

Massachusetts Notice of Benefit and Payment Parameters 2016



March 27, 2015

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Executive Summary

Risk adjustment is a permanent risk mitigation provision under the Patient Protection and Affordable Care Act (“ACA”). It applies to all non-grandfathered health plans offered in the individual and small group markets in a state. The Massachusetts Health Connector (“Health Connector”) administers the risk adjustment program for the Commonwealth using a federally certified risk adjustment methodology that was calibrated to the Massachusetts experience. In accordance with federal requirements¹ we are issuing this Massachusetts Notice of Benefit and Payment Parameters for the 2016 Benefit Year to describe the Commonwealth’s risk adjustment methodology, program operations and processes to ensure program integrity for the 2016 Benefit Year.

At a high level, the 2016 State Payment Notice includes the following main components:

- Risk adjustment methodology
- Transitional Rating Factors
- Small Group Definition
- Model Recalibration
- Commonwealth Care
- Commonwealth Choice
- ICD-10 Conversion
- Policies on Supplemental Diagnoses, Health Assessment and Telehealth
- Risk Adjustment Data Validation
- Risk Adjustment Program Regulations
- Accounting Process

State Payment Notices for the 2014 and 2015 Benefit Years are available on the Health Connector’s website.

1. Risk Adjustment Entity

The Massachusetts Health Connector is the entity responsible for the Commonwealth’s health insurance Exchange marketplace for individual and small group health coverage. In July 2012, the Health Connector was authorized by the Commonwealth’s Legislature to administer the Commonwealth’s risk adjustment program.² In this capacity, the Health Connector assumes the overall responsibilities for implementing the risk adjustment program for the Commonwealth.

¹ 45 CFR §153.100; the timing of the State Notice for the 2015 benefit year is described at 79 FR 13752.

² Chapter 118 of the Acts of 2012.

2. Risk Adjustment Methodology

For the 2016 Benefit Year, the Health Connector will continue to use the federally certified risk adjustment methodology that was published in the 2014 Federal Payment Notice³ and recertified for the 2015 and 2016 Benefit Years. Please refer to the 2014 State Payment Notice and the accompanying technical details that had been previously published and released to the market.

The Health Connector received comments relating to the interaction of regional differences in costs and medical coding practices with risk adjustment; as well as suggestions to consider alternatives to the state average premium as the baseline for risk adjustment calculations. Comments were also received regarding the interaction of care network design and risk adjustment, and with respect to the emergence of new insights concerning the interaction of wellness programs with risk adjustment.

In coordination with the Division of Insurance, we are evaluating these comments and considering a transition from a state-implemented risk adjustment program to a federally-run program in the future.

3. Transitional Rating Factors

In April of 2013 HHS approved a three-year transition period during which plans would be permitted to phase certain small group rating factors that had previously been allowed in the Massachusetts merged market, such as factors based on industry, group size, group participation, intermediary discount and small business cooperative discount. In April 2014, this was extended an additional year. Under this extended transition:

- For policy years beginning on or after January 1, 2014, but before January 1, 2015, small group market issuers may use 2/3 of the disallowed factors;
- For policy years beginning on or after January 1, 2015, but before January 1, 2016, small group market issuers may use 2/3 of the disallowed factors;
- For policy years beginning on or after January 1, 2016, but before January 1, 2017, small group market issuers may use 1/3 of the disallowed factors;
- For policy years beginning on or after January 1, 2017, small group market issuers must be in full compliance with the rating rules under Public Health Service Act section 2701.

As described in the State Payment Notices for 2014 and 2015, in response to this transitional policy, the Commonwealth, in consultation with carriers, considered whether to make adjustments to its federally-certified risk adjustment methodology to provide alignment with the rating rules allowed for under the transition. The Commonwealth considered two options – whether to make adjustments to the risk adjustment methodology to account for the transitional rating factors for small group plans; and whether to continue to apply the “non-group selection factor” that was part of the Commonwealth’s certified risk adjustment methodology.

³ The Commonwealth’s methodology is described at pp. 15439-52.

The Commonwealth, in consultation with HHS and carriers, took into consideration a number of relevant factors and finalized an approach for 2014 articulated in the State's 2014 Payment Notice. This same approach was reiterated in the 2015 Payment Notice. Under this approach:

- No adjustments were made to the risk adjustment methodology to account for the permissible rating variation, recognizing in particular the temporary nature of the transition.
- The "non-group selection adjustment" -- which was part of the original Massachusetts methodology -- was not applied. Applying the non-group selection factor could have the potential (all other things equal) to move dollars through Risk Adjustment transfers from the small group market to non-group market, and could serve potentially to undercut flexibility in pricing associated with the transitional policy.

The Health Connector will use the same approach with regard to these transitional rating factors and the non-group selection adjustment in 2016 as it has used the 2014 and 2015 Benefit Years.

4. Small Group Definition

Currently, Massachusetts exercises its discretion as allowed under federal regulations to define small group to include groups with up to 50 employees. Beginning in 2016, under the ACA, the definition of small employer and small group market is expected to include groups with up to 100 employees.⁴

For risk adjustment purposes, starting in the 2016 Benefit Year, the Health Connector will use the same small group definition as is adopted by the Massachusetts Division of Insurance (DOI) for purposes of regulating the market. DOI is expected to provide technical guidance regarding this definition, and the Massachusetts Center for Health Information and Analysis (CHIA) will follow up with data submission guidance accordingly. The Commonwealth agencies will work collaboratively with carriers to ensure accurate data collection in the coming months.

5. Model Recalibration

Risk adjustment models need constant monitoring to ensure that they remain statistically accurate and can adequately reflect recent health care cost, utilization and treatment experience and other patterns and trends. While we recognize the federal government chose to recalibrate for the 2016 benefit year, the Health Connector evaluated the Massachusetts risk adjustment models using recent simulation data and found their predictive accuracy to remain at a similar level as when the models were originally calibrated. Considering that there appears to be no clear technical reason to recalibrate and that recalibrating the models would require analytic effort and lead time for recertification approval from CMS, and that the diagnosis coding system will convert to ICD-10-CM later this year, the Health Connector will not recalibrate the risk adjustment models to be used for the 2016 Benefit Year, and will use the same risk adjustment models that were part of the federally certified methodology published in

⁴ See ACA § 1304(b).

2014. We will continue to monitor the performance of the risk adjustment models through quarterly simulations and will seek issue feedback when there is sufficient empirical evidence that suggests a recalibration in the future.

The Health Connector has received comments suggesting that the models be recalibrated for the 2016 Benefit Year. We will continue to monitor the performance of the models as additional data become available in consideration of the timing of future potential recalibration.

6. Commonwealth Care

In April, 2014, the Health Connector applied to CMS to include the Commonwealth Care (“CommCare”) program experience in the risk adjustment program for the 2014 Benefit Year. In November, CMS rejected the Health Connector’s application. Based on this decision, the 2014 risk adjustment funds transfer calculations will exclude the experience of CommCare plans. In September, 2014, the Health Connector announced that the CommCare program would extend until January 31, 2015. Accordingly, the CommCare experience during the extension will also not be included in the 2015 risk adjustment funds transfer calculations. We note that ConnectorCare plans, on the other hand, are subject to risk adjustment as they are QHPs offered in the merged market.

7. Commonwealth Choice

In March 2013, the Health Connector announced to the market that members enrolled under the Commonwealth Choice program would have until the end of 2014 to convert to an ACA-compliant plan. We are clarifying here that for purpose of risk adjustment, Commonwealth Choice program members’ experience prior to the conversion is not subject to risk adjustment for the 2014 benefit year.

8. ICD-10 Conversion

On October 1, 2015, all HIPAA-covered entities will convert to ICD-10-CM coding. The Health Connector will release the ICD-10-CM diagnosis mapping to the existing Hierarchical Condition Categories (HCCs) to the market in a separate communication very soon.

9. Policies on Supplemental Diagnoses, Health Assessment and Telehealth

Since September, 2014, the Health Connector has been in discussions with carriers regarding how supplemental diagnoses, health assessments and telehealth will be implemented in the Commonwealth’s risk adjustment program, recognizing that risk adjustment requires accurate collection of diagnosis information and the program operation should not stifle innovations in healthcare delivery. We have previously laid out in guidance to carriers our approach for the 2014 and

2015 benefit years, and we intend to reaffirm this approach in the 2016 State Payment Notice. At a high level, this approach is as follows.

- For the 2014 Benefit Year, claims and diagnoses will continue to be submitted to the APCD using current procedures and files. Consistent with current procedures and practices, issuers will be able to provide updated claims to the APCD to reflect new information or re-adjudication of previous claims and are not required to submit supplemental data through a separate file.
- For the 2015 Benefit Year, carriers will submit supplemental diagnoses to CHIA on a quarterly basis through a separate file.
- Diagnosis information collected through health assessments is acceptable to be used in risk adjustment, as outlined in previous guidance
- Diagnosis information collected through telehealth is acceptable to be used in risk adjustment, as outlined in previous guidance

10. Risk Adjustment Data Validation

For the 2014 Benefit Year, the Health Connector will use a single-level audit approach to RADV and will also collect from carriers a user fee of approximately \$0.54 per unique member per year. The sample size in the single-level audit will be determined by the Health Connector to ensure that it is statistically adequate for error estimation at the issuer level, but not to exceed 200 members per issuer.

Consistent with the federal approach, results from the RADV audit will not lead to adjustments in fund transfer for the 2014 and 2015 Benefit Years.

The Health Connector continues to emphasize the importance of working with carriers and across state agencies to encourage and carry out a robust data quality review process. Consistent with this ongoing goal, the Health Connector is considering additional measures to further enhance data validation processes – particularly for enrollment-related data. We will provide additional details to carriers as part of the implementation of risk adjustment data validation.

11. Risk Adjustment Program Regulation

On December 24, 2014, the Health Connector released 956 CMR 13.00 Draft Risk Adjustment Procedures for Small and Non-Group Market Regulation to the market and sought carrier feedback. We have received comments from a number of carriers and held a public hearing on March 6th, 2015. We will continue to review comments from carriers and will make final recommendations for Board approval. The final regulation, as approved by the Board, will be released to carriers and published in the Massachusetts Register and on the Health Connector's website.

12. Accounting Process

The 2015 State Payment Notice provided details on the Health Connector's accounting process for conducting funds transfers. We will provide bank account and wiring instructions to the market under a separate communication.