50 - History of Risk Adjustment

(Rev. 114, Issued; 06-07-13, Effective: 06- 07-13, Implementation: 06-07-13)

The Balanced Budget Act of 1997 (BBA) mandated that a risk adjustment payment methodology, incorporating information on beneficiaries' health status, be implemented in the Medicare+Choice (M+C) program (now the Medicare Advantage program) no later than January 2000. Under the BBA, risk adjustment of M+C payments was initially to be based only on data from enrollees' inpatient hospital stays, with later implementation of risk adjustment based on data from additional sites of care. CMS selected the Principal Inpatient Diagnostic Cost Group (PIP-DCG) model as the risk adjustment method to be implemented in 2000. This model recognizes diagnoses for which inpatient care is most frequently appropriate and which are predictive of higher future costs.

To assist managed care organizations, CMS provided for a gradual phase-in of risk adjusted payment, initially adjusting only a portion of the total payment based on the PIP-DCG methodology - and later the CMS Hierarchical Condition Category (HCC) methodology - with the remainder still adjusted under the pre-BBA method based only on demographic information. This phase in was intended to provide more stable payments to M+C organizations.

The phase in schedule was as follows:

<table>
<tr><td>Payment year</td><td>MA plans</td><td>Evercare*</td><td>SHMO*</td><td>PACE and dual demonstrations*</td></tr>
<tr><td>2000-2003</td><td>10% risk/90% demographic</td><td>100% demographic</td><td>100% demographic</td><td>100% demographic</td></tr>
<tr><td>2004</td><td colspan="3">30% risk/70% demographic</td><td>10% risk/90% demographic</td></tr>
<tr><td>2005</td><td colspan="2">50% risk/50% demographic</td><td colspan="2">30% risk/70% demographic</td></tr>
<tr><td>2006</td><td colspan="2">75% risk/25% demographic</td><td colspan="2">50% risk/50% demographic</td></tr>
<tr><td>2007</td><td colspan="2" rowspan="2">100% risk/0% demographic</td><td colspan="2">75% risk/25% demographic</td></tr>
<tr><td>2008 and later</td><td colspan="2">100% risk/0% demographic</td></tr>
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*Note: For MA plans (formerly M+C plans), the demographic-only portion of the payment was adjusted for age, gender, Medicaid eligibility, institutional status, and working aged status. For certain demonstrations, the non-risk portion of the payment may have involved a demonstration-specific payment methodology.

ESRD risk adjustment was implemented at 100% in 2005. Part D risk adjustment was implemented at 100% in 2006.

The Benefits Improvement and Protection Act of 2000 (BIPA) required the implementation of a risk adjustment model using not only diagnoses from inpatient hospital stays, but also from ambulatory settings beginning in 2004. The draft CMS-HCC risk adjustment payment model was released on March 29, 2002. The CMS-HCC risk adjustment payment model incorporates disease groups that have a significant impact on Part C expenditures. Submission of ambulatory risk adjustment data (physician and hospital outpatient) began on October 1, 2002 for dates of service beginning July 1, 2002. On March 28, 2003, CMS announced the proposed final version of the CMS-HCC risk adjustment model for use in payment beginning in January 2004.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) was enacted in December 2003, extending prescription drug coverage to Medicare enrollees. With the passage of the MMA, "Medicare+Choice" plans became known as Medicare Advantage (MA) plans. In 2006, the MMA made it possible for Medicare Advantage plans to offer Part D coverage to beneficiaries in addition to coverage comparable to Part A and Part B. The MMA also established a bidding methodology for MA organizations and drug plans in 2006. With the enactment of the MMA, risk adjustment was also established for the Part D program.