



Advising the Congress on Medicare issues

Medicare Advantage coding intensity and health risk assessments

Andy Johnson
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Presentation outline

- Health risk assessments (HRAs)
- Medicare Advantage (MA) risk adjustment
- Impact of HRAs on MA plan payments
- Diagnostic coding differences
- Alternative policies for coding intensity

Health risk assessments

- Preventative care tool to identify health risks and presence of disease or disability
- Framework for providing
 - counseling, follow-up referrals, and patient engagement in health decision-making
- Part of Medicare's annual wellness visit (AWV), available to all Medicare beneficiaries

Health risk assessments in MA

- Administered in enrollee's home:
 - Self-reported medical history, blood or urine tests, review medications, assess home risks
- Initiated by MA organization:
 - Third-party vendors or MA organizations recruit MA enrollees for a home visit
- Increasing number of home visits annually
 - Expansion of related entities

MA risk adjustment

- CMS pays MA plans a capitated rate for each enrollee
- Risk-adjusted using the CMS-hierarchical condition category (HCC) model
 - Model includes demographic information and groups of diagnoses, called HCCs
 - Components associated with an expected cost
- Payment rate is the sum of expected spending for relevant model components

MA risk adjusted payment

- Example payment for 2013:
 - Payment for an 84 year-old male with congestive heart failure:

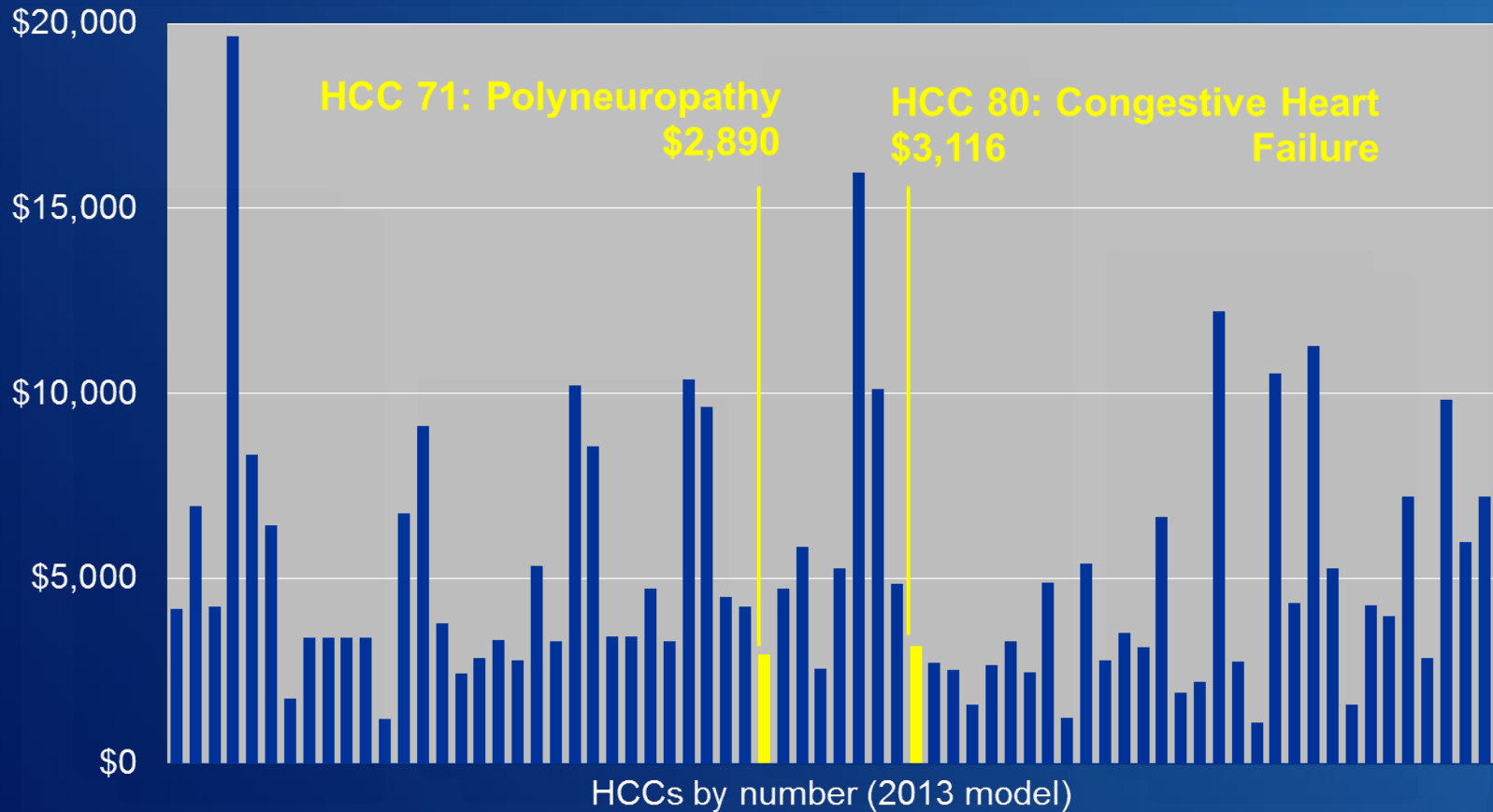
84 year-old male	\$4,727
Congestive Heart Failure	\$3,116
Payment to MA organization: \$7,843	

- Payment with addition of polyneuropathy:

Polyneuropathy	\$2,890
Payment to MA organization: \$10,733	

Source: CMS Advance Notice for 2013 payment.

Increase in annual payment, by HCC



Source: CMS Advance Notice for 2013 payment.

HRA use in MA

- Analyzed 2012 MA encounter data
 - 1) **HRAs** (AWV or HRA admin HCPCS code)
 - 2) **HRAs plus home E&M visits**
- Focus on **HCCs identified only through health risk assessment**
 - Not identified through other encounter used for MA risk adjustment

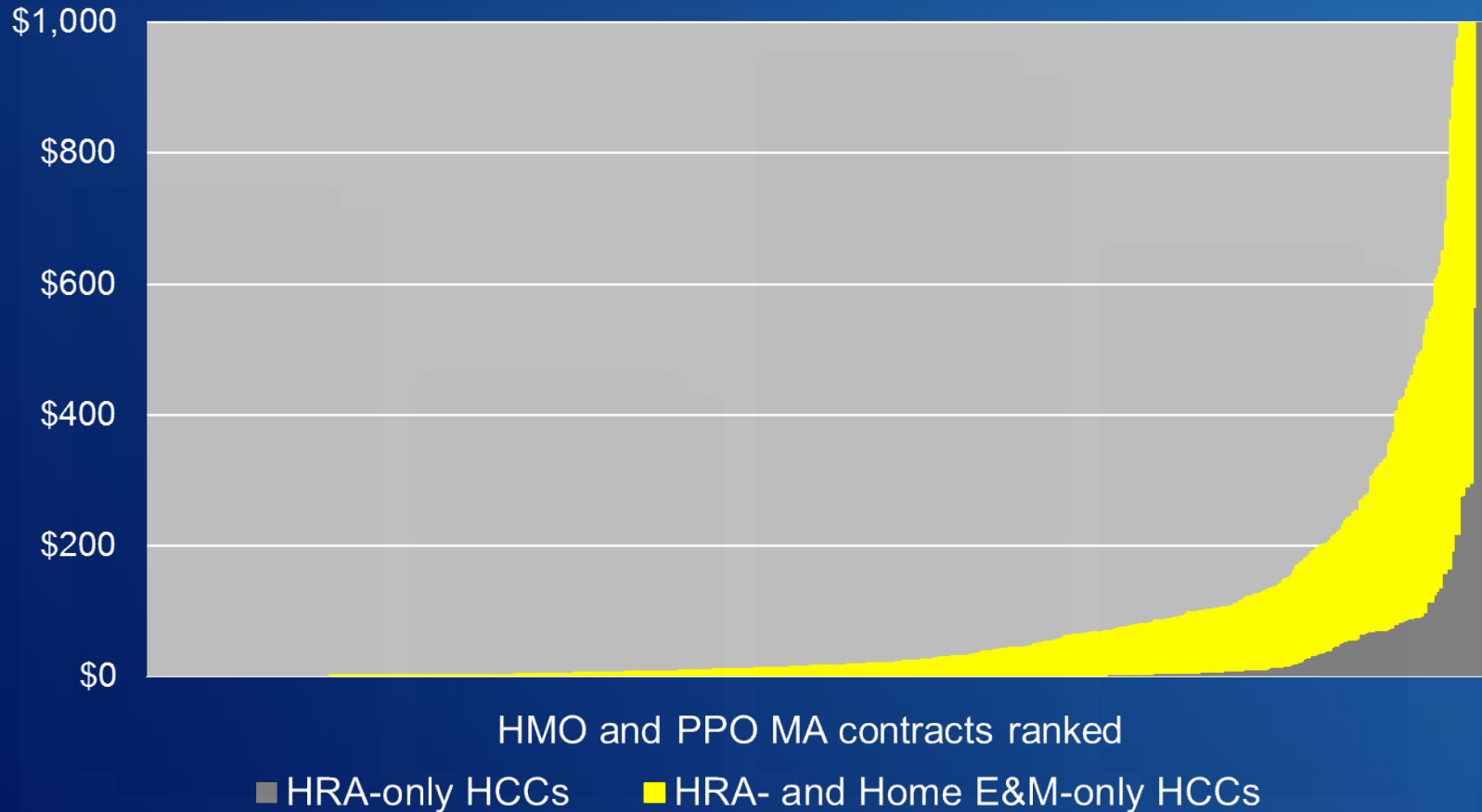
HRA use in MA, 2012

	Health Risk Assessments	HRAs & Home E&M visits
Number of encounters	1.4 million	2.3 million
Number of unique MA enrollees	1.2 million	1.7 million
New HCCs identified	196,625	749,159
Increase in payment to MA organizations, 2013	\$602 million	\$2.3 billion

Note: HCC numbers and payments to MA organizations do not reflect the imposition of hierarchies, which affect certain HCCs.

Source: MedPAC analysis of 2012 MA encounter data. *DATA PRELIMINARY AND SUBJECT TO CHANGE.*

Payment per enrollee for HRA or home E&M-only HCCs, by contract



Source: MedPAC analysis of 2012 MA encounter data. *DATA PRELIMINARY AND SUBJECT TO CHANGE.*

Concerns about using HRA diagnoses in MA payment

- Medicare payments to MA plans aim to cover the plan's cost in treating an enrollee's conditions
 - The circumstances of collecting diagnostic information in the home raises questions about some HCCs
 - Concerns are especially heightened when there is no corroborating medical encounter (e.g., office visit, procedure, treatment, etc.)

Focus groups

- Nearly all MA enrollees received a home visit offer, some received gift cards
 - Half accepted, found the visit pleasant
 - Half declined, annoyed by persistent calls
- Primary care physicians were aware of home visits
 - Did not find home visit reports valuable
 - Some spent time ruling out conditions misdiagnosed during a home visit

Diagnostic coding differences

- Greater incentive to identify diagnoses in MA compared to Medicare FFS increases MA risk scores
- We estimated that **MA risk scores were about 8 percent higher than Medicare FFS in 2013**
 - Kronick and Welch estimate: 9 percent higher
- The impact of coding differences varies across MA contracts and plan type

CMS's approach to addressing coding intensity

- For 2016 payment, CMS will:
 - Reduce all MA payments by 5.41 percent
 - Remove diagnoses with different coding rates
 - Flag home HRA diagnoses & track care
- Coding intensity impact estimate for 2016:
 - 8 or 9 percent (estimated for 2013 risk scores) plus 3 years of accumulated differences
 - Greater than CMS's combined adjustments

Option #1 to address coding intensity

- HRAs can be used as a prevention and care-planning tool
- Exclude diagnoses from HRAs from MA risk adjustment
 - HRA diagnoses resulting in follow-up care will be identified during subsequent encounter
 - Exclude HRA diagnoses from FFS and MA
 - Equitable approach across MA contracts

Option #2 to address coding intensity

- Use 2 years of Medicare FFS and MA diagnostic data for risk adjustment
 - Most HCCs in the model identify chronic conditions that do not change status frequently
 - Reduces the impact of coding differences between FFS and MA

Address remaining coding intensity

- Options 1 and 2 can be implemented simultaneously
- Options 1 and 2 may not address full impact of coding intensity differences
 - Continue to adjust by a single factor
 - More equitable across MA contracts
- Improved data quality and consistency

Commission discussion

- Questions on findings
- Discussion about options for addressing differences in diagnostic coding