HHS-OPERATED RISK ADJUSTMENT DATA VALIDATION (HHS-RADV)
INTRODUCTION
OBJECTIVES

// Introduce the HHS – Operated Risk Adjustment Data Validation (HHS-RADV) Activities for the 2016 Benefit Year
// Overview of the HHS-RADV Program
// Identify HHS-RADV Processes
// Responsibilities of Key Stakeholders
// Upcoming Timelines
HHS-RADV DEFINITIONS

// **HHS** – Governs the HHS-RADV Program

// **CMS** – Designated by HHS to be responsible for implementing the RA premium stabilization program

// **Issuer** – Health plan subject to the HHS-RADV Audit – those offering non-grandfathered ACA compliant individual and/or small group health plans both inside and outside the marketplace

// **IVA** – Entity retained by issuer to perform the Initial Validation Audit (IVA)

// **SVA** – Entity retained by CMS to perform the Secondary Validation Audit (SVA)
HHS-RADV AUTHORITY

// Implemented in accordance with the following regulations:

- 45 CFR Section 153.350
- 45 CFR Section 153.620
- 45 CFR Section 153.630
- Premium Stabilization Final Rule
- 2014 Payment Notice Final Rule
- 2015 Payment Notice Final Rule
HHS-RADV AUTHORITY

// Section 1343 of the Affordable Care Act (ACA) establishes a permanent Risk Adjustment (RA) program

// The Premium Stabilization Final Rule requires states to validate a statistically valid sample of data for all issuers that submit for risk adjustment every year and provide an appeals process

// Finalized in 2018 Payment Notice, HHS implemented a materiality threshold of $15M in total premiums, beginning for the 2017 benefit year HHS-RADV program
RISK ADJUSTMENT OVERVIEW

// What: Budget neutral program that transfers funds from plans with lower risk enrollees to plans with higher risk enrollees in a state market risk pool

// Who Participates: ACA-compliant non-grandfathered individual and small group market plans, inside and outside the Marketplace (Issuers)

// How: Data validation in an audit function ensuring integrity and data provided by issuers
HHS-RADV PROCESSES – SAMPLE SELECTION

CMS provides a sample size of enrollees so that the estimated risk score errors will be statistically sound and the enrollee-risk level risk score distributions will reflect enrollee characteristics for each issuer.

200 enrollees per issuer for each state in which the issuer offers plans that are HHS-RADV eligible will be sampled for the IVA – a sample less than 200 enrollees may be selected for small enrollee populations.
A sample of 200 enrollees will have up to one (1) or more Hierarchical Condition Categories (HCCs)

- CMS requires documentation that supports the presence of the condition and indicate the provider’s assessment and/or plan for management of the condition. This must occur at least once each calendar year in order for CMS to recognize the individual continues to have the condition.
HIERARCHICAL CONDITION CATEGORIES

- Hierarchy logic is imposed on certain disease groups
- The HCC model is cumulative – a patients with more than one HCC are factored into the member’s risk profile
- Disease groups are clinically related diagnoses that have similar Medicare cost implications
- Each disease group relates to a specific ICD-10-CM medical condition. Some HCCs are age-related, such as breast malignancies
HHS-RADV PROCESSES: IVA REGISTRATION

// Issuer identifies IVA Entity – independent auditor to validate demographic and enrollment data and health status information for the enrollee sample(s)

// CMS accepts or rejects the IVA entity

// IVA review of enrollee health status must be conducted by certified coders by a nationally recognized agency
INITIAL VALIDATION AUDIT – DEMOGRAPHICS AND ENROLLMENT – HEALTH STATUS VALIDATION

Source enrollment documentation from the claims processor to the transactions (claims) with the issuer
Issuer provides medical record documentation
IVA entity validates the risk score of each enrollee in the sample(s)
IVA entity provides CMS with final results and supporting documentation
HHS-RADV PROCESSES - SVA

// Following the IVA, the SVA is conducted by a CMS auditor to verify accuracy of the IVA findings
// Issuers may appeal the SVA results and/or accept the error estimation
// CMS determines an adjustment factor and prepares for payment adjustments for the benefit year based on error estimation
HHS-RADV – ISSUER RESPONSIBILITIES

// Identify a “Senior Official” to communicate with CMS regarding audit activities

// Confirm completion of results prior to submission to CMS

// Submit appeals on behalf of the Issuer for the SVA

// Provides all claims, medical records, and enrollment documentation to the IVA entity for the sampled enrollees
HHS-RADV – IVA ENTITY RESPONSIBILITIES

// Be free of conflicts with the issuer
// Attend 2016 benefit year HHS-RADV trainings
// Maintain appropriate personnel to conduct the IVA
  • Claims, demographic, enrollment, finance
  • Ensure certified coders have and maintain current certifications
• Register in the Audit Tool
• Perform IVA, IRR and submit results to CMS, timely
# HHS-RADV Timeline for Benefit Year 2016

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
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<tbody>
<tr>
<td>February 15, 2017</td>
<td>HHS-RADV Training Begins</td>
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<tr>
<td>February 2017 – April</td>
<td>Issuers Select IVA Entity</td>
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<tr>
<td>April 17 – 24, 2017</td>
<td>Issuers submit IVA Entity to CMS for Acceptance</td>
</tr>
<tr>
<td>May 1, 2017</td>
<td>HHS-RADV 2016 Benefit Year Protocols</td>
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<tr>
<td>May 1, 2017</td>
<td>2016 Data Submission Deadline</td>
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<tr>
<td>May 2017</td>
<td>Sample Released to Issuers</td>
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<tr>
<td>June 2017-January 8,</td>
<td>IVA is Conducted</td>
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<tr>
<td>2018</td>
<td></td>
</tr>
<tr>
<td>January 8, 2018</td>
<td>IVA Results and Submissions Due</td>
</tr>
<tr>
<td>January 18, 2018</td>
<td>IVA Entity Submits SVA Subsample to CMS</td>
</tr>
<tr>
<td>January 2018 – April</td>
<td>SVA Conducted</td>
</tr>
<tr>
<td>May 2018 – June 2018</td>
<td>CMS Releases Error Rates to Issuers</td>
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CODING AND DOCUMENTATION - HCCS

All relevant diagnosis codes should be reported at least once per year for each member (preferably every six months)

- On January 1 each year, the member’s diagnosis information is reset in preparation for a new year of diagnosis encounter data

- 2015 initial validation audits completed and will be starting the 2016 audits this spring 2017

- **2015 was a pilot year.** Penalties will begin in 2017 based on results of 2016 audits
CODING AND DOCUMENTATION – COMMON HCCS

// COPD
// Congestive heart failure
// Acute or chronic renal failure
// Malignancies
// Diabetes with manifestations (neuropathy)
// Newborns with problems
// Complicated deliveries
// Complicated pregnancies
DOCUMEN TATION REQUIREMENTS

// The Basics

Each page of a note MUST include:

✓ Patient’s full name
✓ Date of Birth
✓ Date of Service – including year

The Provider’s signature must be legible –

✓ Must also include provider’s credentials
✓ Electronic signatures should include the date and time of authentication, the service provider’s name and credentials and include a statement such as “electronically signed by....” or “authenticated by....”
DIAGNOSIS (HCC) ABSTRACTION - VALIDATION

// Medical record source must be hospital inpatient, outpatient, or professional medical treatment (office visits)

// Face-to-face encounters only

// Follow the “MEAT” documentation criteria – Monitored, Evaluated, Assessed, Treated

// Approved provider types – MD, DO, PA, APRN, Clinical Psychologist, PT, OT, Audiologist, DPM, etc.
LESSONS LEARNED FROM AN ENTITY’S PERSPECTIVE

// Lack of documentation to support the MEAT criteria for correctly capturing the HCCs
// Illegible provider signatures
// Signatures dated the date the documentation request was made
// No birth date on progress note
// Some enrollees had multiple HCCs
LESSONS LEARNED FROM AN ENTITY’S PERSPECTIVE

// Failure to capture HCCs once every 12 months

// Copy and pasted “problem lists” from one encounter to another that could not be used to support the HCC due to not meeting the MEAT criteria

// Newly identified HCCs - an error but has potential result in a positive impact to the Issuer

// Audited a year’s worth of documentation, requested HHS to allow audit be based at claim level in future
LESSONS LEARNED FROM AN ENTITY’S PERSPECTIVE

// Use of quantifying language in the outpatient setting, such as “consistent with, probable, possible....”

// Historical status of a diagnosis unclear, especially with malignancies

// Chronic or coexisting conditions are not documented or are left out of the clinical documentation of an office visit

// Coders did not follow Official Coding Guidelines
MOST AUDITED ENCOUNTER TYPES

// Hospital Anesthesiologist Pre-Evaluations
// Hospital outpatient department records
// Hospital emergency room records
// Hospital inpatient records
// Physician practice office visits – most often
// Oncology and urology coding worst
PROVIDER IMPLICATIONS

- If coding is accurate and complete, ROI processes are minimally disrupted, allowing greater focus on patient care and other business operations.

- If coding is incomplete, higher likelihood of more medical record requests by an Issuer with ROI disruption and cost.

- Follow MEAT criteria and be practically audit-proof.

- Risk adjustment is an expanding arena, started in 2004 with Medicare Advantage.
## RESOURCES: LINKS

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<thead>
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<tr>
<td>CCIIO ACA RA Data Validation Email Address</td>
<td><a href="mailto:CCIIOACARADataValidation@cms.hhs.gov">CCIIOACARADataValidation@cms.hhs.gov</a></td>
</tr>
<tr>
<td>The Center for Consumer Information &amp; Insurance Oversight (CCIIO) web page</td>
<td><a href="https://www.cms.gov/ccio">https://www.cms.gov/ccio</a></td>
</tr>
<tr>
<td>Patient Protection and Affordable Care Act (ACA)</td>
<td><a href="http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/content-detail.html">http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/content-detail.html</a></td>
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