CPAs & ADVISORS

experience **access //**

HFMA LONE STAR – TAHFA EAST TEXAS REGIONAL CONFERENCE – FEBRUARY 24, 2017

Paula Archer, RHIA
Director

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

HHS-RADV PROCESSES – SAMPLE SELECTION

// 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

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

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

DOCUMENTATION 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 – **M**onitored, **E**valuated, **A**ssessed, **T**reated

// 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

Resource	Resource Link
Affordable Care Act (ACA) HHS-Operated Risk Adjustment Data Validation (RADV) Process White Paper, June 22, 2013	https://www.regtap.info/uploads/library/ACA_HHS_OperatedRADVWhitePaper_062213.pdf
CCIIO ACA RA Data Validation Email Address	CCIIOACARADataValidation@cms.hhs.gov
The Center for Consumer Information & Insurance Oversight (CCIIO) web page	https://www.cms.gov/cciio
Patient Protection and Affordable Care Act (ACA)	http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/content-detail.html

DISCLOSURE

// Information contained in this presentation is informational only & is not intended to instruct hospitals & physicians on how to use, or bill for health care procedures. Hospitals & physicians should consult with their respective insurers, including Medicare fiscal intermediaries & carriers, for specific information on proper coding & billing for health care procedures. Additional information may be available from physician specialty societies & hospital associations. Information contained in this presentation is not intended to cover all situations or all payers' rules & policies. Reimbursement laws, regulations, rules & policies are subject to change.

THANK YOU – PAULA ARCHER – PARCHER@BKD.COM

FOR MORE INFORMATION // For a complete list of our offices and subsidiaries, visit **bkd.com**

BKD LLP
CPAs & Advisors