

# Evaluating Risk Adjustment and Medicare Advantage

*Ideas for Improving an Important Tool*

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## Ideas for Improving an Important Tool

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## Executive Summary

During a February 2, 2022, hearing of the Senate Finance Subcommittee on Fiscal Responsibility and Economic Growth, Dr. Michael Chernew, Chair of the Medicare Payment Advisory Commission offered testimony on the practice of risk adjustment. Dr. Chernew noted that while Medicare Advantage (MA) is growing and serving more members, the cost of MA plans continues to outpace traditional Medicare. According to Dr. Chernew, the result of coding practices in MA resulted in an estimated 3.6% greater cost for those members than what the cost would have been in traditional Fee-For-Service Medicare<sup>1</sup>.

Questions raised during the hearing included whether MA members are getting more, or better, care as a result of higher costs to the government and if an overall reduction in payments to MA plans was appropriate and necessary. Dr. Chernew and others in the Senate Finance Subcommittee said further action was needed to address the cost impacts of risk adjustment. In addressing these impacts, one must tread carefully given the high levels of member satisfaction with MA as indicated by its steadily increasing market share in the Medicare space.

The conversation around MA payments has been around for years, fueled by concerns over potential overpayments because MA plans are incented to code for additional diagnoses. It is worth noting that the [statutory requirements for MA](#) specifically state that adjustments to payment amounts must “ensure actuarial equivalence” per the excerpt below and subject to the Secretary’s interpretation.

“The Secretary shall adjust the payment amount under subparagraph (A)(i) and the amount specified under subparagraph (B)(i), (B)(ii), and (B)(iii) for such risk factors as age, disability status, gender, institutional status, and such other factors as the Secretary determines to be appropriate, including adjustment for health status under paragraph (3), so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such adjustment factors if such changes will improve the determination of actuarial equivalence.”

Given actuaries’ deep knowledge of risk adjustment techniques, and the reference to actuarial equivalence in the MA statutory requirements, this topic is of particular interest to the actuarial community. Furthermore, actuaries are held to a [Code of Professional Conduct](#), which calls on the profession to fulfill its responsibility to the public, ensuring that honesty, integrity and competence are leveraged in all actuarial pursuits.

The purpose of this brief is to provide background and perspectives on the use of risk adjustment, especially for MA. The opinions in this brief were collected from a diverse set of actuaries convened by the Health Care Cost Trends Strategic Research Committee of the Society of Actuaries. The goal of the Committee was not to establish a consensus opinion, but rather to give interested parties a sense of the kinds of thinking that actuaries bring to this important and intricate topic.

Members of the SOA see firsthand how risk adjustment is applied in practice in many areas of health care, and the Society of Actuaries has published numerous studies on risk adjustment. We understand the concerns voiced in the Senate hearing, and through previous SOA research we seek to explain why risk adjustment is an important element of MA. To that end, this brief will define risk adjustment and its role in MA specifically, while also enumerating some existing opportunities for the improvement of current practices. The purpose of this paper is to educate and inform. It is not intended to advocate for a specific policy related to risk adjustment practices or directly respond to comments made during the subcommittee hearing referenced above.

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<sup>1</sup> MA Risk Scores were 9.5% higher than scores for similar traditional Medicare beneficiaries with a 5.9% downward coding intensity adjustment.

## Definition of Risk Adjustment

The practice of making adjustments based on the severity of a population has been studied [for more than 40 years](#). Along the way, various risk adjustment models have been used to serve a number of use cases across the health care system.

Both in the U.S. and abroad, risk adjustment has been used to stabilize health insurance plans that operate in markets where individual premiums are regulated. In the case of MA, plans are required to guarantee coverage and uniform premiums for individuals, regardless of disease burden. Risk adjustment is a tool that makes the system work and promotes market stability for both individuals and plans.

In MA, health insurance premium risk adjustment models predict claim costs based on morbidity-related variables. They incorporate data elements such as age and gender, Hierarchical Condition Categories (HCCs) diagnosis codes, and in some cases, pharmacy claims. Each participating plan receives reimbursements that are adjusted for the risk profile of its individual enrollees. Plans receive higher compensation for members who have higher risk scores. Conversely, individuals with lower risk scores generate less revenue for the plan. Fundamentally, risk adjustment for MA is designed to calibrate federal government payments to adjust payment to health plans to reflect the health status of their membership. Risk adjustment also helps protect the system from selection bias, where plans would have financial incentives to avoid certain populations.

The government compensation for MA plans is based on the risk level of the members they enroll. In addition, without risk adjustment, plans will avoid higher cost individuals when possible. Eventually, plans with a disproportionate percentage of sick members will struggle financially, and ultimately not be able, or willing, to participate in the MA program.

The concept of risk adjustment to premiums is a rational means to match premium payments to expected disease burden of a population where underwriting is not allowed. It is also reasonable to examine what incentives risk adjustment practices have on the behaviors of providers and health plans, and whether the current risk adjustment method for MA is creating vulnerabilities in the system. If vulnerabilities do exist, it is important to consider the best courses of action to remedy them through different methods and practices.

## Considerations for Current Risk Adjustment Practices

Current risk adjustment practices have likely contributed to increased government spending on the MA program. Below are considerations that have been considered by actuaries and non-actuaries alike to explore further as we evaluate the current practice of risk adjustment.

### REVISIT THE CMS CODING INTENSITY ADJUSTMENT FACTOR

Each year, the Centers for Medicare and Medicaid Services (CMS) makes a “coding intensity” adjustment to monthly MA plan payments to account for the coding differences in MA organizations relative to traditional Medicare. These differences are present largely because of the incentives provided to MA plans to report more diagnoses. This coding intensity factor currently reduces fees by roughly six percent, but it is applied uniformly to all MA plans, ignoring differences in code reporting among plans. This over-reduces some plan revenues and under-reduces others. It seems reasonable to consider varying the coding intensity factor by plan in order to better reflect the levels of over-coding for each plan.

### INCENTIVIZE BETTER CODING IN TRADITIONAL MEDICARE

There are fewer incentives for fee-for-service providers to code more completely. Most are based on participation of providers within Accountable Care Organizations (ACOs). Introducing incentives for better coding into the traditional Medicare model would potentially address coding intensity differences when compared with MA plans. Coding improvements for ACOs that are within Medicare fee-for-service could help direct more resources to providers in traditional Medicare who are caring for sicker patients. However, any changes made here are subject to the original statutory requirements.

### EVALUATE A ZERO SUM DESIGN

To more tightly control costs, some insurance programs operate with zero-sum designs for risk adjustment. Commercial payments under the Affordable Care Act (ACA) are examples of this approach. Payments for plans in that program are reconciled and distributed from a fixed budget. This means there is one finite pie to divide among plans, versus in MA where the size of the pie is undefined. As a result, more complete coding by payers in MA leads to increases in net new reimbursement costs for the system. This idea has been considered for the Medicare program without any action being taken thus far. A zero-sum design could be considered for the overall Medicare program, or separately within the MA product line.

### MODERNIZE AUDIT AND PENALTY PRACTICES

CMS conducts risk adjustment data validation (RADV) to ensure the accuracy and integrity of risk adjustment data submitted by MA plans. RADV is the process of verifying that diagnosis codes submitted for payment are supported by medical record documentation.

Current RADV audit practices only spot-check coding submissions by plans on a random basis, and there is a lag of multiple years before codes are potentially checked. There are opportunities to improve the ability for CMS to monitor coding practices more tightly among MA plans. For instance, examining the totality of electronic data submitted for risk adjustment, or using artificial intelligence and machine learning to identify outliers could be a more efficient and effective way to police coding practices.

### MINIMIZE OPPORTUNITIES FOR “OVER-CODING”

One way to minimize opportunities for over coding would be to require proof of treatment. For certain conditions, CMS would deny diagnosis codes in the absence of a proof of treatment. As an example, for a patient who carries a depression diagnosis but has not been prescribed medication, counseling, or other supportive treatment, the

depression diagnosis would not count toward risk scoring. Overall, risk scoring methodologies that are less susceptible to improper coding practices would be preferable.

### **USE MULTIPLE YEARS OF DATA**

Currently, risk adjustment within MA uses a single year of claims data for risk scoring. Using multiple years of data instead of a single year could potentially reduce the higher coding of MA plans relative to traditional Medicare, because MA plans do a better job of checking the year-to-year consistency of diagnosis coding for their members. Based on the 21<sup>st</sup> Century Cures Act, the Department of Health and Human Services has the authority to use two years of diagnosis data. This could help reduce risk score differences between MA plans, as well as between the MA and traditional Medicare programs overall. A potential concern is that using multiple years of data may tend to cause erroneous diagnoses to persist for multiple years. This has been come up in discussions around improving risk adjustment and warrants additional scrutiny and consideration if it can be shown to produce more accurate results.

### **CONSIDER PRESCRIPTION DRUG UTILIZATION**

Prescription drug utilization data is standardized and does not have the some of the quality of data issues that affect administrative medical claim data generated by healthcare providers. Filled prescription drugs prescriptions would be the source data, and these require action by a clinician (the prescriber) and the patient (who receives or picks up the drug), so this data is subject to different risks of coding practices than the use of diagnosis codes. That being said, additional considerations when leveraging drug data include the fact that some drugs are used off-label and can be used for multiple diagnoses.

There are risk adjustment models based solely on prescription drug data. Such models could be considered to supplement or supplant a model that relies on medical data. Most, but not all, MA beneficiaries have prescription coverage through Medicare Part D.

### **INCORPORATE SOCIAL DETERMINANTS OF HEALTH**

Incorporating socioeconomic factors into risk adjustment practices could impact risk selection by participating plans. Currently, data such as a patient's zip code could provide insight into their health risk profile and influence a plan's recruitment efforts. As a result, the absence of SDOH metrics within risk adjustment models could unintentionally exacerbate existing disparities by underestimating the care needs for racial and ethnic minorities and rural Americans. It is hard to argue that SDOH is not an important input to appropriately assess and respond to the risk levels and health care needs of Medicare beneficiaries. However, historical under-use or over-use of services by certain socio-economic groups could be preserved through SDOH factors, which could result in over-paying or under-paying plans relative to their enrollees needs. This consideration of SDOH is in its infancy.

### **ADHERE TO THE ACTUARIAL CODE OF CONDUCT**

As a reminder, all actuaries practicing in Medicare Advantage and incorporating risk adjustment into their work must adhere to the actuarial Code of Professional Conduct. In particular, Precept 1 of the Code requires actuaries to act honestly with integrity and competence in fulfilling the profession's responsibility to the public and upholding its reputation. Precept 3 requires actuaries to perform their services under the direction of applicable standards of practice. These and all other precepts of the code must be followed by actuaries in their work with risk adjustment.

## In Conclusion

While risk adjustment within Medicare Advantage is an important tool, the concerns related to how it is applied have merit. There is a significant imbalance in federal spending on MA plans compared to traditional Medicare. Enhancements in risk adjustment methodologies can help close this gap and make the system less vulnerable. Several opportunities to evaluate and improve the existing risk adjustment model have been identified in this paper. These opportunities should not be considered an exhaustive list.

When analyzing risk adjustment as a tool, and when considering the most effective way to enforce appropriate practice, it is important to recognize members of the actuarial profession as knowledgeable resources. Actuaries are well-positioned to identify financial implications of various risk adjustment practices while also keeping a watchful eye on opportunities for manipulation through coding practices. Actuaries are on the ground and deeply entrenched in understanding how financial models are operating in the real world, in real time. As a result, incorporating actuarial expertise is a recommended pathway to charting a better path forward for optimal use of risk adjustment in Medicare Advantage



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## Additional Resources

For further information and research on the topic of risk adjustment within Medicare Advantage, we have curated a collection of articles and research efforts. They are listed below:

Hileman, G; Steele, S. Accuracy of Claims-Based Risk Scoring Models. October, 2016, [Accuracy of Claims-Based Risk Scoring Models \(soa.org\)](#) (accessed January 25, 2023).

Hileman, G; Mehmud, S; Rosenberg, M. Risk Scoring in Health Insurance: A Primer. July, 2016, [Risk Scoring in Health Insurance: A Primer \(soa.org\)](#) (accessed January 25, 2023).

Mehmud, S. Nontraditional Variables in Healthcare Risk Adjustment. July, 2013, [Nontraditional Variables in Healthcare Risk Adjustment \(soa.org\)](#) (accessed January 25, 2023).

Hostetter, M; Klein, S. Taking Stock of Medicare Advantage: Risk Adjustment. February 17, 2022, [Taking Stock of Medicare Advantage: Risk Adjustment | Commonwealth Fund](#) (accessed January 25, 2023).

Beveridge, R, et al. Mortality Differences Between Traditional Medicare and Medicare Advantage: A Risk-Adjusted Assessment Using Claims Data. June 4, 2017, [Mortality Differences Between Traditional Medicare and Medicare Advantage: A Risk-Adjusted Assessment Using Claims Data - PMC \(nih.gov\)](#) (accessed January 25, 2023).

Centers for Medicare & Medicaid Services. 2023 Medicare Advantage and Part D Advance Notice Fact Sheet. February 2, 2017, [Mortality Differences Between Traditional Medicare and Medicare Advantage: A Risk-Adjusted Assessment Using Claims Data - PMC \(nih.gov\)](#) (accessed January 25, 2023).

Warren, Elizabeth. Anticompetitive Behavior, Price Gouging, and Patent Abuse from Corporations Costs Medicare and Consumers Billions. February 2, 2022. [ICYMI: Warren Calls for Expanding and Improving Medicare by Cracking Down on Corporate Profiteering | U.S. Senator Elizabeth Warren of Massachusetts \(senate.gov\)](#), (accessed January 25, 2023).

Beveridge, R, et al. Mortality Differences Between Traditional Medicare and Medicare Advantage: A Risk-Adjusted Assessment Using Claims Data. June 4, 2017, [Mortality Differences Between Traditional Medicare and Medicare Advantage: A Risk-Adjusted Assessment Using Claims Data - PMC \(nih.gov\)](#) (accessed January 25, 2023).

Kang, J; Duncan, I; Huynh, N. Making the Right Diagnosis: A Response to Berwick and Gilfillan. July 8, 2022. [Making The Right Diagnosis: A Response to Berwick and Gilfillan | Health Affairs](#) (accessed January 25, 2023).



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