The Need to Incorporate Additional Patient Information Into Risk Adjustment for Medicare Beneficiaries

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Equitable reimbursement for clinicians, health care facilities, and health plans who serve Medicare beneficiaries with widely varying health risks and medical needs is crucial. In traditional (fee-for-service) Medicare, the Centers for Medicare & Medicaid Services (CMS) increasingly pays via value-based payment (VBP) programs, in which payment is tied to performance based on quality and cost measures. In the Medicare Advantage program, which now serves more than one-third of Medicare beneficiaries, private managed care plans are paid capitated premiums based on each member’s risk profile. Because clinical outcomes and medical spending not only depend on the care that beneficiaries receive, but also on their underlying risk profile, accurate risk adjustment is essential to fairly judge clinicians and facilities in Medicare VBP programs and to fairly pay health plans in Medicare Advantage.

Since the early 2000s, CMS has attempted to accomplish these objectives using a system that adjusts performance and payment for differences in patient characteristics. This system is called the CMS hierarchical condition categories (CMS-HCC) risk adjustment model, and it assigns “points” for age, gender, original reason for Medicare eligibility, dual Medicaid enrollment (in some cases), institutionalization in long-term care, and 83 clinical conditions identified by diagnoses in Medicare claims. However, as more reimbursement is tied to the measurement of risk, there is increasing concern that this model fails to adequately account for differences in patient characteristics and may consequently create unintended consequences.

Consequently, clinicians, facilities, and health plans that serve disproportionate shares of Medicare beneficiaries with depression, dementia, frailty, and social risk factors are penalized by a measurement system that makes their risk-adjusted performance appear worse than it actually is and by a reimbursement system that fails to pay them for the true medical risks of their patients. The concern with the current CMS-HCC risk adjustment model is that it could reward clinicians and health plans that avoid Medicare beneficiaries with these unmeasured risk factors associated with increased costs of care. Studies have found favorable selection in Medicare Advantage, shown by higher rates of poverty, functional impairment, nursing home use, and mortality among beneficiaries who switch from Medicare Advantage to traditional fee-for-service Medicare, and by service-level selection in which private plans reduce coverage for services used by beneficiaries who are not profitable under the CMS-HCC system to induce them to leave the plans.

Potential Solutions

Several solutions could be implemented using available data from Medicare claims. First, International Classification of Diseases, Tenth Revision (ICD-10) diagnostic codes for depression and dementia could be added to the 83 clinical conditions currently included in the CMS-HCC model. Second, CMS already applies a frailty adjustment factor using survey data on difficulties with activities of daily living to adjust payments to Medicare Advantage plans in the Program of All-inclusive Care for the Elderly. Although it is not possible to survey the entire Medicare population on activities of daily living, a number of claims-based frailty measures have been developed that could serve as convenient proxies. These measures use ICD-10 codes for diagnoses, such as infections, open wounds, and anemia, along with Current Procedural Terminology and Healthcare Common Procedure Coding System codes for medical services and equipment, such as wheelchairs, walking aids, and oxygen supplies, to identify frailty.

Third, incorporating measures of social risk could be done within current models. Although dual enrollment in Medicaid is currently used by CMS to identify social risk in several payment models, the sensitivity for identifying people who are living in poverty is only 49%⁶; therefore, obtaining accurate data on actual patient social risk factors is preferable. The advent of the ICD-10 system in 2015 introduced a new set of 2 codes for social determinants of health, including low income, low educational attainment, social isolation, housing problems, and abuse and neglect. Although these codes are not currently in common use by clinicians, if CMS used them in risk models it is likely that they would quickly be
adopted. However, most clinicians have not been taught to assess patient social risk accurately and therefore more work may be needed to understand the validity of these codes before widespread use.

Addressing Standard Objections From CMS

In the past, CMS has resisted incorporating additional diagnosis-based information on depression, dementia, frailty, and social risk, in addition to medical use-based information, into the CMS-HCC risk adjustment model. The rationale is that such information represents “discretionary” judgments made by clinicians and health plans that may be used to increase the risk profile of their patients and to thereby game the system and increase their reimbursement. For example, incorporating the measures above would result in adding points to patients’ risk profiles for diagnoses such as dementia, for receiving equipment such as wheelchairs and oxygen supplies, or for documentation of social risk factors such as poverty.

This longstanding position by CMS needs to be changed given the mounting evidence that the current risk-adjustment system is inequitable. CMS is beginning to signal that it is reconsidering this position: in December 2018 it announced it would consider including dementia in risk adjustment for Medicare Advantage plans in 2020. This shift is important, as are other changes. Most diagnoses made by clinicians are a combination of objective findings and clinical discretion. This is no less true for a diagnosis of chronic kidney disease (currently included in the CMS-HCC model) than a diagnosis of dementia (currently not included). It is the responsibility of all clinicians to use their judgment and skill in diagnosing and treating patients on the basis of their medical needs and according to evidence-based practice.

In addition, it is difficult for the majority of clinicians to exert enough control over their patients to benefit from gaming risk adjustment in VBP programs. Most Medicare beneficiaries have access to multiple clinicians across a wide variety of specialties in a year, with each clinician making independent clinical decisions irrespective of their cumulative effect on the facilities, health systems, or health plans that CMS deems responsible for patients at the end of the year. However, the potential for gaming does exist in Medicare Advantage health maintenance organizations or accountable care organizations that possess the analytic sophistication to nudge clinicians into modifying their behavior to maximize reimbursement. This is a valid concern with an increasing number of eligible patients enrolled in Medicare Advantage. The coding intensity is greater in the Medicare Advantage population than in the traditional fee-for-service population; however, it is not yet clear whether this is a problem of overcoding in the Medicare Advantage program, undercoding in the fee-for-service program, or both.

Furthermore, CMS already has fraud and abuse procedures to deal with clinicians and organizations that make false diagnoses and provide unnecessary services for their own financial benefit rather than the medical needs of their patients. This is important because CMS estimated that 7.25% of Medicare’s fee-for-service budget and 7.87% of the Medicare Advantage budget represented improper payments in 2019. While fraud and abuse protections could and should be strengthened, it is unfair for CMS to penalize clinicians and health plans that care for vulnerable patients because of potential fraud that can best be handled using other more effective means that would not create inequitable reimbursement.

Conclusions

The current CMS-HCC risk adjustment system used by Medicare leads to inequitable performance measurement and reimbursement for clinicians, facilities, and health plans because it fails to include information on important factors such as depression, dementia, frailty, and social risk factors. CMS policy makers should remedy this inequality by adding this patient information to the CMS-HCC model using available Medicare claims data.