



AMERICAN ACADEMY *of* ACTUARIES

January 21, 2011

Ms. Cheri Rice
Acting Director, Medicare Plan Payment Group
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Comment on RADV Sampling and Error Calculation Methodology

Dear Ms. Rice:

On behalf of the American Academy of Actuaries'¹ Health Practice Council, I appreciate this opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) in response to its recent request for comments on the Medicare Advantage (MA) risk adjustment data validation (RADV) payment error calculation methodology. We are concerned that the audit process as currently proposed would apply the risk-adjustment model in a way that is inconsistent with the way it was developed. This letter outlines our concerns.

The Importance of Risk Adjustment

In general, risk adjustment is intended to capture differences in morbidity from one cohort of individuals to another. As such, the CMS hierarchical condition categories (HCC) risk adjustment system is an important component of the MA program. Risk-adjusting plan payments can reduce incentives for plans to avoid high-cost enrollees and can help ensure that plan payments are adequate.

Throughout the development and refinement of the MA risk-adjustment model, CMS has sought to ensure that the risk-adjustment system properly reflects the differences in the risk profile of enrollees in a consistent manner. In addition, CMS has sought to recognize appropriate changes in fee-for-service (FFS) coding over time and differences in coding across programs.

Periodically auditing the data is appropriate to ensure that conditions are coded correctly and that risk scores and the resulting risk-adjusted payments properly reflect the underlying health status of MA enrollees. Because improper coding can result in inaccurate payments to MA plans, RADV audits can help improve plan payment accuracy.

Concerns with Proposed Audit Process

Our primary concern with the proposed audit process is that it creates an inconsistency between how the risk-adjustment factors were developed and how they now would be applied. An underlying principle of risk-adjustment systems is that there needs to be consistency in the way the model was developed and how it is used. The CMS-HCC risk-adjustment factors were developed with FFS data that, to the best of our knowledge, were not validated or audited for accuracy. The proposed audit process, however,

¹ The American Academy of Actuaries is a 17,000-member professional association whose mission is to serve the public on behalf of the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

effectively would apply those factors only to MA data that are validated. In other words, the data used in the RADV audit to determine a plan's payment error are fundamentally and materially different from the data used to develop the risk-adjustment model.

If, as a result of the RADV audit, for example, certain lower-cost enrollees no longer are considered diabetic but would have been considered diabetic in the FFS data used to develop the risk scores, then the payment for diabetic members in the payment year could be inadequate. In this example, the risk score factor associated with diabetes would be understated relative to the factor that would have resulted from using only substantiated diagnoses, because the lower-cost patients would have lowered the average spending amounts among those identified as diabetics in the FFS data. When that factor is applied to similarly non-validated data, the total payments for those with diabetes would be adequate. When that same factor is applied only to those with substantiated data, however, the total payments could be too low.

This type of data inconsistency not only creates uncertainty, it also may create systematic underpayment, undermining the purpose of the risk-adjustment system and potentially resulting in payment inequities. In addition, the uncertainty related to a plan's ultimate post-audit risk score could make it difficult for actuaries to estimate the plan's risk score and certify the plan bid.

Extrapolating RADV payment-error calculations to adjust premium payments to MA plans represents a significant change in the risk-adjustment methodology. The Health Practice Council is concerned that the resulting modified payment methodology may not appropriately reflect the relative risk profile of enrollees in the affected MA plans.

As you may be aware, per a request from CMS (then the Health Care Financing Administration), the Academy reviewed the risk-adjustment methodology that was developed in response to requirements in the Balanced Budget Act of 1997.² We welcome the opportunity to serve as a similar resource to CMS. We would be happy to study more closely the current risk-adjustment and proposed audit processes and to consider potential options for addressing the above concerns. If you have any questions or would like to discuss these comments further, please contact Heather Jerbi, the Academy's senior health policy analyst (202.785.7869; Jerbi@actuary.org).

Sincerely,

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Vice President, Health Practice Council
American Academy of Actuaries

cc: Richard Foster, Chief Actuary, Centers for Medicare & Medicaid Services (CMS)
Paul Spitalnic, Director, Parts C and D Actuarial Group, CMS
Timothy Hill, Deputy Director, Center for Medicare, CMS
Jennifer Harlow, Director, Division of Payment Validation, Medicare Plan Payment Group, CMS

² American Academy of Actuaries' Risk Adjustor Work Group, *Actuarial Review of the Health Status Risk Adjustor Methodology*, Jan. 14, 1999: <http://www.actuary.org/pdf/medicare/hcfariskadj.pdf>.