

Engaging the Physician in Risk Adjustment

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GEMCare Medical Group

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Who are we?

- GEMCare Medical Group (IPA model)
 - 1992
 - 100 PCPs, 200 SPCs, Bakersfield area
 - Commercial and Senior HMO
 - Self-funded groups
- GEMCare Health Plan (Knox-Keene)
 - January 2007
 - MAPD



Best of Both Worlds

- Health Plan
 - Receives 100% of Medicare capitation
 - Can encourage innovation in prevention
- Medical Group
 - Direct involvement with physicians – have the records
 - Pays claims – has the data





Innovative Clinical Resources

- Home Nurse Practitioner Program
- Case Managers
 - Social Workers
 - Palliative Care nurse
- Transportation contract
- After-hours clinic

Physician Engagement

What we've learned



- What's in it for me?
- Medical record-billing disconnect
- Willing to help, unable to change
- What isn't written, can't be coded

Data Resources

- Extensive data warehouses
 - Authorizations
 - Claims
 - Pharmacy
 - Admissions
- Internet-based Case Management EMR
- Brilliant IT department



The Journey Begins

Risk Adjustment of Medicare Capitation Payments Using the CMS-HCC Model

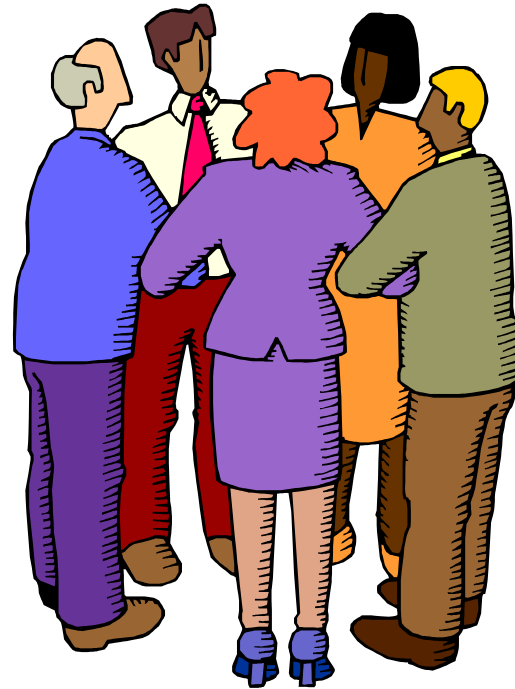
Gregory C. Pope, M.S., John Kautter, Ph.D., Randall P. Ellis, Ph.D., Arlene S. Ash, Ph.D.,
John Z. Ayanian, M.D., M.P.P., Lisa I. Iezzoni, M.D., M.Sc., Melvin J. Ingber, Ph.D., Jesse M. Levy, Ph.D.,
and John Robst, Ph.D.

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Learn and Share

- Secure Horizons
- HealthNet
- Sharp Healthcare
- CMS website
- ScanHealth
- ICE
- Clear Vision



Looking for Gaps



Member Name:
Member ID:

<u>HCC</u>	<u>HCC Description</u>	<u>Status</u>	<u>Time Period</u>
2	Septicemia/Shock	Verified	Calendar 2004
96	Ischemic or Unspecified Stroke	Verified	Calendar 2004
105	Vascular Disease	Verified	Calendar 2004
108	Chronic Obstructive Pulmonary Disease	Verified	Calendar 2003
131	Renal Failure	Verified	Calendar 2003

Suspected HCC: **108**
Suspected Condition: **Chronic Obstructive Pulmonary Disease**

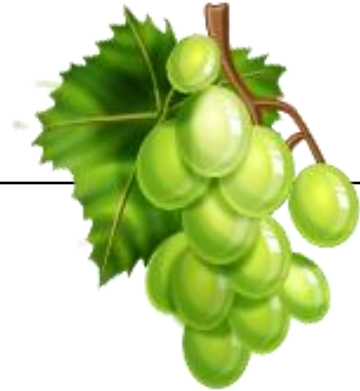
Suspected Time Period(s): **Calendar 2004**

**Last DOS the ICD-9 code
was documented in
medical record for**

**Last DOS the ICD-9 code
was documented in
medical record for**

ICD-9	ICD-9 Description	2003	2004	ICD-9	ICD-9 Description	2003	2004
491	CHRONIC BRONCHITIS*	/ /	/ /	492	EMPHYSEMA*	/ /	/ /
4932	NO DESCRIPTION	/ /	/ /	496	CHR AIRWAY OBSTRUCT NEC	/ /	/ /
5181	INTERSTITIAL EMPHYSEMA	/ /	/ /	5182	COMPENSATORY EMPHYSEMA	/ /	/ /

Low Hanging Fruit



- Ostomies
 - DME
 - No claims
 - Authorizations not in PCP's medical record
- Coumadin clinic
 - V58.61 Long-term use of anticoagulants
- Wound clinic
 - No coding of cause
- Diabetes coding
 - 250.00

Physician Engagement

The Lessons

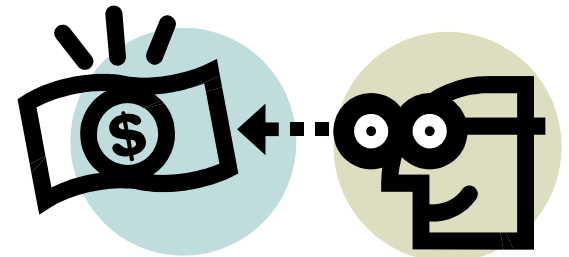
- Need to involve PCPs
 - Prevent the GAPS
 - Identify case management opportunities
 - Better coordination of care
 - Medical home?

Annual Exam for Seniors

- Annual Preventive Visit to PCP
 - HCC
 - Address chronic but stable conditions
 - ICD-9 GAPS
 - Case Management
 - IADL and ADL changes
 - Case management/social work referrals
 - Early identification of worsening symptoms

What's in it for ME?

- Annual Preventive Exam for Seniors
 - \$\$ for 30-40 minute exam
 - Claims with internal modifier



Annual Exam Documentation

- Case Management Assessment Form
 - Restated Problem List and Medication List
 - IADL and ADL
 - Social need changes

- HCC-ICD-9 Cheat Sheet

Provider Education



- Developed “HCC 101”
 - Theory of Risk Adjustment
 - Financial impact to medical group
 - Annual exam to have PCP involved
- Pilot:
 - Medical Director presentation to individual physicians
 - Developed resources for office
 - Patient level detail from RevenueMax
 - Updated monthly ! (Physicians won’t bother with old information)
 - List of patients with “No HCC”
 - HCC-ICD-9 Summary Sheet
 - Complete listing of all HCC diagnoses
- Very interested

CASE MANAGEMENT ASSESSMENT

Name			Today's Date
Gender	Male_____	Female_____	DOB
			Age

Problem List

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Medication List (include OTC and herbals)

1. _____ 5.
2. _____ 6.
3. _____ 7.
4. _____ 8.

Specialists seen in last year (Name, problem)

1. _____
2. _____
3. _____
4. _____

IADL instrumental Activities of Daily Living
 Telephone, Travel, Food shopping, Meal preparation, Medication use, Money management
 Independent_____ Assistance needed_____ Dependent_____

ADL Activities of Daily Living
 Bathing, Dressing, Transferring, Walking, Eating, Toilet
 Independent_____ Assistance needed_____ Dependent_____

Transportation
 Patient drives _____ Lives with driver _____ Friends/Neighbors drive _____

Living Situation
 Alone_____ Independent with spouse _____ With family_____

Preventive Care Needed:

Mammogram_____	Cervical Ca Screen_____	Prostate Ca Screen_____
Colorectal Ca Screen_____	Diabetes self mgmt help_____	
Flu shot_____	Pneumovax_____	

Referrals Needed:
 Case Management _____ Social Work _____ Palliative Care Nurse _____

Advance Directive
 Yes _____ No _____ Durable Power of Atty for HC (name) _____
 Code Status _____

Case Management Assessment form



Using HCC Report

						2008 (2007 Visits)	2009 (2008 Visits)		
1/04/1928	00000460		F	75-79	104 Vascular Disease with Complications	.645		441.01	441.01
9/12/1929	00001118	Xxxxx xxxxx	F	75-79	108 Chronic Obstructive Pulmonary Disease	.398	Not HP	Not HP	
6/16/1920	00000992	xxxxx xxxxx	F			.181	Not HP	250.00	250.00
		xxxxx xxxxx						250.01	250.03
		xxxxx xxxxx			80 Congestive Heart Failure	.395		428.32	428.32
12/22/1924	00002844		M	80-84	83 Angina Pectoris/Old Myocardial Infarction	.231	Not HP		
					108 Chronic Obstructive Pulmonary Disease	.398	496		
2/12/					Congestive Heart Failure	.395	428.0	428.0	
					Myocardial Infarction	.349	410.41	410.41	
					Old Heart Arrhythmias	.295	427.31	427.31	427.81
							427.81	427.81	
					105 Vascular Disease	.324	440.0	440.0	

Still needs to be reported for 2008.

**COPD and CHF shouldn't resolve.
Unless previous ICD-9s were an error.
Please recheck**

Atrial Fib already reported

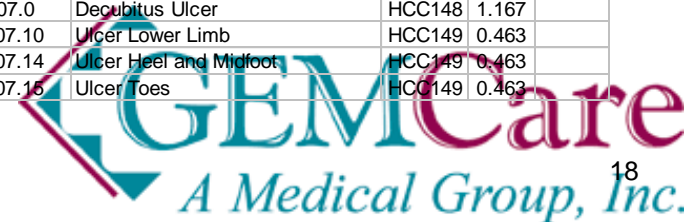
*Report from RevenueMax
by Clear Vision Information Systems*



HCC-ICD-9 Form

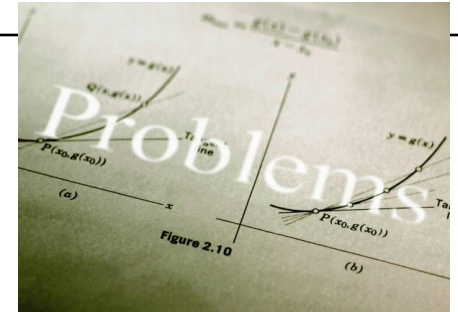
Check ALL appropriate codes

HCC - ICD-9 Sheet - Primary Care						GEMCare Annual Physical Exams					
Name						DOB		DATE		HP	
		ICD-9	DiagDescr	HCC	Coef						
2007	2008					Add on?	2007	2008			Add on?
		001-139 Infectious and Parasitic Disease									
		070.54	Chronic Hep C w/o coma	HCC27	0.303				436	Unspec CVA	HCC96 0.303
		114.0	Prim Coccidiomycosis	HCC112	0.233				438.20	Late Effect of CVA - Hemipleg Her	HCC100 0.41
									440.0	Atherosclerosis of Aorta	HCC105 0.324
		140-239 Neoplasms							440.21	Atherosclerosis of Ext Art w Clauc	HCC105 0.324
		146.9	Malig Oropharynx	HCC9	0.771				441.4	Abd Aneur w/o Rupture	HCC105 0.324
★	★	153.9	Malig Colon	HCC10	0.258				443.81	Peripheral Angiopathy (e.g. diabet	HCC105 0.324 250.7
		154.1	Malig Rectum	HCC10	0.258				443.9	Periph Vasc Disease	HCC105 0.324 250.7
		157.9	Malig Pancreas	HCC8	1.648				451.19	Phlebitis & Thromb Deep Low Ext	HCC105 0.324
		162.9	Malig Lung	HCC8	1.648				453.8	Phlebitis & Thromb Other Veins	HCC105 0.324
		174.9	Malig Breast	HCC10	0.258				460-519 Respiratory System		
		176.9	Kaposi Sarcoma	HCC9	0.771				482.89	Pneumonia Bacterial	HCC111 0.761
		185	Malig Prostate	HCC10	0.258				491.20	Obst Chronic Bronchitis w/o Exac	HCC108 0.398
		188.9	Malig Bladder	HCC10	0.258				492.8	Emphysema	HCC108 0.398
		189.0	Malig Kidney	HCC10	0.258				493.20	Chronic Obst Asthma	HCC108 0.398
		195.0	Malig Head Face Neck	HCC10	0.258			★	496	Chronic Airway Obst	HCC108 0.398
		201.90	Hodgkins	HCC9	0.771				520-579 Digestive system		
		202.80	Other Lymphoma	HCC9	0.771				571.2	Alcoholic Cirrhosis	HCC26 0.519
		203.00	Myeloma w/o remission	HCC9	0.771				571.40	Chronic Hepatitis	HCC27 0.303
		204.10	Lymphoid Leukemia w/o remissior	HCC9	0.771				571.5	Cirrhosis w/o Alcohol	HCC26 0.519
		205.10	Myeloid Leukemia w/o remission	HCC8	1.648				577.1	Chronic Pancreatitis	HCC32 0.383
		238.7	Other Lymp Hemato	HCC44	1.136				580-629 Genitourinary System		
		250.0x	Diabetes w/o Complication	HCC19	0.181				583.81	Nephritis	HCC132 0.182 250.4x
★		250.4x	Diabetes w Renal	HCC15	0.608	583.81			586	Unspecified Renal Failure	HCC131 0.389
	★	250.6x	Diabetes w Neuro	HCC16	0.452	357.2			680-709 Skin and Subcutaneous Tissue		
		250.7x	Diabetes w Periph Vasc	HCC15	0.608	443.81			707.0	Decubitus Ulcer	HCC148 1.167
		250.8x	Diabetes w Ophthal	HCC16	0.452	362.02			707.10	Ulcer Lower Limb	HCC149 0.463
		263.9	Protein-Calorie Malnutrition	HCC21	0.82	V44.x			707.14	Ulcer Heel and Midfoot	HCC149 0.463
									707.15	Ulcer Toes	HCC149 0.463



Brilliant Idea Confronts Real World

- G0344 “Welcome to Medicare”
 - Limited to first 6 months of enrollment
 - Only one-time
- HCFA 1500 form limited to 4 diagnoses
 - V70
- PCPs willing to help, unable to change



Early Results

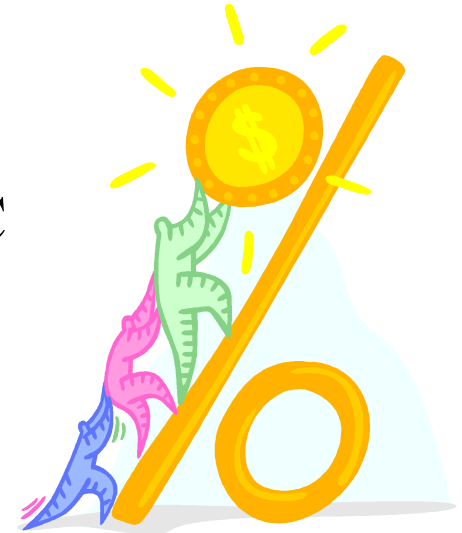
- Physicians delegated task to front office
 - Added “front office” to in-services
- Prior HCCs (GAPS) weren’t addressed
 - Forgot to use the RevenueMax reference
 - Some “chronic” conditions not confirmed
- Billers continue to use V70
 - We added “billers” to in-services
- Limited to 4 codes on 1500 form
 - Administrative data

Medical Record – Billing Disconnect

- Superbill/Charge Slip sent to billing service
 - No documentation sent
 - “Code first”, “also use”, and causality ignored
- Or, Progress note sent to biller
 - Billing service codes the visit
 - No access to prior visits, consult notes, lab, imaging, or medication list
 - Not able to ask questions or offer suggestions
- Medical Record has no billing information
 - Provider doesn’t know what was billed
 - Validation audit

Battle continues

- After nine months
 - 1300 annual exams
 - Each annual exam increased patient's HCC by average .200
 - Not 30 minutes
- Lessening enthusiasm
 - “Nothing's changed since last year's visit!”
 - Problem list/medication list disconnect
- Willing to help, unable to change
 - Office scheduling
 - Office flows



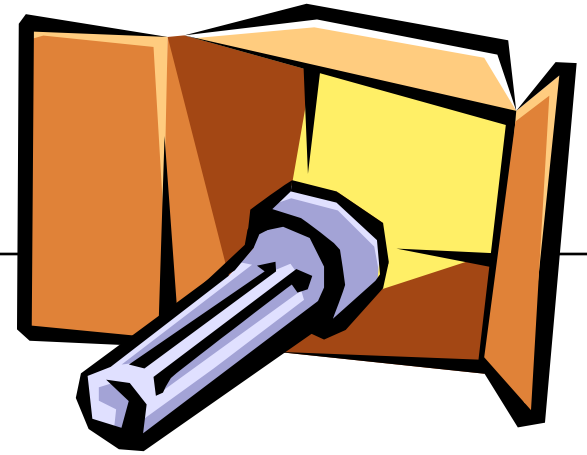
Making it Easier

□ Documentation

- “I don’t want to re-write the Problem List”
 - Submit progress notes and medication list
 - We’ll code

Progress Notes

- There's not much there
 - EMRs
 - Copy-Paste mentality
 - Paper records
 - Poor documentation
 - Use of outside billing service



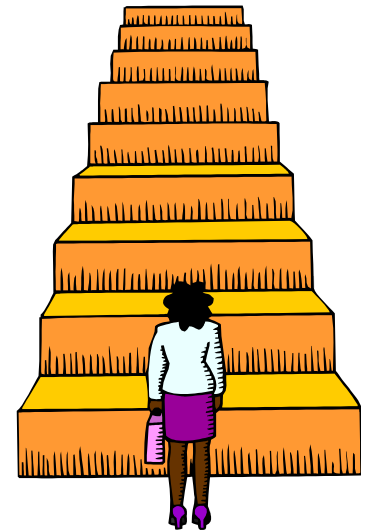
Current Results

- Annual Exam Documentation
 - Medical Record
 - HCC Diagnosis Sheet
 - We code visit
 - Internal Resources
 - Claims and Authorizations
 - Pharmacy records
 - Patient Care Module (in-patient and case management notes)
 - RevenueMax

**Contact Provider
for clarification**

RADV Audit

- Risk Adjustment Data Validation Audit
- Health Plans held accountable for accuracy of coding
 - No direct role in documentation
 - Lack resources for auditing
 - Provider organization role instead
- Difficult for health plans to estimate risk

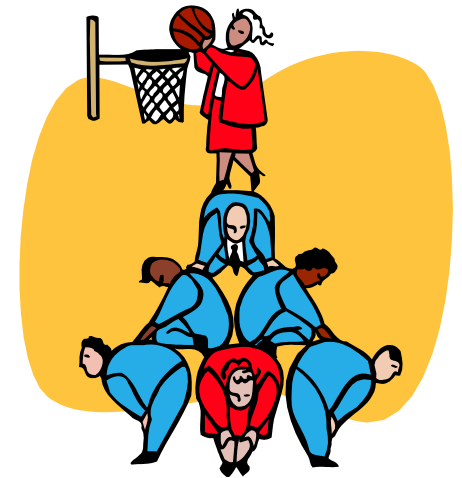


Documentation

- What isn't documented, can't be coded

- Teach physicians to document better
 - Coding is irrational for them
- Use certified coders to code
 - Ask questions of provider

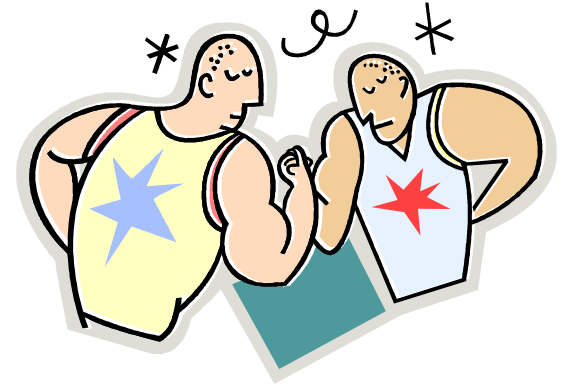
- Health Plan – Physicians
 - Working together?



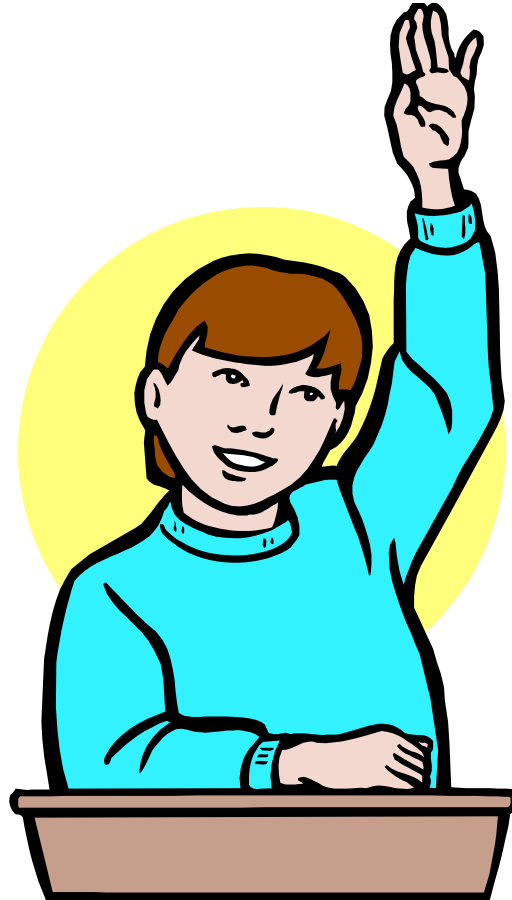
Physician Engagement

What we've learned

- What's in it for me?
 - Hard to show patient care value
 - Pay for their time
- Physician partnership
 - Easier when providers are partners
 - Need current information
- Medical record-billing disconnect
 - Code from medical record
 - Work to improve it
- What isn't written, can't be coded
 - Provide help for coding and billing?
- Willing to help, unable to change
 - Offer money for time
 - Provide human resources for auditing and coding



Questions?



Medicare Advantage Risk Adjustment and Data Validation

Thomas E. Hutchinson
Director, Medicare Plan Payment Group
CMS

*ICE Annual Conference
November 13, 2008*

Presentation Overview

- Review characteristics of the Part C risk adjustment model
- Describe how to calculate risk scores and provide example
- Discuss Risk Adjustment Data Validation (RADV)
 - Purpose, objectives and status
 - Sampling and the medical record request
 - Medical record review and discrepancies
 - Findings, disputes and appeals
 - Lessons learned

Why Do Risk Adjustment?

- Risk adjustment used to standardize bids to determine what CMS' payment rate will be to the plan for each enrollee.
- Risk Adjustment allows direct comparison of bids based on populations with different health status and other characteristics
- Risk adjustment is also used to pay more accurately by adjusting the monthly capitated bid-based payments for enrollee health status

What is Risk Adjustment

- A method used to adjust bidding and payment based on the health status and demographic characteristics of an enrollee
- Pay appropriate and accurate payments for subpopulations with significant cost differences
- Protects plans from adverse selection and decreases incentives for plans to “cherry pick”

CMS Risk Adjustment Models

- Currently CMS implements Part C risk adjustment models for 2 key payment areas:
 - The Part C CMS-HCC Model for aged and disabled beneficiaries
 - Community, Long Term Institutional Models, New Enrollee
 - The CMS-HCC ESRD Model for beneficiaries with ESRD
 - Dialysis, Transplant, and Post-Transplant
- Risk scores produced by each model are distinct based on predicted expenditures for that payment method (Part C, ESRD)
- Risk scores are based on enrollee demographics & diagnosis from MA plans and/or Medicare FFS
- Models share a common basic structure

Common Characteristics of Risk Adjustment Models

- Prospective: diagnosis from base year used to predict payments for following year
- Additive factors
- Demographic factors
- Disease factors
- Disease groups contain clinically related diagnoses with similar cost implications
- Hierarchy logic is imposed on certain related disease groups
- Diagnosis sources are inpatient and outpatient hospitals, and physician settings
- New enrollee model components
- Site neutral

RA Model History

Model	Legislation	Payment Years	R ²	Risk Score Basis
AAPCC	TEFRA	1985-1999	1.0%	Demographic- Characteristics
PIP-DCG	BBA	2000-2003*	6.7%	Demographic- Characteristics Inpatient Dx
CMS- HCC	BIPA	2004- present	10.5%	Demographic- Characteristics Inpatient Dx Ambulatory Dx

Demographic Factors in Risk Adjustment

- Age
- Sex
- Disabled Status
 - Applied to community residents
 - Factors for disabled <65 years –old
 - Interaction factors for disabled and Medicaid
- Original Reason for Entitlement
 - Factors based on age and sex
 - >65 years old and originally entitled to Medicare due to disability
- Medicaid Status (for Part C)

Disease Groups/HCCs

- Approximately 3,000 ICD-9 codes in payment model
- Disease groups are based on clinically related diagnoses that have similar Medicare cost implications
- Each disease group relates to a well specified medical condition (examples- diabetes, congestive heart failure)
- Known as disease category or Condition Category (CC)
- Hierarchy logic is imposed on certain disease groups so model is known as the Hierarchical Condition Category (HCC) Model

Disease Groups/HCC (continued)

- Most body systems covered by diseases in model
- Each disease group has an associated dollar coefficient that represents expected health cost for having the respective disease
- Model heavily influenced by costs associated with chronic diseases
 - Major Medicare costs are captured

Part C Risk Adjusted Calculation

- Example: Mrs. Jones is 83 and resides in her Baltimore home. She was determined to be eligible for Medicaid effective September last year, and has been a member of Silver Health plan for several years. Her plan submitted 2 diagnostic codes with dates of service during last year:
 - 410.11, Ami Anterior Wall, Init
 - 808.51, Fracture of Ilium-Open

Part C Risk Adjusted Calculation

(continued)

- Calculating her risk score:
 - Which risk adjustment model applies:
 - Aged/disabled – community model
 - Which 2007 community risk factors applies?
 - Female 80-84 Years = 0.546
 - Medicaid Female, Aged = 0.177
 - Code 410.11 maps to HCC 81 Acute Myocardial Infarction – 0.349
 - Code 808.51 maps to HCC158 Hip Fracture/Dislocation – 0.450
 - Calculate Mrs. Jones' risk score: the sum of her risk factors = 1.522

Part C Risk Adjusted Calculation

(continued)

- The basic Part C payment formula is:
[Base payment rate* enrollee risk score]+ additional payment amount if plan offers additional benefits
- Payment calculation for Mrs. Jones:
 - Silver Health plan has base payment rate for Baltimore county residents of \$932 per person per month, and receives from CMS an additional payment amount of \$32 per person per month for offering additional vision and dental benefits.
 - CMS' monthly payment to Silver Health plan for Mrs. Jones:
 $(\$932 * 1.522) + \$32 = \$1,450.50$
- Payment calculation for Mrs. Jones if she was not Medicaid eligible and did not have any diagnosis submitted::
 - CMS' monthly payment to Silver Health plan for Mrs. Jones:
 $(\$932 * .546) + \$32 = \$540.87$

Risk Adjustment Data Validation Purpose

- The purpose of Risk Adjustment Data Validation (RADV) is to ensure risk adjusted payment integrity and accuracy.
- RADV process uses medical record review to validate enrollee diagnoses submitted by MA organizations for risk adjusted payments.

Performance of RA Models

- Measured by comparing predicted payments to actual costs
- Predictive Ratio = (Predicted / Actual)
- Predictive Ratios separately for varying risk levels – deciles
- Part C model performs well for dual eligible, institutional and chronic disease populations
- Part D model is performing very well across all levels of risk for both Regular and Low Income Subsidy beneficiaries

Predictive Ratio for Diabetes (2004-2005 Calibration)

Diabetes Diagnosis in 2004 (5% Community and Institutional Sample)

Risk Percentile	Actual	Predicted	Predicted/Actual
First Decile	3,962	3,677	0.928
Second Decile	4,849	4,727	0.975
Third Decile	5,818	5,771	0.992
Fourth Decile	7,050	6,952	0.986
Fifth Decile	8,238	8,313	1.009
Sixth Decile	9,766	9,978	1.022
Seventh Decile	11,726	12,076	1.030
Eighth Decile	14,589	14,988	1.027
Ninth Decile	19,365	19,622	1.013
Tenth Decile	32,364	31,599	0.976

Predictive Ratio for Congestive Heart Failure (2004-2005 Calibration)

Congestive Heart Failure Diagnosis in 2004 (5% Community and Institutional Sample)

Risk Percentile	Actual \$	Predicted \$	Predicted/Actual
First Decile	7,118	6,962	0.978
Second Decile	9,381	9,218	0.983
Third Decile	10,845	10,897	1.005
Fourth Decile	12,483	12,554	1.006
Fifth Decile	13,934	14,280	1.025
Sixth Decile	15,935	16,207	1.017
Seventh Decile	18,284	18,518	1.013
Eighth Decile	21,435	21,596	1.008
Ninth Decile	26,036	26,294	1.010
Tenth Decile	39,438	38,349	0.972

Risk Adjustment Research and Development Part D

- New model will be based on actual experience under the Part D program
 - Similar Methodology to current Part C Model
 - Clinically based
 - Prospective – we will use 2007 predictors and 2008 program drug cost data to develop model
 - We will consider using demographic, diagnostic, and drug data to enhance the predictive power of the model
 - Implemented 2011

Risk Adjustment Operational Policy

- Transitioning from ICD 9 to ICD 10 codes (proposed October 1st, 2011)
- Collection of Encounter Data
 - Regulatory Authority
 - Timeline not established

Information on Risk Adjustment Models and Risk Scores

- The updated CMS-HCC model is available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage
- The Part D risk adjustment model is available at http://www.cms.hhs.gov/DrugCoverageClaimsData/02_RxClaims_PaymentRiskAdjustment.asp#TopOfPage
- Comprehensive list of required ICD-9 Codes for 2005-2008 is available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage

Risk Adjustment Data Validation History

- Starting with CY 2000 payments, CMS has conducted annual RADV audits
- In the early years, payment recovery was conducted on sampled beneficiaries only
- As announced in the 2009 Rate Announcement, CMS has increased focus on the RADV audit process
- Payment error reporting is required to ensure compliance with the Improper Payments Information Act of 2002

Risk Adjustment Data Validation

Current Status

- Currently working on CY 2007 RADV, which is based on CY 2006 diagnostic data
- Earlier in the summer a medical record request was sent to pilot plans. These records are being reviewed now.
- A request to approximately 30 more plans will be sent out in November/December
- Approximately 200 beneficiaries will be sample from each of these plans, which will result in approximately 800 to 1,000 medical records being requested

Risk Adjustment Data Validation Objectives

- Identify risk adjustment discrepancies
- Verify enrollee CMS-HCCs
- Calculate enrollee-level payment error
- Estimate national and contract-level payment errors
- Implement contract-level payment adjustments

Risk Adjustment Data Validation

- Submitted risk adjustment diagnoses map to HCCs and result in payment increases
- All HCCs that contributed to payment for the sampled enrollees will be reviewed
- Medical record documentation must provide diagnosis evidence to substantiate the enrollee HCC(s) being validated

RADV Policies

- CMS will make contract-level payment adjustments based on samples
- Plans should submit the “one best” medical record for each sampled enrollee HCC by the specified deadline.
- Physician attestations for problematic medical records will be allowed during the medical record review in certain circumstances.
 - Missing/illegible signature and/or credential related HCC discrepancies
 - Diagnosis-coding related HCC discrepancies

RADV Policies (continued)

- A Documentation Dispute process will be implemented to allow organizations to dispute the medical record review findings from a coding perspective
- A new Appeals process will follow the Documentation Dispute process

Risk Adjustment Data Validation Stages

<u>Stage</u>	<u>Description</u>
Stage 1	Sampling and Medical Record Request
Stage 2	Medical Record Review (MRR) - initial and second validation reviews
Stage 3	MRR Findings, Attestations, and Contract-level Payment Adjustments
Stage 4	Documentation Dispute
Stage 5	Post Documentation Dispute Payment Adjustment
Stage 6	Appeals

CY 2007 Sample Universe

STAGE 1

- January 2007 contract and enrollee cohort
- Eligible contracts: January 2007 active MA contracts, PACE, and dual demonstration organizations (all receive risk adjusted payments)
- Eligible January 2007 enrollees
 - Continuously enrolled with at least one HCC - enrollees in the same contract from January 2006 through January 2007 (national and contract samples)
- Data collection period: January 2006 through December 2006 dates of service

Stratified Random Sample

STAGE 1

- Enrollees will be sampled and all CMS-HCCs for the enrollee will be validated
- Two types of RADV samples:
 - National sample: estimate national payment error
 - Strata based on national risk score distribution
 - Contract-specific samples: estimate contract-level payment error
 - Contracts targeted from MA Coding Intensity Study
 - Contracts randomly selected from among all active contracts
 - Strata based on contract-specific risk score distribution
 - Approximately 200 beneficiaries will be sampled

Medical Record Request

STAGE 1

- Selected contracts receive
 - Enrollee list containing diagnoses and HCCs to be validated
 - Instructions for submitting medical records
 - Coversheets for each unique enrollee HCC being validated containing
 - Enrollee demographic information
 - Risk adjustment data (HCCs and ICD-9-CM codes)

Medical Record Submission (MAO Response)

STAGE 1

- Select the “one best medical record” for each enrollee HCC
 - Where the enrollee may have medical records from multiple providers and/or dates of service, select and submit only the one best “medical record” to support the HCC
- Medical records will not be accepted after CMS’ official deadline

Medical Record Review

STAGE 2

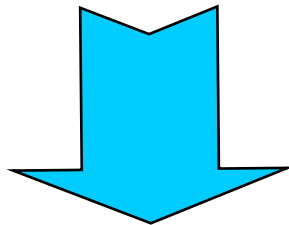
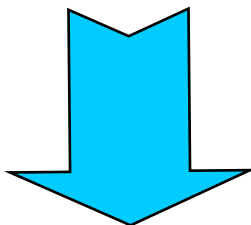
GOOD DOCUMENTATION = ACCURATE PAYMENTS

Visit

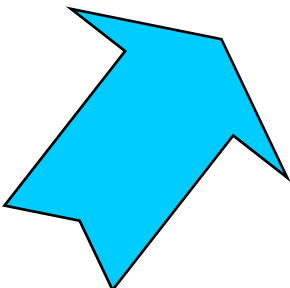
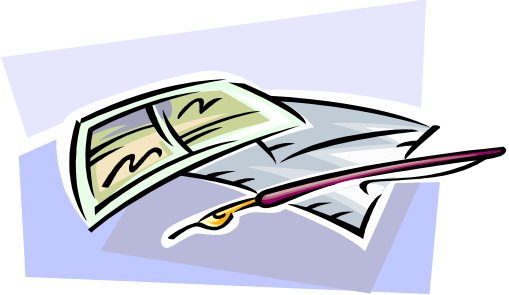


Assign Diagnosis Code

ICD-9 Code



Document Visit



Submit and Obtain Risk Adjusted Payment



RADV Guiding Principle

- Risk adjustment diagnoses submitted for payment must be:
 - Documented in a medical record from a face-to-face encounter (between a patient and provider)
 - Coded in accordance with the *ICD-9-CM Guidelines for Coding and Reporting*
 - Assigned based on dates of service within the data collection period AND
 - From an appropriate RA provider type and RA physician specialty

Risk Adjustment Discrepancy

- Definition: HCC assigned based on submitted risk adjustment diagnoses differs from the HCC assigned after medical record review
- Impacts enrollee risk score
- Changes payment for enrollee

RADV Discrepancies

STAGE 2

- Risk Adjustment Discrepancy Types
 - Invalid Medical Records
 - Unacceptable provider type or physician specialty
 - Date(s) of service outside of data collection period
 - Missing provider signature or credentials
 - Missing Medical Records
 - Cannot assign ICD-9-CM code due to insufficient or incomplete documentation
 - No medical record documentation submitted for the enrollee could support the HCC
 - Coding Discrepancies that change HCC assignment
 - ICD-9-CM code assigned after validation does not support the original enrollee HCC

MRR Findings, Attestations and Contract-Level Payment Adjustments

STAGE 3

- MA organizations will receive:
 - Enrollee level HCC findings
 - An opportunity to provide an attestation related to discrepant diagnosis and physician signature & credentials
- Contract-level payment error estimates and adjustments

Documentation Disputes

STAGE 4

- MA organizations may dispute enrollee-level HCC findings based on the application of the ICD-9-CM guidelines by the MRRCs

Post Documentation Dispute – Payment Adjustment

STAGE 5

- CMS will
 - Use dispute findings to re-estimate payment error
 - Make additional contract-level payment adjustments based on revised error estimates

Appeals

STAGE 6

- Process for filing requests for appeal to CMS Office of Hearings will be announced

Recommendations & Lessons Learned

- Independent (non-CMS) Validation Activities
 - Conduct ongoing internal process to confirm accuracy of risk adjustment diagnoses from providers
 - Organize an internal validation team (e.g., MCO, IT, quality, compliance, coding)
 - Use newsletters and CMS training tools to inform internal staff and physicians about risk adjustment

Recommendations & Lessons Learned to Date (continued)

- CMS-related Validation Activities
 - Query your provider data
 - Establish and maintain communication with providers
 - Organize an internal validation team
 - Plan accordingly—may require more effort to obtain medical records from
 - Specialists
 - Non-contracted providers
 - Hospital outpatient or PCP settings
 - Use data validation technical assistance tools
 - Ensure medical record documentation is complete
 - Adhere to the submission deadline