Case Study: Validating Medicare Risk Adjustments

Medicare pays managed care organizations, or health plans, a fixed monthly rate for inpatient and outpatient health services provided to Medicare beneficiaries. The Centers for Medicare and Medicaid Services (CMS) establishes the amount before services are rendered, as well as an adjustment for the beneficiary's health status. The adjustment aims to minimize the financial risk that a health plan assumes in rendering healthcare for a fixed, predetermined payment amount.

The risk adjustment for a given year depends on the diagnosis codes (currently ICD-9-CM) providers assign to a beneficiary for services received during the previous year. At scheduled intervals, health plans report the codes to CMS. Each code is subsequently mapped to a Hierarchical Condition Category (HCC). Currently, 70 HCCs are in use to adjust payments for hospital, physician, and certain other health services; 78 RxHCCs (prescription drug HCCs) are in use to adjust payments for outpatient medications.

A Medicare beneficiary may be assigned one, multiple, or no HCCs and RxHCCs, depending on the diagnosis codes. Each category has a weight that signifies the relative costliness of providing healthcare to a person with the medical conditions representative of that category. Given a beneficiary's socio-demographic characteristics, higher weight equates to higher expected cost of providing health services to the beneficiary, which usually results in a higher corresponding payment amount. A beneficiary with a risk score of 1.80 would have an expected cost and payment amount twice as large as one with a risk score of 0.90.

Data Validation Audit

CMS annually reviews samples of medical records to assess the accuracy and completeness of the clinical diagnosis codes that health plans report for risk-adjustment purposes. Health plans submit medical records that support the diagnosis codes used to assign HCCs and RxHCCs to sampled beneficiaries. Consequently, inaccurate diagnosis codes, incomplete documentation, or missing medical records may result in flawed risk adjustments and incorrect payment amounts.

For each annual payment audit, medical records are requested for a national and a targeted sample of beneficiaries. Health plans and beneficiaries have to meet various criteria to qualify for sample selection.

© 2011 Ascellon Corporation. All rights reserved.

Medical Record Review

Ascellon, as a Federal "data validation" contractor, employs teams of coders to re-abstract the sampled medical records and map the results to the HCCs and RxHCCs. In general, a data validation audit consists of two major parts—an initial review and a secondary review. The secondary review focuses on the categories the initial review concludes are *discrepant* or *new*, or were not reported previously to CMS. Both discrepant and new categories trigger payment adjustments. Discrepancies decrease payments; new categories increase them. The net financial impact on a health plan may be minor or substantial. In all cases, health plans have an opportunity to appeal intended adjustments.

Ascellon has performed as both the second data validation contractor and the initial contractor on payment audits. As the latter, Ascellon Corporation requested medical records for the sampled beneficiaries, documented health plan responses to the request, re-abstracted the submitted records, entered the findings into specially-designed databases, formulated algorithms to determine the final HCCs and RxHCCs, compared the results with the categories used to calculate the original risk scores, and computed revised risk scores and payment differentials.

Certified coding professionals conducted blind medical record reviews—meaning, they were unaware of the assigned diagnosis codes reported for the sampled beneficiaries and the HCCs and RxHCCs. To help insure the validity of the findings, on a weekly basis, a senior coder reviewed every record indicated as discrepant or new by a primary coder. If the "inter-rater reliability" rate fell below 95 percent, auditors re-abstracted all of the primary coder's records for the week.

Major Findings

The medical record reviews have typically found discrepancy rates that varied by type of sample and category. For example, some reviews concluded that up to one-third of the HCCs and more than 25 percent of the RxHCCs in the national sample were discrepant. Historically, the reviews have also found more than a few new categories, including over 100 HCCs that were not reported previously for beneficiaries in the national sample.

The coding results translated into increased payments for some of the sampled beneficiaries and decreased payments for others. For example, when the net overpayment in the sample is extrapolated, the determination was found to be in excess of $3 billion for the national review for the 2006 payment year.

For more information, contact:
Sheila Scott, Vice President/COO
Phone: 240-737-2025
Email: sscott@ascellon.com

© 2011 Ascellon Corporation. All rights reserved.