2017 Annual Conference

HHS Risk Adjustment Policy and Operations

December 4, 2017

Topics

- Overview
- 2015 HHS-RADV Pilot Results
- HHS-RADV New Audit Tool and 2016 BY Protocol Updates
- Risk Adjustment Benefit Year 2018 Updates
- Payment Notice Proposed Rule for the 2019 BY

Overview of Risk Adjustment and RADV

HHS Risk Adjustment (RA) Overview

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WHAT IS RA	WHO PARTICIPATES	HOW IMPLEMENTED
• A budget neutral program that transfers funds from plans with lower risk enrollees to plans with higher risk enrollees in a state market risk pool	• Affordable Care Act-compliant non-grandfathered individual and small group market plans, inside and outside the Marketplace	• Criteria and methods developed by the Secretary of HHS, in consultation with states and issuers

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2017 Risk Adjustment Data Submission

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- First year incorporating enrollment duration factors in the adult model
- EDGE Data Evaluation Guidance issued November 3, 2017
  - Data submission deadlines will determine an issuer's data sufficiency for use in interim and final risk adjustment calculations
  - Interim 2017 risk adjustment summary report will be published in March 2018, using issuers' data as of January 12, 2018
  - Any state with one or more credible issuers that do not meet data quantity and quality sufficiency for three quarters of annual data by January 12, 2018 will not receive interim risk adjustment results
  - CMS will be conducting outreach from now through final risk adjustment to ensure that issuers have sufficient data quantity and quality for interim and final risk adjustment calculations
  - Available at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/EDGE-Submissions-2017.pdf

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2017 Risk Adjustment Operations Timeline

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STEP	DATE	DESCRIPTION
EDGE 1st Submission Deadline	October 19, 2017	90% Enrollment and Claims for Quarters 1 and 2
EDGE 2nd Submission Deadline	December 7, 2017	90% Enrollment and Claims for Quarters 1, 2 and 3
EDGE 3rd Submission Deadline (Final Deadline for Interim Report)	**January 12, 2018**	**90% Enrollment and Claims for Interim Risk Adjustment Summary Report**
EDGE 4th Submission Deadline	March 1, 2018	90% Enrollment and Claims for Interim Risk Adjustment Summary Report
EDGE Final Data Submission Deadline	**April 30, 2018**	**Final Data Submission**
Final Risk Adjustment Report	June 2018	CMS releases the final risk adjustment summary report

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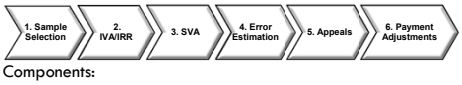
Purpose of Risk Adjustment Data Validation (HHS-RADV)

- To promote confidence in risk adjustment payment transfers by ensuring the integrity and quality of data provided from issuers operating in state markets under the HHS-operated risk adjustment program

HHS-RADV Authority

- States, or HHS on behalf of States, validate a statistically valid sample of data for all issuers that submit for risk adjustment every year and allows states, or HHS on behalf of states, to adjust average actuarial risk for each plan based on the found error rate and to adjust payments and charges based on the changes to average actuarial risk
- For the initial years, the detailed methodology and issuer requirements of the program are provided at Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015, Final Rule, 79 Federal Register 13744-13843

HHS-RADV Processes



Key Components:

1. CMS selects a statistically valid sample of an issuer's enrollees submitted to the issuer's External Data Gathering Environment (EDGE) server
2. Data validation of the selected sample is conducted by an initial validation audit (IVA) auditor (IVA entity) selected by the issuer and reviewed by CMS
3. CMS selects a second validation audit (SVA) entity to validate a subsample of the original IVA sample
4. CMS establishes an issuer-level error rate based on data validation results, and applies the error rate to each issuer's risk adjustment covered plan average liability risk score (PLRS) to produce an error estimate
5. CMS provides an HHS-RADV appeals process for issuers
6. CMS adjusts the PLRS for issuers' risk adjustment covered plans based on errors discovered as a result of data validation

2016 Benefit Year HHS-RADV Important Dates

Date	Description
June 2017 – January 8, 2018*	IVA is conducted
December 18, 2017 – January 8, 2018*	CMS releases the Second Validation Audit (SVA) subsample to IVA Entities, upon issuer signoff of Package 1
January 8, 2018*	IVA Entities submit Package 1 audit findings. This closes the window for the 2016 benefit year HHS-RADV audit submission process
January 18, 2018*	Final day for IVA Entity to submit medical records to CMS for the SVA subsample and final sign-off from issuer
January 2018 – April 2018	SVA is conducted
February 20, 2018	IVA Entity Inter-rater Reliability (IRR) results submission deadline
May 2018 – June 2018	CMS releases 2016 benefit year HHS-RADV error rates to issuers

**Note: These dates have been extended only for issuers receiving extensions due to hurricanes. For these selected issuers, Package 1 is due February 7, 2018 and Package 2 is due February 20, 2018, as indicated in the Audit Tool.*

2015 HHS-RADV Pilot Year Results

2015 Results

- There were 470 HIOS IDs in the 2015 benefit year
- The majority of IVA results had sufficient agreement with the SVA
  - Note: many issuers had sufficient agreement between the IVA and SVA due to a lack of medical records submitted for the audit. In these cases, the SVA agreed with the IVA results, which were used for error estimation.
- Cases without sufficient agreement between IVA and SVA results were primarily due to insufficient documentation or differing diagnoses between IVA and SVA
  - We made changes to 2016 HHS-RADV protocols to clarify coding guidance
- In a payment adjustment year, the SVA results will be used to adjust risk scores

HHS-RADV New Audit Tool and Protocol Updates

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HHS-RADV Audit Tool

- The audit tool is how issuers and their IVAs communicate with CMS regarding the HHS-RADV process
- The audit tool is also used by IVAs to submit the results of their IVA audit
- CMS deployed a new audit tool in 2017
  - The new HHS-RADV Audit Tool is a Salesforce solution built by CMS
- The audit tool utilizes both web forms and a Salesforce Community
- Implemented XML to streamline submission of data to the audit tool

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HHS-RADV 2016 Benefit Year Protocol Updates

- Provided more specific examples for diagnosis abstraction
- Added a list of HCCs (49) that may be considered chronic conditions for HHS-RADV
- Clarification added around the abstraction of diagnoses that may be considered chronic
- Clarification provided for past medical history, problem lists and examples of coding scenarios for guidance with abstraction of chronic conditions in an active state
- Added clarification that CMS will be prioritizing enrollees with medical records in the initial subsample groups of the SVA process
- Added medical record definition

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HHS-RADV Protocol Updates
(continued)

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- Clarification added to the selection of enrollees in the SVA subsample
- Added clarification that a medical record should be signed within 180 days of the date of service depending on the circumstance and type of record

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HHS-RADV Protocol Updates
(continued)

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- CMS eliminated the requirement for State credentials, as we do not believe demonstrating this is necessary for the IVA
- CMS simplified the validation of the following:
  - Demographics and enrollment
  - Premiums
  - Rating areas
- CMS removed requirements for service code modifiers and claims
- CMS continues to receive positive feedback for updated protocols, suggesting chronic conditions and clarifying medical record guidance
- Issuers gearing up to improve medical record retrieval in anticipation of payment year

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Looking Forward:
2018 Risk Adjustment Updates

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Looking forward to 2018

- In the 2018 Payment Notice, we finalized incorporation of a small number of prescription drugs in the adult model
  - We issued a draft prescription drug crosswalk and memo describing drug incorporation process and cross walk for 2018 risk adjustment on September 18, 2017
  - CMS will update the prescription drug crosswalk to incorporate new drugs and USP classification updates prior to 2018 benefit year risk adjustment operations
  - Draft memorandum available at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Draft-RxC-Crosswalk-Memo-9-18-17.pdf
  - Draft crosswalk available at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/RARx_RxCUIs-Crosswalk-9-6-17.xlsx
- We also finalized modifications to the risk adjustment transfer formula to remove a portion of administrative costs, and finalized creation of a high-cost risk pool adjustment to transfers to fund 60 percent of issuers' costs for individuals with claims above $1million

Other Data Analyses

- Using risk adjustment to help inform state risk profiles and forthcoming analysis on top HCCs.
- EDGE Ad-hoc reporting capability will enhance analytic capability
- Age/enrollment duration/ cost differential charts on EDGE vs. MarketScan

2019 Payment Notice Proposed Rule

2019 Payment Notice Proposed Rule: Risk Adjustment Proposals

- Published on November 2, 2017, comments due on November 27, 2017[1]
- Propose to blend coefficients using three years of data including 2014 and 2015 MarketScan data, and 2016 enrollee-level EDGE data for the 2019 benefit year model
- Propose to remove two severity-only drug classes that do not predict meaningful incremental plan risk associated with a severe health condition, from the 2019 benefit year model
- Propose to maintain the high-cost risk pool adjustment parameters established for the 2018 benefit year of $1 million threshold and 60 percent coinsurance rate for the 2019 benefit year
- Propose to permit States to reduce the magnitude of risk adjustment transfers in the small group market to minimize unnecessary volatility in the small group market risk adjustment transfer amounts

[1] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019, Proposed Rule, 82 *Federal Register* 51052-51148. Available at: https://www.federalregister.gov/documents/2017/11/02/2017-23599/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2019

2019 Payment Notice Proposed Rule: RADV Proposals

- A simplified approach to making payment adjustments resulting from RADV error rates under which we would adjust risk scores only when an error rate materially deviates from a statistically meaningful value, like the national central tendency starting with 2017 benefit year
- Payment adjustment for issuers that exit a State market to use the error rate to adjust the issuer's risk score for its final benefit year in the State market and make a retroactive adjustment to the issuer's payment transfer beginning with 2017 benefit year
- Proposal to not require an IVA for issuers with 500 or fewer billable member months
- Delay implementation of materiality threshold ($15M) to 2018 benefit year HHS-RADV

2019 Payment Notice Proposed Rule: RADV Proposals (continued)

- Change the sampling methodology to only include State risk pools where there is more than one issuer
- Mental or behavioral health assessments may be provided beginning with 2016 benefit year HHS-RADV
- Inter-rater reliability (IRR) will be measured at 85% (with no rounding) for the 2016 benefit year HHS-RADV (second pilot year)
- CMS would be given authority to assess civil monetary penalties in the event of misconduct or substantial non-compliance with HHS-RADV

Questions?