W18 – CMS and HHS RADV Audits

Understanding and Preparing for the Marketplace Initial Validation Audit (IVA) and Medicare Advantage Risk Adjustment Data Validation (RADV) Audits
Presented by Scott Weiner

Agenda

► Who is EMSI?
► Risk Adjustment 101
► Medicare Risk Adjustment Data Validation (RADV) Audits
► Health Insurance Marketplace Initial Validation Audits (IVA)
► Understanding the Risk
► Questions
► Appendices

ABOUT EMSI
Solutions Designed to Get Results

Across two operating divisions, we customize and design information solutions to empower our customers to grow and improve profitability.

**Healthcare Services**
- Health Plan Services
  - Risk Adjustment Services
  - Medicare Advantage
  - Commercial
  - Managed Medicaid
  - Data Analysis and Targeting
- Healthy House Calls
- Chart Retrieval
- HCC Coding

We empower Health Plans with comprehensive services for coordination, and to improve the lives of those they serve.

**Insurance Services**
- Health Plan Services
  - Medical Record Retrieval
  - Mobile Paramed Exams
  - Electronic Application Processing / Teleinterviews
  - Underwriting Services
  - Inspections
  - Litigation Record Retrieval
- Employer Services
  - Workplace Services
  - Wellness Services
  - Clinical Services
- Data Analysis and Targeting

Across two operating divisions, we customize and design information solutions to empower our customers to grow and improve profitability.

Medical Information Solutions for:
- Health Plans
- Life Insurers
- Life Sciences
- P&C Insurers
- TPA's / Employers

**Annual Transactions**
- 1.5+ million medical information solutions
- 2.0+ million calls handled at call centers
- 250K+ medical records retrieved
- 7400+ reviews, charts and home visits
- 600K+ chart reviews
- 75K+ claims investigations
- 400K+ drug and alcohol screenings
- 10+ million medical information solutions
- 2.0+ million medical information solutions

**RISK ADJUSTMENT 101**

Irving, Texas
Headquarters
3600+ employees
600K+ chart reviews
250K+ underwriting transactions
400K+ drug and alcohol screenings
75K+ claims investigations

7400+ reviews, charts and home visits
600K+ chart reviews
75K+ claims investigations
400K+ drug and alcohol screenings
What is Risk Adjustment?

- A method used to adjust bidding and payment based on the health status and demographic characteristics of an enrollee
- Pay appropriate and accurate reimbursement for subpopulations with significant cost differences
- Purpose: to pay plans accurately for the risk of the beneficiaries they enroll
- Why: access, quality, protect beneficiaries, reduce adverse selection, etc.

Types of Risk Adjustment

- Prospective/Future Prediction:
  - Uses historical diagnoses as a measure of health status and demographic information to predict future expense
  - Data from 2014 used to predict expected costs in 2015
  - Example: CMS Medicare HCC Model
- Concurrent (aka Retrospective):
  - Uses historical diagnoses as a measure of health status and demographic information to predict expected expense for the current period done from a retrospective perspective
  - Data from 2014 used to retroactively predict expected costs in 2014
  - Example – HHS-CC model for the Health Insurance Marketplace

Why Does CMS Conduct Audits?

“To follow by faith alone is to follow blindly.”

- Benjamin Franklin
Member Example

- 60-year-old male
- Originally disabled
- Medicaid
- Community
- HCC 17 – Diabetes w/Acute Complications
- HCC 19 – Diabetes w/o Complications
- HCC 80 – Congestive Heart Failure
- HCC 92 – Specific Heart Arrhythmias
- Interaction DM_CHF

HCC Calculation

<table>
<thead>
<tr>
<th>Variable</th>
<th>Accurate</th>
<th>Missing</th>
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<tbody>
<tr>
<td>60-year-old male</td>
<td>0.411</td>
<td>0.411</td>
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<tr>
<td>Originally disabled</td>
<td>0.000</td>
<td>0.000</td>
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<tr>
<td>HCC 17 – Diabetes w/Acute Complications</td>
<td>0.339</td>
<td>0.000</td>
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<tr>
<td>HCC 19 – Diabetes w/o Complications</td>
<td>0.162</td>
<td>0.162</td>
</tr>
<tr>
<td>HCC 80 – Congestive Heart Failure</td>
<td>0.410</td>
<td>0.000</td>
</tr>
<tr>
<td>HCC 92 – Specific Heart Arrhythmias</td>
<td>0.293</td>
<td>0.293</td>
</tr>
<tr>
<td>Interaction for Diabetes and CHF</td>
<td>0.154</td>
<td>0.000</td>
</tr>
<tr>
<td>Total Hierarchical HCC weight</td>
<td>1.507</td>
<td>0.868</td>
</tr>
<tr>
<td>Annual payment (assumes $800/mo.)</td>
<td>$15,327</td>
<td>$15,327</td>
</tr>
<tr>
<td>Payment Difference</td>
<td>$7,113</td>
<td>$7,113</td>
</tr>
<tr>
<td>Medical expense (85% MLR)</td>
<td>$12,960</td>
<td>$12,960</td>
</tr>
<tr>
<td>Profit/Loss</td>
<td>$2,357</td>
<td>$(54,645)</td>
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</table>

MEDICARE AND RADV
Medicare HCC Model

- Model is prospective – previous diagnosis data used to predict future member expense
- Model is hierarchical – hierarchies apply to disease categories
- Model was essentially unchanged from 2004 implementation until 2014 payment year
- Risk scores correlate directly to plan payment

Model Comparison 2013 vs. 2016

<table>
<thead>
<tr>
<th>Model Compare</th>
<th>2013 (V12)</th>
<th>2016 (V22)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnoses</td>
<td>2,938</td>
<td>3,033</td>
</tr>
<tr>
<td>Discontinued Diagnoses</td>
<td>129</td>
<td>79</td>
</tr>
<tr>
<td>New Diagnoses</td>
<td>224</td>
<td></td>
</tr>
<tr>
<td>HCC</td>
<td>70</td>
<td>79</td>
</tr>
<tr>
<td>New HCC</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Changed HCC</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Hierarchies</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>Community Interactions</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Institutional Interactions</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>Disability Interactions</td>
<td>5</td>
<td>12</td>
</tr>
</tbody>
</table>

Medicare HCC Audit

- Unlike other Medicare audits, the HCC audits do not have clear guidelines
- Whether a diagnosis is acceptable is often left to plan interpretation
- This may be different than what CMS determines to be acceptable
- Every plan must determine its acceptable level of risk
- Even when CMS provides guidelines, they are not always clear
Acceptable Provider Specialties

CMS RADV Audit Process

► Plan is notified of RADV audit
► Roughly 600 Medicare contracts and only 30 plans are selected annually
  + Odds of being selected for a RADV Audit: ~ 5% per year
► CMS selects 201 members for audit
  + Three strata – Low, Medium and High risk scores
► Plan required to provide support for every HCC via medical record submission to CMS

Or Are They?

Lab and Pathology Reports – Guidance
Some organizations have requested that the raw lab and pathology reports for data submission and medical record reviews. The following guidance must be taken into account when considering data or medical record submission from these sources:

- OFFICIAL GUIDELINES TO QUALITY MEASUREMENT (SECTION 15.8, Abnormal Findings)
- Unacceptable risk adjustment provider sources:
  - Unacceptable risk sources include:
  - PRIMARY SOURCE (e.g. specialty code) unacceptable risk adjustment provider sources:
  - Unacceptable risk adjustment provider sources:
  - PRIMARY SOURCE (e.g. specialty code) unacceptable risk adjustment provider sources:
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  - PRIMARY SOURCE (e.g. specialty code) unacceptable risk adjustment provider sources: 
CMS RADV Process – RAC Audits?

- The ACA required Medicare’s RAC program to be expanded to Medicare Advantage and Part D plans, but that has not happened yet.
- CMS recently released a document explains how that would be done and the scope of the program.
- There is no definitive timeline for when the program would go into effect.
- Under the new Medicare Advantage auditing system, RACs would be tasked with conducting risk adjustment data validation (RADV) reviews.
- In addition to general RADV audits, RACs would conduct “condition-specific” RADV audits. Those reviews would focus on specific medical codes or health conditions, such as diabetes, that have high rates of payment errors.

Is Your Plan at Risk for a RADV Audit?

- Large change in year-over-year risk scores – CMS will focus on plans with big increases in score to ensure it is correct
- Very few delete records – if you are not doing deletes, you are not reviewing your own submissions for accuracy and correcting errors
- Other corrective actions – has your plan been reviewed for something else? It may increase your likelihood of audit as CMS sees you as a risk

Which Members Are Included?

- All Possible Members
- Members effective in claim year
- Had an HCC Diagnosis mapping to an HCC in claim year
- Had Part B coverage for the data collection period
- Not in hospice during 13 mo period
- ESRD
- No ESRD
- Target Population
- Had an HCC Diagnosis mapping to an HCC in claim year
- Members effective in claim year
- Not in hospice during 13 mo period
- Had Part B coverage for the data collection period
- ESRD
- No ESRD
Can I Really Send in That Many Records?

- While the original RADV guidelines allowed for only the one “best medical record,” the new RADV guidelines have changed.
- Plans can now submit up to five medical records to support a diagnosis and HCC.
- The same medical record can be used to support multiple HCC for a member as well.
- But the “best medical record” may not always be the best record to submit.

How Will I Know How the Plan Did?

- CMS will issue a “Preliminary Audit Report of Findings” (AROF).
- Shows HCC-level validation and errors and eligibility for dispute.
- At enrollee-level, AROF will show revised score and payment.
- Information and instructions for Medical Record Dispute (MRD) will be included with report.
- Plans allow to dispute findings only on certain types of RADV-related errors.

Plan Has Multiple Level of Appeals

- Plans can file initial appeal via MRD process for review by “Hearing Officer.”
- The plan must:
  + File appeal within 30 days from receipt of AROF.
  + Submit the “One Best Medical Record” from records submitted to IVC for this review though it does not have to be the record audited.
Plan Has Multiple Level of Appeals

- Plan will receive "Audit Report Post Medical Record Review," detailing results similar to AROF along with additional appeals instructions.
- Only other appeal option is to CMS Administrator.

CMS Identifies HCC Errors

- Charts are read 2x by the IVC Auditors.
- CMS Notifies Plan of Errors.

<table>
<thead>
<tr>
<th>HCC 17</th>
<th>HCC 15</th>
<th>HCC 19</th>
<th>No HCC</th>
</tr>
</thead>
</table>

 CMS Extrapolates Error

- HCC 17 drops to HCC 19 .248 -.459 = .211
- Multiply By Benchmark $800 * (.211) = (168.80)
- Extrapolate to Population (168.80) * 8,000 = $1,350,400
- Other HCC for same member can change
- Interactions may no longer apply

Health Exchange RADV (HHS-RADV) aka Initial Validation Audit (IVA)
Not Your Mother’s 3R’s

Reading
Writing
Arithmetic

HHS-RADV vs. Medicare RADV

<table>
<thead>
<tr>
<th>Item</th>
<th>Medicare RADV</th>
<th>HHS-RADV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment Years</td>
<td>2011 - Forward</td>
<td>2015 - Forward</td>
</tr>
<tr>
<td>Timeline</td>
<td>2-3 years after payment</td>
<td>Six months after year-end</td>
</tr>
<tr>
<td>Minimum Plan Size</td>
<td>Every Plan</td>
<td>Not Addressed</td>
</tr>
<tr>
<td>Number of Plans Audited</td>
<td>Approximately 50</td>
<td>All</td>
</tr>
<tr>
<td>Members</td>
<td>Stratified – 3 Strata</td>
<td>Stratified – 10 Strata</td>
</tr>
<tr>
<td>Diagnoses Included Thru</td>
<td>13 months after year-end</td>
<td>4 months after year-end</td>
</tr>
<tr>
<td>Medical Records</td>
<td>All Supporting</td>
<td>All Supporting</td>
</tr>
<tr>
<td>Extrapolation</td>
<td>Applied to Strata</td>
<td>Not Currently Defined</td>
</tr>
<tr>
<td>Appeal Process</td>
<td>Defined</td>
<td>Defined</td>
</tr>
<tr>
<td>FFS Offset</td>
<td>Included – Est. 11%</td>
<td>Not Applicable 2015</td>
</tr>
<tr>
<td>Clarity</td>
<td>Vague</td>
<td>Vague</td>
</tr>
<tr>
<td>First Round Audits Conducted By</td>
<td>CMS</td>
<td>Plan Contracted Vendor</td>
</tr>
</tbody>
</table>

HHS-HCC Model

- More diagnoses are included and map to additional HCC because of broader disease implications for the commercial population
- What occurs in the year, affects payment for the year – retrospective or concurrent payment model
- Differences in plan type (Bronze, Silver, etc.) affect the risk score and associated payment
- Model is a zero-sum – if one plan’s risk score is higher than another plan’s, the lower risk score plan will have to make payments to higher risk score plan
Zero Sum Payments

<table>
<thead>
<tr>
<th>Plan</th>
<th>Plan A</th>
<th>Plan B</th>
<th>Plan C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Revenue</td>
<td>$10,000,000</td>
<td>$10,000,000</td>
<td>$10,000,000</td>
</tr>
<tr>
<td>Initial Risk Score</td>
<td>1.15</td>
<td>1.07</td>
<td>1.23</td>
</tr>
<tr>
<td>Normalized Risk Score</td>
<td>1.00</td>
<td>0.93</td>
<td>1.07</td>
</tr>
<tr>
<td>Revised Revenue</td>
<td>$10,000,000</td>
<td>$9,304,347</td>
<td>$10,695,653</td>
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<tr>
<td>Payment Change</td>
<td>$0</td>
<td>$(695,653)</td>
<td>$695,653</td>
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</table>

Model Population

► Because the HHS Model includes a much more varied population than the Medicare model, some additional changes were necessary
  + Age groups include infant through adults and seniors.
  + Age groups are banded smaller for children and infants

HHS-RADV Authority

► Section 1343 of the Affordable Care Act (ACA) establishes a permanent Risk Adjustment (RA) program which is intended to provide payments to health insurance issuers that attract higher-risk populations.
  + The Premium Stabilization Final Rule requires states, or HHS on behalf of states, to validate a statistically valid sample of data for all issuers that submit for risk adjustment every year and provide an appeals process.
  + The rule allows states, or HHS on behalf of states, to adjust average actuarial risk for each plan based on the error rate found in validation and adjust payments and charges based on the changes to average actuarial risk.
The Secretary of HHS has designated CMS to implement the HHS-RADV program in accordance with the following regulations:

- 45 CFR §153.350
- 45 CFR §153.620
- 45 CFR §153.630
- Premium Stabilization Final Rule
- 2014 Payment Notice Final Rule
- 2015 Payment Notice Final Rule

Key Components

- CMS selects a statistically valid sample of enrollment and medical claims data submitted to the issuer's EDGE server.
- Data validation of the selected sample is conducted by an initial validation auditor (IVA Entity) selected by the issuer and approved by CMS.
- CMS selects a second validation auditor (SVA Entity) to validate a subsample of the original IVA sample.
- CMS establishes an issuer-level error rate based on data validation results.
- CMS applies the error rate to each issuer's RA covered plan average liability risk score (PLRS) to produce an error estimate.
- CMS provides an HHS-RADV appeals process for issuers.
- CMS adjusts the PLRS for issuer’s risk adjustment covered plans based on errors discovered as a result of data validation.

2015 Payment/Benefit Year Timeline

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
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<tbody>
<tr>
<td>Fall 2015</td>
<td>HHS-RADV Training Begins</td>
</tr>
<tr>
<td>November 31, 2015</td>
<td>Issuer Benefit Year Dates</td>
</tr>
<tr>
<td>March 15, 2016</td>
<td>CMS sends Senior Official (SO) Designation letter</td>
</tr>
<tr>
<td>April 25, 2016</td>
<td>SO Designation Letters due back to CMS</td>
</tr>
<tr>
<td>April 30, 2016</td>
<td>Data Submission Deadline</td>
</tr>
<tr>
<td>May 9, 2016</td>
<td>Issuers must select and submit IVA Entity Attestation letter to CMS</td>
</tr>
<tr>
<td>May 2016</td>
<td>CMS displays HHS-RADV sampling command and Issuer execute command</td>
</tr>
<tr>
<td>June 2016</td>
<td>CMS provides IVA Entities access to audit tool</td>
</tr>
<tr>
<td>June 2016</td>
<td>CMS validates IVA samples</td>
</tr>
<tr>
<td>July 1, 2016</td>
<td>CMS releases IVA samples</td>
</tr>
<tr>
<td>July 1 – December 2016</td>
<td>HHS-RADV Audits are conducted</td>
</tr>
<tr>
<td>December 2016</td>
<td>CMS Entities submit IVA results and supporting documentation</td>
</tr>
<tr>
<td>November 2016 – March 2017</td>
<td>Second Validation Audits are conducted</td>
</tr>
<tr>
<td>Spring 2017</td>
<td>CMS releases Benefit Year 2015 pilot results, lessons learned &amp; error rates</td>
</tr>
</tbody>
</table>
Initial Validation Auditors

- Unlike Medicare Advantage, the Health Insurance Marketplace Initial Validation Auditors are contracted by the plan
  - Both Health Insurance Marketplace and "Off-Exchange Plans" are included
  - Members with and without HCC will be audited
  - All auditors must be certified by the American Association of Professional Coders (AAPC) or the American Health Information Management Association (AHIMA)
  - Senior auditors must have at least three years of experience in 2015 and five years in 2016 and beyond
  - Enrollment sources will be verified
  - Initial Validation Auditors must be free from conflicts of interest

Conflicts of Interest

- Issuer must attest to being conflict free to the best of its knowledge
- Neither the issuer nor any member of its management team (or any member of the immediate family of such a member) may have any material financial or ownership interest in the initial validation auditor
- Owners, directors and officers of the issuer may not be owners, directors or officers of the auditor (and vice versa)
- Audit Team members may not be married to, in domestic relationship with or immediate family of owners, directors, officers or employee of the issuer
- The initial validation auditor may not have had a role in establishing any relevant internal controls of the issuer related to the risk adjustment data validation process

Audit Strata

- 80% of Members
  - No HCC – Demographic Only
    - Adult High Risk Score
    - Child High Risk Score
    - Infant High Risk Score
  - 33% of Sample

- 20% of Members
  - Adult Medium Risk Score
  - Child Medium Risk Score
  - Infant Medium Risk Score
  - Adult Low Risk Score
  - Child Low Risk Score
  - Infant Low Risk Score
  - 67% of Sample
Members with No HCC

- For enrollees without risk adjustment HCCs for whom the issuer has submitted a risk adjustment eligible claim or encounter, HHS would require the initial validation auditor to review all medical record documentation for those risk-adjustment eligible claims or encounters, as provided by the issuer, to determine if HCC diagnoses should be assigned for risk score calculation, provided that the documentation meets the requirements for the risk adjustment data validation audits.

Enrollment Validation

- The initial validation auditor would validate information by reviewing plan source enrollment documentation, such as the 834 transaction, which is the HIPAA-standard form used for plan benefit enrollment and maintenance transactions. These enrollment transactions reflect the data the issuer captured for an enrollee's age, name, sex, plan of enrollment, and enrollment periods in the plan.
While no direct financial penalties will result from the 2015 payment year audit, the possibility of financial penalties and further audit does exist:

- Office of the Inspector General (OIG) – as noted in the OIG Work Plan, the OIG is cracking down on over-coding of HCC.
- False Claims Act – knowingly submitting false diagnoses
- Whistleblowers – disgruntled employees, etc. may cry foul.

**Understanding the Risks**

"**Blind faith in your leaders or anything will get you killed.**"

- Bruce Springsteen, “War”
“Blind faith in your providers and claim submission will get you adverse findings.”

- Scott Weiner, EMSI Health

Top 10 Medicare Risk Adjustment Coding Errors

- The record does not contain a legible signature with credential.
- The electronic health record (EHR) was unauthenticated (not electronically signed).
- The highest degree of specificity was not assigned the most precise ICD-9-CM code to fully explain the narrative description of the symptom or diagnosis in the medical chart.
- A discrepancy was found between the diagnosis codes being billed versus the actual written description in the medical record. If the record indicates depression, NOS (311 Depressive disorder, not elsewhere classified), but the diagnosis code written on the encounter document is major depression (296.20 Major depressive affective disorder, single episode, unspecified), these codes do not match; they map to a different HCC category. The diagnosis code and the description should mirror each other.

Top 10 Medicare Risk Adjustment Coding Errors

- Documentation does not indicate the diagnoses are being monitored, evaluated, assessed/addressed, or treated (MEAT).
- Status of cancer is unclear. Treatment is not documented.
- Chronic conditions, such as hepatitis or renal insufficiency, are not documented as chronic.
- Lack of specificity (e.g., an unspecified arrhythmia is coded rather than the specific type of arrhythmia).
- Chronic conditions or status codes aren’t documented in the medical record at least once per year.
- A link or cause relationship is missing for a diabetic complication, or there is a failure to report a mandatory manifestation code.

## Claims Data Submission

**Advantages**
- Chart review volume would be too great if we had to look at every record
- Can provide additional dates of services for a diagnosis beyond what is found via chart review

**Disadvantages**
- 75% accurate
- Will not stand up to a RADV Audit
- Limited to how many the provider can submit on a claim
- May not be able to tell if the service was done by an acceptable provider

## Medical Record Review

**Advantages**
- More accurate than claim submission only
- More complete than claim submission
- Able to identify the provider of service
- Additional diagnoses that may not have been on claim
- Fix the “30/30” issue

**Disadvantages**
- Time consuming
- Intrusion on the provider office
- Retrospective
- Chart coding is often open to interpretation
- Physician handwriting
- EMR issues

## Prospective Assessments

**Advantages**
- Provides real-time picture of the patient
- Provides a method to address care for home-bound or facility-bound patients
- Provides a look into the member’s living conditions
- More complete than the typical physician’s office health exam
- Not just about risk adjustment
- Provides complete and accurate documentation for RADV support depending on quality of data capture

**Disadvantages**
- More costly than office visit
  - Office visit - $45-205 in Dallas
  - Prospective Assessment ($300+)
- Physicians often see it as competition to their services
- Breaks the PCP/member relationship if not done correctly.
- Changes to CMS guidelines
PAPER VS. EMR Record

<table>
<thead>
<tr>
<th>Paper</th>
<th>Electronic Record</th>
</tr>
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<tbody>
<tr>
<td>► Often not much more than a “super bill”</td>
<td>► Usually cleaner than paper</td>
</tr>
<tr>
<td>► Poor handwriting leads to misinterpretations</td>
<td>► Menial tasks that must be done on a paper claim are done automatically.</td>
</tr>
<tr>
<td>► Need legible signature and credentials on each page</td>
<td>► Several issues do exist with EMR records</td>
</tr>
<tr>
<td>► Need date on each page</td>
<td>► Cloning</td>
</tr>
<tr>
<td>► Need member name on each page</td>
<td>► Drug lists not updated</td>
</tr>
<tr>
<td></td>
<td>► Meaningful use</td>
</tr>
</tbody>
</table>

Reducing the Risk

What Can BE DONE TODAY?

► Assess organizational readiness
► Assess data quality
► Validate existing charts
► Acquire and abstract charts where gaps exist
Assess The Organization

► What does your Revenue Improvement Program look like?
► RADV Response Team includes:
  + Business Sponsor (Senior Executive)
  + Medical Directors to call doctors
  + Executives to call office managers
  + Project Manager(s)
  + Review/Audit staff
  + Other Team Members
► Meet internally to develop strategy for RADV and determine need for assistance from vendor
  • Are policies and procedures up-to-date?

Assess Data

► Assess and clean up data
  • Have “deletes” been processed for bad data?
  • Code Sets
    - Specialty codes (recently released)
    - CPT codes – may be acceptable provider, but not face-to-face visit
    - Are all RAPS (EDPS) resubmitted?
    - Are specialty codes updated?
    - Are CPT/Dx codes reviewed?
  • Update policies and procedures

Charting the Course

► Which HCC do medical charts substantiate?
► Are the diagnoses from acceptable providers?
► Are “Rule-out” diagnoses used?
► What is the frequency of the diagnoses?
► If using a vendor, have all charts been reviewed?
Top 10 Compliance Issues

#3 Electronic Medical Records

Some early adopters of Electronic Medical Records (EMR) software are now having to respond to “cloning” and/or “carry over” concerns raised by ZPICs and Program Safe Guard Contractors (PSCs).

“These audits appear to be the result (at least in part) of inadequately designed software programs which generate progress notes and other types of medical records that do not adequately require the provider to document individualized observations. Instead, the information gathered is often sparse and similar for each of the patients treated.”


Questions?

Ask Us How We Can Help

Scott Weiner

Email: sweiner@EMSinet.com
Phone: (757) 716-7061
Cell: (757) 553-8885
http://www.emsinet.com
### RADV Extrapolation

#### Calculation Sample Strata 1 - Hi Strata 2 - Mid Strata 3 - Low

<table>
<thead>
<tr>
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The total HCC-related payment made by CMS to the plan.

### THE IMPACT

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The net effect of payment errors on the model assuming ~13% error rate.
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Modeled payment for 201 enrollees in the sample and expanded to my entire population of ~24,000...

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\[
\hat{Y}_i = \hat{Y}_{i,0} + \sum_{j=1}^{M} \hat{Y}_{j} \cdot \hat{p}_j
\]

The standard error is \(SE_i = \sqrt{\hat{Y}_i}\)

---

For illustrative purposes only based on 5% of Extrapolated HCC Payments

---

3/22/2016
The Three “R's” of HHS Risk

MARKETPLACE 3 “Rs”

<table>
<thead>
<tr>
<th>Where Sold</th>
<th>Sold Within Exchange</th>
<th>Sold Outside Exchange</th>
<th>Who Administers</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACP Provision</td>
<td>Individual</td>
<td>Small Group</td>
<td>Individual</td>
</tr>
<tr>
<td>Risk Adjustment</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Reinsurance</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk Corridors</td>
<td>Yes</td>
<td>Yes</td>
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Risk Corridors

- Similar to Part D plans at start-up, the federal government will apply risk corridors to profit and loss of individual health plans in and out of the Marketplace.
Risk Corridor – Loss

- Plan has $125M revenue
- Plan expense ratio 15%
- Actual plan medical spend - $120M

<table>
<thead>
<tr>
<th>Total Plan Revenue</th>
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<tbody>
<tr>
<td>Plan Expense</td>
<td>$(18,000,000)</td>
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<tr>
<td>Total Medical Fund</td>
<td>$102,000,000</td>
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</table>

- Medical Spending: $120,000,000
- Lower Loss Limit: $100,000,000
- Upper Loss Limit: $1,000,000
- Above Upper Limit: $(1,000,000)
- HHS Share: $(1,500,000)
- Plan Share: $(1,500,000)

Risk Corridor – Gain

- Plan has $125M revenue
- Plan expense ratio 15%
- Actual plan medical spend - $100M

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- Medical Spending: $100,000,000
- Lower Loss Limit: $100,000,000
- Upper Loss Limit: $1,000,000
- Above Upper Limit: $(1,000,000)
- HHS Share: $(1,500,000)
- Plan Share: $(1,500,000)

Reinsurance

- Reinsurance designed to protect plans from impact of a few high risk member/catastrophic claims
  - For 2014, members with total claims in excess of $45,000 (attachment point) will be covered at 80% to a $250,000 maximum per member/claim
  - For 2015, the attachment point is $70,000
- Payments are funded from payment - all plans pay whether they are in the exchange or not.
  - 2014 - $63 per member payment
  - 2015 - $44 per member
- Plans will typically carry traditional reinsurance above the $250,000 threshold.