the nursing home stay; costs are high in the first six months of nursing home residence and decline gradually over time (Gruenberg 1999). This finding warrants further study of whether the performance of PIP-DCGs might vary depending when the beneficiary was admitted to the home.

Implementation issues

The availability of data was a principal concern of HCFA in choosing a risk adjustment system for Medicare+Choice. It also will be a major concern in choosing a risk adjuster for frail Medicare beneficiaries, including those in specialized programs. Because information about functional and health status is not now included on claims forms or in the encounter data collected from all Medicare+Choice plans, supplemental data collection would be necessary. HCFA would need information from continuing surveys, such as the Medicare Health Outcomes Survey (HOS, formerly the Health of Seniors survey) or the Medicare Current Beneficiary Survey, new surveys, or possibly data from plan administrative records or member medical records. However, the method for calculating Medicare+Choice rates requires data on traditional Medicare beneficiaries at the county level. This method would require surveys of Medicare beneficiaries in the traditional program.

Reliability

Reliability of reported data is also a concern. Although fee-for-service (FFS) claims data are considered generally reliable (but the Department of Health and Human Services Office of Inspector General still reports substantial overpayments because of data errors), information from managed-care organizations is considered less reliable than corresponding FFS data because many of these organizations are relatively new to processing claims data and payment has not been tied to data quality. These limitations also will hinder efforts to refine claims-based models using managed-care data rather than the FFS data with which they were developed.

Health status data raise questions of the reliability and appropriateness of using self-reported data in a payment system, as does functional status if self reported. Many frail beneficiaries are cognitively impaired, and information may be provided by such proxies as adult children or spouses. The use of either health or survey-collected functional status measures in a risk-adjustment model could make payment dependent on subjective self-reported information. Alternatively, nurses or physicians could assess functional status, and plans could include this information with encounter data submitted to HCFA. These clinical assessments, while subject to clinical error, are not subject to error of self-report.

Data availability

HCFA does not now have self-reported health status or functional status data for all Medicare beneficiaries. However, information on functional status is collected by specialized plans, from a representative sample of Medicare+Choice enrollees, and for some users of post-acute care. PACE plans routinely collect functional data on enrollees. S/HMO plans send a health status form to each member annually, and plans complete a comprehensive assessment form for each member eligible for long-term care benefits. S/HMO I plans consider ADL or IADL information when screening for nursing home certifiability, and then systematically collect and regularly update ADL and IADL information for enrollees found to be nursing-home certifiable (based on data from Kaiser Permanente and Elderplan). EverCare collects and updates ADL information. HCFA currently is not requiring Medicare+Choice plans to include such information with the encounter data they must submit.

The cost and complexity of collecting data from all plan members may lead HCFA to collect data by survey. (HCFA

estimates that the cost of collecting functional status information would equal the cost of collecting the full array of encounter data). If HCFA chose to use a new survey to develop data for use in risk adjustment, it would need a way to ensure a representative sample of adequate size for each plan.

If HCFA chose to collect health and functional status information with an existing survey, it might consider using or modifying the Medicare Health Outcomes Survey. HCFA is collecting HOS data from a sample of enrollees in most Medicare+Choice, PACE, S/HMO, and EverCare plans. The HOS is built on the SF-36 survey instrument, which has been used to monitor health, evaluate outcomes, and provide external performance measurement of health plans. It is possible to infer some functional information from SF-36 responses, and the HOS instrument includes explicit questions about ADL and IADL limitations.

One way of collecting functional status assessments would be to use existing plan records. Specialized plans already might be able to report ADL and IADL information from the assessments they do. Medicare+Choice plans currently do not systematically collect such information, but HCFA could require them to collect such data and to include them as part of the mandated submission of encounter data to HCFA. It could encourage plans to view functional status information as valuable clinical information, on a par with diagnosis information. Systematic collection of ADL and IADL information from plan records would impose new costs on plans and on HCFA. However, it would overcome issues of sample design, cost, and data reliability inherent in efforts to collect such information by supplemental survey. As an alternative to requiring submission of data, plans might report disability measures voluntarily.

Implementation of broader risk-adjustment measures would require information at the county level on beneficiaries in the traditional program. The current capitation system makes payments at the county level. The county rate is the Medicare payment for a beneficiary with the national demographic profile. HCFA calculates this county rate by dividing the county rate by average risk factors in the county. Plan payments for each Medicare+Choice enrollee equal the risk factor for that enrollee multiplied by the county rate.

Risk factors under the old system are demographically based and, under the interim Medicare+Choice risk-adjustment system, will be PIP–DCG risk-adjustment weights. HCFA calculates the new risk-adjusted county rates from the 1997 rates, as mandated by the BBA. It multiplies the 1997 county rates, standardized by the demographic factors, by county-specific values that convert them into rates standardized by PIP–DCG factors. A similar calculation would be required if a functional status risk adjuster were used, with county functional status risk weights used in place of PIP–DCG weights. HCFA must have information to calculate risk-adjustment factors for beneficiaries in the traditional program in each county to convert 1997 rates into rates based on the new risk-adjustment system.

Risk-adjustment systems that use information from administrative databases are the least expensive to implement, because they do not require new data collection. This has been a primary advantage of risk adjusters that use beneficiary age and sex. The new Medicare+Choice risk-adjustment system that uses inpatient hospital diagnoses has required new data collection from Medicare+Choice plans, but information on the population in the traditional program in each county already is available on hospital bills.

HCFA believes that one problem with moving to a risk-adjustment system that incorporates information about risk from functional assessments or surveys is that the system would need both from plans and data from beneficiaries in the traditional program. These data would be necessary to standardize national risk adjusters for use with county data. However, it would be possible to develop a national or state adjuster based on a sample and apply it regardless of county differences in functional status. Some functional status information will be collected in the traditional program as part of the case-mix adjustment systems to be used for skilled nursing and home health care prospective payment systems. This information will be incomplete, however, because it will include only functional status information for beneficiaries who use these services.

Manipulating data to increase payments

HCFA will have to pay attention to the possibility of gaming in any risk-adjustment system. If data were collected directly from plans, the organizations might manipulate the data reported. If data were collected by survey, plans might influence which members were included in a sample and how beneficiaries responded to questions. The problems are greater than with claims data because functional status information is more difficult to audit. Incentives to increase the number and type of ADLs and IADLs reported, as with any characteristic with which payment is associated, may be high. If HCFA makes higher payments for beneficiaries with certain characteristics, information on traditional Medicare beneficiaries suggests that the reward for reporting additional disabilities would be great. In the traditional program, spending on care for beneficiaries with one or two ADL impairments is three times the spending for those with none. It is one-third higher for those with three or more ADL impairments compared to spending for those with two (Komisar et al. 1997/1998).

Risk-adjustment recommendations

RECOMMENDATION 5A

The Secretary should study factors affecting the costs of care of frail beneficiaries and all other Medicare beneficiaries to determine if changes are needed to improve Medicare+Choice claims-based risk adjustment for frail beneficiaries. This study should identify data needed to support improvements in the Medicare+Choice risk adjustment system.

The Secretary should continue research into factors that affect the cost of care of Medicare frail beneficiaries and other beneficiaries. This research will help HCFA determine whether modifications of Medicare+Choice risk adjusters are necessary for payment for the care of frail beneficiaries and will help in the design of modified adjusters.

It may be possible to refine existing claims-based risk adjusters, such as PIP–DCGs and HCCs, to make them more sensitive to the differences between frail and other Medicare beneficiaries. An alternative would be to develop risk adjusters based on clinical assessments of functional status collected from plan records, by survey, or by a combination of these methods.

The Commission anticipates that risk adjusters based on clinical assessments of functional status would be combined with claims-based adjusters applied to other Medicare+Choice plans. Data collection costs may be high for developing and implementating risk adjusters not based on claims. HCFA should explore all opportunities to collect necessary data from plan records to reduce costs of data collection and increase data reliability. It also should explore alternatives for collecting similar data in specialized plans, Medicare+Choice plans, and traditional Medicare to permit comparisons of cost and performance in care for all frail Medicare beneficiaries.

RECOMMENDATION 5B

The Secretary should evaluate the use of partial capitation payment approaches for frail Medicare beneficiaries in specialized and Medicare+Choice plans.

HCFA could combine risk adjustment for frail Medicare beneficiaries with basing payments in part on actual services used. The Commission recommends that the Secretary evaluate a system of partial capitation for payment to specialized and Medicare+Choice plans for care to frail Medicare beneficiaries.

In its simplest form, plans paid by partial capitation would submit claims for all services. Plans would receive both a reduced traditional Medicare payment and a reduced capitation rate in some actuarially fair combination. This approach would reduce the loss from enrolling beneficiaries whose costs of care were above the risk-adjusted capitation rate and the profit from those with costs of care below it. By reducing the profit from attracting good risks, this approach would provide greater resources for frail beneficiaries with relatively high costs of care. It would discourage underprovision of care by providing positive payments for all additional services.

Partial capitation complements risk adjustment and may be especially useful in situations—such as care for frail beneficiaries—where existing methods do not predict costs accurately. Partial capitation payments, based partly on actual services used, are on average closer to costs than capitation payments based on risk adjusters that do not predict costs well. By protecting plans from underpayment, partial capitation makes it possible to implement risk adjustment with existing methods as research continues to develop improved adjusters.

Partial capitation would reduce a plan's overall financial risk and would be useful for plans with low enrollment. It might be suitable for plans such as PACE sites, which generally have fewer than 500 members.

Finally, partial capitation provides information on use of services in capitated plans that would strengthen the ability to refine capitation payments. It would provide an incentive to report the information accurately.

Partial capitation has some drawbacks, and it raises issues unique to specialized plans. It introduces fee-for-service incentives in the managed care setting, reducing incentives to control costs and leading to possible management problems. Specialized plans seek to substitute services Medicare does not cover for those that are covered (for example, home- and community-based care for nursing facility care). If partial capitation payments do not include both covered and noncovered services, plans would be encouraged to substitute covered services (which would increase their partial capitation payments) for noncovered services (which would not increase them), seriously undermining the objectives of these programs. On the other hand, including noncovered services in partial capitation payments would constitute an expansion in Medicare-covered services presumably not intended by Congress. Including services in partial capitation payments also would require calculating fee-for-service rates for all the plans' services. While this calculation for covered services can use payment rates in traditional Medicare, it would be necessary to develop rate schedules for noncovered services for which no Medicare payment rates exist.

RECOMMENDATION 5C

The Secretary should postpone by at least one year the application of the interim Medicare+Choice risk adjustment system to specialized plans. Plans should be paid using existing payment methods until a risk adjustment or other payment system is developed that adequately pays for care for frail Medicare beneficiaries.

The Secretary plans to delay application of PIP–DCGs to specialized plans in 2000 and to continue paying them using the current modified Medicare+Choice payment rate methods. The Commission supports a postponement, pending the results of HCFA's study of risk adjustment options for populations specialized plans serve. HCFA will work with specialized plans to acquire encounter data based on both claims and surveys, including inpatient, outpatient, and physician data, as well as functional status information.

RECOMMENDATION 5D

In the long term, the Secretary should set capitation payments for frail beneficiaries based on their characteristics, not the type of plan to which they belong.

Risk adjustment and payment should follow the beneficiary and not be tied to the plan. Making risk-adjusted payments for frail beneficiaries regardless of plan would encourage plans to enroll them and to introduce innovations in their care. HCFA should consider adding functional status information to the encounter data it requests from Medicare+Choice plans in preparation for implementing comprehensive risk adjustment in 2004. These data will permit HCFA to develop adjusters using functional status measures and to test the performance of claims-based adjusters for groups such as frail, functionally impaired beneficiaries.

The Commission recognizes, however, that the Secretary's ability to have payments follow enrollees regardless of plan type is constrained by data availability. Modified risk adjusters may use functional status and health status information not routinely collected by Medicare+Choice plans. Because specialized plans collect functional status information for purposes such as case management and determining nursing home certifiability, they might be able to implement risk adjustment methods using such data before Medicare+Choice plans are able to do so. This activity could combine with a voluntary, phased-in collection of functional status information and its use in payment in Medicare+Choice generally.

Evidence on cost effectiveness and risk selection in specialized plans

Ample evidence suggests that the presence of disabilities is associated with higher costs of care among beneficiaries in the traditional Medicare program (Komisar et al. 1997/1998, Gruenberg et al. 1996, MedPAC 1998). Data from the Medicare Current Beneficiary Survey (MCBS) indicate that beneficiaries in the traditional program who resemble PACE, S/HMO, and EverCare enrollees have higher spending than others (Gruenberg et al. 1999).[4] An independent effort to identify a PACE-like population using MCBS and National Long Term Care Survey data found evidence that the care of nursing home-certifiable, frail beneficiaries might cost about twice as much as the care of average Medicare beneficiaries (Center for Health Systems Research and Analysis 1998).

It is difficult to compare directly the costs of care for beneficiaries in specialized plans, Medicare+Choice plans, and traditional Medicare, because reliable and comparable cost data for all three sites of care are not available. Most studies that attempt to make comparisons identify beneficiaries in the traditional Medicare program with characteristics similar to those of enrollees in specialized plans. They then compare Medicare spending for these individuals with spending for other beneficiaries in the traditional program. One study, however, using actual S/HMO and risk plan expenditure data for 1989–1990, found that spending on all services was 20 percent to 22 percent higher for S/HMO members than risk HMO members, and spending on services covered by both plans was 18 percent to 19 percent higher. These results control for demographic, income, and other factors, indicating that S/HMOs do not succeed in substituting services not covered by Medicare for covered services within a given budget (Dowd et al. 1998).

In the traditional program, Medicare spends more on care for institutionalized beneficiaries than for those not institutionalized. Analysis of MCBS and state data indicates that care for long-term nursing home residents is relatively inexpensive, compared with care for new entrants (Gruenberg et al. 1999), and HCFA analysts note variation in spending levels among post-acute and various long-term care facilities (HCFA 1999a). These findings suggest the average cost of care for EverCare enrollees will depend on the mix of long-term residents and new entrants.

Though PACE, S/HMO, and EverCare plans enroll a high proportion of frail Medicare beneficiaries who are undoubtedly much more expensive than the average beneficiary, these plans might attract a somewhat different profile of frail beneficiaries than in the traditional program. Features of these programs may influence the mix of frail beneficiaries who join. The requirement to use plan providers, for example, may be unattractive to beneficiaries who have strong ties to out-of-network doctors and who may prove to be the sickest patients. A program such as PACE, with a strong Medicaid component, may be unattractive to wealthier beneficiaries.

There is evidence of a different enrollee mix in the PACE and S/HMO demonstrations. The PACE evaluation compared PACE enrollees to those who applied and were found eligible but who then declined to enroll in PACE ("decliners"). One study found significant differences between these groups: decliners were more likely to be in their last three months of life or in the top quartile of prior

4 Cost of care of traditional Medicare beneficiaries provides information on what Medicare would pay if enrollees in specialized plans were enrolled instead in traditional Medicare. It indicates the volume of resources required to treat beneficiaries' health problems. Because specialized plans offer different mixes of services and may operate with different levels of efficiency, cost in the traditional program will not be a measure of the costs to Medicare or costs in total when beneficiaries are enrolled in such plans.

Medicare payments (Irvin et al. 1997). These differences indicate that PACE enrollees are less likely to use services than PACE decliners. Other analysts report that characteristics of PACE enrollees (for example, the relatively favorable experience of enrollees living alone) differ from those of other elderly populations and suggest the possibility of favorable selection. The analysts conclude that it may be inappropriate to generalize results from one population to the other (Mukamel et al. 1998).

Another study for the evaluation that attempted to control for the substantial differences between enrollees and decliners found that capitation payments from Medicare for PACE enrollees were lower than traditional program spending on PACE decliners (White 1998). The author concluded that this finding reflected effective substitution of medical, social, and supportive services for more costly hospital inpatient and nursing home care rather than unmeasured differences between enrollees and decliners. However, the design of this study does not permit understanding of how PACE enrollees compare to the more general population of frail beneficiaries in the traditional program.

Studies by S/HMO evaluation researchers produced inconsistent findings, with early results indicating no favorable selection by S/HMO plans and later work, using different methods, finding evidence of favorable selection. The final evaluation report of the S/HMO demonstration concluded that the S/HMO I projects experienced favorable selection because enrollees who were healthier than the average enrolled in these plans while sicker patients disenrolled (HCFA 1996a). (The S/HMO demonstration was structured to limit the enrollment of functionally impaired people to avoid adverse selection against the plans.) In one study, three of four plans enrolled a population healthier than a comparison group of traditional Medicare beneficiaries. Voluntary disenrollment resulted in favorable selection compared to traditional Medicare (Manton et al. 1994).

Current payment methods for specialized plans

Medicare makes capitation payments to specialized plans supplemented by Medicaid funds for dual eligibles and by private premiums for those without Medicaid coverage. For beneficiaries enrolled in the PACE program, plans receive the Medicare+Choice base payment rates for the counties where enrollees reside multiplied by a frailty adjuster of 2.39. Medicaid policies vary by state (see Appendix B).

Before the BBA changed base payment rates, S/HMOs received a fixed capitation payment equal to the adjusted average per capita costs for the county where enrolled beneficiaries reside (compared with the 95 percent of this amount allowed for risk plans). HCFA recalculated these amounts to reflect changes to the base payment rate under the BBA. The agency also modified the risk adjusters to the base payment. Initially, HCFA paid the rate for institutionalized enrollees for all nursing-home certifiable enrollees, regardless of whether enrollees were in institutions. Later, the program changed the adjustment to a cost factor for nursing-home certifiable enrollees by analyzing data from the National Long Term Care Survey. Rates for nonnursing home certifiable S/HMO enrollees were lowered to reflect their comparatively better health.

EverCare demonstration sites originally were paid 100 percent of the AAPCC. This share was reduced to 95 percent in the second year and then to 93 percent. These amounts now reflect changes to the base payment rate under the BBA. Because EverCare enrollees are all nursing home residents, payment rates incorporate the adjuster that increases Medicare+Choice payments for institutionalized beneficiaries. This adjuster, which varies by age and sex, will be phased out for Medicare+Choice plans between 2000 and 2003. ■

Program standards

As with payment methods, Medicare should carefully consider the rationale for varying standards among programs, particularly given that considerable overlap exists among the types of beneficiaries in different plans and the organizations that sponsor those plans. On the one hand, standards designed to protect beneficiaries probably should apply consistently across programs. On the other hand, Medicare determines what makes these programs different from one another—and from the Medicare+Choice and traditional programs—through statutory and regulatory standards and the degree of flexibility specialized programs have to pursue innovations. This section describes standards for programs for frail Medicare beneficiaries and considers where standards should differ from those for Medicare+Choice.

Educating beneficiaries about their choice of plans

The BBA and earlier initiatives started by the Secretary have led to a new framework for Medicare+Choice that is intended both to move the program toward acting as a prudent purchaser and to support beneficiary choice (see Chapter 4). Medicare now takes an active role as a distributor of comparative information about health plans—including benefits, premiums, and performance measures—through numerous mechanisms prescribed by the Congress. Ideally, requiring plans to report information on performance and then providing that information to

beneficiaries will encourage them to choose the plans that best meet their preferences. Then, plans will have an incentive to compete to provide better benefits and service and higher-quality care. Medicare also can use the information about plan performance in its oversight.

Since 1997, HCFA has required plans to report Health Plan Employer Data and Information Set (HEDIS) measures, including the HOS. Although none of the process measures in HEDIS focuses specifically on frail Medicare beneficiaries, some may be relevant to the health problems of these beneficiaries. The HOS elicits enrollees' perceptions of their health status and asks about their functional limitations, and it is intended to measure changes in health and functional status over time. HCFA also requires plans to arrange a survey of their enrollees' satisfaction and report the results to HCFA.

Several HEDIS and enrollee satisfaction measures thought to be most relevant to consumers are now available on the Internet through the "Medicare Compare" database (see Table 5-7). They also are published in the *Medicare & You* handbook and are printed separately on request from a toll-free telephone line. Problems with the information collected should improve somewhat with the auditing requirement for future measures. The audits will check the accuracy of data to the origin of collection, although problems with completeness and accuracy will persist despite auditing, particularly given the reliance on paper records.

It might seem attractive to fold S/HMO, PACE, and EverCare directly into the Medicare+Choice information campaign so that beneficiaries could compare benefits and plan performance. This approach might make sense for the S/HMOs, particularly because they draw enrollees from the general population and one of the primary differences between Medicare+Choice and the S/HMOs is the benefit package.

Including PACE and EverCare in the Medicare+Choice materials could lead to problems, however, because these programs do not draw from the general population. Because PACE and EverCare enrollees must meet state nursing home eligibility criteria, including these programs in the Medicare+Choice materials might lead to an unwieldy number of inquiries from beneficiaries ineligible for the programs. A disproportionate share of beneficiaries choosing such plans as PACE and EverCare also are cognitively impaired and unlikely themselves to use the complex information comparing plans.

When family members make decisions on behalf of beneficiaries, they likely will be most interested in distinctive features and capabilities of programs that offer coverage of long-term care or enhanced primary care in long-term care settings. Though comparative information about benefits and cost sharing would be useful for choosing among programs (and among plans if more than one was available), the performance measures developed for the general Medicare population probably are less relevant to the intensive needs of frail beneficiaries. Measures also are unlikely to provide sound information for comparing the programs, because the case mix of beneficiaries enrolled in PACE and EverCare is very different from that of the general population and because the number of enrollees at a given plan is low. One approach that merits study is to report satisfaction and other indicators for the subgroup of enrollees who have functional disabilities and to report these indicators consistently across all plans.

Performance measures for programs serving frail Medicare beneficiaries

Though current measures of plan performance may not be as useful in supporting consumer choice, because many potential enrollees are unlikely to

TABLE 5-7

Selected performance measures available on Medicare Compare for Medicare+Choice and Social Health Maintenance Organization plans, 1999

Measure	Average for California plans	SCAN S/HMO	Average for Nevada plans	Health Plan of Nevada S/HMO	Average for New York plans	Elderplan S/HMO
Women who received a mammogram in last two years[a]	72%	39%	62%	60%	75%	46%
Plan members seen by a provider in the past year[a]	77	72	90	94	90	91
Providers who stayed in the plan at least a year[a]	90	73	81	81	93	100
Members rating their plan as the best possible managed care plan	45	45	NA	NA	49	53
Members' satisfaction with ease of getting referrals	86	85	NA	NA	95	96

Note: Separate scores for Kaiser Permanente Northwest's S/HMO were not in the database. S/HMO (Social Health Maintenance Organization). [a]Based on unaudited data. NA (not available).

Source: Medicare Compare at http://www.medicare.gov, March 31,1999.

understand the measures or find them relevant, performance measurement can serve other purposes. Medicare and other purchasers that might pay these plans' premiums could use these measures to evaluate the plans—comparing them to one another and over time. Measures of quality, access, and cost also could support plans' internal quality improvement programs and be shared with providers to help them improve their performance.

Because the purpose of specialized programs for frail Medicare beneficiaries also has been to test innovations such as providing enriched benefit packages, coordinating care, emphasizing case management, and requiring adult day health care, measures for these programs ideally should reflect these innovations' effects. The Medicare program and Medicare+Choice plans looking for tools to manage the care of their frail enrollees can benefit from information that indicates whether these innovations are cost-effective and provide better care outcomes. Other purchasers with frail enrollees, such as Medicaid programs, also should find this information valuable.

Performance measures for programs for frail Medicare beneficiaries should be relevant, scientific, and operationally feasible. Developing measures for comparing plan performance across type—Medicare+Choice, PACE, EverCare, and S/HMO—might be useful but only if they were relevant to frail Medicare beneficiaries. Other considerations suggest a need for at least some specialized measures for these programs. These considerations include the cost of producing HEDIS measures, compared with their relevance for frail populations and how to compare plan performance when the case mix of enrollees is very different.

HCFA's current requirements

HCFA's requirements for performance measurement and reporting vary by program (see Table 5-8). The S/HMOs are treated like Medicare+Choice plans; they must report HEDIS, HOS, and satisfaction measures, and they are presented on Medicare Compare.

Both PACE and EverCare must report HOS data. HCFA likely will use these data to study the feasibility of developing a health outcome measure and a special risk-adjustment method for frail Medicare beneficiaries, although researchers have technical concerns about using HOS and other self-reported information on health status from frail populations. One concern is whether reports of health status from enrollees who are cognitively impaired are as reliable as reports from the populations for which the data collection instrument was developed. Another concern is whether proxies can help fill out survey information on behalf of beneficiaries unable to do so.

PACE plans are not required to report HEDIS or consumer satisfaction measures. On a separate track that predates PACE as a permanent program, HCFA is developing an outcome-based,

TABLE 5-8

Reporting requirements for Medicare+Choice and programs for frail beneficiaries, 1999

Requirement	Medicare+Choice	PACE	S/HMO	EverCare
HEDIS and HEDIS audit	✔		✔	Must provide data, but not audited
Health outcomes survey	✔	✔	✔	✔
Consumer satisfaction survey	✔		✔	
OASIS for home health users (home health agency responsibility)	✔	✔	✔	NA
Minimum data set for nursing home users (nursing home responsibility)	✔	✔	✔	✔
Adjusted community rate proposal	✔		modified for two S/HMOs	✔
Hospital encounter data for risk adjustment	✔	✔	✔	✔
Physician incentive arrangements	✔		✔	✔

Note: PACE (Program of All-Inclusive Care for the Elderly), S/HMO (Social Health Maintenance Organization), HEDIS (Health Plan Employer Data and Information Set), OASIS (Outcome and Assessment Information Set). NA (not available).

continuous quality improvement program for PACE. One component of this research is developing outcome measures that cover:

- changes in health and functional status,
- physiology,
- emotion or behavior,
- use of services,
- sentinel events,
- satisfaction with the program, and
- social services provided by PACE (HCFA 1996b).

HCFA's contractor recently convened a series of clinical panels to review an extensive list of possible measures. The next steps will be to specify the data items needed to calculate the measures and test their feasibility (Center for Health Services and Policy Research 1998).

In addition to HOS data, EverCare plans must report unaudited HEDIS measures, but the plans are not required to survey their enrollees' satisfaction using the standard satisfaction instrument and process. Because EverCare is a relatively new program, the evaluation has not yet been completed. That evaluation will look at a wide variety of performance measures to:

- compare enrollees to nonenrollees,
- describe EverCare implementation and operation,
- measure changes in care processes and quality,
- gauge the effect of the program on providers,
- measure the effect of the program on enrollees' health and health care use,
- assess the satisfaction of enrollees and their families, and
- identify the effect of the program on costs and payers for care (Kane 1998).

Specific outcome measures for EverCare will include beneficiary morbidity and mortality, avoidable deaths, preventable hospitalizations, preventable illnesses, emergency room visits, and nursing home complications. The evaluation also will look at delays in the use of services and access to services, including the amount and timing of primary care. These measures will be drawn from a variety of sources, including the minimum data set (standardized information held by the nursing home), surveys, chart review, and EverCare and Medicare data (Kane 1998).

Patterns of care and diagnoses for frail populations

Examining patterns of care and diagnoses for frail populations is a useful first step toward considering performance measures for plans that specialize in caring for these populations. The overall pattern of spending for care likely will identify the types of services that frail beneficiaries use most and potential opportunities for more cost-effective care management. The diagnoses assigned during care may provide a first glimpse at how the health care problems of these populations might differ from each other and from Medicare beneficiaries generally.

MedPAC compared the profiles of Medicare service use for two groups of Medicare beneficiaries to the profile for average beneficiaries in the traditional program in 1995. The first group, community residents with serious functional limitations, probably resembles the population that would be eligible to enroll in PACE and considered eligible for community long-term care benefits in S/HMOs. These beneficiaries are age 55 or older, and all have significant functional disabilities.[5] The second group, residents of nursing homes, is a relevant population for considering performance measures for EverCare.

Medicare program spending Frail community residents had much higher Medicare spending than that for the average beneficiary, with average total payments of $13,300, more than triple the amount for the average beneficiary in the traditional program (see Table 5-9). Although payments for each type of Medicare service were higher for frail community residents, the largest differences were in inpatient hospital and home health care use. Nursing home residents' total Medicare payments were more than double the payments for average beneficiaries. Nursing home residents' spending for inpatient hospital and skilled nursing facility care also was much higher than the average.

Use of Medicare services In general, frail Medicare beneficiaries who live in the community and in nursing homes are much more likely than the average beneficiary in the traditional Medicare program to use services, particularly post-acute care; and frail beneficiaries who use services also tend to use more of them than the average beneficiary in traditional Medicare who uses services. Greater use of post-acute services suggests that the post-acute care sector may be a good place to focus work to develop quality measures.

Frail beneficiaries in the community were more likely than the average beneficiary in traditional Medicare to use all Medicare services (see Table 5-10). For example, approximately 53 percent of frail beneficiaries in the community used durable medical equipment, compared with only 18 percent of beneficiaries in the traditional Medicare program. Half of the frail beneficiaries in the community used home health care, compared to 10 percent of the beneficiaries in the traditional program. For most services, Medicare spending also was higher when a frail community resident used a given service than when an average beneficiary in the traditional program used the same service.

5 They require either hands-on assistance with three out of five ADLs or hands-on assistance with one ADL and four out of five instrumental ADLs. This definition is similar to the one used in Gruenberg 1999.

TABLE 5-9

Distribution of spending by beneficiary frailty and residence, 1995

Type of service	Average Medicare payment per group member: Beneficiaries in traditional Medicare	Share of total Medicare spending	Frail beneficiaries in community	Share of total Medicare spending	Frail beneficiaries in nursing homes	Share of total Medicare spending
PPS hospital	$1,720	41%	$5,035	38%	$3,324	37%
Physician	1,092	26	1,879	14	1,793	20
Home health agency	472	11	3,658	27	380	4
Outpatient hospital	377	9	572	4	1,152	13
Skilled nursing facility	201	5	818	6	1,375	15
Durable medical equipment	137	3	471	4	464	5
Rehabilitation facility	110	3	515	4	47	1
Other hospital facility	87	2	236	2	403	4
Hospice	19	0	162	1	163	2
Totals	$4,215		$13,346		$9,101	

Note: Analysis is for Medicare beneficiaries in traditional Medicare, with both Part A and Part B coverage, eligible because of age or disability. Frail beneficiaries in community are age 55 or older and require hands-on assistance with three out of five ADLs or one ADL and four out of five IADLs. PPS (Prospective Payment System). Percentages may not sum because of rounding.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use File, 1995.

Nursing home residents were less likely than the average Medicare beneficiary in the traditional program to use home health or rehabilitation facility services, but they were more likely to use most other Medicare services. Compared with both average Medicare beneficiaries and frail community residents, beneficiaries living in nursing homes were more likely to use skilled nursing facility care and had longer lengths of stay.[6] This situation probably reflects both care just before becoming a permanent nursing home resident and care following a hospital stay after a beneficiary had become a nursing home resident.

Differences in hospital diagnoses

Nursing home residents tend to have different common diagnoses than frail beneficiaries living in the community and all beneficiaries in the traditional program (see Table 5-11). For beneficiaries living in nursing homes, at least five of the 10 most commonly assigned diagnoses are not among the most common diagnoses for either frail community residents or beneficiaries in traditional Medicare. Diagnoses such as respiratory infections, kidney and urinary tract infections, nutritional and metabolic disorders, and gastrointestinal hemorrhage among nursing home residents suggest the need for quality measures that reflect the different health care problems of this population.

RECOMMENDATION 5E

Performance measures for programs for frail Medicare beneficiaries should reflect the beneficiaries' health care needs and special practices for their care.

Ideally, innovations and best practices will come from specialized programs and from Medicare+Choice plans. As Medicare has used demonstrations to test new ideas for wider adoption, performance measures developed for these programs also should be tested and used in the mainstream Medicare programs. These performance measures then will provide an indication of how well all plans meet the needs of frail enrollees. The decision about which particular measures to apply in Medicare+Choice should be driven by the percentage of enrollees who might find the measures relevant, the improvement an adjuster might make, and the cost of implementation.

RECOMMENDATION 5F

The Secretary should include special measures for evaluating and monitoring care for frail Medicare beneficiaries in the Medicare+Choice plan quality measurement and reporting requirements.

Data collection burden

As HCFA moves forward on performance measurement for these programs, it will

6 Length of stay includes days paid for by Medicare as well as noncovered days.

TABLE 5-10 **Distribution of Medicare service use, 1995**

Type of service	Beneficiaries in traditional Medicare	Frail beneficiaries in community	Frail beneficiaries in nursing homes
Durable medical equipment			
Beneficiaries using	18.0%	53.0%	33.1%
Payment per user	$760	$889	$1,401
Home health agency			
Beneficiaries using	9.5%	50.0%	8.9%
Visits per user	81.7	123.6	65.0
Payment per user	$4,950	$7,314	$4,250
Rehabilitation facility			
Beneficiaries using	0.9%	5.0%	0.5%
Length of stay per user (days)	19	17	18
Payment per user	$12,169	$10,220	$10,251
PPS hospital			
Beneficiaries using	18.4%	43.1%	33.8%
Length of stay per user (days)	10	14	15
Payment per user	$9,328	$11,671	$9,843
Outpatient hospital			
Beneficiaries using	62.5%	72.3%	85.3%
Payment per user	$603	$791	$1,350
Physician			
Beneficiaries using	92.8%	97.1%	99.5%
Visits per user	10.3	18.0	18.4
Payment per user	$1,177	$1,935	$1,802
Skilled nursing facility			
Beneficiaries using	2.9%	9.6%	16.4%
Length of stay per user (days)	40	32	67
Payment per user	$6,924	$8,504	$8,368

Note: Analysis is for Medicare beneficiaries in traditional Medicare with both Part A and Part B coverage, eligible because of age or disability. Frail beneficiaries in community are age 55 or older and require hands-on assistance with three out of five ADLs or one ADL and four out of five IADLs. PPS (Prospective Payment System).

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use File, 1995.

need to take stock of the multiple assessments that already occur. PACE plans, for example, conduct regular patient assessments as part of their care-management approach and collect centralized data as part of the demonstration agreement with HCFA. Many PACE enrollees use home health care, and those who do will be assessed as part of the Outcome and Assessment Information Set for Medicare-certified home health agencies. PACE enrollees using nursing home care must be assessed as part of Medicare's nursing home standards.

Multiple assessments also occur in the other programs, and the Commission recommends that Medicare's quality assurance and improvement systems work together toward a defined, prioritized set of goals for improving beneficiaries' care (see Chapter 2). Data collection burdens and the lack of coordination across care settings are magnified when patients are frail, use many post-acute providers, and are enrolled in managed care programs responsible for conducting their own quality assurance activities.

Coverage of non-Medicare benefits

HCFA has required PACE and S/HMO plans under their demonstration agreements to provide non-Medicare services. Both PACE and S/HMO demonstration programs required participating plans to cover certain benefits—notably outpatient drugs, community-based long-term care benefits, and case management—not covered under the traditional Medicare program. A critical issue facing the Secretary is whether to continue requiring these plans to cover these benefits even when Medicare's capitation amounts are based on benefits in the traditional program only.

Rules under Medicare+Choice

In the Medicare+Choice program, no plan is required to cover benefits not covered by traditional Medicare, and there is no provision for higher Medicare payments if they do. Coordinated care plans (managed care plans) must provide lower cost sharing or enhanced benefit packages (of their own design) if Medicare's payments are expected to exceed plan costs for providing the Medicare benefit package. As Medicare managed care has become competitive, enhanced benefit packages have become common, but continued enhanced packages are not guaranteed if plans' costs rise faster than their revenues.

Any plan will want to provide non-Medicare benefits to either a general or targeted population to the extent that doing so proves to be more cost-effective than staying within the traditional Medicare package. If benefits are not

TABLE 5-11

Most common diagnosis related groups assigned to PPS hospital stays by beneficiary frailty and residence, 1995

Beneficiary group DRG ranking	DRG Code	DRG	Number of beneficiaries	Share of all DRGs for beneficary group (as percentages)
Beneficiaries in traditional Medicare				
1	127	Heart failure and shock	336,749	7%
2	089	Simple pneumonia and pleurisy with CCs	352,452	7
3	209	Major joint and limb reattachment procedures	264,257	5
4	182	Esophagitis, gastroenteritis and miscellaneous digestive disorders with CCs	224,928	5
5	014	Specific cerebrovascular disorders except TIA	209,942	4
6	138	Cardiac arrhythmia and conduction disorders with CCs	181,167	4
7	088	COPD	181,023	4
8	112	Percutaneous cardiovascular procedures	157,888	3
9	140	Angina pectoris	147,823	3
10	132	Atherosclerosis with CCs	139,563	3
		Total		45%
Frail beneficiaries, 55 years and older, in community				
1	127	Heart failure and shock	38,328	20%
2	089	Simple pneumonia and pleurisy with CCs	23,668	12
3	416	Septicemia	15,032	8
4	014	Specific cerebrovascular disorders except TIA	12,397	6
5	015	TIA and precerebral occlusions	11,782	6
6	415	OR procedure for infectious and parasitic diseases	10,475	5
7	148	Major small and large bowel procedures with CCs	8,244	4
8	210	Hip and femur procedures with CCs	7,612	4
9	209	Major joint and limb reattachment procedures	7,611	4
10	113	Amputation for circulatory system disorders	6,964	4
		Total		73%

continued

cost-effective but are otherwise valuable to Medicare beneficiaries, they should be willing to pay for them through premiums. However, the problem with long-term care benefits is that Medicare beneficiaries tend not to recognize that these benefits are not in the standard Medicare package or to appreciate their likelihood of needing to use the benefits.

Comprehensive benefits define special programs

Because comprehensive benefit packages have in part defined PACE and S/HMO, taking out the requirement that plans offer expanded coverage and leaving the benefit package design to the plans might lead to fewer meaningful differences between PACE, S/HMO, and Medicare+Choice plans. These additional benefits do raise an issue of fairness, however, because they are available to some beneficiaries but not others. The additional benefits may also provide an advantage to those plans that are allowed to offer them.

Case management

A related issue is the extent to which PACE and S/HMO plans must be required to operate case management programs that meet specific criteria. Requiring plans to provide case management may be unnecessary. As with enhanced benefit packages, to the extent that case management leads to more efficient use of Medicare services, plans will have incentives to furnish targeted case-management services. To the extent that case management leads to better outcomes, measuring those outcomes regularly may provide an additional incentive for plans to furnish case management. Furthermore, a requirement to provide case management may not be fair because the Medicare capitation does not include spending for

TABLE 5-11

Most common diagnosis related groups assigned to PPS hospital stays, by beneficiary frailty and residence, 1995 (continued)

Beneficiary Group DRG/Ranking	DRG Code	DRG	Number of beneficiaries	Share of all DRGs for beneficary group (as percentages)
Frail beneficiaries living in nursing homes				
1	089	Simple pneumonia and pleurisy with CCs	65,920	15%
2	127	Heart failure and shock	39,423	9
3	079	Respiratory infections and inflammations with CCs	34,455	8
4	320	Kidney and urinary tract infections with CCs	31,433	7
5	210	Hip and femur procedures with CCs	27,165	6
6	296	Nutritional and miscellaneous metabolic disorders with CCs	26,758	6
7	429	Organic disturbances and mental retardation	25,769	6
8	014	Specific cerebrovascular disorders except TIA	24,623	6
9	209	Major joint and limb reattachment procedures	24,167	5
10	174	Gastrointestinal hemorrhage with CCs	22,231	5
		Total		73%

Note: Analysis is for Medicare beneficiaries in traditional Medicare, with both Part A and Part B coverage, eligible because of age or disability. Frail beneficiaries in community are age 55 or more and require hands-on assistance with three out of five ADLs or one ADL and four out of five IADLs.
(PPS) Prospective Payment System. (CC) Complications and/or comorbidities. (COPD) Chronic obstructive pulmonary disease. (TIA) transient ischemic attack. (OR) operating room.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file.

this service. However, case management is a key feature defining these specialized programs, and is likely to be adopted by mainstream Medicare+Choice plans if disability is included in capitation payments, and plans begin to develop protocols for caring for frail beneficiaries.

Complications for dually eligible beneficiaries

The picture is complicated when specialized programs cover benefits also covered by Medicaid. PACE plans provide all Medicaid-covered services and receive capitation payments for them (either from Medicaid programs for Medicaid-eligible enrollees or as private premiums from those without Medicaid). S/HMO plans cover some benefits that Medicaid would cover (long-term nursing home care is a major exception), but relatively few S/HMO enrollees qualify for Medicaid. If Medicare required PACE and S/HMO plans to cover community-based long-term care and outpatient drugs but did not provide additional payments for those benefits, plans would need to choose between charging beneficiaries premiums for this coverage or funding the coverage out of savings from efficiencies. If plans decided to charge a premium, a Medicaid program would pay it for dually eligible enrollees, but only to the extent that the premium represented the cost of Medicaid-covered benefits.[7] Alternatively, if Medicare decided to pay PACE and S/HMO plans more to help cover non-Medicare benefits, Medicaid programs no longer would need to pay for these benefits for enrollees joining the plans.

Eligibility criteria

PACE, S/HMO, and EverCare all use state definitions of nursing home eligibility to define which beneficiaries may enroll in the programs (PACE and EverCare) and which beneficiaries have access to enhanced benefits (S/HMO). State Medicaid programs use these definitions to determine whether enrollees need nursing home care.[8] Nursing home eligibility criteria vary by state and can have a significant impact on the percentage of Medicare beneficiaries who qualify. A recent study found, for example, that among nine states, the percentage of Medicare beneficiaries eligible for nursing home placement varied from 8.4 percent to 20.7 percent of the population (Center for Health Systems Research and Analysis 1998).

Varying criteria across states may not be a problem when programs for frail Medicare beneficiaries are small or demonstrations. In the short term, having Medicare follow Medicaid policies is simpler than developing a uniform national standard. And for PACE, which

7 For example, Medicaid programs generally provide community long-term care services and case management at their option and under waiver authority to targeted populations.

8 The criteria do not include the financial assessments for general Medicaid eligibility.

serves a high share of dually eligible enrollees, plans can apply a uniform standard for assessing Medicare and Medicaid eligibility for PACE benefits. But as PACE and S/HMO become permanent options and are available more broadly, it may be appropriate for Medicare to define national eligibility criteria. Although PACE remains a relatively small program, drawing many fewer enrollees than are eligible, this is probably a long-term issue to monitor.

Enrollment and disenrollment rules

To establish the rules under which PACE (as a permanent program) and S/HMO (as a Medicare+Choice option) will operate, the Secretary should consider whether to limit enrollment and disenrollment to mirror the Medicare+Choice program. Starting in 2002, enrollment in Medicare+Choice will be primarily annual. Medicare beneficiaries generally will choose between the traditional program and Medicare+Choice plans and among different Medicare+Choice plans in November, with their enrollment effective January 1 of the following year. One switch will be permitted early in the year, after which beneficiaries will be able to change their enrollment only for cause or during the next open enrollment period in November.

Under the PACE, S/HMO, and EverCare demonstrations, beneficiaries have been allowed to enroll in and disenroll from programs for frail Medicare beneficiaries on a monthly basis.[9] Under the permanent PACE program for Medicare, the Congress mandated that PACE enrollees be permitted to disenroll from plans without cause in any month.

The Secretary probably will not wish to limit beneficiary opportunities to enroll in PACE to once per year. First, the Congress required the program to allow voluntary disenrollment at any time, so continuous PACE enrollment would be parallel. Second, beneficiaries with health or social support crises who consider PACE an alternative to nursing home care probably will not be able to wait for an annual enrollment period. Third, mortality for the PACE population is relatively high, so program census could drop significantly over the year because of mortality alone (see Table 5-4). Because PACE uses a relatively large proportion of dedicated, salaried staff, declines in census not made up for by new enrollees would place great financial stress on PACE plans.

RECOMMENDATION 5G

The Secretary should not now limit enrollment into the Program of All-Inclusive Care for the Elderly to a particular time of the year.

The Secretary's decisions about enrollment and disenrollment policies for S/HMOs will hinge on whether the S/HMO program is extended as a demonstration or folded into the Medicare+Choice program.

The question of comparable standards on this issue for EverCare can be deferred because EverCare's demonstration period is set to end before the limits on Medicare+Choice enrollment and disenrollment will go into effect. However, as with PACE enrollees, EverCare enrollees have a very high mortality rate, and patient census in the program would decline significantly over a year if EverCare plans were not permitted to hold monthly open enrollment.

Plan participation criteria: nonprofit requirement for the Program of All-Inclusive Care for the Elderly

The BBA made PACE a permanent program for Medicare in 1997. Under the law, the Congress placed a cap on the number of new PACE plans permitted to enter the program each year—starting with 20 in the first year and cumulating by 20 each subsequent year. Plans may not overlap service areas, so no competition among PACE plans is possible. Seven new plans signed agreements with Medicare and Medicaid in 1998, a much lower number than permitted. This may have happened because HCFA has been slow to issue regulations for PACE, so potential entrants are uncertain of HCFA's requirements. PACE also has been slow to start up because it is relatively capital intensive: an adult day health center must be built as the cornerstone of the program.

By statute, only nonprofit charitable institutions are allowed to participate as PACE plans. This requirement came in response to concerns from PACE plans that for-profit plans might provide fewer services because of pressure to pay stockholders and taxes. MedPAC is required to comment on whether it is appropriate to have for-profit entities in PACE. At the same time the BBA made PACE a permanent program, it required the Secretary to implement a demonstration of for-profit providers wishing to participate in PACE. This demonstration will not start until the PACE regulations take effect, and it will be at least several years before an evaluation of this demonstration is complete.

The Commission is predisposed toward basing participation on standards and performance, not tax status, to qualify entities as PACE plans. The requirement that PACE plans must be nonprofit organizations is inconsistent with Medicare's other program participation standards. Other standards, such as performance measures and program oversight provisions, are likely to be better tools for gauging plan performance than a blanket exclusion of for-profit entities from a program.

RECOMMENDATION 5H

The Commission will await results from the Secretary's demonstration of for-profit entities in the Program of All-Inclusive Care for the Elderly before making a recommendation on allowing them to participate.

9 Kaiser Permanente's S/HMO limits new enrollment to one month per year.

References

Branch LG, Coulam RF, Zimmerman Y. The PACE evaluation: initial findings, The Gerontologist. June 1995, Vol. 35, No. 3, p. 349–359.

Brown RS, Bergeron J, Shin R. Final second annual report on the TEFRA HMO and CMP program evaluation. Report to the Health Care Financing Administration under contract no. 500-88-0006. Princeton (NJ), Mathematica Policy Research. April 1991.

Burstein NR, White AJ, Kidder D. Evaluation of the Program of All-Inclusive Care for the Elderly (PACE) demonstration: the impact of PACE on outcomes. Report to the Health Care Financing Administration under contract No. 500-91-0027. Cambridge (MA), Abt Associates. November 1996.

Center for Health Services and Policy Research, University of Colorado Health Sciences Center. Review of initial draft outcome indicators by two clinical panels, PACE OBCQI: outcome-based continuous quality improvement newsletter. November 1998, Vol. 2, No. 2, p.1.

Center for Health Systems Research and Analysis, University of Wisconsin. PACE rate work: final report. Report to the Health Care Financing Administration under contract No. 500-96-0010. Madison (WI), Research Triangle Institute and Center for Health Systems Research and Analysis. December 1998.

Dowd B, Hillson S, VonSternberg T, Fischer LR. S/HMO versus TEFRA HMO enrollees: analysis of expenditures. Unpublished paper, University of Minnesota, written 1998.

Gruenberg L, Kaganova E, Hornbrook MC. Improving the AAPCC with health-status measures from the MCBS, Health Care Financing Review. Spring 1996, Vol. 17, No. 3, p. 59–75.

Gruenberg L, Silva A, Corazzini KN, Malone JK. An examination of the impact of the proposed new Medicare capitation methods on programs for the frail elderly. Unpublished paper, Long Term Care Data Institute, written January 1999.

Harrington C, Lynch M, Newcomer RJ. Medical services in Social Health Maintenance Organizations, The Gerontologist. December 1993, Vol. 33, No. 6, p. 790–800.

Health Care Financing Administration, Department of Health and Human Services. Report to the Congress: status report on the implementation and evaluation of the Social Health Maintenance Organization demonstration. Washington (DC), HCFA. 1996a.

Health Care Financing Administration, Department of Health and Human Services. Scope of work for task order No. 2 to contract No. 500-96-0004, developing an outcome-based quality assurance and performance improvement system for the Program of All-Inclusive Care for the Elderly. 1996b.

Health Care Financing Administration, Department of Health and Human Services. Report to the Congress: proposed method of incorporating health status risk adjusters into Medicare+Choice payments. Baltimore (MD), HCFA. March 1999a.

Health Care Financing Administration, Department of Health and Human Services. 1999 Medicare compare. February 11, 1999, available at http://www.medicare.gov. 1999b.

Irvin CV, Massey S, Dorsey T. Determinants of enrollment among applicants to PACE, Health Care Financing Review. Winter 1997, Vol. 19, No. 2, p. 135–153.

Kane RL, Huck S. The implementation of the EverCare demonstration project. Paper for the Health Care Financing Administration under contract No. 500-96-0008, task order No. 2. October 1998a.

Kane RL. Proposal to evaluate the EverCare demonstration. 1998.

Komisar HL, Hunt-McCool J, Feder J. Medicare spending for elderly beneficiaries who need long-term care, Inquiry. Winter 1997/1998, Vol. 34, No. 4, p. 302–310.

Manton KG, Tolley HD, Newcomer R, et al. Disenrollment patterns of elderly in managed care and fee for service, Journal of Actuarial Practice. 1994, Vol. 2, No. 2, p. 171–196.

Medicare Payment Advisory Commission. Report to the Congress: context for a changing Medicare program. Washington (DC), MedPAC. June 1998.

Mukamel DB, Temkin-Greener H, Clark ML. Stability of disability among PACE enrollees: financial and programmatic implications, Health Care Financing Review. Spring 1998, Vol. 19, No. 3, p. 83–100.

Neu CR, Harrison SC. Posthospital care before and after the Medicare prospective payment system. Santa Monica (CA), RAND/UCLA Center for Health Care Financing Policy Research. March 1988.

Newcomer R, Harrington C, Preston S. Satisfaction in the social/health maintenance organization: a comparison of members, disenrollees, and those in fee-for-service. In Luft H (ed.), HMOs and the elderly. Ann Arbor (MI), Health Administration Press, 1994, p. 111-139.

Pacala JT, Boult CB, Hepburn KW, et al. Case management of older adults in health maintenance organizations, Journal of the American Geriatrics Society. May 1995, Vol. 43, p. 538–542.

Pope GC, Liu C-F, Ellis RP, Ash AS, et al. Principal inpatient diagnostic cost group models for Medicare risk adjustment: final report. Waltham (MA). Health Economics Research, Inc., report prepared for the Health Care Financing Administration under contract No. 500-95-048. February 24, 1999.

Pope GC, Adamache KW, Walsh EG, Khandker RK. Evaluating alternative risk adjusters for Medicare. Waltham (MA), Center for Health Economics Research. Report to the Health Care Financing Administration under cooperative agreement No. 17–C–90316/1-02. 1998.

Reuben DB, Schnelle JF, Buchanan JL, et al. Primary care of long-stay nursing home residents: approaches of three health maintenance organizations, Journal of the American Geriatrics Society. February 1999, Vol. 47, p. 131–138.

Ware JE, Sherbourne CD. The MOS 36-item short-form health survey (SF-36), Medical Care. June 1992, Vol. 30, No. 6, p. 473–483.

White AJ. Evaluation of the Program of All-Inclusive Care for the Elderly (PACE) demonstration: the effect of PACE on costs to Medicare: a comparison of Medicare capitation rates to projected costs in the absence of PACE. Cambridge (MA), Abt Associates. Report to the Health Care Financing Administration under contract No. 500-96-0003/TQ4. July 1998.