CMS Manual System

Pub. 100-16 Medicare Managed Care

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 47 **Date: February 20, 2004**

I. SUMMARY OF CHANGES:

NEW/REVISED MATERIAL - EFFECTIVE DATE: February 20, 2004

Section 50 - Adjustment of Capitation Rates for National Coverage Determinations (NCD) and Legislative Changes in Benefits - Added "Legislative Changes in Benefits" to section title. Section has been rewritten to add material regarding legislative changes.

Section 50.1 - Criteria for Meeting "Significant Cost" - Changed first paragraph to indicate discussion is of specifically "significant cost" as it relates to an NCD, not of an "NCD" in general. Added third bullet regarding application of significant cost test is applied to all NCD's or legislative changes in benefit in aggregate.

Section 50.2.1 - Before Adjustments to Annual M+C Capitation Rate Are Effective - Incorporated material previously in §50.2 in this section. Added first paragraph regarding exclusion from the M+C organization's contract with CMS of payment adjustments and assumption of risk for services or benefits due to legislative change. This exclusion occurs prior to the year in which payment adjustments that take into account the significant cost of the NCD service or legislative change in benefits are in effect.

Section 50.2.2 - After Adjustments to the Annual M+C Capitation Rates Are in Effect - Added new section regarding inclusion in the M+C organization's contract with CMS of payment adjustments and assumption of risk for services or benefits due to legislative change. This occurs in the year in which payment adjustments that take into account the significant cost of the NCD service or legislative change in benefits are in effect.

Section 91 - The CMS-HCC Risk Adjustment Method for Adjustment of Capitation Rates - Added new sections on the new method for adjusting capitation rates.

Section 91.1 - Demographic Factors Under the CMS-HCC Risk Adjustment Method - Added new sections on the new method for adjusting capitation rates.

Section 91.1.1 - Age and Sex - Added new sections on the new method for adjusting capitation rates.

Section 91.1.2 - Medicaid Eligibility - Added new sections on the new method for adjusting capitation rates.

Section 91.1.3 - Originally Disabled - Added new sections on the new method for adjusting capitation rates.

Section 91.2 - The CMS-HCC Classification System - Added new sections on the new method for adjusting capitation rates.

Section 91.3 - Institutional Adjuster in the CMS-HCC Model - Added new sections on the new method for adjusting capitation rates.

Section 91.4 - Implementation of the CMS-HCC Model - Added new sections on the new method for adjusting capitation rates.

Section 91.4.1 - Elimination of the Data Lag - Added new sections on the new method for adjusting capitation rates.

Section 91.4.2 - Implementation of the Adjustment for Long-Term Institutionalization - Added new sections on the new method for adjusting capitation rates.

Section 91.4.3 - New Enrollees - Added new sections on the new method for adjusting capitation rates.

Section 91.5 - Calculation of Beneficiary Risk Scores - Added new sections on the new method for adjusting capitation rates.

Section 91.6 - Calculation of Monthly Payments to M+C Organizations - Added new sections on the new method for adjusting capitation rates.

Section 91.6.1 - The Rescaling Factor - Added new sections on the new method for adjusting capitation rates.

Section 91.6.2 - Adjustment to Rescaling Factors for Budget Neutrality - Added new sections on the new method for adjusting capitation rates.

Section 91.6.3 - Adjustment in Rescaling Factors for Coding Intensity - Added new sections on the new method for adjusting capitation rates.

Section 91.6.4 - Example: Calculating the Payment Amount Per M+C Enrollee - Added new sections on the new method for adjusting capitation rates.

Section 91.7 - Changes in Methodology for PACE and Certain Demonstrations - Added new sections on the new method for adjusting capitation rates.

Section 91.7.1 - Application of Frailty Model - Added new sections on the new method for adjusting capitation rates.

Section 91.7.2 - Application of Frailty Factor to M+C Organizations - Added new sections on the new method for adjusting capitation rates.

Section 91.8 - Exclusions from Risk Adjustment Payment - Added new sections on the new method for adjusting capitation rates.

Section 111 – Data Collection and Submission for Risk Adjustment Care - Added new section on updated risk adjustment data collection.

Section 111.1 - Hospital Inpatient Data - Added new section on updated risk adjustment data collection.

Section 111.2 - Outpatient Hospital Data - Added new section on updated risk adjustment data collection.

Section 111.3 - Physician Data - Added new section on updated risk adjustment data collection.

Section 111.4 - Alternative Data Sources (ADS) - Added new section on updated risk adjustment data collection.

Section 111.5 - Data Collection - Added new section on updated risk adjustment data collection.

Section 111.6 - Diagnosis Submission - Added new section on updated risk adjustment data collection.

Section 111.6.1 - Submission Methods- Added new section on updated risk adjustment data collection.

Section 111.6.2 - Submission Frequency- Added new section on updated risk adjustment data collection.

Section 111.7 - Certification of Data Accuracy, Completeness, and Truthfulness- Added new section on updated risk adjustment data collection.

Section 111.8 - Data Validation- Added new section on updated risk adjustment data collection.

Section 120 - Announcement of Annual Capitation Rates and Methodology Change - Replaced entire section on procedures and timelines for announcing annual capitation rates.

Exhibit 10 - Community and Institutional Annual Risk Factors for the CMS-HCC Model with Constraints and Demographic/Disease Interactions - Added new exhibit.

Exhibit 15 - List Of Disease Groups (HCCs) with Hierarchies - Added new exhibit.

Exhibit 20 - CMS-HCC Demographic Model for New Enrollees - Added new exhibit.

Exhibit 25 - Data Collection for Risk Adjustment – Facility Types and Physician Specialties - Added new exhibit with Tables 25A, 25B, 25C, 25D.

Exhibit A - Retired material on the PIP-DCG payment methodology (Former Sections 90, 110, Exhibits 4 and 5) - Moved deleted material from §§90, 110 and Exhibits 4 and 5 to this section.

Exhibit B - Retired material on the congestive heart failure extra payment initiative (Former Sections 100 and Exhibits 6 and 7) - Moved deleted material from §100, and Exhibits 6 and 7 to this section.

CLARIFICATION – EFFECTIVE DATE: Not Applicable

Prefatory Note - Entire note replaced. New text states that the CMS-HCC risk adjustment model effective January 1, 2004, is included in this revision, and that information related to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 will be published in future updates.

Table of Contents - Many revisions for section heading changes (50, 50.2), addition of new sections, (50.2.1 - 50.2.2, 91 - 91.8, 111 - 111.8, Exhibits 10, 15, 20, 25, A, B), deletion of sections (90 - 90.6, 100 - 100.3, 110 - 110.6, 220, 230, Exhibits 4 - 7, Table 4 in §70.3). Tables 1 - 5 located in various sections are added to the Table of Contents as well. **NOTE:** Material retired from old sections (90, 100, 110, Exhibits 4 - 7) is retained in this chapter in new exhibits A and B and is shown at the end of the Table of Contents.

Section 20 - General Rules for M+C Payments - In the second paragraph, added "effective CYs 2000 through 2003" to clarify effective date of the risk adjustment method. Added sentence to end of paragraph regarding implementation of the new CMS-HCC risk adjustment for CY 2004 and referred the reader to new §§91 and 111.

Section 20.1.1 - Enrollees With End-Stage Renal Disease (ESRD) - Deleted the reference to Table 1 in the second bullet of the list, and updated the Web site reference to find ESRD payment rates in the last paragraph.

Section 30 - M+C Payment Methodology - At end of the section, referred the reader to Section 91 and new exhibits.

Section 30.1.2 - A Minimum Specified Amount or "Floor" Rate - In the second to last paragraph, updated the Web site to find 2 documents on minimum rates for Calendar Year 2001.

Section 50.2 - Rules for Coverage and Payment of "Significant Cost" NCDs - Added "Significant Cost" to section heading. Material previously in §50.2 has been moved to §50.2.1. Section 50.2 is now a section heading only.

Section 60 - Adjustment of Capitation Rates for Working Aged Status - Added material about changes in the working aged (WA) annotation process.

Section 70 - Adjustment of Capitation Rates for Demographic Characteristics and Health Status - In the "Note," changed "encounter" to "diagnostic."

Section 70.1 - Transition to a Comprehensive Risk Adjustment Method - Updated section for use of the Principal Inpatient Diagnostic Cost Group (PIP-DCG) versus the CMS Hierarchical Condition Category (CMS-HCC) model as the risk adjustment methods under which payments are made in coming years. The reader is referred to new §§91 and 111, and new Exhibits 10 through 20. Deleted old note regarding filing of outpatient encounter data.

Section 70.2 - Transition Schedule for Implementation of the Risk Adjustment Method - Deleted "PIP-DCG" in front "risk adjustment" in the first sentence. Deleted "Note" regarding payment made for certain enrollees with congestive heart failure. In Table 2, updated model to "CMS-HCC model" as model to be used for years 2004 and beyond.

Section 90 - The Principle Inpatient Diagnostic Cost Group Risk Adjustment Method for Adjustment of Capitation Rates - Deleted section. A copy of the text is toward the end of the chapter in "Retired Material on Previous Risk Adjustment Methodology."

Section 90.1 - Demographic Factors Under the PIP-DCG Risk Adjustment Method - Deleted section. A copy of the text is toward the end of the chapter in "Retired Material on Previous Risk Adjustment Methodology."

Section 90.1.1 - Age and Sex - Deleted section. A copy of the text is toward the end of the chapter in "Retired Material on Previous Risk Adjustment Methodology."

Section 90.1.2 - Medicaid Eligibility - Deleted section. A copy of the text is toward the end of the chapter in "Retired Material on Previous Risk Adjustment Methodology."

Section 90.1.3 - Originally Disabled - Deleted section. A copy of the text is toward the end of the chapter in "Retired Material on Previous Risk Adjustment Methodology."

Section 90.2 - Health Status Adjustment Under the PIP-DCG Risk Adjustment Method - Deleted section. A copy of the text is toward the end of the chapter in "Retired Material on Previous Risk Adjustment Methodology."

Section 90.2.1 - The PIP-DCG Classification System - Deleted section. A copy of the text is toward the end of the chapter in "Retired Material on Previous Risk Adjustment Methodology."

Section 90.2.2 - Diagnostic Exceptions Under the PIP-DCG Risk Adjustment Method - Deleted section. A copy of the text is toward the end of the chapter in "Retired Material on Previous Risk Adjustment Methodology."

Section 90.2.3 - New Enrollees - Deleted section. A copy of the text is toward the end of the chapter in "Retired Material on Previous Risk Adjustment Methodology."

Section 90.3 - Calculation of Beneficiary Risk Factors and Payments to M+C Organizations - Deleted section. A copy of the text is toward the end of the chapter in "Retired Material on Previous Risk Adjustment Methodology."

Section 90.4 - Calculation of Monthly Payments to M+C Organizations - Deleted section. A copy of the text is toward the end of the chapter in "Retired Material on Previous Risk Adjustment Methodology."

Section 90.4.1 - The Rescaling Factor - Deleted section. A copy of the text is toward the end of the chapter in "Retired Material on Previous Risk Adjustment Methodology."

Section 90.4.2 - Method for Calculating County Rescaling Factors - Deleted section. A copy of the text is toward the end of the chapter in "Retired Material on Previous Risk Adjustment Methodology."

Section 90.4.3 - Example: Calculating the Payment Amount Per M+C Enrollee - Deleted section. A copy of the text is toward the end of the chapter in "Retired Material on Previous Risk Adjustment Methodology."

Section 90.5 - Treatment of Certain Demonstrations Under the PIP-DCG Risk Adjustment Method - Deleted section. A copy of the text is toward the end of the chapter in "Retired Material on Previous Risk Adjustment Methodology."

Section 90.6 - Exclusions From Risk Adjustment Payment - Deleted section. A copy of the text is toward the end of the chapter in "Retired Material on Previous Risk Adjustment Methodology."

Section 100 - Adjustment of Capitation Rates Under the Congestive Heart Failure (CHF) Initiative - Deleted section. A copy of the text is toward the end of the chapter in "Retired Material on Previous Risk Adjustment Methodology."

Section 100.1 - Extra Payment in Recognition of the Costs of Successful Outpatient CHF Care - Deleted section. A copy of the text is toward the end of the chapter in "Retired Material on Previous Risk Adjustment Methodology."

Section 100.2 - Requirements for Medicare + Choice Organizations to Qualify for Extra Payment in Recognition of the Costs of Successful Outpatient CHF Care Care - Deleted section. A copy of the text is toward the end of the chapter in "Retired Material on Previous Risk Adjustment Methodology."

Section 100.2.1 - Two Required Quality Indicators Care - Deleted section. A copy of the text is toward the end of the chapter in "Retired Material on Previous Risk Adjustment Methodology."

Section 100.2.2 - Designated Measurement Population Care - Deleted section. A copy of the text is toward the end of the chapter in "Retired Material on Previous Risk Adjustment Methodology."

Section 100.2.3 - Thresholds Must Be Met Care - Deleted section. A copy of the text is toward the end of the chapter in "Retired Material on Previous Risk Adjustment Methodology."

Section 100.2.4 - Reporting Care - Deleted section. A copy of the text is toward the end of the chapter in "Retired Material on Previous Risk Adjustment Methodology."

Section 100.2.5 - Extra Payment Care - Deleted section. A copy of the text is toward the end of the chapter in "Retired Material on Previous Risk Adjustment Methodology."

Section 100.2.6 - Auditing Care - Deleted section. A copy of the text is toward the end of the chapter in "Retired Material on Previous Risk Adjustment Methodology."

Section 100.2.7 - Hospitalization Tracking Care - Deleted section. A copy of the text is toward the end of the chapter in "Retired Material on Previous Risk Adjustment Methodology."

Section 100.3 - Questions About the Extra Payment in Recognition of the Costs of Successful Outpatient CHF Care Care - Deleted section. A copy of the text is toward the end of the chapter in "Retired Material on Previous Risk Adjustment Methodology."

Section 110 - Encounter Data Collection for the Risk Adjustment Method Care - Deleted section. A copy of the text is toward the end of the chapter in "Retired Material on Previous Risk Adjustment Methodology."

Section 110.1 - Overview of Encounter Data Care - Deleted section. A copy of the text is toward the end of the chapter in "Retired Material on Previous Risk Adjustment Methodology."

Section 110.2 - Certification of Data Accuracy, Completeness, and Truthfulness Care - Deleted section. A copy of the text is toward the end of the chapter in "Retired Material on Previous Risk Adjustment Methodology."

Section 110.3 - Validation of Data Care - Deleted section. A copy of the text is toward the end of the chapter in "Retired Material on Previous Risk Adjustment Methodology."

Section 110.4 - Hospital Inpatient Encounter Data Requirements Care - Deleted section. A copy of the text is toward the end of the chapter in "Retired Material on Previous Risk Adjustment Methodology."

Section 110.5 - Data Formats and Processing Care - Deleted section. A copy of the text is toward the end of the chapter in "Retired Material on Previous Risk Adjustment Methodology."

Section 110.6 - Deadlines for Submission of Encounter Data Care - Deleted section. A copy of the text is toward the end of the chapter in "Retired Material on Previous Risk Adjustment Methodology."

Section 160.1 - Terminology - Added "renewed by Congress for 2003" in first paragraph.

Section 160.2 - Policy - Deleted first sentence regarding CMS' systems changes to discontinue Medicaid adjustments for QI-1s.

Section 165 - Special Rules for M+C Payments of Department of Veterans Affairs Facilities - Replaced entire section regarding prohibition of M+C organizations to use Medicare funding to pay the Veterans Affairs Healthcare System for VA-covered services rendered to veterans who are also M+C organization enrollees. Exception is provided under §1814(h) of the Social Security Act in rare situations where an M+C Organization enrollee who is a non-veteran is mistakenly admitted to a VA hospital for a service that does not require pre-authorization by their M+C Organization plan.

Section 180.3 - Eligibility for Bonus Payment - The Period of Application - Table 4 is renumbered to Table 5, and the reference in the paragraph preceding the table is changed to Table 5. The Web site referenced in paragraph after Table 5 is updated.

Section 210 - Reconciliation Process for Changes in Risk Adjustment Factors - Deleted second sentence in the first paragraph after the bulleted list regarding encounter data submitted for Part B-only members. Deleted "Note" regarding no adjustment for institutional status under risk adjustment methodology. Deleted first paragraph after **second** bulleted list regarding separate reconciliation process for hospice and ESRD. Added material regarding exclusion from payment under the risk adjustment method for enrollees capitated at hospice and ESRD rates. Further, diagnostic data submitted up to March 5 can be incorporated into final reconciliation process.

Section 210.1 - Reconciliation Schedule and Late Submission of Encounter Data - Deleted this section.

Section 210.2 - Organization of Risk-Adjusted Reconciliation - Deleted this section.

Section 220 - Reconciliation of Payments for Hospice Enrollees - Deleted this section.

Section 230 - Reconciliation of Payments for ESRD Beneficiaries - Deleted this section.

Exhibit 2 - Additional Information on Coverage of Clinical Trials - Deleted two introductory paragraphs, and added "on clinical trial coverage" in the current first paragraph, and made "NCD" plural to "NCDs." Deleted Q & A numbers 1, 5, 7, 8, 11 and renumbered the remaining Q & A's. Added "covered" in front of "clinical trial" throughout exhibit. In Q & A #4, added "their plan rules (which may be the."

Exhibit 4 - Risk Factors for the PIP-DCG Risk Adjustment Payment Model - Deleted this exhibit.

Exhibit 5 - Diagnosis (DxGroups) Included in Each PIP-DCG for the Payment Model - Deleted this exhibit.

Exhibit 6 - Quality Indicators for Extra Payment in Recognition of the Costs of Successful Outpatient Treatment of CHF - Deleted this exhibit.

Exhibit 7 - Report of Performance on Quality Indicators to Qualify for Extra Payment in Recognition of Successful Outpatient Treatment of CHF - Deleted this exhibit.

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	Chapter 7 / Prefatory Note
R	Chapter 7 / Table of Contents
R	Chapter 7 / Section 20 / General Rules for M+C Payments
R	Chapter 7 / Section 20.1.1 / Enrollees With End -Stage Renal Disease (ESRD)
R	Chapter 7 / Section 30 / M+C Payment Methodology
R	Chapter 7 / Section 30.1.2 / A Minimum Specified Amount or "Floor" Rate
R	Chapter 7 / Section 50 / Adjustment of Capitation Rates for National Coverage Determinations (NCD) and Legislative Changes in Benefits

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N	Chapter 7 / Section 50.1 / Criteria for Meeting “Significant Cost”
N	Chapter 7 / Section 50.2 / Rules Coverage and Payment of “Significant Cost” NCDs
N	Chapter 7 / Section 50.2.1 / Before Adjustments to Annual M+C Capitation Rate Are Effective
N	Chapter 7 / Section 50.2.2 / After Adjustments to the Annual M+C Capitation Rates Are in Effect
R	Chapter 7 / Section 60 / Adjustment of Capitation Rates for Working Aged Status
R	Chapter 7 / Section 70 / Adjustment of Capitation Rates for Demographic Characteristics and Health Status
R	Chapter 7 / Section 70.1 / Transition to a Comprehensive Risk Adjustment Method
R	Chapter 7 / Section 70.2 / Transition Schedule for Implementation of the Risk Adjustment Method
D	Chapter 7 / Section 90 / The Principle Inpatient Diagnostic Cost Group Risk Adjustment Method for Adjustment of Capitation Rates
D	Chapter 7 / Section 90.1 / Demographic Factors Under the PIP-DCG Risk Adjustment Method
D	Chapter 7 / Section 90.1.1 / Age and Sex
D	Chapter 7 / Section 90.1.2 / Medicaid Eligibility
D	Chapter 7 / Section 90.1.3 / Originally Disabled
D	Chapter 7 / Section 90.2 / Health Status Adjustment Under the PIP-DCG Risk Adjustment Method
D	Chapter 7 / Section 90.2.1 / The PIP-DCG Classification System
D	Chapter 7 / Section 90.2.2 / Diagnostic Exceptions Under the PIP-DCG Risk Adjustment Method
D	Chapter 7 / Section 90.2.3 / New Enrollees
D	Chapter 7 / Section 90.3 / Calculation of Beneficiary Risk Factors and Payments to M+C Organizations -
D	Chapter 7 / Section 90.4 / Calculation of Monthly Payments to M+C Organizations
D	Chapter 7 / Section 90.4.1 / The Rescaling Factor
D	Chapter 7 / Section 90.4.2 / Method for Calculating County Rescaling Factors
D	Chapter 7 / Section 90.4.3 / Example: Calculating the Payment Amount Per

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
	M+C Enrollee
D	Chapter 7 / Section 90.5 / Treatment of Certain Demonstrations Under the PIP-DCG Risk Adjustment Method
D	Chapter 7 / Section 90.6 / Exclusions From Risk Adjustment Payment
N	Chapter 7 / Section 91 / The CMS-HCC Risk Adjustment Method for Adjustment of Capitation Rates
N	Chapter 7 / Section 91.1 / Demographic Factors Under the CMS-HCC Risk Adjustment Method
N	Chapter 7 / Section 91.1.1 / Age and Sex
N	Chapter 7 / Section 91.1.2 / Medicaid Eligibility
N	Chapter 7 / Section 91.1.3 / Originally Disabled
N	Chapter 7 / Section 91.2 / The CMS-HCC Classification System
N	Chapter 7 / Section 91.3 / Institutional Adjuster in the CMS-HCC Model
N	Chapter 7 / Section 91.4 / Implementation of the CMS-HCC Model
N	Chapter 7 / Section 91.4.1 / Elimination of the Data Lag
N	Chapter 7 / Section 91.4.2 / Implementation of the Adjustment for Long-Term Institutionalization
N	Chapter 7 / Section 91.4.3 / New Enrollees
N	Chapter 7 / Section 91.5 / Calculation of Beneficiary Risk Scores
N	Chapter 7 / Section 91.6 / Calculation of Monthly Payments to M+C Organizations
N	Chapter 7 / Section 91.6.1 / The Rescaling Factor
N	Chapter 7 / Section 91.6.2 / Adjustment to Rescaling Factors for Budget Neutrality
N	Chapter 7 / Section 91.6.3 / Adjustment in Rescaling Factors for Coding Intensity
N	Chapter 7 / Section 91.6.4 / Example: Calculating the Payment Amount Per M+C Enrollee
N	Chapter 7 / Section 91.7 / Changes in Methodology for PACE and Certain Demonstrations
N	Chapter 7 / Section 91.7.1 / Application of Frailty Model
N	Chapter 7 / Section 91.7.2 Application of Frailty Factor to M+C Organizations
N	Chapter 7 / Section 91.8 / Exclusions from Risk Adjustment Payment

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
D	Chapter 7 / Section 100 / Adjustment of Capitation Rates Under the Congestive Heart Failure (CHF) Initiative
D	Chapter 7 / Section 100.1 / Extra Payment in Recognition of the Costs of Successful Outpatient CHF Care
D	Chapter 7 / Section 100.2 / Requirements for Medicare + Choice Organizations to Qualify for Extra Payment in Recognition of the Costs of Successful Outpatient CHF Care Care
D	Chapter 7 / Section 100.2.1 / Two Required Quality Indicators Care
D	Chapter 7 / Section 100.2.2 / Designated Measurement Population Care
D	Chapter 7 / Section 100.2.3 / Thresholds Must Be Met Care
D	Chapter 7 / Section 100.2.4 / Reporting Care
D	Chapter 7 / Section 100.2.5 / Extra Payment Care
D	Chapter 7 / Section 100.2.6 / Auditing Care
D	Chapter 7 / Section 100.2.7 / Hospitalization Tracking Care
D	Chapter 7 / Section 100.3 / Questions About the Extra Payment in Recognition of the Costs of Successful Outpatient CHF Care Care
D	Chapter 7 / Section 110 / Encounter Data Collection for the Risk Adjustment Method Care
D	Chapter 7 / Section 110.1 / Overview of Encounter Data Care
D	Chapter 7 / Section 110.2 / Certification of Data Accuracy, Completeness, and Truthfulness Care
D	Chapter 7 / Section 110.3 / Validation of Data Care
D	Chapter 7 / Section 110.4 / Hospital Inpatient Encounter Data Requirements Care
D	Chapter 7 / Section 110.5 / Data Formats and Processing Care
D	Chapter 7 / Section 110.6 / Deadlines for Submission of Encounter Data Care
N	Chapter 7 / Section 111 / Data Collection and Submission for Risk Adjustment Care
N	Chapter 7 / Section 111.1 Hospital Inpatient Data
N	Chapter 7 / Section 111.2 / Outpatient Hospital
N	Chapter 7 / Section 111.3 / Physician Data
N	Chapter 7 / Section 111.4 Alternative Data Sources (ADS)
N	Chapter 7 / Section 111.5 / Data Collection

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N	Chapter 7 / Section 111.6 / Diagnosis Submission
N	Chapter 7 / Section 111.6.1 / Submission Methods
N	Chapter 7 / Section 111.6.2 / Submission Frequency
N	Chapter 7 / Section 111.7 / Certification of Data Accuracy, Completeness, and Truthfulness
N	Chapter 7 / Section 111.8 / Data Validation
R	Chapter 7 / Section 120 / Announcement of Annual Capitation Rates and Methodology Change
R	Chapter 7 / Section 160.1 / Terminology
R	Chapter 7 / Section 160.2 / Policy
R	Chapter 7 / Section 165 / Special Rules for M+C Payments to Department of Veterans Affairs Facilities
R	Chapter 7 / Section 180.3 / Eligibility for Bonus Payment / The Period of Application
R	Chapter 7 / Section 210 / Reconciliation Process for Changes in Risk Adjustment Factors
D	Chapter 7 / Section 210.1 / Reconciliation Schedule and Late Submission of Encounter Data
D	Chapter 7 / Section 210.2 / Organization of Risk-Adjusted Reconciliation
D	Chapter 7 / Section 220 / Reconciliation of Payments for Hospice Enrollees
D	Chapter 7 / Section 230 / Reconciliation of Payments for ESRD Beneficiaries
R	Chapter 7 / Exhibit 2 / Additional Information on Coverage of Clinical Trials
D	Chapter 7 / Exhibit 4 / Risk Factors for the PIP-DCG Risk Adjustment Payment Model
D	Chapter 7 / Exhibit 5 / Diagnosis (DxGroups) Included in Each PIP-DCG for the Payment Model
D	Chapter 7 / Exhibit 6 / Quality Indicators for Extra Payment in Recognition of the Costs of Successful Outpatient Treatment of CHF
D	Chapter 7 / Exhibit 7 / Report of Performance on Quality Indicators to Qualify for Extra Payment in Recognition of Successful Outpatient Treatment of CHF
N	Chapter 7 / Exhibit 10 / Community and Institutional Annual Risk Factors for the CMS-HCC Model with Constraints and Demographic/Disease Interactions
N	Chapter 7 / Exhibit 15 / List of Disease Groups (HCCs) with Hierarchies
N	Chapter 7 / Exhibit 20 / CMS-HCC Demographic Model for New Enrollees

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N	Chapter 7 / Exhibit 25 / Data Collection for Risk Adjustment / Facility Types and Physician Specialties
N	Exhibit A / Retired Material on the PIP-DCG Payment Methodology (Former Sections 90 and 110, Exhibits 4 and 5)
N	Exhibit B / Retired Material on the Congestive Heart Failure Extra Payment Initiative (Former Section 100 and Exhibits 6 and 7)

III. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Special Notification

Medicare Managed Care Manual

Chapter 7 - Payment to Medicare + Choice (M+C) Organizations

(Last Updated - Rev. 47, 02-20-04)

NOTE 1: *This revision includes information pertaining to the CMS-HCC risk adjustment model effective January 1, 2004. Information pertaining to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 will be included in future updates.*

Table of Contents

Exhibits

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20 - General Rules for M+C Payments

(Rev. 47, 02-20-04)

All payment rates are annual rates, determined and promulgated no later than March 1st for the following calendar year. With the exception of payments to M+C Medical Savings

Account (MSA) plans (§130) and payments for ESRD enrollees in all other plans (§20.1.1), CMS pays M+C organizations, for each enrollee in an M+C plan they offer, an advance monthly payment equal to 1/12th of the annual M+C capitation rates for the payment areas they serve.
These capitation rates are adjusted for demographic factors applicable to each enrollee, such as age, sex, disability status, institutional status, Medicaid status, and other factors determined to be appropriate to ensure actuarial equivalence. Beginning January 1, 2000, CMS implemented a risk adjustment method, *effective CYs 2000 through 2003,* that accounts for *the* variation in per capita cost based on health status and demographic factors, as discussed in *Exhibit A*. *Effective CY 2004, CMS implements the new CMS-HCC risk adjustment method, which is discussed in §§91 and 111.*

20.1.1 - Enrollees With End-Stage Renal Disease (ESRD)

(Rev. 47, 02-20-04)

For the purpose of M+C payment, "ESRD beneficiaries" includes beneficiaries with ESRD, whether entitled to Medicare because of ESRD, disability, or age. For enrollees diagnosed with ESRD, CMS establishes special rates at the State-level. The per capita Part A and Part B rates for each State are based on all fee-for-service ESRD expenditures in that State. Thus, costs related to dialysis, transplantation, and post-transplant drug therapy are included in the M+C rates. Services and supplies that are billable outside of the composite rate under fee-for-service Medicare are included in the M+C capitation rate. In short, all claims for ESRD beneficiaries under original Medicare are included in this tabulation, including claims for treatments not related to ESRD (such as a broken arm). Also, M+C ESRD rates include the costs of beneficiaries with Medicare as Secondary Payer (MSP) and the costs of beneficiaries who have functioning grafts 3 years or less from date of transplant.

In addition, CMS subtracts from the State capitation rate the actuarial value of the amount that the Secretary is authorized to subtract from each composite rate payment for each renal dialysis treatment under original Medicare, as set forth in §1881(b)(7) of the *Social Security Act (the* Act*)*. These funds are to be used to help pay for the ESRD network program in the same manner as similar reductions are used in original Medicare.

Prior to the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), ESRD base rates were built on a base year (1997) amount representing 95 percent of projected State average fee-for-service costs, as determined at the time. The State-level rates were not risk-adjusted. The BIPA required the Secretary to increase M+C ESRD payment rates, using appropriate adjustments, to reflect the rates paid under the ESRD Demonstration (including the risk adjustment methodology associated with those rates) of the social health maintenance organization (SHMO) ESRD capitation demonstrations. The new payment ESRD payment methodology, per the BIPA, is effective January 1, 2002, and involves two basic changes:

- CMS increased the base year rates by 3.0 percent to reach 100 percent of fee-for-service costs as estimated for the base year for M+C purposes (this adopts the approach used under the ESRD SHMO demonstration); and

- CMS tabulated age and sex factors for adjusting the State per capita rates, in order to pay more accurately due to differences in costs among ESRD patients.

See Exhibit 3 for the age and sex factors for M+C ESRD enrollees. To calculate the payment for a given ESRD enrollee, multiply the appropriate age/sex factors by the statewide M+C ESRD payment rates, and then sum the adjusted Part A and B amounts. The ESRD payment rates can be found on the CMS Web site at *http://www.cms.hhs.gov/healthplans/rates/default.asp*.

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30 - M+C Payment Methodology

(Rev. 47, 02-20-04)

Prior to the 1997 BBA, Medicare's capitated payments to risk-contracting managed care organizations for aged and disabled beneficiaries were determined using the Adjusted Average Per Capita Cost (AAPCC) methodology, as defined in §1876 of the Act. (See Exhibit 1 for a description of the AAPCC methodology.)

When Congress created the M+C program in 1997, it mandated a new payment methodology for organizations that enter into M+C contracts (§1853 of the Act). M+C rate calculations begin with the 1997 standardized county rates as a base. The 1997 county rates are standardized by demographic factors to account for differences among counties in the overall demographic profile of their Medicare beneficiaries, the demographic adjustments are carried forward into the M+C payment methodology. The BBA does not stipulate any adjustments to these 1997 base rates, other than to "carve out" a specified portion of the medical education costs implicit in the 1997 base rates (explained in §30.3.3).

Note that the statute permits exceptions to using the 1997 standardized county rates as a base for payment areas where the 1997 rate varied by more than 20 percent from the 1996 rate. For these areas, CMS could have substituted a rate more representative of the costs of enrollees in those areas, but determined that all rates were representative.

The most significant changes in the new methodology are:

- Gradually separating capitated Medicare payments from area-specific fee-for-service rates through the "greatest of three amounts" approach (see §30.1).

- Mandating the use of a risk adjustment method to better account for variation in beneficiary health status (see *§91 and Exhibits 10 - 25*).

30.1.2 - A Minimum Specified Amount or "Floor" Rate

(Rev. 47, 02-20-04)

The BBA set the floor rate for 1998 at $367 per month. For areas outside of the 50 States and the District of Columbia, for 1998 the minimum amount is the lesser of $367 or 150 percent of the 1997 standardized rate. For each succeeding year, the minimum amount rate equals the rate for the preceding year increased by the national per capita M+C growth percentage for the year (defined in §30.3.1).

BIPA Section 601 amends §1853(c)(1)(B) of the Act by establishing new minimum payment amount rates (floor rates) in CY 2001 for months after February. The new monthly minimum rates are as follows:

- $525 for any payment area in a Metropolitan Statistical Area (MSA) within the 50 States and the District of Columbia with a population of more than 250,000;

- $475 for any other area within the 50 States; or

- For any area outside the 50 States and the District of Columbia, $525 or $475 (depending on population size), only to the extent that this is not more than 120 percent of the minimum amount rate determined for CY 2000, which is the maximum established for these areas.

For January and February of 2001, the minimum amount rate is the minimum amount rate for the previous year increased by the national per capita M+C growth percentage, as described in §30.3.1 and 42 CFR 422.254(b), for the year. Minimum amount rates for January and February 2001 are based on the M+C rate book published in the March 1, 2000 "Announcement of Calendar Year (CY) 2001 Medicare+Choice Payment Rates." Minimum amount rates established by the BIPA for March through December 2001, are published in the January 4, 2001 "Revised Medicare+Choice (M+C) Payment Rates for Calendar Year (CY) 2001". Both documents can be found at *http://www.cms.hhs.gov/healthplans/rates/default.asp*.

The BIPA mandated that a single floor rate is now assigned to all counties within MSAs of a certain size, and another floor rate is assigned to all other counties. If a county is located in an MSA with a population greater than 250,000, the BIPA changed the floor rate for that county, effective March 1, 2001. As a result, pre-BIPA revisions to prior years' growth estimates for that county cannot be linked to post-BIPA revisions for that county. Thus, revisions to prior years' growth estimates for area-specific rates will differ from revisions to prior years' growth estimates for floor rates.

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50 - Adjustment of Capitation Rates for National Coverage *Determinations* (NCD) *and Legislative Changes in Benefits*

(Rev. 47, 02-20-04)

A National Coverage Determination (NCD) is a national policy determination made by CMS regarding the coverage status of a particular service under Medicare. An NCD does not include a determination of what code, if any, is assigned to a service or a determination about the payment amount for the service.

A legislative change in benefits is a coverage requirement adopted by the Congress and mandated by statute.

If CMS determines and announces that an individual NCD or legislative change in benefits meets the criteria for "significant cost" described in §50.1, an M+C organization is not required to assume risk for the costs of that service until the contract year for which payments are appropriately adjusted to take into account the cost of the NCD service or legislative change in benefits.

If CMS determines that an NCD or legislative change in benefits does not meet the "significant cost" threshold, the M+C organization is required to provide coverage for the NCD or legislative change in benefits and assume risk for the costs of that service or benefit as of the effective date stated in the NCD or specified in the legislation.

50.1 - Criteria For Meeting "Significant Cost"

(Rev. 47, 02-20-04)

The term "significant cost," as it relates to a particular NCD or legislative change in benefits, means either of the following:

1. The average cost of furnishing a single service exceeds a cost threshold that for calendar years 1998 and 1999 is $100,000, and for calendar year 2000 and subsequent calendar years is the preceding year's dollar threshold adjusted to reflect the national per capita M+C growth percentage (defined in §30.3.1), or

2. The estimated cost of all of Medicare services furnished as a result of a particular NCD or legislative change in benefits represents at least 0.1 percent of the national standardized annual capitation rate (defined in §30.3.4), multiplied by the total number of Medicare beneficiaries nationwide for the applicable calendar year.

3. *For purposes of payment adjustments in 42 CFR §422.256 only, the significant cost test is applied to all NCDs or legislative changes in benefits, in the*

aggregate, for a given year. If the sum of the average cost of each NCD or legislative change in benefits exceeds the amount in #1. of this subsection, or the aggregate costs of all NCDs and legislative changes for a year exceeds the percentage in #2. of this subsection, the costs are considered "significant."

50.2 - Rules for Coverage and Payment of "Significant Cost" NCDs

(Rev. 47, 02-20-04)

50.2.1 - Before Adjustments to Annual M+C Capitation Rate Are Effective

(Rev. 47, 02-20-04)

Before the contract year that payment adjustments that take into account the significant cost of the NCD service or legislative change in benefits become effective, the service or benefit is not included in the M+C organization's contract with CMS, and is not a covered benefit under the contract. The M+C organization must still provide coverage of the NCD service or legislative change in benefits by furnishing or arranging for the service. However, the M+C organization is not required to assume risk for the costs of that service or benefit until the contract year for which payments are appropriately adjusted to take into account the cost of the NCD service or legislative change in benefits. The following rules apply to such services.

Medicare payment for the service or benefit is:

- *In addition to the capitation payment to the M+C organization; and*
- *Made directly by the fiscal intermediary and carrier to the provider furnishing the service or benefit in accordance with original Medicare payment rules, methods, and requirements.*

Costs for NCD services or legislative changes in benefits for which CMS intermediaries and carriers will not make payment and are the responsibility of the M+C organization are:

- *Services necessary to diagnose a condition covered by the NCD or legislative change in benefits;*
- *Most services furnished as follow-up care to the NCD service or legislative change in benefits;*
- *Any service that is already a Medicare-covered service and included in the annual M+C capitation rate; and*

- *Any service, including the costs of the NCD service or legislative change in benefits, to the extent the M+C organization is already obligated to cover it as an additional or supplemental benefit.*

Costs for NCD services or legislative changes in benefits for which CMS intermediaries and carriers make payment are:

- *Costs relating directly to the provision of services related to the NCD or legislative change in benefits that were non-covered services prior to issuance of the NCD or legislative change in benefits; and*

- *A service that is not included in the M+C per capita payment rate.*

If the M+C organization does not provide or arrange for the service consistent with CMS' NCD or legislative change in benefits, enrollees may obtain the services through qualified providers not under contract to the M+C organization, and the M+C organization must pay for the services.

Beneficiaries are liable for any applicable coinsurance amounts.

50.2.2 - After Adjustments to the Annual M+C Capitation Rates Are in Effect

(Rev. 47, 02-20-04)

For the contract year in which payment adjustments that take into account the significant cost of the NCD service or legislative change in benefits are in effect, the service or benefit is included in the M+C organization's contract with CMS and is a covered benefit under the contract. The M+C organization must furnish, arrange, or pay for the NCD service or legislative change in benefits. The M+C organizations may establish separate plan rules for these services, subject to CMS review and approval. The CMS has the discretion to issue overriding instructions limiting or revising the M+C plan rules, depending on the specific NCD or legislative change in benefits.

For these NCD services and legislative changes in benefits, the enrollee is responsible for any M+C plan cost sharing, as approved by CMS, unless otherwise instructed by CMS.

If CMS determines that the cost of furnishing an NCD service or legislative change in benefits is significant, as defined in §50.1, CMS will adjust capitation rates or make other payment adjustments, to account for the cost of the service or legislative change in benefits.

NCD Adjustment Factor

The Office of the Actuary in CMS will apply a new NCD adjustment factor each year that reflects significant costs, in aggregate, of NCDs and legislative changes in benefits for coverage effective in the second prior year. The new NCD adjustment factor will be applied to the 2 percent minimum percentage increase rate (defined in §30.1) each year, beginning CY 2004.

See Chapter 4 of the Medicare Managed Care Manual for additional information on NCDs.

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60 - Adjustment of Capitation Rates for Working Aged Status

(Rev. 47, 02-20-04)

Beneficiaries are "working aged" if they are aged 65 or older, currently working for an employer with 20 or more employees, and have health insurance coverage through the employer's group health plan. Medicare-eligible spouses who are aged 65 or older, with health insurance coverage under a currently employed spouse's employer group health plan (if that employer has 20 or more employees) are also assigned working aged status (even if the currently employed spouse is under 65 years of age and not yet entitled to Medicare).

Medicare spending for working aged beneficiaries is significantly lower than spending for other beneficiaries because other insurers are primary to Medicare. In 1995, working aged status was added as a factor for adjusting payments to managed care organizations with 1876 risk contracts. Payments under the M+C program continue to be adjusted by this factor to take into account that Medicare is the secondary payer for working aged beneficiaries, and that its liability is much smaller than that for non-working aged beneficiaries.

Effective CY 2004, CMS will change the working aged (WA) annotation process from a monthly beneficiary-level adjustment to an annual plan-specific prospective factor representing the proportion of working aged in the plan. This process will decrease the administrative burden of the current methodology and will likely produce the same level of WA payment without the requirement for a protracted retroactive adjustment process. Please note that this process only applies to the demographic portion of the blended payment. Refer to the risk adjustment process at the end of this subsection. Currently, WA status is not considered for ESRD members.

Process - Demographic Portion of the M+C Payment

The M+C organizations will identify their WA members to CMS based on the annual survey. The CMS will use this data to compute an M+C contract-level WA factor based

on the relation between a monthly payment assuming no WA members and a monthly payment including the WA members identified by the M+C Organization. The CMS will then apply the M+C contract-level factor to the M+C organization's net monthly payment as a final adjustment. This adjustment will appear on the Plan Payment Report.

Process – Risk Adjusted Portion of the M+C Payment

The current method is adjust the payment for a WA enrollee to 0.21 of what the payment would be were that enrollee non-WA. For 2004, this reduction will be changed to .215, and the proportion will continue to be applied for non-ESRD members that are identified as WA. The reduction will be applied to their payments for the calendar year.

70 - Adjustment of Capitation Rates for Demographic Characteristics and Health Status

(Rev. 47, 02-20-04)

Prior to the BBA, county-wide payment rates for aged and disabled beneficiaries were adjusted based on the following factors, which were called "demographic" factors: Age, gender, Medicaid eligibility, and institutional status. (Aged rates were also adjusted for working aged status; see §60.) Under the BBA (§1853(a)(3) of the Act, the Secretary is required to develop and implement a risk adjustment method to better reflect the expected relative health status of each enrollee.

The purpose of adding health status to demographic factors is to consider the unique cost implications of characteristics related to diagnoses, and to increase the accuracy of the payment estimates for subgroups of the Medicare population. Thus, the goal of the new methodology is to pay M+C organizations based on better estimates of their enrollees' health care utilization, relative to the fee-for-service (FFS) population. Under the new risk adjustment method, capitation payments are adjusted for demographic factors and health status as captured by diagnoses.

NOTE: In this chapter the term **"demographic only method"** is used to indicate the method that does not include diagnostic data, while **"risk adjustment method"** refers to the new method where *diagnostic* data are incorporated.

70.1 - Transition to a Comprehensive Risk Adjustment Method

(Rev. 47, 02-20-04)

The BBA specifically requires implementation of a risk adjustment method no later than January 1, 2000. Under §1853(a)(3)(B), the BBA also requires "Medicare+Choice organizations (and eligible organizations with risk-sharing contracts under §1876) to submit data regarding inpatient hospital services for periods beginning on or after July 1, 1997, and data regarding other services and other information as the Secretary deems necessary for periods beginning on or after July 1, 1998."

The timing of this data collection authority indicated that the initial risk adjustment method should be based only on data from inpatient hospital stays, with later implementation of a method based on data from additional sites of care. Thus, CMS selected the Principal Inpatient Diagnostic Cost Group (PIP-DCG) model as the risk adjustment method under which payments are made *for 2000 through 2003*. In this model, diagnoses from hospitalizations are used to identify a particularly ill and high cost subset of beneficiaries for whom higher payments will be made in the next year. The system recognizes hospital discharges for which inpatient care is most frequently appropriate and which are predictive of higher future costs.

BIPA Section 603 amended §1853(a)(3)(C) of the Act by extending until 2007 the phase-in of risk adjustment. *For 2000 through 2003*, the PIP-DCG-based risk adjustment method is used to adjust a portion of payment, and the demographic-only method is used to adjust the other portion. *For 2004 through 2006, the CMS-HCC risk adjustment model will be used to adjust the non-demographic portion of the payments. Effective 2007, 100 percent of payments will be adjusted using the CMS-HCC model.* Thus, under the current schedule, there are two methods comprising the M+C payment system until 2007. The demographic-only method is described in §80, the PIP-DCG risk adjustment method is described in *Exhibit A, and the CMS-HCC risk adjustment method is described in §§91 and 111, and Exhibits 10 through 25*.

70.2 - Transition Schedule for Implementation of the Risk Adjustment Method

(Rev. 47, 02-20-04)

Payment amounts for each enrollee are separately determined using the demographic-only method and the risk adjustment method. These separate payment amounts are then blended according to the percentages for the transition year, summarized in Table 2.

Table 2 - Transition Schedule for Implementation of the Risk Adjustent Method

(Rev. 47, 02-20-04)

YEAR	Demographic-only Method (%)	Risk Adjustment Method (%)
CY 2000	90%	10% PIP-DCG model
CY 2001	90%	10% PIP-DCG model [BBRA and BIPA amendment]

YEAR	Demographic-only Method (%)	Risk Adjustment Method (%)
CY2002	90%	10% PIP-DCG model [BIPA amendment]
CY2003	90%	10% PIP-DCG model [BIPA amendment]
CY2004	70%	30% *CMS-HCC model* [BIPA amendment]
CY 2005	50%	50% *CMS-HCC model* [BIPA amendment]
CY 2006	25%	75% *CMS-HCC model* [BIPA amendment]
CY 2007 & succeeding years	0	100% *CMS-HCC model* [BIPA amendment]

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91 - The CMS-HCC Risk Adjustment Method for Adjustment of Capitation Rates

(Rev. 47, 02-20-04)

The Centers for Medicare & Medicaid Services Hierarchical Condition Category (CMS-HCC) model is a selected significant disease type of model because it incorporates a selected subset of ICD-9-CM diagnosis codes. These codes are placed into approximately 64 disease groups called Hierarchical Condition Categories (HCCs). Each disease group includes conditions that are related clinically and have similar cost implications. (See Exhibit 10 for a list of factors for each disease group.) These factors will be used to calculate per person per month payments to M+C organizations, PACE organizations and certain demonstrations.

The model is prospective in the sense that it uses diagnosis information from a base year to predict costs and adjust payments for the next year. Models of this type are largely driven by the costs associated with chronic diseases, and they capture the systematic risk (costs) associated with Medicare populations. For a description of the underlying

principles and development methods for the selected model, see the report on earlier versions of the HCC model, "Diagnostic Cost Group Hierarchical Condition Category Models for Medicare Risk Adjustment (Final Report); December 2000," on the CMS Web site at http://www.cms.hhs.gov/researchers/projects/.

The CMS-HCC risk adjusted payment method adds diagnostic information to demographic information on beneficiaries. It will be implemented for enrollees of M+C organizations effective with the January 1, 2004 payment. The model will apply to M+C organizations, PACE organizations, and certain demonstrations. The Evercare demonstration is currently scheduled to end December 31, 2003. Pending a decision on the extension of the waivers, CMS intends to implement the CMS-HCC model for Evercare in 2004. The CMS-HCC model will also apply to the Social HMOs (S/HMOs), Wisconsin Partnership Program (WPP), Minnesota Senior Health Options (MSHO), and the Minnesota Disability Health Options (MnDHO) demonstrations, as mentioned in §91.5.

CMS uses demographic and diagnostic information from original Medicare and from all organizations a beneficiary may have joined (taken from risk adjustment data submitted by organizations) to determine the appropriate risk factor for each beneficiary. The risk factor is computed for each beneficiary for a given year and applied prospectively. The factor generally follows the beneficiary for one calendar year. Since all Medicare beneficiaries have risk factors (including new M+C enrollees as described in §91.2.5), information is immediately available for payment purposes as beneficiaries join an M+C organization or move among organizations. When an M+C organization forwards beneficiary enrollment information to CMS, CMS then sends the organization the appropriate risk factor for the beneficiary, as well as the resultant payment.

Below are discussions of: demographic factors included in the CMS-HCC risk adjustment method; how CMS-HCC risk scores are calculated; how CMS-HCC risk adjusted payments are calculated; and changes in methodology for PACE and certain demonstrations and application of the frailty factor. Additional tools and information on the CMS-HCC model are available on the CMS Web site at http://www.cms.hhs.gov/healthplans/rates/default.asp.

91.1 - Demographic Factors Under the CMS-HCC Risk Adjustment Method

(Rev. 47, 02-20-04)

As in the Principal Inpatient-Diagnostic Cost Group (PIP-DCG) model described in Exhibit A, there are demographic variables for age and sex, Medicaid eligibility, and originally disabled status. There is also an adjustment for working-aged status. Unlike the PIP-DCG model, which does not have an institutional status risk adjuster, the CMS-HCC model has a modification that distinguishes the community-dwelling Medicare population from the long-term institutionalized populations. This long-term institutional

adjuster differs from the institutional factor used in the demographic-only payment model. The new institutional adjuster is explained at §91.4.2.

91.1.1 - Age and Sex

(Rev. 47, 02-20-04)

Twenty-four age/sex categories are included in the risk adjustment method, which mirror the splits used in the demographic-only method. In the past, CMS has recognized that people have birthdays that put them into age groups during a given year by either switching the payment group during the year in the demographic payment model or by paying a weighted average of the two groups each month to avoid having to switch age groups during the year (as the PIP-DCG model does). The CMS will now base payments on the age an enrollee attains as of February 1st of each year. This change will help simplify the M+C payment system.

91.1.2 - Medicaid Eligibility

(Rev. 47, 02-20-04)

The recognition of the additional costliness to the Medicare program of people characterized by Medicaid eligibility is maintained as it was in the PIP-DCG model. Note, however, that this Medicaid variable has less importance (less incremental cost) in models that recognize health status using disease groups because more of the payments in the model are associated with specific diseases rather than demographic categories. As in PIP-DCG, the Medicaid payment adjustment is triggered by a beneficiary having Medicaid status any one month in the data collection year.

91.1.3 - Originally Disabled

(Rev. 47, 02-20-04)

As in the PIP-DCG model, we also continue to recognize that those eligible for Medicare due to disability, or "originally disabled," continue to be more expensive after they turn 65. There are variables in the model capturing that the original reason for Medicare entitlement was disability.

91.2 - The CMS-HCC Classification System

(Rev. 47, 02-20-04)

The HCCs are disease groups broadly organized into body systems, somewhat analogous to the ICD-9-CM major diagnostic categories. Unlike the ICD-9-CM categories, however, the diagnoses within each disease group are related clinically and in terms of cost to the Medicare program.

Whereas the PIP-DCG model places a person in only a single cost group based on his/her principal inpatient diagnosis with the greatest cost implications, the CMS-HCC model is structured so that each disease group contributes its incremental predicted cost to payment amounts. Conceptually, disease groups are not mutually exclusive because unrelated disease processes each contribute to the predicted costs of care. The CMS-HCC model uses diagnoses from physician visits and hospital inpatient and outpatient stays to assign each beneficiary to none, one, or more than one disease group. For example, an M+C enrollee with heart disease, cerebrovascular disease, and cancer would be assigned to three separate disease groups, and CMS' payment for this enrollee will reflect increments for each of these conditions. We refer to this as an additive model because, in general, each additional diagnosis results in an increased payment.

In some cases, however, an additional diagnosis does not trigger an additional payment increment because a more severe diagnosis supercedes a less serious one in a hierarchy. That is, the CMS-HCC model also can characterize a beneficiary's illness level ***within*** *a disease process. In some disease groups the diagnoses are clinically related and ranked by (cost) severity in a hierarchy, since the more severe manifestations of a disease process principally define the impact of that disease group on cost.*

An example is the diabetes hierarchy. Diabetes diagnoses are organized into four severity groups, ranked from uncomplicated diabetes to diabetes with renal manifestations (highest cost implications). A person may be coded with diagnoses in any or all of the four severity groups, but only the highest code in the hierarchy is used to increment payment for diabetes. There are similar hierarchies among cancers and cardiac diseases. In short, costs are additive across hierarchies and disease groups, but not within hierarchies. (See Exhibit 15 for a list of the disease groups that have hierarchies.)

91.3 - Institutional Adjuster in the CMS-HCC Model

(Rev. 47, 02-20-04)

Unlike the PIP-DCG model, which does not have an institutional status adjuster, the CMS-HCC model includes an institutional status marker that distinguishes the community-dwelling Medicare population from the long-term institutionalized populations. The CMS' research revealed there are differences in cost between the community population and the long-term institutionalized (defined as those in institutions more than 90 days) within the same disease groups. Since we also found that costs for the short-term institutionalized resemble the costs for beneficiaries with similar health status residing in the community, the term "community" is used to refer to community-based and short-term institutionalized populations.

Note in Exhibit 10 that the risk factors for long-term institutionalized beneficiaries in the CMS-HCC model look different than those in the community model. For example, in some cases, these factors are zero for institutionalized persons, but are large for community residents. In order to better differentiate spending patterns for community and

institutionalized populations, the CMS-HCC model was run separately for each population, resulting in some of the coefficients being considerably different. Some of those differences are related to aggregating diseases in order to improve model stability. Also, some coefficients in the institutional model were set at zero dollars because the actual coefficient was negative and statistically significant.

In addition, some factors were considerably lower for the long-term institutionalized population reflecting an appropriate lower level of intensity of care in that setting. Some factors in the institutional model are, in fact, higher than the parallel factors in the community model. Payments for the long-term institutionalized are not systematically reduced by this payment system. Separating the population assures that an appropriate model is used for payment, in particular, one that accounts for the higher mortality rate of the population.

The community and institutional risk adjustment models are prospective payment models and the diagnostic data for both models will come from the data collection year. The long-term institutional indicator is concurrent because this approach more accurately reflects treatment patterns upon which costs are based. The concurrent institutional indicator can be implemented correctly because this population can be readily identified through an administrative data source and without additional burden to the industry. See §91.4.2 on the administrative data source.

91.4 - Implementation of the CMS-HCC Model

(Rev. 47, 02-20-04)

The CMS will implement the CMS-HCC risk adjustment model following the approach used to estimate the model. Below are descriptions of several implementation approaches. See Table 3 for the schedule for submission of risk adjustment data.

For M+C organizations, in 2004 the CMS-HCC model will be implemented at a 30 percent risk adjusted payment, with the remaining 70 percent being a demographic payment. See Table 2 in §70.2 for the transition schedule.

Table 3. Deadlines for Submission of Risk Adjustment Data

(Rev. 47, 02-20-04)

CY	*Data Collection Start Date*	*Dates of Service*	*Initial Submission Deadline*	*Final Data Submission Deadline*
2003	*Jul 1, 2001*	*Jul 1, 2001– Jun 30, 2002*	*Sep 6, 2002*	*Sep 26, 2003*
2004	*Jul 1, 2002*	*Jul 1, 2002– Jun 30, 2003*	*Sep 5, 2003*	*NA*
*2004**	*Jan 1, 2003*	*Jan 1, 2003- Dec 31, 2003*	*Mar 5, 2004*	*Mar 31, 2005*
2005	*Jul 1, 2003*	*Jul 1, 2003- Jun 30, 2004*	*Sep 3, 2004*	***NA***
*2005**	*Jan 1, 2004*	*Jan 1, 2004- Dec 31, 2004*	*Mar 4, 2005*	*Mar 31, 2006*

**Denotes calendar year, or non-lagged data schedule.*

For further information on late data submission and risk adjustment reconciliation see §210 of this manual.

91.4.1 Elimination of the Data Lag

(Rev. 47, 02-20-04)

Also different from the implementation of the PIP-DCG model, is CMS' move away from the "time shifted" model for payment. Instead, CMS will move to a calendar year data collection year, thus eliminating the "data lag." The initial factor for enrollees and associated payment in 2004 will be based on lagged data from July 1, 2002, through June 30, 2003. Under the non-lagged approach, risk adjustment data from January 1, 2003 through December 31, 2003, will be used to assign risk factors for enrollees and calculate payments to M+C organizations for calendar year 2004. The calendar year data factor will be calculated by about July of 2004. The M+C organizations will be paid on this factor for the remainder of the year. In addition, CMS expects to begin making mid-year payment adjustments retroactive to January 2004 in August 2004. These payment adjustments will represent the difference between the payments based on the non-lagged factor and those based on the lagged factor. All organizations must use these non-lagged factors when preparing their adjusted community rate proposals (ACRPs) for 2005.

However, because a few organizations that are owed money by CMS may prefer a delayed adjusted payment, we are allowing organizations to opt-out of this approach. For organizations that opt out, CMS will use the risk factor based on lagged data (i.e., diagnoses from July 2002 to July 2003) for making payments throughout CY 2004. In approximately March 2005, CMS will make payment adjustments for the 2004 payments

to reflect the difference between payments based on the non-lagged factor and those based on the lagged factor. No interest will be paid on these deferred payment adjustments, since the payments would be deferred at the request of the organizations. Organizations that desire to opt out of the implementation approach must notify CMS in writing by March 31, 2004. (This notification should be addressed to Angela Porter via email at aporter@cms.hhs.gov.)

The CMS will increase its monitoring of data submissions from all organizations. The current data requirement is that plans submit some diagnostic data to CMS at least quarterly. This requirement will be strictly upheld; M+C organizations will be required to submit at least 25 percent of their data on a quarterly basis.

91.4.2 - Implementation of the Adjustment for Long-Term Institutionalization

(Rev. 47, 02-20-04)

Institutional status is recognized in the payment year, not the prior year. To implement an adjuster without creating burden for the M+C organizations, CMS is using the Minimum Data Set (MDS) collected routinely from nursing homes to identify the population of long-term institutionalized. The CMS is using the presence of a 90-day assessment in the payment year to identify the long-term institutional residents for payment purposes. Payment at the long-term rate would start in the month following the assessment. Once persons are so identified, they remain in long-term status until discharged home for more than 14 days. Note that this marker is different from the institutionalized marker used in the demographic system. That marker largely captured the higher costs of older and sicker people who receive either skilled or unskilled care in an institution.

For M+C organizations or demonstrations where a majority of enrollees are long-term institutionalized persons, CMS will assume that all of their enrollees are institutionalized during the payment year. In reconciliation, M+C organizations will receive an adjustment reflecting the correct monthly institutional status for each person for each month for 2004 as reported through the MDS.

Payments in 2004 for the Long-Term Institutionalized

The CMS' approach for initial implementation of the institutional adjuster is as follows. The M+C organizations and demonstrations with less than 5 percent long-term institutionalized will be paid initially at the community rate whereas M+C organizations and demonstrations with greater than 5 percent long-term institutionalized will be paid at a rate based on the enrollee's status as of a point in time in the prior year. The CMS will then make adjustments based on the correct monthly institutional status of each person for each month in the year during the final CY 2004 reconciliation.

A primary goal of this implementation approach would be to eliminate the need for monthly monitoring by organizations, and allow CMS to examine MDS reporting for

individuals, if warranted, at the end of the payment year and make the necessary adjustments. We intend to reduce the burden of monthly monitoring by providing payments that are likely to reflect the correct residential status of the individual enrollees. Ultimately, this approach will allow CMS to calculate 12 months of payment based on reconciled data on institutional status for all enrollees.

91.4.3 - New Enrollees

(Rev. 47, 02-20-04)

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 entitlement during the data collection year.

If a beneficiary has less than 12 months of enrollment in Part B during the data collection period, then he/she will be assigned a new enrollee factor. During the payment year, a 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.: See Exhibit 20 for the risk factors used to calculate payments for new enrollees. Note that payments based on Medicaid eligibility will be made retroactively for all new enrollees, once enrollment can be established and verified.

91.5 - Calculation of Beneficiary Risk Scores

(Rev. 47, 02-20-04)

The beneficiary's status on each variable in the model (i.e., age, sex, original reason for entitlement, Medicaid eligibility, institutional status (long-term versus community and short-term), and diagnoses) will be used to determine his/her risk score. The risk score (and frailty factor, if applicable) is then multiplied by the correct rate book amount to determine the risk adjusted payment. The demographic portion of the payment will continue to incorporate demographic variables such as age, sex, Medicaid eligibility, and institutional status. The final step is to implement the correct transition blend (see §70.2 for the blend percentages). Below are several examples of calculation of risk scores.

Example A - *Beneficiary A is a male, aged 82 living in the community, who was originally entitled for Medicare due to disability. He is not eligible for Medicaid (no expenditure increment). He had several diagnoses: Diabetes with Acute Complications (HCC 17), Diabetes without Complications (HCC 19) and Pneumoccal Pneumonia (HCC112).*

Beneficiary A is placed in the appropriate sex and age group. "Male, aged 82, living in the community" carries an incremental risk factor of .657 . He also is assigned "originally disabled" status, which carries an incremental risk factor of .148. For diagnoses, Beneficiary A is assigned a factor of .391 for HCC 17, and HCC 19 is dropped because both HCC 17 and HCC 19 are in the diabetes hierarchy and only the

highest HCC in a hierarchy should be included in the calculation (see §91.2.1 above for additional information on hierarchies). In addition, a factor of .202 for HCC 112 would be added. Adding the incremental risk factors produces an overall risk score of 1.398. This risk score is then multiplied by the county rate book for that beneficiary.

Example B - *Beneficiary B is a female, aged 69, who was not originally disabled (no expenditure increment), is eligible for Medicaid, and living in the community. She had one diagnosis during the base year – specified heart arrhythmias (HCC 92), which is .266 and is added to the risk score. Beneficiary B is placed in the appropriate sex and age group. "Female, aged 69 living in the community" carries an incremental risk factor of .307. She also is assigned "aged with Medicaid" status, which adds an incremental risk factor of .183. The risk factor of .266 is added for HCC 92, so Beneficiary B's overall risk score is .756, which indicates someone who is likely to incur relatively low costs in the payment year. This risk score is then multiplied by the county rate book for that beneficiary.*

Example C *– Beneficiary C is a female, aged 88, who is living in a long-term nursing institution. She has three diagnoses: Polyneuropathy (HCC 71), Ischemic or Unspecified Stroke (HCC 96) and Decubitus Ulcer of Skin (HCC 148).*

Beneficiary C is placed in the appropriate sex and age group. "Female, aged 88 living in an institution" carries an incremental risk factor of .880. The institutional risk factors of .098 (HCC 71), .151 (HCC 96), and .317 (HCC 148) are added for an overall risk score of 1.446. This risk score is then multiplied by the county rate book for that beneficiary.

91.6 - Calculation of Monthly Payments to M+C Organizations

(Rev. 47, 02-20-04)

To determine risk adjusted monthly payment amounts for each Medicare+Choice enrollee, individual risk scores are multiplied by the appropriate area-specific (usually county) risk adjusted payment rate. For county rates, see http://www.cms.hhs.gov/healthplans/rates/default.asp. To derive the risk adjusted county rate, multiple the appropriate demographic county rate by the rescaling factor. The rescaled factor is addressed in §91.6.1.

91.6.1 - The Rescaling Factor

(Rev. 47, 02-20-04)

The demographic-only rate book calculates county rates by dividing county per capita costs by county average demographic factors. Prior to BBA, these rates were updated annually. However, the BBA requires all M+C county rates to have their basis in the 1997 AAPCC Rate Book. Thus, the factors used to standardize this 1997 Rate Book are "locked in" - including the average county demographic factors.

Although both the demographic-only and risk adjustment methods are attempting to measure the same thing - relative health status - the range of factors used in the two methods differs. In order to account for the fact that the factors differ between the two methods, a technical modification is necessary for payments to remain methodologically correct. Without some adjustment, this inconsistency between the demographic-only factors and the risk adjustment factors would result haphazardly in either significant underpayments or overpayments, depending on the county.

By itself, rescaling does not raise or lower payments. Whether aggregate payments to an M+C organization increase or decrease depends upon the risk profile of the beneficiaries enrolled in the plan(s) offered by that M+C organization.

Method for Calculating County Rescaling Factors

First, average county risk factors are computed for each county, using the CMS-HCC risk adjustment payment model. The average county risk factors replace the average county demographic factors applied under the demographic-only methodology.

The CMS' Office of the Actuary (OACT) calculates combined aged, disabled, Parts A, and Part B per capita costs. These combined county costs then are divided by the average county risk factors, creating new area-specific standardized rates. The OACT applies the mandated calculations to these new area-specific rates, e.g., the "greater of three" approach (blends, floors, and two percent increase), budget neutrality, medical education carve outs, etc.

This process generates a risk rate book. To determine the rescaling factor for a county, the per capita risk county rate is divided by the demographic-only county rate. Technically there are two rescaling factors for each county: one to rescale payments for aged enrollees, and the other for disabled enrollees.

In a given county, the rescaling factor used in payments for an aged beneficiary is defined as:

> *(Risk County Rate) / (Aged Demographic-only County Rate) = County Aged Rescaling Factor*

For disabled beneficiaries, the rescaling factor is defined as:

> *(Risk County Rate) / (Disabled Demographic County Rate) = County Disabled Rescaling Factor*

Additional information on average county risk factors is available at CMS' Web site http://cms.hhs.gov/healthplans/rates/. A file containing estimated county risk factors used to create the risk rate book is posted here.

91.6.2 Adjustment to Rescaling Factors for Budget Neutrality

(Rev. 47, 02-20-04)

In 2004, the rescaling factors reflect an adjustment for the implementation of risk adjustment in a budget neutral manner. In an effort to further stabilize the M+C program, the implementation of risk adjustment budget neutral will ensure that risk adjustment does not reduce the aggregate amount of payments to organizations. The Office of the Actuary (OACT) estimated the amount of adjustment to be incorporated into the rescaling factor, which for 2004 redistributes estimated payment reductions that would result from risk adjustment without this adjustment. The estimate is the difference between the aggregate payments that would be made using the demographic-only method for 100 percent of payments versus the aggregate payments that would be made using 100 percent of risk adjusted payments. The budget neutrality estimate is a multiplier applied to the rescaling factor.

Note that M+C organizations are required to reflect payments including the budget neutrality adjuster for 2004 in their 2004 Adjusted Community Rate Proposals (ACRPs). See Chapter 8 for information on ACRPs.

91.6.3 Adjustment in Rescaling Factors for Coding Intensity

(Rev. 47, 02-20-04)

In 2004, the rescaling factors reflect an adjustment for population demographic changes and coding practices or "coding intensity" (i.e., later data tends to reflect more precise coding). Under the original demographic payment methodology, the population average changed slowly over time, and in response, the demographic factors were changed slightly each year. However, the CMS-HCC model, which uses diagnostic information, is sensitive to coding intensity as well as demographic changes. The model requires adjustment to keep the anticipated average risk factor at 1.0 over time. A correction factor will be applied to the ratebook in 2004 to keep the anticipated average risk factor at 1.0 for each year. New data can then be used to refine projections for the next year. This rate book adjustment, which is built into the rescaling factor, should not result in lower payments to plans in 2004 because risk adjustment is being applied in a budget neutral manner as described in the previous section.

91.6.4 - Example: Calculating the Payment Amount Per M+C Enrollee

(Rev. 47, 02-20-04)

Risk adjusted payment amounts for each M+C enrollee are calculated as follows:

> *Payment = Demographic-only County Rate * rescaling factor * Enrollee Risk Factor*

To determine the risk-adjusted portion of payment for an enrollee, CMS payment systems calculate the appropriate Part A and Part B rates (aged or disabled), multiply by the corresponding rescaling factor (for aged or disabled rates), and then multiply by the enrollee risk factor (calculated from the risk factor tables in Exhibit 10). Finally, we apply the blend percentage in effect for the payment year, e.g., for 2004, the blend will be 30 percent rates adjusted by the risk method, and 70 percent demographic-only adjusted rates. (See Table 2 in §70.2 for the transition schedule.)

91.7 – Changes in Methodology for PACE and Certain Demonstrations

(Rev. 47, 02-20-04)

Overview

The CMS has developed a Medicare payment approach that adjusts the risk-adjusted payment to an organization according to the frailty of the organization's enrollees. The frailty adjustment approach will be applied to the PACE organizations, the Social HMOs (S/HMO) demonstration, the Wisconsin Partnership Program (WPP) demonstration, the Minnesota Senior Health Options (MSHO), and the Minnesota Disability Health Options (MnDHO) demonstrations in 2004.

While risk adjustment predicts (or explains) the future Medicare expenditures of individuals based on diagnoses and demographics, it may not explain all of the variation in expenditures for frail community populations. The purpose of frailty adjustment is to predict the Medicare expenditures of community populations with functionally impairments that are unexplained by risk adjustment. The frailty adjustment approach is to be applied in conjunction with the CMS-HCC risk adjustment model. As mentioned above, the CMS-HCC model has been designed to pay appropriately for the long-term institutionalized population. In addition, the CMS-HCC model pays appropriately for the disabled under-55 population regardless of functional impairment. Therefore, the frailty adjustment approach will apply only to community-based and short-term institutionalized enrollees aged 55 and over (i.e., the frailty adjustment for long-term institutionalized enrollees and community under-55 enrollees is zero).

Consistent with the way diagnosis data are used in risk adjustment, the frailty adjuster is prospective. That is, prior-year functional impairment data were used to predict the next-year's payment adjustment. The frailty model is based on Activities of Daily Living (ADLs) a proxy for functional impairment. Frailty factors are associated with difficulty with 0 ADLs, 1 to 2 ADLs, 3 to 4 ADLs, and 5 to 6 ADLS as follows:

Table 4. Frailty Factors for the 55-and-Over Community Populations

(Rev. 47, 02-20-04)

Difficulty in ADLs (Number)	*Frailty Factors*
0	*-0.143*
1-2	*0.172*
3-4	*0.340*
5-6	*1.094*

91.7.1 Application of Frailty Model

(Rev. 47, 02-20-04)

To apply the frailty adjuster, we developed an approach for collecting functional impairment data for an organization's enrollees. The PACE Health Survey (PHS) will be administered to PACE, WPP, MSHO and MnDHO in 2003 and 2004 to support payment adjustment in 2004 and 2005. These organizations must submit up-to-date data contact information for their enrollees respectively to CMS each year prior to survey implementation. For the SHMO demonstration, functional impairment data will be collected via the Health Outcomes Survey (HOS).

Responses from 55-and over participants residing in the community will be used to determine the organization-level frailty scores. Once the data are collected, they will be applied to the frailty model to determine a frailty "score" for each organization. The organization-level frailty score will be calculated as the weighted average frailty factor across all community survey respondents for that organization. For new PACE organizations not active as of January 1, 2002, the frailty score for 2004 payment will be the weighted average factor across all community respondents of all PACE organizations.

Non-response Bias: *Non-response bias occurs if survey respondents are significantly different than non-respondents in terms of their level of functional impairment. After the 2003 PHS and HOS have been administered, CMS will examine the extent of non-response bias for PACE and demonstrations. In order for CMS to detect non-response bias, we would request that organizations electronically submit nursing assessment data from the medical records for all survey participants to CMS. If significant nonresponse bias is detected, PACE payments could be adjusted as part of the 2004 reconciliation.*

Phase-in Schedule for PACE and Certain Demonstrations: *To minimize the impact of risk adjustment on some organizations, the phase-in schedule for these organizations will lag the phase-in of M+C risk adjustment by 1 year. In 2004, the PACE Medicare*

capitation payment will be a blended payment consisting of 90 percent of the current payment (i.e., 2.39 times the demographic rate book amount) plus 10 percent of the frailty adjusted payment. In 2005, the blend will be 70 percent current payment and 30 percent frailty adjustment. The blend will be 50/50 in 2006 and 25/75 in 2007. In 2008, frailty adjustment will be fully phased in for PACE. The phase-in schedule for WPP, MSHO and MnDHO will be consistent with the PACE phase-in schedule. That is, the blend will be 90/10 in 2004 and will continue to lag the M+C phase-in schedule by 1 year through 2008. Payment for the S/HMO demonstration in 2004 will be based on a 90/10 blend, with 90 percent of the payment based on the methodology in prior use during the demonstration, and 10 percent based on the new risk adjustment system with the additional frailty adjustment.

91.7.2 - Application of Frailty Factor to M+C Organizations

(Rev. 47, 02-20-04)

The CMS is working to improve the frailty adjustor to implement for all M+C organizations, while we implement the CMS-HCC model with a frailty adjustor for PACE organizations and certain demonstrations as an initial step. However, our current model needs further validation before implementation could be considered across the M+C program. We also need to develop an appropriate rate book adjustment for frailty.

91.8 - Exclusions From Risk Adjustment Payment

(Rev. 47, 02-20-04)

The M+C organizations with Cost or Health Care Pre-Payment Plan (HCPP) contracts will be excluded from payment under risk adjustment, but risk adjustment rates will be reported to these organizations as "risk equivalent" rates. This will replace the current reporting of the "risk equivalent" demographic-only rates to the Cost and HCPP plans.

The M+C enrollees who are capitated at the hospice rates are excluded from payment under risk adjustment. The M+C organizations will receive the demographic-only rate for these members. The CMS has separate reconciliation processes for hospice (§210).

111 – Data Collection and Submission for Risk Adjustment

(Rev. 47, 02-20-04)

The CMS uses diagnoses to calculate each beneficiary's risk adjustment factor. The risk adjustment factor is then multiplied by the capitation rate assigned to each beneficiary (county of residence) to produce the amount paid the M+C organization for each beneficiary. (See §91.6.4 on M+C payment calculations.)

The M+C organizations may submit diagnoses from certain provider types. Diagnoses received from the provider types defined below may be submitted. The following three

sections discuss provider types. Also see Exhibit 25 for information on facility types and physician specialties, with the ranges of Medicare provider numbers.

111.1 - Hospital Inpatient Data

(Rev. 47, 02-20-04)

Inpatient hospital data should be differentiated based on whether it is received from within or outside of the M+C organization's provider network. Per 42 CFR 422.204(a)3(i) all M+C organization network hospitals must have a Medicare provider agreement; by extension, a network provider should have a Medicare provider billing number for a hospital inpatient facility. If a facility does not have a hospital inpatient Medicare provider number, the M+C organization shall not submit diagnoses from that facility as hospital inpatient data. Please note that it is not necessary for M+C organizations to receive the Medicare provider number from the hospital on incoming transactions, i.e., the M+C organization may utilize its own provider identifications system. Regardless of how M+C organizations identify their facilities, M+C organizations must be able to distinguish diagnoses submitted by facilities that qualify as Medicare hospital inpatient facilities from diagnoses submitted by non-qualifying facilities.

For diagnoses received from non-network facilities, the M+C organization should first check whether the hospital is a Medicare-certified hospital inpatient facility. If the provider is a Medicare-certified hospital inpatient facility, the M+C organization should submit the diagnoses from this facility. If the hospital is not Medicare-certified, but is a Department of Veterans Affairs (VA) or DoD facility, the M+C organization must verify that it is a legitimate inpatient facility by contacting the Customer Service and Support Center (CSSC) prior to submitting data from that facility. If the hospital is not Medicare-certified or VA/DoD, the M+C organization should contact CMS to verify that the facility qualifies as a hospital inpatient facility prior to submitting any diagnoses from that facility.

To aid in determining whether or not a provider is a Medicare-certified hospital inpatient facility, the M+C organization may refer to the Medicare provider number. The Medicare provider number has a two-digit state code followed by four digits that identify the type of provider and the specific provider number. Exhibit 25 outlines the number ranges for all facility types that CMS considers to be Medicare hospital inpatient facilities. If the facility's Medicare provider number is unknown, the M+C organization may verify the provider number with the facility's billing department.

Some hospitals also operate Skilled Nursing Facilities (SNFs) as separate components within the hospital or have components with "swing beds" that can be used for either hospital inpatient or SNF stays. The M+C organizations shall not submit any diagnoses for stays in the SNF component of a hospital or from swing bed stays when the swing beds were utilized as SNF beds. Stays in both of these circumstances qualify as SNF stays and do not qualify as hospital inpatient stays. If the Medicare provider number is

on the incoming transaction from the facility, the M+C organization may distinguish the SNF or SNF swing-bed stays by the presence of a U, W, Y, or Z in the third position of the Medicare provider number (e.g., 11U001).

Principal Hospital Inpatient and Other Hospital Inpatient Diagnoses

The M+C organizations must differentiate between the principal hospital inpatient diagnosis and all other hospital inpatient diagnoses when coding the provider type on the risk adjustment transaction. According to the Official ICD-9 CM Guidelines for Coding and Reporting, the principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care." The principal diagnosis as reported by the hospital shall be coded as Provider Type 01, Principal Hospital Inpatient. The CMS strongly recommends that M+C organizations continue to collect electronic encounter data or claims from hospital inpatient stays to ensure the proper identification of the principal diagnosis.

The remaining diagnoses from a hospital inpatient stay shall be coded as Provider Type 02, Other Hospital Inpatient. The guidance for coding other conditions appears in Official ICD-9 CM Guidelines for Coding and Reporting, as well as in the section of these instructions titled Coexisting Conditions.

111.2 - Outpatient Hospital Data

(Rev. 47, 02-20-04)

Hospital outpatient data includes any diagnoses from a hospital outpatient department, excluding diagnoses that are derived only from claims or encounters for laboratory services, ambulance, or durable medical equipment, prosthetics, orthotics, and supplies. Hospital outpatient departments include all provider types listed in Exhibit 25. Also see Exhibit 25 for the valid Medicare provider number ranges.

Because Medicare has multiple number ranges for many provider types, and continuous number ranges feature multiple provider types, Exhibit 25 also includes a simplified list with the continuous valid Medicare provider number ranges for hospital outpatient facilities. The CMS has included Federally Qualified Health Centers, Community Mental Health Centers, and Rural Health clinics in the list of outpatient facilities to ensure M+C organizations are allowed to submit complete physician data. These three facility types utilize 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.

The M+C organizations should determine which providers qualify as hospital outpatient facilities in a similar manner as they determine which providers qualify as hospital inpatient facilities. As with hospital inpatient data, diagnoses collected from network providers are differentiated from diagnoses collected from non-network providers.

Because all M+C organization network hospitals must have a provider agreement, all network hospital outpatient facilities must have a Medicare provider number within the range of valid hospital outpatient provider numbers (see Exhibit 25). If a facility does not have a hospital outpatient Medicare provider number, the M+C organization shall not submit diagnoses from that facility as hospital outpatient data. It is not necessary that M+C organizations receive the Medicare provider number on incoming risk adjustment transactions, even if the transactions are electronic encounters or claims. However, M+C organizations must be able to distinguish diagnoses submitted by providers that qualify as hospital outpatient facilities from diagnoses submitted by non-qualifying providers.

For diagnoses received from non-network facilities, the M+C organization should first check whether the hospital is a Medicare-certified hospital outpatient facility. If the provider is a Medicare-certified hospital outpatient facility, the M+C organization should submit the diagnoses from this facility. If the hospital is not Medicare certified but is a VA or DoD facility, the M+C organization must verify that it is a legitimate outpatient facility by contacting the Customer Service and Support Center (CSSC) at 1-877-534-2772 prior to submitting data from that facility. If the hospital is not Medicare certified or VA/DoD, the M+C organization should contact CMS to verify that the facility qualifies as a hospital outpatient facility prior to submitting any diagnoses from that facility.

As with hospital inpatient facilities, if the facility's Medicare provider number is unknown, the M+C organization may verify the provider number by contacting the facility's billing department.

111.3 - Physician Data

(Rev. 47, 02-20-04)

For purposes of risk adjustment data, physicians are defined by the specialty list in Exhibit 25. This list includes certain non-physician practitioners, who for purposes of risk adjustment data, will be covered under the broad definition of physicians. This list also includes multi-specialty groups and clinics. This inclusion is solely intended to allow M+C organizations to submit data based on claims received from groups and clinics that bill M+C organizations on behalf of individual practitioners covered on the specialty list.

Physician risk adjustment data is defined as diagnoses that are noted as a result of a face-to-face visit by a patient to a physician (as defined above) for medical services. Pathology and radiology services represent the only allowable exceptions to the face-to-face visit requirement, since pathologists do not routinely see patients and radiologists are not required to see patients to perform their services. Medicare fee-for-service coverage and payment rules do not apply to risk adjustment data; therefore, M+C organizations may submit diagnoses noted by a physician even when the services

rendered on the visit are not Medicare-covered services. The diagnoses should be coded in accordance with the diagnosis coding guidelines in these instructions.

111.4 - Alternative Data Sources (ADS)

(Rev. 47, 02-20-04)

Alternative data sources include diagnostic data from sources other than inpatient hospital, outpatient hospital, and physician services. The M+C organizations may use ADS as a check to ensure that all required diagnoses have been submitted to CMS for risk adjustment purposes. Two examples of ADS include pharmacy records and information provided to national or state cancer registries.

Note that M+C organizations may not utilize ADS as an alternative to diagnoses from a provider. If M+C organizations elect to utilize one or more ADS, they must ensure that the diagnosis reported to CMS is recorded in the beneficiary's medical record for the data collection period or that the medical record documents the clinical evidence of that specific diagnosis for the data collection period.

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

111.5 - Data Collection

(Rev. 47, 02-20-04)

The M+C organizations have several options for collecting data from providers to support the risk adjustment submission. When M+C organizations collect data, they may choose to utilize:(1) the standard claim or encounter formats; (2) a superbill (a common physician office claim form that lists standard ICD-9-CM codes, CPT codes, and beneficiary information); or (3) the minimum data set (HIC, diagnosis, "from date," "through date," and provider type), which is the format used to support CMS' Risk Adjustment Processing System (RAPS).

Standard claim and encounter formats currently include the UB-92, the National Standard Format (NSF), and ANSI X12 837. All M+C organizations that collect electronic fee-for-service claim or no-pay encounters from their provider networks shall utilize the data from these transactions to prepare their risk adjustment data submissions. The M+C organizations with capitated or mixed networks may also choose to use an

electronic claim or encounter format to collect risk adjustment data from their capitated providers.

Under mandatory Health Insurance Portability and Accountability Act (HIPAA) transaction standards, all electronic claims or encounters sent from providers (physicians and hospitals) to health plans (M+C organizations) will constitute HIPAA-covered transactions. Any M+C organization that utilizes an electronic claim or encounter format for their risk adjustment data collection will need to convert to ANSI X12N 837 version 4010.

Any M+C organization that utilizes an electronic claim or encounter to collect diagnoses from their providers shall submit the diagnoses collected on those claims and encounters. The M+C organizations shall not utilize a superbill or the minimum risk adjustment data set to obtain diagnoses from providers who submit electronic claims or encounters, except when correcting erroneous diagnoses or supplementing incomplete diagnoses.

Regardless of the method(s) that the M+C organization utilizes to collect data from providers, any M+C organization may utilize any submission method accepted by CMS (UB-92, NSF, ANSI, risk adjustment data format, or direct data entry).

111.6 - Diagnosis Submission

(Rev. 47, 02-20-04)

For each enrolled beneficiary, M+C organizations shall submit each relevant diagnosis at least once during a data collection period. A relevant diagnosis is one that meets three criteria:

1. *The diagnosis is utilized in the model;*

2. *The diagnosis was received from one of the three provider types covered by the risk adjustment requirements (hospital inpatient, hospital outpatient, and physician); and*

3. *The diagnosis was collected according to the risk adjustment data collection instructions*

The M+C organizations may elect to submit a diagnosis more than once during a data collection period for any given beneficiary, as long as that diagnosis was recorded based on a visit to one of the three provider types covered by the risk adjustment data collection requirements. The M+C organizations may submit any qualifying diagnoses received from one of the three provider types, including diagnoses that are not in the CMS-HCC risk adjustment model. Diagnoses that are in the model, but that were not collected from one of the three provider types should not be submitted as risk adjustment data. See Table 3 in §91.4 for risk adjustment data submission deadlines.

The CMS will utilize the "through date" of a particular diagnosis when determining the "date of service" for purposes of risk adjustment; i.e., all diagnoses that have a "through date" that falls within the data collection year will be utilized in the risk adjustment model.

- *For hospital inpatient diagnoses, the "through date" should be the date of discharge. All hospital inpatient diagnoses shall have a "through date."*

- *For physician and hospital outpatient diagnoses, the "through date" should represent either the exact date of a patient visit or the last visit date for a series of services.*

- *For outpatient and physician diagnoses that correspond to a single date of service, M+C organizations have the option of submitting only the "from date," leaving the "through date" blank.*

When a M+C organization submits a "from date" and no "through date," the Risk Adjustment Processing System (RAPS) will automatically copy the "from date" into the "through date" field. The returned file, provided to the M+C organization, will contain both a "from date" and "through date" for every diagnosis.

Date Span

Date span is the number of days between the "from date" and "through date" on a diagnosis. For inpatient diagnoses, the "from date" and "through date" should always represent the admission and discharge dates respectively. Therefore, the date span should never be greater than the length of the inpatient stay. For physician and hospital outpatient data, the date span shall not exceed 31 days.

111.6.1 - Submission Methods

(Rev. 47, 02-20-04)

Data submission to CMS may be accomplished through any of the following methods:

- *The new RAPS format (all provider types);*

- *Full or abbreviated UB-92 (hospital inpatient and outpatient);*

- *Full or abbreviated National Standard Format (NSF) (physician only);*

- *ANSI X12N 837 Version 30.51 (all provider types, only for those submitters currently utilizing this version);*

- *ANSI X12N 837 Version 40.10 (all provider types); and*

- *Online direct data entry (DDE) available through Palmetto Government Benefits Administrators (all provider types).*

The Risk Adjustment Processing System

RAPS is the data processing system used to edit and store risk adjustment data submitted to CMS through the Front End Risk Adjustment System (FERAS) at Palmetto GBA, South Carolina. The RAPS reports to the submitter the results of each individual transaction at a detail and summary level. The RAPS also provides to all submitters monthly and cumulative summaries of the diagnoses on file.

M+C organizations may elect to utilize more than one submission method. All transactions will be submitted using the same network connectivity that M+C organizations currently utilize for encounter data submission. For assistance in utilizing any of the submission methods, please contact the Computer Service and Support Center (CSSC) at 1-877-534-2772.

Regardless of the method of submission that a M+C organization selects, all transactions will be subject to the same edits. The Front-End Risk Adjustment System (FERAS) will automatically format all DDE transactions in the Risk Adjustment Processing System (RAPS) format. Transactions that are submitted in claim or encounter formats will be converted to the RAPS format prior to going through any editing. The mapping from each claim or encounter transaction to the RAPS format is on the CSSC Web site at www.mcoservice.com.

Electronic Data Interchange (EDI) Agreements

The All M+C organizations should have EDI agreements on file at Palmetto GBA, the front-end recipient of all risk adjustment data. All M+C organizations must complete an EDI agreement prior to submitting to the RAPS system.

Use of Third Party Submitters

The M+C organizations may continue to utilize third-party vendors to submit risk adjustment data. Regardless who submits the data, CMS holds the M+C organization accountable for the content of the submission.

111.6.2 - Submission Frequency

(Rev. 47, 02-20-04)

M+C organizations shall submit risk adjustment data at least once per calendar quarter. Each quarter's submission should represent approximately one quarter of the data that the M+C organization will submit over the course of the year. The amount of records and diagnoses to which this corresponds depends upon the type of submission a M+C organization selects. If a M+C organization elects to use a claim or encounter

submission, the ratio of records and diagnoses to enrollees will be much higher than if a M+C organization elects to use a quarterly summary transaction.

The CMS will monitor submissions to ensure that all M+C organizations meet the quarterly submission requirements. For M+C organizations that do not receive a regular submission of superbills, claims, or encounter data from their providers, CMS strongly recommends that these organizations request new diagnoses from all network providers on a quarterly basis at a minimum to ensure accurate, complete and timely data submission.

111.7 - Certification of Data Accuracy, Completeness, and Truthfulness

(Rev. 47, 02-20-04)

As a condition for receiving a monthly payment under the M+C program, the M+C organization agrees that its chief executive officer (CEO), or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must make a certification in the M+C contract, based on best knowledge, information, and belief, that the risk adjustment data the M+C organization submits to CMS are accurate, complete, and truthful. (This form is appended to Chapter 11 of the Managed Care Manual.) If risk adjustment data are generated by a related entity, contractor, or subcontractor of the M+C organization, such entity, contractor, or subcontractor must similarly certify the accuracy, completeness, and truthfulness of the data. (See 42 CFR 422.502(l).)

The CMS expects M+C organizations to design and implement effective systems to monitor the accuracy, completeness, and truthfulness of risk adjustment data and to exercise due diligence in reviewing the information provided to CMS. The Department of Justice, the Office of Inspector General, and CMS acknowledge that the volume and variety of data make some inaccuracies inevitable, and they will take into account any legitimate difficulties M+C organizations may have with provider compliance. However, this certification standard does not relieve M+C organizations of their obligation to comply fully with the M+C program's risk adjustment data requirements.

The M+C organizations may include in their contracts with providers, suppliers, physicians, and other practitioners, provisions that require submission of complete and accurate data. These provisions may include financial penalties, including withholding payment, for failure to submit complete and accurate data, or for failure to submit data that conform to the requirements for submission.

111.8 - Data Validation

(Rev. 47, 02-20-04)

A sample of risk adjustment data used for making payments may be validated against hospital inpatient, hospital outpatient, and physician medical records to ensure the

accuracy of medical information. Risk adjustment data will be validated to the extent that the diagnostic information justifies appropriate payment under the risk adjustment model. The M+C organizations will be provided with additional information as the process for these reviews is developed.

The M+C organizations must submit risk adjustment data that are substantiated by the physician or provider's full medical record. M+C organizations must maintain sufficient information to trace the submitted diagnosis back to the hospital or physician that originally reported the diagnosis. Since M+C organizations may submit summary level transactions without a link to a specific encounter or claim, establishing an appropriate audit trail to the original source of the data requires diligent information management on the part of the M+C organization.

120 - Announcement of Annual Capitation Rates and Methodology Changes

(Rev. 47, 02-20-04)

Under the BBA, CMS must notify M+C organizations of any proposed changes to the payment methodology no later than 45 days prior to announcement of the annual capitation rates, which must be published annually. The annual rate announcement must include the final county rates, a description of the risk and other factors, and other information necessary to ensure that M+C organizations can calculate the monthly-adjusted capitation rates for individuals in each of their payment areas.

The Public Health Security and Bioterrorism Response Act of 2002 (Public Law 107-188) changed the deadline for the annual announcement of the M+C capitation rates from no later than March 1 to no later than the second Monday in May for 2004 and 2005 rates. Proposed changes to the payment methodology must still be published no later than 45 days before annual announcement of rates.

160.1 - Terminology

(Rev. 47, 02-20-04)

Qualifying Individuals-1 (QI-1s) - Effective 1/1/1998 - 12/31/2002*, renewed by Congress for 2003.* Individuals entitled to Part A of Medicare, with income above 120 percent, but less than 135 percent of the Federal poverty level, resources not exceeding twice the SSI limit, and not otherwise eligible for Medicaid. Eligibility for Medicaid benefits is limited to full payment of Medicare Part B premiums. The number of eligible individuals is limited by the availability of a capped allocation.

Qualifying Individuals-2 (QI-2s) - Effective 1/1/1998 -12/31/2002.Individuals entitled to Part A of Medicare, with income at least 135 percent, but not exceeding 175 percent of

the Federal poverty level, resources not exceeding twice the SSI limit, and not otherwise eligible for Medicaid. Eligibility for Medicaid benefits is limited to partial payment of Medicare Part B premiums (an amount attributable to switching some home health coverage from Part A to Part B).The number of eligible individuals is limited by the availability of the capped allocation.

160.2 - Policy

(Rev. 47, 02-20-04)

For 2001 payments, M+C organizations may not present Qualified Individuals (either QI-1s or QI-2s) as eligible for Medicaid payment adjustments. The CMS does not believe it is appropriate to penalize M+C organizations for shortcomings in the quality of State data CMS uses as the basis for payments. Furthermore, it is not realistic for M+C organizations to verify the Medicaid eligibility status and categories of each of their enrollees. Therefore:

- CMS will not make retroactive adjustments (and collect overpayments) for payments made for based on the Medicaid adjustment for QIs in the past.

- To the extent that CMS systems incorrectly label Qualified Individuals as other groups of Medicaid eligibles (and therefore qualified for Medicaid payment adjustments), CMS will not hold M+C organizations responsible for correcting this information.

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165 - Special Rules for M+C Payments to Department of Veterans Affairs Facilities

(Rev. 47, 02-20-04)

Section 1814(c) of the Social Security Act (the Act) sets forth the general rule that Medicare payments may not be made to any Federal provider of services for any item or service that such provider is obligated by law, or contract with the United States, to render at public expense. The Department of Veteran Affairs (VA) is a federal provider of services that is obligated by law to render services to veterans at public expense. The CMS has clarified that an M+C organization is an entity that "stands in the shoes" of Medicare, and is considered a federal provider of services for purposes of this general rule. This means that an M+C organization may not use Medicare funds to pay the VA Healthcare System for VA-covered services rendered to veterans who are also M+C organization enrollees. This rule prevails for both elective services and the emergency services rendered by the VA to veteran M+C enrollees.

An M+C enrollee who is enrolled in the VA Medical Benefits Plan has dual entitlement to separate government-funded health care systems. This means that the individual may

elect to receive his or her health care either through the VA system or through his or her M+C plan. If the individual elects to receive routine or non-emergency services through the VA system, the VA would be obligated by law to pay for those services and the M+C organization would not be permitted to reimburse for such services under the same law.

Similarly, the M+C organization is not permitted by law to pay the VA system for emergency services rendered by the VA to veterans who are M+C enrollees. This holds true regardless of the circumstances underlying the enrollee's presentation to the VA. Thus, the prohibition against payment to the VA prevails whether the enrollee self-presented to the VA (e.g., walk-in patient), was directed there by a treating physician, or was brought to the VA by ambulance.

While the M+C organization cannot be obligated to pay the VA directly for services rendered to veteran M+C enrollees, the M+C organization may be obligated to indemnify its enrollees for cost-sharing expenses assessed by the VA for emergency services. Federal regulation 42 CFR 422.502(g) obligates the M+C organization to indemnify enrollees for payment of any fees that are the legal obligation of the M+C organization for services furnished by providers that are not contracted with the M+C organization. The M+C organizations are legally obligated to cover both contracted and non-contracted emergency services, per 42 CFR 422.113. Pursuant to this rule, M+C organizations may be obligated to indemnify enrollees for VA-imposed cost-sharing, which should not exceed cost-sharing levels imposed in fee-for-service Medicare.

Non-Veteran M+C enrollees

The rules governing M+C organizations' responsibility for payment differs for services rendered by the VA to non-veteran M+C enrollees. The rule at §1814(c) of the Act prohibiting payment has no application to non-veterans. Non-veteran enrollees are covered under §1814(d), which permits payment to be made to hospitals not contracted with Medicare for emergency services rendered to Medicare beneficiaries. Under 42 CFR 422.100 and 422.113, M+C organizations are responsible for covering emergency and post-stabilization care services rendered to enrollees. M+C organizations are obligated to reimburse the VA for such services, and would be expected to coordinate care of non-veteran enrollees who are in a VA hospital due to an emergency as it would in any other non-contracted or out-of-network hospital.

Exception under Section 1814(h) of the Act

The rules governing M+C organizations' responsibility for payment for services rendered by the VA to non-veteran M+C enrollees also contain a provision at §1814(h) of the Act for circumstances in which a non-veteran is admitted to a VA hospital when both the individual and the VA mistakenly believe that the individual is entitled to VA benefits when in fact they are not. The §1814(h) exception only applies to the unusual situation in which an M+C Organization enrollee who is a non-veteran is mistakenly admitted to a VA hospital for a service that does not require pre-authorization by their M+C Organization plan. The CMS expects that this situation would be very rare.

180.3 - Eligibility for Bonus Payment - The Period of Application

(Rev. 47, 02-20-04)

The BBRA specified that the new entry bonus would only apply to M+C plans that are first offered during the period of application, which is the period beginning January 1, 2000 and ending on December 31, 2001. This period of application is a 2-year window during which an M+C organization that enters a previously unserved payment area and offers the first M+C plan in that area, will be eligible for bonus payments.

Note that although the BIPA changed the time period defining a previously unserved payment area, it did not change the time period defining the period of application. The result of this change is that now the time periods defining "previously unserved" payment area and "period of application" are the same: from January 1, 2000 through December 31, 2001. (The BIPA amendment applies as if it were included in the enactment of the BBRA.) Table 5 shows a comparison of the two different time periods in effect for the new entry bonus.

Table 5 - Comparison of BBRA and BIPA Provisions on New Entry Bonus

Provision	BBRA	BIPA
Time period defining a previously unserved payment area	By January 1, 2000	By January 1, 2000 through or by January 1, 2001
Period of application (the window for M+C organizations to first offer an M+C plan in an unserved area)	January 1, 2000 through December 31, 2001	January 1, 2000 through December 31, 2001

We discussed the BIPA amendment to the new entry bonus in the January 12, 2001 "Advance Notice of Methodological Changes for Calendar Year 2002 Medicare+Choice Payment Rates," published on our Web site at and in the March 1, 2001 "Announcement of Calendar Year 2002 Medicare+Choice Payment Rates" *(both published on our Web site at http://www.cms.hhs.gov/healthplans/rates/default.asp)*. In the March 1 announcement, we indicated that the 1-year extension in the time period defining an unserved area mandated by the BIPA also applied to the 2-year period of application. In effect, this would extend the end of the period of application window from December 31, 2001 to December 31, 2002. As a result, we stated that an M+C organization first offering a plan in a previously unserved payment area on January 1, 2002, would be eligible for the bonus payments.

After further analysis, we have determined that while the BIPA did expand the time period used to define a previously unserved payment area, it did not extend the period of application window during which an M+C organization must first offer a plan in a previously unserved area. The period of application remains January 1, 2000, through December 31, 2001. For example, an M+C organization that first offers a plan in a previously unserved payment area on January 1, 2002, would not be eligible for the new entry bonus payments. However, if the M+C organization first offers a plan in a previously unserved payment area prior to January 1, 2002, then the M+C organization would have first offered an M+C plan within the period of application and the organization would be eligible for new entry bonus payments.

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210 - Reconciliation Process for Changes in Risk Adjustment Factors

(Rev. 47, 02-20-04)

Unlike the demographic-only method, the risk adjustment method generates a beneficiary-specific factor that is effective for a calendar year. This annual risk factor is used to adjust county per capita payment rates to determine per enrollee M+C payment amounts, and is based on the following classes of information:

- Age;
- Gender;
- Medicaid status;
- Disability status ("previously disabled");
- Inpatient diagnoses (PIP-DCGs).

Adjustments to beneficiary risk factors due to corrections in the statuses listed above will not occur during the payment year. Making corrections to beneficiaries' statuses and processing the resulting payment adjustments are accomplished through a reconciliation process that occurs after the end of the payment year.

Changes in beneficiary status that do not impact the risk adjustment factor are processed concurrently during the payment year. They are:

- Enrollment/disenrollment dates;
- Part A/B entitlement;
- State and county codes; and

- Working aged status

***NOTE**: M+C enrollees who are capitated at the hospice rates (see §150) and ESRD rates are excluded from payment under the risk adjustment method; they are capitated at the applicable demographic-only rate.*

Because M+C organizations have only 3 months after the end of a data collection year to submit the diagnostic data that is used to develop risk factors, the final reconciliation for a year allows all the late diagnostic data to be incorporated into the enrollee's risk score. For example, M+C organizations must submit risk adjustment data from the January 1, 2003, through December 31, 2003, data collection period by March 5, 2004, in order for the data to be included in the preliminary risk factor based on non-lagged data for 2004. Diagnostic data submitted after this date will not be incorporated into initial payments based on this data collection period. However, CMS will accept late data for the 2003 calendar year through March 31, 2005. After this date, CMS will no longer accept data for risk adjustment for CY 2004. See Table 3 in §91.4 of this chapter for the schedule for deadlines for data submission.

The reconciliation incorporates all the diagnoses from the correct data collection period in addition to other changes in enrollee's status (i.e., age, gender, Medicaid eligibility, institutional status, and original reason for entitlement) to be factored into each enrollee's risk factor. Then, adjustments are made to ensure that M+C organizations' final payments for a year are correct. There is a single final reconciliation for each payment year. The final reconciliation for 2004 payments will be conducted in the spring of 2005, with final reconciled payments for 2004 expected to be provided to M+C organizations in the August 2005 payments.

Exhibit 2 - Additional Information on Coverage of Clinical Trials

(Rev. 47, 02-20-04)

Below is additional information *on clinical trial coverage* presented in question and answer format. See Chapter 4 of the manual for general information on *NCDs*.

Q1 - May an M+C enrollee participate in clinical trials even when the providers in the trial are not in the M+C organization's network?

A1 - Yes. Medicare regulations require that NCD services be furnished to M+C enrollees even when these services cannot be furnished though an M+C organization network. The nature of *covered* clinical trials is such that many of these services only will be available and accessible to M+C enrollees when furnished by out-of-network providers. For this reason, coverage cannot be limited to trials in which the M+C organization itself may participate or to trials in which M+C organization network providers may participate.

If M+C members ask their organizations for information on Medicare coverage of these clinical trials services, the organizations may wish to direct them to 1-800-MEDICARE for more information.

Q2 - Does the fact that Medicare will be paying for the routine costs of covered clinical trials on a fee-for-service basis *through 2004* mean that all services for M+C enrollees in clinical trials may be billed in this way?

A2 - No. There is no change in M+C organizations' obligation to provide all other benefits that are covered under the contract to beneficiaries who participate in *covered* clinical trials.

Q3 - Medicare+Choice organizations are concerned about losing track of the services and care being provided to members who participate in clinical trials when the organizations do not pay for the services. What can Medicare+Choice organizations do to follow these M+C members?

A3 - *CMS'* payments for *covered* clinical trial services directly to providers may make it hard for M+C organizations to track and coordinate the care for these beneficiaries. M+C organizations may set up a notification process to collect information about which members are in a clinical trial, and which clinical trial they are in. This notification process may not be used in any way as a pre-authorization mechanism, however.

Q 4 - How will payments to providers be calculated?

A 4 - Payment for *covered* clinical trial services furnished to beneficiaries enrolled in Medicare managed care plans is determined according to the applicable fee-for-service rules, except that M+C enrollees are not responsible for meeting either the Part A or Part B deductible (i.e., the deductible is waived). *The* M+C enrollees are liable for the coinsurance amounts applicable to services paid under *their plan rules (which may be the* Medicare fee-for-service rules).

Q5 - What should M+C organizations do if clinical trial providers send them bills?

A5 - If a provider sends a bill with the clinical trial codes on it to an M+C organization, the M+C organization should not pay it. Instead, the organization should inform the provider that the bill should be submitted to the appropriate intermediary or carrier. Of course, M+C organizations continue to be responsible for all other benefits that are covered under the contract to beneficiaries who participate in the clinical trials.

Q6 - Some of the providers in an M+C organization network are involved in clinical trials but are not enrolled as Medicare providers. What do they need to do to enroll?

A6 - Providers serving managed care enrollees receiving *covered* clinical trial services must be enrolled with Medicare in order to bill on a fee-for-service basis for those services. Providers that wish to bill, but that have not yet enrolled with Medicare should contact their local carrier, intermediary, or National Supplier Clearinghouse, as appropriate, to obtain an enrollment application.

Q7 - Do M+C organizations need to furnish non-Medicare benefits as part of the routine costs of *covered* clinical trials?

A7- No. Until the costs of clinical trials' services are factored into M+C capitated payment rates, M+C organizations are not obligated to furnish any additional or supplemental benefits as routine costs of clinical trials.

Q8 - Are M+C organizations responsible for submitting *diagnostic* data for these services?

A8 No. *The* M+C organizations are not responsible for submitting *diagnostic* data from clinical trial providers. Because CMS will be making fee-for-service payments directly to providers for clinical trials services, the information needed for risk adjustment (diagnoses and other data elements) will already be present in CMS' systems.

Q9 - Where can M+C organizations go to get more information on clinical trials?

A9 - If M+C organizations or other entities have further questions regarding the coverage of clinical trials and their responsibilities regarding this coverage they may send an e-mail to clinicaltrials@cms.hhs.gov or contact their plan manager.

Exhibit 10 - Community and Institutional Annual Risk Factors for the CMS-HCC Model with Constraints and Demographic/Disease Interactions

(Rev. 47, 02-20-04)

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

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

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

Variable	*Disease Group*	*Community Factors*	*Institutional Factors*
HCC82	*Unstable Angina and Other Acute Ischemic Heart Disease*	*0.348*	*0.288*
HCC83	*Angina Pectoris/Old Myocardial Infarction*	*0.235*	*0.288*
HCC92	*Specified Heart Arrhythmias*	*0.266*	*0.187*
HCC95	*Cerebral Hemorrhage*	*0.392*	*0.151*
HCC96	*Ischemic or Unspecified Stroke*	*0.306*	*0.151*
HCC100	*Hemiplegia/Hemiparesis*	*0.437*	*0.098*
HCC101	*Cerebral Palsy and Other Paralytic Syndromes*	*0.164*	*0.098*
HCC104	*Vascular Disease with Complications*	*0.677*	*0.509*
HCC105	*Vascular Disease*	*0.357*	*0.114*
HCC107	*Cystic Fibrosis*	*0.376*	*0.230*
HCC 108	*Chronic Obstructive Pulmonary Disease*	*0.376*	*0.230*
HCC111	*Aspiration and Specified Bacterial Pneumonias*	*0.693*	*0.463*
HCC112	*Pneumococcal Pneumonia, Empyema, Lung Abscess*	*0.202*	*0.463*
HCC119	*Proliferative Diabetic Retinopathy and Vitreous Hemorrhage*	*0.349*	*0.995*
HCC130	*Dialysis Status*	*3.076*	*3.112*
HCC131	*Renal Failure*	*0.576*	*0.420*
HCC132	*Nephritis*	*0.273*	*0.420*
HCC148	*Decubitus Ulcer of Skin*	*1.030*	*0.317*
HCC149	*Chronic Ulcer of Skin, Except Decubitus*	*0.484*	*0.262*
HCC150	*Extensive Third-Degree Burns*	*0.962*	*0.248*
HCC154	*Severe Head Injury*	*0.568*	*0.248*
HCC155	*Major Head Injury*	*0.242*	*0.248*
HCC157	*Vertebral Fractures without Spinal Cord Injury*	*0.490*	*0.098*
HCC158	*Hip Fracture/Dislocation*	*0.392*	*0.000*[3]

Variable	*Disease Group*	*Community Factors*	*Institutional Factors*
HCC161	*Traumatic Amputation*	*0.843*	*0.248*
HCC164	*Major Complications of Medical Care and Trauma*	*0.262*	*0.263*
HCC174	*Major Organ Transplant Status*	*0.722*	*0.882*
HCC176	*Artificial Openings for Feeding or Elimination*	*0.790*	*0.882*
HCC 177	*Amputation Status, Lower Limb/Amputation Complications*	*0.843*	*0.248*
Disabled/Disease Interactions			
D-HCC5	*Disabled*Opportunistic Infections*	*0.789*	*0.000*
D-HCC44	*Disabled*Severe Hematological Disorders*	*0.893*	*0.000*
D-HCC51	*Disabled*Drug/Alcohol Psychosis*	*0.509*	*0.000*
D-HCC52	*Disabled*Drug/Alcohol Dependence*	*0.414*	*0.000*
D-HCC107	*Disabled*Cystic Fibrosis*	*1.861*	*0.000*
Disease Interactions			
INT1	*DM*CHF*[3]	*0.253*	*0.207*
INT2	*DM*CVD*	*0.125*	*0.000*
INT3	*CHF*COPD*	*0.241*	*0.372*
INT4	*COPD*CVD*CAD*	*0.079*	*0.000*
INT5	*RF*CHF*[3]	*0.234*	*0.000*
INT6	*RF*CHF*DM*[3]	*0.864*	*0.000*

NOTES

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

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

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

DM= diabetes mellitus (HCCs 15-19)

CHF= congestive heart failure (HCC 80)

COPD= chronic obstructive pulmonary disease (HCC 108)

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

CAD= coronary artery disease (HCCs 81-83)

RF= renal failure (HCC 131)

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

Exhibit 15 - List of Disease Groups (HCCs) With Hierarchies

(Rev. 47, 02-20-04)

DRAFT DISEASE HIERARCHIES		
If the Disease Group is Listed in This Column…		***…Then Drop the Associated Disease Group(s) Listed in This Column***
Disease Group (HCC)	***Disease Group Label***	
5	*Opportunistic Infections*	*112*
7	*Metastatic Cancer and Acute Leukemia*	*8,9,10*
8	*Lung, Upper Digestive Tract, and Other Severe Cancers*	*9,10*
9	*Lymphatic, Head and Neck, Brain and Other Major Cancers*	*10*
15	*Diabetes with Renal Manifestations or Peripheral Circulatory Manifestation*	*16,17,18,19*
16	*Diabetes with Neurologic or Other Specified Manifestation*	*17,18,19*
17	*Diabetes with Acute Complications*	*18,19*
18	*Diabetes with Ophthalmologic or Unspecified Manifestations*	*19*
25	*End-Stage Liver Disease*	*26,27*
26	*Cirrhosis of Liver*	*27*
51	*Drug/Alcohol Psychosis*	*52*
54	*Schizophrenia*	*55*
67	*Quadriplegia/Other Extensive Paralysis*	*68,69,100,101,157*
68	*Paraplegia*	*69,100,101,157*
69	*Spinal Cord Disorders/Injuries*	*157*
77	*Respirator Dependence/ Tracheostomy Status*	*78,79*
78	*Respiratory Arrest*	*79*
81	*Acute Myocardial Infarction*	*82,83*
82	*Unstable Angina and Other Acute Ischemic Heart Disease*	*83*
95	*Cerebral Hemorrhage*	*96*
100	*Hemiplegia/Hemiparesis*	*101*
104	*Vascular Disease with Complications*	*105,149*
107	*Cystic Fibrosis*	*108*

DRAFT DISEASE HIERARCHIES		
If the Disease Group is Listed in This Column…		***…Then Drop the Associated Disease Group(s) Listed in This Column***
Disease Group (HCC)	***Disease Group Label***	
111	*Aspiration and Specified Bacterial Pneumonias*	*112*
130	*Dialysis Status*	*131,132*
131	*Renal Failure*	*132*
148	*Decubitus Ulcer of Skin*	*149*
154	*Severe Head Injury*	*75,155*
161	*Traumatic Amputation*	*177*

How Payments are Made with a Disease Hierarchy

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

Exhibit 20 - CMS-HCC Demographic Model for New Enrollees [1]

(Rev. 47, 02-20-04)

Age/Sex Factors	*Non-Medicaid & Not Originally Disabled*	*Medicaid & Not Originally Disabled*	*Non-Medicaid & Originally Disabled*	*Medicaid & Originally Disabled*
Female0_34	*0.397*	*0.816*	*0*	*0*
Female35_44	*0.601*	*1.019*	*0*	*0*
Female45_54	*0.725*	*1.144*	*0*	*0*
Female55_59	*0.846*	*1.265*	*0*	*0*
Female60_64	*1.009*	*1.428*	*0*	*0*
Female65	*0.486*	*1.004*	*1.100*	*1.619*
Female66	*0.534*	*1.037*	*1.168*	*1.671*
Female67	*0.595*	*1.098*	*1.228*	*1.732*
Female68	*0.612*	*1.115*	*1.246*	*1.749*
Female69	*0.653*	*1.157*	*1.287*	*1.790*
Female70_74	*0.773*	*1.262*	*1.390*	*1.858*
Female75_79	*0.979*	*1.332*	*1.491*	*1.875*
Female80_84	*1.148*	*1.502*	*1.660*	*1.998*
Female85_89	*1.289*	*1.643*	*1.801*	*2.150*
Female90_94	*1.376*	*1.730*	*1.888*	*2.283*
Female95_GT	*1.217*	*1.571*	*1.888*	*2.283*
Male0_34	*0.296*	*0.692*	*0*	*0*
Male35_44	*0.501*	*0.896*	*0*	*0*
Male45_54	*0.648*	*1.043*	*0*	*0*
Male55_59	*0.821*	*1.216*	*0*	*0*
Male60_64	*0.939*	*1.334*	*0*	*0*
Male65	*0.528*	*1.049*	*1.042*	*1.563*
Male66	*0.591*	*1.074*	*1.100*	*1.583*
Male67	*0.651*	*1.134*	*1.160*	*1.643*
Male68	*0.704*	*1.187*	*1.213*	*1.696*
Male69	*0.739*	*1.222*	*1.248*	*1.731*
Male70_74	*0.919*	*1.317*	*1.374*	*1.772*
Male75_79	*1.168*	*1.577*	*1.588*	*1.996*

Male80_84	*1.352*	*1.760*	*1.771*	*2.180*
Male85_89	*1.565*	*1.973*	*1.984*	*2.392*
Male90_94	*1.664*	*2.072*	*2.083*	*2.492*
Male95_GT	*1.655*	*2.064*	*2.083*	*2.492*

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

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

Exhibit 25 - Data Collection for Risk Adjustment – Facility Types and Physician Specialties

(Rev. 47, 02-20-04)

Table 25-A. Hospital Inpatient Facility Types Acceptable for Risk Adjustment Data Submission and Associated Valid Medicare Provider Number Ranges

Type of Inpatient Hospital Facility	*Number Range**
Short-term (General and Specialty) Hospitals	*XX0001-XX0899* *XXS001-XXS899* *XXT001-XXT899*
Medical Assistance Facilities/Critical Access Hospitals	*XX1225-XX1399*
Religious Non-Medical Health Care Institutions (formerly Christian Science Sanatoria)	*XX1990-XX1999*
Long-term Hospitals	*XX2000-XX2299*
Rehabilitation Hospitals	*XX3025-XX3099*
Children's Hospitals	*XX3300-XX3399*
Psychiatric Hospitals	*XX4000-XX4499*
**XX in the first two positions of every number represents the state code*	

Table 25-B. Facility Types Acceptable for Hospital Outpatient Risk Adjustment Data Submission and Associated Valid Medicare Provider Number Ranges

Type of Outpatient Hospital Facility	***Number Range****
Short-term (General and Specialty) Hospitals	*XX0001-XX0899* *XXS001-XXS899* *XXT001-XXT899*
Medical Assistance Facilities/Critical Access Hospitals	*XX1225-XX1399*
Community Mental Health Centers	*XX1400-XX1499* *XX4600-XX4799* *XX4900-XX4999*
Federally Qualified Health Centers/Religious Non-Medical Health Care Institutions (formerly Christian Science Sanatoria)	*XX1800-XX1999*
Long-term Hospitals/	*XX2000-XX2299*
Rehabilitation Hospitals	*XX3025-XX3099*
Children's Hospitals	*XX3300-XX3399*
Rural Health Clinic, Freestanding and Provider-Based	*XX3400-XX3499* *XX3800-XX3999* *XX8500-XX8999*
Psychiatric Hospitals	*XX4000-XX4499*
**XX in the first two positions of every number represents the state code.*	

Table 25-C. Continuous Valid Medicare Provider Number Ranges For Hospital Outpatient Facilities

XX0001-XX0899 (also includes XXS001-XXS899 and XXT001-XXT899)
XX1225-XX1499
XX1800-XX2299
XX3025-XX3099
XX3300-XX3499
XX3800-XX3999
XX4000-XX4499
XX4600-XX4799
XX4900-XX4999

Table 25-D: Specialties Acceptable for Physician Risk Adjustment Data Submission and Associated Medicare Specialty Numbers

01	*General Practice*
02	*General Surgery*
03	*Allergy/Immunology*
04	*Otolaryngology*
05	*Anesthesiology*
06	*Cardiology*
07	*Dermatology*
08	*Family Practice*
10	*Gastroenterology*
11	*Internal medicine*
12	*Osteopathic manipulative therapy*
13	*Neurology*
14	*Neurosurgery*
16	*Obstetrics/gynecology*
18	*Ophthalmology*
19	*Oral Surgery (Dentists only)*
20	*Orthopedic surgery*
22	*Pathology*
24	*Plastic and reconstructive surgery*
25	*Physical medicine and rehabilitation*
26	*Psychiatry*
28	*Colorectal surgery*
29	*Pulmonary disease*
30	*Diagnostic radiology*
33	*Thoracic surgery*
34	*Urology*
35	*Chiropractic*
36	*Nuclear medicine*
37	*Pediatric medicine*
38	*Geriatric medicine*
39	*Nephrology*
40	*Hand surgery*
41	*Optometry (specifically means optometrist)*
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*
67	*Occupational therapist*
68	*Clinical psychologist*
70	*Multispecialty clinic or group practice*
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	*Preventative 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*

RETIRED MATERIAL ON PREVIOUS RISK ADJUSTMENT METHODOLOGY

(Rev. 47, 02-20-04)

Exhibit A - Retired Material on the PIP-DCG Payment Methodology (Former Sections 90 and 110, Exhibits 4 and 5)

Exhibit A.1 - Former Section 90, The Principal Inpatient Diagnostic Cost Group Risk Adjustment Method for Adjustment of Capitation Rates

90 - The Principal Inpatient Diagnostic Cost Group Risk Adjustment Method for Adjustment of Capitation Rates

(Rev. 1,07-02-01)

The Principal Inpatient Diagnostic Cost Group or PIP-DCG risk adjustment payment method adds diagnostic information to demographic information on beneficiaries. It was implemented for members of M+C organizations effective with the January 1, 2000, payment. The CMS applies the PIP-DCG risk adjustment model to payment calculations for all types of M+C plans (except as provided for M+C religious and fraternal benefit plans; see §20.1.3).

The CMS uses demographic information and diagnostic information from original Medicare and from all M+C organizations a beneficiary may have joined (taken from encounter data submitted by M+C organizations) to determine the appropriate PIP-DCG-based risk factor for each beneficiary. The risk factor is computed for each beneficiary for a given year and applied prospectively. The factor follows the beneficiary for one calendar year. Since all Medicare beneficiaries have risk factors (including new M+C enrollees as described in §91.4.3 and the second table in Exhibit 3), information is immediately available for payment purposes as beneficiaries join an M+C organization or move among M+C plans. When an M+C organization forwards beneficiary enrollment information to CMS, CMS then sends the organization the appropriate risk factor for the beneficiary, as well as the resultant payment.

The CMS adopted a "time shifted" model for payment, where the base year -- also known as the data collection year -- is defined as the 12-month period that ends 6 months before the payment year begins. For example, data on inpatient discharges from July 1, 1998, through June 30, 1999, were used to assign risk factors for enrollees and calculate payments to M+C organizations for calendar year 2000.

This section provides an overview of the PIP-DCG risk adjustment method. Several sources of information are available for further detail. Located on CMS' external Web site http://www.cms.hhs.gov/statistics/ are: (1) Basic SAS software for the PIP-DCG grouper; (2) A detailed text file of the mapping of ICD-9-CM codes to DxGroups, and

finally to PIP-DCGs; and (3) Report to Congress on the development of the PIP-DCG model. No technical support is available from CMS for organizations that utilize the version of the PIP-DCG grouper provided on the web.

This section discusses the demographic factors included in the PIP-DCG risk adjustment method; how PIP-DCG risk scores are calculated; and how PIP-DCG risk adjusted payments are calculated.

90.1 - Demographic Factors Under the PIP-DCG Risk Adjustment Method

(Rev. 1,07-02-01)

Note that institutional status is not a factor in the risk adjustment method for several reasons, including the fact that the PIP-DCG model accurately predicts average costs for institutionalized beneficiaries.

90.1.1 - Age and Sex

(Rev. 1,07-02-01)

Twenty-four age/sex categories are included in the risk adjustment method, which mirror the splits used in the demographic-only method. (Compare Exhibits 2 and 3.) Since the risk adjustment method is prospective, however, the value of the age variable is the fraction of the 12 months that person is, for example, 66 before turning 67. Payments for the 12 months are thus set to the weighted average of the two payments for the two different ages, so that no change in payment is necessary during the calendar year to account for birthdays.

90.1.2 - Medicaid Eligibility

(Rev. 1,07-02-01)

Analysis of expenditure patterns for beneficiaries with Medicaid status in original Medicare, revealed that future Medicare expenditures for partial-year Medicaid enrollees are similar to expenditures for full year enrollees. Thus, the measurement of eligibility changed under the risk adjustment method. Beneficiaries who are Medicaid-eligible at any time during the previous data collection year are eligible for the Medicaid payment increment for the entire payment year. (See §80.3 for a discussion of the Medicaid adjustment under the demographic-only method, and §160 for policy on Qualifying Individuals, QI-1s and QI-2s.)

90.1.3 - Originally Disabled

(Rev. 1,07-02-01)

Originally disabled is not a factor under the demographic-only method. Research confirmed, however, that on average originally disabled beneficiaries aged 65 and older have higher Medicare expenditures than the beneficiaries who "age-in" to Medicare eligibility (i.e., were never entitled by reason of disability). Yet under the demographic-only method, for example, a 64 year old disabled but not institutionalized male who is not on Medicaid and not working aged, would be assigned a demographic factor of 1.0 from the disabled table. When he turns 65, he is assigned a factor of 0.65 from the aged table, resulting in a reduction in payment.(See Exhibit 3 for factors under the demographic-only method.)

Hence, under the risk adjustment method, a beneficiary is defined as originally disabled if he or she is currently entitled to Medicare as an aged beneficiary, but was originally entitled by reason of disability. Accordingly, the 64 year old disabled but not institutionalized male who is not on Medicaid and not working aged, would be assigned a base risk score of 0.76. When he turns 65, he is assigned a base score of 0.541 plus a risk score of 0.415 for previously disabled, which sums to 0.956 and triggers an increased payment. (See Exhibit 3 for factors under the risk adjustment method.)

90.2 - Health Status Adjustment Under the PIP-DCG Risk Adjustment Method

(Rev. 1,07-02-01)

90.2.1 - The PIP-DCG Classification System

(Rev. 1,07-02-01)

A PIP-DCG is a payment group that represents a range of Medicare costs. Each PIP-DCG category can include heterogeneous diagnoses, as long as they have similar future cost implications. Since the PIP-DCG model depends on data from just one site of service, only a subset of conditions is recognized for increased payments. That is, the model recognizes admissions for which inpatient care is most frequently appropriate and which are predictive of higher future costs.

Under the risk adjustment method, hospitalizations for diseases most commonly treated on an outpatient basis are placed in a base payment category -- for which payment is a function of age and sex.(Note the category called "base" in Exhibit 3.) Inclusion of these admissions in the PIP-DCG classification system would provide inappropriate incentives for hospitalization. Also included in the base payment category are beneficiary diagnoses reported as a result of a short hospital stay (one day or less). This ensures consistent and appropriate payment levels. Since the majority of one-day stays are for diagnoses already assigned to the base payment category, the effect on payment is small. Short stays are often indicative of less serious, and, hence, less costly cases.

Exhibit 5 describes the primary diagnoses making up each PIP-DCG used for payment. In addition to the base payment category (also called PIP-DCG 4), there are a total of 15 PIP-DCGs included in the risk adjustment payment model.

90.2.2 - Diagnostic Exceptions Under The PIP-DCG Risk Adjustment Method

(Rev. 1,07-02-01)

Under the PIP-DCG payment model, beneficiaries who are hospitalized for chemotherapy (ICD-9 codes V58.1 and V66.2) are treated as exceptions. These codes are indicators of a treatment method, rather than a particular disease. Recognizing, however, that Medicare's current inpatient coding rules require that the diagnoses for beneficiaries who are hospitalized for chemotherapy must be coded using these V-codes as the principal diagnoses, the most appropriate PIP-DCG group for these beneficiaries is assigned based on the type of cancer and using a secondary diagnosis.
In addition, the payment model also treats individuals diagnosed with AIDS as an exception. In this case, individuals with a secondary diagnosis of AIDS are placed in the same PIP-DCG group as individuals with a reported principal diagnosis of AIDS. The CMS' analysis showed that individuals with a secondary diagnosis of AIDS tended to have expenditures similar to those admitted explicitly for the treatment of AIDS.

90.2.3 - New Enrollees

(Rev. 1,07-02-01)

The PIP-DCG model is calculated with encounter data submitted in the data collection year that ends 6 months before the payment year begins. The Medicare program cannot compile diagnosis data on beneficiaries before they enter the M+C program. 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 entitlement.

The CMS applies separate risk factors for new enrollees, based on the demographic factors used in the risk adjustment method. See the second table in Exhibit 4 for the risk factors used to calculate payments for new enrollees. Note that payments based on Medicaid eligibility will be made retroactively for all new enrollees, once enrollment can be established and verified.

90.3 - Calculation of Beneficiary Risk Factors and Payments to M+C Organizations

(Rev. 1,07-02-01)

In its basic form, the PIP-DCG model is an algorithm that uses base year inpatient diagnoses, along with demographic factors, to predict total health spending for beneficiaries for a payment year. In applying the PIP-DCG model to risk adjust payments

for the M+C program, however, the model is used to determine relative risk factors. Below are two examples of calculating beneficiary risk factors, based on Exhibit 4.

Note that beneficiaries whose risk factors are equal to 1.00 are nationally "average."

Example - *Beneficiary A is a male, aged 82, who was originally entitled for Medicare due to disability. He is not eligible for Medicaid (no expenditure increment). He was hospitalized twice during the data collection year (also called the "base year" and distinct from the "base" payment category in Exhibit 4). Encounter data submitted by Beneficiary A's M+C organization reported inpatient diagnoses of Asthma (PIP-DCG 8) and Staphylococcus Pneumonia (PIP-DCG 18).*

Beneficiary A is placed in the appropriate sex and age group. "Male, aged 82" carries an incremental risk factor of 1.077. He also is assigned "ever disabled" status, which carries an incremental risk factor of 0.287. Finally, Beneficiary A is assigned PIP-DCG 18, which carries an incremental risk factor of 2.656. If there is more than one inpatient diagnosis in a data collection year, the risk factor is calculated based on the PIP-DCG category with the highest average expenditures.

Adding the incremental risk factors produces an overall risk factor of 4.02. This risk factor indicates an individual who is likely to incur relatively high costs in the payment year.

Example 2 - *Beneficiary B is a female, aged 69, who is not disabled (no expenditure increment), and is eligible for Medicaid. She had no inpatient admissions during the base year. Therefore, no specific PIP-DCG increment is added, because expenditures for non-hospitalized beneficiaries are included in the base payment category.*

Beneficiary B is placed in the appropriate sex and age group. "Female, aged 69" carries an incremental risk factor of 0.453.She also is assigned "aged with Medicaid" status, which adds an incremental risk factor of 0.433. Beneficiary B's overall risk factor is 0.89, which indicates someone who is likely to incur relatively low costs in the payment year.

90.4 - Calculation of Monthly Payments to M+C Organizations

(Rev. 1,07-02-01)

To determine risk adjusted monthly payment amounts for each Medicare+Choice enrollee, individual risk factors are multiplied by the appropriate area-specific (usually county) payment rate.

First, however, an adjustment to the county rate book amounts will be required before multiplying the rate by each individual risk factor. This adjustment, or rescaling factor, is necessary because the risk adjustment method adds disease information to purely demographic information.

90.4.1 - The Rescaling Factor

(Rev. 1,07-02-01)

The demographic-only rate book calculates county rates by dividing county per capita costs by county average demographic factors. Prior to BBA, these rates were updated annually. However, the BBA requires all M+C county rates to have their basis in the 1997 AAPCC Rate Book. Thus, the factors used to standardize this 1997 Rate Book are "locked in" - including the average county demographic factors.

Although both the demographic-only and risk adjustment methods are attempting to measure the same thing - relative health status - the range of factors used in the two methods differs. In order to account for the fact that the factors differ between the two methods, a technical modification is necessary for payments to remain methodologically correct. Without some adjustment, this inconsistency between the demographic-only factors and the risk adjustment factors would result haphazardly in either significant underpayments or overpayments, depending on the county.

By itself, rescaling does not raise or lower payments. Whether aggregate payments to an M+C organization increase or decrease depends upon the risk profile of the beneficiaries enrolled in the plan(s) offered by that M+C organization.

90.4.2 - Method for Calculating County Rescaling Factors

(Rev. 1,07-02-01)

First, average county risk factors are computed for each county, using the PIP-DCG risk adjustment payment model. The average county risk factors replace the average county demographic factors applied under the demographic-only methodology.

CMS' Office of the Actuary (OACT) calculates combined aged, disabled, Parts A, and Part B per capita costs. These combined county costs then are divided by the average county risk factors, creating new area-specific standardized rates. The OACT applies the mandated calculations to these new area-specific rates, e.g., the "greater of three" approach (blends, floors, and two percent increase), budget neutrality, medical education carve outs, etc.

This process generates a risk rate book. To determine the rescaling factor for a county, the per capita risk county rate is divided by the demographic-only county rate. Technically there are two rescaling factors for each county: one to rescale payments for aged enrollees, and the other for disabled enrollees.

In a given county, the rescaling factor used in payments for an aged beneficiary is defined as:

- *(Risk County Rate)/(Aged Demographic-only County Rate) = County Aged Rescaling Factor*

For disabled beneficiaries, the rescaling factor is defined as:

- *(Risk County Rate)/(Disabled Demographic County Rate) = County Disabled Rescaling Factor*

Additional information on average county risk factors is available at CMS' Web site http://www.cms.hhs.gov/statistics/. A file containing estimated county risk factors used to create the risk rate book is posted here.

90.4.3 - Example: Calculating the Payment Amount Per M+C Enrollee

(Rev. 1,07-02-01)

Risk adjusted payment amounts for each M+C enrollee are calculated as follows:

*Payment = Demographic-only County Rate * rescaling factor * Enrollee Risk Factor*

To determine the risk-adjusted portion of payment for an enrollee, CMS' systems add the appropriate Part A and Part B rates (aged or disabled), multiply by the corresponding rescaling factor (for aged or disabled rates), and then multiply by the enrollee risk factor (calculated from the risk factor tables in Exhibit 4). Finally, we apply the blend percentage in effect for the payment year, e.g., for 2001, the blend is 10 percent rates adjusted by the risk method, and 90 percent demographic-only adjusted rates. (See Table 2 in §70.2.)

90.5 - Treatment of Certain Demonstrations Under the PIP-DCG Risk Adjustment Method

(Rev. 9, 04-01-02)

Certain demonstration projects involve the provision of care to special populations, such as the frail elderly. These projects include Evercare, the Program of All-inclusive Care for the Elderly (PACE), the Social Health Maintenance Organization (SHMO) demonstration, the Minnesota Senior Care Project, and the Wisconsin Partnership Demonstration. These projects currently provide enhanced benefit packages and are paid based on adjustments to M+C capitation rates that are specific to each demonstration model. Given the unique features of these demonstration projects, CMS will not apply the new M+C payment system for these organizations until further notice.

90.6 - Exclusions From Risk Adjustment Payment

(Rev. 2, 10-01-01)

The M+C organizations with Cost or Health Care Pre-Payment Plan (HCPP) contracts will be excluded from payment under risk adjustment, but risk adjustment rates will be reported to these organizations as "risk equivalent" rates. This will replace the current reporting of the "risk equivalent" demographic-only rates to the Cost and HCPP plans.

M+C enrollees who are capitated at the hospice rates are excluded from payment under risk adjustment. M+C organizations will receive the demographic-only rate for these members. The CMS has separate reconciliation processes for ESRD (§230) and hospice (§220).

Exhibit A.2 - Former Section 110, Encounter Data Collection for the Risk Adjustment Method

(Rev. 47, 02-20-04)

110 - Encounter Data Collection for the Risk Adjustment Method

(Rev. 2, 10-01-01)

This section provides an overview of encounter data used for risk adjustment of M+C payments, and also includes information on ***hospital inpatient*** *encounter data requirements. Additional information on hospital inpatient encounter data requirements can be found at http://www.cms.hhs.gov/medicare/, which is Operational Policy Letter 1998.70. In general, information on CMS' M+C encounter data policies, methods, and training materials can be found at http://www.cms.hhs.gov/medicare/*

NOTE: *On May 25, 2001, the Secretary announced that CMS has suspended through July 1, 2002, the required filing by M+C organizations of physician and hospital outpatient encounter data. For this reason, discussions of CMS policy related to these types of encounter data have been deleted from this release.*

110.1 - Overview of Encounter Data

(Rev. 2, 10-01-01)

The CMS uses encounter data to: (1) Calculate each beneficiary's risk adjustment factor; and (2) Adjust the area-specific capitation rate assigned to each beneficiary (county of residence) by the beneficiary's risk adjustment factor. This produces the amount paid the M+C organization for each beneficiary. (See §90.4.3.)

Accordingly, the BBA requires each M+C organization, as well as eligible organizations with risk-sharing contracts under §1876 of the Act, to submit to CMS, in accordance with CMS instructions, all data necessary to characterize the context and purposes of each encounter between a Medicare enrollee and a provider, supplier, physician, or other practitioner. Requirements concerning collection of encounter data apply to M+C organizations with respect to all their M+C plans, including private fee-for-service plans, with the exception of certain demonstration projects discussed in §90.5.

To the extent required by CMS, encounter data must account for services covered under the original Medicare program, for Medicare-covered services for which Medicare is not the primary payer, or for other additional or supplemental benefits that the organization must provide.

The M+C organizations may include in their contracts with providers, suppliers, physicians, and other practitioners, provisions that require submission of complete and

accurate encounter data that conforms to the format used under original Medicare. These provisions may include financial penalties, including withholding payment, for failure to submit complete and accurate data, or for failure to submit data that conform, to the requirements for submission.

Upon enrollment, M+C organizations may obtain permission from the beneficiary to have access to past medical records of their enrollees. However, diagnostic information cannot be passed from CMS to the M+C organizations because of privacy concerns.

NOTE: *The policy discussed in §110.2 is current; however, CMS is conducting a review of policy pertaining to certification.*

110.2 - Certification of Data Accuracy, Completeness, and Truthfulness

(Rev. 2, 10-01-01)

As a condition for receiving a monthly payment under the M+C program, the M+C organization agrees that its chief executive officer (CEO), chief financial officer (CFO), or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must make a certification on Attachment B of the M+C contract, based on best knowledge, information, and belief, that the encounter data the M+C organization submits to CMS are accurate, complete, and truthful. If such encounter data are generated by a related entity, contractor, or subcontractor of the M+C organization, such entity, contractor, or subcontractor must similarly certify the accuracy, completeness, and truthfulness of the data. (See 42 CFR 422.502(l).)

The CMS expects M+C organizations to design and implement effective systems to monitor the accuracy, completeness, and truthfulness of encounter data and to exercise due diligence in reviewing the information provided to CMS. The Department of Justice, the Office of Inspector General, and CMS acknowledge that the volume and variety of data make some inaccuracies inevitable, and they will take into account any legitimate difficulties M+C organizations may have with provider compliance. However, this certification standard does not relieve M+C organizations of their obligation to comply fully with the M+C program's encounter data requirements.

110.3 - Validation of Data

(Rev. 2, 10-01-01)

The M+C organizations and their providers are required to submit medical records for validating encounter data, as prescribed by CMS. Medical record reviews of a sample of hospital encounters may be audited to ensure the accuracy of diagnostic information. Independent contractors will conduct the reviews.

110.4 - Hospital Inpatient Encounter Data Requirements

(Rev. 2, 10-01-01)

As discussed in §70, the timing of encounter data collection set forth in the BBA signaled to CMS that the initial risk adjustment method should be based only on data from inpatient hospital stays, with later implementation of a method based on data from additional sites of care. The CMS selected the Principal Inpatient Diagnostic Cost Group (PIP-DCG) model as the risk adjustment method under which payments are made, beginning January 1, 2000. In this model, diagnoses from hospitalizations are used to identify a particularly ill and high cost subset of beneficiaries for whom higher payments will be made in the next year.

The hospital inpatient encounter data requirements entail submission of data for discharges from inpatient hospitals, including facilities reimbursed under the prospective payment system (PPS), long stay hospitals, psychiatric and rehabilitation hospitals, and psychiatric/rehabilitation distinct parts of hospitals. Encounter data are not currently required for discharges from skilled nursing facilities (SNFs).

NOTE: *In order to participate as a Medicare provider, a hospital must meet certain conditions specified in the Medicare regulations at 42 CFR 482.12. Generally, these conditions pertain to issues such as compliance with applicable Federal, State, and local laws, make*

All discharges reflecting inpatient stays should be submitted. If a patient moves from a one-day hospital stay to a swing bed or skilled nursing facility bed, then this is simply a one-day stay (see §90.2.1). If the patient is transferred to a rehabilitation facility, then the diagnoses from the rehabilitation facility stay may be used to determine the risk adjustment payment.

Contracted and Non-contracted Facilities *- The M+C organization must ensure that CMS receives a record of each hospital discharge for each managed care enrollee, regardless of whether the hospital is a contracted or non-contracted facility. The M+C organizations may need to modify their contracts with hospitals to ensure that all managed care discharges are identified.*

Coding Guidance *- The records that M+C organizations submit should reflect the original diagnosis that the provider submitted to the M+C organization. The M+C organizations should not modify, supplement, or re-sequence diagnosis codes received from hospitals.*

Encounter data should be substantiated by the hospital's medical record. If the M+C organization receives a record from a provider that contains an incorrect code in a critical field (i.e., diagnosis code, procedure code, admission date or discharge date), the organization must make sure that its database matches and supports the provider's database for these fields. Thus, it is recommended that the M+C organization return the

record to the provider for correction and resubmission. For other items on the record, the M+C organization may use its own databases to fill in or correct these items.

Secondary Diagnoses *- If an M+C organization does not report secondary diagnoses, it may not receive the payment to which it is entitled. Generally, the PIP-DCG model uses only the principal diagnosis to assign a beneficiary to a PIP-DCG category. However, there are two exceptions (see §90.2.2). For beneficiaries with a principal diagnosis related to chemotherapy (ICD-9 codes V58.1 and V66.2), the PIP-DCG category is assigned based on the type of cancer, using a secondary diagnosis. Also, all beneficiaries with a secondary diagnosis of AIDS will be placed in the same PIP-DCG category as those with a principal diagnosis of AIDS. M+C organizations should assure that they obtain all diagnostic information from their providers and submit all diagnoses to the Customer Service and Support Contractor.*

110.5 - Data Formats and Processing

(Rev. 2, 10-01-01)

A record of each enrollee discharge should be submitted, from contracted as well as non-contracted hospitals. The M+C organizations may submit to CMS electronic records using either a complete or abbreviated UB-92 format. M+C organizations may also submit using a Medicare Part A ANSI ASC X12 837 format, also called the "ANSI 837.

Abbreviated UB-92 Version 6.0 format *- To indicate that the format being submitted is abbreviated, the "Z" code must be included in the third digit of "Type of bill." The abbreviated UB-92 will not be discontinued. Version 6.0 has been approved by CMS for submission of inpatient encounter data. M+C organizations could begin using Version 6.0 effective August 1, 2000, to submit data to their current FI. All M+C organizations are required to transition from Version 5.0 to Version 6.0 for submissions after December 31, 2000.*

110.6 - Deadlines for Submission of Encounter Data

(Rev. 9, 04-01-02)

NOTE: *On May 25, 2001, the Secretary announced that CMS has suspended through July 1, 2002, the required filing by M+C organizations of physician and hospital outpatient encounter data. For this reason, discussions of policy related to these types of encounter data have been deleted from this release.*

The BBA requires that M+C organizations submit data regarding inpatient hospital services for all enrollee discharges that occur on or after July 1, 1997. Table 3 presents the submission schedule.

TABLE 3. Submission Deadlines for Hospital Inpatient Encounter Data

Data Collection Year Services Dates	***Payment Year (CY)***	***Deadline for Submission****	***Late Encounter Data Deadline *****
July 1, 1997 - June 30, 1998	*Start-up year; not used for payment*	*NA*	*NA*
July 1, 1998 - June 30, 1999	*2000*	*Sept. 10, 1999*	*Sept. 30, 2000*
July 1, 1999 - June 30, 2000	*2001*	*Sept. 8, 2000*	*Dec. 31, 2001*
July 1, 2000 - June 30, 2001	*2002*	*Sept 7, 2001*	*Sept 30, 2002*
July 1, 2001 - June 30, 2002	*2003*	*Sept 6, 2002*	*Sept, 30 2003*
July 1, 2001 - June 30, 2002	*2004*	*Sept 5, 2003*	*Sept. 30 2004*
July 1, 2003 - June 30, 2004	*2005*	*Sept. 3, 2004*	*Sept. 30, 2005*

** Deadline for submission of data. Any data received by CMS after September 30 will be processed as late encounter data. For payment year 2003, CMS must receive the data by September 27, 2002.*

*** Data used for reconciliation; also see §210 on the reconciliation process.*

Risk adjustment factors for each payment year are based on encounter data submitted for services furnished during the 12-month period ending 6 months before to the payment year. (For example, risk adjustment factors for CY 2000 were based on data for services furnished during the period July 1, 199,8 through June 30, 1999.)

Reconciliation of Payments *- Monthly payments during a payment year are based on the encounter data received by CMS by the annual deadlines for the data collection periods listed in Table 3.CMS conducts a reconciliation process to take into account late encounter data submissions, so that total payment for a year will reflect these late submissions. Under the reconciliation process, the deadline for receipt by CMS of all data for a payment year will be September 30 of that payment year for the period ending the previous June 30.*

See §210 for further details on reconciliation.

Exhibit A.3 - Former Exhibit 4, Risk Factors for the PIP-DCG Risk Adjustment Payment Model

(Rev. 47, 02-20-04)

Table 1: Risk Factors for Medicare Beneficiaries Eligible at Least One Year

Sex	Age Category	Base	Previously Disabled Add-On	Medicaid Add-On	PIP-DCG Scores	
Male					DCG	Factor
	0-34	0.367	-	0.125	5	0.375
	35-44	0.38	-	0.283	6	0.458
	45-54	0.487	-	0.37	7	0.697
	55-59	0.615	-	0.397	8	0.822
	60-64	0.76	-	0.418	9	0.915
	65-69	0.541	0.415	0.44	10	1.17
	70-74	0.705	0.398	0.457	11	1.271
	75-79	0.907	0.334	0.461	12	1.662
	80-84	1.077	0.287	0.445	14	2
	85-89	1.258	0.237	0.404	16	2.438
	90-94	1.376	0.189	0.331	18	2.656
	95 +	1.357	0.141	0.242	20	3.392
Female	0-34	0.362	-	0.192	23	3.823
	35-44	0.403	-	0.312	26	4.375
	45-54	0.526	-	0.367	29	5.189
	55-59	0.643	-	0.397		
	60-64	0.891	-	0.412		
	65-69	0.453	0.605	0.433		
	70-74	0.588	0.576	0.44		
	75-79	0.747	0.519	0.454		
	80-84	0.918	0.415	0.423		
	85-89	1.096	0.313	0.327		
	90-94	1.162	0.232	0.231		
	95 +	1.128	0.152	0.168		

Table 2: Risk Factors for New Enrollees

Sex	*Age Category*	*Base*	*Medicaid Add-On*
Male	*0-34*	*0.512*	*0.223*
	35-44	*0.559*	*0.386*
	45-54	*0.649*	*0.464*
	55-59	*0.81*	*0.499*
	60-64	*0.959*	*0.506*
	65	*0.525*	*0.653*
	66	*0.573*	*0.646*
	67	*0.62*	*0.64*
	68	*0.667*	*0.634*
	69	*0.715*	*0.628*
	70-74	*0.847*	*0.594*
	75-79	*1.086*	*0.616*
	80-84	*1.307*	*0.612*
	85-89	*1.518*	*0.609*
	90-94	*1.666*	*0.386*
	95 +	*1.668*	*0.354*
Female	*0-34*	*0.535*	*0.261*
	35-44	*0.579*	*0.423*
	45-54	*0.696*	*0.426*
	55-59	*0.84*	*0.542*
	60-64	*1.11*	*0.451*
	65	*0.446*	*0.603*
	66	*0.484*	*0.603*
	67	*0.522*	*0.603*
	68	*0.559*	*0.602*
	69	*0.597*	*0.602*
	Female, 70-74	*0.703*	*0.577*
	Female, 75-79	*0.899*	*0.594*
	Female, 80-84	*1.111*	*0.589*
	Female, 85-89	*1.328*	*0.424*
	Female, 90-94	*1.429*	*0.328*
	Female, 95 +	*1.381*	*0.18*

Exhibit A.4 - Former Exhibit 5, Diagnoses (DxGroups) Included in Each PIP - DCG for the Payment Model

(Rev. 47, 02-20-04)

PIP - DCG 5

DxGroup	*14*	*Breast Cancer (b)*
	131	*Ongoing Pregnancy with Complications*
	132	*Ongoing Pregnancy with No or Minor Complications*

PIP - DCG 6

DxGroup	*18*	*Cancer of Prostate/ Testis/ Male Genital Organs (b)*

PIP - DCG 7

DxGroup	*1*	*Central Nervous System Infections*
	39	*Abdominal Hernia, Complicated*
	64	*Alcohol/ Drug Dependence*

PIP - DCG 8

DxGroup	*16*	*Cancer of Uterus/ Cervix/ Female Genital Organs (b)*
	36	*Peptic Ulcer*
	77	*Valvular and Rheumatic Heart Disease*
	79	*Hypertension, Complicated*
	80	*Coronary Atherosclerosis*
	84	*Angina Pectoris*
	86	*Atrial Arrhythmia*
	92	*Precerebral Arterial Occlusion*
	96	*Aortic and Other Arterial Aneurysm*
	110	*Asthma*
	153	*Brain Injury*
	158	*Artificial Opening of Gastrointestinal Tract Status*

PIP - DCG 9

DxGroup	*21*	*Other Cancers (b)*
	32	*Pancreatitis/ Other Pancreatic Disorders*
	82	*Acute Myocardial Infarction*
	94	*Transient Cerebral Ischemia*

	145	*Fractures of Skull and Face*
	146	*Pelvic Fracture*
	147	*Hip Fracture*
	150	*Internal Injuries/ Traumatic Amputations/ Third Degree Burns*

PIP - DCG 10

DxGroup	*11*	*Colon Cancer (b)*
	59	*Schizophrenic Disorders*
	81	*Post-Myocardial Infarction*
	83	*Unstable Angina*
	97	*Thromboembolic Vascular Disease*
	116	*Kidney Infection*
	143	*Vertebral Fracture Without Spinal Cord Injury*

PIP - DCG 11

DxGroup	*42*	*Gastroinstestinal Obstruction/ Perforation*
	45	*Gastroinstestinal Hemorrhage*
	87	*Paroxysmal Verticular Tachycardia*
	109	*Bacterial Pneumonia*
	133	*Cellulitis and Bullous Skin Disorders*

PIP - DCG 12

DxGroup	*4*	*Tuberculosis*
	10	*Stomach, Small Bowel, Other Digestive Cancer*
	12	*Rectal Cancer*
	19	*Cancer of Bladder, Kidney, Urinary Organs*
	22	*Benign Brain/ Nervous System Neoplasm*
	26	*Diabetes with Acute Complications/ Hypoglycemic Coma*
	41	*Inflammatory Bowel Disease*
	48	*Rheumatoid Arthritis and Connective Tissue Disease*
	49	*Bone/ Joint Infections/ Necrosis*
	56	*Dementia*
	57	*Drug/ Alcohol Psychoses*
	60	*Major Depression*
	73	*Epilepsy and Other Seizure Disorders*
	91	*Cerebral Hemorrhage*

	93	*Stroke*
	98	*Peripheral Vascular Disease*
	111	*Pulmonary Fibrosis and Brochiectasis*
	113	*Pleural Effusion/ Pneumothorx/ Empyema*

PIP - DCG 14

DxGroup	*2*	*Septicemia/ Shock*
	29	*Adrenal Gland, Metabolic Disorders*
	58	*Delirium/ Hallucinations*
	61	*Paranoia and Other Psychoses*
	63	*Anxiety Disorders*
	66	*Personality Disorders*
	70	*Degenerative Neurologic Disorders*
	144	*Spinal Cord Injury*

PIP - DCG 16

DxGroup	*8*	*Mouth/ Pharynx/ Larynx/ Other Respiratory Cancer*
	13	*Lung Cancer*
	34	*Cirrhosis, Other Liver Disorders*
	89	*Congestive Heart Failure*
	95	*Atherosclerosis of Major Vessel*
	105	*Chronic Obstructive Pulmonary Disease*

PIP - DCG 18

DxGroup	*17*	*Cancer of Placenta/ Ovary/ Uterine Adnexa*
	55	*Blood/ Immune Disorders*
	72	*Paralytic and Other Neurologic Disorders*
	75	*Polyneuropathy*
	108	*Gram-Negative/ Staphylococcus Pneumonia*

PIP - DCG 20

DxGroup	*27*	*Diabetes with Chronic Complications*
	76	*Coma and Encephalopathy*
	112	*Aspiration Pneumonia*
	115	*Renal Failure/ Nephritis*

PIP - DCG 23

DxGroup	*9*	*Liver/ Pancreas/ Esophagus Cancer (b)*
	33	*end-stage Liver Disorders*
	88	*Cardio-Respiratory Failure and Shock*
	134	*Decubitus and Chronic Skin Ulcers*

PIP - DCG 26

DxGroup	*7*	*Metastatic Cancer (b)*
	20	*Brain/ Nervous System Cancers (b)*

PIP - DCG 29

DxGroup	*3*	*HIV/ AIDS (a)*
	15	*Blood, Lymphatic Cancers/ Neoplasms (b)*

Footnotes:

(a) Includes principal and secondary inpatient diagnoses of HIV/AIDs.

(b) Includes principal diagnoses and secondary diagnoses when the principal diagnosis is chemotherapy.

Additional Explanation of Table:

(c) Each PIP-DCG is identified by a number that originally referred to the lower bound of its expenditure range (based on the cost data used to calibrate the model), e.g., PIP-DCG 12 includes those DxGroups with average costs in the range of $12,000 to $13,999. PIP DCGs group heterogeneous diagnoses, as long as they have similar future cost implications.

(d) Each person without a base year hospital admission or with (an) admission(s) only for excluded or certain low-cost diagnoses is assigned to the base category, and is risk-adjusted using demographic factors only.

(e) See the section titled Risk Adjustment Information, Data Files, and Programs at http://www.cms.hhs.gov/statistics/ to obtain files containing crosswalks between ICD-9 codes, PIP-DxGs, and PIP-DCGs for 2000, 2001, and 2002.

Exhibit B - Retired Material on the Congestive Heart Failure Extra Payment Initiative (Former Section 100 and Exhibits 6 and 7)

(Rev. 47, 02-20-04)

Exhibit B.1 - Former Section 100, Adjustment of Capitation Rates Under the Congestive Heart Failure (CHF) Initiative

100 - Adjustment of Capitation Rates Under the Congestive Heart Failure (CHF) Initiative

(Rev. 1, 07-02-01)

This section provides an overview and describes the requirements for extra payment in recognition of the costs of successful outpatient CHF care. The M+C organizations desiring extra payment for eligible heart failure patients, must meet certain thresholds for two quality indicators for all eligible patients. This initiative is described below.

100.1 - Extra Payment In Recognition of the Costs of Successful Outpatient CHF Care

(Rev. 9, 04-01-02)

The current M+C organization risk adjustment payment methodology for CHF, the Principal Inpatient Diagnostic Cost Group (PIP-DCG) model, is based upon inpatient hospitalization discharge diagnoses. Recent studies strongly suggest that excellent outpatient management of CHF may decrease hospitalization rates and improve quality of life for CHF patients. In response to industry concerns, and specifically trying to work within current data constraints, CMS has developed a payment mechanism for recognizing and paying for the costs of this successful outpatient CHF care. To qualify for extra payment in 2002, M+C organizations will identify enrollees who were hospitalized for CHF during a prior 2-year period. To qualify for extra payment in 2003, M+C organizations will identify enrollees who were hospitalized for CHF during a prior 3-year period. M+C organizations will and measure the success in treating these enrollees via two designated quality indicators. M+C organizations achieving threshold levels on both quality indicators will receive extra payment. See §100.2.5 for details on the extra payments.

100.2 - Requirements for Medicare + Choice Organizations to Qualify for Extra Payment in Recognition of the Costs of Successful Outpatient CHF Care

(Rev. 1, 07-02-01)

Extra payments for CHF will be based on enrollees with a greater than 1-day stay for a principal inpatient discharge diagnosis of CHF. Currently, the CHF diagnosis codes are the following, although these codes are subject to change: 402.01, 402.11, 402.91, 404.01, 404.11, 404.91, 428.x.

100.2.1 - Two Required Quality Indicators

(Rev. 2, 10-01-01)

The M+C organizations seeking the extra payment must measure two quality indicators for the entire CHF population (defined below in §100.2.2). No alternative quality indicators may be substituted for the two quality indicators. The required quality indicators are:

- ***Quality Indicator 1*** *- The Proportion of M+C organization enrollees with a greater than one-day stay for a principal inpatient discharge diagnosis of congestive heart failure, and who have evaluation of left ventricular function as of October 1 of the reporting year; and*

- ***Quality 1****-day stay for a principal inpatient discharge diagnosis of congestive heart failure, and who have left ventricular systolic dysfunction (LVSD,) and as of October 1 of the reporting year:1, are prescribed angiotensin converting enzyme inhibitors (ACEI); OR 2, have documented reason for not being on ACEI.*

Additional information on the required quality indicators for extra payment may be found in Exhibit 6.

100.2.2 - Designated Measurement Population

(Rev. 2, 10-01-01)

For payment in 2002 *- The population for which the required quality indicators will be measured must consist of M+C organization's enrollees who have been continuously enrolled in the plan for a minimum of 180 days prior to and including October 1, 2001, who were discharged from an acute care hospital between 7/1/99 and 6/30/01, with a greater than 1-day stay for a principal inpatient discharge diagnosis of CHF (regardless of whether the enrollee was a member of the M+C organization at the time of the hospitalization).*

Where information on an inpatient hospital discharge has been received by CMS, CMS will flag enrollees with CHF diagnoses codes (defined in §100.2.1) on Monthly Membership Reports to M+C organizations to assist them in identifying the designated measurement population.

For payment in 2003 *- The population for which the required quality indicators will be measured must consist of M+C organization's enrollees who have been continuously enrolled in the plan for a minimum of 180 days prior to October 1, 2002, who were discharged from an acute care hospital between 7/1/99, and 6/30/02, with greater than a 1-day stay for a principal inpatient discharge diagnosis of CHF (regardless of whether the enrollee was a member of the M+C organization at the time of the hospitalization).*

Note that the beginning discharge date for payment in 2003 is the same as the beginning discharge date for payment in 2002 (7/1/99) so that M+C organizations can continue to manage the health care of those hospitalized between 7/1/99, and 6/30/00, as well as those hospitalized between 7/1/00, through 6/30/02. Where information on an inpatient hospital discharge has been received by CMS, CMS will flag enrollees with CHF diagnoses codes, (defined in §100.2.1) on Monthly Membership Reports to M+C organizations to assist them in identifying the designated measurement population.

100.2.3 - Thresholds Must Be Met

(Rev. 2, 10-01-01)

The M+C organization must meet threshold levels on both quality indicators defined in §100.2.1 and Exhibit 6 in order to qualify for the extra payment. Quality indicator threshold levels were established by CMS after input from a national clinical expert panel.

The threshold for extra payment for Quality Indicator 1 is 75 percent, and the threshold for Quality Indicator 2 is 80 percent. The M+C organizations must meet or exceed the threshold level on both quality indicators to qualify for the extra payment.

The thresholds were announced by CMS in the "Advance Notice of Methodological Changes in Medicare+Choice Payment Rates for Calendar Year (CY) 2002" published on January 15, 2001. (See http://www.cms.hhs.gov/statistics/.)

100.2.4 - Reporting

(Rev. 2, 10-01-01)

For payment in 2002 *- The M+C organizations shall report to CMS on or after October 1, 2001, for payment in 2002. (Exhibit 7 provides a draft format for reporting, pending OMB approval.) Paper copies of the reports should be sent to the attention of Angela Porter, Centers for Medicare & Medicaid Services Mailstop C4-13-01, 7500 Security Blvd, Baltimore, MD 21244. The M+C organizations may also report to CMS electronically using the Health Plan Management System (HPMS) beginning October 1, 2001. The report must include the following:*

- *The M+C organizations must submit a brief (e.g., two-page) description of their strategies and processes (e.g., disease management program) for managing the care of the designated CHF population.*

- *The M+C organizations who have more than 400 enrollees with the CHF diagnosis (defined in §100.2.1) may sample their population to achieve a sample size of at least 400. The sample must be representative of the population. The CMS expects that few M+C organizations will have sufficient CHF enrollees to*

sample their CHF population for reporting. The M+C organizations doing sampling must report their sampling methodology on the reporting form in Exhibit 7.

- *The M+C organization must report its performance (including numerator, denominator, and proportion) on both of the required quality indicators as of October 1, 2001.The report must be submitted before 2/28/02, to qualify for payment in 2002. For each member of the designated population, M+C organizations must maintain records of the Health Insurance Claim (HIC) numbers, and whether the member appears in the numerator and denominator for each measure. In the event that the M+C organization is subject to an audit, the M+C organization must furnish beneficiary-level results for both of the quality indicators in a format to be designated by CMS (see §100.2.7 below).*

- *Depending upon when M+C organizations report their performance, CMS will make payment in one of two ways: For reports received from M+C organizations between 10/01/01, and 11/30/01, extra payment will be made to qualifying M+C organizations no later than 90 days after 11/30/01. Extra payments will be retroactive to 1/1/02. For reports received from M+C organizations between 12/01/01, and 2/28/02, extra payment will be made no later than 90 days after 2/28/02. Extra payments will be retroactive to 1/1/02. Consistent with the risk adjustment payment system, extra payments will be made on a monthly basis. The M+C organizations must not report their performance any later than 2/28/02, for extra payment in 2002.*

For payment in 2003 - *M+C organizations shall report to CMS on or after October 1, 2002, for payment in 2003. (Exhibit 7 provides a draft format for reporting.) Paper copies of the reports should be sent to the attention of Angela Porter, Center for Medicare Services, Mailstop C4-13-01, 7500 Security Blvd, Baltimore, MD 21244. The M+C organizations may also report to CMS electronically using the Health Plan Management system (HPMS) beginning October 1, 2001. The report must include the following:*

- *The M+C organizations must submit a brief (e.g., 2-page) description of their strategies and processes (e.g., disease management program) for managing the care of the designated CHF population.*

- *The M+C organizations who have more than 400 enrollees with the CHF diagnosis (defined in §100.2.1) may sample their population to achieve a sample size of at least 400. The sample must be representative of the population. The CMS expects that few M+C organizations will have sufficient CHF enrollees to sample their CHF population for reporting. The M+C organizations doing sampling must report their sampling methodology on the reporting form in Exhibit 7.*

- *The M+C organization must report its performance (including numerator, denominator, and proportion) for both of the required quality indicators as of October 1, 2002. The report must be submitted before 1/31/03, to qualify for payment in 2003. For each member of the designated population, M+C organizations must maintain records of the HIC number and whether the member appears in the numerator for each measure. In the event that the M+C organization is subject to an audit, the M+C organization must furnish these beneficiary-level results for both of the quality indicators (see §100.2.7).*

- *Depending on when M+C organizations report their performance, CMS will make payment in one of two reporting waves: For reports received from M+C organizations between 10/1/02, and 11/30/02, extra payment will be made to qualifying M+C organizations no later than 90 days after 11/30/02. Extra payments will be retroactive to 1/1/03. For reports received from M+C organizations between 12/01/02, and 1/31/03, extra payment will be made no later than 90 days after 1/31/03. Extra payments will be retroactive to 1/1/03. Consistent with the risk adjustment payment system, extra payments will be made on a monthly basis. The M+C organizations must not report their performance any later than 1/31/03, for extra payment in 2003.*

100.2.5 - Extra Payment

(Rev. 9, 04-01-02)

Consistent with the risk adjustment payment methodology, extra payment will only be made for those enrollees in a qualifying M+C organization who are identified in CMS' records as having had the required principal inpatient discharge diagnosis of CHF, and who are enrolled in the M+C organization at the beginning of each payment month in 2002 (for payments in CY 2002), or who are enrolled in the M+C organization at the beginning of each payment month in 2003 (for payments in CY 2003).

Note that if an enrollee with a CHF hospitalization disenrolls from an M+C organization that qualified for extra payment and then enrolls in an M+C organization that does not qualify for extra payment, the new M+C organization would not receive the extra payment for that enrollee

Assuming the M+C organization's report on quality indicators shows attainment of the required threshold levels for both quality indicators, extra payments will be made to the M+C organization as follows.

The CMS takes two reporting years into account when assessing whether an M+C organization qualifies for an extra payment in 2002: July 1, 1999, to June 30, 2000; and July 1, 2000, to June 30, 2001. The CMS takes 3 reporting years into account when assessing whether an M+C organization qualifies for an extra payment for CHF enrollees in 2003: July 1, 1999, to June 30, 2000; July 1, 2000, to June 30, 2001; and July 1, 2001, to June 30, 2002. The M+C organizations are paid for a qualifying CHF

diagnosis under several scenarios, listed below. Scenario 1 describes the "normal" payment CMS makes under the PIP-DCG methodology for a principal inpatient diagnosis of CHF during the reporting year. Scenarios 2 and 3 describe special conditions under which M+C organizations may qualify for the CHF extra payment.

Scenario 1

In 2002 -- M+C organizations with enrollees hospitalized with a greater than 1-day stay for a principal diagnosis of CHF between July 1, 2000, and June 30, 2001, will receive the regular PIP-DCG-16 amount, at the phased-in level of 10 percent under the risk adjustment payment methodology.

In 2003 -- M+C organizations with enrollees hospitalized with a greater than 1-day stay for a principal diagnosis of CHF between July 1, 2001, and June 30, 2002, will receive the regular PIP-DCG-16 amount, at the phased-in level of 10 percent under the risk adjustment payment methodology.

Scenario 2

Under the extra payment provision for 2002, qualifying M+C organizations with an enrollee hospitalized with a qualifying CHF diagnosis between July 1, 1999, and June 30, 2000, who did not have a hospital stay during the July 1, 2000, to June 30, 2001, period will receive an extra payment for the CHF hospitalization incurred during the first reporting year (July 1, 1999, to June 30, 2000), based on the CHF extra payment formula described below, at the phased-in level of 10 percent under the risk adjustment payment methodology.

Under the extra payment provision for 2003, qualifying M+C organizations with an enrollee hospitalized with a qualifying CHF diagnosis between July 1, 1999, and June 30, 2000, or July 1, 2000, and June 30, 2001, who did not have a hospital stay during the July 1, 2001, to June 30, 2002, period will receive an extra payment for the CHF hospitalization incurred during either July 1, 1999, to June 30, 2000, or July 1, 2000, to June 30, 2001, based on the CHF extra payment formula described below, at the phased-in level of 10 percent under the risk adjustment payment methodology.

Scenario 3

Under the extra payment provision for 2002, qualifying M+C organizations with an enrollee hospitalized with a qualifying CHF diagnosis between July 1, 1999, and June 30, 2000, who also had a discharge for another diagnosis during the period July 1, 2000, to June 30, 2001, will receive the greater of the two possible payments.

Under the extra payment provision for 2003, qualifying M+C organizations with an enrollee hospitalized with a qualifying CHF diagnosis between July 1, 1999,

and June 30, 2000, or July 1, 2000, to June 30, 2001, who also had a discharge for another diagnosis during the period July 1, 2001, to June 30, 2002, will receive the greater of the two possible payments.

Two examples are provided below:

Example 1

For 2002 -- If an enrollee had a qualifying discharge for CHF between July 1, 1999, and June 30, 2000, and also had a discharge during the period July 1, 2000, to June 30, 2001, that fell into PIP-DCG 8 or higher (which would also include a diagnosis of CHF), the M+C organization will receive payment for the qualifying diagnosis incurred during the second reporting year July 1, 2000, to June 30, 2001), because that payment would be greater than the payment for the CHF diagnosis that occurred during the July 1, 1999, and June 30, 2000, period.

For 2003 -- If an enrollee had a qualifying discharge for CHF between July 1, 1999, and June 30, 2000, or between July 1, 2000, and June 30, 2001, and also had a discharge during the period July 1, 2001, to June 30, 2002, that fell into PIP-DCG 8 or higher (which would also include a diagnosis of CHF), the M+C organization will receive payment for the qualifying diagnosis incurred during July 1, 2001, to June 30, 2002, because that payment would be greater than the payment for the CHF diagnosis that occurred during the July 1, 1999, and June 30, 2000, or July 1, 2000, to June 30, 2001, period.

Example 2

For 2002 --. If an enrollee had a qualifying discharge for CHF between July 1, 1999, and June 30, 2000, and also had a discharge during the period July 1, 2000, to June 30, 2001, that fell into PIP-DCG 7 or below, the M+CO will receive payment for the CHF diagnosis incurred during the first reporting year (July 1, 1999, to June 30, 2000), because that payment would be greater than the payment for the diagnosis that occurred during the July 1, 2000, to June 30, 2001, period.

For 2003 -- If an enrollee had a qualifying discharge for CHF between July 1, 1999, and June 30, 2000, or between July 1, 2000, and June 30, 2001, and also had a discharge during the period July 1, 2001, to June 30, 2002, that fell into PIP-DCG 7 or below, the M+C organization will receive payment for the CHF diagnosis incurred during either July 1, 1999, to June 30, 2000, or July 1, 2000, to June 30, 2001, because that payment would be greater than the payment for the diagnosis that occurred during the July 1, 2001, to June 30, 2002, period.

Payment Formula

For CY 2002, the extra payments made to qualifying M+C organizations for CHF discharges between July 1, 1999, and June 30, 2000, will be based on approximately one-

third of the full PIP-DCG-16 amount, subject to the 10 percent risk adjustment transition schedule. For CY 2003, the extra payments made to qualifying M+C organizations for CHF discharges between July 1, 1999, and June 30, 2000, or between July 1, 2000, and June 30, 2001, will be based minimally on approximately one-third of the full PIP-DCG-16 amount, subject to the 10 percent risk adjustment transition schedule.

*Given the payment blend of 90 percent demographic payment and 10 percent risk-adjusted payment for 2002 and 2003, the additional payments to qualifying M+C organizations would be based approximately on the following formula: 0.33 (representing one-third of PIP-DCG 16 amount) X 2.438 (representing the PIP-DCG-16 risk factor) X 0.10 (representing the risk adjustment transition schedule). (**NOTE:** In addition to this PIP-DCG risk factor calculation for extra payment, the enrollee's risk score also would include the appropriate base factor and, if relevant, Medicaid and previously disabled factors.)*

For 2002, encounters for CHF discharges from July 1, 1999, to June 30, 2000, that are received by CMS after September 30, 2001, ("late encounter data") will be incorporated into a reconciliation conducted during 2003 for payments made to M+C organizations in 2002. For 2003, encounters for CHF discharges from July 1, 2001, to June 30, 2002, that are received by CMS after September 27, 2002, will be incorporated into a reconciliation conducted during 2004 for payments made to M+C organizations in 2003.

100.2.6 - Auditing

(Rev. 1, 07-02-01)

For payment years 2002 and 2003, a sample of M+C organizations will be selected for auditing of the submitted data. Upon notification, M+C organizations must submit beneficiary level information for the numerator and denominator for each quality indicator, as outlined in 100.2.5 above. For example, M+C organizations must maintain records of the HIC number and whether the member appears in the numerator for each measure. (i.e., for each HIC number: LVF evaluation: yes/no, LVSD, yes/no; ACEI for LVSD: yes/no/not indicated).

Using this information and other administrative data, CMS will identify a sample of medical records. For M+C organizations with more than 400 with the CHF diagnosis (defined in 100.2.1) who use sampling, CMS may choose to review the sampling methodology and/or audit medical records of those who were or were not sampled. The CMS will review medical records or other supporting documentation to verify the quality indicator rates. If the review fails to confirm that the M+C organization met both of the quality indicator thresholds, then CMS will recover all associated payments from the M+C organization.

100.2.7 - Hospitalization Tracking

(Rev.1, 07-02-01)

The CMS will track re-hospitalization rates for those enrollees for which the M+C organization is receiving additional payments. The M+C organizations are encouraged to track readmission rates as a means of monitoring their success in preventing re-hospitalization in this population.

100.3 - Questions About the Extra Payment in Recognition of the Costs of Successful Outpatient CHF Care

(Rev. 2, 10-01-01)

Assistance from the Quality Improvement Organization is available to M+C organizations for data abstraction for extra payment as long as the M+C organization is working collaboratively with the QIO on their QAPI project. For questions regarding the requirements for this extra payment, please contact Jane Andrews at CMS' Center for Beneficiary Services, Demonstrations and Data Analysis Group, (410) 786-3133.

Exhibit B.2 - Former Exhibit 6, Quality Indicators for Extra Payment in Recognition of the Costs of Successful Outpatient Treatment of CHF

(Rev. 47, 02-20-04)

DATA SOURCES

Any reviewable data source may be used to obtain the requisite information.

POPULATION/SAMPLING FRAME

Inclusion criteria:

Greater than 1-day stay for a principal inpatient discharge diagnosis of heart failure (ICD-9-CM codes: 402.01, 402.11, 402.91, 404.01, 404.11, 404.91, 428.x) during the following time periods:

- *For reporting on October 1, 2001, discharged July 1, 1999, through June 30, 2001; and*

- *For reporting on October 1, 2002, discharged July 1, 1999, through June 30, 2002.*

AND

Continuously enrolled for at least 180 days prior to and including date of reporting (October 1)

Exclusion criteria:

Any documentation during the 12 months prior to and including the date of reporting suggesting chronic renal dialysis, including any bill/encounter record/discharge record with one or more of the following codes: ICD-9-CM diagnosis codes V56.0, V56.8; ICD-9-CM procedure codes 39.95, 54.98; CPT codes 90935, 90937, 90940, 90945, 90947, 90989, 90993.

Quality Indicator EP 1: Proportion of eligible population who has evaluation of left ventricular function as of date of reporting.

Denominator: Entire population meeting inclusion and exclusion criteria. If this number is greater than 400, then the M+C organization may select a random sample of no fewer than 400.

Numerator: Those in the denominator with documentation of left ventricular function (LVF) evaluation anytime on or before October 1 of the reporting year.

***NOTES**: Billing codes likely to represent LVF assessment include: ICD-9-CM code - 88.72; CPT codes - 78468, 78472, 78473, 78480, 78481, 78483, 78494, 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, 93350.*

Billing codes, which may possibly represent LVF assessment tests: ICD-9-CM codes - 88.5x, 92.05; CPT code - 78414.

LVF may be presumed to be previously assessed if one or more of the following is present anytime before the date of reporting:

- *Report from one of the following diagnostic tests: echocardiogram (echo), MUGA scan, or cardiac catheterization - left ventriculogram (LV gram); OR*
- *Physician/nurse practitioner/physician assistant reference to one of the above diagnostic tests; OR*
- *Physician/nurse practitioner/physician assistant notation of LVF, either as an ejection fraction (EF) or a narrative description, without reference to an actual assessment test. Example - "known systolic dysfunction"*

Quality Indicator EP 2: Proportion of eligible population with left ventricular systolic dysfunction (LVSD) who:

- *Are prescribed angiotensin converting enzyme inhibitors (ACEI); OR*
- *Have documented reason for not being prescribed ACEI.*

Denominator: Those in the numerator of the Quality Indicator EP 1 with ejection fraction less than 40 percent, or equivalent narrative description (see note).

Numerator: Those in the denominator who have:

- *Been prescribed ACEI at any time in the 12 months prior to the date of reporting; OR*
- *Any documentation of aortic stenosis or any coded diagnosis of aortic stenosis (395.0, 395.2, 396.0, 396.2, 396.8, 424.1, 425.1, 747.22) anytime before the date of reporting; OR*
- *Any documentation of bilateral renal artery stenosis or any coded diagnosis of renal artery stenosis (ICD-9-CM code 440.1) anytime before the date of reporting; OR*
- *Any documented history of angioedema, hives, or severe rash with ACEI use anytime before the date of reporting; OR*

- *Serum potassium >5.5 mg/dL on three or more occasions in the 12 months prior to the date of reporting (excluding lab values measured during an acute care admission, an observation unit stay, or an emergency room visit);OR*

- *Serum creatinine >3.0 mg/dL on three or more occasions in the 12 months prior to the date of reporting (excluding lab values measured during an acute care admission, an observation unit stay, or an emergency room visit);OR*

- *Systolic blood pressure less than 80 mm Hg on three or more occasions in the 12 months prior to the date of reporting (excluding blood pressures measured during an acute care admission, an observation unit stay, or an emergency room visit); OR*

- *Any documentation of any specific reason why ACEI not used (e.g., cough, hyperkalemia, hypotension, renal insufficiency/failure, other physician-noted reason) anytime before the date of reporting; OR*

- *Chart documentation of participation in a clinical trial testing alternatives to ACEIs as first-line heart failure therapy in the 12 months prior to the date of reporting.*

***NOTE**: Narrative descriptions from diagnostic test reports or physician/nurse practitioner/physician assistant notes that SHOULD be considered equivalent to an ejection fraction less than 40 percent include the following:*

- *Contractility described solely as abnormal, compromised, decreased, depressed, impaired, low, poor, reduced, or very low;*

- *Ejection fraction (EF) described solely as abnormal, compromised, decreased, depressed, impaired, low, poor, reduced, or very low;*

- *Hypokinesis described as diffuse, generalized, or global;*

- *Left ventricular dysfunction (LVD) described as marked, moderate, moderate-severe, severe, significant, substantial, or very severe, OR the severity is not specified;*

- *Left ventricular ejection fraction (LVEF) described solely as abnormal, compromised, decreased, depressed, impaired, low, poor, reduced, or very low;*

- *Left ventricular function (LVF) described solely as abnormal, compromised, decreased, depressed, impaired, low, poor, reduced, or very low;*

- *Left ventricular systolic dysfunction (LVSD) described as marked, moderate, moderate-severe, severe, significant, substantial, or very severe, OR the severity is not specified systolic dysfunction described as marked, moderate, moderate-*

severe, severe, significant, substantial, or very severe, OR the severity is not specified;

- *Systolic function described solely as abnormal, compromised, decreased, depressed, impaired, low, poor, reduced, or very low;*

- *History or finding of moderate/severe left ventricular systolic dysfunction (or any of the other above inclusions) described using one of the following terms: "consistent with," "diagnostic of," "evidence of," "indicative of," "most likely," "probable," or "suggestive of."*

Narrative descriptions from diagnostic test reports or physician/nurse practitioner/physician assistant notes that SHOULD NOT be considered equivalent to an ejection fraction less than 40 percent include the following: history or finding of moderate/severe left ventricular systolic dysfunction (or any of the other LVSD inclusive terms above) described as "possible" or "questionable."

These narrative descriptions may not represent the universe of possible narrative descriptions. Therefore, if you have other narrative descriptions that you believe meet the LVSD definition and are defensible, then you may use them.

Exhibit B.3 - Former Exhibit 7, Report of Performance on Quality Indicators to Qualify for Extra Payment in Recognition of Successful Outpatient Treatment of CHF

(Rev. 47, 02-20-04)

Instructions:

This report applies only to M+C organizations that are applying for extra payment in recognition of the costs of successful outpatient CHF care. Definitions to be used in this report are provided in section B of the CHF OPL. Established threshold levels for these quality indicators may be found in the "Advanced Notice of Methodological Changes in the Medicare+Choice Payment Rates for Calendar Year (CY) 2002," published on January 15, 2001.

Contact Name: *H-Number:*

M+CO Name:

Telephone Number: *Fax Number:*

I. Quality Indicator EP1:

A. Number of M+C organization enrollees with principal inpatient discharge diagnosis of congestive heart failure (CHF) with a greater than a 1-day stay during index time frame.

_____

B. Number of M+C organization enrollees with a greater than 1- day stay for a principal inpatient discharge diagnosis of CHF during index time frame who had, as of October 1 of the reporting year, evaluation of left ventricular function (LVF)

_____

C. Proportion (defined as B/A) _____

II. Quality Indicator EP2:

D. Number of M+C organization enrollees with a greater than 1-day stay for a principal inpatient discharge diagnosis of CHF during index time frame who had left ventricular systolic dysfunction (LVSD) _____

E. Number of M+C Organization enrollees with a greater than 1-day stay for a principal inpatient discharge diagnosis of CHF during index time frame and documented LVSD who are either prescribed angiotensin converting enzyme inhibitors (ACEI) or have a documented reason for not being on ACEI as of October 1 of the reporting year. _____

F. F. Proportion (defined as E/D) _____

***Notes**: You should review your submission. Note that the number placed in 1.B should be less than the number placed in 1.A. The number in 2.D should also be less than 1.B. The number in 2.E should be less than 2.D.*

Sampling

For M+C organizations with greater than 400 enrollees with a diagnosis of CHF who have sampled their population (your sample size should be no smaller than 400 enrollees), describe your sampling methodology.

Description of CHF Disease Management

Attach a brief description (e.g., two pages) of the strategies and processes (e.g., disease management program) for managing the care of the designated CHF Population Return report no later than January 31, 2002, to:

Centers for Medicare & Medicaid Services
Center for Health Plans and Providers
ATTN: Angela Porter
Mail Stop: C4-13-01
7500 Security Blvd
Baltimore MD 21244-1850

or

aporter@cms.hhs.gov