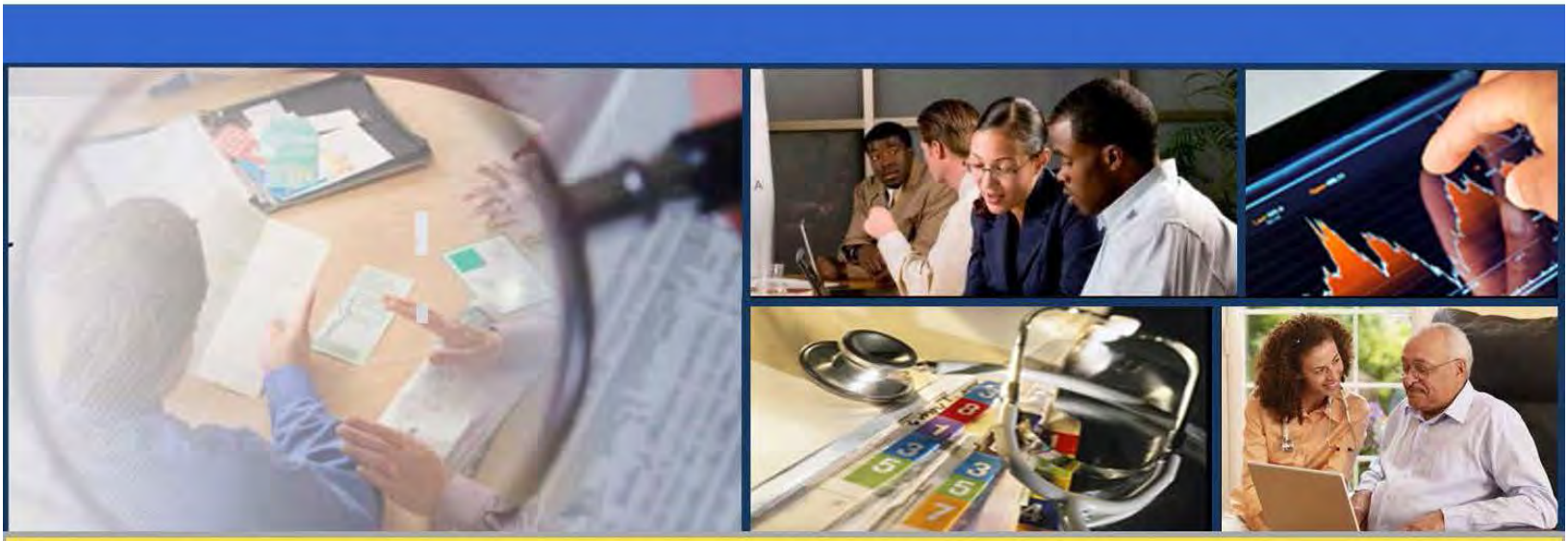
Risk Adjustment 101
Participant Guide



2013 NATIONAL TECHNICAL ASSISTANCE

July 23, 2013

Table of Contents

Tables

Figures

INTRODUCTION

Purpose

The Risk Adjustment 101 session provides an introduction and overview of the risk adjustment process and is intended to be a primer for National Technical Assistance. The session addresses connectivity/testing, key data elements for submission, the Risk Adjustment Processing System (RAPS), and reports. Participants will also be introduced to essential terminology, online resources, and contacts for risk adjustment.

About this Training

This Risk Adjustment training is organized into six modules:

1. **Overview -** Defines risk adjustment and its purpose while also providing essential terminology and acronyms.

2. **Connectivity and Testing -** Discusses the process for connecting to and testing the Risk Adjustment Processing System.

3. **Key Data Elements -** Provides an overview of the types of data required for risk adjustment, as well as acceptable sources for data collection.

4. **The Risk Adjustment Processing System (RAPS) -** Introduces the Risk Adjustment Processing System (RAPS), the format and flow for submitting risk adjustment data, and the timeline for RAPS submissions.

5. **Reports -** Presents the Front-End Risk Adjustment System (FERAS) and the CMS RAPS data logic and editing processes while describing FERAS and RAPS reports used by plans for risk adjustment.

6. **Resources -** Provides access to key resources and important links to ensure a foundation for understanding risk adjustment.

Risk Adjustment 101 Tools

The materials provided in this training include this participant guide and presentation slides. Table 1 provides a description of the materials included as part of this training.

TABLE 1 – RISK ADJUSTMENT 101 TOOLS

TOOLS	DESCRIPTION
Participant Guide	Provides supplemental information to assist participants during the session and to serve as a reference for future use.
Presentation Slides	Guide participants through the session by highlighting the information in the Participant Guide.

Throughout the participant guide, four icons are used to emphasize information. Figure A provides the meaning for each icon.

Figure 1 – Icon Key

ICON KEY	
Definition	
Example	
Reminder	
Resource	

Audience

This Risk Adjustment 101 program is designed for individuals who are either new to the risk adjustment process or desire a refresher of the basics. The primary audience for this program includes:

- 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;
- Specialty plans; and
- Third party submitters contracted to submit data on behalf of risk adjustment organizations.

Learning Objectives

At the completion of the Risk Adjustment 101 training, participants will be able to:

- Explain the history and purpose of risk adjustment.
- Define important risk adjustment terms and acronyms.
- Describe and access connectivity options for plans to submit risk adjustment data.
- List the required data elements for risk adjustment.
- Identify acceptable sources for data collection.
- Define RAPS and be familiar with the RAPS format.
- Follow the data flow for risk adjustment.
- Access the RAPS submission timeline.
- Discuss the logic applied by FERAS and RAPS.
- Identify RAPS transaction and management reports.
- Access valuable resources relating to risk adjustment.

MODULE 1 – OVERVIEW

Purpose

This Overview Module defines risk adjustment and focuses on its purpose and basic terminology in order to set the stage for the rest of the Risk Adjustment 101 session.

Learning Objectives

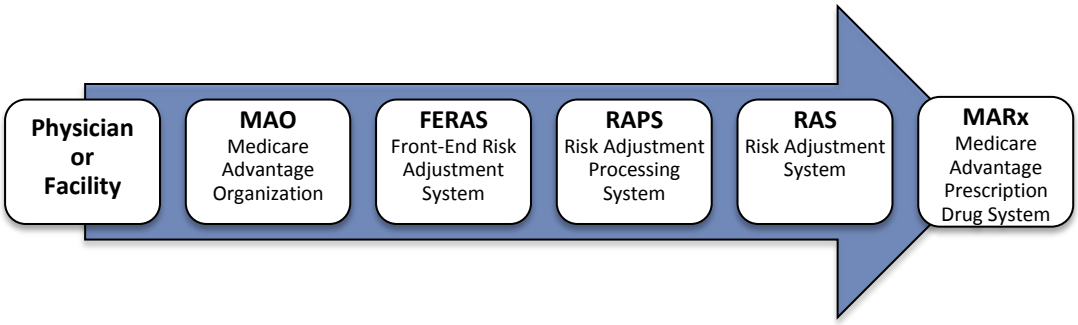
At the completion of this module, participants will be able to:

- Explain the history and purpose of risk adjustment.
- Define important risk adjustment terms and acronyms.
- Understand the practice of using models to calculate risk scores.

1.1 Risk Adjustment Definition

Risk adjustment is the method used to adjust bidding and payment to health plans based on demographics (i.e., age and sex) as well as actual health status of a plan's enrollees. Medicare risk adjustment is prospective, meaning diagnoses from the previous year and demographic information are used to predict future costs, and adjust payment. Figure 2 provides a high-level flow of risk adjustment data from submission to payment. This process is explained in more detail throughout this document.

Figure 2 – High-Level Risk Adjustment Data Flow



1.2 The Purpose of Risk Adjustment

Risk adjustment allows CMS to pay plans for the risk of the beneficiaries they enroll. By risk adjusting plan payments, CMS is able to make appropriate and accurate payments for enrollees with differences in expected costs. Increased accuracy benefits patients, providers, health plans, and the nation as a whole.

1.3 The History of Risk Adjustment

Risk adjustment methodology for Medicare Advantage (formerly Medicare + Choice) was first required in 1997 by the Balanced Budget Act (BBA). When CMS first implemented risk adjustment, hospital inpatient diagnoses were collected to determine payment to Medicare Advantage organizations. In 2000, with the Benefits Improvement and Protection Act of 2000 (BIPA), Congress mandated that ambulatory data also be collected. This change occurred gradually, and was fully implemented in 2007 with completion of 100% risk adjusted payments for the majority of MA organizations. Some demonstration plans, however, were not fully phased in until 2008.

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) established the prescription drug benefit (Part D) to go into effect under risk adjustment methodology in 2006.

1.4 Risk Adjustment Terms and Acronyms

Table 2 provides definitions of acronyms and terms used throughout this participant guide.

TABLE 2 – RISK ADJUSTMENT TERMS

ACRONYM OR TERM	DESCRIPTION
Demographics	Characteristics of a beneficiary such as age, sex, Medicaid status, and disability.
FERAS	Submitters send risk adjustment data to the Front-End Risk Adjustment System (FERAS) where front-end edits are performed.
HCC	The Hierarchical Condition Category is a diagnosis grouping with a single relative factor assigned to it for each model segment.
MARx UI	The Medicare Advantage Prescription Drug System (MARx) User Interface (UI) maintains Medicare beneficiary eligibility and payment data, and calculates the risk payment.
Model Run	The risk adjustment model is run to calculate risk scores for all beneficiaries with available data. This occurs three times each payment year: once for initial risk score, once for the mid-year update, and once for final reconciliation.
RAPS	Risk Adjustment Processing System (RAPS) processes risk adjustment data.
RAS	The Risk Adjustment System (RAS) that calculates the risk score.
Risk Adjustment Model	The risk adjustment model adjusts Medicare capitation payments to Medicare Advantage Organizations (MAOs) for expected health expenditures risk of their enrollees.
Status	Referred to as "Flags" on the MMR, these include additional characteristics of an enrollee that affect payment calculation, such as frailty, Medicaid, ESRD status, Medicare Secondary Payer (MSP) status, and Institutional status.

MODULE 2 – CONNECTIVITY AND TESTING

Purpose

Prior to submitting risk adjustment data, plans must establish a connection to CMS systems. In addition to submitting risk adjustment data to CMS, MA organizations use the electronic connection to receive reports. This module introduces the process for connecting to and testing the connection to CMS systems with the submission of test data.

Learning Objectives

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

- Access the Electronic Data Interchange (EDI) Agreement required for plans to participate in risk adjustment.
- Describe connectivity options for plans to submit risk adjustment data.
- Identify the testing requirements for connectivity.

Connectivity refers to the electronic connection between an MA organization and CMS.

2.1 Enrollment Package

New MA organizations must complete an Electronic Data Interchange (EDI) Agreement with CMS and submit it to the FERAS contractor, CMS Customer Service and Support Center (CSSC or also referred to as Palmetto), 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 by the MA organization. An officer (e.g., CEO) that represents the MA organization must sign this document and properly submit it to CSSC with an original signature. New plans must submit the EDI Agreement within one (1) month of their Health Plan Management System (HPMS) effective date.

MA organizations must make special arrangements to be able 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. Plans using a third party submitter must have a letter on file with CSSC indicating that the third party submitter has permission to submit on behalf of the plan. CMS holds the MA organization accountable for the content of submissions regardless of who submits the data.

MA organizations must complete, sign, and return the EDI Agreement for each plan number submitting data. If a new contract number is assigned, the MA organization must submit a new EDI Agreement.

RAPS Introduction Letter: This document provides instructions for completing the EDI Enrollment and Submitter Applications for Risk Adjustment Data Processing.

EDI Agreement: A CMS EDI Agreement must be completed for the specific data type, Risk Adjustment (RA) or Prescription Drug Event (PDE), by each contract, and be on file with CSSC, prior to submitting Test or Production Data.

Submitter ID Assignment: Submitter IDs are assigned to plans by CSSC and remain effective for ongoing submission of RA. This is the unique ID assigned to the contract that allows data submission and report retrieval. Plans must complete the Submitter Application and return it to CSSC with the completed EDI Agreement.

RAPS Connect:Direct Application: This document provides the Connect:Direct node connection information for CSSC's file transfer software product.

For forms and necessary documentation for connecting to CMS systems for submission of risk adjustment data, refer to the CSSC website at http://www.csscoperations.com > Risk Adjustment Processing System > Enroll to Submit Risk Adjustment Data.

2.2 Connectivity

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 AT&T Global Network Services (AGNS). To become connected, plans should contact AT&T or an AT&T re-seller.

In order to submit claims to FERAS, plans must be enrolled with CSSC. To become enrolled, plans should contact CSSC. As mentioned in the previous section, once plans are enrolled with CSSC to submit and retrieve data electronically, they receive a Submitter ID and a password.

For more information on Data Exchange Preparation Procedures, refer to http://www.cms.gov > Research, Statistics, Data and Systems: CMS Information Technology > MAPD Helpdesk > Plan Reference Guide for CMS Part C/D Systems > Connectivity Preparation > Downloads: Data Exchange Preparation Procedures (DEPP)

Table 3 describes the three connectivity options available to plans.

TABLE 3 – CONNECTIVITY OPTIONS

CONNECTION OPTION	DESCRIPTION
▪ Connect:Direct (File transfer software Product)	• For larger plans with enrollment of 100,000 or more • Formerly Network Data Mover (NDM) • Provides mainframe-to-mainframe connection • Provides next day receipt of FERAS response
▪ File Transfer Protocol (FTP)	• For plans of varying sizes • Provides modem-to-modem (dial-up) or lease line connection • Requires password and phone line • Provides same day receipt of FERAS response
▪ Gentran (CMS Enterprise File Transfer)	• For smaller plans with enrollment of 100,000 or less • Offers two connectivity options: – Secure File Transfer Protocol (SFTP); standards based protocol via a vender – Secure Hyper Text Transfer Protocol (HTTPS), secure web interface • Provides next day receipt of FERAS response
▪ TIBCO MFT Internet Server	• For smaller plans with less than 100,000 in enrollment • Provides IP transmissions over the Internet • Trading Partners must use an SFTP Client to transmit files to CMS • Provides next day receipt of FERAS response • Offers new option in 2013 (2012 was a transition year)

2.3 Testing Requirements

Submitter testing is required to ensure the flow of data from the submitter to FERAS works properly. Testing also ensures the data submitted is valid and formatted correctly. To send data in a test format, plans should contact CSSC at 877-534-2772 to notify them of their test submission. Test data will be processed at CMS, and reports will be available the next morning. When a plan calls CSSC prior to transmission of the first production or test file, a CSSC representative will be able to provide information on how to properly submit a test and/or production file.

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

If a new contract number is assigned to a plan and the submitter's system successfully submitted test data previously, CMS does not require additional testing.

Technical specifications are available based on the communication medium that is in use. The FERAS User Guide are available at http://www.csscoperations.com/ > Risk Adjustment Processing System > Front-End Risk Adjustment System (FERAS). Testing instructions for each medium are included within the document.

MODULE 3 – KEY DATA ELEMENTS

Purpose

For the purpose of risk adjustment, Medicare Advantage (MA) organizations must collect certain data from hospital inpatient facilities, hospital outpatient facilities, and physicians. The collection of data from the appropriate risk adjustment sources is critical for accurate risk adjusted payments. This module provides a high-level overview of the specific types of data that must be collected and submitted for risk adjustment.

Learning Objectives

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

- List the five (5) data elements required to be submitted for risk adjustment, plus the additional data element that will be required beginning with dates of service January 1, 2014
- Identify acceptable sources for data collection.

3.1 Data Elements

Risk scores are based on a combination of demographic and disease data. The demographic data is provided to CMS by the Social Security Administration, while the disease data is submitted by the MA Organizations in the form of diagnosis codes. All of this information is used in the risk adjustment models to calculate a risk score for each beneficiary in order to adjust payments to MA organizations and Prescription Drug Plans (PDPs).

CMS uses the following demographic factors when calculating a risk score:

- Age
- Sex
- Disability
- Original Reason for Entitlement (OREC)
- Medicaid Status
- Institutionalization
- Frailty

Beginning with dates of service January 1, 2014, there will be a new field that MAOs will be required to populate. This new field will identify diagnoses obtained from enrollee risk assessments. More information and guidance will be provided on the process for flagging enrollee risk assessments in the Risk Adjustment Processing System submissions.

The Social Security Administration (SSA) provides demographic information such as age and disability status to CMS. If a plan identifies a discrepancy for a beneficiary, the beneficiary may need to contact SSA to correct the error.

For detailed information on the use of demographics in risk score calculation, refer to the *2012 Risk Adjustment Regional Technical Assistance Participant Guide* at http://www.csscoperations.com/ > Risk Adjustment Processing System > Training

3.2 Submitted Data Elements

MA organizations must collect certain data elements from the sources (providers/physicians) of risk adjustment data. The five (5) minimum data elements that must be collected and submitted are:

- HIC (Health Insurance Claim) number,
- Provider Type
- From Date of Services,
- Through Date of Services, and
- Diagnosis Code.

3.2.1 HIC Number

A HIC number (HICN) 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 six-digit numbers preceded by an alpha character. After 1964, the RRB began using Social Security numbers as Medicare beneficiary identification numbers preceded by an alpha character. Table 4 shows the characteristics for each HIC type.

TABLE 4 – DESCRIPTION OF HIC NUMBERS

HIC TYPE	DESCRIPTION
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

Example 1 – HIC Numbers

A plan wanted to know why HIC numbers might change, so they searched the online FAQs at https://askriskadjustment.com/. They found out that in addition to being a patient's unique identification code, a HIC number also identifies the relationship between the beneficiary and the Medicare primary beneficiary. The SSN or RRB number is the code assigned to the wage earner under whose benefits the eligible person is receiving Medicare. Unlike a SSN, which is assigned only once during a person's lifetime, it is possible for a HIC to change throughout a person's life, when the relationship to the wage earner changes. HICs usually change because of a major life event, such as the death of a spouse. CMS systems crosswalk HIC numbers when they change.

The full FAQ can be found in the "Other" category under the FAQs tab at https://askriskadjustment.com/.

For an article about HIC number naming conventions see the SSA website at http://ssa-custhelp.ssa.gov/app/answers/detail/a_id/1366/~/meaning-of-the-letters-after-a-social-security-or-medicare-number.

3.2.2 Provider Type

MA organizations may only submit data from acceptable sources. Diagnoses must result from a face-to-face visit either with an acceptable physician specialty or from an acceptable facility, as determined by CMS.

3.2.2.1 Acceptable Sources for Data Collection

MA organizations are responsible for ensuring that the data they collect comes from acceptable sources. Acceptable provider types are broken into three categories: hospital inpatient, hospital outpatient, and physician services.

3.2.2.2 Hospital Inpatient Data

Hospital inpatient services include those for which the patient is admitted to the facility for at least one overnight stay. Covered and non-covered hospital inpatient facilities are listed below.

Covered Facilities
- Short-term (general and specialty) Hospitals
- Religious Non-Medical Health Care Institutions
- Long-term Hospitals
- Rehabilitation Hospitals
- Children's Hospitals
- Psychiatric Hospitals
- Medical Assistance Facilities/ Critical Access Hospitals

Non-Covered Facilities*
- 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.

3.2.2.3 Hospital Outpatient Data

Hospital outpatient services are therapeutic and rehabilitative services provided for sick or injured persons who do not require inpatient hospitalization or institutionalization. Covered and non-covered hospital outpatient facilities are listed below.

Covered Facilities
- Short-term (general and specialty) Hospitals
- Medical Assistance Facilities/Critical Access Hospitals
- Community Mental Health Centers
- Federally Qualified Health Centers
- Religious Non-Medical Health Care Institutions
- Long-term Hospitals
- Rehabilitation Hospitals
- Children's Hospitals
- Psychiatric Hospitals
- Rural Health Clinic (Free-standing and Provider-Based)

Non-Covered Facilities*
- 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 a comprehensive list.

Regardless of the type of diagnostic radiology bill (outpatient department or physician component), this hospital outpatient service is not acceptable for risk adjustment.

> Diagnostic radiologists typically do not document confirmed diagnoses. The diagnosis confirmation comes from referring physicians or physician extenders and is therefore not assigned in the medical record documentation from diagnostic radiology services alone.

Example 2 – Acceptable Providers

A plan asked if a claim from an outpatient hospital encounter must be accompanied by a face-to-face physician visit in order to be eligible for risk adjustment submission. They learned that diagnoses submitted to the Risk Adjustment Processing System (RAPS) must result from a face-to-face encounter either with an acceptable physician specialty or from an encounter in an acceptable facility. When a claim is received, a plan needs to determine whether the claim is from a facility or a professional. If the claim is from a facility (outpatient or inpatient), plans should determine whether that facility is acceptable for risk adjustment.

For detailed information on determining whether facilities are acceptable for risk adjustment, refer to the *2008 Participant Guide* at http://www.csscoperations.com/ > Archives > Risk Adjustment Processing System > Training

Please bear in mind that Inpatient coding guidelines differ from Outpatient coding guidelines, so plans should ensure that the diagnoses they submit are acceptable using the appropriate coding guidelines.

3.2.2.4 Provider Data

The collection of provider data for risk adjustment is associated with the provider's specialty. That is, all diagnoses that are required for the risk adjustment models and rendered as a result of face-to-face visits must be collected by MA organizations. This includes data collected from non-network as well as network providers. Table 5 provides the preliminary list of acceptable physician specialty types and their associated specialty codes for the 2014 Payment Year.

TABLE 5 – PRELIMINARY LIST OF ACCEPTABLE PHYSICIAN SPECIALTY TYPES
For 2014 Payment Year (2013 Dates of Service) Risk Adjustment Data Submission

CODE	SPECIALTY
1	General Practice
2	General Surgery
3	Allergy/Immunology
4	Otolaryngology
5	Anesthesiology
6	Cardiology
7	Dermatology
8	Family Practice
9	Interventional Pain Management (IPM)
10	Gastroenterology
11	Internal Medicine
12	Osteopathic Manipulative Medicine
13	Neurology
14	Neurosurgery
15	Speech Language Pathologist
16	Obstetrics/Gynecology
17	Hospice And Palliative Care
18	Ophthalmology
19	Oral Surgery
20	Orthopedic Surgery
21	Cardiac Electrophysiology
22	Pathology
23	Sports Medicine
24	Plastic And Reconstructive Surgery

CODE	SPECIALTY
25	Physical Medicine and Rehabilitation
26	Psychiatry
27	Geriatric Psychiatry
28	Colorectal Surgery
29	Pulmonary Disease
33*	Thoracic Surgery
34	Urology
35	Chiropractic
36	Nuclear Medicine
37	Pediatric Medicine
38	Geriatric Medicine
39	Nephrology
40	Hand Surgery
41	Optometry
42	Certified Nurse Midwife
43	Certified Registered Nurse Anesthetist
44	Infectious Disease
46*	Endocrinology
48*	Podiatry
50*	Nurse Practitioner
62*	Psychologist
64*	Audiologist
65	Physical Therapist
66	Rheumatology

CODE	SPECIALTY
67	Occupational Therapist
68	Clinical Psychologist
72*	Pain Management
76*	Peripheral Vascular Disease
77	Vascular Surgery
78	Cardiac Surgery
79	Addiction Medicine
80	Licensed Clinical Social Worker
81	Critical Care (intensivists)
82	Hematology
83	Hematology/Oncology
84	Preventive Medicine
85	Maxillofacial Surgery
86	Neuropsychiatry
89*	Certified Clinical Nurse Specialist
90	Medical Oncology
91	Surgical Oncology
92	Radiation Oncology
93	Emergency Medicine
94	Interventional Radiology
97*	Physician Assistant
98	Gynecologist/Oncologist
99	Unknown Physician Specialty
C0	Sleep Medicine

* Indicates that a preceding number(s) has been skipped.

Example 3 – Acceptable Physician Specialty Types

A plan asked if the multispecialty code (70) that they used to submit was no longer allowable for submission. They were told that the multispecialty type was no longer on the list of acceptable physician specialty types for risk adjustment data submission and therefore, should not be used.

For previous and current lists of Acceptable Physician Specialty Types, refer to the CSSC website at http://www.csscoperations.com > Risk Adjustment Processing System > References.

3.2.3 Dates of Service

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.

The dates of service submitted must be within the data collection year.

3.2.4 Diagnosis Code

Diagnoses must be supported by appropriate medical record documentation. Diagnosis codes are provided to CMS in the RAPS format. The diagnoses are currently in International Classification of Diseases, 9th Edition Clinical Modification (ICD-9-CM) coding, but are scheduled to be transitioned to the 10th Edition, or ICD-10, on October 1, 2014. Plans do not submit procedure codes [i.e., Current Procedural Terminology (CPT) codes or Healthcare Common Procedure Coding System (HCPCS) codes] to RAPS, but only diagnosis codes.

MODULE 4 – RISK ADJUSTMENT PROCESSING SYSTEM

Purpose

This module provides a definition of the Risk Adjustment Processing System (RAPS), a description of how the data flows through this system, the format for submitting risk adjustment data, and the timeline for RAPS submissions.

Learning Objectives

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

- Define RAPS.
- Describe the elements contained within a diagnosis cluster in the RAPS format.
- Follow the data flow for risk adjustment.
- Access and interpret the RAPS submission timeline.

4.1 RAPS Definition

RAPS is the Risk Adjustment Processing System through which risk adjustment data are processed.

After the data submitted by Medicare Advantage (MA) organizations passes the checks in the Front-End Risk Adjustment System (FERAS), the data is sent to the CMS data center for RAPS processing. RAPS performs complete editing of all detail records which are then stored in the RAPS database.

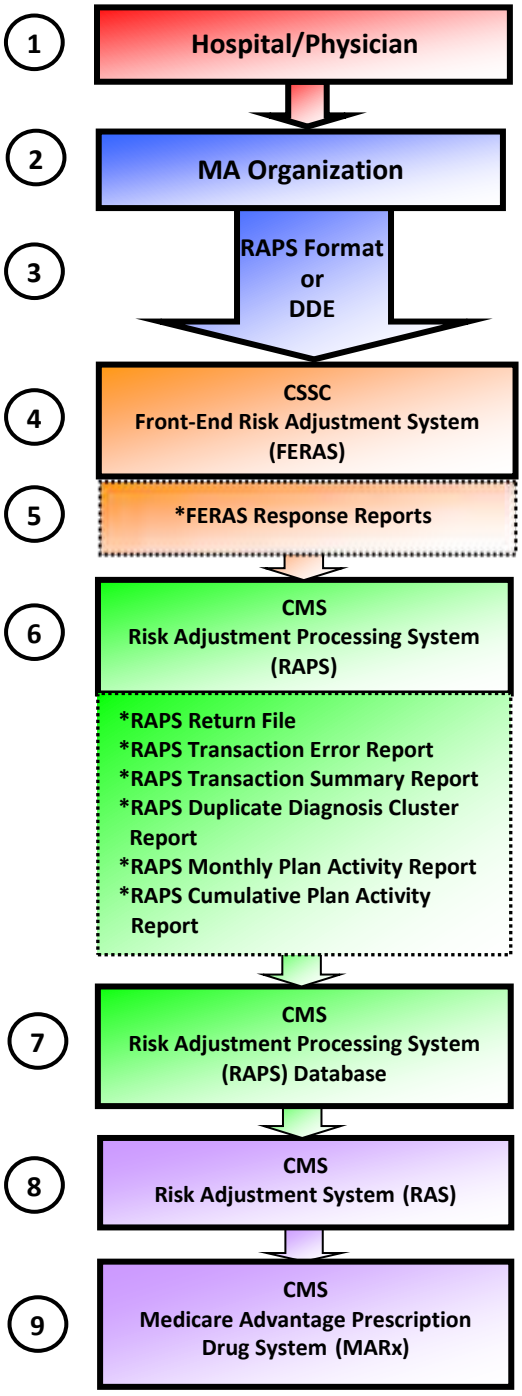
- As a precautionary measure, RAPS performs balancing checks to ensure that the complete file was received from FERAS prior to editing data.
- The RAPS system performs editing on the detail record transactions.
- Data elements edited include HIC Number, Provider Type, From Date, Through Date, and Diagnosis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

The CSSC website, http://www.csscoperations.com/ is the gateway to FERAS and RAPS resources. Visitors to the site can access information about FERAS and RAPS, including opportunities to enroll to submit risk adjustment data, and obtain comprehensive information about data entry and report layouts.

4.2 Data Flow for Risk Adjustment

Risk scores measure individual beneficiaries' relative risk and are used to adjust payments for each beneficiary's expected expenditures. In order to calculate individual risk scores, plans must submit data to RAPS based on beneficiary diagnoses. Accurate risk-adjusted payments rely on the diagnosis coding derived from the member's medical record. Figure 3 is a diagram of risk adjustment processing showing the sources of data and the flow of risk adjustment data from submission to payment.

Figure 3 – Risk Adjustment Dataflow



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

1. A physician documents a patient's visit in their medical record.
2. The physician's office or hospital codes the claim from the medical record and submits the data to the MA organization.
3. The MA organization converts and sends the diagnosis clusters in RAPS format or via Direct Data Entry (DDE) to CSSC's Front-End Risk Adjustment System (FERAS) at least quarterly.
4. The data goes to FERAS for processing where the file-level data, batch-level data, and first and last detail records are checked.
5. If any data are rejected, then data are reported on the FERAS Response Report.
6. After passing the FERAS checks, the file is submitted to the CMS Risk Adjustment Processing System (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 provide 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.
7. The RAPS database stores all finalized diagnosis clusters.
8. The Risk Adjustment System (RAS) executes the risk adjustment models and calculates the risk score using the SAS model.
9. The Medicare Advantage Prescription Drug System (MARx) processes payments to plans and issues the MMR and MOR (Reports).
10. CMS conducts annual data validation audits on selected plans that may have to request medical record documentation from the providers to support the submitted diagnoses.

4.3 RAPS Format

For RAPS processing, plans are required to submit accurate diagnostic data using the RAPS format. These submissions are organized into three levels of data. File-level information identifies the submitter, batch-level information identifies the MA organization, and detail-level information identifies the beneficiary.

There may be more than one batch per file, and more than one claim, or detail record, per batch. Within one file, a submitter may submit data for many MA organizations and many different beneficiaries. The RAPS format allows for up to 9,999,000 batches, and batches may contain up to 9,999,999 detail records. If submitters are going to submit files with greater than one million records in a day, CMS requests that the plan inform the CSSC in advance so that the CMS data center can be notified to expect the large file, and if necessary schedule the submission. Figure 4 provides a graphic representation of the RAPS file logic.

Figure 4 – RAPS File Logic

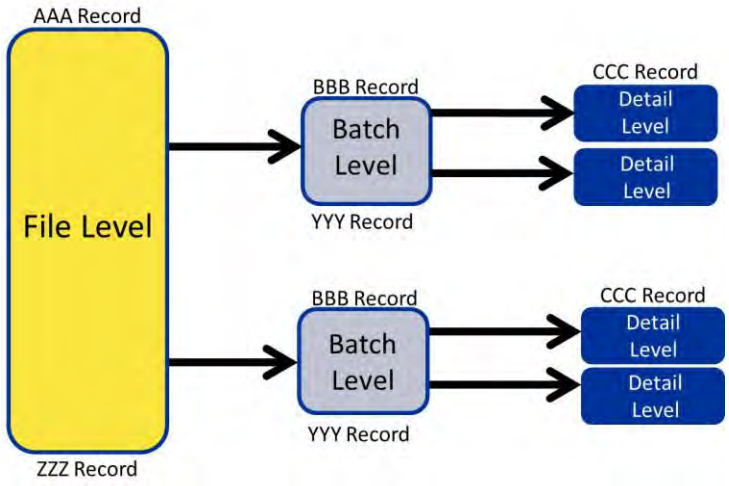


Table 6 shows the record types in the RAPS file layout and includes a brief description of the data included at each level. Tables 7, 8, 9, 10, and 11 show the full RAPS layout.

TABLE 6 – RAPS FILE LAYOUT RECORD TYPES

RECORD LEVEL	RECORD TYPE	DESCRIPTION	# OF FIELDS
File Header	AAA	Contains submitter and file information.	7
Batch Header	BBB	Contains plan and batch information.	4
Detail	CCC	Contains patient information and diagnosis clusters.	17
Batch Trailer	YYY	Contains plan and record trailer information.	5
File Trailer	ZZZ	Contains submitter and batch trailer information.	5

TABLE 7 – AAA RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	VALUE
1	RECORD-ID	1-3	X(3)	'AAA'
2	SUBMITTER-ID	4-9	X(6)	'Shnnnn'
3	FILE-ID	10-19	X(10)	
4	TRANSACTION-DATE	20-27	9(8)	'CCYYMMDD'
5	PROD-TEST-IND	28-31	X(4)	'PROD' Or 'TEST' Or 'CERT'
6	FILE-DIAG-TYPE	32-36	X(5)	'ICD9' Or 'ICD10'
7	FILLER	37-512	X(476)	SPACES

TABLE 8 – BBB RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	VALUE
1	RECORD-ID	1-3	X(3)	'BBB'
2	SEQ-NO	4-10	9(7)	Must begin with '0000001'
3	PLAN-NO	11-15	X(5)	'Hnnnn'
4	FILLER	16-512	X(497)	SPACES

TABLE 9 – CCC RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	VALUE
1	RECORD-ID	1-3	X(3)	'CCC'
2	SEQ-NO	4-10	9(7)	Must begin with '0000001'
3	SEQ-ERROR-CODE	11-13	X(3)	SPACES
4	PATIENT-CONTROL-NO	14-53	X(40)	Optional
5	HIC-NO	54-78	X(25)	
6	HIC-ERROR-CODE	79-81	X(3)	SPACES
7	PATIENT-DOB	82-89	X(8)	'CCYYMMDD'
8	DOB-ERROR-CODE	90-92	X(3)	SPACES
9 – 15	DIAGNOSIS-CLUSTER (10 OCCURRENCES)	93-412		
9.0	PROVIDER-TYPE		X(2)	HOSPITAL IP PRINCIPAL = 01 HOSPITAL IP OTHER = 02 HOSPITAL OP = 10 PHYSICIAN = 20
9.1	FROM-DATE		9(8)	'CCYYMMDD'
9.2	THRU-DATE		9(8)	'CCYYMMDD'
9.3	DELETE-IND		X(1)	SPACE or 'D'
9.4	DIAGNOSIS-CODE		X(7)	ICD-9 or ICD-10
9.5	DIAG-CLSTR-ERROR-1		X(3)	SPACES
9.6	DIAG-CLSTR-ERROR-2		X(3)	SPACES
16	CORRECTED-HIC-NO	413-437	X(35)	SPACES
17	FILLER	438-512	X(75)	SPACES

TABLE 10 – YYY RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	VALUE
1	RECORD-ID	1-3	X(3)	'YYY'
2	SEQ-NO	4-10	9(7)	Must begin with '0000001"
3	PLAN-NO	11-15	X(5)	'Hnnnn'
4	CCC-RECORD-TOTAL	16-22	9(7)	
5	FILLER	23-512	X(490)	SPACES

TABLE 11 – ZZZ RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	VALUE
1	RECORD-ID	1-3	X(3)	'ZZZ'
2	SUBMITTER-ID	4-9	X(6)	'SHnnnn'
3	FILE-ID	10-19	X(10)	
4	BBB-RECORD-TOTAL	20-26	9(7)	
5	FILLER	27-512	X(486)	SPACES

This full RAPS format is also available on the Risk Adjustment section of the CSSC website at: http://www.csscoperations.com > Risk Adjustment Processing System > Risk Adjustment Processing System (RAPS).

The AAA, or File Header record contains submitter and file related information. Data such as the Submitter ID will remain consistent and can be pre-populated. A file ID cannot be reused in a rolling 12-month period.

The BBB, or Batch Header record contains plan and batch information such as the sequence number which identifies the batch submitted since there may be multiple batches in a file. Also included here is the plan number which identifies the MA organization. If a submitter submits for multiple organizations, the plan number will change when they submit for different plans.

The CCC, or detail, record file contains identifying information such as the patient HIC number and date of birth. This record also includes the diagnosis cluster which contains the core information for calculating the risk factor. Table 12 describes the elements contained within the diagnosis cluster.

TABLE 12 – DIAGNOSIS CLUSTER

DATA ELEMENT	DESCRIPTION
Provider Type	• Codes created for risk adjustment and assigned to each source of data: Hospital inpatient (01 for principle diagnosis or 02 for secondary diagnosis) Hospital outpatient (10) Physician (20)
From Date of Service and Through Date of Service	• From and Through Dates of Service must be submitted in CCYYMMDD format. • The "Through Date" defines the data used in the data collection year for risk adjustment purposes.
Delete Indicator	• Allows the MA organization to delete a diagnosis, for correction purposes, that has been stored in the RAPS database. • This field is filled with a space when not being used.
Diagnosis Code	• Each required diagnosis code must be submitted at least once during a reporting period. • The decimal is implied in the format.

Medical history alone may not be used as a source of diagnoses for risk adjustment purposes. For a chronic condition to be accepted for risk adjustment, the patient must have a face-to-face visit each year with a provider/physician who assesses and documents that condition.

A maximum of 10 diagnosis clusters are allowed per detail record. Each cluster must include the items identified above. If a cluster with the same HIC number, provider type, from and through dates, and diagnosis are submitted more than once, a duplicate diagnosis cluster error will occur.

The YYY record, or batch trailer, follows the detail record. The YYY record has many of the same fields with the same information as the BBB, or batch header record.

The ZZZ record is the trailer to the AAA record, and therefore has similar fields. The ZZZ record informs CMS that it is the end of the file being submitted.

4.4 RAPS Submission Timeline

Model Run: The risk adjustment model is run to calculate risk scores for all beneficiaries with available data. This occurs three times each payment year: once for initial risk score, once for the mid-year update, and once for final reconciliation.

In order for data to be included in the model run, MA organizations must meet three submission deadlines each year: the first Friday in September, the first Friday in March, and January 31 after the payment year. It is important for plans to recognize the connection between the model runs and the dates of service. Table 13 shows the timetable for risk adjustment submission.

TABLE 13 – RISK ADJUSTMENT SUBMISSION TIMETABLE

PAYMENT YEAR	MODEL RUN	DATES OF SERVICE	Deadline
2013	Initial	7/1/2011 - 6/30/2012	9/7/2012
2013	Mid-Year	1/1/2012 - 12/31/2012	3/1/2013
2013	Final Reconciliation	1/1/2012 - 12/31/2012	1/31/2014
2014	Initial	7/1/2012 - 6/30/2013	9/6/2013
2014	Mid-Year	1/1/2013 - 12/31/2013	3/7/2014
2014	Final Reconciliation	1/1/2013 - 12/31/2013	1/31/2015

Plans should keep in mind that the model run timetable includes not only diagnosis information, but all statuses that affect risk adjustment. For example, if a beneficiary has a Medicaid status change that was received by CMS in November 2012, then the status change would not be included in the Initial 2013 model run, but would be retroactively adjusted in the Mid-Year 2013 model run.

Example 4 – Risk Adjustment Submission Deadlines

A plan received a diagnosis from a provider in December 2012, but did not submit the diagnosis to RAPS by the March 2013 deadline. The plan asked when the beneficiary's risk score would be adjusted.

The plan was told that since the plan missed the March deadline, the diagnosis would not be included when the beneficiary's risk score was updated in July 2013. In this case, the payment adjustment based on that diagnosis will not be included in the plan's payment until the final reconciliation payment in August of 2014.

The Risk Adjustment Submission Timetable along with a process overview is available on the CSSC website at: http://www.csscoperations.com > Risk Adjustment Processing System > Risk Adjustment Processing System (RAPS).

For more information on risk adjustment timing and payment, refer to the 2012 Regional Technical Assistance Participant Guides for Risk Adjustment and Payment on the CSSC website at: http://www.csscoperations.com > Risk Adjustment Processing System > Training.

MODULE 5 – REPORTS

Purpose

The risk adjustment process includes an editing stage to ensure the accuracy of the data prior to storing the data for risk adjustment calculation. Transaction reports provide the outcome of the editing and disposition of the submitted diagnosis clusters. Management reports provide monthly and cumulative summaries of the transactions. This module provides a high-level overview of the Front-End Risk Adjustment System (FERAS) and the Risk Adjustment Processing System (RAPS) data logic and editing processes, and introduces the FERAS and RAPS transaction and management reports used by plans for risk adjustment to manage their data.

Learning Objectives

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

- Discuss the logic applied by FERAS and RAPS.
- Identify RAPS transaction and management reports.

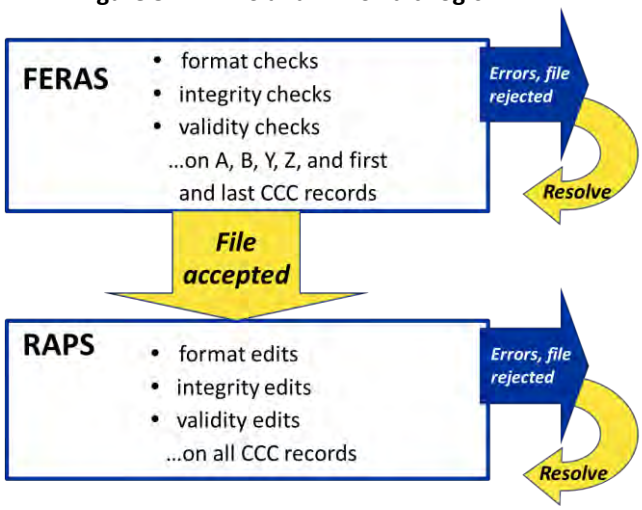
5.1 Edit Logic for FERAS and RAPS

Plans are required to comply with CMS requirements to submit accurate data in a timely manner, which includes submitting diagnoses, meeting the quarterly submission requirement, and not submitting duplicate diagnosis clusters. Plans attest when signing EDI Agreements that they will, to the best of their knowledge, information, and belief, submit risk adjustment data that are accurate, complete, and truthful.

Non-compliance may result in CMS restricting future risk adjustment submissions by an MA organization, so it is important for plans to understand the types of errors that are identified.

To assist plans in ensuring that they submit RAPS compliant files, FERAS first checks the file and batch-level for errors such as duplicate, missing, or invalid data. FERAS also checks the first and last detail record to see if the totals agree and for other edits. If any errors occur in FERAS, the complete file is rejected and returned to the submitter after all possible checks are completed. FERAS returns a response report to plans detailing any errors found. Only after a file passes the checks in FERAS, does the file move to RAPS where all of the detail records are edited for format, integrity, and validity. Figure 5 illustrates these FERAS and RAPs edits.

Figure 5 – FERAS and RAPS Edit Logic



5.1.1 Error Codes

When a Medicare Advantage (MA) organization submits a RAPS file to FERAS, FERAS performs the format and integrity checks. Format and integrity checks include verification that the layout of the file is correct, that valid plan numbers are included, that sequence numbering is correct, and many other general checks to the AAA and ZZZ records. FERAS also checks to ensure that there is at least one CCC record with a diagnosis cluster within a batch in the file.

If all checks pass, the submission 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. Table 14 provides an overview of the FERAS error codes ranges.

TABLE 14 – FERAS ERROR CODE RANGES

ERROR CODE LEVEL	EXPLANATION
100	File-level errors on the AAA or ZZZ records
200	Batch-level errors on the BBB or YYY records
300 and 400	Detail-level errors on the CCC records – first and last only in FERAS

A complete list of all FERAS error codes as well as a FERAS User Guide are available on the CSSC website at http://www.csscoperations.com/> Risk Adjustment Processing System > Front-End Risk Adjustment System (FERAS).

Example 5 – FERAS Error Codes

An MA organization submitted a file and entered “AA1” in record type AAA, field 1. They did not understand why FERAS rejected the entire file with error message 100, so they asked for assistance investigating g the issue. The plan was then informed that 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, and automated formats are programmed and tested, FERAS errors occur less frequently.

In addition to the FERAS error codes, plans receive RAPS error codes. These error codes notify plans of errors in the detail, or CCC, level of the RAPS file, including errors in the diagnosis cluster. RAPS edits include 300, 400, and 500 level edits. The 300 level edits relate to the record while the 400 level relate to the diagnosis cluster within the record. The 500 level edits are informational. Table 15 provides the RAPS error code ranges with explanations and consequences.

TABLE 15 – RAPS ERRORS AND CONSEQUENCES

ERROR SERIES	EXPLANATION 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.

Example 6 – RAPS Error Codes

A plan received a RAPS error code 411, and searched the online FAQs at http://www.askriskadjustment.com. They learned that error code 411 refers to the date of death, and that plans receive the 411 error code if the date of death is prior to the service through date. The FAQ offers options for resolving the error.

5.1.2 RAPS Edits Rules

The RAPS editing process takes place in four logical stages.

5.1.2.1 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.

5.1.2.2 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.

For dates of service included in each data submission period, see the Risk Adjustment Submission Timetable on the CSSC website at: http://www.csscoperations.com > Risk Adjustment Processing System > Risk Adjustment Processing System (RAPS).

5.1.2.3 Stage 3 - Eligibility Edits

The next stage of editing cross checks the appropriate fields against the common tables in the Medicare Beneficiary Database (MBD) and the Medicare Advantage and Part D Inquiry System (MARx). MA organizations may check CMS records of enrollment in MARx, and should also check the organization's internal records. For risk adjustment purposes, these common tables are the authoritative source of beneficiary information, and support 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.

5.1.2.4 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 sex. 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

informational 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 the 2008 Participant Guide found at http://www.csscoperations.com/ > Archives > Risk Adjustment Processing System > Training.

5.1.3 Duplicate Submissions

When submitting a RAPS file, if all attributes of the diagnosis clusters (HIC number, from and through dates of service, diagnosis, and provider type) are submitted more than once for the same HIC number, a duplicate diagnosis cluster error will occur. Plans are encouraged to check for duplicates prior to submission in order to reduce the number of duplicate cluster submissions and burden on the processing system.

Example 7 – Duplicate Diagnosis Clusters

A plan asked if diagnosis clusters could be duplicated over time. In other words, a member might go to the doctor on separate occasions and receive the same diagnosis each time. Since the plan submits RAPS records every month, they wonder if that diagnosis is stored each time a RAPS record is sent/received by CMS, or only the first time the diagnosis cluster was submitted.

The plan learned that in this example, each of the clusters would be unique diagnosis clusters because they have different dates of service. (Duplicate diagnosis clusters are those that have the same HIC, from and through dates of service, diagnosis code, and provider type). Therefore, they will appear on the report in the counts for total stored. The diagnosis would be stored, but later de-duped when the model was run.

Example 8 – Assistance with Duplicate Diagnosis Clusters

Another plan received 502 errors for a member, but could not locate where the diagnosis cluster had been sent on the return file. They learned that plans may contact CSSC at 1-877-534-CSSC for assistance locating the files that triggered the duplicate diagnosis cluster.

For tips on avoiding duplicate submissions, refer to the *2012 Regional Technical Assistance Risk Adjustment Participant Guide* found at http://www.csscoperations.com/ > Risk Adjustment Processing System > Training.

5.2 FERAS and RAPS Transaction and Management Reports

Throughout the year, plans receive reports to communicate activity for their enrolled beneficiaries regarding issues from enrollment to payment. Both the FERAS and RAPS systems generate reports that provide the results of the edit checks. Some reports present summary-level data, while 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.

The various reports display the results of the data submitted to RAPS, such as diagnoses submitted, accepted, and rejected, as well as errors. Tables 16, 17, and 18 provide an overview of the reports that FERAS and RAPS send to plans. Figures 6 and 7 show examples of the reports.

TABLE 16 – FERAS REPORT

REPORT	DESCRIPTION
FERAS Response Report	• Indicates file is accepted or rejected • Identifies reasons for rejection • Report layout • Secured Website and FTP users receive reports the same business day • Connect:Direct users receive reports the next business day • Gentran users currently receive reports the next business day • TIBCO users receive reports the next business day

Figure 6 – 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

TABLE 17 – RAPS TRANSACTION PROCESSING REPORTS

REPORT	DESCRIPTION
RAPS Return File	• Contains the entire submitted transaction • Identifies 300, 400, and 500-level errors • A 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 • A report layout • Received the next business day after submission
RAPS Transaction Summary Report	• Summarizes the disposition of diagnosis clusters • A 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 • A report layout • Received the next business day after submission

Figure 7 – 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			
		00000000000000000001234567890123456789O												
0000005			888888888A		19260217		01	20040212	20040225		486	408		
		00000000000000000001234567567567567567 5												
							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

The RAPS Return File is a flat file format that includes all the records and diagnosis clusters submitted by the MA organization. Any errors identified during the RAPS process will appear next to the field in which the error was found. 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 risk adjustment models. Since this report is a flat file, MA organizations may download the file into a Microsoft Access or Excel database to sort and analyze, and establish a record of each diagnosis that was stored in the risk adjustment 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. When trying to avoid submitting duplicate submissions, plans can review current and previous RAPS Return Files to determine which clusters RAPS stored.

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 the diagnosis records to indicate which diagnoses were rejected.

The RAPS Transaction Summary Report reflects all finalized data sent to the RAPS database along with all rejected data. 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.

The RAPS Duplicate Diagnosis Cluster Report identifies diagnosis clusters submitted with information that duplicates a stored cluster. This report is similar to the RAPS Transaction Error Report, but only 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 were submitted previously to CMS; that is, a cluster with the same HIC number, provider type, from and through dates, and diagnosis is already stored in the RAPS database.

Table 18 provides a list and descriptions of the four RAPS Management Reports.

TABLE 18 – RAPS MANAGEMENT REPORTS

REPORT	DESCRIPTION
RAPS Monthly Plan Activity Report	• Provides monthly summary of the status of submissions by Submitter ID and Plan Number • A report layout • Available for download the second business day of the month • Generated only when plan has activity in current month
RAPS Cumulative Plan Activity Report	• Provides cumulative summary of the status of submissions by Submitter ID and Plan Number • A report layout • Available for download the second business day of the month • Generated only when plan has activity for the month of the report
RAPS Monthly Error Frequency Report	• Provides a monthly summary of all errors associated with files submitted in test and production • A 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 • A report layout • Available for download the second business day of the month following each quarter

The RAPS Monthly Plan Activity Report provides a summary of the status of submissions and is organized by submitter ID and plan number (H number). This allows MA organizations to validate the diagnoses submitted for a one (1) month period based on the date of service (through date). The report is arrayed by provider type and month (determined by through date of service), and displays six months of data on each page.

Using this report, 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 RAPS Cumulative Plan Activity Report provides a cumulative summary of the status of submissions over time, and is organized by plan number. The report is arrayed by provider type and month (determined by through date of service), and reports information by submitter ID and H number. The RAPS Cumulative Plan Activity Reports will now be distributed to plans in ICD-9 and ICD-10 versions following the ICD-10 implementation. Plans can identify each report by the "**ICD9**" or "**ICD10**" label in the report header. This report is not generated if there is no plan activity to be reported for that period.

The RAPS Error Frequency Reports are distributed monthly and quarterly. They 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. The monthly report provides summary information for a month; the quarterly report provides summary information for a three (3) month period.

Figure 8 provides instructions for reading the RAPS Management Reports.

Figure 8 – Analysis of RAPS Management 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?"

REPORTS

It is the plans' responsibility to download and save all reports received. Plans may want to work with their IT Departments to establish a process for downloading and maintaining reports over time. Plans should keep reports for future reference of diagnosis cluster acceptance and other activity, as it is their responsibility to ensure the RAPS data is accepted. If a plan receives errors, they should correct and resubmit as soon as possible because waiting until a submission deadline does not guarantee the diagnosis will be accepted and included in risk score calculation.

It is important to understand that the timing of when plans receive reports is related to the cut-off time for file transfer. The cut-off time for data submission and completion of file transfer is 5:00 PM ET, Monday through Friday. So, if a plan submits a RAPS File, but does not receive the RAPS report the next morning, then the plan did not meet the cut-off. Any files submitted after 5:00 PM ET will be processed the next day, and the reports will come the following morning. If a file is received on Friday after 5:00 PM ET, the file will not go to CMS until Monday, and the reports will be returned Tuesday morning.

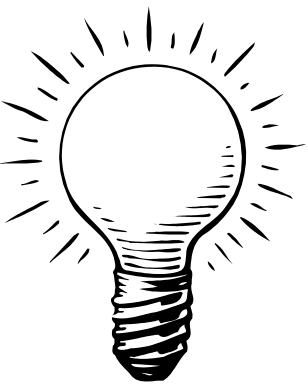
CSSC retains reports for seven (7) years. If needed, plans may contact CSSC at csscoperations@palmettogba.com to request a report be restored. When requesting to restore reports, the plan must provide the File ID and the date the file was submitted. However, if requesting many reports from previous years, CSSC will first contact CMS to obtain permission before restoring the reports.

In addition to the reports generated by FERAS and RAPS, plans receive monthly reports from MARx that can be used in reconciling risk score and payment information; specifically the Monthly Membership Report (MMR) and Model Output Report (MOR).

For information on MARx reporting, refer to the *2012 Regional Technical Assistance Risk Adjustment Participant Guide* found at http://www.csscoperations.com/ > Risk Adjustment Processing System > Training.

The MMR and MOR reports and data file layouts are available in the *Plan Communications User Guide (PCUG) Appendices* on the CMS MAPD Helpdesk website at http://www.cms.gov > Research, Statistics, Data and Systems > CMS Information Technology: MAPD Helpdesk > Medicare Advantage and Prescription Drug Plans Communications User Guide.

Plans should regularly check the MAPD Helpdesk for updates.



MODULE 6 – RESOURCES

Purpose

This module provides Medicare Advantage (MA) organizations guidance in locating information specific to risk adjustment. It identifies and provides key resources and important links to facilitate the submission of risk adjustment data.

Learning Objectives

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

- Locate valuable resources relating to risk adjustment.
- Access online risk adjustment information.
- Identify appropriate contacts for communications regarding risk adjustment.

6.1 Links

6.1.1 CMS Website

The Centers for Medicare & Medicaid Services website (http://www.cms.gov) provides visitors with valuable information regarding Medicare and Medicaid.

Table 19 provides the paths to important risk adjustment resources on the CMS website.

TABLE 19 – RISK ADJUSTMENT INFORMATION ON THE CMS WEBSITE

PAGE NAME	PATH	CONTENTS
Risk Adjustment	http://www.cms.gov > Medicare > Health Plans: Medicare Advantage Rates & Statistics > Risk Adjustment	Medicare information on risk adjustment, including evaluation of the CMS-HCC Risk Adjustment Model; model diagnosis codes; risk adjustment model software; information on customer support for risk adjustment; and HCC, RxHCC, and ESRD software
Announcements and Documents	http://www.cms.gov > Medicare > Health Plans: Medicare Advantage Rates & Statistics > Announcements and Documents	Medicare Advantage (MA) and Medicare+Choice (M+C) advance notices of methodological changes, announcements issued with MA or M+C rates, and special reports
Ratebooks & Supporting Data	http://www.cms.gov > Medicare > Health Plans: Medicare Advantage Rates & Statistics > Ratebooks & Supporting Data	Medicare Advantage (MA) ratebooks, rate calculation data, and risk adjusters

TABLE 19 – RISK ADJUSTMENT INFORMATION ON THE CMS WEBSITE, (continued)

PAGE NAME	PATH	CONTENTS
Medicare Advantage and Prescription Drug Plans Communications User Guide (PCUG)	http://www.cms.gov > Research, Statistics, Data and Systems > CMS Information Technology: MAPD Helpdesk > Medicare Advantage and Prescription Drug Plans Communications User Guide	The Medicare Advantage and Prescription Drug Plan Communications User Guide (PCUG) provides information to plans about the CMS enrollment system and other pertinent CMS system exchanges. It also references information relative to the User Interface (UI) plans use to obtain eligibility and enrollment information online and other information about establishing connections for communication with CMS. The PCUG Appendices present the schedules, report layouts, codes, report files and other system specific information for plans to reference
ICD-9-CM	http://www.cms.gov > Medicare > Coding: ICD-9-CM	Provides information related to ICD-9-CM, including updates to ICD-9-CM (addendum), the process for requesting a new/revised code, ICD-9-CM Coordination and Maintenance Committee meeting agendas and summary reports, registering to attend an ICD-9-CM Coordination and Maintenance Committee meeting, official coding guidelines, lists of new/revised and deleted codes, downloadable files of diagnosis and procedure codes and their abbreviated titles, conversion table (mapping of changes to ICD-9-CM), and information on ICD-10-PCS
ICD-10-CM	http://www.cms.gov > Medicare > Coding: ICD-10	Provides information related to the October 1, 2014, transition to the ICD-10 code sets

6.1.2 Centers for Disease Control and Prevention (CDC)

Information on the ICD-9-CM coding can be found on the Center for Disease Control and Prevention website at http://www.cdc.gov/nchs/icd/icd9cm.htm.

Information on the ICD-10 coding can also be found there at http://www.cdc.gov/nchs/icd/icd10cm.htm.

6.1.3 CMS Customer Service and Support Center (CSSC)

The CMS Customer Service and Support Center (http://www.csscoperations.com/) is the gateway to Medicare Advantage and Prescription Drug Programs. Visitors to the site can access information about Risk Adjustment, Encounter Data and Prescription Drug Programs; including opportunities to enroll to submit data and obtain comprehensive information about data submission and reporting. The site provides valuable links to CMS instructions, past training materials, and other official resources.

Table 20 provides the paths to important risk adjustment resources on the CSSC website.

TABLE 20 – RISK ADJUSTMENT INFORMATION ON THE CSSC WEBSITE

PAGE NAME	PATH	CONTENTS
Enroll to Submit Risk Adjustment Data	http://www.csscoperations.com/ > Risk Adjustment Processing System > Enroll to Submit Risk Adjustment Data	Forms and instructions for EDI Enrollment and Submitter Application for Risk Adjustment Data Processing
Front-End Risk Adjustment System (FERAS)	http://www.csscoperations.com/ > Risk Adjustment Processing System > Front-End Risk Adjustment System (FERAS)	FERAS Error Codes and FERAS User Guide
Job Aids	http://www.csscoperations.com/ > Risk Adjustment Processing System > Job Aids	New Enrollee Job Aid
References	http://www.csscoperations.com/ > Risk Adjustment Processing System > References	Acceptable Physician Specialty Types
Risk Adjustment Processing System (RAPS)	http://www.csscoperations.com/ > Risk Adjustment Processing System > Risk Adjustment Processing System (RAPS)	RAPS Error Code Listing, RAPS Format, Risk Adjustment Submission Timetable, RAPS-FERAS Error Code Lookup, RAPS-FERAS Report Names, and Risk Adjustment System Reports
Training	http://www.csscoperations.com/ > Risk Adjustment Processing System > Training	Participant Guides, Presentation Slides, and Job Aids from 2012 Regional Technical Assistance covering topics such as Risk Adjustment, Enrollment, and Payment
Training (archived)	http://www.csscoperations.com/ > Archives > Risk Adjustment Processing System > Training	Participant Guides, Presentation Slides, and Job Aids from previous years' Technical Assistance. The 2008 Participant Guide has comprehensive information for plans regarding risk adjustment data collection.

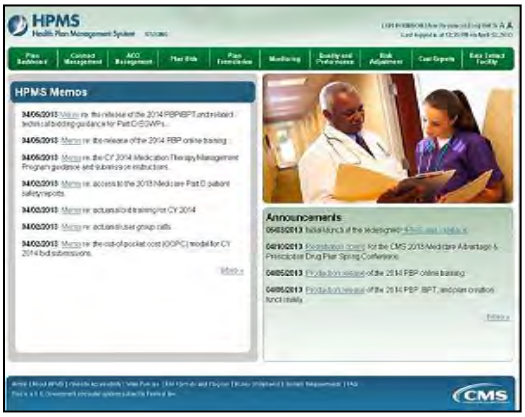
6.1.4 Technical Assistance Registration Service Center (TARSC)

The CMS Technical Assistance Registration Service Center (http://www.tarsc.info) provides information on industry outreach efforts for Risk Adjustment, Encounter Data, Prescription Drug Event (PDE) Data, and Payment. On this site, plans can access information about training opportunities and register to participate.

6.1.5 The Health Plan Management System (HPMS)

The Health Plan Management System (HPMS) (https://gateway.cms.hhs.gov/) is a CMS system available only to registered users. HPMS provides users with access to several modules, important guidance, policy, and regulations. HPMS also serves as the mechanism with which plans submit bids.

To register to use HPMS, plans must submit the Application for Access to CMS Computer Systems found at http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/InformationSecurity/downloads/EUAaccessform.pdf.



6.1.6 Medicare Advantage and Prescription Drug System User Interface (MARx UI)

The MARx UI maintains Medicare beneficiary eligibility and payment data. MARx also generates reports for plans of data used to calculate risk scores used in payment. It is these reports that plans can use to verify their enrollee's risk scores.

To use the MARx system, users must first register in the Individuals Authorized Access to CMS Computer Services (IACS) system at http://www.cms.gov > Research, Statistics, Data and Systems > CMS Information Technology: MAPD Helpdesk > IACS, or by calling the MAPD Help Desk for assistance at 1-800-927-8069.

The Plan Communication Users Guide (PCUG) also provides information to plans regarding the use of MARx systems at http://www.cms.gov > Research, Statistics, Data and Systems > CMS Information Technology: MAPD Helpdesk > Medicare Advantage and Prescription Drug Plans Communications User Guide.

6.2 Important Contacts

Table 21 provides the roles and contact information for important resources.

TABLE 21 – RISK ADJUSTMENT POINTS OF CONTACT

RESOURCE	ROLE	CONTACT INFORMATION
Centers for Medicare & Medicaid Services (CMS) Medicare Plan Payment Group (MPPG)	Develops and implements the risk adjustment payment methodology. In addition, they monitor plans to improve the quality of data.	riskadjustment@cms.hhs.gov
MAPD Help Desk	Provides technical customer support for all connectivity needs, as well as aids in resolving technical application issues.	1-800-927-8069 mapdhelp@cms.hhs.gov
Customer Service and Support Center (CSSC)	Manages the Front-End Risk Adjustment System (FERAS) and hosts technical assistance materials from the sessions as well as connectivity guidance for risk adjustment related systems.	877-534-2772 (toll-free) csscoperations@palmettogba.com www.csscoperations.com
Technical Assistance Registration Center (TARSC)	Provides registration services for Technical Assistance sessions and support information on a variety of topics.	1-888-330-9994 TARegistration@tarsc.info www.tarsc.info
ICD-10 PMO Mailbox	Responds to questions regarding ICD-10.	ICD10.PMO@noblis.org
Risk Adjustment Data Validation (RADV)	Responds to questions regarding RADV.	RADV@cms.hhs.gov

6.2 RISK ADJUSTMENT ACRONYMS

Table 22 provides the terms associated with many of the acronyms used in risk adjustment.

TABLE 22 – RISK ADJUSTMENT ACRONYMS AND TERMS

ACRONYM	TERM
AAPC	American Academy of Professional Coders
ACR	Adjusted Community Rates
ACRP	Adjusted Community Rate Proposal
ADS	Alternative Data Sources
ADL	Activities of Daily Living
AGNS	AT&T Global Network Services

TABLE 22 – RISK ADJUSTMENT ACRONYMS AND TERMS (continued)

ACRONYM	TERM
AHA	American Hospital Association
AHIMA	American Health Information Management Association
AMA	American Medical Association
ANSI	American National Standards Institute
ANSI X12 837	Variable Length File Format for Electronic Submission of Encounter Data
ASC	Ambulatory Surgical Center
BBA	Balanced Budget Act of 1997
BBRA	Balanced Budget Refinement Act 1999
BIC	Beneficiary Identification Code
BIPA	Benefits Improvement and Protection Act of 2000
CAD	Coronary Artery Disease
CFO	Chief Financial Officer
CHF	Congestive Heart Failure
CMHC	Community Mental Health Center
CMS	Centers for Medicare & Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
CPT	Current Procedural Terminology
CSSC	Customer Service and Support Center
CVD	Cerebrovascular Disease
CWF	Common Working File
CY	Calendar Year
DCP	Data Collection Period
DDE	Direct Data Entry
DHHS	Department of Health & Human Services
DM	Diabetes Mellitus
DME	Durable Medical Equipment
DOB	Date of Birth
DoD	Department of Defense
DOS	Dates of Service
DRG	Diagnosis Related Group
DX	Diagnosis
EDI	Electronic Data Interchange
ESRD	End-Stage Renal Disease
ET	Eastern Time
FERAS	Front-End Risk Adjustment System
FFS	Fee for Service
FQHC	Federally Qualified Health Center
FTP	File Transfer Protocol
GUI	Graphical User Interface
H#	MA Organization CMS Contract Number
HCC	Hierarchical Condition Category
HCFA 1500	Medicare Part B Claim Filing Form
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Health Plan Employer Data Information Set
HHS	Department of Health and Human Services
HIC#	Health Insurance Claim Number (Beneficiary Medicare ID#)
HICN	Health Insurance Claim Number (Beneficiary Medicare ID#)
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
HOS	Health Outcomes Survey

TABLE 22 – RISK ADJUSTMENT ACRONYMS AND TERMS (continued)

ACRONYM	TERM
HPMS	Health Plan Management System
ICD-9-CM	International Classification of Diseases, Ninth Revision, Clinical Modification
ICD-10-CM	International Classification of Diseases, Tenth Revision, Clinical Modification
ICN	Internal Claim Number
IP	Internet Protocol
IVC	Initial Validation Contractor
JCAHO	Joint Commission on Accreditation of Health Care Organizations
LTC	Leading Through Change, Inc.
MA	Medicare Advantage
MA-PD	Medicare Advantage Prescription Drug Plan
MARx	Medicare Advantage Prescription Drug System
MBD	Medicare Beneficiary Database
M+C Organization	Medicare+Choice Organization
MCCOY	Managed Care Option Information System
MCO	Managed Care Organization
MDCN	Medicare Data Communications Network
MDS	Minimum Data Set
MMA	Medicare Prescription Drug Modernization Act of 2003
MMCS	Medicare Managed Care System
MMR	Monthly Membership Report
MnDHO	Minnesota Disability Health Options
MOR	Model Output Report
MSA	Medical Savings Account
MSG	Message
MSHO	Minnesota Senior Health Options
NCH	National Claims History
NCHS	National Center for Health Statistics
NCPDP	National Council on Prescription Drug Program
NCQA	National Committee for Quality Assurance
NDM	Network Data Mover
NES	Not elsewhere classified
NMUD	National Medicare Utilization Database
NOS	Not otherwise specified
NPI	National Provider Identifier
NSF	National Standard Format
OIG	Office of Inspector General
OREC	Original Reason for Entitlement Code
Palmetto GBA	Palmetto Government Benefits Administrators
PACE	Program of All-Inclusive Care for the Elderly
PCN	Patient Control Number
PHS	PACE Health Survey
PIP-DCG	Principal Inpatient Diagnostic Cost Group
PPO	Preferred Provider Organization
QIO	Quality Improvement Organization
RAPS	Risk Adjustment Processing System
RAPS Database	Risk Adjustment Processing System Database
RAS	Risk Adjustment System
RHC	Rural Health Clinic
RPT	Report
RRB	Railroad Retirement Board

TABLE 22 – RISK ADJUSTMENT ACRONYMS AND TERMS (continued)

ACRONYM	TERM
RT	Record Type
RxHCC	Prescription Drug Hierarchical Condition Category
SAS	Statistical Analysis Software
SCO	MassHealth Senior Care Option
SH#	Submitter CMS Contract Number
S/HMO	Social Health Maintenance Organizations
SNF	Skilled Nursing Facility
SSD	Selected Significant Disease Model
SSN	Social Security Number
SUB ID	Submitter ID
SVC	Second Validation Contractor
TOB	Type of Bill
UB-04	Uniform Billing Form 04
VA	Veterans Administration
WPP	Wisconsin Partnership Program