2008 Regional Technical Assistance
Risk Adjustment

CMS Centers for Medicare & Medicaid Services

Introduction and Overview

LTC, Inc.

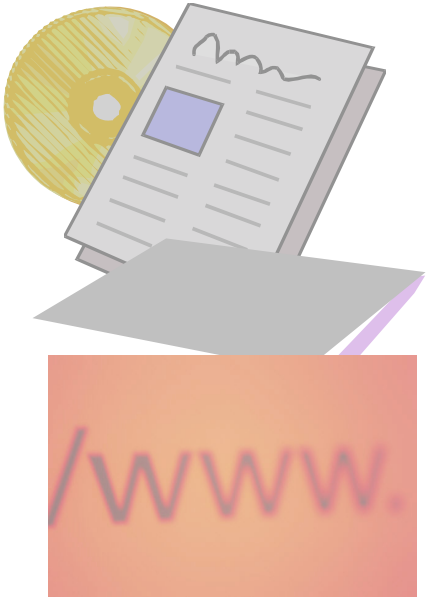
2008 RISK ADJUSTMENT

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.

Technical Assistance Session Tools

- Participant Guide
  - CD with slides
- Job Aids
- www.tarsc.info



Agenda Topics

Introduction and Overview
Risk Adjustment Methodology
Data Collection
Data Submission
Edits and Reports
Data Validation
Verifying Risk Scores

The session includes two 15-minute breaks and 1 hour for lunch.

Learning Objectives

- Identify the CMS Risk Adjustment models
- Describe the requirements for data collection
- Determine the process for submitting data to CMS
- Explain the process for validating risk adjustment data
- Interpret the editing rules and reports available for monitoring RAPS data
- Demonstrate how to verify risk scores

Common Terms

RAS

MARx

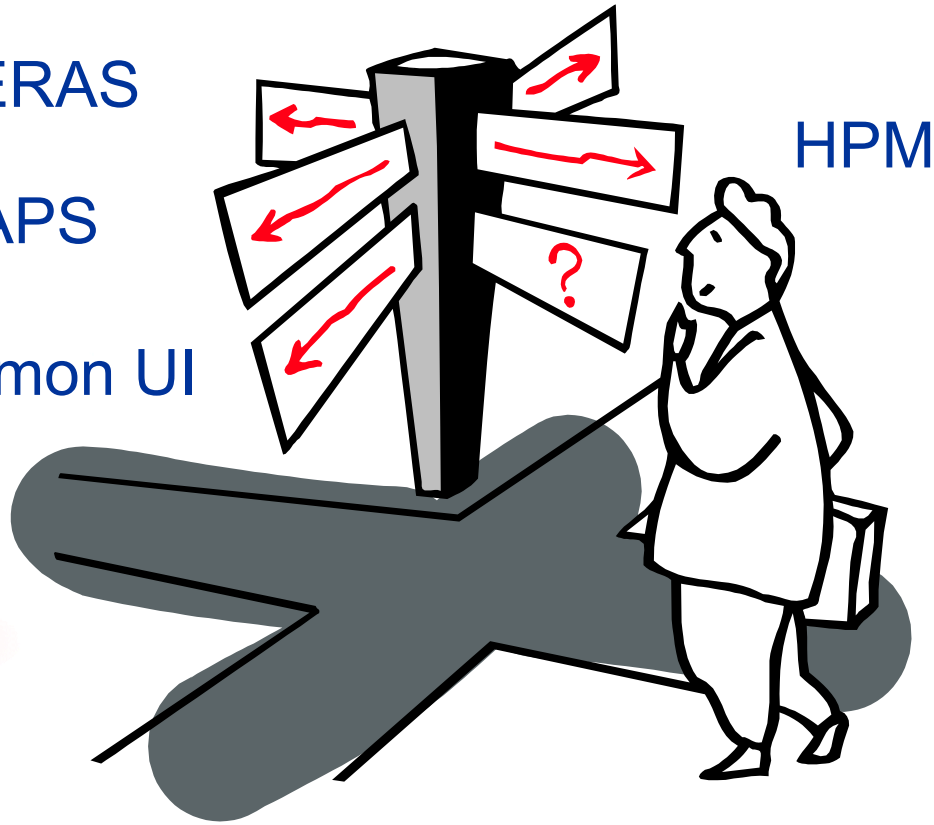
Required Diagnosis

FERAS

HPMS

RAPS

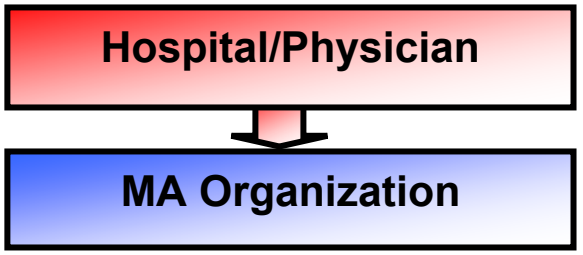
Common UI



Risk Adjustment Data Requirements

- HIC number
- Diagnosis code
- Provider type
- Service from date
- Service through date

Data Collection

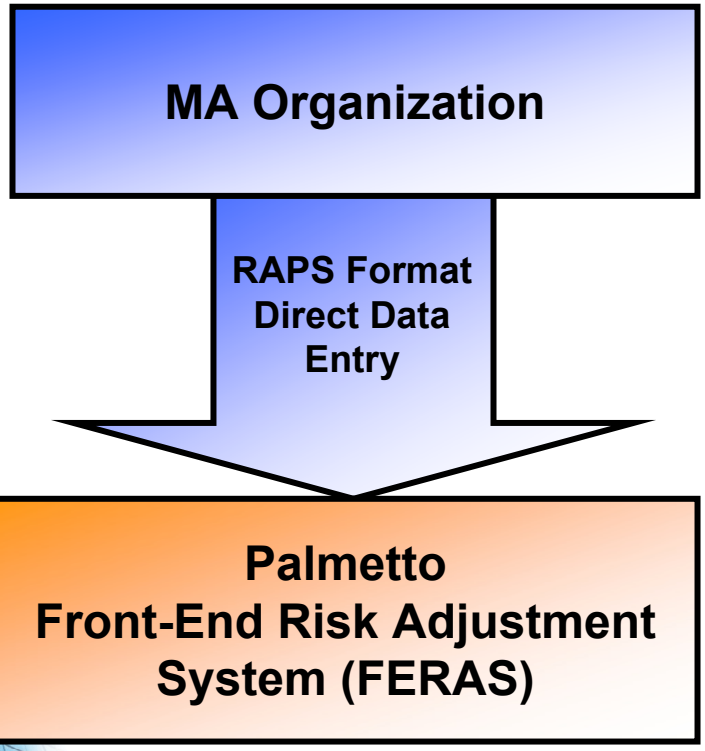


Minimum Data Set

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

- Formats
  - UB-04
  - HCFA 1500
  - NSF
  - ANSI 837
  - Superbill
  - RAPS format

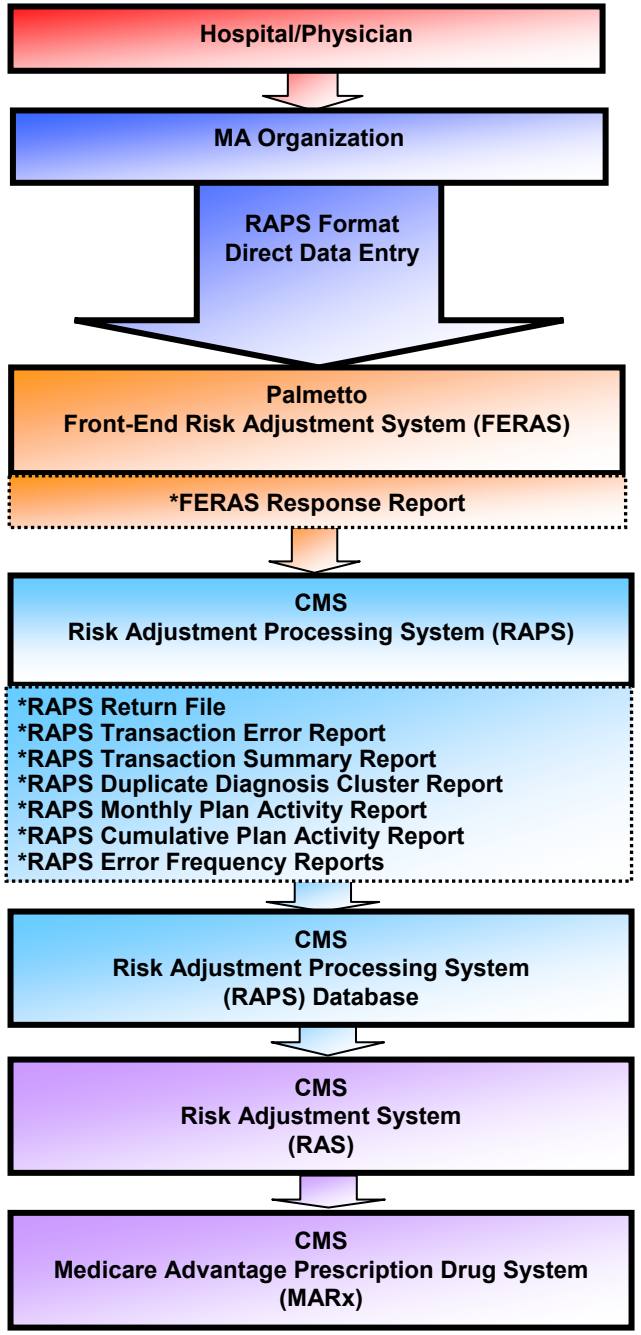
Data Submission



- Formats
  - RAPS format
  - Direct Data Entry

Risk Adjustment Process

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



Submission Schedule

CY	Dates of Service	Initial Submission Deadline	First Payment Date	Final Submission Deadline
08	7/1/06 – 06/30/07	9/7/07	1/1/08	N/A
08	1/1/07 – 12/31/07	3/7/08	7/1/08	1/31/09
09	7/1/07 – 06/30/08	9/5/08	1/1/09	N/A
09	1/1/08 – 12/31/08	3/6/09	7/1/09	1/31/10
10	7/1/08 – 06/30/09	9/4/09	1/1/10	N/A
10	1/1/09 – 12/31/09	3/5/10	7/1/10	1/31/11

Technical Assistance and Support

- Customer Service and Support Center
- www.csscoperations.com
- User Groups
- Onsite Consultation
- www.tarsc.info

Risk Adjustment Methodology

CMS

Purpose

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

Objectives

- Review risk adjustment history
- Review risk adjustment implementation timeline
- Review characteristics of the Part C and Part D risk adjustment models
- Discuss Part C frailty adjuster
- Describe how to calculate risk scores
- Understand the basics of risk adjustment as applied to bidding and payment

Risk Adjustment History

- The Balanced Budget Act (BBA) of 1997:
  - Created Medicare + Choice (M+C) Part C Program
  - Mandated CMS to implement risk adjustment payment methodology to M+C (now MA) organizations beginning in 2000 (PIP-DCG)
  - Payment based on the health status and demographic characteristics of an enrollee
  - Mandated frailty adjustment for enrollees in the Program for All-Inclusive Care for the Elderly (PACE)

Risk Adjustment History (continued)

- Benefits Improvement Act of 2000 (BIPA)
  - Mandated CMS to implement risk adjustment payment methodology to M+C (now MA) organizations based on inpatient and ambulatory data beginning in 2004 (CMS-HCC)
  - Established the implementation schedule to achieve 100% risk adjustment payments by 2007
  - Mandated introduction of risk adjustment to ESRD enrollee payments

Risk Adjustment History (continued)

- Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)
  - Created Medicare Part D - new prescription drug benefit program, which was implemented in 2006
  - Created new program called Medicare Advantage (MA) that replaced M+C program
  - Introduced bidding into the MA program and amended the MA payment methodology. Also retained most M+C provisions
  - Included risk adjustment as a key component of the bidding and payment processes for both the MA program and the prescription drug benefit

MMA – Part D

- Title I - Medicare Prescription Drug Benefit - Part D
  - Two types of sponsors:
    - Stand alone prescription drug plan (PDP)
    - MA organization providing a prescription 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

Part D Bidding

- Plans submit bids representing their revenue needs for offering the type of Part D coverage (e.g. standard or enhanced) in selected Part D regions).
- The law requires CMS to calculate a national average of the bids and a national base beneficiary premium.
- The base beneficiary premium is on average 25.5% of the national average bid (adjusted for reinsurance).
- The basic Part D premium each plan must charge equals the national base beneficiary premium adjusted for the difference between the plan's bid and the national average bid amount.
- MA-PD plans may buy down the basic Part D premium with rebate dollars.

MMA – Part C

- Title II - Medicare Advantage – Part C
  - Medicare Advantage Plan Sponsors could offer
    - 3 types of local plan options
      - Coordinated care plans (HMOs, PPOs, PSO); PFFS plans; and MSA plans
    - Created MA regional coordinated care plans; 26 MA regions announced in December 2004
  - Replaced Adjusted Community Rate (ACR) proposal with bidding process for original Medicare benefits

Part C Bid and Review Process

- By law, the Part C basic plan bid is the total revenue needed to offer original Medicare (Part A & Part B) benefits:
  - to enrollees who live in a specific service area (one or more counties)
  - who have a certain level of average risk expected by the MAO
  - & assuming the plan will charge cost sharing equivalent to FFS
- The law establishes rules for determining plan benchmarks – the upper limit on what the government will pay for each enrollee.
- The law requires CMS to compare the plan basic bid to the plan benchmark to determine whether the plan must charge an enrollee premium or can offer supplemental benefits at a reduced price.
- For MA plans with bids below benchmarks, 75% of the difference ("rebate") must fund coverage of supplemental benefits, e.g. reduction in FFS-level cost sharing and/or coverage of additional non-Medicare covered benefits.

Part C Bid and Review Process
(continued)

- CMS reviews each bid for actuarial soundness
- Ensures that each bid reflects costs of providing proposed benefit package
- Risk adjustment used to standardize bids to determine what CMS' payment rate will be to the plan for each enrollee
- Risk Adjustment allows direct comparison of bids based on populations with different health status and other characteristics
- Risk adjustment is also used to pay more accurately by adjusting the monthly capitated bid-based payments for enrollee health status

What is Risk Adjustment?

- A method used to adjust bidding and payment based on the health status and demographic characteristics of an enrollee
- Prospective - Uses diagnosis as a measure of health status and demographic information
- Pay appropriate and accurate payments for subpopulations with significant cost differences
- Purpose: to pay plans accurately for the risk of the beneficiaries they enroll
- Access, quality, protect beneficiaries, reduce adverse selection, etc.

CMS Risk Adjustment Models

- Currently CMS implements risk adjustment in 3 key payment areas:
  - The Part C CMS-HCC Model for aged and disabled beneficiaries
    - Community, Long Term Institutional Models, New Enrollee
  - The CMS-HCC ESRD Model for beneficiaries with ESRD
    - Dialysis, Transplant, and Post-Transplant
  - The RxHCC Part D drug model for all beneficiaries enrolled in Part D
    - Base Model +
    - Low Income or Long Term Institutional Multipliers
- Risk scores produced by each model are distinct based on predicted expenditures for that payment method (Part C, ESRD, Part D)
- Risk scores are based on diagnoses from either MA plans or Medicare FFS
- Models share a common basic structure

Calibration

- Refers to the base years of data used in the development of the model
- Uses diagnosis in a given year to predict Medicare expenditures in the following year
- Recalibrated every 2 years
  - Appropriate relative weights for each HCC
  - Reflect more recent coding and expenditure patterns

Calibration (continued)

- Regression model - weighted - Medicare liability
- 5% sample – 1.5 million beneficiaries – Fee-For-Service
- Result of the model are estimated coefficients
- Each coefficient shows the incremental predicted expenditures associated with assigned demographic and disease components
- Coefficients divided by overall mean to get relative factors
- Risk scores
  - Assigned to each individual
  - Developed using the relative factors
  - Sum of demographic and disease factors
- Normalization – corrects for population and coding changes between the data years used in the calibration of the model and the payment year

CMS Risk Adjustment and Frailty Implementation Timeline

Year	Implementation Timeline
2004	• Part C risk adjustment using new CMS-HCC model • Frailty adjuster for enrollees of PACE and certain demonstrations under Part C
2005	• End-Stage Renal Disease (ESRD) model for ESRD enrollees
2006	• Part D risk adjustment model (RxHCC) for the new Medicare prescription drug benefit (PDP)
2007	• Updated CMS-HCC model • Normalization of Part C and Post Graft ESRD risk scores
2008	• Updates to ESRD payment models • New/updated normalization factors for all models (Part C, ESRD, and Part D) • Begin frailty payment transition for PACE • Begin frailty payment phase-out for certain demonstration organizations

CMS Risk Adjustment and Frailty Implementation Timeline (continued)

Year	Implementation Timeline
2009	• Updated CMS-HCC model • Updated normalization factors for all models (Part C, ESRD, and Part D) • Updated Frailty adjuster for enrollees of PACE and certain demonstrations under Part C
2010	• Updated normalization factors for all models (Part C, ESRD, and Part D)
2011	• Updated Part D Risk Adjustment Model • Updated CMS-HCC Model • Updated ESRD Model • Updated normalization factors for all models (Part C, ESRD, and Part D)

Common Characteristics of the Risk Adjustment Models

- Prospective: diagnoses from base year used to predict payments for following year
- Demographic factors
- Disease factors
- Disease groups contain clinically related diagnoses with similar cost implications
- Hierarchy logic is imposed on certain related disease groups
- Diagnosis sources are inpatient and outpatient hospitals, and physician settings
- New enrollee model components
- Site neutral
- Additive factors

Demographic Factors in Risk Adjustment

- Age
- Sex
- 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
- Medicaid Status (for Part C)
- LTI and LIS multipliers (for Part D)

Disease Groups/HCCs

- 13,000+ ICD-9 codes
- Grouped together based on diagnosis that are clinically related and have similar Medicare cost implications
- Each group relates to a well specified medical condition (examples - diabetes, congestive heart failure)
- Known as disease category or Condition Category (CC)
- Hierarchy logic is imposed on certain disease groups so model is known as the Hierarchical Condition Category (HCC) Model

Disease Groups/HCCs (continued)

- 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

- Address multiple levels of severity for a disease with varying levels of associated costs
- 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
- Disease within the hierarchy are not additive

Disease Interactions

- Model captures the combined effect of multiple unrelated conditions
  - Example - combined effect of two chronic diseases is greater than the sum of their individual effects
- Additive
- 6 high cost chronic conditions
- There are 6 disease interactions in the Part C model
  - 4 two-way, 2 three-way

Disease Interactions Example

- Two-disease Interaction for Community-Based Enrollee
- Factor 1: Diabetes Mellitus (DM), HCC15 = 0.508
- Factor 2: Congestive Heart Failure (CHF), HCC80 = 0. 410
- Factor 3: Interaction: DM*CHF = 0. 154
- Risk Score = (demographic) + 0.508 + 0.410 + 0.154
- In this case, the enrollee receives an additional interaction instead of only two factors for HCC15 and HCC80.

New Enrollee Factors

- Newly eligible disabled or age-in with less than 12 months of Medicare Part B entitlement during data collection period
- Payments are made retroactively for Medicaid eligibility after enrollment is verified

Part C – CMS-HCC Model Distinctions

- Separate community and institutional models for different treatment costs between community and institutional residents
- Recalibrated: 2004-2005 data
- 70 disease categories for community and long term institutional residents
- Medicaid Status
  - Defined as one month of Medicaid eligibility during data collection period
  - New enrollees use concurrent Medicaid

Part C – Frailty Adjuster

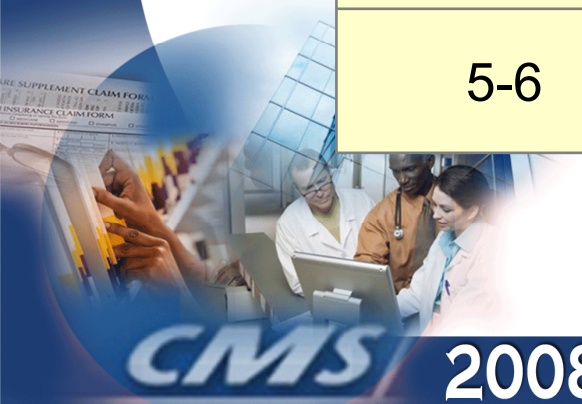
- Predicts Medicare expenditures for the functionally impaired (frail) that are not explained by CMS-HCC model
- Applies only to PACE organizations and certain demonstrations
- Based on relative frailty of organization in terms of number of functional limitations
- Functional limitations measured by activities of daily living (ADLs) – from survey results

Part C – Frailty Adjuster (continued)

- Contract-level frailty score calculated based on ADLs of non-ESRD community residents age 55 or older
- Contract-level frailty score added the risk score of community residing non-ESRD beneficiaries >55 years of age during payment
- Risk + frailty account for variation in health status for frail elderly

Current and Revised Frailty Factors

ADL Limitations	2008 Frailty Factors		2009 Frailty Factors	
	Non-Medicaid	Medicaid	Non-Medicaid	Medicaid
0	-0.089	-0.183	-0.093	-0.18
1-2	+0.110	+0.024	+0.112	+0.035
3-4	+0.200	+0.132	+0.201	+0.155
5-6	+0.377	+0.188	+0.381	+0.2



Part C ESRD Models

- Used for ESRD enrollees in MA organizations and demonstrations
- Address unique cost considerations of ESRD population
- Implemented in 2005 at 100% risk adjustment
- Recalibrated for 2008 using 2002-2003 data

Part C ESRD Models (continued)

- 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
    - Includes factor to account for immunosuppressive drugs and added intensity of care

Part C ESRD Models (continued)

- Dialysis Model – HCCs with different coefficients
  - Multiplied by statewide ESRD ratebook (updated on transition blend beginning 2008)
- 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

Part C Model Comparisons of Coefficients

	Community	Institutional	Dialysis
Metastatic Cancer and Acute Leukemia HCC 7	2.276	0.824	0.189
Diabetes with acute complications HCC 17	0.339	0.459	0.080
Major Depression HCC 55	0.353	0.293	0.123
Age-Sex Factor for 69 year old male	0.328	1.221	0.776
Age-Sex Factor for 88 year old female	0.637	0.704	0.872

*Factors in this example based on 2009 Payment Models

Part D Risk Adjustment (RxHCC)

- Designed to predict plan liability for prescription drugs under the Medicare drug benefit
- Different diseases predict drug costs than Part A/B costs
- Explanatory power of the RxHCC model is R2=0.25 for plan liability, on par with other drug models and is higher than similar Part A/B models because drug costs are more stable

Part D Risk Adjustment (continued)

- Average projected plan liability was ≈ $993 in 2006
- Model includes 113 coefficients
  - 3 age and disease interactions
  - 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 (LI) subsidy eligible or long term institutional (LTI)
- The multipliers are applied to the base Part D risk score predicted by the model
- LI and LTI are hierarchical:
  - If a beneficiary is LTI they can not also receive the LI 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

Part D 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 Adjustment 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 (disabled): risk score = base risk score (1.22 * 1.21) = 1.476
- Apply normalization factor

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 * Individual Risk Score) - Beneficiary Basic Premium
- Sum for all beneficiaries enrolled equals monthly organizational payment

2009 Parts C and D Normalization Factors

Model	Normalization Factor
CMS-HCC Community/Institutional	1.030
ESRD Dialysis/Transplant	1.019
ESRD Functioning Graft	1.058
RxHCC	1.085

Performance of RA Models

- Measured by comparing predicted payments to actual costs
- Predictive Ratio = (Predicted/Actual)
- Predictive Ratios separately for varying risk levels - deciles
- Part D model is performing very well across all levels of risk for both Regular and Low Income Subsidy beneficiaries

Risk Adjustment Research and Development Part C

- Clinical Revision of CMS-HCC model
- Improve Prediction for High Cost Beneficiaries
- Consider Incorporating Prescription Drug Data in Part C Risk Adjuster
- Transition to ICD-10

Risk Adjustment Research and Development Part D

- New model will be based on experience under the Part D program
  - Similar Methodology to current Part C Model
    - Clinically based
    - Prospective – we will use 2007 predictors and 2008 program drug cost data to develop model
    - We will consider using demographic, diagnostic, and drug data to enhance the predictive power of the model
    - Implemented 2011

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 updated CMS-HCC model is available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage
- The Part D risk adjustment model is available at http://www.cms.hhs.gov/DrugCoverageClaimsData/02_RxClaims_PaymentRiskAdjustment.asp#TopOfPage
- Comprehensive list of required ICD-9 Codes for 2005-2008 is available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage

Contacts

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EVALUATION

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

THANK YOU!

Data Collection

LTC, Inc.

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
- List three sources of risk adjustment data
- Describe available data collection formats
- Discuss considerations for methods of data collection
- Apply HIPAA transaction standards

Data Collection

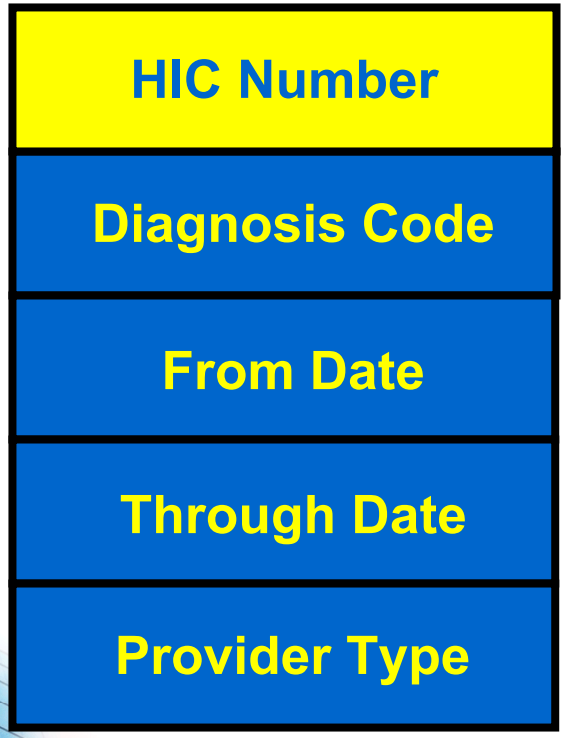
DATA COLLECTION

DATA SUBMISSION

Minimum Risk Adjustment Data Elements

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

Health Insurance Claim (HIC) Number



- Beneficiary identification numbers
- Issued by CMS and the RRB

HIC Number (continued)

CMS Number → 111223334A

SSN BIC

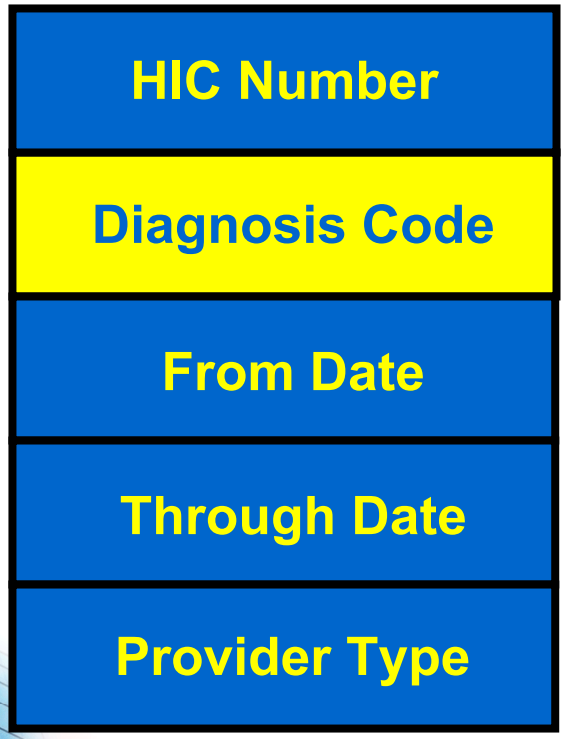
RRB Pre 1964 → WA123456

Prefix Random

RRB Post 1964 → WA123456789

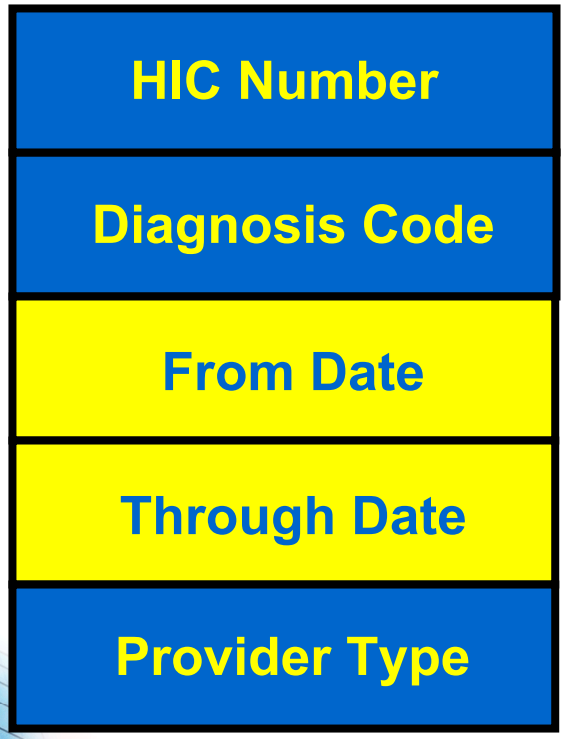
Prefix SSN

ICD-9-CM Diagnosis Codes



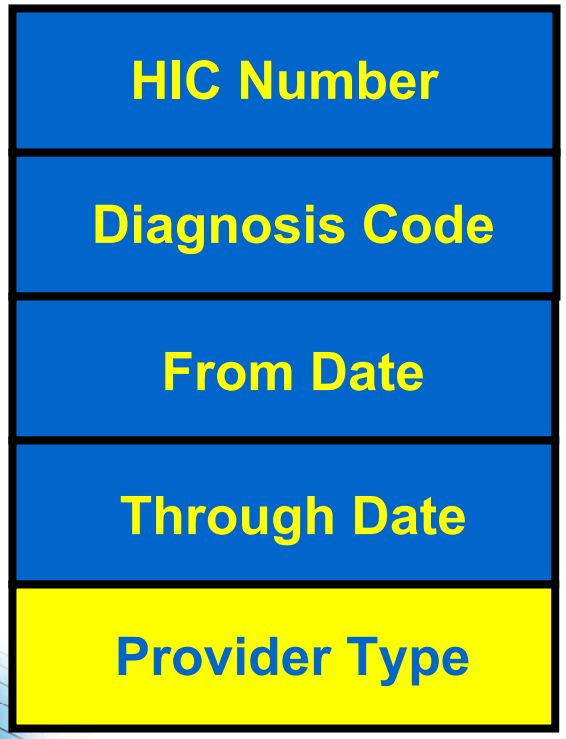
- 3-5 digit code describing clinical reason for treatment
- Drives risk scores, which drive reimbursement

Service From and Through Dates



- Defines when a beneficiary received treatment

Provider Type



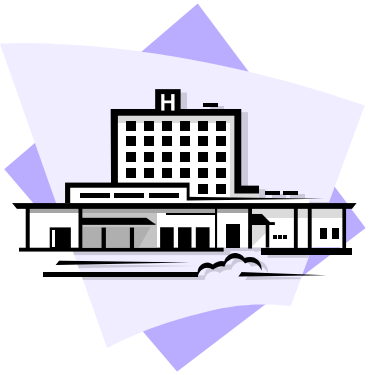
- Facility
  - Hospital inpatient
  - Hospital outpatient
- Physician

Hospital Inpatient Data

- From a hospital or facility where a patient is admitted to at least an overnight stay.
- Determine if a hospital inpatient facility provider is a covered facility.
- SNFs or hospital inpatient swing bed components are not covered facilities.

Hospital Outpatient Data

- Therapeutic and rehabilitation services for sick or injured persons who do not require hospitalization or institutionalization.
- From hospital outpatient departments.
- Determine if a hospital outpatient facility is a covered facility.



Acceptable or Not?

In Network?	*Provider Indicator?	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	Email henry.thomas@cms.hhs.gov

* Provider Indicator within the acceptable range.

Physician Data

- Services provided by a physician or clinical specialist during a face-to-face visit.
- All required diagnoses must be collected from network, as well as non-network physicians.

Exercise

Data Collection Formats

- HCFA 1500
- NSF
- UB-04
- ANSI x12 837
- RAPS format
- Superbill

Factors Affecting Data Collection Method

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
- Listed three sources of risk adjustment data.
- Described available data collection formats
- Discussed considerations for methods of data collection
- Applied HIPAA transaction standards

EVALUATION

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

THANK YOU!

Data Submission

LTC, Inc.

2008 RISK ADJUSTMENT

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.

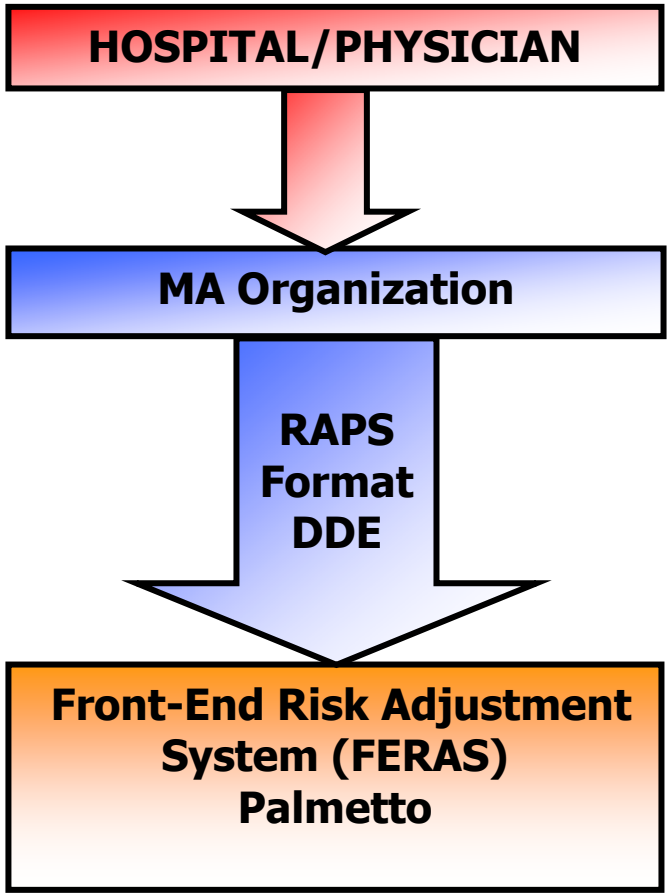
Objectives

- 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

Objectives (continued)

- Understand the Direct Data Entry (DDE) process
- Describe the filtering process
- Describe the diagnosis deletion process

Risk Adjustment Process



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

Connectivity Options

Connect:Direct	– Mainframe-to-mainframe connection – Next day receipt of FERAS response
File Transfer Protocol (FTP)	– Modem-to–modem (dial-up) or lease line connection – Requires password and phone line – Same day receipt of front-end response
CMS Enterprise File Transfer (Gentran)	**Two connectivity options:** – Secure File Transfer Protocol (FTP); standards based protocol via a vendor. – Secure Hypertext Transfer Protocol; secure web interface.

Required Diagnosis

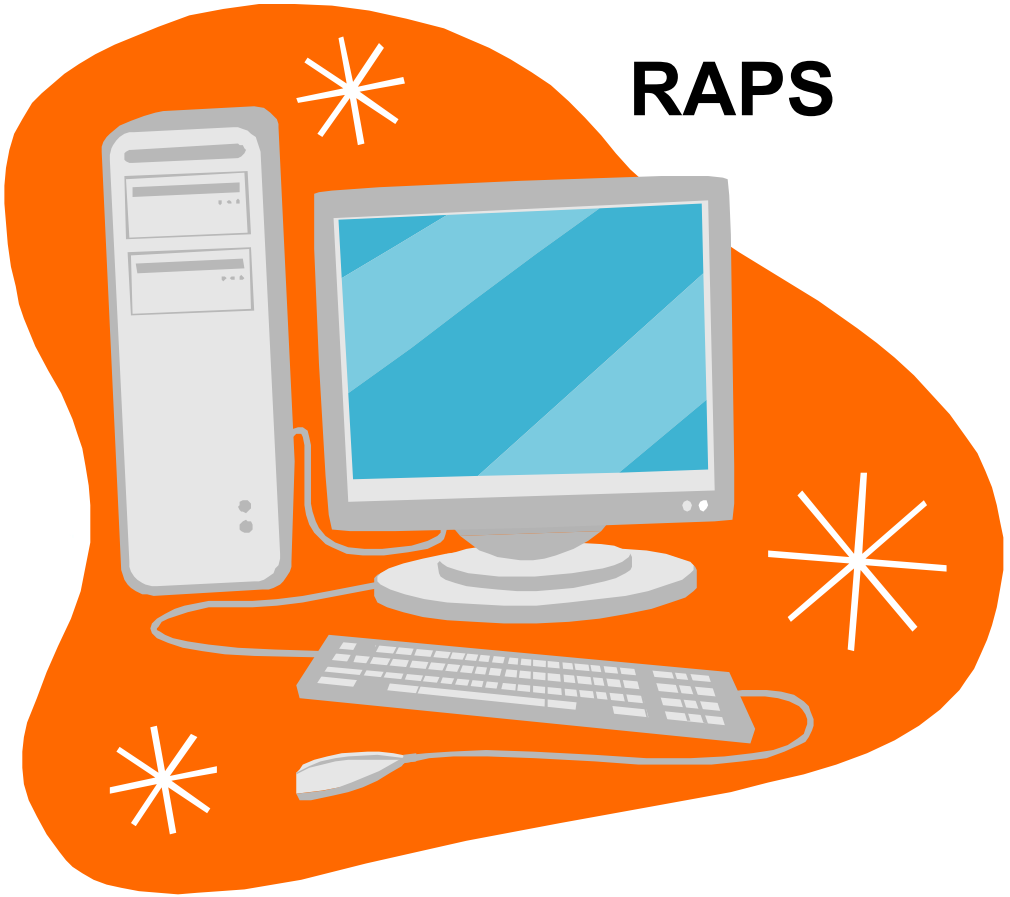
- Current and future diagnoses are included in the risk adjustment models.
- Diagnosis must be received from one of these three provider types: hospital inpatient, hospital outpatient, or physician.
- Diagnosis must be collected according to the risk adjustment data collection instructions.

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

Submission Formats

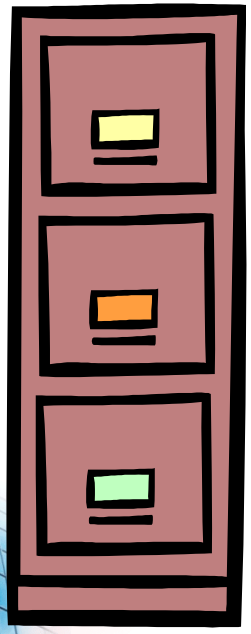
RAPS

DDE

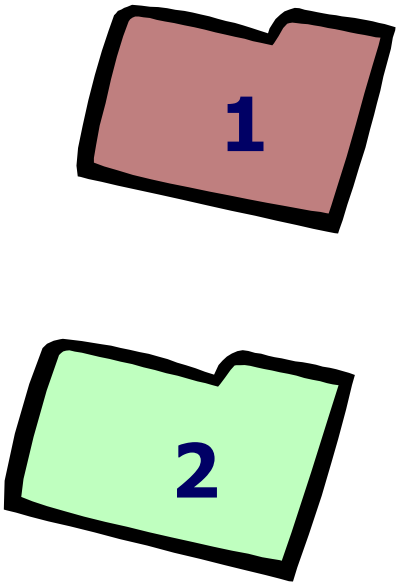


File Logic

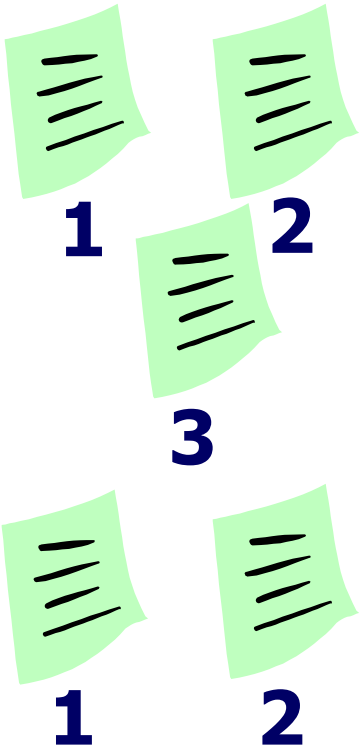
File Level



Batch Level



Detail Level



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.
- NPI is not required.
- Once a cluster is submitted and stored, do not resubmit.

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.

Do not submit risk adjustment diagnoses based on any ***diagnostic radiology services****.*

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.
- Do not resubmit clusters for which there is no modification required.

Steps for Deleting Clusters (continued)

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.

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.

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)

- Provided an overview of the DDE process
- Described the filtering process
- Described the diagnosis deletion process

EVALUATION

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

THANK YOU!

Edits and Reports

LTC, Inc.

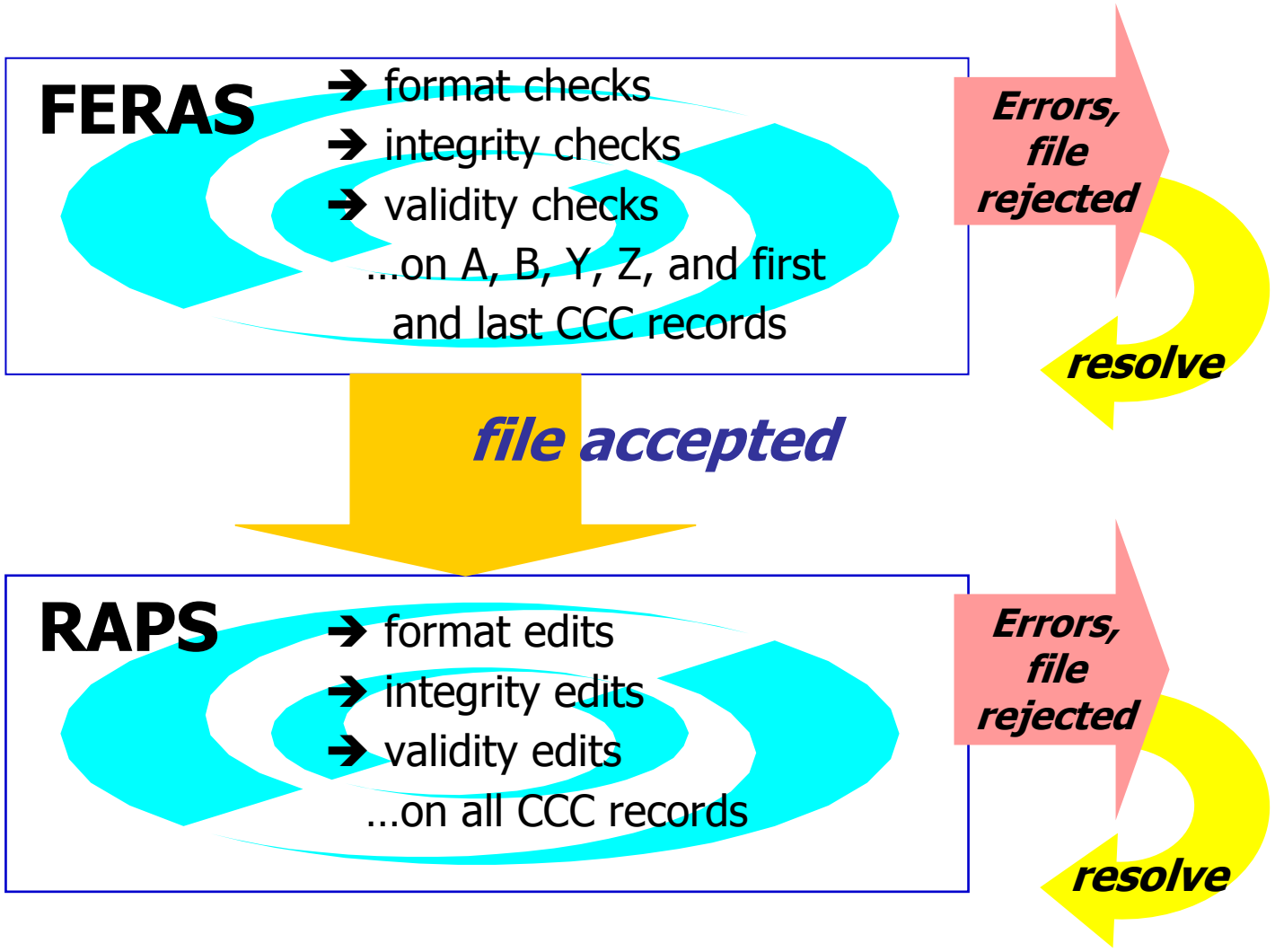
Purpose

- To provide participants with an understanding of the data logic and editing processes in FERAS and RAPS and insight into the appropriate use of risk adjustment reports

Objectives

- Interpret the FERAS and the RAPS data integrity logic and error codes
- Describe the FERAS and RAPS editing processes
- Explain the purpose of the FERAS and RAPS reports in monitoring RAPS data
- Analyze risk adjustment reports to identify and submit corrections

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
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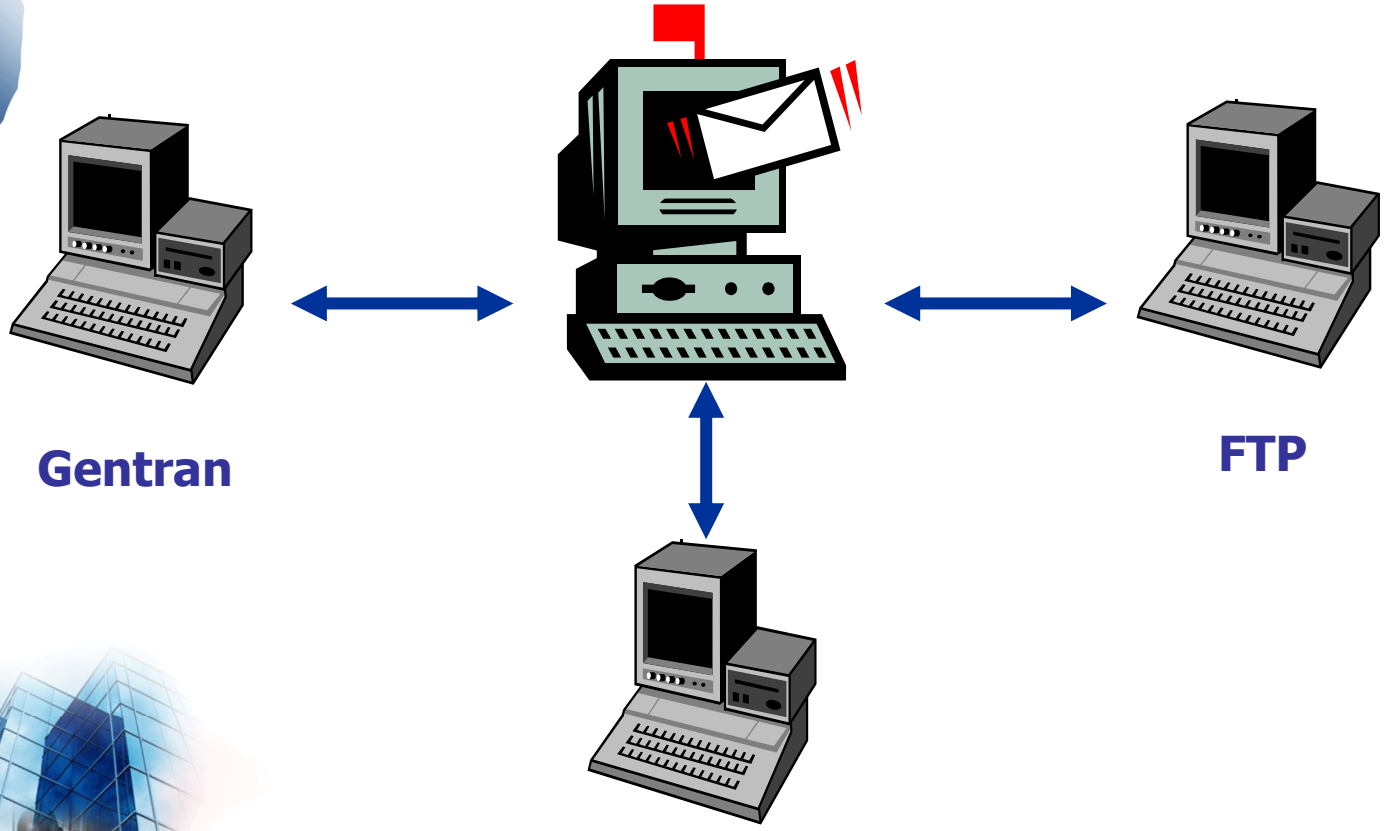
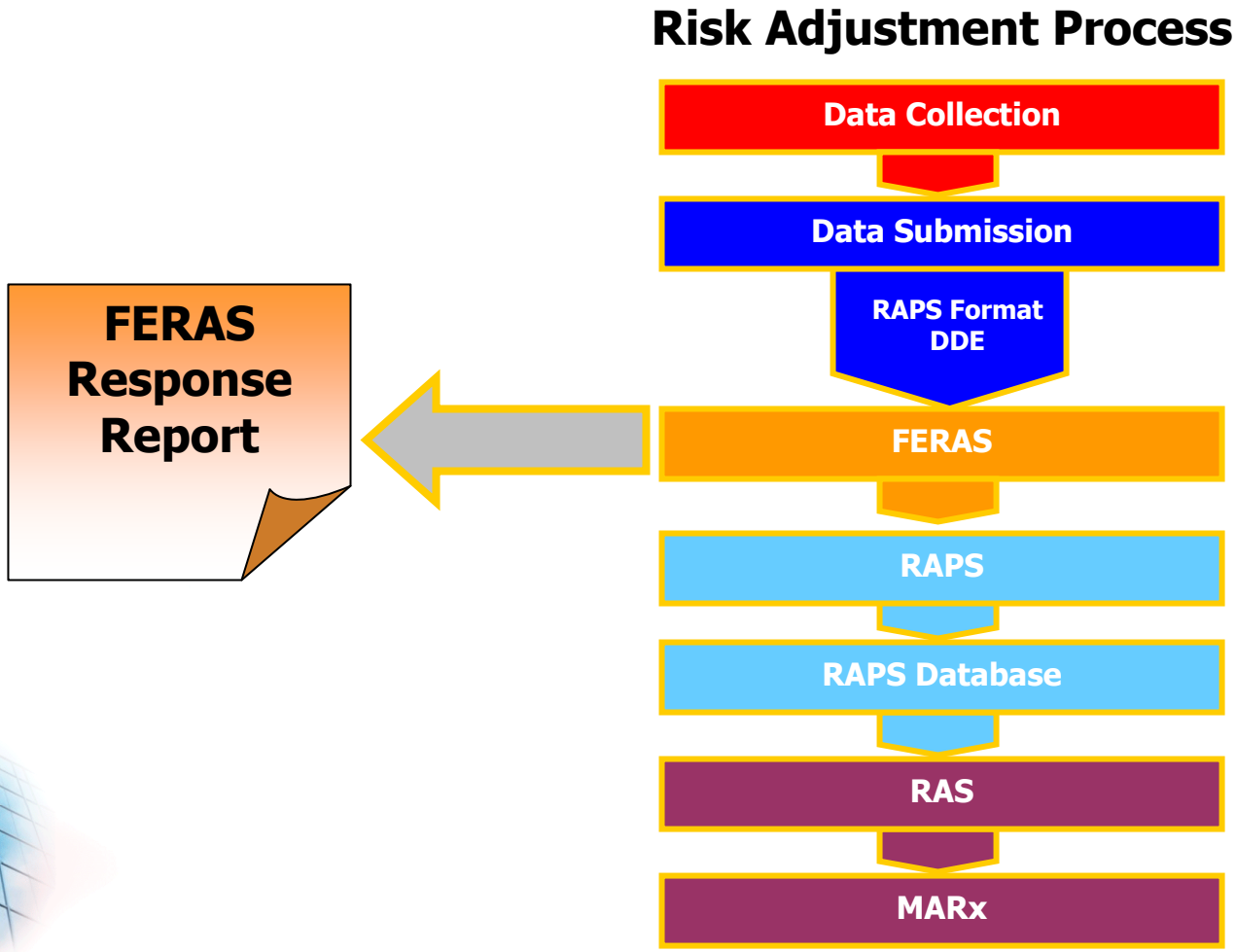
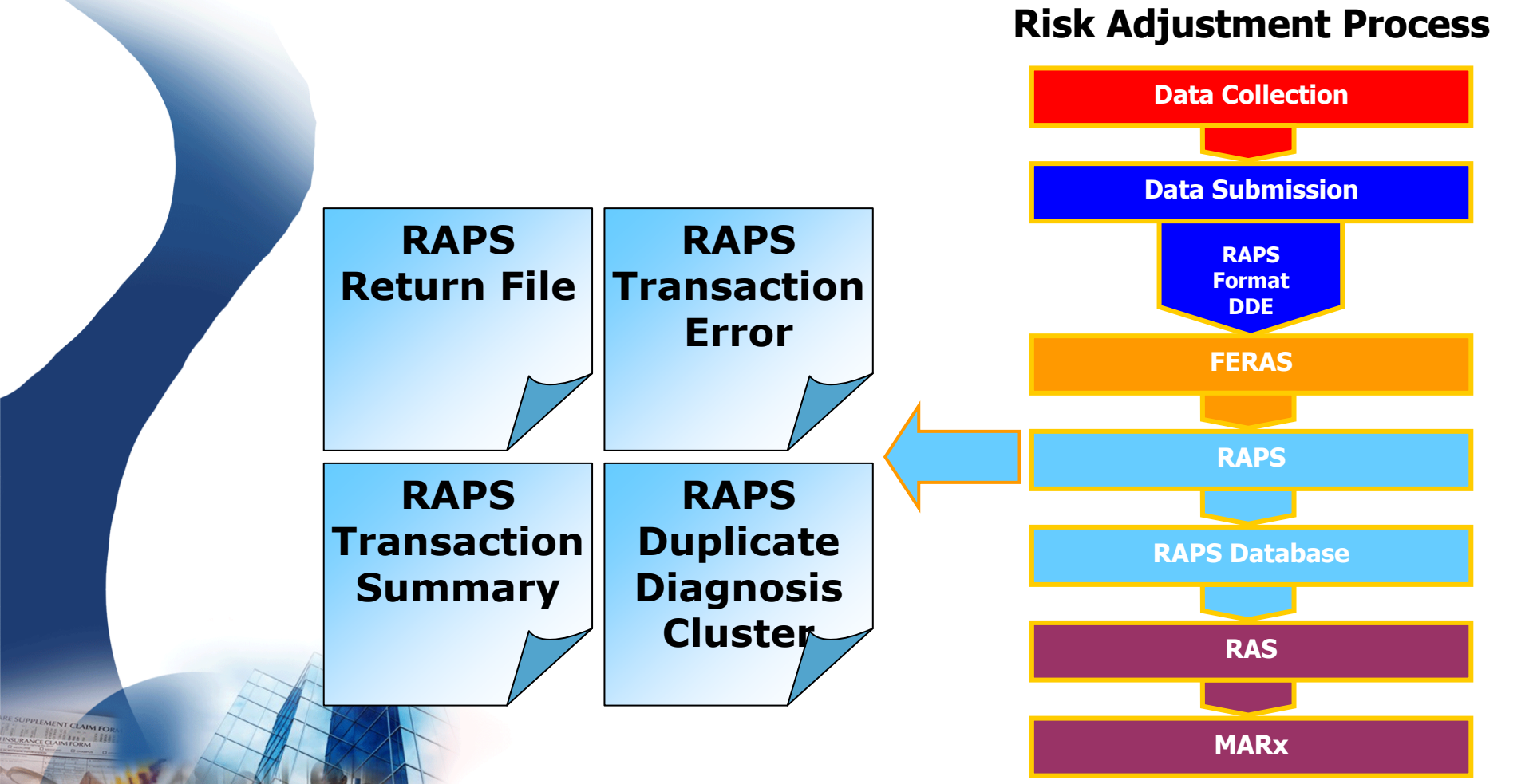
Accessing Reports



Reports Overview



Reports Overview (continued)



Reports Overview (continued)

RAPS Monthly Plan Activity

RAPS Cumulative Plan Activity

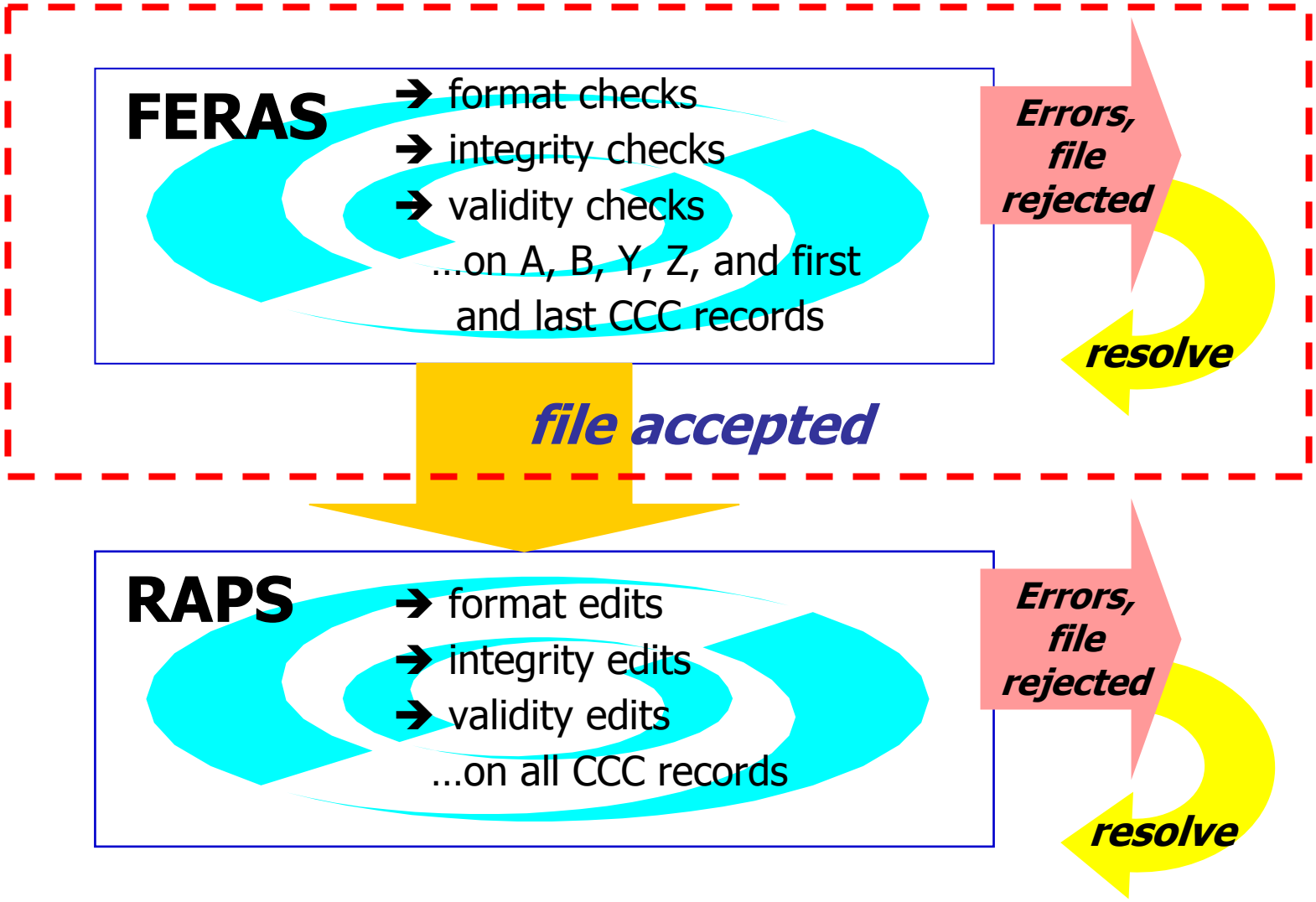
RAPS Monthly/ Quarterly Error Frequency

Management Reports

Risk Adjustment Process

- Data Collection
- Data Submission
- RAPS Format DDE
- FERAS
- RAPS
- RAPS Database
- RAS
- MARx

Data Flow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➔ integrity checks
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…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 Edits Logic

Series	Explanation
100	File level errors on the AAA or ZZZ records
200	Batch level errors on the BBB or YYY records
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

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.

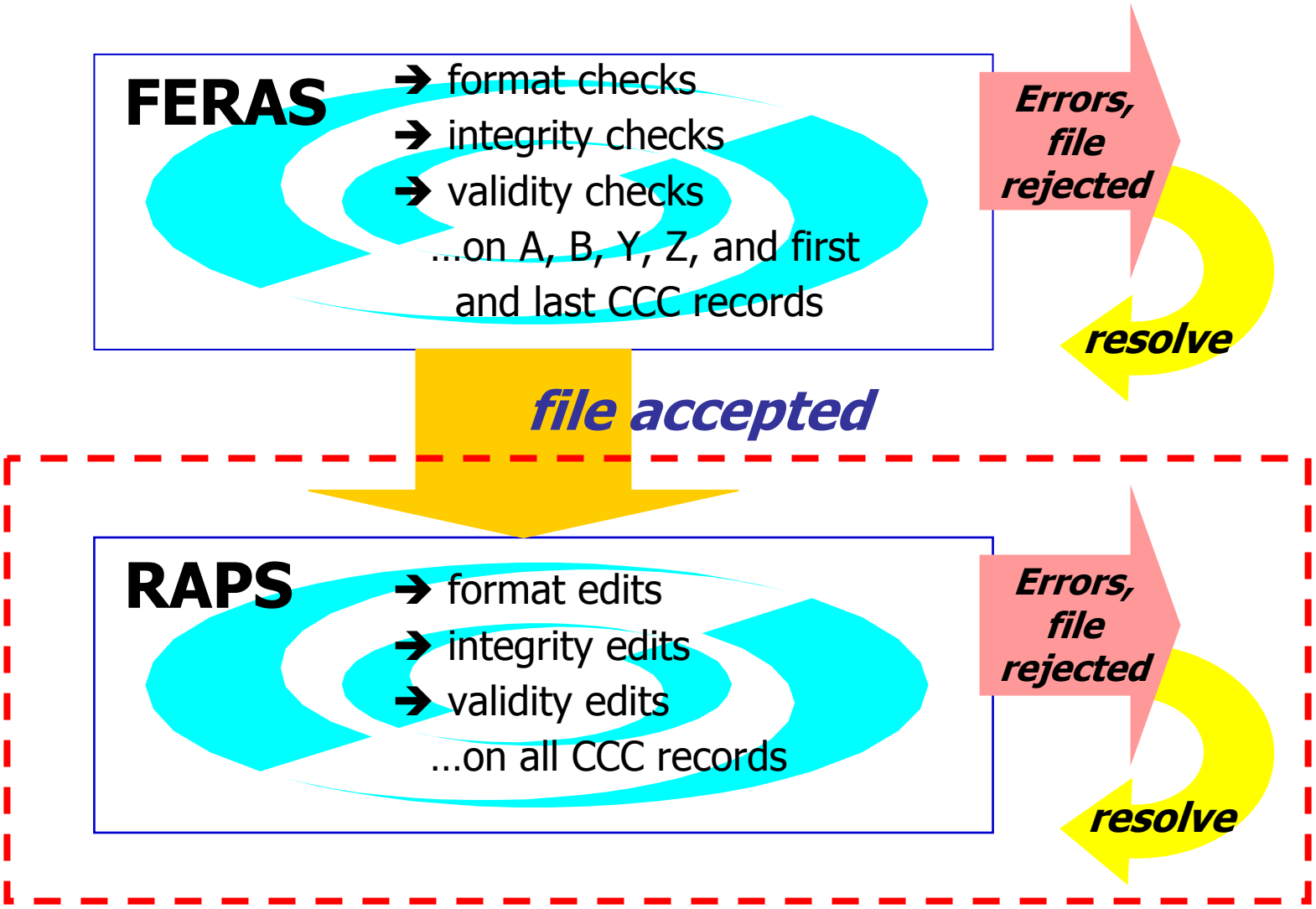
FERAS Response Report

- 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 users)
  - The next business day (Connect:Direct and Gentran users)

FERAS Response Report Example

The MA organization submitted a file containing a file ID that was used within the last twelve months. 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 Edits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Errors, file rejected
resolve
file accepted
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➔ format edits
➔ integrity edits
➔ validity edits
...on all CCC records
Errors, file rejected
resolve

RAPS Editing Rules

- **Stage 1 - Field Validity and Integrity edits**
- Stage 2 - Field-to-Field edits
- Stage 3 - Eligibility edits
- Stage 4 - Diagnosis Code edits

RAPS Editing Rules (continued)

- Stage 1 - Field Validity and Integrity edits
- **Stage 2 - Field-to-Field edits**
- Stage 3 - Eligibility edits
- Stage 4 - Diagnosis Code edits

RAPS Editing Rules (continued)

- Stage 1 - Field Validity and Integrity edits
- Stage 2 - Field-to-Field edits
- **Stage 3 - Eligibility edits**
- Stage 4 - Diagnosis Code edits

RAPS Editing Rules (continued)

- Stage 1 - Field Validity and Integrity edits
- Stage 2 - Field-to-Field edits
- Stage 3 - Eligibility edits
- **Stage 4 - Diagnosis Code edits**

RAPS Error Codes

	Series	Explanation of Errors 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.
Record	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.
Cluster	490-499	Diagnosis delete error - Diagnosis was not deleted.
Cluster	500-599	Informational message, all edits were performed, diagnosis cluster was stored unless some other error is noted.

Example

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 common tables 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 the RAPS database.

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 (continued)

- Communicates information in fields:
  - 3 → Sequence Number error code
  - 6 → HIC Number error code
  - 8 → Date of Birth error code
  - 9.6 → Diagnosis Cluster Error 1
  - 9.7 → Diagnosis Cluster Error 2
  - 19 → Corrected HIC Number

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 MARx. 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 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

Relationship Between Values in RAPS Transaction Summary Report

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

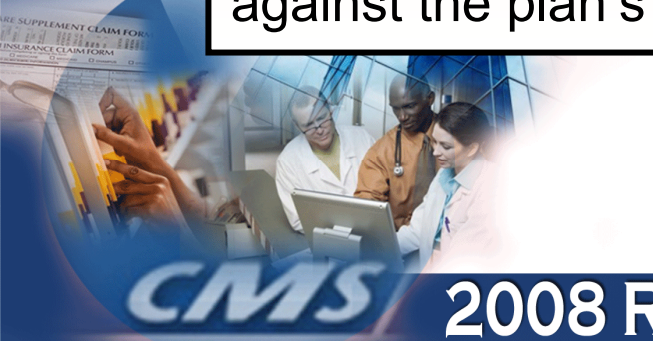
Total Stored ≤ Total Accepted

Total Model Diagnoses Stored ≤ Total Stored

Example

Scenario: Blue Health Plan submitted a CCC record with seven diagnosis clusters in which the sixth diagnosis cluster received an error indicating the diagnosis was not appropriate for the patient sex.

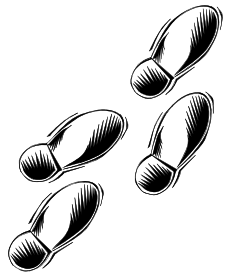
Results: The CCC record with the seven diagnosis clusters received a cluster level error, error code 453 on the sixth cluster. The only cluster not accepted and stored from this CCC record is the sixth cluster. Therefore, the only cluster that should be resubmitted by Blue Health Plan is the sixth cluster, the one that received the error. Resubmitting the other diagnosis clusters that were accepted and stored would result in the Blue Health Plan receiving error code 502 for submitting duplicate diagnosis clusters. This would count against the plan's 5% benchmark.



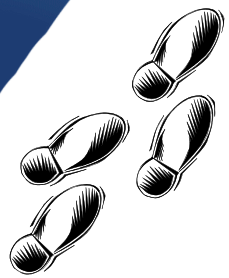
RAPS Duplicate Diagnosis Cluster Report

- 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

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 the next step.
4. Take steps to resolve the error.



Example

Scenario: Horizon Valley Health Plan submitted eight diagnosis clusters. However, the fifth diagnosis cluster was a blank cluster.

Results: Error code 455 occurs. All of the diagnosis clusters following the incomplete cluster received the error code 455. All possible diagnosis edits were performed, but the diagnosis clusters were not stored.

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

Analysis of Management Reports

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 have 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#9999.RSP.FERAS_RESP_ RSP#9999.ZIP.FERAS RESP (zip format)
RAPS Return File	RPT#9999.RPT.RAPS_RETURN_FLAT_ RPT#9999.ZIP.RAPS ERROR RPT (zip format)
RAPS Transaction Error Report	RPT#9999.RPT.RAPS_ERROR_RPT_ RPT#9999.ZIP.RAPS ERROR RPT (zip format)
RAPS Transaction Summary Report	RPT#9999.RPT.RAPS_SUMMARY_ RPT#9999.ZIP.RAPS SUMMARY(zip format)
RAPS Duplicate Diagnosis Cluster Report	RPT#9999.RPT.RAPS_DUPDX_RPT_ RPT#9999.ZIP.RAPS DUPDX RPT (zip format)
RAPS Monthly Plan Activity Report	RPT#9999.RPT.RAPS_MONTHLY_ RPT#9999.ZIP.RAPS MONTHLY (zip format)
RAPS Cumulative Plan Activity Report	RPT#9999.RPT.RAPS_CUMULATIVE_ RPT#9999.ZIP.RAPS CUMULATIVE (zip format)
RAPS Monthly Error Frequency Report	RPT#9999.RAPS_ERRFREQ_MNTH_ RPT#9999.ZIP.RAPS ERRFREQ MNTH (zip format)
RAPS Quarterly Error Frequency Report	RPT#9999.RAPS_ERRFREQ_QTR_ RPT#9999.ZIP.RAPS ERRFREQ QTR (zip format)

Summary

- Interpreted the FERAS and RAPS data integrity logic and error codes
- Described the FERAS and RAPS editing processes
- Explained the purpose of the FERAS and RAPS reports in monitoring RAPS data
- Analyzed risk adjustment reports to identify and submit corrections

EVALUATION

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

THANK YOU!

Data Validation (Medical Record Review)

CMS

2008 RISK ADJUSTMENT

Presentation Purpose

- To provide participants with an understanding of the risk adjustment data validation process

- To provide participants with an understanding of how CMS will identify risk adjustment discrepancies and payment error

Presentation Objectives

- Define
  - Purpose and objectives of risk adjustment data validation (RADV)
  - New RADV policies and parameters
  - RADV stages and requirements
  - Documentation dispute
  - Payment adjustment implementation approach
  - Appeals

Risk Adjustment Data Validation

- Purpose: to ensure risk adjusted payment integrity and accuracy
- Method: Review of hospital (inpatient & outpatient) and physician medical records
- Objectives:
  - Verify enrollee CMS-HCCs
  - Identify risk adjustment discrepancies
  - Calculate enrollee-level payment error
  - Estimate national and contract-level payment errors
  - Implement contract-level payment adjustments

Risk Adjustment Data Validation: New Approaches

- CMS will make contract-level payment adjustments based on findings from enrollee samples
- Documentation dispute process available for organizations to dispute enrollee-level HCC findings
- New documentation for missing medical records will not be allowed during dispute process – organizations should make "best effort" to submit medical records during initial request
- Appeals process will follow documentation dispute process

2007 RADV Project Parameters

- January 2007 contract and enrollee cohort
- Eligible contracts: January 2007 active MA contracts, PACE, and dual demonstration organizations (all receive risk adjusted payments)
- Eligible January 2007 enrollees
  - Continuously enrolled with at least one HCC - enrollees in the same contract from January 2006 through January 2007 (national and contract samples)
  - Non-continuously enrolled with at least one HCC - enrollees who switch between contracts and/or MA and FFS from January 2006 through January 2007 (national sample only)
- Data collection period: January 2006 through December 2006 dates of service

Risk Adjustment Data Validation

- Submitted risk adjustment diagnoses map to HCCs and result in payment increases
- All HCCs that contributed to payment for the sampled enrollees will be reviewed
- Medical record documentation must provide diagnosis evidence to substantiate the enrollee HCC(s) being validated

Risk Adjustment Data Validation Guiding Principle

- Risk adjustment diagnoses submitted for payment must be:
  - Documented in a medical record from a face-to-face encounter (between a patient and provider)
  - Coded in accordance with the ICD-9-CM Guidelines for Coding and Reporting
  - Assigned based on dates of service within the data collection period AND
  - From an appropriate RA provider type and RA physician specialty

Risk Adjustment Discrepancy

- Definition: HCC assigned based on submitted risk adjustment diagnoses differs from the HCC assigned after medical record review
- Impacts enrollee risk score
- Changes payment for enrollee

Medical Record Review Overview

- Core Project Contractors
  - Lead Analytic Contractor (LAC)
    - Facilitates management and tracking of all project data, analysis, and policy decisions
  - Medical Record Review Contractors (MRRCs)
    - Serve as initial and second independent medical record reviewers to confirm risk adjustment discrepancies
    - Use inter-rater reliability (IRR) process to ensure coding consistency and accuracy
    - Conduct documentation dispute process
    - Employs experienced ICD-9-CM coders to
      - Abstract diagnosis codes; and
      - Validate provider type, physician specialty, and date(s) of service

Risk Adjustment Data Validation Process

Stage	Description
Stage 1	Sampling and Medical Record Request
Stage 2	Medical Record Review (MRR) - initial and second validation reviews
Stage 3	MRR Findings and Contract-level Payment Adjustments
Stage 4	Documentation Dispute
Stage 5	Post Documentation Dispute Payment Adjustment
Stage 6	Appeals -- CMS Office of Hearings

Sampling

STAGE 1

- Two types of RADV samples:
  - National sample: estimate national payment error
    - Includes both continuously and non-continuously enrolled beneficiaries in eligible January 2007 contracts
  - Contract-specific samples: estimate contract-level payment error
    - Include:
      - Contracts targeted from MA Coding Intensity Study
      - Contracts randomly selected from among all active contracts
      - Only continuously enrolled beneficiaries with at least one HCC

Medical Record Request

STAGE 1

Three segments

- Request
- Submission (MAO Response)
- Receipt

Request Process (continued)

STAGE 1

Request

- CMS & MRRCs notify MA Compliance Officer of contract selection and request point of contact information
- Selected contracts receive
  - Enrollee list containing diagnoses and HCCs to be validated
  - Instructions for submitting medical records
  - Coversheets for each unique enrollee HCC being validated containing
    - Enrollee demographic information
    - Risk adjustment data (HCCs and ICD-9-CM codes)

Request Process (continued)

STAGE 1

Submission (MAO Response)

- Verify sampled enrollee demographic data on the coversheet
- Use Enrollee List to help identify submitted diagnoses, providers, and service dates
- Establish contact and ongoing communication with providers
- Request and obtain medical records from providers – recommend using CMS provided:
  - Model provider letters
  - CMS-signed explanatory cover letters
  - HIPAA Fact Sheet

Request Process (continued)

STAGE 1

Submission (MAO Response)

- Select the "one best medical record" for each enrollee HCC
  - Where the enrollee may have medical records from multiple providers and/or dates of service, select and submit only the "one best medical record" to support the HCC
- Provide medical records for HCCs where the MAO submitted risk adjustment diagnoses for enrollees
  - Where an enrollee is "non-continuously" enrolled, identify only the HCC(s) for which the MAO submitted RA diagnoses and provide medical record documentation for that HCC
- Complete a medical record coversheet for each enrollee HCC (see sample coversheet)

Request Process (continued)

STAGE 1

Submission (MAO Response)

- Ensure that the medical record
  - Is dated for the date of service (must be within the data collection period)
  - Contains signature and credentials of the provider of service
  - Is sufficient for the coder to determine that a patient evaluation was performed by a physician (or acceptable physician extender)
- Attach coversheet to relevant clinical documentation
  - Each medical record must have at least one coversheet attached
  - Where a medical record supports more than one HCC, attach all relevant HCC coversheets to that medical record

Request Process (continued)

STAGE 1

Submission (MAO Response)

- Package medical records and submit by the deadline
  - Follow all security requirements for medical record packaging, data, and submission
  - Submit medical records via hardcopy, electronic media, or confidential faxed copy
- Medical records will not be accepted after CMS' official deadline

Request Process (continued)

STAGE 1

- Receipt
  - The MRRC will
    - Receive and log medical records and coversheets
    - Conduct administrative and clinical checks
    - Provide technical assistance where possible

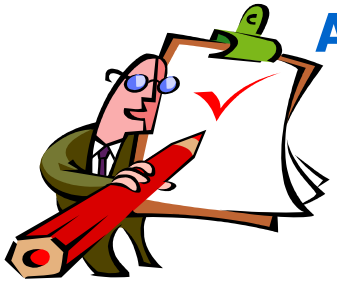
Medical Record Review

STAGE 2

GOOD DOCUMENTATION = ACCURATE PAYMENTS

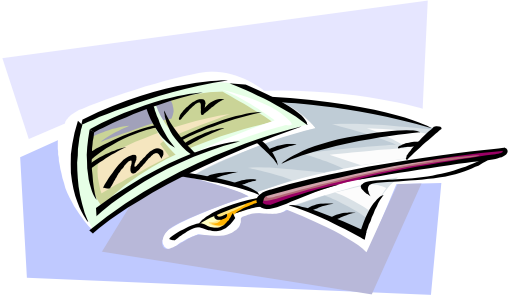
Visit

Assign Diagnosis Code



ICD-9 Code

Document Visit



Submit and Obtain Risk Adjusted Payment

Medical Record Review (continued)

STAGE 2

Requirements for Documentation Submitted for Medical Record Review

Concise	Reason for the face-to-face visit
Consistent	Services rendered
Complete	Conclusions, diagnoses, and follow-up
Logical	Assignment of ICD-9-CM codes based on clear and legible clinical documentation
Authenticated	By the provider of service (signature and credentials)
Dated	Date of service noted

Medical Record Review (continued)

STAGE 2

- Unacceptable Sources of Risk Adjustment Data
  - Follow *Data Collection* module for information on
    - Covered facilities
    - Non-covered facilities
    - Acceptable physician specialties

Medical Record Review (continued)

STAGE 2

- Unacceptable Types of Risk Adjustment Data Validation Documentation
  - Superbill
  - Physician-signed attestation
  - List of patient conditions (hospital outpatient and physician settings - see problem list guidance)
  - Date(s) of service outside the data collection period

Medical Record Review (continued)

STAGE 2

- Unacceptable Types of Diagnoses (outpatient hospital and physician settings)
  - Probable
  - Suspected
  - Questionable
  - Rule out
  - Working

Medical Record Review (continued)

STAGE 2

Types of Acceptable Physician Signatures and Credentials	
Hand-written signature or initials, including credentials	• *Mary C. Smith, MD; or MCS, MD*
Signature stamp, including credentials	• Must comply with state regulations for signature stamp authorization
Electronic signature, including credentials	• Requires authentication by the responsible provider (for example but not limited to "Approved by," "Signed by," "Electronically signed by") • Must be password protected and used exclusively by the individual physician

Medical Record Review (continued)

STAGE 2

Types of Unacceptable Physician Signatures and Credentials	
TYPE	**UNACCEPTABLE unless…**
Typed name	• Authenticated by the provider
Non-physician or non-physician extender (e.g., medical student)	• Co-signed by acceptable physician
Provider of services' signature without credentials	• Name is linked to provider credentials or name on physician stationery

Medical Record Review (continued)

STAGE 2

- Risk Adjustment Discrepancy Types
  - Invalid Medical Records
    - Unacceptable provider type or physician specialty
    - Date(s) of service outside of data collection period
    - Missing provider signature or credentials
  - Missing Medical Records
    - Cannot assign ICD-9-CM code due to insufficient or incomplete documentation
    - No medical record documentation submitted for the enrollee could support the HCC
  - Coding Discrepancies that change HCC assignment
    - ICD-9-CM code assigned after validation changes an original enrollee HCC

MRR Findings and Contract-Level Payment Adjustments

STAGE 3

- MA organizations will receive
  - Enrollee-level HCC findings
  - Contract-level annual payment error estimate
  - Instructions for submitting enrollee HCC-level documentation disputes
  - Contract-level payment adjustments

Documentation Disputes

STAGE 4

- MA organizations may dispute enrollee-level HCC findings based on the application of the ICD-9-CM guidelines by the MRRCs
- The dispute process cannot be used to address:
  - Missing medical records of any kind
  - Additional medical record documentation of any kind

Post Documentation Dispute-Payment Adjustment

STAGE 5

- CMS will
  - Use dispute findings to re-estimate payment error
  - Make additional contract-level payment adjustments based on revised error estimates

Appeals

STAGE 6

Process for filing requests for appeal to CMS Office of Hearings will soon be announced

Recommendations & Lessons Learned

- Independent (non-CMS) Validation Activities
  - Conduct ongoing internal process to confirm accuracy of risk adjustment diagnoses from providers
  - Organize an internal validation team (e.g., MCO, IT, quality, compliance, coding)
  - Use newsletters and CMS training tools to inform internal staff and physicians about risk adjustment

Recommendations & Lessons Learned to Date (continued)

- CMS-related Validation Activities
  - Query your provider data
  - Establish and maintain communication with providers
  - Organize an internal validation team
  - Plan accordingly—may require more effort to obtain medical records from
    - Specialists
    - Non-contracted providers
    - Hospital outpatient or PCP settings
  - Use data validation technical assistance tools
  - Ensure medical record documentation is complete
  - Submit medical records as you receive them from providers
  - Adhere to the submission deadline

CMS Data Validation Team

Name	Role
Jennifer Harlow Jennifer.harlow@cms.hhs.gov	Director, Division of Payment Validation
Lateefah Hughes Lateefah.hughes@cms.hhs.gov	RADV Team Lead Project Officer -- LAC
Mary Guy Mary.guy@cms.hhs.gov	Project Officer -- MRRC

EVALUATION

Please take a moment to complete the evaluation form for the Data Validation (Medical Record Review) Module.

THANK YOU!

Verifying Risk Scores

LTC, Inc.

2008 RISK ADJUSTMENT

Purpose

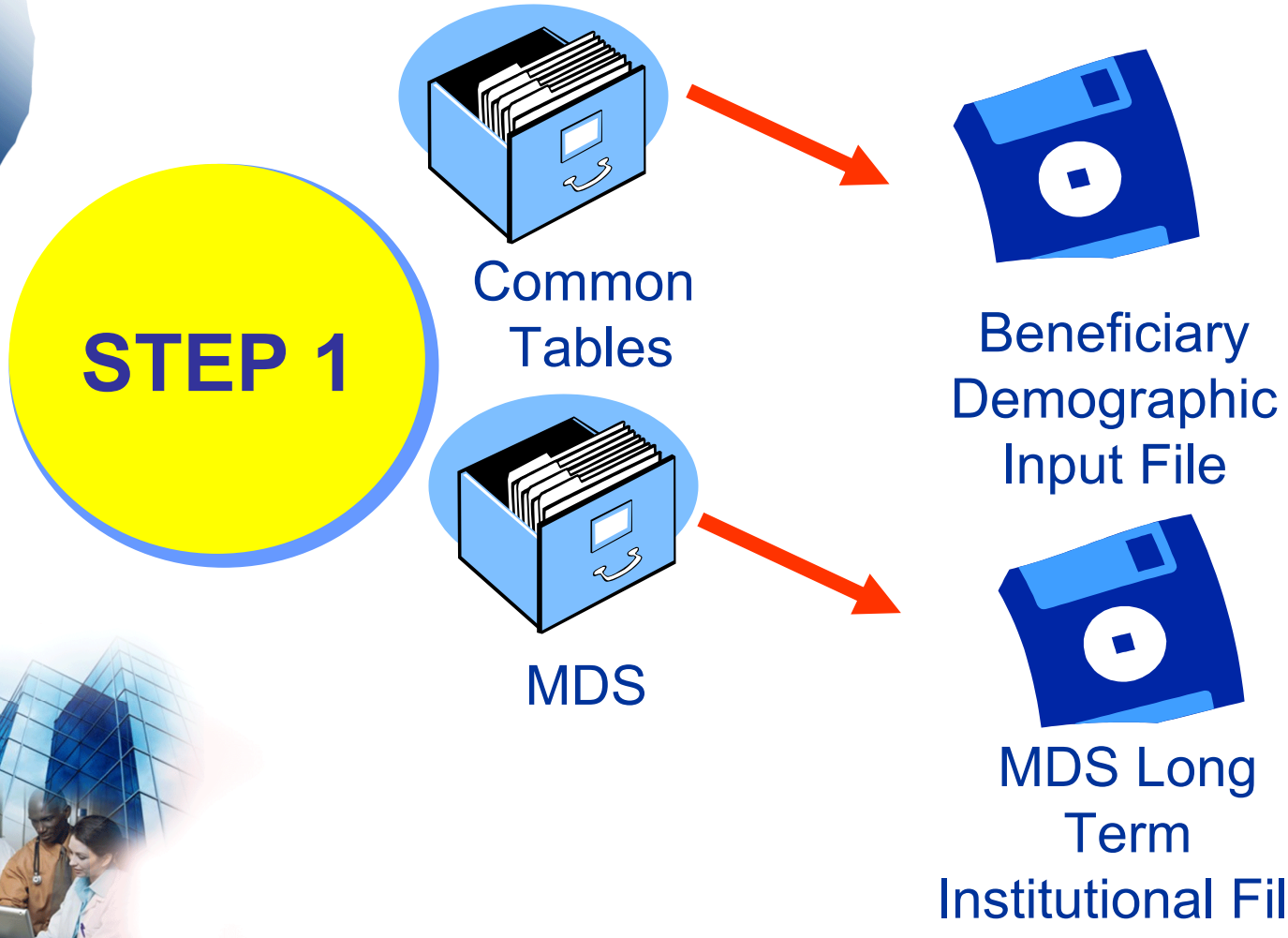
- This module explains the systems involved in the risk score calculations and introduces MA organizations to a variety of verification tools available.

Objectives

- Understand the systems and processes used to calculate the risk scores
- Determine how an organization can use risk adjustment processing and management reports to ensure the accuracy of payment
- Identify the components and uses of the Non-Drug and Drug Monthly Membership Reports
- Explain the Part C Risk Adjustment and RAS RxHCC Model Output Reports

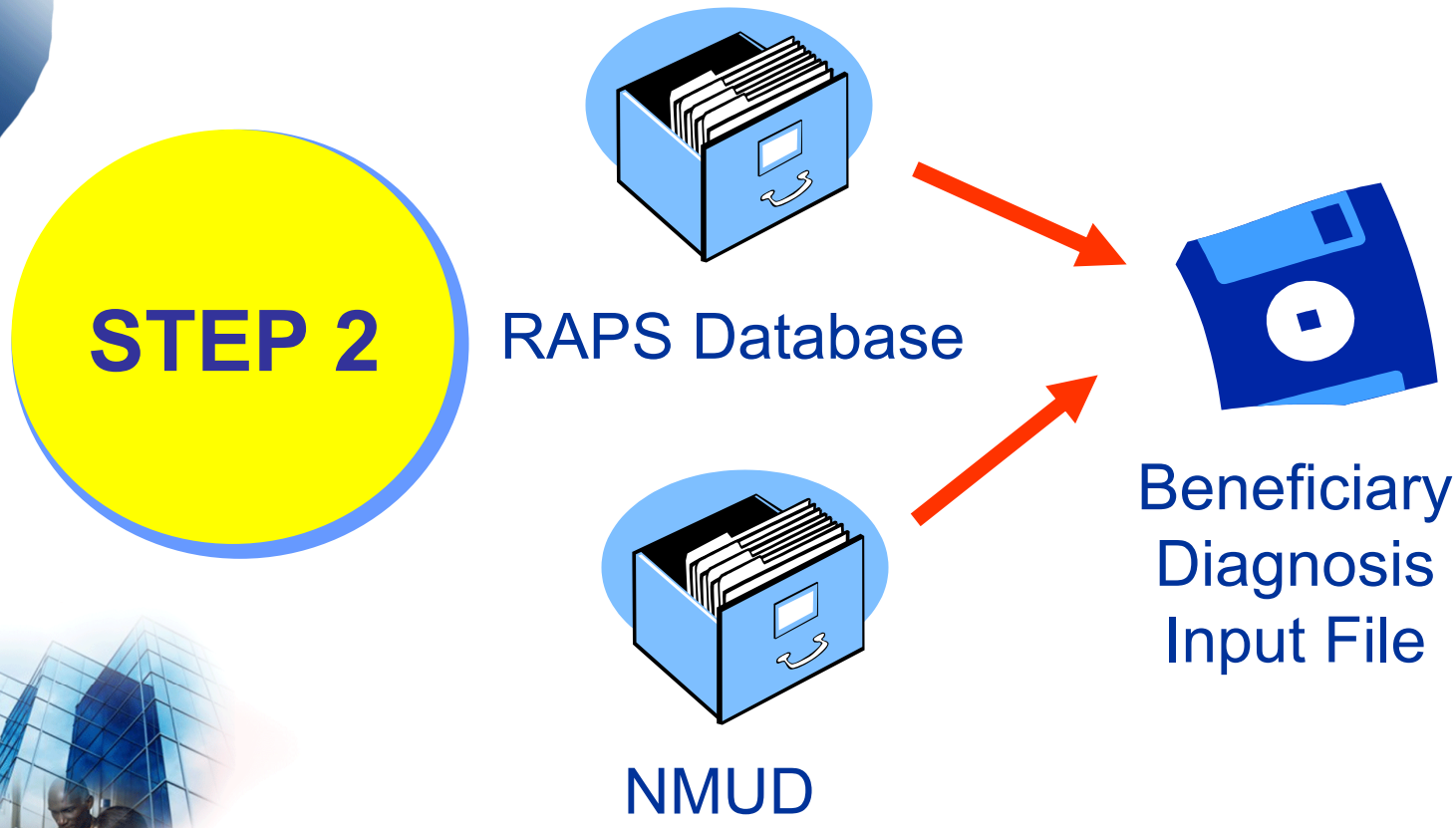
What is the Risk Score?

Calculation of Risk Scores



Calculation of Risk Scores

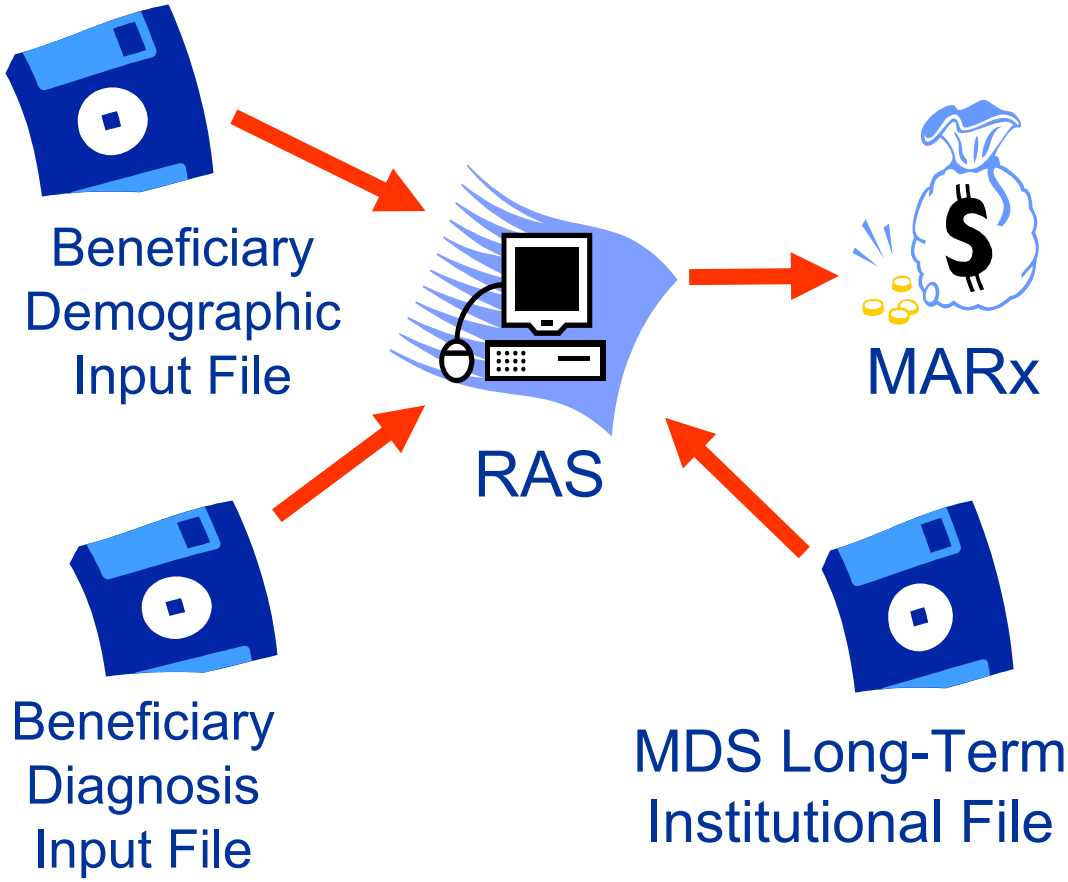
(continued)



Calculation of Risk Scores

(continued)

STEP 3



Verification Tools

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

RAPS Return File/RAPS Transaction Error Report

- Received the next business day after submission
- Provides a record of each diagnosis stored for each enrollee
- Allows results to be stored in a database (e.g., Microsoft Access or Excel) of diagnoses for each enrollee
- Transaction Error Report requires manual updates to a diagnosis file

Database Components

HIC Number	Dx	From Date	Through Date	Provider Type	Date Submitted

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

CMS-HCC Model

- CMS runs the model on a semi-annual basis.
- MA organizations with SAS software may run the model to calculate their enrollee risk scores.
- SAS program is available at: http://cms.hhs.gov/
  - Click on “Medicare” at the top
  - Click on “Health Plans”
  - Click on “Medicare Advantage Rates & Statistics”
  - Click on “Risk Adjustment”
  - Click on “Downloads”
  - Click on “2007 CMS-HCC Model Software (ZIP 53 KB)”

Monthly Membership Report

- Reconciles Medicare Membership payment record
- Available in two formats:
  - Detail
    - Non-Drug MMR
    - Drug MMR
  - Summary
- Generated by MARx
- Beneficiary-level information

Monthly Membership Report Non-Drug

- Contains information on:
  - Rebates, payments, and adjustments
  - Part A & B information
  - Risk Adjustment factors
  - Other detailed beneficiary information

Monthly Membership Report Drug

- Contains information on:
  - Rebates, payments, and adjustments
  - Part A & B information
  - Risk Adjustment factors
  - Other detailed beneficiary information
  - LICS percentages
  - LICS Subsidy

Monthly Membership Report Field Ranges

Field Ranges	Descriptions
1-3	Managed Care Organization Information
4-11	Beneficiary Identification
12-13	Entitlement
14-21	Health Status
22-34	Risk Adjustment/Demographic Payment Adjustment Information
35	Low Income Subsidy Premium Amount
36	ESRD MSP Flag
37-46	Additional Indicators
47	Risk Adjustment Factor Type Code
48	Frailty Indicator
49	Original Reason for Entitlement Code (OREC)
50	Lag Indicator
51	Segment ID for Part D
52	Enrollment Resource
53	EGHP Flag
54-66	Risk Adjustment Premium/Rebate/Payment Information
67	Part D Risk Factor
68-78	Fields supporting the Part D Benefit
79-80	PACE Related Fields

Risk Adjustment Model Output Reports (MOR)

- Supplements the MMR report by identifying specific information used in making risk adjustment calculations:
  - HCC triggered for an individual
  - Disease and demographic interactions
- Two MORs:
  - Part C Risk Adjustment
  - RAS RxHCC
- Available through the MARx system

Risk Adjustment MOR – Part C

- Displays:
  - Demographic information
  - HCCs used by RAS
  - Disease interactions
  - Demographic interactions

Risk Adjustment MOR – RAS RxHCC

- Displays:
  - Demographic information
  - RxHCC Disease Groups
  - Disease interactions
  - Demographic interactions

Summary

- Understand the systems and processes used to calculate the risk scores
- Determined how an organization can use risk adjustment processing and management reports to ensure the accuracy of payment
- Identified the components and uses of the Non-Drug and Drug Monthly Membership Reports
- Explained the Part C Risk Adjustment and RAS RxHCC Model Output Reports

EVALUATION

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

THANK YOU!