CMS

CENTERS for MEDICARE & MEDICAID SERVICES

2005

Regional Training

Risk Adjustment Data Basic Training

August 9, 2005
New Orleans, LA

Aspen Systems Corporation™
Culture of Commitment

Introduction

Presented By:
Aspen Systems Corporation

Purpose
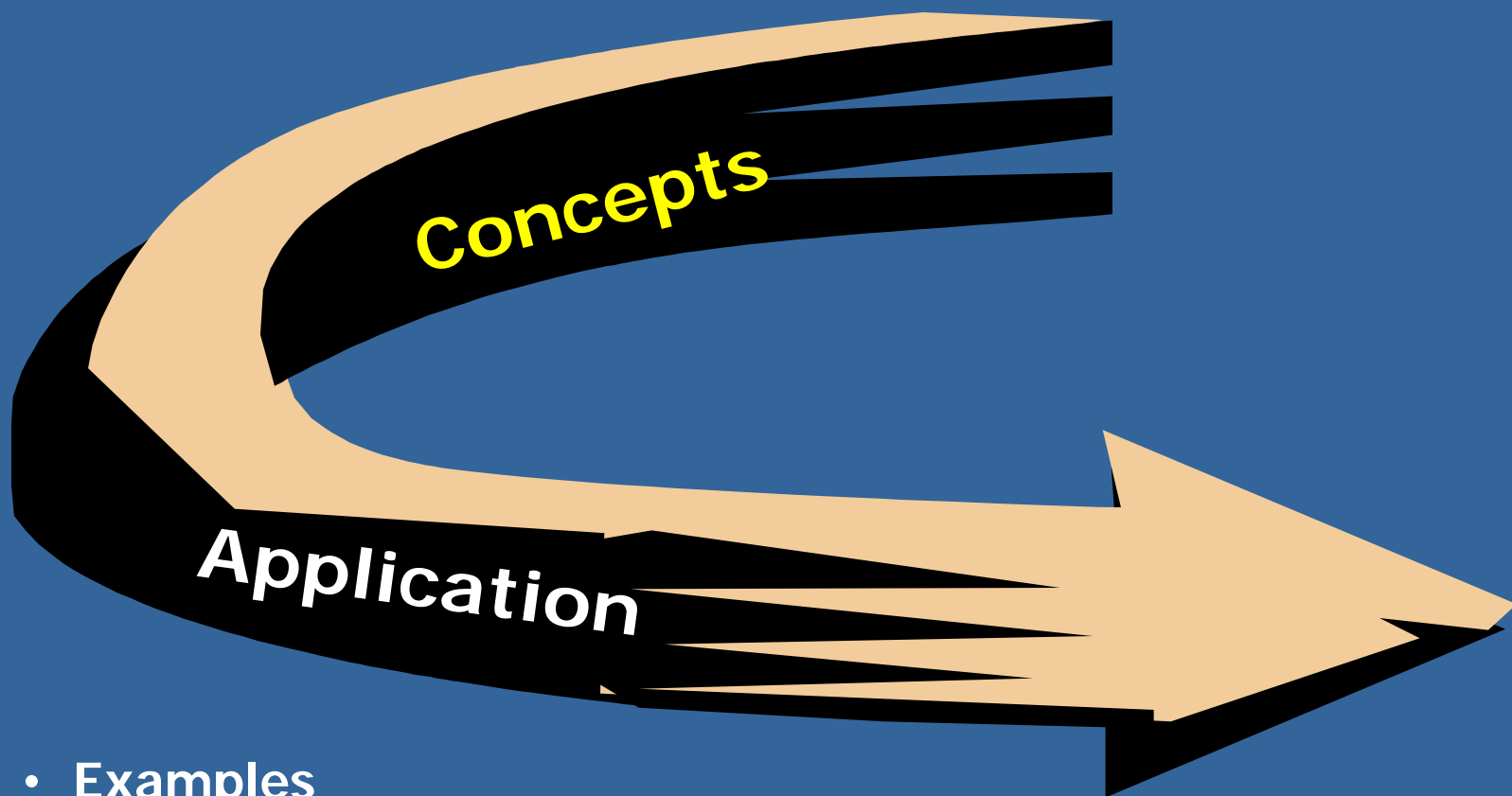
- To provide participants *new* to risk adjustment the support needed to improve the quality and quantity of risk adjustment data collected and submitted in accordance with CMS requirements.

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Risk Adjustment Data Basic Training

I-3

Training Format

Concepts

Application

- **Examples**
- **Exercises**
- **Group Participation**
- **Interactive**

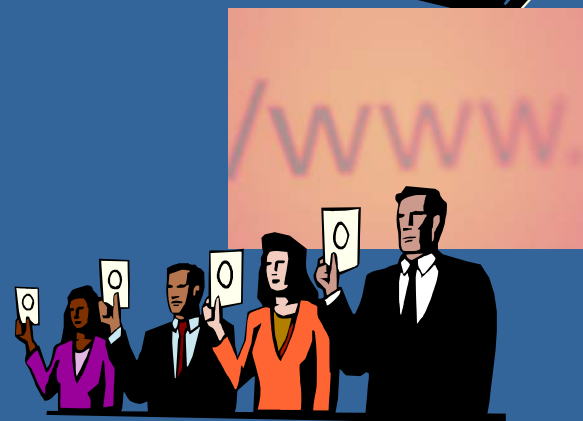# Your Participation Makes the Difference

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Training Tools

- **Participant Guide**
  - **CD w/slides**
- **Job Aids**
- **www.csscoperations.com**
- **Panel of Experts**

Audience

- **New staff**
- **New organizations**
- **Staff unable to attend previous training**
- **Third Party submitters**

Agenda

TIME	TOPIC
8:00 AM – 8:30 AM	Introduction
8:30 AM – 9:30 AM	Risk Adjustment Methodology
9:30 AM – 10:00 AM	Process Overview
10:00 AM – 10:15 AM	**BREAK**
10:15 AM – 11:00 AM	Data Collection
11:00 AM – 12:00 PM	Data Submission
12:00 PM – 12:30 PM	**WORKING LUNCH/BREAK**
12:30 PM – 1:15 PM	Edits
1:15 PM – 2:15 PM	Reports
2:15 PM – 2:30 PM	**BREAK**
2:30 PM – 3:30 PM	Data Validation
3:30 PM – 4:30 PM	Verifying Risk Scores
4:30 PM – 5:00 PM	Question & Answer
5:00 PM	**ADJOURN**

Objectives

- **At the completion of this training, participants will be able to:**
  - Understand the CMS-HCC model and apply the payment methodology.
  - Identify the components of the risk adjustment process and describe the requirements for data collection.
  - Determine the process for submitting data to CMS.
  - Interpret editing rules and error resolution.
  - Identify the type and effective use of information stored in the MBD.

Introducing the Team

CMS

Palmetto (CSSC)

Aspen

Risk Adjustment Methodology

Presented by:
Centers for Medicare & Medicaid Services

Purpose

- To explain risk adjustment under
  - Medicare Advantage.
  - Medicare Part D (Prescription Drug).

Objectives

- Review the history of risk adjustment.
- Understand the basics of risk adjustment as applied to bidding and payment.
- Review characteristics of CMS-HCC risk adjustment model.
- How to calculate risk scores.

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Objectives (continued)

- Discuss implementation of frailty adjuster and its possible future application.

- Review upcoming CMS-HCC model enhancements.

- Understand how the ESRD model operates.

- Describe the Part D risk adjustment model.

Risk Adjustment History

- The Balanced Budget Act of 1997 (BBA) required CMS to implement risk adjustment for M+C organizations in 2000 with inpatient diagnosis data.

- BBA also mandated that payments consider frailty of enrollees in the Program for All-Inclusive Care for the Elderly (PACE).

- CMS implemented the Principal Inpatient Diagnostic Cost Group (PIP-DCG) model in 2000 using 10 percent blended payment.

Risk Adjustment History (continued)

- The Benefits Improvement and Protections Act of 2000 (BIPA) required additional data in risk adjustment model beginning in 2004.

- CMS implemented the CMS-Hierarchical Condition Category (HCC) Model that includes hospital and ambulatory data at 30% blended payment.

  – Model balanced reducing plan data burden with implementing clinically sound model

Risk Adjustment History (continued)

- In 2004, CMS implemented frailty adjuster for enrollees of PACE and certain demonstrations.

- In 2005, CMS implemented the End-Stage Renal Disease (ESRD) model for ESRD MA enrollees.

Risk Adjustment History (continued)

- The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) created new program called Medicare Advantage (MA) Program.
  - Replaced Medicare+Choice program.
  - Retained many of M+C provisions.
  - Created drug benefit to begin in 2006 with drug card program during interim.

Risk Adjustment History (continued)

- The MMA included risk adjustment as a key component of the bidding and payment processes for both the MA program and the prescription drug benefit.

- In 2006, CMS will implement risk adjustment model for new Medicare prescription drug benefit.

MMA in 2006

- Created new Medicare drug benefit as Part D - Two types of sponsors:
  - Stand alone prescription drug plan (PDP).
  - MA organization providing a basic drug benefit (MA-PD)
    - Each MA organization must provide basic drug coverage under one of its plans for each service area it covers.
  - Established reinsurance option and risk corridors to limit risk for participating plans.
  - 34 Part D regions announced in December 2004.

Medicare Advantage in 2006

- TITLE II of the MMA
  - Replaced Adjusted Community Rate (ACR) proposal with bidding process for MA organizations.
  - Maintained local plan options.
    - HMOs, PFFS plans, MSAs, PSOs.
  - Created MA regional plans offering a PPO option.
    - 26 regions announced in December 2004.

MA Organization Bid and Review Process

- The bid is based on amount MA organization determines it will cost to provide its 1.0 benefit package to MA enrollees.

- CMS reviews MA organization bids for their actuarial soundness—ensure that bid reflects costs of providing proposed benefit package.

Overlap of Payment Methods in Titles I and II

- MA organizations intending to offer MA plans and/or drug benefits in 2006 have submitted bids for their basic, and if applicable, supplemental benefit packages.

- Benchmarks will be created for local and/or regional plans for bid-benchmark comparison.

- Monthly capitated payments made based on plan's bid and risk adjusted for health status.

What is Risk Adjustment?

- Risk adjustment is a method used to adjust payment based on the health status and demographic characteristics of an enrollee.

- Allows for comparison of beneficiary to the average Medicare beneficiary.

- Risk adjustment for Medicare is built on FFS data sets.

Risk Adjuster Basics

- Risk adjustment appropriately adjusts payment for the characteristics of the enrolled population.

- In the context of MAs/PDPs, risk adjustment used to standardize bids and applied to payment.

- It allows direct comparison of bids based on populations with different health status and other characteristics.

Risk Adjuster Basics (continued)

- What is a risk score? It is the expected cost of the enrollee normalized to the expected average cost for the population.

- Expected cost is derived from enrollee characteristics:

  – Enrollee's characteristics are assigned risk factors that are added to produce a total risk factor.

- The risk factors are essentially relative weights developed from a prediction model.

CMS Risk Adjustment Models

- Currently CMS has three risk adjustment models:
  - The CMS-HCC model for Part A/B
    - Community and Long Term Institutional
  - The ESRD model for beneficiaries with ESRD
    - Dialysis, Transplant, and Post-Transplant
  - The Part D drug model
    - Base Model +
    - Low Income or Long Term Institutional Multipliers
- These models share a common basic structure.
- Separate scores produced by each model, then applied to the appropriate payment

CMS-Hierarchical Condition Category (HCC) Model

- Model categorizes diagnosis codes into disease groups that include conditions which are clinically related with similar cost implications.

- Prospective-diagnoses from base year used to predict payments for following year.

- In the Part C Model separate community and institutional models account for higher treatment costs of similarly-ill, community residents.

CMS-HCC Model (continued)

- Currently, the CMS-HCC model uses 70 disease categories for community and for long term institutional residents.

- Site neutral payment.

- Diagnosis sources are inpatient and outpatient hospital and physician settings.

- Model is additive.

Demographic Factors in Risk Adjustment

- Age
  - Payment for year based on enrollee age as of February 1st.

- Sex

- Medicaid Status
  - Under CMS-HCC model, applies only to community residents (including short term institutional).
  - Defined as one month of Medicaid eligibility during data collection period.
  - New enrollees use concurrent Medicaid.

Demographic Factors in Risk Adjustment (continued)

- Disabled Status
  - Applied to community residents.
  - Factors for disabled <65 years-old.
  - Factors for disabled and Medicaid.

- Original Reason for Entitlement
  - Factors based on age and sex.
  - >65 years old and originally entitled to Medicare due to disability.

Disease Groups/HCCs

- Most body systems covered by diseases in model.

- Each disease group has an associated coefficient.

- Model heavily influenced by costs associated with chronic diseases.

  – Major Medicare costs are captured

Disease Hierarchies

- Payment based on most severe manifestation of disease when less severe manifestation also present.

- Purposes:
  - Diagnoses are clinically related and ranked by cost.
  - Takes into account the costs of lower cost diseases reducing need for coding proliferation.

Frailty Adjuster - Improvement of CMS-HCC Model

- Created to predict Medicare expenditures of functionally impaired not explained by CMS-HCC model.

- Applied in conjunction with CMS-HCC model.

- Applied to PACE organizations and certain demonstrations.

Frailty Adjuster (continued)

- Adjuster based on relative frailty of organization in terms of number of functional limitations.

- Functional limitations measured by activities of daily living (ADLs) – from survey results.

- CMS calculates organization-level frailty score based on ADLs of those >55 in the community.

RANGE OF FRAILTY SCORES IN 2005

FRAILTY PLAN	RANGE OF FRAILTY SCORES
PACE	.39 - .79
S/HMOs	.07 - .14
WPP	.39 - .53
MSHO	.19 - .70
SCO*	.30 - .30
* Estimated for 2005	

Implications of Frailty Adjuster

- Risk and frailty account for variation in health status of PACE enrollees for which risk and frailty adjustment accounts.

- For MA organizations, addition of frailty factor may improve payment accuracy.

- Frailty adjustment lowers risk scores for individuals with 0 ADLs and raises scores for all other ADL categories.

Frailty Adjuster Development
(continued)

- Policy decision needs to consider multiple factors:
  - Overall technical assessment of frailty factors and the county ratebook adjustments.
  - Impact on accuracy of and payments for all plans.
  - Particular impact on "special needs" plans.

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CMS-HCC Model Enhancements

- CMS is analyzing additional diagnoses to add to current model to improve payment accuracy.

- CMS will be sharing impacts of changes in model with the MA industry this Fall.

ESRD Model

- New model using risk adjustment for ESRD enrollees in MA organizations and demonstrations was applied in 2005.

- Model addresses unique cost considerations of ESRD population.

ESRD Implementation

- BIPA mandated ESRD model reflects methodology used for S/HMO ESRD demonstration.

- ESRD model was implemented at 100% of payment in 2005.

ESRD Model-Three Parts

- Based on treatment costs for ESRD enrollees over time. Three subparts in model:

  - Dialysis - recalibrated CMS-HCC model without kidney disease diagnoses- contains 67 disease groups.

  - Transplant - higher payment amount for 3 months.

    - Reflects higher costs during and after transplant.

  - Functioning Graft - Regular CMS-HCC model used, but includes factor to account for immunosuppressive drugs and added intensity of care.

ESRD Model (continued)

- Dialysis Model—HCCs with different coefficients.

  – Multiplied by statewide ESRD ratebook.

- Transplant Model- Costs for transplant month + next 2 months.

  – National relative factor created by dividing monthly transplant cost by national average costs for dialysis

  – Highest factor is for month 1 where most transplant costs occur

  – Payment for 3-months multiplied by statewide dialysis ratebook

New Enrollees and ESRD Model

- Applies to new enrollees with less than 12 months of data.

- Dialysis and functioning graft subgroups will have new enrollee factors for enrollees with no risk scores available.

- No new enrollee factors for transplant subgroup.

Model Comparisons of Coefficients

	Community	Institutional	Dialysis
Metastatic Cancer and Acute Leukemia HCC 7	1.464	0.540	0.161
Diabetes with acute complications HCC 17	0.391	0.612	0.106
Major Depression HCC 55	0.431	0.221	0.116
Age-Sex Factor for 69 year old male	0.346	1.450	0.775
Age-Sex Factor for 88 year old female	0.665	0.880	0.919

Part D Risk Adjustment

- The drug risk adjustment model (RxHCC) shares most of the characteristics of the CMS-HCC model (prospective, additive, hierarchical, and demographic new enrollee model).

  - The key differences

    - RxHCC model designed to predict plan liability for prescription drugs under the Medicare drug benefit rather than Medicare Part A/B costs.

    - Different diseases predict drug costs than Part A/B costs.

    - Incremental costs of low income (LI) and long term institutional (LTI) beneficiaries are multipliers to the base RxHCC model score.

Part D Risk Adjustment (continued)

- The development of the RxHCC model iterative process–disease groups disassembled into smaller subgroups, then reassembled to allow empirical estimation of costs and incorporate clinical judgment.

- Explanatory power of the RxHCC model is on par with other drug models ($R^2=.25$ for plan liability); is higher than similar Part A/B models because drug costs are more stable.

- Normalization was done on the entire Medicare FFS population.

- Average projected plan liability $\approx$ $993.

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Part D Risk Adjustment (continued)

- Model includes 113 coefficients:
  - 84 disease coefficients,
  - 24 age-sex adjustments,
  - 3 interactions between age and disease,
  - and 2 sex-age-originally disabled status interactions.
- Hierarchies cover 11 conditions.

Low Income and Long Term Institutional

- The Part D model includes incremental factors for beneficiaries who are low income subsidy eligible (LIS) or long term institutional (LTI)

- The factors are multipliers which are applied to the basic Part D risk adjustment factor predicted by the model

- If a beneficiary is LTI they can not also receive the low income factor

Low Income and Long Term Institutional Multipliers

Long Term Institutional		Low Income	
Aged ≥ 65	Disabled < 65	Group 1 – Full subsidy eligible	Group 2 – Partial subsidy eligible (15%)
1.08	1.21	1.08	1.05

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Risk Adjuster Example

Coded Characteristic	Liability Model	
	Payment Increment	Relative Factor
Female, age 76	$ 431	.434
Diabetes, w. complications	255	.258
Diabetes, uncomplicated	*188*	*.190*
High cholesterol	162	.163
Congestive Heart Failure	248	.251
Osteoporosis	110	.115
Total Annual Pred. Spending	**$1,206**	**1.22**

For implementation, predicted dollars are divided by national mean (~ **$993**) to create relative factors that are multiplied by the bid

Risk Adjuster Example (continued)

- Step 1 - derive base risk score – 1.22

- Step 2 - multiply by either LI or LTI factor if they apply for the payment month.

- Full subsidy eligible (group 1): risk score = base risk score (1.22)* 1.08 = 1.318

- Long term institutional (aged): risk score = base risk score (1.22) * 1.08 = 1.318

Risk Adjusted Payments

- For 2006, the CMS-HCC and ESRD models remain unchanged from 2005 and the Part D model is new

- For calculating RA scores for payment diagnoses from either MA or from Medicare FFS

- New Enrollee model used for people new to Medicare with insufficient data for risk adjustment. This model is based solely on demographics.

- Appeal rights—only if we did not follow our published methodology

Simplified Example Illustrating Use of Risk Adjustment in Bidding

- Plan derived costs for benefit package = $1,000
- Plan estimated risk score for population = 1.25
- Standardized plan bid = $800 ($1,000/1.25)
- Plan actual risk score based on enrollment = 1.5
- Risk adjusted plan payment = standardized plan bid * actual risk score = $1,200 ($800*1.5)

Part D - Direct Subsidy Payments

- Monthly direct subsidy made at the individual level.

- Direct subsidy = (Standardized Bid x Individual Risk Score) – Beneficiary Basic Premium.

- Sum for all beneficiaries enrolled equals monthly organizational payment.

Conclusions

- Consistency: CMS approach uses risk adjustment for all types of plans.

- Flexibility: Four pronged approach (HCC, frailty, ESRD, RxHCC) provides flexibility to ensure accurate payments to MA plans and PDPs; provides ability to develop other models as needed.

- Accuracy: Improves our ability to pay correctly for both high and low cost persons.

Information on Risk Adjustment Models and Risk Scores

- The Part D risk adjustment model is available at http://www.cms.hhs.gov/pdps

- The Part C risk adjustment models are available at http://www.cms.hhs.gov/healthplans/rates

- Contact: Cynthia Tudor Ph.D (Cynthia.Tudor@cms.hhs.gov) or Sean Creighton M.Sc. (Sean.Creighton@cms.hhs.gov)

Please take a moment to complete the evaluation form for the Risk Adjustment Methodology Module.

Thank You!

Process Overview

Presented by:
Aspen Systems Corporation

Purpose

- To provide participants with important terms, key resources, and schedule information that establish the foundation for this training

Objectives

- Identify common risk adjustment terminology

- Interpret key components of the risk adjustment process

- Interpret the risk adjustment schedule

- Identify CMS outreach efforts available to organizations

Common Terms

RAS

MMCS

Relevant Diagnosis

FERAS

HPMS

RAPS

MBD
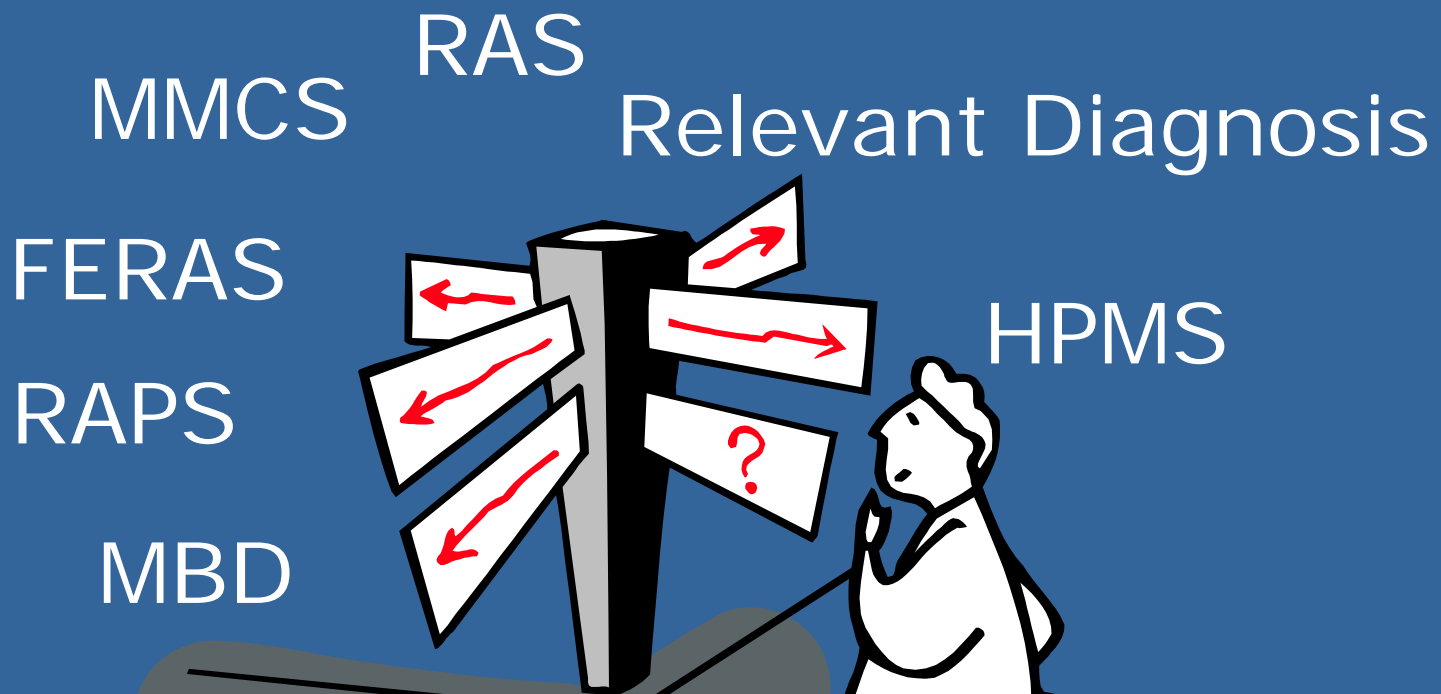
Risk Adjustment Data Requirements

- HIC number

- Diagnosis code

- Provider type

- Service from date

- Service through date

Data Collection

Hospital/Physician

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MA Organization
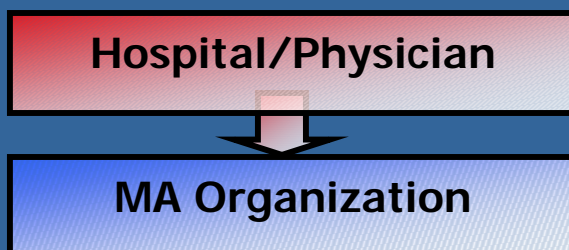
Minimum Data Set

- ✓ HIC number
- ✓ Diagnosis code
- ✓ Service from and through dates
- ✓ Provider type

- Formats
  - UB-92
  - HCFA 1500
  - NSF
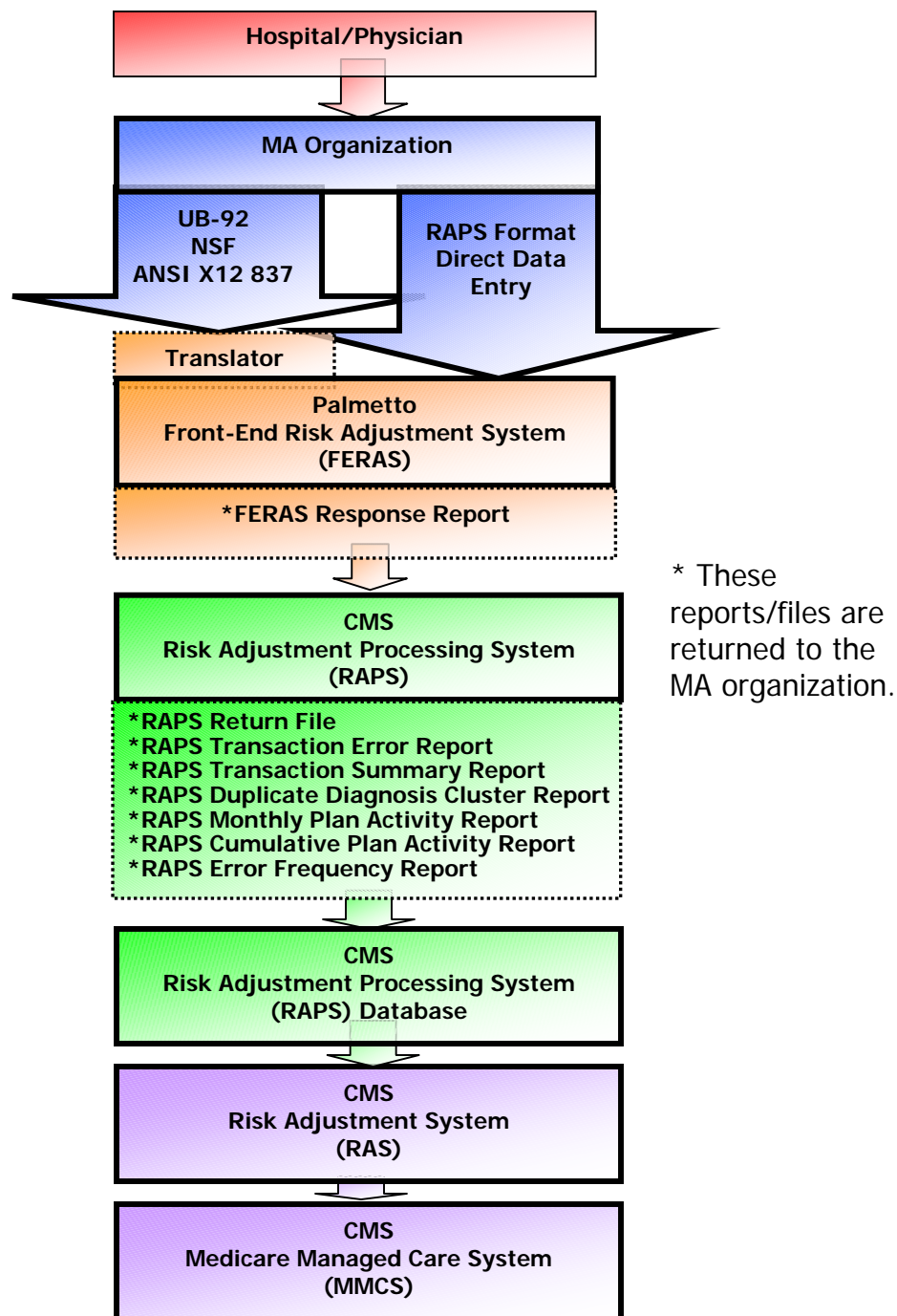 - ANSI 837
  - Superbill
  - RAPS format

Data Submission
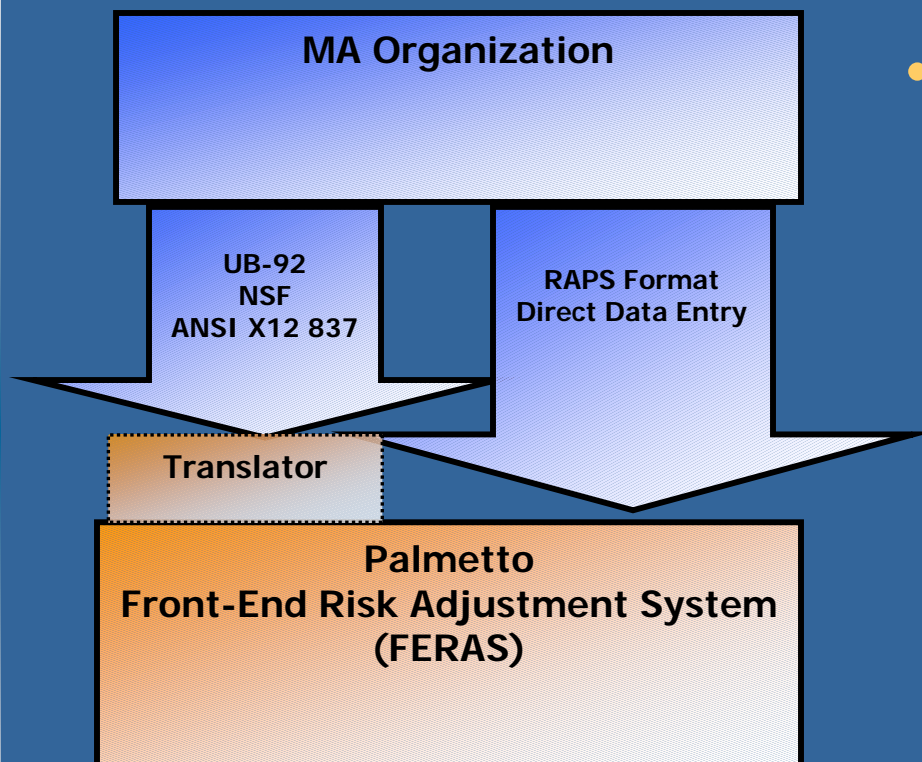
- Formats
  - UB-92
  - NSF
  - ANSI 837
  - RAPS format
  - Direct Data Entry

Risk Adjustment Process

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Hospital/Physician

↓

MA Organization

| UB-92 NSF ANSI X12 837 | | RAPS Format Direct Data Entry |

Translator

Palmetto Front-End Risk Adjustment System (FERAS)

***FERAS Response Report**

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CMS Risk Adjustment Processing System (RAPS)

*RAPS Return File
*RAPS Transaction Error Report
*RAPS Transaction Summary Report
*RAPS Duplicate Diagnosis Cluster Report
*RAPS Monthly Plan Activity Report
*RAPS Cumulative Plan Activity Report
*RAPS Error Frequency Report

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CMS Risk Adjustment Processing System (RAPS) Database

↓

CMS Risk Adjustment System (RAS)

↓

CMS Medicare Managed Care System (MMCS)

* These reports/files are returned to the MA organization.

Submission Schedule

CY	Dates of Service	Initial Submission Deadline	First Payment Date	Final Submission Deadline
05	7/1/03 – 6/30/04	9/3/04	1/1/05	N/A*
05	1/1/04 – 12/31/04	3/4/05	7/1/05	5/15/06
06	7/1/04 – 06/30/05	9/2/05	1/1/06	N/A*
06	1/1/05 – 12/31/05	3/3/06	7/1/06	1/15/07

*With elimination of the payment lag, the final submission deadline (reconciliation) is May 15 in 2006 and changes to January 15 in 2007 and each year thereafter. There is no September 30, 2005 deadline.

Training and Support

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Now Showing

Customer Service and Support Center
www.csscoperations.com
User Groups
Onsite Consultation
Getting Started Video Training
Regional Training

2005 Regional Training
Video

Continuous Updates to
www.csscoperations.com

Coming Attractions!

Summary

- Reviewed common risk adjustment terminology
- Introduced key components of the risk adjustment process
- Reviewed risk adjustment schedule
- Identified outreach and training available to organizations

Please take a moment to complete the evaluation form for the Process Overview Module.

Thank You!

Data Collection

Presented by:
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Purpose

- To provide MA systems personnel with the risk adjustment data collection requirements critical for accurate risk adjusted payment for their organization.

Objectives

- Identify data elements for risk adjustment.
- Identify three sources of risk adjustment data.
- Identify data collection formats available to MA organizations.
- Discuss considerations for methods of data collection.
- Discuss HIPAA transaction standards.

Data Collection

DATA COLLECTION

⬇

DATA SUBMISSION
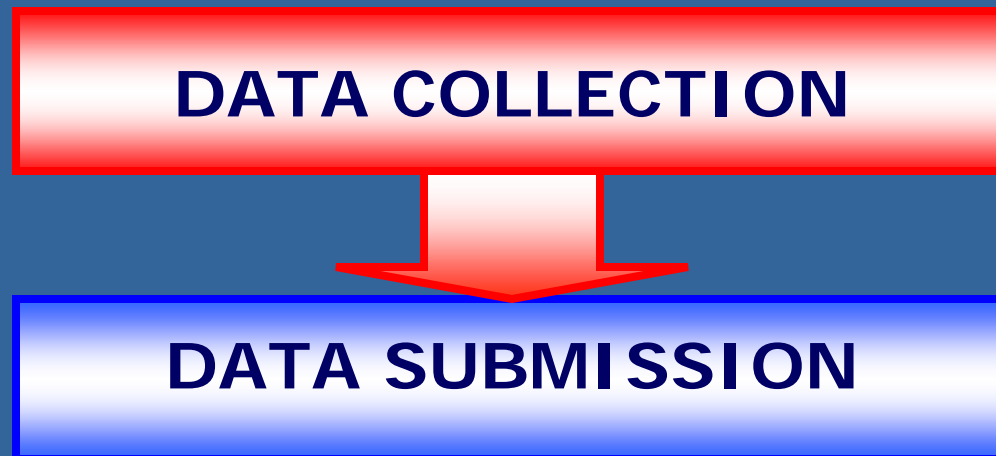
Minimum Risk Adjustment Data Elements

HIC Number

Diagnosis Code

From Date

Through Date

Provider Type

Health Insurance Claim Number

| HIC Number |
| Diagnosis Code |
| From Date |
| Through Date |
| Provider Type |

- HIC numbers are beneficiary identification numbers.

- HIC numbers are issued by CMS and the RRB.

HIC Number (continued)

CMS Number → 111223334A

SSN   BIC

RRB Pre 1964 → WA123456

Prefix   Random

RRB Post 1964 → WA123456789

Prefix   SSN

ICD-9-CM Diagnosis Codes

HIC Number
Diagnosis Code
From Date
Through Date
Provider Type

- 3-5 digit code describing clinical reason for treatment
- Drives risk scores, which drive reimbursement

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Service From and Through Dates

HIC Number
Diagnosis Code
From Date
Through Date
Provider Type

- Defines when a beneficiary received treatment

Provider Type

HIC Number
Diagnosis Code
From Date
Through Date
Provider Type

- Hospital inpatient
- Hospital outpatient
- Physician

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Exercise

Hospital Inpatient Data

- Provided by a hospital or facility where a patient is admitted for at least an overnight stay.

- SNFs or hospital inpatient swing bed components are not covered facilities.

- Determine if a provider is a covered facility.

Hospital Outpatient Data

- Therapeutic and rehabilitation services for sick or injured persons who do not require hospitalization or institutionalization.

- Data collected must be from hospital outpatient departments.

- Determine if a provider is a covered facility.

Acceptable or Not?

In Network?	*Provider Number?	Acceptable?
Yes	Yes	Yes, Submit
Yes	No	No, Do not submit
No	Yes No, but on DoD/VA list	Yes, Submit
No	No & not on DoD/VA list	Call CMS

* Provider number within the acceptable range.

Medicare Provider Number

33 U 020

State where hospital/facility is located

Type of facility

Unique to the facility

NOTE: The presence of a **U, W, Y, Z, 5, or 6** as the third character represents SNF. This should not be submitted.

Physician Data

- Services provided by a physician or clinical specialist during a face-to-face visit.

- All diagnoses that are in the risk adjustment model must be collected from network, as well as non-network, physicians.

Data Collection Formats

- HCFA 1500
- NSF
- UB-92
- ANSI x12 837
- RAPS format
- Superbill

Factors Affecting Data Collection Method

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Business Needs

Data Collection Method
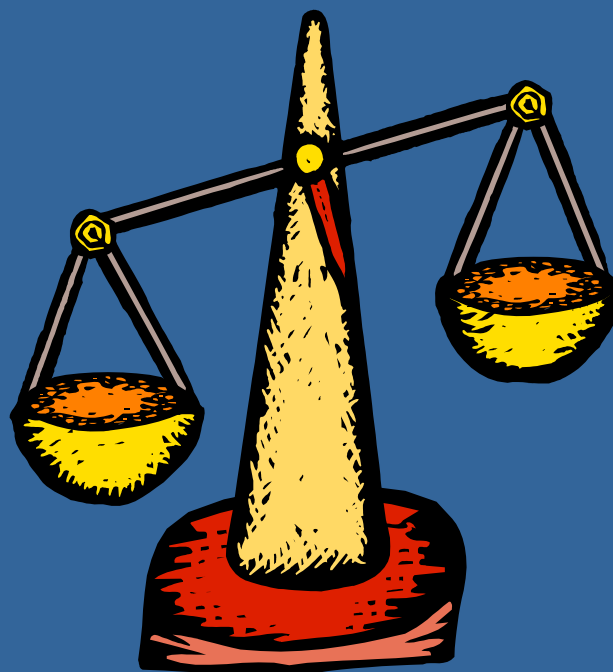
Contractual Relationships

Fee-For-Service

Capitated Payment

Staff Model

Mixed Services Model

HIPAA and Risk Adjustment Rules

Encounter from provider/physician to MA organization

Must be used for risk adjustment

HIPAA Transaction

Summary

- Identified data elements for risk adjustment.

- Identified three sources of risk adjustment data.

- Identified data collection formats available to MA organizations.

- Discussed considerations for methods of data collection.

- Discussed HIPAA transaction standards.

Please take a moment to complete the evaluation form for the Data Collection Module.

Thank You!

Data Submission

Presented by:
Aspen Systems Corporation

Purpose

- MA organizations are required to submit accurate diagnostic data when submitting risk adjustment data. This module describes the file layout for risk adjustment process submission.

Objectives

- Understand the submission process requirements, connectivity options, and RAPS file layout.

- Identify the data elements required to submit risk adjustment data.

- Locate and describe the diagnosis clusters in the RAPS format.

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Objectives (continued)

- Obtain an overview of the DDE process.

- Describe the filtering process.

- Describe the diagnosis deletion process.

Risk Adjustment Process

HOSPITAL/PHYSICIAN

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MA Organization

UB-92 NSF ANSI

RAPS Format Direct Data Entry

Translator

Front-End Risk Adjustment System (FERAS) Palmetto

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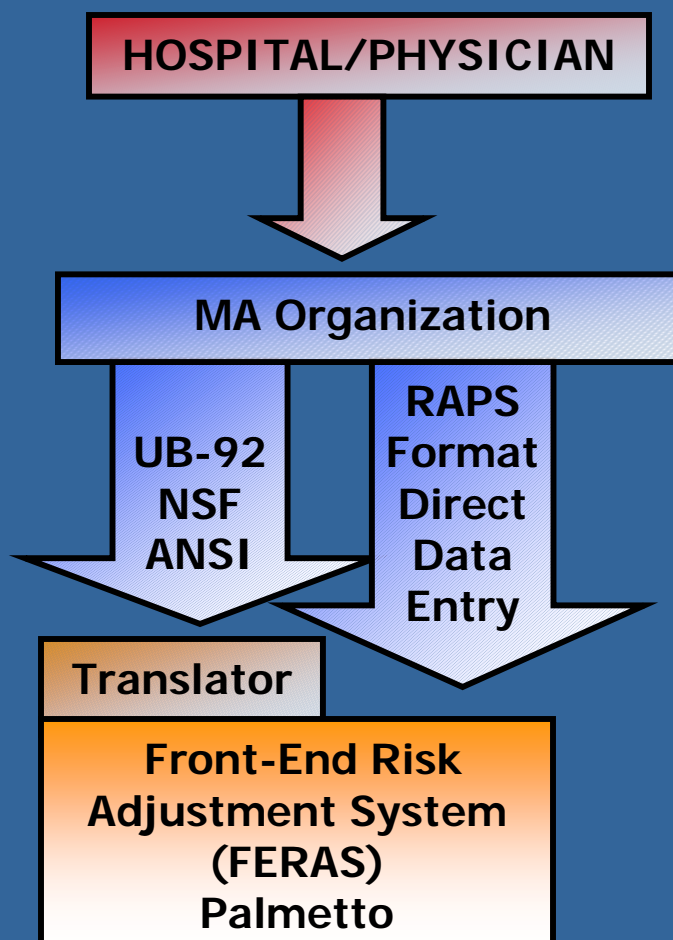
Requirements for New Submitters

- Complete an Electronic Data Interchange (EDI) Agreement and submit to the CSSC.

- Complete contact information and sign.

- Select connectivity method.

- Make special arrangements for third party submitters.

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Connectivity Options

Connect:Direct	• Mainframe-to-mainframe connection • Next day receipt of front-end response
File Transfer Protocol (FTP)	• Modem-to–modem connection • Requires password and phone line • Same day receipt of front-end response
Secure Website	• Extranet site hosted by Palmetto GBA • Point and click features • Same day receipt of front-end response • Direct Data Entry is a connection via a secure website

Relevant Diagnosis

- Diagnosis is included in the CMS-HCC risk adjustment model.

- Diagnosis must be received from one of three provider types.

- Diagnosis must be collected according to the risk adjustment data collection instructions.

Relevant diagnoses must be submitted for each beneficiary at least once during a reporting period.

Submission Formats

RAPS

NSF

UB-92

ANSI

DDE

File Logic

File Level
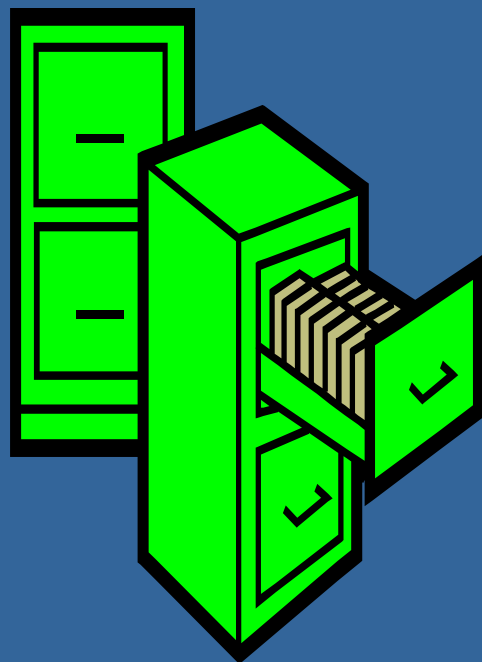
Batch Level

Detail Level

1

2

1   2

3

1   2
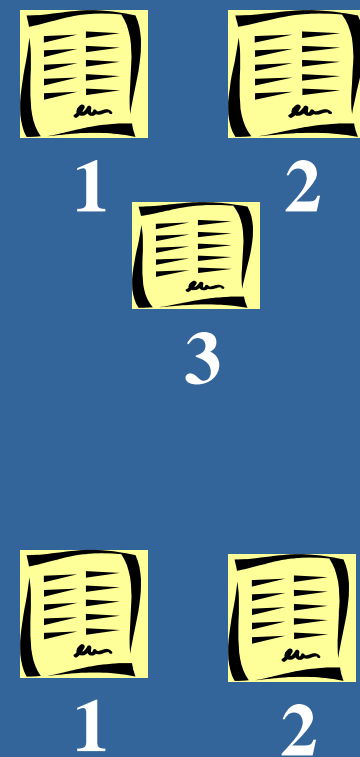
Exercise

Fast Facts

- Same submitter may transmit for several MA organizations.

- More than one batch is allowed per H number.

- More than one detail record is allowed per HIC number.

- Provider numbers are not required.

Filtering Risk Adjustment Data

- MA organizations are required to filter risk adjustment data to ensure they submit data from only hospital inpatient, hospital outpatient, and physician provider types.

Filtering Risk Adjustment Data
(continued)

- Filtering guidelines:
  - Hospital inpatient data require admission and discharge dates of service from appropriate facilities.
  - Physician data require face-to-face visits with a professional listed on the CMS specialty list.
  - Outpatient data require diagnoses from appropriate facilities and covered services contained on the CMS covered outpatient listings.

Modifying Data

- RAPS allows for modifying risk adjustment data previously submitted to CMS.
  - Adding data
  - Deleting data
  - Correcting data

- Incorrect clusters must be deleted from the system before correct cluster information can be added.

Deleting Diagnosis Clusters

- Each unique diagnosis cluster that RAPS accepts is stored separately.

- Only accepted diagnosis clusters may be deleted.

- Deletions may be submitted within a file, batch, or detail record containing previously submitted risk adjustment data.

- Erroneously submitted clusters must be deleted.

Reasons for Deleting Clusters

- Three reasons to delete a cluster:
  - Diagnosis cluster is submitted erroneously
  - Incorrect HIC number used for submission of a beneficiary's diagnostic information
  - Data fields in diagnosis cluster are incorrect

Steps for Deleting Clusters

- Verify diagnosis cluster was accepted.
- Select method for deleting cluster.
  - RAPS format – submit correction using normal submission process with appropriate HIC number included.
  - DDE – submit correction via DDE screens to the front-end system.

Steps for Deleting Clusters (continued)

- Delete the incorrect cluster via RAPS format or DDE screens.
  - "D" is entered into the appropriate field to designate the cluster that needs to be deleted.
- If necessary, enter a cluster with the correct data.

CCC

9.0	Provider Type	20
9.1	From Date	20030715
9.2	Through Date	20030715
9.3	Delete	**D**
9.4	Diagnosis Code	038

10.0	Provider Type	20
10.1	From Date	**20030615**
10.2	Through Date	**20030615**
10.3	Delete	
10.4	Diagnosis Code	038

MA Organization Responsibilities for Deletions

- MA organizations must:
  - Delete a diagnosis cluster when any data in that cluster are in error.
  - When correcting data, submit a corrected cluster to replace the deleted cluster.
  - Corrections and deletions may be submitted on the same record or in the same file.

MA organizations should not delete a diagnosis code or record repeatedly on the same day and in the same record. Duplicate deletes in the same record on the same day cause system problems.

NSF Submissions

- All NSF submissions will be translated to Provider Type 20 in RT CCC 9.0.

- RT CCC 2 will be plugged by Palmetto in the order in which the detail records appear in the batch.

- NSF Record Identifiers - DA0 1.0, EA0 1.0, and FA0 1.0 - must be populated.

UB-92 Submissions

- RT CCC 2 will be plugged by Palmetto in the order in which the detail records appear in the batch.

- UB-92 Record Identifiers must be populated.
  - RT 30/1
  - RT 40/1
  - RT 70/1

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Direct Data Entry

- DDE entries allow for deletion of records for corrections even if another submission format was used.

- DDE screens automatically prevent the placement of incorrect data characters (e.g., alpha characters in the "From Date" or "Through Date" fields).

- DDE submissions are reported in the Front-End Response Report found in the electronic mailbox.

DDE Demonstration
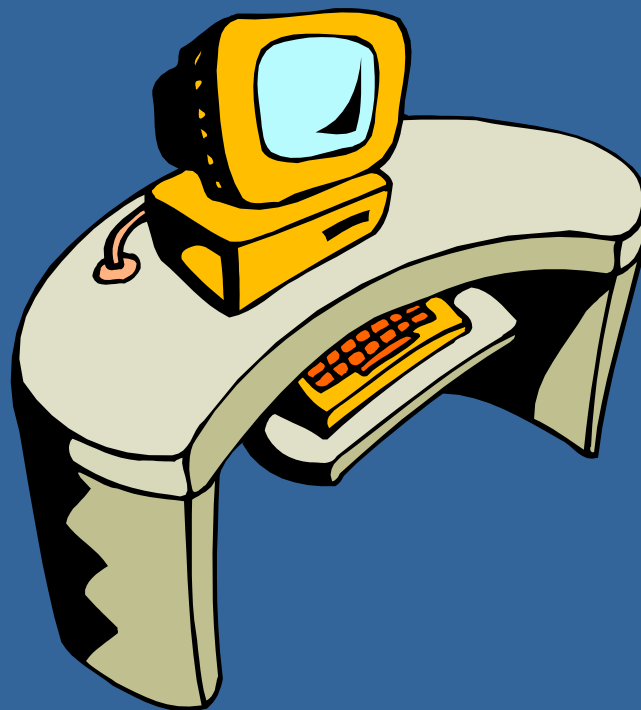
Summary

- Described the submission process requirements, connectivity options, and RAPS file layout.

- Identified the data elements required to submit risk adjustment data.

- Located and described the diagnosis clusters in the RAPS format.

Summary (continued)

- Obtained an overview of the DDE process.

- Described the filtering process.

- Described the diagnosis deletion process.

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Please take a moment to complete the evaluation form for the Data Submission module.

Thank You!

Edits

Presented by:
Aspen Systems Corporation

Purpose

- To provide participants with an understanding of risk adjustment system edits.

- To describe the common edits and assist MA organizations with the required steps to prevent errors in the future.

Objectives

- Understand the FERAS and RAPS data integrity logic and error codes.

- Describe how the Medicare Beneficiary Database supports the editing process.

- Describe the FERAS and RAPS editing processes.

- Recognize common FERAS and RAPS errors and determine action required to avoid or correct them.

Data Flow

FERAS
- ➜ format checks
- ➜ integrity checks
- ➜ validity checks
- ...on A, B, Y, Z, and first and last CCC records

Errors, file rejected

resolve

file accepted

RAPS
- ➜ format edits
- ➜ integrity edits
- ➜ validity edits
- ...on all CCC records

Errors, file rejected

resolve

FERAS Checks

Format Checks · **Integrity Checks** · **Validity Checks** · **Format, Integrity, & Validity Checks**

Checks on file and batch levels

Checks on first & last CCC records

Example 1

Scenario: The MA organization submitted a file and entered "AA1" in record type AAA, field 1.

Result: FERAS will reject the entire file with error message 100. The field must always be populated with "AAA".

Edits Logic

Series	Explanation
100	File level errors on the AAA or ZZZ records. This editing is performed in FERAS.
200	Batch level errors on the BBB or YYY records. This editing is performed in FERAS.
300 & 400	Check performed on first and last CCC records.

The entire file will be returned to the submitter.

Error Code Ranges

100

101-12**5** → AAA

151-17**5** → ZZZ

200

201-22**5** → BBB

251-27**5** → YYY
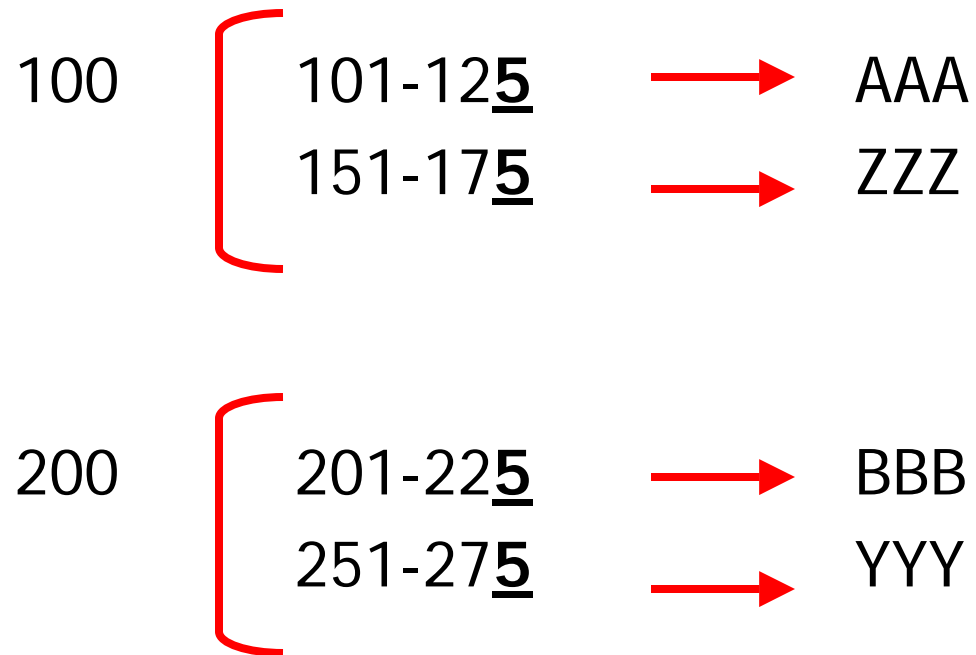
Example 2

Scenario: The MA organization submitted a file with a 2.0 in the Diagnosis Filler field on the first CCC record.

Results: FERAS will reject the complete file due to data being placed in the Filler field of the diagnosis cluster. FERAS will identify this error, since it occurred in the first CCC record.

RAPS Edits

FERAS ➔ format checks
➔ integrity checks
➔ validity checks
...on A, B, Y, Z, and first
and last CCC records

Errors, file rejected

resolve

file accepted

RAPS ➔ format edits
➔ integrity edits
➔ validity edits
...on all CCC records

Errors, file rejected

resolve

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RAPS Editing Rules

Stage 1 - Field Validity and Integrity edits

Stage 2 - Field-to-Field edits

Stage 3 - Medicare Beneficiary Database edits

Stage 4 - Diagnosis Code edits

RAPS Editing Rules

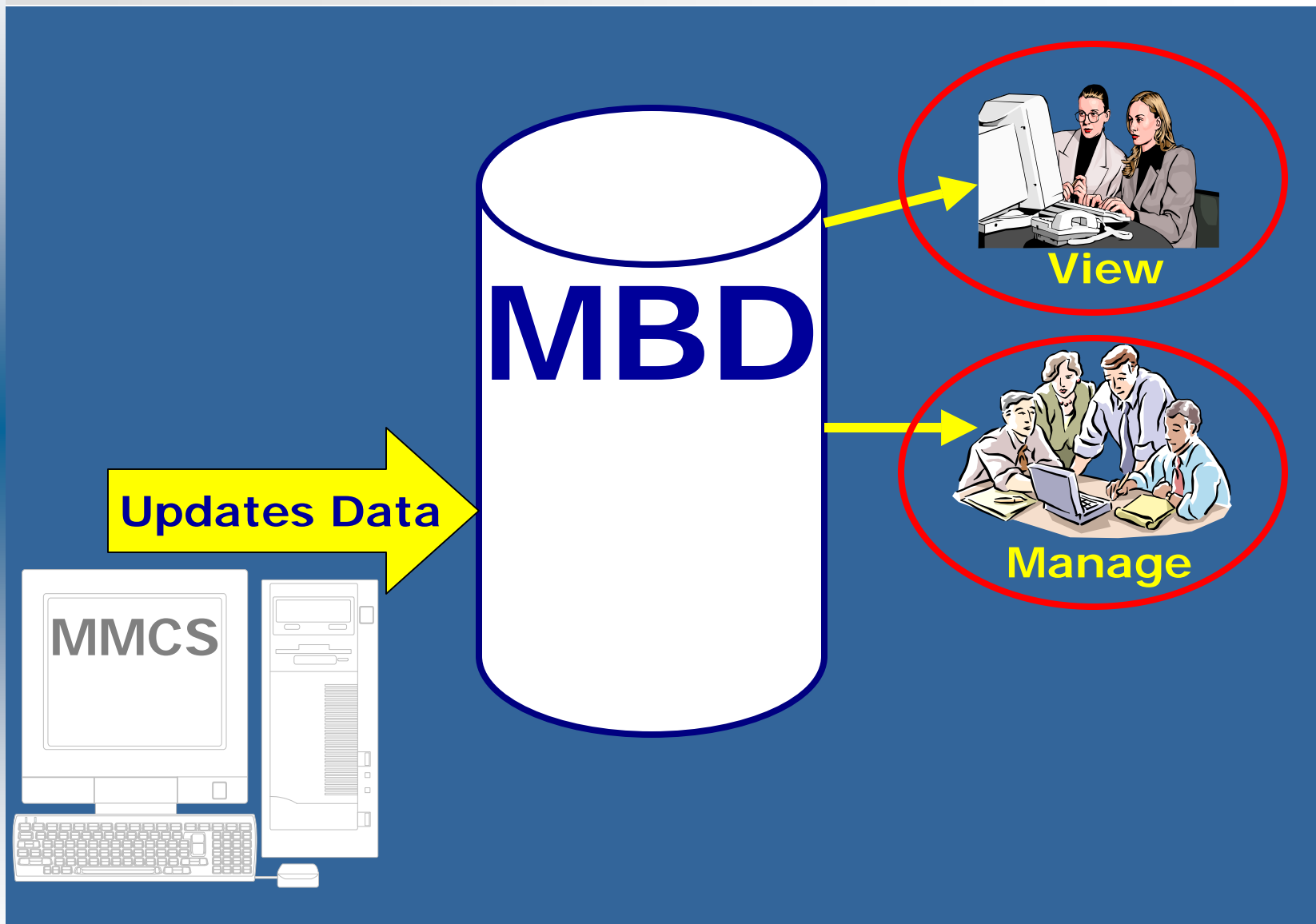Stage 1 - Field Validity and Integrity edits

Stage 2 - Field-to-Field edits

Stage 3 - Medicare Beneficiary Database edits

Stage 4 - Diagnosis Code edits

RAPS Editing Rules

Stage 1 - Field Validity and Integrity edits

Stage 2 - Field-to-Field edits

Stage 3 - Medicare Beneficiary Database edits

Stage 4 - Diagnosis Code edits

Medicare Beneficiary Database
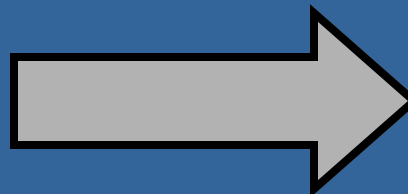
Medicare Beneficiary Database
(continued)

MBD

Updates Data

MMCS

View

Manage

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Data Stored in MBD

MBD

Beneficiary Profile Tab

Entitlement Tab

Coverage Tab

Medicaid Tab

RAPS Editing Rules

Stage 1 - Field Validity and Integrity edits

Stage 2 - Field-to-Field edits

Stage 3 - Medicare Beneficiary Database edits

Stage 4 - Diagnosis Code edits

RAPS Error Codes

Series	Explanation of error and consequences
Record	
300-349	Record-level error - The record was bypassed and all editing was discontinued. No diagnosis clusters from this record were stored.
350-399	Record-level error - All possible edits were performed, but no diagnosis clusters from this record were stored.
Cluster	
400-489	Diagnosis cluster error - All possible diagnosis edits were performed, but the diagnosis cluster is not stored.
490-499	Diagnosis delete error - Diagnosis was not deleted.
500-599	Informational message, all edits were performed, diagnosis cluster was stored unless some other error is noted.

Example 3

Scenario: The Low Rest Insurance Company submitted a risk adjustment transaction for Susan Doe, who was admitted into the hospital. The principal diagnosis submitted was 601.0 for acute prostatitis.

Results: Error code 453 would occur. The system checked that the diagnosis field was complete. Next, the system verified that the HIC number was entered. RAPS then verified that the HIC number was in the MBD and the beneficiary was eligible. The diagnosis was determined to be a valid diagnosis. However, the diagnosis was not valid for the sex. This diagnosis cluster was rejected and not stored in RAS.

Resolution Steps

1. Determine the error level of the code to identify the nature of the problem.

2. Look up the error code and read the associated message.

3. Based on the error message, determine what the next step should be.

4. Take steps to resolve the error.

Example 4

Scenario: John Smart at BaseCare Health Plan deleted a diagnosis cluster. Later the same day, he mistakenly added the same cluster using DDE. Realizing his mistake, John immediately attempted to delete this cluster using DDE.

Results: Error code 492 occurs. The diagnosis cluster was not deleted. A diagnosis cluster with the same attributes was already deleted from the RAPS database on this date.

Exercise

Five Common Errors

113	**Duplicate File Name**
491	**Delete Error, Diagnosis Cluster Previously Deleted**
492	**Diagnosis Cluster Not Successfully Deleted**
408 **409**	**Service Date Not Within** **MA Enrollment**
410	**Not Enrolled in Plan**

In Summary

- Understood the FERAS and RAPS data integrity logic and error codes.

- Described how the Medicare Beneficiary Database supports the editing process.

- Described the FERAS and RAPS editing processes.

- Recognized common FERAS and RAPS errors and determined action required to avoid or correct them.

Please take a moment to complete the evaluation form for the Edits Module.

Thank You!

Reports

Presented by:

Aspen Systems Corporation

Purpose

- To provide insight on the appropriate use of the RAPS reports in managing data collection, data submission, and error resolution.

Objectives

- Identify the purpose of each risk adjustment report.

- Determine the best uses of the reports to monitor data collection and submission processes, and to resolve errors.

- Accurately read the risk adjustment reports and identify and submit corrections.

- Understand the relationship between values in the RAPS Transaction Summary and the management reports.
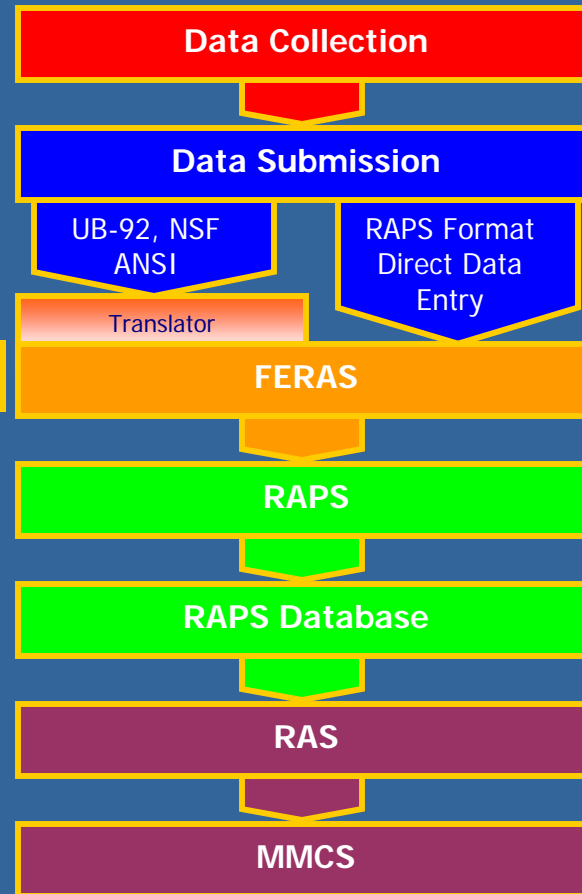
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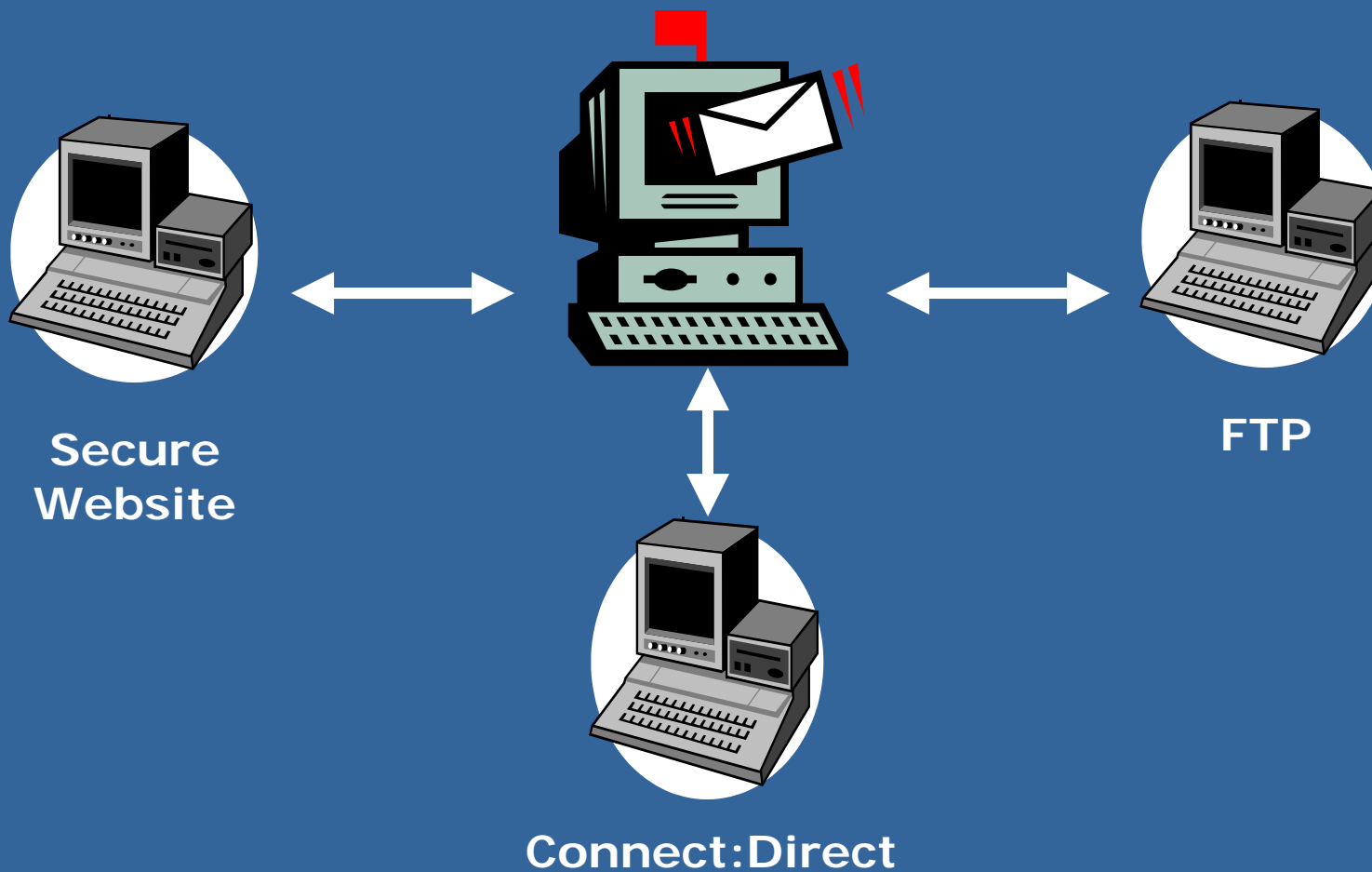
Accessing Reports

Secure Website

FTP

Connect:Direct

Reports Overview

Reports Overview (continued)

Risk Adjustment Process

```
Data Collection
      ↓
Data Submission
  ┌──────────────┐        ┌──────────────┐
  │ UB-92, NSF   │        │ RAPS Format  │
  │ ANSI         │        │ Direct Data  │
  │              │        │ Entry        │
  └──────────────┘        └──────────────┘
  Translator
      ↓
    FERAS
      ↓
     RAPS  ◄─────
      ↓
  RAPS Database
      ↓
      RAS
      ↓
     MMCS
```

RAPS Return File

RAPS Transaction Error

RAPS Transaction Summary

RAPS Duplicate Diagnosis Cluster

Reports Overview (continued)

RAPS Monthly Plan Activity

RAPS Cumulative Plan Activity

RAPS Monthly/ Quarterly Error Frequency
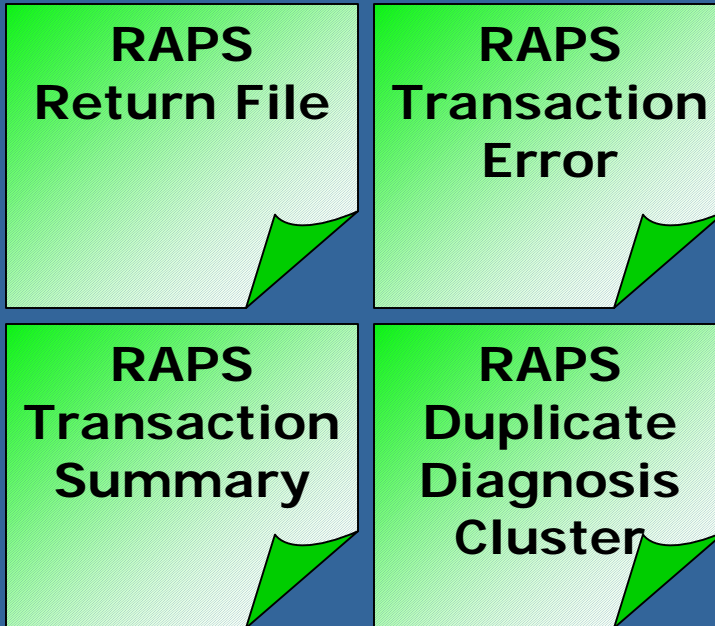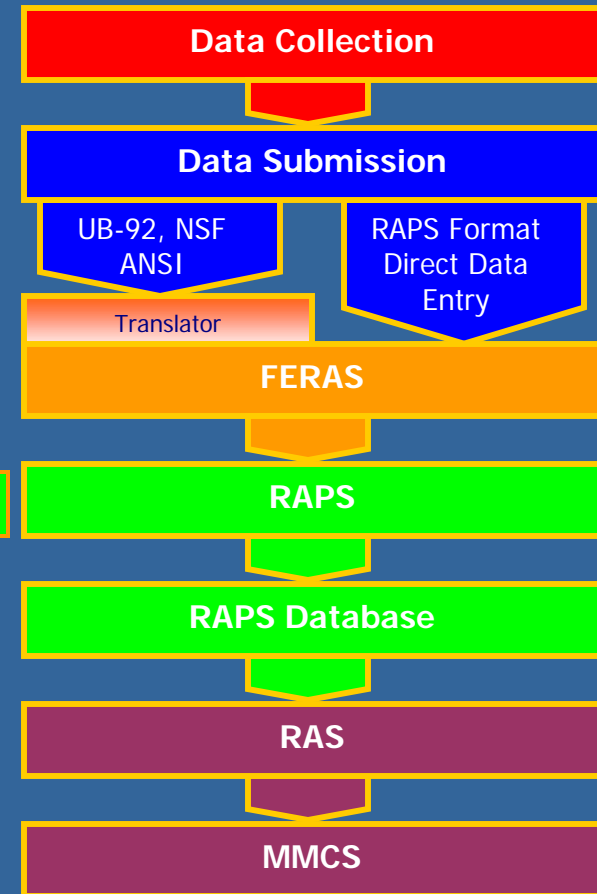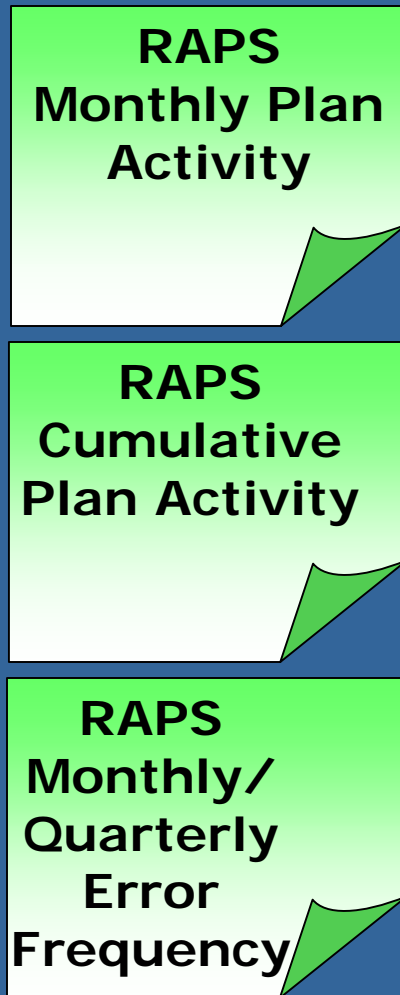
Management Reports

Risk Adjustment Process

Data Collection

Data Submission

UB-92, NSF ANSI

RAPS Format Direct Data Entry

Translator

FERAS

RAPS

RAPS Database

RAS

MMCS
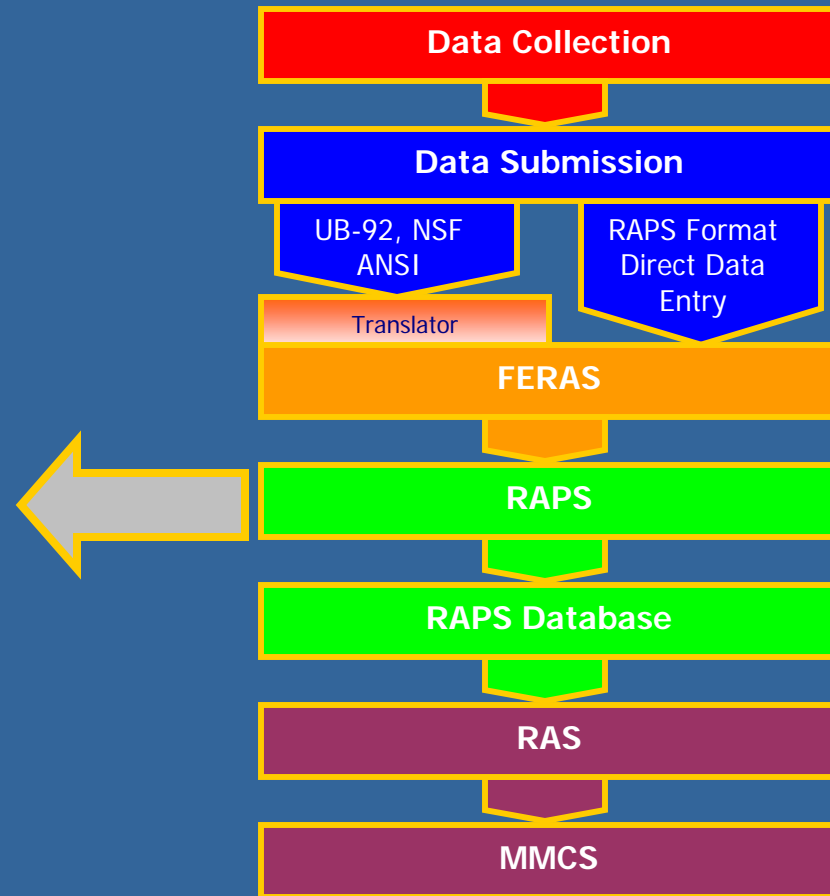
FERAS Response Report

- Indicates that the file has been accepted or rejected by the front-end system
- Identifies reasons for rejection
- Available in report layout only
- Received:
  - The same business day, generally within 15 minutes (FTP and Secure website users)
  - The next business day (Connect:Direct users)

FERAS Response Report Example

The MA organization corrected and submitted a file, but only changed the first character of the File ID. The second batch did not include a plan number. The first detail record was missing a HIC number, and the fourth YYY batch trailer plan number did not match the plan number in the BBB batch header.

RAPS Return File

- Contains all submitted transactions.

- Error codes appear in the file.

- Flat file format may be downloaded to an Access or Excel database.

- Returned the next business day after submission.

RAPS Return File Example

The MA organization submitted a file and included the beneficiary's DOB. RAPS determined a discrepancy between DOB submitted on the file and what is stored in MBD. The submitter received a RAPS Return File.
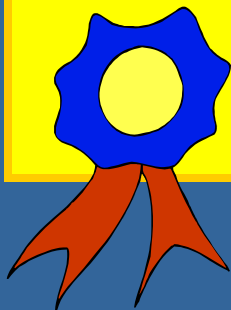
Uses for RAPS Return File Format

Identify steps in the process where there may be data processing issues.

Help physicians & providers submit clean data in a timely manner.

Confirm that the right data and the right amount of data is being submitted.

Improve the quality and quantity of data submissions!

RAPS Transaction Error Report

- Displays detail-level (CCC) record errors that occurred in RAPS.

- Available in report layout only.

- Received the next business day after submission.

RAPS Editing Rules

Stage 1 - Field Validity and Integrity edits

Stage 2 - Field-to-Field edits

Stage 3 - Medicare Beneficiary Database edits

Stage 4 - Diagnosis Code edits

Exercise

RAPS Transaction Summary Report

- Identifies the number of clusters received for each provider type

- Summarizes the disposition of all diagnosis clusters

- Accompanies the RAPS Transaction Error Report

- Available in report layout only

- Received the next business day after submission

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Relationship Between Values in RAPS Transaction Summary Report

Total Rejected
+ Total Accepted
+ Total Deletes Accepted
+ Total Deletes Rejected
= **Total Submitted**

Total Stored ≤ Total Accepted

**Total Model Diagnoses Stored ≤ Total Stored**

RAPS Duplicate Diagnosis Cluster Report

- Lists diagnosis clusters with 502-error information message
- Reflects clusters previously submitted and stored in the RAPS database with same:
  - HIC number
  - Provider type
  - From and through dates
  - Diagnosis
- Received the next business day after submission

Analysis of Management Reports

RAPS MONTHLY PLAN ACTIVITY REPORT

Read the management reports left to right and then top to bottom.
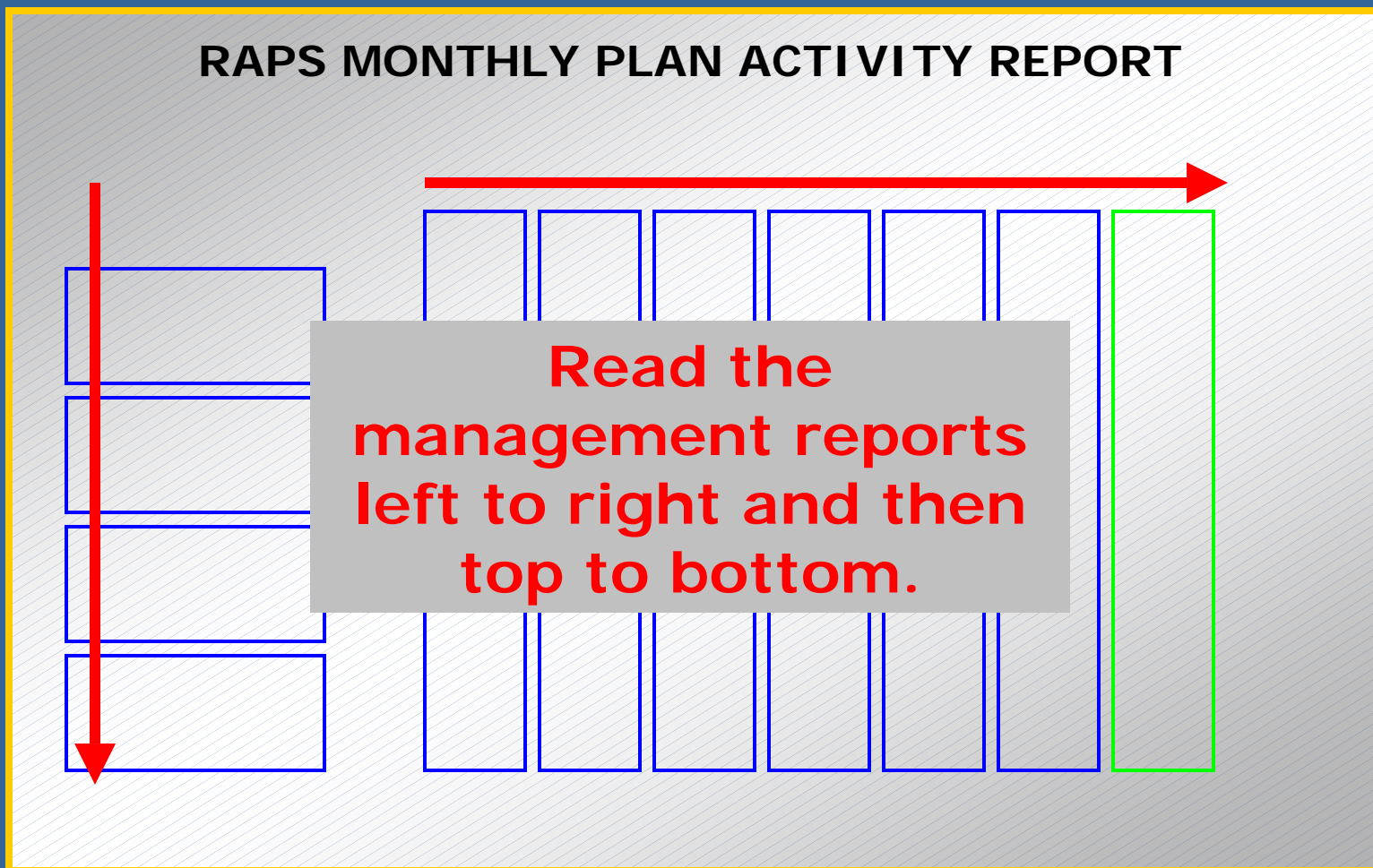
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RAPS Monthly Plan Activity Report

- Provides a summary of the status of submissions for a 1-month period

- Arrayed by provider type and month based on through date of service

- Reported by submitter ID and H number

- Allows tracking on a month-by-month basis of all diagnosis clusters submitted

- Available for download the second business day of the month

RAPS Cumulative Plan Activity Report

- Provides a cumulative summary of the status of submissions

- Report format similar to Monthly Plan Activity Report

- Service year "9999" indicates data has been rejected (not stored)

- Available for download the second business day of the month

RAPS Error Frequency Reports

- Received monthly and quarterly
  - Monthly summary
  - Three-month summary
- Summary of errors received in test and production
- Displays frequencies for all errors received by provider type
- Report layout
- Available for download the second business day of the month/quarter

Correcting Rejected Data

- When submitting corrected data, rejected clusters are reflected in
  - Cumulative totals for month.
  - Total rejections.
- When cluster is counted as stored,
  - It remains part of the stored count on Cumulative Plan Activity Report, even if it is deleted.
- Deleted clusters are included in total stored and total deleted.

Management Reports Summary

- Identify internal processes affecting data collection and submission.

- Identify external issues affecting data collection.

Naming Conventions

REPORT NAME	MAILBOX IDENTIFICATION
FERAS Response Report	RSP####.RSP.FERAS_RESP
RAPS Return File	RPT#####.RPT.RAPS_RETURN_FLAT
RAPS Transaction Error Report	RPT#####.RPT.RAPS_ERROR_RPT
RAPS Transaction Summary Report	RPT#####.RPT.RAPS_SUMMARY
RAPS Duplicate Diagnosis Cluster Report	RPT#####.RPT.RAPS_DUPDX_RPT
RAPS Monthly Plan Activity Report	RPT#####.RPT.RPAS_MONTHLY
RAPS Cumulative Plan Activity Report	RPT#####.RPT.RAPS_CUMULATIVE
RAPS Monthly Error Frequency Report	RPT#####.RPT.RAPS_ERRFREQ_MNTH
RAPS Quarterly Error Frequency Report	RPT#####.RPT.RAPS_ERRFREQ_QTR

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Summary

- Identified the purpose of each risk adjustment report.

- Determined the best uses of the reports to monitor data collection and submission processes, and to resolve errors.

- Accurately read the risk adjustment reports to identify and submit corrections.

- Reviewed the relationship between values in RAPS Transaction Summary and management reports.

Please take a moment to complete the evaluation form for the Reports Module.

Thank You!

Risk Adjustment Data Validation

Presented by:
Centers for Medicare & Medicaid Services

Objectives

- Identify the purpose and goals of risk adjustment data validation.

- Identify and describe the stages of risk adjustment data validation.

- Learn about the components of a medical record request.

Objectives (continued)

- Describe the requirements for acceptable medical record documentation.

- Identify risk adjustment data discrepancies.

- Describe payment adjustments and appeals.

- Provide recommendations and lessons learned.

What is Risk Adjustment Data Validation?

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Purpose: *To ensure risk adjusted payment integrity and accuracy*

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- The process of verifying that diagnosis codes submitted for payment are supported by medical record documentation

- Occurs after data are collected and submitted, and payments are made

- Conducted via medical record review

- Two independent review contractors confirm payment discrepancies
  - Initial validation contractor (IVC)
  - Second validation contractor (SVC)

Data Validation Goals

- Identify:
  - Confirmed risk adjustment discrepancies
  - Plans in need of technical assistance to improve risk adjustment data quality

- Measure:
  - Accuracy of risk adjustment payments
  - Impact of discrepancies on payment

- Improve:
  - Quality of risk adjustment data
  - The CMS-HCC model

- Implement:
  - An accurate MA payment system
  - An improved approach to communicating validation findings

Risk Adjustment Data Validation Background

- CY2000-CY2003 Validation Activities
  - Based on PIP-DCG model
  - Used medical record review to determine PIP-DCG discrepancies
  - Reviewed only hospital inpatient medical records

What is Different for Data Validation Under the CMS-HCC Model?

- Beginning with the CY 2004 Data Validation
  - Hospital inpatient, hospital outpatient,
  - More flexible approach
  - Provider identifiers not given—plans need to track RAPS data to provider

CMS-HCC Data Validation Guiding Principle

The medical record documentation must show that the HCC diagnosis was assigned within the correct data collection period by an appropriate provider type and is coded according to the *ICD-9-CM Guidelines for Coding and Reporting*.

CMS-HCC Data Validation Guidelines

- Medical record documentation must support an assigned HCC.

- Beneficiaries are selected on the basis of RAPS diagnosis clusters.

- Plan must:
  - Select the "one best medical record."
  - Identify date of service and diagnosis code.
  - Submit relevant documentation for dates of service.

CMS-HCC Data Validation Guidelines
(continued)

- "In lieu of" medical records accepted for dates of service not submitted to RAPS.

- Payment adjustments are based on confirmed risk adjustment discrepancies.

- An appeals process is in place for disputes.

Risk Adjustment Data Validation Process

STAGE 1   Plan Selection

STAGE 2   Medical Record Request Process

STAGE 3   Medical Record Review

Risk Adjustment Data Validation Process (continued)

STAGE 4 — Plan-Level Findings

STAGE 5 — Payment Adjustment

STAGE 6 — Appeals

STAGE 7 — Correct Payment

Plan Selection

Sampling

- Designed by CMS to select:
  - MA organizations.
  - Beneficiaries.
  - Beneficiary HCC(s).
  - Sample based on payment year risk adjustment data.
- Every MA organization has a chance of being selected.

Plan Selection (continued) ⇻—STAGE 1

- Random selection.
  - National random sample to derive:
    - Net payment estimates.
    - Data discrepancy rates.
- Targeting criteria may include:
  - Potentially problematic risk adjustment data.
  - Past data validation performance.
  - Specific HCCs.

Medical Record Request Process

Three segments:

- Request

- Submission (Plan Response)

- Receipt

Request

- Plans will receive:
  - Initial contact letter
  - Beneficiary list with diagnosis clusters and validation HCCs identified (Example on page 9-7)
  - Comprehensive instructions
  - Coversheets for each unique beneficiary HCC

Medical Record Request Process (continued)

⚷ STAGE 2

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Submission (Plan Response)

- Select the "one best medical record."

- Recommend selecting institutional medical record (hospital inpatient & hospital outpatient) if a choice is available.

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Submission (Plan Response)

- Medical Record Coversheet (see Attachment A):

  – Is provided for each beneficiary HCC being validated.

  – Shows all RAPS diagnosis clusters for an HCC.

  – Indicates ICD-9 code and service date identified for review.

  – Provides option to identify an "in lieu of" medical record.

Coversheet

IF...

1. You submit a medical record...

2. There are multiple ICD-9 codes and/or dates of service on a coversheet for one HCC...

3. There is no medical record to support the RAPS HCC...

4. There in no medical record to support the HCC...

THEN...

1. ...you must complete coversheet Section 3A or 3B. Do not complete Section 4.

2. ...choose and submit the **one** best medical record to support the HCC, and complete coversheet Section 3A.

3. ...submit an "in lieu of" medical record for dates of service not submitted to RAPS, and complete coversheet Section 3B.

4. ...complete coversheet:
    1. Section 1 - No Record;
    2. Section 4 - Reason; and
    3. Section 5 - Contact person

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IF...

5. You use a contact information label on the coversheets...

6. You find one medical record that supports multiple HCCs...

7. The enrollee information on the coversheet is incorrect...

8. You submit documentation for a physician visit that is part of an inpatient stay but not in RAPS...

THEN...

5. ...the label must not obscure the bar code and number at the bottom of the coversheet.

6. ...staple the coversheet for each HCC to the medical record that supports it. Each coversheet must indicate the date of service.

7. ...legibly write the correct information in the space provided in Section 2. Do not strike any pre-populated information.

8. ...complete coversheet section 3B and the visit date you select must have an associated physician note on the same date in the medical record.

Medical Record Request Process (continued)

Submission (Plan Response)

- "In lieu of" medical records must:
  - Relate to a service not submitted to RAPS or no exact match for a diagnosis cluster.
  - Support a service that occurred during data collection period.
  - Be from acceptable risk adjustment provider type.
  - Provide ICD-9 code and service date on medical record coversheet.

Receipt

The IVC:

- Receives and logs requested medical records and coversheets.

- Conducts administrative and clinical checks.

- Assigns medical records to a category for abstraction: "okay," "problem," or "missing."

Good Documentation = Accurate Payment

Patient Visit

Assign Diagnosis Code

ICD-9 Code

Document Visit

Risk Adjusted Payment

What is Medical Record Documentation?

- Provider medical records support an assigned HCC based on an ICD-9 code from a particular date of service.

- ICD-9 code assigned in accordance with *ICD-9 Coding Guidelines* for medical record documentation.

Medical Record Documentation

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history, including past and present illnesses, examinations, tests, treatments, and outcomes.

Source: *1997 Documentation Guidelines for Evaluation and Management Services*

Medical Record Documentation
(continued)

Must be:
- Clear
- Concise
- Consistent
- Complete
- Legible

Medical Record Documentation
(continued)

- Patient identification

- Date(s) of service

- Person(s) treating patients
  - Physician
  - All participants in care & treatment

- Reason for the visit

- Care rendered

- Conclusion & diagnosis(es)

- Follow-up plan

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Medical Record Documentation
(continued)

- Allowed only from authorized medical staff who are identified by name (including credentials).

- Signatures and dates are required.

Types of Medical Records for Risk Adjustment

- Hospital Inpatient
- Hospital Outpatient
- Physician

Acceptable Documentation

Hospital Inpatient

- May include, but is not limited to:
  - Face sheet
  - History and physical exam
  - Physician orders
  - Progress notes
  - Operative and pathology reports
  - Consultation reports
  - Diagnostic reports
  - Discharge summary

Acceptable Documentation (continued)

Hospital Outpatient & Physician

- May include, but is not limited to:
  - Face sheet
  - History and physical exam
  - Physician orders
  - Progress notes
  - Diagnostic reports
  - Consultation reports

Acceptable Documentation (continued)

Hospital Outpatient & Physician

- General Guidelines
  - Coder able to determine that a patient evaluation was performed by physician
  - ICD-9 code assigned on the basis of patient evaluation and clinical findings/treatment
  - Physician signature and date of service present

Physician Signatures

Acceptable

- Hand-written initials or signature, including credentials (e.g., MCS, MD or Mary Smith, MD)

- Signature stamp
  - <u>with</u> provider initials; or
  - <u>without</u> provider initials*

- Typed signature with authentication by the responsible provider

- Electronic signature with authentication by the responsible provider (e.g., "Approved by," "Signed by," "Electronically signed by")**

  * Signature stamps must comply with state regulations for signature stamp authorization.

** The electronic signature must be password protected and used exclusively by the individual physician.

Physician Signatures (continued)

Unacceptable

IF there is dated medical record documentation (e.g., handwritten or transcribed consultation report, discharge summary)

AND there is <u>no physician signature</u> on the record...

THEN the record is <u>invalid</u> and will not be reviewed.

Hospital Outpatient & Physician Documentation

- Problem Lists
  - No universal definition
  - Must be more than a list of conditions
  - Must be comprehensive and show evaluation and treatment for the visit
  - Must be signed and dated by physician or acceptable physician extender

Hospital Outpatient & Physician Documentation (continued)

- **Problems** with Diagnostic Radiology Reports
  - Generally do not indicate a confirmed diagnosis.
  - MA organizations are relying on the referral diagnosis—this is not a confirmed diagnosis.
  - Generally indicate impression only.
  - Referring physician/PCP usually reviews and documents condition.

Hospital Outpatient & Physician Documentation (continued)

- Guidance for Diagnostic Radiology Reports
  - Do not send diagnostic radiology medical records if other documentation is available.
  - If it is the only documentation, then review to ensure documentation is sufficient to assign code.
  - If documentation is insufficient, then HCC will be discrepant.

Hospital Outpatient & Physician Documentation (continued)

- Nursing home resident medical record—acceptable if:
  - The beneficiary is long-term institutional resident.
  - Physician billing independently (not employed by the nursing home).
  - Visits were face-to-face.

Unacceptable Documentation

Hospital Outpatient & Physician

- Medical record documentation that reflects diagnoses that are:
  - Probable
  - Suspected
  - Questionable
  - Rule out
  - Working

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Unacceptable Documentation
(continued)

Sources

- Skilled nursing facility (SNF)

- Freestanding ambulatory surgical center (ASC)

- Alternative data sources (e.g., pharmacy)

- Inappropriate physician extenders (e.g., nutritionist)

- Durable medical equipment (DME)

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Unacceptable Documentation
(continued)

Types

- Superbill

- Physician-signed attestation

- List of patient conditions

- Diagnostic report that has not been interpreted

- Any documentation for dates of service outside the data collection period

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EXERCISE

Medical Record Review — 🔑 STAGE 3

- Used to validate risk adjustment payments
- Conducted by certified coders who abstract diagnosis codes and validate date(s) of service

Medical Record Review (continued)

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- Additional checks by the medical record coders:
  - Medical record is from an appropriate risk adjustment provider.
  - Provider signature.
  - Dates of service on coversheet and in medical record are in data collection period.

Data Discrepancies

- Identified when risk adjustment diagnosis data are not supported by medical record documentation

- Consist of:
  - Coding discrepancies
  - Invalid medical records and
  - Missing medical records

Coding Discrepancies

- ICD-9 code in the medical record does not match risk adjustment diagnosis code at the 3rd, 4th, and/or 5th digit level

- Examples on pages 9-15 and 9-16

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Invalid Medical Records

- Unacceptable risk adjustment provider type (e.g., SNF)

- Date of service outside of data collection period

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Missing Medical Records

- ICD-9 code cannot be assigned when documentation is insufficient or incomplete.

- No medical record was submitted.

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Risk Adjustment Discrepancies

- The HCC originally assigned based on risk adjustment data differs from the HCC assigned after data validation.

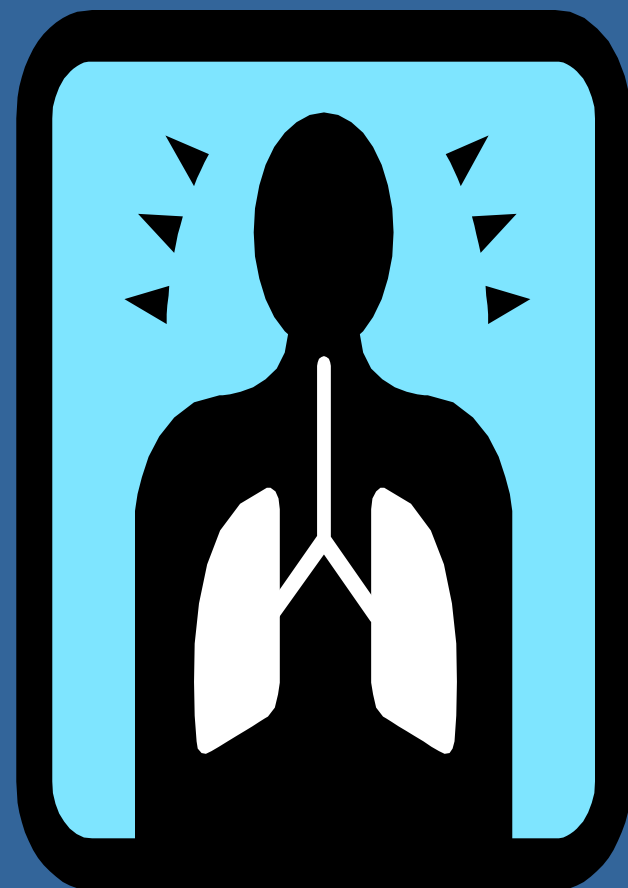- Affects beneficiary risk score.

- Confirmed via the SVC.

Risk Adjustment Discrepancy

Reported Diagnostic Data:

482.4 Staphylococcal Pneumonia (HCC111, .693)

Data Validation Findings:

482.3 Streptococcal Pneumonia (HCC112, .202)
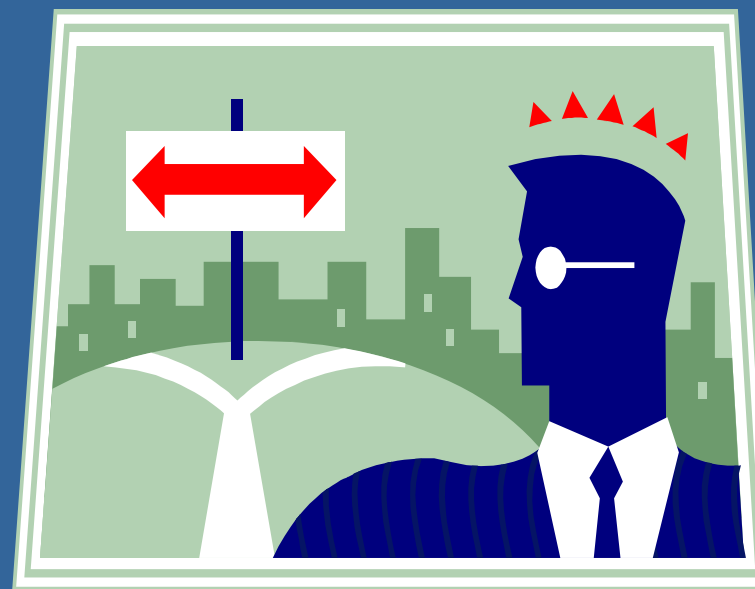
Data Validation Findings

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- MA organization-specific findings shared with data validation participants
  - May include response rate, data discrepancy rate, and risk adjustment discrepancy rate
- Summary findings shared with the MA industry

Payment Adjustment

Payment adjustment decisions are made by the CMS Administrator.

Payment Adjustment
(continued)

- **Purpose:** To correct payments based on confirmed risk adjustment discrepancies

- Serves as the basis for appeals

- Criteria developed by CMS
  - May include "consistent pattern" of inaccurate data for previous and current payment years

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- Consistent patterns may be based on:
  - High risk adjustment discrepancy rates—in comparison to the national average discrepancy rate
  - High payment error rate—in comparison to the national average net payment error rate
  - Two or more consecutive years of inaccurate risk adjustment data validation findings

Appeals

- **Purpose:** To provide MA organizations an opportunity to dispute a payment adjustment.

- Implemented by the SVC.
  - Every appeal reviewed by an expert coding panel.
  - Panel may include senior medical reviewer, senior coder, and physician.

- Consistent with Medicare fee-for-service procedures.

- MA organization has 60 days to file an appeal after adjustment is made and appears on the MMR.

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- MA organizations may offer a different interpretation of the ICD-9 code assignment based on ICD-9 Coding Guidelines.

- MA organizations may provide additional medical record documentation.

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Appeals (continued)

- Appeals must include:
  - A clearly documented reason for disagreement with the medical record review finding

  AND/OR

  - Additional medical record documentation to support reason for appeal

Correct Payment

- Risk adjusted payments are corrected on the basis of the appeals decisions.

- Appeals decisions either uphold or reverse a payment adjustment.

This concludes the 7 Stages of the Risk Adjustment Data Validation Process.

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Recommendations & Lessons Learned to Date

- Establish communications with providers prior to sending the medical record request.

- Use newsletters and CMS training tools to inform physicians about risk adjustment.

- Identify a contact person at the physician's office.

- Send <u>complete</u> information request to providers.

- Determine whether providers require payment in advance of sending medical records.

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Recommendations & Lessons Learned to Date (continued)

- Follow up with physician's office after medical record request is sent.
- Plan accordingly—may require more effort to obtain medical records from:
  - Specialists.
  - Non-contracted providers.
  - Hospital outpatient or physician settings.
- Consider having the provider indicate the date of service and diagnosis code.
- Involve in-house quality assurance staff/medical record reviewers/medical director to identify the "one best medical record."
- Submit <u>complete</u> medical records. as you receive them from providers

Technical Assistance

- Available for MA organizations that need more training or specific assistance with data validation.
  - May include:
    - Site visits
    - Teleconferences
- Contact CMS staff (see page 9-19 of the Participant Guide for contact information).

Current Validation Activities

- CY2003: Completed MRR; awaiting reconciliation

- CY2004: Currently in the review process

- CY2005: Sampling selection expected Fall 2005

Next Steps

- CMS is considering other techniques for monitoring risk adjustment data submissions to improve sampling selection.

- Validating drug data (MMA) will present new issues for data validation.

Please take a moment to complete the evaluation form for the Risk Adjustment Data Validation Module.

Thank You!

Verifying Risk Scores

Presented by:
Aspen Systems Corporation

Purpose

- This module will explain the systems involved in the risk score calculations and introduce MA organizations to a variety of verification tools available.

Objectives

- Understand the systems and processes used to calculate the risk scores.

- Determine how the organization can use risk adjustment processing and management reports to ensure the accuracy of payment.

- Identify the components and uses of the Monthly Membership Report (MMR) and Model Output Report (MOR)/Hierarchical Condition Category(HCC) Report.
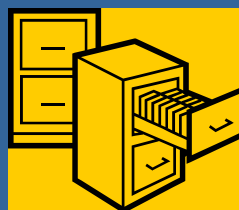
Calculation of Risk Scores

STEP 1

MBD

MDS

Beneficiary Demographic Input File

MDS Long-Term Institutional File

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STEP 2
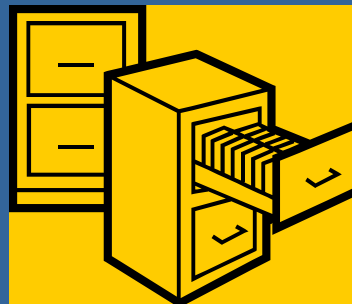
RAPS DB

NMUD

Beneficiary Diagnosis Input File

STEP 3

Beneficiary Demographic Input File

Beneficiary Diagnosis Input File

RAS

MMCS

MDS Long-Term Institutional File

Verification Tools

- RAPS Return File
- Raps Management Reports
- SAS CMS-HCC Model Program
- MMR
- MOR

RAPS Return File/RAPS Transaction Error Report

- Received the next business day after submission.

- Return file provides a record of each diagnosis stored for each enrollee.

- MA organizations may store the results of each RAPS Return File to build and update a record of all diagnoses stored in the model for each enrollee.

- Error Report requires manual updates to a diagnosis file.

Database Components

HIC Number	Diagnosis	Date Submitted	Through Date

RAPS Management Reports

- RAPS Monthly Report

- RAPS Cumulative Plan Activity Report

- Available second day of the month

- Provide the total number of diagnoses stored in the CMS-HCC model

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Run the CMS-HCC Model

- CMS runs the model on a semi-annual basis.

- MA organizations may run the model to calculate their enrollee risk scores.

- SAS program is available at http://cms.hhs.gov/healthplans/rates

Run the CMS-HCC Model (continued)

CMS-HCC Payment Model software and data for 2004

- Note to M+C Organizations Regarding ICD-9 Code Differences in Final CMS-HCC Risk Adjustment Model **(Posted** 07/17/00)
- hccsoftware.zip (49K bytes). This archive expands to 12 files. Read HCCsoft description.rtf (included in the archive) for further details and instructions.
- avgrisk.zip (36K bytes). This archive expands to:
    - avgrisk.csv -- Estimated average county risk factors
- ESRD payment model
    - esrdsoftware2004.zip(50K bytes). This archive expands to 12 files. Read June2004 ESRD Software.doc (included in the archive) for further details and instructions. Please note that CMS used this software to generate ESRD factors for 2005.

http://www.cms.hhs.gov/healthplans/rates

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Monthly Membership Report

- Generated by MMCS.

- Beneficiary-level information.

- Available through the MMCS system.

- For availability, refer to the official schedule for precise dates.

Monthly Membership Report Field Ranges

Field Ranges	Descriptions
1-3	**Managed Care Organization Information**
4-11	**Beneficiary Identification**
12-13	**Entitlement**
14-19	**Health Status**
20-35	**Risk Adjustment/Demographic Payment Adjustment Information**
36-44	**Additional Risk Adjustment Indicators**
45-74	**Fields added to support the Part D Benefit**

Risk Adjustment Model Output Report

- Available through the MMCS system.
- Supplements the MMR report.
- Identifies information used in making risk adjustment calculations.
  - HCC triggered for an individual
  - Disease and demographic interactions

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Summary

- Identified data systems used to calculate risk scores.

- Reviewed how reports can be used to verify risk scores.

Please take a moment to complete the evaluation form for the Verifying Risk Scores Module.

Thank You!