

# Rising to the Challenge!

The Quarterly Newsletter of the Risk adjustment Initiative and Society for Education  
ISSUE 03 March 2011



# RISE

Risk Adjustment Initiative & Society for Education

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## RADV Extrapolation Update

Ever since the first Risk Adjustment Data Validation (RADV) audits were carried out three years ago, the selected pilot plans – and the MA industry in general – have been on edge, trying to understand how CMS would use the results. Finally, there's some clarity, but still a lot of uncertainty as well.

By way of quick background, CMS had audited risk adjustment data integrity for many years. They tested integrity by comparing the Plan's diagnostic data (which came from claim submissions) to medical records. If the diagnosis wasn't found in the medical record, it was deemed impermissible. Plans pointed out that medical records are notoriously incomplete, and that doctors routinely submit diagnoses that might not be identified in charts. CMS held its ground, but it limited revenue take-backs to the relatively few charts that were included in the audit.

With RADV, CMS decided to apply the mismatch rate – the percent of claims-based diagnoses that didn't have a matching chart notation – to the entire contract and all its members. Further, mismatches included charts that contained the proper diagnosis, but not a proper signature. The mismatch rate is in the 15-30% range in most parts (continued on pg 3)

## Finance Departments see Stars!

In most health plans the finance department "pencil pushers" are viewed as Grinches to the Quality Department, refusing to fund the "creative" outreach initiatives of the quality "geeks" that are designed to improve HEDIS® scores but do not generate revenue. The Health Care Reform legislation is threatening to close this chasm by forcing plans to be smart about member touch points. (continued on pg 3)

# 2011 Advance Notice and Call Letter

Quality Bonuses will become more Important than Ever

On February 18<sup>th</sup> CMS released the annual 45 Day Advance Notice/Call Letter that outlines proposed changes to the Medicare Advantage and Medicare Prescription Drug plans for 2012 and the announcement had pertinent ramifications for Risk Adjustment.

On a positive note, CMS made a decision to not implement the proposed changes to the HCC model that were previously announced for 2012 and announced that The Coding Intensity Adjustment is to be set at 3.41% for 2012, the same level it was at in 2011. Historically changes to the HCC model have had negative impacts on MA plan reimbursements. The Advance Notice/Call Letter also detailed a proposal to further develop the Quality Bonus Payment demonstration (Star Ratings) that focuses on quality of care within Medicare Advantage and that will implement a previously announced demonstration that expands the quality bonus

to MA plans with star ratings of 3 or more stars. This will allow plans achieving 3 to 4.5 stars the ability to significantly impact their quality bonuses. Quality bonuses will become very important, especially with an estimated net MA payment hike of 1.6%, as calculated by Jonathan Blum of CMS's Center for Medicare, that will more than likely be much lower than medical cost trends. On the other side of the spectrum, CMS is planning on terminating MA contracts of plans that get summary quality ratings of less than 3 stars for 3 consecutive years. This is a draft notice with the Final notice to be released on April 4<sup>th</sup>.

*Jeff Dumcum, General Manager Risk Adjustment Solutions*

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## ICD-10 Preparedness: Plans and providers preparing for a change

With only 30 months remaining until the switch to ICD-10 codes all parties need to be preparing for the change. As Medicare Advantage plans we are acutely aware of the need for accurate documentation which supports the diagnoses submitted on the claims, leading to HCC assignment and appropriate reimbursement. We are in a unique position to not only be the requestors of the data, but also to help providers understand the need for good coding and billing practices to minimize their need for repeated visits for retrospective chart reviews to seek additional diagnoses and verify the accuracy of what was submitted.

Although training for ICD-10 is recommended to occur 6-9 months prior to implementation, it is important to have internal key staff trained now to understand the impacts of ICD-10 and to be able to explain the impacts to staff interfacing with the providers. Providers need to obtain the draft ICD-10-CM code books to become familiar with the codes related to their specialties, the revised terminology and to know what they need to document so that the correct code can be selected. Many unspecified codes have been eliminated, so the documentation needs to be precise to support the codes selected.

Encouraging an early start in becoming familiar with the new codes and revising documentation practices now will ease the transition for all parties.

*Sheri Patton, RHIA*

*AHIMA Approved ICD-10-CM/PCS Trainer*



## What you need to know about the latest RADV news...

(continued from pg 1) of the country and is independent of payor (unless otherwise incentivized, doctors don't chart better for one payor than another. Factors influencing chart quality include type of practitioner, size of practice, use of EMR, etc.) Obviously, applying a large negative correction to a Plan's entire revenue could be financially disastrous.

Late last fall, CMS informed the initial RADV pilot Plans how it would proceed. In essence, it would provide a generous confidence interval around calculated estimate, but would definitely apply the mismatch rate to the entire contract. In other words, Plans would still face large take-backs. Plans were allowed to appeal, but only on technical issues related to chart review.

As of this note, Plans are still in discussion with CMS, and no demand letters have been issued, but neither has there been any indication of a CMS change in policy. It's possible that one or more Plans will opt to litigate rather than pay, thereby introducing additional months of confusion. Or perhaps CMS will re-

lent, and allow the mismatch rate to be adjusted for the local or national prevailing rate.

So what's a Health Plan to do? You should take an active external approach, and work closely with your providers to improve their charting quality. It is challenging work, and probably requires some financial incentives. But in the long run, it is the safest and most productive approach. Internally, be sure to conduct a mock RADV audit yearly. That way, when your audit letter arrives, you can respond with maximal force and efficiency.

*Daniel C. Lyons, MD, MPH, Chief Medical Officer, **HEALTHRISK PARTNERS***

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## Home Visit Staff bridging the gap between Finance and Medical Management

(continued from pg 1) To succeed in the Medicare Star Ratings Demonstration Project, plans are ramping up their interactions with members with home visits or increased targeted physician interactions to close care gaps, increase HEDIS® scores, Star ratings and increase REVENUE. Suddenly, the quality department has become a revenue center, not just a cost center! And, these same interventions should be employed by the finance department to increase risk scores and REVENUE. Ideally, both interventions should occur during every member interaction the plan initiates. The "stars" have aligned to make the two department's goals symbiotic.

At Gateway, we have come to recognize that both departments have to be part of each other's plans. To that end, our risk score home visit staff are collecting HEDIS® data, and our quality nurses are searching for diagnosis information when performing hybrid measure chart reviews. Both departments are looking for additional ways to collaborate.

The Grinches and Geeks are getting along.

*Michael Madden, MD, Vice President & Chief Medical Officer, **GATEWAY HEALTH PLAN***



## Association Business & News

The RISE Executive Board will be convening for their first annual board meeting this March 27th, just before the general members' meeting in Nashville, TN. We will review the first year of the association, and will plan the organization's activities and goals for 2011/2012. If you have any thoughts, suggestions, or concerns you'd like the board to address during this meeting, please contact us at [krodriguez@rasociety.org](mailto:krodriguez@rasociety.org).

Look for the minutes of this meeting, plus a recap of our general membership meeting and educational conference on the RISE website this April!

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## Upcoming Events

### The Inaugural Meeting of RISE and 5th HCC Management Summit: Conference on March 26-29 in Nashville, TN

We're expecting over 200 healthcare executives at this renowned industry event - there are additional hotel rooms available at other area hotels; [check online](#) for more information

### Managing the complexities of CMS' new encounter data processing requirements: Webcast on April 14th

Join us for an hour presentation detailing the CMS guidelines , plus get answers to frequently asked questions—[complimentary passes](#) are available to RISE members.

### Beyond Submission—Key elements for a successful Encounter Data Reporting Process: Webcast on April 28th

Join us for an in-depth look that goes beyond the basics of encounter data reporting requirements and instead delves into the critical components of your encounter reporting platform—[complimentary passes](#) are available to RISE members.

### The Star Ratings Leadership Summit for MA Plans: Conference on May 23rd in Chicago, IL

Whether you're still struggling to understand the star scoring methodologies or working hard to develop and implement your Star strategies, you can't afford to miss this 2-track event. More information at [www.rasociety.org/calendar.aspx](http://www.rasociety.org/calendar.aspx)

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