

Option Advisor



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

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# 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



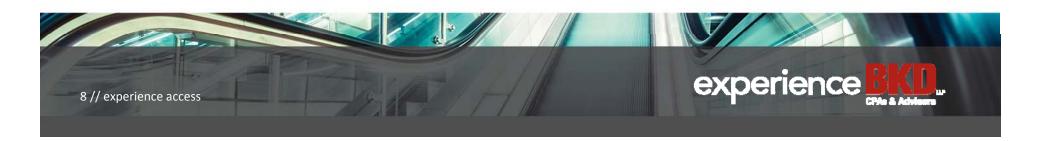
#### RISK ADJUSTMENT OVERVIEW

- // 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



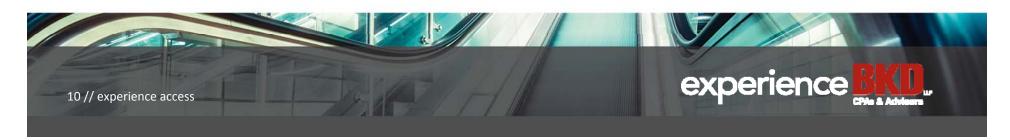


- // A sample of 200 enrollees will have up to one (1) or more **Hierarchical Condition Categories** (HCCs)
- CMS requires documentation that supports the presence of the condition and indicate the provider's assessment and/or plan for management of the condition. This must occur at least <u>once each</u> <u>calendar year in order for CMS to recognize the</u> <u>individual continues to have the condition</u>.



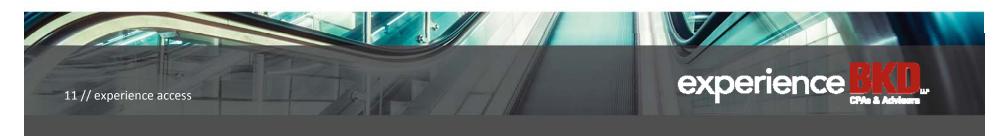
## HIERARCHICAL CONDITION CATEGORIES

- ☐ 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





- // 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





- // 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



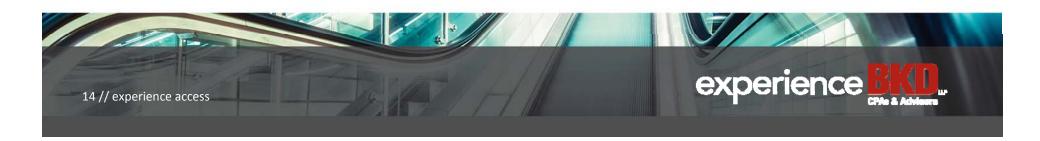
#### **HHS-RADV PROCESSES - SVA**

- // 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



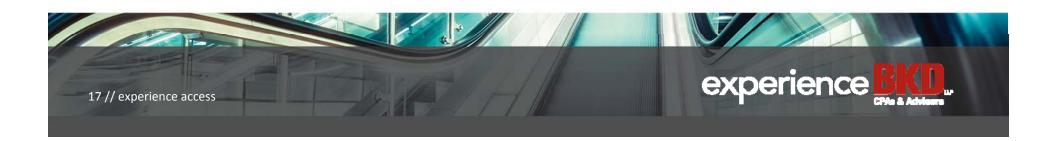
## **HHS-RADV TIMELINE FOR BENEFIT YEAR 2016**

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





- // 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 –
  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



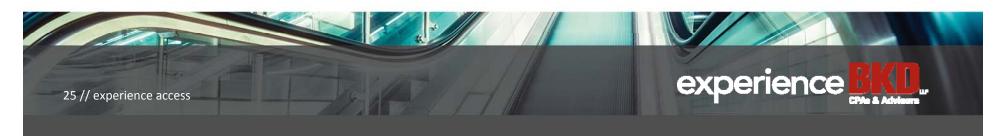
## **MOST AUDITED ENCOUNTER TYPES**

- // 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



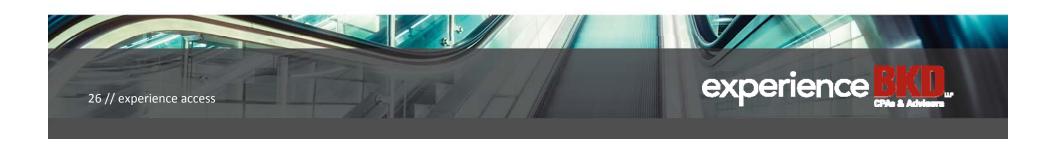
#### PROVIDER IMPLICATIONS

- ☐ 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



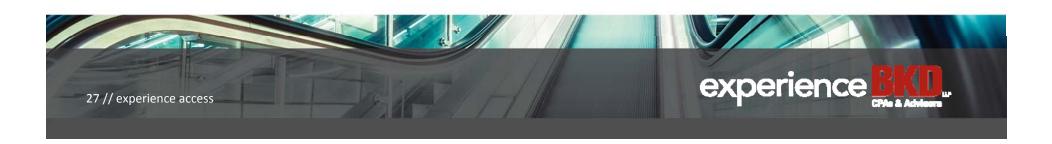
# **RESOURCES: LINKS**

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 062 213.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.



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