WHITE PAPER

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Proposed Changes to HHS RADV Program

Executive Summary

On May 29, 2020, HHS released a proposed rule[1] that would significantly change both the timing and methodology of the risk adjustment data validation (RADV) program beginning with the 2019 benefit year RADV program. This paper summarizes the proposed rule and how it could impact the RADV program. Four key proposed changes of the program in the proposed rule include:

- Combining certain HCCs with the same risk score coefficient for grouping purposes for determining failure rates.
- Reducing the impact of the "payment cliff" by incorporating a sliding scale from 90th to 99.7th percentile of confidence interval
- Constraining the impact of negative error rate outlier issuers with negative failure rates
- Changing impacted year for RADV results, starting with benefit year 2021 (2021 RADV to impact 2021 benefit year risk transfer results instead of 2022)

Changes to Error Calculations: Grouping

The current 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 group[2] to potentially fall in different HCC Groups. This creates a dynamic where a new 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 prevent these interactions, CMS is proposing to update HCC grouping methodology with the following:

[1] https://www.federalregister.gov/documents/2020/06/02/2020-11703/amendments-to-the-hhs-operated-risk-adjustment-data-validation-under-the-patient-protection-and

[2] 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.

- Combining HCC Groups as "Super HCCs" prior to determining failure rate of 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" and a failure rate is calculated for this "Super HCC".
- A priori stability constraints and hierarchy violation constraints used in the development of HHS HCC risk coefficients are not applied but HHS sought comments on their inclusion.
- Other considerations:
    - Whether or not to adopt separate infant model-based Super HCCs.
    - To apply a later applicability date if finalizing the proposal due to COVID pandemic
- CMS modeling shows the national mean and standard deviation as a result of this change are only slightly affected (though issuer-level results may vary)

Changes to the "Payment Cliff"

Currently, HHS' RADV program employs an "outlier" approach. In this approach adjustments are made to an issuer's risk score only if they are outside of a confidence interval. This produces situations where tiny 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 proposed a sliding scale methodology which dampens the magnitudes 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:

- Outliers being determined starting at 90th percentile
- Sliding scale from 90th percentile to 99.7th percentile (1.645 times of standard deviation to 3.0 times of standard deviation).
- No changes to methodology for issuers at or above 3.0 standard deviation

According to CMS' analysis the proposed 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; New HCCs are found. Under current 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).

CMS proposes to constrain the 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 rates[3]. While currently the adjustment is based on the difference between the issuer's failure rate and the weighted mean failure rate, the new approach would be to calculate the negative error rate outlier as the difference between the weighted mean failure rate and the greater of the issuer's failure rate and zero (effectively providing a floor on issuer's failure rate of 0). According to CMS, this policy would result in reduced HHS-RADV adjustments.

Timing Changes

Currently, HHS applies RADV results prospectively from one year to the next cycle. For example, 2018 RADV results affect 2019 risk adjustment transfers. CMS proposes to shift this cycle to a concurrent approach starting with the 2021 RADV such that 2021 RADV results will impact 2021 risk adjustment transfers. If the concurrent approach is adopted, transitional measures would need to be included as there would be two years of RADV results applicable for the first year (i.e. 2020 and 2021 RADV results will be applied to 2021 risk adjustment transfer results). Two transitional measures are proposed:

- Calculate the average value of benefit years 2020 and 2021 RADV error rates and apply this average error rate to 2021 risk scores and subsequently impacting 2021 risk transfers
- Apply benefit years 2020 and 2021 RADV error rates to 2021 benefit year risk scores separately and then take the average adjusted RADV risk scores from both years of RADV to adjust 2021 risk transfers.

Comment Deadline

Comments on the proposed rule are due to CMS by July 2, 2020.

Please contact Matt Sauter at Matt.Sauter@wakely.com with any questions or to follow up on any of the concepts presented here.

[3] Note that failure rates are specific to HCC validation through the RADV program, while error rates are calculated based on failure rates to adjust risk scores. They are not used interchangeably and represent different concepts.