Massachusetts Notice of Benefit and Payment Parameters 2015

April 10, 2014

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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 state alternate risk adjustment methodology that was federally certified and published in the Federal Notice of Benefit and Payment Parameters for 2014 ("2014 Federal Payment Notice")[1] and recertified for use in 2015 in the Federal Notice of Benefit and Payment Parameters for 2015 ("2015 Federal Payment Notice").[2] In accordance with federal requirements,[3] we are issuing this Massachusetts Notice of Benefit and Payment Parameters for the 2015 Benefit Year to describe the Commonwealth's risk adjustment methodology and processes to ensure program integrity for the 2015 Benefit Year.

At a high level, the 2015 State Payment Notice includes the following main components:

- The Health Connector will use the same risk adjustment methodology that has been federally certified in 2014 for the 2015 Benefit Year;
- The Health Connector will use the same Risk Adjustment Data Validation ("RADV") approach for both the 2014 and the 2015 Benefit Years, which is similar to the federal RADV approach - consistent with the federal approach the results from the 2015 RADV audit will not lead to adjustments in risk adjustment funds transfer;
- The Health Connector will impose a default charge to issuers who fail to submit data to the Commonwealth's All-Pay Claims Database ("APCD") managed by the Center for Health Information and Analysis ("CHIA") within the timeframe required to allow the Health Connector to conduct market-wide risk adjustment for the 2015 Benefit Year.

1. Risk Adjustment Entity

The Massachusetts Health Connector is the entity responsible for the Commonwealth's Health Insurance Exchange ("Exchange") or State-based Marketplace ("SBM") for individual and small group health coverage. A state that operates its own Exchange and meets with federal certification by HHS is eligible to establish a state-based risk adjustment program.[4] In July 2012, the Health Connector was authorized by the Commonwealth's Legislature to administer the Commonwealth's risk adjustment program.[5] In this capacity, the Health Connector assumes the overall responsibilities for data collection, calculations of relative risk scores and payment and charges, collecting charges and

[1] 78 FR 15410 (March 11, 2013), available at http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf
[2] Federal Notice of Benefit and Payment Parameters for 2015, 79 FR 13744, available at https://federalregister.gov/a/2014-05052.
[3] 45 CFR §153.100; the timing of the State Notice for the 2015 benefit year is described at 79 FR 13752.
[4] 45 CFR §153.310.
[5] Chapter 118 of the Acts of 2012.

disbursing payments to issuers subject to the risk adjustment program, program oversight and monitoring activities, and records retention.

2. Risk Adjustment Methodology

In March, 2013, the Federal Department of Health and Human Services ("HHS") approved the state alternate risk adjustment methodology proposed by the Health Connector and published it in the 2014 Federal Payment Notice.[6] Subsequently in April, 2013, the Health Connector published the Massachusetts Notice of Benefit and Payment Parameters[7] ("2014 State Payment Notice"), which reiterates the methodology as described in the Federal Payment Notice and provides additional details.

In light of the federal approval of a three-year transitional period that allows Massachusetts issuers to retain flexibility in rating in the individual and small group markets, such as group size adjustment, industry, participation, intermediary discount and small business cooperative discount, collectively referred to as "transitional rating factors", the 2014 State Payment Notice made the following clarification and technical correction to the methodology that was published by HHS in the Federal Payment Notice:

- The Commonwealth's risk adjustment methodology will not account for the transitional rating factors due to their transitional nature
- The nongroup interface adjustment factor as published in the 2014 Federal Payment Notice for Massachusetts will not be used in 2014 because issuers are allowed to vary premiums by the transitional rating factors

In the 2015 Federal Payment Notice, HHS recertified the Commonwealth's risk adjustment methodology that it had approved for 2014. For the 2015 Benefit Year, the Health Connector will use the same risk adjustment methodology as published in the 2014 State Payment Notice. As in 2014, the non-group interface adjustment factor will not be used in 2015.

In addition to the descriptions of the methodology found in the Federal and State Payment Notices for 2014, a technical description of the algorithms, analytical steps, and factors involved in calculating a member-level risk score can be found in Appendix III of the State 2014 Payment Notice. Additional supporting materials can be downloaded from https://www.mahealthconnector.info/portal/site/connector/menuitem.d7b34e88a23468a2dbef6f47d7468a0cd, under "Market-wide Risk Adjustment."

As described in the 2014 State and Federal Payment Notices, the risk adjustment data collection in the Massachusetts risk adjustment program will utilize the Commonwealth's existing All-Payer Claims Database ("APCD") as the venue for data submission. The APCD is managed by the Center for Health Information and Analysis ("CHIA").

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[6] The Commonwealth's methodology is described at pp. 15439-52.

[7] Available at https://www.mahealthconnector.info/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/Overview/Risk%2520Adjustment/MANoticeofBenefitPaymentParameters.pdf. The Commonwealth's Methodology is described in Section 3.

This approach facilitates the Commonwealth's policy goal of administrative simplicity and minimizing the number and types of data submissions by health plan issuers. It also facilitates the use of data that is complete, high in quality, and available in a timely fashion.[8]

3. Risk Adjustment Data Validation

Risk adjustment data validation ("RADV") is the process by which the Health Connector will validate the diagnosis and demographic information for a statistically valid sample of enrollees for each issuer, as described in federal risk adjustment regulations. [9]

For the 2015 Benefit Year, the Health Connector will use the same two-level RADV audit approach as it will use for 2014, which is modeled after the approach that HHS will use when conducting risk adjustment on behalf of a state[10]. The first level audit would involve each issuer engaging a qualified independent validation auditor to conduct an Initial Validation Audit ("IVA") on a sample of the issuer's enrollees selected by the Health Connector, following the standards set forth by the Health Connector. The second level audit would involve an auditor engaged by the Health Connector conducting a Secondary Validation Audit ("SVA") of a subsample of the enrollees audited in the first level audit.

Consistent with the federal approach, for the 2014 and 2015 Benefit Years, the Health Connector will not adjust payments and charges using RADV findings. The Health Connector expects to adjust payments and charges based on RADV results starting with the 2016 Benefit Year.

In the longer term, the Health Connector expects to implement a more analytically-driven RADV approach using statistical data screening supplemented by focused and random audits.

Overall Considerations and Guiding Principles

The overall goals of RADV should be considered in the context of the ACA and Commonwealth. Below we outline principles that have helped to guide our decision-making with respect to different options and paths for RADV. Specifically, the Commonwealth's RADV program seeks to:

- Strike a balance between a RADV process that optimizes the identification of errors and implementing a workable system that is not administratively burdensome.
- To create an approach that encourages accuracy among health insurance issuers, while ensuring that the data validation process itself contributes to the overarching goal of encouraging affordability through premium stabilization, rather than serving as a source of additional material cost;

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[8] A description of the Commonwealth's data collection process can be found in Section 3.8 of the State 2014 Payment Notice.
[9] 45 CFR 153.350.
[10] For more detail on the federal RADV process, see the HHS-Operated Risk Adjustment Data Validation (RADV) Process White Paper (June 22, 2013), available at https://www.regtap.info/uploads/library/ACA_HHS_OperatedRADVWhitePaper_062213_5CR_062213.pdf, and the Federal 2015 Payment Notice.

- Provide a check that helps ensure risk adjusted payments to carriers do in practice correspond to the hierarchical condition code architecture specified in the risk adjustment model;
- Encourage good data management practices and provide a level playing field with respect to data and documentation requirements;
- Avoid unintentionally discouraging clinical encounters occurring in increasingly common and more diverse care settings that may in a broader sense help to address concerns related to physician shortage and cost-effectiveness;
- Provide for consistent and reliable audit results using verifiable and transparent methods.

3.1 Qualification Standards and Requirements for IVA Auditors

Through ongoing consultation with stakeholders, the Health Connector will develop auditing standards for carriers, IVA auditors, and SVA entities by the fourth quarter calendar year 2014, allowing time for carriers to engage IVA auditors by the summer of 2015.

These standards will include provisions to prevent conflict of interests between IVA audit entities and the issuers for whom they are conducting audits, and will be consistent with federal standards established for 2015.

The Initial Validation Auditors shall meet the following general requirements:

- Capable of reviewing enrollee health status against source medical records by medical coders certified after examination by a nationally recognized accrediting agency for medical coding, such as the American Health Information Management Association ("AHIMA");
- Capable of performing audits on member demographic and eligibility information and plan information against source enrollment and plan design information;
- Able to complete the IVA and submit IVA findings to the Health Connector for SVA purposes in the manner and timeframe specified by the Health Connector.

While an issuer can choose its IVA entity, the IVA entity needs to meet requirements established by the Health Connector, and conduct the review in an independent manner and according to minimum audit standards established by the Health Connector through future guidance.

By summer 2015, issuers must identify the IVA auditors they will be engaging to the Health Connector and must attest to the absence of conflict of interest between the IVA auditor and the issuer to the best of their knowledge based on reasonable investigation. Starting in the 2016 Benefit Year, failure to hire an IVA audit will result in the Health Connector assessing a default charge to the issuer's risk adjustment funds transfer calculations, which is described in Section 4.3.

The Health Connector reserves the right to review the IVA auditor's qualifications and relationship to the issuer to verify that the IVA auditor is qualified to perform the audit, and that the issuers and IVA auditors are free of actual or apparent conflicts of interest.

3.2 IVA Sampling

The Health Connector will select a sample of members from each issuer participating in the Commonwealth's risk adjustment program for RADV. For issuers with more than 1,000 RACP members, 200 members will be sampled.

The Health Connector will use stratified sampling to generate the IVA samples. There will be 10 strata, sorted into risk score strata within each of 3 age groups (see below). The stratum for members with no HCCs will not be divided into age groups. Twenty members will be sampled from each stratum (or 10 members from each stratum if issuer has less than 1,000 RACP members). Members do not have to have full-year enrollment to be included in the sample.

Adults (age 18 and older)	high
	medium
	low
Children (age 1-17)	high
	medium
	low
Infants (age less than 1)	high
	medium
	low
No HCC - all ages	

3.4 Initial Data Validation

Issuer Responsibilities

Issuers are responsible for providing IVA auditors with source member demographic and enrollment information, benefit plan information, claims, and medical record documentation from providers of services to enrollees in the IVA sample without unreasonable delay and in a manner that is HIPAA compliant. IVA auditors will work with the issuers to ensure data transmission and audits are conducted in a HIPAA compliant manner.

IVA Enrollment and Demographic Information Review

To validate enrollee enrollment and plan information, issuers shall provide source enrollment documentation such as the 834 transaction.

IVA Medical Records Review

Medical records review is the process for validating health status and the HCCs used for risk scoring through review of acceptable clinical documentation. The IVA auditor would validate the extent to which:

- The records originate from the provider of the medical services;
- The records align with the period of enrollment for the individual as it concerns medical diagnoses;
- The records reflect permitted providers and services;
- The records reflect a face-to-face or telehealth visit documented and authenticated by a permitted provider. The Health Connector expects to provide additional guidance on the use of telehealth for RADV purposes in the future.

Records review shall be performed in accordance with industry standards for coding and reporting, i.e., ICD-9-CM 9th Revision (and/or ICD-10-CM 4th Edition as applicable).

Health Risk Assessment in RADV

In the 2014 Benefit Year, the Health Connector will evaluate the use of Health Risk Assessments ("HRAs") in supporting support medical diagnoses on claims for RADV purposes. Depending on findings from the 2014 RADV, the Health Connector will determine whether or not to accept HRA data in 2015 and future years.

IVA Inter-Rate Reliability

IVA auditors shall report inter-rater reliability rates amongst its reviewers to the issuers and the Health Connector. The minimum threshold for acceptable consistency among reviewers is at 85% for both demographic and enrollment data review and health status data review outcome. Reviews conducted by senior reviewers are used to establish testing thresholds or standards for consistency.

3.5 IVA Findings and Results

A risk adjustment error occurs when a discrepancy uncovered in the RADV process results in a change to the enrollee's risk score. It may result from incorrect demographic data, an unsupported HCC diagnosis, or a new HCC diagnosis identified during the medical record review. An unsupported HCC diagnosis could be the result of missing medical record documentation, medical record documentation that does not reflect the diagnosis, or invalid medical record documentation (e.g., unauthenticated records, or a record that does not meet RA data collection standards).

Risk adjustment error should be confirmed by a senior reviewer with in the IVA entity, who is a reviewer with credentials from AHIMA (or another nationally recognized accrediting agency) with at least 3 years of experience in medical coding.

IVA entities shall document the findings and report to the Health Connector. The Health Connector will provide reporting templates and key metrics to be used for documenting IVA findings in the future. IVA entities shall provide the Health Connector and its SVA auditor with the final results from the IVA and all requested information.

Starting in the 2016 Benefit Year, for those issuers that failed to submit IVA audit findings and results to the Health Connector within the timeframe specified by the Health Connector in the 2016 State Payment Notice, consistent with the Federal Program Integrity Rule, the Health Connector is considering applying a default charge as described in Section 4.3.

We are interested in comments and feedback from the issuers in Massachusetts and the broad stakeholder community regarding this approach, and will finalize the methodology in the 2016 State Notice.

3.5 Second Validation Audit

The Health Connector will engage one or more entities to conduct SVAs. SVA entities shall meet the same general conflict-of-interest requirements as the IVA auditors, and shall also have relevant expertise in conducting SVA. The SVA entity will use the same audit standards as are used in the IVA to conduct its review.

The SVA will be performed on a subset of the IVA sample. The Health Connector will select the SVA sample using a sampling methodology that will allow for pair-wise means testing to establish statistical difference between the IVA sample and the SVA sample.

Pairwise statistical difference between IVA and SVA results will be evaluated by the SVA at the 95% confidence interval. If no statistical difference is found, then the issuer's risk adjustment error rate will be based on the IVA results. If pair-wise test results suggest a statistical difference, the SVA auditor will perform another audit on a larger subsample of up to 100 members from the IVA sample. If no statistical difference is found from the larger sample, the issuer's risk adjustment error rate will be based on the IVA results. Otherwise, the SVA results will be applied.

Extrapolation of the error rate will be based on a stratum-by-stratum basis and then weighted accordingly to achieve an estimate of the correct risk score for each issuer.

3.6 Appeals

Consistent with the federal approach, the Connector will be developing an appeals process for RADV to coincide with the implementation of actual changes to payments and charges as a result of RADV. As described above and consistent with the federal approach, the Connector will not be applying error rates to adjust payments and charges for the initial two years of the program. The Connector anticipates that the appeals process would begin after the completion of the RADV process associated with the 2016 plan year payment cycle (which occurs in 2017).

The Connector will seek input from issuers and other stakeholders on its RADV appeals process. Consistent with the federal approach, for purposes of RADV conducted during the 2014 and 2015 benefit years, the Connector will focus on obtaining feedback from issuers regarding the RADV process in order to learn as much as possible about the accuracy, effectiveness, and efficiency of RADV, and make changes as appropriate.

4. Program Integrity

In this section, we describe the processes and mechanisms the Health Connector will implement to ensure the integrity of the Commonwealth's risk adjustment program.

4.1 Obtaining Complete Risk Adjustment Data

Under federal regulation, risk adjustment payment transfer calculations shall be completed by the end of June of the year following the benefit year. The Health Connector is unable to extend this timeline. Thus, it is important that the Health Connector have contingency plans in place should issues arise that cause delays in the creation of the data extract or the calculation of issuer payments and charges.

Claims incurred between January 1 and December 31 of a Benefit Year and paid through March 31 of the following year by members enrolled in Risk Adjustment Covered Plans ("RACP") will be used for funds settlement for that Benefit Year. As noted above, data collection under the Massachusetts risk adjustment program is facilitated through the State's APCD. Issuers will be required to submit data to the APCD by April 30 of the year following the Benefit Year. CHIA will take some time to conduct online edits, encrypt the member ID, and provide an extract to the Health Connector for risk adjustment calculations. Future years will follow a similar schedule.

Benefit Year	Claims Incurred	Paid Through	Data Submitted to APCD by Issuers	Funds Settlement Calculation
2014	January 1, 2014 - December 31, 2014	March 31, 2015	By April 30, 2015	By June 30, 2015
2015	January 1, 2015 - December 31, 2015	March 31, 2016	By April 30, 2016	By June 30, 2016

Note: Future years follow a similar schedule

It is possible that unexpected issues may arise, such as missing data or delayed data submissions from one or more issuers, which in turn cause delays in the creation and transmission of the risk adjustment data extract. Below we describe the Health Connector's contingency plans should such situations arise.

In the event of unexpected delays or other data issues, issuers shall notify both the Health Connector and CHIA immediately. The Health Connector will obtain a good understanding of the cause and magnitude of the issues and, to the extent possible, estimate a new timeline for completing risk adjustment annual settlement calculations, which are to be completed by June 30, 2016 for the 2015 Benefit Year.

The Health Connector will seek to work with issuers to resolve these issues so as to allow timely completion of the risk adjustment annual settlement calculations. However, if this is not feasible and the delays or data errors would prevent the Health Connector from calculating payment transfers for an issuer by the federal deadline of June 30, the Health Connector plans to use the default charge methodology described in Section 4.3. The default charge will be applied retrospectively to the Benefit Year in question and settled by June 30 of the following year.

4.2 Compliance with RADV Requirements

Starting in the 2016 Benefit Year, RADV findings in a given year will result in adjustments in risk adjustment funds transfer amounts prospectively in the next Benefit Year. The Health Connector is considering options relating to the timing of RADV process for the 2016 Benefit Year. The Health Connector will seek comments and feedback regarding the RADV process for the 2016 Benefit Year, to include insights drawn from earlier years' experience.

4.3 Default Charge

As noted above, the Health Connector is considering imposing a default charge on issuers who fail to submit data to the Commonwealth's APCD within the timeframe required.

The total risk adjustment default charge for a risk adjustment covered plan would be calculated as below.

$T^n = C \times E^n$, where

T^n = total default risk adjustment charge for plan *n;*

C = the highest PMPM transfer amount in the Commonwealth's merged market for a given Benefit Year; and

E^n = total enrolled member months for plan *n*, collected from the issuer directly, or estimated using the geometric average of historic enrollment data for plan *n* in the APCD, or from the MLR and risk corridor filings for the applicable benefit year.

Default charges may be applied for either (i) failure to submit data accurately or on time for the settlement calculations or (ii) failure to submit findings of IVA audit.

- Default charges resulting from data issues and delays are applied retrospectively. As such, the first year a default charge will apply in this situation is for the 2014 Benefit year, retrospectively done by June 30, 2015;
- Default charges relating to RADV are applied prospectively. The first year a default charge will apply in this situation is for the 2016 Benefit Year - applied to the 2017 Benefit Year payment cycle (which will be settled by June 30, 2018).

4.4 Ensuring Complete Payment Transfers

Immediately following the annual risk adjustment funds transfer calculations, the Health Connector will move on to funds transfer settlement for all issuers, in which the Health Connector will collect payments from issuers who will pay into the risk adjustment pools and issue checks to those who will receive a payment from the risk adjustment pool. Below we describe the details of the process, roles and responsibilities, reporting requirements, and timelines and milestones.

The illustrative example below is for the 2014 Benefit Year, and future years will follow the same process unless otherwise specified by the Health Connector.

1. The Health Connector will complete risk adjustment funds transfer calculations and provide notifications all issuers offering risk adjustment covered plans by June 30, 2015
2. The Health Connector Accounting team within the Finance Department will issue invoices to issuers that must contribute to the risk adjustment pool ("Payors"). This will occur within first week of July 2015. Payments must be received by the last business day of July, 2015 and will be held in a designated Health Connector bank account
3. The Health Connector Accounting team will issue risk adjustment transfers to those issuers that are recipients of risk adjustment transfers ("Recipients") and disburse any generated investment income earned on funds held by the Health Connector back to the Payors on or by the 15th business day of August, 2015
4. Upon completing payments to Recipient issuers, the Health Connector will review all financial transfers to ensure that the Health Connector is revenue neutral at the end of the process. The Health Connector's external financial auditor will also audit the process to ensure budget neutrality. Budget reconciliation and balancing records will be retained by the Accounting team. Together with the auditor's report, the records will be submitted to HHS as part of the initial program summary report and the annual program report

Under the risk adjustment program, the Health Connector remains revenue neutral and only provides financial clearance for Payors and Recipients of risk adjustment. As such, it is important for the Health Connector to first receive funds from the Payors before issuing transfers to the Recipients. Late and inadequate payments from Payors negatively impact the Recipients both financially and operationally.

The Health Connector is considering subjecting Payors that fail to make payments in full on time as requested by the Health Connector to financial penalties in addition to the investment income on the funds they owe to the risk adjustment pool. The Health Connector is investigating the authority and mechanisms for assessing financial penalties. The investment income will be disbursed to the Recipients proportional to the funds they will receive from the risk adjustment pool. The Health Connector will calculate available funds and allocate transfers to the Recipient issuers proportionally based on available funds, and make additional transfers when all funds are paid up by those Payors with late or inadequate payments.