

For Clinton and Aides, It Was Just Another Day

By BOB DAVIS

Staff Reporter of THE WALL STREET JOURNAL

WASHINGTON—Two hours before the start of his impeachment trial in the Senate on charges of perjury and obstructing justice, President Clinton unveiled a program to help rid America of crime.

"I don't know of anyone who seriously believes we have a country as safe as it ought to be," Mr. Clinton said at an Alexandria, Va., police station, as he proposed spending \$600 million to hire 30,000 to 50,000 police officers.

Throughout the day, the president and his top advisers seemed to pay little attention to the trial, leading to unintended ironies and an atmosphere oddly out of touch with the day's biggest news. Some staffers said they focused on their individual assignments, like soldiers who blot out upcoming battles so they can get through the day. Others said that scandal allegations have gone on so long they are inured to it all.

"It's an historic day," said Maria Echaveste, the president's deputy chief of staff. "But I haven't had staffers say, with long faces, 'Oh, my God, the trial has started.'"

Mr. Clinton's day began with a 9 a.m.

meeting with four senior staffers. Regarding the trial set to begin four hours later, they noted only that Tuesday's State of the Union address was scheduled to start shortly after the president's lawyers finished their first day of presentations. Would the media ignore the address? they fretted.

The rest of the president's day was dominated by State of the Union preparations, budget announcements and Social Security discussions. Meanwhile, the rest of the White House continued on its usual track: National security staffers focused on Iraq, Africa and Kosovo; economic officials focused on Brazil. Few people outside the press quarters admitted to turning on the television to watch the proceedings. And Mr. Clinton spent most of the day in the Oval Office, which doesn't have a TV.

Much of the tension in the White House stemmed from the president's schedule: A planned 6:15 p.m. trip to a Wall Street conference hosted by the Rev. Jesse Jackson was canceled at the last minute because of bad weather. Meanwhile, his economic advisers finalized an urban investment initiative that Mr. Clinton is to unveil today.

Among other things, the initiative calls for \$1 billion in tax credits over five years to investors who buy into equity funds providing capital to businesses in distressed areas, as well as other incentives. "I haven't had a second to follow what's been going on in the other universe," White House economic adviser Gene Sperling said.

The State of the Union preparations seemed to turn the White House into a kind of impeachment-free zone. Mr. Clinton got the latest draft of the speech in the morning and reviewed it around noon, after his crime-program announcement. Then, at around 3 p.m., he gave his comments to senior staffers and then headed into a meeting on the budget and possible Social Security changes.

At least one White House official was publicly focused on impeachment. At a 9:30 a.m. briefing, spokesman Joe Lockhart blasted House prosecutors for considering calling Mr. Clinton to testify. But then he canceled the day's televised briefing, usually scheduled for 1 p.m. That was when the impeachment trial started; the rest of Washington, the White House figured, would be glued to their TV sets.

THE WALL STREET JOURNAL

FRIDAY, JANUARY 15, 1999

Clinton Administration to Phase In Changes in Medicare Payments to HMOs

By LAURIE MCGINLEY

Staff Reporter of THE WALL STREET JOURNAL

WASHINGTON — In a move that will result in billions of dollars in savings for health-maintenance organizations that participate in Medicare, the Clinton administration has decided to phase in—rather than implement all at once—a major payment change scheduled for next year.

The change, to be announced today by Health and Human Services Secretary Donna Shalala, will save the health plans \$1.4 billion next year and \$4.5 billion over five years, according to administration estimates.

Administration officials said they are trying to ensure stability in the Medicare market; last year, more than 40 HMOs pulled out of Medicare, and dozens more reduced their participation. But industry officials said the administration's move

isn't enough to forestall further defections from the federal health plan for the elderly.

At issue is Medicare's effort to adjust payments to HMOs to reflect their enrollees' health status. The goal is to pay health plans with the sickest senior citizens more than those with the healthiest, so that HMOs don't have an economic incentive to try to enroll only the healthiest beneficiaries.

The 1997 balanced-budget law directed the Health Care Financing Administration, which runs Medicare, to begin making risk-adjusted payments to Medicare next year.

Administration officials said that, if they had decided to fully implement the risk adjustments all at once, government payments to health plans would have been reduced \$1.6 billion, or 7%, next year. Phasing in the changes over five years means payments will be reduced by \$200 million, or less than 1%, next year, they said.

The phase-in means that the risk adjustments will reduce government payments to HMOs by \$11.2 billion over the five years, rather than \$15.7 billion, administration officials said.

The industry, which wants the risk-adjustment effort postponed, wasn't mollified. Karen Ignagni, president of the American Association of Health Plans, an industry group, said that even with the phase-in, the risk-adjusted payments would "affect plan payments dramatically in future years, affecting our ability to meet the needs of seniors." She noted that in addition to the reductions, government payments will be cut more than \$22 billion over five years under the 1997 budget law.

HCFA also will announce plans to clarify and ease some new regulations that apply to Medicare HMOs, in response to industry concerns. And it will announce that a national toll-free number for information on Medicare managed-care plans will be available in the spring, instead of the fall. It is now available in only a handful of states.

In addition, as part of his budget for the 2000 fiscal year, President Clinton plans to make it easier for seniors whose HMOs close to sign up for Medicare supplementary insurance, administration officials said.

**FAX Transmission**

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1/14

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FOR IMMEDIATE RELEASE

January, XX, 1999

Contact: HCFA Press Office
(202) 690-6145**MEDICARE MANAGED CARE RISK ADJUSTMENT METHOD ANNOUNCED**

Health and Human Services Secretary Donna E. Shalala announced today that HCFA will begin implementing, on a phased in basis, a more accurate payment method that will assist Medicare managed care plans that enroll the sickest beneficiaries.

Required by the Balanced Budget Act of 1997, the new payment method -- known as risk adjustment -- will for the first time begin to reflect the health status of Medicare beneficiaries. The new approach, which has a transition period, will increase payments to plans that care for the sickest beneficiaries who stand to gain the most from managed care's focus on coordinating care. Medicare currently pays health maintenance organizations (HMOs) and other managed care plans a fixed monthly amount per beneficiary, adjusted only by demographic factors.

HCFA also announced a preliminary estimate of the average payment increase -- X.X percent -- scheduled for Medicare managed care plans in 2000. The increase is also mandated by the Balanced Budget Act of 1997.

"There is widespread agreement among health care experts that risk-adjusted payments will pay plans more fairly and reduce incentives for plans to enroll only healthier beneficiaries," Secretary Shalala said. "But we want to be sure that as we move to this new payment system, we do our utmost to provide a stable marketplace for HMOs to protect our Medicare beneficiaries who choose managed care plans. I believe HCFA's phased-in approach will do that."

The phased-in risk adjustment methodology will also save taxpayers \$11.2 billion over five years. A number of studies have shown that managed care plans participating in Medicare have tended to attract healthier beneficiaries, leaving the sickest in traditional fee-for-service Medicare. The Physician Payment Review Commission -- a predecessor of the Medicare Payment Advisory Commission -- estimated in a 1997 report to Congress that Medicare overpaid plans by up to \$2 billion a year because the current payment system doesn't reflect beneficiary's health status.

Risk adjustment looks at a person's diagnosis in one year and predicts how much, if any, additional cost there will be for that person the next year. For example, a person who has appendicitis in one year is not expected to have higher than average costs the following year. If a person has a stroke, however, additional costs beyond the average are predicted and a plan would receive a larger payment to cover the additional expected costs.

As required by law, risk-adjusted payments to plans will begin Jan. 1, 2000. However, to ensure that plans have time to adjust to the new payment method, HCFA built a five-year transition period into the risk adjustment methodology it adopted. In 2000, only 10 percent of a plan's payment for each beneficiary will be calculated based on the new risk adjusters, while 90 percent of the payment for each beneficiary will be based on the current system. The full effects of risk adjustment will be fully phased in between 2000 and 2004.

"Introducing risk adjustment into Medicare managed care is an important step in making

sure beneficiaries have access to the care they need and that Medicare pays plans fairly," HCFA Administrator Nancy-Ann DeParle said. "We are taking a careful and balanced approach to risk adjustment, and we will closely monitor the impact on both beneficiaries and plans."

Of Medicare's 39 million beneficiaries, over six million are in managed care and over 32 million are in traditional Medicare. On average 60,000 to 70,000 Medicare beneficiaries enroll in managed care plans every month.

The transition component of HCFA's risk adjustment methodology significantly lessens the financial impact of risk adjustment on plans. If no transition period were included in HCFA's risk adjustment methodology, aggregate payment reductions to plans would have been an estimated 7 percent this year. With a transition, the aggregate reduction is now less than 1 percent in the first year.

Currently, Medicare pays health plans a fixed monthly payment for each beneficiary based largely on fee-for-service Medicare costs in each of the nation's over 3,000 counties. The payments are adjusted by demographic factors such as age, sex, and whether a beneficiary is eligible for Medicaid in an attempt to better reflect the likely future costs of caring for individual beneficiaries. Risk adjustment adds diagnostic information to the payment calculation and significantly improves the accuracy of predicting expected costs.

The best risk-adjustment models, to date, use encounter data -- information about the kind of care provided to individual beneficiaries in encounters with the health system -- to determine diagnoses. The Balanced Budget Act required HCFA to risk-adjust payments to health plans in 2000. It gave the agency the authority to collect encounter data, but limited its authority to collect only hospital inpatient encounter data in the first year of collection. As a result, the risk-adjustment model HCFA is using for 2000 -- known as the Principal Inpatient Diagnostic Cost Group (PIP/DCG) -- is based on inpatient hospital diagnoses. The risk-adjustment model groups hospital inpatient diagnoses into categories according to total predicted costs of each diagnosis in the next year. Although the model uses hospital information to determine a diagnosis, it uses Medicare costs for all services to determine the amount of additional payments to plans.

In any given year, approximately 20 percent of all Medicare beneficiaries are hospitalized. The HCFA model excludes about 40 percent of these admissions from consideration for increased payments by removing diagnoses, such as appendicitis, that have no expected additional costs in the following year. Although HCFA expects plans and hospitals to submit accurate data, the agency is taking a number of steps to ensure the integrity of the system. Based on the advice of an expert clinical panel, HCFA is excluding admissions that are rarely the principal reason for inpatient hospital care or that are vague or ambiguous. One-day hospital stays are also being excluded to reduce the incentive to increase marginal admissions.

The remaining 60 percent of admissions, predicted to account for about 30 percent of all Medicare spending the following year, is classified into 15 different cost categories. If a beneficiary is included in one of these categories, the health plan will receive an additional payment for that beneficiary.

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**Medicare Managed Care Risk Adjustment
Press Questions and Answers
For Internal Use Only
DRAFT 1/14/99 10:52 AM**

Q. Why is HCFA risk adjusting payments to Medicare managed care plans?

- A. Risk adjustment is required by the Balanced Budget Act of 1997 and will assist plans that enroll the sickest beneficiaries and reduce incentives for plans to enroll only healthier beneficiaries. Under risk adjustment, payments to plans for the first time will reflect the health status of Medicare beneficiaries, increasing payments made to plans on behalf of the sickest beneficiaries they enroll.

There is widespread agreement among health care experts that risk-adjusted payments will pay plans more accurately and reduce incentives for plans to enroll only healthier beneficiaries. There is also considerable evidence that Medicare has overpaid managed care plans in part because payments are not now adjusted for health status and because plans tend to attract healthier beneficiaries. The Physician Payment Review Commission -- a predecessor of the Medicare Payment Advisory Commission -- estimated in a 1997 report to Congress that Medicare overpaid plans by up to \$2 billion a year.

Q. Won't risk adjustment hurt plans and decrease their payments?

- A. Introducing risk adjustment into Medicare managed care is an important step in making sure beneficiaries have access to the care they need and that Medicare pays plans fairly. We are taking a careful and balanced approach to risk adjustment, which for the first time will reduce incentives for plans to enroll only healthier beneficiaries. We will also closely monitor the impact of risk adjustment on both beneficiaries and plans.

To ensure that plans have time to adjust to the new payment method, HCFA has incorporated a five-year transition period into the risk adjustment methodology. In 2000, only 10 percent of a plan's payment for each beneficiary will be calculated based on the new risk adjusters, while 90 percent of the payment for each beneficiary will be based on the current system. This will significantly reduce the impact on HMOs. If no transition period were built into the risk adjustment methodology, aggregate payment reductions to plans would have been 7 percent in 2000. With a transition, the aggregate reduction is now less than 1 percent in 2000 and risk-adjustment savings are expected to be \$11.2 billion over five years -- \$4.5 billion less than if no transition were used.

Background: In CY 2001, payments will be based 30 percent on risk adjustment and 70 percent on the current system; in CY 2002, 55 percent risk adjustment, 45 percent current system; in CY 2003, 80 percent risk adjusted, 20 percent current system. In CY 2004, we will use a comprehensive risk adjuster that includes inpatient, outpatient and physician encounter data.

Q. Why is HCFA using only hospital encounter data?

- A. The Balanced Budget Act restricted collection of encounter data -- information about the kind of care provided to beneficiaries -- to hospital inpatient services in the first year of collection. We will soon begin collecting encounter data from other care settings, including hospital outpatient and physician encounter data. By Calendar Year (CY) 2004, HCFA intends to implement a comprehensive risk adjuster that uses inpatient, outpatient and physician encounters to adjust payments to plans based on beneficiaries' health status.

Q. Won't using only hospital encounter data provide a perverse incentive for plans to hospitalize beneficiaries needlessly to increase their payments?

- A. No. It would be very difficult, if not impossible, for plans to implement a medical management program that differentiates among certain patients. To manipulate the risk adjustment model, a plan would have to identify patients who have not been hospitalized this year and try to get them hospitalized for a condition that normally would be treated on an outpatient basis.

Also, there is no guarantee that a beneficiary who is hospitalized will be enrolled with the same plan the following year. The plan must then take the risk of paying for the direct costs associated with an unnecessary hospitalization while having no guarantee that the beneficiary will be in the plan the following year.

Additionally, one-day stays are included in the base payment category so the unnecessary hospitalization has to occur for at least two days, thereby increasing direct costs even more. Also, only the most serious admissions are used in the risk-adjustment model, and other discretionary inpatient stays do not increase payments.

Q. Won't requiring plans to submit all this data and information increase the administrative burden on plans and increase their costs?

- A. Other Medicare providers, such as hospitals, home health agencies, and skilled-nursing facilities are required to provide us with information to ensure they receive accurate payments. Medicare + Choice organizations are being asked to provide similar kinds of information for the same purpose. The information we are requiring from plans is needed to ensure that Medicare pays plans fairly and accurately.

Q. How will risk adjustment work?

- A. Currently, Medicare pays health plans a fixed monthly payment for each beneficiary based largely on fee-for-service Medicare costs in each of the nation's over 3,000 counties. The payments are adjusted by demographic factors such as age, sex and whether

he or she is eligible for Medicaid in an attempt to better reflect the likely future costs of caring for individual beneficiaries. Risk adjustment adds diagnostic information to the payment calculation and significantly improves the accuracy of predicting expected costs.

In any given year, approximately 20 percent of all Medicare beneficiaries are hospitalized. The HCFA model excludes about 40 percent of these admissions from consideration for increased payments by removing diagnoses, such as appendicitis, that have no expected additional costs in the following year. Although HCFA expects plans and hospitals to submit accurate data, the agency is taking a number of steps to ensure the integrity of the system. Based on the advice of an expert clinical panel, HCFA is excluding admissions that are rarely the principal reason for inpatient hospital care or that are vague or ambiguous. One-day hospital stays are also being excluded to reduce the incentive to increase marginal admissions.

The remaining 60 percent of admissions are classified into 15 different cost categories. Beneficiaries in these categories typically account for about 30 percent of all Medicare spending the following year. If a beneficiary is included in one of these categories, the health plan will receive an additional payment for that beneficiary. Each of the demographic factors -- age, sex, Medicaid status, and whether someone was previously disabled -- have payment amounts associated with them and are added as well. The information is converted to an index, and every Medicare beneficiary will have a score used to calculate his or her plan's monthly payment. For example, HCFA would pay \$6,414 for an 85-year-old man, another \$2,060 if he were on Medicaid, another \$1,207 if he was originally disabled, and \$26,464 more if he were admitted to the hospital with AIDS -- a total of \$36,145.

- Q. The plans contend that the switch to risk adjustment is supposed to be budget neutral. Isn't HCFA pulling a fast one here because there are \$11.2 billion in savings predicted over five years?**
- A.** There has never been any question that risk adjustment would result in savings to Medicare because we've known for a long time that Medicare has overpaid managed care plans in part because payments are not now adjusted for health status and because plans tend to attract healthier than average beneficiaries. The Physician Payment Review Commission -- a predecessor of the Medicare Payment Advisory Commission -- estimated in a 1997 report to Congress that Medicare overpaid plans by up to \$2 billion a year. To help foster a stable marketplace, HCFA has chosen to incorporate a transition period into its methodology, significantly lessening the financial impact on plans. With the transition period built into the risk adjustment methodology, risk-adjustment savings are expected to be \$11.2 billion over five years -- \$4.5 billion less than if the methodology did not include a transition period. Under HCFA's methodology, the aggregate reduction is less than 1 percent in 2000.
- Q. What is the preliminary estimated annual payment update for Medicare+Choice plans in 2000 and how is the annual update calculated?**

A. HCFA has estimated that average payment increase scheduled for Medicare+Choice plans in 2000 will be X.X percent. The annual update is based on the projected national average per capita growth percentage in Medicare expenditures for the year that payment rates will go into effect. The Balanced Budget Act of 1997, which defined this update, also provides for an adjustment to the overall growth percentage of -0.5 percent for the year 2000 update. In addition, the Balanced Budget Act provides for adjustments for prior year overestimates or underestimates of the national growth percentages. For 2000, this adjustment for prior years is minimal. The annual update is based on projected expenditures for the Medicare program that are included in the President's FY 2000 Budget.

Q. Why isn't plan-specific information available about the impact of risk adjustment?

A. The information we have now is preliminary and we are finalizing our analyses. We will provide plan-specific information by March 1. Each plan will receive a letter indicating the percentage difference between the plan's payment under risk adjustment and under the current system. Plans with sicker than average beneficiaries will see an increase in payments while plans with healthier than average beneficiaries will see a slight reduction in payments.



D- Sarah B. asked me
to make sure you
had a copy too.

Newly Insured Americans under the Health Care Proposals of Bill Bradley and Al Gore

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This paper summarizes the expected number of newly insured people under the proposals of Senator Bradley and Vice President Gore. The summary estimate is as follows:

Bradley Plan: -- 30 million newly insured
Gore Plan: -- 7 million newly insured

BRADLEY PLAN

The Bradley Plan has several features that will increase insurance coverage. Table 1 summarizes these aspects of the plan. The specific features differ among the following four groups of people:

1. Children

All parents are required to obtain insurance for their children. This mandate is coupled to: (a) universal access to insurance purchased through the Federal Employees Health Benefits Program (FEHBP); (b) a universal tax exclusion for health insurance premiums; (c) and subsidies for children from families whose incomes are 300% of poverty level or below.

The Bradley Plan would cover all of the 11.1 million currently uninsured children.

2. Adults with incomes below the poverty line

Full subsidies are provided to adults with income below the Federal poverty line.

There are 8.1 million uninsured adults who have incomes that fall below the poverty line. They qualify for a full subsidy. Under the Bradley plan, these subsidies would be sent directly to insurers. Adults who qualify for the full subsidy and do not choose a specific

health plan would automatically be enrolled into a default plan. Thus, coverage would effectively be universal for this population. To be conservative, it is assumed that takeup among this population is only 95 percent. This results in additional coverage for 7.7 million people.

3. Adults with income between the poverty line and twice the poverty line

Partial subsidies, a tax exclusion, and the ability to purchase through FEHBP are provided to adults with incomes between 100% and 200% of the federal poverty line.

There are 8.9 million uninsured adults with income between the poverty line and twice the poverty line. These individuals qualify for a partial subsidy that phases out as income rises from the poverty line to 200% of poverty. They also receive a tax exclusion for the purchase of insurance, and will be able to purchase insurance through the FEHBP, which has greater variety and a lower administrative load than the private and small group policies that are the only options currently available for many of these individuals. We assume that two-thirds of these individuals, or 5.9 million individuals, will take up coverage.

4. Adults with incomes more than twice as great as the poverty line

The tax exclusion and the ability to purchase through FEHBP are available to adults with income exceeding 200% of the federal poverty line.

There are 15.7 million uninsured adults whose incomes are more than twice the poverty line. These people will receive the tax exclusion on purchase of insurance and have the option to purchase through FEHBP, with lower administrative expense and greater choice of plans than is currently available to many of them. In addition, some of these individuals are children living in their parent's home (or with other relatives) who will now be eligible for coverage as dependents under their parents' policies. We assume that 1/3 of these individuals, or 5.2 million, will receive coverage.

The total number of people who will be newly insured under the Bradley plan is the sum of the numbers from each of these four groups, or 29.9 million people.

Gore PLAN

The Gore Plan use three mechanisms to increase insurance coverage, as summarized in Table 2.

1. States are allowed to extend eligibility for CHIP to 250 percent of poverty

Because states are not required to extend eligibility, it is impossible to know how many states will take this up. It is likely that many will not; 17 states do not cover children up to the maximum possible (200 percent) today.¹ If they do not take advantage of the existing program provisions, raising the eligibility ceiling to 250 percent of poverty should not give them any further reason to expand the CHIP program. Thus it would be very optimistic to assume that all states extend CHIP to 250 percent of poverty. If they did, this feature would make about 1 million children newly eligible for insurance.

Even with state cooperation, not all of the newly eligible children would be enrolled in the program. Estimates from the Medicaid expansions and CHIP program features suggest that a takeup rate of less than 50% is expected. Some of these newly-insured children (as many as one-half) will have been insured privately

prior to the CHIP expansion, and will thus not reduce the number of uninsured. To estimate an upper range of new coverage, we assume that the takeup rate will be 50%, with no substitution from private to public coverage. This yields an estimate of new enrollment of about 0.5 million.

2. Medicaid and CHIP eligibility is extended to adults when children are eligible

There are 3.3 million uninsured adults with incomes below 250 percent of poverty whose children are currently enrolled in Medicaid or CHIP. Not all of these parents will enroll in the new program. Estimates in the literature suggest that a CHIP expansion might insure 80 percent of eligible adults.² These estimates imply that the extension of adult eligibility will lead to 2.6 million newly insured parents.

Some parents of the newly eligible children will also enroll in the program. We assume there is one new parent enrolled for each new child enrolled (some children are from the same family; some families have only one adult). This yields 0.5 million new parents with insurance.

3. Increase outreach efforts for children and adults eligible but not enrolled in Medicaid and CHIP

Many children and adults eligible for Medicaid/CHIP do not choose to enroll in the program. The Gore plan states that it would increase outreach efforts to enroll these groups, although it does not describe how outreach would be conducted. It also proposes additional financial inducements for states to cover these children. Since many states already receive close to 100 percent Federal subsidies for their Medicaid and CHIP programs, it is unclear how effective the unspecified financial incentives would be. To account for the effects of increased outreach, it is assumed that these efforts will result in the enrollment of 0.5 million new children and parents.

4. Medicare buy-in for people 55-64 and Medicare/Medicaid buy-in for the disabled

Consistent with the CBO, these policies are assumed to cover 0.6 million people.

5. Tax credits for small firms and individuals

The Gore plan includes: (a) a 25 percent refundable tax credit for people lacking access to employer-based health insurance who purchase coverage in the individual market; and (b) a 25 percent tax credit for premium costs for each employee of a small business that joins a "purchasing coalition." Net of the other initiatives, there are 39 million people to whom these options would apply.

Analysts have highlighted three aspects of program design that influence how many people enroll in a health insurance plan: price and income; barriers to enrollment, such as the ease of obtaining benefits; and cash flow and uncertainty.³ The response to this policy is likely to be lower than to the Bradley proposals, for each of the following reasons.

First, the subsidies are less generous than the Bradley proposal. The Gore Plan's refundable tax credit is modest and does not even reach the level of the tax credits that recent legislation has made available to the self-employed. Second, insurance policies sold to individuals are as much as 35 percent more expensive and are less generous than FEHBP policies.⁴ Individual insurance purchasers rarely have a range of choices as extensive as those offered through FEHBP. Third, the active effort required to enroll in an individual plan and to obtain the tax credit is a major barrier that

will discourage many from taking advantage of the tax credit by obtaining insurance. Fourth, the FEHBP is more familiar to people than the individual market and has government backing, leading to less uncertainty about benefits. Fifth, there are few purchasing alliances or coalitions today, and they might not be available to most of the uninsured.

Estimates from the Institute for Health Policy Solutions indicate that fewer than 350,000 people are insured through purchasing alliances today, compared to nine million people insured through the FEHBP. To estimate the effects of this policy on coverage, we assume that for every 10 percent reduction in insurance price, 2.5 percent more people enroll in coverage. This increases coverage by 2.5 million people.

The total estimated effect of the Gore Plan would be to increase coverage by 7.2 million people.

COMPARISON WITH OTHER ESTIMATES

These estimates differ from the Kenneth Thorpe numbers cited by the Gore campaign in several ways:

1. The Thorpe estimate does not account for the mandate that parents cover their children. This increases the number of children to be insured by 5 million.
2. The Thorpe estimate assumes that only 75 percent of adults eligible for a full subsidy will take up the subsidy. As noted above, the Bradley plan proposes universal coverage of this group by choosing a default plan for those who do not elect a plan on their own. As such, the Bradley plan will at minimum insure 95 percent of this population. This increases the number of insured adults by 2 million.
3. The Thorpe estimate is that 4.8 million children will be covered by the CHIP expansion and outreach efforts. About 7 million children who are currently eligible for Medicaid/CHIP are not enrolled, and an additional one million would be made newly eligible under the Gore proposal. With a 50% expected enrollment rate, only 0.5 million additional children (50% of the additional one million eligible children) could be expected to enroll under the proposed CHIP expansion. Consequently, to be consistent with Thorpe's estimates, the outreach efforts would need to produce 4.3 million additional enrollees, the vast majority of whom come from the pool of children who are already eligible but not enrolled. Enrollment at these rates would exceed estimates of enrollment even for the poorest of families that receive cash benefits as well as Medicaid.
4. The Thorpe estimate assumes that current definitions of health insurance units remain in place, but the Bradley plan proposes to change this. This change will make it possible for adult children and other relatives residing in a single family to be covered through that family's policy. This will increase the number of adult children and other adults covered by making it possible for them to obtain coverage at little or no incremental cost to the family. The net effect of this policy is several million newly covered people.
5. The Thorpe estimate assumes that the features of the Gore and Bradley plans will promote the purchase of insurance by about the same amount, given equal dollar subsidies. In fact, the Bradley plan is likely to be more effective at increasing insurance enrollments, for five reasons:
 1. the Bradley plan will automatically enroll individuals who qualify for the full subsidy in a health plan, unless they choose otherwise;

2. the FEHBP option in the Bradley plan is more familiar and more easily accessible than the individual market or the yet-to-be-created purchasing pools for small firms in the Gore proposal, reducing uncertainty about benefits;
3. administrative costs and thus premiums will be lower in the FEHBP than the individual market, by as much as 35 percent;
4. the range of choices in the FEHBP is greater than people can receive in the individual market;
5. and the Bradley proposal gives the tax credit to individuals, so no employer action is needed to activate any part of the subsidy.

¹ Frank Ullman, Ian Hill, and Ruth Almeida, "CHIP: A Look at Emerging State Programs", Washington, D.C.: The Urban Institute, September 1999.

² The number of uninsured and takeup rates are discussed in Judith Feder, Cori Uccello, and Ellen O'Brien, "The Difference Different Approaches Make: Comparing Proposals to Expand Health Insurance", Kaiser Family Foundation, October 1999.

³ Judith Feder, Cori Uccello, and Ellen O'Brien, "The Difference Different Approaches Make: Comparing Proposals to Expand Health Insurance", Kaiser Family Foundation, October 1999.

⁴ Congressional Research Service, Costs and Effects of Extending Health Insurance Coverage, Washington, D.C.: Library of Congress, 1988.

Table 1: Estimates of New Coverage Under the Bradley Plan	
Children:	11.1 million
Subsidies and insurance mandate	
Children, Total	11.1 million
Adults:	
Below poverty	7.7 million
Between poverty and twice poverty	5.9 million
Above twice poverty	5.2 million
Adults, Total	18.8 million
Total	29.9 million

Table 2: Estimates of New Coverage Under the Gore Plan	
Children:	0.5 million
Extend CHIP to 250 percent of poverty	
Tax subsidies for individuals/small firms	0.6 million
Increased outreach	0.5 million
Children, Total	1.6 million
Adults:	
Extend eligibility for Medicaid/CHIP	2.6 million
Parents of newly eligible children	0.5 million
Medicare/Medicaid buy-in for disabled and People 55-64	0.6 million
Tax subsidies for individuals/small firms	1.9 million
Adults, Total	5.6 million
Total	7.2 million

Table 3. Newly Insured and Remaining Uninsured Under Status Quo, Gore Plan, and Bradley Plan			
Plan	Status Quo	Gore	Bradley
Newly Insured	--	7 million	30 million
Remaining Uninsured	44 million	37 million	14 million
Total Insured,	224 million	231 million	254 million
Percentage of Population Insured	84%	86%	95%

Revised and authorized by

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Economic Advisers Find That Bradley Plan Extends Insurance Coverage to 30 Million

December 17 -- In a report released today, three economic advisers to Democratic presidential candidate Bill Bradley conclude that the Bradley plan insures 30 million new people while the Gore proposal only expands insurance coverage by 7 million. The report, released by the Bradley campaign in New Hampshire, also finds that the Bradley plan covers an additional 11 million children while the Gore proposal reaches only 1.6 million uninsured children.

"This report validates the fact that Al Gore and I have very different goals on health care, and very different proposals. I cover all children. He does not. I broaden access to all Americans. He does not. I help millions of hard-working Americans pay for the health insurance they have. He does not. I give the poor on Medicaid something better. He perpetuates a two-tiered health system that stigmatizes low-income people," Bradley said.

"Leadership is about having a big idea and never losing sight of it," he said.

The report released today was prepared by Harvard University economics professor David Cutler, Stanford University Health Research and Policy Director Alan Garber, and Neal Masia, Director of Strategic Planning at ChannelPoint Inc. All three were advisers to Bradley on his health care proposal.

The report also points out several flaws with an earlier analysis by Ken Thorpe, a former adviser to the Gore campaign. For instance, the report states that Thorpe did not account for the mandate that parents cover their children, he underestimated the number of low-income adults who will take advantage of the Bradley subsidy, and he overestimates the number of children who will be covered by outreach and expansion of the Children's Health Insurance Program in the Gore plan.

Finally, the report concludes that Bradley's proposal will be far more effective than the Gore plan in increasing the number of people with health insurance for the following reasons: greater choice and more simplicity in the FEHBP, lower administrative and therefore lower premium costs through FEHBP, automatic enrollment under the Bradley plan for those who qualify full subsidy (unless they choose otherwise), and direct tax credits to individuals without the need for employer action.

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I. RISK ADJUSTMENT MODEL

I-1. Why is HCFA implementing risk adjusted payments?

Current payments to Medicare+Choice organizations are based on the demographic factors of age, gender, Medicaid eligibility, institutional status, and working aged status. Risk adjustment modifies payment to plans to reflect the projected health care needs of the beneficiaries they enroll.

- There is considerable evidence that Medicare has overpaid managed care plans, and that it continues to overpay these plans, in part because payments are not adjusted for risk.
 - + The Physician Payment Review Commission (PPRC), in its 1997 Annual Report to Congress, estimated that Medicare has been making up to \$2 billion a year in excess payments to managed care plans. PPRC noted that, unlike the private sector where managed care has slowed health care cost growth, *managed care has increased Medicare program outlays*. In addition, the PPRC's 1996 report found that those who enroll in managed care tend to be healthy and those who disenroll tend to be unhealthy, exacerbating Medicare losses.
- Demographic factors alone do not adequately adjust for variation in the health care needs of beneficiaries enrolled in plans. This is because demographic factors do not necessarily equate with differences in health status, for example, older beneficiaries are not always sicker.
- Demographic factors alone are not as effective at accounting for the more severe health conditions which require more health care resources. As a result, payments to plans, that serve beneficiaries requiring comparatively more health care services, are not adjusted adequately.
- Risk adjustment factors employ diagnostic information to predict future use of health care services. Diagnoses coupled with demographic factors provide a better explanation of future health service use than demographic information alone.

I-2. Why is HCFA implementing an inpatient risk adjustment model?

The Balanced Budget Act requires risk adjustment of Medicare+Choice payments beginning in 2000. In addition to the statutory requirement, there are a number of sound policy reasons for proceeding with risk adjustment based only on an inpatient hospital data methodology:

- The inpatient model is the only alternative that can be quickly implemented without major disruptions to health plans, which is why the BBA required collection of inpatient data

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before collection of all encounter data.

- The PIP-DCG methodology is immensely superior to the current demographic model in detecting selection bias.
- Hospitalized beneficiaries are the sickest and highest cost beneficiaries and represent most of the Medicare expenditures in any given year.

1-3. Why did HCFA decide to phase-in risk adjusted payments to Medicare+Choice organizations, rather than to fully implement the model in year 2000?

The PIP-DCG model is being phased in gradually over the next several years for a number of reasons, including the following:

- Transitions serve as an effective method for introducing major changes in payment methodologies without causing abrupt changes in payment levels that could generate financial problems for Medicare +Choice organizations or disrupt services for Medicare beneficiaries. The general rationale of avoiding abrupt changes in the flow of payments applies in the case of risk adjustment.
- There is substantial precedent in the Medicare program for phasing in significant changes in payment methodology. Among these precedents are a four year phase in of the prospective payment system for inpatient hospital operating costs, a ten year phase in of the prospective payment system for inpatient hospital capital costs, and a five year transition to payment under the physician fee schedule.

I-4. Why was FFS data rather than encounter data used to develop the model?

- Medicare payments to managed care plans have always been linked to county level FFS costs. The risk adjustment model uses FFS claims data to calibrate payments based on FFS practice patterns for different disease groups.
- While it may be appropriate at some point to use or to include managed care encounter data when determining the relative costliness of different disease groupings, this is not possible until full encounter data is available from health plans. Full encounter data is needed in order to estimate total spending for all services on a beneficiary specific basis.

1-5. What are the key elements of the final PIP-DCG model? How are the working aged and those newly 65 paid for under risk adjustment?

- The PIP-DCG model is an “additive” model, meaning that incremental dollars are added together based on each beneficiary’s characteristics. The predicted annual expenditures

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for an enrollee are converted to a relative risk factor. Payment to a plan is the risk factor for the beneficiary multiplied by the BBA ratebook amount for the beneficiary's county of residence.

- Beneficiaries are placed in demographic groups according to age, sex, Medicaid status and whether they were previously disabled. Adjustments are also made for the working aged.
- Inpatient diagnosis data are used to place beneficiaries in PIP-DCG groups. About 12% of Medicare beneficiaries are assigned to 15 risk classes of diagnoses that are associated with higher Medicare costs in the following year. The PIP-DCG groupings allow us to identify and pay more for many of the most costly Medicare beneficiaries.
- In the case of newly disabled or aged beneficiaries, for whom we do not have inpatient data, a separate demographic model was developed. We developed predicted cost factors for these beneficiaries using only demographic variables because no other data are available.

I-6. How have one-day hospital stays been handled in terms of risk adjustment, and why?

- Several modifications were undertaken to ensure that the PIP-DCG model was appropriate for payment. One strategy used to ensure consistent and appropriate payment levels was to leave short hospital stays (1 day or less) in the base payment category.
- Since the majority of 1 day stays are for diagnoses already assigned to the base group, the effect on payment is small. Also, short stays are indicative of less serious and hence, less costly cases.
- It is important to note that these modifications do not mean that these expenditures have been excluded from the model. Rather the payments associated with these diseases are captured in increased payments for the base payment category, where the majority of enrollees are paid based on demographic factors.

I-7. How is chronic illness being addressed by the risk adjustment model?

- Hospitalization is the most significant indicator of illness in a Medicare beneficiary. In any given year, approximately 20% of fee-for-service beneficiaries are hospitalized. Many of those hospitalized are for treatment of illnesses associated with chronic illnesses, such as heart disease and diabetes.
- The 20% of beneficiaries who are hospitalized account for 80% of Medicare spending in the year of hospitalization. The PIP-DCG model identifies 12% of total beneficiaries as

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having illnesses that place them into predictably more expensive classes.

- Since people with chronic illnesses are hospitalized at a higher rate for a large array of other illnesses, the inpatient model should pay more for these individuals than the current Medicare payment method. For example, analysis of the Medicare Current Beneficiary Survey show that 35% of beneficiaries with myocardial infarction were hospitalized in 1996, compared with 19% of all beneficiaries.

I-8. Doesn't the PIP DCG model provide incentives to hospitalize beneficiaries unnecessarily?

- No. Health plans will not needlessly hospitalize patients because that's not the way they provide care. Generally health plans have been very good at providing care on an outpatient basis and not hospitalizing patients unnecessarily. There are several other reasons why plans can't just hospitalize patients unnecessarily.
- First, it would be very difficult, if not impossible, to implement a medical management program that differentiates among certain patients. Most medical management programs are designed to prevent unnecessary hospitalizations by assuring that treatment is provided on an outpatient basis if possible. Thus, to game the risk adjustment model, a plan would have to identify those patients who have not been hospitalized in the past year and try to get them hospitalized for a condition, which under normal circumstances is treated on an outpatient basis.
 - + For example, there are two patients with the same level of diabetes. One was hospitalized previously in the year for a heart attack, and therefore the plan will receive extra payment for that beneficiary in the following year, and the other has not been in the hospital. Suppose the physician requests admission for the first patient on Monday and the plan's medical management program denies admission and suggests outpatient treatment. Now suppose the physician requests admission for the second patient on Tuesday. How can the plan justify allowing admission for this patient but not the first without undermining the legitimacy of the medical management program?
 - + This would reverse the success plans have had in shifting care to an outpatient basis and would also increase their costs.
- Second, unless the plan games the system only late in the year, there is a risk that the patient would have been hospitalized later in the year anyway.
- Third, one-day stays are included in the base payment category so the unnecessary hospitalization has to occur for at least two days, thereby increasing direct costs even

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primary or secondary diagnosis, AIDS is treated as the principal diagnoses for purposes of the model.

I-11. How will risk adjusted payment be calculated for new organizations?

- Payment is based on the individual beneficiary. The same payment is made whether they are in a new or an old plan.

I-12. What is rescaling and why is this needed in the risk adjustment process?

- Rescaling is a process to place the rate book and the payment factors on the same scale. Under the current methodology, payment rates are developed by standardizing base rates according to a set of demographic factors and then paying organizations with the same set of demographic factors. Under the new risk adjustment process, payments will now be made based on a new set of factors which are based on health status as well as demographic factors. Therefore, the payment rates in the rate book should be standardized using the same set of new risk adjustment factors. However, the Balanced Budget Act requires that the rates be at least 2 percent higher than the actual published rate from the prior year. Also, the BBA does not allow for a restandardization of the base 1997 rates. Because the 1999 payment rates were developed from 1997 base rates which were standardized using only demographic factors and the risk adjusted rates in 2000 should be developed from base rates standardized using the new risk factors, we have an inconsistency.
- Rescaling allows us to develop a demographic only county rate book, as we currently do, then multiply each county rate by a factor which will adjust the rate book to a risk factor basis. This is done by defining the county rescaling factor as the ratio of the risk county rate to the demographic county rate. When this rescaling factor is multiplied by the demographic county rate, you get precisely the risk county rate. The risk county rate is developed by restandardizing the base 1997 rates for health and demographic factors and then projecting forward to the 2000 rates using the current rules as required by the BBA (blends, floors, 2 percent minimum increase, etc). You can then apply the risk factors for each managed care enrollee to determine payment to the managed care plan. Rescaling preserves the current demographic rate book as the basis for future rates, consistent with the intent of the BBA.

I-13. How are "atypical" hospitalizations handled?

- A clinical panel reviewed the placement of diagnostic groups and their resulting predicted expenditures, to determine the appropriateness of their application in a payment model.
- Through this process, about 1/3 of admissions were identified as: (1) representing only a

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minor or transitory disease or disorder, not clinically likely to result in significant future medical costs, (2) rarely the main cause of an inpatient stay, or (3) vague or ambiguous. These groups, as recommended by the clinical panel, were identified as those most likely to result in inconsistent or inappropriate payment and were not used in the assignment of PIP-DCGs. We identified this group as "excepted" diagnoses.

- Expenditures associated with people who only had these diagnoses are recognized in the base categories that are adjusted only by demographic factors.

I-14. Isn't risk adjustment like experience rating?

- No. Under experience rating, individuals are charged a premium based on their health status so that sick individuals pay more to the insurance company than healthy individuals. This practice can serve to discourage sick individuals from applying for insurance. Under risk adjustment, if a plan charges a premium, all enrollees will continue to pay the same premium regardless of their health. However, HCFA's payment to the plan will be based on the health status of each of its enrollees. Risk adjustment works in the same way as age, gender, and other demographic factors now work...it simply adds one more element to better predict an enrollee's health needs.

I-15. How flexible will HCFA be if a better risk adjustment model or method is developed?

- Just as health plans and providers adapt to new practices, technology, and other changes in the delivery system, HCFA is willing and prepared to adjust the risk adjustment model. Improvements to the model can be made each year as necessary. We have had, and continue to have, discussions with researchers from academia and health plans about improving the model to assure that we make the most appropriate payment possible. We will continue to do so, even after fully implementing risk adjustment. (Can we add anything about how we make improvements to I/p PPS or RBRVS?)

I-16. How will inpatient encounter data be used to calculate an enrollee's risk factor?

- The inpatient encounter data submitted for the period July 1, 1997 through June 30, 1998 (referred to as the start-up year) is being used to prepare an estimate of the plan's Average Payment Rate (APR) for use in preparing the Adjusted Community Rate (ACR) for 2000. We will use data from the period July 1, 1998 through June 30, 1999 as the basis for calculating the risk factor for each enrollee for CY 2000. The industry preferred this period rather than a later one that would require a retrospective adjustment.
- Each enrollee's risk factor for a payment year will be calculated using encounter data submitted by one or more managed care organizations, in addition to any encounters

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experienced if the beneficiary received care in the Medicare fee-for-service sector during the period of data collection. Risk factors for new Medicare beneficiaries will be assigned on the basis of demographic factors only.

- Managed care organizations must submit data for the period July 1, 1998 through June 30, 1999 to their fiscal intermediary no later than September 17, 1999. Data received at HCFA after this date will be used in a reconciliation process to be conducted after the payment year is concluded.

I-17. Are comprehensive models available now? Will HCFA have difficulty developing a full model?

- HCFA has comprehensive risk adjustment models available now and does not anticipate any developmental problems. The principal constraint in implementing a comprehensive model has been the availability of encounter data from health plans.
- All of the comprehensive models continue to be refined and updated with later Medicare data. The DCG based Hierarchical Coexisting Conditions (HCC) model was developed by researchers at Boston University, Health Economics Research and the Harvard University School of Medicine. A key feature of the model is that it is additive, in that each coexisting condition adds to a beneficiary's total risk score.
- ACGs, referred to as Ambulatory Care Groups, were developed by researchers at the Johns Hopkins University. The ADG-HosDom variation of the ACGs uses ambulatory and hospital diagnoses as well as a category of diagnoses with over 50% hospital admission rates.
- Other models are also under development by other researchers. Kaiser is developing a model using managed care data. RAND has a model called CD-RISC. 3-M will soon be reporting on a more clinically based classification system that uses multiple years of data.

I-18. What will the comprehensive risk adjustment model look like?

- Several versions of comprehensive models have been developed to date. The consistent feature among the models is that they use demographic information and diagnoses from inpatient, outpatient, and physician encounters.
- Comprehensive models are better able to detect the presence and costliness of chronic diseases than a purely inpatient model. Among non-hospitalized beneficiaries, the comprehensive models will assign higher risk scores to those people with chronic diseases and lower scores to those who are healthy. Consequently, comprehensive models are much more sensitive to selection bias than an inpatient model.

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- Models using functional status are dependent on self reported survey data. It is not clear that these data result in a more accurate model. We are planning to explore the use of the Health Outcomes Survey (HOS) to determine whether the addition of functional status information would improve the model. We do not believe functional status is necessary for mainstream health plans, hence our efforts will focus primarily on existing demonstration plans such as PACE, Social HMOs, Evercare, and Medicaid/Medicare dual eligible plans. The use of survey data would require significant survey expense. Fee-for-service surveys would need to be conducted in every county in order to precisely recalibrate the county rate book.

II. IMPACTS**II-1. Won't plans have to cut back on extra benefits such as drugs?**

- Not necessarily. Each year plans decide on the benefits they will offer based on a number of factors including expected payments from HCFA, local market competition, the needs of their beneficiaries, profit margins, and the plan's philosophy of care. Although plans with a healthier than average population will face a slight reduction in payments because of risk adjustment, other plans with a sicker population will receive higher payments which may allow them to expand their drug benefits, reduce premiums, or otherwise increase benefits for their enrollees. Just as they do with their commercial enrollees, plans with healthier enrollees may have to make some adjustments in provider reimbursement, benefits and other aspects of the plan.

II-2. What is the impact on the average plan?

- We are finalizing our analyses. On March 1, 1999 each organization will receive a letter indicating the percentage difference between the organizations' payment under risk adjustment and under the current system. Plans with sicker than average enrollees will see an increase in payments while plans with healthier than average enrollees will see a slight reduction in payments.

II-3. How can plans continue to participate in the program when faced with cuts in their payments?

- Under the provisions of the BBA, plans are guaranteed a minimal 2 percent update in their county rates. Under the phase in strategy for risk adjustment, payments to organizations will be calculated using a blend of the current demographically based payments and risk

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adjusted payments. During 2000, payments will be based on 90 percent of the demographically based payments, and 10 percent of risk adjusted payments. Based on the BBA-guaranteed 2 percent update and the blend percentages for 2000 and assuming no substantial changes in the characteristics of enrollees for a plan, **preliminary analyses suggest that no plan in the aggregate will experience payment decreases during 2000.**

II-4. Will this risk adjustment methodology have a greater impact on smaller plans?

- Preliminary impact analyses do not suggest that the risk adjustment methodology will have a disproportionate impact on smaller plans.

II-5. Have safeguards been implemented to protect rural areas?

- Preliminary impact analyses do not suggest large variations in the impact of risk adjustment by type of organization. The blend methodology which we are adopting for the transition period moderates the impact of risk adjustment on all organizations. We will, however, continue to monitor the impact of risk adjustment as the transition proceeds to determine whether specific safeguards for rural organizations or other types of organizations might become warranted

III. LONG TERM CARE PLANS

III-1. Why does HCFA believe it is necessary to postpone the implementation of a risk adjustment payment methodology for certain demonstration projects?

HCFA is conducting a number of demonstrations to test innovations in organizational structures and service delivery. All new innovations need to be evaluated before implementing risk adjusted payments. Examples of these demonstrations include the following:

- The SHMO demonstration began in 1985 with an enhanced payment to recognize additional health services mandated for the program's special population. It is scheduled to continue through 2000. The BBA requires the Secretary to develop a plan to transition SHMOs to the M+C program with a recommendation for a payment approach that takes into account the risk factors appropriate to the population served.
- PACE began in 1987 with an enhanced payment to recognize the health status of the very frail beneficiaries they serve. It will be converted to a permanent benefit under Medicare within the next 3 years. It provides a variety of mandated community-based services to complement its adult day care program. PACE enrollees have a high level of functional impairment.

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- EverCare offers a unique model of care focusing exclusively on nursing home residents. The demonstration is designed to manage the acute needs of nursing home residents using primary and preventive services and, thus, avoid hospitalization.

III-2. What is HCFA doing to develop a risk adjustment payment methodology for its long-term care demonstration projects?

- At the present time, we are conducting some demonstrations that provide services to special populations: The Social Health Maintenance Organization (SHMO), Program of All-Inclusive Care for the Elderly (PACE), EverCare, Minnesota Senior Care Options and dual eligible projects.
- We are assessing refinements to the risk adjustment methodology for these specific demonstrations. These analyses cannot be completed in time to apply any recommended refinements in 2000. Therefore, we have decided to delay implementation of a risk-adjusted payment system for organizations participating in these demonstrations.
- SHMO demonstration sites are currently providing encounter data. We will be working with the PACE, EverCare, and other sites to obtain complete and accurate encounter data and Health Outcomes Survey (HOS) data.

III-3. What is HCFA doing to obtain encounter data from these demonstration projects?

- We are working with the organizations participating in these demonstrations to acquire encounter data and survey-based functional status data. We will collect data in 1998, 1999, and 2000.

IV. IMPLEMENTATION

IV-1. Why did HCFA not release additional information in October concerning the model?

- The Federal Register notice on the implementation of risk adjustment, which was published on September 8, 1998, indicated that additional materials on risk adjustment would be available on or after October 5, 1998.
- Because of unforeseen delays, those materials could not be made available prior to the publication of the 45 day notice, released on January 15, 1999.

IV-2. Why is there a six-month lag between the 12 month period upon which payment is based and the start of the risk adjusted payment?

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characteristics will be employed

V-3. How have you ensured the integrity of the data?

- The integrity of the data is assured through a 3-step process. First, data are edited by the fiscal intermediaries and other HCFA processors to assure that the diagnostic information submitted by the plans is complete. Secondly, HCFA has conducted internal data analyses, for example distributions of demographic information, monthly discharges and diagnostic information, to help identify gaps and other problematic encounter data. Thirdly, HCFA has hired a contractor that will be involved in working with the plans to assess the quality of the data through medical record reviews and site visits to plans
- HCFA's contractor will conduct targeted medical record reviews, assess data and data systems capabilities, and provide technical assistance to plans to help improve the quality of the data submitted.
- For the start-up year, plans will also have the opportunity to review information on the inpatient encounter data received by HCFA. For example, in early December 1998, plans received a month by month profile of the volume of inpatient encounter data received by HCFA for the 7/1/97 through 6/30/98 period. This profile can be used by plans to assess the completeness of the data submitted and received by HCFA.

V-4. How will you deal with potential "up-coding" by plans to get the best payment rate?

- HCFA has hired a contractor to assess the validity and completeness of the data. The contractor will conduct targeted medical record reviews and conduct site visits. "Up-coding" will be an issue that the contractor will specifically focus on during the comparative analysis of encounter data against the information in the medical records.

V-5. Will the use of the abbreviated data collection instrument be extended?

- We have already extended the use of the abbreviated data collection instrument for hospital encounter data through the end of December 1999. At this point we have no plans to extend the use of the abbreviated data set past December 1999, but no final decisions have been made.

V-6. How will plans with "incomplete data" be assigned risk scores for payment during CY2000?

- Risk scores for beneficiaries enrolled in plans with incomplete data will be assigned using the same methodology that is used for assigning risk scores to beneficiaries in plans with

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complete data. All enrollees who were members of that plan for a full year will be risk adjusted using whatever data have been received from the plan for that period. New Medicare beneficiaries enrolled in any plan will be assigned risk factors based on demographic factors only. Enrollees that were previously receiving care through the fee-for-service sector will be risk adjusted using a combination of data from the fee for service data and managed care encounter data.

- Note that we expect the number of plans with incomplete data to be low, since plans should have had sufficient time to solve any data processing problems they experienced. In any case, we will continue to provide technical assistance to plans to improve data collection efforts.

V-7. Will encounter data be used for purposes other than risk adjustment?

- Encounter data, similar to data from the Medicare fee-for-service sector, can serve multiple purposes. Initially, we will conduct utilization analyses using the inpatient hospital data. For example, we can develop hospitalization rates by age and gender cohorts for managed care, and compare these with rates for the fee-for-service sector, helping to pinpoint inappropriate or insufficient care in both settings.
- As we collect outpatient and physician data, we will be able to conduct other utilization analyses. In addition, such data can be used for quality monitoring and development of benchmarks. When combined with outcomes data, encounter data from the best performing plans can be used to help benchmark best practices.

V-8. How much hospital inpatient encounter data was collected?

- Hospital encounter data were collected from managed care organizations for discharges between July 1, 1997 and June 30, 1998. Approximately 1.2 million encounters were submitted to HCFA by 335 organizations for over 5.3 million beneficiaries. (These numbers exclude data submitted by cost and health care prepayment plans, but include terminating plans.)
- The majority of the data (over 700,000 encounters) were submitted using an abbreviated UB-92 (the standard billing format used by most payers). An additional 500,000 encounters were submitted either directly by hospitals or by plans using the full UB-92.

V-9. Isn't there a risk that the March 1999 estimated APR is inaccurate, given that the data are unaudited and may be potentially incomplete?

- HCFA is making every effort to assure that the March 1999 estimated APR is accurate. By March 1999, plans will have several opportunities to assess the completeness of the

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data, including information on the volume of data submitted by month as well as the distribution of the encounters into the various PIP-DCG groups. This will help plans assess the accuracy of the APR estimate and provide any necessary corrections to HCFA.

- Further, HCFA has hired a contractor to assess the completeness and quality of the data. The contractor will conduct targeted medical record reviews and site visits to assess the integrity of the data collection process and provide technical assistance to plans where data completeness may be a problem.
- The March 1999 estimated APR is only an estimate. For example, plans may modify the estimate provided by HCFA to reflect changes in their enrollee population.

V-10. Will a plan's payment be adjusted if some encounters are submitted after the data collection phase has ended?

- Plans have approximately 3 months after the end of a data collection year to submit the encounter data to their fiscal intermediary. For example, plans must submit encounter data for the period July 1, 1998 through June 30, 1999 to their fiscal intermediary by September 17, 1999. If plans submit encounters after this date, they will not be incorporated into payments for CY 2000.
- However, in response to concerns expressed by plans over this short time frame, HCFA is expecting to institute a reconciliation process that will take into account late data submissions. Plans should attempt to have all data in by the deadline of September 17, 1999. However, if plans receive UB-92s from hospitals after this date, they may submit the encounter to their fiscal intermediary and the data will be processed. After the payment year is completed, HCFA will recalculate risk factors for individuals who have late encounters submitted. Then, we will determine any payment adjustments that are required. This reconciliation will be undertaken after the close of a payment year and will be a one-time only reconciliation for each payment year.
- Additional information on the reconciliation approach will be provided to plans over the next several months.

VI. TRANSITION STRATEGY

VI-1. What is the transition strategy and why was this transition strategy chosen over the other alternatives?

- Many commentors on the September 8, 1998 Federal Register notice on risk adjustment recommended a transition to full implementation of the methodology. There is substantial precedent in the Medicare program for phasing in significant changes in payment

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methodology. In some cases (e.g., the physician fee schedule), phase in of the new payment methodology has been required by statute. In other cases (e.g., the prospective payment system for hospital capital-related costs), the agency has used its discretion to provide for a transition. In general, transitions have served well to introduce major changes in payment methodologies without causing abrupt changes in payment levels that could generate financial problems for providers or disrupt services for beneficiaries.

- We agree with the cementors that a transition to full implementation of risk adjustment would be an appropriate measure for avoiding abrupt changes in payments to M+C organizations. Such a transition could also serve to address concerns about the perceived inadequacy of the inpatient-only model.
- HCFA will provide for a transition to full implementation of risk adjustment, using a blend of payment rates under the current demographic system and the PIP-DCG risk adjustment methodology.

VI - 2. What are the potential financial risks to plans of the transition strategy? Are there limits on a plan's financial risk? What are these limits?

- The transition schedule provides inherent limits on a plan's risk. In the first year, only 10% of payments will be based on risk adjustment. We will continue to monitor the impacts on organizations throughout the transition period.

VI-3. What is the blend schedule?

- The blend percentages for the first year of the transition will be 90 percent of the demographically adjusted rates, and 10 percent of the risk-adjusted payment rate (abbreviated as 90 percent/10 percent) using the PIP-DCG model. Blend percentages for subsequent years are as follows:

2001	70 percent / 30 percent
2002	45 percent / 55 percent
2003	20 percent / 80 percent

We will fully implement the comprehensive model in 2004. Final blend percentages are in the 45 day notice of changes in payment rate methodology, which was published on January 15, 1999.

VI-4. What is the rationale behind a longer transition strategy for the PIP-DCG model than for the comprehensive model?

- The longer transition strategy provides more predictable payments to plans for several

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years. While the PIP-DCG model bases payments on inpatient diagnoses only, the comprehensive risk adjustment model will not present the inadequacies that many perceive in the PIP-DCG model. For example, there will no longer be any issue of encouraging unnecessary hospitalizations under comprehensive risk adjustment. Therefore, we believe that comprehensive risk adjustment can and should be phased in more quickly than the PIP-DCG model.

VII. TIMELINE**VII-1. What is the timeline for the implementation of risk adjustment?**

The implementation of risk adjustment includes several key dates, including the following:

- *January 15, 1999*

The 45 day notice was released on January 15, 1999 and is similar to the 45 day notice published in 1998. This notice describes proposed methodological changes to managed care payments. The notice in 1999 includes the following: the complete PIP-DCG model, including the coefficients and a description of the model; a description of the transition approach to be used in implementing risk adjustment in CY 2000; and a description of the average county risk factor that will be used in the restandardization process for the county rate book.

- *March, 1999*

The final notice will be released on March 1, 1999. This notice must include the final county rates for CY 2000, the rescaling factor for each county, the PIP-DCG model, and other information necessary to ensure that readers are able to recalculate the final county rates.

In addition, each organization will be sent a letter indicating the percentage difference between the organization's payment under risk adjustment and payment under the current system. The letter will also include the distribution of enrollees for an average month by PIP-DCG category and for other demographic factors (e.g., age, gender, Medicaid status, previously disabled, and working aged); and the distribution of PIP-DCG scores for that organization. This information can be used by plans to develop their benefit packages for 2000.

- *September, 1999*

The deadline for receipt of encounter data from the period July 1, 1998 through June 30, 1999 is September 17, 1999. Encounter data received by that date will be used to

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calculate each enrollee's risk factor to be used in payments to organizations for CY 2000. Data received after that time will be used in a reconciliation process that will be undertaken after the close of the payment year.

- *January, 2000*

Beginning January, 2000, on a monthly basis, the organization will be provided with information on each enrollee, including the county of residence, age, gender, Medicaid status and previously disabled status, PIP-DCG score, and payment amount.

VII-2. Does HCFA expect that there may be delays in risk adjustment implementation?

- HCFA is fully prepared to implement risk adjustment in CY2000 as required by the Balanced Budget Act of 1997. A number of steps are planned for implementation. A 45 day notice was published on January 15, 1999 that describes the proposed methodology for risk adjustment implementation. On March 1, 1999, HCFA intends to publish the final notice, which will provide the final county rates for use in CY 2000. On that date, organizations will also be provided with an estimate of their average payment rates under risk adjustment so that they can develop benefit packages for 2000.
- Encounter data from the period July 1, 1998 through June 30, 1999 will be used to calculate risk factors for use in payment in the year 2000. A phase-in period is expected for the PIP-DCGs. We will be implementing a comprehensive risk adjustor, incorporating physician, outpatient, and inpatient encounters no later than CY2004.

VII-3. Why did HCFA delay the collection of outpatient and physician encounter data for another year?

- The collection of inpatient data required plans to modify their data processing systems quickly in order to submit their data in a timely manner. While plans were generally able to accomplish these tasks, we learned from this process that longer lead times are crucial to facilitate the collection of data.
- Our experience with the Medicare Choices Demonstrations suggested that there are many difficulties experienced by organizations in the submission of hospital outpatient and physician data. These problems include data processing problems within each organization, difficulties establishing data linkages with multiple providers and physicians within the organization's network, and developing edit routines to ensure easier processing on HCFA's part.
- In order to solve these problems, longer lead times are required. Thus, we are delaying implementation of hospital outpatient, physician, SNF, and home health data until

January 7, 1999

CY2000.

VIII. BUDGET

VIII-1. Will the implementation of risk adjustment be budget neutral?

- It was not the intention of Congress to implement risk adjustment in a budget neutral way. Risk adjustment is a mechanism to more accurately pay managed care enrollees based on a model which predicts future expenditures for an enrollee based on health status and demographic factors. The current model is based on demographic factors only. Based on the new model, if a managed care enrollee is predicted to have a higher level of expenses, then payments will be higher. Conversely, if predicted expenses are lower, payments will be lower. The rate book under the new risk adjustment methodology will be developed in a budget neutral fashion according to the provisions of the Balanced Budget Act of 1997. The BBA requires that a budget neutral calculation be done to the rate book to ensure that aggregate payments made under the greater of the three provisions (blended rates, 2 percent minimum increase, and floor) be equal to aggregate payments that would have been made if payments were made on the basis of local rates only. This budget neutral calculation is done to the rate book only. Payments to managed care plans can be greater or less than under the current system based on the predicted expenses from the risk adjustment model for each enrollee.

VIII-2. How much does the HCFA expect to save next year and over the next 6 years? Not sure if we should answer this question beyond the first year.

- Given the transition policy that the administration has adopted, we expect the first year savings (FY 2000) to be about \$X.X billion. Over the first six years, projected savings are as follows:

<u>Fiscal Year</u>	<u>Savings (in billions)</u>
2000	\$X.X
2001	X.X
2002	X.X
2003	X.X
2004	X.X
2005	X.X

These estimates are based on the Presidents FY 2000 Budget assumptions.

VIII-3 Aren't plans already being given lower updates because of BBA? Wouldn't the currently scheduled BBA reductions more than compensate for the selection bias?

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- The Balanced Budget Act did reduce the update factors for 1998 to 2002. The cumulative reduction in the update factor over this 5-year period is 2.8 percent. The preliminary impact analysis of implementing the full PIP model indicates that the average reduction is substantially more than 2.8 percent. Hence, the lower updates mandated by the BBA do not more than compensate for the selection bias.

VIII-4. What is the expected cost to a plan of implementing the collection of encounter data?

- While organizations may have experienced some costs in implementing the collection of hospital encounter data, these data are necessary in order to implement a more accurate and fair payment system.
- Other Medicare providers, such as hospitals, home health agencies, and SNFs, are required to provide us with claims data in order to assure more accurate payments. Medicare+Choice organizations are being asked to provide similar kinds of information for the same purpose.
- There are few published sources of information that provide dollar estimates of the cost of collecting encounter data. One study estimated that first year costs to collect diagnosis codes and assign risk scores for a plan with 150,000 enrollees range from \$30,000 for plans that currently collect diagnoses to approximately \$750,000 for a plan that collects demographic data but does not have an encounter data system. Once a system is developed, ongoing costs would be approximately \$30,000 per year. (All these numbers are in 1994 dollars.) (Source: Physician Payment Review Commission, Final Report, Grant Number 93-007, 1994).

IX. EXTERNAL COMMENT/INPUT ON THE POLICY

IX-1 Has the industry been consulted in the process of developing this policy?

- Over the past 15 months, HCFA has met numerous times with the industry and provider representatives on the collection of hospital encounter data and the implementation of risk adjustment. Initially, HCFA met with groups concerning the methodology for collecting hospital encounter data. Based on the input provided by these organizations, a number of changes were made to our proposed approach for collecting these data. For example, because of computer processing system issues faced by these organizations, HCFA designed an abbreviated UB-92 that could be submitted in place of the full UB-92. Initially in place for only the six month period, July, 1997 - December, 1997, the abbreviated format has been extended through CY 1999 because of concerns expressed by organizations over data processing problems.
- The proposed risk adjustment methodology has been discussed with organizations in a

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series of meetings. Throughout 1998, meetings were held that addressed our initial plans for risk adjustment. As the methodology developed, plans were provided with an update.

- A Federal Register notice was published on September 8, 1998, that provided a description of the draft risk adjustment model and the proposed implementation approach. Interested parties were asked to comment on the notice. Over 30 letters were received in response to the notice, including comments from the Association of American Health Plans (AAHP), the American Hospital Association (AHA), Health Insurance Association of America (HIAA), and the American Medical Association (AMA).
- The Federal Register notice asked the industry to provide input on whether payment in CY 2000 should be based on data collected from the previous calendar year (e.g., 1999) or whether it should be based on data from an earlier period (e.g., July, 1998 - June, 1999). Pros and cons of each approach were included in the notice. Most commenters believed that risk adjusted payments in CY 2000 should be based on data from the earlier period (July, 1998 - June, 1999). Based on this input from the industry, HCFA decided to implement risk adjustment in CY 2000 using data from a July to June period, rather than from a calendar year.

IX-2. Has MEDPAC endorsed the implementation of risk adjustment?

- Yes - MEDPAC has recommended the implementation of risk adjustment and has generally endorsed moving to the PIP-DCG model as an interim step towards comprehensive risk adjustment.
- In 1997 both the Physician Payment Review Commission and the Prospective Payment Assessment Commission endorsed risk adjustment of Medicare capitation payments to managed care plans. Both commissions recommended that Medicare adopt risk-adjusted capitation rates based on health status, and that plans be required to report new data to HCFA to calculate those rates. These commissions were merged to form the Medicare Payment Advisory Commission (MedPAC) in 1998. MedPAC's March 31, 1998 Report to the Congress recommended "an orderly phase-in for all components of the risk adjustment system." During the phase-in, the Commission believes that "changes in plan payment rates should be limited to protect plans and the beneficiaries they serve from sharp swings in payment." At that time, the Commission identified blending of the risk-adjusted and demographic rates, and setting some limit on the maximum payment change that an organization could experience in one year, as possible transition methodologies. The Commission has not formally endorsed a specific transition methodology.

IX-3. What other external entities have endorsed the risk adjustment model?

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- The BBA requires a March 1, 1999 Report to Congress, and an independent, external actuarial review. To meet this requirement, HCFA arranged for a panel of experts under the aegis of the American Academy of Actuaries to review and comment on both the risk adjustment model and its application to the Medicare+Choice program. We anticipate their review will be included as part of the Report to Congress.

IX-4. Do other large organizations use risk adjustment for payment purposes?

- A number of capitated programs that originally applied demographics-only risk factors are now moving towards more sophisticated diagnoses-based models, such as variants of the DCGs and the Hopkins ACG models. Examples include the Washington Health Care Authority, the Minneapolis Buyers Health Care Action Group, and the Maryland HealthChoice Medicaid programs that are implementing variants of comprehensive risk adjustment models.
- For these programs, their rationale for this change is the same as for Medicare: demographic-only adjusters are inadequate, and diagnostic-based models offer a significant improvement in accuracy.

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FACT SHEET

Implementation of Risk Adjustment

I. Background

Section 1853(a)(3) of the Balanced Budget Act of 1997 (BBA) requires the Secretary to develop and implement a new risk adjustment methodology to be used to adjust the county-wide rates under section 1853 of the Act to reflect the expected relative health status of each enrollee. This new methodology, which must be implemented by January 1, 2000, will replace the current method of adjusting county-wide rates based on demographic factors only.

The BBA also requires the Secretary to collect inpatient encounter data for discharges on or after July 1, 1997 for use in a risk adjustment model. Because the legislation does not allow for the collection of any data other than inpatient data in the near term, HCFA is constrained initially to using a model that requires inpatient only data.

II. Description of the model

The Principal Inpatient Diagnostic Cost Group (PIP-DCG) model is the only risk adjuster model that has been developed to run solely on inpatient data. HCFA intends to implement this model in CY2000.

The model predicts total expected costs for the following year across all sites of Medicare services. The final PIP-DCG methodology places beneficiaries in one of 15 cost groupings. In addition, the originally disabled variable and the Medicaid eligible variable are added interactively with any age/sex cell.

Most beneficiaries (88 percent) will be placed in the "base" group, where payments are determined mostly by demographic characteristics. Beneficiaries with certain inpatient diagnoses (12 percent) will be placed in one of the disease groupings which trigger increased payments.

Predicted expenditures for an enrollee from the PIP-DCG model will be converted to an index (predicted expenditures relative to the mean) for the purposes of implementation. Data from multiple plans and/or fee-for-service will be integrated

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as appropriate for each individual. This beneficiary specific risk score follows the beneficiary as he/she moves between plans.

A new model was estimated for beneficiaries for whom no Medicare diagnostic data are available (ie., new 65 year olds and newly Medicare disabled). Predicted cost estimates were derived for these beneficiaries using only demographic factors. These predicted cost estimates were compared to the mean expenditures to determine an index for a particular set of demographics. In effect, an average risk score has been imputed for each demographic group for which diagnostic data is unavailable.

A re-scaling factor is applied to address inconsistencies between demographic factors used in the current rate book and the factors used in risk adjustment. The re-scaling factor translates the current rate book amounts to the same language (or "scale") used under the risk adjustment methodology.

While the model was originally calibrated assuming no time lag between the data collection period (e.g., CY 1999) and the predicted payment year (e.g., CY 2000) we are implementing the PIP-DCG model using data from an earlier period. That is, we will use data from the period July 1, 1998 through June 30, 1999 as the basis for calculating the risk factor for each enrollee for CY 2000.

HCFA will institute a reconciliation process for plans that have hospital encounter data that were not submitted to HCFA within the 3 month time period after the data collection year. This reconciliation will be undertaken after the close of the payment year.

III. Timeline

On January 15, 1999, the 45 day notice will be released. The notice will include the complete PIP-DCG model, including the coefficients and a description of the model and the proposed implementation approach. The notice will also include a description of the transition approach and the average county risk factor that will be used in the restandardization process for the rate book.

On March 1, 1999, a Report to Congress on the final risk adjustment methodology is due. On that same date, the final notice will be released, which will include the

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county rates for CY 2000, the rescaling factor for each county, the PIP-DCG model, and other information necessary to recalculate the final county rates.

In addition, on March 1, 1999, each organization will receive a letter indicating the percentage difference between the organization's payment under risk adjustment and payment under the current system. The letter will also include other descriptive information concerning the PIP-DCG scores for that organization.

Beginning January, 2000, on a monthly basis, the organization will be provided with information on each enrollee, including the beneficiary identification number, county of residence, PIP-DCG score, and payment amount.

IV. Transition Strategy

We are proposing a transition to risk adjustment. Transitions serve as an effective method for introducing major changes in payment methodologies without causing abrupt changes in payment levels that could generate financial problems for Medicare+Choice organizations or disrupt services for Medicare beneficiaries.

HCFA intends to implement a comprehensive risk adjustor within the next several years that uses inpatient, hospital outpatient, and physician encounters in determining risk scores for enrollees. We are implementing a hospital-based only model as part of the transition to a comprehensive risk adjustment methodology.

HCFA will transition using a blend approach. In CY2000, we are proposing a 10/90 blend. That is, payments will be based 10% on the risk adjusted payment methodology and 90% on the current methodology. We are also proposing a five-year transition, culminating in full implementation of risk adjustment using all encounter data in the fifth year. The proposed transition schedule is as follows:

CY 2000	90 percent demographic method	10 percent PIP-DCG method
CY 2001	70 percent demographic method	30 percent PIP-DCG method
CY 2002	45 percent demographic method	55 percent PIP-DCG method
CY 2003	20 percent demographic method	80 percent PIP-DCG method
CY 2004	100 percent comprehensive risk adjustment	

V. Long Term Care Demonstrations

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We expect to delay the implementation of risk adjustment for four demonstration projects. These projects are the Social Health Maintenance Organization (HMO) Demonstration, the Program of All-Inclusive Care for the Elderly (PACE), EverCare, and the Minnesota Senior Care Project. Because of the unique features of these specific demonstration projects, we are considering refinements to risk-adjusted payment methodology for them. We expect to maintain the present payment approaches in year 2000 for these demonstrations.

**United States Senate
COMMITTEE ON THE BUDGET**

Republican Staff

621 Dirksen Senate Office Building, Washington, D.C. 20510

Pete V. Domenici, Chairman

Frank R. Lautenberg, Ranking Minority Member

FAX COVER SHEET

Fax Number (202)224-1446

Sending To: Chris Jennings

Fax Number: 456-5557

Date: January 15, 1999

From: G. William Hoagland

3 page(s) (including this cover sheet)

Call (202) 224-6988 if you have any questions

Comments: Please find attached a letter from Chairman Domenici sent to President Clinton regarding HCFA risk adjustment regulations.

This message is intended only for the use of the individual or entity to which it is addressed, and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering this message to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify the Committee immediately (202/224-6988) and return the original message to the Committee at 621 Dirksen Senate Office Building, Washington, D.C. 20510 via United States Post Office.

PETE V. DOMENICI,

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United States Senate

COMMITTEE ON THE BUDGET

WASHINGTON, DC 20510-6100

G. WILLIAM HOAGLAND, STAFF DIRECTOR
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<http://www.senate.gov/committees/budget.html>

January 12, 1999

The President
The White House
Washington, D.C. 20500

Dear Mr. President:

I am writing to urge your Administration to defer implementation of the risk adjustment system for the Medicare+Choice program so that Congress and the Health Care Financing Administration (HCFA) can work together on a bipartisan plan to ensure choice, fairness, and a level playing field for Medicare beneficiaries and the health plans that serve them.

As you know, in the last year, nearly 100 health plans have dropped out of the Medicare program. These plans served approximately 500,000 senior citizens. Now, the HCFA is moving ahead with a risk adjustment system, using a dubious methodology, that will arbitrarily cut payment rates for many health plans. I believe implementation of this system could drive scores of health plans out of Medicare+Choice, leaving our senior citizens with less comprehensive coverage and choice.

When the Balanced Budget Act of 1997 was negotiated, it was assumed the risk adjustment system would be budget neutral, not a device to cut payments to health plans and derail Medicare+Choice. Further, this decision cannot be made in isolation of other Medicare changes being debated in Congress this Spring.

I believe it would be extremely shortsighted for HCFA to move ahead with these risk adjustment regulations this week at a time when both Congress and the National Commission on the Future of Medicare are looking for ways to make choice and competition central features of a reformed Medicare system that is solvent well into the next century. I further hope that your Administration will work with me and other Senators who want to address these issues on a bipartisan basis.

Sincerely,



Pete V. Domenici
United States Senator

16:16:16
*Verarah***DRAFT MEDICARE RISK ADJUSTMENT ROLLOUT**

Necessary paper (provided by Press Office):

- Fact sheet
- News release
- Questions and Answers
- Talking points

1/14

- Midafternoon, possible early alert for MedPAC by Bob Berenson/Barbara Cooper/Kathy Buto:

Gail Wilensky, MedPAC
Joe Newhouse, MedPAC

- Midafternoon, Press Office will notify the media regarding the Friday 10:30 press briefing (see below).
- 3:00-4:30 -- Briefing of Majority and Minority Staff (Ways & Means, Finance, Commerce) and staff from CBO, GAO, CRS, and Medpac. LEAD: Peter Hickman/HCFA OL. Presenters include Bob Berenson and Barbara Cooper.
- Late in the day -- CHPP to notify trade associations of Friday briefing (see below)
- Additional calls to interested parties by Bob Berenson/Barbara Cooper/Kathy Buto:

Bob Riechauer, Brookings Inst. (202) 797-6956
Uwe Reinhardt, Princeton U.
Karen Davis, Commonwealth Fund (215) 535-0400
Marilyn Moon, Urban Institute (202) 261-5691
Hal Luft, UCSF, Center for Studying Health System Change
(415) 476-5147; (415) 476-0705

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- 10:00-10:30 -- Press Briefing in the OA conference room. Brief introduction by Mike Hash with Bob Berenson and staff going into greater technical detail. Followed up by q/a session. LEAD: Chris Peacock
- Press Office to distribute news release and fact sheet to the press at the meeting, and provide internal q/a's and talking points for staff use.
- Late in the day -- CHPP and OSP meet or have conference call with 3 major trade

associations (AAHP, HIAA, and Blue Cross). Associations will also be offered followup briefings for their member plans the week of 1/19. LEAD: Bob Berenson

Weeks of 1/19 or 1/25

- Separate briefing for Legislative Assistants from personal staff of each of the members of the Authorizing Committees (committee staff to arrange). LEAD: HCFA OL.
- Separate briefing for House and Senate Dems -- LEAD: HCFA OL
- Potential briefing for member plans of industry associations (AAHP, HIAA, BCBSA). LEAD: Bob Berenson.
- Potential briefings for other interested parties (AMA, AHA, nursing homes, beneficiary groups, independent researchers). HCFA Participants to include CHPP, OSP, CBS.

**DRAFT**

Medicare+Choice Initiatives

Risk adjustment is merely one aspect of an overall HHS initiative to manage Medicare+Choice effectively so that beneficiaries have as many choices of quality care as possible -- because health care providers are paid fairly, and taxpayers pay appropriately and to promote stability in the Medicare managed care market.

Help HMOs adjust to requirements of the new law.

- Risk adjustment transition. Risk adjustment will be implemented, as mandated in the Balanced Budget Act. However, HCFA will provide a transition to make it easier for HMOs to adjust to this new system.
- Reducing administrative burdens -- The Secretary has asked that HCFA take steps as quickly as possible to help ease the administrative burden of participating in M+C. Therefore HCFA is working on a regulation that will address issues which were included in the interim final rule published last summer but which require clarification and are time sensitive. HCFA is considering modifying provider participation rules which must be followed by health plans; clarifying the provider appeals process; and clarifying elements of the quality improvement program.

Help beneficiaries learn more about their options.

- 1-800-MEDICARE. HCFA had initially planned to phase in this new toll-free service across the country through August 1999. Based on experience with the number in five pilot states, HCFA now expects to make the number available to all beneficiaries this spring. [Is this ahead of schedule? Wasn't the initial plan to have it available earlier, then scaled back in consultation with Chairman Thomas?]
- CAHPS and HEDIS. HCFA will make these satisfaction and quality indicators -- based on a survey of beneficiaries and quality information on managed care plans -- available on Medicare.gov by February 1.

Help protect beneficiaries.

- The President's Budget will include Medigap and other reforms to protect beneficiaries. These proposals build on the strong Administration initiatives that were enacted in the BBA. The President's Budget include the following protections.
 - Initial open enrollment for beneficiaries who are eligible for Medicare because they are disabled or have End Stage Renal Disease. Enactment of this proposal would assure Medigap access in all states for disabled and ESRD beneficiaries both upon initial eligibility for Medicare and also in the case of Medicare+Choice plan termination.
 - Special, one-time open enrollment period to allow beneficiaries who were left without a plan option to purchase Medigap coverage.
 - Expand the choice of Medigap plans available during special enrollment periods.
 - Ban the use of attained age rating. -- Medigap premiums could not increase as a person ages.
 - Increase fines for Medigap insurers that violate open enrollment protections.

6 Uvurah**INTERNAL***Jan. 14, 1998 at 12:30pm***Medicare+Choice Initiatives**

Risk adjustment is merely one aspect of an overall HHS initiative to manage Medicare+Choice (M+C) effectively so that the Medicare managed care market is stable. HCFA is committed to ensuring that beneficiaries have as many choices of quality care as possible by working towards a system that pays health care providers fairly and by providing as much protection and information to beneficiaries as possible.

Help HMOs adjust to requirements of the new law.

- Risk adjustment transition. Risk adjustment will be implemented, as mandated in the Balanced Budget Act. However, HCFA will provide a transition to make it easier for HMOs to adjust to this new system.
- Reducing administrative burdens. The Secretary has asked that HCFA take steps, as quickly as possible, to help ease the administrative burden of participating in M+C. Therefore, HCFA is working towards the release of a regulation that will address administrative issues that require clarification and are time sensitive. HCFA is considering modifying the provider participation rules that must be followed by health plans; clarifying the provider appeals process; and clarifying elements of the quality improvement program. By focusing on these issues first in our regulatory process, HCFA hopes to increase market stability by easing unnecessary administrative burdens on plans.

Help beneficiaries learn more about their options.

- 1-800-MEDICAR[E]. This toll free line was available only in the five pilot states beginning in November. We expect the 1-800-MEDICAR[E] will be available to all beneficiaries in the Spring of 1999. Originally, we expected that full implementation would occur in August, 1999.
- CAHPS and HEDIS. By February 1, HCFA will release CAHPS and HEDIS information that will provide comparative quality and satisfaction information to Medicare beneficiaries to help them make more informed choices among health plans. This is the largest release of comparable nationwide plan comparison information for CAHPS and HEDIS.

Help protect beneficiaries.

- The President's Budget will include Medigap and other reforms to protect beneficiaries. These proposals build on the strong Administration initiatives that were enacted in the BBA. The President's Budget includes the following protections:
 - Initial open enrollment for beneficiaries who are eligible for Medicare because they are disabled or have End Stage Renal Disease. Enactment of this proposal would assure Medigap access in all states for disabled and ESRD beneficiaries both upon initial eligibility for Medicare and also in the case of Medicare+Choice plan termination.
 - Special, one-time open enrollment period to allow beneficiaries who were left without a plan option to purchase Medigap coverage.

DRAFT No. 1 -- January 8, 1999FOR IMMEDIATE RELEASE
January, XX, 1999Contact: HCFA Press Office
(202) 690-6145**MEDICARE MANAGED CARE RISK ADJUSTMENT METHOD ANNOUNCED**

HHS Secretary Donna E. Shalala announced today that HCFA will be implementing a new payment method that will reward Medicare managed care plans that enroll ~~sicker~~ *the sickest* beneficiaries.

Required by the Balanced Budget Act of 1997, the new payment method -- known as risk adjustment -- will reflect for the first time the health status of Medicare beneficiaries. The new approach will increase payments to plans that care for sicker beneficiaries who stand to gain the most from managed care's focus on coordinating care. Medicare currently pays health maintenance organizations (HMOs) and other managed care plans one fixed amount per beneficiary, regardless of their health status.

"There is widespread agreement among health care experts that risk-adjusted payments will level the playing field among Medicare managed care plans and reduce incentives for plans to enroll only healthier beneficiaries," Secretary Shalala said. "But we want to be sure that as we move to this new payment system, we do our utmost to provide a stable market place for HMOs and adequate protections for our Medicare beneficiaries who chose managed care plans. I believe HCFA's phased-in approach will do that."

msg to leave [The phased in move to risk adjustment ~~will~~ *will* also save taxpayers \$11.2 billion over five years. A number of studies have shown that managed care plans participating in Medicare have tended to attract healthier beneficiaries, leaving the sickest in traditional fee for service Medicare, which has an open-ended payment system. The Physician Payment Review Commission -- now known as the Medicare Payment Advisory Commission -- in a 1997 report to Congress estimated that Medicare overpaid plans by up to \$2 billion a year because the actual health status of managed care enrollees was not accounted for.] *savings to HMOs*

Risk adjustment looks at a person's diagnosis in one year and predicts how much, if any, additional cost there will be for that person the next year. For example, if a person has appendicitis, there are no additional costs predicted for the next year. If a person has a stroke, however, additional costs are predicted and a plan would receive a larger payment to cover the additional expected costs.

As required by law, risk-adjusted payments to plans will begin Jan. 1, 2000, but to ensure that plans have time to adjust to the new payment method, HCFA has decided to use a five-year transition period. In 2000, only 10 percent of a plan's payments will be calculated based on risk adjustment, while 90 percent of payments will be based on the current system. *Risk adjustment will be fully phased in between 2000 and 2005.*

"Introducing risk adjustment into Medicare managed care is an important step in making sure beneficiaries have access to the care they need and that Medicare pays plans fairly," HCFA Administrator Nancy-Ann DeParle said. "We are taking a careful and balanced approach to risk adjustment, and we will closely monitor the impact on both beneficiaries and plans."

add gpa on geographic disparity

Of Medicare's 38 million beneficiaries, six million are in managed care and 32 million are in traditional Medicare. On average 60,000 to 70,000 Medicare beneficiaries enroll in managed care plans every month.

Using a transition significantly lessens the financial impact of risk adjustment on plans. Without a transition average payment reductions to plans would have been 7 percent this year. With a transition, the average reduction is now less than 1 percent in the first year.

Currently, Medicare pays health plans a fixed monthly payment for each beneficiary based largely on fee-for-service Medicare costs in each of the nation's 3,223 counties. The payments are adjusted by demographic factors such as age, sex, whether a beneficiary is institutionalized and whether he or she is eligible for Medicaid in an attempt to better reflect the likely future costs of caring for individual beneficiaries. Risk adjustment adds diagnostic information to the payment calculation and significantly improves the accuracy of predicting expected costs.

The best risk-adjustment models, to date, use encounter data -- information about the kind of care provided to individual beneficiaries -- to determine diagnoses. The Balanced Budget Act requires HCFA to risk-adjust payments in 2000 and gave the agency the authority to collect encounter data, but limited HCFA to collect only hospital inpatient encounter data in the first year. Therefore, the risk-adjustment model HCFA is using for 2000 -- known as the Principal Inpatient Diagnostic Cost Group (PIP/DCG) -- is based on inpatient hospital diagnoses.

The risk-adjustment model groups hospital inpatient diagnoses into categories according to total predicted costs of each diagnosis in the next year. Although the model uses hospital information to determine a diagnosis, it uses all Medicare costs to determine additional payments.

In any given year, approximately 20 percent of all Medicare beneficiaries are hospitalized. The HCFA model excludes about 40 percent of these admissions from consideration for increased payments by removing diagnoses, such as appendicitis, that have no expected additional costs in the following year. Based on the advice of an expert clinical panel, HCFA is also excluding one-day hospital stays and discretionary admissions, such as those for iron-deficiency anemia. Excluding these types of diagnoses for increased payments will help improve the integrity of the system.

The remaining 60 percent of admissions, accounting for about 30 percent of all Medicare spending the following year, is classified into 15 different cost categories. If a beneficiary is included in one of these categories, the health plan will receive an additional payment for that beneficiary. Each of the demographic factors -- age, sex, Medicaid status, and whether someone was previously disabled -- have payment amounts associated with them and are added as well. The information is converted to an index, and every Medicare beneficiary will have a score used to calculate the monthly payment to his or her plan.

#

ROBERT DONNELLY

12/23/98 06:17:26 PM

Record Type: Record

To: Daniel N. Mendelson/OMB/EOP, Christopher C. Jennings/OPD/EOP, Jeanne Lambrew/OPD/EOP
cc: Mark E. Miller/OMB/EOP, Barry T. Clendenin/OMB/EOP, Gaylee L. Morgan/OMB/EOP
Subject: Risk adjustment transition follow-up

Our conference call with HCFA produced very little progress. We expect them to call Dan and Chris soon to discuss this issue further.

We had particular trouble on three items:

1. Incorporating outpatient data in the system ASAP: HCFA was resistant to the idea of portraying the phase-in as "we expect that we'll be ready to pay based on outpatient data by 2004, but we'll start earlier if possible." They believe strongly that they will not be able to implement a risk adjustment system based on inpatient and outpatient data before 2004, and so they are skittish about promising anything more.

2. 5-year phase-in: They are afraid that the five-year schedule will require year-to-year cuts that are too deep to sustain.

3. Portraying the phase-in as a \$10 billion gift to the industry: We explained that we need to include the amount of foregone savings in the Q and A's so that you can make the rhetorical point that the plans should stop complaining, because we are giving them billions of dollars. Jane Horvath and Kathy King opposed this approach, saying that the plans will see any risk adjustment savings as an unwarranted cut (as opposed to seeing the phase-in as a help).

Other items:

First year: HCFA informed us that the blend needed to hit the assumed budget savings in the first year is 90% old (current payment system)/ 10% new (inpatient-only risk adjustment). Since this is consistent with the guidance (i.e., a blend is acceptable and it should match the budget assumption) from our meeting with you, we advised them to begin work on the 45-day notice so that it can be ready by January 15th.

What to include in the 45-day notice: HCFA will include only the first year phase-in information in the 45-day notice. Further information about the blend will be included in Q and A-type documents.

Talking to the industry: They are clear that they are not to tell the industry anything about the transition prior to the 45-day notice. Mike Hash mentioned that the trade press has surmized that a phase-in is likely. We said that you are aware of that, but that they still cannot talk to the industry.

Review of Q and A information: We were clear that you expect to review Q and A's (and fact sheets, etc.) when they are prepared.



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January, XX, 1999

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MEDICARE MANAGED CARE RISK ADJUSTMENT METHOD ANNOUNCED

Health and Human Services Secretary Donna E. Shalala announced today that HCFA will begin implementing, on a phased in basis, a more accurate payment method that will assist Medicare managed care plans that enroll the sickest beneficiaries.

Required by the Balanced Budget Act of 1997, the new payment method -- known as risk adjustment -- will for the first time begin to reflect the health status of Medicare beneficiaries. The new approach, which has a transition period, will increase payments to plans that care for the sickest beneficiaries who stand to gain the most from managed care's focus on coordinating care. Medicare currently pays health maintenance organizations (HMOs) and other managed care plans a fixed monthly amount per beneficiary, adjusted only by demographic factors.

HCFA also announced a preliminary estimate of the average payment increase -- X.X percent -- scheduled for Medicare managed care plans in 2000. The increase is also mandated by the Balanced Budget Act of 1997.

"There is widespread agreement among health care experts that risk-adjusted payments will pay plans more fairly and reduce incentives for plans to enroll only healthier beneficiaries," Secretary Shalala said. "But we want to be sure that as we move to this new payment system, we do our utmost to provide a stable marketplace for HMOs to protect our Medicare beneficiaries who choose managed care plans. I believe HCFA's phased-in approach will do that."

The phased-in risk adjustment methodology will also save taxpayers \$11.2 billion over five years. A number of studies have shown that managed care plans participating in Medicare have tended to attract healthier beneficiaries, leaving the sickest in traditional fee-for-service Medicare. The Physician Payment Review Commission -- a predecessor of the Medicare Payment Advisory Commission -- estimated in a 1997 report to Congress that Medicare overpaid plans by up to \$2 billion a year because the current payment system doesn't reflect beneficiary's health status.

Risk adjustment looks at a person's diagnosis in one year and predicts how much, if any, additional cost there will be for that person the next year. For example, a person who has appendicitis in one year is not expected to have higher than average costs the following year. If a person has a stroke, however, additional costs beyond the average are predicted and a plan would receive a larger payment to cover the additional expected costs.

As required by law, risk-adjusted payments to plans will begin Jan. 1, 2000. However, to ensure that plans have time to adjust to the new payment method, HCFA built a five-year transition period into the risk adjustment methodology it adopted. In 2000, only 10 percent of a plan's payment for each beneficiary will be calculated based on the new risk adjusters, while 90 percent of the payment for each beneficiary will be based on the current system. The full effects of risk adjustment will be fully phased in between 2000 and 2004.

"Introducing risk adjustment into Medicare managed care is an important step in making

sure beneficiaries have access to the care they need and that Medicare pays plans fairly," HCFA Administrator Nancy-Ann DeParle said. "We are taking a careful and balanced approach to risk adjustment, and we will closely monitor the impact on both beneficiaries and plans."

Of Medicare's 39 million beneficiaries, over six million are in managed care and over 32 million are in traditional Medicare. On average 60,000 to 70,000 Medicare beneficiaries enroll in managed care plans every month.

The transition component of HCFA's risk adjustment methodology significantly lessens the financial impact of risk adjustment on plans. If no transition period were included in HCFA's risk adjustment methodology, aggregate payment reductions to plans would have been an estimated 7 percent this year. With a transition, the aggregate reduction is now less than 1 percent in the first year.

Currently, Medicare pays health plans a fixed monthly payment for each beneficiary based largely on fee-for-service Medicare costs in each of the nation's over 3,000 counties. The payments are adjusted by demographic factors such as age, sex, and whether a beneficiary is eligible for Medicaid in an attempt to better reflect the likely future costs of caring for individual beneficiaries. Risk adjustment adds diagnostic information to the payment calculation and significantly improves the accuracy of predicting expected costs.

The best risk-adjustment models, to date, use encounter data -- information about the kind of care provided to individual beneficiaries in encounters with the health system -- to determine diagnoses. The Balanced Budget Act required HCFA to risk-adjust payments to health plans in 2000. It gave the agency the authority to collect encounter data, but limited its authority to collect only hospital inpatient encounter data in the first year of collection. As a result, the risk-adjustment model HCFA is using for 2000 -- known as the Principal Inpatient Diagnostic Cost Group (PIP/DCG) -- is based on inpatient hospital diagnoses. The risk-adjustment model groups hospital inpatient diagnoses into categories according to total predicted costs of each diagnosis in the next year. Although the model uses hospital information to determine a diagnosis, it uses Medicare costs for all services to determine the amount of additional payments to plans.

In any given year, approximately 20 percent of all Medicare beneficiaries are hospitalized. The HCFA model excludes about 40 percent of these admissions from consideration for increased payments by removing diagnoses, such as appendicitis, that have no expected additional costs in the following year. Although HCFA expects plans and hospitals to submit accurate data, the agency is taking a number of steps to ensure the integrity of the system. Based on the advice of an expert clinical panel, HCFA is excluding admissions that are rarely the principal reason for inpatient hospital care or that are vague or ambiguous. One-day hospital stays are also being excluded to reduce the incentive to increase marginal admissions.

The remaining 60 percent of admissions, predicted to account for about 30 percent of all Medicare spending the following year, is classified into 15 different cost categories. If a beneficiary is included in one of these categories, the health plan will receive an additional payment for that beneficiary.

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**Medicare Managed Care Risk Adjustment
Press Questions and Answers
For Internal Use Only
DRAFT 1/14/99 10:52 AM**

Q. Why is HCFA risk adjusting payments to Medicare managed care plans?

- A. Risk adjustment is required by the Balanced Budget Act of 1997 and will assist plans that enroll the sickest beneficiaries and reduce incentives for plans to enroll only healthier beneficiaries. Under risk adjustment, payments to plans for the first time will reflect the health status of Medicare beneficiaries, increasing payments made to plans on behalf of the sickest beneficiaries they enroll.

There is widespread agreement among health care experts that risk-adjusted payments will pay plans more accurately and reduce incentives for plans to enroll only healthier beneficiaries. There is also considerable evidence that Medicare has overpaid managed care plans in part because payments are not now adjusted for health status and because plans tend to attract healthier beneficiaries. The Physician Payment Review Commission -- a predecessor of the Medicare Payment Advisory Commission -- estimated in a 1997 report to Congress that Medicare overpaid plans by up to \$2 billion a year.

Q. Won't risk adjustment hurt plans and decrease their payments?

- A. Introducing risk adjustment into Medicare managed care is an important step in making sure beneficiaries have access to the care they need and that Medicare pays plans fairly. We are taking a careful and balanced approach to risk adjustment, which for the first time will reduce incentives for plans to enroll only healthier beneficiaries. We will also closely monitor the impact of risk adjustment on both beneficiaries and plans.

To ensure that plans have time to adjust to the new payment method, HCFA has incorporated a five-year transition period into the risk adjustment methodology. In 2000, only 10 percent of a plan's payment for each beneficiary will be calculated based on the new risk adjusters, while 90 percent of the payment for each beneficiary will be based on the current system. This will significantly reduce the impact on HMOs. If no transition period were built into the risk adjustment methodology, aggregate payment reductions to plans would have been 7 percent in 2000. With a transition, the aggregate reduction is now less than 1 percent in 2000 and risk-adjustment savings are expected to be \$11.2 billion over five years -- \$4.5 billion less than if no transition were used.

Background: In CY 2001, payments will be based 30 percent on risk adjustment and 70 percent on the current system; in CY 2002, 55 percent risk adjustment, 45 percent current system; in CY 2003, 80 percent risk adjusted, 20 percent current system. In CY 2004, we will use a comprehensive risk adjuster that includes inpatient, outpatient and physician encounter data.

Q. Why is HCFA using only hospital encounter data?

- A. The Balanced Budget Act restricted collection of encounter data -- information about the kind of care provided to beneficiaries -- to hospital inpatient services in the first year of collection. We will soon begin collecting encounter data from other care settings, including hospital outpatient and physician encounter data. By Calendar Year (CY) 2004, HCFA intends to implement a comprehensive risk adjuster that uses inpatient, outpatient and physician encounters to adjust payments to plans based on beneficiaries' health status.

Q. Won't using only hospital encounter data provide a perverse incentive for plans to hospitalize beneficiaries needlessly to increase their payments?

- A. No. It would be very difficult, if not impossible, for plans to implement a medical management program that differentiates among certain patients. To manipulate the risk adjustment model, a plan would have to identify patients who have not been hospitalized this year and try to get them hospitalized for a condition that normally would be treated on an outpatient basis.

Also, there is no guarantee that a beneficiary who is hospitalized will be enrolled with the same plan the following year. The plan must then take the risk of paying for the direct costs associated with an unnecessary hospitalization while having no guarantee that the beneficiary will be in the plan the following year.

Additionally, one-day stays are included in the base payment category so the unnecessary hospitalization has to occur for at least two days, thereby increasing direct costs even more. Also, only the most serious admissions are used in the risk-adjustment model, and other discretionary inpatient stays do not increase payments.

Q. Won't requiring plans to submit all this data and information increase the administrative burden on plans and increase their costs?

- A. Other Medicare providers, such as hospitals, home health agencies, and skilled-nursing facilities are required to provide us with information to ensure they receive accurate payments. Medicare+Choice organizations are being asked to provide similar kinds of information for the same purpose. The information we are requiring from plans is needed to ensure that Medicare pays plans fairly and accurately.

Q. How will risk adjustment work?

- A. Currently, Medicare pays health plans a fixed monthly payment for each beneficiary based largely on fee-for-service Medicare costs in each of the nation's over 3,000 counties. The payments are adjusted by demographic factors such as age, sex and whether

he or she is eligible for Medicaid in an attempt to better reflect the likely future costs of caring for individual beneficiaries. Risk adjustment adds diagnostic information to the payment calculation and significantly improves the accuracy of predicting expected costs.

In any given year, approximately 20 percent of all Medicare beneficiaries are hospitalized. The HCFA model excludes about 40 percent of these admissions from consideration for increased payments by removing diagnoses, such as appendicitis, that have no expected additional costs in the following year. Although HCFA expects plans and hospitals to submit accurate data, the agency is taking a number of steps to ensure the integrity of the system. Based on the advice of an expert clinical panel, HCFA is excluding admissions that are rarely the principal reason for inpatient hospital care or that are vague or ambiguous. One-day hospital stays are also being excluded to reduce the incentive to increase marginal admissions.

The remaining 60 percent of admissions are classified into 15 different cost categories. Beneficiaries in these categories typically account for about 30 percent of all Medicare spending the following year. If a beneficiary is included in one of these categories, the health plan will receive an additional payment for that beneficiary. Each of the demographic factors -- age, sex, Medicaid status, and whether someone was previously disabled -- have payment amounts associated with them and are added as well. The information is converted to an index, and every Medicare beneficiary will have a score used to calculate his or her plan's monthly payment. For example, HCFA would pay \$6,414 for an 85-year-old man, another \$2,060 if he were on Medicaid, another \$1,207 if he was originally disabled, and \$26,464 more if he were admitted to the hospital with AIDS -- a total of \$36,145.

- Q. The plans contend that the switch to risk adjustment is supposed to be budget neutral. Isn't HCFA pulling a fast one here because there are \$11.2 billion in savings predicted over five years?**
- A. There has never been any question that risk adjustment would result in savings to Medicare because we've known for a long time that Medicare has overpaid managed care plans in part because payments are not now adjusted for health status and because plans tend to attract healthier than average beneficiaries. The Physician Payment Review Commission -- a predecessor of the Medicare Payment Advisory Commission -- estimated in a 1997 report to Congress that Medicare overpaid plans by up to \$2 billion a year. To help foster a stable marketplace, HCFA has chosen to incorporate a transition period into its methodology, significantly lessening the financial impact on plans. With the transition period built into the risk adjustment methodology, risk-adjustment savings are expected to be \$11.2 billion over five years -- \$4.5 billion less than if the methodology did not include a transition period. Under HCFA's methodology, the aggregate reduction is less than 1 percent in 2000.
- Q. What is the preliminary estimated annual payment update for Medicare+Choice plans in 2000 and how is the annual update calculated?**

A. HCFA has estimated that average payment increase scheduled for Medicare+Choice plans in 2000 will be X.X percent. The annual update is based on the projected national average per capita growth percentage in Medicare expenditures for the year that payment rates will go into effect. The Balanced Budget Act of 1997, which defined this update, also provides for an adjustment to the overall growth percentage of -0.5 percent for the year 2000 update. In addition, the Balanced Budget Act provides for adjustments for prior year overestimates or underestimates of the national growth percentages. For 2000, this adjustment for prior years is minimal. The annual update is based on projected expenditures for the Medicare program that are included in the President's FY 2000 Budget.

Q. Why isn't plan-specific information available about the impact of risk adjustment?

A. The information we have now is preliminary and we are finalizing our analyses. We will provide plan-specific information by March 1. Each plan will receive a letter indicating the percentage difference between the plan's payment under risk adjustment and under the current system. Plans with sicker than average beneficiaries will see an increase in payments while plans with healthier than average beneficiaries will see a slight reduction in payments.



Briefing Note

RISK ADJUSTMENT AND MEDICARE

June 1999

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Most experts concur that the existing Medicare risk adjustment system used to reimburse managed care plans for providing care to beneficiaries should be revamped. In fact, Congress already mandated changes to the risk adjustment process as part of the 1997 Balanced Budget Act, and the Health Care Financing Administration plans to implement a new risk adjustment method beginning in 2000.

Even those changes, however, will not be sufficient to bring payments to managed care plans more in line with the actual cost of treatment, according to a new study. In *Risk Adjustment and Medicare*, by Joseph P. Newhouse, Melinda Beeuwkes Buntin, and John D. Chapman of Harvard University, the authors build on proposals put forth in their 1997 Commonwealth Fund report on risk adjustment. Primarily, they call for combining new adjusters proposed by the Health Care Financing Administration with partial capitation. Partial capitation bases some part of lump-sum payments to health plans on the services the plans deliver.

The adjusted average per capita cost (AAPCC) methodology historically used for Medicare is problematic because it may lead managed care plans to "skim" the healthiest and avoid the sickest potential members. Risk adjustment would more adequately match payments with expected individual spending. Fortunately, diagnostic-based adjustment techniques such as hierarchical coexisting conditions, diagnostic cost groups (DCGs), and ambulatory care groups are making a substantial improvement over AAPCC.

HCFA plans to start using a variant of the DCG method on January 1, 2000, in an attempt to improve on the AAPCC by using diagnostic information to predict spending. The authors, however, say the DCG method leaves two potential problems. First, managed care plans still have an incentive, albeit much reduced, to select healthier people. Second, plans may continue to stint on care. Moreover, HCFA's inability in the short term to include diagnostic information from outpatient settings gives plans greater incentive to avoid bad risks.

Shifting policy from exclusive reliance on a lump-sum, risk-adjusted payment would mitigate many of these problems, according to the authors. As the Medicare program grows, lack of satisfactory risk adjustment is causing serious problems.

Facts and Figures

- Risk adjusters in the current AAPCC formula explain only 1 percent of the variance in actual spending on Medicare beneficiaries, while an ideal adjuster might explain 20 times more variance.
 - Among health plan enrollees, 18 percent reported their general health to be fair or poor, compared with 26 percent of enrollees in traditional Medicare.
 - Although the figures vary slightly from year to year, the 5 percent of Medicare beneficiaries who die each year account for 25 to 30 percent of dollars spent on Medicare.
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RISK ADJUSTMENT AND MEDICARE

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Revised June 1999

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RISK ADJUSTMENT AND MEDICARE

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EXECUTIVE SUMMARY

Almost all observers agree in principle that the Medicare program needs better risk adjusters than the adjusted average per capita cost (AAPCC) methodology it has historically used in calculating payments to at-risk health care plans. Indeed, Congress mandated changes in risk adjustment methods as part of the 1997 Balanced Budget Act.

The lack of adequate risk adjustment results in favorable risk selection of beneficiaries into health plans, which in turn causes three problems: potential barriers to access for beneficiaries seen as bad risks; incentives for plans to spend resources toward ends that are not socially productive; and increased costs to the Medicare program. Strong evidence suggests that, as a group, at-risk plans have benefited from favorable risk selection; that is, they have disproportionately attracted low-cost enrollees. Additionally, payment of a lump sum, independent of use, leaves a financial incentive to stint on services.

Adequate risk adjustment would cause payment to match expected individual spending closely. The adjusters in the current AAPCC formula explain only about 1 percent of the variance in actual spending, while an ideal adjuster might explain 20 times more variance. Fortunately diagnostic-based adjustment techniques such as hierarchical coexisting conditions (HCCs), diagnostic cost groups (DCGs), and ambulatory care groups (ACGs) have advanced to the point of making a substantial improvement over the AAPCC. In terms of ability to explain variance prospectively using Medicare data, the HCC model appears to do better, explaining about 8 to 9 percent (Ellis et al., 1996).¹ By contrast, ADGs explain about 6 percent (Weiner et al., 1996), as do PIP-DCGs. Although these figures are still a fair distance from the 20-25 percent lower bound, each is clearly a substantial improvement on the AAPCC.

In addition to explained variance, both Ellis et al. and Weiner et al. (1996) present data on how these risk adjusters affect profitability, thereby suggesting both the improvement that they make and the magnitude of the remaining problem. For example, Ellis and colleagues calculate that plans would experience substantial average profits and losses in 1992 from enrolling those in the lowest and highest quintiles of 1991 expenditures, assuming that 1992 spending by the plan would be the same as spending in traditional Medicare (table 1).

Table 1. Effect of the AAPCC and HCC Adjusters on Average Estimated Profit and Loss

Subgroup	Profit or Loss in 1992: AAPCC Adjusters	Profit or Loss in 1992: HCC Adjusters
Top 20% of Spenders, 1991	-\$4,425	-\$1,311
Bottom 20% of Spenders, 1991	+\$2,134	+\$424

Source: Ellis et al., 1996. Assumes plan was paid 100% of the AAPCC.

As table 1 shows, the HCC method yields a noteworthy reduction in incentives to cream and dump, cutting profits and losses by more than a factor of three relative to the AAPCC. Nonetheless, HCCs leave nontrivial levels of profits and, especially, losses.² (For purposes of scaling these figures, mean spending in 1992 was \$3,800.)

The Health Care Financing Administration (HCFA) has announced its intention to proceed with a variant of the DCG method beginning January 1, 2000. Even this method, however, leaves two potential problems: there is still an incentive, though substantially reduced, to select good risks; and there is still an incentive to stint on care. Moreover, the incentive to avoid bad risks is increased by HCFA's inability in the short term to include diagnostic information from outpatient settings in the risk adjustment formula.

Recent research has also documented substantial underpayment for frail elderly beneficiaries, even after diagnosis-based risk adjustment. To deal with this problem, the Medicare program would need to adopt risk adjustment based on functional status—which in turn poses difficult implementation problems. Similarly, once Medicare moves to an annual rather than a monthly enrollment period in 2002, payment for new nursing home entrants who are also eligible for Medicaid appears much too low.

All these problems would be mitigated by moving policy away from exclusive reliance on a lump-sum, risk adjusted payment. Partial capitation—under which payment for an individual enrollee would combine capitation methods and some reflection of that person's actual use of services—would address both selection and stinting incentives. A somewhat analogous but less desirable approach would be to require that capitation payments carry a reinsurance or a formal outlier policy, under which very expensive cases would be reimbursed an additional amount. Another proposal, potentially useful for terminally ill patients, would allow plans to name in advance a percentage of high-cost cases for which they would be partially or wholly reimbursed using traditional Medicare.

As the Medicare at-risk program grows, lack of satisfactory risk adjustment is causing serious problems. Better risk adjusters now exist. For valid reasons, HCFA is proposing to introduce them into the program slowly. Even when fully implemented, however, it is highly optimistic to think that current problems of selection will fall to negligible levels. Taking some account of the actual use of services will likely be necessary to keep risk selection negligible.

RISK ADJUSTMENT AND MEDICARE

INTRODUCTION

Almost all observers agree in principle that the Medicare program needs better risk adjusters than the adjusted average per capita cost (AAPCC) methodology it has historically used in calculating payments to at-risk health care plans. Indeed, Congress—the most influential “observer” of all—mandated changes in risk adjustment methods as part of the 1997 Balanced Budget Act (BBA).

In January 2000, the Medicare program will begin to phase in a set of diagnosis-based risk adjusters proposed by the Health Care Financing Administration (HCFA), including an interim adjuster based on certain diagnoses of hospitalized patients. The planned changes should produce some improvements, yet they also raise serious questions of effectiveness and the possible creation of new, unwanted incentives. An alternative method—partial capitation—would address many of the problems of the current approach while increasing the accuracy of the proposed system.

THE PROBLEM OF FAVORABLE SELECTION

The lack of adequate risk adjustment creates incentives for favorable selection of beneficiaries into at-risk plans. Favorable selection, in turn, causes three major problems that affect both individuals and government: potential access barriers for beneficiaries seen as bad risks; incentives to spend resources to attract good risks; and increased costs to the Medicare program.

Under current methods of reimbursing plans, people who are bad risks—especially chronically ill beneficiaries—face potential access problems because health plans are reimbursed the same amount for beneficiaries with very different levels of expected treatment costs. Without adequate risk adjustment, plans have a financial incentive to avoid marketing to patients likely to incur high costs and to induce more expensive patients already enrolled to disenroll. Plans also have reason to configure themselves so as not to appeal to bad risks: under current reimbursement arrangements, a reputation for offering the best cancer service in town is not healthy for the bottom line. Further, in a local market where no plan is discriminating against bad risks, a new entrant may attempt to do so. Then, if many good risks switch to the new entrant, existing plans may have to choose between discriminating against bad risks themselves and losing money.³

Further, although it makes financial sense for a plan to spend up to the amount of profit on a good risk to attract such a person, resources used toward that goal represent an inefficient use of funds.⁴ A subsidized health club membership, for example, is an added benefit that also disproportionately attracts good risks. Yet good risks probably do not value the benefit as much as it costs the health plan to provide it or they would already have bought

a membership. At the same time, plans have an incentive to spend money to avoid bad risks, an expenditure that is not socially productive.

Finally, if Medicare pays a plan more to treat a person than it would have paid had that person remained in traditional Medicare, government spending by definition has increased. Most analysts, including the General Accounting Office (GAO), believe that such overspending has occurred (GAO, June 1999).

Under the AAPCC formula, plans are paid 95 percent of average spending for "comparable" patients in traditional Medicare, defined as people of the same age, sex, welfare status, institutional status, and employment status. Within a broad demographic category, then, plans have an incentive to attract enrollees whose expected spending is less and avoid people whose expected spending is more than the payment established for the group. An incentive may be acted upon to a greater or lesser degree, but the evidence suggests that plans have disproportionately attracted beneficiaries whose expected spending is less than AAPCC-generated payment.

Strong evidence of favorable selection comes from analyses of the Physician Payment Review Commission (PPRC, 1996). The commission analyzed a random sample of more than 40,000 persons who had enrolled in at-risk plans between 1989 and 1994 and compared their spending with that of a control group of individuals who remained in traditional Medicare. The comparison was made for periods when individuals in both groups were enrolled in traditional Medicare. The commission also calculated how much of the spending difference could be accounted for by variables in the AAPCC, a technique analogous to controlling for those variables.

The commission found that, during the six months preceding enrollment, the group that entered at-risk plans spent 63 percent as much as the average Medicare beneficiary. After adjustment by the AAPCC variables, this figure actually fell to 62 percent. People who disenrolled and returned to traditional Medicare spent 160 percent as much as the average beneficiary in the six months following disenrollment. After adjustment using the variables in the AAPCC, the figure was 142 percent. In other words, below-average spenders were enrolling and above average spenders were disenrolling, while the AAPCC risk adjustment categories failed to account for more than a small percentage of the variation.

The commission also looked at mortality in the years following enrollment. After adjusting for age and sex, the group in at-risk plans had lower mortality for the first three years of enrollment. During the first six months after enrollment, the mortality difference between new enrollees and a control group matched by age and sex was a hefty 25 percent. Although some of the mortality difference could theoretically be due to better care in the at-risk plans, selection seems a more likely explanation for most of the difference.

These large differences in spending and mortality tend to shrink as an individual remains in the at-risk plan, but the evidence is conflicting on whether or not the differences are ever fully eliminated. Our reading, and the analysis of others, suggests that they are not (Welch, 1985; Newhouse et al., 1989; Physician Payment Review Commission, 1996).

Riley and colleagues (1996) generated further evidence through their analysis of self-reported health status from the 1994 Medicare Current Beneficiary Survey. Consistent with favorable selection, they found that self-reported health was notably better among health plan enrollees; for example, 18 percent of health plan enrollees reported their general health to be fair or poor, compared with 26 percent of enrollees in traditional Medicare.

PRACTICAL CHALLENGES IN THE DEVELOPMENT OF RISK ADJUSTERS

An ideal risk adjuster would modify payment to match an individual's expected spending: that is, what a person with particular characteristics and average luck would likely spend in the future. A set of adjusters capable of causing payment to match expected individual spending would need to account for the variance in expected spending across individuals.

The variance in expected spending differs from the variance in actual spending according to the amount of luck. Thus, a person with obstructed coronary arteries is at higher risk of a heart attack than a similar person with no obstructions and so has higher expected spending. If the risk is not much increased—because, for example, the arteries are not much obstructed—expected spending is not much increased. Actual spending, however, will be much increased if a heart attack actually occurs (and the person does not die immediately from the attack). Even so, a good risk adjuster would not need to explain variance in actual spending due to luck; purely random effects on spending, such as being hit by a drunk driver, should not cause plans either to desire or to shun a particular enrollee.⁵

The demographic adjusters in the current AAPCC formula explain about 1 percent of the variance in actual spending. One percent is better than nothing, but not much better. Expected spending levels for two 70-year-old, noninstitutionalized women—one with colon cancer and one with no chronic illness—are very different, yet the present formula pays the same amount for each. A health plan contemplating the enrollment of these two women clearly faces very different financial incentives with respect to each.

If 1 percent does not get the job done, what percentage of the variance in actual spending should an adequate risk adjuster explain? This is a difficult question for three reasons:

- The percentage that is ideally possible to explain cannot be estimated precisely. At best, we can hope to establish a lower bound on the relevant figure.

- It is unclear how accurate a predictor must be to make the rewards from selection less than the costs of engaging in it; in other words, it is not known to what degree plans can or will act on changes in incentives.
- The adequacy of an adjuster presupposes agreement on appropriate treatments and hence the relative expense of various diseases. In many cases, that agreement is lacking.

These three questions represent major technical challenges for the creation of an adequate system of risk adjustment. Readers interested primarily in policy implications may wish to skip the following discussion.

Identifying a Lower Bound for Explaining Variation

What we wish to know—the variance in expected spending—we do not directly observe, which is why the literature analyzes variance in actual spending.⁶ We can, however, try to estimate the variance in expected spending from observations on actual spending. This is commonly done by dividing the variance in actual spending into three components, the first two of which comprise the variance in expected spending.

The first component is termed a fixed effect, or a constant amount that puts a person above or below the community mean indefinitely. An example would be a person with a chronic disease, such as diabetes, who could be expected to incur spending above the mean indefinitely. The second component is a predictable but time-varying effect; that is, a factor that would put the person above or below the community mean in the following month or year but that would not persist indefinitely. An example would be a person who had stopped smoking and whose risk of cancer from smoking declines each year. The remaining variance, the third component, is by definition random.

The first, or fixed, effect can be approximated by estimating the mean spending of a person over a period of years. Thus, using a person's mean spending over the past several years as an estimate of expected spending for the following year, one can estimate what percentage of the actual variance in spending across people can be explained by a fixed person-specific effect. There is reasonable consensus in the literature that the proportion of variance in actual annual spending that could be explained in this fashion is on the order of 15–20 percent (Newhouse, 1996).

In addition, if a person's spending last year was above the person's long-term average, it is more likely than not that this year's spending will also be above average; conversely, if last year's spending was below average, next year's is likely to be low. Again, there is something of a consensus that if one knows last year's spending, and to a lesser degree spending in the years preceding, one could explain another 3–5 percentage points of variance above the 15–20

percent that the fixed effect can predict. Thus, it appears that anyone observing past spending of a given person could explain around 20-25 percent of the variance in annual spending in a given year.

This value is, however, a lower bound on the ability to predict future spending because other predictive factors, such as a pregnancy or a recent diagnosis of cancer, may be observed but not reflected in past spending. In other words, plans or physicians accepting capitation could potentially predict more than the 20-25 percent, although how much more is unclear. That ambiguity did not matter in appraising the adequacy of the AAPCC; clearly, if at least 20-25 percent of the actual variance is predictable, a formula that explains only around 1 percent leaves substantial incentives for creaming and dumping. As adjusters improve, however, ambiguity will begin to matter more.

Assessing the Impact of Incentives on Plans' Actions

Regardless of how good risk adjusters become, we will never have a perfect formula, only better or worse approximations of it. Thus, the question arises of how close to perfect the formula must be to reduce plans' incentive and ability to seek favorable enrollment to negligible or tolerable levels. The short answer is that we do not know.

Although evidence shows that favorable selection is occurring, actions to enroll better risks can be costly. As risk adjustment formulas improve and the profitability of creaming and dumping correspondingly diminishes, plans may not find it worthwhile to spend resources to take such actions (Newhouse, 1996). Moreover, better risk adjustment formulas are also likely to change the profile of "good" and "bad" risks. Good risks will no longer necessarily be healthier persons in general, but rather those who are healthier within each class recognized in the formula. Such a change may materially alter the cost or difficulty of achieving a given level of favorable selection. Thus, a workable adjuster need not achieve the ideal, but how close to perfection will be sufficient is unknown.⁷

Accounting for Variations in Treatment Methods

Estimates of use at the individual level have not typically been available for enrollees in the at-risk program. As a result, most risk adjustment methods have been calibrated using data from fee-for-service providers, either from traditional Medicare or from nonelderly individuals. The question therefore arises of whether the relative weight accorded to different classes of enrollees by current or suggested adjusters is appropriate; that is, are weights calibrated on indemnity plan patterns suitable for at-risk plans?

To the degree that at-risk programs simply reduce use proportionately across all persons, relative weights calculated from indemnity plan data would be unaffected, but such proportionate reductions are unlikely. Cutler, McClellan, and Newhouse (1997), for example,

find that nonelderly persons enrolled in Massachusetts HMOs and who had a heart attack received approximately the same proportion of catheterization and revascularization as those enrolled in an indemnity plan.⁸ That is, use of these invasive procedures seems little affected by HMO enrollment.

By contrast, Frank and colleagues (in press) find that acute depression is treated much less intensively in managed behavioral health care, although, as far as is known, outcomes appear to be similar. Similarly, the RAND Health Insurance Experiment found 40 percent fewer hospital admissions (across all diagnoses) among a group of persons randomly assigned to a staff model HMO when compared with a similar group enrolled in a comparable indemnity plan (Newhouse and the Insurance Experiment Group, 1993). Together, these findings indicate not only that at-risk plans treat conditions differently than indemnity plans, but that the reduction in services will not be spread uniformly across conditions. Likewise, to the degree that organized plans either prevent disease better, detect it at an earlier stage, or better coordinate care, those effects will likely be dissimilar by age group or disease class.

One can draw two conclusions from the disproportionate reductions in use across classes of people. First, most existing risk adjusters, whether based on age, diagnosis, or health status, are distorted in a world of managed care because they have been calibrated on “unmanaged” patterns of treatment. That is, even if 95 percent of the AAPCC were the right aggregate payment level, there would be profits and losses on particular subgroups with resulting incentives to favor or disfavor those groups. (The analog in Medicare’s Prospective Payment System is getting the weights across DRGs right.) Second, and in some ways more important, risk adjustment by definition sets the payments for different classes of people—for example, people with and without certain diagnoses, if adjusters based on diagnoses are used. As such, risk adjustment embodies a judgment about how individuals with a certain diagnosis should be treated if there are treatment options of varying cost.

Most existing research on risk adjusters does not face up to this problem; rather, the work simply assumes that the relative resource allocation across groups of persons implied by existing fee-for-service treatment is appropriate. Of course, it is also unlikely that any two at-risk plans would treat conditions similarly, so simply using data from at-risk plans rather than traditional Medicare to calculate weights is no assurance that the resulting relative weights would be appropriate.

A Practical Standard (and a Technical Caveat)

In sum, an ideal risk adjuster that used no information from current or past utilization to set rates (that is, was prospective in nature) should explain at least 20–25 percent of the variance in spending across beneficiaries. In addition, a plan could observe factors that would predict next year’s spending but would not affect this year’s spending or would affect it minimally. As

a result, the actual portion of variance that might be predictable could be higher than 20-25 percent, perhaps much higher.

It should be pointed out, however, that if the preceding analysis had been based on monthly data, the 20-25 percent lower bound figure would be smaller. This discussion has been couched in terms of annual spending, since that is the time period the literature has used.

Until 2002, Medicare regulations will allow beneficiaries to enroll in and disenroll from at-risk plans monthly.⁹ In general, monthly spending is more difficult to estimate than annual spending because random or unpredictable events play a proportionately larger role in a shorter period: an individual is not likely to have, for example, a serious car accident every month. Although policy conclusions drawn from analyses of annual data would probably hold if monthly data were used instead, demonstrating this empirically remains for future work. Beginning in 2003, however, this technical caveat will be of little importance.

THE STATE OF THE ART OF RISK ADJUSTMENT: RECENT ADVANCES

Five years ago, Newhouse (1994) assessed the state of the art in risk adjustment as primitive. Since that time, HCFA and others have continued to support the development of risk adjustment methods, particularly by incorporating information on diagnosis and self-reported health status. The following selective review covers recent advances, focusing on the Medicare population, and considers problems implicit in current assumptions within the field. (For a more thorough review of the literature, see van de Ven and Ellis [in press].)

Incorporating Information on Diagnosis

Two groups of researchers have done most of the work on incorporating diagnosis in risk adjusters for the Medicare population. A team based at Boston University initially developed the diagnostic cost group (DCG) model, which has now evolved into the hierarchical coexisting conditions (HCC) model and the principal inpatient procedure-diagnostic cost group (PIP-DCG) model (Ash et al., 1989; Ellis and Ash, 1995/96; Ellis et al., 1996). A group at Johns Hopkins University has developed the ambulatory care group (ACG) and ambulatory diagnosis group (ADG) models (Weiner et al., 1996).¹⁰ All the methods attempt to improve on the AAPCC by exploiting diagnostic information to predict expected spending. Thus, to continue the example used above, all the methods would predict that a 70-year-old, non-institutionalized woman with colon cancer would spend more than an otherwise similar woman without colon cancer and would pay more to a plan that enrolled such a woman. The PIP-DCG approach differs from the HCC approach in that it utilizes diagnostic information on hospitalized patients only.

In addition to the Boston University and Johns Hopkins groups, Richard Kronick and others at the University of California at San Diego have developed a diagnosis-based risk

adjuster for the disabled on Medicaid, the disability payment system (Kronick et al., 1996). Kronick's work regarding Medicaid recipients has produced results broadly similar to those of the diagnosis-based systems for Medicare.

The principal criterion for judging the value of new adjusters is the amount of variance in spending they are able to explain. That amount depends upon whether the methods are implemented prospectively or retrospectively. Prospective methods use only diagnostic information from a past period or periods, usually the previous year, then apply it to the year ahead; retrospective methods use diagnostic information from the current period, then apply it to the current year. Thus, if a person is diagnosed with diabetes mellitus in 1997, a prospective adjuster would use that information to set reimbursement in 1998, whereas a retrospective adjuster would use the information for setting 1997 reimbursement.

A retrospective adjuster will explain more variance in actual spending than a prospective adjuster because it explains some random variation or luck. Suppose, for example, that a man with no known diseases has a heart attack in the current year, a random event that could not be predicted in advance. The additional current year spending associated with the heart attack will be partly explained by a retrospective adjuster and will place the man in a higher category, reflecting the diagnosis of acute myocardial infarction. As pointed out above, explaining random variation is not important for purposes of reducing selection behavior.¹¹

The variance that can be explained by prospective rather than retrospective adjusters deserves attention for three reasons. First and most important, HCFA is proposing to implement a prospective adjuster, as described below. Second, there is no standard for how much variance a good retrospective adjuster should explain. Third, as just described, explaining random variation is not important to reducing selection behavior, and at least some of the additional variation explained by a retrospective adjuster is random. Unfortunately, the evidence is conflicting on how much is random.

Ellis et al. (1996) and Dunn et al. (1996) find that prospective and retrospective adjusters do about equally well in explaining next year's spending by this year's high and low spenders and also for persons with certain chronic diseases. Thus, their results imply that much of the gain in explained variation achieved by retrospective adjusters comes from explaining random spending. By contrast, Chapman (1996), using data from individuals under 65, finds that retrospective adjusters do detect some spending that appears predictable, suggesting that the use of a retrospective adjuster could reduce the incentives to select. For example, a plan may know from the results of clinical tests that a person is at above-average risk for a heart attack within the group of people with identified heart disease; with a retrospective adjuster, the plan can recoup some of the expense of the heart attack if it occurs.

In terms of ability to explain variance prospectively using Medicare data, the HCC model appears to do better, explaining about 8 to 9 percent (Ellis et al., 1996).¹² By contrast, ADGs explain about 6 percent (Weiner et al., 1996), as do PIP-DCGs. Although these figures are still a fair distance from the 20-25 percent lower bound, each is clearly a substantial improvement on the AAPCC.

In addition to explained variance, both Ellis et al. and Weiner et al. (1996) present data on how these risk adjusters affect profitability, thereby suggesting both the improvement that they make and the magnitude of the remaining problem. For example, Ellis and colleagues calculate that plans would experience substantial average profits and losses in 1992 from enrolling those in the lowest and highest quintiles of 1991 expenditures, assuming that 1992 spending by the plan would be the same as spending in traditional Medicare (table 1).

Table 1. Effect of the AAPCC and HCC Adjusters on Average Estimated Profit and Loss

Subgroup	Profit or Loss in 1992: AAPCC Adjusters	Profit or Loss in 1992: HCC Adjusters
Top 20% of Spenders, 1991	-\$4,425	-\$1,311
Bottom 20% of Spenders, 1991	+\$2,134	+\$424

Source: Ellis et al., 1996. Assumes plan was paid 100% of the AAPCC.

As table 1 shows, the HCC method yields a noteworthy reduction in incentives to cream and dump, cutting profits and losses by more than a factor of three relative to the AAPCC. Nonetheless, HCCs leave nontrivial levels of profits and, especially, losses.¹³ (For purposes of scaling these figures, mean spending in 1992 was \$3,800.) Whether the changes in profitability brought about by HCCs or ADGs would reduce selection behavior to negligible levels is an empirical question whose answer cannot be known before the methods are implemented. Unfortunately, implementing HCCs poses serious problems, as described below.

Accounting for Information on Functional Status and Self-Assessed Health

Another strand of risk adjustment literature uses functional status or variants of self-reported health status such as the RAND-36 instead of or in addition to diagnostic information. In general, self-reported health status by itself does not explain as much variation as do the diagnostic-based measures. When used in conjunction with diagnostic measures, self-reported health status appears to add around one percentage point of explained variation (Newhouse et al., 1989; Fowles et al., 1994; Gruenberg et al., 1996, 1999; Pope et al., 1999).

Although the increment of improvement gained by including self-assessed health status is modest overall, functional status appears to be an important predictor of spending by the frail elderly, those impaired in activities of daily living (ADLs) or instrumental activities of daily living (IADLs) (Gruenberg et al., 1999; Pope et al., 1999).¹⁴ In particular, the diagnostic-

based measures underpredict spending for the frail elderly and correspondingly overpredict for elderly who are not frail. In other words, plans are underpaid for the frail elderly and overpaid for the nonfrail elderly.

The Medicare Payment Advisory Commission (MedPAC) (1999) shows that differences in spending by frailty status are large. Using 1995 data from the Medicare Current Beneficiary Survey, MedPAC estimates that the average spending for a frail elderly person in the community was more than three times as great as for the average beneficiary and that average spending for nursing home residents was almost twice as high (table 2). (A frail person in the community was someone age 55 or more who required hands-on assistance with three out of five ADLs or one ADL and four out of five IADLs.¹⁵) Spending in all categories was notably higher for the frail group, but home health spending was particularly higher.

**Table 2. Medicare Fee-for-Service Spending,
by Beneficiary Frailty and Residence, 1995**

Provider Type	All Fee-for-Service	Frail in Community	Nursing Home
PPS Hospital	\$1,720	\$ 5,035	\$3,324
Physician	1,092	1,879	1,793
Home Health	472	3,658	380
Outpatient Dept	377	572	1,152
SNF	201	818	1,375
DME	137	471	464
Rehab Facility	110	515	47
Other Hospital	87	236	403
Hospice	19	162	163
Total	\$4,215	\$13,346	\$9,102

Source: Medicare Current Beneficiary Survey, Cost and Use File 1995, as reported in Medicare Payment Advisory Commission (1999). Frail in the community are those 55 or over who require hands-on assistance with three of five ADLs or one ADL and four of five IADLs.

Adding HCCs and an adjustment for functional status appears to improve payment accuracy considerably for subgroups with ADL limitations (table 3). Table 3 shows how well various adjusters perform for subgroups that differ in functional status. In particular, it shows the extent to which 1992 spending can be predicted based on 1991 functional status or 1993 spending based on 1992 status (Pope et al., 1999). A value of less than 1 means payment was less than actual spending, while a value of more than 1 indicates that payment exceeded actual spending. The AAPCC method dramatically overpays for elderly with no functional status limitations (by 39 percent) and underpays for the other groups. HCCs substantially reduce overpayment and underpayment. Adding several survey-based measures of self-reported health

status reduces the discrepancies even further. Unfortunately, there are also serious problems with implementing measures of functional status and self-rated health status, as discussed below.

Table 3. Effect of Survey-Based Risk Measures on the Ratio of Average Payment to Actual Spending, by Functional Status

Functional Status	AAPCC	HCC	HCC+Survey
5–6 ADLs	0.64	0.88	1.09
3–4 ADLs	0.71	0.86	0.96
1–2 ADLs	0.85	0.93	1.06
No ADLs	1.39	1.16	0.95

Source: Pope et al., 1999. Survey measures include self-reported chronic conditions, functional status, and self-rated health status. Data based on the 1991–93 Medicare Current Beneficiary Survey.

Gruenberg et al. (1999) find similar results for the dually eligible (Medicare and Medicaid) population if prospective adjusters are used. A problem occurs, however, because the rate is set using last year's information, although spending for new entrants to nursing homes is very high—5.7 times the Medicare average—and HCCs and PIP-DCGs do not begin to compensate for the difference. As a result, payment for the dually eligible is too low even after adjustment with the diagnosis-based methods. The amount of the shortfall varies between 7 percent and 24 percent for HCCs and 20 percent and 33 percent for PIP-DCGs, depending on the data set used in making the calculations.¹⁶

Rethinking Assumptions about Incentives to Overserve

Risk adjustment as usually discussed involves a lump sum payment to a health plan or a provider for a given patient's care. There seems to be a taboo against paying a health plan anything for providing more services. Indeed, the language of the BBA appears to be very restrictive with respect to such payment.¹⁷

The philosophy of paying nothing for doing more has carried into the construction of the PIP-DCGs and HCCs; they have been deliberately chosen to minimize the effect of reimbursement method on choices regarding the treatment of a particular patient. The creators of the HCC method have taken special care to limit higher payments for diagnoses for which treatment is relatively nondiscretionary. But a higher amount of variance in expected cost could be explained—and selection incentives correspondingly reduced—if categories were created that paid more for cases in which discretionary treatment was rendered.

Minimizing incentives for discretionary treatment at the possible expense of increasing incentives to select—the choice the creators of the HCCs made—follows a dominant view in the literature that payment to health plans should be independent of actual use, or at least independent of any use that is discretionary. This view reflects an implicit assumption that,

given a choice of treatment, the less costly method is preferred. There are, however, important objections to this view.

First and most important, if reimbursement is independent of use, additional revenue from doing more is by definition zero. But if excess services appear to be related to overly generous fees, so does underservice appear to be related to no payment (Pauly, 1980).¹⁸ In short, even apart from issues of selection, the policy of making no payment for additional services raises the issue of possible stinting. For example, Medicare's Prospective Payment System pays more for a patient with heart disease who has a coronary bypass operation than for a similar patient who does not have an operation. Although there is often an element of discretion in having a bypass operation, the planners who created the DRGs presumably deemed that paying nothing more for cases in which a bypass operation was performed would likely lead to too few bypass operations. Although excessive fees can potentially induce unwanted or unnecessary services, the conclusion that marginal revenue should always be zero seems to be an overreaction to the excesses of reimbursement in the indemnity insurance system.¹⁹

Second, a substantial amount of medicine involves learning by doing. When first introduced, open heart surgery took much more time and yielded much poorer results than it does today; over time, however, cardiac surgeons became better at performing the operation. If the lowest cost option is always chosen, the possibility that a more expensive option today will become cheaper tomorrow is lost. A third and related point is that, even putting aside learning by doing, there may be substantial uncertainty about which course of treatment is better. Without some variation in treatment, we will not learn.²⁰

Thus, as described in greater detail below, it seems wise to base some portion of reimbursement to a health plan on actual use. Such a policy could potentially reduce selection even further, while also curbing possible stinting, although overservice could result if payments became too high. Another possible model would use a much finer classification of diagnoses to reimburse plans than the DCGs or HCCs now employ, especially for high cost diagnoses. This approach is desirable in principle, but obtaining stable and appropriate relative weights for more numerous categories is problematic.

POTENTIAL PROBLEMS IN IMPLEMENTING BETTER RISK ADJUSTERS

The Medicare program is poised to proceed with the implementation of diagnostic-based risk adjustment in January 2000, despite one major implementation problem: the absence of reliable diagnosis information on outpatient claims. HCFA therefore proposes that next January's implementation use the PIP-DCG method, which takes account of inpatient diagnostic information only, rather than the HCC method, which is substantially more accurate but requires outpatient diagnostic information. PIP-DCGs explain somewhat under 6 percent of the variance in spending, whereas HCCs explain 8 to 9 percent (Ellis et al., 1996).

Moreover, HCFA proposes to implement the PIP-DCG system gradually, giving health plans time to adjust. Only 10 percent of the payments is to be based on the PIP-DCG adjusted payment in 2000, with the remaining 90 percent based on the current AAPCC method. The percentage based on the PIP-DCG method would steadily increase, reaching 30 percent in 2001, 55 percent in 2002, and 80 percent in 2003. In 2004, payment would be entirely based on diagnostic-based methods, and at that time HCFA would move from the PIP-DCG method and introduce outpatient diagnoses into the adjustment method.

The Unreliability of Outpatient Diagnostic Data

An analysis by MedPAC (1998) amply demonstrates the inaccuracy of current outpatient diagnosis coding. For the purposes of the study, MedPAC selected beneficiaries whose Medicare Part B claims in 1994 showed a diagnosis of one of 11 serious diseases, then checked for claims for the same diagnosis in 1995. As shown in table 4, the likelihood of a claim in 1995 was only about 50-60 percent for each of the 11 diagnoses. One would not expect the likelihood to be 100 percent. A few patients may have been misdiagnosed in 1994, and a few more may have had no physician contact in 1995. It seems likely, however, that most of the 1995 shortfall is attributable to physicians simply neglecting to fill in the diagnosis on the Part B claim or recording some other diagnosis. After all, no payment turned on filling in the diagnosis. Two consequences follow.

Table 4. Persistence in Diagnostic Coding

Diagnosis on 1994 Part B Claim	Of Those Identified in 1994, Percent with Part B Claim in 1995
Hypertension	59%
Coronary Artery Disease	53
COPD	62
Congestive Heart Failure	61
Stroke	51
Dementia	59
Rheumatoid Arthritis	55
High Cost Diabetes	58
Renal Failure	56
Quadriplegia/Paraplegia	52
Dialysis	59

Source: Medicare Payment Advisory Commission, March 1998, p. 17. Excludes those who died in 1994 or 1995.

First, introducing payment based on outpatient diagnosis offers enormous potential for “upcoding”—the equivalent of DRG creep in hospital payment—and resulting increases in overall spending. Because the increment in payment can be several thousand dollars per year depending on the exact diagnosis, there is a powerful incentive to be complete with coding. Increasing the completeness of coding would inappropriately raise payment for the same mix of patients. When faced with similar problems in the past, HCFA has adjusted rates down before the fact on the assumption that more complete coding would occur. For example, when HCFA introduced the Resource Based Relative Value Scale (RBRVS) for physician services, it lowered fees by a few percent before the fact to compensate for anticipated volume changes. Even this level of adjustment caused considerable controversy. It is inconceivable that HCFA could lower payments to plans by the amount suggested by the MedPAC study—say 40 percent. On the other hand, if payments were left unchanged, overall spending would probably increase greatly.

As a result, it seems likely that payment based on outpatient diagnoses will have to be phased in, just as the PIP-DCG system is being phased in. For example, if only 10 percent of the payment were based on outpatient diagnoses in the first year, plans would still have an incentive to code much more completely, but the expenditure risk to the government would be limited. Thus, the transition to fully incorporate outpatient diagnoses may extend well beyond 2004.

A second, more subtle consequence of incomplete coding is that weights in the new system may be seriously in error. The weights determine how much more is paid for a patient with a particular diagnosis, analogous to the weight for each DRG. The HCC weights have necessarily been calculated using existing Part A and Part B data and are approximately proportional to mean Medicare expenditure for patients with given diagnoses. Thus, weights will be relatively more skewed for diagnoses in which a higher proportion of the bill is for Part B spending and for diagnoses that are less likely to be reported.

The Problem of Relying on Inpatient Information

Exclusive reliance on the PIP-DCGs and inpatient diagnosis information raises the issue that plans may find it profitable to hospitalize inappropriately. For example, a plan would receive additional reimbursement for a cancer patient only if the patient received inpatient treatment. HCFA is aware of this problem and has taken several steps to minimize it:

- The increment in payment will be based on average spending in the year following the hospitalization; for example, plans enrolling patients hospitalized for heart attacks will receive a higher reimbursement, but the increment will be based on spending in the year following the heart attack, not the year of the heart attack. As a result, spending for the initial hospitalization will not figure into the incremental amount paid.

- Causes of admission that are discretionary or vague will not trigger additional payment; about 40 percent of the admissions fall into this category.
- One-day stays will not generate additional payment.

Although these steps reduce the incentive to hospitalize for financial reasons, they also blunt the gain from risk adjustment; that is, they do not diminish incentives to select good risks and avoid bad risks as much as HCCs. HCFA estimates that the amount of explained variance from the PIP-DCG method will be about 5.8 percent.²¹

The Shortcomings of Functional Status and Self-Ratings

HCFA is not proposing to implement adjusters based on functional status or self-ratings of health status, which seemed plagued by even more serious implementation issues than the diagnosis-based methods. The problems turn on the feasibility and expense of obtaining reliable information when it will be used for payment purposes.

First, many of those who are functionally impaired are also cognitively impaired or demented, which makes filling out a self-administered form problematic. This is especially true for the frail elderly, where use of self-rated measures seems most important for accurate adjustment. Although another party could in principle rate functional status, it is harder to see how a proxy respondent could be used for self-rated health status. Second, if a third party rater is not used, nonresponse may bias the results. Third, in the case of self-rated health status, providers may “prescribe disability,” leading beneficiaries to report lower health status, or beneficiaries may respond strategically if they realize provider reimbursement depends upon their survey answers. Fourth, self-rated health status, as distinct from functional status, cannot be audited. Fifth, it is not clear how frequently surveys would be carried out, but, if less than annually, results would not be as favorable as those reported above because some beneficiaries would have moved to more impaired categories but reimbursement would not adjust. Sixth, the expense of collecting such information would clearly be substantial, especially if a third party were used. There would have to be an adequate sample of enrollees in each plan; indeed, some might argue that 100 percent samples would be needed in order to set adjustment for those transferring from one plan to another. These considerations make clear that introducing functional status into the risk adjustment system is a daunting task.

Beyond these practical problems are important questions of the incentives that might be produced. Would increased payment for poorer functional status induce worse performance?²² Or perhaps less aggressive efforts at rehabilitation? To what degree would increased payment for entrants to nursing homes induce more nursing home admissions?

CONTENDING WITH THE REALITY OF INADEQUATE RISK ADJUSTMENT

Risk adjustment is not likely to be adequate for many years for three reasons:

- HCFA's current plans do not call for using outpatient diagnostic information until 2004. In fact, full implementation of an outpatient-based method is likely to be even further off because of the potential for upcoding.
- There are no current plans to measure functional status using survey-based risk adjusters. Indeed, it is not clear it would ever be practical to use them for payment purposes.
- Even full implementation of both diagnostic- and survey-based methods is unlikely to reduce selection to negligible levels because the amount of explained variance falls far short of what an ideal adjuster should predict.

Given this reality, several alternatives or adjustments to HCFA's plans deserve attention.

Partial Capitation

Newhouse has elsewhere proposed the adoption of partial capitation, or a blend of adjusted capitated payment and payment under the traditional program (Newhouse, 1994, 1996, 1998). Specifically, for each enrollee, a plan would receive part (perhaps 75 percent) of its payment under a risk-adjusted capitation formula and part (perhaps 25 percent) based on the amount paid through traditional Medicare. This could be done in a budget neutral fashion, and the proper mix could be developed through experimentation.²³ This method would require collecting and coding encounter data for each person, but these tasks are already required by the Balanced Budget Act in order to introduce outpatient-based diagnosis as a risk adjuster.

Under this method, plans would be paid more for enrolling those who use more services and less for those using fewer. Because sicker patients use more services, the losses plans incur from enrolling them would be cut, as would profits from enrolling healthy persons. This would reduce the incentive to cream and dump.²⁴

Outlier Systems

An alternative plan with somewhat similar properties is an outlier or reinsurance scheme. Under this method, payments for additional use would be made only after some threshold spending level had been exceeded, analogous to the outlier payments in the Prospective Payment System. Such a system would target payment toward high spenders, the individuals for whom selection incentives appear to have the worst effect.

Relative to a blend of capitation and traditional Medicare, however, a reinsurance or outlier proposal has three important drawbacks. First, reinsurance for large spenders does

nothing about a plan's incentive to spend resources to attract good risks, whereas a blend would reduce payments for a good risk. Second, the ideally designed outlier policy still leaves plans incurring a loss on high cost cases, thereby making such cases unattractive, whereas the ideally designed blend does not. Third, for all non-outlier cases, there is an incentive to stint. Moreover, the apparent advantages of an outlier scheme may not be real. The additional payments would not necessarily be generated by the cases with the largest predictable losses; to the degree that outlier spending arises from random events, there is no selection problem for those cases.

Whether additional payment for additional services should be limited to high-cost cases or should apply to all cases depends on how serious the problem of selection is under each method and how much an actual, as opposed to an ideal, fee-for-service payment might degrade efficient production. Some support for an outlier arrangement, as opposed to a blend, seems to arise from the notion that additional payments for additional services should be minimized, which, as explained above, is too facile a view.

A High-Cost Case Pool

A different, not mutually exclusive reinsurance method, proposed by van Barneveld et al. (1996), would improve targeting by making additional payment to cases that the plan had predicted in advance would incur high costs. Made in the Dutch context, the proposal would have plans cede a certain portion of their cases, specifically those they predict will be the most costly, to a pool. Although the percentage to be ceded is a policy choice, the authors illustrate the likely results of using 2 percent and 4 percent of cases in each plan.

In the Medicare context, there is no common pool to which to cede cases. Even so, one could adapt the idea by stipulating that a plan could continue to treat an enrollee but, instead of receiving a capitated payment, would be reimbursed partly or entirely under traditional Medicare for some prearranged fraction of its enrollees. This transaction could be kept invisible to the enrollee and conducted solely between Medicare and the plan. Van Barneveld and colleagues estimate that, if 4 percent of the Dutch cases were ceded in advance, about 25 percent of the spending in any given year would be covered by the pool, a fraction that would probably be roughly similar in Medicare.²⁵ In short, plans could effectively place their costliest cases in traditional Medicare, thereby receiving additional reimbursement and mitigating the financial hit from those cases.

It is not hard to see administrative concerns with this proposal. For example, a plan could not cede cases until after a person had enrolled but would obtain information about that person's current use only over time. Nevertheless, the proposal may be useful for dealing with new nursing home entrants and terminally ill patients.

Special Payments for Terminally Ill Patients

It is well known that those who die in any year are disproportionately costly (Lubitz and Riley, 1993). Although the figures vary slightly from year to year, the 5 percent of Medicare beneficiaries who die each year account for 25 to 30 percent of dollars spent. There are thus strong incentives for health plans to avoid the terminally ill and leave this population in traditional Medicare. The distribution of deaths seems consistent with these incentives; as already noted, the death rate for new enrollees in the at-risk program during the first six months is 75 percent of the death rate in the traditional program, after adjusting for age and sex. To the degree that terminally ill patients are disproportionately covered under traditional Medicare, the opportunity for managed care to increase coordination and cut waste in their care is not being fully exploited.

Insofar as better risk adjusters would pay additional amounts for enrollees with diagnoses that carry a high risk of mortality, this problem would be mitigated. For reasons of appearance, however, one would not want to pay more simply because an enrollee died, just as the Prospective Payment System does not pay more for patients who die in the hospital.²⁶ If a plan could cede certain individuals back to traditional Medicare, however, these might well be those identified as terminally ill, a solution that would avoid the appearances problem. If the plan remained partially at risk for patients it ceded, Medicare expenses could potentially be reduced. Even without the blend, however, a managed care plan might be more efficient for terminally ill patients because it might use similar treatment methods for its Medicare and commercial business.

Van Vliet and Lamers (1998) have shown that demographic information, prior spending, and inpatient diagnostic information are not good predictors of those who die, in that expenditures of Dutch decedents were 250 percent above what the model would predict. They conclude that "most of the excess costs were unpredictable." That they were not predictable for the analyst, however, does not mean that they were not predictable for the plan or the physician. Particularly in the case of cancer, physicians may be able to observe a terminal phase that could last several weeks or months (Medicare Payment Advisory Commission, June 1998). Indeed, eligibility for hospice services is premised on the assumption that such a terminal phase can be identified for many diseases.

CONCLUDING COMMENT

As the Medicare at-risk program grows, Congress has recognized that lack of satisfactory risk adjustment is causing serious problems. Better risk adjusters that improve on the AAPCC exist, and HCFA is proposing to introduce them into the program. Even when fully implemented, however, these risk adjusters are not likely to reduce current selection problems to negligible levels. The Medicare program could do better by combining these methods with

partial capitation; that is, making some part of the payment to health plans depend on the services they deliver.

Partial capitation would reduce plans' incentives to select good risks—the intent of risk adjustment—and also reduce the financial incentive to underserve or stint. By reducing incentives to underserve, the payment method would reduce the burden that any patient protection legislation would need to carry.

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NOTES

¹ Dunn et al. (1996) find ADGs better than DCGs using under-65 data but do not estimate results for HCCs.

² If payment were 95 percent of the AAPCC, profits on the low-spending group would be less and losses on the high-spending group would be greater. The asymmetry between the profit from creaming and the loss from not dumping reflects the skewed distribution of spending, which is not mirrored in the reimbursement formula.

³ In the commercial market, plans with disproportionate numbers of bad risks tend to charge higher premiums, thereby leading to a potential death spiral (Cutler and Reber, 1998). In the Medicare program, charging enrollees more is possible only to a limited degree. To the degree it is possible, it lessens beneficiaries' ability to insure against the risk of chronic illness because those with chronic illnesses will in effect pay more.

⁴ Airlines before deregulation were in a similar position: fare regulations made long distance routes profitable, while short haul routes, typically between small towns, were unprofitable, but regulators required that airlines serving long distance routes also serve short haul routes. Because the profitable but regulated fares on long distance routes could not be bid down, airlines serving such routes found other ways to compete; notably, they scheduled frequent flights, with the result that load factors on long distance routes were relatively low (Winston, 1993). But half empty planes are an inefficient use of the profit in the fare structure; although an empty adjacent seat may be of some value to the passenger, a reduction in the fares would presumably have been valued more highly, at least by passengers paying their own fares.

⁵ Plans must be reimbursed at least the average amount of such random expense, or they will not choose to participate.

⁶ The proportion of variance explained has become a principal measure of the adequacy of risk adjustment measures. Some literature explains the variance in spending across groups (actual or hypothetical) rather than individuals because averaging random events within the group allows a higher fraction of the spending variation to be explained. In our view, however, group spending is relevant only if the group as a whole is enrolling in a plan (as when employer enrolls all employees in a single group). If individuals are free to choose plans, as they are in Medicare, the variance across individuals is relevant because the group is not fixed.

⁷ We do know that, as explained variation improves, incentives to select do not diminish proportionately (Newhouse et al., 1989, 1996).

⁸ Cost, however, is much lower in the HMOs because prices paid for treatment are lower.

⁹ In 2003 and after, beneficiaries will generally be "locked in" to a plan choice, but may disenroll during the first three months. (In 2002 they may disenroll during the first six months.)

¹⁰ The Ambulatory Care Groups were originally designed as a case-mix measure for non-aged populations. The ACG classification methodology was subsequently augmented with

inpatient ICD-9-CM diagnosis information to form the ADG model risk adjustment model for Medicare beneficiaries.

¹¹ Explaining random variation could be important if plans face a nontrivial risk of bankruptcy from random health events, but this risk should be unimportant for plans with tens of thousands of enrollees.

¹² Dunn et al. (1996) find ADGs better than DCGs using under-65 data but do not estimate results for HCCs.

¹³ If payment were 95 percent of the AAPCC, profits on the low-spending group would be less and losses on the high-spending group would be greater. The asymmetry between the profit from creaming and the loss from not dumping reflects the skewed distribution of spending, which is not mirrored in the reimbursement formula.

¹⁴ Even though the adjustment is quantitatively important for the frail elderly, it does not much affect explained variation because the frail subgroup is relatively small and hence its spending does not contribute much to total variation. This illustrates one weakness of simply using explained variation in comparing adjustment methods.

¹⁵ The six ADLs include: transferring into and out of chairs; dressing; bathing; walking; toileting; eating; and maintaining continence. The five IADLs include housework; meal preparation; managing finances; using the telephone; and shopping for personal items. Hands-on assistance means the person has a “need for assistance” with the ADL rather than simply “has difficulty.” The group that has a need for assistance has both much higher Medicare costs and a much greater discrepancy with predicted costs relative to the group that simply reports disability (Gruenberg et al., 1999).

¹⁶ Gruenberg et al., tables 4-10 and 4-12.

¹⁷ Section 1855(b) of the 1997 Balanced Budget Act: “Assumption of Full Financial Risk. The Medicare+Choice organization shall assume full financial risk on a prospective basis for the provision of health care services...except that the organization: 1) may obtain insurance...for the cost of...such services the aggregate value of which exceeds such aggregate level as the Secretary specifies from time to time...3) may obtain insurance...for not more than 90 percent of the amount by which its costs...exceed 115 percent of its income for such fiscal year.” In other words, plan payment should be fully prospective except for outlier payments above a HCFA-determined amount and reinsurance for costs exceeding 115 percent of revenue should the plan wish to purchase such reinsurance. Similar language about payment to health plans being fully prospective appeared in the Clinton Health Security Act.

¹⁸ One will not observe underservice if the consumer can monitor the actual delivery of services that should be in the bundle. But information is notoriously asymmetric between providers and patients. Compounding the problem is that a nontrivial percentage of the Medicare population is demented.

¹⁹ The ideal payment would be at the marginal cost that would induce the optimal quantity (Pauly, 1980). Combined with ideal capitation, this would address concerns of both selection and stinting. In practice, we do not know marginal cost and thus will not have this

fee structure. The argument about the tradeoff between selection and efficient production thus reduces to the system that in practice is likely to be closer to the ideal. A different argument is that a manager who keeps the entire dollar from any savings puts the optimal amount of effort into efficient production (Newhouse, 1996). This, however, is an argument against cost-based reimbursement; it does not argue against paying plans a set rate for additional procedures. Related to this point, patients may prefer a higher-cost discretionary option and may be willing to pay an extra premium for it. Willingness to pay is a standard economic test for efficiency.

²⁰ Where possible, this variation should take place in the context of a randomized trial, but for ethical and other reasons a randomized trial is not always possible. It is also true that under fee-for-service there can be too little incentive to find cost-reducing technologies.

²¹ Daniel Zabinski, personal communication.

²² There is a similar problem in principle with respect to prevention for the diagnosis-based information, but it seems much less serious. That is, it does not seem likely that plans would markedly reduce effective preventive efforts for, say, cancer, simply because their payment would not be as great. And of course expenses would rise to treat sick patients, so it is not clear that the plan is any more profitable from failure to prevent.

²³ See Keeler, Carter, and Newhouse (1998) for some evidence that a 75-25 mix may be about right.

²⁴ In terms of the R^2 criterion used above, the portion of payment based on traditional Medicare would exactly match the dependent variable; thus, the overall proportion of explained variation under this system would be $wR_1^2 + (1-w)$, where w is the weight on the capitation method and R_1^2 is the proportion of variance explained by the capitation method. This number, however, cannot be compared with the 20 to 25 percent criterion for a fully prospective adjuster because this method is not fully prospective.

²⁵ Ex post about 1 percent of cases account for a quarter of spending, but ex ante the percentage accounting for a quarter of cases will be larger because of the inability to predict random events.

²⁶ Acute myocardial infarction (AMI) is the one exception, because those dying from AMI are on average cheaper than those who survive.

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