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CMS HHS-RADV Final Rule

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Executive Summary

On November 24, 2020, CMS issued a final rule¹ that finalized several proposed changes to the timing and methodology of the U.S. Department of Health and Human Services' risk adjustment data validation (HHS-RADV) program beginning with the 2019 benefit year HHS-RADV program. This paper summarizes the final rule and its impacts to the HHS-RADV program. Four key changes to the program include:

1. Aggregating HCCs with the same risk score coefficient into “Super HCCs” before determining failure rates.
2. Reducing the impact of the “payment cliff” by incorporating a sliding scale from 90th to 99.7th percentile of confidence interval.
3. Constraining the impact of negative error rate outlier issuers with negative failure rates.
4. Changing to a concurrent HHS-RADV program by adjusting risk transfers for the same benefit year as being audited, starting with benefit year 2021. 2020 will be a transition year. 2019 & 2020 benefit year HHS-RADV data will be used to adjust 2020 risk adjustment transfers².

While most of the above topics were finalized as proposed, the last topic (changes to a concurrent model) included a change from the proposed rule. Specifically, the transition year was changed from the 2021 benefit year risk adjustment transfers to the 2020 benefit year. We expect the above changes to have the following key impacts:

1. An increase in the frequency of issuers categorized as outliers but a reduction in the average magnitude of those HHS-RADV adjustments.
2. Final risk adjustment transfers with HHS-RADV adjustments will be released approximately one year after the initial risk adjustment transfers are released.

¹ <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS-9913-F.pdf>

² Both 2019 and 2020 HHS-RADV results will be released in calendar year 2022. 2019 HHS-RADV process was delayed due to COVID-19 pandemic.

3. Operational timing for the 2019 & 2020 benefit year (BY) HHS-RADV programs will be tight for issuers. We anticipate 2019 BY HHS-RADV IVA results to be due by September 2021 and 2020 BY HHS-RADV IVA to be due by January 2022³.

The below sections expand on the above potential impacts and changes.

Impact to Results

The aggregate impact of the finalized changes above are expected to increase frequency of outliers but reduce the magnitude of HHS-RADV error rates and therefore reduce the total dollars transferred as a result of the HHS-RADV program. HHS final rule release includes data and tables displaying national changes to HCC Group counts, failure rates, and error rates between the historical and finalized methodologies on 2017 & 2018 HHS-RADV data. The data showed:

1. The grouping of Super HCCs resulted in minimal changes to HCC Group designations and HCC Group failure rates.
2. More issuers are classified as outliers due to changes to lower and upper bounds of each HCC group (change from 95% to 90% confidence interval).
3. Average HHS-RADV error rates are notably smaller in the finalized methodology than the historical methodology due to constraining effect of negative outliers as well as the implementation of a sliding scale for the outlier adjustments.

Separately, Wakely conducts a HHS-RADV IVA study each year⁴ to provide preliminary issuer, market, and national HHS-RADV estimates months before CMS results using national data from over 70 issuers or over 80% of national HIOS IDs. Modeling these changes using data from the Wakely study produced similar observations as provided by CMS. Table 1 below shows the results from our study.

³ https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/HRADV_Timeline_073120_5CR_073120.pdf

⁴ Wakely's HHS-RADV IVA Study provides participants with timely HHS-RADV estimates to help with pricing and financial accruals before CMS releases official results. Contact Matt.Sauter@Wakely.com for more information.

Table 1: Outlier Counts Between Methodologies
Based on Wakely 2018 HHS-RADV IVA Study Data (297 HIOS IDs collected)

	2018 Methodology	Finalized Methodology
Issuer		
Average Negative Error Rate	-5.94%	-1.94%
Average Positive Error Rate	6.87%	2.21%
Count of Negative Error Rate Issuers	19	37
Count of Positive Error Rate Issuers	20	36
Total Issuers Count	297	297
Market		
Average Negative Error Rate	-1.85%	-0.86%
Average Positive Error Rate	1.22%	0.77%
Count of Negative Error Rate Markets	14	18
Count of Positive Error Rate Markets	16	23
Total Market Count	62	62

Participants in our study received detailed issuer, market, and national results based on the proposed (now finalized) changes in June 2020. We advise participants to review these results for more detailed issuer and market information. Since the error calculation changes are finalized as proposed, no additional study were performed.

Finalized Changes: Detailed Discussion

[Changes to Failure Rate Calculations: Super HCCs](#)

The current HHS-RADV program analyzes each HCC individually – calculating failure rates and grouping each HCC into high, medium, and low failure rate HCC Groups. This allows for a set of HCCs that are in the same coefficient estimation group⁵ to potentially fall in different HCC Groups. This creates a dynamic where a newly coded HCC of different severity (e.g. finding support for a more severe diabetes diagnosis of HCC 19 Diabetes with Acute Complications where only the less severe HCC 21 Diabetes without Complications existed originally) can generate failure rates (negative and positive) in different HCC Groups despite the risk weight not changing from one HCC to another. To better account for the difficulties in categorizing these types of conditions and to refine how the program measures risk differences, CMS finalized a modification to calculating failure rates beginning with the 2019 benefit year HHS-RADV program. HCCs in the same risk coefficient group will be aggregated into “Super HCCs” prior

⁵ An example of same coefficient estimation group under the 2019 HHS HCC model is the set of HCCs 19, 20 and 21. They are diabetes related HCCs and have their risk coefficients constrained to be equal to one another.

to determining failure rates of these Super HCCs and HCC Groups. For example, all diabetic HCCs 19, 20, and 21 would be treated as G01 (HCC Group 1) or a “Super HCC” where a failure rate is calculated for this “Super HCC”.

Changes to the “Payment Cliff”

Currently, HHS’ HHS-RADV program employs an “outlier” approach. In this approach, adjustments are made to an issuer’s risk score only if their data is outside of a national confidence interval. This produces situations where marginal changes in an issuer’s failure rate can produce significant changes to the size of the adjustment, and in other words, a “payment cliff”. To reduce the uncertainty that the payment cliff introduced, HHS amended the HHS-RADV methodology to include a sliding scale which dampens the magnitude of adjustments the closer an issuer is to the confidence interval bounds. This creates a more gradual increase in the size of adjustments and removes the “payment cliff”. The sliding scale includes:

1. Outliers begin at the 90th percentile
2. Sliding scale from 90th percentile to 99.7th percentile (1.645 standard deviations to 3.0 standard deviations away from the mean).
3. No changes to methodology for issuers at or above 3.0 standard deviation

According to CMS’ analysis, the sliding scale option would result in more issuers being considered as outliers but with reduced magnitude of HHS-RADV adjustments.

Constrain Negative Failure Rate

Negative failure rates occur when the medical records validate new HCCs that were not included in original EDGE submission, i.e. new HCCs are found. Under current HHS-RADV methodology, if an issuer’s failure rate for a given HCC Group is below the national confidence, the issuer receives a negative error rate (its risk score is increased).

HHS finalized the constraint on failure rates of HCC Groups with a floor of 0.0 when determining error rates, effectively constraining the size of the negative error rate adjustment when an issuer has negative failure rates⁶. While the current adjustment is based on the difference between the issuer’s failure rate and the weighted mean failure rate, the finalized methodology calculates the lower bound outlier as the difference between the weighted mean failure rate and the greater of the issuer’s failure rate and zero. This constraint effectively creates a floor on issuer’s failure rate of 0.0 and results in reduced HHS-RADV adjustments.

⁶ Note that failure rates are specific to HCC validation through the HHS-RADV program, while error rates ultimately adjust risk scores and are calculated using failure rates. They are not used interchangeably and represent different concepts.

Timing Changes

Historically, HHS-RADV results have been applied prospectively using one year's data to adjust the subsequent year's risk transfers. For example, 2018 HHS-RADV results affect 2019 risk adjustment transfers. With this final rule, HHS will transition to a concurrent approach starting with the 2020 HHS-RADV program. 2019 & 2020 HHS-RADV results will be aggregated to adjust 2020 benefit year risk transfers as part of the transition to the concurrent methodology. 2019 & 2020 HHS-RADV programs will be carried out separately with the two error rates being averaged together and then applied to 2020 risk transfers. For 2021 benefit year HHS-RADV audits and forward, the benefit year being audited will be used to adjust the same benefit year's risk adjustment transfers.

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