

2006


Regional Training

Risk Adjustment Data Basic Training

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

July 19, 2006
Baltimore, MD

Introduction

Presented By:

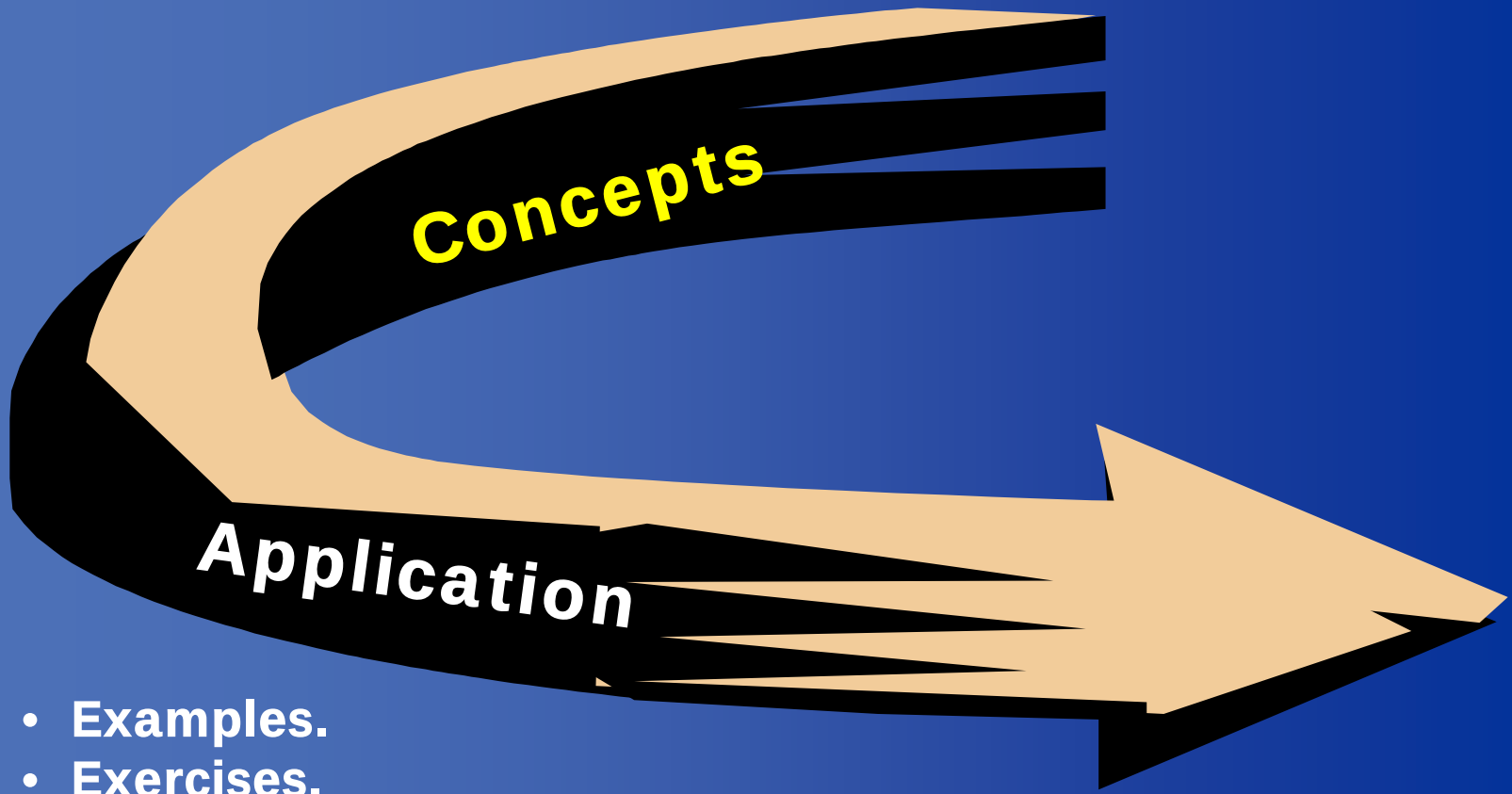
Lockheed Martin

(formerly Aspen Systems Corporation)

Purpose

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

Training Format



- Examples.
- Exercises.
- Group Participation.
- Interactive.

Your Participation Makes the Difference

Training Tools

- Participant Guide
  - CD with slides
- Job Aids
- www.csscoperations.com
- Panel of Experts

Audience

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

Agenda

TIME	TOPIC
8:00 AM – 8:30 AM	Introduction
8:30 AM – 9:30 AM	Risk Adjustment Methodology
9:30 AM – 10:00 AM	Process Overview
10:00 AM – 10:15 AM	**BREAK**
10:15 AM – 11:00 AM	Data Collection
11:00 AM – 12:00 PM	Data Submission
12:00 PM – 1:00 PM	**LUNCH ON YOUR OWN**
1:00 PM – 1:45 PM	Edits
1:45 PM – 2:45 PM	Reports
2:45 PM – 3:00 PM	**BREAK**
3:00 PM – 4:00 PM	Data Validation
4:00 PM – 5:00 PM	Verifying Risk Scores
5:00 PM – 5:30 PM	Question & Answer
5:30 PM	**ADJOURN**

Objectives

- Identify the CMS Risk Adjustment models.
- Explain the components of the risk adjustment process.
- Describe the requirements for data collection.
- Determine the process for submitting data to CMS.
- Interpret editing rules and error resolution.

Objectives (continued)

- Name and interpret the reports available for risk adjustment monitoring.
- Apply the data validation approach subject to the Risk Adjustment models.
- Demonstrate how to verify risk scores.

Introducing the Team

CMS

Palmetto (CSSC)

Aspen Systems Corporation

Risk Adjustment Methodology

Presented by:

Centers for Medicare & Medicaid Services

Purpose

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

Objectives

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

Objectives (continued)

- Discuss implementation of frailty adjuster and its possible future application.
- Review upcoming CMS-HCC model enhancements.
- Understand how the ESRD model operates.
- Describe the Part D risk adjustment model.

Risk Adjustment History

- The Balanced Budget Act of 1997 (BBA) required CMS to implement risk adjustment for M+C organizations in 2000 with inpatient diagnosis data.
- BBA also mandated that payments consider frailty of enrollees in the Program for All-Inclusive Care for the Elderly (PACE).
- CMS implemented the Principal Inpatient Diagnostic Cost Group (PIP-DCG) model in 2000 using 10 percent blended payment.

Risk Adjustment History (continued)

- The Benefits Improvement and Protections Act of 2000 (BIPA) required additional data in risk adjustment model beginning in 2004.
- In 2004, CMS implemented the CMS-Hierarchical Condition Category (HCC) Model that includes hospital and ambulatory data at 30% blended payment.
  - Model balanced reducing plan data burden with implementing clinically sound model.

Risk Adjustment History
(continued)

- 2004 - implemented frailty adjuster for enrollees of PACE and certain demonstrations.
- 2005 - implemented the End-Stage Renal Disease (ESRD) model for ESRD MA enrollees.
- 2006 - implemented a risk adjustment model for the new Medicare prescription drug benefit.
- 2007 - CMS will transition to an updated CMS-HCC model for Part C payment

Risk Adjustment History
(continued)

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

Risk Adjustment History
(continued)

- The MMA included risk adjustment as a key component of the bidding and payment processes for both the MA program and the prescription drug benefit.
- In 2006, CMS implemented risk adjustment model for new Medicare prescription drug benefit.

MMA in 2006

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

Medicare Advantage in 2006

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

MA Organization Bid and Review Process

- The bid is based on amount MA organization determines it will cost to provide its 1.0 benefit package to MA enrollees.
- CMS reviews MA organization bids for their actuarial soundness—ensure that bid reflects costs of providing proposed benefit package.

Overlap of Payment Methods in Titles I and II

- MA organizations intending to offer MA plans and/or drug benefits in 2006 had submitted bids for their basic, and if applicable, supplemental benefit packages.
- Benchmarks were created for local and/or regional plans for bid-benchmark comparison.
- Monthly capitated payments made based on plan's bid and risk adjusted for health status.

What is Risk Adjustment?

- Risk adjustment is a method used to adjust payment based on the health status and demographic characteristics of an enrollee.
- Allows for comparison of beneficiary to the average Medicare beneficiary.
- Risk adjustment for Medicare is built on FFS data sets.

Risk Adjuster Basics

- Risk adjustment appropriately adjusts payment for the characteristics of the enrolled population.
- In the context of MAs/PDPs, risk adjustment used to standardize bids and applied to payment.
- It allows direct comparison of bids based on populations with different health status and other characteristics.

Risk Adjuster Basics
(continued)

- What is a risk score? It is the expected cost of the enrollee normalized to the expected average cost for the population.
- Expected cost is derived from enrollee characteristics:
  - Enrollees' characteristics are assigned risk factors that are added to produce a total risk factor.
- The risk factors are essentially relative weights developed from a prediction model.

CMS Risk Adjustment Models

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

CMS-Hierarchical Condition Category (HCC) Model

- Model categorizes diagnosis codes into disease groups that include conditions which are clinically related with similar cost implications.
- Prospective-diagnoses from base year used to predict payments for following year.
- In the Part C Model separate community and institutional models account for higher treatment costs of similarly-ill, community residents.

CMS-HCC Model (continued)

- Currently, the CMS-HCC model uses 70 disease categories for community and for long term institutional residents.
- Site neutral payment.
- Diagnosis sources are inpatient and outpatient hospital and physician settings.
- Model is additive.

Demographic Factors in Risk Adjustment

- Age
  - Payment for year based on enrollee age as of February 1st.
- Sex
- Medicaid Status.
  - Under CMS-HCC model, applies only to community residents (including short term institutional).
  - Defined as one month of Medicaid eligibility during data collection period.
  - New enrollees use concurrent Medicaid.

Demographic Factors in Risk Adjustment (continued)

- Disabled Status
  - Applied to community residents.
  - Factors for disabled <65 years-old.
  - Factors for disabled and Medicaid.
- Original Reason for Entitlement
  - Factors based on age and sex.
  - >65 years old and originally entitled to Medicare due to disability.

Disease Groups / HCCs

- Most body systems covered by diseases in model.
- Each disease group has an associated coefficient.
- Model heavily influenced by costs associated with chronic diseases.
  - Major Medicare costs are captured.

Disease Hierarchies

- Payment based on most severe manifestation of disease when less severe manifestation also present.
- Purposes:
  - Diagnoses are clinically related and ranked by cost.
  - Takes into account the costs of lower cost diseases reducing need for coding proliferation.

Frailty Adjuster - Improvement of CMS-HCC Model

- Created to predict Medicare expenditures of functionally impaired not explained by CMS-HCC model.
- Applied in conjunction with CMS-HCC model.
- Applied to PACE organizations and certain demonstrations.

Frailty Adjuster (continued)

- Adjuster based on relative frailty of organization in terms of number of functional limitations.
- Functional limitations measured by activities of daily living (ADLs) – from survey results.
- CMS calculates organization-level frailty score based on ADLs of those >55 in the community.

Range of Frailty Scores In 2006

FRAILTY PLAN	RANGE OF FRAILTY SCORES
PACE	.30 - .81
S/HMOs	.09 - .15
WPP	.40 - .61
MSHO	.19 - .70
SCO	.17 - .44

Implications of Frailty Adjuster

- Risk and frailty account for variation in health status of PACE enrollees for which risk and frailty adjustment accounts.
- For MA organizations, addition of frailty factor may improve payment accuracy.
- Frailty adjustment lowers risk scores for individuals with 0 ADLs and raises scores for all other ADL categories.

Frailty Adjuster Development

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

CMS-HCC Model Enhancements

- CMS is analyzing additional diagnoses to add to current model to improve payment accuracy.
- CMS will share impacts of changes in model with the MA industry.

ESRD Model

- New model using risk adjustment for ESRD enrollees in MA organizations and demonstrations was applied in 2005.
- Model addresses unique cost considerations of ESRD population.

ESRD Implementation

- BIPA mandated ESRD model reflects methodology used for S/HMO ESRD demonstration.
- ESRD model was implemented at 100% of payment in 2005.

ESRD Model-Three Parts

- Based on treatment costs for ESRD enrollees over time. Three subparts in model:
  - Dialysis - recalibrated CMS-HCC model without kidney disease diagnoses- contains 67 disease groups.
  - Transplant - higher payment amount for 3 months.
    - Reflects higher costs during and after transplant.
  - Functioning Graft - regular CMS-HCC model used, but includes factor to account for immunosuppressive drugs and added intensity of care.

ESRD Model (continued)

- Dialysis Model-HCCs with different coefficients.
  - Multiplied by statewide ESRD ratebook.
- Transplant Model-Costs for transplant month + next 2 months.
  - National relative factor created by dividing monthly transplant cost by national average costs for dialysis.
  - Highest factor is for month 1 where most transplant costs occur.
  - Payment for 3-months multiplied by statewide dialysis ratebook.

New Enrollees and ESRD Model

- Applies to new enrollees with less than 12 months of data.
- Dialysis and functioning graft subgroups will have new enrollee factors for enrollees with no risk scores available.
- No new enrollee factors for transplant subgroup.

Model Comparisons of Coefficients

	Community	Institutional	Dialysis
Metastatic Cancer and Acute Leukemia HCC 7	1.648	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

- The drug risk adjustment model (RxHCC) shares most of the characteristics of the CMS-HCC model (prospective, additive, hierarchical, and demographic new enrollee model).
  - The key differences:
    - RxHCC model designed to predict plan liability for prescription drugs under the Medicare drug benefit rather than Medicare Part A/B costs.
    - Different diseases predict drug costs than Part A/B costs.
    - Incremental costs of low income (LI) and long term institutional (LTI) beneficiaries are multipliers to the base RxHCC model score.

Part D Risk Adjustment
(continued)

- The development of the RxHCC model is a iterative process–disease groups disassembled into smaller subgroups, then reassembled to allow empirical estimation of costs and incorporate clinical judgment.
- Explanatory power of the RxHCC model is on par with other drug models (R^2=.25 for plan liability); is higher than similar Part A/B models because drug costs are more stable.
- Normalization is done on the entire Medicare FFS population.
- Average projected plan liability is ≈ $993.

Part D Risk Adjustment
(continued)

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

Low Income and Long Term Institutional

- The Part D model includes incremental factors for beneficiaries who are low- income subsidy eligible (LIS) or long term institutional (LTI).
- The factors are multipliers that are applied that the basic Part D risk adjustment factor predicted by the model.
- If a beneficiary is LTI they can not also receive the low income factor.

Low Income and Long Term Institutional Multipliers

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

Risk Adjuster Example

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

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

Risk Adjuster Example
(continued)

- Step 1 - derive base risk score – 1.22.
- Step 2 - multiply by either LI or LTI factor if they apply for the payment month.
- Full subsidy eligible (group 1): risk score = base risk score (1.22)* 1.08 = 1.318.
- Long term institutional (aged): risk score = base risk score (1.22) * 1.08 = 1.318.

Risk Adjusted Payments

- For 2007, the CMS-HCC model has been updated while the ESRD and Part D models remain unchanged from 2006.
- For calculating RA scores for payment diagnoses from either MA or from Medicare FFS.
- New Enrollee model used for people new to Medicare with insufficient data for risk adjustment. This model is based solely on demographics.
- Appeal rights—only if we did not follow our published methodology.

Simplified Example Illustrating Use of Risk Adjustment in Bidding

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

Part D - Direct Subsidy Payments

- Monthly direct subsidy made at the individual level.
- Direct subsidy = (Standardized Bid * Individual Risk Score) – Beneficiary Basic Premium.
- Sum for all beneficiaries enrolled equals monthly organizational payment.

Conclusions

- Consistency: CMS approach uses risk adjustment for all types of plans.
- Flexibility: Four pronged approach (HCC, frailty, ESRD, RxHCC) provides flexibility to ensure accurate payments to MA plans and PDPs; provides ability to develop other models as needed.
- Accuracy: Improves our ability to pay correctly for both high and low cost persons.

Information on Risk Adjustment Models and Risk Scores

- The 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

- Contact: Sean Creighton, M.Sc. (Sean.Creighton@cms.hhs.gov).
- Thomas Kornfield, MPP (Thomas.Kornfield@cms.hhs.gov).

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

Thank You!

Process Overview

Presented by:

Lockheed Martin

(formerly Aspen Systems Corporation)

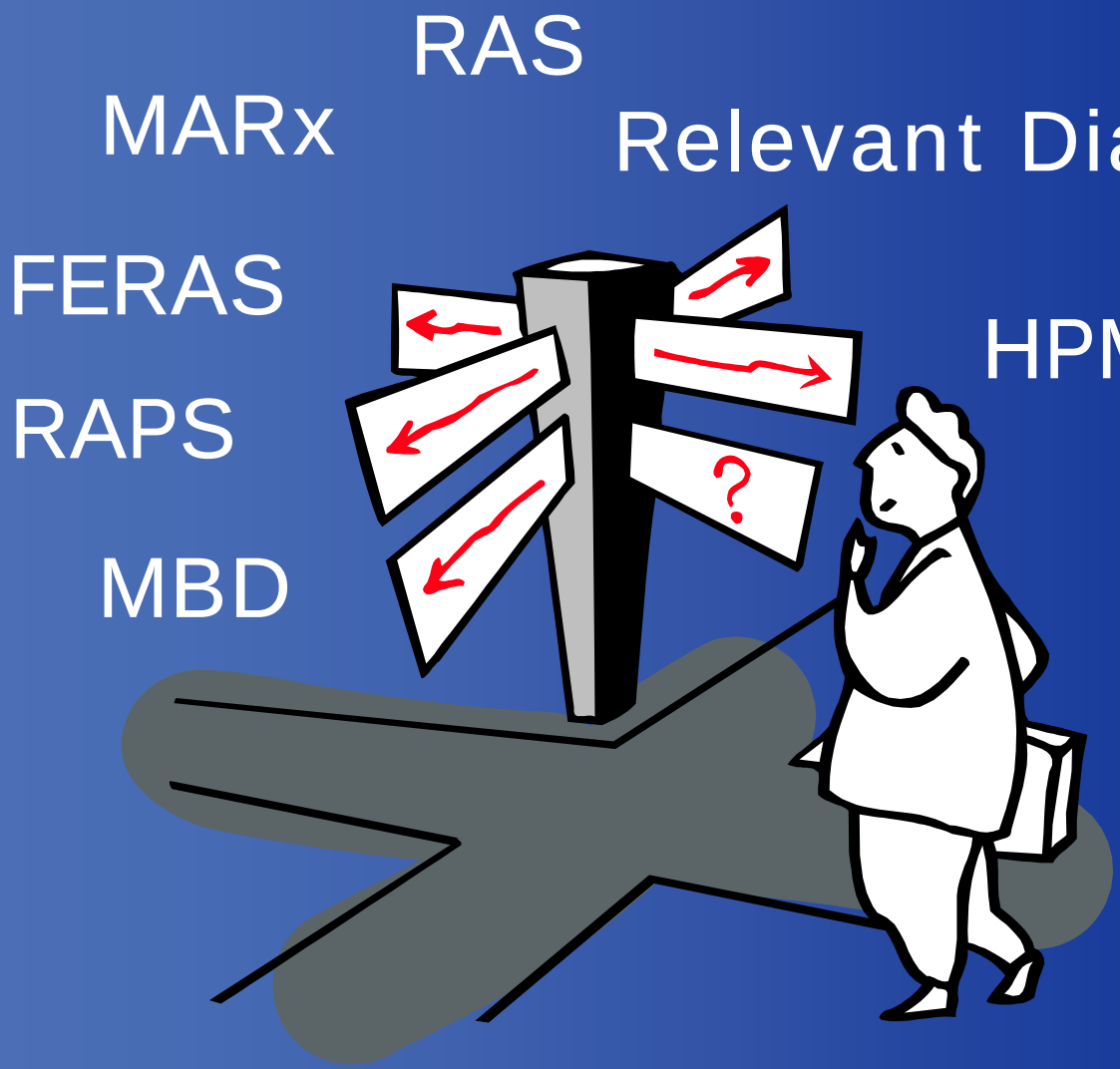
Purpose

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

Objectives

- Define common risk adjustment terminology.
- Demonstrate key components of the risk adjustment process.
- Interpret the risk adjustment schedule.
- Identify CMS outreach efforts available to organizations.

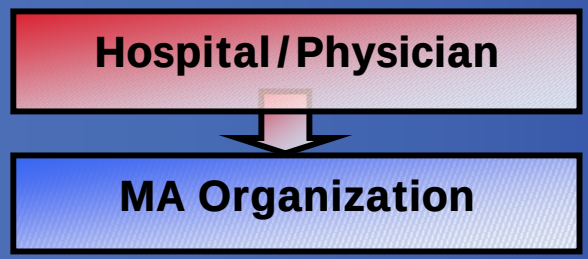
Common Terms



Risk Adjustment Data Requirements

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

Data Collection

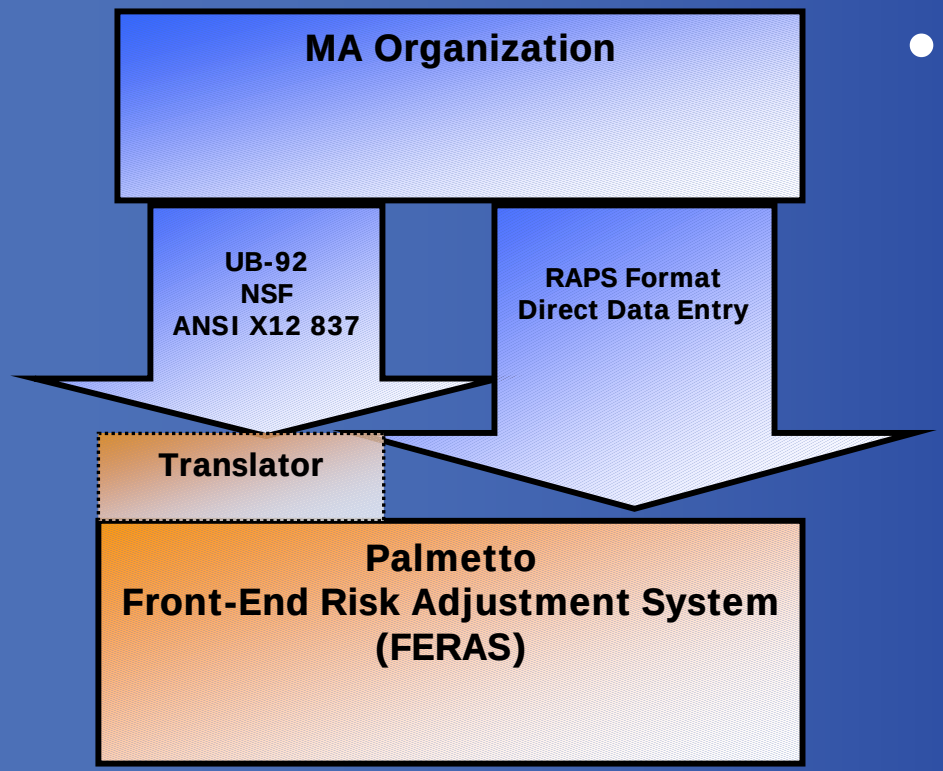


Minimum Data Set

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

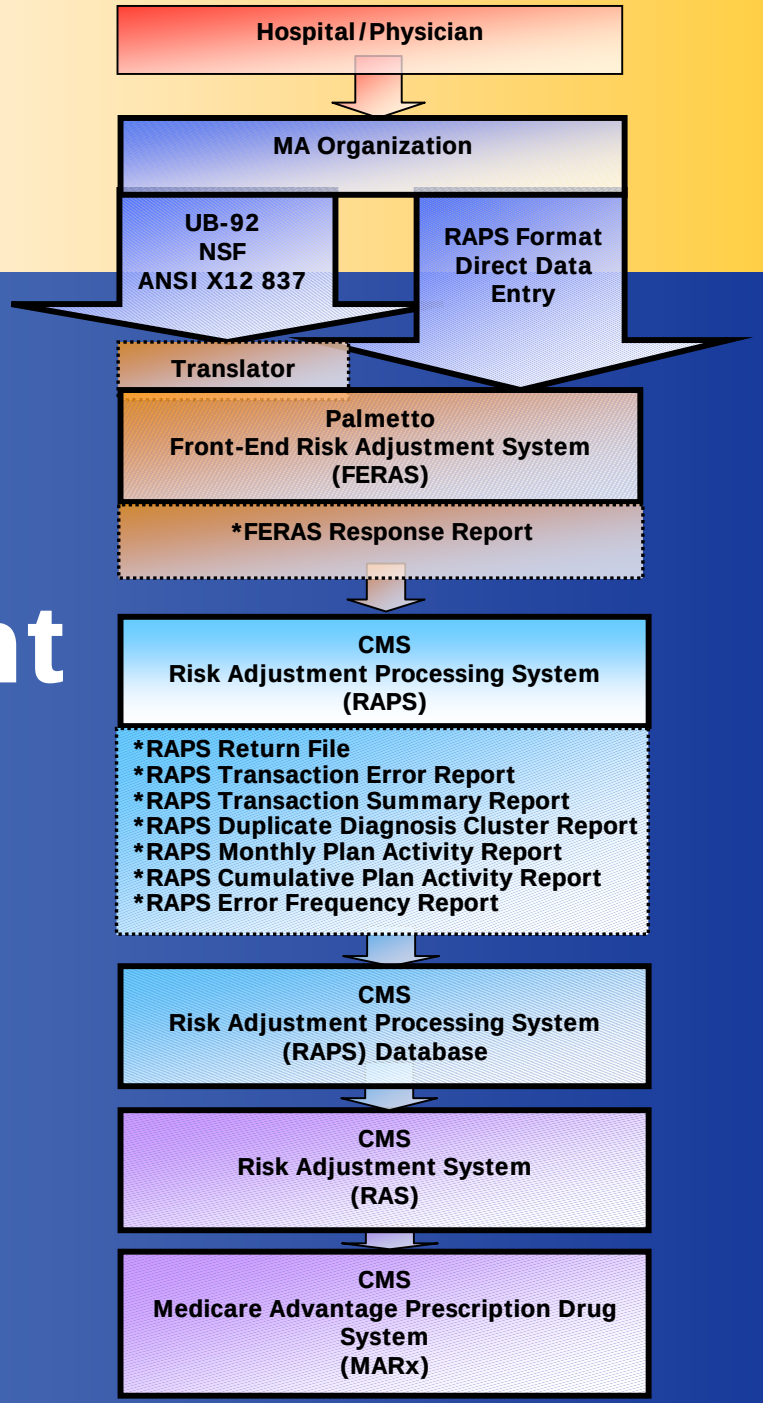
- Formats
  - UB-92
  - HCFA 1500
  - NSF
  - ANSI 837
  - Superbill
  - RAPS format

Data Submission



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

Risk Adjustment Process



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

Submission Schedule

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

Training and Support

- Customer Service and Support Center
- www.csscoperations.com
- User Groups
- Onsite Consultation
- Regional Training

Summary

- Defined common risk adjustment terminology.
- Demonstrated key components of the risk adjustment process.
- Interpreted risk adjustment schedule.
- Identified outreach and training available to organizations.

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

Thank You!

Data Collection

Presented By:

Lockheed Martin

(formerly Aspen Systems Corporation)

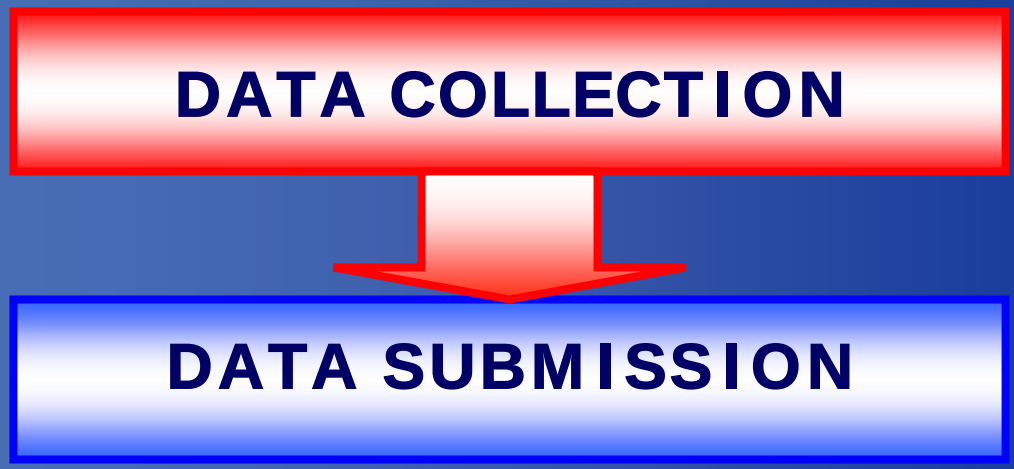
Purpose

- 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 data collection formats available to MA organizations.
- Discuss considerations for methods of data collection.
- Apply HIPAA transaction standards.

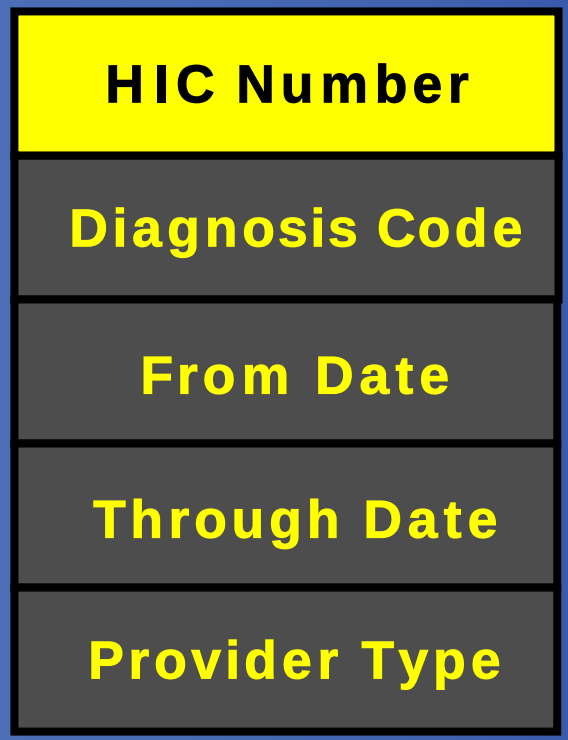
Data Collection



Minimum Risk Adjustment Data Elements

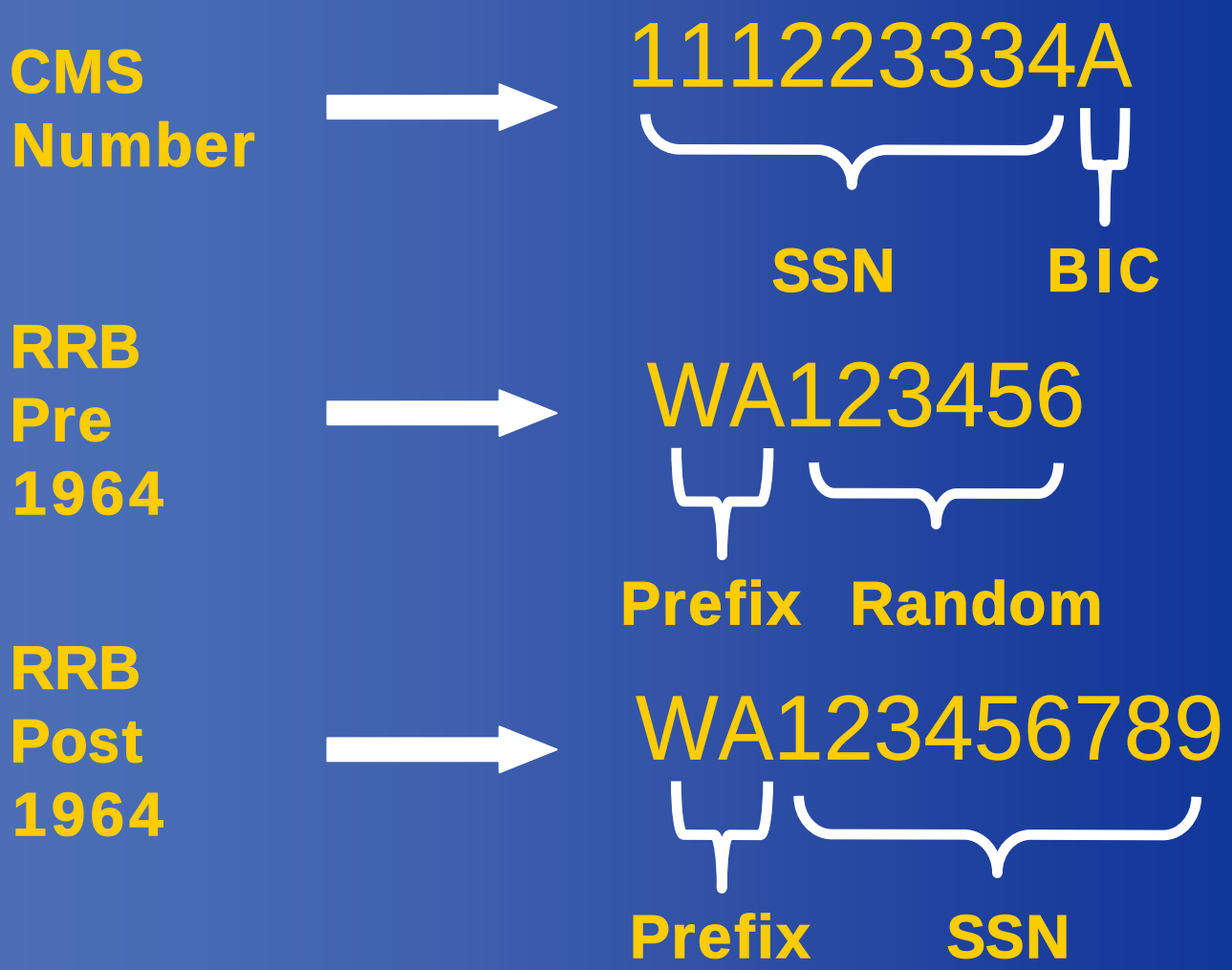
- HIC Number
- Diagnosis Code
- From Date
- Through Date
- Provider Type

Health Insurance Claim Number

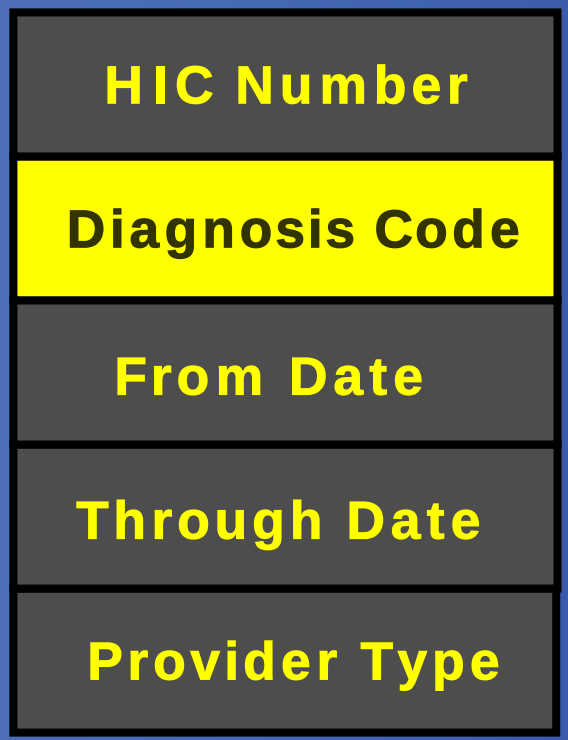


- HIC numbers are beneficiary identification numbers.
- HIC numbers are issued by CMS and the RRB.

HIC Number (continued)

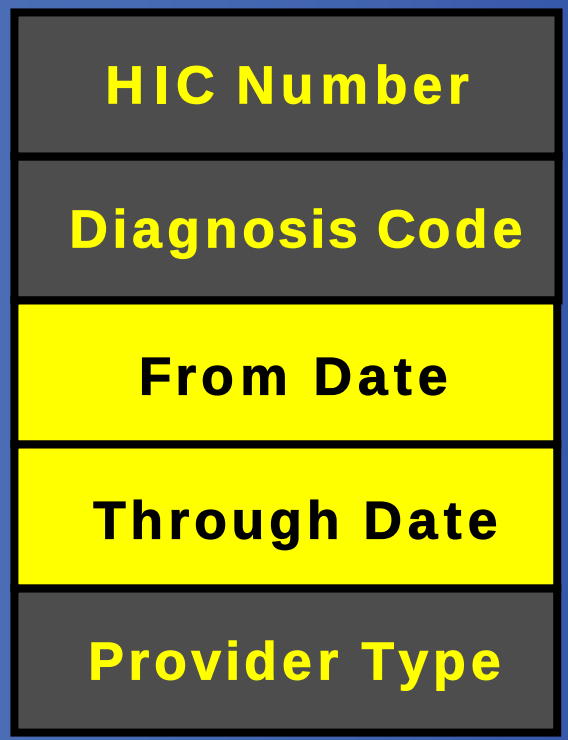


ICD-9-CM Diagnosis Codes



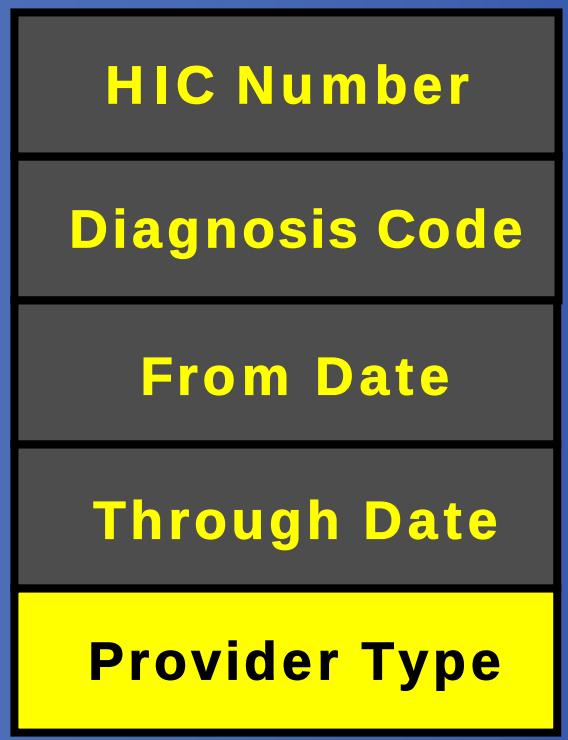
- 3-5 digit code describing clinical reason for treatment
- Drives risk scores, which drive reimbursement

Service From and Through Dates



- Defines when a beneficiary received treatment

Provider Type



- Hospital inpatient
- Hospital outpatient
- Physician

Hospital Inpatient Data

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

Hospital Outpatient Data

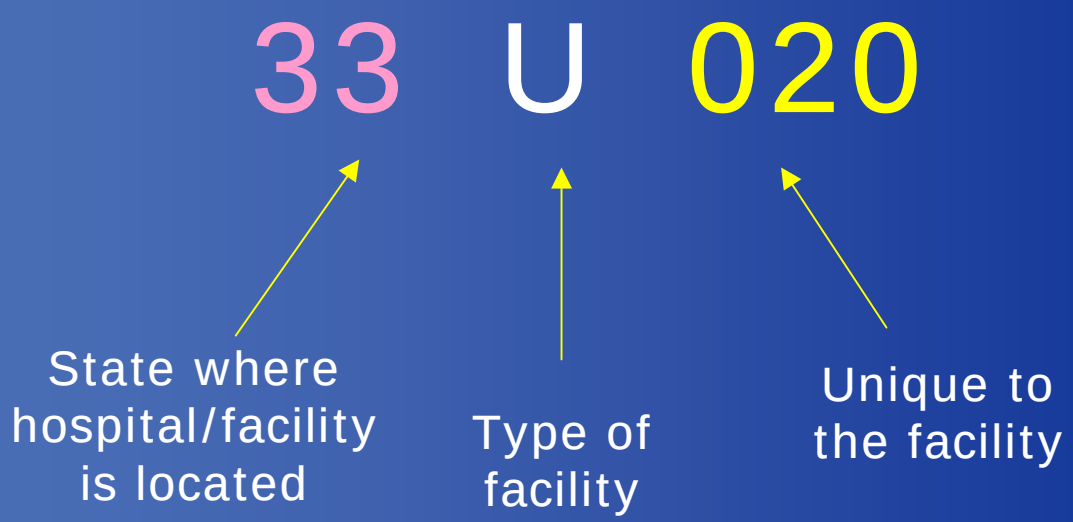
- Therapeutic and rehabilitation services for sick or injured persons who do not require hospitalization or institutionalization.
- Data collected must be from hospital outpatient departments.
- Determine if a provider is a covered facility.

Acceptable or Not?

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

* Provider number within the acceptable range.

Medicare Provider Number



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

Physician Data

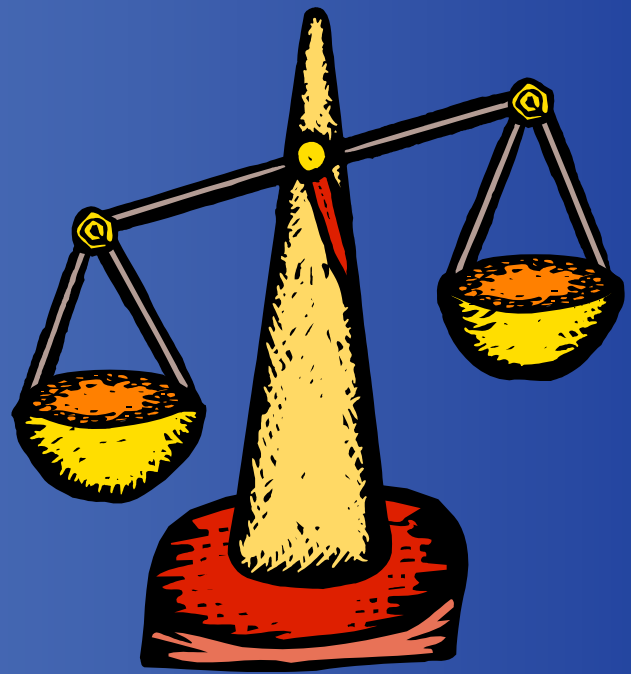
- Services provided by a physician or clinical specialist during a face-to-face visit.
- All diagnoses that are in the risk adjustment model must be collected from network, as well as non-network, physicians.

Exercise

Data Collection Formats

- HCFA 1500
- NSF
- UB-92
- 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

Summary

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

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

Thank You!

Data Submission

Presented By:

Lockheed Martin

(formerly Aspen Systems Corporation)

Purpose

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

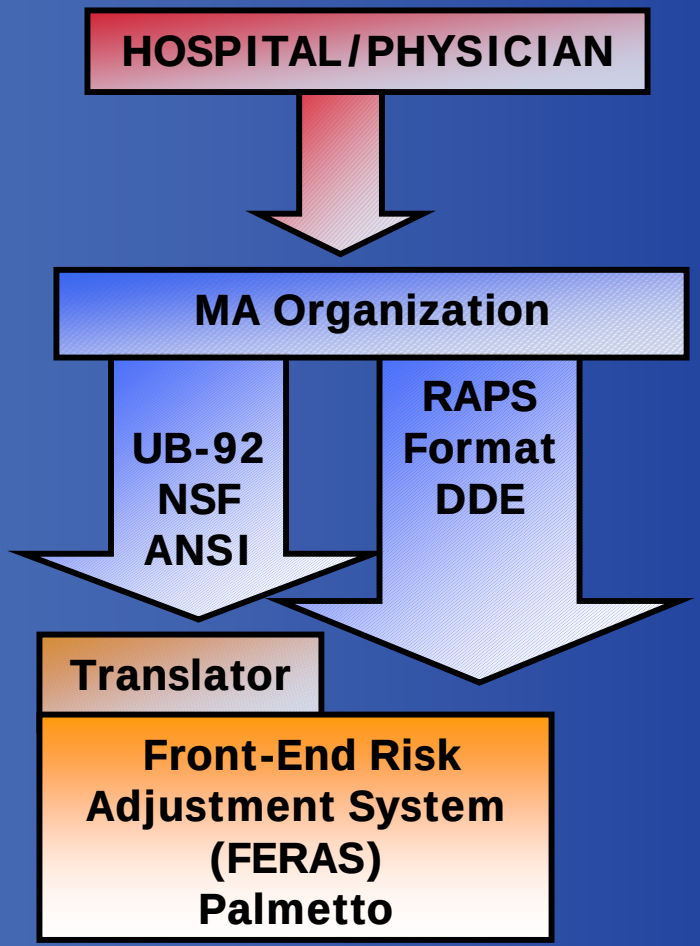
Objectives

- Understand the submission process requirements, connectivity options, and RAPS file layout.
- Identify the data elements required to submit risk adjustment data.
- Locate and describe the diagnosis clusters in the RAPS format.

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

Connectivity Options
(continued)

Gentran	**Two connectivity options**: • Secure File Transfer Protocol (SFTP); standards based protocol via a vendor. • Secure Hyper Text 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 of 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

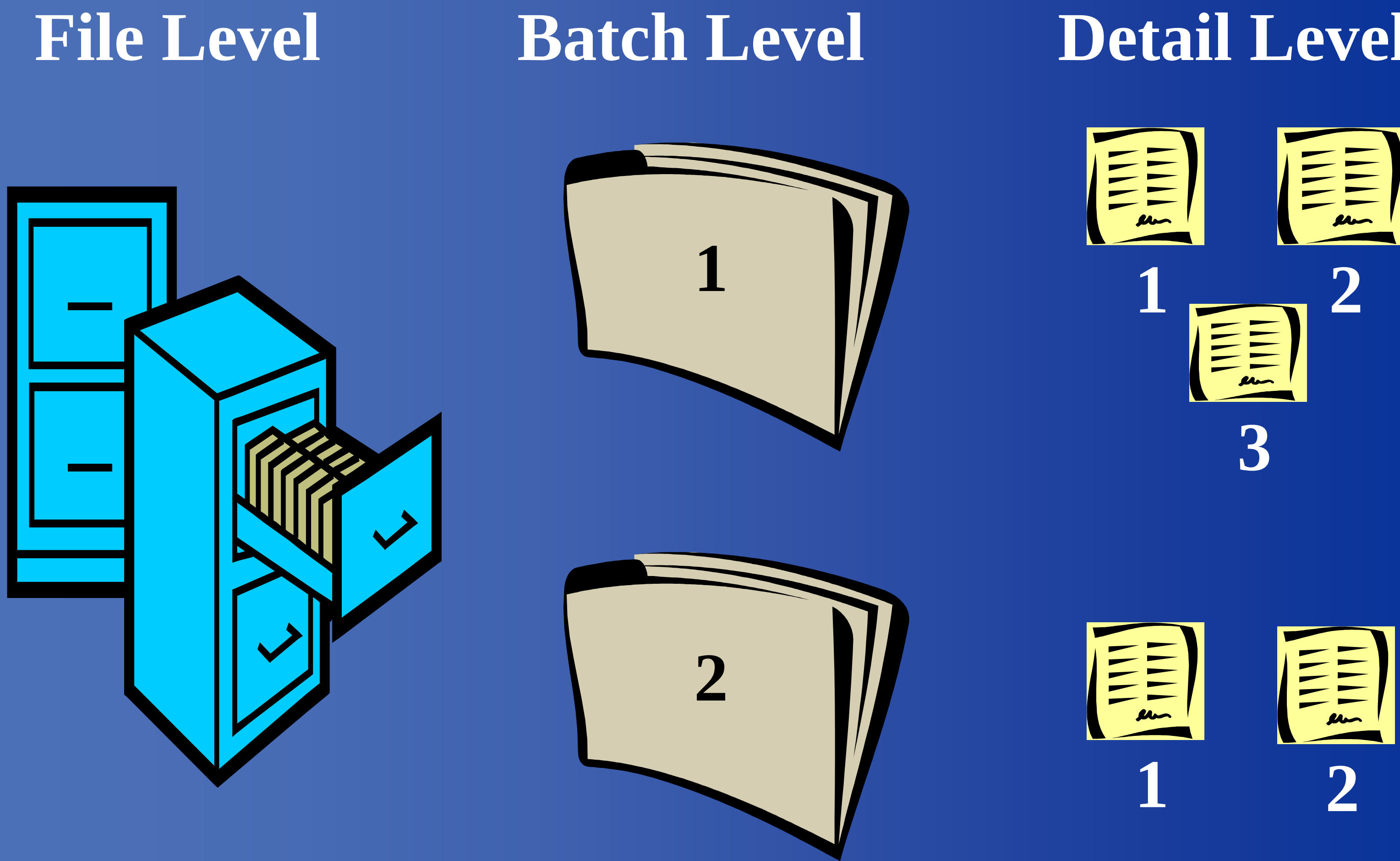
NSF

UB-92

ANSI

DDE

File Logic



Exercise

Fast Facts

- Same submitter may transmit for several MA organizations.
- More than one batch is allowed per H number.
- More than one detail record is allowed per HIC number.
- Provider numbers are not required.

Filtering Risk Adjustment Data

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

Filtering Risk Adjustment Data (continued)

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

Modifying Data

- RAPS allows for modifying risk adjustment data previously submitted to CMS.
  - Adding data
  - Deleting data
  - Correcting data
- Incorrect clusters must be deleted from the system before correct cluster information can be added.

Deleting Diagnosis Clusters

- Each unique diagnosis cluster that RAPS accepts is stored separately.
- Only accepted diagnosis clusters may be deleted.
- Deletions may be submitted within a file, batch, or detail record containing previously submitted risk adjustment data.
- Erroneously submitted clusters must be deleted.

Reasons for Deleting Clusters

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

Steps for Deleting Clusters

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

Steps for Deleting Clusters (continued)

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

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.

NSF Submissions

- All NSF submissions will be translated to Provider Type 20 in RT CCC 9.0.
- RT CCC 2 will be processed by Palmetto in the order in which the detail records appear in the batch.
- NSF Record Identifiers AA0 1.0, BA0 1.0, CCC 1.0, YA0 1.0, and ZA0 1.0 must be populated.

UB-92 Submissions

- RT CCC 2 will be processed by Palmetto in the order in which the detail records appear in the batch.
- UB-92 Record Identifiers must be populated.
  - RT 01 1.0
  - RT 10 1.0
  - RT 20 1.0
  - RT 95 1.0
  - RT 99 1.0

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.

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

Thank You!

Edits

Presented By:

Lockheed Martin

(formerly Aspen Systems Corporation)

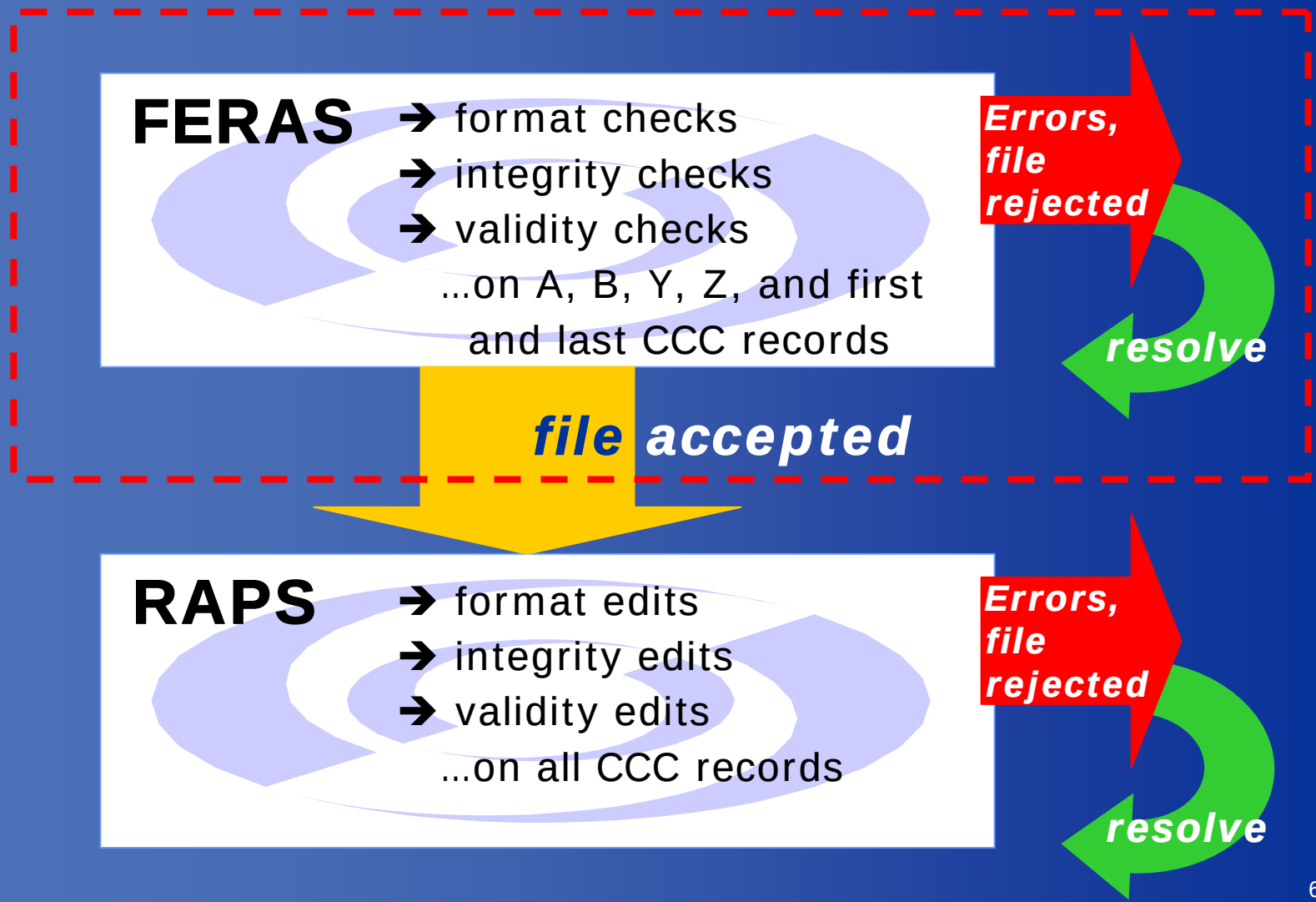
Purpose

- To provide participants with an understanding of risk adjustment system edits.
- To describe the common edits and assist MA organizations with the required steps to prevent errors in the future.

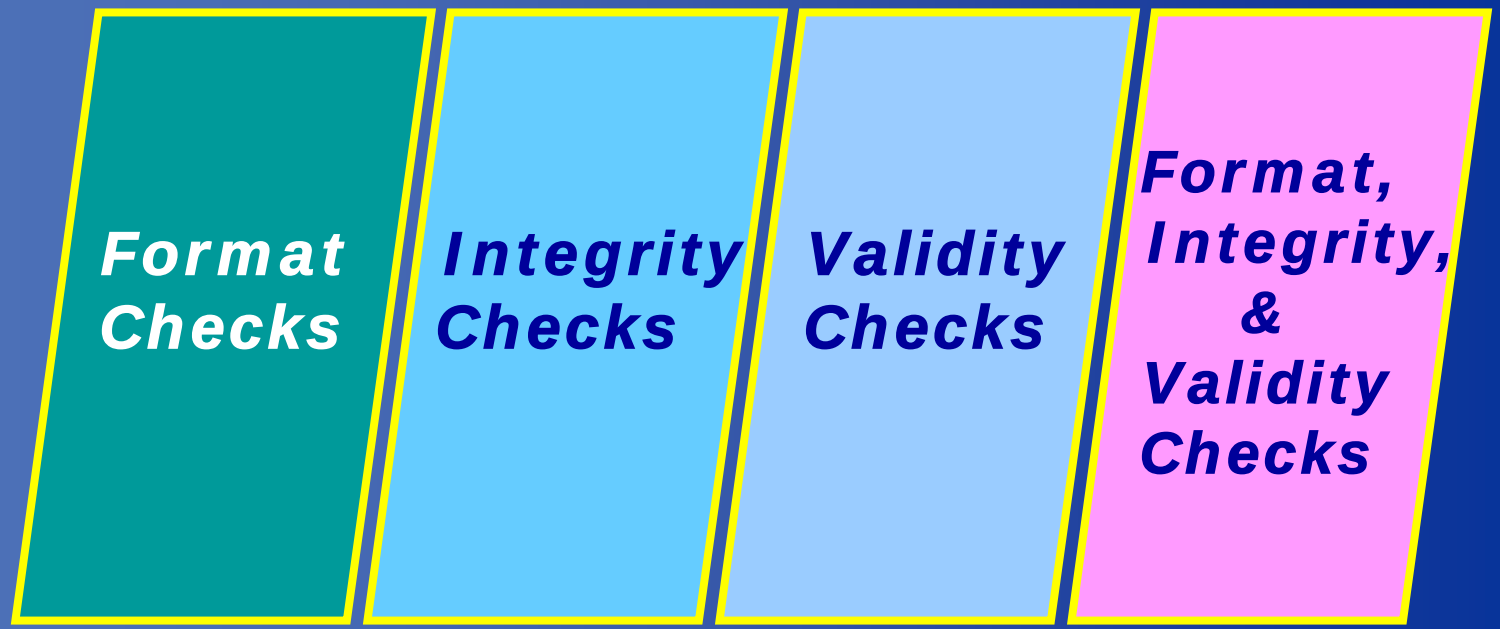
Objectives

- Interpret the FERAS and RAPS data integrity logic and error codes.
- Explain how the Medicare Beneficiary Database (MBD) supports the editing process.
- Describe the FERAS and RAPS editing processes.
- Recognize common FERAS and RAPS errors and determine action required to avoid or correct them.

Data Flow


FERAS
➔ format checks
➔ integrity checks
➔ validity checks
...on A, B, Y, Z, and first and last CCC records
Errors, file rejected
resolve
file accepted
RAPS
➔ format edits
➔ integrity edits
➔ validity edits
...on all CCC records
Errors, file rejected
resolve

FERAS Checks



Checks on file and batch levels

Checks on first & last CCC records

Example 1

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

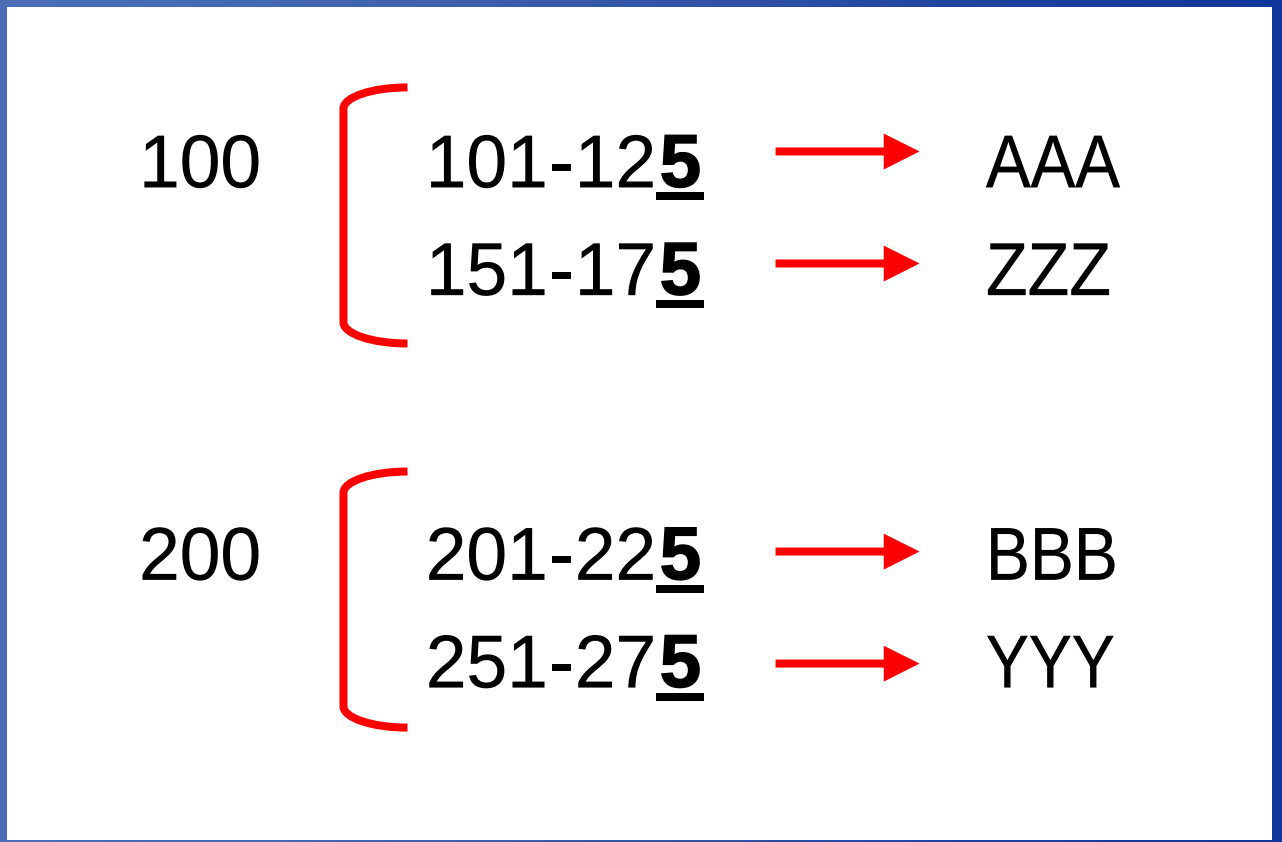
Result: FERAS will reject the entire file with error message 100. The field must always be populated with “AAA”.

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

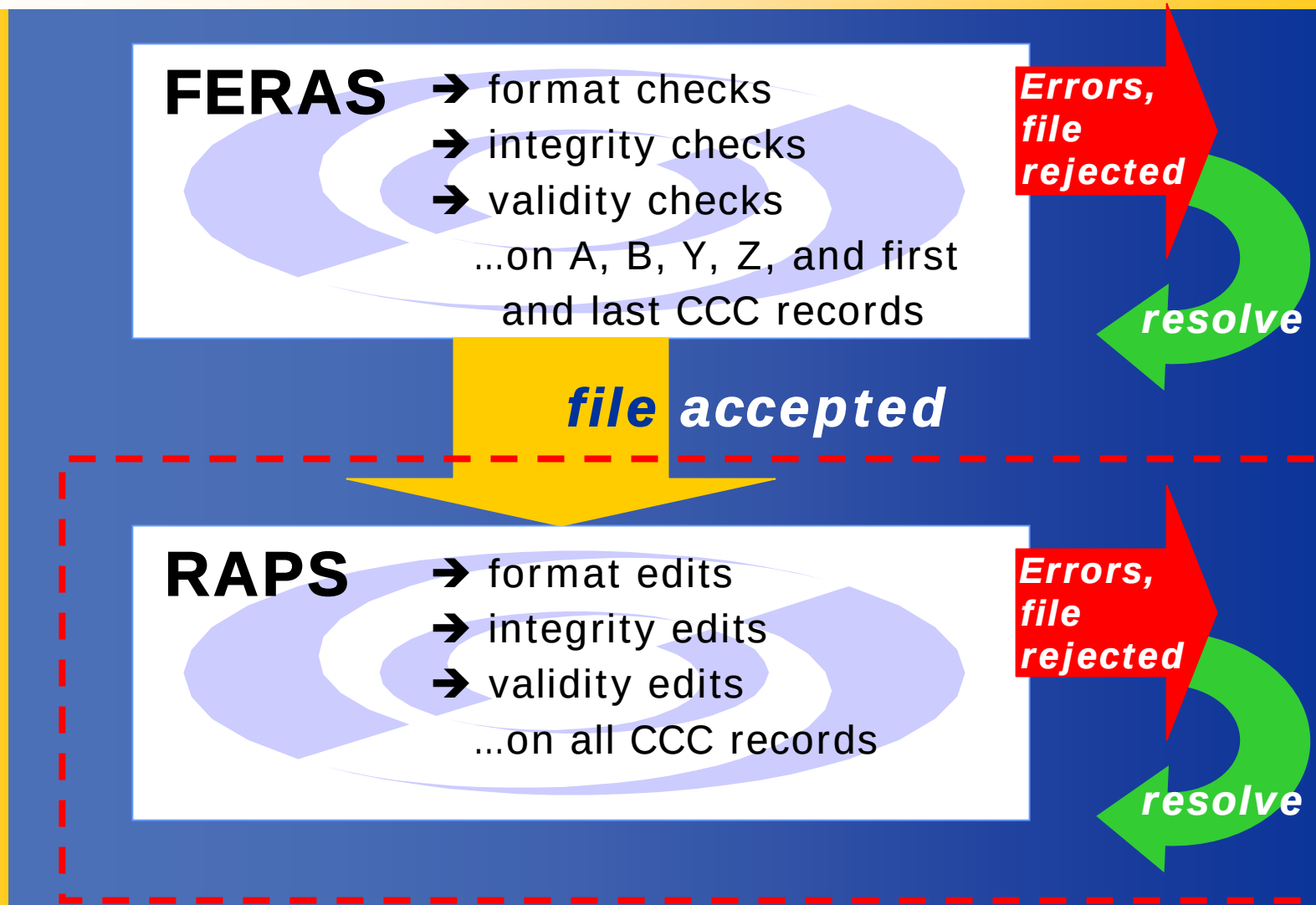


Example 2

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

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

RAPS Edits


FERAS
➔ format checks
➔ integrity checks
➔ validity checks
...on A, B, Y, Z, and first and last CCC records
Errors, file rejected
resolve
file accepted
RAPS
➔ format edits
➔ integrity edits
➔ validity edits
...on all CCC records
Errors, file rejected
resolve

RAPS Editing Rules

Stage 1 - Field Validity and Integrity edits

Stage 2 - Field-to-Field edits

Stage 3 - Medicare Beneficiary Database edits

Stage 4 - Diagnosis Code edits

RAPS Editing Rules

Stage 1 - Field Validity and Integrity edits

Stage 2 - Field-to-Field edits

Stage 3 - Medicare Beneficiary Database edits

Stage 4 - Diagnosis Code edits

RAPS Editing Rules

Stage 1 - Field Validity and Integrity edits

Stage 2 - Field-to-Field edits

Stage 3 - Medicare Beneficiary Database edits

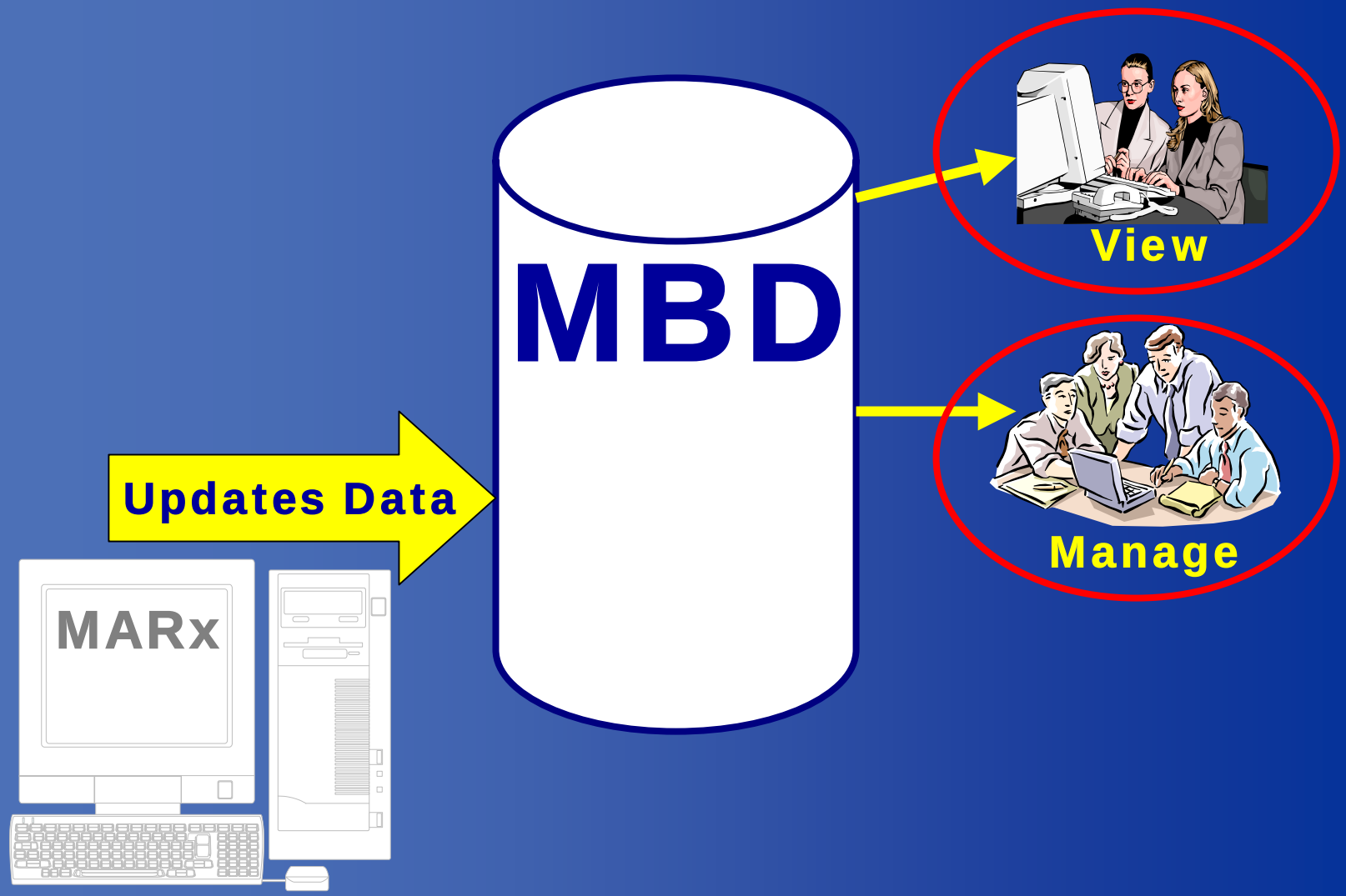
Stage 4 - Diagnosis Code edits

Medicare Beneficiary Database

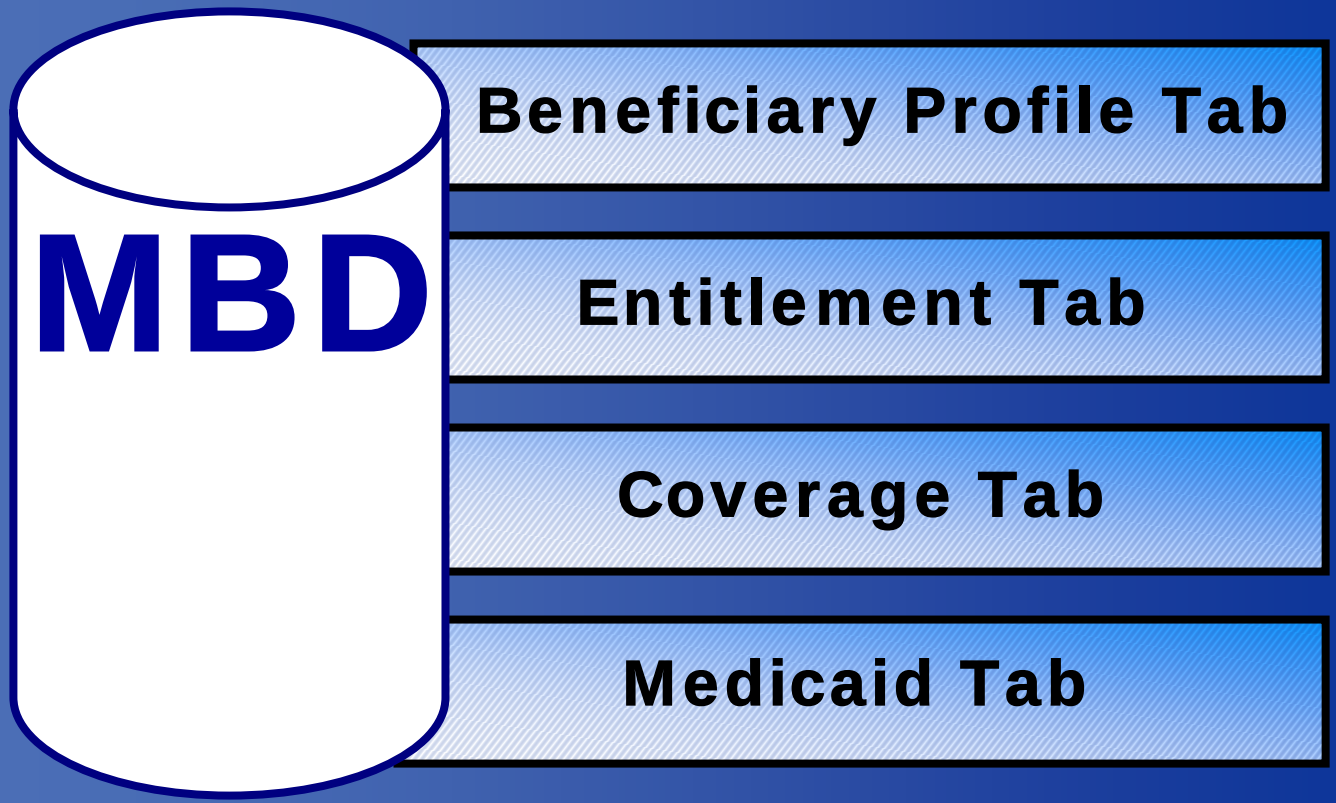
MBD

Source for demographic, enrollment, and entitlement information

Medicare Beneficiary Database (continued)



Data Stored in MBD



RAPS Editing Rules

Stage 1 - Field Validity and Integrity edits

Stage 2 - Field-to-Field edits

Stage 3 - Medicare Beneficiary Database edits

Stage 4 - Diagnosis Code edits

RAPS Error Codes

	Series	Explanation of error and consequences
Record	300-349	Record-level error - The record was bypassed and all editing was discontinued. No diagnosis clusters from this record were stored.
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.

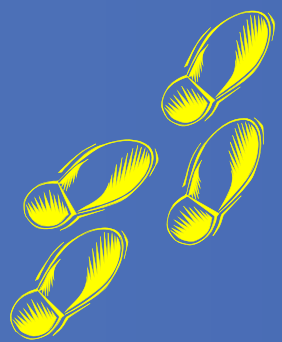
Example 3

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

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

Exercise

Five Common Errors

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

Summary

- Interpreted the FERAS and RAPS data integrity logic and error codes.
- Explained how the Medicare Beneficiary Database supports the editing process.
- Described the FERAS and RAPS editing processes.
- Recognized common FERAS and RAPS errors and determined action required to avoid or correct them.

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

Thank You!

Reports

Presented By:

Lockheed Martin

(formerly Aspen Systems Corporation)

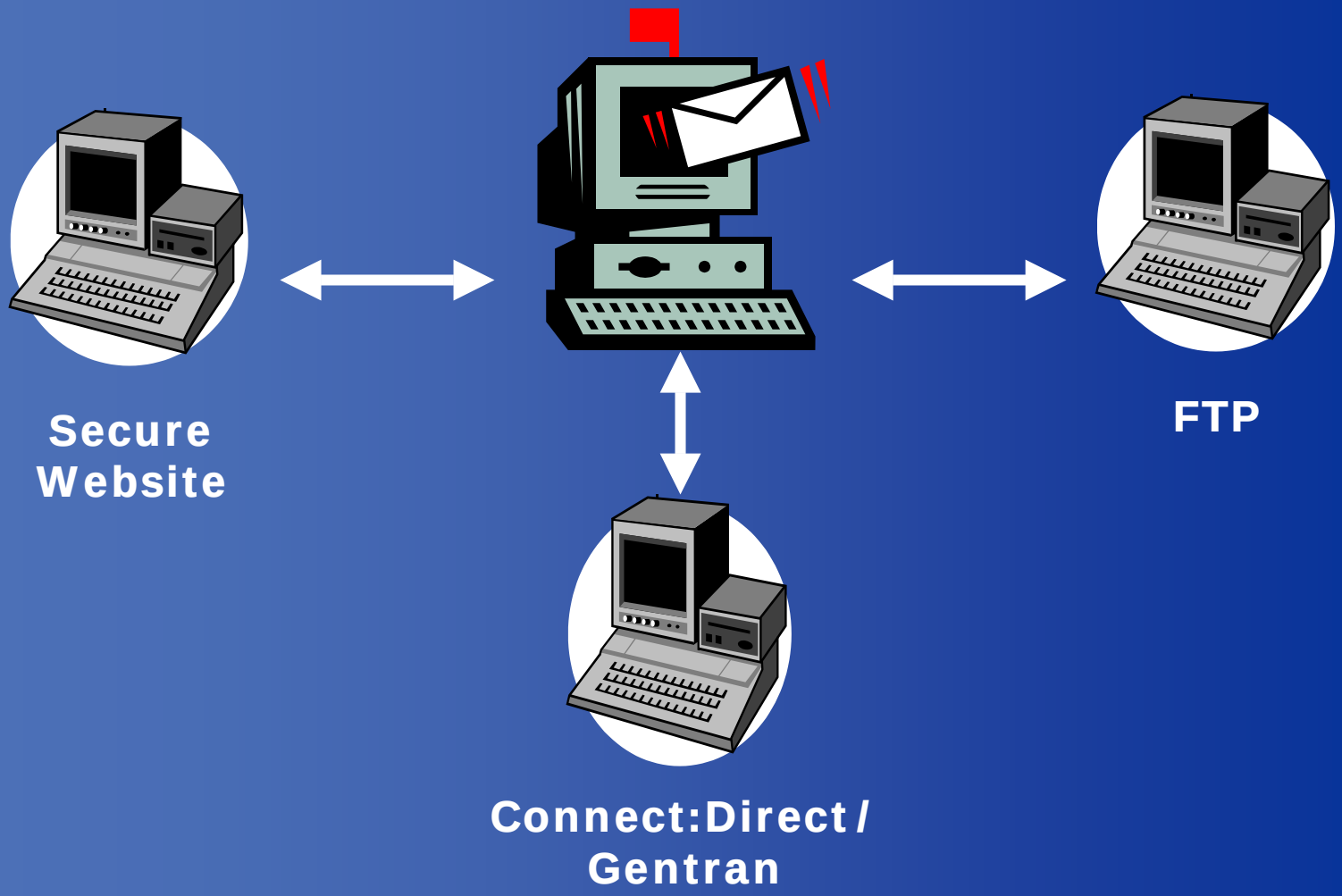
Purpose

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

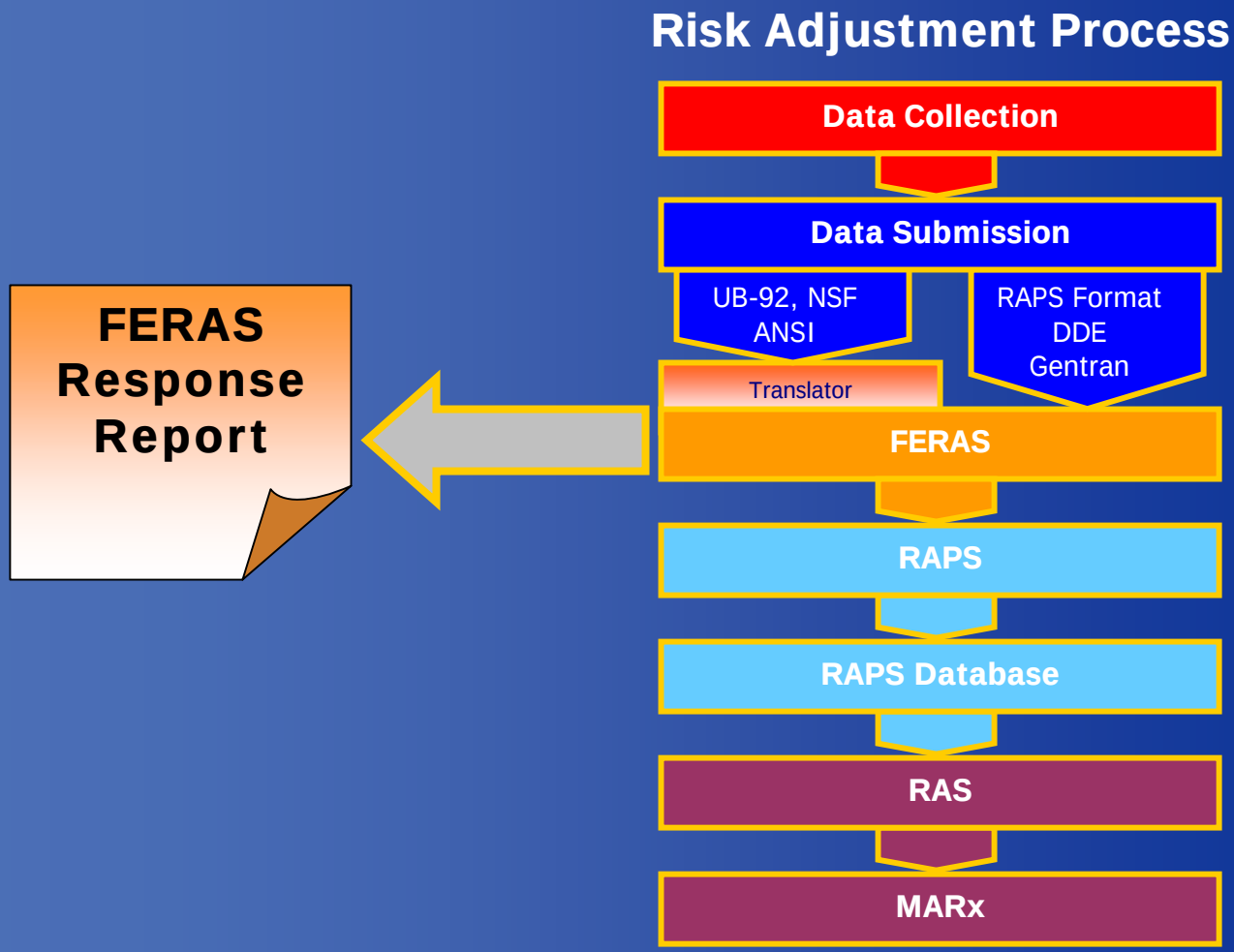
Objectives

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

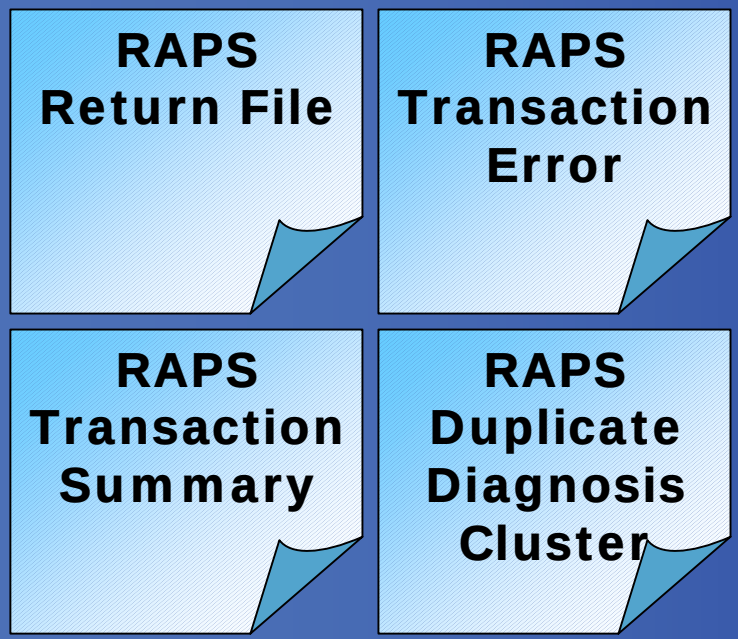
Accessing Reports

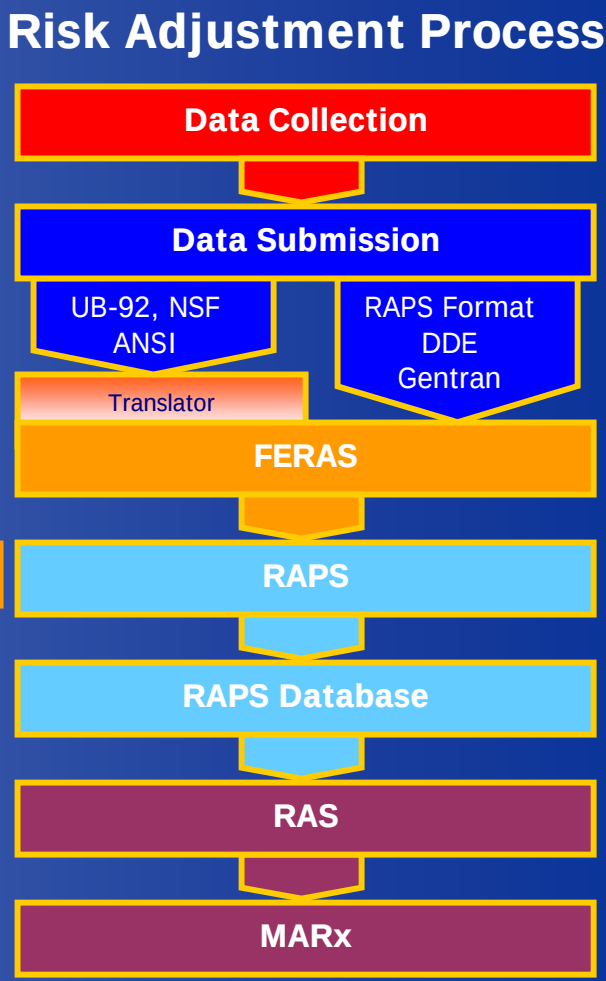


Reports Overview

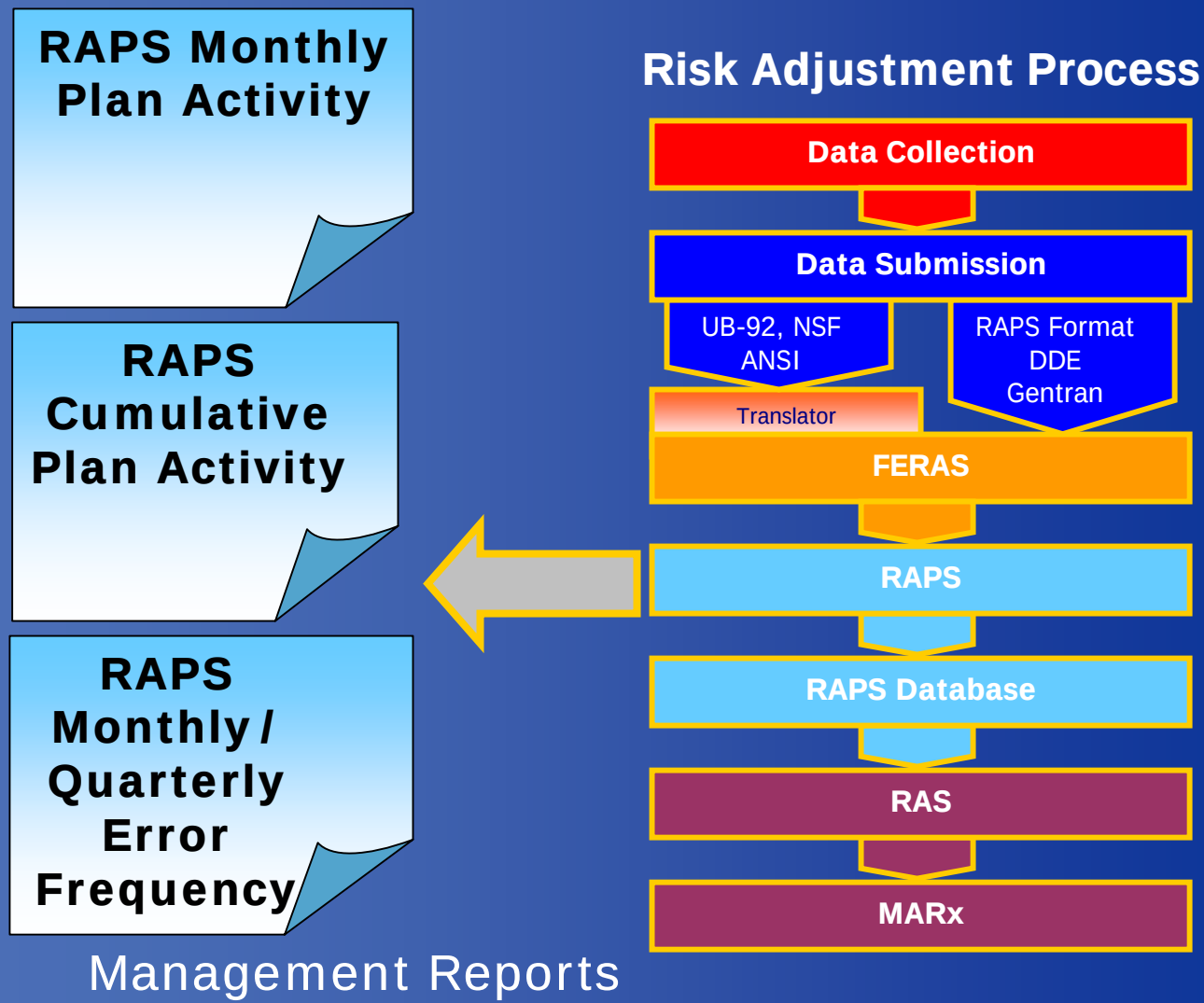


Reports Overview
(continued)





Reports Overview (continued)



FERAS Response Report

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

FERAS Response Report Example

The MA organization 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 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

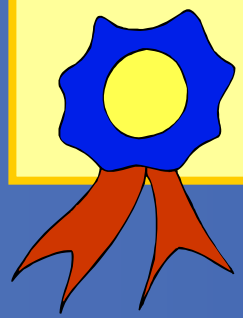
The MA organization submitted a file and included the beneficiary's DOB. RAPS determined a discrepancy between DOB submitted on the file and what is stored in MBD. The submitter received a RAPS Return File.

Uses for RAPS Return File Format

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

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

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



Improve the quality and quantity of data submissions!

RAPS Transaction Error Report

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

RAPS Editing Rules

Stage 1 - Field Validity and Integrity edits

Stage 2 - Field-to-Field edits

Stage 3 - Medicare Beneficiary Database edits

Stage 4 - Diagnosis Code edits

Exercise

RAPS Transaction Summary Report

- Identifies the number of clusters received for each provider type.
- Summarizes the disposition of all diagnosis clusters.
- Accompanies the RAPS Transaction Error Report.
- Available in report layout only.
- Received the next business day after submission.

Relationship Between Values in RAPS Transaction Summary Report

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

Total Stored ≤ Total Accepted

Total Model Diagnoses Stored ≤ Total Stored

RAPS Duplicate Diagnosis Cluster Report

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

Analysis of Management Reports

RAPS Monthly Plan Activity Report

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

Summary

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

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

Thank You!

Risk Adjustment Data Validation

Presented by:

Centers for Medicare & Medicaid Services

Purpose

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

Objectives

- Identify purpose and goals of risk adjustment data validation
- Identify and describe stages of risk adjustment data validation
- Learn about the components of a medical record request
- Describe requirements for acceptable medical record documentation

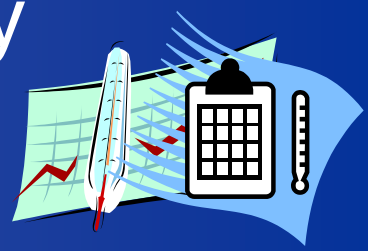
Objectives (continued)

- Identify risk adjustment discrepancies
- Describe payment adjustments and appeals
- Provide recommendations and lessons learned

What is Risk Adjustment Data Validation?

- Process of verifying that diagnosis codes submitted for payment by the MA organization are supported by medical record documentation for an enrollee

- ***Purpose***: to ensure risk adjusted payment integrity and accuracy



Data Validation Goals

- Identify:
  - Confirmed risk adjustment discrepancies
  - Plans in need of technical assistance to improve risk adjustment data quality
- Measure:
  - Accuracy of risk adjustment data
  - Impact of discrepancies on payment
- Improve/Inform:
  - Quality of risk adjustment data
  - The CMS-Hierarchical Condition Category (HCC) model

Risk Adjustment Data Validation Background

CY2000 – CY2003
• Based on Principle Inpatient Diagnostic Cost Group (PIP-DCG) model • Reviewed only hospital inpatient medical records for exact RAPS dates of service
CY2004 and Beyond
• Based on CMS Risk Adjustment models • Review hospital inpatient, hospital outpatient, and physician medical records • More flexible approach for selecting medical records

CMS-HCC Data Validation Guiding Principle

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

Risk Adjustment Data Validation Process

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

Plan Selection

STAGE 1

Two types of samples

- Random sample is used to derive:
  - National net payment error estimates; and
  - National risk adjustment discrepancy rates
- Targeted sample may include plans with:
  - Potentially problematic risk adjustment data; and/or
  - Problematic past data validation findings

Every MA organization has equal opportunity of being selected.

Medical Record Request Process

STAGE 2

Three segments:

- Request
- Submission (Plan Response)
- Receipt

Request Process (continued)

STAGE 2

Request

CMS & Initial Validation Contractor (IVC)

- Plans receive:
  - Initial contact letter
  - Beneficiary list containing diagnoses and HCCs to be validated
  - Comprehensive instructions
  - Coversheets for each unique beneficiary HCC being validated

Request Process (continued)

STAGE 2

Submission (Plan Response)

- Plan must:
  - Select “one best medical record”
  - Complete medical record coversheet for each beneficiary HCC
  - Identify date(s) of service and diagnosis code
  - Attach coversheet to relevant clinical documentation and submit by the deadline

Multiple HCCs may be supported by one medical record; thus attach all coversheets to the appropriate related record.

Request Process (continued)

STAGE 2

Submission (Plan Response)

- Medical Record Coversheet Contains
  - Enrollee demographic information
  - Stored risk adjustment data (HCC and ICD-9 codes)

Date(s) of service must be within the data collection period.

Request Process (continued)

STAGE 2

Receipt

The IVC

- Receive and log medical records and coversheets
- Conduct administrative and clinical checks

Medical Record Review Process

STAGE 3

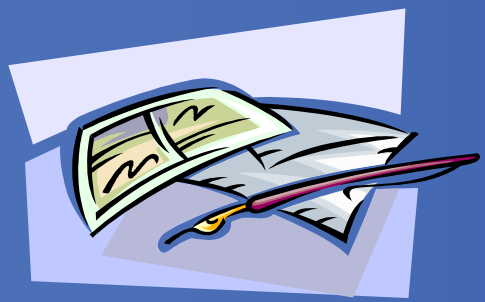
Good Documentation = Accurate Payment

Conduct Visit

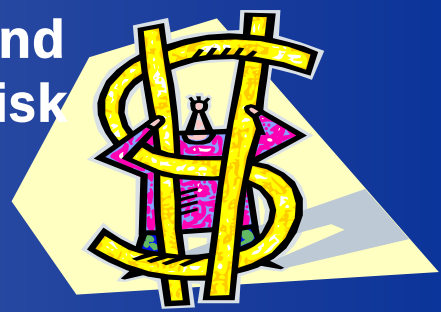
Assign Diagnosis Code

ICD-9 Code

Document Visit



Submit and Obtain Risk Adjusted Payment



Review Process (continued)

STAGE 3

All documentation submitted for medical record review must be:

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

Review Process
(continued)

STAGE 3

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*

Review Process (continued)

STAGE 3

Guidelines for Acceptable Documentation

- Coder able to determine that a patient evaluation was performed by physician
- ICD-9-CM code assigned in accordance with *ICD-9-CM Guidelines for Clinical Documentation*
  - *Inpatient*
  - *Outpatient*
- Physician signature and date of service present

Review Process
(continued)

STAGE 3

Hospital Outpatient and Physician Documentation

Problem Lists

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

Review Process
(continued)

STAGE 3

Hospital Outpatient and Physician Documentation

Diagnostic Radiology

- Indicates only impression or unconfirmed diagnosis
- The referral diagnosis is not a confirmed diagnosis; thus the HCC cannot be confirmed
- Referring physician/PCP usually reviews and documents condition

(Diagnostic radiology will not be accepted beginning with CY2006)

Review Process (continued)

STAGE 3

Acceptable Physician Signatures	
Hand-written signatures or initials, including credentials	• Mary C. Smith, MD; or MCS, MD
Signature stamp	• Must comply with state regulations for signature stamp authorization
Typed name	• Requires authentication by the respective provider
Electronic signature	• Requires authentication by the responsible provider (e.g., "Approved by," "Signed by," "Electronically signed by") • Must be password protected and used exclusively by the individual physician

Review Process
(continued)

STAGE 3

Several sources of medical records, and types of documentation are **not acceptable** for risk adjustment data validation.

1. Sources
2. Types
3. Diagnoses

Review Process
(continued)

STAGE 3

Unacceptable Sources of Care

- Skilled nursing facility (SNF)
- Freestanding ambulatory surgical center (ASC)
- Alternative data sources (e.g., pharmacy)
- Inappropriate physician extenders (e.g., nutritionist)
- Durable medical equipment (DME)

Review Process
(continued)

STAGE 3

Unacceptable Types of Documentation

- Superbill
- Physician-signed attestation
- List of patient conditions
- Un-interpreted diagnostic report
- Documentation for dates of service outside the data collection period

Review Process
(continued)

STAGE 3

Unacceptable Types of Diagnoses

- Probable
- Suspected
- Questionable
- Rule out
- Working

Review Process
(continued)

STAGE 3

- Certified coders abstract diagnosis codes and validate date(s) of service.
- Risk adjustment discrepancies identified when RAPS HCC differs from HCC assigned after validation.

Risk adjustment discrepancies effect the beneficiary risk score.

A second independent validation contractor (SVC) confirms all risk adjustment discrepancies.

Review Process (continued)

STAGE 3

Risk Adjustment Discrepancies

- Invalid Medical Records
  - Unacceptable provider type or source
  - Date of service outside of data collection period
  - Missing provider signature
- Missing Medical Records
  - Cannot assign ICD-9-CM code due to insufficient or incomplete documentation
  - No medical record was submitted to support the HCC
- Coding Discrepancies that change HCC assignment
  - ICD-9-CM code assigned after validation changes an original beneficiary HCC

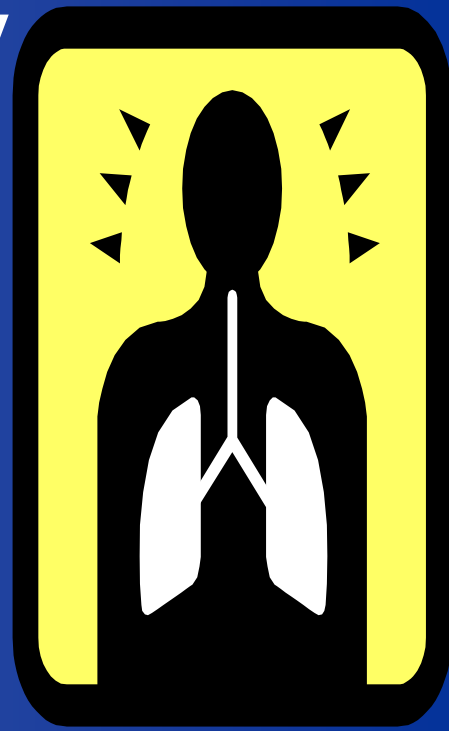
Review Process
(continued)

STAGE 3

Risk Adjustment Discrepancy

Reported Diagnostic Data:
482.4 Staphylococcal Pneumonia (HCC111, .693)

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



Data Validation Findings

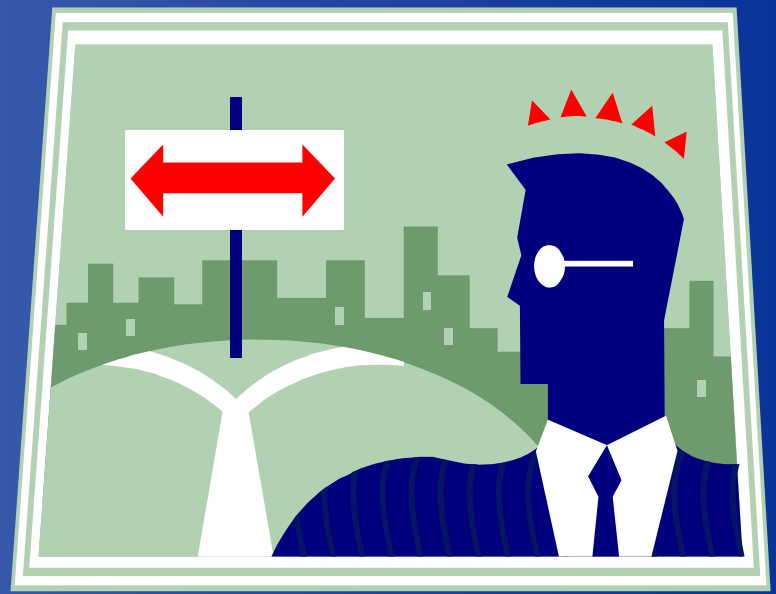
STAGE 4

- MA organization-specific findings shared with data validation participants.
  - May include response rate, risk adjustment discrepancy rate, and all beneficiaries with an HCC discrepancy.
- Summary findings are communicated to the MA industry.

Payment Adjustments

STAGE 5

Payment adjustment decisions are made by the CMS Administrator



Payment Adjustments (continued)

STAGE 5

- Corrects payments based on confirmed validation discrepancies
- Generally made at the beneficiary level
- Serve as the forum for appeals

Appeals

STAGE 6

Purpose: To provide MA organizations an opportunity to challenge a payment adjustment

- Implemented by the SVC
- Consistent with Medicare fee-for-service procedures
- MA organizations given 60 days to file a written appeals after being informed by CMS

Correct Payment

STAGE 7

- Risk adjusted payments are corrected based on the outcome of the appeals decision
- Appeals decisions either uphold or reverse payment adjustments
- All appeals decisions are final

Technical Assistance

- Available for MA organizations that require specific assistance with:
  - Data completeness
  - Data accuracy, and
  - Areas of concerns identified via validation
- CMS is considering other techniques to monitor risk adjustment data submissions and enhance communication efforts
- Contact CMS staff

Current Validation Activities

CY2003
• Currently in the appeals process phase • Payment adjustments based on appeals outcomes will take place during the 2003 final reconciliation
CY2004
• Anticipate release of validation findings in late August
CY2005
• Distributed initial notification letters to MA organizations selected for CY 2005 data validation

Recommendations & Lessons Learned to Date

- Establish and maintain communication with providers.
  - Establish communications with the providers prior to sending the medical record request
    - Send complete CMS request to providers
    - Follow up with physician's office after medical record request is sent
  - Determine provider expectations for sending medical records (e.g., advance payment)
  - Ensure medical record documentation is signed and dated by an appropriate provider type
  - Use newsletters and CMS training tools to inform physicians about risk adjustment

Recommendations & Lessons Learned to Date (continued)

- Plan accordingly—may require more effort to obtain medical records from:
  - Specialists
  - Non-contracted providers
  - Hospital outpatient or PCP settings
- Consider having the provider indicate the date of service and diagnosis code
- Enlist the involvement of in-house quality assurance staff/medical record reviewers to identify the “one best medical record’
- Submit complete medical records to CMS contractor as you receive them from providers

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

Thank You!

Verifying Risk Scores

Presented By:

Lockheed Martin
(formerly Aspen Systems Corporation)

Purpose

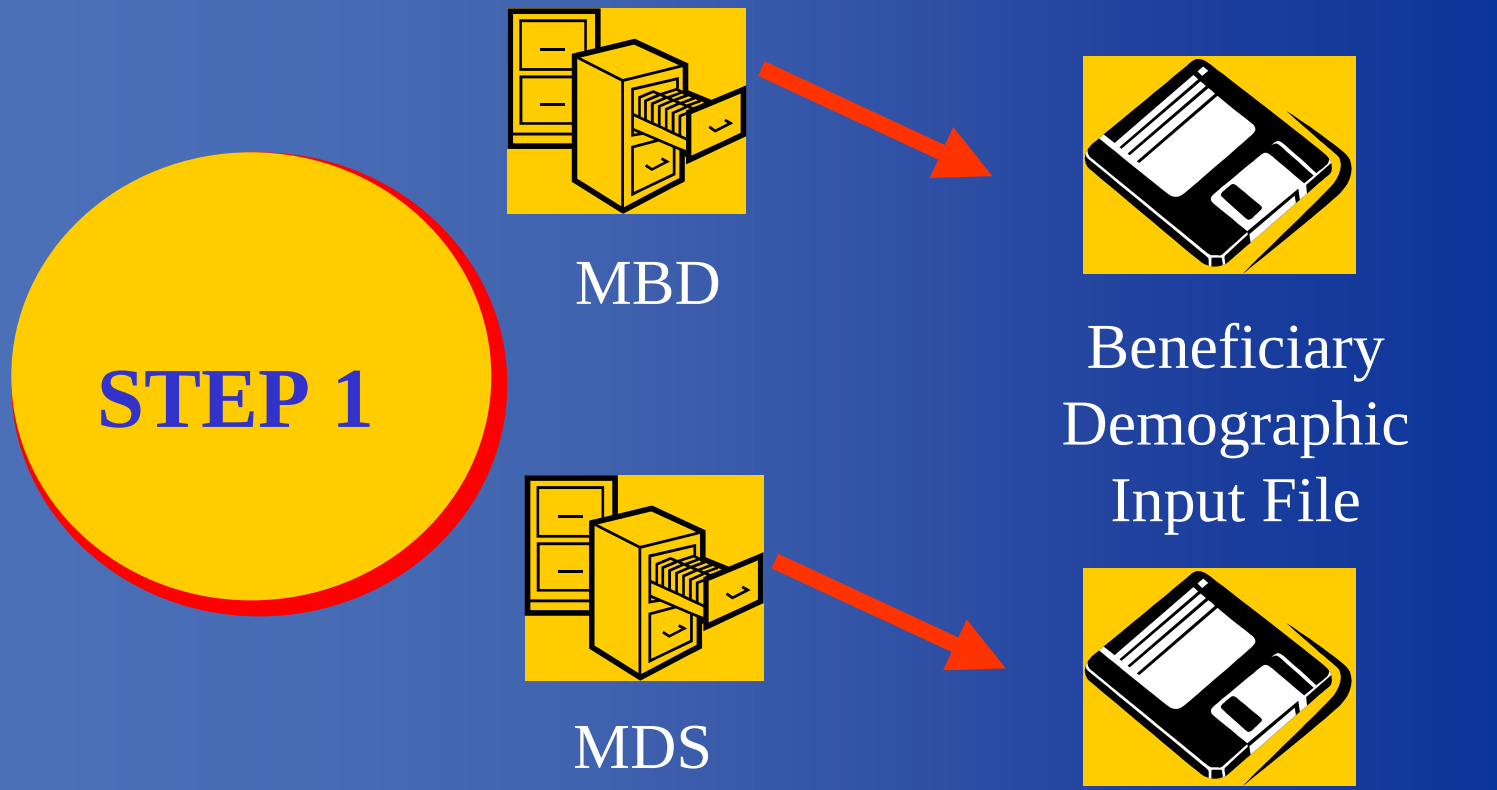
- This module explains the systems involved in the risk score calculations and introduces MA organizations to a variety of verification tools available.

Objectives

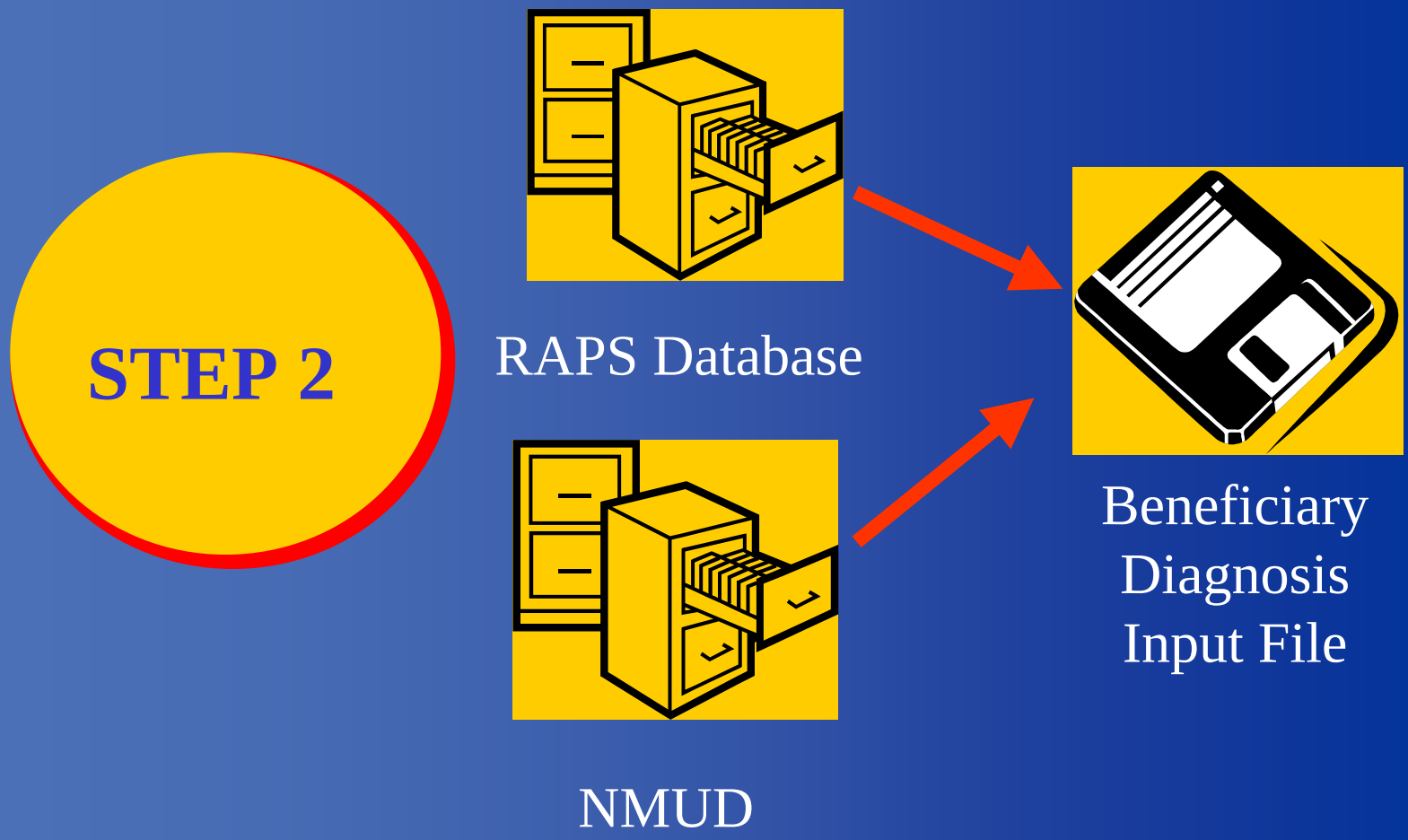
- Understand the systems and processes used to calculate the risk scores.
- Determine how an organization can use risk adjustment processing and management reports to ensure the accuracy of payment.
- Identify the components and uses of the Non-Drug and Drug Monthly Membership Reports.
- Explain the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

What is the Risk Score?

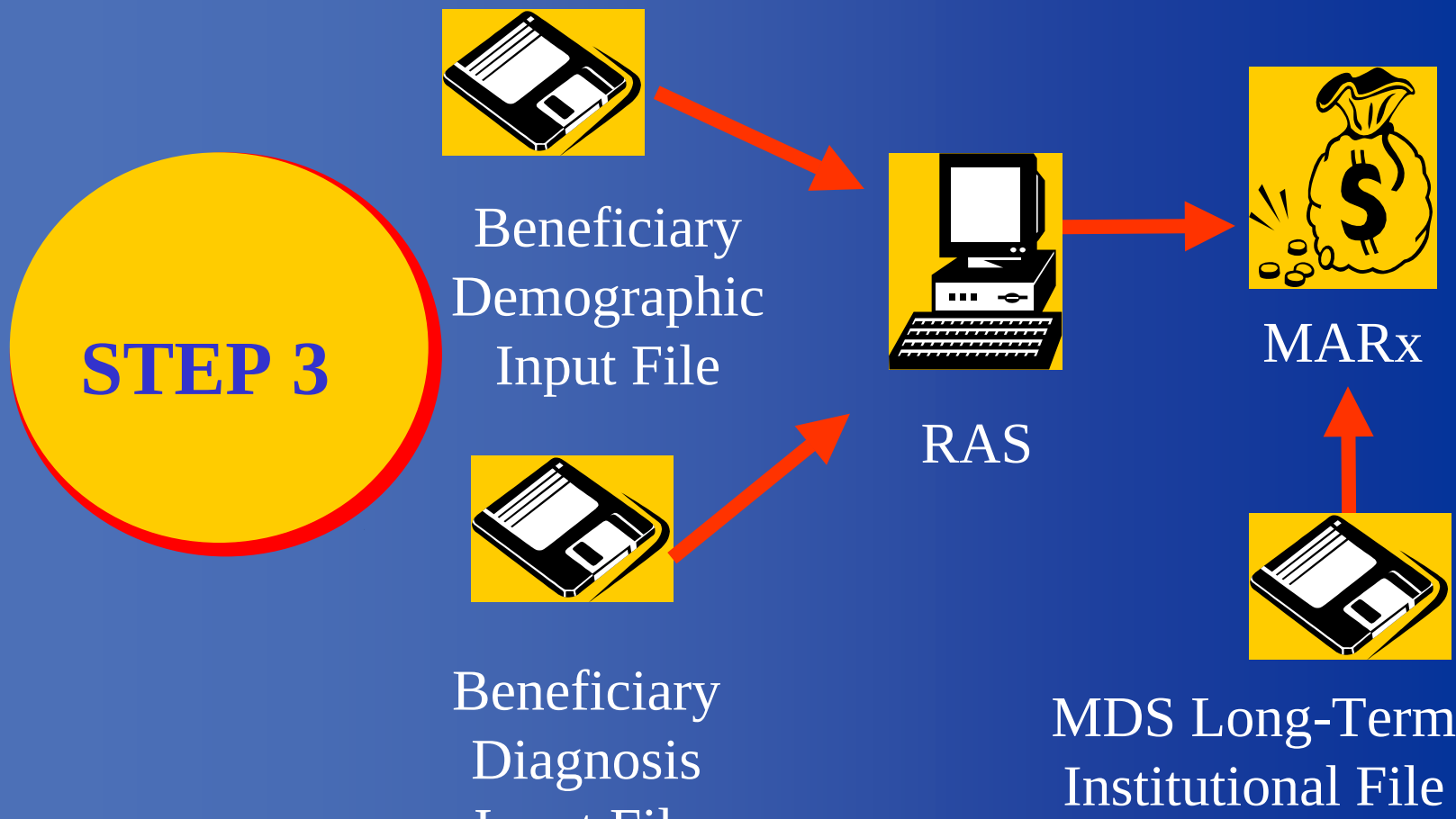
Calculation of Risk Scores



Calculation of Risk Scores
(continued)



Calculation of Risk Scores
(continued)



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 (Microsoft Access or Excel) of diagnoses for each enrollee.
- Transaction Error Report requires manual updates to a diagnosis file.

Database Components

HIC Number	Diagnosis	Date Submitted	Through Date

RAPS Management Reports

- RAPS Monthly Report
- RAPS Cumulative Plan Activity Report
- Available second day of the month
- Provide the total number of diagnoses stored in the CMS-HCC model

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 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

- Based on the CMS-HCC Risk Adjustment Model
- Contains Part A and B information

Monthly Membership Report - Drug

- Predicts drug costs other than Part A/B costs.
- Different diseases predict drug cost.
- Contains information on:
  - 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
35-37	Additional Indicators
38-47	Additional Risk Adjustment Indicators
48-76	Fields added to support the Part D Benefit

Risk Adjustment Model Output Reports

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

Risk Adjustment MOR – RAS RxHCC

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

Summary

- Identified data systems used to calculate risk scores.
- Reviewed how reports can be used to verify risk scores.

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

Thank You!