REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-I-19

Subject: Improving Risk Adjustment in Alternative Payment Models

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Referred to: Reference Committee J
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Medicare and other payers are shifting away from the fee-for-service (FFS) model toward alternative payment models (APMs). A goal of APMs is to better deliver high quality care in a cost-efficient manner to improve outcomes. APMs can eliminate barriers to care coordination that are often present in traditional payment systems. For example, FFS generally does not support the resources that would be required to take after-hours calls from patients to help them avoid emergency visits; provide self-management education to help patients manage their conditions at home; or conduct proactive outreach to ensure patients get needed preventive services.

Often, the complex FFS patient will have additional insurance claims filed for their additional needed services. APMs that pay for services in a more aggregated way, such as a bundled payment for an episode of care or a monthly payment for each patient, need to have a means of adjusting payments to account for patients that need more services. Risk adjustment can serve as a tool to make APM payments better reflect differences in patient characteristics and need for services.

It is important to note that risk adjustment is distinct from both the assumption of financial risk and risk associated with professional liability. In an APM with downside financial risk, APM providers may be accountable for providing care within a capped payment amount and need to either absorb or repay spending in excess of that amount. Risk adjustment, the focus of this report, is a mechanism for adjusting payment rates, budgets, or both, based on the health status and expected spending on a patient population. Improved risk adjustment models will have positive spillover effects in other areas of payment policy, importantly in the Merit-based Incentive Payment System (MIPS), which adjusts FFS payments up or down according to performance in four categories. Similar to APMs, MIPS scores should be risk adjusted to account for variations in patient complexity, sociodemographic factors, and costs outside of the physician's control. As many small and specialty practices will stay in MIPS, better risk adjustment is needed to avoid unfairly penalizing those who care for the sickest and most vulnerable.

This report, initiated by the Council, provides background on risk adjustment; outlines refinement strategies; summarizes relevant policy; details American Medical Association (AMA) work on adjustment improvements; and presents policy recommendations to improve risk adjustment.

BACKGROUND

Risk is the process of modifying payments and benchmarks and allowing payers to estimate future spending. Risk adjustment systems assign patients a risk score based on demographic factors and health status. Demographic factors may include age, gender, dual eligibility for Medicare and Medicaid (a proxy for socioeconomic status or disability), and whether the patient resides in the

community or in a health care facility. Patient health status is usually based on the diagnosis codes submitted on claims in a calendar year. The importance of accurate risk adjustment is increasing as organizations such as Accountable Care Organizations (ACOs) and other APMs bear financial risk for managing a patient population as well as understanding the needs of individual patients and tailoring care delivery to each patient.

Despite the rising importance of risk adjustment, there are fundamental problems with current risk adjustment methodologies. Most risk adjustment systems only predict about 20-30 percent of the variation in services and spending across patients and are designed to predict spending on a large insured patient population, not adjust for differences in patient needs.[1] For example, risk adjustment that significantly weighs factors such as age and gender communicates a limited picture of the patient. Such simplistic design can reinforce inappropriate spending, penalize efforts to reduce overuse, and cause providers to focus spending reduction efforts on the wrong patients.[2] Additionally, the current risk adjustment methodologies do not adequately address treatment and outcome differences related to patient characteristics. They do not consider the complexity of a patient's disease nor social risk factors that are outside of the physician's control, such as lack of transportation or food insecurity. Basing risk scores solely on diagnosis, age and gender, for example, can lead to the same scores being assigned to patients who have drastically different needs. Poorly designed risk adjustment likely distorts comparisons of physician spending.

Moreover, most risk adjustment systems use historical information on patient characteristics and not the most current information. Many systems rely on ICD codes via retrospective review of claims data. Basing risk adjustment on prior claims data means that it accounts for the health conditions patients experienced in previous years but not for significant changes in the patient's health status or permanent conditions.[3] Some risk adjustment methods do not account for a patient's disease stage, such as cancer or a patient's functional status, and they often do not account for factors that influence whether a patient is an appropriate candidate for a procedure or treatment. For instance, risk adjustment systems do not distinguish between patients with different cancer stage diagnoses nor do they account for how the patient's disease affects activities of daily living or whether they have a caregiver at home.

Importantly, most risk adjustment systems do not account for social determinants of health (SDOH). The link between non-medical factors and poor health outcomes is well documented; however, non-medical factors largely are absent from risk adjustment methods.[4] To enhance fairness in performance assessment, some hospitals have implemented peer group methodology aimed at creating groups of similar hospitals for comparison purposes to account for hospitals that treat a significant number of patients with SDOH challenges. However, peer group comparisons do not take place at a more micro level, and risk adjustment methods are not sophisticated enough to reliably differentiate between poor quality of care and high medical and social risk. These methodological flaws have the unfortunate effect of inappropriately penalizing physicians who care for patients with SDOH challenges. Ultimately, not accounting for SDOH can make it harder for physicians caring for vulnerable patients to maintain a sustainable practice and therefore can reduce access to care for these populations exacerbating the challenge of getting vulnerable populations the care they need.

VARIOUS RISK ADJUSTMENT STRATEGIES

Risk Stratification

Risk stratification is the process of segmenting patients into groups of similar complexity and care needs.[5] The first step in risk stratification is to identify high-risk patients. After stratifying patients

into groups, practices can more easily make targeted care management decisions and identify those patients that may have particular care needs. Consequently, the usefulness of stratification models relies on data availability, which should encompass the patient's own assessment of his or her health including SDOH. To date, most risk stratification models use a diagnosis-based formula and do not include many SDOH that materially affect patient's health and ability to follow a particular treatment plan.

One popular method of risk stratification is Medicare Advantage's (MA) Hierarchical Condition Categories (HCC). Both MA plans and Medicare Shared Savings Program (MSSP) ACOs use the HCC methodology,[6] which relies on ICD-10 coding to assign risk scores derived from retrospective claims data review. The algorithm takes into account demographic factors like age and gender, and insurance companies use HCC coding to assign patients a risk adjustment factor (RAF). In turn, insurers then use the RAF score to help portray patients' conditions and predict future costs.[7]

Outlier Payments or Individual Stop Loss Insurance

Outlier payments are additional payments paid for by insurers to physicians or organizations to account for encounters and patients that are exceptionally costly. Outlier payments function as a form of stop-loss insurance. Stop-loss insurance protects the provider against significantly higher than intended patient costs. This strategy is particularly useful when available for providers who care for vulnerable populations. Because many SDOH are not yet included in risk stratification systems and overall risk adjustment systems, the ability to access outlier payments after caring for individuals with known high costs is critical for practice financial viability. The strategy also ensures access to care and appropriate treatment for high-risk populations.

Risk Corridors or Aggregate Stop Loss Insurance

Risk corridors are another mechanism that can protect against adverse selection and insufficient physician payments. Risk corridors function by limiting losses and gains beyond an allowable range.[8] Risk corridors set a target spending amount, and insurers pay into the program to compensate those physicians with patient costs exceeding the target. Risk corridors mirror aggregate stop loss insurance in that physicians are protected against higher than expected total spending.

Payment Adjustment for External Price Changes

Adjustment for external price changes is an important protection for physicians operating in a value-based payment delivery system. Under this mechanism, the physician payment is adjusted for changes in the prices of drugs or services from other providers that are beyond the control of the provider accepting the APM payment.[9] Physicians must only be responsible for the services that they deliver and cannot be held financially or otherwise accountable for spending outside of their control. Payment adjustments protect physicians from spending costs outside of their control.

AMA POLICY

AMA policy promotes physician-led payment reform programs that serve as models for others working to improve patient care and lower costs (Policy D-385.963). Policy H-390.844 emphasizes the importance of physician leadership and accountability to deliver high quality and value to patients. The AMA advocates for providing opportunities for physicians to determine payment models that work best for their patients, their practices, and their regions (Policy H-390.844).

Policy D-390.953 directs the AMA to advocate with the Centers for Medicare & Medicaid Services (CMS) and Congress for APMs developed with specialty and state medical societies.

With respect to risk adjustment, Policy H-165.842 states that health insurance coverage of high-risk individuals should be subsidized through mechanisms such as risk adjustment. Policy H-395.908 states that the AMA will work with CMS and interested organizations to design systems that identify new data sources to enable adequate analyses of clinical and non-clinical factors that contribute to a patient's health and success of treatment, such as disease stage and SDOH factors. It also calls to account for differences in patient needs, such as functional limitations, changes in medical conditions compared to historical data, and ability to access health care services. Policy H-395.908 further calls for the AMA to explore an approach in which physicians managing patient care can contribute additional information, such as disease severity, that may not be available in existing risk adjustment methods to more accurately determine the appropriate risk stratification. Policy H-390.849 calls for adequate risk adjustment methodologies and encourages attribution processes that emphasize voluntary agreements between patients and physicians. The policy also states that reformed payment rates must be sufficient to maintain a sustainable medical practice and that payment reform implementation should be undertaken within a reasonable timeframe and with adequate assistance.

AMA ACTIVITY

Risk adjustment and risk stratification for APMs have been important components of AMA advocacy on ACOs and other APMs. The AMA has long called for Medicare to allow ACO patients' risk scores to increase over time if their health care needs warrant, and the 2018 Pathways to Success ACO regulation finally permits such an increase for the first time since the program's inception. The AMA also has discussed new approaches to risk stratification and risk adjustment in physician-focused APMs at its APM workshops. AMA comments to the Physician-focused Payment Model Technical Advisory Committee and the Center for Medicare and Medicaid Innovation on proposed APMs have repeatedly urged improved approaches to risk adjustment and urged Medicare to provide organizations developing APM proposals with claims and other data analyses that they can use to improve their risk adjustment methods.

The AMA also is advocating for improvements to the risk adjustment methodologies in MIPS. For instance, the AMA supports and is engaged in developing episode-based cost measures which account for Medicare Parts A and B spending around a clinically cohesive set of medical services rendered to treat a given medical condition. With AMA input, CMS has developed risk adjustment methods for the episodes that account for patient characteristics that can influence spending outside of the control of the clinician. These measures were first introduced in 2019, and more evidence and testing are needed to determine the accuracy and validity of these measures and their methodologies. In addition, the AMA has advocated for the elimination of the flawed total cost of care measure, which holds physicians accountable for costs outside of their control.

The AMA continues to support the complex patient bonus in MIPS, which applies at the final score to adjust for patient complexity. The complex patient bonus is based on the physician's attributed beneficiaries' average HCC risk score and the proportion of dually eligible patients. This serves as a proxy to capture the clinical complexity of the patient panels for a physician or practice. However, this approach does not sufficiently identify patients with social risk factors that can affect a patient's access to medications, treatments, and other services. While adjustment based on the clinical complexity of the patients served through the complex patient bonus is a step toward addressing disparities, CMS must continue to explore and incorporate additional risk factors and strategies.

Additionally, the AMA's Integrated Health Model Initiative (IHMI) has developed a data model related to the common data elements and terminologies for communicating SDOH. The AMA is collaborating with the largest SDOH standards project in the health information technology community, known as the Gravity Project hosted by the Social Interventions Research and Evaluation Network at the University of California – San Francisco (SIREN).[10] IHMI and UnitedHealth Group (UHG) plan to jointly develop a set of use cases that leverage this common data set and publish this use case via the Gravity project. Once the data are standardized and there are sufficient data in the form of patient outcomes related to the standardized SDOH, data driven predictive risk analyses can be formulated. At this point, SDOH risk calculation can be achieved and is based on published research and limited and non-standardized data sets. The goal is to ensure the industry-backed and accepted SDOH data set is complete and suitable for clinician decision making to improve patient outcomes. Moreover, IHMI is working on the creation of 23 new ICD-10 codes related to SDOH such as access to nutritious food and the financial ability to pay for medications.

DISCUSSION

Adverse selection of high-risk patients is an impediment to equitable patient care and successful payment reform. Evidence confirms that factors such as functional impairment and socioeconomic status are strongly associated with increased costs and hospital readmissions, and the exclusion of such factors from risk adjustment systems negatively affects the financial viability of physicians and organizations serving high-risk individuals. Thus, poorly designed risk adjustment systems are a harm to vulnerable populations who may experience decreased access to care.[11] The Council reiterates that this report is about risk adjustment, not the assumption of risk. However, it recognizes that the two concepts are linked in that physicians must have better risk adjustment methods available if they are to be expected to access risk arrangements.[12] The Council believes that proper risk adjustment is essential if providers are to be held accountable for outcomes.

Throughout the transition to value-based care, the AMA has been vocal that physician accountability must be limited to aspects of spending and quality that they can reasonably influence. Accordingly, the Council recommends supporting payment adjustment for external price changes that are beyond the physician's control and supporting accountability measures that exclude services that the physician does not deliver, or order, or otherwise have the ability to influence. The AMA also continues to advocate for reduced administrative burden, particularly that related to electronic health records, and the Council reaffirms this commitment.

Additionally, a payment formula that relies solely on medical problems but ignores social risk and functional status can have the effect of underpaying those who care for vulnerable populations and exacerbate health disparities.[13] Clinical coding must be coupled with risk adjustment systems, and the two concepts must work in concert to find ways to distinguish between disease states and functional status. Meaningful risk adjustment must allow for variance within existing general diagnoses to capture characteristics specific to individual patients. To that end, the Council recommends supporting risk stratification that varies payment rates based on patient characteristics, including SDOH. Further, the Council recommends supporting outlier payments that increase payment if spending on an individual exceeds a pre-defined threshold or supporting individual stop-loss insurance paid by insurers. Similarly, the Council recommends supporting risk corridors that increase payment if spending on all patients exceeds a pre-defined percentage above the payments or supporting aggregate stop loss insurance. If physicians received extra payments for caring for high-risk and vulnerable populations, these payments could help not only sustain physician practices but also fund services that improve health equity.

Improving risk adjustment and its functions will become increasingly relevant to the viability of practices and the overall health care system. Thorough and accurate risk adjustment not only helps physicians garner the appropriate payment to support practice sustainability, but also helps physicians become more successful in managing their patients. The Council believes that the goal of proper risk adjustment and delivery system reform is tailored interventions and better patient outcomes, and it believes that its recommendations are a step in the right direction. The Council will continue to monitor the rapidly evolving area of risk adjustment methodologies.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-385.908 stating that the AMA will work with the Centers for Medicare & Medicaid Services and interested organizations to design systems that identify data sources to enable adequate analyses of clinical and non-clinical factors that contribute to a patient's health and success of treatment, such as disease stage and socio-demographic factors; account for differences in patient needs, such as functional limitations, changes in medical conditions, and ability to access health care services; and explore an approach in which the physician managing a patient's care can contribute additional information, such as disease severity, that may not be available in existing risk adjustment methods to more accurately determine the appropriate risk stratification. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy D-478.995 advocating for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records so that capturing patient characteristics and risk adjustment measures do not add to physician and practice administrative burden. (Reaffirm HOD Policy)

3. That our AMA support risk stratification systems that use fair and accurate payments based on patient characteristics, including socioeconomic factors, and the treatment that would be expected to result in the need for more services or increase the risk of complications. (New HOD Policy)

4. That our AMA support risk adjustment systems that use fair and accurate outlier payments if spending on an individual patient exceeds a pre-defined threshold or individual stop loss insurance at the insurer's cost. (New HOD Policy)

5. That our AMA support risk adjustment systems that use risk corridors that use fair and accurate payment if spending on all patients exceeds a pre-defined percentage above the payments or support aggregate stop loss insurance at the insurer's cost. (New HOD Policy)

6. That our AMA support risk adjustment systems that use fair and accurate payments for external price changes beyond the physician's control. (New HOD Policy)

7. That our AMA support accountability measures that exclude from risk adjustment methodologies any services that the physician does not deliver, order, or otherwise have the ability to influence. (New HOD Policy)

8. That our AMA support risk adjustment mechanisms that allow for flexibility to account for changes in science and practice as to not discourage or punish early adopters of effective therapy. (New HOD Policy)

Fiscal Note: Less than $500

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[12] *Supra* note 6.
[13] *Supra* note 4.