RISK ADJUSTMENT: PROPOSED CHANGES & NEW REGULATIONS

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Risk Adjustment and Star Ratings have been hot topics for the Centers for Medicare & Medicaid Services (CMS) over the last few months, and the proposed changes, along with the new regulations, not only have an impact on health plans and providers, the vendor solutions companies are feeling the pressure, too.

In most recent news, the Medicare Payment Advisory Commission (MedPAC) unanimously voted to eliminate the double bonuses associated with Star Ratings and has virtually unanimously voted to exclude diagnoses collected during In-Home Assessments from the Risk Adjustment model.

Conversely, those companies providing products and services to health plans and providers have a unique opportunity to proactively mitigate and eliminate the potential risks implicated by these changes, but are their business models flexible enough to adapt and reinvent themselves in time?

At this point, health plans, providers, and vendors should be very concerned about how these looming changes will impact their revenues and operations as well as the downstream impact on their members, providers, and clients.

Here is a recap of the most recent news from both CMS and MedPAC:

- Proposed changes to the [CMS-HCC Risk Adjustment Model for Payment year 2017](#) to account for dual eligibility and aged/disabled status in a payment year.
- CMS’ [announcement to expand its Medicare Recovery Audit Program](#), vastly expanding audits of Medicare Advantage (MA) plans to identify instances where Medicare is overpaying.
- [MedPAC’s 15-1 vote](#) to not factor in diagnoses from In-Home Assessments and the recommendation to eliminate the double bonuses.

Daniel Weinrieb, Senior Vice President of Healthcare Analytics and Risk Adjustment Solutions at Gorman Health Group (GHG), along with John Criswell, Chief Executive Officer of partner company, Pulse8, have provided background commentary and interpreted the impact of these potential changes:

For years, we have heard community and hospital-system affiliated providers push back when health plans deliver data which portrays provider performance in key areas like quality, “efficiency,” risk, and cost trends. Most typically, and most justified, the argument is made from a provider his/her patient panel is far more complex than his/her peers. The data just isn’t indicative of how truly sick and how much care and support the provider’s patients need and require. The data is old, the data is incomplete, this patient isn’t even mine…and so on and so on. As our industry attempts to move from volume to value, this concern remains a point of contention and will continue to be questioned unless system integration and interoperability are implemented and coupled with a strong analytics and data governance strategy—another reason why GHG and Pulse8 have partnered to deliver tools and tactics to health plans and providers.
The intent of reporting and delivering “big data” is two-fold. On one hand, it can/should engage the provider community by delivering actionable, meaningful information specific to their patients, demonstrating what their individual role is in the rising costs of healthcare. The data should be accompanied by proposed solutions and support, with the hope of improving care, service, access, and outcomes, while ensuring the accuracy of member-level data, clinical and administrative. Ideally, health plans can become an extension of the provider’s practice and a contributing member of the care team.

On the other hand, health plans and entities offering a government-sponsored health insurance benefit are constantly in pursuit of “data nirvana,” a state where member-level clinical and administrative data is accurate, complete, and compliant. Why? Government-sponsored programs, MA, Dual Eligible, Medicaid, Special Needs Plans (SNPs), Program of All-Inclusive Care for the Elderly (PACE) Organizations, Accountable Care Organizations (ACOs), and now the Commercial Marketplace are all programs relying on patient data in order to accurately predict the cost of care for their beneficiaries and receive payment from CMS which should be used to fund the design of clinically-relevant benefits, build networks, and create an infrastructure and inventory of programs and services which can facilitate increased access to quality of care and service.

At least, that is the intent. However, the realities of the inequities in both patient populations and the delivery system itself force the hand that feeds us (CMS) to continue to reinvent and shift the models and regulations, keeping health plans, providers, and vendors on their toes – keeping us all honest, perhaps leveling the playing field and theoretically creating an environment of continuous improvement.

GHG and Pulse8 have seen highly successful and comprehensive programs which demonstrate superior outcomes in both Risk Adjustment and Quality, but we have also seen, and have been asked to help, programs realize their full potential.

**THE CHALLENGE**

Risk Adjustment and Quality of Care are two substantial contributors to a health plan’s bottom line, but it isn’t free money – both come with stringent guidelines and heavily regulated operational requirements and are, by no means, easy to manage.

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**PROPOSED CHANGES TO THE CMS-HCC RISK ADJUSTMENT MODEL FOR PAYMENT YEAR 2017 TO ACCOUNT FOR DUAL ELIGIBILITY AND AGED/DISABLED STATUS IN A PAYMENT YEAR.**

When we look at the proposed changes to the Hierarchical Condition Category (HCC) model to account for the disparities within our most vulnerable populations, we applaud CMS for recognizing not all patients/members are created equal. We agree this effort will help to improve CMS’ efforts to attribute and align appropriate levels of payment to account for the social and economic factors impacting a patient’s health, and we hope the quality measures follow suit.

Today, The CMS-HCC model has been calibrated using two full risk segments with separate coefficients to reflect the unique cost patterns of beneficiaries in the community and beneficiaries residing in long term care institutional facilities. The community segment of the model predicts costs for beneficiaries who reside in the
community or have been in an institution for fewer than 90 days. The institutional segment of the model predicts costs for beneficiaries who have been in an institution for 90 days or longer.

The announcement forecasts that CMS is developing a revised CMS-HCC model that creates up to six separate community segments based on dual and aged/disabled status in the payment year. The analysis indicates that this revised model would improve predictive performance for aged and disabled full benefit dual, partial benefit dual, and non-dual beneficiaries in the community. The updated model results in more appropriate relative weights for the HCCs because the relative weights reflect the disease and expenditure patterns of each of the six community segments.

In addition, CMS is exploring minor updates to the institutional and new enrollee segments of the model to distinguish between full and partial benefit duals. CMS also notes that it will explore whether updating the Medicaid factors to reflect concurrent (payment year) dual status improves the predictive ratios of the institutional segment of the model. The relative factors of the revised model are not being included in this solicitation for comment, since CMS have not completed development work; they plan to include the factors in the 2017 Advance Notice and accept public comment on them after the February 19 release.

What does this mean for health plans? Managing a single HCC model and corresponding payments for MA beneficiaries, which makes up nearly one-third of Medicare enrollment, still poses challenges. Now add the potential of six different equations to calculate payment for varying levels of the dual-eligible population – big data will yield bigger problems.

Pulse8 and GHG anticipate data overload and data integrity issues, resulting in health plans investing more dollars in system reconfiguration to account for the varying levels of dual-eligible beneficiaries; segmenting, monitoring, and reporting the membership status for each and then deploying of traditional interventions like Chart Reviews and In-Home Assessments (maybe) to identify risk-adjustable diagnoses. Not to mention the operational challenges of adjusting the models to account for each sub-population and then integrating data and programs for those health plans which have Medicaid, MA, and Commercial Marketplace products.

The application of analytics to perform targeted interventions also fosters improved relationships with providers eliminating burdensome requests to review charts having a very low likelihood of containing the documentation needed to substantiate the diagnoses in the first place.

Changes in the HCC model to improve payment accuracy and better meet the needs of the dual-eligible population and its subsets are needed and could address the historic underpayment to plans offering benefits to this segment of the community. With that said, health plans and at-risk providers have to start planning now
to account for the impact these model changes could have on their analytics, their eligibility status processes, their provider engagement strategies, and their interventions for Risk Adjustment diagnosis collection and validation programs.

**CMS' ANNOUNCEMENT TO EXPAND ITS MEDICARE RECOVERY AUDIT PROGRAM**

We all know how much the provider community loves chart reviews, not just for Risk Adjustment, but for the Healthcare Effectiveness Data and Information Set (HEDIS®), too...which are proven to be nearly impossible to coordinate. Now that CMS has introduced the Medicare Recovery Audit Program, vastly expanding audits of MA plans and at-risk providers to identify instances where Medicare is overpaying, the industry will experience increased oversight, enhanced scrutiny, and amplified demands for data accuracy, vendor oversight, provider education, and code validation.

The Affordable Care Act (ACA) required Medicare's Recovery Audit Contractors (RACs) to be expanded to MA and Part D Plans. Although that has not happened YET, CMS outlined how the program would be implemented, explaining the Risk Adjustment Data Validation (RADV) audit program would extend beyond the traditional 30 plans, tasking the RACs with conducting “condition-specific” RADV audits, focusing on specific medical codes or health conditions having historically high rates of payment errors. RACs would be paid by CMS, earning anywhere from 9% to 12.5% of recouped overpayments..."hired guns," to quote most. At the end of the day, CMS continues to watch and listen — our message is the same to our health plan and provider clients: you need to watch and listen within your own operations, or suffer the consequences.

This means health plans and providers need to be equipped with the information and the infrastructure to not only identify coding patterns and operational breaks in the system which raise red flags, but they also need to be prepared to deploy resources and implement programs which resolve these issues and eliminate inaccuracies moving forward.

GHG and Pulse8 continue to offer solutions and actionable tactics to mitigate risk and ensure compliance. Together, we have helped clients apply two proven approaches which will allow health plans and providers to develop and implement internal controls when it comes to RADV:

- **Leverage analytics to identify areas of exposure**: We support our clients in guarding against the financial consequences of data validation audits by revealing risk factors which cannot be validated in the medical record and providers who are not documenting and coding properly. Pulse8's Detector8 technology looks at conditions with the greatest risk of failing a RADV audit, whether or not they have been submitted to the Department of Health and Human Services (HHS)/CMS/Medicaid Server (EDGE, Encounter Data Submission (EDS)/Risk Adjustment Processing System (RAPS), MEDS II), and assesses the strength of the data supporting each condition and the financial exposure associated with each.

- **Apply the results to design and implement risk mitigation tactics and internal controls**: Once the analytics have produced actionable data, we work to develop operational work plans and strategies. We build clinical documentation improvement programs and design compliant coding policies which are
applied to monitor the accuracy of your vendor’s coding patterns and support your provider network through targeted, relevant education and case-by-case rounding. By aligning the data with operations, health plans and providers can confidently manage internal RADV control and risk mitigation programs, identifying the root-cause issues and applying processes for ongoing monitoring and continuous improvement.

Comments on the MA RAC program are due by February 1, 2016. Regardless of CMS’ decision to implement this program, your organization needs to have protections in place. Seeing your name on the RADV audit list is like getting hit in the face in dodgeball...either don’t play, or practice more!

MEDPAC’S 15-1 VOTE TO NOT FACTOR IN DIAGNOSES FROM IN-HOME ASSESSMENTS AND THE UNANIMOUS RECOMMENDATION TO ELIMINATE THE DOUBLE BONUSES FOR STAR RATINGS.

On January 14, MedPAC announced recommendations that it anticipates a savings of up to $5 billion in MA.

  • MedPAC members unanimously voted to request that Congress pass legislation allowing the HHS secretary to eliminate benchmark caps and the “double bonuses” now given to MA plans.

If CMS aims to simplify the MA payment system and reward top-performing plans purely based on quality performance alone, we believe this is a step in the right direction. When John Criswell and Dan Weinrieb discussed how this decision could impact the industry, they both agreed that, taken together, the two changes might net out to a wash, but the elimination of the benchmark caps will benefit far more counties (1,400) than will be hurt by the elimination of the double bonuses (236). Sure, it amounts to economic redistribution, but the benchmark caps have created geographic inequities from the use of outdated comparative yardsticks and need to go away.

We asked ourselves, what will those plans do to make up for the loss if this recommendation were to be put into effect? The answer was clear: compliant, comprehensive, and effective Risk Adjustment programs.

Top-rated MA plans in large urban areas would lose out on a 5% revenue kicker, with no direct means of getting it back. An elimination of the double bonus would make the relative importance of an effective Risk Adjustment program all the more essential. Pulse8’s pragmatic solutions for closing gaps in documentation, coding, and quality would provide an indirect means of recouping any lost revenue.

Also, consider the impact your Risk Adjustment program can have on your other core business functions: Quality, Medical Management, Pharmacy, Member Retention, etc. If your programs are built to span across your organization, recouping these lost dollars can present themselves in any number of operational efficiencies and multidisciplinary provider and/or member-centric initiatives.
Being prepared for these changes in payment methodology is critical, and there is a common theme presenting itself time and time again: applying a combination of advanced analytics and cross-functional work plans remain keys to a health plan’s success. Pulse8 applies analytics and predictive models to a vast array of multi-year data sources in order to help our clients assess how the quality of care varies by a number of factors, including geography, population density, and medical group.

Together, GHG and Pulse8 believe quality-driven payments, penalties, and bonuses should be uniformly applied to providers and plans, regardless of population density and geography, and welcome the opportunity to help our clients thrive in an ever-changing, quality metric-driven world.

- MedPAC panel members also voted 15-1 on a proposal that would change the CMS risk adjustment model to not factor in diagnoses from health risk assessments (HRAs).

We all remember when CMS proposed eliminating In-Home Assessments from the risk score calculation, deeming all risk-adjustable diagnoses and HCCs collected during the assessments inadmissible for risk adjustment payment. This announcement from MedPAC brings back the flood of worry and panic from health plans and vendors, especially those who have made significant investments and rely heavily on the In-Home Assessment intervention.

When CMS decided to continue to support In-Home Assessments in the 2016 Call Letter announcement, plans and vendors breathed a collective sigh of relief. However, the announcement did not come without clear guidance on how CMS expected health plans to revamp this prospective initiative, making it a collaborative cog in the care coordination wheel. CMS offered 10 items for considered best practices for In-Home Assessments, including a well-documented operating procedure for medication reconciliation, referrals to care management, and closing the loop back to the member’s Primary Care Provider (PCP). Each recommendation aimed to eliminate the stigma that these assessments were a health plan and vendor effort to collect HCCs and generate revenue for both sides of the coin.

Since the announcement from CMS, we have seen significant effort by both health plans and vendors to make these visits more clinically and socially focused. Melissa Smith, Senior Consultant at GHG and Star Ratings Operations leader, comments,

“Although in-home health risk assessments may have been borne from their impact on revenue, health plans have attempted to ensure that their value has transcended their financial contribution.”

Members often perceive in-home, personalized care planning as a service differentiator, and many MA plans have layered important care management and Star Ratings activities into in-home assessment workflows. In addition, members often value the relationship established with the in-home visitor who completes the risk assessment, and their behavior is often influenced through these in-home evaluations, which can directly impact Star Ratings through clinical and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Star Ratings measures.”
When health plans applied the guidance from CMS, these assessments clearly took on new meaning, supporting risk adjustment, supporting quality, and improving care. However, not all have implemented these changes, perhaps there wasn’t enough time.

Smith continues to say, “As new pathways are developed to deliver care to members historically served through in-home assessments, plans will need to carefully evaluate the full spectrum of organizational needs, processes, and workflows which are intertwined with the services rendered, and data collected, during in-home risk assessments. Such services and data are likely integral to population health management strategies, Star Ratings-impactful work streams, and effective care management.”

This decision clearly impacts the trifecta of health plan goals: Quality, Medical Management, and Risk Adjustment. If implemented, connecting homebound members who have previously placed high value on in-home care management delivered through the In-Home Assessment with more traditional providers will require careful planning in order to prevent erosion of Star Ratings and may require plans to offer carefully chosen additional benefits to encourage the member to proactively seek clinical services. This could cause additional bottlenecks in an already overwhelmed and tapped-out provider market.

For those MA beneficiaries who are not homebound but are still targeted for In-Home Assessments, health plans will need to identify innovative strategies to engage those members and encourage office visits with their doctors. PCPs will also need to review their office workflows, make additional investments, and perhaps increase staff to accommodate health plan requests for increased encounters to support Risk Adjustment and Quality gap closure efforts which would have historically been addressed during an In-Home Assessment.

Strategic planning may also be needed to ensure capacity exists within the current provider network to service all needs previously met through in-home risk assessments, to ensure Star Ratings and Risk Adjustment gaps previously closed through in-home assessments can be served by the provider’s work streams, and potentially to identify opportunities where providers may need supplemental support to be successful.

Again, a key to success is continuing to refine and leverage analytics to make informed business decisions that are efficient, compliant, and effective. Gorman Health Group’s experienced team, powered by the advanced analytics from Pulse8, are prepared to help your organization navigate through these changes...that are just around the corner.

For information on how GHG can support your Risk Adjustment Programs, please contact me directly at dweinrieb@gormanhealthgroup.com.