

Understanding Risk Adjustment in Medicare Advantage

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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 program relies on risk adjustment to maintain predictable and actuarially sound payments to Medicare Advantage 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 Medicare Advantage beneficiaries.

Overview of Medicare Advantage

Medicare Advantage, 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 & Medicaid Services (CMS) and the program undergoes an annual review process that makes policy changes and sets payment rates for the next year.

Medicare Advantage 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 Medicare Advantage plans also include additional benefits, such as vision, hearing, dental, fitness, and wellness. Unlike FFS Medicare, Medicare Advantage also has an out-of-pocket maximum to protect beneficiaries.

Key Medicare Advantage Facts

- **One third of Medicare beneficiaries — over 18.5 million individuals** have chosen to receive their Medicare coverage through Medicare Advantage.¹
- **Over 36% of MA beneficiaries** have annual incomes of less than \$20,000.²
- **Nearly one third of African American Medicare beneficiaries and 44% of Hispanic Medicare beneficiaries** are enrolled in Medicare Advantage.³
- **Roughly 1 in 4 individuals dually eligible for Medicare and Medicaid** are enrolled in Medicare Advantage.⁴
- **Medicare Advantage beneficiaries are satisfied** — 91% of beneficiaries report they are satisfied with their coverage.⁵
- **99% of Medicare-eligible individuals** have access to a Medicare Advantage plan in their area.⁶
- **Medicare Advantage enrollment is projected to reach 31 million beneficiaries** and 41% of Medicare by 2027.⁷

FIGURE 1

Medicare Population 57 Million⁸

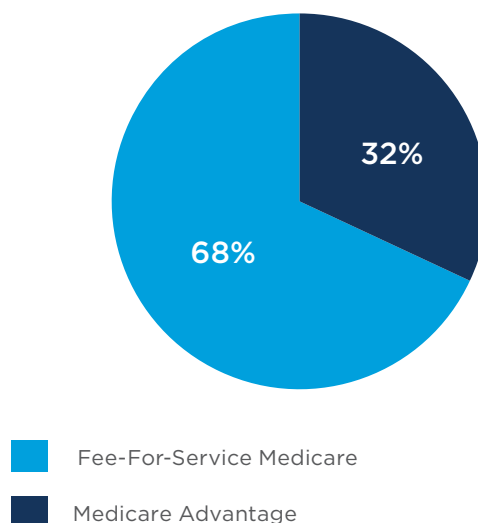
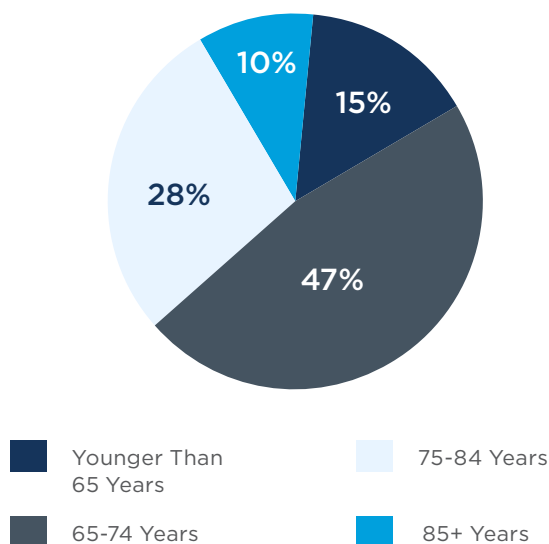


FIGURE 2

Age Demographics⁹



Key Differences Between Medicare Advantage and Fee-For-Service Medicare

It is important to understand the significant differences between Medicare Advantage and Traditional Fee-For-Service (FFS) Medicare.

1. Medicare Advantage is paid a capitated amount per beneficiary

The Federal government pays Medicare Advantage plans a fixed (or capitated) monthly amount per beneficiary to provide health benefits to that individual. Medicare Advantage then contracts with and pays clinicians, hospitals, and other providers to care for beneficiaries. In FFS Medicare, 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 Medicare beneficiary.

2. Medicare Advantage focuses on preventive care and early intervention

Because Medicare Advantage plans are paid a capitated amount, they are incentivized to provide high-value care to keep beneficiaries healthy and minimize disease progression. Medicare Advantage places an emphasis on identifying and treating early stage chronic disease. Since FFS Medicare is paid by volume (per service), this incentive does not exist.

3. Medicare Advantage incentivizes innovation and care coordination

Medicare Advantage deploys innovative models for delivering and coordinating health care, such as home care by nurse practitioners, dynamic disease management strategies, and specialized care for individuals living with multiple conditions. Such robust activities are absent in FFS Medicare.

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

Focus on Chronic Disease

As millions of Baby Boomers enter Medicare, attention is turning to how to effectively address the high incidence of chronic illness among Medicare beneficiaries. According to the most recent CMS data, over two thirds of Medicare beneficiaries, or 21.4 million beneficiaries are living with two or more chronic conditions.⁸ 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.

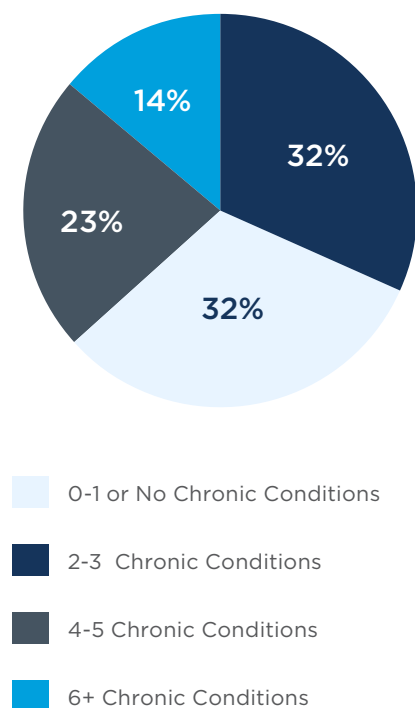
Risk adjustment is critical to ensuring that Medicare Advantage has adequate resources to provide needed, quality care to their beneficiaries.

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

- Medicare Advantage plans are actively engaged in identifying and documenting beneficiary health conditions in order to initiate early intervention and slow disease progression.
- Medicare Advantage 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.
- Medicare Advantage 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, Medicare Advantage payments must accurately reflect the health status of Medicare Advantage enrollees.

FIGURE 3

Medicare Populations With Chronic Conditions¹¹



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 Medicare Advantage plans are reduced each year by the coding intensity adjustment. The amount is determined at the discretion of CMS.

Risk Adjustment Methodology

The patient population that chooses Medicare Advantage includes individuals with a wide variation in health and disease status. CMS pays Medicare Advantage plans on a per enrollee capitated basis. Medicare Advantage 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 Medicare Advantage plans to reflect the health of each beneficiary.

CMS uses the risk adjustment process to ensure Medicare Advantage 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 Medicaid eligibility, are used to predict beneficiaries' total care costs. The system is prospective, which means it uses beneficiary diagnoses from one year to calculate a risk adjustment factor used to establish a payment for the following year.

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

BENCHMARK RATE

X

RISK SCORE

=

MONTHLY CAPITATED
PAYMENT TO
MEDICARE
ADVANTAGE

Clinical Coding Patterns

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

Medicare Advantage 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 Medicare Advantage.

Medicare Advantage 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.

- Medicare Advantage enrollees experience a more clinically appropriate use of health care services than beneficiaries in FFS Medicare. For example, Medicare Advantage beneficiaries experience lower incidence of emergency services and receive fewer hip and knee replacements.¹²
- Medicare Advantage beneficiaries are 20% more likely to have an annual preventive care visit than their FFS Medicare counterparts.¹³

Recent Changes to Risk Adjustment

Coding Intensity Adjustment

Since 2010, Congress has required CMS to apply a coding intensity adjustment to Medicare Advantage payments that is an across the board cut to Medicare Advantage risk scores. The purpose of the adjustment is to account for differences in coding patterns between Medicare Advantage and FFS Medicare — differences that are a function of the differences between the structural payment and care models in the Medicare Advantage and FFS Medicare programs. Per statute, the coding intensity adjustment has increased from a 3.41% reduction in 2010 to a 5.91% reduction for payment year 2018. The coding intensity adjustment must remain no less than a 5.91% reduction to risk scores for all subsequent years. CMS has the authority to determine the amount above the statutory minimum. To date, CMS has applied the minimum coding intensity adjustment required by law.

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

Coding Intensity Adjustment	
2010 to 2013	-3.41%
2013	-4.91%
2014	-5.16%
2015	-5.41%
2016	-5.66%
2017	-5.91%
2018+	At Least -5.91%

Changes to the Risk Adjustment Model

- In 2013, CMS announced it would phase in a new CMS-HCC risk adjustment model (the “2014 Model”) that removed certain diagnosis codes related to early stages of chronic diseases, such as diabetes and chronic kidney disease, meaning plans would no longer get payment for those diagnoses. The elimination of these codes reduced the resources that were previously available for early intervention of chronic disease.
- In 2017, CMS adopted a change to the CMS-HCC risk adjustment model to address concerns that the model didn’t accurately predict the full cost of treating high-risk beneficiaries who are dually eligible for Medicare and Medicaid. Under the new methodology, CMS divides beneficiaries into six groups:
 1. Full benefit dual aged
 2. Full benefit dual disabled
 3. Partial benefit dual aged
 4. Partial benefit dual disabled
 5. Non-dual aged; and
 6. Non-dual disabled.
- Evidence shows that the risk adjustment model still does not adequately account for the cost of treating beneficiaries with multiple chronic conditions.

An Example of Medicare Advantage Payments in 2018

\$790.52*
 Average Monthly Cost or Benchmark of a Medicare Beneficiary in Erie County, New York

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 to be illustrative examples.

*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.

EXAMPLE ONE



Maria is 65 years old and has rheumatoid arthritis, but is otherwise healthy. Maria is not low income.

FEMALE AGED 65-69 = 0.312
 RHEUMATOID ARTHRITIS (HCC40) = 0.423

0.735
 Total Unadjusted Risk Score
 Sum of risk score factors before coding intensity adjustment

\$790.52
 Capitation Rate*


\$581.03
 Unadjusted monthly payment to plan

↓

-\$33.99
 Reduction to payment due to 2018 coding intensity adjustment of -5.91% that reduces Risk Score to 0.692

\$547.04
 Final Monthly Plan

EXAMPLE TWO



Philip is 88 years old, has lung cancer, diabetes, macular degeneration, is depressed, and is low income and is dual eligible for Medicare and Medicaid.

MALE/85-89 YEARS OLD = 1.009
 DIABETES WITH CHRONIC COMPLICATIONS (HCC18) = 0.346
 LUNG CANCER (HCC9) = 0.973
 MAJOR DEPRESSIVE DISORDER (HCC58) = 0.444
 EXUDATIVE MACULAR DEGENERATION (HCC124) = 0.0.278

3.050
 Total Unadjusted Risk Score
 Sum of risk score factors before coding intensity adjustment

\$790.52
 Capitation Rate*

\$2,411.09
 Unadjusted monthly payment to plan

↓

-\$142.30
 Reduction to payment due to 2018 coding intensity adjustment of -5.91% that reduces Risk Score to 2.870

\$2,268.79
 Final Monthly Plan

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

*NOTE: This simplified example uses the 2017 CMS-HCC model and does not include several additional adjustments to Medicare Advantage payments, including for normalization and quality bonus payments. It assumes the plan bid is set to the benchmark and therefore there is no rebate payment.

Conclusion

Risk adjustment is critical to ensuring that Medicare Advantage plans have the resources necessary to provide innovative, affordable, high quality care to all Medicare eligible beneficiaries who choose Medicare Advantage. One third of Medicare eligible beneficiaries – 18.5 million seniors and people with disabilities depend on Medicare Advantage.

Medicare Advantage 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. Medicare Advantage’s approach depends on the accurate clinical identification of health status to reflect the needs of beneficiaries. It is this process that allows Medicare Advantage 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 Medicare Advantage is accurate, stable, and predictable. This enables Medicare Advantage 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 Medicare Advantage plans have the resources to provide quality, innovative, and effective care for all their beneficiaries.

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