

## **Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits**

### **Introduction**

On December 21, 2010 the Centers for Medicare and Medicaid Services (CMS) posted on its website the “Medicare Advantage Risk Adjustment Data Validation (RADV) Notice of Payment Error Calculation Methodology for Part C Organizations Selected for RADV Audit – Request for Comment”. CMS invited public comment on the proposed methodology, with such comments to be submitted in writing by Friday, January 21, 2011.

CMS carefully reviewed the more than 500 comments received on the draft methodology. This Notice responds to the analytic concerns raised relating to extrapolation and payment recovery and presents the final methodology for the RADV payment error calculation.

Following the background section, this Notice provides a general walkthrough of the RADV payment error calculation methodology in two sections: (A) sampling; and (B) payment error calculation.

This methodology will be applied to the next round of RADV contract-level audits, which will be conducted on payment year 2011. Payment year 2011 is the first year for which payment recovery based on extrapolated estimates will be conducted for Medicare Advantage (MA). Note that sampling for RADV audits will occur after the close of final reconciliation for the payment year being audited.

CMS’ RADV audit initiative is the Agency’s primary strategy to address the national payment error rate for the MA program, which is currently estimated to be 11 percent for FY 2011. In addition to recovery of overpayments through RADV audits, CMS also expects that these contract-level audits will have a sentinel effect on the quality of risk adjustment data submitted for payment by MA organizations.

### **Background**

Section 1853(a)(3) of the Social Security Act requires that CMS risk adjust payments to Medicare Advantage (MA) organizations. In general, the current risk adjustment methodology relies on enrollee diagnoses, as specified by the International Classification of Disease, Ninth Revision Clinical Modification guidelines (ICD-9-CM), to prospectively adjust capitation payments for a given enrollee based on the health status of the enrollee. Diagnosis codes submitted by MA organizations are used to determine beneficiary risk scores, which in turn determine the risk-adjusted reimbursement.

RADV audits determine whether the diagnosis codes submitted by MA organizations can be validated by supporting medical record documentation. This medical record documentation must meet certain criteria and standards specified in RADV materials that CMS provides to audited contracts. Diagnoses that cannot be validated contribute to a payment error rate. This document describes the sampling

methodology that CMS will use for RADV audits and the methodology for calculating the payment error for each audited Medicare Advantage contract.

#### **A. Sampling**

To conduct these audits, CMS selects a set of MA contracts for each RADV audit cycle. Enrollees are sampled from each selected MA contract for the purpose of estimating payment error related to risk adjustment.

##### *Sampling Frame*

First, CMS identifies all beneficiaries under each MA contract who are “RADV-eligible” because they meet the following criteria:

1. Enrolled in an MA contract (H-number, E-number, or R-number) in January of the payment year— based on CMS' monthly member enrollment files;
2. Continuously enrolled in the same MA contract (as identified in step (1) above) from January of the data collection year through January of the payment year;
3. Non-End Stage Renal Disease (non-ESRD) status from January of the data collection year through January of the payment year;
4. Non-hospice status from January of the data collection year through January of the payment year;
5. Enrolled in Medicare Part B coverage for all 12 months during the data collection year (i.e., defined as full risk enrollees for risk adjusted payment); and
6. Had at least one risk adjustment diagnosis (ICD-9-CM code) submitted during the data collection year that led to at least one CMS-Hierarchical Condition Category (HCC) assignment for the payment year.

##### *Sample Size and Strata*

Next, CMS selects a sample of beneficiaries from each contract’s cohort of RADV-eligible enrollees. Enrollee-based stratification will be used in the process of sampling enrollees. In order to derive the strata, the RADV-eligible enrollees in each contract will be ranked from lowest to highest based on their community risk score. The enrollees will then be divided into three equal groups based on the total number of eligible enrollees, where the first group will include the third of enrollees with the highest risk scores and the third group will include the third of enrollees with the lowest risk scores. The remaining enrollees will be in the middle stratum.

CMS will select up to 201 enrollees for medical record review from each contract selected for a contractlevel audit. For smaller contracts, i.e., those with fewer than 1,000 RADV-eligible enrollees, CMS will individually adjust their sample sizes by using the finite population correction factor. The sample sizes for these smaller contracts will be 201 or fewer enrollees.

To achieve a sample size of 201 enrollees per contract, sixty-seven (67) enrollees will be randomly sampled from each group or stratum. The corresponding stratum-based enrollee weights will be computed as the number of RADV-eligible enrollees in the population grouping (or stratum) divided by the number of enrollees selected from that grouping for the sample, i.e.,  $N_h/n_h$ , where  $h$  represents the corresponding stratum.

For example, if a contract has 3,000 RADV-eligible enrollees, the enrollees would be ranked by risk score, then divided into three equal groups of 1,000 enrollees each (to represent high, medium, and low strata). An equal number of enrollees will be randomly selected from each group. The weight for each sampled enrollee will equal 14.925 (i.e.,  $1,000/67$ ).

For small contracts with fewer than 1,000 RADV-eligible enrollees, the same enrollee-based stratification process will be applied; however, a proportionally smaller number of enrollees will be randomly sampled from each group or stratum.

The enrollee sampling weights will be used as multipliers to scale-up (or extrapolate) the sample payment error findings to the population it represents.

Once enrollees have been selected, the MA contract will be required to submit medical records to support all CMS-HCCs represented in the sampled beneficiaries' risk scores for the payment year.

Effective with the CY 2011 RADV audit, CMS will allow audited MA contracts to submit multiple medical records for each CMS-HCC being validated. All diagnoses will be abstracted from the first medical record that validates the CMS-HCC under review. The one best medical record policy will continue to apply to the RADV audit dispute and appeal processes outlined in 42 CFR §422.311. CMS will provide more detailed information in the RADV audit procedures that will be distributed to audited MA contracts.

## **B. Payment Error Calculation**

### *Enrollee-level Payment Error Calculation*

CMS will calculate each contract's payment error based on the validation results. For each sampled enrollee, the RADV-corrected risk score and corrected payment will be calculated based on the CMSHCCs that are supported by RADV medical record review findings for the enrollee. Enrollee-level payment errors will be defined as the difference between the original payment and the RADV-corrected payment (per member per month). The payment error for each enrollee will be either positive (representing a net overpayment), or negative (representing a net underpayment). An annual payment error amount will be calculated for each sampled enrollee based on the number of months the person was enrolled in the selected MA contract (and was not in ESRD or hospice status) during the payment year.

### Payment Error Extrapolation Calculation

To derive the payment error estimate for each MA contract, the annual payment error for each sampled enrollee will be multiplied by the enrollee's sampling weight (computed for each stratum [h] during the sampling phase as  $N_h/n_h$ , where N represents the number of enrollees in the RADV-eligible population and n is the number of enrollees sampled). The weighted enrollee annual payment error will be summed across all enrollees in the sample to determine an estimated payment error for the MA contract (the "point estimate"). A 99 percent confidence interval (CI) will then be calculated for the estimated payment error for each audited MA contract.

The following formulas illustrate computation of a 99 percent CI around the payment error estimate for one contract, assuming a sample size of 201, with 67 enrollees selected from each of three strata groupings.

The lower bound of the 99 percent CI is computed as the estimated payment error for the contract (PE) minus (2.575 multiplied by the standard error), or  $(PE - (2.575 * SE))$ . The standard error (SE) can be calculated as follows:

1. Derive the variance,  $v_h$ , (standard deviation squared) of the unweighted enrollee payment errors across the sample enrollees within each of the three strata ( $h$ ).
2. Calculate the variance of the estimated total ( $V_{T^*}$ ) payment error, where N represents the number of enrollees in the RADV-eligible population of the  $h^{th}$  (1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>) stratum:

$$= \sum_h^3 \frac{N_h^2}{67} V_{T^*} v_h$$

3. The standard error is  $SE_{T^*} = \sqrt{V_{T^*}}$

### Payment Recovery Amount and the Fee-For-Service Adjuster

If the CI for the point estimate includes zero or is below zero, the contract will have the payment recovery amount constrained to zero.

If the CI for the point estimate is above zero, the payment recovery amount for the contract will be determined as follows. First, a preliminary payment recovery amount will be set at the lower bound of the 99 percent CI for the contract's point estimate. Second, to determine the final payment recovery amount, CMS will apply a Fee-for-Service Adjuster (FFS Adjuster) amount as an offset to the preliminary recovery amount. If the FFS Adjuster amount is greater than the preliminary recovery amount, the final recovery amount is equal to zero.

The 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). The actual amount of the adjuster will be calculated by CMS based on a RADV-like review of records submitted to support FFS claims data.