2010 Risk Adjustment User Group

April Meeting Notes

Meeting Date: April 21, 2010

Meeting Time: 1:30 p.m. – 2:30 p.m. EST

Topics:

User Group (UG) Process

Following the UG presentation, participants have an opportunity to ask questions. Plans may also submit payment-related questions to analyst@askriskadjustment.com and data validation related questions to mary.guy@cms.hhs.gov, following the UG session. PIN is required each time participants log into the UG session.

For additional information regarding the UG registration process, refer to the March 2010 UG slides posted on the www.csscoperations.com website.

Payment Process

Payment Questions Response Update

CMS encourages plans to continue to submit payment-related questions to the analyst@askriskadjustment.com email address. CMS encourages plans that submit questions directly to Sean Creighton carbon copy (CC) the analyst@askriskadjustment.com email address. Currently, the status of the response rates to questions submitted as of April 2010 is as follows:

- 81% January 2010
- 91% for February 2010
- 60% for March 2010

FAQ

Why would a beneficiary enrolled in a plan for more than 12 months have a RA Factor Type Code of "E"?

A training initiative presented by

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Beneficiaries can be enrolled in a plan more than 12 months and still have a RA Factor Type Code of "E" because the new enrollee factor ("E") is defined as 12 months in the data collection period and not 12 calendar months.

For example: A member enrolled in a plan in August of 2008, must have 12 months of Part B in the data collection period which is January 2009 through December 2009. Following the mid-year run in July 2010, the plan will notice the change from new enrollee status because at mid-year (July 2010) was the first opportunity the beneficiary had 12 months of Part B in the data collection period. CMS then reflects the new risk score and adjusts the risk score from January through June for the member.

Payment Update

Plans should refer to the 2009 Rate Announcement to obtain the risk adjustment factors for the 2011 payment year CMS-HCC model, and refer to the 2008 Rate Announcement to obtain the risk adjustment factors for the 2011 payment year CMS-HCC ESRD model.

Data Validation

- 2007 Targeted and 2008 National Samples
    - CMS has received the records for CY 2007 and 2008
    - CMS is now moving forward in reviewing the records
- CMS is in the process of selecting plans for the 2008 Contract-level Sample and expects to send medical record requests to plans in the next three to four months.

- CMS may send plans participating in the 2007 Targeted Sample and 2008 National Sample, two types of reports, Technical Assistance (TA) and/or Medical Records Receipt reports.
- The TA Report identifies records that may be problematic (e.g., an incomplete coversheet received).
- The Medical Record Receipt Report outlines what CMS has received from the plan. Plans must review this report to validate that what CMS received is consistent with what the plan submitted. Plans should communicate any discrepancies to CMS.

For more additional information on these reports, refer to the April 2010 UG Slides (http://www.csscoperations.com/new/usergroup/2010usergroupinfo.html).

- CMS sends reports to the Medicare Compliance Officer and Primary and Secondary contact on file. Healthcare Management Solutions (HMS) is available to respond to questions regarding technical issues.
- CMS will provide training to selected organizations participating in the CY 2008 Risk Adjustment Data Validation (RADV) Contract-Level Sample.

RADV Appeals

Medicare Advantage and Prescription Drug Plans Part C & D Policy & Technical Rule (CMS-4085-F) was published at http://www.federalregister.gov/inspection.aspx#special for display on April 6, 2010 and the expected publication was published on April 15, 2010.

Plans should also review the preamble to the rule to completely understand the regulation.

Two-Pronged RADV Appeal Approach

Medicare Advantage organizations may appeal medical record review determinations and payment error calculations.

- Appeal of medical record review determinations

  First Stage

  - CMS first completes an audit report of findings that specifies the HCCs eligible for appeal. Not all HCCs submitted will be eligible for appeals. For example, CMS will not consider HCCs not submitted within the medical record submission deadline for an appeal.

  - The MA organization makes the appeal to an independent CMS designated hearing officer, who will render an independent determination.

  - If dissatisfied with the results, the MA organization may appeal to the CMS Administrator. However, the administrator has discretionary rights whether to hear the appeal.

  Second Stage

  - Following the findings CMS will issue a revised audit report with the HCCs accepted.
  - MA Organizations may then invoke the Payment Error Calculation Appeal.

- Payment Error Calculation Appeal
  - MA organizations may invoke their right to appeal after receiving the initial audit report or revised audit report.
    - Organizations may appeal CMS' calculation of RADV contract-level error-estimate
  - MA organizations must adhere to established RADV audit requirements
  - CMS' payment error calculation methodology is not eligible for appeal
- Three Stage Process
  - *Reconsideration level review* - CMS official not otherwise involved in the initial calculation in the error rate will render a determination.
    - Decision is issued to both parties, CMS and MA organization, and either party may request a hearing.
  - *Hearing* – A hearing officer will have jurisdiction over the hearing process. Hearing will be a review of the paper trail that led to the determination. The officer may choose to hear testimony. If either party is not satisfied with the decision of the hearing officer, they may appeal to the CMS administrator for a Discretionary Administrator Review.
  - *Discretionary Administrator Review* – The organization may appeal to the CMS Administrator. However, the administrator has discretionary rights whether to hear the appeal.

CMS will provide additional appeals information to MA organizations.

Operations Update

- Some tips regarding data submission include:

- Same submitter may transmit for several MA organizations.
- Multiple batches are allowed per Hxxxx number.
- More than one detail record (CCC) is allowed per HIC number.
- NPI (National Provider Identifier) is not required for risk adjustment.
- Once a cluster is submitted and stored, it is not necessary/required to resubmit.

Operations FAQ

Q: Can I delete all the errors I received in my file, to lower my error percentage rate?

No - claims that receive an error are not stored. In order for an error to be deleted, it must be stored in the system.

Q. Why is risk adjustment important to physicians and providers?

The risk adjustment model relies on the ICD-9-CM diagnosis codes to prospectively reimburse MA organizations based on the health status of their enrolled beneficiaries. Physicians and providers must focus attention on complete and accurate diagnosis reporting according to the official ICD-9-CM coding guidelines.

Technical Assistance Update

Next User Group meeting scheduled: Wednesday, May 19, 2010, at 1:30 p.m. EST.