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INTRODUCTION

Purpose (Slide 3)

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

About This Training

ICON KEY	
Example	
Reminder	
Resource	

This technical assistance session is organized into eight modules:

1. **Risk Adjustment Methodology**
   Provides an understanding of CMS' Risk Adjustment models and payment methodologies.

2. **Risk Adjustment Process Overview**
   Identifies the systems and timeline for the risk adjustment data collection, submission, editing, and reporting processes.

3. **Data Collection**
   Describes the acceptable sources of risk adjustment data and data collection formats.

4. **Data Submission**
   Describes the acceptable formats for submitting risk adjustment data.

5. **Edits and Reports**
   Identifies data integrity logic and error codes, error resolution, and suggestions for avoiding errors. In addition, describes risk adjustment reports, and defines their uses in monitoring data collection and submission processes.

6. **Diagnosis Codes & Risk Adjustment**
   Provides important medical record documentation and coding guidelines related to risk adjustment.

7. **Data Validation (Medical Record Review)**
   Identifies the data validation approach under the CMS' Risk Adjustment models, including responding to CMS medical record requests.

8. **Verifying Risk Scores**
   Describes the process for calculating the risk score and its impact on risk adjusted payment.

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

TABLE A – TRAINING TOOLS

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

Future Use of This Participant Guide

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

Audience

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

- Staff of new Medicare Advantage (MA) and Medicare Advantage – Prescription Drug (MA-PD) organizations, Regional and Employer Group Health plans, demonstration projects, Program of All-Inclusive Care for the Elderly (PACE) organizations, Cost Plans and specialty plans.
- Existing staff unable to attend previous training sessions.
- New staff at the existing organizations mentioned above.
- Third party submitters contracted to submit data on behalf of MA Risk Adjustment organizations.

The organizations listed in Table B will be used throughout this session.

TABLE B – ORGANIZATION DESCRIPTION

NAME	DESCRIPTIONS
MA Organizations	Organizations, including Health Maintenance Organizations with or without Prescription Drug Programs, Employer Group Health and Medical Savings Account organizations, private fee-for-service organizations, preferred provider organizations, and provider sponsored organizations that receive capitated payments to provide comprehensive medical services to Medicare beneficiaries.
PACE	Program of All-Inclusive Care for the Elderly (PACE) that serves a community of frail and elderly individuals who are eligible for nursing home placement based on State Medicaid criteria.
MSHO/ MnDHO	Minnesota Senior Health Options (MSHO) and Minnesota Disability Health Options (MnDHO) are managed care products in a ten-county area in Minnesota, including the Twin Cities. They integrate Medicare and Medicaid financing of acute and long-term care service delivery for dually eligible and Medicaid eligible physically disabled adults and elderly. MnDHO is approved for Carver, Scott, Washington, Hennepin, Ramsey, Dakota, and Anoka counties.
S/HMO	Social Health Maintenance Organizations (SHMO) offer seniors an expanded care benefits package that may include prescription drugs and community-based services, which enables them to maintain independence and avoid nursing home placement.
WPP	Wisconsin Partnership Program (WPP) is a comprehensive program for Medicaid and Medicare beneficiaries who are elderly or disabled and meet the State's nursing home criteria. WPP integrates health and long-term support services, and includes home and community-based waiver services (HCBS), physician services, and all other medical care.
SCO	The MassHealth Senior Care Option (SCO) is a dual eligible demonstration that CMS and the Division of Medical Assistance for the Commonwealth of Massachusetts developed. The contractors provide care through managed care organizations to beneficiaries who enroll voluntarily. SCOs serve community-well, community-frail, and institutionalized beneficiaries age 65 and older. SCOs are required to contract with State Aging Services Access Point providers as part of the SCO care management team, which deliver home and community-based services as part of an integrated model of care.
Capitated Demonstration Projects	Capitated demonstration projects use alternative capitated financing to allow the provider to offer comprehensive medical service.
Cost Plans	A Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) that operates in accordance with a cost reimbursement contract under Section 1876(h) of the Act. These contracts provide the full Medicare benefit packages. Payment is based on the reasonable cost of providing services. Beneficiaries are not restricted to the HMO or CMP to receive covered Medicare services (i.e., services may be received through non-HMO/CMP sources and are reimbursed by Medicare intermediaries and carriers).

Learning Objectives (Slide 6)

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

- Identify Risk Adjustment and payment methodologies.
- Describe the requirements for data collection.
- Determine the process for submitting data to CMS.
- Explain the process for validating risk adjustment data.
- Interpret the editing rules and reports for monitoring RAPS data.
- Demonstrate how to verify risk scores.

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

TABLE C – RISK ADJUSTMENT PROCESS POINTS OF CONTACT

ORGANIZATION	ROLE	CONTACT INFORMATION
CMS Center for Beneficiary Choices	Develops and implements the risk adjustment payment methodology for the MMA program. Monitors plans to improve the quality of data.	Sean Creighton sean.creighton@cms.hhs.gov Henri Thomas henry.thomas@cms.hhs.gov Louis Johnson louis.johnson@cms.hhs.gov Stephen Calfo stephen.calfo@cms.hhs.gov
CMS Regional Offices	Provide assistance to Risk Adjustment organizations and beneficiaries regarding various issues related to the Medicare program.	Contact your plan manager.
Palmetto Government Benefits Administration (Palmetto GBA)	Manages the Front-End Risk Adjustment System (FERAS) and the Customer Service and Support Center (CSSC).	www.csscoperations.com
Leading Through Change, Inc. (LTC, Inc.)	Training Contractor responsible for risk adjustment training initiatives, including regional training programs and User Group meetings.	TAregistration@tarsc.info

MODULE 1 – RISK ADJUSTMENT METHODOLOGY

Purpose (Slide 2)

To provide information on risk adjusted data submission and payment under the risk payment models. The goal of risk adjustment is to pay applicable Parts C and D organizations accurately and fairly by adjusting payment for enrollees based on demographics and health status. Changes to risk adjustment under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) are also provided in this module.

Learning Objectives (Slide 3)

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

- Define the purpose of risk adjustment.
- Identify the components of risk adjusted payments.
- Describe the Part C community model.
- Describe how to calculate the frailty adjuster.
- Describe Part C Community and Long-term institutional models.
- Describe how to calculate a risk factor.
- Recognize the components of the Part C End-Stage Renal Disease (ESRD) model.
- Describe the Part D Prescription Drug Risk Adjustment model.
- Identify the new enrollee factors.

ICON KEY
Definition
Example
Reminder
Resource

1.1 Risk Adjustment History (Slides 4-9)

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

- Balanced Budget Act of 1997 (BBA) (42 CFR 422).
  - Created the Medicare+Choice (M+C) program.
  - Mandated risk adjustment payment methodology to increase payment accuracy.
  - Mandated the implementation of a frailty adjuster for the Program for All-Inclusive Care for the Elderly (PACE) organizations.

- August 1998
  - Hospital inpatient encounter data collection began.

- January 2000 – Principal Inpatient Diagnostic Cost Group (PIP-DCG) Payment Model implemented.
  - Gradual phase-in of risk adjustment based on principal inpatient diagnosis and demographic factors (age, sex, Medicaid status, original reason for Medicare entitlement).
  - Implemented at 10 percent PIP-DCG and 90 percent demographic.
  - The PIP-DCG model is based on hospital inpatient diagnoses only.

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

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

- January 2002 – CMS announced new risk adjustment data processing system—RAPS (Risk Adjustment Processing System).

- March 2002 – Draft CMS-HCC Payment Model selected.
  - New risk adjustment model needed to accommodate other types of data (hospital outpatient and physician)
  - Included approximately 70 condition groups with reduced number of diagnostic codes.
  - Proposed for implementation in calendar year 2004.

- February 3, 2003 – CMS presented a draft CMS-HCC model discussed at national public meeting and addressed the elimination of the data lag for payment.

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

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

See 2004 45-Day Notice at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2004.pdf and May 12, 2003 Announcement of Rates for 2004 at: http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2004.pdf

- December 8, 2003 – Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) Enacted (P.L. 108-173).
  - Created MA program to replace M+C program.
  - Retained many M+C provisions while introducing new plan types and new payment rules.
  - Created Medicare drug benefit to begin in 2006.
  - Established bidding methodology for MA organizations and drug plans in 2006.

- January 16, 2004-New ratebook for 2004 published.
  - Revised ratebook took into account changes from MMA, including introduction of a new rate - 100% of average FFS costs.
  - 2004 was a transitional year for the capitation rate setting – the FFS rate was the 4th prong to the previous "highest of three rates" methodology so for 2004 each county capitation rate was the higher of its FFS amount, minimum percentage increase rate, floor rate, or blended rate. (See Section 1.2.1 below.) Also, the MMA changed the calculation of the for 2004 and modifying the minimum percentage increase rate for 2004 and beyond.
  - Under the MMA, for 2005 and onward capitation rates are the minimum percentage increase rate, except in years when CMS retabulates "(rebases") the FFS amounts, and in rebasing years the rate is the higher of the two.

📖 See January 16, 2004 cover letter regarding revised MA rates at:
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2004b.pdf

- March 26, 2004-Advanced Notice of Methodological Changes for 2005 (i.e., 45-Day notice) published.
  - Announcement of MMA-required, ratebook transitions to "highest of 2."
  - Proposes ESRD model for implementation in 2005.

📖 See 2005 45-Day Notice for additional details at:
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2005.pdf

- May 2004-Announcement of draft diagnoses collected for drug risk adjustment model for payment beginning in 2006 and additional codes for CMS-HCC risk adjustment models.

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

- February 18, 2005-Advanced Notice of Methodological Changes for 2006 (i.e., 45-Day notice) published.
  - Proposed changes in the MA capitation rate methodology due to implementation of MMA bidding and proposed changes to risk adjustment methodology under Part C.
  - Proposed the health status risk adjustment methodology for Part D [Draft Prescription Drug (RxHCC) Model].
  - Proposed payment methodologies for the direct, low income, and reinsurance subsidies, and risk sharing.

📖 See 2006 45-Day Notice for additional details at:
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2006.pdf

📖 April 4, 2005-Announcement of rates for 2006.
  - Announced final Part D risk adjustment model.
  - Rolled back proposed changes to MA risk adjustment model outlined in February 18, 2005 Advance Notice.
  - April 8, 2005-Updated regional rates.
  - April 13, 2005-Updated ratebook.

See Final 2006 Notice for additional details at:
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2006.pdf

April 7, 2005- Risk Adjustment models and ICD-9/HCC crosswalks posted at
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp

April 3, 2006-Announcement of 2007 Payments posted at
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2007.pdf.

- Announced recalibrated version of the CMS-HCC model for 2007
- Announced updated normalization factor for CMS-HCC models

April 2, 2007—Announcement of 2008 Payments posted at
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2008.pdf.

- Announced recalibrated versions of ESRD models for 2008
- Announced normalization factor for Part D risk adjustment model
- Announced updated normalization factor for Part C CMS-HCC and functioning graft models
- Announced normalization factor for ESRD dialysis and transplant models
- Announced recalibrated frailty model
- Announced new frailty payment implementation for PACE and certain demonstration organizations

April 7, 2008—Announcement of 2009 Payments posted at
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2009.pdf.

- Announced recalibrated version of the Part C CMS-HCC model for 2009
- Announced updated normalization factors for Part C CMS-HCC, ESRD Dialysis model, and the functioning graft model
- Announced updated normalization factor for the Part D risk adjustment model
- Announced recalibrated frailty factors for 2009
- Announced standard set of ICD-9 Diagnosis codes for Risk Adjustment

1.2 Calculating Payments

1.2.1 Payments for 2004 and 2005

Traditionally, payments to MA organizations were based solely on demographic information. Risk adjustment provides more accurate payments for MA organizations. Payments are higher for less healthy enrollees and lower for more healthy enrollees. For 2004 and 2005, MA risk payment calculations involved two steps:

1. Identify the county risk rate for the enrollee's county of residence , and
2. Multiply by the enrollee's individual risk factor.

CMS derived county risk rates for Part A and Part B by multiplying the unadjusted Part A and Part B demographic county rates (used for demographic payments) by a rescaling factor, based on the CMS-HCC risk factor of the FFS enrollees in that county. The demographic rates were used in the older payment method where the county rate was standardized by the county average FFS demographic factor (based on age, sex, Medicaid, institutional, disabled, and working aged statuses) and payment equaled the county rate multiplied by the individual demographic factor, which was a proxy for expected health risk.) Under the new risk adjustment method being phase-in beginning in 2000, this county risk rate was then multiplied by the individual's CMS-HCC risk factor to determine the appropriate payment amount. The schedule from 2004-2007 for phasing-out the demographic payment method and phasing-in the risk-adjustment payment method was as follows:

- For 2004, MA organizations were paid using 70 percent of the demographic payments and 30 percent of the CMS-HCC payments.
- For 2005, MA organizations were paid using 50 percent of the demographic payments and 50 percent of the CMS-HCC payments.
- For 2006, MA organizations were paid using 25 percent of the demographic payments and 75 percent of the CMS-HCC payment.
- For 2007 and beyond, MA organizations are paid using 100 percent of the CMS-HCC payment.

Prior to the passage of the MMA, the 2004 MA (then M+C) rates for each county were defined as the highest of three rates: the blended capitation rate, minimum "floor" amount, or minimum two percent increase rate. With the enactment of the MMA in December 2003, the original 2004 payment methodology changed and required CMS to issue revised capitation rates for CY 2004.

The MMA mandated that a new rate type, 100 percent of projected average fee-for-service Medicare costs (with adjustments to exclude direct medical education and include a VA/DOD adjustment) be added to the payment methodology. Introducing the 100% FFS reconnects the link between managed care payment rates and fee-for-service spending at the county level that had existed prior to the BBA. For 2004 only (a transition year under the MMA rate-setting rules), the county capitation rate was this highest of four rates: blended rate, floor amount, minimum increase rate, and FFS rate.

For 2005 and subsequent years, the MA capitation rate for a county is the minimum percentage increase rate, except for years when CMS re-tabulates ("rebases") the FFS rates. In rebasing years, the county capitation rate is the higher of the minimum percentage increase rate or the FFS rate.

In addition, from 2004 onward, the MMA modifies the methodology for calculating the minimum percentage increase. The previous year's rate is increased by the larger of:

- 2 percent

or

- the Medicare growth percentage, - with no adjustments to this growth trend for over/under projections for years before 2004.

The Deficit Reduction Act of 2005 redefined the minimum percentage increase rate to be the previous year's rate increased by the Medicare growth percentage, with no adjustments for over/under projections for years before 2004.

1.2.2 MA Capitation Rates for 2006 through 2008

CY 2006 was the first year that MAOs were paid based on the MMA bid-based methodology. Thus, the capitation rates are no longer the same as payment rates. Capitation rates are used to establish benchmarks, and payment rates are plan-specific per capita monthly bids (adjusted).

For 2006, the final estimate of the increase in the National Per Capita Medicare Advantage Growth Percentage for aged beneficiaries was 4.8 percent, which is greater than 2 percent. Therefore, 4.8 percent was used as the minimum update percentage in calculating the 2006 rates. For 2006, all capitation rates are the 2005 rate increased by 4.8 percent. Per the MMA, CMS is not required to rebase the county fee-for-service rate every year and did not do so for 2006. In addition, for 2006, MA organizations were paid using 25 percent of the demographic payments and 75 percent of the CMS-HCC risk payments.

For 2007, the final estimate of the National Per Capita Medicare Advantage Growth Percentage was 7.1 percent. Because fee-for-service rates were rebased (to reflect more recent county growth trends in fee-for-service expenditures), counties where the FFS rate is greater than the minimum percentage increase rate received the FFS rate. For 2007, 6 percent of the counties received the FFS rates. For 2007 and beyond, payments to MA organizations will be at 100 percent of the CMS-HCC risk rate.

For 2008, the final estimate of the National Per Capita MA Growth Percentage is 5.7%. This final estimate includes 4.3 percent for the 2008 underlying trend change and 1.3 percent due to corrections to prior years' estimates, as required by law. CMS did not re-tabulate the FFS rates for 2008, so all MA capitation rate are minimum percentage increase rates.

For 2009, the final estimate of the National Per Capita MA Growth Percentage is 4.2%. This final estimate includes 0.48 percent due to corrections to prior years' estimates, as required by law.

1.2.3 Risk Ratebook

For payments years through 2006, a rescaling factor has been used to convert the demographic capitation rates to the risk adjusted capitation rates for each county. This is referred to a restandardizing the ratebook. The rescaling factor is defined as the county rate properly standardized to the new risk adjustment factors divided by the demographic county rate. In addition to restandardizing the ratebook, a budget neutrality factor is applied to make risk adjustment budget neutral. (see below for more information)

Section 5301 of the Deficit Reduction Act (DRA) changes the way CMS develops its capitation rates, beginning in 2007. The DRA established a single risk ratebook for monthly capitation rates, because the statutory transition for MA plans from payment based on the demographic rates and demographic adjustment factors to payment based on risk adjustment rates and risk adjustment factors were completed in 2006. Effective 2007, MA capitation rates are risk rates. Capitation risk rates are used to determine the plan benchmarks for virtually all MA plans and MAOs set their bids in relation to their benchmarks.

The DRA defines the risk rates as the base ratebook, so CMS will now publish two sets of rates – risk and demographic rates. CMS will continue to publish the demographic rates because they are used in budget neutrality (BN) factor calculations. Also, the demographic rates will be used in 2007 to determine

payments to certain demonstrations and PACE organizations, which lag one year in the transition blend so that 25 percent of their payments will be based on demographic rates.

In addition, the FFS normalization factor, which was applied in the rate book prior to 2007, is instead applied to the risk scores starting in 2007. The result of these two approaches is mathematically the same.

Table 1A shows the risk adjustment models and updates implemented for payments beginning with 2004. Note that all models are implemented with their associated new enrollee models.

TABLE 1A – RISK ADJUSTMENT MODEL IMPLEMENTATION FOR PAYMENT (Slides 16, 17, & 42)

PAYMENT YEAR	RISK ADJUSTMENT MODEL IMPLEMENTED FOR PAYMENT	CALIBRATION YEARS	NORMALIZATION FACTOR
2004-2006	CMS-HCC Community & Institutional	1999-2000	1.05
2005-2007	ESRD Functioning Graft	1999-2000	1.05
	ESRD Dialysis and Transplant	1999-2000	N/A
2006-current	RxHCC	2002-2006	N/A
2007-current	Recalibrated CMS-HCC Community & Institutional	2002-2003	1.029
2008	Recalibrated ESRD Functioning Graft	2002-2003	1.04
	Recalibrated ESRD Dialysis and Transplant	2002-2003	1.010
	Recalibrated CMS-HCC Community and Institutional	2002-2003	1.04*
	RxHCC	2002-2006	1.065**
2009	Recalibrated ESRD Functioning Graft	2002-2003	1.058
	Recalibrated ESRD Dialysis and Transplant	2002-2003	1.019
	Recalibrated CMS-HCC Community and Institutional	2004-2005	1.03
	RxHCC	2002-2006	1.085

*The 2008 normalization factor for the CMS-HCC community and institutional models was updated from 2007 to include one additional year of FFS data. Note that the 2007 recalibrated model did not change for 2008 payments.
**The 2008 normalization factor for the RxHCC model will be first implemented in 2008. Note that the 2006 model did not change for 2008 payments.

1.2.3.1 Adjustment for Budget Neutrality

While risk adjustment (without the implementation of budget neutrality) would reduce aggregate payments to the MA program, compared to aggregate payments under the older demographic method, budget neutrality redistributes these payments as a constant percentage to organizations affected by risk adjustment (including MA organizations, PACE, and certain demonstrations). In other words, under

budget neutrality, savings that would have accrued to the Medicare Trust Fund due to the application of risk adjustment are instead redistributed among MA organizations. The budget neutrality factor is calculated as the difference between payments under 100 percent of the risk adjustment method (i.e., under the CMS-HCC model) versus payment under 100 percent of the demographic only method.

The following sections discuss recent changes in the application of budget neutrality policy.

1.2.3.2 Change in the Budget Neutrality Calculation to Account for Different Payment Methodologies for Local MA Plans Versus Regional MA Plans

Because of the difference in payment methods for local MA plans versus regional MA plans beginning in 2006, CMS will modify the budget neutrality calculation. Budget neutrality is calculated as the difference between aggregate MA payments at the local MA benchmark rate that would have been made using the demographic method for 100 percent of payments and the aggregate payments that would be made using 100 percent of risk adjusted payments. Budget neutrality will be applied to both local and regional MA plans. For regional plans, this means that the budget neutrality factor will be applied to the statutory component of the benchmark.

1.2.3.3 Phase Out of Budget Neutrality

The DRA mandates the phase-out schedule for the BN factor from 2007 through 2010. The phase out schedule is shown in Table 1B. Under the budget neutrality methodology, in 2006, 100 percent of the difference between payment under the demographic method and payment under risk adjustment was added back to the risk payment rates via a rescaling factor. However, due to the payment blend for 2006 this will result in 75 percent of the budget neutrality amount being added back to the blended benchmark. For 2007, 55 percent of the BN factor was applied to every risk rate. The percentage applied will decrease each year until 2011, when it is 0 percent (see Table 1B).

TABLE 1B – PHASE-OUT SCHEDULE FOR BUDGET NEUTRAL RISK ADJUSTMENT PAYMENTS

YEAR	BUDGET NEUTRALITY PERCENTAGE
2006	100% [1/]
2007	55%
2008	40%
2009	25%
2010	5%
2011	0%

[1/] 100 percent of the difference between payment under the demographic method and the payment under the risk adjusted method will be added to the risk adjusted payment rates. However, due to the payment blend for 2006 of 25 percent demographic and 75 percent risk adjustment the net effect is a 75 budget neutrality adjustment.

1.2.4 Payment Blends

The schedule for implementing risk adjusted payments based on the CMS-HCC model and the blended transitional approach is shown below. In 2004, the CMS-HCC model was implemented at a 30 percent risk adjusted payment, with the remaining 70 percent represented by the demographic payment. The

portion of risk adjusted payment will increase to 50 percent in 2005, to 75 percent in 2006, and finally to 100 percent in 2007. There was not blended payment transition for the Part C ESRD and Part D models. Payments under these models were implemented at 100 percent risk adjustment from the beginning. The CMS-HCC implementation schedule is shown in Table 1C. The Part C blended payment transition schedule for PACE and certain demonstration organizations is on a one year lag from the payment transition for MA organizations. Table 1D shows that CMS-HCC implementation schedule for specialty organizations.

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

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

TABLE 1D – PAYMENT BLEND SCHEDULE FOR SPECIALTY ORGANIZATIONS

TYPE OF HEALTH PLAN	PART C TRANSITION BLEND*				
	2004	2005	2006	2007	2008
PACE	90/10%	70/30%	50/50%	25/75%	100%
WPP	90/10%	70/30%	50/50%	25/75%	100%
MSHO and MnDHO	90/10%	70/30%	50/50%	25/75%	100%
S/HMOs	90/10%	70/30%	50/50%	25/75%	100%
SCO	90/10%	70/30%	50/50%	25/75%	100%

*Represents percentage of original demographic payment methodology (specific to each plan type) versus CMS-HCC risk adjusted portion of payment. ESRD and Part D risk adjustment were implemented at 100 percent risk.

1.2.5 Fee-for-Service Normalization Adjustment (Slide 42)

The purpose of the fee-for-service normalization adjustment is so that CMS payments are based on a population with an average risk score of 1.0. The CMS-HCC models are calibrated with FFS claims data. Because average predicted FFS expenditures increase after the model calibration year due to coding and population changes, CMS applies a normalization factor to adjust beneficiaries' risk scores so that the average risk score is 1.0 in subsequent years. Through 2006, CMS adjusted the restandardized ratebook to the appropriate denominator for the payment year. The denominator represented the national average predicted fee-for-service expenditures per beneficiary in that year. Every year there are shifts in the Medicare population. Specifically, fee-for-service coding across all sites of service, coding has not yet stabilized as much as inpatient hospital coding. Therefore, it has been necessary to apply a fee-for-service normalization factor to adjust for changes in coding patterns.

The DRA required CMS to apply the fee-for-service normalization factor to the risk scores. For 2007 the Part C normalization factor for the recalibrated CMS-HCC model is 1.029, and 1.05 for the ESRD functioning graft models. The functioning graft normalization factor remained unchanged from the previous year since the ESRD models were not recalibrated for 2007. There was no normalization factor applied to the dialysis and transplant risk scores for 2007. For 2008, the normalization factor is 1.04 for the CMS-HCC and ESRD functioning graft risk scores. The Part D normalization factor is 1.065.

CMS will implement a four-year normalization phase-in of the Part C - ESRD dialysis and transplant risk scores. For 2008 (Y1) through 2011 (Y4), CMS will calculate a yearly normalization factor. The calculated normalization factor for each year will be adjusted using the specified phase-in percentage for that year. The risk scores will then be divided by the resulting adjusted normalization factor for that year. For example, in 2008 (Y1), dialysis and transplant risk scores will be divided by 25% of the calculated 2008 normalization factor. The normalization factor calculated for 2008 is .039 (or 3.9%). This factor will be multiplied by 25% to get the adjusted normalization factor. Therefore, the ESRD dialysis and transplant risk score normalization formula is [risk score/(1+(the adjusted factor))], which is 1.010 (i.e., 1+(.039 *25%)) (See Table 1E).

Beneficiary risk scores are divided by a normalization factor. The fee-for-service normalized risk scores will appear on the MMRs. If plans calculate their own raw risk scores using the CMS-provided software, they will need to divide these raw risk scores by the respective normalization factors to obtain the risk scores used for payment.

TABLE 1E – DIALYSIS AND TRANSPLANT RISK SCORE NORMALIZATION PHASE-IN SCHEDULE

YEAR	ADJUSTED NORMALIZATION FACTOR PHASE-IN PERCENTAGE
2008 (Y1)	1+ (.039*25%)
2009 (Y2)	1+ (Calculated Normalization Factor * 50%)
2010 (Y3)	1+ (Calculated Normalization Factor * 75%)
2011 (Y4) (forward)	1+ (Calculated Normalization Factor * 100%)

For a complete explanation of the derivation of the demographic and risk adjusted ratebook, see the following: http://www.cms.hhs.gov/manuals/Downloads/mc86c08.pdf

1.2.6 Payments for 2006 and Beyond

1.2.6.1 Bidding Background

Beginning in 2006, CMS' payments for plan enrollees are based on the plan bid relative to the plan benchmark. An MA organization's combined bid for its service area, for both local and regional organizations (and service area segment, in the case of a local organization), will have three parts:

- An amount for the provision of Medicare Parts A and B medical benefits. (This is the standardized A/B bid, and does not include beneficiary cost-sharing.)
- An amount for basic coverage of Medicare prescription drug benefits (if any).
- An amount for the provision of supplemental medical and prescription drug benefits (if any).

Benchmarks. For both local and regional MA plans, the plan A/B benchmark, when compared against the plan A/B bid, determines whether a plan will have savings and rebates to offer additional benefits, or whether the MA organization will have to charge a basic premium for the plan's coverage of Part A and B benefits.

For local plans, the plan A/B benchmark is determined according to formulas established in the MMA. For a single-county plan (or segment), the plan A/B benchmark is the capitation rate for that county, adjusted to reflect the plan's projected risk profile to allow comparison to the plan A/B bid.

For local plans serving more than one county, the plan A/B benchmark is the enrollment-weighted average of all the county capitation rates in the plan's service area (or segment), adjusted by the projected risk profile of the plan. (In determining the enrollment-weighted average, the weights are based on the plan's projected enrollment in each county of its service area.)

The standardized benchmark for each MA region is a blend of two components: a statutory component consisting of the weighted average of the county capitation rates across the region; and, a competitive component consisting of the weighted average of all of the standardized A/B bids for regional plans in the region. The weighting for the statutory component is based on MA eligible individuals in the region. "MA eligibles" refers to all Medicare beneficiaries in the FFS and MA programs. The weighting for the competitive component (which includes each regional plan's bid) is based on the projected enrollment of the regional plans competing in the region. The blend of the two components will reflect the market share of traditional Medicare (for the statutory component) and the market share of all MA organizations (for the competitive component) in the Medicare population nationally.

1.2.7 Intra-Service Area Rate (ISAR) Adjusted County Payment Rates

In 2006 and beyond, payments to MA organizations must be adjusted to account for variations in MA local payment rates among the different MA local areas included in the MA plan's service area. For each MA plan, CMS will apply an ISAR adjustment based on the variation among MA capitation rates in the counties of a MA plan's service area. The ISAR is used to convert the plan's service-area bid into plan-specific county rates.

The ISAR factor is calculated as the ratio of a county rate to the weighted average of all county rates for the service area, using plan projected county enrollment as the weights. For example, a plan with a service area of three counties (X, Y, and Z) could have ISAR factors of 0.98 for county X, 1.12 for county Y, and 0.9 for county Z. The weighted average of all the plan's county ISAR factors for that plan's service area must equal 1.0. Thus, for each county in the plan's service area, there will be a plan-specific county rate derived from the bid and the ISAR factor. Each county's ISAR factor is multiplied by the plan's standardized bid amount to derive the plan-specific payment rate for each county in the plan's service area.

1.2.8 Plan Payments

Plan payments Part C benefits are based on the relationship of the plan's bid with the plan benchmark.

(a) If the plan bid is less than the plan benchmark, monthly payment from CMS for an enrollee is:

ISAR-adjusted county rate × enrollee risk factor + rebate

(b) If the plan bid is equal to the plan benchmark, monthly payment from CMS for an enrollee is:

ISAR-adjusted county rate × enrollee risk factor

There is no rebate and no basic beneficiary premium.

(c) If the plan bid is greater than the plan benchmark, monthly payment from CMS for an individual is:

ISAR-adjusted county rate × enrollee risk factor + government premium adjustment.

There is no rebate and the enrollee pays a basic premium. The combined payment from CMS and the enrollee will on average equal the organization's bid (based on enrollment assumed in the bid submission).

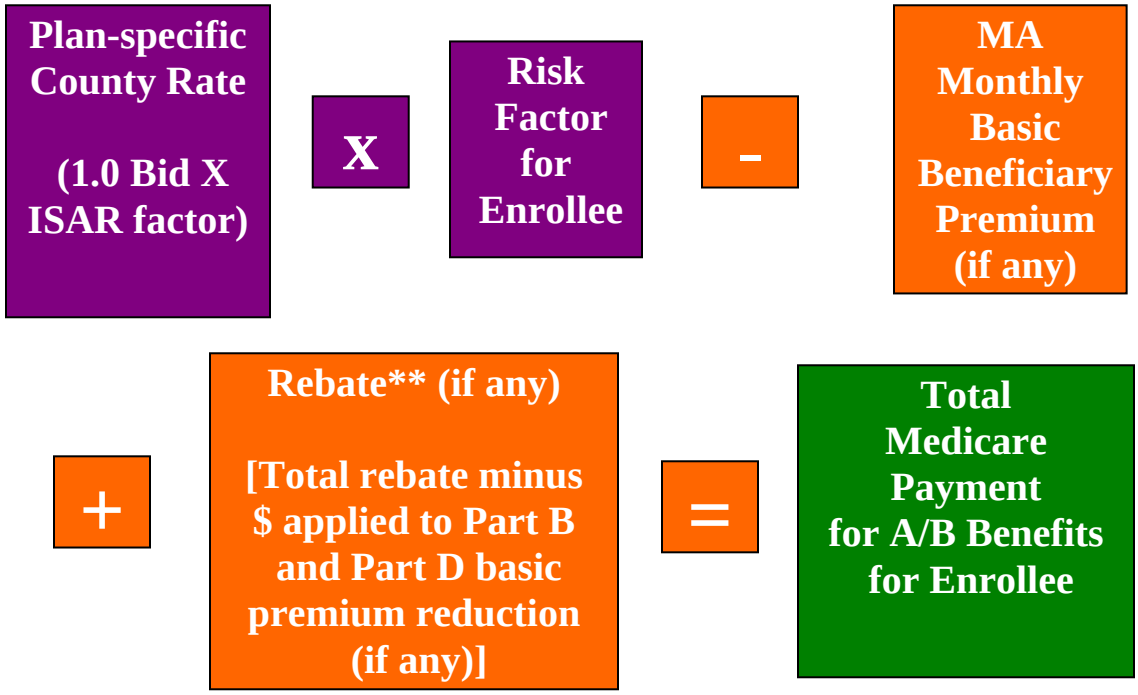
For enrollees who are out of the service area, the base payment will be the 1.0 bid (with individual-level risk adjustment for demographic and health status factors). (Note that for plans with bids above benchmarks, the base payment for out-of-area enrollees is the benchmark because the beneficiary premium is subtracted from CMS' payment.) The rebate amount is not geographically or otherwise adjusted. It is a fixed amount determined through comparison of the plan A/B bid to the plan A/B benchmark based on the plan's projected enrollment.

Example: Plan with a Rebate

- Mr. Jones' plan:
  - Standardized ("1.0") A/B bid = $600
  - Rebate = $54
  - His plan's county ISAR factor = .98
  - His risk factor = 1.2
- ISAR–adjusted payment rate for Mr. Jones' county for his plan: ($600 X .98) = $588
- Monthly Part C payment for Mr. Jones for his plan:
  ($588 X 1.2) + 54 = $759.60

Figure 1A illustrates the calculation of Risk Adjusted Payment for Plans.

Figure 1A – Calculation of Risk Adjusted Payment for Plans



**** Rebate applied to buy down the Part D basic premium is reflected in the part D payment; and rebate applied to buy-down the Part B premium is foregone revenue.**

1.3 Risk Adjustment Payment Models for Payment (Slide 13)

In 2003, after public comment, the CMS-HCC model was finalized as the risk adjustment payment model. The goal was to select a clinically sound risk adjustment model that improved payment accuracy while minimizing the administrative burden on MA organizations.

The model is a revision of the Hierarchical Condition Category model, originally developed by Health Economics Research, Inc. The CMS-HCC model functions by categorizing *International Classification of Diseases, 9th Edition, Clinical Modification* (ICD-9-CM) codes into separate groups of clinically related codes, (e.g., diabetes, cancer, ischemic heart disease, infections, etc.) that have similar cost implications.

In order to improve payment further, CMS has developed separate models for different populations who have different cost patterns than the general Medicare population. There are four CMS-HCC models used to calculate risk scores for MA plans: a community model, a long-term institutional model, an ESRD

model, and a new enrollee model. The new enrollee model is different than the other models in that it is not disease based.

CMS implemented the Prescription Drug (RxHCC) model in 2006 for payment under Part D. The RxHCC model is also a disease based model similar to the CMS-HCC model. However, it varies in that there is a base model and there are separate multipliers for the long term institutionalized (LTI) and low income beneficiaries which are applied to payment outside the model. The RxHCC model is described in detail towards the end of this module.

CMS has updated all of its Part C models and the frailty adjustment model, which is used for Non-ESRD $\geq$55 community residents. The result of the model recalibrations also yields updated normalization factors. Application of the normalization factors is described later in this module.

In 2007, CMS implemented updated versions of the CMS-HCC community and institutional risk adjustment models. Fee-for-service (FFS) claims data for the years 2002 and 2003 were used in the recalibrated model. Diagnosis data for 2002 predict 2003 expenditures. As these data are more current than the 1999 and 2000 data used for the original CMS-HCC model, the updated models reflect newer treatment and coding patterns in Medicare FFS.

For 2008, CMS recalibrated the original Part C ESRD models, and refined the frailty adjustment factors that are applied to the Part C community model risk scores. Similar to the community and institutional recalibration efforts, the ESRD models were recalibrated using 2002 and 2003 FFS claims data for ESRD enrollees. The frailty factors are used to calculate frailty scores applied to the payments to PACE organizations and certain demonstration plans. For PACE plans, CMS will transition from using the frailty factors used in 2007 to the revised frailty factors over five years. CMS will apply the current frailty adjustment factors to MA demonstration organization's payments on a phased-out schedule (described in the frailty section).

CMS' suite of payment models share common conceptual framework in general; however, the purpose for each is distinct to the expenditure patterns for specific Medicare populations.

Table 1F describes the characteristics of the Part C (CMS-HCC) and Part D (RxHCC) models.

TABLE 1F – CHARACTERISTICS OF THE RISK ADJUSTMENT MODELS

CHARACTERISTIC	DESCRIPTION
SIMILAR MODEL CHARACTERISTICS (PART C AND PART D)	
Selected Significant Disease (SSD) Model	• Serious manifestations of a condition are considered rather than all levels of severity of a condition. • Models are additive. • Include most body systems and conditions.
Prospective Model	• Uses diagnostic information from a base year to predict total costs for the following year.
Site Neutral	• Models do not distinguish payment based on a site of care.
Diagnostic Sources	• Models recognize diagnoses from hospital inpatient, hospital outpatient, and physician settings.
Multiple Chronic Diseases Considered	• Risk adjusted payment is based on assignment of diagnoses to disease groups, also known as HCCs. • Model is most heavily influenced by Medicare costs associated with chronic diseases.
Disease Interactions and Hierarchies Included	• Interactions allow for additive factors based on chronic conditions and disabled status to increase payment accuracy. • Hierarchies allow for payment based on the most serious conditions when less serious conditions also exist.
Demographic Variables	• Models include four demographic factors: age, sex, disabled status, and original reason for entitlement. • These factors are typically measured as of the data collection period.
PART C SPECIFIC CHARACTERISTICS	
Frailty Adjuster	• Frailty add-on is used for PACE and certain demonstration plans with a frail elderly population in the community.
Medicaid Eligibility	• Medicaid status for full risk enrollees is prospective and always determined based on the data collection period. • Medicaid status for new enrollees is concurrent and based on Medicaid status during the payment year (during final payment).
Community-Based and Long-Term Institutionalized Enrollees Distinguished	• Long-term institutionalized is defined as enrollees with 90 days or greater of residence in a nursing home. • Institutional model is not based on institutional factor demographic-only model. • Separate models account for higher treatment costs of similarly-ill community residents. • Community and institutional models both include 70 disease groups.
ESRD CMS-HCC Model	• Model addresses disparate treatment costs structures related to ESRD enrollee status. • The model includes specific payments for individuals with dialysis, transplant, and functioning graft. • The ESRD model includes 67 disease groups.
PART D SPECIFIC CHARACTERISTICS	
LTI Multiplier	• Long term institutional (LTI) factor – gets assigned to the risk scores of beneficiaries with 90 days of residence or greater in a nursing home. • LTI status is determined based on the data collection period.
LIS Multiplier	• Two low income status (LIS) factors (full subsidy, and partial subsidy) – one or the other gets assigned to the risk score for enrollees based on their Part D determined LIS status. • LIS status is determined during the payment year.

1.3.1 Components of the Risk Score in the CMS-HCC Model

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

The risk score used in calculating payments under the CMS-HCC model includes demographics as part of the risk model as well as different disease groups or HCCs. The model allows for the recognition of coexisting diseases when calculating payment by recognizing multiple chronic conditions listed for the beneficiary. Interactions (i.e., combinations) are used to account for expected costs that are higher because, for example, multiple coexisting diseases cause additional complications. Hierarchies are imposed to provide payments only for the most severe manifestation of a certain disease.

1.3.1.1 Demographic Factors (Slide 19)

The risk score uses five demographic factors in calculating the risk score under the CMS-HCC model, including age, sex, Medicaid status, disability, and original reason for Medicare entitlement (i.e., disability).

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

Under the CMS-HCC model, CMS bases payments for the entire payment year upon the age an enrollee attains as of February 1st of each year with one exception, when an enrollee ages in to Medicare. (i.e., Beneficiaries are treated as age 65 for risk adjustment purposes when they attained 65 years of age in the payment year and the reason for entitlement is age.)

Disabled Status: The disabled factors for enrollees under 65 years old are labeled as "disabled" and those over 65 years old are labeled as "aged." Under the CMS-HCC model, additional payments are made for Medicaid eligible disabled individuals.

Original Reason for Medicare Entitlement (OREC): The factors labeled "originally disabled" apply to enrollees that are 65 years old or over who were originally entitled for Medicare due to disability. Under the CMS-HCC model, additional payments are made for OREC individuals with Medicaid based on age and sex.

Medicaid Status: The Medicaid factor applies to enrollees who are entitled to Medicaid under Title XIX of the Social Security Act. A Medicaid factor is applied based on the "aged", "disabled", or "originally disabled" status of the Medicaid enrollee.

1.3.1.2 Disease Groups/HCCs (Slide 20)

Disease groups contain major diseases and are broadly organized into body systems. For risk adjustment purposes, CMS refers to disease groups as HCCs. The HCC assigned to a disease is determined by the

ICD-9-CM diagnosis codes submitted during a data collection period. Only selected diagnosis codes are included in the CMS-HCC model. There are 70 distinct disease groups for payment for community and long-term institutionalized residents. The ESRD model has approximately 67 disease groups, depending on the subpart of the model.

Example 1

DISEASE GROUP/HCC	DESCRIPTION
HCC92	Specified Heart Arrhythmia
HCC158	Hip Fracture/Dislocation

1.3.1.3 Disease Hierarchies (Slide 22)

Finally, the CMS-HCC model incorporates disease hierarchies. These hierarchies are used to provide payments for only the most severe manifestation of a disease, even when diagnoses for less severe manifestations of a disease are also present in the beneficiary during the data collection year. For example, an individual with diabetes that progresses over a year from having no complications (HCC19) to having acute complications (HCC17) would trigger the payments for HCC17 but not for HCC19. (Note that payments for HCC17 are higher than for HCC19.)

Example 2

Cancer

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

1.3.1.4 Disease Interactions (Slide 23 & 24)

Certain combinations of coexisting diagnoses for an individual can increase their medical costs. The CMS-HCC model recognizes these higher costs through incorporating payments for disease interactions.

There are six disease interactions in the community model and five in the institutional model. Examples of the disease interactions include a two-way combination of diabetes mellitus (DM) and congestive heart failure (CHF) or a three-way combination of chronic obstructive pulmonary disease (COPD), cerebrovascular disease (CVD), and coronary artery disease (CAD).

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

Example 3

Two-disease Interaction for Community-Based Enrollee
Factor 1: Diabetes Mellitus (DM), HCC15 = 0.508
Factor 2: Congestive Heart Failure (CHF), HCC80 = 0.410
Factor 3: Interaction: DM*CHF = 0.154

Risk Score = (demographics) + 0.508 + 0.410 + 0.154

In this case, the enrollee receives an additional interaction instead of only two factors for HCC15 and HCC80.

1.3.1.5 Disabled/Disease Interactions

Another type of interaction accounted for in the CMS-HCC model involves certain diseases and the disabled status for an enrollee. There are five disabled/disease interactions in the community model and four in the institutional model.

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

Example 4

Disabled/Disease Interaction for Community-Based Enrollee
Factor 1: Rheumatoid Arthritis, HCC38 = 0.346
Factor 2: Opportunistic Infection, HCC5 = 0.300
Factor 2: Disabled * Opportunistic Infection, D HCC5 = 0.623

Risk Score = (demographics) + 0.346 + 0.300 + 0.623

1.3.2 New Enrollee Factors

For purposes of risk adjustment, new enrollees are defined as newly eligible disabled or age-in beneficiaries (including “ever-disabled” age-in beneficiaries) with less than 12 months of Medicare Part B entitlement during the data collection year. Note that payments based on Medicaid eligibility will be made retroactively for all new enrollees, once enrollment can be established and verified.

As indicated in Table 1G, beneficiaries with 12 or more months of Medicare Part B enrollment during the data collection period (previous calendar year) are considered full risk enrollees. The new enrollee factors do not apply.

Beneficiaries with less than 12 months of entitlement to benefits under Part A and less than 12 months of Part B enrollment during the data collection period will be treated as new enrollees.

Previously, beneficiaries with 12 or more months of entitlement to benefits under Part A and less than 12 months of Part B enrollment during the data collection period (referred to as "Part A-only" enrollees) are considered new enrollees for the purpose of risk adjusted payments. Because of concerns expressed by some demonstrations that "Part A only" enrollees are always considered to be new enrollees, CMS has created an option for determining payments for this category of enrollees. Effective for 2006 payments, organizations may elect to have CMS determine payments for all "Part A-only" enrollees using either new enrollee factors or full risk adjustment factors. The organization's decision will be applied to **all** "Part A-only" enrollees in the plan. Plans may not elect to move some eligible "Part A-only" enrollees into risk adjustment, while retaining others as new enrollees.

This option elected by the organization will remain turned "on" until CMS is notified otherwise prior to August 31st of any successive year. CMS will apply this option during reconciliation for a payment year only (that is, it will not be applied prospectively). Plans interested in this option must contact: Henry Thomas at Henry.Thomas@cms.hhs.gov by 8/31/2008 to elect this option.

TABLE 1G – WHICH RISK ADJUSTMENT FACTORS APPLY TO PAYMENT*

Time Period Beneficiary Has Been Enrolled in Part B Medicare**	Time Period Beneficiary Has Been Entitled to Benefits under Part A Medicare**	
	0 - 11 months	≥ 12 months
0 – 11 months	new enrollee factors	Plan's option: new enrollee or full risk adjustment factors
≥ 12 months	full risk adjustment factors	full risk adjustment factors

*Applies to Part C and D payments for MA plans, demonstrations, and PACE organizations. Note that MA enrollees must be entitled to benefits under Part A and enrolled in Part B.
** During data collection period (previous calendar year).

During the payment year, a new enrollee factor will also be assigned to any beneficiary whose risk score is not available. In this case, the beneficiary's correct risk score will be determined during the next reconciliation.

The new enrollee factors for Part C are available at:
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2009.pdf

1.3.3 Community and Long-Term Institutional Model Distinctions

The CMS risk adjustment approach for Part C uses separate models for non-ESRD community and long-term institutional residents. Separate models were necessary because there are significant cost differences between the traditional community-based MA beneficiary population and the long-term institutionalized beneficiary population with the same disease profile. An adjustment for place of residence improves the payment accuracy of risk adjustment.

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

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

TABLE 1H – COMMUNITY VERSUS LONG-TERM INSTITUTIONALIZED POPULATIONS

CMS-HCC MODEL CONSIDERATIONS FOR COMMUNITY AND LONG-TERM INSTITUTIONALIZED POPULATIONS	
Community-Based	**Long-Term Institutionalized**
• Disease-related incremental payments for the community population are generally higher. • Community-based payment includes costs for the short term institutionalized (i.e., less than 90 days in an institution). • Community-based population payment would over predict costs for long-term institutionalized population, even with the same health status. • Currently, most MA organizations have a small proportion of long-term institutionalized enrollees (less than **10** organizations have more than 5% long-term institutionalized enrollees). • For 2004 and 2005, CMS paid all enrollees in most MA organizations as community based. Beginning in 2006, CMS will make prospective payments based on the beneficiaries' statuses (i.e., community or institutional). • The final reconciliation for a payment year will incorporate the correct institutional status for each enrollee for each month.	• Age and sex payment factors are generally higher for the long-term institutionalized population. • Many of the costs of the long-term institutionalized population are not paid for by Medicare. • Institutional model merges a number of disease groups to assure stable coefficients for this population. • Long-term institutional status will be recognized in the payment year. • MDS collected from nursing homes will be used to identify long-term institutionalized enrollees. • The presence of a 90-day assessment and current residence in an institution = long-term institutionalized enrollee. • No additional reporting by MA organizations is required. • Enrollees remain in long-term institutionalized status until discharged to the community for more than 14 days.

As described above in Table 1H, institutional status will be determined from information included in the MDS that is reported by Medicare certified nursing homes. Under the CMS-HCC model, MA organizations **will not report** the institutional status of their enrollees.

Example 5

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

DISEASE GROUP	DESCRIPTION	COMMUNITY FACTOR	INSTITUTIONAL FACTOR
HCC1	HIV/AIDS	0.945	0.967
HCC8	Lung, Upper Digestive Tract, and Other Severe Cancers	1.053	0.470

1.3.4 Frailty Adjuster (Slides 27-30)

The frailty adjuster is included as part of risk adjusted payments for A and B services to PACE and certain demonstration organizations. The purpose of the frailty adjuster is to predict Medicare expenditures that are unexplained by the risk adjustment methodology alone. The CMS-HCC model uses diagnoses to adjust the payments to MA organizations. This model was calibrated based on the general Medicare population that has an average level of functional impairment. The frailty model further adjusts payment based on whether an organization's enrollees are more or less frail than the average.

Under frailty adjustment, the relative frailty of an organization is measured in terms of the number of functional limitations as represented by the Activities of Daily Living (ADL) scale. There are six ADLs: 1) bathing and showering; 2) dressing; 3) eating; 4) getting in or out of bed or chairs; 5) walking; and 6) using the toilet. A sample of individuals in each organization is surveyed to determine the relative frailty of the organization. Frailty adjustment lowers risk scores for individuals with 0 ADLs and increases risk scores for all of the categories of ADLs.

1.3.4.1 Why is There a Frailty Adjuster?

- The Balanced Budget Act of 1997 (BBA) mandated that Medicare capitated payments to PACE organizations be based on MA payment rates, adjusted to account for the comparative frailty of PACE enrollees.

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

1.3.4.2 Which Organizations Are Currently Being Paid Under Frailty Adjustment?

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

TABLE 1I – PLANS RECEIVING FRAILTY ADJUSTMENT

TYPE OF HEALTH PLAN	FRAILTY ADJUSTER IS PART OF RISK ADJUSTED PAYMENT
MA	NO
PACE	YES
Wisconsin Partnership Program (WPP)	YES
Minnesota Senior Care Options (MSHO) and Disability Health Options (MnDHO)	YES
Social Health Maintenance Organizations (S/HMOs)	YES
Massachusetts Senior Options (SCO)	YES

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

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

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

1.3.4.4 Frailty Model Development (Slide 27)

The current frailty factors were calibrated using ADL limitation information from the Medicare Current Beneficiary Survey (MCBS) -- which is a face-to-face survey. Annual frailty factors were calculated using the Health Outcomes Survey – Modified (HOS-M) -- which is an anonymous mail-in survey with telephone follow-up.

For 2008 payments, CMS has changed its source for calibrating the frailty model from the MCBS to the FFS CAHPS data. The change has the advantage of using two surveys with similar methodologies for calibrating the model and for calculating annual frailty scores -- both the HOS-M and FFS CAHPS collect ADL information via mail surveys with telephone follow-up. CMS added questions regarding ADLs to the FFS CAHPS surveys collected between March 2003 and February 2004, used claims data for the beneficiaries in the sample, and recalibrated the frailty factors with these data. For 2009 payments, CMS will continue to use the FFS CAHPS data as the data source for calibrating the frailty model.

The revised frailty factors are also generally lower because:

1. Through mail versus face-to-face survey, beneficiaries more accurately report their functional impairments. Researchers have recognized that written surveys capture more accurate accounts of personal reporting than surveys that are conducted face-to-face. The changes in reporting of ADL limitations resulted in more accurate accounting of the residual expenditures from the CMS-HCC model; and

2. The decrease in home health payments mandated by BBA—as frailty is highly correlated with home health expenditures in a community setting. CMS will continue to use the current frailty methodology to transition frailty payment for PACE organizations and phase-out frailty payments for certain demonstration organization. This implementation schedule is provided in Section 1.3.4.5.

The CAHPS frailty calibration sample is much larger than the MCBS sample. These data have helped to better determine the relationship between frailty and costs given Medicaid and non-Medicaid status in the general Medicare population. For this reason, CMS is able to reliably estimate separate frailty factors for Medicaid and non-Medicaid frail Medicare beneficiaries—because the Medicaid and non-Medicaid frail populations show differences in the relationships between unexplained expenditures (in the CMS-HCC model) and functional impairments. Table 1J provides the Current and Revised Frailty Factors by ADL distribution.

CMS has considered the impact of applying a program wide frailty adjuster and the effect of this on the current bidding methodology. CMS decided that the frailty adjuster will not be applied across all MA organizations. Methodologically, a program-wide adjustment does not improve payment accuracy for two reasons:

1. The HOS data used currently to determine frailty scores for payment is sampled only at the contract level, and therefore, does not allow for accurate calculation of frailty scores at the plan benefit package (PBP) level--thus, contract level frailty scores would lead to inconsistent payments across plans and beneficiaries; and

2. MA organizations would need to project frailty scores in their bids. Due to the changing nature of the marketplace and the different enrollment profiles of plans from year to year, this creates a risk that the level of frailty assumed by a plan in its bid would not reflect its actual score in the payment year.

TABLE 1J – 2008 AND 2009 FRAILTY FACTORS

ADL LIMITATIONS	2008 FRAILTY FACTORS		2009 FRAILTY FACTORS	
	NON-MEDICAID	MEDICAID	NON-MEDICAID	MEDICAID
0	-0.089	-0.183	-.093	-0.180
1-2	+0.110	+0.024	+0.112	+0.035
3-4	+0.200	+0.132	+0.201	+0.155
5-6	+0.377	+0.188	+0.381	+0.200

1.3.4.5 Frailty Payment Implementation

In 2008, CMS will begin transitioning PACE organization payments to 100 percent of the revised frailty factors over a 5-year period through 2012. In each year, the monthly PACE organizations payment would be based on the A/B risk score plus the established frailty transition amount. CMS will also begin a four year phase-out of frailty payments using the current methodology through 2011 for the dual demonstration organizations-- Social Health Maintenance Organizations (S/HMOs), Minnesota Senior Health Options (MSHO)/Minnesota Disability Health Options (MnDHO), Wisconsin Partnership Program (WPP), and Massachusetts Senior Care Options (SCO). Table 1K shows the frailty payment implementation schedule for PACE and demonstration organizations. The percentage (%) represents the percent of the contract-level frailty factor (current and/or revised) that will be added to the monthly A/B risk scores for payment.

TABLE 1K – FRAILTY PAYMENT IMPLEMENTATION SCHEDULE FOR PACE AND DUAL DEMONSTRATION ORGANIZATIONS

TYPE OF CONTRACT	2008 FRAILTY PAYMENT SCHEDULE	2009 FRAILTY PAYMENT SCHEDULE	2010 FRAILTY PAYMENT SCHEDULE	2011 FRAILTY PAYMENT SCHEDULE	2012 FRAILTY PAYMENT SCHEDULE
	% current frailty factor / % revised frailty factor				
PACE	90 / 10	70 / 30	50 / 50	25 / 75	0 / 100
Wisconsin Partnership Program (WPP)	75 / 0	50 / 0	25 / 0	0 / 0	
Minnesota Senior Care Options (MSHO) and Disability Health Options (MnDHO)	75 / 0	50 / 0	25 / 0	0 / 0	
Social Health Maintenance Organizations (S/HMOs)	75 / 0	50 / 0	25 / 0	0 / 0	
Massachusetts Senior Options (SCO)	75 / 0	50 / 0	25 / 0	0 / 0	

The range of frailty scores varies considerably among the organizations to which frailty adjustment applies (i.e., "frailty" plans). Table 1L shows a range of frailty scores by type of organizations for the current frailty methodology conducted using the MCBS and the new frailty calibration methodology using the FFS CAHPS data.

TABLE 1L – RANGE OF FRAILTY SCORE BY TYPE OF ORGANIZATION

ORGANIZATION TYPE	CURRENT MODEL FRAILTY SCORE (MCBS DATA)	RECALIBRATED—MEDICAID/ NON-MEDICAID FRAILTY SCORE (FFS CAHPS DATA)
PACE	0.375 – 0.791	0.064-0.226
S/HMOs	0.057 – 0.122	0.008-0.039
WPP	0.371 – 0.574	0.091-0.162
MnDo	0.583	0.143
MSHO	0.176 – 0.263	-0.017-0.009
SCO	0.166 – 0.414	-0.033-0.053

1.3.4.6 ADL Information Collection and Frailty Adjuster Development

CMS will continue to calculate annual contract-level frailty scores using results from the HOS-M survey. The revised frailty adjuster that will be used for PACE organization payments will include eight factors (instead of four factors under the current model): Medicaid eligible ADL limitations 0, 1-2, 3-4, and 5-6; and Non-Medicaid ADL limitations 0, 1-2, 3-4, and 5-6. The weighted factors will be summed to get the

contract-level frailty score for payment. Demonstration organizations stated in Section 1.3.4.4 will continue to receive frailty payments based on the single frailty factor that is calculated using the current methodology (i.e., MCBS).

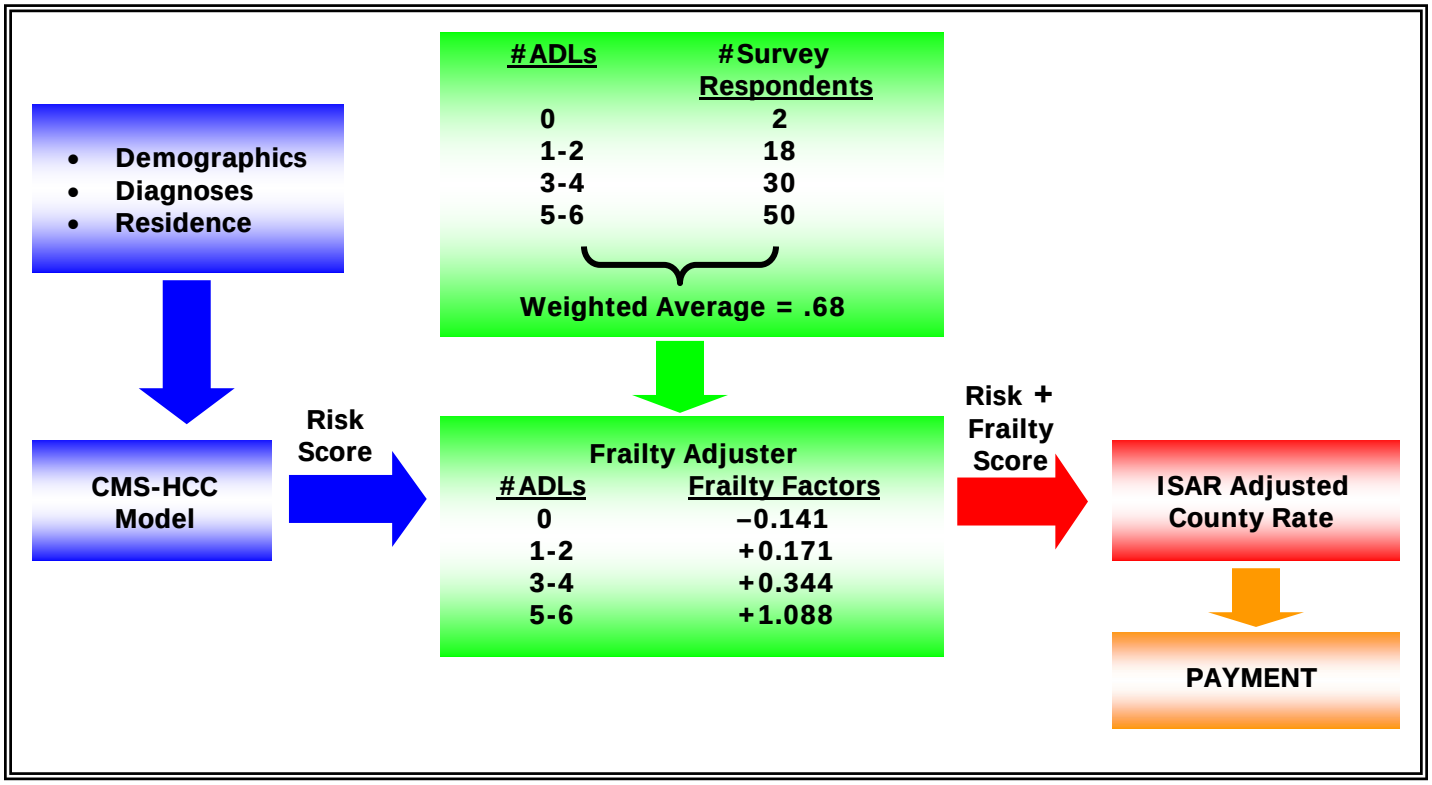
1.3.4.7 Calculating the Frailty Score for Payment

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

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

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

Figure 1B – Frailty Adjustment Calculation



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

1.3.5 Payment Methodology for ESRD Enrollees (Slides 30-32)

In order to further improve payment accuracy, CMS implemented the ESRD risk adjustment model. Effective January 2005, MA enrollees with ESRD were incorporated into diagnosis-based risk adjustment using a different version of the CMS-HCC model. This ESRD models were re-estimated for payments beginning in 2007 and ESRD risk score normalization of dialysis and transplant risk scores will be implemented in 2008. Section 605 of BIPA required CMS to adjust its approach to computing ESRD payment rates to reflect the method used in the ESRD S/HMO demonstration then in place.
The three parts of the ESRD CMS-HCC model are:

Dialysis Status–A risk adjustment model that is calibrated for people on dialysis, so the payment weights are unique to these beneficiaries. The State ratebook used for dialysis payments was rebased with more recent data.

Transplant Status–Kidney or Kidney/Pancreas – CMS calculates the payment amount by calculating the cost of services during the month of the transplant and for the two succeeding months. CMS makes different payments for those who have a kidney transplant and for those who have a pancreas transplant simultaneous with the kidney transplant. However, because the initial data system used for payment will not be able to distinguish individuals with a double transplant in a timely manner, all transplants will initially be paid at the kidney transplant rate. The rarer double transplant will be taken into account in reconciliation. CMS also differentiates payments for months close to the transplant period from those further out.

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

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

CMS updated the state ratebook used to make payments for enrollees in dialysis and transplant status. CMS will phase-in the revised State rates by blending payments based on the current ratebook and the ratebook using the dialysis-only trend. Over a 4-year period, CMS will apply the payment blend according to the schedule described below in Table 1M.

TABLE 1M – NEW ESRD DIALYSIS AND TRANSPLANT PAYMENT TRANSITION

YEAR	CURRENT RATEBOOK PERCENTAGE	REVISED RATEBOOK PERCENTAGE
2008	75%	25%
2009	50%	50%
2010	25%	75%
2011	0	100%

1.3.5.1 Risk Adjustment Model for Dialysis Patients

The dialysis model has the same HCC categories used for the CMS-HCC model. The exception is that the HCCs representing dialysis status and kidney failure are excluded (HCC130 to HCC131). This means that the ESRD model has only 68 HCC categories. The model is calibrated only on dialysis patients, so the disease weights used for payment recognize disease and expenditure patterns are unique to this population.

The data used for calibrating the ESRD models were 2002 (diagnostic) and 2003 (program payment) data on fee-for-service ESRD beneficiaries. For example, expenditures for a fee-for-service beneficiary on dialysis from January through August 2003 who received a transplant in September 2003 are included in the dialysis group for eight months, but then are excluded. From September through November 2003, this beneficiary's costs are included in the transplant data to determine estimated average transplant costs. As of December 2003, this beneficiary is included in the functioning graft model.

1.3.5.2 Transplant Model

To accommodate the high one-time cost of a transplant, CMS will make payments over three months to cover the costs for this transplant and payments for the immediate subsequent services. CMS calibrated the payments by using fee-for-service hospital stay payments for the transplant, and physician and other services rendered for the hospital stay and the two months after discharge. The national average was converted to a relative factor by dividing by the national average payment for dialysis patients. For example, the factor for month 1 is calculated as: $32,558 (average transplant costs in month 1) divided by $5,039 (mean monthly dialysis costs, i.e., $60,471/12). The relative factors for transplant reflect the costs in each month; therefore, the 1st month has a substantially higher factor (6.45) than months 2 and 3 (1.01). The transplant factor is applied to the dialysis state ratebook to provide a transplant payment. Payment will be made in practice by determining the month of transplant and paying the amount over the three-month period starting with the transplant month.

1.3.5.3 Functioning Graft Model

The model for functioning graft enrollees is based on the model for the general population, except that HCCs for kidney transplant status, dialysis status, and renal failure are excluded. For their members with functioning grafts, as for dialysis members, MA organizations will be paid in 2008 based on the diseases reported from all risk adjustment sources in the prior year. However, functioning graft status is recognized in the payment year. In the adapted general population model, almost all of the HCC disease

coefficients have been held to their general population values. A few HCCs have been removed and extra terms have been added specific to being in functioning graft status.

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

1.3.5.4 Model Comparison of Coefficients (Slide 33)

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

1.3.5.5 New Enrollee Factor

The dialysis and functioning graft models have new enrollee factors for enrollees whose risk scores are not available. New enrollees with transplants receive the normal transplant model factors.

1.3.5.6 Reporting of ESRD Status

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

1.3.6 Medicare Part D

Medicare Part D Drug Benefit. In Title I, in addition to the creation of the MA program in Title II of the MMA, Congress added a voluntary prescription drug benefit to Medicare (known as Part D) to be made available for all Medicare beneficiaries through either the MA program or the prescription drug plans. To that end, MA organizations will be required to provide at least one MA plan that provides a "required drug coverage" in each of its service areas. MA plans that offer drug coverage are called MA prescription drug plans (MA-PDs). Beneficiaries receiving health care benefits through fee-for-service Medicare will have the option of accessing prescription drug coverage through sponsors of prescription drug plans (PDPs). Unlike PDPs which can offer supplemental drug coverage only when they offer a standard package in an area, MA-PDs can offer plans with supplemental coverage that qualify as "required prescription drug coverage." Similar to the MA program, CMS established regions (34) through which PDP sponsors will offer Part D drug coverage. To the extent practicable, CMS designed the PDP

regions to overlap with the MA regions. Payments to PDP plans for eligible low-income Medicare beneficiaries will be subsidized at different levels depending upon the income and asset of the enrollee.

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

1.3.6.1 Part D Risk Adjustment Model (Slides 34-37)

The Part D model is similar to the CMS-HCC risk adjustment model. The model includes 113 coefficients: 84 disease groups, 24 age-sex adjustments, 3 interactions between age and disease, and 2 sex-age-originally disabled status interactions. The model was developed assuming an unlimited drug benefit, and was then adjusted for the plan's liability under the Medicare standard Part D benefit.

CMS announced the final Part D risk adjustment on April 4, 2005. The model is published at:
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp

The Part D risk adjustment model shares most of the characteristics of the CMS-HCC model. That is, the model is: prospective, additive, hierarchical, and contains demographic new enrollee model.

The key differences are:

- The Part D model is designed to predict plan liability for prescription drugs under the Medicare drug benefit rather than Medicare Part A/B costs.
- Different diseases predict drug costs than Part A/B costs.
- Incremental costs of low-income (LI) and long term institutional (LTI) beneficiaries are multipliers to the base RxHCC model score.

As in the CMS-HCC model, some of the disease groups fall into hierarchies. Drug regimens may intensify and more drugs added in cases where a disease has a higher severity. In such an instance, the highest cost category of the related diseases is triggered and the lower cost category does not increase the Part D risk score.

Like the CMS-HCC model, the Part D model uses the presence of particular demographic characteristics and diagnoses to predict costs in the following year for an individual. The model clusters a set of ICD-9-CM diagnoses within groups that are similar clinically and in terms of their expected costs. The groupings used to predict drug spending are variants of the groups used to predict Part A and B spending, and the data sources for diagnoses are the same as those used in Part C. Disease groups and draft coefficients for the Part D risk adjustment can be found on the CMS web site at:
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp

In development of the model, drug spending in dollars is used as the dependent variable of a regression model that estimates the marginal or incremental spending related to each of the explanatory variables (demographics and conditions) in the model. The model is ultimately expressed not in dollars, but as relative factors. The incremental dollars associated with each variable in the model are divided by the mean predicted dollars to produce a "relative costliness" or risk factor. Summing the risk factors for an individual yields a total risk adjustment factor that, when multiplied by a base rate, yields an individualized capitation rate.

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

Using a similar methodology to that used for the development of the CMS-HCC risk adjustment model, CMS created a list of diagnoses for the drug risk adjuster and, in April 2005, announced the final list of conditions for inclusion in the drug risk adjustment model. Some of the diagnoses overlap with the current CMS-HCC model and others do not. In particular, there are 1,540 ICD-9 codes unique to the CMS-HCC model, 1,940 ICD-9 codes unique to the Part D risk adjustment model, and 1,622 ICD-9 codes included in both models. Collection of the diagnoses for the CMS drug risk adjustment model from current MA organizations began in July 2004 and will begin payment in January 2006.

Beneficiaries with less than 12 months of Part B enrollment prior to the payment year and who do not have a complete diagnostic record in the Medicare files will be classified as new enrollees. These individuals will receive the new enrollee factor for the RxHCC model.

1.3.6.2 Low Income and Long Term Institutionalization Multipliers (Slides 36-37)

Base Part D risk factors are incremented by either a LI or a LTI multiplier to account for the additional costs of beneficiaries in these categories. See Table 1N for the definition of LI multipliers for the Part D benefit.

TABLE 1N – DEFINITION OF THE LOW INCOME MULTIPLIERS FOR PART D BENEFIT

	GROUP 1	GROUP 1	GROUP 2	GROUP 2
Income test	Medicaid Dual <100% FPL	<135% FPL	<135% FPL	135-150% FPL
Asset test	<2× SSI	<3× SSI	>3× SSI & <$10,000 single $20,000 couple	<$10,000 single $20,000 couple
Deductible	$0	$0	$50	$50
Copay for generic drugs up to catastrophic threshold	$1	$2	—	—
Copay for brand-name drugs up to catastrophic threshold	$3	$5	—	—
Coinsurance up to catastrophic threshold	—	—	15%	15%
Coinsurance above catastrophic threshold	0%	0%	0%	0%
Copay for generic drugs above catastrophic threshold	$0	$0	$2	$2
Copay for brand-name drugs above catastrophic threshold	$0	$0	$5	$5
Premium subsidy	100%	100%	100%	Sliding scale

The LI multiplier is estimated to be 1.08 for Group 1 LI individuals (as defined above) and 1.05 for Group 2 individuals (as defined above). This multiplier is defined on a concurrent basis. (For example, if an individual were not defined as LI for January 2007 but was determined to be a Group 1 beneficiary for February 2007, the plan would receive the LI multiplier for February (and beyond) but not for January.)

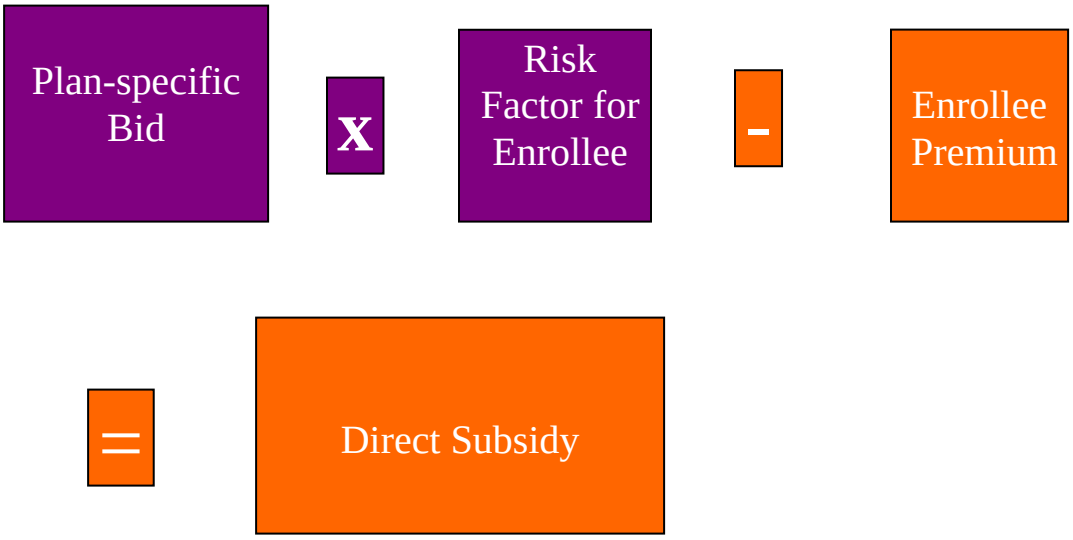
An enhancement was also computed for the predicted spending by persons institutionalized in nursing facilities for more than 90 days. Spending for this group is expected to be higher because prices for the specific packages of drugs they receive are somewhat higher than the same drugs in the community. (An analysis of drug data done by IMS Health shows that the price differences in the claims were small, particularly for brand name drugs that dominate the spending.) There are also effects related to compliance in acquiring and taking drugs in the institutional environment. On the other side, often patients take fewer drugs because of more careful monitoring of interactions.

An analysis was done for the spending by the institutionalized by first using the base model to predict for this population and then comparing the actual spending and liability to the predicted. For the case of spending, there was a significant positive effect for the aged and the disabled who are in institutions. The effect for the disabled is greater than for the aged. It was also observed that average spending for both groups was in the 100 percent coinsurance range. The disabled mean was quite close to the catastrophic limit. The implications of additional demand being, to a large extent, in the range in which plans do not have incremental liability means that the effect on plan liability is much smaller than the effect on spending. The final payment adjustments for the institutionalized are smaller for the aged than for the

disabled and smaller perhaps than some people expect because the final measure is plan liability rather than spending.

Figure 1C illustrates the calculation of the Part D Direct Subsidy.

Figure 1C – Calculation of Part D Direct Subsidy



1.4 Parts C and D Final Submission of Risk Adjustment Data (Reconciliation)

Reconciliation is used to complete the implementation of payments, with CMS calculating final risk adjustment factors and beneficiary status based on complete data. CMS continues to allow a period (approximately 13 months after the data collection year) for submitting final RAPS data for the appropriate data collection period. Data not received or submitted by the initial submission deadline for a data collection period can be submitted by the final submission deadline (reconciliation). In addition to incorporating new RAPS and fee-for-service diagnoses, reconciliation takes into account necessary adjustments to institutional status and demographic data for enrollees.

Note: CMS reconciles risk-adjusted payments for a calendar year only one time. When submitting risk adjustment data for reconciliation, plans may submit as well as correct data that was previously submitted.

1.4.1 Parts C and D Risk Adjustment Schedule & Elimination of the Payment Lag

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

Example: 6

Data Collection Period: July 1, 2006 through June 30, 2007
Data Collection End Date: June 30, 2007
CY2007: First payment made based on this collection period = January 1, 2008
As you can see, payments began 6 months after the end of the data collection period.

Note: The purpose of eliminating the lag between the end of the data collection period and the payment based on that year's data is to use the most recent data for more accurate payment.

Data Collection Period: January 1, 2007 through December 31, 2007
Data Collection End Date: December 31, 2007
CY2007: Updated payment made based on the non-lagged data collection period = July, 2008

- CMS calculates a preliminary risk factor based on lagged data. For 2008, it will be based on data from July 2006 through June 2007. Payments from January 2008 through June 2008 will be based on this factor.

- In July 2008 CMS will use a risk factor based on non-lagged data (i.e., from calendar year 2007) for calculating payments. That factor will be used for the remainder of the year.

- By eliminating the lag, the collection period will change from July 1 through June 30 to January 1 through December 31 (or a calendar year).

1.5 Updating Diagnosis Codes in the Parts C and D Risk Adjustment Models

CMS updates the risk adjustment models to reflect the annual updates to the ICD-9 diagnostic code set. After clinical review, new ICD-9 diagnosis codes are added to the appropriate diagnostic categories and included in the CMS-HCC model. A comprehensive listing of the ICD-9 codes that MA organizations are required to submit for all risk adjustment models can be found at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage. This list will be updated annually to take into account new codes that are required for risk adjustment.

MODULE 2 – RISK ADJUSTMENT SUBMISSION PROCESS OVERVIEW

Purpose

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

Learning Objectives

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

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

ICON KEY
Example
Reminder
Resource

2.1 Common Risk Adjustment Terms (Slide 7)

Table 2A provides descriptions of common risk adjustment terminology.

TABLE 2A – RISK ADJUSTMENT COMMON TERMS

TERM	DESCRIPTION
FERAS	Risk adjustment submitters send data to Palmetto through the **Front-End Risk Adjustment System**.
RAPS	Risk adjustment data are processed by the **Risk Adjustment Processing System.**
RAS	The **Risk Adjustment System** calculates the risk score.
MARx	The **Medicare Advantage Prescription Drug System** calculates the risk payment.
Common UI	The **Common UI** maintains Medicare beneficiary eligibility data.
HPMS	The **Health Plan Management System** is a CMS MA information system that contains health plan-level data.
Required Diagnosis	ICD-9-CM diagnosis codes required to be submitted for the CMS-Hierarchical Condition Category (HCC) model and for future model development.

2.2 Risk Adjustment Process Overview

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

2.2.1 Risk Adjustment Data Requirements (Slide 8)

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

2.2.2 Risk Adjustment Data Collection (Slide 9)

- MA organizations may choose to collect data from providers in a variety of formats:
  - Standard fee-for-service claim or encounter formats
    - Uniform Billing Form (UB-04)
    - HCFA 1500
    - National Standard Format (NSF) v3.01
    - American National Standards Institute (ANSI) X12 837 v30.51 or v40.10. Health Insurance Portability and Accountability Act (HIPAA) mandated transactions must use v40.10.
  - Superbill
  - RAPS format
    - HIC number
    - Provider type
    - Diagnosis code
    - Service from date
    - Service through date

2.2.3 Risk Adjustment Data Submission (Slide 10)

- MA organizations must submit data to CMS through FERAS (Palmetto GBA) utilizing the following formats:

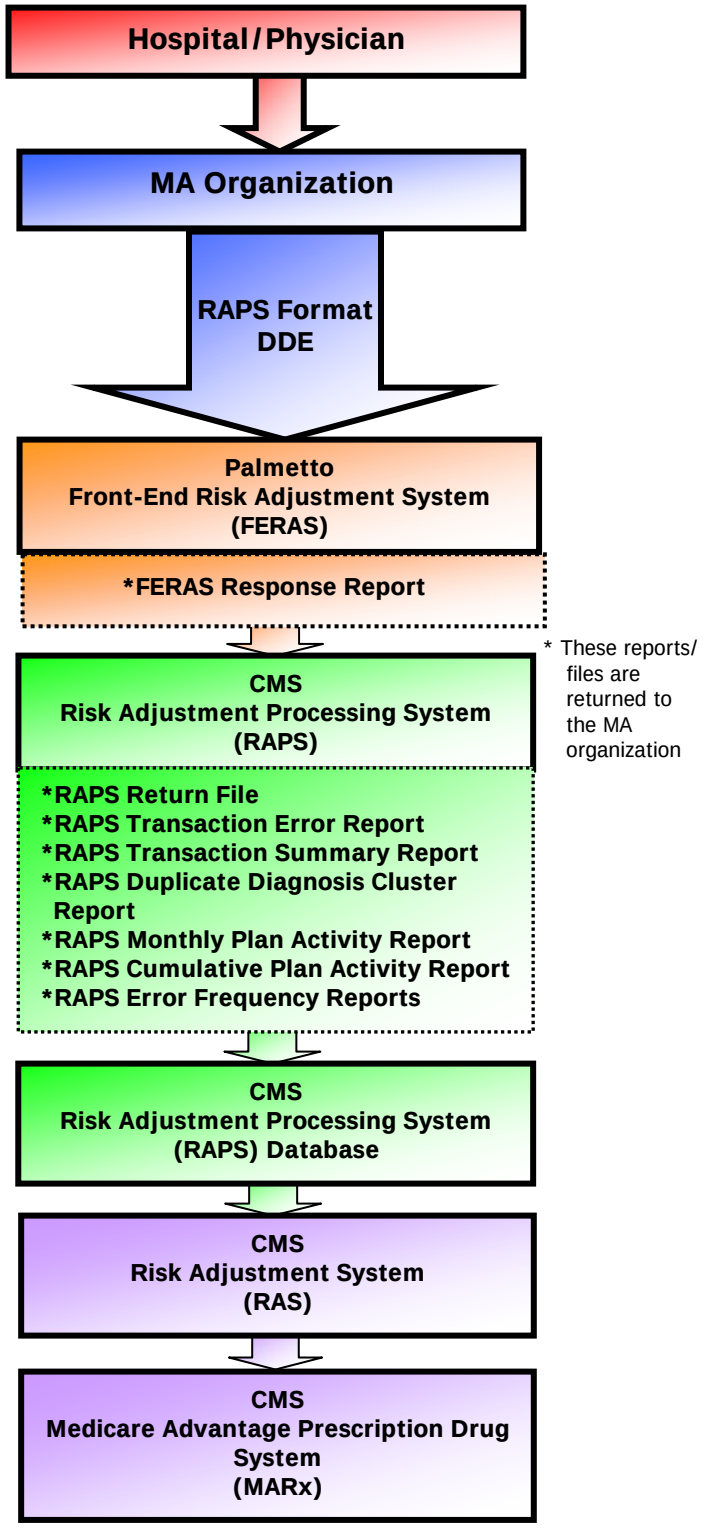
  - RAPS format (all types of data)
  - Direct Data Entry Screen (all types of data)

Figure 2A illustrates the risk adjustment dataflow.

2.2.4 Risk Adjustment Dataflow (Slide 11)

- Hospital/physician submits data to MA organization via:
  - Full or abbreviated UB-04, HCFA 1500, NSF v3.01, ANSI x837 v30.51 or v40.10, Superbill or RAPS format.
- The MA organization submits these data at least quarterly to Palmetto GBA.
- The MA organization submits the data via Direct Data Entry or in the RAPS format.
- The data are sent to FERAS for processing where the file-level data, batch-level data, and first and last detail records are checked.
- If any data are rejected, then data are reported on the FERAS Response Report.
- After passing the FERAS checks, the file is submitted to RAPS where detail editing is performed.
- The RAPS Return File is returned daily and shows all records approved and where errors occurred.
- The RAPS Transaction Error Report displays records on which errors occurred.
- The RAPS Transaction Summary Report is sent to the MA organization daily and identifies data that have been finalized in RAPS database.
- The Duplicate Diagnosis Cluster Report identifies diagnosis clusters submitted with information that duplicates a stored cluster.
- The RAPS Monthly Plan Activity Report and Cumulative Plan Activity Report provides a summary of all diagnoses stored for a given time period.
- Distributed monthly and quarterly, the Error Frequency Report provides an overview of all errors associated with files submitted in test and production.
- RAPS database stores all finalized diagnosis clusters.
- RAS calculates the Risk Adjuster Factors by executing the CMS-HCC model.
- MARx is used in the calculation of payments and determination of plan payments. MARx replaced Medicare Managed Care System (MMCS) on November 15, 2005.

Figure 2A – Risk Adjustment Dataflow



2.2.5 Important Information About Risk Adjustment Processing

- MA organizations transmit data to FERAS at Palmetto GBA.
- FERAS performs format and face validity checks on the file- and batch- level as well as formatting verification on the first and last detail record (CCC) in the file.
- If the data fail the front-end checks, the complete file is rejected at the front end.
- The FERAS Response Report identifies whether the file is accepted or rejected up front.
- Once the file has passed front-end checks, it moves to RAPS. All validity edits on detail-level data are performed in this system.
- Processing time from beginning to end should take approximately 1 to 2 days.
- After the file has processed through RAPS, the MA organization will receive a RAPS Return File and RAPS Transaction Error Report identifying any errors.
- All ICD-9-CM diagnoses that pass validity edits are stored in the RAPS database.
- The MA organization will also receive a RAPS Transaction Summary Report reflecting all finalized data sent to the RAPS database along with all rejected data.
- The MA organization also receives two monthly risk adjustment management reports: 1) the RAPS Monthly Plan Activity Report and 2) the RAPS Cumulative Plan Activity Report.
- All data are converted to the RAPS format and returned in the RAPS Return File.
- Interim bills (112 and 113 bill types) are not accepted. If a MA organization receives interim bills, do not submit the hospital inpatient diagnoses on receipt of the final bill (114 bill type).

2.3 Submission Schedule (Slide 12)

The elimination of the payment lag changes the submission schedule. This requires MA organizations to meet three submission deadlines—the first Friday in September, the first Friday in March of each year, and a reconciliation (final submission) deadline of January 31. The schedule is illustrated in Table 2B.

TABLE 2B – SUBMISSION TIMETABLE

CY	DATES OF SERVICE	INITIAL SUBMISSION DEADLINE	FIRST PAYMENT DATE	FINAL SUBMISSION DEADLINE
2008	July 1, 2006 through June 30, 2007	September 7, 2007	January 1, 2008	NA
2008	January 1, 2007 through December 31, 2007	March 7, 2008	July 1, 2008	January 31, 2009
2009	July 1, 2007 through June 30, 2008	September 5, 2008	January 1, 2009	NA
2009	January 1, 2008 through December 31, 2008	March 6, 2009	July 1, 2009	January 31, 2010
2010	July 1, 2008 through June 30, 2009	September 4, 2009	January 1, 2010	N/A
2010	January 1, 2009 through December 31, 2009	March 5, 2010	July 1, 2010	January 31, 2011

2.4 Training and Support (Slide 13)

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

TABLE 2C – TRAINING AND SUPPORT

INITIATIVE	DESCRIPTION
Customer Service & Support Center (CSSC)	This toll free help line (1-877-534-2772) is available Monday – Friday, 9:00 a.m. to 7:00 p.m. Eastern Time (ET) (with the exception of corporate observed holidays) to provide assistance. The support center provides ongoing assistance. The FERAS system is available to submit risk adjustment data 24 hours a day, 7 days a week regardless of holidays. The only exception is from 5:00 PM EST - 10:00 PM EST on Sunday when systems and equipment undergo routine maintenance.
www.csscoperations.com	The CSSC website, www.csscoperations.com is the gateway to RAPS. Visitors to the site can access information about RAPS/FERAS, including opportunities to register for service, enroll to submit risk adjustment data, and obtain comprehensive information about data entry and report layouts. In addition, the site provides valuable links to CMS instructions and other official resources. Monthly User Group and other training information are regularly posted. Finally, the site provides up-to-date system status alerts and answers to frequently asked questions (FAQs) about risk adjustment. To register for email updates, go to www.csscoperations.com, click on Risk Adjustment Processing System (RAPS), and then click on "Register for Medicare Advantage". Afterwards, click on "new registrations only" and complete the registration form.
User Groups	Conducted once each month from 1:30 – 2:30 p.m. ET. The purpose of the User Group meeting is to share information among participants, distribute new information, and identify issues for future resolution. Meeting notes and Q&As are provided. To register online for User Groups, go to ugregistration@tarsc.info.
Onsite Consultation	On-site consultation visits provide MA organizations with the opportunity to gain valuable information about risk adjustment data submission and data validation processes. These consultations generally occur between April and May. Each visit includes a review of the MA organization's system.
www.tarsc.info	The website, www.tarsc.info is the website for risk adjustment training and User Group information. The website includes information about trainings and user groups, training dates, locations, online registration, and training FAQs.

MODULE 3 – DATA COLLECTION

Purpose (Slide 2)

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

Learning Objectives (Slide 3)

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

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

ICON KEY	
Example	
Reminder	
Resource	

3.1 Required Risk Adjustment Data Elements (Slide 5)

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

- Health Insurance Claim (HIC) Number
- ICD-9-CM Diagnosis Codes
- Service From Date
- Service Through Date
- Provider Type

3.1.1 HIC Number (Slides 6-7)

A HIC number is a Medicare beneficiary's identification number. Both CMS and the Railroad Retirement Board (RRB) issue Medicare HIC numbers. The format of a HIC number issued by CMS is a Social Security number followed by an alpha or alphanumeric Beneficiary Identification Code (BIC). RRB numbers issued before 1964 are 6-digit numbers preceded by an alpha prefix. After 1964, the RRB began using Social Security numbers as Medicare beneficiary identification numbers preceded by an alpha prefix. Table 3A shows the characteristics for each HIC type.

TABLE 3A – STRUCTURE OF HIC NUMBERS

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

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

3.1.2 ICD-9-CM Diagnosis Code (Slide 8)

International Classification of Diseases-9th Edition-Clinical Modification (ICD-9-CM) codes are 3- to 5-digit codes used to describe the clinical reason for a patient's treatment. ICD-9-CM codes do not describe the service performed, just the patient's medical condition. Diagnosis codes drive the risk scores, which drive the risk adjusted reimbursement from CMS to MA organizations.

3.1.2.1 Description of Diagnosis Code Files

Current model diagnoses.xls:
Comprehensive list of all risk adjustment model diagnoses used for risk adjustment payments in 2004-2009.

Specifically, the file:

- Contains all diagnoses used in the CMS-HCC models and the RxHCC (prescription Drug Risk Adjustment Model)
- Indicates whether or not the diagnosis code is used for payment for 2004-2009.
- Includes the associated condition category for the RxHCC model and/or the CMS-HCC model, and
- Indicates the diagnosis code effective date.

Please see http://www.cms.hhs.gov.MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage and click on "Risk model diagnosis codes" for more information about model diagnosis codes.

Future model diagnoses.xls:

Comprehensive list of all additional model diagnoses that plans are required to collect and submit. These diagnoses, while not used for payment, are needed so that CMS can conduct analyses of future models that may include these diagnoses. Please note that these codes are sometimes referred to as "Non-model" diagnosis codes. Please see http://www.cms.hhs.gov.MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage and click on "Future model diagnoses" for more information regarding future model diagnoses codes.

3.1.3 Service From and Through Dates (Slide 9)

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

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

3.1.4 Provider Type (Slide 10)

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

- Hospital inpatient facilities
- Hospital outpatient facilities
- Physicians

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

3.2 Data Sources

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

3.2.1 Hospital Inpatient (Slide 11)

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

Inpatient hospital data should be differentiated based on whether it is received from within or outside of the MA organization's provider network. Effective May 1, 2007, a network hospital should have a National Provider Identifier (NPI) number as a hospital inpatient facility. Table 3B identifies covered and non-covered facilities with regard to risk adjustment data collection.

TABLE 3B – HOSPITAL INPATIENT

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

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

When submitting hospital inpatient data, MA organizations must make a distinction between the principal diagnosis and other diagnoses. The Data Submission Module covers the details of submitting data.

3.2.2 Hospital Outpatient (Slide 12)

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

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

TABLE 3C – HOSPITAL OUTPATIENT

PROVIDER TYPE	COVERED FACILITIES	NON-COVERED FACILITIES*
Hospital Outpatient	• Short-term (general and specialty) Hospitals • Medical Assistance Facilities/Critical Access Hospitals • Community Mental Health Centers 1** • Federally Qualified Health Centers 2/ Religious Non-Medical Health Care Institutions (formerly Christian Science Sanatoria) ** • Long-term Hospitals • Rehabilitation Hospitals • Children's Hospitals • Psychiatric Hospitals • Rural Health Clinic (Free-standing and Provider-Based) 3**	• Free-standing Ambulatory Surgical Centers (ASCs) • Home Health Care • Free-standing Renal Dialysis Facilities
	NON-COVERED SERVICES	
	• Laboratory Services • Ambulance • Durable Medical Equipment • Prosthetics	• Orthotics • Supplies • Radiology Services

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

** Facilities use a composite bill that covers both the physician and the facility component of the services, and services rendered in these facilities do not result in an independent physician claim.

1. Community Mental Health Centers (CMHCs) provide outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at an inpatient facility.
2. Federally Qualified Health Centers (FQHCs) are facilities located in a medically underserved area that provide Medicare beneficiaries with preventive primary medical care under the general direction of a physician.
3. Rural Health Clinics (RHCs) are Medicare certified facilities that are located in a rural, medically underserved area that provide ambulatory primary medical care under the general direction of a physician.

It is important for MA organizations to note that regardless of the type of diagnostic radiology bill (outpatient department or physician component), the services are not acceptable for risk adjustment. Diagnostic radiologists typically do not document confirmed diagnoses. The diagnosis confirmation comes from referring physicians or physician extenders and therefore not assigned in the medical record documentation from diagnostic radiology services alone.

3.2.2.1 Determining Whether Facilities Are Acceptable for Risk Adjustment (Slide 13)

MA organizations are responsible for ensuring data collected and submitted are acceptable for the risk adjustment process. In the past, the provider number has been used to assist in this. However, CMS is in the process of implementing a new provider identifier, the National Provider Identification (NPI) number.

As will be discussed below, the CMS will continue to allow the use of the legacy provider number along with the new NPI for a transition time. However, the NPI does not have intelligence, so a new code called the "taxonomy code" was developed to help identify types of providers. Both the legacy provider number and the taxonomy code can be used in determining the appropriateness of the covered hospital entities for the purposes of risk adjustment data collection. Table 3D illustrates the steps MA organizations may use to identify the provider numbers or taxonomy codes for facilities.

TABLE 3D – DETERMINING COVERED HOSPITAL ENTITY PROVIDER NUMBERS

SITUATION	ISSUE	ACTION
Situation 1	The provider number or taxonomy code is identified.	Determine if the number is in an acceptable range for risk adjustment. If in the acceptable range, submit the data.
Situation 2	An in-network provider submitted a claim but did not include the provider number or taxonomy code.	Obtain the provider number or taxonomy code and determine if the number is in an acceptable range for risk adjustment. If in the acceptable range, submit the data. **NOTE:** All network providers are required to have certified Medicare provider numbers or taxonomy codes; therefore, do not submit risk adjustment data for this provider until these numbers are obtained.
Situation 3	An out-of-network provider submits a claim without a provider number.	Try to obtain a provider number or taxonomy code, if possible. If not available, check the list of Veterans Administration and Department of Defense (VA/DoD) listings published on csscoperations.com. If the provider is listed there, submit the data. If the provider is not on the VA/DoD list, the organization may need to contact CMS to determine if the provider is acceptable for risk adjustment. **NOTE:** All network providers are required to have certified Medicare provider numbers or taxonomy codes; therefore, do not submit risk adjustment data for this provider until these numbers are obtained.

3.2.2.2 National Provider Identifier

CMS has recently issued contingency guidance for National Provider Identifier implementation. This contingency guidance provides that, for a period of 12 months after the NPI Rule compliance date of May 23, 2007, CMS will not impose civil money penalties on covered entities that deploy contingency plans, including (in order to ensure the smooth flow of payments) continuing to use and accept legacy identifiers on HIPAA transactions, if they have made reasonable and diligent efforts to become compliant

and, in the case of health plans (that are not small health plans), in order to facilitate the compliance of their trading partners.

MA organizations should verify that diagnoses are collected from Medicare certified hospitals/facilities and that data from all Medicare certified network hospital/facilities include the associated Medicare provider identifiers (NPI and taxonomy code; and in the interim the legacy provider number). They should also verify that the Medicare certified hospitals/facilities providing the data are from acceptable facilities and services. As stated above, plans may use either the legacy Medicare provider numbers or the taxonomy code to determine if facilities and services are acceptable for risk adjustment.

MA organizations may wish to create a system for checking if the data are from acceptable facilities and for acceptable services. They may check the legacy provider number against the provider number ranges or check the taxonomy code against the taxonomy code ranges, both of which identify what type of service has been rendered.

If using the provider number, please note that it has six characters. The first two characters are numerals and represent the state/territory as illustrated in Table 3E.

TABLE 3E – PROVIDER NUMBER STATE ASSIGNMENTS

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

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

The third character may be a numeral or a letter. Provider numbers with a **U, W, Y, Z, 5** or **6** in the third character indicate that the service was provided in a swing bed component of a hospital or a skilled

nursing facility, which, are not covered entities. The last three characters are numerals unique to the facility.

If using the taxonomy code, the bill type will be needed to identify if the service was provided in non-covered entity such as a swing bed component of a hospital or a skilled nursing facility.

As an additional check, refer to Tables 3F and 3G, which provide the only acceptable ranges for hospital facilities. The tables reflect the range of provider numbers for risk adjustment covered hospital entities. Risk Adjustment data are not acceptable when received from facilities with numbers outside the ranges.

Skilled nursing facilities, home health care and hospital inpatient swing bed components are not covered entities for risk adjustment data.

TABLE 3F – HOSPITAL INPATIENT COVERED ENTITIES

TYPE OF HOSPITAL INPATIENT FACILITY	PROVIDER NUMBER RANGE	TAXONOMY CODE/ TYPE OF BILL(TOB)
Short-term (General and Specialty) Hospital	XX0001-XX0899 XXS001-XXS899 XXT001-XXT899	282N00000X 273R00000X 273Y00000X
Medical Assistance Facilities/Critical Access Hospitals	XX1225-XX1399	282NC0060X
Religious Non-Medical Health Care Institutions	XX1990-XX1999	TOB 4XX
Long-term Hospitals	XX2000-XX2299	282E00000X
Rehabilitation Hospitals	XX3025-XX3099	283X00000X
Children's Hospitals	XX3300-XX3399	282NC2000X
Psychiatric Hospitals	XX4000-XX4499	283Q00000X

TABLE 3G – HOSPITAL OUTPATIENT COVERED ENTITIES

TYPE OF HOSPITAL OUTPATIENT FACILITY	PROVIDER NUMBER RANGE	TAXONOMY CODE/ TYPE OF BILL (TOB)
Short-term (General and Specialty) Hospital	XX0001-XX0899 XXS001-XXS899 XXT001-XXT899	282N00000X 273R00000X 273Y00000X
Medical Assistance Facilities/Critical Access Hospitals	XX1225-XX1399	282NC0060X
Community Mental Health Centers	XX1400-XX1499 XX4600-XX4799 XX4900-XX4999	TOB 76X
Federally Qualified Health Centers/Religious Non-Medical Health Care Institutions	XX1800-XX1999	TOB 73X for FQHC TOB 4XX for RNHCI
Long-term Hospitals	XX2000-XX2299	282E00000X
Rehabilitation Hospitals	XX3025-XX3099	283X00000X
Children's Hospitals	XX3300-XX3399	282NC2000X
Rural Health Clinics, Freestanding and Provider-Based	XX3400-XX3499 XX3800-XX3999 XX8500-XX8999	TOB 71X
Psychiatric Hospitals	XX4000-XX4499	283Q00000X

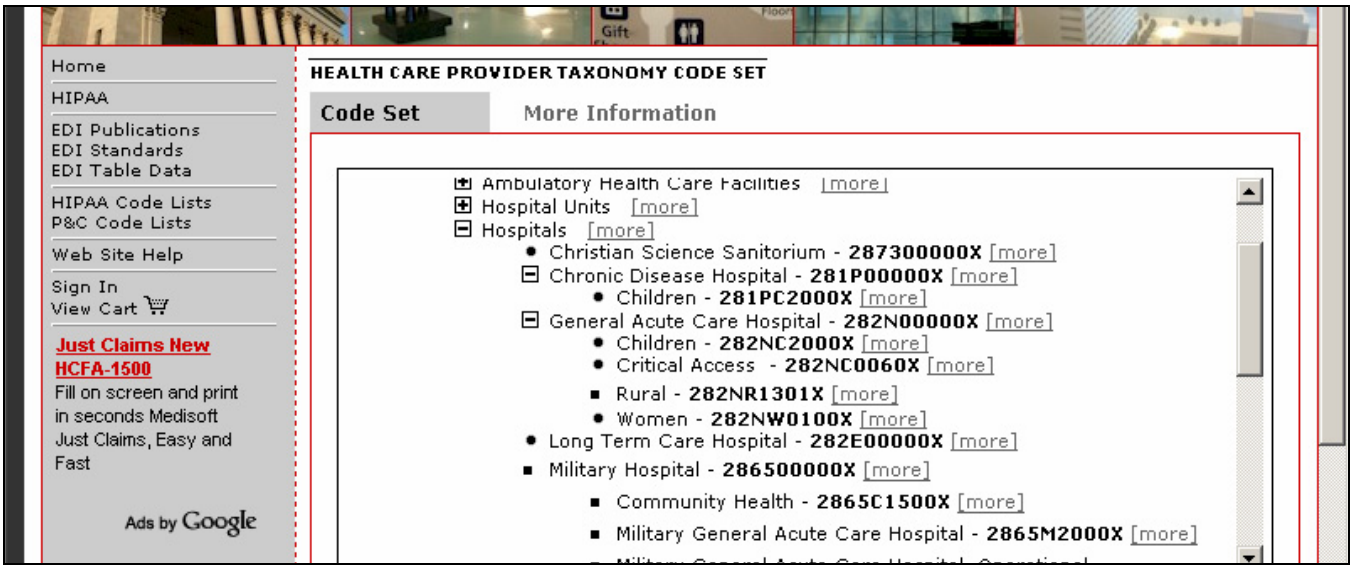
The implementation of the NPI did not change the valid Hospital Inpatient and Outpatient facilities for submission of risk adjustment data nor eliminate the process for receiving and verifying information from Medicare health care providers that are in network. Institutional providers that currently bill Medicare using more than one legacy identifier in order to identify subparts of their facility are required to submit a taxonomy code on all of the claims they submit to Medicare.

The following web site serves as a reference to types of facilities and taxonomy codes.

http://www.wpc-edi.com/codes/taxonomy

Figure 3A is a screen shot of the wpc-edi.com website which serves as a reference tool to determine types of facilities and taxonomy codes.

Figure 3A – WPC-EDE.COM

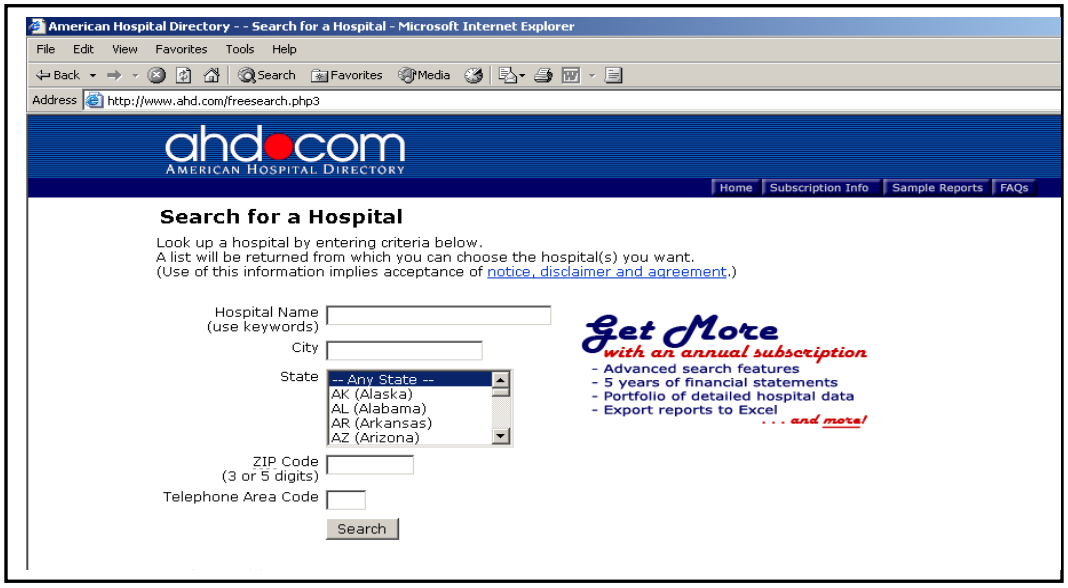


The following website serves as a reference for hospital provider numbers:
http://www.ahd.com/freesearch.php3

Figure 3B is a screenshot of the search page on the American Hospital Directory website. This web-based search database allows MA organizations the opportunity to access Medicare provider number by entering key words, city, state, zip code, or area code. When using the search tool, users need to be aware of the following:

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

Figure 3B – American Hospital Directory



📖 See Resource Guide for more information about Medicare provider numbers.

3.2.3 Physician Data (Slide 14)

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

Only those physician specialties and other clinical specialists identified in Table 3H are acceptable for risk adjustment.

TABLE 3H – ACCEPTABLE PHYSICIAN SPECIALTIES

CODE	SPECIALTY	CODE	SPECIALTY	CODE	SPECIALTY
01	General Practice	29	Pulmonary Disease	70*	Multispecialty Clinic or Group Practice
02	General Surgery	33*	Thoracic Surgery	72*	Pain Management
03	Allergy/Immunology	34	Urology	76*	Peripheral Vascular Disease
04	Otolaryngology	35	Chiropractic	77	Vascular Surgery
05	Anesthesiology	36	Nuclear Medicine	78	Cardiac Surgery
06	Cardiology	37	Pediatric Medicine	79	Addiction Medicine
07	Dermatology	38	Geriatric Medicine	80	Licensed Clinical Social Worker
08	Family Practice	39	Nephrology	81	Critical Care (Intensivists)
10*	Gastroenterology	40	Hand Surgery	82	Hematology
11	Internal Medicine	41	Optometry (specifically means optometrist)	83	Hematology/Oncology
12	Osteopathic Manipulative Therapy	42	Certified Nurse Midwife	84	Preventive Medicine
13	Neurology	43	Certified Registered Nurse Anesthetist	85	Maxillofacial Surgery
14	Neurosurgery	44	Infectious Disease	86	Neuropsychiatry
16*	Obstetrics/Gynecology	46*	Endocrinology	89*	Certified Clinical Nurse Specialist
18*	Ophthalmology	48*	Podiatry	90	Medical Oncology
19	Oral Surgery (Dentists only)	50*	Nurse Practitioner	91	Surgical Oncology
20	Orthopedic Surgery	62*	Psychologist	92	Radiation Oncology
22*	Pathology	64*	Audiologist	93	Emergency Medicine
24*	Plastic and Reconstructive Surgery	65	Physical Therapist	94	Interventional Radiology
25	Physical Medicine and Rehabilitation	66	Rheumatology	97*	Physician Assistant
26	Psychiatry	67	Occupational Therapist	98	Gynecologist/Oncologist
28*	Colorectal Surgery	68	Clinical Psychologist	99	Unknown Physician Specialty

* Indicates that a number has been skipped.

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

3.2.4 Alternative Data Sources

Alternative data sources (ADS) include diagnostic data from sources other than hospital inpatient, hospital outpatient, and physician services. MA organizations may use ADS as a ***check*** to ensure that all required diagnoses have been submitted to CMS for risk adjustment purposes, such as pharmacy records and information provided to national or state cancer registries. The MA organization may not, however, use ADS as substitutes for documenting diagnoses from a hospital/physician. As in all diagnoses submitted, there must be medical record documentation to support the diagnosis as having been documented as a result of a hospital inpatient stay, a hospital outpatient visit, or a physician face-to-face visit during the data collection period.

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

3.2.5 Excluded Providers

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

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

3.3 Data Collection Formats and Considerations

There are several formats that MA organizations can accept when collecting data from medical providers. Table 3I lists the formats by provider type.

3.3.1 Data Collection Formats (Slide 16)

For facility services, the standard billing format is UB-04 (Uniform Billing Form–2004 version). The HCFA 1500 form is the standard format for physician services.

TABLE 3I – DATA COLLECTION FORMATS

HOSPITAL INPATIENT/HOSPITAL OUTPATIENT	• UB-04 • ANSI X12 837 4010 • RAPS Format
PHYSICIAN	• HCFA 1500 • NSF 3.01 • ANSI X12 837 4010 • RAPS Format • Superbill

3.3.2 Collection Format Features

MA organizations need to carefully consider decisions regarding data collection tools, as they may impact the volume and accuracy of data received from physicians and providers. When examining the data collection options, the organization's management should consider the features of each of the approved data collection tools. Table 3J describes key features of each data collection tools.

TABLE 3J – COLLECTION FORMAT FEATURES

FORMAT	FEATURE					
	PHYSICIAN SERVICES	HOSPITAL INPATIENT/ OUTPATIENT SERVICES	MINIMUM DATA SET	FULL CLAIMS DATA	PAPER FORMAT	ELECTRONIC
HCFA 1500*	•			•	•	
UB-04*		•		•	•	
NSF*	•			•	•	•
ANSI X12 837	•	•		•		•
Superbill	•		•		•	
RAPS Format	•	•	•			•

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

The data collection options provided by CMS offer the MA organization the ability to determine which format works best for each of the plan's providers. A variety of collection formats may be used for different providers. If an organization plans to use multiple collection formats, consideration should be given to the complexity and costs associated with supporting these formats (e.g., systems, processes, staffing, etc.).

3.3.3 Collecting Data from Physicians Using a Superbill

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

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

Examples

Examples of Superbills

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

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

FIGURE 3C – SAMPLE FEE-FOR-SERVICE SUPERBILL

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

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

PATIENT NAME | INSURANCE

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

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

OFFICE SERVICE

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

PHYSICALS

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

INITIAL HOSPITAL CARE

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

DAILY HOSPITAL CARE

Level 1	98231	___ ___	___
From _____ To _____ @ $55			
Level 2	99232	___ ___	___
From _____ To _____ @ $87			
Level 3	99	___ ___	___
From _____ To _____ @$145			
Discharge	98238	___	___
Discharge-over 30	99239	___	___

NURSING HOME CARE

Partial Detailed	99302	___	3 ___
Partial Comprehensive	99303	___	___
Follow Up Level 1	99311	___	___
Follow Up Level 2	99312	___	71 ___
Follow Up Level 3	99313	___	99 ___
Discharge-30 minutes or less	99315	___ ___	___
Discharge-over 30 minutes	99316	___ ___	___

PROCEDURES

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

IMMUNIZATIONS & INJECTIONS

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

NOT INTENDED FOR REPRODUCTION

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

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

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

☐ PNEUMOVAX
80732 Shot
90471 Admin
V03.82 Vaccine Dx

☐ MCR PNEUMOVAX
90732 Shot
G0008 Admin
V03 Vac

☐ HEPATIT
9074 ult Sh
9074 ld Sh
90 in
V0 ne Dx

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

☐ TETANUS
90707 Shot
90471 Admin
906.5 Vaccine Dx

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

Next Visit

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

Physician Signature Date

DIAGNOSIS CODES: ICD-9-CM

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

FIGURE 3D – SAMPLE RISK ADJUSTMENT SUPERBILL

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

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

PATIENT NAME			INSURANCE

DR#

ACCIDENT TYPE
☐ Work Comp
☐ Auto
☐ Other

DATE OF ACCIDENT
_____/_____/_____

DIAGNOSIS CODES: ICD-9-CM

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

Other:

Next Visit

Total: $ _____
Amt Pd $ _____

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

Physician Signature Date

3.3.4 Factors Affecting Data Collection Method (Slide 17)

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

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

3.3.4.1 Contractual Relationships and Implications for Data Collection (Slide 18)

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

TABLE 3K – CONTRACTUAL PAYMENT RELATIONSHIPS

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

3.4 Health Information Portability and Accountability Act (HIPAA) (Slide 19)

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

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

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

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

3.5 Provider Communication and Risk Adjustment

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

3.5.1 Key Messages

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

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

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

- **What are the responsibilities of physicians and providers?**
  Physicians must report the ICD-9-CM diagnosis codes to the highest level of specificity and report these codes accurately. This requires accurate and complete medical record documentation. They are required to alert the MA organization of any erroneous data submitted and to follow the MA organization's procedures for correcting erroneous data. Finally, they must report claims and encounter information in a timely manner, generally within 30 days of the date of service (or discharge for hospital inpatient facilities).

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

3.5.2 Characteristics of Effective Communication

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

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

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

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

- **Consistent**
  Send consistent messages about risk adjustment. MA organizations can contact the Customer Service and Support Center (CSSC) anytime to confirm that information they are about to send out to providers is correct. Physicians and providers appreciate receiving the right information the first time and every time.

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

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

3.5.3 Communication Methods

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

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

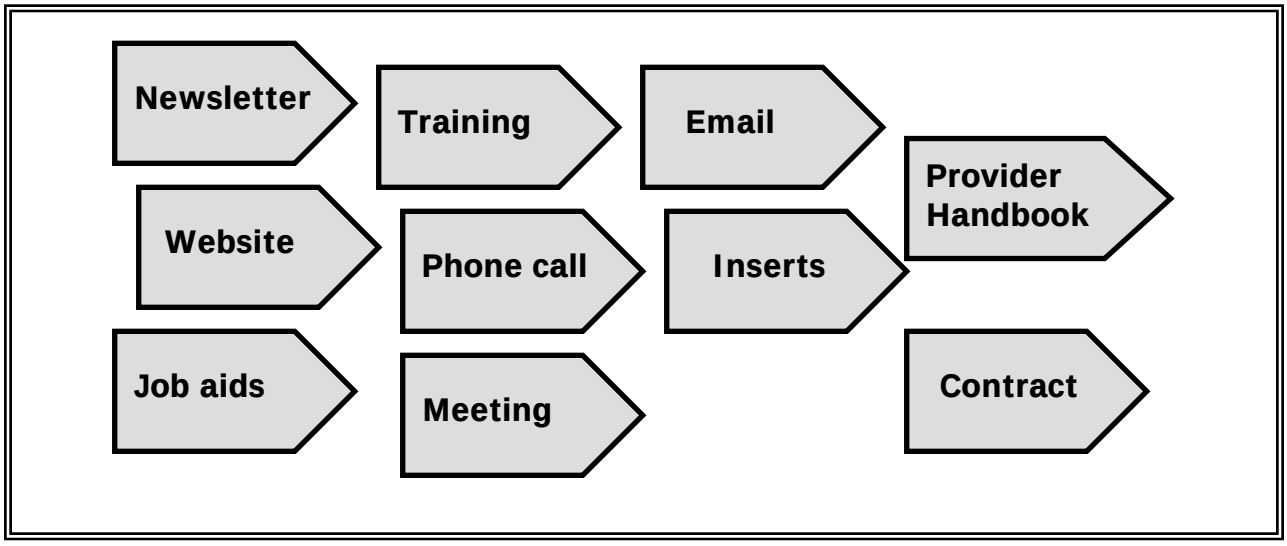
- **Identify the methods that tend to work best for the organization.** Many MA organizations indicate that the organization's provider Web page and newsletters reach audiences, but small and large group training sessions are most successful for causing a change in action.

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

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

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

Figure 3E – Communication Methods



MODULE 4 – DATA SUBMISSION

Purpose (Slide 2)

Medicare Advantage (MA) organizations must submit accurate diagnostic data when submitting risk adjustment data. This module describes the file layout for risk adjustment process submissions.

Learning Objectives (Slides 3-4)

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

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

ICON KEY	
Example	
Reminder	
Resource	

4.1 Submission Process Requirements (Slide 6)

New MA organizations must complete an Electronic Data Interchange (EDI) Agreement with the Centers for Medicare & Medicaid Services (CMS) and submit that Agreement to the Customer Service and Support Center (CSSC) prior to submitting risk adjustment data. The EDI Agreement is a contract between the MA organization and CMS attesting to the accuracy of the data submitted. An officer (e.g., CEO) that represents the MA organization must sign this document. New Plans must submit the EDI Agreement within 1 month of the HPMS effective date.

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

New MA organizations must submit test data within 3 months of the HPMS effective date and a production file must be submitted within 4 months of the effective date.

If a new contract number is assigned, the MA organization must submit a new EDI agreement. If the submitter's system successfully submitted test data previously, CMS does not require additional testing.

MA organizations must submit during each calendar quarter, at a minimum, approximately one-fourth of their total risk adjustment data submission for the collection period. More frequent submissions are recommended and may benefit MA organizations in identifying data collection and submission issues early.

4.2 Connectivity Options (Slide 7)

Connectivity refers to the electronic connection between the MA organization and CMS. MA organizations use the electronic connection to submit risk adjustment data to CMS and receive information in return. All third party submitters and large plans that submit their own data must establish a connection to the Front End Risk Adjustment System (FERAS) through the Medicare Data Communication Network (MCDN) that AT&T Global Network Services (AGNS) provides. The MCDN is the secure network linking RAPS data processing entries. Table 4A describes the three connectivity options.

TABLE 4A – CONNECTIVITY OPTIONS

Connect:Direct (File transfer software Product)	Formerly Network Data Mover (NDM). Mainframe-to-mainframe connection. Next day receipt of FERAS response.
File Transfer Protocol (FTP)	Modem-to-modem (dial-up) or lease line connection. Requires password and phone line. Same day receipt of FERAS response.
Gentran (CMS Enterprise File Transfer)	Two connectivity options: -Secure File Transfer Protocol (SFTP); standards based protocol via a vender. -Secure Hyper Text Transfer Protocol (HTTPS), secure web interface.

Small plans with less then or equal to 100,000 members may submit data using the Gentran Mailbox. For technical support questions regarding Gentran mailbox, users may contact the Customer Support for Medicare Modernization (CSMM) by calling (800) 927-8069, emailing mmahelp@cms.hhs.gov, or viewing the website at http://www.cms.hhs.gov/mmahelp.

4.3 Required Diagnosis (Slide 8)

Valid diagnosis codes are ICD-9-CM codes that CMS accepts as valid, but may not be included in the CMS-HCC Model. Required diagnosis codes are ICD-9-CM codes that CMS accepts as valid, and are included in the current or future CMS HCC Models.

MA organizations must submit each required diagnosis at least once during a reporting period for each enrolled beneficiary.

For payments beginning on January 1, 2009, the initial submission deadline is September 5, 2008 for the reporting period July 1, 2007 through June 30, 2008. For payments beginning on July 1, 2009, March 6, 2009 is the submission deadline for reporting data with dates of service January 1, 2008 through December 31, 2008. **Refer to the Risk Adjustment Process Overview module, Table 2B.**

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

- The diagnosis is included in the current or future CMS-Hierarchical Condition Category (CMS-HCC), Prescription Drug (RxHCC) or End Stage Renal Disease (ESRD) risk adjustment models.
- The diagnosis must be received from one of the three provider types (hospital inpatient, hospital outpatient, and physician) covered by the risk adjustment requirements.
- The diagnosis must be collected according to the risk adjustment data collection instructions.

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

A list of valid ICD-9-CM codes for the risk adjustment models for any given payment year includes a list of published NCHS/CMS codes that are valid for the payment year. The list is posted on the CMS website at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage, listed under "Risk Model Diagnosis Codes (ZIP, 340 KD) – Updated 10/04/2008 for current model codes, and future model codes are listed under "Future Model Diagnoses." Please be aware that both models (i.e., **Current Model** and **Future Model**) are required.

Do not submit risk adjustment diagnoses based on any diagnostic radiology services, regardless of the type of diagnostic radiology bill (outpatient department or physician component). Diagnostic radiologists typically do not document confirmed diagnoses. Confirmed diagnoses come from referring physician or physician extenders.

4.4 Submission Formats (Slide 9)

Effective October 1, 2007, MA organizations must submit data electronically using one of two formats:

- RAPS format (all provider types)
- DDE screen (all provider types)

4.5 Submission File Layout Logic (Slide 10)

Submissions are organized into three levels of data:

- File-level information—identifies the submitter
- Batch-level information—identifies the MA organization
- Detail-level information—identifies the beneficiary

Figure 4A illustrates a summary of the RAPS file structure.

Figure 4A – RAPS File Structure Summary

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

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

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

- Record ID
- Sequence Number
- Plan Number
- Filler

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

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

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

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

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

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

DETAIL LEVEL
BATCH LEVEL
FILE LEVEL

4.6 Diagnosis Cluster

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

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

A maximum of 10 diagnosis clusters are allowed per CCC record. Each cluster must include the items identified above. If any of these attributes are submitted more than once for the same HIC number, a duplicate diagnosis cluster error will occur.

4.7 Provider Type

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

Type of Bill (TOB), which is coded on the UB-04 during the collection of hospital data, may be used to assist in translating the correct provider type. Table 4B also shows the TOB and provider type correlation.

TABLE 4B – PROVIDER TYPES

PROVIDER TYPE	CODE	TYPE OF BILL
Principal Hospital Inpatient (principal diagnosis)	01	111 or 11Z
Hospital Inpatient Other (other diagnosis)	02	111 or 11Z
Hospital Outpatient	10	131, 13Z, 141 or 14Z
Physician	20	N/A

Interim bills (112 and 113 bill types) are not accepted. If an MA organization receives interim bills, do not submit the hospital inpatient diagnoses until the receipt of the final interim bill (114 bill type).

4.8 From and Through Dates

- CCYYMMDD is the correct submission format for the “From and Through” dates of service.
- The “Through Date” defines the data used in the data collection year for risk adjustment purposes.

June 30, 2006 is submitted as 20060630.

Table 4C shows the “From” and “Through Dates” for each provider type.

TABLE 4C – FROM AND THROUGH DATES

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

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

4.9 Diagnosis Code

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

4.10 RAPS Format

Table 4D describes each field of the RAPS file layout.

- The shaded fields in the table represent where the RAPS Return File provides new information after data processes through RAPS.
- There are two diagnosis cluster error fields because MA organizations can receive up to two errors on any diagnosis cluster.

TABLE 4D – RAPS FILE LAYOUT

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

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

TABLE 4D – RAPS FILE LAYOUT (CONTINUED)

RAPS RECORD CCC – DETAIL LEVEL				
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**FIELD NAME**	**EXPLANATION**
1	1-3	Required	Record ID	Detail-level information that identifies the beneficiary information. This field should always be populated with "CCC."
2	4-10	Required	Sequence Number	This field identifies the detail record submitted. The first detail record in a batch must begin with 0000001. All successive detail sequence numbers in the batch must be incremented by one. This is a numeric field. Limited to 1,000,000 per day.
3	11-13	RAPS RETURN	Sequence Number Error Code	This field must be submitted with spaces. Upon return, this field is populated with an error code if RAPS finds an error in the sequence number, or will remain blank if no errors were detected in the sequence number.
4	14-53	Optional	Patient Control Number	This optional field may be used by the MA organization to identify the claim submitted. The field allows up to 40 alphanumeric characters.
5	54-78	Required	HIC	The Health Insurance Claim number for the beneficiary. This is a 25-digit alphanumeric field. Enter spaces, not zeros, in unused spaces.
6	79-81	RAPS RETURN	HIC Error Code	This should be submitted with spaces. Upon return, this field is populated with an error code if RAPS finds an error in the HIC number, or remains blank if no errors were detected in the HIC number.
7	82-89	Optional	Patient DOB	This optional field may be populated with the patient's date of birth and is used to verify that the correct beneficiary identification was submitted. If the field is populated, it must be formatted as CCYYMMDD, and CMS edits this field against the information on file at the MBD. If no DOB is submitted, fill with spaces.
8	90-92	RAPS RETURN	DOB Error Code	This field must be submitted with spaces. Upon return, this field is populated with an error code if RAPS finds an error with DOB, or remains blank if no errors were detected in the DOB.

TABLE 4D – RAPS FILE LAYOUT (CONTINUED)

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

TABLE 4D – RAPS FILE LAYOUT (CONTINUED)

RAPS RECORD YYY – BATCH TRAILER				
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**FIELD NAME**	**EXPLANATION**
1	1-3	Required	Record ID	Batch trailer information should be populated with "YYY."
2	4-10	Required	Sequence Number	A 7-digit numeric character identifying the batch submitted. Must match the "BBB" record.
3	11-15	Required	"H" Number	"H" number assigned by CMS to identify the MA organization. Must match the "H" number in the corresponding "BBB" record (i.e., the "BBB" record with the same sequence number).
4	16-22	Required	CCC Record Total	This field should total the number of CCC records in the batch. This field is numeric and should be filled with leading zeroes (e.g., 0000001). Limited to 1,000,000 per day.
5	23-512	Spaces	Filler	Must be populated with 490 spaces. The "Filler" field allows for additional fields in the future.

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

4.11 Filtering Risk Adjustment Data (Slides 13-14)

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

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

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

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

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

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

For those plans that use CPT codes to screen diagnosis codes that are submitted to CMS, please note that the CPT range for radiology is 70000 through 79999. The following CPT codes indicate diagnostic radiology and other diagnoses that should not be submitted as risk adjustment data: 70010 through 76999 and 78000 through 78999. Plans should update these codes annually.

4.12 Modifying Risk Adjustment Data (Slide 15)

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

4.13 Deleting Diagnosis Clusters (Slide 16)

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

4.14 Reasons to Delete a Diagnosis Cluster (Slide 17)

There are three reasons MA organizations may delete a diagnosis cluster:

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

MA organizations submit deletions within a file, batch, or record containing previously submitted risk adjustment data.

4.15 Steps for Deleting a Diagnosis Cluster (Slides 18-20)

Before deleting an error, verify that the diagnosis cluster appears on the RAPS Return File. Only diagnosis clusters accepted by RAPS and stored in the RAPS database may be deleted.

There are two methods for deleting diagnosis clusters:

Method 1 for Deleting Clusters

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

Method 2 for Deleting Clusters

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

4.16 MA Organization Responsibilities Regarding Deletions (Slide 21)

- MA organizations must submit delete records when an erroneous diagnosis cluster has been accepted by RAPS and stored in the RAPS database.

- If a diagnosis cluster is deleted for the purpose of correcting data, the MA organization is responsible for submitting the correct diagnosis cluster. Conversely, if the MA organization submits corrected data, the MA organization must submit the appropriate deletion record. That is, if the correct diagnosis cluster is submitted, the erroneous diagnosis cluster cannot be ignored.

- If a correction applies to the same beneficiary as the deletion, the correction may be included in the same "CCC" record as the deletion. (Do not exceed 10 diagnosis clusters per "CCC" record.)

- If only one of several clusters within the CCC record requires modification, do not resubmit all other associated clusters. If clusters are resubmitted exactly the same without the delete indicator, the plans will generate a duplicate cluster error.

- If the corrected diagnosis cluster belongs to a different beneficiary than the deleted diagnosis cluster, the correct diagnosis cluster may be submitted in the same file as the deletion.

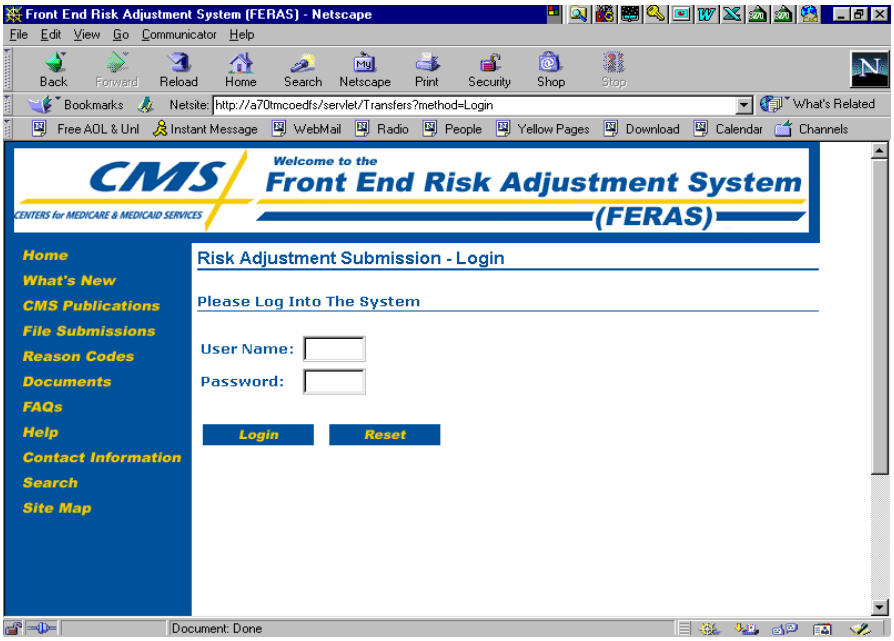
MA organizations should not delete a diagnosis code or record repeatedly on the same day and on the same record. MA organizations should implement a process to ensure that only one instance of a specific diagnosis cluster (either add or delete) is submitted on a given day.

4.17 Direct Data Entry (Slide 22)

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

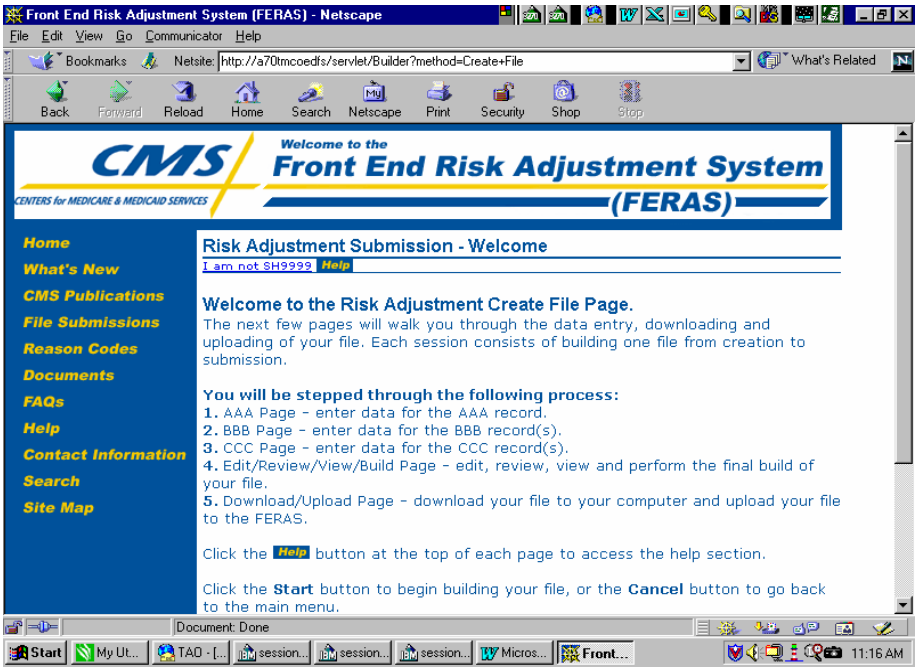
- DDE entries allow for deletion of records for corrections even if another submission format was used.
- The DDE screens, as shown in Figures 4B through 4G, automatically prevent the placement of incorrect data characters (e.g., alpha characters will not be accepted in the "From" or "Through Date" fields).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

Figure 4B – DDE 1



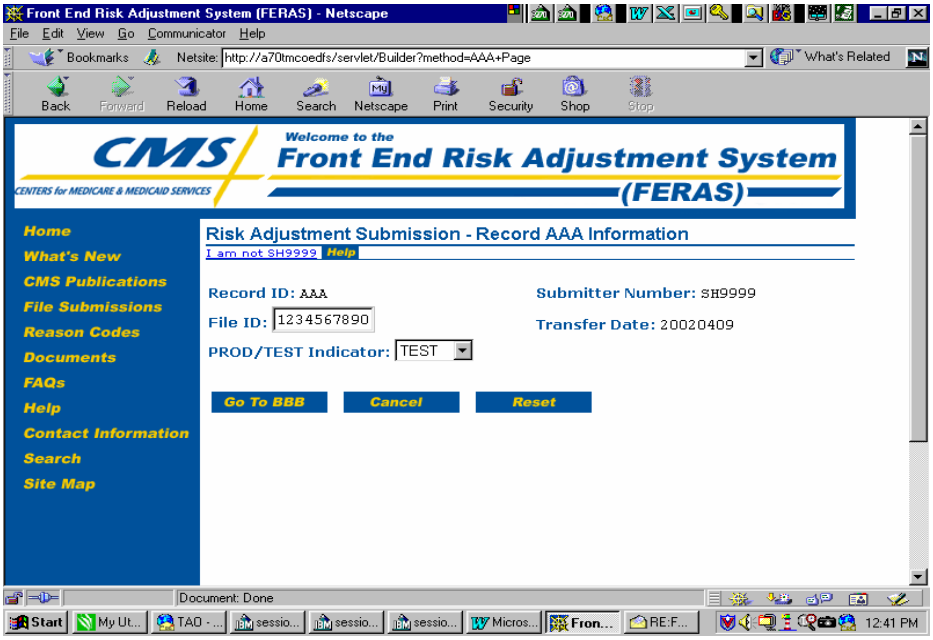
LOGIN PAGE – Submitters are assigned a User Name and Password to access the DDE application.

Figure 4C – DDE 2



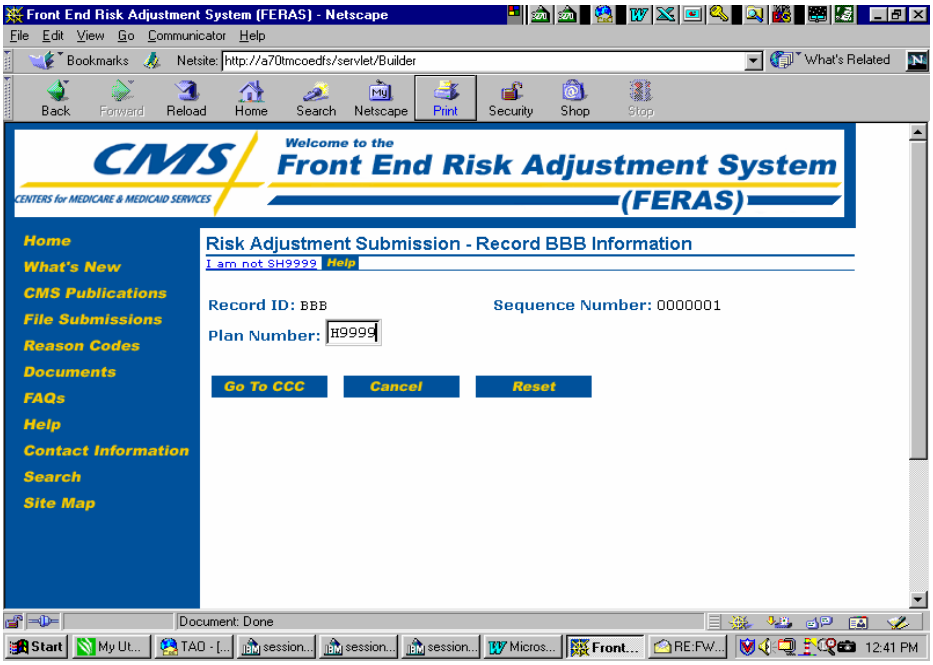
WELCOME PAGE – Submitters are provided instructions on the use of the DDE.

Figure 4D – DDE 3



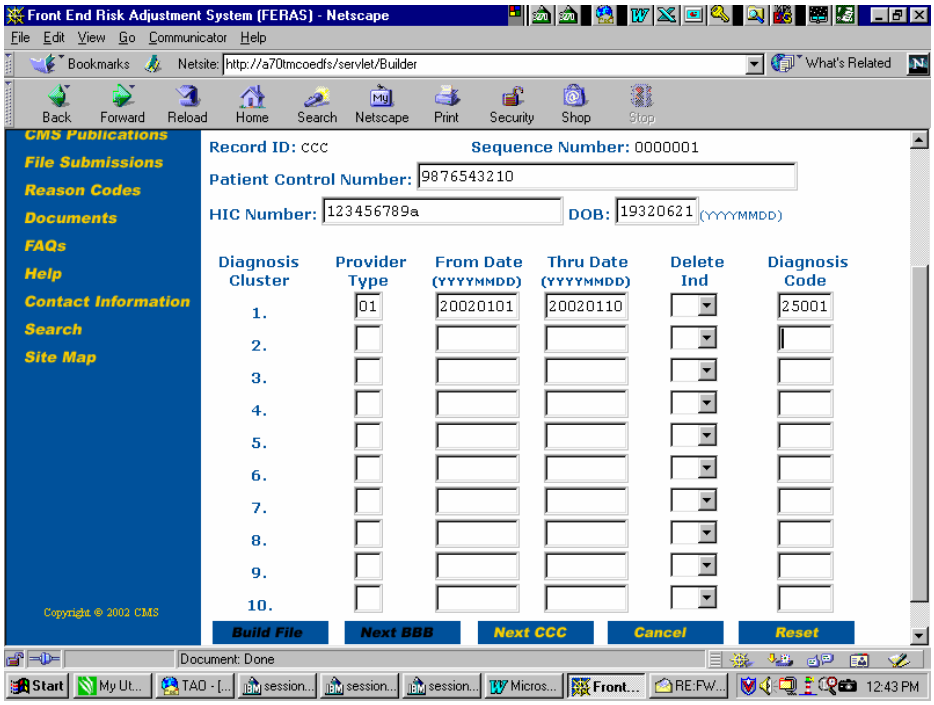
The file-level information is entered and must begin with RT AAA.

Figure 4E – DDE 4



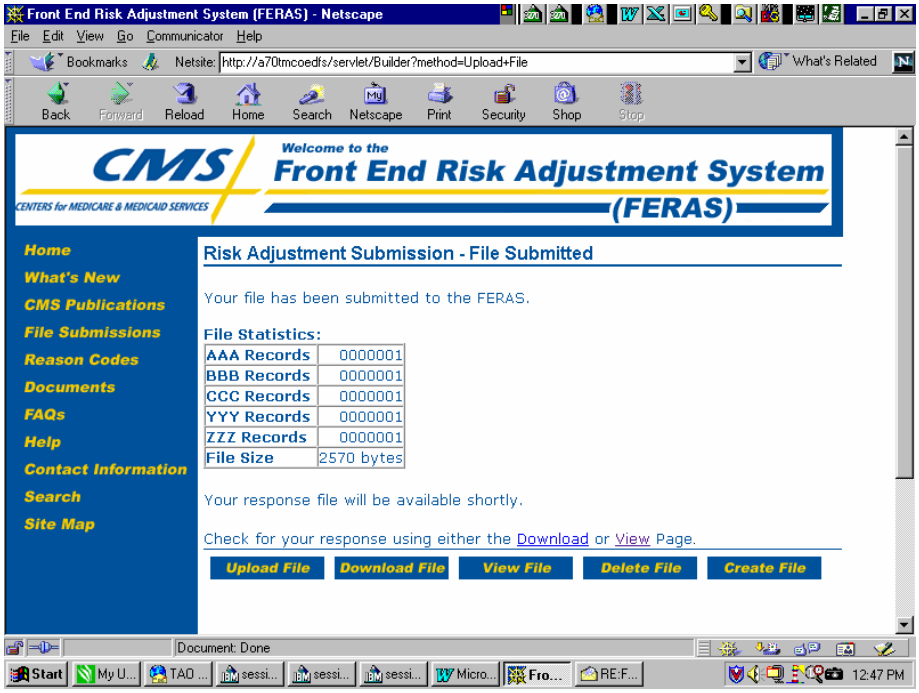
The batch-level information is entered and must begin with RT BBB.

Figure 4F – DDE 5



The CCC Record allows up to 10 diagnostic clusters.

Figure 4G – DDE 6



The file has been uploaded to FERAS.

MODULE 5 – EDITS AND REPORTS

Purpose (Slide 2)

The risk adjustment process includes an editing stage to ensure the accuracy of the data prior to storing the data for risk adjustment calculation and the status of submitted diagnosis clusters via reports. This module introduces participants to the Front-End Risk Adjustment System (FERAS) and the Centers for Medicare & Medicaid Services (CMS) Risk Adjustment Processing System (RAPS) data logic and editing processes and provides insights on the appropriate use of the risk adjustment reports to manage data collection, data submission, and error resolution processes.

Learning Objectives (Slide 3)

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

- Interpret the FERAS and the RAPS data integrity logic and error codes.
- Describe the FERAS and RAPS editing processes.
- Explain the purpose of the FERAS and RAPS reports in monitoring RAPS data.
- Analyze risk adjustment reports to identify and submit corrections.

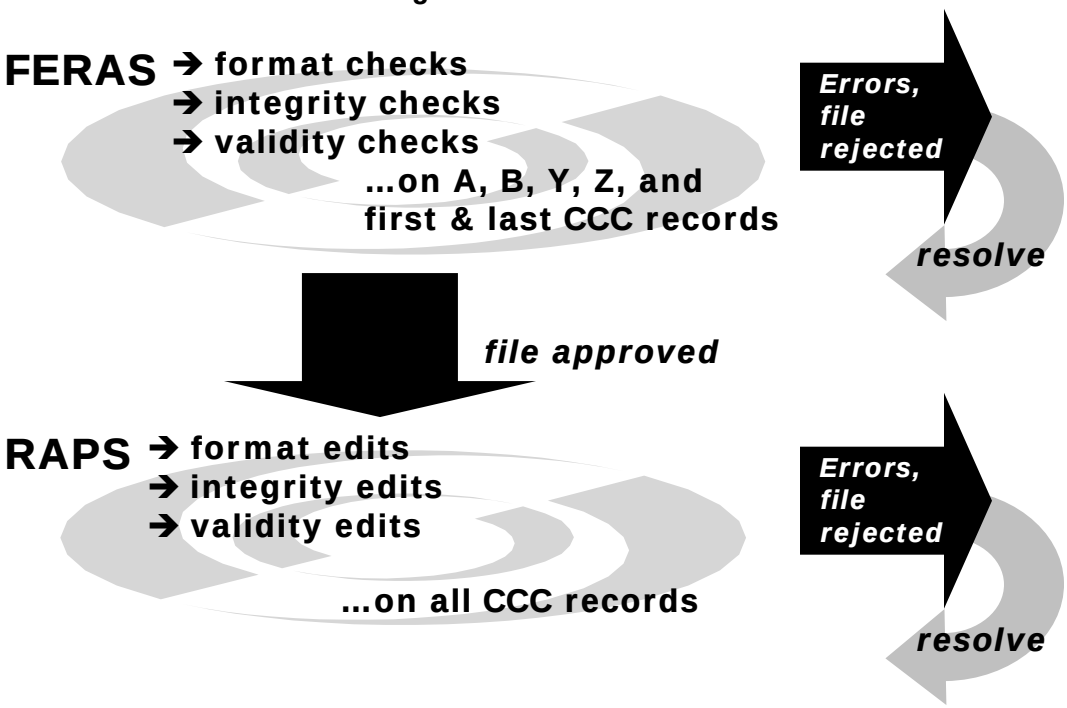
ICON KEY	
Example	
Reminder	
Resource	

5.1 Data Flow and Reporting

After MA organizations submit data to Palmetto, FERAS performs format and integrity checks on the file and batch levels, as well as on the first and last detail (CCC) record. After the data pass the checks, they are sent to RAPS for complete editing of all detail records before they are stored in the RAPS database.

Files submitted in Test and Production are processed through FERAS and RAPS, and all edits are performed. Test files, however, are not stored in the RAPS database. Figure 5A illustrates the flow of data for edit processing.

Figure 5A – Data Flow



Both the FERAS and RAPS systems generate reports that provide the results of the edit checks in each stage of processing. Some reports present summary-level data, others present details about individual diagnosis clusters, including whether or not a cluster generated an error in RAPS. In addition, RAPS generates a series of management reports to assist plans with managing data collection and submission. It is essential that the appropriate staff at MA organizations understand how to read the reports and resolve any issues identified.

Table 5A provides basic information about accessing and printing reports. Table 5B summarizes the content and general information about each of the reports.

TABLE 5A – ACCESSING AND PRINTING REPORTS

Accessing Reports	
Methods of Access	• File Transfer Protocol (FTP) • Connect:Direct • Gentran
Report Receipt following File Submission	FTP Users: • Receive FERAS reports typically within 15 minutes of submission • Receive RAPS transaction processing reports the day after submission Connect:Direct and Gentran Users: • Receive FERAS reports the following business day if the file transfer is complete by 5:00 p.m. Eastern Time (ET) • Receive FERAS reports 2 business days after submission if the file transfer is complete after 5:00 p.m. ET • Receive RAPS transaction processing reports the day after submission
Report Distribution	• Reports are sent to the mailbox identified on the submitter application. • Since the processing systems generate the reports out of CMS and then send to Palmetto for distribution, the systems cannot duplicate reports and send to multiple mailboxes. • MA organizations may request reports in zip format. To avoid difficulties opening zip reports, users should: - Rename the file with the ".zip" extension. - Change the command to binary when using the FTP command line.
Report Retention	• The processing systems, FERAS and RAPS, send the reports to the submitter's mailbox, where they remain for 14 days. • The systems automatically delete reports from the mailbox after 14 days, but MA organizations can access reports through the Customer Service and Support Center (CSSC). • For Gentran users CSSC restores reports from the date of mailbox setup to the current date only.
Printing Reports	
	• All risk adjustment reports are delivered as text reports, with the exception of the RAPS Return File. • Organizations may download reports in Note Pad and should change the print orientation to landscape to ensure that all information on the report prints on one page. • Reports opened in Note Pad, automatically include page breaks for printing. • Users should avoid opening reports in Microsoft Word to avoid the default programming that occurs.

TABLE 5B – REPORTS OVERVIEW

FERAS Report	
FERAS Response Report	• Indicates file is accepted or rejected • Identifies reasons for rejection • Report layout • FTP users receive reports the same business day • Connect:Direct and Gentran users receive reports the next business day
RAPS Reports	
RAPS Return File	• Contains the entire submitted transaction • Identifies 300-, 400-, and 500-level errors • Flat file layout • Received the next business day after submission
RAPS Transaction Error Report	• Communicates errors found in CCC records during processing • Displays only 300-, 400-, and 500-level error codes • Report layout • Received the next business day after submission
RAPS Transaction Summary Report	• Summarizes the disposition of diagnosis clusters • Report layout • Received the next business day after submission
RAPS Duplicate Diagnosis Cluster Report	• Identifies diagnosis clusters with 502-error message • Clusters accepted, but not stored • Report layout • Received the next business day after submission
RAPS Management Reports	
RAPS Monthly Plan Activity Report	• Provides monthly summary of the status of submissions by Submitter ID and Plan Number • Report layout • Available for download the second business day of the month
RAPS Cumulative Plan Activity Report	• Provides cumulative summary of the status of submissions by Submitter ID and Plan Number • Report layout • Available for download the second business day of the month
RAPS Monthly Error Frequency Report	• Provides a monthly summary of all errors associated with files submitted in test and production • Report layout • Available for download the second business day of the month
RAPS Quarterly Error Frequency Report	• Provides a quarterly summary of all errors on all file submissions within the 3-month quarter • Report layout • Available for download the second business day of the month following each quarter

5.2 FERAS System

MA organizations submit data to FERAS, which performs the format and integrity checks.

- FERAS performs format and integrity checks on file- and batch-level data.
- FERAS checks the first and last detail records in each batch.
- FERAS accepts or rejects the entire file.
- FERAS ensures that all accepted transactions contain the following correct data:
  - AAA and ZZZ record.
  - At least one BBB record for each YYY record.
  - Following each BBB record, at least one CCC record with at least one diagnosis cluster populated.
  - Valid submitter ID and plan numbers.
  - Valid record and file totals.
  - The first and last CCC record will be edited to ensure that the submitted data are in the correct location on the record (i.e., spaces are where they should be located).
  - Record Type CCC must be present in the first field.
  - The first sequence number must equal 0000001.
  - The last sequence number must equal the total CCC record count in the YYY record.
  - The "HIC (Health Insurance Claim) Error Code" and "Diagnosis Code – Filler" fields contain spaces. Do not fill fields with zeros.

If all checks pass, the transaction processing continues in RAPS. If any of the data fail, FERAS rejects the complete file and generates the FERAS Response Report. The FERAS Response Report identifies the errors discovered during the edit check.

Example: 1

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

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

Generally, FERAS errors occur during the initial establishment of the system and risk adjustment process in MA organizations. After data are processed, automated formats are programmed, and FERAS errors occur less frequently.

5.2.1 FERAS Error Code Logic

When a FERAS check fails, an associated error code is created. Table 5C describes the error code logic. If any errors occur in FERAS, the complete file is rejected and returned to the submitter after all checks are completed.

TABLE 5C – FERAS ERROR CODE LOGIC

SERIES	EXPLANATION
100	File-level errors on the AAA or ZZZ records.
200	Batch-level errors on the BBB or YYY records.
300-400	Check performed on first and last CCC records.

- The 100- and 200- series error codes are assigned based on the level of checks that are performed, as well as the location of the edit.
- The entire file is returned to the submitter.

5.2.2 FERAS Error Code Ranges

Error code ranges are explained in Table 5D.

TABLE 5D - ERROR CODE RANGES

SERIES	EXPLANATION
100	Indicates that the system could not determine the record type; all editing stopped at that point.
101-109	Indicates a failure of a face-validity edit on the AAA record (file-level header). The last digit indicates the specific field in which the error was found. For example, the 101-error code refers to an error found in field 1 on the AAA record.
111-125	Indicates a failure of a cross-reference edit between a field on the AAA (file-level header) record and a look-up table, a field on another record, or a value calculated from another record. The last digit will indicate the specific AAA field against which the cross-check was performed. For example, the 112-error code indicates that the submitter ID in field 2 did not appear on a look-up table of valid submitter IDs.
151-159	Indicates a failure of a face-validity edit on the ZZZ record (file-level trailer). The last digit indicates the specific field in which the error was found. For example, the 151-error code refers to an error found in field 1 on the ZZZ record.
161-175	Indicates a failure of a cross-reference edit between a field on the ZZZ (file-level trailer) record and a look-up table, a field on another record, or a value calculated from another record. The last digit will indicate the specific ZZZ field against which the cross-check was performed. For example, the 162-error code indicates that the submitter ID, field 2 in ZZZ record, does not match the submitter ID on the AAA record.
201-209	Indicates a failure of a face-validity edit on the BBB (batch-level header) record. The last digit indicates the specific field in which the error was found. For example, the 201-error code refers to an error found in field 1 on the BBB record.

TABLE 5D - ERROR CODE RANGES (CONTINUED)

211-225	Indicates a failure of a cross-reference edit between a field on the BBB (batch-level header) record and a look-up table, a field on another record, or a value calculated from another record. The last digit will indicate the specific BBB field against which the cross-check was performed. For example, the 213-error code indicates that the submitter ID, field 3 in BBB record, is not authorized to submit for the plan ID.
251-259	Indicates a failure of a face-validity edit on the YYY (batch-level trailer) record. The last digit indicates the specific field in which the error was found. For example, the 251-error code refers to an error found in field 1 in the YYY record.
261- 275	Indicates a failure of a cross-reference edit between a field on the YYY (batch-level header) record and a look-up table, a field on another record, or a value calculated from another record. The last digit will indicate the specific YYY field against which the cross-check was performed. For example, the 262-error code indicates that the sequence number in the YYY record field 2 does not match the sequence number in field 2.
301-489	Indicates a format problem with the first or last CCC record. The problem is either with the face validity of the data in specific fields or the presence of data in fields that are required to be blank. In either circumstance, the basic CCC record format is assumed to be in error and the entire file is rejected.

Note: FERAS checks the validity and format of an individual field before performing checks between fields. For example, the system first checks that there is a valid submitter ID on the AAA record before it checks that the submitter ID reported in the YYY record is identical. Table 5E describes FERAS file-level, batch-level, and detail-level error codes.

TABLE 5E – FERAS ERROR CODES

FILE-LEVEL ERROR CODES

ERROR CODE	RECORD ID	ERROR DESCRIPTION
100	AAA	INVALID RECORD TYPE
101	AAA	AAA RECORD MISSING FROM TRANSACTION
102	AAA	MISSING / INVALID SUBMITTER-ID ON AAA RECORD
103	AAA	MISSING FILE-ID ON AAA RECORD
104	AAA	MISSING / INVALID TRANSACTION DATE ON AAA RECORD
105	AAA	MISSING / INVALID PROD-TEST-INDICATOR ON AAA RECORD
112	AAA	SUBMITTER ID NOT ON FILE
113	AAA	FILE NAME DUPLICATES ANOTHER FILE ACCEPTED WITHIN LAST 12 MONTHS
114	AAA	TRANSACTION DATE IS GREATER THAN CURRENT DATE
151	ZZZ	ZZZ RECORD MISSING FROM TRANSACTION
152	ZZZ	MISSING / INVALID SUBMITTER-ID ON ZZZ RECORD
153	ZZZ	MISSING / INVALID FILE-ID ON ZZZ RECORD
154	ZZZ	MISSING / INVALID BBB-RECORD-TOTAL
162	ZZZ	ZZZ SUBMITTER-ID DOES NOT MATCH SUBMITTER-ID ON AAA RECORD
163	ZZZ	FILE ID DOES NOT MATCH FILE ID ON AAA RECORD
164	ZZZ	ZZZ VALUE IS NOT EQUAL TO THE NUMBER OF BBB RECORDS

TABLE 5E – FERAS ERROR CODES (CONTINUED)

BATCH-LEVEL ERROR CODES

ERROR CODE	RECORD ID	ERROR DESCRIPTION
201	BBB	BBB RECORD MISSING FROM TRANSACTION
202	BBB	MISSING / INVALID SEQUENCE NUMBER ON BBB RECORD
203	BBB	MISSING / INVALID PLAN NUMBER ON BBB RECORD
212	BBB	SEQUENCE NUMBER ON BBB RECORD IS OUT OF SEQUENCE
213	BBB	SUBMITTER ID NOT AUTHORIZED TO SUBMIT FOR THIS PLAN ID
251	YYY	YYY RECORD MISSING FROM TRANSACTION
252	YYY	MISSING / INVALID SEQUENCE NUMBER ON YYY RECORD
253	YYY	MISSING / INVALID PLAN NUMBER ON YYY RECORD
254	YYY	MISSING / INVALID CCC-RECORD-TOTAL
262	YYY	LAST YYY SEQUENCE NUMBER IS NOT EQUAL TO NUMBER OF YYY RECORDS
263	YYY	PLAN NUMBER DOES NOT MATCH PLAN NUMBER IN BBB RECORD
264	YYY	YYY VALUE IS NOT EQUAL TO THE NUMBER OF CCC RECORDS
272	YYY	SEQUENCE NUMBER ON YYY RECORD IS OUT OF SEQUENCE

DETAIL-LEVEL ERROR CODES

ERROR CODE	RECORD ID	ERROR DESCRIPTION
301	CCC	CCC RECORD MISSING FROM TRANSACTION
302	CCC	MISSING / INVALID SEQ-NO ON CCC RECORD
303	CCC	SEQUENCE-ERROR-CODE FILLER NOT EQUAL TO SPACES
304	CCC	HIC-ERROR-CODE FILLER NOT EQUAL TO SPACES
305	CCC	DOB-ERROR-CODE FILLER NOT EQUAL TO SPACES
306	CCC	DIAGNOSIS CODE-FILLER NOT EQUAL TO SPACES
307	CCC	DIAGNOSIS-CLUSTER-ERROR-1 NOT EQUAL TO SPACES
308	CCC	DIAGNOSIS-CLUSTER-ERROR-2 NOT EQUAL TO SPACES
309	CCC	SEQUENCE-NUMBER ON CCC RECORD IS OUT OF SEQUENCE
310	CCC	MISSING / INVALID HIC-NO ON CCC RECORD
311	CCC	AT LEAST ONE DIAGNOSIS CLUSTER REQUIRED ON TRANSACTION
313	CCC	DELETE-INDICATOR MUST BE BLANK OR EQUAL TO “D”
314	CCC	INVALID DIAGNOSIS CODE FORMAT ON CCC RECORD
315	CCC	CORRECTED HIC NOT EQUAL TO SPACES
350	CCC	INVALID PATIENT-DOB ON CCC RECORD
400	CCC	MISSING / INVALID PROVIDER-TYPE ON CCC RECORD
401	CCC	INVALID FROM-DATE ON CCC RECORD
402	CCC	INVALID THRU-DATE ON CCC RECORD

Example: 2

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

Results: FERAS would reject the complete file due to data being placed in the "Diagnosis Code – Filler" field of the diagnosis cluster, because the "Diagnosis Code – Filler" must be populated with spaces. FERAS would identify this error, since it occurred in the first CCC

FERAS errors rarely occur after MA organizations program file layouts and adequately test the formats before submission to CMS.

5.2.3 FERAS Response Report

The FERAS Response Report reflects FERAS checks (format, integrity, and validity) that occur in the file, batch, and first and last detail-level records. It indicates if the file has been accepted or rejected by the front-end system. If accepted, the report specifies that the file is completely accepted. If the file is rejected, the report identifies the reason(s) for the rejection. Figure 5B illustrates the fields on the FERAS Response Report and describes these fields.

The report is available in a report layout file in each submitter's mailbox. FTP users typically receive their reports within 15 minutes of submission. Connect:Direct and Gentran users receive their reports the next business day.

Figure 5B – Rejected FERAS Response Report

[1]REPORT: FERAS-RESP **[2]**FRONT END RISK ADJUSTMENT SYSTEM
[3]RUN DATE: 20030407 FERAS RESPONSE REPORT

[4]SUBMITTER ID: SH7777
[5]FILE ID: 0000000001

[6]FILE STATUS: REJECTED PROD

[7] RECORD TYPE	**[8]** SEQ NO	**[9]** ERROR CODE	**[10]** ERROR DESCRIPTION
AAA		113	DUPLICATE FILE ID ACCEPTED WITHIN 12 MONTHS
END OF REPORT			

Field No.	Field Name	Field Description
1	Report Name	Name of the report as it appears in submitter's mailbox.
2	Report Full Name	Full name of the report.
3	Report Run Date	Date the report was generated by Palmetto (CCYYMMDD format).
4	Submitter ID	Report is grouped by submitter identification number. A submitter may submit for more than one plan. A different report is generated for each plan.
5	File ID	The 10-character alphanumeric field identifying the specific file submitted.
6	File Status	Identifies whether the file was completely accepted or completely rejected. This field also identifies if the file is TEST or PRODUCTION.
7	Record Type	Identifies the level of the error (file-, batch-, or detail-record level).
8	Sequence Number	Identifies the batch or detail-level record where the error occurred.
9	Error Code	Identifies the 3-digit number error message that caused the file to reject.
10	Error Code Description	Explains the error code.

NOTE: There are three reasons why users would not receive the FERAS Response Report:

- The AAA record is not included on the file. Submitters receive an "INVALID_FILE_HDR" message.
- No Submitter ID on the AAA record.
- The login ID used to submit data to FERAS does not match the submitter ID. Submitters receive a "SUBMITTER ID IN FILE DOES NOT MATCH THE LOGIN ID" message (FTP and Secure Website users only).

Example: 3

The MA organization submitted a file containing a File ID already used within the last twelve months. The second batch did not include a plan number i.e., an H number. The first detail record was missing a Health Insurance Claim (HIC) number, and the fourth YYY batch trailer plan number did not match the plan number in the fourth BBB batch header. Figure 5C illustrates this example.

Figure 5C – FERAS Response Report

REPORT: FERAS-RESP **FRONT END RISK ADJUSTMENT SYSTEM**
RUN DATE: 20040304 **FERAS RESPONSE REPORT**

SUBMITTER ID: SH9999
FILE-ID: 0000000001 REJECTED PROD

RECORD TYPE	SEQ NO	ERROR CODE	ERROR CODE DESCRIPTION
AAA		113	FILE NAME DUPLICATES ANOTHER FILE ACCEPTED WITHIN LAST 12 MONTHS
BBB	0000002	203	MISSING/INVALID PLAN NUMBER ON BBB RECORD
CCC	0000001	310	MISSING/INVALID HIC NUMBER ON CCC RECORD
YYY	0000004	263	PLAN NUMBER DOES NOT MATCH PLAN NUMBER IN BBB RECORD

The FERAS Response Report indicates errors in the first and last detail-level (CCC) record.

5.3 RAPS System

After data pass the FERAS checks, the file is sent via Connect:Direct to the CMS data center for RAPS processing.

- As a precautionary measure, RAPS performs balancing checks to ensure that the complete file was received from Palmetto prior to editing data.
- The RAPS system performs editing on the CCC transactions.
- The data elements edited include HIC Number, Provider Type, Diagnosis Code, From Date, and Through Date.
- If Date of Birth is submitted, RAPS performs an edit on that field.

5.3.1 RAPS Edits Rules

The RAPS editing process takes place in four logical stages.

Stage 1- Field Validity and Integrity Edits

RAPS performs format and integrity checks on all CCC-level fields as a first level of editing. If there are data in the "HIC Error Code" or "Diagnosis Code - Filler" fields, the entire detail record is rejected with no further editing performed. If a record fails this stage of editing, it is assumed that the data are corrupt.

The dates also are checked at this stage. If the dates within a diagnosis cluster are not valid dates, then RAPS stops the editing process for that diagnosis cluster because all other data edits within a diagnosis cluster depend upon the validity of the dates.

Stage 2 - Field-to-Field Edits

After RAPS checks format and integrity of the fields, the field-to-field editing takes place.

- RAPS ensures that the from date is equal or prior to the through date.
- RAPS also checks all diagnosis clusters for hospital outpatient and physician provider types to ensure compliance with the 31-day span rule.
- RAPS checks all data to make certain that MA organizations submit the reconciliation data properly. See Submission Timetable in Module 2 (Risk Adjustment Process Overview) for dates of service included in each data submission period.

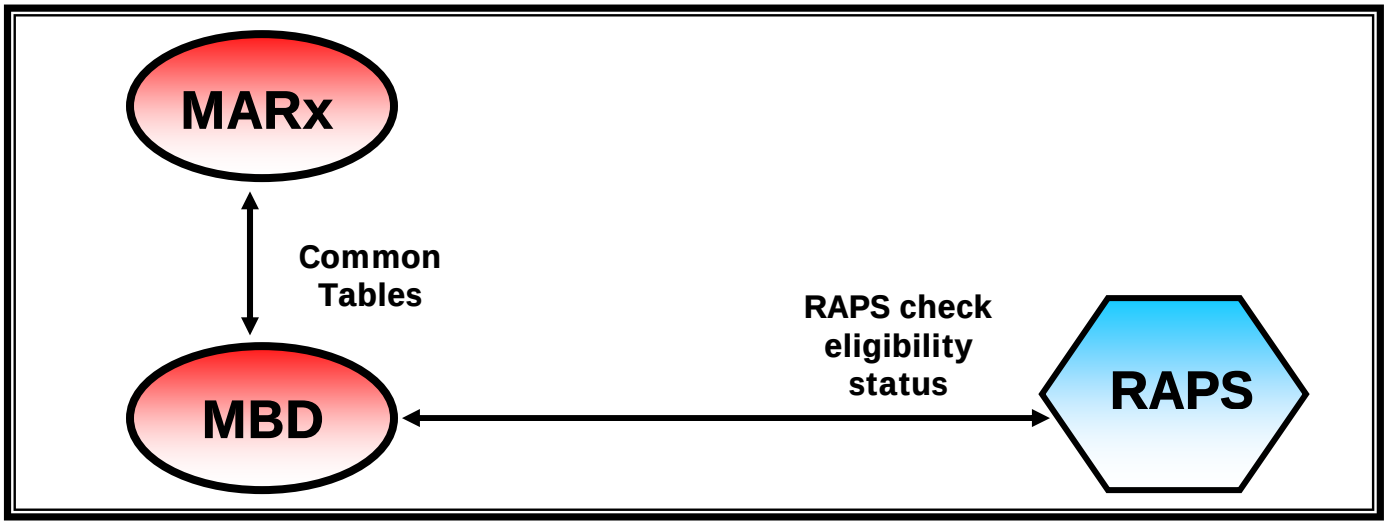
Stage 3 - Eligibility Edits

The next stage of editing cross-checks the appropriate fields against the common tables in MBD and MARx. MA organizations may access MBD through the common user interface, Medicare Advantage & Part D Inquiry System. For risk adjustment purposes, these common tables are the authoritative source of beneficiary information, and supports managed care enrollments to MA organizations.

In this editing stage, the HIC number, date of birth, and Medicare entitlement are checked. For example, in Stage 1 editing, the system ensured that a valid HIC number was present in field 5 of the CCC record. In Stage 3 editing, the system makes certain that the HIC number exists on the common tables.

Figure 5D illustrates the flow of data between MARx and MBD and RAPS.

Figure 5D –Flow of Data for Eligibility Checks



The HIC number is a common way to begin researching data in the common tables.

- The common tables store historical data on file, so if a beneficiary's HIC number changed, the common tables will cross-reference the old and new numbers.
- Railroad Retirement Board (RRB) beneficiary numbers are cross-referenced automatically. This allows users to research demographic and eligibility information for beneficiaries with RRB and HIC numbers.

Stage 4 - Diagnosis Code Edits

After RAPS edits the integrity of the individual fields and validates the HIC number and eligibility, it edits the diagnosis code against the Diagnosis Lookup Table in RAPS. In this stage, the system first ensures that each diagnosis code is valid. Then the system checks each diagnosis code against service dates and gender. If any of these edits fail, the diagnosis cluster is not stored in the RAPS database. The edits at this stage also include an edit to check if the diagnosis code is in the risk adjustment model. If the diagnosis code is not in the model, an information error is returned. The diagnosis cluster is stored if an information-only error is returned, and no further action by the MA organization is required.

Explanations of error codes and their consequences, RAPS error codes, informational edits, and duplicate diagnosis cluster edit are presented in Tables 5F, 5G, 5H, and 5I, respectively.

TABLE 5F – EXPLANATION OF ERROR AND CONSEQUENCES

SERIES	EXPLANATION OF ERROR AND CONSEQUENCES
300-349	Record-level error. The record was bypassed and all editing was discontinued. No diagnosis clusters from this record were stored.
350-399	Record-level error. All possible edits were performed, but no diagnosis clusters from this record were stored.
400-489	Diagnosis cluster error. All possible diagnosis edits were performed, but the diagnosis cluster is not stored.
490-499	Diagnosis delete error; diagnosis was not deleted.
500-599	Informational message, all edits were performed; diagnosis cluster was stored unless some other error is noted.

TABLE 5G – RAPS ERROR CODES

ERROR CODE	RECORD ID	ERROR DESCRIPTION
301	CCC	CCC RECORD MISSING FROM TRANSACTION
302	CCC	MISSING / INVALID SEQUENCE-NUMBER ON CCC RECORD
303	CCC	SEQUENCE-ERROR-CODE FILLER NOT EQUAL TO SPACES
304	CCC	HIC-ERROR-CODE FILLER NOT EQUAL TO SPACES
305	CCC	DOB-ERROR-CODE FILLER NOT EQUAL TO SPACES
306	CCC	DIAGNOSIS CODE FILLER NOT EQUAL TO SPACES
307	CCC	DIAGNOSIS-CLUSTER-ERROR-1 NOT EQUAL TO SPACES
308	CCC	DIAGNOSIS-CLUSTER-ERROR-2 NOT EQUAL TO SPACES
309	CCC	SEQUENCE-NUMBER ON CCC RECORD IS OUT OF SEQUENCE
310	CCC	MISSING / INVALID HIC-NUMBER ON CCC RECORD
311	CCC	AT LEAST ONE DIAGNOSIS CLUSTER REQUIRED ON TRANSACTION
313	CCC	DELETE-INDICATOR MUST EQUAL SPACE OR “D” FOR DELETE
314	CCC	INVALID DIAGNOSIS CODE FORMAT ON CCC RECORD
315	CCC	CORRECTED HIC NOT EQUAL TO SPACES
350	CCC	INVALID PATIENT-DOB ON CCC RECORD
353	CCC	HIC NUMBER DOES NOT EXIST ON MBD
354	CCC	PATIENT DOB DOES NOT MATCH WITH MBD DOB

TABLE 5G – RAPS ERROR CODES (CONTINUED)

ERROR CODE	RECORD ID	ERROR DESCRIPTION
400	CCC	MISSING / INVALID PROVIDER-TYPE CODE ON CCC RECORD
401	CCC	INVALID SERVICE FROM-DATE ON CCC RECORD
402	CCC	INVALID SERVICE THROUGH-DATE ON CCC RECORD
403	CCC	SERVICE THROUGH-DATE MUST BE GREATER THAN 12/31/2004
404	CCC	SERVICE FROM-DATE MUST BE LESS THAN OR EQUAL TO THROUGH-DATE
405	CCC	DOB IS GREATER THAN SERVICE FROM-DATE
406	CCC	SERVICE FROM-DATE IS NOT WITHIN MEDICARE ENTITLEMENT PERIOD
407	CCC	SERVICE THROUGH-DATE IS NOT WITHIN MEDICARE ENTITLEMENT PERIOD
408	CCC	SERVICE FROM-DATE IS NOT WITHIN MA ORG ENROLLMENT PERIOD
409	CCC	SERVICE THROUGH-DATE IS NOT WITHIN MA ORG ENROLLMENT PERIOD
410	CCC	BENEFICIARY IS NOT ENROLLED IN PLAN ON OR AFTER SERVICE FROM-DATE
411	CCC	SERVICE THROUGH-DATE IS GREATER THAN DATE OF DEATH
412	CCC	SERVICE FROM-DATE GREATER THAN TRANSACTION DATE
413	CCC	SERVICE THROUGH-DATE GREATER THAN TRANSACTION DATE
450	CCC	DIAGNOSIS DOES NOT EXIST FOR THIS SERVICE THROUGH-DATE
451	CCC	SERVICE THROUGH-DATE IS GREATER THAN DIAGNOSIS END DATE
453	CCC	DIAGNOSIS CODE IS NOT APPROPRIATE FOR PATIENT SEX
454	CCC	DIAGNOSIS IS VALID, BUT IS NOT SUFFICIENTLY SPECIFIC FOR RISK ADJUSTMENT GROUPING
455	CCC	DIAGNOSIS CLUSTER NOT EDITED DUE TO RECORD FORMAT ERROR
460	CCC	SERVICE FROM- AND THROUGH-DATE SPAN IS GREATER THAN 31 DAYS
490	CCC	COULD NOT DELETE, DIAGNOSIS CLUSTER NOT IN RAPS DATABASE BENEFICIARY RECORD
491	CCC	DELETE ERROR, DIAGNOSIS CLUSTER PREVIOUSLY DELETED
492	CCC	DELETE ERROR, DIAGNOSIS CLUSTER WAS NOT DELETED. A DIAGNOSIS CLUSTER WITH THE SAME ATTRIBUTES WAS ALREADY DELETED FROM THE RAPS DATABASE ON THIS DATE

TABLE 5H – INFORMATIONAL EDITS

ERROR CODE	RECORD ID	ERROR DESCRIPTION
500	CCC	BENEFICIARY HIC NUMBER HAS CHANGED ACCORDING TO CMS RECORDS; USE CORRECT HIC NUMBER FOR FUTURE SUBMISSIONS
501	CCC	VALID DIAGNOSIS BUT NOT INCLUDED IN THE CURRENT RISK ADJUSTMENT MODEL DURING THIS SERVICE PERIOD

TABLE 5I – DUPLICATE DIAGNOSIS CLUSTER EDIT

ERROR CODE	RECORD ID	ERROR DESCRIPTION
502	CCC	DIAGNOSIS CLUSTER WAS ACCEPTED BUT NOT STORED. A DIAGNOSIS CLUSTER WITH THE SAME ATTRIBUTES IS ALREADY STORED IN THE RAPS DATABASE

Example: 4

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

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

5.3.2 RAPS Processing Reports

Generally, the RAPS processing reports allow MA organizations to see all records and diagnosis clusters submitted. They also communicate existing errors and report any exact duplicate clusters. Organizations use these reports to determine if they need to correct and resubmit their data.

5.3.2.1 RAPS Return File

The RAPS Return File contains all transactions submitted by the MA organization. If there are errors or informational edits, they appear next to the field in which the error was found. The file is delivered in the same flat file format used for the RAPS input. It may be downloaded and imported into Microsoft Access or Excel. The data can then be converted to display the necessary fields.

MA organizations receive the RAPS Return File the next business day following a submission.

Table 5J represents the RAPS record layout and the information contained in a flat file format for the RAPS Return File. The shaded areas on the CCC record represent fields where RAPS can report error information.

Table 5J – RAPS Record Layout
RECORD AAA – FILE HEADER

FIELD NO	FIELD NAME
1	Record ID
2	Submitter ID
3	File-ID
4	Transaction Date
5	Production-Test-Indicator
6	Filler

RECORD BBB – BATCH HEADER

FIELD NO	FIELD NAME
1	Record ID
2	Sequence Number
3	Plan Number
4	Filler

RECORD CCC – DETAIL LEVEL

FIELD NO	FIELD NAME
1	Record ID
2	Sequence Number
3	Sequence Number Error Code
4	Patient Control Number
5	HICN
6	HICN Error Code
7	Patient DOB
8	DOB Error Code
9.0	Provider Type
9.1	From Date
9.2	Through Date
9.3	Delete-Indicator
9.4	Diagnosis Code
9.5	Diagnosis Code Filler
9.6	Diagnosis Cluster Error 1
9.7	Diagnosis Cluster Error 2
19	Corrected HICN
20	Filler

TABLE 5J – RAPS RECORD LAYOUT (CONTINUED)

RECORD YYY – BATCH TRAILER

FIELD NO	FIELD NAME
1	Record ID
2	Sequence Number
3	Plan Number
4	CCC-Record-Total
5	Filler

RECORD ZZZ – FILE TRAILER

FIELD NO	FIELD NAME
1	Record ID
2	Submitter ID
3	File-ID
4	BBB Record Total
5	Filler

Example: 5

The MA organization submitted a file and included the date of birth (DOB) for the beneficiary. RAPS determined a discrepancy between the DOB submitted on the file and what is stored in the Medicare Advantage Prescription Drug System (MARx). The submitter received a RAPS Return File. Figure 5E illustrates the portion of the RAPS Return File that contains the DOB, as well as an error code indicating that the submitted DOB is incorrect.

Figure 5E – RAPS Return File

AAASH777700000000000120030411PROD
BBB0000001H9999
CCC0000001 7321430 123456789A **19350305354**0120030314200303184359
YYY0000001H99990000003
ZZZSH777700000000010000003

DOB and

RAPS reports include the sequence number of the file, batch, and detailed record as submitted by the organization.

5.3.2.2 RAPS Transaction Error Report

The RAPS Transaction Error Report displays only those detail-level (CCC) records where errors were found during RAPS processing. Every record with errors is displayed in full with the appropriate error code next to the field in error. The report is available in a report layout file in each submitter's mailbox. It is organized by H number, and may prove useful to MA organizations that use a manual tracking process. Figure 5F illustrates the RAPS Transaction Error Report and describes the report's fields.

Submitters receive a RAPS Transaction Error Report the next business day after submitting a file.

Figure 5F – RAPS Transaction Error Report

[1]REPORT : RAPS002 **[2]**RISK ADJUSTMENT PROCESSING SYSTEM **[3]**PAGE: 1
[4]RUN DATE : 20030411 TRANSACTION ERROR REPORT **[5]**TRANS DATE: 20030411
[6]SUBMITTER ID SH7777 **[7]**FILE ID: 0000000005 **[8]**PLAN ID: H7777 **[9]**BATCH NUMBER: 0000001

[10] SEQ NUM	[11] SEQ ERR	[12] PATIENT CONTROL NUM	[13] HIC	[14] HIC ERR	[15] DOB	[16] DOB ERR	[17] PVDR TYPE	[18] FROM DATE	[19] THRU DATE	[20] DEL IND	[21] DGNS CODE	[22] DGNS ERR1	[23] DGNS ERR2	[24] CORRECTED HIC
0000002		123456789012345676878812347654165464515	123456789A		19350305	354	01	20030314	20030318		4359	501		

END OF FILE

Field No.	Field Name	Field Description
1	Report Name	Name of the report as it appears in the Submitter's mailbox.
2	Report Full Name	Full name of the report.
3	Page Number	Page number of the report.
4	Report Run Date	Date CMS generated the report (CCYYMMDD).
5	MCO Transmit Date	Date the MA organization created the transaction.
6	Submitter ID	Report is grouped by submitter identification number. A submitter may submit for more than one organization.
7	File ID	The 10-character alphanumeric field identifying the specific file submitted.
8	Plan Number	The H-number assigned by CMS; A different report is printed for each organization (H-number).
9	Batch ID	The 7-digit batch identification number.
10	Sequence Number	Detail-level record where the error occurred.
11	Sequence Number Error Code	The 3-digit error code associated with the sequence number.
12	MCO Patient Control Number	Patient control number assigned by the MA organization, if any.
13	HIC Number	The 10-character (alpha-numeric) Health Insurance Claim (HIC) Number of the beneficiary.
14	HIC Number Error Code	The 3-digit error code associated with the HIC Number.
15	Date of Birth	Patient's date of birth (CCYYMMDD format).
16	Date of Birth Error Code	The 3-digit error code associated with the patient's date of birth.
17	Provider Type	The 2-digit code identifying the provider type (01, 02, 10, or 20).
18	Service From Date	Date of admission (inpatient) or date of treatment (outpatient facility or physician).
19	Service Through Date	Date of discharge (inpatient) or date of treatment (outpatient facility or physician).
20	Delete Indicator	The 1-character place holder that identifies diagnosis clusters that will be or are deleted. This field is populated with a "D" if the cluster was deleted. If no deletion has occurred, the space will be blank.
21	Diagnosis Code	The 5-character ICD-9-CM diagnosis code.
22	Diagnosis Code Error 1	Error code associated with submitted diagnosis code, if any.
23	Diagnosis Code Error 2	Error code associated with submitted diagnosis code, if any.
24	Corrected HIC Number	If an error code indicates there is a corrected HIC number, it is listed here.

When RAPS identifies no errors, the system sends a Transaction Error Report with the message "ALL DIAGNOSES PROCESSED WITHOUT ERRORS."

Example: 6

The MA organization submitted a batch that included eight records (Figure 5G). Since errors occurred in records three, five, and seven, only those sequence numbers are reflected on the report. In record three, the plan submitted a HIC that does not appear on the common tables. The plan received a 353-error for this record, and the diagnosis was not stored. The fifth record included three clusters for a hospital inpatient stay, two of which received errors due to the beneficiary not being enrolled in a health plan on the date that the beneficiary was admitted to the hospital. The hospital inpatient clusters received the 408-error message, but no 409-error message. Hospital inpatient rules hold the MA organization responsible for reporting patient admissions for all enrollees. The submission rules also require that the entire stay be reported, even if the patient was not enrolled in the health plan on the discharge date.

On the seventh record, the health plan attempted to delete one diagnosis cluster and replace that cluster with one containing the same diagnosis and different service dates. This record had errors for both actions. The original cluster had previously been deleted and received a 491-error code. The new cluster received 408- and 409-errors because the beneficiary was not enrolled in the plan on or after the dates of service.

Figure 5G – RAPS Transaction Error Report

REPORT: RAPS002 **RISK ADJUSTMENT PROCESSING SYSTEM**
RUN DATE: 20040523 **TRANSACTION ERROR REPORT** PAGE: 22
TRANS DATE: 20040521

SUBMITTER ID: SH9999 FILE ID: 0000000001 PLAN: H9999 BATCH NUMBER: 0000001

SEQ NO	SEQ ERR	PATIENT CONTROL NUMBER	HIC NUMBER	HIC ERR	DOB	DOB ERR	PVDR TYPE	FROM DATE	THRU DATE	DEL IND	DGNS CODE	DGNS ERR1	DGNS ERR2	CORRECTED HIC
0000003			999999999A	353	19301206		01	20040101	20040105		4823			
		00000000000000000012345678901234567890												
0000005			888888888A		19260217		01	20040212	20040225		486	408		
		00000000000000000012345675675675675675												
							02	20040212	20040225		2508	408		
							02	20040312	20040325		496			
0000007			666666666D		19301206		20	20040101	20040105	D	25004	491		
							20	20040411	20040422		25004	408	409	

END OF FILE

5.3.2.3 RAPS Transaction Summary Report

The MA organization receives the RAPS Transaction Summary Report each time RAPS processes a submitted file. This report identifies the number of clusters received for each provider type, and summarizes the disposition of all diagnosis clusters that were present on the submitted file. Figure 5H illustrates the RAPS Transaction Summary Report and describes its fields.

Submitters receive a RAPS Transaction Summary Report the next business day after submitting files.

Figure 5H – RAPS Transaction Summary Report

RISK ADJUSTMENT PROCESSING SYSTEM
TRANSACTION SUMMARY REPORT

[1]REPORT: RAPS001
[2]RUN DATE: 20030412 **[3]**TRANS DATE:20030411

[4]SUBMITTER ID SH7777 **[5]**PLAN ID: H7777 **[6]**FILE ID: 0000000001

[7]PROVIDER TYPE	PRINCIPAL INPATIENT	OTHER INPATIENT	OUTPATIENT	PHYSICIAN	**[8]**UNIDENTIFIED	TOTAL
[9]TOTAL SUBMITTED	207	1,213	0	0	0	1,420
[10]TOTAL REJECTED	9	49	0	0	0	58
[11]TOTAL ACCEPTED	198	1,164	0	0	0	1,362
[12]TOTAL STORED	189	1,099	0	0	0	1,288
[13]TOTAL MODEL STORED	103	368	0	0	0	471
[14]TOTAL DELETE ACPTD	0	0	0	0	0	0
[15]TOTAL DELETE RJCTD	0	0	0	0	0	0

Field No.	Field Name	Field Description
1	Report Name	Name of the report as it appears in the submitter's mailbox.
2	Report Run Date	Date CMS generated the report.
3	MCO Transmit Date	Date the submitter created the transmission.
4	Submitter ID	Report is grouped by submitter identification number. A submitter may submit for more than one organization.
5	Plan Number	H-number assigned by CMS; a different report is printed for each organization (H-number).
6	File ID	The 10-character alphanumeric field identifying the specific file submitted.
7	Provider Type	This header row identifies the provider sources for which data are listed: principal inpatient, other inpatient, outpatient, physician, unidentified, and total.
8	Unidentified Provider Type	Indicates the number of diagnosis clusters in transactions that did not include a valid provider type. Valid provider types are "01," "02," "10," and "20."
9	Total Submitted	The total number of clusters submitted in the file.
10	Total Rejected	The total number of clusters submitted in the file and rejected.
11	Total Accepted	The total number of clusters submitted in the file and accepted.
12	Total Stored	The total number of clusters stored in the risk adjustment database – includes all accepted clusters that are non-duplicates.
13	Total Model Stored	The total number of required clusters that were stored, and are included in the CMS-HCC model)
14	Total Delete Accepted	The total number of deletes submitted for the file that were accepted in the database.
15	Total Delete Rejected	The total number of deletes submitted, but rejected, for the file.

5.3.2.4 Relationships Between Values in Report

The relationships between values found on various lines of the report are illustrated using the following formulas:

- The sum of total rejected, total accepted, total deletes accepted, and total deletes rejected equal total submitted. Line 10 + Line 11 + Line 14 + Line 15 = Line 9.

- The total stored (Line 12) is less than or equal to the total accepted (Line 11). The Risk Adjustment Database stores all required diagnosis clusters, including diagnoses that are not used in the current risk adjustment model. The difference between total accepted and total stored reflects the number of exact duplicate diagnosis clusters.

- The total stored in the model (Line 13) is less than or equal to the total diagnosis clusters stored (Line 12).

Example: 7

Based on the information displayed in Figure 5H, the MA organization can make the following conclusions:

- About four percent of the clusters were rejected due to error.
- Seventy-four duplicates were submitted (total accepted minus total stored).
- About one-third of the diagnoses submitted were in the model.

MA organizations can use the reports not only to correct errors, but to track the errors and implement automated or manual systems to prevent the same errors from occurring in the future.

Example: 8

In Figure 5I, the MA organization submitted a file that included 72 duplicate diagnosis clusters, and 3,299 diagnosis codes that were not relevant. The RAPS Transaction Summary Report also indicates that clusters were submitted with missing or invalid provider types. In addition, the organization had 12 deletes rejected, meaning the organization attempted to perform the delete function against a diagnosis cluster that was already deleted, or tried to delete a cluster that never stored. The RAPS Return File or the RAPS Transaction Error Report communicates the specific reason for each rejection.

Figure 5I – Transaction Summary Report

RISK ADJUSTMENT PROCESSING SYSTEM
TRANSACTION SUMMARY REPORT

REPORT: RAPS001
RUN DATE: 20040503 TRANS DATE:20040430

SUBMITTER ID SH7777 PLAN ID: H9999 FILE ID: 0000000001

PROVIDER TYPE	Principal Inpatient	Other Inpatient	Outpatient	Physician	Unidentified	Total
TOTAL SUBMITTED	870	3480	629	348	2	5329
TOTAL REJECTED	26	104	18	13	2	163
TOTAL ACCEPTED	842	3367	606	333	0	5148
TOTAL STORED	840	3335	581	320	0	5076
TOTAL MODEL STORED	295	1167	203	112	0	1777
TOTAL DELETE ACPTD	2	2	0	2	0	6
TOTAL DELETE RJCTD	0	7	5	0	0	12

The sum of total rejected, total accepted, total deletes accepted, and total deletes rejected is equal to the total submitted.

The values in the "Unidentified" column on the report represent the number of clusters for which RAPS is unable to identify a provider type. These clusters are reflected only in the "Total Submitted" and "Total Rejected" rows of the report.

5.3.2.5 Informational Error Messages

RAPS generates informational messages that do not stop processing of data, i.e., no immediate action is necessary. However, these messages, illustrated in Table 5K, provide MA organizations with information to improve future submissions.

TABLE 5K – INFORMATIONAL MESSAGE CODES

ERROR CODE	RECORD ID	ERROR DESCRIPTION	PROCESS IMPROVEMENT
500	CCC	BENEFICIARY HIC NUMBER HAS CHANGED ACCORDING TO CMS RECORDS; USE CORRECT HIC NUMBER FOR FUTURE SUBMISSIONS.	USE UPDATED HIC NUMBER ON ALL FUTURE SUBMISSIONS FOR THIS BENEFICIARY.
501	CCC	VALID DIAGNOSIS BUT NOT INCLUDED IN THE CURRENT RISK ADJUSTMENT MODEL DURING THIS SERVICE PERIOD.	DETERMINE IF FILTERING SHOULD BE INCORPORATED INTO SUBMISSION PROCESS TO REDUCE NUMBER OF 501 MESSAGES.

5.3.2.5.1 Duplicate Diagnosis Cluster Error and 5 Percent Benchmark

CMS has put a 5 percent benchmark requirement in place for 502 errors, "Diagnosis cluster was accepted but not stored. A diagnosis cluster with the same attributes is already stored in the RAPS database," CMS monitors plans with error rates that exceed the benchmark. CMS defines a duplicate submission as a diagnosis cluster with the same attributes (provider type, from date, through date, diagnosis code, and HIC number) that are already stored in the RAPS database.

Each duplicate cluster that receives a 502-error code counts toward the 5 percent benchmark. For example, if a record included 10 diagnosis clusters and each one was a duplicate of another cluster, there would be 10 502-error codes and all 10 would count towards the 5 percent benchmark.

CMS will look at the overall metrics per file, as this is the easiest way to measure the benchmark. CMS will look at files on a weekly basis to determine volume and the number of duplicates the plan receives to determine if a compliance letter needs to be sent.

If the submitter is a third party and the file contains records for multiple plans, the review will occur at the plan level within the file. Table 5L provides examples of how CMS reviews plan submissions against the benchmark.

TABLE 5L – 502 BENCHMARK COMPARISON EXAMPLES

EXAMPLE NUMBER	EXAMPLE DESCRIPTION
1	If a plan submitted one file in a given week with two records and they were duplicates, the plan would have a 100% duplicate rate, but with only two records.
2	Afterwards, the plan submitted additional files that had 10,000 records and a 2% duplicate rate. In this case, CMS would not send this plan a compliance letter.
3	If, on the other hand, a plan submitted a file with 2 million records and 1 million of them were duplicates, CMS would send a compliance letter.

5.3.2.6 RAPS Duplicate Diagnosis Cluster Report

This report lists diagnosis clusters with a 502-error information message (diagnosis cluster was accepted but not stored) appearing on the RAPS Return File and the RAPS Transaction Error Report. Clusters appearing on this report had been submitted previously to CMS; that is, a cluster with the same HIC number, provider type, from and through dates, and diagnosis are already stored in the RAPS database. Figure 5J illustrates the file layout and provides a key to the fields.

Organizations are notified through a www.csscoperations.com update when this report is available.

MA organizations that submit using Connect:Direct do not have to obtain the Duplicate Diagnosis Cluster Report. Connect:Direct submitters are usually large-volume users, and they can reference the RAPS Return File to review 502 informational messages.

Figure 5J – Duplicate Diagnosis Cluster Report

(1) REPORT: RAPS002 **(2) RISK ADJUSTMENT PROCESSING SYSTEM**
(4) RUN DATE: 20030523 **DUPLICATE DIAGNOSIS CLUSTER REPORT** (3) PAGE: 22
(5) TRANS DATE: 20030521

(6) SUBMITTER ID:SH9999 (7) FILE ID: 0000000001 (8) PLAN: H9999 (9) BATCH NUMBER: 0000001

(10) SEQ NO	(11) SEQ ERR	(12) PATIENT CONTROL NUMBER	(13) HIC NUMBER	(14) HIC ERR	(15) DOB	(16) DOB ERR	(17) PVDR TYPE	(18) FROM DATE	(19) THRU DATE	(20) DEL IND	(21) DGNS CODE	(22) DGNS ERR1	(23) DGNS ERR2	(24) CORRECTED HIC
0000003			999999999A		19301206		01	20030101	20030105		4823	502		
		00000000000000000012345678901234567890												

Field No.	Field Name	Field Description
1	Report Name	Name of the report as it appears in the submitter's mailbox.
2	Report Full Name	Full name of the report.
3	Page Number	Page number of the report.
4	Report Run Date	Date CMS generated the report (CCYYMMDD).
5	MCO Transmit Date	Date the submitter created the transaction.
6	Submitter ID	Report is grouped by submitter identification number. A submitter may submit for more than one organization (H-number).
7	File ID	The 10-character alphanumeric field identifying the specific file submitted.
8	Plan Number	H-number assigned by CMS; a different report is printed for each MA organization (H-number).
9	Batch ID	The 7-digit batch identification number.
10	Sequence Number	Detail-level record where the error occurred.
11	Sequence Number Error Code	The 3-digit error code associated with the sequence number.
12	MCO Patient Control Number	Patient control number assigned by the MA organization, if any.
13	HIC Number	The 10-digit (alpha-numeric) HIC Number of the beneficiary.
14	HIC Number Error Code	The 3-digit error code associated with the HIC Number.
15	Date of Birth	Patient's date of birth (CCYYMMDD format).
16	Date of Birth Error Code	The 3-digit error code associated with the patient's date of birth.
17	Provider Type	The 2-digit code identifying the provider type (01, 02, 10, or 20).
18	Service From Date	Date of admission (inpatient) or date of treatment (outpatient facility or physician).
19	Service Through Date	Date of discharge (inpatient) or date of treatment (outpatient facility or physician).
20	Delete Indicator	The 1-character place holder identifies diagnosis clusters that will be or are deleted. This field is populated with a "D" if the cluster was deleted. If no deletion has occurred, the space will be blank.
21	Diagnosis Code	The 5-character ICD-9-CM diagnosis code.
22	Diagnosis Code Error 1	Error code associated with submitted diagnosis code, if any.
23	Diagnosis Code Error 2	Error code associated with submitted diagnosis code, if any.
24	Corrected HIC Number	If an error code indicates there is a corrected HIC number, it is listed here.

Submitters should consider establishing an automated system or a process that checks previously submitted files for accepted diagnosis clusters in order to minimize or eliminate the resubmission of duplicate diagnosis clusters.

While this is an informational error and does not require action in terms of correcting an error, it is critical that plans self-monitor their submissions so that they do not exceed the 5 percent benchmark requirement on 502 errors. Table 5M provides tips to ensure plans are compliant with the guidance on the 5 percent benchmark for duplicate diagnosis cluster errors.

TABLE 5M – TIPS FOR ENSURING COMPLIANCE WITH THE 5 PERCENT BENCHMARK FOR DUPLICATE DIAGNOSIS CLUSTER ERROR GUIDANCE

TIP	DESCRIPTION
Tip 1: Identify a Duplicate Diagnosis Cluster	CMS defines a Duplicate Diagnosis Cluster as one that shares all of the same attributes (HIC Number, Provider Type, From and Through Dates and Diagnosis) as one previously submitted and stored in the RAPS database.
Tip 2: Review Your Reports	Review your current and previous RAPS Return Files to determine which clusters were stored. If the cluster was stored, do not resubmit.
Tip 3: Understand Error Resolution	If you are resolving an error, you do not necessarily need to resubmit all clusters included in the record. If you are resolving a 300-level error, this indicates that none of the diagnosis clusters were stored because there was a record level error. If this is the case, you will need to resubmit all clusters associated with the record. This would not create a duplicate diagnosis because none of the records were previously stored. If you are resolving a 400-level error, this indicates that a specific diagnosis cluster was not stored. You should only resubmit the specific cluster that resulted in the 400-level error message. *Do not* resubmit all clusters within the record. If there were ten clusters within the record, but you received a 400-level error message on only two of the clusters, you should only resubmit the two clusters where the error occurred.
Tip 4: Understanding Modifying Data	In the case of self-identified errors, those not reported as an error on the RAPS reports, you should be careful to only resubmit the diagnosis clusters that require a modification. If you submit a record with eight clusters, but the following week you realize that the date of service was incorrect in one of the clusters, you would submit that specific cluster with a "D" in the delete indicator field, and submit a new cluster with the correct date. Resubmitting all of the remaining seven clusters would create seven duplicates.

Use the tips above to assist your plan in reducing or eliminating the submission of duplicate diagnosis clusters to avoid implications that may result in suspension of data submission privileges and ultimately impact your payments.

Example: 9

Scenario:
Blue Health Plan submitted a CCC record with seven diagnosis clusters in which the sixth diagnosis cluster received an error indicating the diagnosis was not appropriate for the patient sex.

Results:
The CCC record with the seven diagnosis clusters received a cluster level error, error code 453 on the sixth cluster. The only cluster not accepted and stored from this CCC record is the sixth cluster. Therefore, the only cluster that should be resubmitted by Blue Health Plan is the sixth cluster, the one that received the error. Resubmitting the other diagnosis clusters that were accepted and stored would result in the Blue Health Plan receiving error code 502 for submitting duplicate diagnosis clusters. This would count against the plan's 5% benchmark.

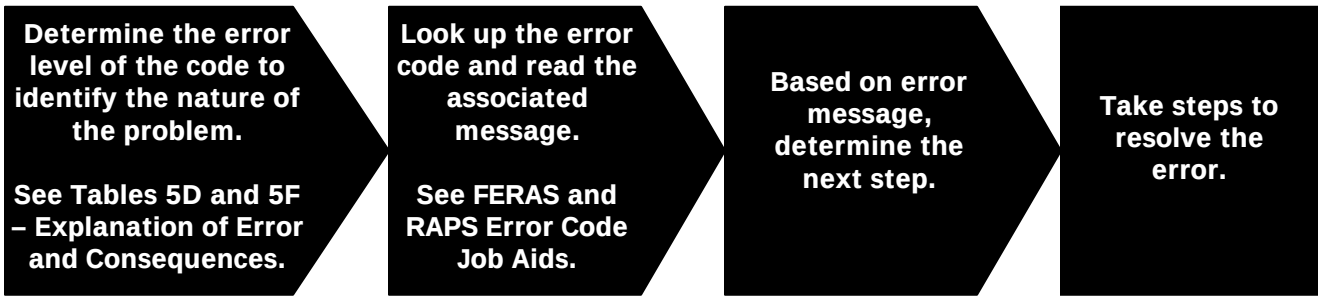
5.4 Resolving Errors

CMS began accepting risk adjustment data in FERAS and processing data through RAPS in October 2002. While the error rate is less than one percent, there are several errors that represent the majority of the common errors seen.

5.4.1 Resolution Steps

It is the MA organization's responsibility to resolve errors that CMS identifies. Described below in Figure 5K are the basic steps required to resolve errors. If inaccurate data are the cause of the error, the organization must submit a new record with corrected information to resolve the error.

Figure 5K – Resolution Steps



System problems may occur when MA organizations submit and delete the same diagnosis cluster several times on the same day. Error code 492 occurs if the organization tries to delete the same cluster more than once.

Example: 10

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

Results: The error code 492 occurs, indicating that (1) the diagnosis cluster was not successfully deleted and (2) that the cluster is already stored as a delete and another delete is not necessary.

Effective January 3, 2006, CMS added error code 455 to the RAPS Error Codes list. The message reads "Diagnosis cluster not edited due to record format error." The diagnosis cluster is not stored. A plan will receive this error if the plan leaves a cluster blank within a CCC record, and then populates the next cluster. Error code 455 clusters may occur with, or after, the first blank diagnosis cluster. Blank clusters will not receive a 455 error.

When a submitter receives a 455-error code, "Diagnosis Cluster Not Edited Due to Record Format Error," apply the resolution steps outlined in Figure 5K:

- Since this is a 400-level error code message, the submitter will refer to the diagnosis cluster.
- The error code series 400-489 indicates that all possible diagnosis edits were performed but the diagnosis cluster is not stored.
- The submitter should ensure that the CCC record contains valid clusters, left justified in the record, followed by blank clusters.
- Resubmit following correction.

Example: 11

Scenario: Horizon Valley Health Plan submitted eight diagnosis clusters. However, the fifth diagnosis cluster was a blank cluster.

Results: Error code 455 occurs. All of the diagnosis clusters following the blank cluster received the error code 455. All possible diagnosis edits were performed, but the diagnosis clusters were not stored.

5.4.2 Common Errors

In an effort to prevent common errors, the next section describes the errors and steps that MA organizations may take to minimize their occurrence.

5.4.2.1 File Name Duplicates Another File Accepted Within Last 12 Months

To identify the unique file that has been accepted, CMS requires that all files include a 10-digit alpha-numeric file ID. This file ID is required when submitting test or production data. Once a file ID has been submitted and accepted in test or production, the same file ID may not be submitted on any other files within 12 months.

Example: 12

SenCare Health Plan submitted a risk adjustment inpatient transaction file in August 2002 and a risk adjustment physician transaction test file in August 2002. The plan cannot submit both files with the same file ID within 12 consecutive months (between August 2002 and August 2003).

Prevention

Submitters should consider establishing an automated system to assign a file sequence number during the establishment of the data file.

Correction

When a submitter receives a 113-error code, “File name duplicates another file accepted within the last 12 months”, the following steps should be taken:

- Since this is a 100-level error code message, the submitter will refer to the AAA record.
- The error code 11**3**, describes the field within the AAA record that must be corrected.
- The submitter must enter a valid 10-digit file ID in AAA 3.
- The file must be resubmitted following correction.

Since this file was rejected by FERAS, it will not be processed in RAPS until the data are corrected.

5.4.2.2 Delete Error, Diagnosis Cluster Previously Deleted

When a plan submits a delete and RAPS accepts it, the cluster is not physically deleted from the RAPS database. The RAPS database stores a “D” in the delete indicator and enters a delete date to indicate when the diagnosis was deleted. If a plan tries to delete the exact same diagnosis cluster at a later time, the system will generate a 491-error code, informing the plan that the cluster was already deleted.

Prevention

This issue normally occurs when plans delete all clusters from a previously submitted file, and the original file included duplicate diagnosis clusters. One way to prevent the errors is to check for duplicate diagnosis clusters prior to submitting the file with the deletes on it.

Correction

There is no corrective action necessary because the 491-error code indicates that the cluster has already been deleted.

5.4.2.3 Diagnosis Cluster Not Successfully Deleted. Another Diagnosis Cluster With the Same Attributes Was Already Deleted From the RAPS Database On This Date

When plans submit delete records, the "D" indicator and the delete date become part of the unique database key for the diagnosis cluster. Diagnosis clusters must have one unique attribute in the database key in order to be stored. The 492-error code occurs when a plan deletes, adds, and then attempts to delete the exact same cluster during a single processing day. The delete will successfully process, as will the following add transaction. The add transaction will create a new record for this diagnosis cluster. The second delete cannot process, since accepting the second delete will cause the creation of a duplicate record in the RAPS database. This error is different from the 491 in that the last record on file will be the add record; that is, the diagnosis cluster has not been successfully deleted.

Prevention

Again, this error normally occurs when plans submit large files of correction records. Plans should check when deleting records that they are not adding the exact same cluster in the same file, or on different files on the same day. If a plan detects multiple submissions of the same diagnosis cluster, the plan should determine the final status of the cluster, deleted or active, and take appropriate action.

Correction

When a submitter receives a 492-error code, "Diagnosis Cluster Not Successfully Deleted", the following steps should be taken:

- Since this is a 400-level error code message, the submitter will refer to the CCC record.
- The error code series 490-499 indicates that it is a deletion problem.
- The submitter must determine if the diagnosis cluster should be deleted or active as a final action.
- If the cluster should be active, no further action is required.
- If the diagnosis is supposed to be deleted, the plan must submit one delete record. Since any future submissions will have a different delete date than any other clusters on file, a single delete record will successfully process.

5.4.2.4 Service From Date Is Not Within MA Organization Enrollment

MA organizations can reduce the numbers of errors that are returned due to invalid eligibility by accessing the common user interface to determine eligibility and other demographic information stored on the common tables. Implementing the following procedures can reduce time spent on resolving errors.

- Develop a monthly validation protocol verifying eligibility of MA organization enrollees.
- Program internal information systems that cross check the common tables before submitting data to FERAS.

The Beneficiary Eligibility and Beneficiary Detail screens in the common user interface provide information that supports the MA risk adjustment requirements. The information includes:

- Date of birth.
- HIC Number.
- Medicare effective date.
- Medicare termination date.

Note: MA organizations can manually research each beneficiary online or electronically research beneficiaries in batches using the Batch Eligibility Query Request File.

The beneficiary receiving services under the MA program must be enrolled in Medicare during the service period. The dates of service reported in the diagnosis clusters must be within the enrollment dates that are posted on the common tables. RAPS cross-references the common tables to verify that the beneficiary was covered during the identified from and through dates of service. Prior to March 2003, MA organizations received the 408- and 409-error codes to reflect data inconsistencies between various CMS systems.

The 408-error code occurs with all data. The 409-error code occurs only with hospital outpatient and physician data.

Prevention

Submitters should check the from and through dates of service against internal enrollment records. Remember that for hospital outpatient and physician data, both the from and through dates must be within MA enrollment periods. For hospital inpatient data, only the from dates must be within MA enrollment periods. Performing these pre-edits will minimize the number of errors received regarding enrollment information.

Correction

When a submitter receives a 408-error code “Service from date is not within MA organization enrollment period”, or a 409-error code “Service through date is not within MA organization enrollment period”, the following steps should be taken:

- Since this is a 400-level error code message, the submitter will refer to the diagnosis cluster.

- The submitter must ensure that the correct service from date was entered in CCC 9.1.

- The submitter must ensure that the correct service through date was entered in CCC 9.2.
- The submitter should check these dates against the plan enrollment dates in the common tables.
- If the submitter determines that there are discrepancies in the data in CMS systems, contact CSSC.
- If the CSSC determines that the common tables require updated plan enrollment data, contact the MMA Help Desk.
- After the data have been corrected, resubmit.

Since this is not a format or integrity edit, this error will not be detected in FERAS; therefore, DDE users may encounter this error. When this is detected in RAPS, the problem must be corrected in order to store any diagnosis clusters associated with this record.

5.4.2.5 Beneficiary Is Not Enrolled In Plan On or After Service From Date

Beneficiaries must be enrolled in the plan on or after the date of the service provided.

Prevention

Using information from the monthly membership report and internal enrollment files, submitters should be knowledgeable regarding the enrollment and eligibility of their beneficiaries. Establishing a systematic beneficiary enrollment tracking system will reduce the number of errors associated with this edit.

The 408- and 409-error code messages indicate that the service occurred while the beneficiary was not participating in *any* MA program. The 410-error code message indicates that the service occurred while the beneficiary was not enrolled in *your* organization.

Correction

When a submitter receives a 410-error code "Beneficiary is not enrolled in 'your' plan on or after service from date", the following steps should be taken:

- Since this is a 400-level error code message, the submitter will refer to the diagnosis cluster.
- The submitter must ensure that the correct service from date was entered in CCC 9.1.
- The submitter should check the service from date against the plan enrollment dates to confirm that the beneficiary was enrolled in their plan on or after the from date.
- If the submitter determines that there are discrepancies in the beneficiary's enrollment data in CMS systems, contact the MMA Help Desk.
- After the data have been corrected, resubmit.

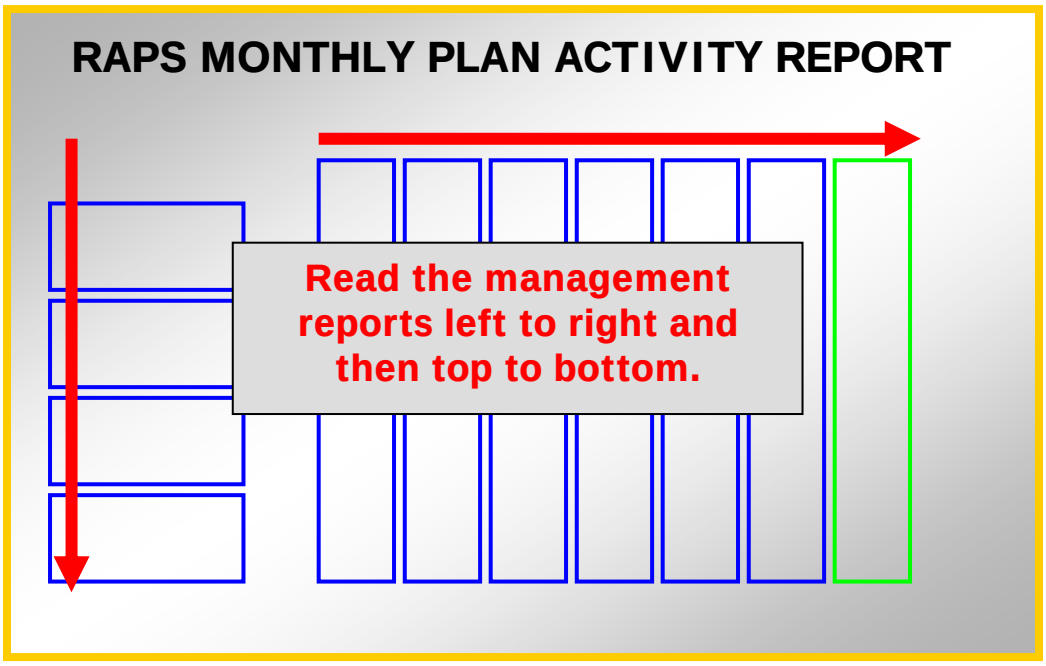
Since this is not a format or integrity edit, this error will not be detected in FERAS; therefore, DDE users may encounter this error. When this is detected in RAPS, the problem must be corrected in order to store any diagnosis clusters associated with this record.

5.5 RAPS Management Reports

CMS developed four management reports that provide detail on the amount of data submitted and stored for each provider type and any error codes associated with processing. The reports are delivered to the user on the second business day of the month.

When reviewing the management reports, it is helpful to read the report from left to right and then from top to bottom as illustrated in Figure 5L.

Figure 5L – Analysis of Management Reports



5.5.1 RAPS Monthly Plan Activity Report

The RAPS Monthly Plan Activity Report provides a summary of the status of all submissions by the submitter ID and plan number (H number). It allows MA organizations to validate the diagnoses submitted for a 1-month period. The report is arrayed by provider type and month (determined by through date of service). The report displays information by submitter ID and H number, and displays six months of data on each page. Figure 5M illustrates the report and its fields.

Delivered to users on the second business day of the month.

This report allows MA organizations to validate submitted diagnoses during a 1-month period, based on the date of service (through date). MA organizations can determine the number of clusters sent and

processed during the month, and the status of that data (accepted, rejected, stored, model stored, and accepted and rejected deletes) by source. By analyzing this report, the MA organization can determine if they are receiving and submitting sufficient data from sources, and the rejection rates for each data source. All this information is helpful in managing the data collection, data submission, and error resolution processes.

The total diagnosis clusters stored includes all non-duplicate clusters accepted, while the total model stored includes only diagnosis clusters identified in the CMS-Hierarchical Condition Category (HCC) model.

Figure 5M – RAPS Monthly Plan Activity Report Layout

[1]REPORT: RAPS0010 CMS RAPS ADMINISTRATION **[2]**PAGE: 2
[3]RUN DATE: 20040503 **[4]** RAPS MONTHLY PLAN ACTIVITY REPORT **[5]** SERVICE YEAR: 2003

[6]SUBMITTER ID: SH7777 **[7]**FOR THE MONTH OF APRIL, 2004
[8]PLAN ID: H7777

PROVIDER TYPE/TOTALS	**[9]**JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	TOTAL
PRINCIPAL INPATIENT							
[10]TOTAL SUBMITTED	19	25	28	73	404	1704	2253
[11]TOTAL REJECTED	10	7	11	19	106	426	579
[12]TOTAL ACCEPTED	9	18	17	54	298	1248	1674
[13]TOTAL STORED	9	18	17	54	298	1248	1674
[14]TOTAL MODEL STORED	5	8	12	27	158	646	856
[15]TOTAL DELETE ACPTD	0	0	0	0	0	0	0
[16]TOTAL DELETE RJCTD	0	0	0	0	0	0	0
OTHER INPATIENT							
[10]TOTAL SUBMITTED	103	113	143	407	244	10561	13774
[11]TOTAL REJECTED	49	44	55	112	638	2634	3532
[12]TOTAL ACCEPTED	54	69	88	295	1809	7927	10242
[13]TOTAL STORED	54	69	88	295	1809	7927	10242
[14]TOTAL MODEL STORED	18	24	26	95	575	2574	3312
[15]TOTAL DELETE ACPTD	0	0	0	0	0	0	0
[16]TOTAL DELETE RJCTD	0	0	0	0	0	0	0
OUTAPTIENT							
[10]TOTAL SUBMITTED	329	490	761	1691	9526	33693	46490
[11]TOTAL REJECTED	115	179	219	531	2523	8769	12336
[12]TOTAL ACCEPTED	214	311	542	1160	7003	24924	34154
[13]TOTAL STORED	214	311	542	1160	7003	24924	34154
[14]TOTAL MODEL STORED	35	82	135	244	1779	5305	7580
[15]TOTAL DELETE ACPTD	0	0	0	0	0	0	0
[16]TOTAL DELETE RJCTD	0	0	0	0	0	0	0
PHYSICIAN							
[10]TOTAL SUBMITTED	2450	3221	4812	12429	31573	130564	185049
[11]TOTAL REJECTED	224	206	527	928	2039	6026	9950
[12]TOTAL ACCEPTED	2226	3015	4285	11501	29534	124538	175099
[13]TOTAL STORED	2226	3015	4285	11501	29534	124538	175099
[14]TOTAL MODEL STORED	608	721	1116	2797	7426	29413	42117
[15]TOTAL DELETE ACPTD	0	0	0	0	0	0	0
[16]TOTAL DELETE RJCTD	0	0	0	0	0	0	0

FIELD DESCRIPTIONS ON NEXT PAGE

Figure 5M– RAPS Monthly Plan Activity Report Layout (continued)

Field No.	Field Name	Field Description
1	Report Name	Name of the report as it appears in submitter's mailbox.
2	Page Number	Page number of the report. Six months arrayed per page.
3	Report Run Date	Date CMS generated the report.
4	Report Full Name	Full name of the report.
5	Service Year	The year of the service through date.
6	Submitter ID	Report is grouped by submitter identification number. A submitter may submit for more than one organization (H number).
7	Report Year and Date	Month and year of the submission.
8	Plan Number	H number assigned by CMS; a different report is printed for each organization (H number).
9	Month	The month of the service through date.
10	Total Submitted	The total number of clusters submitted during the report period by the MA organization.
11	Total Rejected	The total number of clusters submitted during the report period by the MA organization rejected due to errors.
12	Total Accepted	The total number of clusters submitted during the report period by the MA organization accepted without errors.
13	Total Stored	The total number of clusters submitted by the MA organization and accepted by RAPS during the report period, and stored in the database (does not include duplicates if identical clusters already stored in the database).
14	Total Model Stored	The total number of ***required*** diagnosis clusters submitted by the MA organization and accepted by RAPS during the report period, and stored in the database.
15	Total Deletes Accepted	The total number of deleted clusters submitted by the MA organization during the report period that were accepted with no errors.
16	Total Deletes Rejected	The total number of deleted clusters submitted by the MA organization during the report period that were rejected with errors.

Example: 13

An MA organization's management can determine how effectively it has submitted data by reviewing the number of clusters submitted and stored on a monthly basis. Figure 5N illustrates that the submissions for service year 2004 are going relatively well. There is an error rate of approximately three percent during the period identified on page 2 of the April 2004 report. The error rate is calculated by dividing the total records rejected into the total submitted; for example, April 2004 principal inpatient has 26 rejected out of 824 submitted, a three percent error rate. There is very little lag between the date of the visit or stay and the date those data were collected and submitted. For every inpatient principal diagnosis on page 2 of the March 2004 report, there are four secondary diagnoses, which is appropriate.

An area of concern may be the number of physician services. In the April 2004 report, no data for physicians were submitted with dates of service between July 2003 and December 2003. However, 350 clusters with dates of service between January 2004 and April 2004 were submitted. For all data with dates of service between January 2004 and April 2004, only seven percent of the data were from physicians. It is typical for about three-quarters of the data submitted to be from physicians, so this finding might be indicative of a problem. However, this may be explainable if the organization simply

submitted its physician data before April 1 or after April 30, (i.e., the organization is submitting sufficient data, but did not send any physician data in April). Management should compare the data submitted during the previous month and take the MA organization's enrollment into account when interpreting this report and resolving potential issues.

During the month of April there was a group of clusters submitted for services performed in September 2003. One explanation for this could be difficulty collecting from particular providers. The error rate for the September 2003 data was 92 percent. Management should consider identifying the sources of that data and offering outreach or training to prevent this problem from occurring in the future.

Figure 5N – RAPS Monthly Plan Activity Report

REPORT: RAPS0010 — CMS RAPS ADMINISTRATION — PAGE: 2
RUN DATE: 20040402 — RAPS MONTHLY PLAN ACTIVITY REPORT — SERVICE YEAR: 2003

SUBMITTER ID: SH7777
PLAN NO: H7777
FOR THE MONTH OF MARCH, 2004

PROVIDER TYPE/TOTALS	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	TOTAL
PRINCIPAL INPATIENT							
TOTAL SUBMITTED	20915	17891	1739	1365	1721	2837	46468
TOTAL REJECTED	209	93	33	27	35	55	452
TOTAL ACCEPTED	20706	17798	1706	1338	1686	2782	46016
TOTAL STORED	20706	17798	1706	1338	1686	2782	46016
TOTAL MODEL STORED	17186	14772	599	455	573	946	34531
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OTHER INPATIENT							
TOTAL SUBMITTED	69458	47939	19020	14618	14264	20945	186244
TOTAL REJECTED	695	240	381	293	274	419	2302
TOTAL ACCEPTED	68763	47699	18639	14325	13990	20526	183942
TOTAL STORED	68763	47699	18639	14325	13990	20526	183942
TOTAL MODEL STORED	57073	39114	5965	4584	4285	6568	117589
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OUTPATIENT							
TOTAL SUBMITTED	60838	59543	11621	21381	23879	47758	225020
TOTAL REJECTED	61	30	175	321	359	717	1663
TOTAL ACCEPTED	60777	59513	11446	21060	23520	47041	223357
TOTAL STORED	60777	59513	11446	21060	23520	47041	223357
TOTAL MODEL STORED	50445	48801	3892	7161	7997	15994	134290
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
PHYSICIAN							
TOTAL SUBMITTED	172301	101277	179713	173688	214495	129995	971469
TOTAL REJECTED	1723	1013	3595	3474	4290	2600	16695
TOTAL ACCEPTED	170578	100264	176118	170214	210205	127395	954774
TOTAL STORED	170578	100264	176118	170214	210205	127395	954774
TOTAL MODEL STORED	141580	83219	61642	59575	73572	44589	464177
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0

Figure 5N – RAPS Monthly Plan Activity Report (continued)

REPORT: RAPS0010 — CMS RAPS ADMINISTRATION — PAGE: 1
RUN DATE: 20040402 — RAPS MONTHLY PLAN ACTIVITY REPORT — SERVICE YEAR: 2004

SUBMITTER ID: SH7777
PLAN NO: H7777
FOR THE MONTH OF MARCH, 2004

PROVIDER TYPE/TOTALS	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	TOTAL
PRINCIPAL INPATIENT							
TOTAL SUBMITTED	1297	1301	293	0	0	0	2891
TOTAL REJECTED	26	26	0	0	0	0	52
TOTAL ACCEPTED	1261	1275	288	0	0	0	2824
TOTAL STORED	1235	1269	283	0	0	0	2787
TOTAL MODEL STORED	432	444	99	0	0	0	975
TOTAL DELE ACPTD	10	0	5	0	0	0	15
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OTHER INPATIENT							
TOTAL SUBMITTED	8431	13489	411	0	0	0	22331
TOTAL REJECTED	169	270	3	0	0	0	442
TOTAL ACCEPTED	8262	13219	405	0	0	0	21886
TOTAL STORED	8261	13216	404	0	0	0	21881
TOTAL MODEL STORED	2891	4625	141	0	0	0	7657
TOTAL DELE ACPTD	0	0	1	0	0	0	1
TOTAL DELE RJCTD	0	0	2	0	0	0	2
OUTPATIENT							
TOTAL SUBMITTED	23415	17342	84	0	0	0	40841
TOTAL REJECTED	351	260	3	0	0	0	614
TOTAL ACCEPTED	23064	17081	81	0	0	0	40226
TOTAL STORED	20989	15199	77	0	0	0	36265
TOTAL MODEL STORED	7346	5320	27	0	0	0	12693
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	1	0	0	0	0	1
PHYSICIAN							
TOTAL SUBMITTED	111207	189171	0	0	0	0	300378
TOTAL REJECTED	2224	3783	0	0	0	0	6007
TOTAL ACCEPTED	108983	185388	0	0	0	0	294371
TOTAL STORED	108978	164995	0	0	0	0	273973
TOTAL MODEL STORED	38142	57748	0	0	0	0	95890
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0

Figure 5N – RAPS Monthly Plan Activity Report (continued)

REPORT: RAPS0010 CMS RAPS ADMINISTRATION PAGE: 2
RUN DATE: 20040503 RAPS MONTHLY PLAN ACTIVITY REPORT SERVICE YEAR: 2003

SUBMITTER ID: SH7777 FOR THE MONTH OF APRIL, 2004
PLAN NO: H7777

PROVIDER TYPE/TOTALS	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	TOTAL
PRINCIPAL INPATIENT							
TOTAL SUBMITTED	0	0	74	0	0	0	74
TOTAL REJECTED	0	0	60	0	0	0	60
TOTAL ACCEPTED	0	0	14	0	0	0	14
TOTAL STORED	0	0	14	0	0	0	14
TOTAL MODEL STORED	0	0	6	0	0	0	6
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OTHER INPATIENT							
TOTAL SUBMITTED	0	0	296	0	0	0	296
TOTAL REJECTED	0	0	280	0	0	0	280
TOTAL ACCEPTED	0	0	16	0	0	0	16
TOTAL STORED	0	0	7	0	0	0	7
TOTAL MODEL STORED	0	0	2	0	0	0	2
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OUTPATIENT							
TOTAL SUBMITTED	0	0	0	0	0	0	0
TOTAL REJECTED	0	0	0	0	0	0	0
TOTAL ACCEPTED	0	0	0	0	0	0	0
TOTAL STORED	0	0	0	0	0	0	0
TOTAL MODEL STORED	0	0	0	0	0	0	0
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
PHYSICIAN							
TOTAL SUBMITTED	0	0	0	0	0	0	0
TOTAL REJECTED	0	0	0	0	0	0	0
TOTAL ACCEPTED	0	0	0	0	0	0	0
TOTAL STORED	0	0	0	0	0	0	0
TOTAL MODEL STORED	0	0	0	0	0	0	0
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0

Figure 5N – RAPS Monthly Plan Activity Report (continued)

REPORT: RAPS0010 — CMS RAPS ADMINISTRATION — PAGE: 1
RUN DATE: 20040503 — RAPS MONTHLY PLAN ACTIVITY REPORT — SERVICE YEAR: 2004

SUBMITTER ID: SH7777
PLAN NO: H7777
FOR THE MONTH OF APRIL, 2004

PROVIDER TYPE/TOTALS	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	TOTAL
PRINCIPAL INPATIENT							
TOTAL SUBMITTED	100	435	200	89	0	0	824
TOTAL REJECTED	0	4	20	2	0	0	26
TOTAL ACCEPTED	100	429	180	87	0	0	796
TOTAL STORED	90	420	180	80	0	0	770
TOTAL MODEL STORED	30	152	52	26	0	0	260
TOTAL DELE ACPTD	0	2	0	0	0	0	2
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OTHER INPATIENT							
TOTAL SUBMITTED	400	1740	696	348	0	0	3184
TOTAL REJECTED	12	52	21	10	0	0	95
TOTAL ACCEPTED	388	1688	666	338	0	0	3080
TOTAL STORED	386	1668	661	333	0	0	3048
TOTAL MODEL STORED	135	583	232	117	0	0	1067
TOTAL DELE ACPTD	0	0	2	0	0	0	2
TOTAL DELE RJCTD	0	0	7	0	0	0	7
OUTPATIENT							
TOTAL SUBMITTED	0	377	252	0	0	0	629
TOTAL REJECTED	0	10	8	0	0	0	18
TOTAL ACCEPTED	0	362	244	0	0	0	606
TOTAL STORED	0	350	231	0	0	0	581
TOTAL MODEL STORED	0	123	80	0	0	0	203
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	5	0	0	0	0	5
PHYSICIAN							
TOTAL SUBMITTED	308	40	0	0	0	0	350
TOTAL REJECTED	9	4	0	0	0	0	13
TOTAL ACCEPTED	299	36	0	0	0	0	335
TOTAL STORED	284	36	0	0	0	0	320
TOTAL MODEL STORED	99	13	0	0	0	0	112
TOTAL DELE ACPTD	2	0	0	0	0	0	2
TOTAL DELE RJCTD	0	0	0	0	0	0	0

5.5.2 RAPS Cumulative Plan Activity Report

The RAPS Cumulative Plan Activity Report provides a cumulative summary of the status of submissions. The report is arrayed by provider type and month (determined by through date of service), and reports information by submitter ID and H number. Figure 5O illustrates the report and its fields.

The Cumulative Plan Activity Report is delivered to users on the second business day of each month.

Figure 5O – RAPS Cumulative Plan Activity Report Layout

[1]REPORT: RAPS0010 CMS RAPS ADMINISTRATION **[2]**PAGE: 2
[3]RUN REPORT: DATE: 20040503 **[4]** RAPS CUMULATIVE PLAN ACTIVITY REPORT **[5]**SERVICE YEAR: 2003

[6]SUBMITTER ID: SH7777 **[7]**FOR PERIOD ENDING APRIL 30, 2004
[8]PLAN NO: H7777

PROVIDER TYPE/TOTALS	**[9]**JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	TOTAL
PRINCIPAL INPATIENT							
[10]TOTAL SUBMITTED	22	25	40	29	39	61	216
[11]TOTAL REJECTED	0	0	2	0	3	1	6
[12]TOTAL ACCEPTED	22	25	38	29	36	60	210
[13]TOTAL STORED	22	25	38	29	36	60	210
[14]TOTAL MODEL STORED	18	24	26	23	33	44	168
[15]TOTAL DELETE ACPTD	0	0	0	0	0	0	0
[16]TOTAL DELETE RJCTD	0	0	0	0	0	0	0
OTHER INPATIENT							
[10]TOTAL SUBMITTED	56	92	157	108	99	178	690
[11]TOTAL REJECTED	0	0	8	0	15	4	27
[12]TOTAL ACCEPTED	56	92	149	108	84	174	663
[13]TOTAL STORED	56	92	149	108	84	174	663
[14]TOTAL MODEL STORED	29	67	66	58	51	104	375
[15]TOTAL DELETE ACPTD	0	0	0	0	0	0	0
[16]TOTAL DELETE RJCTD	0	0	0	0	0	0	0
OUTAPTIENT							
[10]TOTAL SUBMITTED	7	4	3	19	8	16	57
[11]TOTAL REJECTED	0	0	0	0	0	0	0
[12]TOTAL ACCEPTED	7	4	3	19	8	16	57
[13]TOTAL STORED	7	4	3	19	8	16	57
[14]TOTAL MODEL STORED	7	4	3	19	8	16	57
[15]TOTAL DELETE ACPTD	0	0	0	0	0	0	0
[16]TOTAL DELETE RJCTD	0	0	0	0	0	0	0
PHYSICIAN							
[10]TOTAL SUBMITTED	14	28	14	13	37	16	122
[11]TOTAL REJECTED	0	0	4	6	1	0	11
[12]TOTAL ACCEPTED	14	28	10	7	36	16	111
[13]TOTAL STORED	13	26	10	7	31	14	101
[14]TOTAL MODEL STORED	13	26	10	7	31	14	101
[15]TOTAL DELETE ACPTD	0	0	0	0	0	0	0
[16]TOTAL DELETE RJCTD	0	0	0	0	0	0	0

FIELD DESCRIPTIONS ON NEXT PAGE

Figure 5O – RAPS Cumulative Plan Activity Report Layout (continued)

Field No.	Field Name	Field Description
1	Report Name	Name of the report as it appears in submitter's mailbox.
2	Page Number	Page number of the report. Six months arrayed per page.
3	Report Run Date	Date CMS generated the report.
4	Report Full Name	Full name of the report.
5	Service Year	The year of the service through date.
6	Submitter ID	Report is grouped by submitter identification number. A submitter may submit for more than one MA organization (H-number).
7	Report Year and Date	Month and year of the submission.
8	Plan Number	H-number assigned by CMS; a different report is printed for each organization (H-number).
9	Month	The month of the service through date.
10	Total Submitted	The total number of clusters submitted during the report period.
11	Total Rejected	The total number of clusters submitted during the report period that were rejected due to errors.
12	Total Accepted	The total number of clusters submitted during the report period that were accepted without errors.
13	Total Stored	The total number of required diagnosis clusters submitted, accepted, and stored and were not duplicates.
14	Total Model Stored	The total number of ***required,*** diagnosis clusters submitted, accepted stored and included in the current risk adjustment model during the report period.
15	Total Deletes Accepted	The total number of deleted clusters submitted during the report period that were accepted without errors.
16	Total Deletes Rejected	The total number of deleted clusters submitted during the report period that were rejected with errors.

A service year of 9999 on a Monthly or Cumulative Plan Activity Report indicates that the data submitted have not been appropriately stored and have been rejected. The RAPS Return File will list error codes 402 (invalid service through date on CCC record) and 403 (service through date must be greater than December 31, 2002). With each of these error codes, the system cannot recognize and properly file the rejected data since the dates of service are either outside of the reporting period or unrecognizable. Data that cannot be associated with one of the years on the Monthly and Cumulative Plan Activity Reports must be filed in the service year of 9999.

Example: 14

Using the RAPS Cumulative Plan Activity Report, the MA organization can effectively monitor the quantity of data submitted for each provider type. The submission numbers are higher for previous months than the more current dates of service months, which indicate a lag between the dates of service provided, collected, and submitted. Comparing Figure 8K to the Cumulative Plan Activity Report (Figure 8M) illustrates April transactions accounted for very few of the January, February, and March numbers indicating collection and submission problems in the month of April. This can be explained by new staff, competing internal priorities, or system implications. Management should consider the root cause of this decline to prevent this in the future.

The third page of this report indicates diagnosis clusters submitted where the service dates could not be identified. These are reported on the service year 9999.

Figure 5P – RAPS Cumulative Plan Activity Report

RAPS0020 CMS RAPS ADMINISTRATION PAGE: 2
RUN REPORT: DATE: 20040503 RAPS CUMULATIVE PLAN ACTIVITY REPORT SERVICE YEAR: 2003

SUBMITTER ID: SH7777 FOR PERIOD ENDING APRIL 30, 2004
PLAN NO: H7777

PROVIDER TYPE/TOTALS	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	TOTAL
PRINCIPAL INPATIENT							
TOTAL SUBMITTED	62747	53673	5389	4096	5162	8517	139584
TOTAL REJECTED	627	278	108	82	103	170	1368
TOTAL ACCEPTED	62120	53395	5281	4014	5059	8347	138216
TOTAL STORED	62120	53395	5281	4014	5059	8347	138216
TOTAL MODEL STORED	51560	44316	1796	1365	1720	2838	103595
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OTHER INPATIENT							
TOTAL SUBMITTED	208372	143816	57058	43852	40989	62833	556920
TOTAL REJECTED	2084	719	1141	877	820	1257	6898
TOTAL ACCEPTED	206288	143097	55917	42975	40169	61576	550022
TOTAL STORED	206288	143097	55917	42975	40169	61576	550022
TOTAL MODEL STORED	171219	117340	17893	13752	12854	19704	352762
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OUTPATIENT							
TOTAL SUBMITTED	182512	178628	34860	64142	71635	143270	675047
TOTAL REJECTED	183	89	523	962	1075	2149	4981
TOTAL ACCEPTED	182329	178539	34337	63180	70560	141121	670066
TOTAL STORED	182329	178539	34337	63180	70560	141121	670066
TOTAL MODEL STORED	151333	146402	11675	21481	23990	47981	402862
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
PHYSICIAN							
TOTAL SUBMITTED	516903	303829	539136	521062	643485	389984	2914399
TOTAL REJECTED	5169	3038	10783	10421	12870	7799	50080
TOTAL ACCEPTED	511734	300791	528353	510641	630615	382185	2864319
TOTAL STORED	511734	300791	528353	510641	630615	382185	2864319
TOTAL MODEL STORED	424739	249657	184924	178724	220715	133765	1392524
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0

Figure 5P – RAPS Cumulative Plan Activity Report (continued)

REPORT: RAPS0020 CMS RAPS ADMINISTRATION PAGE: 1
RUN DATE: 20040503 RAPS CUMULATIVE PLAN ACTIVITY REPORT SERVICE YEAR: 2004

SUBMITTER ID: SH7777 FOR PERIOD ENDING APRIL 30, 2004
PLAN NO: H7777

PROVIDER TYPE/TOTALS	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	TOTAL
PRINCIPAL INPATIENT							
TOTAL SUBMITTED	3891	3905	879	91	0	0	8766
TOTAL REJECTED	77	78	2	2	0	0	159
TOTAL ACCEPTED	3784	3825	863	89	0	0	8561
TOTAL STORED	3704	3808	849	80	0	0	8441
TOTAL MODEL STORED	1296	1333	297	26	0	0	2952
TOTAL DELE ACPTD	30	2	14	0	0	0	46
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OTHER INPATIEN							
TOTAL SUBMITTED	25292	40467	1234	348	0	0	67341
TOTAL REJECTED	506	809	9	10	0	0	1334
TOTAL ACCEPTED	24786	39658	1216	338	0	0	65998
TOTAL STORED	24784	39648	1211	333	0	0	65976
TOTAL MODEL STORED	8674	13876	423	117	0	0	23090
TOTAL DELE ACPTD	0	0	2	0	0	0	2
TOTAL DELE RJCTD	0	0	7	0	0	0	7
OUTPATIENT							
TOTAL SUBMITTED	70246	52027	252	0	0	0	122525
TOTAL REJECTED	1053	780	8	0	0	0	1841
TOTAL ACCEPTED	69193	51242	244	0	0	0	120679
TOTAL STORED	62966	45598	231	0	0	0	108795
TOTAL MODEL STORED	22038	15959	80	0	0	0	38077
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	5	0	0	0	0	5
PHYSICIAN							
TOTAL SUBMITTED	333621	567512	0	0	0	0	901133
TOTAL REJECTED	6672	11350	0	0	0	0	18022
TOTAL ACCEPTED	326949	556162	0	0	0	0	883111
TOTAL STORED	326934	494984	0	0	0	0	821918
TOTAL MODEL STORED	114426	173244	0	0	0	0	287670
TOTAL DELE ACPTD	2	0	0	0	0	0	2
TOTAL DELE RJCTD	0	0	0	0	0	0	0

Figure 5P – RAPS Cumulative Plan Activity Report (continued)

REPORT: RAPS0020 CMS RAPS ADMINISTRATION PAGE: 1
RUN DATE: 20040503 RAPS CUMULATIVE PLAN ACTIVITY REPORT SERVICE YEAR: 9999

SUBMITTER ID: SH7777 FOR PERIOD ENDING APRIL 30, 2004
PLAN NO: H7777

PROVIDER TYPE/TOTALS	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	TOTAL
PRINCIPAL INPATIENT							
TOTAL SUBMITTED	25	0	0	0	0	0	25
TOTAL REJECTED	25	0	0	0	0	0	25
TOTAL ACCEPTED	0	0	0	0	0	0	0
TOTAL STORED	0	0	0	0	0	0	0
TOTAL MODEL STORED	0	0	0	0	0	0	0
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OTHER INPATIENT							
TOTAL SUBMITTED	0	0	0	0	0	0	0
TOTAL REJECTED	0	0	0	0	0	0	0
TOTAL ACCEPTED	0	0	0	0	0	0	0
TOTAL STORED	0	0	0	0	0	0	0
TOTAL MODEL STORED	0	0	0	0	0	0	0
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OUTPATIENT							
TOTAL SUBMITTED	0	0	0	0	0	0	0
TOTAL REJECTED	0	0	0	0	0	0	0
TOTAL ACCEPTED	0	0	0	0	0	0	0
TOTAL STORED	0	0	0	0	0	0	0
TOTAL MODEL STORED	0	0	0	0	0	0	0
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
PHYSICIAN							
TOTAL SUBMITTED	0	0	0	0	0	0	0
TOTAL REJECTED	0	0	0	0	0	0	0
TOTAL ACCEPTED	0	0	0	0	0	0	0
TOTAL STORED	0	0	0	0	0	0	0
TOTAL MODEL STORED	0	0	0	0	0	0	0
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0

5.5.3 Correcting Rejected Data

When MA organizations correct data that originally received errors in RAPS, the originally rejected data are still reflected on the cumulative totals for the appropriate month, and in the number of total rejections. After a diagnosis cluster is counted as stored, it remains part of the stored count on the RAPS Cumulative Plan Activity Report even if it is later deleted. When MA organizations delete a cluster, the number is included in the total stored as well as the total deleted.

Example: 15

The April RAPS Cumulative Plan Activity Report (Figure 5P) displays a high reject rate in the data submitted for dates of service July – September (page 2 of the report). The report shows the plan corrected the previously submitted errors and began submitting data more accurately. The April Cumulative Report reflects that the rate of rejection (Total Rejected) remained high for July – September, but decreased for October – December.

5.5.4 RAPS Error Frequency Reports

The two RAPS Error Frequency Reports, Monthly and Quarterly, provide a summary of the number of errors submitted during the reporting period. This includes files submitted in test and production arrayed by error code and provider type. The reports are generated by submitter ID and plan number (H number). These reports are an effective tool that MA organizations can use to analyze error codes and frequency and reconcile data submissions. In addition, the reports include the total number of CCC records, total diagnoses, and total accepted and rejected diagnosis clusters.

Both the Monthly and Quarterly RAPS Error Frequency Reports utilize the report layout illustrated in Figure 5Q, however the report names differ as follows:

- RAPS Monthly Error Frequency Report: RAPS04M
- RAPS Quarterly Error Frequency Report: RAPS04Q

The monthly report provides summary information for a month; the quarterly report provides summary information for a 3-month period.

The Monthly RAPS Error Frequency Report is delivered to users on the second business day of the month.

The Quarterly RAPS Error Frequency Report is delivered to users on the second business day of the month following each quarter's end date.

Figure 5Q - RAPS Monthly Error Frequency Report Layout

[1] REPORT: RAPS04M PALMETO GBA [2]PAGE: 1

[3]RUN TIME: 10.06.09 [4]RISK ADJUSTMENT PROCESSING ERROR FREQUENCY SUMMARY [5]RUN DATE:20050502

[6]SUBMITTER ID: SH9999 [7] FOR THE MONTH OF APRIL, 2005

[8] PLAN NO: H9999

[9TOTAL CCC RECORDS: 7,831[10] TOTAL DIAGNOSIS: 16,465 [11]TOTAL ACCEPTED: 14,517 [12]TOTAL REJECTED:1,948

[13] ERROR CODE	[14] <==PROVIDER TYPE XX==> <=UNKNOWN PROV TYPE=>	[15] <==PROVIDER TYPE 01==> <PRINCIPAL INPATIENT>	[16] <==PROVIDER TYPE 02==> <==OTHER INPATIENT==>	[17] <==PROVIDER TYPE 10==> <=====OUTPATIENT=====>	[18] <==PROVIDER TYPE 20==> <=====PHYSICIAN =====>
353	81	0	0	0	0
354	0	4	32	105	581
408	0	10	73	120	883
409	0	0	0	120	883
410	0	10	73	114	845
460	0	0	0	1	14
500	6	0	0	0	0
501	0	17	140	875	3,927
502	0	7	51	79	1,272

FIELD DESCRIPTIONS ON NEXT PAGE

Figure 5Q – RAPS Monthly Error Frequency Report Layout (continued)

Field No.	Field Name	Field Description
1	Report Name	Name of the report as it appears in the Submitter's mailbox.
2	Page Number	Page number of the report.
3	Run Time	Time report was generated.
4	Full Name	Full name of the report.
5	Report Run Date	Date CMS generated the report.
6	Submitter ID	Report is grouped by submitter identification number. A submitter may submit for more than one organization.
7	Month	The month of the service through date.
8	Plan Number	H-number assigned by CMS; a different report is printed for each organization (H-number).
9	Total CCC Records	Total number of detailed records submitted during the report period.
10	Total Diagnosis	Total number of diagnosis clusters submitted during the report period
11	Total Accepted	The total number of diagnosis clusters submitted during the report period and accepted without errors.
12	Total Rejected	The total number of diagnosis clusters submitted during the report period and rejected with errors.
13	Error Code	Message sent back by CMS indicating there is an error in the data submitted during the report period.
14	Provider Type – Unknown	Indicates the number of errors associated with an unknown provider type. The transactions did not include a valid provider type. Valid provider types are "01", "02", "10", and "20".
15	Provider Type – Principal Inpatient	Identifies the principal inpatient provider source and the quantity of each error code associated with principal inpatient during the report period.
16	Provider Type – Other Inpatient	Identifies the other inpatient provider source and the quantity of each error code associated with other inpatient during the report period.
17	Provider Type – Outpatient	Identifies the outpatient provider source and the quantity of each error code associated with outpatient during the report period.
18	Provider Type – Physician	Identifies the physician provider source and the quantity of each error code associated with physician during the report period.

Example: 16

The sample RAPS Monthly Error Frequency Report (Figure 5R) indicates that the error occurring most frequently was an informational error code (501). However, error code, 410 accounted for the most rejected clusters. There were also high counts of rejected clusters associated with error codes 408 and 409. These error codes are all related to beneficiary enrollment in a specific MA plan or any MA plan in Medicare. Management should investigate possible discrepancies between their internal enrollment systems and the common tables.

Figure 5R – RAPS Monthly Error Frequency Report

REPORT: RAPS004M PALMETO GBA]PAGE: 1
RUN TIME: 13.31.06 RISK ADJUSTMENT PROCESSING RUN DATE:20050219
ERROR FREQUENCY SUMMARY

SUBMITTER ID: SH9999 FOR THE MONTH OF APRIL, 2005
PLAN NO: H9999

TOTAL CCC RECORDS: 4,647 TOTAL DIAGNOSIS: 17,660 TOTAL ACCEPTED: 15,403 TOTAL REJECTED:2,257

ERROR CODE	<==PROVIDER TYPE XX==> <=UNKNOWN PROV TYPE=>	<==PROVIDER TYPE 01==> <PRINCIPAL INPATIENT>	<==PROVIDER TYPE 02==> <==OTHER INPATIENT==>	<==PROVIDER TYPE 10==> <=====OUTPATIENT=====>	<==PROVIDER TYPE 20==> <=====PHYSICIAN =====>
353	75	0	0	0	0
354	0	7	38	108	618
403	0	1	0	0	0
408	0	14	79	132	859
409	0	0	0	116	782
410	0	12	67	110	980
460	0	0	0	5	12
500	6	0	0	0	0
501	0	18	148	578	2,297
502	0	5	63	97	1,741

5.6 Analysis of Reports

When analyzing the monthly RAPS management reports, CMS urges MA organizations to consider the following questions:

- "Is my organization collecting enough data from physicians and providers?"
- "Is my organization collecting the correct data from physicians and providers?"
- "Are external issues affecting data collection?"
- "Are internal processes supporting data submissions?"

Each question is discussed below.

5.6.1 Collecting Sufficient Accurate Data

The Monthly Plan Activity Report is a good place to start the analysis. Because this report provides a summary of the status of data submitted for each month, it allows organizations to check, on a monthly basis, the number of diagnosis clusters submitted overall, the number of clusters submitted by data source (hospital inpatient, hospital outpatient, and physician), and the status of those clusters.

Reading the report from left to right, the report identifies the number of clusters submitted in the reporting month (April 2004 in Figure 5P) for every month in the data collection period.

Example: 17

Figure 5S on the next page illustrates a Cumulative Plan Activity Report for April 2004. It reports the number of diagnoses submitted from July 2003 through March 2004. Analysis of this report might begin with a review of the number of clusters submitted by provider (source) type. This plan is doing well because it is submitting the vast majority of its hospital inpatient data for service through dates within 90 days of the report date. If the organization is submitting data at about the same pace received, then the number of clusters seems appropriate, at least for hospital inpatient.

CMS recommends MA organizations collect data from providers and physicians within 90 days of the service through date. Consistent collection lags of more than 90 days may cause problems in submitting data in a timely manner.

The average rate of rejected data is below one percent for MA organizations. The plan in this example has a rejection rate for hospital inpatient services at about nine percent during April. If the other provider type information reflects a similar rate of rejected data, it is higher than it should be and a cause for investigation.

Figure 5S – Analysis of Cumulative Plan Activity Report

REPORT: RAPS0010 CMS RAPS ADMINISTRATION PAGE: 1
RUN DATE: 20040501 RAPS CUMULATIVE PLAN ACTIVITY REPORT SERVICE YEAR: 2003

SUBMITTER ID: SH8888 FOR THE MONTH OF APRIL, 2004
PLAN NO: H8888

PROVIDER TYPE/TOTALS	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	TOTAL
PRINCIPAL INPATIENT							
TOTAL SUBMITTED	12	30	21	43	58	101	265
TOTAL REJECTED	5	3	4	5	2	8	27
TOTAL ACCEPTED	7	27	17	38	56	93	238

REPORT: RAPS0010 CMS RAPS ADMINISTRATION PAGE: 2
RUN DATE: 20040501 RAPS CUMULATIVE PLAN ACTIVITY REPORT SERVICE YEAR: 2004

Data collection "lag" is 90 days.

SUBMITTER ID: SH8 FOR THE MONTH OF APRIL, 2004
PLAN NO: H8

High rate of rejected data.

PROVIDER TYPE/TOTALS	JANUARY	FEBUARY	MARCH	APRIL	MAY	JUNE	AL
PRINCIPAL INPATIENT							
TOTAL SUBMITTED	1940	1944	643	50	0	0	4577
TOTAL REJECTED	158	203	54	5	0	0	415
TOTAL ACCEPTED	1782	1741	589	45	0	0	4157

On the Cumulative Report, MA organizations should review the data across the collection period, ensuring that the number of data for each month is consistent. Low submission months or significant spikes in the data submitted for a month may indicate a problem in either data collection from providers and physicians, or issues related to data submission. Generally, each quarter of data should reflect about 25 percent of the expected data for the collection period.

5.6.2 External Issues Affecting Data Collection

When reviewing the management reports, MA organizations should consider external issues that affect data collection. The Cumulative Report is a good place to start analysis because it gauges the number of data collected and submitted over the course of the collection year. For an organization just starting operations, a steady increase in data submissions from month to month is expected. However, an MA organization that has a relatively stable population should have consistent numbers from month to month. Significant fluctuations from month to month may be cause for investigation.

The risk adjustment rules require that for each quarter MA organizations submit approximately 25 percent of the total expected data for the year for each provider type (source). Meeting or exceeding this standard (e.g., submitting monthly or weekly) helps organizations avoid "playing catch up" at the end of the collection year and helps ensure accurate risk adjustment calculation. If data are not submitted in a timely and consistent manner, there may be a data collection issue. Provider education may be necessary to remedy the problem. Also, it may be necessary to check that third party billers used by providers (especially large volume providers) are current on risk adjustment procedures and the importance of timely filing.

5.6.3 Internal Processes Supporting Data Submissions

The RAPS management reports can help MA organizations identify internal processes negatively affecting data collection and submission. Organizations should check to make certain that data, as it is collected, is properly translated for submission.

MA organizations should take steps to ensure they have, or have access to, the proper medical documentation to support diagnoses being submitted for risk adjustment. MA organizations are responsible for the accuracy of the data submitted to CMS. When necessary, they should obtain the proper documentation to support diagnoses and maintain an efficient system for tracking diagnoses back to medical records.

Example: 18

If the appropriate amount of data are collected from providers and physicians for a month or quarter, but only a fraction of the data are submitted, there may be an over filtering issue, i.e., the plan may not be submitting all required data. Also, the plan should check for higher than normal rejection rates, possibly indicating a problem with the data submission system (bad formatting, assigning the wrong HIC, etc.).

If an organization is submitting well above the benchmark levels, it should check to see if proper filtering occurred before submission. Many plans collect data from provider types not covered by the risk adjustment instructions. Submitting data from these non-covered provider types violates the instructions and will probably cause the diagnostic-to-beneficiary ratios to be high.

5.7 Report Naming Conventions

Table 5N provides the naming conventions for reports placed in the submitter's mailbox.

TABLE 5N – REPORT NAMING CONVENTIONS

REPORT NAME	MAILBOX IDENTIFICATION
FERAS Response Report	RSP#9999.RSP.FERAS_RESP_ RSP#9999.ZIP.FERAS RESP (zip format)
RAPS Return File	RPT#9999.RPT.RAPS_RETURN_FLAT_ RPT#9999.ZIP.RAPS ERROR RPT (zip format)
RAPS Transaction Error Report	RPT#9999.RPT.RAPS_ERROR_RPT_ RPT#9999.ZIP.RAPS ERROR RPT (zip format)
RAPS Transaction Summary Report	RPT#9999.RPT.RAPS_SUMMARY_ RPT#9999.ZIP.RAPS SUMMARY (zip format)
RAPS Duplicate Diagnosis Cluster Report	RPT#9999.RPT.RAPS_DUPDX_RPT_ RPT#9999.ZIP.RAPS DUPDX RPT (zip format)
RAPS Monthly Plan Activity Report	RPT#9999.RPT.RAPS_MONTHLY_ RPT#9999.ZIP.RAPS MONTHLY (zip format)
RAPS Cumulative Plan Activity Report	RPT#9999.RPT.RAPS_CUMULATIVE_ RPT#9999.ZIP.RAPS CUMULATIVE (zip format)
RAPS Monthly Error Frequency Report	RPT#9999.RAPS_ERRFREQ_MNTH_ RPT#9999.ZIP.RAPS ERRFREQ MNTH (zip format)
RAPS Quarterly Error Frequency Report	RPT#9999.RAPS_ERRFREQ_QTR_ RPT#9999.ZIP.RAPS ERRFREQ QTR (zip format)

5.8 Plan Monitoring Process

The Plan Monitoring Process allows CMS to monitor MA organization submission rates and ensure that they are submitted accurately and paid appropriately. The process is designed to assist MA organizations and to provide guidance to meet risk adjustment data collection and submission requirements. The process is administered as follows:

- CSSC contacts the identified MA organizations to address problems, discuss specific issues, offer technical assistance, and develop an action plan.

- The CMS Compliance Division may contact MA organizations that are not responsive to the risk adjustment team's assistance.

MODULE 6 – DIAGNOSIS CODES & RISK ADJUSTMENT

Purpose

It is neither the intention of this module nor the purpose of this training to provide diagnostic coding training. However, this module does provide Risk Adjustment organizations with an introduction to diagnosis coding and stresses the importance of accurate diagnosis documentation and coding for risk adjustment. The module first explains the structure and layout of the official Centers for Medicare & Medicaid Services (CMS) diagnosis coding set-- the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). The module also discusses the diagnosis coding guidelines that apply to the ICD-9-CM, and how following these guidelines ensures accurate risk adjustment payments. The module demonstrates how verification of compliance with coding guidelines depends upon accurate documentation in the medical record. Finally, the module provides information to assist MA organizations in communicating with their physicians regarding proper documentation and diagnosis coding.

Learning Objectives

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

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

ICON KEY

Example 

Reminder 

Resource 

6.1 Introduction

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

- Implement procedures to ensure that diagnoses are coming from physician, hospital inpatient, or hospital outpatient provider types.
- Submit all required ICD-9-CM diagnosis codes for each beneficiary.
- Submit required diagnoses at least once during the risk adjustment data reporting period.

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

Required diagnoses are defined as those diagnoses collected from one of the three provider types that are used in the Risk Adjustment models (i.e., CMS-HCC, ESRD, and RxHCC models), and those diagnoses required for payment simulation.

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

6.1.1 Benefit to the MA Organization and Physician

Benefits to the MA organization and physician are illustrated in Table 6A.

TABLE 6A – BENEFITS TO MA ORGANIZATIONS AND PHYSICIANS

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

6.2 Structure and Terminology of ICD-9-CM

ICD-9-CM diagnosis codes are 3- to 5-digit codes used to describe the clinical reason for a patient's treatment. They do not describe the service performed, just the patient's medical condition. For any

classification system to be reliable, the application of the codes must be consistent across users. Therefore, CMS, the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), and the National Center for Health Statistics (NCHS) together have developed official coding guidelines. These guidelines are available on: http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/icdguide07.pdf. The diagnosis portion of ICD-9-CM consists of two volumes: the Disease Tabular and the Disease Index.

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

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

6.2.1 Special Notes and Abbreviations

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

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

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

Not otherwise specified (NOS): Basically means “unspecified.” The documentation does not provide additional information to assign a more specific code in the particular category. In many (but not all) code categories, the fourth digit “9” signifies an unspecified code.

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

6.2.2 Supplemental Classifications and Tables

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

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

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

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

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

6.3 ICD-9-CM Updates

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

The ICD-9-CM diagnosis code listing is updated on October 1 and April 1 (beginning April 2005). The ICD-9-CM Coordination and Maintenance Committee holds a public forum for requested updates and publishes a transcript of their recommendations on the CMS website and in the *Federal Register*. Revisions discussed at the April and December meetings generally become effective in October the following year. A complete listing and description of annual updates are available in *Coding Clinic for ICD-9-CM* during the fourth quarter of each year. More information on the process for updating ICD-9 codes may be found at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/.

Note: The annual ICD-9-CM diagnosis codes update may result in updates to the list of diagnosis codes used in the Risk Adjustment models. CMS posts a list of new codes in the CMS-HCC model annually, prior to the codes taking effect on October 1.

The ICD-9-CM coding guidelines are not updated as frequently as the list of diagnosis codes. The most recent official guideline revision is published on the National Center for Health Statistics website (http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/icdguide07.pdf) and is effective October 2007.

6.3.1 Valid Diagnosis Codes Phase-in Schedule

Prior to 2009, CMS did not impose strict validity checks on diagnosis codes submitted for risk adjustment.

As described in Table 6B below, starting with 2008 payment, the list of acceptable ICD-9-CM codes for the CMS-HCC, ESRD, and RxHCC risk adjustment models for risk adjustment for any given payment year will comprise the list of published NCHS/CMS codes that are valid for the payment year.

TABLE 6B – RISK ADJUSTMENT PHASE-IN SCHEDULE FOR NEW LISTS OF DIAGNOSIS CODES

YEAR OF PAYMENT	DATE COLLECTION PERIOD	DESCRIPTION/SOURCE OF CODES
2007	1/06 – 12/06	The list of codes is published on our website at: http:\www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage, which lists acceptable codes by years.
2008	1/07 – 12/07	The list of codes is published on our website at: http:\www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage
2009	1/08 – 12/08	Valid diagnoses in Fiscal Years 2008, 2009
2010	1/09 – 12/09	Valid diagnoses in Fiscal Years 2009, 2010
2011	1/10 – 12/10	Valid diagnoses in Fiscal Years 2010, 2011

6.3.2 International Classification of Diseases 10th Revision, Clinical Modification (ICD-10-CM)

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

6.4 Coding Guidelines Impacting the CMS-HCC Model

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

6.4.1 Co-Existing and Related Conditions

The instructions for risk adjustment implementation refer to the official coding guidelines for ICD-9-CM, published at www.cdc.gov/nchs/icd9.htm and in the *Coding Clinic*. Physicians should code all documented conditions that co-exist at the time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history

codes (V10-V19 not in HCC model) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

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

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

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

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

Example: 1

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

6.4.1.1 Combination Codes

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

Example: 2

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

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

Example: 3

Some diabetes codes carry "Code also" instructions that impact directly on the Risk Adjustment models.

- If a patient has diabetic retinopathy (250.50, HCC 18), the tabular section requires a code for also the manifestation (if known). The ICD-9-CM offers several different manifestations, such as blindness (369.00-369.9, not in the CMS-HCC model) or proliferative diabetic retinopathy (362.02, HCC 119). Here, coding the correct manifestation is essential to correct HCC assignment.

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

6.4.2 Unconfirmed Diagnoses

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

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

Example: 4

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

6.4.3 Clinical Specificity in Documentation

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

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

Example: 5

Anemia (285.9) is the most commonly coded form of anemia in physician offices. However, there are many types of anemia. Some are in the models and some are not. If the term “neutropenia” is used to describe the anemia, it must be coded to the more specific diagnosis code 288.0 (agranulocytosis), which groups to HCC 45. “Refractory” anemia is coded 238.7 (HCC 44). It is important that physicians code these types of anemia accurately.

Example: 6

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

Example: 7

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

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

Example: 8

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

Example: 9

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

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

Example: 10

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

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

Complete Neoplasm guidelines are included in the Resource Guide.

6.4.3.1 History and Physical (H&P), and Lab and Pathology Reports – Guidance

Some organizations have inquired about the use of the History and Physical (H&P), and Lab and Pathology Reports for data submission and medical record review. If an organization decides to use either as a source for justify ICD-9-CM code submission and/or subsequent medical record review, the

following guidance must be taken into account when considering the appropriate ICD-9-CM coding guidelines to be used.

Inpatient Documentation – History and Physical (H&P) Guidance

CMS recommends submitting diagnoses and medical records documentation based on a complete inpatient medical record for a hospital inpatient stay. If an organization chooses to use H&P as stand-alone documentation for submitting ICD-9 codes or medical record documentation for validation, the following guidance applies:

- **H&P as part of the inpatient full medical record**
  - Will **not** contain reportable final/confirmed diagnoses
  - Typically contains
    - Admission symptoms and co-existing conditions as well as
    - Admission/working diagnoses, which may or may not be one of the final diagnoses for the inpatient admission

  Note that upon medical record review, discharge/final diagnoses– not the H&P alone –will be reviewed in accordance with the Inpatient ICD-9 coding guidelines

- H&P representing an independent physician visit from an inpatient stay
  If a physician submits a separate claim/encounter to the organization based on his/her evaluation of the patient as reflected on the H&P
  - H&P (face-to-face encounter) is viewed as a physician visit
  - Reportable diagnoses documented in the H&P
    - Could be used as final
    - Could be used for risk adjustment; HOWEVER,
    - The medical record documentation will be reviewed in accordance with the Outpatient ICD-9 coding guidelines

- H&P Conclusion
  The following applies for both data submission and data validation requirements
  - Risk Adjustment is based on final/confirmed diagnoses.
  - Risk adjustment diagnoses should only be submitted based on the H&P alone when there is an independent physician claim associated with the diagnosis.
  - Upon validation, if an organization submits an H&P as stand-alone documentation, the Outpatient guidelines will be applied to determine if there is a confirmed diagnosis.

Lab and Pathology Reports

The following guidance must be taken into account when considering data or medical record submission from lab and pathology sources.

- Official Guidelines for Coding and Reporting (Section III, B. Abnormal Findings)
- "Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the physician indicated their clinical significance."
- Coders should not arbitrarily assign a final ICD-9 code based solely on an abnormal finding
- Written interpretation (alone) of a tissue biopsy is not equivalent to the attending/referring physician's complete clinical assessment used to assign a diagnosis.
- If submitting risk adjustment data or medical records based on pathology, note the following:
  - Outpatient pathology facilities are unacceptable risk adjustment provider sources

- Physician pathology (i.e., specialty code 22) is acceptable for risk adjustment. When submitting risk adjustment diagnoses or medical records based on physician specialty code 22 refer to the guidance stated in this section.

AND

- Medical records submitted as stand-alone documentation from these sources will be reviewed in accordance with the Outpatient guidelines and will likely result in a risk adjustment discrepancy since these source do not typically render confirmed diagnoses.

6.4.4 Coding to the Highest Specificity-Fourth and Fifth Digits

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

Example: 11

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

Example: 12

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

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

6.4.5 V Codes

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

6.4.6 E Codes

The HCC models include codes E950-E959 describing suicide or self inflicted injuries (HCC 55, Major Depressive Disorders). Therefore, it is important that the physician documents and codes the appropriate external cause of all self-inflicted injuries and poisonings so the MA organization can report them as diagnoses appropriately.

6.5 Supporting Documentation Summary

Accurate coding begins with complete documentation. Characteristics of effective documentation include quality documentation as a team effort that may require some intervention by the MA organization. Table 6C lists documentation considerations.

TABLE 6C – DOCUMENTATION CONSIDERATIONS

Documentation Guidelines
• Reported diagnoses must be supported with medical record documentation. • Medical records and codes are subject to CMS validation. • Characteristics of acceptable documentation include: – Clear. – Concise. – Consistent. – Complete. – Legible.
Physician Documentation and Communication Tips
• Document and report co-existing diagnoses. • Communicate issues regarding inadequate documentation. • Adhere to proper methods for appending (late entries) or correcting inaccurate data entries. – Lab/Radiology results. – Strike through, initial, and date. Do not obliterate. • Use only standard abbreviations. • Identify patient and date on each page of the record.
SOAP Notes
• SOAP note format assists both the physician and record reviewer/coder in identifying key documentation elements. SOAP stands for: – **S**ubjective: How the patients describe their problem or illness. – **O**bjective: Data obtained from examinations, lab results, vital signs, etc. – **A**ssessment: Listing of the patient's current condition and status of all chronic conditions. How the objective data relate to the patient's acute problem. – **P**lan: Next steps in diagnosing problem further, prescriptions, consultation referrals, patient education, and recommended time to return for followup.

6.6 Provider and Staff Training

Remaining current on medical record documentation and coding guidelines is important to ensure accurate risk adjustment payment. Table 6D provides examples of resources available for medical record documentation and coding guidelines.

TABLE 6D – DOCUMENATION AND CODING RESOURCES

TRAINING SOURCES	DESCRIPTION
Official Coding Guidelines on CDC Website Available at www.cdc.gov/nchs/icd9.htm	The Official ICD-9-CM Coding Guidelines are available as an Adobe .pdf file, or as a CD-ROM. The CDC site has the .pdf file for download, as well as information to order the CD-ROM from the Government Printing Office.
Coding Clinic for ICD-9-CM Available through AHA.	Published quarterly by the AHA. It is the official publication for ICD-9-CM coding guidelines and advice as designated by the AHA, AHIMA, CMS, and the NCHS.
American Health Information Management Association (AHIMA) www.ahima.org	AHIMA is a professional association for health information management professionals. Members make information accessible to healthcare providers and work in the healthcare industry and in the public sector by managing, analyzing, and using data that are critical to patient care. The AHIMA Catalog online offers tools for coders such as audio seminars, books, and continuing education courses.
American Academy of Professional Coders (AAPC) www.aapc.com	AAPC provides education and certification for professional medical coders. Certifications focus on physician practice (CPC) and hospital outpatient facility (CPC-H) coding. Students learn Current Procedural Terminology (CPT) Codes, diagnosis codes (ICD-9-CM), and Healthcare Common Procedure Coding System (HCPCS) while focusing on HIPAA, Office of Inspector General (OIG), and Medicare compliance.
American Medical Association (AMA) www.ama-assn.org	AMA is an advocate of physician and patient rights. Coders may access the AMA Press Online Catalog to find current resources on medical record documentation and the medical record review process.
American Hospital Association (AHA) www.aha.org	AHA is a national organization that serves and represents hospitals, healthcare networks, and their patients. The AHA Online Store offers coders online reference materials including ICD-9-CM, HCPCS, and testing and certification for HIPAA.
Local Colleges Check local community and 4-year colleges for courses.	These provide online courses in clinical coding and guidelines.

MODULE 7 – RISK ADJUSTMENT DATA VALIDATION (MEDICAL RECORD REVIEW)

Presentation Purpose (Slide 2)

To provide participants with an understanding of:
- The risk adjustment data validation (RADV) process AND
- CMS' approaches for:
  - Identifying risk adjustment discrepancies,
  - Estimating payment error, and
  - Conducting contract-level payment adjustments

Presentation Objectives (Slide 3)

Define
- Purpose and objectives of risk adjustment data validation (RADV)
- New RADV policies and parameters
- RADV stages and requirements
- Documentation Dispute
- Payment adjustment implementation approach
- Appeals

ICON KEY

Example 

Reminder 

Resource 

7.1 Risk Adjustment Data Validation (RADV)

7.1.1 RADV – Purpose, Method, and Objectives (Slide 4)

Risk adjustment data validation (RADV) occurs after the final risk adjustment data submission deadline for the MA contract payment year. The purpose of RADV is to ensure risk adjusted payment integrity and accuracy. CMS reviews medical records from hospital (inpatient and outpatient) and physician providers to validate enrollee CMS-HCCs that were assigned based on risk adjustment diagnoses submitted by MA organizations for payment. As a basic risk adjustment rule, all risk adjustment diagnosis codes submitted by MA organizations must be supported by medical record documentation.

The primary objectives of RADV are to:
- Verify enrollee CMS-HCCs used for payment
- Identify risk adjustment discrepancies
- Calculate enrollee-level payment error
- Estimate national and contract-level payment errors
- Implement contract-level payment adjustments

7.1.2 RADV - New Approaches (Slide 5)

In its *Announcement of Calendar Year (CY) 2009 Medicare Advantage (MA) Capitation Rates and Medicare Advantage and Part D Payment Policies* (available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/AD/list.asp#TopOfPage), CMS informed Part C sponsors of its decision to establish payment adjustment policies based on RADV findings beginning with CY 2007 payments.

The following new approaches will be incorporated into the RADV activities beginning with CY 2007 payments:

- CMS will make contract-level payment adjustments based on statistical findings from enrollee samples. This is a change from previous years when, although statistically valid samples were selected, CMS adjusted payments only for those sampled enrollees whose risk scores were not supported by medical record review
- Medical records will not be accepted after CMS' official deadline
- A Documentation Dispute process will be available for organizations to dispute enrollee-level HCC findings
- New documentation for missing medical records will not be allowed during the Documentation Dispute process
- An Appeals process will be facilitated by the CMS Office of Hearings and will occur after the Documentation Dispute process

7.1.3 RADV – 2007 Parameters (Slide 6)

The 2007 RADV project parameters will be based on the following:

- Eligible contracts will include all MA Contracts, PACE, and dual demonstration organizations that were active in January 2007 (all of which received risk adjustment payments for 2007). CMS may exclude contracts (from these groups) that terminated prior to the start of the 2007 RADV process.
- Within each eligible contract a statistical enrollee sample will be selected from all eligible enrollees – defined as enrollees with at least one HCC. Eligible enrollees are identified as either "continuously enrolled" or "non-continuously enrolled". Continuously enrolled beneficiaries are those who were in the same eligible contract from January 2006 through January 2007. Non-continuously enrolled beneficiaries are those who switched between contracts and/or MA and Medicare fee-for-service (FFS) between January 2006 and January 2007. Note the non-continuously enrolled beneficiaries will not be included in the contract-level payment error estimate that will be used for contract-level payment adjustments.
- Data collection period will include dates of service that occurred from January 2006 through December 2006 for the eligible enrollee population.

7.1.4 RADV – Core Concept (Slide 7)

The guidelines for risk adjustment data validation reflect the purpose and objectives described above. Beginning with CY2007 payments, the RADV functions will expand to include contract-level payment adjustments.

RADV Core Concept – Enrollee HCCs are assigned based on risk adjustment diagnoses that were present on FFS claims, or submitted by MA organizations via RAPS. The CMS-HCCs contribute to payment increases for enrollees. As a principal risk adjustment rule, risk adjustment diagnoses submitted for enrollees must be supported by medical record documentation and based on a face-to-face encounter. CMS uses RADV activities to confirm the presence of risk adjustment conditions (i.e., diagnoses that map to HCCs) for enrollees. Therefore, all CMS-HCCs for sampled enrollees will be reviewed and for these HCCs, CMS will review medical record records and abstract ICD-9-CM codes to confirm HCCs that contributed to enrollee payments.

7.1.5 RADV – Guiding Principle (Slide 8)

The risk adjustment guiding principle states that all diagnoses submitted for payment (i.e., used for HCCs) must be:

- Documented in a medical record that was based on a face-to-face health service encounter between a patient and a healthcare provider
- Coded in accordance with the *ICD-9-CM Guidelines for Coding and Reporting*
- Assigned based on dates of service within the data collection period AND
- From an acceptable RA provider type and RA physician specialty

This guiding principle is what's used as the key guideline for medical records review.

7.1.6 Risk Adjustment Discrepancy (Slides 9)

The primary focus of medical record review is on the HCC because any change to an enrollee's HCC profile will impact payment at the enrollee-level. For medical record review, ICD-9 codes abstracted from the medical record are mapped to HCCs. The HCCs based on medical record review are then compared to the HCCs based on submitted risk adjustment data.

Risk adjustment discrepancies are identified when the HCC(s) assigned based on risk adjustment data submitted by the MA organization differs from the HCC(s) assigned after validation. Risk adjustment discrepancies affect the beneficiary risk score because of the change in the HCC(s).

7.1.7 Medical Record Review Overview (Slide 10)

The RADV process involves coordination between multiple entities such as CMS, MA organizations, and CMS contractors. CMS will use a number of contractors to support the RADV efforts. These contractors will have defined roles for the RADV project, and will collaborate, and work in cooperation with CMS to achieve the overall project goals.

The Core Project Contractors include:

- A Lead Analytic Contractor (LAC) to coordinate the overall analytic approach and process for the RADV activities. This will involve facilitating all project mechanisms to accomplish sampling, analysis reporting, estimating national and contract-level payment errors, policy and process decision tracking, and overall tracking and management of the RADV project data.

- Medical Record Review Contractors (MRRCs) to conduct the initial and second independent reviews to confirm risk adjustment discrepancies. Both MRRC processes include inter-rater reliability (IRR) reviews to ensure coding consistency and accuracy. The MRRCs use certified coders to abstract diagnosis codes and validate provider type, physician specialty, and date(s) of service.

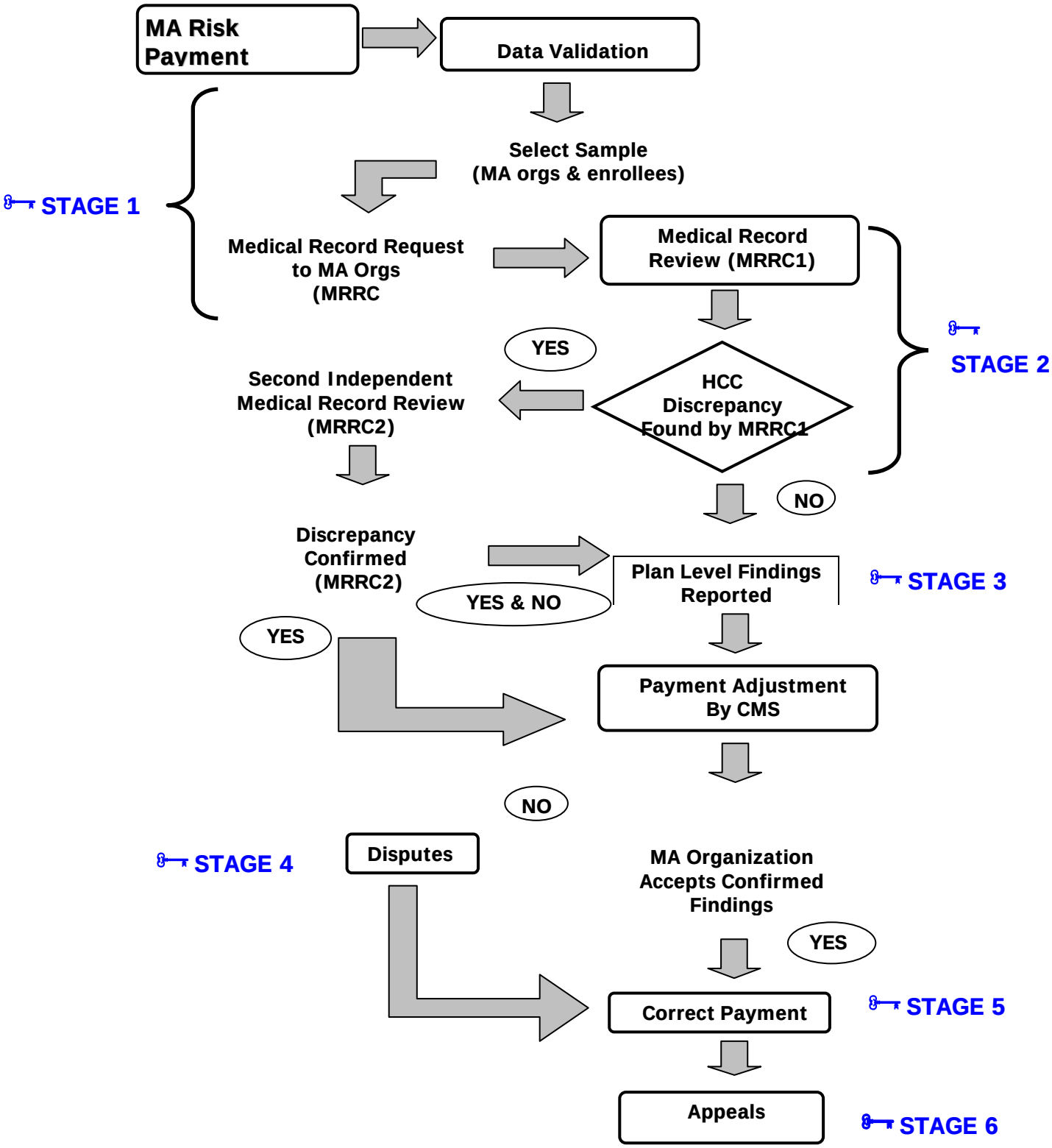
The MRRCs will serve as CMS' primary entity responsible for communicating with the MA organizations throughout the RADV process, and limited communication will take place between the LAC and the MA contracts. The MRRC will facilitate the medical record requests, reviews, and Documentation Disputes processes (Stages 1, 2, and 4), while the LAC will facilitate the sampling and payment analysis for payment adjustments (Stages 3, and 5). Note that the LAC and the MRRCs will have shared functions for the MRR findings under Stage 3. CMS also uses other support contractors throughout the RADV process for purposes of reviewing statistical, analytic, and technical data approaches.

7.1.8 RADV- Process (Slide 11)

The core RADV process begins with MA organizations and enrollee selection, and ends with a second round of payment adjustments after MA organization submission of HCC-level disputes for sampled enrollees. After the core process, an Appeals stage will be implemented by the CMS Office of Hearings. Figure 7A illustrates the overall data validation process. The RADV process stages are as follows and described in detail in this module:

- **STAGE 1 Sampling and Medical Record Request**
- **STAGE 2 Medical Record Review (MRR)**
- **STAGE 3 MRR Findings and Contract-level Payment Adjustments**
- **STAGE 4 Documentation Dispute**
- **STAGE 5 Post Documentation Dispute Payment Adjustments**
- **STAGE 6 Appeals**

Figure 7A – Data Validation Process



7.2 RADV Stages

7.2.1 Sampling Selection and Medical Record Request -- STAGE 1 (Slides 12-19)

7.2.1.1 Sampling

Organizations and enrollees will be sampled for national and contract-specific payment error estimates. The **national** enrollee sample will be used to estimate national annual payment error. For 2007, CMS will select the national sample from the eligible January 2007 contracts (based on the RADV parameters). The sample will consist of continuously and non-continuously enrolled beneficiaries with at least one CMS-HCC.

Contract-specific enrollee samples will be used to estimate annual payment error at the contract level. CMS will target or randomly select contracts. The group of targeted contracts will be chosen from among MA contracts included in the MA Coding Intensity Study, which was conducted to analyze differences in risk score changes (and risk score disease component changes) over time between MA and FFS. The group of randomly selected contracts will be chosen from all active eligible contracts. Contracts selected via the targeting criteria will not be eligible for random selection. Statistical enrollee samples will be selected from among the continuously-enrolled populations within each targeted and randomly selected contract.

All active contracts will be eligible for contributing enrollees to the national sample. CMS is considering a stratified random enrollee sampling approach for the national and contract-specific samples. Note that some organizations may be requested to contribute medical records for only the national sample.

7.2.1.2 Medical Record Request

Upon completion of the sampling, the MRRCs will request medical records from the selected organizations. The Medical Record Request is defined by three distinct segments: 1) medical record request; 2) medical record submission (contract response); and 3) medical record receipt.

1. The medical record request includes the initial notification of RADV selection, the enrollee list, and the official medical record request instructions.
2. Medical record submission refers to the MA organization's response to the medical record request and addresses medical record obtainment and submission requirements.
3. Medical record receipt refers to the process used by the MRRC for receiving, logging and tracking of medical records.

Medical Record Request - Initial Contact Letter

The MRRC will send a CMS Notification Letter to the Medicare Compliance Officer (MCO) for each MA organization selected for validation. The purpose of the initial contact letter is to: 1) inform the MCO that its contract was selected for data validation; and 2) request primary and secondary points of contact (either the compliance officer or a designee) to be responsible for facilitating the medical record request process for the organization. The Compliance Officer is given approximately 5-days to respond to the initial request.

Medical Record Request - Enrollee List

A list of enrollees selected from each organization will be sent to the confirmed primary and secondary contact persons for the MA organization. The list will be provided to MA organizations either in advance of or in conjunction with the medical record request instructions package. The purpose of the list is to provide organizations the opportunity to easily identify the selected enrollees in their systems, and start establishing contact with the specific provider(s) of services for those enrollees. CMS does not require or store provider identification numbers as part of risk adjustment data. Therefore, the MA organization must use its data systems that can:

- Track and locate dates of service.
- Link a specific diagnosis to a specific provider.

The enrollee list is provided in an electronic spreadsheet format, which displays:

- Organization's name,
- Enrollee ID,
- Current Contract ID (H-number), and
- Previous Contract ID (H-number)—this information is furnished if the contract ID used during the data collection period differs from the current contract ID.

For each selected enrollee the following information is included in the beneficiary list:

- Coversheet ID number (A masked ID tracking number that can be found on the bottom left of each HCC coversheet)
- Enrollee Last Name
- Enrollee First Name
- Enrollee Date of Birth
- Enrollee HIC Number
- Validation HCC
- ICD-9-CM code(s) related to the validation HCC

ABOUT YOUR LISTED ENROLLEES

The enrollee list will contain a line for each enrollee's unique HCC. This means that if an enrollee has multiple different HCCs, each line for the enrollee will comprise a unique HCC and all associated risk adjustment diagnoses that were stored for that HCC. Therefore, a complete enrollee HCC profile could comprise multiple lines on the beneficiary list. Table 7A displays an example request sample beneficiary list. The information shown on the line with each beneficiary HCC reflects all ICD-9 codes stored that HCC. Each enrollee will have at least one HCC and one corresponding risk adjustment ICD-9 code(s) stored for that HCC.

The listed enrollees are those who spent at least one month in your contract during the data collection period.

- If your organization is selected for one of the contract-specific samples, your list will contain all enrollees with continuous enrollment status (i.e., continuously enrolled) who were selected for your contract-level estimate.

- If your organization has enrollees selected from the national sample, your list may include enrollees with continuous enrollment status and/or enrollees with non-continuous enrollment status (i.e. non-continuously enrolled).

Enrollees with non-continuous enrollment status are those who were either 1) enrolled in your contract in January 2007, but were not enrolled (in your contract) for all twelve (12) months during the data collection period, or 2) not enrolled in your contract in January 2007, but were enrolled (in your contract) for at least one month during the data collection period.

The Enrollee List will include the complete HCC and stored risk adjustment diagnosis profile for all selected enrollees. For enrollees with non-continuous enrollment status, the organization must identify, via its internal systems, whether it submitted risk adjustment diagnoses (during the data collection period) for any of the HCCs listed for these enrollees. If the organization submitted diagnoses data for at least one of the HCCs, the organization must identify providers (and date(s) of service) from which the data were collected, and request a medical record for the HCC(s).

If the organization did not submit any risk adjustment data for a non-continuously enrolled enrollee the organization must immediately notify the MRRC of this finding.

Example 1

For beneficiary Joe K. Smith - HCCs 38, 80 and 16 will be validated. For HCC 38, the MA organization may rely on one of the five ICD-9 codes associated with that HCC to identify the date of service, provider, and **"one best medical record"** for review. The organization could also opt to identify a provider that rendered a diagnosis that is not on the list, but will map to HCC 38. Contracts should take advantage of whichever approach yields the most efficient results. Table 7A provides an enrollee list for the example.

TABLE 7A – ENROLLEE LIST

MA Organization Name – Health Plan for People with Medicare
Current Contract ID: H1111
Previous Contract ID: H0000

Coversheet ID #	ENROLLEE ID	LAST NAME	FIRST NAME	MI	DOB	HIC	HCC	ICD-9 CODE	ICD-9 CODE	ICD-9 CODE	ICD-9 CODE	ICD-9 CODE
H1111-10005-HCC38	6225841	Smith	Joe	K	09/02/1925	12345678A	HCC 38	7101	446	4460	4465	71430
H1111-10005-HCC80							HCC 80	40201	40491	416		
H1111-10005-HCC16							HCC 16	2506	25062	2508	25080	
H1111-10006-HCC16	5457845	Johnson	James		8/16/1937	12345679A	HCC 16	2506	2508			
H1111-10007-HCC2	1545154	Mumford	Anne	A	03/15/1933	12345670A	HCC 2	0382	0389			
H1111-10007-HCC79							HCC 79	42741	51883			

Medical Record Request - Instructions and Coversheets

An instructions package is sent to MA organizations to facilitate the request for submitting medical records. This package will at a minimum include the following:

- Detailed instructions for requesting records from providers and submitting to the MRRC
- Guidance and best practices to further assist organizations with the request process
- A list of the selected enrollees (as previously described) and their HCCs
- CMS-signed cover provider letters
- HIPAA Fact Sheet to discuss HIPAA privacy AND

- A coversheet for each unique enrollee HCC

7.2.2 Medical Record Submission

MA organizations must submit medical records and all corresponding coversheets for each enrollee HCC to the MRRC. In responding to the medical record request, MA organizations must select the "one best medical record" to support the enrollee HCC.

Medical Record Submission and Coversheets

REQUEST MEDICAL RECORDS FROM PROVIDERS

Organizations must request medical records from hospital inpatient, hospital outpatient, or physician providers. When requesting medical records from your providers, be sure to attach the HIPAA fact sheet, your MA organization contact, and as appropriate, the CMS-signed and sample provider letters. This will facilitate the provider's contact with your organization in the event the provider has questions with regard to the medical record request.

When requesting medical records from providers, the organization must make every effort to limit disclosure of beneficiary health information to the minimum necessary as it pertains to the specific diagnosis(es) as rendered by the provider. This means that if the organization finds a date of service for which one provider rendered specific diagnoses then the organization should request medical record documentation from that provider for only those specific diagnoses, and the organization must not disclose of any additional health information from the enrollee HCC profile.

SELECT THE "ONE BEST MEDICAL RECORD" AND SUBMIT WITH COMPLETED COVERSHEET(S)

The coversheet is where the concept of the "one best medical record" is applied. The coversheet will at a minimum provide enrollee demographic information and stored risk adjustment data (HCC and ICD-9 codes). The MA organization must select and submit the best medical record and indicate on the coversheet the provider type and date(s) of service to be reviewed for the HCC. The date(s) of service could include a range of consecutive dates if the record is from a hospital inpatient provider or one date if the record is from a hospital outpatient or physician provider.

One coversheet will be generated and provided for each HCC being validated for each selected enrollee. Each coversheet shows every risk adjustment diagnosis that was stored by CMS and generated the HCC. A hierarchy (Y/N) indicator is included on the coversheet to identify if a specific HCC is part of a hierarchy. Where the HCC is part of a hierarchy, the HCC listed on the coversheet will be that which led to the most severe manifestation for the condition based on stored risk adjustment data. Only one coversheet will be issued for the general hierarchy condition, and within that condition only the most severe manifestation based on stored diagnoses will be displayed. Note that there may be other risk adjustment data that were stored and led to less severe manifestations for a condition. Attachment A provides a sample beneficiary HCC coversheet with directions for completion.

If one enrollee has two or more different HCCs, the contract will receive a separate HCC coversheets for each unique enrollee HCC; however, ,one medical record could be used to support multiple HCCs. If you identify a medical record that supports more than one HCC selected for validation, then complete each HCC coversheet, and attach them to that one medical record. For HCCs that are part of a hierarchy

(described above), the MA organization could submit a medical record for either the HCC hierarchy level listed on the coversheet, or a different level (higher or lower) within the hierarchy, but only one medical record should be submitted for the general condition.

All coversheets must be returned regardless of whether a medical record is submitted to support the HCC. MA organizations must complete the coversheets to identify the information being submitted. Complete medical record coversheets are essential for timely medical record review.

If an MA organization is unable to submit the required medical record(s) to support the enrollee HCC(s), it must complete the coversheet as per the instructions package prior to submitting the coversheet to the MRRC. This will inform the MRRC that no medical record could be obtained to support the HCC.

Guidance for Submitting Medical Records to the MRRC

1. Do not submit medical records for date(s) of service that occurred outside of the data collection period.

2. Do not submit medical records without provider signature and credentials.

3. Submit medical records from acceptable risk adjustment providers and physician specialties only.

4. If you select an inpatient discharge to substantiate the HCC(s), submit the entire inpatient medical record. Do not just submit parts of the record that may state the diagnosis; doing so would likely result in the record being reviewed in accordance with outpatient guidelines, which differ from inpatient depending on the type of diagnosis. The organizations should opt to submit the entire inpatient record if it's available.

5. Several organizations choose to submit medical record documentation that reflects only the physician face-to-face portion of an inpatient record when the entire inpatient record is not available. When this is the case, complete the coversheet to reflect a "physician" provider type and the date of service in the medical record for which the physician visit occurred during the inpatient stay. Only submit the medical record page(s) for the selected physician face-to-face.

6. In order to prevent medical record information from inadvertently being attached to the wrong coversheet(s), be sure that all coversheets are attached (e.g., rubber banded, paper clipped, or stapled) to the record. Do not clip together medical records for multiple different enrollees and enrollee HCCs.

7. If you are submitting for multiple organizations (i.e., those with different "H" numbers), separate the records for the different organizations.

8. Submit only one medical record per enrollee HCC being validated. Only one medical record–the first received for each HCC—will be accepted.

9. If you are unsure whether a record substantiates an HCC, you must determine whether to submit it or wait for another record. When in doubt about the clinical documentation in a medical record and you have no viable substitute, send the medical record even if you do not believe the record supports the HCC. We may find that the record does support the HCC being validated

10. **SUBMIT ALL MEDICAL RECORDS AND COMPLETED COVERSHEETS BY THE OFFICIAL DEADLINE. MEDICAL RECORDS WILL NOT BE ACCEPTED AFTER CMS' OFFICIAL DEADLINE.**

MEDICAL RECORD SUBMISSION METHODS AND SECURITY REQUIREMENTS

Extreme caution must be utilized when sending medical records and coversheets to the MRRC because of the protected health information (PHI), and/or personal identifiable information (PII) included in these documents. Medical records may be sent via electronic media (e.g., CD or USB), fax, or hardcopy. CMS prefers electronic media whenever feasible for medical record submission. **Do not e-mail medical records to the MRRC.**

All medical record submission packets must include a manifest of its contents, and records being sent via hardcopy or electronic media must be sent in tamper-proof packaging via U.S. Postal Service (USPS) certified mail with return receipt. Electronic media files must be encrypted. Faxed medical records must be sent using secured faxing procedures outline in the Medical Record Request Instructions packet. Organizations must follow all policies defined in the Instructions packet for submitting medical records.

7.2.3 Medical Record Receipt by the MRRC and Reimbursement

Once medical records are selected by the organization, the records must be submitted to the MRRC for medical record review. Upon receipt, the MRRC will log medical records into a chart-tracking database on the basis of the coversheet ID on each medical record coversheet. The date the medical record was received for a given HCC will be recorded.

When the coversheet and medical record are received by the MRRC, the following intake process is initiated:

- Administrative check—confirms beneficiary demographic information, including name, HIC number, and service date within or outside of the collection period.

- Clinical check—determines whether the:
  - Record is from an appropriate provider type.
  - Pertinent components needed for coding are included in the record.
  - Record is dated and signed.

Based on the administrative and clinical checks, the MRRC may elect to contact (telephone call or email message) the MA organization to request clarification or additional information.

CMS reimburses MA organizations for each medical record submitted per beneficiary HCC; however, only one medical record per beneficiary HCC will be accepted for reimbursement. If one record supports more than one beneficiary HCC, then the contract will receive reimbursement for one record. **This rule applies regardless of the method chosen for medical record submission.** Reimbursement checks are sent by the MRRC after completion of data validation activities**.**

7.2.4. Medical Record Review STAGE 2 (Slides 20-27)

CMS uses medical record review to validate risk adjusted payments. The process involves the review of submitted medical record documentation by a certified coder. The coders abstract all diagnosis codes –in accordance with the *ICD-9-CM Coding Guidelines*—based on the medical record documentation.

During medical record review, the certified coder specifically checks for the following:

- The service was provided by an acceptable risk adjustment provider type and physician specialty.
- Dates of service are within the data collection period.
- A provider signature and credentials for each note.
- Acceptable documentation based on documentation guidance.
- Diagnoses supported by medical record documentation.

Proper medical record documentation is the key to accurate payment and successful data validation. The accurate assignment of ICD-9-CM diagnosis codes is based on thorough medical record documentation. Therefore, risk adjusted payment accuracy also relies on medical record documentation. Remember, beneficiary HCCs are assigned based on plan reported or FFS submitted risk adjustment diagnoses. Below are some general guidelines for medical record documentation, based on the sources of the documentation.

General Guidelines for Hospital Inpatient Medical Record Documentation

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

CODING

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

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

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

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

General Guidelines for Hospital Outpatient and Physician Medical Record Documentation

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

- Face sheet
- History and physical exam

- Physician orders
- Progress notes
- Diagnostic reports (to support documentation)
- Consultation reports

Submit all relevant medical record components needed to validate the date of service, beneficiary, the HCC, and ICD-9 code selected. When you submit medical record documentation to support only the physician face-to-face visit that occurred during an inpatient stay, the same medical components are needed; however, the medical record documentation will be reviewed in accordance with *Diagnostic Coding and Reporting Guidelines for Outpatient Services*.

Only services that occurred on the date of service are reviewed. The overall guidelines for medical record documentation from hospital outpatient sites and physician offices are:

- A coder can determine from the documentation that an evaluation of the patient was performed by a physician or an acceptable physician extender (e.g., physician assistant, nurse practitioner).

- An ICD-9-CM code can be assigned on the basis of the evaluation and clinical findings/treatment.

- Physician signature, physician credentials and date entries are present.

CODING

Per the *ICD-9-CM Official Guidelines for Coding and Reporting* (October 1, 2003):

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

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

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

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

In some cases, additional guidance is needed when relying on certain types of hospital outpatient and physician office medical record documentation. (For additional information, see the *Guidance for Problem Lists*, *Guidance for Radiology Reports*, and *Guidance for Nursing Home Resident Medical Records* sections of this module.)

7.2.4.1 Unacceptable Documentation

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

Unacceptable Sources of Medical Records

- Skilled nursing facility (SNF) (See *Additional Guidance*)
- Diagnostic Radiology
- Freestanding ambulatory surgical center (ASC)
- Alternative data sources (e.g., pharmacy)
- Unacceptable physician extenders (e.g., nutritionist)
- Durable medical equipment (DME)

Unacceptable Types of Medical Record Documentation

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

Unacceptable Types of Diagnoses (outpatient hospital and physician settings)

- Probable
- Suspected
- Questionable
- Rule out
- Working

For additional information about unacceptable types of risk adjustment diagnoses, see Module 5 of the Participant's Guide.

7.2.4.2 Physician Signatures, Physician Credentials, and Dates of Service

As stated in CMS' 2008 Call Letter (available on the CMS web site at http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CallLetter.pdf):

> For purposes of risk adjustment data submission and validation, the MA organizations must ensure that the provider of service for face-to-face encounters is appropriately identified on medical records via their signature and physician specialty credentials. (Examples of acceptable physician signatures are: handwritten signature or initials; signature stamp that complies with state regulations; and electronic signature with authentication by the respective provider.) This means that the credentials for the provider of services must be somewhere on the medical record—either next to the provider's signature or pre-printed with the provider's name on the group practice's stationery. If the provider of services is not listed on the stationery, then the credentials must be part of the signature for that provider. In these instances, the coders are able to determine that the beneficiary was evaluated by a physician or an acceptable physician

specialty. (For additional information on acceptable physician specialties, see the above section titled *Filtering for Acceptable Provider Types and Physician Specialties*.)

We have identified medical records where it is unclear if the beneficiary is actually evaluated by a physician, physician extender, or other. In several cases, we have found encounters that are documented on physician's stationery but appear to be signed by a non-physician provider. For example, a medical record appears on group stationery for a given date of service. The medical record is signed but the provider's name and credentials are not furnished on the stationery. Thus, the coders are unable to determine whether the beneficiary was evaluated by a physician, medical student, nurse practitioner, registered nurse, or other provider. This type of medical record documentation is incomplete and unacceptable for risk adjustment and, therefore, will be counted as a risk adjustment discrepancy.

Thus, all dates of service that are identified for review must be signed (with credentials) and dated by the physician or an appropriate physician extender (e.g., nurse practitioner). The physician must authenticate each note for which services were provided. Acceptable physician authentication comes in the forms of handwritten signatures, signature stamps, and electronic signature. Signature stamps must comply with state regulations for authentication. For example, some states may require provider initials in conjunction with the stamped signature.

If electronic signatures are used as a form of authentication, the system must authenticate the signature at the end of each note. **Some examples of acceptable electronic signatures are: "Electronically signed by," "Authenticated by," "Approved by," "Completed by," "Finalized by," or "Validated by," and include the practitioner's name and credentials and the date signed.**

Medical records will be reviewed if there is dated medical record documentation (e.g., handwritten or transcribed consultation report, discharge summary) with a physician signature and credentials.

A medical record that lacks a date or physician signature and credentials is invalid and will not be reviewed.

Tables 7B and 7C identify types of acceptable and unacceptable physician signatures and credentials.

TABLE 7B – TYPES OF ACCEPTABLE PHYSICIAN SIGNATURES AND CREDENTIALS

TYPE	ACCEPTABLE
• Hand-written signature or initials, including credentials	• Mary C. Smith, MD; or MCS, MD
• Signature stamp, including credentials	• Must comply with state regulations for signature stamp authorization
• Electronic signature, including credentials	• Requires authentication by the responsible provider (for example but not limited to "Approved by," "Signed by," "Electronically signed by")
	• Must be password protected and used exclusively by the individual physician

TABLE 7C – TYPES OF UNACCEPTABLE PHYSICIAN SIGNATURES AND CREDENTIALS

TYPE	UNACCEPTABLE unless…
• Typed name	• Authenticated by the provider
• Non-physician or non-physician extender (e.g., medical student)	• Co-signed by acceptable physician
• Provider of services' signature without credentials	• Name is linked to provider credentials or name on physician stationery

7.2.4.3 Additional Guidance

To further assist MA organizations in determining the "one best medical record", below is guidance on radiology reports, problem lists, nursing home resident medical records. Information about medical record documentation resources is also furnished.

Guidance for Nursing Home Resident Medical Records

Although CMS does not accept risk adjustment data from nursing home facilities, some beneficiaries who reside in a nursing home will have a nursing home medical record as the only source to support their diagnostic data (i.e., there is no other medical record that documents the diagnosis submitted for risk adjusted payment; the nursing home record is the record of last resort). Only in certain circumstances will CMS accept nursing home medical records for purposes of data validation. We will accept a medical record from a nursing home providing it is the only medical record for the enrollee that documents the diagnosis submitted for risk adjustment and:

1. The provider's encounter must have been face-to-face with the beneficiary;
2. The clinical provider rendering the services must be an acceptable physician specialty for risk adjustment;
3. The medical record must clearly document the provider's signature and credentials; and
4. The beneficiary must be identified in the Minimum Data Set (MDS) as a long-term institutional resident.

Guidance for Problem Lists

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

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

Inpatient Documentation – History and Physical (H&P) Guidance

As previously mentioned CMS recommends submitting the complete inpatient medical record for a hospital inpatient stay. Some organizations have inquired about the use of the H&P as stand-alone documentation when submitting risk adjustment and medical records. The following guidance must be taken into account if organizations are considering these options.

- H&P submitted as part of the complete inpatient medical record
  - Will **not** contain reportable final/confirmed diagnoses
    - Typically contains
    - Admission symptoms and co-existing conditions as well as
    - Admission/working diagnoses, which may or may not be one of the final diagnoses for the inpatient admission

    Note that discharge/final diagnoses– not the H&P alone –will be reviewed in accordance with the Inpatient ICD-9 coding guidelines.

- H&P submitted as an independent physician visit from an inpatient stay

  If a physician submits a separate claim/encounter based on his/her evaluation of the patient as reflected on the H&P
  - H&P (face-to-face encounter) is viewed as a physician visit
  - Reportable diagnoses documented in the H&P
    - Could be used as final
    - Could be used for risk adjustment; HOWEVER,
    - The medical record documentation will be reviewed in accordance with the Outpatient ICD-9 coding guidelines
- H&P Conclusion
  - Risk Adjustment is based on final/confirmed diagnoses.
  - Risk adjustment diagnoses should only be submitted based H&P alone when there is an independent physician claim associated with the diagnosis.
  - Upon validation, if an organization submits the H&P as stand-alone documentation, the Outpatient guidelines will be applied to determine if there is a confirmed diagnosis.

Lab and Pathology Reports – Guidance

Some organizations have inquired about the use of Lab and Pathology Reports for data submission and medical record review. The following guidance must be taken into account when considering data or medical record submission from these sources.

- Official Guidelines for Coding and Reporting (Section III, B. Abnormal Findings)
- "Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the physician indicated their clinical significance."
- Coders should not arbitrarily assign a final ICD-9 code based solely on an abnormal finding.
- Written interpretation (alone) of a tissue biopsy is not equivalent to the attending/referring physician's complete clinical assessment used to assign a diagnosis.
- If submitting risk adjustment data or medical records based on pathology, note the following:
  - Outpatient pathology facilities are unacceptable risk adjustment provider sources.
  - Physician pathology (i.e., specialty code 22) is acceptable for risk adjustment. When submitting risk adjustment diagnoses for data submission or as a stand-alone medical record for RADV refer to the guidance stated in this section. AND
  - Medical records submitted as stand-alone documentation from these sources will be reviewed in accordance with the Outpatient guidelines, and will likely result in a risk adjustment discrepancy since these sources do not typically render confirmed diagnoses.

Medical Record Documentation Resources

- *ICD-9-CM Official Guidelines for Coding and Reporting*, October 1, 2003 (Section IV is specific to ambulatory coding), http://www.cdc.gov/nchs/data/icd9/icdguide.pdf
- *ICD-9 Coding Clinic Guidelines*
- *CMS 2004 Physicians and Medicare Advantage Risk Adjustment CD*
- American Health Information Management Association, http://www.ahima.org/
- American Medical Association, http://www.ama-assn.org/
- *Bates Guide to the Physical Examination and History Taking*, 7th Edition, Chapter 21 (The Patient's Record)
- *Fundamentals of Clinical Practice*, Mengel, Holleman, and Fields (Eds.), Kluwer Academic/Plenum Publishers, Chapter 12 (Record Keeping and Presentation)

7.2.4.4 Risk Adjustment Discrepancies

As previously stated, a risk adjustment discrepancy occurs when the enrollee HCC(s) assigned after medical record review differs from the enrollee HCC(s) assigned based on submitted risk adjustment data. To give a general understanding of the types of discrepancies that may be identified, the following descriptions are provided:

- Invalid
  - The medical record documentation submitted for review is from an unacceptable provider type and physician specialty for risk adjustment (e.g., SNF).
  - The date of service (visit date) for the medical record documentation submitted does not fall within the risk adjustment data collection period.

- The medical record is missing provider signature and credentials.

- Missing
  - Incomplete—an ICD-9 diagnosis code cannot be assigned as per ICD-9 Coding Clinic Guidelines for the date of service if the documentation is insufficient or incomplete (i.e., the record is missing components that are required to code in accordance with ICD-9 Coding Clinic Guidelines).
  - Never sent—no medical record documentation was received for a beneficiary HCC selected for data validation.

- Coding Discrepancies
  - The ICD-9 code abstracted from the medical record does not match the risk adjustment diagnosis code at the 3rd, 4th, or 5th digit level.

Some risk adjustment discrepancy examples are provided below.

Example 2

Risk Adjustment Discrepancy – Example (Non-Hierarchical CMS-HCC)

Reported Diagnosis Data: 0031 Septicemia Shock (HCC2)
Data Validation Findings: HCC2 was not supported by the submitted medical record

The CMS-HCC Community Factor for HCC2 is .887. The submitted medical record documentation was reviewed and the abstracted diagnoses **did not** support HCC2. This finding results in a risk adjustment discrepancy because the enrollee HCC was not supported; thus, the associated factor should not be included in the enrollee's risk score. The enrollee's corrected (MRR) risk score will not reflect .887 for HCC2.

Example 3

Risk Adjustment Discrepancy – Example (Hierarchy CMS-HCC)

Reported Diagnosis Data: 4824 Staphylococcal Pneumonia (HCC111)
Data Validation Findings: 4823 Streptococcal Pneumonia (HCC112)

The medical record documentation supports the code 482.3 streptococcal pneumonia, not 482.4 staphylococcal pneumonia. The CMS-HCC Community Factor associated with HCC 111 is .761. The factor associated with HCC112 (the final HCC) is .233. This will result in a risk adjustment discrepancy finding because the enrollee HCC changed levels within the hierarchy. The enrollee's corrected (MRR) risk score will reflect a change from .761 (HCC111) to .233 (HCC112) based on this MRR finding.

All risk adjustment discrepancies identified by the initial MRRC are referred to a second independent MRRC for confirmation. Each independent MRRC implements an inter-rater reliability (IRR) process to ensure coding consistency and accuracy across coders. Risk adjustment discrepancies that are confirmed by both independent MRRCs will contribute to the payment error estimate and resulting contract-level payment adjustment for your organizations. (See *Stage 3* of this module.)

7.3 MRR Findings and Contract-Level Payment Adjustments STAGE 3 (Slide 28)

Once all enrollee-level HCC findings are confirmed through two independent levels of review, CMS will provide each selected organization with the RADV findings. This communication will be sent as a report to the selected organizations and include 1) detailed enrollee information relating to the enrollee HCC discrepancies, 2) the contract-level payment adjustment amount (in absolute dollars) to be made, 3) an approximate timeframe for the payment adjustment, and 4) the requirements for the Documentation Dispute process if your organization decides to dispute enrollee HCC discrepant findings.

7.4 Documentation Disputes STAGE 4 (Slide 29)

A Documentation Dispute process will be implemented to address organization disputes regarding interpretation of the ICD-9-CM guidelines used by the MRRCs to assigned ICD-9 codes. The process will be facilitated by the MRRC and has some similarities to CMS' prior RADV Appeals processes where:

- Only enrollee HCC-level discrepancy findings will be allowed for dispute.
- MA organizations may dispute the application of the ICD-9-CM guidelines for the particular medical record date of service submitted during the Medical Record Request Stage (Stage 1).
- MA organizations will be given 60 days to submit a documentation dispute.
- An expert coding panel reviews every dispute. The panel is typically comprised of a senior medical reviewer, a senior coder, and a physician. The physician assesses whether any clinical factors may change the outcome of the appeals determination.

The Documentation Dispute process will not be used to address missing medical records of any kind, or additional medical record documentation of any kind. This means that MA organizations cannot use Documentation Dispute as a forum for first time submission of medical records and any additional medical record documentation to support their dispute(s). To clarify, the following information will not be accepted for Documentation Disputes:

- Medical records that were originally missing (i.e., the organization submitted no medical record) for an HCC, which resulted in Risk Adjustment Discrepancy Type = "Missing (never sent)".
- Medical records that resulted in a Risk Adjustment Discrepancy Type = "Missing (invalid)".
- Additional medical record documentation for HCCs that resulted in a Risk Adjustment Discrepancy Type = "Coding Discrepancy". The organization must submit the dispute based solely on the information that was originally submitted for the HCC during the Medical Record Request Stage.
- Additional medical record documentation for HCCs that were not originally assigned for 2007 payments for an enrollee.

When submitting a dispute, an MA organization must offer a clearly documented reason for disagreement with the MRRC regarding the ICD-9 code assignment and a different interpretation of the *ICD-9-CM Coding Guidelines*.

7.5 Post Documentation Dispute -- Payment Adjustment STAGE 5 (Slide 30)

The enrollee-level findings will be re-calculated based on findings from the Documentation Dispute process (Stage 4) and contract-level level payment error will be re-estimated. Additional payment adjustments will be made based on these findings. Organization will be notified of the revised payment error estimate and resulting payment adjustment.

7.6 Appeals STAGE 6 (Slide 31)

This concludes the CORE Stages of the RADV Process. STAGES 1- 6

Following the core RADV process stages 1-5, CMS will implement a formal Appeals process, which will be facilitated by the CMS Office of Hearings. This process and the requirements will be announced prior to the Appeals process being implemented.

7.7 Recommendations & Lessons Learned to Date (Slides 32-33)

Recommendations and lessons learned about the medical record request process that may assist contracts in planning and implementing their contract's activities include the following:

- **CMS-related Validation Activities**
  - Adhere to the submission deadline and plan accordingly.
  - Organize an internal validation team (e.g., Medicare compliance officer, information technology, quality, compliance, coding) to conduct internal validation activities.
  - Involve in-house quality assurance staff/medical record reviewers/medical director to identify the "one best medical record."
  - Query your data based on the beneficiary list that is furnished by the MRRC.
  - Establish communications with the providers prior to sending the medical record request.
  - Identify a contact person at the physician's office.
  - Send complete request information to providers.
  - Use newsletters and CMS training tools to inform physicians about risk adjustment.
  - Determine whether providers require payment in advance of sending medical records.
  - Follow up with the physician's office after the medical record request is sent.
  - Plan accordingly to ensure that you receive the medical records you need. It may require more effort to obtain medical records from—
    - Specialists
    - Non-contracted providers
    - Hospital outpatient or primary care provider settings.
  - Ensure that medical record documentation is signed (with physician credentials) and dated by an appropriate provider type and physician specialty.
  - Ensure that medical record documentation is complete.
  - Submit medical records on an on-going basis as you receive them from providers.

- **Conduct Ongoing Independent (non-CMS) Data Validation Activities**

MA organizations may choose to undertake data validation activities independent of CMS' efforts. When this is the case, CMS encourages organizations to clearly emphasize to their providers that the activity is **not** a CMS-sponsored activity. As a courtesy to providers, we ask that MA organizations limit to distribution of enrollee confidential health information to the minimum information necessary to accomplish the purpose of their activity. This means that an organization should not provide enrollee

diagnoses data to providers who were not responsible for rendering specific treatment for enrollees. For example, if a provider submitted diabetes on a claim for an enrollee, the MA organization should only disclose diabetes to that provider and no other diagnoses as determined by other providers. In other words, the organization should not provide universal lists of enrollee diagnoses to multiple providers. Doing so, may raise concerns about the organization's compliance with the Privacy Rules.

If undertaking independent data validation activities, below are some additional considerations:

- Conduct ongoing internal processes to confirm the accuracy of risk adjustment diagnoses from providers.
- Organize an internal validation team (e.g., Medicare compliance officer, information technology, quality, compliance, coding) to conduct internal validation activities.
- Use newsletters and CMS training tools to inform physicians about risk adjustment.

7.8 Technical Assistance

To improve the quality of risk adjustment data, CMS has technical assistance contractors available for any MA organization that needs help with CMS data validation processes, data completeness and accuracy, documentation requirements, and areas of concern identified by medical record review. Technical assistance may include site visits and teleconferences. To discuss your technical assistance needs, please contact the appropriate CMS staff member as identified in the *Current Validation Activities* section below.

7.9 CMS Data Validation Team Contacts (Slide 34)

Table 7D lists the CMS staff for the RADV project.

TABLE 7D – CMS STAFF

CMS CONTACT	CONTACT INFORMATION	ROLE
Jennifer Harlow	jennifer.harlow@cms.hhs.gov	Director, Division of Payment Validation
Lateefah Hughes	lateefah.hughes@cms.hhs.gov	RADV Project Team Lead Project Officer - LAC
Mary Guy	mary.guy@cms.hhs.gov	Project Officer- MRRC

7.10 Next Steps

As risk adjustment data validation activities continue, CMS will consider other techniques for monitoring risk adjustment data submissions to improve the sampling selection and receipt of quality medical record documentation.

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Attachment A –Medical Record Request Coversheet

INSTRUCTIONS: When completing this coversheet, please refer to the *Instructions Packet* that was mailed with your medical record request packet. Complete all applicable sections.

MA Organization Name:	
2008 Contract ID (E- or H-Number):	**2006 Contract ID (E- or H-number):**

Name of Health Plan
Designee Submitting Coversheet: _____
Date: __ __/__ __/2008

I. ENROLLEE DEMOGRAPHIC INFORMATION—Provide corrected information as necessary.

PRE-POPULATED INFORMATION	CORRECTED INFORMATION
HIC #:	
Last Name:	
First Name:	
DOB:	

II. STORED RISK ADJUSTMENT (RA) DATA[1]

ENROLLEE CMS-HCC FOR VALIDATION	ICD-9-CM CODE(S) SUBMITTED FOR PAYMENT THAT MAP TO THE ENROLLEE CMS-HCC FOR VALIDATION									CMS-HCC HIERARCHY (YES/NO)?

III. MEDICAL RECORD NON-SUBMISSION—Prior to completing this section, please thoroughly review the footnote that appears at the bottom of this coversheet regarding hierarchies.

☐ Check here if not submitting a medical record.

IV. MEDICAL RECORD SUBMISSION—If submitting a medical record, complete this section.

SERVICE DATES[2]		PROVIDER TYPE (CHECK ONLY ONE BOX)
START (MM/DD/YYYY)	END (MM/DD/YYYY)	
__ __/ __ __/ 2006	__ __/ __ __/ 2006	□ Hospital Inpatient □ Hospital Outpatient □ Physician/Specialist

[1] In Section II we provide:

- Enrollee CMS-HCC for Validation—this is the CMS-HCC that was assigned based on the stored RA data;
- ICD-9-CM Code(s) Submitted for Payment that Map to the Enrollee CMS-HCC for Validation—displays the ICD-9-CM code(s) used to assign the "Enrollee CMS-HCC for Validation"; and
- CMS-HCC Hierarchy (YES/NO)?—identifies whether the "Enrollee CMS-HCC for Validation" is part of a hierarchy. If you cannot provide supporting medical record documentation for the Enrollee CMS-HCC specified, you may submit medical record documentation with this coversheet that supports another CMS-HCC within the same hierarchy. The *Instructions Packet* provides a full list of CMS-HCCs, CMS-HCC hierarchies, and the ICD-9-CM codes.

Note CMS-HCCs that are not supported by medical record documentation will result in a payment adjustment.

[2] Applicable service dates must have occurred between January 1, 2006 and December 31, 2006.

MODULE 8– VERIFYING RISK SCORES

Purpose (Slide 2)

The risk score calculation is based on data captured from a variety of systems. To ensure that accurate payments are made, Medicare Advantage (MA) organizations may verify the components of the risk score calculation throughout the year. This module is designed to explain the systems involved in the risk score calculations and introduce MA organizations to a variety of verification tools available to them.

Learning Objectives (Slide 3)

At the completion of this module, participants will:

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

ICON KEY	
Example	
Reminder	
Resource	

8.1 Calculating Risk Scores (Slides 5-7)

The risk score used in calculating payments under the Centers for Medicare & Medicaid Services (CMS)-HCC model includes demographics as part of the risk model as well as different disease groups or HCCs. The risk score calculation gathers the critical data from a variety of systems, including risk adjustment data from the Risk Adjustment Processing System (RAPS) database, Fee-For-Service (FFS) information from the National Medicare Utilization Database (NMUD), and demographic data captured from the Common Tables.

The risk score calculation considers the following:

- Demographics
- Disease groups
- Disease interactions
- Disease hierarchies
- Disabled indicators
- Residence in a long-term care institution
- End-Stage Renal Disease (ESRD) Status

Figure 8A illustrates the flow of data used to calculate the risk score.

Figure 8A - Risk Score Calculation Process

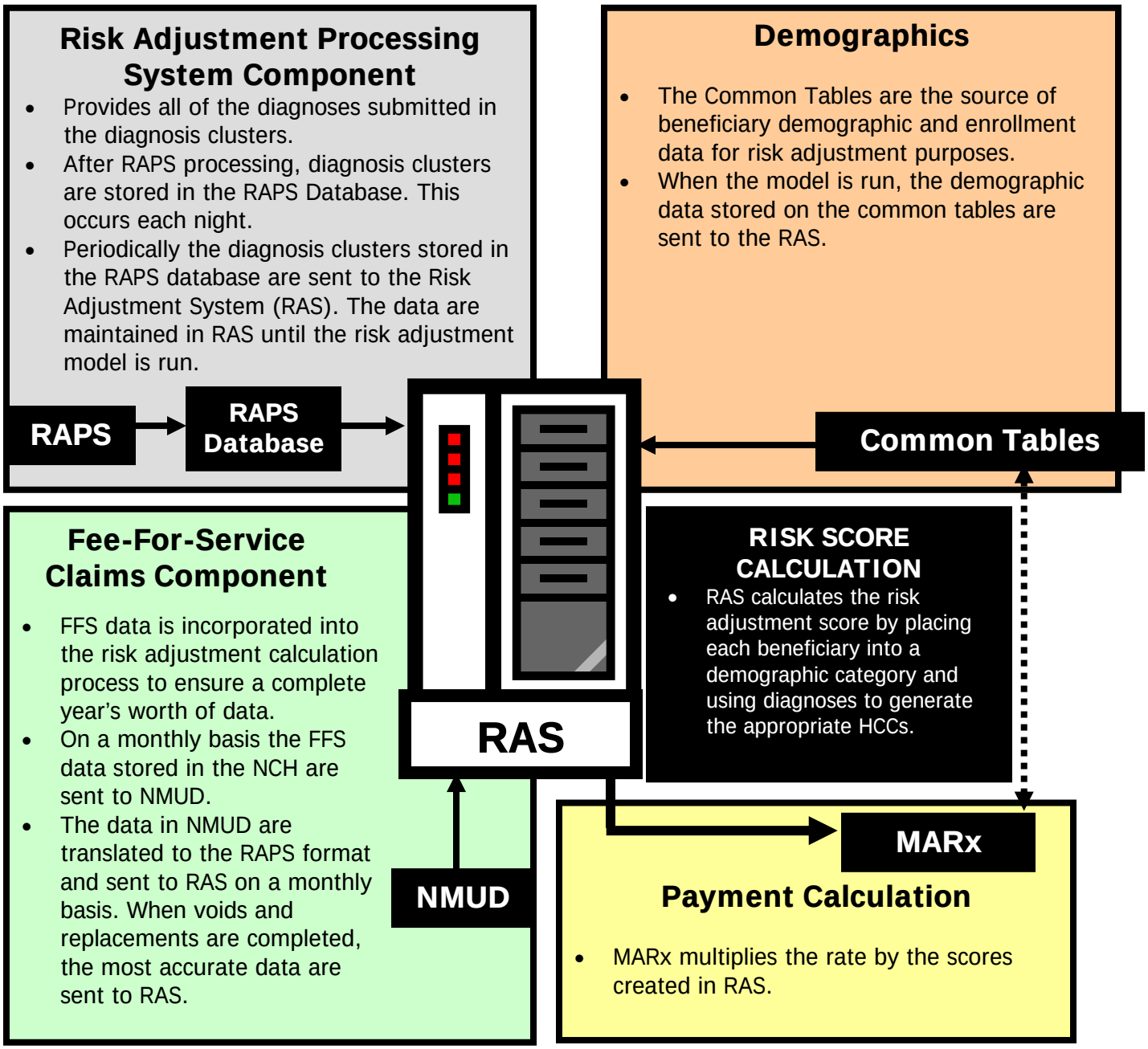

Table 8A describes the eight steps in the risk score calculation.

TABLE 8A - RISK SCORE CALCULATION STEPS

STEP	DESCRIPTION
1 Define Cohort	Each year CMS defines a cohort of beneficiaries for whom risk scores will be calculated and used for making payments beginning the following January. Typically, CMS calculates scores for all Medicare beneficiaries.
2 Obtain Beneficiary Specific Information	For this cohort, CMS obtains beneficiary-specific information from Medicare's enrollment databases. Beneficiary information includes the months of enrollment in Part A and Part B, age, sex, original reason for Medicare entitlement, etc. for each beneficiary in the cohort. Medicaid information is obtained from the third party payor file. In addition, plan-submitted Medicaid status information is included and beneficiaries with an ESRD flag are identified. CMS ensures that all Health Insurance Claim (HIC) numbers associated with each individual in the file have been identified. CMS uses all of this information to create a beneficiary demographic input file.
3 Extract Long-term Institutional Information from MDS	Next, for this cohort, CMS extracts assessments from the Minimum Data Set (MDS). CMS identifies the beneficiaries who have resided in a long-term institution for 90 days or more and classifies these individuals as long-term institutional beneficiaries. CMS passes beneficiary long-term institutional file to the RAS system.
4 Obtain Diagnosis Information	Next, CMS obtains all diagnostic information from Medicare data files for the cohort. These data include all diagnoses for the data collection period from the three types of data sources: physician services, hospital outpatient, and hospital inpatient. These diagnoses come from the RAPS database as well as Medicare fee-for-service files. From these data, CMS creates a beneficiary diagnosis input file.
5 Run the Model	The beneficiary demographic and beneficiary diagnosis input files are used to run the CMS-HCC and ESRD models and the Prescription Drug HCC (RxHCC) model. The ESRD model is run only on those beneficiaries with ESRD flags from the Common Tables. Each model determines a new enrollee factor for individuals who had fewer than 12 months of Part B enrollment during the data collection period. The model filters out diagnoses that do not correlate, such as ovarian cancer in a male patient. For individuals with 12 months of Part B enrollment, the software produces two risk scores: one based on the community model and one on the institutional model. In addition, for individuals with ESRD, the ESRD model will create additional risk scores appropriate to that model. The software also shows which HCC group (as well as which demographics, interactions, etc.) is associated with the risk scores. Only the most severe disease classification within a hierarchy is shown in the output. Based on this information, an output file is created and sent to the payment system.

TABLE 8A – RISK SCORE CALCULATION STEPS (CONTINUED)

STEP	DESCRIPTION
6 Send Model Output to MARx	The output from the CMS-HCC model is provided to MARx for use in making payments to plans. In addition, the model output serves as the basis for the MMR reports provided to plans and the risk adjustment MOR.
7 Apply Additional Payment Factors	Plan-level instructions are provided to MARx to determine which factors should be used in actually making payments.
8 Calculate Payment	MARx identifies individuals enrolled in an organization for a particular month. Then it accesses the risk factor file to retrieve the appropriate risk factor for each individual. MARx uses the individual's state and county code to determine the correct county capitation rate and then multiplies the risk factor by that rate. After calculating the correct demographic payment for the same individual, MARx then calculates the correct payment by blending the appropriate proportion of risk and demographic payments. Then the demographic and risk adjusted amounts are totaled.

Note: For each risk adjustment model run, the process is repeated, updating the data used for the model to include new diagnoses received for the data collection period, as well as changes in any of the demographic factors. During final reconciliation, long-term institutional status is determined for each month during the payment year, and ESRD status is reconciled to obtain the most precise month-by-month status.

8.2 Risk Score Verification Tools (Slide 8)

CMS offers a variety of tools that MA organizations can use at various stages in the risk adjustment process to ensure that the risk score reported by CMS is in close alignment with the score that the organization expects to receive. This section of the training module describes each of the tools, identifies the method of access and timeframe, and provides information on how an organization can use the tool to increase the accuracy of payment projections.

The verification tools include:

- RAPS Return File/RAPS Transaction Error Report
- RAPS Monthly and Cumulative Plan Activity Reports
- SAS CMS-HCC Model Program
- MMR
- Part C MOR (Non-Drug) and the new RAS RxHCC MOR

Information on the tools are illustrated in Table 8B

TABLE 8B – RISK SCORE VERIFICATION TOOLS

REPORT NAME	ACCESS	AVAILABLE
RAPS Return File/RAPS Transaction Error Report	RAPS Mailbox RPT####.RPT.RAPS_RETURN_FLAT RPT#####.ZIP.RAPS RETURN FLAT (zip format) RPT#####.RPT.RAPS_ERROR_RPT RPT#####.ZIP.RAPS ERROR RPT (zip format)	Next business day following data submission
RAPS Monthly and Cumulative Plan Activity Reports	RAPS Mailbox RPT####.RPT.RAPS_MONTHLY RPT#####.ZIP.RAPS MONTHLY (zip format) RPT####.RPT.RAPS_CUMULATIVE RPT#####.ZIP.RAPS CUMULATIVE (aip format)	Second business day of the month
Risk Adjustment SAS Programs	http://cms.hhs.gov/MedicareAdvtgSpecRateStats *Ratebooks & Supporting Data, 2004 Mar-Dec, Downloads*	2003-present
MMR Non-Drug and Drug Reports	Through MARx	Refer to the 2006 MARx Monthly Schedule
MOR HCC Part C and RAS RxHCC MOR	Through MARx	Refer to the 2006 MARx Monthly Schedule

Locate the 2008 MARx Monthly Schedule from: http://www.cms.hhs.gov/MMAHelp/.
For applicable diagnoses by payment years (2004-2009) for CMS-HCC and RxHCC models see http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage.

8.2.1 RAPS Return File/RAPS Transaction Error Report (Slide 9)

The RAPS Return File contains all transactions submitted by the MA organization. Any errors identified during the RAPS process will appear next to the field in which the error was found. This indicates that the diagnosis was not stored. The file is delivered in the same flat file format used for the RAPS input. Unique diagnosis clusters that are returned without an error are stored in the RAPS database at CMS. CMS uses the diagnosis clusters that contain relevant diagnosis codes to calculate risk adjustment factors when running the CMS-HCC model or ESRD model. Since this report is a flat file, MA organizations may download the file into a Microsoft Access or Excel database, and establish a record of each diagnosis that was stored in the CMS-HCC model for each enrollee. Larger organizations also use this file in mainframe databases. Organizations that employ automated update processes for their databases typically use the Return File.

The RAPS Transaction Error Report contains only those records that contain errors, causing one or more diagnosis clusters to be rejected. The RAPS Transaction Error Report is typically used by organizations that employ a non-automated update process when maintaining their diagnosis files. To use this report, an individual at the health plan normally downloads the report, prints it, and then manually updates their diagnosis records to indicate which diagnoses were rejected.

The database will serve several purposes:

1. The MA organization will have a history of all diagnosis clusters submitted and stored, which can be used to prevent future submissions of duplicate diagnosis clusters.
2. The MA organization will have the data required to determine which diagnoses were stored for each beneficiary for the payment period.

3. CMS requires plans to submit all required diagnoses, and recommends maintaining an accurate record of all data submitted and stored.

MA organizations must submit each required diagnosis at least once during a reporting period for each enrolled beneficiary.

Example: 1

The MA organization received a RAPS Return File that included three records and one cluster within each record. Using the data communicated on the RAPS Return File, the organization captured information that could be used later to verify the risk score. The plan developed an internal database that captured each HIC number and each relevant diagnosis that is stored in the RAPS database for that beneficiary. Based on the RAPS Return File (see Figure 8B), the plan captured the 70710 (ulcer of the lower limb) and 311 (depression) diagnoses, since both were accepted to RAPS. Figure 8C illustrates the database content based on the results of this RAPS Return File.

Note: The plan should maintain 311 in its database. 311 is a required diagnosis that was stored in the RAPS database even though is not a model diagnosis. 250, in the third CCC record, is a model diagnosis, however it was returned with an error code (i.e., 354). Therefore, the plan should not maintain this diagnosis in its database until the error has been successfully addressed.

Note: Figure 8B is an abbreviated version of the RAPS Return File due to space limitations on the page.

Figure 8B – RAPS Return File

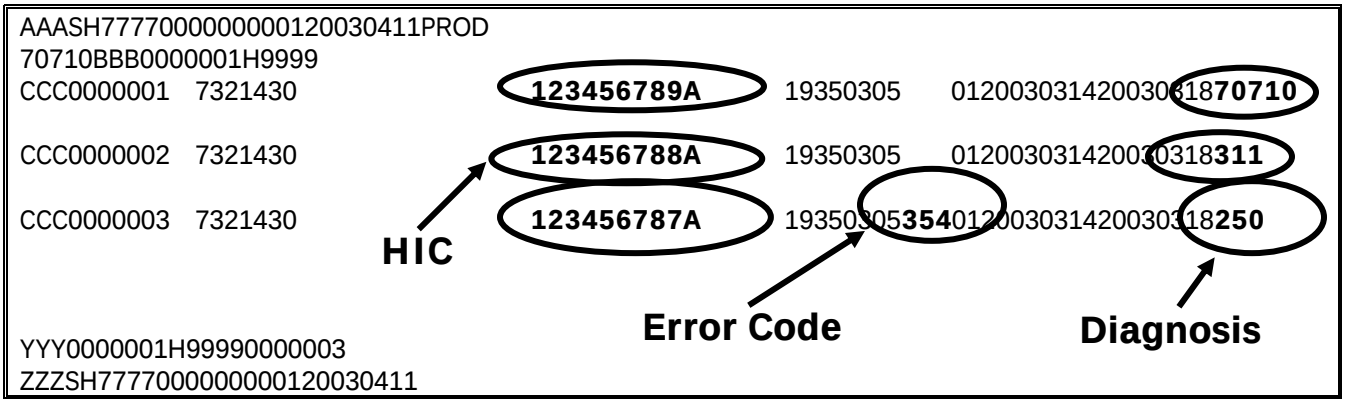

Figure 8C – Internal Diagnosis Cluster Database

HIC	Dx	From Date	Thru Date	Provider Type	Date Submitted
123456789A	70710	20030314	20030318	01	20030411
123456788A	311	20030314	20030318	01	20030411

Note: The MA organization may include other fields, such as Patient Control Number (PCN), in the database for a variety of reasons. The PCN can help the plan find the original source document for the diagnosis. This sample database includes only the minimal components required for verifying the accuracy of the number of clusters stored for risk score calculation and elements that define a duplicate cluster.

8.2.2 RAPS Management Reports (Slide 11)

The RAPS Monthly and Cumulative Plan Reports (Figure D) are available the second business day of the month. These reports assist in the confirmation of the total number of diagnoses stored in the CMS-HCC model.

The reports are delivered in report layout format. MA organizations can compare their internal database developed from the RAPS Return File to the number of diagnoses stored on the report. The cumulative report reflects the total number of diagnoses stored to date for the H number. The database should reflect all diagnosis clusters stored for the health plan for the data collection period

Figure 8D – RAPS Cumulative Plan Activity Report

RAPS0020 CMS RAPS ADMINISTRATION PAGE: 1
RUN REPORT: DATE: 20070203 RAPS CUMULATIVE PLAN ACTIVITY REPORT SERVICE YEAR: 2006

SUBMITTER ID: SH7777 FOR PERIOD ENDING January 30, 2004
PLAN NO: H7777

PROVIDER TYPE/TOTALS	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	TOTAL
PRINCIPAL INPATIENT							
TOTAL SUBMITTED	22	35	29	19	27	25	157
TOTAL REJECTED	2	4	7	5	3	3	24
TOTAL ACCEPTED	20	31	22	14	24	22	133
TOTAL STORED	20	31	22	16	24	24	137
TOTAL MODEL STORED	0	0	2	0	2	0	4
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OTHER INPATIENT							
TOTAL SUBMITTED	64	83	51	48	40	60	346
TOTAL REJECTED	8	10	11	6	5	4	44
TOTAL ACCEPTED	56	73	40	42	35	56	302
TOTAL STORED	56	73	40	42	35	56	302
TOTAL MODEL STORED	0	0	0	1	0	0	1
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OUTPATIENT							
TOTAL SUBMITTED	98	87	43	37	44	76	385
TOTAL REJECTED	7	5	3	4	5	4	28
TOTAL ACCEPTED	91	82	40	33	39	72	357
TOTAL STORED	91	82	40	33	39	72	357
TOTAL MODEL STORED	0	0	3	3	1	0	7
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
PHYSICIAN							
TOTAL SUBMITTED	99	77	92	90	97	79	534
TOTAL REJECTED	5	5	8	6	8	5	37
TOTAL ACCEPTED	94	72	84	84	89	74	497
TOTAL STORED	94	72	84	84	89	74	497
TOTAL MODEL STORED	0	0	2	1	0	1	4
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0

8.2.3 CMS-HCC Risk Adjustment Model Software (Slide 12)

The software is a SAS program that allows the organization to verify and predict risk scores. Click on HCC Software (ZIP 49KB), open the zip file, and double click on "hccsoftdescription.rtf." CMS published the ESRD model on the web after publication of the final payment notice for 2005. Users must have a SAS license to use the SAS program.

MA organizations may access the CMS-HCC Risk Model software at **http://cms.hhs.gov/**.

- Select:
  - Medicare
  - Health Plans
  - Medicare Advantage Rates & Statistics
  - Risk Adjustment
  - Downloads
  - 2007 CMS-HCC software (ZIP 53KB)

The software includes an HCCSOFT SAS program that uses several SAS Macros to create HCC score variables using coefficients from the following regression models:

- Community
- Institutional
- New enrollee

The HCCSOFT software supplies user parameters to the main SAS Macro program MACROSFT. This macro program takes user-provided files and assigns HCCs for each person. The program follows these major steps when calculating risk scores.

1. The program assigns each beneficiary to an appropriate age/sex grouping, and adds in the interactions for Medicaid, disabled, and previously disabled.

2. The program crosswalks diagnoses to Condition Categories using SAS formats that were previously stored in the FORMAT library.

3. The program then creates HCCs by imposing hierarchies on the Condition Categories.

4. The program creates the interactions.

5. The program computes predicted scores from three regression models.

Note: For beneficiaries without relevant diagnoses from RAPS or FFS claims data, zeros are assigned to all HCCs.

Table 8C lists the software-provided files.

TABLE 8C – SOFTWARE-PROVIDED FILES

FILE NAME	DESCRIPTIONS
V1206D4P	Main program that supplies user parameters to the main SAS macro program.
V1206D4M	Main macro that creates HCC and Score variables by calling other external macros.
AGESEXVR	Creates age/sex, originally disabled, disabled variables.
EDITICD9	Performs edits to International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) code.
V12H70M	Assigns ICD-9-CM diagnosis code to multiple CCs where required.
V12H70L	Assigns labels to HCCS.
V12H70H	Sets HCC=0 according to hierarchies.
SCOREVR	Calculates a score variable.
F1206D4Y	Format library that has a crosswalk from ICD-9-CM codes to CC categories that are transformed to HCC categories by the software.
C1206D4Y	Coefficients for three regression models.

Table 8D provides a list of user supplied files.

TABLE 8D – USER SUPPLIED FILES

FILE NAME	DESCRIPTION
Person File	A person-level file of demographic and enrollment information
Diagnosis File	A diagnosis-level input file of diagnoses

8.2.4 Monthly Membership Reports (MMR) (Slides 13-16)

The MMR provides information to reconcile the Medicare membership and payment record to the records maintained by CMS. The MMR is available in two formats – report and data file, which are posted monthly. The report and data file formats provide summary and detail-level information on beneficiaries belonging to the MA organization.

Summary: This format presents a summary of the payments and adjustments applicable to the MA organization's Medicare membership. This format shows the total number of beneficiaries for whom a hospice, ESRD, or institutionalized payment was received.

Detail: This format contains a detailed list of beneficiaries for whom a payment was made to the MA organization for that month: either a monthly or an adjustment payment. This allows the MA organization to compare its beneficiary records with those maintained by CMS.

The MMR Reports communicate information on a beneficiary level.

Questions regarding accessing and understanding the MMR should be directed to the plan's regional contact at the CMS Central Office.

8.2.4.1 Monthly Membership Summary Reports (Slide 13)

The MMR Summary is available in both data file and report layout format. Both the data file and the report include summaries of drug and non-drug data.

8.2.4.2 Monthly Membership Detail Reports (Slide 13)

The MMR Detail is available in a data file that includes both drug and non-drug data. CMS extracts data from the data file and generates two formatted reports, one for drug data and one for non-drug data. The reports display payment information as it relates to the appropriate payment model. The two detail reports are described below.

8.2.4.2.1 Non-Drug Monthly Membership Report (Slide 14)

The Non-Drug MMR contains information such as rebates, payments and adjustments, Part A and Part B information, risk adjustment factors for Part A and Part B, and other detailed beneficiary information.

8.2.4.2.2 Drug Monthly Membership Report (Slide 15)

The Drug MMR contains information such as basic premiums, estimated reinsurance, payments and adjustments, low-income cost sharing percentage, low-income cost sharing subsidy, risk adjustment factors, and other detailed beneficiary information.

Table 8E describes the MMR field ranges. Table 8F provides the complete record layout for the MMR.

TABLE 8E – SUMMARY OF THE MMR DETAIL RECORD LAYOUT FIELD RANGES

FIELD RANGE	GENERAL DESCRIPTION OF FIELD RANGE
1-3	Managed Care Organization Information
4-11	Beneficiary Identification
12-13	Entitlement
14-21	Health Status
22-34	Risk Adjustment/Demographic Payment Adjustment Information
35	Low Income Subsidy Premium Amount
36	ESRD MSP Flag
37-46	Additional Indicators
47	Risk Adjustment Factor Type Code
48	Frailty Indicator
49	Original Reason for Entitlement Code (OREC)
50	Lag Indicator
51	Segment ID for Part D
52	Enrollment Resource
53	EGHP Flag
54-66	Risk Adjustment Premium/Rebate/Payment Information
67	Part D Risk Factor
68-78	Fields supporting the Part D Benefit
79-80	PACE related fields

Note: In 2006, CMS added a Low-Income Subsidy (LIS) Premium Amount field to filler field #35. This field contains the amount of Part D premium paid to MA organizations on behalf of affected members.

TABLE 8F – MONTHLY MEMBERSHIP REPORT (MMR) (DRUG AND NON-DRUG FIELDS)

MMR FLAT FILE LAYOUT

#	Field Name	Len	Pos	Description
1	MCO Contract Number	5	1-5	MCO Contract Number
2	Run Date of the File	8	6-13	YYYYMMDD
3	Payment Date	6	14-19	YYYYMM
4	HIC Number	12	20-31	Member's HIC #
5	Surname	7	32-38	First 7 letters of the member's surname
6	First Initial	1	39-39	First initial of the member's first name
7	Sex	1	40-40	M = Male, F = Female
8	Date of Birth	8	41-48	YYYYMMDD
9	Age Group	4	49-52	BBEE BB = Beginning Age EE = Ending Age
10	State & County Code	5	53-57	
11	Out of Area Indicator	1	58-58	Y = Out of Contract-level service area Always Spaces on Adjustment
12	Part A Entitlement	1	59-59	Y = Entitled to Part A
13	Part B Entitlement	1	60-60	Y = Entitled to Part B
14	Hospice	1	61-61	Y = Hospice
15	ESRD	1	62-62	Y = ESRD
16	Aged/Disabled MSP	1	63-63	Y = Working Aged
17	Institutional	1	64-64	Y = Institutional (monthly)
18	NHC	1	65-65	Y = Nursing Home Certifiable
19	Medicaid Beneficiary Medicaid Status Flag	1	66-66	Y = Default Part C risk factor used, Medicaid Beneficiary N = Default Part C risk factor used, non-Medicaid beneficiary Blank = No Part C default factor used or the beneficiary is Part D only
20	LTI Flag	1	67-67	Y = Part C Long Term Institutional
21	Medicaid Indicator	1	68-68	Y = Medicaid Add-on to beneficiary RAS factor Blank = No Medicaid Add-on
22	PIP-DCG	2	69-70	PIP-DCG Category - Only on pre-2004 adjustments
23	Default Indicator	1	71-71	Y = default RA factor in use • For pre-2004 adjustments, a 'Y' indicates that a new enrollee RA factor is in use • For post-2003 payments and adjustments, a 'Y' indicates that a default factor was generated by the system due to lack of a RA factor.

MMR FLAT FILE LAYOUT (CONTINUED)

#	Field Name	Len	Pos	Description
24	Risk Adjuster Factor A	7	72-78	NN.DDDD
25	Risk Adjuster Factor B	7	79-85	NN.DDDD
26	Number of Paymt/Adjustmt Months Part A	2	86-87	99
27	Number of Paymt/Adjustmt Months Part B	2	88-89	99
28	Adjustment Reason Code	2	90-91	FORMAT: 99 Always Spaces on Payment and MSA Deposit or Recovery Records
29	Paymt/Adjustmt Start Date	8	92-99	FORMAT: YYYYMMDD
30	Paymt/Adjustmt End Date	8	100-107	FORMAT: YYYYMMDD
31	Demographic Paymt/ Adjustmt Rate A	9	108-116	FORMAT: -99999.99
32	Demographic Paymt/ Adjustmt Rate B	9	117-125	FORMAT: -99999.99
33	Risk Adjuster Paymt/ Adjustmt Rate A	9	126-134	Part A portion for the beneficiary's payment or payment adjustment dollars. For MSA Plans, the amount does not include any lump sum deposit or recovery amounts. It is the Plan capitated payment only, which includes the MSA monthly deposit amount as a negative term. FORMAT: -99999.99
34	Risk Adjuster Paymt/ Adjustmt Rate B	9	135-143	Part B portion for the beneficiary's payment or payment adjustment dollars. For MSA Plans, the amount does not include any lump sum deposit or recovery amounts. It is the Plan capitated payment only, which includes the MSA monthly deposit amount as a negative term. FORMAT: -99999.99
35	LIS Premium Subsidy	8	144-151	FORMAT: -9999.99
36	ESRD MSP Flag	1	152-152	Format X. Values = 'Y' or 'N'(default) Indicates if Medicare is the Secondary Payer for an ESRD member
37	MSA Part A Deposit/ Recovery Amount	8	153-160	Medicare Savings Account (MSA) lump sum Part A dollars to be deposited/recovered. Deposits are positive values and recoveries are negative. FORMAT: -9999.99
38	MSA Part B Deposit/ Recovery Amount	8	161-168	Medicare Savings Account (MSA) lump sum Part B dollars to be deposited/recovered. Deposits are positive values and recoveries are negative. FORMAT: -9999.99
39	MSA Deposit/Recovery Months	2	169-170	Number of months associated with MSA deposit or recovery dollars

MMR FLAT FILE LAYOUT (CONTINUED)

#	Field Name	Len	Pos	Description
40	FILLER	1	171-171	SPACES
41	Risk Adjuster Age Group (RAAG)	4	172-175	BBEE BB = Beginning Age EE = Ending Age
42	Previous Disable Ratio (PRDIB)	7	176-182	NN.DDDD Percentage of Year (in months) for Previous Disable Add-On – Only on pre-2004 adjustments
43	De Minimis	1	183-183	'N' = "de minimis" does not apply 'Y' = "de minimis" applies
44	FILLER	2	184-184	SPACES
45	Plan Benefit Package Id	3	185-187	Plan Benefit Package Id FORMAT 999
46	Race Code	1	188-188	Format X Values: 0 = Unknown 1 = White 2 = Black 3 = Other 4 = Asian 5 = Hispanic 6 = N. American Native
47	RA Factor Type Code	2	189-190	Type of factors in use (see Fields 24-25): C = Community C1 = Community Post-Graft I (ESRD) C2 = Community Post-Graft II (ESRD) D = Dialysis (ESRD) E = New Enrollee ED = New Enrollee Dialysis (ESRD) E1 = New Enrollee Post-Graft I (ESRD) E2 = New Enrollee Post-Graft II (ESRD) G1 = Graft I (ESRD) G2 = Graft II (ESRD) I = Institutional I1 = Institutional Post-Graft I (ESRD) I2 = Institutional Post-Graft II (ESRD)
48	Frailty Indicator	1	191-191	Y = MCO-level Frailty Factor Included
49	Original Reason for Entitlement Code (OREC)	1	192-192	0 = Beneficiary insured due to age 1 = Beneficiary insured due to disability 2 = Beneficiary insured due to ESRD 3 = Beneficiary insured due to disability and current ESRD

MMR FLAT FILE LAYOUT (CONTINUED)

#	Field Name	Len	Pos	Description
50	Lag Indicator	1	193-193	Y = Encounter data used to calculate RA factor lags payment year by 6 months.
51	Segment ID	3	194-196	Identification number of the segment of the PBP. Blank if there are no segments.
52	Enrollment Source	1	197	The source of the enrollment. Values are A = Auto-enrolled by CMS, B = Beneficiary election, C = Facilitated enrollment by CMS, D = Systematic enrollment by CMS (rollover) , E = Auto-enrolled by Plans, F = Facilitated enrollment by Plans, G = POS submitted enrollment, H = Re-assignment enrollment by CMS or Plans and I = Enrollments submitted by Plans with enrollment source other that B, E, F, G, H and blank.
53	EGHP Flag	1	198	Employer Group flag; Y = member of employer group, N = member is not in an employer group
54	Part C Basic Premium – Part A Amount	8	199-206	The premium amount for determining the MA payment attributable to Part A. It is subtracted from the MA plan payment for plans that bid above the benchmark. -9999.99
55	Part C Basic Premium – Part B Amount	8	207-214	The premium amount for determining the MA payment attributable to Part B. It is subtracted from the MA plan payment for plans that bid above the benchmark. -9999.99
56	Rebate for Part A Cost Sharing Reduction	8	215-222	The amount of the rebate allocated to reducing the member's Part A cost-sharing. This amount is added to the MA plan payment for plans that bid below the benchmark. -9999.99
57	Rebate for Part B Cost Sharing Reduction	8	223-230	The amount of the rebate allocated to reducing the member's Part B cost-sharing. This amount is added to the MA plan payment for plans that bid below the benchmark. -9999.99
58	Rebate for Other Part A Mandatory Supplemental Benefits	8	231-238	The amount of the rebate allocated to providing Part A supplemental benefits. This amount is added to the MA plan payment for plans that bid below the benchmark. -9999.99
59	Rebate for Other Part B Mandatory Supplemental Benefits	8	239-246	The amount of the rebate allocated to providing Part B supplemental benefits. This amount is added to the MA plan payment for plans that bid below the benchmark. -9999.99

MMR FLAT FILE LAYOUT (CONTINUED)

#	Field Name	Len	Pos	Description
60	Rebate for Part B Premium Reduction – Part A Amount	8	247-254	The Part A amount of the rebate allocated to reducing the member's Part B premium. This amount is retained by CMS for non- ESRD members and it is subtracted from ESRD member's payments. -9999.99
61	Rebate for Part B Premium Reduction – Part B Amount	8	255-262	The Part B amount of the rebate allocated to reducing the member's Part B premium. This amount is retained by CMS for non- ESRD members and it is subtracted from ESRD member's payments. -9999.99
62	Rebate for Part D Supplemental Benefits – Part A Amount	8	263–270	Part A Amount of the rebate allocated to providing Part D supplemental benefits. -9999.99
63	Rebate for Part D Supplemental Benefits – Part B Amount	8	271–278	Part B Amount of the rebate allocated to providing Part D supplemental benefits. -9999.99
64	Total Part A MA Payment	10	279–288	The total Part A MA payment. -999999.99
65	Total Part B MA Payment	10	289–298	The total Part B MA payment. -999999.99
66	Total MA Payment Amount	11	299-309	The total MA A/B payment including MMA adjustments. This also includes the Rebate Amount for Part D Supplemental Benefits -9999999.99
67	Part D RA Factor	7	310-316	The member's Part D risk adjustment factor. NN.DDDD
68	Part D Low-Income Indicator	1	317	An indicator to identify if the Part D Low-Income multiplier is included in the Part D payment. Values are 1 (subset 1), 2 (subset 2) or blank.
69	Part D Low-Income Multiplier	7	318-324	The member's Part D low-income multiplier. NN.DDDD
70	Part D Long Term Institutional Indicator	1	325	An indicator to identify if the Part D Long-Term Institutional multiplier is included in the Part D payment. Values are A (aged), D (disabled) or blank.
71	Part D Long Term Institutional Multiplier	7	326-332	The member's Part D institutional multiplier. NN.DDDD
72	Rebate for Part D Basic Premium Reduction	8	333-340	Amount of the rebate allocated to reducing the member's basic Part D premium. -9999.99

MMR FLAT FILE LAYOUT (CONTINUED)

#	Field Name	Len	Pos	Description
73	Part D Basic Premium Amount	8	341-348	The plan's Part D premium amount. -9999.99
74	Part D Direct Subsidy Payment Amount	10	349-358	The total Part D Direct subsidy payment for the member. -999999.99
75	Reinsurance Subsidy Amount	10	359-368	The amount of the reinsurance subsidy included in the payment. -999999.99
76	Low-Income Subsidy Cost-Sharing Amount	10	369-378	The amount of the low-income subsidy cost-sharing amount included in the payment. -999999.99
77	Total Part D Payment	11	379-389	The total Part D payment for the member -999999.99.
78	Number of Paymt/Adjustmt Months Part D	2	390-391	99
79	PACE Premium Add On	10	392-401	Total Part D PACE Premium Add-on amount -999999.99
80	PACE Cost Sharing Add on	10	402-411	Total Part D PACE Cost Sharing Add-on amount -999999.99

Plans may access the MMR Report format. Figure 8E illustrates an example of the MMR for Non-Drug.

Figure 8E –MMR REPORT FORMAT – NON-DRUG

```
RUN DATE:20050115                             MONTHLY MEMBERSHIP REPORT - NON DRUG                                 PAGE:         1
PAYMENT MONTH:200502                    PLAN(H4444) PBP(nnn) SEGMENT(mmm) IRIS INSURANCE OF INDIANA

                            ------------------------------------------------- REBATES -----------------------------------------------
           BASIC PREMIUM | COST SHR REDUC   MAND SUPP BENEFIT  PART D SUPP BENEFIT     PART B BAS PRM REDUC    PART D BAS PRM REDUC
    PART A  $sss9.99     |      N/A              N/A                  N/A                       N/A                     N/A
    PART B  $sss9.99     |      N/A              N/A                  N/A                       N/A                     N/A

             S                 -----------  FLAGS  ------------    ----------------------- PAYMENTS/ADJUSTMENTS --------------------
CLAIM        E AGE  STATE        P P         M F   A D   S A MTHS         DATES         LAG    FTYPE
NUMBER       X GRP  CNTY         A A H E I   C R O D E E O D A B       START   END
------------ - ---- -----      O R R O S N N A A R D F G U M ---- --- ------------------------------------------------------------
   SURNAME F   DMG  BIRTH      O T T S R S H I I E O A H R S PIP  ADJ
           I   RA   DATE       A A B P D T C D L C N U P C P DCG  REA FCTR-A FCTR-B     PART A     PART B      TOTAL PAYMENT
------------ - ---- -----      - - - - - - - - - - - - - - - ---  ------------------------------------------------------------
1234567890AB F 8084 33800                                             200405 200405      Y       C
   LEONARD G   8084 19200206 Y Y N     Y                    Z9Z9  ZZ 1.0650 1.0650   $sssssss9.99 $sssssss9.99   $ssssssss9.99
0987654321AB M 8084 33800                                             200405 200405      Y       C
   MARION  H   8084 19251008 Y Y Y     N                    Z9Z9  ZZ 1.0650 1.0650   $sssssss9.99 $sssssss9.99   $ssssssss9.99
```

Source: Plan Communications User's Guide Appendices, Version 3.1 (April 18, 2008). Centers for Medicare & Medicaid Services.

Plans may access the MMR Report format. Figure 8F illustrates an example of the MMR report for Drug.

Figure 8F –MMR REPORT FORMAT – DRUG

```
1RUN DATE:20061027                          MONTHLY MEMBERSHIP REPORT - DRUG                                  PAGE:1
 PAYMENT MONTH:200601                    PLAN(H9999) PBP(999) SEGMENT(000) ACME HEALTH SERVICES
0                                                 BASIC PREMIUM | ESTIMATED REINSURANCE
                                           PART D      $10.60   |         $0.00
0             S                 ---  FLAGS  ---      ------------------ PAYMENTS/ADJUSTMENTS ---------------------------
 CLAIM        E AGE  STATE       P P   S L L D  ADJ RA FCTR     DATES       LOW-INCOME COST     LOW-INCOME COST
 NUMBER       X GRP  CNTY        A A E 0 O I E  REA          START  END     SHARING PERCENTAGE  SHARING SUBSIDY
 ------------ - ---- -----    O R R G U I N M ---- ------------------------------------------------------------------
    SURNAME F   DMG  BIRTH    O T T H R N S I MTHS DIRECT SUBSIDY        PACE           PACE COST
            I   RA   DATE     A A B P C C T N  D    PAYMENT AMT     PREMIUM ADD-0N    SHARING ADD-ON     TOTAL PAYMENT
 ------------ - ---- -----    - - - - - --- - ---- ------------------------------------------------------------------
 123456789A   F 5559 33700                          1.9770  200601 200601        000                   $0.00
    FIRST   S   5559 19491130         B     N   1        $129.17           $0.00             $0.00             $129.17
 987654321A   F 8084 10050                          1.0300  200601 200601        000                   $0.00
    SECOND  M   8084 19240306         B     Y   1         $62.22           $0.00             $0.00              $62.22
```

Source: Plan Communications User's Guide Appendices, Version 3.1 (April 18, 2008). Centers for Medicare & Medicaid Services.

8.2.5 Risk Adjustment Model Output Reports (MOR) (Slides 17-19)

CMS has developed two reports to support the MMR – the Part C Risk Adjustment MOR and the new RxHCC MOR. The MORs are used in conjunction with the MMR and beneficiary-specific information (residence-community vs. institution, Medicaid status, disability, etc.) to verify risk scores.

The reports are available monthly through MARx in flat file and report layout.

8.2.5.1 Part C Risk Adjustment MOR (Slide 18)

The Part C Risk Adjustment MOR displays the HCCs used by RAS to calculate risk adjustment factors for each beneficiary. This report displays the HCC Disease Groups used by the CMS-HCC model and disease and demographic interactions.

The Part C Risk Adjustment MOR provides detailed beneficiary level information on:

- Enrollee identifiers (HICs, name, date of birth).
- The appropriate sex and age group, as well as other demographic factors for an individual (if applicable).
- The specific disease groups (HCCs) triggered.
- Disease interactions.

The Part C Risk Adjustment MOR provides detailed information on the specific disease groups and disease interactions triggered for an enrollee. Disease hierarchies are not identified separately. If a hierarchy exists, only the most severe manifestation in the hierarchy is displayed on the report.

Example: 3

If a beneficiary triggered HCC 7 (Metastatic Cancer and Acute Leukemia) and HCC 9 (Lymphatic, Head and Neck, Brain, and Other Major Cancers), the report will reflect HCC 7, not HCC 9 because HCC7 is the most severe manifestation of the disease.

Organizations receiving frailty adjustment should review their overall risk score, which represents the output of the CMS-HCC model and the frailty score. Beneficiaries under the age of 55 and beneficiaries who have an institutional factor do not receive frailty scores. Organizations receiving frailty adjustment can find their plan level frailty score on HPMS. PACE organizations must then determine whether the score is a new enrollee or institutional score and determine which factors on a given HCC apply. The report includes Medicaid information, individual HCCs, and the interaction of HCCs. PACE organizations should also review the values associated with each individual condition and the appropriate community or institutional numbers. A final reconciliation of HCCs may prove useful in the analysis.

Table 8G provides descriptions of the fields in the Part C MOR, and Table 8I provides the complete record layout for the Part C MOR.

TABLE 8G – PART C RISK ADJUSTMENT MOR FIELD SUMMARY

REPORT BODY = 162 bytes	
Fields	**Description**
1	Record Type
2-8	Beneficiary Identifying Information.
9-20	The sex and age group for the female beneficiary.
21-32	The sex and age group for the male beneficiary.
33-34	Medicaid indicators for Female Beneficiary.
35-36	Medicaid indicators for Male Beneficiary.
37	Originally Disabled Female.
38	Originally Disabled Male.
39-108	Disease Coefficients. Field 38 represents HCC 1. Field 107 represents HCC 177.
109-113	Disabled Disease HCC. Field 108 represents HCC 5. Field 112 represents HCC 107.
114-119	Disease Interactions.

8.2.5.2 RAS RxHCC MOR (Slide 19)

With the implementation of Part D, CMS created the RxHCC model for Prescription Drug Plans. The Part D model predicts plan liability for prescription drugs, uses different diseases to predict drug costs, and includes multipliers for incremental costs related to low-income and long term institutional beneficiaries.

The Part D model, like the CMS-HCC model, provides for some disease groups to fall into hierarchies. Diseases with higher levels of severity may include intensified drug regimens or additional drug needs for treatment. The hierarchies for the Part D model are triggered by the highest cost category of the related diseases. Lower cost categories do not increase the Part D risk score.

The RAS RxHCC MOR displays the RxHCCs for each beneficiary. The report is formatted similarly to the Part C Risk Adjustment MOR. The RxHCCs can be used by plans to verify the beneficiaries risk factors provided in the MMR. Summing the risk factors for an individual beneficiary yields a total risk adjustment factor.

Table 8H provides a sample description of the fields in the RxHCC MOR, and Table 8J provides the complete record layout for the RxHCC MOR.

TABLE 8H – RXHCC MOR FIELD SUMMARY

REPORT BODY = 164 bytes	
Fields	**Description**
1	Record Type
2-8	Beneficiary Identifying Information.
9-20	The sex and age group for the female beneficiary.
21-32	The sex and age group for the male beneficiary.
33	Originally Disabled Female.
34	Originally Disabled Male.
35-119	Disease Coefficients RxHCCs. Field 35 represents RxHCC1. Field 119 represents RxHCC 187.
120-122	Disabled Disease RxHCC. Field 120 represents RxHCC 65. Field 122 represents RxHCC 108.

TABLE 8I – PART C RISK ADJUSTMENT MODEL OUTPUT DATA FILE

Header Record Format

#	Field Name	Len	Pos	Description
1	Record Type	1	1	Set to '1'
2	Contract Number	5	2 – 6	Managed Care Organization (MCO) identification number
3	Run Date	8	7 – 14	Date when file was created, YYYYMMDD
4	Payment Year and Month	6	15 – 20	Identifies the risk adjustment payment year and month for the model run
5	Filler	142	21 – 162	Spaces

Detail/Beneficiary Record Format

#	Field Name	Len	Pos	Description
1	Record Type	1	1	Set to '2'
2	Health Insurance Claim Number	12	2 – 13	This is the Health Insurance Claim Number (known as HICN) identifying the primary Medicare Beneficiary under the SSA or RRB programs. The HICN consist of Beneficiary Claim Number (BENE_CAN_NUM) along with the Beneficiary Identification Code (BIC_CD) uniquely identifies a Medicare Beneficiary. For the RRB program, the claim account number is a 12 bytes account number.
3	Beneficiary Last Name	12	14 – 25	First 12 bytes of the Beneficiary Last Name
4	Beneficiary First Name	7	26 – 32	First 7 bytes of the Beneficiary First Name
5	Beneficiary Initial	1	33	Beneficiary Initial
6	Date of Birth	8	34 – 41	The date of birth of the Medicare Beneficiary. Format as YYYYMMDD.
7	Sex	1	42	Represents the sex of the Medicare Beneficiary. Examples include Male and Female. 0=unknown, 1=male, 2=female
8	Social Security Number	9	43 – 51	The beneficiary's current identification number that was assigned by the Social Security Administration.
9	Age Group Female0_34	1	51	The sex and age group for the beneficiary base on a given as of date. Female between ages of 0 through 34. Set to "1" if existed, otherwise '"0".
10	Age Group Female35_44	1	52	The sex and age group for the beneficiary base on a given as of date. Female between ages of 35 through 44. Set to "1" if existed, otherwise '"0".

TABLE 8I – PART C RISK ADJUSTMENT MODEL OUTPUT DATA FILE (CONTINUED)

Detail/Beneficiary Record Format

#	Field Name	Len	Pos	Description
11	Age Group Female45_54	1	54	The sex and age group for the beneficiary base on a given as of date. Female between ages of 45 through 54. Set to "1" if existed, otherwise '"0".
12	Age Group Female55_59	1	55	The sex and age group for the beneficiary base on a given as of date. Female between ages of 55 through 59. Set to "1" if existed, otherwise '"0".
13	Age Group Female60_64	1	56	The sex and age group for the beneficiary base on a given as of date. Female between ages of 60 through 64. Set to "1" if existed, otherwise '"0".
14	Age Group Female65_69	1	57	The sex and age group for the beneficiary base on a given as of date. Female between ages of 65 through 69. Set to "1" if existed, otherwise '"0".
15	Age Group Female70_74	1	58	The sex and age group for the beneficiary base on a given as of date. Female between ages of 70 through 74. Set to "1" if existed, otherwise '"0".
16	Age Group Female75_79	1	59	The sex and age group for the beneficiary base on a given as of date. Female between ages of 75 through 79. Set to "1" if existed, otherwise '"0".
17	Age Group Female80_84	1	60	The sex and age group for the beneficiary base on a given as of date. Female between ages of 80 through 84. Set to "1" if existed, otherwise '"0".
18	Age Group Female85_89	1	61	The sex and age group for the beneficiary base on a given as of date. Female between ages of 85 through 89. Set to "1" if existed, otherwise '"0".
19	Age Group Female90_94	1	62	The sex and age group for the beneficiary base on a given as of date. Female between ages of 90 through 94. Set to "1" if existed, otherwise '"0".
20	Age Group Female95_GT	1	63	The sex and age group for the beneficiary base on a given as of date. Female between age of 95 and greater. Set to "1" if existed, otherwise '"0".
21	Age Group Male0_34	1	64	The sex and age group for the beneficiary base on a given as of date. Male between ages of 0 through 34. Set to "1" if existed, otherwise '"0".
22	Age Group Male35_44	1	65	The sex and age group for the beneficiary base on a given as of date. Male between ages of 35 through 44. Set to "1" if existed, otherwise '"0".
23	Age Group Male45_54	1	66	The sex and age group for the beneficiary base on a given as of date. Male between ages of 45 through 54. Set to "1" if existed, otherwise '"0".

TABLE 8I – PART C RISK ADJUSTMENT MODEL OUTPUT DATA FILE (CONTINUED)

Detail/Beneficiary Record Format

#	Field Name	Len	Pos	Description
24	Age Group Male55_59	1	67	The sex and age group for the beneficiary base on a given as of date. Male between ages of 55 through 59. Set to "1" if existed, otherwise '"0".
25	Age Group Male60_64	1	68	The sex and age group for the beneficiary base on a given as of date. Male between ages of 60 through 64. Set to "1" if existed, otherwise '"0".
26	Age Group Male65_69	1	69	The sex and age group for the beneficiary base on a given as of date. Male between ages of 65 through 69. Set to "1" if existed, otherwise '"0".
27	Age Group Male70_74	1	70	The sex and age group for the beneficiary base on a given as of date. Male between ages of 70 through 74. Set to "1" if existed, otherwise '"0".
28	Age Group Male75_79	1	71	The sex and age group for the beneficiary base on a given as of date. Male between ages of 75 through 79. Set to "1" if existed, otherwise '"0".
29	Age Group Male80_84	1	72	The sex and age group for the beneficiary base on a given as of date. Male between ages of 80 through 84. Set to "1" if existed, otherwise '"0".
30	Age Group Male85_89	1	73	The sex and age group for the beneficiary base on a given as of date. Male between ages of 85 through 89. Set to "1" if existed, otherwise '"0".
31	Age Group Male90_94	1	74	The sex and age group for the beneficiary base on a given as of date. Male between ages of 90 through 94. Set to "1" if existed, otherwise '"0".
32	Age Group Male95_GT	1	75	The sex and age group for the beneficiary base on a given as of date. Male between age of 95 and greater. Set to "1" if existed, otherwise '"0".
33	Medicaid Female Disabled	1	76	Beneficiary is a female disabled and also entitled to Medicaid. Set to "1" if existed, otherwise '"0".
34	Medicaid Female Aged	1	77	Beneficiary is a female aged (> 64) and also entitled to Medicaid. Set to "1" if existed, otherwise '"0".
35	Medicaid Male Disabled	1	78	Beneficiary is a male disabled and also entitled to Medicaid. Set to "1" if existed, otherwise '"0".
36	Medicaid Male Aged	1	79	Beneficiary is a male aged (> 64) and also entitled to Medicaid. Set to "1" if existed, otherwise '"0".

TABLE 8I – PART C RISK ADJUSTMENT MODEL OUTPUT DATA FILE (CONTINUED)

Detail/Beneficiary Record Format

#	Field Name	Len	Pos	Description
37	Originally Disabled Female	1	80	Beneficiary is a female and original Medicare entitlement was due to disability. Set to "1" if existed, otherwise '"0".
38	Originally Disabled Male	1	81	Beneficiary is a male and original Medicare entitlement was due to disability. Set to "1" if existed, otherwise '"0".
39	Disease Coefficients HCC1	1	82	HIV/AIDS. Set to "1" if existed, otherwise '"0".
40	Disease Coefficients HCC2	1	83	Septicemia/Shock. Set to "1" if existed, otherwise '"0".
41	Disease Coefficients HCC5	1	84	Opportunistic Infections. Set to "1" if existed, otherwise '"0".
42	Disease Coefficients HCC7	1	85	Metastatic Cancer and Acute Leukemia. Set to "1" if existed, otherwise '"0".
43	Disease Coefficients HCC8	1	86	Lung, Upper Digestive Tract, and Other Severe Cancers. Set to "1" if existed, otherwise '"0".
44	Disease Coefficients HCC9	1	87	Lymphatic, Head and Neck, Brain, and Other Major Cancers. Set to "1" if existed, otherwise '"0".
45	Disease Coefficients HCC10	1	88	Breast, Prostate, Colorectal and Other Cancers and Tumors. Set to "1" if existed, otherwise '"0".
46	Disease Coefficients HCC15	1	89	Diabetes with Renal or Peripheral Circulatory Manifestation. Set to "1" if existed, otherwise '"0".
47	Disease Coefficients HCC16	1	90	Diabetes with Neurologic or Other Specified Manifestation. Set to "1" if existed, otherwise '"0".
48	Disease Coefficients HCC17	1	91	Diabetes with Acute Complications. Set to "1" if existed, otherwise '"0".
49	Disease Coefficients HCC18	1	92	Diabetes with Ophthalmologic or Unspecified Manifestation. Set to "1" if existed, otherwise '"0".

TABLE 8I – PART C RISK ADJUSTMENT MODEL OUTPUT DATA FILE (CONTINUED)

Detail/Beneficiary Record Format

#	Field Name	Len	Pos	Description
50	Disease Coefficients HCC19	1	93	Diabetes without Complication. Set to "1" if existed, otherwise '"0".
51	Disease Coefficients HCC21	1	94	Protein-Calorie Malnutrition. Set to "1" if existed, otherwise '"0".
52	Disease Coefficients HCC25	1	95	End-Stage Liver Disease. Set to "1" if existed, otherwise '"0".
53	Disease Coefficients HCC26	1	96	Cirrhosis of Liver Set to "1" if existed, otherwise '"0".
54	Disease Coefficients HCC27	1	97	Chronic Hepatitis. Set to "1" if existed, otherwise '"0".
55	Disease Coefficients HCC31	1	98	Intestinal Obstruction/Perforation. Set to "1" if existed, otherwise '"0".
56	Disease Coefficients HCC32	1	99	Pancreatic Disease. Set to "1" if existed, otherwise '"0".
57	Disease Coefficients HCC33	1	100	Inflammatory Bowel Disease. Set to "1" if existed, otherwise '"0".
58	Disease Coefficients HCC37	1	101	Bone/Joint/Muscle Infections/Necrosis. Set to "1" if existed, otherwise '"0".
59	Disease Coefficients HCC38	1	102	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease. Set to "1" if existed, otherwise '"0".
60	Disease Coefficients HCC44	1	103	Severe Hematological Disorders. Set to "1" if existed, otherwise '"0".
61	Disease Coefficients HCC45	1	104	Disorders of Immunity. Set to "1" if existed, otherwise '"0".
62	Disease Coefficients HCC51	1	105	Drug/Alcohol Psychosis. Set to "1" if existed, otherwise '"0".

TABLE 8I – PART C RISK ADJUSTMENT MODEL OUTPUT DATA FILE (CONTINUED)

Detail/Beneficiary Record Format

#	Field Name	Len	Pos	Description
63	Disease Coefficients HCC52	1	106	Drug/Alcohol Dependence. Set to "1" if existed, otherwise "'0".
64	Disease Coefficients HCC54	1	107	Schizophrenia. Set to "1" if existed, otherwise "'0".
65	Disease Coefficients HCC55	1	108	Major Depressive, Bipolar, and Paranoid Disorders. Set to "1" if existed, otherwise "'0".
66	Disease Coefficients HCC67	1	109	Quadriplegia, Other Extensive Paralysis. Set to "1" if existed, otherwise "'0".
67	Disease Coefficients HCC68	1	110	Paraplegia. Set to "1" if existed, otherwise "'0".
68	Disease Coefficients HCC69	1	111	Spinal Cord Disorders/Injuries. Set to "1" if existed, otherwise "'0".
69	Disease Coefficients HCC70	1	112	Muscular Dystrophy. Set to "1" if existed, otherwise "'0".
70	Disease Coefficients HCC71	1	113	Polyneuropathy. Set to "1" if existed, otherwise "'0".
71	Disease Coefficients HCC72	1	114	Multiple Sclerosis. Set to "1" if existed, otherwise "'0".
72	Disease Coefficients HCC73	1	115	Parkinson's and Huntington's Diseases. Set to "1" if existed, otherwise "'0".
73	Disease Coefficients HCC74	1	116	Seizure Disorders and Convulsions. Set to "1" if existed, otherwise "'0".
74	Disease Coefficients HCC75	1	117	Coma, Brain Compression/Anoxic Damage. Set to "1" if existed, otherwise "'0".
75	Disease Coefficients HCC77	1	118	Respirator Dependence/Tracheostomy Status. Set to "1" if existed, otherwise "'0".

TABLE 8I – PART C RISK ADJUSTMENT MODEL OUTPUT DATA FILE (CONTINUED)

Detail/Beneficiary Record Format

#	Field Name	Len	Pos	Description
76	Disease Coefficients HCC78	1	119	Respiratory Arrest. Set to "1" if existed, otherwise '"0".
77	Disease Coefficients HCC79	1	120	Cardio-Respiratory Failure and Shock. Set to "1" if existed, otherwise '"0".
78	Disease Coefficients HCC80	1	121	Congestive Heart Failure. Set to "1" if existed, otherwise '"0".
79	Disease Coefficients HCC81	1	122	Acute Myocardial Infarction. Set to "1" if existed, otherwise '"0".
80	Disease Coefficients HCC82	1	123	Unstable Angina and Other Acute Ischemic Heart Disease. Set to "1" if existed, otherwise '"0".
81	Disease Coefficients HCC83	1	124	Angina Pectoris/Old Myocardial Infarction. Set to "1" if existed, otherwise '"0".
82	Disease Coefficients HCC92	1	125	Specified Heart Arrhythmias. Set to "1" if existed, otherwise '"0".
83	Disease Coefficients HCC95	1	126	Cerebral Hemorrhage. Set to "1" if existed, otherwise '"0".
84	Disease Coefficients HCC96	1	127	Ischemic or Unspecified Stroke. Set to "1" if existed, otherwise '"0".
85	Disease Coefficients HCC100	1	128	Hemiplegia/Hemiparesis. Set to "1" if existed, otherwise '"0".
86	Disease Coefficients HCC101	1	129	Cerebral Palsy and Other Paralytic Syndromes. Set to "1" if existed, otherwise '"0".
87	Disease Coefficients HCC104	1	130	Vascular Disease with Complications. Set to "1" if existed, otherwise '"0".
88	Disease Coefficients HCC105	1	131	Vascular Disease. Set to "1" if existed, otherwise '"0".

TABLE 8I – PART C RISK ADJUSTMENT MODEL OUTPUT DATA FILE (CONTINUED)

Detail/Beneficiary Record Format

#	Field Name	Len	Pos	Description
89	Disease Coefficients HCC107	1	132	Cystic Fibrosis. Set to "1" if existed, otherwise "'0".
90	Disease Coefficients HCC108	1	133	Chronic Obstructive Pulmonary Disease. Set to "1" if existed, otherwise "'0".
91	Disease Coefficients HCC111	1	134	Aspiration and Specified Bacterial Pneumonias. Set to "1" if existed, otherwise "'0".
92	Disease Coefficients HCC112	1	135	Pneumococcal Pneumonia, Empyema, Lung Abscess. Set to "1" if existed, otherwise "'0".
93	Disease Coefficients HCC119	1	136	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage. Set to "1" if existed, otherwise "'0".
94	Disease Coefficients HCC130	1	137	Dialysis Status. Set to "1" if existed, otherwise "'0".
95	Disease Coefficients HCC131	1	138	Renal Failure. Set to "1" if existed, otherwise "'0".
96	Disease Coefficients HCC132	1	139	Nephritis. Set to "1" if existed, otherwise "'0".
97	Disease Coefficients HCC148	1	140	Decubitus Ulcer of Skin. Set to "1" if existed, otherwise "'0".
98	Disease Coefficients HCC149	1	141	Chronic Ulcer of Skin, Except Decubitus. Set to "1" if existed, otherwise "'0".
99	Disease Coefficients HCC150	1	142	Extensive Third-Degree Burns. Set to "1" if existed, otherwise "'0".
100	Disease Coefficients HCC154	1	143	Severe Head Injury. Set to "1" if existed, otherwise "'0".
101	Disease Coefficients HCC155	1	144	Major Head Injury Set to "1" if existed, otherwise "'0".

TABLE 8I – PART C RISK ADJUSTMENT MODEL OUTPUT DATA FILE (CONTINUED)

Detail/Beneficiary Record Format

#	Field Name	Len	Pos	Description
102	Disease Coefficients HCC157	1	145	Vertebral Fractures without Spinal Cord Injury. Set to "1" if existed, otherwise '"0".
103	Disease Coefficients HCC158	1	146	Hip Fracture/Dislocation. Set to "1" if existed, otherwise '"0".
104	Disease Coefficients HCC161	1	147	Traumatic Amputation. Set to "1" if existed, otherwise '"0".
105	Disease Coefficients HCC164	1	148	Major Complications of Medical Care and Trauma. Set to "1" if existed, otherwise '"0".
106	Disease Coefficients HCC174	1	149	Major Organ Transplant Status. Set to "1" if existed, otherwise '"0".
107	Disease Coefficients HCC176	1	150	Artificial Openings for Feeding or Elimination. Set to "1" if existed, otherwise '"0".
108	Disease Coefficients HCC177	1	151	Amputation Status, Lower Limb/Amputation Complications. Set to "1" if existed, otherwise '"0".
109	Disabled Disease HCC5	1	152	Disabled*Opportunistic Infections. Set to "1" if existed, otherwise '"0".
110	Disabled Disease HCC44	1	153	Disabled*Severe Hematological Disorders. Set to "1" if existed, otherwise '"0".
111	Disabled Disease HCC51	1	154	Disabled*Drug/Alcohol Psychosis. Set to "1" if existed, otherwise '"0".
112	Disabled Disease HCC52	1	155	Disabled*Drug/Alcohol Dependence. Set to "1" if existed, otherwise '"0".
113	Disabled Disease HCC107	1	156	Disabled*Cystic Fibrosis. Set to "1" if existed, otherwise '"0".
114	Disease Interactions INT1	1	157	DM_CHF. Set to "1" if existed, otherwise '"0".
115	Disease Interactions INT2	1	158	DM_CVD. Set to "1" if existed, otherwise '"0".

TABLE 8I – PART C RISK ADJUSTMENT MODEL OUTPUT DATA FILE (CONTINUED)

Detail/Beneficiary Record Format

#	Field Name	Len	Pos	Description
116	Disease Interactions INT3	1	159	CHF_COPD. Set to "1" if existed, otherwise "'0".
117	Disease Interactions INT4	1	160	COPD_CVD_CAD. Set to "1" if existed, otherwise "'0".
118	Disease Interactions INT5	1	161	RF_CHF. Set to "1" if existed, otherwise "'0".
119	Disease Interactions INT6	1	162	RF_CHF_DM. Set to "1" if existed, otherwise "'0".

Trailer Record Format

#	Field Name	Len	Pos	Description
1	Record Type	1	1	Set to '3'
2	Contract Number	5	2 – 6	Managed Care Organization (MCO) identification number
3	Total Record Count	9	7 – 15	Record count in display format 9(9). Includes header and trailer records.
4	Filler	147	16 – 162	Spaces

TABLE 8J – RAS Rx-HCC MOR RECORD FORMAT

Header Record Format

#	Field Name	Data Type	Starting Position	Ending position	Field Length	Comment	Field Description
1	Record Type Code	Char(1)	1	1	1	Set to "1"	1 = Header, 2 = Details, 3 = Trailer
2	Contract Number	Char(5)	2	6	5		Unique identification for a Medicare Advantage or stand-alone Prescription Drug Plan contract.
3	Run Date	Char(8)	7	14	8	Format as yyyymmdd	The run date when this file was created.
4	Payment Year and Month	Char(6)	15	20	6	Format as yyyymm	This identifies the risk adjustment payment year and month for the model run.
5	Filler	Char(142)	21	**164**	**144**	Spaces	

Detail/Beneficiary Record Format

#	Field Name	Data Type	Starting Position	Ending position	Field Length	Comment	Field Description
1	Record Type Code	Char(1)	1	1	1	Set to "2"	1 = Header, 2 = Details, 3 = Trailer
2	Health Insurance Claim Account Number	Char(12)	2	13	12	Also known as HICAN	This is the Health Insurance Claim Account Number (known as HICAN) identifying the primary Medicare Beneficiary under the SSA or RRB programs. The HICAN consist of Beneficiary Claim Number (BENE_CAN_NUM) along with the Beneficiary Identification Code (BIC_CD) uniquely identifies a Medicare Beneficiary. For the RRB program, the claim account number is a 12-byte account number.

TABLE 8J – RAS Rx-HCC MOR RECORD FORMAT (CONTINUED)

Detail/Beneficiary Record Format

#	Field Name	Data Type	Starting Position	Ending position	Field Length	Comment	Field Description
3	Beneficiary Last Name	Char(12)	14	25	12	First 12 bytes of the Bene Last Name	Beneficiary Last Name
4	Beneficiary First Name	Char(7)	26	32	7	First 7 bytes of the bene First Name	Beneficiary First Name
5	Beneficiary Initial	Char(1)	33	33	1	1 byte Initial	Beneficiary Initial
6	Date of Birth	Char(8)	34	41	8	Formatted as yyyymmdd	The date of birth of the Medicare Beneficiary
7	Sex	Char(1)	42	42	1	0=unknown, 1=male, 2=female	Represents the sex of the Medicare Beneficiary. Examples include Male and Female.
8	Social Security Number	Char(9)	43	51	9	Also known as SSN_NUM	The beneficiary's current identification number that was assigned by the Social Security Administration.
9	Age Group Female 0-34	Char(1)	52	52	1	Set to "1" if applicable, otherwise "'0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 0 through 34.
10	Age Group Female35_44	Char(1)	53	53	1	Set to "1" if applicable, otherwise "'0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 35 through 44.
11	Age Group Female45_54	Char(1)	54	54	1	Set to "1" if applicable, otherwise "'0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 45 through 54.

TABLE 8J – Rx-HCC HCC MOR RECORD FORMAT (CONTINUED)

Detail/Beneficiary Record Format

#	Field Name	Data Type	Starting Position	Ending position	Field Length	Comment	Field Description
12	Age Group Female55_59	Char(1)	55	55	1	Set to "1" if applicable, otherwise "'0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 55 through 59.
13	Age Group Female60_64	Char(1)	56	56	1	Set to "1" if applicable, otherwise "'0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 60 through 64.
14	Age Group Female65_69	Char(1)	57	57	1	Set to "1" if applicable, otherwise "'0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 65 through 69.
15	Age Group Female70_74	Char(1)	58	58	1	Set to "1" if applicable, otherwise "'0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 70 through 74.
16	Age Group Female75_79	Char(1)	59	59	1	Set to "1" if applicable, otherwise "'0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 75 through 79.
17	Age Group Female80_84	Char(1)	60	60	1	Set to "1" if applicable, otherwise "'0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 80 through 84.
18	Age Group Female85_89	Char(1)	61	61	1	Set to "1" if applicable, otherwise "'0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 85 through 89.
19	Age Group Female90_94	Char(1)	62	62	1	Set to "1" if applicable, otherwise "'0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 90 through 94.

TABLE 8J – RAS Rx-HCC MOR RECORD FORMAT (CONTINUED)

Detail/Beneficiary Record Format

#	Field Name	Data Type	Starting Position	Ending position	Field Length	Comment	Field Description
20	Age Group Female95_GT	Char(1)	63	63	1	Set to "1" if applicable, otherwise "'0"	The sex and age group for the beneficiary based on a given as of date. Female between ages of 95 and greater.
21	Age Group Male0_34	Char(1)	64	64	1	Set to "1" if applicable, otherwise "'0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 0 through 34.
22	Age Group Male35_44	Char(1)	65	65	1	Set to "1" if applicable, otherwise "'0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 35 through 44.
23	Age Group Male45_54	Char(1)	66	66	1	Set to "1" if applicable, otherwise "'0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 45 through 54.
24	Age Group Male55_59	Char(1)	67	67	1	Set to "1" if applicable, otherwise "'0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 55 through 59.
25	Age Group Male60_64	Char(1)	68	68	1	Set to "1" if applicable, otherwise "'0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 60 through 64.
26	Age Group Male65_69	Char(1)	69	69	1	Set to "1" if applicable, otherwise "'0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 65 through 69.
27	Age Group Male70_74	Char(1)	70	70	1	Set to "1" if applicable, otherwise "'0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 70 through 74.

TABLE 8J – RAS Rx-HCC MOR RECORD FORMAT (CONTINUED)

Detail/Beneficiary Record Format

#	Field Name	Data Type	Starting Position	Ending position	Field Length	Comment	Field Description
28	Age Group Male75_79	Char(1)	71	71	1	Set to "1" if applicable, otherwise "'0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 75 through 79.
29	Age Group Male80_84	Char(1)	72	72	1	Set to "1" if applicable, otherwise "'0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 80 through 84.
30	Age Group Male85_89	Char(1)	73	73	1	Set to "1" if applicable, otherwise "'0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 85 through 89.
31	Age Group Male90_94	Char(1)	74	74	1	Set to "1" if applicable, otherwise "'0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 90 through 94.
32	Age Group Male95_GT	Char(1)	75	75	1	Set to "1" if applicable, otherwise "'0"	The sex and age group for the beneficiary based on a given as of date. Male between ages of 95 and greater.
33	Originally Disabled Female	Char(1)	76	76	1	Set to "1" if applicable, otherwise "'0"	Beneficiary is a female aged (age>64) and original Medicare entitlement was due to disability.
34	Originally Disabled Male	Char(1)	77	77	1	Set to "1" if applicable, otherwise "'0"	Beneficiary is a male aged (age>64) and original Medicare entitlement was due to disability.
35	Disease Coefficients RXHCC1	Char(1)	78	78	1	Set to "1" if applicable, otherwise "'0"	HIV/AIDS

TABLE 8J – RAS Rx-HCC MOR RECORD FORMAT (CONTINUED)

Detail/Beneficiary Record Format

#	Field Name	Data Type	Starting Position	Ending position	Field Length	Comment	Field Description
36	Disease Coefficients RXHCC2	Char(1)	79	79	1	Set to "1" if applicable, otherwise "'0"	Opportunistic Infections
37	Disease Coefficients RXHCC3	Char(1)	80	80	1	Set to "1" if applicable, otherwise "'0"	Infectious Diseases
38	Disease Coefficients RXHCC8	Char(1)	81	81	1	Set to "1" if applicable, otherwise "'0"	Acute Myeloid Leukemia
39	Disease Coefficients RXHCC9	Char(1)	82	82	1	Set to "1" if applicable, otherwise "'0"	Metastatic Cancer, Acute Leukemia, and Severe Cancers
40	Disease Coefficients RXHCC10	Char(1)	83	83	1	Set to "1" if applicable, otherwise "'0"	Lung, Upper Digestive Tract, and Other Severe Cancers
41	Disease Coefficients RXHCC17	Char(1)	84	84	1	Set to "1" if applicable, otherwise "'0"	Diabetes with Specified Complications
42	Disease Coefficients RXHCC18	Char(1)	85	85	1	Set to "1" if applicable, otherwise "'0"	Diabetes without Complication
43	Disease Coefficients RXHCC19	Char(1)	86	86	1	Set to "1" if applicable, otherwise "'0"	Disorders of Lipoid Metabolism
44	Disease Coefficients RXHCC20	Char(1)	87	87	1	Set to "1" if applicable, otherwise "'0"	Other Significant Endocrine and Metabolic Disorders

TABLE 8J – RAS Rx-HCC MOR RECORD FORMAT (CONTINUED)

Detail/Beneficiary Record Format

#	Field Name	Data Type	Starting Position	Ending position	Field Length	Comment	Field Description
45	Disease Coefficients RXHCC21	Char(1)	88	88	1	Set to "1" if applicable, otherwise "'0"	Other Specified Endocrine/Metabolic/ Nutritional Disorders
46	Disease Coefficients RXHCC24	Char(1)	89	89	1	Set to "1" if applicable, otherwise "'0"	Chronic Viral Hepatitis
47	Disease Coefficients RXHCC31	Char(1)	90	90	1	Set to "1" if applicable, otherwise "'0"	Chronic Pancreatic Disease
48	Disease Coefficients RXHCC33	Char(1)	91	91	1	Set to "1" if applicable, otherwise "'0"	Inflammatory Bowel Disease
49	Disease Coefficients RXHCC34	Char(1)	92	92	1	Set to "1" if applicable, otherwise "'0"	Peptic Ulcer and Gastrointestinal Hemorrhage
50	Disease Coefficients RXHCC37	Char(1)	93	93	1	Set to "1" if applicable, otherwise "'0"	Esophageal Disease
51	Disease Coefficients RXHCC39	Char(1)	94	94	1	Set to "1" if applicable, otherwise "'0"	Bone/Joint/Muscle Infections/Necrosis
52	Disease Coefficients RXHCC40	Char(1)	95	95	1	Set to "1" if applicable, otherwise "'0"	Bechets Syndrome and Other Connective Tissue Disease
53	Disease Coefficients RXHCC41	Char(1)	96	96	1	Set to "1" if applicable, otherwise "'0"	Rheumatoid Arthritis and Other Inflammatory Polyarthropathy

TABLE 8J – RAS Rx-HCC MOR RECORD FORMAT (CONTINUED)

Detail/Beneficiary Record Format

#	Field Name	Data Type	Starting Position	Ending position	Field Length	Comment	Field Description
54	Disease Coefficients RXHCC42	Char(1)	97	97	1	Set to "1" if applicable, otherwise "'0"	Inflammatory Spondylopathies
55	Disease Coefficients RXHCC43	Char(1)	98	98	1	Set to "1" if applicable, otherwise "'0"	Polymyalgia Rheumatica
56	Disease Coefficients RXHCC44	Char(1)	99	99	1	Set to "1" if applicable, otherwise "'0"	Psoriatic Arthropathy
57	Disease Coefficients RXHCC45	Char(1)	100	100	1	Set to "1" if applicable, otherwise "'0"	Disorders of the Vertebrae and Spinal Discs
58	Disease Coefficients RXHCC47	Char(1)	101	101	1	Set to "1" if applicable, otherwise "'0"	Osteoporosis and Vertebral Fractures
59	Disease Coefficients RXHCC48	Char(1)	102	102	1	Set to "1" if applicable, otherwise "'0"	Other Musculoskeletal and Connective Tissue Disorders
60	Disease Coefficients RXHCC51	Char(1)	103	103	1	Set to "1" if applicable, otherwise "'0"	Severe Hematological Disorders
61	Disease Coefficients RXHCC52	Char(1)	104	104	1	Set to "1" if applicable, otherwise "'0"	Disorders of Immunity
62	Disease Coefficients RXHCC54	Char(1)	105	105	1	Set to "1" if applicable, otherwise "'0"	Polycythemia Vera

TABLE 8J – RAS Rx-HCC MOR RECORD FORMAT (CONTINUED)

Detail/Beneficiary Record Format

#	Field Name	Data Type	Starting Position	Ending position	Field Length	Comment	Field Description
63	Disease Coefficients RXHCC55	Char(1)	106	106	1	Set to "1" if applicable, otherwise "'0"	Coagulation Defects and Other Specified Blood Diseases
64	Disease Coefficients RXHCC57	Char(1)	107	107	1	Set to "1" if applicable, otherwise "'0"	Delirium and Encephalopathy
65	Disease Coefficients RXHCC59	Char(1)	108	108	1	Set to "1" if applicable, otherwise "'0"	Dementia with Depression/Behavioral Disturbance
66	Disease Coefficients RXHCC60	Char(1)	109	109	1	Set to "1" if applicable, otherwise "'0"	Dementia/Cerebral Degeneration
67	Disease Coefficients RXHCC65	Char(1)	110	110	1	Set to "1" if applicable, otherwise "'0"	Schizophrenia
68	Disease Coefficients RXHCC66	Char(1)	111	111	1	Set to "1" if applicable, otherwise "'0"	Other Major Psychiatric Disorders
69	Disease Coefficients RXHCC67	Char(1)	112	112	1	Set to "1" if applicable, otherwise "'0"	Other Psychiatric Symptoms/Syndromes
70	Disease Coefficients RXHCC75	Char(1)	113	113	1	Set to "1" if applicable, otherwise "'0"	Attention Deficit Disorder
71	Disease Coefficients RXHCC76	Char(1)	114	114	1	Set to "1" if applicable, otherwise "'0"	Motor Neuron Disease and Spinal Muscular Atrophy

TABLE 8J – RAS Rx-HCC MOR RECORD FORMAT (CONTINUED)

Detail/Beneficiary Record Format

#	Field Name	Data Type	Starting Position	Ending position	Field Length	Comment	Field Description
72	Disease Coefficients RXHCC77	Char(1)	115	115	1	Set to "1" if applicable, otherwise "'0"	Quadriplegia, Other Extensive Paralysis, and Spinal Cord Injuries
73	Disease Coefficients RXHCC78	Char(1)	116	116	1	Set to "1" if applicable, otherwise "'0"	Muscular Dystrophy
74	Disease Coefficients RXHCC79	Char(1)	117	117	1	Set to "1" if applicable, otherwise "'0"	Polyneuropathy, Except Diabetic
75	Disease Coefficients RXHCC80	Char(1)	118	118	1	Set to "1" if applicable, otherwise "'0"	Multiple Sclerosis
76	Disease Coefficients RXHCC81	Char(1)	119	119	1	Set to "1" if applicable, otherwise "'0"	Parkinson's Disease
77	Disease Coefficients RXHCC82	Char(1)	120	120	1	Set to "1" if applicable, otherwise "'0"	Huntington's Disease
78	Disease Coefficients RXHCC83	Char(1)	121	121	1	Set to "1" if applicable, otherwise "'0"	Seizure Disorders and Convulsions
79	Disease Coefficients RXHCC85	Char(1)	122	122	1	Set to "1" if applicable, otherwise "'0"	Migraine Headaches
80	Disease Coefficients RXHCC86	Char(1)	123	123	1	Set to "1" if applicable, otherwise "'0"	Mononeuropathy, Other Abnormal Movement Disorders

TABLE 8J – RAS Rx-HCC MOR RECORD FORMAT (CONTINUED)

Detail/Beneficiary Record Format

#	Field Name	Data Type	Starting Position	Ending position	Field Length	Comment	Field Description
81	Disease Coefficients RXHCC87	Char(1)	124	124	1	Set to "1" if applicable, otherwise "'0"	Other Neurological Conditions/Injuries
82	Disease Coefficients RXHCC91	Char(1)	125	125	1	Set to "1" if applicable, otherwise "'0"	Congestive Heart Failure
83	Disease Coefficients RXHCC92	Char(1)	126	126	1	Set to "1" if applicable, otherwise "'0"	Acute Myocardial Infarction and Unstable Angina
84	Disease Coefficients RXHCC98	Char(1)	127	127	1	Set to "1" if applicable, otherwise "'0"	Hypertensive Heart Disease or Hypertension
85	Disease Coefficients RXHCC99	Char(1)	128	128	1	Set to "1" if applicable, otherwise "'0"	Specified Heart Arrhythmias
86	Disease Coefficients RXHCC102	Char(1)	129	129	1	Set to "1" if applicable, otherwise "'0"	Cerebral Hemorrhage and Effects of Stroke
87	Disease Coefficients RXHCC105	Char(1)	130	130	1	Set to "1" if applicable, otherwise "'0"	Pulmonary Embolism and Deep Vein Thrombosis
88	Disease Coefficients RXHCC106	Char(1)	131	131	1	Set to "1" if applicable, otherwise "'0"	Vascular Disease
89	Disease Coefficients RXHCC108	Char(1)	132	132	1	Set to "1" if applicable, otherwise "'0"	Cystic Fibrosis

TABLE 8J – RAS Rx-HCC MOR RECORD FORMAT (CONTINUED)

Detail/Beneficiary Record Format

#	Field Name	Data Type	Starting Position	Ending position	Field Length	Comment	Field Description
90	Disease Coefficients RXHCC109	Char(1)	133	133	1	Set to "1" if applicable, otherwise "'0"	Asthma and COPD
91	Disease Coefficients RXHCC110	Char(1)	134	134	1	Set to "1" if applicable, otherwise "'0"	Fibrosis of Lung and Other Chronic Lung Disorders
92	Disease Coefficients RXHCC111	Char(1)	135	135	1	Set to "1" if applicable, otherwise "'0"	Aspiration and Specified Bacterial Pneumonias
93	Disease Coefficients RXHCC112	Char(1)	136	136	1	Set to "1" if applicable, otherwise "'0"	Empyema, Lung Abscess, and Fungal and Parasitic Lung Infections
94	Disease Coefficients RXHCC113	Char(1)	137	137	1	Set to "1" if applicable, otherwise "'0"	Acute Bronchitis and Congenital Lung/Respiratory Anomaly
95	Disease Coefficients RXHCC120	Char(1)	138	138	1	Set to "1" if applicable, otherwise "'0"	Vitreous Hemorrhage and Vascular Retinopathy, Except Diabetic
96	Disease Coefficients RXHCC121	Char(1)	139	139	1	Set to "1" if applicable, otherwise "'0"	Macular Degeneration and Retinal Disorders, Except Detachment and Vascular Retinopathies
98	Disease Coefficients RXHCC122	Char(1)	140	140	1	Set to "1" if applicable, otherwise "'0"	Open-angle Glaucoma
99	Disease Coefficients RXHCC123	Char(1)	141	141	1	Set to "1" if applicable, otherwise "'0"	Glaucoma and Keratoconus

TABLE 8J – RAS Rx-HCC MOR RECORD FORMAT (CONTINUED)

Detail/Beneficiary Record Format

#	Field Name	Data Type	Starting Position	Ending position	Field Length	Comment	Field Description
100	Disease Coefficients RXHCC126	Char(1)	142	142	1	Set to "1" if applicable, otherwise "'0"	Larynx/Vocal Cord Diseases
101	Disease Coefficients RXHCC129	Char(1)	143	143	1	Set to "1" if applicable, otherwise "'0"	Other Diseases of Upper Respiratory System
102	Disease Coefficients RXHCC130	Char(1)	144	144	1	Set to "1" if applicable, otherwise "'0"	Salivary Gland Diseases
103	Disease Coefficients RXHCC132	Char(1)	145	145	1	Set to "1" if applicable, otherwise "'0"	Kidney Transplant Status
104	Disease Coefficients RXHCC134	Char(1)	146	146	1	Set to "1" if applicable, otherwise "'0"	Chronic Renal Failure
105	Disease Coefficients RXHCC135	Char(1)	147	147	1	Set to "1" if applicable, otherwise "'0"	Nephritis
106	Disease Coefficients RXHCC137	Char(1)	148	148	1	Set to "1" if applicable, otherwise "'0"	Urinary Obstruction and Retention
107	Disease Coefficients RXHCC138	Char(1)	149	149	1	Set to "1" if applicable, otherwise "'0"	Fecal Incontinence
108	Disease Coefficients RXHCC139	Char(1)	150	150	1	Set to "1" if applicable, otherwise "'0"	Incontinence

TABLE 8J – RAS Rx-HCC MOR RECORD FORMAT (CONTINUED)

Detail/Beneficiary Record Format

#	Field Name	Data Type	Starting Position	Ending position	Field Length	Comment	Field Description
109	Disease Coefficients RXHCC140	Char(1)	151	151	1	Set to "1" if applicable, otherwise "'0"	Impaired Renal Function and Other Urinary Disorders
110	Disease Coefficients RXHCC144	Char(1)	152	152	1	Set to "1" if applicable, otherwise "'0"	Vaginal and Cervical Diseases
111	Disease Coefficients RXHCC145	Char(1)	153	153	1	Set to "1" if applicable, otherwise "'0"	Female Stress Incontinence
112	Disease Coefficients RXHCC157	Char(1)	154	154	1	Set to "1" if applicable, otherwise "'0"	Chronic Ulcer of Skin, Except Decubitus
113	Disease Coefficients RXHCC158	Char(1)	155	155	1	Set to "1" if applicable, otherwise "'0"	Psoriasis
114	Disease Coefficients RXHCC159	Char(1)	156	156	1	Set to "1" if applicable, otherwise "'0"	Cellulitis and Local Skin Infection
115	Disease Coefficients RXHCC160	Char(1)	157	157	1	Set to "1" if applicable, otherwise "'0"	Bullous Dermatoses and Other Specified Erythematous Conditions
116	Disease Coefficients RXHCC165	Char(1)	158	158	1	Set to "1" if applicable, otherwise "'0"	Vertebral Fractures without Spinal Cord Injury
117	Disease Coefficients RXHCC166	Char(1)	159	159	1	Set to "1" if applicable, otherwise "'0"	Pelvic Fracture

TABLE 8J – RAS Rx-HCC MOR RECORD FORMAT (CONTINUED)

Detail/Beneficiary Record Format

#	Field Name	Data Type	Starting Position	Ending position	Field Length	Comment	Field Description
118	Disease Coefficients RXHCC186	Char(1)	160	160	1	Set to "1" if applicable, otherwise '"0"	Major Organ Transplant Status
119	Disease Coefficients RXHCC187	Char(1)	161	161	1	Set to "1" if applicable, otherwise '"0"	Other Organ Transplant/Replacement
120	Disabled Disease RXHCC65	Char(1)	162	162	1	Set to "1" if applicable, otherwise '"0"	Disabled (Age<65) and Schizophrenia
121	Disabled Disease RXHCC66	Char(1)	163	163	1	Set to "1" if applicable, otherwise '"0"	Disable (Age<65) and Other Major Psychiatric Disorders
122	Disabled Disease RXHCC108	Char(1)	164	164	1	Set to "1" if applicable, otherwise '"0"	Disabled (Age<65) and Cystic Fibrosis
			164	164	164		

TABLE 8J – RAS Rx-HCC MOR RECORD FORMAT (CONTINUED)

Trailer Record Format

#	Field Name	Data Type	Starting Position	Ending Position	Field Length	Comment	Field Description
1	Record Type Code	Char(1)	1	1	1	Set to "3"	1 = Header, 2 = Details, 3 = Trailer
2	Contract Number	Char(5)	2	6	5		Unique identification for a Medicare Advantage or stand-alone Prescription Drug Plan contract.
3	Total Record Count	Char(9)	7	15	9	Includes all header and trailer records	Record count in display format 9(9).
4	Filler	Char(151)	16	164	149	Spaces	

Figure 8G illustrates an example of a Part C MOR report. Figure 8H illustrates an example of a RAS RxHCC MOR report.

Figure 8G – Part C MOR Report Format

```
1***GROUP=H8888,CONTRACT=H8888,
1RUN DATE: 20031219                    RISK ADJUSTMENT MODEL OUTPUT REPORT
PAGE:     1
PAYMENT MONTH: 200401                 PLAN: H8888 CHAMPION INSURANCE
RAPMORP1
0             LAST            FIRST                                        DATE OF
 HIC          NAME            NAME            I                            BIRTH    SEX & AGE GROUP
------------ --------------- ---------------  -                            -------- ---------------

 123456789A   WOOD            CHARLES         W                            19250225   Male75-79

 123456789B   TREE            LILLIAN         L                            19270418   Female75-79

 123456789A   GRASS           ALBERT          A                            19421213   Male60-64
 HCC DISEASE  GROUPS:  HCC019 Diabetes without Complication
                       HCC080 Congestive Heart Failure
                       HCC092 Specified Heart Arrhythmias
 INTERACTIONS:         INTI01 DM_CHF
```

Source: Plan Communications User's Guide Appendices, Version 3.1 (April 18, 2008). Centers for Medicare & Medicaid Services.

Figure 8H - RAS RxHCC MOR Report Format

```
1RUN DATE: 20060124                    RISK ADJUSTMENT MODEL OUTPUT REPORT
PAGE:     1
PAYMENT MONTH: 200602                 PLAN: H9999 ACME INSURANCE COMPANY
RAPMORP2
0             LAST                                    FIRST                                  DATE OF
 HIC          NAME                                    NAME                              I  BIRTH   SEX & AGE GROUP
 ------------ --------------------------------------- ---------------------------------- - -------- ------

 123456789A   TWO                                     RUTH                               M 19181122 Female85-89
 RXHCC DISEASE  GROUPS:  RXHCC019 Disorders of Lipoid Metabolism
                         RXHCC048 Other Musculoskeletal and Connective Tissue Disorders
                         RXHCC092 Acute Myocardial Infarction and Unstable Angina
                         RXHCC098 Hypertensive Heart Disease or Hypertension
                         RXHCC159 Cellulitis, Local Skin Infection

 123456789A   BREEZE                                  WINDY                              T 19620730 Female35-44
 RXHCC DISEASE  GROUPS:  RXHCC045 Disorders of the Vertebrae and Spinal Discs
                         RXHCC085 Migraine Headaches
                         RXHCC098 Hypertensive Heart Disease or Hypertension
                         RXHCC113 Acute Bronchitis and Congenital Lung/Respiratory Anomaly
                         RXHCC129 Other Diseases of Upper Respiratory System
                         RXHCC144 Vaginal and Cervical Diseases
```

Source: Plan Communications User's Guide Appendices, Version 3.1 (April 18, 2008). Centers for Medicare & Medicaid Services.