Pulse8
EVERY NUMBER IS A LIFE.

Affordable Care Act

2020 HHS RADV Final Rule

Pulse8 Active Intelligence Brief: Expert Insight

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PULSE8 is privileged to bring you an insightful summarization of the important changes and updates to the ACA HHS Risk Adjustment Data Validation (RADV) program for Benefit Year 2020 as documented in the, ***"Amendments to the HHS-Operated Risk Adjustment Data Validation (HHS-RADV) Under the Patient Protection and Affordable Care Act's HHS-Operated Risk Adjustment Program"*** posting to the Federal Register website: www.federalregister.gov/d/2020-26338

Pulse8 has prepared, for the convenience of our customers and industry partners, a summary level interpretation of a complex and detailed amendment to Federal Law. Any questions concerning the meaning, interpretation, or effect the changes may or may not have on any given ACA health plan issuer should be directed to legal counsel.

BACKGROUND

The Affordable Care Act from March of 2010 established a permanent risk adjustment program providing payments to health insurance issuers that attract higher-than-average risk populations from those that attract lower-than-average risk populations.

The CMS-administrated, HHS-ACA risk adjustment program was designed with the requirement that the data used to calculate risk scores (and the corresponding transfer payments), is to be regularly validated by a separate Risk Adjustment Data Validation (RADV) process.

OVERVIEW OF RADV ERROR RATE "BUCKET" METHODOLOGY

The RADV audit process begins with CMS identifying 200 enrollees of each ACA plan, for whom all EDGE-submitted and accepted Hierarchical Condition Codes (HCCs) must be validated with CMS. Enrollee HCC validation requires condition-documenting information recorded within the medical chart records of the identified enrollee.

RADV data from all ACA plans, nationwide, to establish error rate benchmarks:

1. CMS calculates an error rate for each HCC.
2. CMS allocates each HCC to an error rate bucket of low, medium, or high.
3. For each of the three buckets, CMS calculates an error rate mean with upper and lower confidence interval benchmarks.

RADV data from the audited plan for statistical comparison to benchmarks:

1. CMS applies the HCC-to-Bucket assignments from the nationwide analysis to the audited plans for statistical comparison of plan bucket error rate average to the nationwide confidence interval benchmarks.
2. Audited plans with bucket error rate averages below the upper confidence interval and above lower, are consistent with national rates and are not subject to risk score/transfer payment adjustment, neither positive nor negative.
3. Audited plans with bucket error rate averages above the upper confidence interval are outliers and are subject to a negative risk score/transfer payment adjustment.
4. Audited plans with bucket error rate averages below the lower confidence interval are outliers and are subject to a positive risk score/transfer payment adjustment.

OVERVIEW OF FINAL RADV CHANGES

Shift to Concurrent Benefit Year RADV Audit Application

Previously, RADV audit results of EDGE-submitted encounter data of any given Benefit Year (BY) were applied to risk score/payment transfer calculations of the following Benefit Year. For example, RADV audit results from EDGE data with 2018 service dates were used to modify the risk score/payment transfer calculations of BY2019 enrollment and claims experience.

Per the Final Rule, the application of RADV audit results is shifting to a concurrent model paradigm, as follows:

- The BY2020 risk score/transfer payments will be adjusted by the average error rates of both the BY2019 and BY2020 RADV audit results. Note, the Final Rule did not give a timeline for identification of BY2020 sample enrollees.
- Starting with BY2021 and thereafter, RADV results from any given benefit year will be used to adjust the risk scores and transfer amounts for same benefit year, entirely.

***PULSE8 INSIGHT**: In general, the shift to a concurrent benefit year RADV adjustment methodology will yield more accurate risk score/transfer payments. For plans with large BY-to-BY enrollment swings and new-to-market plans, the concurrent shift will remedy unfair adjustments arising from the prior prospective model.*

RADV Super HCCs

ACA risk adjustment scoring methodology groups clinically alike HCCs to avoid duplicative score increase. For example, the diabetes HCCs 19, 20, and 21 are grouped as risk score category G01; an enrollee with ICD10s mapping to each 19, 20 and 21 does not receive three risk scores, but rather only one, HCC-grouper (G01) risk score. There are 19 such risk score category groups made-up of 41 HCCs.

Previously, RADV methodology analyzed all HCCs independently in determining error rates, i.e., without application of risk score HCC-grouping methodology, generating 128 HCC-level error rate data points.

Per the Final Rule, starting with BY2020, CMS will apply the risk score HCC-grouping methodology for error rate calculation. As a result, the RADV error rate calculus will now generate 106 error rate comparison values: 87, stand-alone HCCs plus 19 HCC-groupers, referred to as "Super HCCs" within Final Rule documentation.

***PULSE8 INSIGHT**: The likelihood of a medical record having information documenting <u>any</u> diagnosis within a disease/condition group is significantly greater than the likelihood of a medical record having information documenting a <u>specific</u> diagnosis within a disease/condition group.*

The reduction in diagnosis specificity requirements introduced by the application of Super HCCs will decrease overall error rates for all plans, as it will also decrease the standard deviation amongst plan average error rates. The combined result being less differentiation in RADV audit impact from plan to plan.

While the effects of this Super HCC methodology seem to lessen overall RADV audit impact, plans should still be actively messaging providers to document and code diseases and conditions to the highest degree of accuracy, specificity, and severity for purposes of keeping the overall monetary cost determinations of the HHS-HCC model aligned with financial reality. In other words, if non-specific coding wins the day, risk scores for the sickest/most costly members will be under reported, leading to inaccurate cost coverage and eventual financial losses for ACA plans.

Smoothing of the Error Rate "Payment Cliff' for Outlier Plans

Audited plans with bucket error rate averages above the upper confidence interval and/or below the lower confidence interval are deemed outliers and are subject to a negative or positive risk score/transfer payment adjustment.

The 2020 HHS-RADV Final Rule is altering the methodology used to calculate both negative and positive outlier risk score/transfer payment adjustments.

CMS is expanding the error rate confidence interval to identify outlier plans, from 95% to 90%, thereby increasing the count of outlier plans. The addition of more outlier plans with error rates closer to the mean will, in and of itself, help to flatten the outlier/insider delta.

In addition, CMS will apply a statistical "tuning" factor based on the magnitude of a plan's statistical distance from the confidence interval threshold: Plans with error rates closer to the outlier threshold will have a smaller adjustment to their risk score/transfer payment calculus than those plans with error rates further from the threshold.

***PULSE8 INSIGHT**: These changes wills serve to increase the number of outlier plans, while at the same time reduce the average risk sore/transfer payment impact adjustment rates (both positive and negative) for outlier plans close to the threshold.*

Constraining Negative Error Rates to Zero

Over the course of a RADV audit chart review, plans will find documentation for HCCs that were not originally submitted in EDGE data. CMS allows plans to submit these added conditions to the RADV analysis, allowing for the possibility of an HCC to have a "negative" error rate. For example, if a RADV sample requires "Plan A" to support the Diabetes Super HCC for 10 enrollees, but Plan A submits documentation that supports the Diabetes Super HCC for 15 enrollees, Plan A would have a Diabetes Super HCC error rate of -50.0%.

Assume the Diabetes Super HCC falls into the High Error Rate bucket. Assume again that the Diabetes Super HCC's negative error rate of -50.0% propels Plan A's overall High Error Rate bucket to -5.0%. Figure 1 below, displays how constraining Plan A's negative error rate to 0.0% (up from -5.0%), reduces the positive impact to Plan A's overall risk score from 9.6% (4.6% less -5.0%) under BY2019 rules, to 4.6% (4.6% less 0.0%) under BY2020 Rules.

Figure 1.

HCC/Super HCC Error Rate Bucket	Bucket Threshold %	Plan A Error Rate	Plan A RS Adjustment % BY2019 Rules	Plan A RS Adjustment % BY2020 Rules
High	4.6%	-5.0%	9.6%	4.6%

***PULSE8 INSIGHT**: This change will help offset an unintended "loophole" within HHS-RADV that rewards health plans with RADV chart review results that document significant volumes of enrollee HCCs not previously submitted to EDGE. The HHS-HCC risk adjustment model relies on EDGE data to be as complete and as accurate as possible. By reducing the positive impact of unsubmitted HCCs, plans will be incentivized to re-focus on EDGE data workflows.*

CONCLUSION

The 2020 HHS-RADV Final Rule has implemented changes that culminate into a clustering effect on ACA risk adjustment data integrity assessment. The Final Rule modifications will increase the count of both positively impacted and negatively impacted outlier plans. However, the level of impact to outlier plans' risk score/transfer payment calculation will be less, with extra discount to positive adjustment calculation.

In the big picture, for the sake of the viability of the now ten years old ACA health insurance program, participating plans should continue efforts to influence providers to continuously code and document conditions accurately, to improve EDGE data submission completeness, and to work to avoid negative outlier status. ACA plans should use their RADV audited results as a grading mechanism of their commitment to the entire ACA mission.