# Risk Adjustment Program: HHS Operations

Center for Consumer Information and Insurance Oversight

Centers for Medicare & Medicaid Services

Department of Health and Human Services

May 8, 2012

# CONTEXT

The contents of this presentation represent preliminary information with the purpose of soliciting stakeholder feedback. Proposed policies for the risk adjustment program will be announced in the draft HHS notice of benefit and payment parameters, which will be subject to comment before finalized. More information on the HHS proposed operational approach when operating risk adjustment on behalf of non-electing States can be found in the Risk Adjustment Bulletin at http://cciio.cms.gov/resources/files/ppfm-risk-adj-bul.pdf.

# Contents

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- Coordination with existing State risk adjustment data collection
- Timeline and process for implementation

# Background

Overall goals:

- Mitigate the impacts of potential adverse selection
- Stabilize premiums in the individual and small group markets

Aim:

- Premiums reflect differences in benefits and plan efficiency, not health status of enrolled population

# Risk Adjustment Under the ACA

- **What**: Transfers funds from lower risk plans to higher risk plans
- **Who participates**: Non-grandfathered individual and small group market plans, inside and outside the Exchange
- **How**: Criteria and methods developed by the Secretary, in consultation with States. May be similar to criteria and methods utilized under Part C or D of Medicare

# Risk Adjustment Methodology

- Risk adjustment methodology is defined in Premium Stabilization final rule as:
  - Risk adjustment model
  - Calculation of plan average actuarial risk
    - Includes removing rating variation for age, geography, tobacco use, and family status
  - Calculation of payments and charges
  - Data collection approach
  - Schedule for implementation

# Overview of Risk Adjustment Methodologies

- HHS, in consultation with States, will develop a risk adjustment methodology for use when operating risk adjustment on behalf of a State
- A State may propose an alternate risk adjustment methodology for certification by HHS
- Any Federally certified risk adjustment methodology (including the methodology developed by HHS) could be used by a State operating risk adjustment

# Risk Adjustment Timeline

# HHS Operated Risk Adjustment Program: Payments and Charges Timing

- The risk adjustment program would balance payments within a State and within a market
- HHS would not remit payments to issuers until after receipt of charges owed by issuers in that State. HHS may adjust payments based on receipt of funds to ensure that payments and charges remain balanced
- The intent is that payments and charges would be calculated at the plan level, and would be aggregated up to the issuer level

# HHS Risk Adjustment Data Collection: Policy Objectives

- To minimize data transfers in order to lower privacy and data security risks
- To ensure that issuer proprietary data remains within the issuer environment
- To standardize software processes, timing and rules in order to apply risk adjustment uniformly across issuers
- To ensure an audit sample is controlled and maintained

# HHS Risk Adjustment Data Collection Approach

- HHS intends on utilizing a distributed approach to data collection
- Two distributed approaches are being considered:
  1. HHS runs software. HHS would run risk adjustment software on enrollee data that resides on issuer's server and provides enrollee level risk scores to the issuer. HHS would calculate enrollee level risk scores.
  2. Issuer runs software provided by HHS. Issuer would run HHS risk adjustment software using enrollee data on its own server and reports back enrollee risk scores to HHS. The issuers would calculate enrollee level risk scores.

# HHS Distributed Model in IT Infrastructure

- **Who:** Issuer would house the claims data. HHS would run software on issuer claims information.

- **Where:** Copy of claims information would be stored in a secure system within the issuer's data environment (e.g. edge server or secure cloud storage center). Claims data would not be sent to HHS.

- **What:** HHS would obtain and retain plan-level summarized and individual, de-identified risk score results to run risk adjustment, rather than collect enrollee-level claims information

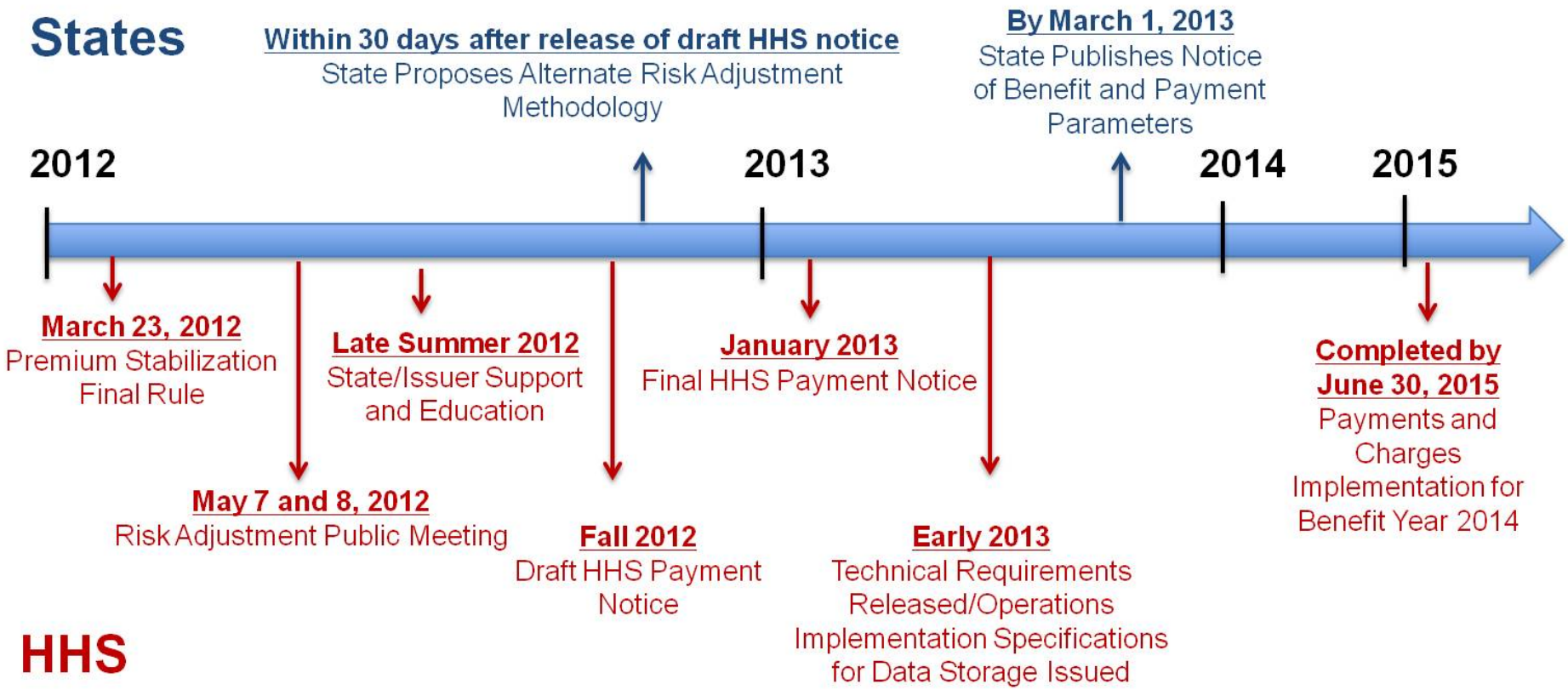
# HHS Coordination with Existing State Data Collection

- HHS will work with States that express an interest in utilizing existing data to assess the appropriateness of the data for risk adjustment. States certified to run an Exchange can elect to run the risk adjustment program
- Potential considerations include:
  - Do States have the authority to collect risk adjustment data?
  - What issuers are included in the existing data?
  - Are data elements required for risk adjustment being collected?
  - What kind of quality checks, audit or review of data is conducted?

# HHS Coordination with States

- HHS would enter into agreements or memoranda of understanding (MOUs) with States when HHS operates risk adjustment on behalf of States.
- The purpose of these agreements would be to collaborate and build on existing State resources to help carry out risk adjustment functions.

# Summary of Risk Adjustment Process Timeline



# HHS Operated Risk Adjustment Data Validation

# Purpose

The purpose of data validation is to promote confidence in the application of a Federally certified risk adjustment methodology

# Background

- The Premium Stabilization Final Rule requires States, or HHS on behalf of States, to:
  - Validate a statistically valid sample of data for all issuers that submit for risk adjustment every year
  - Provide an appeals process
- The rule allows States, or HHS on behalf of States, to:
  - Adjust average actuarial risk for each plan based on the error rate found in validation
  - Adjust payments and charges based on the changes to average actuarial risk

# HHS Considerations for Proposed Approach

- **Integrity.** Promote confidence in risk adjustment data across market
- **Flexibility.** Allow issuers to set their own internal timelines and workflows for completing the initial audits within the period specified by HHS
- **Privacy.** Limit data transfers and apply privacy protections
- **Consistency.** Permit HHS to establish uniform audit requirements to ensure a level playing field across issuers
- **Burden.** Issuers are better able to leverage existing resources to conduct their data validation
- **Data.** Leverage issuer access to data to conduct data validation activities
- **Accurate Relative Risk.** Account for accurate health status of both healthy and sick enrollees
- **Precedent.** Adopt and build on concepts from other standard industry audit practices

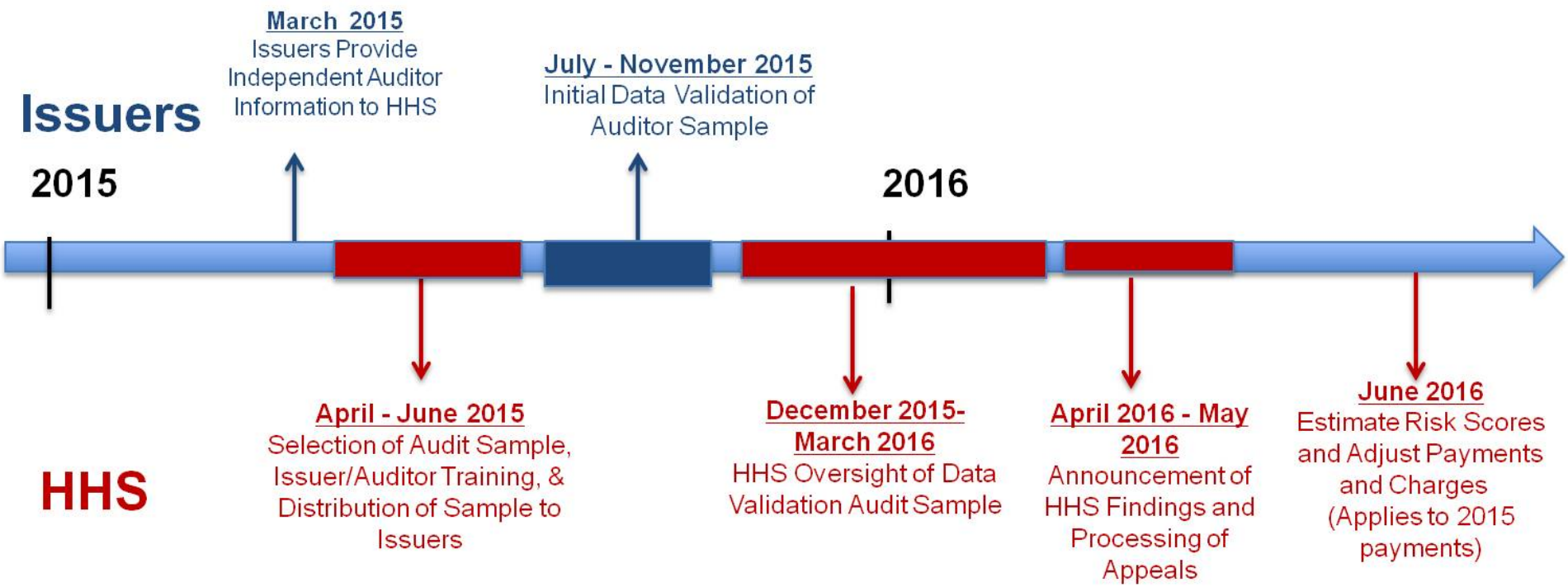
# HHS Proposed Data Validation Approach

- In a process similar to HEDIS audits, issuers would hire independent auditors to conduct validation of their risk adjustment data
- HHS would audit the independent auditors to confirm findings
- HHS would establish baseline requirements to be used by initial and second validation auditors when conducting the validation process

# HHS Proposed Data Validation Approach

- Risk score error would be extrapolated to the issuer level using a representative sample of enrollees
- Risk score error from 2014 validation would not apply to payments and charges for 2014 benefit year
- HHS would evaluate error rates using 2014 data for potential adjustments beginning in 2016 for calculations of payments and charges for the 2015 benefit year
- Adjustments would not be applied retroactively

# Proposed Data Validation Process Set Up and Implementation Timeline for Benefit Year 2014



# Proposed Key Roles in the Data Validation Process

- **HHS:** Establishes sampling; Performs Second Validation Audit; and Estimates Error Rates
- **Issuers:** Provide access to information to support risk adjustment data for the audit sample
- **Initial Validation Auditors:** Validate issuer-submitted risk adjustment data
- **Second Validation Auditors:** Confirm initial findings and compliance with audit requirements

# Proposed Data Validation Process

- **Stage 1. Sampling.** HHS selects a statistical sample of enrollees from each issuer
- **Stage 2. Initial Validation Audits**
  - Issuers provide relevant review documentation to the Initial Validation Audits
  - Initial Validation Audits review documentation in accordance with HHS baseline standards and report findings to HHS within the established timeframe
- **Stage 3. HHS Second Validation Audits**
  - HHS performs oversight audits to confirm data validation findings from the Initial Validation Audits
  - HHS provides the opportunity for appeals
- **Stage 4. Payment Adjustments**
  - HHS calculates error rates
  - HHS evaluates error rates for potential adjustments to payments and charges