

2007 REGIONAL TRAINING

Risk Adjustment Data

INTRODUCTION & OVERVIEW

LTC, Inc.



Risk Adjustment Data Training • August 2007

I/2-1

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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Training Tools

- ◆ **Participant Guide**
 - ◆ CD with slides
- ◆ **Job Aids**
- ◆ **www.medicaretraining.net**



Agenda Topics

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

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



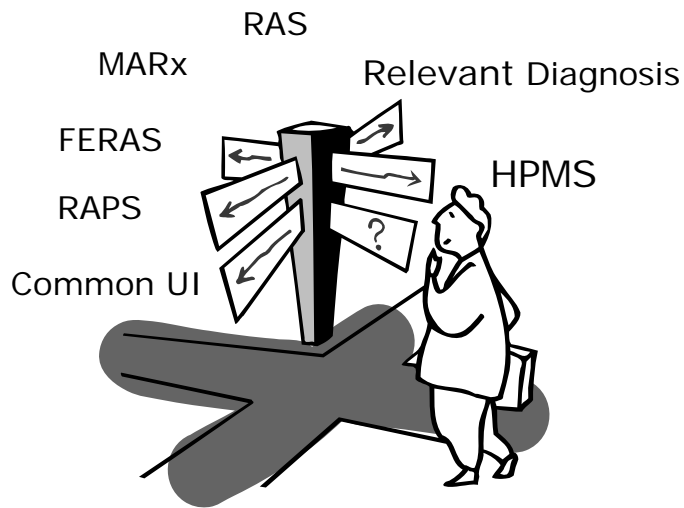


Learning Objectives

- ◆ Identify the CMS Risk Adjustment models
- ◆ Describe the requirements for data collection
- ◆ Determine the process for submitting data to CMS
- ◆ Interpret editing rules and error resolution
- ◆ Describe the data validation process
- ◆ Name and interpret the reports available for risk adjustment monitoring
- ◆ Demonstrate how to verify risk scores



Common Terms





Risk Adjustment Data Requirements

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

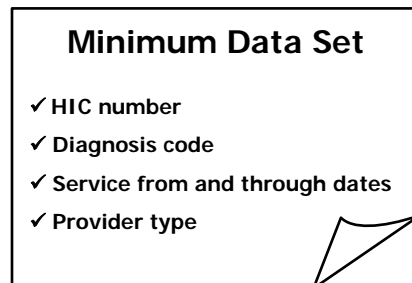
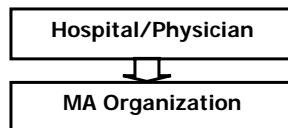


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Data Collection



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

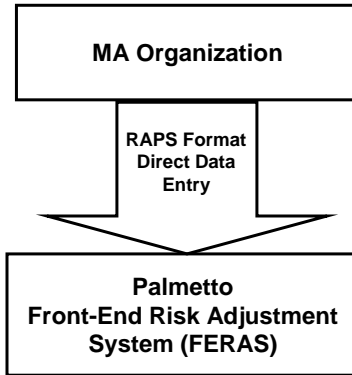


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Data Submission



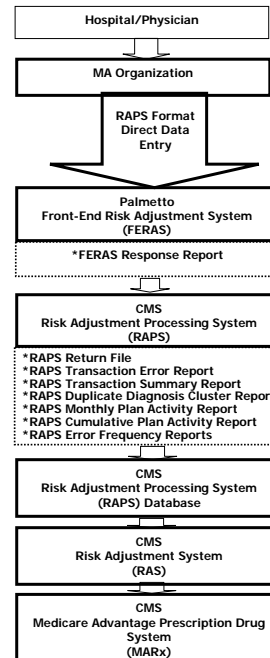
◆ Formats

- ◇ 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
07	7/1/05 – 06/30/06	9/1/06	1/1/07	N/A
07	1/1/06 – 12/31/06	3/2/07	7/1/07	1/31/08
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



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RISK ADJUSTMENT METHODOLOGY

CMS



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Purpose

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



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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

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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
 - ◇ Mandated frailty adjustment for enrollees in the Program for All-Inclusive Care for the Elderly (PACE)

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Risk Adjustment History (continued)

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



Medicare Advantage (MA) 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 actuarial soundness—ensures 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 must submit bids for their basic, and if applicable, supplemental benefit packages
- ◆ Benchmarks are 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

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What is Risk Adjustment?

- ◆ A method used to adjust bidding and 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 MA is built on FFS data sets

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Risk Adjuster Basics MA/PDPs

- ◆ Risk adjustment used to standardize bids
- ◆ Allows direct comparison of bids based on populations with different health status and other characteristics
- ◆ Applied to payment



CMS Risk Adjustment and Frailty Implementation Timeline

Year	Implementation Timeline
2004	<ul style="list-style-type: none"> ◆ Part C risk adjustment using new CMS-HCC model ◆ Frailty adjuster for enrollees of PACE and certain demonstrations under Part C
2005	<ul style="list-style-type: none"> ◆ End-Stage Renal Disease (ESRD) model for ESRD enrollees
2006	<ul style="list-style-type: none"> ◆ Part D risk adjustment model (RxHCC) for the new Medicare prescription drug benefit (PDP)
2007	<ul style="list-style-type: none"> ◆ Updated CMS-HCC model ◆ Normalization of Part C and Post Graft ESRD risk scores
2008	<ul style="list-style-type: none"> ◆ 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 Models

- ◆ Currently CMS implements risk adjustment in 3 key payment areas:
 - ◇ The CMS-HCC for Part A/B non-ESRD beneficiaries
 - ❖ Community and Long Term Institutional Models
 - ◇ The ESRD models for beneficiaries with ESRD
 - ❖ Dialysis, Transplant, and Post-Transplant
 - ◇ The Part D drug model
 - ❖ 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

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Common Characteristics of the Risk Adjustment Models

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

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Demographic Factors in Risk Adjustment

- ◆ 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)

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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

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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



Part C – CMS-HCC Models

- ◆ Separate community and institutional models for different treatment costs between community and institutional residents
- ◆ Recalibrated: 2002 - 2003 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





2008 Frailty Adjustment Research and Policy Update

- ◆ Research undertaken to update current frailty factors and examine expanding frailty methodology to MA program
- ◆ Updated data source for frailty calibration: 2003 FFS CAHPS versus (1994-1997) MCBS
- ◆ Larger sample - reliable estimates for frailty factors for Medicaid/non-Medicaid beneficiaries computed (residual cost differences)
- ◆ Impact of adjusting MA benchmarks and applying frailty program wide to MA plans studied

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Current and Revised Frailty Factors

ADL Limitations	Current Factor	Revised Model Factors	
		Non-Medicaid	Medicaid
0	-0.141	-0.089	-0.183
1-2	+0.171	+0.110	+0.024
3-4	+0.344	+0.200	+0.132
5-6	+1.088	+0.377	+0.188

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2008 Current and Revised Organization Frailty Score Range

Organization Type	Current Model Frailty Score (MCBS Data)	Recalibrated Frailty Score (FFS CAHPS Data)
PACE	0.375 – 0.791	0.064 - 0.226
S/HMOs	0.057 – 0.122	0.008 - 0.039
WPP	0.371 – 0.574	0.091 - 0.162
MnDo	0.583	0.143
MSHO	0.176 – 0.263	-0.017 - 0.009
SCO	0.166 – 0.414	-0.033 - 0.053
MA	-0.036 - 0.291	-0.035 - 0.106



Policy on Frailty Implementation - 2008 Forward

- ◆ No program-wide frailty implementation
 - ◇ Concerns about the inclusion of frailty in current bidding process (plans ability to bid accurately)
 - ◇ Operational concerns – conducting HOS-M survey at plan benefit package level
- ◆ Five year frailty transition to 100% revised factors for PACE organizations using current MCBS and new CAHPS factors
- ◆ Four year frailty phase-out for certain demonstrations using current MCBS factors
- ◆ CMS will continue to research beneficiaries with high residual cost





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, but 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	1.648	0.568	0.161
Diabetes with acute complications HCC 17	0.364	0.466	0.106
Major Depression HCC 55	0.370	0.308	0.116
Age-Sex Factor for 69 year old male	0.330	1.140	0.775
Age-Sex Factor for 88 year old female	0.637	0.694	0.919





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 $R^2=0.25$ for plan liability, on par with other drug models and is higher than similar Part A/B models because drug costs are more stable

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Part D Risk Adjustment (continued)

- ◆ Average projected plan liability was \approx \$993 in 2006
- ◆ Model includes 113 coefficients
 - ◆ 3 age and disease interactions
 - ◆ 2 sex-age-originally disabled status interactions
- ◆ Hierarchies cover 11 conditions

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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



<u>Coded Characteristic</u>	<i>Liability Model</i>	
	<u>Payment Increment</u>	<u>Relative Factor</u>
Female, age 76	\$ 431	.434
Diabetes, w. complications	255	.258
<i>Diabetes, uncomplicated</i>	188	.190
High cholesterol	162	.163
Congestive Heart Failure	248	.251
Osteoporosis	110	.115
<hr/>		
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






2008 Parts C and D Normalization Factors



Model	Normalization Factor
CMS-HCC Community/Institutional	1.040
ESRD Functioning Graft	1.040
ESRD Dialysis/Transplant	1.010
RxHCC	1.065



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 2004-2007 is available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage



Contacts

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DATA COLLECTION

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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.



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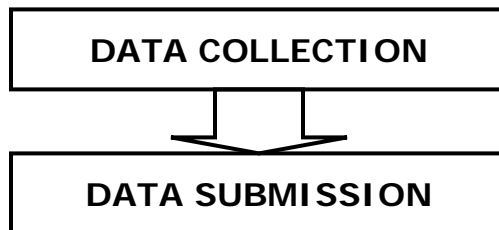


Objectives

- ◆ 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





Minimum Risk Adjustment Data Elements

HIC Number
Diagnosis Code
From Date
Through Date
Provider Type

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Health Insurance Claim (HIC) Number

HIC Number
Diagnosis Code
From Date
Through Date
Provider Type

- ◆ Beneficiary identification numbers
- ◆ Issued by CMS and the RRB

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HIC Number (continued)

CMS Number

→

111223334A

SSN BIC

RRB Pre 1964

→

WA123456


Prefix Random

RRB Post 1964

→

WA123456789

Prefix SSN




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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

- ◆ 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.





CMS

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.



CMS

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.





Exercise



Data Collection Formats

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





Factors Affecting Data Collection Method



**Data
Collection
Method**



**Business
Needs**



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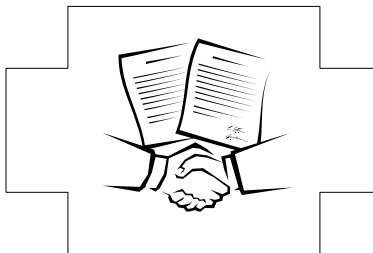


Contractual Relationships



**Capitated
Payment**

Fee-For-Service




**Staff
Model**

**Mixed Services
Model**



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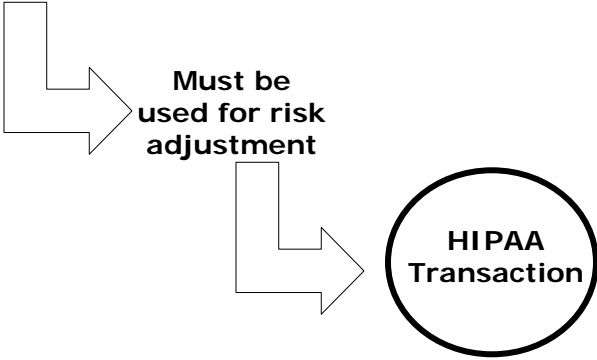


HIPAA and Risk Adjustment Rules



Encounter from provider/physician to MA organization

Must be used for risk adjustment


HIPAA Transaction



The diagram illustrates a process flow. It starts with the text 'Encounter from provider/physician to MA organization'. A large L-shaped arrow points from this text to the text 'Must be used for risk adjustment'. From there, another large L-shaped arrow points to a circle containing the text 'HIPAA Transaction'.





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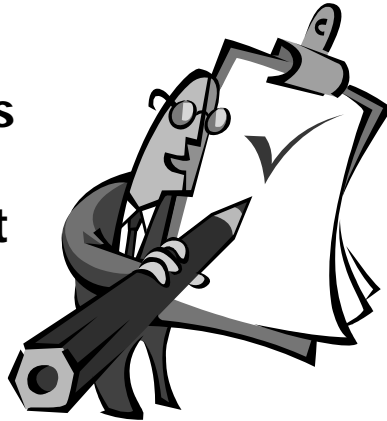
Summary

- ◆ 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



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DATA SUBMISSION

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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.



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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



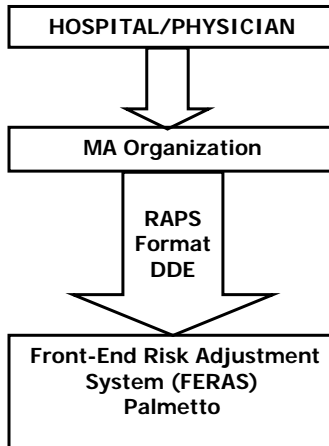
Objectives (continued)

- ◆ Understand the 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	<ul style="list-style-type: none"> ◇ Mainframe-to-mainframe connection ◇ Next day receipt of FERAS response
File Transfer Protocol (FTP)	<ul style="list-style-type: none"> ◇ 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)	<p><u>Two connectivity options:</u></p> <ul style="list-style-type: none"> ◇ Secure File Transfer Protocol (FTP); standards based protocol via a vendor. ◇ Secure Hypertext Transfer Protocol; secure web interface.



Relevant Diagnosis

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

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





Submission Formats



RAPS



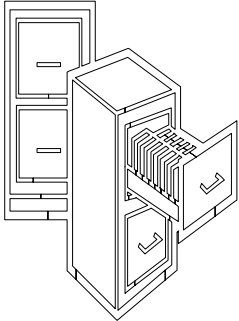
DDE



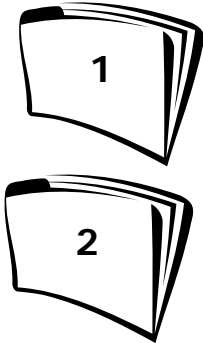
File Logic



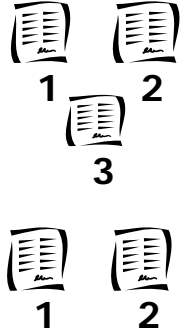
File Level



Batch Level



Detail Level





CMS

Exercise



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CMS

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.



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

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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

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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



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Risk Adjustment Data



EDITS

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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



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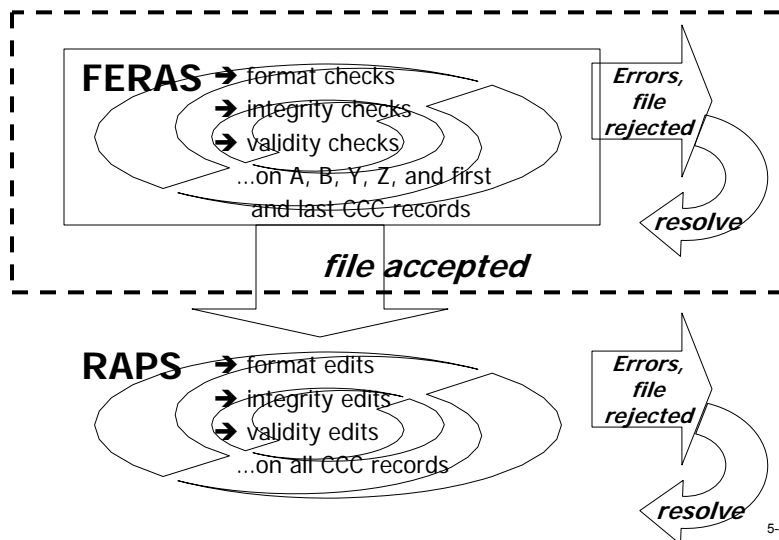



Objectives

- ◆ Interpret the FERAS and RAPS data integrity logic and error codes
- ◆ 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 Checks



Format Checks	Integrity Checks	Validity Checks	Format, Integrity, & Validity Checks
----------------------	-------------------------	------------------------	---


Checks on file and batch levels

Checks on first & last CCC records




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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”.



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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	[101-125	→	AAA
		151-175	→	ZZZ
200	[201-225	→	BBB
		251-275	→	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

file accepted

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

Errors, file
rejected

resolve

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



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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**



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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.
	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 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.





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 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.





Example 5

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.



Example 6

Scenario: Blue Health Plan submitted a CCC record with five diagnosis clusters in which the third diagnosis cluster has an invalid HIC number. Blue Health Plan also 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 five diagnosis clusters received a record level error, error code 310 on the third cluster. This means that the diagnosis clusters were not stored for this CCC record and all the diagnosis clusters in this record should be resubmitted.

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.





Exercise



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





Summary

- ◆ Interpreted the FERAS and RAPS data integrity logic and error codes
- ◆ Described the FERAS and RAPS editing processes
- ◆ Recognized common FERAS and RAPS errors and determined action required to avoid or correct them



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Risk Adjustment Data

DATA VALIDATION

CMS



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Purpose

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



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Objectives

- ◆ Identify
 - ◇ Purpose and goals of risk adjustment data validation
 - ◇ Stages of risk adjustment data validation
 - ◇ Risk adjustment discrepancies
- ◆ Understand
 - ◇ Components of a medical record request
 - ◇ Requirements for acceptable medical record documentation
 - ◇ Payment adjustments and appeals
- ◆ Provide
 - ◇ Recommendations and lessons learned



Purpose of Risk Adjustment Data Validation

- ◆ To ensure risk adjusted payment integrity and accuracy





Objectives of Risk Adjustment Data Validation

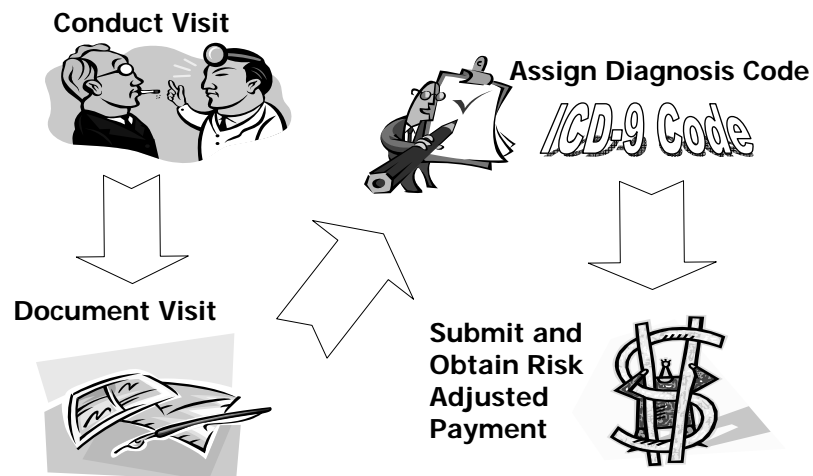
- ◆ Identify
 - ◇ Confirmed risk adjustment discrepancies
 - ◇ Contracts in need of technical assistance to improve quality of risk adjustment data
- ◆ Measure
 - ◇ Accuracy of risk adjustment data
 - ◇ Impact of discrepancies on payment
- ◆ Improve/Inform
 - ◇ Quality of risk adjustment data
 - ◇ The CMS risk adjustment models

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Good Documentation = Accurate Payment



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CMS Risk Adjustment Data Validation Guiding Principle

The risk adjustment diagnosis must be:

- ◆ Based on clinical medical record documentation from a face-to-face encounter;
- ◆ Coded according to the *ICD-9-CM Guidelines for Coding and Reporting*;
- ◆ Assigned based on dates of service within the data collection period; and
- ◆ Submitted to the MA organization from an appropriate—
 - ◇ RA provider type; and
 - ◇ RA physician data source



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*





Overview of Risk Adjustment Data Validation

- ◆ Process of verifying that diagnosis codes submitted by the MA organization for payment are supported by medical record documentation for an enrollee
- ◆ Review of hospital inpatient, hospital outpatient, and physician medical records
- ◆ Flexible approach to selecting medical records from providers
- ◆ Based on CMS Risk Adjustment models
 - ◇ CMS-HCC—CY 2004 and beyond for Part C
 - ◇ CMS RxHCC—CY 2006 and beyond for Part D

Hereafter, for purposes of this presentation, the term “HCC” refers to both CMS-HCCs and RxHCCs



Overview of Risk Adjustment Data Validation (continued)

- ◆ CMS uses two independent QIO or QIO-equivalent contractors
 - ◇ Initial validation contractor (IVC)
 - ❖ Facilitates the medical record process
 - ❖ Conducts initial review to identify discrepancies
 - ◇ Second validation contractor (SVC)
 - ❖ Receives discrepant medical records from IVC
 - ❖ Conducts second review to confirm discrepancies
 - ❖ Implements appeals process
- ◆ Both IVC and SVC use certified coders to—
 - ◇ Abstract diagnosis codes
 - ◇ Validate provider type, physician data source, and date(s) of service





Risk Adjustment Discrepancies

- ◆ Initial risk adjustment discrepancies are identified when HCC assigned based on risk adjustment data submitted by the MA organization differs from HCC assigned after validation

Risk adjustment discrepancies affect the beneficiary risk score



Data Validation Activities (Current and Future)

- ◆ CY 2004
 - ◇ July 12, 2007: Disseminated plan-specific findings to MA organizations in the targeted sample.
 - ◇ August 29, 2007: Conducted teleconference to communicate the CY 2004 pre-reconciled medical record review national results.
 - ◇ Mid-October 2007: Anticipate mailing pre-reconciled findings to MA organizations with enrollees selected for the national sample.
- ◆ CY 2005
 - ◇ Quality checking the IVC and SVC results.
 - ◇ Anticipate releasing national findings in the late fall.
- ◆ CY 2006
 - ◇ Selected contracts notified in May 2007.
- ◆ CY 2007
 - ◇ CMS to sample after final data submission deadline (January 31, 2008).





Risk Adjustment Data Validation Process

- ↔ STAGE 1 Contract Selection
- ↔ STAGE 2 Medical Record Request Process
- ↔ STAGE 3 Medical Record Review Process
- ↔ STAGE 4 Contract-level Findings
- ↔ STAGE 5 Payment Adjustment
- ↔ STAGE 6 Appeals
- ↔ STAGE 7 Correct Payment

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Contract Selection ↔ STAGE 1

- ◆ Two types of samples
 - ◇ National sample—used to derive
 - ❖ National net payment error estimates; and
 - ❖ National risk adjustment discrepancy rates
 - ◇ Contract-specific sample—may include:
 - ❖ Targeting contracts with
 - Potentially problematic risk adjustment data; and/or
 - Problematic past data validation findings
 - ❖ Random selection of specific contract type(s)
- ◆ Every MA organization has equal opportunity of being selected

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Request Process

↔ **STAGE 2**



Three segments

- Request
- Submission (Contract Response)
- Receipt



Request Process (continued)

↔ **STAGE 2**



Request

- ◇ CMS & IVC notify MA compliance officer of contract selection and request point of contact information
- ◇ Selected contracts receive
 - ❖ Beneficiary list containing diagnoses and HCCs to be validated
 - ❖ Comprehensive instructions
 - ❖ Coversheets for each unique beneficiary HCC being validated containing
 - Enrollee demographic information
 - Risk adjustment data (HCCs and ICD-9-CM codes)





Request Process (continued)

→ **STAGE 2**

Submission (Contract Response)

◇ Contract must

- ❖ Verify enrollee demographic data
- ❖ Select “one best medical record”
- ❖ Complete medical record coversheet for each beneficiary HCC
- ❖ 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
- ❖ Submit by the deadline



Request Process (continued)



→ **STAGE 2**

Receipt

◇ The IVC

- ❖ Receives and logs medical records and coversheets
- ❖ Conducts administrative and clinical checks
- ❖ Provides technical assistance







Review Process



← STAGE 3

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



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Review Process

(continued)

← STAGE 3

Unacceptable Sources of Risk Adjustment Data

- ◇ *Follow Module 3. Data Collection* for information on
 - ❖ Covered facilities
 - ❖ Non-covered facilities
 - ❖ Acceptable physician data sources



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Review Process (continued)

→ **STAGE 3**

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)
- ◇ Un-interpreted diagnostic report (see diagnostic radiology guidance)
- ◇ Date(s) of service outside the data collection period



Review Process (continued)

→ **STAGE 3**

Unacceptable Types of Diagnoses (outpatient hospital and physician settings – see Module 5)

- ◇ Probable
- ◇ Suspected
- ◇ Questionable
- ◇ Rule out
- ◇ Working





Review Process (continued)

← STAGE 3

Types of Acceptable Physician Signatures and Credentials

TYPE	ACCEPTABLE
Hand-written signature or initials, including credentials	◆ <i>Mary C. Smith, MD; or M.C.S. MD</i>
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



Review Process (continued)

← STAGE 3

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





Review Process (continued)

← **STAGE 3**

Risk Adjustment Discrepancies

- ◇ Invalid Medical Records
 - ❖ Unacceptable provider type or physician data source
 - ❖ 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

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Contract-level Findings

← **STAGE 4**

- ◆ MA organization receives beneficiary-level HCC findings—may include
 - ◇ Contract response rate
 - ◇ Number of risk adjustment discrepancies
 - ◇ Number of additional HCCs identified
- ◆ Summary findings are communicated to the MA industry

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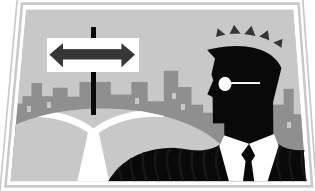
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Payment Adjustment


← STAGE 5

- ◆ Decisions are made by the CMS CBC Director
- ◆ Corrects payments based on confirmed validation discrepancies
- ◆ Serves as the forum for appeals



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Appeals

← STAGE 6

Provides MA organizations an opportunity to challenge a payment adjustment

- ◆ Consistent with Medicare fee-for-service procedures
- ◆ MA organizations given 60 days (after CMS notification) to file a written appeal



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Correct Payment

← **STAGE 7**

- ◆ Risk adjusted payments are corrected based on the outcome of the appeals
- ◆ Appeals decisions
 - ◇ Uphold or reverse payment adjustments
- ◆ All appeals decisions are final

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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

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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

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Technical Assistance

- ◆ Available for MA organizations that require specific assistance with
 - ◇ Data completeness
 - ◇ Data accuracy
 - ◇ Areas of concerns identified via validation
- ◆ CMS is considering other strategies to
 - ◇ Monitor risk adjustment data submissions
 - ◇ Enhance communication efforts
- ◆ Contact CMS staff

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CMS Data Validation Team

CONTACT

ROLE



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CY 2006



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REPORTS

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Purpose



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



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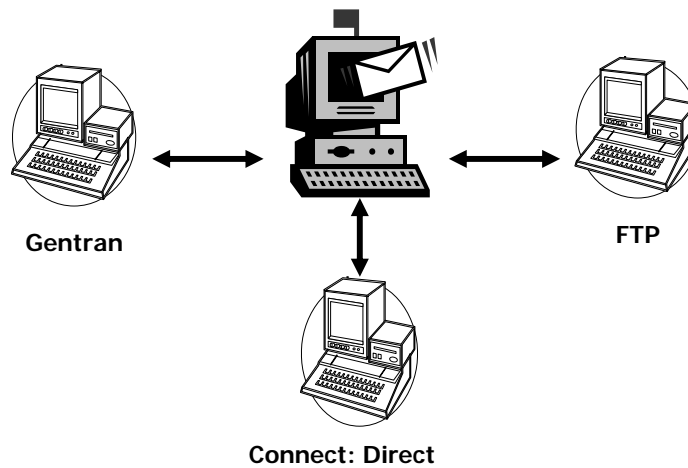


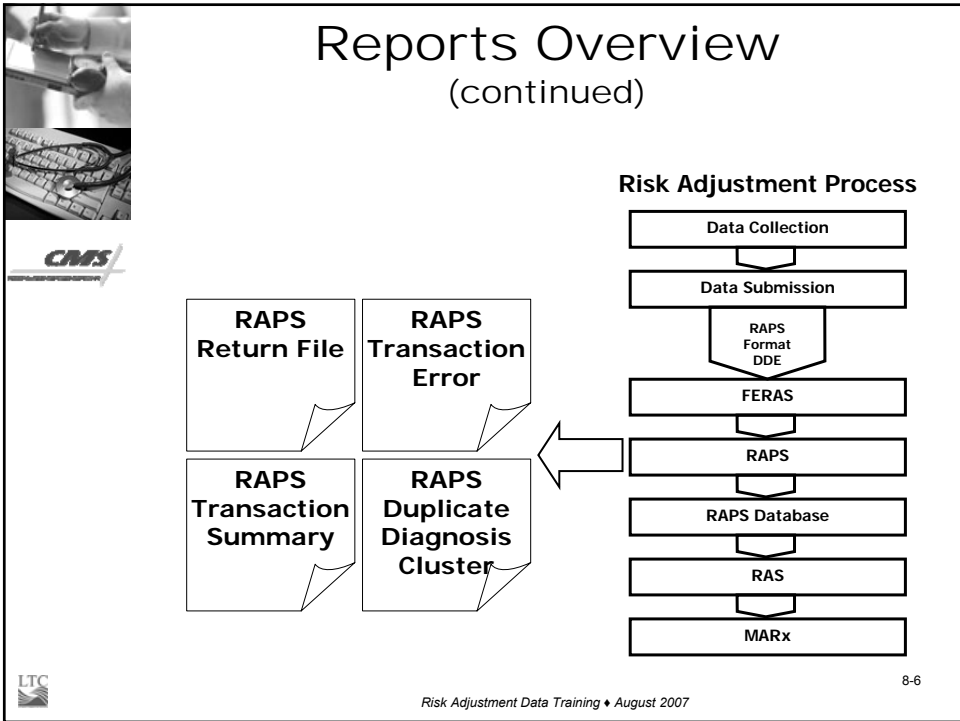
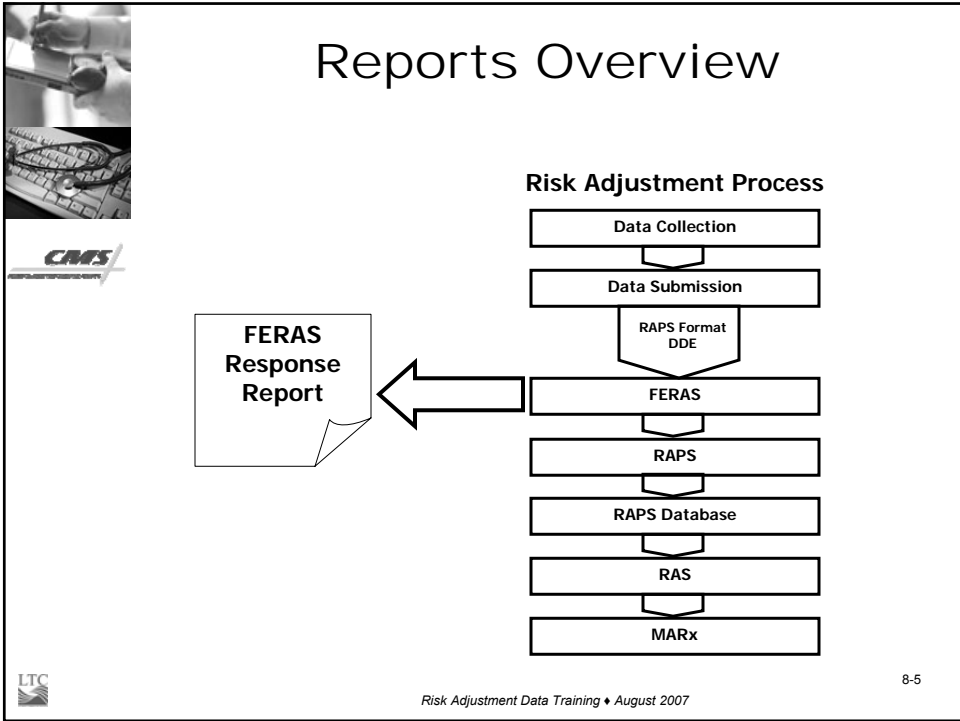
Objectives

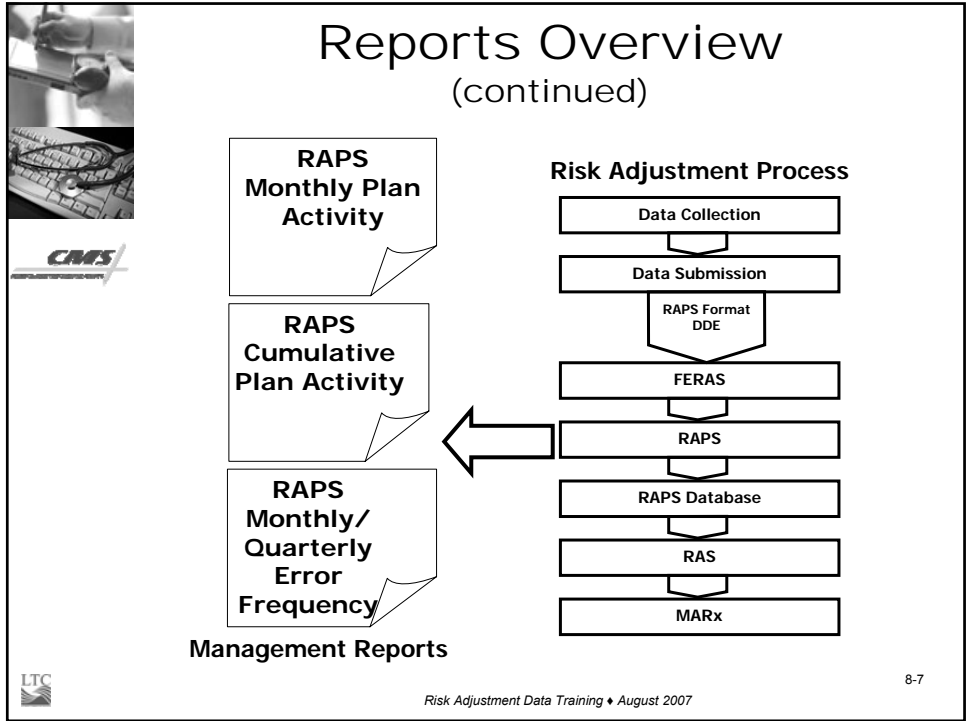
- ◆ Identify the purpose of each risk adjustment report
- ◆ Determine the best uses of the reports to monitor data collection and submission processes, and to resolve errors
- ◆ Accurately read the risk adjustment reports and identify and submit corrections
- ◆ Understand the relationship between values in the RAPS Transaction Summary and the management reports



Accessing Reports







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)

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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.



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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



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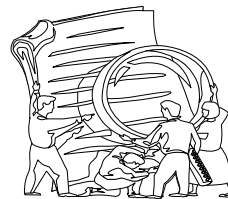
RAPS Return File (continued)


- ◆ 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

CMS


- 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!

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RAPS Transaction Error Report

CMS

- ◆ Displays detail-level (CCC) record errors that occurred in RAPS
- ◆ Available in report layout only
- ◆ Received the next business day after submission

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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



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



Relationship Between Values in RAPS Transaction Summary Report

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

Total Stored \leq Total Accepted

Total Model Diagnoses Stored \leq Total Stored





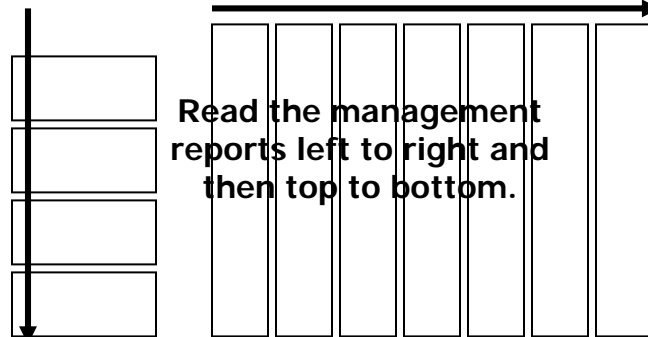
RAPS Duplicate Diagnosis Cluster Report

- ◆ 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





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



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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



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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

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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

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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_
RAPS Return File	RPT#9999.RPT.RAPS_RETURN_FLAT_
RAPS Transaction Error Report	RPT#9999.RPT.RAPS_ERROR_RPT_
RAPS Transaction Summary Report	RPT#9999.RPT.RAPS_SUMMARY_
RAPS Duplicate Diagnosis Cluster Report	RPT#9999.RPT.RAPS_DUPDX_RPT_
RAPS Monthly Plan Activity Report	RPT#9999.RPT.RAPS_MONTHLY_
RAPS Cumulative Plan Activity Report	RPT#9999.RPT.RAPS_CUMULATIVE_
RAPS Monthly Error Frequency Report	RPT#9999.RAPS_ERRFREQ_MNTH_
RAPS Quarterly Error Frequency Report	RPT#9999.RAPS_ERRFREQ_QTR_





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



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Thank you!





2007 REGIONAL TRAINING

Risk Adjustment Data

VERIFYING RISK SCORES

LTC, Inc.



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Purpose

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



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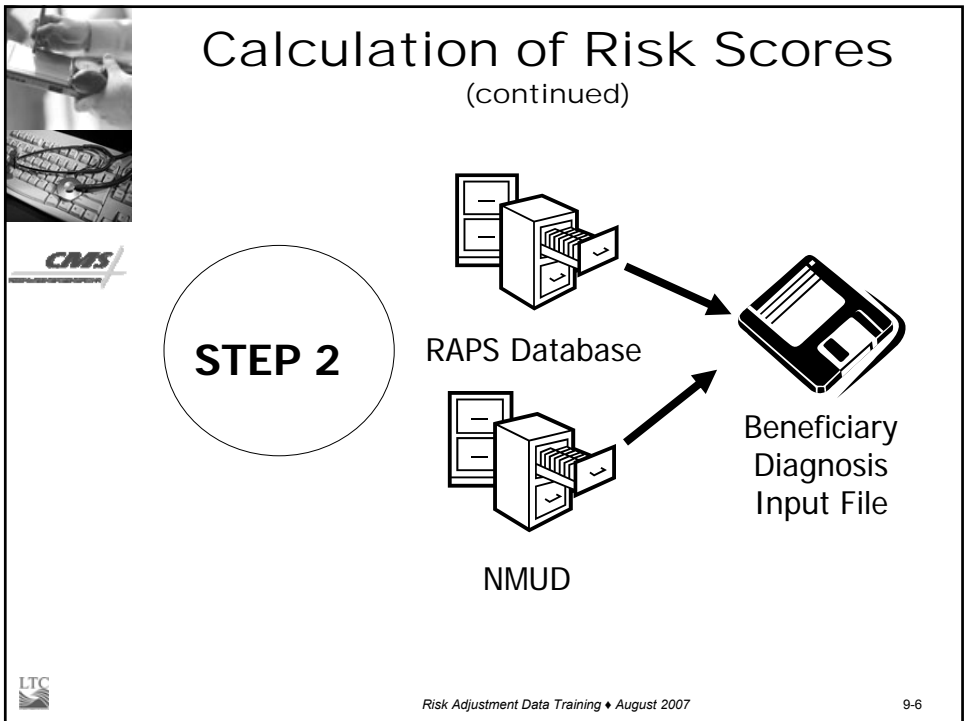
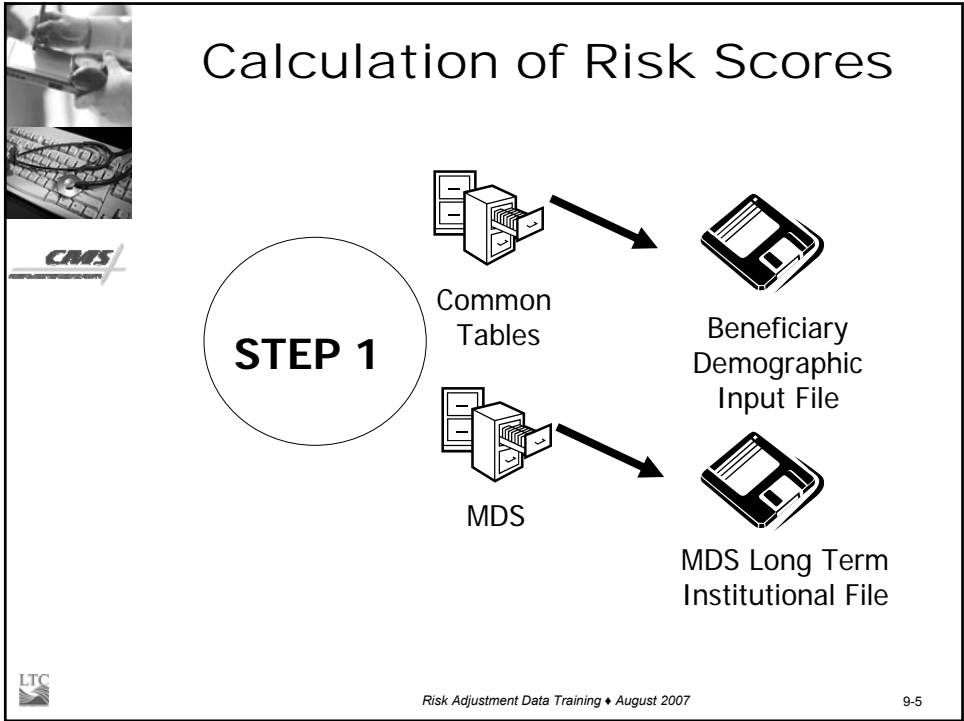
Objectives

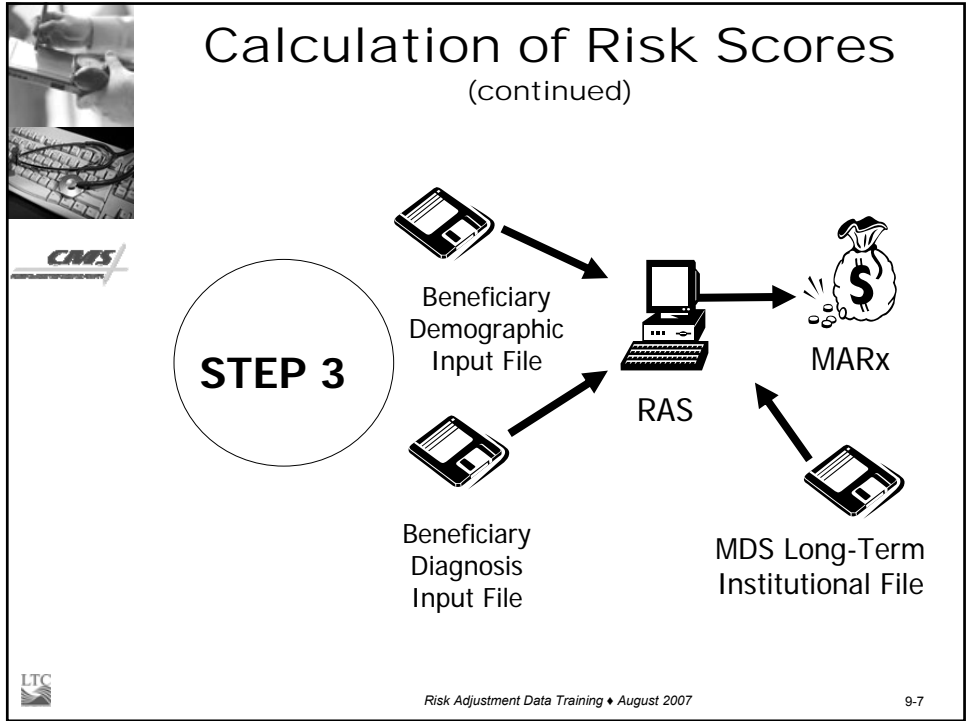
- ◆ Understand the systems and processes used to calculate the risk scores
- ◆ Determine how an organization can use risk adjustment processing and management reports to ensure the accuracy of payment
- ◆ Identify the components and uses of the Non-Drug and Drug Monthly Membership Reports
- ◆ Explain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



What is the
Risk Score?







- ## Verification Tools
- ◆ RAPS Return File
 - ◆ RAPS Management Reports
 - ◆ SAS Software CMS-HCC Model Program
 - ◆ MMR
 - ◆ MOR
-
- CMS*
- LTC*
- Risk Adjustment Data Training • August 2007*
- 9-8



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
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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

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Monthly Membership Report Non-Drug

- ◆ Based on the CMS-HCC Risk Adjustment Model
- ◆ Contains Part A and B information
- ◆ Contains information on:
 - ◇ Rebates, payments, and adjustments
 - ◇ Part A & B information
 - ◇ Risk Adjustment factors
 - ◇ Other detailed beneficiary information

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Monthly Membership Report Drug

- ◆ Predicts drug costs other than Part A/B costs
- ◆ Different diseases predict drug cost
- ◆ 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
37-42	Additional Indicators
43	Risk Adjustment Factor Type Code
44	Frailty Indicator
45-46	Additional Indicators
47	Segment ID for Part D
48	Enrollment Resource
49	EGHP Flag
50-62	Risk Adjustment Premium/Rebate/Payment Information
63	Part D Risk Factor
64-74	Fields added to support the Part D Benefit
75-76	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

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