March 31, 2016, HHS-Operated Risk Adjustment Methodology Meeting

Questions & Answers

The purpose of this document is to set forth the major questions asked and answered during the March 31, 2016, HHS-Operated Risk Adjustment Methodology Public Meeting (Risk Adjustment Conference).

I. General Topics

Question: How will CMS modify the risk adjustment models in the 2018 Payment Notice?

Answer: CMS intends to propose a number of improvements to the HHS risk adjustment methodology in the 2018 Payment Notice. While we continue to consider additional proposals, there are two we expect to include. First, we intend to propose a modification to the HHS risk adjustment methodology to account for partial year enrollment. The modification would add 11 monthly indicator variables to reflect additional predicted risk for enrollees with different enrollment duration (that is, one indicator variable signifying 1-month enrollment duration, a different indicator variable signifying 2-month enrollment duration, etc., with enrollees with 12 months of enrollment being treated as the baseline). The risk factors associated with enrollment duration would decrease monotonically (with the 1-month duration group having the highest coefficient). This modification will be proposed for both the 2018 and 2017 benefit years.

Second, we intend to propose to incorporate a small number of prescription drug classes as predictors in the HHS risk adjustment methodology for the 2018 benefit year to impute missing diagnoses and to indicate severity of illness. We believe that including prescription drugs as a proxy for missing diagnoses could reduce the extent to which an issuer's risk score depends upon its level of experience with medical coding, and result in more accurate risk scores for enrollees with prescription drug claims, but who have not had a provider encounter with a documented diagnosis. Using prescription drug data as an indicator of the severity of a particular diagnosis can also offer a more complete picture of enrollee health status. A more complete measurement of enrollee health status should improve the accuracy of risk adjustment across all health plans. We intend to limit the number of prescription drug classes included as predictors to only those drug classes where we are confident that the risk of unintended effects on provider prescribing behavior is low; we intend to monitor prescription drug utilization for unintended effects, and may remove drug classes based on such evidence.

We may also propose other changes to the risk adjustment methodology discussed in the March 31, 2016 Risk Adjustment Meeting Discussion Paper[1] and during the Risk Adjustment Conference. We will seek comment on all proposed changes during the rulemaking process.

Question: In 2017, the HHS risk adjustment methodology will take into account preventive services. Please comment on how exactly it will be done, and what the Centers for Medicare and Medicaid Services (CMS) expects to accomplish by doing it?

---

[1] Avaliable at: https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/RA-March-31-White-Paper-032416.pdf.

Answer: CMS incorporated preventive services into the simulation of plan liability in the recalibration of the risk adjustment models for 2017. This incorporation of preventive services is intended to more accurately compensate risk adjustment covered plans with enrollees who use preventive services. Section 2713 of the PHS Act, as added by the Affordable Care Act, requires that individual and small group non-grandfathered plans (among others) provide coverage for a range of preventive services and may not impose cost sharing on patients receiving those services. By incorporating zero cost sharing preventive services in the calculation of plan liability when calibrating the models' coefficients, we will increase the accuracy of the model overall, accounting for any differential use of preventive services at the plan level.

Question: Going forward, will a statewide interim risk score be provided to issuers so they can predict the financial impact of their own specific interim risk scores?

Answer: For the 2015 benefit year, we released the interim report year in March 2016.[2] We will assess the impact and usefulness of releasing the interim report for future years. Once we are able to compare the results of this year's release, we will make that determination.

Question: Would you be willing to release the plan-level data used in the slides during the Risk Adjustment Conference?

Answer: In the June 30, 2015 *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year*,[3] CMS has made the issuer-level data available, but not the plan-level results. We do not currently have plans to release plan-level results.

Question: It is possible that consumer behavior on the Marketplaces differs significantly from the privately insured data used to calibrate the HHS risk adjustment models. Is CMS considering use of Marketplace data to develop or recalibrate the risk models in lieu of MarketScan?

Answer: Yes. One of the proposals presented in the White Paper and during the Risk Adjustment Conference discusses usingenrollee-level data from the External Data Gathering Environment (EDGE) server to calibrate the risk adjustment models based on actual individual and small group market data, rather than MarketScan data, to improve the precision of the HHS risk adjustment model. However, we would note that at this point in time, we have no evidence that using MarketScan data is any less accurate than using actual individual and small group market data.

Question: Would CMS consider using the EDGE data to calibrate the risk adjustment model as early as the 2018 benefit year?

Answer: In order to use the EDGE data to recalibrate the risk adjustment model, CMS would first need to establish the policy to use the enrollee-level data. Once CMS has established the policy, we would need to implement and execute the code on EDGE to collect enrollee-level

---

[2] Avaliable at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/InterimRAReport_BY2015_5CR_032816.pdf.
[3] Latest version available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-REVISED-9-17-15.pdf).

data. After this point, CMS would be able to analyze the EDGE data and use it to recalibrate the risk adjustment model for a subsequent year. The earliest we are able to establish policy to collect enrollee-level data from EDGE is in rulemaking for the 2018 benefit year to run reports in the spring of 2017 on EDGE 2016 benefit year data. We would be able to use EDGE 2016 benefit year data to recalibrate the model for the 2019 benefit year. If the data collection policy was finalized for the 2018 benefit year, we would be able to use EDGE 2016 benefit year data to recalibrate the model for the 2019 benefit year at the earliest.

Question: For the enrollee-level data collection proposal to recalibrate the risk adjustment model on the EDGE data, would CMS publish the encrypted, de-identified national data set, or a subset thereof, that is being proposed to calibrate the 2019 HHS risk adjustment models?

Answer: We are still considering the the policy and analytical implications of using de-identified enrollee-level data that is currently maintained on issuers' EDGE servers to recalibrate the risk adjustment models in future years. If we decide to move forward with the proposal, we will propose this policy in notice and comment rulemaking and solicit comment on whether and in what circumstances to release that data.

Question: For the enrollee-level data use proposal, if an enrollee stays with an issuer for multiple years, will CMS be able to link data for the enrollee across multiple plan years to facilitate longitudinal studies?

Answer: Because we have not used enrollee-level data to date in the risk adjustment program, CMS has not provided any guidance on how issuers should create enrollee IDs across multiple years. We do state at 45 CFR 153.720(a)(2) that an issuer must maintain the same deidentified enrollee ID for an enrollee across enrollments or plans within the issuer, within the state, during a benefit year. That is, if an enrollee switches plans within the same issuer in a benefit year, the issuer should use the same enrollee ID throughout the year so that the enrollee can be matched with their associated enrollment periods and claims for the full year.

Question: Would CMS be willing to do a risk adjustment calculation (and hypothetical transfer) under the current risk score methodology and proposed recalibration in parallel to help issuers understand how the new model will behave?

Answer: Currently, we do not have the technical capacity to conduct those parallel operations, but we are exploring avenues for doing so. We are also exploring whether we have the operational capacity to conduct these calculations in parallel, given the timing of EDGE operations, and whether performing these parallel calculations could introduce or reduce uncertainty in the market.

Question: The last slide of the presentation on using enrollee-level data from the EDGE server showed data going to CMS before encryption. Is data encrypted before or after going to CMS?

Answer: Data from the EDGE server is encrypted before it is transmitted to CMS. When CMS receives the data it is in the encrypted format, at which point the data is available for recalibration and analysis. This was a typographical error on the slide.

Question: The HHS-Operated Risk Adjustment Methodology Meeting presentation showed the analysis of risk transfers between small plans versus large plans. An issuer requested to see how risk is being transferred between fast-growing and new plans versus slower growing or more established plans. Has CMS done that analysis, and if so can CMS release it to issuers?

Answer: The current set up of the EDGE server makes it difficult for CMS to conduct longitudinal, cross-year, and other detailed analyses. We will continue to assess ways to understand differences in outcomes for new and fast-growing plans and the more established plans in the market.

Question: A national actuarial firm is estimating that some of the rate increases for 2017 are due to the uncertainty of risk adjustment. Is CMS concerned about this?

Answer: Our analysis of the 2014 risk adjustment transfers indicates the model is working to stabilize the market by transferring payments to issuers with sicker enrollees, but we are always considering ways to improve the model. We believe there will be more certainty over time and we have worked to reduce uncertainty by incorporating feedback received from issuers (e.g., releasing interim risk scores prior to final risk scores). As the Marketplace matures, we believe that issuers' experience will mitigate any uncertainty over the effects of risk adjustment.

II. Model Overview

Question: What is CMS's process for evaluating the hierarchical condition categories (HCCs) included in the risk adjustment models? Is CMS considering adding HCCs or splitting Hepatitis C off from the Chronic Hepatitis HCC?

Answer: Splitting the Chronic Hepatitis HCC is something we have previously received comments on in the Payment Notice. We are currently considering the implications of this. We do not believe at this stage we need to re-evaluate all of our HCC classifications, however, CMS will revisit HCCs as clinically necessary in future years and as better data becomes available.

Question: Why has only one state elected to operate its own risk adjustment program?

Answer: The Affordable Care Act and implementing regulations allowed states to opt out of operating their own risk adjustment program. Many states chose not to operate a separate risk adjustment model, as such CMS operated the risk adjustment program on behalf of those states. Massachusetts was not recertified to operate its alternate risk adjustment methodology for the 2017 benefit year. CMS will transition to operate risk adjustment in Massachusetts in 2017.

Question: The Risk Adjustment Conference presentation on results from the 2014 benefit year risk adjustment program seemed to indicate large subsidization of gold and platinum plans by bronze policy-holders. Have you considered separate risk adjustment calculations for each metal level?

Answer: We believe that the risk adjustment program is working as intended by correctly transferring payments from issuers with high proportions of bronze metal level enrollment,

which attracted many healthy enrollees, to issuers with high proportions of platinum metal level enrollment, which are more subject to adverse selection.

III.   Prescription Drug Data

Question: Please provide a specific example of "gaming" risk associated with adding prescription drug claims to the risk adjustment methodology. What drug would be so low cost while also impacting risk score enough that an issuer would be motivated to increase utilization?

Answer: In the White Paper we provided an example of diabetes treatments that could be prescribed in lieu of diet and exercise management treatments.

Question: Has the assumption that Prescription Drug Categories (RXCs) impute an HCC been empirically tested and have the medical records for such members been reviewed to substantiate or negate the imputed HCC? For example, the White Paper gives counts where an RXC imputes an HCC. The relationship between a prescription drug and a particular medical condition may not be strong enough to warrant an imputation type model.

Answer: We have not attempted to validate RXC imputations with medical records. We have assessed cases where an individual is in two consecutive years in the MarketScan data. For instances where the individual has the prescription drug without the associated diagnosis that we are attempting to impute, we looked at the following year and a number of those individuals do have the diagnosis in the following year. The percentage of individuals with diagnosis coded in the following year varies by drug category.

Question: Could CMS go into more depth about auditing challenges that will arise if prescription drugs are added to the model? There is a concern that if prescription drugs are added to the model, plans will compete on their ability to induce providers to prescribe drugs in the RXCs chosen for the model, regardless of clinical need. Could CMS build an auditing process that would promote confidence in the RXCs to reflect health status and not the relative ability of plans to induce extra prescriptions?

Answer: Avoiding unintended incentives is a challenge when incorporating prescription drugs into our model or any utilization-based method of risk adjustment. We are investigating ways of mitigating this risk by incorporating high-cost drugs with specific, limited uses. We do not believe an audit plan would consist of CMS conducting medical review or utilization review activity to determine the appropriateness of a course of treatment.

Question: New and fast-growing plans are particularly likely to have missing or incomplete diagnoses. The use of prescription drug data in the risk adjustment model could help impute these missing diagnoses in 2018 and later. Has CMS considered using a "credibility approach" in the near term to determine the extent to which risk adjustment should apply? Plans with a high proportion of truly new members could be subject to reduced levels of risk adjustment transfers from 2015 through 2017 until the prescription drug hybrid model could be implemented.

Answer: At this time, we do not have data to evaluate whether these types of plans are particularly likely to have mising or incomplete diagnoses. We will continue to assess ways to evaluate how the risk adjustment program is affecting different types of issuers.

Question: What were the "select few" drugs and diagnoses that had high predictive power?

Answer: Use of Hepatitis C drug data significantly increased predictive power. A number of other high-cost drugs did so as well. Please refer to the White Paper for more information.

Question: One of the principles of the diagnosis based HCC risk adjustment model is to encourage more complete and accurate documentation and coding of conditions. Could the proposal to incorporate prescription drug data to impute conditions violate that principle and relieve plans of the responsibility to completely and accurately code conditions?

Answer: The hybrid model would use both conditions and prescription drugs, and the incentive to code fully varies by the type of hybrid model. None of the hybrid models would induce a penalty for recording additional diagnoses. We do not currently believe a hybrid model would encourage issuers to reduce accurate documentation and coding of conditions.

Question: To minimize gaming with the pharmacy indicator, is CMS considering a long minimum drug usage such as the 181 days of daily dosage used by Germany and the Netherlands?

Answer: CMS has assessed instances for which length of use indicates the different conditions and different treatment patterns. We believe the length of use can be used to distinguish disease severity and prophylactic use, but we are conscious of the tradeoff that would occur in imputing missing diagnoses for enrollees with partial year enrollment if we were to implement a long minimum days supply requirement.

IV. Partial Year Enrollment

Question: Is it possible that new or fast-growing plans could be helped by incorporating the plan's proportion of partial year enrollment into risk adjustment, which CMS has begun to study?

Answer: We believe that adjusting for partial year enrollment could make the risk adjustment methodology more accurate for all plans. We therefore intend to propose a modification to do so, and will seek comment on this modification to the methodology as part of the 2018 Payment Notice.

Question: For partial year modeling, would MarketScan data be relevant? It is mainly employer-sponsored insurance (ESI) data from employees/dependents with stable, 12-month enrollment. New hires and terms might be quite different from the Affordable Care Act individual and small group markets' partial year enrollees. Should CMS wait for actual individual and small group market data?

Answer: The MarketScan data may not entirely reflect the nuances of partial year enrollment in the individual and small group markets. However, we do believe that these data are useful in

analyzing the effects of partial year enrollees in the risk adjustment model calibration, and in developing methods to adjust for partial year enrollees.

V.   Transfer Formula

Question: If you were to use the plan's own premium rather than the statewide average premium, how would you maintain the program's budget neutrality?

Answer: We have considered a few options to achieve budget neutrality in risk adjustment transfers if we used a plan's own premium instead of statewide average premium, but are continuing to assess the best approach to calculating transfers.

Question: Has CMS considered the impact of the updates to the risk adjustment methodology on preservation of competition within the individual and small group markets?

Answer: CMS carefully considers the impact of any changes to the risk adjustment methodology on individual and small group market dynamics. Our goal is to continually improve the accuracy of the risk adjustment models. We believe that a robust risk adjustment program is critical to providing all issuers – large and small, new and established – with the incentive to serve all consumers in the broad risk pool.

Question: Is there any consideration being given to implementing a cap on risk adjustment transfers as a percent of premium perhaps related to Medical Loss Ratio (MLR)?

Answer: CMS has considered such a limit on risk adjustment transfers. However, we are concerned that any cap on charges would also result in a cap on payments that CMS is able to make to issuers with adverse selection into their plans, undermining the goal of the program.

VI.   High Risk Pooling

Question: How would the high risk enrollee pool concept discussed in the White Paper interact with commercial reinsurance purchased by the issuer?

Answer: The high risk enrollee pool concept would be modeled into the risk adjustment program and transfers would be calculated in accordance with newly recalibrated models incorporating this concept. CMS would not dictate issuers' decisions on the use of commercial reinsurance.

Question: Issuers may renegotiate or incentivize large claims from providers in exchange for reductions elsewhere. The potential for gaming the high risk enrollee pool likely outweighs any predictive gain. Additionally, while issuers can avoid sick members, it is difficult to see how they can avoid members with catastrophic claims. Does this problem currently exist and how will large claims be validated?

Answer: A high risk pool may help issuers with catastrophic costs that are unavoidable, and are otherwise detrimental to issuers since the individual and small group markets do not have annual limits or lifetime limits. These costs can be exceptionally high compared to what issuers have experienced in the past. We also continue to believe that high risk pooling would be a useful

tool for discouarging issuers from avoiding members with conditions that may be particularly likely to trigger catastrophic claims.

Question: There are significant variations in provider fee levels around the country and even within a city. The variation could inappropriately impact the high risk pooling concept and pooling transfers. Does CMS plan to address the impact provider fee variations may cause on pooling transfers?

Answer: CMS understands this concern and we are evaluating concerns that a national high risk enrollee pooling mechanism could result in low cost geographic areas or states funding high cost geographic areas or states.