WEDI Virtual Event
Medicare Advantage: Lessons Learned

An Overview of Health Insurance Exchange
and What It Means to Your Business

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About Our Presenter

• Dawn Carter is a Product Manager for Verisk Health, focusing on the Encounter Data Submission product. Her background in healthcare administration spans 18 years and encompasses claims processing, electronic data interchange, practice management, business and systems analysis, and project management. She has expertise in revenue cycle management and healthcare electronic transactions and is an integral part of Verisk’s Encounter Data Submission team. Dawn holds a Bachelor of Science in Business Administration and is a frequent national presenter and author for topics relevant to the healthcare industry.
After this session, you should...

- Understand the basic history of risk adjustment as it exists for today’s Medicare Advantage Organizations (MAOs)
  - Definition
  - Key legislation

- Understand the implications of the Affordable Care Act legislation and its incorporation of risk adjustment methodologies into HIX
  - Definition and scope
  - The anticipated challenges of risk adjustment in uncharted territory

- Understand the dependencies on the data that drives risk-adjusted payments
  - CMS’ move from RAPS submissions to the ANSI X12 837I/P: The EDS Transition
  - How risk adjustment is likely to be affected by the EDS transition
Administered by CMS, Medicare is one of the world’s largest health insurance programs, providing insurance to approximately 47 million beneficiaries. About one-fourth of Medicare beneficiaries receive health benefits through private health care plans or insurers, a program known as Medicare Advantage (MA).

– Medicare pays these participating insurers a monthly capitation rate to provide health care services for their enrollees.

– Risk adjustment is a method of adjusting these capitation payments to health plans to account for the differences in expected health costs of individuals.
Health plans determine their revenue needs based on a variety of factors, including trends in medical expenditures and anticipated enrollment. The insurer will also determine how much to vary the premium charged to individuals or small groups of enrollees using population characteristics such as age and past history of illness.

The risk adjustment models used in the MA program function as more comprehensive methods of underwriting in which diagnoses and demographic information are used to set each enrollee’s monthly capitation rate remitted to the MAO by CMS.
History of Risk Adjustment –
Key Legislative Background

• The Balanced Budget Act of 1997
  – Heralded the beginning of the risk adjustment payment methodology
    • Created the Medicare Part C program and mandated CMS to begin risk adjustment payment methodology in 2000
    • Payments to the participating health plans would be based upon the health status and demographic characteristics of enrollees, which was a significant diversion from the traditional fee-for-service (FFS) model
History of Risk Adjustment – Key Legislative Background

• **Beneficiary Improvement Act of 2000 (BIPA)**
  
  • Mandated the more comprehensive CMS-Hierarchical Condition Category (HCC) risk adjustment model beginning in 2004
  
  • There are approximately 70 HCC codes which represent the predicted cost of a given disease derived from the approximately 13,000 ICD-9 diagnosis codes. The International Classification of Diseases (ICD-9) is used by medical professionals to determine the condition of a patient. The HCC is determined by CMS based upon the MAO’s reporting of the diagnoses for plan enrollees via regular data submissions in a specified format (RAPS).

  • Established a schedule to mandate 100% risk-adjusted payments for Medicare Part C (now known as Medicare Advantage Organizations – MAOs) by 2007
History of Risk Adjustment –
Key Legislative Background

Medicare Prescription Drug, Improvement and
Modernization Act (MMA – 2003)

- Replaced the Medicare Part C with MA organizations and
introduced the concept of bidding into the MA program with
risk adjustment as its key component

  • A bid is the total revenue required to offer Medicare Part A
  (hospitalization) and Part B (outpatient and physician services)
  benefits to enrollees living in a specific service area and who have
  a certain level of average risk expected by the MAO. CMS assumes
  that the MAO will charge cost-sharing equivalent to the traditional
  fee-for-service (FFS) model (copay, deductibles, etc.).

  • After CMS reviews each bid for actuarial soundness and an
    accurate reflection of costs for benefit coverage, the risk
    adjustment calculation is used to standardize bids to determine
    CMS’ payment rate to the insurer for each enrollee.
History of Risk Adjustment – Key Legislative Background

(continued)

Medicare Prescription Drug, Improvement and Modernization Act (MMA – 2003)

• Thus, risk adjustment allows direct comparison of bids based upon populations with different health status and geographic locations, and is used to pay more accurately by adjusting the monthly bid-based payments for enrollee health status. The health status (diagnosis) data comes from data submissions based on claims data (RAPS).

• From 2007 onward, risk scores have been based entirely upon the HCC model and 100% of payments made to MAOs are risk adjusted.

• Many risk adjustment experts have emphasized that evaluation and application of the HCC model is complicated because it lacks comprehensive cost or claims data from the MA plans; the RAPS format is abbreviated and contains only diagnostic data from a very limited subset of claims data.
Along with the Health Care and Education Reconciliation Act of 2010, the PPACA is the principal piece of healthcare reform legislation.

- Increases coverage of preexisting conditions
- Contains an individual mandate to purchase coverage. An estimated 30 million people expected to gain coverage this way.
- Establishment of health insurance exchanges (HIX) by October 2014. Half of the 30 million will gain coverage this way.
What is a Health Insurance Exchange (HIX)?

• “HIX” are a set of state-regulated and standardized health care plans, from which individuals may purchase health insurance that is eligible for Federal subsidies.
• Designed to help insurers comply with consumer protections and to promote transparency and accountability of the insurers.
• They are not themselves insurers, and by promoting enrollment in the exchange they assist in preventing “adverse selection” and spreading risk more broadly across large groups.
Why is this of concern to private insurers?

• Restricted eligibility and too-small market size could result in higher premiums as well as “cherry-picking” a healthier membership.

• Texas and California attempted to institute similar exchanges but failed; some suspect due to the above reason.

• Because of the individual mandate, the pool of insured consumers will significantly deepen; thus, insurance carriers will compete on price and quality.

• Insurers are still concerned about adverse selection, because cost and utilization patterns of this new insured population will be unknown.
  – Many are uninsured due to preexisting conditions, which increases the risk of costly care
Why is this of concern to private insurers?

- The PPACA addresses this concern by mandating risk adjustment to the requirements for exchanges.
- If a state does not establish a system of risk adjustment, the Department of Health and Human Services (HHS) will establish and operate one for that state
  - On March 23, 2012, HHS published a final rule on risk adjustment along with two related programs—a transitional “reinsurance program” and so-called risk corridors, both of which are discussed below. HHS plans to publish its proposed risk-adjustment methodology in the fall of 2012.
  - Risk adjustment will be required of all qualified health insurance plans sold to individuals and small groups both within and outside of the exchanges. “Grandfathered” health insurance plans—those in existence at the time the Affordable Care Act was signed into law—are exempt from risk adjustment as well as many other provisions of the health care reform law. However, it is widely expected that many of these plans will disappear over time.
Why risk adjust?

- Assess the health status of individuals and groups, and thus accurately predict costs
- Base payments to health plans on the relative health of their covered populations, ensure fairness and reduce adverse selection. Reducing the incentive for positive selection is one of the main objectives of implementing health-based risk adjustment. With health-based risk adjustment, MCOs are paid based on the health status of their enrollees. MCOs are not financially rewarded or penalized based on the health status of their enrolled population.
- Address avoidable utilization, such as admission, readmission and ER use
- Plan for and manage care effectively across large and varied patient populations
- Reform the way providers are paid
- Measure the quality of providers’ care
Who currently risk adjusts?

- Medicare
- State Medicaid programs which contract with managed care organizations
  - Employ a variety of approaches and methodologies
- Massachusetts – the Commonwealth Care program
  - Offers subsidized health insurance coverage to income-eligible individuals
  - Set up structurally like a Medicaid managed care program in which private health insurance companies bid for the ability to enroll eligible members.
  - Risk adjustment has been implemented to mitigate selection issues among the health plans, with risk-adjustment factors based on demographics and diagnoses to mitigate adverse selection.
Who currently risk adjusts?

- New York – uses a form of risk adjustment known as a “market stabilization pool”
  - Main goal is to discourage adverse selection; largely based on demographics and high-cost medical conditions
- Many employer-based health plans
  - Particularly when employers offer multiple plan options to their employees, depending on the average risk profile of employees enrolled in each plan.
### 2014-2016: Mitigating financial risk during the start of risk adjustment

#### Exhibit 1

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<thead>
<tr>
<th>Risk Adjustment-Related Provisions in the Affordable Care Act</th>
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<td><strong>Time span</strong></td>
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<td>Risk adjustment</td>
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<td>Risk corridors</td>
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http://www.healthaffairs.org/healthpolicybriefs/
The unique challenges of risk adjustment for HIX

- Current risk adjustment systems are designed for specific populations: commercial, Medicare or Medicaid. None of these is fit on an “all-population” enrollment. There are 3 predominant models – ACG, CDPS, and DCG. DCG is currently in use by CMS.
  - Almost all models overpredict for healthy people and underpredict for sicker people
  - All recalibrate based upon the unique needs of the population they serve.
The unique challenges of risk adjustment for HIX

• The greatest hurdle when implementing a risk adjustment system in an exchange is lack of data or inconsistent data
  – Many states have very poor encounter data, and some do not even collect at all
  – More expansive, complete and concise coding required for ICD10, will allow more robust diagnosis-related data to be captured for risk adjustment purposes

• Some states may decide to contract with an outside third party or private service provider to set up and manage their risk-adjustment systems, especially if they lack the experience or necessary systems infrastructure.
Why will it be so hard to choose a risk adjustment model for HIX?

• It is likely that custom risk adjustment models will have to be developed for special populations, such as veterans, the chronically uninsured, and geographic areas that network extensively with academic medical centers because they tend to attract the more severely ill.

• In both the Medicare and Medicaid models beneficiaries can choose to not participate in managed care.

• Maternity/newborn care and injuries also cause challenges for choosing and implementing an RA model.
Why will it be so hard to choose a risk adjustment model for HIX?

• Aside from predictive accuracy, other criteria are important when evaluating and selecting a risk-assessment model, including cost, ease of use, access to quality data, underlying logic of the model, transparency, and resistance to gaming.

• The Secretary of Health and Human Services, in consultation with states, the National Association of Insurance Commissioners (NAIC), and other interested parties, will establish the criteria and methods to be used in the risk-adjustment process.
The challenges of data management and risk adjustment

- CMS attempted to require the collection of encounter data in the early 1998; but suspended it in 2001 due to MCOs’ complaints about the burden.

- In 2004, CMS implemented the DCG (diagnostic cost group)/HCC model to be consistent with the simplified data strategy and to further customize for Medicare subpopulations.
The challenges of data management and risk adjustment

• Data accuracy concerns:
  
  – Costs that insurers will have to pay for care won’t just be driven by those individuals’ underlying health status – they will also be driven by how doctors, hospitals, and other providers “code” the cases for payment by insurers.

  – Providers may code patients’ conditions (diagnoses) at the highest level of severity consistent with the treatment they provide, a practice known as upcoding. They may also treat and seek payment for additional medical conditions, such as arthritis or diabetes in a heart patient, even when these conditions might not be relevant to the particular clinical event.
The challenges of data management and risk adjustment

- **Data accuracy concerns (cont.):**
  
  - Upcoding can undermine risk adjustment if it distorts the actual health-risk profile of a plan, for example, by suggesting that the people that the plan has enrolled are actually sicker than they really are. Plans will need to be audited to enforce coding “integrity”—that is, consistent use of diagnosis and procedure codes to negate any effect of upcoding.
Recommendations for the ACA RA System

- States should be required to establish an all-claims database (meeting federal and state patient privacy protection standards) to provide information for risk adjustment and other purposes, such as initiatives to improve patient safety and the quality of privately insured health care.
  - Using the 837 transaction will account for the compliance and privacy issues
  - RAPS format does not allow for the collection of data from all claims
Recommendations for the ACA RA System

- The Secretary should establish a standard risk adjustment methodology to be used by all states. The Secretary should build upon the risk adjustment systems used in the Medicare Advantage and Part D prescription drug programs, making the necessary adjustments to account for the differences between Medicare and the individual and small-group health insurance markets.
Recommendations for the ACA RA System

• The Secretary should also set uniform rules for the data elements (demographic, diagnosis, and pharmacy claims) that are to be reported by insurers and for how they will be used by a standard risk assessment tool to determine plan risk scores. These standards should also provide for the collection of encounter data from insurers with the expectation that such data will later be used to improve the predictive power of the risk assessment tool.
Starting in January 2012, the 2010 CMS mandate would require the monthly submission of encounter data in the form of an ANSI X12 837 Institutional or Professional transaction to replace the RAPS abbreviated format in use since 1998.

- Replaced the 5-data-element RAPS format with the over-700-data-element ANSI X12 837, and increased the scope of the data collected.

- Poor quality data that does not pass basic 837 format, syntax, and CMS-specific edits will not be accepted for risk adjustment, which in turn will ultimately affect plan revenues. An effective tool should also be able to efficiently handle the submission of supplemental diagnosis data to CMS, which is a unique technical challenge of the process.
Encounter Data Submission – The “Mandate” of October 2010

• It is imperative that MAOs utilize tools and effective reporting to manage revenue integrity. These tools should include data cleansing in the form of transformation logic and error correction prior to submission to CMS as well as comparative analytics, since CMS is using 2012 as a benchmark year wherein RAPS and EDS 837 submissions will operate in parallel.

• The parallel submission period will provide CMS valuable information that will likely be used in recalibration of the risk model, and as such, appropriate tools will assist MAOs in providing CMS the quality data necessary to refine predictive modeling while preserving revenue integrity.
What is likely to happen if plans do not manage EDS well?

• Revenue risk
  – Monthly submissions ensure integrity of the revenue stream and increase the ability to properly forecast.

• Industry dilution of the risk model. Incomplete or poor quality data could cause:
  - HCC weights to drop
  - Age and gender weights to rise, which blunts the incentives of a risk-adjustment system

• STAR rating impact
• CMS sanctions
The “Iceberg Slide”

File Formatting

The REAL EDS Challenge
In Summary:

Over the six years of the EDS implementation, CMS hopes to gain a more accurate picture across the industry of the range and intensity of services provided to the MA enrollment,

– CMS has chosen to do this by increasing the depth and breadth of data collection by transitioning to the X12 837 format and inclusion of all claim types.

– If the encounter data input for risk adjustment is incomplete or of poor quality, the output in the form of reimbursement across the industry could be negatively impacted.
Q&A

Ask the presenter a question by clicking the chat button in the lower right.

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Click the slot number to minimize the chat window.