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# INTRODUCTION

## Purpose (Slide 3)

The purpose of this training is to provide participants who are new to risk adjustment the support needed to understand risk adjustment. This information will enable new participants to collect and submit risk adjustment data in accordance with Centers for Medicare & Medicaid Services (CMS) requirements.

## About This Training

| ICON KEY | |
|---|---|
| Example | |
| Reminder | |
| Resource | |
| Information Systems Track | |
| Quality & Compliance Track | |

This training is organized into 11 modules:

1. **Risk Adjustment Methodology**
   *Provides an understanding of the CMS-Hierarchical Condition Category (CMS-HCC) model and payment methodology.*
2. **Risk Adjustment Process Overview**
   *Identifies the systems and timeline for the risk adjustment data collection, submission, editing, and reporting processes.*
3. **Data Collection**
   *Describes the acceptable sources of risk adjustment data and data collection formats.*
4. **Data Submission**
   *Describes the acceptable formats for submitting risk adjustment data.*
5. **Diagnosis Codes & Risk Adjustment**
   *Provides important medical record documentation and coding guidelines related to risk adjustment.*
6. **Data Validation**
   *Identifies the data validation approach under the CMS-HCC model, including responding to CMS medical record requests.*
7. **Edits**
   *Identifies data integrity logic and error codes, error resolution, and suggestions for avoiding errors.*
8. **Medicare Beneficiary Database**
   *Identifies how Medicare+Choice (M+C) organizations can access and use the Medicare Beneficiary Database (MBD) to assist with their risk adjustment monitoring efforts.*
9. **Reports**
   *Describes risk adjustment reports, and defines their uses in monitoring data collection and submission processes.*
10. **Verifying Risk Scores**
    *Describes the process for calculating the risk score and its impact on risk adjustment payment.*
11. **The Three C's of Risk Adjustment**
    *Describes the importance of effective internal and external communication, collaboration, and coordination activities required to successfully manage the risk adjustment process.*

This participant guide is designed as the foundation of the training program. The presentation slides complement the participant guide, and both will be used extensively throughout this training. The participant binder includes the participant guide, presentation slides, a resource guide, and job aids. Collectively, these tools enhance the learning experience. Sections of the binder are described in Table A.

**TABLE A – TRAINING TOOLS**

| SECTION | DESCRIPTION |
|---|---|
| **Participant Guide** | • Detailed description of relevant risk adjustment information<br>• Case studies<br>• Exercises<br>• Answer keys |
| **Slides** | • Organized by module<br>• Printed two slides per page |
| **Resource Guide** | • List of common acronyms<br>• Risk adjustment instructions<br>• Contact information<br>• Other source documents |

## Future Use of This Participant Guide

The participant guide, slides, and resource guide are designed for use when participants return to their organizations. Additional copies of the training materials are available at www.mcoservice.com. CMS revises training materials, when required. An appropriate label will appear in the footer of the replacement pages affected by the revisions. Organizations are encouraged to register at www.mcoservice.com to receive notification for these revisions.

In addition to the participant guide, the Getting Started Video Program and the Physicians and Medicare+Choice Risk Adjustment CD will be used throughout this training to explain and reinforce key concepts.

## Audience (Slide 7)

This training program is designed for individuals new to the risk adjustment process. The primary audiences for this training are:

- Staff of new M+C organizations, capitated demonstration projects, Program for All-Inclusive Care of the Elderly (PACE) organizations, and specialty plans.
- Existing staff that were unable to attend previous training sessions.
- New staff at the existing organizations mentioned above.
- Third party submitters, contracted to submit data on behalf of M+C organizations.

Throughout this training, the term M+C organization includes all organizations listed in Table B.

**TABLE B – ORGANIZATION DESCRIPTION**

| NAME | DESCRIPTIONS |
|---|---|
| **M+C Organizations** | Organizations, including M+C organizations, private fee-for-service organizations, preferred provider organizations, and provider sponsored organizations that receive capitated payments to provide comprehensive medical services to Medicare beneficiaries. |
| **PACE** | Program of All Inclusive Care for the Elderly (PACE) that serves a community of frail and elderly individuals who are eligible for nursing home placement based on State Medicaid criteria. |
| **MSHO/ MnDHO** | Minnesota Senior Health Options (MSHO) and Minnesota Disability Health Options (MnDHO) are managed care products that integrate Medicare and Medicaid financing of acute and long-term care service delivery for dually eligible and Medicaid eligible physically disabled adults and elderly in a ten county area in Minnesota, including the Twin Cities. MnDHO is approved in Carver, Scott, Washington, Hennepin, Ramsey, Dakota, and Anoka counties. |
| **S/HMO** | Social Health Maintenance Organizations offer seniors an expanded care benefits package that may include prescription drugs and community-based services, which enables them to maintain independence and avoid nursing home placement. |
| **WPP** | Wisconsin Partnership Program (WPP) is a comprehensive program for Medicaid and Medicare beneficiaries who are elderly or disabled and meet the State's nursing home criteria. WPP integrates health and long-term support services, and includes home and community-based waiver services (HCBS), physician services, and all other medical care. |
| **EverCare** | The EverCare demonstration was developed to study the effect of providing enhanced primary and preventive care to Medicare beneficiaries who are long-stay nursing home residents. EverCare's model uses nurse practitioners as care providers and coordinators for the chronically ill and frail elderly living in nursing facilities. |
| **Capitated Demonstration Projects** | Capitated demonstration projects use alternative capitated financing to allow the provider to offer comprehensive medical service. |

This training is designed for the two specific audiences indicated in Table C.

**TABLE C – TRAINING TRACKS**

| TRACK | AUDIENCE |
|---|---|
| **Information Systems** | Information needs of systems/technology participants who are primarily responsible for the submission of risk adjustment data to CMS. |
| **Quality & Compliance** | Information needs of participants responsible for overall program management, compliance, and data collection. |

## Learning Objectives (Slides 11-12)

At the completion of this training, participants will be able to:

- Identify the CMS-HCC model and payment methodology.
- Identify the components of the risk adjustment process.
- Describe the requirements for data collection.
- Interpret key medical record documentation and coding guidelines.
- Determine the process for submitting data to CMS.
- Interpret the editing rules and steps in the error resolution process.
- Identify the type of information stored in the Medicare Beneficiary Database (MBD) and the effective use of the resource.
- Identify and interpret the reports available for risk adjustment monitoring.
- Understand the data validation approach under the CMS-HCC model.
- Understand how to verify risk scores.
- Recognize how effective internal and external communication, collaboration, and coordination can positively influence the risk adjustment process and payment.

The roles and contact information for important resources are provided in Table D.

**TABLE D – RISK ADJUSTMENT PROCESS POINTS OF CONTACT**

| ORGANIZATION | ROLE | CONTACT INFORMATION |
|---|---|---|
| **Centers for Medicare & Medicaid Services (CMS) Center for Beneficiary Choices** | Develops and implements the risk adjustment payment methodology for the Medicare+Choice program. Monitors plans to improve the quality of data | Cynthia Tudor<br>ctudor@cms.hhs.gov<br>Jeff Grant<br>jgrant1@cms.hhs.gov<br>Henri Thomas<br>hthomas@cms.hhs.gov<br>Jan Keys<br>jkeys@cms.hhs.gov |
| **CMS Regional Offices** | Provide assistance to M+C organizations and beneficiaries regarding various issues related to the Medicare program. | Contact your plan manager. |
| **Palmetto Government Benefits Administration (Palmetto GBA)** | Manages the Front-End Risk Adjustment System (FERAS) and the Customer Service and Support Center (CSSC). | www.mcoservice.com<br>mcoservice@palmettogba.com |
| **Aspen Systems Corporation** | Training Contractor responsible for risk adjustment training initiatives, including regional training programs and User Group meetings. | encounterdata@aspensys.com<br>Angela Reddix<br>areddix@aspensys.com<br>Ed Sommers<br>esommers@aspensys.comT |

# MODULE 1 – RISK ADJUSTMENT & THE CMS-HCC MODEL

## Purpose (Slide 2)

To provide information on risk adjustment for 2004 and 2005 and on changes to risk adjustment under the Medicare Prescription Drug, Modernization Act of 2003 (MMA) for 2006 and beyond.

## Objectives (Slides 3-4)

In completing this module, participants will:

- Review the history of risk adjustment.
- Understand changes to the Medicare Advantage (MA) program (formerly the Medicare+Choice program) payment methodology in 2004.
- Practice calculating risk scores.
- Discuss implementation of frailty adjuster for Program for All-Inclusive Care for the Elderly (PACE) and certain demonstrations.
- Learn about upcoming Centers for Medicare & Medicaid Services-Hierarchical Condition Category (CMS-HCC) model enhancements.
- Understand how the new ESRD model operates.
- Review some highlights of Medicare legislative reform in Titles I and II of the MMA.
- Learn how risk adjustment fits into Medicare reform.

**ICON KEY**

| | |
|---|---|
| Example | |
| Reminder | |
| Resource | |
| Information Systems Track | |
| Quality & Compliance Track | |

## 1.1 Risk Adjustment History (Slide 5-7)

The following is a list of key dates that have occurred during the process of implementing a risk adjustment payment methodology:

- August 1997- Balanced Budget Act of 1997 (BBA).
  - Created the Medicare+Choice (M+C) program.
  - Mandated risk adjustment payment methodology to improve payment accuracy.
  - Mandated the implementation of a frailty adjuster for the PACE organizations.

- August 1998.
  - Hospital inpatient encounter data collection began.

- January 2000 – Principal Inpatient Diagnostic Cost Group (PIP-DCG) Risk Adjustment Model Implemented.
  - Gradual phase-in of model based on principal inpatient diagnosis and demographic risk factors (age, sex, Medicaid status, and original reason for Medicare entitlement).
  - Implemented at 10 percent risk adjusted payment and 90 percent demographic payment for years 2000 – 2003.
  - Uses principal inpatient discharge diagnosis to assign an enrollee's risk group.

- December 2000- Benefits Improvement and Protection Act of 2000 (BIPA).
  - Established the current implementation schedule to achieve 100 percent risk adjusted payment in 2007.
  - Mandated the incorporation of ambulatory data into the CMS risk adjustment model.

- October 2000 – CMS began collecting physician data.

- April 2001 – CMS began collecting hospital outpatient data.

- May 2001 – Secretary of the Department of Health and Human Services suspended collection of ambulatory data to seek burden reduction for M+C organizations.

- January 2002 – CMS announced new risk adjustment data processing system—RAPS (Risk Adjustment Processing System).
  - Burden reduced by 95 percent.
  - Required data elements reduced from 50 to 5.
  - Required only the submission of those diagnoses needed for calculating risk adjusted payment.

- March 2002 – Draft CMS-Hierarchical Condition Category (CMS-HCC) Payment Model Selected.
  - New risk adjustment model needed to accommodate other types of data (hospital outpatient and physician).

See March 29, 2002 announcement letter at: http://www.cms.hhs.gov/healthplans/riskadj.

- July 2002 – CMS began collecting data for 2004 payment with the CMS-HCC model in the RAPS format.

- March 28, 2003 – Advanced Notice of Methodological Changes (i.e., 45-Day notice) published proposing the final CMS-HCC model, frailty adjuster, and elimination of the data lag.

- May 12, 2003 – Published final M+C rates for 2004 payment.
  - Announced final CMS-HCC risk adjustment model with the institutional, community and new enrollee models and the use of a frailty adjuster for PACE organizations and certain demonstrations.
  - Provided risk adjustment new enrollee factors.
  - Delayed implementation of ESRD model for M+C until 2005.
  - Described process for elimination of the data lag.

See 2004 45-Day Notice at: http://cms.hhs.gov/healthplans/rates/2004/45day.pdf
and May 12, 2003 Announcement of Rates for 2004 at: http://cms.hhs.gov/healthplans/rates/.

- Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) Enacted (P.L. 108-173).
  - Creates Medicare Advantage (MA) program to replace M+C program.
  - Many M+C provisions are retained.
  - Creates drug benefit to begin in 2006.
  - Establishes bidding methodology for MA organizations and drug plans in 2006.
  - Bidding methodology uses risk adjustment county level risk adjustment factors for new bid and benchmark calculations.

- January 16, 2004-New ratebook for 2004 published.
  - Revised ratebook took into account changes from MMA—adding 4th prong to the "highest of" methodology for 2004 and modifying the minimum percentage increase rate for 2004 and beyond.

📖 See March 16, 2004 cover letter regarding revised MA rates at: http://www.cms.hhs.gov/healthplans/rates/2004ma/cover.pdf.

- March 26, 2004- Advanced Notice of Methodological Changes for 2005 (i.e., 45-Day notice) published Proposes revised MA payment methodology—based on MMA, ratebook transitions to "highest of 2".
  - Proposes End-Stage Renal Disease (ESRD) model for implementation in 2005.
  - Proposes new enrollee factors for ESRD model.

📖 See 2005 45-Day Notice for additional details at: http://cms.hhs.gov/healthplans/rates/2005/45day.pdf.

- April 2004-Announcement of draft diagnoses to be collected for drug risk adjustment model for payment beginning in 2006.

- May 10, 2004-Announcement of Rates for 2005.
  - Will announce MA county capitation rates.
  - Will announce final ESRD CMS-HCC risk adjustment model.

## 1.2 County Ratebook Calculations

Since the inception of the managed care program, capitated payments to plans have been set using county-level rates for aged and disabled beneficiaries and state-level rates for beneficiaries with end-stage renal disease. The BBA mandated that the 1997 pre-BBA ratebook was the basis for the new M+C ratebook. The MMA "relinked" county payment rates to local fee-for-service rates.

### 1.2.1 Characteristics of the Managed Care Ratebook Prior to 1997

- Managed care capitated rates were based on average cost experience found in a county for fee-for-service Medicare, using a five year moving average of the county's share of the national average costs.

- County average per capita costs were standardized according to the average demographics observed for beneficiaries in that county—age, sex, institutional status, Medicaid eligibility, and beginning in 1995, working aged status.

- Average county fee-for-service costs were discounted by 5 percent due to cost efficiencies of managed care health management.

### 1.2.2 County Ratebook Calculation After the BBA Before MMA

In 1997, the BBA changed the method for computing the county ratebook. This modification was done to meet a number of policy objectives, including a desire to create a minimum rate for traditionally low rate counties, and a flattening of the variability of county rates by basing these rates in part on local factors and in part on national experience. This formula broke the direct link between managed care payment rates and fee-for-service spending at the county level. For every year between 1998 and 2003, the M+C rates for each county were defined as the maximum of three possible categories: the blended capitation rate, minimum "floor" amount, or minimum 2 percent increase. Table 1A describes the three possible categories in the county ratebook.

**TABLE 1A – COUNTY RATEBOOK**

| BLENDED RATES | FLOOR AMOUNTS | MINIMUM 2% |
|---|---|---|
| • Blended rates are a combination of national average rates and local rates.<br>• Under the BBA, the "local" rate is the 1997 county rate (tied to county fee-for-service costs) updated each subsequent year by a national factor—the national M+C growth percentage.<br>• The national rate is a weighted average of all local rates.<br>• The blend percentage for 2003 and beyond is 50%. | • Floor amounts were set by the BBA.<br>• Floor rates are increased annually by the national M+C growth percentage. | • The minimal percentage update amount has generally been an increase of 2% over the M+C rate in the county for the prior year. |

Once we determined which of the 3 rates was the highest in each county, a budget neutrality factor was applied to the blended rates. The budget neutrality-adjusted blended rates must be equal to aggregate national Part A and B estimated payments (using the national per capita costs trended 1997 ratebook). If the rates are not equal, then the rates are reduced for blended rate counties in order to attain budget neutrality in those counties. In 2004, there are no blended rate counties.

### 1.2.3 2004 MA Payment Rates (Slides 8-9)

With the enactment of the MMA in December 2003, the original 2004 payment methodology changed and required a recalculation of the 2004 ratebook. For 2004, the MMA mandated that a fourth amount, 100 percent of projected fee-for-service Medicare costs (with adjustments to exclude direct medical education and include a VA/DOD adjustment) be added to the payment methodology. With the addition of this 4$^{th}$ prong to the MA payment methodology, the formula reconnects the link between managed care payment rates and fee-for-service spending at the county level.

In addition, for 2004, the MMA modifies the methodology for calculating the minimum update rate (2 percent in 2003) to be the larger of:

- 102 percent of the previous year's rate.

or

- An increase by the Medicare growth percentage over the previous year's rate, with no adjustment to this rate for over-under projection for years before 2004.

The blended rate formula (combination of the national average and local rates) is calculated as it was under the M+C payment methodology with one exception. The MMA eliminated the budget neutrality requirement for the ratebook for 2004 and subsequent years. (This has no effect on budget neutrality for risk adjustment.) In addition, the minimum floor amount is calculated in the same manner as it was in the M+C payment methodology.

### 1.2.4 Impact of MMA on MA Organizations (Slide 10)

The MA payment methodology changes mandated by the MMA have resulted in immediately improved payments to MA organizations. While all plans are positively impacted, about **34** organizations are receiving a greater than 9 percent increase in payment in comparison to pre-MMA annual 2004 ratebook. Similarly, an additional **50** organizations are receiving between a 5-9 percent increase in payment.

### 1.2.5 MA Payment Rates in 2005 and Beyond (Slide 11)

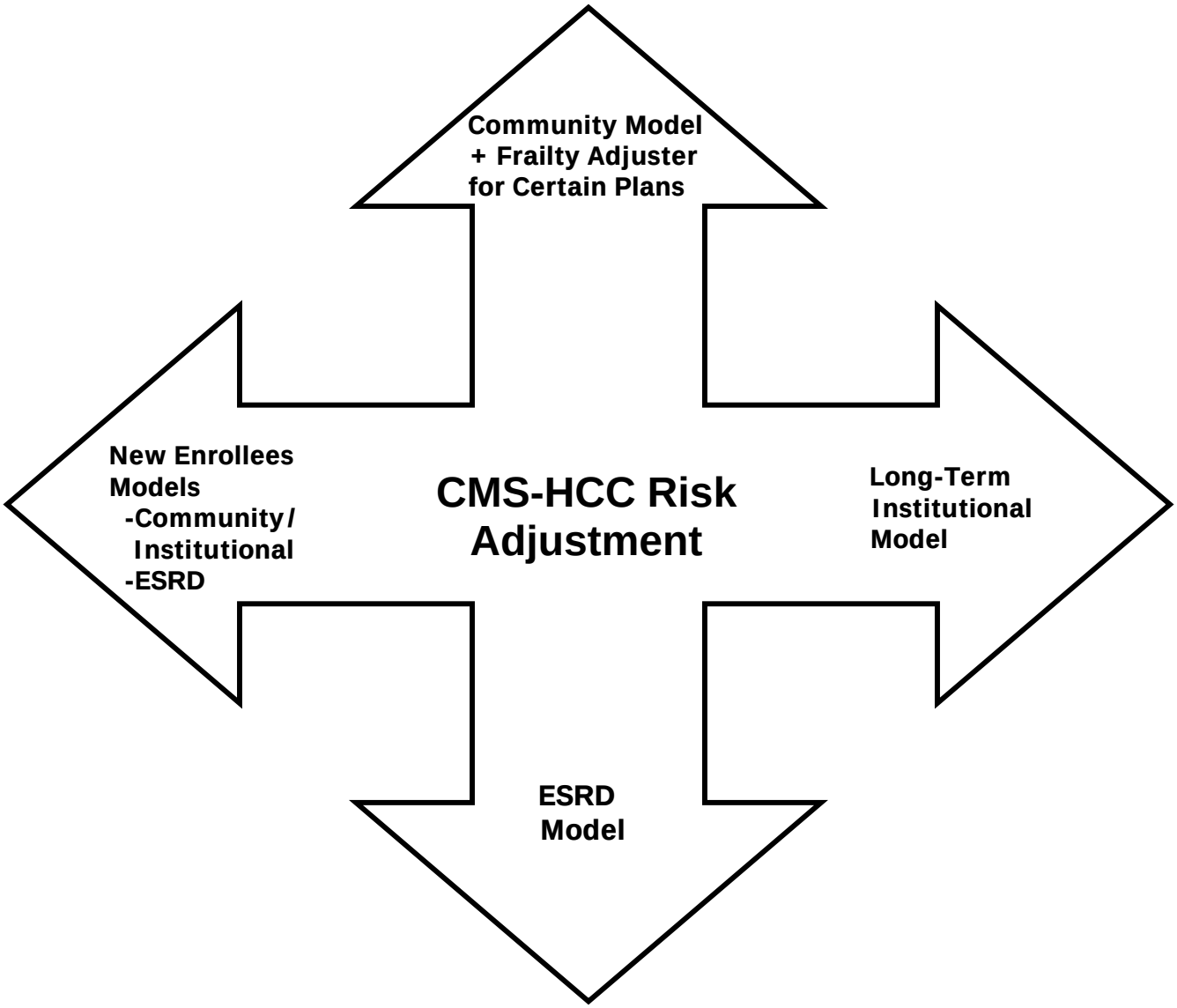
For 2005 and succeeding years, the MA county payment rate is the minimum update rate, except in those years when CMS recalculates the 100 percent fee-for-service rate. (For years after 2004, CMS is required to recalculate the 100 percent of the fee-for-service Medicare costs at least every 3 years.) In those years, the MA county payment rate becomes the higher of the minimum update rate and the 100 percent fee-for-service rate.

## 1.3 CMS-HCC Risk Adjustment Model (Slides 12-13)

In response to a statutory mandate, CMS selected a new risk adjustment model that incorporated diagnoses from multiple sites of care rather than having a model that only uses principle inpatient hospital diagnoses as with the PIP-DCG model. The model is a revision of the HCC model, originally developed by Health Economics Research, Inc. The goal was to select a clinically sound risk adjustment model that improved payment accuracy while minimizing the administrative burden on M+C organizations. The CMS-HCC model operates by categorizing *International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM)* codes into separate groups of clinically related codes, e.g., diabetes, cancer, ischemic heart disease, infections, etc. that have similar cost implications. In order to improve payment accuracy further, CMS has developed separate models for different populations who have different cost patterns than the general Medicare population. There is a community model, long-term institutional and ESRD model, and new enrollee models for the community/institutional populations and the ESRD population. Figure 1A illustrates the CMS-HCC risk adjustment model.

See the 2004 Preliminary Notice (released March 28, 2003) and the Medicare+Choice Rates (released May 12, 2003) for a full description of the CMS-HCC model, as well as the risk adjustment factors and hierarchies in the model. These notices are available at: http://cms.hhs.gov/healthplans/rates/.

**Figure 1A – CMS-HCC Risk Adjustment**



**Characteristics of the CMS-HCC Model**

***Selected Significant Disease (SSD) Model***
- Serious manifestations of a condition are considered rather than all levels of severity of a condition.
- Model is additive.
- Includes most body systems and conditions with high prevalence among the frail elderly.

***Prospective***
- Uses diagnostic information from a base year to predict total costs for the following year.

***Site Neutral***
- Model does not distinguish payments based on a site of care.

***Diagnostic Sources***
- Model recognizes diagnoses from inpatient hospital, hospital outpatient and physician settings.

***Considers Multiple Chronic Diseases***
- Risk adjusted payment is based on the assignment of diagnoses to disease groups, known as HCCs.
- Model is most heavily influenced by Medicare costs associated with chronic diseases**.**

***Includes Disease Interactions and Hierarchies***
- Interactions allow for additive factors based on chronic conditions and disabled status to improve payment accuracy.
- Hierarchies allow for payment based on the most serious conditions when less serious conditions also exist.

***Includes Demographic Factors***
- Like the PIP-DCG model, this model includes 4 demographic factors: age, sex, Medicaid eligibility and original reason for disability status.
- These factors are typically measured as of the data collection period.

**Frailty Adjuster**
- Frailty add-on is used for PACE and certain demonstration plans with frail elderly population in the community.

***Separate community and institutional models account for higher treatment costs of similarly-ill community residents***
- Long-term institutionalized defined as enrollees with more than 90 days in an institution.
- Institutional model is not based on institutional factor demographic-only model.
- Community and institutional models both includes 70 disease groups.

***Separate ESRD CMS-HCC Model***
- Three-part model to address fluctuating treatment costs for ESRD enrollees over time.
- The model includes specific payments for individuals with dialysis, transplant, and functioning graft statuses, each with different associated payment amounts.
- The ESRD model includes 67 disease groups.

## 1.3.1 Demographic Factors in Risk Adjustment (Slides 14-15)

As a part of the risk adjustment payment calculation, a risk score for a beneficiary must be calculated. The risk score uses five demographic factors in calculating the risk score under the CMS-HCC model, including age, sex, Medicaid status, disability and original reason for Medicare entitlement (i.e., disability). Each of these characteristics was part of the PIP-DCG calculation as well.

***Age and Sex***: Based upon the enrollee's age and sex, risk adjusted demographic factors are assigned for the calculation of the enrollee's risk factor.

In the past, the model has considered a person's increasing age by placing them into age groups during a given year by either switching the payment group during the year in the demographic payment model or by paying a weighted average of the 2 groups each month to avoid having to switch age groups during the year (as with the PIP-DCG model). Under the CMS-HCC model CMS will now base payments for the entire payment year upon the age an enrollee attains as of **February 1st** of each year. This change will help simplify the calculation of the risk score for plans.

See Attachment B for the complete list of age and sex risk factors for the CMS-HCC model and see Attachment G for the draft list of age and sex factors for the ESRD model.

***Medicaid***: The Medicaid status of an enrollee will continue to be part of the risk adjusted payment calculation under the CMS-HCC model, but only for individuals residing in the community.

Medicaid status is defined as at least one month of Medicaid eligibility during the data collection period (which is typically defined as the year prior to payment). Medicaid status will be handled the same way for the dialysis and functioning graft subparts of the ESRD model as it is described about above for the community model. New enrollees within the community and ESRD models with a Medicaid status will be identified for each month in the payment year and paid at reconciliation.

An individual's Medicaid status will be identified using the Medicare Beneficiary Database (MBD). The source of the Medicaid designation is either from the health plan or from third party payor files.

See Attachment D for the complete list of Medicaid factors for 2004.

***Disabled Status***: Under the CMS-HCC model, additional payments are made for disabled individuals residing in the community. The disabled factors for enrollees under 65 years-old are labeled as "disabled" and those over 65 years-old are labeled as "aged". Disabled status is identified by using the Medicare Beneficiary Database (MBD).

***Original Reason for Medicare Entitlement***: The factors labeled "originally disabled" apply to enrollees that are 65 years-old or over who were originally entitled for Medicare due to disability.

### 1.3.2 Disease Groups/HCCs (Slide 16)

Disease groups contain major diseases and are broadly organized into body systems. For risk adjustment purposes, we will refer to disease groups as HCCs. The HCCs consist of the ICD-9-CM diagnosis codes that are submitted during a data collection period. Beneficiary diagnoses are assigned to an HCC. Only selected diagnosis codes are included in the CMS-HCC model. There are 70 distinct disease groups for payment for community and for long term institutionalized residents. The ESRD model has approximately 67 disease groups depending on the subpart of the model. Each disease group has an associated coefficient that represents the relative Medicare costs of treatment for that particular disease. The CMS-HCC model is structured so that each disease group contributes its incremental predicted cost to the total payment amount. The model is heavily influenced by the Medicare costs associated with chronic diseases.

**Example: 1**

| DISEASE GROUP/HCC | DESCRIPTION |
|---|---|
| HCC 92 | Specified Heart Arrhythmia |
| HCC 158 | Hip Fracture/Dislocation |

CMS's payment for an enrollee with the above conditions will reflect payment increments for each condition. This is a characteristic of the additive nature of the CMS-HCC model.

For a complete listing of all Disease Groups/HCCs for the CMS-HCC model, see Attachment C.
For a complete listing of all Disease Groups/HCCs for the ESRD model, see Attachment G.

**Example: 2**

Below is an example of the different HCC factors for community, long-term institutional and ESRD enrollees.

| DISEASE GROUP | DESCRIPTION | COMMUNITY FACTOR | INSTITUTIONAL FACTOR | ESRD FACTOR |
|---|---|---|---|---|
| HCC 1 | HIV/AIDS | 0.685 | 1.344 | 0.174 |
| HCC 8 | Lung, Upper Digestive Tract, and Other Severe Cancers | 1.464 | 0.540 | 0.161 |

See Attachment B for the complete list of community and institutional payment factors for the CMS-HCC model.
See Attachment G for the draft list of dialysis, transplant, and functioning graft payment factors for the ESRD model.

### 1.3.3 Disease Interactions

Certain combinations of coexisting conditions are associated with an additional increase in overall medical costs. The CMS-HCC model recognizes these higher costs through incorporating payments for disease interactions.

There are six disease interactions in the community model, two in the institutional model, and none in the ESRD model. Examples of the disease interactions include a two-way combination of diabetes mellitus (DM) and congestive heart failure (CHF) or a three-way combination of chronic obstructive pulmonary disease (COPD), cerebrovascular disease (CVD), and coronary artery disease (CAD).

In calculating this part of the risk score for an individual, the individual score for each HCC is added and then the disease interaction score is added. In the example below, the risk adjusted payment would include an additional factor when an enrollee has both diabetes mellitus and congestive heart failure.

**Example: 3**

Two-disease Interaction for Community-Based Enrollee (with two HCCs and an additional interaction factor to be added).

Factor 1: Diabetes Mellitus (DM), HCC15 = 0.764 factor
Factor 2: Congestive Heart Failure (CHF), HCC80 = 0.417 factor
Factor 3: Interaction: DM*CHF = 0.253 factor

Risk Score = (demographics) + 0.764 + 0.417 + 0.253

In this case, the enrollee receives an additional interaction factor reflecting higher expected costs from having both diseases above the cost of having each disease separately.

### 1.3.4 Disabled/Disease Interactions

Another type of interaction accounted for in the CMS-HCC model involves certain diseases and the disabled status for an enrollee. There are 5 disabled/disease interactions in the community model and in the ESRD model and none in the institutional model.

Below is an example of an individual who is disabled and has been diagnosed with rheumatoid arthritis and an opportunistic infection.

**Example: 4**

Disabled/Disease Interaction for ESRD Enrollee who is Disabled (with two HCCs and an additional interaction factor to be added)

Factor 1: Rheumatoid Arthritis, HCC38 = 0.092 factor
Factor 2: Opportunistic Infections, HCC5 = 0.070 factor
Factor 2: Disabled * Opportunistic Infections (D_HCC5) = 0.083 factor

Risk Score = (demographics) + 0.092 + 0.070+ 0.083

See Attachment B for the complete list of all HCCs and interactions in the community model.
See Attachment G for the complete list of all HCCs and interactions in the ESRD model.

### 1.3.5 Disease Hierarchies (Slide 17)

Finally, the CMS-HCC model incorporates disease hierarchies. The purpose of disease hierarchies is to ensure that diagnoses in a given hierarchy are ranked by cost and are clinically related. In addition, they take into account the costs of lower cost diseases in order to mitigate code proliferation. These hierarchies are used to provide payments for only the most severe manifestation of a disease, when

diagnoses for less severe manifestations of a disease are also present in the beneficiary during the data collection year. For example, an individual with diabetes that progresses over a year from having no complications (HCC 19) to having acute complications (HCC 17) would trigger the payments for HCC 17 but not for HCC 19. (Note that payments for HCC 17 are higher than for HCC 19.)

**Example: 5**

| CMS-HCC DISEASE HIERARCHIES | | | |
|---|---|---|---|
| **If the Disease Group is Listed in This Column...** | | **...Then Drop the Associated Disease Group(s) Listed in This Column** | |
| **HCC** | **Disease Group Label** | **HCC** | **Disease Group Label** |
| 9 | Lymphatic, head & neck, brain & other major cancers | 10 | Breast, prostate, colorectal & other cancers & tumors |

See Attachments C and G for the complete list of disease hierarchies for the CMS-HCC and ESRD models.

## 1.4 Beneficiary Disease Profile Data

CMS uses diagnoses from either Medicare fee-for-service or from RAPS for determining the HCCs for an enrollee. Medicare fee-for-service data is utilized for risk adjusted payment when an enrollee joins a MA organization (or PACE/demonstration) after opting-out of traditional Medicare fee-for-service coverage. That is, if an enrollee enrolls in January of a calendar year in a MA organization, CMS will use the last 12-months of fee-for-service data within the data collection period (from both Medicare Parts A and B) to obtain diagnoses. If data for a person have been submitted via RAPS, those data are also used in calculating the risk score for the person.

## 1.5 Components of the Risk Score

The risk score used in calculating payments under the CMS-HCC model includes demographics as part of the risk model as well as different disease groups or HCCs. The model allows for the recognition of coexisting diseases when calculating payments by recognizing multiple chronic conditions that the beneficiary has. Interactions factors are used to account for combinations of conditions with expected costs that are higher. For example, multiple, coexisting diseases may cause additional complications and result in higher costs. Hierarchies are imposed to provide payments only for the most severe manifestation of a certain disease and to reduce coding proliferation.

### 1.5.1 Calculating Risk Scores (Slide 21)

See Attachment A for Examples and Answers to Exercise for Practice on Calculating Risk Scores.

## 1.6 Calculating Payments (Slides 22-24)

Prior to 2000, M+C payments were computed using only demographic characteristics. The demographic factors were age, sex, Medicaid, and institutional status. The demographic factors were then multiplied separately by the Part A and Part B county rates (separately for aged versus disabled beneficiaries) and then added. M+C organizations were paid 100 percent of this rate. Per statutory mandate, CMS was required to begin using a risk adjustment payment methodology as a part of its calculation of payment to M+C plans beginning in January 2000.

The implementation of risk adjusted payments has involved a transition based upon a blended payment. This blended payment includes a risk adjusted payment component and a demographic payment component. For 2000 through 2003, 10 percent of the payment is risk adjusted using the PIP-DCG model and 90 percent of the payment is based on the traditional demographic payment. In 2004, 30 percent of the payment is based on the CMS-HCC model, and 70 percent is based on the demographic payment. **(See Section 1.13 for a complete listing of the transition payment blends for all types of plan.)**

As shown in Figure 1B, the payment calculation has two steps. The first step is to determine the demographic portion of the payment. This involves multiplying the Part A and Part B county rates by the demographic factor for each individual. The second step is to determine the risk adjusted portion of the payment. This involves calculating a risk factor for an individual based on demographic characteristics within the risk model (i.e., age, gender, Medicaid status, original reason for Medicare entitlement) and any applicable HCCs for an individual. The total Part A and Part B county rates are multiplied by a rescaling factor (which is determined using the CMS-HCC model) to derive the county rate for risk adjustment. This amount is then multiplied by the individual's CMS-HCC risk factor. The demographic portion and risk adjusted portion are then added to yield the total payment amount.

Different risk adjustment models have been developed for community residents (which include beneficiaries with short-term institutional stays) and long-term institutional residents. There is a new ESRD model for 2005. Also, there are new enrollee models for community/institutional populations and for different subgroups of new enrollees with ESRD. In 2005, 50 percent of payments will be calculated using demographic information only, and 50 percent will be calculated using the beneficiary's risk score. However, payments for ESRD enrollees will be based on a fully implemented ESRD model.

📖 For a complete explanation of the derivation of the demographic and risk adjusted ratebook, see the following: http://cms.hhs.gov/manuals/116_mmc/mc86toc.asp.

📖 See Attachment A for payment calculation example.

### 1.6.1 Risk Ratebook (Slide 26)

Once the demographic rates are determined, a rescaling factor is used to convert the demographic ratebook to get the risk adjusted rate for each county (referred to as restandardizing the ratebook). The rescaling factor is defined as the county rate properly standardized to the new risk adjustment factors divided by the demographic county rate. Two adjustments are included in the 2004 rescaling factor. The first is the fee-for-service normalization factor and the second is an adjustment to make risk adjustment budget neutral (distinct from the budget neutrality for rate-setting discussed above).

#### 1.6.1.1 Fee-for-Service Normalization

The purpose of fee-for-service normalization is to adjust the restandardized ratebook to the appropriate denominator for the payment year. The number represents the extent to which the risk score in fee-for-service has been inflated as a result of coding practices. Every year there are shifts in the Medicare population. Generally, later data tends to reflect more precise coding. These changes must be accounted for using an adjustment to the rescaling factor. Therefore, a change to the ratebook to adjust for coding patterns is necessary. The adjustment for CY2004 is 1/1.05 or .9524. The adjustment for 2005 will be announced in the May 10, 2005 Announcement.

#### 1.6.1.2 Adjustment for Budget Neutrality (Slide 27)

While risk adjustment (without the implementation of budget neutrality) would reduce aggregate payments to the MA organizations, budget neutrality redistributes these payments as a constant percentage to organizations affected by risk adjustment (including MA organizations, PACE, and certain demonstrations). In other words, under budget neutrality, savings that would have accrued to the Medicare Trust Fund would instead be redistributed among MA organizations. The budget neutrality proportion is calculated as the difference between payments under 100 percent of the risk adjustment method (i.e., under the CMS-HCC model) versus payment under 100 percent of the demographic only method.

The initial budget neutrality factor (based on only about 94 organizations that submitted sufficient data for an estimate in 2003) was 16.3 percent. Then, in early 2004 we re-estimated budget neutrality based on data submitted for actual payments in 2004 and the new ratebooks under the MMA. As a result, the budget neutrality estimate was lowered to 8.3 percent, roughly half of the prior estimate. The lowered estimate was a result of additional quality and quantity of data and ratebook changes (from pre- and post- MMA).

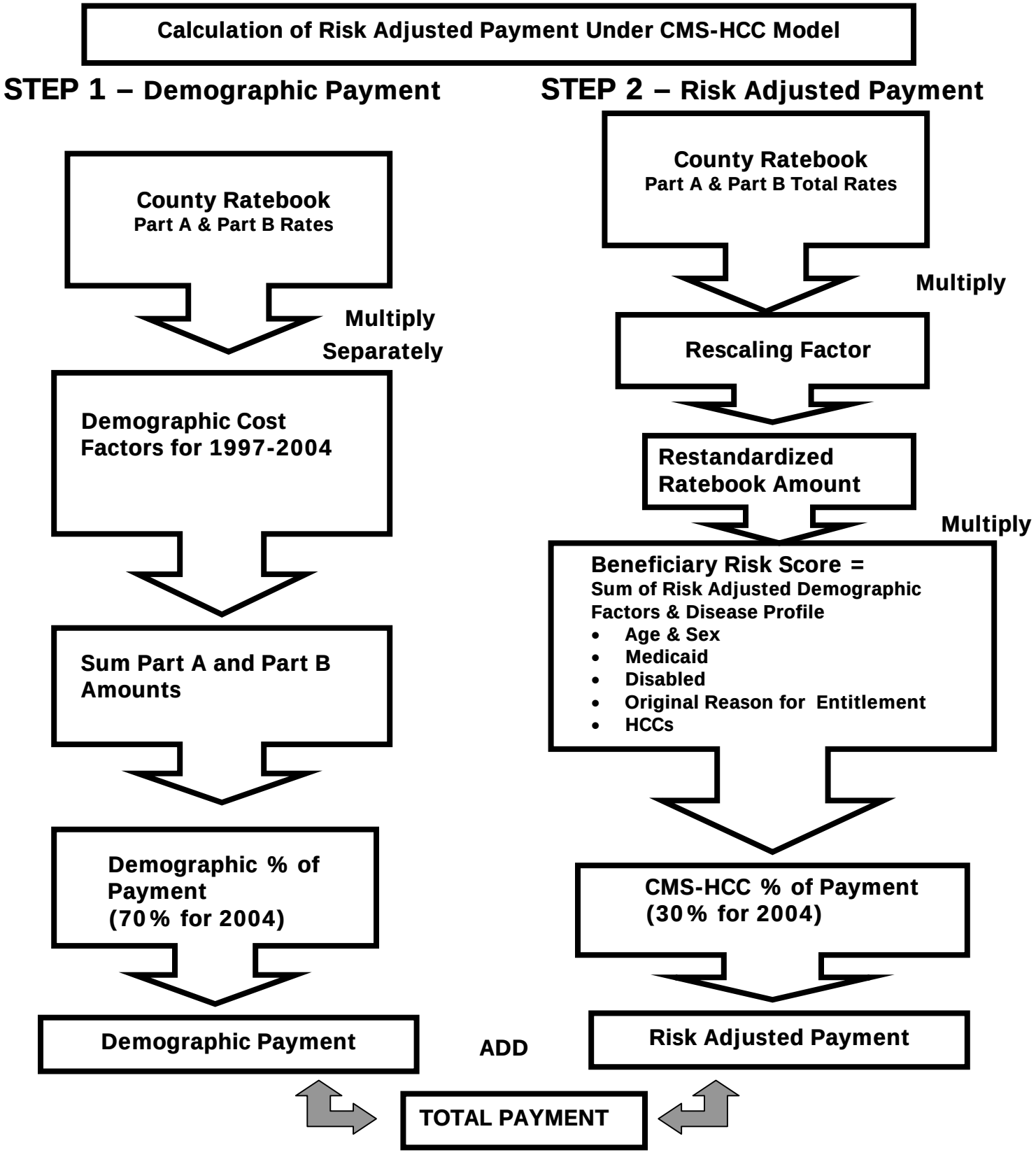
In 2005, risk adjustment will continue to be implemented in a budget neutral manner. CMS will estimate the amount of adjustment to be incorporated into the rescaling factor, which for 2005 redistributes estimated payment reductions that would result if risk adjustment were implemented without budget neutrality. Because the budget neutrality estimate is subject to change, CMS is considering technical improvements to the budget neutrality estimation methodology in order to improve the accuracy of payments based on this estimate. CMS announced a proposal in the Advanced Notice of Methodological Changes for Calendar Year 2005 Medicare Advantage (MA) payment rates (published on March 26, 2004) to use a trend analysis to adjust the estimate.

This approach would adjust our current methodology to consider the effect of certain factors. These factors include: changes in average organization level risk scores due to death and disenrollment; the effect of using non-lagged risk adjustment data in the budget neutrality estimate; and the effect of the increase in risk scores because data are submitted for a data collection period (a 12 month period) after the budget neutrality estimate has been calculated for that year. (**Note:** non-lagged data is defined as using diagnoses from the calendar year immediately preceding the payment year, while lagged data moves the data collection period back 6 months (to a July to June data collection period).) This approach would require analyzing the trends in these factors and adjusting for them. Some of the factors would have the effect of lowering the budget neutrality estimate (i.e. risk scores for a plan would rise because more data were submitted), while others would raise the estimate (risk scores for a plan would be lower due to deaths and disenrollment).

MA organizations will be required to reflect budget neutrality payments for 2005 in their 2005 Adjusted Community Rate Proposals (ACRPs). The ACRPs for 2005 are due by statute in September 2004. MA organizations will see payments that reflect this budget neutral approach in the beneficiary-level amounts that are shown on the Monthly Membership Report (MMR.) The adjustment to budget neutrality will be announced in the May 10, 2004 Announcement.

For a discussion of these issues refer to the May 12, 2003 Announcement and the March 26, 2004 45-day Notice, available at: http://cms.hhs.gov/healthplans/rates.

Figure 1B – Calculation of Risk Adjusted Payment Under CMS-HCC Model



**Note:** Until the CMS-HCC is implemented at 100 percent in 2007, a demographic payment as calculated above will continue to be part of the risk adjusted payment (Except for ESRD).

📖 The county ratebook for 2004 payment is available at: http://cms.hhs.gov/healthplans/rates/.

### 1.6.1.3 Impact on Payment of 90/10% Versus 70/30% (Slide 28)

It is noteworthy that the CMS-HCC model implemented at a 70/30 percent payment blend reflects more of the variation in enrollee health status than the PIP-DCG model implemented at a 90/10 percent payment blend. This better measurement of health status results in more variable payment impacts. On average, organizations with less healthy enrollees have more positive payment impacts than the organizations with a healthier population.

### 1.6.1.4 The Impact of MMA Rate Changes With and Without Budget Neutrality (Slide 29)

Based on the heath status of M+C enrollees in 2003 (with the plan average risk score being .87), we would have expected that with the transition to the CMS-HCC model (affecting 30 percent of payment) would have had a greater impact on plans. However, the MMA significantly increased payment rates. Budget neutrality further increased the payment rates. As such, almost no plans had negative payment impacts in 2004.

## 1.7 New Enrollee Factors

New enrollee factors have been developed for the CMS-HCC model. The model includes factors for different age and gender combinations by Medicaid status and the original reason for Medicare entitlement. If a beneficiary has less than 12 months of enrollment in Part B during the data collection period, then he/she will be assigned a new enrollee factor. During the payment year, a default factor, which is defined as a new enrollee factor, will also be assigned to any beneficiary whose risk score is not available. In this case, the beneficiary's correct risk score will be determined during the next reconciliation.

📖 New enrollee factors for 2004 are available at:
http://cms.hhs.gov/healthplans/rates/2004/cover-exhibit-3.asp.

## 1.8 Frailty Adjuster (Slides 30-31)

The frailty adjuster is included as part of risk adjusted payments for PACE and certain demonstrations. The purpose of the frailty adjuster is to predict Medicare expenditures that are unexplained by the risk adjustment methodology alone. Under frailty adjustment, the relative frailty of an organization is measured in terms of the number of functional limitations as represented by the Activities of Daily Living (ADL) scale. There are six ADLs: 1) bathing and showering; 2) dressing; 3) eating; 4) getting in or out of bed or chairs; 5) walking; and 6) using the toilet. A sample of individuals in each organization is surveyed to determine the relative frailty of the organization.

### 1.8.1 Why Do We Have a Frailty Adjuster?

- The Balanced Budget Act of 1997 (BBA) mandated that Medicare capitated payments to PACE (Program of All-inclusive Care for the Elderly) organizations be based on M+C payment rates, adjusted to account for the comparative frailty of PACE enrollees.

- Risk adjustment does not explain all of the variation in expenditures for the frail, community-based population. So the frailty adjuster is used to explain the Medicare expenditures of community populations age 55 and over that are unexplained by risk adjustment.

### 1.8.2 Which Organizations Are Currently Being Paid Under Frailty Adjustment?

Table 1B lists the types of health plans being paid under frailty adjustment.

**TABLE 1B – PLANS RECEIVING FRAILTY ADJUSTMENT**

| TYPE OF HEALTH PLAN | FRAILTY ADJUSTER IS PART OF RISK ADJUSTED PAYMENT |
|---|---|
| MA | NO |
| PACE | YES |
| WPP | YES |
| MSHO/MnDHO | YES |
| S/HMOs | YES |
| EverCare | NO |

### 1.8.3 How Does the Frailty Adjuster Work Under the CMS-HCC Model?

The frailty adjustment factors were designed to explain (or predict) the Medicare expenditures that are unexplained by risk adjustment for groups with similar functional impairments. Therefore, frailty adjustment was designed to be applied in conjunction with the CMS-HCC model. Since the CMS-HCC model adequately predicts the Medicare expenditures of the long-term institutionalized and the under-55 disabled population, frailty adjustment is only applied to community residents who are 55 and over.

CMS calculates an organization-level frailty score based on the difficulties in activities of daily living (ADLs) that are reported by enrollees. The organization-level frailty score is then added to the risk score for each 55 and over community resident.

### 1.8.4 How is ADL Information Collected?

CMS collects the ADL data from organizations using either the Health Outcomes Survey (HOS) or the PACE Health Survey (PHS). CMS pilot-tested the PHS in 2002 and implemented it for PACE, MSHO/MnDHO, and WPP in 2003 to support payment adjustment for these organizations in 2004. CMS is using 2003 HOS data to support frailty adjustments for S/HMO organizations in 2004.

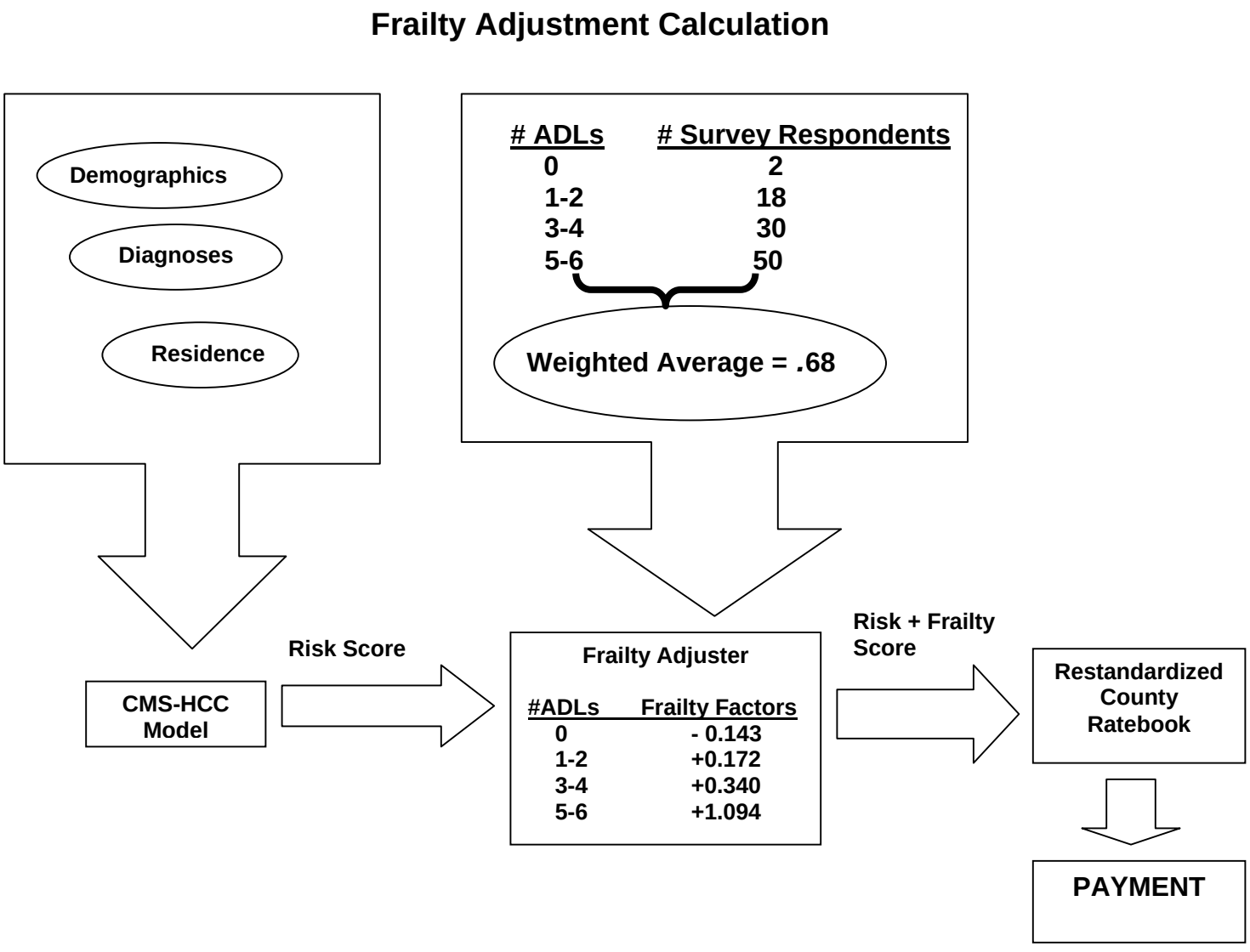
### 1.8.5 Calculating the Frailty Score

The organization-level frailty score is calculated as the weighted average frailty factor across all 55 and over community survey respondents for that organization. The first step is to determine the number of

ADLs with which each respondent has difficulty or is unable to do. Then the number of respondents in each ADL category (0 ADLs, 1 to 2 ADLs, 3 to 4 ADLs and 5 to 6 ADLs) is counted. These counts are multiplied by the corresponding frailty factor for each ADL category. The resulting products are then summed for each organization. This sum is divided by the number of 55 and over community respondents, yielding a weighted average factor (or frailty score) for each organization. The same frailty score is used for all 55 and over respondents and non-respondents of a plan who reside in the community.

This frailty score is added to the risk score of each 55 and over community enrollee in the organization (including new enrollees), resulting in a risk+frailty score for each individual. Payments to these plans are the product of this combined score and the risk adjusted county rate. Figure 1C illustrates this calculation and includes the ADL-based frailty factors.

**Figure 1C – Frailty Adjustment Calculation**



**Note:** For new PACE organizations that do not yet participate in the survey, the frailty score is the weighted average factor across all community respondents of all PACE organizations.

### 1.8.6 Range of Frailty Scores and Implications For Payment (Slides 32-33)

The range of frailty scores varies considerably among the organizations to which frailty adjustment applies (i.e., "frailty" plans). Note that there is considerable variation in the frailty scores among PACE organizations. Moreover, there is variation in the health status of PACE enrollees for which risk and frailty adjustment accounts. The SHMO frailty scores and impact analyses suggest that the current S/HMO payment levels may not be justified by SHMO enrollees' level of risk and frailty.

The CMS-HCC model uses diagnoses to adjust the payment to MA organizations. This model was calibrated based on the general Medicare population that has an average level of functional impairment. The frailty model further adjusts payment based on whether an organization's enrollees are more or less frail than the average. Frailty adjustment lowers risk scores for individuals with 0 ADLs and raises risk scores for all of the categories of ADLs. CMS is investigating whether the addition of a frailty factor would improve payment accuracy for MA organizations.

### 1.8.7 Frailty Adjuster Development (Slides 34-35)

CMS is in the midst of conducting a survey of fee-for-service beneficiaries regarding the level of frailty in the Medicare fee-for-service population. These data will help us to better determine the relationship between frailty and Medicare costs in the general Medicare population. CMS is considering using this information to develop a more accurate frailty adjuster for the Medicare Advantage program. Specifically, we must assess technical improvements in the adjuster by reviewing its impact on the county level ratebook and on payments for various biased sub-groups. We also need to consider the impact of the interaction between applying a program wide frailty adjuster and the implementation of the new bidding methodology concurrently.

Once our technical analyses are complete, CMS must consider many policy factors in deciding whether to implement a frailty adjuster across all MA organizations. First, we want to understand the payment impact of a frailty adjuster for different types of plans with various enrollee mixes. We also must evaluate the impact of the frailty adjuster on plans that serve special populations, including the new specialized needs plans. Based on technical merit and policy justifications, CMS will determine whether to implement a frailty adjuster across the MA program.

## 1.9 CMS-HCC Model Enhancements-Updating Diagnosis Codes in the Model (Slides 36-37)

CMS will update the CMS-HCC risk adjustment model to reflect the annual updates to the ICD-9 diagnostic code set. After clinical review, new ICD-9 diagnosis codes will be added to the appropriate diagnostic category and included in the CMS-HCC model. Organizations will be informed of the new diagnostic codes to be collected and submitted via an announcement in the Health Plan Management System (HPMS).

## 1.10 Payment Methodology for End-Stage Renal Disease (ESRD) Enrollees (Slides 38-39)

In order to further improve payment accuracy, CMS has proposed the implementation of the ESRD risk adjustment model. Effective January 2005, MA enrollees with ESRD will be incorporated into diagnosis-based risk adjustment using a different version of the CMS-HCC model. (See Attachment G for a draft list of coefficients for each disease group.) Section 605 of the Benefits Improvement and Protection Act of 2003 (BIPA) required CMS to adjust our approach to computing ESRD payment rates to reflect the method used in the ESRD social health maintenance organization (S/HMO) demonstration then in place.

We interpret this to mean that ESRD payments to MA organizations should employ the same basic approach as under the ESRD demonstration referenced in section 605. The new ESRD payment model will align us further with the method used in the ESRD S/HMO demonstration by allowing us to capture co-morbidity information in addition to demographic information and basic disease markers for ESRD beneficiaries. Since Section 605 of BIPA required CMS to adjust our approach to computing ESRD payment rates to reflect the method used in the ESRD social HMO (S/HMO) demonstration then in place, we interpret this to mean that the new three-part model should be implemented at 100 percent of payments for 2005, just as the 2002 changes to the ESRD methodology per BIPA were implemented at 100 percent.

The three parts of the ESRD CMS-HCC model are:

1. **Dialysis Status–**A full risk adjustment model for people on dialysis that is calibrated only on this population, so the payment weights are unique to these beneficiaries. A rescaled state-level ratebook will be created to reflect this population's program costs.

2. **Transplant Status–**Kidney or Kidney/Pancreas – CMS calculates the payment amount by calculating the cost of services during the month of the transplant and for the two succeeding months. We will also make different payments for those who have a kidney transplant and for those who have a pancreas transplant simultaneous with the kidney transplant. However, because the initial data system used for payment will not be able to distinguish the double transplant in a timely manner, all transplants will initially be paid at the kidney transplant rate. The rarer double transplant will be taken into account in reconciliation. We also differentiate payments for months close to the transplant period from those further out. The former have a higher intensity of care. We are working to implement these differential amounts during the 2005 reconciliation.

3. **Functioning Graft Status–**A modified version of the regular CMS-HCC model for people who have functioning kidney grafts, i.e. that they have received a kidney transplant or kidney/pancreas transplant at least three months ago and have not had to receive dialysis since the transplant. The model has an additional term to recognize the extra costs of immunosuppressive drugs and higher intensity of care for this group.

CMS developed this three-part model in response to our findings on expenditure patterns for ESRD beneficiaries. Dialysis patients have high ongoing costs, while transplant patients incur a very high one-time cost. Functioning graft patients are much more similar to the general population than they are to dialysis patients except for the cost of immunosuppressive drugs. Using the same payment weights for all three groups would lead to over- or underpayments to MA organizations. To address this problem, CMS developed separate payment approaches for these three populations.

### 1.10.1 Risk Adjustment Model for Dialysis Patients (Slide 40)

The dialysis model has the same HCC categories used for the CMS-HCC model. One exception is that the HCCs representing kidney disease diagnoses are excluded (HCC128 to HCC132). This means that the ESRD model has only 67 HCC categories. The model is calibrated only on dialysis patients, so the disease weights used for payment recognize disease and expenditure patterns that are unique to this population.

The data used for calibrating the ESRD models were 1999 (diagnostic) and 2000 (program payment) data on fee-for-service ESRD beneficiaries. For example, expenditures for a fee-for-service beneficiary on dialysis from January through August 2000 who received a transplant in September 2000 are included in the dialysis group for eight months, but then are excluded. From September through November 2000, this beneficiary's costs are included in the transplant data to determine estimated average transplant costs. As of December 2000, this beneficiary is included in the functioning graft model.

### 1.10.2 Transplant Patients

To accommodate the high one-time cost of a transplant, CMS will make payments over three months to cover the costs for this transplant and payments for the immediate subsequent services. CMS calibrated the payments by using fee-for-service hospital stay payments for the transplant, and physician and other services rendered for the hospital stay and the two months after discharge. The national average was converted to a relative factor by dividing by the national average payment for dialysis patients. The transplant factor is applied to the dialysis state ratebook to provide a transplant payment. Transplant payments, thus have geographic adjustments. Payment will be made in practice by determining the month of transplant and paying the amount over the three-month period starting with the transplant month.

The simplest method of paying the total amount would be to divide the total factor by three and pay in equal parts. For example, assuming that the national average three-month program cost for a transplant is $40,000 and that the national average monthly cost for a dialysis patient is $3,500, the relative factor would be 3.81 (i.e., [40,000/3]/3500). Payments for a transplant for an average ESRD enrollee would be 3.81 x 3,500 = $13,335 for each of the three months. Payments in higher or lower cost areas would vary.

By examining data from 2002, when a new diagnosis related group (DRG) was added that clearly specified payment for a kidney/pancreas simultaneous transplant, CMS has been able to determine a differential payment for the two transplant types. Each type will have a different factor.

### 1.10.3 Functioning Graft Beneficiary Model

The model for functioning graft enrollees is based on the model for the general population, except that HCCs for kidney transplant status, dialysis status and renal failure are excluded. For their members with functioning grafts as for dialysis members, MA organizations will be paid in 2005 based on the diseases reported from all risk adjustment sources in the prior year. However, functioning graft status is recognized in the payment year. In the adapted general population model, almost all of the HCC disease coefficients have been held to their general population values. A few HCCs have been removed and extra terms have been added specific to being in functioning graft status.

The values for the add-on terms have been estimated with data specific to this population and recognize the Medicare coverage of immunosuppressive drugs and the added intensity of services required by this population. They are identified as "graft factors" in the functioning graft model. The graft factors include 2 sets of coefficients. One set is used between the fourth and the end of the ninth month after a transplant and the second set is used for tenth month and all months thereafter. The functioning graft payment automatically begins the month after the third transplant payment unless CMS hears from the MA organization or the CMS data system that the member has returned to dialysis or had to have another transplant. Anytime a functioning graft patient returns to dialysis, payment is made using the dialysis model.

### 1.10.4 New Enrollee Factor (Slide 41)

The dialysis and functioning graft models will have new enrollee factors for enrollees whose risk scores are not available.

### 1.10.5 Reporting of ESRD Status

In moving to the implementation of the new ESRD risk adjustment method, CMS will utilize the existing systems for identification of enrollees receiving dialysis services. Currently, MA enrollees are assigned ESRD status as a result of a physician certifying their ESRD status on CMS Form 2728, the End-Stage Renal Disease Medical Evidence Report. The ESRD facility sends Form 2728 to the Renal Network, which then transmits the status to CMS systems where various databases are updated to record the ESRD status. Payments for dialysis are triggered by this system.

The ESRD information system would also remain the standard for identifying enrollees who received a transplant. However, MA organizations would be given the opportunity to notify CMS directly of a transplant in order to receive more timely payments for a transplant. Ultimately, MA organization-reported ESRD status will be reconciled against CMS's existing ESRD information reporting system to determine final ESRD status for payment. CMS will provide additional information to plans regarding direct notification of a transplant in early fall.

## 1.11 Model Comparison of Coefficients (Slide 42)

The ESRD dialysis model has a higher base factor (age/sex) and lower factors associated with diagnoses than does the CMS-HCC model. This is because Medicare costs for ESRD beneficiaries are much higher than they are for the average Medicare beneficiary, but they are relatively uniform. This means that the Medicare costs for ESRD beneficiaries do not vary as much as the Medicare costs for Medicare beneficiaries in general. Hence, diseases do not explain as much of the cost variation among ESRD beneficiaries and therefore, these costs are retained in the age/sex coefficient in the ESRD dialysis model.

## 1.12 Medicare Reform (Slides 43-47)

**Part C Medicare Advantage Program.** In December 2003, the Medicare, Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) was enacted. Title II of the MMA created a new program called the Medicare Advantage (MA) program, which replaced the Medicare+Choice program under Part C of Medicare. Many of the M+C provisions were retained such as the eligibility, enrollment, grievance and appeals sections. Some MMA changes will be made immediately in 2004, such as revisions to the MA payment methodology. However, in 2006, a broader restructuring of the entire program will

occur. The MMA retains all of the M+C plan options in the MA program. In addition, the MMA created a new option, a regional preferred provider organization (PPO), to be available to beneficiaries beginning in 2006. (Currently, there are only local PPOs.)

The MMA requires CMS to create between 10-50 PPO regions under which MA organizations can offer Medicare Part A/B basic benefits, supplemental and/or drug benefits in various plans as regional PPOs. In order to encourage plans to participate, Congress established a stabilization fund for regional PPOs to enter and remain in the MA program. Also, medical savings accounts (MSAs) plans have been made a permanent part of the program and have been converted from demonstration status. In addition, Congress created a new designation, specialized Medicare Advantage plans for "special needs" beneficiaries. These plans may serve such individuals exclusively or disproportionately. (MMA has directed CMS to define the conditions upon which these designations apply).

The broader restructuring of the M+C program includes changes to the way Medicare pays plans. Previously, in the M+C program, plan payments have been only indirectly linked (via the Adjusted Community Rate Proposal (ACRP)) to what it costs plans to provide Medicare benefits. Beginning in 2006, the ACR process will be replaced by a bidding process whereby MA organizations will be required to submit bids on their estimated costs of providing original Medicare benefits and supplemental and/or drug benefits if relevant. Those bids will be based on a nationally average beneficiary (i.e. the 1.0 beneficiary). The MMA requires these bids to be actuarially sound. Once received, CMS will compare the risk adjusted bids to risk adjusted benchmark amounts (calculated differently depending upon what type of plan) to determine plan payment and beneficiary premium amounts.

**Medicare Part D Drug Benefit (Title I).** In addition to the creation of the MA program in the MMA, in Title I, Congress has added a voluntary prescription drug benefit to Medicare (known as Part D) to be made available for all Medicare beneficiaries through either the Medicare Advantage program or the prescription drug plans. To that end, MA organizations will be required to provide at least one MA plan that provides a "required drug coverage" in each of its service areas. MA plans that offer drug coverage are called MA prescription drug plans (MA-PDs). Beneficiaries receiving health care benefits through fee-for-service Medicare will have the option of accessing prescription drug coverage through sponsors of prescription drug plans (PDPs). Unlike PDPs which can offer supplemental drug coverage only when they offer a standard package in an area, MA-PDs can offer plans with supplemental coverage that qualify as "required prescription drug coverage". Similar to the MA program, CMS will establish between 10 and 50 regions through which PDP sponsors will offer Part D drug coverage. To the extent practicable, CMS will design the PDP regions to overlap the MA regions. Payments to PDP plans for eligible low-income Medicare beneficiaries will be subsidized at different levels depending upon the income and asset of the enrollee.

### 1.12.1 Overlap of Titles I and II (Slide 48)

The MMA requires organizations intending to offer MA plans with original Medicare Parts A and B benefits and/or Part D benefits to submit bids in early June of each year for their basic, supplemental and/or Part D benefit packages. Each bid must reflect a plan's actual revenue requirements to provide the benefits offered in the proposed benefit packages. Benchmarks will be created for local and/or regional plans for bid-benchmark comparisons. Monthly capitated payments will be made based on each plan's bid risk adjusted for health status minus the beneficiary premium amount. The MMA mandates MA organizations and PDPs to provide basic prescription drug coverage as one of their benefit plans.

### 1.12.2 Where Does Risk Adjustment Fit Into Titles I and II of the MMA? (Slide 49)

Risk adjustment will be used in a similar manner for MA and PDP plans as it was in the M+C Program. Payments for original Medicare benefits and the new drug benefits will be risk adjusted at the beneficiary level. As a part of each type of plans' bidding process, CMS will calculate a somewhat similar risk adjusted bid benchmarks for comparison purposes in order to determine plan payments for both MA and PDP plans. The benchmark for PDPs is calculated as the national weighted average of bids submitted under Title I, while the benchmark for local MA plans is simply the weighted average of the relevant MA annual county capitation rates in a plan's service area. For regional MA plans, the benchmark is a blended amount. Ultimately, plans will be paid a monthly risk adjusted capitated payment amount which is partially based on a risk adjusted plan bid.

### 1.12.3 Additional MMA Changes --Specialty Plans (Slide 50)

The MMA establishes a new type of plan as a permanent part of the program called "specialized MA plans for special needs individuals". These are plans that exclusively serve the special needs individuals such as those who are institutionalized, Medicaid eligible or as CMS determines would benefit from enrollment in such a specialized plan and who are suffering from severe or disabling chronic conditions. Note that there is no special payment provision that applies to these types of plans.

### 1.12.4 Drug Risk Adjustment for 2006 (Slides 51-52)

Recent research has found that the variation in drug expenditures that can be explained is primarily driven by chronic conditions persisting from year to year. Research also suggests that many of the diagnoses that we use for the CMS-HCC model will be needed for the drug risk adjustment model in addition to new diagnoses codes we could collect. For example, the findings indicate that certain chronic conditions such as congestive heart failure and schizophrenia (CMS-HCC model diagnoses) are good predictors of drug expenditures. However, this research also shows that hypertension and glaucoma, not currently in the model, are also key predictors of drug expenditures. Hence, such findings lead to the conclusion that additional diagnoses, beyond those in the current CMS-HCC model, will need to be collected to properly develop a drug risk adjustment model. It is equally true that some conditions currently included in the CMS-HCC model are predictive of Medicare Part A and B treatment costs, but would not be predictive of Part D costs. As such, these diseases could decrease drug expenditures.

Currently, CMS is in the midst of analyzing the list of conditions that should be included in our drug risk adjustment model. Similar to the CMS-HCC risk adjustment model process, CMS will create a list of diagnoses for the drug risk adjuster projected to be announced in late April 2004. Some of the diagnoses will overlap with the current CMS-HCC model and others will not. Collection of the diagnoses for the CMS drug risk adjustment model from current MA organizations will begin in July 2004 to begin payment in January 2006. Also, CMS is developing an abbreviated claims format based on the National Council on Prescription Drug Program (NCPDP) format for collection of prescription drug claim data from PDP sponsors providing Part D drug benefits beginning in January 2006 for payment purposes.

## 1.13 Payment Blends

Schedule for implementing risk adjusted payments based on the CMS-HCC model and a blended transitional approach is provided below. In 2004, the CMS-HCC model was implemented at a 30 percent risk adjusted payment, with the remaining 70 percent represented by the demographic payment. The portion of risk adjusted payment will increase to 50 percent in 2005, to 75 percent in 2006 and finally to 100 percent in 2007. The CMS-HCC implementation schedule is shown in Table 1C.

**TABLE 1C – RISK ADJUSTMENT IMPLEMENTATION SCHEDULE FOR MA ORGANIZATIONS AND FOR MA-PDS AND PDPS FOR DRUG BENEFIT**

| PAYMENT YEAR | CMS-HCC MODEL -COMMUNITY -INSTITUTIONAL | ESRD CMS-HCC MODEL | DRUG BENEFIT MODEL |
|---|---|---|---|
| 2004 | 70% Demographic<br>30% CMS-HCC Model | N/A | N/A |
| 2005 | 50% Demographic<br>50% CMS-HCC Model | 100% | N/A |
| 2006 | 25% Demographic<br>75% CMS-HCC Model | 100% | 100% |
| 2007 | 100% CMS-HCC Model | 100% | 100% |

Table 1D illustrates the risk adjustment implementation schedules for certain specialty plans.

**TABLE 1D – PAYMENT BLENDS FOR SPECIALTY PLANS**

| TYPE OF HEALTH PLAN | TRANSITION BLEND: REPRESENTS THE PERCENTAGE OF CURRENT VERSUS RISK ADJUSTED PAYMENT PORTION OF PAYMENT | | | | |
|---|---|---|---|---|---|
| | 2004 | 2005 | 2006 | 2007 | 2008 |
| **Program for All-inclusive Care for the Elderly (PACE)** | 90/10% | 70/30% | 50/50% | 25/75% | 100% |
| **Wisconsin Partnership Program (WPP)** | 90/10% | 70/30% | 50/50% | 25/75% | 100% |
| **Minnesota Senior Care Options (MSHO) and Disability Health Options (MnDHO)** | 90/10% | 70/30% | 50/50% | 25/75% | 100% |
| **Social Health Maintenance Organizations (S/HMOs)** | 90/10% | 70/30% | 50/50% | 25/75% | 100% |
| **EverCare** | 70/30% | 50/50% | 25/75% | 100% | 100% |

## 1.14 Conclusions (Slide 53)

CMS expects that implementing risk adjustment in a way that considers the expected costs of different types of beneficiaries will improve payment for all types of plans. This is a more comprehensive manner to adjust payment for services that considers diagnoses provided in all major treatment settings and for more enrollees (including ESRD beneficiaries now). It will enhance our ability to pay accurately for high and low costs individuals.

## 1.15 Next Steps (Slide 54)

CMS intends to publish proposed regulations separately in the *Federal Register* for the implementation of Titles I and II of the MMA shortly. CMS expects to publish the Title II proposed rule in May 2004 and Title I in June 2004. The public will have 60 days to comment on the proposed regulations. Once the comments are received and the draft regulations are finalized, CMS will provide additional training on the new MA bidding methodology and any new elements of risk adjustment, including the new drug risk adjustment model.

## 1.16 Additional Information from Previous Participant Guides

### 1.16.1 Final Submission of Risk Adjustment Data (Reconciliation)

Reconciliation is used to complete the implementation of payments—account for the correct institutional status of beneficiaries and to keep adjustments to a minimum. CMS will continue to allow a period (approximately 6-8 months after the payment year) for submitting final risk adjusting processing system (RAPS) data for the appropriate data collection period. Final submission of risk adjustment data (or reconciliation) applies to data that is late or incorrect and was not received by the initial submission deadline for a data collection period. In addition to incorporating new RAPS and fee-for-service diagnoses, reconciliation takes into account necessary adjustments to institutional status and demographic data for enrollees. Note: CMS reconciles risk adjusted payments for a calendar year only one time.

### 1.16.2 Risk Adjustment Schedule & Elimination of the Payment Lag

Risk adjusted payments were originally implemented with a 6-month payment lag from the end of the collection period to the start of revised payments based on the data collected.

**Example: 6**

Data Collection Period: July 1, 1998 through June 30, 1999
Data Collection End Date: June 30, 1999
CY Year 2000: First payment made based on this collection period = January 1, 2000

As you can see, payments began 6 months after the end of the data collection period.

**The purpose of eliminating the lag between the end of the data collection period and the payment based on that year's data is to pay more accurately based on the most recent data.**

- Beginning with risk-adjusted payments in about July 2004, the 6-month lag will be eliminated.
- As in the previous years, CMS will calculate a preliminary risk factor based on lagged data (for 2004, it will be based on data from July 2002 through June 2003). Payments from January 2004 through June 2004 will be based on this factor.
- In July 2004 CMS will use a risk factor based on non-lagged data (i.e., from calendar year 2003) for calculating payments. That factor will be used for the remainder of the year.
- The majority of M+C organizations supported the elimination of the data lag.
- By eliminating the lag, the collection period will change from July 1 through June 30 to January 1 through December 31 (or a calendar year).

**Organizations that desire to opt-out of the standard implementation approach for elimination of the payment lag must have notified CMS in writing by March 31, 2004.**

## 1.16.3 Additional Information on the Long-Term Institutional Model

In 2004, the CMS risk adjustment approach began including separate models for enrollees that are considered to be long-term institutional residents. Separate models were necessary because there are significant cost differences between the traditional community-based M+C beneficiary population and a long-term institutionalized beneficiary with the same disease profile. An adjustment for place of residence improves the payment accuracy of risk adjustment

A long-term institutionalized MA enrollee is defined as someone who resides in an institution for more than 90 days as identified using the Minimum Data Set (MDS). The costs of the short term institutionalized (less than 90 days) are recognized in the community model.

Table 1E reflects the distribution of Medicare beneficiaries in the September 2003 cohort who had been institutionalized longer than 90 days as of July 2003.

**TABLE 1E – DISTRIBUTION OF LONG-TERM INSTITUTIONALIZED BENEFICIARIES ACROSS PLAN TYPES**

| PLAN TYPE | TOTAL NUMBER BENEFICIARIES | NUMBER BENEFICIARIES INSTITUTIONAL | PERCENT OF BENEFICIARIES INSTITUTIONAL | NUMBER OF PLANS | NUMBER OF PLANS >5% OF BENEFICIARIES INSTITUTIONAL |
|---|---|---|---|---|---|
| SHMO | 116,104 | 963 | 0.829% | 4 | 0 |
| PPO | 73,732 | 194 | 0.829% | 31 | 0 |
| M+C | 4,609,312 | 39,189 | 0.850% | 149 | 5 |
| WPP | 1,184 | 56 | 4.730% | 4 | 2 |
| PACE | 8,119 | 486 | 5.986% | 28 | 18 |
| MSHO | 4,756 | 2,574 | 54.121% | 4 | 4 |
| Evercare | 17,340 | 15,740 | 90.773% | 6 | 6 |
| **Total** | **4,830,547** | **59202** | **1.226%** | **191** | **35** |

As described above, institutional status will be determined from information included in the Minimum Data Set (MDS) that is reported by Medicare certified nursing homes. Under the CMS-HCC model, MA organizations **will not report** the institutional status of their enrollees. **Note:** MA organizations must continue to track the institutional status of their enrollees to ensure that CMS correctly identifies institutional status for demographic payments via the monthly membership reports.

Table 1F lists the considerations for community and long-term institutionalized populations.

**TABLE 1F – COMMUNITY VERSUS LONG-TERM INSTITUTIONALIZED POPULATIONS**

| CMS-HCC MODEL CONSIDERATIONS FOR COMMUNITY AND LONG-TERM INSTITUTIONALIZED POPULATIONS | |
|---|---|
| **Community-Based** | **Long-Term Institutionalized** |
| • Disease-related incremental payments for the community population are generally higher<br>• Community-based payment includes costs for the short term institutionalized (i.e., less than 90 days in an institution)<br>• Community-based population payment would overpredict costs for long-term institutionalized population, even with the same health status<br>• Currently, most M+C organizations have a small proportion of long-term institutionalized enrollees (less than **10** organizations have more than 5% long-term institutionalized enrollees)<br>• For 2004, CMS will assume that all enrollees in most M+C organizations are community-based. Payments will be based during the payment year on the community version of the risk adjustment model. This will minimize tracking problems for M+C organizations. The final reconciliation for a payment year will incorporate the correct institutional status for each enrollee for each month. | • Age and sex payment factors are generally higher for the long-term institutionalized population<br>• Much of the costs of the long-term institutionalized population are not paid for by Medicare<br>• Institutional model merges a number of disease groups to assure stable coefficients for this population<br>• Long-term institutional status will be recognized in the payment year—more flexible<br>• Minimum Data Set (MDS) collected from nursing homes will be used to identify long-term institutionalized enrollees<br>• The presence of a 90-day assessment and current residence in an institution = long-term institutionalized enrollee<br>• No additional reporting by M+C organizations is required<br>• Enrollees remain in long-term institutionalized status until discharged to the community for more than 14 days |

## HOW TO CALCULATE DEMOGRAPHIC AND CMS-HCC RISK ADJUSTED PAYMENTS

The transition to 100% risk adjusted payment in 2007 requires that a portion of the M+C payment is based on the traditional demographic payment methodology, with the remainder of the payment based on risk adjustment payment methodology. For 2004 payment, the payment blend is 70% demographic and 30% CMS-HCC risk adjusted.

The web address http://cms.hhs.gov/healthplans/rates/ provides all the information necessary for the following calculations.

**Example: Calculate the CY 2004 M+C payment for a 72 year-old female living in Howard County, Maryland, living in the community (non-institutionalized), who was originally entitled to Medicare due to disability. She is not entitled to Medicaid (no expenditure increment).**
**She has several diagnoses during the data collection period:**

- **Diabetes with Acute Complications (HCC 17)**
- **Diabetes without Complications (HCC 19)**
- **Pneumococcal Pneumonia (HCC 112)**

### STEP 1—CALCULATE DEMOGRAPHIC PAYMENT AT 70% FOR 2004

A. Go to http://cms.hhs.gov/healthplans/rates/ and find the Part A and Part B "M+C Monthly Capitation Rates" for a beneficiary living in Howard County, Maryland.
- Monthly "aged" rate book amounts for Howard County, Maryland
- Part A aged rate = $366.51
- Part B aged rate = $295.41

B. Go to http://cms.hhs.gov/healthplans/rates/ and find the "Demographic Cost Factors for 1997-2004" for a 72 year-old female, non-institutionalized, non-Medicaid.
- Part A = .70
- Part B = .85

C. Multiply the demographic cost factor for Part A and Part B by the corresponding Part A and Part B county rate amount, then add the Part A and Part B amounts together.
- Part A = $366.51 x .70 = $256.55
- Part B = $295.41 x .85 = $251.09
- $256.55 + $251.09 = **$507.64**

D. Multiply the total amount by the 2004 demographic payment percentage (70%).
- $507.64 x .70 = **$355.35**

The product of $355.35 is the 2004 demographic payment amount for the beneficiary.

## STEP 2—CALCULATE RISK ADJUSTED PAYMENT AT 30% FOR 2004

A. Convert the Part A and Part B M+C county rates to risk adjusted rates (restandardizing): Go to http://cms.hhs.gov/healthplans/rates/ and find the "aged" rescaling factor from the "M+C Monthly Capitation Rates" (same source as "A" in Step 1) for a beneficiary living in Howard County, Maryland.
   - Part A: $366.51 + Part B: $295.41 = $661.92
   - Rescaling factor = 0.958620
   - $661.92 x **0.958620** = **$634.30**

B. Calculate the beneficiary risk factor: Go to http://cms.hhs.gov/healthplans/rates/ and find the "Community and Institutional Annual Risk Factors for the CMS-HCC Model" (Exhibit 1—for beneficiaries with 12+ months of Medicare experience).

   Find the community factors for beneficiary described in the example:

- 72-year old female, living in the community (non-institutional), base factor = .384
  - Originally-disabled female (non-Medicaid) = .236
  - Diabetes with Acute Complications (HCC 17) = .391
  - Diabetes without Complications (HCC 19) = .200* (dropped because of hierarchy)
  - Pneumococcal Pneumonia (HCC 112) = .202
- Add all risk adjustment factors = .384 + .236 + .391 + .202 = 1.213
- Beneficiary risk factor = **1.213**

*The .200 factor for a diagnosis of Diabetes without Complications (HCC 19) is dropped because both HCC 17 and HCC 19 are in the diabetes hierarchy. HCC 17 represents the more severe manifestation of diabetes.

C. Calculate 100% risk adjusted monthly payment amount by multiplying the beneficiary risk factor by the risk adjusted Part A and Part B total (step "A" above)
   - $634.30 x 1.213 = **$769.41**
   - $769.41 is the 100% risk adjusted payment amount

D. Multiply the total amount by the 2004 risk adjusted payment percentage (30%).
   - $769.41 x .30 = **$230.82**

## STEP 3—SUM THE DEMOGRAPHIC AND RISK ADJUSTED PAYMENT AMOUNTS TO GET THE MONTHLY M+C PAYMENT

   - Demographic Payment = $355.35
   - Risk Adjusted Payment = $230.82
- **$355.35 + $230.82 = $586.17/month or $7,034.04 annually**

# EXHIBIT 1.

## Community And Institutional Annual Risk Factors for the CMS-HCC Model with Constraints And Demographic/Disease Interactions

| Variable | Disease Group | Community Factors | Institutional Factors |
|---|---|---|---|
| **Age/Sex Factors** | | | |
| Female0-34 | | 0.117 | 1.064 |
| Female35-44 | | 0.197 | 1.064 |
| Female45-54 | | 0.214 | 1.064 |
| Female55-59 | | 0.265 | 1.064 |
| Female60-64 | | 0.375 | 1.064 |
| Female65-69 | | 0.307 | 1.164 |
| Female70-74 | | 0.384 | 1.179 |
| Female75-79 | | 0.483 | 0.992 |
| Female80-84 | | 0.572 | 0.938 |
| Female85-89 | | 0.665 | 0.880 |
| Female90-94 | | 0.795 | 0.789 |
| Female95+ | | 0.805 | 0.581 |
| Male0-34 | | 0.068 | 1.104 |
| Male35-44 | | 0.120 | 1.104 |
| Male45-54 | | 0.190 | 1.104 |
| Male55-59 | | 0.270 | 1.104 |
| Male60-64 | | 0.342 | 1.104 |
| Male65-69 | | 0.346 | 1.450 |
| Male70-74 | | 0.453 | 1.238 |
| Male75-79 | | 0.577 | 1.211 |
| Male80-84 | | 0.657 | 1.209 |
| Male85-89 | | 0.790 | 1.241 |
| Male90-94 | | 0.901 | 1.049 |
| Male95+ | | 1.035 | 0.836 |

| | | | |
|---|---|---|---|
| **Medicaid & Originally Disabled Interactions with Age & Sex** | | | |
| **Medicaid Female, Disabled** | | 0.221 | 0.000 |
| **Medicaid Female, Aged** | | 0.183 | 0.000 |
| **Medicaid Male, Disabled** | | 0.115 | 0.000 |
| **Medicaid Male, Aged** | | 0.184 | 0.000 |
| **Originally-Disabled Female** | | 0.236 | 0.000 |
| **Originally-Disabled Male** | | 0.148 | 0.000 |
| **Disease Group Factors[1]** | | | |
| **HCC1** | HIV/AIDS | 0.685 | 1.344 |
| **HCC2** | Septicemia/Shock | 0.890 | 0.946 |
| **HCC5** | Opportunistic Infections | 0.652 | 1.344 |
| **HCC7** | Metastatic Cancer and Acute Leukemia | 1.464 | 0.540 |
| **HCC 8** | Lung, Upper Digestive Tract, and Other Severe Cancers | 1.464 | 0.540 |
| **HCC9** | Lymphatic, Head and Neck, Brain, and Other Major Cancers | 0.690 | 0.452 |
| **HCC10** | Breast, Prostate, Colorectal and Other Cancers and Tumors | 0.233 | 0.259 |
| **HCC15** | Diabetes with Renal or Peripheral Circulatory Manifestation | 0.764 | 0.612 |
| **HCC16** | Diabetes with Neurologic or Other Specified Manifestation | 0.552 | 0.612 |
| **HCC17** | Diabetes with Acute Complications | 0.391 | 0.612 |
| **HCC18** | Diabetes with Ophthalmologic or Unspecified Manifestation | 0.343 | 0.612 |
| **HCC19** | Diabetes without Complication | 0.200 | 0.255 |
| **HCC21** | Protein-Calorie Malnutrition | 0.922 | 0.427 |
| **HCC25** | End-Stage Liver Disease | 0.900 | 0.268 |

| | | | |
|---|---|---|---|
| **HCC26** | Cirrhosis of Liver | 0.516 | 0.268 |
| **HCC27** | Chronic Hepatitis | 0.359 | 0.268 |
| **HCC31** | Intestinal Obstruction/Perforation | 0.408 | 0.268 |
| **HCC32** | Pancreatic Disease | 0.445 | 0.268 |
| **HCC33** | Inflammatory Bowel Disease | 0.307 | 0.268 |
| **HCC37** | Bone/Joint/Muscle Infections/Necrosis | 0.496 | 0.495 |
| **HCC38** | Rheumatoid Arthritis and Inflammatory Connective Disease Tissue | 0.322 | 0.285 |
| **HCC44** | Severe Hematological Disorders | 1.011 | 0.448 |
| **HCC45** | Disorders of Immunity | 0.830 | 0.448 |
| **HCC51** | Drug/Alcohol Psychosis | 0.353 | 0.221 |
| **HCC52** | Drug/Alcohol Dependence | 0.265 | 0.221 |
| **HCC54** | Schizophrenia | 0.543 | 0.221 |
| **HCC55** | Major Depressive, Bipolar, and Paranoid Disorders | 0.431 | 0.221 |
| **HCC67** | Quadriplegia/Other Extensive Paralysis | 1.181 | 0.098 |
| **HCC 68** | Paraplegia | 1.181 | 0.098 |
| **HCC69** | Spinal Cord Disorders/Injuries | 0.492 | 0.098 |
| **HCC70** | Muscular Dystrophy | 0.386 | 0.098 |
| **HCC71** | Polyneuropathy | 0.268 | 0.098 |
| **HCC72** | Multiple Sclerosis | 0.517 | 0.098 |
| **HCC73** | Parkinson's and Huntington's Diseases | 0.475 | 0.098 |
| **HCC74** | Seizure Disorders and Convulsions | 0.269 | 0.098 |
| **HCC75** | Coma, Brain Compression/Anoxic Damage | 0.568 | 0.098 |
| **HCC77** | Respirator Dependence/Tracheostomy Status | 2.102 | 1.415 |
| **HCC78** | Respiratory Arrest | 1.429 | 1.415 |
| **HCC79** | Cardio-Respiratory Failure and Shock | 0.692 | 0.289 |
| **HCC80** | Congestive Heart Failure | 0.417 | 0.176 |
| **HCC81** | Acute Myocardial Infarction | 0.348 | 0.288 |
| **HCC82** | Unstable Angina and Other Acute Ischemic Heart Disease | 0.348 | 0.288 |

| | | | |
|---|---|---|---|
| **HCC83** | Angina Pectoris/Old Myocardial Infarction | 0.235 | 0.288 |
| **HCC92** | Specified Heart Arrhythmias | 0.266 | 0.187 |
| **HCC95** | Cerebral Hemorrhage | 0.392 | 0.151 |
| **HCC96** | Ischemic or Unspecified Stroke | 0.306 | 0.151 |
| **HCC100** | Hemiplegia/Hemiparesis | 0.437 | 0.098 |
| **HCC101** | Cerebral Palsy and Other Paralytic Syndromes | 0.164 | 0.098 |
| **HCC104** | Vascular Disease with Complications | 0.677 | 0.509 |
| **HCC105** | Vascular Disease | 0.357 | 0.114 |
| **HCC107** | Cystic Fibrosis | 0.376 | 0.230 |
| **HCC 108** | Chronic Obstructive Pulmonary Disease | 0.376 | 0.230 |
| **HCC111** | Aspiration and Specified Bacterial Pneumonias | 0.693 | 0.463 |
| **HCC112** | Pneumococcal Pneumonia, Empyema, Lung Abscess | 0.202 | 0.463 |
| **HCC119** | Proliferative Diabetic Retinopathy and Vitreous Hemorrhage | 0.349 | 0.995 |
| **HCC130** | Dialysis Status | 3.076 | 3.112 |
| **HCC131** | Renal Failure | 0.576 | 0.420 |
| **HCC132** | Nephritis | 0.273 | 0.420 |
| **HCC148** | Decubitus Ulcer of Skin | 1.030 | 0.317 |
| **HCC149** | Chronic Ulcer of Skin, Except Decubitus | 0.484 | 0.262 |
| **HCC150** | Extensive Third-Degree Burns | 0.962 | 0.248 |
| **HCC154** | Severe Head Injury | 0.568 | 0.248 |
| **HCC155** | Major Head Injury | 0.242 | 0.248 |
| **HCC157** | Vertebral Fractures without Spinal Cord Injury | 0.490 | 0.098 |
| **HCC158** | Hip Fracture/Dislocation | 0.392 | 0.000[2] |
| **HCC161** | Traumatic Amputation | 0.843 | 0.248 |
| **HCC164** | Major Complications of Medical Care and Trauma | 0.262 | 0.263 |
| **HCC174** | Major Organ Transplant Status | 0.722 | 0.882 |
| **HCC176** | Artificial Openings for Feeding or Elimination | 0.790 | 0.882 |
| **HCC 177** | Amputation Status, Lower Limb/Amputation Complications | 0.843 | 0.248 |

| | | | |
|---|---|---|---|
| **Disabled/Disease Interactions** | | | |
| **D-HCC5** | Disabled*Opportunistic Infections | 0.789 | 0.000 |
| **D-HCC44** | Disabled*Severe Hematological Disorders | 0.893 | 0.000 |
| **D-HCC51** | Disabled*Drug/Alcohol Psychosis | 0.509 | 0.000 |
| **D-HCC52** | Disabled*Drug/Alcohol Dependence | 0.414 | 0.000 |
| **D-HCC107** | Disabled*Cystic Fibrosis | 1.861 | 0.000 |
| **Disease Interactions** | | | |
| **INT1** | DM*CHF[3] | 0.253 | 0.207 |
| **INT2** | DM*CVD | 0.125 | 0.000 |
| **INT3** | CHF*COPD | 0.241 | 0.372 |
| **INT4** | COPD*CVD*CAD | 0.079 | 0.000 |
| **INT5** | RF*CHF[3] | 0.234 | 0.000 |
| **INT6** | RF*CHF*DM[3] | 0.864 | 0.000 |

**NOTES**

[1] Beneficiaries with HCC128 Kidney Transplant Status were excluded from the sample because they will be included in the ESRD model sample.

[2] Factor constrained to zero because it was negative.

[3] Beneficiaries with the three-way interaction RF*CHF*DM are excluded from the two-way interactions DM*CHF and RF*CHF. Thus, the three-way interaction term RF*CHF*DM is not additive to the two-way interaction terms DM*CHF and RF*CHF. Rather, it is hierarchical to, and excludes these interaction terms. A beneficiary with all three conditions is not "credited" with the two-way interactions. All other interaction terms are additive.

DM= diabetes mellitus (HCCs 15-19)

CHF= congestive heart failure (HCC 80)

COPD= chronic obstructive pulmonary disease (HCC 108)

CVD= cerebrovascular disease (HCCs 95-96, 100-101)

CAD= coronary artery disease (HCCs 81-83)

RF= renal failure (HCC 131)

**Source:** RTI Analysis of 1999/2000 Medicare 5% Sample.

# EXHIBIT 2.

## List Of Disease Groups (HCCs) with Hierarchies

| DISEASE HIERARCHIES | | |
|---|---|---|
| **If the Disease Group is Listed in This Column...** | | **...Then Drop the Associated Disease Group(s) Listed in This Column** |
| **Disease Group (HCC)** | **Disease Group Label** | |
| **5** | Opportunistic Infections | 112 |
| **7** | Metastatic Cancer and Acute Leukemia | 8,9,10 |
| **8** | Lung, Upper Digestive Tract, and Other Severe Cancers | 9,10 |
| **9** | Lymphatic, Head and Neck, Brain and Other Major Cancers | 10 |
| **15** | Diabetes with Renal Manifestations or Peripheral Circulatory Manifestation | 16,17,18,19 |
| **16** | Diabetes with Neurologic or Other Specified Manifestation | 17,18,19 |
| **17** | Diabetes with Acute Complications | 18,19 |
| **18** | Diabetes with Ophthalmologic or Unspecified Manifestations | 19 |
| **25** | End-Stage Liver Disease | 26,27 |
| **26** | Cirrhosis of Liver | 27 |
| **51** | Drug/Alcohol Psychosis | 52 |
| **54** | Schizophrenia | 55 |
| **67** | Quadriplegia/Other Extensive Paralysis | 68,69,100,101,157 |
| **68** | Paraplegia | 69,100,101,157 |
| **69** | Spinal Cord Disorders/Injuries | 157 |
| **77** | Respirator Dependence/ Tracheostomy Status | 78,79 |
| **78** | Respiratory Arrest | 79 |
| **81** | Acute Myocardial Infarction | 82,83 |

| | | |
|---|---|---|
| **82** | Unstable Angina and Other Acute Ischemic Heart Disease | 83 |
| **95** | Cerebral Hemorrhage | 96 |
| **100** | Hemiplegia/Hemiparesis | 101 |
| **104** | Vascular Disease with Complications | 105,149 |
| **107** | Cystic Fibrosis | 108 |
| **111** | Aspiration and Specified Bacterial Pneumonias | 112 |
| **130** | Dialysis Status | 131,132 |
| **131** | Renal Failure | 132 |
| **148** | Decubitus Ulcer of Skin | 149 |
| **154** | Severe Head Injury | 75,155 |
| **161** | Traumatic Amputation | 177 |

**How Payments are Made with a Disease Hierarchy**

**EXAMPLE:** If a beneficiary triggers Disease Groups 148 (Decubitus Ulcer of the Skin) and 149 (Chronic Ulcer of Skin, Except Decubitus), then DG 149 will be dropped. In other words, payment will always be associated with the DG in column 1, if a DG in column 3 also occurs during the same collection period. Therefore, the M+C organization's payment will be based on DG 148 rather than DG 149.

# Exhibit 3.

## CMS-HCC Demographic Model for New Enrollees[1]

| Age/Sex Factors | Non-Medicaid & Not Originally Disabled | Medicaid & Not Originally Disabled | Non-Medicaid & Originally Disabled | Medicaid & Originally Disabled |
|---|---|---|---|---|
| Female0_34 | 0.397 | 0.816 | 0 | 0 |
| Female35_44 | 0.601 | 1.019 | 0 | 0 |
| Female45_54 | 0.725 | 1.144 | 0 | 0 |
| Female55_59 | 0.846 | 1.265 | 0 | 0 |
| Female60_64 | 1.009 | 1.428 | 0 | 0 |
| Female65 | 0.486 | 1.004 | 1.100 | 1.619 |
| Female66 | 0.534 | 1.037 | 1.168 | 1.671 |
| Female67 | 0.595 | 1.098 | 1.228 | 1.732 |
| Female68 | 0.612 | 1.115 | 1.246 | 1.749 |
| Female69 | 0.653 | 1.157 | 1.287 | 1.790 |
| Female70_74 | 0.773 | 1.262 | 1.390 | 1.858 |
| Female75_79 | 0.979 | 1.332 | 1.491 | 1.875 |
| Female80_84 | 1.148 | 1.502 | 1.660 | 1.998 |
| Female85_89 | 1.289 | 1.643 | 1.801 | 2.150 |
| Female90_94 | 1.376 | 1.730 | 1.888 | 2.283 |
| Female95_GT | 1.217 | 1.571 | 1.888 | 2.283 |
| Male0_34 | 0.296 | 0.692 | 0 | 0 |
| Male35_44 | 0.501 | 0.896 | 0 | 0 |
| Male45_54 | 0.648 | 1.043 | 0 | 0 |
| Male55_59 | 0.821 | 1.216 | 0 | 0 |
| Male60_64 | 0.939 | 1.334 | 0 | 0 |
| Male65 | 0.528 | 1.049 | 1.042 | 1.563 |
| Male66 | 0.591 | 1.074 | 1.100 | 1.583 |
| Male67 | 0.651 | 1.134 | 1.160 | 1.643 |
| Male68 | 0.704 | 1.187 | 1.213 | 1.696 |

| | | | | |
|---|---|---|---|---|
| **Male69** | 0.739 | 1.222 | 1.248 | 1.731 |
| **Male70_74** | 0.919 | 1.317 | 1.374 | 1.772 |
| **Male75_79** | 1.168 | 1.577 | 1.588 | 1.996 |
| **Male80_84** | 1.352 | 1.760 | 1.771 | 2.180 |
| **Male85_89** | 1.565 | 1.973 | 1.984 | 2.392 |
| **Male90_94** | 1.664 | 2.072 | 2.083 | 2.492 |
| **Male95_GT** | 1.655 | 2.064 | 2.083 | 2.492 |

[1] For payment purposes, a new enrollee is a beneficiary who did not have 12 months of Part B eligibility in the calendar year prior to the payment year.

Source: RTI Analysis of 1999/2000 Medicare 5% sample.

# EXHIBIT 4.

## Final Frailty Factors for the Community Population Aged 55-And-Over[1]

| Difficulty in Activities of Daily Living (ADLs) | Additive Frailty Factor |
|---|---|
| 0 ADLs | -0.143 |
| 1-2 | +0.172 |
| 3-4 | +0.340 |
| 5-6 | +1.094 |

[1] Frailty factors are applied to PACE plans and certain demonstrations.

# Demographic Cost Factors for 1997-2004

## Aged

| Part | Sex | Age | Institutionalized | Non-Institutionalized | | |
|---|---|---|---|---|---|---|
| | | | | Medicaid | Non-Medicaid | Working aged |
| A | Male | 65-69 | 1.75 | 1.15 | 0.65 | 0.40 |
| | | 70-74 | 2.25 | 1.50 | 0.85 | 0.45 |
| | | 75-79 | 2.25 | 1.95 | 1.05 | 0.70 |
| | | 80-84 | 2.25 | 2.35 | 1.20 | 0.80 |
| | | 85+ | 2.25 | 2.60 | 1.35 | 0.90 |
| | Female | 65-69 | 1.45 | 0.80 | 0.55 | 0.35 |
| | | 70-74 | 1.80 | 1.05 | 0.70 | 0.45 |
| | | 75-79 | 2.10 | 1.45 | 0.85 | 0.55 |
| | | 80-84 | 2.10 | 1.70 | 1.05 | 0.70 |
| | | 85+ | 2.10 | 2.10 | 1.20 | 0.80 |
| B | Male | 65-69 | 1.60 | 1.10 | 0.80 | 0.45 |
| | | 70-74 | 1.80 | 1.35 | 0.95 | 0.65 |
| | | 75-79 | 1.95 | 1.55 | 1.10 | 0.80 |
| | | 80-84 | 1.95 | 1.70 | 1.15 | 0.90 |
| | | 85+ | 1.95 | 1.70 | 1.15 | 1.00 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | **Female** | **65-69** | 1.50 | 1.05 | 0.70 | 0.40 |
| | | **70-74** | 1.65 | 1.15 | 0.85 | 0.55 |
| | | **75-79** | 1.65 | 1.25 | 0.95 | 0.70 |
| | | **80-84** | 1.65 | 1.25 | 0.95 | 0.75 |
| | | **85+** | 1.65 | 1.25 | 1.00 | 0.85 |

## Disabled

| | | | | Non-Institutionalized | | |
|---|---|---|---|---|---|---|
| **Part** | **Sex** | **Age** | **Institutionalized** | **Medicaid** | **Non-Medicaid** | **Working aged** |
| **A** | **Male** | **<35** | 1.80 | 1.10 | 0.60 | N/A |
| | | **35-44** | 1.45 | 1.20 | 0.70 | N/A |
| | | **45-54** | 1.10 | 1.30 | 0.65 | N/A |
| | | **55-59** | 0.90 | 1.60 | 0.85 | N/A |
| | | **60-64** | 0.60 | 1.85 | 1.00 | N/A |
| | **Female** | **<35** | 1.80 | 1.20 | 0.55 | N/A |
| | | **35-44** | 1.40 | 1.20 | 0.60 | N/A |
| | | **45-54** | 1.15 | 1.20 | 0.75 | N/A |
| | | **55-59** | 0.95 | 1.35 | 0.95 | N/A |
| | | **60-64** | 0.70 | 1.55 | 1.30 | N/A |

| | | | | | | |
|---|---|---|---|---|---|---|
| **B** | **Male** | **<35** | 1.70 | 1.10 | 0.45 | N/A |
| | | **35-44** | 1.50 | 1.15 | 0.55 | N/A |
| | | **45-54** | 1.25 | 1.15 | 0.60 | N/A |
| | | **55-59** | 1.10 | 1.30 | 0.75 | N/A |
| | | **60-64** | 0.95 | 1.45 | 0.95 | N/A |
| | **Female** | **<35** | 1.95 | 1.05 | 0.75 | N/A |
| | | **35-44** | 1.85 | 1.15 | 0.85 | N/A |
| | | **45-54** | 1.60 | 1.25 | 0.95 | N/A |
| | | **55-59** | 1.35 | 1.35 | 1.05 | N/A |
| | | **60-64** | 1.15 | 1.55 | 1.20 | N/A |

## ESRD for 2002-2004

| Age | Part A | | Part B | |
|---|---|---|---|---|
| | **Male** | **Female** | **Male** | **Female** |
| **0-34** | 0.55 | 0.70 | 0.70 | 0.75 |
| **35-44** | 0.65 | 0.70 | 0.80 | 0.80 |
| **45-54** | 0.70 | 0.85 | 0.85 | 0.90 |
| **55-59** | 0.80 | 0.95 | 0.90 | 1.00 |
| **60-64** | 0.90 | 1.10 | 0.90 | 1.10 |
| **65-69** | 1.15 | 1.35 | 1.10 | 1.20 |
| **70-74** | 1.25 | 1.45 | 1.15 | 1.25 |
| **75-79** | 1.30 | 1.55 | 1.20 | 1.25 |
| **80-84** | 1.40 | 1.60 | 1.20 | 1.25 |
| **85+** | 1.45 | 1.60 | 1.20 | 1.25 |

## CAPITATED PAYMENT UNDER THE ESRD RISK ADJUSTMENT MODEL

Organizations that are paid under the End-Stage Renal Disease (ESRD) risk adjustment system will be paid using a three tier approach corresponding to whether a beneficiary is in dialysis status, is receiving a transplant or is in functioning graft status.

For a patient receiving dialysis, a model calibrated solely on dialysis patients has been developed. The model is similar to the Centers for Medicare & Medicaid Services-Hierarchical Condition Category (CMS-HCC) model used for Medicare+Choice (M+C) plans in that it accounts for demographics and diseases in assigning a risk factor. Monthly payment is computed by multiplying this factor by a base rate for each state. There is a new enrollee dialysis model that is used for beneficiaries without sufficient Medicare history for risk adjustment.

If a beneficiary receives a kidney transplant, the plan is paid using the transplant model for the month of the transplant and the two subsequent months, regardless of whether the beneficiary returns to dialysis status during that time period. The transplant model uses the Medicare costs for these months to assign a factor to each of the months. The factor is applied to the dialysis ratebook. There are two sets of factors, one for a kidney transplant and one for a simultaneous kidney/pancreas transplant. Initially the former will be applied. Payment will be reconciled later if the simultaneous transplant occurred.

After the three-month transplant period, the plan is paid under a model similar to the M+C general model but with added factors indicating either that the beneficiary had a kidney transplant within 9 months or the transplant was further in the past. Payments for the months immediately after the transplant period are higher.

If the graft fails, and CMS receives notice of the start of dialysis, payment reverts to the dialysis model. If there is a second transplant, the transplant model would again apply.

There are five tables with more detail on the model structure for each of the tiers. One of the tables has the hierarchical structure of the models reflecting that, for closely related disease groups, a code for a higher cost group will take precedence over a code for a related lower group.

| CMS-HCC DIALYSIS MODEL[1] | | |
|---|---|---|
| Risk factors are relative to average total Medicare expenditures per capita for dialysis patients | | |
| Mean Year 2000 Total Expenditures[2] = $53,404.31 | | |
| Variable | Label | Relative Factors |
| Age/Sex Groups | | |
| MC0_34 | | 0.647 |
| MC35_44 | | 0.651 |
| MC45_54 | | 0.673 |
| MC55_59 | | 0.721 |
| MC60_64 | | 0.715 |
| MC65_69 | | 0.769 |
| MC70_74 | | 0.781 |
| MC75_79 | | 0.799 |
| MC80_84 | | 0.826 |
| MC85_GT | | 0.868 |
| WC0_34 | | 0.721 |
| WC35_44 | | 0.722 |
| WC45_54 | | 0.739 |
| WC55_59 | | 0.731 |
| WC60_64 | | 0.752 |
| WC65_69 | | 0.822 |
| WC70_74 | | 0.843 |
| WC75_79 | | 0.858 |
| WC80_84 | | 0.863 |
| WC85_GT | | 0.913 |
| Disease Groups | | |
| HCC1 | HIV/AIDS | 0.186 |
| HCC2 | Septicemia/Shock | 0.077 |
| HCC5 | Opportunistic Infections | 0.068 |
| HCC7 | Metastatic Cancer and Acute Leukemia | 0.168 |
| HCC8 | Lung, Upper Digestive Tract, and Other Severe Cancers | 0.168 |
| HCC9 | Lymphatic, Head and Neck, Brain and Other Major Cancers | 0.151 |
| HCC10 | Breast, Prostate, Colorectal and Other Cancers and Tumors | 0.049 |
| HCC15 | Diabetes with Renal or Peripheral Circulatory Manifestation | 0.105 |
| HCC16 | Diabetes with Neurologic or Other Specified Manifestation | 0.105 |
| HCC17 | Diabetes with Acute Complications | 0.105 |
| HCC18 | Diabetes with Ophthalmologic or Unspecified Manisfestation | 0.105 |

| | | |
|---|---|---|
| HCC19 | Diabetes without Complication | 0.105 |
| HCC21 | Protein-Calorie Malnutrition | 0.071 |
| HCC25 | End-Stage Liver Disease | 0.116 |
| HCC26 | Cirrhosis of Liver | 0.104 |
| HCC27 | Chronic Hepatitis | 0.034 |
| HCC31 | Intestinal Obstruction/Perforation | 0.065 |
| HCC32 | Pancreatic Disease | 0.079 |
| HCC33 | Inflammatory Bowel Disease | 0.103 |
| HCC37 | Bone/Joint/Muscle Infections/Necrosis | 0.138 |
| HCC38 | Rheumatoid Arthritis and Inflammatory Connective Tissue Disease | 0.093 |
| HCC44 | Severe Hematological Disorders | 0.095 |
| HCC45 | Disorders of Immunity | 0.061 |
| HCC51 | Drug/Alcohol Psychosis | 0.029 |
| HCC52 | Drug/Alcohol Dependence | 0.029 |
| HCC54 | Schizophrenia | 0.116 |
| HCC55 | Major Depressive, Bipolar, and Paranoid Disorders | 0.116 |
| HCC67 | Quadriplegia, Other Extensive Paralysis | 0.261 |
| HCC68 | Paraplegia | 0.261 |
| HCC69 | Spinal Cord Disorders/Injuries | 0.091 |
| HCC70 | Muscular Dystrophy | 0.075 |
| HCC71 | Polyneuropathy | 0.049 |
| HCC72 | Multiple Sclerosis | 0.082 |
| HCC73 | Parkinson's and Huntington's Diseases | 0.037 |
| HCC74 | Seizure Disorders and Convulsions | 0.069 |
| HCC75 | Coma, Brain Compression/Anoxic Damage | 0.073 |
| HCC77 | Respirator Dependence/Tracheostomy Status | 0.195 |
| HCC78 | Respiratory Arrest | 0.181 |
| HCC79 | Cardio-Respiratory Failure and Shock | 0.065 |
| HCC80 | Congestive Heart Failure | 0.083 |
| HCC81 | Acute Myocardial Infarction | 0.097 |
| HCC82 | Unstable Angina and Other Acute Ischemic Heart Disease | 0.097 |
| HCC83 | Angina Pectoris/Old Myocardial Infarction | 0.036 |
| HCC92 | Specified Heart Arrhythmias | 0.067 |
| HCC95 | Cerebral Hemorrhage | 0.059 |
| HCC96 | Ischemic or Unspecified Stroke | 0.059 |
| HCC100 | Hemiplegia/Hemiparesis | 0.084 |
| HCC101 | Cerebral Palsy and Other Paralytic Syndromes | 0.064 |
| HCC104 | Vascular Disease with Complications | 0.145 |
| HCC105 | Vascular Disease | 0.060 |
| HCC107 | Cystic Fibrosis | 0.072 |
| HCC108 | Chronic Obstructive Pulmonary Disease | 0.072 |
| HCC111 | Aspiration and Specified Bacterial Pneumonias | 0.121 |

| | | |
|---|---|---|
| HCC112 | Pneumococcal Pneumonia, Emphysema, Lung Abscess | 0.043 |
| HCC119 | Proliferative Diabetic Retinopathy and Vitreous Hemorrhage | 0.037 |
| HCC148 | Decubitus Ulcer of Skin | 0.177 |
| HCC149 | Chronic Ulcer of Skin, Except Decubitus | 0.113 |
| HCC150 | Extensive Third-Degree Burns | 0.083 |
| HCC154 | Sever Head Injury | 0.073 |
| HCC155 | Major Head Injury | 0.040 |
| HCC157 | Vertebral Fractures without Spinal Cord Injury | 0.046 |
| HCC158 | Hip Fracture/Dislocation | 0.051 |
| HCC161 | Traumatic Amputation | 0.093 |
| HCC164 | Major Complications of Medical Care and Trauma | 0.027 |
| HCC174 | Major Organ Transplant Status | 0.193 |
| HCC176 | Artificial Openings for Feeding or Elimination | 0.071 |
| HCC177 | Amputation Status, Lower Limb/Amputation Complications | 0.093 |

| Medicaid Interactions with Age and Sex | |
|---|---|
| MEDICAID_FEMALE_AGED | 0.033 |
| MEDICAID_FEMALE_DISABLED | 0.052 |
| MEDICAID_MALE_AGED | 0.047 |
| MEDICAID_MALE_DISABLED | 0.042 |

| Originally Disabled Interactions With Sex | | |
|---|---|---|
| ORIGESR_FEMALE | Female, 65+, Originally Entitled due to ESRD/ w or wo Disability | -0.067 |
| ORIGESR_MALE | Male, 65+, Originally Entitled due to ESRD/ w or wo Disability | -0.049 |
| ORIG1_FEMALE | Female, 65+, Originally Entitled due to Disability (non-ESRD) | 0.052 |
| ORIG1_MALE | Male, 65+, Originally Entitled due to Disability (non-ESRD) | 0.023 |

| Disabled/Disease Interactions | | |
|---|---|---|
| D_HCC5 | <65*Opportunistic Infections | 0.092 |
| D_HCC44 | <65*Severe Hematological Disorders | 0.070 |
| D_HCC51 | <65*Drug/Alcohol Psychosis | 0.095 |
| D_HCC52 | <65*Drug/Alcohol Dependence | 0.095 |
| D_HCC107 | <65*Cystic Fibrosis | 0.181 |

[1]This model is used for those enrollees who have a full year of base year claims data.
[2] Mean over all dialysis patients including those with Medicare as secondary payer

## CMS-HCC DIALYSIS MODEL FOR NEW ENROLLEES[1]

Mean Year 2000 Total Expenditures[2] = $53,404.31

| Variable | Label | Relative Factors |
|---|---|---|
| Age/Sex Groups | | |
| MC0_34 | | 0.686 |
| MC35_44 | | 0.765 |
| MC45_54 | | 0.805 |
| MC55_59 | | 0.864 |
| MC60_64 | | 0.895 |
| MC65_69 | | 1.019 |
| MC70_74 | | 1.092 |
| MC75_79 | | 1.122 |
| MC80_84 | | 1.168 |
| MC85_GT | | 1.204 |
| WC0_34 | | 0.790 |
| WC35_44 | | 0.819 |
| WC45_54 | | 0.899 |
| WC55_59 | | 0.909 |
| WC60_64 | | 0.940 |
| WC65_69 | | 1.102 |
| WC70_74 | | 1.189 |
| WC75_84 | | 1.215 |
| WC85_GT | | 1.256 |
| | | |
| Medicaid Interactions with Age and Sex | | |
| MEDICAID_FEMALE_AGED | | 0.104 |
| MEDICAID_FEMALE_DISABLED | | 0.183 |
| MEDICAID_MALE_AGED | | 0.144 |
| MEDICAID_MALE_DISABLED | | 0.184 |
| | | |
| Originally Disabled Interactions With Sex | | |
| ORIGDISM | Male <65, originally entitled due to disability (non-ESRD) | 0.206 |
| ORIGDISM | Male 65+, originally entitled due to disability (non-ESRD) | 0.206 |
| ORIGDISF | Female <65, originally entitled due to disability (non-ESRD) | 0.215 |
| ORIGDISF | Female 65+, originally entitled due to disability (non-ESRD) | 0.215 |

[1]New Enrollees are those enrollees who do not have a full year of base year claims data.
[2] Mean over all dialysis patients including those with Medicare as secondary payer

## Payment for Transplants

Under the risk adjusted system of payments for ESRD patients, payment for transplants is carved out of the payments for all ESRD patients. The payment factor for a transplant is based on the average Medicare costs for transplant admissions and the two months subsequent to discharge. When CMS is notified of a transplant three monthly payments are made. Instead of a dialysis risk factor being the basis for payment in those months, a transplant factor is used and applied to the dialysis ratebook. After the three months, payment is made at the functioning graft rate or at the dialysis rate, as appropriate.

**TRANSPLANT CALCULATIONS**

| | KIDNEY ONLY | KIDNEY PLUS PANCREAS | KIDNEY ONLY | KIDNEY PLUS PANCREAS |
|---|---|---|---|---|
| | $ | $ | Relative Factor | Relative Factor |
| | | | | |
| month1 | 33424 | 50136 | 7.510 | 11.266 |
| month2 | 4523 | 6785 | 1.016 | 1.525 |
| month3 | 4523 | 6785 | 1.016 | 1.525 |
| total | 42470 | 63705 | | |

To compute the relative factors, the national mean of annual dialysis patient costs was converted to a monthly amount and the transplant monthly costs were divided by this number.

| | |
|---|---|
| Mean annual dialysis costs | 53404.31 |
| Costs per month | 4450.36 |

## CMS-HCC COMMUNITY AND INSTITUTIONAL MODELS FOR FUNCTIONING GRAFT

**Note:** Additional payment factors for functioning graft status are at bottom

| | | Community | | | Institutional | |
|---|---|---|---|---|---|---|
| | | Relative | | | Relative | |
| Variable | Label | Factor | | | Factor | |
| Female0_34 | | 0.117 | | | 1.064 | |
| Female35_44 | | 0.197 | | | 1.064 | |
| Female45_54 | | 0.214 | | | 1.064 | |
| Female55_59 | | 0.265 | | | 1.064 | |
| Female60_64 | | 0.375 | | | 1.064 | |
| Female65_69 | | 0.307 | | | 1.164 | |
| Female70_74 | | 0.384 | | | 1.179 | |
| Female75_79 | | 0.483 | | | 0.992 | |
| Female80_84 | | 0.572 | | | 0.938 | |
| Female85_89 | | 0.665 | | | 0.880 | |
| Female90_94 | | 0.795 | | | 0.789 | |
| Female95_GT | | 0.805 | | | 0.581 | |
| Male0_34 | | 0.068 | | | 1.104 | |
| Male35_44 | | 0.120 | | | 1.104 | |
| Male45_54 | | 0.190 | | | 1.104 | |
| Male55_59 | | 0.270 | | | 1.104 | |
| Male60_64 | | 0.342 | | | 1.104 | |
| Male65_69 | | 0.346 | | | 1.450 | |
| Male70_74 | | 0.453 | | | 1.238 | |
| Male75_79 | | 0.577 | | | 1.211 | |
| Male80_84 | | 0.657 | | | 1.209 | |
| Male85_89 | | 0.790 | | | 1.241 | |
| Male90_94 | | 0.901 | | | 1.049 | |
| Male95_GT | | 1.035 | | | 0.836 | |
| | | | | | | |
| Medicaid and Originally Disabled Interactions with Age and Sex[3] | | | | | | |
| Medicaid_Female_Disabled | | 0.221 | | | | |
| Medicaid_Female_Aged | | 0.183 | | | | |
| Medicaid_Male_Disabled | | 0.115 | | | | |
| Medicaid_Male_Aged | | 0.184 | | | | |
| | | | | | | |
| OriginallyDisabled_Female | Male, 65+, Originally Entitled due to Disability | 0.236 | | | | |
| OriginallyDisabled_Male | Male, 65+, Originally Entitled due to Disability | 0.148 | | | | |
| | | | | | | |
| Disease Coefficients | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| HCC1 | HIV/AIDS | 0.685 | | | 1.344 | C3 |
| HCC2 | Septicemia/Shock | 0.890 | | | 0.946 | |
| HCC5 | Opportunistic Infections | 0.652 | | | 1.344 | C3 |
| HCC7 | Metastatic Cancer and Acute Leukemia | 1.464 | | | 0.540 | |
| HCC8 | Lung, Upper Digestive Tract, and Other Severe Cancers | 1.464 | | | 0.540 | |
| HCC9 | Lymphatic, Head and Neck, Brain and Other Cancers | 0.690 | | | 0.452 | |
| HCC10 | Breast, Prostate, Colorectal and Other Cancers and Tumors | 0.233 | | | 0.259 | |
| HCC15 | Diabetes with Renal or Peripheral Circulatory Manifestation | 0.764 | | | 0.612 | |
| HCC16 | Diabetes with Neurologic or Other Specified Manifestation | 0.552 | | | 0.612 | |
| HCC17 | Diabetes with Acute Complications | 0.391 | | | 0.612 | |
| HCC18 | Diabetes with Ophthalmologic or Unspecified Manifestation | 0.343 | | | 0.612 | |
| HCC19 | Diabetes without Complication | 0.200 | | | 0.255 | |
| HCC21 | Protein-Calorie Malnutrition | 0.922 | | | 0.427 | |
| HCC25 | End-Stage Liver Disease | 0.900 | | | 0.268 | |
| HCC26 | Cirrhosis of Liver | 0.516 | | | 0.268 | |
| HCC27 | Chronic Hepatitis | 0.359 | | | 0.268 | |
| HCC31 | Intestinal Obstruction/Perforation | 0.408 | | | 0.268 | |
| HCC32 | Pancreatic Disease | 0.445 | | | 0.268 | |
| HCC33 | Inflammatory Bowel Disease | 0.307 | | | 0.268 | |
| HCC37 | Bone/Joint/Muscle Infections/Necrosis | 0.496 | | | 0.495 | |
| HCC38 | Rheumatoid Arthritis and Inflammatory Connective Tissue Disease | 0.322 | | | 0.285 | |
| HCC44 | Severe Hematological Disorders | 1.011 | | | 0.448 | |
| HCC45 | Disorders of Immunity | 0.830 | | | 0.448 | |
| HCC51 | Drug/Alcohol Psychosis | 0.353 | | | 0.221 | |
| HCC52 | Drug/Alcohol Dependence | 0.265 | | | 0.221 | |
| HCC54 | Schizophrenia | 0.543 | | | 0.221 | |
| HCC55 | Major Depressive, Bipolar, and Paranoid Disorders | 0.431 | | | 0.221 | |
| HCC67 | Quadriplegia, Other Extensive Paralysis | 1.181 | | | 0.098 | |
| HCC68 | Paraplegia | 1.181 | | | 0.098 | |
| HCC69 | Spinal Cord Disorders/Injuries | 0.492 | | | 0.098 | |
| HCC70 | Muscular Dystrophy | 0.386 | | | 0.098 | |
| HCC71 | Polyneuropathy | 0.268 | | | 0.098 | |
| HCC72 | Multiple Sclerosis | 0.517 | | | 0.098 | |

| | | | | | | |
|---|---|---|---|---|---|---|
| HCC73 | Parkinson's and Huntington's Diseases | 0.475 | | | 0.098 | |
| HCC74 | Seizure Disorders and Convulsions | 0.269 | | | 0.098 | |
| HCC75 | Coma, Brain Compression/Anoxic Damage | 0.568 | C1 | | 0.098 | C4 |
| HCC77 | Respirator Dependence/Tracheostomy Status | 2.102 | | | 1.415 | |
| HCC78 | Respiratory Arrest | 1.429 | | | 1.415 | |
| HCC79 | Cardio-Respiratory Failure and Shock | 0.692 | | | 0.289 | |
| HCC80 | Congestive Heart Failure | 0.417 | | | 0.176 | |
| HCC81 | Acute Myocardial Infarction | 0.348 | | | 0.288 | |
| HCC82 | Unstable Angina and Other Acute Ischemic Heart Disease | 0.348 | | | 0.288 | |
| HCC83 | Angina Pectoris/Old Myocardial Infarction | 0.235 | | | 0.288 | |
| HCC92 | Specified Heart Arrhythmias | 0.266 | | | 0.187 | |
| HCC95 | Cerebral Hemorrhage | 0.392 | | | 0.151 | |
| HCC96 | Ischemic or Unspecified Stroke | 0.306 | | | 0.151 | |
| HCC100 | Hemiplegia/Hemiparesis | 0.437 | | | 0.098 | |
| HCC101 | Cerebral Palsy and Other Paralytic Syndromes | 0.164 | | | 0.098 | C4 |
| HCC104 | Vascular Disease with Complications | 0.677 | | | 0.509 | |
| HCC105 | Vascular Disease | 0.357 | | | 0.114 | |
| HCC107 | Cystic Fibrosis | 0.376 | | | 0.230 | |
| HCC108 | Chronic Obstructive Pulmonary Disease | 0.376 | | | 0.230 | |
| HCC111 | Aspiration and Specified Bacterial Pneumonias | 0.693 | | | 0.463 | |
| HCC112 | Pneumococcal Pneumonia, Emphysema, Lung Abscess | 0.202 | | | 0.463 | |
| HCC119 | Proliferative Diabetic Retinopathy and Vitreous Hemorrhage | 0.349 | | | 0.995 | |
| HCC130[2] | Dialysis Status | | | | | |
| HCC131[2] | Renal Failure | | | | | |
| HCC132 | Nephritis | 0.273 | | | 0.420 | |
| HCC148 | Decubitus Ulcer of Skin | 1.030 | | | 0.317 | |
| HCC149 | Chronic Ulcer of Skin, Except Decubitus | 0.484 | | | 0.262 | |
| HCC150 | Extensive Third-Degree Burns | 0.962 | | | 0.248 | |
| HCC154 | Sever Head Injury | 0.568 | C1 | | 0.248 | |
| HCC155 | Major Head Injury | 0.242 | | | 0.248 | C5 |
| HCC157 | Vertebral Fractures without Spinal Cord Injury | 0.490 | | | 0.098 | C4 |

| | | | | | | |
|---|---|---|---|---|---|---|
| HCC158[3] | Hip Fracture/Dislocation | 0.392 | | | | |
| HCC161 | Traumatic Amputation | 0.843 | C2 | | 0.248 | C5 |
| HCC164 | Major Complications of Medical Care and Trauma | 0.262 | | | 0.263 | |
| HCC174 | Major Organ Transplant Status | 0.261 | | | 0.319 | |
| HCC176 | Artificial Openings for Feeding or Elimination | 0.790 | | | 0.882 | |
| HCC177 | Amputation Status, Lower Limb/Amputation Complications | 0.843 | C2 | | 0.248 | C5 |
| | | | | | | |
| Disabled/Disease Interactions[3] | | | | | | |
| D_HCC5[3] | <65*Opportunistic Infections | 0.789 | | | | |
| D_HCC44[3] | <65*Severe Hematological Disorders | 0.893 | | | | |
| D_HCC51[3] | <65*Drug/Alcohol Psychosis | 0.509 | | | | |
| D_HCC52[3] | <65*Drug/Alcohol Dependence | 0.414 | | | | |
| D_HCC107[3] | <65*Cystic Fibrosis | 1.861 | | | | |
| | | | | | | |
| Disease Interactions[1] | | | | | | |
| INT1 | DM_CHF | 0.253 | | | 0.207 | |
| INT2[3] | DM_CVD | 0.125 | | | | |
| INT3 | CHF_COPD | 0.241 | | | 0.372 | |
| INT4[3] | COPD_CVD_CAD | 0.079 | | | | |
| INT5[2] | RF_CHF | | | | | |
| INT6[2] | RF_CHF_DM | | | | | |
| | | | | | | |
| Graft Factors[4] | | | | | | |
| DDUR4-9 | <65, with duration since transplant of 4-9 months | 3.091 | | | 3.091 | |
| ADUR4-9 | 65+, with duration since transplant of 4-9 months | 3.425 | | | 3.425 | |
| DDUR10+ | <65, with duration since transplant of 10 months or more | 1.620 | | | 1.620 | |
| ADUR10+ | 65+, with duration since transplant of 10 months or more | 1.691 | | | 1.691 | |

Notes:
To determine payment for persons with functioning grafts, the computed risk factor should be applied to the appropriate cell in the CMS-HCC county risk ratebook for the aged and disabled.
"|" means coefficients of HCCs are constrained to be equal. C1, C2, etc. denote non-contiguous constraints.[1]
Diseases in interactions are:.
DM = diabetes mellitus (HCCs 15-19)
CHF = congestive heart failure (HCC 80)
COPD = chronic obstructive pulmonary disease (HCC 108)
CVD = cerebrovascular disease (HCCs 95-96, 100-101)
CAD = coronary artery disease (HCCs 81-83)
RF = renal failure (HCC 131)

[2] These HCC's are not in the model for those in functioning graft status.
[3] These HCCs not present in institutional model
[4]The graft factors are additive, similar to any other factors in the CMS-HCC model. The factor is higher during the months immediately after the transplant period to account for a high level of monitoring and services.
For payment in any month, duration is measured from the month of transplant to the first day of that month.
All coefficients except for the graft factors and HCC174 are restricted to the values estimates for the CMS-HCC payment models.

# MODULE 2 – RISK ADJUSTMENT PROCESS OVERVIEW

## Purpose (Slide 2)

The success of Medicare+Choice (M+C) risk adjustment is dependent on organizations understanding the process of collecting and submitting accurate risk adjustment data. The purpose of this module is to provide participants with important terms, key resources, and schedule information that will provide the foundation for this training.

## Learning Objectives (Slide 3)

At the completion of this module, participants will be able to:

- Identify common risk adjustment terminology.
- Demonstrate knowledge in interpreting key components of the risk adjustment process.
- Interpret the risk adjustment schedule.
- Identify the Centers for Medicare & Medicaid Services (CMS) outreach efforts available to organizations.

**ICON KEY**

Example

Reminder

Resource

Information Systems Track

Quality & Compliance Track

## 2.1 Common Risk Adjustment Terms (Slide 4)

Table 2A provides descriptions for common risk adjustment terminology.

**TABLE 2A – RISK ADJUSTMENT COMMON TERMS**

| TERM | DESCRIPTION |
|---|---|
| **FERAS** | Risk adjustment submitters send data to Palmetto through the **Front-End Risk Adjustment System**. |
| **RAPS** | Risk adjustment data is processed by the **Risk Adjustment Processing System.** |
| **RAS** | The **Risk Adjustment System** calculates the risk adjusted payment. |
| **MBD** | The **Medicare Beneficiary Database** maintains Medicare beneficiary eligibility data. |
| **HPMS** | The **Health Plan Management System** is a CMS M+C information system that contains health plan-level data. |
| **Relevant Diagnosis** | ICD-9-CM diagnosis code in the CMS-Hierarchical Condition Category (HCC) model. |

## 2.2 Risk Adjustment Process Overview

Hospital inpatient, hospital outpatient, and physician risk adjustment data must be submitted at least quarterly. Risk adjustment data is processed through RAPS.

### 2.2.1 Risk Adjustment Data Requirements (Slide 5)

- The data required under the risk adjustment process include:
  - Health Insurance Claim (HIC) number.
  - Diagnosis code.
  - Service from/through dates.
  - Provider type (hospital inpatient, hospital outpatient, physician).
  - Patient control number (optional).
  - Date of birth (optional).
- M+C organizations must submit data at least quarterly to CMS.
- Each quarterly submission should represent approximately one-fourth of the data that the M+C organization will submit during a data collection year. M+C organizations will be monitored to ensure compliance.
- All beneficiary ICD-9-CM diagnosis codes relevant for the CMS-HCC risk adjustment model must be reported at least once per enrollee in the data collection period.

### 2.2.2 Risk Adjustment Data Collection (Slide 6)

- M+C organizations may choose to collect data from providers in a variety of formats:
  - Standard fee-for-service claim or encounter formats
    - Full or abbreviated Uniform Billing Form 92 (UB-92) v6.0
    - HCFA 1500
    - National Standard Format (NSF) v3.01
    - American National Standards Institute (ANSI) X12 837 v30.51 or v40.10. Health Insurance Portability and Accountability Act (HIPAA) mandated transactions must use v40.10.
  - Superbill
  - RAPS format
    - HIC number
    - Provider type
    - Diagnosis code
    - Service from date
    - Service through date

### 2.2.3 Risk Adjustment Data Submission (Slide 7)

- M+C organizations must submit data to CMS through FERAS (Palmetto GBA) utilizing any of the following formats:

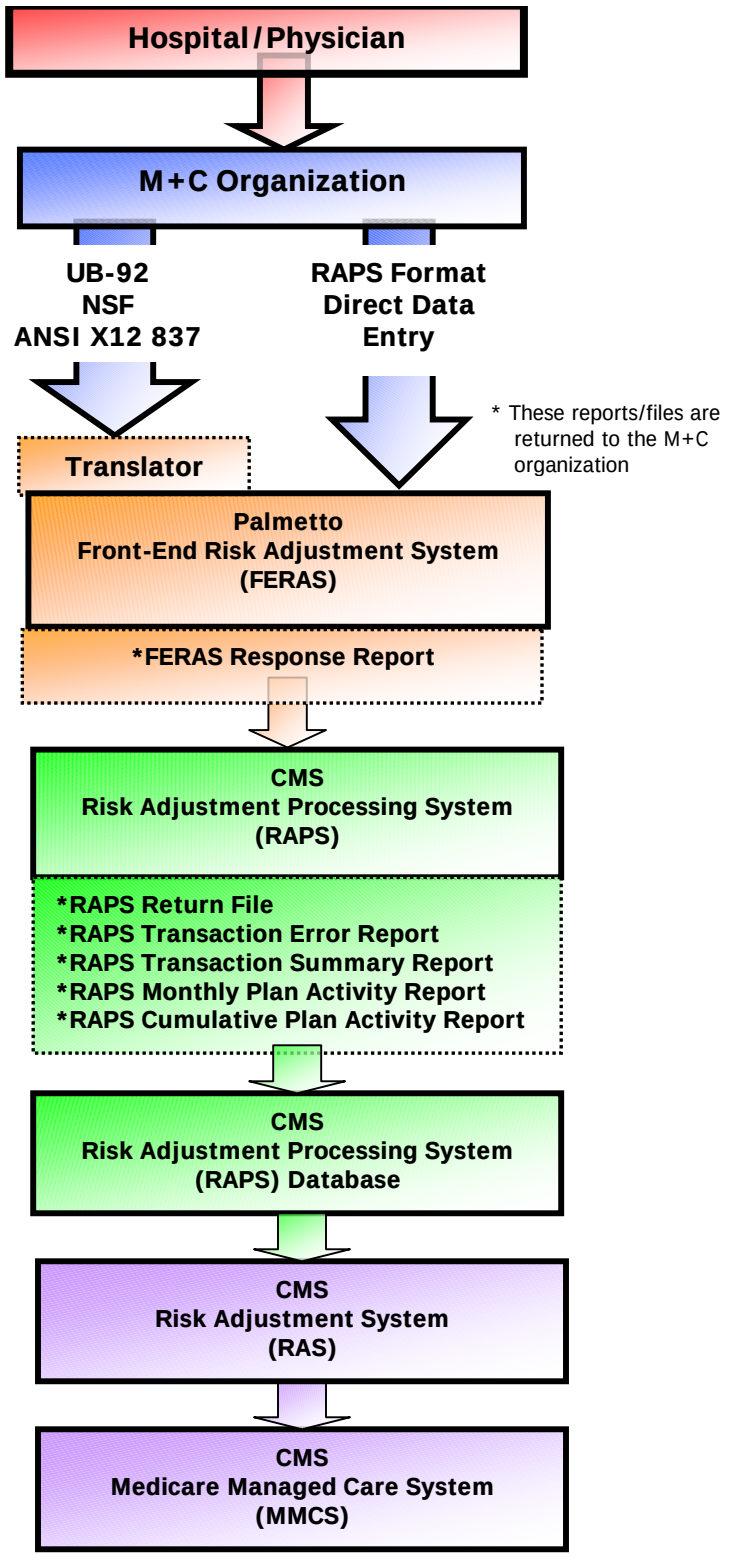
  - Full or abbreviated UB-92 v6.0 (hospital inpatient and hospital outpatient)
  - NSF v3.01 (physician)
  - ANSI X12 837 v30.51 or v40.10 (all types of data) (HIPAA uses v40.10)
  - RAPS format (all types of data)
  - Direct Data Entry Screen (all types of data)

Figure 2A illustrates the risk adjustment dataflow.

## 2.2.4 Risk Adjustment Dataflow (Slide 8)

- Hospital/physician submits data to M+C organization via:
  - Full or abbreviated UB-92 v 6.0, HCFA 1500, NSF v3.01, ANSI x837 v30.51 or v40.10, Superbill or RAPS format.
- The M+C organization submits the data on at least a quarterly basis to Palmetto GBA.
- If the M+C organization submits data via the UB-92, NSF, or ANSI formats, Palmetto will translate the data to the RAPS format.
- If the M+C organization submits the data via Direct Data Entry or in the RAPS format, data does not need translation.
- The data are sent to FERAS for processing where the file-level data, batch-level data, and first and last detail records are checked.
- If any data are rejected, then data will be reported on the FERAS Response Report.
- After passing the FERAS checks, the file is submitted to RAPS where detail editing is performed.
- The RAPS Return File is returned daily and shows all records approved and where errors occurred.
- The RAPS Transaction Error Report displays records on which errors occurred.
- The RAPS Transaction Summary Report is sent to the M+C organization daily and identifies data that have been finalized in RAPS database.
- The RAPS Monthly Plan Activity Report and Cumulative Plan Activity Report will provide a summary of all diagnoses stored for a given time period.
- RAPS database stores all finalized diagnosis clusters.
- RAS calculates the Risk Adjuster Factors by executing the CMS-HCC model.
- MMCS is used in the calculation of payments and determination of plan payments. MMCS will replace GHP in mid-2004.

**Figure 2A – Risk Adjustment Dataflow**



### 2.2.5 Important Information About Risk Adjustment Processing

- M+C organizations transmit data to FERAS at Palmetto GBA. If the data are submitted to FERAS via the UB-92, NSF, or ANSI X12 837 formats, the file is automatically translated to the RAPS format.
- FERAS performs format and face validity checks on the file and batch level as well as formatting verification on the first and last detail record (CCC) in the file.
- If the data fail the front-end checks, the complete file is rejected at the front end.
- The FERAS Response Report identifies whether the file is accepted or rejected up front.
- Once the file has passed front-end checks, it moves to RAPS. All validity edits on detail-level data are performed in this system.
- Processing time from beginning to end should take approximately 1 to 2 days.
- After the file has processed through RAPS, the M+C organization will receive a RAPS Return File and RAPS Transaction Error Report identifying any errors.
- All ICD-9-CM diagnoses that pass validity edits are stored in the RAPS database.
- The M+C organization will also receive a RAPS Transaction Summary Report reflecting all finalized data that have been sent to the RAPS Database and all rejected data.
- The M+C organization will also receive two risk adjustment management reports: 1) the RAPS Monthly Plan Activity Report and 2) the RAPS Cumulative Plan Activity Report (monthly).
- All data will be converted to the RAPS format and returned in the RAPS Return File.
- Interim hospital inpatient bills (112, 113, and 114 bill types) must not be submitted. If an M+C organization receives interim bills, the organization should submit the hospital inpatient diagnoses on receipt of the final bill (114). This means the appropriate discharge diagnoses will be submitted for risk adjustment, rather than the admitting diagnoses.

## 2.3 Submission Schedule (Slide 9)

The elimination of the payment lag changes the submission schedule. This will require M+C organizations to meet three submission deadlines—the first Friday in September, the first Friday in March of each year, and a yearly reconciliation deadline of May 15 beginning in 2005. The schedule and these changes are illustrated in Table 2B.

**TABLE 2B – SUBMISSION TIMETABLE**

| CY | DATES OF SERVICE | INITIAL SUBMISSION DEADLINE | FIRST PAYMENT DATE | FINAL SUBMISSION DEADLINE |
|---|---|---|---|---|
| 2004 | July 1, 2002 through June 30, 2003 | September 5, 2003 | January 1, 2004 | NA* |
| 2004 | January 1, 2003 through December 31, 2003 | March 5, 2004 | July 1, 2004 | May 13, 2005 |
| 2005 | July 1, 2003 through June 30, 2004 | September 3, 2004 | January 1, 2005 | NA* |
| 2005 | January 1, 2004 through December 31, 2004 | March 4, 2005 | July 1, 2005 | May 15, 2006 |
| *With elimination of the payment lag, the final submission deadline (reconciliation) changes to May 15th of each year. There is no September 30, 2004 deadline. | | | | |

## 2.4 Training and Support (Slides 10-11)

In an effort to ensure that participating organizations have the necessary tools and information to be successful with the risk adjustment process, CMS has planned the following outreach efforts, as described in Table 2C.

**TABLE 2C – TRAINING AND SUPPORT**

| INITIATIVE | DESCRIPTION |
|---|---|
| **Customer Service & Support Center** | This toll free help line (1-877-534-2772) is available Monday – Friday 9:00 a.m. to 7:00 p.m. ET (with the exception of corporate observed holidays) to provide assistance.<br><br>The support center provides ongoing assistance.<br><br>The FERAS system is available for submission of risk adjustment data 24 hours a day, 7 days a week regardless of holidays. The only exception would be from midnight Saturday through noon Sunday when systems and equipment are routinely maintained. |
| **www.mcoservice.com** | The CSSC website, www.mcoservice.com is the gateway to the Risk Adjustment Processing System. Visitors to the site can access information about RAPS/FERAS, including opportunities to register for service, enroll to submit risk adjustment data, and obtain comprehensive information about data entry and report layouts. In addition, the site provides valuable links to CMS instructions and other official resources. Monthly user group and other training information are regularly posted. Finally, the site provides up-to-date system status alerts and answers to frequently asked questions about risk adjustment.<br><br>To register for email updates, go to www.mcoservice.comT and click on M+CO Email Registration. Then click on “new registration” and complete the registration form. |
| **Onsite Consultation** | Onsite consultation visits provide M+C organizations with the opportunity to gain valuable information about risk adjustment data submission and data validation processes. These consultations generally occur between April and May. Each visit includes a review of the M+C organization’s system. |
| **Getting Started Training Program** | The program presents the basics about the risk adjustment process for M+C organizations and staff new to risk adjustment. It includes a self-paced video, workbook, and resource guide. |
| **Regional Training Program** | The program provides practical training for new and current users. |
| **Regional Training Video** | A video version of the 2004 training. Expected availability is September 2004. |
| **Physician Training CD** | An interactive CD provides important risk adjustment medical record documentation and coding guidelines in accordance with the CMS risk adjustment data collection requirements. |

# MODULE 3 – DATA COLLECTION

## Purpose (Slide 2, 2)

For the purpose of risk adjustment, Medicare+Choice (M+C) organizations must collect data from hospital inpatient facilities, hospital outpatient facilities, and physicians. The collection of data from the appropriate risk adjustment sources and formats is critical for accurate risk adjusted payment for your organization. This module is designed to offer participants an opportunity to apply data collection principles in accordance with Centers for Medicare & Medicaid Services (CMS) requirements.

## Learning Objectives (Slide 3, 3)

At the completion of this module, participants will be able to:

- Identify the data elements required for risk adjustment.
- Identify the three sources of risk adjustment data.
- Identify data collection formats available to M+C organizations.
- Discuss factors to consider when determining the method for collection of diagnostic data.
- Discuss Health Insurance Portability and Accountability Act (HIPAA) transaction standards for purposes of risk adjustment data collection.

**ICON KEY**

| | |
|---|---|
| Example | |
| Reminder | |
| Resource | |
| Information Systems Track | |
| Quality & Compliance Track | |

## 3.1 Required Risk Adjustment Data Elements (Slide 5, 5)

M+C organizations must collect certain data elements from the sources (providers/physicians) of risk adjustment data described in this module. The minimum data elements that must be collected are:

- HIC number.
- ICD-9-CM diagnosis codes.
- Service from date.
- Service through date.
- Provider type.

### 3.1.1 HIC Number (Slides 6-7, 6)

A HIC number (Health Insurance Claim Number) is a Medicare beneficiary's identification number. Both CMS and the Railroad Retirement Board (RRB) issue Medicare HIC numbers. The format of a HIC number issued by CMS is a Social Security number followed by an alpha or alpha-numeric Beneficiary

Identification Code (BIC). RRB numbers issued before 1964 are 6-digit numbers followed with an alpha prefix. After 1964, the RRB began using Social Security numbers as Medicare beneficiary identification numbers preceded by an alpha prefix. Table 3A shows the characteristics for each HIC type.

**TABLE 3A – STRUCTURE OF HIC NUMBERS**

| HIC TYPE | CHARACTERISTICS |
|---|---|
| **CMS** | • 9-digit Social Security number<br>• alpha suffix<br>- "A" beneficiary<br>- "B" spouse<br>- "C" children<br>- "D" divorced spouse, widow, widower<br>• alpha-numeric suffix<br>- indicates number of children (e.g., "C1" first child) |
| **RRB pre-1964** | • alpha prefix<br>• 6-digit random numbers |
| **RRB post-1964** | • alpha prefix<br>• 9-digit Social Security number |

**Note:** M+C organizations are not required to collect HIC numbers from physicians and providers, but must identify beneficiaries using the HIC number when submitting data to CMS.

### 3.1.2 ICD-9-CM Diagnosis Code (Slide 8, 7)

ICD-9-CM codes are 3- to 5-digit codes used to describe the clinical reason for a patient's treatment. They do not describe the service performed, just the patient's medical condition. Diagnosis codes drive the risk scores, which drive the risk adjusted reimbursement from CMS to M+C organizations.

### 3.1.3 Service From and Through Dates (Slide 9, 8)

The dates of service define when a beneficiary received medical treatment from a physician or medical facility. For outpatient and physician services, the From Date and Through Date may be identical. For inpatient services, these dates are different, reflecting the dates of admission to and discharge from a facility.

Date span is the number of days between the From Date and Through Date for a reported diagnosis. For risk adjustment, the date span is important to determine if the reported diagnosis cluster falls within the data reporting period.

### 3.1.4 Provider Type (Slide 10, 9)

For the purpose of risk adjustment, M+C organizations must collect data from the following provider types:

- Hospital inpatient facilities
- Hospital outpatient facilities
- Physicians

These are the three principal sources of data. M+C organizations are responsible for determining provider type based on the source of the data.

## 3.2 Data Sources (Slide 10)

M+C organizations are responsible for ensuring that the data they collect comes from acceptable sources. These sources are hospital inpatient facilities, hospital outpatient facilities, and physicians.

### 3.2.1 Hospital Inpatient (Slide 12, 11)

A hospital inpatient service is one provided by a hospital during which a patient is admitted to the facility for at least an overnight stay.

Inpatient hospital data should be differentiated based on whether it is received from within or outside of the M+C organization's provider network. A network hospital should have a Medicare provider billing number as a hospital inpatient facility. Table 3B identifies covered and non-covered facilities with regard to risk adjustment data collection.

**TABLE 3B – HOSPITAL INPATIENT**

| PROVIDER TYPE | COVERED FACILITIES | | NON-COVERED FACILITIES* |
|---|---|---|---|
| **Hospital Inpatient** | • Short-term (general and specialty) Hospitals<br>• Religious Non-Medical Health Care Institutions (formerly Christian Science Sanatoria) | • Long-term Hospitals<br>• Rehabilitation Hospitals<br>• Children's Hospitals<br>• Psychiatric Hospitals<br>• Medical Assistance Facilities/Critical Access Hospitals | • Skilled Nursing Facilities (SNFs)<br>• Hospital Inpatient Swing Bed Components<br>• Intermediate Care Facilities<br>• Respite Care<br>• Hospice |

* These are examples of non-covered facilities and not a comprehensive list.

When submitting hospital inpatient data, M+C organizations must make a distinction between the principal diagnosis and other diagnoses. This will be covered in the Data Submission module.

Table 3D illustrates the steps M+C organizations may use to identify the provider numbers of facilities.

### 3.2.2 Hospital Outpatient (Slide 13, 13)

Hospital outpatient services are therapeutic and rehabilitation for sick or injured persons who do not require inpatient hospitalization or institutionalization.

Data must be collected from hospital outpatient departments. As with hospital inpatient facilities, the M+C organization must determine which facilities are Medicare certified, network, or non-network. Table 3C identifies covered and non-covered hospital outpatient facilities.

**TABLE 3C – HOSPITAL OUTPATIENT**

| PROVIDER TYPE | COVERED FACILITIES | | NON-COVERED SERVICES | NON-COVERED FACILITIES* |
|---|---|---|---|---|
| **Hospital Outpatient** | • Short-term (general and specialty) Hospitals<br>• Medical Assistance Facilities/Critical Access Hospitals<br>• Community Mental Health Centers**<br>• Federally Qualified Health Centers/Religious Non-Medical Health Care Institutions (formerly Christian Science Sanatoria)** | • Long-term Hospitals<br>• Rehabilitation Hospitals<br>• Children's Hospitals<br>• Psychiatric Hospitals<br>• Rural Health Clinic (Free-standing and Provider-Based)** | • Laboratory services<br>• Ambulance<br>• Durable medical equipment<br>• Prosthetics<br>• Orthotics<br>• Supplies<br>• Radiology services | • Free-standing Ambulatory Surgical Centers (ASCs)<br>• Home Health Care<br>• Free-standing Renal Dialysis Facilities |

* These are examples of non-covered facilities and not a comprehensive list.
** Facilities use a composite bill that covers both the physician and the facility component of the services, and services rendered in these facilities do not result in an independent physician claim.

- **Community Mental Health Centers (CMHCs)** provide outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at an inpatient facility.

- **Federally Qualified Health Centers (FQHCs)** are facilities located in a medically underserved area that provide Medicare beneficiaries with preventive primary medical care under the general direction of a physician.

- **Rural Health Clinics (RHCs)** are Medicare certified facilities that are located in a rural, medically underserved area and that provide ambulatory primary medical care under the general direction of a physician.

### 3.2.2.1 Determining Whether Facilities Are Acceptable For Risk Adjustment (Slide 14)

M+C organizations are responsible for ensuring that data collected and then submitted are acceptable for the risk adjustment process. The Medicare provider number is the most appropriate indicator in determining the appropriateness of the covered hospital entities for the purposes of risk adjustment data collection. Table 3D illustrates the steps M+C organizations may use to identify the provider numbers of facilities.

**TABLE 3D – DETERMINING COVERED HOSPITAL ENTITY PROVIDER NUMBERS**

| SITUATION | ISSUE | ACTION |
|---|---|---|
| **Situation 1** | The provider number has been identified. | Determine if the number is in an acceptable range for risk adjustment. If in the acceptable range, submit the data. |
| **Situation 2** | An in-network provider submitted a claim but did not include the provider number. | Obtain the provider number and determine if the number is in an acceptable range for risk adjustment. If in the acceptable range, submit the data.<br>NOTE: All network providers are required to have certified Medicare provider numbers; therefore, do not submit risk adjustment data for this provider until the provider number can be obtained. |
| **Situation 3** | An out-of-network provider submits a claim without a provider number. | Try to obtain a provider number, if possible. If no provider number is available check the list of Veterans Administration and Department of Defense (VA/DoD) listings published on the mcoservice.com website. If the provider is listed there, submit the data.<br><br>If the provider is not on the VA/DoD list, the organization may need to contact CMS to determine if the provider is acceptable for risk adjustment. |

### 3.2.2.2 Medicare Provider Numbers (Slide 15, 12)

There are several sources that may be used to verify that the data are acceptable for risk adjustment. Hospital inpatient (and hospital outpatient) data have associated Medicare provider numbers.

- M+C organizations should verify that diagnoses are provided by Medicare certified hospitals/facilities.
- All network hospital/facilities must be Medicare certified and will have a Medicare provider number.

The provider number has six characters. The first two characters are numerals and represent the state/territory as illustrated in Table 3E.

**TABLE 3E – PROVIDER NUMBER STATE ASSIGNMENTS**

| STATE | CODE | STATE | CODE | STATE | CODE |
|---|---|---|---|---|---|
| Alabama | 01 | Kentucky | 18 | Oklahoma | 37 |
| Alaska | 02 | Louisiana | 19 | Oregon | 38 |
| American Samoa | 64 | Maine | 20 | Palau | N/A |
| Arizona | 03 | Maryland | 21 | Pennsylvania | 39 |
| Arkansas | 04 | Massachusetts | 22 | Puerto Rico | 40 |
| California | 05 | Michigan | 23 | Rhode Island | 41 |
| Colorado | 06 | Minnesota | 24 | South Carolina | 42 |
| Connecticut | 07 | Mississippi | 25 | South Dakota | 43 |
| Delaware | 08 | Missouri | 26 | Tennessee | 44 |
| District of Columbia | 09 | Montana | 27 | Texas | 45 |
| Florida | 10 | Nebraska | 28 | Utah | 46 |
| Georgia | 11 | Nevada | 29 | Vermont | 47 |
| Guam | 65 | New Hampshire | 30 | Virgin Islands | 48 |
| Hawaii | 12 | New Jersey | 31 | Virginia | 49 |
| Idaho | 13 | New Mexico | 32 | Washington | 50 |
| Illinois | 14 | New York | 33 | West Virginia | 51 |
| Indiana | 15 | North Carolina | 34 | Wisconsin | 52 |
| Iowa | 16 | North Dakota | 35 | Wyoming | 53 |
| Kansas | 17 | Ohio | 36 | | |

States and territories are included in the list of Medicare provider numbers.

The third character may be a numeral or a letter, with the exception of **U, W, Y, Z, 5 or 6**. These exceptions indicate that the service was provided in a swing bed component of a hospital or a skilled nursing facility. The last three characters are numerals unique to the facility. As an additional check, refer to Tables 3F and 3G, which provide the only acceptable ranges for hospital facilities. The tables reflect the range of provider numbers for risk adjustment covered hospital entities. Risk adjustment data are not acceptable when received from facilities with numbers outside the ranges.

Skilled nursing facilities and home health care are not covered entities for risk adjustment data.

M+C organizations may wish to create a system for checking the Medicare provider number against a list of provider number ranges that identify what type of service has been rendered. The following two tables (3F and 3G) provide the range of potential characters for inpatient and outpatient facility services.

**TABLE 3F – HOSPITAL INPATIENT COVERED ENTITIES**

| TYPE OF HOSPITAL INPATIENT FACILITY | NUMBER RANGE |
|---|---|
| Short-term (general and specialty) Hospitals | XX0001 – XX0899<br>XXS001 – XXS899<br>XXT001 – XXT899 |
| Medical Assistance Facilities/Critical Access Hospitals | XX1225 – XX1399 |
| Religious Non-Medical Health Care Institutions (formerly Christian Science Sanatoria) | XX1990 – XX1999 |
| Long-term Hospitals | XX2000 – XX2299 |
| Rehabilitation Hospitals | XX3025 – XX3099 |
| Children's Hospitals | XX3300 – XX3399 |
| Psychiatric Hospitals | XX4000 – XX4499 |

**TABLE 3G – HOSPITAL OUTPATIENT COVERED ENTITIES**

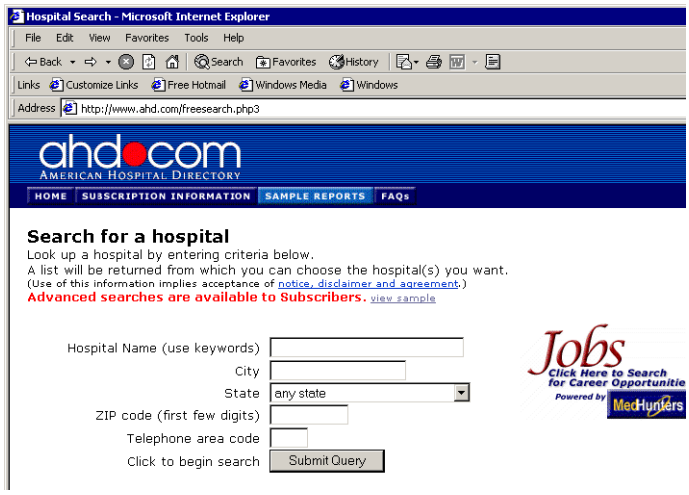
| TYPE OF HOSPITAL OUTPATIENT FACILITY | NUMBER RANGE |
|---|---|
| Short-term (general and specialty) Hospitals | XX0001 – XX0899<br>XXS001 – XXS899<br>XXT001 – XXT899 |
| Medical Assistance Facilities/Critical Access Hospitals | XX1225 – XX1399 |
| Community Mental Health Centers | XX1400 – XX1499<br>XX4600 – XX4799<br>XX4900 – XX4999 |
| Federally Qualified Health Centers/Religious Non-Medical Health Care Institutions (formerly Christian Science Sanatoria) | XX1800 – XX1999 |
| Long-term Hospitals | XX2000 – XX2299 |
| Rehabilitation Hospitals | XX3025 – XX3099 |
| Children's Hospitals | XX3300 – XX3399 |
| Rural Health Clinics, Freestanding and Provider-Based | XX3400 – XX3499<br>XX3800 – XX3999<br>XX8500 – XX8999 |
| Psychiatric Hospitals | XX4000 – XX4499 |

M+C organizations may access the **American Hospital Directory** www.ahd.com/freesearch.php3 for assistance in determining hospital provider numbers. This web-based search database allows M+C organizations the opportunity to access the Medicare provider number by entering key words, city, state, zip code, or area code. When using the search tool, users should be aware of the following:

- The most effective search option is to select the state where the provider is located.
- When entering the hospital name, users should be aware that the official name of the hospital might be different than what is included in the database.
- Avoid entering abbreviations.

Figure 3A is a picture of the search page on the American Hospital Directory website.

**Figure 3A – American Hospital Directory**




See Resource Guide for more information about Medicare provider numbers.

## 3.2.3 Physician Data (Slide 16, 14)

The collection of physician data relevant for risk adjustment is associated with the physician's specialty. That is, all ICD-9-CM diagnoses that are in the risk adjustment model and rendered as a result of visit to a physician must be collected by the M+C organization. This includes data collected from non-network as well as network physicians.

Only those physician specialties and other clinical specialists identified in Table 3H are acceptable for risk adjustment. The Medicare provider number does not apply to the collection of physician data.

**TABLE 3H – ACCEPTABLE PHYSICIAN DATA SOURCES**

| CODE | SPECIALTY | CODE | SPECIALTY | CODE | SPECIALTY |
|---|---|---|---|---|---|
| 01 | General Practice | 29 | Pulmonary Disease | 68 | Clinical Psychologist |
| 02 | General Surgery | 30 | Diagnostic Radiology | 70* | Multispecialty Clinic or Group Practice |
| 03 | Allergy/Immunology | 33* | Thoracic Surgery | 76 | Peripheral Vascular Disease |
| 04 | Otolaryngology | 34 | Urology | 77 | Vascular Surgery |
| 05 | Anesthesiology | 35 | Chiropractic | 78 | Cardiac Surgery |
| 06 | Cardiology | 36 | Nuclear Medicine | 79 | Addiction Medicine |
| 07 | Dermatology | 37 | Pediatric Medicine | 80 | Licensed Clinical Social Worker |
| 08 | Family Practice | 38 | Geriatric Medicine | 81 | Critical Care (Intensivists) |
| 10* | Gastroenterology | 39 | Nephrology | 82 | Hematology |
| 11 | Internal Medicine | 40 | Hand Surgery | 83 | Hematology/Oncology |
| 12 | Osteopathic Manipulative Therapy | 41 | Optometry (specifically means optometrist) | 84 | Preventive Medicine |
| 13 | Neurology | 42 | Certified Nurse Midwife | 85 | Maxillofacial Surgery |
| 14 | Neurosurgery | 43 | Certified Registered Nurse Anesthetist | 86 | Neuropsychiatry |
| 16* | Obstetrics/ Gynecology | 44 | Infectious Disease | 89* | Certified Clinical Nurse Specialist |
| 18 | Ophthalmology | 46* | Endocrinology | 90 | Medical Oncology |
| 19 | Oral Surgery (Dentists Only) | 48* | Podiatry | 91 | Surgical Oncology |
| 20 | Orthopedic Surgery | 50* | Nurse Practitioner | 92 | Radiation Oncology |
| 22* | Pathology | 62* | Psychologist | 93 | Emergency Medicine |
| 24 | Plastic and Reconstructive Surgery | 64 | Audiologist | 94 | Interventional Radiology |
| 25 | Physical Medicine and Rehabilitation | 65 | Physical Therapist | 97* | Physician Assistant |
| 26 | Psychiatry | 66 | Rheumatology | 98 | Gynecologist/Oncologist |
| 28* | Colorectal Surgery | 67 | Occupational Therapist | 99 | Unknown Physician Specialty |

* Indicates that a number has been skipped.

Qualified physician data for risk adjustment requires a face-to-face visit with the exception of pathology and radiology services (professional component only).

### 3.2.4 Alternative Data Sources

Alternative data sources (ADS) include diagnostic data from sources other than hospital inpatient, hospital outpatient, and physician services. M+C organizations may use ADS as a ***check*** to ensure that all required diagnoses have been submitted to CMS for risk adjustment purposes such as pharmacy records and information provided to national or state cancer registries. The M+C organization may not,

however, use ADS as substitutes for diagnoses from a hospital/physician. As in all diagnoses submitted, there must be medical record documentation to support the diagnosis as having been documented as a result of a hospital inpatient stay, a hospital outpatient visit, or a physician visit during the data collection period.

For example, a prescription for an ACE inhibitor, alone, would not be considered as sufficient for the sole data source of "clinical evidence" of congestive heart failure (CHF); instead the medical record would need to document an appropriate clinician's diagnosis of CHF during the data collection period (e.g., where an "appropriate clinician" is a physician/nurse practitioner/physician assistant). A laboratory test showing one reading of high blood sugar would also not be considered to be sufficient "clinical evidence" of diabetes—the medical record would need to document a clinician's diagnosis of diabetes during the data collection period.

### 3.2.5 Excluded Providers (Slide 15)

Medicare will not pay for items or services rendered to beneficiaries and recipients by an excluded provider or by entities owned or managed by an excluded provider. Providers are excluded for the following reasons: a program related crime, patient abuse or neglect, health care fraud in any health care program, and convictions relating to controlled substances.

The HHS monthly exclusion notification can be found at http://oig.hhs.gov/fraud/exclusions.html.

## 3.3 Data Collection Formats And Considerations

There are several formats that M+C organizations can accept when collecting data from medical providers. The formats are listed by provider type in Table 3I.

### 3.3.1 Data Collection Formats (Slide 17, 16)

For facility services, the standard billing format is a UB-92 (Universal Billing Form – 1992 version). The HCFA 1500 form is the standard format for physician services.

**TABLE 3I – DATA COLLECTION FORMATS**

| | |
|---|---|
| **HOSPITAL INPATIENT/ HOSPITAL OUTPATIENT** | • Full UB-92<br>• Abbreviated UB-92<br>• ANSI X12 837 4010<br>• RAPS Format |
| **PHYSICIAN** | • HCFA 1500<br>• NSF 3.01<br>• ANSI X12 837 4010<br>• RAPS Format<br>• Superbill |

### 3.3.2 Collection Format Features (Slide 17)

The decision regarding the data collection tool should be considered carefully, as it may impact the volume and accuracy of data received from physicians and providers. When examining the data collection options, the organization's management should consider the features of each of the approved data collection tools. Table 3J describes key features of each of the data collection tools.

**TABLE 3J – COLLECTION FORMAT FEATURES**

| FORMAT | FEATURE | | | | | |
|---|---|---|---|---|---|---|
| | PAPER FORMAT | FULL CLAIMS DATA | MINIMUM DATA SET | ELECTRONIC | PHYSICIAN SERVICES | HOSPITAL INPATIENT/ OUTPATIENT SERVICES |
| HCFA 1500 | ● | ● | | | ● | |
| UB-92* | | ● | | ● | | ● |
| Abbreviated UB-92* | | ● | | ● | | ● |
| NSF* | | ● | | ● | ● | |
| ANSI X12 837 | | ● | | ● | ● | ● |
| Superbill | ● | | ● | | ● | |
| RAPS Format | | | ● | ● | ● | ● |

* These data collection formats are not HIPAA compliant transactions. However, if your plan is HIPAA compliant and your trading partners are not HIPAA compliant, CMS is allowing receipt of the non-HIPAA formats until such time as your trading partners are prepared to submit the HIPAA transaction sets.

The data collection options provided by CMS offer the M+C organization the ability to determine which format works best for each of their providers. A variety of collection formats may be used for different providers. If you are planning to use multiple collection formats, you may need to consider the complexity and costs associated with supporting these formats (e.g. systems, processes, staffing, etc.).

### 3.3.3 Collecting Data from Physicians Using a Superbill

The superbill is a data collection option for risk adjustment. The superbill is a common physician office claim form that lists standard ICD-9-CM codes, CPT (Current Procedural Terminology) codes, and beneficiary information. Typically, physicians use the superbill to record clinical information with the appropriate codes to aid in preparing claims or encounter data for submission. M+C organizations may

develop superbills for use by their capitated physicians for capturing diagnostic information for risk adjustment.

If the M+C organization currently utilizes a superbill that works well for its data collection needs, then it is not necessary to create a new format for risk adjustment data collection. Additionally, if a physician group has a superbill that will capture all relevant risk adjustment diagnoses, it is not necessary for the M+C organization to replace that superbill with one that is specific to risk adjustment requirements.

## Examples

### Examples of Superbills

Two examples of superbills are provided in Figures 3B and 3C. The first example is a typical fee-for-service superbill for an internist. This superbill contains both ICD-9-CM diagnosis codes and CPT procedure codes. For illustrative purposes, the relevant risk adjustment diagnoses have been bolded.

The second example illustrates what the same superbill might look like if it were used specifically for collection of risk adjustment data. The ICD-9-CM code list provided by CMS is used to develop the list of common internist ICD-9-CM diagnoses codes on the superbill. Codes that are relevant diagnoses for the risk adjustment model, related conditions that are not specific to risk adjustment as well as other common internist diagnoses. A space was left for the internist to enter diagnoses that are not on the list. Note that there are no CPT procedure codes on the superbill because they are not required for risk adjustment.

**Figure 3B – SAMPLE FEE-FOR-SERVICE SUPERBILL**

**JOHN E. DOE, M.D.**
*Internal Medicine*
*Board Certified*

123 Main Street
Anytown, UL 99999
Office (555) 555-5555
Billing (555) 555-5550
TAX I.D. #12345678

PATIENT NAME | INSURANCE

OFFICE **847** | PATIENT NUMBER | ADMIT DATE | DIAGNOSIS

DR# | ACCIDENT TYPE ☐ Work Comp ☐ Auto ☐ Other | DATE OF ACCIDENT _____/_____/_____ | 1) | 2) | 3) | 4)

OFFICE SERVICE

| | New | Mod | Fee | DX | Est. | Mod | Fee | DX |
|---|---|---|---|---|---|---|---|---|
| Level 1 | 99201 | ___ | 48 | ___ | 99211 | ___ | 27 | ___ |
| Level 2 | 99202 | ___ | 82 | ___ | 99212 | ___ | 48 | ___ |
| Level 3 | 99203 | ___ | 121 | ___ | 99213 | ___ | 67 | ___ |
| Level 4 | 99204 | ___ | 176 | ___ | 99214 | ___ | 105 | ___ |
| Level 5 | 99205 | ___ | 222 | ___ | 99215 | ___ | 155 | ___ |

PHYSICALS

| | New | Mod | Fee | DX | Est. | Mod | Fee | DX |
|---|---|---|---|---|---|---|---|---|
| 2-17yrs | 99354 | ___ | 168 | ___ | 99394 | ___ | 133 | ___ |
| 18-39yrs | 99385 | ___ | 182 | ___ | 99385 | ___ | 140 | ___ |
| 40-64yrs | 99386 | ___ | 189 | ___ | 99396 | ___ | 147 | ___ |
| >65yrs | 99387 | ___ | 203 | ___ | 99397 | ___ | 154 | ___ |

INITIAL HOSPITAL CARE

| | | | |
|---|---|---|---|
| Level 1 | 99221 | ___ | 95 ___ |
| Level 2 | 99222 | ___ | 156 ___ |
| Level 3 | 99223 | ___ | 213 ___ |

DAILY HOSPITAL CARE

| | | | |
|---|---|---|---|
| Level 1 | 98231 | ___ ___ | ___ |
| From _____ To _____ @ $55 | | | |
| Level 2 | 99232 | ___ ___ | ___ |
| From _____ To _____ @ $87 | | | |
| Level 3 | 99233 | ___ ___ | ___ |
| From _____ To _____ @$145 | | | |
| Discharge | 99238 | ___ | 9[illegible] |
| Discharge-over 30 minutes | 99239 | ___ | 1[illegible] |

NURSING HOME CARE

| | | | |
|---|---|---|---|
| Partial Detailed | [illegible] | | 13 ___ |
| Partial Comprehensive | 99303 | ___ | 6 ___ |
| Follow Up Level 1 | 99311 | ___ | 5 ___ |
| Follow Up Level 2 | 99312 | ___ | [illegible] |
| Follow Up Level 3 | 99313 | ___ | 99 ___ |
| Discharge-30 minutes or less | 99315 | ___ | ___ ___ |
| Discharge-over 30 minutes | 99316 | ___ | ___ ___ |

PROCEDURES

| | | | |
|---|---|---|---|
| Venipuncture | 38415 | ___ | 17 ___ |
| Ear Irrigation | 69210 | ___ | 44 ___ |
| ECG With Interpretation & Report | 93000 | ___ | 39 ___ |
| ECG Only | 93005 | ___ | 25 ___ |
| ID Abcess | 10060 | ___ | 119 ___ |
| ID | 86580 | ___ | 12 ___ |
| Stool WBC | 82270 | ___ | 6 ___ |
| Analysis with Micro | 81000 | ___ | 9 ___ |
| Analysis without Micro | 81002 | ___ | 7 ___ |

IMMUNIZATIONS & INJECTIONS

| | | | |
|---|---|---|---|
| B-12 | J3420 | ___ | 3 ___ |
| Hepatitis A, Adult | 90632 | ___ | 70 ___ |
| Hepatitis B, Adult | 90746 | ___ | 70 ___ |
| Hepatitis B, adolescent | 90744 | ___ | 60 ___ |
| Influenza-Whole | 90550 | ___ | 15 ___ |
| MMR | 90707 | ___ | 57 ___ |
| Pneumovax | 90732 | ___ | 40 ___ |
| Tetanus | 90703 | ___ | 26 ___ |
| Other _____ | ____ | ___ | ___ |
| Other _____ | ____ | ___ | ___ |

**NOT INTENDED FOR REPRODUCTION**

☐ MCR PAP SMEAR
992__-25 E&M
Q0091 Pap $50
G0101 P&B Exam $60
V15.80 High Risk Dx
V76.2 Routine Dx

☐ FLU SHOT
90659 Flu Shot
90471 Admin
V04.8 Flu Vaccine Dx

☐ MCR FLU SHOT
90859 Flu Shot
G0008 Admin
V04.8 Flu Vaccine Dx

☐ PNEUMOVAX
80732 Shot
90471 Admin
V03.82 Vaccine Dx

☐ MCR PNEUMOVAX
90732 Shot
G0008 Admin
V0[illegible] Vacc[illegible]

☐ HEPATIT[illegible]
9074[illegible] ult Sh[illegible]
9074[illegible] ld Sh[illegible]
90[illegible] in
V0[illegible] ne Dx

☐ HEPATITIS A
90632 Shot
90471 Admin
V08.3 Vaccine Dx

☐ TETANUS
90707 Shot
90471 Admin
906.5 Vaccine Dx

☐ B-12 INJECTION
J3420 Shot
80782 Admin
266.2 B-12 Dx

Next Visit

Total: $ _____
Amt Pd $ _____
11 ☐ Check # _____
43 ☐ Co-Pay Not Collected

_____
Physician Signature Date

DIAGNOSIS CODES: ICD-9-CM

__789.00 Abdominal Pain, NEC
__796.4 Abnor Unexpl Tst
__762.3 Adema
__**427.31 A. Fib.**
__285.9 Anemia NOS
__**413.9 Angina**
__V58.61 Anticoag Med
__300.00 Anxiety
__427.9 Arythmia NOS
__719.40 Arthralgia
__716.00 Arthritis Acu Chron
__**714.0 Arthritis, Rheum**
__429.2 ASCVD
__493.90 Asthma
__724.2 Back Pain
__578.1 Blood in Stool
__726.91 Bone Spur
__**174.9 Breast CA, Female**
__611.72 Breast Lump
__490 Bronchitis
__727.3 Bursitis
__ 682.9 Cellulitis, NOS
__767.99 Chg/Bowel/Habits
__780.9 Chg
__786.50 Chest Pain
__**428.0 CHF**
__574.20 Cholellthlasis, NOS
__153.9 Colon CA
__564.0 Constipation
__**496 COPD**
__**436 CVA**
__799.4 Deconditior
__276.5 Dehydratior
__294.8 Dementia
__311 Depression
__692.9 Dermatitis
__**250.92 Diabetes[illegible]tle**
__**250.42 [illegible]ab Ne[illegible]s**
__**250.62 [illegible]ab Ne[illegible]thy**
__**250.00 Diabetes, NIDDM**
__**250.50 Diabs, Retinopathy**
__**250.00 Diabetes, Type II**
__**250.32 Diabetic Coma**
__787.91 Diarrhea
__562.11 Diverticulitis
__780.4 Dizziness/Vertigo
__**453.8 DVT**
__787.2 Dysphagia
__780.7 Fatigue
__610.1 Fibrocystic Breast Dis
__729.1 Fibromyalgia
__558.9 Gastroenteritis
__530.81 GERD
__578.9 GI Bleeding
__240.9 Goiter
__274.9 Gout
__242.0 Graves Disease
__245.2 Hashimotos
__307.81 Headache, Tension
__784.0 Headache
__V70.0 Health Maint
__V43.2 Heart Valve Repl
__455.6 Hemorrhoids
__573.3 Hepatitis, NOS
__070.1 Hepatitis A
__070.30 Hepatitis B
__070.61 Hepatitis C, Acute
__**070.54 Hepatitis, C, Chron**
__V05.3 Hepatitis Viral, Vac
__704.1 Hirsutism
__276.7 Hyperka
__272.4 Hyper
__276.0 Hyper
__252.0 Hyperparathyroid
__401.9 Hypertension
__242.90 Hyperthyroid
__276.8 Hypokalemia
__276.1 Hyponatremus
__244.9 Hypothyroid
__788.30 Incon Urinary
__487.1 Influenza
__V04.8 Influenza Vac
__780.52 Insomnia
__564.1 Irrit Bowel Syn
__386.30 Labyrinthitis
__**710.0 Lupus**
__**263.9 Malnutrition**
__995.2 Med Side Effect
__**410.9 MI, Acu, Unspec**
__412 MI, Old 8+ wks
__424.0 Vive Pro
__728.85 Muscle Spasm
__355.9 Neuropathy
__278.00 Obesity
__110.0 Onychomycosis
__733.00 Osteopotasin
__388.70 Otalgia
__362.9 Otitis Media
__V15.89 Pap High Risk
__V76.2 Pap Rout MCR
__625.9 Pelvic Pain, Fem
__281.0 Perrouout Anem
__462. Pharyngitis
__486 Pneumonia
__V03.82 Pneumonia Vac
__627.2 Post Meno Synd
__V72.84 Preop Exam
__**185 Prostate Cancer**
__600.0 Prostate Hyper
__601.9 Prostatis
__896.1 Psoriasis
__**415.19 Pulmon Embol**
__569.3 Rectal Bleeding
__592.9 Renal Lithisis
__477.9 Rhinitis, Allergic
__473.9 Sinusitis
__709.9 Skin Lesion
__305.10 Smoker
__848.9 Strain/Spasm, NOS
__780.2 Syncope/Collapse
__079.89 System Vrt Infect
__451.9 Thrombophlebitia
__**193 Thyroid CA**
__241.0 Thyroid Nodule
__245 Thyroiditis
__533.9 Ulcer, Peptic
__**411.1 Unstable Angina**
__465.9 URI
__599.0 UTI
__616.10 Vaginitis
__286.2 Vit B-12 Deficiency
__380.4 Wax in Ears
__783.2 Weight Loss
__V72.3 Well Woman

**Figure 3C – SAMPLE RISK ADJUSTMENT SUPERBILL**

| | | | |
|---|---|---|---|
| **JOHN E. DOE, M.D.**<br>*Internal Medicine*<br>*Board Certified*<br><br>123 Main Street<br>Anytown, UL 99999<br>Office (555) 555-5555<br>Billing (555) 555-5550<br>TAX I.D. #12345678 | PATIENT NAME | | INSURANCE |
| | | | |
| DR# | ACCIDENT TYPE<br>☐ Work Comp<br>☐ Auto<br>☐ Other | DATE OF ACCIDENT<br>_____/_____/_____ | |

DIAGNOSIS CODES: ICD-9-CM

| | |
|---|---|
| __427.3 | A. Fib/flutter |
| __427.9 | Arrythmia |
| __285.9 | Anemia,NOS |
| __284 | Aplastic Anemia |
| __413 | Angina |
| __300.00 | Anxiety |
| __716.90 | Arthritis, NOS |
| __714 | Arthritis, Rheumatoid |
| __427.9 | Arrythmia,NOS |
| __429.2 | ASCVD |
| __493.90 | Asthma |
| __493.2 | [illegible] with CO[illegible] |
| __174 | [illegible]east C[illegible]male |
| __611.72 | [illegible]east [illegible] |
| __490 | [illegible]onchi[illegible]NOS |
| __466.0 | [illegible]onchitis, acute |
| __491 | [illegible]onchitis, chroni |
| __682.9 | [illegible]llulitis, NOS |
| __786.50 | Chest pain |
| __428 | CHF |
| __574.20 | Cholelithiasis, NOS |
| __153 | Colon CA |
| __496 | COPD |
| __436 | CVA |
| __276.5 | Dehydration |
| __294.8 | Dementia |
| __311 | Depression |
| __296 | Depression, major |
| __692.9 | Dermatitis |
| __250 | Diabetes |
| __250.9 | Diabetes, Brittle |
| __250.3 | Diabetic Coma |
| __250.1 | Diabetic Keto |
| __250.4 | Diabetic Nephrosis |
| __250.6 | Diabetic Neuropathy |
| __250.0 | Diabetes,NIDDM |
| __250.7 | Diabetic PVD |
| __250.5 | Diabetic Retinopathy |
| __562.11 | Diverticulitis |
| __453.8 | DVT |
| __610.1 | Fibrocystic Breast |
| __729.1 | Fibromyalagia |
| __558.9 | Gastroenteritis |
| __530.81 | GERD |
| __578.9 | GI Bleeding |
| __240.9 | Goiter |
| __274.9 | Gout |
| __242.0 | Graves' Disease |
| __573.3 | Hepatitis,NOS |
| __070.1 | Hepatitis A |
| __070.30 | Hepatitis B |
| __070.51 | Hepatitis C, Acute |
| __070.54 | Hepatitis C, Chronic |
| __401.9 | Hypertension |
| __242.90 | Hyperthyroidism |
| __276.8 | Hypokalemia |
| __276.0 | Hyponatremia |
| __244.9 | Hypothyroidism |
| __487.1 | Influenza |
| __564.1 | Irrit. Bowel Syn |
| __386.30 | Labyrinthitis |
| __710 | Lupus |
| __263 | Malnutrition |
| __995.2 | Medicine Side Effect |
| __410 | MI |
| __424.0 | Mitral Valve |
| __355.9 | Neuropathy |
| __110.0 | Onychomycosis |
| __715.90 | Osteoarthritis |
| __733.00 | Osteoporosis |
| __427.0 | PAT |
| __427.1 | PVT |
| __427.2 | Parox Tachycardia |
| __462 | Pharyngitis |
| __486 | Pneumonia |
| __48_ | Pneumonia, specified |
| __185 | Prostate Cancer |
| __600.00 | Prostate Hypertrophy |
| __415.19 | Pulmonary Embolism |
| __592.0 | Renal Lithiasis |
| __477.9 | Rhinitis, Allergic |
| __473.9 | Sinusitis |
| __079.89 | Systemic Viral Infec |
| __451.9 | Thrombophlebitis |
| __193 | Thyroid Cancer |
| __241.0 | Thyroid Nodule |
| __245.9 | Thyroiditis |
| __533.9 | Ulcer, Peptic |
| __53_._ | Ulcer, perforated |
| __411 | Unstable Angina |
| __465.9 | URI |
| __599.0 | UTI |

Other: _____

_____

_____

_____
Next Visit

Total: $ _____
Amt Pd $ _____

12 ☐ Check # _____
44 ☐ Co-Pay Not Collected

_____
Physician Signature Date

### 3.3.4 Factors Affecting Data Collection Method (Slide 18, 18)

The risk adjustment model requires that M+C organizations collect a subset of data from their providers/physicians. While CMS requires that only the minimum data are collected for risk adjustment, M+C organizations should also consider their business needs.

- The organization may decide to collect full claims data for a variety of reasons:
  - The organization has fee-for-service contracts and pays providers and physicians based on the specific service provided to patients.
  - The organization is earning or maintaining National Committee for Quality Assurance (NCQA) accreditation and is therefore required to collect Health Employers Data Information Set (HEDIS) data that is used to evaluate the plan's performance in areas of customer service, access to care, and claims processing.
  - The organization has established an internal process for credentialing purposes that require evidence of compliance with regulatory and other standards of practice such as Joint Commission on Accreditation of Health Care Organizations (JCAHO). The JCAHO certification requires extensive onsite review to evaluate the health organization's performance in areas that impact healthcare.
- The organization may decide to collect the minimum data set for a variety of reasons:
  - The organization has a capitated payment arrangement with physicians and providers, and pays a fixed amount for services provided.
  - The organization's physicians are paid employees of the managed care plan.

#### 3.3.4.1 Contractual Relationships and Implications for Data Collection (Slide 19, 20)

There are several types of contractual payment relationships that M+C organizations have with network physicians. These relationships include: fee-for-service, capitated, staff model, and mixed services. These contractual relationships will affect how data are collected from physicians. Table 3K describes the contractual payment relationships.

**TABLE 3K – CONTRACTUAL PAYMENT RELATIONSHIPS**

| | |
|---|---|
| **FEE-FOR-SERVICE** | In a fee-for-service contract, the physician is paid based on the specific services provided to each patient. |
| **CAPITATED** | The physician is paid a fixed amount per patient per month, regardless of the types of services provided. |
| **STAFF MODEL** | Physicians are paid employees of the managed care plan. Physicians generally provide services in a clinic setting. |
| **MIXED SERVICES MODEL** | In a mixed services model environment, managed care organizations use a combination of contractual arrangements. |

## 3.4 Health Information Portability and Accountability Act (HIPAA) (Slide 20)

Effective October 16, 2003, when HIPAA transaction standards became mandatory, all *electronic* claims/encounters sent from providers/physicians to M+C organizations (health plans) constitute a HIPAA-covered transaction. Any M+C organization that receives an electronic claim/encounter from a provider/physician must use the ANSI X12 837 v.40.10 format. This means that after the M+C organization receives electronic data in HIPAA format, it cannot request that the physician resubmit the identical information (same patient, same diagnosis) in a different format (e.g., HCFA 1500) for purposes of risk adjustment data collection.

However, if correcting to clarify original information or to obtain additional information, M+C organizations may use an abbreviated data collection instrument for the sole purpose of collecting supplemental diagnostic information.

UB-92 and NSF are the old data collection formats and are not HIPAA compliant transactions. However, if your plan is HIPAA compliant and your trading partners are not HIPAA compliant, CMS is allowing receipt of the non-HIPAA formats until such time as your trading partners are prepared to submit the HIPAA transaction sets. This allowance is not an extension of the mandatory date of HIPAA (October 2003), and all organizations must be able to accept the HIPAA transactions. This extension simply allows plans to continue electronic commerce while their trading partners work towards compliance.

**If** the transaction is from a provider to an M+C organization (i.e., data collection) **and** the transaction is a claim or an encounter, **then** data must be used for risk adjustment **and** the same data cannot be requested in a different format from the provider.

## 3.5 Case Studies

### 3.5.1 Case Study 1 – Sources of Data

The Winfield Care Health Plan has approximately 25,000 Medicare+Choice enrollees, and has implemented a data collection process for risk adjustment. The plan collected diagnoses for more than 300,000 services from various providers for the 2003 data collection period.

The Winfield Care Health Plan project manager contacted the Customer Service and Support Center (CSSC) with questions regarding four of the services collected. The first service was submitted for a stay at a network hospital for provider number 33U020. The second service submitted was from a hospital outpatient facility and included several diagnoses from provider number 330033. On the second service, one of the procedures submitted was for a radiology service for a cancer diagnosis. The third service had three diagnoses derived from a home health agency following discharge from the hospital. The fourth service seemed to have a connection to the radiology service submitted on the second service described, except the radiologist submitted it.

#### Guiding Questions

1. What are the appropriate sources of data?
2. Are the providers covered entities for risk adjustment?
3. Which of the diagnoses presented in Scenario 1 may be included for risk adjustment?

### 3.5.2 Case Study 2 – Data Collection Formats

The Yellowstone Foundation Health Plan is new to the M+C program and has approximately 80 beneficiaries and is growing. The plan has recently contracted with the Phy-Med Group. This 3-person physician practice currently has 10 beneficiaries that are enrolled in the Yellowstone Foundation. Yellowstone Foundation has negotiated a capitated arrangement with the Phy-Med Group. The providers that cover the remainder of their beneficiaries are through a variety of capitated and fee-for-service contracting relationships. The operations staff realized there were several issues that impacted how they collect data from providers and physicians. The plan is considering the use of superbills for all capitated arrangements including the Phy-Med Group. The management team has been charged with deciding on the best collection tools for their business.

#### Guiding Questions

1. What are the acceptable formats for data collection?
2. Which data collection tool is best for my organization's needs?
3. Are organizations required to collect using one standard format?
4. Do physicians have specific data collection issues?
5. What is the best data collection method for Yellowstone?

### 3.5.3 Case Study 3 – Risk Adjustment and HIPAA Rules

The ComCet Care Health Plan has grown by leaps and bounds. Their Chief Financial Officer (CFO) believes this is due to the variety of physicians and providers offered to their organization's enrollees. During May 2003, the plan received more than 4,000 claims from their providers/physicians by ANSI X12 837 40.10. About 50 percent were from their fee-for-service providers. Another 35 percent were from their capitated providers and about 15 percent were from their staff model providers. They received all of their data in the ANSI format, but realized that they preferred to have all providers use the new RAPS format. The project manager drafted a letter requesting that all providers resubmit their data with dates of service January 2003-May 2003, using the RAPS format.

#### Guiding Questions

1. Do the Administrative Simplification Standards adopted by Health and Human Services (HHS) under the HIPAA of 1996 impact the decision on data collection methods?
2. Do the HIPAA regulations impact modifying data?
3. What is the best data collection strategy for ComCet Care Health Plan?

## 3.6 Answers to Case Studies

### 3.6.1 Case Study 1 – Sources of Data

The Winfield Care Health Plan has approximately 25,000 Medicare+Choice enrollees, and has implemented a data collection process for risk adjustment. The plan collected diagnoses for more than 300,000 services from various providers for the 2003 data collection period.

The Winfield Care Health Plan project manager contacted the CSSC with questions regarding four of the services collected. The first service was submitted for a stay at a network hospital for provider number 33U020. The second service submitted was from a hospital outpatient facility and included several diagnoses from provider number 330033. On the second service, one of the procedures submitted was for a radiology service for a cancer diagnosis. The third service had three diagnoses derived from a home health agency following discharge from the hospital. The fourth service seemed to have a connection to the radiology service submitted on the second service described, except the radiologist submitted it.

1. What are the appropriate sources of data?

   **Hospital Inpatient** Those facilities that offer medical services that require an overnight stay.

   **Hospital Outpatient** Therapeutic and rehabilitation services for sick or injured persons who do not require inpatient hospitalization or institutionalization.

   **Physician** Medical services provided by a physician or by specific non-physician practitioners as the result of a face-to-face visit.

2. Are the providers covered entities for risk adjustment?

   There are several sources that may be used to verify that the data are acceptable for risk adjustment.

   Hospital inpatient and hospital outpatient data have associated Medicare provider numbers. **Refer to the following sections:**

   **Section 3.2.2.2 Medicare Provider Numbers**
   **Section 3.2.1 Hospital Inpatient**
   **Section 3.2.2 Hospital Outpatient**
   **Section 3.2.3 Physician Data**

3. Which of the diagnoses presented in Scenario 1 may be included for risk adjustment?

   - Service 1 – The two diagnoses derived from a New York facility, provider number 33U020, were from the swing bed component of the hospital. Diagnoses derived from this record are not acceptable for risk adjustment. The professional component may be submitted as physician data if the physician is not a member of the SNF staff. **Refer to Sections 3.2.1 and 3.2.2.2.**

   - Service 2 – The diagnoses were submitted as hospital outpatient data. Radiology services from a hospital outpatient facility are not acceptable for risk adjustment. **Refer to Section 3.2.2.**

- Service 3 – Diagnoses generated from home health agencies are not acceptable. **Refer to Section 3.2.2.**

- Service 4 – While radiology services are not acceptable under hospital outpatient services, the radiologist may submit the diagnosis on a professional bill. **Refer to Section 3.2.3**.

### 3.6.2 Case Study 2 – Data Collection Formats

The Yellowstone Foundation Health Plan is new to the M+C program and has approximately 80 beneficiaries and is growing. The plan has recently contracted with the Phy-Med Group. This 3-person physician practice currently has 10 beneficiaries that are enrolled in the Yellowstone Foundation. Yellowstone Foundation has negotiated a capitated arrangement with the Phy-Med Group. The providers that cover the remainder of their beneficiaries are through a variety of capitated and fee-for-service contracting relationships. The operations staff realized there were several issues that impacted how they collect data from providers and physicians. The plan is considering the use of superbills for all capitated arrangements including the Phy-Med Group. The management team has been charged with deciding on the best collection tools for their business.

#### Guiding Questions

1. What are the acceptable formats for data collection?

   Under the risk adjustment process, CMS allows more flexibility for collecting and submitting risk adjustment data. The focal point of the data collection is the diagnosis. M+C organizations are required to submit, at a minimum, only those ICD-9-CM diagnosis codes that are in the CMS-HCC risk adjustment model. In addition, ICD-9-CM diagnosis codes must be sufficiently specific to allow appropriate grouping of the diagnosis by the model. **Refer to the following sections:**

   **Section 3.3.1 Data Collection Formats**
   **Section 3.3.2 Collection Format Features**
   **Section 3.3.3 Factors Affecting Data Collection Method**

2. Which data collection tool is best for my organization's needs?

   The decision regarding the data collection tool should be considered carefully, as it may impact the volume and accuracy of data received from physicians and providers. When examining the data collection options, the organization's management should consider the features of each of the approved data collection tools. Table 3J describes key features of each of the data collection tools. **Refer to Section 3.3.2 Collection Format Features.**

3. Are organizations required to collect using one standard format?

   The data collection options provided by CMS offer the M+C organization the ability to determine which format works best for each of their providers. A variety of collection formats may be used for different providers. If you are planning to use multiple collection formats, you may need to consider the complexity and costs associated with supporting these formats (e.g. systems, processes, staffing, etc.). **Refer to Sections 3.3.2, 3.3.3, and 3.3.3.1.**

4. Do physicians have specific data collection issues?

   - Physicians who are accustomed to billing Medicare fee-for-service will utilize the HCFA 1500 or NSF and will be required to use ANSI v40.10 when HIPAA mandated transactions are effective. **Refer to Section 3.4.**

   - M+C organizations should consider that physicians use data collection formats as part of their normal physician office operations. A common format for collecting data is a superbill.

   - As part of the provider contracting process, consider how data will be collected from physicians.

5. What is the best data collection method for Yellowstone?

   - Yellowstone has providers that are under a capitated arrangement. It would be appropriate for these providers to submit data using any of the collection options identified in Table 3J. Yellowstone should make every attempt to allow the physicians the option that is as close to the collection option currently being used. This will increase the likelihood of receiving accurate and timely data from physicians and providers.

   - Since Yellowstone has a mixture of fee-for-service and capitated arrangements, the superbill is probably not the most appropriate method if a uniform collection method is desired by Yellowstone. **Refer to Table 3J**.

### 3.6.3 Case Study 3 – Risk Adjustment and HIPAA Rules (Slide 22)

The ComCet Care Health Plan has grown by leaps and bounds. Their Chief Financial Officer (CFO) believes this is due to the variety of physicians and providers offered to their organization's enrollees. During May 2003, the plan received more than 4,000 claims from their providers/physicians by ANSI X12 837 40.10. About 50 percent were from their fee-for-service providers. Another 35 percent were from their capitated providers and about 15 percent were from their staff model providers. They received all of their data in the ANSI format, but realized that they preferred to have all providers use the new RAPS format. The project manager drafted a letter requesting that all providers resubmit their data with dates of service January 2003-May 2003, using the RAPS format.

### Guiding Questions

1. Do the Administrative Simplification Standards adopted by Health and Human Services (HHS) under the HIPAA of 1996 impact the decision on data collection methods?

   **Refer to Section 3.4** for information regarding HIPAA and risk adjustment rules.

2. Do the HIPAA regulations impact modifying data?

   Correcting data is not covered under the HIPAA rules. M+C organizations may use any data collection format to request data for the purpose of correcting or clarifying original information.

3. What is the best data collection strategy for ComCet Care Health Plan?

   While the HIPAA transaction regulations have been extended until October 2003, risk adjustment rules state that if M+C organizations collect claims data, regardless of the claims format use (paper or electronic), the claims data must be used as the primary source for risk adjustment data.

   📖 The risk adjustment instructions can be found in the Resource Guide.

   According to risk adjustment rules, if a provider/physician has already submitted data, ComCet Care Health Plan cannot request the same data be resubmitted in another format. Additionally, since 50 percent of their providers are in a fee-for-service contracting arrangement, the RAPS format is not a suitable submission option. Although they are not required to collect full claims data from their capitated and staff model providers, they should consider using a full claims format for all providers.

## 3.7 Provider Communication and Risk Adjustment (Slide 23)

Communicating risk adjustment requirements to physicians and providers can help to improve the quality and quantity of the data submitted by M+C organizations. It can also help physicians and providers understand the importance of accurate coding and medical record documentation, and their role in data validation. This section describes key messages to include in provider communications, characteristics of effective communication with physicians and providers, and communication methods to consider when sending messages about risk adjustment.

### 3.7.1 Key Messages (Slides 24-25)

Physicians and providers receive many messages from M+C and other managed care organizations. It is easy for a message about risk adjustment to get lost in the stream of communications sent to physicians and providers. To help ensure that messages about risk adjustment get the attention of the provider community, it is important that organizations routinely include basic information about risk adjustment in a variety of provider communications. The key messages to reinforce are:

- **What is the purpose of risk adjustment?**
  Risk adjustment strengthens the Medicare program by ensuring that accurate payments are made to M+C organizations based on the health status of their enrolled beneficiaries. Accurate payments to M+C organizations help ensure that providers are paid appropriately for the services they provide to M+C beneficiaries. Finally, risk adjustment provides M+C organizations with incentives to enroll and treat less healthy individuals.

- **Why is risk adjustment important to physicians and providers?**
  The risk adjustment model relies on ICD-9-CM diagnosis codes to prospectively reimburse M+C organizations based on the health status of their enrolled beneficiaries. Physicians and providers must focus attention on complete and accurate diagnosis reporting according to the official ICD-9-CM coding guidelines.

- **What are the responsibilities of physicians and providers?**
  Physicians must report ICD-9-CM diagnosis codes to the highest level of specificity and report these codes accurately. This requires accurate and complete medical record documentation. They are required to alert the M+C organization of any erroneous data that has been submitted and to follow

the M+C organization's procedures for correcting erroneous data. Finally, they must report claims and encounter information in a timely manner, generally within 30 days of the date of service (or discharge for hospital inpatient facilities).

Your organization also may want to include information about the correct data collection formats available to them, as well as any information revealed through analysis of data collection trends uncovered through monitoring of the risk adjustment process.

### 3.7.2 Characteristics of Effective Communication (Slide 27)

Physicians and providers tend to respond more positively to communications from M+C organizations when the messages are considered reliable, accurate, timely, and helps them make their organization or practice more efficient. For this reason, it may be helpful to consider the following characteristics when developing provider communications:

- **Authoritative**
  Make the "look and feel" of provider communications conservative, official, and factual. Be certain all information is accurate. Grammar, spelling, and punctuation must be perfect, or the errors will undercut the reader's level of confidence in the message.

- **Current**
  Ensure that risk adjustment information is the most recent available. Update provider handbooks, websites, job aids, and training materials routinely so all information are current. Physicians and providers will not spend time reading information they know is outdated.

- **Timely**
  Provide information to providers when they need to know it. For example, if M+C organizations need physicians and providers to send their diagnostic data via a specific format by a certain date, send that message to them with enough lead-time to allow them to prepare for and meet the deadline for the change.

- **Consistent**
  Send consistent messages about risk adjustment. M+C organizations can contact the CSSC anytime to confirm that information they are about to send out to providers is correct. Physicians and providers appreciate receiving the right information the first time and every time.

- **Practical, relevant and well organized**
  Delete "background noise" from your physician and provider messages. That is, identify the primary message you want to send and provide the key information necessary to make the point. That is, focus the message. Identify any specific actions that are required in clear, easy-to-read language.

- **Accessible**
  Create materials for physicians and providers that are easy to access. Information that physicians and providers can locate quickly helps to ensure compliance with risk adjustment requirements, whether that information is available on the Internet, or in a paper document.

When developing communications for physicians and providers, use the "Communicating with Physicians and Providers about Risk Adjustment" job aid.

### 3.7.3 Communication Methods (Slides 28-29)

Many M+C organizations indicate that communicating to physicians and providers through a single medium, like a newsletter, is not effective. A multimodal approach is more successful at reaching the provider community because it reaches a broader audience, and reinforces the message in a number of different formats.

When deciding the methods to communicate with physicians and providers, consider the following steps:

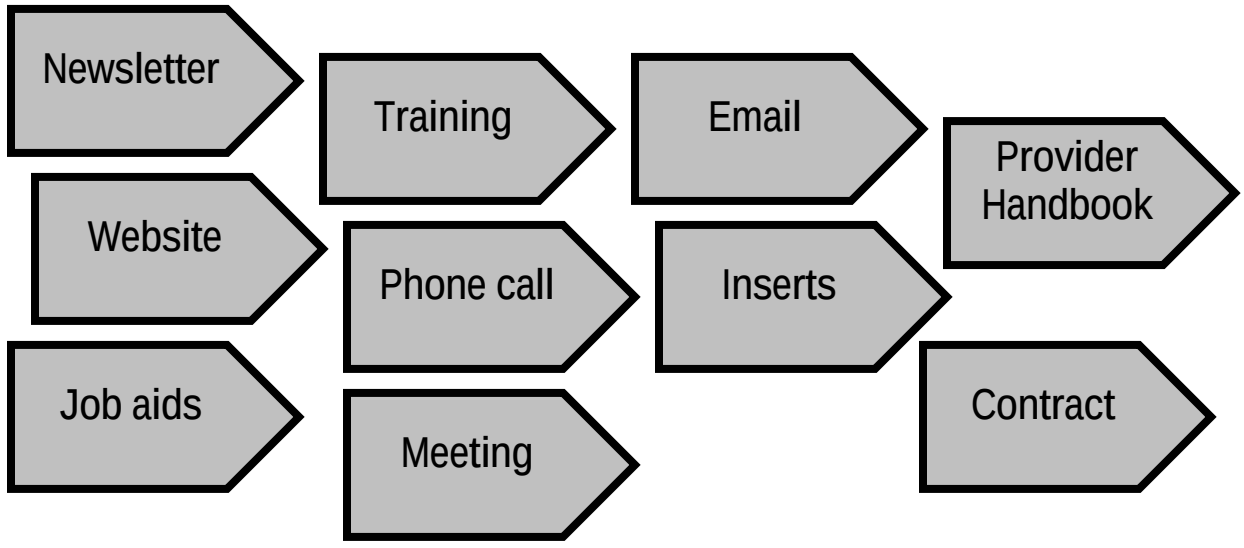
1. **Identify the methods that tend to work best for your organization.** Many M+C organizations indicate that the organization's provider Web page and newsletters reach a large audience, but small and large group training sessions are most successful for causing a change in action.

2. **Determine the goal of the message.** If the message's intent is to raise awareness about a topic, then broad-based communication methods may be appropriate. However, if the message is intended to change the way physicians and providers do something, then group meetings, followed up by emails, and provider handbook and contract updates may be excellent options.

3. **Consider the physicians' and providers' response.** If the message is likely to provoke a negative reaction from the provider community, then meetings with them can be helpful in addressing and clarifying issues, and discussing possible solutions to problems.

There are a number of methods M+C organizations may use to communicate risk adjustment messages to the provider community. These are illustrated in Figure 3D. Understand that, once your organization establishes a communication channel, physicians and providers will rely on that channel to receive information. Any new channels M+C organizations use may not be as effective as established ones.

**Figure 3D – Communication Methods**



# MODULE 4 – DATA SUBMISSION

## Purpose (Slide 2, 2)

Medicare+Choice (M+C) organizations must submit accurate diagnostic data when submitting risk adjustment data. This module describes the file layout for risk adjustment process submissions.

## Learning Objectives (Slides 3-4, 3)

At the completion of this module, participants will be able to:

- Understand the submission process requirements, connectivity options, and Risk Adjustment Processing System (RAPS) file layout.
- Identify the data elements required to submit risk adjustment data.
- Locate and describe the diagnosis clusters in the RAPS format.
- Obtain an overview of the Direct Data Entry (DDE) process.
- Describe the filtering process.
- Describe the diagnoses deletion process.

**ICON KEY**

| | |
|---|---|
| Example |  |
| Reminder |  |
| Resource |  |
| Information Systems Track |  |
| Quality & Compliance Track |  |

## 4.1 Submission Process Requirements (Slide 6)

New M+C organizations must complete an Electronic Data Interchange (EDI) Agreement with the Centers for Medicare & Medicaid Services (CMS) and submit the Agreement to the Customer Service and Support Center (CSSC) prior to submitting risk adjustment data. The EDI Agreement is a contract between the M+C organization and CMS attesting to the accuracy of the data submitted. An officer (e.g., CEO) that represents the M+C organization must sign this document.

M+C organizations must make special arrangements in order to use a third party submitter. If the submitter is an entity other than an M+C organization, the submitter must complete the Submitter ID Application Form, and the M+C organization must complete the EDI Agreement. Organizations must complete, sign, and return the EDI Agreement for each plan number submitting data. CMS holds the M+C organization accountable for the content of submissions regardless of who submits the data.

M+C organizations must submit, at a minimum, approximately one-fourth of their total risk adjustment data submission for the collection period each quarter. More frequent submissions are recommended and present benefits to M+C organizations, which include assisting the organizations to identify data collection and submission issues early.

## 4.2 Connectivity Options (Slide 7)

Connectivity refers to the electronic connection used to submit risk adjustment data from the M+C organization to CMS and receive information from CMS. The three connectivity options are described in Table 4A.

**TABLE 4A – CONNECTIVITY OPTIONS**

| | |
|---|---|
| **NDM**<br>**Network Data Mover** | Mainframe-to-mainframe connection<br>Next day receipt of front-end response |
| **FTP**<br>**File Transfer Protocol** | Modem-to-modem connection<br>Requires password and phone line<br>Same day receipt of front-end response |
| **Secure Website** | Extranet site hosted by Palmetto GBA<br>Point and click features<br>Same day receipt of front-end response<br>Direct Data Entry is a connection via a secure website |

## 4.3 Relevant Diagnosis (Slide 8, 9)

M+C organizations must submit each relevant diagnosis at least once during a reporting period for each enrolled beneficiary.

For payments beginning on January 1, 2005, September 3, 2004, is the initial submission deadline, and the reporting period is July 1, 2003, through June 30, 2004. March 4, 2005, is the initial submission deadline for reporting data with dates of service January 1, 2004, through December 31, 2004, for payments beginning on July 1, 2005. **Refer to the Risk Adjustment Process Overview module, Table 2B.**

A relevant (model) diagnosis must meet the following criteria:

- The diagnosis is included in the CMS-Hierarchical Condition Category (CMS-HCC) risk adjustment model;
- The diagnosis must be received from one of the three provider types (hospital inpatient, hospital outpatient, and physician) covered by the risk adjustment requirements; and
- The diagnosis must be collected according to the risk adjustment data collection instructions.

M+C organizations may elect to submit a diagnosis more than once during a data collection period for any given beneficiary, as long as that diagnosis was recorded based on a face-to-face visit with one of the three provider types covered under risk adjustment. M+C organizations may submit any diagnoses received from the three covered provider types, including diagnoses that are not in the CMS-HCC risk adjustment model. Diagnoses that are in the model but that were not collected from one of the three provider types shall not be submitted as risk adjustment data.

## 4.4 Submission Formats (Slide 9, 4)

M+C organizations must submit data electronically using one of five formats:

- RAPS format (for all provider types)
- National Standard Format (NSF) (physician only)
- Universal Bill - 92 (UB-92) (hospital inpatient and hospital outpatient)
- American National Standards Institute (ANSI) (all provider types)
- DDE screen (all provider types)

## 4.5 Submission File Layout Logic (Slides 10, 5-6)

Submissions are organized into three levels of data:

- File-level information—identifies the submitter
- Batch-level information—identifies the M+C organization
- Detail-level information—identifies the beneficiary

A summary of the RAPS file structure may be seen in Figure 4A.

**Figure 4A – RAPS File Structure Summary**

**RT AAA – FILE HEADER (Submitter Info)**
Always the first record on the file, and must be followed by Record Type (RT) BBB.

- Record ID
- Submitter ID
- File ID
- Transaction Date
- Production/Test Indicator
- Filler

**RT BBB – BATCH HEADER (M+C Organization Info)**
Must follow RT AAA or RT YYY and must be followed by RT CCC.

- Record ID
- Sequence Number
- Plan Number
- Filler

**RT CCC – DETAIL RECORD (Beneficiary Info)**
Must follow RT BBB or RT CCC and may be followed by another RT CCC.

- Record ID
- Sequence Number
- Sequence Number Error
- Patient Control Number (optional)
- HIC Number
- HIC Error Code
- Patient Date of Birth (optional)
- Date of Birth Error Code
- Diagnosis Cluster (10 Occurrences)
  - Provider Type
  - From Date
  - Through Date
  - Delete Indicator
  - Diagnosis Code
  - Diagnosis Code – Filler
  - Diagnosis Cluster – Error 1
  - Diagnosis Cluster – Error 2
- Corrected HIC Number
- Filler

**RT YYY – BATCH TRAILER**
Must follow RT CCC and may be followed by another RT BBB or RT ZZZ.

- Record ID
- Sequence Number
- Plan Number
- CCC Record Total
- Filler

**RT ZZZ – FILE TRAILER**
Must follow RT YYY, and must be the last record on the file.

- Record ID
- Submitter ID
- File ID
- BBB Record Total
- Filler

DETAIL LEVEL
BATCH LEVEL
FILE LEVEL

## 4.6 Diagnosis Cluster (Slides 7-8)

The diagnosis cluster contains the core information used to calculate a risk adjustment factor. The following components are included in the cluster:

- Provider type
- From date
- Through date
- Diagnosis code

A maximum of 10 diagnosis clusters are allowed per CCC record. Each cluster must include the items identified above.

## 4.7 Provider Type (Slide 7)

M+C organizations must submit risk adjustment data for hospital inpatient, hospital outpatient, and physician services. All provider types may be submitted in the same CCC record. The provider type must be coded accurately. There is one provider type per diagnosis cluster. Table 4B shows the provider types and their codes.

**TABLE 4B – PROVIDER TYPES**

| PROVIDER TYPE | CODE |
|---|---|
| Principal Hospital Inpatient (principal diagnosis) | 01 |
| Hospital Inpatient Other (other diagnosis) | 02 |
| Hospital Outpatient | 10 |
| Physician | 20 |

All records submitted in the NSF format are considered to be physician records and will automatically be translated to provider type code "20." M+C organizations must submit only those data that qualify as physician data when using the NSF.

All records submitted on the UB-92 must include a type of bill so that the correct provider type can be translated. Table 4C shows the bill types.

**TABLE 4C – BILL TYPES**

| PROVIDER TYPE | BILL TYPE |
|---|---|
| 01 or 02 | 111 or 11Z |
| 10 | 131, 13Z, 141, or 14Z |

## 4.8 From and Through Dates (Slide 7)

- Format should always be CCYYMMDD.
- "Through Date" determines the date of service for risk adjustment purposes.

Table 4D shows the "From" and "Through Dates" for each provider type.

**TABLE 4D – FROM AND THROUGH DATES**

| PROVIDER TYPE | FROM DATE | THROUGH DATE |
|---|---|---|
| Hospital Inpatient | Admission Date | Must have a through date and must be the discharge date |
| Hospital Outpatient | Exact date of patient visit or the first date service began for a series of services | Exact date of patient visit or the last date of service for a series of services |
| Physician | | |

June 30, 2002 should be submitted as 20020630.

When a submitter submits a "From Date" and does not include a "Through Date" for physician or hospital outpatient services, RAPS automatically copies the "From Date" into the "Through Date" field.

Interim bills (112, 113, & 114 bill types) are not accepted. If an M+C organization receives interim bills, submit the hospital inpatient diagnoses upon the receipt of the final interim bill (114). If the M+C organization uses the UB-92, submit the final interim bill as bill type 111 or 11Z. This means the appropriate discharge diagnoses are submitted for risk adjustment, rather than the admission diagnoses.

## 4.9 Diagnosis Code (Slide 7)

- Each relevant (model) diagnosis code must be submitted at least once during a reporting period.
- The decimal is implied in the format.

## 4.10 RAPS Format

- Each field of the RAPS file layout is described below in Table 4E.
- The shaded fields in the table represent where new information will be provided on the RAPS Return File after data is processed through RAPS.
- There are two diagnosis cluster error fields because M+C organizations normally can receive up to two errors on any diagnosis cluster.

## TABLE 4E – RAPS FILE LAYOUT

| RAPS RECORD AAA – FILE HEADER | | | | |
|---|---|---|---|---|
| **FIELD NO** | **POSITION** | **SUBMISSION STATUS** | **FIELD NAME** | **EXPLANATION** |
| 1 | 1-3 | Required | Record ID | File-level information that identifies the submitter. This field should always be populated with “AAA”. |
| 2 | 4-9 | Required | Submitter ID | Identifies the submitter and should be populated with the six-digit alphanumeric SH# assigned by the CSSC. |
| 3 | 10-19 | Required | File ID | 10-digit alphanumeric character identifying the specific file submitted. This file name may not be repeated within a 12-month period. |
| 4 | 20-27 | Required | Transaction Date | Specifies the date that the file was submitted to Palmetto and should be formatted as CCYYMMDD. |
| 5 | 28-31 | Required | Production Test Indicator | Must be populated with “PROD” or “TEST”. Submission test data will proceed through the entire process. |
| 6 | 32-512 | Spaces | Filler | Must be populated with 481 spaces. The “Filler” field allows for additional fields in the future. |

| RAPS RECORD BBB – BATCH HEADER | | | | |
|---|---|---|---|---|
| **FIELD NO** | **POSITION** | **SUBMISSION STATUS** | **FIELD NAME** | **EXPLANATION** |
| 1 | 1-3 | Required | Record ID | Batch-level information that identifies the M+C organization. This field should always be populated with “BBB”. |
| 2 | 4-10 | Required | Sequence Number | This field identifies the batch submitted. The first batch in a file must begin with 0000001. All successive batch sequence numbers in the file must be incremented by one. This is a numeric field. |
| 3 | 11-15 | Required | Plan Number | Identifies the M+C organization and should be populated with the five-digit alphanumeric H# assigned by CMS. |
| 4 | 16-512 | Spaces | Filler | Must be populated with 497 spaces. The “Filler” field allows for additional fields in the future. |

## TABLE 4E – RAPS FILE LAYOUT (CONTINUED)

| RAPS RECORD CCC – DETAIL LEVEL | | | | |
|---|---|---|---|---|
| **FIELD NO** | **POSITION** | **SUBMISSION STATUS** | **FIELD NAME** | **EXPLANATION** |
| 1 | 1-3 | Required | Record ID | Detail-level information that identifies the beneficiary information. This field should always be populated with "CCC". |
| 2 | 4-10 | Required | Sequence Number | This field identifies the detail record submitted. The first detail record in a batch must begin with 0000001. All successive detail sequence numbers in the batch must be incremented by one. This is a numeric field. |
| 3 | 11-13 | RAPS RETURN | Sequence Number Error Code | This field must be submitted with spaces. Upon return, this field will be populated with an error code if RAPS finds an error in the sequence number, or will remain blank if no errors were detected in the sequence number. |
| 4 | 14-53 | Optional | Patient Control Number | This optional field may be used by the M+C organization to identify the claim submitted. The field allows up to 40 alphanumeric characters. |
| 5 | 54-78 | Required | HICN | The Health Insurance Claim number for the beneficiary. This is a 25-digit alphanumeric field. Enter spaces, not zeros, in unused spaces. |
| 6 | 79-81 | RAPS RETURN | HICN Error Code | This should be submitted with spaces. Upon return, this field will be populated with an error code if RAPS finds an error in the HIC number, or remain blank if no errors were detected in the HIC number. |
| 7 | 82-89 | Optional | Patient DOB | This optional field may be populated with the patient's date of birth and used to verify that the correct beneficiary was submitted. If the field is populated, it must be formatted as CCYYMMDD. If this field is populated, CMS will edit this field against the information on file at the MBD. If no DOB is submitted, fill with spaces. |
| 8 | 90-92 | RAPS RETURN | DOB Error Code | This field must be submitted with spaces. Upon return this field will be populated with an error code if RAPS finds an error with DOB, or remain blank if no errors were detected in the DOB. |

## TABLE 4E – RAPS FILE LAYOUT (CONTINUED)

| RAPS RECORD CCC – DETAIL LEVEL (CONTINUED) | | | | |
|---|---|---|---|---|
| **FIELD NO** | **POSITION** | **SUBMISSION STATUS** | **FIELD NAME** | **EXPLANATION** |
| | 93-412 | DIAGNOSIS-CLUSTER (10 occurrences) | | The following 8 fields (9.0-9.7) may be repeated 10 times in the same "CCC" record with one diagnosis per cluster. Each diagnosis cluster must contain 32 characters or spaces. If there are more than 10 diagnoses, a new "CCC" record must be established. |
| 9.0 | | Required | Provider Type | This two-digit alphanumeric field identifies the site of service provided (01,02,10,20). |
| 9.1 | | Required | From Date | For hospital inpatient this describes the admission date. For physician and hospital outpatient this field describes the date of service. Must be formatted as CCYYMMDD. |
| 9.2 | | Required | Through Date | For hospital inpatient this describes the discharge date. For physician and hospital outpatient this field may be left blank and the system will fill with the "From Date." Must be formatted as CCYYMMDD. |
| 9.3 | | Conditional | Delete Indicator | This field allows the M+C organization to delete a diagnosis, for correction purposes, that has been stored in the RAPS database. Enter a "D" or space. |
| 9.4 | | Required | Diagnosis Code | This field is populated with the three-to five-digit ICD-9-CM diagnosis code. The decimal is implied and should not be included (e.g., 42732). |
| 9.5 | | SPACE | Diagnosis Code Filler | This field is designed to allow space for future ICD-10-CM codes and any other growth in the diagnosis cluster. This field must be populated with spaces. |
| 9.6 | | RAPS RETURN | Diagnosis Cluster Error 1 | This field must be submitted with spaces. Upon return, this field will be populated with one error code if RAPS finds an error in the diagnosis cluster, or remain blank if no errors were detected in the diagnosis cluster. |
| 9.7 | | RAPS RETURN | Diagnosis Cluster Error 2 | This field must be submitted with spaces. Upon return, this field will be populated with one error code if RAPS finds an error in the diagnosis cluster, or remain blank if no errors were detected in the diagnosis cluster. |
| 19 | 413-437 | RAPS RETURN | Corrected HICN | This must be submitted with spaces. If the M+C organization has submitted an outdated HIC, upon return, this field will be populated with the most current HICN and the "HIC Error" field will contain an information error code. |
| 20 | 438-512 | Spaces | Filler | Must be populated with 75 spaces. The "Filler" field allows for additional fields in the future. |

## TABLE 4E – RAPS FILE LAYOUT (CONTINUED)

| RAPS RECORD YYY – BATCH TRAILER | | | | |
|---|---|---|---|---|
| **FIELD NO** | **POSITION** | **SUBMISSION STATUS** | **FIELD NAME** | **EXPLANATION** |
| 1 | 1-3 | Required | Record ID | Batch trailer information should be populated with "YYY". |
| 2 | 4-10 | Required | Sequence Number | 7-digit numeric character identifying the batch submitted. Must match the "BBB" record. |
| 3 | 11-15 | Required | Plan Number | H# assigned by CMS to identify the M+C organization. Must match the H# in the corresponding "BBB" record (i.e., the "BBB" record with the same sequence number). |
| 4 | 16-22 | Required | CCC Record Total | This field should total the number of CCC records in the batch. This field is numeric and should be filled with leading zeroes (e.g., 0000001). |
| 5 | 23-512 | Spaces | Filler | Must be populated with 490 spaces. The filler field allows for additional fields in the future. |

| RAPS RECORD ZZZ – FILE TRAILER | | | | |
|---|---|---|---|---|
| **FIELD NO** | **POSITION** | **SUBMISSION STATUS** | **FIELD NAME** | **EXPLANATION** |
| 1 | 1-3 | Required | Record ID | File Trailer Information should be populated with "ZZZ". |
| 2 | 4-9 | Required | Submitter ID | Identifies the submitter and must match the 6-digit alphanumeric SH# in the AAA records. |
| 3 | 10-19 | Required | File ID | 10-digit alphanumeric character identifying the specific file submitted. Must match the File ID in the "AAA" record. |
| 4 | 20-26 | Required | BBB Record Total | This field should total the number of batches in the file. This field is numeric and should be filled with leading zeros (e.g., 0000001). |
| 5 | 27-512 | Required | Filler | Must be populated with 486 spaces. The "Filler" field allows for additional fields in the future. |

## 4.11 Filtering Risk Adjustment Data (Slides 13-14, 10-11)

M+C organizations are required to filter risk adjustment data to ensure that they submit only data from appropriate data sources (hospital inpatient, hospital outpatient, and physician provider types). The filtering process is used to identify the correct provider types in claims and encounter data. CMS further recommends the following filtering guidelines:

- Hospital inpatient data require admission and discharge dates of service from appropriate facilities. **Refer to the Data Collection module, Table 3B** for examples of covered facilities.
- Physician data require face-to-face visits with a professional listed on the CMS specialty list. **Refer to the Data Collection module, Table 3H** for the list of acceptable physician data sources.
- Hospital outpatient data require the most demanding or accurate filtering. Data requirements include diagnoses from appropriate facilities and covered services contained on the CMS covered outpatient listings. **Refer to the Data Collection module, Table 3C** for examples of covered facilities and non-covered services/facilities.

The following over-filtering and under-filtering examples may be useful:

a) Hospital Inpatient:
   - Over-filtering - Failing to submit data from specialized facilities (e.g., Rehabilitation and Psychiatric Hospitals).
   - Under-filtering - Submitting data from interim bills or from non-covered institutional stays (e.g., nursing facility data).

b) Hospital Outpatient:
   - Over-filtering - Failing to submit data from specialized facilities, particularly those that do not appear on the inpatient provider list (e.g., Rural Health Clinics, Federally Qualified Health Centers), excluding bills with both covered and non-covered procedure codes.
   - Under-filtering - Submitting data from non-covered facilities or submitting non-covered services from covered facilities (e.g., laboratory only or radiology only claims).

c) Physicians:
   - Over-filtering - Failing to capture data from non-physician practitioners that appear on the physician specialty list (e.g., nurse practitioners, physician assistants, etc.).
   - Under-filtering - Submitting all paid claims from the claims database, including laboratory, Durable Medical Equipment (DME), ambulance, etc.

## 4.12 Modifying Risk Adjustment Data (Slide 15, 12)

RAPS allows for the correction of risk adjustment data that has been submitted to CMS. This correction process is based on the concept that the incorrect cluster must be deleted from the system before the correct cluster information is added. For this reason, correction of data is at least a two-step process.

Duplicate checking is not performed by the data processing system. That is, there are no duplicate-checking edits in Front-End Risk Adjustment System (FERAS) or RAPS.

## 4.13 Deleting Diagnosis Clusters (Slide 16)

Each diagnosis cluster ("Diagnosis Code," "From Date," "Through Date," and "Provider Type") is stored separately as a unique cluster associated with a beneficiary's HIC number. If a diagnosis was submitted in error and needs to be corrected, the original diagnosis cluster must be resubmitted with a delete indicator in the appropriate field. **Delete transactions may only be submitted using the RAPS format or the DDE function.** When a delete record is received, CMS maintains the original diagnosis cluster on file and adds a delete indicator to it and the date of the deletion.

## 4.14 Reasons to Delete a Diagnosis Cluster (Slide 17)

There are three reasons M+C organizations may delete a diagnosis cluster:

- Diagnosis cluster is submitted erroneously (e.g., data from an interim bill was submitted for hospital inpatient).
- Incorrect HIC number was used for submission of a beneficiary's diagnostic information.
- Any error in a diagnosis cluster field (i.e., "Provider Type," "Dates of Service," "Diagnosis Code").

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

## 4.15 Steps for Deleting a Diagnosis Cluster (Slides 18-20, 14-15)

Before deleting an error, verify that the diagnosis cluster appears on the RAPS Return File. Only diagnosis clusters accepted by RAPS and stored in Risk Adjustment System (RAS) may be deleted.

There are two methods for deleting diagnosis clusters:

**Method 1 for Deleting Clusters**

1. Submit RAPS format using normal submission process with appropriate HIC number included.
2. Enter information in the diagnosis cluster fields (9.0, 9.1, 9.2, 9.4, 9.5) exactly as it appeared in the original submission.
3. In field 9.3 enter a "D" for delete.
4. Enter the appropriate information in all other records to ensure the submission file is complete.
5. Transmit the file to FERAS.

**Method 2 for Deleting Clusters**

1. Create a file using the DDE screens available through the FERAS at Palmetto GBA (detailed information about the DDE process is located in Section 4.20).
2. Enter information exactly as it appeared in the original submission.
3. In the DDE "CCC" record screen, hit the down arrow key and select "D".
4. Proceed with entering all appropriate information.
5. Upload the file created in DDE to the FERAS at Palmetto GBA.

## 4.16 M+C Organization Responsibilities Regarding Deletions (Slide 21)

- M+C organizations must submit delete records when an erroneous diagnosis cluster has been accepted by RAPS and stored in RAS.
- If a diagnosis cluster is deleted for the purpose of correcting data, the M+C organization is responsible for submitting the correct diagnosis cluster. Conversely, if the M+C organization submits corrected data, the M+C organization must submit the appropriate deletion record. That is, if the correct diagnosis cluster is submitted, the erroneous diagnosis cluster cannot be ignored.
- If a correction applies to the same beneficiary as the deletion, the correction may be included in the same "CCC" record as the deletion (Do not exceed 10 diagnosis clusters per "CCC" record).
- If the corrected diagnosis cluster belongs to a different beneficiary than the deleted diagnosis cluster, the correct diagnosis cluster may be submitted in the same file as the deletion.

M+C organizations should not delete a diagnosis code or record repeatedly on the same day and on the same record. M+C organizations should implement a process to ensure that only one instance of a specific diagnosis cluster (either add or delete) is submitted on a given day.

## 4.17 National Standard Format (NSF) (Slide 22)

- NSF format is used to submit physician data.
- Table 4F below describes the minimum data set required for NSF submission. This format is translated into the necessary RAPS data set in FERAS prior to applying the editing process. In order to protect the integrity of the file, the data must be located in the correct position in the flat file format.
- Files processed by FERAS must be submitted with Payor ID C80883 (NSF RT AA0 17.0).

**TABLE 4F – NSF MINIMUM REQUIRED FIELDS**

| RECORD TYPE/ FIELD NO | NSF POSITION | NSF FIELD NAME | NSF EXPLANATION | RAPS FIELD | RAPS CROSSWALK EXPLANATION |
|---|---|---|---|---|---|
| AA0 1.0 | 1-3 | RECORD ID | The first record in the file. Must be "AA0". | AAA 1 | The first record in the file. Will be translated to "AAA". |
| AA0 2.0 | 4-19 | SUBMITTER ID (SHnnnn) | The 6 alphanumeric characters assigned by the CSSC that identify the submitter. Always begins with SH. Field is left justified and space filled | AAA 2 | The 6 alphanumeric characters assigned by CSSC that identify the submitter. |
| AA0 5.0 | 35-40 | SUBMISSION NUMBER | The inventory file number assigned by the submitter's system. Must be unique for every new file submitted. This number may not be reused in a 12-month period. | AAA 3, ZZZ 3 | This field allows for 6 alphanumeric characters. This file identification number is assigned by the submitter for tracking submissions. This number may not be duplicated within a 12-month period. |
| AA0 15.0 | 213-220 | CREATION DATE | The date the file was created. | AAA 4 | Transmission Date. Date file was submitted to the front-end in the CCYYMMDD format. |
| AA0 21.0 | 254-257 | TEST/ PRODUCTION INDICATOR | This alpha field indicates to Palmetto whether the file submitted should be used as a test submission or as a routine production submission. | AAA 5 | This alpha field indicates to Palmetto whether the file submitted should be used as a test submission or as a routine production submission. |
| BA0 1.0 | 1-3 | RECORD ID | The first record in the batch. Must be "BA0". | BBB 1 | The first record in the batch. Will be translated to "BBB". |
| BA0 4.0 | 22-25 | BATCH NUMBER | Sequential number assigned by the submitter to each batch of claims. Must be numeric 0001 through 9999. Increment by 1 for each BA0 record. | BBB 2 | Sequential number assigned by the submitter to each batch of detail records. Contains 7 digits beginning with 0000001. FERAS will right justify and zero fill the first 3 positions. |

**TABLE 4F – NSF MINIMUM REQUIRED FIELDS (CONTINUED)**

| RECORD TYPE/ FIELD NO | NSF POSITION | NSF FIELD NAME | NSF EXPLANATION | RAPS FIELD | RAPS CROSSWALK EXPLANATION |
|---|---|---|---|---|---|
| BA0 9.0 | 48-62 | PLAN NUMBER | In encounter data, M+C organizations enter the H number of the M+C organization assigned by CMS, left justified and space filled. | BBB 3, YYY 3 | The plan number indicates the unique H number of the M+C organization assigned by CMS. Field is 5 characters with no spaces. |
| CA0 1.0 | 1-3 | RECORD ID | The first record in the claim. Must be "CA0". | CCC 1 | The first record in the detail record. Will be translated to "CCC". |
| CA0 3.0 | 6-22 | PATIENT CONTROL NUMBER | This field contains up to 17 characters that identify the encounter data transaction of the beneficiary. The patient control number is assigned by the M+C organization. | CCC 4 | This field allows up to 40 characters that identify the beneficiary. Upon translation, the 17 character NSF PCN will be left justified and space filled. The patient control number is assigned by the M+C organization. This field is optional. |
| CA0 8.0 | 59-66 | PATIENT DATE OF BIRTH | This field must indicate the date of birth for the beneficiary in CCYYMMDD format. This date must be prior to or equal to the From Date. | CCC 7 | This optional field indicates the date of birth for the beneficiary in CCYYMMDD format. This date must be prior to or equal to the From Date. |
| DA0 18.0 | 157-181 | MEDICARE NUMBER (HICN) | The HIC Number indicates the Health Insurance Claim Number of the beneficiary for whom the claim is submitted. The first 9 characters must be numeric. The 10th character must be alpha (no space). The 11th and 12th characters must be alphanumeric. The remainder of the field must be spaces. | CCC 5 | The HIC Number indicates the Health Insurance Claim Number of the beneficiary for whom the claim is submitted. The first 9 characters must be numeric. The 10th character must be alpha (no space). The 11th and 12th characters must be alphanumeric. The remainder of the field must be spaces. |

**TABLE 4F – NSF MINIMUM REQUIRED FIELDS (CONTINUED)**

| RECORD TYPE/ FIELD NO | NSF POSITION | NSF FIELD NAME | NSF EXPLANATION | RAPS FIELD | RAPS CROSSWALK EXPLANATION |
|---|---|---|---|---|---|
| EA0 32.0 | 179-183 | DIAGNOSIS CODE 1 | ICD-9-CM format – DO NOT use a decimal point. | CCC 9.4 | The valid ICD-9-CM code for this submission. Do not use a decimal point. |
| EA0-33 | 184-188 | DIAGNOSIS CODE 2 | ICD-9-CM format – DO NOT use a decimal point. | CCC 10.4 | |
| EA0-34 | 189-193 | DIAGNOSIS CODE 3 | ICD-9-CM format – DO NOT use a decimal point. | CCC 11.4 | |
| EA0-35 | 194-198 | DIAGNOSIS CODE 4 | ICD-9-CM format – DO NOT use a decimal point. | CCC 12.4 | |
| FA0 5.0 | 40-47 | SERVICE FROM DATE | Date service was initiated. This date indicates the date of the encounter. Must be present, must be a valid date and cannot be greater than the current date. | CCC 9.1<br>CCC 10.1<br>CCC 11.1<br>CCC 12.1 | This same date will be used for each diagnosis cluster in this record. |
| FA0 6.0 | 48-55 | SERVICE TO DATE | Must be equal to or greater than service from date. This date indicates the date of the encounter. Must be present, must be a valid date and cannot be greater than the current date. | CCC 9.3<br>CCC 10.3<br>CCC 11.3<br>CCC 12.3 | If left blank, RAPS will insert same date as the From Date. These same dates will be used for each diagnosis cluster in this record. |
| YA0 1.0 | 1-3 | RECORD ID | Must be “YA0”.<br>This is the last record of any electronically submitted batch. It contains information pertinent to the balancing of each batch (i.e., batch record count, batch charges) within a file. | YYY 1 | The batch level trailer record. Will be translated to “YYY”. |

**TABLE 4F – NSF MINIMUM REQUIRED FIELDS (CONTINUED)**

| RECORD TYPE/ FIELD NO | NSF POSITION | NSF FIELD NAME | NSF EXPLANATION | RAPS FIELD | RAPS CROSSWALK EXPLANATION |
|---|---|---|---|---|---|
| YA0 4.0 | 22-25 | BATCH NUMBER | Sequential number assigned by the submitter to each batch of claims. Must be numeric 0001 through 9999. Increment by 1 for each BA0 record. | YYY 2 | This 4-digit number must agree with the BBB 2 record. |
| YA0 10.0 | 61-67 | BATCH CLAIM COUNT | May not be blank. Must be numeric. Must be computed sum of all Record Types CA0 included between this Batch Trailer Record (YA0) and preceding Batch Header Record (BA0). Right justify, zero fill. | YYY 4 | This 7-digit number must agree with the total number of records in the "CCC" file. |
| ZA0 1.0 | 1-3 | RECORD ID | Must be "ZA0". This is the last record of any file submitted. It contains information pertinent to the balancing of the file (i.e., File Record Counts File Charges) within a file. | ZZZ 1 | The file level trailer record. Will be translated to "ZZZ". |
| ZA0 2.0 | 4-19 | SUBMITTER ID (SHnnnn) | The 6 alphanumeric characters assigned by the CSSC that identify the submitter. Always begins with SH. Field is left justified and space filled. | ZZZ 2 | The 6 alphanumeric characters assigned by CSSC that identify the submitter. Field is 6 characters with no spaces. |
| ZA0 8.0 | 66-69 | BATCH COUNT | May not be blank. Must be numeric. Must be computed sum of all Record Types YA0 within this file. Right justify. Zero fill. | ZZZ 4 | This number indicates the total number of batches contained in the file. |

- All NSF submissions will be translated to Provider Type 20 in CCC 9.0. Only physician data will be accepted via the NSF format.
- A CCC record is created in the RAPS format each time a new beneficiary claim is identified in the NSF format.
- Palmetto plugs the CCC 2 in the order in which the detail records appear in the batch.
- Record Identifiers DA0 1.0, EA0 1.0, and FA0 1.0 must be populated. These are not optional fields when submitting via NSF.

## 4.18 UB-92 (Slide 23)

- UB-92 format is used to submit hospital outpatient and hospital inpatient data.
- Table 4G describes the format as translated into the necessary RAPS data set in FERAS prior to applying the checks. In order to protect the integrity of the file, all of the other fields must be populated with zeros or spaces.
- Files processed in FERAS must be submitted with Payor ID C80884. (UB-92 RT 01, Field 6).

**TABLE 4G – UB-92 REQUIRED FIELDS**

| RECORD TYPE/ FIELD NO | UB-92 POSITION | UB-92 FIELD NAME | UB-92 EXPLANATION | RAPS FIELD | RAPS CROSSWALK EXPLANATION |
|---|---|---|---|---|---|
| 01 1.0 | 1-2 | RECORD TYPE | The first record in the file. Must be "01". | AAA 1 | The first record in the file. Will be translated to "AAA". |
| 01 2.0 | 3-12 | SUBMITTER ID (SHnnnn) | The 6 alphanumeric characters assigned by the CSSC that identify the submitter. Always begins with SH. Field is left justified and space filled. | AAA 2 | The 6 alphanumeric characters assigned by CSSC that identify the submitter. |
| 01 17.2 | 137-142 | FILE SERIAL NUMBER | File Serial Number. When submitting risk adjustment data, use 6 characters only, right justify the field and fill first position with space. | AAA 3 | This field allows for 6 alphanumeric characters. This file identification number is assigned by the submitter for tracking submissions. |
| 01 18.0 | 143-146 | TEST/PROD INDICATOR | Test/Prod Indicator | AAA 5 | This alpha field indicates to Palmetto whether the file submitted should be used as a test submission or as a routine production submission. |
| 01 20.0 | 155-162 | PROCESSING DATE | Date Bill Submitted on the UB-92 (CCYYMMDD) | AAA 4 | This indicates the date on which the file is transmitted to FERAS. |
| 10 1.0 | 1-2 | RECORD TYPE | The first record in the batch. Must be "10". | BBB 1 | The first record in the file. Will be translated to "BBB". |
| 10 3.0 | 6-7 | BATCH NUMBER | Batch Number. Must start with 01 and increment by one for every new batch. | BBB 2 | Will be zero filled for first 5 spaces, then will have batch number submitted by M+C organization in last 2 spaces. |

**TABLE 4G – UB-92 REQUIRED FIELDS (CONTINUED)**

| RECORD TYPE/ FIELD NO | UB-92 POSITION | UB-92 FIELD NAME | UB-92 EXPLANATION | RAPS FIELD | RAPS CROSSWALK EXPLANATION |
|---|---|---|---|---|---|
| 20 1.0 | 1-2 | RECORD TYPE | The first record in the claim. Must be "20". | CCC 1 | The first record in the file. Will be translated to "CCC". |
| 20 3.0 | 5-24 | PATIENT CONTROL NUMBER | Patient Control Number. This field is limited to 20 characters that identify the encounter data transaction or the beneficiary. The patient control number is assigned by the M+C organization. | CCC 4 | This optional field allows 40 characters for PCN. When translated, the PCN will be left justified with all remaining positions of this field filled with spaces. |
| 20 8.0 | 56-63 | PATIENT DATE OF BIRTH | Birth Date (CCYYMMDD). This date must be prior to or equal to the From Date. This field must be space filled. | CCC 7 | This optional field indicates the date of birth for the beneficiary in CCYYMMDD format. |
| 20 19.0 | 133-140 | STATEMENT COVERS PERIOD FROM | Statement Covers Period From Date (CCYYMMDD.) For inpatient, must be the admission date. For outpatient, should be the date of service or the first date of a series of services. | CCC 9.1 | This date is required for inpatient and outpatient submissions. |
| 20 20.0 | 141-148 | STATEMENT COVERS PERIOD TO | Statement Covers Period Through Date (CCYYMMDD.) For inpatient, must be the discharge date. For outpatient, must be the date of service or the last date of service for a series of services (with the date span between from and through dates not to exceed 31 days). Do not submit interim bills. | CCC 9.2 | This date is required for all hospital inpatient submissions. If left blank, CMS will insert same date as the From Date for physician and hospital outpatient submissions. |

**TABLE 4G – UB-92 REQUIRED FIELDS (CONTINUED)**

| RECORD TYPE/ FIELD NO | UB-92 POSITION | UB-92 FIELD NAME | UB-92 EXPLANATION | RAPS FIELD | RAPS CROSSWALK EXPLANATION |
|---|---|---|---|---|---|
| 30 7.0 | 35-53 | HICN | HIC Number | CCC 5 | The HIC number indicates the Health Insurance Claim Number of the beneficiary for whom the claim is submitted. The first nine characters must be numeric. The 10th character must be alpha (no space). The 11th and 12th characters must be alphanumeric. The remainder of the field must be spaces. |
| 31 15.0 | 178-182 | CONTRACTOR NUMBER | Contractor Number (HMO) | BBB 3<br>YYY 3 | The plan number indicates the unique H number of the M+C organization assigned by CMS. |
| 40 4.0 | 25-27 | TYPE OF BILL | Type of Bill. Must be 11Z or 111 for inpatient, 131, 13Z, 141, or 14Z for outpatient. | CCC 9.0 | If 111 or 11Z, this field indicates the provider type for all diagnoses on this encounter will be inpatient. The principal diagnosis on this UB-92 will translate to provider type 01, all other diagnoses to 02. If 131, 13Z, 141, 14Z, this field indicates that all diagnoses will be outpatient. |

**TABLE 4G – UB-92 REQUIRED FIELDS (CONTINUED)**

| RECORD TYPE/FIELD NO | UB-92 POSITION | UB-92 FIELD NAME | UB-92 EXPLANATION | RAPS FIELD | RAPS CROSSWALK EXPLANATION |
|---|---|---|---|---|---|
| 70 4.0 | 25-78 | PRINCIPAL | Principal Diagnosis Code (ICD-9) | CCC 9.4 | The valid ICD-9-CM code for this submission. When bill type is 111 or 11Z, the principal diagnosis will be associated with provider type 01. |
| 70 5.0 – 12.0 | | OTHER DIAGNOSIS CODES | Other Diagnosis Code (occurs 8x) | CCC 10.4, 11.4, 12.4, 13.4, 14.4, 15.4, 16.4, 17.4 | When bill type is 111 or 11Z, these diagnosis codes will be associated with Provider Type 02. |
| 95 1.0 | 1-2 | RECORD TYPE | The first record in the batch trailer. Must be “95”. | YYY 1 | The first record in the batch trailer. Will be translated to “YYY”. |
| 95 6.0 | 25-30 | NUMBER OF CLAIMS | The number of claims in the batch. Zero fill and right justify. | YYY 4 | This field indicates the total number of CCC records contained within the batch. |
| 99 1.0 | 1-2 | RECORD TYPE | The first record in the file trailer. Must be “99”. | ZZZ 1 | The first record in the file trailer. Will be translated to “ZZZ”. |
| 99 2.0 | 3-12 | SUBMITTER ID (SHnnnn) | The 6 alphanumeric characters assigned by the CSSC that identify the submitter. Always begins with SH. Field is left justified and space filled. | ZZZ 2 | The 6 alphanumeric characters assigned by CSSC that identify the submitter. |
| 99 5.0 | 22-25 | NUMBER OF BATCHES BILLED THIS FILE | Number of batches billed this file. Zero fill and right justify. | ZZZ 4 | This number indicates the total number of batches contained in the file. |

- A CCC record is created in the RAPS format each time a new beneficiary claim is identified in the UB-92 format.
- Palmetto plugs the CCC 2 in the order in which the detail records appear in the batch.
- Record Identifiers 30.1, 40.1, and 70.1 must be populated. These are not optional fields when submitting via UB-92.

## 4.19 ANSI 837

- ANSI 837 is the HIPAA compliant American National Standard Institute electronic format that can be used for data collection.
- This is an optional transmission format for submitting to RAPS.
- ANSI 837 Institutional is used for hospital inpatient and outpatient data, and ANSI 837 Professional is used for physician data.
- HIPAA does not require an M+C organization to use the ANSI 837 to submit risk adjustment data to CMS.

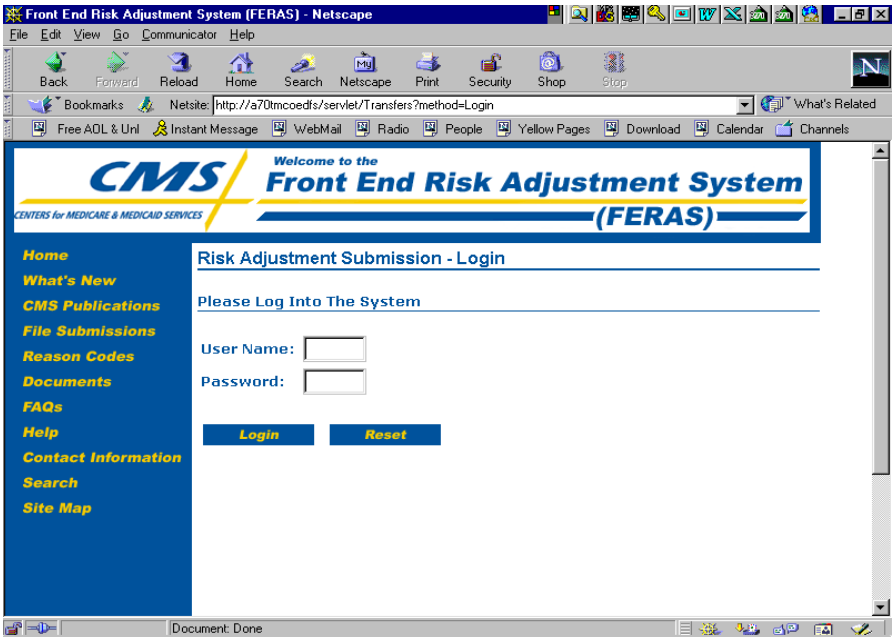
See Resource Guide for ANSI crosswalk.

## 4.20 Direct Data Entry (Slide 24)

M+C organizations have the option of manually entering diagnostic information via the DDE application offered by Palmetto GBA. DDE instructions are illustrated in the screen shots below. DDE is available in FERAS at Palmetto GBA via the Medicare Data Communications Network (MDCN).

- DDE entries allow for deletion of records for corrections even if another submission format was used.
- The DDE screens, as shown in Figures 4B through 4G, will automatically prevent the placement of incorrect data characters (e.g., alpha characters will not be accepted in the “From” or “Through Date” fields).
- After the user has entered all relevant data, the user will click on the “Create File” button in FERAS. This will create a file on the user’s local PC.
- After the file is created on the local PC, the user must upload the file to FERAS in order to complete the process.
- Files created in DDE and uploaded to FERAS, will receive a front-end response report, which may be downloaded from the M+C organization’s electronic mailbox.

**Figure 4B – DDE 1**




**LOGIN PAGE – Submitters are assigned a User Name and Password to access the DDE application.**

**Figure 4C – DDE 2**

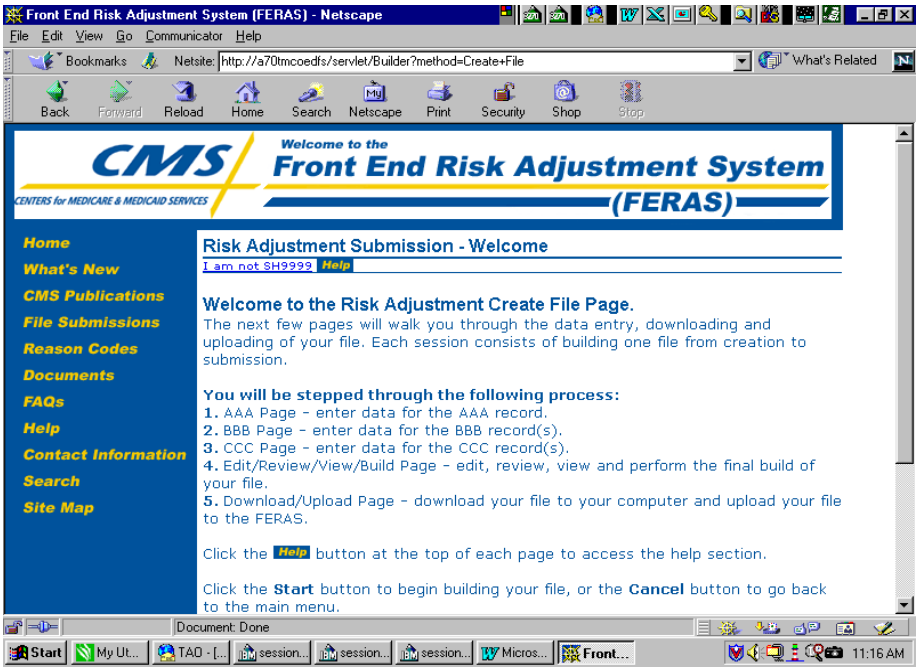
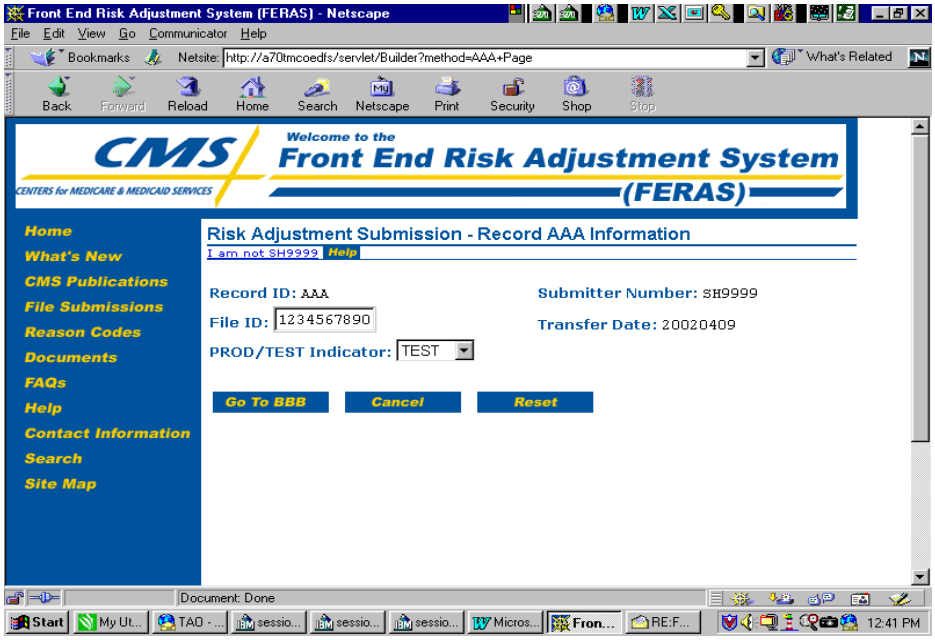
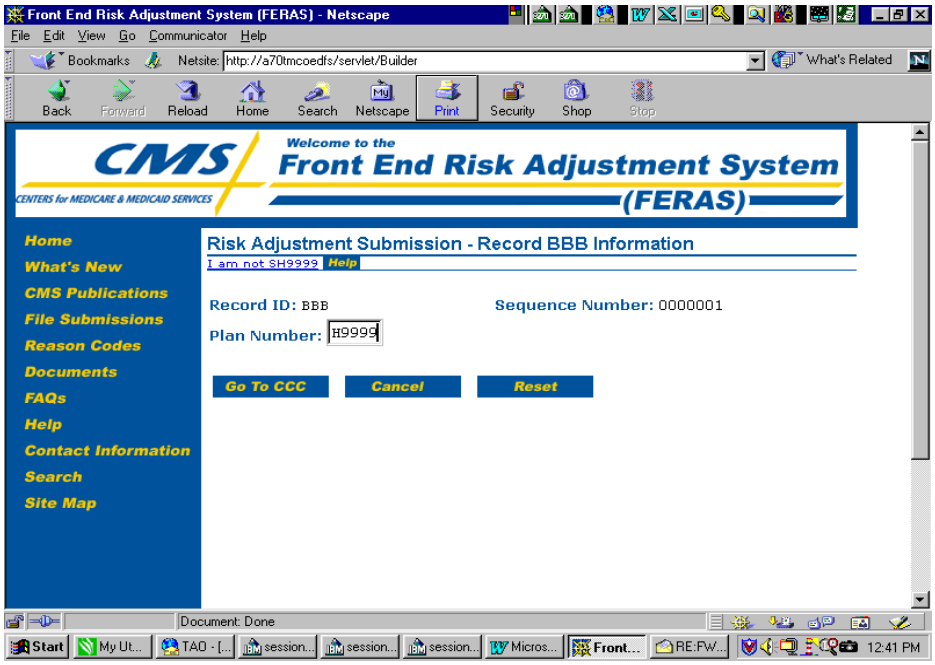


**Figure 4D – DDE 3**



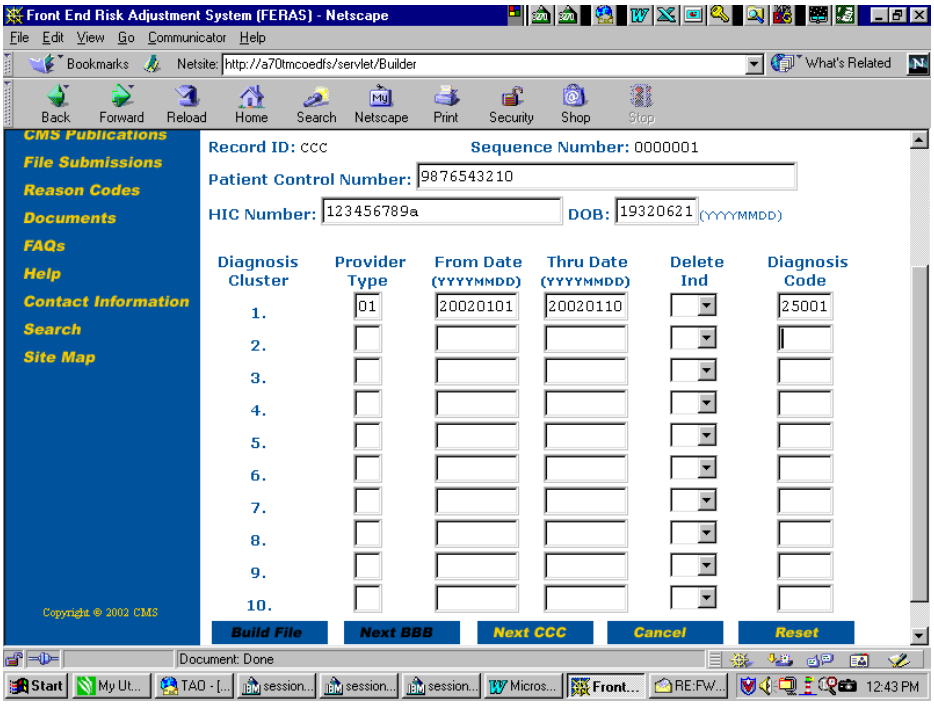

**The file-level information is entered and must begin with RT AAA.**

**Figure 4E – DDE 4**



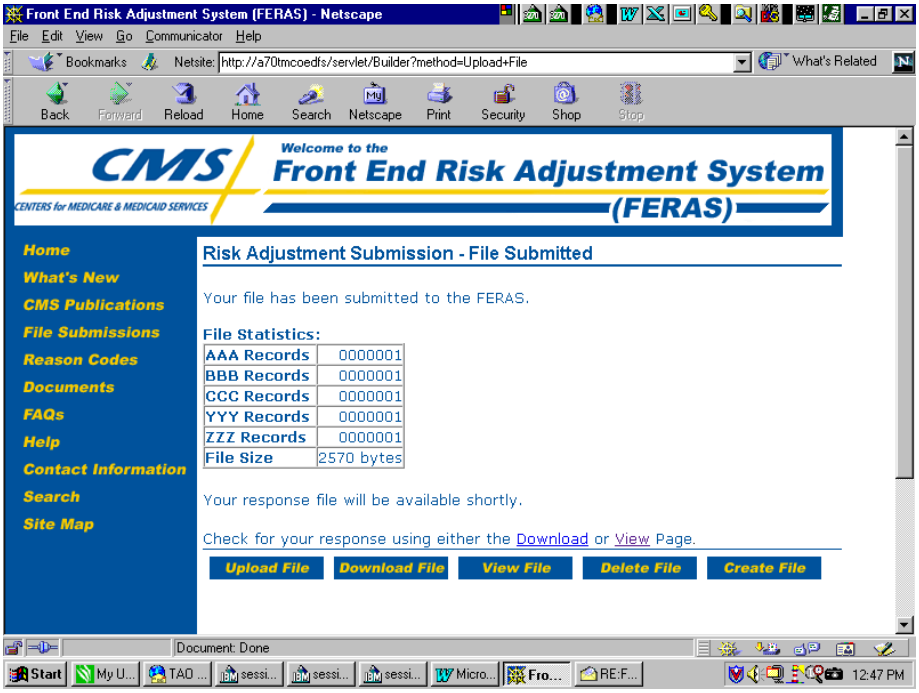

**The batch-level information is entered and must begin with RT BBB.**

**Figure 4F – DDE 5**




**The CCC Record allows up to 10 diagnostic clusters.**

**Figure 4G – DDE 6**




**The file has been uploaded to FERAS.**

# MODULE 5 – DIAGNOSIS CODES & RISK ADJUSTMENT

## Purpose (Slide 2)

This module provides Medicare+Choice (M+C) organizations an introduction to diagnosis coding and the importance of accurate diagnosis documentation and coding for risk adjustment. The module first explains the structure and layout of the official CMS diagnosis coding set, the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). The module also discusses the diagnosis coding guidelines that apply to the ICD-9-CM, and how following those guidelines ensures accurate risk adjustment. The module demonstrates how verification of compliance with coding guidelines depends upon accurate documentation in the medical record. Finally, the module provides information to assist M+C organizations in communicating with their physicians regarding proper documentation and diagnosis coding.

## Learning Objectives (Slides 3-4)

At the completion of this module, participants will be able to:

- Identify the background, key terms, and organization of ICD-9-CM.
- Describe the coding update process, recent and proposed changes impacting risk adjustment, and the status of ICD-10-CM.
- Apply official coding guidelines to common Medicare diagnoses and understand the impact on associated Hierarchical Condition Category (HCC) assignment.
- Define and identify V codes and E codes in the HCC model.
- Describe the importance of ICD-9-CM and medical record documentation to risk adjustment.
- Identify resources available for additional training and policy formation regarding documentation and coding.

**ICON KEY**

| | |
|---|---|
| Example | |
| Reminder | |
| Resource | |
| Information Systems Track | |
| Quality & Compliance Track | |

## 5.1 Introduction

Medicare uses ICD-9-CM as the official diagnosis code set for all lines of business including determination of risk adjustment factors. M+C organizations must:

- Implement procedures to ensure that diagnoses are coming from one of the three allowed physician/provider types.
- Submit all relevant ICD-9-CM diagnosis codes for each beneficiary.
- Submit unique diagnoses at least once during the risk adjustment data reporting period.

The source medical record documentation that supports each coded diagnosis must be obtainable and demonstrate adherence to official coding guidelines.

Relevant diagnoses are defined as those diagnoses collected from one of the three provider types that are used in the Centers for Medicare & Medicaid Services (CMS)-HCC model.

This module emphasizes physician documentation and reporting of diagnosis codes. Historically, physician reimbursement in fee-for-service is primarily based on procedures or services rather than diagnoses, and physicians are very familiar with documentation guidelines for procedures and services. Physicians generally are not as familiar with diagnosis codes and their associated documentation guidelines as they are with procedure coding rules. The CMS-HCC model depends upon accurate diagnosis coding, which means that physicians must fully understand and comply with documentation and coding guidelines for reporting diagnoses.

### 5.1.1 Benefit to the M+C Organization and Physician (Slide 5)

Benefits to the M+C organization and physician are illustrated in Table 5A.

**TABLE 5A – BENEFITS TO M+C ORGANIZATIONS AND PHYSICIANS**

| **A basic understanding of ICD-9-CM process and guidelines assists M+C organizations in:** |
|---|
| • Interpreting and designing management reports.<br>• Determining possible causes of ICD-9-CM errors.<br>• Communicating diagnosis-related collection issues to the provider staff.<br>• Developing and maintaining information systems that meet the clinical data collection needs of the organization.<br>• Understanding clinical issues important to beneficiaries.<br>• Planning for future M+C organization services. |
| **Medical record documentation and coding impacts several important issues to the physician and M+C organization including:** |
| • Accurate reimbursement.<br>– ICD-9-CM codes are the basis of the CMS-HCC model.<br>– Accurate diagnosis codes are a result of clear, consistent, and complete documentation.<br>– CMS may verify the accuracy of the diagnoses submitted relative to the medical record documentation.<br>• Communication among all members of the health care team.<br>• Evaluation of the care provided.<br>• Research and education.<br>• Practice patterns. |

## 5.2 Structure and Terminology of ICD-9-CM (Slide 6)

ICD-9-CM diagnosis codes are 3- to 5-digit codes used to describe the clinical reason for a patient's treatment. They do not describe the service performed, just the patient's medical condition.
For any classification system to be reliable, the application of the codes must be consistent across users. Therefore, CMS, the American Hospital Association (AHA), the American Health Information Management

Association (AHIMA), and the National Center for Health Statistics (NCHS) together have developed official coding guidelines. These guidelines are available on the following website: www.cdc.gov/nchs/data/icd9/icdguide.pdf. The diagnosis portion of ICD-9-CM consists of two volumes, the Disease Index and the Disease Tabular.

- **The Disease Index (Alphabetical)** is also known as Volume I of ICD-9-CM. It is an index of all diseases and injuries categorized in ICD-9-CM. When a code is listed after the description, it means the reader should look up that code in the Disease Tabular section to determine if that is the most specific code to describe the diagnosis. The index is organized by main terms and subterms that further describe or specify the main term. In general, the main term is the condition, disease, symptom, or eponym (disease named after a person), not the organ or body system involved.

- **The Disease Tabular (Numeric)** is also known as Volume II of ICD-9-CM. It is a numeric listing of codes organized primarily by body system. The Disease Tabular provides much more detail than the Alphabetic Index on conditions included and excluded in the code selected. Another code in the same category may represent the diagnostic description better than the one indicated in the Disease Index.

To learn the steps of the actual coding process, see the informational pamphlet entitled *Focus on ICD-9-CM Coding* included with the training materials.

### 5.2.1 Special Notes and Abbreviations (Slide 8)

Throughout ICD-9-CM, there are notes and cross references to assist the coder in arriving at the most accurate code according to official coding guidelines. Examples include:

*Excludes* notes: Informs the coder which diagnosis codes are not included in the code selected.

*Use Additional Code* note: Informs the coder that more than one code is needed to fully describe the condition and gives examples of common associated conditions.

*Not otherwise specified (NOS)* is an abbreviation frequently used in ICD-9-CM. Basically it means "unspecified." The documentation does not provide additional information to assign a more specific code in the particular category. In many (but not all) code categories, the fourth digit "9" signifies an unspecified code.

*Not elsewhere classified (NEC)* also is present in ICD-9-CM. It is used when the medical record documents a condition to a level of specificity not identified by a specific ICD-9-CM code. In some cases the fifth digit "8" represents an NEC code.

### 5.2.2 Supplemental Classifications and Tables

Included in Volumes I and II are supplemental classifications and special tables that provide additional guidance in determining the most accurate code.

- **V codes** are a section of ICD-9-CM diagnosis codes that represent factors that influence health status or describe contact with health services. They are used to describe those circumstances or reasons for encounter other than for disease or injury. Selected V codes are included in the HCC model and are described later in this module.

- **E codes** are a supplemental classification included in ICD-9-CM used for reporting external causes of injuries and poisonings. The HCC model includes codes E950-E959, describing suicide or self-inflicted injuries.

- **Neoplasm Table** located in the Alphabetic Index (see *Neoplasm*) lists all cancer codes by site and nature of the disease (malignant primary or secondary, benign, or unspecified behavior).

- **Table of Drugs and Chemicals** is located at the end of the Alphabetic Index. It lists drug classifications as well as specific names of drugs, identifies the code for poisoning by that drug, and the associated E code to specify if the poisoning was accidental, an adverse effect (therapeutic use), suicide attempt, assault, or undetermined.

## 5.3 ICD-9-CM Updates (Slide 9)

To assist users of ICD-9-CM in interpreting and clarifying the guidelines, as well as publishing updated codes and applications, the American Hospital Association (AMA) Central Office on ICD-9-CM publishes quarterly official code advice in *Coding Clinic for ICD-9-CM*. The *Coding Clinic for ICD-9-CM* is the approved resource to update and clarify the use of ICD-9-CM. The small volumes (typically about 20 pages) include clarifications of previous advice and guidelines, or new information on a specific diagnosis coding practice by means of articles and a question and answer section.

The ICD-9-CM diagnosis code listing is updated on October 1 and April 1 (beginning April 2005). The ICD-9-CM Coordination and Maintenance Committee holds a public forum for requested updates and publishes a transcript of their recommendations on the CMS website and the *Federal Register*. Revisions discussed at the April and December meetings of one year generally become effective in October the following year. A complete listing and description of annual updates are available in *Coding Clinic for ICD-9-CM* the fourth quarter of each year.

The annual ICD-9-CM diagnosis codes update may result in updates to the list of diagnosis codes used in the CMS-HCC model. CMS will post a list of new codes in the CMS-HCC model annually, prior to the codes taking effect on October 1 and April 1.

The ICD-9-CM coding guidelines are not updated as frequently as the list of diagnosis codes. The most recent official guideline revision is published in *Coding Clinic for ICD-9-CM*, fourth quarter, 2002.

### 5.3.1 October 2003 Update

The most recent ICD-9-CM annual update was effective October 1, 2003. Selected new codes that are relevant to risk adjustment are listed below:

- New codes for Sickle-cell thalassemias codes 282.41 and 282.42 (HCC 44) with revisions to associated descriptions.
- New code for Acute chest syndrome 517.3 (HCC 44).
- New fifth digit for Myasthenia gravis specifying acute exacerbation (HCC 71).
- New fifth digit for Septic shock (HCC 2).

- Clarification of the clinical difference between sepsis and septicemia (HCC 2) and instructions on proper coding of the two conditions with the code for systemic inflammatory response (SIRS) (995.9X added in October 2002).

### 5.3.2 October 2004 Update (proposed)

The ICD-9-CM Coordination and Maintenance Committee has discussed the following changes for implementation October 1, 2004. The proposed rule on these changes will be published in the *Federal Register* in May 2004, and the final rule in August 2004. Codes that may impact the CMS-HCC model are listed below:

- Decubitus Ulcers (HCC 148) will have new fifth digit to specify site.
- Deep vein thrombosis (HCC 105) will be assigned a new code 453.40 instead of 453.8.
- Diabetes (HCC 15-19) descriptions will have the terms IDDM (Insulin Dependent Diabetes Mellitus) removed. The standard terminology should be only Type I or Type II.
- Affective psychoses (HCC 55) description will change to “episodic mood disorder.”
- The term “sepsis” will no longer index to code 038.9 (Septicemia HCC 2) but to SIRS. The instructions with 995.9X direct coders to code first the underlying systemic infection (such as septicemia), which will assure that the condition will continue to properly group to HCC 2.

### 5.3.3 International Classification of Diseases 10th Revision, Clinical Modification (ICD-10-CM) (Slide 10)

ICD-10-CM is the clinical modification of ICD-10, which was adopted by the World Health Organization in July 2000. In 1994, the National Center for Health Statistics (NCHS) began a comprehensive evaluation of ICD-10-CM to determine if it is a significant improvement over ICD-9-CM and should be implemented in the United States. The new system was tested and results were favorable. In November 2003, the National Committee on Vital and Health Statistics recommended that the Secretary of the Department of Health and Human Services (HHS) approve ICD-10-CM for all lines of business. The Secretary of HHS is studying this recommendation. He would have to propose any new coding system as part of the Health Insurance Portability and Accountability Act (HIPAA). The Federal government would need to first publish a notice of proposed rule-making, requesting public comment on the new policy.

## 5.4 Coding Guidelines Impacting the CMS-HCC Model (Slide 11)

Standard ICD-9-CM coding practices support the CMS-HCC model. In all cases, the documentation must support the code selected and substantiate that the proper coding guidelines were followed. Data validation ensures that both are appropriate. Upcoding or changing diagnoses to obtain higher reimbursement without supporting source documents is fraudulent. However, thoroughly reviewing documentation and coding practices through internal auditing procedures to ensure that data has been reported correctly and that appropriate reimbursement is received benefits both the M+C organization and physician/provider. Several guidelines that impact physician documentation and reporting of diagnosis data are listed in the following sections.

### 5.4.1 Co-Existing and Related Conditions (Slide 12)

The instructions for risk adjustment implementation refer to the official coding guidelines for ICD-9-CM, published at www.cdc.gov/nchs.icd9.htm and in the *Coding Clinic*. Physicians should "code all documented conditions that co-exist at the time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (V10-V19 not in HCC model) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment."

Co-existing conditions include chronic, ongoing conditions such as diabetes (250.XX, HCCs 15-19), congestive heart failure (428.0, HCC 80), atrial fibrillation (427.31, HCC 92), chronic obstructive and pulmonary disease (COPD) (496, HCC 108). These diseases are generally managed by ongoing medication and have the potential for acute exacerbations if not treated properly, particularly if the patient is experiencing other acute conditions. It is likely that these diagnoses would be part of a general overview of the patient's health when treating co-existing conditions for all but the most minor of medical encounters.

Co-existing conditions also include ongoing conditions such as multiple sclerosis (340, HCC 72), hemiplegia (342.9, HCC 100), rheumatoid arthritis (714.0, HCC 38) and Parkinson's (332.0, HCC 73). Although they may not impact every minor healthcare episode, it is very likely that patients having these conditions would have their general health status evaluated within a data reporting period, and these diagnoses would be documented and reportable at that time.

M+C organizations must submit each relevant diagnosis at least once during a risk adjustment reporting period. Therefore, these co-existing conditions should be documented by one of the allowable provider types at least once within the data reporting period.

Another type of co-existing conditions is symptoms. Symptoms that are integral to an underlying condition should not be coded.

**Example: 1**

Initial myocardial infarction (410.91, HCC 81) is a specific condition that, when coded, would eliminate the need to code symptoms of that condition. For example, unstable angina (411.1, HCC 82) or angina pectoris (413.9, HCC 83) are symptoms of initial myocardial infarction and various other cardiovascular conditions and would not typically be coded in addition to the underlying problem.

#### 5.4.1.1 Combination Codes (Slide 13)

Often ICD-9-CM combines two or more conditions into one code when both conditions occur together or when one is a manifestation of the other. When a combination code fully describes the encounter, the combination code is reported, not the separate component codes. However, when ICD-9-CM instructions include "Code also" notes, follow the directions to fully describe the encounter.

**Example: 2**

Hypertension (401.9) is not in the risk adjustment model; however it may be associated with other conditions resulting in combination codes that are in the model. The documentation must specifically and directly connect the conditions using terms such as "due to", "associated with", or hypertensive. The mere listing of the diseases in the same paragraph or diagnosis list does not assume the connection. For example "congestive heart failure *due to* hypertension" is coded 402.91 (hypertensive heart disease with CHF, HCC 80). Other examples include hypertensive renal disease with renal failure (403.91, HCC 131) and hypertensive heart and renal disease with heart failure and renal failure (404.93, HCC 131 & 80).

**Code-also combinations**
Some codes have suggestions of related codes that might further explain the exact nature of the condition. While these codes are not required to be present, in many cases a second code is appropriate and should be utilized.

**Example: 3**

Some diabetes codes carry "code also" instructions that impact directly on the CMS-HCC model.

- If a patient has diabetic retinopathy (250.50, HCC 18), the tabular section instructs you to code also the manifestation (if known). The ICD-9-CM offers several different manifestations, such as blindness (369.00-369.9, not in the CMS-HCC model) or proliferative diabetic retinopathy (363.02, HCC 119). Here, coding the correct manifestation is essential to correct HCC assignment.

- Diabetic ulcers are one of the conditions covered under diabetes with other specified manifestations (250.80, HCC 16). If ulcers are the specific manifestation, the guidelines say you should code also the site of the ulcer such as lower extremity (707.10, HCC 149). If the specific manifestation is diabetic bone changes (731.8), that code is not in the CMS-HCC model, but should be coded as instructed in the tabular section. Again, coding the correct specific manifestation ensures appropriate HCC assignment.

## 5.4.2 Unconfirmed Diagnoses (Slide 14)

Physicians and hospital outpatient departments shall not code diagnoses documented as "probable," "suspected," "questionable," "rule out," or "working." Rather, the condition(s) shall be coded to the highest degree of certainty known for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit. CMS recognizes that this is an area where the physician-reported diagnosis and hospital inpatient diagnosis for the same encounter may disagree, since hospital inpatient rules allow for coding suspected conditions as if they were confirmed.

It also is understood that the physician record is not a static document. Positive test results and notations regarding contact with the patient for a revised plan of treatment often are added to the record several days after the patient encounter. When these addenda are made, corrections or additions to the diagnoses reported to M+C organizations may be recommended, particularly if the HCC assignment is impacted.

**Example: 4**

A physician removes a mole during an office visit and sends the specimen for pathology. The diagnosis documented is "suspicious skin lesion" (709.9, not in model), "rule out melanoma." At this point, the diagnosis 709.9 may be submitted, but the diagnosis of melanoma may not. The pathology report is returned several days later and confirms malignant melanoma (172.9, HCC 10). The physician reviews the findings, initials the report and documents in the record the results and notification to the patient. Since the removal of the mole was done during the office visit, the new code (172.9, melanoma) should be submitted with that date of service.

### 5.4.3 Clinical Specificity in Documentation (Slide 15)

Clinical specificity involves having a diagnosis fully documented in the source medical record instead of routinely defaulting to a general term for the diagnosis. It is important to understand medical terminology in order to identify terms in the medical record that may be a more specific description of a general term. Communication with the physician is key to improving documentation skills that allow for more specific coding. The following examples are guidelines and specific conditions selected from various chapters of ICD-9-CM (Circulatory, Respiratory, Neoplasm, etc.) that are representative of documentation and coding decisions that impact HCCs.

The first three examples involve situations in which a physician may use the most common code for all forms of a disease and conditions. Remember, this practice has had no impact in the past on physician reimbursement. With the CMS-HCC model, physicians must be careful to code the correct forms and manifestations of diseases and conditions.

**Example: 5**

Anemia (285.9), is the most commonly coded form of anemia in physician offices. However, there are many types of anemia. Some are in the model and some are not. If the term "neutropenia" is used to describe the anemia, a more specific diagnosis code is 288.0 (agranulocytosis), which groups to HCC 45. It is important that physicians code these types of anemia accurately.

**Example: 6**

Pneumonia (486) unspecified is not in the model. If the organism responsible for the pneumonia (HCC 111-112) is known or if the physician documents that the patient aspirated prior to developing pneumonia (507.0 HCC 111), the more specific code should be reported.

**Example: 7**

**Mental disorders in the CMS-HCC model require particular attention to specific wording in documentation and coding**. Affective psychoses (296.XX, HCC 55) are mental diseases that include mood disturbances such as major depression (296.2X-296.3X). Physicians are encouraged to carefully document the characteristics of the mood disturbance (mania, depression, single episode, recurrent episode, circular) and use specific mental disorder terminology in the final diagnosis. The coder is cautioned to only code exactly the narrative provided by the physician in the final diagnosis and not make any further assumptions based on the patient work-up. For example, in coding depression, careful use of the ICD-9-CM index directs the coder to the correct type documented. If the physician does not document specific descriptor terms such as "major" or "recurrent", code 311 (depression, not otherwise specified, not in the model) is used.

## (Slide 16)

**Use of "history of."** In ICD-9-CM, "history of" means the patient no longer has the condition and the diagnosis often indexes to a V code not in the HCC model. A physician can make errors in one of two ways with respect to these codes. One error is to code as active a condition that is now a "history of" that condition. The opposite error is to code as "history of" a condition when that condition is still active. Both of these errors can impact risk adjustment.

**Example: 8**

The diagnosis statement "history of hip fracture" is not coded as a current hip fracture (820.8, HCC 158), but with a V code for orthopedic aftercare (V54.X) or history of injury (V15.5), if appropriate. Neither of these "history of" codes is in the CMS-HCC model. If a patient has a current acute condition, then the "history of" wording should not be used to describe the recent occurrence.

**Example: 9**

The physician may actually intend to communicate that a condition is ongoing, but code the "history of" a condition. An example of this is history of Hepatitis C (V12.09 personal history of other infectious disease). Hepatitis C generally presents as a chronic condition (070.54, HCC 27) that is rarely fully eradicated. While assigning V12.09 is not necessarily an example of incorrect coding, but it may indicate that the physician is not coding correctly. Again, communication and clear documentation are essential to make the appropriate determination.

**Correct use of associated terms**. Some conditions are described by more than one term depending on the clinical presentation and medical terminology practices of the physician. Coders must be careful not to diagnose a condition that is not specified by the physician and cannot be validated by the medical record.

**Example: 10**

Epilepsy (345.90, HCC 74) is one type of seizure disorder (780.39), and is not in the model. However, it is not the only cause of seizures, though the same medication may be used for both.

**Example: 11 (Slide 17)**

**Cancer coding requires detailed specificity**. Several different HCCs exist for cancer, and assigning the appropriate HCC depends upon closely following the cancer coding guidelines. The HCC varies depending on whether the cancer is a primary site or a secondary site. Coding guidelines state that if the malignant status is not specified, code to the primary site, except for the following sites: bone, brain, diaphragm, heart, liver, lymph nodes, mediastinum, meninges, peritoneum, pleura, retro peritoneum, and spinal cord. Applying this rule assures that the correct HCC for secondary malignant neoplasm is assigned rather than an HCC for primary malignant neoplasms. For example, bone cancer (primary) (170.9, HCC 9) vs. bone cancer (secondary) (198.5, HCC 7). Since the cancer is not specified as primary or secondary, and bone is one of the sites listed above, the correct HCC is 7.

Cancer codes are part of a multi-category HCC hierarchy. It is not unusual for a patient to have more than one type of cancer. However, only the most severe and costly form of cancer is recognized in the CMS-HCC model. Even if the type of cancer included in HCC 7 is of a different site/origin, any other cancer the patient has that is included in HCCs 8, 9, and 10 are dropped by the CMS-HCC model.

Complete Neoplasm guidelines are included in the Resource Guide.

### 5.4.4 Coding to the Highest Specificity-Fourth and Fifth Digits (Slide 18)

ICD-9-CM codes have three, four, or five digits. Diagnoses should be reported to the highest level of code available for that category. In selected cases, the fifth digit may impact whether the code is in the model, but at a different HCC level, which could impact reimbursement.

**Example: 12**

Myocardial infarction (MI) (heart attack, 410.XX) unspecified or subsequent episode fifth digits 0 and 2 are in HCC 82. All initial care for a new MI (from physician office to emergency room to hospital) should have the fifth digit of “1” and group to HCC 81.

**Example: 13**

Diabetes (250.XX) codes group into HCCs 15, 16, 17, 18, or 19 depending on the fourth digit applied. The fourth digit designates manifestations or complications of diabetes such as neurological conditions, eye disorders, or diabetic ulcers.

At a minimum, the submitted ICD-9-CM codes must be sufficiently specific to allow appropriate grouping of the diagnoses in the risk adjustment model. CMS encourages M+C organizations to use the full level of specificity in submitting data in order to provide the most accurate coding and grouping of codes in the model.

### 5.4.5 V Codes

Health status situations that should be described by V codes are very common in physician documentation. Those that impact risk adjustment include HIV status, transplant status, artificial opening status or maintenance, dialysis status or encounter, and amputation status. These V codes are used in several HCCs.

### 5.4.6 E Codes

The HCC model includes codes E950-E959 describing suicide or self inflicted injuries (HCC 55, Major Depressive Disorders). The injury or poisoning diagnosis codes that would be reported with these E codes are not included as relevant diagnoses. Therefore, it is important that the physician documents and codes the appropriate external cause of all self-inflicted injuries and poisonings so the M+C organization can report them as relevant diagnoses.

📖 The complete list of V codes and E codes in the model is provided in the Resource Guide.

## 5.5 Supporting Documentation Summary (Slides 19, 21)

Accurate coding begins with complete documentation. Characteristics of effective documentation include quality documentation as a team effort that may require some intervention by the M+C organization. Table 5B lists documentation considerations.

📖 The 2003 Physicians and Medicare+Choice Risk Adjustment CD provides examples and documentation tips. It is available through encounterdata@aspensys.com.

**TABLE 5B – DOCUMENTATION CONSIDERATIONS**

| **Documentation Guidelines** |
|---|
| • Reported diagnoses must be supported by medical record documentation.<br>• Medical records and codes are subject to validation by CMS.<br>• Characteristics of acceptable documentation include:<br>– Clear.<br>– Concise.<br>– Consistent.<br>– Complete.<br>– Legible. |
| **Physician Documentation and Communication Tips** |
| • Documenting and reporting co-existing diagnoses.<br>• Communicating issues regarding inadequate documentation.<br>• Adhering to proper methods for appending (late entries) or correcting inaccurate data entries.<br>– Lab/Radiology results.<br>– Strike through, initial, and date. Do not obliterate.<br>• Use only standard abbreviations.<br>• Identify patient and date on each page of the record. |

**TABLE 5B – DOCUMENTATION CONSIDERATIONS (CONTINUED)**

| SOAP Notes |
|---|
| • SOAP note format assists both the physician and record reviewer/coder in identifying key documentation elements. SOAP stands for:<br>– **S**ubjective: How the patients describe their problem or illness.<br>– **O**bjective: Data obtained by the exam, lab results, vital signs, etc.<br>– **A**ssessment: Listing of the patient's current condition and status of all chronic conditions. How the objective data relates to the patient's acute problem.<br>– **P**lan: Next steps in diagnosing problem further, prescriptions, consultation referrals, patient education, and recommended time to return for followup. |

## 5.6 Provider and Staff Training

Remaining current on medical record documentation and coding guidelines is important to ensuring accurate risk adjustment payment. Table 5C provides examples of sources available for medical record documentation and coding guidelines.

**TABLE 5C – DOCUMENATION AND CODING RESOURCES**

| TRAINING SOURCES | DESCRIPTION |
|---|---|
| **2003 Physicians and Medicare+Choice Risk Adjustment CD**<br>Available through encounterdata@aspensys.com. | The 2003 Physicians and Medicare+Choice Risk Adjustment CD provides the physician and physician office staff with risk adjustment information and useful resources. |
| **Official Coding Guidelines on CDC Website**<br>Available at www.cdc.gov/nchs/icd9.htm | The Official ICD-9 Coding Guidelines are available as an Adobe .pdf file, or as a CD-ROM. The CDC site has the .pdf file for download, as well as information about ordering the CD-ROM from the Government Printing Office. |
| ***Coding Clinic for ICD-9-CM***<br>Available through AHA. | Published quarterly by the AHA. It is the official publication for ICD-9-CM coding guidelines and advice as designated by the AHA, AHIMA, CMS, and the NCHS. |
| **American Health Information Management Association (AHIMA)**<br>www.ahima.org | AHIMA is a professional association for health information management professionals. Members make information accessible to healthcare providers and work in the healthcare industry and in the public sector by managing, analyzing, and using data that is critical to patient care. The AHIMA Catalog online offers tools for coders such as audio seminars, books, and continuing education courses. |
| **American Academy of Professional Coders (AAPC)**<br>www.aapc.com | AAPC provides education and certification for professional medical coders. Certifications focus on physician practice (CPC) and hospital outpatient facility (CPC-H) coding. Students learn Current Procedural Terminology (CPT) Codes, diagnosis codes (ICD-9-CM), and Healthcare Common Procedure Coding System (HCPCS) while focusing on HIPAA, OIG, and Medicare compliance. |

**TABLE 5C – DOCUMENATION AND CODING RESOURCES (CONTINUED)**

| | |
|---|---|
| **American Medical Association (AMA)**<br>www.ama-assn.org | AMA is an advocate of physician and patient rights. Coders may access the AMA Press Online Catalog to find current resources on medical record documentation and the medical record review process. |
| **American Hospital Association (AHA)**<br>www.aha.org | AHA is a national organization that serves and represents hospitals, healthcare networks, and their patients. The AHA Online Store offers coders online reference materials including ICD-9-CM, HCPCS, and testing and certification for the HIPAA. |
| **Local Colleges**<br>Check local community and 4-year colleges for courses. | Provide online courses in clinical coding and guidelines. |

# MODULE 6 – RISK ADJUSTMENT DATA VALIDATION

## Purpose

To describe the risk adjustment data validation process.

## Objectives (Slides 2-3)

- Identify the purpose and goals of risk adjustment data validation
- Identify the stages of risk adjustment data validation
- Learn about the components of a medical record request
- Describe the requirements for acceptable medical record documentation
- Identify risk adjustment data discrepancies
- Describe payment adjustments and appeals
- Provide communication messages

**ICON KEY**

Example 
Reminder 
Resource 
Information Systems Track 
Quality & Compliance Track 

## 6.1 What is Risk Adjustment Data Validation? (Slides 4-5)

Data validation occurs after risk adjustment data is collected and payment is made to the Medicare+Choice (M+C) organization. Data validation is currently conducted using medical record review but could also include other activities. For example, the Centers for Medicare & Medicaid Services (CMS) may consider monitoring risk adjustment data submission to better identify plans for data validation.

***Risk adjustment data validation is the process of verifying that diagnosis codes submitted by the M+C organization are supported by medical record documentation for an enrollee.***

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

### 6.1.1 Goals of Risk Adjustment Data Validation (Slides 6-7)

The primary goals of risk adjustment data validation are to:

- Implement an accurate M+C payment system
- Measure the accuracy of risk adjusted payments made to M+C organizations
- Improve the quality of risk adjustment data
- Improve the CMS-Hierarchical Condition Category (HCC) risk adjustment model
- Identify risk adjustment data discrepancies
- Communicate risk adjustment data validation findings to M+C organizations to improve accuracy
- Identify plans that need additional technical assistance to improve the quality of risk adjustment data

### 6.1.2 Risk Adjustment Data Validation Process (Slides 10-11)

Risk adjustment data validation occurs every year. Figure 6A illustrates the overall data validation process. This process involves the coordination of multiple entities such as CMS, M+C organizations, and CMS contractors. The data validation process begins with sampling M+C organizations and then beneficiary HCCs. It occurs after the risk adjustment data submission deadline for calendar year payment. The stages of the risk adjustment data validation process are briefly described below:

**STAGE 1** **Plan Selection/Medical Record Request:** CMS designs a sampling plan to select M+C organizations to participate in risk adjustment data validation. Once the M+C organizations are selected, individual beneficiary HCCs are selected based on the sampling frame. After the sample has been drawn, the CMS Initial Validation Contractor (IVC) requests medical records from the participating M+C organizations. All correspondence with M+C organizations related to Stage 1 is facilitated by the IVC.

**STAGE 2** **Medical Record Review:** After medical records are requested by the IVC, certified ICD-9 coders review the selected medical records and conduct data validation. During this stage, data discrepancies are identified. Data discrepancies happen when beneficiary medical record documentation does not match risk adjustment data. A data discrepancy that results in an HCC assignment change is known as a risk adjustment discrepancy. All identified risk adjustment discrepancies undergo a second, independent medical record review to confirm the discrepancy. The second medical record review is conducted by the Second Validation Contractor (SVC). This activity is transparent to M+C organizations. There is no correspondence between the SVC and plans during this stage.

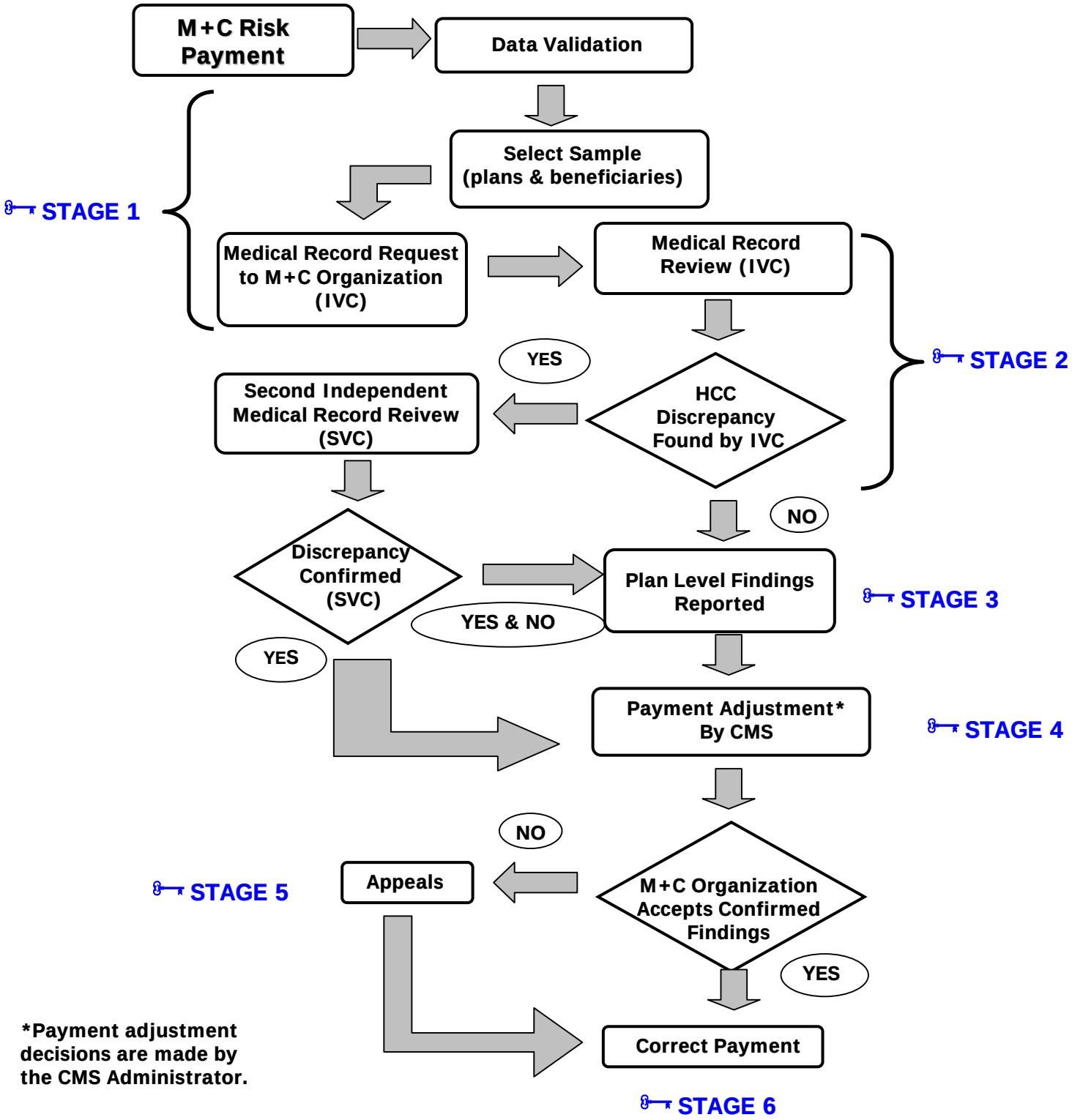
**STAGE 3** **Plan-Level Findings:** At this point in the data validation process, CMS communicates plan-level findings from Stage 2 to participating M+C organizations. Data discrepancies determined by medical record review are described. Additional feedback such as plan response rates and discrepancy rates are provided. Plan patterns and systemic problems may be identified and shared with M+C organizations. The need for additional technical assistance may be identified during this stage.

- **STAGE 4** **Payment Adjustment:** After Stage 3 is completed, CMS analyzes plan-level findings and makes recommendations to the CMS Administrator on payment adjustment. A payment adjustment is based on a confirmed risk adjustment discrepancy. If the CMS Administrator decides to make the adjustment, then the change in risk adjustment payment is made. Payment adjustments are reflected in the Monthly Membership Report (MMR).

- **STAGE 5** **Appeals:** After a payment adjustment is made, M+C organizations have the option of appealing the change. In the event that a plan chooses to appeal, then the M+C organization has 60 days from the date of the payment adjustment to respond. This process is fully described later in this module (Section 6.8).

- **STAGE 6** **Correct Payment:** Once Stage 5 is complete the risk adjusted payment is now correct.

**Figure 6A – Data Validation Process**




*Payment adjustment decisions are made by the CMS Administrator.

### 6.1.3 Guidelines for Data Validation (Slides 12-14)

The guidelines for risk adjustment data validation reflect the purpose and goals described above. From CY2000 through CY2003, data validation activities involved only hospital inpatient medical records. Beginning in CY2004, risk adjustment data validation will include hospital inpatient, hospital outpatient, and physician medical records. This change reflects the implementation of the CMS-HCC model that began with CY2004 payment. In an effort to make the data validation more flexible for M+C organizations, CMS developed the following Guiding Principle.

**Guiding Principle:** The medical record documentation must show that the HCC diagnosis was assigned within the correct data collection period by an appropriate provider type (hospital inpatient, hospital outpatient, and physician) as defined in the CMS instructions for risk adjustment implementation. In addition, the diagnosis must be coded according to *ICD-9-CM Guidelines for Coding and Reporting*. M+C organizations will be allowed more flexibility, per the guiding principle, in the submission of supporting medical record documentation when responding to a medical record request.

In addition to the Guiding Principle, the risk adjustment data validation guidelines include:

- The medical record documentation must support an assigned HCC.
- Beneficiary records are selected based on risk adjustment diagnosis clusters (provider type, HIC number, service date(s), and ICD-9 code) submitted to RAPS.
- Because of the flexibility of the Guiding Principle, plans must select **"one best medical record"** to support each HCC identified for validation. This means the plan decides whether to submit a hospital inpatient, hospital outpatient, or physician medical record if more than one choice is available.
- Because CMS does not collect provider identifiers for risk adjustment, M+C organizations must be able to track and locate supporting medical record documentation.
- Once an M+C organization selects their "one best medical record", a date of service must be identified to facilitate the medical record review process. This means that coders who review medical records will not search beyond the date of service identified for the review.
- Additional medical records may be submitted for data validation. An additional medical record is based on data that was not submitted to RAPS but complies with the Guiding Principle. See Section 6.2.2.2 for more detail.
- M+C organizations have the option of submitting an entire beneficiary medical record for the data collection year or parts of a medical record.
- All risk adjustment discrepancies (change in HCC) are sent for a second, independent medical record review.
- Payment adjustments are based on confirmed risk adjustment discrepancies.
- An appeals process is in place to address disagreement with a confirmed risk adjustment discrepancy.

## 6.2 Components of the Risk Adjustment Data Validation Process (Slide 15)

There are several components of the data validation process that are important to understand. These include the basis for sampling, the medical record request package, and receipt of medical records by the IVC.

### 6.2.1 Sampling STAGE 1 (Slides 16-17)

Data validation sampling is conducted on an annual basis. Sampling involves the selection of plans and beneficiary HCCs for data validation. The sample is drawn from risk adjustment data submitted for the payment year (data collection period January 1 through December 31). The data sampling approach includes both random and targeted components. Some plans may be selected randomly, while others may be targeted.

Under the CMS-HCC model, CMS expects to draw a national random sample for each payment year. The purpose of the national sample is to develop a net payment error for the payment year as well as a national risk adjustment discrepancy rate.

In addition to the national random sample, some targeted sampling will be employed. The targeting criteria may include:

- Patterns in the risk adjustment data that are suggestive of potential problems
- Past performance from previous data validation years
  - A plan may be targeted for data validation because the risk adjustment data for that plan showed a disproportionately high number of HCCs
  - A plan may be reselected for medical record review as a result of a high risk adjustment data discrepancy rate based on prior validation activities
- Specific HCCs may be targeted due to known ICD-9 coding problems or other issues related to a condition

The medical records reviewed for a beneficiary may reflect the entire HCC profile (all HCCs) or a subset of one or more HCCs.

### 6.2.2 Medical Record Request Package STAGE 1 (Slides 18)

During Stage 1 of the data validation process, CMS and the IVC provide a comprehensive package of information to M+C organizations to facilitate the request for medical records. This package will generally include: detailed instructions, the list of beneficiaries and HCCs selected, CMS letters addressed to providers for use when requesting records, a HIPAA factsheet, a sample request letter, and coversheets.

M+C organizations must have data systems in place to track and locate the requested medical records. As mentioned previously, CMS does not require or store provider identification numbers as part of risk adjustment data. Therefore, the M+C organization must be able to link a specific diagnosis back to a specific provider.

CMS will reimburse M+C organizations for each medical record submitted per beneficiary HCC—only one medical record per beneficiary HCC will be accepted. If one record supports more than one beneficiary

HCC, then the plan will receive reimbursement for one record. Reimbursement checks are sent by the IVC after data validation activities have been completed.

### 6.2.2.1 Beneficiary List STAGE 1

The beneficiary list is generated from the sample and is based on risk adjustment data submitted to CMS. The beneficiary list will be provided in an electronic spreadsheet format (with beneficiary name, HIC, diagnosis clusters, and HCC assignments) and is part of the medical record request package. In some cases, M+C organizations will need to review available medical records to identify the most appropriate documentation.

**Example 1**

For beneficiary Joe K. Smith, HCC 16, HCC 38, and HCC 80 will be validated. To validate HCC 16, the M+C organization may rely on one of the two diagnosis clusters (ICD-9 code, service date, and physician provider type) associated with HCC 16 as the source of data to select the "one best medical record" to support HCC 16. HCC 38 and HCC 80 are based on one entry each; therefore, there is only one source (provider type) of the medical record for each of these HCCs unless an "additional medical record" is selected (see Section 6.2.2.2 below).

**TABLE 6A – BENEFICIARY LIST**

| LAST NAME | FIRST NAME | MI | DOB | HIC | HCC | ICD-9 CODE | DATE OF SERVICE | PROVIDER TYPE | CASE ID* |
|---|---|---|---|---|---|---|---|---|---|
| Smith | Joe | K | 9/2/1925 | 183838279A | HCC 38 | 7101 | 1/15/2003 | Physician | H1234-101-HCC 19 |
| | | | | | HCC 80 | 40201 | 12/3/2003 | Outpatient | H1234-101-HCC 18 |
| | | | | | HCC 16 | 2506 | 4/15/2003 | Inpatient | H1234-101-HCC 16-1 |
| | | | | | HCC 16 | 2506 | 4/30/2003 | Physician | H1234-101-HCC 16-2 |
| Mumford | Anne | A | 3/15/1933 | 986023456A | HCC 2 | 0382 | 8/27/2003 | Inpatient | H2351-102-HCC 2 |
| | | | | | HCC 79 | 42741 | 5/13/2003 | Physician | H2351-102-HCC 79 |
| *Case IDs are provided for illustration purposes only. Case IDs will be specific to the data validation year. | | | | | | | | | |

### 6.2.2.2.1 Medical Record Coversheets STAGE 1 (Slide 19)

Under the CMS-HCC model, beneficiaries may have more than one HCC. This means that more than one medical record may be used for validating beneficiary HCCs. Complete medical record coversheets are essential to timely medical record review.

Once a sample of beneficiaries has been selected for a plan, a coversheet will be generated for every HCC being validated for each beneficiary. Attachment A is an example of a coversheet. Each coversheet will show every diagnosis cluster that was submitted to RAPS and generated the same HCC. The coversheet is where the concept of the "one best medical record" is applied. The M+C organization has the option of selecting the best medical record from the submitted RAPS data (diagnosis clusters) by indicating on the coversheet which diagnosis cluster matches the submitted medical record for the HCC being validated. In addition, M+C organizations have the option of selecting an additional medical record

that validates an HCC and is from the data collection year from an acceptable risk adjustment provider type (see below).

**Additional Medical Records (Slide 20)**

In addition to using a beneficiary's diagnosis clusters to choose the "one best medical record", M+C organizations may submit an "additional medical record". An "additional medical record" is related to a service where the data was not submitted to RAPS or there is no exact match for the ICD-9 code and date of service provided on the coversheet (diagnosis cluster). For instance, your plan may have chosen to submit CMS-HCC model diagnoses only once per beneficiary during the data collection period. Consequently, the "one best medical record" to validate a beneficiary HCC is not based on submitted RAPS data. In this case, you may submit an "additional medical record" as long as the service occurred during the data collection period and is from an acceptable risk adjustment provider type. The ICD-9 code and service date must be provided on the beneficiary HCC coversheet for the "additional medical record" to be acceptable for data validation. **Note:** If this data is not provided for an "additional medical record", then the record will not be reviewed.

## 6.2.3 Receipt of Medical Records by the IVC STAGE 1 (Slide 21)

Once medical records are selected, they must be sent to the IVC for data validation. Upon receipt, all medical records are logged into a chart-tracking database based on the barcode on each medical record coversheet. This method maintains the date the medical record was received. In order to protect patient confidentiality, all records are stored in a designated area accessible only to those having direct responsibility for risk adjustment data validation.

A review of the attached medical record coversheet at medical record intake will be undertaken. The initial medical record intake may include an "administrative check" to confirm beneficiary demographics including name, HIC number and service date within the data collection period. A "clinical check" may also take place at medical record intake. A clinical check may include determining appropriate risk adjustment provider type and may include phone calls or emails to participating M+C organization for purposes of clarification.

After intake, the medical record (with coversheet) will be assigned to a category. The possible categories include:

- Unit of analysis received and identified as "OK" for review
- Problem
  or
- Missing medical record

Throughout the data validation process, CMS and its contractors will make a reasonable effort to alert M+C organizations of medical record documentation issues that will allow plans the opportunity to correct problems.

## 6.3 Medical Record Documentation (Slides 22-27)

Proper medical record documentation is the key to successful data validation. The accurate assignment of ICD-9 diagnosis codes is based on medical record documentation. Therefore, risk adjusted payment accuracy also relies on medical record documentation. The CMS-HCC model includes many more diagnoses from additional settings. Data from physician settings will comprise a large portion of the diagnoses submitted. Depending on the beneficiaries selected for data validation, your M+C organization may select a hospital inpatient, hospital outpatient, or physician medical record to support the validation of a beneficiary HCC. Remember, a beneficiary HCC is assigned based on a diagnosis cluster that has been submitted to RAPS.

Below are some general guidelines for medical record documentation based on the source of the documentation.

### 6.3.1 General Guidelines for Hospital Inpatient Medical Record Documentation (Slide 29)

Hospital inpatient medical records are generally considered to be the most reliable source of diagnostic coding because hospitals employ certified professional coders.

**Coding**

According to the *ICD-9-CM Official Guidelines for Coding and Reporting,* for hospital inpatient stays code the principal diagnosis and:

> "...all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded."

The required medical record documentation should include, but is not limited to, the following:

- Face sheet
- History and physical exam
- Physician orders
- Progress notes
- Operative and pathology reports
- Consultation reports
- Diagnostic (radiology, cardiology, etc.) testing reports
- Discharge summary

### 6.3.2 General Guidelines for Hospital Outpatient and Physician Medical Record Documentation (Slides 30-32)

The overall guidelines for medical record documentation from hospital outpatient sites and physician offices are:

- A coder can determine from the documentation that an evaluation of the patient was performed by a physician or an acceptable physician extender (e.g., physician assistant, nurse practitioner);
- an ICD-9 code can be assigned based on the evaluation and clinical findings/treatment; and
- physician signature and date entries are present.

## Coding

Per the *ICD-9-CM Official Guidelines for Coding and Reporting*:

> "Code all documented conditions that coexist at time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (V10-V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment."

Per Section IV Diagnostic Coding and Reporting Guidelines for Outpatient Services, Part C of the *ICD-9-CM Official Guidelines for Coding and Reporting* (October 1, 2003):

> "For accurate reporting of ICD-9-CM diagnosis codes, the documentation should describe the patient's condition, using terminology which includes specific diagnoses as well as symptoms, problems, or reasons for the encounter. There are ICD-9-CM codes to describe all of these."

Remember, "probable", "suspected", "questionable", "rule out", or "working" diagnoses cannot be reported to CMS as valid diagnoses by a physician.

Hospital outpatient and physician office medical records should include, but are not limited to the following:

- Face sheet
- History and physical exam
- Physician orders
- Progress notes
- Diagnostic reports (for support documentation)
- Consultation reports

**Note:** Submit all relevant medical record components needed to validate the beneficiary, the HCC, ICD-9 code and date of service selected. All diagnostic documentation should be signed and dated by the physician and have the beneficiary's name. Only services occurring during the date of service will be reviewed.

In some cases, additional guidance is needed when relying on certain types of hospital outpatient and physician office medical record documentation (see below).

**Guidance for Problem Lists (Slide 33)**

Although the term "problem list" is commonly used with regard to ambulatory medical record documentation, a universal definition does not exist. The problem list is generally used by a coder to gain an overall clinical picture of a patient's condition(s). Problem lists are usually supported by other medical record documentation such as SOAP notes (subjective, objective, assessment, plan), progress notes, consultation notes, and diagnostic reports.

For CMS' risk adjustment data validation purposes, an acceptable problem list must be comprehensive and show evaluation and treatment for each condition that relates to an ICD-9 code on the date of service, and is signed and dated by the physician or physician extender.

**Guidance for Radiology Reports (Slides 34-35)**

Medical record documentation from radiologists present an interesting challenge for data validation. The radiologist generally provides two types of radiology services—diagnostic (e.g., chest x-ray) and therapeutic (e.g., radiation therapy). Based on experience with radiology documentation from an ambulatory setting we have found:

1. In the case of diagnostic radiology services M+C organizations are relying on the referral diagnosis for the radiology service as the actual diagnosis code. ***This code cannot be sent in as risk adjustment data because it has not been confirmed.***
2. While most diagnostic radiology reports do indicate findings or an impression, ***these reports do not indicate a diagnosis***. The radiologist typically sends a report to the referring physician who then reviews the findings and documents a diagnosis based on those findings.
3. Therapeutic radiology services are delivered after a confirmed diagnosis is assigned, thus a report for this type of service would normally reflect a confirmed diagnosis.

Given these findings, CMS suggests the following guidelines:

1. Do not send diagnostic radiology medical records for validation if other medical record documentation is available.
2. If a diagnostic radiology medical record is the only documentation of a diagnosis, then the M+C organization should review the medical record to ensure that the documentation is sufficient to support an HCC diagnosis.
3. If an insufficiently documented radiologist medical record is submitted, then the HCC diagnosis will be discrepant.

**For Payment Year 2006 (dates of service: January 1 through December 31, 2005), CMS expects to re-estimate the CMS-HCC model. At that time, we expect to eliminate the radiology specialty as an acceptable risk adjustment physician provider. Until that time, please consider the above guidance with regard to radiology reports.**

**Guidance for Nursing Home Resident Medical Records (Slide 36)**

Although CMS does not accept risk adjustment data from nursing home facilities, some beneficiaries that reside in a nursing home will have a nursing home medical record as the only source to support their diagnostic data. Since independently billing physicians (not employed by the nursing home) visit patients in nursing homes, the medical record documentation for a beneficiary HCC may come from a nursing home **only if the beneficiary is identified in the MDS (Minimum Data Set) as a long term institutional resident and the physician visit is face-to-face.**

### 6.3.3 Unacceptable Medical Record Documentation (Slides 37-38)

There are several sources of medical records and types of documentation that are **not acceptable** for risk adjustment data validation. These include:

**Unacceptable Sources of Medical Records**

- Skilled Nursing Facility (SNF)
- Freestanding Ambulatory Surgical Center (ASC)
- Alternative Data Sources (e.g. pharmacy)
- Unacceptable Physician Extenders (e.g., nutritionist)

**Unacceptable Types of Medical Record Documentation**

- Superbill
- Physician Signed Attestation
- A list of patient conditions
- A diagnostic report that has not been interpreted
- Any documentation for dates of service outside the data collection period

### 6.3.4 Selecting Medical Records for Data Validation STAGE 1 (Slide 39)

To avoid delays and identification of data discrepancies, remember the following points:

- Select the "one best medical record" that supports each HCC that is identified for data validation. If an HCC is associated with more than one provider type (hospital inpatient, hospital outpatient, physician), then the M+C organization has the option of selecting the best medical record for validation.

- Due to variation in physician office medical record documentation, CMS suggests that the M+C organization first select an institutional medical record (hospital inpatient, hospital outpatient) when the choice of documentation is between an institutional record and a physician record.

**Medical Record Documentation Resources**

- ICD-9-CM Official Guidelines for Coding and Reporting, October 1, 2003 (Section IV is specific to ambulatory coding), http://www.cdc.gov/nchs/data/icd9/icdguide.pdf
- ICD-9 Coding Clinic Guidelines
- CMS 2003 Physicians and Medicare+Choice Risk Adjustment CD
- American Health Information Management Association, http://www.ahima.org/
- American Medical Association, http://www.ama-assn.org/
- Bates Guide to the Physical Examination and History Taking, 7th Edition, Chapter 21 (The Patient's Record)
- *Fundamentals of Clinical Practice*, Mengel, Holleman, and Fields (Eds.), Kluwer Academic/Plenum Publishers, Chapter 12 (Record Keeping and Presentation)

## 6.4 Medical Record Reviews STAGE 2 (Slides 41-42)

The medical record review process involves review of submitted medical record documentation by a certified coder. The reviewer validates the date of service and the diagnosis code identified by the M+C organization on the medical record coversheet. Medical record review includes abstracting a diagnosis code when it is based on the accompanying medical record documentation.

During medical record review the following items will be checked/captured:

- Diagnosis code supported by medical record documentation per ICD-9 Coding Guidelines
- Check for a provider signature for each note
- Check coversheet diagnosis against the medical record diagnosis
- Indicate yes/no for date of service within data collection period
- Coder notes on diagnosis code assignment

## 6.5 Data Discrepancies and CMS-HCC Risk Adjustment Discrepancies STAGE 2

During medical record review, medical record data discrepancies may be identified. Data discrepancies occur when the diagnostic data selected for risk adjustment data validation is not supported by medical record documentation. There are several types of data discrepancies.

### 6.5.1 Data Discrepancies STAGE 2 (Slides 43-46)

In order to give a general understanding of the types of data discrepancies that may be identified, the following descriptions are provided:

- Coding Discrepancies
  - The medical record documentation substantiates a different ICD-9 code at the 3 digit level than the ICD-9 code identified by the M+C organization for medical record review.
  - The medical record documentation substantiates a different ICD-9 code at the 4$^{th}$ and 5$^{th}$ digit level than the ICD-9 code identified by the M+C organization for medical record review.
  - The medical record documentation submitted for review is insufficient to justify the assignment of an ICD-9 code per ICD-9 Coding Clinic Guidelines.
- Invalid
  - The medical record documentation submitted for review is from an unacceptable provider type for risk adjustment (e.g., SNF).
  - The medical record documentation submitted for review is missing components of the medical record required to code in accordance with ICD-9 Coding Clinic Guidelines.
  - The date of service (visit date) for the medical record documentation submitted does not fall within the risk adjustment data collection period.
- Missing
  - An ICD-9 diagnosis code cannot be assigned for the date of service.
  - No medical record documentation was received for a beneficiary HCC selected for data validation.

### Example 2

**Example of a Coding Discrepancy**

The reported diagnosis was 428.0 for congestive heart failure (HCC 80). Upon review of medical record documentation the code 402.91 (HCC 80) Hypertensive Heart Disease should have been coded.

### Example 3

**Example of a Coding Discrepancy**

The risk adjustment data indicated a code of 250 (diabetes mellitus or HCC 19). After medical record review, the correct code assigned was 250.02 (diabetes mellitus without complications uncontrolled, HCC 19). This is a level of specificity coding discrepancy.

## 6.5.2 Risk Adjustment Discrepancies STAGE 2 (Slides 47-49)

A risk adjustment discrepancy is identified when an HCC originally assigned to an enrollee based on submitted risk adjustment data is different from the HCC assigned after data validation. A risk adjustment discrepancy may affect the final risk score for a beneficiary. An example of a risk adjustment data discrepancy is provided below:

### Example 4

**Example of a Risk Adjustment Discrepancy**

| | |
|---|---|
| Reported Diagnostic Data: | 482.4 Staphylococcal Pneumonia (HCC 111) |
| Data Validation Findings: | 482.3 Streptococcal Pneumonia (HCC 112) |

The medical record documentation supports the code 482.3 streptococcal pneumonia, not 482.4 staphylococcal pneumonia. The factor associated with HCC 111 is .693. The factor associated with HCC 112 (the final HCC) is .202. If confirmed, this finding results in a risk adjustment discrepancy because the beneficiary HCC changes.

A risk adjustment discrepancy will go to the SVC for a second medical record review and confirmation. Risk adjustment discrepancies confirmed by the SVC will provide the basis for a payment adjustment. See Section 6.7 Payment Adjustment and Section 6.8 Appeals.

## 6.6 Risk Adjustment Data Validation Findings STAGE 3 (Slide 50)

The purpose of risk adjustment data validation is to improve risk adjusted payment integrity and accuracy. This is accomplished by identifying problems and sharing findings. CMS will continue to provide M+C organization specific (H number level) and summary findings from the data validation process to participating M+C organizations. M+C organization specific findings may include a response rate, data discrepancy rates and risk adjustment discrepancy rates. Additionally, summarized information such as

risk adjustment data discrepancy rates at the national level and problematic diagnosis codes will be shared with the M+C industry. CMS will make every effort to provide timely feedback.

## 6.7 Payment Adjustment STAGE 4 (Slides 51-53)

Again, the purpose of risk adjustment data validation is to ensure risk adjusted payment integrity and accuracy. Once a risk adjustment data discrepancy that affects payment has been identified and confirmed by the SVC, CMS makes a correction when the CMS Administrator determines that a payment adjustment should be made. A payment adjustment may increase or decrease risk adjusted payment.

CMS' general approach to making payment adjustments is to first develop the criteria that will identify an M+C organization for payment adjustment. For example, the criteria could include the following:

- Payment adjustment based on a "consistent pattern" of inaccurate data for previous and current payment years being validated. Consistent patterns may include:
  - Significantly high risk adjustment discrepancy rate—at least two standard deviations above the national average discrepancy rate.
  - Significantly high payment error rate—at least two standard deviations above the national average payment error rate.
  - Plans with two consecutive years of inaccurate risk adjustment data based on validation findings.

## 6.8 Appeals STAGE 5 (Slides 54-57)

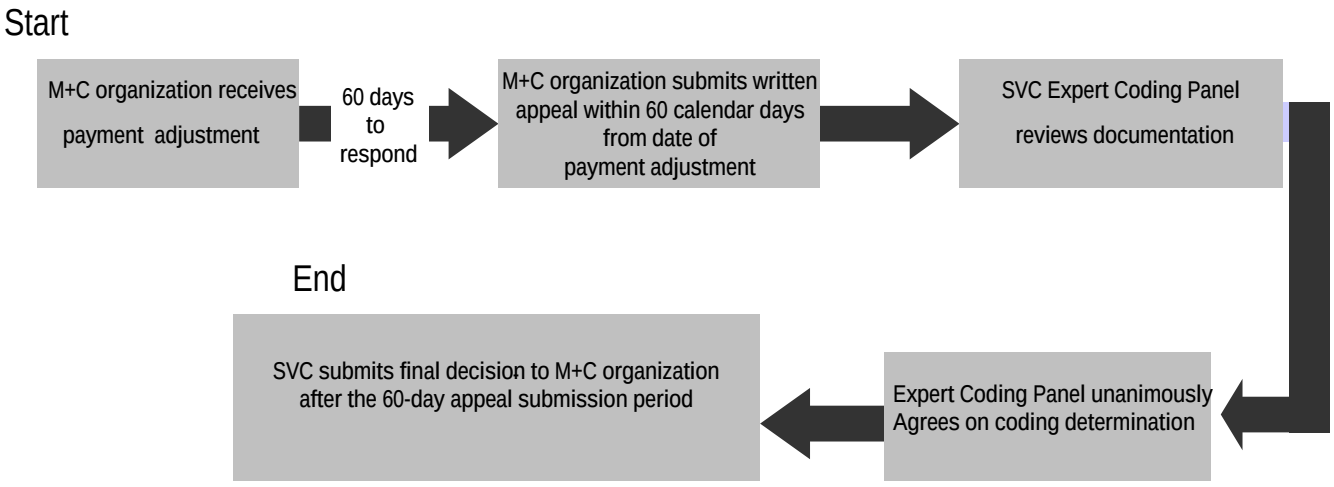
An appeals process is in place if an M+C organization disputes a payment adjustment. Consistent with Medicare fee-for-service, an M+C organization will have one opportunity to challenge a payment adjustment. The M+C organization has 60 days to file an appeal once a payment adjustment has been made and appears on the Monthly Membership Report (MMR). The appeals process is conducted by the SVC.

Each appeal must include, at a minimum, a clearly documented reason for disagreement with the medical record review finding and, in some cases, additional medical record documentation to support the reason for appeal.

An expert coding panel will review every appeal. The panel is typically comprised of a senior medical reviewer, a senior coder, and a physician. The physician will assess whether any clinical factors might change the outcome of the appeals determination.

Figure 6B illustrates the timing of the appeals process.

**Figure 6B – Appeals Process Timeline**




## 6.9 Correct Payment STAGE 6 (Slide 58)

The conclusion of the appeals process establishes the correct risk adjusted payment for an M+C organization that disagrees with a payment adjustment. Based on the outcome of an appeal, the payment adjustment may stand or is reversed.

## 6.10 Lessons Learned from the CMS-HCC Pilot Test (Physician Medical Records) (Slides 59-60)

In early 2004, CMS conducted a CMS-HCC model risk adjustment data validation pilot test to review only physician medical records. Nine M+C organizations participated in the pilot and approximately 194 medical records were reviewed. Below are some lessons learned about the medical record request and submission process:

- Notify each physician prior to sending the actual medical record request.
- Identify a contact person at the physician's office.
- Follow-up with the physician's office after the medical record(s) request is sent.
- Sending a medical record request to a "physician group practice" may not be effective, rather it should be sent to the individual physician, if known.
- Involve in-house quality assurance staff/medical record reviewers/medical director to help with the identification of the "one best medical record".
- On average, it took approximately 2 weeks for the M+C organization to receive a physician medical record.
- Medical records from specialists and non-contracted providers may be more difficult to obtain.
- Some plans had to pay a medical record fee to a physician prior to receipt of a medical record.

Please note that as of the printing of this module, pilot test medical record reviews are still in process. Additional information from the pilot test will be shared with all M+C organizations when the pilot test is completed.

## 6.11 M+C Organization Considerations for Risk Adjustment Data Validation (Slides 61-62)

CMS suggests the following items for an M+C organization to consider if selected for risk adjustment data validation:

- The medical record request process your plan employed for previous risk adjustment data validation activities (hospital inpatient records only) may not be sufficient for ambulatory medical record data validation.
- To select the "one best medical record", plans could review medical records prior to submission for data validation.
- M+C organizations may decide to have the physician supplying the medical record indicate the date of service and diagnosis code that is supported by their medical record.
- Tracking the status of medical record requests is critical to the process.
- Consider that organization staff involved in the medical record request process may need to be educated about risk adjustment and the CMS-HCC data validation process.
- Include staff involved in the medical record request process in all conference calls with CMS and the IVC.

## 6.12 Communication Messages (Slides 63-64)

Communicating important information to colleagues and providers is essential for successful risk adjustment data validation. CMS suggest the following communication messages to facilitate the data validation process:

- Every M+C organization (at the H number level) has a chance of being selected for risk adjustment data validation.
- Good medical record documentation equals accurate ICD-9 coding; accurate ICD-9 coding equals accurate risk adjusted payment.
- Ensure that all your M+C organization staff involved in the request for medical records are informed about and understand the risk adjustment data validation process.
- The specific date of service and ICD-9 code selected to support an HCC must be identified by the M+C organization on the coversheet.
- Ensure that diagnosis codes can be tracked back to providers
- Notify physicians at the earliest possible time that a medical record will be requested.
- Use newsletters and CMS risk adjustment training tools to inform physicians about risk adjustment and the importance of good medical record documentation for ICD-9 coding.

## 6.13 Technical Assistance (Slide 65)

In order to improve the quality of risk adjustment data, CMS has technical assistance contractors available for any M+C organization that needs help with data completeness, data accuracy, and areas of concern identified by medical record review. Contact the CMS staff member identified below for the appropriate data validation payment year.

## 6.14 CMS Risk Adjustment Data Validation Contacts

CMS staff and contractors responsible for risk adjustment data validation activities by payment year are identified in Table 6B.

**TABLE 6B – CMS STAFF AND CONTRACTORS**

| PAYMENT YEAR / CONTRACT TYPE | CMS CONTACT | CMS CONTRACTOR |
|---|---|---|
| ***CY2003 IVC*** | Jennifer Harlow (jharlow@cms.hhs.gov) | BearingPoint |
| ***CY2003 SVC & Appeals*** | Lateefah Hughes (lhughes@cms.hhs.gov) | AdvanceMed |
| ***CY2004 IVC*** | Bobbie Knickman (bknickman@cms.hhs.gov) | BearingPoint |
| ***CY2004 SVC & Appeals*** | Lateefah Hughes (lhughes@cms.hhs.gov) | Aspen Systems |
| ***CY2005 IVC*** | Lateefah Hughes (lhughes@cms.hhs.gov) | TBA |
| ***CY2005 SVC & Appeals*** | Bobbie Knickman (bknickman@cms.hhs.govT) | TBA |

# MODULE 7 – EDITS

## Purpose (Slide 2, 2)

The risk adjustment process includes an editing stage to ensure the accuracy of the data prior to storing the data for risk adjustment calculation. When Medicare+Choice (M+C) organizations understand common errors and steps to prevent such errors, the efficiency of the risk adjustment process is increased. The module introduces participants to the Front-End Risk Adjustment System (FERAS) and the Centers for Medicare & Medicaid Services (CMS) Risk Adjustment Processing System (RAPS) data logic and editing processes. It provides information to assist M+C organizations in minimizing data errors and taking appropriate steps in correcting errors that occur.

## Learning Objectives (Slide 3, 3)

At the completion of this module, participants will be able to:

- Understand the FERAS and the 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.

**ICON KEY**

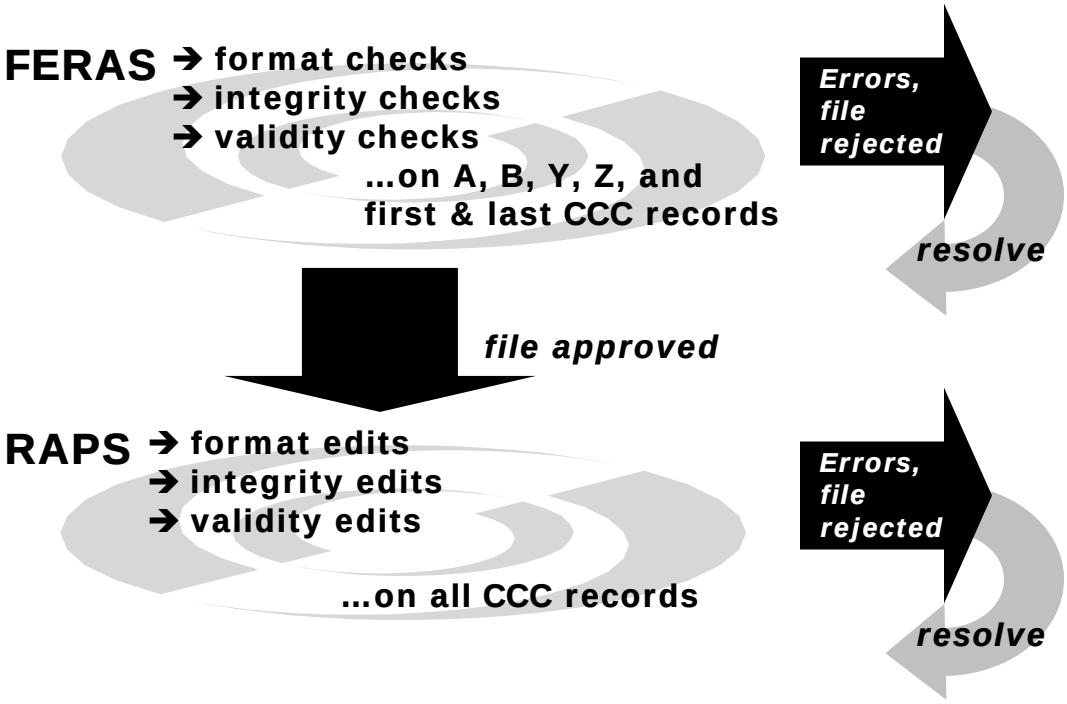
| | |
|---|---|
| Example | |
| Reminder | |
| Resource | |
| Information Systems Track | |
| Quality & Compliance Track | |

## 7.1 Data Flow (Slide 4, 4)

After M+C organizations submit data to Palmetto, FERAS performs format and integrity checks on the file and batch levels, as well as on the first and last detail (CCC) record. After the data pass the checks, they are sent to RAPS for complete editing of all detail records before they are stored in the RAPS database.

Files submitted in Test and Production are processed through FERAS and RAPS, and all edits are performed. Test files, however, are not stored in the RAPS database. The flow of edits is illustrated in Figure 7A.

**Figure 7A – Data Flow**




All data submitted via Universal Billing form – version 1992 (UB-92), National Standard Format (NSF), and American National Standards Institute (ANSI) formats are translated by Palmetto to the RAPS format prior to applying any FERAS checks or RAPS edits.

### 7.1.1 FERAS System (Slide 5, 5)

M+C organizations submit data to FERAS, which performs the format and integrity checks.

- FERAS performs format and integrity checks on file- and batch-level data.
- FERAS checks the first and last detail records in each batch.
- FERAS accepts or rejects the entire file.
- FERAS ensures that all accepted transactions contain the following correct data:
  - AAA and ZZZ record.
  - At least one BBB record for each YYY record.
  - Following each BBB record, at least one CCC record with at least one diagnosis cluster populated.
  - Valid submitter ID and plan numbers.
  - Valid record and file totals.
  - The first and last CCC record will be edited to ensure that the submitted data are in the correct location on the record (i.e., spaces are where they should be located).
  - Record Type CCC must be present in the first field.
  - The first sequence number must equal 0000001.
  - The last sequence number must equal the total CCC record count in the YYY record.

- The "HIC (Health Insurance Claim) Error Code" and "Diagnosis Code – Filler" fields contain spaces. Do not fill fields with zeros.

If all checks pass, the transaction processing continues in RAPS. If any of the data fail, the complete file is rejected.

**Example: 1**

**Scenario**: The M+C organization submitted a file and entered "AA1" in record type AAA, field 1.

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

Generally, FERAS errors occur primarily during the initial establishment of the system and risk adjustment process in M+C organizations. After data are processed, automated formats are programmed, and FERAS errors occur less frequently.

### 7.1.2 FERAS Error Code Logic (Slide 7, 7)

When a FERAS check fails, an associated error code is created. Table 7A describes the error code logic. If any errors occur in FERAS, the complete file is rejected and returned to the submitter after all checks are completed.

**TABLE 7A – FERAS ERROR CODE 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 100 and 200 series error codes are assigned based on the level of checks that are performed, as well as the location of the edit.
- The entire file is returned to the submitter.

### 7.1.3 FERAS Error Code Ranges (Slide 8)

Error code ranges are explained in Table 7B.

**TABLE 7B - ERROR CODE RANGES**

| SERIES | EXPLANATION |
|---|---|
| **100** | A 100-error code indicates that the system could not determine the record type; all editing stopped at that point. |
| **101-109** | Indicates a failure of a face-validity edit on the AAA record (file-level header). The last digit indicates the specific field in which the error was found. For example, the 101-error code refers to an error found in field 1 on the AAA record. |
| **111-149** | Indicates a failure of a cross-reference edit between a field on the AAA (file-level header) record and a look-up table, a field on another record, or a value calculated from another record. The last digit will indicate the specific AAA field against which the cross-check was performed. For example, the 112-error code indicates that the submitter ID in field 2 did not appear on a look-up table of valid submitter IDs. |
| **151-159** | Indicates a failure of a face-validity edit on the ZZZ record (file-level trailer). The last digit indicates the specific field in which the error was found. For example, the 151-error code refers to an error found in field 1 on the ZZZ record. |
| **161-189** | Indicates a failure of a cross-reference edit between a field on the ZZZ (file-level trailer) record and a look-up table, a field on another record, or a value calculated from another record. The last digit will indicate the specific ZZZ field against which the cross-check was performed. For example, the 162-error code indicates that the submitter ID, field 2 in ZZZ record, does not match the submitter ID on the AAA record. |
| **201-209** | Indicates a failure of a face-validity edit on the BBB (batch-level header) record. The last digit indicates the specific field in which the error was found. For example, the 201-error code refers to an error found in field 1 on the BBB record. |
| **211-249** | Indicates a failure of a cross-reference edit between a field on the BBB (batch-level header) record and a look-up table, a field on another record, or a value calculated from another record. The last digit will indicate the specific BBB field against which the cross-check was performed. For example, the 162-error code indicates that the submitter ID, field 2 in ZZZ record, does not match the submitter ID on the AAA record. |
| **251-259** | Indicates a failure of a face-validity edit on the YYY (batch-level trailer) record. The last digit indicates the specific field in which the error was found. For example, the 251-error code refers to an error found in field 1 in the YYY record. |
| **261- 299** | Indicates a failure of a cross-reference edit between a field on the YYY (batch-level header) record and a look-up table, a field on another record, or a value calculated from another record. The last digit will indicate the specific YYY field against which the cross-check was performed. For example, the 262-error code indicates that the sequence number in the YYY record field 2 does not match the sequence number in field 2. |
| **301-489** | Indicates a format problem with the first or last CCC record. The problem is either with the face validity of the data in specific fields or the presence of data in fields that are required to be blank. In either circumstance, the basic CCC record format is assumed to be in error and the entire file is rejected |

**NOTE**: FERAS checks the validity and format of an individual field before performing checks between fields. For example, the system first checks that there is a valid submitter ID on the AAA record before it checks that the submitter ID reported in the YYY record is identical. FERAS file-level, batch-level, and detail-level error codes are described in Table 7C.

**TABLE 7C – FERAS ERROR CODES**

**FILE-LEVEL ERROR CODES**

| ERROR CODE | RECORD ID | ERROR DESCRIPTION |
|---|---|---|
| 100 | AAA | INVALID RECORD TYPE |
| 101 | AAA | AAA RECORD MISSING FROM TRANSACTION |
| 102 | AAA | MISSING / INVALID SUBMITTER-ID ON AAA RECORD |
| 103 | AAA | MISSING FILE-ID ON AAA RECORD |
| 104 | AAA | MISSING / INVALID TRANSACTION DATE ON AAA RECORD |
| 105 | AAA | MISSING / INVALID PROD-TEST-INDICATOR ON AAA RECORD |
| 112 | AAA | SUBMITTER ID NOT ON FILE |
| 113 | AAA | FILE NAME DUPLICATES ANOTHER FILE ACCEPTED WITHIN LAST 12 MONTHS |
| 114 | AAA | TRANSACTION DATE IS GREATER THAN CURRENT DATE |
| 151 | ZZZ | ZZZ RECORD MISSING FROM TRANSACTION |
| 152 | ZZZ | MISSING / INVALID SUBMITTER-ID ON ZZZ RECORD |
| 153 | ZZZ | MISSING / INVALID FILE-ID ON ZZZ RECORD |
| 154 | ZZZ | MISSING / INVALID BBB-RECORD-TOTAL |
| 162 | ZZZ | ZZZ SUBMITTER-ID DOES NOT MATCH SUBMITTER-ID ON AAA RECORD |
| 163 | ZZZ | FILE ID DOES NOT MATCH FILE ID ON AAA RECORD |
| 164 | ZZZ | ZZZ VALUE IS NOT EQUAL TO THE NUMBER OF BBB RECORDS |

**BATCH-LEVEL ERROR CODES**

| ERROR CODE | RECORD ID | ERROR DESCRIPTION |
|---|---|---|
| 201 | BBB | BBB RECORD MISSING FROM TRANSACTION |
| 202 | BBB | MISSING / INVALID SEQUENCE NUMBER ON BBB RECORD |
| 203 | BBB | MISSING / INVALID PLAN NUMBER ON BBB RECORD |
| 212 | BBB | SEQUENCE NUMBER ON BBB RECORD IS OUT OF SEQUENCE |
| 213 | BBB | SUBMITTER ID NOT AUTHORIZED TO SUBMIT FOR THIS PLAN ID |
| 251 | YYY | YYY RECORD MISSING FROM TRANSACTION |
| 252 | YYY | MISSING / INVALID SEQUENCE NUMBER ON YYY RECORD |
| 253 | YYY | MISSING / INVALID PLAN NUMBER ON YYY RECORD |
| 254 | YYY | MISSING / INVALID CCC-RECORD-TOTAL |
| 262 | YYY | LAST YYY SEQUENCE NUMBER IS NOT EQUAL TO NUMBER OF YYY RECORDS |
| 263 | YYY | PLAN NUMBER DOES NOT MATCH PLAN NUMBER IN BBB RECORD |
| 264 | YYY | YYY VALUE IS NOT EQUAL TO THE NUMBER OF CCC RECORDS |
| 272 | YYY | SEQUENCE NUMBER ON YYY RECORD IS OUT OF SEQUENCE |

**TABLE 7C – FERAS ERROR CODES (CONTINUED)**

**DETAIL-LEVEL ERROR CODES**

| ERROR CODE | RECORD ID | ERROR DESCRIPTION |
|---|---|---|
| 301 | CCC | CCC RECORD MISSING FROM TRANSACTION |
| 302 | CCC | MISSING / INVALID SEQ-NO ON CCC RECORD |
| 303 | CCC | SEQUENCE-ERROR-CODE FILLER NOT EQUAL TO SPACES |
| 304 | CCC | HIC-ERROR-CODE FILLER NOT EQUAL TO SPACES |
| 305 | CCC | DOB-ERROR-CODE FILLER NOT EQUAL TO SPACES |
| 306 | CCC | DIAGNOSIS CODE-FILLER NOT EQUAL TO SPACES |
| 307 | CCC | DIAGNOSIS-CLUSTER-ERROR-1 NOT EQUAL TO SPACES |
| 308 | CCC | DIAGNOSIS-CLUSTER-ERROR-2 NOT EQUAL TO SPACES |
| 310 | CCC | MISSING / INVALID HIC-NO ON CCC RECORD |
| 311 | CCC | AT LEAST ONE DIAGNOSIS CLUSTER REQUIRED ON TRANSACTION |
| 313 | CCC | DELETE-INDICATOR MUST BE BLANK OR EQUAL TO “D” |
| 314 | CCC | INVALID DIAGNOSIS CODE FORMAT ON CCC RECORD |
| 315 | CCC | CORRECTED HIC NOT EQUAL TO SPACES |
| 350 | CCC | INVALID PATIENT-DOB ON CCC RECORD |
| 400 | CCC | MISSING / INVALID PROVIDER-TYPE ON CCC RECORD |
| 401 | CCC | INVALID FROM-DATE ON CCC RECORD |
| 402 | CCC | INVALID THRU-DATE ON CCC RECORD |

**Example: 2**

**Scenario**: The M+C organization submitted a file with a 2.0 in the “Diagnosis Code – Filler” field on the first CCC record.

**Results:** FERAS would reject the complete file due to data being placed in the “Diagnosis Code – Filler” field of the diagnosis cluster. FERAS would identify this error, since it occurred in the first CCC record.

FERAS errors rarely occur after M+C organizations program file layouts and adequately test the formats before submission to CMS.

### 7.1.4 RAPS Edits (Slide 10, 8)

After data passes the FERAS checks, the file is sent via Network Data Mover (NDM) to the CMS data center for RAPS processing.

- As a precautionary measure, RAPS performs balancing checks to ensure that the complete file was received from Palmetto prior to editing data.
- The RAPS system performs editing primarily on the CCC transactions.

- The data elements edited include HIC number, provider type, diagnosis code, from date, and through date.
- If date of birth is submitted, RAPS performs an edit on that field.

### 7.1.5 RAPS Editing Rules (Slide 11, 9)

The RAPS editing process takes place in four logical stages.

#### Stage 1- Field Validity and Integrity

RAPS performs format and integrity checks on all CCC-level fields as a first level of editing. If there are data in the "HIC Error Code" or "Diagnosis Code - Filler" fields, the entire detail record rejects with no further editing performed. If a record fails this stage of editing, it is assumed that the data are corrupt.

The dates also are checked at this stage. If the dates within a diagnosis cluster are not valid dates, then RAPS stops the editing process for that diagnosis cluster because all other data edits within a diagnosis cluster depend upon the validity of the dates.

#### Stage 2 - Field-to-Field Editing

After RAPS checks format and integrity of the fields, the field-to-field editing takes place.

- RAPS ensures that the from date is equal or prior to the through date.
- RAPS also checks all diagnosis clusters for hospital outpatient and physician provider types to ensure compliance with the 31-day span rule.
- RAPS checks all data to ensure that M+C organizations submit the reconciliation data properly. See Submission Timetable in Module 2 (Risk Adjustment Process Overview) for dates of service included in each data submission period.

#### Stage 3 - Medicare Beneficiary Database Edits

The next stage of editing cross-checks the appropriate fields against the Medicare Beneficiary Database (MBD). In this process the HIC number, date of birth, and Medicare entitlement are checked. For example, in Stage 1 editing, the system ensured that a valid HIC number was present in field 5 of the CCC record. In Stage 3 editing, the system ensures that the HIC number exists on the MBD.

#### Stage 4 – Diagnosis Code Editing

After RAPS edits the integrity of the individual fields and validates the HIC number and eligibility, it edits the diagnosis code against the Diagnosis Lookup Table in RAPS. In this stage, the system first ensures each diagnosis code is valid. Then the system checks each diagnosis code against service dates and gender. If any of these edits fail, the diagnosis cluster is not stored in the Risk Adjustment System (RAS). The edits at this stage also include an edit to check if the diagnosis code is in the risk adjustment model. If the diagnosis code is not in the model, an information error is returned. The diagnosis cluster is stored if an information-only error is returned and no further action by the M+C organization is required.

Explanations of error codes and their consequences, RAPS error codes, and informational edits are presented in Tables 7D, 7E, and 7F, respectively.

**TABLE 7D – EXPLANATION OF ERROR AND CONSEQUENCES**

| SERIES | EXPLANATION OF ERROR AND CONSEQUENCES |
|---|---|
| **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. |
| **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. |

**TABLE 7E – RAPS ERROR CODES**

| ERROR CODE | RECORD ID | ERROR DESCRIPTION |
|---|---|---|
| 301 | CCC | CCC RECORD MISSING FROM TRANSACTION |
| 302 | CCC | MISSING / INVALID SEQUENCE-NUMBER ON CCC RECORD |
| 303 | CCC | SEQUENCE-ERROR-CODE FILLER NOT EQUAL TO SPACES |
| 304 | CCC | HIC-ERROR-CODE FILLER NOT EQUAL TO SPACES |
| 305 | CCC | DOB-ERROR-CODE FILLER NOT EQUAL TO SPACES |
| 306 | CCC | DIAGNOSIS CODE FILLER NOT EQUAL TO SPACES |
| 307 | CCC | DIAGNOSIS-CLUSTER-ERROR-1 NOT EQUAL TO SPACES |
| 308 | CCC | DIAGNOSIS-CLUSTER-ERROR-2 NOT EQUAL TO SPACES |
| 309 | CCC | SEQUENCE-NUMBER ON CCC RECORD IS OUT OF SEQUENCE |
| 310 | CCC | MISSING / INVALID HIC-NUMBER ON CCC RECORD |
| 311 | CCC | AT LEAST ONE DIAGNOSIS CLUSTER REQUIRED ON TRANSACTION |
| 313 | CCC | DELETE-INDICATOR MUST EQUAL SPACE OR “D” FOR DELETE |
| 314 | CCC | INVALID DIAGNOSIS CODE FORMAT ON CCC RECORD |
| 315 | CCC | CORRECTED HIC NOT EQUAL TO SPACES |
| 350 | CCC | INVALID PATIENT-DOB ON CCC RECORD |
| 353 | CCC | HIC NUMBER DOES NOT EXIST ON MBD |
| 354 | CCC | PATIENT DOB DOES NOT MATCH WITH MBD DOB |

**TABLE 7E – RAPS ERROR CODES (CONTINUED)**

| ERROR CODE | RECORD ID | ERROR DESCRIPTION |
|---|---|---|
| 400 | CCC | MISSING / INVALID PROVIDER-TYPE CODE ON CCC RECORD |
| 401 | CCC | INVALID SERVICE FROM-DATE ON CCC RECORD |
| 402 | CCC | INVALID SERVICE THROUGH-DATE ON CCC RECORD |
| 403 | CCC | SERVICE THROUGH DATE MUST BE GREATER THAN 12/31/2002 |
| 404 | CCC | SERVICE FROM DATE MUST BE LESS THAN OR EQUAL TO THRU DATE |
| 405 | CCC | DOB IS GREATER THAN SERVICE FROM DATE |
| 406 | CCC | SERVICE FROM DATE IS NOT WITHIN MEDICARE ENTITLEMENT PERIOD |
| 407 | CCC | SERVICE THROUGH DATE IS NOT WITHIN MEDICARE ENTITLEMENT PERIOD |
| 408 | CCC | SERVICE FROM DATE IS NOT WITHIN M+C ORG ENROLLMENT PERIOD |
| 409 | CCC | SERVICE THROUGH DATE IS NOT WITHIN M+C ORG ENROLLMENT PERIOD |
| 410 | CCC | BENEFICIARY IS NOT ENROLLED IN PLAN ON OR AFTER SERVICE FROM DATE |
| 411 | CCC | SERVICE THROUGH DATE IS GREATER THAN DATE OF DEATH |
| 412 | CCC | SERVICE FROM DATE GREATER THAN TRANSACTION DATE |
| 413 | CCC | SERVICE THROUGH DATE GREATER THAN TRANSACTION DATE |
| 450 | CCC | DIAGNOSIS DOES NOT EXIST FOR THIS SERVICE THROUGH DATE |
| 451 | CCC | SERVICE THROUGH DATE IS GREATER THAN DIAGNOSIS END DATE |
| 453 | CCC | DIAGNOSIS CODE IS NOT APPROPRIATE FOR PATIENT SEX |
| 454 | CCC | DIAGNOSIS IS VALID, BUT IS NOT SUFFICIENTLY SPECIFIC FOR RISK ADJUSTMENT GROUPING |
| 460 | CCC | SERVICE FROM AND THROUGH DATE SPAN IS GREATER THAN 31 DAYS |
| 490 | CCC | COULD NOT DELETE, DIAGNOSIS CLUSTER NOT IN RAPS DATABASE BENEFICIARY RECORD |
| 491 | CCC | DELETE ERROR, DIAGNOSIS CLUSTER PREVIOUSLY DELETED |
| 492 | CCC | DELETE ERROR, DIAGNOSIS CLUSTER WAS NOT DELETED. A DIAGNOSIS CLUSTER WITH THE SAME ATTRIBUTES WAS ALREADY DELETED FROM THE RAPS DATABASE ON THIS DATE |

**TABLE 7F – INFORMATIONAL EDITS**

| ERROR CODE | RECORD ID | ERROR DESCRIPTION |
|---|---|---|
| 500 | CCC | BENEFICIARY HIC NUMBER HAS CHANGED ACCORDING TO CMS RECORDS; USE CORRECT HIC NUMBER FOR FUTURE SUBMISSIONS |
| 501 | CCC | VALID DIAGNOSIS BUT NOT A RELEVANT DIAGNOSIS FOR RISK ADJUSTMENT DURING THIS SERVICE PERIOD |
| 502 | CCC | DIAGNOSIS CLUSTER WAS ACCEPTED BUT NOT STORED. A DIAGNOSIS CLUSTER WITH THE SAME ATTRIBUTES IS ALREADY STORED IN THE RAPS DATABASE |

**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:** The 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 RAS.

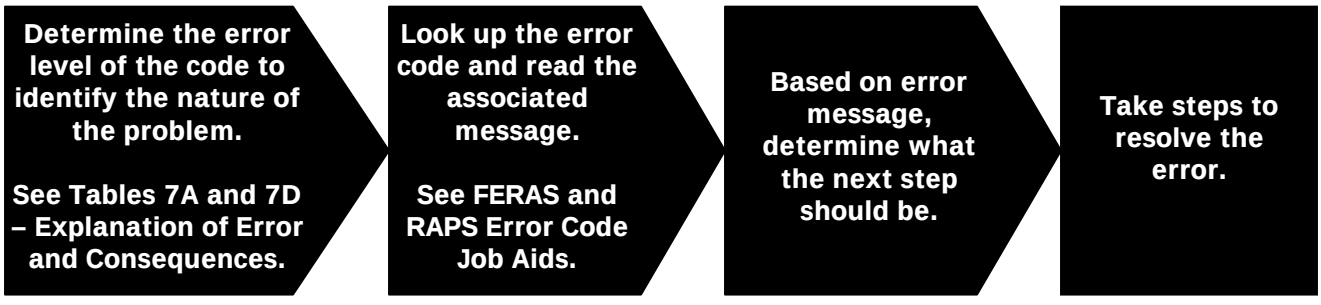
## 7.2 Resolving Error Codes

CMS began accepting risk adjustment data in FERAS and processing data through RAPS in October 2002. As of January 2004, more than 227 million diagnosis clusters were processed. While the error rate is less than 1 percent, there are several errors that represent the majority of the common errors seen.

### 7.2.1 Resolution Steps (Slide 14, 11)

It is the M+C organization's responsibility to resolve errors that CMS identifies. Described below are the basic steps required to resolve errors. If inaccurate data is the cause of the error, the organization must submit a new record with corrected information to resolve the error.

**Figure 7B – Resolution Steps**




System problems may occur when M+C organizations submit and delete the same diagnosis cluster several times on the same day. The error code 492 will occur if the organization tries to delete the same cluster more than once.

**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:** The error code 492 occurs, indicating that the diagnosis cluster was not successfully deleted, indicating that the cluster is already stored as a delete and another delete is not necessary.

### 7.2.2 Common Errors (Slide 17, 12)

In an effort to prevent common errors, the next section describes the errors and steps that M+C organizations may take to minimize the occurrence of these common errors.

#### 7.2.2.1 File Name Duplicates Another File Accepted Within Last 12 Months (Slides 18-19, 13-14)

In order to identify the unique file that has been accepted, CMS requires that all files include a ten-digit alpha-numeric file ID. The file ID is required when submitting test or production data. Once a file ID has been submitted and accepted in test or production, the same file ID should not be submitted on any other files within 12 months.

If a File ID was accepted in encounter data processing prior to October 2003, the file ID should not be used for Risk Adjustment processing within 12 months. The NSF and UB-92 formats support a 10-digit file number, while the RAPS format requires a 6-digit format. FERAS performs an edit of the last six digits, so submitters should ensure that those digits are unique.

**Example: 5**

SenCare Health Plan submitted an encounter data hospital inpatient production file in August 2002, and an encounter data physician test file in August 2002. The plan cannot submit those files with the same file ID until September 2003.

**Prevention**

Submitters should consider establishing an automated system that assigns a file sequence number during the process of establishing the data file.

## Correction

When a submitter receives a 113-error code, "File name duplicates another file accepted within the last 12 months", the following steps should be taken:

- Since this is a 100-level error code message, the submitter will refer to the AAA record.
- The error code 11**3**, describes the field within the A record that must be corrected.
- The submitter must enter a valid 10-digit file ID in AAA 3.
- Resubmit following correction.

Since this file was rejected by FERAS, it will not be processed in RAPS until the data is corrected.

### 7.2.2.2 Delete Error, Diagnosis Cluster Previously Deleted (Slides 20-21, 15-16)

When a plan submits a delete and RAPS accepts it, the cluster is not physically deleted from the RAPS database. The RAPS database stores a "D" in the delete indicator and enters a delete date to indicate when the diagnosis was deleted. If a plan tries to delete the exact same diagnosis cluster at a later time, the system will generate a 491-error code, informing the plan that the cluster is already deleted.

## Prevention

This issue normally occurs when plans delete all clusters from a previously submitted file, and the original file included duplicate diagnosis clusters. One way to prevent the errors is to check for duplicate diagnosis clusters prior to submitting the file with the deletes on it.

## Correction

There is no corrective action necessary, because the 491-error code indicates that the cluster has already been deleted.

### 7.2.2.3 Diagnosis Cluster Not Successfully Deleted. Another Diagnosis Cluster With the Same Attributes Was Already Deleted From the RAPS Database On This Date (Slides 22-23, 17-18)

When plans submit delete records, the "D" indicator and the delete date become part of the unique database key for the diagnosis cluster. Diagnosis clusters must have one unique attribute in the key in order to be stored. The 492-error code occurs when a plan deletes, adds, and then attempts to delete the exact same cluster during a single processing day. The delete will successfully process, as will the following add transaction. The add transaction will create a new record for this diagnosis cluster. The second delete cannot process, since accepting the second delete will cause the creation of a duplicate record on the RAPS database. This error is different from the 491 in that the last record on file will be the add record; that is, the diagnosis cluster has not been successfully deleted.

## Prevention

Again, this error normally occurs when plans submit large files of correction records. Plans should check when deleting records that they are not adding the exact same cluster in the same file, or on different

files on the same day. If a plan detects multiple submissions of the same diagnosis cluster, the plan should determine what the final status of the cluster should be, deleted or active, and take appropriate action.

## Correction

When a submitter receives a 492-error code, "Diagnosis Cluster Not Successfully Deleted", the following steps should be taken:

- Since this is a 400-level error code message, the submitter will refer to the CCC record.
- The error code series 490-499 indicates that it is a deletion problem.
- The submitter must determine if the diagnosis cluster should be deleted or active as a final action.
- If the cluster should be active, no further action is required.
- If the diagnosis is supposed to be deleted, the plan must submit one delete record. Since any future submissions will have a different delete date than any other clusters on file, a single delete record will successfully process.

### 7.2.2.4 Service From Date Is Not Within M+C Organization Enrollment (Slides 24-25, 19-20)

The beneficiary receiving services under the Medicare+Choice program must be enrolled in Medicare during the service period. The dates of service reported in the diagnosis clusters must be within the enrollment dates that are posted in the MBD. RAPS cross-references MBD to verify that the beneficiary was covered during the identified from and through dates of service. Prior to March 2003, M+C organizations received the 408- and 409-error codes due to data inconsistencies between various CMS systems. In early March, the MBD and Group Health Plan (GHP) database were synchronized, which eliminated much of the problem.

The 408-error code occurs with all data. The 409-error code occurs only with hospital outpatient and physician data.

## Prevention

Submitters should check the from and through dates of service against internal enrollment records. Remember that for hospital outpatient and physician data, both the from and through dates must be within M+C enrollment periods. For hospital inpatient data, only the from dates must be within M+C enrollment periods. Performing these pre-edits will minimize the number of errors received regarding enrollment information.

## Correction

When a submitter receives a 408-error code, "Service from date is not within M+C organization enrollment period", or a 409-error code, "Service through date is not within M+C organization enrollment period", the following steps should be taken:

- Since this is a 400-level error code message, the submitter will refer to the diagnosis cluster.
- The submitter must ensure that the correct service from date was entered in CCC 9.1.
- The submitter must ensure that the correct service through date was entered in CCC 9.2.

- The submitter should check these dates against the plan enrollment dates in the Managed Care Option Information System (MCCOY) and MBD.
- If MCCOY shows that the beneficiary was enrolled in the plan on the from/through dates of service and MBD has different data, contact Customer Service and Support Center (CSSC).
- If the CSSC determines that the MBD needs to have the plan enrollment data updated, resubmit following correction of the MBD data.

Since this is not a format or integrity edit, this error will not be detected in FERAS; therefore, Direct Data Entry (DDE) users may encounter this error. When this is detected in RAPS, the problem must be corrected in order to store any diagnosis clusters associated with this record.

### 7.2.2.5 Beneficiary Is Not Enrolled In Plan On or After Service From Date (Slides 26-27, 21-22)

In March 2003, CMS synchronized the data that is stored in the GHP with information in MBD. This provided the most current and accurate information regarding Medicare beneficiary enrollment information. Beneficiaries must be enrolled in the plan on or after the date of the service provided.

#### Prevention

Using information from the monthly membership report and internal enrollment files, submitters should be knowledgeable regarding the enrollment and eligibility of their beneficiaries. Establishing a systematic beneficiary enrollment tracking system will reduce the number of errors associated with this edit.

The 408- and 409-error code messages indicate that the service occurred while the beneficiary was not participating in *any* M+C program. The 410-error code message indicates that the service occurred while the beneficiary was not enrolled in *your* organization.

#### Correction

When a submitter receives a 410-error code, “Beneficiary is not enrolled in plan on or after service from date”, the following steps should be taken:

- Since this is a 400-level error code message, the submitter will refer to the diagnosis cluster.
- The submitter must ensure that the correct service from date was entered in CCC 9.1.
- The submitter should check the service from date against the plan enrollment dates to ensure that the beneficiary was enrolled in this plan on or after the from date.
- If MCCOY shows that the beneficiary was enrolled in the plan on the from/through dates of service and MBD has different data, contact CSSC.
- If CSSC determines that the MBD needs to have the plan enrollment data updated, resubmit following correction of the MBD data.

Since this is not a format or integrity edit, this error will not be detected in FERAS; therefore, DDE users may encounter this error. When this is detected in RAPS, the problem must be corrected in order to store any diagnosis clusters associated with this record.

### 7.2.3 Informational Error Messages

The RAPS system generates informational messages that do not stop processing of data, i.e., no immediate action is necessary. However, these messages, illustrated in Table 7G, provide M+C organizations with information to improve future submissions.

**TABLE 7G – INFORMATIONAL MESSAGE CODES**

| ERROR CODE | RECORD ID | ERROR DESCRIPTION | PROCESS IMPROVEMENT |
|---|---|---|---|
| 500 | CCC | BENEFICIARY HIC NUMBER HAS CHANGED ACCORDING TO CMS RECORDS; USE CORRECT HIC NUMBER FOR FUTURE SUBMISSIONS. | USE UPDATED HIC NUMBER ON ALL FUTURE SUBMISSIONS FOR THIS BENEFICIARY. |
| 501 | CCC | VALID DIAGNOSIS BUT NOT A RELEVANT DIAGNOSIS FOR RISK ADJUSTMENT DURING THIS SERVICE PERIOD. | DETERMINE IF FILTERING SHOULD BE INCORPORATED INTO SUBMISSION PROCESS TO REDUCE NUMBER OF 501 MESSAGES. |
| 502 | CCC | DIAGNOSIS CLUSTER WAS ACCEPTED BUT NOT STORED. A DIAGNOSIS CLUSTER WITH THE SAME ATTRIBUTES IS ALREADY STORED IN THE RAPS DATABASE. | CREATE INTERNAL EDITING SYSTEMS THAT ALERT SUBMITTER WHEN FEATURES OF A UNIQUE DIAGNOSIS CLUSTER (PROVIDER TYPE, FROM/TRHOUGH DATE, DIAGNOSIS CODE) FOR EACH HIC ARE SUBMITTED. |

# MODULE 8 – MEDICARE BENEFICIARY DATABASE

## Purpose (Slide 2, 2)

Demographic and eligibility information are crucial components of the risk adjustment payment calculation. The Risk Adjustment Processing System (RAPS) performs edits to ensure that data submitted is consistent with the demographic information on file in the Medicare Beneficiary Database (MBD). Understanding the information stored in the MBD and the appropriate ways to update and retrieve that information may assist plans with decreasing overall reject rates due to demographic data. This module provides details on using the MBD to access and research crucial risk adjustment eligibility data.

## Learning Objectives (Slide 3, 3)

At the completion of this module, participants will be able to:

- Identify the purpose of the Medicare Beneficiary Database.
- Interpret system access instructions.
- Understand common risk adjustment uses of the database.
- Contact appropriate resources.

**ICON KEY**

| | |
|---|---|
| Example | |
| Reminder | |
| Resource | |
| Information Systems Track | |
| Quality & Compliance Track | |

## 8.1 Medicare Beneficiary Database (Slides 4-5, 4-5)

The Centers for Medicare & Medicaid Services (CMS) is moving toward an information-centered approach to record keeping, with an initial focus on the beneficiary data. One of the objectives is to establish a common enterprise-wide information solution that will provide for better data integration throughout the Medicare program.

The MBD was created to provide CMS with a centralized database that is able to communicate with other systems while being able to view, manage, and update beneficiary information. The MBD, for risk adjustment purposes, is the authoritative source of beneficiary information. The MBD will be used to support managed care enrollments and payments to Medicare+Choice (M+C) organizations. M+C organizations access the MBD via a Graphical User Interface (GUI).

## 8.2 Types of Data Stored in the MBD (Slides 6-10, 6-10)

Data stored in the MBD is categorized into four distinct groups. Each group represents a tab within the application. Table 8A describes the type of data found within each of the tabs.

**TABLE 8A- CATAGORIES OF MBD INFORMATION**

| | |
|---|---|
| **BENEFICIARY PROFILE**<br>Provides the necessary information on personal characteristics to uniquely identify Medicare beneficiaries. | |
| **Beneficiary Address** | Provides access to mailing, residence, and temporary residence address information. |
| **Beneficiary Communication Profile** | Provides information about the beneficiary's choices regarding the reception of correspondence, including language and delivery type preferences. |
| **Representative Payee Communication Profile** | Provides information about the representative payee's choices regarding the reception of correspondence, including language and delivery type preferences. |
| **Miscellaneous Information** | Includes the Common Working File (CWF) host site ID. |
| **ENTITLEMENT TAB**<br>Provides data necessary to determine an individual's entitlement to Medicare. | |
| **Enrollment Coverage** | Provides information specific to the periods of Part A and Part B enrollment coverage. |
| **COVERAGE TAB**<br>Contains information about Beneficiary Service Delivery Elections and Choices. Coverage includes details related to current End-Stage Renal Disease (ESRD) and Hospice periods. Historical hospice and ESRD periods are available. | |
| **Medicare+Choice Elections** | Users can view unique information about the Coordinated Care Plans and Private Fee-For-Service (FFS) plans. |
| **Other Beneficiary Explicit Elections** | Provides details on Demonstrations and Cost/Health Care Prepayment Plan (HCPP). |
| **Fee-For-Service Periods** | Includes details on the FFS periods that are the default if no other option has been elected. |
| **Managed Care Institutional Status** | Contains information about the current and historical periods of inpatient residence in a medical treatment facility, regardless of Medicaid eligibility status. Also contains information about beneficiaries who remained in a non-institutional residence when their health status warranted nursing home inpatient care. |
| **Other Insurance Profile** | Contains current and historical information about a beneficiary's insurance choices and coverage in addition to Medicare or Medicaid. |
| **MEDICAID TAB**<br>Provides information on Medicaid Eligibility. | |
| **Medicaid Eligibility Periods** | Provides a profile of current and historical Medicaid eligibility periods. |

## 8.3 Accessing the MBD (Slides 11-12, 11-12)

The M+C organization must complete and submit an MBD Access Application to their regional contact in central office. Table 8B identifies the contacts by region. Users may download the application at http://cms.hhs.gov/mdcn/access.pdf. Users must submit completed applications to the appropriate contacts and the CMS contract manager must approve the application. Users should allow five business days for processing.

Organizations should complete the MBD access application when a user:

- Requires new access.
- Changes names.
- Changes access needs/job duties.
- Seeks recertification.
- Retires, resigns, or is removed from the organization.

To gain access to the MBD, a user ID and password is required. Based on the information populated on the application, the user will be assigned the ability to update and view information at a level appropriate for their role. Restrictions to access include:

- M+C organizations will only have access to information for those beneficiaries currently enrolled in the organization.
- Viewing of enrollment is limited to the contract numbers associated with the user ID logged on to the system.
- If a user does not have access to view a particular MBD element, asterisks (***) will display in that field.
- If the user does not have authority to update, add, or delete, the element will be protected.

The MBD allows inquiry access only. This access allows users to view beneficiary information. The information available for display will be more limited for non-members of an organization than for members. The M+C organization currently providing services to a beneficiary will have more access to information related to that beneficiary than any other M+C organization.

**TABLE 8B – REGIONAL OFFICE MBD CONTACTS**

| REGION | POINT-OF-CONTACT | TECHNICAL SUPPORT |
|---|---|---|
| Boston | Jackie Buise, 410-786-7607 | Sarah Brown, 410-786-6358 |
| New York | Juan Lopez, 410-786-7621 | Sarah Brown, 410-786-6358 |
| Philadelphia | James Dorsey, 410-786-1143 | Sarah Brown, 410-786-6358 |
| Atlanta | Gloria Webster, 410-786-7655 | Susan Hartmann, 410-786-6192 |
| Chicago | Janice Bailey, 410-786-7603 | Susan Hartmann, 410-786-6192 |
| Dallas | Joanne Weller, 410-786-5111 | Susan Hartmann, 410-786-6192 |
| Kansas City | Gloria Webster, 410-786-7655 | Sarah Brown, 410-786-6358 |
| Denver | David Evans, 410-786-0412 | Sue Mathis, 410-786-6938 |
| San Francisco | Ed Howard, 410-786-6368<br>Jim Logan, 410-786-7625 | Sue Mathis, 410-786-6938 |
| Seattle | David Evans, 410-786-0412 | Sue Mathis, 410-786-6938 |

### 8.3.1 Connectivity

- Connection to the MBD is obtained through the Medicare Data Communications Network (MDCN) that is currently maintained by AT&T Global Networking Services (AGNS). The AGNS dialer software can be downloaded at ftp://ftp.attglobal.net/pub/Client/win32/setup.exe. Using this address will cause the software to download automatically. The dialer is also available from the CMS Extranet at http:/158.73.207.36/attsetup.exe. If users are unable to access the Internet to download the dialer, contact CMS at 410-786-6008 or RemoteAccess@cms.hhs.gov.

- Users should contact their Regional Office contact to ensure that the AGNS ID has been added to the MBD group, which allows connection to the MBD production server. If a T1 high-speed connection is being used for the first time at your location, send an email to MDCN@cms.hhs.gov.

- An organizational access form is required to gain access to the MBD GUI production server (IP address 158.73.105.55) and web server (IP address 158.73.207.36).

- To check connectivity to the MBD server, use the PING or TRACERT command. Execute the command in a DOS window (e.g., TRACERT 158.73.105.55).

- To avoid firewall problems, contact IT support to ensure access to the production server (IP address 158.73.105.55, port 5000) and the web server (IP address 158.73.207.36).

### 8.3.2 Installation

Users will receive a password and software from CMS once the system access application form is processed. Figure 8A illustrates the network logon screen. Close attention must be given to following the detailed installation instructions to prevent future system errors.

- Double-click the self-extracting zip file MBD_Websphere Version 5.exe. Click Unzip to install the files into a new directory, C:\Mbdtcpi, which is created automatically during the unzip process.
- Access Windows Explorer by clicking Start, then Programs, then Windows Explorer.
- Click on the C:\Mbdtcpi folder to view its contents.

- If there is no connection to the CMS Data Center via a T1 line, connect to the AGNS network via the AGNS dialer.
- Click on the MBD_X_0321.htm file.
- The browser will display the MBD web page, which should automatically launch the MBD GUI application. When prompted with a security warning to install and run the ActiveX control, click 'Yes'.

**Note:** When accessing the MBD for the first time, users will experience a longer wait while the application files are downloaded to the computer. The client server picture and small window in the center of the computer screen indicates that the files are being downloaded, as illustrated in Figure 8B. A "broken link" icon in the center of the page indicates that a connection has not been made. Contact CMS for assistance.

**Figure 8A – Network Logon Screen**

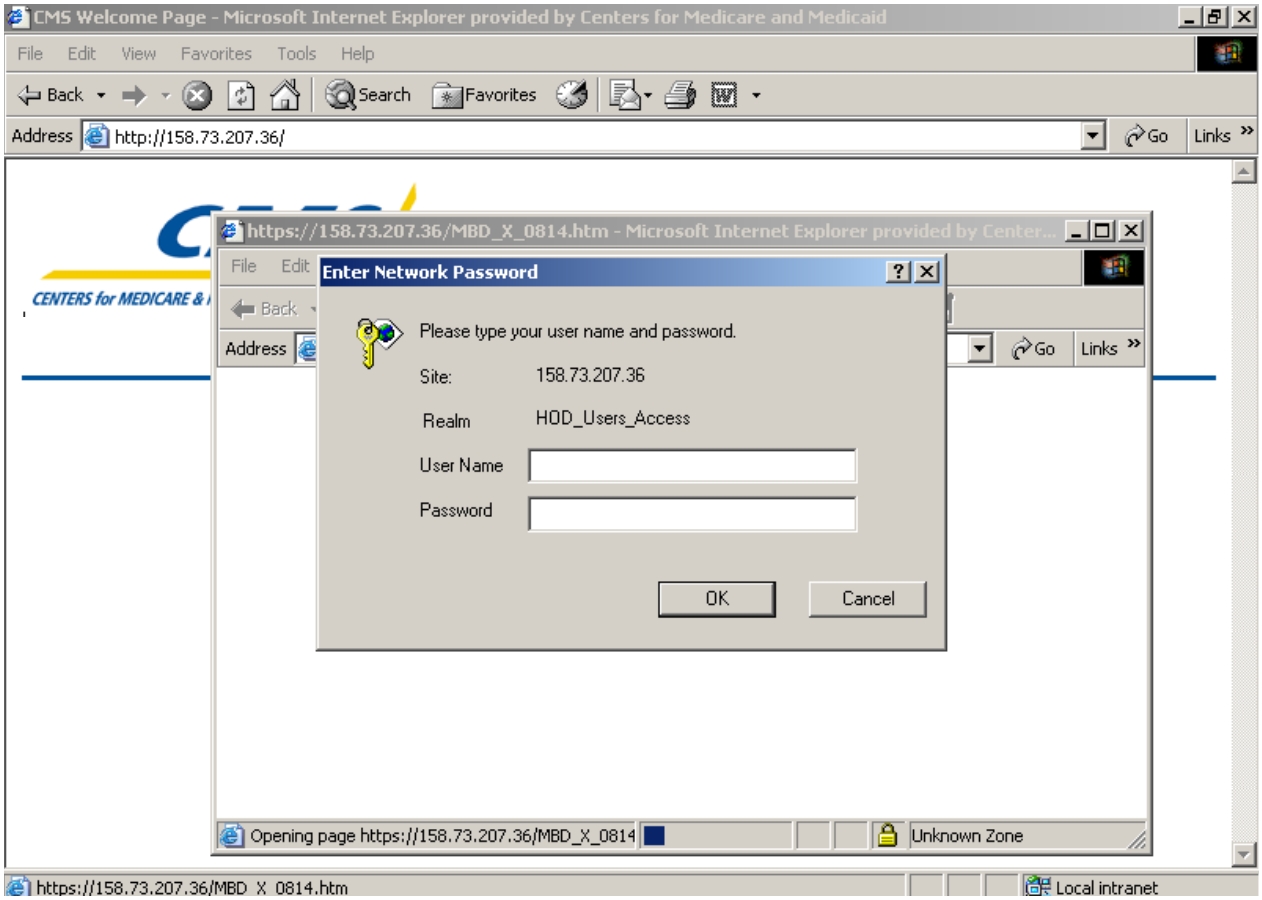
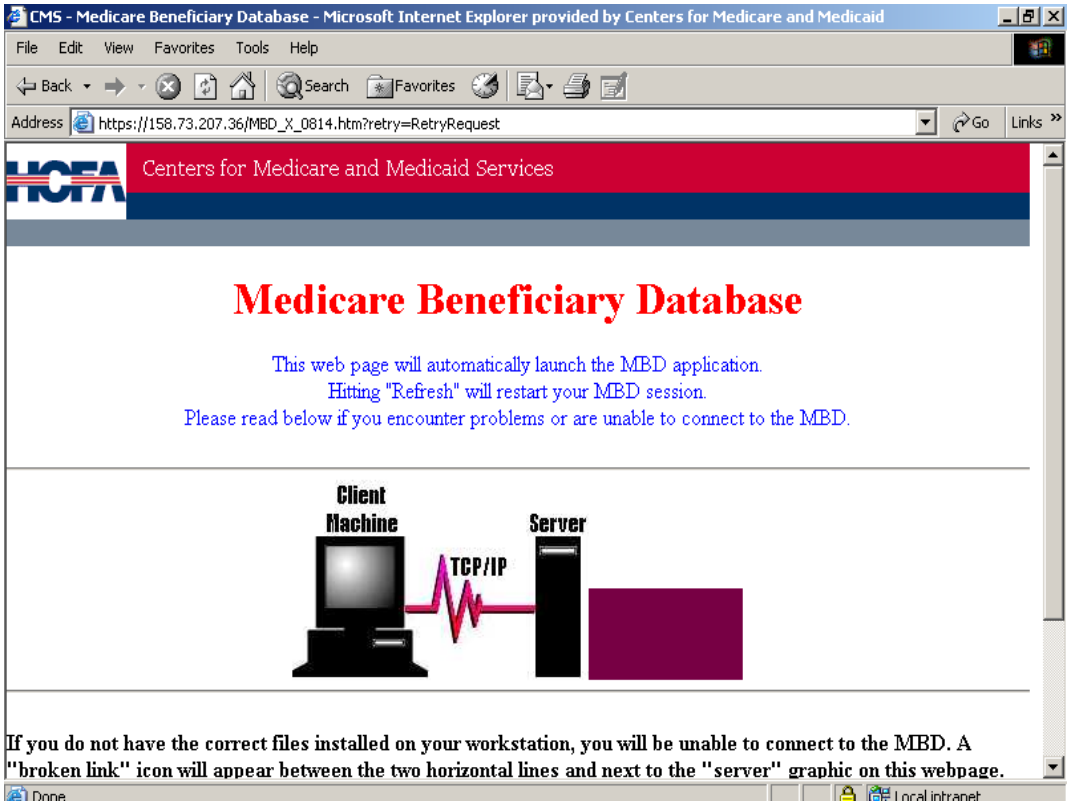


**Figure 8B – MBD Connection Screen**



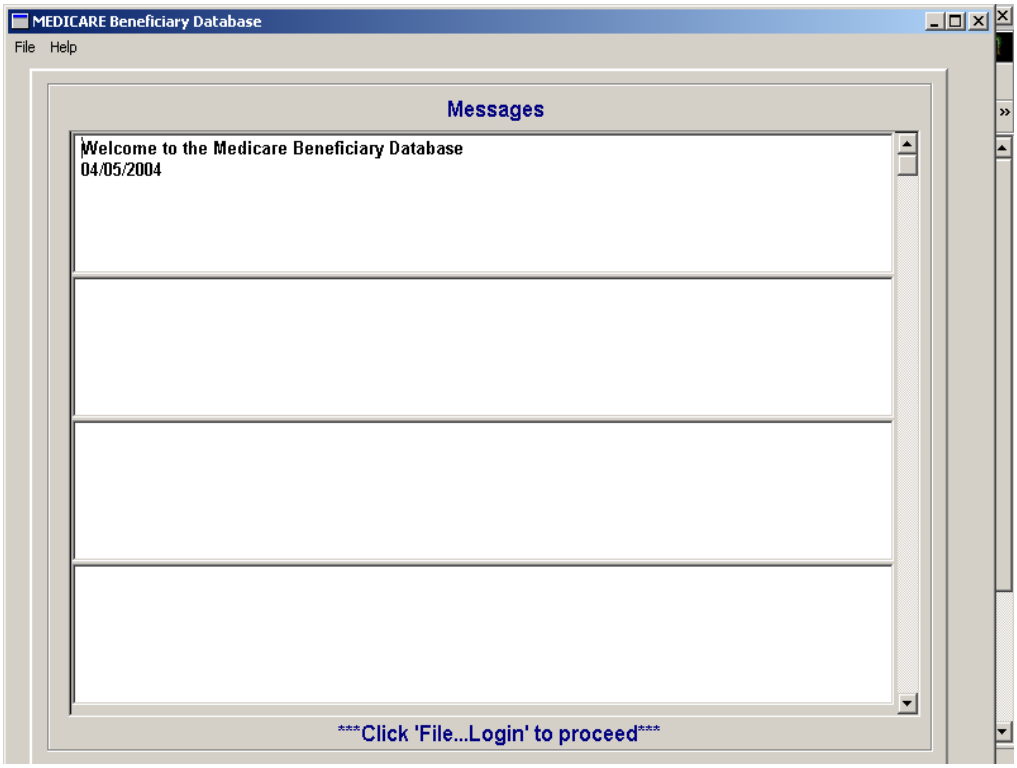

- After a successful connection, the MBD_X_0321.htm and sp2tc.cab files may be deleted from the C:\mbdtcpi folder. Copy the WebSphere MBD shortcut to the desktop and use this to access the MBD. The WebSphere MBD shortcut will provide password maintenance and periodic informational messages to users.

- If the WebSphere MBD shortcut does not work, speak to your CMS contact to ensure that the AGNS account or T1 connection have the proper authority settings.

The MBD software is distributed in three parts. First, is the GUI software that installs on the client machine. Second, the installation manual with detailed steps to perform. Third, is a document with Frequently Asked Questions.

Figure 8C illustrates the welcome screen.

**Figure 8C – Welcome Screen**




The MBD User's Guide is located in the Resource Guide.

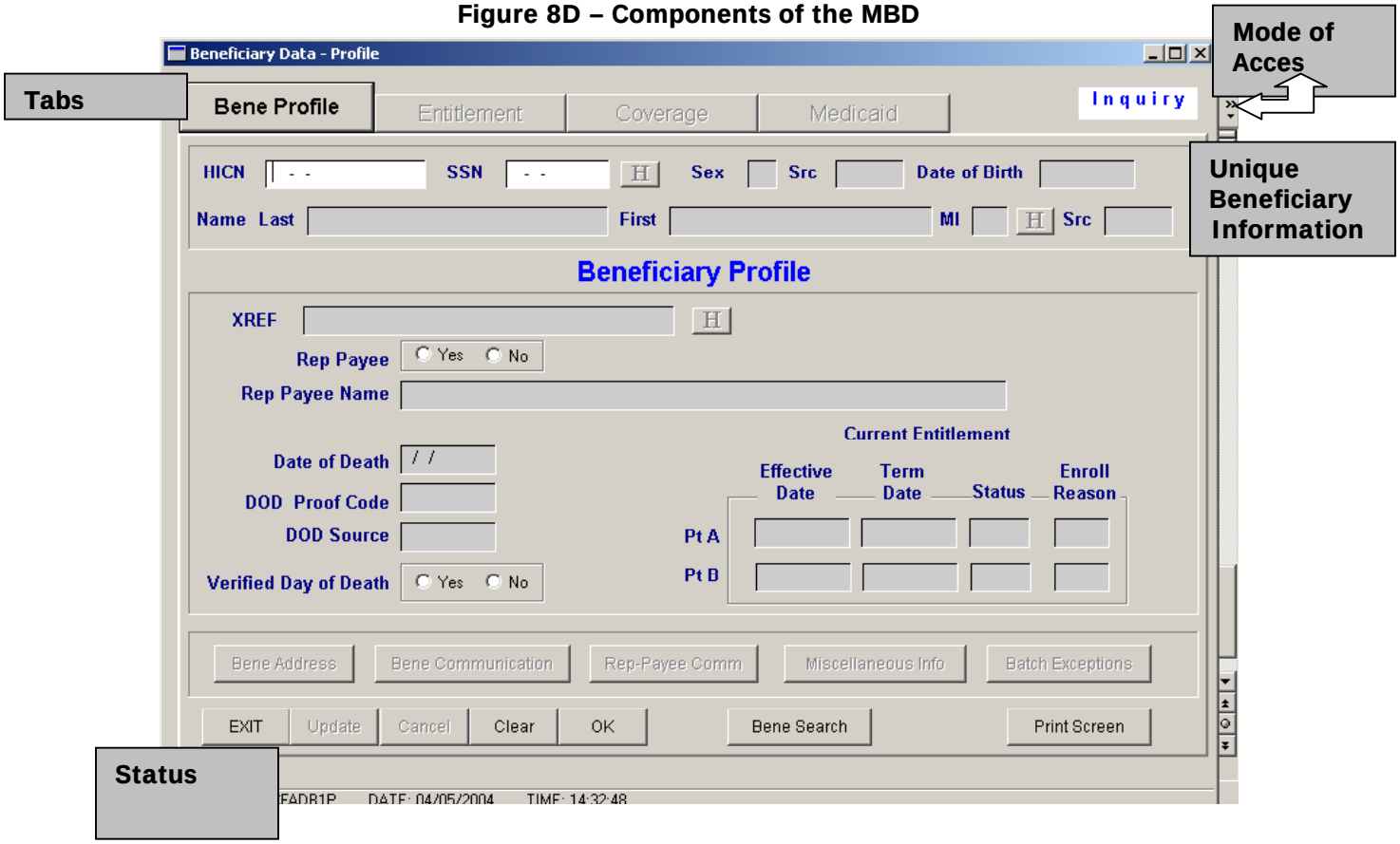
## 8.4 Components of the MBD (Slides 13-15, 13-15)

There are four components of the MBD application that are important to understand for the purpose of navigating the application. Table 8C describes the features of each of the components. Figure 8D illustrates how these components appear within the application.

**TABLE 8C- COMPONENTS OF THE MBD**

| | |
|---|---|
| **MODE OF ACCESS** | On the top right corner of each window or tab, the user will see the word *Inquiry* or *Update*. This indicates which access the user selected. |
| **TABS** | The MBD application is separated into four different tabs, which contain different types/categories of data. Each tab contains buttons, which provide access to more information. |
| **UNIQUE BENEFICIARY INFORMATION** | At the top of each tab is an area of information that remains constant from tab to tab. This information includes the key fields used to identify the beneficiary and includes the beneficiary's<br>• Health insurance claim (HIC) number.<br>• Social Security number (SSN).<br>• Sex and source code.<br>• Date of birth.<br>• Name and source code. |
| **STATUS BAR** | At the bottom of each screen is a status bar containing the name of the database the user accessed, the current date, and the current time. |

**Figure 8D – Components of the MBD**



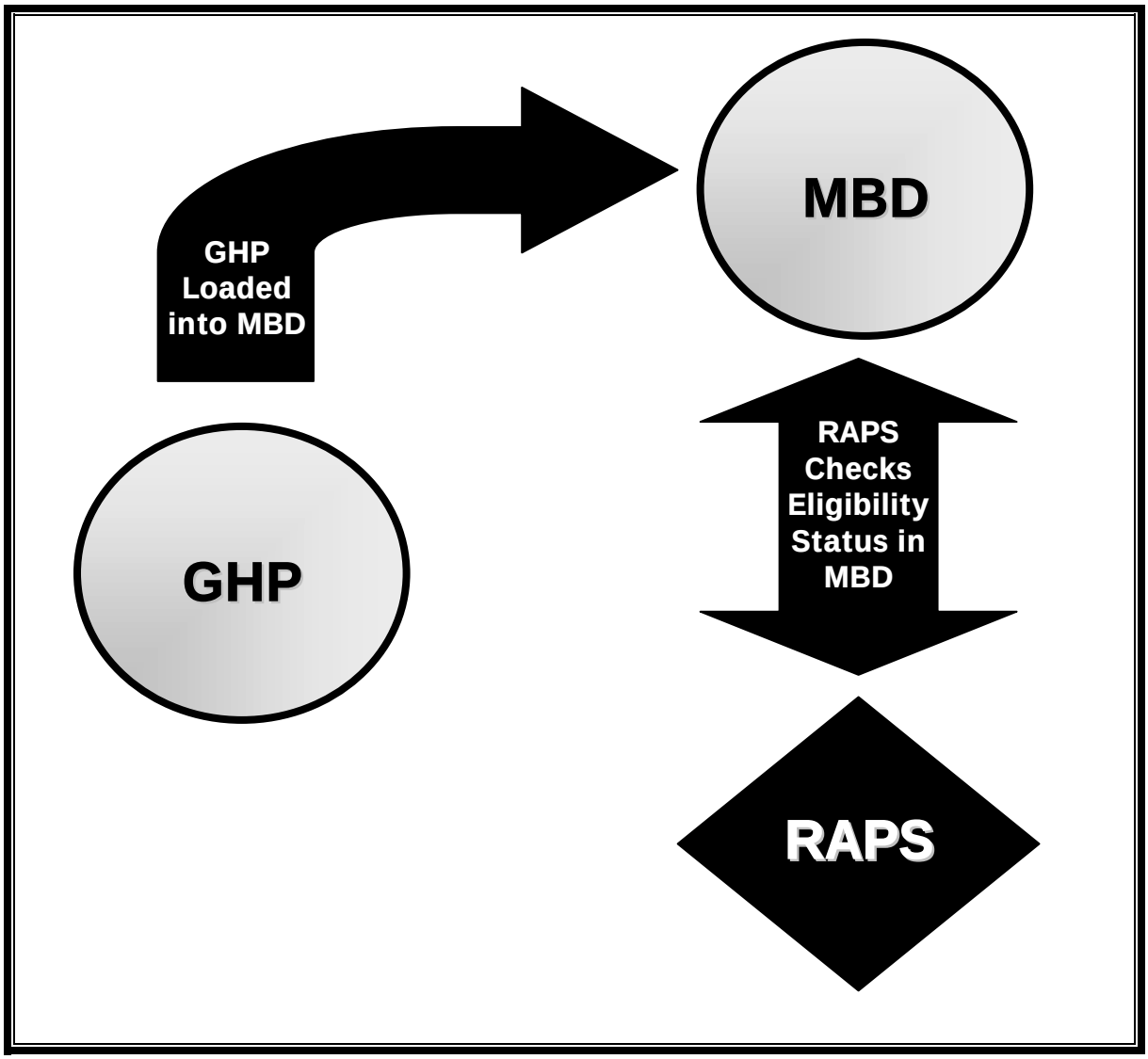
## 8.5 MBD Risk Adjustment Overview (Slide 16, 16)

During processing of the risk adjustment data, RAPS checks the eligibility of the Medicare beneficiary against the MBD. In March 2003, The Group Health Plan (GHP) System database was loaded to the MBD. This ensured that the MBD eligibility information was consistent with GHP, the sole system for Medicare enrollment information.

Information in MBD is updated nightly with GHP files. In 2004, the MMCS will replace GHP. The RAPS bases M+C eligibility verification on data from the MBD. M+C organizations will continue, until further notified, to use the Managed Care Option Information System (MCCOY), which is the interface between M+C organizations and the GHP system for managed care enrollment and payment calculations. Since GHP is the source system for the plan enrollment data in the MBD and MCCOY, both databases should reflect the same data.

Figure 8E illustrates the flow of data from GHP to MBD and between MBD and RAPS.

**Figure 8E – MBD Flow of Data**




## 8.6 MBD Common Risk Adjustment Uses

M+C organizations can reduce the numbers of errors that are returned due to invalid eligibility by accessing the MBD to determine the eligibility and other demographic information. Implementing the following procedures in your organization will reduce the time spent on resolving errors.

- Develop a monthly validation protocol that verifies the eligibility of the M+C organization enrollees.
- Program the internal information systems to cross check the MBD before submitting the data to the Front-End Risk Adjustment System (FERAS).

The most common uses for MBD to support the M+C risk adjustment requirements can be found in the Inquiry mode under the Beneficiary Profile tab of MBD. The information includes:

- Date of birth.
- Date of death.
- Medicare effective date.
- Medicare termination date.

**Note:** M+C organizations will need to manually research each beneficiary. A batch load is not available through MBD.

## 8.7 HIC Numbers and the MBD

The HIC number is a common way to begin researching data in the MBD.

- MBD keeps historical data on file, so if a beneficiary's HIC number changed, the MBD will cross-reference the old and new numbers.
- CMS developed a conversion program that allows Railroad Retirement Board (RRB) beneficiary numbers to cross-reference automatically for all applications of MBD. This allows the users to research demographic and eligibility information for beneficiaries with RRB and HIC numbers.

## 8.8 CSSC and the MBD (Slide 20, 20)

The Customer Service and Support Center (CSSC) has access to the MBD and should be the M+C organization's first point of contact for questions regarding concerns with data that impact their risk adjustment. Examples of the type of assistance that CSSC provides with researching MBD include:

- While waiting for access to MBD to be granted, M+C organizations may contact CSSC for assistance obtaining information.
- Assist Program for All-Inclusive Care for the Elderly (PACE) and demonstration organizations in checking a beneficiary's status until they are assigned an H number. **Note:** A plan can contact the state Medicaid agency to determine Medicaid eligibility.
- If M+C organizations determine that the information contained in the MBD differs from the information in MCCOY, they may contact the CSSC for assistance investigating the issue. The CSSC will log the concern and provide guidance on correcting the issue.

**Example 1**

The M+C organization includes the date of birth for an enrollee in their submission, but found that the majority of their errors were related to the date of birth. The organization implemented a system to reduce the number of errors returned for eligibility issues. Figures 8F and 8G illustrate the log in and inquiry screens. Figure 8H illustrates the process of researching the date of birth of a beneficiary.

**Figure 8F – Log In**

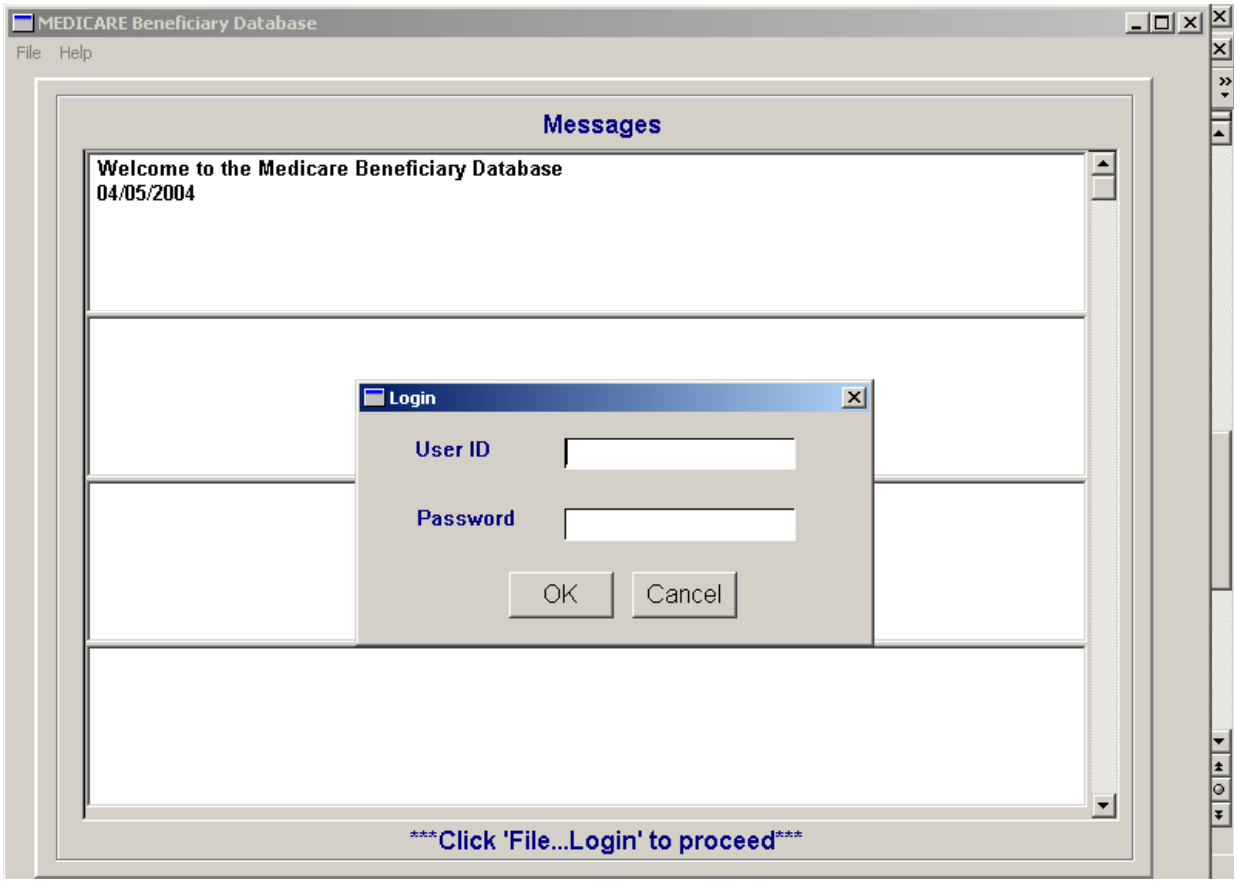


**Figure 8G – Inquiry Screen**

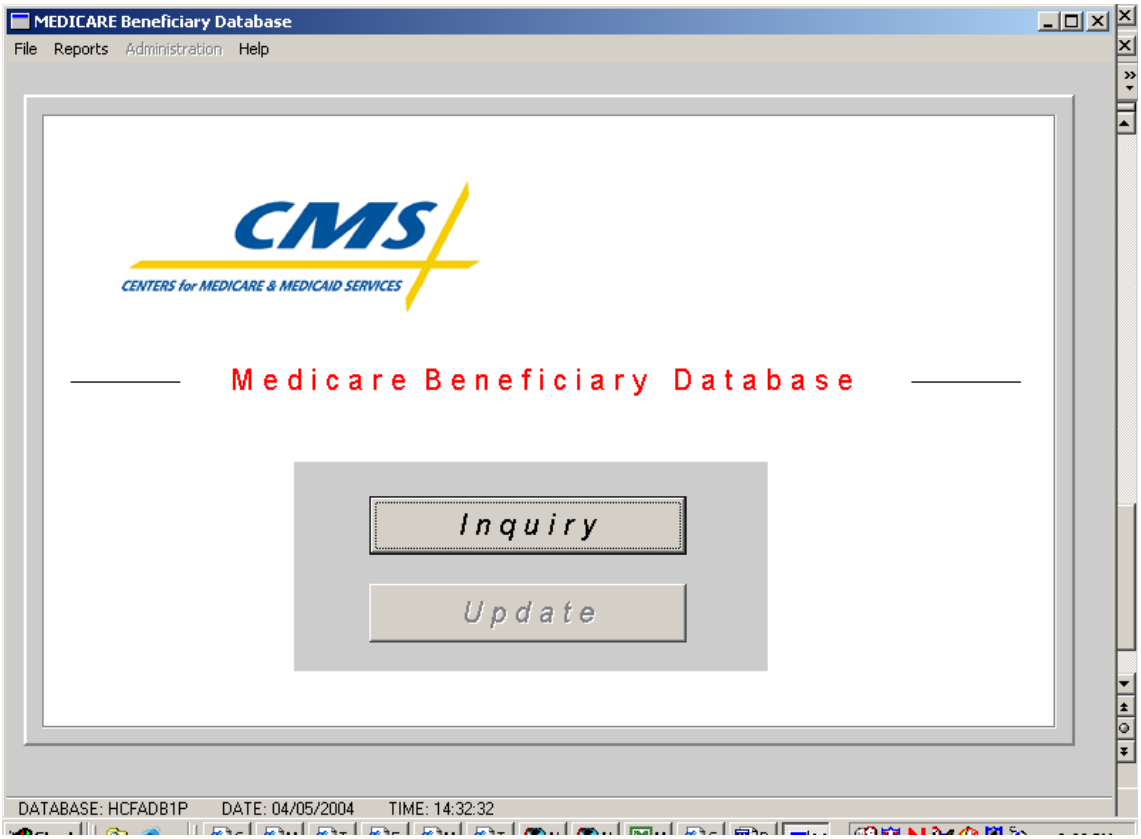
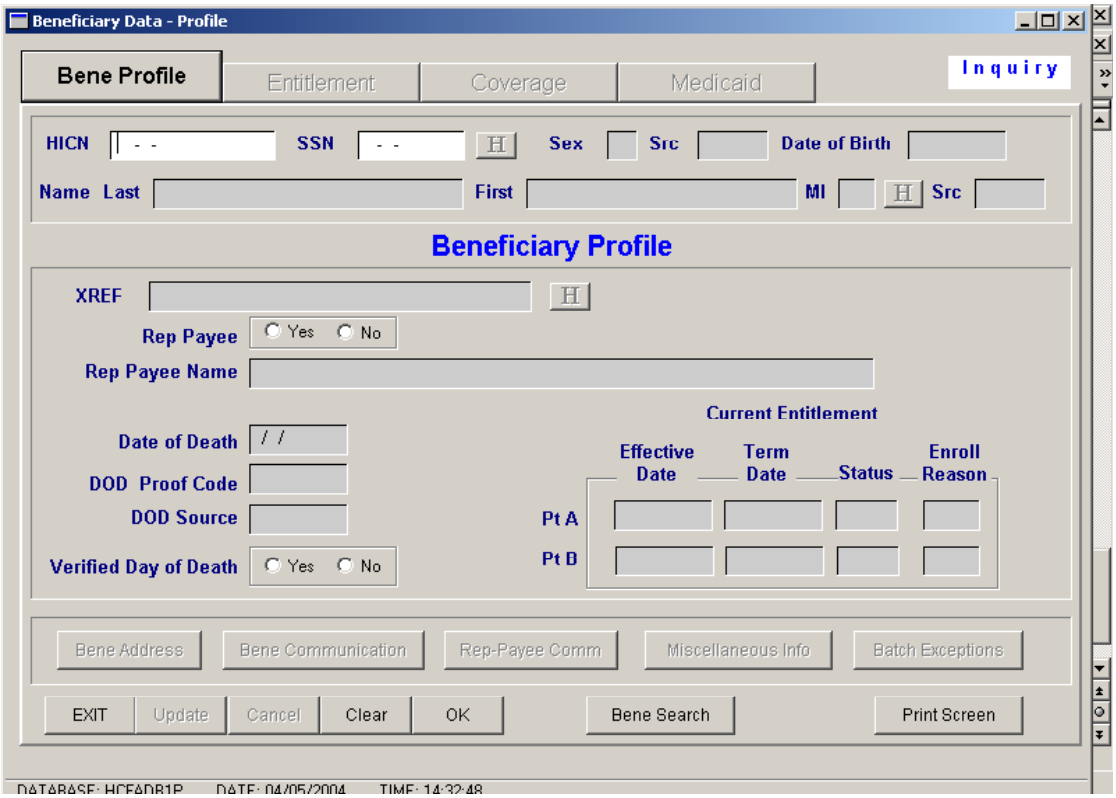


**Figure 8H – Checking DOB**



# MODULE 9 – REPORTS

## Purpose (Slide 2, 2)

The Centers for Medicare & Medicaid Services (CMS) communicates the status of submitted diagnosis clusters to submitters on a variety of reports. Some reports present summary level data, others present details about individual diagnosis clusters, including whether or not a cluster generated an error in the Risk Adjustment Processing System (RAPS). It is essential that the appropriate staff at Medicare+Choice (M+C) organizations understand how to read reports and resolve any issues the reports may identify. This module provides insights on the appropriate use of the RAPS reports to manage data collection, data submission, and error resolution processes.

## Learning Objectives (Slides 3-4, 3-4)

At the completion of this module, participants will be able to:

- Identify the purpose of each of the risk adjustment reports.
- Determine 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.
- Understand the relationship between values in the RAPS Transaction Summary and management reports.
- Compare accepted diagnosis clusters to benchmarks.

**ICON KEY**

| | |
|---|---|
| Example | |
| Reminder | |
| Resource | |
| Information Systems Track | |
| Quality & Compliance Track | |

## 9.1 Accessing Risk Adjustment Processing Reports (Slide 5)

M+C organizations access the reports designed to support the risk adjustment process through three methods:

- Secure Website
- File Transfer Protocol (FTP)
- Network Data Mover (NDM)

Secure Website and FTP users receive reports generated by the Front-End Risk Adjustment System (FERAS) typically within 15 minutes of submission. NDM users should receive reports the following business day if the file transfer is complete by 5 p.m. Eastern Time (ET). If the submission is received after 5:00 p.m. ET, the NDM user will receive the report 2 business days after submission.

The processing systems, FERAS and the RAPS, send the reports to the submitter's mailbox, where they remain for 14 days. The systems automatically delete reports from the mailbox after 14 days, but M+C organizations can access reports through the Customer Service and Support Center (CSSC) for 7 years. Reports are sent to the mailbox identified on the submitter application. Since the reports are generated out of the processing systems at CMS and sent to Palmetto for distribution, the reports cannot be duplicated and sent to multiple mailboxes.

M+C organizations may request reports in zip format. To avoid difficulties opening zip reports, users should:

- Rename the file with the ".zip" extension.
- Change the command to binary when using the FTP command line.

## 9.2 Printing Reports

All risk adjustment reports are delivered as text reports, with the exception of the RAPS Return File. Organizations may download the reports in Note Pad and change the print orientation to landscape to ensure that all information on the report prints on one page. Users should avoid opening the report in Microsoft Word to prevent the default programming that occurs. When users open the reports in Note Pad, the report prints with the automatic page breaks incorporated.

## 9.3 Report Overview (Slides 6-8, 5-7)

Table 9A summarizes the content and general information about each of the reports.

**TABLE 9A – REPORTS OVERVIEW**

| | |
|---|---|
| **FERAS Report** | |
| **FERAS Response Report** | • Indicates file is accepted or rejected<br>• Identifies reasons for rejection<br>• Report layout<br>• Secured Website and FTP users receive reports the same business day<br>• NDM users receive reports the next business day |
| **RAPS Reports** | |
| **RAPS Return File** | • Contains the entire submitted transaction<br>• Identifies 300-, 400-, and 500-level errors<br>• Flat file layout<br>• Received the next business day after submission |
| **RAPS Transaction Error Report** | • Communicates errors found in CCC records in transaction<br>• Displays only 300-, 400-, and 500-level error codes<br>• Report layout<br>• Received the next business day after submission |
| **RAPS Transaction Summary Report** | • Summarizes the disposition of diagnosis clusters<br>• Report layout<br>• Received the next business day after submission |
| **RAPS Duplicate Diagnosis Cluster Report** | • Identifies diagnosis clusters with 502 error message<br>• Clusters accepted, but not stored<br>• Report layout<br>• Received the next business day after submission |
| **RAPS Management Reports** | |
| **RAPS Monthly Plan Activity Report** | • Provides monthly summary of the status of submissions by submitter and plan number<br>• Report layout<br>• Available for download the second business day of the month |
| **RAPS Cumulative Plan Activity Report** | • Provides cumulative summary of the status of submissions by Submitter ID and plan number<br>• Report layout<br>• Available for download the second business day of the month |

## 9.4 FERAS Response Report (Slides 9-10, 8)

The FERAS Response Report reflects FERAS checks (format, integrity, and validity) that occur in the file, batch, and first and last detail-level records. It indicates that the file has been accepted or rejected by the front-end system. If accepted, the report specifies that the file is completely accepted. If the file is rejected, the report identifies the reason(s) for the rejection. Figure 9A illustrates the fields on the FERAS Response Report and describes the report's fields.

The report is available in a report layout file in each submitter's mailbox. FTP and Secured Website users typically receive their reports within 15 minutes of submission. NDM users should receive their reports the next business day.

**Figure 9A – Rejected FERAS Response Report**

**[1]**REPORT: FERAS-RESP **[2]**FRONT END RISK ADJUSTMENT SYSTEM
**[3]**RUN DATE: 20030407 FERAS RESPONSE REPORT

**[4]**SUBMITTER ID: SH7777
**[5]**FILE ID: 0000000001

**[6]**FILE STATUS: REJECTED PROD

| **[7]** RECORD TYPE | **[8]** SEQ NO | **[9]** ERROR CODE | **[10]** ERROR DESCRIPTION |
|---|---|---|---|
| AAA | 0000001 | 113 | DUPLICATE FILE ID ACCEPTED WITHIN 12 MONTHS |

END OF REPORT

| Field No. | Field Name | Field Description |
|---|---|---|
| 1 | Report Name | Name of the report as it appears in submitter's mailbox. |
| 2 | Report Full Name | Full name of the report. |
| 3 | Report Date | Date the report was generated by Palmetto (CCYYMMDD format). |
| 4 | Submitter ID | Report is grouped by submitter identification number. A submitter may submit for more than one plan. A different report is generated for each plan. |
| 5 | File ID | The 10-digit file identification number. |
| 6 | File Status | Identifies whether the file was completely accepted or completely rejected. This field also identifies if the file is TEST or PRODUCTION. |
| 7 | Record Type | Identifies the level of the error (File, Batch, or Detail record level). |
| 8 | Sequence Number | Identifies the batch or Detail-level record where the error occurred. |
| 9 | Error Code | Identifies the 3-digit number error message that caused the file to reject. |
| 10 | Error Code Description | Explains the error code. |

**NOTE:** There are three reasons why users would not receive the FERAS Response Report:

- The AAA record is not included on the file. Submitters receive an "INVALID_FILE_HDR" message.
- No Submitter ID on the AAA record.
- The login ID used to submit data to FERAS does not match the submitter ID. Submitters receive a "SUBMITTER ID IN FILE DOES NOT MATCH THE LOGIN ID" message (FTP and Secure website users only).

**Example: 1**

The M+C organization corrected and submitted a file, but only changed the first character of the file ID. The second batch did not include a plan number (H number). The first detail record was missing a Health Insurance Claim (HIC) number, and the fourth YYY batch trailer plan number did not match the plan number in the BBB batch header. Figure 9B illustrates this example.

**Figure 9B – FERAS Response Report**

REPORT: FERAS-RESP **FRONT END RISK ADJUSTMENT SYSTEM**
RUN DATE: 20040304 **FERAS RESPONSE REPORT**

SUBMITTER ID: SH9999
FILE-ID: 0000000001 REJECTED

| RECORD TYPE | SEQ NO | ERROR CODE | ERROR CODE DESCRIPTION |
|---|---|---|---|
| AAA | | 113 | FILE NAME DUPLICATES ANOTHER FILE ACCEPTED WITHIN LAST 12 MONTHS |
| BBB | 0000002 | 203 | MISSING/INVALID PLAN NUMBER ON BBB RECORD |
| CCC | 0000001 | 310 | MISSING/INVALID HIC NUMBER ON CCC RECORD |
| YYY | 0000004 | 263 | PLAN NUMBER DOES NOT MATCH PLAN NUMBER IN BBB RECORD |

The FERAS Response Report indicates errors in the first and last detail-level (CCC) record.

## 9.5 RAPS Processing Reports

Generally, the RAPS processing reports allow submitters to see all records and diagnosis clusters submitted. They also communicate the errors that exist and any report exact duplicate clusters. Organizations use these reports to determine if they need to correct and resubmit their data.

### 9.5.1 RAPS Return File (Slides 11-12, 9-10)

The RAPS Return File contains all transactions submitted by the M+C organization. If there are errors or informational edits, they appear next to the field in which the error was found. The file is delivered in the same flat file format used for the RAPS input. It may be downloaded to an Access or Excel database and converted to display the necessary fields.

M+C organizations receive the RAPS Return File the next business day following a submission.

Table 9B represents the RAPS record layout and the information contained in a flat file format for the RAPS Return File.

**TABLE 9B – RAPS RECORD LAYOUT**

**RECORD AAA – FILE HEADER**

| FIELD NO | FIELD NAME |
|---|---|
| 1 | Record ID |
| 2 | Submitter ID |
| 3 | File-ID |
| 4 | Transaction Date |
| 5 | Production-Test-Indicator |
| 6 | Filler |

**RECORD BBB – BATCH HEADER**

| FIELD NO | FIELD NAME |
|---|---|
| 1 | Record ID |
| 2 | Sequence Number |
| 3 | Plan Number |
| 4 | Filler |

**RECORD CCC – DETAIL LEVEL**

| FIELD NO | FIELD NAME |
|---|---|
| 1 | Record ID |
| 2 | Sequence Number |
| 3 | Sequence Number Error Code |
| 4 | Patient Control Number |
| 5 | HICN |
| 6 | HICN Error Code |
| 7 | Patient DOB |
| 8 | DOB Error Code |
| 9.0 | Provider Type |
| 9.1 | From Date |
| 9.2 | Through Date |
| 9.3 | Delete-Indicator |
| 9.4 | Diagnosis Code |
| 9.5 | Diagnosis Code Filler |
| 9.6 | Diagnosis Cluster Error 1 |
| 9.7 | Diagnosis Cluster Error 2 |
| 19 | Corrected HICN |
| 20 | Filler |

**TABLE 9B – RAPS RECORD LAYOUT (CONTINUED)**

**RECORD YYY – BATCH TRAILER**

| FIELD NO | FIELD NAME |
|---|---|
| 1 | Record ID |
| 2 | Sequence Number |
| 3 | Plan-Number |
| 4 | CCC-Record-Total |
| 5 | Filler |

**RECORD ZZZ – FILE TRAILER**

| FIELD NO | FIELD NAME |
|---|---|
| 1 | Record ID |
| 2 | Submitter ID |
| 3 | File-ID |
| 4 | BBB Record Total |
| 5 | Filler |

**Example: 2**

The M+C organization submitted a file and included the date of birth (DOB) for the beneficiary. RAPS determined a discrepancy between the DOB submitted on a file and what is stored in the Medicare Beneficiary Database (MBD). The submitter received a RAPS Return File. Figure 9C illustrates the portion of the RAPS Return File that contains the DOB, as well as an error code indicating that the submitted DOB is incorrect.

**Figure 9C – RAPS Return File**

AAASH777700000000000120030411PROD
BBB0000001H9999
CCC0000001 7321430 123456789A **19350305354**0120030314200303184359
YYY0000001H99990000003
ZZZSH777700000000010000003

DOB

RAPS reports include the sequence number of the file, batch, and detailed record as submitted by the organization.

## 9.5.2 RAPS Transaction Error Report (Slide 15, 11)

The RAPS Transaction Error Report displays only those detail-level (CCC) records where errors were found during RAPS processing. Every record that has errors is displayed in full with the appropriate error code next to the field where the error was found. The report is available in a report layout file in each submitter's mailbox. It is organized by H number, and may prove useful to M+C organizations that use a manual tracking process. Figure 9D illustrates the RAPS Transaction Error Report and describes the report's fields.

Submitters receive a RAPS Transaction Error Report the next business day after submitting a file.

**Figure 9D – RAPS Transaction Error Report**

**[1]** REPORT : RAPS002 **[2]**RISK ADJUSTMENT PROCESSING SYSTEM **[3]** PAGE: 1
**[4]** RUN DATE : 20030411 TRANSACTION ERROR REPORT **[5]** TRANS DATE: 20030411
**[6]**SUBMITTER ID SH7777 **[7]**FILE ID: 0000000005 **[8]**PLAN ID: H7777 **[9]**BATCH NUMBER: 0000001

| **[10]** SEQ NUM | **[11]** SEQ ERR | **[12]** PATIENT CONTROL NUM | **[13]** HIC | **[14]** HIC ERR | **[15]** DOB | **[16]** DOB ERR | **[17]** PVDR TYPE | **[18]** FROM DATE | **[19]** THRU DATE | **[20]** DEL IND | **[21]** DGNS CODE | **[22]** DGNS ERR1 | **[23]** DGNS ERR2 | **[24]** CORRECTED HIC |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0000002 | | 123456789A | | | 19350305 | 354 | 01 | 20030314 | 20030318 | | 4359 | 501 | | |
| | | 12345676878812347654165464515 | | | | | | | | | | | | |

**END OF FILE**

| Field No. | Field Name | Field Description |
|---|---|---|
| 1 | Report Name | Name of the report as it appears in the Submitter's mailbox. |
| 2 | Report Full Name | Full name of the report. |
| 3 | Page Number | Page number of the report. |
| 4 | Report Run Date | Date CMS generated the report (CCYYMMDD). |
| 5 | MCO Transmit Date | Date the M+C organization created the transaction. |
| 6 | Submitter ID | Report is grouped by submitter identification number. A submitter may submit for more than one organization. |
| 7 | File ID | The 10-character file identification number. |
| 8 | Plan Number | The H-number assigned by CMS; A different report is printed for each organization (H-number). |
| 9 | Batch ID | The 7-digit batch identification number. |
| 10 | Sequence Number | Detail-level record where the error occurred. |
| 11 | Sequence Number Error Code | The 3-digit error code associated with the sequence number. |
| 12 | MCO Patient Control Number | Patient control number assigned by the M+C organization, if any. |
| 13 | HIC Number | The 10-character(alpha-numeric) Health Insurance Claim Number of the beneficiary. |
| 14 | HIC Number Error Code | The 3-digit error code associated with the HIC Number. |
| 15 | Date of Birth | Patient's date of birth (CCYYMMDD format). |
| 16 | Date of Birth Error Code | The 3-digit error code associated with the patient's date of birth. |
| 17 | Provider Type | The 2-digit code identifying the provider type (01, 02, 10, or 20). |
| 18 | Service From Date | Date of admission (inpatient) or date of treatment (outpatient facility or physician). |
| 19 | Service Through Date | Date of discharge (inpatient) or date of treatment (outpatient facility or physician). |
| 20 | Delete Indicator | The 1-character place-holder to identify diagnosis clusters that will be or are deleted. This field will be populated with a "D" if the cluster was deleted. If no deletion has occurred, the space will be blank. |
| 21 | Diagnosis Code | The five-character ICD-9-CM diagnosis code. |
| 22 | Diagnosis Code Error 1 | Error code associated with diagnosis code submitted. |
| 23 | Diagnosis Code Error 2 | Error code associated with diagnosis code submitted, if any. |
| 24 | Corrected HIC Number | If an error code indicates there is a corrected HIC number, it is indicated here. |

RAPS performs edits on all CCC records. Table 9C describes the steps.

**TABLE 9C – STEPS IN RAPS EDIT PROCESS**

| | |
|---|---|
| **Step 1** | Check all CCC records. |
| **Step 2** | Crosscheck fields in CCC records against other fields. |
| **Step 3** | Apply MBD edits. |
| **Step 4** | Edit diagnosis code against the Diagnosis Lookup Table. |

When RAPS identifies no errors, the system sends a Transaction Error Report with the message "ALL DIAGNOSES PROCESSED WITHOUT ERRORS."

- 300 – 349 Error Codes indicate a record level error. The record was bypassed and all editing was discontinued. No diagnosis clusters from this record were stored.
- 350 – 399 error codes indicate a record level error. All possible edits were performed, but no diagnosis clusters from this record were stored.
- 400 – 489 error codes indicate a diagnosis cluster error. All possible diagnosis edits were performed, but the specific diagnosis cluster was not stored.
- 490 – 499 error codes indicate a diagnosis delete error. The diagnosis was not deleted.
- 500 – 599 error codes are informational messages. All edits were performed, and diagnosis cluster(s) were stored unless another error is listed.

**Example: 3**

The M+C organization submitted a batch that included eight records (Figure 9E). Since errors occurred in records three, five, and seven, only those sequence numbers are reflected on the report. In record three, the plan submitted a HIC that does not appear in MBD. The plan received a 353-error for this record, and the diagnosis was not stored. The fifth record included three clusters for a hospital inpatient stay, which received errors due to the beneficiary not being enrolled in a health plan on the date that the beneficiary was admitted to the hospital. The hospital inpatient clusters received the 408-error message, but no 409-error message. Hospital inpatient rules hold the M+C organization responsible for reporting patient admissions for all enrollees. The submission rules also require that the entire stay be reported, even if the patient was not enrolled in the health plan on the discharge date.

On the seventh record, the health plan attempted to delete one diagnosis cluster and replace that cluster with one containing the same diagnosis and different service dates. This record had errors for both actions. The original cluster had previously been deleted and received a 491-error code. The new cluster received 408- and 409-errors because the beneficiary was not enrolled in the plan on or after the dates of service.

**Figure 9E – RAPS Transaction Error Report**

REPORT: RAPS002 **RISK ADJUSTMENT PROCESSING SYSTEM**
RUN DATE: 20040523 **TRANSACTION ERROR REPORT** PAGE: 22
TRANS DATE: 20040521

SUBMITTER ID:SH9999 FILE ID: 0000000001 PLAN: H9999 BATCH NUMBER: 0000001

| SEQ NO | SEQ ERR | PATIENT CONTROL NUMBER | HIC NUMBER | HIC ERR | DOB | DOB ERR | PVDR TYPE | FROM DATE | THRU DATE | DEL IND | DGNS CODE | DGNS ERR1 | DGNS ERR2 | CORRECTED HIC |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0000003 | | | 999999999A | 353 | 19301206 | | 01 | 20040101 | 20040105 | | 4823 | | | |
| | | 00000000000000000012345678901234567890 | | | | | | | | | | | | |
| 0000005 | | | 888888888A | | 19260217 | | 01 | 20040212 | 20040225 | | 486 | 408 | | |
| | | 00000000000000000012345675675675675675 | | | | | | | | | | | | |
| | | | | | | | 02 | 20040212 | 20040225 | | 2508 | 408 | | |
| | | | | | | | 02 | 20040312 | 20040325 | | 496 | | | |
| 0000007 | | | 666666666D | | 19301206 | | 20 | 20040101 | 20040105 | D | 25004 | 491 | | |
| | | | | | | | 20 | 20040411 | 20040422 | | 25004 | 408 | 409 | |

**END OF FILE**

## 9.5.3 RAPS Transaction Summary Report (Slide 19, 14)

The M+C organization receives the RAPS Transaction Summary Report each time RAPS processes a submitted file. This report identifies the number of clusters received for each provider type, and summarizes the disposition of all diagnosis clusters that were present on the submitted file. Figure 9F illustrates the RAPS Transaction Summary Report and describes its fields.

Submitters receive a RAPS Transaction Summary Report the next business day after submitting files.

## Figure 9F – RAPS Transaction Summary Report

**[1]**REPORT : RAPS001 **RISK ADJUSTMENT PROCESSING SYSTEM**
**[2]**RUN DATE : 20030412 **TRANSACTION SUMMARY REPORT** **[3]**TRANS DATE:20030411

**[4]**SUBMITTER ID SH7777 **[5]**PLAN ID: H7777 **[6]**FILE ID: 0000000001

| **[7]**PROVIDER TYPE | PRINCIPAL INPATIENT | OTHER INPATIENT | OUTPATIENT | PHYSICIAN | **[8]**UNIDENTIFIED | TOTAL |
|---|---|---|---|---|---|---|
| **[9]**TOTAL SUBMITTED | 207 | 1,213 | 0 | 0 | 0 | 1,420 |
| **[10]**TOTAL REJECTED | 9 | 49 | 0 | 0 | 0 | 58 |
| **[11]**TOTAL ACCEPTED | 198 | 1,164 | 0 | 0 | 0 | 1,362 |
| **[12]**TOTAL STORED | 189 | 1,099 | 0 | 0 | 0 | 1,288 |
| **[13]**TOTAL MODEL STORED | 103 | 368 | 0 | 0 | 0 | 471 |
| **[14]**TOTAL DELETE ACPTD | 0 | 0 | 0 | 0 | 0 | 0 |
| **[15]**TOTAL DELETE RJCTD | 0 | 0 | 0 | 0 | 0 | 0 |

| Field No. | Field Name | Field Description |
|---|---|---|
| 1 | Report Name | Name of the report as it appears in the Submitter's mailbox. |
| 2 | Report Run Date | Date CMS generated the report. |
| 3 | MCO Transmit Date | Date the M+C organization created the transmission. |
| 4 | Submitter ID | Report is grouped by submitter identification number. A submitter may submit for more than organization. |
| 5 | Plan Number | H-number assigned by CMS; a different report is printed for each organization (H-number). |
| 6 | File ID | The 10-character file identification number. |
| 7 | Provider Type | This header row identifies the provider sources for which data is listed: principal inpatient, other inpatient, outpatient, physician, unidentified, and total. |
| 8 | Unidentified Provider Type | Indicates the number of diagnosis clusters in transactions that did not include a valid provider type. Valid provider types are "01," "02," "10," and "20." |
| 9 | Total Submitted | The total number of clusters submitted in the file by the submitter. |
| 10 | Total Rejected | The total number of clusters submitted in the file by the submitter and rejected. |
| 11 | Total Accepted | The total number of clusters submitted in the file by the submitter and accepted by the system. |
| 12 | Total Stored | The total number of clusters stored in the risk adjustment database – includes all accepted clusters that are non-duplicates. |
| 13 | Total Model Stored | The total number of relevant clusters stored (clusters associated with diagnoses that are in the CMS-HCC model). |
| 14 | Total Delete Accepted | The total number of deletes submitted for the file that were accepted in the database. |
| 15 | Total Delete Rejected | The total number of deletes submitted, but rejected, for the file. |

### 9.5.3.1 Relationships Between Values in Report (Slide 20, 15)

The relationships between values found on various lines of the report are illustrated using the following formulas:

- The sum of total rejected, total accepted, total deletes accepted, and total deletes rejected equal total submitted. Line 10 + Line 11 + Line 14 + Line 15 = Line 9.

- The total stored (Line 12) is less than or equal to the total accepted (Line 11). The Risk Adjustment Database stores all unique, valid diagnosis clusters, including diagnoses that are not used in the risk adjustment model. The difference between total accepted and total stored reflects the number of exact duplicate diagnosis clusters.

- The total stored in the model (Line 13) is less than or equal to the total diagnosis clusters stored (Line 12).

**Example: 4**

Based on the information displayed in Figure 9F, the organization can make the following conclusions:

- About four percent of the clusters were rejected due to error.
- Seventy-four duplicates were submitted (total accepted minus total stored)
- About one-third of the diagnoses submitted were in the model.

M+C organizations can use the reports not only to correct errors, but also to track the errors and implement automated or manual systems to prevent the same errors from occurring in the future.

**Example: 5**

In Figure 9G, the M+C organization submitted a file that included 72 duplicate diagnosis clusters, and 3,299 diagnosis codes that were not relevant. The RAPS Transaction Summary Report also indicates that clusters were submitted with missing or invalid provider types. In addition, the organization had 12 deletes rejected, meaning the organization attempted to perform the delete function against a diagnosis cluster that was already deleted, or tried to delete a cluster that had never been stored. The RAPS Return File or the RAPS Transaction Error Report will communicate to the organization the specific reason for each rejection.

**Figure 9G – Transaction Summary Report**

**RISK ADJUSTMENT PROCESSING SYSTEM**
**Transaction Summary Report**

REPORT ID: RAPS001
RUN DATE: 20040503 TRANS-DATE: 20040431

SUBMITTER ID: SH7777 FILE ID: 0000000005 PLAN NO: H9999

| PROVIDER TYPE/ | Principal Inpatient | Other Inpatient | Outpatient | Physician | Unidentified | Total |
|---|---|---|---|---|---|---|
| TOTAL SUBMITTED | 870 | 3480 | 629 | 348 | 2 | 5329 |
| TOTAL REJECTED | 26 | 104 | 18 | 13 | 2 | 163 |
| TOTAL ACCEPTED | 842 | 3367 | 606 | 333 | 0 | 5148 |
| TOTAL STORED | 840 | 3335 | 581 | 320 | 0 | 5076 |
| TOTAL MODEL STORED | 295 | 1167 | 203 | 112 | 0 | 1777 |
| TOTAL DELE ACPTD | 2 | 2 | 0 | 2 | 0 | 6 |
| TOTAL DELE RJCTD | 0 | 7 | 5 | 0 | 0 | 12 |

The sum of total rejected, total accepted, total deletes accepted, and total deletes rejected will equal total submitted.

The values in the "Unidentified" column on the report represent the number of clusters for which RAPS is unable to identify a provider type. These clusters are reflected only in the "Total Submitted" and "Total Rejected" rows of the report.

### 9.5.4 RAPS Duplicate Diagnosis Cluster Report (Slide 21, 16)

This report lists diagnosis clusters with a 502-error information message (diagnosis cluster was accepted but not stored) appearing on the RAPS Return File and the RAPS Transaction Error Report. Clusters appearing on this report had previously been submitted to CMS, that is, a cluster with the same HIC number, provider type, from and through dates, and diagnosis are already stored in the RAPS database. Figure 9H illustrates the file layout and provides a key to the fields.

Organizations are notified through a www.mcoservice.com update when this report is available.

M+C organizations that submit using NDM do not have to obtain the Duplicate Diagnosis Cluster Report. NDM submitters are usually large-volume users, and they can reference the RAPS Return File to review 502 informational messages.

## Figure 9H – Duplicate Diagnosis Cluster Report

(1) REPORT: RAPS002 **(2) RISK ADJUSTMENT PROCESSING SYSTEM**
(4) RUN DATE: 20030523 **DUPLICATE DIAGNOSIS CLUSTER REPORT** (3) PAGE: 22
(5) TRANS DATE: 20030521

(6) SUBMITTER ID:SH9999 (7) FILE ID: 0000000001 (8) PLAN: H9999 (9) BATCH NUMBER: 0000001

| (10) SEQ NO | (11) SEQ ERR | (12) PATIENT CONTROL NUMBER | (13) HIC NUMBER | (14) HIC ERR | (15) DOB | (16) DOB ERR | (17) PVDR TYPE | (18) FROM DATE | (19) THRU DATE | (20) DEL IND | (21) DGNS CODE | (22) DGNS ERR1 | (23) DGNS ERR2 | (24) CORRECTED HIC |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0000003 | | | 999999999A | | 19301206 | | 01 | 20030101 | 20030105 | | 4823 | 502 | | |
| | | 00000000000000000012345678901234567890 | | | | | | | | | | | | |

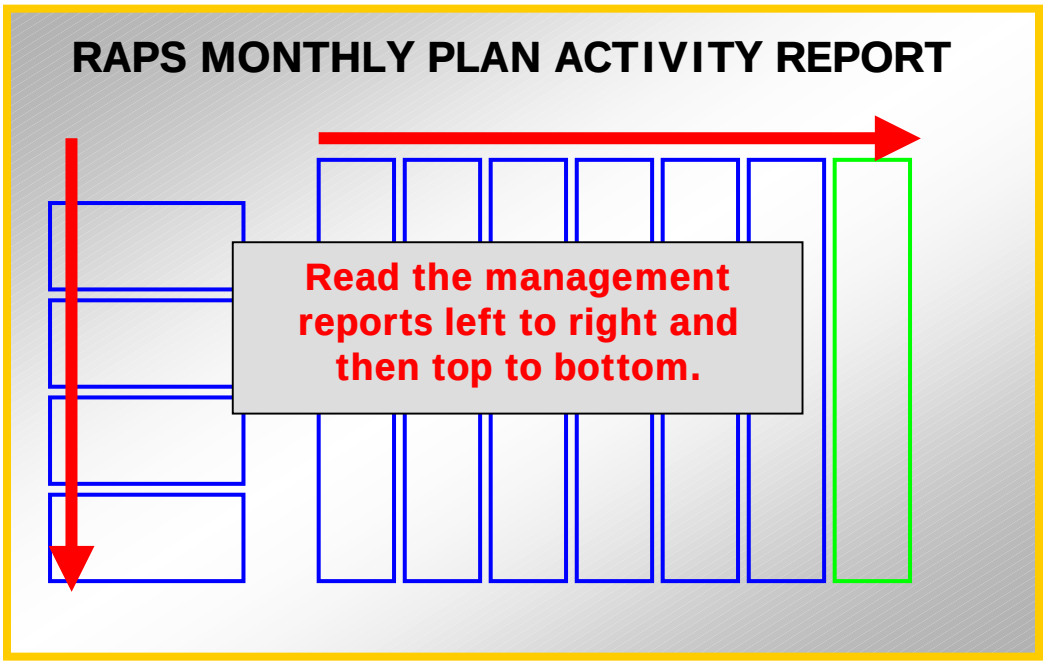
| Field No. | Field Name | Field Description |
|---|---|---|
| 1 | Report Name | Name of the report as it appears in the Submitter's mailbox. |
| 2 | Report Full Name | Full name of the report. |
| 3 | Page Number | Page number of the report. |
| 4 | Report Run Date | Date CMS generated the report (CCYYMMDD). |
| 5 | MCO Transmit Date | Date the M+C organization created the transaction. |
| 6 | Submitter ID | Report is grouped by submitter identification number. A submitter may submit for more than one organization (H-number). |
| 7 | File ID | The 10-character file identification number. |
| 8 | Plan Number | H-number assigned by CMS; a different report is printed for each organization (H-number). |
| 9 | Batch ID | The 7-digit batch identification number. |
| 10 | Sequence Number | Detail-level record where the error occurred. |
| 11 | Sequence Number Error Code | The 3-digit error code associated with the sequence number. |
| 12 | MCO Patient Control Number | Patient control number assigned by the M+C organization, if any. |
| 13 | HIC Number | The 10-digit (alpha-numeric) Health Insurance Claim Number of the beneficiary. |
| 14 | HIC Number Error Code | The 3-digit error code associated with the HIC Number. |
| 15 | Date of Birth | Patient's date of birth (CCYYMMDD format). |
| 16 | Date of Birth Error Code | The 3-digit error code associated with the patient's date of birth. |
| 17 | Provider Type | The 2-digit code identifying the provider type (01, 02, 10, or 20). |
| 18 | Service From Date | Date of admission (inpatient) or date of treatment (outpatient facility or physician). |
| 19 | Service Through Date | Date of discharge (inpatient) or date of treatment (outpatient facility or physician). |
| 20 | Delete Indicator | The 1-character place-holder to identify diagnosis clusters that will be or are deleted. This field will be populated with a "D" if the cluster was deleted. If no deletion has occurred, the space will be blank. |
| 21 | Diagnosis Code | The 5-character ICD-9-CM diagnosis code. |
| 22 | Diagnosis Code Error 1 | Error code associated with diagnosis code submitted. |
| 23 | Diagnosis Code Error 2 | Error code associated with diagnosis code submitted, if any. |
| 24 | Corrected HIC Number | If an error code indicates there is a corrected HIC number, it is indicated here. |

## 9.6 RAPS Management Reports (Slide 22)

CMS developed two management reports that provide the organization with details on the amount of data submitted and stored for each provider type. The reports are delivered to the user on the second business day of the month.

When reviewing both the Monthly and the Cumulative Plan Activity Reports, it is helpful to read the report first across from left to right and then from top to bottom as illustrated in Figure 9I.

**Figure 9I – Analysis of Management Reports**




### 9.6.1 RAPS Monthly Plan Activity Report (Slide 23, 17)

The RAPS Monthly Plan Activity Report provides a monthly summary of the status of all submissions by the submitter ID and plan number (H number). It allows submitters to validate the diagnoses submitted for a 1-month period. The report is arrayed by provider type and month (determined by through date of service). The Report displays information by submitter ID and H number, and displays 6 months of data on each page. Figure 9J illustrates the report and its fields.

Delivered to users on the second business day of the month.

This report allows submitters to validate diagnoses submitted during a 1-month period, based on the date of service (through date). M+C organizations can determine the number of clusters sent and processed during the month, the status of that data (accepted, rejected, stored, model stored, and accepted and rejected deletes) by source. By analyzing this report, the organization also can determine if they are

receiving and submitting enough data from sources, and the rejection rates for each data source. All this information is helpful in managing the data collection, data submission, and error resolution processes.

The total diagnosis clusters stored includes all non-duplicate clusters accepted, while the total model stored includes only diagnosis clusters identified in the CMS-Hierarchical Condition Category (HCC) model.

**Figure 9J – RAPS Monthly Plan Activity Report Layout**

[1]REPORT: RAPS0010 CMS RAPS ADMINISTRATION [2]PAGE: 2
[3]RUN DATE: 20040503 [4]RAPS MONTHLY PLAN ACTIVITY REPORT [5]SERVICE YEAR:2003

[6]SUBMITTER ID: SH7777 [7]FOR THE MONTH OF APRIL, 2004
[8]PLAN NO: H7777

| PROVIDER TYPE/TOTALS | [9]JULY | AUGUST | SEPTEMBER | OCTOBER | NOVEMBER | DECEMBER | TOTAL |
|---|---|---|---|---|---|---|---|
| PRINCIPAL INPATIENT | | | | | | | |
| [10]TOTAL SUBMITTED | 19 | 25 | 28 | 73 | 404 | 1704 | 2253 |
| [11]TOTAL REJECTED | 10 | 7 | 11 | 19 | 106 | 426 | 579 |
| [12]TOTAL ACCEPTED | 9 | 18 | 17 | 54 | 298 | 1278 | 1674 |
| [13]TOTAL STORED | 9 | 18 | 17 | 54 | 298 | 1278 | 1674 |
| [14]TOTAL MODEL STORED | 5 | 8 | 12 | 27 | 158 | 646 | 856 |
| [15]TOTAL DELE ACPTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| [16]TOTAL DELE RJCTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| OTHER INPATIENT | | | | | | | |
| [10]TOTAL SUBMITTED | 103 | 113 | 143 | 407 | 2447 | 10561 | 13774 |
| [11]TOTAL REJECTED | 49 | 44 | 55 | 112 | 638 | 2634 | 3532 |
| [12]TOTAL ACCEPTED | 54 | 69 | 88 | 295 | 1809 | 7927 | 10242 |
| [13]TOTAL STORED | 54 | 69 | 88 | 295 | 1809 | 7927 | 10242 |
| [14]TOTAL MODEL STORED | 18 | 24 | 26 | 95 | 575 | 2574 | 3312 |
| [16]TOTAL DELE ACPTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| [16]TOTAL DELE RJCTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| OUTPATIENT | | | | | | | |
| [10]TOTAL SUBMITTED | 329 | 490 | 761 | 1691 | 9526 | 33693 | 46490 |
| [11]TOTAL REJECTED | 115 | 179 | 219 | 531 | 2523 | 8769 | 12336 |
| [12]TOTAL ACCEPTED | 214 | 311 | 542 | 1160 | 7003 | 24924 | 34154 |
| [13]TOTAL STORED | 214 | 311 | 542 | 1160 | 7003 | 24924 | 34154 |
| [14]TOTAL MODEL STORED | 35 | 82 | 135 | 244 | 1779 | 5305 | 7580 |
| [15]TOTAL DELE ACPTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| [16]TOTAL DELE RJCTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| PHYSICIAN | | | | | | | |
| [10]TOTAL SUBMITTED | 2450 | 3221 | 4812 | 12429 | 31573 | 130564 | 185049 |
| [11]TOTAL REJECTED | 224 | 206 | 527 | 928 | 2039 | 6026 | 9950 |
| [12]TOTAL ACCEPTED | 2226 | 3015 | 4285 | 11501 | 29534 | 124538 | 175099 |
| [13]TOTAL STORED | 2226 | 3015 | 4284 | 11492 | 29533 | 124538 | 175088 |
| [14]TOTAL MODEL STORED | 608 | 721 | 1116 | 2797 | 7462 | 29413 | 42117 |
| [15]TOTAL DELE ACPTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| [16]TOTAL DELE RJCTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

**FIELD DESCRIPTIONS ON NEXT PAGE**

**Figure 9J – RAPS Monthly Plan Activity Report Layout (continued)**

| Field No. | Field Name | Field Description |
|---|---|---|
| 1 | Report Name | Name of the report as it appears in submitter's mailbox. |
| 2 | Report Full Name | Full name of the report. |
| 3 | Page Number | Page number of the report. Six months arrayed per page. |
| 4 | Report Run Date | Date CMS generated the report. |
| 5 | Service Year | The year of the service through date. |
| 6 | Submitter ID | Report is grouped by submitter identification number. A submitter may submit for more than one organization (H number). |
| 7 | Report Year and Date | Month and year of the submission. |
| 8 | Plan Number | H number assigned by CMS; a different report is printed for each organization (H number). |
| 9 | Month | The month of the service through date. |
| 10 | Total Submitted | The total number of clusters submitted during the report period by the M+C organization. |
| 11 | Total Rejected | The total number of clusters submitted during the report period by the M+C organization rejected due to errors. |
| 12 | Total Accepted | The total number of clusters submitted during the report period by the M+C organization accepted without errors. |
| 13 | Total Stored | The total number of clusters submitted by the M+C organization and accepted by RAPS during the report period, and stored in the database (does not include duplicates if identical clusters already stored in the database). |
| 14 | Total Model Stored | The total number of ***relevant*** diagnosis clusters submitted by the M+C organization and accepted by RAPS during the report period, and stored in the database. |
| 15 | Total Deletes Accepted | The total number of deleted clusters submitted by the M+C organization during the report period that were accepted with no errors. |
| 16 | Total Deletes Rejected | The total number of deleted clusters submitted by the M+C organization during the report period that were rejected with errors. |

**Example: 6**

An organization's management can determine how effectively it has submitted data by reviewing the number of clusters submitted and stored on a monthly basis. Figure 9K illustrates that the submissions for service year 2004 are going relatively well. There is approximately three percent error rate during this period. Error rate is calculated by taking the total rejected over the total submitted; for example, 2004 principal inpatient has 26 rejected out of 818 submitted, a three percent error rate. There is very little lag between the date of the visit or stay, and the date that the data describing that visit/stay was collected and submitted. For every inpatient principal diagnosis, there appears to be four secondary diagnoses, which is appropriate. There seems to be a screening process in place to prevent high number of duplicate clusters being submitted.

An area of concern may be the number of physician services compared to the national benchmark. For April 2004, physician service represented six percent of the clusters submitted instead of the 75.7 percent included as a benchmark. However, the national average for hospital inpatient is 6.1 percent and they are operating at 69 percent. This may be explainable on the monthly report if the organization simply submitted its physician data before April 1 or after April 30, i.e., the organization is submitting sufficient data, but did not send any physician data in April. But if the organization was trying to submit physician

data on an ongoing basis, these totals indicate a potential problem. Management should compare the data it submitted to the organization's enrollment to determine where the problem lies; e.g., the incorrect provider type is being submitted in the cluster or it has failed to collect or submit all of the physician data.

During the month of April, there was a group of clusters submitted for services performed in September 2003. One explanation for this could be a difficulty collecting from one particular provider. The error rate for that data was 81 percent. Management should consider identifying the source of that data and offering outreach or training to prevent this problem from occurring in the future.

## Figure 9K – RAPS Monthly Plan Activity Report

REPORT: RAPS0010 — CMS RAPS ADMINISTRATION — PAGE: 2
RUN DATE: 20040402 — RAPS MONTHLY PLAN ACTIVITY REPORT — SERVICE YEAR: 2003

SUBMITTER ID: SH7777 — FOR THE MONTH OF MARCH, 2004
PLAN NO: H7777

| PROVIDER TYPE/TOTALS | JULY | AUGUST | SEPTEMBER | OCTOBER | NOVEMBER | DECEMBER | TOTAL |
|---|---|---|---|---|---|---|---|
| PRINCIPAL INPATIENT | | | | | | | |
| TOTAL SUBMITTED | 20915 | 17891 | 1739 | 1365 | 1721 | 2837 | 46468 |
| TOTAL REJECTED | 209 | 93 | 33 | 27 | 35 | 55 | 452 |
| TOTAL ACCEPTED | 20706 | 17798 | 1706 | 1338 | 1686 | 2782 | 46016 |
| TOTAL STORED | 20706 | 17798 | 1706 | 1338 | 1686 | 2782 | 46016 |
| TOTAL MODEL STORED | 17186 | 14772 | 599 | 455 | 573 | 946 | 34531 |
| TOTAL DELE ACPTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL DELE RJCTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| OTHER INPATIENT | | | | | | | |
| TOTAL SUBMITTED | 69458 | 47939 | 19020 | 14618 | 14264 | 20945 | 186244 |
| TOTAL REJECTED | 695 | 240 | 381 | 293 | 274 | 419 | 2302 |
| TOTAL ACCEPTED | 68763 | 47699 | 18639 | 14325 | 13990 | 20526 | 183942 |
| TOTAL STORED | 68763 | 47699 | 18639 | 14325 | 13990 | 20526 | 183942 |
| TOTAL MODEL STORED | 57073 | 39114 | 5965 | 4584 | 4285 | 6568 | 117589 |
| TOTAL DELE ACPTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL DELE RJCTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| OUTPATIENT | | | | | | | |
| TOTAL SUBMITTED | 60838 | 59543 | 11621 | 21381 | 23879 | 47758 | 225020 |
| TOTAL REJECTED | 61 | 30 | 175 | 321 | 359 | 717 | 1663 |
| TOTAL ACCEPTED | 60777 | 59513 | 11446 | 21060 | 23520 | 47041 | 223357 |
| TOTAL STORED | 60777 | 59513 | 11446 | 21060 | 23520 | 47041 | 223357 |
| TOTAL MODEL STORED | 50445 | 48801 | 3892 | 7161 | 7997 | 15994 | 134290 |
| TOTAL DELE ACPTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL DELE RJCTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| PHYSICIAN | | | | | | | |
| TOTAL SUBMITTED | 172301 | 101277 | 179713 | 173688 | 214495 | 129995 | 971469 |
| TOTAL REJECTED | 1723 | 1013 | 3595 | 3474 | 4290 | 2600 | 16695 |
| TOTAL ACCEPTED | 170578 | 100264 | 176118 | 170214 | 210205 | 127395 | 954774 |
| TOTAL STORED | 170578 | 100264 | 176118 | 170214 | 210205 | 127395 | 954774 |
| TOTAL MODEL STORED | 141580 | 83219 | 61642 | 59575 | 73572 | 44589 | 464177 |
| TOTAL DELE ACPTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL DELE RJCTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

## Figure 9K – RAPS Monthly Plan Activity Report (continued)

REPORT: RAPS0010 — CMS RAPS ADMINISTRATION — PAGE: 1
RUN DATE: 20040402 — RAPS MONTHLY PLAN ACTIVITY REPORT — SERVICE YEAR: 2004

SUBMITTER ID: SH7777
PLAN NO: H7777

FOR THE MONTH OF MARCH, 2004

| PROVIDER TYPE/TOTALS | JANUARY | FEBRUARY | MARCH | APRIL | MAY | JUNE | TOTAL |
|---|---|---|---|---|---|---|---|
| PRINCIPAL INPATIENT | | | | | | | |
| TOTAL SUBMITTED | 1297 | 1301 | 293 | 0 | 0 | 0 | 2891 |
| TOTAL REJECTED | 26 | 26 | 0 | 0 | 0 | 0 | 52 |
| TOTAL ACCEPTED | 1261 | 1275 | 288 | 0 | 0 | 0 | 2824 |
| TOTAL STORED | 1235 | 1269 | 283 | 0 | 0 | 0 | 2787 |
| TOTAL MODEL STORED | 432 | 444 | 99 | 0 | 0 | 0 | 975 |
| TOTAL DELE ACPTD | 10 | 0 | 5 | 0 | 0 | 0 | 15 |
| TOTAL DELE RJCTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| OTHER INPATIENT | | | | | | | |
| TOTAL SUBMITTED | 8431 | 13489 | 411 | 0 | 0 | 0 | 22331 |
| TOTAL REJECTED | 169 | 270 | 3 | 0 | 0 | 0 | 442 |
| TOTAL ACCEPTED | 8262 | 13219 | 405 | 0 | 0 | 0 | 21886 |
| TOTAL STORED | 8261 | 13216 | 404 | 0 | 0 | 0 | 21881 |
| TOTAL MODEL STORED | 2891 | 4625 | 141 | 0 | 0 | 0 | 7657 |
| TOTAL DELE ACPTD | 0 | 0 | 1 | 0 | 0 | 0 | 1 |
| TOTAL DELE RJCTD | 0 | 0 | 2 | 0 | 0 | 0 | 2 |
| OUTPATIENT | | | | | | | |
| TOTAL SUBMITTED | 23415 | 17342 | 84 | 0 | 0 | 0 | 40841 |
| TOTAL REJECTED | 351 | 260 | 3 | 0 | 0 | 0 | 614 |
| TOTAL ACCEPTED | 23064 | 17081 | 81 | 0 | 0 | 0 | 40226 |
| TOTAL STORED | 20989 | 15199 | 77 | 0 | 0 | 0 | 36265 |
| TOTAL MODEL STORED | 7346 | 5320 | 27 | 0 | 0 | 0 | 12693 |
| TOTAL DELE ACPTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL DELE RJCTD | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| PHYSICIAN | | | | | | | |
| TOTAL SUBMITTED | 111207 | 189171 | 0 | 0 | 0 | 0 | 300378 |
| TOTAL REJECTED | 2224 | 3783 | 0 | 0 | 0 | 0 | 6007 |
| TOTAL ACCEPTED | 108983 | 185388 | 0 | 0 | 0 | 0 | 294371 |
| TOTAL STORED | 108978 | 164995 | 0 | 0 | 0 | 0 | 273973 |
| TOTAL MODEL STORED | 38142 | 57748 | 0 | 0 | 0 | 0 | 95890 |
| TOTAL DELE ACPTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL DELE RJCTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

## Figure 9K – RAPS Monthly Plan Activity Report (continued)

REPORT: RAPS0010 CMS RAPS ADMINISTRATION PAGE: 2
RUN DATE: 20040503 RAPS MONTHLY PLAN ACTIVITY REPORT SERVICE YEAR: 2003

SUBMITTER ID: SH7777 FOR THE MONTH OF APRIL, 2004
PLAN NO: H7777

| PROVIDER TYPE/TOTALS | JULY | AUGUST | SEPTEMBER | OCTOBER | NOVEMBER | DECEMBER | TOTAL |
|---|---|---|---|---|---|---|---|
| PRINCIPAL INPATIENT | | | | | | | |
| TOTAL SUBMITTED | 0 | 0 | 74 | 0 | 0 | 0 | 74 |
| TOTAL REJECTED | 0 | 0 | 60 | 0 | 0 | 0 | 60 |
| TOTAL ACCEPTED | 0 | 0 | 14 | 0 | 0 | 0 | 14 |
| TOTAL STORED | 0 | 0 | 14 | 0 | 0 | 0 | 14 |
| TOTAL MODEL STORED | 0 | 0 | 6 | 0 | 0 | 0 | 6 |
| TOTAL DELE ACPTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL DELE RJCTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| OTHER INPATIENT | | | | | | | |
| TOTAL SUBMITTED | 0 | 0 | 296 | 0 | 0 | 0 | 296 |
| TOTAL REJECTED | 0 | 0 | 280 | 0 | 0 | 0 | 280 |
| TOTAL ACCEPTED | 0 | 0 | 16 | 0 | 0 | 0 | 16 |
| TOTAL STORED | 0 | 0 | 7 | 0 | 0 | 0 | 7 |
| TOTAL MODEL STORED | 0 | 0 | 2 | 0 | 0 | 0 | 2 |
| TOTAL DELE ACPTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL DELE RJCTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| OUTPATIENT | | | | | | | |
| TOTAL SUBMITTED | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL REJECTED | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL ACCEPTED | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL STORED | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL MODEL STORED | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL DELE ACPTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL DELE RJCTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| PHYSICIAN | | | | | | | |
| TOTAL SUBMITTED | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL REJECTED | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL ACCEPTED | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL STORED | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL MODEL STORED | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL DELE ACPTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL DELE RJCTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

## Figure 9K – RAPS Monthly Plan Activity Report (continued)

REPORT: RAPS0010 — CMS RAPS ADMINISTRATION — PAGE: 1
RUN DATE: 20040503 — RAPS MONTHLY PLAN ACTIVITY REPORT — SERVICE YEAR: 2004

SUBMITTER ID: SH7777
PLAN NO: H7777

FOR THE MONTH OF APRIL, 2004

| PROVIDER TYPE/TOTALS | JANUARY | FEBRUARY | MARCH | APRIL | MAY | JUNE | TOTAL |
|---|---|---|---|---|---|---|---|
| PRINCIPAL INPATIENT | | | | | | | |
| TOTAL SUBMITTED | 100 | 435 | 200 | 89 | 0 | 0 | 824 |
| TOTAL REJECTED | 0 | 4 | 20 | 2 | 0 | 0 | 26 |
| TOTAL ACCEPTED | 100 | 429 | 180 | 87 | 0 | 0 | 796 |
| TOTAL STORED | 90 | 420 | 180 | 80 | 0 | 0 | 770 |
| TOTAL MODEL STORED | 30 | 152 | 52 | 26 | 0 | 0 | 260 |
| TOTAL DELE ACPTD | 0 | 2 | 0 | 0 | 0 | 0 | 2 |
| TOTAL DELE RJCTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| OTHER INPATIENT | | | | | | | |
| TOTAL SUBMITTED | 400 | 1740 | 696 | 348 | 0 | 0 | 3184 |
| TOTAL REJECTED | 12 | 52 | 21 | 10 | 0 | 0 | 95 |
| TOTAL ACCEPTED | 388 | 1688 | 666 | 338 | 0 | 0 | 3080 |
| TOTAL STORED | 386 | 1668 | 661 | 333 | 0 | 0 | 3048 |
| TOTAL MODEL STORED | 135 | 583 | 232 | 117 | 0 | 0 | 1067 |
| TOTAL DELE ACPTD | 0 | 0 | 2 | 0 | 0 | 0 | 2 |
| TOTAL DELE RJCTD | 0 | 0 | 7 | 0 | 0 | 0 | 7 |
| OUTPATIENT | | | | | | | |
| TOTAL SUBMITTED | 0 | 377 | 252 | 0 | 0 | 0 | 629 |
| TOTAL REJECTED | 0 | 10 | 8 | 0 | 0 | 0 | 18 |
| TOTAL ACCEPTED | 0 | 362 | 244 | 0 | 0 | 0 | 606 |
| TOTAL STORED | 0 | 350 | 231 | 0 | 0 | 0 | 581 |
| TOTAL MODEL STORED | 0 | 123 | 80 | 0 | 0 | 0 | 203 |
| TOTAL DELE ACPTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL DELE RJCTD | 0 | 5 | 0 | 0 | 0 | 0 | 5 |
| PHYSICIAN | | | | | | | |
| TOTAL SUBMITTED | 308 | 40 | 0 | 0 | 0 | 0 | 350 |
| TOTAL REJECTED | 9 | 4 | 0 | 0 | 0 | 0 | 13 |
| TOTAL ACCEPTED | 299 | 36 | 0 | 0 | 0 | 0 | 335 |
| TOTAL STORED | 284 | 36 | 0 | 0 | 0 | 0 | 320 |
| TOTAL MODEL STORED | 99 | 13 | 0 | 0 | 0 | 0 | 112 |
| TOTAL DELE ACPTD | 2 | 0 | 0 | 0 | 0 | 0 | 2 |
| TOTAL DELE RJCTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

## 9.6.2 RAPS Cumulative Plan Activity Report (Slide 24, 21)

The RAPS Cumulative Plan Activity Report provides a cumulative summary of the status of submissions. It allows submitters to compare their accepted diagnosis clusters to benchmarks. The report is arrayed by provider type and month (determined by through date of service), and reports information by submitter ID and H number. Figure 9L illustrates the report and its fields.

The Cumulative Plan Activity Report is delivered to users on the second business day of each month.

**Figure 9L – RAPS Cumulative Plan Activity Report Layout**

**[1]**RAPS0020 CMS RAPS ADMINISTRATION **[2]**PAGE: 2
**[3]**RUN REPORT: DATE: 20040503 **[4]**RAPS CUMULATIVE PLAN ACTIVITY REPORT **[5]**SERVICE YEAR: 2003

**[6]**SUBMITTER ID: SH7777 **[7]**FOR PERIOD ENDING April 30, 2004
**[8]**PLAN NO: H7777

| PROVIDER TYPE/TOTALS | **[9]**JULY | AUGUST | SEPTEMBER | OCTOBER | NOVEMBER | DECEMBER | TOTAL |
|---|---|---|---|---|---|---|---|
| PRINCIPAL INPATIENT | | | | | | | |
| **[10]**TOTAL SUBMITTED | 22 | 25 | 40 | 29 | 39 | 61 | 216 |
| **[11]**TOTAL REJECTED | 0 | 0 | 2 | 0 | 3 | 1 | 6 |
| **[12]**TOTAL ACCEPTED | 22 | 25 | 38 | 29 | 36 | 60 | 210 |
| **[13]**TOTAL STORED | 22 | 25 | 38 | 29 | 36 | 60 | 210 |
| **[14]**TOTAL MODEL STORED | 18 | 24 | 26 | 23 | 33 | 44 | 168 |
| **[15]**TOTAL DELE ACPTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **[16]**TOTAL DELE RJCTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| OTHER INPATIENT | | | | | | | |
| **[10]**TOTAL SUBMITTED | 56 | 92 | 157 | 108 | 99 | 178 | 690 |
| **[11]**TOTAL REJECTED | 0 | 0 | 8 | 0 | 15 | 4 | 27 |
| **[12]**TOTAL ACCEPTED | 56 | 92 | 149 | 108 | 84 | 174 | 663 |
| **[13]**TOTAL STORED | 56 | 92 | 149 | 108 | 84 | 174 | 663 |
| **[14]**TOTAL MODEL STORED | 29 | 67 | 66 | 58 | 51 | 104 | 375 |
| **[15]**TOTAL DELE ACPTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **[16]**TOTAL DELE RJCTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| OUTPATIENT | | | | | | | |
| **[10]**TOTAL SUBMITTED | 7 | 4 | 3 | 19 | 8 | 16 | 57 |
| **[11]**TOTAL REJECTED | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **[12]**TOTAL ACCEPTED | 7 | 4 | 3 | 19 | 8 | 16 | 57 |
| **[13]**TOTAL STORED | 7 | 4 | 3 | 19 | 8 | 16 | 57 |
| **[14]**TOTAL MODEL STORED | 7 | 4 | 3 | 19 | 8 | 16 | 57 |
| **[15]**TOTAL DELE ACPTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **[16]**TOTAL DELE RJCTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| PHYSICIAN | | | | | | | |
| **[10]**TOTAL SUBMITTED | 14 | 28 | 14 | 13 | 37 | 16 | 122 |
| **[11]**TOTAL REJECTED | 0 | 0 | 4 | 6 | 1 | 0 | 11 |
| **[12]**TOTAL ACCEPTED | 14 | 28 | 10 | 7 | 36 | 16 | 111 |
| **[13]**TOTAL STORED | 13 | 26 | 10 | 7 | 31 | 14 | 101 |
| **[14]**TOTAL MODEL STORED | 13 | 26 | 10 | 7 | 31 | 14 | 101 |
| **[15]**TOTAL DELE ACPTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **[16]**TOTAL DELE RJCTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

**FIELD DESCRIPTIONS ON NEXT PAGE**

**Figure 9L – RAPS Cumulative Plan Activity Report Layout (continued)**

| Field No. | Field Name | Field Description |
|---|---|---|
| 1 | Report Name | Name of the report as it appears in submitter's mailbox. |
| 2 | Report Full Name | Full name of the report. |
| 3 | Page Number | Page number of the report. Six months arrayed per page. |
| 4 | Report Run Date | Date CMS generated the report. |
| 5 | Service Year | The year of the service through date. |
| 6 | Submitter ID | Report is grouped by submitter identification number. A submitter may submit for more than one organization (H-number). |
| 7 | Report Year and Date | Month and year of the submission. |
| 8 | Plan Number | H-number assigned by CMS; a different report is printed for each organization (H-number). |
| 9 | Month | The month of the service through date. |
| 10 | Total Submitted | The total number of clusters submitted during the report period by the M+C organization. |
| 11 | Total Rejected | The total number of clusters submitted during the report period by the M+C organization rejected due to errors. |
| 12 | Total Accepted | The total number of clusters submitted during the report period by the M+C organization accepted without errors. |
| 13 | Total Stored | The total number of clusters submitted by the M+C organization and accepted by RAPS during the report period, and stored in the database (does not include duplicates if identical clusters already stored in the database). |
| 14 | Total Model Stored | The total number of ***relevant*** diagnosis clusters submitted by the M+C organization and accepted by RAPS during the report period, and stored in the database. |
| 15 | Total Deletes Accepted | The total number of deleted clusters submitted by the M+C organization during the report period that were accepted with no errors. |
| 16 | Total Deletes Rejected | The total number of deleted clusters submitted by the M+C organization during the report period that were rejected with errors. |

A service year of 9999 on a Monthly or Cumulative Plan Activity Report indicates that the data submitted has not been appropriately stored and has been rejected. The RAPS Return File will list error codes 402 (invalid service through date on CCC record) and 403 (service through date must be greater than December 31, 2002). With each of these error codes, the system cannot recognize and properly file the rejected data since the dates of service are either outside of the reporting period or unrecognizable. Data that cannot be associated with one of the years on the Monthly and Cumulative Plan Activity Reports must be filed in the service year of 9999.

**Example: 7**

Using the RAPS Cumulative Plan Activity Report, the organization can effectively monitor the quantity of data submitted for each provider type. The report in Figure 9M reflects that the source of data is relatively consistent with the national benchmarks. The submission numbers are higher for previous months than the more current dates of service months, which indicate a lag between the dates of service provided, collected, and submitted. Comparing Figure 9K to this Cumulative Plan Activity Report, we can see that the April transaction accounted for very few of the January, February, and March numbers, which would indicate that there were collection and submission problems in the month of April. This can be explained by new staff, competing internal priorities, or system implications. Management should consider the root cause of this decline to prevent the occurrence of this in the future.

The third page of this report indicates that there were diagnosis clusters submitted where the service dates could not be identified. These are reported on the service year 9999.

## Figure 9M – RAPS Cumulative Plan Activity Report

RAPS0020 CMS RAPS ADMINISTRATION PAGE: 2
RUN REPORT: DATE: 20040503 RAPS CUMULATIVE PLAN ACTIVITY REPORT SERVICE YEAR: 2003

SUBMITTER ID: SH7777 FOR PERIOD ENDING APRIL 30, 2004
PLAN NO: H7777

| PROVIDER TYPE/TOTALS | JULY | AUGUST | SEPTEMBER | OCTOBER | NOVEMBER | DECEMBER | TOTAL |
|---|---|---|---|---|---|---|---|
| PRINCIPAL INPATIENT | | | | | | | |
| TOTAL SUBMITTED | 62747 | 53673 | 5389 | 4096 | 5162 | 8517 | 139584 |
| TOTAL REJECTED | 627 | 278 | 108 | 82 | 103 | 170 | 1368 |
| TOTAL ACCEPTED | 62120 | 53395 | 5281 | 4014 | 5059 | 8347 | 138216 |
| TOTAL STORED | 62120 | 53395 | 5281 | 4014 | 5059 | 8347 | 138216 |
| TOTAL MODEL STORED | 51560 | 44316 | 1796 | 1365 | 1720 | 2838 | 103595 |
| TOTAL DELE ACPTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL DELE RJCTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| OTHER INPATIENT | | | | | | | |
| TOTAL SUBMITTED | 208372 | 143816 | 57058 | 43852 | 40989 | 62833 | 556920 |
| TOTAL REJECTED | 2084 | 719 | 1141 | 877 | 820 | 1257 | 6898 |
| TOTAL ACCEPTED | 206288 | 143097 | 55917 | 42975 | 40169 | 61576 | 550022 |
| TOTAL STORED | 206288 | 143097 | 55917 | 42975 | 40169 | 61576 | 550022 |
| TOTAL MODEL STORED | 171219 | 117340 | 17893 | 13752 | 12854 | 19704 | 352762 |
| TOTAL DELE ACPTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL DELE RJCTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| OUTPATIENT | | | | | | | |
| TOTAL SUBMITTED | 182512 | 178628 | 34860 | 64142 | 71635 | 143270 | 675047 |
| TOTAL REJECTED | 183 | 89 | 523 | 962 | 1075 | 2149 | 4981 |
| TOTAL ACCEPTED | 182329 | 178539 | 34337 | 63180 | 70560 | 141121 | 670066 |
| TOTAL STORED | 182329 | 178539 | 34337 | 63180 | 70560 | 141121 | 670066 |
| TOTAL MODEL STORED | 151333 | 146402 | 11675 | 21481 | 23990 | 47981 | 402862 |
| TOTAL DELE ACPTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL DELE RJCTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| PHYSICIAN | | | | | | | |
| TOTAL SUBMITTED | 516903 | 303829 | 539136 | 521062 | 643485 | 389984 | 2914399 |
| TOTAL REJECTED | 5169 | 3038 | 10783 | 10421 | 12870 | 7799 | 50080 |
| TOTAL ACCEPTED | 511734 | 300791 | 528353 | 510641 | 630615 | 382185 | 2864319 |
| TOTAL STORED | 511734 | 300791 | 528353 | 510641 | 630615 | 382185 | 2864319 |
| TOTAL MODEL STORED | 424739 | 249657 | 184924 | 178724 | 220715 | 133765 | 1392524 |
| TOTAL DELE ACPTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL DELE RJCTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

## Figure 9M – RAPS Cumulative Plan Activity Report (continued)

REPORT: RAPS0020 — CMS RAPS ADMINISTRATION — PAGE: 1
RUN DATE: 20040503 — RAPS CUMULATIVE PLAN ACTIVITY REPORT — SERVICE YEAR: 2004

SUBMITTER ID: SH7777
PLAN NO: H7777

FOR PERIOD ENDING APRIL 30, 2004

| PROVIDER TYPE/TOTALS | JANUARY | FEBRUARY | MARCH | APRIL | MAY | JUNE | TOTAL |
|---|---|---|---|---|---|---|---|
| PRINCIPAL INPATIENT | | | | | | | |
| TOTAL SUBMITTED | 3891 | 3905 | 879 | 91 | 0 | 0 | 8766 |
| TOTAL REJECTED | 77 | 78 | 2 | 2 | 0 | 0 | 159 |
| TOTAL ACCEPTED | 3784 | 3825 | 863 | 89 | 0 | 0 | 8561 |
| TOTAL STORED | 3704 | 3808 | 849 | 80 | 0 | 0 | 8441 |
| TOTAL MODEL STORED | 1296 | 1333 | 297 | 26 | 0 | 0 | 2952 |
| TOTAL DELE ACPTD | 30 | 2 | 14 | 0 | 0 | 0 | 46 |
| TOTAL DELE RJCTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| OTHER INPATIEN | | | | | | | |
| TOTAL SUBMITTED | 25292 | 40467 | 1234 | 348 | 0 | 0 | 67341 |
| TOTAL REJECTED | 506 | 809 | 9 | 10 | 0 | 0 | 1334 |
| TOTAL ACCEPTED | 24786 | 39658 | 1216 | 338 | 0 | 0 | 65998 |
| TOTAL STORED | 24784 | 39648 | 1211 | 333 | 0 | 0 | 65976 |
| TOTAL MODEL STORED | 8674 | 13876 | 423 | 117 | 0 | 0 | 23090 |
| TOTAL DELE ACPTD | 0 | 0 | 2 | 0 | 0 | 0 | 2 |
| TOTAL DELE RJCTD | 0 | 0 | 7 | 0 | 0 | 0 | 7 |
| OUTPATIENT | | | | | | | |
| TOTAL SUBMITTED | 70246 | 52027 | 252 | 0 | 0 | 0 | 122525 |
| TOTAL REJECTED | 1053 | 780 | 8 | 0 | 0 | 0 | 1841 |
| TOTAL ACCEPTED | 69193 | 51242 | 244 | 0 | 0 | 0 | 120679 |
| TOTAL STORED | 62966 | 45598 | 231 | 0 | 0 | 0 | 108795 |
| TOTAL MODEL STORED | 22038 | 15959 | 80 | 0 | 0 | 0 | 38077 |
| TOTAL DELE ACPTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL DELE RJCTD | 0 | 5 | 0 | 0 | 0 | 0 | 5 |
| PHYSICIAN | | | | | | | |
| TOTAL SUBMITTED | 333621 | 567512 | 0 | 0 | 0 | 0 | 901133 |
| TOTAL REJECTED | 6672 | 11350 | 0 | 0 | 0 | 0 | 18022 |
| TOTAL ACCEPTED | 326949 | 556162 | 0 | 0 | 0 | 0 | 883111 |
| TOTAL STORED | 326934 | 494984 | 0 | 0 | 0 | 0 | 821918 |
| TOTAL MODEL STORED | 114426 | 173244 | 0 | 0 | 0 | 0 | 287670 |
| TOTAL DELE ACPTD | 2 | 0 | 0 | 0 | 0 | 0 | 2 |
| TOTAL DELE RJCTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

## Figure 9M – RAPS Cumulative Plan Activity Report (continued)

REPORT: RAPS0020 CMS RAPS ADMINISTRATION PAGE: 1
RUN DATE: 20040503 RAPS CUMULATIVE PLAN ACTIVITY REPORT SERVICE YEAR: 9999

SUBMITTER ID: SH7777 FOR PERIOD ENDING APRIL 30, 2004
PLAN NO: H7777

| PROVIDER TYPE/TOTALS | JANUARY | FEBRUARY | MARCH | APRIL | MAY | JUNE | TOTAL |
|---|---|---|---|---|---|---|---|
| PRINCIPAL INPATIENT | | | | | | | |
| TOTAL SUBMITTED | 25 | 0 | 0 | 0 | 0 | 0 | 25 |
| TOTAL REJECTED | 25 | 0 | 0 | 0 | 0 | 0 | 25 |
| TOTAL ACCEPTED | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL STORED | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL MODEL STORED | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL DELE ACPTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL DELE RJCTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| OTHER INPATIENT | | | | | | | |
| TOTAL SUBMITTED | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL REJECTED | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL ACCEPTED | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL STORED | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL MODEL STORED | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL DELE ACPTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL DELE RJCTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| OUTPATIENT | | | | | | | |
| TOTAL SUBMITTED | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL REJECTED | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL ACCEPTED | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL STORED | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL MODEL STORED | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL DELE ACPTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL DELE RJCTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| PHYSICIAN | | | | | | | |
| TOTAL SUBMITTED | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL REJECTED | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL ACCEPTED | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL STORED | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL MODEL STORED | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL DELE ACPTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL DELE RJCTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

### 9.6.3 Correcting Rejected Data (Slide 26)

When submitters correct data that originally received errors in RAPS, the originally rejected data is still reflected on the cumulative totals for the appropriate month, and in the number of total rejections. After a diagnosis cluster is counted as stored, it remains part of the stored count on the RAPS Cumulative Plan Activity Report even if it is later deleted. When submitters delete a cluster, the number is included in the total stored as well as the total deleted.

**Example: 8**

The April RAPS Cumulative Plan Activity Report (Figure 9M) displays a high reject rate in the data submitted with dates of service July – September (page 1 of the report). The report shows that the plan corrected the previously submitted errors and began submitting data more accurately. The April Cumulative Report reflects that the rate of rejection (Total Rejected) remained high for July – September, but decreased for October – December.

## 9.7 Analysis of Reports

When analyzing the monthly RAPS management reports, CMS urges M+C organizations to consider the following questions:

- "Is my organization collecting enough data from physicians and providers?"
- "Is my organization collecting the correct data from physicians and providers?"
- "Are external issues affecting data collection?"
- "Is my organization meeting data collection benchmarks?"
- "Are internal processes supporting data submissions?"

Each question is discussed below.

### 9.7.1 Collecting Sufficient Data

The Monthly Plan Activity Report is a good place to start the analysis. Because this report provides a summary of the status of data submitted for each month, it allows organizations to check, on a monthly basis, the number of diagnosis clusters submitted overall, the number of clusters submitted by data source (hospital inpatient, hospital outpatient, and physician), and the status of those clusters.

Reading the report from left to right, the report identifies the number of clusters submitted in the reporting month in (April 2004 in Figure 9M) for every month in the data collection period.

**Example: 9**

Figure 9N on the next page illustrates a Cumulative Plan Activity Report for April 2004. It reports the number of diagnoses submitted from July 2003 through March 2004. Analysis of this report might begin with a review of the number of clusters submitted by provider (source) type. This plan is doing well because it is submitting the vast majority of its hospital inpatient data for service through dates within 90 days of the report date. If the organization is submitting data at about the same pace it is receiving it, then the number of clusters seems appropriate, at least for hospital inpatient.

CMS recommends M+C organizations collect data from providers and physicians within 90 days of the Service Through Date. Consistent collection lags of more than 90 days could cause problems in submitting data in a timely manner at the end of the collection period.

The average rate of rejected data is below one percent for organizations. The plan in this example has an April rejected rate for hospital inpatient services at about nine percent. If the other provider type information reflects a similar rate of rejected data, it is higher than it should be.

**Figure 9N – Analysis of Cumulative Plan Activity Report**

```
REPORT:   RAPS0010                        CMS RAPS ADMINISTRATION                          PAGE:     1
RUN DATE: 20040501                  RAPS CUMULATIVE PLAN ACTIVITY REPORT          SERVICE YEAR: 2003

SUBMITTER ID:       SH8888                  FOR THE MONTH OF APRIL, 2004
PLAN NO:            H8888
PROVIDER TYPE/TOTALS       JULY      AUGUST   SEPTEMBER     OCTOBER    NOVEMBER    DECEMBER       TOTAL
PRINCIPAL INPATIENT
   TOTAL SUBMITTED           12          30          21          43          58         101         265
   TOTAL REJECTED             5           3           4           5           2           8          27
   TOTAL ACCEPTED             7          27          17          38          56          93         238
```

```
REPORT:   RAPS0010                        CMS RAPS ADMINISTRATION                          PAGE:     2
RUN DATE: 20040501                  RAPS CUMULATIVE PLAN ACTIVITY REPORT          SERVICE YEAR: 2004

SUBMITTER ID:       SH8                     FOR THE MONTH OF APRIL, 2004
PLAN NO:            H88

PROVIDER TYPE/TOTALS     JANUARY     FEBUARY       MARCH       APRIL         MAY        JUNE        AL
PRINCIPAL INPATIENT
   TOTAL SUBMITTED          1940        1944         643          50           0           0       4577
   TOTAL REJECTED            158         203          54           5           0           0        415
   TOTAL ACCEPTED           1782        1741         589          45           0           0       4157
```

Data collection "lag" is 90 days.

High rate of rejected data.

On the Cumulative Report, M+C organizations should review the data across the collection period, ensuring that the number of data for each month is consistent. Low submission months or significant spikes in the data submitted for a month could indicate a problem in either data collection from providers and physicians, or issues related to data submission. Generally, each quarter of data should reflect about 25 percent of the expected data for the collection period.

## 9.7.2 External Issues Affecting Data Collection

When reviewing the management reports, M+C organizations should consider external issues that may affect data collection. The Cumulative Report is a good place to start analysis because it gauges the number of data collected and submitted over the course of the collection year. For an organization just starting operations during the collection year, a steady increase in data submissions from month to month is common. However, an M+C organization that has a relatively stable population should have consistent numbers from month to month. Significant fluctuations from month to month may be cause for investigation.

The risk adjustment rules require that M+C organizations submit approximately 25 percent of the data they expect to submit for the year by each provider type (source). Meeting or exceeding this standard

(e.g., submitting monthly or weekly) helps organizations avoid "playing catch up" at the end of the collection year and help ensure accurate risk adjustment calculation. If data is not being submitted in a timely and consistent manner, there may be a data collection issue. Provider education may be necessary to remedy the problem. Also, check to ensure that third party billers used by providers (especially large volume providers) are current on risk adjustment procedures and the importance of timely filing.

## 9.8 Diagnosis Cluster Benchmarks

The estimated benchmarks in Table 9D are based on Medicare fee-for-service claims data. Your specific experience may vary significantly based on a number of factors.

- Health status of beneficiaries varies among counties and among health plans within counties.
- Health plans may use different collection and/or submission rules for different provider types or provider networks.
- Patterns of care and utilization of each of the provider types may vary between fee-for-service and M+C, as well as among various M+C organizations.

**TABLE 9D - MEDICARE FEE-FOR-SERVICE ESTIMATED BENCHMARKS**

| PROVIDER TYPE | TOTAL DIAGNOSES | | MODEL DIAGNOSES | | UNIQUE MODEL DX | |
|---|---|---|---|---|---|---|
| | NUMBER | PERCENT | NUMBER | PERCENT | NUMBER | PERCENT |
| PHYSICIAN | 25 | 75.7% | 6 | 74.1% | 2.2 | 66.7% |
| HOSPITAL OUTPATIENT | 6 | 18.2% | 1.3 | 16.0% | 0.4 | 12.1% |
| HOSPITAL INPATIENT | 2 | 6.1% | 0.8 | 9.9% | 0.7 | 21.2% |
| TOTAL | 33 | 100.0% | 8.1 | 100.0% | 3.3* | 100.0% |

*Unique diagnoses were not unduplicated across provider types.

### 9.8.1 Benchmark Analysis (Slide 25, 23)

The majority of the diagnoses come from the physician office setting, but many of these diagnoses are not in the model. Only one in four physician diagnoses is part of the CMS-HCC model. By comparison, nearly half of the inpatient diagnoses are part of the model. Also, a much higher percentage of model diagnoses are unique in the inpatient hospital setting as compared with the physician office.

CMS estimates that the diagnoses from the physician setting are the result of approximately 12-14 physician office visits per beneficiary. The inpatient diagnoses result from approximately 0.35 discharges per beneficiary. Therefore, when viewed in terms of visits, one hospital stay results in two unique model diagnoses, while 20 physician office visits result in 2.2 unique diagnoses. Clearly, it is most critical that plans capture every inpatient stay and submit the diagnoses from each stay. By contrast, missing one physician office visit is unlikely to have a major, if any, impact on risk adjustment.

Physician data produces the highest number of diagnosis clusters on reports because beneficiaries are more likely to obtain health services from a physician than seek treatment from an outpatient facility or through an inpatient admission.

### 9.8.2 Utilizing the Benchmarks

To utilize the benchmarks, M+C organizations first must analyze how they submit data, e.g., all diagnoses, or only those diagnoses that are in the model. Knowing the submission criteria will steer the submitter to the appropriate column in Table 9D. When using the fee-for-service benchmarks, M+C organizations should also consider comparative utilization of services (e.g., does an organization use more ambulatory surgical centers than hospital outpatient services) and comparative health status of the counties in the organization's service area.

The simplest way to utilize the benchmarks is to compare the ratios of the various provider types. Regardless of utilization patterns and submission criteria, the majority of all diagnoses will come from physician data.

## 9.9 Internal Processes Supporting Data Submissions

The RAPS management reports can help M+C organizations identify internal processes negatively affecting data collection and submission. Organizations should check to make certain that data, as it is collected, is properly translated for submission.

M+C organizations should take steps to ensure that they have, or have access to, the proper medical documentation to support diagnoses being submitted for risk adjustment. M+C organizations are responsible for the accuracy of the data they submit to CMS. Where necessary, they should obtain the proper documentation to support diagnoses and maintain an efficient system for tracking diagnoses back to medical records.

**Example: 10**

If the appropriate amount of data is collected from providers and physicians for a month or quarter, but only a fraction of the data are being submitted, there may be an overfiltering issue, i.e., the plan may be filtering out data that should be submitted. Also, the plan should check for higher than normal rejection rates, possibly indicating a problem with the data submission system (bad formatting, assigning the wrong HIC, etc.).

If an organization is submitting well above the benchmark levels, it should check to see if proper filtering is being performed before submission. Many plans collect data from provider types not covered by the risk adjustment instructions. Submitting data from these non-covered provider types violates the instructions and will probably cause the diagnostic-to-beneficiary ratios to be high.

## 9.10 Report Naming Conventions (Slide 28, 27)

Table 9E provides the naming conventions for reports placed in the submitter's mailbox.

**TABLE 9E – REPORT 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.RAPS_MONTHLY |
| RAPS Cumulative Plan Activity Report | RPT#####.RPT.RAPS_CUMULATIVE |

## 9.11 Plan Monitoring Process (Slide 29, 28)

The Plan Monitoring Process allows CMS to monitor M+C organization submission rates and ensure that they are submitting accurately and being paid appropriately. The process is designed to assist organizations and provide them with guidance to ensure they meet risk adjustment data collection and submission requirements. The process is administered as follows:

- CMS reviews monthly Cumulative Plan Activity Reports and compares them to submission benchmarks for each organization.
- CMS places organizations that do not meet benchmarks on a monitoring list (used at the CSSC to monitor submissions) and notifies the organizations by letter.
- CSSC contacts the identified organizations to address the problem, discuss specific issues, offer technical assistance, and develop an action plan.
- The CMS Compliance Division may contact M+C organizations that are not responsive to the risk adjustment team's assistance

# MODULE 10 – VERIFYING RISK SCORES

## Purpose (Slide 2)

The risk score calculation is based on data captured from a variety of systems. In order to ensure that accurate payments are made, Medicare+Choice (M+C) organizations may verify the components of the risk score calculation throughout the year. This module is designed to explain the systems involved in the risk score calculations and introduce M+C organizations to a variety of verification tools available to them.

## Learning Objectives (Slides 3-4)

At the completion of this module, participants will be able to:

- Understand the systems and processes used to calculate the risk scores.
- Determine how the organization can use risk adjustment processing and management reports to ensure the accuracy of payment.
- Identify the components and uses of the Monthly Membership Report (MMR) and Model Output Report (MOR)/Hierarchical Condition Category (HCC) Report.
- Interpret the HCC Submission Status Report.
- Understand how to interpret benchmarks.

**ICON KEY**

| | |
|---|---|
| Example |  |
| Reminder |  |
| Resource |  |
| Information Systems Track |  |
| Quality & Compliance Track |  |

## 10.1 Calculating Risk Scores (Slides 6-8)

The risk score used in calculating payments under the Centers for Medicare & Medicaid Services (CMS)-HCC model includes demographics as part of the risk model as well as different disease groups or HCCs. The risk score calculation gathers the critical data from a variety of systems, including risk adjustment data from the Risk Adjustment Processing System (RAPS) database, Fee-For-Service (FFS) information from the National Medicare Utilization Database (NMUD), and demographic data captured from the Medicare Beneficiary Database (MBD).

For January payment, CMS typically performs a data sweep after completing the nightly RAPS process on the last business day in September.

From October 1st – November 15th each year, CMS calculates the risk scores that are associated with the January risk adjustment payment. The risk score calculation considers the following:

- Demographics
- Disease groups
- Disease interactions
- Disabled indicators
- Disease hierarchies
- Residence in a long-term care institution
- End-Stage Renal Disease (ESRD) Status

**Note:** Plans can continue to submit 2004 payment data after the deadline. CMS does not guarantee successful processing of any data received after the initial deadline, but will do its best to process everything possible. All data from the data collection period that is stored in the RAPS database at the time of the sweep are used for risk adjustment calculation.

From November 15th until mid-December, the payment system [currently GHP, Medicare Managed Care System (MMCS) in the future] loads risk scores and calculates payment amounts.

Figure 10A illustrates the flow of data used to calculate the risk score.

**Figure 10A - Risk Score Calculation**

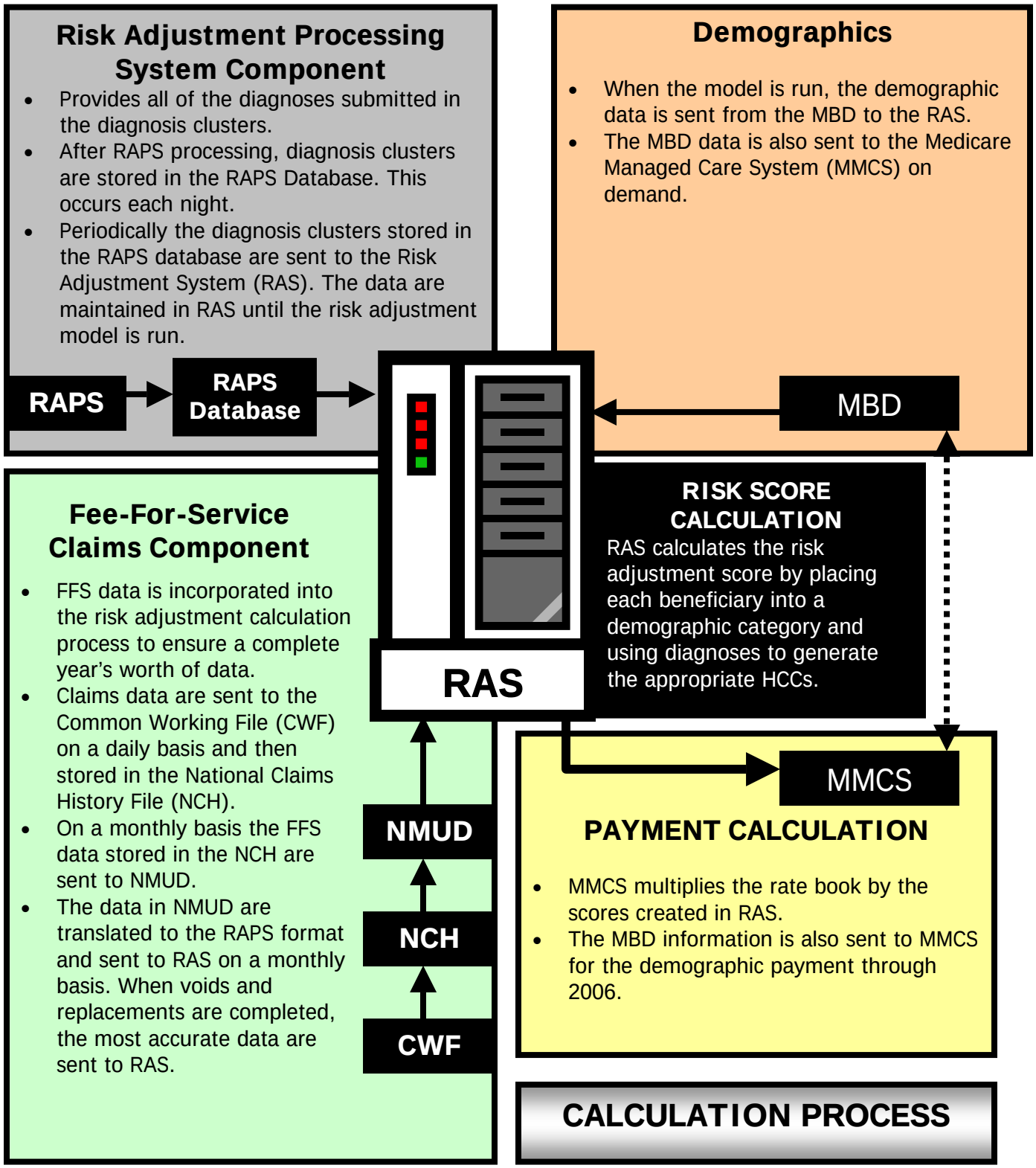


Table 10A describes the 8 steps in the risk score calculation.

**TABLE 10A - RISK SCORE CALCULATION STEPS**

| STEP | DESCRIPTION |
|---|---|
| **1 Define Cohort** | Each year CMS defines a cohort of beneficiaries for whom risk scores will be calculated and used for making payments beginning the following January. Typically, CMS calculates scores for all Medicare beneficiaries. |
| **2 Obtain Beneficiary Specific Information** | For this cohort, CMS obtains beneficiary specific information from Medicare's enrollment databases including the MBD. Beneficiary information includes the months of enrollment in Part A and Part B, age, sex, original reason for Medicare entitlement, etc. for each beneficiary in the cohort. Medicaid information is obtained from the third party payor file. Plan submitted Medicaid status information is also included. Beneficiaries with an ESRD flag are also identified. CMS ensures that all Health Insurance Claim (HIC) numbers associated with each individual in the file have been identified. CMS uses all of this information to create a beneficiary demographic input file. |
| **3 Extract Long-term Institutional Information from MDS** | Next, for this cohort, CMS extracts assessments from the Minimum Data Set (MDS). CMS identifies the beneficiaries who have resided in a long-term institution for the past 90 days or more and classifies these individuals as long-term institutional beneficiaries. CMS holds the long-term institutional file until the data reach the payment stage. |
| **4 Obtain Diagnosis Information** | Next, CMS obtains all diagnostic information from Medicare data files for the cohort. These data include all diagnoses for the data collection period for the three types of data sources: physician services, hospital outpatient, and hospital inpatient. These diagnoses come from the RAPS database as well as Medicare fee-for-service files. From these data, CMS creates a beneficiary diagnosis input file. |
| **5 Run the Model** | The beneficiary demographic and beneficiary diagnosis input files are used to run the CMS-HCC and ESRD models. The ESRD model is normally run only on those beneficiaries with ESRD flags from MBD. Each model determines a new enrollee factor for individuals who had less than 12 months of Part B enrollment during the data collection period. The model filters out diagnoses that do not correlate, such as ovarian cancer in a male patient. For individuals with 12 months of Part B enrollment, the software produces two risk scores: one based on the community model and one on the institutional model. In addition, for individuals with ESRD, the ESRD model will create additional risk scores appropriate to that model. The software also shows which HCC group (as well as which demographics, interactions, etc.) is associated with the risk scores. Only the most severe disease classification within a hierarchy is shown in the output. Based on this information, an output file is created and sent to the payment system. |

**TABLE 10A – RISK SCORE CALCULATION STEPS (CONTINUED)**

| STEP | DESCRIPTION |
|---|---|
| **6 Send Model Output to GHP** | The output from the CMS-HCC model is provided to the Group Health Plan payment system (GHP) for use in making payments to plans in January. GHP will be replaced with the MMCS in 2004. In addition, the model output serves as the basis for the MMR reports provided to plans and the risk adjustment MOR. |
| **7 Apply Additional Payment Factors** | Plan level instructions are also provided to the GHP for use in determining which factor, community or institutional, should be used in actually making payments. For example, one list informs the payment system of those plans that should receive a frailty adjuster. Another list includes plans that have a large percentage of institutionalized enrollees. For these plans, the payment system will use the MDS long-term institutionalized indicator for an individual to determine whether to use the community or institutional risk factor in making payments. |
| **8 Calculate Payment** | GHP identifies individuals enrolled in an organization for a particular month. Then it accesses the risk factor file to retrieve the appropriate risk factor for each individual. The GHP uses the individual's state and county code to determine the correct county capitation rate and then multiplies the risk factor by that rate. After calculating the correct demographic payment for the same individual, the GHP then calculates the correct payment by blending the appropriate proportion of risk and demographic payments. Then the demographic and risk adjusted amounts are totaled. |

**NOTE**: For mid-year and reconciliation factor calculations, the process is repeated, updating the data used for the model to include new diagnoses received for the data collection period, as well as changes in any of the demographic factors. During final reconciliation, long-term institutional status is determined for each month during the payment year, and ESRD status is reconciled to obtain the most precise month-by-month status.

## 10.2 Risk Score Verification Tools (Slide 9)

CMS offers a variety of tools that M+C organizations can use at various stages in the risk adjustment process to ensure that the risk score reported by CMS is in close alignment with the score that the organization expects to receive. This section of the training module describes each of the tools, identifies the method of access and timeframe, and provides information on how an organization can use the tool to eliminate unrealistic payment projections.

The verification tools include:

- RAPS Return File/RAPS Transaction Error Report
- RAPS Monthly and Cumulative Plan Activity Reports
- SAS CMS-HCC Model Program
- MMR
- MOR/HCC Report
- HCC Submission Status Report

**TABLE 10B – RISK SCORE VERIFICATION TOOLS**

| REPORT NAME | ACCESS | AVAILABLE |
|---|---|---|
| RAPS Return File/RAPS Transaction Error Report | RAPS Mailbox<br>RPT####.RPT.RAPS_RETURN_FLAT<br>RPT#####.RPT.RAPS_ERROR_RPT | Next business day following data submission |
| RAPS Monthly and Cumulative Plan Activity Reports | RAPS Mailbox<br>RPT####.RPT.RAPS_MONTHLY<br>RPT####.RPT.RAPS_CUMULATIVE | Second business day of the month |
| SAS CMS-HCC Model Program | http://cms.hhs.gov/healthplans/rates | June 2003 |
| MMR | GHP Group Output User Communication Help (GROUCH) System | Refer to MCCOY schedule |
| MOR/HCC Report | GROUCH System | Refer to MCCOY schedule |
| HCC Submission Status Report | Health Plan Management System (HPMS) | Quarterly |

## 10.2.1 RAPS Return File/RAPS Transaction Error Report (Slide 10)

The RAPS Return File contains all transactions submitted by the M+C organization. Any errors that were identified during the RAPS process will appear next to the field in which the error was found. This indicates that the diagnosis was not stored. The file is delivered in the same flat file format used for the RAPS input. Unique diagnosis clusters that are returned without an error are stored in the RAPS database at CMS. The diagnosis clusters that contain a relevant diagnosis code will be used to calculate risk adjustment factors when CMS runs the CMS-HCC model or ESRD model. Since this report is a flat file, M+C organizations may download the file into an Access or Excel database, and establish a record of each diagnosis that was stored in the CMS-HCC model for each enrollee. This file is also utilized in mainframe databases at larger organizations. The Return File is typically used by organizations that employ automated update processes for their databases.

The RAPS Transaction Error Report contains only those records that contain errors, causing one or more diagnosis clusters to be rejected. The RAPS Transaction Error Report is typically used by organizations that employ a non-automated update process when maintaining their diagnosis files. To use this report, an individual at the health plan normally downloads the report, prints it, and then manually updates their diagnosis records to indicate which diagnoses were rejected.

The database can also identify whether the diagnosis was already stored for the enrollee for that payment period.

M+C organizations must submit each relevant diagnosis at least once during a reporting period for each enrolled beneficiary.

**Example: 1**

The M+C organization received a RAPS Return File that included two records and one cluster within each record. Using the data communicated on the RAPS Return File, the organization captured information that could be used later to verify the risk score. The plan developed an internal database that captured each HIC number and each relevant diagnosis that is stored in the RAPS database for that beneficiary. Based on the RAPS Return File (see Figure 10B), the plan captured the 70710 (ulcer of the lower limb) and 311 (depression) diagnoses, since both were accepted to RAPS. **Note:** that although 311 is not a relevant diagnosis for the CMS-HCC model, CMS recommends that plans submitting all diagnoses maintain an accurate record of all data submitted and stored. Therefore, the plan should store a record of this diagnosis. The diagnosis included in CCC record 3 is a relevant diagnosis cluster, but was returned with an error, so the cluster was not stored in the RAPS database. Therefore, the plan's database will not capture this information. Figure 10C illustrates the database content based on the results of this RAPS Return File.

**Note:** Figure 10B is an abbreviated version of the RAPS Return file due to space limitations on the page.

**Figure 10B – RAPS Return File**

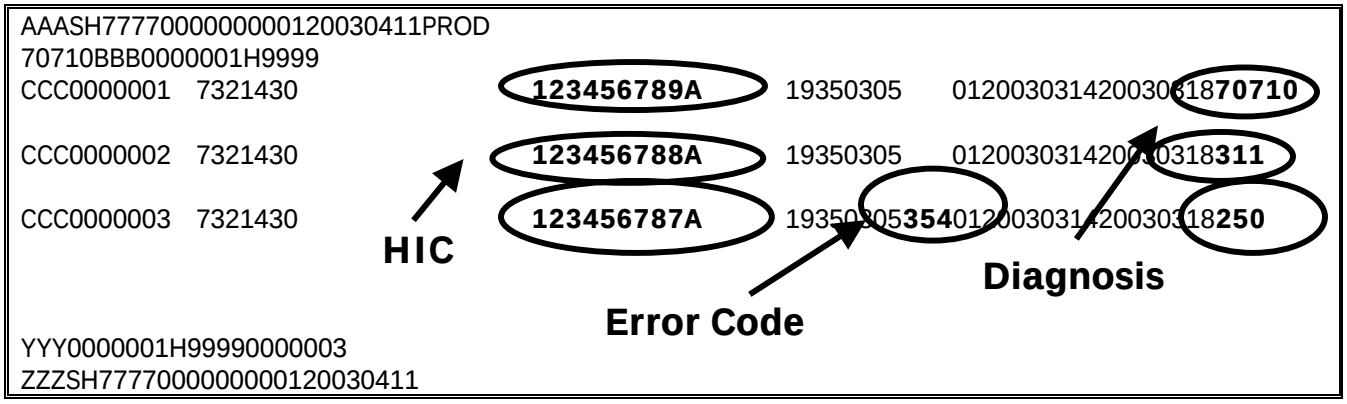



**Figure 10C – Internal Diagnosis Cluster Database**

| HIC | Dx | Date Submitted | Thru Date | Dx | Date Submitted | Thru Date | Dx | Date Submitted | Thru Date |
|---|---|---|---|---|---|---|---|---|---|
| 123456789A | 70710 | 20030411 | 20030318 | 311 | 20030411 | 20030318 | | | |

**Note:** The M+C organization may include other fields in the database for a variety of reasons, such as Patient Control Number (PCN), which can help the plan find the original source document for the diagnosis. This sample database includes only the minimal components required for verifying the accuracy of the number of clusters store for risk score calculation.

## 10.2.2 RAPS Management Reports (Slide 12)

The RAPS Monthly and Cumulative Plan Reports are available the second business day of the month. These reports assist in the confirmation of the total number of diagnoses stored in the CMS-HCC model.

The reports are delivered in report layout format. M+C organizations can compare their internal database developed from the RAPS Return File to the number of diagnoses stored on the report. The cumulative report reflects the total number of diagnoses stored to date for the H number. The database should reflect all diagnosis clusters stored for the health plan for the data collection period.

**Example: 2**

If the M+C organization stores all unique diagnosis clusters that are not returned on the RAPS Return File for each beneficiary, they would potentially have a database with information such as that included in Figure 10D. The total clusters stored in the organization's internal database should equal the total clusters stored on the Cumulative Plan Activity Report, Figure 10E.

**Figure 10D – Internal Diagnosis Cluster Database**

| HIC | Dx | Date Submitted | Thru Date | Dx | Date Submitted | Thru Date | Dx | Date Submitted | Thru Date |
|---|---|---|---|---|---|---|---|---|---|
| 123456789A | 70710 | 20040111 | 20031210 | 2910 | 20031015 | 20030910 | 7854 | 20031101 | 20031027 |
| 123456789B | 4254 | 20031010 | 20030917 | V4321 | 20031120 | 20031022 | | | |
| 123467892A | 1629 | 20031123 | 20031003 | 481 | 20031125 | 20031006 | 185 | 20031028 | 20030926 |
| 123456789D | 2880 | 20040130 | 20031202 | 71150 | 20031206 | 20031103 | 4280 | 20031006 | 20030901 |
| 123456788A | 4111 | 20031202 | 20031114 | 41091 | 20031201 | 20031107 | 41092 | 20031110 | 20031016 |
| 123456786A | 20198 | 20031121 | 20031008 | | | | | | |
| 123456788A | 20480 | 20040117 | 20031212 | 2639 | 20031002 | 20030904 | 1500 | 20031014 | 20030919 |
| 123456789A | 25001 | 20031027 | 20030912 | 29590 | 20031113 | 20031013 | | | |
| **Subtotal** | **8** | | | **7** | | | **5** | | |
| **Grand Total** | | | | | | | | | **20** |

**Note:** Figure 10D is an abbreviated version of the RAPS Return file due to space limitations on the page. The fields includes are the minimum required to verify risk scores.

## Figure 10E – RAPS Cumulative Plan Activity Report

RAPS0020 CMS RAPS ADMINISTRATION PAGE: 1
RUN REPORT: DATE: 20040503 RAPS CUMULATIVE PLAN ACTIVITY REPORT SERVICE YEAR: 2003

SUBMITTER ID: SH7777 FOR PERIOD ENDING January 30, 2004
PLAN NO: H7777

| PROVIDER TYPE/TOTALS | JULY | AUGUST | SEPTEMBER | OCTOBER | NOVEMBER | DECEMBER | TOTAL |
|---|---|---|---|---|---|---|---|
| PRINCIPAL INPATIENT | | | | | | | |
| TOTAL SUBMITTED | 22 | 35 | 29 | 19 | 27 | 25 | 157 |
| TOTAL REJECTED | 2 | 4 | 7 | 5 | 3 | 3 | 24 |
| TOTAL ACCEPTED | 20 | 31 | 22 | 14 | 24 | 22 | 133 |
| TOTAL STORED | 20 | 31 | 22 | 14 | 24 | 22 | 133 |
| TOTAL MODEL STORED | 0 | 0 | 2 | 2 | 2 | 2 | 8 |
| TOTAL DELE ACPTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL DELE RJCTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| OTHER INPATIENT | | | | | | | |
| TOTAL SUBMITTED | 64 | 83 | 51 | 48 | 40 | 60 | 346 |
| TOTAL REJECTED | 8 | 10 | 11 | 6 | 5 | 4 | 44 |
| TOTAL ACCEPTED | 56 | 73 | 40 | 42 | 35 | 56 | 302 |
| TOTAL STORED | 56 | 73 | 40 | 42 | 35 | 56 | 302 |
| TOTAL MODEL STORED | 0 | 0 | 0 | 1 | 0 | 0 | 1 |
| TOTAL DELE ACPTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL DELE RJCTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| OUTPATIENT | | | | | | | |
| TOTAL SUBMITTED | 98 | 87 | 43 | 37 | 44 | 76 | 385 |
| TOTAL REJECTED | 7 | 5 | 3 | 4 | 5 | 4 | 28 |
| TOTAL ACCEPTED | 91 | 82 | 40 | 33 | 39 | 72 | 357 |
| TOTAL STORED | 91 | 82 | 40 | 33 | 39 | 72 | 357 |
| TOTAL MODEL STORED | 0 | 0 | 3 | 3 | 1 | 0 | 7 |
| TOTAL DELE ACPTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL DELE RJCTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| PHYSICIAN | | | | | | | |
| TOTAL SUBMITTED | 99 | 77 | 92 | 90 | 97 | 79 | 534 |
| TOTAL REJECTED | 5 | 5 | 8 | 6 | 8 | 5 | 37 |
| TOTAL ACCEPTED | 94 | 72 | 84 | 84 | 89 | 74 | 497 |
| TOTAL STORED | 94 | 72 | 84 | 84 | 89 | 74 | 497 |
| TOTAL MODEL STORED | 0 | 0 | 2 | 1 | 0 | 1 | 4 |
| TOTAL DELE ACPTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL DELE RJCTD | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

### 10.2.3 CMS-HCC Risk Adjustment Model Software (Slides 14-15)

M+C organizations may access the CMS-HCC Risk Model software on http://cms.hhs.gov/healthplans/rates/. The software is a SAS program that allows the organization to verify and predict risk scores. Click on "hccsoftware.zip," open the zip file, and double click on "hccsoftdescription.rtf." CMS will publish the ESRD model on the web after publication of the final payment notice for 2005.

The software includes a HCCSOFT SAS program that uses several SAS Macros to create HCC score variables using coefficients from the following regression models:

- Community
- Institutional
- New enrollee

The HCCSOFT software supplies user parameters to the main SAS Macro program MACROSFT. This macro program takes user-provided files and assigns HCCs for each person. The program follows these major steps when calculating risk scores.

1. The program assigns each beneficiary to an appropriate age/sex grouping, and adds in the interactions for Medicaid, disabled, and previously disabled.
2. The program crosswalks diagnoses to Condition Categories using SAS formats which were previously stored in the FORMAT library.
3. The program then creates HCCs by imposing hierarchies on the Condition Categories.
4. The program creates the interactions.
5. The program computes predicted scores from 3 regression models.

**Note:** For beneficiaries without relevant diagnoses from RAPS or FFS claims data, zeros are assigned to all HCCs.

Table 10C lists the software-provided files.

**TABLE 10C – SOFTWARE-PROVIDED FILES**

| FILE NAME | DESCRIPTIONS |
|---|---|
| **HCCSOFT** | Main program that supplies user parameters to the main SAS macro program. |
| **MACROSFT** | Main macro that creates HCC and Score variables by calling other external macros |
| **MAGESEX** | Creates age/sex, originally disabled, disabled variables |
| **EDITICD** | Performs edits to ICD-9 code |
| **MLTCCDG** | Assigns ICD-9 diagnosis code to multiple CCs where required |
| **HCCLABL** | Assigns labels to HCCS |
| **MCMSHIER** | Sets HCC=0 according to hierarchies |
| **SCORECAL** | Calculates a score variable |
| **FMTCMSCC** | Format library that has a cross-walk from ICD-9-CM codes to CC categories that are transformed to HCC categories by the software. SAS transport files, which may be used on any platform running SAS |
| **HCC COEFN** | Coefficients for 3 regression models SAS transport files, which may be used on any platform running SAS |

Table 10D provides a list of user supplied files.

**TABLE 10D – USER SUPPLIED FILES**

| FILE NAME | DESCRIPTION |
|---|---|
| **Person File** | A person-level file of demographic and enrollment information |
| **Diagnosis File** | A diagnosis-level input file of diagnoses |

The complete instructions for using the Model software are included in the resource section.

### 10.2.4 Monthly Membership Report (Slide 16)

The MMR is created and posted monthly. It provides information to reconcile the Medicare membership and payment record to the records maintained by CMS. The report is available in two formats – detail and summary.

**Detail:** The first report contains a detailed list of beneficiaries for which a payment was made to the M+C organization for that month: either a monthly payment or an adjustment payment. This allows the M+C organization to compare its beneficiary records with those maintained by CMS.

**Summary:** The second format presents a summary of the payments and adjustments applicable to the M+C organization's Medicare membership. This format shows the total number of beneficiaries for whom a hospice, ESRD, or institutionalized payment was received.

The report is available in the GROUCH system and may be downloaded in report layout or flat file formats.

The MMR communicates information on a beneficiary level.

In June 2003, CMS modified the format of the MMR to support the 2004 risk adjustment process. The revised report incorporates the following:

- Multiple disease groupings; up to 64 are possible for a member.
- The previously disabled ratio reverts to a flag.
- There are Part A and B risk factors, as well as three possible factor types at the beneficiary level.
- A plan level frailty factor will be included in the risk adjustment factors for members of Program for All-Inclusive Care for the Elderly (PACE), Social Health Maintenance Organizations (SHMO), Minnesota Senior Health Options (MSHO), Minnesota Disability Health Option (MnDHO) Wisconsin Partnership Program (WPP), Evercare organizations.
- Lag factor identification.
- A field to support drug legislation.

Questions regarding accessing and understanding the MMR should be directed to the plan's regional contact in CMS Central Office. The complete list of names and numbers can be found in **Module 7, Table 7B.**

**Note:** Additional changes to the MMR may be made to support risk adjustment or other capitated payment changes for 2005.

Table 10E describes the MMR field ranges.

**TABLE 10E – SUMMARY OF MMR FIELD RANGES**

| FIELD RANGE | GENERAL DESCRIPTION OF FIELD RANGE |
|---|---|
| 1-3 | Plan Identification Information |
| 4-11 | Beneficiary Identification |
| 12-13 | Entitlement |
| 14-19 | Health Status |
| 20-37 | Risk Adjustment/Demographic Payment Adjustment Information |
| 38-49 | Additional Risk Adjustment Indicators |

**Example: 3**

The Suntrust Health Plan chief financial officer (CFO) decided to implement a process to predict the financial implication of risk adjustment. The CFO requested that the operation's group run the CMS-HCC model program on a quarterly basis. The second part of the process would require the operation's group to pull the demographic data from the MMR to verify the risk score.

Table 10F provides a detail of the file layout.

**TABLE 10F – MMR FLAT FILE LAYOUT**

| # | FIELD NAME | LEN | POS | DESCRIPTION |
|---|---|---|---|---|
| 1 | MCO Contract Number | 5 | 1-5 | MCO Contract Number |
| 2 | Run Date of the File | 8 | 6-13 | YYYYMMDD |
| 3 | Payment Date | 6 | 14-19 | YYYYMM |
| 4 | HIC Number | 12 | 20-31 | Member's HIC # |
| 5 | Surname | 7 | 32-38 | |
| 6 | First Initial | 1 | 39-39 | |
| 7 | Sex | 1 | 40-40 | M = Male, F = Female |
| 8 | Date of Birth | 8 | 41-48 | YYYYMMDD |
| 9 | Age Group | 4 | 49-52 | BBEE<br>BB = Beginning Age<br>EE = Ending Age |
| 10 | State & County Code | 5 | 53-57 | |
| 11 | Out of Area Indicator | 1 | 58-58 | Y = Out of Contract-level service area<br>Always Spaces on Adjustment |
| 12 | Part A Entitlement | 1 | 59-59 | Y = Entitled to Part A |
| 13 | Part B Entitlement | 1 | 60-60 | Y = Entitled to Part B |
| | Demographic Health Status Indicators: | | | |
| 14 | Hospice | 1 | 61-61 | Y = Hospice |
| 15 | ESRD | 1 | 62-62 | Y = ESRD |

**TABLE 10F – MMR FLAT FILE (CONTINUED)**

| # | FIELD NAME | LEN | POS | DESCRIPTION |
|---|---|---|---|---|
| 16 | Working Aged | 1 | 63-63 | Y = Working Aged |
| 17 | Institutional | 1 | 64-64 | Y = Institutional |
| 18 | NHC | 1 | 65-65 | Y = Nursing Home Certifiable |
| 19 | Medicaid | 1 | 66-66 | Y = Medicaid Status |
| | Risk Adjuster Indicators: | | | |
| 20 | FILLER | 1 | 67-67 | SPACES |
| 21 | Medicaid Indicator | 1 | 68-68 | Y = Medicaid Addon |
| *22 | PIP-DCG | 2 | 69-70 | PIP-DCG Category - **Only on pre-2004 adjustments** |
| ***23** | **Default Indicator** | **1** | **71-71** | Y = default RA factor in use<br>• For pre-2004 adjustments, a "Y" indicates that a new enrollee RA factor is in use<br>• For post-2003 payments and adjustments, a "Y" indicates that a default factor was generated by the system due to lack of a RA factor. |
| 24 | Risk Adjuster Factor A | 7 | 72-78 | NN.DDDD |
| 25 | Risk Adjuster Factor B | 7 | 79-85 | NN.DDDD |

**TABLE 10F – MMR FLAT FILE (CONTINUED)**

| # | FIELD NAME | LEN | POS | DESCRIPTION |
|---|---|---|---|---|
| | Fields 26 - 30 applicable to both Demographic and Risk Adjuster: | | | |
| 26 | Number of Paymt/Adjustmt Months Part A | 2 | 86-87 | 99 |
| 27 | Number of Paymt/Adjustmt Months Part B | 2 | 88-89 | 99 |
| 28 | Adjustment Reason Code | 2 | 90-91 | 99<br>Always Spaces on Payment |
| 29 | Paymt/Adjustmt Start Date | 8 | 92-99 | YYYYMMDD |
| 30 | Paymt/Adjustmt End Date | 8 | 100-107 | YYYYMMDD |
| 31 | Demographic Paymt/Adjustmt Rate A | 9 | 108-116 | -$$$$$.99 |
| 32 | Demographic Paymt/Adjustmt Rate B | 9 | 117-125 | -$$$$$.99 |
| 33 | Risk Adjuster Paymt/Adjustmt Rate A | 9 | 126-134 | -$$$$$.99 |
| 34 | Risk Adjuster Paymt/Adjustmt Rate B | 9 | 135-143 | -$$$$$.99 |
| 35 | Blended Paymt/Adjustmt Rate A | 9 | 144-152 | -$$$$$.99 |
| 36 | Blended Paymt/Adjustmt Rate B | 9 | 153-161 | -$$$$$.99 |
| 37 | Total Paymt/Adjustmt | 9 | 162-170 | -$$$$$.99 |

**TABLE 10F – MMR FLAT FILE (CONTINUED)**

| # | FIELD NAME | LEN | POS | DESCRIPTION |
|---|---|---|---|---|
| | Additional Risk Adjuster Indicators: | | | |
| *38 | FILLER | 1 | 171-171 | SPACES |
| 39 | Risk Adjuster Age Group (RAAG) | 4 | 172-175 | BBEE<br>BB = Beginning Age<br>EE = Ending Age |
| 40 | Previous Disabled Ratio (PRDIB) | 7 | 176-182 | NN.DDDD<br>Percentage of Year (in months) for Previous Disabled Add-On – **Only on pre-2004 adjustments** |
| 41 | FILLER | 1 | 183-183 | SPACES |
| 42 | FILLER | 1 | 184-184 | SPACES |
| 43 | Plan Benefit Package Id | 3 | 185-187 | Plan Benefit Package Id<br>FORMAT 999 |
| 44 | Race Code | 1 | 188-188 | Format X<br>Values:<br>0 = Unknown<br>1 = White<br>2 = Black<br>3 = Other<br>4 = Asian<br>5 = Hispanic<br>6 = N. American Native |

**TABLE 10F – MMR FLAT FILE (CONTINUED)**

| # | FIELD NAME | LEN | POS | DESCRIPTION |
|---|---|---|---|---|
| *45 | RA Factor Type Code | 2 | 189-190 | Type of factors in use (see Fields 24-25):<br>C = Community<br>CP = Community Post-Graft (ESRD)<br>D = Dialysis (ESRD)<br>E = New Enrollee<br>ED = New Enrollee Dialysis (ESRD)<br>EP = New Enrollee Post-Graft (ESRD)<br>G = Graft (ESRD)<br>I = Institutional<br>IP = Institutional Post-Graft (ESRD) |
| *46 | Frailty Indicator | 1 | 191-191 | Y = MCO-level Frailty Factor Included |
| *47 | Previously Disabled Indicator | 1 | 192-192 | Y = Previously Disabled – **Only on post-2003 payments/adjustments** |
| *48 | Lag Indicator | 1 | 193-193 | Y = Encounter data used to calculate RA factor lags payment year by 6 months |
| *49 | Future Flag Indicator | 1 | 194 | Member eligible for new provision |
| | FILLER | 6 | 195-200 | SPACES |

* Indicates fields added to support the CMS-HCC model.

The plans may access the MMR Report format. Figure 10F illustrates an example of the MMR.

**Figure 10F –MMR REPORT FORMAT**

```
RUN DATE:20040419                          MONTHLY MEMBERSHIP REPORT                                                    PAGE:        9
PAYMENT MONTH:200312                    PLAN: H7777 SUNTRUST HEALTH PLAN

                                                                                                  PAYMENT DATE       BLENDED PAYMENT
                                AGE  STATE O  P P          M  F P A D MTHS                        START   END
                                GRP  CNTY  U  A A H E   I  C  R R D E A B                        ------------------------------------------
                  S             ---  ----- A  R R O S   N N A  A D D F --- ADJ                    FCTR-A FCTR-B
CLAIM             F E DATE OF   DMG  PBP      T T S R W S H I  I I O A PIP REA                    ------------------------------------------
NUMBER      NAME  I X  BIRTH    RA   ID       A B P D A T C D  L B N U DCG CDE  LAG    FTYPE       PART A      PART B    TOTAL AMT
_____________________________________________________________________________________________________________________________________
[PAYMENT FORMAT]
 123456789A  GREEN  B F 19240605 8084 MDUSA Y  Y Y Y Y Y Y Y Y  Y Y Y Y 1 1      200312 200412
                                 9999 999                                      5.4321 9.8765
                                                                               Y      XX           $37.42     $26.22     $63.64
[ADJUSTMENT FORMAT, POST-2003]
  987654321B  ORANGE G M 19300615 7074 SCUSA Y  Y Y XXXXXXXXXXXX Y Y Y YZ9Z9  99  200401 200212
                                 9999                                          1.2345 3.4567
                                                                               Y      XX           $-15.00      $-0      $-15.00
[ADJUSTMENT FORMAT, PRE-2004]
  191319321B  CRIMSONC F 19400205 6569 DCUSA Y  Y Y XXXXXXXXXXXX   Y Y YZ9Z9  99  200003 200403
                                 9999                                99     1.3131 3.1313
                                                                               Y      XX           $-50.00      $-0      $-50.00
```

## 10.2.5 Risk Adjustment Model Output Report (Slide 18)

The Risk Adjustment MOR provides detailed information reflecting the basis for the risk adjustment score reflected in the MMR. Risk scores are calculated using the CMS-HCC model. The report provides detailed information on the specific disease groups and disease interactions triggered for an enrollee. The report is available in GROUCH on the second day of the month and is downloaded in the same manner as the MMR. The MOR displays the following information:

- Enrollee identifiers (HICs, name, date of birth)
- The appropriate sex and age group, as well as other demographic interacts for an individual (if applicable)
- The specific disease groups (HCCs) triggered
- Disease interactions

Disease hierarchies are not identified separately. If a hierarchy exists, only the most severe manifestation in the hierarchy will be displayed on the report.

This report provides detail on a beneficiary level.

**Example: 4**

If a beneficiary triggered HCC 7 (Metastatic Cancer and Acute Leukemia) and HCC 9 (Lymphatic, Head and Neck, Brain, and Other Major Cancers), the report will reflect HCC 7, not HCC 9

The MOR is used in conjunction with the MMR and beneficiary-specific information (residence-community vs. institution, Medicaid status, disability, etc.) to verify risk scores. The report is available as a flat file and report layout. Table 10G provides descriptions of the fields in the MOR.

**TABLE 10G – MOR FIELD SUMMARY**

| CONTRACT FILE HEADER = 161 bytes | |
|---|---|
| **Field** | **Description** |
| 1 | Contract Number |
| 2 | Run Date |
| 3 | Payment Year and Month |
| 4 | Filler |

**TABLE 10G – MOR FIELD SUMMARY (CONTINUED)**

| REPORT BODY = 161 bytes | |
|---|---|
| **Fields** | **Description** |
| 1 – 7 | Beneficiary Identifying Information |
| 8-19 | The sex and age group for the female beneficiary based on a given "as of date." Each field represents a range of ages. Field 8 represents 0 –34. Field 19 represents 95 and greater |
| 20 – 31 | The sex and age group for the male beneficiary based on a given "as of date." Each field represents a range of ages. Field 8 represents 0 –34. Field 19 represents 95 and greater |
| 32-33 | Medicaid indicators for Female Beneficiary |
| 34-35 | Medicaid indicators for Male Beneficiary |
| 36 | Originally Disabled Female |
| 37 | Originally Disabled Male |
| 38–107 | Disease Coefficients. Field 38 represents HCC 1. Field 107 represents HCC 177 |
| 108-112 | Disabled Disease HCC. Field 108 represents HCC 5. Field 112 represents HCC 107 |
| 113-118 | Disease Interactions |

| CONTRACT FILE TRAILER = 161 bytes | |
|---|---|
| **Field** | **Description** |
| 1 | Contract Number |
| 2 | Total Record Count |
| 4 | Filler |

Organizations receiving frailty adjustment should review their overall risk score, which represents the output of the CMS-HCC model and the frailty score. Beneficiaries under the age of 55 and beneficiaries who have an institutional factor do not receive frailty scores. Organizations receiving frailty adjustment can find their plan level frailty score on HPMS. PACE organizations must then determine whether the score is a new enrollee or institutional score and determine which factors on a given HCC apply. The MOR provides information on demographic, sex, and age variables. The report includes Medicaid information, individual HCCs, and the interaction of HCCs. PACE organizations should also review the values associated with each individual condition and the appropriate community or institutional numbers. A final reconciliation of HCCs may prove useful in the analysis.

Figure 10G illustrates an example of an MOR report.

**Figure 10G – MOR Report Format**

RUN DATE: 20040119 RISK ADJUSTMENT MODEL OUTPUT REPORT PAGE: 53687
PAYMENT MONTH: 200312 PLAN: H7777 BELLBRIGHTS HEALTH PLAN RASXXXR1

| HIC | LAST NAME | FIRST NAME | I | DATE OF BIRTH | SEX & AGE GROUP |
|---|---|---|---|---|---|
| 123456789A | JOHNSON | JOHN | J | 19300615 | MALE70 74 |

HCC DISEASE GROUPS:

| | |
|---|---|
| HCC019 | DIABETES WITHOUT COMPLICATION |
| HCC052 | DRUG/ALCOHOL DEPENDENCE |
| HCC074 | SEIZURE DISORDERS AND CONVULSIONS |
| HCC105 | VASCULAR DISEASE |
| HCC155 | MAJOR HEAD INJURY |

INTERACTIONS: D HCC44 DISABLED* SEVERE HEMATOLOGICAL DISORDER

| | | | | | |
|---|---|---|---|---|---|
| 987654321B | LEE | BETTY | L | 19400205 | FEMALE65 69 |

MEDICAID FEMALE AGED

HCC DISEASE GROUPS:

| | |
|---|---|
| HCC0008 | LUNG, UPPER DIGESTIVE TRACT, AND OTHER SEVERE CANCERS |
| HCC018 | DIABETES WITH OPHTAHLMOLOGIC OR UNSPECIFIED MANIFESTATION |
| HCC052 | DRUG/ALCOHOL DEPENDENCE |
| HCC078 | RESPIRATORY ARREST |

INTERACTIONS: INT5 RF CHF

### 10.2.6 HCC Submission Status Report (Slide 19)

Quarterly, CMS provides a summary of the total HCCs submitted for the collection period. The report provides the total HCCs on a contract level and includes two tables.

The HCC submission status report is available in HPMS and identifies the date that the numbers were updated.

The HCC report will only capture what has been reported for the most recent H-number.

The HCC Submission Status Report includes two tables, which are described in Table 10H.

**TABLE 10H - HCC SUBMISSION STATUS REPORT**

| TABLE NUMBER | DESCRIPTION |
|---|---|
| **1 Number of Beneficiaries Per Number of Conditions** | Displays the number and percentage of beneficiaries for an organization by the number of condition categories (HCCs) triggered. Each beneficiary is assigned to only one group in this table. CMS updates this table on a quarterly basis based on current data. |
| **2 Number of Beneficiaries With Conditions in the Model** | Displays the number and percentage of beneficiaries for an organization by the specific HCC category (categories) triggered. Only beneficiaries that triggered one or more condition categories (HCCs) are reflected in this table. The report may reflect an enrollee in more than one table. CMS updates this table on a quarterly basis based on current data. |

Table 10I is an example of an HCC Submission Status Report updated on January 17, 2004.

**TABLE 10I(1-2) – HCC SUBMISSION STATUS REPORT**

**H7777 – DunDri HEALTH PLAN**

**From 7/1/2002 through 6/30/2003**
**(updated 01/17/04)**

**Enrollment in September 2003 Enrolled Beneficiaries: 3,452**

| TABLE 1 – NUMBER OF BENEFICIARIES PER NUMBER OF CONDITIONS | | |
|---|---|---|
| **Condition** | **Number** | **Percent** |
| Number of beneficiaries with 0 conditions | 629 | 83.87% |
| Number of beneficiaries with 1 condition | 47 | 6.27% |
| Number of beneficiaries with 2 conditions | 34 | 4.53% |
| Number of beneficiaries with 3 conditions | 18 | 2.40% |
| Number of beneficiaries with 4 conditions | 13 | 1.73% |
| Number of beneficiaries with 5 conditions | 4 | 0.53% |
| Number of beneficiaries with 6 conditions | 3 | 0.40% |
| Number of beneficiaries with 7 or more conditions | 2 | 0.27% |
| Total Number of Beneficiaries in Risk Models | 750 | 100% |

| TABLE 2– NUMBER OF BENEFICIARIES WITH CONDITIONS IN MODEL | | | |
|---|---|---|---|
| **Code** | **Condition** | **Number** | **Percent** |
| HCC 1 | HIV/AIDS | 0 | 0.0% |
| HCC 2 | Septicemia/Shock | 17 | 0.5% |
| HCC 5 | Opportunistic Infections | 0 | 0.0% |
| HCC 7 | Metastasis Cancer and Acute Leukemia | 18 | 0.6% |
| HCC 174 | Major Organ Transplant Status | 5 | 0.2% |
| HCC 176 | Artificial Openings for Feeding or Elimination | 0 | 0.0% |
| HCC 177 | Amputation Status, Lower Limb/Amputation Complications | 2 | 0.1% |

## 10.3 Benchmarking (Slides 20-21)

M+C organizations have access to a number of sources of information that can be used to determine if sufficient diagnoses have been submitted to CMS. These sources include specific reports provided to the M+C organization through RAPS and HPMS.

For example, RAPS reports can inform the organization about the number of diagnoses submitted and accepted from each provider type for an organization or the number of relevant diagnoses accepted for a data collection period. Through HPMS, organizations are provided with quarterly reports that profile the data submitted for a given data collection period. The data in HPMS will reflect non-duplicated diagnoses that trigger HCCs for a person. Using the RAPS reports and the HPMS tables, M+C organizations can compare their distributions to published benchmarks.

M+C organizations can access benchmarks from www.cms.hhs.gov/healthplans/riskadj/T to obtain:

- Average Risk Scores by State from M+C Data (posted 8/19/03).
- Number and Percent of FFS Beneficiaries Nationally by Demographic Characteristics and Disease Groups (posted 5/30/03).
- Number and Percent of FFS Beneficiaries by County and Demographic Characteristics and Disease Groups (posted 6/13/03).

For example, Tables 10J and 10K below are based on beneficiaries enrolled in M+C organizations that submitted sufficient data from the July 2002-June 2003 data collection period. These data were used to generate an estimate of the impacts of the CMS-HCC model for use in developing Adjusted Community Rates (ACRs) for 2004. While the number of organizations reflected in these data is not necessarily representative of the entire M+C program, the distribution does reflect diagnostic data for over 3.4 million persons.

**TABLE 10J – NUMBER OF ENROLLEES PER NUMBER OF CONDITIONS**

**M+C NATIONAL ESTIMATES**

| CONDITION | NUMBER | PERCENT |
|---|---|---|
| Number of enrollees with 0 conditions | 1,855,524 | 54.0% |
| Number of enrollees with 1 condition | 844,722 | 24.6% |
| Number of enrollees with 2 conditions | 372,525 | 10.8% |
| Number of enrollees with 3 conditions | 175,556 | 5.1% |
| Number of enrollees with 4 conditions | 89,798 | 2.6% |
| Number of enrollees with 5 conditions | 47,108 | 1.4% |
| Number of enrollees with 6 conditions | 24,996 | 0.7% |
| Number of enrollees with 7 or more conditions | 28,517 | 0.8% |
| Total number of (non-new) enrollees | 3,438,746 | 100.0% |

### 10.3.1 Analyzing the Data

By comparing their results to the national benchmarks, plans can conduct further analysis to identify potential problems with data collection and data submission. The benchmarks also assist plans in identifying the relative "healthiness" of their enrollee population. When using the benchmarks, the plans should consider the following:

- Does your data look like the data for the national average plan? Where does it differ?
- Does the organization's data differ at the extremes? Do you have a significantly larger percentage of enrollees with zero conditions? Do you have a lower percentage with seven or more conditions?
- If the distribution looks different, what information is available from the frequency by HCCs? How does this distribution look relative to the national FFS frequencies?
- What specific HCCs are affected? Are there specific provider types or physicians associated with this HCC?

# MODULE 11 – THREE C'S OF RISK ADJUSTMENT

## Purpose (Slide 2)

While the proper implementation and management of the risk adjustment process requires an understanding of the policy, systems, and reports, consideration must be given to the organization's infrastructure. Medicare+Choice (M+C) organizations that experience optimal results incorporate ideas and solutions that are communicated across the organization, based on a collaboration of efforts, and carefully coordinated. The purpose of this module is to share winning strategies that will allow organizations to build an adequate infrastructure to support the risk adjustment process using internal and external resources.

## Learning Objectives (Slides 3-4)

At the completion of this module, participants will be able to:

- Discuss the opportunity to improve the quality of the risk adjustment process.
- Ensure submission of the appropriate quantity of data in the risk adjustment process.
- Identify effective internal and external communication strategies.
- Define the Risk Adjustment Collaboration Model.
- Identify recommended steps to risk adjustment project coordination.

**ICON KEY**

| | |
|---|---|
| Example |  |
| Reminder |  |
| Resource |  |
| Information Systems Track |  |
| Quality & Compliance Track |  |

## 11.1 Quality and Quantity (Slides 5-10)

Centers for Medicare & Medicaid Services (CMS) continues to provide information and material to assist the M+C organizations improve the overall quality and submit the appropriate quantity of risk adjustment data. As M+C organizations develop processes to support the collection and submission of risk adjustment data, the organization should consider the key quality and quantity concepts described in Figure 11A.

**Figure 11A – Stages of Quality and Quantity**

# QUALITY QUANTITY

## DATA COLLECTION

- Collect from appropriate sources.
- Collect the relevant diagnoses.
- Ensure that physicians and providers are coding to the 5th digit where appropriate
- Educate physicians and providers regarding the correct coding guidelines
- Develop mechanisms to receive all data from physicians and providers in a timely manner.
- Collect relevant diagnosis at least once per year for a beneficiary.
- Consider data collection tool that will be most convenient for the physician/provider.

## DATA SUBMISSION

- Pay close attention to the file logic and the components of the diagnosis cluster.
- Delete any self-identified inaccurate data.
- Submit at least quarterly.
- Filter appropriately following examples to prevent over-filtering and under-filtering

## FERAS & RAPS DATA PROCESSING

- Establish internal editing systems to perform edits prior to sending the file to Palmetto.
- Read and reconcile reports to reduce the numbers of errors generated in the future.
- Analyze reports to determine the number of clusters stored.
- Compare submission levels to data received from physicians and providers.

## VERIFYING RISK SCORES

- Using the MMR/MOR, verify that individual beneficiaries have the appropriate HCCs and risk scores based on plan data submissions and reports of data stored
- Ensure that overall plan payments and average risk adjustment factors are at or near expected values

## DATA VALIDATION

- Identify best medical record to support the diagnosis that is being validated.
- Develop internal system to quickly identify the source (specific physician/hospital) of the data being validated.
- Ensure there are no missing medical records.

## 11.2 Approaches to Achieve Risk Adjustment Goals (Slides 11-17)

Whether an organization is new to risk adjustment or attempting to improve their existing process, incorporating the Three C's into the organizations infrastructure will provide the foundation to meet the overall goal. Effective communication, collaboration, and coordination can make the difference in a successful program. Table 11A provides an overview of the Three C's of Risk Adjustment.

**TABLE 11A – OVERVIEW OF THE THREE C'S OF RISK ADJUSTMENT**

| COMMUNICATION |
|---|
| • Inform the organization of the CMS risk adjustment requirements.<br>• Convey to Executives the resources and risks associated with the project.<br>• Describe the benefits to the organization.<br>• Celebrate success and identify opportunities for improvement.<br>• Attend user groups and trainings to receive updates and official information<br>• Call the Customer Service and Support Center (CSSC) to resolve data submission or processing problems<br>• Contact CMS with questions about risk adjustment requirements, factor discrepancies, payments, etc. |
| **COLLABORATION** |
| • Generate ideas for process improvement from all departments impacted by risk adjustment.<br>• Define a workgroup aligned around a clear purpose.<br>• Gain buy-in by group to work towards reaching the ultimate risk adjustment goal.<br>• Develop a process for making decisions and resolving conflict.<br>• Work with CMS and CSSC to ensure successful compliance with requirements.<br>• Obtain physician and provider input regarding process improvement for data collection. |
| **COORDINATION** |
| • Identify key resources required to meet the risk adjustment requirements.<br>• Determine what individual or group "owns" risk adjustment.<br>• Establish an internal process to collect, submit, and reconcile risk adjustment data.<br>• Define project roles and responsibilities.<br>• Coordinate internal activities with appropriate external groups, e.g., CMS, CSSC, physicians and providers, third party submitters |

### 11.2.1 Case Study 1

Jamie Thomas, Chief Financial Officer (CFO) of Ridgeway Health Plan, decided to become a member of the M+C program in an effort to build another line of business for the organization. Jamie identified two members of the Medicare Compliance department and a claims processor to form the Risk Adjustment Workgroup. After receiving an email from Jamie, which instructed them to form a group to make the risk adjustment process work for Ridgeway, the three-team members began meeting. The group met for five months and tried to develop a process similar to what they were familiar with, Fee-For-Service. They attempted to have Jamie review their draft process, but Jamie was busy working on other priority areas. Jamie sent the group an email letting the group know that she was confident in their abilities and to proceed with the process. Ridgeway began collecting data and held the data until the initial submission deadline. They were extremely proud of their achievement because they feared that they would be late. Their error rate was 63 percent and physician data represented only four percent of their data submitted. Ridgeway appeared on the CMS monitoring list, so the CSSC placed a call to Jamie to discuss their submission and error rate. Jamie responded to CSSC that she would investigate the matter and call them back. Jamie tracked down the members of the team. CMS and the CSSC followed up with a series of calls to Ridgeway to try to resolve their difficulties, ultimately contacting the CFO. The CFO could not get a clear answer regarding the cause of the high error rate because each member said that a different member had the answer. After further investigation, the CFO realized that none of the team members had a clear understanding of the process or requirements. After a month of attempting to work through Ridgeway's data problems, CMS contacted the CFO to offer a technical assistance visit. The CFO was delighted to have CMS assist the team and scheduled the meeting. CMS worked out an agenda for the day that involved all members of the Ridgeway team, including the CFO. When CMS arrived at Ridgeway, they were greeted by the secretary and escorted to the conference room where the three-team members awaited. The secretary apologized on behalf of the CFO. She was unable to attend due to a scheduling conflict.

***What advice could you give Ridgeway to improve their internal process?***

## 11.3 Communication (Slide 19)

Communication is the lifeline of an organization or project. The risk adjustment process requires communication within the organization as well as externally. While there are basic components that remain consistent for internal and external communications, this section will describe effective methods specific to the risk adjustment process.

### 11.3.1 Internal Communication

Ensuring that day-to-day operations are supported adequately, and that the bottom line is met often requires effective internal communications at all levels of the organization. Gaining an understanding of effective upward, downward, and lateral communication builds a strong base for support of risk adjustment for years to come. Table 11B lists the benefits, success strategies, and potential barriers of three communication channels.

**TABLE 11B – COMMUNICATION CHANNELS**

| TYPE | BENEFITS | SUCCESS STRATEGIES | POTENTIAL BARRIERS |
|---|---|---|---|
| **Upward Communication** | • Provides management with details regarding the benefits of a project. Builds loyalty and trust. Increase opportunity for executive sponsorship. | • Executive briefings<br>• Roundtable discussions<br>• Workgroup sponsorship | • Organization size<br>• Fear of punishment when admitting problems<br>• Gatekeepers |
| **Downward Communication** | • Provides direction and goals to front-line staff. Builds morale and a sense of belonging. | • Team briefings<br>• Weekly status meetings | • Missing the timeliness of the communication<br>• Company's growth and schedule makes face-to-face meetings impractical |
| **Lateral Communications** | • Allows the project team to assess the staff's perception of the project. | • Clearly defined organizational structure<br>• Regular meetings<br>• Clear job descriptions. | • Departmental competition<br>• Personality Clashes |

### 11.3.2 External Communication

The risk adjustment process requires communication to several external sources. Table 11C identifies the various sources of communication, purpose of communication, and most effective methods.

**TABLE 11C – SOURCES OF RISK ADJUSTMENT EXTERNAL COMMUNICATION**

| SOURCE | PURPOSE | METHOD |
|---|---|---|
| **Physicians/Providers** | • Collect accurate and timely data according to the risk adjustment rules.<br>• Gather medical record documentation to support the data validation process. | • Conduct training sessions with physicians incorporating the physician-CD.<br>• Develop and distribute paper-based and electronic newsletters to physician/provider community describing updates to risk adjustment and the data validation process. |
| **Third Party Submitters** | • Ensure that data submission occurs at least quarterly with minimal errors. | • Conduct monthly conference calls to address concerns.<br>• Require monthly reports to remain aware of the status of submissions. |
| **CMS** | • Gain insight on the risk adjustment calculations and policy. | • Contact CMS via email and copy other members of the policy or operations team. (see contact information in Methodology module). |
| **CSSC** | • Develop an understanding of error messages and reports. | • Call 1-877-534-2772 or send email to mcoservice@palmettogba.com. Provide H number. |
| **Aspen Systems (User Groups)** | • Receive new information, share best practices, ask questions, and identify issues. | • Register for User Groups at www.aspenxnet.com/registration/. |

### 11.3.3 CMS Communication Tools

CMS recognizes the importance of communicating the risk adjustment requirements, processes, and system updates on a consistent basis. Therefore, CMS developed several communication tools that M+C organizations may use to support their internal and external communication needs. Table 11D, Risk Adjustment Communication Tools, provides a list of those tools.

**TABLE 11D – RISK ADJUSTMENT COMMUNICATION TOOLS**

| TOOL | INTERNAL USE | EXTERNAL USE |
|---|---|---|
| **Monthly User Group Meetings** | • Share information received from CMS/CSSC/Aspen with affected departments within the health plan | • Inform CMS/CSSC of data processing or other risk adjustment issues |
| **Risk Adjustment Training** | • Train staff on risk adjustment payment methodology and processes required to support submission of complete and accurate data<br>• Inform upper management of risk adjustment methodology, requirements and deadlines | • Ask questions of CMS and CSSC representatives<br>• Direct activities of any third party contractors<br>• Communicate coding and documentation guidelines to network physicians and providers |
| **Annual National Meetings** | • Inform team members of upcoming policy changes<br>• Involve team in developing responses to policy proposals<br>• Plan system and process changes to implement policy | • Respond to CMS regarding new policy proposals<br>• Share new policy proposals with appropriate partners (physicians, providers, third party submitters) |
| **Getting Started Video** | • Orientation for new staff on the risk adjustment process<br>• Provide accessible information on risk adjustment to senior management | • Provide to third party submitters to ensure compliance with requirements |
| **Physician CD** | • Share with provider relations staff to ensure compliance with risk adjustment requirements | • Train network physicians on risk adjustment requirements and basics of diagnosis coding guidelines |
| **Training Participant's Guide** | • Provide as desk reference to staff who are actively involved in collection or submission | • Provide to third party contractors to help ensure compliance with requirements |

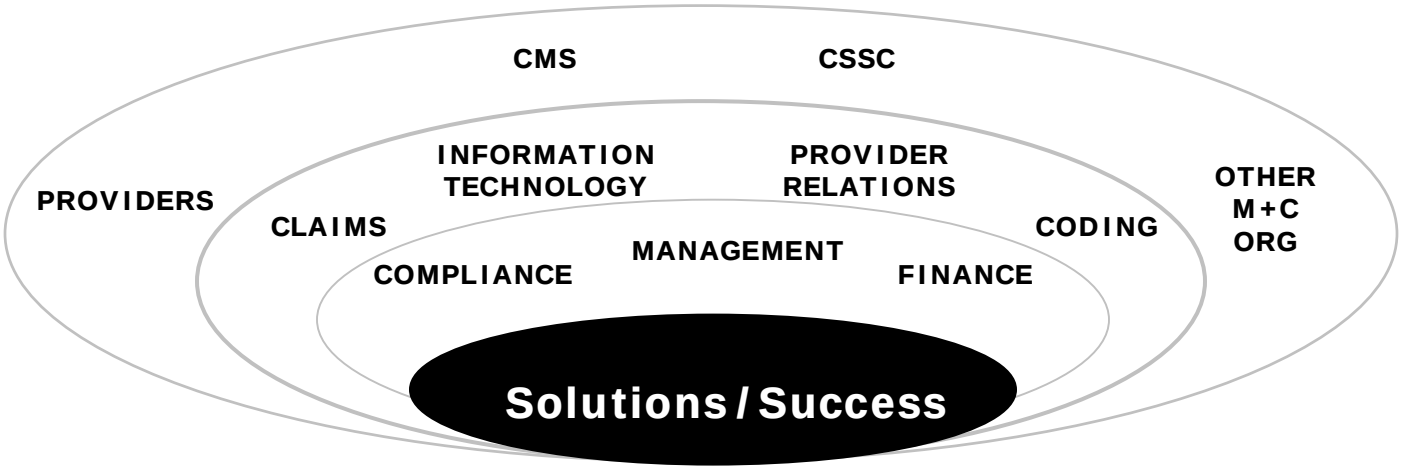
## 11.4 Collaboration (Slides 20-21)

Most effective risk adjustment teams provide a mechanism for bringing together the ideas and experiences of a variety of departments within the organization. It is the collection of these ideas that provide the knowledge to make informed decisions that may save the organization dollars by preventing unnecessary errors and increase the revenue by accurately collecting and submitting risk adjustment data. The structure of M+C organizations varies, but include a variety of disciplines.

The Risk Adjustment Collaboration Model, illustrated in Figure 11B, is anchored by the organization's desire to create solutions that will lead to the successful collection and submission of risk adjustment data. The management team drives this concept based on business needs and considers compliance and financial issues. The core group generally consists of those functional areas that are closely related to the process. In general, that includes the Claims, Information Technology, Provider Relations, and Coding departments of the organization. The core group receives direction and support from the management group regarding the business requirements, and feeds information to that group regarding the work process and implications. The core group also gathers information from external sources. CMS and CSSC provide policy and operation guidance to this group; other M+C organizations share lessons learned; and providers/physicians provide information that may impact decisions regarding data collection.

**NOTE:** The model can be applied differently depending on the size and structure of your organization.

**Figure 11B – Risk Adjustment Collaboration Model**



### 11.4.1 Effective Collaboration Strategies

Collaboration allows the organization to consider all aspects of the project. When implemented correctly, the organization can save time, money, and frustration. Table 11E describe key strategies that will lead to effective collaboration efforts.

**TABLE 11E – COLLABORATION STRATEGIES**

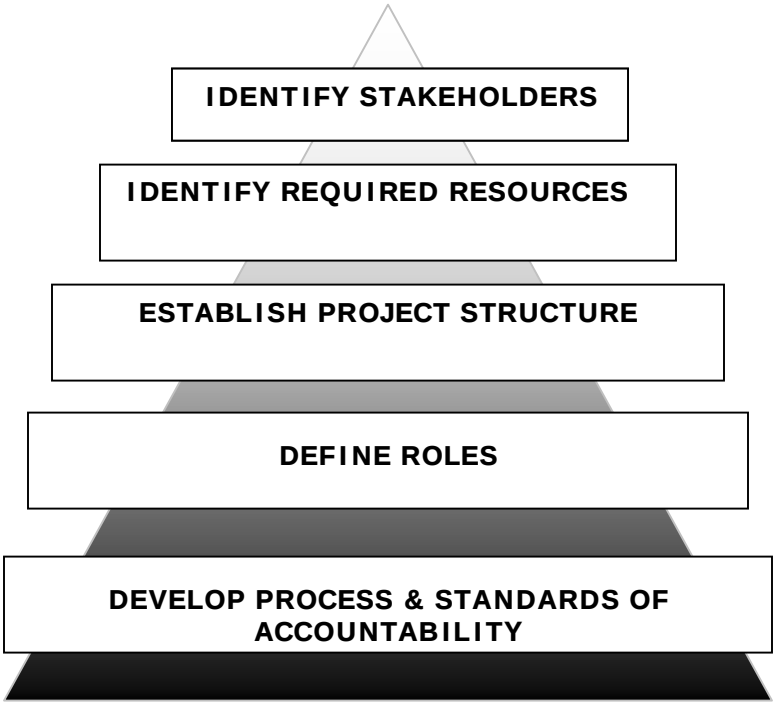
| TASK | DESCRIPTION |
|---|---|
| **Generate Ideas** | • Provide a supportive environment for brainstorming and sharing of solutions that will increase the project's success rate. |
| **Allow equal contribution** | • Provide an opportunity for everyone on the team to contribute to the team's discussions and problem-solving process. |
| **Create a purpose** | • Center the team around a mission created by the team. Establish ground-rules and enforce those rules. |
| **Post weekly status** | • Create a project status form that can be posted electronically, so that all members of the team remain current on action items and accomplishments. |
| **Keep Project Deliverable deadlines** | • Once a project deliverable deadline is established, honor that commitment. Missing deadlines has a negative impact on the team's momentum. |

## 11.5 Coordination (Slides 22-28)

Communication and collaboration are vital to the success of the risk adjustment program, but if those efforts are not adequately coordinated, the effectiveness diminishes tremendously.

Organizing the structure and the process of the risk adjustment team and developing those structures to effectively work with physicians, providers, third party submitters, CSSC, Aspen and CMS require a blend of understanding the organization's business need as well as the five components of project coordination described in Figure 10C.

**Figure 11C – Project Coordination Components**




### 11.5.1 Identify Stakeholders

When implementing the risk adjustment process, the organization must identify the stakeholders. Those individuals or organizations that have a vested interest in the success of the project. Stakeholders in the risk adjustment process include management, end-users, providers/physicians, contractors, system developers, finance representatives, and others who have interest in the project. Identifying the stakeholders allows the organization to determine who is a natural fit for the project core team. While all stakeholders will not become members of the project team, they may influence decisions regarding resources and timelines.

### 11.5.2 Identify Required Resources

Based on the CMS requirements, organizations must assess the resources required to implement and improve their risk adjustment process. Resources include technology, people, and money. Resources also include information with respect to what is needed and from whom (e.g. CSSC, CMS, etc). It is critical that the organization assesses the resource requirements so that the core team can make appropriate decisions based on the resources that the organization is willing to invest.

### 11.5.3 Establish Structure

The structure of the project workgroup depends on the structure of the organization. The two most common structures are the self-directed teams or the traditional hierarchical structure.

**Self-Directed team** is a group of people working together towards a common goal created by the team. For risk adjustment this could consist of a cross-functional workgroup from several areas of the organization. While there is a team lead, the team lead is not the supervisor of record. This is matrix management. The team lead focuses on the performance of the team as a whole, instead of supervisory issues. The benefits of self-directed teams include:

- Increased enthusiasm
- Shared responsibility
- Increased accountability

When establishing self-directed teams consideration should be given to:

- Size
- Purpose
- Goals
- Skills

If an organization decides to utilize a self-directed team, the plan should be aware of the challenges of this approach. The team must agree to define jobs and roles. The team must have rules for how to reach decisions (consensus, voting, etc.). Consensus is often successfully employed by self-directed teams because it forces members to think more broadly about an issue and reach a decision that all members are committed to, rather than forcing a minority to accept the majority decision. Finally, team members must remain accountable for the successful outcomes of the process.

**Hierarchical Structure** is the traditional structure that allows direction and communication to flow from a central point of authority. In this structure the lead is responsible for the management of personnel as well as the management of the process. The benefits of hierarchical structure include:

- Clear lines of authority
- Jobs and roles are clear
- Managers lead and employees follow
- Easy to enforce measures of accountability

When choosing a hierarchical structure, roles and accountability are strengthened, but communication may not be as complete unless management actively solicits staff input, and staff input is received without repercussions, particularly when staff may disagree with management's opinion. Although decisions are a management responsibility when using a hierarchical structure, it is important for management to be certain that staff input is given appropriate consideration in their decisions.

**External Input to Project Team** is an essential element to ensure success. As part of the activities of a risk adjustment project team, organizations should actively seek input and information from appropriate external parties, such as CMS, CSSC, Aspen, physician networks, etc. This external input to the process should be used to inform decisions about all aspects of the risk adjustment process, ensuring the organization successfully submits complete, appropriate and accurate risk adjustment data to CMS.

### 11.5.4 Define Roles

Identifying the individual roles and responsibilities for a project team is a crucial step in the development or refinement of your existing risk adjustment process. When determining roles, attention should be given to the steps in the overall risk adjustment process. This will provide a roadmap to the overall risk adjustment needs of the project. Table 11F illustrates what project roles should include.

**TABLE 11F – PROJECT ROLES**

| TITLE | DESCRIPTION |
|---|---|
| **Project Executive** | Provides executive support and ensures that the project has all of the required resources. Shares business context and participates in goal setting. Monitors group progress, establishes a recognition program, and administers rewards. |
| **Team Lead** | Project owner. Provides day-to-day direction for the project. Communicates project expectations and establishes deliverable deadlines. Primary point-of-contact for CMS and CSSC communications. Ensures that team members are informed of training opportunities. |
| **Information Technology Representative** | Leads efforts regarding establishing and maintaining systems to support the risk adjustment process. Provides guidance on designing internal editing and tracking systems. Offers information regarding establishing an efficient reports reconciliation process. |
| **Provider Relations Representative** | Informs the group of provider and physician concerns. Develops tools to assist with the collection of data from the providers and physicians. |
| **Team Members** | Attend workgroup meeting and contribute based on areas of expertise. Completes action items to assist the workgroup in meeting the project goals. |

### 11.5.5 Establish Process and Standards

Once the workgroup is established the process and standards must be developed. The process allows all members to understand how their role impacts the overall project. The process includes the following:

- When and how often the team will meet
- Deliverable deadlines
- Strategies for decision making
- How the team will handle conflict

The group will also develop project standards. These standards allow the group to understand how there contribution will be measured. The group will determine the accountability measures.

## 11.6 Case Study 2

Jamie Thomas of Ridgeway Health Plan realized the need to incorporate the Three C's in their approach to implementing the risk adjustment process in their organization. Using the information described in Case Study 1, create the optimal project based on the components of communication, collaboration, and coordination.

# MODULE 3 – DATA COLLECTION – TRACK 1

## *Exercise 1*

Yellowstone Health Plan collected data on a HCFA 1500 from one of its providers. The HCFA 1500 submitted by the physician includes four diagnoses, each with a different date of service. From the information provided, does the health plan have the minimum data required for risk adjustment?

# MODULE 5 – DIAGNOSIS CODES & RISK ADJUSTMENT – TRACK 2

## *Exercise 1*

Progressive Health Plan identified that one of its major providers, Family Health Associates, consistently does not follow proper documentation guidelines. Documentation issues include lack of supporting notes for codes submitted, illegibility, and inconsistency. The provider relation's staff offered to outline a *Document Improvement Plan* for Family Health Associates.

**Suggestions for Documentation Improvement Plan**

- Develop consistent diagnosis terminology and abbreviations.
- Identify potential problems, standards of practice, assessment questions, and medical review protocol.
- Develop documentation criteria and chart review process.
- Distribute documentation guidelines to staff.
- Conduct staff education at least annually.

***Using the documentation improvement tips in the* 2003 Physicians and M+C Risk Adjustment *CD presented during this module, identify additional steps for implementing the plan. When outlining the plan, consider the appropriate staff member in the practice who could be assigned to the step.***

**Documentation Improvement Plan for Family Health Associates**

I. Progressive Health Plan has identified a pattern of inconsistencies between the reported diagnosis code and supporting medical record documentation potentially including:

a. Lack of/or incomplete documentation including follow up documentation subsequent to hospitalizations or testing.
b. Illegible documentation.
c. Inconsistent documentation between providers.
d. Inappropriate use of abbreviations.
e. Discrepancies in use of clinical terms.
f. Lack of staff training in coding updates and documentation guidelines.

**II. Documentation Improvement Plan steps**

Step 1: Discuss problem and documentation improvement plan process with staff and physicians.

Step 2:

Step 3:

Step 4:

Step 5:

Step 6:

Step 7:

Step 8:

Step 9:

Step 10:

# MODULE 4 – DATA SUBMISSION – TRACK 1 & TRACK 2

## *Exercise 1*

Bill Doe received health care on several occasions during the second quarter of 2004. The Winfield Health Care Plan submitted the following diagnoses in one CCC record. The plan submits all diagnoses whether they are in the model or not, and filters by source of data.

1. Mr. Doe visited his primary physician on 4/5/04 for increased weakness and tremor. The physician diagnosed Parkinson's Disease **332.0**, ordered a CAT scan and MRI of the brain to rule out any tumors or stroke, and referred him to a neurologist for further evaluation.

2. Mr. Doe has his CAT scan and MRI at a free-standing radiology center on 4/7/04. The results reported by the facility was "small lacunar infarct, possibly old" **434.91**.

3. The neurologist saw Mr. Doe on 4/9/04, reviewed the MRI findings and concurred with the radiologist interpretation of cerebrovascular infarct **434.91** and referred Mr. Doe for admission to Community Hospital.

4. Community Hospital admitted Mr. Doe on 4/9/04 and discharged him to a rehabilitation facility on 4/15/04 with the following diagnoses: principal diagnosis: CVA **436**; other diagnoses: Parkinson's **332.0** and Emphysema **492.8**.

5. The Skilled Nursing Rehabilitation facility admitted Mr. Doe on 4/15/04. Several days later, the patient aspirated fluids, developed pneumonia, and was transferred back to the hospital on 4/22/04 with a discharge diagnosis of: Admission for Rehabilitation **V57.89**, dysphagia due to CVA **438.82**, and aspiration pneumonia **507.0**.

6. Community Hospital readmitted Mr. Doe on 4/22/04, and he was discharged to home care on 4/30/04 with the diagnoses of Pneumonia **486**.

7. The home care claim diagnoses from 4/30/04 through 5/28/04 included **V57.89**, **436**, and **492.8**.

***Complete the following CCC record layout given the information above.***

| CLUSTER 1 | | CLUSTER 2 | | CLUSTER 3 | | CLUSTER 4 | | CLUSTER 5 | | CLUSTER 6 | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| FIELD | DATA | FIELD | DATA | FIELD | DATA | FIELD | DATA | FIELD | DATA | FIELD | DATA |
| 9.0 | | 10.0 | | 11.0 | | 12.0 | | 13.0 | | 14.0 | |
| 9.1 | | 10.1 | | 11.1 | | 12.1 | | 13.1 | | 14.1 | |
| 9.2 | | 10.2 | | 11.2 | | 12.2 | | 13.2 | | 14.2 | |
| 9.3 | | 10.3 | | 11.3 | | 12.3 | | 13.3 | | 14.3 | |
| 9.4 | | 10.4 | | 11.4 | | 12.4 | | 13.4 | | 14.4 | |
| 9.5 | | 10.5 | | 11.5 | | 12.5 | | 13.5 | | 14.5 | |
| 9.6 | | 10.6 | | 11.6 | | 12.6 | | 13.6 | | 14.6 | |
| 9.7 | | 10.7 | | 11.7 | | 12.7 | | 13.7 | | 14.7 | |

## MODULE 4 – DATA SUMBISSION – TRACK 2

### *Exercise 2*

Winfield Health Care Plan utilizes automated extraction techniques from its databases, including review of alternative data sources. When comparing the skilled nursing claim and the subsequent Community Hospital claim in Exercise 1 (numbers 5 and 6) they noticed pneumonia was coded two different ways. Pneumonia, unspecified, code **486** is not in the model. Aspiration pneumonia **507.0** is in HCC 111. The medical record from Community Hospital supported the code **507.0**, aspiration pneumonia. A correction was submitted by the hospital to the plan changing principal diagnosis code **486** to code **507.0** for dates of service 4/22/04 through 4/30/04.

***Complete the following CCC record to make this correction.***

### New CCC Record-Corrected Data

| CLUSTER 1 | | CLUSTER 2 | |
|---|---|---|---|
| FIELD | DATA | FIELD | DATA |
| 9.0 | | 10.0 | |
| 9.1 | | 10.1 | |
| 9.2 | | 10.2 | |
| 9.3 | | 10.3 | |
| 9.4 | | 10.4 | |
| 9.5 | | 10.5 | |
| 9.6 | | 10.6 | |
| 9.7 | | 10.7 | |

## MODULE 7 – EDITS – TRACK 1

### *Exercise 1*

***Read the following scenario and determine if there is an error. If there is an error, determine if FERAS or RAPS would generate the error message. Identify the error code and explain the consequences of the error.***

1. The M+C organization submitted a diagnosis cluster with provider type 40. This occurred in the fourth record of seven records in the batch.

2. The M+C organization submitted a diagnosis cluster with information populated in the diagnosis cluster error code fields. This occurred in the second record of four records in the batch.

3. The M+C organization submitted a valid diagnosis that is not included on the list of model diagnoses. This was in the second record of eight records in the batch.

4. The M+C organization submitted a record with a from date of 20040113 and the through date of 20040115 for a hospital inpatient provider. This occurred in the fourth record of nine records in the batch.

5. The M+C organization submitted a record with a sequence number 0000002. This was the first record of six records in the batch.

# MODULE 8 – MBD – TRACK 1 & TRACK 2

## *Exercise 1*

The Winfield Care Health Plan submitted a batch with three records. They received a Transaction Error Report that reflected three errors. The first record contained a cluster with a 409-error code. The second record contained a 314-error code. The third record contained a cluster with a 500-error code.

### *Guiding Questions*

1. What steps should Winfield Care Health Plan take to address these codes?
2. How can the staff at Winfield Care Health Plan use MBD in relation to these error codes?
3. What steps will Winfield Care Health Plan staff take after researching these error codes?

## MODULE 9 – REPORTS – TRACK 1 & TRACK 2

### *Exercise 1*

In Figure 9E in your Participant Guide on page 9-10, an M+C organization submitted a batch with 8 records.

***Review the report and respond to the following:***

1. What records had errors?

2. For each of the errors, identify the code, description, and steps for resolution using the form below.

| Record # | Associated Error Code | Error Code Description | Resolution Steps |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

# MODULE 9 – REPORTS – TRACK 2

## *Exercise 2*

The Quality Manager at plan number H-7777 is reviewing its management reports for April 2004. The RAPS reports she is using are illustrated in the following figures:

- Figure 9K – Monthly Plan Activity Reports March 2004 (9-19) and April 2004 (9-21)
- Figure 9M – Cumulative Plan Activity Report April 2004 (9-26)

***Use these reports to discuss as a group the answers to the questions below.***

*In reviewing the Monthly Plan Activity Report for April (9-21), the manager asked the following questions.*

1. Is the plan submitting all diagnoses, or only model diagnoses?

2. The IT manager indicated that a process was instituted to prevent submitting duplicate diagnosis clusters. Does it appear that the prevention process is working?

*Comparing the Monthly Plan Activity Reports for March (9-19) and April (9-21), the manager asked the following questions.*

3. The Monthly Plan Activity Report for March showed a much larger total data submission than April. Might this be a cause for concern? Why?

*The manager reviewed the Cumulative Monthly Plan Activity Report for April (9-26). She wanted to see how the plan was doing up to this point on submissions. She had the following questions.*

4. Does it look like the plan is submitting about 25 percent of its total data for the period each quarter?

5. Is the plan submitting the appropriate amount of risk adjustment data by provider type?

# MODULE 10 – VERIFYING RISK SCORES

## *Exercise 1*

Suntrust Health Plan's HCC Submission Status Report reflected the following.

| CONDITION | NUMBER | PERCENT |
|---|---|---|
| Number of enrollees with 0 conditions | 17,847 | 47.2% |
| Number of enrollees with 1-6 conditions | 19,397 | 51.3% |
| Number of enrollees with 7 or more conditions | 567 | 1.5% |
| Total number of (non-new) enrollees | 37,811 | 100.0% |

**Based on the considerations addressed in the Verifying Risk Scores module, Section 10.3.1 Analyzing the Data, what conclusions would you draw from this report?**

# MODULE 10 – VERIFYING RISK SCORES

## *Exercise 2*

Shade Tree Health Plan's HCC Submission Status Report reflected the following.

| CONDITION | NUMBER | PERCENT |
|---|---|---|
| Number of enrollees with 0 conditions | 52,460 | 20% |
| Number of enrollees with 1-6 conditions | 183,610 | 70% |
| Number of enrollees with 7 or more conditions | 26,230 | 10% |
| Total number of (non-new) enrollees | 262,300 | 100% |

**Based on the considerations addressed in the Verifying Risk Scores module, Section 10.3.1 Analyzing the Data, what conclusions would you draw from this report?**

# MODULE 1 – RISK ADJUSTMENT METHODOLOGY

## CALCULATING DEMOGRAPHIC AND RISK FACTORS FOR JANUARY 2004

These exercises will teach participants to calculate demographic and risk factors. Participants will need the attached exhibits (1-4) to do the exercises.

### *Exercise 1*

John Hope is an enrollee in a M+C plan. He is not in a long-term care institution. He was born February 2, 1919. His plan submitted the following diagnoses for him:

- 5311 (Acute Stomach Ulcer with Perforation), HCC 31 and (Intestinal Obstruction/Perforation)
- 4321 (Subdural Hemorrhage), HCC 95 (Cerebral Hemorrhage).

Calculate John Hope's demographic and risk factors for January 2004 and March 2004:

January 2004

**a) Demographic Factors:**

**b) Risk Factors:**

March 2004

**a) Demographic Factors:**

**b) Risk Factors:**

# MODULE 1 – RISK ADJUSTMENT METHODOLOGY

## *Exercise 2*

Mary Parks is an enrollee in a M+C plan. She first became eligible for Medicare (Parts A and B) when she turned 65 in June 2003. She is not in a long-term care institution, and was born June 2, 1938. The plan submitted the following diagnoses for her for physician services rendered in June 2003:

- 07023 (Chronic Hepatitis B with Coma), HCC 27 (Chronic Hepatitis)
- 2515 (Abnormal Gastrin Secretion), HCC 32 (Pancreatic Disease).

Mary Park's demographic and risk factors:

January 2004

**a) Demographic Factors:**

**b) Risk Factors:**

# MODULE 1 – RISK ADJUSTMENT METHODOLOGY

## *Exercise 3*

Virginia Smalls is an enrollee in a M+C plan. She is in a long-term care institution, and was born February 2, 1980. The plan submitted the following diagnosis for her:

- 1749 (Breast Cancer), HCC 10 (Breast, Prostate, Colorectal and Other Cancers).

Virginia Smalls' demographic and risk factors:

January 2004

**a) Demographic Factors:**

**b) Risk Factors:**

# MODULE 1 – RISK ADJUSTMENT METHODOLOGY

## *Exercise 4*

George Halls is an enrollee in a M+C plan. He is not in a long-term care institution. He was born February 1, 1919. George has Medicaid eligibility and was originally entitled to Medicare due to a disability. His plan submitted the following diagnoses for him:

- 1124 (Candidiasis of Lung), HCC 5 (Opportunistic Infection);
- 1982 (Sec Malignant Skin Neoplasm), HCC 7 (Metastatic Cancer and Acute Leukemia);
- 1516 (Malignant Neoplasm Stomach), HCC 8 (Upper Digestive Tract Cancer);
- 1460 Malignant Neoplasm Tonsil), HCC 9 (Lymphatic, Head, Neck, Brain and Other Major Cancers);
- 1727 (Malignant Neoplasm Leg), HCC 10 (Breast, Prostate, Colorectal and Other Cancers);
- 25070 (Diabetes with Peripheral Circulatory Disorders), HCC 15 (Diabetes with Renal or Circulatory Manifestation);
- 2508 (Diabetes with Other Specified Manifestation), HCC 16 (Diabetes with Other Specified Manifestation);
- 25012 (Diabetes with Ketoacidosis), HCC 17 (Diabetes with Acute Complications);
- 2509 (Diabetes, with Unspecified Complication), HCC 18 (Diabetes with Opthalmic or Unspecified Manifestation) and
- 428 (Heart Failure), HCC 80 (Congestive Heart Failure).

George Halls' demographic and risk factors:

January 2004

**a) <u>Demographic Factors</u>:**

**b) <u>Risk Factors</u>:**

# MODULE 3 – DATA COLLECTION – TRACK 1

## *Exercise 1*

Yellowstone Health Plan collected data on a HCFA 1500 from one of its providers. The HCFA 1500 submitted by the physician includes four diagnoses, each with a different date of service. From the information provided, does the health plan have the minimum data required for risk adjustment?

## *Answer Key – Exercise 1*

The data collected by Yellowstone Health Plan on the HCFA 1500 includes:

a. The service from dates
b. The service through dates
c. The four ICD-9-CM diagnoses codes
d. The provider type (of the three sources of data, this data collection, based on the HCFA 1500 format, represents data from a physician.)

While the HCFA 1500 form includes the space for a HIC number, the example does not indicate whether or not the physician included the HIC number on the form.

# MODULE 5 – DIAGNOSIS CODES & RISK ADJUSTMENT – TRACK 2

## *Exercise 1*

Progressive Health Plan has identified that one of its major providers, Family Health Associates, consistently does not follow proper documentation guidelines. Documentation issues include lack of supporting notes for codes submitted, illegibility, and inconsistency. The provider relations' staff has offered to outline a *Document Improvement Plan* for Family Health Associates.

***Using the documentation improvement tips in the 2003 Physicians and M+C Risk Adjustment CD presented during this module, identify additional steps for implementing the plan. When outlining the plan, consider the appropriate staff member in the practice who could be assigned to the step.***

**Documentation Improvement Plan for Family Health Associates**

I. Progressive Health Plan has identified a pattern of inconsistencies between the reported diagnosis code and supporting medical record documentation potentially including:

1. Lack of/or incomplete documentation including follow up documentation subsequent to hospitalizations or testing.
2. Illegible documentation.
3. Inconsistent documentation between providers.
4. Inappropriate use of abbreviations.
5. Discrepancies in use of clinical terms.
6. Lack of staff training in coding updates and documentation guidelines.

II. Documentation Improvement Plan steps

## *Answer Key – Exercise 1*

Suggestions:

1. Discuss problem and documentation improvement plan process with staff and physicians.
2. Select sampling methodology to include all physicians in practice.
3. Develop assessment questions and design a review tool.
4. Assign appropriate staff to review records or arrange for a professional review consultant. Conduct the review.
5. Categorize findings by type of discrepancy and report by individual physician and group.
6. Discuss findings with physician advisor or other appointed staff member.
7. Have physician advisor review findings with group of physicians and individually if indicated.
8. Create or revise documentation and coding procedures. Design new forms if needed.
9. Educate staff on new procedures.
10. Plan for continued staff training (at least annually) and follow up review.

# MODULE 4 – DATA SUBMISSION – TRACK 1 & TRACK 2

## *Exercise 1*

Bill Doe received health care on several occasions during the second quarter of 2004. The Winfield Health Care Plan submitted the following diagnoses in one CCC record. The plan submits all diagnoses whether they are in the model or not, and filters by provider type.

1. Mr. Doe visited his primary physician on 4/5/04 for increased weakness and tremor. The physician diagnosed Parkinson's Disease **332.0**, ordered a CAT scan and MRI of the brain to rule out any tumors or stroke, and referred him to a neurologist for further evaluation.

2. Mr. Doe has his CAT scan and MRI at a free-standing radiology center on 4/7/04. The results reported by the facility was "small lacunar infarct, possibly old" **434.91**.

3. The neurologist saw Mr. Doe on 4/9/04, reviewed the MRI findings and concurred with the radiologist interpretation of cerebrovascular infarct **434.91** and referred Mr. Doe for admission to Community Hospital.

4. Community Hospital admitted Mr. Doe on 4/9/04 and discharged him to a rehabilitation facility on 4/15/04 with the following diagnoses: principal diagnosis: CVA **436;** other diagnoses: Parkinson's **332.0** and Emphysema **492.8**.

5. The Skilled Nursing Rehabilitation facility admitted Mr. Doe on 4/15/04. Several days later, the patient aspirated fluids, developed pneumonia, and was transferred back to the hospital on 4/22/04 with a discharge diagnosis of: Admission for Rehabilitation **V57.89**, dysphagia due to CVA **438.82**, and aspiration pneumonia **507.0**.

6. Community Hospital readmitted Mr. Doe on 4/22/04 and he was discharged to home care on 4/30/04 with the diagnoses of Pneumonia **486**.

7. The home care claim diagnoses from 4/30/04 through 5/28/04 included **V57.89**, **436**, and **492.8**.

***Complete the following CCC record layout given the information above.***

## *Answer Key – Exercise 1*

1. Cluster 1 is from a physician office; therefore, provider type 20 is entered in field 9.0. The date of service in both 9.1 and 9.2 is in the CCYYMMDD format. Field 9.3 should always contain 1 space, unless the cluster is being deleted. The diagnosis code in the scenario, 3320, is entered in field 9.4 with no decimal and one space following the code to complete the 5-character field. This is a relevant diagnosis in HCC 73. Fields 9.5, 9.6, and 9.7 are filled with spaces.

2. Scenario 2 is not an acceptable source of data. The provider source of data should be filtered at the plan and the diagnosis not submitted to CMS.

3. Cluster 2 is from a physician office; therefore, provider type 20 is entered in field 10.0. The date of service is entered in 11.1 and diagnosis code 434.91 is entered in 11.4. Code 434.9 is on HCC 96.

4. Scenario 4, cluster 3 is from a hospital inpatient provider type 01 in filed 11.0 for the principal diagnosis. The admission date is entered in 11.1 and the through date is entered in 11.2. Code 436 followed by two spaces, is entered in 11.4. Code 436 is also HCC 96.

   Scenario 4, cluster 4 is from a hospital inpatient, secondary diagnoses. Enter 02 in field 12.0 and the same admission and discharge dates as cluster 3. Diagnosis code 3320 plus space is entered in field 12.4, even though this is a repeat of a diagnosis, it is important that internally the plan has captured that the source of this diagnosis can also be found from an inpatient record.

   Scenario 4, Cluster 5 repeats data from cluster 4 with new code, 4928 plus a space, in field 13.4.

5. A skilled nursing facility is not an acceptable source of data; therefore, the health plan should not submit these for risk adjustment. Filtering on the provider number ranges should be done.

6. Scenario 6, Cluster 6 is from an inpatient hospital; enter provider type 01 in field 14.0 since the only code listed is assumed to be the principal diagnosis. Admission and discharge dates are entered in fields 14.1 and 14.2. The diagnosis code 486 followed by two spaces is entered in field 14.4. Code 486 is not a relevant diagnosis.

7. Scenario 7 is from home health, which is not an acceptable provider type.

| CLUSTER 1 | | CLUSTER 2 | | CLUSTER 3 | | CLUSTER 4 | | CLUSTER 5 | | CLUSTER 6 | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| FIELD | DATA | FIELD | DATA | FIELD | DATA | FIELD | DATA | FIELD | DATA | FIELD | DATA |
| 9.0 | 20 | 10.0 | 20 | 11.0 | 01 | 12.0 | 02 | 13.0 | 02 | 14.0 | 01 |
| 9.1 | 20040405 | 10.1 | 20040409 | 11.1 | 20040409 | 12.1 | 20040409 | 13.1 | 20040409 | 14.1 | 20040422 |
| 9.2 | 20040405 | 10.2 | 20040409 | 11.2 | 20040415 | 12.2 | 20040415 | 13.2 | 20040415 | 14.2 | 20040430 |
| 9.3 | Space | 10.3 | Space | 11.3 | Space | 12.3 | Space | 13.3 | Space | 14.3 | Space |
| 9.4 | 3320 *(space)* | 10.4 | 43491 | 11.4 | 436 *(2 spaces)* | 12.4 | 3320 *(space)* | 13.4 | 4928 *(space)* | 14.4 | 486 *(2 spaces)* |
| 9.5 | Space | 10.5 | Space | 11.5 | Space | 12.5 | Space | 13.5 | Space | 14.5 | Space |
| 9.6 | Space | 10.6 | Space | 11.6 | Space | 12.6 | Space | 13.6 | Space | 14.6 | Space |
| 9.7 | Space | 10.7 | Space | 11.7 | Space | 12.7 | Space | 13.7 | Space | 14.7 | Space |

# MODULE 4 – DATA SUMBISSION – TRACK 2

## *Exercise 2*

Winfield Health Care Plan utilizes mining techniques, including review of alternative data sources. When comparing the skilled nursing claim and the subsequent Community Hospital claim in Exercise 1 (numbers 5 and 6) they noticed pneumonia was coded two different ways. Pneumonia, unspecified, code **486** is not in the model. Aspiration pneumonia **507.0** is in HCC 111. The medical record from Community Hospital supported the code **507.0**, aspiration pneumonia. A correction was submitted by the hospital to the plan changing principal diagnosis code **486** to code **507.0** for dates of service 4/22/04 through 4/30/04.

***Complete the following CCC record to make this correction.***

## *Answer Key – Exercise 2*

### New CCC Record-Corrected Data

| CLUSTER 1 | | CLUSTER 2 | |
|---|---|---|---|
| **FIELD** | **DATA** | **FIELD** | **DATA** |
| 9.0 | 01 | 10.0 | 01 |
| 9.1 | 20040422 | 10.1 | 20040422 |
| 9.2 | 20040430 | 10.2 | 20040430 |
| 9.3 | D | 10.3 | Space |
| 9.4 | 486 *(2 spaces)* | 10.4 | 5070 *(space)* |
| 9.5 | Space | 10.5 | Space |
| 9.6 | Space | 10.6 | Space |
| 9.7 | Space | 10.7 | Space |

# MODULE 7 – EDITS – TRACK 1

## *Exercise 1*

***Read the following scenario and determine if there is an error. If there is an error, determine if FERAS or RAPS would generate the error message. Identify the error code and explain the consequences of the error.***

## *Answer Key – Exercise 1*

1. The M+C organization submitted a diagnosis cluster with provider type 40. This occurred in the fourth record of seven records in the batch.
   **Answer:** Since this occurred in the fourth record of the batch, the error is identified in RAPS. The submitter receives error code 400, "MISSING/INVALID PROVIDER-TYPE CODE ON CCC RECORD." This diagnosis cluster with the incorrect provider type is not stored. RAPS continues editing.

2. The M+C organization submitted a diagnosis cluster with information populated in the diagnosis cluster error code fields. This occurred in the second record of four records in the batch.
   **Answer:** The submitter receives error code 307, "DIAGNOSIS CLUSTER-ERROR 1 NOT EQUAL TO SPACES" and 308 "DIAGNOSIS CLUSTER-ERROR 2 NOT EQUAL TO SPACES" from RAPS, not FERAS, because this error did not occur in the first or last CCC record in the batch. This is a record level error and causes all editing to discontinue on this record. No clusters in this record are stored. Remember, error code fields must be populated with spaces, not zeros, when submitting data.

3. The M+C organization submitted a valid diagnosis that is not included on the list of model diagnoses. This was in the second record of eight records in the batch.
   **Answer:** RAPS processes the diagnosis as valid and, assuming there are no other errors in the cluster, it is stored. However, the cluster does not count towards risk adjustment, as indicated by the informational message, error code 501, "VALID DIAGNOSIS BUT NOT A RELEVANT DIAGNOSIS FOR RISK ADJUSTMENT DURING THIS SERVICE PERIOD."

4. The M+C organization submitted a record with a from date of 20040113 and the through date of 20040115 for a hospital inpatient provider. This occurred in the fourth record of nine records in the batch.
   **Answer:** FERAS accepts the cluster and sends it to RAPS. Assuming there are no other errors, no edit messages are received because the from and through dates are valid.

5. The M+C organization submitted a record with a sequence number 0000002. This was the first record of six records in the batch.
   **Answer:** Because the first record in the batch should be sequence number 0000001, not 0000002, error code 302, "MISSING/INVALID SEQUENCE NUMBER ON CCC RECORD" would be received by FERAS. FERAS would completely reject the file.

# MODULE 8 – MBD – TRACK 1 & TRACK 2

## *Exercise 1*

The Winfield Care Health Plan submitted a batch with three records. They received a Transaction Error Report that reflected three errors. The first record contained a cluster with a 409-error code. The second record contained a 314-error code. The third record contained a cluster with a 500-error code.

### *Guiding Questions*

1. What steps should Winfield Care Health Plan take to address these codes?
2. How can the staff at Winfield Care Health Plan use MBD in relation to these error codes?
3. What steps will Winfield Care Health Plan staff take after researching these error codes?

## *Answer Key – Exercise 1*

It is the responsibility of the M+C organization to resolve errors that CMS identifies. To resolve these errors, the plan must identify the error code and read the associated message. Winfield will want to make sure that staff has the FERAS and RAPS Error code job aids (laminates).

The first error code, 409, indicates the patient was not enrolled with any M+C organization on the through date of service. The Winfield staff first must ensure that the date of service is correct. The next step is to check MBD, using the Coverage Tab, to verify the beneficiary's enrollment information. If there is a discrepancy between the enrollment data in MCCOY and MBD, the staff at Winfield can contact CSSC. Because this is a diagnosis cluster error, the cluster was not stored. If, after researching, the staff at Winfield Care Health Plan finds that the date of service is different than first submitted and is acceptable data for risk adjustment, they may resubmit the data. If there is a problem with the accuracy of the enrollment or entitlement information, the organization must ensure the enrollment data is corrected prior to resubmitting the transaction.

The second transaction contains a 314-error code, "INVALID DIAGNOSIS FORMAT ON CCC RECORD." This is a record level error. The record was bypassed, all editing was discontinued, and the clusters from this record were not stored. Stage 3 errors are associated with MBD edits. Error code 314 is a Stage 1 edit (field validity and integrity edits).

The other error code, 500, is an informational message indicating that CMS records (and MBD) indicate a different beneficiary HIC number. Winfield should update their internal systems to reflect the new HIC number and use it for all future submissions. Clusters related to this informational message are accepted by RAPS.

# MODULE 9 – REPORTS – TRACK 1 & TRACK 2

## *Exercise 1*

In Figure 9E in your Participant Guide on page 9-10, and M+C organization submitted a batch with 8 records.

***Review the report and respond to the following:***

## *Answer Key – Exercise 1*

**1. What records had errors?**

The Transaction Error Report indicated errors in records three, five, and seven. Records one, two, four, six, and eight received no error code messages.

**2. For each of the errors, identify the code, description, and steps for resolution using the form below.**

| Record # | Associated Error Code | Error Code Description | Resolution Steps |
|---|---|---|---|
| 3 | 353 | HIC NUMBER DOES NOT EXIST ON MBD. | See A below. |
| 5 (3 clusters) | 408 | SERVICE FROM DATE IS NOT WITHIN MEDICARE ENTITLEMENT PERIOD. | See B below. |
| 7 (cluster 1) | 491 | DELETE ERROR, DIAGNOSIS CLUSTER PREVIOUSLY DELETED. | See C below. |
| 7 (clusters 2,3) | 408 | SERVICE FROM DATE IS NOT WITHIN M+C ORG ENTITLEMENT PRIOD. | See C below. |
| 7 (clusters 2,3) | 409 | SERVICE THROUGH DATE IS NOT WITHIN M=C ORG ENROLLMENT PERIOD | See C below. |

A. Record three received a HIC error code (353) indicating that the "HIC NUMBER DOES NOT EXIST ON MBD." This error code occurred during the third stage of editing. The M+C organization should check the accuracy of the HIC number, and check to see if new information was updated in MBD overnight that would resolve the error.

B. Record five received the 408-error code on three of its clusters because the beneficiary was not in enrolled in a M+C organization at the time of the hospital inpatient admission. The M+C organization should double-check the dates of service to ensure they are correct. If they are not correct, the clusters should be corrected and resubmitted. If they are correct, then the organization should verify that the enrollment data found in MBD is accurate. If the enrollment information in MBD is different from the information found in MCCOY, the organization can contact CSSC for assistance.

C. Record seven received errors on two of its clusters. The first cluster received a 491-error code because the M+C organization attempted to delete a diagnosis cluster with the same attributes as was already deleted from the RAPS database on the same date. No further action is required. The second cluster received both 408- and 409-error codes for the physician visit because the beneficiary was not enrolled in a M+C organization on both the from and through dates of service.

# MODULE 9 – REPORTS – TRACK 2

## *Exercise 2*

The Quality Manager at plan number H-7777 is reviewing its management reports for April 2004. The RAPS reports she is using are illustrated in the following figures:

- Figure 9K – Monthly Plan Activity Reports (March 2004 and April 2004)
- Figure 9M – Cumulative Plan Activity Report (May 3, 2004 run date)

***Use these reports to discuss as a group the answers to the questions below.***

## *Answer Key Exercise 2*

**Monthly Plan Activity Report for April**

1. Is the plan submitting all diagnoses, or only model diagnoses?
   **Answer:** The plan is submitting all diagnoses that are valid. The total stored and total model stored are different.

2. The IT manager indicated that duplicates diagnoses were being filtered out. Does it appear that the filter is working?
   **Answer:** Yes, there appears to be a screening process that prohibits large numbers of duplicate clusters from being submitted. Total Accepted minus Total Stored equals the number of duplicates.

**Monthly Plan Activity Reports for March and April**

3. The Monthly Plan Activity Report for March showed a much larger total data submission than April. Might this be a cause for concern? Why?
   **Answer:** The comparison of the two reports indicates that there was a significant drop in clusters submitted in April. Since the plan was relatively consistent in the data they submitted in past months, it is likely an internal issue impacted submissions in April.

**Cumulative Monthly Plan Activity Report for April**

4. Does it look like the plan is submitting about a 25 percent of its total data for the period each quarter?
   **Answer:** Generally, yes. Looking across the report for each provider type, the plan appears to be submitting about 25 percent of its data each quarter. For example, the number of clusters submitted for any provider type in July, August, and September is roughly the same as the amount submitted in October, November, and December, and January, February, and March.

5. Is the plan submitting the appropriate amount of risk adjustment data by provider type?
   **Answer:** To determine if the organization is submitting the appropriate amount of data, the Quality Manager should:
   a) Identify how the organization submits data -- all diagnoses, only model diagnoses, or unique model diagnoses -- and identify the benchmarks for each provider type. This plan is submitting

all diagnoses (see answer to #1 above), so the benchmarks for each provider type are: physician - 75.7%, hospital outpatient - 18.2%, hospital inpatient - 6.1%.

b) Consider the organization's comparative utilization of services. From the information provided in this example, the plan's enrollee population utilization cannot be determined. However, organizations should consider their enrollees' utilization patterns when applying the benchmarks.

c) Apply the benchmark guidelines to the organization's submissions reflected in the Cumulative Plan Activity Report. This organization's submission trends are: physician - 68.0%, hospital outpatient - 15.7%, hospital inpatient - 16.3%.

# MODULE 10 – VERIFYING RISK SCORES

## *Exercise 1*

Suntrust Health Plan's HCC Submission Status Report reflected the following.

| CONDITION | NUMBER | PERCENT |
|---|---|---|
| Number of enrollees with 0 conditions | 17,847 | 47.2% |
| Number of enrollees with 1-6 conditions | 19,397 | 51.3% |
| Number of enrollees with 7 or more conditions | 567 | 1.5% |
| Total number of (non-new) enrollees | 37,811 | 100.0% |

**Based on the considerations addressed in the Verifying Risk Scores module, Section 10.3.1 Analyzing the Data, what conclusions would you draw from this report?**

## *Answer Key – Exercise 1*

The Suntrust Health Plan has a less healthy population, based on the M+C national estimates. Only 47 percent of Suntrust's beneficiaries experienced none of the conditions associated with the model; the national average is 54 percent.

1.5 percent of Suntrust's population had more than seven conditions, compared to the 0.8 percent national estimate.

None of these figures necessarily indicate a data problem, unless Suntrust has reason to believe that its beneficiary population is as healthy or healthier than average.

# MODULE 10 – VERIFYING RISK SCORES

## *Exercise 2*

Shade Tree Health Plan's HCC Submission Status Report reflected the following.

| CONDITION | NUMBER | PERCENT |
|---|---|---|
| Number of enrollees with 0 conditions | 52,460 | 20% |
| Number of enrollees with 1-6 conditions | 183,610 | 70% |
| Number of enrollees with 7 or more conditions | 26,230 | 10% |
| Total number of (non-new) enrollees | 262,300 | 100% |

**Based on the considerations addressed in the Verifying Risk Scores module, Section 10.3.1 Analyzing the Data, what conclusions would you draw from this report?**

## *Answer Key – Exercise 2*

The Shade Tree Health Plan has a less healthy population, based on the M+C national estimates. Only 20 percent of Shade Tree's beneficiaries experienced none of the conditions associated with the model; the national average is 54 percent.

Ten percent of Shade Tree's population had more than seven conditions, compared to the 0.8 percent national estimate.

These results indicate that Shade Tree is well beyond any normally expected variation. These numbers would indicate serious data problems with data collection, diagnosis coding, and/or submission. Shade Tree should immediately begin assessing all risk adjustment processes to find the source of the data problem.

# MODULE 1 – RISK ADJUSTMENT METHODOLOGY

## CALCULATING DEMOGRAPHIC AND RISK FACTORS FOR JANUARY 2004

### *Answer Key – Exercise 1*

John Hope is an aged male in a community setting. John's age for purposes of calculating demographic and risk adjustment factors is the same for January payments, 84. This age differs for March payments. In March, his age for the demographic factor is 85, while the age used for calculating the risk adjustment factor remains unchanged, 84. The age used for calculating demographic factors changes when a birthday moves a beneficiary to a new rate cell (in this case from the 80-84 cell to the 85+ cell). The age for risk adjustment purposes is calculated as a constant throughout the year, specifically, the age as of February 1 of the payment year. In this example, on February 1, 2004, John Hope was 84, so his risk adjustment age category is 80-84.

**January 2004**

**a) Demographic Factors:**

| | |
|---|---|
| **Part A** (Community, Aged, Male) | 1.20 |
| **Part B** (Community, Aged, Male) | 1.15 |

**b) Risk Factors:**

| | |
|---|---|
| **Base Factor:** (Community, Male80-84) | 0.657 |
| **CMS-HCC:** | |
| HCC 31 | 0.408 |
| HCC 95 | 0.392 |
| **Total** | **1.457** |

**March 2004**

**c) Demographic Factors:**

| | |
|---|---|
| **Part A** (Community, Aged, Male) | 1.35 |
| **Part B** (Community, Aged, Male) | 1.15 |

**d) Risk Factors:**

| | |
|---|---|
| **Base Factor:** (Community, Male80-84) | 0.657 |
| **CMS-HCC:** | |
| HCC 31 | 0.408 |
| HCC 95 | 0.392 |
| **Total** | **1.457** |

# MODULE 1 – RISK ADJUSTMENT METHODOLOGY

## *Answer Key – Exercise 2*

Mary is an aged female in a community setting. She will receive the new enrollee risk factors, because she had less than 12 months of Part B eligibility during the data collection period (January 1, 2003 – December 31, 2003).

**January 2004**

**a) Demographic Factors:**

| | |
|---|---|
| **Part A** (Community, Aged, Female) | 0.55 |
| **Part B** (Community, Aged, Female) | 0.70 |

**b) Risk Factors:**

| | |
|---|---|
| **Base Factor:** (Community, Female 65-69) | 0.0 |
| **New Enrollee Factor** (Female 65; Non-Medicaid & Not Originally Disabled) | 0.486 |
| **CMS-HCC:** | |
| HCC 27 | 0.0 |
| HCC 32 | 0.0 |
| **Total** | **0.486** |

# MODULE 1 – RISK ADJUSTMENT METHODOLOGY

## *Answer Key – Exercise 3*

Virginia is a young (i.e. disabled, since less than age 65) female in a long-term care institutional setting.

**January 2004**

**a) Demographic Factors:**

| | |
|---|---|
| **Part A** (Institutional, Disabled, Female, <35) | 1.80 |
| **Part B** (Institutional, Disabled, Female, <35) | 1.95 |

**b) Risk Factors:**

| | |
|---|---|
| **Base Factor:** (Institutional, Female 0-34) | 1.064 |
| **CMS-HCC:** | |
| HCC 10 | 0.259 |
| **Total** | **1.323** |

# MODULE 1 – RISK ADJUSTMENT METHODOLOGY

## *Answer Key – Exercise 4*

George is an aged male, who resides in a community setting, is Medicaid eligible, and was originally eligible for Medicare due to a disability. His demographic and risk adjustment ages differ in January 2004, with demographic age being 84 and risk adjustment age being 85. Remember from Example 1, demographic age will change during the year if an age increase changes the appropriate demographic rate cell, while risk adjustment age is set as of February 1 of the payment year. The Disease Hierarchy plays significant roles with HCCs 7 (8,9, and 10 were dropped) and for 15 (16,17 and 18 were dropped). The Disease Interaction (INT1) is required, because George has Diabetes (HCC 15) and Congestive Heart Failure (HCC 80).

**January 2004**

**a) Demographic Factors:**

| | |
|---|---|
| **Part A** (Community, Medicaid, Aged, Male) | 2.35 |
| **Part B** (Community, Medicaid, Aged, Male) | 1.70 |

**b) Risk Factors:**

| | |
|---|---|
| **Base Factor:** (Community, Male 85-89) | 0.790 |
| **Risk Factors (Demo/Disease Interactions):** | |
| (Community, Medicaid, Aged) | 0.184 |
| (Community, Originally-Disabled Male) | 0.148 |
| **CMS-HCC:** | |
| HCC 5 | 0.652 |
| HCC 7 | 1.464 |
| HCC 15 | 0.764 |
| HCC 80 | 0.417 |
| INT1 (Community) | 0.253 |
| **Total** | **4.672** |

# FERAS Error Codes

| ERROR CODE 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 |

**FILE LEVEL**

| ERROR CODE | RECORD ID | ERROR DESCRIPTION |
|---|---|---|
| 100 | AAA | INVALID RECORD TYPE |
| 101 | AAA | AAA RECORD MISSING FROM TRANSACTION |
| 102 | AAA | MISSING / INVALID SUBMITTER-ID ON AAA RECORD |
| 103 | AAA | MISSING FILE-ID ON AAA RECORD |
| 104 | AAA | MISSING / INVALID TRANSACTION DATE ON AAA RECORD |
| 105 | AAA | MISSING / INVALID PROD-TEST-INDICATOR ON AAA RECORD |
| 112 | AAA | SUBMITTER ID NOT ON FILE |
| 113 | AAA | FILE NAME DUPLICATES ANOTHER FILE ACCEPTED WITHIN LAST 12 MONTHS |
| 114 | AAA | TRANSACTION DATE IS GREATER THAN CURRENT DATE |
| 151 | ZZZ | ZZZ RECORD MISSING FROM TRANSACTION |
| 152 | ZZZ | MISSING / INVALID SUBMITTER-ID ON ZZZ RECORD |
| 153 | ZZZ | MISSING / INVALID FILE-ID ON ZZZ RECORD |
| 154 | ZZZ | MISSING / INVALID BBB-RECORD-TOTAL |
| 162 | ZZZ | ZZZ SUBMITTER-ID DOES NOT MATCH SUBMITTER-ID ON AAA RECORD |
| 163 | ZZZ | FILE ID DOES NOT MATCH FILE ID ON AAA RECORD |
| 164 | ZZZ | ZZZ VALUE IS NOT EQUAL TO THE NUMBER OF BBB RECORDS |

***If any errors occur in FERAS, the complete file is rejected and returned to the submitter after all possible checks are completed.***

# FERAS Error Codes

**BATCH LEVEL**

| ERROR CODE | RECORD ID | ERROR DESCRIPTION |
|---|---|---|
| 201 | BBB | BBB RECORD MISSING FROM TRANSACTION |
| 202 | BBB | MISSING / INVALID SEQUENCE NUMBER ON BBB RECORD |
| 203 | BBB | MISSING / INVALID PLAN NUMBER ON BBB RECORD |
| 212 | BBB | SEQUENCE NUMBER ON BBB RECORD IS OUT OF SEQUENCE |
| 213 | BBB | SUBMITTER ID NOT AUTHORIZED TO SUBMIT FOR THIS PLAN ID |
| 251 | YYY | YYY RECORD MISSING FROM TRANSACTION |
| 252 | YYY | MISSING / INVALID SEQUENCE NUMBER ON YYY RECORD |
| 253 | YYY | MISSING / INVALID PLAN NUMBER ON YYY RECORD |
| 254 | YYY | MISSING / INVALID CCC-RECORD-TOTAL |
| 262 | YYY | LAST YYY SEQUENCE NUMBER IS NOT EQUAL TO NUMBER OF YYY RECORDS |
| 263 | YYY | PLAN NUMBER DOES NOT MATCH PLAN NUMBER IN BBB RECORD |
| 264 | YYY | YYY VALUE IS NOT EQUAL TO THE NUMBER OF CCC RECORDS |
| 272 | YYY | SEQUENCE NUMBER ON YYY RECORD IS OUT OF SEQUENCE |

**DETAIL LEVEL**

| ERROR CODE | RECORD ID | ERROR DESCRIPTION |
|---|---|---|
| 301 | CCC | CCC RECORD MISSING FROM TRANSACTION |
| 302 | CCC | MISSING / INVALID SEQUENCE NUMBER ON CCC RECORD |
| 303 | CCC | SEQUENCE-ERROR-CODE FILLER NOT EQUAL TO SPACES |
| 304 | CCC | HIC-ERROR-CODE FILLER NOT EQUAL TO SPACES |
| 305 | CCC | DOB-ERROR-CODE FILLER NOT EQUAL TO SPACES |
| 306 | CCC | DIAGNOSIS CODE-FILLER NOT EQUAL TO SPACES |
| 307 | CCC | DIAGNOSIS-CLUSTER-ERROR-1 NOT EQUAL TO SPACES |
| 308 | CCC | DIAGNOSIS-CLUSTER-ERROR-2 NOT EQUAL TO SPACES |
| 310 | CCC | MISSING / INVALID HIC-NO ON CCC RECORD |
| 311 | CCC | AT LEAST ONE DIAGNOSIS CLUSTER REQUIRED ON TRANSACTION |
| 313 | CCC | DELETE-INDICATOR MUST BE BLANK OR EQUAL TO “D” |
| 314 | CCC | INVALID DIAGNOSIS CODE FORMAT ON CCC RECORD |
| 315 | CCC | CORRECTED HIC NOT EQUAL TO SPACES |
| 350 | CCC | INVALID PATIENT-DOB ON CCC RECORD |
| 400 | CCC | MISSING / INVALID PROVIDER-TYPE ON CCC RECORD |
| 401 | CCC | INVALID FROM-DATE ON CCC RECORD |
| 402 | CCC | INVALID THRU-DATE ON CCC RECORD |

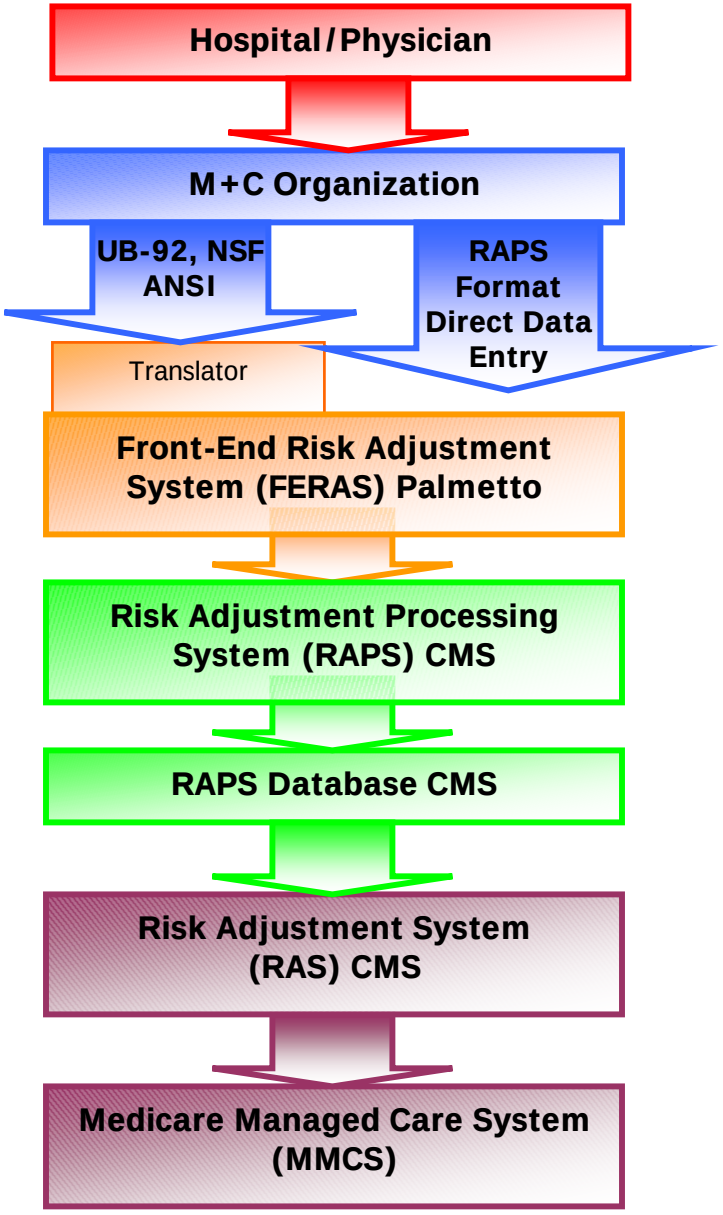
***If any errors occur in FERAS, the complete file is rejected and returned to the submitter after all possible checks are completed.***

# Risk Adjustment Submission Timetable

| CY | Dates of Service | Initial Submission Deadline | First Payment Date | Final Submission Deadline |
|---|---|---|---|---|
| 2004 | 7/1/02 – 6/30/03 | 9/5/03 | 1/1/04 | NA* |
| 2004 | 1/1/03 – 12/31/03 | 3/5/04 | 7/1/04 | 5/13/05 |
| 2005 | 7/1/03 – 6/30/04 | 9/3/04 | 1/1/05 | NA* |
| 2005 | 1/1/04 – 12/31/04 | 3/4/05 | 7/1/05 | 5/15/06 |

* With the elimination of the payment lag, the final submission deadline (reconciliation) changes to May 15 of each year. There is no September 30, 2004 deadline.

# Risk Adjustment Process Overview




CMS
CENTERS for MEDICARE & MEDICAID SERVICES

April 2004

# RAPS Error Codes

| SERIES | EXPLANATION OF ERROR AND CONSEQUENCES |
|---|---|
| **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. |
| **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. |

| ERROR CODE | RECORD ID | ERROR DESCRIPTION |
|---|---|---|
| 301 | CCC | CCC RECORD MISSING FROM TRANSACTION |
| 302 | CCC | MISSING / INVALID SEQUENCE-NUMBER ON CCC RECORD |
| 303 | CCC | SEQUENCE-ERROR-CODE FILLER NOT EQUAL TO SPACES |
| 304 | CCC | HIC-ERROR-CODE FILLER NOT EQUAL TO SPACES |
| 305 | CCC | DOB-ERROR-CODE FILLER NOT EQUAL TO SPACES |
| 306 | CCC | DIAGNOSIS CODE FILLER NOT EQUAL TO SPACES |
| 307 | CCC | DIAGNOSIS-CLUSTER-ERROR-1 NOT EQUAL TO SPACES |
| 308 | CCC | DIAGNOSIS-CLUSTER-ERROR-2 NOT EQUAL TO SPACES |
| 309 | CCC | SEQUENCE-NUMBER ON CCC RECORD IS OUT OF SEQUENCE |
| 310 | CCC | MISSING / INVALID HIC-NUMBER ON CCC RECORD |
| 311 | CCC | AT LEAST ONE DIAGNOSIS CLUSTER REQUIRED ON TRANSACTION |
| 313 | CCC | DELETE-INDICATOR MUST EQUAL SPACE OR “D” FOR DELETE |
| 314 | CCC | INVALID DIAGNOSIS CODE FORMAT ON CCC RECORD |
| 315 | CCC | CORRECTED HIC NOT EQUAL TO SPACES |
| 350 | CCC | INVALID PATIENT-DOB ON CCC RECORD |
| 353 | CCC | HIC NUMBER DOES NOT EXIST ON MBD |
| 354 | CCC | PATIENT DOB DOES NOT MATCH WITH MBD DOB |

# RAPS Error Codes

| ERROR CODE | RECORD ID | ERROR DESCRIPTION |
|---|---|---|
| 400 | CCC | MISSING / INVALID PROVIDER-TYPE CODE ON CCC RECORD |
| 401 | CCC | INVALID SERVICE FROM-DATE ON CCC RECORD |
| 402 | CCC | INVALID SERVICE THROUGH-DATE ON CCC RECORD |
| 403 | CCC | SERVICE THROUGH DATE MUST BE GREATER THAN 12/31/2002 |
| 404 | CCC | SERVICE FROM DATE MUST BE LESS THAN OR EQUAL TO THROUGH DATE |
| 405 | CCC | DOB IS GREATER THAN SERVICE FROM DATE |
| 406 | CCC | SERVICE FROM DATE IS NOT WITHIN MEDICARE ENTITLEMENT PERIOD |
| 407 | CCC | SERVICE THROUGH DATE IS NOT WITHIN MEDICARE ENTITLEMENT PERIOD |
| 408 | CCC | SERVICE FROM DATE IS NOT WITHIN M+C ORG ENROLLMENT PERIOD |
| 409 | CCC | SERVICE THROUGH DATE IS NOT WITHIN M+C ORG ENROLLMENT PERIOD |
| 410 | CCC | BENEFICIARY IS NOT ENROLLED IN PLAN ON OR AFTER SERVICE FROM DATE |
| 411 | CCC | SERVICE THROUGH DATE IS GREATER THAN DATE OF DEATH |
| 412 | CCC | SERVICE FROM DATE GREATER THAN TRANSACTION DATE |
| 413 | CCC | SERVICE THROUGH DATE GREATER THAN TRANSACTION DATE |
| 450 | CCC | DIAGNOSIS DOES NOT EXIST FOR THIS SERVICE THROUGH DATE |
| 451 | CCC | SERVICE THROUGH DATE IS GREATER THAN DIAGNOSIS END DATE |
| 453 | CCC | DIAGNOSIS CODE IS NOT APPROPRIATE FOR PATIENT SEX |
| 454 | CCC | DIAGNOSIS IS VALID, BUT IS NOT SUFFICIENTLY SPECIFIC FOR RISK ADJUSTMENT GROUPING |
| 460 | CCC | SERVICE FROM AND THROUGH DATE SPAN IS GREATER THAN 31 DAYS |
| 490 | CCC | COULD NOT DELETE, DIAGNOSIS CLUSTER NOT IN RAPS DATABASE BENEFICIARY RECORD |
| 491 | CCC | DELETE ERROR, DIAGNOSIS CLUSTER PREVIOUSLY DELETED |
| 492 | CCC | DIAGNOSIS CLUSTER WAS NOT SUCCESSFULLY DELETED. A DIAGNOSIS CLUSTER WITH THE SAME ATTRIBUTES WAS ALREADY DELETED FROM THE RAPS DATABASE ON THIS DATE. |

**INFORMATIONAL EDITS**

| ERROR CODE | RECORD ID | ERROR DESCRIPTION |
|---|---|---|
| 500 | CCC | BENEFICIARY HIC NUMBER HAS CHANGED ACCORDING TO CMS RECORDS; USE CORRECT HIC NUMBER FOR FUTURE SUBMISSIONS |
| 501 | CCC | VALID DIAGNOSIS BUT NOT A RELEVANT DIAGNOSIS FOR RISK ADJUSTMENT DURING THIS SERVICE PERIOD |
| 502 | CCC | DIAGNOSIS CLUSTER WAS ACCEPTED BUT NOT STORED. A DIAGNOSIS CLUSTER WITH THE SAME ATTRIBUTES IS ALREADY STORED IN THE RAPS DATABASE. |

# RAPS Record Layout

**AAA RECORD**

| FIELD NO. | FIELD NAME | POSITION | PICTURE | VALUE |
|---|---|---|---|---|
| 1 | RECORD-ID | 1 – 3 | X(3) | 'AAA' |
| 2 | SUBMITTER-ID | 4 – 9 | X(6) | 'Shnnnn' |
| 3 | FILE-ID | 10 – 19 | X(10) | |
| 4 | TRANSACTION-DATE | 20 – 27 | 9(8) | 'CCYYMMDD' |
| 5 | PROD-TEST-IND | 28 – 31 | X(4) | 'PROD' Or 'TEST' |
| 6 | FILLER | 32 - 512 | X(481) | SPACES |

**BBB RECORD**

| FIELD NO. | FIELD NAME | POSITION | PICTURE | VALUE |
|---|---|---|---|---|
| 1 | RECORD-ID | 1 – 3 | X(3) | 'BBB' |
| 2 | SEQ-NO | 4 – 10 | 9(7) | Must begin with '0000001' |
| 3 | PLAN-NO | 11 – 15 | X(5) | 'Hnnnn' |
| 4 | FILLER | 16 – 512 | X(497) | SPACES |

**CCC RECORD**

| FIELD NO. | FIELD NAME | POSITION | PICTURE | VALUE |
|---|---|---|---|---|
| 1 | RECORD-ID | 1 – 3 | X(3) | 'CCC' |
| 2 | SEQ-NO | 4 – 10 | 9(7) | Must begin with '0000001' |
| 3 | SEQ-ERROR-CODE | 11 – 13 | X(3) | SPACES |
| 4 | PATIENT-CONTROL-NO | 14 – 53 | X(40) | Optional |
| 5 | HIC-NO | 54 – 78 | X(25) | |
| 6 | HIC-ERROR-CODE | 79 – 81 | X(3) | SPACES |
| 7 | PATIENT-DOB | 82 – 89 | 9(8) | 'CCYYMMDD' |
| 8 | DOB-ERROR-CODE | 90 – 92 | X(3) | SPACES |
| 9 – 18 | DIAGNOSIS-CLUSTER (10 OCCURRENCES) | 93 – 412 | | |
| 9.0 | PROVIDER-TYPE | | X(2) | HOSPITAL IP PRINCIPAL = 01<br>HOSPITAL IP OTHER = 02<br>HOSPITAL OP = 10<br>PHYSICIAN = 20 |
| 9.1 | FROM-DATE | | 9(8) | 'CCYYMMDD' |
| 9.2 | THRU-DATE | | 9(8) | 'CCYYMMDD' |
| 9.3 | DELETE-IND | | X(1) | SPACE or 'D' |
| 9.4 | DIAGNOSIS-CODE | | X(5) | |
| 9.5 | DC-FILLER | | X(2) | SPACES |
| 9.6 | DIAG-CLSTR-ERROR-1 | | X(3) | SPACES |
| 9.7 | DIAG-CLSTR-ERROR-2 | | X(3) | SPACES |
| 19 | CORRECTED-HIC-NO | 413 – 437 | X(25) | SPACES |
| 20 | FILLER | 438 - 512 | X(75) | SPACES |

**YYY RECORD**

| FIELD NO. | FIELD NAME | POSITION | PICTURE | VALUE |
|---|---|---|---|---|
| 1 | RECORD-ID | 1 – 3 | X(3) | 'YYY' |
| 2 | SEQ-NO | 4 – 10 | 9(7) | Must begin with '0000001' |
| 3 | PLAN-NO | 11 – 15 | X(5) | 'Hnnnn' |
| 4 | CCC-RECORD-TOTAL | 16 – 22 | 9(7) | |
| 5 | FILLER | 23 – 512 | X(490) | SPACES |

**ZZZ RECORD**

| FIELD NO. | FIELD NAME | POSITION | PICTURE | VALUE |
|---|---|---|---|---|
| 1 | RECORD-ID | 1 – 3 | X(3) | 'ZZZ' |
| 2 | SUBMITTER-ID | 4 – 9 | X(6) | 'SHnnnn' |
| 3 | FILE-ID | 10 – 19 | X(10) | |
| 4 | BBB-RECORD-TOTAL | 20 – 26 | 9(7) | |
| 5 | FILLER | 27 – 512 | X(486) | SPACES |

## BACKGROUND

Medical information is critical to many areas of the M+C organization and healthcare in general. In order to be statistically useful, however, narrative descriptions of diagnoses must be converted into numbers. This is the practice of coding. The International Classification of Diseases (ICD) is published by the World Health Organization. The United States modifies the ICD to meet the needs of American hospitals and physicians. The ninth revision, clinical modification (ICD-9-CM) has been in use since 1978. Although the original intent of the system remains statistical in nature, it is widely used as a basis for various reimbursement systems in many healthcare settings.

## UPDATES

ICD-9-CM is updated on October 1 and April 1 (beginning April 2005). The ICD-9-CM Coordination and Maintenance Committee holds a public forum for requested updates and publishes a transcript of their recommendations on the CMS website and the *Federal Register*. Revisions discussed at the April and December meetings of one year generally become effective during October of the following year. Update explanations are published in the fourth quarter *Coding Clinic for ICD-9-CM* each year and are available from the American Hospital Association.

## GUIDELINES

cdc.gov/nchs/data/icd9/icdguide.pdf

*Coding Clinic for ICD-9-CM, fourth quarter, 2002.*

## ABBREVIATIONS & NOTES

*Excludes and Includes* notes: Informs the coder which diagnosis codes are included or excluded in the code selected.
*Use Additional Code* note: Signifies that more than one code is needed to fully describe the condition and gives examples of common associated conditions.
*Not otherwise specified (NOS)* : Means "unspecified" generally. The documentation does not provide additional information to be coded.

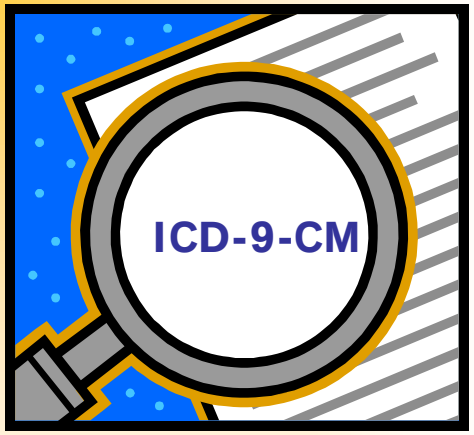
## RESOURCES

- CMS.hhs.gov
- PhysicianS and Medicare+Choice Risk Adjustment CD
- Coding Clinic for ICD-9-CM and other resources published by the American Hospital Association www.aha.org
- American Health Information Management Association (AHIMA) www.ahima.org (coding and documentation books, audio seminars and distance learning)
- American Academy of Professional Coders (AAPC) www.aapc.org
- American Medical Association (AMA) www.ama.org

Aspen Systems Corporation
2277 Research Boulevard, Mail Stop 6T
Rockville, MD 20850
Phone (301) 519-5742 ▪ Fax (301) 519-5855

4/16/04
Rev. 05/05/04

# FOCUS ON:




International Classification of Diseases 9th revision

## CLINICAL MODIFICATION

## STRUCTURE OF ICD-9-CM

***Volume I*** - Disease Index *an alphabetical listing of diseases and conditions. Including the following tables:*

- Hypertension Table
- Neoplasm Table
- Table of Drugs and Chemicals
- External Cause of Injury Index

***Volume II*** – Disease Tabular *numerical code listing organized by body system with instructional notes to direct the user to the most specific code.*

Each code consists of three, four or five characters separated by a decimal after the third character. Codes range from 001.0-999.9. Additionally, there are two sets of alphanumeric codes beginning with letters V and E. Codes are reported to the highest level of character available for the code category.

## ICD-9-CM PROCESS

- Review the medical record documentation to determine the reason for the patient visit.
- Determine if any other conditions or patient status issues (potential V codes) are present and are related to this visit.
- Look up the main terms of the diagnoses/conditions/symptoms in the ICD-9-CM alphabetic index. More than one term may be needed to fully describe the condition.
- Search the indented (sub-terms) to select the code with the closest description to the condition(s) documented. The index may refer you to another related term.
- Look up the selected code in the Tabular (numeric) index.
- Read and be guided by all the definitions and notes for the category including external causes for poisoning and injuries (E-codes).
- Code to the highest number of digits available.
- Determine if any of the conditions can be combined into one code according to ICD-9-CM guidelines.
- Do not code common symptoms if another more definitive diagnosis can be documented and coded. For example do not code both cough and bronchitis.
- For physician office and outpatient settings, code only to the level of certainty known at the time of the visit. Do not code conditions described by "rule out" or "suspected."
- Clarify physician use of conditions described as "history of …" to determine if the diagnosis is no longer present or is an ongoing, chronic condition.

## ICD –9-CM CHAPTER CONTENT

(WITH RANGE OF CODE THREE DIGIT LEVEL CATEGORIES)

1. Infectious and Parasitic Disease (001-139)
2. Neoplasms (140-239)
3. Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders (240-279)
4. Diseases of the Blood and Blood-forming organs (280-289)
5. Mental Disorders (290-319)

**V CODES**
Classification of Factors Influencing Health Status and Contact with Health Services

6. Diseases of Nervous and Sense Organs (320-389)
7. Diseases of the Circulatory System (390-459)
8. Diseases of the Respiratory System (460-519)
9. Diseases of the Digestive System (520-579)
10. Diseases of the Genitourinary System (580-629)
11. Complication of Pregnancy, Childbirth, and the Puerperium (630-677)

**E CODES**
Classification of External Causes of Injury and Poisoning

12. Diseases of the Skin and Subcutaneous System (680-709)
13. Diseases of the Musculoskeletal System and Connective Tissue (710-739)
14. Congenital Anomalies (740-759)
15. Certain Conditions Originating in the Perinatal Period (760-779)
16. Symptoms, Signs, and Ill-Defined Conditions (780-799)
17. Injury and Poisonings (800-999)

# Data Validation

Risk adjustment data validation is the process of verifying that a diagnosis code submitted by the M+C organization to CMS are supported by the medical record documentation of the M+C enrollee. CMS validates medical records to ensure payment integrity and accuracy. The primary steps in the process are identified below.

**Primary Steps in the Data Validation Process**

| | |
|---|---|
| Step 1 | CMS selects a sample of M+C beneficiary HCCs and requests medical records from the M+C organization. |
| Step 2 | The M+C organization responds to the request by gathering the requested medical records. Physicians and providers should respond quickly to requests for medical records. |
| Step 3 | M+C organization sends the requested medical records to the initial validation contractor, who reviews the records and identifies any data discrepancies. |

- Physicians and providers should follow general principles of medical record documentation. For data validation, the M+C organization may request medical records from physicians.
- A request for records may include the M+C beneficiary's Medicare HIC number and date or dates of service.
- When submitting a medical record, physicians and providers must ensure that all of the documentation to support a reported diagnosis on a given date or range of dates is provided.
- Response to a request should include supporting documents referred to in the notes, such as test results or problem lists.
- Respond to a request quickly, and send all records in an organized, secure, and confidential manner as directed by the M+C organization.

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# Communicating with Physicians & Providers about Risk Adjustment

## Key Messages

It is important when communicating with physicians and providers, that they understand the risk adjustment requirements and their responsibilities under the new payment model. Reinforce the following messages by including them in several provider communication channels.

**What is the purpose of risk adjustment?** Risk adjustment strengthens the Medicare program by ensuring that accurate payments are made to Medicare+Choice (M+C) organizations based on the health status of their enrolled beneficiaries. Accurate payments to M+C organizations help to ensure that physicians and providers are paid appropriately for the services they render to M+C beneficiaries and provide incentives to enroll and treat less than health individuals.

**Why risk adjustment is important to providers and physicians?** While procedure codes may remain important for providers' reimbursement of services to fee-for-service Medicare beneficiaries, the risk adjustment payment model relies on ICD-9-CM diagnosis code specificity.

**What are physicians' and providers' responsibilities?** For their M+C beneficiaries, providers and physicians must:

- Report ICD-9-CM diagnosis codes to the highest level of specificity and report these codes accurately.
- Maintain accurate and complete medical record documentation.
- Alert the M+C organization of any erroneous data that has been submitted, and follow the procedures for correcting erroneous data.
- Report claims and encounter data in a timely manner, generally within 30 days of the date of service (or discharge from hospital inpatient facilities).

*Your organization also may include other key messages in provider communications, which may include appropriate format for data collection, data beyond the risk adjustment elements required by your organization, and instruction based on analysis of risk adjustment process reports.*

Remember, refer physicians to the "Physicians & Medicare+Choice Risk Adjustment" CD for additional information about risk adjustment. The CD includes brief, self-paced modules on physicians' responsibilities regarding risk adjustment, medical record documentation and coding guidelines, reporting patient diagnostic data, and a summary of the data validation process.

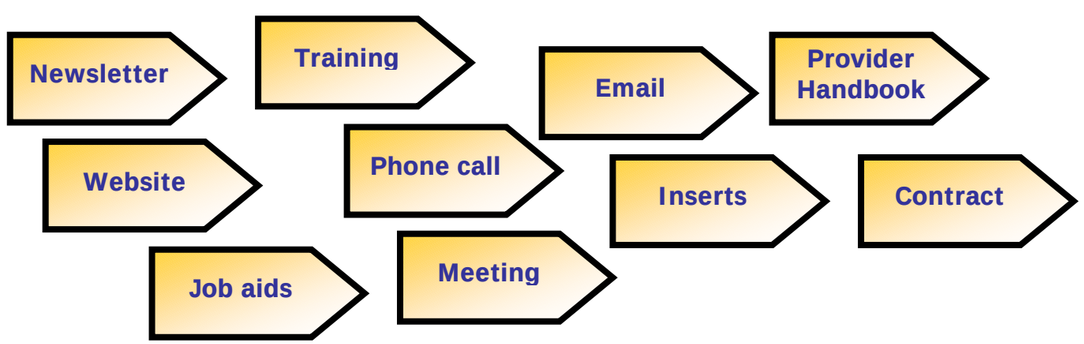
# Communication Characteristics

Providers respond more positively to communication pertaining to risk adjustment from M+C organizations when that communication is considered reliable, accurate, and meets specific needs. When developing communications and education for providers using any format, M+C organizations are encouraged to consider the following characteristics of effective provider communications:

**Authoritative** – Make the "look and feel" of provider communications conservative, official, and factual. Be certain all information is accurate. Grammar, spelling, and punctuation must be perfect.
**Current** – Ensure that information is the most recent available. Update provider handbooks, websites, job aids, and training materials routinely so all information are current.
**Timely** – Provide information to providers when need to know it.
**Consistent** – Send consistent messages about risk adjustment to providers. Ensure that provider relations, claims, and medical review staff convey the same messages.
**Practical, relevant & well organized** – Delete "background noise" from your physician and provider messages. That is, identify the primary message, provide the key information necessary to make the point, and identify any specific actions that are required. Physicians and provider staff appreciate easy-to-use information that is written in clear, concise language.
**Accessible** – Create materials for physicians and providers that are easy to access. Information that physicians and providers can locate quickly helps to ensure compliance with risk adjustment requirements.

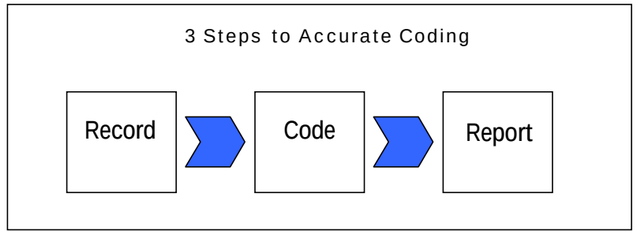
# Communication Methods

Many M+C organizations have indicated that a multimodal approach to provider education works better than a single mode approach. For example, rather than sending important information by newsletter only, organizations use a variety of communications including onsite visits, large group training sessions, provider handbooks, newsletters, and, increasingly, the Web. Additionally, different communication channels can be used for different provider groups. For example, a M+C organization may communicate with a key physician group or a system of high-volume hospitals via email and regularly scheduled meetings.




# Coding & Medical Record Documentation

There are three steps physicians and providers must follow to ensure accurate diagnosis codes are sent to M+C organizations.




① Medical record documentation is important for risk adjustment because quality documentation leads to correct code specificity and accurate risk adjusted payment.

② Physicians and providers should report all diagnoses that impact the patient's care, and ensure these diagnoses are accurately documented in a medical record. This includes the main reason for the episode of care; and all co-existing, acute or chronic conditions; and pertinent past conditions that impact clinical evaluation and therapeutic treatment. Symptoms that are common to the main reportable diagnosis should not be coded. Coding to the highest degree of specificity provides the most accurate coding and ensures appropriate grouping in the risk adjustment model.

③ Report all claims and/or encounter information using the format(s) identified by the M+C organization.

# Data Collection

Under the risk adjustment model, physicians and providers must submit the following elements to M+C organizations:

- ICD-9-CM diagnosis code.
- Service from date.
- Service through date.
- HIC number of M+C beneficiary (M+C organizations are not required to collect this number from physicians and providers, however, they must be able to identify beneficiaries when they submit data to CMS).

| Format | Data Collection Tool Features | | | | | |
|---|---|---|---|---|---|---|
| | Paper Format | Full Claims Data | Minimum Data Set | Electronic | Physician Services | Hospital Inpatient / Outpatient Services |
| HCFA 1500 | ● | ● | | | ● | |
| UB-92* | | ● | | ● | | ● |
| Abbreviated UB-92* | | ● | | ● | | ● |
| NSF* | | ● | | ● | ● | |
| ANSI X12 837 | | ● | | ● | ● | ● |
| Superbill | ● | | ● | | ● | |
| RAPS Format | | | ● | ● | ● | ● |

Remember, contractual relationships with physicians and providers impacts the format used to collect risk adjustment data from them.

*These data collection formats are not HIPAA compliant transactions. However, if your plan is HIPAA compliant and your trading partners are not HIPAA compliant, CMS is allowing receipt of the non-HIPAA formats until such time as your trading partners are prepared to submit the HIPAA transaction sets.