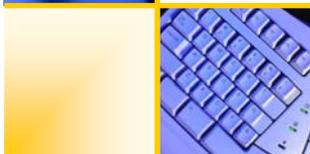


2004 Regional Risk Adjustment Training for Medicare+Choice Organizations



August 2-3, 2004
Chicago, IL

2004 Regional Risk Adjustment Training
for Medicare+Choice Organizations

Introduction

Angela Reddix
Aspen Systems Corporation



I-2



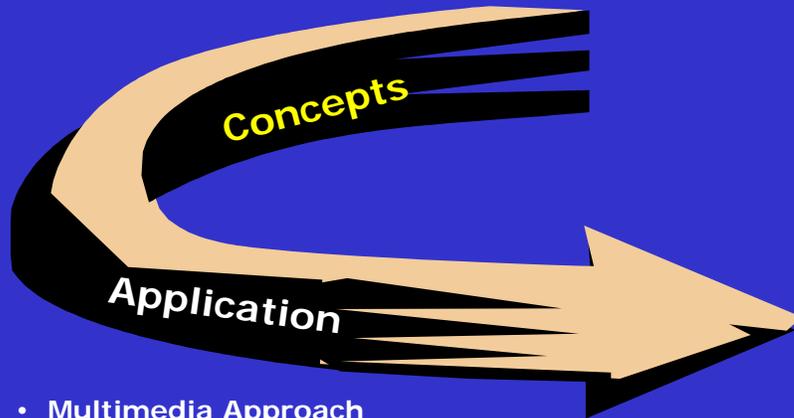
Purpose

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

I-3



Training Format



- Multimedia Approach
- Examples
- Exercises
- Group Participation
- Interactive

I-4



Your Participation Makes the Difference



I-5



Training Tools

- ▶ Participant Guide
 - CD w/slides, both tracks
- ▶ Job Aids
- ▶ www.mcoservice.com
- ▶ Panel of Experts



I-6



Audience

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

I-7



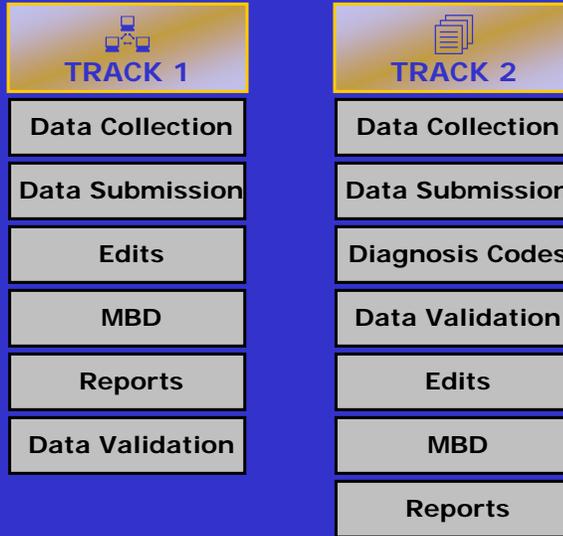
Training Tracks

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

I-8

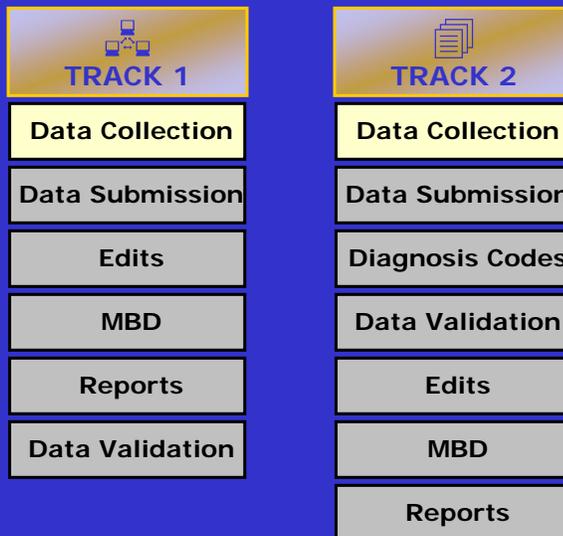


Risk Adjustment Modules



Risk Adjustment Modules

(continued)





Objectives

- ▶ At the completion of this training, participants will be able to:
 - Understand the CMS-HCC model & apply the payment methodology.
 - Identify the components of the risk adjustment process and describe the requirements for data collection.
 - Interpret key medical record documentation & coding guidelines.

I-11



Objectives (continued)

- Determine the process for submitting data to CMS.
- Interpret editing rules and error resolution.
- Identify the type and effective use of information stored in the MBD.
- Recognize the importance of the three C's.

I-12

Introducing the Team

CMS



Palmetto
(CSSC)

Aspen

Risk Adjustment Methodology

Jennifer Harlow
Centers for Medicare & Medicaid Services

1-1

Purpose

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

1-2



Objectives

- ▶ Review the history of risk adjustment.
- ▶ Understand there are changes to MA (formerly M+C) payment methodology in 2004 and beyond.
- ▶ Review characteristics of CMS-HCC risk adjustment model.
- ▶ Practice calculating risk scores.

1-3



Objectives (continued)

- ▶ Discuss implementation of frailty adjuster in 2004 and its possible future application.
- ▶ Review upcoming CMS-HCC model enhancements.
- ▶ Understand how the ESRD model operates.
- ▶ Review highlights of Medicare reform in Titles I & II of the MMA.

1-4



Risk Adjustment History

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

1-5



Risk Adjustment History (continued)

- ▶ The Benefits Improvement and Protections Act of 2000 (BIPA) required CMS to implement risk adjustment using gradual phase-in until 2007 with additional data in risk adjustment model in 2004.
- ▶ CMS implemented the CMS-Hierarchical Condition Category (HCC) Model in 2004 that includes hospital and ambulatory data at 30% blended payment.
 - Model balanced reducing plan data burden with implementing clinically sound model.

1-6



Risk Adjustment History (continued)

- ▶ In 2004, CMS implemented frailty adjuster for enrollees of PACE and certain demonstrations.
- ▶ In 2005, CMS will implement End Stage Renal Disease (ESRD) model for ESRD MA enrollees.
- ▶ In 2006, CMS will implement risk adjustment model for new Medicare prescription drug benefit.

1-7



2004 MA Payment Rates

- ▶ The MA payment rates for 2004 are the greater of:
 - Blended Formula
 - Calculated same way as under M+C methodology
 - Except: budget neutrality requirement for ratebook is eliminated
 - Minimum Floor
 - No change to how floor amount is calculated

1-8

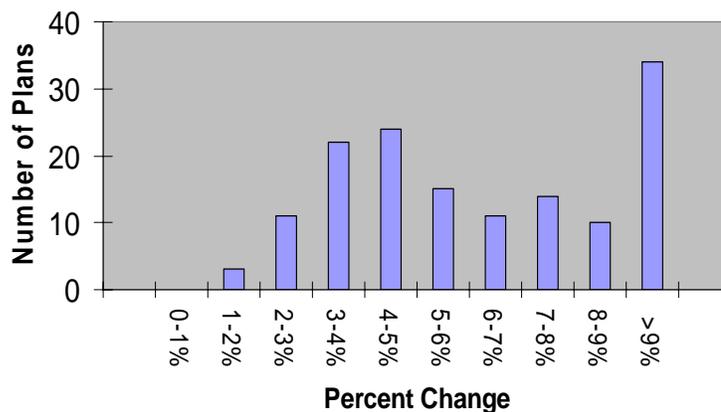
2004 MA Payment Rates (continued)

- ▶ Minimum Percentage Increase
 - Greater of 102% of previous year's rate or previous year's rate increased by Medicare growth percentage
- ▶ 100% of County FFS Costs
 - Rebased at least every 3 years



1-9

Impact of Medicare Modernization Act on M+C Organizations



1-10



MA Payment Rates in 2005 and Beyond

- ▶ For 2005 and years thereafter, MA county payment rate is minimum percentage increase, except in years when CMS recalculates the 100% FFS rate.
- ▶ In those years, MA county payment rate becomes higher of minimum percentage increase versus the 100% FFS rate.

1-11



CMS-Hierarchical Condition Category (HCC) Model

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

1-12



CMS-HCC Model (continued)

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

1-13



Demographic Factors in Risk Adjustment

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

1-14

Demographic Factors in Risk Adjustment (continued)

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



1-15

Disease Groups/HCCs

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



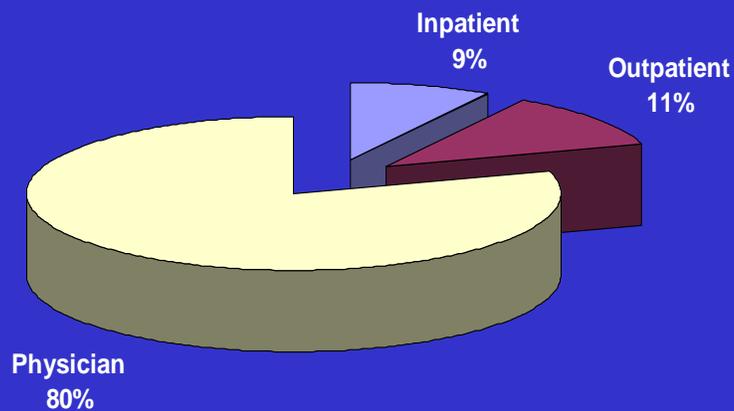
1-16

Disease Hierarchies

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

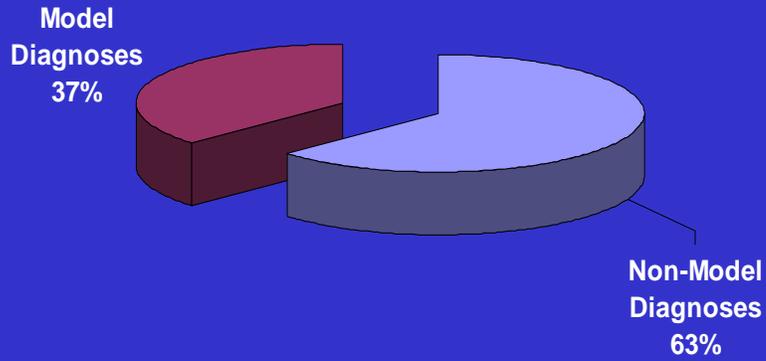
1-17

Diagnoses Extracted from RAPS on April 1, 2004

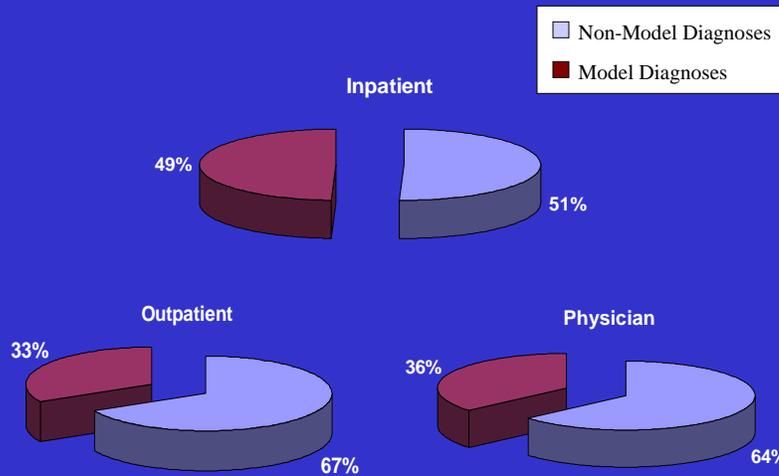


1-18

Model and Non-Model Diagnoses in RAPS



Model and Non-Model Diagnoses by Provider Type



Exercise



Calculating Payments

- ▶ Step 1: Calculate Demographic Portion of Payment
 - Use lookup tables for demographic cost factors and county rates.
 - Must multiply rates by factors for Part A & B, and then sum each result for a 100% demographic payment.
 - Apply appropriate payment blend percentage to full amount (50% in 2005).

See Example in Participant Guide.



Calculating Payment (continued)

- ▶ Step 2: Calculate the risk portion of payment
 - A rescaling factor is applied to convert demographic ratebook into a risk ratebook to calculate risk adjusted rate for each county.
 - Multiply risk ratebook for Part A and Part B by risk score for each enrollee to yield 100% risk adjusted payment amount.
 - Apply appropriate transition blend.

1-23



Risk Adjusted Payment Calculation

- ▶ Use the Part A & B demographic MA county rates to convert into county risk rates.
- ▶ Apply appropriate rescaling factor for relevant county.
- ▶ Calculate Beneficiary Risk Factor by considering all relevant factors:
 - Age, Sex
 - Institutional v. Community
 - Medicaid Eligibility
 - Currently Disabled, Originally Disabled
 - Diagnoses found in HCCs

1-24



Risk Adjusted Payment Calculation

(continued)

- ▶ Multiply the combined Part A & B risk adjusted monthly capitation rates by the beneficiary's risk factor = 100% risk adjusted payment.
- ▶ Apply appropriate payment blend percentage to 100% payment (50% in 2005).

See Example in Participant Guide.

1-25



Risk Ratebook

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

1-26



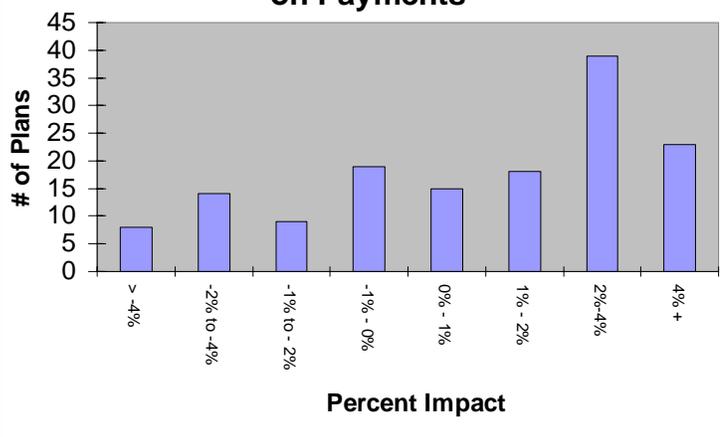
Risk Ratebook (continued)

- ▶ Budget Neutrality
 - Difference between 100% risk adjusted payment v. 100% demographic payment.
 - Redistributes reduced aggregate payments as constant percentage to organizations.
 - Pre-MMA 2004 budget neutrality factor = 1.163.
 - Post MMA 2004 budget neutrality factor = 1.0829.

1-27

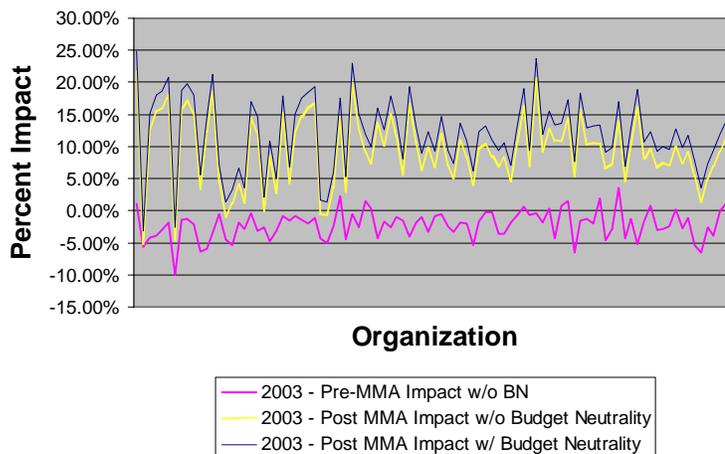


**Impact of 90/10% vs. 70/30% Blend
on Payments**



1-28

Impact of MMA Rate Changes w/ and w/o Budget Neutrality



Frailty Adjuster – Improvement of CMS-HCC Model

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



Frailty Adjuster (continued)

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

1-31



RANGE OF FRAILTY SCORES IN 2004

| FRAILTY PLAN | RANGE OF FRAILTY SCORES |
|--------------|-------------------------|
| PACE | .41 - .77 |
| S/HMOs | .06 - .18 |
| WPP | .45 - .57 |
| MSHO | .18 - .78 |

1-32



Implications of Frailty

- ▶ Variation exists in health status of PACE enrollees for which risk and frailty adjustment accounts.
- ▶ Current S/HMO payment levels may not be justified by enrollees' level of risk and frailty.
- ▶ For MA organizations, addition of frailty factor may improve payment accuracy.
- ▶ Frailty adjustment lowers risk scores for individuals with 0 ADLs and raises scores for all other ADL categories.

1-33



Frailty Adjuster Development

- ▶ Technical Work
 - Conducting survey of FFS beneficiaries regarding level of frailty in FFS Medicare population.
 - Develop more accurate frailty adjuster for improved estimates.
 - Determine if ratebook adjustment is necessary.

1-34

Frailty Adjuster Development (continued)

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



1-35

CMS-HCC Model Enhancements

- ▶ CMS is analyzing additional diagnoses to add to current model to improve payment accuracy.
- ▶ CMS expects to announce additional diagnoses in April 2004.



1-36



CMS-HCC Model Enhancements in 2005

- ▶ New model using risk adjustment for ESRD enrollees in MA organizations and demonstrations applied in 2005.
- ▶ Model will address unique cost considerations of ESRD population.
- ▶ Draft ESRD model announced in 45-day Notice.

1-37



ESRD Implementation

- ▶ BIPA mandated ESRD model reflects methodology used for S/HMO ESRD demonstration.
- ▶ CMS will implement ESRD model at 100% of payments in 2005.

1-38



ESRD Model-Three Parts

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

1-39



ESRD Model (continued)

- ▶ Dialysis Model—HCCs with different coefficients.
 - Multiplied by statewide ESRD ratebook.
- ▶ Transplant Model- Costs for transplant month + next 2 months summed and divided by 3 to yield average monthly cost for 3 months of transplant status.
 - National relative factor created by dividing average monthly cost by national average costs for dialysis.
 - Payment for 3 months multiplied by statewide dialysis ratebook.

1-40

New Enrollees and ESRD Model

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



1-41

Model Comparisons of Coefficients

| | Community | Institutional | Dialysis |
|---|-----------|---------------|----------|
| Metastatic Cancer and Acute Leukemia HCC 7 | 1.464 | 0.540 | 0.161 |
| Diabetes with acute complications HCC 17 | 0.391 | 0.612 | 0.106 |
| Major Depression HCC 55 | 0.431 | 0.221 | 0.116 |
| Age-Sex Factor for 69 year old male | 0.346 | 1.450 | 0.775 |
| Age-Sex Factor for 88 year old female | 0.665 | 0.880 | 0.919 |



1-42

Medicare Reform

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

1-43

MMA in 2006

- ▶ TITLE I
 - Creates new Medicare drug benefit as Medicare Part D - Two types of sponsors:
 - Stand alone prescription drug plan (PDP).
 - MA organization providing a basic drug benefit (MA-PD).
 - Each MA organization must provide basic drug coverage under one of its plans for each service area it covers.
 - Establishes reinsurance option and risk corridors to limit risk for participating plans.

1-44



MA in 2006

▶ TITLE II

- Replaces Adjusted Community Rate (ACR) proposal with bidding process for MA organizations.
- Maintains local plan options.
 - HMOs, PPOs, PFFS plans, MSAs, PSOs.
- Creates MA regional plans offering a PPO option.
 - 10-50 regions to be determined.

1-45



MA in 2006

(continued)

- Regions designed to maximize plan participation. Regional PPO must cover entire region.
- Regional plans will have extra incentives to participate including:
 - Risk sharing in 2006 and 2007.
 - Stabilization fund.
 - Bonus payment.

1-46



MA Organization Bid and Review Process

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

1-47



Overlap of Payment Methods in Titles I and II

- ▶ Organizations intending to offer MA plans and/or drug benefits will have to submit bids for their basic, and if applicable, supplemental benefit packages.
- ▶ Benchmarks will be created for local and/or regional plans for bid-benchmark comparison.
- ▶ Monthly capitated payments made based on plan's bid and risk adjusted for health status minus beneficiary premium amount.

1-48



Where does Risk Adjustment fit in within the MMA?

- ▶ Risk adjustment used in similar way for MA program as in M+C program.
- ▶ Payments for original Medicare benefits and the new drug benefit will be risk adjusted at beneficiary level.
- ▶ In MA Program, risk adjusted bids and risk adjusted benchmarks will be compared to each other to help determine beneficiary rebate amounts and benefit packages.

1-49



Additional MMA Change – Special Needs Plans

- ▶ Statute calls for specialty plans for individuals who are:
 - Institutionalized;
 - Medicaid eligible; or
 - Have severe or disabling chronic condition(s).
- ▶ No special payment provision.

1-50



Drug Risk Adjustment

- ▶ Risk adjustment is more accurate in predicting drug costs than it is for healthcare costs.
- ▶ Drug risk adjuster likely to involve different diseases than risk adjuster for non-drug costs.
- ▶ For example, glaucoma and hypertension were not good predictors of significant Part A/B costs, but they are predictive of higher drug costs.
- ▶ Some diseases currently in CMS-HCC model might decrease drug expenditures.

1-51



Implementation of Drug Benefit in 2006

- ▶ Drug risk adjustment model being developed to reflect variation of costs based on health status of enrollees.
- ▶ Similar to CMS-HCC risk adjustment, list of diagnoses identified for drug risk adjuster for collection from MA organizations to begin in July 2004.
- ▶ CMS is developing data collection strategy based on National Council for Prescription Drug Programs (NCPDP) format for collection of drug claims data from PDP sponsors beginning in 2006.

1-52



Conclusions

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

1-53



Next Steps

- ▶ NPRM published on Titles I and II of MMA.
- ▶ Comments received within 60 days.
- ▶ Final Rule published in 2005.
- ▶ Additional training and support on new MA bidding methodology and new drug risk adjustment model.

1-54



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

Thank You!

Process Overview

Angela Reddix
Aspen Systems Corporation

2-1

Purpose

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

2-2

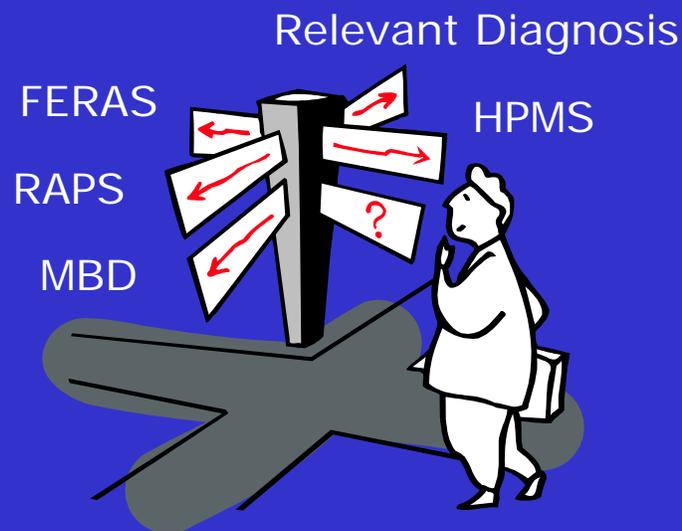
Objectives

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



2-3

Common Terms



2-4



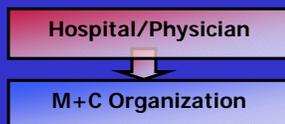
Risk Adjustment Data Requirements

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

2-5



Data Collection



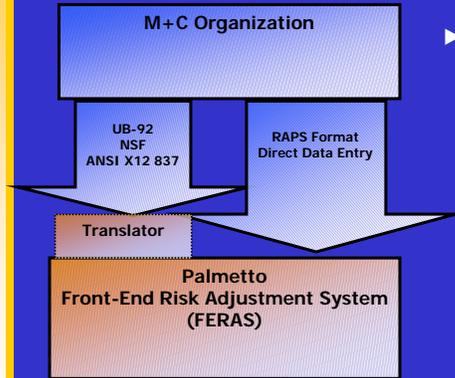
Minimum Data Set

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

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

2-6

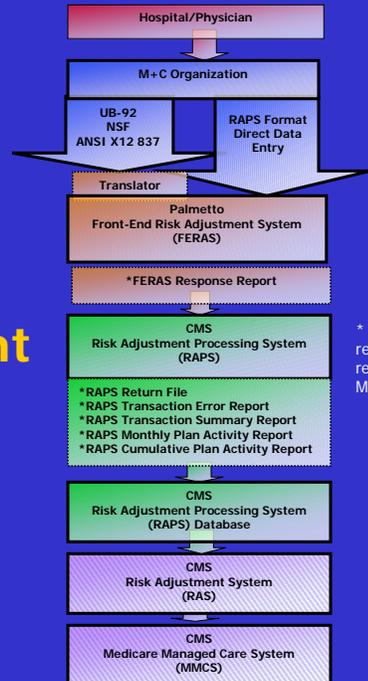
Data Submission



▶ Formats

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

Risk Adjustment Process



* These reports/files are returned to the M+C organization.



Submission Schedule

| CY | Dates of Service | Initial Submission Deadline | First Payment Date | Final Submission Deadline |
|----|-------------------|-----------------------------|--------------------|---------------------------|
| 04 | 7/1/02 – 6/30/03 | 9/5/03 | 1/1/04 | N/A* |
| 04 | 1/1/03 – 12/31/03 | 3/5/04 | 7/1/04 | 5/13/05 |
| 05 | 7/1/03 – 6/30/04 | 9/3/04 | 1/1/05 | N/A* |
| 05 | 1/1/04 – 12/31/04 | 3/4/05 | 7/1/05 | 5/15/06 |

*With elimination of the payment lag, the final submission deadline (reconciliation) changes to May 15th of each year. There is no September 30, 2004 deadline.



Training and Support



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User Groups

Onsite Consultation

Getting Started Video Training

Regional Training

Physician Training CD



Training and Support



2004 Regional Training
Video

Special Sessions

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www.mcoservice.com

Updated Getting Started
Video Training

Coming Attractions!

2-11



Summary

- ▶ Reviewed common risk adjustment terminology.
- ▶ Introduced key components of the risk adjustment process.
- ▶ Reviewed risk adjustment schedule.
- ▶ Identified outreach and training available to organizations.

2-12



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

Thank You!

Data Collection



Kathy Faber
Aspen Systems Corporation

Purpose

- ▶ To provide M+C systems personnel with the risk adjustment data collection requirements critical for accurate risk adjusted payment for their organization.

Objectives

- ▶ Identify data elements for risk adjustment.
- ▶ Identify three sources of risk adjustment data.
- ▶ Identify data collection formats available to M+C organizations.
- ▶ Discuss considerations for methods of data collection.
- ▶ Discuss HIPAA transaction standards.

3-3

Data Collection



3-4

Minimum Risk Adjustment Data Elements

HIC Number

Diagnosis Code

From Date

Through Date

Provider Type



3-5

Health Insurance Claim Number

HIC Number

Diagnosis Code

From Date

Through Date

Provider Type

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



3-6



Service From and Through Dates

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

- ▶ Defines when a beneficiary received treatment.

3-9



Provider Type

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

- ▶ Hospital inpatient
- ▶ Hospital outpatient
- ▶ Physician

3-10

Exercise



Hospital Inpatient Data

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



Hospital Outpatient Data

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

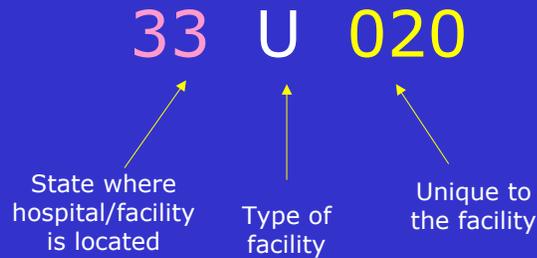


Acceptable or Not?

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

* Provider number within the acceptable range.

Medicare Provider Number



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



3-15

Physician Data



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



3-16

Data Collection Formats

- ▶ HCFA 1500
- ▶ NSF
- ▶ UB-92
- ▶ ANSI x12 837
- ▶ RAPS format
- ▶ Superbill



3-17

Factors Affecting Data Collection Method



Data
Collection
Method

Business
Needs



3-18

Contractual Relationships

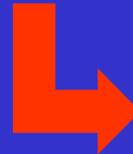


HIPAA and Risk Adjustment Rules

Encounter from
provider/physician to
M+C organization



Must be
used for risk
adjustment



Exercise



3-21

Communicating with Providers



Physicians and Medicare+Choice Risk Adjustment



*Self-paced, CD-based program on risk
adjustment for physicians*



3-22

What is the Provider's and Physician's Role in Data Collection?

- ▶ Contribute to strengthening Medicare program.
- ▶ Assist in ensuring CMS reimburses M+C organizations accurately.
- ▶ Assist in ensuring that M+C organizations reimburse providers and physicians accurately.



3-23

Summary

- ▶ Identified data elements for risk adjustment.
- ▶ Identified three sources of risk adjustment data.
- ▶ Identified data collection formats available to M+C organizations.
- ▶ Discussed considerations for methods of data collection.
- ▶ Discussed HIPAA transaction standards.



3-24



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

Thank You!

Data Submission



Stephanie Kipnis
Aspen Systems Corporation

4-1

Purpose

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

4-2

Objectives

- ▶ Understand the submission process requirements, connectivity options, and RAPS file layout.
- ▶ Identify the data elements required to submit risk adjustment data.

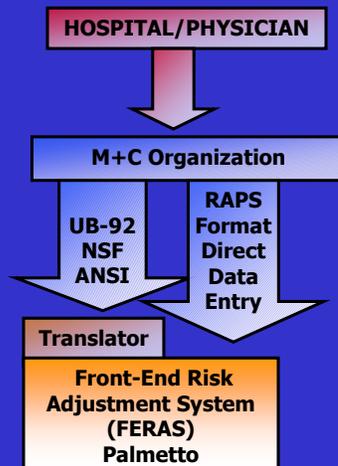
4-3

Objectives (continued)

- ▶ Locate and describe the diagnosis clusters in the RAPS format.
- ▶ Obtain an overview of the DDE process.
- ▶ Describe the filtering process.
- ▶ Describe the diagnoses deletion process.

4-4

Risk Adjustment Process



Requirements for New Submitters

- ▶ Complete an Electronic Data Interchange (EDI) Agreement and submit to the CSSC.
- ▶ Complete contact information and sign.
- ▶ Select connectivity method.
- ▶ Make special arrangements for third party submitters.

Connectivity Options

| | |
|-------------------------------------|--|
| Network Data Mover (NDM) | <ul style="list-style-type: none"> •Mainframe-to-mainframe connection •Next day receipt of front-end response |
| File Transfer Protocol (FTP) | <ul style="list-style-type: none"> •Modem-to-modem connection •Requires password and phone line •Same day receipt of front-end response |
| Secure Website | <ul style="list-style-type: none"> •Extranet site hosted by Palmetto GBA •Point and click features •Same day receipt of front-end response •Direct Data Entry is a connection via a secure website |

Relevant Diagnosis

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

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

Submission Formats

RAPS

NSF



UB-92

ANSI

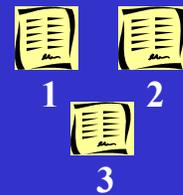
DDE

File Logic

File Level

Batch Level

Detail Level



Exercise



Fast Facts

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

Filtering Risk Adjustment Data

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



4-13

Filtering Risk Adjustment Data (continued)

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



4-14



Modifying Data

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

4-15



Deleting Diagnosis Clusters

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

4-16



Reasons for Deleting Clusters

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

4-17



Steps for Deleting Clusters

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

4-18

Steps for Deleting Clusters (continued)

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



Steps for Deleting Clusters (continued)

| | | |
|-------------|-----------------------|-----------------|
| CCC | | |
| 9.0 | Provider Type | 20 |
| 9.1 | From Date | 20030715 |
| 9.2 | Through Date | 20030715 |
| 9.3 | Delete | D |
| 9.4 | Diagnosis Code | 038 |
| | | |
| 10.0 | Provider Type | 20 |
| 10.1 | From Date | 20030615 |
| 10.2 | Through Date | 20030615 |
| 10.3 | Delete | |
| 10.4 | Diagnosis Code | 038 |



M+C Organization Responsibilities for Deletions

- ▶ M+C organizations must:
 - Delete a diagnosis cluster when any data in that cluster are in error.
 - When correcting data, submit a corrected cluster to replace the deleted cluster.
 - Corrections and deletions may be submitted on the same record or in the same file.

M+C organizations should not delete a diagnosis code or record repeatedly on the same day and in the same record. Duplicate deletes in the same record on the same day cause system problems.



NSF Submissions

- ▶ All NSF submissions will be translated to Provider Type 20 in RT CCC 9.0.
- ▶ RT CCC 2 will be plugged by Palmetto in the order in which the detail records appear in the batch.
- ▶ NSF Record Identifiers - DA0 1.0, EA0 1.0, and FA0 1.0 - must be populated.





UB-92 Submissions

- ▶ RT CCC 2 will be plugged by Palmetto in the order in which the detail records appear in the batch.
- ▶ UB-92 Record Identifiers must be populated.
 - RT 30/1
 - RT 40/1
 - RT 70/1

4-23

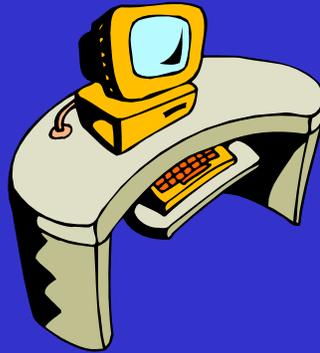


Direct Data Entry

- ▶ DDE entries allow for deletion of records for corrections even if another submission format was used.
- ▶ DDE screens automatically prevent the placement of incorrect data characters (e.g., alpha characters in the "From Date" or "Through Date" fields).
- ▶ DDE submissions are reported in the Front-End Response Report found in the electronic mailbox.

4-24

DDE Demonstration



Summary

- ▶ Described the submission process requirements, connectivity options, and RAPS file layout.
- ▶ Identified the data elements required to submit risk adjustment data.

Summary (continued)

- ▶ Located and described the diagnosis clusters in the RAPS format.
- ▶ Obtained an overview of the DDE process.
- ▶ Described the filtering process.
- ▶ Described the diagnoses deletion process.



4-27



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

Thank You!



4-28

Edits



Stephanie Kipnis
Aspen Systems Corporation

7-1

Purpose

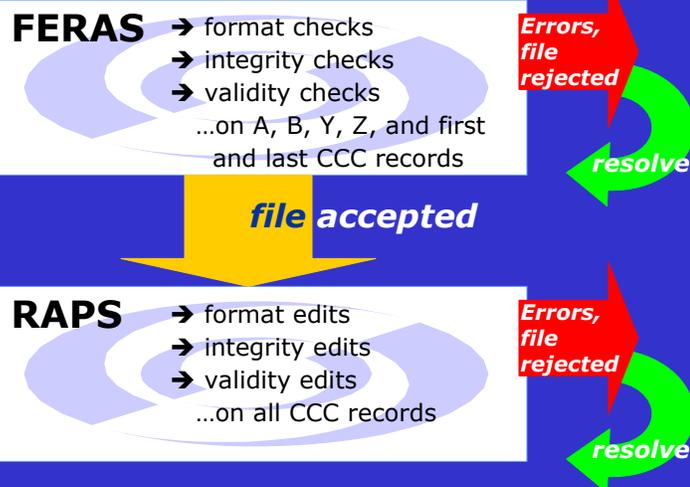
- ▶ To provide participants with an understanding of risk adjustment system edits.
- ▶ To describe the common edits and assist M+C organizations with the required steps to prevent errors in the future.

7-2

Objectives

- ▶ Understand the FERAS and RAPS data integrity logic and error codes.
- ▶ Describe the FERAS and RAPS editing processes.
- ▶ Recognize common FERAS and RAPS errors and determine action required to avoid or correct them.

Data Flow



FERAS Checks



Checks on file and batch levels

Checks on
first & last
CCC records

Example 1

Scenario: The M+C organization submitted a file and entered "AA1" in record type AAA, field 1.

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

Edits Logic

| Series | Explanation |
|----------------------|--|
| 100 | File level errors on the AAA or ZZZ records. This editing is performed in FERAS. |
| 200 | Batch level errors on the BBB or YYY records. This editing is performed in FERAS. |
| 300 & 400 | Check performed on first and last CCC records. |

The entire file will be returned to the submitter.

Error Code Ranges

100 [101-149 → AAA
151-189 → ZZZ

200 [201-249 → BBB
251-299 → YYY

Example 2

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

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

RAPS Edits

FERAS → format checks
→ integrity checks
→ validity checks
...on A, B, Y, Z, and first
and last CCC records

Errors,
file
rejected

resolve

file accepted

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

Errors,
file
rejected

resolve



RAPS Editing Rules

Stage 1 - Field Validity and Integrity edits

Stage 2 - Field-to-Field edits

Stage 3 - Medicare Beneficiary Database edits

Stage 4 - Diagnosis Code edits



RAPS Error Codes

| | Series | Explanation of error and consequences |
|---------|---------|--|
| Record | 300-349 | Record-level error - The record was bypassed and all editing was discontinued. No diagnosis clusters from this record were stored. |
| | 350-399 | Record-level error - All possible edits were performed, but no diagnosis clusters from this record were stored. |
| Cluster | 400-489 | Diagnosis cluster error - All possible diagnosis edits were performed, but the diagnosis cluster is not stored. |
| | 490-499 | Diagnosis delete error - Diagnosis was not deleted. |
| | 500-599 | Informational message, all edits were performed, diagnosis cluster was stored unless some other error is noted. |



Example 3

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

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



7-13

Resolution Steps

1. Determine the error level of the code to identify the nature of the problem.
2. Look up the error code and read the associated message.
3. Based on the error message, determine what the next step should be.
4. Take steps to resolve the error.



7-14

Example 4

Scenario: John Smart at BaseCare Health Plan deleted a diagnosis cluster. Later the same day, he mistakenly added the same cluster using DDE. Realizing his mistake, John immediately attempted to delete this cluster using DDE.

Results: Error code 492 occurs. The diagnosis cluster was not deleted. A diagnosis cluster with the same attributes was already deleted from the RAPS database on this date.

Exercise



FIVE COMMON ERRORS

7-17

1

"DUPLICATE FILE NAME" Error

- ▶ File identifier must be unique.
- ▶ Submitter cannot reuse within 12 months if accepted in Test or Production.

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

7-18

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 AAA 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.

7-19

2

"DELETE ERROR, DIAGNOSIS CLUSTER PREVIOUSLY DELETED" Error

- ▶ Cluster are never physically deleted from the RAPS database.
- ▶ RAPS database stores a "D" in the delete indicator and delete date.
- ▶ Cannot delete the exact same cluster more than once.

7-20

2

"DELETE ERROR, DIAGNOSIS CLUSTER PREVIOUSLY DELETED" Correction

- ▶ This error will be identified in RAPS.
- ▶ This will generate a 400-level error code – 491.
- ▶ No corrective action is necessary because the cluster has already been deleted.



7-21

3

"DIAGNOSIS CLUSTER NOT SUCCESSFULLY DELETED" Error

- ▶ Another diagnosis exists with the same attributes and has already been deleted.
- ▶ Diagnosis cluster must have one unique attribute in the key in order to be stored.
- ▶ Creation of a second delete cannot process, since second delete will cause the creation of a duplicate record.



7-22

3

"DIAGNOSIS CLUSTER NOT SUCCESSFULLY DELETED" Correction

- ▶ This error will be identified in RAPS.
- ▶ This will generate a 400-level error code – 492.
- ▶ Determine if the cluster should be deleted or active as a final action.
 - If active – no further action required
 - If delete – organization must submit one delete record



7-23

4

"SERVICE DATE NOT WITHIN M+C ENROLLMENT" Error

- ▶ Patient was not enrolled in the M+C organization at the time of service.
- ▶ 408 occurs with all data.
- ▶ 409 occurs with hospital outpatient and physician data only.



7-24

4

"SERVICE DATE NOT WITHIN M+C ENROLLMENT" Correction

- ▶ Verify M+C organization enrollment in MBD.
- ▶ Check service dates and correct if necessary.
- ▶ Create a new file, batch, and C record.
 - Correct 408 in record field 9.1
 - Correct 409 in record field 9.2

7-25

5

"NOT ENROLLED IN PLAN" Error

- ▶ Patient was not enrolled in your plan on or after the From Dates of Service.
- ▶ RAPS checks eligibility in Stage 3 of the editing process.

7-26

5

"NOT ENROLLED IN PLAN" Correction

- ▶ Verify plan enrollment in MBD.
- ▶ Check service dates and correct if necessary.
- ▶ Create file, batch, and C record.

In Summary

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



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

Thank You!

Medicare Beneficiary Database



Kathy Faber
Aspen Systems Corporation

8-1

Purpose

- ▶ To provide details and instructions on accessing and researching crucial eligibility and demographic data using the Medicare Beneficiary Database (MBD).

8-2

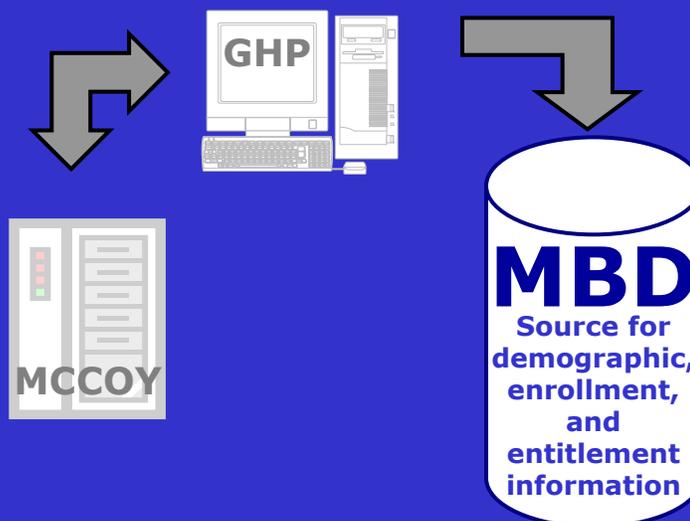
Objectives

- ▶ Identify the purpose of the Medicare Beneficiary Database.
- ▶ Identify major categories of data in MBD.
- ▶ Interpret system access instructions.
- ▶ Understand common risk adjustment uses of the database.
- ▶ Contact appropriate resources.

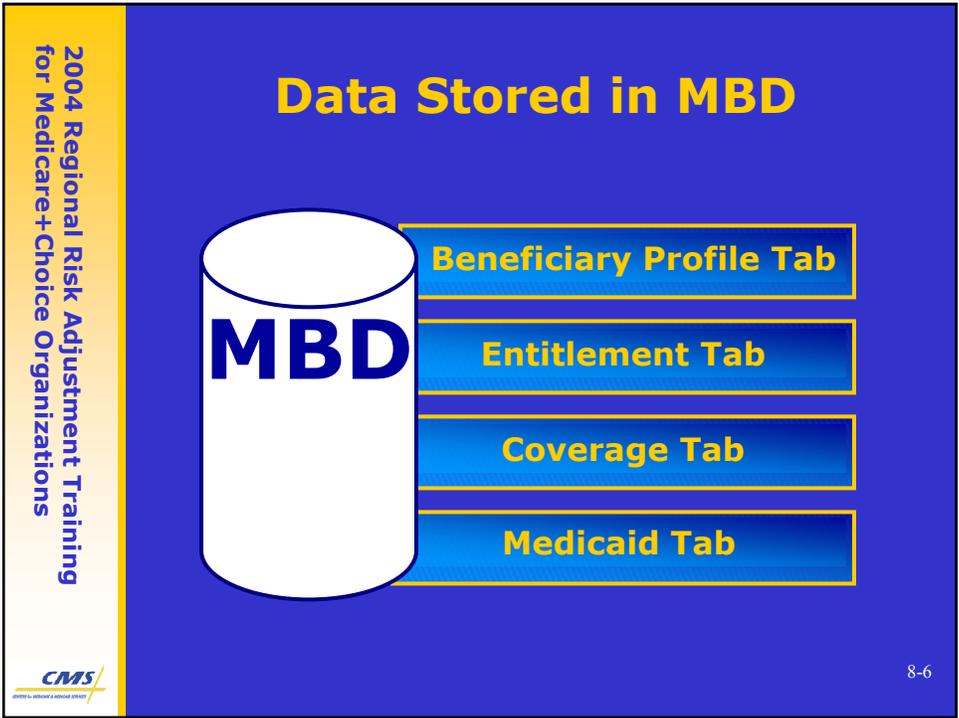
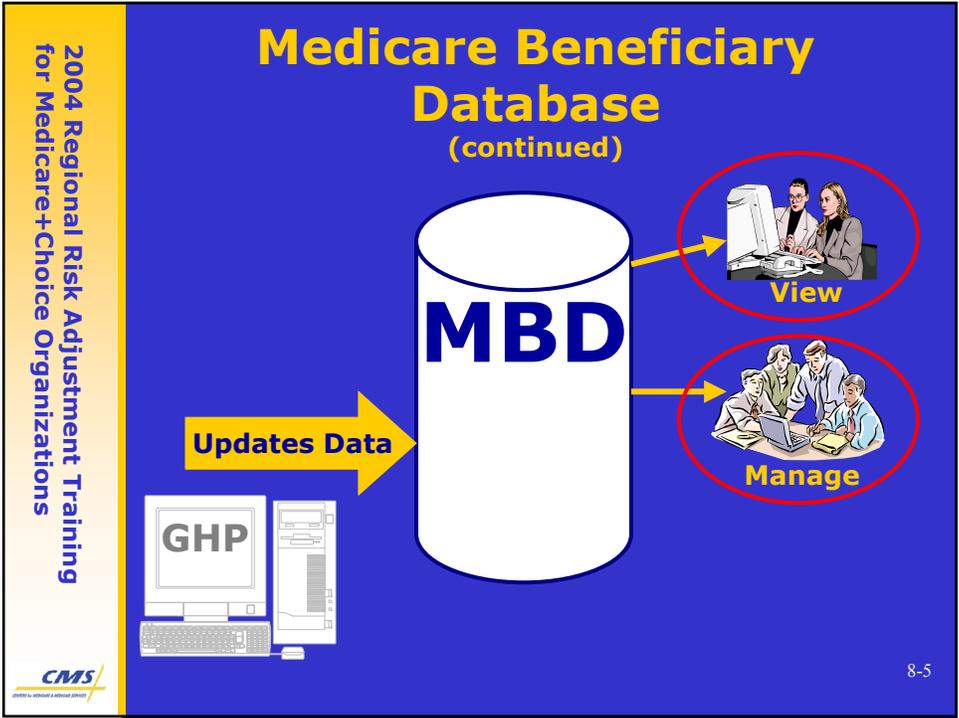


8-3

Medicare Beneficiary Database



8-4



Beneficiary Profile

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

8-7

Entitlement Tab

- ▶ Enrollment Coverage
 - Part A and Part B Only
 - Entitlement Effective Date
 - Entitlement Termination Date
 - Entitlement Status Code
 - Entitlement Reason Code

8-8

Coverage Tab

- ▶ Medicare+Choice Elections – Plan Number
- ▶ Enrollment Effective Date
- ▶ FFS Period Effective Date
- ▶ Managed Care Institutional Status
- ▶ Coverage Effective Date
- ▶ Coverage Termination Date
- ▶ Other Insurance Profile

8-9

Medicaid Tab

- ▶ Medicaid Eligibility Periods
 - Provides a profile of current and historical Medicaid eligibility periods

8-10

Completing MBD Access Application

- ▶ Download MBD application:
<http://cms.hhs.gov/mdcn/access.pdf>
- ▶ When necessary:
 - To acquire new access
 - To change names
 - To change access needs/job duties
 - To seek recertification
 - When user retires, resigns, or leaves organization



8-11

Accessing MBD



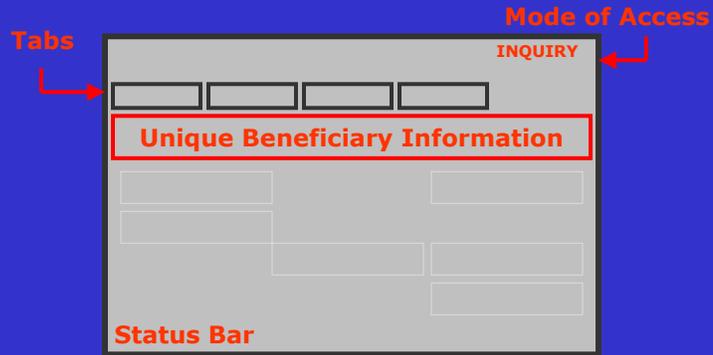
- ▶ Required:
 - User ID & password
 - Authorized level to update & view
- ▶ Security levels restrict access



8-12



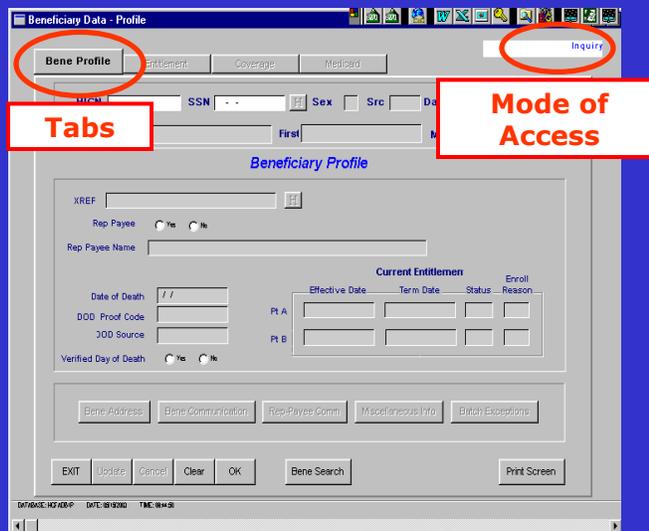
Navigating MBD



8-13



Components of the MBD



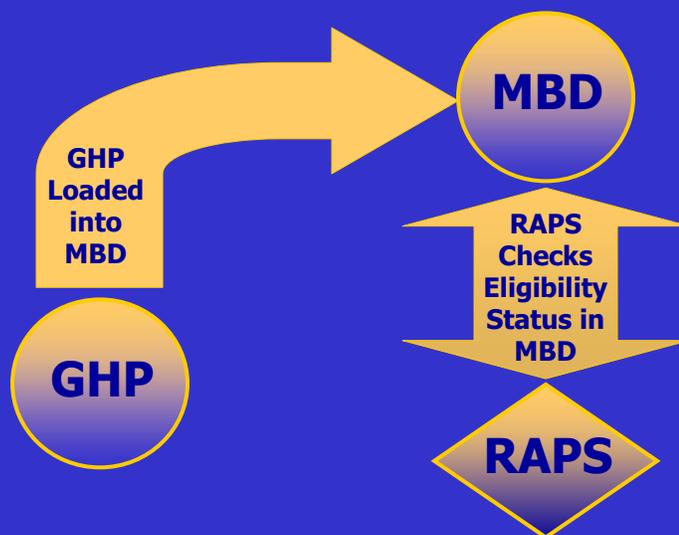
8-14

Components of the MBD (continued)

The screenshot shows a software window titled "Beneficiary Data - Profile". At the top, there are tabs for "Beneficiary Profile", "Entitlement", "Coverage", and "Medicaid". Below the tabs are input fields for "HICN", "SSN", "Sex", "Src", and "Date of Birth". A red oval highlights this entire section, with a red box below it containing the text "Unique Beneficiary Information". Below this are fields for "Name" (Last, First, MI, Src) and "Beneficiary Profile". Further down are fields for "Rep Payee Name", "Date of Death", "DOD Prod Code", "JOD Source", "Verified Day of Death", and "Current Entitlement" (Effective Date, Term Date, Status, Reason). A red box highlights the "Status Bar" at the bottom, which contains "EXIT", "Update", and "Print Screen" buttons. At the very bottom, a status bar shows "DATE: 02/14/04" and "TIME: 10:51".

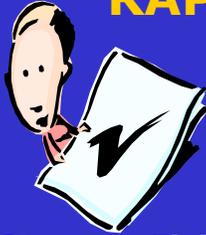
8-15

MBD Flow of Data



8-16

RAPS Editing Rules



Stage 1 - Field Validity and Integrity edits

Stage 2 - Field-to-Field edits

Stage 3 - Medicare Beneficiary Database edits

Stage 4 - Diagnosis Code edits



8-17

MBD/RAPS Editing Process

| Error Code | Record ID | Error Description |
|------------|-----------|--|
| 353 | CCC | HIC number does not exist on MBD. |
| 354 | CCC | Patient DOB does not match with MBD DOB. |
| 406/407 | CCC | Service date(s) outside of beneficiary entitlement date. |
| 408/409 | CCC | Patient not enrolled with any M+C at time of service(s). |
| 410 | CCC | Patient was not enrolled in your M+C plan at time of service(s). |
| 411 | CCC | Service through date greater than date of death. |



8-18

Exercise



Your One Stop Shop for Assistance



CSSC
(877) 534-2772

- ▶ Need information while waiting for access.
- ▶ Check beneficiary status until H number is assigned.
- ▶ Receive assistance with data issues when MBD differs from MCCOY.

Summary

- ▶ Identified the purpose of the Medicare Beneficiary Database.
- ▶ Interpreted system access instructions.
- ▶ Covered common risk adjustment uses of the database.
- ▶ Identified appropriate resource contacts.



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

Thank You!

Reports



Angela Reddix
Aspen Systems Corporation

9-1

Purpose

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

9-2



Objectives

- ▶ Identify the purpose of each risk adjustment report.
- ▶ Determine the best uses of the reports to monitor data collection and submission processes, and to resolve errors.
- ▶ Accurately read the risk adjustment reports and identify and submit corrections.

9-3

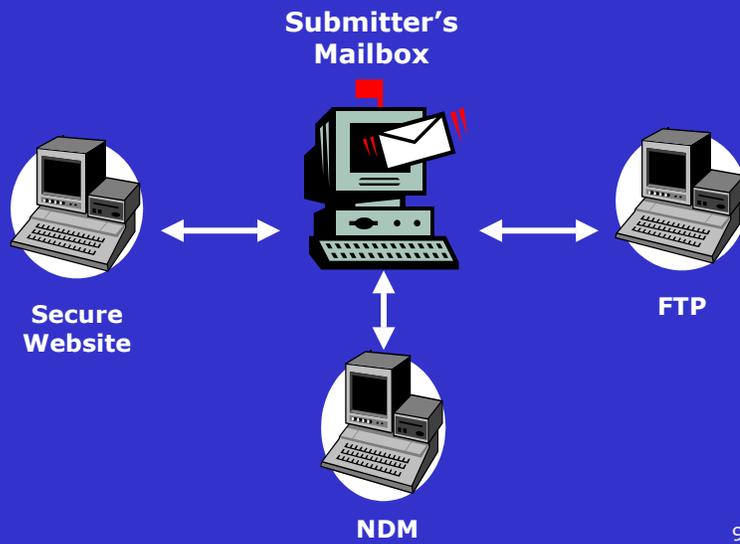


Objectives (continued)

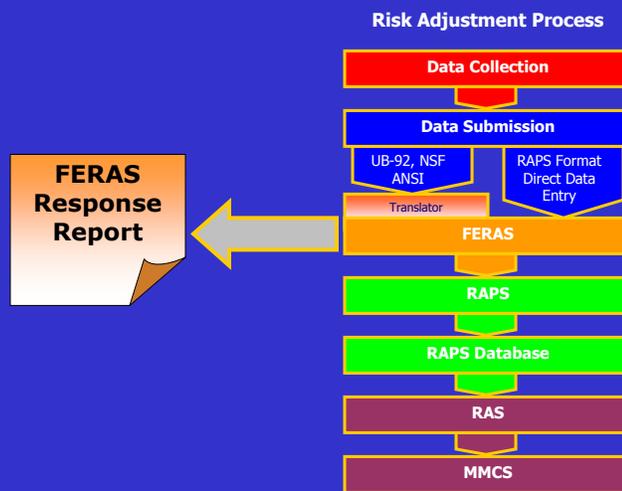
- ▶ Understand the relationship between values in the RAPS Transaction Summary and the management reports.
- ▶ Compare accepted diagnosis clusters to benchmarks.

9-4

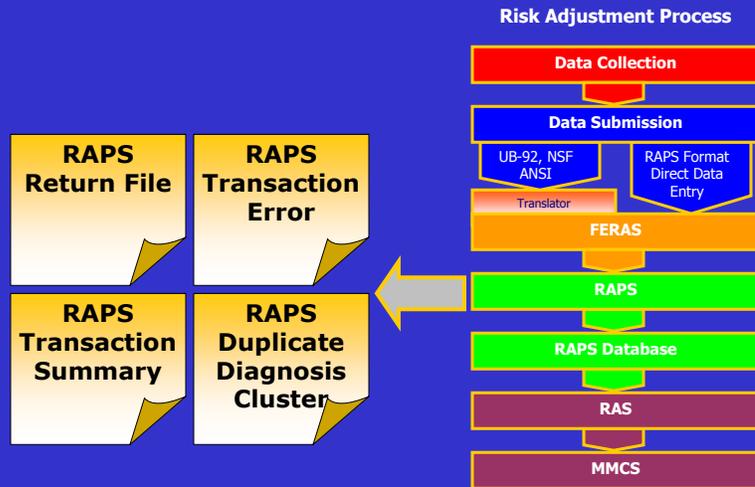
Accessing Reports



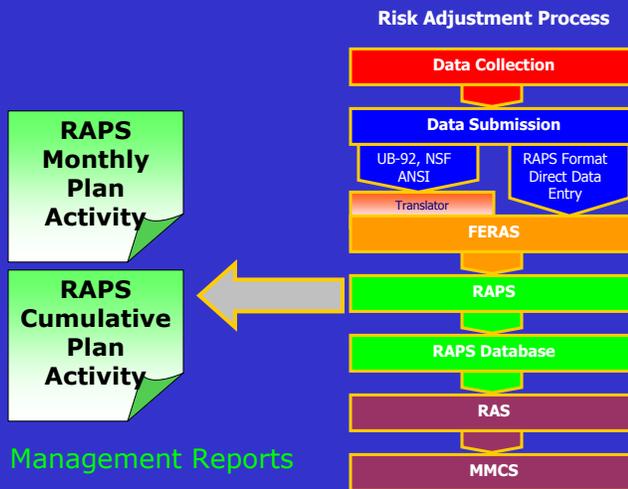
Reports Overview



Reports Overview



Reports Overview





FERAS Response Report

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

9-9



FERAS Response Report Example

The M+C organization corrected and submitted a file, but only changed the first character of the File ID. The second batch did not include a plan number. The first detail record was missing a HIC number, and the fourth YYY batch trailer plan number did not match the plan number in the BBB batch header.



9-10



RAPS Return File

- ▶ Contains all submitted transactions.
- ▶ Error codes appear in the file.
- ▶ Flat file format may be downloaded to an Access or Excel database.
- ▶ Returned the next business day after submission.

9-11



RAPS Return File (continued)

- ▶ Communicates information in fields:
 - 3 → Sequence number error code
 - 6 → HIC number error code
 - 8 → Date of birth error code
 - 9.6 → Diagnosis cluster error 1
 - 9.7 → Diagnosis cluster error 2
 - 19 → Corrected HIC number

9-12



RAPS Return File Example

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



9-13



Uses for RAPS Return File Format

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

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

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



Improve the quality and quantity of data submissions!

9-14

RAPS Transaction Error Report

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



9-15

RAPS Editing Rules



Stage 1 - Field Validity and Integrity edits

Stage 2 - Field-to-Field edits

Stage 3 - Medicare Beneficiary Database edits

Stage 4 - Diagnosis Code edits



9-16

RAPS Error Codes

| | Series | Explanation of error and consequences |
|---------|---------|--|
| Record | 300-349 | Record-level error - The record was bypassed and all editing was discontinued. No diagnosis clusters from this record were stored. |
| | 350-399 | Record-level error - All possible edits were performed, but no diagnosis clusters from this record were stored. |
| Cluster | 400-489 | Diagnosis cluster error - All possible diagnosis edits were performed, but the diagnosis cluster is not stored. |
| | 490-499 | Diagnosis delete error - Diagnosis was not deleted. |
| | 500-599 | Informational message, all edits were performed, diagnosis cluster was stored unless some other error is noted. |

Exercise



RAPS Transaction Summary Report

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



9-19

Relationship Between Values in RAPS Transaction Summary Report

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

Total Stored \leq Total Accepted

Total Model Diagnoses Stored \leq Total Stored



9-20

RAPS Duplicate Diagnosis Cluster Report

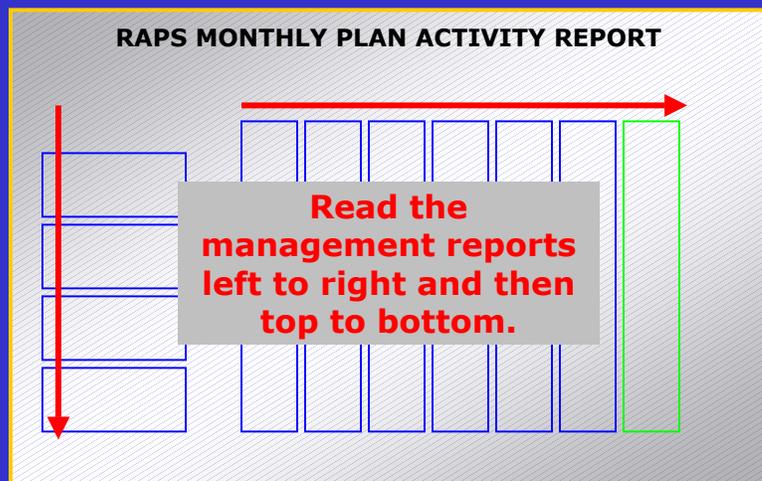
- ▶ Lists diagnosis clusters with 502-error information message.
- ▶ Reflects clusters previously submitted and stored in the RAPS database with same:
 - HIC number
 - Provider type
 - From and through dates
 - Diagnosis
- ▶ Received the next business day after submission.



9-21

Analysis of Management Reports

RAPS MONTHLY PLAN ACTIVITY REPORT



9-22

RAPS Monthly Plan Activity Report

- ▶ Provides a summary of the status of submissions for a one-month period.
- ▶ Arrayed by provider type and month based on through date of service.
- ▶ Reported by submitter ID and H number.
- ▶ Allows tracking on a month-by-month basis of all diagnosis clusters submitted.
- ▶ Available for download the second business day of the month.



9-23

RAPS Cumulative Plan Activity Report

- ▶ Provides a cumulative summary of the status of submissions.
- ▶ Report format similar to Monthly Plan Activity Report.
- ▶ Allows M+C organizations to compare submission rates to benchmarks.
- ▶ Service year "9999" indicates data has been rejected (not stored).
- ▶ Available for download the second business day of the month.



9-24

Estimated Benchmarks

| Provider Type | Total Diagnoses | | All Model Diagnoses | | Unique Model Diagnoses | |
|---------------------|-----------------|------|---------------------|------|------------------------|------|
| | n | % | n | % | n | % |
| Physician | 25 | 75.7 | 6 | 74.1 | 2.2 | 66.7 |
| Hospital Outpatient | 6 | 18.2 | 1.3 | 16.0 | 0.4 | 12.1 |
| Hospital Inpatient | 2 | 6.1 | 0.8 | 9.9 | 0.7 | 21.2 |
| Total | 33 | 100 | 8.1 | 100 | 3.3* | 100 |

*Are not unduplicated across provider types.



9-25

Correcting Rejected Data

- ▶ When submitting corrected data, rejected clusters are reflected in
 - Cumulative totals for month.
 - Total rejections.
- ▶ When cluster is counted as stored,
 - It remains part of the stored count on Cumulative Plan Activity Report.
 - Even if it is deleted.
- ▶ Deleted clusters are included in total stored and total deleted.



9-26

Management Reports Summary



- ▶ Identify internal processes affecting data collection and submission.
- ▶ Identify external issues affecting data collection.
- ▶ Compare data submitted to benchmarks.



Naming Conventions

| REPORT NAME | MAILBOX IDENTIFICATION |
|--------------------------------------|-------------------------------|
| FERAS Response Report | RSP#####.RSP.FERAS_RESP |
| RAPS Return File | RPT#####.RPT.RAPS_RETURN_FLAT |
| RAPS Transaction Error Report | RPT#####.RPT.RAPS_ERROR_RPT |
| RAPS Transaction Summary Report | RPT#####.RPT.RAPS_SUMMARY |
| RAPS Duplicate Cluster Report | RPT#####.RPT.RAPS_DUPDX_RPT |
| RAPS Monthly Plan Activity Report | RPT#####.RPT.RPAS_MONTHLY |
| RAPS Cumulative Plan Activity Report | RPT#####.RPT.RAPS_CUMULATIVE |



Plan Monitoring Process

1

CMS compares organization cumulative submissions to benchmarks.

2

CMS notifies organizations placed on a monitoring list.

3

CSSC contacts notified organizations to offer technical assistance and develop action plan.



9-29

Summary

- ▶ Identified the purpose of each risk adjustment report.
- ▶ Determined the best uses of the reports to monitor data collection and submission processes, and to resolve errors.
- ▶ Accurately read the risk adjustment reports to identify and submit corrections.



9-30

Summary (continued)

- ▶ Reviewed the relationship between values in RAPS Transaction Summary and management reports.
- ▶ Compared accepted diagnosis clusters to benchmarks.



9-31



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

Thank You!



9-32

Risk Adjustment Data Validation

Lateefah Hughes
Centers for Medicare & Medicaid Services

6-1

Objectives

- ▶ Identify the purpose and goals of risk adjustment data validation
- ▶ Identify the stages of risk adjustment data validation
- ▶ Learn about the components of a medical record request

6-2

Objectives

- ▶ Describe the requirements for acceptable medical record documentation
- ▶ Identify risk adjustment data discrepancies
- ▶ Describe payment adjustments and appeals
- ▶ Provide communication messages

6-3

What is Risk Adjustment Data Validation?

- ▶ The process of verifying that diagnosis codes submitted are supported by medical record documentation
- ▶ Occurs after data is collected and payment is made
- ▶ Currently conducted using medical record review
- ▶ CMS may consider monitoring risk adjustment data submission to better identify plans for data validation

6-4

What is Risk Adjustment Data Validation?

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



6-5

Data Validation Goals

- ▶ Implement an accurate M+C payment system
- ▶ Measure the accuracy of risk adjusted payments
- ▶ Improve the quality of risk adjustment data
- ▶ Improve the CMS-HCC risk adjustment model



6-6

Data Validation Goals

- ▶ Identify risk adjustment data discrepancies
- ▶ Communicate risk adjustment data validation findings
- ▶ Identify plans that need additional technical assistance to improve the quality of risk adjustment data

6-7

Risk Adjustment Data Validation Background

- ▶ Data validation activities for CY2000, CY2001, CY2002, and CY2003 based on PIP-DCG model
- ▶ Medical record review used to determine PIP discrepancies
- ▶ Only reviewed hospital inpatient medical records

6-8



What is Different for Data Validation Under the CMS-HCC Model?

- ▶ We review hospital inpatient, hospital outpatient and physician medical records
- ▶ More flexible approach
- ▶ Provider identifiers not given—plans need to track RAPS data to provider

6-9



Risk Adjustment Data Validation Process

← STAGE 1

Plan Selection/Medical Record Request

← STAGE 2

Medical Record Review

← STAGE 3

Plan-Level Findings

6-10

Risk Adjustment Data Validation Process

← STAGE 4

Payment Adjustment

← STAGE 5

Appeals

← STAGE 6

Correct Payment



6-11

Guiding Principle

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



6-12



Guidelines for Data Validation

- ▶ Medical record documentation must support an assigned HCC
- ▶ Beneficiaries selected based on RAPS diagnosis clusters
- ▶ Plan selects “one best medical record”
 - Plan must identify date of service and dx code

6-13



Guidelines for Data Validation

- ▶ Submit entire medical record for the year or parts of the record
- ▶ Allow for “additional medical records”—not linked to diagnosis clusters
- ▶ Payment adjustments are based on confirmed risk adjustment discrepancies
- ▶ Appeals process in place for disputes

6-14

Components of Data Validation Process

- ▶ Sampling
- ▶ Medical Record Request Package
- ▶ Receipt of Medical Records by the Initial Validation Contractor (IVC)



6-15

← STAGE 1

Sampling

- ▶ CMS designs sampling plan to select M+C organizations for data validation
- ▶ M+C organizations selected first; beneficiary HCCs selected second
- ▶ Sample based on payment year risk adjustment data



6-16

← **STAGE 1**

Sampling

- ▶ Random and targeted selection
- ▶ National random sample to estimate:
 - Net payment error
 - Data discrepancy rates
- ▶ Targeting criteria may include:
 - Patterns in risk adjustment data suggesting problems
 - Plan past performance in data validation
 - Specific HCCs



← **STAGE 1**

Medical Record Request Package

- ▶ Plans will receive comprehensive instructions
- ▶ Beneficiary list with diagnosis clusters and validation HCCs identified (example on page 6-7)



STAGE 1

Medical Record Request Package

- ▶ Medical Record Coversheet
 - One coversheet for each beneficiary HCC being validated
 - Shows all RAPS diagnosis clusters for an HCC
 - Plan must identify ICD-9 code and service date selected
 - Used to identify an “additional medical record”
 - See Attachment A



6-19

STAGE 1

Additional Medical Records

- ▶ Related to a service not submitted to RAPS or no exact match for a diagnosis cluster
- ▶ Service must occur during data collection period
- ▶ Must be from acceptable risk adjustment provider type
- ▶ Must provide ICD-9 code and service date on medical record coversheet



6-20

← **STAGE 1**

Receipt of Medical Records by the IVC

- ▶ All requested medical records and coversheets sent to IVC
- ▶ IVC logs the receipt of medical records
- ▶ May include administrative check and clinical check
- ▶ All medical records assigned to a category: "OK", problem, or missing



6-21

What Do We Mean by Medical Record Documentation?

- ▶ Parts of the provider/physician medical record that support an assigned HCC based on an ICD-9 code from a particular date of service
- ▶ ICD-9 code must be assigned in accordance with *ICD-9 Coding Guidelines* based on medical record documentation



6-22

Medical Record Documentation

- ▶ Clear
- ▶ Concise
- ▶ Consistent
- ▶ Complete
- ▶ Legible

6-23

Medical Record Documentation

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes.

Source: 1997 Documentation Guidelines for Evaluation and Management Services

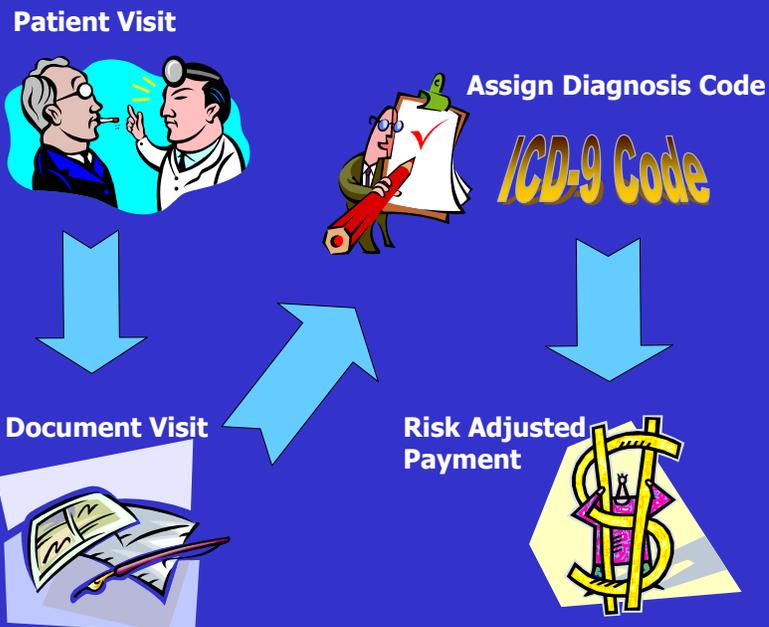
6-24

Medical Record Documentation

- ▶ Patient identification
- ▶ Date(s) of service
- ▶ Persons treating patients
 - Physician
 - All participants in care & treatment
- ▶ Reason for the visit
- ▶ Care rendered
- ▶ Conclusion & diagnosis(es)
- ▶ Follow-up plan



6-25



6-26

Medical Record Documentation

- ▶ Only authorized medical staff may document the patient medical record
- ▶ The person who documents the record must be identified
- ▶ Signatures are required



6-27

Types of Medical Records for Risk Adjustment

- ▶ Hospital Inpatient
- ▶ Hospital Outpatient
- ▶ Physician



6-28

Hospital Inpatient Documentation

- ▶ May include, but not limited to:
 - Face sheet
 - History and physical exam
 - Physician orders
 - Progress notes
 - Operative and pathology reports
 - Consultation reports
 - Diagnostic reports
 - Discharge summary

Hospital Outpatient & Physician Documentation

- ▶ General Guidelines
 - Coder able to determine that a patient evaluation was performed by physician
 - ICD-9 code assigned based on patient evaluation and clinical findings/treatment
 - Physician signature and date of service present

Hospital Outpatient & Physician Documentation

- ▶ May include, but not limited to:
 - Face sheet
 - History and physical exam
 - Physician orders
 - Progress notes
 - Diagnostic reports
 - Consultation reports

Hospital Outpatient & Physician Documentation

- ▶ Do not send medical record documentation that reflects a “probable”, “suspected”, “questionable”, “rule out”, or “working” diagnosis



Hospital Outpatient & Physician Documentation

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

6-33



Hospital Outpatient & Physician Documentation

- ▶ **Problems** with Diagnostic Radiology Reports
 - M+C organizations are relying on the referral diagnosis—this is not a confirmed diagnosis
 - Generally do not indicate a confirmed diagnosis
 - Generally indicate impression only
 - Referring physician/PCP usually reviews and documents condition

6-34



Hospital Outpatient & Physician Documentation

- ▶ Guidance for Diagnostic Radiology Reports
 - Do not send diagnostic radiology medical records if other documentation is available
 - If it is the only documentation, then review to ensure documentation is sufficient to assign code
 - If documentation is insufficient, then HCC will be discrepant

6-35



Hospital Outpatient & Physician Documentation

- ▶ Nursing Home Resident Medical Record
 - OK if beneficiary is long term institutional resident
 - Physician billing independently (not employed by the nursing home)
 - Visits must be face-to-face

6-36



What is Unacceptable Medical Record Documentation?

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

6-37



What is Unacceptable Medical Record Documentation?

- ▶ Unacceptable Types of Documentation
 - Superbill
 - Physician signed attestation
 - List of patient conditions
 - Diagnostic report that has not been interpreted
 - Any documentation for dates of service outside the data collection period

6-38

STAGE 1

Selecting Medical Records for Data Validation

- ▶ Select “one best medical record”
- ▶ Due to variation in physician office medical record documentation, select institutional medical record (hospital inpatient & hospital outpatient) if a choice is available



6-39

EXERCISE



6-40

STAGE 2

Medical Record Review

- ▶ Data validation is accomplished through medical record review
- ▶ Certified coders review records and abstract diagnosis code
- ▶ Coder validates date of service



6-41

STAGE 2

Medical Record Review

- ▶ During medical record review the following are checked/captured:
 - Check for provider signature
 - Check coversheet diagnosis against medical record diagnosis
 - Indicate yes/no for date of service in data collection period
 - Coder notes on diagnosis code assignment
 - Medical record from an acceptable provider type



6-42

STAGE 2

Data Discrepancies

- ▶ Identified when the diagnostic data selected for risk adjustment data validation is not supported by medical record documentation
- ▶ Include coding discrepancies, invalid medical records, and missing medical records

6-43

STAGE 2

Coding Discrepancies

- ▶ ICD-9 code at the 3 digit level does not match selected data
- ▶ ICD-9 code at the 4th and 5th digit level does not match selected data
- ▶ Medical record documentation is insufficient to justify the assignment of an ICD-9 code
- ▶ Examples on page 6-14

6-44

STAGE 2

Invalid Medical Records

- ▶ Unacceptable risk adjustment provider type (e.g., SNF)
- ▶ Missing components required to code (e.g., surgeon record missing operative report)
- ▶ Date of service outside of data collection period



6-45

STAGE 2

Missing Medical Records

- ▶ ICD-9 code cannot be assigned for the date of service
- ▶ No medical record was submitted



6-46

STAGE 2

Risk Adjustment Discrepancies

- ▶ Identified when an HCC originally assigned based on submitted risk adjustment data is different from the HCC assigned after data validation
- ▶ Affects beneficiary risk score



6-47

STAGE 2

Risk Adjustment Discrepancies

Reported Diagnostic Data:

482.4 *Staphylococcal Pneumonia* (HCC111, .693)

Data Validation Findings:

482.3 *Streptococcal Pneumonia* (HCC112, .202)



6-48

← STAGE 2

Risk Adjustment Discrepancies

- ▶ All risk adjustment discrepancies go to the SVC for second, independent medical record review
- ▶ Basis for payment adjustment



6-49

← STAGE 3

Data Validation Findings

- ▶ M+C organization specific information shared with data validation participants
 - May include: response rate, data discrepancy rate, & risk adjustment discrepancy rate
- ▶ Summary findings shared with the M+C industry



6-50

STAGE 4

Payment Adjustment

- ▶ Ensures risk adjusted payment integrity and accuracy
- ▶ Based on confirmed risk adjustment discrepancies
- ▶ CMS develops payment adjustment criteria
- ▶ Criteria may include “consistent pattern” of inaccurate data for previous and current payment years



6-51

STAGE 4

Payment Adjustment

- ▶ Consistent patterns may be based on:
 - High risk adjustment discrepancy rates—(≥ 2 standard deviations above national average discrepancy rate)
 - High payment error rate—(≥ 2 standard deviations above national average payment error rate)
 - 2 consecutive years of inaccurate risk adjustment data (based on validation findings)

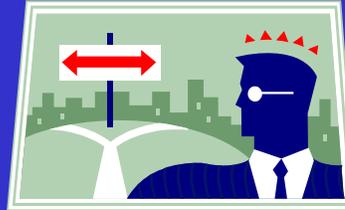


6-52

STAGE 4

Payment Adjustment

Payment adjustment decisions are made by the CMS Administrator



STAGE 5

Appeals

- ▶ Purpose: To allow M+C organizations an opportunity to dispute a payment adjustment
 - M+C organizations may offer a different interpretation of the ICD-9 code assignment based on *ICD-9 Coding Guidelines*
 - M+C organizations may provide additional medical record documentation

← STAGE 5

Appeals

- ▶ Consistent with Medicare fee-for-service procedures
- ▶ M+C organization has 60 days to file an appeal after adjustment is made and appears on the MMR



6-55

← STAGE 5

Appeals

- ▶ Appeals must include:
 - A clearly documented reason for disagreement with the medical record review findingAND/OR
 - Additional medical record documentation to support reason for appeal



6-56

STAGE 5

Appeals

- ▶ Every appeal reviewed by an expert coding panel
- ▶ Panel may include: senior medical reviewer, senior coder, and physician
- ▶ SVC implements the appeals process



6-57

STAGE 6

Correct Payment

- ▶ Risk adjusted payment is determined to be correct after data validation if:
 - No risk adjustment discrepancies were found
 - A risk adjustment discrepancy resulted in a payment adjustment and is not appealed
 - If payment adjustment appealed, then post-appeals payment decision is correct



6-58

Lessons Learned from CMS-HCC Pilot Test

- ▶ Notify physician prior to sending the medical record request
- ▶ Identify a contact person at the physician's office
- ▶ Follow-up with physician's office after medical record request is sent
- ▶ Sending request to a "physician group practice" may not be effective, rather send to the individual physician, if known



6-59

Lessons Learned from CMS-HCC Pilot Test

- ▶ Involve in-house quality assurance staff/medical record reviewers/medical director to help with the identification of the "one best medical record"
- ▶ On average, it took approximately 2 weeks to receive a physician medical record
- ▶ Medical records from specialists and non-contracted providers may be more difficult to obtain
- ▶ Some plans had to pay a fee prior to receiving requested medical records



6-60



M+C Organization Considerations for Data Validation Participation

- ▶ Previous medical record request process (hospital inpatient records only) may not be sufficient for ambulatory medical records
- ▶ Plans could review medical records prior to submission for data validation
- ▶ Consider having the physician indicate the date of service and diagnosis code

6-61



M+C Organization Considerations for Data Validation Participation

- ▶ Tracking the status of medical record requests is critical to the process
- ▶ Consider that organization staff involved in the medical record request process may need to be educated about risk adjustment and the CMS-HCC data validation process
- ▶ Include staff involved in the medical record request process in all conference calls with CMS and the IVC

6-62



Communication Messages

- ▶ Every M+C organization (H #) has a chance of being selected for risk adjustment data validation
- ▶ Good medical record documentation = accurate ICD-9 codes = accurate risk adjusted payment
- ▶ All staff involved should be informed about and understand risk adjustment data validation process

6-63



Communication Messages

- ▶ Plan is responsible for identifying date of service and ICD-9 code submitted for HCC validation
- ▶ Plan must be able to track diagnosis codes back to providers
- ▶ Notify physicians early in the medical record request process
- ▶ Use newsletters and CMS training tools to inform physicians about risk adjustment

6-64

Technical Assistance

- ▶ Available for M+C organizations that need more training or specific assistance with data validation
- ▶ Contact CMS staff (see page 6-18 for contact information)



6-65

Current vs. Future Data Validation

- ▶ Current
 - Based on PIP-DCG risk adjustment model and hospital inpatient risk adjustment data
 - CY2001: Payment adjustments conducted
 - CY2002: Finalizing medical record review findings
 - CY2003: Medical records requested; due April 30, 2004



6-66

Current vs. Future Data Validation

- ▶ Future
 - Based on hospital inpatient, hospital outpatient, and physician risk adjustment data
 - CY2004: Medical record requests expected in Fall 2004



6-67

Next Steps

- ▶ CMS is considering other ways to validate risk adjustment data
- ▶ Validating drug data (MMA) will present new issues for data validation



6-68



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

Thank You!

Verifying Risk Scores

Angela Reddix
Aspen Systems Corporation

10-1

Purpose

- ▶ This module will explain the systems involved in the risk score calculations and introduce M+C organizations to a variety of verification tools available.

10-2



Objectives

- ▶ Understand the systems and processes used to calculate the risk scores.
- ▶ Determine how the organization can use risk adjustment processing and management reports to ensure the accuracy of payment.

10-3



Objectives (continued)

- ▶ Identify the components and uses of the Monthly Membership Report(MMR) and Model Output Report (MOR)/Hierarchical Condition Category(HCC) Report.
- ▶ Interpret the HCC Submission Status Report.
- ▶ Understand how to interpret benchmarks.

10-4

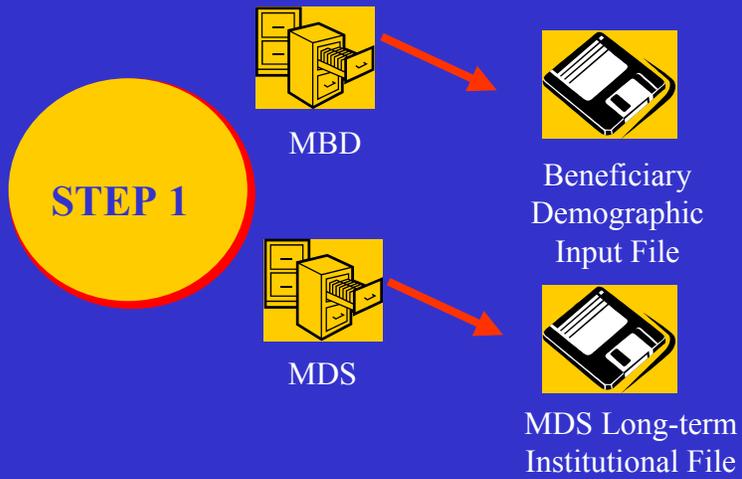


What is the Risk Score?

10-5

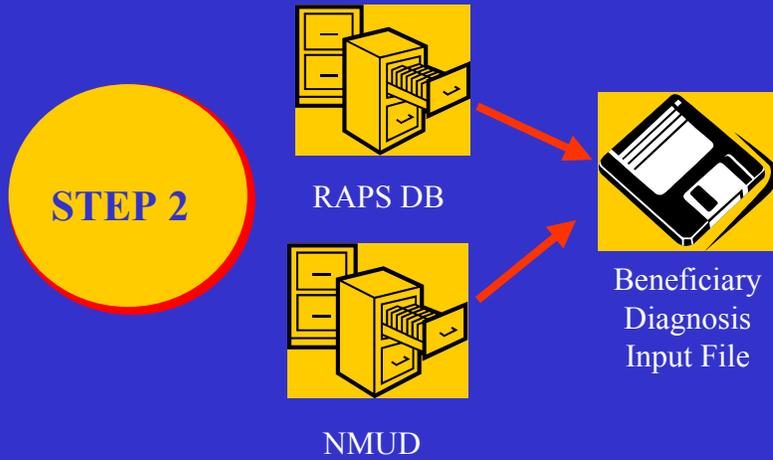


Calculation of Risk Scores

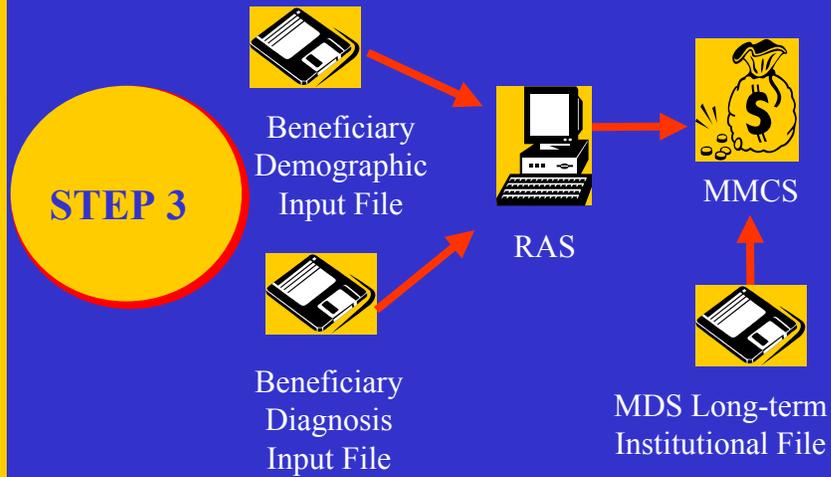


10-6

Calculation of Risk Scores (continued)



Calculation of Risk Scores (continued)





Verification Tools



- ▶ RAPS Return File
- ▶ Raps Management Reports
- ▶ SAS CMS-HCC Model Program
- ▶ Monthly Membership Report
- ▶ Risk Adjustment Model Output Report
- ▶ HCC Submission Status Report

10-9



RAPS Return File/ RAPS Transaction Error Report

- ▶ Received the next business day after submission.
- ▶ Return file provides a record of each diagnosis stored for each enrollee.
- ▶ M+C organizations may store the results of each RAPS Return File to build and update a record of all diagnoses stored in the model for each enrollee.
- ▶ Error Report requires manual updates to a diagnosis file.

10-10

Database Components

| | | | |
|------------|-----------|----------------|--------------|
| HIC number | Diagnosis | Date submitted | Through date |
|------------|-----------|----------------|--------------|



10-11

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



10-12

Exercise



Run the CMS-HCC Model

- ▶ CMS runs the model on an annual basis.
- ▶ M+C organizations may run the model to calculate their enrollee risk scores.
- ▶ SAS program available at <http://cms.hhs.gov/healthplans/rates>

Run the CMS-HCC Model (continued)

Risk Adjustment Information, Data files, & Programs

CMS-HCC Payment Model software and data for 2004

- Note to M+C Organizations Regarding ICD-9 Code Differences in Final CMS-HCC Risk Adjustment Model. (Posted 07/17/03)
- [hccsoftware.zip](#) (9K bytes) This archive expands to 12 files. Read [hccsoftwaredescription.rtf](#) (included in the archive) for further details and instructions.
- [avgrisk.zip](#) (36K bytes) This archive expands to:
 1. avgrisk.csv -- Estimated average county risk factors
- Additional data pertaining to the [CMS-HCC model](#).

<http://www.cms.hhs.gov/healthplans/rates/>



10-15

Monthly Membership Report

- ▶ Generated by GHP.
- ▶ Beneficiary-level information.
- ▶ Available through the GROUCH system.
- ▶ For availability, refer to the official schedule for precise dates.



10-16

Monthly Membership Report Field Ranges

| Field Ranges | Descriptions |
|--------------|--|
| 1-3 | Managed Care Organization Information |
| 4-11 | Beneficiary Identification |
| 12-13 | Entitlement |
| 14-19 | Health Status |
| 20-37 | Risk Adjustment/Demographic Payment Adjustment Information |
| 38-49 | Additional Risk Adjustment Indicators |

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

HCC Submission Status Report

- ▶ Access via HPMS.
- ▶ Indicates plan level risk score and HCC distribution.
- ▶ Includes two tables
 - Number of beneficiaries per number of conditions
 - Number of beneficiaries with conditions in model



10-19

Benchmarking

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



10-20

Benchmarking (continued)

Centers for Medicare & Medicaid Services
 Home | About CMS | FAQs | Feedback | Search now
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Risk Adjustment Model for 2004
 (Note: Final Model Announcement, Factors, Rates, and Software can be found at <http://cms.hhs.gov/healthplans/rates/>)

| File Description | File Name(s) | Format |
|---|---|--------------------------|
| Average Risk Scores By State From M+C Data. (posted 08/19/03) | technotetstscrs.asp stvlrskscores.zip (3K) | Zipped .XLS file or HTML |
| Number and Percent of FFS beneficiaries Nationally by Demographic Characteristics and Disease Groups. (posted 05/30/03) | NatlFreq.zip (107K) | Zipped .XLS file |
| Number and Percent of FFS beneficiaries by County and Demographic Characteristics and Disease Groups. (posted 06/13/03) | ffsdist1997edited.zip (3,616K) | Zipped .XLS file |

<http://cms.hhs.gov/healthplans/riskadj/>

Exercise



Summary

- ▶ Identified data systems used to calculate risk scores.
- ▶ Reviewed how reports can be used to verify risk scores.
- ▶ Described the use of benchmarks.



10-23



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

Thank You!



10-24

Three C's of Risk Adjustment

Angela Reddix
Aspen Systems Corporation

11-1

Purpose

- ▶ The purpose of this module is to share winning strategies that will allow organizations to build an adequate infrastructure to support the risk adjustment process.
- ▶ A successful infrastructure will utilize appropriate internal and external resources.

11-2

Objectives

- ▶ Discuss the opportunity to improve the quality of the risk adjustment process.
- ▶ Ensure the submission of the appropriate quantity of data in the risk adjustment process.
- ▶ Identify effective internal and external communication strategies.



11-3

Objectives (continued)

- ▶ Define the Risk Adjustment Collaboration Model.
- ▶ Identify recommended steps to risk adjustment project coordination.



11-4



Quality and Quantity

- ▶ CMS provides information and material to assist M+C organizations in improving overall quality and submitting the appropriate quantity of risk adjustment data.
- ▶ M+C organizations develop processes to support collection and submission of risk adjustment data.
- ▶ M+C organizations should consider key quality and quantity concepts.

11-5



Data Collection

Quality

- ▶ Collect from appropriate sources.
- ▶ Collect the relevant diagnoses.
- ▶ Ensure coding to the 5th digit.
- ▶ Educate physicians/providers regarding correct coding guidelines.

Quantity

- ▶ Develop tools to receive all data in a timely manner.
- ▶ Collect relevant diagnosis at least once per year for a beneficiary.
- ▶ Consider data collection tool convenient for the physician/provider.

11-6

Data Submission

Quality

- ▶ Pay close attention to the file logic and the components of the diagnosis cluster.
- ▶ Delete any self-identified inaccurate data.

Quantity

- ▶ Submit at least quarterly.
- ▶ Filter appropriately following examples to prevent over-filtering and under-filtering.



11-7

FERAS & RAPS Data Processing

Quality

- ▶ Establish internal editing systems to perform edits prior to sending the file to Palmetto.
- ▶ Read and reconcile reports to reduce the numbers of errors generated in the future.

Quantity

- ▶ Analyze reports to determine the number of clusters stored.
- ▶ Compare submission levels to data received from physicians and providers.



11-8



Verifying Risk Scores

Quality

- ▶ Using the MMR/MOR, verify that individual beneficiaries have the appropriate HCCs and risk scores based on plan data submissions and reports of data stored.

Quantity

- ▶ Ensure that overall plan payments and average risk adjustment factors are at or near expected values.

11-9



Data Validation

Quality

- ▶ Identify best medical record to support the diagnosis that is being validated.

Quantity

- ▶ Develop internal system to quickly identify the source (specific physician/hospital) of the data being validated.
- ▶ Ensure there are no missing medical records.

11-10

Three C's of Risk Adjustment

- 1 COMMUNICATION
- 2 COLLABORATION
- 3 COORDINATION



Three C's of Risk Adjustment (continued)

COMMUNICATION



1. Inform the organization of the CMS risk adjustment requirements.
2. Convey to Executives the resources and risks associated with the project.
3. Describe the benefits to the organization.
4. Celebrate success and identify opportunities for improvement.



Three C's of Risk Adjustment (continued)



COMMUNICATION

5. Attend user groups and trainings to receive updates and official information.
6. Call CSSC to resolve data submission or processing problems.
7. Contact CMS with questions about risk adjustment requirements, factor discrepancies, payments, etc.

Three C's of Risk Adjustment (continued)



COLLABORATION

1. Generate ideas for process improvement from all departments impacted by risk adjustment.
2. Define a workgroup aligned around a clear purpose.
3. Gain buy-in by group to work towards reaching the ultimate risk adjustment goal.
4. Develop a process for making decisions and resolving conflict.

Three C's of Risk Adjustment (continued)



COLLABORATION

5. Work with CMS and CSSC to ensure successful compliance with requirements.
6. Obtain physician/provider input regarding process improvement for data collection.



11-15

Three C's of Risk Adjustment (continued)



COORDINATION

1. Identify key resources required to meet the risk adjustment requirements.
2. Determine what individual or group "owns" risk adjustment.
3. Establish an internal process to collect, submit, and reconcile risk adjustment data.



11-16

Three C's of Risk Adjustment (continued)



COORDINATION

4. Define project roles and responsibilities.
5. Coordinate internal activities with appropriate external groups, e.g., CMS, CSSC, physicians/providers, third party submitters.

Case Study 1



Communication



- ▶ Internal
- ▶ External

11-19

Collaboration



- ▶ The collection of ideas that provide the knowledge to make informed decisions that save money, time, and resources.

11-20

Risk Adjustment Collaboration Model



Coordination



- ▶ Organizing the structure and the process of the risk adjustment team to function well internally and externally.

Required Project Coordination Components



Required Project Coordination Components (continued)



2004 Regional Risk Adjustment Training
for Medicare+Choice Organizations

Required Project Coordination Components

(continued)

IDENTIFY STAKEHOLDERS

IDENTIFY REQUIRED RESOURCES

ESTABLISH PROJECT STRUCTURE

DEFINE ROLES

DEVELOP PROCESS & STANDARDS OF ACCOUNTABILITY

CMS

11-25

2004 Regional Risk Adjustment Training
for Medicare+Choice Organizations

Required Project Coordination Components

(continued)

IDENTIFY STAKEHOLDERS

IDENTIFY REQUIRED RESOURCES

ESTABLISH PROJECT STRUCTURE

DEFINE ROLES

DEVELOP PROCESS & STANDARDS OF ACCOUNTABILITY

CMS

11-26

2004 Regional Risk Adjustment Training
for Medicare+Choice Organizations

Required Project Coordination Components

(continued)

IDENTIFY STAKEHOLDERS

IDENTIFY REQUIRED RESOURCES

ESTABLISH PROJECT STRUCTURE

DEFINE ROLES

DEVELOP PROCESS & STANDARDS OF ACCOUNTABILITY

CMS

11-27

2004 Regional Risk Adjustment Training
for Medicare+Choice Organizations

Required Project Coordination Components

(continued)

IDENTIFY STAKEHOLDERS

IDENTIFY REQUIRED RESOURCES

ESTABLISH PROJECT STRUCTURE

DEFINE ROLES

DEVELOP PROCESS & STANDARDS OF ACCOUNTABILITY

CMS

11-28

Case Study 2



Summary

- ▶ Discussed the opportunity to improve the quality of the risk adjustment process.
- ▶ Ensured the submission of the appropriate quantity of data in the risk adjustment process.
- ▶ Identified effective internal and external communication strategies.

Summary (continued)

- ▶ Defined the Risk Adjustment Collaboration Model.
- ▶ Identified recommended steps to risk adjustment project coordination.



11-31



Please take a moment to complete the evaluation form for the Three C's of Risk Adjustment Module.

Thank You!



11-32

2004 Regional Risk Adjustment Training for Medicare+Choice Organizations



August 2-3, 2004
Chicago, IL

2004 Regional Risk Adjustment Training
for Medicare+Choice Organizations

Introduction

Angela Reddix
Aspen Systems Corporation



I-2

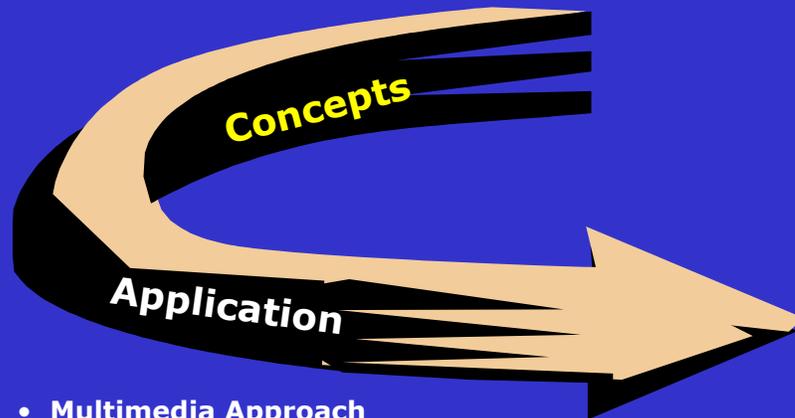
Purpose

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



I-3

Training Format



- Multimedia Approach
- Examples
- Exercises
- Group Participation
- Interactive



I-4

Your Participation Makes the Difference



Training Tools

- ▶ **Participant Guide**
 - CD w/slides, both tracks
- ▶ **Job Aids**
- ▶ **www.mcoservice.com**
- ▶ **Panel of Experts**



Audience

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



I-7

Training Tracks

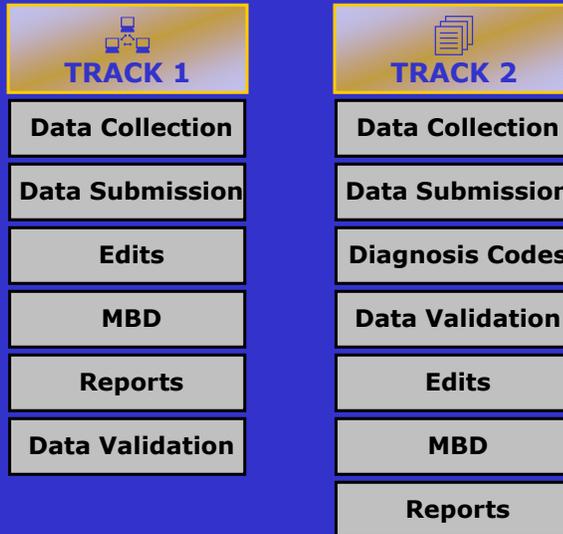
| Track | Audience |
|--|--|
| Information Systems  | Information needs of systems technology participants who are primarily responsible for the submission of risk adjustment data to CMS |
| Quality & Compliance  | Information needs of participants responsible for overall program management, compliance,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



I-8



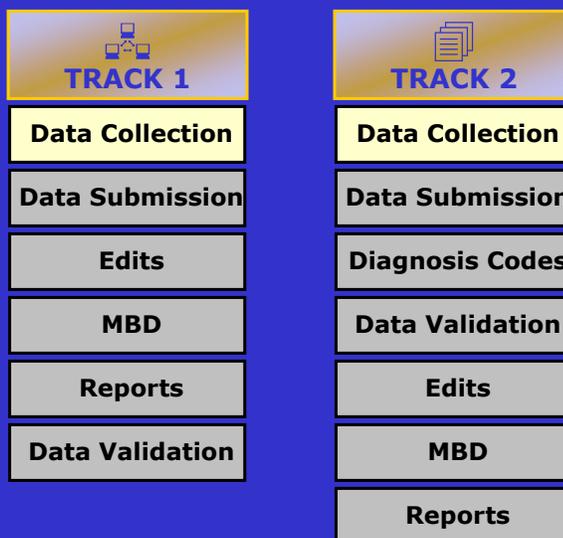
Risk Adjustment Modules



I-9



Risk Adjustment Modules (continued)



I-10



Objectives

- ▶ At the completion of this training, participants will be able to:
 - Understand the CMS-HCC model & apply the payment methodology.
 - Identify the components of the risk adjustment process and describe the requirements for data collection.
 - Interpret key medical record documentation & coding guidelines.

I-11



Objectives (continued)

- Determine the process for submitting data to CMS.
- Interpret editing rules and error resolution.
- Identify the type and effective use of information stored in the MBD.
- Recognize the importance of the three C's.

I-12

Introducing the Team

CMS



Palmetto
(CSSC)

Aspen

Risk Adjustment Methodology

Jennifer Harlow
Centers for Medicare & Medicaid Services

1-1

Purpose

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

1-2



Objectives

- ▶ Review the history of risk adjustment.
- ▶ Understand there are changes to MA (formerly M+C) payment methodology in 2004 and beyond.
- ▶ Review characteristics of CMS-HCC risk adjustment model.
- ▶ Practice calculating risk scores.

1-3



Objectives (continued)

- ▶ Discuss implementation of frailty adjuster in 2004 and its possible future application.
- ▶ Review upcoming CMS-HCC model enhancements.
- ▶ Understand how the ESRD model operates.
- ▶ Review highlights of Medicare reform in Titles I & II of the MMA.

1-4



Risk Adjustment History

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

1-5



Risk Adjustment History (continued)

- ▶ The Benefits Improvement and Protections Act of 2000 (BIPA) required CMS to implement risk adjustment using gradual phase-in until 2007 with additional data in risk adjustment model in 2004.
- ▶ CMS implemented the CMS-Hierarchical Condition Category (HCC) Model in 2004 that includes hospital and ambulatory data at 30% blended payment.
 - Model balanced reducing plan data burden with implementing clinically sound model.

1-6

Risk Adjustment History (continued)

- ▶ In 2004, CMS implemented frailty adjuster for enrollees of PACE and certain demonstrations.
- ▶ In 2005, CMS will implement End Stage Renal Disease (ESRD) model for ESRD MA enrollees.
- ▶ In 2006, CMS will implement risk adjustment model for new Medicare prescription drug benefit.



1-7

2004 MA Payment Rates

- ▶ The MA payment rates for 2004 are the greater of:
 - Blended Formula
 - Calculated same way as under M+C methodology
 - Except: budget neutrality requirement for ratebook is eliminated
 - Minimum Floor
 - No change to how floor amount is calculated



1-8



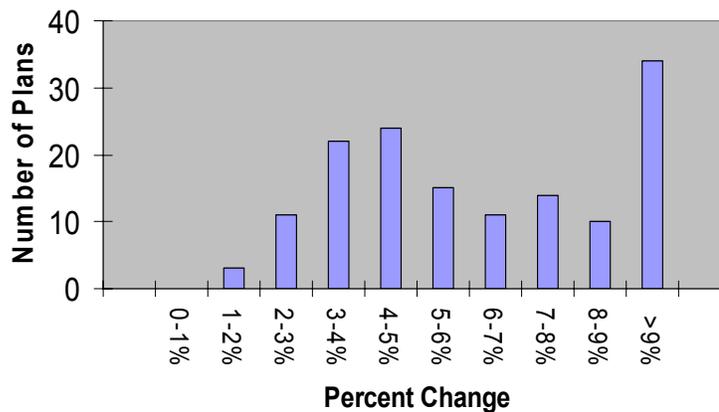
2004 MA Payment Rates (continued)

- ▶ Minimum Percentage Increase
 - Greater of 102% of previous year's rate or previous year's rate increased by Medicare growth percentage
- ▶ 100% of County FFS Costs
 - Rebased at least every 3 years

1-9



Impact of Medicare Modernization Act on M+C Organizations



1-10



MA Payment Rates in 2005 and Beyond

- ▶ For 2005 and years thereafter, MA county payment rate is minimum percentage increase, except in years when CMS recalculates the 100% FFS rate.
- ▶ In those years, MA county payment rate becomes higher of minimum percentage increase versus the 100% FFS rate.

1-11



CMS-Hierarchical Condition Category (HCC) Model

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

1-12



CMS-HCC Model (continued)

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

1-13



Demographic Factors in Risk Adjustment

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

1-14

Demographic Factors in Risk Adjustment

(continued)

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



1-15

Disease Groups/HCCs

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



1-16

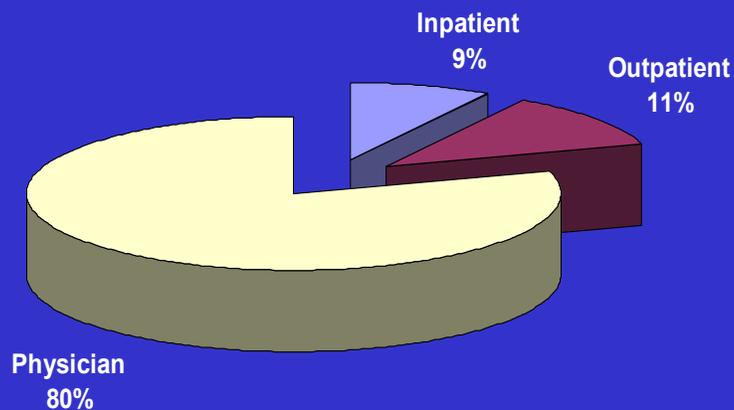
Disease Hierarchies

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



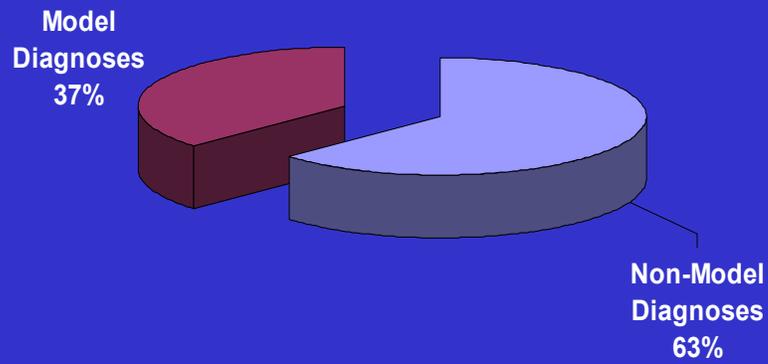
1-17

Diagnoses Extracted from RAPS on April 1, 2004

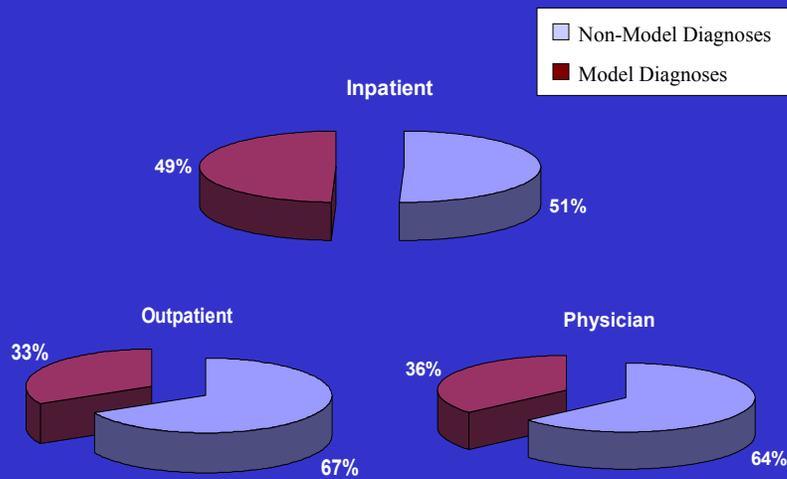


1-18

Model and Non-Model Diagnoses in RAPS



Model and Non-Model Diagnoses by Provider Type



Exercise



Calculating Payments

- ▶ Step 1: Calculate Demographic Portion of Payment
 - Use lookup tables for demographic cost factors and county rates.
 - Must multiply rates by factors for Part A & B, and then sum each result for a 100% demographic payment.
 - Apply appropriate payment blend percentage to full amount (50% in 2005).

See Example in Participant Guide.

Calculating Payment (continued)

- ▶ Step 2: Calculate the risk portion of payment
 - A rescaling factor is applied to convert demographic ratebook into a risk ratebook to calculate risk adjusted rate for each county.
 - Multiply risk ratebook for Part A and Part B by risk score for each enrollee to yield 100% risk adjusted payment amount.
 - Apply appropriate transition blend.



1-23

Risk Adjusted Payment Calculation

- ▶ Use the Part A & B demographic MA county rates to convert into county risk rates.
- ▶ Apply appropriate rescaling factor for relevant county.
- ▶ Calculate Beneficiary Risk Factor by considering all relevant factors:
 - Age, Sex
 - Institutional v. Community
 - Medicaid Eligibility
 - Currently Disabled, Originally Disabled
 - Diagnoses found in HCCs



1-24

Risk Adjusted Payment Calculation

(continued)

- ▶ Multiply the combined Part A & B risk adjusted monthly capitation rates by the beneficiary's risk factor = 100% risk adjusted payment.
- ▶ Apply appropriate payment blend percentage to 100% payment (50% in 2005).

See Example in Participant Guide.



1-25

Risk Ratebook

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



1-26



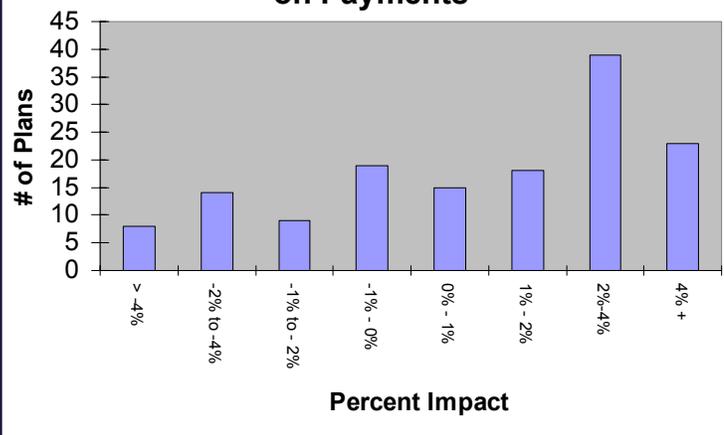
Risk Ratebook (continued)

- ▶ Budget Neutrality
 - Difference between 100% risk adjusted payment v. 100% demographic payment.
 - Redistributes reduced aggregate payments as constant percentage to organizations.
 - Pre-MMA 2004 budget neutrality factor = 1.163.
 - Post MMA 2004 budget neutrality factor = 1.0829.

1-27



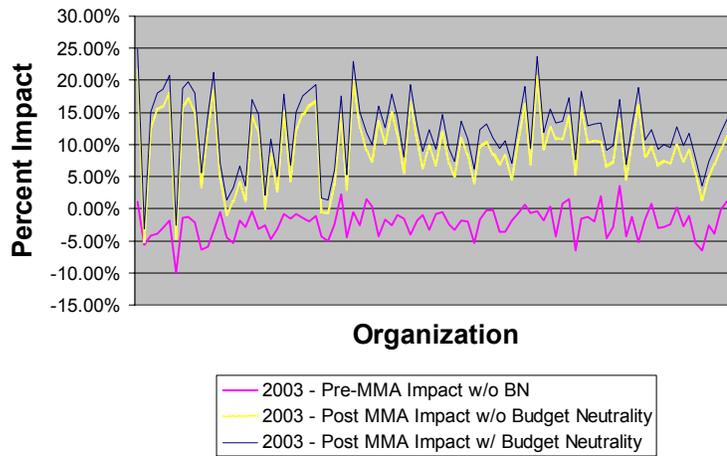
Impact of 90/10% vs. 70/30% Blend
on Payments



1-28



Impact of MMA Rate Changes w/ and w/o Budget Neutrality



1-29



Frailty Adjuster – Improvement of CMS-HCC Model

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

1-30

Frailty Adjuster (continued)

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



1-31

RANGE OF FRAILTY SCORES IN 2004

| FRAILTY PLAN | RANGE OF FRAILTY SCORES |
|--------------|-------------------------|
| PACE | .41 - .77 |
| S/HMOs | .06 - .18 |
| WPP | .45 - .57 |
| MSHO | .18 - .78 |



1-32

Implications of Frailty

- ▶ Variation exists in health status of PACE enrollees for which risk and frailty adjustment accounts.
- ▶ Current S/HMO payment levels may not be justified by enrollees' level of risk and frailty.
- ▶ For MA organizations, addition of frailty factor may improve payment accuracy.
- ▶ Frailty adjustment lowers risk scores for individuals with 0 ADLs and raises scores for all other ADL categories.

1-33

Frailty Adjuster Development

- ▶ Technical Work
 - Conducting survey of FFS beneficiaries regarding level of frailty in FFS Medicare population.
 - Develop more accurate frailty adjuster for improved estimates.
 - Determine if ratebook adjustment is necessary.

1-34

Frailty Adjuster Development (continued)

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



1-35

CMS-HCC Model Enhancements

- ▶ CMS is analyzing additional diagnoses to add to current model to improve payment accuracy.
- ▶ CMS expects to announce additional diagnoses in April 2004.



1-36

CMS-HCC Model Enhancements in 2005

- ▶ New model using risk adjustment for ESRD enrollees in MA organizations and demonstrations applied in 2005.
- ▶ Model will address unique cost considerations of ESRD population.
- ▶ Draft ESRD model announced in 45-day Notice.



1-37

ESRD Implementation

- ▶ BIPA mandated ESRD model reflects methodology used for S/HMO ESRD demonstration.
- ▶ CMS will implement ESRD model at 100% of payments in 2005.



1-38



ESRD Model-Three Parts

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

1-39



ESRD Model (continued)

- ▶ Dialysis Model—HCCs with different coefficients.
 - Multiplied by statewide ESRD ratebook.
- ▶ Transplant Model- Costs for transplant month + next 2 months summed and divided by 3 to yield average monthly cost for 3 months of transplant status.
 - National relative factor created by dividing average monthly cost by national average costs for dialysis.
 - Payment for 3 months multiplied by statewide dialysis ratebook.

1-40

New Enrollees and ESRD Model

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



1-41

Model Comparisons of Coefficients

| | Community | Institutional | Dialysis |
|---|-----------|---------------|----------|
| Metastatic Cancer and Acute Leukemia HCC 7 | 1.464 | 0.540 | 0.161 |
| Diabetes with acute complications HCC 17 | 0.391 | 0.612 | 0.106 |
| Major Depression HCC 55 | 0.431 | 0.221 | 0.116 |
| Age-Sex Factor for 69 year old male | 0.346 | 1.450 | 0.775 |
| Age-Sex Factor for 88 year old female | 0.665 | 0.880 | 0.919 |



1-42



Medicare Reform

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

1-43



MMA in 2006

- ▶ TITLE I
 - Creates new Medicare drug benefit as Medicare Part D - Two types of sponsors:
 - Stand alone prescription drug plan (PDP).
 - MA organization providing a basic drug benefit (MA-PD).
 - Each MA organization must provide basic drug coverage under one of its plans for each service area it covers.
 - Establishes reinsurance option and risk corridors to limit risk for participating plans.

1-44

MA in 2006

- ▶ TITLE II
 - Replaces Adjusted Community Rate (ACR) proposal with bidding process for MA organizations.
 - Maintains local plan options.
 - HMOs, PPOs, PFFS plans, MSAs, PSOs.
 - Creates MA regional plans offering a PPO option.
 - 10-50 regions to be determined.



1-45

MA in 2006 (continued)

- Regions designed to maximize plan participation. Regional PPO must cover entire region.
- Regional plans will have extra incentives to participate including:
 - Risk sharing in 2006 and 2007.
 - Stabilization fund.
 - Bonus payment.



1-46

MA Organization Bid and Review Process

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



1-47

Overlap of Payment Methods in Titles I and II

- ▶ Organizations intending to offer MA plans and/or drug benefits will have to submit bids for their basic, and if applicable, supplemental benefit packages.
- ▶ Benchmarks will be created for local and/or regional plans for bid-benchmark comparison.
- ▶ Monthly capitated payments made based on plan's bid and risk adjusted for health status minus beneficiary premium amount.



1-48

Where does Risk Adjustment fit in within the MMA?

- ▶ Risk adjustment used in similar way for MA program as in M+C program.
- ▶ Payments for original Medicare benefits and the new drug benefit will be risk adjusted at beneficiary level.
- ▶ In MA Program, risk adjusted bids and risk adjusted benchmarks will be compared to each other to help determine beneficiary rebate amounts and benefit packages.



1-49

Additional MMA Change – Special Needs Plans

- ▶ Statute calls for specialty plans for individuals who are:
 - Institutionalized;
 - Medicaid eligible; or
 - Have severe or disabling chronic condition(s).
- ▶ No special payment provision.



1-50



Drug Risk Adjustment

- ▶ Risk adjustment is more accurate in predicting drug costs than it is for healthcare costs.
- ▶ Drug risk adjuster likely to involve different diseases than risk adjuster for non-drug costs.
- ▶ For example, glaucoma and hypertension were not good predictors of significant Part A/B costs, but they are predictive of higher drug costs.
- ▶ Some diseases currently in CMS-HCC model might decrease drug expenditures.

1-51



Implementation of Drug Benefit in 2006

- ▶ Drug risk adjustment model being developed to reflect variation of costs based on health status of enrollees.
- ▶ Similar to CMS-HCC risk adjustment, list of diagnoses identified for drug risk adjuster for collection from MA organizations to begin in July 2004.
- ▶ CMS is developing data collection strategy based on National Council for Prescription Drug Programs (NCPDP) format for collection of drug claims data from PDP sponsors beginning in 2006.

1-52

Conclusions

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

1-53

Next Steps

- ▶ NPRM published on Titles I and II of MMA.
- ▶ Comments received within 60 days.
- ▶ Final Rule published in 2005.
- ▶ Additional training and support on new MA bidding methodology and new drug risk adjustment model.

1-54



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

Thank You!

Process Overview

Angela Reddix
Aspen Systems Corporation

2-1

Purpose

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

2-2

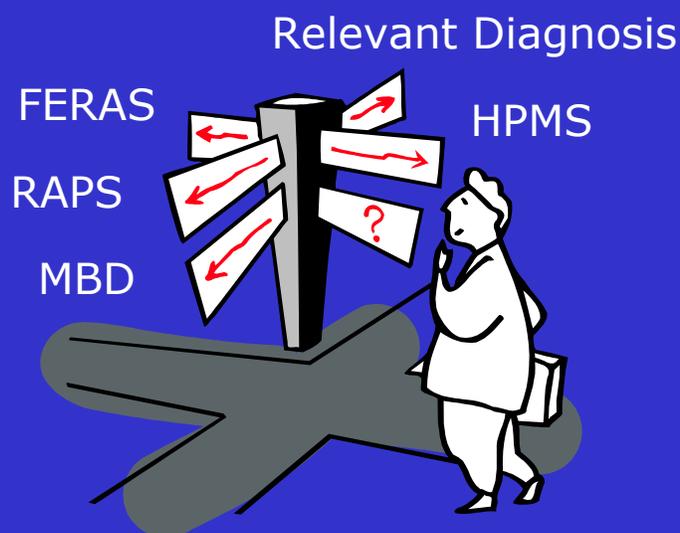
Objectives

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



2-3

Common Terms



2-4

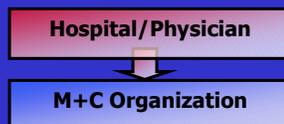
Risk Adjustment Data Requirements

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



2-5

Data Collection



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

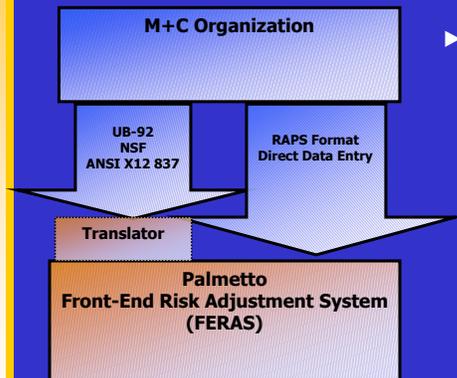
Minimum Data Set

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



2-6

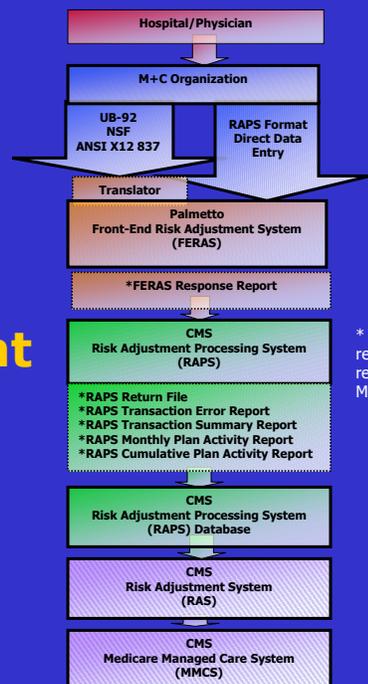
Data Submission



▶ Formats

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

Risk Adjustment Process



* These reports/files are returned to the M+C organization.

Submission Schedule

| CY | Dates of Service | Initial Submission Deadline | First Payment Date | Final Submission Deadline |
|----|-------------------|-----------------------------|--------------------|---------------------------|
| 04 | 7/1/02 - 6/30/03 | 9/5/03 | 1/1/04 | N/A* |
| 04 | 1/1/03 - 12/31/03 | 3/5/04 | 7/1/04 | 5/13/05 |
| 05 | 7/1/03 - 6/30/04 | 9/3/04 | 1/1/05 | N/A* |
| 05 | 1/1/04 - 12/31/04 | 3/4/05 | 7/1/05 | 5/15/06 |

*With elimination of the payment lag, the final submission deadline (reconciliation) changes to May 15th of each year. There is no September 30, 2004 deadline.



Training and Support



Now Showing

Customer Service and Support Center

www.mcoservice.com

User Groups

Onsite Consultation

Getting Started Video Training

Regional Training

Physician Training CD





Training and Support



2004 Regional Training
Video

Special Sessions

Continuous Updates to
www.mcoservice.com

Updated Getting Started
Video Training

Coming Attractions!

2-11



Summary

- ▶ Reviewed common risk adjustment terminology.
- ▶ Introduced key components of the risk adjustment process.
- ▶ Reviewed risk adjustment schedule.
- ▶ Identified outreach and training available to organizations.

2-12



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

Thank You!

Data Collection



Ed Sommers
Aspen Systems Corporation

3-1

Purpose

- ▶ To enable staff responsible for quality and compliance to apply data collection principles in accordance with CMS requirements, and obtain complete and accurate risk adjustment data from physicians and providers.

3-2

Objectives

- ▶ Identify data elements and data sources required for risk adjustment.
- ▶ Identify available collection formats.
- ▶ Discuss factors to consider when determining data collection methods.
- ▶ Discuss HIPAA transaction standards for purposes of risk adjustment.



3-3

Data Collection



3-4



Minimum Data Elements

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

3-5



Health Insurance Claim Number

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

- ▶ Beneficiary's identification number.
- ▶ Railroad Retirement Board number.
- ▶ Not required to collect, but must be able to identify beneficiary.

3-6

ICD-9-CM Diagnosis Codes

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

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

Service From and Through Dates

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

- ▶ For hospital inpatient: admission and discharge dates.
- ▶ For hospital outpatient and physician: date of treatment.

Provider Type

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

- ▶ Hospital Inpatient
- ▶ Hospital Outpatient
- ▶ Physician

Data Sources



Hospital Inpatient

Hospital Outpatient



Physicians

Hospital Inpatient



- ▶ Short-/long-term hospitals
- ▶ Religious non-medical institutions
- ▶ Specialty hospitals
- ▶ Medical assistance/critical access facility

Medicare Provider Number

42 S 001 → Valid
42 U 001 → Invalid

State where hospital/facility is located

Type of Facility

Unique to the facility

Hospital Outpatient



- ▶ Short-/long-term hospitals
- ▶ Federally qualified centers & religious non-medical institutions
- ▶ Specialty hospitals
- ▶ Rural health clinics
- ▶ Community mental health centers

3-13

Physician



- ▶ General and specialty physicians
- ▶ Other specialties
- ▶ Requires face-to-face visit
- ▶ Professional component of pathology and radiology services

3-14



Excluded Providers

- ▶ Medicare does not pay for items or services rendered by excluded providers!
- ▶ Providers may be excluded for:
 - Program-related crime.
 - Patient abuse or neglect.
 - Health care fraud.
 - Convictions related to controlled substances.
- ▶ Check <http://oig.hhs.gov/fraud/exclusions.html>

3-15



Data Collection Formats

| | |
|--|--|
| <p>HOSPITAL INPATIENT & HOSPITAL OUTPATIENT</p> | <ul style="list-style-type: none"> • Full UB-92 • Abbreviated UB-92 • ANSI X12 837 4010 • RAPS Format |
| <p>PHYSICIAN</p> | <ul style="list-style-type: none"> • HCFA 1500 • NSF 3-01 • ANSI X12 837 4010 • RAPS Format • Superbill |

3-16



Data Collection Features

| 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 | | | • | • | • | • |

* See Participant Guide 3.3.2 for details.

3-17



Factors Affecting Data Collection

- ▶ Data necessary for operations
 - Minimum data set?
 - Full claims data?
 - Something in between?
- ▶ Contractual relationships with providers
- ▶ HIPAA considerations
- ▶ Other considerations

3-18

How Much Data is Enough?

- ▶ While CMS requires only the minimum data set be collected, organizations should consider business needs.
 - Full data or minimum set?
 - NCQA (HEDIS), JCAHO.



What Contractual Relationships?

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





What is HIPAA's Impact?

- ▶ Turn to Case Study 3
 - Participant Guide, page 3-17



3-21



ComCet Care Case Study: Key Issues

HIPAA's impact on data collection

HIPAA's impact on data corrections

Contractual relationships with providers

Other business needs

3-22

Communicating with Providers



Key Messages Regarding Data Collection

- ▶ Purpose of risk adjustment.
- ▶ Provider and physician roles and responsibilities.
- ▶ Importance of accuracy in diagnosis coding and timeliness of submission.

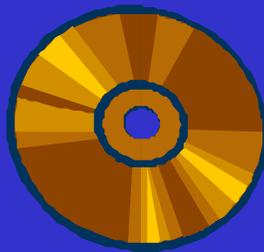
What is Risk Adjustment?

- ▶ Strengthens Medicare program.
- ▶ Ensures CMS reimburses M+C organizations accurately.
- ▶ Provides M+C organization incentives to enroll and treat less healthy individuals.



3-25

Communicating with Physicians about Risk Adjustment



Physicians and Medicare+Choice Risk Adjustment

Self-paced, CD-based program on risk adjustment for physicians



3-26

Characteristics of Effective Communication

- ▶ Authoritative
- ▶ Current and timely
- ▶ Consistent
- ▶ Practical, relevant, and well-organized
- ▶ Accessible

3-27

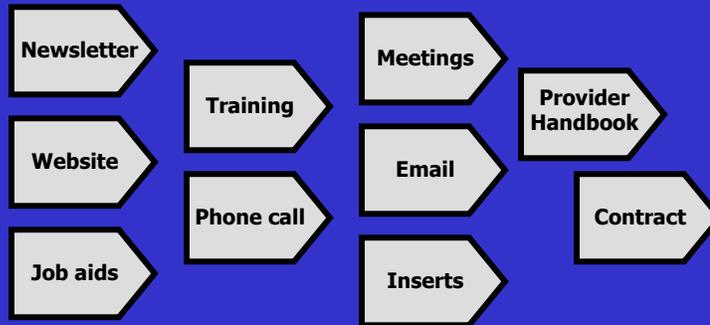
Communication Methods

- ▶ Include risk adjustment communication in existing provider communication channels.
- ▶ Speak with authority about risk adjustment. If unsure, speak with CSSC.
- ▶ Work with local association chapters, if appropriate.

3-28

Communication Methods (continued)

- ▶ Use multi-modal approach



Summary

- ▶ Data collection basics
 - Data sources, minimum data elements, and collection formats
- ▶ Decisions
 - Acceptable sources, collection format selection considerations
- ▶ Provider communication
 - Key messages, characteristics, and methods



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

Thank You!

Diagnosis Codes and Risk Adjustment



Janet Fry
Aspen Systems Corporation

5-1

Purpose

- ▶ To introduce diagnosis coding and the importance of accurate documentation and coding for risk adjustment.
- ▶ To provide information to assist M+C organizations in communicating with their physician community regarding proper documentation and diagnosis coding.

5-2



Objectives

- ▶ Identify the background, key terms, and organization of ICD-9-CM.
- ▶ Describe the coding update process.
- ▶ Apply common coding guidelines to codes in the CMS-HCC model.

5-3



Objectives (continued)

- ▶ Define and identify V and E codes in the model.
- ▶ Describe the importance of quality documentation.
- ▶ Identify additional resources for training and policy formation.

5-4

Coding & Documentation Benefits

Accurate reimbursement

Management report interpretation

Communication

Planning

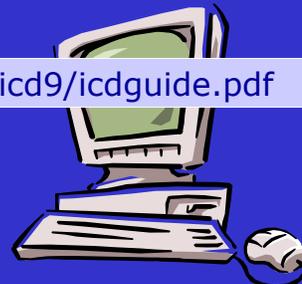
Evaluation

5-5

ICD-9-CM Structure

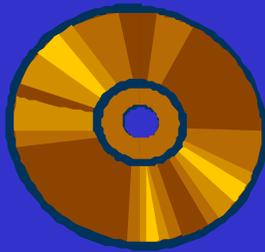
- ▶ Three to five characters.
- ▶ Consistent across publishers.
- ▶ Official guidelines are at:

www.cdc.gov/nchs/data/icd9/icdguide.pdf



5-6

ICD-9-CM Basics



Physicians and Medicare+Choice Risk Adjustment

*Self-paced, CD-based
program on risk adjustment
for physicians.*

ICD-9-CM Basics (continued)

- ▶ Special notes:
 - Excludes/Includes
 - Use additional code
- ▶ Abbreviations:
 - NOS
 - NEC



ICD-9-CM Updates

- ▶ Updated on October 1.
- ▶ 2003 revisions.
- ▶ 2004 proposed revisions.



5-9

ICD-10-CM

- ▶ Background
- ▶ Regulatory process
- ▶ Advantages
- ▶ Basic structure



5-10

CMS-HCC Listing

- ▶ Listing available at:
www.cms.hhs.gov/healthplans/riskadj/
- ▶ Must be supported by medical record.
- ▶ Subject to validation.



5-11

Guidelines Impacting Risk Adjustment

Coexisting conditions

Combination codes

Unconfirmed diagnoses

Clinical documentation specificity

5-12

Guidelines Impacting Risk Adjustment

Coexisting conditions

Combination codes

Unconfirmed diagnoses

Clinical documentation specificity



Guidelines Impacting Risk Adjustment

Coexisting conditions

Combination codes

Unconfirmed diagnoses

Clinical documentation specificity



Guidelines Impacting Risk Adjustment

Coexisting conditions

Combination codes

Unconfirmed diagnoses

Clinical documentation specificity

Guidelines Impacting Risk Adjustment (continued)

"History of" conditions

Cancer codes

Digit specificity (4th and 5th)

Guidelines Impacting Risk Adjustment (continued)

"History of" conditions

Cancer codes

Digit specificity (4th and 5th)



5-17

Guidelines Impacting Risk Adjustment (continued)

"History of" conditions

Cancer codes

Digit specificity (4th and 5th)



5-18



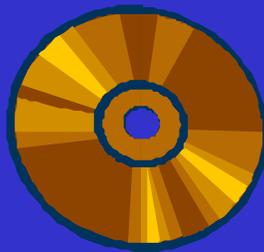
Medical Record Documentation is the Source of all Codes.



5-19



Medical Record Documentation



Physicians and Medicare+Choice Risk Adjustment

*Self-paced, CD-based
program on risk adjustment
for physicians.*

5-20

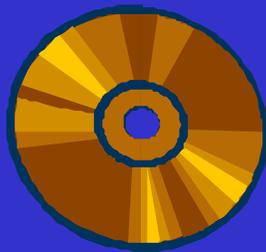
Documentation Tips

- ▶ Use standard abbreviations.
- ▶ Identify each page.
- ▶ Make corrections properly.
- ▶ Evaluate documentation practices.
 - Documentation Improvement Plan



5-21

Medical Record Documentation



Physicians and Medicare+Choice Risk Adjustment

Self-paced, CD-based program on risk adjustment for physicians.



5-22

Exercise



Summary

- ▶ Reviewed benefits of documentation and coding, and importance to risk adjustment.
- ▶ Reviewed structure and update process of ICD-9-CM and ICD-10-CM.
- ▶ Related several common coding guidelines to risk adjustment.
- ▶ Identified resources for training and policy formation.
- ▶ Outlined Documentation Improvement Plan.



Please take a moment to complete the evaluation form for the Diagnosis Codes and Risk Adjustment Module.

Thank You!

Risk Adjustment Data Validation

Lateefah Hughes
Centers for Medicare & Medicaid Services

6-1

Objectives

- ▶ Identify the purpose and goals of risk adjustment data validation
- ▶ Identify the stages of risk adjustment data validation
- ▶ Learn about the components of a medical record request

6-2

Objectives

- ▶ Describe the requirements for acceptable medical record documentation
- ▶ Identify risk adjustment data discrepancies
- ▶ Describe payment adjustments and appeals
- ▶ Provide communication messages

6-3

What is Risk Adjustment Data Validation?

- ▶ The process of verifying that diagnosis codes submitted are supported by medical record documentation
- ▶ Occurs after data is collected and payment is made
- ▶ Currently conducted using medical record review
- ▶ CMS may consider monitoring risk adjustment data submission to better identify plans for data validation

6-4

What is Risk Adjustment Data Validation?

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



6-5

Data Validation Goals

- ▶ Implement an accurate M+C payment system
- ▶ Measure the accuracy of risk adjusted payments
- ▶ Improve the quality of risk adjustment data
- ▶ Improve the CMS-HCC risk adjustment model



6-6

Data Validation Goals

- ▶ Identify risk adjustment data discrepancies
- ▶ Communicate risk adjustment data validation findings
- ▶ Identify plans that need additional technical assistance to improve the quality of risk adjustment data

6-7

Risk Adjustment Data Validation Background

- ▶ Data validation activities for CY2000, CY2001, CY2002, and CY2003 based on PIP-DCG model
- ▶ Medical record review used to determine PIP discrepancies
- ▶ Only reviewed hospital inpatient medical records

6-8



What is Different for Data Validation Under the CMS-HCC Model?

- ▶ We review hospital inpatient, hospital outpatient and physician medical records
- ▶ More flexible approach
- ▶ Provider identifiers not given—plans need to track RAPS data to provider

6-9



Risk Adjustment Data Validation Process

← STAGE 1

Plan Selection/Medical Record Request

← STAGE 2

Medical Record Review

← STAGE 3

Plan-Level Findings

6-10

Risk Adjustment Data Validation Process

← STAGE 4

Payment Adjustment

← STAGE 5

Appeals

← STAGE 6

Correct Payment



6-11

Guiding Principle

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



6-12



Guidelines for Data Validation

- ▶ Medical record documentation must support an assigned HCC
- ▶ Beneficiaries selected based on RAPS diagnosis clusters
- ▶ Plan selects “one best medical record”
 - Plan must identify date of service and dx code

6-13



Guidelines for Data Validation

- ▶ Submit entire medical record for the year or parts of the record
- ▶ Allow for “additional medical records”—not linked to diagnosis clusters
- ▶ Payment adjustments are based on confirmed risk adjustment discrepancies
- ▶ Appeals process in place for disputes

6-14

Components of Data Validation Process

- ▶ Sampling
- ▶ Medical Record Request Package
- ▶ Receipt of Medical Records by the Initial Validation Contractor (IVC)



6-15

← STAGE 1

Sampling

- ▶ CMS designs sampling plan to select M+C organizations for data validation
- ▶ M+C organizations selected first; beneficiary HCCs selected second
- ▶ Sample based on payment year risk adjustment data



6-16

← **STAGE 1**

Sampling

- ▶ Random and targeted selection
- ▶ National random sample to estimate:
 - Net payment error
 - Data discrepancy rates
- ▶ Targeting criteria may include:
 - Patterns in risk adjustment data suggesting problems
 - Plan past performance in data validation
 - Specific HCCs



6-17

← **STAGE 1**

Medical Record Request Package

- ▶ Plans will receive comprehensive instructions
- ▶ Beneficiary list with diagnosis clusters and validation HCCs identified (example on page 6-7)



6-18

STAGE 1

Medical Record Request Package

- ▶ Medical Record Coversheet
 - One coversheet for each beneficiary HCC being validated
 - Shows all RAPS diagnosis clusters for an HCC
 - Plan must identify ICD-9 code and service date selected
 - Used to identify an “additional medical record”
 - See Attachment A



6-19

STAGE 1

Additional Medical Records

- ▶ Related to a service not submitted to RAPS or no exact match for a diagnosis cluster
- ▶ Service must occur during data collection period
- ▶ Must be from acceptable risk adjustment provider type
- ▶ Must provide ICD-9 code and service date on medical record coversheet



6-20

← **STAGE 1**

Receipt of Medical Records by the IVC

- ▶ All requested medical records and coversheets sent to IVC
- ▶ IVC logs the receipt of medical records
- ▶ May include administrative check and clinical check
- ▶ All medical records assigned to a category: "OK", problem, or missing



6-21

What Do We Mean by Medical Record Documentation?

- ▶ Parts of the provider/physician medical record that support an assigned HCC based on an ICD-9 code from a particular date of service
- ▶ ICD-9 code must be assigned in accordance with *ICD-9 Coding Guidelines* based on medical record documentation



6-22

Medical Record Documentation

- ▶ Clear
- ▶ Concise
- ▶ Consistent
- ▶ Complete
- ▶ Legible

6-23

Medical Record Documentation

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes.

Source: 1997 Documentation Guidelines for Evaluation and Management Services

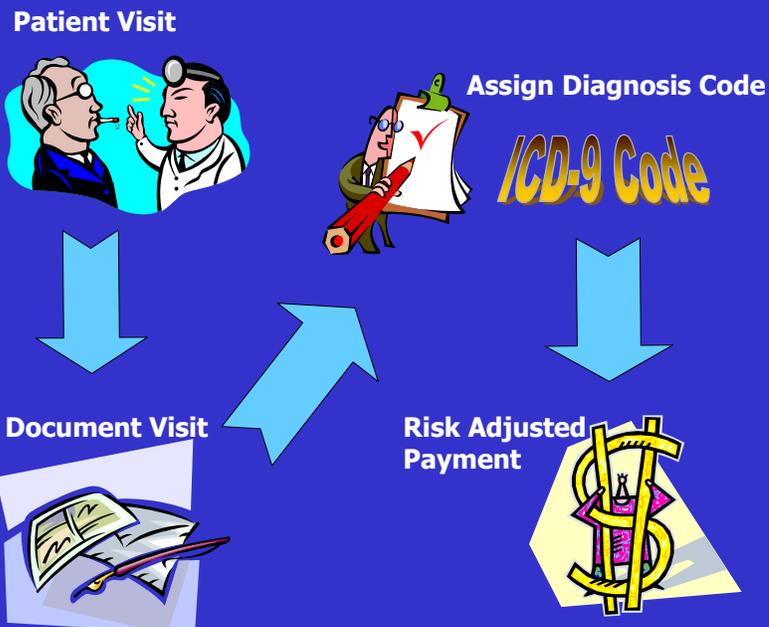
6-24

Medical Record Documentation

- ▶ Patient identification
- ▶ Date(s) of service
- ▶ Persons treating patients
 - Physician
 - All participants in care & treatment
- ▶ Reason for the visit
- ▶ Care rendered
- ▶ Conclusion & diagnosis(es)
- ▶ Follow-up plan



6-25



6-26

Medical Record Documentation

- ▶ Only authorized medical staff may document the patient medical record
- ▶ The person who documents the record must be identified
- ▶ Signatures are required



6-27

Types of Medical Records for Risk Adjustment

- ▶ Hospital Inpatient
- ▶ Hospital Outpatient
- ▶ Physician



6-28

Hospital Inpatient Documentation

- ▶ May include, but not limited to:
 - Face sheet
 - History and physical exam
 - Physician orders
 - Progress notes
 - Operative and pathology reports
 - Consultation reports
 - Diagnostic reports
 - Discharge summary

Hospital Outpatient & Physician Documentation

- ▶ General Guidelines
 - Coder able to determine that a patient evaluation was performed by physician
 - ICD-9 code assigned based on patient evaluation and clinical findings/treatment
 - Physician signature and date of service present



Hospital Outpatient & Physician Documentation

- ▶ May include, but not limited to:
 - Face sheet
 - History and physical exam
 - Physician orders
 - Progress notes
 - Diagnostic reports
 - Consultation reports

6-31



Hospital Outpatient & Physician Documentation

- ▶ Do not send medical record documentation that reflects a “probable”, “suspected”, “questionable”, “rule out”, or “working” diagnosis

6-32



Hospital Outpatient & Physician Documentation

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

6-33



Hospital Outpatient & Physician Documentation

- ▶ **Problems** with Diagnostic Radiology Reports
 - M+C organizations are relying on the referral diagnosis—this is not a confirmed diagnosis
 - Generally do not indicate a confirmed diagnosis
 - Generally indicate impression only
 - Referring physician/PCP usually reviews and documents condition

6-34

Hospital Outpatient & Physician Documentation

- ▶ Guidance for Diagnostic Radiology Reports
 - Do not send diagnostic radiology medical records if other documentation is available
 - If it is the only documentation, then review to ensure documentation is sufficient to assign code
 - If documentation is insufficient, then HCC will be discrepant

6-35

Hospital Outpatient & Physician Documentation

- ▶ Nursing Home Resident Medical Record
 - OK if beneficiary is long term institutional resident
 - Physician billing independently (not employed by the nursing home)
 - Visits must be face-to-face

6-36



What is Unacceptable Medical Record Documentation?

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

6-37



What is Unacceptable Medical Record Documentation?

- ▶ Unacceptable Types of Documentation
 - Superbill
 - Physician signed attestation
 - List of patient conditions
 - Diagnostic report that has not been interpreted
 - Any documentation for dates of service outside the data collection period

6-38

← STAGE 1

Selecting Medical Records for Data Validation

- ▶ Select “one best medical record”
- ▶ Due to variation in physician office medical record documentation, select institutional medical record (hospital inpatient & hospital outpatient) if a choice is available

EXERCISE



STAGE 2

Medical Record Review

- ▶ Data validation is accomplished through medical record review
- ▶ Certified coders review records and abstract diagnosis code
- ▶ Coder validates date of service



6-41

STAGE 2

Medical Record Review

- ▶ During medical record review the following are checked/captured:
 - Check for provider signature
 - Check coversheet diagnosis against medical record diagnosis
 - Indicate yes/no for date of service in data collection period
 - Coder notes on diagnosis code assignment
 - Medical record from an acceptable provider type



6-42

STAGE 2

Data Discrepancies

- ▶ Identified when the diagnostic data selected for risk adjustment data validation is not supported by medical record documentation
- ▶ Include coding discrepancies, invalid medical records, and missing medical records

6-43

STAGE 2

Coding Discrepancies

- ▶ ICD-9 code at the 3 digit level does not match selected data
- ▶ ICD-9 code at the 4th and 5th digit level does not match selected data
- ▶ Medical record documentation is insufficient to justify the assignment of an ICD-9 code
- ▶ Examples on page 6-14

6-44

STAGE 2

Invalid Medical Records

- ▶ Unacceptable risk adjustment provider type (e.g., SNF)
- ▶ Missing components required to code (e.g., surgeon record missing operative report)
- ▶ Date of service outside of data collection period



6-45

STAGE 2

Missing Medical Records

- ▶ ICD-9 code cannot be assigned for the date of service
- ▶ No medical record was submitted



6-46

STAGE 2

Risk Adjustment Discrepancies

- ▶ Identified when an HCC originally assigned based on submitted risk adjustment data is different from the HCC assigned after data validation
- ▶ Affects beneficiary risk score



6-47

STAGE 2

Risk Adjustment Discrepancies

Reported Diagnostic Data:

482.4 *Staphylococcal Pneumonia* (HCC111, .693)

Data Validation Findings:

482.3 *Streptococcal Pneumonia* (HCC112, .202)



6-48

← STAGE 2

Risk Adjustment Discrepancies

- ▶ All risk adjustment discrepancies go to the SVC for second, independent medical record review
- ▶ Basis for payment adjustment



6-49

← STAGE 3

Data Validation Findings

- ▶ M+C organization specific information shared with data validation participants
 - May include: response rate, data discrepancy rate, & risk adjustment discrepancy rate
- ▶ Summary findings shared with the M+C industry



6-50

STAGE 4

Payment Adjustment

- ▶ Ensures risk adjusted payment integrity and accuracy
- ▶ Based on confirmed risk adjustment discrepancies
- ▶ CMS develops payment adjustment criteria
- ▶ Criteria may include “consistent pattern” of inaccurate data for previous and current payment years



6-51

STAGE 4

Payment Adjustment

- ▶ Consistent patterns may be based on:
 - High risk adjustment discrepancy rates—(≥ 2 standard deviations above national average discrepancy rate)
 - High payment error rate—(≥ 2 standard deviations above national average payment error rate)
 - 2 consecutive years of inaccurate risk adjustment data (based on validation findings)

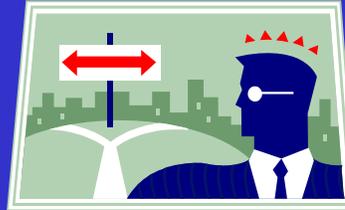


6-52

STAGE 4

Payment Adjustment

Payment adjustment decisions are made by the CMS Administrator



STAGE 5

Appeals

- ▶ Purpose: To allow M+C organizations an opportunity to dispute a payment adjustment
 - M+C organizations may offer a different interpretation of the ICD-9 code assignment based on *ICD-9 Coding Guidelines*
 - M+C organizations may provide additional medical record documentation

← STAGE 5

Appeals

- ▶ Consistent with Medicare fee-for-service procedures
- ▶ M+C organization has 60 days to file an appeal after adjustment is made and appears on the MMR



6-55

← STAGE 5

Appeals

- ▶ Appeals must include:
 - A clearly documented reason for disagreement with the medical record review findingAND/OR
 - Additional medical record documentation to support reason for appeal



6-56



STAGE 5

Appeals

- ▶ Every appeal reviewed by an expert coding panel
- ▶ Panel may include: senior medical reviewer, senior coder, and physician
- ▶ SVC implements the appeals process

6-57



STAGE 6

Correct Payment

- ▶ Risk adjusted payment is determined to be correct after data validation if:
 - No risk adjustment discrepancies were found
 - A risk adjustment discrepancy resulted in a payment adjustment and is not appealed
 - If payment adjustment appealed, then post-appeals payment decision is correct

6-58

Lessons Learned from CMS-HCC Pilot Test

- ▶ Notify physician prior to sending the medical record request
- ▶ Identify a contact person at the physician's office
- ▶ Follow-up with physician's office after medical record request is sent
- ▶ Sending request to a "physician group practice" may not be effective, rather send to the individual physician, if known



6-59

Lessons Learned from CMS-HCC Pilot Test

- ▶ Involve in-house quality assurance staff/medical record reviewers/medical director to help with the identification of the "one best medical record"
- ▶ On average, it took approximately 2 weeks to receive a physician medical record
- ▶ Medical records from specialists and non-contracted providers may be more difficult to obtain
- ▶ Some plans had to pay a fee prior to receiving requested medical records



6-60



M+C Organization Considerations for Data Validation Participation

- ▶ Previous medical record request process (hospital inpatient records only) may not be sufficient for ambulatory medical records
- ▶ Plans could review medical records prior to submission for data validation
- ▶ Consider having the physician indicate the date of service and diagnosis code

6-61



M+C Organization Considerations for Data Validation Participation

- ▶ Tracking the status of medical record requests is critical to the process
- ▶ Consider that organization staff involved in the medical record request process may need to be educated about risk adjustment and the CMS-HCC data validation process
- ▶ Include staff involved in the medical record request process in all conference calls with CMS and the IVC

6-62



Communication Messages

- ▶ Every M+C organization (H #) has a chance of being selected for risk adjustment data validation
- ▶ Good medical record documentation = accurate ICD-9 codes = accurate risk adjusted payment
- ▶ All staff involved should be informed about and understand risk adjustment data validation process

6-63



Communication Messages

- ▶ Plan is responsible for identifying date of service and ICD-9 code submitted for HCC validation
- ▶ Plan must be able to track diagnosis codes back to providers
- ▶ Notify physicians early in the medical record request process
- ▶ Use newsletters and CMS training tools to inform physicians about risk adjustment

6-64

Technical Assistance

- ▶ Available for M+C organizations that need more training or specific assistance with data validation
- ▶ Contact CMS staff (see page 6-18 for contact information)



6-65

Current vs. Future Data Validation

- ▶ Current
 - Based on PIP-DCG risk adjustment model and hospital inpatient risk adjustment data
 - CY2001: Payment adjustments conducted
 - CY2002: Finalizing medical record review findings
 - CY2003: Medical records requested; due April 30, 2004



6-66



Current vs. Future Data Validation

- ▶ Future
 - Based on hospital inpatient, hospital outpatient, and physician risk adjustment data
 - CY2004: Medical record requests expected in Fall 2004

6-67



Next Steps

- ▶ CMS is considering other ways to validate risk adjustment data
- ▶ Validating drug data (MMA) will present new issues for data validation

6-68



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

Thank You!

Data Submission



Janet Fry
Aspen Systems Corporation

4-1

Purpose

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

4-2

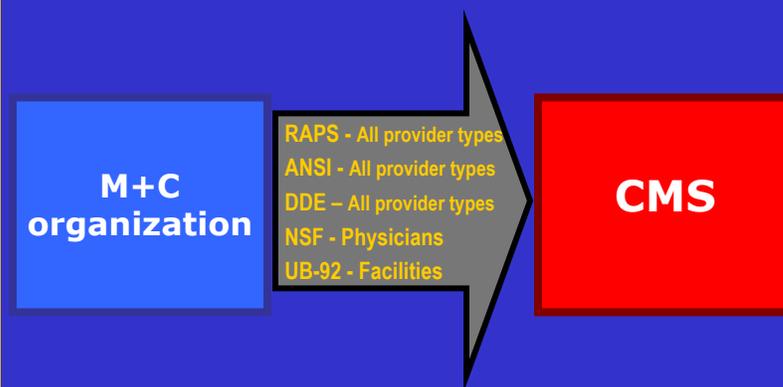
Objectives

- ▶ Understand the basics of RAPS file layout.
- ▶ Identify and describe diagnosis clusters in the RAPS format.
- ▶ Describe the process for modifying cluster data.



4-3

Submission Formats

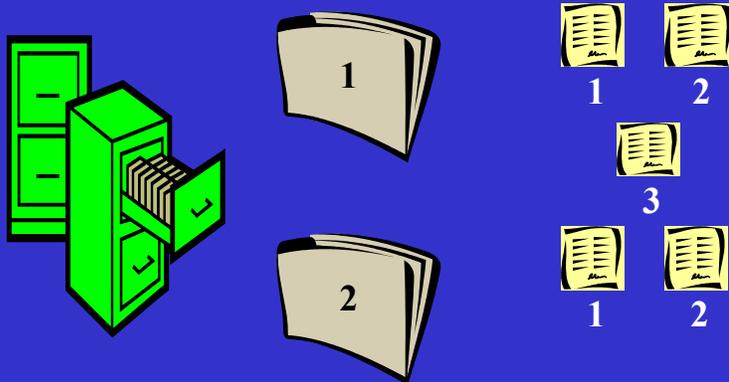


4-4



File Layout Logic

File Level **Batch Level** **Detail Level**



4-5



File Logic

RT AAA – File Header (Submitter Info) Always the first record on the file, and must be followed by RT BBB.

**F
I
L
E**

**B
A
T
C
H** **RT BBB – Batch Header (Plan Info)**
Must follow RT AAA or RT YYY, and must be followed by RT CCC.

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

RT YYY – Batch Trailer
Must follow RT CCC and may be followed by another RT BBB or RT ZZZ.

RT ZZZ – File Trailer
Must follow RT YYY, and must be the last record on the file.

4-6



Diagnosis Cluster

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

4-7



Diagnosis Cluster Information

Patient control number, HIC number, and date of birth

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|-----|------|------|------|------|------|------|------|------|------|
| 9.0 | 10.0 | 11.0 | 12.0 | 13.0 | 14.0 | 15.0 | 16.0 | 17.0 | 18.0 |
| 9.1 | 10.1 | 11.1 | 12.1 | 13.1 | 14.1 | 15.1 | 16.1 | 17.1 | 18.1 |
| 9.2 | 10.2 | 11.2 | 12.2 | 13.2 | 14.2 | 15.2 | 16.2 | 17.2 | 18.2 |
| 9.3 | 10.3 | 11.3 | 12.3 | 13.3 | 14.3 | 15.3 | 16.3 | 17.3 | 18.3 |
| 9.4 | 10.4 | 11.4 | 12.4 | 13.4 | 14.4 | 15.4 | 16.4 | 17.4 | 18.4 |
| 9.5 | 10.5 | 11.5 | 12.5 | 13.5 | 14.5 | 15.5 | 16.5 | 17.5 | 18.5 |
| 9.6 | 10.6 | 11.6 | 12.6 | 13.6 | 14.6 | 15.6 | 16.6 | 17.6 | 18.6 |
| 9.7 | 10.7 | 11.7 | 12.7 | 13.7 | 14.7 | 15.7 | 16.7 | 17.7 | 18.7 |

One CCC Record

4-8



Relevant Diagnosis

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

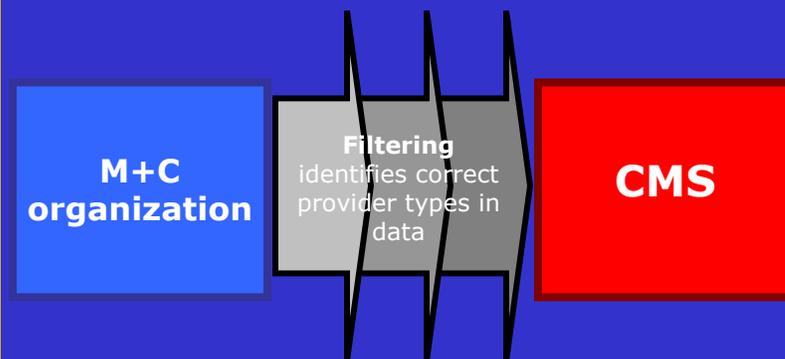


TIP!
Submit at least once during a reporting period for each beneficiary.

4-9



Filtering Data



4-10

Filtering Data (continued)

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



4-11

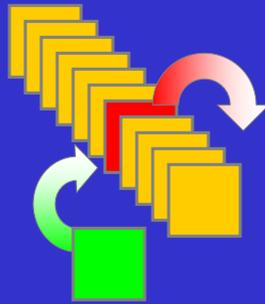
Modifying Data

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



4-12

Correcting Data



▶ Two-step process:

- Delete incorrect data from cluster.
- Add correct data to cluster.

4-13

Correcting Data: Step 1 - Delete Incorrect Cluster

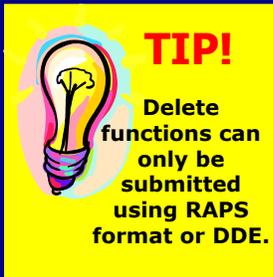
- ▶ Identify incorrect cluster.
- ▶ Enter "D" in appropriate field.
- ▶ Submit file.
- ▶ Transmit to FERAS.

DDE is a slightly different process!

4-14

Step 2: Add Correct Cluster

- ▶ Submit correct data cluster in a succeeding file transmission.



Exercise



Summary

- ▶ Reviewed the RAPS file layout and critical elements required for risk adjustment.
- ▶ Described the filtering process.
- ▶ Completed an exercise on correcting data that has been stored.



4-17



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

Thank You!



4-18

Edits



Ed Sommers
Aspen Systems Corporation

7-1

Purpose

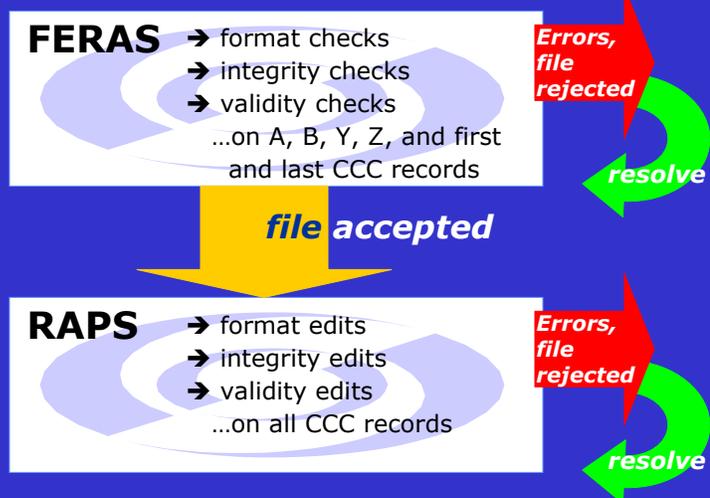
- ▶ To provide participants with an understanding of risk adjustment system edits.
- ▶ To describe common edits and assist M+C organizations with the required steps to prevent future errors.

7-2

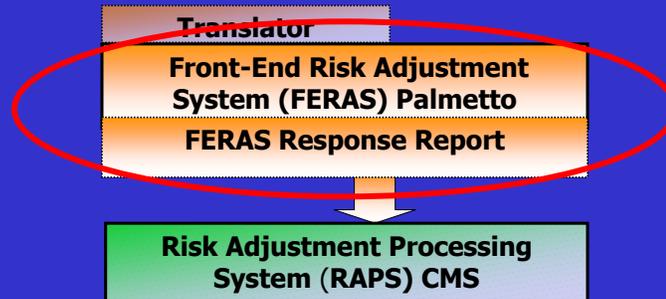
Objectives

- ▶ Understand FERAS and RAPS data integrity logic and error codes.
- ▶ Describe FERAS and RAPS editing processes.
- ▶ Recognize common FERAS and RAPS errors and determine action required to avoid or correct them.

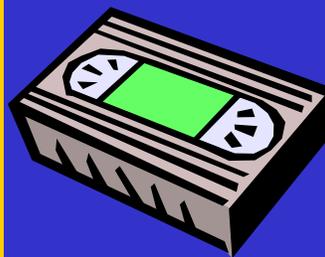
Data Flow



FERAS Checks



Getting Started



Getting Started Video Training Program

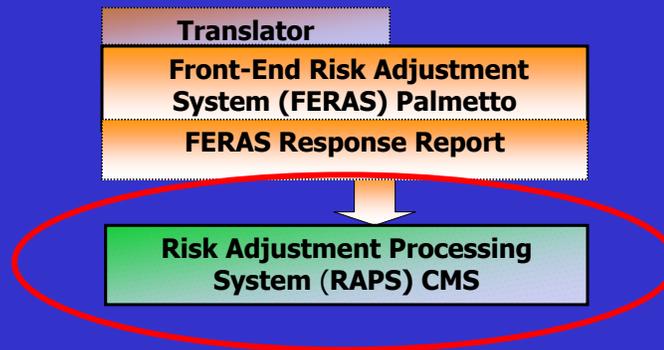
*Self-paced, video-based
training program on risk
adjustment for M+C
organizations*

Edits Logic

| Series | Explanation |
|-----------|--|
| 100 | File level errors on the AAA or ZZZ records. This editing is performed in FERAS. |
| 200 | Batch level errors on the BBB or YYY records. This editing is performed in FERAS. |
| 300 & 400 | Check performed on first and last CCC records. |

The entire file is returned to the submitter.

RAPS Edits





RAPS Editing Rules

Stage 1 - Field Validity and Integrity edits

Stage 2 - Field-to-Field edits

Stage 3 - Medicare Beneficiary Database edits

Stage 4 - Diagnosis Code edits



7-9

RAPS Error Codes

| | Series | Explanation of error and consequences |
|---------|---------|--|
| Record | 300-349 | Record level error - The record was bypassed and all editing was discontinued. No diagnosis clusters from this record were stored. |
| | 350-399 | Record level error - All possible edits were performed, but no diagnosis clusters from this record were stored. |
| Cluster | 400-489 | Diagnosis cluster error - All possible diagnosis edits were performed, but the diagnosis cluster is not stored. |
| | 490-499 | Diagnosis delete error - Diagnosis was not deleted. |
| | 500-599 | Informational message, all edits were performed, diagnosis cluster was stored unless some other error is noted. |



7-10

Resolution Steps

- 1 Determine error level of code to identify nature of problem.**
- 2 Look up error code and read its associated message.**
- 3 Based on error message, determine next step.**
- 4 Take steps to resolve error.**

FIVE COMMON ERRORS



"Duplicate File Name" Error

- ▶ File identifier must be unique.
- ▶ Submitter cannot reuse within 12 months if accepted in Test or Production.

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

7-13



"Duplicate File Name" Correction

- ▶ This error is identified in FERAS.
- ▶ This generates a 100 level error code – 113.
- ▶ Correct data in the AAA 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.

7-14



“Delete Error, Diagnosis Cluster Previously Deleted” Error

- ▶ Clusters are never physically deleted from the RAPS database.
- ▶ RAPS database stores a “D” in the delete indicator and delete date.
- ▶ Cannot delete the exact same cluster more than once.

7-15



“Delete Error, Diagnosis Cluster Previously Deleted” Correction

- ▶ This error is identified in RAPS.
- ▶ This generates a 400 level error code – 491.
- ▶ No corrective action is necessary because the cluster has already been deleted.

7-16



"Diagnosis Cluster Not Successfully Deleted" Error

- ▶ Diagnosis cluster must have one unique attribute in the key in order to be stored.
- ▶ Creation of a second delete cannot process since second delete will cause the creation of a duplicate record.



"Diagnosis Cluster Not Successfully Deleted" Correction

- ▶ This error is identified in RAPS.
- ▶ This generates a 400 level error code – 492.
- ▶ Determine if cluster should be deleted or active as a final action.
 - If active – no further action required
 - If delete – organization must submit one delete record



"Service Date Not Within M+C 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.



"Service Date Not Within M+C Enrollment" Correction

- ▶ Check service dates and correct if necessary.
- ▶ Verify M+C enrollment in MBD.
- ▶ Create a new file, batch, and CCC record.
 - Correct 408 in record field 9.1
 - Correct 409 in record field 9.2



"Not Enrolled In Plan" Error

- ▶ Patient was not enrolled in your plan on or after the from dates of service.
- ▶ RAPS checks eligibility in Stage 3 of the editing process.

7-21



"Not Enrolled In Plan" Correction

- ▶ Verify plan enrollment in MBD.
- ▶ Check service dates and correct if necessary.
- ▶ Create file, batch, and CCC record.

7-22

Summary

- ▶ Described FERAS checks for format, integrity and base validity of data.
- ▶ Discussed that RAPS edits the detail level data.
- ▶ Identified five common errors.
- ▶ Outlined steps required to prevent and common errors.



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

Thank You!

Medicare Beneficiary Database



Ed Sommers
Aspen Systems Corporation

8-1

Purpose

- ▶ To provide details and instructions on accessing and researching crucial eligibility and demographic data using the Medicare Beneficiary Database (MBD).

8-2

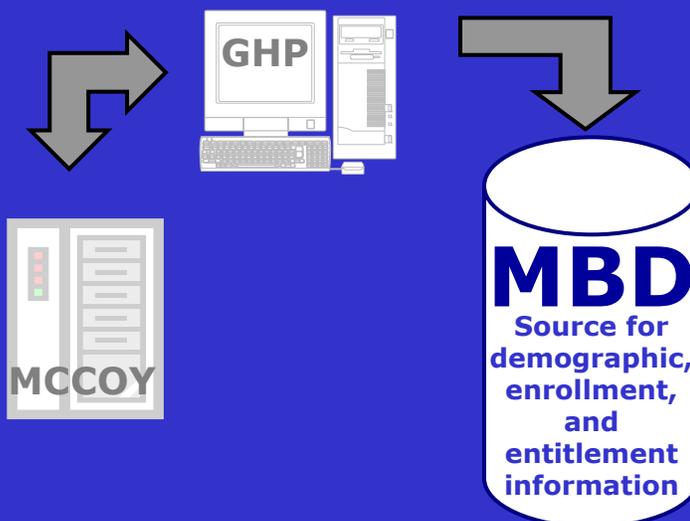
Objectives

- ▶ Identify the purpose of the Medicare Beneficiary Database.
- ▶ Identify major categories of data in MBD.
- ▶ Interpret system access instructions.
- ▶ Understand common risk adjustment uses of the database.
- ▶ Contact appropriate resources.

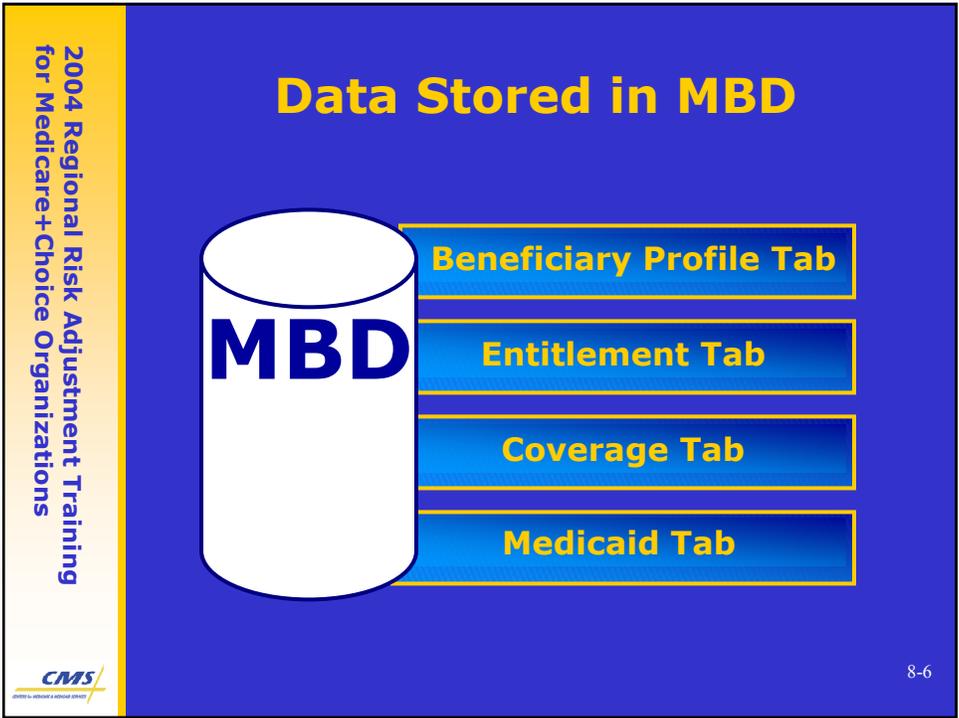
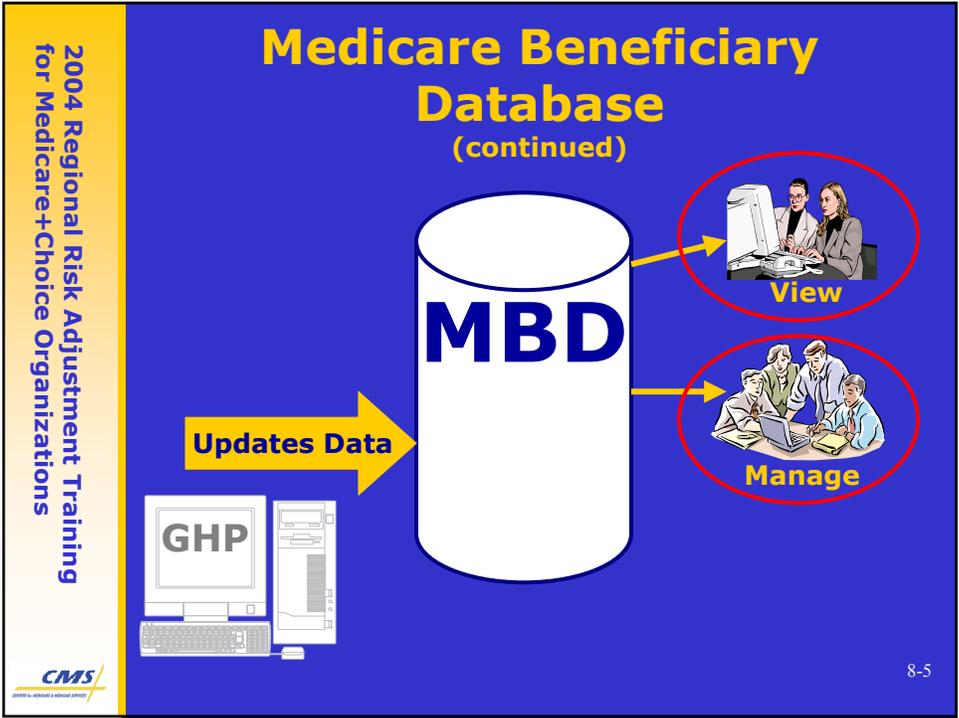


8-3

Medicare Beneficiary Database



8-4





Beneficiary Profile

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

8-7



Entitlement Tab

- ▶ Enrollment Coverage
 - Part A and Part B Only
 - Entitlement Effective Date
 - Entitlement Termination Date
 - Entitlement Status Code
 - Entitlement Reason Code

8-8

Coverage Tab

- ▶ Medicare+Choice Elections – Plan Number
- ▶ Enrollment Effective Date
- ▶ FFS Period Effective Date
- ▶ Managed Care Institutional Status
- ▶ Coverage Effective Date
- ▶ Coverage Termination Date
- ▶ Other Insurance Profile

8-9

Medicaid Tab

- ▶ Medicaid Eligibility Periods
 - Provides a profile of current and historical Medicaid eligibility periods

8-10

Completing MBD Access Application

- ▶ Download MBD application:
<http://cms.hhs.gov/mdcn/access.pdf>
- ▶ When necessary:
 - To acquire new access
 - To change names
 - To change access needs/job duties
 - To seek recertification
 - When user retires, resigns, or leaves organization



8-11

Accessing MBD



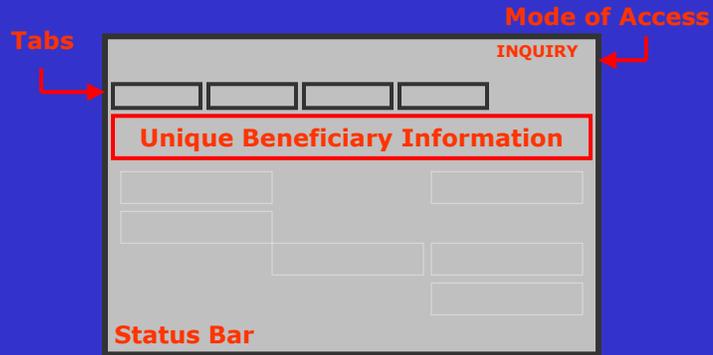
- ▶ Required:
 - User ID & password
 - Authorized level to update & view
- ▶ Security levels restrict access



8-12



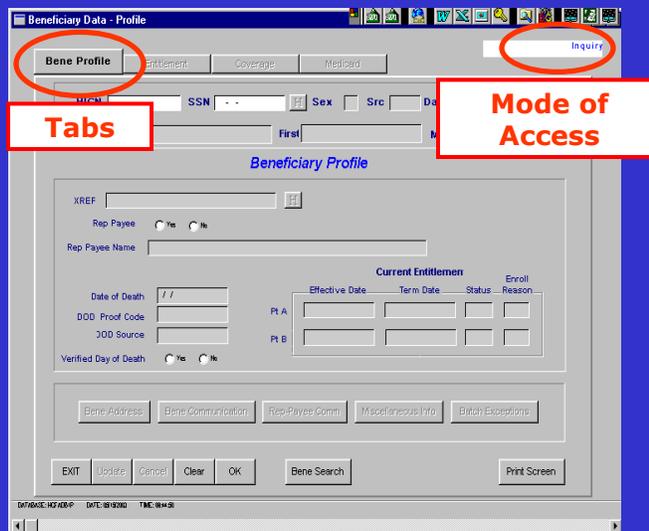
Navigating MBD



8-13



Components of the MBD



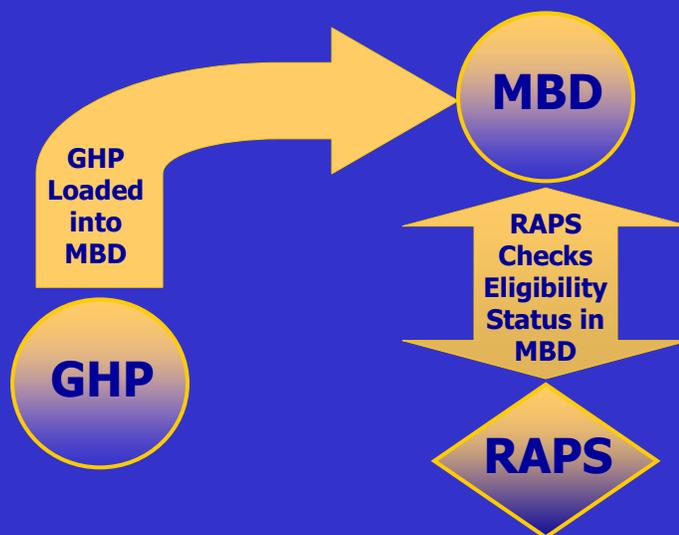
8-14

Components of the MBD (continued)

The screenshot shows a software window titled "Beneficiary Data - Profile". It contains several tabs: "Beneficiary Profile", "Entitlement", "Coverage", and "Medicaid". The "Beneficiary Profile" tab is active. The form includes fields for HICN, SSN, Sex, Date of Birth, Name (Last, MI, First), and Rep Payee Name. There is a section for "Current Entitlement" with fields for Effective Date, Term Date, Status, and Reason. Below this are buttons for "Basic Address", "Basic Communication", "Rep Payee Comm", "Miscellaneous Info", and "Batch Exceptions". At the bottom, there is a "Status Bar" with "EXIT", "Update", and "Print Screen" buttons. A red oval highlights the top navigation tabs, and another red oval highlights the "Unique Beneficiary Information" fields. A red box highlights the "Status Bar".

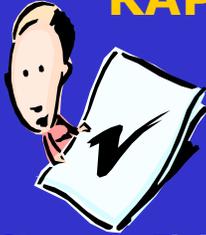
8-15

MBD Flow of Data



8-16

RAPS Editing Rules



Stage 1 - Field Validity and Integrity edits

Stage 2 - Field-to-Field edits

Stage 3 - Medicare Beneficiary Database edits

Stage 4 - Diagnosis Code edits



8-17

MBD/RAPS Editing Process

| Error Code | Record ID | Error Description |
|------------|-----------|--|
| 353 | CCC | HIC number does not exist on MBD. |
| 354 | CCC | Patient DOB does not match with MBD DOB. |
| 406/407 | CCC | Service date(s) outside of beneficiary entitlement date. |
| 408/409 | CCC | Patient not enrolled with any M+C at time of service(s). |
| 410 | CCC | Patient was not enrolled in your M+C plan at time of service(s). |
| 411 | CCC | Service through date greater than date of death. |



8-18

Exercise



Your One Stop Shop for Assistance



CSSC
(877) 534-2772

- ▶ Need information while waiting for access.
- ▶ Check beneficiary status until H number is assigned.
- ▶ Receive assistance with data issues when MBD differs from MCCOY.

Summary

- ▶ Identified the purpose of the Medicare Beneficiary Database.
- ▶ Interpreted system access instructions.
- ▶ Covered common risk adjustment uses of the database.
- ▶ Identified appropriate resource contacts.



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

Thank You!

Reports



Ed Sommers
Aspen Systems Corporation

9-1

Purpose

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

9-2



Objectives

- ▶ Identify the purpose of each risk adjustment report.
- ▶ Determine the best uses of the reports to monitor data collection and submission processes, and to resolve errors.
- ▶ Accurately read the risk adjustment reports and identify and submit corrections.

9-3

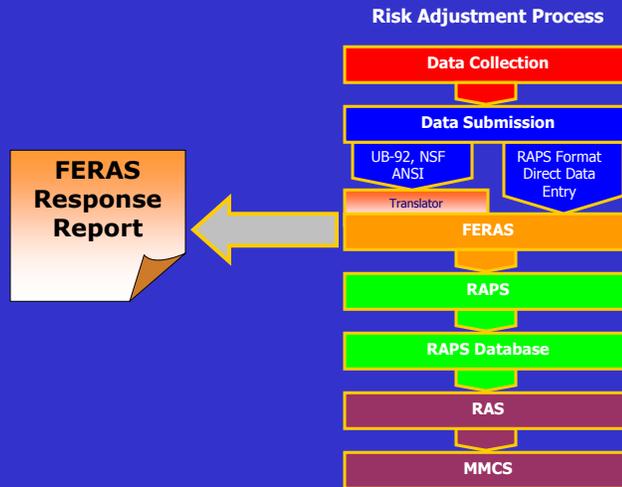


Objectives (continued)

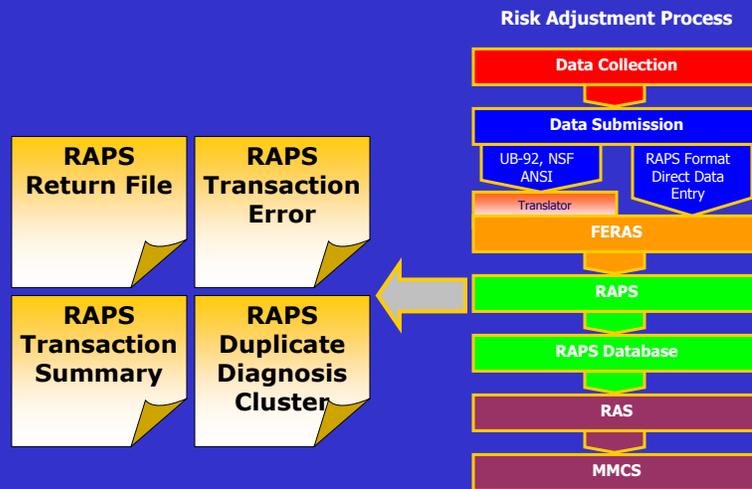
- ▶ Understand the relationship between values in the RAPS Transaction Summary and the management reports.
- ▶ Compare accepted diagnosis clusters to benchmarks.

9-4

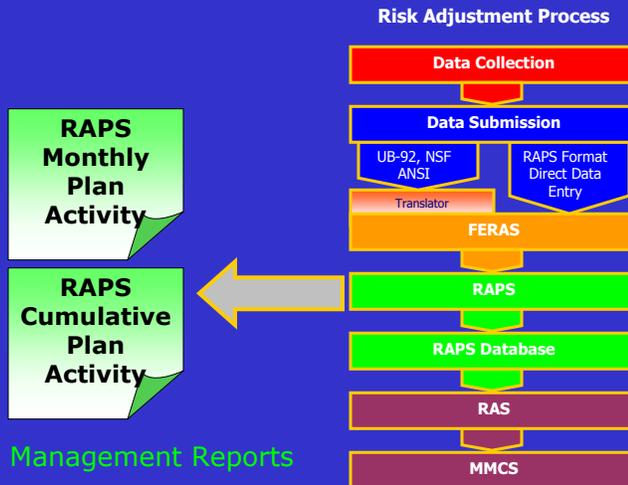
Reports Overview



Reports Overview



Reports Overview



FERAS Response Report

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

RAPS Return File

- ▶ Contains all submitted transactions.
- ▶ Error codes appear in the file.
- ▶ Flat file format may be downloaded to an Access or Excel database.
- ▶ Returned the next business day after submission.



9-9

Uses for RAPS Return File Format

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

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

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



Improve the quality and quantity of data submissions!



9-10

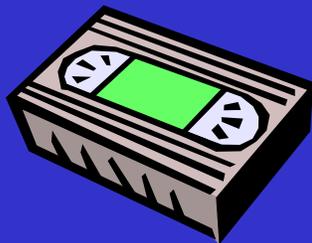
RAPS Transaction Error Report

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



9-11

Getting Started



Getting Started Video Training Program

*Self-paced, video training
program on risk adjustment
for M+C organizations and
other submitters*



9-12

Exercise



RAPS Transaction Summary Report

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

Relationship Between Values in RAPS Transaction Summary Report

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

Total Stored \leq Total Accepted

Total Model Diagnoses Stored \leq Total Stored



9-15

RAPS Duplicate Diagnostic Cluster Report

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



9-16

RAPS Monthly Plan Activity Report

- ▶ Provides a summary of the status of submissions for a one-month period.
- ▶ Arrayed by provider type and month based on through date of service.
- ▶ Reported by submitter ID and H number.
- ▶ Allows tracking on a month-by-month basis of all diagnosis clusters submitted.
- ▶ Available for download the second business day of the month.



9-17

Analysis of Monthly Plan Activity Report

RAPS MONTHLY PLAN ACTIVITY REPORT



9-18

Analysis of Monthly Plan Activity Report

RAPS MONTHLY PLAN ACTIVITY REPORT

The diagram shows a grid for the RAPS Monthly Plan Activity Report. On the left, there are four empty rectangular boxes representing rows. A red arrow points downwards along the left side of these boxes. To the right, there are seven columns representing months: July, Aug, Sept, Oct, Nov, Dec, and Total. A red arrow points horizontally across the top of these columns. A grey text box is overlaid on the grid with the text: "Review data submitted across the page by month."

Analysis of Monthly Plan Activity Report

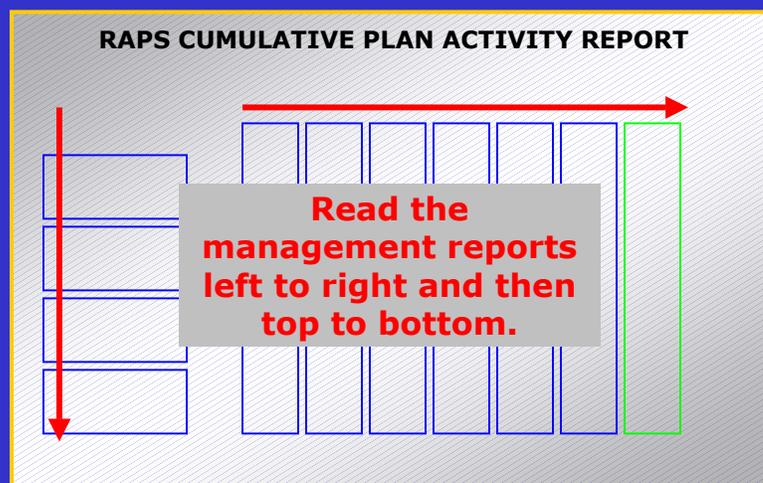
RAPS MONTHLY PLAN ACTIVITY REPORT

The diagram shows a grid for the RAPS Monthly Plan Activity Report. On the left, there are four boxes representing provider types: Principal Inpatient, Other Inpatient, Outpatient, and Physician. A red arrow points downwards along the left side of these boxes. To the right, there are seven columns representing months: July, Aug, Sept, Oct, Nov, Dec, and Total. A red arrow points horizontally across the top of these columns. A grey text box is overlaid on the grid with the text: "Review data down the page by provider type."

RAPS Cumulative Plan Activity Report

- ▶ Provides a cumulative summary of the status of submissions.
- ▶ Report format similar to Monthly Plan Activity Report.
- ▶ Allows M+C organizations to compare submission rates to benchmarks.
- ▶ Service year "9999" indicates data has been rejected (not stored).
- ▶ Available for download the second business day of the month.

Analysis of Cumulative Plan Activity Report



Estimated Benchmarks

| Provider Type | Total Diagnoses | | All Model Diagnoses | | Unique Model Diagnoses | |
|---------------------|-----------------|------|---------------------|------|------------------------|------|
| | n | % | n | % | n | % |
| Physician | 25 | 75.7 | 6 | 74.1 | 2.2 | 66.7 |
| Hospital Outpatient | 6 | 18.2 | 1.3 | 16 | 0.4 | 12.1 |
| Hospital Inpatient | 2 | 6.1 | 0.8 | 9.9 | 0.7 | 21.2 |
| Total | 33 | 100 | 8.1 | 100 | 3.3* | 100 |

*Are not unduplicated across provider types.



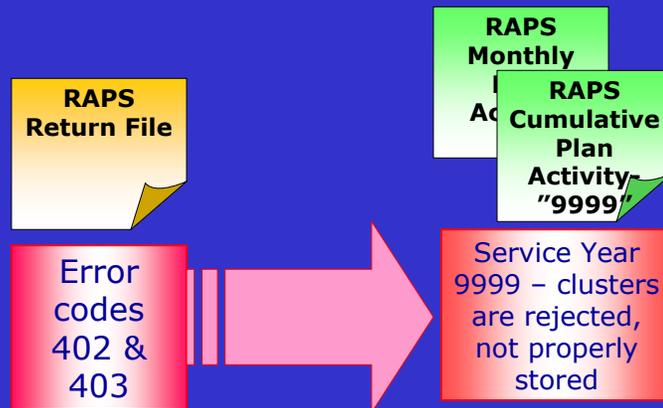
9-23

Exercise



9-24

Management Reports "9999"



Management Reports Summary



- ▶ Identify internal processes affecting data collection and submission.
- ▶ Identify external issues affecting data collection.
- ▶ Compare data submitted to benchmarks.



Naming Conventions

| REPORT NAME | MAILBOX IDENTIFICATION |
|--------------------------------------|------------------------------|
| FERAS Response Report | RSP####.RSP.FERAS_RESP |
| RAPS Return File | RPT####.RPT.RAPS_RETURN_FLAT |
| RAPS Transaction Error Report | RPT####.RPT.RAPS_ERROR_RPT |
| RAPS Transaction Summary Report | RPT####.RPT.RAPS_SUMMARY |
| RAPS Duplicate Cluster Report | RPT####.RPT.RAPS_DUPDX_RPT |
| RAPS Monthly Plan Activity Report | RPT####.RPT.RPAS_MONTHLY |
| RAPS Cumulative Plan Activity Report | RPT####.RPT.RAPS_CUMULATIVE |

9-27



Plan Monitoring Process

- 1 CMS compares organization cumulative submissions to benchmarks.
- 2 CMS notifies organizations placed on a monitoring list.
- 3 CSSC contacts notified organizations to offer technical assistance and develop action plan.

9-28



Summary

- ▶ Identified the purpose of each risk adjustment report.
- ▶ Determined the best uses of the reports to monitor data collection and submission processes, and to resolve errors.
- ▶ Accurately read the risk adjustment reports to identify and submit corrections.

9-29



Summary (continued)

- ▶ Reviewed the relationship between values in RAPS Transaction Summary and management reports.
- ▶ Compared accepted diagnosis clusters to benchmarks.

9-30



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

Thank You!

Verifying Risk Scores

Angela Reddix
Aspen Systems Corporation

10-1

Purpose

- ▶ This module will explain the systems involved in the risk score calculations and introduce M+C organizations to a variety of verification tools available.

10-2

Objectives

- ▶ Understand the systems and processes used to calculate the risk scores.
- ▶ Determine how the organization can use risk adjustment processing and management reports to ensure the accuracy of payment.



10-3

Objectives (continued)

- ▶ Identify the components and uses of the Monthly Membership Report(MMR) and Model Output Report (MOR)/Hierarchical Condition Category(HCC) Report.
- ▶ Interpret the HCC Submission Status Report.
- ▶ Understand how to interpret benchmarks.



10-4

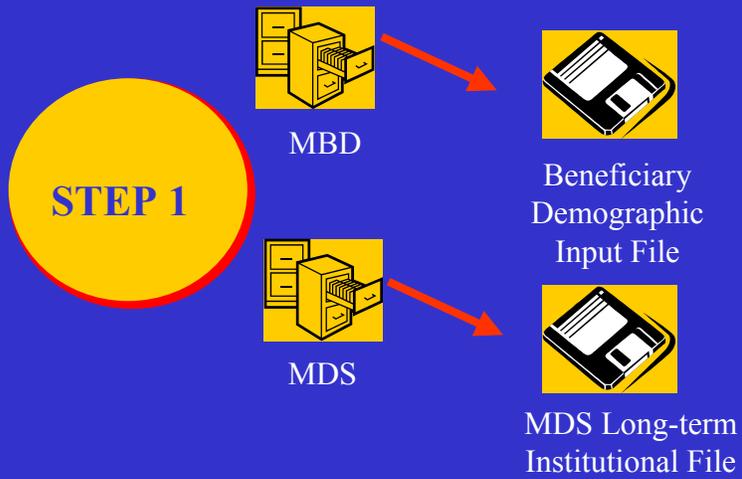


What is the Risk Score?

10-5

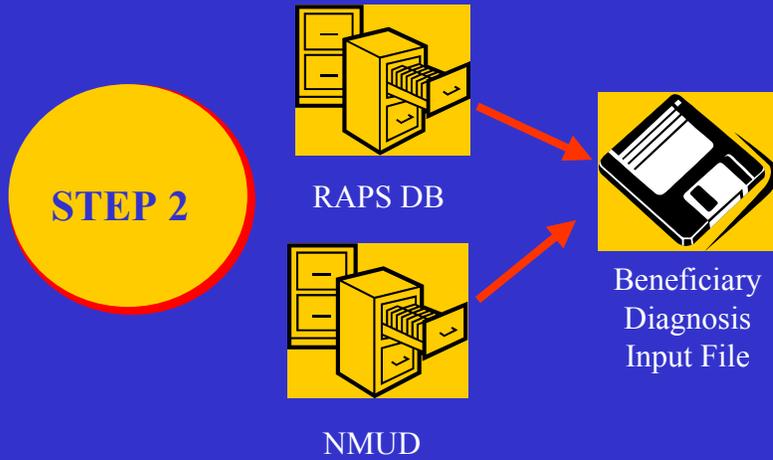


Calculation of Risk Scores

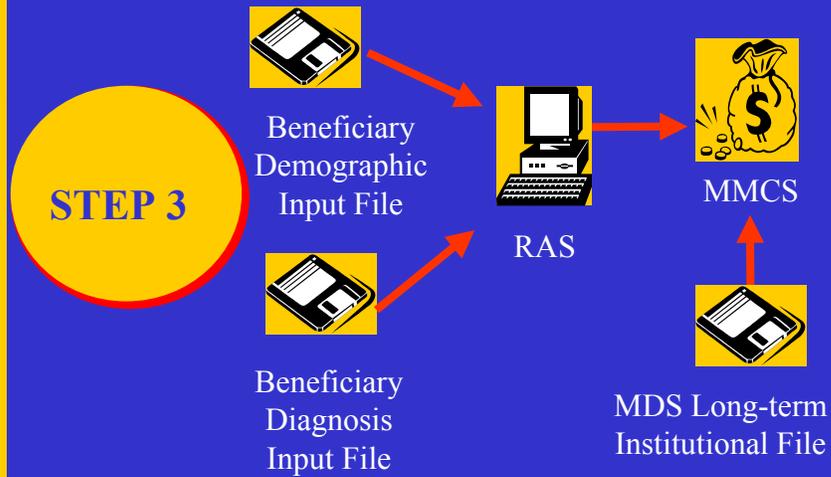


10-6

Calculation of Risk Scores (continued)



Calculation of Risk Scores (continued)





Verification Tools



- ▶ RAPS Return File
- ▶ Raps Management Reports
- ▶ SAS CMS-HCC Model Program
- ▶ Monthly Membership Report
- ▶ Risk Adjustment Model Output Report
- ▶ HCC Submission Status Report

10-9



RAPS Return File/ RAPS Transaction Error Report

- ▶ Received the next business day after submission.
- ▶ Return file provides a record of each diagnosis stored for each enrollee.
- ▶ M+C organizations may store the results of each RAPS Return File to build and update a record of all diagnoses stored in the model for each enrollee.
- ▶ Error Report requires manual updates to a diagnosis file.

10-10

Database Components

| | | | |
|------------|-----------|----------------|--------------|
| HIC number | Diagnosis | Date submitted | Through date |
|------------|-----------|----------------|--------------|



10-11

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



10-12

Exercise



Run the CMS-HCC Model

- ▶ CMS runs the model on an annual basis.
- ▶ M+C organizations may run the model to calculate their enrollee risk scores.
- ▶ SAS program available at <http://cms.hhs.gov/healthplans/rates>

Run the CMS-HCC Model (continued)

Risk Adjustment Information, Data files, & Programs

CMS-HCC Payment Model software and data for 2004

- Note to M+C Organizations Regarding ICD-9 Code Differences in Final CMS-HCC Risk Adjustment Model. (Posted 07/17/03)
- [hccsoftware.zip](#) (9K bytes) This archive expands to 12 files. Read [hccsoftwaredescription.rtf](#) (included in the archive) for further details and instructions.
- [avgrisk.zip](#) (36K bytes) This archive expands to:
 1. [avgrisk.csv](#) -- Estimated average county risk factors
- Additional data pertaining to the [CMS-HCC model](#).

<http://www.cms.hhs.gov/healthplans/rates/>



10-15

Monthly Membership Report

- ▶ Generated by GHP.
- ▶ Beneficiary-level information.
- ▶ Available through the GROUCH system.
- ▶ For availability, refer to the official schedule for precise dates.



10-16

Monthly Membership Report Field Ranges

| Field Ranges | Descriptions |
|--------------|--|
| 1-3 | Managed Care Organization Information |
| 4-11 | Beneficiary Identification |
| 12-13 | Entitlement |
| 14-19 | Health Status |
| 20-37 | Risk Adjustment/Demographic Payment Adjustment Information |
| 38-49 | Additional Risk Adjustment Indicators |



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



HCC Submission Status Report

- ▶ Access via HPMS.
- ▶ Indicates plan level risk score and HCC distribution.
- ▶ Includes two tables
 - Number of beneficiaries per number of conditions
 - Number of beneficiaries with conditions in model



10-19

Benchmarking

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



10-20

Benchmarking (continued)

Centers for Medicare & Medicaid Services
 Home | About CMS | FAQs | Feedback | Search now GO
 Professionals | Governments | Consumers | Public Affairs

Risk Adjustment Model for 2004
 (Note: Final Model Announcement, Factors, Rates, and Software can be found at <http://cms.hhs.gov/healthplans/rates/>)

| File Description | File Name(s) | Format |
|---|---|--------------------------|
| Average Risk Scores By State From M+C Data. (posted 08/19/03) | technotetstscrs.asp stvlrskscores.zip (3K) | Zipped .XLS file or HTML |
| Number and Percent of FFS beneficiaries Nationally by Demographic Characteristics and Disease Groups. (posted 05/30/03) | NatlFreq.zip (107K) | Zipped .XLS file |
| Number and Percent of FFS beneficiaries by County and Demographic Characteristics and Disease Groups. (posted 06/13/03) | ffsdist1997edited.zip (3,616K) | Zipped .XLS file |

<http://cms.hhs.gov/healthplans/riskadj/>

Exercise



Summary

- ▶ Identified data systems used to calculate risk scores.
- ▶ Reviewed how reports can be used to verify risk scores.
- ▶ Described the use of benchmarks.



10-23



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

Thank You!



10-24

Three C's of Risk Adjustment

Angela Reddix
Aspen Systems Corporation

11-1

Purpose

- ▶ The purpose of this module is to share winning strategies that will allow organizations to build an adequate infrastructure to support the risk adjustment process.
- ▶ A successful infrastructure will utilize appropriate internal and external resources.

11-2

Objectives

- ▶ Discuss the opportunity to improve the quality of the risk adjustment process.
- ▶ Ensure the submission of the appropriate quantity of data in the risk adjustment process.
- ▶ Identify effective internal and external communication strategies.

11-3

Objectives (continued)

- ▶ Define the Risk Adjustment Collaboration Model.
- ▶ Identify recommended steps to risk adjustment project coordination.

11-4



Quality and Quantity

- ▶ CMS provides information and material to assist M+C organizations in improving overall quality and submitting the appropriate quantity of risk adjustment data.
- ▶ M+C organizations develop processes to support collection and submission of risk adjustment data.
- ▶ M+C organizations should consider key quality and quantity concepts.

11-5



Data Collection

Quality

- ▶ Collect from appropriate sources.
- ▶ Collect the relevant diagnoses.
- ▶ Ensure coding to the 5th digit.
- ▶ Educate physicians/providers regarding correct coding guidelines.

Quantity

- ▶ Develop tools to receive all data in a timely manner.
- ▶ Collect relevant diagnosis at least once per year for a beneficiary.
- ▶ Consider data collection tool convenient for the physician/provider.

11-6

Data Submission

Quality

- ▶ Pay close attention to the file logic and the components of the diagnosis cluster.
- ▶ Delete any self-identified inaccurate data.

Quantity

- ▶ Submit at least quarterly.
- ▶ Filter appropriately following examples to prevent over-filtering and under-filtering.



11-7

FERAS & RAPS Data Processing

Quality

- ▶ Establish internal editing systems to perform edits prior to sending the file to Palmetto.
- ▶ Read and reconcile reports to reduce the numbers of errors generated in the future.

Quantity

- ▶ Analyze reports to determine the number of clusters stored.
- ▶ Compare submission levels to data received from physicians and providers.



11-8



Verifying Risk Scores

Quality

- ▶ Using the MMR/MOR, verify that individual beneficiaries have the appropriate HCCs and risk scores based on plan data submissions and reports of data stored.

Quantity

- ▶ Ensure that overall plan payments and average risk adjustment factors are at or near expected values.

11-9



Data Validation

Quality

- ▶ Identify best medical record to support the diagnosis that is being validated.

Quantity

- ▶ Develop internal system to quickly identify the source (specific physician/hospital) of the data being validated.
- ▶ Ensure there are no missing medical records.

11-10

Three C's of Risk Adjustment

- 1** **COMMUNICATION**
- 2** **COLLABORATION**
- 3** **COORDINATION**



11-11

Three C's of Risk Adjustment (continued)



COMMUNICATION

1. Inform the organization of the CMS risk adjustment requirements.
2. Convey to Executives the resources and risks associated with the project.
3. Describe the benefits to the organization.
4. Celebrate success and identify opportunities for improvement.



11-12

Three C's of Risk Adjustment (continued)



COMMUNICATION

5. Attend user groups and trainings to receive updates and official information.
6. Call CSSC to resolve data submission or processing problems.
7. Contact CMS with questions about risk adjustment requirements, factor discrepancies, payments, etc.

Three C's of Risk Adjustment (continued)



COLLABORATION

1. Generate ideas for process improvement from all departments impacted by risk adjustment.
2. Define a workgroup aligned around a clear purpose.
3. Gain buy-in by group to work towards reaching the ultimate risk adjustment goal.
4. Develop a process for making decisions and resolving conflict.

Three C's of Risk Adjustment (continued)



COLLABORATION

5. Work with CMS and CSSC to ensure successful compliance with requirements.
6. Obtain physician/provider input regarding process improvement for data collection.



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Three C's of Risk Adjustment (continued)



COORDINATION

1. Identify key resources required to meet the risk adjustment requirements.
2. Determine what individual or group "owns" risk adjustment.
3. Establish an internal process to collect, submit, and reconcile risk adjustment data.



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Three C's of Risk Adjustment (continued)



COORDINATION

4. Define project roles and responsibilities.
5. Coordinate internal activities with appropriate external groups, e.g., CMS, CSSC, physicians/providers, third party submitters.

Case Study 1



Communication



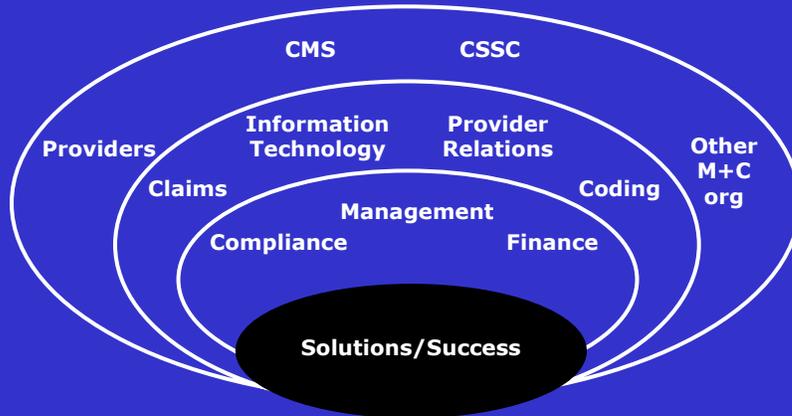
- ▶ Internal
- ▶ External

Collaboration



- ▶ The collection of ideas that provide the knowledge to make informed decisions that save money, time, and resources.

Risk Adjustment Collaboration Model



Coordination



- ▶ Organizing the structure and the process of the risk adjustment team to function well internally and externally.

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Required Project Coordination Components

The diagram is a pyramid with five horizontal levels, each containing a text box. From top to bottom, the levels are: 1. IDENTIFY STAKEHOLDERS (white box), 2. IDENTIFY REQUIRED RESOURCES (white box), 3. ESTABLISH PROJECT STRUCTURE (white box), 4. DEFINE ROLES (white box), and 5. DEVELOP PROCESS & STANDARDS OF ACCOUNTABILITY (white box). The pyramid's top is a red triangle, and the base is a yellow trapezoid.

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Required Project Coordination Components (continued)

The diagram is a pyramid with five horizontal levels, each containing a text box. From top to bottom, the levels are: 1. IDENTIFY STAKEHOLDERS (yellow box), 2. IDENTIFY REQUIRED RESOURCES (white box), 3. ESTABLISH PROJECT STRUCTURE (white box), 4. DEFINE ROLES (white box), and 5. DEVELOP PROCESS & STANDARDS OF ACCOUNTABILITY (white box). The pyramid's top is a red triangle, and the base is a yellow trapezoid.

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Required Project Coordination Components (continued)

IDENTIFY STAKEHOLDERS

IDENTIFY REQUIRED RESOURCES

ESTABLISH PROJECT STRUCTURE

DEFINE ROLES

DEVELOP PROCESS & STANDARDS OF ACCOUNTABILITY

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Required Project Coordination Components (continued)

IDENTIFY STAKEHOLDERS

IDENTIFY REQUIRED RESOURCES

ESTABLISH PROJECT STRUCTURE

DEFINE ROLES

DEVELOP PROCESS & STANDARDS OF ACCOUNTABILITY

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Required Project Coordination Components (continued)

IDENTIFY STAKEHOLDERS

IDENTIFY REQUIRED RESOURCES

ESTABLISH PROJECT STRUCTURE

DEFINE ROLES

DEVELOP PROCESS & STANDARDS OF ACCOUNTABILITY

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Required Project Coordination Components (continued)

IDENTIFY STAKEHOLDERS

IDENTIFY REQUIRED RESOURCES

ESTABLISH PROJECT STRUCTURE

DEFINE ROLES

DEVELOP PROCESS & STANDARDS OF ACCOUNTABILITY

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Case Study 2



Summary

- ▶ Discussed the opportunity to improve the quality of the risk adjustment process.
- ▶ Ensured the submission of the appropriate quantity of data in the risk adjustment process.
- ▶ Identified effective internal and external communication strategies.

Summary (continued)

- ▶ Defined the Risk Adjustment Collaboration Model.
- ▶ Identified recommended steps to risk adjustment project coordination.



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Please take a moment to complete the evaluation form for the Three C's of Risk Adjustment Module.

Thank You!



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