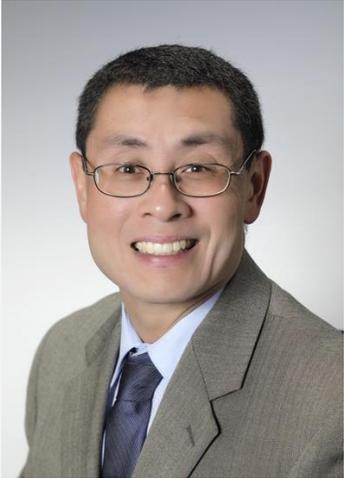


It's worth the risk: Medicare Advantage risk adjustment hot topics



Presenters



Jason Choi
Consulting Actuary



Karin Cross
Actuarial Analyst



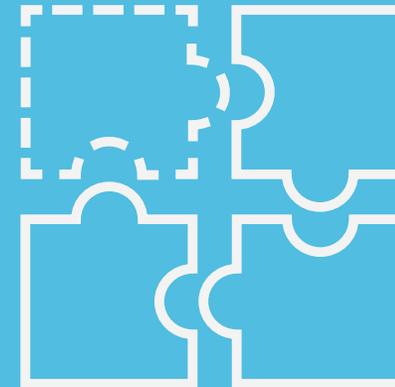
Rebecca Gergen
Associate Actuary

2024 Part C

Proposed risk score model changes

Proposed 2024 MA risk score model updates

- CMS is proposing a new risk score model for 2024 (v28)
- Model is proposed to have the same structure as the PY 2023 model
 - Eight model segments
 - Condition count variables
- Updated data used for model calibration
 - Calibrated using 2018 diagnoses to predict 2019 expenditures
- Updated denominator year
- Reclassification of HCCs using ICD-10 diagnosis codes



Proposed 2024 MA risk score model updates

CMS incorporated updates based on an assessment of conditions that are coded more frequently in MA than FFS

- Proposed model includes additional constraints and the removal of several HCCs
- 118 HCCs total in comparison to 86 in the 2020 model (used for PY 2023)

Revisions focused on conditions subject to coding variation

- Constrained conditions to carry the same weight
 - Diabetes HCCs (36, 37, and 38)
 - Congestive Heart Failure HCCs (224, 225, and 226)
- Removed condition categories that “do not accurately predict the projected cost of a beneficiary”
 - HCC 47 (Protein Calorie Malnutrition)
 - HCC 230 (Angina Pectoris)
 - HCC 265 (Atherosclerosis of Arteries of the Extremities, with Intermittent Claudication)

Source: <https://www.cms.gov/files/document/2024-advance-notice.pdf>

Proposed 2024 MA risk score model updates

MA risk score coefficients for Community, NonDual, Aged Population

2024 Model (proposed for PY 2024)			2020 Model (used for PY 2023)		
HCC	HCC description	Coefficient	HCC	HCC description	Coefficient
HCC 36	Diabetes with severe acute complications	0.166	HCC 17	Diabetes with acute complications	0.302
HCC 37	Diabetes with chronic complications	0.166	HCC 18	Diabetes with chronic complications	0.302
HCC 38	Diabetes with glyceemic, unspecified, or no complications	0.166	HCC 19	Diabetes without complications	0.105

2024 MA risk score model impact

- CMS estimated the model change impact to be **-3.12%**
- CMS estimated MA risk score trend is **+3.30%**
- Actual impact of the model change will vary by MAO

Source: <https://www.cms.gov/newsroom/fact-sheets/2024-medicare-advantage-and-part-d-advance-notice-fact-sheet>



2024 MA risk score model impact

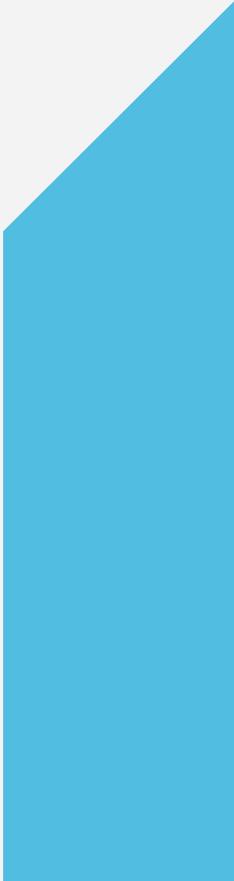
CMS released plan level files to HPMS with risk score impact

- Includes risk scores under the current model (2020) and the proposed model (2024)
- Based on July 2021 enrollment with diagnoses from 2020 dates of service
- Risk scores have not been normalized
- Risk scores do not include frailty

To estimate changes to risk score due to model change, appropriate normalization factors should be applied

2024 MA risk score model impact

- Milliman authored a study on expected high level impacts of the proposed 2024 model
- Impacts vary widely by plan type
- Study based on 2020 eligibility with 2019 dates of service



Plan type	Model impact
General enrollment	-3.10%
EGWP	-1.60%
D-SNP	-5.80%
C-SNP	-11.10%
I-SNP	-1.80%
MA total	-3.50%

Source: https://www.milliman.com/-/media/milliman/pdfs/2023-articles/2-28-23_2024-proposed-cms-hcc-model-impact.ashx

Part D

Risk score considerations

Risk score basics

Key elements of Part D risk scores

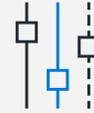
- Plan liability
- Part D basic benefit
- Adjusts the direct subsidy

Risk score basics



RxHCC models

- New enrollee
 - Applies to members with less than 12 months of Part B enrollment during the diagnosis collection period
 - Factor based only on age / gender / low income (“LI”) / originally disabled / ESRD status
- Community
 - Applies to majority of Medicare Advantage members
 - Also includes Prescription Drug Hierarchical Condition Categories (RxHCCs)
- Institutional (Same as Community model, but different coefficients)
 - Also includes RxHCCs



Calculation components

- RxHCC models
 - Demographics (age / gender / originally disabled)
 - Includes interactions
- FFS normalization
 - CMS adjustment to normalize total risk scores to 1.00
 - Varies by year

Risk score basics

Basis of diagnoses

Source data for model coefficients and diagnosis assignments

- 2022 RxHCC model
 - 2017 diagnoses from FFS claims
 - 2018 Prescription Drug Event (“PDE”) expenditure data
 - 2022 Defined Standard (“DS”) parameters
- 2023 RxHCC model
 - 2018 diagnoses from FFS claims
 - 2019 PDEs
 - 2023 Defined Standard (“DS”) parameters



Risk score basics

Part D risk scores are NOT Part C risk scores

Differences

- Models are based on LI, not Medicaid, status
- RxHCCs differ from CMS-HCCs
- RxHCCs are assigned from ICD-9/ICD-10 (medical) diagnosis codes

HIV / AIDS		Parkinson's		Hypertension	
Community NLI	Community	Community NLI	Community	Community NLI	Community
Aged	NonDual Aged	Aged	NonDual Aged	Aged	NonDual Aged
RxHCC 1	HCC 1	RxHCC 161	HCC 78	RxHCC 187	n/a
4.759	0.335	0.537	0.606	0.111	

Sample calculation – Raw



D.B.

Stats

- Male, 84 years old
- Aged in
- Not low income (but he is an artist)

Diagnoses

- RxHCC005 (1/7/2022)
- RxHC355 (5/9/2022)
- RxHCC005 (5/9/2022)
- RxHCC227 (5/9/2022)
- RxHCC229 (8/12/2022)
- RxHCC226 (12/4/2022)

Raw risk score

Calculation

Demographic coefficients

0.142

RxHCC coefficients

0.337

0.752

n/a

~~0.365~~

n/a

2.616

3.847

Sample calculation – Final



D.B.

Stats

- Male, 84 years old
- Aged in
- Not low income (but he is an artist)

Diagnoses

- RxHCC005 (1/7/2022)
- RxHC355 (5/9/2022)
- RxHCC005 (5/9/2022)
- RxHCC227 (5/9/2022)
- RxHCC229 (8/12/2022)
- RxHCC226 (12/4/2022)

Raw risk score

Normalization

Final risk score

Calculation

Demographic coefficients

0.142

RxHCC coefficients

0.337

0.752

n/a

~~0.365~~

n/a

2.616

3.847

1.063

3.619

Sample calculation – The bid picture

Real world calculation

Bid calculation

1.0 Bid (from bid)	\$60.00	A
NABA	\$34.71	B
NAMP	\$32.74	C
Direct Subsidy	\$1.97	$D = B - C$
Basic Premium	\$58.03	$E = A - D$

Actual calculation (high risk score)

Actual risk score	1.050	A
1.0 Bid	\$60.00	B
NABA	\$34.71	C
NAMP	\$32.74	D
Direct subsidy	\$4.97	$E = A * B - (B - C + D)$

Actual calculation (low risk score)

Actual risk score	0.900	A
1.0 Bid	\$60.00	B
NABA	\$34.71	C
NAMP	\$32.74	D
Direct subsidy	-\$4.03	$E = A * B - (B - C + D)$

Sample calculation – The bid picture

Wait...

Bid calculation		
1.0 Bid (from bid)	\$60.00	A
NABA	\$34.71	B
NAMP	\$32.74	C
Direct Subsidy	\$1.97	$D = B - C$
Basic Premium	\$58.03	$E = A - D$

Actual calculation (high risk score)			Actual calculation (low risk score)		
Actual risk score	1.050	A	Actual risk score	0.900	A
1.0 Bid	\$60.00	B	1.0 Bid	\$60.00	B
NABA	\$34.71	C	NABA	\$34.71	C
NAMP	\$32.74	D	NAMP	\$32.74	D
Direct subsidy	\$4.97	$E = A * B - (B - C + D)$	Direct subsidy	-\$4.03	$E = A * B - (B - C + D)$

- Part D risk adjustment impact is tied to direct subsidy and 1.0 bid
- Risk-adjusted direct subsidies can be negative

Bid risk score projection components

- Plan specific coding trend
 - Revenue only
- Population change
 - Should include a corresponding claims adjustment
- Expected RxHCC model changes

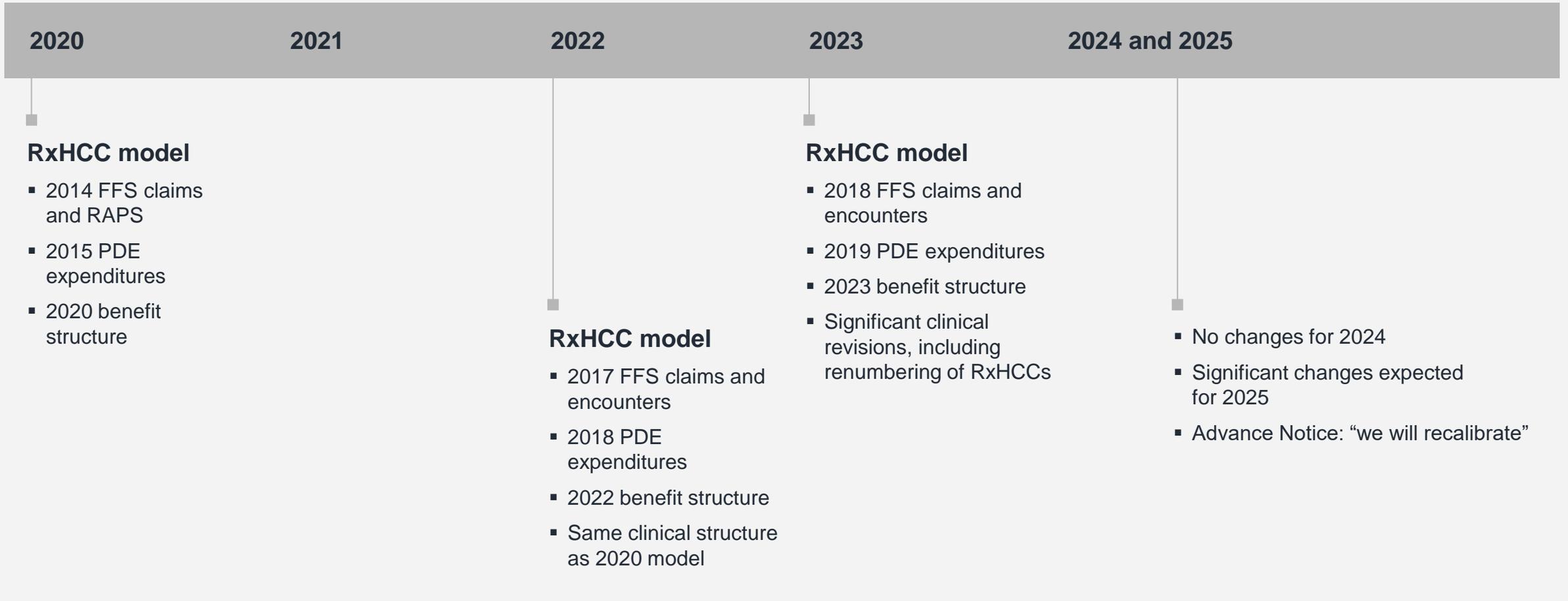
Bid risk score projection components

Coding trend

- Diagnoses are tied to medical data, not drug data
- Diagnosis submissions impact Part C risk payments more than Part D risk payments
- Therefore, Part D coding is not often a focus
- Internal study indicates that for most carriers, Part C coding efforts translate to 80% to 100% for Part D

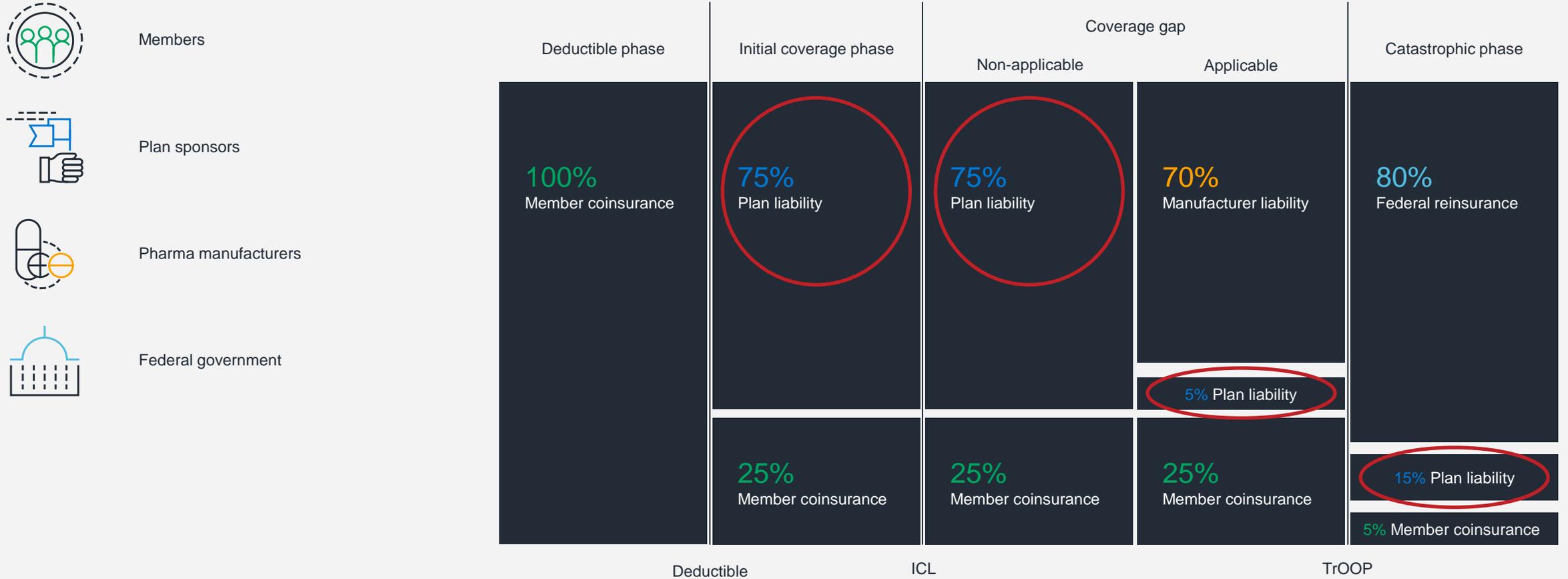
A brief history

What to expect when you're expecting



Part D benefit redesign – 2025

Current Part D benefit: NLI beneficiaries



Part D benefit redesign – 2025

IRA Part D benefit



Members



Plan sponsors



Pharma manufacturers



Federal government

- Increased plan liabilities
- 6% premium cap → higher direct subsidies
- Increased importance on risk adjustment

	Deductible phase	Standard coverage phase		Post-threshold phase	
		Non-applicable	Applicable	Non-applicable	Applicable
Members	100% Member coinsurance	75% Plan liability	65% Plan liability	60% Plan liability	60% Plan liability
Pharma manufacturers			10% Manufacturer liability	40% Federal reinsurance	20% Manufacturer liability
Federal government		25% Member coinsurance	25% Member coinsurance		20% Federal reinsurance
	Deductible	MOOP			

Risk adjustment data validation final rule

What is a RADV audit?

- RADV audits are the process used to verify diagnosis data submitted for risk adjustment
- Typically done by sampling members for whom plans provide medical record documentation
- If any diagnoses are not sufficiently documented, plans must give money back

What is the final rule about?

- Can audit results for sampled members be extrapolated?
- Which RADV audit years are affected?
- Will CMS apply a FFS adjuster to the results?

More about the FFS adjuster

- CMS finalized the intention to not use a FFS adjuster
- Adjusts for the impact of using unsupported diagnoses in the Medicare FFS data used to calibrate the risk adjustment model
- Example

FFS Adjuster for apples – Part 1

The owner of an apple orchard wants to sell apples by the number of apples rather than by weight, and needs to estimate the average weight and then set the per apple price accordingly

The owner weighs a crate of 100 apples:

- The crate includes an unknown mix of Honeycrisp apples and crab apples
- The contents of the crate weighs 40 pounds
- They calculate that an apple weighs 0.4 pounds, on average (40 pounds / 100 apples)
- The owner wants to charge \$1.50 per pound, or \$60 for 40 pounds
- The equivalent price per apple is then \$0.60 per apple (\$60 / 100 apples)

FFS Adjuster for apples – Part 2

Because crab apples weigh a lot less than Honeycrisp apples, the owner's original estimate of the average weight of an apple was too low

In fact, the true average weight of only the Honeycrisp apples in the original crate was 0.48 pounds

The orchard sold 1,000 Honeycrisp apples, which weighed 480 pounds, for \$600

- The average price per pound was then $\$600 / 480 \text{ pounds} = \1.25 per pound
- But the owner needed a price per pound of \$1.50
- The apples were sold for \$0.25 per pound less than intended, unintentionally giving a 17% discount!

Why did CMS say no to the FFS adjuster?

- RADV audits are a payment integrity tool and are not required to be actuarially equivalent
- CMS is the only one with authority and access to determine the error rate in the FFS data

Extrapolation

- No extrapolation for 2011-2017
- For 2018+ CMS can use any valid statistical method
 - TBD but plan to publish more info
 - Significant uncertainty
- Can now collect improper payments from OIG audits too

Targeted audits

- Focusing on contracts and diagnoses with the highest risk for improper payments
- Audits focused on specific conditions
- Goals:
 - Increase efficiency
 - Minimize burdens on MAOs
 - Maximize recoveries

What can plans do?

- Stay up to date on CMS and OIG guidance when assessing submitted HCCs
- Use two-way chart reviews to find both adds and deletes
- Ensure conditions at high risk for over-coding are properly documented
- Oversight of vendors and providers

Caveats

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Thank you

