

2003 Regional Risk Adjustment Training for Medicare+Choice Organizations



Track 1
IT/Systems
Training Slides

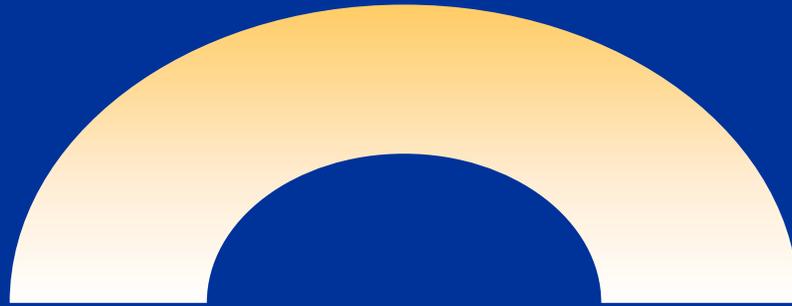
Introduction

**Angela Reddix
Aspen Systems Corporation**

Purpose

The purpose of this training is to provide participants with information and resources specific to the role they play in the risk adjustment process. This information will lead to improvements in the quality and quantity of risk adjustment data submitted and ultimately more accurate payment by CMS.

Training Format

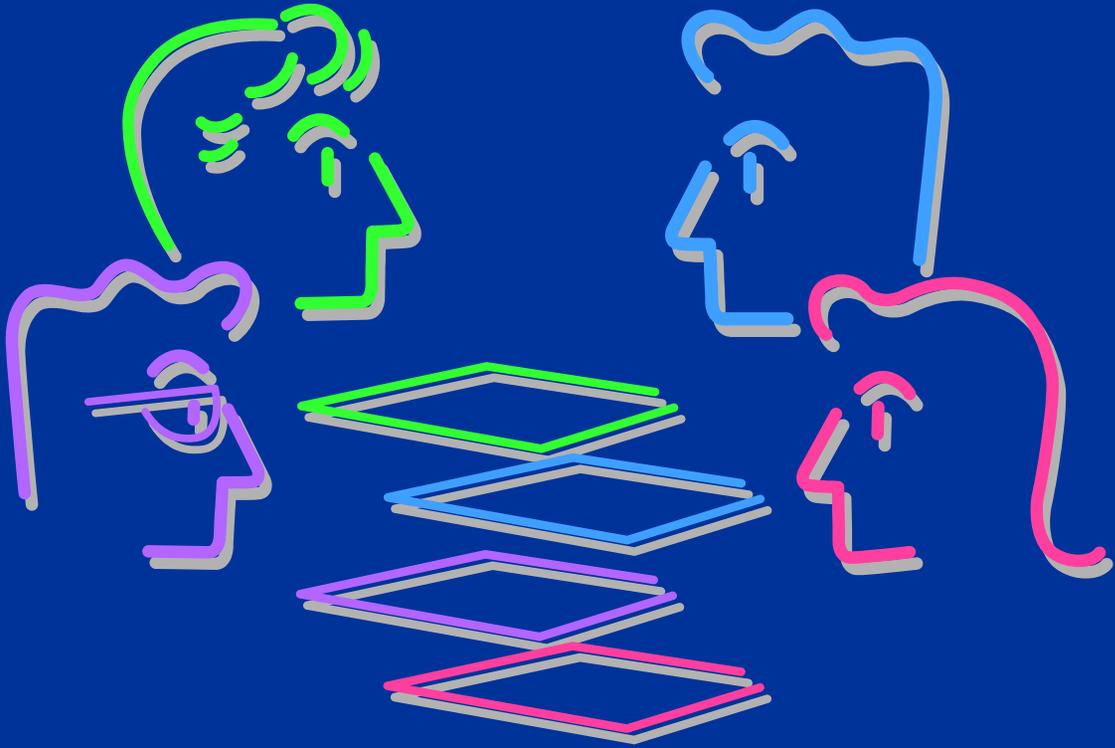


Concepts

Application

- **Case Studies**
- **Sharing Lessons Learned**
- **Group Participation**
- **Casual**
- **Interactive**

Your Involvement Makes the Difference



**2003 Regional Risk Adjustment Training
for Medicare+Choice Organizations**

Two Tracks

Training designed to meet the needs
of two specific audiences



Track 1 – IT/Systems Track



Track 2 – Data Collection/Clinical Coding
Track

Audience



- M+C organizations
- PACE plans
- Minnesota Senior Health Options
- Social Health Maintenance Organizations
- Wisconsin Partnership Program
- EverCare
- Capitated Demonstration Projects

Objectives

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

- Identify the final CMS-HCC model and payment methodology
- Describe the requirements for data collection
- Determine the process for submitting data to CMS
- Interpret the editing rules and the resolution of errors

Objectives

(continued)

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

- Gain an understanding of strategies employed by other organizations
- Understand how to verify risk scores reported in the Monthly Membership Report (MMR)
- Understand the data validation approach under the CMS-HCC Model

Training Team

CMS



Palmetto

Aspen

Risk Adjustment & The CMS-HCC Model

CMS Staff

2003 Regional Risk Adjustment Training
for Medicare+Choice Organizations

CMS

CENTERS for MEDICARE & MEDICAID SERVICES

Purpose

- To provide an explanation of risk adjusted payment under the CMS-HCC payment model for the Medicare+Choice program.

Objectives

- Understand the components of risk adjusted payment
- Understand how demographic & risk adjusted payments are calculated
- Understand the new enrollee factors
- Understand the long-term institutional model

Objectives (continued)

- Understand the frailty adjuster
- Understand the new payment schedule based on elimination of the payment lag
- Understand plan-level data reported in HPMS

Characteristics of the CMS-HCC Model

- Selected Significant Disease
- Prospective
- Demographic Variables
- Site Neutral

Characteristics of the CMS-HCC Model (continued)

- Considers Multiple Chronic Diseases
- Includes Disease Interactions & Hierarchies
- Distinguishes Between Community-Based and Long-Term Institutionalized Enrollees

M+C Rate Book

- Capitated payments to plans are set using a county-level rate
- The 1997 rate book is the statutory basis for M+C capitated payments

M+C Rate Book After BBA

- Rate book calculation changed from pre-BBA standard to create stability in rate changes from year to year & reduce substantial geographic variation in payment rates
- Broke direct link between M+C payment and FFS spending
- Introduced the “highest of 3 rates” method

M+C Rate Book After BBA

(continued)

- 3 Rates
 - Blended capitation: a combination of national average rates and local rates
 - Minimum Floor: Set by BBA & updated by Congress in 2000; national growth percentage
 - Minimum percent update: Generally an increase of 2%

Calculating Payments

Example:

- 72-year old female
- Residence: Howard County, Maryland
- Community (non-institutionalized)
- Originally entitled to Medicare due to disability
- Not entitled to Medicaid
- Diagnoses during the data collection period:
Diabetes with Acute Complications (HCC 17),
Diabetes without Complications (HCC 19) and
Pneumococcal Pneumonia (HCC 112)

Calculating Payments

(continued)

STEP 1

Calculate
Demographic
Payment

County Rate
Book
Part A & Part
B Rates

Attachment A

Monthly rate book
amounts for Howard
County, MD

Part A = **\$348.93**

Part B = **\$281.71**

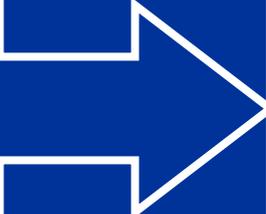
Calculating Payments

(continued)

STEP 1 Attachment B

Calculate
Demographic
Payment

Demographic Cost
Factors



Factors for 72 year-old
female, community:

Multiply by Demographic
Cost Factors for 1997-2004

$$\text{Part A} = .70 \times \$348.93$$

$$\text{Part B} = .85 \times \$281.71$$

$$\text{Part A} = \$244.25$$

$$\text{Part B} = \$239.45$$

$$\text{A} + \text{B} = \mathbf{\$483.70}$$

Calculating Payments

(continued)

STEP 1

County Rate
Book
Part A & Part
B Rates

Demographic Cost
Factors

*Demographic
Payment*

Multiply Total by
Demographic % for
2004

$$A+B = \$483.70 \times .70 =$$

\$338.59

Risk Rate Book

- A rescaling factor is applied to convert the rate book and get the risk adjusted rate for each county
- Rescaling factor =

$$\frac{\text{Re-standardized County Rate}}{\text{Demographic County Rate}}$$

CY2004 Rescaling Factor

- Two adjustments for 2004
 - Budget Neutrality:
 - Separate from rate book adjustment discussed earlier
 - Represents difference between 100% risk adjusted payment vs. 100% demographic payment
 - Redistributes reduced aggregate payments as a constant percentage to organizations
 - CY2004 adjustment for budget neutrality = 1.163

CY2004 Rescaling Factor

(continued)

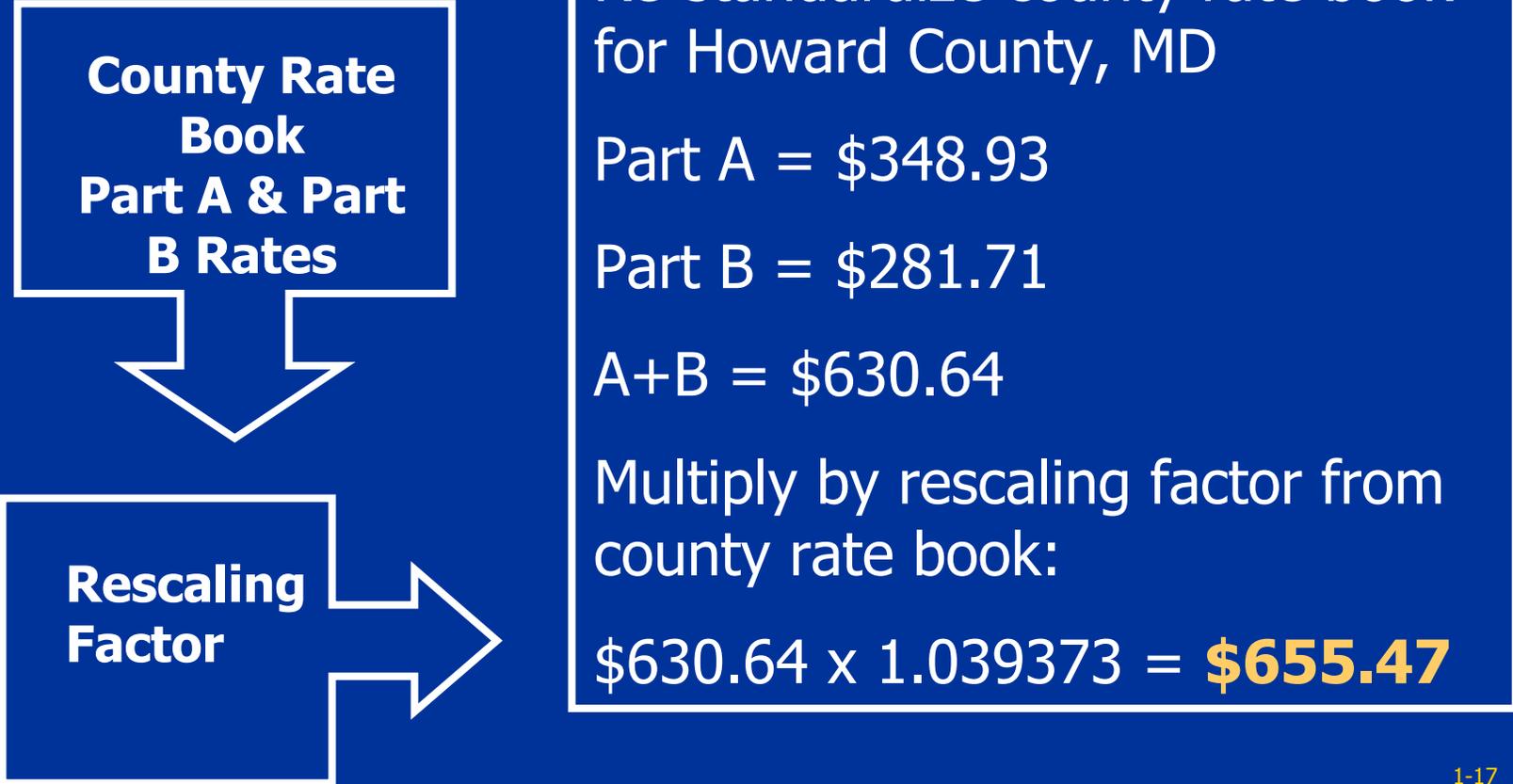
- Two adjustments for 2004
 - FFS Normalization:
 - Necessary for changes in the national average predicted expenditures from 1997
 - Changing demographics, average disease burdens, & coding patterns
 - CMS uses actuarial adjustment to the national mean predicted expenditures
 - CY2004 FFS normalization adjustment = $1/1.05$

Calculating Risk Adjusted Payment

STEP 2

Attachment A

County Rate
Book
Part A & Part
B Rates



Rescaling
Factor

Re-standardize county rate book
for Howard County, MD

Part A = \$348.93

Part B = \$281.71

A+B = \$630.64

Multiply by rescaling factor from
county rate book:

$\$630.64 \times 1.039373 = \mathbf{\$655.47}$

Demographic Factors in Risk Adjustment

- Age
 - Payment year based on enrollee age as of February 1st
- Sex
- Medicaid Status
 - Under CMS-HCC applies only to community residents
 - Defined as 1 month of Medicaid eligibility during data collection period
 - New enrollees use concurrent Medicaid

Demographic Factors in Risk Adjustment (continued)

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

Calculating Risk Adjusted Payment

STEP 2

Attachment C

Risk Adjusted
Demographics



Demographics:

72 year-old female, community = .384

Originally disabled = .236

Disease Groups/HCCs

- Contain major diseases & broadly organized by body system
- Determined by ICD-9 codes
- Approx. 3,100 ICD-9 codes in CMS-HCC model
- 65 disease groups for payment categories
- Additive

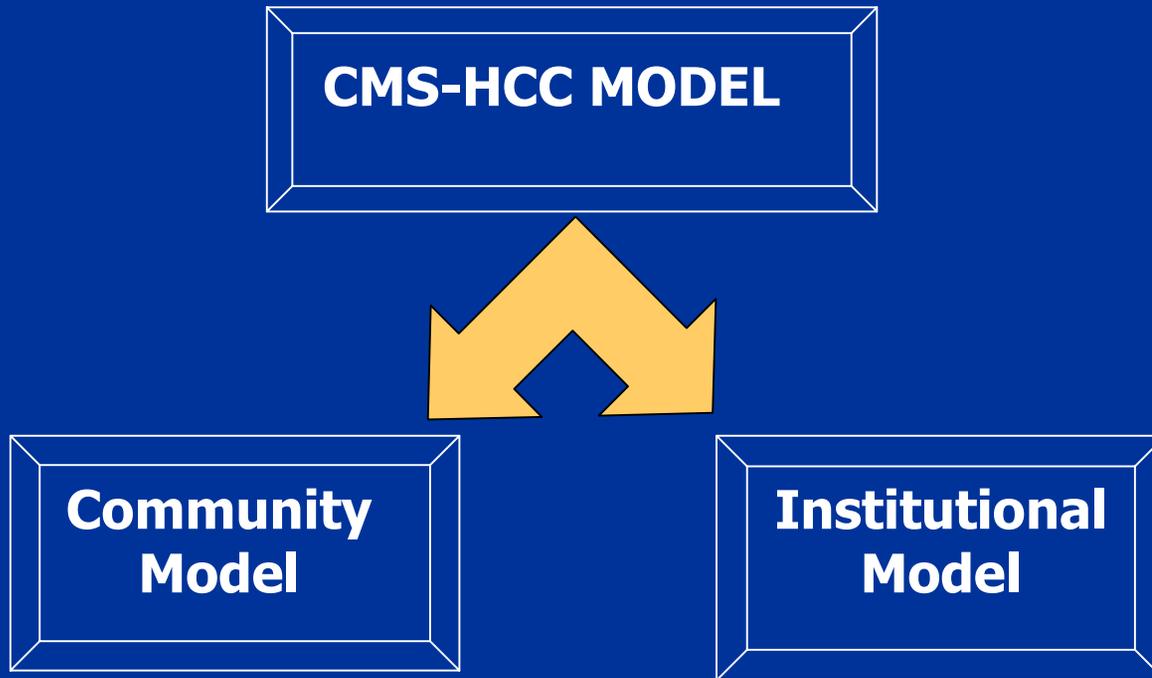
Disease Interactions

- Combinations of coexisting conditions
- 6 disease interactions for community model
- Additive

Disease Hierarchies

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

Community & Institutional Models



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Calculating Risk Adjusted Payment

STEP 2

Attachment C

Risk Adjusted
Demographics
& Disease
Profile
= Beneficiary
Risk Factor

Disease Profile:

HCC17 = .391

HCC19 = .200*

HCC112 = .202

Total risk adjustment factor = .384 +
.236 + .391 + .202 = **1.213**

*dropped because in hierarchy;
payment based on HCC17

Calculating Risk Adjusted Payment (continued)

STEP 2

Apply
CMS-HCC
2004 %

Risk Adjusted Payment

$\$655.47 \times 1.213 = \795.09 at
100%

Calculate 30% risk adjusted
amount for 2004:

$\$795.09 \times .30 =$ **\$238.53**

Calculating Risk Adjusted Payment (continued)

STEP 3

Sum the demographic &
risk adjusted payments

$$\begin{aligned} \text{Total Payments} &= \\ \$338.59 + \$238.53 &= \mathbf{\$577.12/\text{month}} \\ &= \mathbf{\$6,925.44 \text{ annual total}} \end{aligned}$$

Financial Impact of Not Submitting Risk Adjustment Data

- Demographic payment (70% for 2004) remains the same: \$338.59
- Risk adjusted factor becomes
 $.384 + .236 = .620$ vs. 1.213
- $\$655.47 \times .620 = \406.39 vs. \$795.09
- $\$406.39 \times 30\% = \121.92 vs. \$238.53

Financial Impact of Not Submitting Risk Adjustment Data (continued)

- Total payment = \$460.51 vs. \$577.12/month
- Yearly payment = \$5,526.12 vs. \$6,925.44
- **Annual difference \$1,399.32**

Annual Financial Impact

- Annual difference at 30% (CY 2004 payments) = \$1399.35
- Annual difference at 50% (CY 2005 payments) = \$2332.20
- Annual difference at 75% (CY 2006 payments) = \$3498.33
- Annual difference at 100% (CY 2007 and beyond) = \$4664.40

***Using 2004 rate book**

New Enrollee Factors

- New factors developed specifically for CMS-HCC model
- Includes age/sex combinations for Medicaid & disabled
- New enrollee factor applies when enrollee has <12 months of enrollment in Part B during data collection period

Long-Term Institutional Model

- Separate model developed due to cost differences between community & long-term institutional populations
- Apply long-term institutional model for enrollees who reside in an institution for 90+ days

Long-Term Institutional Model (continued)

- Designation is made by MDS (Minimum Data Set)
- Plans **will not report** the institutional status

Frailty Adjuster

- Purpose: To predict Medicare expenditures of the functionally impaired that are unexplained by risk adjustment methodology alone
- Applied to PACE plans and certain demonstrations

Frailty Adjuster (continued)

- Mandated by BBA
- Adjuster based on the relative frailty of an organization in terms of number of functional limitations
- Measured by ADLs (Activities of Daily Living)

Frailty Adjustment

Type of Health Plan	Frailty Adjuster is Part of Risk Adjusted Payment
M+C Organizations	NO
PACE	YES
WPP	YES
MSHO/MnDHO	YES
S/HMOs	YES
EverCare	NO

Frailty Adjustment (continued)

- Applied in conjunction with the CMS-HCC model
- Applies only for community residents who are 55 or older
- CMS calculates organization-level frailty score based on ADLs
- ADLs are reported by survey

Frailty Adjustment Calculation

Refer to Figure 1C in your
Participant Guide

M+C ESRD Payment

- Payment methodology delayed one year, except for ESRD demonstrations
- 3 Parts
 - Dialysis – CMS-HCC payment factors
 - Transplant – lump sum payment
 - Functioning Graft – modified CMS-HCC payment

Yearly Reconciliation

- Reconciliation occurs 6-8 months after end of payment year
- Incorporates data that is late or incorrect
- Includes changes to any demographic variables in the model

Payment Blends

**Refer to Tables 1D & 1E in your
Participant Guide**

Elimination of the Payment Lag

- Beginning with payments in July 2004, the 6-month data lag will be eliminated
- Purpose: To pay more accurately based on the most recent data
- Collection period changes to January 1 through December 31

Elimination of the Payment Lag (continued)

Preliminary Payment Data Collection Period:	July 1, 2002 through June 30, 2003
Deadline for Preliminary Payment Calculation:	September 5, 2003
Data Collection Year	January 1, 2003 through December 31, 2003
Initial Submission Deadline for Data Collection Period	March 5, 2004
Final Submission Deadline for Data Collection Period (Reconciliation):	March 31, 2005

Elimination of the Payment Lag (continued)

- CMS is allowing organizations to opt-out of elimination of the lag for CY2004
- If opt-out, then CMS uses risk factors based on lagged data
- If opt-out, then notify CMS by **March 31, 2004**

Estimator Data Impacts

- Based on data submitted for dates of service: July 1, 2001 through June 30, 2002
- Includes ambulatory data
- Average risk score
- Average impact of 70%/30% vs. 90%/10%

Quarterly Diagnosis Counts Report in HPMS

- Similar to estimator data posting
- Updated quarterly
- First counts posted around November 2003

Quarterly Diagnosis Counts Report in HPMS

(continued)

- Includes:
 - Number of beneficiaries per number of CMS-HCC conditions
 - Number of beneficiaries in each HCC

Summary

- Learned how the CMS-HCC model calculates payment
- Described how HCCs work
- Discussed the financial impact of **not** submitting risk adjustment data

Summary (continued)

- Described the long-term institutional model
- Described the frailty adjuster
- Discussed elimination of the payment lag
- Learned about new HPMS reports

Risk Adjustment Process Overview

Angela Reddix
Aspen Systems Corporation

**2003 Regional Risk Adjustment Training
for Medicare+Choice Organizations**

Purpose

- Provide the participants with important terms, key resources, and submission schedule information that will provide the foundation for this training.

Objectives

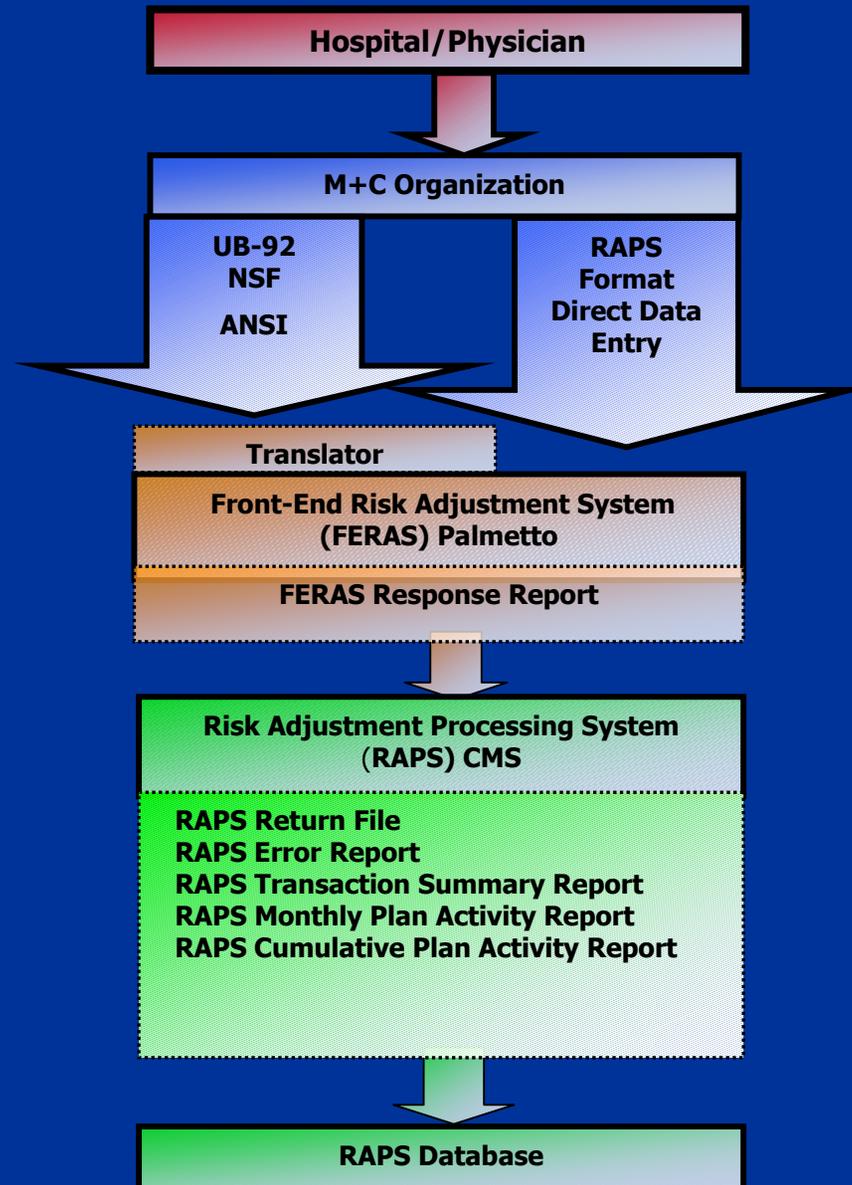
- Identify common risk adjustment terminology
- Demonstrate knowledge in interpreting key components of the risk adjustment process
- Interpret the risk adjustment schedule
- Identify the CMS outreach efforts available to organizations

Risk Adjustment Process Success

- 300 Plan IDs submitted data
- Over 100,000,000 CCC records submitted to FERAS
- 5% initial RAPS error rate
- 1% current RAPS error rate

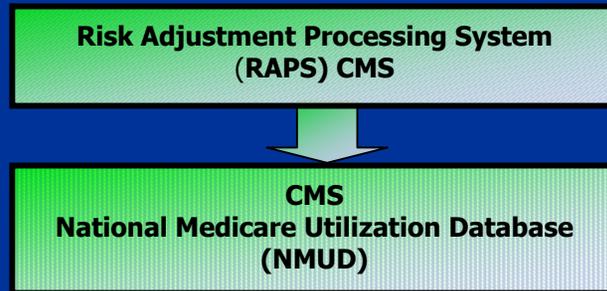
Risk Adjustment Dataflow

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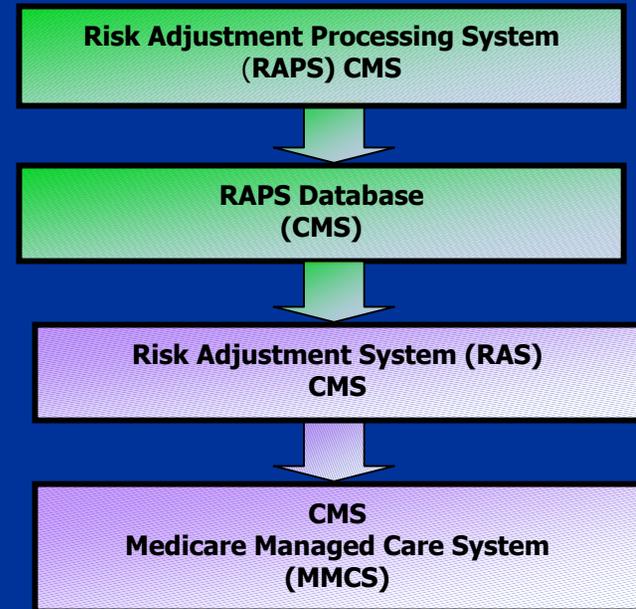


What is New In The Process?

OLD



NEW



Submission Schedule

CY	DATES OF SERVICE	INITIAL SUBMISSION DEADLINE	FIRST PAYMENT DATE	FINAL SUBMISSION DEADLINE
2003	July 1, 2001 through June 30, 2002	September 6, 2002	January 1, 2003	September 26, 2003
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	March 31, 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	March 31, 2006

* With elimination of the payment lag, the final submission deadline (reconciliation) changes to March 31st of each year. There is no September 30, 2004 deadline.

CMS Outreach Efforts

2003 Regional Risk Adjustment Training
for Medicare+Choice Organizations

CSSC	<ul style="list-style-type: none">▪ 1-877-534-2772▪ Monday-Friday▪ 9a.m. – 7p.m.
MCOservice.com	<ul style="list-style-type: none">▪ Gateway to risk adjustment information▪ FAQs▪ Training information▪ Automatic Updates
User Groups	<ul style="list-style-type: none">▪ Monday-Thursday▪ 1 week per month▪ 2-3p.m. EST
Onsite Consultation	<ul style="list-style-type: none">▪ Generally April-May▪ Assists with data collection and submission▪ Voluntary

CMS Training Efforts

2003 Regional Risk Adjustment Trainings
for Medicare+Choice Organizations

Getting Started Training Program	<ul style="list-style-type: none">▪ Self-paced video and workbook▪ Risk Adjustment basics▪ New staff and new plans▪ Expected in August 2003
Regional Training Program	<ul style="list-style-type: none">▪ Practical training for new and current risk adjustment users▪ Printed and CD versions of the training materials
Regional Training Video	<ul style="list-style-type: none">▪ Video version of the June 2003 training▪ Expected in July 2003
Physician Training CD	<ul style="list-style-type: none">▪ Interactive CD providing risk adjustment medical record documentation and coding guidelines▪ Expected September 2003

Data Collection



**Stephanie Grefsheim
Aspen Systems Corporation**

Purpose

- To enable systems/IT staff to help plan staff apply correct data collection principles to ensure accurate payment.

Objectives

- Review M+C data requirements
- Identify the types of services that are used for risk adjustment
- Use case studies to:
 - Identify potential data collection challenges
 - Identify the risk adjustment and HIPAA rules related to data collection
 - Suggest steps to achieve successful data collection

What Data Does CMS Require?

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

Case Study 1

Data Sources

- 1** A stay at a network hospital under provider number 33U020.
- 2** A hospital outpatient service under provider number 330033 that includes a radiology service for a cancer diagnosis.
- 3** A home health service following a hospital inpatient discharge.
- 4** A radiologist service related to the cancer diagnosis for service #2.

Case Study 1

Data Sources

- 1** A stay at a network hospital under provider number 33U020.
- 2**
- 3**
- 4**

Medicare Provider Numbers

33 U 020

State where
hospital/facility
is located

Type of
Facility

Unique to
the facility

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

Case Study 1 Data Sources

The screenshot shows a Microsoft Internet Explorer browser window titled "Hospital Search - Microsoft Internet Explorer". The address bar contains the URL "http://www.ahd.com/freesearch.php3". The website header features the "ahd.com AMERICAN HOSPITAL DIRECTORY" logo and navigation links for "HOME", "SUBSCRIPTION INFORMATION", "SAMPLE REPORTS", and "TOOLS". The main content area is titled "Search for a hospital" and includes instructions: "Look up a hospital by entering criteria below. A list will be returned from which you can choose the hospital(s) you want. (Use of this information implies acceptance of [notice, disclaimer and agreement.](#)) **Advanced searches are available to Subscribers.** [view sample](#)". Below the instructions are input fields for "Hospital Name (use keywords)", "City", "State" (a dropdown menu currently set to "any state"), "ZIP code (first few digits)", and "Telephone area code". A "Submit Query" button is positioned below the "Click to begin search" text. At the bottom of the page, there is a "Having problems?" section with a bullet point: "The most common problem is caused by entering too many criteria. Try entering just the state and you will get a list of every hospital in the state to choose from." The browser's taskbar at the bottom shows the Start button, several open applications including "Inbox - Micro...", "FW: Best Practi...", "2003 Regional ...", and "Hospital Sear...", along with system icons and the time "11:17 AM".

URL for the American Hospital Directory. Provides assistance in determining hospital provider numbers.

Most effective search option.

Case Study 1 Data Sources

The screenshot shows a Microsoft Internet Explorer browser window displaying the American Hospital Directory (ahd.com) search results page. The browser title is "The American Hospital Directory: List of Search Results - Microsoft Internet Explorer". The address bar shows a search URL with parameters for name, city, state, and zip. The website header includes the "ahd.com" logo and navigation buttons for "HOME", "NEW SEARCH", and "BACK TO LIST". A red banner indicates that additional data like DRG and APC statistics is available to subscribers. Below this, a message states that 262 hospitals match the search criteria and provides a note about telephone numbers. A table lists several hospitals with their names, cities, and states. A yellow callout box points to the table, stating that the state search provides a listing of hospitals in that state. The Windows taskbar at the bottom shows the Start button, several open applications, and the system clock at 11:18 AM.

**Additional data is available to Subscribers
DRG and APC Statistics** [More Info](#)

There are 262 hospitals that match your search criteria.
Click on the hospital's name to see its profile.
Note: Telephone numbers omitted on lists with more than 25 hospitals (Free Service only)

Link	Hospital Name	City	State
Adirondack Medical Center	Adirondack Medical Center	SARANAC LAKE	NY
Albany Medical Center	Albany Medical Center	ALBANY	NY
Albany Memorial Hospital	Albany Memorial Hospital	ALBANY	NY
Albert Lindley Lee Mem Hosp	Albert Lindley Lee Memorial Hospital	FULTON	NY
Alice Hyde Medical Center	Alice Hyde Medical Center	MALONE	NY
Amsterdam Memorial Hospital	Amsterdam Memorial Hospital	AMSTERDAM	NY

The State search provides a listing of hospitals in that state.

Case Study 1

Data Sources

1

A hospital inpatient charge under provider number 33W020.

2

A hospital outpatient service under provider number 330033 that includes a radiology service for a cancer diagnosis.

3

A home health record for services following a hospital inpatient discharge.

4

A radiologist record related to the second records cancer diagnosis.

Case Study 1

Data Sources

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A hospital inpatient charge under provider number 33W020.

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A hospital outpatient record under provider number 330033 that includes a radiology service for a cancer diagnosis.

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A radiologist record related to the second records cancer diagnosis.

Case Study 1

Data Sources

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A home health record for services following a hospital inpatient discharge.

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A radiologist service related to the cancer diagnosis for service #2.

Case Study 2

Data Collection Formats

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Case Study 3

Risk Adjustment and HIPAA Rules

- Provider electronic claims data submitted to plans are HIPAA transactions
- Plan risk adjustment submissions to CMS are not HIPAA transactions

HIPAA Standards Must Be Met by October 16, 2003

- Electronic transactions from providers to M+C organizations must use the ANSI X12 837 v.40.10 format
- Plans may not request data more than once
 - Unless it is for data clarification or correction

Risk Adjustment Rule

- Same as HIPAA rule
- For risk adjustment it applies for paper format also

Summary

- Reviewed M+C data requirements
- Clarified the types of services that are used for risk adjustment calculations
- Used case studies to:
 - Identified potential data collection challenges
 - Identified the risk adjustment and HIPAA rules related to data collection
 - Suggested steps to achieve successful data collection

Data Submission



**Stephanie Grefsheim
Aspen Systems Corporation**

Purpose

- To build on your file layout knowledge to ensure accurate data submission.

Objectives

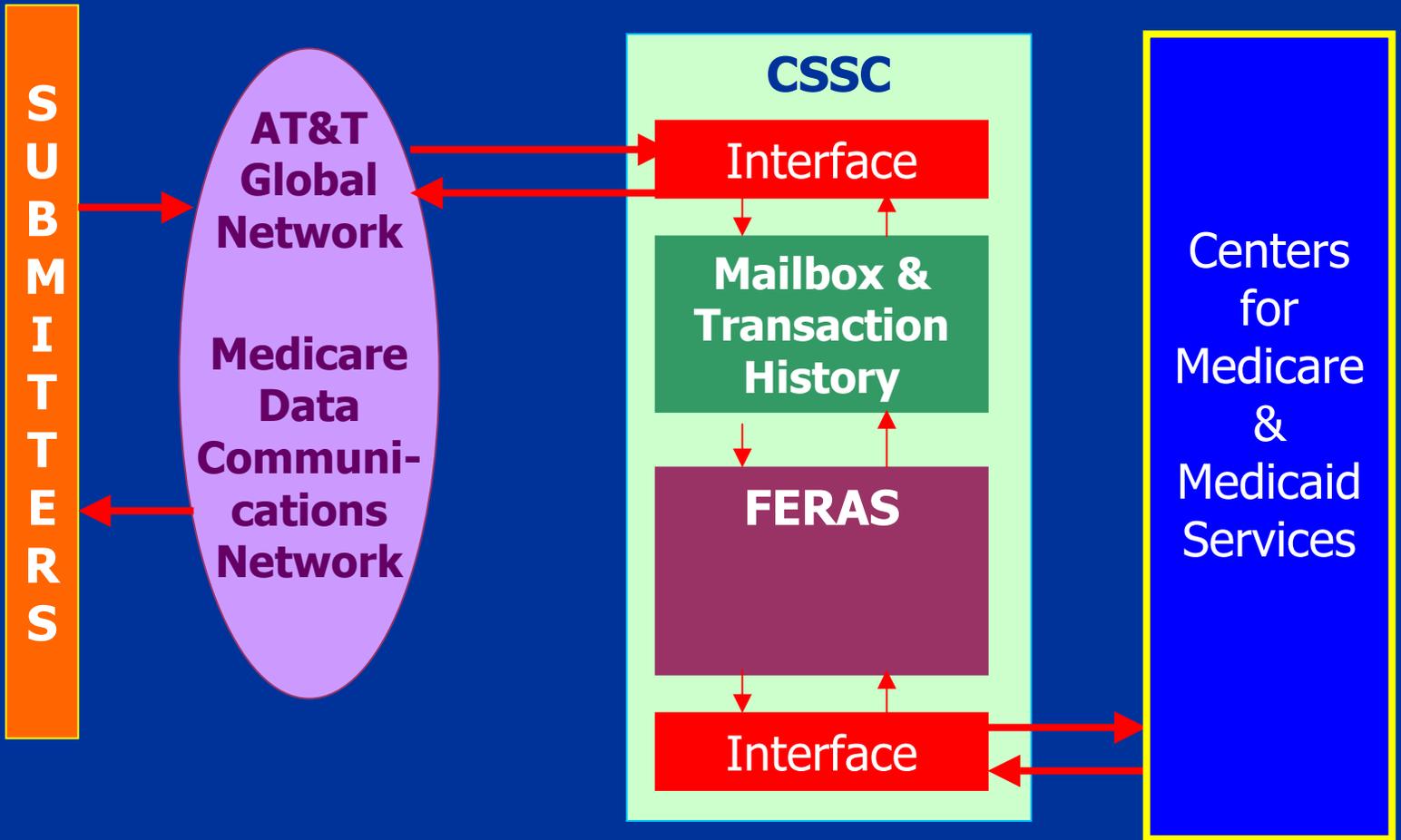
- Facilitate discussion about data submission procedures.
- Discuss the diagnosis clusters in the RAPS format.
- Identify required risk adjustment data elements.
- Walk through a DDE submission.

EDI Agreement

- Must be completed prior to submitting data
- If using a third party submitter, be sure to follow directions for proper completion of EDI agreement

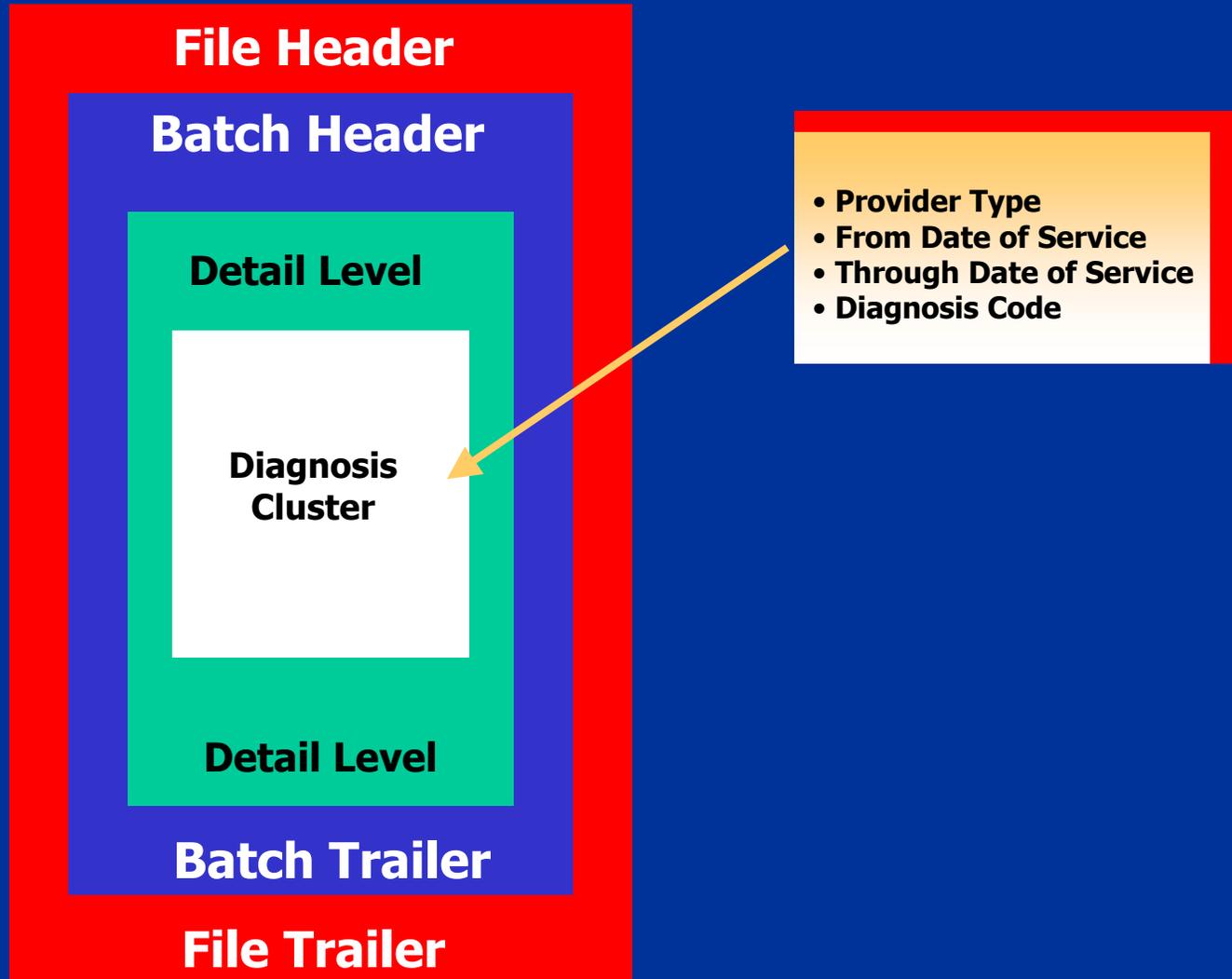
Submit the most accurate contact information to CSSC

Connectivity



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File Logic



Diagnosis Cluster

- Unique diagnosis clusters are stored in RAPS Database.
 - Provider Type
 - From Date of Service
 - Through Date of Service
 - Diagnosis
- Risk adjustment factors calculated using Diagnosis Cluster data

Relevant Diagnosis

- The diagnosis is included in the CMS-HCC risk adjustment model.
- The diagnosis must be received from one of the three provider types.
- The diagnosis must be collected according to the risk adjustment data collection instructions.

Relevant Diagnosis

Relevant diagnosis must be collected and submitted in the collection period.

Translation Issues

- Payor ID
 - 80883 – NSF
 - 80884 – UB-92
- Bill Type for UB-92
 - 111/11Z Hospital Inpatient
 - 131/13Z/141/14Z Hospital Outpatient

Scenario

- Evermore received an NSF encounter with four diagnosis codes. There was a pointer on the first two codes identifying the dates of service, but the last two diagnosis did not have a date of service identified.

What steps should be taken?

Correcting Data

- Data should be corrected when:
 - The cluster was submitted in error.
 - The HIC number was incorrect.
 - Any component of the cluster is incorrect and stored in the RAPS Database.

Correcting Data (continued)

- Two ways to correct data:
 - Recreate the initial RAPS file and add delete indicators
 - Use the DDE function
- Corrections can not be done in:
 - NSF
 - UB-92
 - ANSI

DDE DEMONSTRATION

**2003 Regional Risk Adjustment Training
for Medicare+Choice Organizations**

Summary

- We described benefits of the various connectivity options.
- We discussed the need for established internal processes to support the submission of data and the correction process.
- We demonstrated the DDE function.

Risk Adjustment Data Edits



**Angela Reddix
Aspen Systems Corporation**

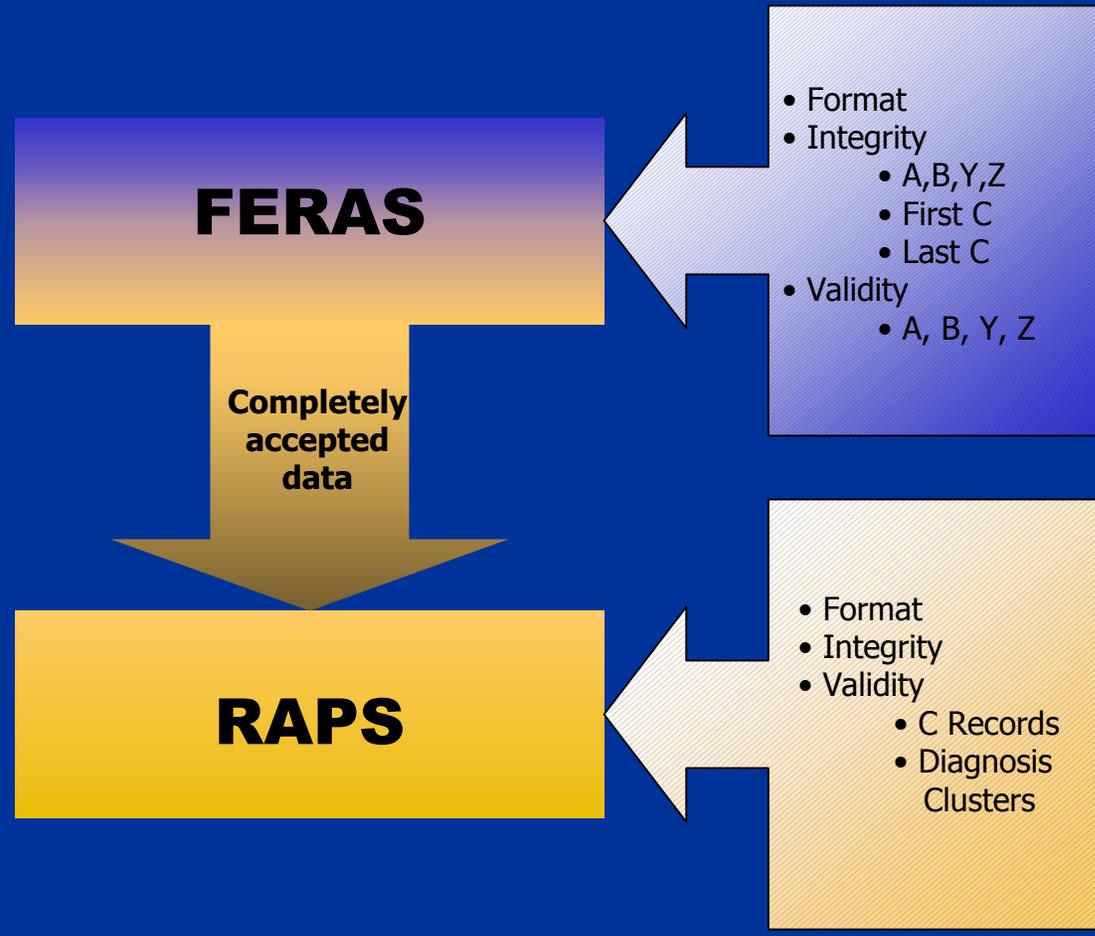
Purpose

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

Objectives

- Identify the top ten common errors.
- Interpret steps required to prevent and correct the common errors.

Data Edit Flow



TOP 10 COMMON ERRORS

**2003 Regional Risk Adjustment Training
for Medicare+Choice Organizations**

1

Duplicate File Name Error

- File identifier must be unique.
- Submitter cannot reuse within 12 months if accepted in Test or Production.
- File numbers used for encounter data with the last 12 months are included in the rule.

FERAS performs the check on the last six digits of the File ID. Users must be certain that these characters are unique.

1

Duplicate File Name Correction

- This error will be identified in FERAS.
- This will generate a 100 level error code – 113.
- The submitter should correct the data that is populated in the A record field 3.

FERAS performs the check on the last six digits of the File ID. Users must be certain that these characters are unique.

2

Invalid BBB Sequence Error

- Each file can contain multiple batches.
- Batches must be identified with a sequence number.
- The first batch in a file must always be 000001.
- Each subsequent batch should be incremented by 1.

2

Invalid BBB Sequence Correction

- The error is a batch level error.
- The error code generated is a 200 level error code – 202.
- The submitter must recreate the file and batch.
- Enter the appropriate batch number in RT B field 2.

3

Data in Error Fields Error

- Error code fields should only be populated by CMS.
- Files must be submitted with spaces in the Error Code field.
- Files should not be submitted with zeros or data.

3

Data in Error Fields Correction

- These are detail record level errors.
- If the error occurs on the first or last C record FERAS will reject the data.
- If the error occurs on any other C record, RAPS will discontinue editing and no clusters will be stored.
- Submitter must enter spaces in the error code field.

4

DOB Not In MBD Error

- Date of Birth is an optional field.
- Date of Birth must match MBD if submitted.

4

DOB Not in MBD Correction

- Delete DOB and resubmit
 - or -
- Research the patient's DOB in MBD.
- If MBD is different, but correct,
 - Create a new file.
 - Create a new batch.
 - Enter correct DOB in RT C field 7.
- If MBD is incorrect
 - Contact CSSC.

5

Missing/Invalid Provider Type Error

- Provider Type must be:
 - 01
 - 02
 - 10
 - 20
- DDE users will not receive this error.
- UB-92 formats require correct bill types.

5

Missing/Invalid Provider Type Correction

- This is a 400 level error code – 400.
- The cluster will not be stored.
- Create a new file, a new batch, and record.
- Enter the provider type in RT C field 9.

6

Service Date Not Within Enrollment Error

- Patient was not enrolled in the Medicare+Choice program at the time of service.
- 408 occurs with all data.
- 409 occurs with hospital outpatient and physician data only.
- CMS synchronized MBD and GHP.

6 Service Date Not Within M+C Enrollment Correction

- Research eligibility in MBD.
- Check service dates and correct if necessary.
- Create a new file, batch, and claim.
 - Correct 408 in record field 9.1
 - Correct 409 in record field 9.2

7

Not Enrolled In Plan Error

- Patient was not enrolled in your plan during the dates of service.
- RAPS checks eligibility in Stage 3 of the editing process.

7

Not Enrolled In Plan Correction

- Research MBD.
- Check service dates and correct if necessary.
- Create file, batch, and C records.

8

Date Span Exceeds 31 Days Error

- This error applies only to hospital outpatient and physician data.
- Span was extended from 30 days to 31 days.
- Primarily seen in physical therapy claims.

8

Date Span Exceeds 31 Days Correction

- Establish a new file and new batch.
- Create a new C record.
- Separate the diagnosis into individual clusters with appropriate spans.

9

Diagnosis to Patient Sex Error

- Diagnosis must be appropriate for the patient's sex.
- CMS has published a list of gender specific error codes on mcoservice.com.
- The database can be downloaded into the organization's database.

9

Diagnosis to Patient Sex Correction

- Verify patient sex in MBD.
- Verify the diagnosis and correct if necessary.
- Create a file, batch, and C record.
- If the diagnosis code is different, correction will be made in CCC 9.4.

10

Diagnosis Not In Model Error

- Information edit
- Indicates the diagnosis will not count towards risk adjustment
- No action required

Summary

- Identified the top ten common errors.
- Outlined the steps required to prevent and correct the common errors.

Reports



**Angela Reddix
Aspen Systems Corporation**

Purpose

- To provide information about how to use and read risk adjustment reports in order to improve the completeness and accuracy of data submissions

Objectives

- Review the purpose of each risk adjustment report briefly
- Identify key elements of reports that aid in the collection and submission of sufficient and accurate data
- Analyze report information to help improve the effectiveness of data collection and submission

Accessing Reports

Methods of Access

Secure Website

File Transfer Protocol

Network Data Mover

FYI

- Secure website and FTP users receive FERAS reports within 15 minutes
- NDM users receive FERAS reports next day
- Reports stay in mailbox 14 days
- After that, request reports through CSSC
- Organizations can request reports in zipped format

Purpose of Reports

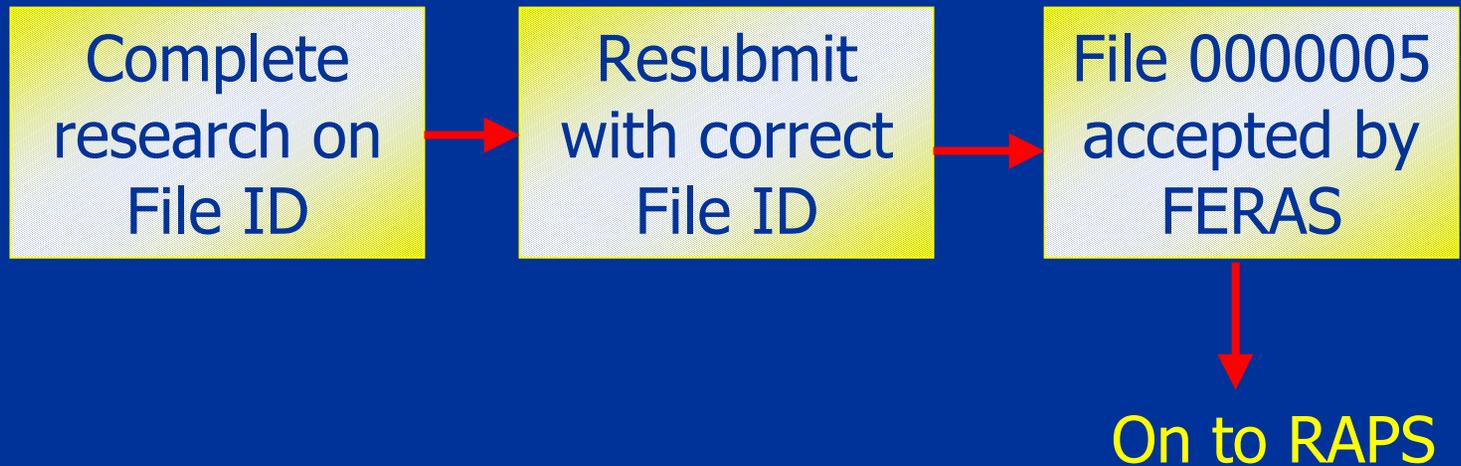
- What information does the report contain?
- How is this information helpful in managing the data collection and submission process?



Rosemount Health Plan Example

- Submitted file 0000001; not first file
- File included 1 batch, 3 records
- HIC #113334567A
- DOB March 5, 1935; different DOB on MBD

Rosemount Health Plan Example (continued)



Rosemount Health Plan Example (continued)

- RAPS Return File Report
 - DOB discrepancy identified
 - 501 information edit identified
- RAPS Transaction Error Report
 - DOB error (code 354) and informational message (code 501)
 - No clusters in this record were stored, but all editing was performed

Rosemount Health Plan Example (continued)

■ RAPS Transaction Summary Report

PROVIDER TYPE	PRINCIPAL INPATIENT	OTHER INPATIENT	OUTPATIENT	PHYSICIAN	UNIDENTIFIED	TOTAL
TOTAL SUBMITTED	207	1,213	0	0	0	1,420
TOTAL REJECTED	9	49	0	0	0	58
TOTAL ACCEPTED	198	1,164	0	0	0	1,362
TOTAL STORED	189	1,099	0	0	0	1,288
TOTAL MODEL STORED	103	368	0	0	0	471
TOTAL DELETE ACPTD	0	0	0	0	0	0
TOTAL DELETE RJCTD	0	0	0	0	0	0

Error rate is 4.1%

Rosemount Health Plan Example (continued)

RAPS Transaction Summary Report

1REPORT : RAPS001 RISK ADJUSTMENT PROCESSING SYSTEM
 RUN DATE : 20030412 TRANSACTION SUMMARY REPORT
 DATE:20030411 TRANS

0
 SUBMITTER ID SH7777 PLAN ID: H7777 FILE ID: 0000005

PROVIDER TYPE	PRINCIPAL INPATIENT	OTHER INPATIENT	OUTPATIENT	PHYSICIAN	UNIDENTIFIED	TOTAL
TOTAL SUBMITTED	207	1,213	0	0	0	1,420
TOTAL REJECTED	9	49	0	0	0	58
TOTAL ACCEPTED	198	1,164	0	0	0	1,362
TOTAL STORED	189	1,099	0	0	0	1,288
TOTAL MODEL STORED	103	368	0	0	0	471
TOTAL DELETE ACPTD	0	0	0	0	0	0
TOTAL DELETE RJCTD	0	0	0	0	0	0

**74
duplicates**

Rosemount Health Plan Example (continued)

■ RAPS Transaction Summary Report

1REPORT : RAPS001
RUN DATE : 20030412
DATE:20030411

RISK ADJUSTMENT PROCESSING SYSTEM
TRANSACTION SUMMARY REPORT

TRANS

0

SUBMITTER ID SH7777 PLAN ID: H7777 FILE ID: 0000005

PROVIDER TYPE	PRINCIPAL INPATIENT	OTHER INPATIENT	OUTPATIENT	PHYSICIAN	UNIDENTIFIED	TOTAL
TOTAL SUBMITTED	207	1,213	0	0	0	1,420
TOTAL REJECTED	9	49	0	0	0	58
TOTAL ACCEPTED	198	1,164	0	0	0	1,362
TOTAL STORED	189	1,099	0	0	0	1,288
TOTAL MODEL STORED	103	368	0	0	0	471
TOTAL DELETE ACPTD	0	0	0	0	0	0
TOTAL DELETE RJCTD	0	0	0	0	0	0

**90.7% of diagnoses
submitted were
stored**

Rosemount Health Plan Example (continued)

■ RAPS Transaction Summary Report

1REPORT : RAPS001		RISK ADJUSTMENT PROCESSING SYSTEM					TRANS
RUN DATE : 20030412		TRANSACTION SUMMARY REPORT					
DATE:20030411							
0							
SUBMITTER ID SH7777		PLAN ID: H7777	FILE ID: 0000005				
PROVIDER TYPE	PRINCIPAL INPATIENT	OTHER INPATIENT	OUTPATIENT	PHYSICIAN	UNIDENTIFIED	TOTAL	
TOTAL SUBMITTED	207	1,213	0	0	0	1,420	
TOTAL REJECTED	9	49	0	0	0	58	
TOTAL ACCEPTED	198	1,164	0	0	0	1,362	
TOTAL STORED	189	1,099	0	0	0	1,288	
TOTAL MODEL STORED	103	368	0	0	0	471	
TOTAL DELETE ACPTD	0	0	0	0	0	0	
TOTAL DELETE RJCTD	0	0	0	0	0	0	

36.5% of the diagnoses that were stored are in the CMS-HCC model

Management Reports

- RAPS Monthly Plan Activity Report
 - Allows submitters to validate diagnoses submitted during month
- RAPS Cumulative Plan Activity Report
 - Allows submitters to compare accepted clusters to benchmarks

Are you collecting enough data?

- Check the amount of data being submitted on a regular basis
- Check to make sure you are getting enough data from sources
- Check on rejection rates by provider type over time

Are external issues affecting data collection?

- Check to make sure that you receive about 25% of data each quarter
- Check to make sure providers are submitting data in a timely fashion
- Check on third party billers

Medicare FFS Benchmarks

Provider Type	All Dx	All Model Dx	Unique Model Dx
Physician	40	12.2	2.2
Hospital Outpatient	6	1.3	0.4
Hospital Inpatient	2	0.8	0.7
Total	48	14.3	3.3*

*Total does not un-duplicate between provider types

What is the appropriate benchmark?

- Depends on how you submit data
 - All diagnoses (maximum)
 - Model diagnoses only
 - Unique model diagnoses only (minimum)
 - Combination of methods
- Utilization patterns vary, especially for ambulatory data

Are you meeting benchmarks?

- Is the data you collect appropriately distributed between provider types?
- Is the number of diagnosis clusters you have submitted sufficient given your enrollee population?
- Be sure to use the right benchmark based on your submission practices

Do internal processes support submissions?

- Check to ensure that collected data is being translated properly
- Ensure that internal data systems are preparing data properly
- Take steps to ensure that medical documentation supports submitted diagnoses

Correcting Rejected Data

- Check internal records to ensure submission matches data on file at M+C organization
- Obtain corrected information from providers if necessary
- Timely response to requests is critical

Summary

- Reviewed the purpose of each risk adjustment report briefly
- Identified key elements of reports that aid in the collection of sufficient and accurate data
- Analyzed report information to help improve the effectiveness of data collection

RAPS Strategies



**2003 Regional Risk Adjustment Training
for Medicare+Choice Organizations**

New Orleans, LA and San Diego, CA



RAPS Strategies



Pam Klugman & Tom Peterson
Blue Shield of California

Purpose

- Provide background about our company and risk adjustment team
- Share a few of our successes and how we achieved them
- Discuss lessons learned along the way

Background

- Non-profit health plan
- Mid-size M+C membership
- Separate IT platform for Medicare business

Staff History

- Department created in 1998
- No significant staff turnover
 - 5 systems analysts
 - 1 shared administrative resource
- “Hybrid” department
 - IT and operational responsibilities

Successes

- Industry Collaboration Effort
- Providers are part of the process
- Internal systems accommodate “less than perfect” data from providers
- Share successes and failures with other plans

Lessons Learned

- Work with third party submitters
- Develop flexible data processing systems
- Know your internal systems
- Analyze clinical quality of data
- Ensure “clean” data is submitted
- Maintain a “sent history”

Summary

- Maintain a cross-trained staff
- Collaborate with providers, other plans, associations and CMS
- Refashion systems to work efficiently
- Check your data

New York, NY

**2003 Regional Risk Adjustment Training
for Medicare+Choice Organizations**

RAPS Strategies



Phyllis Marino
HIP Health Plan of New York

Purpose

- Provide background about our company and risk adjustment plan
- Share knowledge about HIP's success with data submission and error resolution
- Discuss lessons learned along the way

Background

- Largest HMO in NY metro area
- Ranked #1 Medicare and Medicaid Provider in the State
- Current M+C organization membership is over 100,000

Submission

- Began transmitting in 1998
- Connectivity - NDM
- Collection – All diagnoses
- Submission – RAPS format

Success

- “Trigger File” Development
- Error Correction – Monitoring Mechanism
- Reconciliation Tool

Trigger File Development

- Use RAPS return file
- Pulls out errors
- Uses Patient Control Number Field
- Identifies Specific Provider
- Provides Access for Error Correction
- Recycles claims until error is corrected-storing mechanism

2003 Regional Risk Adjustment Training
for Medicare+Choice Organizations

Exhibit 2 - Microsoft Word

File Edit View Insert Format Tools Table Window Help

OPID AIR8 ----- *O/CARE *----- REG O1 SITE 0001

05/08/03 TRIGGER FILE DELETE 15:46

CLAIM NUMBER:

<<< TOP OF LIST >>>

00012003111111111111
00012003222222222222
00012003333333333333
00012003444444444444
00012003555555555555
00012003666666666666
00012003777777777777
00012003888888888888
00012003999999999999
00012003111111111112
00012003222222222223
00012003333333333334
00012003444444444445

PLACE CURSOR ON DESIRED LINE AND PRESS ENTER

CLEAR = MAIN MENU PF3 = CLAIMS MENU
PF4 = TOP PF5 = BOTTOM PF7 = BACKWARD PF8 = FORWARD

Page Sec At Ln Col REC TRK EXT OVR

Start | Inbox - Mi... | Track 1 - I... | Microsoft ... | FW: Best ... | Exhibit 2 ... | 4:38 PM

2003 Regional Risk Adjustment Trainings for Medicare+Choice Organizations

Microsoft Excel - Exhibit 1

RISK ADJUSTMENT PROCESSING SYSTEM. TRANSACTION ERROR REPORT. PLAN ID: H3330 FOR 04/02/2003

1	EM. TRANSACTION ERROR REPORT. PLAN ID									
2	PATIENT_CNTRL_NO	HIC_ERRVND_TYI	DIAG_CODE	DIAG_ERR1	PRVD_TYPE	DIAG_CODE	DIAG_ERR1	DIAG		
3	00012003111111111111	310	20	2899		20 V769				
4	00012003222222222222	310	20	1727						
5	00012003333333333333		20				311			
6	00012003444444444444		20	2630			404			
7	00012003555555555555		20	25000		20	2720		404	
8	00012003666666666666		20	V501			404			
9	00012003777777777777		20	V048			406			
10	00012003888888888888		20	78559		20	486		410	
11	00012003999999999999		1	51881			411			
12	00012003111111111112		10	26500			460			
13	0012003222222222223		20	99999			450			
14	0012003333333333334		20	8605			314			
15	2003444444444444445		20	38010			408			
16										
17										
18										
19	00012003333333333333 3333333333333314HH	310	20	78650		20	53081			
20	00012003444444444444 4444444444444414HH	310	20	78650		20	53081			
21	00012003555555555555 555555555555514HH	310	20	V048						
22	00012003666666666666 666666666666614HH	310	20	V048						
23	00012003777777777777323	310	20	V711						
24	00012003888888888888323	310	20	78820						
25	00012002399999999999 9999999 14MM	353	20	4019			501			
26	00012003111111111111 111111111111114HH	353	20	1101		20	7295		501	
27	0001200322222222222834	353	20	4019		20	2724		501	

Sum=3327961

4:51 PM

Summary

- Control over Transmitted Data
- Monitoring error correction
- Comprehensive Reconciliation Report Process

Baltimore, MD

**2003 Regional Risk Adjustment Training
for Medicare+Choice Organizations**



RAPS Strategies



Charles L. Andrews
Hopkins ElderPlus
Johns Hopkins Bayview Medical Center

Purpose

- To show how PACE sites regardless of size can adapt to the M+C requirements.

Plan Characteristics

- Urban, campus-setting, with IS support
- 150 maximum participants, current census 142 with 40 people on a waiting list
- Planned opening of a 15 bed assisted living facility in July
- Electronically submitted hospital inpatient for periods 7/1/00 – 6/30/01 from UB-92 over the AT&T Global Network via PC-ACE Pro-32
- Began electronic submission data from 7/1/02 of:
 - Hospital inpatient
 - Hospital outpatient
 - Physician encounter data

Main Issues/Challenges

- Educate medical staff about the new payment methodology and the significance of diagnostic data
- Establish a process for collecting diagnostic data
- Establish a process for submitting diagnostic data and responding to error codes
- Train back-up person to submit data

Main Issues/Challenges

(continued)

- Refine understanding of the new payment methodology and process (ongoing)
- Participate in the ongoing PACE dialogue about the new payment methodology and process (ongoing)
- Maximize reimbursement based on the new payment methodology

Data Collection & Submission Method

- Using PACE generated superbill for physician encounters, UB-92 and outside bills for inpatient and other outpatient charges

Data Entry Method

**2003 Regional Risk Adjustment Training
for Medicare+Choice Organizations**

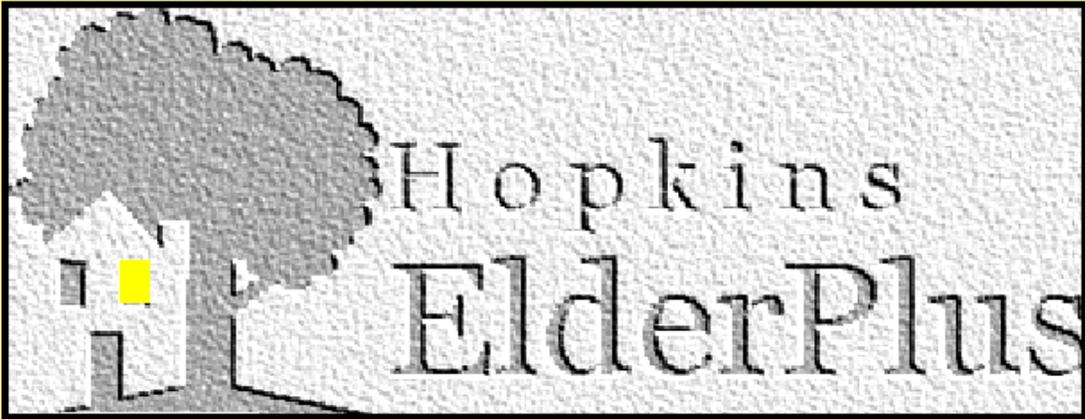
Data Entry Method Risk Adjustment Database

2003 Regional Risk Adjustment Training
for Medicare+Choice Organizations

Microsoft Access - [Form1 : Form]

File Edit View Insert Format Records Tools Window Help

Welcome to Hopkins ElderPlus. Risk Adjustment
Remember, we'll leave a light on for you.



Hopkins
ElderPlus

Continue

Record: 1 of 1

Form View

Start Microsoft Word... Microsoft Acces... Microsoft Acc... 12:09 PM

Data Entry Method

(continued)

- Simple Access database
- Look up by name, MR# or HIC#
- Program automatically enters the HIC# in the table
- No chance of typing incorrect HIC#

Data Entry Screen

2003 Regional Risk Adjustment Training
for Medicare+Choice Organizations

Microsoft Access - [MANE]

File Edit View Insert Format Records Tools Window Help

Risk Adjustment Data Entry Screen

Hopkins ElderPlus

Plan # H2109

Participant Name Medical Record # Medicare #

CCC

	SEQ NO	HIC #	CONTROL #	
	PROVIDER	From Date	Thru Date	DIAG
1.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
6.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
7.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
8.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
9.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
10.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Record: 1 of 1

Record: 169 of 169

Form View

Start | Microsoft Word | Microsoft Acces... | Microsoft Acc... | 1:17 PM

Provider Type Key

In House Provider	20
Outside Provider	10
Hospital In-patient	01
Hospital Out-Patient	02

Create RAPS Formatted File

2003 Regional Risk Adjustment Training
for Medicare+Choice Organizations

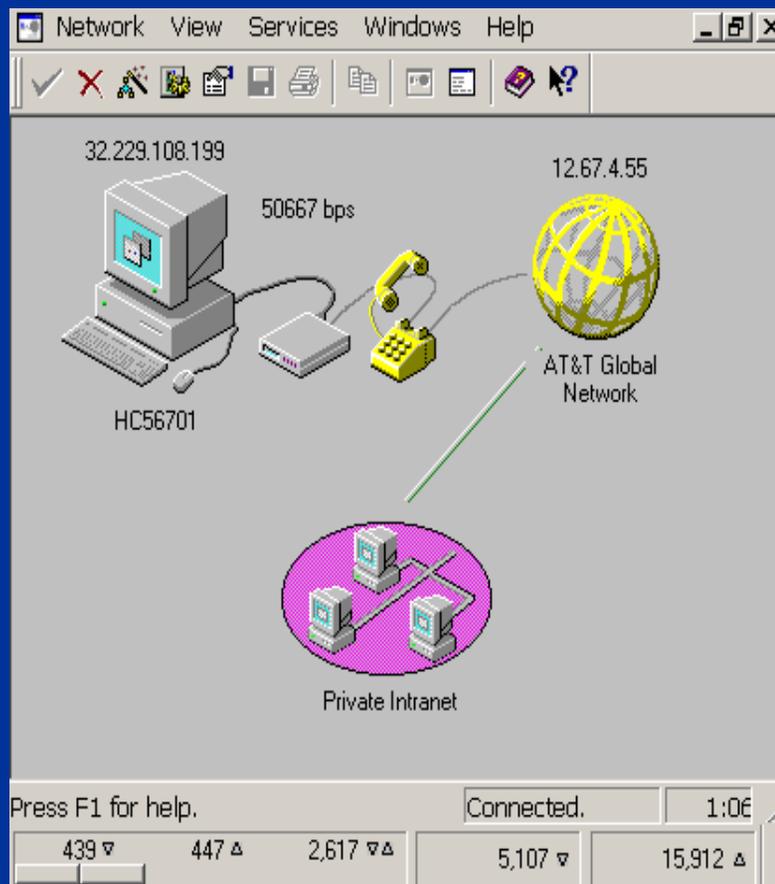
```
SH2107_20030506_0000000017.txt - Notepad
File Edit Format Help
AAASH2109000000001720030506PROD
BBB00000001H2109
CCC00000001
CCC00000002
CCC00000003
CCC00000004
CCC00000005
CCC00000006
CCC00000007
CCC00000008
CCC00000009
CCC00000010
CCC00000011
CCC00000012
YYY00000001H21090000012
ZZZSH210900000000170000001
```

CICS ID	HIC #	Status
CCC00000001	20200	
CCC00000002	20200	
CCC00000003	01200	
CCC00000004	10200	
CCC00000005	20200	
CCC00000006	10200	
CCC00000007	20200	
CCC00000008	20200	
CCC00000009	01200	
CCC00000010	20200	
CCC00000011	20200	
CCC00000012	20200	

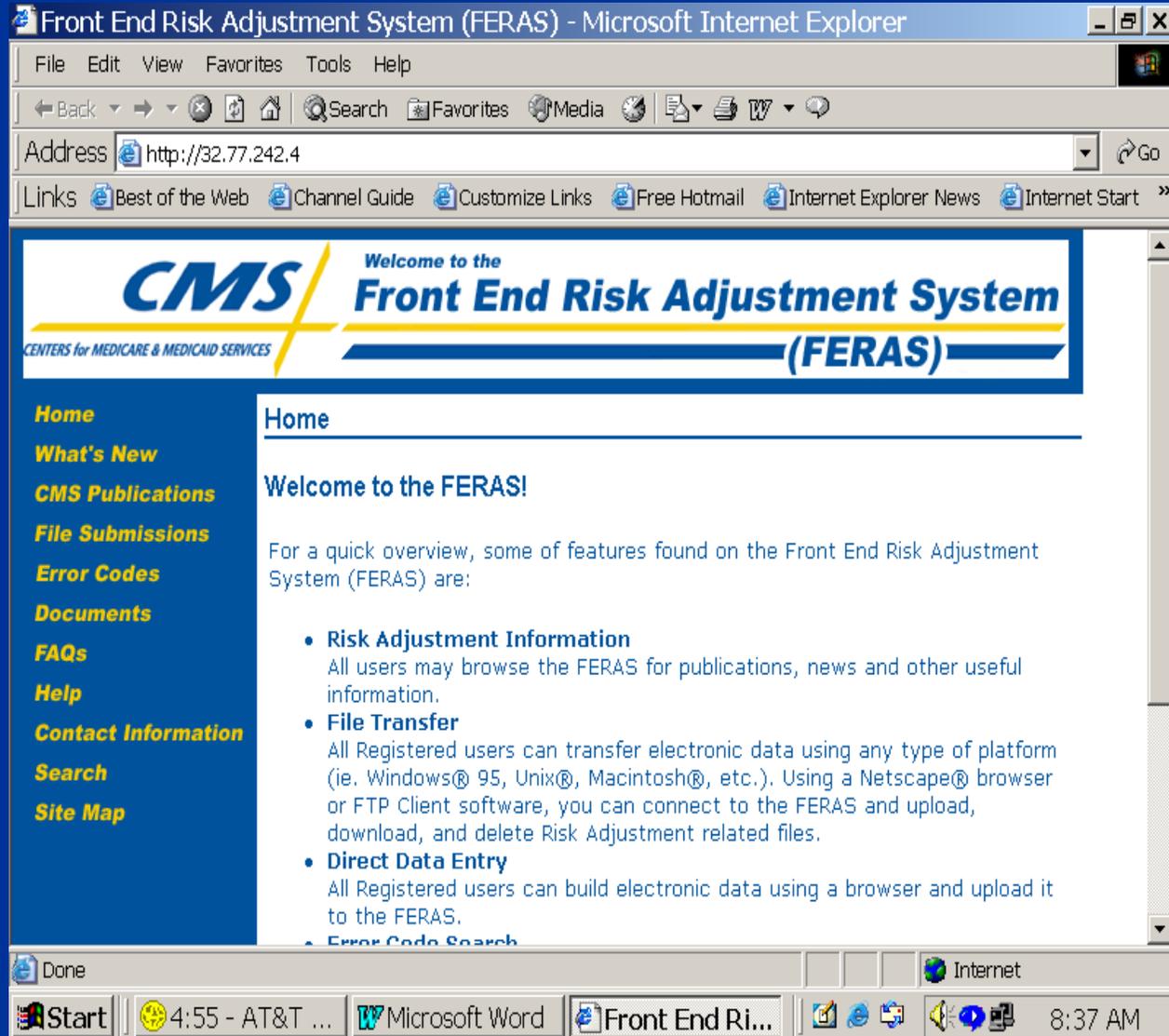
HIC #
Blocked
Out
For
Security

Connectivity Method

2003 Regional Risk Adjustment Training
for Medicare+Choice Organizations



Submission Method



Submission Method (continued)

Front End Risk Adjustment System (FERAS) - Microsoft Internet Explorer

File Edit View Favorites Tools Help

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Address <http://32.77.242.4/servlet/FileUpload?method=UploadPage>

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Risk Adjustment Submission - Upload File

TIP: Although this site can be used to transfer files up to 75 megabytes, we recommend that large files be transferred using command line FTP.

To submit a Risk Adjustment File:

1. Choose your file by pressing the **Browse** button, or typing in the full path to your file.

NOTE: Please enter the entire path and file name (example: if your file is named 'mytransfer.txt' in the directory 'myfiles' on the 'C:' drive, enter c:\myfiles\mytransfer.txt).

2. Click the **Upload File** button to upload your file.

Done Internet

Start Microsoft Wor... 1:56 - AT&T ... Front End Ri... 3:13 PM

Report Method

Front End Risk Adjustment System (FERAS) - Microsoft Internet Explorer

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Address <http://32.77.242.4/servlet/FileViewer?method=FileSelectionPage>

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Risk Adjustment Submission - View File

[Latest Views](#) - retrieves the last list of files you viewed

Available Response Files:
Select multiple files by holding the **Ctrl** key while selecting, or to select a range by holding the **Shift** key. **Limit 5 files per request.**

```
RPT00074.RPT.RAPS_SUMMARY
RPT00079.RPT.RAPS_RETURN_FLAT
RPT00080.RPT.RAPS_RETURN_FLAT
RPT00081.RPT.RAPS_ERROR_RPT
RPT00082.RPT.RAPS_ERROR_RPT
RPT00083.RPT.RAPS_SUMMARY
RPT00084.RPT.RAPS_SUMMARY
RSP00075.RSP.FERAS_RESP
RSP00078.RSP.FERAS_RESP
```

<http://32.77.242.4/whatsnew.htm> Internet

Start | 8:16 - AT&T ... | Microsoft Wor... | Front End Ri... | 8:40 AM

Report of Accepted Production

Front End Risk Adjustment System (FERAS) - Microsoft Internet Explorer

File Edit View Favorites Tools Help

Back Forward Stop Home Search Favorites Media Print Copy Paste W Help

Address http://32.77.242.4/servlet/FileViewer?method=ViewFile&ViewFile=RSP00078_RSP_FERAS_RESP Go

Links [Best of the Web](#) [Channel Guide](#) [Customize Links](#) [Free Hotmail](#) [Internet Explorer News](#) [Internet Start](#) >>

[Back](#)

Contents of file:RSP00078_RSP_FERAS_RESP

REPORT: FERAS-RESP FRONT END RISK ADJUSTMENT SYSTEM
RUN DATE: 20030506 FERAS RESPONSE REPORT

SUBMITTER ID: SH2109
FILE ID: 0000000018 ACCEPTED PROD

RECORD	SEQ	ERROR	TYPE	NO	CODE	ERROR DESCRIPTION
END OF REPORT						

End of File Contents

[Back to Top](#)

Done Internet

Start 9:09 - AT&T ... Microsoft Wor... Front End Ri... 8:41 AM

Transaction Summary and Error Repots

- The next day you can review summary and error reports

Transaction Summary Report (Sample)

1REPORT : RAPS001
 RUN DATE : 20030506
 TRANS DATE:20030506

RISK ADJUSTMENT PROCESSING SYSTEM
 TRANSACTION SUMMARY REPORT

SUBMITTER ID	SHXXXX	PLAN ID: HXXXX		FILE ID: 0000000017			TOTAL
		PRINCIPAL	OTHER	OUTPATIENT	PHYSICIAN	UNIDENTIFIED	
PROVIDER TYPE		INPATIENT	INPATIENT	OUTPATIENT	PHYSICIAN	UNIDENTIFIED	TOTAL
TOTAL SUBMITTED		5	40	102	175	0	322
TOTAL REJECTED		3	17	24	31	0	75
TOTAL ACCEPTED		2	23	78	144	0	247
TOTAL STORED		0	7	52	141	0	200
TOTAL MODEL STORED		0	0	11	48	0	59
TOTAL DELETE ACPTD		0	0	0	0	0	0
TOTAL DELETE RJCTD		0	0	0	0	0	0

Transaction Error Report

(Sample)

REPORT : RAPS002 RISK ADJUSTMENT PROCESSING SYSTEM PAGE: 1
 RUN DATE : 20030506 TRANSACTION ERROR REPORT
 TRANS DATE: 20030506
 SUBMITTER ID SHXXXX FILE ID: 0000000017 PLAN ID: HXXXX BATCH NUMBER: 0000001
 OSEQ SEQ PATIENT CONTROL HIC HIC DOB PVDR FROM THRU DEL DGNS DGNS DGNS CORRECTED
 ERR NUMBER NUMBER ERR DOB ERR TYPE DATE DATE IND CODE ERR1 ERR2 HIC

HIC #
 BLOCKED
 FOR SECURITY

HIC #
 BLOCKED
 FOR
 SECURITY

0000002						20	20030206	20030206	2662	501		
						20	20030206	20030206	41516	450		
						20	20030206	20030206	3310	501		
0000004						10	20021228	20021228	4013	450		
0000005						10	20030204	20030204	11721	450		
						10	20030204	20030204	11055	450		
0000015						10	20030205	20030205	0140	408	409	
0000016						20	20021229	20021226	45981	404	501	
						01	20030113	20030114	56090	450		
0000017						20	20030211	20030211	14100	450		
0000018						10	20030204	20030204	11721	450		
0000022						10	20030107	20030107	11721	450		
0000023						10	20030107	20030107	11721	450		
0000029						20	20021231	20021231	27200	450		
0000030						10	20030107	20030107	10060	450		

Completed Submission of Diagnosis Cluster

- You have:
 - an original hard copy of the encounter as the back up documentation
 - a hard copy of the file transmitted
 - acknowledgement of receipt at CMS
 - a summary report showing what was accepted, rejected, stored in the CMS system and stored in the model
 - a hard copy of actual errors, which can be corrected and resubmitted

Summary

- Become familiar with the new program
- Educate staff about the system
- Design user-friendly system
- Review and refine system as needed
- Train back up person

Chicago, IL

**2003 Regional Risk Adjustment Training
for Medicare+Choice Organizations**

RAPS Strategies



Tina Wolfe
Community Care HMO

Purpose

- Provide background about our company and risk adjustment plan
- Share knowledge about Community Care's success with data submission
- Discuss lessons learned along the way

Background

- Small plan owned by two local hospitals
- 20,000 members in senior health plan
- Located in Tulsa, Oklahoma

Submission

- Connectivity – AT&T
- Collection – All diagnoses
- Submission – RAPS format

Successful RAPS Submission

- Selection Criteria
 - ✓ Dates of Service \geq 06/01/02
 - ✓ Status of Paid or Denied
 - ✓ Not Previously Submitted

Distinguish Claims

- Inpatient – Room and Board Codes
- Outpatient-Non-inpatient hospital or DME
- Non-covered Services
- Physician-Non-hospital with Approved Provider Specialties

Submission Tips

- Create Hard-coded Fields
- Output Data to a Text File
- Count Total DC and Total for each Provider Type
- Return File into SAS

Summary

- Establish Selection Criteria
- Distinguish Among Types of Claims
- Import Return File into Master Submission File

San Diego, CA

**2003 Regional Risk Adjustment Training
for Medicare+Choice Organizations**

RAPS Strategies



Arlene L. Avestruz

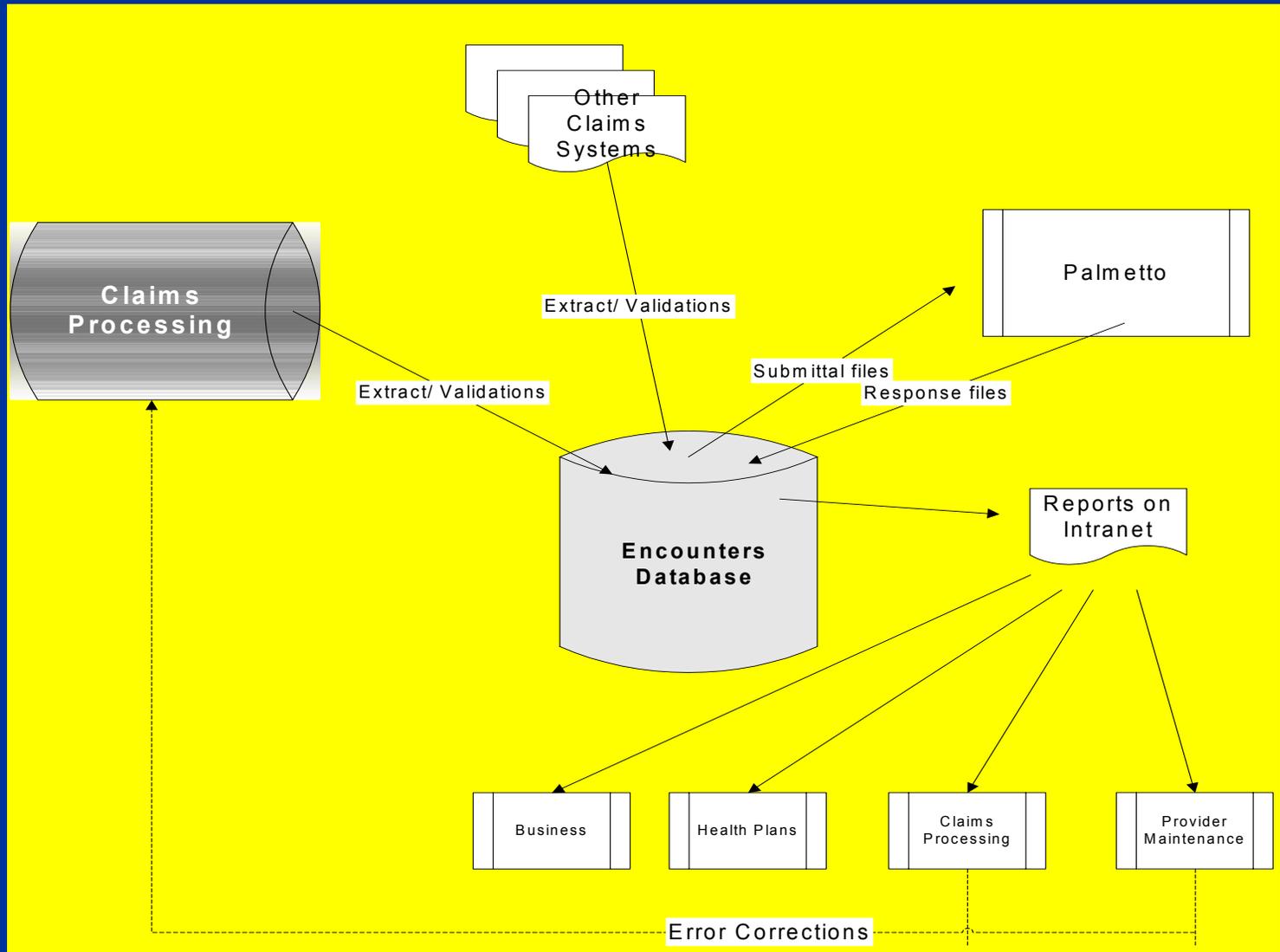
Ovations

A United Health Group Company

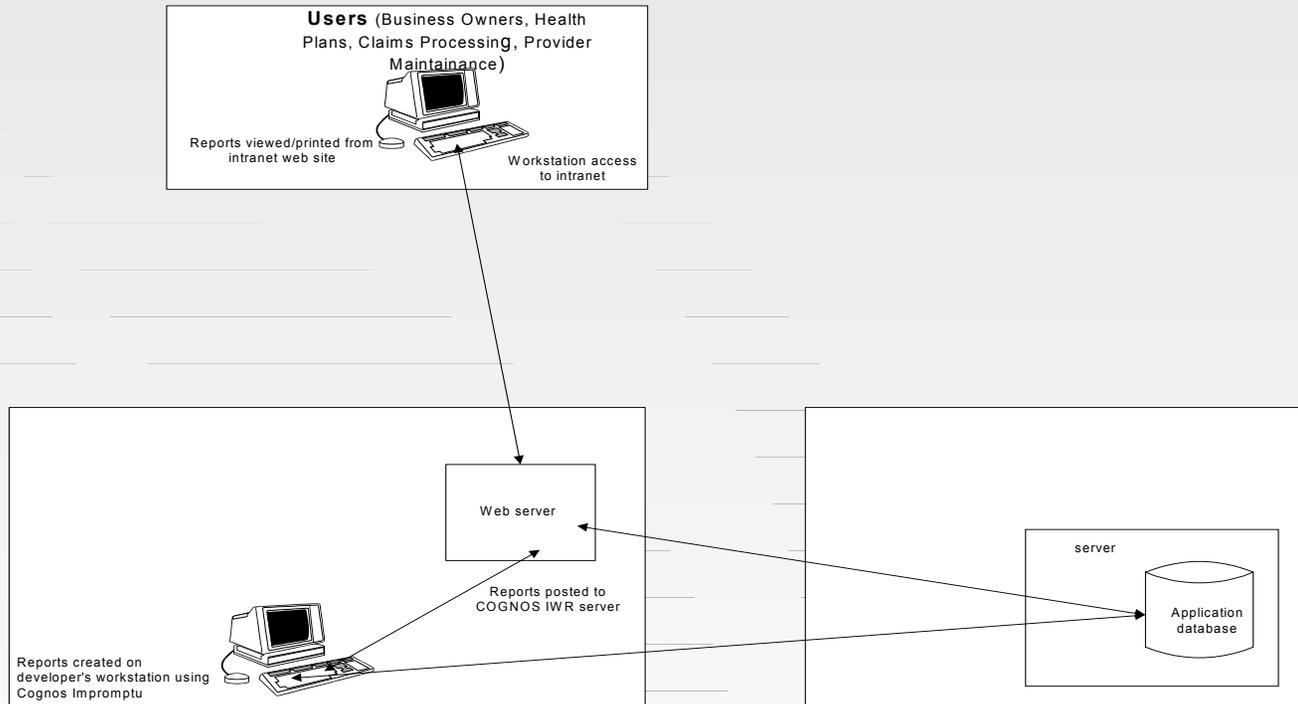
Purpose

- Provide background about our company and risk adjustment plan

Current Process Model



Reporting Environment



Roles

Business

- Manage business and financial impacts
- Own communications and reports
CMS, Health Plans, States, Ovarions
- Lead error correction process
- Act as focal point for health plan relationships
- Act as focal point for Eau Claire
- Act as focal point for NDM (provider error correction)
- Provide clinical interpretations (risk adjustment model, data mapping)
- Create and maintain policies and procedures

Roles

(continued)

Operations

- Investigate errors
- Correct errors
- If necessary, change and improve policies and procedures

Operations IT

- Manage technical solution
- Develop end-to-end technical system
- Submit files and process responses
- Design and develop reporting environment

Roles (continued)

Error Correction Team

- Lead by business project manager
 - IT
 - Eau Claire
 - NDM
 - Health plan representation as required
- Weekly teleconference
- Review intranet reports
- Prioritize error correction
- Investigate errors
- Correct errors
- Identify ways to prevent errors

Benefits

Business

- **Single business owner provides accountability**
- **Increased visibility provides improved opportunities for financial recovery**
- **Common system and encounters tracking reports provide sound comparisons across plans**

Operations

- **Single error correction team leverages error investigations and correction processes**
- **Error corrections across plans reveal opportunities for improved claims processing**
- **Time efficiencies gained through common encounters error reports and processes**

IT

- **Development efficiencies gained using common database and reporting tool**
- **Data mapping knowledge leveraged across plans**
- **Positioned for minimal turnaround if format changes required in future**

Medicare Beneficiary Database



**Angela Reddix
Aspen Systems Corporation**

Purpose

- Provide instructions on accessing and using the Medicare Beneficiary Database (MBD).

Objectives

- Identify the purpose of the Medicare Beneficiary Database.
- Interpret system access instructions.
- Understand common risk adjustment uses of the database.
- Contact appropriate resources.

Medicare Beneficiary Database

- Beneficiary Profile
- Entitlement
- Coverage
- Medicaid

Beneficiary Profile

- HIC Number
- Social Security Number
- Birth Date
- Sex Code
- Date of Death
- Mailing Address
- Temporary Mailing Address
- Residence Information

Entitlement

- Part A
 - Entitlement Effective Date
 - Entitlement Termination date
 - Entitlement Status Code
 - Enrollment Reason Code
- Part B
 - Entitlement Effective Date
 - Entitlement Termination Date
 - Entitlement Status Code
 - Enrollment Reason Code

Coverage

- Plan Number
- Enrollment Effective Date
- FFS Period Effective Date
- Hospice Period Termination Date
- ESRD Coverage
- Coverage effective Date
- Coverage Termination Date

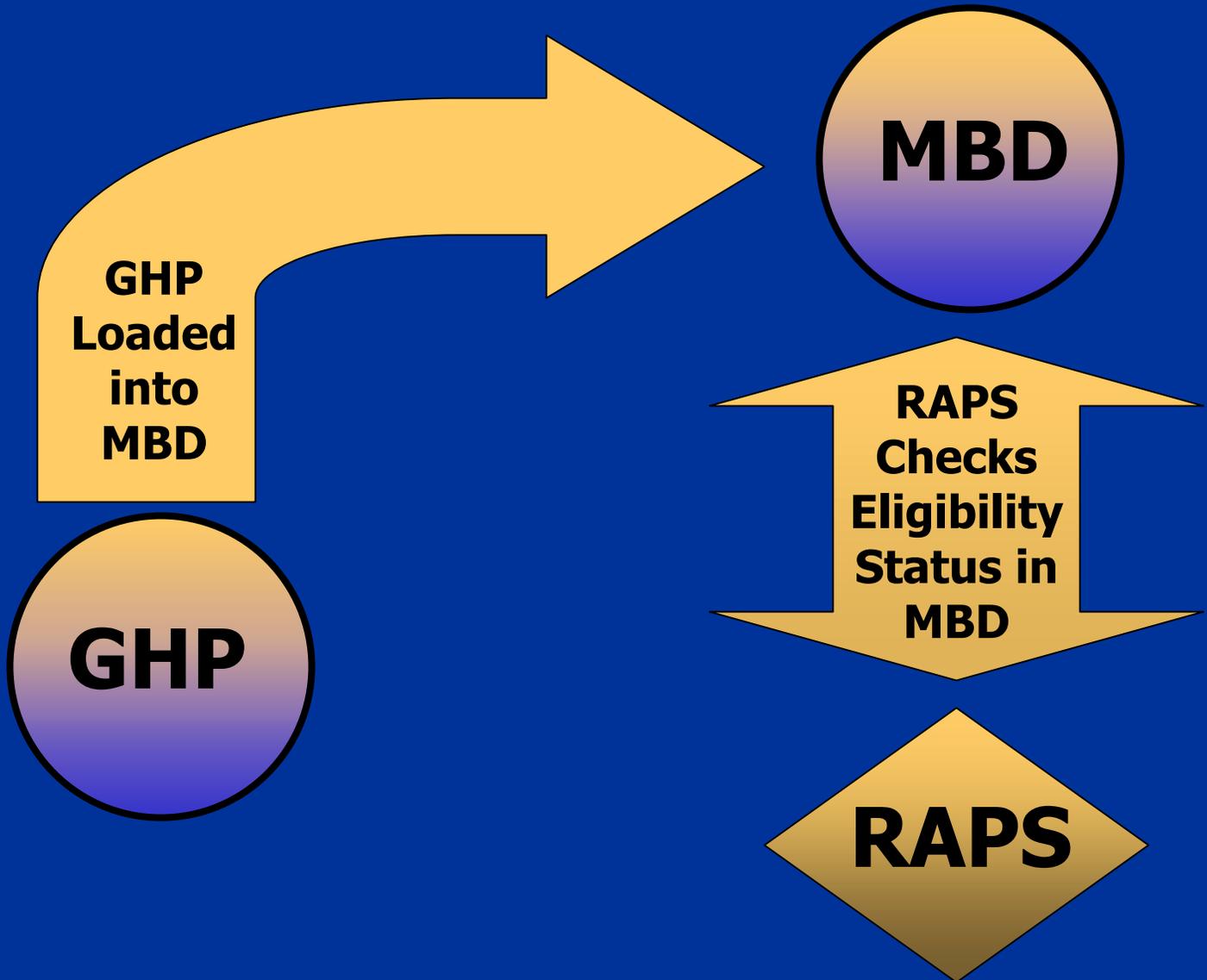
Medicaid

- Medicaid Effective Date
- Medicaid Termination Date
- Medicaid Audit Indicator
- Medicaid Eligibility Source Code

Accessing MBD

- Download MBD application
<http://cms.hhs.gov/mdcn/access.pdf>
- Submit application to regional office contact
- Security levels restrict access
- FTP and NDM access

Risk Adjustment & MBD



2003 Regional Risk Adjustment Training
for Medicare+Choice Organizations

MBD/RAPS Editing Process

- **HIC**
 - Error Code 353/HIC number does not exist in MBD
- **DOB**
 - Error Code 354/Patient DOB does not match DOB in MBD
 - Error Code 405/DOB is greater than service from date

MBD/RAPS Editing Process

- Date of Death
 - Error Code 411/Service Through Date Is Greater than Date of Death.
- Medicare Entitlement
 - Error Code 406/Service From Date is Not Within Medicare Entitlement Period
 - Error Code 407/Service Through Date is Not Within Medicare Entitlement Period.

MBD/RAPS Editing Process

- Enrollment
 - Error Code 408/Service From date is not within M+C organization Enrollment Period.
 - Error Code 409/Service Through Date is not within M+C organization Enrollment Period.
 - Error Code 410/Beneficiary is not Enrolled In Plan on or After Service From Date

Summary

- Identified the purpose of the Medicare Beneficiary Database.
- Interpreted system access instructions.
- Understand common risk adjustment uses of the database.
- Contacting appropriate resources.

Verifying Risk Scores

**Angela Reddix
Aspen Systems Corporation**

Purpose

- This module will identify systems that are used to calculate risk scores and reports that are available to verify risk scores.

Objectives

- Describe how to use reports to verify risk scores
- Identify data systems used to calculate risk scores
- Interpret the Impact Data Report
- Identify changes to the MMR
- Discuss benchmarks

Verification Tools



- RAPS Management Reports
- Raps Return File
- Monthly Membership Report
- Risk Adjustment Model Output Report
- CMS-HCC Model

RAPS Management Reports

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

RAPS Return File

- Received the next day after submission
- Provides a record of each diagnosis stored for each enrollee
- M+C organizations may store the results of each RAPS Return File to establish a record of each diagnosis stored in the model for each enrollee

Monthly Membership Report

- Generated by GHP
- Beneficiary-level information
- Available through the GROUCH system
- Usually provided the third week of every month

Monthly Membership Report Highlights

- Fields 7-21
 - Applicable to demographic and risk adjuster
- Field 40 Previously Disabled Ratio
 - Only on pre-2004 adjustments
- Field 46 Frailty Indicator
- Field 47 Previously Disabled Indicator
 - Only on post 2003 payments/adjustment
- Field 48 Lag Indicator

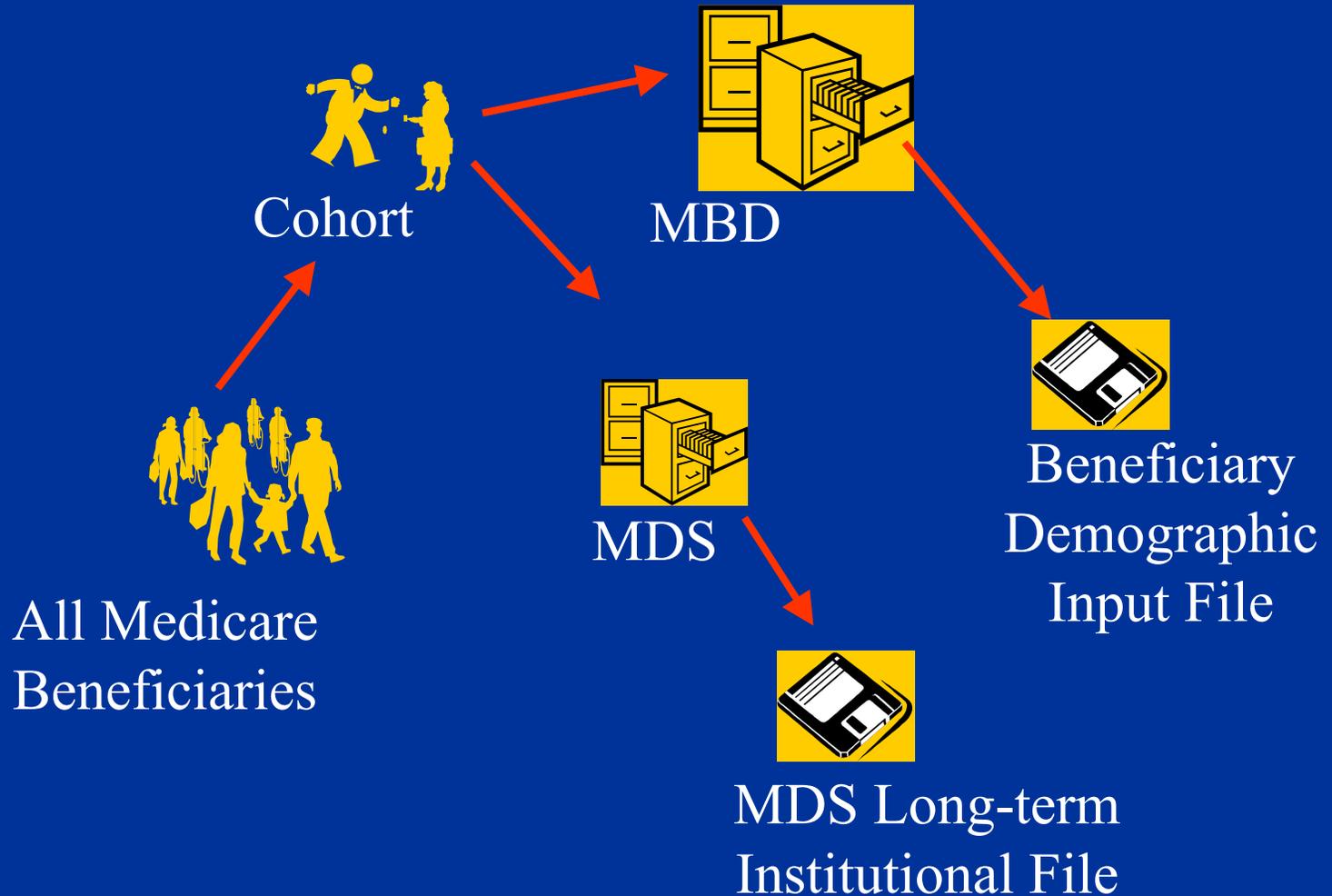
Risk Adjustment Model Output Report

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

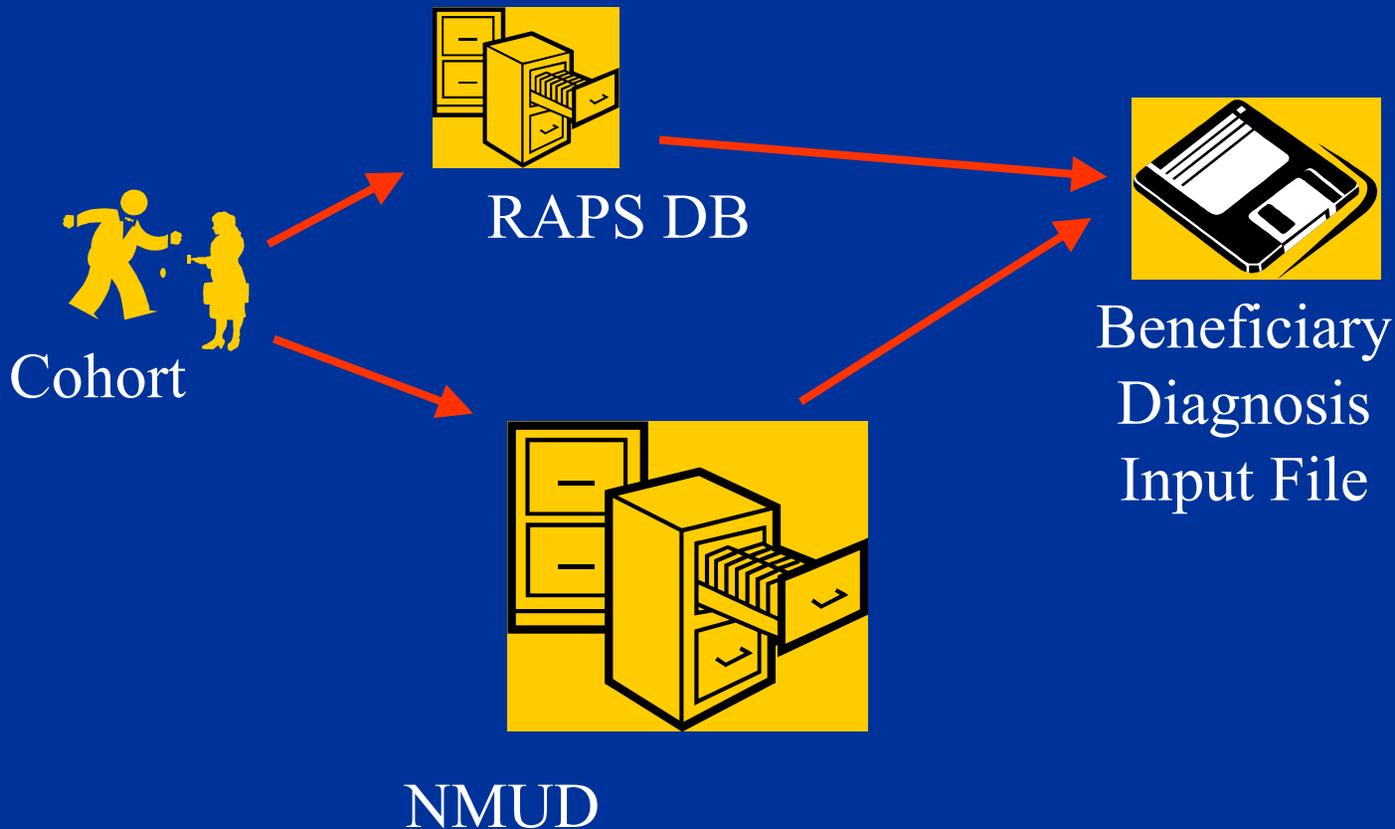
Run the CMS-HCC Model

- CMS runs model on an annual basis
- SAS program available at the CMS website soon
- M+C organizations may run the model to calculate their enrollee risk scores

Calculation of Risk Factors



Calculation of Risk Factors



Calculation of Risk Factors



Beneficiary
Demographic
Input File



Risk Adjustment
System (RAS)



Medicare
Managed Care
System

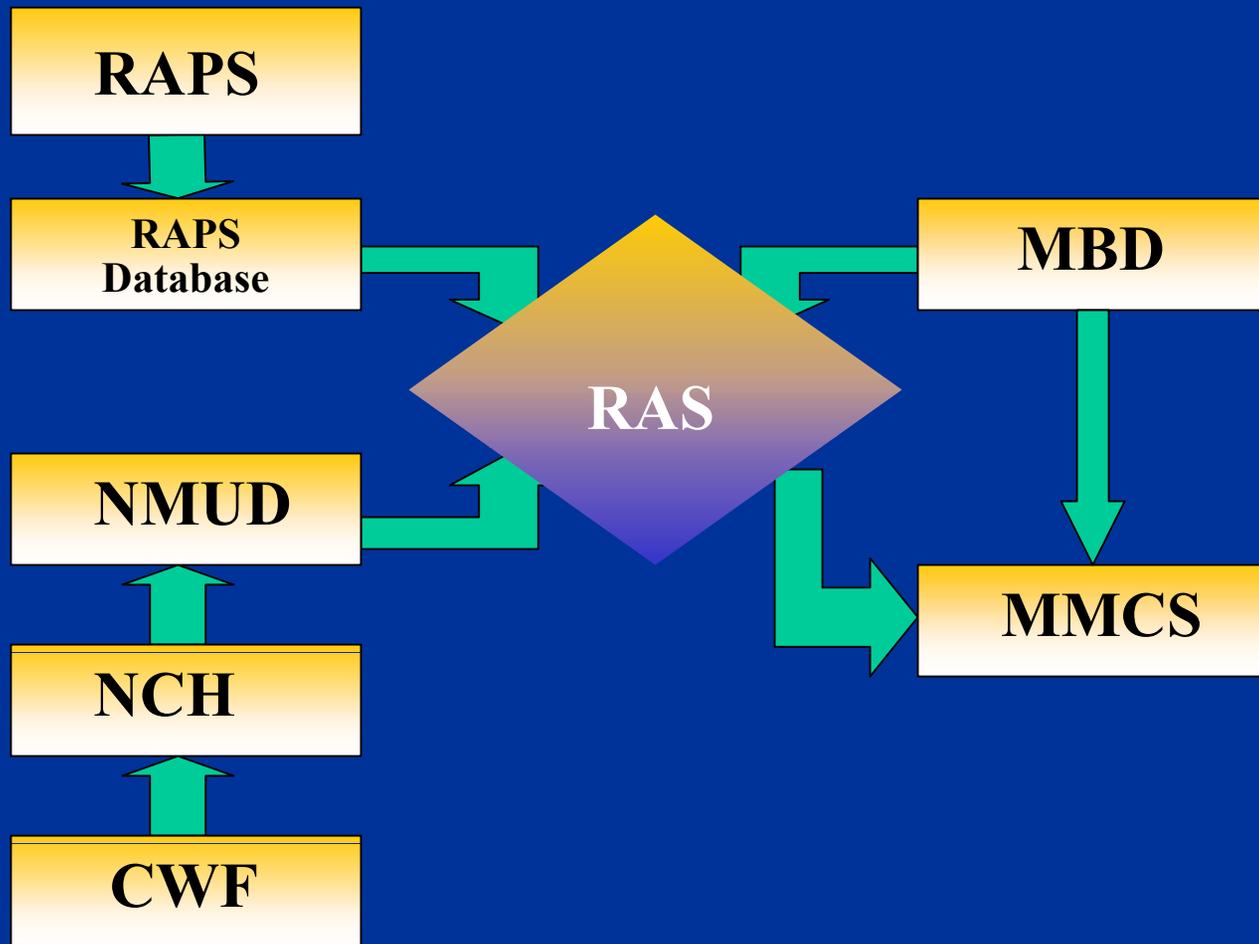


Beneficiary
Diagnosis
Input File



MDS Long-term
Institutional File

Calculation of Risk Factors



Impact Data Report

- Access via HPMS
- Indicates plan level risk score and HCC distribution
- Provided to plans that submitted risk adjustment estimator data

Impact Data Report

Based on:

- Dates of service July 1, 2001 – June 30, 2002
- Hospital inpatient, hospital outpatient, and physician data
- Estimator data submitted in RAPS
- Fee-For-Service claims data
- M+C encounter data submitted prior to October 1, 2002
- Enrollee in September 2002 Cohort 12 month period

Impact Data Report

Table 1

- Aggregate plan information
- Estimated impact for the plan
- Estimated risk factor for the plan
- M+C organizations risk scores
- Estimated national payment change

Table 2

- Number and percentage of beneficiaries by number of condition categories triggered
- Each beneficiary assigned to one group

Table 3

- Number and percentage of beneficiaries by the specific HCC triggered
- Beneficiaries that triggered one or more HCC reflected

Benchmarking

- RAPS and HPMS reports may be used to compare to national estimates
- HCCs for Medicare Fee-For-Service will be available on cms.hhs.gov

Rosemount Health Plan

Condition	Number	Percent
Number of enrollees with 0 conditions	2,112	63.8%
Number of enrollees with 1-6 conditions	1,036	31.3%
Number of enrollees with 7 or more conditions	161	4.8%
Total number of (non new) enrollees	3,309	100.0%

Summary

- Reviewed how reports can be used to verify risk scores
- Identified data systems used to calculate risk scores
- Interpreted the Impact Data Report
- Identified changes in the Monthly Membership Report
- Described the use of benchmarks

Risk Adjustment Data Validation

CMS Staff

Purpose

- To describe the data validation approach under the CMS-HCC model.

Objectives

- Understand the risk adjustment data validation process and principles
- Identify the guidelines for medical record documentation
- Understand the risk adjustment data sampling approach

Objectives (continued)

- Understand the medical record review process and data validation
- Identify risk adjustment data discrepancies
- Understand payment adjustments and appeals

What is Risk Adjustment Data Validation?

- Occurs after data is collected and payment is made
- The process of verifying that diagnosis codes submitted are supported by the medical record documentation

What is Risk Adjustment Data Validation? (continued)

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

Principles of Risk Adjustment Data Validation

- Similar to process applied under PIP-DCG
- New Components:
 - now validate physician and hospital outpatient data
 - validation based on minimum required data set
 - M+C organizations now have more flexibility in the selection of records for review

Guiding Principle

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

Principles of Risk Adjustment Data Validation

- May submit a complete or less than complete medical record
- May identify any medical record, per the requirements outlined in the guiding principle, which supports the diagnosis under review

Guidelines for Medical Record Documentation

- Medical record documentation of a reported diagnosis is critical for accurate risk adjusted payment
- Physician data will likely be the primary source of risk adjustment data
- Refer to page 3 in the Participant Guide

Acceptable Types of Documentation

Refer to Table 12A in the Participant Guide

Risk Adjustment Data Sampling Approach

STAGE 1

- Select M+C Organizations
- Range: 30-50 plans
- Random & Targeted
- Targeting based on profile of data submitted and past performance in validation

STAGE 2

- Select Beneficiaries
- Range: 50-400 Beneficiaries
- Random & Targeted based on the HCCs assigned

STAGE 3

- Entire HCC profile of the beneficiary or subset of HCCs or diagnoses
- Range: 50-600 HCCs and/or diagnoses

Medical Record Request

- May require documentation to support one or more individual HCCs
- May identify one or more sources of data for organization
- M+C organizations will need to track and locate the requested medical records

Medical Record Request

- CMS will provide letter to providers and physicians regarding the medical record request
- Letter will include HIPAA privacy language
- CMS does not violate HIPAA privacy because we are validating Medicare payments

Medical Record Request

Refer to example on page 12-9
of the Participant Guide

Responding to the Medical Record Request

- Select one record that best supports each diagnosis or HCC
- CMS recommends selecting an institutional record first (hospital inpatient/hospital outpatient) when a choice is available

Data Discrepancies

- Coding Discrepancy
 - Diagnosis reported to CMS is not supported by medical record documentation
- Medical record documentation is missing or incomplete
- Records are not valid for risk adjustment
 - invalid provider type
 - documentation is not from data collection period

Risk Adjustment Discrepancies

- One or more HCCs originally assigned differs from the HCC(s) assigned after medical record review and validation
- May affect risk score

Risk Adjustment Discrepancies (continued)

- **UPCODING:**
 - The final risk score calculated after the medical record review is lower than the risk score calculated based on submitted data
 - Results in overpayment

Risk Adjustment Discrepancies (continued)

- **DOWNCODING:**
 - The final risk score calculated after the medical record review is higher than the risk score calculated based on submitted data
 - Results in underpayment

Examples of Risk Adjustment Discrepancies

Refer to examples on page 12-11
of the Participant Guide

Second Independent Review

- If a risk adjustment discrepancy affects payment, then the record automatically undergoes a second independent review
- Typically done by QIO

Payment Adjustments & Appeals

- CMS developing criteria based on CY2001 and CY2002 data validation studies
- For 2001/2002 adjustments could apply when an organization demonstrates consistent patterns of payment inaccuracies that yield overpayments
- CY2004 activities will consider new model and new data requirements

Payment Adjustments & Appeals (continued)

- Appeals process in place when the M+C organization disagrees with the findings
- Appeals occurs after payment adjustment has been made
- Opportunity to challenge payment adjustment with **one** substitute record

Analysis and Findings

- Plan-specific findings will be shared with the M+C organization
- Aggregate findings will be shared with all plans

Pilot Test of CY2003 Estimator Data

- CMS will sample approximately 10 plans (volunteers)
- Sample approximately 20 beneficiaries/plan
- Plan-specific findings will be “blind” to CMS
- Will occur in Fall of 2003

CY2004 Timeline

- Data validation will be based on non-lagged data (Jan-Dec 2003)
- Records request spring CY2004

Physician Training

- CMS “Risk Adjustment Physician CD” available September 2003
- Utilize current training materials such as this module

Summary

- Described how the risk adjustment data validation process will work for CMS-HCC data
- Identified the guiding principle for data validation activities
- Described the risk adjustment data sampling approach

Summary (continued)

- Described how a medical record request will look
- Identified risk adjustment data discrepancies
- Described payment adjustments and appeals

2003 Regional Risk Adjustment Training for Medicare+Choice Organizations



**Track 2
Data Collection/Clinical Coding
Training Slides**

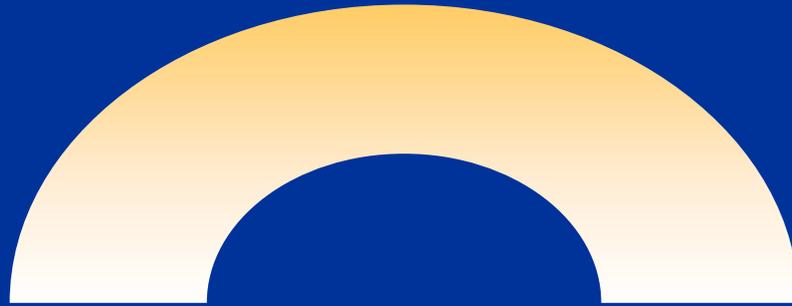
Introduction

**Angela Reddix
Aspen Systems Corporation**

Purpose

The purpose of this training is to provide participants with information and resources specific to the role they play in the risk adjustment process. This information will lead to improvements in the quality and quantity of risk adjustment data submitted and ultimately more accurate payment by CMS.

Training Format

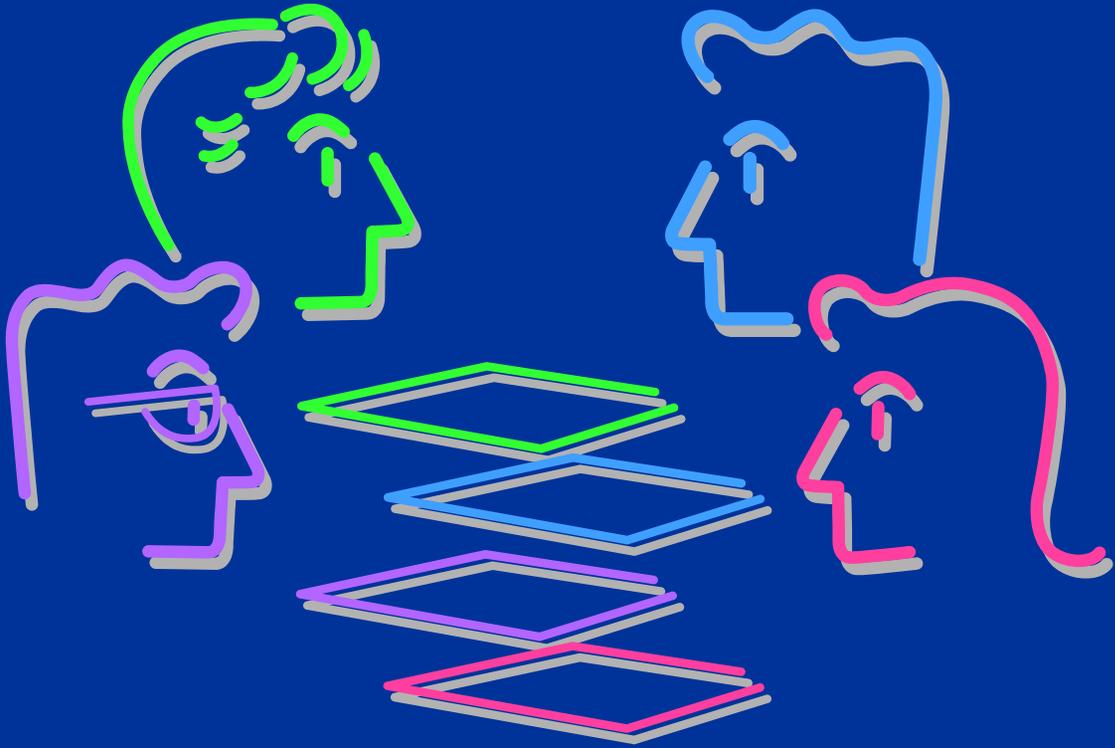


Concepts

Application

- **Case Studies**
- **Sharing Lessons Learned**
- **Group Participation**
- **Casual**
- **Interactive**

Your Involvement Makes the Difference



**2003 Regional Risk Adjustment Training
for Medicare+Choice Organizations**

Two Tracks

Training designed to meet the needs
of two specific audiences



Track 1 – IT/Systems Track



Track 2 – Data Collection/Clinical Coding
Track

Audience



- M+C organizations
- PACE plans
- Minnesota Senior Health Options
- Social Health Maintenance Organizations
- Wisconsin Partnership Program
- EverCare
- Capitated Demonstration Projects

Objectives

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

- Identify the final CMS-HCC model and payment methodology
- Describe the requirements for data collection
- Determine the process for submitting data to CMS
- Interpret the editing rules and the resolution of errors

Objectives

(continued)

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

- Gain an understanding of strategies employed by other organizations
- Understand how to verify risk scores reported in the Monthly Membership Report (MMR)
- Understand the data validation approach under the CMS-HCC Model

Training Team

CMS



Palmetto

Aspen

Risk Adjustment & The CMS-HCC Model

CMS Staff

2003 Regional Risk Adjustment Training
for Medicare+Choice Organizations

CMS

CENTERS for MEDICARE & MEDICAID SERVICES

Purpose

- To provide an explanation of risk adjusted payment under the CMS-HCC payment model for the Medicare+Choice program.

Objectives

- Understand the components of risk adjusted payment
- Understand how demographic & risk adjusted payments are calculated
- Understand the new enrollee factors
- Understand the long-term institutional model

Objectives (continued)

- Understand the frailty adjuster
- Understand the new payment schedule based on elimination of the payment lag
- Understand plan-level data reported in HPMS

Characteristics of the CMS-HCC Model

- Selected Significant Disease
- Prospective
- Demographic Variables
- Site Neutral

Characteristics of the CMS-HCC Model (continued)

- Considers Multiple Chronic Diseases
- Includes Disease Interactions & Hierarchies
- Distinguishes Between Community-Based and Long-Term Institutionalized Enrollees

M+C Rate Book

- Capitated payments to plans are set using a county-level rate
- The 1997 rate book is the statutory basis for M+C capitated payments

M+C Rate Book After BBA

- Rate book calculation changed from pre-BBA standard to create stability in rate changes from year to year & reduce substantial geographic variation in payment rates
- Broke direct link between M+C payment and FFS spending
- Introduced the “highest of 3 rates” method

M+C Rate Book After BBA

(continued)

- 3 Rates
 - Blended capitation: a combination of national average rates and local rates
 - Minimum Floor: Set by BBA & updated by Congress in 2000; national growth percentage
 - Minimum percent update: Generally an increase of 2%

Calculating Payments

Example:

- 72-year old female
- Residence: Howard County, Maryland
- Community (non-institutionalized)
- Originally entitled to Medicare due to disability
- Not entitled to Medicaid
- Diagnoses during the data collection period:
Diabetes with Acute Complications (HCC 17),
Diabetes without Complications (HCC 19) and
Pneumococcal Pneumonia (HCC 112)

Calculating Payments

(continued)

STEP 1

Calculate
Demographic
Payment

County Rate
Book
Part A & Part
B Rates

Attachment A

Monthly rate book
amounts for Howard
County, MD

Part A = **\$348.93**

Part B = **\$281.71**

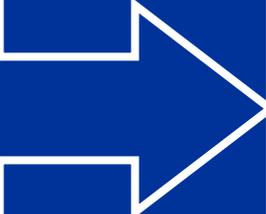
Calculating Payments

(continued)

STEP 1 Attachment B

Calculate
Demographic
Payment

Demographic Cost
Factors



Factors for 72 year-old
female, community:

Multiply by Demographic
Cost Factors for 1997-2004

$$\text{Part A} = .70 \times \$348.93$$

$$\text{Part B} = .85 \times \$281.71$$

$$\text{Part A} = \$244.25$$

$$\text{Part B} = \$239.45$$

$$\text{A} + \text{B} = \mathbf{\$483.70}$$

Calculating Payments

(continued)

STEP 1

County Rate
Book
Part A & Part
B Rates

Demographic Cost
Factors

Demographic Payment

Multiply Total by
Demographic % for
2004

$$A+B = \$483.70 \times .70 =$$

\$338.59

Risk Rate Book

- A rescaling factor is applied to convert the rate book and get the risk adjusted rate for each county
- Rescaling factor =

$$\frac{\text{Re-standardized County Rate}}{\text{Demographic County Rate}}$$

CY2004 Rescaling Factor

- Two adjustments for 2004
 - Budget Neutrality:
 - Separate from rate book adjustment discussed earlier
 - Represents difference between 100% risk adjusted payment vs. 100% demographic payment
 - Redistributes reduced aggregate payments as a constant percentage to organizations
 - CY2004 adjustment for budget neutrality = 1.163

CY2004 Rescaling Factor

(continued)

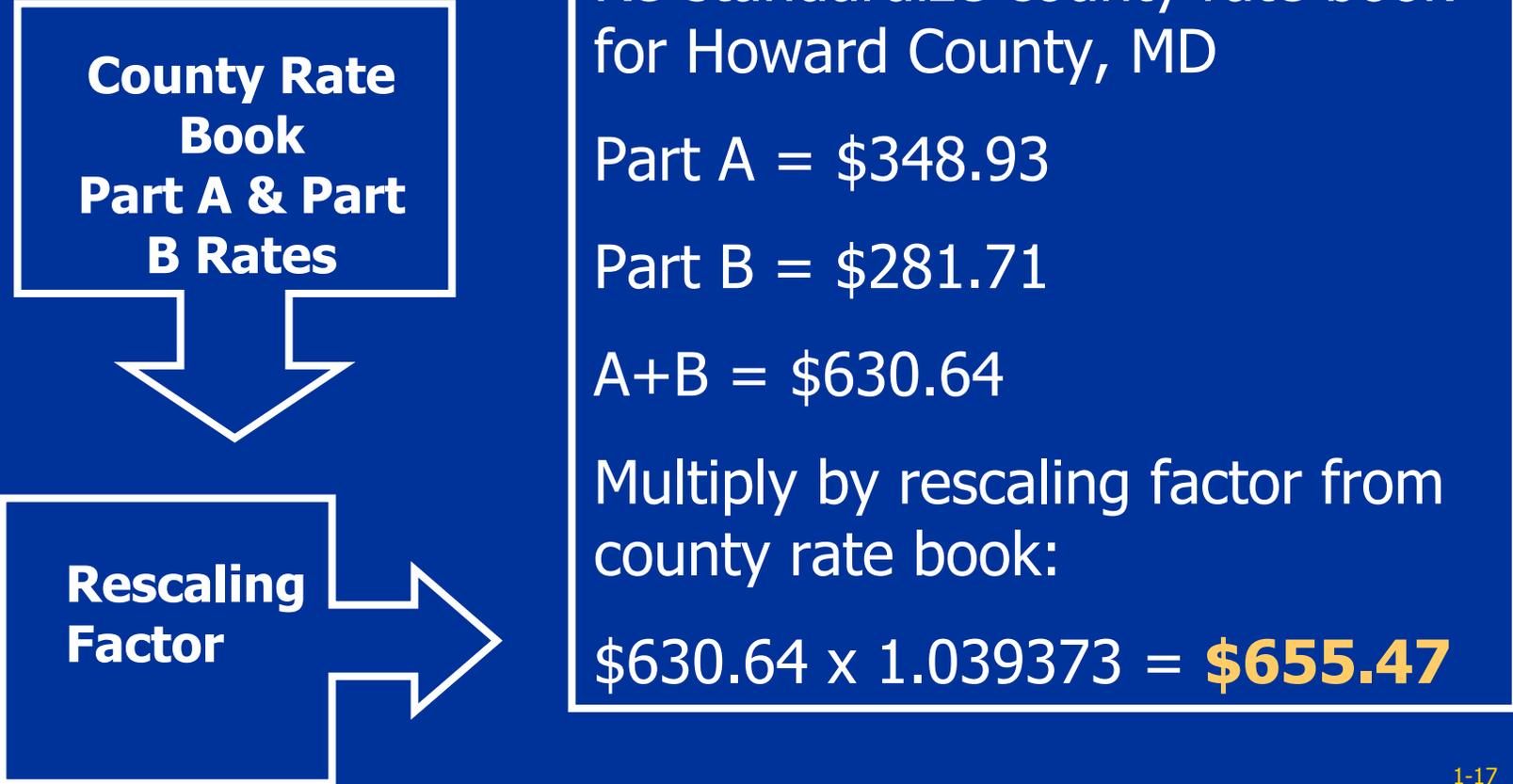
- Two adjustments for 2004
 - FFS Normalization:
 - Necessary for changes in the national average predicted expenditures from 1997
 - Changing demographics, average disease burdens, & coding patterns
 - CMS uses actuarial adjustment to the national mean predicted expenditures
 - CY2004 FFS normalization adjustment = $1/1.05$

Calculating Risk Adjusted Payment

STEP 2

Attachment A

County Rate
Book
Part A & Part
B Rates



Rescaling
Factor

Re-standardize county rate book
for Howard County, MD

Part A = \$348.93

Part B = \$281.71

A+B = \$630.64

Multiply by rescaling factor from
county rate book:

$\$630.64 \times 1.039373 = \mathbf{\$655.47}$

Demographic Factors in Risk Adjustment

- Age
 - Payment year based on enrollee age as of February 1st
- Sex
- Medicaid Status
 - Under CMS-HCC applies only to community residents
 - Defined as 1 month of Medicaid eligibility during data collection period
 - New enrollees use concurrent Medicaid

Demographic Factors in Risk Adjustment (continued)

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

Calculating Risk Adjusted Payment

STEP 2

Attachment C

Risk Adjusted
Demographics



Demographics:

72 year-old female, community = .384
Originally disabled = .236

Disease Groups/HCCs

- Contain major diseases & broadly organized by body system
- Determined by ICD-9 codes
- Approx. 3,100 ICD-9 codes in CMS-HCC model
- 65 disease groups for payment categories
- Additive

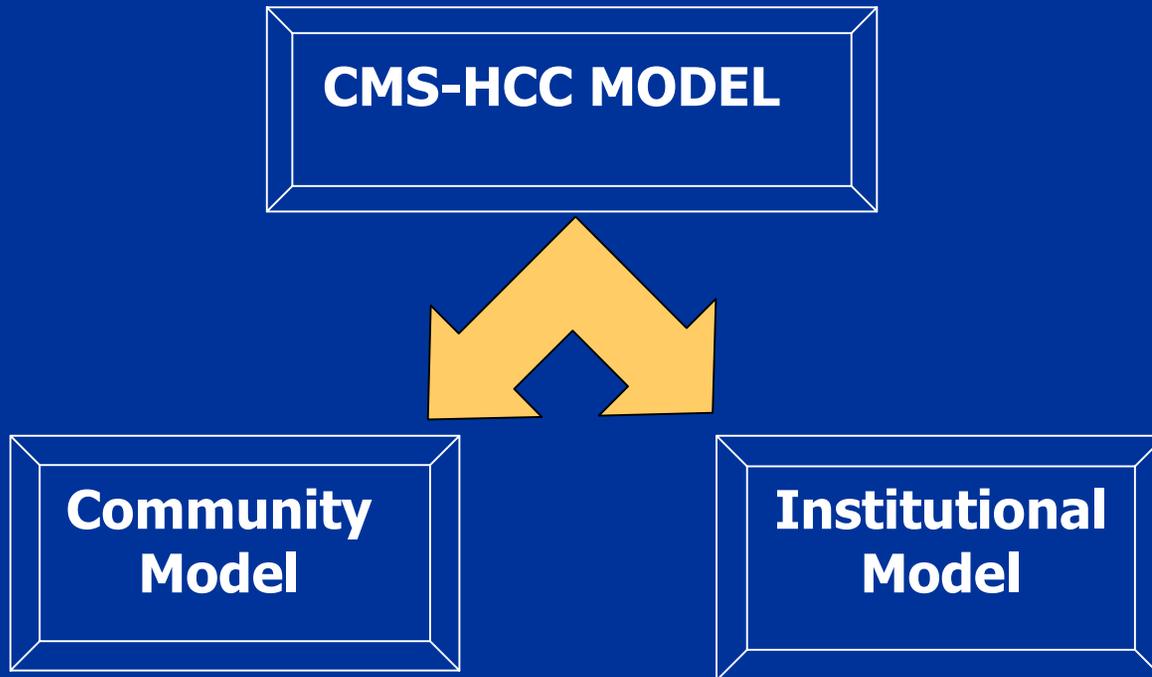
Disease Interactions

- Combinations of coexisting conditions
- 6 disease interactions for community model
- Additive

Disease Hierarchies

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

Community & Institutional Models



**2003 Regional Risk Adjustment Training
for Medicare+Choice Organizations**

Calculating Risk Adjusted Payment

STEP 2

Attachment C

Risk Adjusted
Demographics
& Disease
Profile
= Beneficiary
Risk Factor

Disease Profile:

HCC17 = .391

HCC19 = .200*

HCC112 = .202

Total risk adjustment factor = .384 +
.236 + .391 + .202 = **1.213**

*dropped because in hierarchy;
payment based on HCC17

Calculating Risk Adjusted Payment (continued)

STEP 2

Apply
CMS-HCC
2004 %

Risk Adjusted Payment

$\$655.47 \times 1.213 = \795.09 at
100%

Calculate 30% risk adjusted
amount for 2004:

$\$795.09 \times .30 = \mathbf{\$238.53}$

Calculating Risk Adjusted Payment (continued)

STEP 3

Sum the demographic &
risk adjusted payments

$$\begin{aligned} \text{Total Payments} &= \\ \$338.59 + \$238.53 &= \mathbf{\$577.12/\text{month}} \\ &= \mathbf{\$6,925.44 \text{ annual total}} \end{aligned}$$

Financial Impact of Not Submitting Risk Adjustment Data

- Demographic payment (70% for 2004) remains the same: \$338.59
- Risk adjusted factor becomes
 $.384 + .236 = .620$ vs. 1.213
- $\$655.47 \times .620 = \406.39 vs. \$795.09
- $\$406.39 \times 30\% = \121.92 vs. \$238.53

Financial Impact of Not Submitting Risk Adjustment Data (continued)

- Total payment = \$460.51 vs. \$577.12/month
- Yearly payment = \$5,526.12 vs. \$6,925.44
- **Annual difference \$1,399.32**

Annual Financial Impact

- Annual difference at 30% (CY 2004 payments) = \$1399.35
- Annual difference at 50% (CY 2005 payments) = \$2332.20
- Annual difference at 75% (CY 2006 payments) = \$3498.33
- Annual difference at 100% (CY 2007 and beyond) = \$4664.40

***Using 2004 rate book**

New Enrollee Factors

- New factors developed specifically for CMS-HCC model
- Includes age/sex combinations for Medicaid & disabled
- New enrollee factor applies when enrollee has <12 months of enrollment in Part B during data collection period

Long-Term Institutional Model

- Separate model developed due to cost differences between community & long-term institutional populations
- Apply long-term institutional model for enrollees who reside in an institution for 90+ days

Long-Term Institutional Model (continued)

- Designation is made by MDS (Minimum Data Set)
- Plans **will not report** the institutional status

Frailty Adjuster

- Purpose: To predict Medicare expenditures of the functionally impaired that are unexplained by risk adjustment methodology alone
- Applied to PACE plans and certain demonstrations

Frailty Adjuster (continued)

- Mandated by BBA
- Adjuster based on the relative frailty of an organization in terms of number of functional limitations
- Measured by ADLs (Activities of Daily Living)

Frailty Adjustment

Type of Health Plan	Frailty Adjuster is Part of Risk Adjusted Payment
M+C Organizations	NO
PACE	YES
WPP	YES
MSHO/MnDHO	YES
S/HMOs	YES
EverCare	NO

Frailty Adjustment (continued)

- Applied in conjunction with the CMS-HCC model
- Applies only for community residents who are 55 or older
- CMS calculates organization-level frailty score based on ADLs
- ADLs are reported by survey

Frailty Adjustment Calculation

Refer to Figure 1C in your
Participant Guide

M+C ESRD Payment

- Payment methodology delayed one year, except for ESRD demonstrations
- 3 Parts
 - Dialysis – CMS-HCC payment factors
 - Transplant – lump sum payment
 - Functioning Graft – modified CMS-HCC payment

Yearly Reconciliation

- Reconciliation occurs 6-8 months after end of payment year
- Incorporates data that is late or incorrect
- Includes changes to any demographic variables in the model

Payment Blends

**Refer to Tables 1D & 1E in your
Participant Guide**

Elimination of the Payment Lag

- Beginning with payments in July 2004, the 6-month data lag will be eliminated
- Purpose: To pay more accurately based on the most recent data
- Collection period changes to January 1 through December 31

Elimination of the Payment Lag (continued)

Preliminary Payment Data Collection Period:	July 1, 2002 through June 30, 2003
Deadline for Preliminary Payment Calculation:	September 5, 2003
Data Collection Year	January 1, 2003 through December 31, 2003
Initial Submission Deadline for Data Collection Period	March 5, 2004
Final Submission Deadline for Data Collection Period (Reconciliation):	March 31, 2005

Elimination of the Payment Lag (continued)

- CMS is allowing organizations to opt-out of elimination of the lag for CY2004
- If opt-out, then CMS uses risk factors based on lagged data
- If opt-out, then notify CMS by **March 31, 2004**

Estimator Data Impacts

- Based on data submitted for dates of service: July 1, 2001 through June 30, 2002
- Includes ambulatory data
- Average risk score
- Average impact of 70%/30% vs. 90%/10%

Quarterly Diagnosis Counts Report in HPMS

- Similar to estimator data posting
- Updated quarterly
- First counts posted around November 2003

Quarterly Diagnosis Counts Report in HPMS

(continued)

- Includes:
 - Number of beneficiaries per number of CMS-HCC conditions
 - Number of beneficiaries in each HCC

Summary

- Learned how the CMS-HCC model calculates payment
- Described how HCCs work
- Discussed the financial impact of **not** submitting risk adjustment data

Summary (continued)

- Described the long-term institutional model
- Described the frailty adjuster
- Discussed elimination of the payment lag
- Learned about new HPMS reports

Risk Adjustment Process Overview

Angela Reddix
Aspen Systems Corporation

**2003 Regional Risk Adjustment Training
for Medicare+Choice Organizations**

Purpose

- Provide the participants with important terms, key resources, and submission schedule information that will provide the foundation for this training.

Objectives

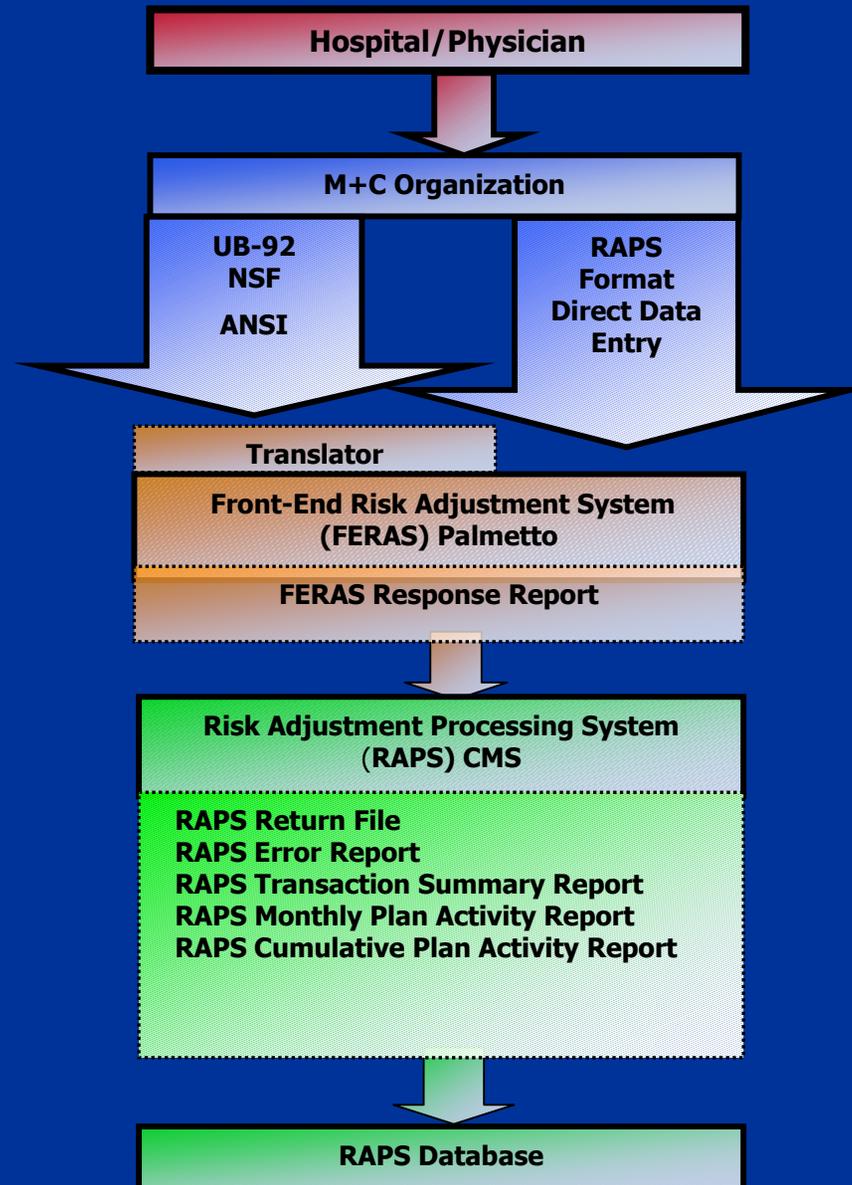
- Identify common risk adjustment terminology
- Demonstrate knowledge in interpreting key components of the risk adjustment process
- Interpret the risk adjustment schedule
- Identify the CMS outreach efforts available to organizations

Risk Adjustment Process Success

- 300 Plan IDs submitted data
- Over 100,000,000 CCC records submitted to FERAS
- 5% initial RAPS error rate
- 1% current RAPS error rate

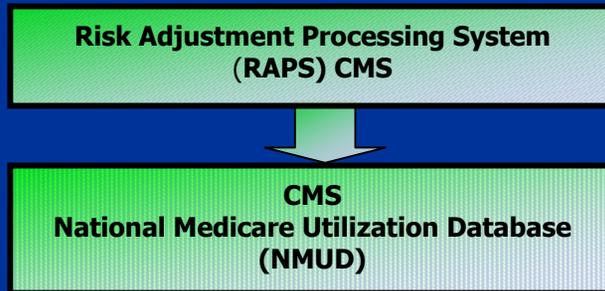
Risk Adjustment Dataflow

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for Medicare+Choice Organizations

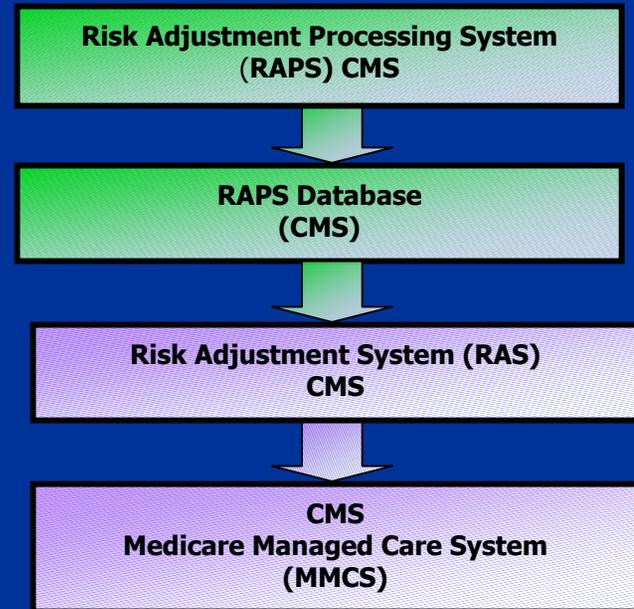


What is New In The Process?

OLD



NEW



Submission Schedule

CY	DATES OF SERVICE	INITIAL SUBMISSION DEADLINE	FIRST PAYMENT DATE	FINAL SUBMISSION DEADLINE
2003	July 1, 2001 through June 30, 2002	September 6, 2002	January 1, 2003	September 26, 2003
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	March 31, 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	March 31, 2006

* With elimination of the payment lag, the final submission deadline (reconciliation) changes to March 31st of each year. There is no September 30, 2004 deadline.

CMS Outreach Efforts

2003 Regional Risk Adjustment Training
for Medicare+Choice Organizations

CSSC	<ul style="list-style-type: none">▪ 1-877-534-2772▪ Monday-Friday▪ 9a.m. – 7p.m.
MCOservice.com	<ul style="list-style-type: none">▪ Gateway to risk adjustment information▪ FAQs▪ Training information▪ Automatic Updates
User Groups	<ul style="list-style-type: none">▪ Monday-Thursday▪ 1 week per month▪ 2-3p.m. EST
Onsite Consultation	<ul style="list-style-type: none">▪ Generally April-May▪ Assists with data collection and submission▪ Voluntary

CMS Training Efforts

2003 Regional Risk Adjustment Training
for Medicare+Choice Organizations

Getting Started Training Program	<ul style="list-style-type: none">▪ Self-paced video and workbook▪ Risk Adjustment basics▪ New staff and new plans▪ Expected in August 2003
Regional Training Program	<ul style="list-style-type: none">▪ Practical training for new and current risk adjustment users▪ Printed and CD versions of the training materials
Regional Training Video	<ul style="list-style-type: none">▪ Video version of the June 2003 training▪ Expected in July 2003
Physician Training CD	<ul style="list-style-type: none">▪ Interactive CD providing risk adjustment medical record documentation and coding guidelines▪ Expected September 2003

Data Collection



**Ed Sommers
Aspen Systems Corporation**

Purpose

- To enable clinical/coding/provider relations staff to apply data collection principles in accordance with CMS requirements, and obtain complete and accurate risk adjustment data from physicians and providers.

Objectives

- Examine case studies related to data collection
- Discuss coding and data collection issues related to each case study
- Develop suggestions to address issues presented in each case



Case Studies

- Examine the case study
- Discuss coding and data collection issues related to the case
- Develop suggestions to address issues presented
- “Elect” an individual to present for your group

Group Summaries

- Briefly summarize primary issues
 - What are the key points of the case?
- Identify the main considerations
 - What are the primary considerations related to collection of data?
- Outline suggestions for the health plan in your case
 - What would you recommend as a course of action?



Rosemount: Key Issues

Appropriate data sources

Covered provider types

Covered services

Appropriate diagnoses for risk adjustment

Data Sources

URL for the American Hospital Directory. Provides assistance in determining hospital provider numbers.

Jobs
Most effective search option.

Having problems?

- The most common problem is caused by entering too many criteria. Try entering just the state and you will get a list of every hospital in the state to choose from.

Data Sources

The screenshot shows a Microsoft Internet Explorer browser window displaying the American Hospital Directory website. The address bar shows a search query for New York state. The website header includes the logo 'ahd.com AMERICAN HOSPITAL DIRECTORY' and navigation buttons for 'HOME', 'NEW SEARCH', and 'BACK TO LIST'. A red box highlights a 'More Info' button next to the text 'Additional data is available to Subscribers DRG and APC Statistics'. Below this, a message states 'There are 262 hospitals that match your search criteria.' and provides a note about telephone numbers. A table lists several hospitals in New York state.

Link	Hospital Name	City	State
Adirondack Medical Center	Adirondack Medical Center	SARANAC LAKE	NY
Albany Medical Center	Albany Medical Center	ALBANY	NY
Albany Memorial Hospital	Albany Memorial Hospital	ALBANY	NY
Albert Lindley Lee Mem Hosp	Albert Lindley Lee Memorial Hospital	FULTON	NY
Alice Hyde Medical Center	Alice Hyde Medical Center	MALONE	NY
Amsterdam Memorial Hospital	Amsterdam Memorial Hospital	AMSTERDAM	NY

The State search provides a listing of hospitals in that state.



Greentree: Key Issues

Acceptable data collection formats

Provider types from whom data is collected

Effective data collection tools

Plan's business needs

Key Features of Formats

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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	•		•	•	•	•



Fair House: Key Issues

HIPAA's impact on data collection

HIPAA's impact on data corrections

Contractual relationships with providers

Other business needs

HIPAA Impacts

- Transaction standards effective October 16, 2003
- Cannot request identical information when data submitted electronically
- Corrections not a HIPAA covered transaction

Risk Adjustment Rule

- Same as HIPAA rule
- For risk adjustment it applies for paper format also

Summary

- Reviewed essential data collection issues
- Discussed decision-making steps associated with data collection issues
- Suggested potential steps to successfully collect data

Coding Workshop



Janet Fry

Aspen Systems Corporation

**2003 Regional Risk Adjustment Training
for Medicare+Choice Organizations**

Purpose

- To gain an understanding of standard medical record documentation and diagnosis coding guidelines and apply them to risk adjustment.

Objectives

- To review medical record documentation practices
- To understand the basics of ICD-9-CM coding
- To identify the importance of diagnosis documentation and coding specificity and how it relates to the CMS-HCC model

Documentation Elements

- Clear
- Concise
- Consistent
- Complete
- Legible

Medical Record Essentials

- Patient identification
- Date(s) of service
- Persons treating patient
 - Provider/physician
 - All participants in the care and treatment
- Reason for the visit
- Care rendered
- Conclusion & diagnosis
- Follow-up plan

SOAP Notes



S.O.A.P.

- Subjective
- Objective
- Assessment
- Plan

Case Study 1

- What are some key differences in documentation practices among various provider types?

Documentation Practices

- Hospital Inpatient
- Hospital Outpatient
- Physician Offices

ICD-9-CM

- Official code set for reporting diagnoses
- Used in CMS-HCC model
- Guidelines & clarifications available
- Updated yearly
- Brief status of ICD-10-CM

ICD-9 Basic Steps

- Identify main term
- Look up in Alphabetic Index
- Identify non-essential modifiers & subterms
- Select referenced code
- Look up in Tabular Index

Special Instructions

- NOS-Not otherwise specified
- NEC-Not elsewhere classified
- “Includes”
- “Excludes”
- “Code also”

Reporting Diagnoses

- All diagnoses that impact the patients evaluation, care and treatment
 - Main reason for visit
 - Co-existing acute conditions
 - Chronic conditions
 - Pertinent past conditions

Case Study 2



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AIDS vs HIV+

- Only confirmed cases documented as AIDS or symptomatic HIV should be coded 042
- HIV positive or asymptomatic HIV infection is coded V08

Hospital Outpatient and Physician:

***Code to highest level of
certainty known.***

Do not code:

- Symptoms that are common to the main diagnosis
- “History of” codes that are no longer pertinent to the current problem
- “Rule out” codes for outpatient and physician visits

V Codes and E Codes

- V codes-factors that influence health
- E codes-external causes of injury and poisonings
- Those that impact Risk Adjustment are listed in the Resource Guide

Clinical Specificity

- Importance to risk adjustment
- Cancer Code Example
 - Hierarchy
 - ICD-9-CM guidelines for neoplasm are in the Resource Guide

Example 3



Concluding Tips

- Verify codes are supported by the medical record
- Fully communicate diagnosis details to coding staff
- Use current version of ICD-9-CM
- Use codes to highest level of specificity
- Train office staff in ICD-9-CM

Exercise & Discussion: Communicating Coding and Documentation Issues to Physician Offices

- Information needed to research case
- Procedure & method of communicating case

Data Collection Strategies



New Orleans, LA and San Diego, CA



Data Collection Strategies



Pam Klugman & Tom Peterson
Blue Shield of California

**2003 Regional Risk Adjustment Training
for Medicare+Choice Organizations**

Purpose

- Provide background about our company and risk adjustment team
- Share a few of our successes and how we achieved them
- Discuss lessons learned along the way

Background

- Non-profit health plan
- Mid-size M+C membership

Staff History

- Department created 1998
- No significant staff turnover
 - 5 systems analysts
 - 1 shared administrative resource

Successes

- Industry Collaboration Effort
 - Consistent application of regulations
 - Provider reporting
 - Provider education materials
- Provider communication efforts
- Ability to accept data directly from providers

Lessons Learned

- Sub-contracted services
- Global fees
- Hospital coding
- Delegated providers/TPA /MSO

Summary

- Collaborate with providers, other plans, associations and CMS
- Refashion systems to work efficiently with incoming data
- Adjust to meet demands of real world
- Focus your communication with providers

New York, NY

**2003 Regional Risk Adjustment Training
for Medicare+Choice Organizations**

Data Collection Strategies



Benjamin J. Paolucci, Jr.

and

Rachel A. Powell

Health Alliance Plan, Michigan

**2003 Regional Risk Adjustment Training
for Medicare+Choice Organizations**

Health Alliance Plan

- Located in Southeastern Michigan
- 540,000 Members Overall
- Currently 15,238 Senior HMO Members
- Part of Medicare Program since at least 1986!

RAPS Data Collection/ Submission

- Connectivity method
 - 56K Dial up modem - via AT&T Global Network Dialer (data zipped, in RAPS format)
- Collection method
 - Claims and encounters are processed through full claims system, stored in data warehouse
 - Monthly extract is made to produce RAPS record
- Submission method
 - RAPS effective 10/1/02, for DOS starting 7/1/02
 - All diagnosis submitted
 - UB92 for DOS prior to 7/1/02

Encounter Data Process

- Senior Product small % of business
- Complied with IPD Encounter Data Process
- Designed data extract programs
- Set up data transfer process to CMS

Encounter Data Process

(continued)

- Over time there were changes in
 - staffing
 - claims/billing systems
 - claims/billing processes
- Quality and quantity of data deteriorated

Encounter Data Process

(continued)

- CMS staff identified decreases in HAP's data submissions
- CMS offered an onsite technical consultation visit in spring of 2002
- HAP accepted and then began research effort to determine issues

Encounter Data Process

Researched Areas

- Four major areas identified for potential data leakage:
 - Missing Encounters from Major Provider
 - Rejections of Encounters in HAP's front end editor or in claims processor
 - Data Extraction from Data Warehouse
 - Rejected Records from CMS Intermediary

Encounter Data Process

Research Results

- Compared admission authorizations to claims and encounters processed, found majority of admissions were in data warehouse
- Major issue - Data extract had logic error
- Fixed program, worked with CMS staff to send missing admissions
- Result - Increase Premium levels for 2003 and will be receiving additional premiums for 2002

Encounter Data Process

Learnings from the CMS On-site Visit

- Major data problem for Encounter Data Process was identified and resolved
- Rejections of Encounters, more of a problem for Outpatient and Professional charges
- CMS Staff outlined new RAPS program
- Development for the new process, RAPS would require more formalized approach

RAPS Development

- Created new position with overall responsibility for Risk Adjustment/Data Submission process
- Created team to rewrite production jobs for data extraction, submission to CMS, development of model to store data, retrieve results from CMS, create reports, etc.

RAPS Development

Working with Major Provider

- Working with major provider to insure 100% capture of encounter data
- Working with major provider to fix any operational processes resulting in rejections on front end data submission or in claim processing

RAPS Development

Working with Major Provider (continued)

- Previously, lack of incentive for major provider to ensure 100% encounters sent and cleared through HAP
- Major provider carried majority of risk and was paid capitation
- Changes in the risk arrangement and payment method increasing the need for complete data transfer from the provider's point of view

RAPS Development

Working with Major Provider (continued)

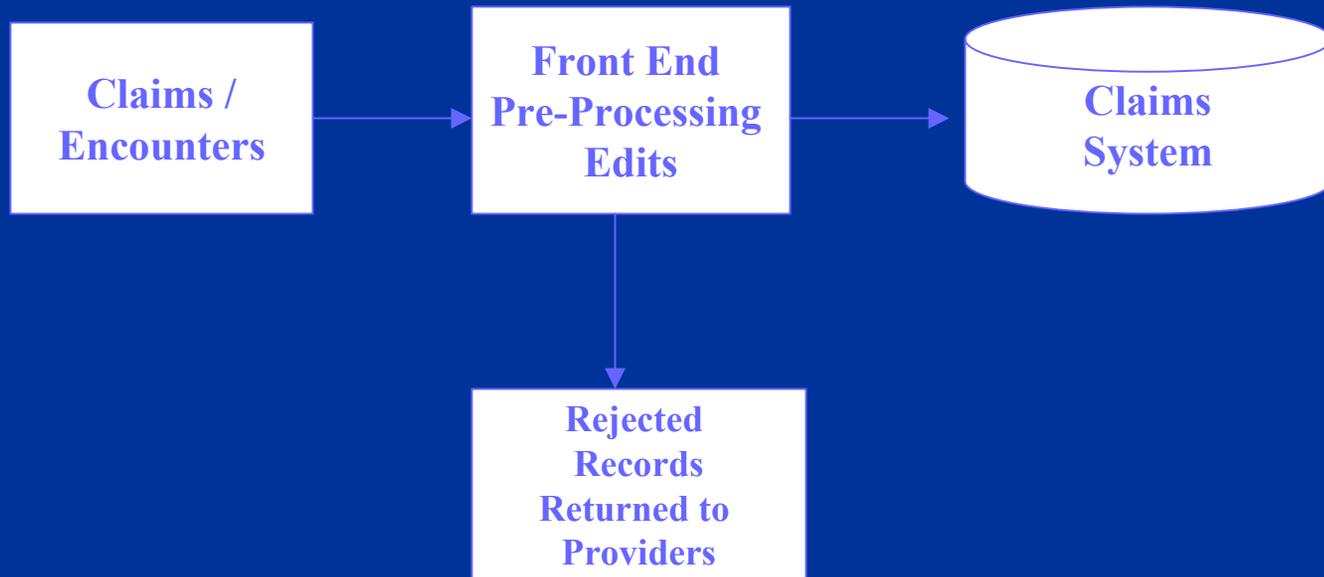
- HAP has dedicated resources to work closely with major provider to identify patterns in rejected encounters
- Provider has dedicated resources to work with front end operations and/or billing department to fix problems upfront
- Where possible, HAP or Provider has “rebilled” previously rejected encounters, with fixes

RAPS Development

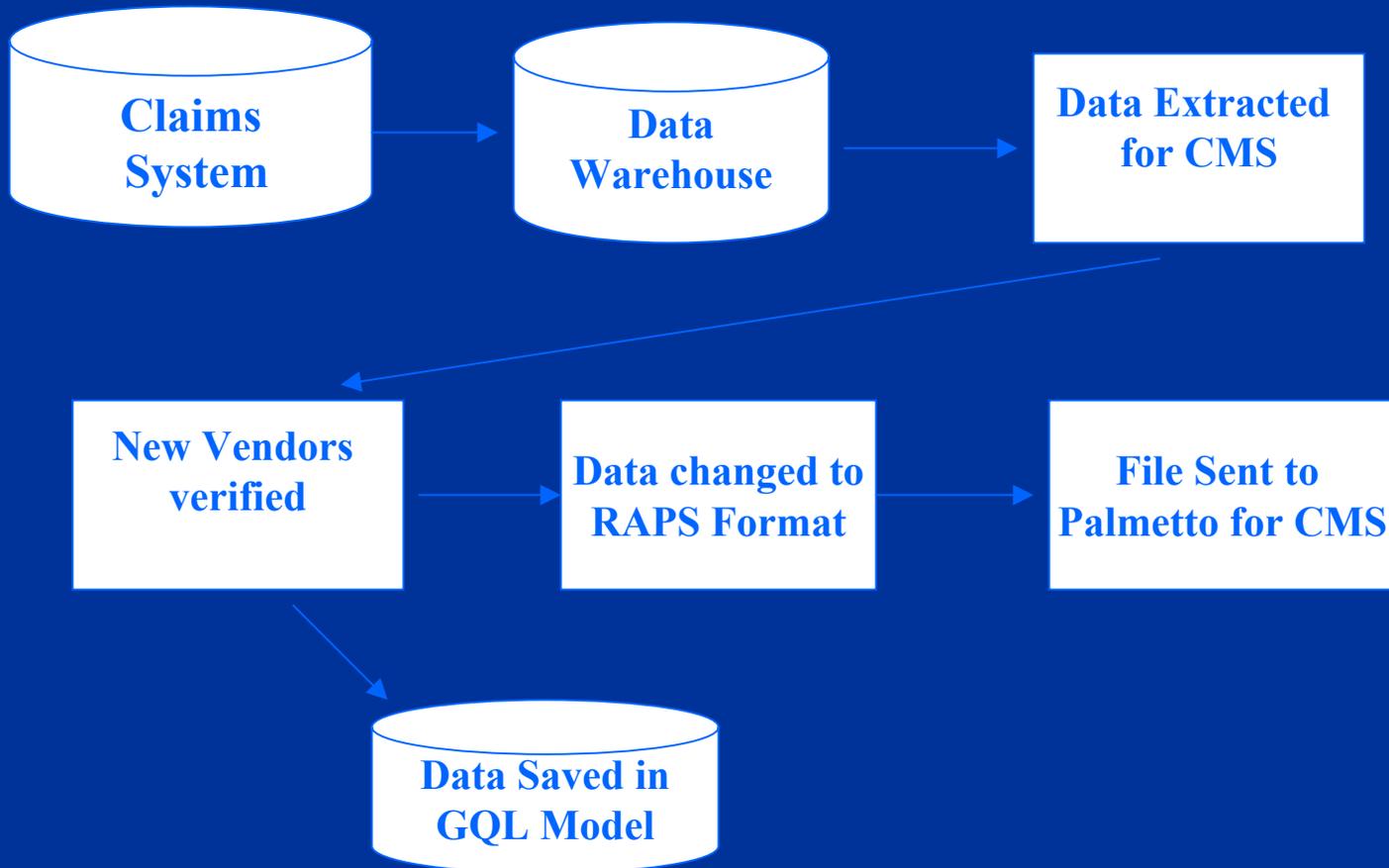
GQL Model

- Monthly submission data stored in GQL Model
- CMS Flat file is used to update data for acceptance or rejection of diagnosis
- Model is used to identify rejected records, make corrections and to create corrected records for resubmission to CMS

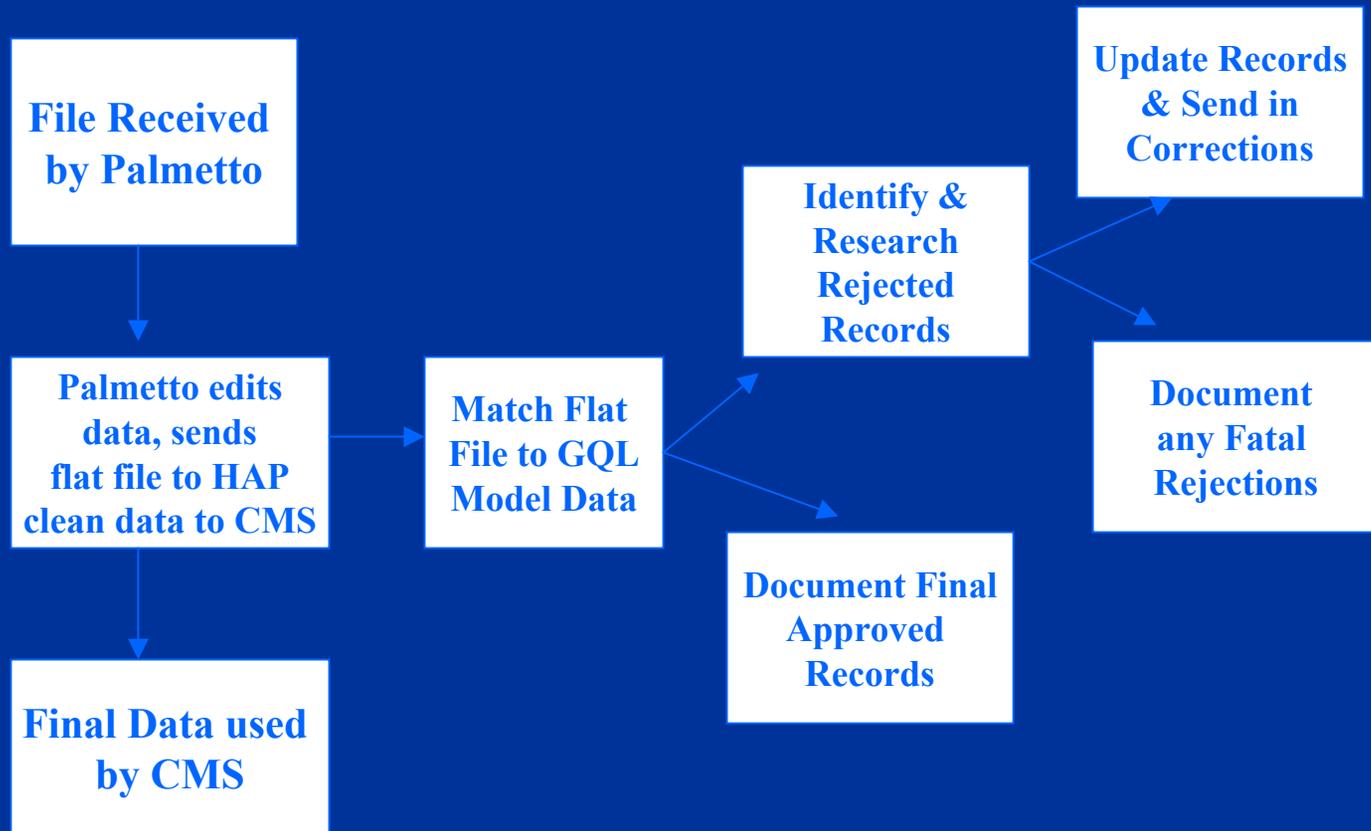
HAP Claim Pre-Processing



CMS Data Extract Process



CMS Update Process



Key Learnings

- Need ultimate owner of data submission process
- Owner needs to work closely with Information Technology to ensure quality of data
- HMO needs to work closely with providers
 - Provide incentives to send encounter data
 - Offer resources to work out issues with data
- CMS on-site technical consultations really help!

Discussion

**2003 Regional Risk Adjustment Training
for Medicare+Choice Organizations**

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Baltimore, MD

**2003 Regional Risk Adjustment Training
for Medicare+Choice Organizations**

Data Collection Strategies



Mary Martin
Elder Health Maryland HMO, Inc.

Purpose

- Purpose of this presentation is to share Elder Health's experience in working with our network to capture encounter data.

About our Health Plan

- Operational as an HMO since January 1, 2001
- Medicare line of business only
- Approximately 3,000 members
- Focused on medically and socially frail members, particularly those dually eligible for Medicare and Medicaid
- High burden of chronic disease

About our Health Plan

- 70% of members live in the community
- 30% of members live in nursing homes

Historical Perspective

- Before 2001, Elder Health operated as a provider group sub-capitated with CareFirst
- Before 2002, most PCP care for community members was rendered in two “Health Suites” owned by Elder Health
- Before 2001, PCPs received capitation
- SCP contracts FFS as a % of Medicare

Changes in 2002

- Care for community-dwelling members transitioned to PCP offices
- Existing PCPs offered a choice of capitation or FFS
- New PCPs offered FFS reimbursement
- By 2003, approximately 25% of Elder Health members cared for under PCP capitation arrangements

Two Challenges

- How can Elder Health obtain encounter data from practitioners who are paid on a capitation basis?
- How can Elder Health assure that encounters accurately and completely capture the chronic disease burden of the membership?

Obtaining Encounters from Capitated PCPs

- Contract required encounter data submission: but no rewards or penalties
- Encounter data submission variable: data obtained from a few
- No improvement from reminders in Provider Newsletter

Decision

- In order to obtain encounter data from all PCPs, Elder Health needed to change their contracts to FFS reimbursement arrangements.

Recontracting Initiative

- Top to bottom organizational commitment
- Discussions with key providers in advance
- No pushback from providers on reimbursement mechanism

Capturing Chronic Disease Burden

- Tie ICD-9 coding to reimbursement
- Connect diagnoses and co-morbidities to ability to be reimbursed for level 4 and level 5 visits
- Provide list of diagnosis codes that may be overlooked or used incorrectly
- Communicate with providers using provider newsletter and direct mailing

Chicago, IL

**2003 Regional Risk Adjustment Training
for Medicare+Choice Organizations**



Data Collection Strategies



Cindy Cowie

Community Care Organization, Inc.

PACE and Wisconsin Partnership Programs

**2003 Regional Risk Adjustment Training
for Medicare+Choice Organizations**

Purpose

- Purpose of this presentation is to share Community Care Organization's experience in collecting encounter data.

About our Health Plan

- PACE: Special managed care organization that cares for frail elderly.
- Six different sites
- 10 different teams (including 1 in a NH)
- Approximately 725 members

About our Health Plan

(continued)

- 82% of members live in the community
- Approximately 12% live in a GH and 6% live in a NH

Data Collection

- Submit primary care, specialty physician, and inpatient diagnostic data on all participants in the program
- Connectivity: DDE
- Collection: For internal Primary Care we use Participant Medical Problem List Encounter form (developed internally – Access)
- External specialty and inpatient data collected from provider bills

Data Collection Problem/Solution

- Problem:
 - System is manual
 - Time-consuming
 - Requires consultant for coding
- Solution:
 - Electronic Medical Record System

Data Submission

- RAPS through DDE
- Submit all diagnoses whether they are in the model or not

Summary

- Small specialty plan
- Data comes from variety of sources
- New Electronic Medical Record system will facilitate data collection – unsure of impact on data submission

Data Submission



Janet Fry
Aspen Systems Corporation

Purpose

- To describe how data collection and coding elements impact risk adjustment data submission

Objectives

- Understand the basics of the RAPS data file layout
- Identify data collection elements that are required to submit risk adjustment data
- Locate and describe the diagnosis clusters in the new RAPS format
- Understand the correction process

Relevant Diagnoses

- Included in the CMS-HCC model
- Received from a valid provider type
- Collected according to instructions
- Submitted at least once during the reporting period

Can we submit diagnoses not in the CMS-HCC model?

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YES!

M+C organizations may submit any and all diagnoses received from any of the three provider types

Submission Logic

- File level-identifies the submitter
- Batch level-identifies the M+C organization
- Detail level-identifies the beneficiary
 - RAPS CCC record

Diagnosis Cluster

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

Provider Type

- 01=Principal (dx) hospital inpatient
- 02=Inpatient other (secondary dx)
- 10=Hospital outpatient
- 20=Physician

From and Through Dates

- Inpatient:
 - Admission date
 - Discharge date
 - No interim bills
- Hospital Outpatient & Physician:
 - Service date
 - Series of service dates

Diagnosis Code

- Three to five digits, left justified
- No decimal is entered
- Remember, leading zeros in codes have meaning
 - 038.42=03842 not 3842

Exercise



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Oops! I made a mistake. Now what?



Data Needs to be Modified If it was...

- Submitted in error
 - Accepted by RAPS
 - Stored in the RAPS Database
 - Reported in a RAPS Transaction Error Report

Delete the Cluster if there is an:

- Incorrect HIC number
- Incorrect provider type
- Incorrect dates of service
- Incorrect diagnosis code

Correcting Data

- Delete the incorrect data
- Is the diagnosis to be corrected relevant?
 - If yes:
 - Enter the appropriate data (RAPS or DDE)
 - If no:
 - Correction is optional

Exercise



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Summary

- Coding and Provider Relations staff responsibilities do not end with data collection.
- Determine which diagnoses will be submitted.
- Submission of “clean” data from the start will make everyone’s job easier.
- Identify errors and implement a process for modifying data.

Reports



**Ed Sommers
Aspen Systems Corporation**

Purpose

- To provide information about how to use and read risk adjustment reports in order to improve the completeness and accuracy of data submissions

Objectives

- Review the purpose of each risk adjustment report briefly
- Identify key elements of reports that aid in the collection and submission of sufficient and accurate data
- Analyze report information to help improve the effectiveness of data collection and submission

Accessing Reports

Methods of Access

Secure Website

File Transfer Protocol

Network Data Mover

FYI

- Secure website and FTP users receive FERAS reports within 15 minutes
- NDM users receive FERAS reports next day
- Reports stay in mailbox 14 days
- After that, request reports through CSSC
- Organizations can request reports in zipped format

Purpose of Reports

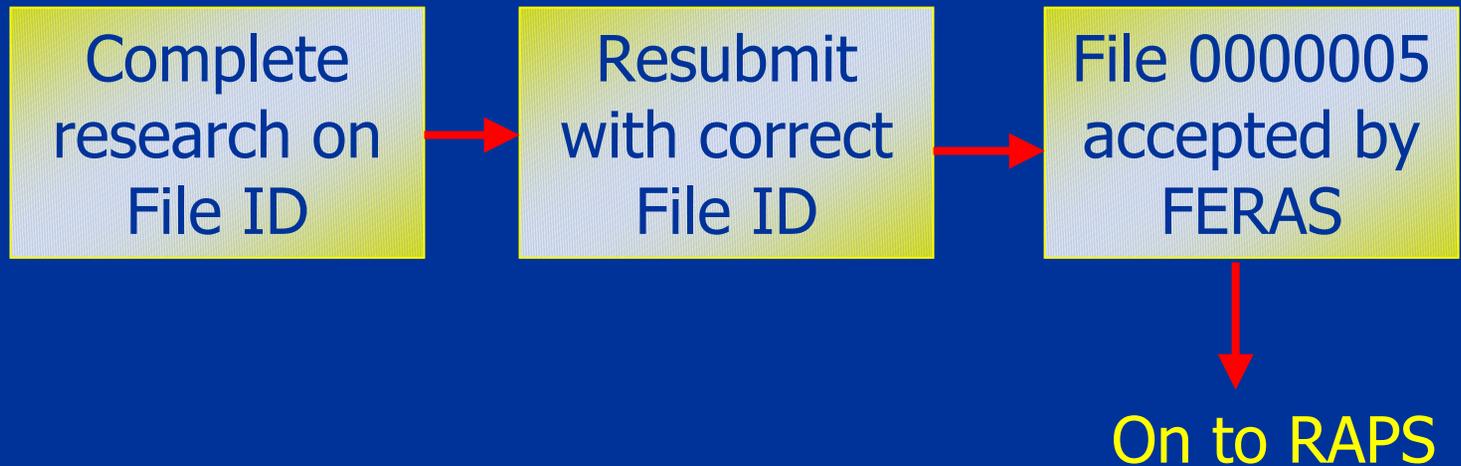
- What information does the report contain?
- How is this information helpful in managing the data collection and submission process?



Rosemount Health Plan Example

- Submitted file 0000001; not first file
- File included 1 batch, 3 records
- HIC #113334567A
- DOB March 5, 1935; different DOB on MBD

Rosemount Health Plan Example (continued)



Rosemount Health Plan Example (continued)

- RAPS Return File Report
 - DOB discrepancy identified
 - 501 information edit identified
- RAPS Transaction Error Report
 - DOB error (code 354) and informational message (code 501)
 - No clusters in this record were stored, but all editing was performed

Rosemount Health Plan Example (continued)

■ RAPS Transaction Summary Report

1REPORT : RAPS001		RISK ADJUSTMENT PROCESSING SYSTEM					TRANS
RUN DATE : 20030412		TRANSACTION SUMMARY REPORT					
DATE:20030411							
0							
SUBMITTER ID SH7777		PLAN ID: H7777	FILE ID:	0000005			
PROVIDER TYPE	PRINCIPAL INPATIENT	OTHER INPATIENT	OUTPATIENT	PHYSICIAN	UNIDENTIFIED	TOTAL	
TOTAL SUBMITTED	207	1,213	0	0	0	1,420	
TOTAL REJECTED	9	49	0	0	0	58	
TOTAL ACCEPTED	198	1,164	0	0	0	1,362	
TOTAL STORED	189	1,099	0	0	0	1,288	
TOTAL MODEL STORED	103	368	0	0	0	471	
TOTAL DELETE ACPTD	0	0	0	0	0	0	
TOTAL DELETE RJCTD	0	0	0	0	0	0	

**Error rate
is 4.1%**

Rosemount Health Plan Example (continued)

■ RAPS Transaction Summary Report

1REPORT : RAPS001 RISK ADJUSTMENT PROCESSING SYSTEM
 RUN DATE : 20030412 TRANSACTION SUMMARY REPORT TRANS
 DATE:20030411

0
 SUBMITTER ID SH7777 PLAN ID: H7777 FILE ID: 0000005

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TOTAL DELETE ACPTD	0	0	0	0	0	0
TOTAL DELETE RJCTD	0	0	0	0	0	0

**74
duplicates**

Rosemount Health Plan Example (continued)

- RAPS Transaction Summary Report

1REPORT : RAPS001		RISK ADJUSTMENT PROCESSING SYSTEM					TRANS
RUN DATE : 20030412		TRANSACTION SUMMARY REPORT					
DATE:20030411							
0							
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TOTAL MODEL STORED	103	368	0	0	0	471	
TOTAL DELETE ACPTD	0	0	0	0	0	0	
TOTAL DELETE RJCTD	0	0	0	0	0	0	

90.7% of diagnoses submitted were stored

Rosemount Health Plan Example (continued)

■ RAPS Transaction Summary Report

1REPORT : RAPS001		RISK ADJUSTMENT PROCESSING SYSTEM					TRANS
RUN DATE : 20030412		TRANSACTION SUMMARY REPORT					
DATE:20030411							
0							
SUBMITTER ID SH7777		PLAN ID: H7777	FILE ID: 0000005				
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TOTAL MODEL STORED	103	368	0	0	0	471	
TOTAL DELETE ACPTD	0	0	0	0	0	0	
TOTAL DELETE RJCTD	0	0	0	0	0	0	

36.5% of the diagnoses that were stored are in the CMS-HCC model

Management Reports

- RAPS Monthly Plan Activity Report
 - Allows submitters to validate diagnoses submitted during month
- RAPS Cumulative Plan Activity Report
 - Allows submitters to compare accepted clusters to benchmarks

Are you collecting enough data?

- Check the amount of data being submitted on a regular basis
- Check to make sure you are getting enough data from sources
- Check on rejection rates by provider type over time

Are external issues affecting data collection?

- Check to make sure that you receive about 25% of data each quarter
- Check to make sure providers are submitting data in a timely fashion
- Check on third party billers

Medicare FFS Benchmarks

Provider Type	All Dx	All Model Dx	Unique Model Dx
Physician	40	12.2	2.2
Hospital Outpatient	6	1.3	0.4
Hospital Inpatient	2	0.8	0.7
Total	48	14.3	3.3*

*Total does not un-duplicate between provider types

What is the appropriate benchmark?

- Depends on how you submit data
 - All diagnoses (maximum)
 - Model diagnoses only
 - Unique model diagnoses only (minimum)
 - Combination of methods
- Utilization patterns vary, especially for ambulatory data

Are you meeting benchmarks?

- Is the data you collect appropriately distributed between provider types?
- Is the number of diagnosis clusters you have submitted sufficient given your enrollee population?
- Be sure to use the right benchmark based on your submission practices

Do internal processes support submissions?

- Check to ensure that collected data is being translated properly
- Ensure that internal data systems are preparing data properly
- Take steps to ensure that medical documentation supports submitted diagnoses

Correcting Rejected Data

- Check internal records to ensure submission matches data on file at M+C organization
- Obtain corrected information from providers if necessary
- Timely response to requests is critical

Summary

- Reviewed the purpose of each risk adjustment report briefly
- Identified key elements of reports that aid in the collection of sufficient and accurate data
- Analyzed report information to help improve the effectiveness of data collection

Verifying Risk Scores

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Purpose

- This module will identify systems that are used to calculate risk scores and reports that are available to verify risk scores.

Objectives

- Describe how to use reports to verify risk scores
- Identify data systems used to calculate risk scores
- Interpret the Impact Data Report
- Identify changes to the MMR
- Discuss benchmarks

Verification Tools



- RAPS Management Reports
- Raps Return File
- Monthly Membership Report
- Risk Adjustment Model Output Report
- CMS-HCC Model

RAPS Management Reports

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

RAPS Return File

- Received the next day after submission
- Provides a record of each diagnosis stored for each enrollee
- M+C organizations may store the results of each RAPS Return File to establish a record of each diagnosis stored in the model for each enrollee

Monthly Membership Report

- Generated by GHP
- Beneficiary-level information
- Available through the GROUCH system
- Usually provided the third week of every month

Monthly Membership Report Highlights

- Fields 7-21
 - Applicable to demographic and risk adjuster
- Field 40 Previously Disabled Ratio
 - Only on pre-2004 adjustments
- Field 46 Frailty Indicator
- Field 47 Previously Disabled Indicator
 - Only on post 2003 payments/adjustment
- Field 48 Lag Indicator

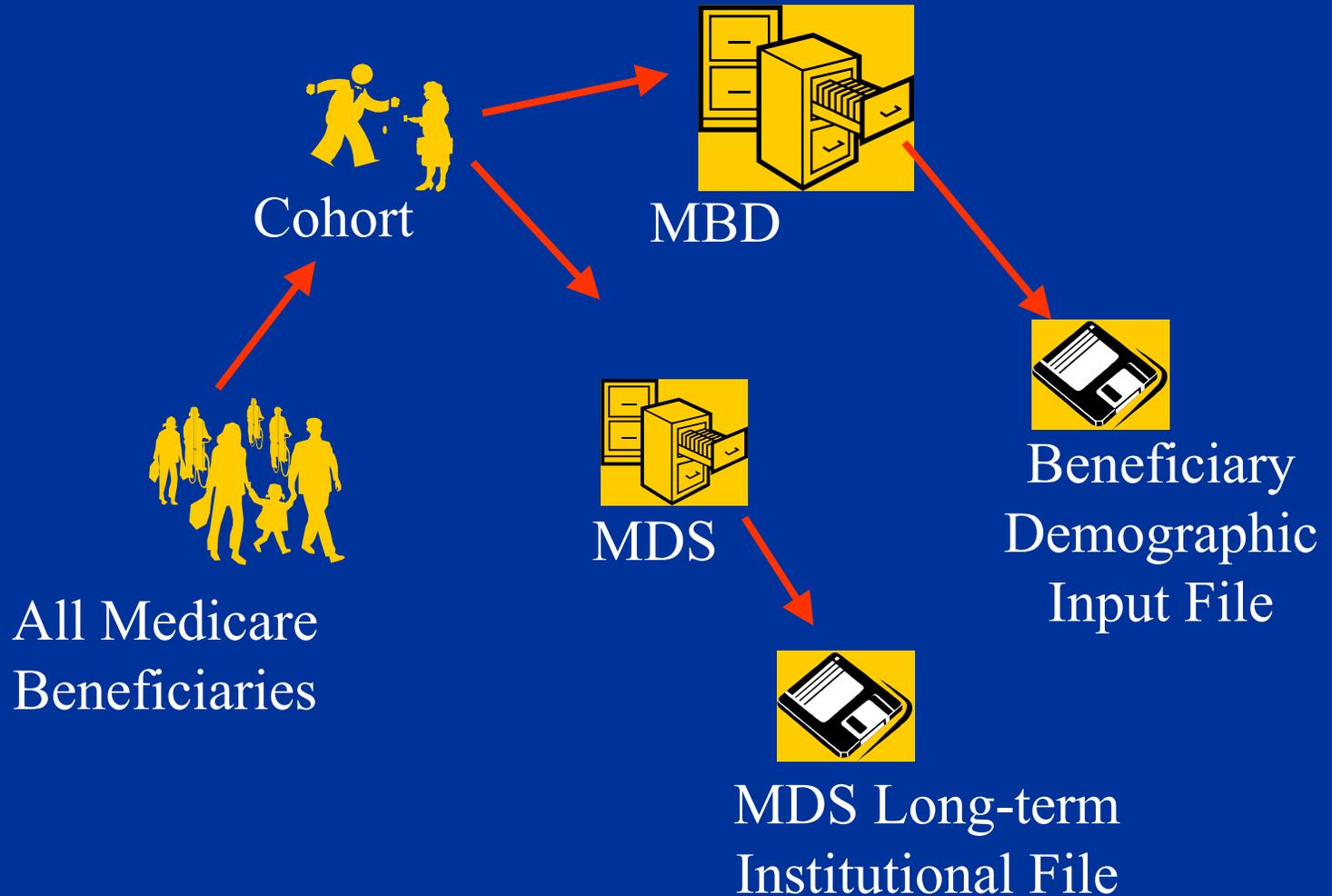
Risk Adjustment Model Output Report

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

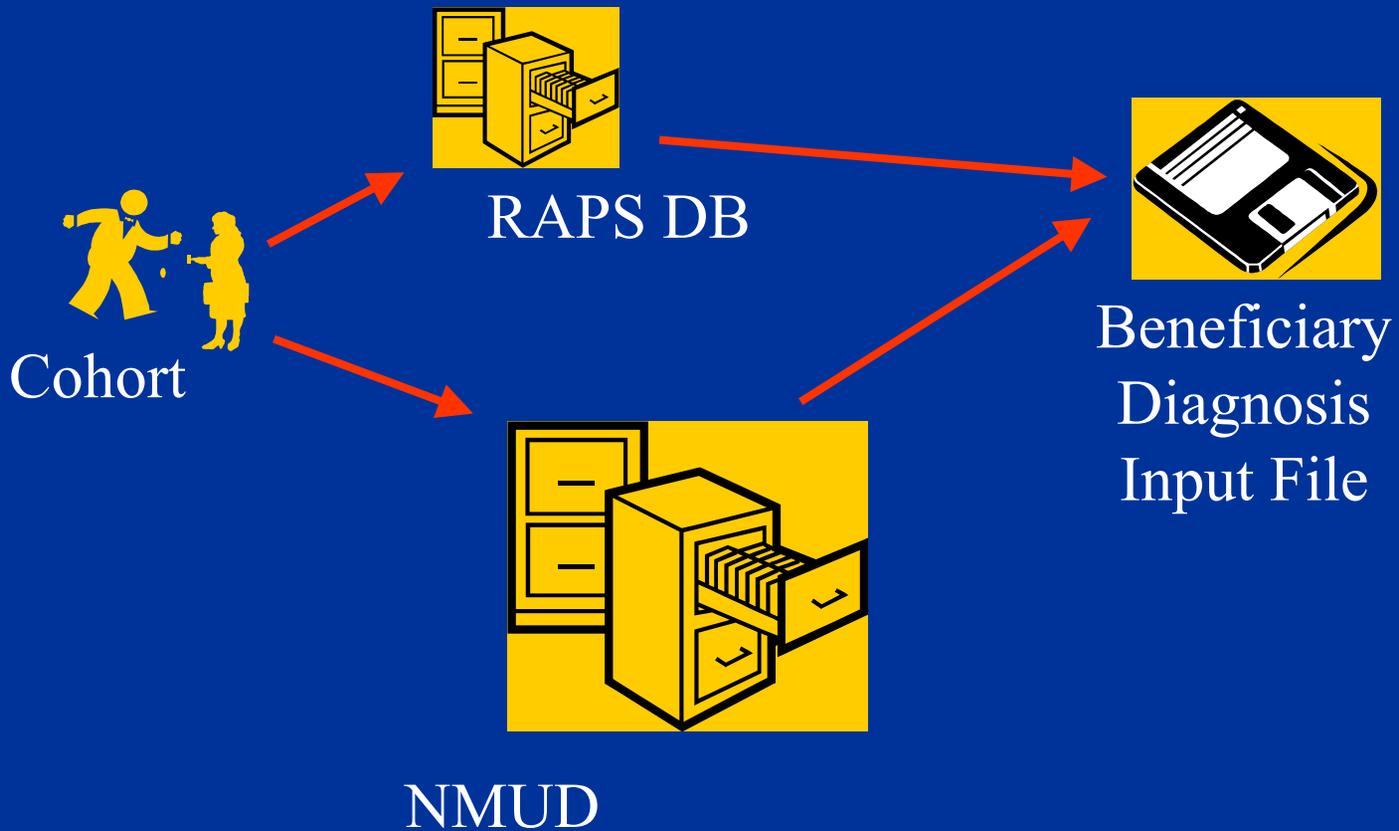
Run the CMS-HCC Model

- CMS runs model on an annual basis
- SAS program available at the CMS website soon
- M+C organizations may run the model to calculate their enrollee risk scores

Calculation of Risk Factors



Calculation of Risk Factors



Calculation of Risk Factors



Beneficiary
Demographic
Input File



Risk Adjustment
System (RAS)



Medicare
Managed Care
System

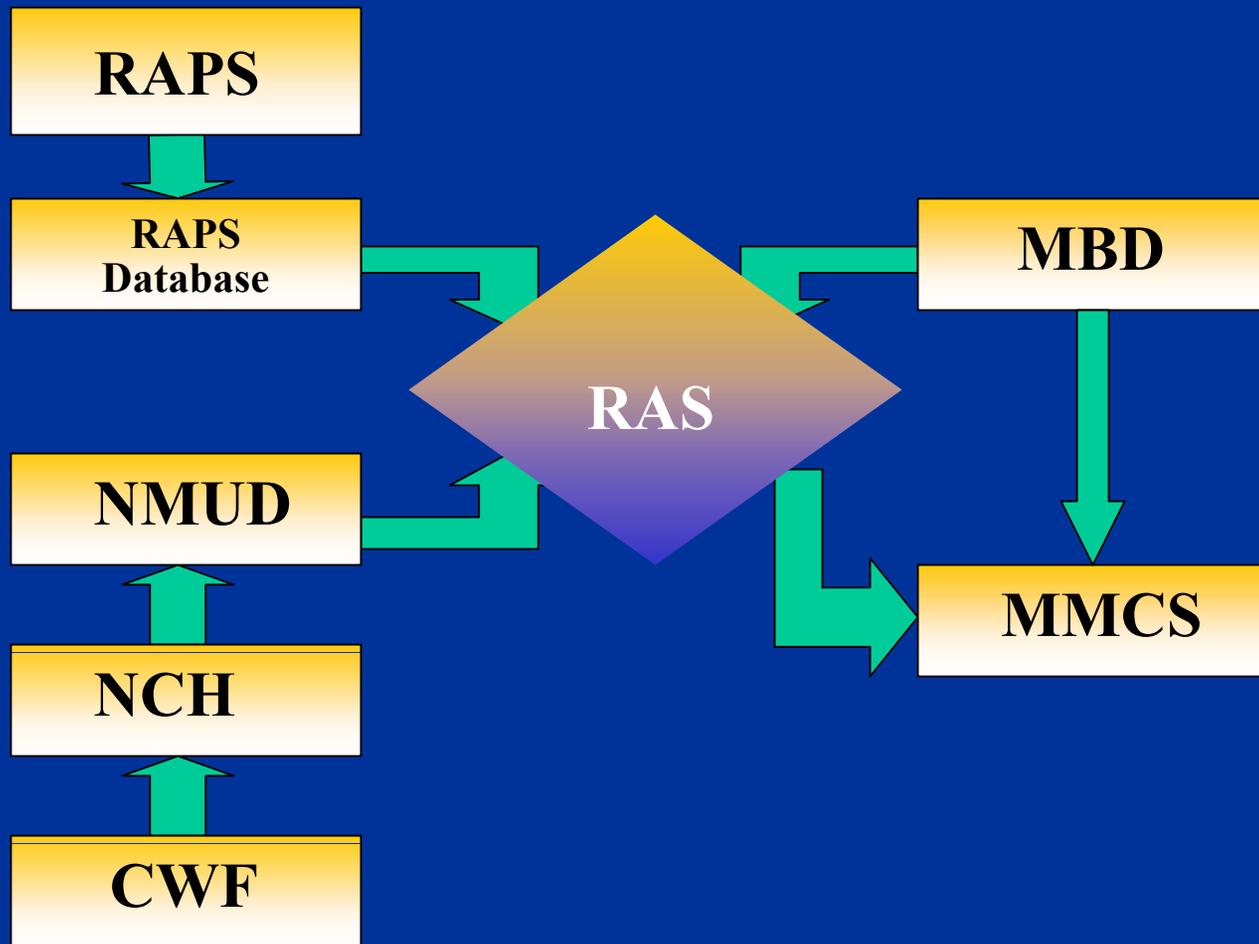


Beneficiary
Diagnosis
Input File



MDS Long-term
Institutional File

Calculation of Risk Factors



Impact Data Report

- Access via HPMS
- Indicates plan level risk score and HCC distribution
- Provided to plans that submitted risk adjustment estimator data

Impact Data Report

Based on:

- Dates of service July 1, 2001 – June 30, 2002
- Hospital inpatient, hospital outpatient, and physician data
- Estimator data submitted in RAPS
- Fee-For-Service claims data
- M+C encounter data submitted prior to October 1, 2002
- Enrollee in September 2002 Cohort 12 month period

Impact Data Report

Table 1

- Aggregate plan information
- Estimated impact for the plan
- Estimated risk factor for the plan
- M+C organizations risk scores
- Estimated national payment change

Table 2

- Number and percentage of beneficiaries by number of condition categories triggered
- Each beneficiary assigned to one group

Table 3

- Number and percentage of beneficiaries by the specific HCC triggered
- Beneficiaries that triggered one or more HCC reflected

Benchmarking

- RAPS and HPMS reports may be used to compare to national estimates
- HCCs for Medicare Fee-For-Service will be available on cms.hhs.gov

Rosemount Health Plan

Condition	Number	Percent
Number of enrollees with 0 conditions	2,112	63.8%
Number of enrollees with 1-6 conditions	1,036	31.3%
Number of enrollees with 7 or more conditions	161	4.8%
Total number of (non new) enrollees	3,309	100.0%

Summary

- Reviewed how reports can be used to verify risk scores
- Identified data systems used to calculate risk scores
- Interpreted the Impact Data Report
- Identified changes in the Monthly Membership Report
- Described the use of benchmarks

Risk Adjustment Data Validation

CMS Staff

Purpose

- To describe the data validation approach under the CMS-HCC model.

Objectives

- Understand the risk adjustment data validation process and principles
- Identify the guidelines for medical record documentation
- Understand the risk adjustment data sampling approach

Objectives (continued)

- Understand the medical record review process and data validation
- Identify risk adjustment data discrepancies
- Understand payment adjustments and appeals

What is Risk Adjustment Data Validation?

- Occurs after data is collected and payment is made
- The process of verifying that diagnosis codes submitted are supported by the medical record documentation

What is Risk Adjustment Data Validation? (continued)

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

Principles of Risk Adjustment Data Validation

- Similar to process applied under PIP-DCG
- New Components:
 - now validate physician and hospital outpatient data
 - validation based on minimum required data set
 - M+C organizations now have more flexibility in the selection of records for review

Guiding Principle

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

Principles of Risk Adjustment Data Validation

- May submit a complete or less than complete medical record
- May identify any medical record, per the requirements outlined in the guiding principle, which supports the diagnosis under review

Guidelines for Medical Record Documentation

- Medical record documentation of a reported diagnosis is critical for accurate risk adjusted payment
- Physician data will likely be the primary source of risk adjustment data
- Refer to page 3 in the Participant Guide

Acceptable Types of Documentation

Refer to Table 12A in the Participant Guide

Risk Adjustment Data Sampling Approach

STAGE 1

- Select M+C Organizations
- Range: 30-50 plans
- Random & Targeted
- Targeting based on profile of data submitted and past performance in validation

STAGE 2

- Select Beneficiaries
- Range: 50-400 Beneficiaries
- Random & Targeted based on the HCCs assigned

STAGE 3

- Entire HCC profile of the beneficiary or subset of HCCs or diagnoses
- Range: 50-600 HCCs and/or diagnoses

Medical Record Request

- May require documentation to support one or more individual HCCs
- May identify one or more sources of data for organization
- M+C organizations will need to track and locate the requested medical records

Medical Record Request

- CMS will provide letter to providers and physicians regarding the medical record request
- Letter will include HIPAA privacy language
- CMS does not violate HIPAA privacy because we are validating Medicare payments

Medical Record Request

Refer to example on page 12-9
of the Participant Guide

Responding to the Medical Record Request

- Select one record that best supports each diagnosis or HCC
- CMS recommends selecting an institutional record first (hospital inpatient/hospital outpatient) when a choice is available

Data Discrepancies

- Coding Discrepancy
 - Diagnosis reported to CMS is not supported by medical record documentation
- Medical record documentation is missing or incomplete
- Records are not valid for risk adjustment
 - invalid provider type
 - documentation is not from data collection period

Risk Adjustment Discrepancies

- One or more HCCs originally assigned differs from the HCC(s) assigned after medical record review and validation
- May affect risk score

Risk Adjustment Discrepancies (continued)

- **UPCODING:**
 - The final risk score calculated after the medical record review is lower than the risk score calculated based on submitted data
 - Results in overpayment

Risk Adjustment Discrepancies (continued)

- **DOWNCODING:**
 - The final risk score calculated after the medical record review is higher than the risk score calculated based on submitted data
 - Results in underpayment

Examples of Risk Adjustment Discrepancies

Refer to examples on page 12-11
of the Participant Guide

Second Independent Review

- If a risk adjustment discrepancy affects payment, then the record automatically undergoes a second independent review
- Typically done by QIO

Payment Adjustments & Appeals

- CMS developing criteria based on CY2001 and CY2002 data validation studies
- For 2001/2002 adjustments could apply when an organization demonstrates consistent patterns of payment inaccuracies that yield overpayments
- CY2004 activities will consider new model and new data requirements

Payment Adjustments & Appeals (continued)

- Appeals process in place when the M+C organization disagrees with the findings
- Appeals occurs after payment adjustment has been made
- Opportunity to challenge payment adjustment with **one** substitute record

Analysis and Findings

- Plan-specific findings will be shared with the M+C organization
- Aggregate findings will be shared with all plans

Pilot Test of CY2003 Estimator Data

- CMS will sample approximately 10 plans (volunteers)
- Sample approximately 20 beneficiaries/plan
- Plan-specific findings will be “blind” to CMS
- Will occur in Fall of 2003

CY2004 Timeline

- Data validation will be based on non-lagged data (Jan-Dec 2003)
- Records request spring CY2004

Physician Training

- CMS “Risk Adjustment Physician CD” available September 2003
- Utilize current training materials such as this module

Summary

- Described how the risk adjustment data validation process will work for CMS-HCC data
- Identified the guiding principle for data validation activities
- Described the risk adjustment data sampling approach

Summary (continued)

- Described how a medical record request will look
- Identified risk adjustment data discrepancies
- Described payment adjustments and appeals