Part C IPM: Process & Results Cheat Sheet

A high-level overview of the Part C IPM team's processes, from sample design through reporting the error rate. For additional resources and materials, please visit the CMS MAO IPM Resources site. Any further questions can be directed to PartC_IPM@cms.hhs.gov

1. Sample Design Finalization
2. Sample Draw and Evaluation
3. MAO Notification and EDP
4. Sample Go-Live
5. Data Preparation
6. Payment Error Calculation
7. Reporting

Payment Error Reporting Benefits to the MAO

Understanding program-wide implications and benefits including insight into potential CMS policy changes and bottom-line impact for MAOs to improve their internal processes.

Tracking historical payments and payment errors as benchmarks for future risk adjustment and/or contract level sampling, and payment error.

Providing additional data for external reporting that MAOs regularly reference for risk adjustment (e.g., IFRs and FFRs) and that beneficiaries can use as resources (e.g., the yearly AFR).

Best practices and reminders for physicians and hospitals to submit accurate medical records with relevant diagnosis information, promote quality of care that matches patient needs.

1 Sample Design Finalization

CMS initiates the sampling process after confirming Sampling Frames, Stratification, Population, and Enrollee Eligibility Criteria. Stratification is based on enrollee risk scores (i.e., low, medium, and high), with a fourth ESRD stratum starting in CY22. Eligibility consists of continuously enrolled full-risk beneficiaries with risk eligible claims.

2 Sample Draw and Evaluation

The Part C IPM sample is drawn according to the sample design and population/enrollee selection specifications. After the sample has been confirmed to be representative, the sample is finalized. Since 2017, some statistics **per sample** are:

990
Sampled Enrollees (930 Prior to CY22)

200-250
Range of Contracts in the sample

0-20
CMS-HCCs per Enrollee (mean= 4.5)

3 MAO Notification and EDP

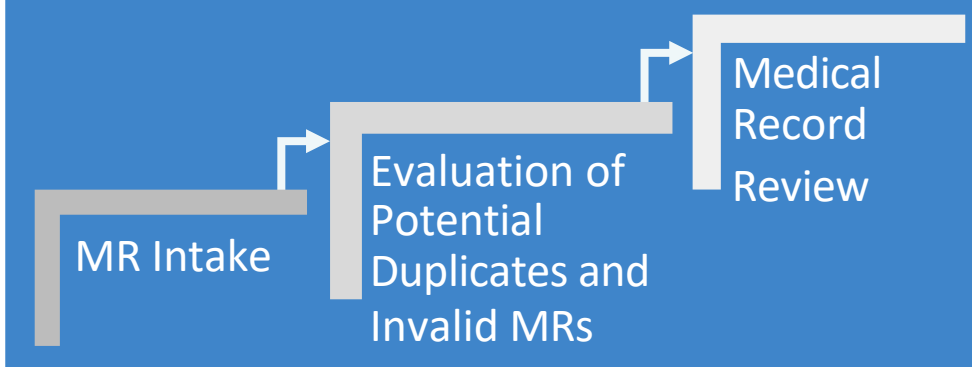
After finalizing the sample, MAO Medicare Compliance Officers and Chief Executive Officers from selected contracts receive email notifications with instructions for accessing HPMS. Once notified, Enrollee Data Packages are available and MAOs identify the medical records needed to validate sampled CMS-HCCs submitted during the data collection year. Each MAO receives an Enrollee Data Package containing the following files:

- Enrollee Data List: A report of enrollees sampled for whom MR substantiation must be submitted (includes a dictionary of report variables).
- MR Attestation: A form to verify provider credentials on MR submissions, if needed.
- Hospital & Physician Letters: Notifications to providers to comply with MR Request(s)

4 Sample Go-Live (Mid-January)

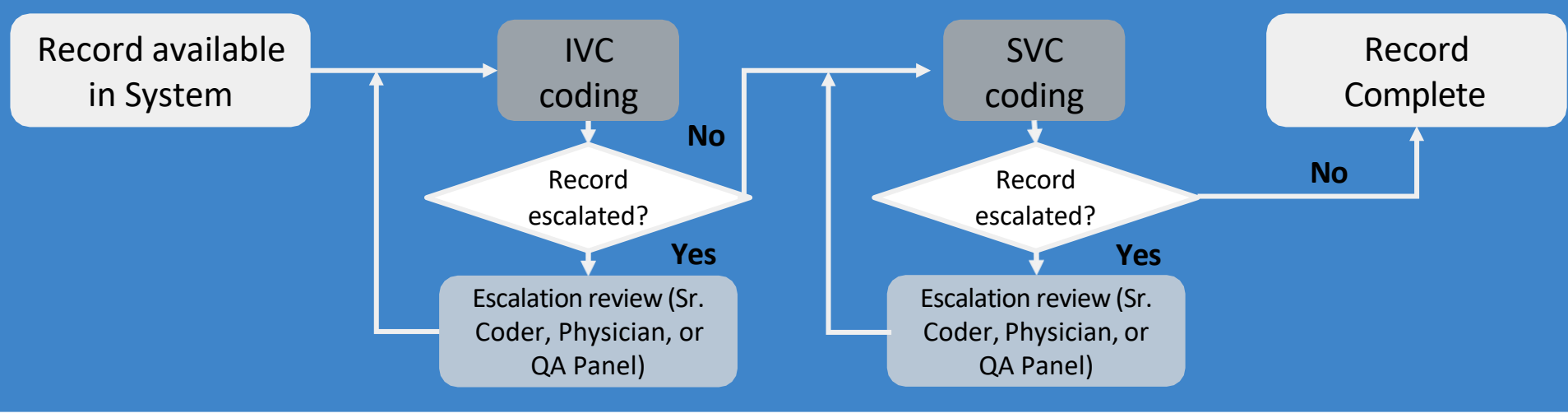
5 Data Preparation: Serves as inputs to Part C payment error analysis.

Part 1 – Medical Record Review Process



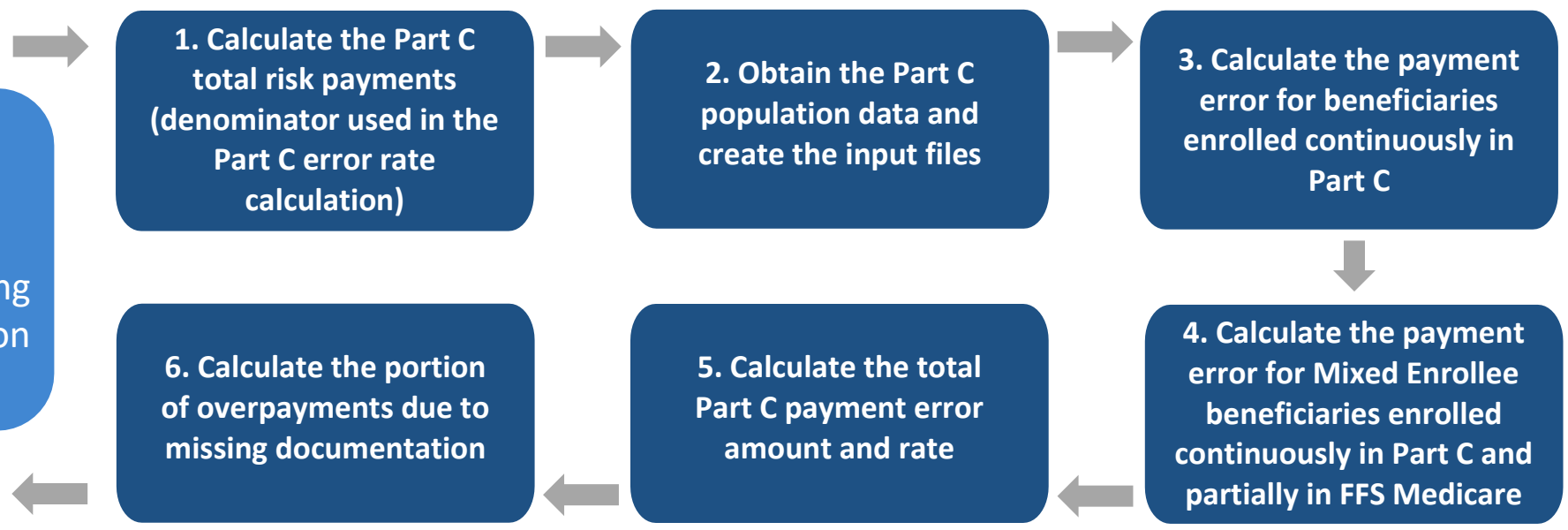
Part 2 - Analytical Data Preparation

- Submission, intake, and MR results data are extracted from HPMS
- Valid MRs are processed, and final CMS-HCC dispositions are determined by comparing pre- and post- MRR results
- Original and corrected risk scores are compared to determine a risk score error, which is translated into payment errors for the sample
- Analytical data sets for generating the PEC and various reports/analyses are created from the processed MR data



6 Payment Error Calculation (PEC)

The Payment Error Calculation process can be seen in the following graphic. Payment error information feeds into external reports.



7 Reporting

MAO specific reporting is included in the Part C IPM process; four reports go directly to the MAOs, and three are external for MAOs to reference.

External Reporting

HHS Agency Financial Report	OMB Payment Accuracy Reporting	Part C IPM Website Content

Reports to the MAOs

Interim Findings Report
Provides a snapshot of submitted MRs and interim results for proactive correction of discrepant CMS-HCCs and other issues.

HCC Outcomes Detail Report
Delivers daily updates to the plan user on sample submission progress, CMS-HCC level outcomes, and MA Contract Suggested Action.

Final Findings Report
Provides MAOs with final CMS-HCC dispositions and a summary of the contract's audit outcomes compared to the entire sample.

Concurrence/Non-Concurrence Report
New in CY23, provides MAOs an opportunity to indicate a disposition for each discrepant HCC decision.

Glossary

AFR: Agency Financial Report
CMS: Centers for Medicare & Medicaid Services
CMS-HCC: CMS Hierarchical Condition Category
CEO: Chief Executive Officer
ESRD: End Stage Renal Disease
EDP: Enrollee Data Package
FFR: Final Findings Report
FFS: Fee-for-Service
HPMS: Health Plan Management System
HHS: Department of Health and Human Services
HCC: Hierarchical Condition Category
IPM: Improper Payment Measure
IFR: Interim Findings Report
IVC: Initial Validation Contractor
MA: Medicare Advantage
MAO: Medicare Advantage Organization
MCO: Medicare Compliance Officer
MR: Medical Record
MRR: Medical Record Review
OMB: Office of Management and Budget
PEC: Payment Error Calculation
QA: Quality Assurance
SVC: Secondary Validation Contractor