Medicare Managed Care Manual

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

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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.*

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This chapter sets forth the policies and methods CMS follows in determining the amount of payment a Medicare+Choice (M+C) organization will receive for Medicare beneficiaries who are enrolled in an M+C plan offered by the organization. The regulations that govern these policies and methods are set forth in Part 422 Subpart F of the Code of Federal Regulations, and are based primarily on §1853 of the Social Security Act (the Act).

10 - Terminology

(Rev. 1, 07-02-01)

10.1 - Capitation Rate and Per Capita Rate

(Rev. 1, 07-02-01)

"Capitation rate" and "per capita rate" are used interchangeably.

10.2 - Payment Area

(Rev. 1, 07-02-01)

The general rule is that the payment area is a county or an equivalent geographic area specified by CMS (for example, an island or parish). For ESRD enrollees, there is a special rule that the M+C payment area is a State or other geographic area specified by CMS.

10.3 - "Area" In the Term "Area-Specific Rate"

(Rev. 1, 07-02-01)

"Area" in the term "area-specific rate" refers to a payment area (see §10.2).

NOTE: area-specific rate is also referred to in the statute and in §30.3.2 as the "annual area-specific capitation rate."

10.4 - Metropolitan Statistical Area, Primary Metropolitan Statistical Area, and Consolidated Metropolitan Statistical Area

(Rev. 1, 07-02-01)

These terms mean any areas so designated by the Secretary of Commerce. (See http://www.census.gov/main/www/cen2000.html. Select "Glossary.") In tabulating M+C rates for March through December 2001 (published January 4, 2001) and for CY 2002 (published March 1, 2001), CMS used the latest Census Bureau's Metropolitan Area Population Estimates, which were July 1, 1999.

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 - Special Rules for M+C Payments for Certain Types of Enrollees

(Rev. 9, 04-01-02)

Exceptions to the general rule for payments are explained in the section below. See the following sections for explanations of additional special rules:

Section 50.2, Rules for coverage and payment of National Coverage Determinations (NCDs);

Section 55, Coverage of Clinical Trials

Section 130, Special rules for beneficiaries enrolled in M+C Medical Savings Account (MSA) plans;

Section 140, Special rules for coverage that begins or ends during an inpatient hospital stay;

Section 150, Special rules for payments to M+C organizations for their beneficiaries enrolled in Hospice;

Section 160, Special rules for M+C payments for beneficiaries enrolled as Qualifying Individuals;

Section 165, Special Rules for M+C Payments to Department of Veterans Affairs Facilities; and

Section 180, Special rules for new entry bonus payments to M+C organizations.

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*.

20.1.2 - Enrollees in MSA Plans

(Rev. 1, 07-02-01)

The MSA design is intended to save a portion of the annual capitation rate in a savings account that an enrollee can use to pay medical expenses, until the large deductible specified by their plan is met and the plan begins to cover the enrollee's medical expenses. For enrollees in MSA plans, CMS subtracts 1/12th of the amount CMS deposits in the enrollee's MSA from the monthly payment that would otherwise be made to the M+C organization. The MSA deposit is calculated using methods discussed in §130. Note that capitation rates for M+C MSA plans are adjusted for enrollee demographic and health status factors.

20.1.3 - Enrollees in Religious and Fraternal Benefit Societies' Plans

(Rev. 1, 07-02-01)

For payments for M+C plans offered by Religious and Fraternal Benefit Societies (RFB plans), CMS adjusts capitation payments to ensure that the payment level is appropriate for the actuarial characteristics and experience of these enrollees. Adjustments to capitation payments can be made on an individual or organizational basis.

20.2 - Adjustment of Payments to Reflect the Number of Medicare Enrollees

(Rev. 1, 07-02-01)

CMS applies payment rates and adjustment factors applicable to the month of enrollment. Monthly payments to M+C organizations reflect existing enrollees, enrollees whose

enrollment will be effective before the month for which the payment is made, and enrollees whose enrollment will be effective in the month for which payment is made. For example, the payment for January 1, 2000, reflected members enrolled prior to December 1999, members with enrollments effective on December 1, 1999, and members with enrollments effective January 1, 2000.

CMS makes retroactive adjustments to the aggregate monthly payments to take into account any difference between the actual number of Medicare enrollees in a plan and the number on which CMS had based the organization's advance monthly payment.

If the beneficiary certifies that, at the time of enrollment under the M+C plan, he or she received from the M+C organization the disclosure statement specified at 42 CFR 422.111, CMS may make retroactive enrollment adjustments for a period (not to exceed 90 days) that begins when a beneficiary elects a group health plan (as defined at 42 CFR 422.101) offered by an M+C organization and ends when the beneficiary is enrolled in an M+C plan offered by an M+C organization. See Chapter 4 of this manual for information on disclosure requirements.

20.3 - Geographic Adjustment of Payment Areas

(Rev. 1, 07-02-01)

For contract years beginning after 1999, a State's chief executive may request a geographic adjustment of the State's payment areas for the following calendar year.The State must notify CMS by February 1 of its request to change from the single-county methodology to a geographically adjusted methodology for the following year. The statute specifies the following alternatives for geographical adjustments of payment areas:

1. One statewide M+C payment area, i.e., the same rate for every county in the state.

2. A metropolitan-based system with one rate for all non-metropolitan statistical area (MSA) counties and separate rates for all portions of each MSA in the State; or in the case of a consolidated MSA, separate rates for all portions of each primary MSA within each consolidated MSA.

3. A separate rate for a grouping of noncontiguous counties selected by the State (i.e., grouping counties that do not share a border).

20.4 - Budget Neutrality Adjustment for Geographically Adjusted Payment Areas

(Rev. 1, 07-02-01)

If CMS adjusts a State's payment areas in accordance with §20.3, at that time and each year afterwards, CMS adjusts the capitation rates so that the aggregate Medicare

payments do not exceed the aggregate Medicare payments that would have been made to all the State's payment areas without the geographic adjustment. As long as the governor's request for new payment areas remains in effect, this budget neutral adjustment is made annually.

20.5 - Adjustment of Payment Rates for County Mergers

(Rev. 1, 07-02-01)

If a county merges with another county, future M+C payment rates will be calculated only for the county whose Social Security Administration State and county code survives the merger.

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 - Greatest of Three Amounts Methodology for Calculating Capitation Rates

(Rev. 1, 07-02-01)

Under the M+C program, the annual capitation rate for a particular payment area is the greatest of three amounts:

- A minimum percentage increase of 2 percent over the rate for the previous year;
- A minimum specified amount or "floor" rate; or
- A blended payment rate.

30.1.1 - A Minimum Percentage Increase Over the Rate for the Previous Year

(Rev. 1, 07-02-01)

For 1998, the minimum percentage increase is 102 percent of the 1997 standardized county payment rates.(The BBA establishes the 1997 rates as the base rates for the M+C payment methodology.) The rates for 1999 and 2000 were increased 102 percent of the preceding year's rate.

BIPA Section 602 amends §1853(c)(1)(C) of the Act by specifying that for March through December 2001, the minimum percentage increase rate is changed to 103 percent of the annual M+C capitation rate for a payment area for 2000. For January and February of 2001, for 2002, and for each succeeding year, the minimum percentage increase rate will be 102 percent of the prior year's annual M+C capitation rate.

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.

30.1.3 - A Blended Payment Rate

(Rev. 1, 07-02-01)

The blended rate is based on a composite of area-specific and national rates in proportions defined by law and summarized in Table 1 below. The national rate gradually makes up a larger share of the blended rate until 2003, when the composite remains at 50 percent area-specific rate and 50 percent national rate. The blended rate is subject to budget neutrality (see below).

30.2 - Budget Neutrality Adjustment for the Blended Capitation Rates

(Rev. 1, 07-02-01)

Under budget neutrality, the aggregate national payments that would be made under the BBA's "greatest-of-three-amounts" methodology must equal the aggregate national payments that would have been made if payments were based entirely on area-specific

rates. Note that the budget neutrality adjustment applies only to the blended capitation rate.

Once the three rates (minimum percentage increase, floor, and blend) are determined for each payment area, a budget neutrality adjustment must be applied to the blended rate. CMS modifies rates in those counties whose greatest rate is the blended rate. If it is necessary to reduce the blended rates, these reductions can result in the greatest rate for a county changing from the blended rate to the minimum percent increase rate or the floor rate.Depending on factors such as the size of original Medicare's annual growth rate (which determines the M+C growth rate), counties whose blended rates are relatively higher than their floor or minimum percent rates - compared to other counties - could retain the blended rate as their greatest rate following the budget neutrality adjustment. The final payment rate is based on the highest of the minimum percentage increase rate, the minimum amount rate (floor), and blended rate after budget neutrality adjustment.

30.3 - Calculation of Factors Used to Adjust Capitation Rates

(Rev. 1, 07-02-01)

The following are the factors used in calculating M+C per capita payment rates.

30.3.1 - The National Per Capita M+C Growth Percentage

(Rev. 1, 07-02-01)

This annual national growth percentage is CMS's projection of the national average rate of growth in per capita expenditures for Medicare, reduced by an amount specified in law. (The statutorily required reductions are summarized in Table 1 below.) Note that what makes this national growth rate unique to the M+C program is the reductions summarized in Table 1, which are reflected or "carried forward" in all future rates. (Also note that the growth percentage includes revisions to prior years' estimates of the growth rate; see §40.)

30.3.2 - The Annual Area-Specific Component of the Blended Capitation Rate

(Rev. 1, 07-02-01)

For 1998, the base for the area-specific rate is the 1997 county per capita payment rate (which is 95 percent of the AAPCC). To calculate the area-specific rate, the base rate is adjusted by the national per capita M+C growth percentage (see §30.3.1) for 1998, and also adjusted by the exclusion of a percentage of medical education costs (see §30.3.3)**.** For subsequent years, the area-specific rate determined for the previous year is adjusted by the national per capita M+C growth percentage for the year, and also adjusted by the

medical education “carve out” percentage for that year, according to the schedule summarized in Table 1 below.

The annual increases in the area-specific rates and the floor amounts are indexed in future years to the national per capita M+C growth percentage. CMS began this adjustment in 1999 for the area-specific rates. (See §4 for further detail.)

30.3.3 - Medical Education Payment Adjustments

(Rev. 1, 07-02-01)

For the purposes of calculating the annual area-specific capitation rate, the statute directs CMS to adjust the 1997 rates by “carving out” the amounts included in those rates for the indirect costs of medical education and the direct costs of graduate medical education.This adjustment is phased in over five years, and the amounts “carved out” are paid directly to teaching hospitals. For example, for 1998, 20 percent of medical education payments were removed from the 1997 rates (which are the M+C base rates). Table 1 below presents the schedule of adjustments.

To the extent that CMS estimates that the 1997 per capita base rate reflects payments to State hospitals (under §1814(b)(3) of the Act), CMS makes an appropriate payment adjustment to the M+C payment rate, so that it is comparable to the medical education adjustment that would have been made if the hospitals were not reimbursed under §1848(b)(3). Under this provision, payments are made to hospitals located in Maryland, until the waiver is rescinded.

Table 1 - Schedule for Phasing In of the Statutory Reduction to the M+C Growth Rate, Exclusion of Medical Education Expenses, and Blending of Area-Specific and National Capitation Rates

Table 1 - Schedule for Phasing In of the Statutory Reduction to the M+C Growth Rate, Exclusion of Medical Education Expenses, and Blending of Area-Specific and National Capitation Rates

Calendar Year	Statutory reduction in national per capita M+C growth %	% Exclusion of graduate medical education expenses from area-specific capitation rate	Blending % for blended rate: Area-specific capitation rate/ national capitation rate
1998	0.8%	20%	90% / 10%
1999	0.5%	40%	82% / 18%
2000	0.5%	60%	74% / 26%
2001	0.5%	80%	56% / 34%
2002	0.3%	100%	58% / 42%
2003 and later	none	100%	50% / 50%

30.3.4 - The National Component of the Blended Capitation Rate

(Rev. 1, 07-02-01)

The national component of the blended capitation rate is calculated in two steps:

1. The national standardized annual capitation rate; and

2. The national input-price adjusted capitation rate.

The calculations are described below.

Step 1. The national standardized annual capitation rate is a weighted average of all area-specific capitation rates. The national standardized rate is calculated separately for Part A and Part B.

1. The weight used to standardize the area-specific capitation rate for each payment area is calculated as follows: The number of all Medicare beneficiaries residing in the payment area is multiplied by the average demographic factor or average risk factor for the payment area (generally a county). This weight represents the total adjusted enrollment for each payment area.

2. Sum the weights described above in (1) across all payment areas to generate the total national adjusted enrollment, which is used in (4) below.

3. Multiply the annual area-specific capitation rate for a payment area by the weight described in (1) for that payment area. Sum these dollar amounts across all payment areas to generate the total national adjusted reimbursement amount, which is used in (4) below.

4. The national standardized annual capitation rate isthe total national adjusted reimbursement amount divided by the total national adjusted enrollment.

Step 2. The national standardized annual capitation rates (for Parts A and B) are input price adjusted for each payment area to produce the input-price adjusted annual national capitation rates. Input-prices adjustments account for geographic variation in the prices of goods and services used to produce medical services. CMS applies two indices from original Medicare: the area hospital wage index, and the geographic practice cost index for physicians.

For each payment area, the annual input-price adjusted rate (calculated separately for Parts A and B) is equal to the product of three amounts:

(1) The national standardized annual capitation rate;

(2) The proportion of the annual rate attributable to Part A services (or Part B services for the Part B calculation); and

(3) An index that reflects (for that year and that type of service) the relative input price of services in the area, as compared to the national average input price for these services.

The two input-price adjusted rates for Part A and B services are then added together to get a combined input-price adjusted national average for the payment area.

The statute specifies the following method for calculating input-price adjustments for 1998:

- The proportion of Medicare services attributable to Part A is the ratio (expressed as a percentage) of the national average per capita rate of payment for Part A services for 1997 to the national average per capita rate of payment for Part A and Part B services for that year. The proportion attributable to Part B services is 100 percent minus the ratio for Part A.

- Input-price indices - For Part A, 70 percent of the payments attributable to those services is adjusted by the area hospital wage index used under §1886(d)(3)(E) of the Act. For Part B, 66 percent of the payments attributable to those services is adjusted by the geographic practice cost index for physicians (under §1848(e) of

the Act) and of the remaining 34 percent, 40 percent is adjusted by the hospital wage index.

Therefore, the national input-price adjusted rate is the national capitation rate adjusted for local input prices. For years after 1998, the statute does not mandate a specific method for calculating input-price adjustment. Instead, CMS is given the authority to apply indices used in updating national payment rates for particular areas and localities. Currently, CMS will apply this method in future years.

CMS uses original Medicare's most recent updates to the inpatient hospital Prospective Payment System (PPS) wage index and to the geographic adjustment factors used for physician payments. For information on the PPS area wage index, see http://www.cms.hhs.gov/medicare/. For information on geographic practice cost prices, see pages 160 to 166 of the document found at http://www.cms.hhs.gov/regulations.

The input-price adjusted national average for each payment area is used with the area-specific rate to calculate the blended payment rate, in proportions listed in Table 1 above. Payment rates are developed separately for aged, disabled, and ESRD beneficiaries. See http://www.cms.hhs.gov/statistics/ to review payment files used to calculate the annual capitation rates.

40 - Adjustment of Capitation Rates for Over or Under Projection of National Per Capita M+C Growth Percentages

(Rev. 1, 07-02-01)

Section 1853(c)(6)(C) of the Act provided for adjustments to M+C capitation rates to reflect revisions to prior years' projections of growth rates. Beginning with the 1999 payment rates, CMS annually adjusts all area-specific capitation rates (and as a result, the national input-price adjusted rates) to reflect any differences between the projected and current estimates of the national per capita M+C growth percentages. Beginning in 2000, CMS also adjusts the minimum amount rate in the same manner.

Congress mandated a new floor rate for CY 1998 (§1853(c)(1)(B)(i) of the Act), which established CY 1998 as the statutory base year for the floor rate. For this reason, when calculating the ratebook for CY 1999, CMS assumed that the floor rates set by Congress as appropriate for CY 1998 were deemed to include any appropriate revisions to prior years' estimates of the M+C Growth Percentage. CMS corrects only estimates in the rates of increase after the base year, and the 1998 base year was specified by Congress.

When calculating the ratebook for CY 2000, the rate of increase for the floor included, for the first time, an adjustment for the fact that the current estimate of the prior year's M+C Growth Percentage was different than the estimate actually used in calculating the 1999 ratebook. Note that in CY 2000 the total change in estimates of the M+C Growth Percentage differed for area-specific and the floor rates, because adjustments to the area-specific rates due to revisions in prior years' estimates of growth did include a revised

estimate for CY 1998, while adjustments to the floors did not include revised estimates for CY 1998.

Under the BIPA, Congress again took the approach of specifying appropriate floor rates in the statute for CY 2001, rather than building on prior year rates, estimates, or expenditure data. The revised CY 2001 rates implementing BIPA (published January 4, 2001) are effective March through December 2001. Again, we believe Congress should be deemed to have included in the new base rates any appropriate adjustments due to revisions of prior years' estimates of growth. As in the case of the year following the year after the BBA-specified floor rate, in the CY 2003 ratebook, CMS will adjust the new BIPA-based floor rates with revised estimates of prior years' growth projections for the first time, using revised estimates for CY 2002.

Information on corrections to prior estimates can be found each year in Enclosure I of the March 1 Announcement of M+C payment rates.See http://www.cms.hhs.gov/statistics/ for all March 1 Announcements.

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.

55 - Coverage of Clinical Trials

(Rev. 9, 04-01-02)

For Calendar Years (CY) 2002 and 2003, CMS will continue the CY 2001 policy of making fee-for-service payments for covered clinical trial costs.

On September 19, 2000, the Centers for Medicare & Medicaid Services (CMS) published a National Coverage Determination (NCD) regarding coverage of certain benefits related to clinical trials that were not covered by Medicare prior to that date. (See §30.1 of the Coverage Issues Manual at http://www.cms.hhs.gov/manuals/06_cim/ci00.asp.) Since the cost of covering these new benefits was not included in the 2001 M+C capitated payment rates, and since this cost met the threshold for "significant cost" under 42 CFR 422.109(c), Medicare paid for covered clinical trial services outside of the M+C capitated payment rate through CY 2001. Medicare intermediaries and carriers made payments on behalf of M+C organizations directly to providers of covered clinical trial services, on a fee-for-service basis.

We reviewed the M+C payment rates for CY 2002, which were published on March 1, 2001, and determined that these rates do not reflect any adjustment for this significant

cost NCD. We have determined, therefore, that the published CY 2002 rates do not adjust appropriately for the costs of this NCD, as required under §1853(c)(7) of the Act. As a result, for CY 2002 CMS will continue the CY 2001 policy of making payments on a fee-for-service basis for covered clinical trial costs. Medicare intermediaries and carriers will make payments on behalf of M+C organizations directly to providers of covered clinical trial services, on a fee-for-service basis.

For CY 2003, we will continue paying M+C organizations on a fee-for-service basis for covered clinical trial items and services provided to their members.

As in CY 2001, payment for clinical trial services furnished to beneficiaries enrolled in M+C plans will be determined according to the applicable fee-for-service rules. M+C organizations may continue operating under the rules and procedures they have in place for CY 2001 clinical trial benefits, including beneficiary cost-sharing, coverage of complications, and any prior notification rules in effect. In addition, M+C organizations may continue to use their CY 2001 Explanation of Coverage (EOC) language on clinical trials.

In CY 2001, original Medicare cost-sharing amounts applied automatically to clinical trial services covered by the NCD because they were covered "outside" the M+C contract. For CY 2002 and CY2003, however, these services are now considered part of the M+C plan, even though CMS is continuing to pay for them on a fee-for-service basis. Thus, while M+C organizations may retain the existing cost-sharing structure for these services, they also have the flexibility to adopt their own cost-sharing structures for these services (even though CMS's payment will be based on the original Medicare rules). Because benefits and cost-sharing for CY 2002 have already been established, this could only be done for 2002 as a "mid-year benefit enhancement." M+C organizations also could make changes in beneficiary liability for these services in the ACRs they submit for 2003.

Program Memorandum AB-01-103, available at http://cms.hhs.gov/manuals/pm_trans/AB01130.pdf, gives instructions to providers and suppliers on billing intermediaries and carriers for clinical trial services. Beginning January 1, 2002 M+C organizations should continue operating under the procedures in this PM until further notice (extension of this PM or release of a new one.)

Under Original Medicare, providers and suppliers must include ICD-9 code V70.7 (Examination of Participation in Clinical Trial) as the second or subsequent diagnosis code on the UB-92 submitted to intermediaries. In addition, they must include the "QV" procedure code modifier on the line item of all clinical trial services submitted to carriers. Starting April 1, 2001, they also must use condition code 30 on UB-92 claim forms. Providers and suppliers may resubmit rejected claims with the clinical trial codes if they were inadvertently omitted. These codes must be present in order for the claims to be resubmitted or otherwise brought to the attention of the M+C organization.

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 Adjustment 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]
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]

80 - The Demographic-Only Method for Adjustment of Capitation Rates

(Rev. 1, 07-02-01)

Recall that for 1998, the base for area-specific rates under the new M+C payment system is the 1997 per capita rates. Built into these 1997 rates are the demographic adjustments for sex, age, institutional status, and Medicaid eligibility that were used under the pre-BBA methodology. Thus, the demographic adjustments from the prior system are "carried forward' into the M+C system.

Under this demographic-only method, each combination of demographic characteristics (for example, females aged 70 to 74 who are institutionalized) is assigned a demographic factor. The demographic factor is a relative cost ratio of the national average per capita cost for FFS beneficiaries per cell (i.e., per combination of demographic characteristics) to the national average per capita cost across all cells (all FFS beneficiaries). There are 80 factors (including working aged status, see §60) for aged beneficiaries, and 60 factors for disabled beneficiaries (excluding working aged status).

Each factor applied under the demographic-only method is defined below. Exhibit 3 lists the factors applied under the demographic-only method.

80.1 - Age and Sex

(Rev. 1, 07-02-01)

There are 24 age/sex categories representing aged and disabled beneficiaries in Parts A and B.

80.2 - Institutional Status

(Rev. 1, 07-02-01)

Institutional status is a concurrent adjustment factor. For each prior month in a certified institution, a beneficiary is assigned the institutional rate cell the following month.(See §170 for a definition of certified institution.)

80.3 - Medicaid Eligibility

(Rev. 1, 07-02-01)

Medicaid status is a concurrent adjustment factor. A Medicare beneficiary is assigned the age-sex-appropriate Medicaid factor based on his or her current Medicaid enrollment status. Payments vary according to month-to-month Medicaid eligibility in the payment year. (See §160 for policy on Qualifying Individuals, QI-1s and QI-2s.)

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.

130 - Special Rules for Beneficiaries Enrolled in M+C Medical Savings Account (MSA) Plans

(Rev. 1, 07-02-01)

The statute directs CMS to allocate the per capita amount associated with each M+C MSA enrollee in two portions: the deposit CMS makes to the enrollee's MSA and the premium CMS pays to the M+C organization offering the MSA plan.

CMS allocates the capitated amount associated with each M+C MSA enrollee into a plan premium and an MSA deposit as follows:

- First, CMS compares the monthly M+C MSA premium filed by the organization offering the MSA plan to 1/12th of the annual M+C capitation rate for the payment area in which the beneficiary resides.

- If the monthly M+C MSA premium is less than the monthly capitation rate (see §30.1), then CMS deposits into the individual's M+C MSA account a lump sum equal to the annual difference between these two amounts.

- This annual difference is calculated as the monthly difference multiplied by 12 or by the number of months remaining in the calendar year when the individual becomes covered under the M+C MSA plan.

- CMS deposits the lump-sum payment to which a beneficiary is entitled for the calendar year, beginning with the month in which M+C MSA coverage begins.

- If the beneficiary's coverage under the M+C MSA plan ends before the end of the calendar year, CMS will recover the amount that corresponds to the remaining months of that year.

- Second, CMS's advance payment of the monthly premium to the M+C MSA plan for an enrollee is equal to the county per capita rate, adjusted by the enrollee's demographic and risk factors, minus 1/12th of CMS's lump sum contribution to the enrollee's MSA.

The premium filed by the organization offering the M+C MSA plan is uniform for all enrollees under a single M+C MSA plan. This results in a uniform amount being deposited in enrollees' M+C MSAs in a given payment area, since the uniform premium amount will be subtracted from the uniform capitation rate for every enrollee in that payment area. While monthly premiums are uniform within a plan, the advance monthly payments CMS makes to an M+C organization for each enrollee may differ because the area-specific per capita rate is adjusted for each enrollee's demographic characteristics and health status -- under the blend appropriate for that payment year of demographic-only and risk adjustment methods.

130.1 - Example: Allocating the Per Capita Rate Between the Enrollee's MSA Account and the M+C MSA Plan

(Rev. 1, 07-02-01)

Calculation of payments for two beneficiaries of different ages living in the same county and enrolled in the same M+C MSA plan is performed as follows, assuming a monthly county per capita rate of $500, and a monthly M+C MSA plan premium of $400.

Calculation of CMS's annual contribution to the enrollees' M+C MSA plan is equal to the county per capita rate minus monthly plan premium. For this example, ($500-$400) * 12 months = $1,200 for any MSA enrollee in the county.

Calculation of CMS's advance monthly payments

- First, adjust the county per capita rates:
    - $500 * demographic factor for the 65 year old beneficiary = $450
    - $500 * demographic factor for the 85 year old beneficiary = $700
- Second, calculate the advance monthly payment to the plan:
    - Recall that 1/12th of CMS's lump sum contribution to the enrollee's MSA is $1200 or $100 per month.
    - For the 65 year old beneficiary = $450 - $100 = $300
    - For the 85 year old beneficiary =$700 - $100 = $600

Thus, each month, CMS pays the organization offering the M+C MSA plan $300 for the 65 year old enrollee and $600 for the 85 year old enrollee.

130.2 - Establishment and Designation of Medical Savings Accounts (MSAs)

(Rev. 1, 07-02-01)

A beneficiary who elects coverage under an M+C MSA plan must establish an account with an entity that acts as a qualified trustee or custodian. A trustee must meet the following requirements:

- Register with CMS;

- Certify that it is a licensed bank, insurance company, or other entity qualified under the IRS Code to act as a trustee of Individual Retirement Accounts;

- Agree to comply with the IRS rules concerning MSAs; and

- Provide any other information that CMS may require.

An enrollee may establish more than one account, but must designate the particular account under the M+C MSA to which CMS makes payments.

140 - Special Rules for Coverage that Begins or Ends During an Inpatient Hospital Stay

(Rev. 1, 07-02-01)

If coverage under an M+C plan offered by an M+C organization begins while the beneficiary is receiving inpatient hospital services from a hospital covered under original Medicare's Prospective Payment System (PPS), payment for inpatient services continues to be the responsibility of original Medicare or the previous M+C organization, until the date of the beneficiary's discharge.

- The M+C organization offering the newly elected M+C plan is not responsible for the inpatient services until the date of the beneficiary's discharge.

- Original Medicare or the previous M+C organization pays the full amount for that beneficiary for that inpatient episode, even if it extends beyond the effective date of a beneficiary's M+C election.

- In the case where a beneficiary's M+C plan election ends while he or she is a hospital inpatient, the M+C organization remains responsible for payment for inpatient hospital services furnished by a hospital after expiration of enrollment until the date of discharge. Payment for these services would not be made under Medicare's PPS system, and the responsible M+C organization would not receive any payment from CMS for the hospitalized individual during the period the individual was not enrolled.

150 - Special Rules for Payments to M+C Organizations for Their Beneficiaries Enrolled in Hospice

(Rev. 1, 07-02-01)

M+C organizations must inform each Medicare enrollee who is eligible to elect hospice care under §1812(d)(1) of the Act about the availability of hospice care. M+C enrollees should be informed if there is a Medicare-certified hospice program in the plan's service area. Additionally, if it is common practice to refer patients to Medicare-certified

hospice programs outside that area, the M+C organization must inform enrollees about the availability of Medicare-certified hospice care. See Chapter 4 for additional information on hospice benefits.

150.1 - Enrollment Status

(Rev. 1, 07-02-01)

Unless the enrollee disenrolls from the M+C plan upon electing hospice, a beneficiary continues his or her enrollment in the M+C plan and is entitled to receive, through the M+C plan, any benefits other than those that are the responsibility of the Medicare hospice.

150.2 - Payment for Hospice Services

(Rev. 1, 07-02-01)

During the time the hospice election is in effect, CMS's monthly capitation payment to the M+C organization is reduced to an amount equal to the adjusted excess amount in the M+C plans' approved ACRP. (See Chapter 8 for information on ACRPs.)

CMS pays the hospice program, through the original Medicare program and subject to the usual rules of payment, for hospice care furnished to the Medicare enrollee.

CMS pays the M+C organization or provider or supplier for other Medicare-covered services furnished to the enrollee. Other services refer to non-hospice services that are not related to the terminal illness.

The M+C organization is responsible for providing to its members who have elected hospice all Medicare-covered non-hospice services and also any non-hospice services that are not Medicare-covered but are additional benefits provided under the plan. For example, any services provided by an attending physician to an M+C enrollee who has elected hospice are non-hospice services if the physician is not employed or contracted by the enrollee's hospice program.

Since an M+C organization cannot bill a Fiscal Intermediary (FI), nor can an FI make payments to M+C organizations, below are examples of how M+C organizations may choose to handle billing for non-hospice services:

- The M+C organization may authorize the provider (e.g., hospital or physician) or supplier to bill the FI or carrier directly. (In this situation, the M+C organization might choose to incorporate rate adjustments in contracts to account for the provision of non-hospice services by providers and suppliers that bill original Medicare directly.)

- In the case of physician and supplier services, the M+C organization may direct them to submit claims for non-hospice services to the M+C organization. The M+C organization would bill the carrier and make payments to the physicians/suppliers.

Under original Medicare (and thus under the M+C program for hospice election), the beneficiary is responsible for the following cost sharing upon electing hospice:

- Co-pay for drug and biologicals: 5 percent per prescription filled.

- Co-pay for a respite care day: 5 percent of the payment that Medicare makes for a respite care day, not to exceed the hospital inpatient deductible.

160 - Special Rules for M+C Payments for Beneficiaries Enrolled as Qualifying Individuals

(Rev. 9, 04-01-02)

The BBA established "Qualified Individuals" (QIs) for CY 1998 through 2002. Qualified Individuals are low-income Medicare beneficiaries for whom State Medicaid programs cover all or a portion of Medicare Part B premiums. Qualified Individuals, by definition, have higher incomes than other groups for whom Medicaid pays Medicare cost sharing and premiums.

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.

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.

170 - Clarification of the Definition of "Certified Institution" for Adjusting Payments Under the Demographic-Only Method

(Rev. 1, 07-02-01)

One of the categories for which payment adjustments are made under the demographic-only method is institutional status, referring to Medicare beneficiaries who are under care or custody in institutions.To be considered institutionalized, an enrolled member must:

- Be a resident in an institution, or distinct part of an institution, that is one of the seven following types of institutions certified under Title XVIII (Medicare) or Title XIX (Medicaid); and

- Satisfy the qualifying period of residency in a certified institution (or distinct part of an institution) that is Title XVIII or Title XIX certified.

170.1 - Types of Certified Institutions

(Rev. 9, 04-01-02)

Medicare and Medicaid certified institutions are:

- **Skilled Nursing Facility (SNF)**, as defined at §1819(a) of the Act, is an institution, or distinct part of an institution, primarily engaged in providing skilled nursing care or rehabilitative services to residents which has in effect an agreement with a hospital that ensures transfer of patients will be affected between the two whenever such transfer is medically appropriate.

- **Nursing Facility (NF),** as defined at §1919(a) of the Act, is the same as a SNF but also includes institutions that provide health-related care and services to residents who because of their mental or physical condition require care and services, which can be made available to them only through institutional facilities.

- **Intermediate Care Facility for the mentally retarded (ICF/MR**), as defined at §1905(d) of the Act, is an institution that provides health or rehabilitative services for mentally retarded residents receiving active treatment under Medicaid.

- **Psychiatric Hospital or Unit,** as defined at §1886(d)(1)(B) of the Act,is an institution, or distinct part of an institution, primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons.

- **Rehabilitation Hospital or Unit,** as defined at §1886(d)(1)(B) of the Act, is an institution that serves an inpatient population of whom the vast majority require intensive rehabilitative services for the treatment of certain conditions, e.g., stroke, amputation, brain or spinal cord injuries, and neurological disorders.

- **Long-term Care Hospital**, as defined at §1886(d)(1)(B) of the Act) is a hospital, which has an average inpatient length of stay of greater than 25 days.

- **Swing-bed Hospital,** as defined under §1883 of the Act, is a hospital, which has entered into an agreement whereby its inpatient hospital facilities may be used for the furnishing of services of the type which, if furnished by a SNF, would constitute extended care service.

In the case of an enrolled member in a swing-bed hospital, the enrolled member must be receiving post-hospital extended care services or SNF services.

See http://www.cms.hhs.gov/statistics for files containing the names and contact information for certified institutions, which are updated quarterly.

170.2 - Residency Requirements

(Rev. 2, 10-01-01)

A Medicare enrollee must have been a resident of one or more of the above certified institutions for a minimum of 30 consecutive days, which includes, as the 30th day, the last day of the month prior to the month for which the higher institutional rate is paid. This qualifying period of residency must be satisfied each month in order for the M+C organization to be paid at the higher institutional rate.

The term "calendar month" cannot be used. A calendar month can have 28 to 31 days and thus cannot be substituted for 30 days. For example, in a month with 31 days, a beneficiary would have to be institutionalized from the 2nd - 31st day of the month to meet the requirements for reporting institutionalized status.

Temporary Absences - CMS will continue to pay the institutionalized rate while an enrolled member is temporarily absent from the facility for hospitalization or therapeutic leave, if the member returns to a certified institution, or distinct part of an institution. Temporary absences (less than 15 days) for medical necessity will be counted toward the 30-day requirement.

Note: "Therapeutic" means requested or supported by a physician; site of service is irrelevant.

170.3 - Payment for Institutional Status

(Rev. 9, 04-01-02)

CMS determines whether an M+C organization should be paid at the institutional rate for an enrollee by asking two questions:

- Did the enrollee fulfill the 30-day residency requirement in a certified institution (where the 30th day is the last day of the month)? Is the

- Is the M+C organization entitled to payment based on this qualifying residency?

Conceptually, the institutional payment is prospective. Generally, for example, when an enrollee satisfies the residency requirement in April, the M+C organization is entitled to an institutional payment in May. In practice, however, the payment mechanism is retroactive. Given the residency requirement, where the 30th day must be the last day of the month, our payment system could not receive and process monthly status information in time to use a prospective payment system As a result CMS makes a retroactive payment adjustment two months after the month where an enrollee satisfies the residency requirement. for example, when an enrollee satisfies the residency requirement in April, the June 1 capitation payment for this enrollee is adjusted to bring the May 1 payment retroactively up to the full amount owed the M+C Corporation in May because of the enrollee's qualifying residency.

Death or discharge on the last day of the month - If an M+C enrollee is discharged or dies on the last day of the month (and this is the 30th consecutive day of residency in a certified institution), then the beneficiary has satisfied the residency requirement

Original Medicare does not count the day of discharge towards residency requirements. However, capitated payments made to the M+C organizations are not for units of service or treatment, as in original Medicare. Under the M+C program, institutional status is a proxy for health status, not a unit of service. In this context, it is appropriate to count the day of discharge towards residency requirement.

The next step is to determine whether the M+C organization is entitled to a prospective payment at the institutional rate for the qualifying residency. The M+C plan elected by the beneficiary for the month subsequent to the qualifying period of residency is entitled to receive the institutional amount

This is not necessarily the same as M+C plan elected by the beneficiary while a resident of the institution. For example (assuming the beneficiary has satisfied the residency requirement):

- If the beneficiary is discharged on the last day of the month of the qualifying period of residency and the beneficiary is enrolled in the same plan of the subsequent month, payment would be made to that plan

- If the beneficiary is discharged on the last day of the month of the qualifying period of residency and the beneficiary is enrolled in a new plan on the first day of the subsequent month, payment would be made to the new plan.

- However, if the beneficiary dies on the last day of the qualifying period of residency, that beneficiary would not be enrolled in any plan on the first day of the subsequent month. Therefore, payment would not be made to any M+C plan.

Payment examples - Below are examples clarifying when M+C organizations are entitled to payment at the institutional status rate:

1. On March 2, a member of an M+C organization enters a certified institution. On March 20, the individual is hospitalized for a surgical procedure. On April 2, the individual is discharged from the hospital, re-enters the institution, and remains there continuously through April 15. The individual does meet the residency requirement (March 2 through March 31) and has remained in the same plan for the subsequent month. The M+C organization is paid the institutional rate for the month of April through a retroactive adjustment to the capitated payment for May.

2. Mr. X, whose M+C enrollment is effective April 1, enters a certified institution on April 15 and remains there continuously until his discharge on May 25. He does not meet the criteria for reporting institutionalized status for May or June. Although he was institutionalized for at least 30 days, in May his residency did not include the last day of the month as the 30th day. His stay would have had to continue through May 31 in order to be reported for an institutional payment for the month of June. If Mr. X had been discharged on May 31, his M+C organization would be entitled to payment at the institutional rate in June.

3. Ms. Y, whose M+C enrollment is effective April 1, enters a certified institution on February 28 and remains there continuously until her discharge on April 25th. She does meet the qualifying period of residency for reporting institutionalized status for April (March 2 through March 31) but not for May. The qualifying period of residency for a payment in May at the institutional rate is April 1 through April 30. Note that Ms. Y was not a member of the M+C organization during the qualifying period of residency (March 2 through March 31). It is not required that Ms. Y be a member of M+C organization during the qualifying period of residency. Thus, the M+C organization in which she is enrolled on April 1 is paid the institutional rate in April for her qualifying period of residency in March. The M+C organization would not be paid the institutional rate for the month of May because the qualifying period of residency (April 1 through April 30) was not satisfied.

180 - Special Rules for New Entry Bonus Payments to M+C Organizations

(Rev. 1, 07-02-01)

The Balanced Budget Refinement Act (BBRA) established bonus payments to encourage M+C organizations to offer plans in payment areas that would otherwise not have a plan

participating in the M+C program. The application of the new entry bonus is governed by three factors: The definition of unserved payment area, the date a plan is first offered, and the period of application for the bonus.

180.1 - Previously Unserved Payment Area

(Rev. 2, 10-01-01)

The BBRA defined a previously unserved payment area as:

- A payment area in which an M+C plan had not been offered since 1997; or
- A payment area in which an M+C plan had been offered since 1997, but in which every M+C organization offering an M+C plan in that payment area since then has notified CMS (no later than October 13, 1999) that it would no longer offer M+C plans in that payment area as of January 1, 2000.

BIPA §608 extended by 1 year (to January 31, 2001) the time period during which an area must have had no M+C plans(s)offered in order for that area to be eligible for the bonus. The BIPA mandates that a payment area now will be considered unserved for purposes of bonus payments if:

- An M+C plan (or plans) had been offered since 1997; and
- Every M+C organization offering an M+C plan in that payment area then notified CMS no later than October 3, 2000, that it would no longer offer M+C plans in that payment area as of January 1, 2001.

The effect of this section of the BIPA was to include additional payment areas in the definition of previously unserved payment areas.

M+C organizations entering a payment area that is a county which is partially unserved are not eligible for a New Entry Bonus. CMS does not have that discretion under the law.The statute refers to a payment area, and most payment areas are counties. Therefore, if a plan already is offered in part of a county, any M+C organization offering a plan in that county could not be considered entering a previously unserved payment area since there is already a plan serving that county.

NOTE: A payment area that has §1876 cost plans only, but no M+C plans, would be considered a “previously unserved payment area,” justifying the bonus payment.

180.2 - The Date on Which a Plan is Offered

(Rev. 1, 07-02-01)

The date on which a plan is offered is the date on which the M+C organization's contract is effective and an M+C eligible beneficiary is eligible to enroll in the M+C plan, without regard to when an individual enrollment is effective or services are received (see 42 CFR 422.250(g)(3)). Because contract approval dates may vary, two or more M+C organizations with different contract approval dates may be eligible for a bonus in the same area if the M+C plans covered under the contract are first offered in the area on the same date. If an M+C organization first offers two M+C plans simultaneously in a previously unserved payment area, the M+C organization will receive the bonus for enrollees in both plans, since that "organization" is entitled to the bonus. Likewise, if more than two M+C organizations enter at the same time and each has more than one plan, the M+C organizations will receive a bonus for all enrollees in all of the plans offered in a previously unserved payment area. See Operational Policy Letter 2000.117 for additional discussion.

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.

180.4 - Method for Calculating Bonus Payments

(Rev. 1, 07-02-01)

The first M+C plan offered in a previously unserved payment area receives a 5 percent bonus payment during its first 12 months in that payment area and a 3 percent bonus payment during the second 12 months. For example, an M+C organization that enters a previously unserved payment area on March 1, 2000, will receive 5 percent bonus payments until February 2001, and 3 percent bonus payments until February 2002. The

BBRA provides for no bonus payments after this second 12-month period. Under the BIPA extension of the time period delineating an "unserved payment area," an M+C organization that enters a previously unserved payment area on March 1, 2001, will receive 5 percent bonus payments until February 2002, and 3 percent bonus payments until February 2003.

The payment is calculated on a beneficiary level and the 5 percent will be added to the payment calculated for each beneficiary residing in a payment area for which their M+C organization is eligible to receive bonus payments. M+C organizations that qualify for the bonus will be notified by CMS that they will receive these additional payments.

180.5 - Relation of Bonus Payments to the Adjusted Community Rate (ACR) Proposal

(Rev. 1, 07-02-01)

M+C organizations should not include bonus payments in the revenue portion of the ACR proposal.

190 - Source of Payment and Effect of Election of the M+C Plan Election on Payment

(Rev. 1, 07-02-01)

Payments to M+C organizations or M+C MSAs are made from the Federal Hospital Insurance Trust Fund or the Supplementary Medical Insurance Trust Fund in proportions that reflect the relative weights that benefits under Part A and Part B represent of the actuarial value of total Medicare benefits.

190.1 - Payments to the M+C Organization

(Rev. 1, 07-02-01)

CMS's payments under a contract with an M+C organization with respect to an individual electing an M+C plan offered by the organization are instead of the amounts, which, in the absence of the contract, would otherwise, be payable under original Medicare for items and services furnished to the individual. This statement is subject to provisions set forth in the Act:

- 412.105(g) detailing payments made to a hospital for indirect medical costs for discharges of managed care enrollees;

- 413.86(d) concerning calculations of payments to hospitals for graduate medical education costs;

- 42 CFR 422.109 concerning National Coverage Determinations;
- 42 CFR 422.264 on special rules for coverage that begins;or ends during an inpatient hospital stay; and
- 42 CFR 422.266 on special rules for hospice care.

190.2 Only the M+C Organization is Entitled to Payment

(Rev. 1, 07-02-01)

Only the M+C organization is entitled to receive payment from CMS under title XVIII of the Act for items and services furnished to the individual. This statement is subject to provisions set forth in the M+C regulations: 42 CFR 422.262 on special rules for beneficiaries enrolled in M+C MSA plans; 42 CFR 422.264 on special rules for coverage that begins or ends during an inpatient hospital stay; 42 CFR 422.266 on special rules for hospice care; and 42 CFR 422.520 detailing the M+C prompt payment provisions specifying conditions under which CMS may make direct payments to providers or M+C private-fee-for service plan enrollees. This statement is also subject to the following provisions of the Act: §1886(d) concerning additional payment amounts to any subsection (d) hospital with an approved medical residency training program for applicable discharges of M+C en enrollees; and §1886(h)(3)(D) concerning calculations of payments to hospitals for direct graduate medical education costs.

NOTE: Although the policies discussed below on retroactive payment adjustments are current, CMS is conducting a review of all policies pertaining to retroactive payment adjustments.

200 - Retroactive Payment Adjustments for M+C Organizations

(Rev. 1, 07-02-01)

Retroactive payment adjustments (both increases and decreases) are limited to a three-year period preceding the month in which CMS receives any data indicating a change is needed to a Medicare enrollee's record. For example, if a payment adjustment is proposed in February 2000 to cover a period of at least 36 months, a payment adjustment will be made beginning in February 1997 (assuming all documentary requirements are met).

This policy applies to retroactive deletions of and changes in the demographic classes and working aged status in which a Medicare enrollee is grouped. In addition, this policy applies to corrections in date of death and administrative errors.

210 - Reconciliation Process for Changes in Risk Adjustment Factors

(Rev. 2, 10-01-01)

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 notoccur during the payment year. This includes encounter data submitted for Part B-only members. 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.

Note: There is no adjustment for institutional status under the risk adjustment methodology as it has been accounted for in the development of the risk adjustment factors.

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

CMS has separate reconciliation processes for hospice (§220) ESRD (§230). (M+C enrollees who are capitated at the ESRD and hospice rates are excluded from payment under the risk adjustment method; they are capitated at the applicable demographic-only rate.)

Exhibits

Exhibit 1 - Previous Adjusted Average Per Capita Cost (AAPCC) Methodology

(Rev. 1, 07-02-01)

- First, HCFA made actuarial estimates of the per capita costs Medicare incurred paying claims on a fee-for-service (FFS) basis in a beneficiary's county of residence.

- The adjusted average per capita cost (AAPCC) consists of the per capita rates standardized by demographic factors to account for differences among counties in the overall demographic profile of their Medicare beneficiaries. The demographic characteristics used to describe beneficiaries were sex, age, institutional status, Medicaid eligibility, and beginning in 1995, working aged status.

- HCFA next reduced the AAPCCs by 5 percent, acknowledging that costs were expected to be lower due to managed care efficiencies.

- These final capitation rates were published annually in the county rate book, with separate rates for aged and disabled for both Part A (hospital) and Part B (physician and supplies) services. The county rate book also included separate estimates for beneficiaries with end-stage renal disease, which were based on Medicare's costs in paying claims on a statewide basis.

- To calculate the monthly payment amount to a managed care organization for each enrollee, the capitation rate for the county of residence was adjusted by the individual enrollee's demographic factor. Managed care organizations received prospective monthly payments that were the sum of these calculations for all their enrollees.

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 3 - Demographic Cost Factors for Aged, Disabled, and ESRD Beneficiaries

(Rev. 9, 04-01-02)

Demographic Factors for Aged Beneficiaries, CY2000

Part	Sex	Age	Institutionalized	Non-Institutionalized		
				Medicaid	Non-Medicaid	Working Aged
A	Male	65-69	1.75	1.15	0.65	0.4
		70-74	2.25	1.5	0.85	0.45
		75-79	2.25	1.95	1.05	0.7
		80-84	2.25	2.35	1.2	0.8
		85+	2.25	2.6	1.35	0.9
	Female	65-69	1.45	0.8	0.55	0.35
		70-74	1.8	1.05	0.7	0.45
		75-79	2.1	1.45	0.85	0.55
		80-84	2.1	1.7	1.05	0.7
		85+	2.1	2.1	1.2	0.8
B	Male	65-69	1.6	1.1	0.8	0.45
		70-74	1.8	1.35	0.95	0.65
		75-79	1.95	1.55	1.1	0.8
		80-84	1.95	1.7	1.15	0.9
		85+	1.95	1.7	1.15	1
	Female	65-69	1.5	1.05	0.7	0.4
		70-74	1.65	1.15	0.85	0.55
		75-79	1.65	1.25	0.95	0.7
		80-84	1.65	1.25	0.95	0.75
		85+	1.65	1.25	1	0.85

Demographic Factors for Disabled Beneficiaries

Part	Sex	Age	Institutionalized	Non-Institutionalized		
				Medicaid	Non-Medicaid	Working Aged
A	Male	< 35	1.8	1.1	0.6	N/A
		35-44	1.45	1.2	0.7	N/A
		45-54	1.1	1.3	0.65	N/A
		55-59	0.9	1.6	0.85	N/A
		60-64	0.6	1.85	1	N/A
	Female	< 35	1.8	1.2	0.55	N/A
		35-44	1.4	1.2	0.6	N/A
		45-54	1.15	1.2	0.75	N/A
		55-59	0.95	1.35	0.95	N/A
		60-64	0.7	1.35	1.3	N/A
B	Male	< 35	1.7	1.1	0.45	N/A
		35-44	1.5	1.15	0.55	N/A
		45-54	1.25	1.15	0.6	N/A
		55-59	1.1	1.3	0.75	N/A
		60-64	0.95	1.45	0.95	N/A
	Male	< 35	1.95	1.05	0.75	N/A
		35-44	1.85	1.15	0.85	N/A
		45-54	1.6	1.25	0.95	N/A
		55-59	1.35	1.35	2.05	N/A
		60-64	1.15	1.55	1.2	N/A

NOTE: Since the BBA stipulated that the base year for the new M+C payment method would be 1997 (the last year of the AAPCC method) and since the BBA did not stipulate any adjustments to these 1997 AAPCC standardized county rates (other than to "carve out" a specified portion of the rates representing medical education expenses), CMS cannot restandardize the 1997 ratebook with new demographic factors. Thus, the above national demographic factors have been used since 1997.

County average demographic factors (ADFs), however, are calculated every year, using updated information on the number of beneficiaries in each county and the average demographic factor for these beneficiaries. The county ADFs are used to calculate the national average input-price adjusted capitation rate, which is then used in combination with area-specific rates to calculate blended rates.

Age/Sex Factors for M+C ESRD Beneficiaries

Age	Part A		Part B	
	Male	Female	Male	Female
0-34	.55	.70	.70	.75
35-44	.65	.70	.80	.80
45-54	.70	.85	.85	.90
55-59	.80	.95	.90	1.00
60-64	.90	1.10	.90	1.10
65-69	1.15	1.35	1.10	1.20
70-74	1.25	1.45	1.15	1.25
75-79	1.30	1.55	1.20	1.25
80-84	1.40	1.60	1.20	1.25
85+	1.45	1.60	1.20	1.25

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.

<u>Denominator:</u> 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.

<u>Numerator:</u> 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