



USING ENCOUNTER DATA IN MEDICARE ADVANTAGE RISK ADJUSTMENT

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Project overview

Summit topics

- What are the objectives of risk adjustment in the Medicare Advantage program?
- What are the strengths and weaknesses of the current Medicare Advantage risk adjustment system?
- What are the goals for using encounter data in the Medicare Advantage risk adjustment system?
- What are the potential benefits and drawbacks of calibrating the risk adjustment model with encounter data?

An issue brief summarizing the discussion at the summit is being released today.

Today's panelists all attended the summit.

October 23 Summit

Jonathan Blum, Health Management Associates

Kristina Cournoyer, Anthem

Sean Creighton, Avalere

Errin Crowell, Aetna

Frank Cunningham, Eli Lilly & Company

Randall Ellis, Boston University

Doug Fearrington, Anthem

Michael Geruso, University of Texas at Austin

Gretchen Jacobson, Kaiser Family Foundation

Lisa Joldersma, Pharmaceutical Research and Manufacturers of America

Tom Kornfield, America's Health Insurance Plans (AHIP)

Julia Lambert, Wakely Consulting Group

David Lipschutz, Center for Medicare Advocacy

Thomas McGuire, Harvard University

Mark Miller, Laura and John Arnold Foundation

Rob Pipich, Milliman

Marc Russo, Anthem

Valinda Rutledge, America's Physician Groups

Doug Stoss, Humana

Cori Uccello, American Academy of Actuaries

Jonathan Weiner, Johns Hopkins University

General Objectives of Risk Adjustment

- Risk adjustment encourages plans to compete by offering value. Without adequate risk adjustment, plans face incentives to compete by avoiding risk.
 - If insurers are paid per enrollee without risk adjustment, they have an incentive to focus on enrolling healthy beneficiaries and avoiding sick beneficiaries.
 - Attempts to draw favorable selection can occur by discouraging initial enrollment and by encouraging sicker beneficiaries to disenroll.
 - Research suggests that overall favorable selection into MA was reduced by the introduction of the risk adjustment program, but some research continues to show higher disenrollment among sicker beneficiaries and selection along dimensions not included in the risk adjustment formula.
- Risk adjustment supports plans' efforts to invest in innovative benefit designs and care management of chronic conditions and other costly beneficiaries.

How MA Risk Adjustment Works

- MA plans are paid a capitated, per-enrollee rate that is based on a plan's bid to provide Part A and B benefits to an average risk enrollee (risk score = 1.0).
 - This capitated rate is adjusted by an enrollee's risk score:
Payment = base rate x beneficiary-specific risk score
- Payments are higher for more costly/less healthy beneficiaries with risk scores above 1.0 and lower for less costly/healthier beneficiaries with risk scores below 1.0.
- Risk scores are calculated using the CMS-HCC model:
 - The model uses diagnoses and demographics to calculate a risk score.
 - The model is prospective, meaning it uses diagnoses from the prior year to calculate risk scores for the current year.
- Risk scores are calculated with distinct sets of coefficients depending on which of eight segments a beneficiary is assigned to:
 - New enrollees;
 - Continuing enrollees residing in the community, with 6 different segments depending on disability and dual eligible status (full-benefit, partial-benefit, or non-dual);
 - Continuing enrollees who are in a long-term institutional stay.

Background on Encounter Data in MA Risk Adjustment

- In 2008, CMS clarified its authority to collect encounter data for use in the risk adjustment system, including for potential calibration of the risk adjustment models.
- In 2012, MA plans began submitting encounter data through the Encounter Data System (EDS).
- Prior to 2015, MA risk scores were calculated solely from diagnoses submitted by MA plans to the Risk Adjustment Processing System (RAPS).
- In 2015, CMS first used encounter data to supplement diagnoses in RAPS.
- In 2016, CMS began calculating blended risk scores using scores based on RAPS and EDS; a 25/75% blend of RAPS and EDS scores is being applied in 2019, and CMS expects risk scores will be 100% based on encounter data diagnoses in 2022.
- CMS has signaled interest in using encounter data to estimate the risk adjustment model.
- The ACA provides that the coding intensity adjustment will no longer be required once the MA risk adjustment model is calibrated on MA encounter data.

What would it mean to calibrate the model with encounter data?

- Currently, traditional Medicare spending and utilization data are used to estimate the coefficients for the risk adjustment model.
- In the future, CMS may use MA encounter data to estimate these coefficients so that they reflect MA spending and utilization patterns—rather than create an entirely new model.
- CMS may also need to rethink which current risk factors to include in an encounter data-based model, and if using the current 6-segment approach with MA data will yield large enough sample sizes to estimate all 6 segments of the model.
- Consideration will also have to be given to whether it makes sense for MA risk scores to be calculated on MA data, but have MA benchmarks continue to be calculated based on TM costs.

Key points from summit

- The MA risk adjustment system balances the goals of payment accuracy and creating appropriate incentives for plans to compete by offering value, rather than by avoiding risk.
 - Calibrating the model with encounter data could improve accuracy, but could also change the incentives for MA plans to enroll a broad array of risks, placing these two key risk adjustment goals in conflict.
- Recalibrating the risk adjustment model with MA encounter data does not, by itself, solve most of the problems stakeholders identified with the current risk adjustment system, including:
 - Transparency in the model and policy development processes
 - Adequate payment for new enrollees and new plans
- Recalibration could create new problems in the risk adjustment system, including:
 - Payment instability during the transition
 - Changes to the viability of special needs plans (SNPs) focused on particular chronic conditions
- Risk adjustment is only one piece of the MA payment and policy system, and recalibrating the risk adjustment model with encounter data could have ripple effects.

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<http://www.urban.org/about/funding-and-annual-reports>



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