130 - Glossary of Terms

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Beneficiary Demographic Input File - Contains beneficiary demographic data captured from Common Medicare Environment. The demographic data is used by the Risk Adjustment System (RAS) to calculate a beneficiary's risk score and to determine payment.

Beneficiary Diagnosis Input File - Contains beneficiary diagnosis data captured from Risk Adjustment Processing System (RAPS) and National Medicare Utilization Database (NMUD). The diagnosis data is used by the Risk Adjustment System to calculate a beneficiary's risk score and to determine payment.

Common Medicare Environment (CME) – Tables sourced from the Medicare Beneficiary Database (MBD) and the Enrollment Database (EDB) that provide beneficiary demographic and enrollment data.

Connect: Direct - A type of electronic connection between MA organizations and CMS used to submit risk adjustment data and receive information. This connection involves mainframe-to-mainframe connection with a submission response from FERAS.

Data Collection Period - The 12 month period from which CMS uses diagnoses submitted by MA organizations to calculate a beneficiary's risk score.

Data Submission - The process in which MA organizations submit required data elements to CMS for risk adjustment purposes.

Data Validation - The process of validating that enrollee diagnosis codes submitted for payment by MA organizations are supported by the medical record documentation.

Diagnosis Cluster - Core information submitted by MA organizations for each diagnoses submitted. The following are included: provider type, from date of service, through date of service, delete indicator, and diagnosis code.

Dialysis Status - CMS risk adjusts payments for a beneficiary using the CMS-HCC dialysis model when we are notified that the beneficiary is receiving dialysis.

Direct Data Entry (DDE) - An electronic data exchange between providers and health plans where health plans enter RAPS data directly into an online screen for processing.

Disabled Status - Demographic factor for beneficiaries who became eligible for Medicare based on a disability.

Disease Hierarchy - *International Classification of Diseases Clinical Modification (ICD-9-*CM *or ICD-10 CM as applicable)* diagnosis codes that address multiple levels of severity for a disease with varying levels of associated medical costs.

Dual Eligible - An MA eligible individual who is also entitled to Medical Assistance under a State Plan under Title XIX (Medicaid). A chart describing the various categories of individuals who are collectively known as dual-eligibles can be found at: https://www.cms.gov/MedicareEnRpts/Downloads/Buy-InDefinitions.pdf.

Electronic Data Interchange (EDI) Agreement - An agreement MA organizations have with CMS to follow provisions for submitting risk adjustment data through one of CMS' accepted types of electronic connections.

End Stage Renal Disease (ESRD) - Permanent kidney failure requiring dialysis or a kidney transplant.

Enrollment Database (EDB) – A data repository that contains Medicare entitlement information for beneficiaries entitled to Medicare.

File Transfer Protocol (FTP) - A type of electronic connection between MA organizations and CMS used to submit risk adjustment data and receive information. The connection uses modem-to-modem (i.e., dial up) or lease line connection with a submission response from FERAS.

Frailty Adjuster - Predicts Medicare expenditures of community populations with functional impairments that are unexplained by the risk adjustment methodology alone. The frailty adjuster is included as part of risk adjusted payments for PACE organizations and, through 2011, for certain demonstration organizations. Beginning in 2012, certain Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) are eligible to receive frailty adjustment.

Front End Risk Adjustment (FERAS) - Performs the initial file editing for risk adjustment data submitted by Medicare Advantage and Medicare Advantage-Prescription Drug plans and transmits files to the Risk Adjustment Processing System (RAPS).

Full Risk - Medicare beneficiaries that have 12 months of Part B coverage during the data collection period.

Gentran - A type of electronic connection between MA organizations and CMS used to submit risk adjustment data and receive information. Gentran users are issued a mailbox and it is used as a vehicle to transmit and receive reports on RAPS data sent to CMS.

Health Plan Management System (HPMS) - CMS information system used by Medicare Advantage and Prescription Drug plans to upload bid, Plan Benefit Package, and marketing information, and is used by CMS to send information to plans.

Hierarchical Condition Category (HCC) - Groupings of clinically similar diagnoses in each risk adjustment model. Conditions are categorized hierarchically and the highest severity takes precedence over other conditions in a hierarchy. Each HCC is assigned a relative factor which is used to produce risk scores for Medicare beneficiaries, based on the data submitted in the data collection period.

Health Insurance Portability and Accountability Act (HIPAA) - Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) required the Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addressed the security and privacy of health data and contained health insurance reforms intended to promote access and portability of insurance coverage. The implementation of HIPPA improved the use of electronic data exchange in the national health care system.

International Classification of Diseases-9th Edition-Clinical Modification (ICD-9-CM) Codes - 3 to 5-digit codes used to describe the clinical reason for a patient's treatment. The codes do not describe the service performed, just the patient's medical condition. Diagnosis codes drive the risk scores, which drive the risk adjusted reimbursement from CMS to MA organizations. *ICD-9-CM codes are used for inpatient discharges before the implementation date of ICD-10, and for outpatient and physician services before that date.*

***International Classification of Diseases-10th Edition-Clinical Modification (ICD-10-CM) Codes** - 3- to 7-digit codes used to describe the clinical reason for a patient's*

treatment. The codes do not describe the service performed, just the patient's medical condition. Diagnosis codes drive the risk scores, which drive the risk adjusted reimbursement from CMS to MA organizations. ICD-10-CM codes are used for inpatient discharges on and after the implementation date of ICD-10, and for outpatient and physician services on and after that date.

Long-term Institutionalized (LTI) Status - CMS identifies whether a Medicare beneficiary is in a long term institution for both model development and risk score calculation purposes. CMS considers a beneficiary as having long term institutional status if they have been in an institution for 90 days or more. CMS obtains this information from the Minimum Data Set (MDS), which stores dates of 90-day assessments reported by nursing homes.

Low-income Subsidy (LIS) - Provides financial assistance for beneficiaries who have limited income and resources; individuals eligible for this low-income subsidy will receive assistance with paying for their monthly premium, yearly deductible, prescription coinsurance and copayments and coverage in the gap.

Medicaid - Title XIX of the Social Security Act is a Federal/State entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources.

Medicare Advantage Prescription Drug (MARx) System - Receives beneficiary level risk adjustment factors from RAS for use in Part C and Part D payment calculations.

Medicare Beneficiary Database (MBD) – A data repository that contains eligibility and enrollment data for Medicare beneficiaries.

Minimum Data Set (MDS) - A part of the Resident Assessment Instrument (RAI) developed by CMS to assist Medicare/Medicaid certified nursing homes in developing a comprehensive care plan for each resident.

Minimum Data Set (MDS) Long Term Institutional File - Identifies beneficiaries that resided in a long term institution for 90 days or more, which classifies them as long term institutional (LTI) beneficiaries. The file is used to identify Medicare beneficiaries that reside in LTI for risk adjustment purposes.

National Medicare Utilization Database (NMUD) - Contains Medicare claims data, including diagnostic data submitted by fee-for-service providers for beneficiaries new to Medicare Advantage with less than 12 months of risk adjustment data. The diagnostic data stored in NMUD is translated to the risk adjustment format.

National Provider Identifier (NPI) - The NPI is a 10-digit, intelligence free numeric identifier (10 digit number). Intelligence free means that the numbers do not carry information about health care providers, such as the state in which they practice or their provider type or specialization.

New Enrollee - A Medicare beneficiary who has less than 12 months of Part B entitlement during the data collection period.

Normalization Factor - Factor used to correct population and coding changes between the data years used in model calibration and the payment year.

Original Reason for Entitlement Code (OREC) - A demographic factor added to the risk score for beneficiaries 65 years of age or older who were originally entitled to Medicare due to disability. The factor varies based on the age and sex of the beneficiary.

Post-Graft (Functioning Graft) - A beneficiary is in post-graft status when they have received a kidney transplant or kidney/pancreas transplant at least three months ago and did not return to dialysis status since the transplant. There is a separate segment of the CMS-HCC ESRD model for people who have functioning kidney grafts.

Principal Inpatient Diagnostic Cost Group (PIP-DCG) - The PIP-DCG model was a precursor to the CMS-HCC risk adjustment model CMS used the PIP-DCG model from 2000-2003. In this model, CMS used diagnoses from hospitalizations to identify a particularly ill and high cost subset of beneficiaries for whom CMS will make higher payments in the next year. The system recognized admissions for which inpatient care is most frequently appropriate and which are predictive of higher future costs.

Program of All-Inclusive Care for the Elderly (PACE) - A unique capitated managed care benefit for frail and elderly individuals provided by a public entity or private entity. PACE features a comprehensive medical and social service delivery system using an interdisciplinary team approach in an adult day health center that is supplemented by in-home and referral services in accordance with participants' needs.

Reconciliation - The CMS process of updating beneficiaries' statuses and processing the resulting payment adjustments.

Risk Adjustment Processing System (RAPS) – An application that stores diagnoses data submitted by MA Organizations. Upon completion of the initial file processing, FERAS sends the risk adjustment data to RAPS to perform low level edits to the file header and record.

Risk Adjustment System (RAS) – A system used to calculate a beneficiary's risk score from enrollment and diagnosis data received from Common Medicare Environment (CME), National Medicare Utilization Database (NMUD) system and Risk Adjustment Processing System (RAPS). After the risk scores are calculated in RAS, they are sent to MARx to use in calculating beneficiary level prospective payments.

Special Needs Plan (SNP) - An MA coordinated plan that limits enrollment to special needs individuals, i.e., those who are dual-eligible, institutionalized, or have one or more

severe or disabling chronic conditions, as set forth at 42 CFR 422.4(a)(1)(iv) of the MA regulation, and provides Part D benefits under 42 CFR Part 423.

Taxonomy Code - An external non-medical data code set designed for use in classifying health care providers according to provider type or practitioner specialty in an electronic environment, specifically within the American National Standards Institute, Accredited Standards Committee health care transaction.

Transplant Status - A Medicare beneficiary is in Transplant Status for the three months commencing with a kidney transplant.