The Next Generation of Risk Adjustment: Policy Opportunities to Advance Reform

April 19th, 2023

Duke Margolis Center for Health Policy
Agenda

• The Current Status of Risk Adjustment - Taking Stock of CMS’ Policies
  Presenters: Frank McStay, Duke-Margolis & Erica Everhart, CareJourney

• Immediate Policy Opportunities to Support an Improved Risk Adjustment System
  Moderator: Mark McClellan, Duke-Margolis
  Panelists: Rick Gilfillan, formerly Trinity Health & Rahul Rajkumar, Accompany

• Transition to the Next Generation of Risk Adjustment
  Moderator: Mark McClellan
  Panelists: Erica Everhart and Dana Safran, National Quality Forum

• Audience Question and Answer

• Wrap up
The Current Status of Risk Adjustment
Taking Stock of CMS’ Policies

Assistant Research Director, Duke-Margolis, Former Senior Policy Advisor, Baylor Scott and White

Head of Thought Leadership, CareJourney and Former Attorney Brian V. Ebert, PC

Frank McStay, MPA

Erica Everhart, JD
Growing Importance of Risk Adjustment – and Growing Challenges with Current Methods

• Risk adjustment can substantially alter the per-beneficiary payments a plan receives
  • HCC predicts a 74 y/o male living in the community with no coded conditions would have annual expenditures of $2,885
  • Same man with coded diagnoses of diabetes with chronic complications, congestive heart failure, and heart attack would have annual expenditures of $11,772

• Significant concerns about undesirable consequences of current risk adjustment model
  • Increases Medicare costs in ways that do not necessarily reflect value or beneficiary needs
  • Percentage of premium models lead to growing coding intensity factor (CIF) adjustments and higher payments
  • Important to accurately code diagnoses, but substantial investments focused on coding that aren’t being used for quality/care management
Current system still on FFS chassis that challenges transformation and whole-person care

- Do not incorporate social risk factors (ex: neighborhood factors like ADI) or functional status into risk adjustment algorithms
  - Some examples in ACO REACH and MCO contracts, but concerns about unintended consequences

- Risk adjustment system is based on FFS claims in Traditional Medicare, where data are not representative and flawed
  - MA approximately half of Medicare beneficiaries and growing, which is problematic for methods based on FFS administrative data.
  - Still based on volume and does not represent high-value care
  - Undercoding of diagnoses in Traditional Medicare
Recently Proposed and Finalized MA Rule Responds to (Some of) These Challenges, But Questions Remain

• CY 2024 Final Notice phased in proposed changes to HCC model, including moving to ICD-10 and dropping or constraining certain diagnosis codes used more and more frequently in MA vs Traditional Medicare (ex: atherosclerosis, diabetes, heart failure, mild depression)

• CMS acknowledges the trade-offs between Principles 1 and 2 (clinically meaningful and predicting expenditures), 5 (encouraging specific coding) , and 10 (discretionary coding)

• Finalized risk adjustment reforms shift payments away from beneficiaries with the included diagnoses, which are more prevalent in lower-income beneficiaries and minoritized racial and ethnic groups
Overall assessment of initial V28 proposal

<table>
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<tr>
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<th>Raw V.24</th>
<th>Raw V.28</th>
<th>% Difference - Raw</th>
<th>Normalized v.24</th>
<th>Normalized v.28</th>
<th>% Difference</th>
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<td>1.217</td>
<td>1.209</td>
<td>-0.60%</td>
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<tr>
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<td>1.231</td>
<td>1.090</td>
<td>-11.46%</td>
<td>1.074</td>
<td>1.074</td>
<td>-0.03%</td>
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Widening racial disparities. Duals are more impacted.

<table>
<thead>
<tr>
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<th>v.24 HCC</th>
<th>v.28 HCC</th>
<th>2021 PMPY FFS</th>
<th>2021 PMPY MSSP</th>
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<tr>
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<td>1.576</td>
<td>1.548</td>
<td>$19,023</td>
<td>$18,367</td>
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<td>% Difference</td>
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<td>86.4%</td>
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</table>

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<tbody>
<tr>
<td>White</td>
<td>1.115</td>
<td>1.115</td>
<td>$11,607</td>
<td>$12,332</td>
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<td>1.208</td>
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<td>13.9%</td>
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Impacts by plan

ISNPs see mostly decreased risk scores.

CSNPs see mostly decreased risk scores.

DSNPs have a mix of +/- scores

Non-SNPs see mostly increased risk scores.
Impact by disease group

v.28 predicts $6.4B less in costs for treating depression over v.24.
What does this all mean? Need additional information and reforms to improve system

• Need standardized, systematic approaches to analyses on risk adjustment and proposed reforms given data limitations and evolving market and evaluation techniques
  • CMS provided enhanced model and software specifics to assist in stakeholder analysis and aide in transparency
  • CMS released some additional analysis in final notice on duals differential impact and directly to plans improved impact understanding, especially as it relates to changes focused on principle 10

• Finalized reforms may shift payments away from beneficiaries with the included diagnoses, which are more prevalent in lower-income beneficiaries and racial and ethnic minorities

• Underscores need to move away from FFS and toward category 3 and 4 payments
Immediate Policy Opportunities to Support an Improved Risk Adjustment System

Former CEO of Trinity Health System, and Deputy Administrator of CMS

CEO of Accompany, Former COO of Optum Care Solutions, CMO of BCBS NC and CareFirst

Rick Gilfillan, MD, MBA

Rahul Rajkumar MD, JD, FACP
Transitioning to a Reformed Risk Adjustment System

Erica Everhart, JD

Dana Gelb Safran, ScD

Head of Thought Leadership, CareJourney and Former Attorney
Brian V. Ebert, PC

President/CEO
National Quality Forum and Former Executive at Blue Cross Blue Shield of Massachusetts
Question and Answer
Thank You!

Contact Us

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