OLIVER WYMAN

2016 Risk Adjustment Analysis – Chronic Kidney Disease

March 31, 2015

Glenn Giese
FSA, MAAA

Kevin Meyer
ASA, MAAA

Overview

The recent proposal by the Centers for Medicare & Medicaid Services (CMS) to fully phase in the 2014 CMS-HCC risk adjustment model will significantly impact Medicare Advantage plans' population-based approach to care that has resulted in fewer preventable hospitalizations, better access to primary and preventive care, and more appropriate utilization of services as documented in recent studies.[1] The results of our findings indicate a 23% reduction in plan payments for individuals with Chronic Kidney Disease (CKD).[2] Overall, the full impact of changes from the 2013 to the 2014 model for members with CKD is estimated to be a 37.8% decrease in risk scores. Since the 2014 model was 33% transitioned in 2015, the estimated decrease of 2016 risk scores for those members with CKD is 25.3%. These cuts mean less reimbursement for Medicare Advantage plan investments in activities designed to identify diseases at their earliest stages and implement care management protocols to slow their progression.

Our analysis also finds 56% of the population with a CKD HCC in the 2013 risk model would no longer have a CKD HCC under the 2014 risk adjustment model. The 2014 model therefore significantly reduces its emphasis on this disease, which according to the Centers for Disease Control (CDC), affects over 15% of all Medicare beneficiaries.[3]

CMS estimates that the impact of fully implementing the 2014 HCC model cuts the program by 1.7%[4] or approximately $3.5 billion.[5] This number is much lower than Medicare spending (excluding prescription drugs) for patients with kidney failure, which reached nearly $29 billion in 2012, accounting for about 6% of the Medicare budget costs.[6] It is critical CMS keep in place policies to prevent, monitor, and appropriately treat CKD before it progresses and becomes life threatening to beneficiaries and more costly.

---

[1] See for example Ayanian, John Z. Landon, Bruce E. Newhouse, Joseph P. et al. Analysis of Medicare Advantage HMOs Compared with Traditional Medicare Shows Lower Use of Many Services During 2003-09. Health Affairs 31. No. 12: 1-9. December 2012 and Cohen, Robb. Lemieux, Jeff. Mulligan, Teresa. Schoenborn, Jeff. Medicare Advantage Chronic Special Needs Plan Boosted Primary Care Reduced Hospital Use Among Diabetes Patients. Health Affairs 31. No.1: 110-119. January 2012.

[2] Calculated by multiplying the 25.3% reduction in risk scores from the 2015 to 2016 payment years by the portion of total plan payments that are risk adjustment (total payments minus rebates), which are estimated to be approximately 92% based on data recently reported by MedPAC.

[3] See http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Dashboard/Chronic-Conditions-County/CC_County_Dashboard.html.

[4] CMS Fact Sheet: Moving Medicare Advantage and Part D Forward." February 20, 2015. http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-02-20-2.html

[5] Estimate based on application of this cut to 2016 estimated expenditures included in the March 2015 Congressional Budget Office baseline found at http://www.cbo.gov/sites/default/files/cbofiles/attachments/44205-2015-03-Medicare.pdf

[6] See CDC fact sheet found at http://www.cdc.gov/diabetes/projects/pdfs/ckd_summary.pdf

Brief Description of Analysis

America's Health Insurance Plans (AHIP) engaged the Actuarial Practice of Oliver Wyman to calculate the impact of the change in the CMS Risk Adjustment model on Chronic Kidney Disease (CKD). For CKD, there are 23 diagnoses that are mapped to HCC131 in the 2013 risk adjustment model. For the 2014 model, six of the diagnosis codes were removed and only 17 diagnoses are being mapped to CKD. Also, the number of coefficients is being increased from 1 to 3 (HCC135-137). The CKD coefficient is increasing 60% for HCC135 in 2014 relative to HCC131 in 2013, but decreasing 25% for HCCs 136 and 137. In addition to these changes, it is estimated that 56% of the population with a CKD HCC in 2013 will no longer have a CKD HCC under the 2014 risk adjustment model.

Our analysis was based on a comprehensive review of 2012 diagnoses data for the Medicare FFS population. Using the 2012 diagnosis codes from the FFS 5% sample database, we are estimating an average decrease in the raw risk for seniors with CKD of 37.8% under the 2014 model when compared to 2013. Since the 2014 model was 33% transitioned in 2015, the estimated decrease on 2016 risk scores for those members with CKD is 25.3%.

Considerations and Limitations

The opinions and conclusions expressed herein reflect technical assessments and analyses, and do not reflect statements or views with respect to public policy.

The Actuarial Practice of Oliver Wyman was commissioned by America's Health Insurance Plans to prepare this report in response to CMS' Advance Notice of Methodological Changes for Calendar Year 2016 Medicare Advantage Capitation Rates and Part C and Part D Payment Policies. Oliver Wyman shall not have any liability to any third party in respect of this report or any actions taken or decisions made as a consequence of anything set forth herein. The opinions expressed herein are valid only for the purpose stated herein and as of the date hereof. Information furnished by others, upon which all or portions of this report are based, is believed to be reliable but has not been verified. No warranty is given as to the accuracy of such information. Public information and industry and statistical data are from sources Oliver Wyman deems to be reliable; however, Oliver Wyman makes no representation as to the accuracy or completeness of such information and has accepted the information without further verification. No responsibility is taken for changes in market conditions or laws or regulations and no obligation is assumed to revise this report to reflect changes, events or conditions, which occur subsequent to the date hereof.


OLIVER WYMAN