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Risk Adjustment, RADV Audits and Impact on Providers

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Agenda

- Basics of Risk Adjusted Payments
- Risk Adjustment Data Validation (RADV) Audits
- What Risk Adjustment Means to Providers

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Risk Adjusted Payments – How Medicare Organizations are Paid

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Payments to Medicare Advantage Organizations (MAOs)

- The Bid Amount in Relation to the Benchmark and then adjusted
  - FFS Normalization Adjustment
  - Coding Intensity Adjustment
  - Risk Adjustment Factors

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Risk Adjusted Payments – High-Level Basics

- Capitated payments are “risk adjusted” to account for the health status of each enrollee.
  - Risk scores measure relative risk
  - Used to adjust payments for each beneficiary’s expected expenditures
  - Based on an individual's **diagnoses** and **demographics**
- MAOs submit diagnosis data to CMS in order to receive these risk adjusted payments.
  - Diagnosis data received from providers.

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Risk Adjusted Payments - HCCs

- CMS has implemented the CMS Hierarchical Condition Category Model (“CMS-HCC model”) that groups medical conditions that have similar costs of treatment into Hierarchical Condition Categories (HCCs) to establish a “risk score” for each enrollee.
  - Statistical model that measures *incremental predicted costs* associated with a person’s age, gender and disease.
  - Developed using Medicare fee-for-service claims data.
  - Links ICD-9 codes to HCCs.
  - There are currently 70 HCCs.

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Risk Adjusted Payments – HCCs (cont.)

- Each HCC is assigned a coefficient. Each coefficient represents the incremental predicted expenditures associated with assigned demographic and disease.

Disease Coefficients	Description Label	Community Factors	Institutional Factors
HCC1	HIV/AIDS	0.458	1.732
HCC2	Septicemia/Shock	0.766	0.796
HCC5	Opportunistic Infections	0.465	0.471
HCC7	Metastatic Cancer and Acute Leukemia	2.175	0.910
HCC8	Lung, Upper Digestive Tract, and Other Severe Cancers	0.919	0.576
HCC9	Lymphatic, Head and Neck, Brain, and Other Major Cancers	0.706	0.413
HCC10	Breast, Prostate, Colorectal and Other Cancers and Tumors	0.187	0.240
HCC15	Diabetes with Renal or Peripheral Circulatory Manifestation[1,4]	0.371	0.413
HCC16	Diabetes with Neurologic or Other Specified Manifestation[1,4]	0.371	0.413
HCC17	Diabetes with Acute Complications[1,4]	0.371	0.413
HCC18	Diabetes with Ophthalmologic or Unspecified Manifestation[1,4]	0.371	0.413
HCC19	Diabetes without Complication[1]	0.127	0.173

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Risk Adjusted Payments – HCCs (cont.)

- The risk model is *prospective.*
- Diagnoses from hospital inpatient, hospital outpatient, and physician offices are used to develop risk coefficients.
- The risk factors for disease groups are additive when the diseases are not closely related.
- The groups may be in hierarchies when related.
- The model is periodically calibrated.
  - Calibrated in 2007 and 2009
  - Recalibrated for 2013 using 2008 and 2009 FFS claims
- Premised on the concept that an average risk score is 1.0.

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Risk Adjusted Payments – HCCs (cont.)

- A 1.0 risk score represents average annual Medicare costs for an individual of $7,463.14*
- A risk score higher than 1.0 means the individual is likely to incur costs higher than $7,463.14
- A risk score less than 1.0 means the individual will incur costs less than $7,463.14

** CMS calculates the national predicted average annual costs to be $9,004.65 in the 2013 Advanced Notice*

CMS, Risk Adjustment Slide Presentations, 2011 Regional IT Technical Assistance. Sept. 1, 2011

Risk Adjusted Payments

- Required data elements for risk adjustment:
  - Health Insurance Claim (HIC) Number
  - ICD-9- Diagnosis Code
  - Service From Date – NOTE: the “from” date must be within the data collection year.
  - Service Through Date – NOTE: the “through” date must be within the data collection year.
  - Permissible Provider Type
    - Hospital Inpatient
    - Hospital Outpatient
    - Physician services
  - Remember: New CMS Encounter Data Requirements

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Risk Adjusted Payments

- Some services cannot be used for risk adjustment:
  - Laboratory Services
  - Ambulance
  - Durable Medical Equipment
  - Prosthetics
  - Orthotics
  - Supplies
  - Radiology Services

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Are Plans Paid Correctly?

Risk Adjustment Data Validation Audits

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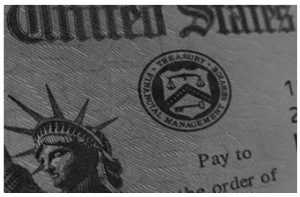
RADV Audits



- CMS issues "improper payment" reports for government programs
- For Medicare Advantage, CMS focuses on risk adjustment errors (that is, whether submitted diagnosis codes are validated by a medical record)
  - CMS estimates that national payment error rate is 11% for FY2011
  - Down from 14% in FY2010
- Risk adjustment data validation (RADV) audits are the process CMS uses to audit HCCs

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RADV Audits (cont.)

- Previous RADV Audits
  - *Pilot audits.* In July 2008, CMS announced a pilot program in which five plans would be subject to RADV audits for CY 2007 payments based on CY 2006 payment data.
  - *Targeted audits.* In 2009, CMS expanded its audits to a broader cohort of plans that also would be subject to RADV audits. These audits are being conducted on a separate timeline from the pilot audits.
- February 24, 2012: Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract – Level Audits
  - CMS plans to conduct 30 RADV audits on payment year 2011
  - Payment errors will be extrapolated to the contract level
  - Extrapolation will incorporate an "FFS Adjuster"
  - "CMS … expects that these contract-level audits will have a sentinel effect on the quality of risk adjustment data submitted for payment…"

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RADV Audits - Authorities and Guidance

- Regulations include RADV appeal process, a document dispute process, and a procedure for obtaining physician-signature attestations. (42 C.F.R. § 422.311)
- However, there is limited information in CMS regulations governing RADV audits themselves.

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RADV Audits - Authorities and Guidance (cont.)

- Process for RADV audits is outlined through sub-regulatory guidance and through correspondence with audited plans.
  - Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide
  - 2009 Call Letter for MAOs
  - Announcement of CY 2009 Medicare Advantage Capitation Rates and MA and Part D Payment Policies
  - MA RADV Notice of Payment Error Calculation Methodology

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RADV Process

Sampling (1)	Medical Record Request (2)	Medical Record Receipt (3)	Medical Record Review (4)	PREL. Audit Report of Findings (5)	Medical Record Dispute (6)	FINAL Audit Report of Findings (7)

CMS, MA Plan Payment Data Initiatives, *CMS Priorities for 2011*, 2010

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RADV Audits -Sampling

- CMS selects MAOs to participate in an audit based on a number of criteria
  - Targeted selection (e.g., based on how the growth in the plans' risk adjustment score compared to that of FFS Medicare)
    - Reading tea leaves?
  - Random selection

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RADV Audits – Sampling (cont.)

- CMS will select 201 "RADV-eligible" enrollees for medical record review
- Enrollees divided into 3 equal groups (strata) based on community risk score
  - 67 enrollees selected from each group
  - 201 enrollees could represent 400-750 (or more) HCCs
- Contracts with fewer than 1,000 RADV-eligible enrollees will be subject to similar stratification process

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RADV Audits
Medical Record Submission

- Initial Validation Contractors (IVC) request medical record documentation to support ***each*** HCC identified for validation
- ***Revised policy***: MAOs may submit multiple medical records for each audited HCC, <u>but</u>
- The "one best medical record" policy will apply to the RADV audit dispute and appeal process

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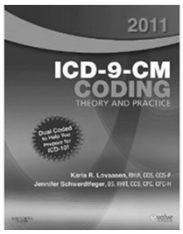
RADV Audits
Medical Record Dispute Process



One Best Medical Record

- Following CMS' review of medical records, CMS will issue a preliminary audit report of findings
- MAOs may challenge specific findings through a medical dispute process
- MAOs may dispute the outcome of CMS' review of coding of submitted medical record documentation
- No new medical record documentation is allowed

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RADV Audits
Medical Record Review Determination

- CMS provides MAOs with a list of HCC errors that are eligible for appeal
- MAOs may only submit for review the one best medical record and attestation previously submitted
- 42 C.F.R. § 422.311 establishes two appeal processes:
  - Medical record review determination appeals
  - Payment error calculation appeals
- Appeal levels
  - Hearing by CMS designated officer
  - Review by CMS Administrator at his/her discretion

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RADV Audits - Payment Error Adjustments

- Following the Medical Record Dispute process, CMS will calculate the payment error adjustment amount
- CMS will recover net overpayments identified during the RADV audit that result from diagnosis data that is not justified by the medical record documentation
- Payment error extrapolation calculation incorporates FFS Adjuster
  - FFS Adjuster accounts for the fact that the documentation standard used in RADV audits to determine a contract's payment error (medical records) is different from the documentation standard used to develop the Part C risk-adjustment model (FFS claims)

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RADV Audits
Payment Error Calculation Appeals

- MAOs may appeal the calculation of RADV payment error
- MAOs may not appeal:
  - RADV payment error calculation methodology
  - Methodologies that CMS applies during the RADV audit
- Appeal levels:
  - Reconsideration by CMS or CMS contractor
  - Hearing by CMS hearing officer
  - Review by CMS Administrator at his/her discretion

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What's the Big Deal?

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Risk Adjustment Payments and RADV Audits

- MAOs want to ensure that all legitimate diagnosis codes are reported
- MAOs must rely on providers to capture these diagnosis codes
- Many MAOs reimburse providers based on Medicare revenue
- Previously, CMS applied payment adjustments only at the enrollee level (i.e., a payment adjustment was made only to the enrollee for whom an HCC was determined to be discrepant)
- Depending on the application of the FFS adjuster, extrapolating discrepancies to the contract level could have a significant impact

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Risk Adjustment Payments and RADV Audits

Things to Consider

- Increased auditing and monitoring of records
- Potential impact on contracting between MAOs and providers
- How will “one best medical record” be defined through the document dispute process?
- Relationship between the FFS adjuster and the national payment error rate
- Appropriate coding of coexisting chronic conditions

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Risk Adjustment and Providers

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AGENDA

- Evaluation of RAF on Contract Terms
- Physician Revenue Enhancement Strategies
  - IT Tools
  - PCP Capitation Adjustment
  - Surplus Distribution
- Contract Compliance

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CMIPA – WHO ARE WE?

- Largest independent physician group in Central Massachusetts
  - >200 Primary care physicians and specialists
- Non-hospital affiliated
- 90% practice in 1,2 or 3 physician offices
- 93 separate practices with 17 disparate EMRs

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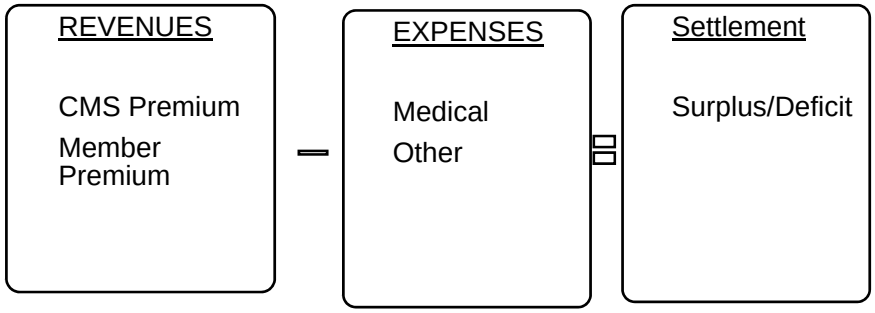
ELEMENTS OF CONTRACT



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EVALUATION OF RAF SCORE ON CONTRACTS

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REVENUES

- On average 90% of the revenue in a provider group's budget comes from CMS premium while 10% comes from Member premium.
- **CMS Premium**:
  - The Health Plan receives monthly payments from CMS for its Medicare Advantage population.
  - Member level dollars are group by IPA and then allocated as appropriate to the Provider's budget.
  - Member level reimbursement is driven by demographics and severity of illness.
- **Member Premium:**
  - The Health Plan collects the monthly member premium.
  - Premium dollars less bad debt are allocated as appropriate to the Provider's budget.

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BREAKDOWN OF CMS PREMIUM

- Premium in health plan product is tied to member.
- Premium is based on demographics, setting and HCCs:
  - John Smith, Male, 65, CHF, Diabetes
    - HCC 80 CHF (RFV 0.395); HCC 15 Diabetes with Renal Manifestation (RFV 0.608)/Age + Sex (.330)
    - Risk Score = .395 + .608 + .330 = 1.333
- HCCs based on prior year's coded diagnoses from IP and OP ICD-9 codes.
- Physician diagnostic coding impacts revenues (RAF).

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APPLICATION OF TOTAL REVENUE

Member Enrollment	**558 members**	**6696 member months**	
Revenue:		Dollars	PMPM
CMS		$4,532,656.3	$676.92
	Adjuster for retroactive payment	$132,312.96	$19.76
	CMS Total	$4,664,969.20	$699.67
Member Premium		$551,147.76	$82.31
Total Revenue		$5,216,116.9	$778.98
	@87% premium =		$677.71

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PAYMENT DATES

- September 2010 submission drives 2011 preliminary report based on 7/09-6/10 DOS
- January 2011 submission drives Final 2010 payment for CY 2009 DOS
- March 2011 submission drives 2011 actual payment based on CY 2010
- August 2011 final payment for CY 2009 DOS
- September 2011 submission drives 2012 preliminary report based on 7/10-6/11 DOS
- January 2012 submission drives Final 2011 payment for CY 2010 DOS

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EXPENSES

- Key drivers to managing expenses:
  - Medical expenses
    - Facility based services (HSF Fund)
    - Physician/Outpatient services (MSF Fund)
  - Care Management
    - Care Manager (nurses)
    - Complex member and chronic disease management programs
  - Coding
    - Chart reviews, PAF process, Coding tool, training and reporting
  - Reinsurance
    - Member level stop-loss
    - Aggregate stop-loss

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CARE MANAGEMENT EXPENSES

- **PCP Education and Incentives**
- **Office Wellness Visits**
- **Home Wellness Visits**
- **Hospital/SNF Coding**
- **IT Tool**
- **Retro-Coding Chart Reviews and Audits**
- ***Care Management Expenses:***
  - **<u>Total</u> Cost = $11-$19 PMPM**
    → Can Bring up to $550 PMPM <u>and Quality↑</u>

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BREAKDOWN OF EXPENSES

- CMS sends risk adjusted (including adjustments for the RAF, county base rate, and rescaling) global payments to Health Plan monthly for enrolled members.
- Health Plan collects premiums monthly from enrolled members.
- These 2 are put together into a budget which Health Plan keeps in their bank.
- Health Plan deducts roughly 11-% to 19% from budget, depending on the contract for the services, including delegated oversight, out of area care, psych UM, regulatory and other compliance, CMS submissions.
- Health Plan divides the remainder (as per each contract) into two funds – the medical service fund (MSF) and the hospital service fund (HSF).

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BREAKDOWN OF EXPENSES

- The Health Plan pays all fee-for service claims directly from the appropriate funds:
  - Hospital claims are paid from the HSF and physician claims are paid from the MSF
  - The Health Plan, or the delegated UM entity, determines the approval or denial of claims, but the Health Plan issues the notices.

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BREAKDOWN OF EXPENSES

- The Health Plan gives the Provider Group a monthly payment (some from the MSF and some from the HSF) for:
  - PCP capitation payments and accounting
  - PCP and other incentives (if any)
  - Rounding subsidies (about $4.00 PMPM)
  - Reinsurance and related activities
  - IPA medical director functions (about $3.00 PMPM)
  - Quality support (about $3.00)
  - Network and network functions
  - Care Management
  - Coding programs (IT Tool, NP-wellness, Auditing…) programs
  - Data programs and related IT functions.
  - Regulatory compliance

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Application of Total Expenses

Member Enrollment	**558**	**6696 member months**	**PMPM**
Medical HSF			$409.89
Medical MSF			$247.25
CM Programs		@87% Premium	$7.45
CM Support		100% Group	$5.48
Coding		@ 87% Premium	$3.53
Total Expenses			$673.60

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Revenue:		Dollars	PMPM	Surplus
CMS [RAF SCORE .8618]			$676.92	
			$19.76	
	CMS Total		$699.67	
Member Premium			$82.31	
Total Revenue			$778.98	
@87% premium =			$677.71	
Expenses::		**Dollars**	**PMPM**	
Medical HSF			$409.89	
Medical MSF			$247.25	
CM Programs			$7.45	
CM Support			$5.48	
Coding			$3.53	
Total Expenses			$673.60	
Surplus				$4.12

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RAF SCORE

- RAF score for an individual patient represents all of the hierarchical condition categories (HCCs) that have been submitted for that person to CMS during the course of a calendar year.
- The HCCs are the medical conditions that have been identified as those that most predictably affect the health status and health care costs of any individual patient.

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EFFECT OF RISK SCORES ON BUDGET

	Risk Score	Baseline Revenue	Potential Increase	Potential PMPM revenue 100% baseline
Existing Scenario	.8618	$676.92		
Scenario 1	.90	$676.92	$53.59	$730.50
Scenario 2	.95	$676.92	$94.17	$771.09
Scenario 3	1.0	$676.92	$134.76	$811.67

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PHYSICIAN REVENUE ENHANCEMENT STRATEGIES

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REVENUE ENHANCEMENT STRATEGIES FOR PHYSICIANS

- Understand the importance of coding
- Know high revenue HCCs that are often undiagnosed or undercoded
- Train central coders on HCCs and importance of ICD-9 codes
- Ensure encounter data submission
- Ensure coding forms or electronic systems do not limit the number of diagnoses per visit (EMRs limit number of codes that can be submitted to 3-5).

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BARRIERS TO CODING

- Most EMRs only allow the electronic filing of a claim through their system with 4 billing ICD-9 codes.
- Many EMRs do not have the capability to identify and track codes that have been submitted in the past from other providers because they do not incorporate claims data.
- Ideal coding systems allow the provider to identify and track codes that have been submitted in the past, and in the current year, such that the provider can easily identify which additional problems need to be addressed clinically. Thus codes can be appropriately submitted (annually) to increase the RAF scores.

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REVENUE ENHANCEMENT STRATEGIES FOR PROVIDER GROUPS

- Review missing diagnoses from prior years' HCCs and send reminders to MDs
- Audits of records vs. codes for missing codes: last year and this year.
- Conduct annual comprehensive exams for members who have not yet been seen early in the year.

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REVENUE ENHANCEMENT STRATEGIES FOR PROVIDER GROUPS

- As part of the annual exam, integrate a Patient Assessment Form or other IT Tool
  - Hire an NP to conduct exams
- Develop measures to encourage physicians to engage with patients:
  - Use of IT Tool
  - Complete PAFs
  - See % of members annually in the office
- Reward/incentivize for compliance with measures:
  - Increase Surplus allocation
  - Adjust PCP capitation payments, if negotiated a cap rate with payor

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PCP CAPITATION PAYMENT ADJUSTMENT

- The PCP capitation payment for the first six month of 2012 is $44 per member per month.
- For example, if you have 100 members in your Tufts panel, your monthly capitation will be $4,400.
- PCP capitation payment may be adjusted according to your use of
  - IT Tool;
  - RAF score; and
  - Group's average RAF score.

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PCP CAPITATION PAYMENT ADJUSTMENT

- Adjust capitation payment by multiplying it by the average RAF.
- CMIPA average RAF of at least 1.00
- If RAF score is below 1.00, guaranty the average of the year 1 payments to be at least $36.
- If Group's RAF score is greater than 1.00, then any PCP with an individual RAF >1 who uses the IT Tool and sees at least 80% of his/her panel during the previous 6 month time period, will increase his PCP capitation by certain percentage

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CONTRACT COMPLIANCE

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CONCERNS WITH PHYSICIAN CODING

- "Codes submitted for payment must be **supported** by visit documentation that is evidence of the problem having been addressed, with the note dated and signed in the patient record."
- Checking off a code on the form does not meet documentation requirements.
- Diagnosis must be in the medical record progress notes from a face to face encounter/visit
- Documentation of each counter (DOS) in the Medical Record must stand alone
- The condition must be clearly identified and include a brief assessment and plan
- Only conditions evaluated during the current face to face encounter should be documented and coded.
- Documentation must support that the condition was evaluated. Listing it in the assessment without further elaboration is not sufficient. It must be supported in the history, exam, and/or plan.

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CONCERNS WITH PHYSICIAN CODING

- Do not use the following words when documenting:
  - Probable
  - Suspected
  - Question of ?
  - Rule Out
  - History Of – Do not write “history of” if condition remains current and continues to be treated.
- Examples of terms that support EVALUATIVE documentation are:
  - Stable on medications
    - Listing medications alone does not meet documentation requirements to indicate that condition was done.
  - Condition worsening – medication adjusted
  - Tests ordered – documentation reviewed
  - Condition improving – continue current regimen
    - Do not code conditions as current if they no longer exist and the patient is no longer receiving treatment

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Questions

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