Risk Adjustment 101: Health-Based Payment Adjustment Methodology

Presented by:

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Agenda

- Foundational
  - Risk Adjustment Overview—Definition & Background
  - Goals & Benefits of Risk Adjustment
- Mechanics
  - Risk Adjustment Models
    - CMS-HCC
    - HHS-HCC
    - Medicaid Managed Care
  - Prospective vs. Concurrent
- Risk Adjustment Validation Differences
  - Risk Adjustment Data Validation Audit (RADV)
- Operational Practicalities
  - Data that Counts
  - Provider Considerations
  - Risk Adjustment Evaluations
- Legal Considerations
- Q&A
What is Risk Adjustment?

- Actuarial tool used to calibrate payments to health plans based on the relative health of the at-risk population.
- Risk adjustment helps ensure that health plans are appropriately compensated for the risks they enroll.
- The goal is for payments to a health plan to reflect the expected costs of providing care to its members.
- A risk score compares the predicted costs for members of a health plan with that of the average costs for the population eligible for enrollment.
Why is Risk Adjustment Important?

- Plans/Issuers that cherry pick or have adverse selection will be paid accurately for the risk they’ve assumed to insure their members
- Risk adjustment does not happen automatically

<table>
<thead>
<tr>
<th>Passive Approach</th>
<th>Active Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plans/Issuers get what they’re given</td>
<td>Plans/Issuers get their fair share</td>
</tr>
</tbody>
</table>
## Sample Patient Pre-Risk Adjustment

<table>
<thead>
<tr>
<th>Status</th>
<th>Risk Score*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient lives in own home, has diabetes with neural manifestations; only coded as a simple diabetic</td>
<td>0.20</td>
</tr>
<tr>
<td>Patient also has depression which the doctor hasn’t billed for</td>
<td>0.00</td>
</tr>
<tr>
<td>28 year old female in Monroe County</td>
<td>0.12</td>
</tr>
<tr>
<td><strong>Total Risk Score</strong></td>
<td><strong>0.32</strong></td>
</tr>
<tr>
<td><strong>Multiplied by the County Rate of $700 (per member per month)</strong></td>
<td><strong>$224.00</strong></td>
</tr>
</tbody>
</table>
### Sample Patient Post-Risk Adjustment

<table>
<thead>
<tr>
<th>Status</th>
<th>Risk Score*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient lives in own home, has diabetes with neural manifestations which is captured via risk adjustment</td>
<td>0.452</td>
</tr>
<tr>
<td>Patient also has depression documented in visit notes &amp; captured via risk adjustment</td>
<td>0.431</td>
</tr>
<tr>
<td>28 year old female in Monroe County</td>
<td>0.120</td>
</tr>
<tr>
<td><strong>REVISED Total Risk Score</strong></td>
<td><strong>1.003</strong></td>
</tr>
<tr>
<td><strong>Multiplied by the County Rate of $700 (per member per month)</strong></td>
<td><strong>$702.10</strong></td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
</tr>
<tr>
<td>------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| CMS-HCC    | 3 models currently in use:  
  • Model 12/22 blended for CY 2014 & 2015  
  • Model 21 for PACE & ESRD | • Funded by CMS  
  • Applied to each individual beneficiary  
  • Added to base premium | • Medicare Advantage (including PACE)  
  • Duals Demonstration  
  • Medicare MSSP ACOs |
| HHS-HCC    | **Federal:**  
  • 15 models or “3x5”  
  • 3 populations (adult, child, infant) x 5 metal levels | • Funded by Issuers  
  • Calculated for applicable individuals but applied at the Issuer level  
  • State budget neutral; transfer of funds between Issuers | • Issuers offering direct & small group coverage on/off the Exchange  
  • Massachusetts |
|           | **State:**  
  • Only Massachusetts has own model |                                                                      |                                                |
## Risk Adjustment Models, cont’d

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Budget/Payment</th>
<th>Applies To</th>
</tr>
</thead>
</table>
| Medicaid Managed Care        | • Variety of different models; accommodates different aid categories | • Funded by State budget  
• Calculated for applicable individuals but applied at the MCO/MCE regional level  
• Regional budget neutral; transfer of funds between MCOs/MCEs | • States that risk adjust Medicaid Managed Care |

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## State Risk Adjustment Models: Medicaid Managed Care

<table>
<thead>
<tr>
<th>Model</th>
<th>Data Requirements</th>
<th>States (with existing risk adjustment models)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Rx (MRx)</td>
<td>Hierarchical: Drugs</td>
<td>California, Missouri, Florida, South Carolina</td>
</tr>
<tr>
<td>Chronic Illness &amp; Disability Payment System (CDPS) &amp; CDPS + MRx</td>
<td>Hierarchical: Diagnosis Codes</td>
<td>Pennsylvania, New Jersey, Delaware, Virginia, Michigan, Illinois, Ohio, Kentucky, Wisconsin, Texas, Utah, Oregon, Washington</td>
</tr>
<tr>
<td>Diagnostic Cost Groups (DCG)</td>
<td>Hierarchical: Diagnosis Codes</td>
<td>Massachusetts</td>
</tr>
</tbody>
</table>

2012 data
State Risk Adjustment Models: Medicaid Managed Care

<table>
<thead>
<tr>
<th>Model</th>
<th>Data Requirements</th>
<th>States (with existing risk adjustment models)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Risk Groups (CRG)</td>
<td>Categorical: Diagnosis Codes, Drugs</td>
<td>New York</td>
</tr>
<tr>
<td>Adjusted Clinical Groups (ACG)</td>
<td>Categorical: Diagnosis Codes</td>
<td>Maryland, Tennessee, Minnesota, Louisiana</td>
</tr>
<tr>
<td>Episode Risk Groups (ERG)</td>
<td>Categorical: Diagnosis Codes, Drugs</td>
<td>Arizona</td>
</tr>
</tbody>
</table>

2012 data
Prospective vs. Concurrent:

- Medicare Advantage, Medicaid Managed Care, & Duals risk adjustment operates on a prospective basis—a calendar year of risk assessment is used to determine capitation payments for subsequent calendar year
- Health Insurance Exchange operates on concurrent basis—risk assessment year is the same as the payment year
- Concurrent risk adjustment is more accurate than prospective risk adjustment but much harder to administer
<table>
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<tr>
<th>Business Segment</th>
<th>Regulator, Frequency, Sample Size, &amp; Scope</th>
<th>Financial Impact</th>
</tr>
</thead>
</table>
| Medicare Advantage RADV (includes MSSP ACOs) | • **Regulated by:** CMS  
  **Frequency:** 30 Plans selected annually  
  **Size:** 201 member sample  
  **Scope:** HCC validation | Extrapolation methodology                                                        |
| Health Insurance Exchange RADV   | • **Regulated by:** HHS  
  **Frequency:** every Issuer audited every year; 6 steps  
  **Size:** 200 member sample  
  **Scope:** bi-directional HCC & demographic validation/missing HCCs  
  • Issuers have to use an independent auditor for the 2nd Step: Initial Validation Audit | Payment transfer + extrapolation methodology proposed to start in 2016              |

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</table>
| Medicaid Managed Care                  | • Regulated by: State Departments of Health & and/or Insurance  
Frequency: varies  
Size: varies  
Scope: aid category & payment adjustments  
-and also-  
• At discretion of OMIG | • Recapture of overpayment  
• Recapture of overpayment |
| Duals (follow Medicare Advantage RADV & State Medicaid Managed Care) | • Regulated by: CMS  
Frequency: 30 Plans selected annually  
Size: 201 member sample  
Scope: HCC validation  
-and-  
• Regulated by: State Departments of Health & and/or Insurance  
Frequency: varies  
Size: varies  
Scope: aid category & payment adjustments  
-and also-  
• At discretion of OMIG | • Extrapolation methodology  
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Q & A
What is Risk Adjustment?

- Actuarial tool used to calibrate payments to health plans based on the relative health of the at-risk population.

- Risk adjustment helps ensure that health plans are appropriately compensated for the risks they enroll.

- The goal is for payments to a health plan to reflect the expected costs of providing care to its members.

- A risk score compares the predicted costs for members of a health plan with that of the average costs for the population eligible for enrollment.
A Well-Designed Risk Adjustment System Will:

- Minimize incentives for plans and providers to selectively enroll healthier members.
- Ensure sufficient resources to provide effective treatment for high-cost patients.
- Foster competition among MCOs based on how well they can deliver care and negotiate provider reimbursement rather than whether they can enroll the healthiest individuals.
- Align incentives, limit gaming, and protect risk-bearing entities.
Every Risk Adjustment System Must Answer Three Questions.

• How will risk be measured?
  – What health conditions increase costs and therefore risk?

• How will the data be collected and used?
  – What data counts?
  – Will risk scores be calculated looking back or going forward?

• How will the system verify the data and risk scores?
  – Audits
How is Risk Measured?

• In general, all risk adjustment begins with a risk assessment, which assigns a risk score to plan members.

• To conduct a risk assessment, information that can be used to predict health care costs of enrollees is collected. This data typically can include:
  – Demographics: age, gender, family size, geography, coverage eligibility, etc.
  – Diagnoses
  – Prescription Drugs
  – Functional Status
  – Self-Reported Health Status
  – Prior Utilization or Expenditures
How is Risk Measured? (cont.)

• Diagnoses—every risk adjustment system studies data regarding how much it costs to treat conditions.

• Easiest and fastest way for government risk adjustment systems to cut reimbursement is by deciding that certain conditions will no longer be included in the risk adjustment model.

• In addition to costs, for Medicare Advantage, CMS also considers whether the diagnostic classifications measure the disease burden and whether diagnosis codes are subject to discretionary or inappropriate coding.
How is Data Collected and Used?

• What data counts?
  – Limited types of providers
  – Limited types of interactions
  – Reporting a diagnosis versus treating a diagnosis

• What actions can an MCO take to ensure it receives complete and accurate data from the providers who provide services to the MCO's members?
How is Data Collected and Used? (cont.)

• Member data is collected in one of three ways:
  – Prospective: Using prior year data to predict future costs.
    • These models have been shown to under-predict costs of high-cost patients and over-predict costs for low-cost patients.
  – Concurrent: Using the same year's data to predict costs.
    • These models predict expenses more accurately than prospective models.
  – Hybrid: Blending prospective and concurrent data.
    • These models may be the most effective cost-predictor.
How Will the System Verify the Data and Risk Scores?

• Audit methodologies
• Who can audit?
• What data and records count in an audit?
• What can audit findings result in?
Recent Government Guidance

• CMS Call Letters
  – Medicare Advantage health risk assessments
  – Home visits
  – Deleting certain conditions

• CMS Proposed Regulations
  – Gives more agencies the ability to conduct RADV audits

• OIG Work Plans
Legal Issues to Consider in Risk Adjustment Systems

• The most robust risk adjustment systems operate as part of a federal health care program.

• Data provided to the federal government for payment must be accurate, truthful, and complete.

• Providing false data to the government can potentially result in significant legal actions including suits under the federal False Claims Act.
Trends and Reported Legal Cases

• Many cases and investigations in the risk adjustment area are whistle blower actions.

• Government's theories are becoming more complex.

• Cases:
  – U.S. v. Janke and Medical Resources, LLC
  – U.S. v. Kernan Hospital