Calendar Year 2011, 2012, and 2013 Contract-level CHECK-IN

July 11th, 2019
1:30 to 3:00 p.m., ET
To submit or withdraw questions by phone:
- Dial *# (star-pound) on your phone’s keypad to ask a question.
- Dial *# (star-pound) on your phone’s keypad to withdraw your question.

To submit questions by webinar:
- Type your question in the text box under the ‘Q&A’ tab.
Contract-level RADV Team

Center for Program Integrity (CPI)
Alec Alexander – Center Director
George Mills, Jr. – Deputy Director

Jonathan Smith – Program Manager (RADV Team)

RADV Team Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beth Schalm</td>
<td>Gulnur Freeman</td>
</tr>
<tr>
<td>Brenda Marie Johnson</td>
<td>Joanne Davis</td>
</tr>
<tr>
<td>Esmail Essajee</td>
<td>Larry Johnson</td>
</tr>
<tr>
<td>Evan Boyarsky</td>
<td>Mary B. Walker</td>
</tr>
<tr>
<td>Delois Newkirk</td>
<td>Melissa Heesters</td>
</tr>
</tbody>
</table>
Agenda

- RADV Policy and Requirements
- Inquiries submitted to CMS
- Understanding Reporting and Results
- Questions and Answers
RADV Process
RADV audits are conducted in accordance with 42 Code of Federal Regulations (CFR) §422.310 and 42 CFR §422.311.

Subsection 422.310(e) requires MA Organizations, providers, and practitioners to submit accurate medical records for the validation of risk adjustment data as required by CMS.
CMS is legislatively mandated to risk adjust Medicare Part C payments, validate the payments (diagnoses), and report a Part C payment error rate.

RADV is CMS’ primary strategy to address the Part C error rate.

RADV validates diagnoses submitted for payment.
Medical Record Review Process

The process begins with:

- Submitted record with Coversheet adheres to CMS Submission Instructions.

- Medical record processes through the CDAT system.

- Complete review of the medical record and appropriate supporting data.
Inquiries Submitted to CMS
Question: How do we compare the results of the Contract-level audit to the error rates from the National audit?

Answer: The rates are different and not meant to compare across the RADV Contract-level recovery and the National payment error results. The enrollee sampling methodology is different between the two audits: the National audit assesses the program level measurement of error whereas the Contract-level essentially reviews submitted medical records for improper payment at the Contract-level.
Question: Results showing in the Plan Feedback Report (PFR) are ‘preliminary.’ Since the audit submission period is closed should these reports show as final?

Answer: The PFR does not display the final RADV audit outcomes. The PFR report identifies an exact match of audited enrollee CMS-HCC(s) with CMS-HCC(s) found during medical record review (MRR). Other CMS-HCCs and those within hierarchies found during MRR will be included in the RADV Audit Report.
**Question:** Are plans able to appeal any preliminary findings or do we need to wait until the final report is completed? Where is the appeals process information?

**Answer:** The Plan Feedback Report details coding results after medical record intake and abstraction and is intended to provide plans with preliminary review findings. The PFR is not intended to provide appeals process information. After issuance of the RADV Audit Report, MA Organizations will receive further instructions on how to appeal medical record review Determinations and Payment Error Calculations via the appeals process.
Understanding Reporting and Results
The Plan Feedback Report (PFR) provides MA Organizations with feedback from the medical record review (MRR) process and preliminary MRR findings. The report displays MRR results based only on exact match with the audited CMS-HCCs.

The PFR also provides key metrics around the audited enrollees, audited CMS-HCCs, and top invalid medical record reasons.

MA Organizations can view details for each medical record submission including the submission date, validity status, invalid reason(s) if applicable, and initial preliminary coding determinations.
The **CON11, 12, and 13 Plan Feedback Report (PFR)** is based on the enrollee CMS-HCCs audited in the CON11,12, and 13 audit samples. The samples are complete. The report includes information based on static data which does not include associated payment information.

The **CON14 Continuous Plan Feedback Report (CPFR)** provides early feedback on the MRR process progress and preliminary MRR findings for an active sample. The CPFR includes associated payment information, additional columns to reflect the blended models, and dynamic data which is regularly updated based on current findings.
The PFR provides “exact match” outcomes…

- The PFR is based on the audited enrollee CMS-HCCs provided in the CON11, 12, and 13 audit samples. The outcome displayed in the report is determined based on the exact match of the CMS-HCC found during MRR to audited CMS-HCC.

…but it does not provide hierarchies and additionals:

- The Plan Feedback Report is not intended to provide feedback on additional or hierarchical CMS-HCCs.

- Hierarchies and additional CMS-HCCs are not considered an exact match and are displayed as "HCC Not Found" in the Plan Feedback Report.
Sample Plan Feedback Report

Note: Data on report is fictitious
Interpreting the “Not Found Rate”

The percent of CMS-HCCs “Not Found” in the Sample Summary box and the Preliminary Findings Summary pie chart are calculated differently.

Formula for the "Not Found Rate”* in the Sample Summary:

\[
\frac{\text{Number of CMS-HCCs that were not found during MRR}}{\text{Total number of CMS-HCCs submitted on valid medical records}} \times 100\%
\]

<table>
<thead>
<tr>
<th>Sample Summary</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td># of Enrollees in the Sample</td>
<td>201</td>
</tr>
<tr>
<td># of Enrollees with at least 1 MR Submitted</td>
<td>196 (97.51%)</td>
</tr>
<tr>
<td># of CMS-HCCs in the Sample</td>
<td>620</td>
</tr>
<tr>
<td># of CMS-HCCs Submitted</td>
<td>599 (96.61%)</td>
</tr>
<tr>
<td># of Medical Records Submitted</td>
<td>541</td>
</tr>
<tr>
<td># of Invalid Medical Records</td>
<td>48 (8.87%)</td>
</tr>
<tr>
<td>CMS-HCC Not Found Rate</td>
<td>37.77%</td>
</tr>
</tbody>
</table>

*HCCs that are submitted on invalid medical records are not included in calculation.

Note: Data on chart is fictitious
Interpreting Percent “HCC Not Found”

\[
\frac{\text{Number of audited CMS-HCCs not found during MRR}}{\text{Total number of audited CMS-HCCs}} = \text{“HCC Not Found” in the Preliminary Findings Summary}
\]

Note: Data on chart is fictitious
The Top 3 INV Reasons Across CON11, 12, and 13 box shows the most common invalid MR reasons for an individual MA Organization, compared to the sample.

The information in this graph can help users understand and address causes of invalid MRs.

For example, INV 2 (lack of signature) and INV7 (lack of credential) are often the result of illegible signatures and provider names in electronic medical records.

Note: Data on chart is fictitious
The Detail Report provides MAOs with granular information on submissions to substantiate audited CMS-HCC(s) for enrollees:

- Key information includes: submission status and type, INV reason(s) MR was deemed invalid, attestation status (if applicable) and the submission review status.

The last column provides information on initial findings. (Note that no financial data is included.)

<table>
<thead>
<tr>
<th>Contract ID</th>
<th>Enrollee ID</th>
<th>Audited CMS-HCC</th>
<th>Coversheet ID</th>
<th>Submission Status</th>
<th>Submission Date</th>
<th>Rank</th>
<th>Valid/Invalid MR</th>
<th>Invalid MR Reason(s)</th>
<th>Invalid Attestation?</th>
<th>Review Status</th>
<th>Initial Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0001</td>
<td>123456_01</td>
<td>HCC30</td>
<td></td>
<td>Not Submitted</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>HCC Found</td>
</tr>
<tr>
<td>H0001</td>
<td>123456_01</td>
<td>HCC79</td>
<td>CY 2019 Contract RADV-294839_01-2540</td>
<td>Submitted</td>
<td>Mar 12, 2015 04:45 PM</td>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td>Complete</td>
<td>HCC Found</td>
</tr>
</tbody>
</table>

*Note: Data on chart is fictitious*
CMS Support

Make sure all Technical questions are sent to: radvcon11@radvcdat.com, radvcon12@radvcdat.com, radvcon13@radvcdat.com.

CMS interacts with Points of Contacts (POCs) approved by the plan CEO or MCO.

Policy concerns should be addressed to: radv@cms.hhs.gov.
Questions???
To submit or withdraw questions by phone:

- Dial *# (star-pound) on your phone’s keypad to ask a question.
- Dial *# (star-pound) on your phone’s keypad to withdraw your question.

To submit questions by webinar:

- Type your question in the text box under the ‘Q&A’ tab.

Please state your HMOID#.