Medicare Advantage Risk Adjustment: Strategies for Plan Sponsors
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In Final Notice, MAOs Get Partial Win on Encounter Data; Benchmark Caps Remain

As expected, the final 2018 payment notice and Call Letter for Medicare Advantage and Part D plans posted April 3, 2017, contained no drastic alterations to the MA program and few deviations from policies proposed 60 days earlier in the Advance Notice. But one significant change that gave MA plans a bit of relief was a partial retreat on the percent of encounter data used in risk scores, although industry experts are quick to remind plan sponsors that encounter data aren’t going away and that CMS will continue its efforts to make sure plans are submitting accurate data. Meanwhile, plans were disappointed with CMS’s conclusion that it does not have the authority to eliminate the Affordable Care Act’s ceiling on payment rates (a.k.a. benchmark caps) and the apparent return of the ACA-established health insurer fee that was temporarily set aside for 2017.

CMS in 2012 began collecting data from MA organizations (MAOs) through the encounter data system and in 2016 started phasing in EDS-based payments, beginning with 10% of the payment based on EDS scoring, while the other 90% came from the old risk adjustment payment system (RAPS) that relies on a much less complex set of data elements. CMS’s intent was to advance to a 50/50 mix for 2017, but it revised the blend to 25% EDS/75% RAPS after hearing the concerns of stakeholders about plan readiness and the quality of the data coming from providers. For 2018, CMS in the February draft notice proposed keeping that same blend but in the final notice walked it back even further to 15% EDS/85% RAPS.

Ankur Goel, a partner in the Washington, D.C., office of the law firm McDermott Will & Emery, in an April 6, 2017, client advisory suggested that CMS’s latest revision to the EDS/RAPS blend is a clear indicator that CMS recognizes that there are numerous problems with encounter data, but it “leaves open the prospect that risk scores will not consistently and accurately reflect the health status of an MAO’s member population.”

While EDS is theoretically supposed to capture the same diagnoses in RAPS, various studies have demonstrated that there are significant differences in the RAPS and EDS scores that are being reported back to plans, and researchers say the filtering logic used by CMS is leading to diagnoses that would have been included in RAPS not being applied to the risk score. Recent research from Avalere Health LLC, for example, showed that the average EDS risk score was 16% lower in the 2016 payment year than the average RAPS-based score. And Milliman, which used a slightly different plan composition and methodology to conduct its own study of select MAOs’ risk scores, found that those based on encounter data for 2016 were on average 4% lower than RAPS-based scores.

These differences can have major reimbursement implications for plans. “If a patient has [congestive heart failure] and the risk score isn’t captured, you’ve still got the CHF member, and you have to provide the services. And the risk scores are supposed to be connected with the cost of care. So if you don’t get credit for the disease state that that person has, you’re paying for them, and you just don’t get the money. It’s a big deal,” remarked Stephen Wood, co-founder and managing partner with Clear View Solutions, LLC, speaking during a session of the National Medicare Advantage Summit held April 5-7 in Arlington, Va.
CMS in the Advance Notice asked for feedback on the idea of a “uniform industry-wide adjustment” to the EDS data to account for the differences, but it abandoned that idea in the final notice. Tom Hutchinson, a strategic advisor with the EBG Advisors unit of the health care law firm Epstein Becker & Green and a former top CMS official who also spoke at the National Medicare Advantage Summit, said the problem with such an adjuster is that it would have essentially given “everybody a break” when certain plans were struggling with their scores and others had no issues. “So instead of doing an across-the-board adjuster, going back...to 15% in a sense is a plan-specific adjuster. If you’ve been really good at getting your encounter data in, you’re not getting much of a plus on that. If you haven’t done all that good, that’s actually a fairly decent adjuster.”

CMS’s original goal was to transition to full use of EDS by 2020, but with the latest revision, its timeline is unknown. Sources say that after publication of the final Call Letter, CMS stated during a user call that it was not announcing its plan for percentages in future years. CMS also has twice pushed back the deadline for submitting calendar year 2017 encounter data.

**CMS Will Continue to Monitor EDS Compliance**

While CMS is scaling back use of encounter data in the risk score calculation, it will continue to enhance monitoring and compliance activities to ensure the accuracy and completeness of data being submitted. CMS has been conducting basic monitoring of MAOs’ encounter data submissions and will now be using performance measures tied to data submission to guide oversight and enforcement in this area. As stated in the draft Call Letter, CMS has identified several performance measures — four on operational performance and three on completeness performance — and will communicate acceptable performance thresholds through future memos and other guidance. Taking an “incremental approach,” CMS will use these measures to identify contracts that are failing to meet performance standards and will conduct compliance activity, “including but not limited to notices of non-compliance, warning letters, and corrective action plans as needed to improve performance.”

CMS also is conducting site visits with a sample of MAOs to understand their different approaches to and issues with encounter data processing, and to identify areas where CMS can improve technical assistance and guidance. Speaking at the same conference session as Wood, Inovalon Senior Director Arati Swadi reminded plan sponsors that this effort is not an audit and represents an opportunity for plans to provide feedback on how the system can be improved. She said CMS is in the process of sharing “very detailed” questionnaires with about 20 plans across the U.S. in an effort to “understand how the systems are behaving.”

She continued, “I think it’s going to be very collaborative, and we are going to make sure we are giving as much feedback as possible when we do meet with CMS.” More information on the benchmarking of encounter data and a simplification of the many data requirements involved in the EDS are two critical areas she said she hopes many plans address in their responses.

**CMS Maintains EGWP Pay Blend, CAI**

Other changes finalized in the recent payment notice and Call Letter include:

◆ **Plans will on average see a pay boost of 0.45%,** compared with the 0.25% average increase that was included in the Advance Notice. Factoring in an anticipated upward coding trend of 2.5%, plans will see a total pay increase of 2.95%, estimated CMS.
In determining payment levels for MA Employer Group Waiver Plans, CMS will continue using a blend of individual market plan bids and EGWP bids from the prior payment year. This is a departure from its original plan of moving from a separate bidding process to one based on the individual market that would result in an overall 2.5% payment reduction by 2018.

Stabilizing MA plan payments in Puerto Rico, rates will take into account the significant increases in the fee-for-service physician fee schedule there, and a majority of counties will qualify for double quality bonuses.

CMS will continue to use the Categorical Adjustment Index (CAI) to address disparities among low-income subsidy/dual eligible plans and non-LIS/duals plans, although it will exclude plan all-cause re-admissions and reducing the risk of falling. CMS also will establish separate adequacy evaluations of provider networks specific to MA Special Needs Plans.

Meanwhile, CMS noted that a “large number” of commenters expressed concern that the current system diminishes incentives for high-quality plans that offer services in higher-cost areas since top-rated plans are not receiving their deserved quality bonus payments because of the rate ceiling established by the ACA. However, CMS responded that it has not “identified discretion” under the law to do away with applying the pre-ACA rate cap or exclude the bonus payment from the cap calculation.

New RFI Seeks Ideas on MA Transformation

In addition, CMS for the first time used the notice to make a request for information (RFI) soliciting ideas on ways CMS can bring more transparency, flexibility, program simplification and innovation to the MA and Part D programs that could be incorporated into future regulatory, subregulatory, policy, practice and procedural changes from the agency.

“The RFI is written broadly, and stakeholders can provide feedback on many topics,” observes Mike Adelberg, a former top CMS MA official who is now principal with FaegreBD Consulting. “The agency likely cannot make wholesale program changes based on feedback, but this is a particularly good opportunity to seek small bore changes, perhaps tweaks to star ratings, benefits or compliance rules and processes.”

During the National Medicare Advantage Summit, Humana Inc. Vice President, Public Policy Analysis, Mark Newsom called the RFI an opportunity to take MA “into the future” and streamline the program, whether it’s through simplified beneficiary communication requirements or alignment between performance measurement under the provider payment portion of the Medicare Access and CHIP Reauthorization Act and MA star quality ratings that reduces provider burden. Hutchinson added that the RFI indicates there is the potential to see some star ratings changes between now and when CMS releases its annual request for comments on enhancements to the program. The final notice included a few changes around star ratings, including a decision to retain the current Beneficiary Access and Performance Problems measure and plans to include a revised version as a 2019 display measure.
MedPAC Report Suggests Balancing of Star Ratings, Plan Payments

The latest report to Congress from the Medicare Payment Advisory Commission (MedPAC), issued March 15, 2017, includes several recommendations that could lead to payment adjustments for Medicare Advantage plans, including a possible 1% bump on average if CMS were to exclude Part A-only beneficiaries from its benchmark formula. But what’s caught the attention of some industry experts is the commission’s advice on star quality ratings that would essentially even the playing field among plan sponsors and further CMS’s goal of helping seniors make informed choices.

In the 455-page report, MedPAC revisits several MA-related issues from prior reports, including the potential for contract consolidation and “cross-walking” to “erode the validity of the star rating system as a measure of plan performance in a given area.”

CMS for years has been encouraging companies offering MA plans to consolidate contracts for the purposes of streamlining contract administration, but since the advent of bonus payments in 2012, the cross-walking of beneficiaries from a closed contract to another contract has created a two-fold problem, the commission suggests. One is that enrollees end up being moved from a contract for which the organization would not have received bonus payments for their enrollees to a contract that qualifies for bonuses. The second is that the cross-walking process leads to beneficiaries receiving “inaccurate information” about the quality of care in MA plans available in their area because of the manner in which quality data are reported, asserts MedPAC. In 2017 alone, contract consolidation resulting in a bonus-level star rating impacted more than 700,000 enrollees, observes the report.

“The issue has been happening for years, generally only in the larger payers where they have a portfolio of contract numbers to work with and the strategic leadership and infrastructure needed to support doing this cross-walking and these carefully crafted consolidations,” observes Melissa Smith, vice president of star ratings with Gorman Health Group. “So if you’re a plan and you want to reduce the number of contracts, which CMS has encouraged over time, it would be a natural motivation to close down contracts that are below 4 stars and move those members into a contract that is at or above 4 stars. And you can actually see that play out inside the bell curve, where the contracts on the lowest performing end just disappear from one year to the next. And a lot of that is purposeful where the plan is working to retire contract numbers.”

MedPAC Proposes ‘Averaging Method’

UnitedHealth Group, for example, merged two regional plans operating in the southern United States — with enrollment of 380,000 members and a star rating below 4 stars — into the company’s northeastern regional plan that serves about 20,000 enrollees and has a 4-star rating, observes the report.

One potential solution offered by MedPAC is to use an “averaging method” to calculate the rating for the surviving contract, where the members in the old contract essentially bring forward their star ratings — the 380,000 members going into the 20,000-member UnitedHealth plan — to result in a proportionate recalculation of the surviving contract’s star rating. This solution, Smith contends, would be “reasonable, manageable and doable” with “very little noise” and
presents a “high-value way to help beneficiaries.” Another alternative presented by MedPAC is to award bonus payments as though the cross-walking hadn’t occurred (e.g., the Northeast plan receives bonus payments for just the 20,000 enrollees).

MedPAC also pointed out that consolidation has continued so much that, as of 2016, about one-third of MA enrollees were in contracts with substantial enrollment in noncontiguous states across the country, and in many states, statewide contracts serve market areas within a state that have “very different characteristics and can have differing levels of quality,” the commission pointed out. And one suggestion that has come up before is the implementation of market-specific quality reporting.

“MedPAC has talked about this on and off for some time, but I think what they’re concerned about now is that these organizations are grouping like service areas into contracts simply to kind of game the system and get a star rating bonus,” suggests Eric Goetsch, a principal and consulting actuary in the Milwaukee office of Milliman. Under the current system, plans with noncontiguous service areas can receive an overall star quality rating that might have differed for one market had the measures been reported separately for each market. Reporting quality at the market-area level would “bring more fairness to the MA world,” which is likely to gain some traction with CMS, observes Goetsch.

MedPAC also recommended displaying a comparison of MA and fee-for-service (FFS) quality in the same small market areas. “It’s burdensome and a new hassle factor to deal with from a reporting perspective, but again, that presents very high value for the beneficiaries…and would add a new nuance of relativity into the star ratings,” adds Smith.

With any of these star rating recommendations, Smith says the timing is right because HHS Secretary Tom Price, M.D., is likely to make changes to the star ratings program. “Price has made no secret that he is a physician advocate and that the current system, not just MA but everything, has made it too challenging for physicians. So MedPAC has specifically called out increasing the focus on outcomes measures, which is a great way to keep the focus where it needs to be and could be the launching pad to really start doing things like removing the longstanding HEDIS measures that are not changing quality performance or clinical practice patterns,” she adds.

**Altering Benchmark Math Could Boost Pay**

Aside from suggesting changes to quality measurements, the report also finalizes a draft recommendation from January that CMS include FFS spending data for only beneficiaries with Medicare Parts A and B in the calculation of benchmarks used to determine MA plan payments. Under the current system, CMS uses spending data for all FFS beneficiaries (who have either Part A or Part B or both) to determine the average FFS spending amount in a county. MedPAC observed that with a rising share of Medicare beneficiaries enrolled in the MA program, a larger percentage of those remaining in traditional Medicare do not enroll in Part B, and the average risk-adjusted beneficiary spending is higher for individuals enrolled in both Part A and Part B than the average for those enrolled just in Part A. Removing the portion of low cost, Part A-only beneficiaries from the calculation would result in a higher average cost in a given county and raise the benchmark accordingly. The commission estimated this could increase benchmark pay-
ments by about 1% nationally, although that will vary anywhere from 0% to 3% depending on the county.

“As this idea gets traction and organizations are looking to lobby for this or not, they’re going to be looking at their own counties and what the impact would be in their service areas,” suggests Goetsch. “And those that are going to get the 2% or 3% increase are going to clearly be a lot more vocal in trying to get this as part of the MA program.” Moreover, it’s logical to use the FFS data for a population that matches it in MA, he adds, and the only reason that idea might not have made sense until now is because of the mix of people in MA vs. Part A vs. Parts A and B, etc.

The report also stressed a prior recommendation to use two years of FFS and MA diagnostic data in MA risk adjustment, which would address the wide variation in coding intensity among MA plans and the “inequity” of the across-the-board intensity adjustment CMS makes on a yearly basis. And while that idea appeared as an option for the HHS secretary in the 21st Century Cures Act, Goetsch says he doesn’t think CMS is likely to adopt it soon given the significant changes it made in 2017 to the risk adjustment methodology.

**Risk Adjustment Pressure Builds for MA Plans as DOJ Joins Second Qui Tam Suit**

After unveiling its intent to intervene in a five-year-old *qui tam* lawsuit filed by a former UnitedHealth Group employee alleging practices of diagnosis “upcoding,” the Dept. of Justice (DOJ) in March 2017 said it would join another lawsuit claiming that UnitedHealth and other Medicare Advantage insurers fraudulently collected payments by exaggerating risk adjustment claims. And with the recent disclosure that the DOJ is looking into the risk adjustment practices of four other MA plan sponsors named in the original complaint, the pressure on MA plans to self-check their own risk adjustment practices is growing.

In a March 24, 2017, court filing, federal prosecutors indicated that they will intervene in allegations against UnitedHealth contained in a whistleblower suit originally filed in 2009 by former SCAN Health Plan employee James Swoben. That case resurfaced in an appeals court last September, and alleged that MA insurers such as Aetna Inc., UnitedHealth and WellPoint, Inc. inflated risk scores to receive higher reimbursements. SCAN had already removed itself from the suit by paying a $322 million settlement. The fourth amended complaint (*U.S. ex rel. James M. Swoben v. Secure Horizons*) charges that the defendants conducted retrospective reviews of patient records in order to identify additional diagnosis codes that would lead to enhanced payments but did not use the reviews to withdraw or report previously submitted codes that were not supported.

The DOJ in February also said it planned to intervene in the allegations against UnitedHealth and its WellMed subsidiary contained in *U.S. ex rel. Benjamin Poehling v. UnitedHealth Group, Inc. et al.*, which was filed by former UnitedHealth employee Benjamin Poehling on Oct. 27, 2011, and sealed until February. That suit names United/WellMed, 12 other MA plan sponsors and a health care technology firm. By submitting exaggerated or “upcoded” risk adjustment claims, the defendants fraudulently collected and kept “hundreds of millions — and likely billions — of dollars” in MA payments, alleges the suit. The complaint also charges that UnitedHealth and
others failed to fix previously submitted Medicare risk adjustment claims even when they knew, or should have known, that such claims were false, and that UnitedHealth incentivized the elevation of risk scores. The Justice Dept. requested a hearing to consolidate the cases.

UnitedHealth has said it rejects and plans to protest the claims in the original suit, and in a statement provided by company spokesperson Matt Burns regarding the new case, it asserted, “Litigating against Medicare Advantage plans to create new rules through the courts will not fix widely-acknowledged government policy shortcomings or help Medicare Advantage members. We are honored to serve millions of seniors through Medicare Advantage, proud of the access to quality health care we provided, and confident we complied with program rules.”

Meanwhile, the DOJ in a March 14, 2017, filing said it “has been conducting, and continues to conduct, ongoing investigations of” four other defendants: Aetna, Inc., Cigna Corp. subsidiary Bravo Health, Inc., Health Net, Inc., and Humana Inc. Until those investigations are completed, the federal government said it cannot reach a decision about the insurers’ liability under the False Claims Act as to the “truthfulness of their claims to the Medicare Program for risk adjustment payments, the truthfulness of their risk adjustment attestations to the Medicare Program, or their possible improper avoidance of returning overpayments.” The DOJ added that it will file its complaint against UnitedHealth and WellMed by May 16, 2017.

**DOJ Is Investigating Four Other Firms**

Centene Corp., which acquired Health Net in March 2016, disclosed its participation in the investigation in its annual report filed Feb. 21, 2017, with the U.S. Securities and Exchange Commission.

According to that document, Centene in December 2016 received a Civil Investigative Demand from the DOJ regarding Health Net’s submission of risk adjustment claims under Parts C and D that it believed to be related to the whistleblower suit. “The Company is complying with the CID and will vigorously defend any lawsuits,” stated the filing. “At this point, it is not possible to determine what level of liability, if any, the Company may face as a result of this matter.”

And in an emailed statement from Humana, the insurer said it “has robust risk adjustment policies and procedures, routinely performs self-audits to improve accuracy and investigates allegations of fraud or misconduct related to risk adjustment.” It continued, “We are confident in our risk adjustment practices and our compliance program around them, and we will continue to cooperate with the investigation.”

Aetna, meanwhile, reminds AIS Health that it does not “comment on pending litigation.” Cigna did not reply to a request for comment.

In a March 20, 2017, blog post, health care attorney Steven Chananie warned that the DOJ’s involvement in the first lawsuit, combined with other enforcement actions, can only mean that more lawsuits and enforcement will follow and that plans in the meantime should make sure their risk adjustment practices under the current system are up to code.

“The urgency for [MA plans] to proactively and immediately conduct a comprehensive review of their overall approach to the HCC-RAF [Heirarchical Condition Categories and Risk Adjustment Factor] risk adjustment process has been underscored by the government’s announcement,” suggested Chananie, a partner in the Corporate Practice Group in the New York
office of the law firm Sheppard, Mullin, Richter & Hampton LLP. “Keep tuned for further developments against the other defendants and against other possible targets. In the meantime, it is certainly prudent for [MA plans] to consider an internal review that includes a careful examination not only of auditing protocols, but also of all relevant operational issues ranging from how relationships with providers and vendors are being handled and overseen to how incentive compensation is structured for employees, vendors and providers.”

DOJ Intervenes in MA ‘Upcoding’ Suit Against UnitedHealth Group

The Dept. of Justice (DOJ) has joined a five-year-old qui tam lawsuit alleging that UnitedHealth Group and various subsidiaries and affiliates knowingly submitted overblown risk adjustment claims in order to receive higher payment under Medicare Parts C and D. While other insurers have been the target of similar “upcoding” complaints, this is the first lawsuit the federal government has intervened in and, as one analyst suggested, could lead to greater scrutiny of risk adjustment claims, possibly pushing CMS to widen its scope of risk adjustment data validation (RADV) audits.

The original suit names 12 other Medicare Advantage plan sponsors and health care technology firm MedAssurant, Inc. (now Inovalon). Centene Corp. in its most recent annual report filed with the Securities and Exchange Commission disclosed that its Health Net, Inc. subsidiary — which was named in the whistleblower complaint — in December 2016 received a Civil Investigative Demand from the Justice Dept. that may be related to the lawsuit. But the DOJ is intervening only in the claims against UnitedHealth and WellMed, a Texas-based physician-owned practice management company that was acquired by the insurer in 2011 “in spite of evidence WellMed was fraudulently inflating its risk scores,” according to a Feb. 16, 2017, press release from Constantine Cannon LLP, the firm representing the whistleblower along with Phillips and Cohen LLP.

The first amended complaint (United States of America, ex. rel. v. UnitedHealth Group, Inc. et al., Civil Action No. 11-cv-0258-A, U.S. District Court for the Western District of New York), which was filed by former UnitedHealth employee Benjamin Poehling on Oct. 27, 2011, and sealed until February 2017, alleges that the defendants had submitted exaggerated risk adjustment claims “since at least 2006.” These firms allegedly provided “upcoded” claims to Medicare indicating that a patient had been treated in the relevant time period for: (a) diagnoses that the beneficiary did not have; (b) more severe diagnoses than the one the patient had; and/or (c) diagnoses for which the beneficiary had previously been treated but not during the relevant year. Poehling was director of finance in the company’s Medicare & Retirement segment.

The complaint also alleges that UnitedHealth and others failed to fix previously submitted Medicare risk adjustment claims even when they knew, or should have known, that such claims were false, and that UnitedHealth incentivized the elevation of risk scores. For example, the whistleblower claims that he and other staff members were given specific performance goals for increasing scores and that he received a $15,000 bonus in 2010 for his work in meeting certain internal operating income targets from risk adjustment payments.
Meanwhile, no such incentives were provided for ensuring the overall accuracy of risk adjustment submissions. “United has steadfastly refused to take anything more than token steps to ‘look both ways’” for “both helpful and harmful errors,” added the complaint.

“There is some legal ambiguity, however, on the obligation to ‘look both ways,’” pointed out securities analyst Michael Newshel in Feb. 17, 2017, research note from Evercore ISI. “Notably CMS made an explicit proposal in 2014 that medical record reviews should be designed to find errors whether positive or negative for payment, but retracted that provision in the final version of the rule while still reiterating a general requirement that plans certify the accuracy of their risk adjustment data.” He added that while the DOJ joining the case does “heighten the risk” for UnitedHealth, the suit doesn’t present any “particularly damning new evidence.”

DOJ Involvement Is First for Upcoding Cases

Several lawsuits have emerged in recent years accusing MA insurers of submitting false claims to inflate risk scores, including one filed by a former SCAN Health Plan employee that resurfaced in an appeals court last fall. But the Justice Dept.’s decision to join this particular suit may have some significance, suggests Denise Bloch, counsel at Sandberg Phoenix & von Gontard P.C. “Whenever the Justice Dept. intervenes, it’s generally an indication that they’ve done a lot of research going in and [based on] what they’ve been able to obtain through discovery, they may believe they have a smoking gun; otherwise they would in all likelihood not intervene,” she observes. “It doesn’t mean that they do, but it just is an indication that there is a chance that they have found something supporting that whistleblower’s case. But it’s too early to be able to say whether that’s true.”

She continues, “And even with things like ‘upcoding,’ it’s so subjective because you can have two different professionals review those medical records and find different opinions as far as whether or not something was medically necessary and reasonable and appropriately coded. It really depends on how the documentation was provided.”

Suit Could Push CMS to Widen RADV

In a Feb. 17, 2017, research note, Cowen & Co. securities analyst Christine Arnold suggested the suit could “spell trouble for other industry participants” in that it will likely create “additional scrutiny on Medicare Advantage risk adjustment claims.”

CMS in 2008 began conducting RADV audits to recover improper payments by determining whether the diagnosis codes submitted by an MA organization are supported by a beneficiary’s medical record documentation. But its early attempts to collect overpayments based on extrapolated audit findings were unsuccessful, and while the agency continues to conduct RADV audits on a limited basis, pulling claims samples from 30 or so contracts a year, questions remain about its extrapolation methodology.

In a report published in 2016, the Government Accountability Office criticized CMS for underdelivering on its RADV audits and estimated that the contract-level audits of 2011 payments would recover only about 3% of MA improper payments for that year after extrapolation. Arnold suggested that the lawsuit could put added pressure on CMS to increase the scope of RADV audits and/or alter the risk adjustment model. At press time, CMS was reportedly in the process of contracting with a Recovery Audit Contractor to perform additional audits.
“The [Justice Dept.’s] decision to jump into the case certainly sends a message — and could have some sentinel effect across the industry,” weighs in Michael Adelberg, a former top CMS MA official who is now principal with FaegreBD Consulting. “Of course, the industry and CMS have both invested a lot of time and resources in refining risk adjustment processes since 2010, so circumstances of this particular case might not be operative in 2017.”

UnitedHealth rejects and plans to contest the claims, according to a statement from the company.

Fearing Lower Risk-Adjusted Pay, MA Plans Want CMS to Go ‘Back to Zero’ on EDS Use

At a recent congressional briefing at which various Medicare Advantage industry leaders discussed changes proposed in the 2018 Advance Notice and draft Call Letter, panelists argued that the encounter data system (EDS) is still not ready to ensure accurate and adequate risk-adjusted reimbursement and that CMS should halt its transition to EDS-based pay and continue using the old system. And on Feb. 24, 2017, Avalere Health LLC posted new research that adds to a growing body of evidence showing that the EDS is leading to lower risk scores and supporting plans’ pleas to revert to full use of the risk adjustment payment system (RAPS) while improving the new system.

CMS in 2012 began collecting encounter data from MA plans and in 2016 started phasing in EDS-based payments, beginning with 10% of the payment based on EDS scoring, with the eventual goal of 100% EDS by 2020. But recognizing that there have been challenges with the transition, CMS in the 2018 Advance Notice proposed keeping the same blend of 25% EDS and 75% RAPS that was used for 2017. The new system is intended to capture the same diagnoses identified in RAPS, yet there’ve been many reported problems with the filtering logic used by CMS that is leading to diagnoses that would have been included in RAPS not being applied to the risk score. As a result, plans are concerned that the continued transition to EDS will lead to lower risk scores.

For example, a collaborative research project between RISE, Avalere and its parent company, Inovalon, analyzed data from eight MAOs representing 1.1 million members in more than 30 unique plans and found significant differences between RAPS and EDS scoring. The study looked at the RAPS Return files that inform plans of the disposition of diagnosis clusters submitted to CMS and the MAO-004 reports that inform plans of risk-adjustment-eligible diagnoses submitted to EDS. The average EDS risk score was 26% lower than the RAPS score in the 2015 payment year, and 16% lower in the 2016 payment year, according to the final report from Avalere, which had posted a high-level summary of its findings in January.

While discussing Avalere’s research at the Feb. 22, 2017, briefing hosted by America’s Health Insurance Plans (AHIP), Christie Teigland, Ph.D., vice president of advanced analytics, suggested that the improvement from 2015 to 2016 came from some fixes CMS made to the system as well as plans getting better at gathering and submitting the data. “But again, it is the idea that the same data should be resulting in the same risk scores,” and even though plans ranged from a 2% to a 28% difference for 2016, “every plan was impacted regardless of the size of the plan.” And while all age groups are affected by the difference in risk scores, Avalere observed that the
impact on scores was greater for the high-cost, high-need younger disabled MA beneficiaries than for those age 65 and over. Moreover, the top 10 chronic conditions are being rejected up to 40% more often with EDS than with RAPS, said Teigland.

To demonstrate the potential financial impact using the average study plan of 140,000 members in 2015 and the per-member per-month difference of $155 based on a 100% shift to EDS, Avalere estimated that a full transition to EDS would result in a decrease of $260.4 million per year in risk-adjusted funds for the average plan, and if applying the 25% EDS/75% RAPS blend, the decrease is $68.3 million. “If we’re not giving plans the dollars they need to take care of those most disadvantaged members, they’re not going to get the services they need and that could ultimately cost more in the long run,” asserted Teigland. “So [this has] a very significant impact on the plans; finding those diagnoses that members have is critical.”

Meanwhile, a recent Milliman study involving 15 MAOs representing 900,000 members in 154 plans found that risk scores based on encounter data for payment year 2016 were on average 4% lower than those based on RAPS. That analysis estimated the difference would result in a reduction of approximately $40 per member per year, assuming approximately $800 in Part C risk-adjusted revenue and a 1.0 RAPS-only risk score. The percentage difference was even larger for Special Needs Plans (SNPs).

And while a recent Oliver Wyman analysis conducted on behalf of AHIP observed that continuing the 25% EDS-based payment methodology would have “no incremental effect for 2018,” it suggested that “plans will continue to see reductions in payments until the infrastructure is in place to make encounter data reporting complete, accurate, reliable.” The report estimated that those reductions could be anywhere between $2 billion and $9 billion for 2018 (or between a 1% and 4% hit to overall payments).

MAOs Are Still Navigating Complexity of EDS

Part of the challenge of collecting and submitting encounter data to CMS is the sheer volume of data elements plans are required to capture — at least 112 vs. only five with RAPS — and the transition to an “unstable” system has been too swift, added panelist Eric Cahow, vice president of Medicare revenue management at Anthem, Inc. As a result, he said Anthem and other plans are urging CMS to “roll it back to zero” on the EDS transition, which he suggested would not be a problem for plans at this point because they haven’t “sunseted” the old system.

“Really operationally, it’s just more of the same. The interesting question that comes up is how do you incent plans to continue to improve and grow in that direction?” he asked. “If you can ensure that your payment data is stable [and plans will be paid accurately], I’ll get rid of [the old RAPS]. But what we have right now is an unstable system where I don’t know where I stand at the end of the day. So leaning on the legacy RAPS system is really not a problem at all and it’s a very simple case of giving me the clarity of the roadmap and timing [for encounter data] and I’ll be ready. The issue is CMS isn’t ready; it’s not my readiness.”

“One of the discussions we’d like to have with CMS is what is the ultimate goal of collecting all of this data, whether it’s star ratings or risk adjustment or anything else that we’re submitting,” added Daphne Klausner, senior vice president of government markets at Independence Blue Cross, who also spoke on the panel. “The amount of data that we submit to CMS is astronomical….It’s significant. And how that comes back to the plans or to the program from a policy
CMS Takes Measured Approach in 2018 ‘60-Day’ Notice and Draft Call Letter

The 2018 Advance Notice and draft Call Letter for Medicare Advantage and Part D plans posted Feb. 1, 2017, by CMS contained very few proposals that could be considered major or surprising, industry experts tell AIS Health. Adding to the dullness of the annual notice, which is now required to come out 60 days in advance of the final payment notice instead of 45 days, was a modest pay hike to the tune of 0.25% on average for MA plans.

CMS in the 2017 final payment notice forecast an average pay boost of 0.85% for that year and predicted that improved diagnosis coding would add another 2.2% to the average revenue change, bringing the total to 3.05%, although some MA plans said the coding rise wouldn’t be anywhere near as large as CMS predicted. This time, CMS is factoring in an estimated 2.5% coding trend for 2018, which it said would bring up plans’ pay by 2.75% on average.

Eric Goetsch, a principal and consulting actuary in the Milwaukee-area office of Milliman, suggests the 2.75% assumed improvement in revenue is “modest yet relatively expected” and could vary widely by plan since it is “completely depending on how each individual health plan improves the diagnosis coding.” Contributing to the modest estimated increase is a fee-for-
service normalization factor decrease of 1.9%, which Goetsch points out has in the past changed from the Advance Notice to the final version.

“Many of the provisions are things that the agency had previously signaled that they were going to do, are a continuation of things they were already doing or are a pause on transitions,” observes Ankur Goel, a partner in the Washington, D.C., office of the law firm McDermott Will & Emery. “I think in broad strokes there are things that are of interest and significant but from a policy standpoint the document doesn’t have the same level of major new policy proposals” that CMS has included in past years.

Perhaps the most meaningful transitional “pause” is CMS’s proposal to decelerate its timeline for phasing in the use of encounter data for calculating risk scores. CMS in 2016 proposed that risk-adjusted pay for MA plans be based 50% on the old risk adjustment payment system (RAPS) and 50% on encounter data, which it began collecting from plans in 2012. But after hearing the concerns of stakeholders about plan readiness and the quality of the data coming from providers, the agency in the final 2017 notice scaled that back to 25% encounter data and stressed its intent to move to 100% encounter data by 2020.

In the most recent notice, CMS proposed to keep the same 75%/25% blend of RAPS and encounter data. When asked by AIS Health to explain the agency’s rationale for the delay, CMS officials during a Feb. 1, 2017, press conference said the proposal stemmed from “plans’ concerns about the impact on payment of transitioning to encounter data” and that this would give plans some “payment stability.” As for the goal of moving to 100% encounter data by 2020, the agency indicated the decision to revise that timeline will be made at a later date. But CMS’s efforts to validate encounter data used to ensure proper payments to MA plans have been questioned, most recently in a Government Accountability Office report suggesting that CMS fully assess data quality before use.

“I think [the latest proposal] all relates to CMS having some technical difficulties implementing the EDS [encounter data system] use,” remarks Kirk Twiss, principal and consulting actuary with Clear View Solutions, LLC. “They’ve been unable to release risk score calculations solely from the EDS information, so I think they’re just pausing the mix in the hopes that they can get their system up to where they want it to be and then start moving it forward again.” In addition, CMS solicited comment on a proposal to apply a “uniform industry-wide adjustment” to the EDS data, “sort of like a budget-neutrality transition to get from RAPS to EDS,” notes Twiss.

That’s important because many MA organizations have seen their risk scores go down as a result of the increased use of encounter data in the risk score calculation, suggests Goetsch. A recent Milliman study involving 15 MA organizations representing 900,000 members in 154 plans found that risk scores based on encounter data for payment year 2016 were on average 4% lower than those based on RAPS, resulting in a reduction of approximately $40 per member per year, assuming approximately $800 in Part C risk-adjusted revenue and a 1.0 RAPS-only risk score. The percentage difference was even larger for Special Needs Plans (SNPs).

In addition, the document proposed certain monitoring and compliance actions and said it will now use performance measures related to encounter data submission to “guide oversight and enforcement in this area, with the goal of further ensuring complete and accurate submissions.” Goel points out that the mention of tying compliance actions to a failure to comply with encounter data submission standards is new. “I think there will be some comments around that
issue because it’s part of the broader issue with encounter data...[and] that the encounter data is really not a reliable process at this point for calculating risk scores. And I think that whole area of encounter data and compliance issues is going to continue to increase in importance so long as CMS is going to use that data as part of the blend for risk scores.”

**CMS Considers Same EGWP Pay Methodology**

CMS in last year’s final 2017 payment notice and Call Letter opted to phase in over two years a new policy moving MA Employer Group Waiver Plans (EGWPs) from a separate bidding process to one based on individual MA market data that will ultimately result in a 2.5% payment reduction. The methodology for 2017 involved bid-to-benchmark ratios reflecting a blend of individual market plan bids and EGWP bids from the prior payment year.

CMS for 2018 had intended to switch to full use of individual market data for 2018, but in the latest notice said it is seeking comment on whether it should fully implement the individual market methodology or continue using the blend for 2018, effectively alleviating some payment uncertainty for EGWP sponsors. What kind of impact the initial change had on the group marketplace may not be fully known until the full 2017 Annual Election Period enrollment results are posted later in February 2017, but preliminary results released in January showed an increase in group coverage.

The call letter portion of the document also included some expected changes to the star ratings, such as a proposal to revise the Beneficiary Access and Performance Problems measure and the continuation of the Categorical Adjustment Index to address disparities among low-income subsidy/dual eligible plans and non-LIS/duals plans. But one proposal that could impact high performers is the suggested modification to the methodology to determine “double-bonus” counties, whereby MA plans with a rating of 4 or more stars can get an additional 5% bonus on top of their payment rate in certain counties, points out Goetsch. Moreover, with no mention of keeping the moratorium on the health insurer fee, “we have to assume that plans are going to have to pay that fee again and include it in their administrative cost bids,” adds Goetsch.

The call letter also proposed establishing separate adequacy evaluations of provider networks specific to MA SNPs, with the goal of ensuring “adequate access” for particularly vulnerable MA enrollees who require enhanced care coordination. Noting that the key differences between non-SNP MA plans and SNPs, which have always had to follow the same rules, is that SNPs provide focused care to special target populations (e.g., institutionalized, dual eligible, disabled) based on their unique health care needs. CMS asked SNP stakeholders to weigh in on how SNP-specific networks currently differ from other MA networks, what would be desirable in SNP-specific network adequacy evaluation, and how it would improve patient health or quality of care.

Twiss and fellow Clear View principal Stephen Wood tell AIS Health this would be a great benefit to the SNPs they work with because many of them are long-term care providers and argue that the network they need to contract with is very different than that of a regular MA plan. “For instance, in almost every organization we’ve been working [with] lately, one approach is to have a podiatrist that makes rounds in the nursing home, but he doesn’t have an office, so CMS can basically say, ‘You don’t exist’ and force the plan to contract with a podiatrist who has an office. So we think more customization over these networks will make a lot of sense,” says Wood.
Meanwhile, the document contained very little change for Part D plans. One area where CMS chose to maintain the status quo was preferred cost-sharing pharmacies (PCSPs). Whereas beneficiary access to and confusion around PCSPs (formerly known as preferred pharmacy networks) was a focus of previous call letters, CMS proposed to keep the policies it established for calendar year 2016 regarding access to these types of pharmacies. These include posting information about the current year’s PCSP access levels on the CMS website, requiring outlier plans to disclose that their plan’s PCSP network offers lower access than other plans’, and working with “extreme outliers” to address concerns about beneficiary access and marketing representations relative to preferred cost sharing. Additionally, CMS will hold plans to the same access standards it did in 2016, considering plans such as those with network PCSPs that are within 15 miles of less than 70% of beneficiaries in rural areas as outliers. Those that fail to use the required marketing disclosure language and/or do not meet the terms of bid negotiation agreements will be subject to compliance and/or enforcement actions, CMS reminded plan sponsors.

**ASPE Report Supports Case for Long-Term Stars Changes for Duals**

A recent report from the HHS Assistant Secretary for Planning and Evaluation (ASPE) found that social risk factors and indicators such as disability status, low income and lack of social supports were strong signals of poor health outcomes and negatively affected performance on Medicare quality measures and value-based reimbursement programs. Dual-eligible status was the greatest predictor of poor health outcomes in the quality measures studied. The report made various recommendations for addressing inequities in performance assessment across organization types that industry experts say bode well for high-dual health plans and safety net providers that want to see additional enhancements to the quality ratings system.

The 374-page report, released Dec. 21, 2017, examined nine Medicare payment programs, including the Hospital Readmissions Reduction Program, the Physician Value-Based Payment Modifier Program (soon to be replaced by the Merit-based Incentive Payment System) and the Medicare Advantage Quality Star Rating Program. Beneficiaries with “social risk factors” (replacing the term low socioeconomic status as per a recommendation from the National Academies of Sciences, Engineering and Medicine) demonstrated worse outcomes on many quality measures, regardless of the providers they saw.

Outcomes in many instances were found to be particularly poor for those dually eligible for Medicare and Medicaid. For example, dually enrolled beneficiaries had significantly greater odds of hospital readmission than non-dually enrolled patients even within the same hospitals. And after adjusting for clinical risk factors, their odds of readmission remained higher for duals vs. non-duals.

Using data from performance year 2014, researchers observed that dually enrolled or low-income subsidy (LIS) beneficiaries, black and rural beneficiaries, beneficiaries living in low-income neighborhoods, and beneficiaries with disabilities experienced worse outcomes compared to other beneficiaries on “many to most” of the star ratings metrics.
To evaluate the impact of social risk factors on stars performance, ASPE used an analytic sample containing 15,282,565 MA beneficiaries (or about 97% of total MA enrollees in 2014), of which 18.2% were partially or fully dual-enrolled, 14.6% had disabilities and 3.6% qualified for LIS. ASPE considered these a single group for the purposes of its analysis. After removing contracts that didn’t have 2015 star ratings (e.g., those that were too new or too small to be rated), the sample consisted of 505 contracts, which included HMOs, PPOs and private fee-for-service plans.

Researchers considered total and within-contract differences for 19 of the 47 MA star ratings measures, all of which were beneficiary-level measures, and found that for 16 of the measures, performance was worse for dual/LIS beneficiaries within a contract, although to what degree they differed varied. For example, dual/LIS members had 32% lower odds of having their blood sugar controlled than non-dual/non-LIS beneficiaries but only 7% lower odds of having their kidneys appropriately monitored.

ASPE concluded that its analyses showed “evidence of a significant within-contract impact of a number of social risk factors on performance on individual measures in the Star Ratings.” However, ASPE observed that since most of these measures are not adjusted for clinical risk, the research does not show whether the differences are due to the social risk factor itself or to the fact that beneficiaries with social risk factors also have a higher risk for certain medical conditions.

Although some contracts serving a high proportion of dual/LIS members earned high star ratings, such contracts generally fared worse on overall quality scores, added ASPE. As a result, plans with a high proportion of duals members are much less likely to receive quality bonus payments. “The impact is really significant for these plans, and I think this report confirmed prior research and strengthened our current thinking, which is that we need to use better data,” observes Christie Teigland, Ph.D., vice president of advanced analytics with Avalere Health.

Teigland currently sits on the standing disparities committee of the National Quality Forum (NQF), which is nearing the end of a two-year pilot to assess the impact of social risk factors on quality outcomes. But the various measures NQF’s developers have tested thus far found little impact of social risk factors, reports Teigland, who argues that more robust data is needed to “accurately measure which of these social risk factors are having the biggest impact on quality outcomes.”

After separate studies from Avalere and CMS supported the theory that SES can have an adverse effect on star ratings, CMS in 2015 attempted to address the concerns of plans with large percentages of dually eligible beneficiaries by adding a Categorical Adjustment Index (CAI) to the star ratings for contracts that serve a high proportion of duals/LIS members and/or patients with disabilities. But only 15 out of 364 contracts saw their 2017 summary rating go up by half a star, estimated Avalere’s parent company, Inovalon, Inc.

The ASPE report outlined several MA-related strategies that fell into three buckets: (1) measure and report quality for beneficiaries with social risk factors, which included enhancing data collection and developing statistical techniques to allow such actions on key measures; (2) set high, fair standards for all beneficiaries; and (3) reward and support better outcomes for beneficiaries with social risk factors, such as by providing targeted star adjustments to reward contracts that demonstrate high quality or significant improvements in quality for dual eligibles.
“I think they’re moving in the right direction,” observes Teigland of the ASPE recommendations. “If you look at what the [CAI] adjustment did, less than 3% of plans getting any kind of impact [shows] it’s not going far enough. The ASPE report acknowledges that we need to go further.”

**Report Validates SNP Concerns**

The SNP Alliance also agrees with ASPE’s recommendations in terms of implementing changes to the quality measurement and reporting system under Medicare. This would include improving measures, risk adjusting for social determinants of health and dual status, enhancing data collection, grouping like plans, and moving toward more meaningful population groups for measurement and reporting. The alliance tells AIS Health that the ASPE report “validates some of the points the Alliance has been making for the last few years about the effects of a high proportion of duals on observed quality outcomes.” The alliance strongly supports, for example, comparing like plans to like plans (e.g., Fully Integrated Dual Eligible Special Needs Plans to other FIDE-SNPs), considering specific exclusions or exceptions, and adjusting more of the star ratings to take into account dual status.

“Our sense is that CMS was really waiting for this ASPE report before they went ahead and developed or proposed a long-term solution to the star ratings methodology, so the report could inform CMS’s thinking in terms of how they propose to really adjust the star ratings for social risk factors,” adds Christine Lynch, senior vice president of policy and external affairs at The SNP Alliance.

That said, while the alliance is “very concerned about advancing fair and appropriate performance measurement, we also don’t want to sweep poor performance under the rug,” adds Rich Bringewatt, co-founder and CEO of the National Health Policy Group, of which the alliance is an initiative. “We want to report it where it exists and want to do everything we can to improve clinical and care outcomes as well as address imperfections in performance ratings.”

In addition, researchers looked at the impact of Medicare’s current value-based payment programs on providers serving socially at-risk beneficiaries and found that those who served a disproportionate number of disadvantaged beneficiaries also tended to perform worse on quality measures.

“I think what’s important about this report is it not only substantiates the importance of social risk factors in caring for poor beneficiaries, it really proves the pervasive extent to which performance rating methods have really failed to account for all of this across the spectrum of plans and providers,” weighs in Bringewatt.

**Minimal Impact of SES Adjustment on 2017 Stars May Prompt Further Research**

As expected, an interim adjustment used to address socio-economic status (SES) in CMS’s star quality ratings aided a small portion of Medicare Advantage plans serving dual eligible and low-income subsidy (LIS) members, according to a new Inovalon, Inc. analysis of the 2017 star ratings data posted by CMS in October 2016. Star ratings experts from the technology firm and its health care consulting subsidiary, Avalere Health, during a recent AIS webinar said
these findings indicate that the new categorical adjustment index (CAI) methodology used by CMS had a minimal impact, providing a boost for a handful of plans on the edge of achieving a higher star rating and demonstrating a need for further research in this area.

After two major studies supported the theory that socioeconomic factors such as income, education and social supports can have an adverse effect on star quality ratings, CMS in late 2015 considered a pair of complex approaches for adjusting the 2017 star ratings to take into account the impact of SES and disability. One of them was Indirect Standardization, which would have applied to a subset of the individual star ratings measure scores. What CMS ultimately settled on, however, was applying a CAI factor to a contract’s overall and/or summary rating to adjust for within-contract disparities based on an MA contract’s percentages of dual eligible/LIS beneficiaries.

**CAI Factor Lifted Few Plans’ Stars**

Based on its own analysis of the 2017 star ratings data, which broke down the ratings to plan-specific and measure-specific levels, Inovalon estimates that 15 contracts out of 364 had a half-star increase, while 96% of contracts saw no change in their overall star rating, explained Patrick Donnelly, director of product execution with Inovalon, during the Nov. 2, 2016, AIS webinar, “The 2017 Medicare Star Ratings: How to Translate New CMS Data Into Future Successes.” These included one contract that would have been rated 2 stars and moved up to 2.5, one that went up to 3, and eight 3-star contracts that actually moved up to 3.5. Additionally, five contracts that were at 3.5 stars “really hit the mark” and earned 4 stars, he observed. “That’s incredibly significant for those plans, especially when they’re dealing with a disadvantaged population like that.”

The new figures don’t deviate much from earlier CMS estimates that applying the CAI data to the 2016 star ratings would have moved 11 plans up half a star, although CMS had estimated that one contract’s rating would have actually dropped half a star. When considering the small number of plans that actually saw improvements and a growing body of research into the effect of SES on health outcomes and quality metrics, it’s clear that there’s still work to be done when adjusting star ratings for duals’ characteristics, suggested Avalere’s vice president of advanced analytics, Christie Teigland, Ph.D., who also spoke at the webinar.

Using a highly representative sample of the Medicare population and market indices data from Acxiom, Inovalon in 2014 conducted a major study that found a significant impact of socio-economic factors after adjusting for dual status. For example, living in a high-poverty area can lead to lower scores on the three medication adherence measures and all-cause readmissions. The health care data analytics firm also found a significant effect of chronic conditions, age, gender and other community resource characteristics after adjusting for dual status.

A subsequent CMS study conducted by RAND Corp. reviewed 16 measures, and showed significant “within contract” differences in the average scores for 12 measures. That study, however, concluded that the dual status effect was not sensitive to patient characteristics such as age, gender, hierarchical condition category and end-stage renal disease and socio-economic factors measured at the Census American Community Survey (ACS) block level after adjusting for within-plan effects for seven of the nine star measures evaluated. And its use of five-digit ZIP code level and ACS block group data, only representing about 1.6% of all U.S. households,
may not have allowed for a very precise assignment of socioeconomic characteristics to members compared with the Inovalon study, suggested Teigland.

CMS chose to adjust seven measures on which it observed differences in performance among low-SES members vs. non-duals/LIS members within plans. These included reduced risk of falling, for which duals/LIS members actually scored better than non-duals and may impact plans’ upward adjustments, pointed out Teigland. The six measures with a negative impact on ratings for plans with duals comprised 13.6% of the 44 star measures for 2015. But factoring in the contribution of each of the measures to the overall rating, the maximum contribution these adjusted measures could make is 19.4%, she observed. And contracts must have a change in star ratings for all six measures to see any change in their overall star rating, she suggested.

If there were more comprehensive risk adjustment of certain measures or if CMS adjusted for between-contract disparities, for example, there might be more improvement from those plans “in the middle,” suggested Teigland. And the plans she’s spoken with argue that more research needs to be done into the clinical characteristics of duals vs. non-duals and what’s driving the differences in risk scores. “There are a lot of questions left to be answered and I think the plans really don’t think that this has really fully addressed the problems that they face,” she said. Teigland is currently working with an expert panel group of the Pharmacy Quality Alliance, which develops the three medication adherence measures, on the question of risk adjusting those measures for SES. And the panel “is making some significant progress…in trying to find the right socioeconomic data to use in its recommendations,” she told listeners.

One of the trade groups that initially expressed doubts about CMS’s interim SES adjustment, The SNP Alliance, which represents 28 health plan members that serve 55% of all Special Needs Plan enrollees, continues to advocate for adjustments to account for SES in the star ratings. Given that 15 plans gained half a star, the interim adjustment is “still severely inadequate for dealing with the problem,” observes Rich Bringewatt, co-founder and CEO of the National Health Policy Group, of which The SNP Alliance is an initiative.

“While I’m delighted that there’s finally an accounting and recognition that the star ratings are adversely affected by the extra burden that dual beneficiaries bring, what we’re doing is just not enough,” he tells AIS Health. “Thanks to the research from Inovalon, we now know more about which factors affect health outcomes and we know more about what methodology we should use in order to account for those factors. And so we believe that CMS should move beyond their CAI methodology to more fully account for the adverse effect that social factors as well as illness complexity have on star ratings. And the technology is there to do something.”

Meanwhile, another stars expert tells AIS Health that she’s heard very little concern from duals plans since the adjustment was made. “It’s almost as if when CMS heard this and factored it in, it truly just ended the discussion,” weighs in Melissa Smith, vice president of stars at Gorman Health Group. “And we exist to be advocates for health plans — not to be in the shadow of CMS — but the fact that CMS responded to the feedback is pretty remarkable because a lot of government agencies would dig their heels in the sand. And I think it’s pretty fabulous that CMS is keeping an open dialogue and researching the issues.”