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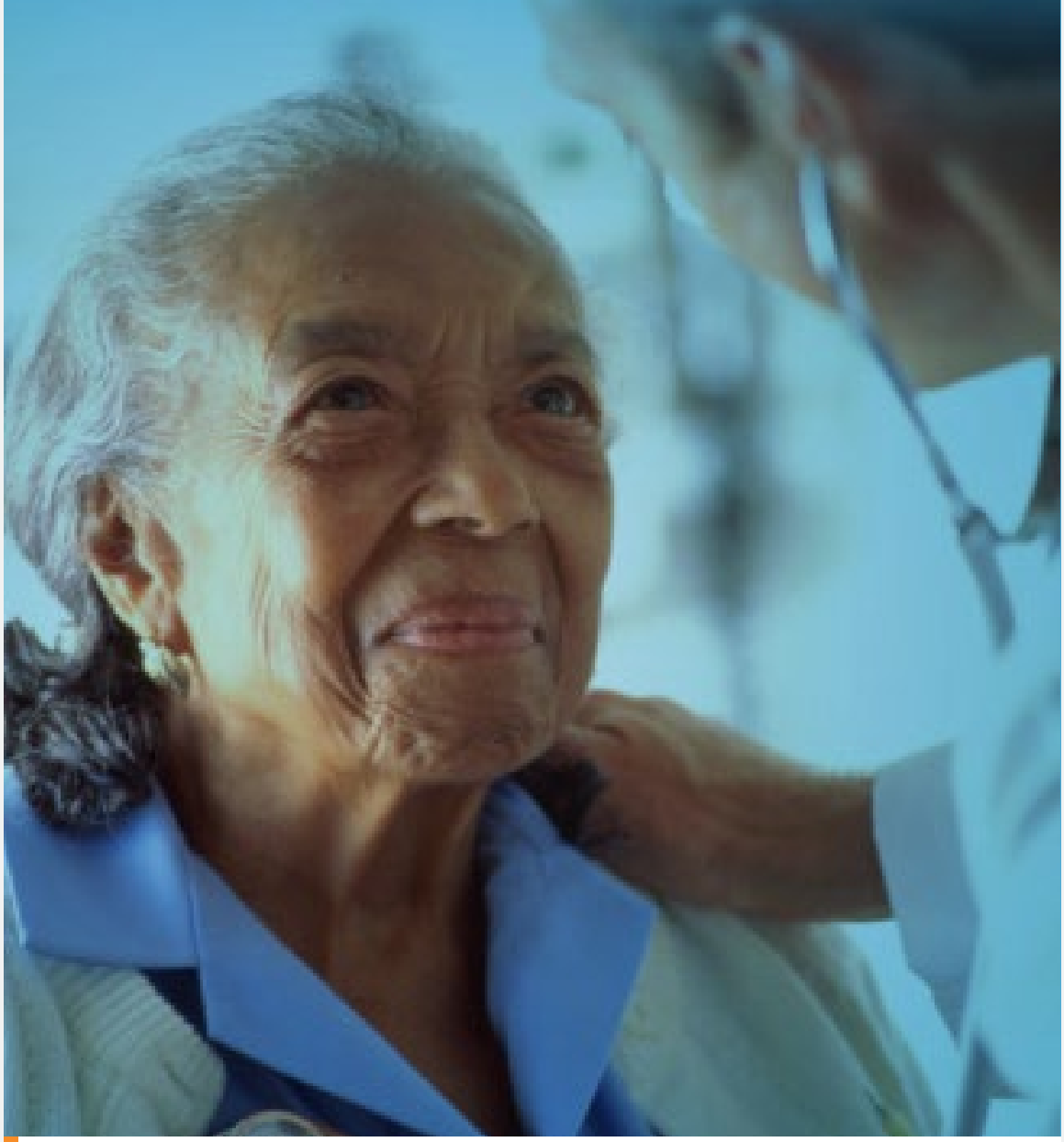
UNDERSTANDING RISK ADJUSTMENT IN MEDICARE ADVANTAGE



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A MESSAGE FROM BETTER MEDICARE ALLIANCE

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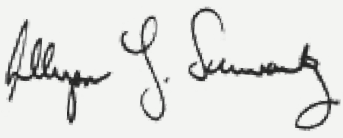
Better Medicare Alliance (BMA) is the leading coalition of nurses, doctors, employers, aging service agencies, retiree organizations, and beneficiaries who support Medicare Advantage as an option under Medicare. BMA works to ensure the sustainability and stability of Medicare Advantage through information, research, education, commentary on policy, and advocacy.

Better Medicare Alliance presents this paper, "Understanding Risk Adjustment in Medicare Advantage," to educate and inform policymakers, media, advocates, and beneficiaries about the complexities and consequences of the annual regulatory changes that affect the stability and sustainability of Medicare Advantage.

The information in this paper explains risk adjustment in the Medicare Advantage program, and sheds light on the importance of the accuracy of this mechanism to ensure appropriate resources for beneficiaries, health plans, and providers. The information also identifies the significant differences in how the Medicare Advantage and Traditional Fee-For-Service Medicare programs identify and account for the health status of beneficiaries.

Most importantly, this paper seeks to highlight the need to get risk adjustment in Medicare Advantage ***right*** as we work together to improve care for seniors, particularly those with multiple chronic conditions.



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BETTER MEDICARE ALLIANCE

RISK ADJUSTMENT IN MEDICARE ADVANTAGE

Risk adjustment is an essential mechanism used in health insurance programs to account for the overall health and expected medical costs of each individual enrolled in a health plan. Accurate documentation of diagnoses by clinicians is a critical component of the risk adjustment process.

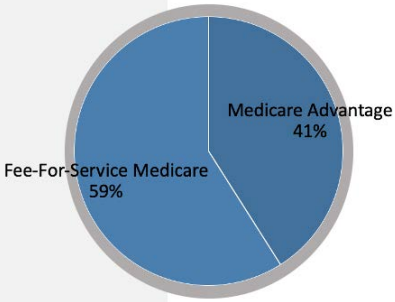
The Medicare Advantage (MA) program relies on risk adjustment to maintain predictable and actuarially sound payments to MA plans to provide benefits to all enrollees.

A stable risk adjustment system is essential to ensure sustainability in benefits provided to enrollees and to the continued innovation in the delivery of high quality, coordinated, and affordable care to all MA beneficiaries.

OVERVIEW OF MEDICARE ADVANTAGE

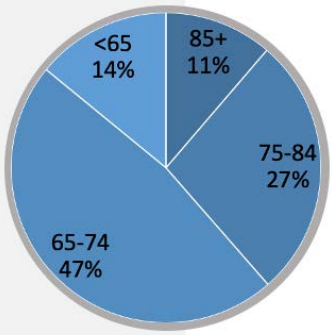
Medicare Advantage (MA), also known as Medicare Part C, is the part of Medicare through which health plans provide health care coverage to people over 65 and individuals with disabilities. These plans are approved and regulated by the Centers for Medicare and Medicaid Services (CMS) and the program undergoes an annual review process that makes policy changes and sets payment rates for the next year.

MEDICARE POPULATION[4] 62 MILLION



MA is required to cover all Medicare Part A (hospital) and Medicare Part B (provider) benefits that are covered by Traditional Fee-For-Service (FFS) Medicare. Almost all MA plans also include additional benefits, such as vision, hearing, dental, fitness, and wellness. Unlike FFS, MA also has out-of-pocket cost protections for beneficiaries.

AGE DEMOGRAPHICS[5]



KEY MEDICARE ADVANTAGE FACTS

- **More than a third of Medicare beneficiaries — over 25 million individuals** — have chosen to receive their Medicare coverage through MA.[1]
- **Approximately 33% of MA beneficiaries** have annual incomes of less than $20,000.
- **Over 40% of African American Medicare beneficiaries and 47% of Hispanic Medicare beneficiaries** are enrolled in MA.[2]
- **39% of all individuals dually eligible for Medicaid and Medicare** are enrolled in MA.
- **MA beneficiaries are satisfied —** 99% of beneficiaries report they are satisfied with their coverage.
- **99% of Medicare-eligible individuals** have access to a MA plan in their area.
- **MA enrollment is projected to reach 33 million beneficiaries** and 46.5% of Medicare by 2025.[3]

KEY DIFFERENCES BETWEEN MEDICARE ADVANTAGE AND FEE-FOR-SERVICE MEDICARE

In order to understand Medicare Advantage (MA), it is important to understand the significant differences between MA and Traditional Fee-For-Service (FFS) Medicare.

1 *MA is paid a capitated amount per beneficiary*

The Federal government pays MA plans a fixed (or capitated) monthly amount per beneficiary to provide health benefits to that individual. MA then contracts with and pays practitioners, hospitals, and other providers to care for beneficiaries. In FFS, the Federal government reimburses hospitals and other providers directly on a "fee-for-services" basis — in other words — for each discrete service provided to a FFS beneficiary.

2 *MA is incentivized to provide coordinated, preventive care*

Because MA plans are paid a capitated amount, they are strongly incentivized to provide coordinated, high-value care to keep beneficiaries healthy and minimize disease progression. Since FFS is paid by volume (per service), this incentive does not exist.

3 *MA focuses on early intervention and care coordination*

MA deploys innovative models for delivering health care such as, home care by nurse practitioners to identify, document, and treat early stage chronic diseases, enable early intervention for at-risk beneficiaries, coordinate care for those with multiple conditions, and provide disease management programs to slow disease progression. Such robust activities are absent in FFS.

4 *MA uses risk adjustment to account for beneficiary differences*

To ensure capitated payments reflect the expected cost of providing medical care to each beneficiary, payments to MA are risk adjusted to reflect the specific characteristics of each enrolled beneficiary, including demographics, Medicaid eligibility, and health status. In MA, it is important that practitioners document clinical diagnoses accurately to ensure that beneficiaries receive the appropriate care management and related services they need based on their condition. In FFS, payment is not risk adjusted, and thus coding patterns are different.

Despite these core differences between MA and FFS, Congress mandated MA payments be reduced every year to reflect the documented health status of FFS beneficiaries. This reduction fails to recognize the underlying differences in the programs and the positive clinical impact early identification and early treatment of illness has in MA as compared to FFS — effectively disincentivizing MA plans and clinicians who are trying to improve chronic disease management and care coordination.

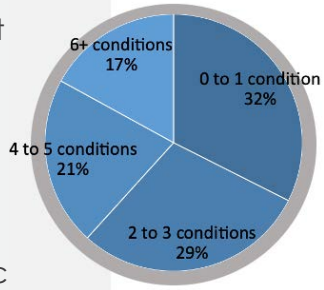
FOCUS ON CHRONIC DISEASE

As millions of Baby Boomers enter the Medicare system, attention is turning to how to effectively address the high incidence of chronic illness among Medicare beneficiaries. According to CMS data, almost 70 percent of Medicare beneficiaries, had two or more chronic conditions in 2017.[6] Almost one in every three Medicare beneficiaries has diabetes. For beneficiaries between 65 and 70, the average diabetes health care expenditures are $13,030. For beneficiaries age 70 and over, the average health care expenditures for diabetes care are $12,340.[7] Active and effective management of these conditions is essential to ensuring that Medicare beneficiaries receive the best possible care and that the Medicare program is sustainable.

> *Risk adjustment is critical to ensuring that MA has adequate resources to provide needed, quality care to their beneficiaries.*

Medicare Advantage (MA) is uniquely positioned to address chronic disease — unlike FFS, the payment model in MA encourages providers to identify, manage, and treat chronic illness in innovative ways that are cost- effective and produce high-quality outcomes.[8, 9]

MEDICARE POPULATION WITH CHRONIC CONDITIONS[12]



- MA plans are actively engaged in helping to identify and document beneficiary health conditions in order to initiate early intervention and slow disease progression.[10]
- MA plans emphasize preventive services and primary care. Primary care teams coordinate care for beneficiaries and work to ensure proper screening and disease management, particularly for those with chronic conditions.[11]
- MA plans offer services specifically designed to help beneficiaries with chronic conditions stay as healthy and active as possible. Through robust health information technology platforms and programs that coordinate care for beneficiaries who see multiple health care providers, MA works to ensure that chronically ill beneficiaries receive the most clinically appropriate care.

To ensure effective identification and treatment of beneficiaries with chronic illness, MA payments must accurately reflect the health status of MA enrollees. Accounting for the health status of beneficiaries for payment purposes is called *risk adjustment and ensures MA has adequate resources to reimburse providers treating MA beneficiaries, including individuals with complex chronic diseases.*

RISK ADJUSTMENT METHODOLOGY

STEP 1

CMS determines the county benchmark payment rate.

STEP 2

CMS determines risk scores to predict cost of care for beneficiary.

STEP 3

County benchmark rate is adjusted for beneficiary risk score.

STEP 4

Payments to MA plans are reduced each year by the coding intensity adjustment. The amount is determined at the discretion of CMS.

The patient population that chooses Medicare Advantage (MA) includes individuals with a wide variation in health and disease status. CMS pays MA plans on a per enrollee capitated basis. MA benchmark base rates are determined for each county and then are risk adjusted for each enrollee by CMS to account for the cost differences associated with various diseases and demographic factors. In other words, CMS modifies the payments to MA plans to reflect the health of each beneficiary.

CMS uses the risk adjustment process to ensure MA functions effectively by paying more for enrollees who are expected to cost more to take care of and paying less for healthier enrollees. ***Risk adjustment is critical to ensuring beneficiary health status is fully captured and resources are appropriately allocated to treat and manage beneficiary care.***

Health conditions and diseases are assigned diagnosis codes. CMS groups individual diagnosis codes into broader diagnosis groups, which are then refined into Hierarchical Condition Categories (HCCs). HCCs, together with demographic factors such as age and gender, are used to predict beneficiaries' total care costs. The system is prospective, which means it uses a beneficiary's diagnoses from one year to calculate a risk adjustment factor used to establish a payment for the following year.

Despite the inefficiencies in FFS and inherent differences between MA and FFS, MA risk adjustment and payment is primarily based on coding patterns and costs in FFS.

BENCHMARK RATE X RISK SCORE = **PAYMENT TO MA MONTHLY CAPITATED**

CLINICAL CODING PATTERNS

Accurately identifying illness is key to the comprehensive approach to care in Medicare Advantage (MA). FFS reimburses providers separately for each episode of care. In contrast, MA is structured to encourage early identification of illness, coordinated care, and improved beneficiary health outcomes.

MA encourages clinicians to identify and treat illness in early stages to enable early intervention, coordinate care for those seeing multiple providers, and provide disease management programs to slow disease progression. These approaches often include care coordination teams focused on beneficiaries with multiple conditions, case managers who support beneficiaries to better ensure compliance with appointment schedules and prescription protocols, exercise and nutrition counseling, and in-home care and evaluation.

Diagnoses in FFS are less reflective of the early identification of chronic illnesses compared to MA.

> *MA initiatives to identify and treat chronic disease are demonstrating evidence of fewer hospital admissions and readmissions, improved use of preventive and primary care services, and higher rates of screening and outcome metrics for chronic diseases.*

- MA enrollees experience a more clinically appropriate use of health care services than beneficiaries in FFS. For example, MA beneficiaries experience lower incidence of emergency services and receive fewer hip and knee replacements.[13]
- MA's hospital readmission rate was found to be about 13% to 20% lower than FFS.[14]
- MA's emergency room visits were found to be 20% to 25% lower and inpatient medical days were found to be 25% to 35% lower than FFS.[15]
- MA beneficiaries are 20% more likely to have an annual preventive care visit than their FFS counterparts.[16]

MODIFICATIONS TO RISK SCORES

CODING INTENSITY ADJUSTMENT

Since 2010, Congress has required CMS to apply a coding intensity adjustment to Medicare Advantage (MA) payments that is an across the board cut to MA risk scores. The purpose of the adjustment is to account for differences in coding patterns between MA and FFS — differences that are a function of the differences between the structural payment and care models in the MA and FFS programs. Under current law, the statutory minimum coding intensity adjustment is 5.91%. CMS has the discretion to determine the amount above the statutory minimum. To date, CMS has applied the minimum coding intensity adjustment required by law.

Payments to MA plans are reduced each year by the coding intensity adjustment.

CHANGES TO THE RISK ADJUSTMENT MODEL

The 21st Century Cures Act mandated certain changes to the Medicare Advantage risk adjustment model. Notably, the law required that CMS implement a risk adjustment model that takes into account the number of conditions a beneficiary has, in addition to adjusting for the various conditions, and make an adjustment as the number of conditions increases. The law also requires that CMS transition to exclusive use of encounter data for risk adjustment calculations rather than the Risk Adjustment Processing System (RAPS). For 2021, CMS is using encounter data to calculate 75% of risk scores and RAPS data to calculate 25% of risk scores, and will transition to 100% encounter data in 2022.

BMA encourages CMS to ensure there is technical support available to Medicare Advantage plans and providers for any questions on the encounter data system related to the submission of encounters, and urges CMS to permit the use of audio-only telehealth encounters for risk adjustment.

AN EXAMPLE OF RISK AD JUSTED MAPAYMENTS IN 2021

$895.61*

Average Monthly Cost or Benchmark of a Medicare Beneficiary in Erie County, New York

**Note: Setting of benchmark rates includes variation by county and adjustments for demographic characteristics, which are not represented here. Assuming the plan's bid has been set to the benchmark their monthly "Capitation Rate" is the benchmark.*

Risk scores assigned to each ***individual*** beneficiary based on health and demographics.

LOWER RISK — HIGHER RISK

**These examples do not represent any individual and are intended as illustrations.*

EX AMPLE ONE

Maria is 65 years old and has rheumatoid arthritis, but is otherwise healthy

FEMALE AGED 65-69 = 0.323

RHEUMATOID ARTHRITIS (HCC40) = 0.421

0.744
Total Unadjusted Risk Score
sum of risk score factors before coding intensity adjustment

$895.61
Capitation Rate*

$666.33
Unadjusted monthly payment to plan

–$39.38
Reduction to payment due to 2016 coding intensity adjustment of -5.41% that reduces Risk Score to 0.626

$626.95
Final monthly payment to plan

EX AMPLE TW O

Philip is 88 years old, has lung cancer, diabetes, macular degeneration, and is depressed

MALE/85-89 YEARS OLD = 0.686

DIABETES WITH CHRONIC COMPLICATIONS(HCC18) = 0.302

LUNG CANCER (HCC9) = 1.024

MAJOR DEPRESSIVE DISORDER (HCC58) = 0.309

EXUDATIVE MACULAR DEGENERATION (HCC124) = 0.521

2.842
Total Unadjusted Risk Score
sum of risk score factors before coding intensity adjustment

$895.61
Capitation Rate*

$2,545.32
Unadjusted monthly payment to plan

–$150.43
Reduction to payment due to 2016 coding intensity adjustment of -5.41% that reduces Risk Score to 2.543

$2,545.32
Final monthly payment to plan

Risk Adjustment Data Validation (RADV) audits are conducted to ensure the accuracy of diagnoses codes

**NOTE: This simplified example uses the 2014 model (not the blended model) and does not include several additional adjustments to MA payments, including for normalization and quality bonus payments.*

CONCLUSION

Risk adjustment is critical to ensuring that Medicare Advantage (MA) plans have the resources necessary to provide innovative, affordable, high quality care to all Medicare eligible beneficiaries who choose MA. More than one third of Medicare eligible beneficiaries — 25 million seniors and people with disabilities depend on MA.

MA relies on an accurate and stable risk adjustment that ensures plans are able to provide high value care to all beneficiaries, including those with complex health needs. MA's approach depends on the accurate clinical identification of health status to reflect the needs of beneficiaries. It is this process that allows MA plans to provide the high quality care that works to identify illness early, coordinate care, and slow disease progression.

It is essential that risk adjustment in MA is accurate, stable, and predicable. This enables MA plans to offer innovative, effective, quality care that is highly valued by millions of beneficiaries, their families, and providers.

> *Risk adjustment that is stable and accurate is critical to ensuring that MA plans have the resources to provide quality, innovative, and effective care for all their beneficiaries.*

SOURCES

[1] CMS data, November 2020. Available at: https://www.cms.gov/Research-Statistics-Data-and- Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/index.html.

[2] CMS. Medicare Current Beneficiary Survey (MCBS), 2017 data. Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/index.html.

[3] Congressional Budget Office, March 2020 Baseline. (March 6, 2020). Available at: https://www.cbo.gov/system/files/2020-03/51302-2020-03-medicare.pdf.

[4] Kaiser Family Foundation, April 2020. Available at: https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2020.

[5] CMS. Medicare Current Beneficiary Survey (MCBS), 2017 data. Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/index.html.

[6] CMS. Chronic Conditions Among Medicare Beneficiaries. Chartbook: 2017 Edition. Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Chartbook_Charts.

[7] American Diabetes Association. Economic Costs of Diabetes in the U.S. in 2017. Diabetes Care. March 20, 2018 Available at: https://care.diabetesjournals.org/content/diacare/early/2018/03/20/dci18-0007.full.pdf.

[8] Miller, Mark. Statement to the U.S. Senate, Committee on Finance. Improving care for beneficiaries with chronic conditions, Hearing, May 14, 2015. Available at: http://medpac.gov/documents/congressional-testimony/testimony-improving-care-for-beneficiaries-with-chronic-conditions-(senate-finance).pdf.

[9] Ibid.

[10] Newhouse, J.P., McGuire, T.G. How Successful Is Medicare Advantage? The Milbank Quarterly, 92, 2 (June 2014): 351-394.

[11] Landon, B.E., Zaslavsky, A.M., Saunders, R.C. Pawlson, G. et al., Analysis of Medicare Advantage HMOs Compared With Traditional Medicare Shows Lower Use of Many Services During 2003-2009. Health Affairs, 31, 12 (2012).

[12] CMS. Chronic Conditions Among Medicare Beneficiaries. Chartbook: 2017 Edition. Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Chartbook_Charts

[13] Ayanian, J.Z., Landon, B.E., Newhouse, J.P. et. al. Analysis of Medicare Advantage HMOs Compared with Traditional Medicare Shows Lower Use of Many Services During 2003-09. Health Affairs, 31, 12 (December 2012): 1-9.

SOURCES

[14] Jeff Lemieux, MA; Cary Sennett, MD; Ray Wang, MS; Teresa Mulligan, MHSA; and Jon Bumbaugh, MA. Hospital Readmission Rates in Medicare AdvantagePlans-Am J Manag Care, 18, no. 2 (2012):96-104.

[15] Landon, B.E., Zaslavsky, A.M., Saunders, R.C. Pawlson, G. et al., Analysis of Medicare Advantage HMOs Compared With Traditional Medicare Shows Lower Use of Many Services During 2003-2009. Health Affairs, 31, 12 (2012).

[16] Sukyung Chung, Lenard I. Lesser, Diane S. Lauderdale, Nicole E. Johns, Latha P. Palaniappan and Harold S. Luft. Medicare Annual Preventive Care Visits: Use Increased Among Fee-For-Service Patients, But Many Do Not Participate. Health Affairs, 34, no.1 (2015):11-20.

QUESTIONS OR COMMENTS?
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