CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Advantage Risk Adjustment Data Validation (RADV) Training

Contract-Level Industry-Wide Training Event

January 29, 2019

1:00 – 2:30 p.m., ET

Welcome and Introductions

Center for Program Integrity (CPI)

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Agenda Highlights

- Contract-Level RADV Policy
- Risk Adjustment (RA)
- Contract-Level RADV Time Frame
- Sampling Methodology
- Central Data Abstraction Tool (CDAT) Modernization
- Medical Record Reviewer (MRR) Guidance
- Continuous Plan Feedback Report
- Next Steps & Resources

Contract-Level RADV Terminology

Term	Definition
CY	Calendar Year
CON14 RADV	CY 2014 Contract-Level RADV
CMS	Centers for Medicare & Medicaid Services
CDAT	Central Data Abstraction Tool
HCC	Hierarchical Condition Category
INV	Invalid

Contract-Level RADV Terminology

Term	Definition
ICD-9-CM	International Classification of Diseases, Ninth Revision, Clinical Modification
ICD-10-CM	International Classification of Diseases, Tenth Revision, Clinical Modification
MAO	Medicare Advantage Organization
MRR	Medical Record Review
PHI	Protected Health Information
PII	Personally, Identifiable Information
RA	Risk Adjustment

Contract-Level RADV Terminology

Term	Definition
RADV	Risk Adjustment Data Validation
RAPS	Risk Adjustment Processing System
CON	Contract-Level
RECON	Reconsideration
CC	Condition Category

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Contract-Level RADV Policy

Contract-Level RADV Regulations

- Regulations at 42 C.F.R. 422.2, 422.310 (e) and 422.311 govern the RADV process including:
  - Audit procedures and compliance dates
  - Appeals processes
    - Reconsideration process for CON14 and contract future years
  - Issuers eligible and ineligible for appeals

Contract-Level RADV and Improper Payment

- Contract-Level RADV was implemented as the primary corrective action plan to reduce the Part C error rate in compliance with the Improper Payments Elimination Act (IPIA) of 2002, as amended by the Improper Payments Elimination and Recovery Act (IPERA) of 2010 and updated by the Improper Payments Elimination and Recovery Improvement Act (IPERIA) of 2012.
- Contract-Level RADV audits support integrity of Part C payments by ensuring diagnoses submitted for risk adjustment are supported by medical record documentation.

Contract-Level RADV Policy

- The goal of Contract-Level RADV is to identify discrepancies in payments by comparing RA diagnosis data submitted by a MAO for payment against medical record documentation provided by MAOs during Contract-Level RADV audits.

Contract-Level RADV Policy

- All RAPS submitted RA diagnoses submitted by a MAO must be:
  - Based on the clinical medical record documentation from a face-to-face encounter between patient and physician/practitioner.
  - Coded in accordance with the *ICD-9-CM Official Guidelines for Coding and Reporting and ICD-10-CM Official Guidelines* to diagnosis codes with dates of service after 10/01/15.
  - Assigned based on dates of service within the data collection period.

Contract-Level RADV Policy

- RA diagnoses submitted to CMS by MAOs must be from an acceptable:
  - RA provider type (Physician, Hospital Inpatient, or Hospital Outpatient)
  - RA data source
  - RA physician specialty type

Contract-Level RADV Policy

- MAOs selected for CON14 will have 20 weeks.
  1. Request medical records from providers.
  2. Prepare medical record files in PDF format.
  3. Submit the PDF files via a secure system called the Central Data Abstraction Tool (CDAT).
- Medical record file submission will be available in CDAT from the beginning of the 20-week period.

Part C Risk Adjustment Model

- The Part C CMS-HCC model is used to pay MAO plans for non-End Stage Renal Disease (ESRD) enrollees (with 12 months of Medicare Part B coverage during the data reporting period [i.e., full risk beneficiaries]).
- There are three (3) possible scores produced by the model:
  - **Community**: Based on enrollees with less than 90 days in an institution.
  - **Long-Term Institutional**: Based on enrollees with more than 90 days in an institution.
  - **New Enrollee**: Used for enrollees who are new to Medicare; operationalized as beneficiaries with less than 12 months of Medicare Part B coverage.

Risk Adjustment – How It Works

- CMS develops prospective RA models for Part C:
  - Diagnoses from Year One (1) are used to predict average spending for Medicare fee-for-service populations in Year Two (2).
  - Models contain approximately 3,000 diagnosis codes. This is the number of (ICD-9) diagnoses mappings to CMS-HCCs.
- Models include components for:
  - Demographics (Age, Sex, Medicaid Status, Original Reason for Medicare Entitlement)
  - Disease groupings referred to as CMS-HCCs
    - CMS-HCCs represent the disease component of the enrollee risk scores.

Creating the Risk Adjustment Model

- Condition Categories (CCs):
  - ICD codes are clustered into related CCs.
  - Contain diagnoses that are clinically related and with similar Medicare predicted cost implications.
  - Relate to well-specified medical conditions:
    - Hierarchy logic is imposed on certain CCs to account for hierarchical costs for the conditions (thus “HCCs”).
    - CCs have relative risk factors assigned based on the predicted costs.
    - Risk factors represent marginal predicted costs, relative to the average Medicare beneficiary.

Reporting and Risk Score Calculation

- MAOs submit RAPS diagnosis data to CMS:
  - Enrollee diagnoses from dates of service within the data collection period.
- Risk scores are calculated for:
  - Every Medicare beneficiary
    - ICD-9-CM codes from Fee-for-Service (FFS) claims and data submitted from plans (risk score data can derive from plan submitted data and FFS claims data).
  - A specific beneficiary
    - Identify model (community, institutional, new enrollee, ESRD).
    - Identify risk factors within model which apply (one [1] or more).
    - Enrollee risk score = Sum of all relative and frailty factors.

Calculating the Risk Score

- **Example:** Mr. Jones is 73-years old and resides in Baltimore, Maryland. He was determined to be eligible for Medicaid effective September 2012 and has been a member of the Silver Health Plan for several years, having originally qualified for Medicare due to disability. The MA contract also offers additional vision and dental benefits. His MAO submitted two (2) ICD-9 diagnostic codes with dates of service during 2013, the data collection year for payment year 2014:
  1. 185 – Prostate cancer (Malignant neoplasm prostate)
  2. 491.21 – Obstructive chronic bronchitis with (acute) exacerbation

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Calculating the Risk Score

- Sum the following relative factors:
  - Model variables for Mr. Jones:
    - 73-year old male
    - Non-institutionalized
    - Medicaid
    - Originally disabled
  - Disease Coefficients:
    - V12 CMS-HCC model: HCC10, HCC108
    - V22 CMS-HCC model: HCC12, HCC111

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Example of Payment Calculation

- Apply risk score(s) to payment using the basic Part C formula:
  [Base payment rate * enrollee risk score] + additional payment amount if MA contract offers certain supplemental benefits
  - Base payment rate = $932 per member per month
  - Beneficiary risk score (unnormalized and unadjusted)
    - V12 model = 1.265
    - V22 model = 1.196
    - Blended Risk score = 0.25 (1.265) + 0.75(1.196) = 1.213
  - Additional payment amount of $32 for supplemental benefits
  - CMS' monthly payment to Silver Health Plan for Mr. Jones:
    ($932 * 1.213) + $32 = $1,162.52

All Data Provided on this Slide is Fictitious

Mr. Jones and the Contract-Level RADV Process

- **Example:** Mr. Jones is selected for the CY 2014 Contract-Level RADV audit. Because Mr. Jones is selected, Silver Health Plan must submit medical records to validate HCC10|HCC12 and HCC108|HCC111 from dates of service within the data collection period (January 1, 2013 through December 31, 2013).
- After Silver Health Plan has submitted medical records for HCC10|HCC12 and HCC108|HCC111, contract-level RADV medical record coders review the records. During medical record review, coders validate HCC10|HCC12 but do not validate HCC108|HCC111.

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Calculating Mr. Jones' Post Contract-Level RADV Risk Score

- Because HCC108|HCC111 were not validated during the RADV audit Mr. Jones' risk score is recalculated using only HCC10|HCC12
- Sum the following relative factors:
  - The model variables for Mr. Jones are still the same:
    - 73-year old male
    - Non-institutionalized
    - Medicaid
    - Originally disabled
  - The Disease Coefficients for Mr. Jones have changed:
    - V12 CMS-HCC model: HCC10
    - V22 CMS-HCC model: HCC12

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Silver Health Plan's Post Contract-Level RADV Payment

- Apply the **post RADV** risk score to payment using the basic Part C formula to calculate Silver Health Plan's post RADV payment:

  [Base payment rate * post RADV enrollee risk score] + additional payment amount if MA contract offers certain supplemental benefits

  - Base payment rate = $932 per member per month
  - **Post RADV** Beneficiary risk score (unnormalized and unadjusted)
    - V12 model = 0.925
    - V22 model = 0.850
    - Blended Risk score = 0.25 (0.925) + 0.75(0.850) = 0.869
  - Additional payment amount of $32 for supplemental benefits
  - CMS' **post RADV** monthly payment to Silver Health Plan for Mr. Jones:

    ($932 * 0.869) + $32 = $841.91

All Data Provided on this Slide is Fictitious

Payment Adjustment for Mr. Jones

- CMS initially paid $1,162.52 monthly to Silver Health Plan
- According to the contract-level RADV audit results for Mr. Jones, CMS should have paid Silver Health Plan $841.91 monthly
- In this case, CMS initially overpaid Silver Health Plan
- Based on the circumstances of this example, CMS will proceed with a payment adjustment for Silver Health Plan

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Helpful Resources on Risk Adjustment (RA) and Risk Scores

- MAO Advance Notices of Methodological Changes, announcements issued for MA rates, and special reports are available at:

  https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html

Contract-Level RADV Time Frame

Activity	Period
MAOs Selected for Audit	TBD
MAOs Access to the CDAT Resource Library	3 weeks after selection notification
MAOs Selected Plans Training	1 day before submission window opens
Submission Window	MAOs will have 20 weeks to submit records

NOTE: an HPMS memo is forthcoming with the actual dates.

Sampling Methodology

Sampling

- CMS selects enrollees from eligible MA contracts according to certain criteria, including:
  - Examples of contract eligibility criteria
    - Coordinated Care Plans (CCPs), including local HMOs, Local PPOs, Regional PPOs, PSOs, SNPs
    - Demonstrations
    - MSA contracts
    - PFFS Contracts
    - Employer/Union Only Direct Contract PFFS
  - Examples of enrollee eligibility criteria
    - At least one (1) CMS-HCC assigned resulting in a positive risk-adjustment payment amount for the payment year in question
    - Continuous enrollment in the contract for the entire data collection period and the first month of the payment year
    - No end-stage renal disease (ESRD) and hospice status
  - For selected enrollees, all audited CMS-HCCs that contributed to the risk-adjusted payments for the payment year in question will be reviewed.

Proposed Sampling Methodology

- Based on statistically valid sampling and proposed* extrapolation methodologies within MA contracts and/or sub-cohorts
  - Determine MA contract
  - Select statistically valid random sample of enrollees
  - Review enrollee medical records
  - Calculate payment adjustments

*Although audits will be designed so that the individuals selected will form a statistically significant sample that would support an extrapolated recovery, we will not seek to recover on an extrapolated basis until an extrapolation methodology is finalized. At the very least, these audits will support enrollee level recoveries.

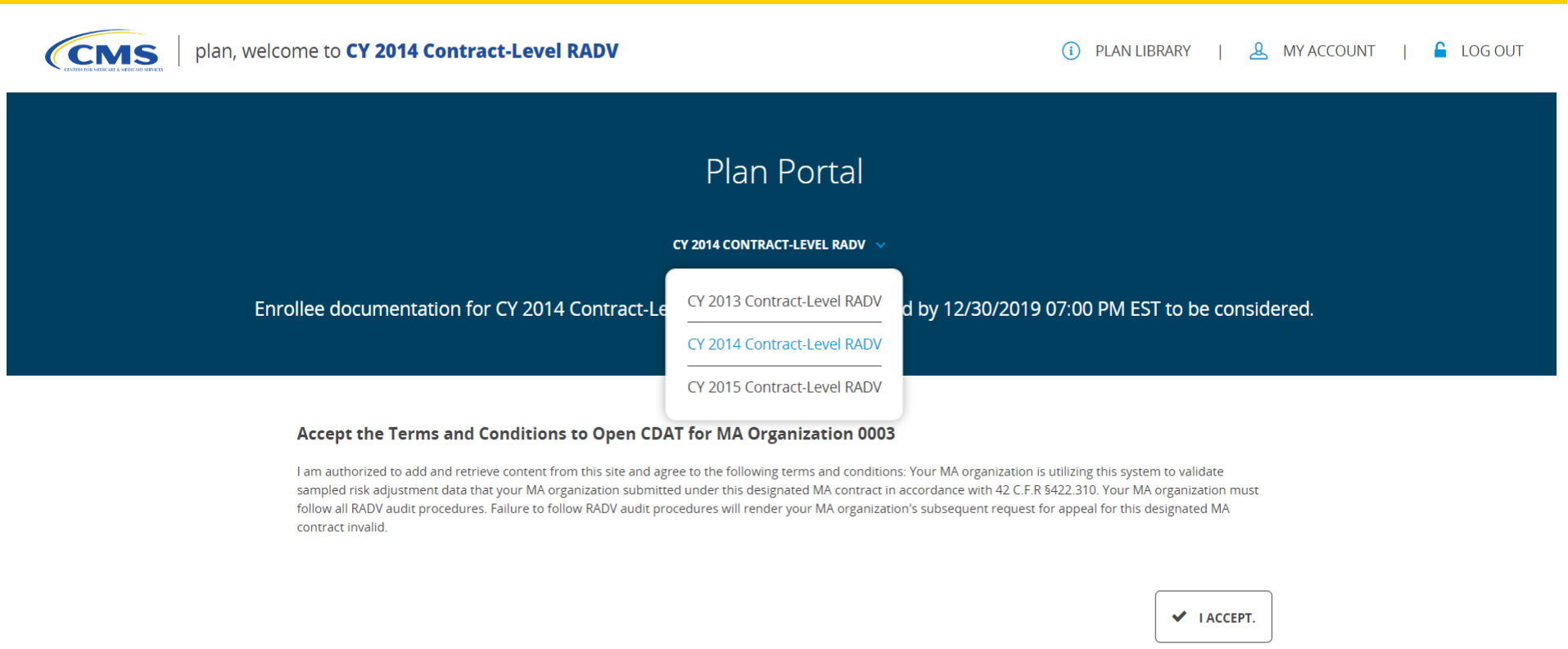
CDAT Modernization

CDAT Modernization

Objectives of Modernization:

- Improved user experience to include:
  - Screen consolidation – fewer clicks resulting in better user productivity
  - Modern look and feel – better presentation, easier to navigate
  - More information readily available – provide users with information aide in timely processing of tasks
  - User self management – ability to self manage accounts, currently a Help Desk function
  - Improved system performance – will increase user productivity

CDAT Modernization – Plan Portal



- Default to Plan Portal screen upon login
- One URL for CDAT; multiple sample selection based on authorization
- Plan Library, My Account and Log Out accessible on all screens of the application
- Terms and Conditions acceptance upon login for ALL authorized HMOIDs

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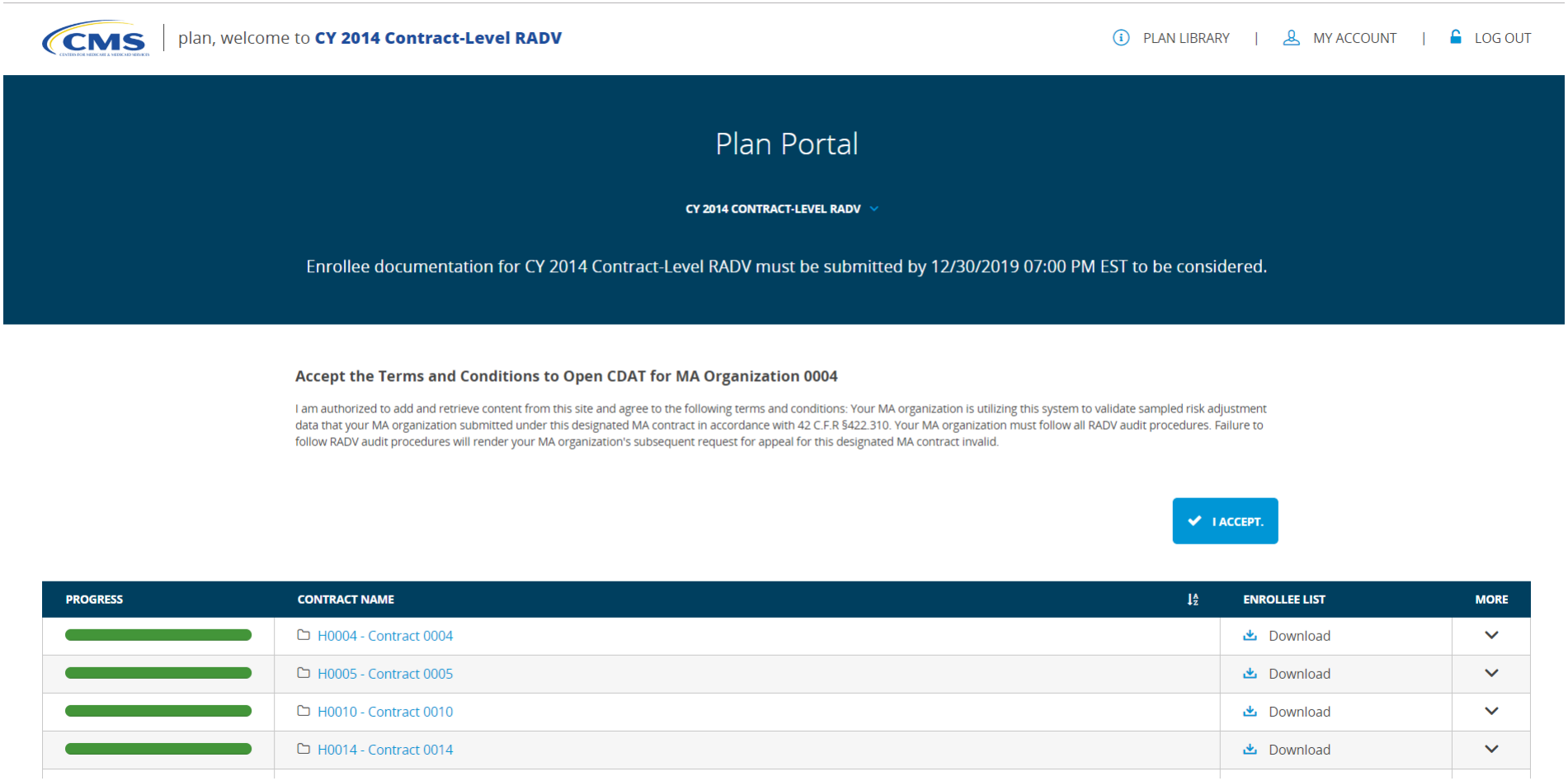
CDAT Modernization - Plan Portal: Terms and Conditions



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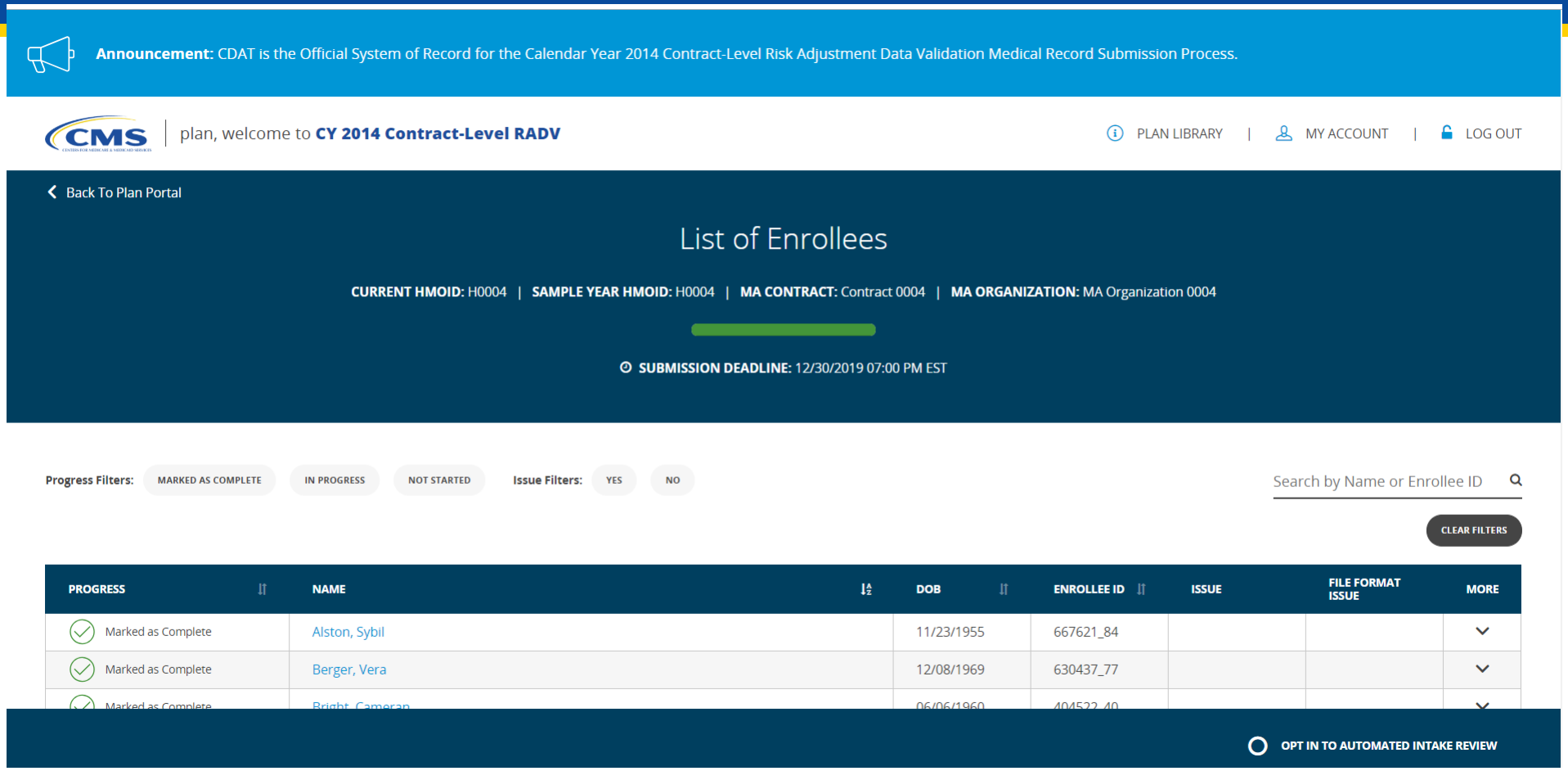
CDAT Modernization - List of Enrollees



- No scroll horizontal bar in grid
- One click on the enrollee name to open the record
- “Back to” links return user to previous page
- Search by Enrollee ID functionality
- Progress Filters

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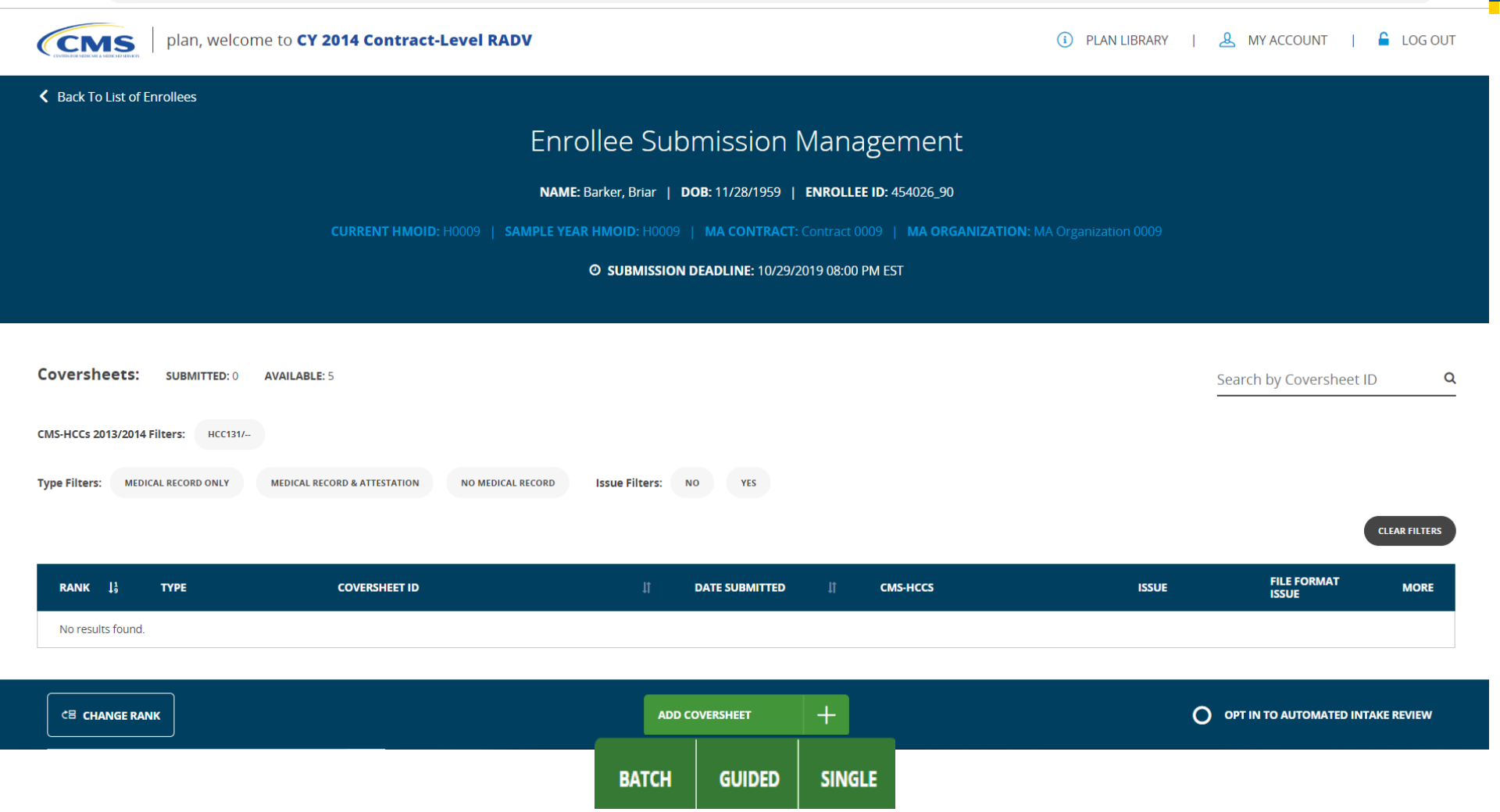
CDAT Modernization -Enrollee Submission Management



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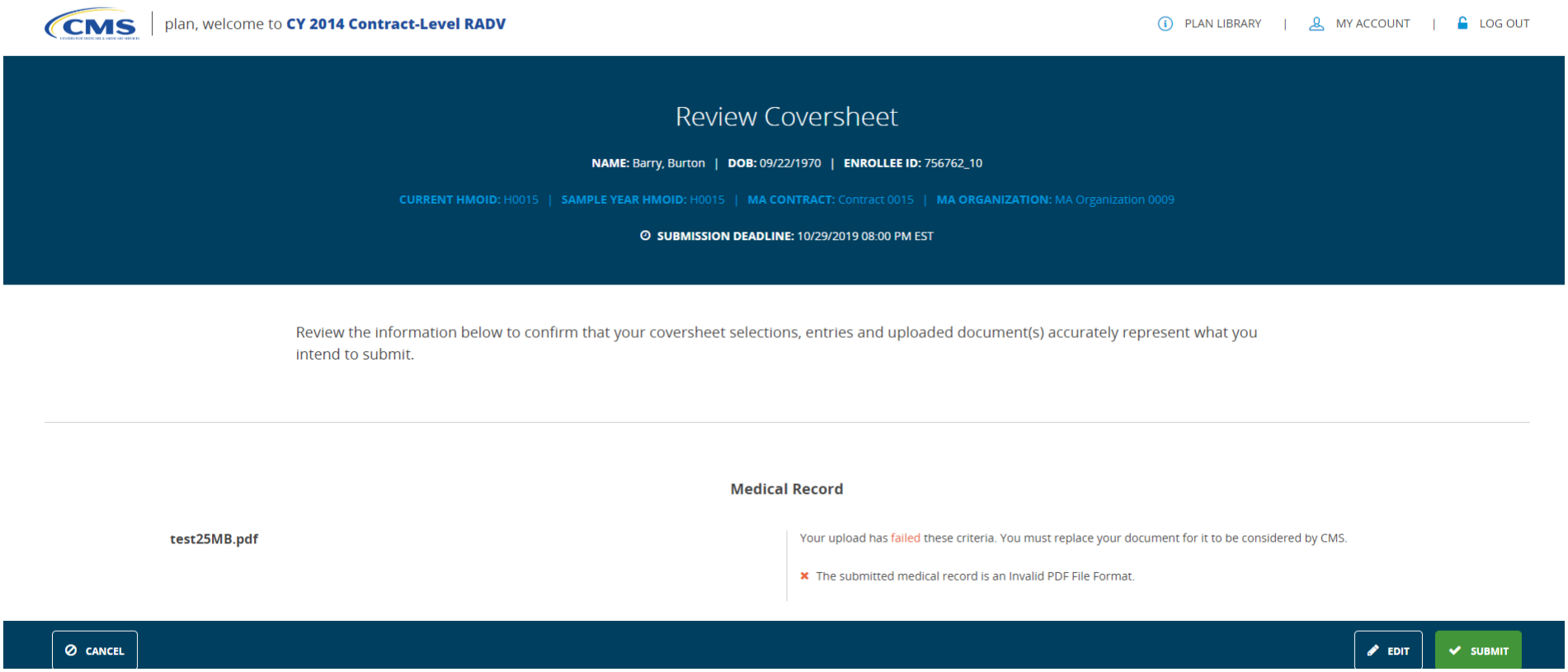
CDAT Modernization - Enrollee Submission Management Continued

- Back to link returns the user to the previous screen
- Search by Coversheet ID
- Filters by CMS-HCC, Type and Issue
- CMS-HCCs are presented on the screen rather than in a scrolling grid
- Add Coversheet provides 2 format options; Guided and Single
  - –Guided format for a novice user
  - –Single format for an experienced user

CDAT Modernization – Review Coversheet



All Data Provided on this Slide is Fictitious

Automated Intake Option

Objectives:

- Automates portions of the CDAT medical record (MR) intake review process
- Conducts around-the-clock review of MR submissions in accordance with current RADV parameters, submission rules, and coding guidance

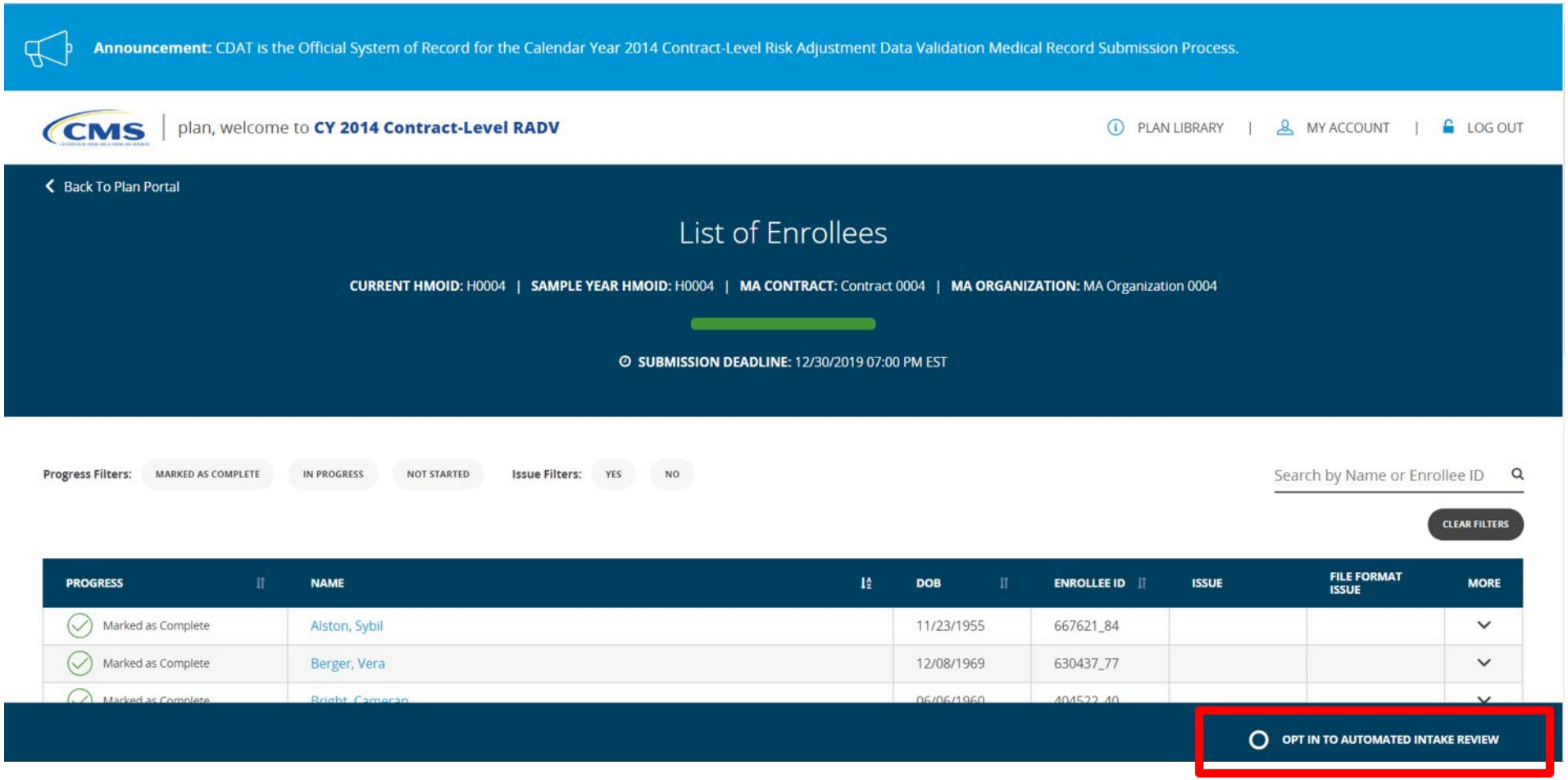
Benefits:

- Improves the overall speed of review
- Provides faster feedback to MAOs on the validity of the submission

Considerations:

- MR submissions identified with potential issues or that cannot be processed with a high degree of confidence during automated intake review will be escalated to manual review for confirmation
- The MAO will be given the choice to “opt in” to automated review

Automated Intake Option Continued



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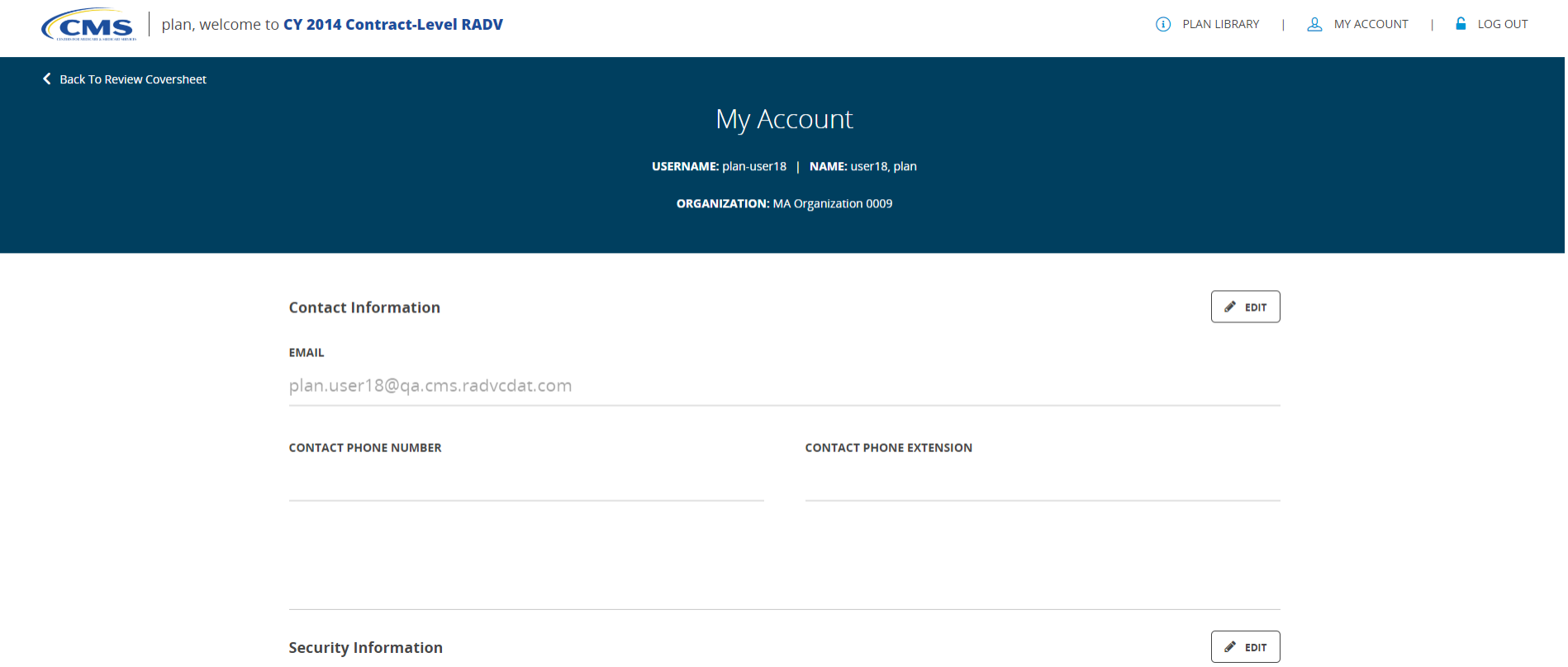
CDAT Modernization – My Account



All Data Provided on this Slide is Fictitious

CDAT Modernization – My Account Continued

- Users are able to edit the following information on the My Account screen:
  - Email address, contact phone and mobile phone
  - Reset password
  - Update Security question and answer
  - Update multi-factor authentication method

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Medical Record Reviewer (MRR) Guidance

Medical Record Reviewer Guidance

- Posted on the Medicare RADV Program Website:
  - https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-Risk-Adjustment-Data-Validation-Program/Resources.html.
- Purpose:
  - To guide MAO pre-submission medical record review/selection decisions.
  - To provide consistent application of documentation validity decisions to the CMS review contractors.
  - To reiterate policies, submission instructions, and official coding guidance that apply to RADV.

Medical Record Reviewer Guidance Content

- RADV policy with excerpts from contract-level RADV submission instructions
- Attestation validity
- Submission/intake validity and compliance
- Signature and Credentials
- Dates
- Provider type/record (source) type
- Reporting of chronic and other additional diagnoses in ICD-9-CM (applicable for CON14)
- Acceptable RA Physician Specialty list

Medical Record Review

- The specific documentation, ICD-9-CM guidelines, provider type and dates of service identified and selected for review may result in coding decisions that have a direct impact on the medical record review results and payment error estimate.
- CDAT CMS coversheet is first compared to the medical record submitted.

Medical Record Review (continued)

- Prior to coding, CMS medical record review contractors review each medical record submitted for validity.
- At a minimum, medical records must meet the following requirements to avoid a discrepant finding:
  - Acceptable RA provider type (Physician, Hospital Inpatient, Hospital Outpatient)
  - Physician specialty
  - Dates of service within the data collection period
  - Contain valid signatures and credentials
    - If missing, use CMS-Generated Attestation
  - Correct beneficiary

Medical Record Review (continued)

- Medical records are reviewed to determine if they are valid for RADV purposes.
- Reasons a medical record could be invalid include:

Code	Description
INV1	Wrong enrollee/No name
INV2	Missing signature
INV3	Name variation
INV4	Date missing
INV5	Invalid source
INV7	Unacceptable credential/specialty
INV14	Date outside data collection period
INV15	Provider type mismatch
INV17	Unacceptable medical record documentation
INV20	Other

Medical Record Review (continued)

- RADV coders will review and code the valid medical record submitted to confirm the documentation is:
  - Based on the clinical face-to-face encounter between patient and physician/practitioner.
  - Coded in accordance with the *ICD-9-CM Official Guidelines for Coding and Reporting and AHA Coding Clinic for ICD 9* (or *ICD-10-CM Official Guidelines for Coding and Reporting and AHA Coding Clinic for ICD 10*).
- Coders will abstract all reportable codes within acceptable date(s) of service in the data collection year.
- CDAT tool HCC mapping result is compared to RAPS enrollee profile to determine discrepancies.
- All coding discrepancies are confirmed using independent coders.
- Coders consult the RADV Medical Record Reviewer Guidance when faced with potential inconsistencies in medical record documentation.

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Continuous Plan Feedback Report

Continuous Plan Feedback Report (CPFR)

CPFR provides early feedback to plans

- **Increases transparency** and **reduces plan burden** by providing interim results on a rolling basis
- Allows plans to stay current on submission progress
- **Near real time reporting** of preliminary MRR Outcomes

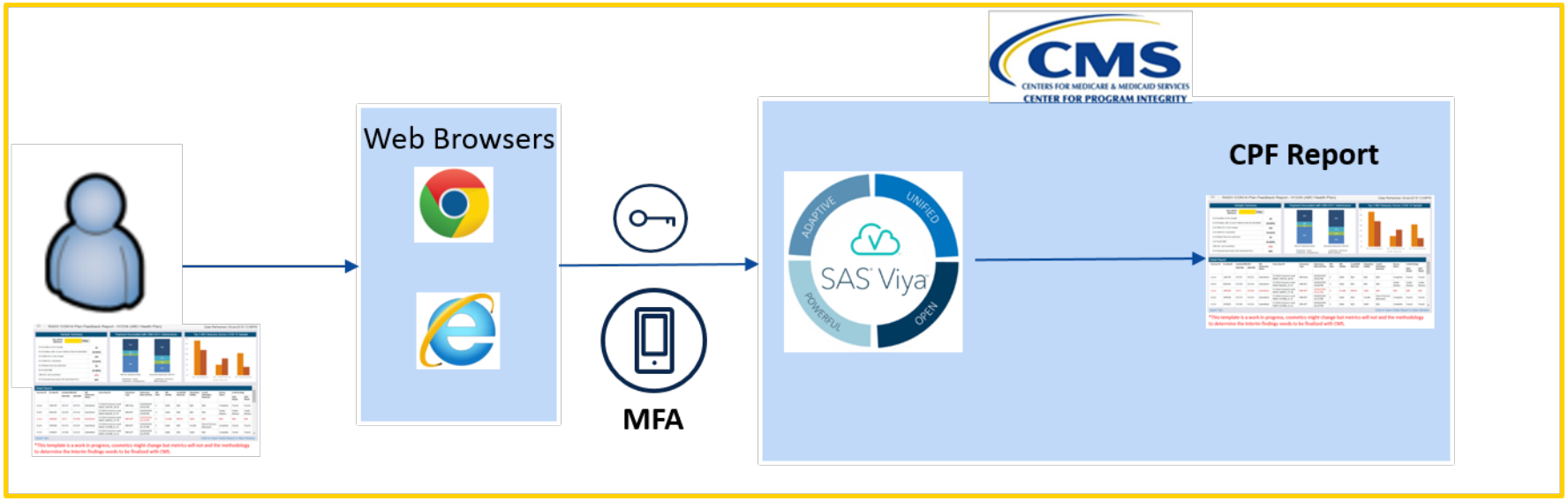
CPFR shows key metrics on MRR on a real-time basis

- **Key metrics** provide information around a plan's audited enrollees, audited CMS-HCCs, top invalid MR reasons, and associated payments
- **Detailed view of** each Medical Record submission
  - Ex. Submission date, validity status, reasons for invalid, initial findings

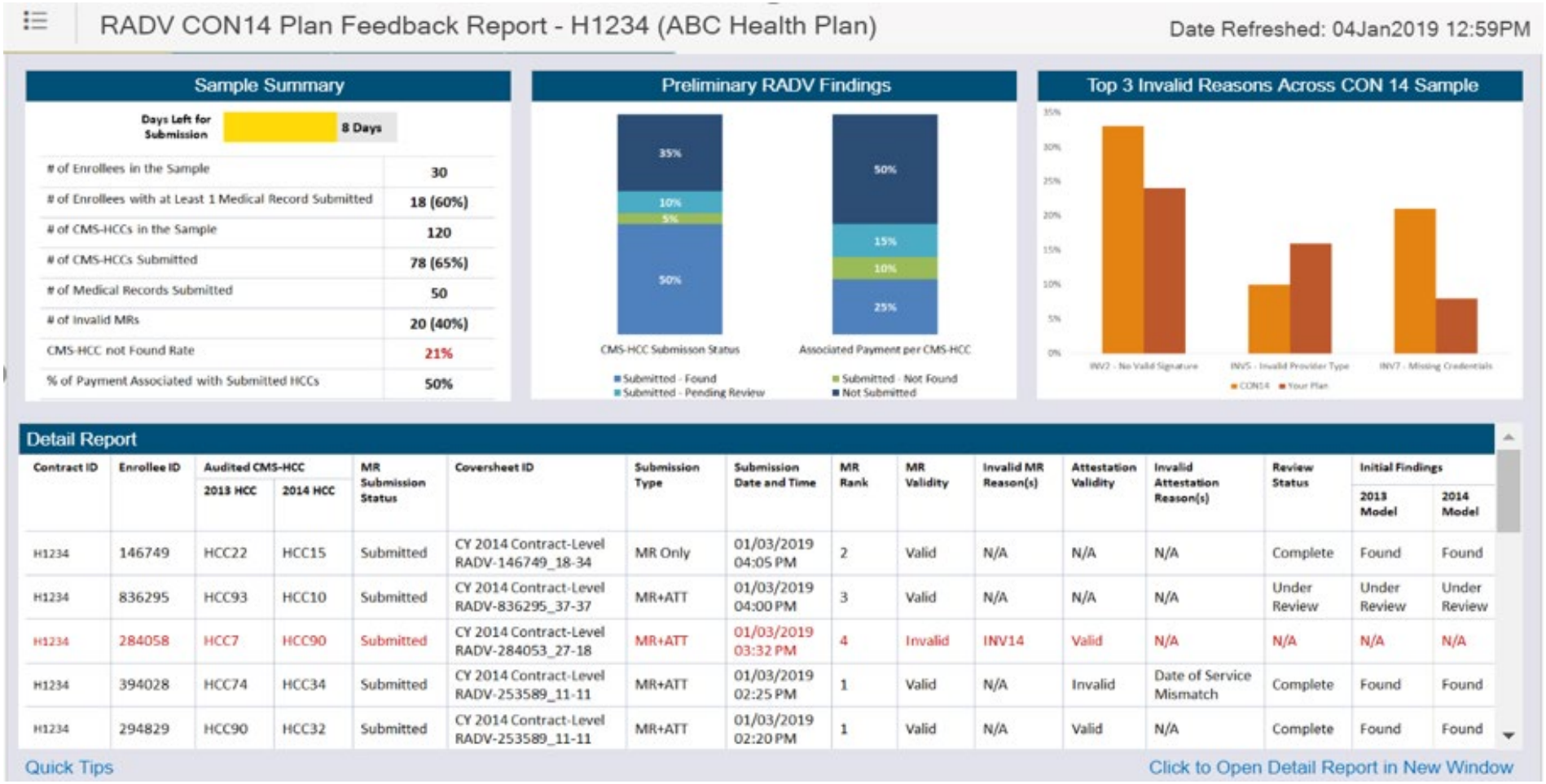
Accessing the Continuous Plan Feedback Report (CPFR)

Users can access reports directly through the SAS Visual Analytics Portal

- Plan Points of Contact may view reports for their authorized plans
- Authorized users can access reports using Chrome or IE
- Log in to the **SAS Visual Analytics** portal using **Multi-Factor Authentication (MFA)**



Continuous Plan Feedback Report Template



RADV CON14 Plan Feedback Report - H1234 (ABC Health Plan)

Date Refreshed: 04Jan2019 12:59PM

Sample Summary

Days Left for Submission	8 Days
# of Enrollees in the Sample	30
# of Enrollees with at Least 1 Medical Record Submitted	18 (60%)
# of CMS-HCCs in the Sample	120
# of CMS-HCCs Submitted	78 (65%)
# of Medical Records Submitted	50
# of Invalid MRs	20 (40%)
CMS-HCC not Found Rate	21%
% of Payment Associated with Submitted HCCs	50%

Preliminary RADV Findings

Top 3 Invalid Reasons Across CON 14 Sample

Detail Report

Contract ID	Enrollee ID	Audited CMS-HCC		MR Submission Status	Coversheet ID	Submission Type	Submission Date and Time	MR Rank	MR Validity	Invalid MR Reason(s)	Attestation Validity	Invalid Attestation Reason(s)	Review Status	Initial Findings	
		2013 HCC	2014 HCC											2013 Model	2014 Model
H1234	146749	HCC22	HCC15	Submitted	CY 2014 Contract-Level RADV-146749_18-34	MR Only	01/03/2019 04:05 PM	2	Valid	N/A	N/A	N/A	Complete	Found	Found
H1234	836295	HCC93	HCC10	Submitted	CY 2014 Contract-Level RADV-836295_37-37	MR+ATT	01/03/2019 04:00 PM	3	Valid	N/A	N/A	N/A	Under Review	Under Review	Under Review
H1234	284058	HCC7	HCC90	Submitted	CY 2014 Contract-Level RADV-284053_27-18	MR+ATT	01/03/2019 03:32 PM	4	Invalid	INV14	Valid	N/A	N/A	N/A	N/A
H1234	394028	HCC74	HCC34	Submitted	CY 2014 Contract-Level RADV-253589_11-11	MR+ATT	01/03/2019 02:25 PM	1	Valid	N/A	Invalid	Date of Service Mismatch	Complete	Found	Found
H1234	294829	HCC90	HCC32	Submitted	CY 2014 Contract-Level RADV-253589_11-11	MR+ATT	01/03/2019 02:20 PM	1	Valid	N/A	Valid	N/A	Complete	Found	Found

Quick Tips

Click to Open Detail Report in New Window

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Next Steps & Resources

Additional Resources

- RA Website:
  - https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html
- Medicare RADV Program Website:
  - https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-Risk-Adjustment-Data-Validation-Program/Overview.html

Contact Information

The CMS RADV Team is available to provide assistance throughout this process.

- Email is the most effective means of communication.
- Support hours are 9:00 a.m. to 6:00 p.m. ET.
- All questions related to RADV policies and procedures should be directed to CMS at radv@cms.hhs.gov.
  - Use the RADV Enrollee ID or Coversheet ID when communicating about a specific enrollee or submission.
  - Responses will be provided during normal business hours.

Final Reminders

- Share this slide deck with others in your MAO working on Contract-Level RADV (e.g., those selecting medical records for submission).

- Do not send PHI/PII to the RADV@cms.hhs.gov mailbox.

Conclusion

- If you have any further questions about CMS Contract-Level RADV, please contact CMS at radv@cms.hhs.gov with subject “RADV.”
- Additional communication resources will be provided at a later date if your MA Contract is selected for a future audit.
- Thank you for your participation!


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