March 27, 2023

VIA ECF

The Honorable Joseph C. Spero
Chief Magistrate Judge
United States District Court
Northern District of California
450 Golden Gate Avenue
San Francisco, California 94102

Re: ***United States ex rel. Osinek v. Kaiser Permanente, et al.,*** **No. 3:13-cv-03891-EMC**

Dear Judge Spero:

Defendants seek the Court's assistance to resolve a dispute with Plaintiff concerning Defendants' request to take more than one deposition of Plaintiff pursuant to Federal Rule of Civil Procedure 30(b)(6). The parties have met and conferred in good faith for five months, including over videoconference on October 27, 2022 and with lead trial counsel on March 20, 2023, consistent with the Court's Civil Standing Order Part E.9.

Defendants' Position. Defendants seek the Court's leave to take an *initial* Rule 30(b)(6) deposition of Plaintiff focused solely on basic, foundational topics—the organizational structure, responsibilities, reporting lines, relevant processes, and document retention policies of divisions within the U.S. Department of Health and Human Services ("HHS") related to guidance documents and contracts at issue in this case (together, "the Organizational Topics"). Defendants have shared with Plaintiff a draft Rule 30(b)(6) notice ("Notice") detailing the specific topics about which Defendants are seeking testimony from Plaintiff. *See* Ex. 1. The twin goals for this *initial* deposition are 1) to provide Defendants with the foundational information necessary to understand the documents that Plaintiff has only recently started to produce, and 2) to tailor future discovery requests in a more informed manner by, for example, targeting the divisions and personnel within HHS that are reasonably likely to have the evidence Defendants need to support their defenses. To be clear, this dispute is not about the relevance, scope, or interpretation of any specific Organizational Topics in the Notice. The dispute presented here is solely whether Defendants may take a Rule 30(b)(6) deposition on the Organizational Topics now, to guide future discovery, without prejudicing their right to take a separate substantive deposition, or instead must wait to obtain this foundational information when they serve a later Rule 30(b)(6) deposition notice seeking merits testimony after substantial completion of document discovery.[1] *See Heath v. Google LLC*, 2018 WL 4491368, at *2 (N.D. Cal. Sept. 19, 2018) (explaining that the "one-deposition provision could be an obstacle to sensible handling of Rule 30(b)(6) organizational depositions" where "there is a strong reason to take such depositions early in the case," such as to address foundational issues, and noting that it

[1] Plaintiff focuses on whether, procedurally, Defendants must serve an initial deposition notice and take that deposition, risking their ability to take a later deposition. In a case of this complexity, Defendants should not need to take that risk given that an initial deposition of the type proposed here will streamline discovery for both parties.

would be "counterproductive for" an "early and narrow deposition to foreclose" a later substantive one). During the parties' extensive meet and confer, Plaintiff did not contest that a litigant may question the opponent about its relevant organizational structure, reporting lines, and responsibilities. Defense counsel specifically offered to engage in further discussions with Plaintiff's counsel regarding any specific objections to the Notice but sought confirmation that Plaintiff would be willing to provide testimony *now* if the parties could resolve those concerns through further negotiations. In response, Plaintiff's counsel confirmed that Plaintiff objected to the concept of an initial Rule 30(b)(6) deposition on the Organizational Topics and, thus, reaffirmed that further negotiations about specific language in the Notice would not resolve the parties' threshold dispute about the *timing* of the requested testimony.

Background. On October 10, 2022, Defendants requested Plaintiff's consent to an initial Rule 30(b)(6) deposition on the Organizational Topics. *See* Ex. 2. Defendants enclosed the Notice, but did not serve it, as part of a good-faith effort to explain the utility of an initial Rule 30(b)(6) deposition and to facilitate Plaintiff's consideration of Defendants' request. *See* Ex. 1.[2] Plaintiff declined to consent and said that obtaining this information through written discovery requests would be "far more efficient." Ex. 3, at 3. Defendant Kaiser Foundation Health Plan ("KFHP") had already served its First Set of Requests for Production ("RFPs") ten months earlier in January 2022 and was skeptical that the documents alone would suffice but agreed in the interest of compromise to await a more complete document production to decide whether the documents would address its discovery needs. To ensure that it had all documents that might bear on the utility of an initial Rule 30(b)(6) deposition on the Organizational Topics, KFHP served a Second Set of RFPs in December 2022, asking Plaintiff to produce responsive documents within 30 days. *See generally* Ex. 4. More than one year since KFHP served its First Set of RFPs and over 90 days since KFHP served the Second Set of RFPs, Plaintiff's productions confirm that Defendants cannot obtain the needed foundational information sought in the Notice through the documents alone.

Plaintiff's Incomplete Productions Lack Key Information. While Plaintiff has produced directories and organizational charts that list roles and responsibilities for various HHS divisions and agencies, those documents alone fail to provide the information Defendants need to focus future discovery. For example: a 2018 document discussing "CMS's use of information gathered during Risk Adjustment Data Validation (RADV) audits" states that the Medicare Plan Payment Group ("MPPG") is the "owner" of data submitted in connection with RADV audits and that the Center for Program Integrity ("CPI") "performed reviews of RADV submissions." Ex. 5. This document suggests that *both* the MPPG and CPI have at least some involvement in RADV audits, but the produced documents do not clearly delineate or explain each group's specific role or responsibilities. This document is just one illustration among a larger pattern where produced documents provide some information about the roles, responsibilities, and reporting lines of relevant HHS divisions and personnel but not enough to fully understand their historical

[2] During its eight-year investigation of Defendants prior to filing suit, Plaintiff conducted multiple examinations of Defendants' personnel and asked the same types of foundational and organizational questions in Defendants' Notice. Thus, Plaintiff already has a foundational understanding of the organizational structure and reporting lines among the Defendant entities. Nonetheless, to facilitate a negotiated resolution, Defendants offered to consent to a reciprocal initial Rule 30(b)(6) deposition on the same types of Organizational Topics. *See* Ex. 2, at 5.

operations and communications during the period in dispute. Additionally, the produced documents do not fully cover the time period in dispute. *See, e.g.*, Ex. 6. Some documents show that substantive changes were made to the roles and responsibilities of certain HHS divisions over time but do not explain the practical effect of these changes and raise additional questions about how the roles and responsibilities of the relevant HHS divisions and personnel evolved during those key years. *See, e.g.*, Ex. 7. Furthermore, the Notice is intended to elicit testimony concerning which HHS divisions are responsible for particular processes related to the issues in this case, including document retention and developing and disseminating key guidance to participants in the Medicare Advantage program. Yet the documents received to date do not provide this information, in part because Plaintiff's productions are limited to documents concerning the Centers for Medicare and Medicaid Services as opposed to *all* relevant HHS divisions. *See, e.g.*, Ex. 8. Through an initial Rule 30(b)(6) deposition, Defendants intend to fill these important gaps and seek basic information about the Organizational Topics.[3]

An Initial Rule 30(b)(6) Deposition Would Be Far Less Burdensome Than Proceeding with Only Written Discovery on the Organizational Topics. Contrary to Plaintiff's contention that written discovery would be "far more efficient," the documents received thus far raise more questions than they answer. Moreover, forcing Defendants to build a jigsaw puzzle out of disparate productions will take many months, even if Plaintiff produced all responsive documents in its possession immediately. Further delay is highly prejudicial to Defendants' persistent efforts to gather the basic information needed to build their defenses. After more than a full year of fact discovery, Defendants are no closer to gaining a complete and thorough understanding of the organizational structure and responsibilities of relevant HHS divisions, necessitating the proposed Notice shared with Plaintiff over five months ago. Plaintiff's objections and incomplete document productions have hamstrung Defendants from obtaining the information necessary to move the case forward promptly. There is now less than one year left in fact discovery. It is unfairly prejudicial to require Defendants to wait many more months to learn this foundational information, or hope that Plaintiff will produce it in the future—at which point, critical months of fact discovery will have been lost. Defendants thus respectfully request that the Court grant them leave to take an initial Rule 30(b)(6) deposition on the Organizational Topics without prejudicing their right to take a later Rule 30(b)(6) deposition on the merits.

The United States' Position. Through this letter, Defendants seek leave to take two Rule 30(b)(6) depositions before they have served notice of, let alone taken, the first. Defendants' request is unsupported, procedurally improper, and should be rejected as merely another attempt to bog down this case with unnecessary discovery.

Defendants provided the proposed first Notice on October 10, 2022, as an attachment to a letter requesting that the United States consent to a second Rule 30(b)(6) deposition—on future unknown topics—before they noticed the first. Ex. 2. The United States declined to consent to Defendants' proposal. Ex. 9. If Defendants serve a Rule 30(b)(6) notice in the future, the United

[3] Defendants sent the draft Notice to Plaintiff in October 2022 prior to the parties' negotiating a resolution to their dispute about the standards for which Plaintiff agreed to search for non-public documents; thus, Defendants are willing to amend Exhibit A to the Notice so that it is consistent with the parties' subsequent agreement. *See* Joint Suppl. Report Pursuant to Nov. 4, 2022 Order Concerning Discovery Dispute, Nov. 18 (Dkt. 234).

States will have the opportunity to respond with any objections and the parties can confer about the matters proposed for examination.[4]

There is no support for Defendants' request for preemptive leave to take two Rule 30(b)(6) depositions. Numerous courts, including Judge Chen, have found that only one Rule 30(b)(6) deposition is permitted absent leave of court and that serial depositions are disfavored. *See Blackwell v. City & Cty. of S.F.*, 2010 WL 2608330, at *1-2 (N.D. Cal. June 25, 2010) (declining to grant leave for second Rule 30(b)(6) deposition); *see also Updike v. Clackamas Cty.*, 2016 WL 11782507, at *10 (D. Or. June 21, 2016) ("[T]he the majority of courts have held that the policy disfavoring multiple depositions of the same deponent applies to depositions of organizations"); *State Farm Mut. Auto. Ins. Co. v. New Horizont, Inc.*, 254 F.R.D. 227, 235 (E.D. Pa. 2008) ("Taking serial depositions of a single corporation may be as costly and burdensome, if not more so, as serial depositions of an individual."). Defendants have not cited a single case in which a party was granted leave to take a second Rule 30(b)(6) deposition before taking the first.

The lone case cited by Defendants as authority—*Heath*, 2018 WL 4491368—did not involve an early Rule 30(b)(6) deposition and provides no support for one. In *Heath*, the plaintiff moved to take a second Rule 30(b)(6) deposition after having already taken a first; the court rejected most of plaintiff's proposed second deposition, only granting leave to take a second 3.5-hour deposition on a single topic that the defendant had objected to at the first. *Id.* at *3-4. There is nothing in *Heath* to support what Defendants are proposing. The quote cited by Defendants from *Heath* is from a treatise, and Defendants have identified no support for it in the case law.

In October, we explained to Defendants that the "organizational" information sought by Defendants could be more easily obtained via written discovery, as is routinely done in cases of all types and sizes. Ex. 9. We noted that "it would be far more efficient to issue interrogatories and/or document requests targeting the requested organizational information than force the United States to expend resources preparing for multiple Rule 30(b)(6) depositions." *Id.* Defendants waited nearly two months before serving 19 far-reaching RFPs. Ex. 4. These 19 RFPs (Nos. 131-149) were not targeted to the Notice or this case. For example, RFP No. 133 sought documents sufficient to identify anyone at HHS from 2009 to the present who "Develop, Review, Promulgate, or Interpret" over 60 different "Standards," many of which relate to the Affordable Care Act, which is not at issue in this case.[5] Likewise, RFP No. 135 sought documents sufficient to identify anyone at HHS during the same time period who "Develop, Review, Promulgate, or Interpret" Medicare Advantage Contracts, of which there are hundreds, when this case concerns only particular provisions in two of Defendants' contracts.[6] Finally, Defendants have not served any additional interrogatories focused on the topics in the Notice.

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[4] The actual scope of the Notice is a moving target. Defendants stated for the first time in this letter that they are willing to amend the Notice so that it is consistent with the parties' prior agreement reached after the November 4, 2022 hearing before this Court.

[5] These RFPs were served after the parties resolved their earlier Standards dispute, Dkt. 234, but nonetheless included RFPs related to dozens of Standards on irrelevant topics that were not part of the parties' prior agreement. *See* Ex. A to KFHP's Second Set of RFPs.

[6] We provided timely R&Os to these RFPs and offered a number of compromises. Defendants have not responded and our productions are ongoing. This case concerns Medicare Advantage, a

Despite Defendants' scattershot and overbroad approach to discovery, the United States has already produced numerous documents that answer many of the organizational questions posed by the Notice. For example, Defendants' RFP No. 126 asked for documents sufficient to identify employees within each of the following groups since 2010: CPI; MPPG; Medicare Parts C and D Oversight and Enforcement Group; and the Offices of the Administrator, Acting Administrator, Director, Acting Director, and Deputy Directors of Medicare. We provided organizational information for each of these groups, for each year, from 2010-2021, including CMS' organizational charts for each year and (because these charts do not show all lower-level employees) many additional group-specific directories. Because we were unable to find CPI directories for two particular years (2010 and 2011), we also produced spreadsheets listing the name and title of *everyone employed at CMS* for the missing years, as well as several other years.

We have also produced documents that explain the roles and responsibilities of relevant groups and people, including training presentations, as well as functional statements and other non-public documents. *See., e.g.,* Exs. 10-14. Defendants claim confusion, *supra*, about the specific roles and responsibilities of MPPG and CPI with respect to RADV audits. Our production, however, includes an internal memorandum that explains how responsibility for RADV shifted from MPPG to CPI in 2016, Ex. 15, and RADV presentations describing the roles of relevant CMS personnel. *See, e.g.*, Exs. 16-19. Defendants' claim of prejudice and that they are "no closer" to gaining an understanding of the structure of relevant HHS divisions is not true. We have provided the "basic," and "foundational" information that Defendants insist justifies the initial Rule 30(b)(6) deposition, before Defendants have even answered the complaint.

To the extent Defendants seek additional "organizational" information, they have "ample opportunity to obtain the information" by less burdensome means. Fed. R. Civ. P. 26(b)(2)(C). As Defendants note, the United States took non-30(b)(6) testimony of (six) fact witnesses during its investigation. Each side in this case is allowed to take 75 depositions, and there is nothing preventing Defendants from deposing agency personnel about their roles and responsibilities.

Moreover, it is a misnomer to characterize Defendants' proposed Rule 30(b)(6) topics as merely "organizational." For example, Topic No. 4 seeks information about the "processes" used by various HHS Divisions for a long list of items. This request is by no means limited to "organizational" information and would open up the "foundational" deposition to a wide range of substantive issues. Defendants underscore this point, stating that the deposition is required to "fully understand the *operations and communications*" of relevant HHS divisions and personnel.

Finally, the proposed "organizational" topics are particularly ill-suited for a Rule 30(b)(6) deposition, for which a representative from HHS would need to be educated about the roles and responsibilities of potentially hundreds of employees covering a more than 10-year period. There are other tools available to Defendants for obtaining this information, and Defendants should not be able to invent a new process—preemptive leave to take two Rule 30(b)(6) depositions—that would impose undue burden on the agency without justification.

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program administered exclusively by CMS. In an attempt to compromise, we have agreed to collect information from two agencies with tangential information. Our future productions will include information from those agencies, some of which Defendants already have. Ex. 20 at 2.

Sincerely,

UNITED STATES OF AMERICA

/s/ Laurie A. Oberembt

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CERTIFICATION

Pursuant to Civil L.R. 5-1(h)(3), the undersigned hereby attests that Laurie A. Oberembt has concurred in the filing of this document.

DATED: March 27, 2023

O'MELVENY & MYERS LLP

By: */s/ Stephen M. Sullivan*

Stephen M. Sullivan, Esq.
Attorney for Defendants

EXHIBIT 1

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA ex rel. RONDA OSINEK,

Plaintiffs,

v.

KAISER PERMANENTE, et al.,

Defendants.

Case No. 3:13-cv-03891-EMC

DEFENDANTS' NOTICE OF DEPOSITION OF PLAINTIFF UNITED STATES OF AMERICA PURSUANT TO FED. R. CIV. P. 30(b)(6)

(CAPTION CONTINUED)

UNITED STATES OF AMERICA ex rel. NASER AREFI, AJITH KUMAR and PRIME HEALTHCARE SERVICES, INC., Plaintiff, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	Case No. 3:16-cv-01558-EMC **DEFENDANTS' NOTICE OF DEPOSITION OF PLAINTIFF UNITED STATES OF AMERICA PURSUANT TO FED. R. CIV. P. 30(b)(6)**

UNITED STATES OF AMERICA ex rel. MARCIA STEIN and RODOLFO BONE, Plaintiff, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	Case No. 3:16-cv-05337-EMC **DEFENDANTS' NOTICE OF DEPOSITION OF PLAINTIFF UNITED STATES OF AMERICA PURSUANT TO FED. R. CIV. P. 30(b)(6)**

UNITED STATES OF AMERICA ex rel. GLORY ANNE BRYANT and VICTORIA HERNANDEZ, Plaintiff, v. KAISER PERMANENTE, et al., Defendants.	Case No. 3:18-cv-01347-EMC **DEFENDANTS' NOTICE OF DEPOSITION OF PLAINTIFF UNITED STATES OF AMERICA PURSUANT TO FED. R. CIV. P. 30(b)(6)**

(CAPTION CONTINUED)

UNITED STATES OF AMERICA and STATE OF CALIFORNIA ex rel. MICHAEL BICOCCA, Plaintiffs, v. PERMANENTE MEDICAL GROUP, INC., et al., Defendants.	Case No. 3:21-cv-03124-EMC **DEFENDANTS' NOTICE OF DEPOSITION OF PLAINTIFF UNITED STATES OF AMERICA PURSUANT TO FED. R. CIV. P. 30(b)(6)**

UNITED STATES OF AMERICA ex rel. JAMES M. TAYLOR, Plaintiff, v. KAISER PERMANENTE, et al., Defendants.	Case No. 3:21-cv-03894-EMC **DEFENDANTS' NOTICE OF DEPOSITION OF PLAINTIFF UNITED STATES OF AMERICA PURSUANT TO FED. R. CIV. P. 30(b)(6)**

PLEASE TAKE NOTICE that, pursuant to Rules 30(b)(6) and 32 of the Federal Rules of Civil Procedure, Defendants Kaiser Foundation Health Plan, Inc. ("KFHP"), Kaiser Foundation Health Plan of Colorado ("KFHP-CO"), The Permanente Medical Group, Inc., Southern California Permanente Medical Group, and Colorado Permanente Medical Group, P.C. (together, "Defendants"), by and through their undersigned attorneys, will take the deposition of Plaintiff, the United States of America ("Plaintiff" or "the United States"). Pursuant to Federal Rule of Civil Procedure 30(b)(6), the United States is requested to designate one or more officers, directors, managing agents, or other person(s) to testify on its behalf as to the topics identified on the attached Schedule A. The designated representative(s) must testify about information known or reasonably available to the Plaintiff.

The deposition described herein shall take place on November 14, 2022 beginning at 9:00 a.m., in person at O'Melveny & Myers, LLP, 1625 Eye Street, NW, Washington, D.C. 2006. The deposition will be conducted under oral examination, under oath, before such officer authorized to administer oaths by the laws of the United States and/or the District of Columbia, who may be present at the time and place set forth herein, and shall be recorded by both videotape and stenographic method with the capacity to provide instant visual display of the testimony. If said deposition is not completed on the date set forth herein, the taking thereof shall continue day to day thereafter, at the same place, Sundays and holidays excluded, until completed.

As permitted under Federal Rule of Civil Procedure 32, Defendants reserve the right to use either the stenographic or videotaped version of the deposition of the deponent, or portions thereof, at trial and/or for any other purpose permitted by law.

Dated: October 10, 2022

Respectfully submitted,

By: /s/ *K. Lee Blalack, II*
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SCHEDULE A

DEFINITIONS

The following terms and phrases shall have the meanings set forth below whenever used in any Topic stated in this Schedule A. Any term or phrase not defined in the Definitions below shall have the same meaning that is included in KFHP's January 26, 2022 First Sets of Requests for Production and Interrogatories. Consistent with the Definitions set forth in KFHP's January 26, 2022 First Sets of Requests for Production and Interrogatories, each word, term, or phrase defined below and used in the following Topics is intended to have the broadest meaning permitted under the Federal Rules of Civil Procedure and the Local Rules.

1. "2018 Proposed Risk Adjustment Data Validation Audit Rule" means the rule proposed in Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program for All-Inclusive Care for the Elderly (PACE), Medicaid Fee-for-Service, and Medicaid Managed Care Programs for Years 2020 and 2021, 83 Fed. Reg. 54982 (proposed Nov. 1, 2018) (to be codified at 42 C.F.R. §§ 422, 423, 438, 498).

2. "Addenda" means "addendum" as used in Paragraph 124 of the Complaint.

3. "CDC" means the U.S. Centers for Disease Control and Prevention, a Division of HHS. *See* https://www.hhs.gov/about/agencies/hhs-agencies-and-offices/index.html and https://www.hhs.gov/about/agencies/orgchart/index.html.

4. "CMS" means the U.S. Centers for Medicare and Medicaid Services, its agencies, departments, agents, representatives, contractors, consultants, and all other Persons acting on its behalf.

5. "Coding Clinic" means the "official publication for ICD-9-CM coding guidelines and advice as designated by the American Hospital Association, AHIMA, CMS, and the NCHS" that is "published quarterly by the American Hospital Association," as defined in the CMS Risk Adjustment Data Technical Assistance for Medicare Advantage Organizations Participant Guide, at 6-13 (2008).

6. "Communicate" or "Communication" means the transmittal of information (in the

form of facts, ideas, inquiries or otherwise) and refers to every manner or means of disclosure, transfer, or exchange of information orally or in writing, and to both actual and attempted communications of any kind.

7. "Complaint" means the complaint-in-intervention that Plaintiff filed in the above-captioned case (Dkt. 110) on October 25, 2021, and any forthcoming amended complaint(s) filed by Plaintiff.

8. "Defendants" means, collectively, Defendant Kaiser Foundation Health Plan, Inc.; Defendant Kaiser Foundation Health Plan of Colorado; Defendant The Permanente Medical Group, Inc.; Defendant Southern California Permanente Medical Group; and Defendant Colorado Permanente Medical Group, P.C.

9. "Develop" means to create or produce.

10. "Diagnosis Codes" means ICD-9-CM or ICD-10-CM diagnosis codes as used in Paragraph 62 of the Complaint.

11. "Diagnosis Coding" means "Diagnosis Coding" as defined in the United States' February 25, 2022 First Set of Requests for Production to Defendants.

12. "Division" or "Divisions" means any department, unit, component, arm, section, subdivision, branch, section, sector, or office, as that term is used on the HHS.gov website (https://www.hhs.gov/about/agencies/hhs-agencies-and-offices/index.html and https://www.hhs.gov/about/agencies/orgchart/index.html), and Includes any contractors, vendors, volunteers, agents, affiliates, or anyone acting at HHS's direction.

13. "Document" or "Documents" means all electronically stored information ("ESI") and written matter of every type, including Communications, as the term is broadly defined under Rule 34 of the Federal Rules of Civil Procedure.

14. "Exhibit A" means Exhibit A to KFHP's September 12, 2022 Letter to the United States and reproduced in full with this Notice.

15. "HHS" means the U.S. Department of Health and Human Services, as used in Paragraph 12 of the Complaint, and all of the Divisions within HHS.

16. "HHS-OIG" means the Office of the Inspector General of HHS.

17. "ICD-9-CM" means the *International Classification of Disease, Ninth Revision, Clinical Modification, Volumes 1 and 2*, Including the index and tabular list of Diagnosis Codes, for the period from October 16, 2002 through September 30, 2015, as referenced in 45 C.F.R. § 162.1002.

18. "ICD-10-CM" means the *International Classification of Diseases, Tenth Revision, Clinical Modification*, which contains an index and tabular list of Diagnosis Codes, for the period on and after October 1, 2015, as referenced in 45 C.F.R. § 162.1002.

19. "Include" or "Including" means "without limitation" and shall be construed as broadly as possible.

20. "Interpret" or "Interpreting" means to understand or explain the meaning of information, words, or actions.

21. "KFHP" means Kaiser Foundation Health Plan, Inc.

22. "KFHP-CO" means Kaiser Foundation Health Plan of Colorado.

23. "Medicare Advantage Contract" means any contract between an MA Plan or MAO and CMS, Including any contract alleged in Paragraph 74 of the Complaint.

24. "MAO" means "MA Organizations" as used in Paragraph 55 of the Complaint.

25. "MA Plan" means "MA plans" as used in Paragraph 55 of the Complaint.

26. "Overview" means a general explanation or summary.

27. "Participation" means the action of taking part in or being involved in something.

28. "Person" or "Persons" means any natural person or entity, firm, association, organization, partnership, business, trust, corporation, electronic mailbox, or public entity and their officers, directors, members, principals, employees, agents, contractors, representatives, parents, acquisitions, successors or predecessors, all persons acting on their behalf, and any and all persons associated with, affiliated with, or controlled by them.

29. "Process," "Processes," and "Processing" means the series of actions or steps to achieve a particular end or carry out a particular task.

30. "Promulgate" means "promulgated" as used in Paragraph 73 of the Complaint.

31. "Received" means to have been given or to have taken delivery of something.

32. "Review" or "Reviewing" means assessments, analyses, evaluations, or examinations of various types, Including as exemplified in the multiple uses of the term within 42 C.F.R. § 422.311.

33. "Risk Adjustment Attestation" means "Risk Adjustment Attestation" as used in Paragraph 79 of the Complaint.

34. "Risk Adjustment Data" means "'risk adjustment' data" as used in Paragraph 2 of the Complaint.

35. "Risk Adjustment Data Validation Audits" means audits conducted by or on behalf of CMS pursuant to 42 C.F.R. §§ 422.2 and 422.311(a).

36. "Risk Adjustment Payments" means "risk-adjustment payments" as used in Paragraph 12 of the Complaint.

37. "Standard" or "Standards" means statutes, rules, regulations, guidance documents, or contracts related to the parties' claims and defenses in this action, Including the meaning of the term "standard" or "standards" as used in the headings to Sections V.B and VI and in Paragraphs 5-8, 61, 81, 90, 130, 148, 160, 190, 191, 193, 200 of the Complaint.

INSTRUCTIONS

1. Unless stated otherwise in a Topic or in Exhibit A, these Topics cover the time period from January 1, 2009 to the present.

2. Each individual Topic should be construed independently, and no Topic shall be viewed as limiting the scope of any other Topic.

3. If Plaintiff believes the meaning of any term in any Topic is unclear, then Plaintiff must assume a reasonable meaning, state what that assumed meaning is, and respond to the Topic according to that assumed meaning.

4. Any noun used in the singular form shall be construed and applied so as to Include the plural form also, and vice versa.

5. The words "and" and "or" shall be construed either conjunctively or disjunctively, as required by the context to bring all information within the scope of the Topic.

6. The terms "all," "any," and "each" shall each be construed as encompassing any

and all.

7. "Between" and "among" shall be construed as "between or among" as the context so requires, so that each Topic shall be construed broadly, rather than narrowly, to bring within the scope of each Topic all testimony that might otherwise be construed to be outside its scope.

8. Whenever necessary to bring within the scope of any Topic that which might otherwise be construed to be outside the scope: (a) the use of any verb in any tense shall be construed as the use of that verb in all other tenses; and (b) the use of a word in its singular form shall be deemed to Include within its use the plural form and vice versa.

TOPICS FOR DEPOSITION

1. The organizational structure and responsibilities of the HHS Divisions, Including but not limited to CMS, CDC, and HHS-OIG, and Persons within each HHS Division that Develop, Review, Promulgate, and Interpret Diagnosis Coding Standards, Including but not limited to the following:

A. ICD-10-CM § IV.H; ICD-9-CM § IV.I;

B. ICD-10-CM § IV.I; ICD-9-CM § IV.J;

C. ICD-10-CM § IV.J; ICD-9-CM § IV.K; and

D. ICD-10-CM § I.A.19.

2. The organizational structure and responsibilities of the HHS Divisions, Including but not limited to CMS, CDC, and HHS-OIG, and Persons within each HHS Division that Develop, Review, Promulgate, and Interpret the Standards in Exhibit A and the following Standards:

A. Medicare Advantage Contracts, Including between KFHP and CMS and KFHP-CO and CMS, and

B. CMS HHS Center for Consumer Information and Insurance Oversight, Benefit Year Protocols, PPACA HHS – Operated Risk Adjustment Data Validation, (2016 Benefit Year Protocols, Version 14, Oct. 20, 2017), (2017 Benefit Year Protocols, Version 1, May 21, 2018; Version 2, Aug. 10, 2018), (2018 Benefit Year Protocols, Version 6, May 24, 2019; Version 7, June 24, 2019), (2019 Benefit Year Protocols, Version 8, Nov. 12, 2020), (2020 Benefit Year Protocols, Version 10, May 26, 2020), (2022 Benefit Year Protocols, Version 1, May 20, 2022).

3. The location of Documents stored and retained by HHS, Including but not limited to CMS, CDC, and HHS-OIG, and the Persons responsible for storing and retaining such Documents, related to Diagnosis Coding Standards, the Standards in Exhibit A, and the following Standards:

A. ICD-10-CM § IV.H; ICD-9-CM § IV.I;

B. ICD-10-CM § IV.I; ICD-9-CM § IV.J;

C. ICD-10-CM § IV.J; ICD-9-CM § IV.K;

D. ICD-10-CM § I.A.19;

E. Medicare Advantage Contracts, Including between KFHP and CMS and KFHP-CO and CMS; and

F. CMS HHS Center for Consumer Information and Insurance Oversight, Benefit Year Protocols, PPACA HHS – Operated Risk Adjustment Data Validation, (2016 Benefit Year Protocols, Version 14, Oct. 20, 2017), (2017 Benefit Year Protocols, Version 1, May 21, 2018; Version 2, Aug. 10, 2018), (2018 Benefit Year Protocols, Version 6, May 24, 2019; Version 7, June 24, 2019), (2019 Benefit Year Protocols, Version 8, Nov. 12, 2020), (2020 Benefit Year Protocols, Version 10, May 26, 2020), (2022 Benefit Year Protocols, Version 1, May 20, 2022).

4. An Overview of the Process or Processes used by HHS Divisions, Including but not limited to CMS, CDC, and HHS-OIG related to the following:

A. Addenda;

B. Diagnosis Codes;

C. Diagnosis Coding Standards;

D. Medicare Advantage Contracts;

E. Risk Adjustment Data Validation Audits;

F. 2018 Proposed Risk Adjustment Data Validation Audit Rule;

G. Risk Adjustment Attestations;

H. Risk Adjustment Data, Including Processing Risk Adjustment Data Received from MAOs or other entities;

I. Risk Adjustment Payments disbursed by CMS to MAOs; and

J. Participation in Coding Clinic.

5. The Persons responsible for Reviewing or Interpreting Defendants' Diagnosis Codes, Diagnosis Coding, Addenda, Risk Adjustment Data, Risk Adjustment Data Validation

Audits, and Risk Adjustment Attestations.

Dated: October 10, 2022

Respectfully submitted,

By: /s/ *K. Lee Blalack, II*
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Exhibit A to KFHP's September 12, 2022 Letter to the United States – Passages from Standards for Which KFHP Seeks Non-Public Documents

Standard	Relevant Provision or Passage
ICD Guidelines, Preamble.	These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses that are to be reported.
ICD Guidelines, Preamble.	These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD-10-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS.
ICD Guidelines, Preamble.	These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-10-CM itself.
ICD Guidelines, Preamble.	Adherence to these guidelines when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA). The diagnosis codes (Tabular List and Alphabetic Index) have been adopted under HIPAA for all healthcare settings. A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures.
ICD Guidelines, Preamble.	The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved.
ICD Guidelines, Preamble.	The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.
CMS 2003 Regional Risk Adjustment Training For Medicare+Choice Organizations Participant Guide ("2003 Participant Guide") § 3.1.2, at 3-5.	Qualified physician data for risk adjustment requires a face-to-face visit with the exception of pathology and radiology services (professional component only).
2003 Participant Guide § 6.3, at 6-2 B.	M+C organizations must submit each relevant diagnosis at least once during a report period (currently July 1 – June 30 of each year) for each enrolled beneficiary. A relevant diagnosis must meet the following criteria: • The diagnosis is included in the CMS+HCC risk adjustment model. • The diagnosis must be received from one of the three provider types (hospital inpatient, hospital outpatient, and physician) covered by the risk adjustment requirements. • The diagnosis must be collected according to the risk adjustment data collection instructions. 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 face-to-face visit with one of the three provider types covered under risk adjustment. M+C organizations may submit any diagnoses received from the three covered 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 shall not be submitted as risk adjustment data.
2003 Participant Guide § 12.3, at 12-5 A.	Acceptable Types of Documentation by Source. . . Diagnoses documented by the physician in the medical record as part of the treatment and evaluation of the enrollee with the date of the encounter. Note - it may be documented in different components of the medical record, e.g. progress notes or the history and physical, as long as that diagnosis is dated within the correct data collection period.

Standard	Relevant Provision or Passage
2003 Participant Guide § 12.3, at 12-6.	**Example 1:** The patient has a broken leg and Congestive Heart Failure (CHF). The physician documents a diagnosis for the broken leg in the medical record, but does not reference the CHF in the medical record documentation on the date of service when he attended to the broken leg. In this case, the M+C organization cannot submit the code for CHF because the physician did not document the diagnosis of CHF on that date.
2003 Participant Guide § 12.3, at 12-6.	**Example 2: The patient has a broken leg, CHF and Chronic Obstructive Pulmonary Disease (COPD).** The physician documents a diagnosis for the broken leg for the patient, and also notes that the patient has CHF and COPD in the medical record documentation on the date of service when he is attending to the broken leg. The physician, however, fails to communicate the CHF or the COPD diagnoses to the plan for the submission of this data to CMS. The plan learns that that patient did have diagnoses of CHF and COPD assigned by the physician during the visit for the broken leg visit. In this case, because the physician has noted the diagnoses in the documentation, the plan may submit the CHF and COPD diagnoses as risk adjustment data, assuming the dates of service fall within the correct data collection period.
2003 Participant Guide § 12.3, at 12-6.	**Example 3: The patient has diabetes with complications – ophthalmic manifestations.** In this case, the physician submitted to the plan a diagnosis code of diabetes without mention of complications (code 250.0). However, in the medical record documentation the physician has noted on the date of the face-to-face encounter with the patient that the patient has a diagnosis of diabetes with ophthalmic complications (250.5). The plan is made aware of the diabetes diagnosis with the higher level of specificity in the medical record documentation. In this case, the plan may correct the risk adjustment data and change the diagnosis from 250.0 to 250.5.
2003 Participant Guide § 12.6, at 12-10.	Data discrepancies include the following: Coding Discrepancies, which occur when: • The diagnosis code recorded in the risk adjustment record is not supported by the medical record documentation according to the ICD-9 Guidelines for Coding and Reporting. Missing or Incomplete medical record discrepancies, which occur when: • There is a no documentation • There is insufficient documentation to support a diagnosis • The dates of service are not within the correct data collection period Invalid risk adjustment record discrepancies, which occur when: • The medical record documentation is not provided by an appropriate provider type (hospital inpatient, hospital outpatient, physician) as defined in the CMS instructions for risk adjustment implementation, for example, a skilled nursing facility.
2003 Participant Guide, *QUICK FACTS ICD-9-CM*.	**RELATE DIAGNOSIS TO SERVICE PERFORMED & DOCUMENT** • The medical record must justify the diagnosis. • The diagnosis reported must match the coding submitted by the hospital/physician as documented in the medical record. • Report all secondary diagnoses that impact clinical evaluation, management and/or treatment. • Report all relevant V-codes and E-codes pertinent to the care provided.
CMS 2004 Regional Risk Adjustment Training For	Qualified physician data for risk adjustment requires a face-to-face visit with the exception of pathology and radiology services (professional component only).

Standard	Relevant Provision or Passage
Medicare+Choice Organizations Participant Guide ("2004 Participant Guide") § 3.2.3, at 3-9.	
2004 Participant Guide § 5.4, at 5-5.	Upcoding or changing diagnoses to obtain higher reimbursement without supporting source documents is fraudulent. However, thoroughly reviewing documentation and coding practices through internal auditing procedures to ensure that data has been reported correctly and that appropriate reimbursement is received benefits both the M+C organization and physician/provider.
2004 Participant Guide § 5.4.1, at 5-6.	Co-existing conditions include chronic, ongoing conditions such as diabetes (250.XX, HCCs 15-19), congestive heart failure (428.0, HCC 80), atrial fibrillation (427.31, HCC 92), chronic obstructive and pulmonary disease (COPD) (496, HCC 108). These diseases are generally managed by ongoing medication and have the potential for acute exacerbations if not treated properly, particularly if the patient is experiencing other acute conditions. It is likely that these diagnoses would be part of a general overview of the patient's health when treating co-existing conditions for all but the most minor of medical encounters.
2004 Participant Guide § 5.4.1, at 5-6.	Co-existing conditions also include ongoing conditions such as multiple sclerosis (340, HCC 72), hemiplegia (342.9, HCC 100), rheumatoid arthritis (714.0, HCC 38) and Parkinson's (332.0, HCC 73). Although they may not impact every minor healthcare episode, it is very likely that patients having these conditions would have their general health status evaluated within a data reporting period, and these diagnoses would be documented and reportable at that time.
2004 Participant Guide § 5.4.1, at 5-6.	M+C organizations must submit each relevant diagnosis at least once during a risk adjustment reporting period. Therefore, these co-existing conditions should be documented by one of the allowable provider types at least once within the data reporting period.
2004 Participant Guide § 5.4.2, at 5-7.	It also is understood that the physician record is not a static document. Positive test results and notations regarding contact with the patient for a revised plan of treatment often are added to the record several days after the patient encounter. When these addenda are made, corrections or additions to the diagnoses reported to M+C organizations may be recommended, particularly if the HCC assignment is impacted.
2004 Participant Guide § 6.1.3, at 6-5.	Beginning in CY2004, risk adjustment data validation will include hospital inpatient, hospital outpatient, and physician medical records. This change reflects the implementation of the CMS-HCC model that began with CY2004 payment. In an effort to make the data validation more flexible for M+C organizations, CMS developed the following Guiding Principle. **Guiding Principle:** The medical record documentation must show that the HCC diagnosis was assigned within the correct data collection period by an appropriate provider type (hospital inpatient, hospital outpatient, and physician) as defined in the CMS instructions for risk adjustment implementation. In addition, the diagnosis must be coded according to ICD-9 CM Guidelines for Coding and Reporting. M+C organizations will be allowed more flexibility, per the guiding principle, in the submission of supporting medical record documentation when responding to a medical record request.
2004 Participant Guide § 6.3.2, at 6-10.	Although the term "problem list" is commonly used with regard to ambulatory medical record documentation, a universal definition does not exist. The problem list is generally used by a coder to gain an overall clinical picture of a patient's condition(s). Problem lists are usually supported by other medical record documentation such as SOAP notes (subjective, objective, assessment, plan), progress notes, consultation notes, and diagnostic reports. For CMS' risk adjustment data validation purposes, an acceptable problem list must be comprehensive and show evaluation and treatment for each condition that relates to an ICD-9 code on the date of service, and is signed and dated by the physician or physician extender.
2004 Participant Guide § 6.5.1, at 6-13.	In order to give a general understanding of the types of data discrepancies that may be identified, the following descriptions are provided: • Coding Discrepancies

Standard	Relevant Provision or Passage
	○ The medical record documentation substantiates a different ICD-9 code at the 3 digit level than the ICD-9 code identified by the M+C organization for medical record review. ○ The medical record documentation substantiates a different ICD-9 code at the 4th and 5th digit level than the ICD-9 code identified by the M+C organization for medical record review. ○ The medical record documentation submitted for review is insufficient to justify the assignment of an ICD-9 code per ICD-9 Coding Clinic Guidelines. • Invalid ○ The medical record documentation submitted for review is from an unacceptable provider type for risk adjustment (e.g., SNF). ○ The medical record documentation submitted for review is missing components of the medical record required to code in accordance with ICD-9 Coding Clinic Guidelines. ○ The date of service (visit date) for the medical record documentation submitted does not fall within the risk adjustment data collection period. • Missing ○ An ICD-9 diagnosis code cannot be assigned for the date of service. ○ No medical record documentation was received for a beneficiary HCC selected for data validation.
2004 Participant Guide, *Communicating with Physicians & Providers about Risk Adjustment – Coding & Medical Record Documentation*.	Physicians and providers should report all diagnoses that impact the patient's care, and ensure these diagnoses are accurately documented in a medical record. This includes the main reason for the episode of care; and all co-existing, acute or chronic conditions; and pertinent past conditions that impact clinical evaluation and therapeutic treatment. Symptoms that are common to the main reportable diagnosis should not be coded. Coding to the highest degree of specificity provides the most accurate coding and ensures appropriate grouping in the risk adjustment model.
CMS 2005 Risk Adjustment Data Basic Training For Medicare Advantage Organizations Participant Guide ("2005 Participant Guide") § 3.2.3, at 3-9.	Qualified physician data for risk adjustment requires a face-to-face visit with the exception of pathology and radiology services (professional component only).
2005 Participant Guide § 5.4, at 5-5.	Upcoding or changing diagnoses to obtain higher reimbursement without supporting source documents is fraudulent. However, thoroughly reviewing documentation and coding practices through internal auditing procedures to ensure that data has been reported correctly and that appropriate reimbursement is received benefits both the MA organization and physician/provider.
2005 Participant Guide § 5.4.1, at 5-5.	Co-existing conditions include chronic, ongoing conditions such as diabetes (250.XX, HCCs 15-19), congestive heart failure (428.0, HCC 80), atrial fibrillation (427.31, HCC 92), chronic obstructive and pulmonary disease (COPD) (496, HCC 108). These diseases are generally managed by ongoing medication and have the potential for acute exacerbations if not treated properly, particularly if the patient is experiencing other acute conditions. It is likely that these diagnoses would be part of a general overview of the patient's health when treating co-existing conditions for all but the most minor of medical encounters.

Standard	Relevant Provision or Passage
2005 Participant Guide § 5.4.1, at 5-5.	Co-existing conditions also include ongoing conditions such as multiple sclerosis (340, HCC 72), hemiplegia (342.9, HCC 100), rheumatoid arthritis (714.0, HCC 38) and Parkinson's (332.0, HCC 73). Although they may not impact every minor healthcare episode, it is very likely that patients having these conditions would have their general health status evaluated within a data reporting period, and these diagnoses would be documented and reportable at that time.
2005 Participant Guide § 5.4.1, at 5-6.	MA organizations must submit each relevant diagnosis at least once during a risk adjustment reporting period. Therefore, these co-existing conditions should be documented by one of the allowable provider types at least once within the data reporting period.
2005 Participant Guide § 5.4.2, at 5-7.	It also is understood that the physician record is not a static document. Positive test results and notations regarding contact with the patient for a revised plan of treatment often are added to the record several days after the patient encounter. When these addenda are made, corrections or additions to the diagnoses reported to MA organizations may be recommended, particularly if the HCC assignment is impacted.
2005 Participant Guide § 9.1.3, at 9-2.	Beginning in CY2004, risk adjustment data validation includes hospital inpatient, hospital outpatient, and physician medical records. This change reflects the implementation of the CMS-HCC model that began with CY2004 payment. To make the data validation more flexible for MA organizations, CMS developed the following Guiding Principle. **Guiding Principle:** The medical record documentation must show that the HCC diagnosis was assigned within the correct data collection period by an appropriate provider type (hospital inpatient, hospital outpatient, and physician) as defined in the CMS instructions for risk adjustment implementation. In addition, the diagnosis must be coded according to ICD-9-CM Guidelines for Coding and Reporting. MA organizations will be allowed more flexibility, per the guiding principle, in the submission of supporting medical record documentation when responding to a medical record request.
2005 Participant Guide § 9.2.4.4, at 9-12.	Although the term "problem list" is commonly used with regard to ambulatory medical record documentation, a universal definition does not exist. The problem list is generally used by a coder to gain an overall clinical picture of a patient's condition(s). Problem lists are usually supported by other medical record documentation such as SOAP notes (subjective, objective, assessment, plan), progress notes, consultation notes, and diagnostic reports. For CMS' risk adjustment data validation purposes, an acceptable problem list must be comprehensive and show evaluation and treatment for each condition that relates to an ICD-9 code on the date of service, and it must be signed and dated by the physician or physician extender.

2005 Participant Guide § 9.2.5.1, at 9-15.	During medical record review, medical record data discrepancies may be identified. Data discrepancies occur when the diagnostic data selected for risk adjustment data validation is not supported by medical record documentation. There are several types of data discrepancies. To give a general understanding of the types of data discrepancies that may be identified, the following descriptions are provided:
	• Coding Discrepancies
	  ○ The ICD-9 code abstracted from the medical record does not match the risk adjustment diagnosis code at the 3rd, 4th, or 5th digit level.
	• Invalid
	  ○ The medical record documentation submitted for review is from an unacceptable provider type for risk adjustment (e.g., SNF).
	  ○ The date of service (visit date) for the medical record documentation submitted does not fall within the risk adjustment data collection period.
	• Missing
	  ○ Incomplete—an ICD-9 diagnosis code cannot be assigned as per ICD-9 Coding Clinic Guidelines for the date of service if the documentation is insufficient or incomplete (i.e., the record is missing components that are required to code in accordance with ICD-9 Coding Clinic Guidelines.)
	  ○ Never sent—no medical record documentation was received for a beneficiary HCC selected for data validation.

CMS 2006 Risk Adjustment Data Basic	Qualified physician data for risk adjustment requires a face-to-face visit with the exception of pathology services (professional component only).

Standard	Relevant Provision or Passage
Training For Medicare Advantage Organizations Participant Guide ("Feb. 2006 Participant Guide") § 3.2.3, 3-9 (Feb. 2006).	
Feb. 2006 Participant Guide § 5.4, at 5-5.	Upcoding or changing diagnoses to obtain higher reimbursement without supporting source documents is fraudulent. However, thoroughly reviewing documentation and coding practices through internal auditing procedures ensure that data have been reported correctly and that appropriate reimbursement is received. This benefits both the MA organization and physician/provider.
Feb. 2006 Participant Guide § 5.4.1, at 5-5–5-6.	Co-existing conditions include chronic, ongoing conditions such as diabetes (250.XX, HCCs 15-19), congestive heart failure (428.0, HCC 80), atrial fibrillation (427.31, HCC 92), chronic obstructive and pulmonary disease (496, HCC 108). These diseases are generally managed by ongoing medication and have the potential for acute exacerbations if not treated properly, particularly if the patient is experiencing other acute conditions. It is likely that these diagnoses would be part of a general overview of the patient's health when treating co-existing conditions for all but the most minor of medical encounters.
Feb. 2006 Participant Guide § 5.4.1, at 5-6.	Co-existing conditions also include ongoing conditions such as multiple sclerosis (340, HCC 72), hemiplegia (342.9X, HCC 100), rheumatoid arthritis (714.0, HCC 38) and Parkinson's disease (332.0, HCC 73). Although they may not impact every minor healthcare episode, it is likely that patients having these conditions would have their general health status evaluated within a data reporting period, and these diagnoses would be documented and reportable at that time.
Feb. 2006 Participant Guide § 5.4.1, at 5-6.	MA organizations must submit each relevant diagnosis at least once during a risk adjustment reporting period. Therefore, these co-existing conditions should be documented by one of the allowable provider types at least once within the data reporting period.
Feb. 2006 Participant Guide § 5.4.2, at 5-7.	It also is understood that the physician record is not a static document. Positive test results and notations regarding contact with the patient for a revised plan of treatment often are added to the record several days after the patient encounter. When these addenda are made, corrections or additions to the diagnoses reported to MA organizations may be recommended, particularly if the HCC assignment is impacted.
Feb. 2006 Participant Guide § 8.1.3, at 8-2.	Beginning in CY2004, risk adjustment data validation includes hospital inpatient, hospital outpatient, and physician medical records. This change reflects the implementation of the CMS-HCC model that began with CY2004 payment. To make the data validation more flexible for MA organizations, CMS developed the following Guiding Principle. **Guiding Principle:** The medical record documentation must show that the HCC diagnosis was assigned within the correct data collection period by an appropriate provider type (hospital inpatient, hospital outpatient, and physician) as defined in the CMS instructions for risk adjustment implementation. In addition, the diagnosis must be coded according to International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Guidelines for Coding and Reporting. MA organizations will be allowed more flexibility, per the guiding principle, in the submission of supporting medical record documentation when responding to a medical record request.
Feb. 2006 Participant Guide § 8.2.4.4, at 8-12.	Although the term "problem list" is commonly used with regard to ambulatory medical record documentation, a universal definition does not exist. The problem list is generally used by a coder to gain an overall clinical picture of a patient's condition(s). Problem lists are usually supported by other medical record documentation such as SOAP notes (subjective, objective, assessment, plan), progress notes, consultation notes, and diagnostic reports. For CMS' risk adjustment data validation purposes, an acceptable problem list must be comprehensive and show evaluation and treatment for each condition that relates to an ICD-9 code on the date of service, and it must be signed and dated by the physician or physician extender.

Standard	Relevant Provision or Passage

Feb. 2006 Participant Guide § 8.2.5.1, at 8-15.	During medical record review, medical record data discrepancies may be identified. Data discrepancies occur when the diagnostic data selected for risk adjustment data validation is not supported by medical record documentation. There are several types of data discrepancies.
	To give a general understanding of the types of data discrepancies that may be identified, the following descriptions are provided:
	• Coding Discrepancies
	  ○ The ICD-9 code abstracted from the medical record does not match the risk adjustment diagnosis code at the 3rd, 4th, or 5th digit level.
	• Invalid
	  ○ The medical record documentation submitted for review is from an unacceptable provider type for risk adjustment (e.g., SNF).
	  ○ The date of service (visit date) for the medical record documentation submitted does not fall within the risk adjustment data collection period.
	• Missing
	  ○ Incomplete—an ICD-9 diagnosis code cannot be assigned as per ICD-9 Coding Clinic Guidelines for the date of service if the documentation is insufficient or incomplete (i.e., the record is missing components that are required to code in accordance with ICD-9 Coding Clinic Guidelines).
	  ○ Never sent—no medical record documentation was received for a beneficiary HCC selected for data validation.

CMS 2006 Risk Adjustment Data Basic Training For Medicare Advantage Organizations Participant Guide ("July 2006 Participant Guide") § 3.2.3, at 3-9 (July 2006).	Qualified physician data for risk adjustment requires a face-to-face visit with the exception of pathology services (professional component only).
July 2006 Participant Guide § 5.4, at 5-5.	Upcoding or changing diagnoses to obtain higher reimbursement without supporting source documents is fraudulent. However, thoroughly reviewing documentation and coding practices through internal auditing procedures ensure that data have been reported correctly and that appropriate reimbursement is received. This benefits both the MA organization and physician/provider.
July 2006 Participant Guide § 5.4.1, at 5-6.	Co-existing conditions include chronic, ongoing conditions such as diabetes (250.XX, HCCs 15-19), congestive heart failure (428.0, HCC 80), atrial fibrillation (427.31, HCC 92), chronic obstructive and pulmonary disease (496, HCC 108). These diseases are generally managed by ongoing medication and have the potential for acute exacerbations if not treated properly, particularly if the patient is experiencing other acute conditions. It is likely that these diagnoses would be part of a general overview of the patient's health when treating co-existing conditions for all but the most minor of medical encounters.
July 2006 Participant Guide § 5.4.1, at 5-6.	Co-existing conditions also include ongoing conditions such as multiple sclerosis (340, HCC 72), hemiplegia (342.9X, HCC 100), rheumatoid arthritis (714.0, HCC 38) and Parkinson's disease (332.0, HCC 73). Although they may not impact every minor healthcare episode, it is likely that patients having these conditions would have their general health status evaluated within a data reporting period, and these diagnoses would be documented and reportable at that time.
July 2006 Participant Guide § 5.4.1, at 5-6.	MA organizations must submit each relevant diagnosis at least once during a risk adjustment reporting period. Therefore, these co-existing conditions should be documented by one of the allowable provider types at least once within the data reporting period.

Standard	Relevant Provision or Passage
July 2006 Participant Guide § 5.4.2, at 5-7.	It also is understood that the physician record is not a static document. Positive test results and notation regarding contact with the patient for a revised plan of treatment often are added to the record several days after the patient encounter. When these addenda are made, corrections or additions to the diagnoses reported to MA organizations may be recommended, particularly if the HCC assignment is impacted.
July 2006 Participant Guide § 8.1.3, at 8-2.	Beginning with the CY2004 payments, validation activities incorporated the review of hospital inpatient, hospital outpatient, and physician medical records. This process reflects the implementation of the CMS HCC model that began with CY2004 payment. To make the data validation flexible for MA organizations, CMS developed the following Guiding Principle. **Guiding Principle:** The medical record documentation must show that the HCC diagnosis was assigned within the correct data collection period by an appropriate provider type (hospital inpatient, hospital outpatient, and physician) as defined in the CMS instructions for risk adjustment implementation. In addition, the diagnosis must be coded according to International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Guidelines for Coding and Reporting. MA organizations will be allowed more flexibility, per the guiding principle, in the submission of supporting medical record documentation when responding to a medical record request.
July 2006 Participant Guide § 8.2.4.4, at 8-14.	Although the term "problem list" is commonly used with regard to ambulatory medical record documentation, a universal definition does not exist. The problem list is generally used by a coder to gain an overall clinical picture of a patient's condition(s). Problem lists are usually supported by other medical record documentation such as SOAP notes (subjective, objective, assessment, plan), progress notes, consultation notes, and diagnostic reports. For CMS' risk adjustment data validation purposes, an acceptable problem list must be comprehensive and show evaluation and treatment for each condition that relates to an ICD-9 code on the date of service, and it must be signed and dated by the physician or physician extender.

July 2006 Participant Guide § 8.2.5.1, at 8-17.	During medical record review, medical record data discrepancies may be identified. Data discrepancies occur when the diagnostic data selected for risk adjustment data validation is not supported by medical record documentation. There are several types of data discrepancies. To give a general understanding of the types of data discrepancies that may be identified, the following descriptions are provided:
	• Coding Discrepancies
	  ○ The ICD-9 code abstracted from the medical record does not match the risk adjustment diagnosis code at the 3rd, 4th, or 5th digit level.
	• Invalid
	  ○ The medical record documentation submitted for review is from an unacceptable provider type for risk adjustment (e.g., SNF).
	  ○ The date of service (visit date) for the medical record documentation submitted does not fall within the risk adjustment data collection period.
	• Missing
	  ○ Incomplete—an ICD-9 diagnosis code cannot be assigned as per ICD-9 Coding Clinic Guidelines for the date of service if the documentation is insufficient or incomplete (i.e., the record is missing components that are required to code in accordance with ICD-9 Coding Clinic Guidelines).
	  ○ Never sent—no medical record documentation was received for a beneficiary HCC selected for data validation.

CMS 2007 Risk Adjustment Data Training For Medicare Advantage Organizations Participant Guide ("2007 Participant Guide") § 3.2.3, at 3-10.	Qualified physician data for risk adjustment requires a face-to-face visit with the exception of pathology services (professional component only).

Standard	Relevant Provision or Passage
2007 Participant Guide § 6.4, at 6-5.	Upcoding or changing diagnoses to obtain higher reimbursement without supporting source documents is fraudulent. However, thoroughly reviewing documentation and coding practices through internal auditing procedures ensure that data have been reported correctly and that appropriate reimbursement is received. This benefits both the MA organization and physician/provider.
2007 Participant Guide § 6.4.1, at 6-6.	Co-existing conditions include chronic, ongoing conditions such as diabetes (250.XX, HCCs 15-19), congestive heart failure (428.0, HCC 80), atrial fibrillation (427.31, HCC 92), chronic obstructive and pulmonary disease (496, HCC 108). These diseases are generally managed by ongoing medication and have the potential for acute exacerbations if not treated properly, particularly if the patient is experiencing other acute conditions. It is likely that these diagnoses would be part of a general overview of the patient's health when treating co-existing conditions for all but the most minor of medical encounters.
2007 Participant Guide § 6.4.1, at 6-6.	Co-existing conditions also include ongoing conditions such as multiple sclerosis (340, HCC 72), hemiplegia (342.9X, HCC 100), rheumatoid arthritis (714.0, HCC 38) and Parkinson's disease (332.0, HCC 73). Although they may not impact every minor healthcare episode, it is likely that patients having these conditions would have their general health status evaluated within a data reporting period, and these diagnoses would be documented and reportable at that time.
2007 Participant Guide § 6.4.1, at 6-6.	MA organizations must submit each relevant diagnosis at least once during a risk adjustment reporting period. Therefore, these co-existing conditions should be documented by one of the allowable provider types at least once within the data reporting period.
2007 Participant Guide § 6.4.2, at 6-7.	It also is understood that the physician record is not a static document. Positive test results and notations regarding contact with the patient for a revised plan of treatment often are added to the record several days after the patient encounter. When these addenda are made, corrections or additions to the diagnoses reported to MA organizations may be recommended, particularly if the HCC assignment is impacted.
2007 Participant Guide § 7.1.4, at 7-2.	Beginning with the CY2004 payments, validation activities incorporated the review of hospital inpatient, hospital outpatient, and physician medical records. This process reflects the implementation of the CMS-HCC model that began with CY2004 payment. Beginning with CY2006 payments, validation activities incorporated RxHCC data. This process reflects the implementation of the CMS RxHCC model that began with CY2006 payment. **Guiding Principle:** The risk adjustment diagnosis must be based on clinical medical record documentation from a face-to-face encounter, coded according to the ICD-9-CM Guidelines for Coding and Reporting; assigned based on dates of service within the data collection period, and submitted to the MA organization from an appropriate risk adjustment provider type and an appropriate risk adjustment physician data source.
2007 Participant Guide § 7.2.4.6, at 7-18.	Although the term "problem list" is commonly used with regard to ambulatory medical record documentation, a universal definition does not exist. The problem list is generally used by a coder to gain an overall clinical picture of a patient's condition(s). Problem lists are usually supported by other medical record documentation such as SOAP notes (subjective, objective, assessment, plan), progress notes, consultation notes, and diagnostic reports. For CMS' risk adjustment data validation purposes, an acceptable problem list must be comprehensive and show evaluation and treatment for each condition that relates to an ICD-9 code on the date of service, and it must be signed and dated by the physician or physician extender.

2007 Participant Guide § 7.2.5.1, at 7-19.	Risk Adjustment Discrepancies
	To give a general understanding of the types of discrepancies that may be identified, the following descriptions are provided:
	• Invalid
	  ○ The medical record documentation submitted for review is from an unacceptable provider type for risk adjustment (e.g., SNF).
	  ○ The date of service (visit date) for the medical record documentation submitted does not fall within the risk adjustment data collection period.
	  ○ The medical record is missing provider signature and credentials.
	• Missing

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	○ Incomplete—an ICD-9 diagnosis code cannot be assigned as per ICD-9 Coding Clinic Guidelines for the date of service if the documentation is insufficient or incomplete (i.e., the record is missing components that are required to code in accordance with ICD-9 Coding Clinic Guidelines). ○ Never sent—no medical record documentation was received for a beneficiary HCC selected for data validation. • Coding Discrepancies ○ The ICD-9 code abstracted from the medical record does not match the risk adjustment diagnosis code at the 3rd, 4th, or 5th digit level. A risk adjustment discrepancy is identified when an HCC originally assigned to an enrollee on the basis of submitted risk adjustment data differs from the HCC assigned after data validation. A risk adjustment discrepancy may affect the final risk score for a beneficiary.
CMS 2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide ("2008 Participant Guide") § 3.2.3, at 3-11.	Qualified physician data for risk adjustment requires a face-to-face visit with the exception of pathology services (professional component only).
2008 Participant Guide § 6.4, at 6-5.	Upcoding or changing diagnoses to obtain higher reimbursement without supporting source documents is fraudulent. However, thoroughly reviewing documentation and coding practices through internal auditing procedures ensure that data have been reported correctly and that appropriate reimbursement is received. This benefits both the MA organization and physician/provider.
2008 Participant Guide § 6.4.1, at 6-6.	Co-existing conditions include chronic, ongoing conditions such as diabetes (250.XX, HCCs 15-19), congestive heart failure (428.0, HCC 80), atrial fibrillation (427.31, HCC 92), chronic obstructive and pulmonary disease (496, HCC 108). These diseases are generally managed by ongoing medication and have the potential for acute exacerbations if not treated properly, particularly if the patient is experiencing other acute conditions. It is likely that these diagnoses would be part of a general overview of the patient's health when treating co-existing conditions for all but the most minor of medical encounters.
2008 Participant Guide § 6.4.1, at 6-6.	Co-existing conditions also include ongoing conditions such as multiple sclerosis (340, HCC 72), hemiplegia (342.9X, HCC 100), rheumatoid arthritis (714.0, HCC 38) and Parkinson's disease (332.0, HCC 73). Although they may not impact every minor healthcare episode, it is likely that patients having these conditions would have their general health status evaluated within a data reporting period, and these diagnoses would be documented and reportable at that time.
2008 Participant Guide § 6.4.1, at 6-6.	MA organizations must submit each required diagnosis at least once during a risk adjustment reporting period. Therefore, these co-existing conditions should be documented by one of the allowable provider types at least once within the data reporting period.
2008 Participant Guide § 6.4.2, at 6-7.	It also is understood that the physician record is not a static document. Positive test results and notations regarding contact with the patient for a revised plan of treatment often are added to the record several days after the patient encounter. When these addenda are made, corrections or additions to the diagnoses reported to MA organizations may be recommended, particularly if the HCC assignment is impacted.
2008 Participant Guide § 7.1.5, at 7-3.	The risk adjustment guiding principle states that all diagnoses submitted for payment (i.e., used for HCCs) must be: ○ Documented in a medical record that was based on a face-to-face health service encounter between a patient and a healthcare provider ○ Coded in accordance with the ICD-9-CM Guidelines for Coding and Reporting ○ Assigned based on dates of service within the data collection period AND ○ From an acceptable RA provider type and RA physician specialty

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	This guiding principle is what's used as the key guideline for medical records review.
2008 Participant Guide § 7.2.4.3, at 7-17.	Although the term "problem list" is commonly used with regard to ambulatory medical record documentation, a universal definition does not exist. The problem list is generally used by a coder to gain an overall clinical picture of a patient's condition(s). Problem lists are usually supported by other medical record documentation such as SOAP notes (subjective, objective, assessment, plan), progress notes, consultation notes, and diagnostic reports. For CMS' risk adjustment data validation purposes, an acceptable problem list must be comprehensive and show evaluation and treatment for each condition that relates to an ICD-9 code on the date of service, and it must be signed and dated by the physician or physician extender.

2008 Participant Guide § 7.2.4.4, at 7-19–7-20.	As previously stated, a risk adjustment discrepancy occurs when the enrollee HCC(s) assigned after medical record review differs from the enrollee HCC(s) assigned based on submitted risk adjustment data. To give a general understanding of the types of discrepancies that may be identified, the following descriptions are provided:
	• Invalid
	  ○ The medical record documentation submitted for review is from an unacceptable provider type and physician specialty for risk adjustment (e.g., SNF).
	  ○ The date of service (visit date) for the medical record documentation submitted does not fall within the risk adjustment data collection period.
	  ○ The medical record is missing provider signature and credentials.
	• Missing
	  ○ Incomplete—an ICD-9 diagnosis code cannot be assigned as per ICD-9 Coding Clinic Guidelines for the date of service if the documentation is insufficient or incomplete (i.e., the record is missing components that are required to code in accordance with ICD-9 Coding Clinic Guidelines).
	  ○ Never sent—no medical record documentation was received for a beneficiary HCC selected for data validation.
	• Coding Discrepancies
	  ○ The ICD-9 code abstracted from the medical record does not match the risk adjustment diagnosis code at the 3rd, 4th, or 5th digit level.

CMS 2012 Regional Technical Assistance Encounter Data Participant Guide ("2012 Encounter Data Participant Guide") § 2.5.4, at 2-10.	MAOs and other entities are responsible for the accuracy of all encounter data submitted and must ensure that every submission can be supported by an original source document (i.e. a medical record). MAOs and other entities must also attest that the data submitted is based on best knowledge, information, and belief and be accurate and truthful.
2012 Encounter Data Participant Guide § 3.5.7, at 3-30.	All chart review encounter data must be from an appropriate provider "specialty," from an allowed provider type (inpatient, outpatient, physician), and within 25 months of the data collection period. Further, all diagnoses codes submitted through chart review must be based on a face-to-face visit and supported by a medical record.
CMS 2012 Regional Technical Assistance Risk Adjustment Participant Guide ("2012 Risk	Diagnoses must be supported by appropriate medical record documentation and the dates of service must be within the data collection year. Diagnosis codes are provided to CMS in the RAPS format. The diagnoses are currently in International Classification of Diseases, 9th Edition Clinical Modification (ICD-9-CM) coding, but is scheduled to be transitioned to the 10th Edition or ICD-10 on October 1, 2014.

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Adjustment Participant Guide") § 2.2, at 2-5.[1]	
2012 Risk Adjustment Participant Guide § 2.2, at 2-5.	Diagnosis codes are provided to CMS in the RAPS format. The diagnoses are currently in International Classification of Diseases, 9th Edition Clinical Modification (ICD-9-CM) coding, but is scheduled to be transitioned to the 10th Edition or ICD-10 on October 1, 2014.
2012 Risk Adjustment Participant Guide § 2.2.1.3, at 2-6.	That is, all ICD-9-CM diagnoses that are required for the risk adjustment models and rendered as a result of a physician face-to-face visit must be collected by the MA organization.
CMS 2013 National Technical Assistance Risk Adjustment 101 Participant Guide ("2013 Participant Guide") § 3.2.2, at 9 (July 23, 2013).	Diagnoses must result from a face-to-face visit either with an acceptable physician specialty or from an acceptable facility, as determined by CMS.
2013 Participant Guide § 3.2.2.3, at 10.	Diagnostic radiologists typically do not document confirmed diagnoses. The diagnosis confirmation comes from referring physicians or physician extenders and is therefore not assigned in the medical record documentation from diagnostic radiology services alone.
2013 Participant Guide § 3.2.4, at 12.	Diagnoses must be supported by appropriate medical record documentation. Diagnosis codes are provided to CMS in the RAPS format. The diagnoses are currently in International Classification of Diseases, 9th Edition Clinical Modification (ICD-9-CM) coding, but are scheduled to be transitioned to the 10th Edition, or ICD-10, on October 1, 2014.
CMS Risk Adjustment Data Validation (RADV) Medical Record Intake Process and Guidance to Coders, CY2011 Contract Level RADV, Version 4.0 ("2014 RADV Medical Record Reviewer Guidance"), at 5 (May 8, 2014).	Though official coding rules do not change based on the type of audit, the coder should be aware of the background and prospective nature of the RA payment process including its basis on chronic conditions, and dependence on validating chronic conditions for an annual payment on just the review of one record. It is imperative therefore to code all chronic conditions documented by an acceptable provider type during a face to face encounter with the patient, whether or not there was specific treatment mentioned in the one record submitted. Mention or EMR population of the diagnoses narrative list can be interpreted as management and care for the applicable chronic conditions of the patient once all other coding rules and checks for consistency have been applied. This is where RADY HCC audits may differ in guideline interpretation from fee-for-service, DRG audits or others based on just the payment for one specific encounter.

[1] The CMS 2012 Regional Technical Assistance Risk Adjustment Participant Guide is included pursuant to KFHP's express "right to modify, amend, and supplement" the list of statutes, rules, regulations, guidance documents, and contracts included in KFHP's August 8, 2022 Letter to the United States Department of Justice ("DOJ"). *See* August 8, 2022 Letter from KFHP to DOJ, at 5.

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2014 RADV Medical Record Reviewer Guidance, at 44.	Although Risk Adjustment (RA) submission requires a face-face visit (with the exception of pathology), RADV medical records may include **interpretations** of diagnostic tests or related interventional, minimally invasive procedures that do not involve a face-face visit with the interpreting physician specialist. Even if the services are not acceptable to submit diagnoses for risk adjustment (i.e., non-hospital based outpatient services); RADV allows the interpreted reports to support CMS HCCs in the data year.
2014 RADV Medical Record Reviewer Guidance, at 74.	**Acceptable Amendment** – An amendment must be completed in a timely manner (up to 90 days is a general guideline used for RADV but there could be exceptions i.e. extended specialized or revised lab/path results or autopsies, legal cases sequestered before completing record, natural disasters, physician called to military service), based on an observation of the patient on the date of service and signed by the physician (e.g., follow-up note based on a diagnostic test ordered and test results received subsequent to the patient visit).
2014 RADV Medical Record Reviewer Guidance, at 74.	Sufficient information must be contained in the amendment to verify the documentation was completed in a timely manner by the attending or treating physician.
2014 RADV Medical Record Reviewer Guidance, at 74-75.	**Unacceptable Amendment** – It is **unacceptable** for a third party that was not involved in the treatment and evaluation of the patient (e.g., coder, reviewer, etc.) to amend the medical record. It is not appropriate to add diagnoses to the medical record that have been identified by a source other than the treating physician (e.g., identifying diabetes from a disease management program).
CMS Contract-Level Risk Adjustment Data Validation, Medical Record Reviewer Guidance, As of 09/27/2017 ("2017 RADV Medical Record Reviewer Guidance"), at 34 (Sept. 27, 2017).	Evaluate the problem list for evidence of whether the conditions are chronic or past and if they are consistent with the current encounter documentation (i.e., have they been changed or replaced by a related condition with different specificity). Evaluate conditions listed for chronicity and support in the full medical record, such as history, medications, and final assessment.
2017 RADV Medical Record Reviewer Guidance, at 34.	Problem lists are evaluated on a case-by-case basis when the problem list is not clearly dated as part of the face to face encounter indicated on the coversheet or there are multiple dates of conditions both before and after the DOS.
2017 RADV Medical Record Reviewer Guidance, at 34.	Mention or EMR population of diagnoses in a list will be considered on a case-by-case basis for RADV once all other coding rules and checks for consistency have been applied.
2017 RADV Medical Record Reviewer Guidance, at 41.	Policies may differ depending on the provider type. Review of the entire medical record, including all terms directly attributed to the condition and who documented the condition, are important in making these reporting decisions. Conditions, diagnoses, or "problems" can be listed in various sections of a medical record. With an EMR, conditions from previous encounters are often brought forward/cut and pasted/auto-filled into the current encounter template by various methods. The question is whether these conditions should be reported for the current encounter and how to interpret "treatment and care" and "affect patient management" in the *Official Guidelines for Coding and Reporting* quoted below. Section numbers are indicated after each quote. Conversely, some conditions

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	are listed as a current condition, but the content of the full record indicates the condition is no longer present. Therefore, reviewers should evaluate all listed conditions for consistency within the full provider documentation with the understanding that specific management and treatment of every chronic condition is not always going to be clearly documented in the one record submitted to validate the CMS-HCC. Mention of EMR population of diagnoses in a list will be considered on a case-by-case basis for RADV once all other coding rules and checks for consistency have been applied.
2017 RADV Medical Record Reviewer Guidance, at 49.	**Acceptable Amendment:** An amendment must be based on an observation of the patient on the date of service and signed by the physician. Only the attending physician can amend the medical record. The most common example is for follow-up notes based on a diagnostic test ordered and related test results received subsequent to the patient visit. Sufficient information must be contained in the amendment to verify the documentation was completed in a timely manner by the attending or treating physician. For RADV 'timely manner' generally means up to 90 days from the encounter but there could be exceptions such as extended specialized or revised lab/path results or autopsies, legal cases sequestered before completing record, natural disasters, or delays due to physicians called to military service.
CMS Contract-Level Risk Adjustment Data Validation, Medical Record Reviewer Guidance, In effect as of 03/20/2019 ("2019 RADV Medical Record Reviewer Guidance"), at 52 (Mar. 20, 2019).	Policies may differ depending on the provider type. Review of the entire medical record, including all terms directly attributed to the condition and who documented the condition, are important in making these reporting decisions. Conditions, diagnoses, or "problems" can be listed in various sections of a medical record. With an EMR, conditions from previous encounters are often brought forward/cut and pasted/auto-filled into the current encounter template by various methods. The question is whether these conditions should be reported for the current encounter and how to interpret "treatment and care" and "affect patient management" in the Official Guidelines for Coding and Reporting quoted below. Section numbers are indicated after each quote. Conversely, some conditions are listed as a current condition, but the content of the full record indicates the condition is no longer present. Therefore, reviewers should evaluate all listed conditions, both chronic and acute or short-term conditions for consistency within the full provider documentation of the one encounter submitted for RADV. Mention of EMR population of diagnoses in a list will be considered on a case-by-case basis for RADV once all other coding rules and checks for consistency have been applied.
2019 RADV Medical Record Reviewer Guidance, at 69 (Source AHIMA corrections, amendments and addendum tool kit).	An amendment is an alteration of the health information by modification, correction, addition, or deletion. There are many terms used that ultimately amend the health record. For the purpose of this toolkit, the term "amendment" is the overarching term indicating that documentation has been altered. There are many ways that a health record may be altered; these terms may include corrections, addendums, retractions, deletions, late entries, re-sequencing, and reassignment. An amendment is made after the original documentation has been completed and signed by the provider. It should be noted that unsigned documentation will have changes and then be signed, the changes made prior to the initial signature need to be tracked as well. All amendments should be timely and bear the current date and time of documentation. Entries added to a health record to provide additional information in conjunction with a previous entry. The addendum should be timely, bear the current date, time, and reason for the additional information being added to the health record, and be electronically signed.
CMS Contract-Level 15 Risk Adjustment Data Validation, Medical Record Reviewer Guidance, In effect as of 01/10/2020, Version 2.0 ("2020 RADV Medical Record Reviewer	Policies may differ depending on the provider type. Review of the entire medical record, including all terms directly attributed to the condition and who documented the condition, are important in making these reporting decisions. Conditions, diagnoses, or "problems" can be listed in various sections of a medical record. With an EMR, conditions from previous encounters are often brought forward/cut and pasted/auto-filled into the current encounter template by various methods. The question is whether these conditions should be reported for the current encounter and how to interpret "treatment and care" and "affect patient management" in the Official Guidelines for Coding and Reporting quoted below. Section numbers are indicated after each quote. Conversely, some conditions are listed as a current condition, but the content of the full record indicates the condition is no longer present. Therefore, reviewers should evaluate all listed conditions, both chronic and acute or short-term conditions for consistency within the full provider documentation of the one encounter submitted for RADV. Mention of EMR population of diagnoses in a list will be considered on a case-by-case basis for RADV once all other coding rules and checks for consistency have been applied.

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Guidance"), at 51 (Jan. 10, 2020).	
2020 RADV Medical Record Reviewer Guidance, at 69 (Source AHIMA corrections, amendments and addendum tool kit).	An amendment is an alteration of the health information by modification, correction, addition, or deletion. There are many terms used that ultimately amend the health record. For the purpose of this toolkit, the term "amendment" is the overarching term indicating that documentation has been altered. There are many ways that a health record may be altered; these terms may include corrections, addendums, retractions, deletions, late entries, re-sequencing, and reassignment. An amendment is made after the original documentation has been completed and signed by the provider. It should be noted that unsigned documentation will have changes and then be signed, the changes made prior to the initial signature need to be tracked as well. All amendments should be timely and bear the current date and time of documentation. Entries added to a health record to provide additional information in conjunction with a previous entry. The addendum should be timely, bear the current date, time, and reason for the additional information being added to the health record, and be electronically signed.
Medicare Managed Care Manual ("MMCM") Chapter 7, § 111.3 (Rev. 57, Aug. 13, 2004).	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.
MMCM Chapter 7, Exhibit 30 (Rev. 57, Aug. 13, 2004).	Medicare utilizes ICD-9-CM as the official diagnosis code set for all lines of business. The "Official ICD-9 CM Guidelines for Coding and Reporting" provides guidance on diagnosis coding. This document provides guidelines for hospital inpatient, hospital outpatient and physician services. In accordance with this policy, CMS will utilize ICD-9 diagnosis codes in the determination of risk adjustment factors. M+C organizations must submit for each beneficiary all relevant ICD-9 codes that are utilized in the risk adjustment model. M+C organizations must submit each relevant diagnosis at least once during a risk adjustment data reporting period with the first period being July 1, 2002 – June 30, 2003. See http://www.cms.hhs.gov/paymentsystems/icd9/default.asp for information regarding ICD-9-CM codes.
MMCM Chapter 7, Exhibit 30 (Rev. 57, Aug. 13, 2004).	At a minimum, the submitted ICD-9 codes must be sufficiently specific to allow appropriate grouping of the diagnoses in the risk adjustment model. For the complete list of diagnoses used in the risk adjustment model, as well as the list of minimal ICD-9 codes required to group diagnoses for risk adjustment, see http://www.cms.hhs.gov/healthplans/riskadj/. In all cases, coding to the highest degree of specificity provides the most accurate coding and ensures appropriate grouping in the risk adjustment model.
MMCM Chapter 7, Exhibit 30 (Rev. 57, Aug. 13, 2004).	M+C organizations must apply the following guidelines when collecting data from their provider networks. If the M+C organization utilizes an abbreviated method of collecting diagnoses, such as a superbill, the diagnoses may be coded to the highest level of specificity or to the level of specificity necessary to group the diagnosis appropriately for risk adjusted payments. If the M+C organization collects data using an encounter or claim format, the codes should already be at the highest level of specificity. CMS encourages M+C organizations to utilize the full level of specificity in submitting risk adjustment data. Regardless of the level of specificity of submitted diagnoses, a medical record must substantiate all diagnostic information provided to CMS.
MMCM Chapter 7, Exhibit 30 (Rev. 57, Aug. 13, 2004).	**Coexisting Conditions -** Physicians and providers should use the "Official ICD –9-CM Guidelines for Coding and Reporting" (found at http://www.cms.hhs.gov/paymentsystems/icd9/default.asp) and Medicare fee-for-service rules when submitting risk adjustment data to M+C organizations. The official guidelines that govern those coexisting conditions that may be coded and reported by hospital inpatient, hospital outpatient and physician providers are summarized below. The guidelines for inpatient hospital stays are as follows: "…all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded." The guidelines for coexisting conditions that should be coded for hospital outpatient and physician services are as follows: "Code all documented

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	conditions that coexist at time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (V10-V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment." Physicians and hospital outpatient departments shall not code diagnoses documented as "probable," "suspected," "questionable," "rule out," or "working" diagnosis. Rather, physicians and hospital outpatient departments shall code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.
MMCM Chapter 7 (Rev. 114, June 7, 2013).	All diagnosis codes submitted must be documented in the medical record and must be documented as a result of a face-to-face visit.
MMCM Chapter 7 (Rev. 114, June 7, 2013).	The diagnosis must be coded according to *International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) Guidelines for Coding and Reporting*.
MMCM Chapter 7 (Rev. 118, Sept. 19, 2014).	All diagnosis codes submitted must be documented in the medical record and must be documented as a result of a face-to-face visit.
MMCM Chapter 7 (Rev. 118, Sept. 19, 2014).	The diagnosis must be coded according to *International Classification of Diseases, (ICD) Clinical Modification Guidelines for Coding and Reporting*.
CMS Medicare Program Integrity Manual, Ch. 3	Regardless of whether a documentation submission originates from a paper record or an electronic health record, documents submitted to MACs, CERT, Recovery Auditors, SMRC and UPICs containing amendments, corrections or addenda must: 1. Clearly and permanently identify any amendment, correction or delayed entry as such, and 2. Clearly indicate the date and author of any amendment, correction or delayed entry, and 3. Clearly identify all original content, without deletion.
CMS document bearing the titles "Model Calibration Factor" available at the Overpayment Rule Litigation docket (ECF Nos. 44-3) ("Model Calibration Factor"), at 7.	Entire Standard, including the following passage: Why does FFS Diagnosis Error Matter? • CMS uses diagnosis and cost information from FFS claims to assign values to each condition category for MA payment purposes • Inclusion of undocumented diagnoses tends to reduce risk adjustment values
Model Calibration Factor, at 10.	Entire Standard, including the following passage: Model Calibration Factor • Model Calibration Factor (aka "FFS Adjustor") takes into account how CMS payments would change if perfection standard that is applied under RADV was also used when calculating risk adjustment model values • Ensures that RADV and MA payments are on same documentation standard • MCF applied as an offset to recovery amounts under RADV

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CMS document bearing the title "Three RADV Policy Issues," available at the Overpayment Rule Litigation docket (ECF No. 44-4), at 3.	Entire Standard, including the following passage: • Plans have raised the concern that we are holding them to a standard of perfection for diagnosis coding but that physician claims in FFS Medicare often include diagnoses that aren't supported in the medical record. • So they argue that we have two different documentation standards – one for MA and one for FFS. • And this wouldn't matter except that we use FFS claims data to develop our risk adjustors for Medicare Advantage. • In risk adjustment model, we are estimating the average relative cost of any given condition given the people who are reported to have it. • So when we estimate the relative cost of any given condition, we use diagnosis and cost data from FFS Medicare. • So implicit in all of the adjustments we make to plans payments to account for the relative risk of their populations, are the factors that we developed using FFS data. • If we include diagnoses for beneficiaries who don't actually have the disease, or for whom the medical record documentation is not clear, this tends to reduce the estimated average cost of various conditions and therefore our risk adjustment factors.
Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits ("Notice of Final Payment Error Calculation Methodology", at 4 (Feb. 24, 2012).	Entire Standard, including the following passage: Second, to determine the final payment recovery amount, CMS will apply a Fee-for-Service Adjuster (FFS Adjuster) amount as an offset to the preliminary recovery amount. If the FFS Adjuster amount is greater than the preliminary recovery amount, the final recovery amount is equal to zero.
Notice of Final Payment Error Calculation Methodology, at 4-5.	Entire Standard, including the following passage: The FFS adjuster accounts for the fact that the documentation standard used in RADV audits to determine a contract's payment error (medical records) is different from the documentation standard used to develop the Part C risk-adjustment model (FFS claims). The actual amount of the adjuster will be calculated by CMS based on a RADV-like review of records submitted to support FFS claims data.
MMCM Chapter 11 § 130 (Rev. 79, Feb. 17, 2006).	As a condition for receiving a MA related monthly payment from CMS, the MAO agrees that its chief executive officer (CEO), chief financial officer (CFO), or an individual delegated the authority to sign on behalf of one of these officers, and who reports directly to such officer, must request payment under the contract on a document that attests to (based on best knowledge, information and belief, as of the date specified on the certification form) the accuracy, completeness, and truthfulness of relevant data that CMS requests. Such data include specified enrollment/disenrollment information, changes in benefit packages, and other information that CMS may specify.
42 C.F.R. § 422.504(l).	***Certification of data that determine payment.*** As a condition for receiving a monthly payment under subpart G of this part, the MA organization agrees that its chief executive officer (CEO), chief financial officer (CFO), or an individual delegated the authority to sign on behalf of one of these officers, and who reports

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	directly to such officer, must request payment under the contract on a document that certifies (based on best knowledge, information, and belief) the accuracy, completeness, and truthfulness of relevant data that CMS requests. Such data include specified enrollment information, encounter data, and other information that CMS may specify. **(1)** The CEO, CFO, or an individual delegated the authority to sign on behalf of one of these officers, and who reports directly to such officer, must certify that each enrollee for whom the organization is requesting payment is validly enrolled in an MA plan offered by the organization and the information relied upon by CMS in determining payment (based on best knowledge, information, and belief) is accurate, complete, and truthful. **(2)** The CEO, 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 certify (based on best knowledge, information, and belief) that the data it submits under § 422.310 are accurate, complete, and truthful. **(3)** If such data are generated by a related entity, contractor, or subcontractor of an MA organization, such entity, contractor, or subcontractor must similarly certify (based on best knowledge, information, and belief) the accuracy, completeness, and truthfulness of the data. **(4)** The CEO, CFO, or an individual delegated the authority to sign on behalf of one of these officers, and who reports directly to such officer, must certify (based on best knowledge, information, and belief) that the information in its bid submission is accurate, complete, and truthful and fully conforms to the requirements in § 422.254. **(5)** ***Certification of accuracy of data for overpayments.*** The CEO, CFO, or COO must certify (based on best knowledge, information, and belief) that the information provided for purposes of reporting and returning of overpayments under § 422.326 is accurate, complete, and truthful.
42 U.S.C. § 1395w-23(a)(1)(C)(i).	Subject to subparagraph (I), the Secretary shall adjust the payment amount under subparagraph (A)(i) and the amount specified under subparagraph (B)(i), (B)(ii), and (B)(iii) for such risk factors as age, disability status, gender, institutional status, and such other factors as the Secretary determines to be appropriate, including adjustment for health status under paragraph (3), so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such adjustment factors if such changes will improve the determination of actuarial equivalence.
42 U.S.C. § 1395w-27(a).	The Secretary shall not permit the election under section 1395w–21 of this title of a Medicare+Choice plan offered by a Medicare+Choice organization under this part, and no payment shall be made under section 1395w–23 of this title to an organization, unless the Secretary has entered into a contract under this section with the organization with respect to the offering of such plan. Such a contract with an organization may cover more than 1 Medicare+Choice plan. Such contract shall provide that the organization agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.
45 C.F.R. § 162.1002.	The Secretary adopts the following maintaining organization's code sets as the standard medical data code sets: **(a)** For the period from October 16, 2002 through October 15, 2003: **(1)** ***International Classification of Diseases, 9th Edition, Clinical Modification, (ICD-9-CM), Volumes 1 and 2*** (including The Official ICD-9-CM Guidelines for Coding and Reporting), as maintained and distributed by HHS, for the following conditions: **(i)** Diseases. **(ii)** Injuries. **(iii)** Impairments. **(iv)** Other health problems and their manifestations. **(v)** Causes of injury, disease, impairment, or other health problems.

Standard	Relevant Provision or Passage
	(2) ***International Classification of Diseases, 9th Edition, Clinical Modification, Volume 3 Procedures*** (including The Official ICD-9-CM Guidelines for Coding and Reporting), as maintained and distributed by HHS, for the following procedures or other actions taken for diseases, injuries, and impairments on hospital inpatients reported by hospitals: **(i)** Prevention. **(ii)** Diagnosis. **(iii)** Treatment. **(iv)** Management. **(3)** ***National Drug Codes*** (NDC), as maintained and distributed by HHS, in collaboration with drug manufacturers, for the following: **(i)** Drugs **(ii)** Biologics. **(4)** ***Code on Dental Procedures and Nomenclature,*** as maintained and distributed by the American Dental Association, for dental services. **(5)** The combination of ***Health Care Financing Administration Common Procedure Coding System (HCPCS),*** as maintained and distributed by HHS, and *Current Procedural Terminology, Fourth Edition (CPT-4),* as maintained and distributed by the American Medical Association, for physician services and other health care services. These services include, but are not limited to, the following: **(i)** Physician services. **(ii)** Physical and occupational therapy services. **(iii)** Radiologic procedures. **(iv)** Clinical laboratory tests. **(v)** Other medical diagnostic procedures. **(vi)** Hearing and vision services. **(vii)** Transportation services including ambulance. **(6)** The ***Health Care Financing Administration Common Procedure Coding System (HCPCS),*** as maintained and distributed by HHS, for all other substances, equipment, supplies, or other items used in health care services. These items include, but are not limited to, the following: **(i)** Medical supplies. **(ii)** Orthotic and prosthetic devices. **(iii)** Durable medical equipment. **(b)** For the period on and after October 16, 2003 through September 30, 2015: **(1)** The code sets specified in paragraphs (a)(1), (a)(2),(a)(4), and (a)(5) of this section. **(2)** ***National Drug Codes (NDC),*** as maintained and distributed by HHS, for reporting the following by retail pharmacies: **(i)** Drugs. **(ii)** Biologics. **(3)** ***The Healthcare Common Procedure Coding System (HCPCS),*** as maintained and distributed by HHS, for all other substances, equipment, supplies, or other items used in health care services, with the exception of drugs and biologics. These items include, but are not limited to, the following: **(i)** Medical supplies.

Standard	Relevant Provision or Passage
	(ii) Orthotic and prosthetic devices. **(iii)** Durable medical equipment. **(c)** For the period on and after October 1, 2015: **(1)** The code sets specified in paragraphs (a)(4), (a)(5), (b)(2), and (b)(3) of this section. **(2)** International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) (including The Official ICD-10-CM Guidelines for Coding and Reporting), as maintained and distributed by HHS, for the following conditions: **(i)** Diseases. **(ii)** Injuries. **(iii)** Impairments. **(iv)** Other health problems and their manifestations. **(v)** Causes of injury, disease, impairment, or other health problems. **(3)** International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) (including The Official ICD-10-PCS Guidelines for Coding and Reporting), as maintained and distributed by HHS, for the following procedures or other actions taken for diseases, injuries, and impairments on hospital inpatients reported by hospitals: **(i)** Prevention. **(ii)** Diagnosis. **(iii)** Treatment. **(iv)** Management.
42 C.F.R. § 422.308(c).	CMS will adjust the payment amounts under § 422.304(a)(1), (a)(2), and (a)(3) for age, gender, disability status, institutional status, and other factors CMS determines to be appropriate, including health status, in order to ensure actuarial equivalence. CMS may add to, modify, or substitute for risk adjustment factors if those changes will improve the determination of actuarial equivalence.
42 C.F.R. § 422.310(b).	Each MA organization must submit to CMS (in accordance with CMS instructions) the data necessary to characterize the context and purposes of each item and service provided to a Medicare enrollee by a provider, supplier, physician, or other practitioner. CMS may also collect data necessary to characterize the functional limitations of enrollees of each MA organization.
42 C.F.R. § 422.310(d).	**(1)** MA organizations must submit data that conform to CMS' requirements for data equivalent to Medicare fee-for-service data, when appropriate, and to all relevant national standards. CMS may specify abbreviated formats for data submission required of MA organizations. **(2)** The data must be submitted electronically to the appropriate CMS contractor. **(3)** MA organizations must obtain the risk adjustment data required by CMS from the provider, supplier, physician, or other practitioner that furnished the item or service. **(4)** MA organizations may include in their contracts with providers, suppliers, physicians, and other practitioners, provisions that require submission of complete and accurate risk adjustment data as required by CMS. These provisions may include financial penalties for failure to submit complete data. **(5)** For data described in paragraph (d)(1) of this section as data equivalent to Medicare fee-for-service data, which is also known as MA encounter data, MA organizations must submit a NPI in a billing provider field on each MA encounter data record, per CMS guidance.
42 C.F.R. § 422.504(h)(2).	The MA organization agrees to comply with . . . HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164.

Standard	Relevant Provision or Passage
Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program for All-Inclusive Care for the Elderly (PACE), Medicaid Fee-for-Service, and Medicaid Managed Care Programs for Years 2020 and 2021, 83 Fed. Reg. 54,982, 55,037 (proposed Nov. 1, 2018) (to be codified at 42 C.F.R. §§ 422, 423, 438, 498).	Entire Standard, including the following passage: When MA organizations certify that their diagnosis codes are ‘‘accurate’’ and ‘‘truthful’’ to the ‘‘best knowledge, information, and belief’’ of the certifying individual, the existence of adequate medical record documentation is one important standard by which accuracy and truthfulness are measured (42 CFR 422.504(l)(1)).
Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program for All-Inclusive Care for the Elderly (PACE), Medicaid Fee-for-Service, and Medicaid Managed Care Programs for Years 2020 and 2021, 83 Fed. Reg. 54,982, 55,037 (proposed Nov. 1, 2018) (to be codified at 42 C.F.R. §§ 422, 423, 438, 498).	Entire Standard, including the following passage: Diagnosis codes determine the risk scores, which in turn determine the risk-adjusted payments. As a result, MA organizations and providers must focus attention on complete, truthful, and accurate diagnosis reporting according to the official ICD-10-CM coding guidelines.
Medicare and Medicaid Programs; Policy and Technical Changes to the	Entire Standard, including the following passage:

Standard	Relevant Provision or Passage
Medicare Advantage, Medicare Prescription Drug Benefit, Program for All-Inclusive Care for the Elderly (PACE), Medicaid Fee-for-Service, and Medicaid Managed Care Programs for Years 2020 and 2021, 83 Fed. Reg. 54,982, 55,037 (proposed Nov. 1, 2018) (to be codified at 42 C.F.R. §§ 422, 423, 438, 498).	In general, the current risk adjustment methodology relies on enrollee diagnoses and encounters, as specified by the International Classification of Disease, currently the Tenth Revision Clinical Modification guidelines (ICD–10–CM), to prospectively adjust capitation payments for a given enrollee based on the health status of the enrollee.
Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program for All-Inclusive Care for the Elderly (PACE), Medicaid Fee-for-Service, and Medicaid Managed Care Programs for Years 2020 and 2021, 83 Fed. Reg. 54,982, 55,040 (proposed Nov. 1, 2018) (to be codified at 42 C.F.R. §§ 422, 423, 438, 498).	Entire Standard, including the following passage: This proposal would announce CMS' intention to recover improper payments based on extrapolation of payment error from RADV audit samples to MA organization specified populations.
Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program for	Entire Standard, including the following passage: We propose that MA organizations be required to remit funds that CMS calculates as improper payments through the extrapolated RADV audit findings in accordance with §§ 422.310(e).

Standard	Relevant Provision or Passage
All-Inclusive Care for the Elderly (PACE), Medicaid Fee-for-Service, and Medicaid Managed Care Programs for Years 2020 and 2021, 83 Fed. Reg. 54,982, 55,040 (proposed Nov. 1, 2018) (to be codified at 42 C.F.R. §§ 422, 423, 438, 498).	
Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs, 79 Fed. Reg. 29,844, 29,923 (May 23, 2014) (to be codified at 42 C.F.R. §§ 417, 422, 423, 424).	For many years organizations have been obliged to submit accurate, complete, and truthful payment-related data, as described at §§ 422.504(l) and 423.505(k). Further, CMS has required for many years that diagnoses that MA organizations submit for payment be supported by medical record documentation. Thus, we have always expected that MA organization or Part D sponsor implement, during the routine course of business, appropriate payment evaluation procedures in order to meet the requirement of certifying the data they submit to CMS for purposes of payment.
Medicare Program, Medicare+Choice Program, 65 Fed. Reg. 40,170, 40,176 (June 29, 2000).	As to the requirement for certifications as to the accuracy of data, we clearly explained in the preamble that we believed that since payments to M+C organizations are based on such data, the submission of the data is part of a ''claim'' for payment in the amount dictated by the data in question. We further explained that a certification of the accuracy of this information will help ensure accurate data submissions, and assist us and the DHHS Office of Inspector General in anti-fraud activities.
Medicare Program, Medicare+Choice Program, 65 Fed. Reg. 40,170, 40,268 (June 29, 2000).	In developing the certification forms M+C organizations would use to meet the payment data certification requirement, we consulted with OIG and DoJ in drafting language that requires the M+C organization to certify the accuracy, completeness, and truthfulness of this data based on "best knowledge, information, and belief." This language was included in the 1999 contract forms in recognition of the fact that M+C organizations cannot reasonably be expected to know that every piece of data is correct, nor is that the standard that HCFA, the OIG, and DOJ believe is reasonable to enforce.
Publication of the Office of the Inspector General's Compliance Program Guidance for	The requirement that the CEO or CFO certify as to the accuracy, completeness and truthfulness of data, based on best knowledge, information and belief, does not constitute an absolute guarantee of accuracy. Rather, it creates a duty on the Medicare+Choice organization to put in place an information collection and reporting system reasonably designed to yield accurate information. Further, the Medicare+Choice organization should exercise due diligence to ensure that

Standard	Relevant Provision or Passage
Medicare+Choice Organizations Offering Coordinated Care Plans, 64 Fed. Reg. 61,893, 61,900 (Nov. 15, 1999).	these systems are working properly. The exact methods used by the Medicare+Choice organization to accomplish this can be determined by the organization, however, it should ordinarily conduct sample audits and spot checks of this system to verify whether it is yielding accurate information.

EXHIBIT 2

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VIA EMAIL

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Re: ***United States ex rel. Osinek v. Kaiser Permanente, Case No. 3:13-cv-03891-EMC—Request for Consent for Defendants to Conduct Early Rule 30(b)(6) Deposition of the United States on Organizational Topics***

Dear Ms. Oberembt:

I write on behalf of Defendants Kaiser Foundation Health Plan, Inc. ("KFHP"), Kaiser Foundation Health Plan of Colorado, The Permanente Medical Group, Inc., Southern California Permanente Medical Group, and Colorado Permanente Medical Group, P.C. (collectively, "Defendants") in the above-referenced matter to seek your consent for Defendants' forthcoming deposition of the United States pursuant to Federal Rule of Civil Procedure 30(b)(6), focused on a discrete set of topics enumerated in the enclosed deposition notice ("Notice").[1] As reflected in the Notice, Defendants seek to depose the United States' representative(s) on or around November 14, 2022 or some other mutually convenient date about the organizational structure, responsibilities, processes, and document retention policies of the U.S. Department of Health and Human Services ("HHS") related to the statutes, rules, regulations, guidance documents, and contracts ("Standards") identified in the Notice (together, the "Organizational Topics"). For abundance of clarity, Defendants do *not* intend to examine the United States regarding its substantive contentions on the merits of the above-referenced case—for example, the United States' interpretation of the Standards referenced in the Notice. As explained here, the United States' continued response to KFHP's organizational-based written discovery *together with* Rule 30(b)(6) testimony on the Organizational Topics may resolve or at least narrow certain discovery disputes and allow Defendants to target future discovery requests, eliminating the need for the Court's intervention. Absent your agreement to an early Rule 30(b)(6) deposition on the

[1] Although the Ninth Circuit "has not decided whether a corporation is a 'deponent' subject to the limitations of Rule 30(a)(2)(A)(ii), or whether those limitations apply only to individual deponents," for purposes of this letter, Defendants intend to move the Court for leave to take more than one Rule 30(b)(6) deposition absent an agreement. *Heath v. Google LLC*, 2018 WL 4491368, at *2 (N.D. Cal. Sept. 19, 2018).

Organizational Topics, Defendants intend to move the Court for leave, which we expect will be readily granted for the reasons explained below.

Please confirm by October 20, 2022 (1) whether you agree to proceed with the Rule 30(b)(6) deposition so that the Organizational Topics go forward on or around November 14, 2022, and (2) when you plan to produce documents responsive to the written discovery that will facilitate the Rule 30(b)(6) deposition on Organizational Topics—*i.e.*, respond to KFHP's First Set of Requests for Production ("RFPs") Nos. 126 and 128 and Interrogatory No. 9, supplement your responses to KFHP's Interrogatories Nos. 3, 6, and 7, and further supplement your response to KFHP's Interrogatory No. 8.

I. The Parties' Discovery Record Demonstrates the Ripeness of a Rule 30(b)(6) Deposition on Organizational Topics.

The Northern District of California has recognized that the "one-deposition provision could be an obstacle to sensible handling of Rule 30(b)(6) organizational depositions," acknowledging "that there is a strong reason to take such depositions early in the case" to address foundational issues, like "a party's electronic information systems."[2] In such circumstances, it would be "counterproductive for that early and narrow deposition to foreclose a later deposition addressed to the merits of the case."[3] Here, Defendants seek to first depose the United States on the Organizational Topics so that Defendants can appropriately focus discovery during the balance of the fact discovery period, which is slated to close on March 25, 2024. Given the overall efficiencies to be achieved by such an early deposition, Defendants seek to conduct it without prejudicing their ability to depose the United States about the merits of its case later in discovery when Defendants expect to have received and reviewed substantial document productions from the United States.

As I am sure you will recall, Defendants first indicated that they would seek to take a foundational Rule 30(b)(6) deposition during the parties' Rule 26(f) conference.[4] Defendants explained then that such a deposition is necessary to advance the parties' interests in expeditious and targeted fact discovery.[5] You objected to this request on two grounds: (1) a foundational deposition would be duplicative and premature because KFHP had "already served interrogatories asking for the same information" and (2) such a deposition is unnecessary because the United States "did not serve any interrogatories on Kaiser during its investigation, nor did it require Kaiser to prepare any witnesses for a 'foundational' deposition of the sort Kaiser now proposes."[6] Both objections are baseless and we urge you to reconsider these objections to avoid burdening the Court with further motions practice.

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[2] *Id.* at *2 (quoting Richard A. Marcus, *Federal Practice & Procedure* § 2104 (3d ed., 2018 Supp.) (internal quotation marks omitted)).

[3] *Id.*

[4] Joint Case Mgmt. Statement and Rule 26(f) Rep. ("Joint Rule 26(f) Report") 17-18, Feb. 8, 2022, ECF No. 150.

[5] *Id.* at 18.

[6] *Id.* at 16-17.

A. Rule 30(b)(6) Deposition on Organizational Topics Is Not Duplicative.

Your first objection is contradicted by the parties' discovery record in this case. You now have responded to KFHP's seven organizational-based RFPs and Interrogatories, lodging objections to these requests as, essentially, overbroad and in some instances, irrelevant.[7] Where the United States does respond, its responses are insufficient for KFHP to understand how HHS is organized and which current and former government officials are likely to have knowledge about the disputed issues in this case—basic information that is foundational to KFHP's ability to continue to craft targeted substantive discovery requests.[8] Indeed, in Appendix A to your June 17, 2022 letter, you stated that the United States intends to produce documents responsive to RFP No. 126—which seeks names, titles, and reporting structure of personnel from four specific divisions of CMS—and to supplement your responses to Interrogatories Nos. 6 through 8—which seek the identities of the individuals responsible for reviewing Defendants' addenda, risk adjustment data, and risk adjustment attestations.[9] Following up on your June 17, 2022 representations, on July 15, 2022, KFHP asked if you would agree to commence those document productions by July 29, 2022. We specifically sought confirmation that the United States would commence production of (a) "documents from at least [CMS] and [HHS-OIG] responsive to the RFPs on which the parties substantially agree," including RFP No. 126, and (b) "supplement your responses to Interrogatory Nos. 1, 3, 6, 7, and 8."[10] On August 16, 2022, having not received further information or documents responsive to this subset of organizational-based RFPs and Interrogatories, KFHP reiterated its request that you begin to produce documents and information responsive to the requests identified in its earlier correspondence.[11] To date, however, you only have provided a partial supplemental response to Interrogatory No. 8,[12]

[7] *See* United States' Responses and Objections to KFHP's First Set of Requests for Production, Feb. 28, 2022, at 55-56 & 58-59 (objecting to RFP Nos. 126 and 128 on relevance, overbreadth, and proportionality/burden grounds and refusing to respond at all to RFP No. 128 (which seeks the names and titles of personnel who developed certain Standards) while agreeing to search for and produce documents responsive to RFP No. 126 (which seeks "CMS employee names, titles, and lines of authority (Including but not limited to organizational charts)" from four CMS departments) *and* United States' Responses and Objections to KFHP's First Set of Interrogatories, Feb. 28, 2022, at 7 & 9-12 (refusing to respond to Interrogatory No. 9 and offering a partial or insufficient response to Interrogatories Nos. 3, 6, 7, and 8). *See also* United States' First Amended and Supplemental Responses and Objections to KFHP's First Set of Interrogatories, Sept. 15, 2022, at 13-14 (partially supplementing response to KFHP's Interrogatory No. 8—based on a clarified understanding of the term "Review"—by listing seven individuals who "Reviewed Defendants' Risk Adjustment Attestations" and indicating that the United States would continue to supplement this response).

[8] *See id.*

[9] June 17, 2022 Letter from DOJ to KFHP, Appendix A, at 238-40 & 263-66.

[10] July 15, 2022 Letter from KFHP to DOJ, at 2.

[11] August 16, 2022 Letter from KFHP to DOJ, at 1-2.

[12] *See* United States' First Amended and Supplemental Responses and Objections to KFHP's First Set of Interrogatories, Sept. 15, 2022, at 12-14 (partially supplementing response to KFHP's Interrogatory No. 8 based on a clarified understanding of the term "Review," but not supplementing responses to other organizational-based Interrogatories that use the term "Review"—Interrogatory No. 6 ("Identify all Persons who Reviewed Defendants' Addenda") and Interrogatory No. 7 ("Identify all Persons who Reviewed Defendants' Risk Adjustment Data")).

without further information or documents responsive to KFHP's remaining organizational-based RFPs and Interrogatories.

This example demonstrates why relying on written discovery alone to obtain organizational information is inefficient and delays the progress of meaningful merits discovery. We submit that the time is right for a Rule 30(b)(6) deposition on Organizational Topics.

The cases the United States cites in the Joint Rule 26(f) Report to support its contention that a Rule 30(b)(6) deposition on Organizational Topics will be duplicative of future Rule 30(b)(6) deposition testimony on substantive issues are inapposite. In *Bank of America, N.A. v. SFR Investments Pool 1 LLC*, the court granted plaintiff's motion for a protective order to preclude the Rule 30(b)(6) deposition as duplicative because the notice was served "contemporaneously with [defendant's] written discovery requests" and, thus, "was not reasonably tailored to inquire into those factual or legal issues that were not fully or adequately covered by [plaintiff's] written discovery responses."[13] The court further acknowledged that plaintiff's written discovery responses "may provide [defendant] with legitimate grounds" to "conduct a follow-up Rule 30(b)(6) deposition."[14] But unlike in *Bank of America*, Defendants here did not serve their Notice contemporaneously with written discovery; rather, they sent it more than seven months after receiving the United States' February 28, 2022 responses and objections to KFHP's First Sets of RFPs and Interrogatories, and after protracted meet-and-confer discussions with the United States did not produce all of the responsive information requested. Moreover, Defendants have tailored the Notice to discrete Organizational Topics as informed by the parties' meet-and-confer correspondence.

And in *Gen-Probe Inc. v. Becton, Dickinson & Co.*, the court did not make a blanket assertion that interrogatories are a necessarily more effective means of discovery than a Rule 30(b)(6) deposition. Rather, the court's inquiry was proscribed to "[w]hether 'contention' 30(b)(6) topics are appropriate" in a case involving patent enforcement.[15] The court found that "where the contention topics relate to questions of infringement and invalidity," the Rule "30(b)(6) deposition would be unduly burdensome and the discovery would be more efficiently conducted through contention interrogatories."[16] Unlike in *Gen-Probe*, the Organizational Topics in the Notice do not seek testimony regarding the United States' substantive contentions and positions on the merits of the case.

B. A Rule 30(b)(6) Deposition on Organizational Topics Is Particularly Justified Given the Discovery Asymmetry Between the Parties.

As to your second objection, throughout its eight-year pre-suit investigation, the U.S. Department of Justice ("DOJ") sought and received substantial discovery from Defendants comprising "314 separate volumes of documents, collectively containing nearly 900,000

[13] *Bank of Am., N.A. v. SFR Inv. Pool 1 LLC*, 2016 WL 2843802, at *3 (D. Nev. May 12, 2016).

[14] *Id*. at *4.

[15] *Gen-Probe Inc. v. Becton, Dickinson & Co.*, 2012 WL 12845593, at *1 (S.D. Cal. Mar. 28, 2012).

[16] *Id*. at *2.

documents and nearly 4.7 million pages"[17] and six examinations of former and current personnel.[18] Based on this one-sided discovery, the United States already possesses meaningful information about Defendants' organizational structure, allowing it to identify key departments and individuals at the various Defendant entities. KFHP's request for the United States' consent to an early Rule 30(b)(6) testimony on the Organizational Topics would begin to level the informational asymmetry between the parties; even so, KFHP reiterates its offer from the Joint Rule 26(f) Report for this agreement to apply reciprocally to the United States.[19]

II. An Early Rule 30(b)(6) Deposition on Organizational Topics Benefits the Court and Both Parties.

The United States should agree to Defendants' request for an early foundational Rule 30(b)(6) deposition on Organizational Topics because it would also benefit the Court and both parties.

A. A Rule 30(b)(6) Deposition on the Organizational Topics May Resolve or Narrow Current Discovery Disputes.

Certain discovery disputes may be resolved, or at least narrowed, through a Rule 30(b)(6) deposition on Organizational Topics. For example, to date, the parties have been unable to reach an agreement regarding the definition of "You" and "Your"—terms that permeate KFHP's January 26, 2022 First Sets of RFPs and Interrogatories. As explained in its July 15, 2022 letter, KFHP has offered a middle ground approach for DOJ to search for responsive documents and information within only a single agency—HHS—but DOJ has refused this compromise.[20] A

[17] Joint Rule 26(f) Report, at 7.

[18] July 27, 2022 Letter from DOJ to KFHP regarding Production Vol. 1 (describing production of "transcripts of testimony and exhibits" for six current and former personnel during the investigation where DOJ questioned each individual about Defendants' organizational structure, reporting lines, and key personnel). *See, e.g.*, Andersen Dep. 36:22–24, Oct. 1, 2020, US-DOJ-KAISER-00000010 at US-DOJ-KAISER-00000045 ("Encounter Information Operations, what was their role in the way coding went down in the Northern California region?"); Bliss Dep. 92:9–12, Oct. 2, 2020, US-DOJ-KAISER-00000570 at US-DOJ-KAISER-00000661 ("And what is [the CMS lead's] specific job … relating to CMS?"); Franklin Dep. 43:15–20, Oct. 7, 2020, US-DOJ-KAISER-00001114 at US-DOJ-KAISER-00001156 ("So you talked a little about the NCO and mentioned the Medicare regional reporting group, the RRG? ... Q: Is that a department within Kaiser? Can you discuss what the RRG is?"); Graham Dep. 135:11, Oct. 5, 2020, US-DOJ-KAISER-00002241 at US-DOJ-KAISER-00002375 ("What is the program office?"); Walsleben Dep. 35:2–14, Sept. 29, 2020, US-DOJ-KAISER-00002827 at US-DOJ-KAISER-00002861 ("[N]ational Medicare finance … is part of the programs office; is that correct? … Q: What other entities are part of the programs office? … Q: [W]ho does the programs office report to?"); Welsh Dep. 60:6–17, Oct. 2, 2020, US-DOJ-KAISER-00003263 at US-DOJ-KAISER-00003322 ("There's two pages to this exhibit which are two organizational charts for Colorado risk adjustment. … Q: Does this generally look like the structure of … the people that you were working with on risk adjustment issues in Colorado?").

[19] Joint Rule 26(f) Report, at 18.

[20] *See* Aug. 16, 2022 Letter from KFHP to DOJ, at 2 n.4; Aug. 1, 2022 Letter from KFHP to DOJ, at 4 n.9; July 22, 2022 Letter from DOJ to KFHP, at 1-2; July 15, 2022 Letter from KFHP to DOJ, at 2-4; June 17, 2022 Letter from DOJ to KFHP, at 1-2.

Rule 30(b)(6) deposition on Organizational Topics would provide Defendants the information necessary to identify the HHS divisions and persons to which discovery should be targeted, likely resolving the instant dispute over the definition of "You" and "Your" and enabling KFHP to tailor future discovery requests to specific HHS divisions or personnel. Using the Rule 30(b)(6) deposition to resolve this core dispute—and potentially other disputes around relevance, scope, and burden—may prevent time-consuming motion practice before the Court.

B. A Rule 30(b)(6) Deposition on the Organizational Topics Allows for More Efficient and More Targeted Future Discovery of the United States.

Proceeding with a Rule 30(b)(6) deposition on Organizational Topics as the United States continues responding to written discovery is the most efficient method for obtaining organizational information from the United States. The United States' limited responses to KFHP's Interrogatories Nos. 3, 6, 7, and 8 and entirely lacking responses to KFHP's RFP Nos. 126 and 128 and Interrogatory No. 9[21] underscore the need to couple written discovery in tandem with a Rule 30(b)(6) deposition on Organizational Topics.[22]

In *English v. Washington Metropolitan Area Transit Authority*, for example, the court granted the plaintiff's motion to compel further responses to specific written discovery requests and denied the defendant's motion for a protective order preventing the plaintiff from taking a Rule 30(b)(6) deposition where defendants failed to provide (a) sufficient detail in their interrogatory responses about how the incident at issue occurred and (b) identifying information about the persons involved.[23] Defendants in *English* argued that the 30(b)(6) deposition topics would be "unreasonably cumulative and/or duplicative" of written discovery requests but the court dismissed this argument, noting that "[t]here is no rule that prohibits a party from deposing witnesses on the same topics that have been addressed in written discovery" and that depositions "typically provide an opportunity to further probe the facts elicited through interrogatories and requests for production."[24]

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[21] *See* United States' Responses and Objections to KFHP's First Set of Interrogatories, Feb. 28, 2022, at 7, 9-10; United States' Responses and Objections to KFHP's First Set of RFPs, Feb. 28, 2022, at 55-56 & 58-59; United States' First Amended and Supplemental Responses and Objections to KFHP's First Set of Interrogatories, Sept. 15, 2022, at 13-14. *See also* June 17, 2022 Letter from DOJ to KFHP, Appendix A, at 238-40 & 246-47 (memorializing parties' positions on KFHP's RFP Nos. 126 & 128); 255-58 & 263-70 (memorializing parties' positions on KFHP's Interrogatories Nos. 3, 6-9); May 18, 2022 Letter from KFHP to DOJ (explaining deficiencies with United States' RFP responses in Appendix A and deficiencies with United States' Interrogatory responses in Appendix B).

[22] *See Bank of Am.*, 2016 WL 2843802, at *4 (noting that written discovery responses "may provide [defendant] with legitimate grounds to either seek supplementation of the written responses, conduct a follow-up Rule 30(b)(6) deposition, or possibly both").

[23] 323 F.R.D. 1, 18-21 (D.D.C. 2017).

[24] *Id*. at 26.

Here, as in other cases, a foundational Rule 30(b)(6) deposition benefits both parties by providing an efficient means for targeting future written discovery and deposition requests.[25]

* * *

Please confirm by October 20, 2022 (1) whether you consent to an early Rule 30(b)(6) deposition of the United States on the Organizational Topics, and (2) when you plan to produce documents responsive to KFHP's RFP Nos. 126 and 128, respond to KFHP's Interrogatories Nos. 3 and 9, supplement your responses to KFHP's Interrogatories Nos. 6 and 7, and further supplement your response to KFHP's Interrogatory No. 8. If you object, please provide your availability for a meet and confer.

Sincerely,

/s/ *Stephen M. Sullivan*

Stephen M. Sullivan
Partner
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cc: (via email only)
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Dimitri Portnoi, Esq.

Enclosure

[25] *See Diaz v. Cuatro T Constr., Inc.*, 2021 WL 2709681, at *1 n.2 (W.D. Tex. Mar. 19, 2021) (noting that "conducting a Rule 30(b)(6) deposition in the first instance may (i) narrow the scope of the topics covered in subsequent depositions and/or (ii) refine the lines of questioning that are pursued in subsequent depositions"); *News Am. Mktg. In-Store Servs., LLC v. Floorgraphics, Inc.*, 2012 WL 1986493, at *3 (D.N.J. May 30, 2012) (finding that a Rule 30(b)(6) deposition was the preferred means of resolving electronic discovery disputes between the parties where the dispute concerned information uniquely available to defendants).

EXHIBIT 3

U.S. Department of Justice

Civil Division

JAY:PLH:LAOberembt
DJ No. 46-11-3388

(202) 514-3345

Washington, DC 20530

November 3, 2022

VIA EMAIL

Stephen Sullivan, Esq.
O'Melveny & Myers LLP
400 South Hope Street
18th Floor
Los Angeles, CA 90071-2899

Re: *United States ex rel. Osinek v. Kaiser Permanente*, Case No. 3:13-cv-0381-EMC – Request for Consent for Defendants to Conduct Early Rule 30(b)(6) Deposition of United States on Organizational Topics

Dear Mr. Sullivan:

I write on behalf of the United States in response to Defendants' letter of October 28, 2022, regarding the October 27, 2022 meet-and-confer. The meet-and-confer and your letter concerned two discovery-related issues: (1) the United States' responses to Kaiser's Interrogatory Nos. 1 and 2 and Request for Production ("RFP") No. 64; and (2) Kaiser's proposed "foundational" Rule 30(b)(6) deposition. We are writing to respond to points raised in Section II.b of your letter, concerning certain aspects of the proposed Rule 30(b)(6) deposition.

As we explained in our October 20 letter, we do not think your proposal to take one Rule 30(b)(6) deposition of the United States now and an additional Rule 30(b)(6) deposition in the future is appropriate. It is not legally supported and would impose unnecessary burden. During the October 27 meet-and-confer, we stated that the type of information sought in Kaiser's proposed Rule 30(b)(6) Notice is more appropriately sought through written discovery (i.e., interrogatories or requests for production). We anticipated that Kaiser would serve *additional* written discovery seeking the information not covered by its existing discovery requests.

Instead, in your letter you asked us to "search for and produce information and documents addressing all aspects of the deposition topics" and requested that we prioritize producing documents responsive to certain specific topics. If Kaiser would like the United States to conduct searches specifically aimed at the documents listed in the proposed 30(b)(6) Notice, then it should serve discovery requests asking for that information. Short of that, the United States will not prioritize searches for documents based on a proposed 30(b)(6) Notice.

During the meet-and-confer, you asked whether we might be able to avoid a dispute about the early Rule 30(b)(6) deposition if Kaiser issued *new* requests seeking the information in the Rule 30(b)(6) Notice. Instead, your October 29 letter memorializing the meet-and-confer lists a number of broad non-organizational RFPs already served by Kaiser that were not discussed during the meet-and-confer that you now claim overlap with the Rule 30(b)(6) deposition topics. Even if we agreed that the listed RFPs encompassed the information sought by the proposed Rule 30(b)(6) topics, it is impractical to respond to these RFPs piecemeal in a manner that "prioritizes" any such overlap, and we do not plan to do so.[1] This is particularly true given that the United States (1) has numerous outstanding objections to many of these RFPs[2]; and (2) has not been given an opportunity to make objections specific to the Rule 30(b)(6) topics.

We hope that this letter clarifies our position regarding Section II.b of your letter. While we agree that written discovery would be more efficient than the proposed foundational Rule 30(b)(6) Notice, we cannot agree to treat the proposed Rule 30(b)(6) topics as if they were valid requests for written discovery.

Sincerely,

Laurie A. Oberembt

Laurie A. Oberembt
Senior Trial Counsel

Cc: Assistant U.S. Attorney Shiwon Choe (N.D. Cal.)
Assistant U.S. Attorney David Moskowitz (D. Co.)
Assistant U.S. Attorney Ben Wolinsky (N.D. Cal.)

[1] In contrast, as discussed during our meet-and-confer, we are willing to prioritize proper requests for written discovery seeking exclusively the sort of "organizational" information encompassed by the proposed Rule 30(b)(6) topics—including, for example, Request 126.

[2] *See* June 17, 2022 Letter from DOJ to Kaiser, Appendix A. Of the thirteen RFPs listed in your letter, the only requests we consider resolved are Requests 5, 8, and 65. The United States has already begun reviewing and producing documents responsive to those requests.

EXHIBIT 4

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, *ex rel.*, RONDA OSINEK

Plaintiffs,

v.

KAISER PERMANENTE,

Defendant.

Case No. No. 3:13-cv-03891-EMC

KAISER FOUNDATION HEALTH PLAN, INC.'S SECOND SET OF REQUESTS FOR PRODUCTION TO PLAINTIFF, UNITED STATES OF AMERICA

(CAPTION CONTINUED)

UNITED STATES OF AMERICA ex rel. ANASER AREFI, AJITH KUMAR and PRIME HEALTHCARE SERVICES, INC., Plaintiff, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	Case No. 3:16-cv-01558-EMC **KAISER FOUNDATION HEALTH PLAN, INC.'S SECOND SET OF REQUESTS FOR PRODUCTION TO PLAINTIFF, UNITED STATES OF AMERICA**
UNITED STATES OF AMERICA ex rel. MARCIA STEIN and RODOLFO BONE, Plaintiff, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	Case No. 3:16-cv-05337-EMC **KAISER FOUNDATION HEALTH PLAN, INC.'S SECOND SET OF REQUESTS FOR PRODUCTION TO PLAINTIFF, UNITED STATES OF AMERICA**
UNITED STATES OF AMERICA ex rel. GLORYANNE BRYANT and VICTORIA HERNANDEZ, Plaintiff, v. KAISER PERMANENTE, INC., et al, Defendants.	Case No. 3:18-cv-01347-EMC **KAISER FOUNDATION HEALTH PLAN, INC.'S SECOND SET OF REQUESTS FOR PRODUCTION TO PLAINTIFF, UNITED STATES OF AMERICA**
UNITED STATES OF AMERICA and STATE OF CALIFORNIA ex rel. MICHAEL BICOCCA, Plaintiffs, v. PERMANENTE MEDICAL GROUP, INC., et al.,	Case No. 3:21-cv-03124-EMC **KAISER FOUNDATION HEALTH PLAN, INC.'S SECOND SET OF REQUESTS FOR PRODUCTION TO PLAINTIFF, UNITED STATES OF AMERICA**

Defendants.

UNITED STATES OF AMERICA ex rel. JAMES M. TAYLOR,

Plaintiff,

v.

KAISER PERMANENTE, INC., et al.,

Defendants.

Case No. 3:21-cv-03894-EMC

KAISER FOUNDATION HEALTH PLAN, INC.'S SECOND SET OF REQUESTS FOR PRODUCTION TO PLAINTIFF, UNITED STATES OF AMERICA

PROPOUNDING PARTY: Defendant Kaiser Foundation Health Plan, Inc.

RESPONDING PARTY: Plaintiff United States

SET NUMBER: Two (Numbers 131 - 149)

Pursuant to Rules 26 and 34 of the Federal Rules of Civil Procedure and the Local Rules for the United States District Court for the Northern District of California ("Local Rules"), Defendant Kaiser Foundation Health Plan, Inc. ("Defendant") propounds this Second Set of Requests for Production of Documents ("Requests") on Plaintiff United States of America ("Plaintiff"). Defendant requests that Plaintiff produce all responses to these Requests to O'Melveny & Myers LLP, Two Embarcadero Center, 28th Floor, San Francisco, California 94111 within thirty (30) calendar days of the date of service, or at such other date and/or location upon which counsel for the parties may agree.

The following definitions and instructions apply to these Requests.

DEFINITIONS

Each word, term, or phrase defined below and used in these Requests is intended to have the broadest meaning permitted under the Federal Rules of Civil Procedure and the Local Rules.

1. "Addenda" means "addendum" as used in Paragraph 129 of the Complaint.

2. "CMS" means the U.S. Centers for Medicare & Medicaid Services, its agencies, departments, agents, representatives, contractors, consultants, and all other Persons acting on its

behalf.

3. "Coding Clinic" means the "official publication for ICD-9-CM coding guidelines and advice as designated by the American Hospital Association, AHIMA, CMS, and the NCHS" that is "published quarterly by the American Hospital Association," as defined in the CMS Risk Adjustment Data Technical Assistance for Medicare Advantage Organizations Participant Guide, at 6-13 (2008).

4. "Communication" means the transmittal of information (in the form of facts, ideas, inquiries, or otherwise) and refers to every manner or means of disclosure, transfer, or exchange of information orally or in writing, and to both actual and attempted communications of any kind.

5. "Complaint" means the amended complaint-in-intervention that Plaintiff filed in the above-captioned case (Dkt. 240) on December 12, 2022.

6. "Develop(s)" means to create or produce.

7. "Diagnosis Coding" means "Diagnosis Coding" as defined in the United States' February 25, 2022 First Set of Requests for Production to Defendants.

8. "Division" or "Divisions" means any department, unit, component, arm, section, subdivision, branch, section, sector, or office, as that term is used on the HHS.gov website (https://www.hhs.gov/about/agencies/hhs-agencies-and-offices/index.html and https://www.hhs.gov/about/agencies/orgchart/index.html), and Includes any contractors, vendors, volunteers, agents, affiliates, or anyone acting at HHS's direction.

9. "Document" or "Documents" means all electronically-stored information ("ESI") and written matter of every type, Including Communications, as the term is broadly defined under Rule 34 of the Federal Rules of Civil Procedure.

10. "Exhibit A" means Exhibit A to KFHP's Second Set of Requests for Production.

11. "HHS" means the U.S. Department of Health and Human Services, as used in Paragraph 12 of the Complaint, and all of the Divisions within HHS.

12. "Include" or "Including" means "without limitation" and shall be construed as broadly as possible.

13. "Interpret(s)" or "Interpreting" means to understand or explain the meaning of information, words, or actions.

14. "Identify" or "Identification" when referring to the identification of a Person, means to give, to the extent known, the Person's full name, present or last known residence address and telephone number, their current and past positions and titles as well as the dates during which they held those positions and titles, the present or last known place of employment and the business address and telephone number and email. When referring to the identification of an organization, "Identify" or "Identified" means the organization's full name and the address of its principal place of business. When referring to the identification of Documents, "Identify" or "Identified" means to give to the extent known the: (a) type of Document; (b) general subject matter; (c) the format in which it is maintained (e.g., written Document, computer file (and filetype), audio or video recording, or any other form); (d) location of the Document; (e) name and address of the custodian of the Document (f) date of the Document; and (g) author(s), addressee(s), and recipient(s).

15. "KFHP" means Kaiser Foundation Health Plan, Inc.

16. "KFHP-CO" means Kaiser Foundation Health Plan of Colorado.

17. "Medicare Advantage Contract" means a contract between an MA Plan or MAO and CMS, Including any contract alleged in Paragraph 76 of the Complaint.

18. "MAO" means "MA Organizations" as used in Paragraph 57 of the Complaint.

19. "MA Plan" means "MA plans" as used in Paragraph 57 of the Complaint.

20. "Overview" means a general explanation or summary.

21. "Participation" or "Participating" means the action of taking part in or being involved in something.

22. "Person" or "Persons" means any natural person or entity, firm, association, organization, partnership, business, trust, corporation, electronic mailbox, or public entity, and their officers, directors, members, principals, employees, agents, contractors, representatives, parents, acquisitions, successors or predecessors, all persons acting on their behalf, and any and

all persons associated with, affiliated with, or controlled by them.

23. "Process," "Processes," and "Processing" means the series of actions or steps to achieve a particular end or carry out a particular task.

24. "Promulgate(s)" means "promulgated" as used in Paragraph 75 of the Complaint.

25. "Received" means to have been given or to have taken delivery of something.

26. "Responsibilities" means "responsibilities" as used in the United States' February 25, 2022 First Sets of Requests for Production and Interrogatories to Defendants.

27. "Responsible" means "responsible" as used in the United States' February 25, 2022 First Sets of Requests for Production and Interrogatories to Defendants.

28. "Review(s)" or "Reviewing" means assessments, analyses, evaluations, or examinations of various types, Including as exemplified in the multiple uses of the term within 42 C.F.R. § 422.311.

29. "Risk Adjustment Attestation" means "Risk Adjustment Attestation" as used in Paragraph 81 of the Complaint.

30. "Risk Adjustment Data" means "risk adjustment data" as used in Paragraph 3 of the Complaint.

31. "Risk Adjustment Data Validation Audits" means audits conducted by or on behalf of CMS pursuant to 42 CFR §§ 422.2 and 422.311(a).

32. "Risk Adjustment Payments" means "risk-adjustment payments" as used in Paragraph 14 of the Complaint.

33. "Standards" means statutes, rules, regulations, guidance documents, or contracts related to the parties' claims and defenses in this action, Including the meaning of the term "standards" as used in the headings to Sections V.B and VI and in Paragraphs 5-7, 62, 83, 92, 136, 158, 171, 207, 208, 210, 217 of the Complaint.

34. "You" or "Your" means all Divisions within the United States Department of Health and Human Services.

INSTRUCTIONS

1. Each Request extends to any Documents in the possession, custody, or control of Your employees, agents, or representatives.

2. Each non-identical copy of a Document, whether different from the original because of indications of the recipient(s), handwritten notes, marks, attachments, marginalia, or any other reason, is a separate Document that must be Identified.

3. If You object to a Request on the ground of privilege, You must respond to the Request by providing such non-privileged Documents as are responsive.

4. If for any reason You withhold any Document or portion of a Document is responsive to these Requests, you shall provide a log entry describing the Document in accordance with the privilege log provisions set forth in the Joint Stipulation and Order Re: Discovery of Electronically Stored Information, Dkt. No. 189.

5. If You object to any portion of a Request, You must provide Documents responsive to the remaining portion.

6. If the basis of an objection to any Request, or any portion thereof, is a statute, contract or other agreement, or any other obstacle to production that You assert is based in the law, You must Identify that legal obstacle with specificity.

7. These Requests are continuing in nature and You should produce additional Documents as they become known or available to You as required by Rule 26(e).

8. You shall Identify, by control number, the Documents responsive to each Request herein.

9. Any noun used in the singular form shall be construed and applied so as to Include the plural form also, and vice versa.

10. The words “and” and “or” shall be construed either conjunctively or disjunctively, as required by the context to bring all information within the scope of these Requests.

11. If You believe the meaning of any term in any Request is unclear, then You must assume a reasonable meaning, state what that assumed meaning is, and respond to the Request according to that assumed meaning.

12. While some Requests may seek Documents from earlier periods, unless otherwise indicated, the relevant time period for these Requests is January 1, 2009 through present.

REQUESTS FOR PRODUCTION

REQUEST NO. 131:

Documents sufficient to show the organizational structure of any HHS Division that Develops, Reviews, Promulgates, or Interprets the Standards in Exhibit A.

REQUEST NO. 132:

Documents sufficient to show the Responsibilities of any HHS Division that Develops, Reviews, Promulgates, or Interprets the Standards in Exhibit A.

REQUEST NO. 133:

Documents sufficient to Identify the Persons within each HHS Division who Develop, Review, Promulgate, or Interpret the Standards in Exhibit A.

REQUEST NO. 134:

Documents sufficient to show the organizational structure of any HHS Division that Develops, Reviews, Promulgates, or Interprets Medicare Advantage Contracts, Including Medicare Advantage Contracts between KFHP and CMS and KFHP-CO and CMS.

REQUEST NO. 135:

Documents sufficient to show the Responsibilities of any HHS Division that Develops, Reviews, Promulgates, or Interprets Medicare Advantage Contracts, Including Medicare Advantage Contracts between KFHP and CMS and KFHP-CO and CMS.

REQUEST NO. 136:

Documents sufficient to Identify the Persons within each HHS Division who Develop, Review, Promulgate, or Interpret Medicare Advantage Contracts, Including Medicare Advantage Contracts between KFHP and CMS and KFHP-CO and CMS.

REQUEST NO. 137:

Documents sufficient to Identify the location of Documents stored and retained by any HHS Division Concerning the Standards in Exhibit A.

REQUEST NO. 138:

Documents sufficient to Identify the location of Documents stored and retained by any HHS Division Concerning Medicare Advantage Contracts, Including Medicare Advantage Contracts between KFHP and CMS and KFHP-CO and CMS.

REQUEST NO. 139:

Documents sufficient to Identify the Persons within HHS Responsible for storing and retaining Documents Concerning the Standards in Exhibit A.

REQUEST NO. 140:

Documents sufficient to Identify the Persons within HHS Responsible for storing and retaining Documents Concerning Medicare Advantage Contracts, Including Medicare Advantage Contracts between KFHP and CMS and KFHP-CO and CMS.

REQUEST NO. 141:

Documents sufficient to Identify all Persons Responsible for Reviewing or Interpreting Diagnosis Coding.

REQUEST NO. 142:

Documents sufficient to show an Overview of the Process or Processes used by any HHS Division Concerning Addenda, Including the Identification of all Persons Responsible for Reviewing or Interpreting Addenda.

REQUEST NO. 143:

Documents sufficient to show an Overview of the Process or Processes used by any HHS Division Concerning Diagnosis Coding Standards, Including the Identification of all Persons Responsible for Reviewing or Interpreting Diagnosis Coding Standards.

REQUEST NO. 144:

Documents sufficient to show an Overview of the Process or Processes used by any HHS

Division Concerning Medicare Advantage Contracts, Including the Identification of all Persons Responsible for Reviewing or Interpreting Medicare Advantage Contracts.

REQUEST NO. 145:

Documents sufficient to show an Overview of the Process or Processes used by any HHS Division Concerning Risk Adjustment Data Validation Audits, Including the Identification of all Persons Responsible for Reviewing or Interpreting Risk Adjustment Data Validation Audits.

REQUEST NO. 146:

Documents sufficient to show an Overview of the Process or Processes used by any HHS Division Concerning Risk Adjustment Attestations, Including the Identification of all Persons Responsible for Reviewing or Interpreting Risk Adjustment Attestations.

REQUEST NO. 147:

Documents sufficient to show an Overview of the Process or Processes used by any HHS Division Concerning Processing Risk Adjustment Data Received from MAOs or other entities, Including the Identification of all Persons Responsible for Processing, Reviewing, or Interpreting Risk Adjustment Data.

REQUEST NO. 148:

Documents sufficient to show an Overview of the Process or Processes used by any HHS Division Concerning Risk Adjustment Payments disbursed by CMS to MAOs, Including the Identification of all Persons Responsible for Risk Adjustment Payments disbursed by CMS.

REQUEST NO. 149:

Documents sufficient to show an Overview of the Process or Processes used by any HHS Division Concerning Participation in Coding Clinic, Including the Identification of all Persons Participating in Coding Clinic.

Dated: December 15, 2022

O'MELVENY & MYERS LLP

By: /s/ *Stephen M. Sullivan*

K. LEE BLALACK, II
DAVID DEATON
STEPHEN M. SULLIVAN
CAITLIN M. BAIR
DIMITRI D. PORTNOI

Attorneys for Defendant Kaiser Foundation Health Plan, Inc.

Exhibit A to KFHP's Second Set of Requests for Production

Standard	
ICD-9-CM Official Guidelines for Coding and Reporting, Section I.V.I.	**I. Uncertain diagnosis** Do not code diagnoses documented as "probable", "suspected," "questionable," "rule out," or "working diagnosis" or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit. Please note: This differs from the coding practices used by short-term, acute care, long-term care and psychiatric hospitals.
ICD-9-CM Official Guidelines for Coding and Reporting, Section I.V.J.	**J. Chronic diseases** Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).
ICD-9-CM Official Guidelines for Coding and Reporting, Section I.V.K.	**K. Code all documented conditions that coexist** Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (V10-V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.
ICD-10-CM Official Guidelines for Coding and Reporting, Section I.A.19.	**19. Code assignment and Clinical Criteria** The assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists. The provider's statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.
ICD-10-CM Official Guidelines for Coding and Reporting, Section IV.H.	**H. Uncertain diagnosis** Do not code diagnoses documented as "probable", "suspected," "questionable," "rule out," "compatible with," "consistent with," or "working diagnosis" or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit. Please note: This differs from the coding practices used by short-term, acute care, long-term care and psychiatric hospitals.
ICD-10-CM Official Guidelines for Coding and Reporting, Section IV.I.	**I. Chronic diseases** Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).
ICD-10-CM Official Guidelines for Coding and Reporting, Section IV.J.	**J. Code all documented conditions that coexist** Code all documented conditions that coexist at the time of the encounter/visit and that require or affect patient care, treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.
CMS Medicare Program Integrity Manual, Ch. 3.	Regardless of whether a documentation submission originates from a paper record or an electronic health record, documents submitted to MACs, CERT, Recovery Auditors, SMRC and UPICs containing amendments, corrections or addenda must: 1. Clearly and permanently identify any amendment, correction or delayed entry as such, and 2. Clearly indicate the date and author of any amendment, correction or delayed entry, and 3. Clearly identify all original content, without deletion.

Standard	
CMS HHS Center for Consumer Information and Insurance Oversight, 2016 Benefit Year Protocols, PPACA HHS – Operated Risk Adjustment Data Validation (Version 14, Oct. 20, 2017) ("2016 Benefit Year Protocols"), at 70-74.	**Section 5.6.11 - Diagnosis Abstraction Coding**.
2016 Benefit Year Protocols, at 102-04.	**Appendix C: Chronic Condition HCCs**.
CMS HHS Center for Consumer Information and Insurance Oversight, 2017 Benefit Year Protocols, PPACA HHS – Operated Risk Adjustment Data Validation (Version 1, May 21, 2018) ("2017 Version 1 Benefit Year Protocols"), at 72-76.	**Section 5.6.11 - Diagnosis Abstraction Coding**.
2017 Version 1 Benefit Year Protocols, at 124-25.	**Appendix C: Chronic Condition HCCs**.
CMS HHS Center for Consumer Information and Insurance Oversight, 2017 Benefit Year Protocols, PPACA HHS – Operated Risk Adjustment Data Validation (Version 2, Aug. 10, 2018) ("2017 Version 2 Benefit Year Protocols"), at 72-77.	**Section 5.6.11 - Diagnosis Abstraction Coding**.
2017 Version 2 Benefit Year Protocols, at 127-28.	**Appendix C: Chronic Condition HCCs**.
CMS HHS Center for Consumer Information and Insurance Oversight, 2018 Benefit Year Protocols, PPACA HHS – Operated Risk Adjustment Data Validation (Version 6, May 24, 2019), ("2018 Version 6 Benefit Year Protocols"), at 68-69.	For 2018 benefit year HHS-RADV, CMS has revised HHS-RADV specific guidance for the abstraction of lifelong permanent health conditions. CMS has eliminated the 'Chronic Condition HCC' list of the 2017 benefit year HHS-RADV protocols, and has revised this Protocols document to include a simplified list of health conditions which share similar characteristics of being lifelong, permanent conditions. Conditions selected by CMS for inclusion in the 'Lifelong Permanent Conditions' list may be abstracted if documented in any of the documentation provided for an enrollee's medical history. This includes documentation of the condition outside of the benefit year subject to audit. Refer to Appendix E (Lifelong Permanent Conditions) for additional information. CMS encourages the utilization of the ICD-10-CM Official Guidelines for Coding and Reporting, the AHA Coding Clinic and the HHS-RADV 2018 benefit year Protocols, along with professional judgment to make final determinations when abstracting diagnoses related to all conditions not contained within this list.

Standard	
2018 Version 6 Benefit Year Protocols, at 133-34.	**Appendix E: Lifelong Permanent Conditions**.
CMS HHS Center for Consumer Information and Insurance Oversight, 2018 Benefit Year Protocols, PPACA HHS – Operated Risk Adjustment Data Validation (Version 7, June 24, 2019) ("2018 Version 7 Benefit Year Protocols"), at 68-69.	For 2018 benefit year HHS-RADV, CMS has revised HHS-RADV specific guidance for the abstraction of lifelong permanent health conditions. The 'Chronic Condition HCC' list of the 2017 benefit year HHS-RADV protocols is no longer valid. CMS has revised the 2018 Protocols document to include a simplified list of health conditions which share similar characteristics of being lifelong, permanent conditions. Conditions selected by CMS for inclusion in the 'Lifelong Permanent Conditions' list may be abstracted if documented in any of the documentation provided for an enrollee's medical history. Refer to Appendix E (Lifelong Permanent Conditions) for additional information. CMS encourages the utilization of the ICD-10-CM Official Guidelines for Coding and Reporting, the American Hospital Association (AHA) Coding Clinic, and the HHS-RADV 2018 benefit year Protocols, along with professional judgment to make final determinations when abstracting diagnoses related to all conditions not contained within this list.
2018 Version 7 Benefit Year Protocols, at 133-36.	**Appendix E: Lifelong Permanent Conditions**.
CMS HHS Center for Consumer Information and Insurance Oversight, 2019 Benefit Year Protocols, PPACA HHS – Operated Risk Adjustment Data Validation (Version 8, Nov. 12, 2020) ("2019 Version 8 Benefit Year Protocols"), at 84-85.	**Appendix E** - Lifelong Permanent Conditions for additional information includes a simplified list of lifelong, permanent conditions. IVA Entities may abstract conditions included in the 'Lifelong Permanent Conditions' list if documented in any of the documentation provided for an enrollee's medical history. For all conditions not on the 'Lifelong Permanent Conditions' list, CMS encourages IVA Entities to use the ICD-10-CM Official Guidelines for Coding and Reporting and the American Hospital Association (AHA) Coding Clinic, along with professional judgment, to abstract diagnoses.
2019 Version 8 Benefit Year Protocols, at 96.	**Note**: With the exception of Lifelong Permanent Conditions, diagnoses cannot be abstracted from a past medical history portion of a medical record without the provider substantiating that the diagnosis coexists at the time of the encounter/visit and requires or affects patient care, treatment or management.
2019 Version 8 Benefit Year Protocols, at 100.	**Note:** CMS cannot provide specific coding guidance, beyond the 'Lifelong Permanent Conditions' list (see **Appendix C**). CMS encourages coders to use the ICD-10-CM Official Guidelines for Coding and Reporting (see **Appendix C**), the AHA Coding Clinic, and the HHS-RADV 2019 Benefit Year Protocols 'Lifelong Permanent Conditions' list along with professional judgment to make final determinations when abstracting diagnoses.
2019 Version 8 Benefit Year Protocols, at 128-30.	**Appendix C: Lifelong Permanent Conditions**.
CMS HHS Center for Consumer Information and Insurance Oversight, 2020 Benefit Year Protocols, PPACA HHS – Operated Risk Adjustment Data Validation (Version 10, May 26, 2021) ("2020 Version 10 Benefit Year Protocols"), at 94.	**Appendix C** – Lifelong Permanent Conditions for additional information includes a simplified list of lifelong, permanent conditions. The 'Lifelong Permanent Conditions' list is a set of health conditions selected by CMS that require ongoing medical attention and where all associated diagnoses are typically unresolved once diagnosed. IVA entities may abstract conditions included in the 'Lifelong Permanent Conditions' list if documented in any of the documentation provided for an enrollee's medical history. For all conditions not on the 'Lifelong Permanent Conditions' list, CMS encourages IVA Entities to use the ICD-10-CM Official Guidelines for Coding and Reporting and the American Hospital Association (AHA) Coding Clinic, along with professional judgment, to abstract diagnoses.

Standard	
2020 Version 10 Benefit Year Protocols, at 105.	**Note:** With the exception of Lifelong Permanent Conditions, diagnoses cannot be abstracted from a past medical history portion of a medical record without the provider substantiating that the diagnosis coexists at the time of the encounter/visit and requires or affects patient care, treatment or management.
2020 Version 10 Benefit Year Protocols, at 110.	**Note:** CMS cannot provide specific coding guidance, beyond the 'Lifelong Permanent Conditions' list (see **Appendix C**). CMS encourages coders to use the ICD-10-CM Official Guidelines for Coding and Reporting (see **Appendix C**), the AHA Coding Clinic, and the HHS-RADV 2020 Benefit Year Protocols 'Lifelong Permanent Conditions' list along with professional judgment to make final determinations when abstracting diagnoses.
2020 Version 10 Benefit Year Protocols, at 114-15.	**9.2.6.12.6 Past Medical History**.
2020 Version 10 Benefit Year Protocols, at 179-181.	**Appendix C: Lifelong Permanent Conditions**.
CMS HHS Center for Consumer Information and Insurance Oversight, 2021 Benefit Year Protocols, PPACA HHS – Operated Risk Adjustment Data Validation (Version 1, May 20, 2022) ("2021 Version 1 Benefit Year Protocols"), at 116.	**Note:** With the exception of Lifelong Permanent Conditions (see **Appendix C**), diagnoses cannot be abstracted from a past medical history portion of a medical record without the provider substantiating that the diagnosis coexists at the time of the encounter/visit and requires or affects patient care, treatment or management.
2021 Version 1 Benefit Year Protocols, at 122.	**Note:** CMS cannot provide specific coding guidance, beyond the 'Lifelong Permanent Conditions' list (see **Appendix C**). CMS encourages coders to use the following hierarchy of published coding guidance: • ICD-10-CM and ICD-10-PCS classification • ICD-10-CM Official Guidelines for Coding and Reporting • AHA Coding Clinic HHS-RADV 2021 Benefit Year Protocols 'Lifelong Permanent Conditions' list along with professional judgment should be used in conjunction with the above to make final determinations when abstracting diagnoses.
2021 Version 1 Benefit Year Protocols, at 126.	**9.2.6.11.6 Lifelong Permanent Conditions**.
2021 Version 1 Benefit Year Protocols, at 126-27.	**9.2.6.11. 7 Past Medical History**.
2021 Version 1 Benefit Year Protocols, at 153-56.	**Appendix C: Lifelong Permanent Conditions**.
CMS 2003 Regional Risk Adjustment Training For Medicare+Choice Organizations Participant Guide ("2003 Participant Guide") § 3.1.2, at 3-5.	Qualified physician data for risk adjustment requires a face-to-face visit with the exception of pathology and radiology services (professional component only).

Standard	
2003 Participant Guide § 12.3, at 12-5 A.	**Acceptable Types of Documentation by Source**. . . Diagnoses documented by the physician in the medical record as part of the treatment and evaluation of the enrollee with the date of the encounter. Note - it may be documented in different components of the medical record, e.g. progress notes or the history and physical, as long as that diagnosis is dated within the correct data collection period.
2003 Participant Guide § 12.3, at 12-6.	**Example 1:** The patient has a broken leg and Congestive Heart Failure (CHF). The physician documents a diagnosis for the broken leg in the medical record, but does not reference the CHF in the medical record documentation on the date of service when he attended to the broken leg. In this case, the M+C organization cannot submit the code for CHF because the physician did not document the diagnosis of CHF on that date. **Example 2: The patient has a broken leg, CHF and Chronic Obstructive Pulmonary Disease (COPD).** The physician documents a diagnosis for the broken leg for the patient, and also notes that the patient has CHF and COPD in the medical record documentation on the date of service when he is attending to the broken leg. The physician, however, fails to communicate the CHF or the COPD diagnoses to the plan for the submission of this data to CMS. The plan learns that that patient did have diagnoses of CHF and COPD assigned by the physician during the visit for the broken leg visit. In this case, because the physician has noted the diagnoses in the documentation, the plan may submit the CHF and COPD diagnoses as risk adjustment data, assuming the dates of service fall within the correct data collection period. **Example 3: The patient has diabetes with complications – ophthalmic manifestations.** In this case, the physician submitted to the plan a diagnosis code of diabetes without mention of complications (code 250.0). However, in the medical record documentation the physician has noted on the date of the face-to-face encounter with the patient that the patient has a diagnosis of diabetes with ophthalmic complications (250.5). The plan is made aware of the diabetes diagnosis with the higher level of specificity in the medical record documentation. In this case, the plan may correct the risk adjustment data and change the diagnosis from 250.0 to 250.5.
CMS 2004 Regional Risk Adjustment Training For Medicare+Choice Organizations Participant Guide ("2004 Participant Guide") § 3.2.3, at 3-9.	Qualified physician data for risk adjustment requires a face-to-face visit with the exception of pathology and radiology services (professional component only).
2004 Participant Guide § 5.4, at 5-5.	Upcoding or changing diagnoses to obtain higher reimbursement without supporting source documents is fraudulent. However, thoroughly reviewing documentation and coding practices through internal auditing procedures to ensure that data has been reported correctly and that appropriate reimbursement is received benefits both the M+C organization and physician/provider.
2004 Participant Guide § 5.4.1, at 5-6.	Co-existing conditions include chronic, ongoing conditions such as diabetes (250.XX, HCCs 15-19), congestive heart failure (428.0, HCC 80), atrial fibrillation (427.31, HCC 92), chronic obstructive and pulmonary disease (COPD) (496, HCC 108). These diseases are generally managed by ongoing medication and have the potential for acute exacerbations if not treated properly, particularly if the patient is experiencing other acute conditions. It is likely that these diagnoses would be part of a general overview of the patient's health when treating co-existing conditions for all but the most minor of medical encounters.
2004 Participant Guide § 5.4.1, at 5-6.	Co-existing conditions also include ongoing conditions such as multiple sclerosis (340, HCC 72), hemiplegia (342.9, HCC 100), rheumatoid arthritis (714.0, HCC 38) and Parkinson's (332.0, HCC 73). Although they may not impact every minor healthcare episode, it is very likely that patients having these conditions would have their general health status evaluated within a data reporting period, and these diagnoses would be documented and reportable at that time.

Standard	
2004 Participant Guide § 6.3.2, at 6-10.	Although the term "problem list" is commonly used with regard to ambulatory medical record documentation, a universal definition does not exist. The problem list is generally used by a coder to gain an overall clinical picture of a patient's condition(s). Problem lists are usually supported by other medical record documentation such as SOAP notes (subjective, objective, assessment, plan), progress notes, consultation notes, and diagnostic reports. For CMS' risk adjustment data validation purposes, an acceptable problem list must be comprehensive and show evaluation and treatment for each condition that relates to an ICD-9 code on the date of service, and is signed and dated by the physician or physician extender.
2004 Participant Guide, *Communicating with Physicians & Providers about Risk Adjustment – Coding & Medical Record Documentation*.	Physicians and providers should report all diagnoses that impact the patient's care, and ensure these diagnoses are accurately documented in a medical record. This includes the main reason for the episode of care; and all co-existing, acute or chronic conditions; and pertinent past conditions that impact clinical evaluation and therapeutic treatment. Symptoms that are common to the main reportable diagnosis should not be coded. Coding to the highest degree of specificity provides the most accurate coding and ensures appropriate grouping in the risk adjustment model.
CMS 2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide ("2008 Participant Guide") § 3.2.3, at 3-11.	Qualified physician data for risk adjustment requires a face-to-face visit with the exception of pathology services (professional component only).
2008 Participant Guide § 6.4, at 6-5.	Upcoding or changing diagnoses to obtain higher reimbursement without supporting source documents is fraudulent. However, thoroughly reviewing documentation and coding practices through internal auditing procedures ensure that data have been reported correctly and that appropriate reimbursement is received. This benefits both the MA organization and physician/provider.
2008 Participant Guide § 6.4.1, at 6-6.	Co-existing conditions include chronic, ongoing conditions such as diabetes (250.XX, HCCs 15-19), congestive heart failure (428.0, HCC 80), atrial fibrillation (427.31, HCC 92), chronic obstructive and pulmonary disease (496, HCC 108). These diseases are generally managed by ongoing medication and have the potential for acute exacerbations if not treated properly, particularly if the patient is experiencing other acute conditions. It is likely that these diagnoses would be part of a general overview of the patient's health when treating co-existing conditions for all but the most minor of medical encounters.
2008 Participant Guide § 6.4.1, at 6-6.	Co-existing conditions also include ongoing conditions such as multiple sclerosis (340, HCC 72), hemiplegia (342.9X, HCC 100), rheumatoid arthritis (714.0, HCC 38) and Parkinson's disease (332.0, HCC 73). Although they may not impact every minor healthcare episode, it is likely that patients having these conditions would have their general health status evaluated within a data reporting period, and these diagnoses would be documented and reportable at that time.
2008 Participant Guide § 6.4.2, at 6-7.	It also is understood that the physician record is not a static document. Positive test results and notations regarding contact with the patient for a revised plan of treatment often are added to the record several days after the patient encounter. When these addenda are made, corrections or additions to the diagnoses reported to MA organizations may be recommended, particularly if the HCC assignment is impacted.

Standard	
2008 Participant Guide § 7.1.5, at 7-3.	The risk adjustment guiding principle states that all diagnoses submitted for payment (i.e., used for HCCs) must be: o Documented in a medical record that was based on a face-to-face health service encounter between a patient and a healthcare provider o Coded in accordance with the ICD-9-CM Guidelines for Coding and Reporting o Assigned based on dates of service within the data collection period AND o From an acceptable RA provider type and RA physician specialty This guiding principle is what's used as the key guideline for medical records review.
2008 Participant Guide § 7.2.4.3, at 7-17.	Although the term "problem list" is commonly used with regard to ambulatory medical record documentation, a universal definition does not exist. The problem list is generally used by a coder to gain an overall clinical picture of a patient's condition(s). Problem lists are usually supported by other medical record documentation such as SOAP notes (subjective, objective, assessment, plan), progress notes, consultation notes, and diagnostic reports. For CMS' risk adjustment data validation purposes, an acceptable problem list must be comprehensive and show evaluation and treatment for each condition that relates to an ICD-9 code on the date of service, and it must be signed and dated by the physician or physician extender.
CMS Risk Adjustment Data Validation (RADV) Medical Record Intake Process and Guidance to Coders, CY2011 Contract Level RADV, Version 4.0 ("2014 RADV Medical Record Reviewer Guidance"), at 5 (May 8, 2014).	Though official coding rules do not change based on the type of audit, the coder should be aware of the background and prospective nature of the RA payment process including its basis on chronic conditions, and dependence on validating chronic conditions for an annual payment on just the review of one record. It is imperative therefore to code all chronic conditions documented by an acceptable provider type during a face to face encounter with the patient, whether or not there was specific treatment mentioned in the one record submitted. Mention or EMR population of the diagnoses narrative list can be interpreted as management and care for the applicable chronic conditions of the patient once all other coding rules and checks for consistency have been applied. This is where RADY HCC audits may differ in guideline interpretation from fee-for-service, DRG audits or others based on just the payment for one specific encounter.
2014 RADV Medical Record Reviewer Guidance, at 74.	**Acceptable Amendment** – An amendment must be completed in a timely manner (up to 90 days is a general guideline used for RADV but there could be exceptions i.e. extended specialized or revised lab/path results or autopsies, legal cases sequestered before completing record, natural disasters, physician called to military service), based on an observation of the patient on the date of service and signed by the physician (e.g., follow-up note based on a diagnostic test ordered and test results received subsequent to the patient visit).
2014 RADV Medical Record Reviewer Guidance, at 74.	Sufficient information must be contained in the amendment to verify the documentation was completed in a timely manner by the attending or treating physician.
CMS Contract-Level Risk Adjustment Data Validation, Medical Record Reviewer Guidance, As of 09/27/2017 ("2017 RADV Medical Record Reviewer Guidance"), at 34 (Sept. 27, 2017).	Evaluate the problem list for evidence of whether the conditions are chronic or past and if they are consistent with the current encounter documentation (i.e., have they been changed or replaced by a related condition with different specificity). Evaluate conditions listed for chronicity and support in the full medical record, such as history, medications, and final assessment.
2017 RADV Medical Record Reviewer Guidance, at 34.	Problem lists are evaluated on a case-by-case basis when the problem list is not clearly dated as part of the face to face encounter indicated on the coversheet or there are multiple dates of conditions both before and after the DOS.

Standard	
2017 RADV Medical Record Reviewer Guidance, at 41.	Policies may differ depending on the provider type. Review of the entire medical record, including all terms directly attributed to the condition and who documented the condition, are important in making these reporting decisions. Conditions, diagnoses, or "problems" can be listed in various sections of a medical record. With an EMR, conditions from previous encounters are often brought forward/cut and pasted/auto-filled into the current encounter template by various methods. The question is whether these conditions should be reported for the current encounter and how to interpret "treatment and care" and "affect patient management" in the *Official Guidelines for Coding and Reporting* quoted below. Section numbers are indicated after each quote. Conversely, some conditions are listed as a current condition, but the content of the full record indicates the condition is no longer present. Therefore, reviewers should evaluate all listed conditions for consistency within the full provider documentation with the understanding that specific management and treatment of every chronic condition is not always going to be clearly documented in the one record submitted to validate the CMS-HCC. Mention of EMR population of diagnoses in a list will be considered on a case-by-case basis for RADV once all other coding rules and checks for consistency have been applied.
2017 RADV Medical Record Reviewer Guidance, at 49.	**Acceptable Amendment:** An amendment must be based on an observation of the patient on the date of service and signed by the physician. Only the attending physician can amend the medical record. The most common example is for follow-up notes based on a diagnostic test ordered and related test results received subsequent to the patient visit. Sufficient information must be contained in the amendment to verify the documentation was completed in a timely manner by the attending or treating physician. For RADV 'timely manner' generally means up to 90 days from the encounter but there could be exceptions such as extended specialized or revised lab/path results or autopsies, legal cases sequestered before completing record, natural disasters, or delays due to physicians called to military service.
CMS Contract-Level Risk Adjustment Data Validation, Medical Record Reviewer Guidance, In effect as of 03/20/2019 ("2019 RADV Medical Record Reviewer Guidance"), at 42 (Mar. 20, 2019).	Evaluate the problem list for evidence of whether the conditions are chronic or past and if they are consistent with the current encounter documentation (i.e., have they been changed or replaced by a related condition with different specificity). Evaluate conditions listed for chronicity and support in the full medical record, such as history, medications, and final assessment.
2019 RADV Medical Record Reviewer Guidance, at 42.	Problem lists are evaluated on a case-by-case basis when the problem list is not clearly dated as part of the face to face encounter indicated on the coversheet or there are multiple dates of conditions both before and after the DOS.
2019 RADV Medical Record Reviewer Guidance, at 52.	Policies may differ depending on the provider type. Review of the entire medical record, including all terms directly attributed to the condition and who documented the condition, are important in making these reporting decisions. Conditions, diagnoses, or "problems" can be listed in various sections of a medical record. With an EMR, conditions from previous encounters are often brought forward/cut and pasted/auto-filled into the current encounter template by various methods. The question is whether these conditions should be reported for the current encounter and how to interpret "treatment and care" and "affect patient management" in the Official Guidelines for Coding and Reporting quoted below. Section numbers are indicated after each quote. Conversely, some conditions are listed as a current condition, but the content of the full record indicates the condition is no longer present. Therefore, reviewers should evaluate all listed conditions, both chronic and acute or short-term conditions for consistency within the full provider documentation of the one encounter submitted for RADV. Mention of EMR population of diagnoses in a list will be considered on a case-by-case basis for RADV once all other coding rules and checks for consistency have been applied.

Standard	
2019 RADV Medical Record Reviewer Guidance, at 60.	**Acceptable Amendment**: An amendment must be based on an observation of the patient on the date of service and signed by the physician. Only the attending physician can amend the medical record. The most common example is for follow-up notes based on a diagnostic test ordered and related test results received subsequent to the patient visit. Sufficient information must be contained in the amendment to verify the documentation was completed in a timely manner by the attending or treating physician. For RADV "timely manner" generally means up to 90 days from the encounter but there could be exceptions such as extended specialized or revised lab/path results or autopsies, legal cases sequestered before completing record, natural disasters, or delays due to physicians called to military service.
2019 RADV Medical Record Reviewer Guidance, at 69 (Source AHIMA corrections, amendments and addendum tool kit).	An amendment is an alteration of the health information by modification, correction, addition, or deletion. There are many terms used that ultimately amend the health record. For the purpose of this toolkit, the term "amendment" is the overarching term indicating that documentation has been altered. There are many ways that a health record may be altered; these terms may include corrections, addendums, retractions, deletions, late entries, re-sequencing, and reassignment. An amendment is made after the original documentation has been completed and signed by the provider. It should be noted that unsigned documentation will have changes and then be signed, the changes made prior to the initial signature need to be tracked as well. All amendments should be timely and bear the current date and time of documentation. Entries added to a health record to provide additional information in conjunction with a previous entry. The addendum should be timely, bear the current date, time, and reason for the additional information being added to the health record, and be electronically signed.
CMS Contract-Level 15 Risk Adjustment Data Validation, Medical Record Reviewer Guidance, In effect as of 01/10/2020, Version 2.0 ("2020 RADV Medical Record Reviewer Guidance"), at 42 (Jan. 10, 2020).	Evaluate the problem list for evidence of whether the conditions are chronic or past and if they are consistent with the current encounter documentation (i.e., have they been changed or replaced by a related condition with different specificity). Evaluate conditions listed for chronicity and support in the full medical record, such as history, medications, and final assessment.
2020 RADV Medical Record Reviewer Guidance, at 42.	Problem lists are evaluated on a case-by-case basis when the problem list is not clearly dated as part of the face to face encounter indicated on the coversheet or there are multiple dates of conditions both before and after the DOS.
2020 RADV Medical Record Reviewer Guidance, at 51.	Policies may differ depending on the provider type. Review of the entire medical record, including all terms directly attributed to the condition and who documented the condition, are important in making these reporting decisions. Conditions, diagnoses, or "problems" can be listed in various sections of a medical record. With an EMR, conditions from previous encounters are often brought forward/cut and pasted/auto-filled into the current encounter template by various methods. The question is whether these conditions should be reported for the current encounter and how to interpret "treatment and care" and "affect patient management" in the Official Guidelines for Coding and Reporting quoted below. Section numbers are indicated after each quote. Conversely, some conditions are listed as a current condition, but the content of the full record indicates the condition is no longer present. Therefore, reviewers should evaluate all listed conditions, both chronic and acute or short-term conditions for consistency within the full provider documentation of the one encounter submitted for RADV. Mention of EMR population of diagnoses in a list will be considered on a case-by-case basis for RADV once all other coding rules and checks for consistency have been applied.

Standard	
2020 RADV Medical Record Reviewer Guidance, at 60.	**Acceptable Amendment**: An amendment must be based on an observation of the patient on the date of service and signed by the physician. Only the attending physician can amend the medical record. The most common example is for follow-up notes based on a diagnostic test ordered and related test results received subsequent to the patient visit. Sufficient information must be contained in the amendment to verify the documentation was completed in a timely manner by the attending or treating physician. For RADV "timely manner" generally means up to 90 days from the encounter but there could be exceptions such as extended specialized or revised lab/path results or autopsies, legal cases sequestered before completing record, natural disasters, or delays due to physicians called to military service.
2020 RADV Medical Record Reviewer Guidance, at 69 (Source AHIMA corrections, amendments and addendum tool kit).	An amendment is an alteration of the health information by modification, correction, addition, or deletion. There are many terms used that ultimately amend the health record. For the purpose of this toolkit, the term "amendment" is the overarching term indicating that documentation has been altered. There are many ways that a health record may be altered; these terms may include corrections, addendums, retractions, deletions, late entries, re-sequencing, and reassignment. An amendment is made after the original documentation has been completed and signed by the provider. It should be noted that unsigned documentation will have changes and then be signed, the changes made prior to the initial signature need to be tracked as well. All amendments should be timely and bear the current date and time of documentation. Entries added to a health record to provide additional information in conjunction with a previous entry. The addendum should be timely, bear the current date, time, and reason for the additional information being added to the health record, and be electronically signed.
MMCM Chapter 7, Exhibit 30 (Rev. 57, Aug. 13, 2004).	**Coexisting Conditions -** Physicians and providers should use the "Official ICD –9-CM Guidelines for Coding and Reporting" (found at http://www.cms.hhs.gov/paymentsystems/icd9/default.asp) and Medicare fee-for-service rules when submitting risk adjustment data to M+C organizations. The official guidelines that govern those coexisting conditions that may be coded and reported by hospital inpatient, hospital outpatient and physician providers are summarized below. The guidelines for inpatient hospital stays are as follows: "…all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded." The guidelines for coexisting conditions that should be coded for hospital outpatient and physician services are as follows: "Code all documented conditions that coexist at time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (V10-V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment." Physicians and hospital outpatient departments shall not code diagnoses documented as "probable," "suspected," "questionable," "rule out," or "working" diagnosis. Rather, physicians and hospital outpatient departments shall code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.
MMCM Chapter 7 (Rev. 114, June 7, 2013).	All diagnosis codes submitted must be documented in the medical record and must be documented as a result of a face-to-face visit.
MMCM Chapter 7 (Rev. 114, June 7, 2013).	The diagnosis must be coded according to *International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) Guidelines for Coding and Reporting*.
MMCM Chapter 7 (Rev. 118, Sept. 19, 2014).	All diagnosis codes submitted must be documented in the medical record and must be documented as a result of a face-to-face visit.
MMCM Chapter 7 (Rev. 118, Sept. 19, 2014).	The diagnosis must be coded according to *International Classification of Diseases, (ICD) Clinical Modification Guidelines for Coding and Reporting*.

EXHIBIT 5

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
WASHINGTON, DC 20201

Impact of Health Risk Assessments and Chart Reviews
on Risk Adjustment Payments in Medicare Advantage

(OEI-03-17-00470)

CMS Questionnaire

INSTRUCTIONS: This questionnaire requests information on the actions that CMS has taken to review the impact of health risk assessments (HRAs) and chart reviews on Medicare Advantage (MA) risk adjustment payments.

The questionnaire is divided into the following two sections:

A. Health Risk Assessments
B. Chart Reviews

For sections that request documentation, please submit the requested documentation with your completed questionnaire.

By **August 20, 2018**, please email the completed questionnaire and requested documents to joanna.bisgaier@oig.hhs.gov.

If you have any questions about this questionnaire, please contact Joanna Bisgaier at (215) 861-4559 or joanna.bisgaier@oig.hhs.gov, or Jacqualine Reid at (215) 861-4546 or jacqualine.reid@oig.hhs.gov.

Thank you for your assistance and cooperation.

US-DOJ-KAISER-00077119
US-DOJ-KAISER-00077119

Section A. Health Risk Assessments

The questions in this section pertain to the actions that CMS has taken to review and address the impact of HRAs on MA payments and the care provided to beneficiaries who received HRAs.

HRAs are assessments administered by a physician or other health care professional to collect self-reported information from a beneficiary about their health status, health risks, and daily activities. We understand that in the MA program, HRAs may be part of annual wellness visits or may be conducted during other visits with beneficiaries—including visits to beneficiaries' homes that are also known as "enrollee risk assessments" or "home assessments."

We are interested in the actions, if any, that CMS has taken to review the financial impact of HRAs using Risk Adjustment Processing System (RAPS) data, MA encounter data, and/or any other data sources. We are also interested in CMS's use of information gathered during Risk Adjustment Data Validation (RADV) audits to review the impact of HRAs on MA payments. [We are not requesting information regarding actions CMS has taken to standardize the initial HRA required for all beneficiaries enrolled in Special Needs Plans.]

REVIEWS OF HRAS USING RAPS DATA AND/OR ENCOUNTER DATA

The following questions focus on whether and how CMS has used RAPS data and/or encounter data to review the impact of HRAs on MA payments. Examples of these reviews may include, but are not limited to, identifying the amount of MA payments resulting from HRAs and/or identifying variation among MAOs in their HRA submissions. We are also interested in how CMS has tracked and/or analyzed the care provided to beneficiaries who received HRAs.

Reviews of HRAs Using RAPS Data

A1. In the RAPS data, CMS has required MAOs to flag diagnosis codes collected during HRAs since 2014. How has CMS used this HRA flag in the RAPS data to review the impact of HRAs on MA payments? If CMS has not performed this kind of review, please describe CMS's reason(s) for not performing such reviews.

Visual Axis recommends that CPI request this information from CM/MPPG as the owners of the data. Alternatively, if CPI desires, VA can pull the data and provide statistics on the presence of HRAs for a defined data collection period(s).

A2. In 2015, CMS stated that it would use the HRA flag in the RAPS data to track and analyze the care provided to beneficiaries following in-home HRAs. How has CMS used this HRA flag in the RAPS data to track and analyze the care provided to beneficiaries following HRAs? If CMS has not performed this kind of review, please describe CMS's reason(s) for not performing such reviews.
Visual Axis recommends that CPI request this information from CM/MPPG as the owners of the data.

A3. What were the main findings from reviews that used the HRA flag in the RAPS data? If CMS has not performed these reviews, please write, "Reviews not performed." HRAs identified in the table below are from a CPI analysis and not from HRA flags in RAPS. The records reviewed were a sample of all the RAPS submissions for payment years 2011, 2012, and 2013.

Centers for Medicare & Medicaid Services (CMS)
Contract Sample
CY 2011 MEDICARE ADVANTAGE RISK ADJUSTMENT DATA VALIDATION

Physician Form Analysis - Outcome Summary Report

Report Parameters	
Contract	All Contract
Sample	Samples

				Non-Compliant Flag Checked		Physician Query Forms			HRAs					
Sample Year	Contract ID	# of MRs Eligible for Review N1	Total Number of MRs reviewed N2	Yes	NO	Coder Query n3	MAO Generated Query n4	Total PQ Forms N5	Stand Alone HRA n6	Non Face-to-Face HRA n7	HRA with Encounter n8	Total HRA N9	Total MRs With PQ or HRA form	Total MRs with no PQ or HRA
CON11	All CON11	30980	30978	535	30445	29	111	140	292	0	102	394	534 (1.72%)	30444 (98.28%)
CON12	All CON12	35432	34490	455	34061	6	29	35	302	2	110	414	449 (1.30%)	34041 (98.70%)
CON13	All CON13	33943	33875	1677	32266	7	78	85	1325	3	218	1546	1631 (4.81%)	32244 (95.19%)

Reviews of HRAs Using Encounter Data

A4. How has CMS used the MA encounter data to review the impact of HRAs on MA payments? If CMS has not performed this kind of review, please describe CMS's reason(s) for not performing such reviews.

A5. How has CMS used the MA encounter data to track and analyze the care provided to beneficiaries who received HRAs? If CMS has not performed this kind of review, please describe CMS's reason(s) for not performing such reviews.

A6. How has CMS identified HRAs in the encounter data? If CMS has not identified HRAs in the MA encounter data, please write, "Not done."

A7. What were the main findings from reviews of HRAs that used the MA encounter data? If CMS has not performed these reviews, please write, "Reviews not performed."

REVIEWS OF HRAS USING INFORMATION GATHERED DURING RADV AUDITS

According to CMS's *Medical Record Reviewer Guidance* dated September 27, 2017, contract-level RADV auditors should ensure that HRAs submitted to CMS for risk adjustment payment comply with CMS's guidance. For example, auditors should check to ensure that HRAs were completed during face-to-face visits by valid risk adjustment provider specialties.

The following charts contains the criteria used when determining the different types of forms

Form Type	Form Description	Standard Non-Compliance Comment
Stand-alone HRA	HRAs are typically a form created by the MAO and often includes past diagnoses the MAO is looking for the provider to confirm. The HRA is sent in lieu of a medical record but is face-to-face by a valid risk adjustment provider. May or may not be performed by the patient's regular provider but often done by a provider contracted by the MAO.	03HRA
Non Face-to-face HRA	HRA is a list of diagnosis but does not appear to have been performed face-to-face with the patient/provider.	04NonFTFHRA
HRA with Encounter	HRA form sent in addition to an encounter medical record performed by the provider that is being performed on the same date. Submission would include the HRA/HCMR report or list of diagnoses along with a separate encounter note.	05HRAEncounter

The following questions focus on CMS's use of information gathered from RADV audits to review the impact of HRAs on improper MA payments. Examples of these reviews may include, but are not limited to, identifying the amount of MA payments resulting from HRAs that did not comply with CMS's requirements.

See the table under A3, specifically the non-face to face HRA column. A total of 5 forms were found to be non-compliant with the requirements.

A8. What other guidance, if any, has CMS provided RADV auditors related to HRAs other than the *Medical Record Reviewer Guidance*? If there is no other guidance for RADV auditors related to HRAs please write, "No guidance."

CMS initiated reviews of additional documentation submitted by MAOs for the contract-level RADV audits for payment years 2011, 2012, and 2013. CMS provided instructions to coders to identify HRAs from three specific sources(1) HRA based on a face-to-face encounter, (2) HRA stand-alone, and (3) HRA accompanying a MR for the same encounter. Coders used these instructions to re-evaluate the RADV submissions to identified HRAs resent in this data.

A9. How has CMS used the information gathered during RADV audits to review the impact of HRAs on MA payments? If CMS has not performed this kind of review, please describe CMS's reason(s) for not performing such reviews.

Presently, the data was used to identify the encounter related information present in the HRA. Impact of HRAs on MA payment has not been completed under the analysis described in the A* response.

A10. What were the main findings from reviews of HRA-related information gathered during RADV audits? If CMS has not performed these reviews, please write, "Reviews not performed."



Centers for Medicare & Medicaid Services (CMS)
Contract Sample
CY 2011 MEDICARE ADVANTAGE RISK ADJUSTMENT DATA VALIDATION

Physician Form Analysis - Outcome Summary Report

Report Parameters	
Contract	All Contract Samples
Sample	

				Non-Compliant Flag Checked		Physician Query Forms			HRAs					
Sample Year	Contract ID	# of MRs Eligible for Review N1	Total Number of MRs reviewed N2	Yes	NO	Coder Query n3	MAO Generated Query n4	Total PQ Forms N5	Stand Alone HRA n6	Non Face-to-Face HRA n7	HRA with Encounter n8	Total HRA N9	Total MRs With PQ or HRA form	Total MRs with no PQ or HRA
CON11	All CON11	30980	30978	535	30445	29	111	140	292	0	102	394	534 (1.72%)	30444 (98.28%)
CON12	All CON12	35432	34490	455	34061	6	29	35	302	2	110	414	449 (1.30%)	34041 (98.70%)
CON13	All CON13	33943	33875	1677	32266	7	78	85	1325	3	218	1546	1631 (4.81%)	32244 (95.19%)

ANY OTHER REVIEWS OF HRAS

The following questions focus on whether and how CMS has performed any other reviews of the impact of HRAs on MA payments that were not covered by prior questions in Section A. Examples of other types of reviews that CMS may have performed include, but are not limited to, interviews with MAOs and/or focus groups with MA beneficiaries about HRAs.

A11. How has CMS performed any other review(s) of the impact of HRAs on MA payments? Please include in your response, a description of the data source(s) used. If CMS has not performed this kind of review, please describe CMS's reason(s) for not performing such reviews.

A12. How has CMS used any other reviews to track and analyze the care provided to beneficiaries who received HRAs? Please include in your response, a description of the data source(s) used. If CMS has not performed this kind of review, please describe CMS's reason(s) for not performing such reviews.

A13. What were the main findings of any other review(s) of HRAs? If CMS has not performed any other reviews, please write, "Reviews not performed."

REGULARITY OF REVIEWS AND CHALLENGES FACED

A14. For any of the reviews described in Section A, what procedures does CMS have in place to perform these reviews on a recurring basis? Please include in your response, a description of how often CMS performs recurring reviews. If CMS does not have such procedures in place, please write, "No procedures in place."

CMS is developing a standard operating procedure that describes steps taken to identify HRAs in RADV data.

A15. For any of the reviews described in Section A, what challenges has CMS faced in performing reviews related to HRAs in the MA program?

Flagging HRAs in RAPS/Encounter Data submissions have not historically been consistent and/or required for successful transmission to CMS data systems. CPI performed reviews of RADV submissions to definitively identify HRAs included with medical record documentation. CPI is also exploring required flagging of the presence of an HRA in RADV data in the RADV system of record Central Data Abstraction Tool (CDAT).

ACTIONS TO ADDRESS ISSUES/CONCERNS RELATED TO HRAS

A16. As a result of the reviews described in Section A, has CMS identified issues or concerns related to the impact of HRAs on MA payments or the care provided to beneficiaries who received HRAs? If yes, please provide examples of the kinds of issues or concerns that CMS has identified.

A17. What actions, if any, has CMS taken to address any issues or concerns related the impact of HRAs on MA payments or the care provided to beneficiaries who received HRAs? If CMS has not taken actions to address an issue or concern, please describe CMS's reason(s) for not taking action for each unaddressed issue or concern.

a. In 2015, CMS encouraged MAOs to adopt best practices for HRAs, including in-home assessments. What actions has CMS taken to assess whether MAOs (not including Special Needs Plans) are following these best practices? If CMS has not assessed whether MAOs are following these best practices, please provide CMS's reason(s) for this decision.

b. Please describe any plans that CMS has to add an HRA flag to the MA encounter data. If CMS does not have such plans, please describe CMS's reason(s) for this decision.

c. Please describe any plans that CMS has to exclude from risk adjustment payments diagnosis codes submitted by MAOs through HRAs. If CMS does not have such plans, please describe CMS's reason(s) for this decision.

d. Please describe any plans that CMS has to select certain MAOs for RADV audits based on HRA submissions. If CMS does not have such plans, please describe CMS's reason(s) for this decision.

e. What challenges has CMS faced in taking action to address issues or concerns related to HRAs in the MA program? For example, are there any actions that are *not available* to CMS that would improve CMS's ability to address issues or concerns related to HRAs in the MA program?

REQUEST FOR DOCUMENTATION

A18. Please provide the requested documentation listed in the table below submitted with your questionnaire response. If the requested documentation does not exist, please check "Does Not Exist."

Requested Documentation	Check here to indicate that requested documentation will be submitted:
a. All written documentation related to best practice guidelines for HRAs in the MA program and/or related to assessments of MAOs' adoption of these best practices.	☐ Yes ☐ No ☐ Does Not Exist
b. Any documentation that describes CMS's issues or concerns related to HRAs in the MA program.	☐ Yes ☐ No ☐ Does Not Exist
c. All written documentation related to any guidance that CMS has provided RADV auditors related to HRAs, other than the *Medical Record Reviewer Guidance* dated September 27, 2017.	☐ Yes ☐ No ☐ Does Not Exist

ADDITIONAL COMMENTS

A19. Please use this space to provide any additional comments and/or concerns related to HRAs in the MA program.

Section B. CHART REVIEWS

MAOs may perform chart reviews to identify diagnosis codes that (1) providers did not originally submit to the plan or (2) providers submitted in error. The questions in this section pertain to the actions CMS has taken to review and address the impact of chart reviews on MA payments and the care provided to beneficiaries for diagnoses added by chart reviews. We are interested in the actions, if any, that CMS has taken to review the financial impact of chart reviews using MA encounter data, RAPS data, and/or any other data sources. We are also interested in CMS's use of information gathered during RADV audits to review the impact of chart reviews on MA payments.

REVIEWS OF CHART REVIEWS USING ENCOUNTER DATA AND/OR RAPS DATA

The following questions focus on whether and how CMS has used encounter data and/or RAPS data to review

the impact of chart reviews on MA payments. In the MA encounter data, chart review records may be *linked* or *unlinked*. A *linked* chart review record may add or delete a diagnosis code from an existing encounter record. An *unlinked* chart review record may add a diagnosis code to the encounter data without identifying an existing encounter record associated with that diagnosis code. We are interested in how CMS's reviews differed for *linked* versus *unlinked* chart review records in the encounter data. Examples of these reviews may include, but are not limited to, identifying the amount that MA payments increased or decreased due to chart reviews and/or identifying variation among MAOs in their chart review submissions.

We are also interested in how CMS has tracked and/or analyzed the care provided to beneficiaries for diagnoses added by chart reviews.

Reviews of Chart Reviews Using Encounter Data

B1. In the MA encounter data, CMS has instructed MAOs to flag diagnosis codes collected during chart reviews since 2012. How has CMS used this chart review flag in the encounter data to review the impact of chart reviews on MA payments? Please include in your response a description of how these reviews differed for *linked* versus *unlinked* chart review records. If CMS has not performed this kind of review, please describe CMS's reason(s) for not performing such reviews.

B2. How has CMS used the MA encounter data to track and analyze the care provided to beneficiaries for diagnoses added by chart reviews? Please include in your response a description of how these reviews differed for *linked* versus *unlinked* chart review records. If CMS has not performed this kind of review, please describe CMS's reason(s) for not performing such reviews.

B3. What were the main findings from reviews that used the chart review flag in the MA encounter data? Please include in your response a description of how these findings differed for *linked* versus *unlinked* chart review records. If CMS has not performed these reviews, please write, "Reviews not performed."

Reviews of Chart Reviews Using RAPS Data

B4. How has CMS used the RAPS data to review the impact of chart reviews on MA payments? If CMS has not performed this kind of review, please describe CMS's reason(s) for not performing such reviews.

B5. How has CMS used the RAPS data to track and analyze the care provided to beneficiaries for diagnoses added by chart reviews? If CMS has not performed this kind of review, please describe CMS's reason(s) for not performing such reviews.

B6. How has CMS identified chart reviews in the RAPS data? If CMS has not identified chart reviews in the RAPS data, please write, "Not done."

B7. What were the main findings from reviews of chart reviews that used the RAPS data? If CMS has not performed these reviews, please write, "Reviews not performed."

REVIEWS OF CHART REVIEWS USING INFORMATION GATHERED DURING RADV AUDITS

The following questions focus on CMS's use of information gathered from RADV audits to review the impact of chart reviews on improper MA payments. Examples of these reviews may include, but are not limited to, identifying the amount of MA payments resulting from diagnosis codes added by chart reviews that were not supported by medical records.

B8. What guidance, if any, has CMS provided to RADV auditors related to the review of chart reviews? If there is no guidance for RADV auditors related to chart reviews please write, "No guidance."

B9. How has CMS used the information gathered during RADV audits to review the impact of linked and/or unlinked chart reviews on MA payments? If CMS has not performed this kind of review, please describe CMS's reason(s) for not performing such reviews.

B10. What were the main findings from the chart review-related information gathered during RADV audits? If CMS has not performed these reviews, please write, "Reviews not performed."

ANY OTHER REVIEWS OF CHART REVIEWS

The following questions focus on whether and how CMS has performed any other reviews of the impact of chart reviews on MA payments that were not covered by prior questions in Section B. Examples of other types of reviews that CMS may have performed include, but are not limited to, surveys or interviews with MAOs.

B11. How has CMS performed any other review(s) of the impact of chart reviews on MA payments? Please include in your response, a description of the data source(s) used. If CMS has not performed this kind of review, please describe CMS's reason(s) for not performing such reviews.

B12. How has CMS used any other reviews to track and analyze the care provided to beneficiaries for diagnoses added by chart reviews? If CMS has not performed this kind of review, please describe CMS's reason(s) for not performing such reviews.

B13. What were the main findings of any other review(s) of chart reviews? If CMS has not performed these

reviews, please write, "Reviews not performed."

REGULARITY OF REVIEWS AND CHALLENGES FACED

B14. For any of the reviews described in Section B, what procedures does CMS have in place to perform these reviews on a recurring basis? Please include in your response, a description of how often CMS performs recurring reviews. If CMS does not have such procedures in place, please write, "No procedures in place."

B15. For any of the reviews described in Section B, what challenges has CMS faced in performing reviews related to chart reviews in the MA program?

ACTIONS TO ADDRESS ISSUES/CONCERNS RELATED TO CHART REVIEWS

B16. As a result of the reviews described in Section B, has CMS identified issues or concerns related to the impact of chart reviews on MA payments or the care provided to beneficiaries for diagnoses added by chart reviews? If yes, please provide examples of the kinds of issues or concerns that CMS has identified.

B17. Please describe CMS's reason(s) for allowing MAOs to submit unlinked chart review records to the MA encounter data.

B18. Please describe CMS's reason(s) for allowing MAOs to submit default procedure codes on unlinked chart review records to the MA encounter data.

B19. What actions, if any, has CMS taken to address any issues or concerns related the impact of chart reviews on MA payments, or the care provided to beneficiaries for diagnoses added by chart reviews? If CMS has not taken actions to address an issue or concern, please describe CMS's reason(s) for not taking action for each unaddressed issue or concern.

a. In April 2016, GAO recommended that CMS improve contract-level RADV audits by (1) modifying the calculation of coding intensity by taking actions such as separately calculating coding intensity scores related only to diagnosis codes added by chart reviews, and (2) modifying CMS's selection of contracts for contract-level RADV audits to focus on those with high rates of unsupported diagnosis codes. CMS concurred with GAO's recommendations. To what extent has CMS taken actions to address these recommendations? If CMS has not addressed these recommendations, please describe CMS's

reason(s) for not taking actions to address them.

The RADV methodology was updated addressing recommendations in GAO 16-76. The new methodology targets payment error using historical payment error data. RADV audits for payment years 2014 and 2015 are expected to commence of the fall of CY 2018.

b. Please describe any other plans (not covered by your response to question B19a) that CMS has to select certain MAOs for RADV audits based on chart review submissions. If CMS does not have such plans, please describe CMS's reason(s) for this decision.

c. What challenges has CMS faced in taking action to address issues or concerns related to chart reviews in the MA program? For example, are there any actions that are *not available* to CMS, but that would improve CMS's ability to address issues or concerns related to chart reviews in the MA program?

REQUEST FOR DOCUMENTATION

B20. Please provide the requested documentation listed in the table below submitted with your questionnaire response. If the requested documentation does not exist, please check "Does Not Exist."

Requested Documentation	**Check here to indicate that requested documentation will be submitted:**
a. Any other documentation that describes CMS's issues or concerns related to chart reviews in the MA program.	☐ Yes ☐ No ☐ Does Not Exist
b. All written documentation related to any guidance or instructions on chart reviews that CMS has provided to RADV auditors.	☐ Yes ☐ No ☐ Does Not Exist

ADDITIONAL COMMENTS

B21. Please use this space to provide any additional comments and/or concerns related to chart reviews in the MA program.

US-DOJ-KAISER-00077129
US-DOJ-KAISER-00077119

Please email the completed questionnaire and all requested documents as attachments to: joanna.bisgaier@oig.hhs.gov on or before August 20, 2018.

Thank you for your assistance and cooperation.

EXHIBIT 6

Center for Program Integrity Directories Produced to Date:[1]

	Bates Number	Date
CPI 2009 Directory	**Missing**	**N/A**
CPI 2010 Directory	**Missing**	**N/A**
CPI 2011 Directory	**Missing**	**N/A**
CPI 2012 Directory	US-DOJ-KAISER-00049319	8/6/2012
CPI 2013 Directory	US-DOJ-KAISER-00049337	3/28/2013
CPI 2014 Directory	US-DOJ-KAISER-00049363 US-DOJ-KAISER-00049364 US-DOJ-KAISER-00049371	5/5/2014 5/5/2014 11/30/2014
CPI 2015 Directory	US-DOJ-KAISER-00049369	7/16/2015
CPI 2016 Directory	US-DOJ-KAISER-00049367	6/24/2016
CPI 2017 Directory	US-DOJ-KAISER-00049317	6/5/2017
CPI 2018 Directory	US-DOJ-KAISER-00057132	2/4/2018
CPI 2019 Directory	US-DOJ-KAISER-00080773	7/X/2019
CPI 2020 Directory	US-DOJ-KAISER-00057355	1/X/2020
CPI 2021 Directory	US-DOJ-KAISER-00067988	4/13/2021
CPI 2022 Directory	**Missing**	**N/A**

[1] Duplicate and undated CPI directories were excluded from this list. These documents are inclusive of all documents produced by DOJ as of their tenth production on March 17, 2023.

EXHIBIT 7

Date: April 11, 2010

Centers for Medicare & Medicaid Services
Office of the Administrator
Center for Medicare

Medicare Plan Payment Group
(FCHK)

- Develops and improves all bidding and payment policies related to the Medicare Prescription Drug Benefit and the Medicare Advantage (MA) program for the individual and employer sponsored group market, including rules regarding how plans are to structure their bids, bid review criteria, benchmark computations, use of beneficiary rebates, development and refinement of risk adjustors, low income subsidy, reinsurance, risk sharing, and the MA regional stabilization fund.

- Directs all operations, policy, and research related to risk adjustment of payments to MA Organizations and Prescription Drug Plans.

- Serves as business owner for the following data collection and processing systems: Medicare Advantage-Prescription Drug, Premium Withhold, Payment Reconciliation, Drug Data Processing, Automated Plan Payment and Risk Adjustment.

- Validates payments to Prescription Drug Plans and MA Organizations, including routine annual risk adjustment data validation based on medical record review.

- Manages, in coordination with the front office of the Center for Medicare and the Office of Information Services, Chief Operating Officer (COO), the Part D and MA change control board.

- Coordinates the development and management of business requirements for the national systems for payment of the Part D prescription drug and MA organizations. Provides operational and technical support to managed care organizations, contractors, CMS staff and other stakeholders on prescription drug benefit, and Medicare managed care payment systems.

- Communicates policy and operational information to Parts C and D plan sponsors.

- Serves as the focal point for all CMS interactions with employers, unions, employees, retirees and others operating on their behalf pertaining to issues related to CMS regulations, guidance, operations, as well as outreach and education activities concerning the Retiree Drug Subsidy (RDS) Program. Develops national policy and oversees operational implementation for all issues related to the RDS Program, a system of payments to employer and union sponsors of qualified retiree prescription drug plans.

US-DOJ-KAISER-00060989

Date: April 11, 2010

Medicare Plan Payment Group
(continued)

- In collaboration with CM's Business Operations Staffs and the Office of Acquisition and Grants Management, COO develops and negotiates procurement contracts which include the development of contractor specifications, work statements, and evaluation criteria to support group programmatic functions, as needed. Evaluates, assesses, and monitors contractors' performance to ensure compliance with contractor requirements and the Federal Manager's Financial Integrity Act.

US-DOJ-KAISER-00060990
US-DOJ-KAISER-00060989

EXHIBIT 8

To: Simons, Kellie M. (CMS/CM)[Kellie.Simons@cms.hhs.gov]
From: Chaudhuri, Ilina (CMS/CM)
Sent: Tue 12/12/2017 6:43:03 PM (UTC)
Subject: FW: Proposed Agenda: CMS/UHC Leadership Meeting (12/15/17 - Friday) 1:30-2:30ET
UHC Physician Query Summary 12.15.17 .docx

Ilina Chaudhuri
Division of Payment Validation
Medicare Plan Payment Group
410-786-8628
ilina.chaudhuri@cms.hhs.gov

This communication may contain confidential and legally privileged information and may not have been publicly disclosed. Unauthorized disclosure may result in prosecution to the fullest extent of the law. If you are not an intended recipient, or have received this message in error, please delete and e-mail the sender.

From: Rice, Cheri M. (CMS/CM)
Sent: Monday, December 11, 2017 7:28 PM
To: Morse, Jonathan D. (CMS/CPI) <Jonathan.Morse@cms.hhs.gov>; Kreisel, Johanna (OS/OGC) <Johanna.Kreisel@hhs.gov>
Cc: Paul, Rebecca (CMS/CM) <REBECCA.PAUL@CMS.HHS.GOV>; Harlow, Jennifer A. (CMS/CM) <Jennifer.Harlow@cms.hhs.gov>; Chaudhuri, Ilina (CMS/CM) <Ilina.Chaudhuri@cms.hhs.gov>
Subject: FW: Proposed Agenda: CMS/UHC Leadership Meeting (12/15/17 - Friday) 1:30-2:30ET

FYI – write up from United on the medical record reviewer guidance

---

From: O'Brien, Jennifer M [mailto:jennifer.obrien@uhc.com]
Sent: Monday, December 11, 2017 6:31 PM
To: Rice, Cheri M. (CMS/CM) <Cheri.Rice@cms.hhs.gov>; Ahern, Robert J. (CMS/CM) <Robert.Ahern@cms.hhs.gov>
Cc: Korinko, Anna L <anna_l_korinko@uhc.com>; Ward, Kendra <kendra_ward@uhc.com>
Subject: RE: Proposed Agenda: CMS/UHC Leadership Meeting (12/15/17 - Friday) 1:30-2:30ET

Cheri – thanks for the response. We can definitely make 2:30 work if you need to change it and appreciate your effort and interest in attending. We'll still plan on 1:30 but once you get confirmation just let us know if you need to push it back an hour.

As for the Medical Record Reviewer Guidance – that is interesting that it did not come from the Center for Medicare. We have some concerns about the guidance and how it might impact Medicare Advantage more generally, even outside the Risk Adjustment Data Validation context. For a variety of reasons, there is a timing sensitivity to this and we wanted to share our specific concerns about the guidance with you this week, if possible, so we've attached a short summary for you. After you have a chance to review it, can you let us know whether it's something we could connect with you on or, if not, who we should speak to instead? Your help with this is much appreciated.

Also – we'll await confirmation from you or Rob for the meeting starting time on Friday as well and look forward to seeing you and your team.

Jenny O'Brien JD, CHC, CHPC
UnitedHealthcare Chief Compliance Officer
9700 Health Care Lane | MN17-E010 | Minnetonka, MN 55343
☎: Office 952-979-6099 Cell 612-308-6869 | 🖷: Fax 888-999-1319 | ✉: jennifer.obrien@uhc.com

Executive Assistant: Kendra Ward (952-979-5971), kendra_ward@uhc.com
■ Integrity ■ Compassion ■ Relationships ■ Innovation ■ Performance



From: Rice, Cheri M. (CMS/CM) [mailto:Cheri.Rice@cms.hhs.gov]

US-DOJ-KAISER-00074211

Sent: Monday, December 11, 2017 2:41 PM
To: O'Brien, Jennifer M; Ahern, Robert J. (CMS/CM)
Cc: Korinko, Anna L; Ward, Kendra
Subject: RE: Proposed Agenda: CMS/UHC Leadership Meeting (12/15/17 - Friday) 1:30-2:30ET

Hi Jenny – thanks for your note. Agenda looks fine. I am waiting for confirmation but there is a possibility that I will have a conflicting meeting at 1:30 on Friday. If there is a conflict, would pushing our meeting back to 2:30 work for you? Hopefully I will know definitively tomorrow about the Friday schedule.

The Medical Record Reviewer Guidance was not released by the Center for Medicare so I wouldn't be the right person to discuss that. Will circle back with you on best next steps on that.

From: O'Brien, Jennifer M [mailto:jennifer.obrien@uhc.com]
Sent: Thursday, December 7, 2017 4:49 PM
To: Rice, Cheri M. (CMS/CM) <Cheri.Rice@cms.hhs.gov>; Ahern, Robert J. (CMS/CM) <Robert.Ahern@cms.hhs.gov>
Cc: Korinko, Anna L <anna_l_korinko@uhc.com>; Ward, Kendra <kendra_ward@uhc.com>
Subject: Proposed Agenda: CMS/UHC Leadership Meeting (12/15/17 - Friday) 1:30-2:30ET

Cheri and Rob,

Anna and I wanted to reach out to you as we get ready for our meeting with you and your leadership team next Friday (12/15) from 1:30-2:30ET. We wanted to share a proposed agenda and ask if there are any topics CMS would like to add:

Proposed Agenda:

Medicare Business Updates

* Update on AEP Results
* Innovation and New Growth
    * 2018 Operational & Pharmacy Readiness

Medicare Advantage Program Priorities

* Ongoing discussion regarding important policy topics

CMS Topics

* <TBD>

I know Anna reached out to you as well as BT was hoping to grab some time before or after the meeting to discuss "Medical Record Reviewer Guidance" we identified on the CMS website. We realize this is short notice but there is some urgency around the timing of this meeting so if it doesn't work to meet as proposed we are available at your convenience but do need 30 minutes of your time on this topic before the holiday break (12/21) due to the sensitive of the timing.

Thanks again for the opportunity to connect with you and your team and let us know if you'd like anything added to agenda.

Jenny O'Brien JD, CHC, CHPC
UnitedHealthcare Chief Compliance Officer
9700 Health Care Lane | MN17-E010 | Minnetonka, MN 55343
☎: Office 952-979-6099 Cell 612-308-6869 | 🖷: Fax 888-999-1319 | ✉: jennifer.obrien@uhc.com

Executive Assistant: Kendra Ward (952-979-5971), kendra_ward@uhc.com
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EXHIBIT 9

U.S. Department of Justice

Civil Division

JAY:PLH:LAOberembt
DJ No. 46-11-3388

(202) 305-8586

Washington, DC 20530

October 20, 2022

VIA EMAIL

Stephen Sullivan, Esq.
O'Melveny & Myers LLP
400 South Hope Street
18th Floor
Los Angeles, CA 90071-2899

Re: *United States ex rel. Osinek v. Kaiser Permanente*, Case No. 3:13-cv-0381-EMC – Request for Consent for Defendants to Conduct Early Rule 30(b)(6) Deposition of United States on Organizational Topics

Dear Mr. Sullivan:

I am writing on behalf of the United States in response to your October 10 letter that requested our consent for Kaiser to conduct an early Rule 30(b)(6) deposition of the United States. In your letter, you proposed that Kaiser be able to take more than one Rule 30(b)(6) deposition: a "foundational" 30(b)(6) deposition now and an additional 30(b)(6) deposition in the future. The United States does not consent to Kaiser's proposal. As explained further below, your proposal to take two Rule 30(b)(6) depositions is not legally supported and imposes unnecessary burden where more efficient methods to obtain the information are available.

As an initial matter, you have not provided any legal support for your proposal. Although there is some disagreement about whether a corporation is a "deponent" subject to the one-deposition-limit of Rule 30(a)(2)(A)(ii), most courts, including Judge Chen, have found that only one Rule 30(b)(6) deposition is permitted absent leave of the court. *See Blackwell v. City & Cty. of San Francisco*, No. C-07-4629 SBA (EMC), 2010 WL 2608330, at *1 (N.D. Cal. June 25, 2010). You have not cited any case in which a court granted leave for a foundational Rule 30(b)(6) deposition in addition to a subsequent Rule 30(b)(6) deposition on the merits.

In *Blackwell*, Judge Chen adopted the reasoning of *State Farm Mut. Auto. Ins. Co. v. New Horizont, Inc.*, 254 F.R.D. 227 (E.D. Pa. 2008) in concluding that leave of the court is required to proceed with two Rule 30(b)(6) depositions. As explained in *State Farm*, allowing multiple Rule 30(b)(6) depositions is "costly and burdensome," "provides the deposing party with an unfair strategic advantage," and contravenes the Federal Rules, by allowing the defendant to "avoid drafting a comprehensive notice of deposition and instead conduct depositions seriatim, thereby

shifting costs to the opposing side." 254 F.R.D. at 235-36. Kaiser's unprecedented request raises all of the same concerns as in *State Farm*.

Judge Chen found in *Blackwell* that whether leave for a second deposition should be granted is based on the factors identified in Federal Rule of Civil Procedure 26(b)(2), which include whether the proposed deposition "is unreasonably cumulative or duplicative, or can be obtained from some other source that is more convenient, less burdensome, or less expensive." Fed. R. Civ. P. 26(b)(2)(C)(i). Here, as in *Blackwell*, the Rule 26(b)(2) factors do not support taking two Rule 30(b)(6) depositions. Kaiser's proposal would require a second deponent to needlessly prepare for and attend a Rule 30(b)(6) deposition on topics that could more easily be responded to via written discovery. The proposed foundational Rule 30(b)(6) deposition is less convenient, more burdensome, and more expensive than the alternatives. As we noted in our Rule 26(f) submission, courts routinely decline to impose the burden of a Rule 30(b)(6) deposition that duplicates interrogatories. Joint Rule 26(f) Report, at 17. This is because interrogatories are less burdensome and "prevent the undue burden of a witness or witnesses learning and remembering to state all facts" that could otherwise be provided via interrogatory. *Gen-Probe Inc. v. Becton, Dickinson & Co.*, No. 09-cv-2319 BEN (NLS), 2012 WL 12845593, at *2 (S.D. Cal. Mar. 28, 2012).

The principal case that you rely on in your letter—*Heath v. Google LLC*, No. 15-cv-01824-BLF (VKD), 2018 WL 4491368 (N.D. Cal. Sept. 19, 2018)—did not involve an early foundational Rule 30(b)(6) deposition and provides no support for one. In *Heath*, the court rejected most of plaintiff's proposed second Rule 30(b)(6) deposition, only granting leave to take a second 3.5-hour deposition on a single topic that the defendant had objected to at the first deposition. *Id.* at 3-4. There was nothing at issue in *Heath* to support what Kaiser is now proposing. *English v. Wash. Metro. Area Transit Auth.*, 323 F.R.D. 1, 27 (D.D.C. 2017), which is also cited in your letter, is even further afield. That case only involved a single Rule 30(b)(6) deposition; the question of having two Rule 30(b)(6) depositions, let alone a foundational one, was not under consideration.

The specific topics included in your proposed Rule 30(b)(6) notice underscore the impropriety of your request.

First, several of the requests seek organizational information related to the dozens of topics listed in Exhibit A of the Rule 30(b)(6) Notice. *See* Topic Nos. 2-3. These are the *exact same* items whose relevance is currently at issue in the discovery dispute before Magistrate Judge Spero. The 30(b)(6) deposition cannot be used as an end run around this ongoing dispute. Likewise, we disagree with your contention that "certain discovery disputes may be resolved, or at least narrowed, through a Rule 30(b)(6) deposition." To the extent there is a dispute related to a written discovery request, the same dispute would exist with respect to a parallel Rule 30(b)(6) topic.

Second, many of the proposed Rule 30(b)(6) topics seek information that Kaiser has not previously requested through written discovery. For example, Topics 3 and 4 cover brand new ground related to HHS's processes and document retention, while the other topics seek information about HHS's organizational structure that is far more expansive than anything Kaiser has previously asked for. You contend that an early Rule 30(b)(6) deposition is necessary

because the United States has not provided the same information in response to interrogatories and document requests. This is largely because Kaiser has not requested the information now sought. While the United States reserves the right to object to any such discovery requests, it would be far more efficient to issue interrogatories and/or document requests targeting the requested organizational information than to force the United States to expend resources preparing for multiple Rule 30(b)(6) depositions. *See Groupion, LLC v. Groupon, Inc.*, No. 11-0870 MEJ, 2012 WL 359699, at *5–6 (N.D. Cal. Feb. 2, 2012) (denying leave for second Rule 30(b)(6) deposition where plaintiff "failed to establish that it even attempted to obtain the requested discovery through less intrusive methods"); *Bank of Am., N.A. v. SFR Invs. Pool 1 LLC*, No. 2:15-cv-01042-APG-GWF, 2016 WL 2843802, at *3 (D. Nev. May 12, 2016) (precluding proposed Rule 30(b)(6) deposition where the requested information could "clearly be provided more efficiently and fairly through answers to interrogatories").

To the extent the topics in your proposed Rule 30(b)(6) Notice do overlap with previous written discovery requests, we have largely provided the requested information. Your letter ignores that we have provided responses to Interrogatory Nos. 3, 6, 7, and 8; each of these requests asked us to identify various government employees, which we have done. In addition, subject to certain limitations, we agreed to provide the CMS organizational information requested in Request for Production No. 126 and are actively working to do so shortly.

Third, it is a misnomer to characterize all of the proposed Rule 30(b)(6) topics as "Organizational Topics," as you do in your letter. Specifically, Topic No. 4 broadly seeks information about the "processes" used by various HHS Divisions for a long list of items, including "Addenda" "Diagnosis Codes," and "Medicare Advantage Contracts." This request cannot be characterized as merely organizational. This broad and ill-defined topic would open up the supposedly foundational Rule 30(b)(6) deposition to a wide range of substantive contentions on the merits.

For the reasons set forth above, the United States does not consent to Kaiser's proposal to take two Rule 30(b)(6) depositions of the United States.

Sincerely,

Laurie A. Oberembt

Laurie A. Oberembt
Senior Trial Counsel

Cc: Assistant U.S. Attorney Shiwon Choe (N.D. Cal.)
Assistant U.S. Attorney David Moskowitz (D. Co.)
Assistant U.S. Attorney Ben Wolinsky (N.D. Cal.)

EXHIBIT 10

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2013 NATIONAL TECHNICAL ASSISTANCE

Risk Adjustment 101

July 22, 2013

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RISK ADJUSTMENT 101

Introduction Overview Connectivity/Testing
Key Data Elements RAPS Reports Resources

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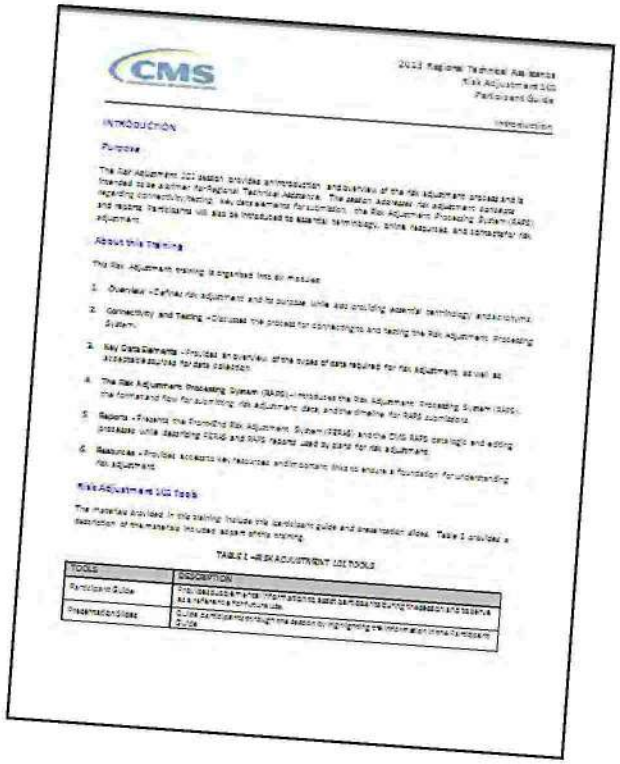
Purpose

- Provide an introduction and overview of the risk adjustment process
- Address:
  - Connectivity/testing
  - Key data elements for submission
  - Risk Adjustment Processing System (RAPS)
  - Reports
- Introduce terminology, online resources, and contacts for risk adjustment

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Risk Adjustment 101 Tools

- The materials provided in this training include:
  - Participant Guide
    - Provides additional material to support the session
    - Designed as a reference for future use
  - Presentation Slides
    - Highlight the information covered during the session



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Questions & Answers



Your Questions are Important!

Thank you!

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Contact Information



During the webinar



For questions regarding logistics or registration by phone call **888-330-9994.**

After the webinar: riskadjustment@cms.hhs.gov

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RISK ADJUSTMENT 101

Introduction | **Overview** | Connectivity/Testing

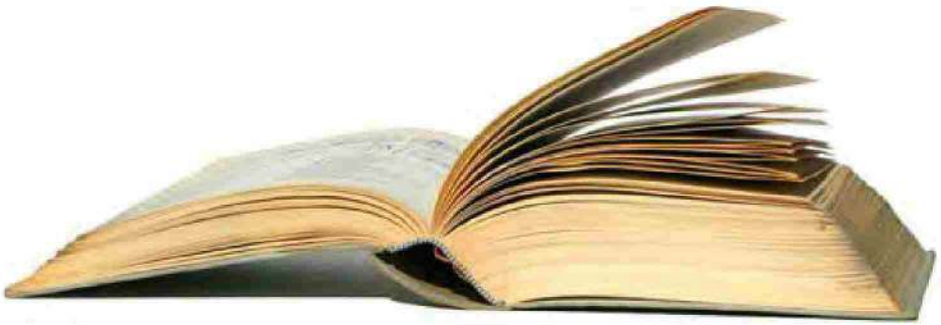
Key Data Elements | RAPS | Reports | Resources

US-DOJ-KAISER-00049651

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Overview Learning Objectives

- Learn the purpose and history of risk adjustment
- Define important risk adjustment terms and acronyms



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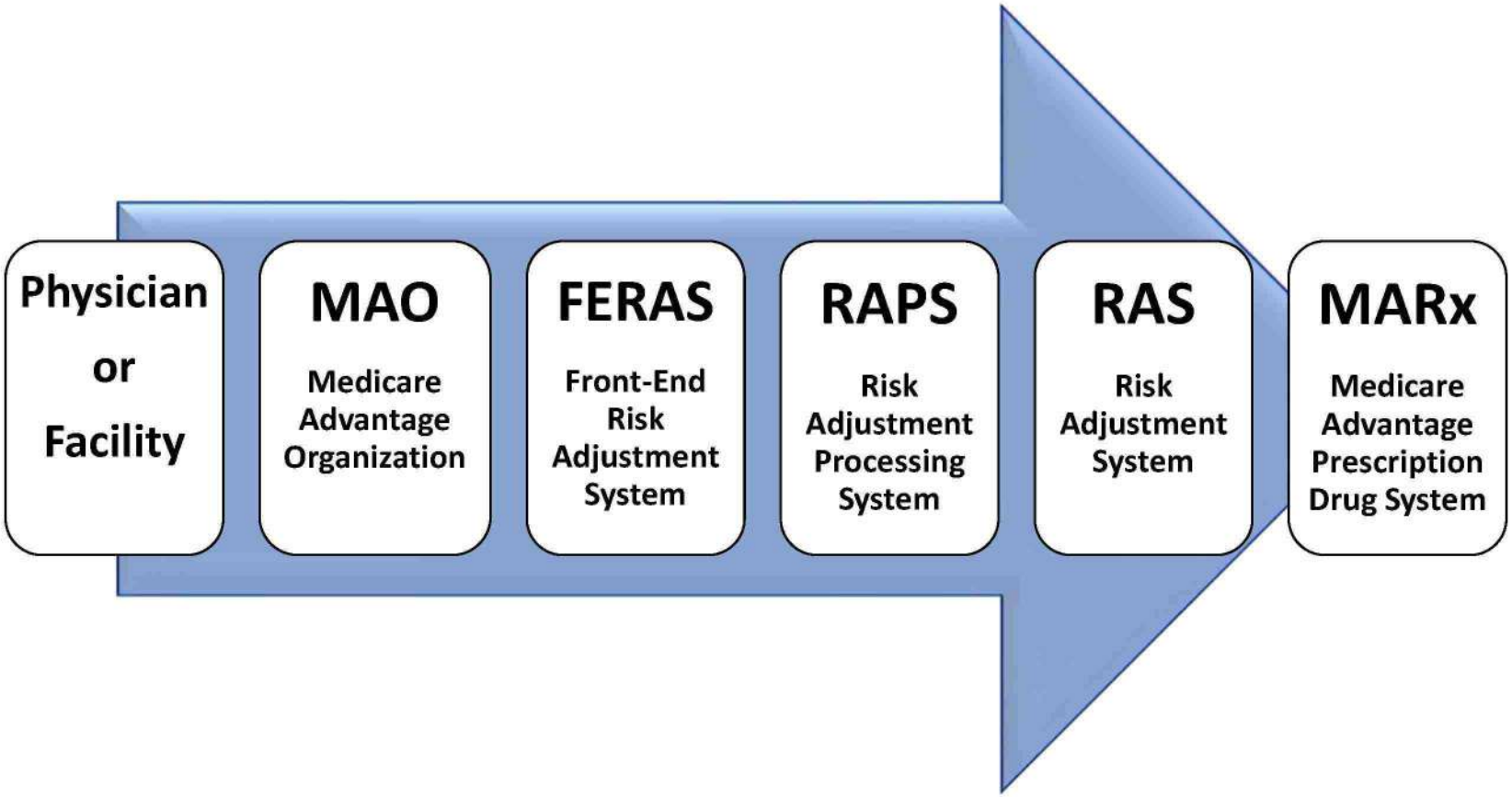
Risk Adjustment Definition

- The method used to adjust bidding and payments based on the health status and demographic characteristics of an enrollees

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Risk Adjustment Data Flow



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Risk Adjustment History

Balanced Budget Act (BBA)
1997

2000
Benefits Improvement Act (BIPA)

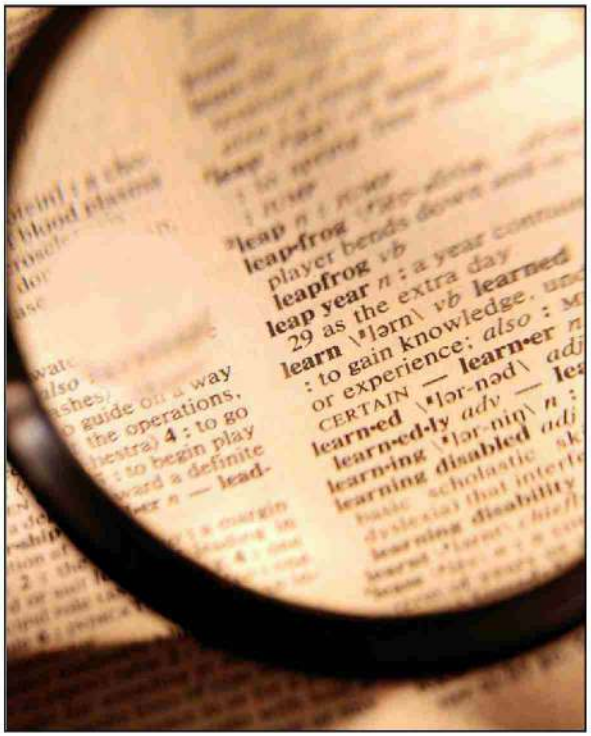
Medicare Prescription Drug, Improvement, and Modernization Act (MMA)
2003

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Risk Adjustment Terms and Acronyms

- Demographics
- FERAS
- HCC
- MARx UI
- Model Run
- RAPS
- RAS
- Risk Adjustment Model
- Status



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Questions & Answers



Your Questions are Important!

Thank you!

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RISK ADJUSTMENT 101

Introduction > Overview > **Connectivity/Testing**

Key Data Elements > RAPS > Reports > Resources

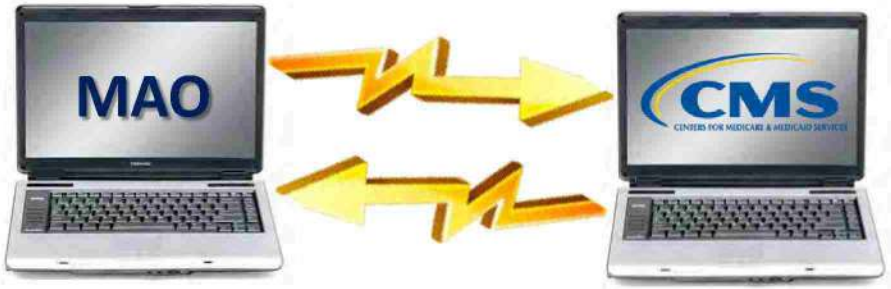
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CONNECTIVITY

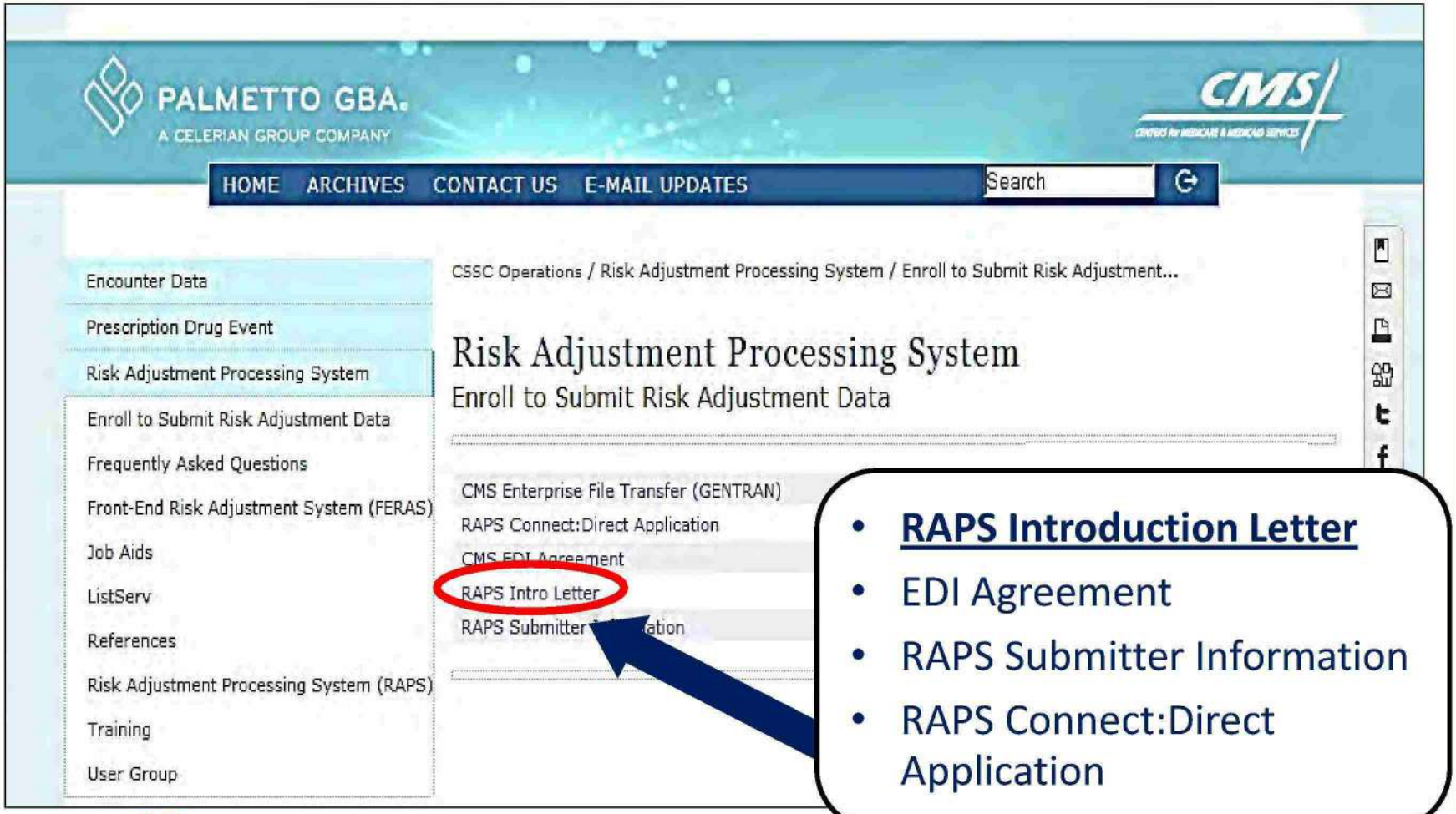
Connectivity Learning Objectives

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



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RAPS Introduction Letter



http://www.csscoperations.com

CONNECTIVITY



MEDICARE
Palmetto GBA
CSSCOperations AG-570

TO: Medicare Advantage Organizations Submitting Risk Adjustment Data

RE: EDI Enrollment and Submitter Application for Risk Adjustment Data Processing

Welcome to the Customer Service and Support Center (CSSC) for Medicare Advantage (MA) Organizations submitting Risk Adjustment Data. The CSSC and the Front-End Risk Adjustment System (FERAS) look forward to working with you in all aspects of the submission of risk adjustment data.

The following information must be completed and sent to the CSSC for enrollment for the submission of data for Risk Adjustment:

- EDI Agreement for Risk Adjustment Data collection
- Submitter Application
- Risk Adjustment Connect:Direct Specifications (For Connect:Direct users only)

Please note the following for submitting Risk Adjustment Data:

- A CMS Risk Adjustment Data EDI Agreement must be completed by each submitter and on file with CSSC, prior to submitting Risk Adjustment Data. The agreement must be signed by an authorized agent of the organization and returned to CSSC Operations at the address provided.

- **Use of Third Party Submitters:** If the submitter will be an entity other than an MA organization, the Submitter must complete the Submitter ID Application form and the MA organization must complete the EDI Agreement. This EDI Agreement must be completed, signed and returned for each Plan number submitting data. Regardless who submits the data, CMS holds the MA organization accountable for the content of the submission.

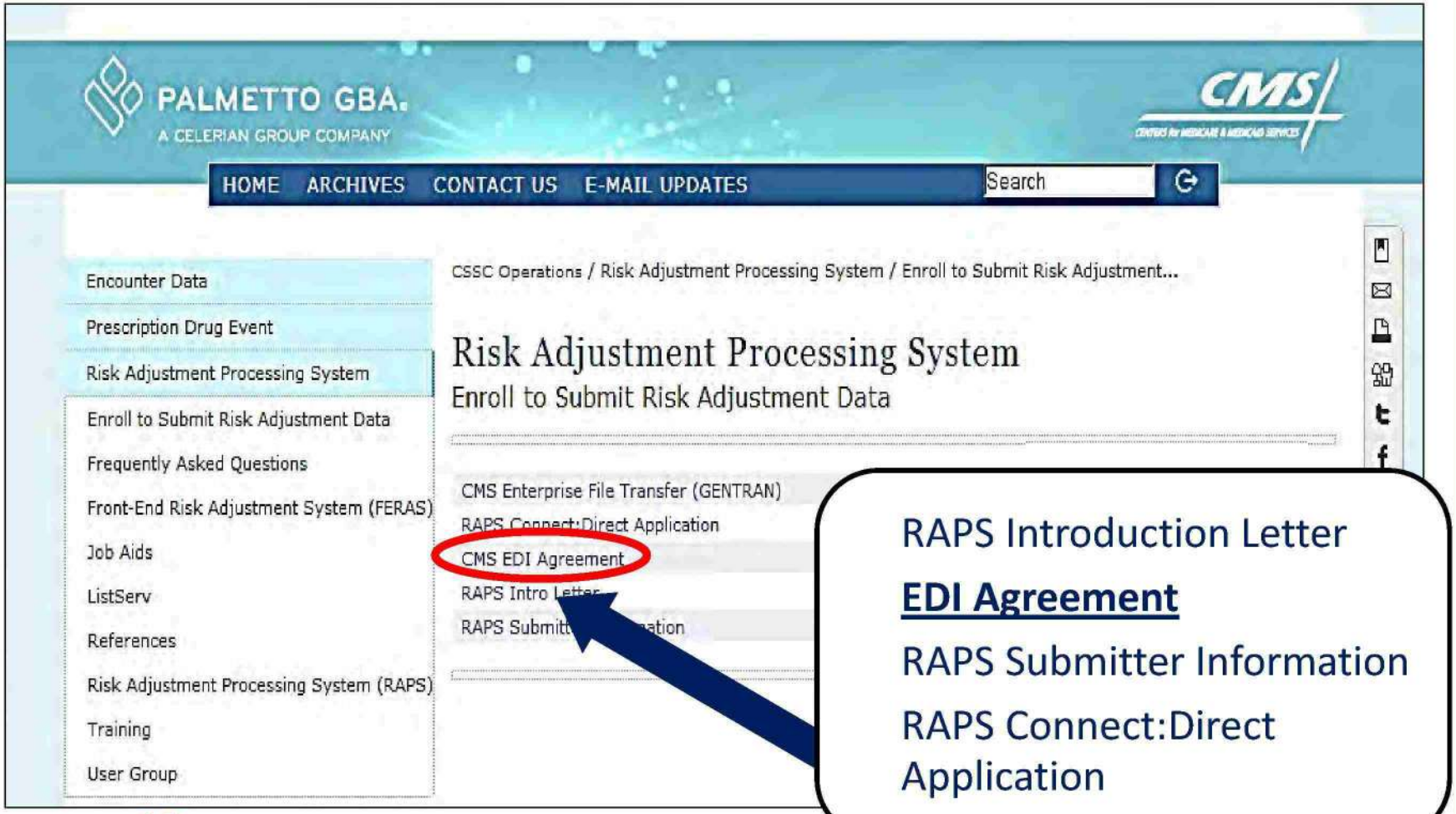
- A Submitter ID (SHnnnn) will be assigned to you by the CSSC and will remain effective for ongoing submission of risk adjustment data. This is the unique ID assigned to the Plan or entity that will submit data and retrieve reports. Please complete the Submitter Application return it to CSSC Operations with the completed EDI Agreement.

Palmetto GBA
CSSC Operations AG-570
2300 Springdale Drive Bldg. One • Camden, South Carolina • 29020-1728
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EDI Agreement



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Medicare Advantage Organization

Electronic Data Interchange Enrollment Form

MANAGED CARE ELECTRONIC DATA INTERCHANGE (EDI) ENROLLMENT FORM

ONLY for the Collection of Risk Adjustment Data and/or

With Medicare Advantage Eligible Organizations

The eligible organization agrees to the following provisions for submitting Medicare risk adjustment data electronically to The Centers for Medicare & Medicaid Services (CMS) or to CMS's contractors:

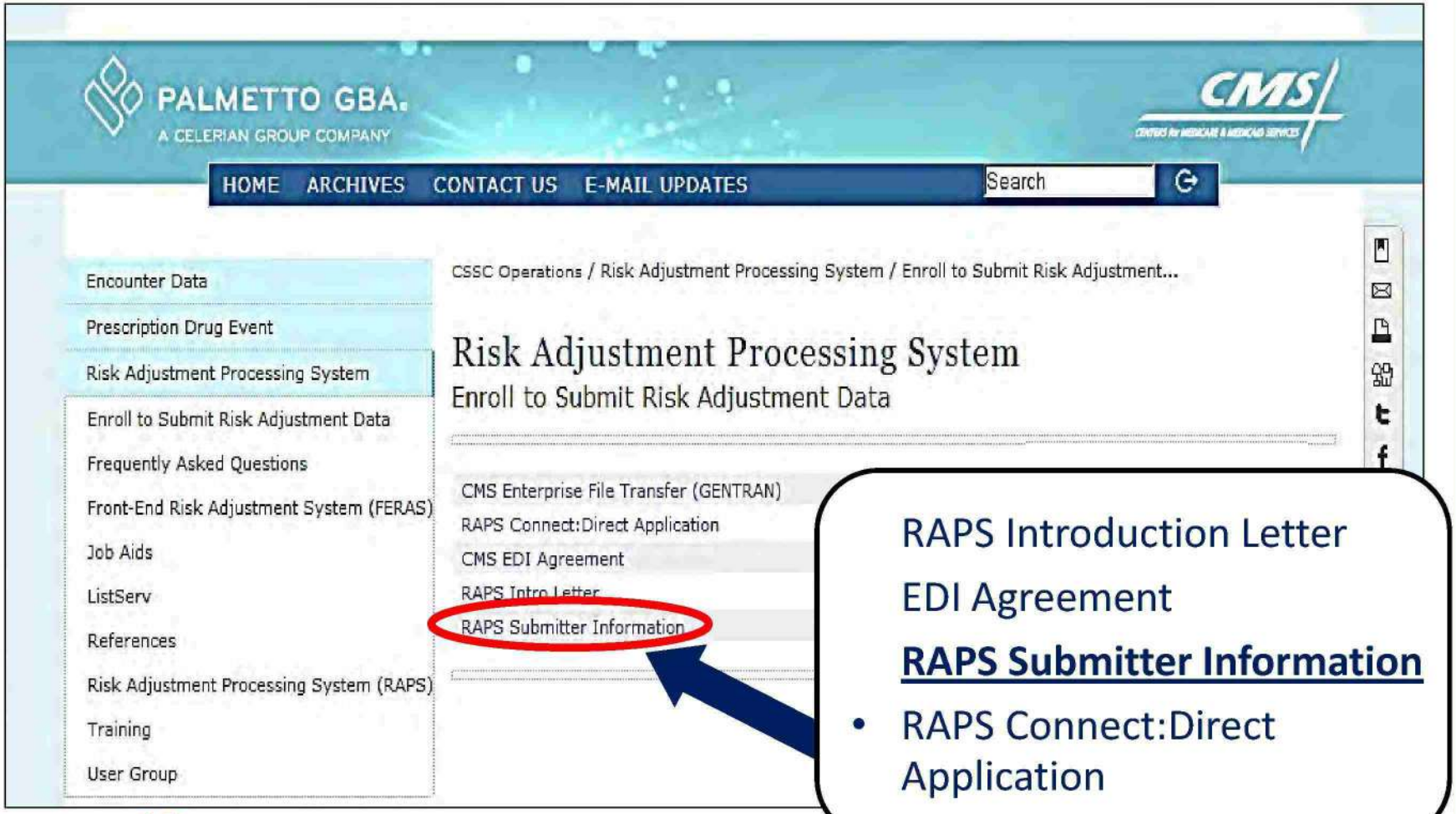
A. **The Eligible Organization Agrees:**

1. That it will be responsible for all Medicare risk adjustment data submitted to CMS by itself, its employees, or its agents.
2. That it will not disclose any information concerning a Medicare beneficiary to any other person or organization, except CMS and/or its contractors, without the express written permission of the Medicare beneficiary or his/her parent or legal guardian, or where required for the care and treatment of a beneficiary who is unable to provide written consent, or to bill insurance primary or supplementary to Medicare, or as required by State or Federal law.
3. That it will ensure that every electronic entry can be readily associated and identified with an original source document. Each source document must reflect the following information:
   - Beneficiary's name,
   - Beneficiary's health insurance claim number,
   - Date(s) of service,
   - Diagnosis/nature of illness
4. That the Secretary of Health and Human Services or his/her designee and/or the contractor has the right to audit and confirm information submitted by the eligible organization and shall have access to all original source documents and medical records related to the eligible organization's submissions, including the beneficiary's authorization and signature.
5. Based on best knowledge, information, and belief, that it will submit risk adjustment data that are accurate, complete, and truthful.
6. That it will retain all original source documentation and medical records pertaining to any such particular Medicare risk adjustment data for a period of at least 6 years, 3 months after the risk adjustment data is received and processed.
7. That it will affix the CMS-assigned unique identifier number of the eligible organization on each risk adjustment data electronically transmitted to the contractor.
8. That the CMS-assigned unique identifier number constitutes the eligible organization's legal electronic signature.
9. That it will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all beneficiary-specific data from improper access.
10. That it will establish and maintain procedures and controls so that information concerning Medicare beneficiaries, or any information obtained from CMS or its contractor, shall not be used by agents, officers, or employees of the billing service except as provided by the contractor (in accordance with §1106(a) of the Act).
11. That it will research and correct risk adjustment data discrepancies.

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RAPS Submitter Information



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MEDICARE
CSSC OPERATIONS

CSSC Risk Adjustment Data Submitter Application

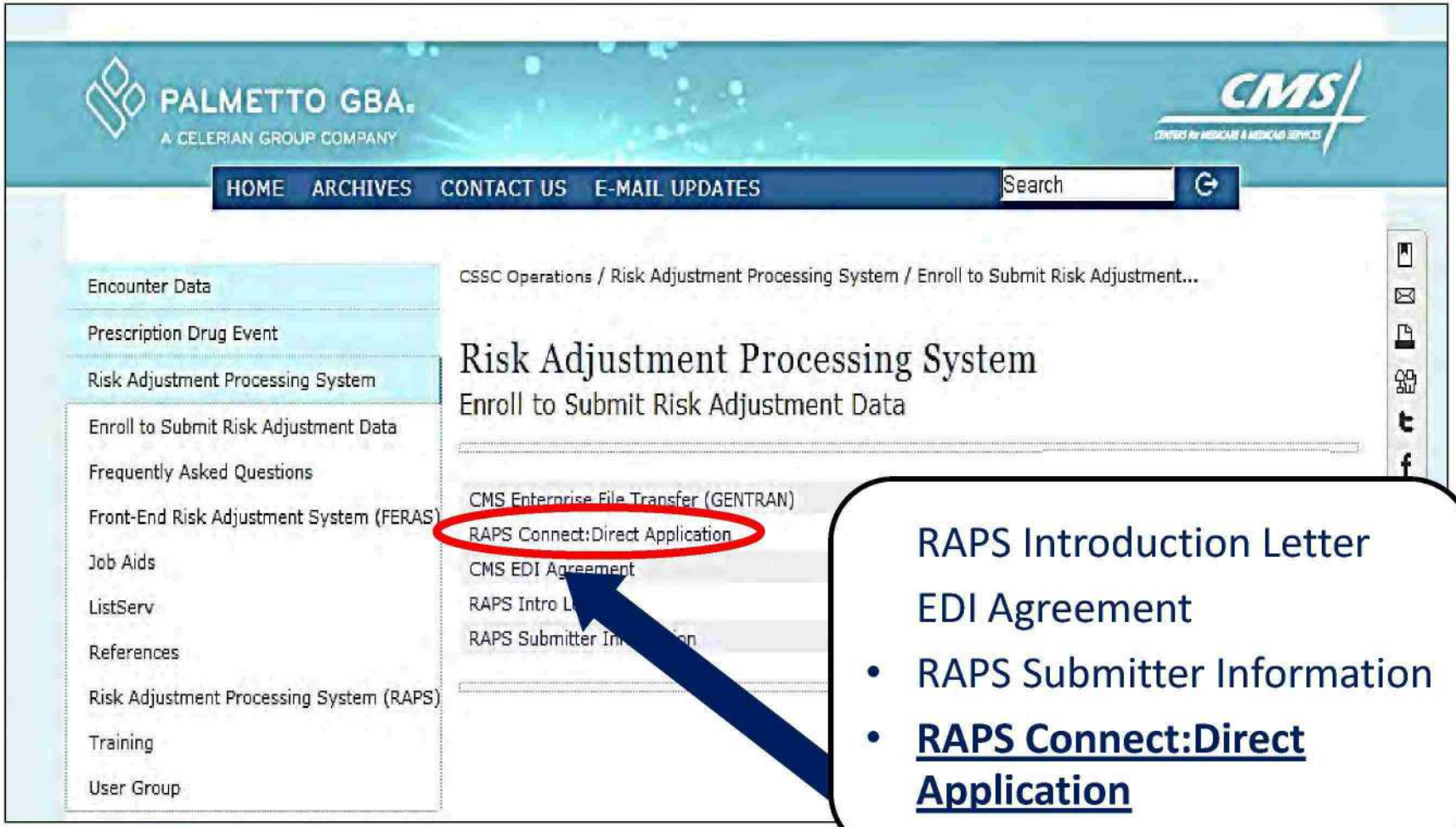
New Submitter ID:	☐ Yes ☐ No
If no, please provide your existing submitter number:	
If yes, please indicate who will submit your data:	☐ Self ☐ Third Party Submitter
If Third Party Submitter is selected, please provide the Third Party's name:	
Plan Number:	
Plan Name:	
Address:	
Fax Number :	
Operations Contact Person:	
E-Mail address:	
Phone Number:	
Technical Contact Person:	
E-Mail address:	

Palmetto GBA
CSSC Operations, AG-570
2300 Springdale Drive, Bldg. One • Camden, South Carolina • 29020
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RAPS Connect:Direct Application



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Risk Adjustment Connect:Direct Specifications

The Connect:Direct Node Connection Information for Palmetto is defined as follows:

NAT'd IP Address: 32.90.254.160
Listener Port: 1369
NODE ID: SCA.A70NDM.MC
AGNS ID: PGBA

PLEASE ENTER YOUR Connect:Direct INFORMATION (Required):

NAT'd IP Address _____
Listener Port _____
NODE ID: _____
AGNS ID: _____

Your Connect:Direct User ID and password (if datasets are racf protected)

User ID: _____
Password: _____

RAPS Transaction Submission

DSN: **MAB.PROD.NDM.RAPS.PROD.submitter id(+1)**
DISP: (NEW,CATLG,DELETE)
UNIT: SYSDG
SPACE: (CYL,(75,10),RLSE)
DCB: (RECFM=FB,LRECL=512,BLKSIZE=27648)

Note: For testing, use **MAB.PROD.NDM.RAPS.TEST. submitter id(+1)**

Please note that the test/prod indicator in the file, AAA 6, must also indicate "TEST" or "PROD", depending on the type of file being submitted.

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Learn about your healthcare options

Search

Medicare | Medicaid/CHIP | Medicare-Medicaid Coordination | Insurance Oversight | Innovation Center | Regulations and Guidance | Research, Statistics, Data and Systems | Outreach and Education

MAPD Help Desk

Return to List

Details for Topic: C. Connectivity Preparation

Topic	C. Connectivity Preparation
Description	Information and detailed instructions for physically connecting to CMS for electronic file transfers, MARX User Interface access, and MBD User Interface access.
File List	Data Exchange Preparation Procedures (DEPP), Connectivity and Access Configuration Process, CMS Connectivity for MA/PDP/MA-PD and 3rd Party Organizations, Connecting to the CMS Enterprise, MDCN Extranet DNS Reference for CMS Business Partners, Connect:Direct Setup Form, Connect:Direct Setup Checklist, Connect:Direct Secure Point of Entry (SPOE), Connect: Enterprise Secure Client (HTTPS examples), EFT Verisign Certificates, and Secure FTP SSH Client Internet reference.

This information below provides brief detailed descriptions of each document in this section. The actual documentation is available toward the bottom of this page in the section titled "Downloads".

Downloads

Data Exchange Preparation Procedures (DEPP), Version 7, July 3, 2012 [PDF, 292KB]
Connect:Direct Secure Point of Entry (SPOE) Form [PDF, 188KB]
Connect:Enterprise Secure Client (HTTPS examples), 2006-2007 [PDF, 25MB]
EFT Verisign Certificates, August 10, 2005 [PDF, 187KB]
Internet Security Certificate, August 2005 [ZIP, 1KB]
Secure FTP SSH Client Internet, Version8, August 2006 [PDF, 6MB]

Help with File Formats and Plug-Ins

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CONNECTIVITY

Connection Options

- Connect:Direct
  - Mainframe-to-mainframe
- File Transfer Protocol (FTP)
  - Modem-to-modem
- Gentran
  - Through vendor or web interface
- TIBCO MFT
  - IP Internet transmissions



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Connectivity Testing

- Verifies successful flow of data from submitter to FERAS
- Ensures submitted data is valid and formatted correctly



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US-DOJ-KAISER-00049670

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Front End Risk Adjustment System

[FERAS]

User Guide

Palmetto GBA

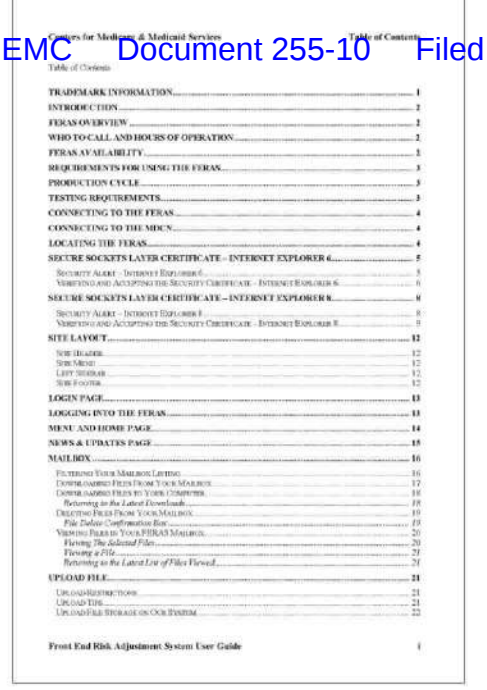
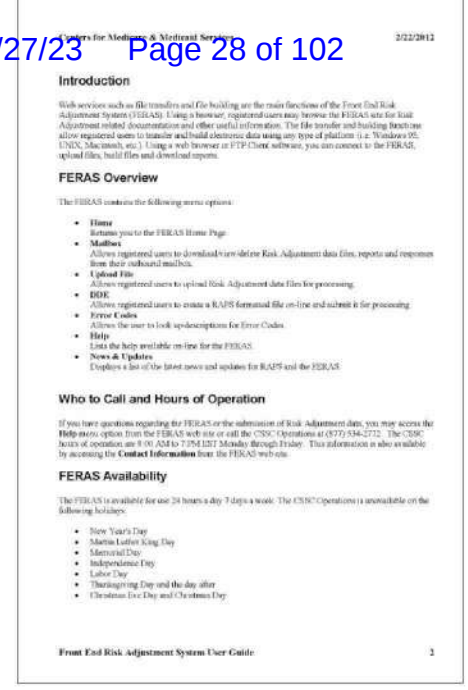

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Centers for Medicare & Medicaid Services 2/22/2012

Introduction

Web services such as file transfers and file building are the main functions of the Front End Risk Adjustment System (FERAS). Using a browser, registered users may browse the FERAS site for Risk Adjustment related documentation and other useful information. The file transfer and building functions allow registered users to transfer and build electronic data using any type of platform (i.e. Windows 95, UNIX, Macintosh, etc.). Using a web browser or FTP Client software, you can connect to the FERAS, upload files, build files and download reports.

FERAS Overview

The FERAS contains the following menu options:

- **Home**
  Returns you to the FERAS Home Page.
- **Mailbox**
  Allows registered users to download/view/delete Risk Adjustment data files, reports and responses from their outbound mailbox.
- **Upload File**
  Allows registered users to upload Risk Adjustment data files for processing.
- **DDE**
  Allows registered users to create a RAPS formatted file on-line and submit it for processing.
- **Error Codes**
  Allows the user to look up descriptions for Error Codes.
- **Help**
  Lists the help available on-line for the FERAS.
- **News & Updates**
  Displays a list of the latest news and updates for RAPS and the FERAS.

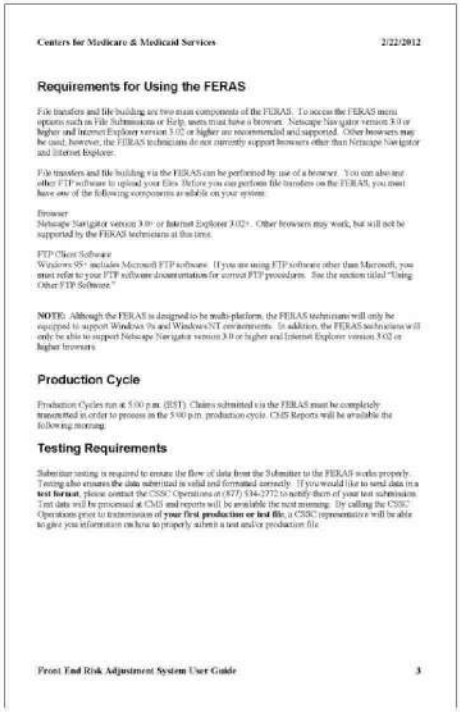
Who to Call and Hours of Operation

If you have questions regarding the FERAS or the submission of Risk Adjustment data, you may access the **Help** menu option from the FERAS web site or call the CSSC Operations at (877) 534-2772. The CSSC hours of operation are 8:00 AM to 7:PM EST Monday through Friday. This information is also available by accessing the **Contact Information** from the FERAS web site.

FERAS Availability

The FERAS is available for use 24 hours a day 7 days a week. The CSSC Operations is unavailable on the following holidays:

- New Year's Day
- Martin Luther King Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day and the day after
- Christmas Eve Day and Christmas Day


Centers for Medicare & Medicaid Services 2/22/2012

Requirements for Using the FERAS

File transfers and file building are two main components of the FERAS. To access the FERAS menu options such as File Submissions or Help, users must have a browser. Netscape Navigator version 3.0 or higher and Internet Explorer version 3.02 or higher are recommended and supported. Other browsers may be used, however, the FERAS technicians do not currently support browsers other than Netscape Navigator and Internet Explorer.

File transfers and file building via the FERAS can be performed by use of a browser. You can also use other FTP software to upload your files. Before you can perform file transfers on the FERAS, you must have one of the following components available on your system:

Browser
Netscape Navigator version 3.0+ or Internet Explorer 3.02+. Other browsers may work, but will not be supported by the FERAS technicians at this time.

FTP Client Software
Windows 95+ includes Microsoft FTP software. If you are using FTP software other than Microsoft, you must refer to your FTP software documentation for correct FTP procedures. See the section titled "Using Other FTP Software."

NOTE: Although the FERAS is designed to be multi-platform, the FERAS technicians will only be equipped to support Windows 9x and Windows/NT environments. In addition, the FERAS technicians will only be able to support Netscape Navigator version 3.0 or higher and Internet Explorer version 3.02 or higher browsers.

Production Cycle

Production Cycles run at 5:00 p.m. (EST). Claims submitted via the FERAS must be completely transmitted in order to process in the 5:00 p.m. production cycle. CMS Reports will be available the following morning.

Testing Requirements

Submitter testing is required to ensure the flow of data from the Submitter to the FERAS works properly. Testing also ensures the data submitted is valid and formatted correctly. If you would like to send data in a **test format**, please contact the CSSC Operations at (877) 534-2772 to notify them of your test submission. Test data will be processed at CMS and reports will be available the next morning. By calling the CSSC Operations prior to transmission of **your first production or test file**, a CSSC representative will be able to give you information on how to properly submit a test and/or production file.


Centers for Medicare & Medicaid Services 2/22/12

Connecting to the FERAS

To establish an IP connection with the FERAS, you must be connected to the Medicare Data Communications Network (MDCN), which is provided by AT&T Global Network Services. The MDCN is the secure network linking the Risk Adjustment data processing systems. If you are not connected to the MDCN, please contact AT&T at 1-800-955-2000.

All submitters with IP network access have been addressed to connect to the FERAS.

In order to submit claims to the FERAS via the MDCN, you must be enrolled with the CSSC. If you are not enrolled, please contact the CSSC Operations at (877) 534-2772. Once enrolled with the CSSC to submit and retrieve data electronically, you will receive a Submitter ID and a password.

NOTE: The password is case sensitive. You must enter your original password exactly as it was assigned to you by the CSSC. See the Changing Passwords section for information on how to change your password.

Connecting to the MDCN

1. Refer to your MDCN instructions for dialing into the MDCN.
2. Once you have dialed in to the MDCN, start your browser. At the Uniform Resource Locator (URL) or address field, type: https://32.97.242.4/feras as shown in Figure 1, and press **ENTER**. See the figure below for locating the FERAS site using Internet Explorer.

NOTE: If you type http://32.97.242.4/feras in the URL, you will be prompted to use the secure version and then automatically be forwarded to the Secure Sockets Layer (SSL) version of the site.

Locating the FERAS

Enter the address of the FERAS into the browsers location or address bar and press the Enter key.

Figure 1 Entering the FERAS IP Address

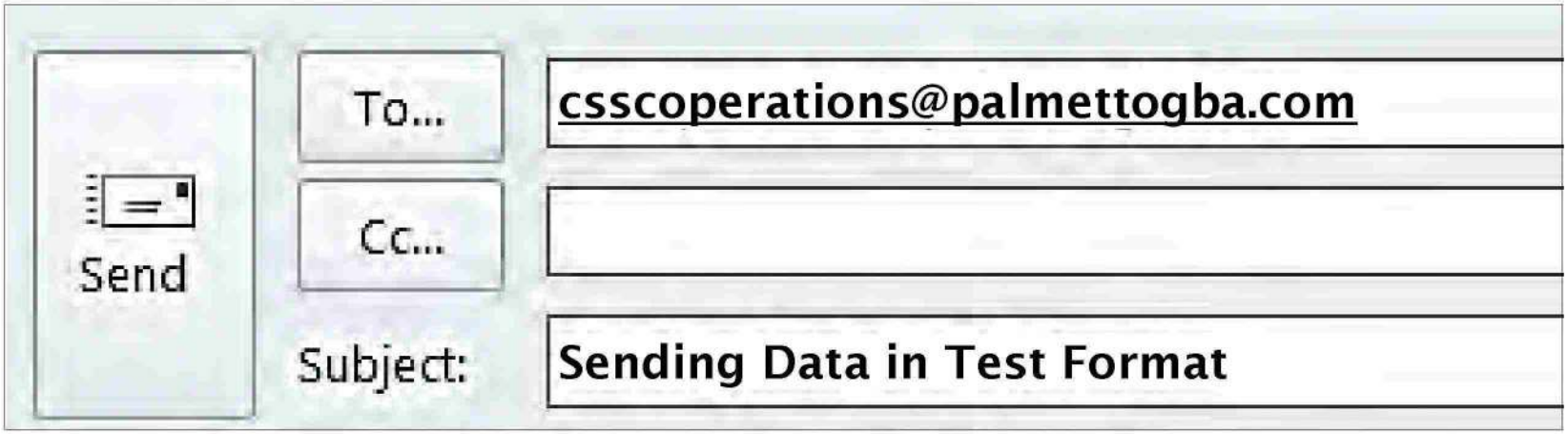
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Connectivity Testing (continued)

- Contact CSSC Operations to send data in test format





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Test Your Knowledge

- What are the connectivity options?

Connect:Direct
FTP
Gentran
TIBCO MFT



- Which one of these does your plan have?

That depends…

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CONNECTIVITY

Test Your Knowledge

- Who is the main contact for connectivity information and to arrange testing?

CSSC



- When do plans submit test data?

Within three months of their HPMS effective date

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CONNECTIVITY

Questions & Answers



Your Questions are Important!

Thank you!

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RISK ADJUSTMENT 101

Introduction > Overview > Connectivity/Testing

Key Data Elements > RAPS > Reports > Resources

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Key Data Elements Learning Objectives

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

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Data Elements



Data Elements:

- include demographic and disease data
- are used to calculate a risk score for each beneficiary

KEY DATA ELEMENTS

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Submitted Data Elements

Risk Adjustment requires five (5) minimum data elements :

- HIC (Health Insurance Claim) Number
- Provider Type
- "From" Date of Service
- "Through" Date of Service
- Diagnosis Code

KEY DATA ELEMENTS

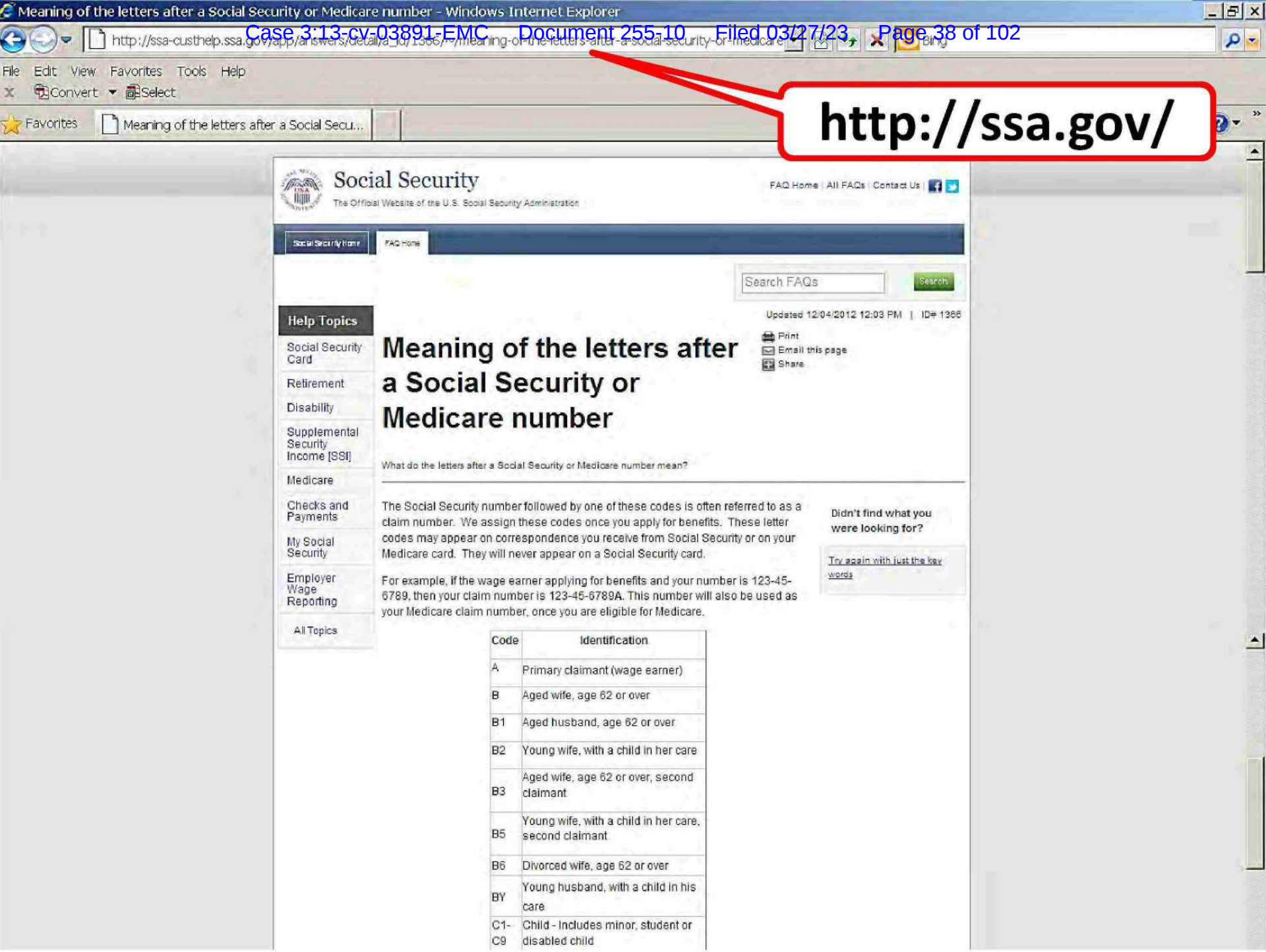
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HIC Number Descriptions

HIC TYPE	DESCRIPTIONS
CMS	• 9-Digit Social Security number • alpha suffix – "A" beneficiary – "B" spouse – "C" children – "D" divorced spouse, widow, widower • alpha-numeric suffix - indicates number of children – "C1" first child
RRB pre-1964	• alpha prefix • 6-digit random numbers
RRB post-1964	• alpha prefix • 9-digit Social Security number

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Code	Identification
A	Primary claimant (wage earner)
B	Aged wife, age 62 or over
B1	Aged husband, age 62 or over
B2	Young wife, with a child in her care
B3	Aged wife, age 62 or over, second claimant
B5	Young wife, with a child in her care, second claimant
B6	Divorced wife, age 62 or over
BY	Young husband, with a child in his care
C1-C9	Child - Includes minor, student or disabled child

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Provider Type

- Hospital Inpatient
- Hospital Outpatient
- Physician Services



KEY DATA ELEMENTS

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Acceptable Sources



Diagnoses submitted for risk adjustment must result from a face to face encounter with either:

- ✓ an acceptable physician specialty
- ✓ an acceptable facility

KEY DATA ELEMENTS

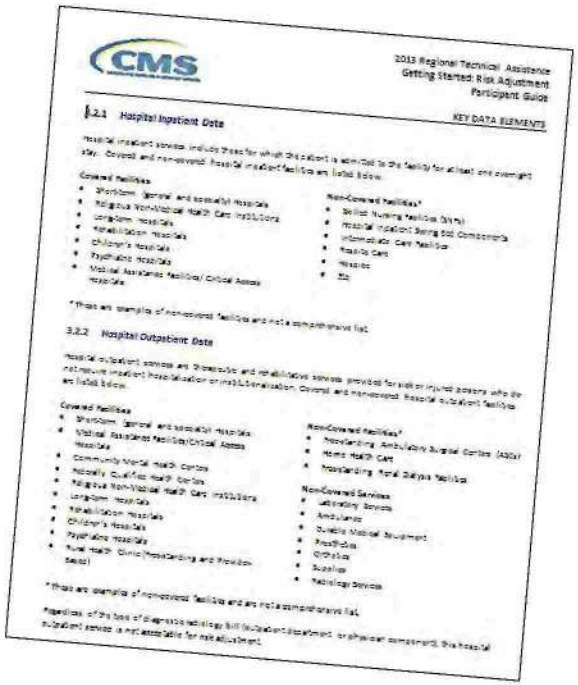
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Hospital Outpatient Example

Q: Does a claim from an outpatient hospital encounter have to be accompanied by a face-to-face physician visit in order to be eligible for risk adjustment?

A: The diagnoses submitted to RAPS must result from a face-to-face encounter with an acceptable physician specialty OR from an encounter in an acceptable facility.


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2013 Regional Technical Assistance
Getting Started: Risk Adjustment
Participant Guide

KEY DATA ELEMENTS

3.2.1 Hospital Inpatient Data

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

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

Non-Covered Facilities*
- Skilled Nursing Facilities (SNFs)
- Hospital inpatient Swing Bed Components
- Intermediate Care Facilities
- Hospice Care
- Hospices
- Etc.

*These are examples of non-covered facilities and not a comprehensive list.

3.2.2 Hospital Outpatient Data

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

Covered Facilities
- Short-term (general and specialty) hospitals
- Medical Assistance Facilities/Critical Access Hospitals
- Community mental health centers
- Federally Qualified Health Centers
- Religious Non-Medical Health Care Institutions
- Long-term hospitals
- Rehabilitation hospitals
- Children's hospitals
- Psychiatric hospitals
- Rural Health Clinic (Freestanding and Provider-based)

Non-Covered Facilities*
- Freestanding Ambulatory Surgical Centers (ASCs)
- Home Health Care
- Freestanding Renal Dialysis Facilities

Non-Covered Services
- Laboratory Services
- Ambulance
- Durable Medical Equipment
- Prosthetics
- Orthotics
- Supplies
- Radiology Services

*These are examples of non-covered facilities and are not a comprehensive list.

Regardless of the type of diagnostic radiology (x-ray) or laboratory test, outpatient services is not acceptable for risk adjustment.

KEY DATA ELEMENTS

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Physician Data

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Acceptable Physician Specialty Types for 2014 Payment Year (2013 Dates of Service) Risk Adjustment Data Submission

CODE	SPECIALTY	CODE	SPECIALTY	CODE	SPECIALTY
1	General Practice	25	Physical Medicine And Rehabilitation	67	Occupational Therapist
2	General Surgery	26	Psychiatry	68	Clinical Psychologist
3	Allergy/Immunology	27	Geriatric Psychiatry	72*	Pain Management
4	Otolaryngology	28	Colorectal Surgery	76*	Peripheral Vascular Disease
5	Anesthesiology	29	Pulmonary Disease	77	Vascular Surgery
6	Cardiology	33*	Thoracic Surgery	78	Cardiac Surgery
7	Dermatology	34	Urology	79	Addiction Medicine
8	Family Practice	35	Chiropractic	80	Licensed Clinical Social Worker
9	Interventional Pain Management (IPM)	36	Nuclear Medicine	81	Critical care (intensivists)
10	Gastroenterology	37	Pediatric Medicine	82	Hematology
11	Internal Medicine	38	Geriatric Medicine	83	Hematology/Oncology
12	Osteopathic Manipulative Medicine	39	Nephrology	84	Preventive Medicine
13	Neurology	40	Hand Surgery	85	Maxillofacial Surgery
14	Neurosurgery	41	Optometry	86	Neuropsychiatry
15	Speech Language Pathologist	42	Certified Nurse Midwife	89*	Certified Clinical Nurse Specialist
16	Obstetrics/Gynecology	43	Certified Registered Nurse Anesthetist	90	Medical Oncology
17	Hospice And Palliative Care	44	Infectious Disease	91	Surgical Oncology
18	Ophthalmology	46*	Endocrinology	92	Radiation Oncology
19	Oral Surgery	48*	Podiatry	93	Emergency Medicine
20	Orthopedic Surgery	50*	Nurse Practitioner	94	Interventional Radiology
21	Cardiac Electrophysiology	62*	Psychologist	97*	Physician Assistant
22	Pathology	64*	Audiologist	98	Gynecologist/Oncologist
23	Sports Medicine	65	Physical Therapist	99	Unknown Physician Specialty
24	Plastic And Reconstructive Surgery	66	Rheumatology	C0	Sleep Medicine

* Indicates that a number has been skipped.

KEY DATA ELEMENTS

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KEY DATA ELEMENTS

Dates of Service

- When a beneficiary received medical treatment from a physician/facility
- "From" and "through" dates may be identical for outpatient/physician services



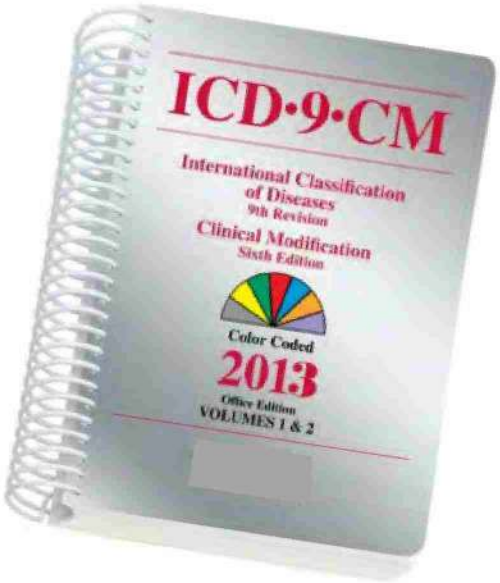
- Reflect admission and discharge dates for inpatient services

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Diagnosis Codes

- Procedure codes (CPTs or HCPCS) not allowed
- Medical record documentation required
- RAPS format
- ICD-9-CM through 9/30/14
- ICD-10-CM replacing ICD-9-CM effective 10/1/2014



KEY DATA ELEMENTS

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New field – Enrollee Risk Assessment Code

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

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Test Your Knowledge

- What five data elements must plans submit for risk adjustment?

HIC Number
Provider Type
"From" & "Through"
DOS Diagnosis Code



- What about the demographic data?

It is already in the system

KEY DATA ELEMENTS

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Test Your Knowledge

- Where do the diagnoses come from?

Hospital Inpatient
Hospital Outpatient
Physician Services



- Can diagnoses from a sports medicine specialist be submitted for risk adjustment?

Yes - Beginning with 2011 Dates of Service

KEY DATA ELEMENTS

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Questions & Answers



Your Questions are Important!

Thank you!

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RISK ADJUSTMENT 101

Introduction > Overview > Connectivity/Testing
Key Data Elements > **RAPS** > Reports > Resources

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RAPS Learning Objectives

- Define RAPS
- Describe the elements contained within a diagnosis cluster in the RAPS format
- Follow the data flow for Risk Adjustment
- Access the RAPS submission timeline

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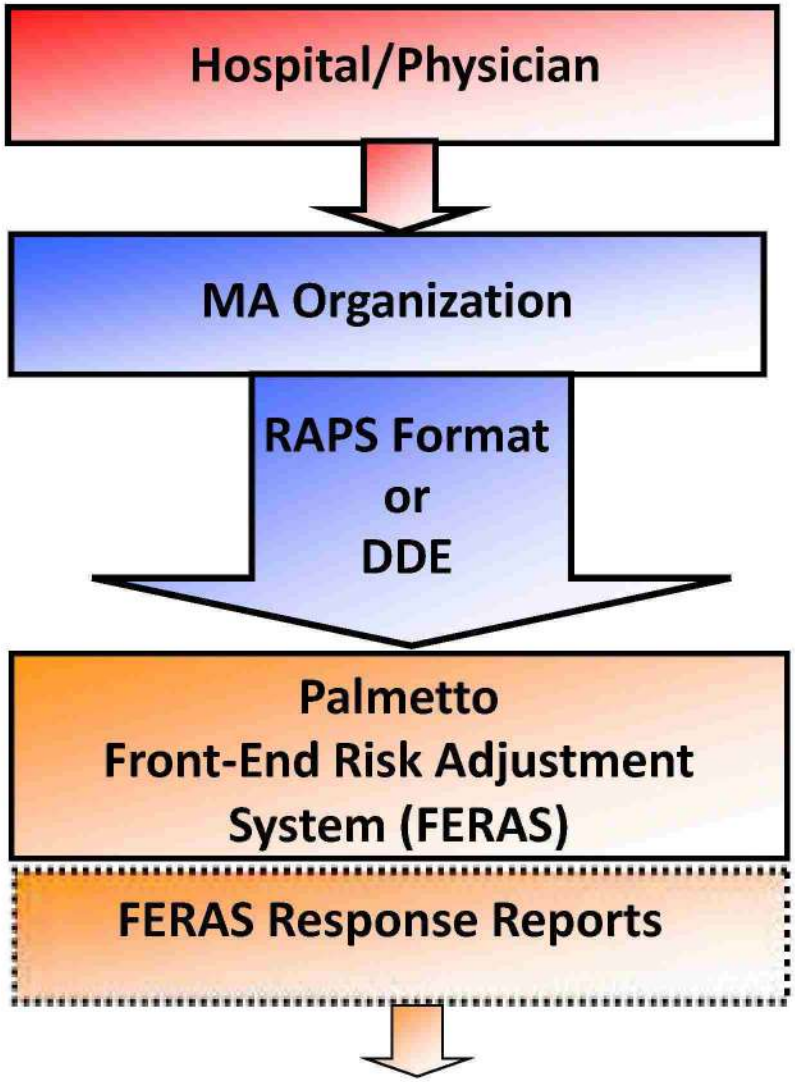
Risk Adjustment Processing System (RAPS) Definition

- System that processes risk adjustment data
- Data passes through FERAS before going to RAPS
- RAPS edits all detail records and stores them in RAPS database
  - HIC Number
  - Date of Birth (if submitted)
  - Provider Type
  - From Date
  - Through Date
  - Diagnosis Code

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RAPS

Risk Adjustment Data Flow

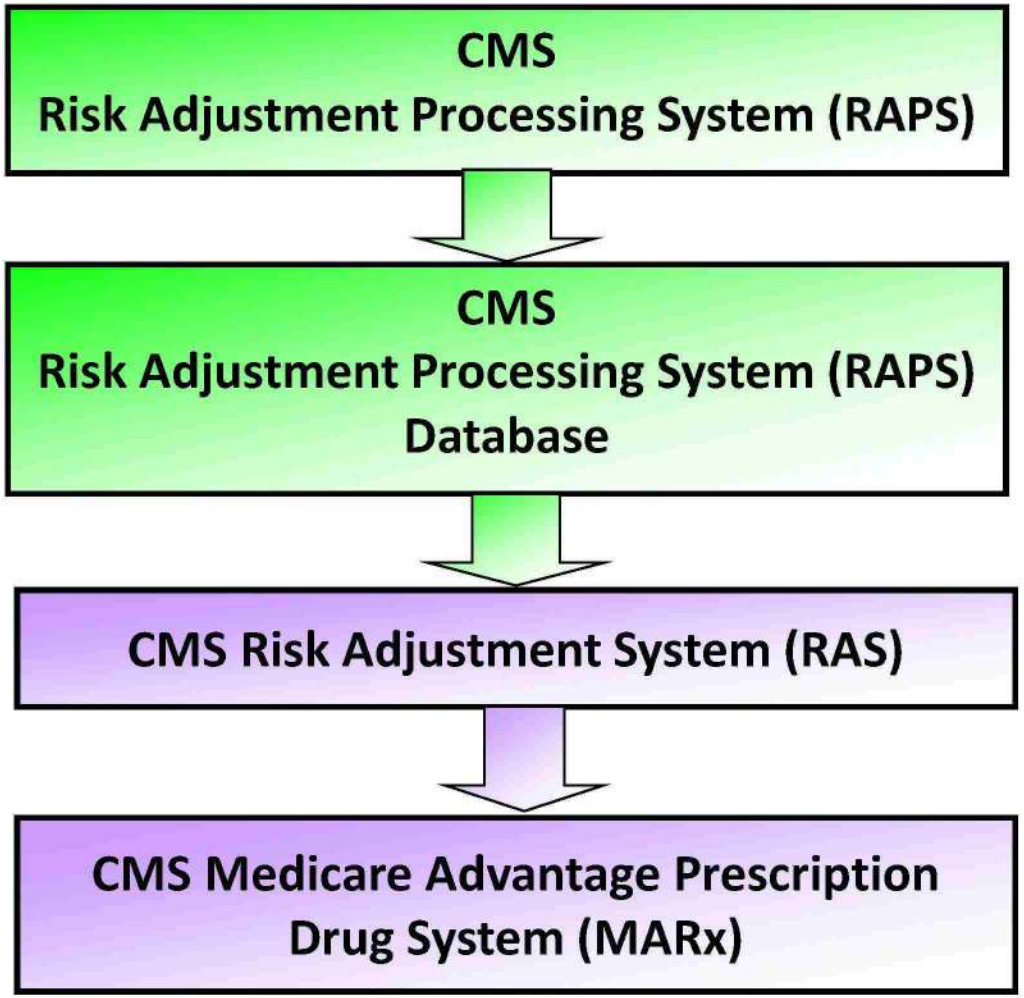


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R A P S

Risk Adjustment Data Flow (continued)

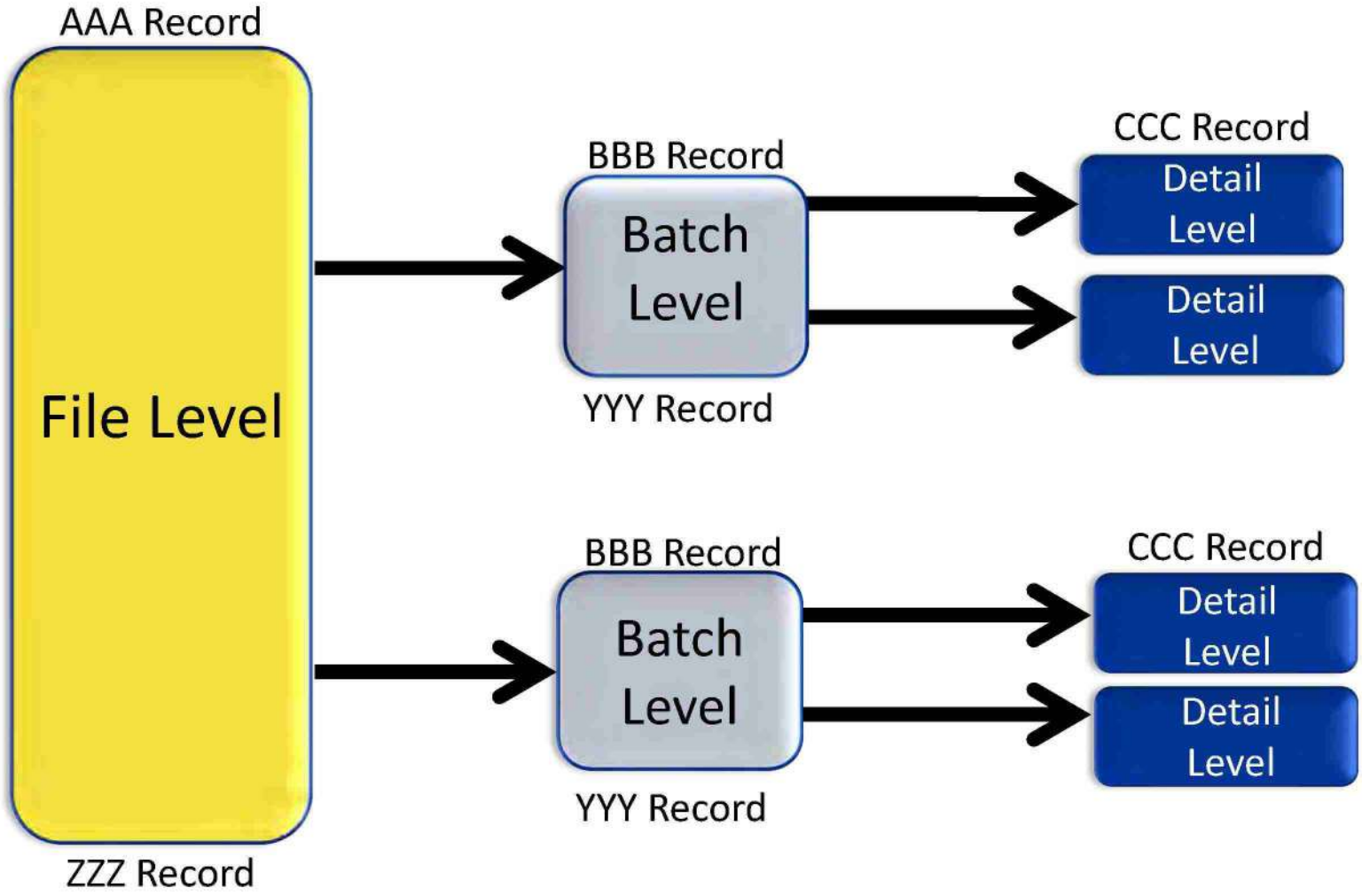


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RAPS

RAPS File Logic



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RAPS Format

File Layout Record Types:

- AAA – File Header
- BBB – Batch Header
- CCC – Detail
- YYY – Batch Trailer
- ZZZ – File Trailer

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AAA RECORD

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

BBB RECORD

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

CCC RECORD

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

YYY RECORD

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

ZZZ RECORD

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

RAPS

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RAPS Format – Data Elements

- Data Elements:
  - HIC Number
  - Date of Birth (optional)
  - Provider Type
  - From and Through Dates of Service
  - Delete Indicator
  - Diagnosis Code



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RAPS

RAPS Submission Timeline

Payment Year	Model Run	Dates of Service	Deadline
2013	Initial	7/1/2011 – 6/30/2012	**9/7/2012**
2013	Mid-year	1/1/2012 – 12/31/2012	**3/1/2013**
2013	Final	1/1/2012 – 12/31/2012	**1/31/2014**

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RAPS Submission Deadline Example

Q: We received a diagnosis from a provider 12/2012, but we didn't submit it to RAPS by the 3/2013 deadline. When will the beneficiary's risk score be adjusted?

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

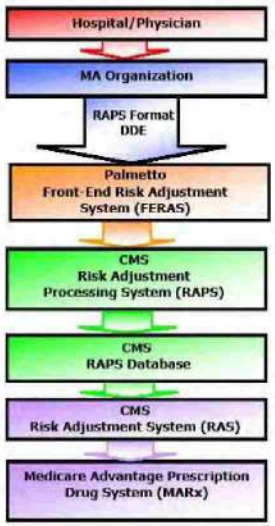
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Risk Adjustment Submission Timetable

CY	Dates of Service	Initial Submission Deadline	First Payment Date	Final Submission Deadline
09	7/1/07 – 06/30/08	9/5/08	1/1/09	N/A
09	1/1/08 – 12/31/08	3/6/09	7/1/09	1/31/10
10	7/1/08 – 06/30/09	9/4/09	1/1/10	N/A
10	1/1/09 – 12/31/09	3/5/10	7/1/10	1/31/11
11	7/1/09-6/30/10	9/3/2010	1/1/2011	N/A
11	1/1/10-12/31/10	3/4/2011	7/1/2011	1/31/2012
12	7/1/10-6/30/11	9/2/2011	1/1/2012	N/A
12	1/1/11-12/31/11	3/2/2012	7/1/2012	1/31/2013
13	7/1/11-6/30/12	9/7/2012	1/1/2013	N/A
13	1/1/12-12/31/12	3/1/2013	7/1/2013	1/31/2014
14	7/1/12-6/30/13	9/6/2013	1/1/2014	N/A
14	1/1/13-12/31/13	3/7/2014	7/1/2014	1/31/2015

Risk Adjustment Process Overview



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Test Your Knowledge

- What are the three levels of data in the RAPS file layout?

File-level
Batch-level
Detail-level



- Which of these data levels contains the key data elements?

Key data elements are stored in the CCC (detail) record file

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RAPS

Test Your Knowledge

- What dates of service are included in the Mid-Year Model Run for the 2013 Payment Year?

1/1/12 – 12/31/12



- Where can the Risk Adjustment Submission Timetable be found?

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RAPS

Questions & Answers



Your Questions are Important!

Thank you!

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RISK ADJUSTMENT 101

Introduction > Overview > Connectivity/Testing

Key Data Elements > RAPS > **Reports** > Resources

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Reports Learning Objectives

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

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FERAS and RAPS Edit Logic

FERAS:

- Checks file and batch level for errors
- Checks first and last detail record to see if totals agree
- Rejects complete file if errors are found

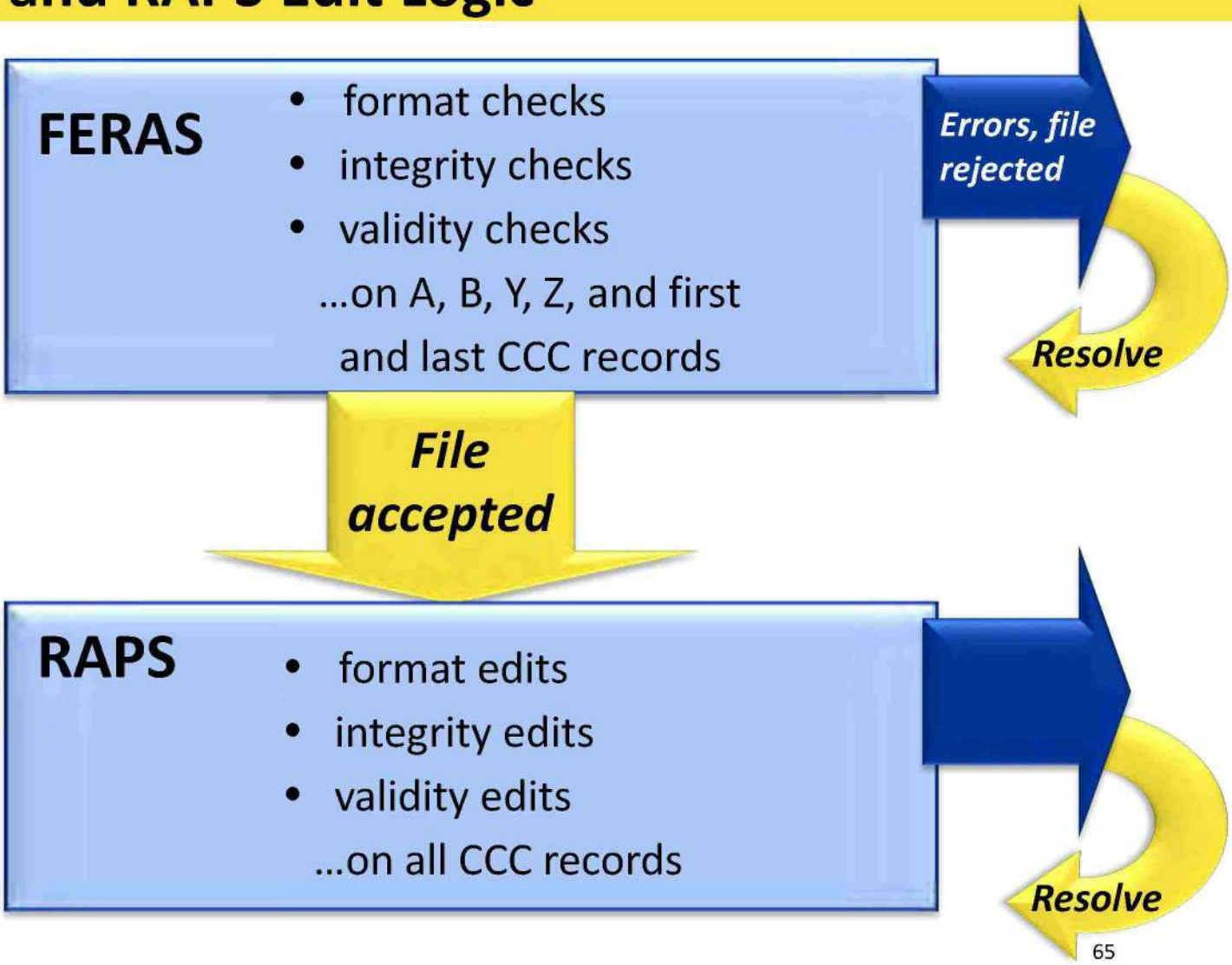
RAPS:

- Checks all detail records for format, integrity, and validity

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FERAS and RAPS Edit Logic



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FERAS Error Codes

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

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FERAS Error Example

Q: Why did FERAS reject an entire file with error message 100?

A: The plan submitted a file with "AA1" entered in the record type AAA, field 1. This field must be populated with "AAA."

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RAPS Error Codes

ERROR SERIES	EXPLANATION AND CONSEQUENCES
300-399	Record-level errors
400-489	Diagnosis cluster errors
490-499	Diagnosis delete errors
500-599	Informational message

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RAPS Error Code

Q: Why did we receive a RAPS error code 411?

A: Error code 411 refers to the date of death, and plans receive the 411 error code if the date of death is prior to the service through date.

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RAPS Editing Process

- Stage 1 – Field Validity and Integrity Edits
- Stage 2 – Field-to-Field Edits
- Stage 3 – Eligibility Edits
- Stage 4 – Diagnosis Code Edits



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Stage 1 – Field Validity and Integrity Edits

- Checks format and integrity on all CCC-level fields
- Entire record is rejected if data in the "HIC Error Code" or "Diagnosis Code - Filler" fields
- Dates within a diagnosis cluster must be valid

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Stage 2 – Field-to-Field Edits

- "From Date" ≤ "Through Date"
- Hospital outpatient and physician provider types comply with 31-day span rule
- Reconciliation data submitted properly



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Stage 3 – Eligibility Edits

- Cross-checks fields against common tables between MBD and MARx
- Checks HIC Number, date of birth, and Medicare entitlement
- Ensures HIC Number exists on common tables

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Stage 4 – Diagnosis Code Edits

- Ensures each diagnosis code is valid
- Checks each diagnosis code against service dates and sex
- Checks to see if diagnosis codes are in the risk adjustment model

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Duplicate Submissions

Original Submission		Duplicate Submission
HIC Number	=	HIC Number
From Date of Service	=	From Date of Service
Through Date of Service	=	Through Date of Service
Diagnosis Code	=	Diagnosis Code
Provider Type	=	Provider Type

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Duplicate Diagnosis Cluster Example

Q: If a beneficiary goes to a doctor on separate occasions and receives the same diagnosis each time, is that diagnosis code stored each time it is sent to RAPS? Can diagnosis clusters be duplicated over time?

A: Each of the clusters is a unique diagnosis cluster because they have different dates of service. However, it will only be counted once in the risk score calculation.

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REPORTS

FERAS Response Report

REPORT: FERAS-RESP **FRONT END RISK ADJUSTMENT SYSTEM**
RUN DATE: 20040304 **FERAS RESPONSE REPORT**

SUBMITTER ID: SH9999
FILE-ID: 0000000001 REJECTED PROD

RECORD TYPE	SEQ NO	ERROR CODE	ERROR CODE DESCRIPTION
AAA		113	FILE NAME DUPLICATES ANOTHER FILE ACCEPTED WITHIN LAST 12 MONTHS
BBB	0000002	203	MISSING/INVALID PLAN NUMBER ON BBB RECORD
CCC	0000001	310	MISSING/INVALID HIC NUMBER ON CCC RECORD
YYY	0000004	263	PLAN NUMBER DOES NOT MATCH PLAN NUMBER IN BBB RECORD

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RAPS Transaction Processing Reports

- RAPS Return File – flat file layout
- RAPS Transaction Error Report
- RAPS Transaction Summary Report
- RAPS Duplicate Diagnosis Cluster Report

Report layout

REPORT: RAPS002 RISK ADJUSTMENT PROCESSING SYSTEM PAGE: 22
RUN DATE: 20040523 TRANSACTION ERROR REPORT TRANS DATE: 20040521

SUBMITTER ID: SH9999 FILE ID: 0000000001 PLAN: H9999 BATCH NUMBER: 0000001

SEQ NO	SEQ ERR	PATIENT CONTROL NUMBER	HIC NUMBER	HIC ERR	DOB	DOB ERR	PVDR TYPE	FROM DATE	THRU DATE	DEL IND	DGNS CODE	DGNS ERR1	DGNS ERR2	CORRECTED HIC
0000003			999999999A	353	19301206		01	20040101	20040105		4823			
		00000000000000000012345678901234567890												
0000005			888888888A		19260217		01	20040212	20040225		486	408		
		00000000000000000012345675675675675675												
							02	20040212	20040225		2508	408		
							02	20040312	20040325		496			
0000007			666666666D		19301206		20	20040101	20040105	D	25004	491		
							20	20040411	20040422		25004	408	409	

END OF FILE

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REPORTS

Return File Example

Q: We received 502 errors for a member, but cannot locate where the diagnosis cluster was sent on the return file. What should we do?

A: Plans may contact the Customer Service and Support Center (CSSC) to assist in locating the files that triggered the duplicate diagnosis cluster.



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REPORTS

RAPS Management Reports

- RAPS Monthly Plan Activity Report
- RAPS Cumulative Plan Activity Report
- RAPS Monthly Error Frequency Report
- RAPS Quarterly Error Frequency Report



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REPORTS

Analysis of RAPS Management Reports



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REPORTS

Plan Considerations

- Is my organization collecting enough data from physicians and providers?
- Is my organization collecting the correct data from physicians and providers?
- Are external issues affecting data collection?
- Are internal processes supporting data submissions?

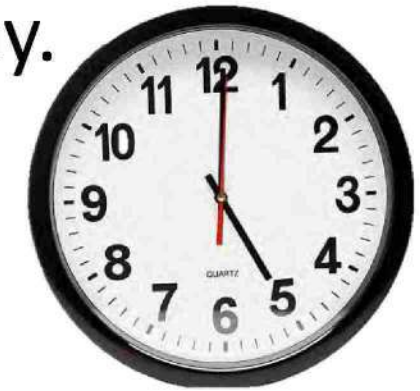
US-DOJ-KAISER-00049726

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REPORTS

Reminders

- Plans are responsible for downloading and maintaining reports.
- Plans should correct errors and resubmit as soon as possible.
- The cut-off time for data submission and completion of file transfer is 5:00 PM ET, Monday through Friday.



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REPORTS

Test Your Knowledge

- What does RAPS check that FERAS does not check?

All the detail records



- What happens if FERAS finds any errors?

The entire file is rejected

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Test Your Knowledge

- Which RAPS report has a flat file layout?

The RAPS Return File



- Why are the reports important?

Error notification
Data management
Process improvement

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REPORTS

Questions & Answers



Your Questions are Important!

Thank you!

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RISK ADJUSTMENT 101

Introduction > Overview > Connectivity/Testing
Key Data Elements > RAPS > Reports > **Resources**

US-DOJ-KAISER-00049731

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RESOURCES

Resources Learning Objectives

- Know how to access risk adjustment resources
- Identify appropriate contacts for risk adjustment

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CMS Website



http://www.cms.gov

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE

RESOURCES

CMS Website

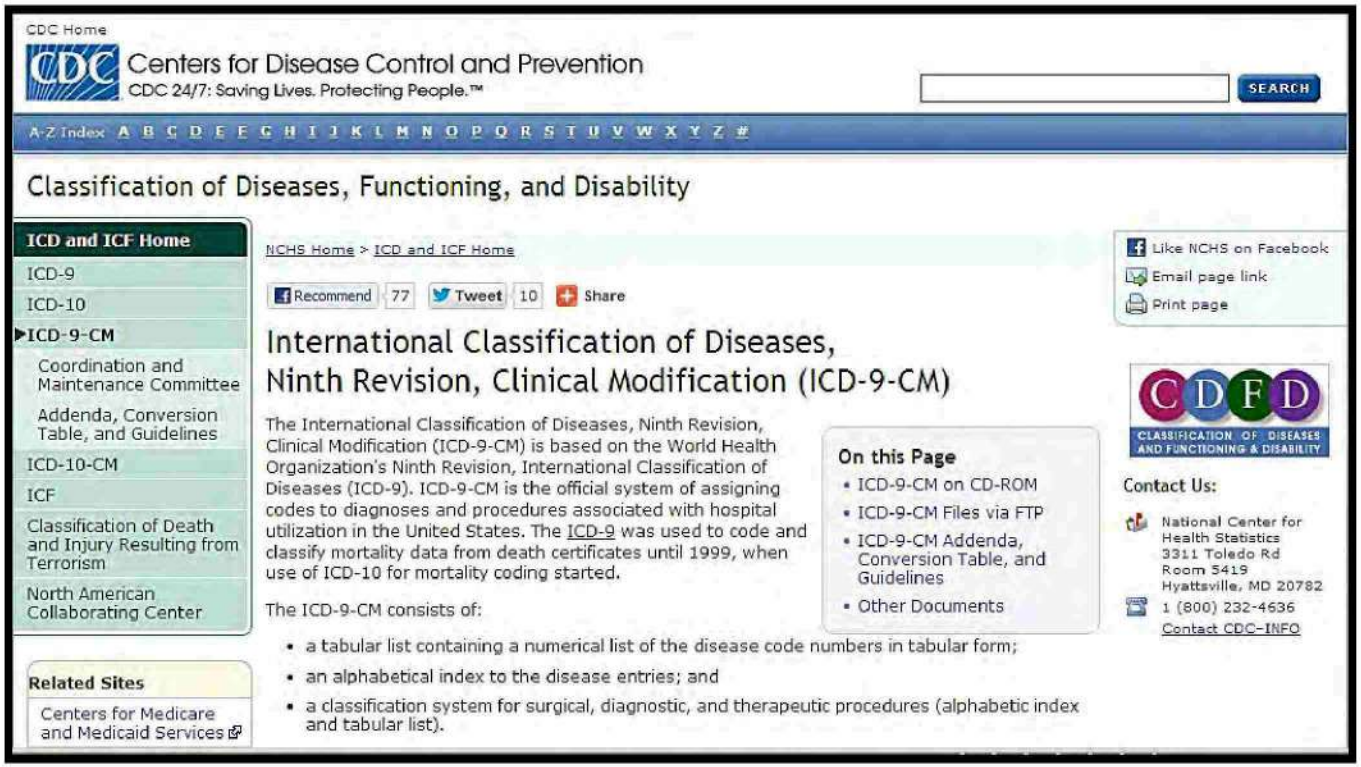
- Risk Adjustment
- Announcements and Documents
- Ratebooks and Supporting Data
- Medicare Advantage and Prescription Drug Plans Communications User Guide (PCUG)
- ICD-9-CM
- ICD-10-CM

US-DOJ-KAISER-00049734

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RESOURCES

Centers for Disease Control and Prevention (CDC)

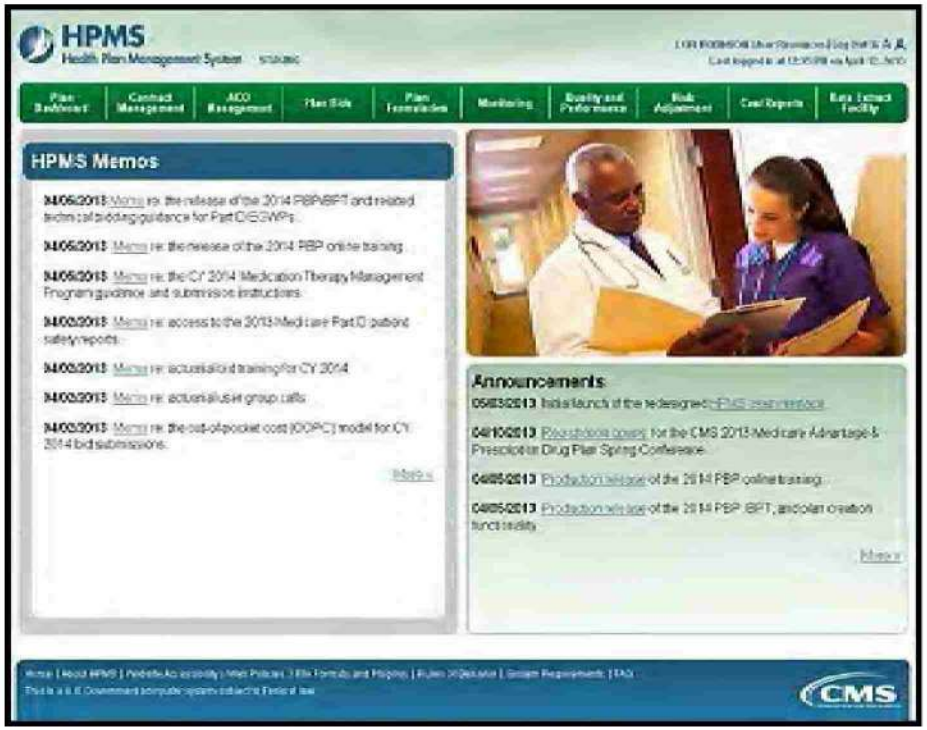


ICD-9-CM: http://www.cdc.gov/nchs/icd/icd9cm.htm

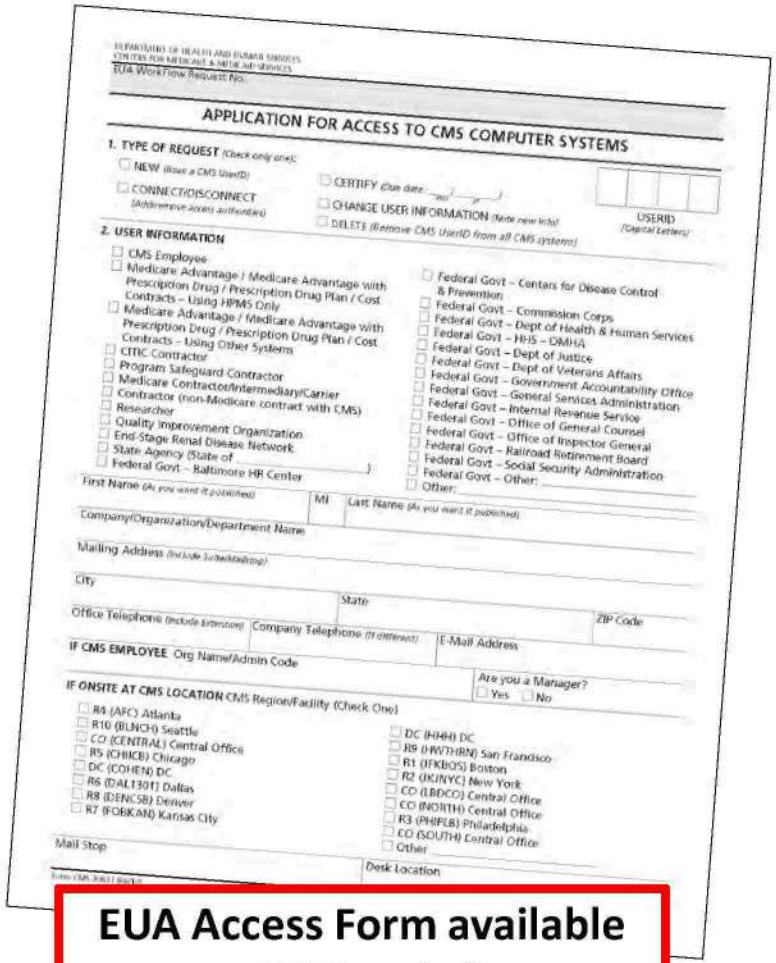
ICD-10-CM: http://www.cdc.gov/nchs/icd/icd10cm.htm

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The Health Plan Management System (HPMS)



https://gateway.cms.hhs.gov/



EUA Access Form available on CMS website.

RESOURCES

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CMS Customer Service and Support Center (CSSC)



http://www.csscoperations.com/

RESOURCES

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RESOURCES

CSSC Website - Risk Adjustment Information

- Enroll to Submit Risk Adjustment
- Front-End Risk Adjustment System (FERAS)
- Job Aids
- References
- Risk Adjustment Processing System (RAPS)
- Training
- Training (archived)

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Technical Assistance Registration Service Center (TARSC)



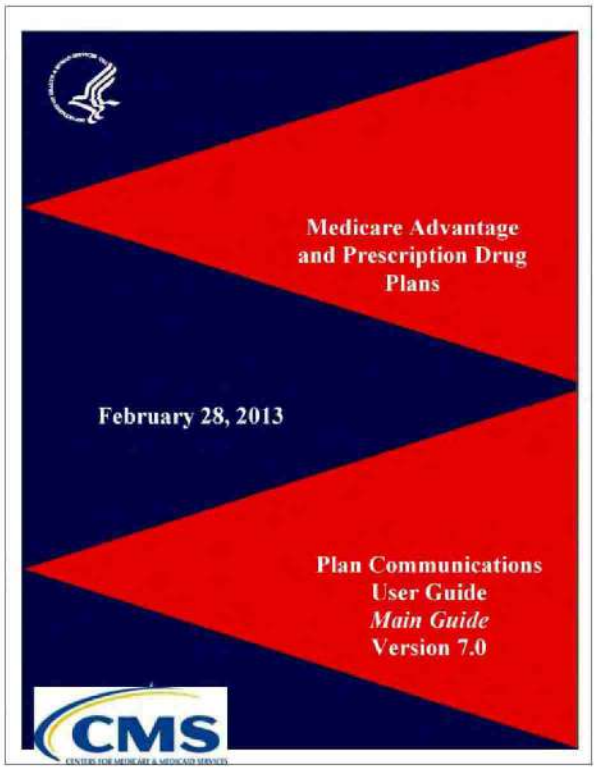
http://www.tarsc.info

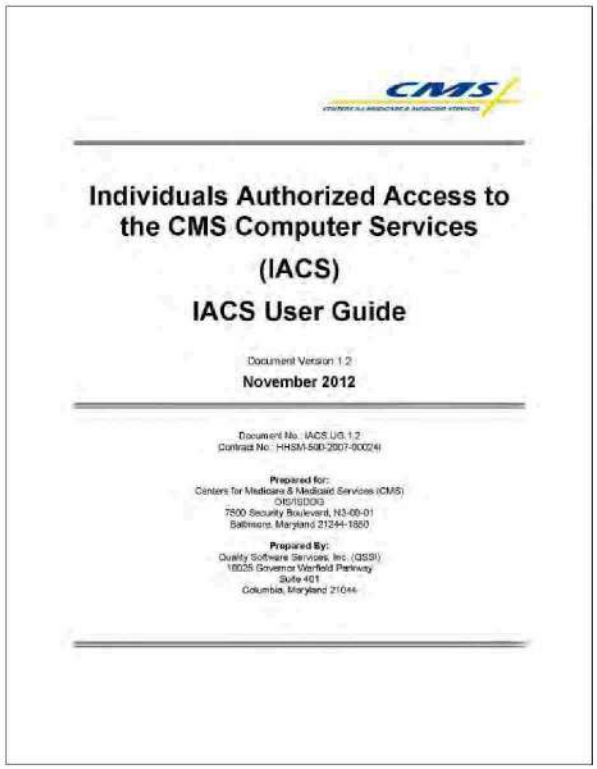
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Medicare Advantage & Prescription Drug System User Interface

MARx UI







RESOURCES

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RESOURCES

Risk Adjustment Points of Contact

- CMS Medicare Plan Payment Group (MPPG)
- MAPD Helpdesk
- Customer Service and Support Center (CSSC)
- Technical Assistance Registration Center (TARSC)
- ICD-10 PMO Mailbox
- Risk Adjustment Data Validation (RADV) Mailbox

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Risk Adjustment Acronyms



RESOURCES

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RESOURCES

Summary

- Defined Risk Adjustment
- Introduced the process for connecting to RAPS
- Described the data elements submitted for Risk Adjustment
- Explained the format, flow, and timeline for RAPS
- Discussed the data logic, editing processes and reports for the FERAS and RAPS
- Identified key resources and contacts for risk adjustment

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RESOURCES

Questions & Answers



Your Questions are Important!

Thank you!

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RESOURCES

Evaluation



Please take a moment to complete the evaluation form for **Risk Adjustment 101**.

http://www.ardx.net/RA101TAEvaluation

Your Feedback is Important!

Thank you!

Stay Connected with CMS

EXHIBIT 11

Message

From: Deming, Nicole M. (CMS/CM) [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=880B32A325EC4360BBDA7A8C6880DBC6-D2EI]
Sent: 11/1/2016 3:18:00 PM
To: Harlow, Jennifer A. (CMS/CM) [/o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=8ca0a20d92d84d598a12b1a4ab2d71e5-H111]; Beder, Victoria M. (CMS/CM) [/o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=f0211e55dddd4fa4a4cf3d0928cbd55c-B139]
CC: Rice, Cheri M. (CMS/CM) [/o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=320f389b49d743e5b27fffd308c3225c-R14L]; Rogers, Carol L. (CMS/CMMI) [/o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=dfdf57cb05824690b4af3ce4d4377e2d-RY3L]
Subject: RE: DPO - Functional Statement
Attachments: FCHKB.pdf; FCHKH.pdf; FCHKA Function Statement.pdf; FCHKC Function Statement.pdf; FCHKG Function Statement.pdf; FCHKJ Function Statement.pdf

Hi Jennifer,

I attached all of your function statements so you would have them. FCHKB is DPO's function statement.

Nicole

From: Harlow, Jennifer A. (CMS/CM)
Sent: Tuesday, November 1, 2016 11:14 AM
To: Beder, Victoria M. (CMS/CM) <Victoria.Beder@cms.hhs.gov>; Deming, Nicole M. (CMS/CM) <Nicole.Deming@CMS.hhs.gov>
Cc: Rice, Cheri M. (CMS/CM) <Cheri.Rice@cms.hhs.gov>; Rogers, Carol L. (CMS/CMMI) <Carol.Rogers@cms.hhs.gov>
Subject: DPO - Functional Statement

Hi – Could you please forward me a copy of the DPO functional statement?

Date: April 11, 2010

Centers for Medicare & Medicaid Services
Office of the Administrator
Center for Medicare
Medicare Plan Payment Group

Division of Payment Operations
(FCHKB)

- Manages, in coordination with the front office of the Center for Medicare and the Office of Information Services, Chief Operating Officer (COO), the Part D and Medicare Advantage (MA) change control board.

- Identifies, diagnoses, and resolves issues related to payment systems in coordination with beneficiary enrollment operations, policy and systems components. This function includes identifying and diagnosing payment errors.

- Coordinates with the Office of Financial Management, COO on all financial management, banking and 1099 issues related to the Part D prescription drug plans and MA plans.

- Develops and analyzes financial management reports to detect payment trends and problems.

- Develops and implements internal controls, procedures and instructions regarding payment for the Part D prescription drug and MA plans.

- Provides technical support and training in the area of plan payment for the Part D prescription drug plans, MA plans, contractors and regional Consortium for Medicare Health Plans Operations, COO and Central Office components.

- Performs the monthly payment approval process.

- Provides interim payments, when necessary, to Parts C and D plan sponsors.

- Validates monthly prospective plan payments at the plan level.

- Provides technical assistance to plan sponsors and Medicare Advantage Organizations on payment issues.

- Business owner for the Automated Plan Payment System.

Date: February 14, 2012

Centers for Medicare & Medicaid Services
Office of the Administrator
Center for Medicare
Medicare Plan Payment Group

Division of Payment Policy
(FCHKH)

- Develops and improves all bidding and payment policies related to the Medicare Prescription Drug Benefit and the Medicare Advantage (MA) program for the individual and employer sponsored group market, including rules regarding how plans are to structure their bids, bid review criteria, benchmark computations, use of beneficiary rebates, development and refinement of risk adjustors, low income subsidy, reinsurance, risk sharing, pay-for-performance and the MA regional stabilization fund.

- Develops and evaluates changes to, and revises, Part C and Part D risk adjustment models, which includes analyzing the technical and operational requirements for the implementation of new risk adjustment models or changes to existing models.

- Develops, evaluates, and reviews regulations, rulings, manuals, program guidelines, program memoranda, policy letters and instructions to disseminate and effectively communicate program policies to health plans, program contractors, and other users in the health care field and beneficiary community on the division's subject areas of responsibility.

- Interprets established policies and provides technical assistance to Department and CMS staff, the Consortium for Medicare Health Plans Operations, Chief Operating Officer, program contractors, health plans and representatives of the health delivery system, health policy community, congressional staff, standard setting organizations and other interested parties, on issues within its area of responsibility.

- Maintains continuing liaison with provider groups, industry associations, patient organizations, medical associations, other purchasers of health services, including employers, Office of Personnel Management, Department of Defense, the Department of Veterans Affairs, and other Federal and State purchasing and regulatory agencies.

- Participates in the development and evaluation of proposed legislation pertaining to the division's subject areas of responsibility.

- Reviews policies and procedures developed by other Center for Medicare components to provide technical assistance and to review their impact on the division's subject areas of responsibility.

- Develops the annual Advance Notice of Methodological Changes for Medicare Advantage Capitation Rates and Part D Payment Policies, the annual Announcement of Medicare Advantage Payment Rates, and regulations relating to its area of expertise.

- Develops and maintains Parts C and D payment demonstration projects.

Date: April 11, 2010

Centers for Medicare & Medicaid Services
Office of the Administrator
Center for Medicare
Medicare Plan Payment Group

Division of Payment Validation
(FCHKA)

- Validates monthly payments at the beneficiary level for Part C and Part D prior to payment authorization. Coordinates with staff in the Office of Information Services and CMS contractors to access and analyze monthly payment files. Maintains, expands and/or revises as necessary payment validation analyses and protocols. Maintains history of payment validation findings for audit purposes. Documents and implements internal controls relating to payment validation functions. Responds to annual audit requirements.

- Identifies and analyzes payment system issues relating to payment error. Tracks and monitors payment issues over time and works with the Medicare Advantage Prescription Drug System contractors and other CMS contractors to clarify and resolve problems. Validates proposed solutions to ensure the integrity of proposed payment adjustments and software fixes.

- Develops error rates for Part C and Part D relating to prospective payments and final payment reconciliation. Improves error rate design and estimates error rates on a routine annual basis in response to Improper Payments Information Act reporting requirements. Coordinates estimate development and reporting with HHS and the Office of Management and Budget.

- Performs routine annual risk adjustment data validation based on medical record review. Designs and implements sampling frames to allow for plan and national payment error estimates. Pulls and reviews medical records relating to Part C payments. Conducts quality assurance of medical record review findings. Adjusts plan payments and implements an appeal process. Manages and coordinates multiple contractors to implement the entire process.

- Reviews and assesses plan requests for retro enrollment, disenrollment, and other status changes. Upon review, allows appropriate changes to be implemented.

- Reviews and validates plan submissions relating to direct and indirect remuneration. Uses outlier analyses, comparisons with quarterly reporting and other descriptive statistics to identify plan sponsors with rebate and payment anomalies.

- Develops and coordinates accrual estimates for financial statements as appropriate.

Date: April 11, 2010

Centers for Medicare & Medicaid Services
Office of the Administrator
Center for Medicare
Medicare Plan Payment Group

Division of Payment Reconciliation
(FCHKC)

- Coordinates the development and management of business requirements for the national systems for payment of the Part D prescription drug and Medicare Advantage (MA) organizations.
- Acts as the business owner of the Drug Data Processing System (DDPS), the system that receives prescription drug event (PDE) data and manages the contract responsible for receipt of PDE data.
- Acts as the business owner of the Payment Reconciliation System (PRS), which calculates retroactive Parts C and D payment adjustments to plans due to reconciliation, and validates the PRS calculations.
- Provides technical support and training in the area of plan payment for the Part D prescription drug plans, MA plans, contractors and Regional Consortium for Medicare Health Plans Operations, Chief Operating Officer and Central Office components.
- Performs enrollment reconciliation as it relates to this division's responsibilities.
- Reviews plan submissions relating to Direct and Indirect Remuneration.
- Identifies and diagnoses enrollment/payment issues.
- Analyzes and resolves PDE issues.
- Performs benefit administration, benefit reporting, and reconciliation data analysis.
- Communicates with plan sponsors on reconciliation and PDE issues.

Date: February 14, 2012

Centers for Medicare & Medicaid Services
Office of the Administrator
Center for Medicare
Medicare Plan Payment Group

Division of Payment Systems
(FCHKG)

- Business owner for the Medicare Advantage Prescription Drug System (MARx) and manages the process for MARx change requests.
- Supports the testing and validation of prescription drug and MA enrollment and payment systems to ensure that they operate consistent with business requirements.
- Identifies and diagnoses enrollment/payment issues relating to the MARx.
- Works with appropriate components, to resolve enrollment/payment issues within its purview.
- Provides education and outreach on the operation of, and issues relating to MARx.
- Reviews statutes, regulations, policies, procedures, and other guidance to ensure that the MARx system complies with all applicable initiatives.
- Develops the policy and operational support mechanisms for the MA HITECH Electronic Health Record Incentive program, and creates the MA Eligible Professional payments.
- Serves as Information Systems Security Officer (ISSO) for MARx including developing the Systems security plan and meeting the requirements to obtain the Authority To Operate (ATO) certification.
- Serves as the focal point for all CMS interactions with employers, unions, employees, retirees and others operating on their behalf pertaining to issues related to CMS regulations, guidance, operations, as well as outreach and education activities concerning the Retiree Drug Subsidy (RDS) Program.
- Develops national policy and oversees implementation for all Medicare issues related to the RDS Program, a system of payments to employer and union sponsors of qualified retiree prescription drug plans.
- Develops and implements regulations, guidance, operational procedures and conducts outreach and education activities for the RDS Program.
- Develops and oversees the implementation and ongoing management of a paperless web-based automated RDS system.
- Serves as the CMS lead in determining the impact of CMS policy, operations and outreach on employers, unions, employees and retirees in relation to the RDS Program.

Date: February 14, 2012

Division of Payment Systems
(continued)

- Coordinates interaction between central office and the consortia on RDS Program issues.
- Develops outreach and education materials including brochures, fact sheets, training materials and presentations concerning the RDS Program.
- Conducts outreach and education activities relating to the RDS Program.

Date: February 14, 2012

Centers for Medicare & Medicaid Services
Office of the Administrator
Center for Medicare
Medicare Plan Payment Group

Division of Encounter Data and Risk Adjustment Operations
(FCHKJ)

- Provides technical assistance to plans on diagnosis submissions.
- Monitors plan data submissions.
- Validates initial, mid-year, and final risk scores, which includes validating risk adjustment data via medical record review.
- Serves as the business owner for risk adjustment data collection and processing systems, including the Front End Risk Adjustment System which accepts plan data submissions, the Risk Adjustor Processing System to store the data at CMS, and the Risk Adjustor System to combine plan reported and fee-for-service data to calculate risk adjustment factors for all 40 million plus Medicare beneficiaries.
- Provides the business rules to the payment systems (Medicare Managed Care System/Medicare Advantage Prescription Drug) for the appropriate use of risk adjustment factors in payment.
- Analyzes the trends in risk adjustment Medicare Advantage (MA) and fee-for-service data submissions and provides technical assistance to plans with data submission problems.
- Analyzes the financial impacts of risk adjustment models (CMS-Hierarchical Coexisting Conditions, End-Stage Renal Disease, Part D) on plans and the trends in risk adjusted payments.
- Conducts outreach and education with the industry and MA organizations on the implementation of risk adjustment policy and the impacts of risk adjustment.
- Identifies and diagnoses payment errors.
- Collects encounter data from Medicare Advantage plans to describe Medicare Advantage beneficiary health care encounters.
- Analyzes encounter data to recalibrate risk adjustment model factors, validate Medicare utilization and expenditures, conduct geographic acuity studies, monitor performance, evaluate managed care cost and utilization trend information, and monitor performance.

EXHIBIT 12

To: CMS - CPI ALL[CPI@cms.hhs.gov]
From: Handley, Elisabeth (CMS/CPI)
Sent: Tue 1/8/2013 10:30:46 PM (UTC)
Subject: Center for Program Integrity Announcements
Functional Statements--CPI-PEOG--101812.pdf.pdf
Functional Statements--CPI-DSPG--121912.pdf.pdf
Organization Chart--CPI-DSPG--121912.pdf

I am pleased to announce that in the recent past the Office of Operations Management (OOM) has approved two reorganizations within the Center for Program Integrity (CPI). Both changes will help us meet our mission more effectively.

As of October 18, 2012 the following changes are effective for the Provider Enrollment Operations Group (PEOG):

1. PEOG now has two divisions; the Division of Enrollment Systems (DES) and the Division of Enrollment Policy (DEP).

- The Division of Enrollment Systems oversees the development, implementation, and integration of provider enrollment and enumeration systems. DES is be under the leadership of Zabeen Chong, Acting Director.
- The Division of Enrollment Policy focuses on the implementation of provider enrollment operating procedures and policies. DEP is be under the leadership of Mark Majestic, Acting Director.

2. In addition, effective December 19, 2012, we established the Data Sharing and Partnership Group (DSPG). Dr. Shantanu Agrawal will serve as the Group Director and Anita Griner will serve as the Deputy Director. Dr. Agrawal will also continue in his role as the CPI Medical Director. The focus of DSPG will be on programs which develop and implement large-scale capabilities for the data sharing and transparency and involve a high degree of external partnership such as the Affordable Care Act (ACA) "Sunshine Act" and the Healthcare Fraud Prevention Partnership (HFPP).

- DSPG has two divisions; the Division of Policy & External Partnership (DPEP) and the Division of Health Informatics & Systems (DHIS). DPEP will be under the leadership of Toula Bellios, Acting Director. DHIS will be under the leadership of Douglas Brown, Director.

For your convenience attached are an updated CPI organizational chart as well as the functional statements. Please let me know if you have any questions.

Thanks,

Lis Handley
Deputy Center Director for Operations
CPI

Date: October 18, 2012

Centers for Medicare & Medicaid Services
Office of the Administrator
Center for Program Integrity

Provider Enrollment Operations Group
(FCLC)

- Serves as CMS primary focal point for all provider enrollment and compliance functions.
- Develops budget guidelines and cost estimates for Medicare provider/supplier application processing activities.
- Responds to media inquiries and requests for interview or data/information related to Medicare program integrity initiatives and activities.
- Maintains liaison with providers, contractors, and other partners for purposes of ensuring that continuous improvements are made to CMS provider/supplier enrollment processes and that the interests of customers and partners are considered.
- Maintains liaison with representatives of the health care industry to ensure that CMS provider/supplier enrollment processes are compatible with their administrative practices.

Date: October 18, 2012

Centers for Medicare & Medicaid Services
Office of the Administrator
Center for Program Integrity
Provider Enrollment Operations Group

Division of Enrollment Systems
(FCLCA)

- Oversees the national Medicare provider enrollment system. This includes release planning, requirements gathering, and user acceptance testing of all enhancements to the system.

- Oversees the National Plan & Provider Enumeration System (NPPES). This includes oversight of the NPPES helpdesk contractor, requirements gathering, and release planning.

- Primary responsibility over development, implementation, and integration of systems and ancillary functions related to provider enrollment processes such as fingerprint and criminal background check contractor, PAY.GOV and automated provider screening.

Date: October 18, 2012

Centers for Medicare & Medicaid Services
Office of the Administrator
Center for Program Integrity
Provider Enrollment Operations Group

Division of Enrollment Policy
(FCLCB)

- Works with the Medicare Administrative Contractors, legacy contractors, and other stakeholders within the Medicare program on provider enrollment issues.

- Develops and issues general provider operating policy and procedures for the processing of Medicare enrollment applications and enumeration of provider applicants, including standardizing the format(s), identifying data to be furnished by providers, and contractor validation/verification of application data submitted by providers/suppliers.

- Oversees the National Supplier Clearinghouse and the National Site Visit Contractor.

- Identifies vulnerabilities and implements policies directed at preventing fraud and abuse and to improve administrative efficiencies in Medicare enrollment of providers and suppliers.

Date: December 19, 2012

Centers for Medicare & Medicaid Services
Office of the Administrator
Center for Program Integrity

Data Sharing and Partnership Group
(FCLF)

- Formulates, plans and implements programs associated with creating collaboration information transparency to enable and expand program integrity (PI) capabilities to combat fraud, waste and abuse for CMS and cooperating external partners. Directs the activities necessary to ensure the successful completion of planning, developing, implementing, monitoring and controlling, and closing the comprehensive project and program management activities for the transparency programs.

- Performs business process modeling and defines business requirements necessary to implement the policy and regulations through consulting widely with representatives of CMS, relevant Federal agencies, physicians, manufactures, clinical and analytic experts, states, health care providers, beneficiaries and other stakeholders to obtain and further develop requirements for the transparency programs.

- Consults closely with outreach, stakeholder engagement, and communications staff throughout CMS and the Department to conduct open door forums and other sessions for communicating about the transparency programs. Utilizes a broad array of learning network techniques – campaigns, improvement projects, online communities, large and small scale events, etc. to enable learning around the transparency programs.

- Designs and implements tools and technologies that will foster broad learning and enable learning network participants to interact with each other such as public information portals and processes for the initiatives to engage the stakeholder community applicable to the transparency programs.

- Prepares the required reports to Congress and States as stipulated in the legislation of the transparency programs and through other Congressional inquiries.

- Plans, designs, implements and maintains technologies including systems, databases, portals, documentation and training to support the transparency programs.

Date: December 19, 2012

Data Sharing and Partnership Group
(continued)

- Develops and implements strategies for ensuring that data assets of the transparency programs are usable, of value to the users and supported by technical architecture appropriate to support and achieve goals and objectives including mechanisms and engages relevant stakeholders (users) for insights into data usage, informatics and reports pertaining to program data and innovation around solutions.

- Creates integrated reports and dashboards for the transparency programs. Informs leadership on the health of the transparency portfolio through information and analysis of program management (PM) information. Leads and/or conducts complex studies relating to project evaluation and performance management. Analyzes project issues related to risks, status, change management and scope and makes recommendations,

- Provides oversight and leadership for establishing and maintaining a mature and disciplined PM capability for the Group. Leads on strategic planning and implementation of transparency programs creating integrated management plans across all programs. Develops and implements processes and tools necessary for the effective and consistent application of management for scope, schedule, risk, quality, communications, and reporting on the transparency programs.

- Prepares budget and resource requests, including estimates of costs and benefits, as appropriate, to support the work of the Group and associated procurements. Performs financial management and reporting including audit responses. Collaborates with CPI's Business Operations Staff regarding resource requests for the Office of Financial Management.

- Performs operational business processes to support the Group including executive and staff support, information and correspondence management, finance and solicitation support, timekeeping, supplies, travel, calendaring, correspondence management, training, recruitment and compliance with CMS policies.

Date: December 19, 2012

Centers for Medicare & Medicaid Services
Office of the Administrator
Center for Program Integrity
Data Sharing and Partnership Group

Division of Policy and External Partnership
(FCLFA)

- In collaboration with CMS policy, legislative and legal components, champions business engineering capabilities necessary to implement the policy and regulations for the collaborative information transparency programs.

- Consults widely, with representatives of CMS, relevant Federal agencies, physicians, manufactures, clinical and analytic experts, states, health care providers, beneficiaries and other stakeholders to inform the business requirements for the transparency programs.

- Collaborates with CMS enterprise architecture and other CMS components to document business processes, business rules, and business requirements for the transparency programs.

- Provides oversight and leadership to the requirements for the public information portals and processes for the collaborative information transparency initiatives to engage the stakeholder community and prepares and finalizes all content for inclusion, ensuring adherence to CMS and Federal standards, including Section 508.

- In collaboration with CMS central and regional components, conducts open door forums and other sessions necessary for the requisite partner engagement for the transparency programs.

- Monitors day-to-day operations of policy, strategy or partner engagement contracts. Monitors funding levels and burn rates, develops award fees, and conducts regular oversight of contract provisions associated with the collaborative information transparency programs.

- Prepares the required reports to Congress and States as stipulated in the legislation of the transparency programs and through other Congressional inquiries.

- Consults closely with outreach, stakeholder engagement, and communications staff throughout CMS and the Department to prepare materials and stakeholder networks to better ensure program success.

Date: December 19, 2012

Division of Policy and External Partnership
(continued)

- Designs and implements tools and informs technologies that will foster broad learning and enable learning network participants to interact with each other.

- As appropriate, works on collaboration with other CMS components to make use of a broad array of learning network techniques – campaigns, improvement projects, online communities, large and small scale events, etc to enable learning around the transparency programs. Creates mechanisms for rapid and effective transfer of knowledge within the learning networks associated with the transparency programs.

- Provides program management support for the policy and external engagement initiatives for the transparency programs including necessary operational support mechanisms, progress, statistics and makes recommendations to Senior Leadership on operational health.

- Develops and maintains full scale project plans for the transparency initiatives including schedule, risk, issues, decisions, actions, document management, budget and procurement and related areas for the policy and external engagement initiatives.

Date: December 19, 2012

Centers for Medicare & Medicaid Services
Office of the Administrator
Center for Program Integrity
Data Sharing and Partnership Group

Division of Health Informatics and Systems
(FCLFB)

- Plans, designs, implements and maintains technologies including systems, databases, portals, documentation and training to support the information transparency programs.
- Directs the development and maintenance of technical requirements, develops service level requirements, analyzes alternatives and selects technology solutions for transparency programs.
- Identifies needs of systems/databases, analyzes user requirements and creates business models for software being designed.
- Develops strategies for ensuring that data assets are usable, of value to the users and supported by technical architecture appropriate to support and achieve goals and objectives.
- Creates mechanisms and engages relevant stakeholders (users) for insights into data usage, informatics and reports pertaining to program data and innovation around solutions.
- Assumes “ownership” of aspects of day-to-day IT operations when programs go into operation. Monitors the ongoing operations of the transparency programs information technology systems including performance of technical contractors and participating users, data exchanges and needed updates to the program operations.
- Ensures appropriate testing of technologies in compliance with technical specifications and compliance with technology standards and operating protocols (security, IDM, TRA etc.) Validates requirements through tracing the business requirements to test case/scenarios for development projects through collaboration with the Office of Information Services (OIS), Chief Operating Officer testing divisions or CMS components.
- Provides education and training on software capabilities and functionalities.
- Creates technical specifications and design of data reports and query capabilities.

Date: December 19, 2012

Division of Health Informatics and Systems
(continued)

- Coordinates with other programs data utilization initiatives (CPI's Data Analytics and Control Group), technology partners, systems interfaces, and relevant technical stakeholders and partner governance boards (Capital Investment Review Board, OIS Technical Review Board, etc.)

- Monitors day-to-day operations of information technology (IT) contracts supporting the transparency programs. Monitors funding levels and burn rates, develops award fees, and conducts regular oversight of contract provisions associated with the IT supporting the transparency programs.

- Provides program management support for the information technology initiatives supporting the transparency programs including necessary operational support mechanisms, progress, statistics and makes recommendations to Senior Leadership on operational health.

- Develops and maintains full scale project plans for the transparency programs including schedule, risk, issues, decisions, actions, document management, budget and procurement and related areas for the IT initiatives.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR PROGRAM INTEGRITY

APPROVED
December 19, 2012

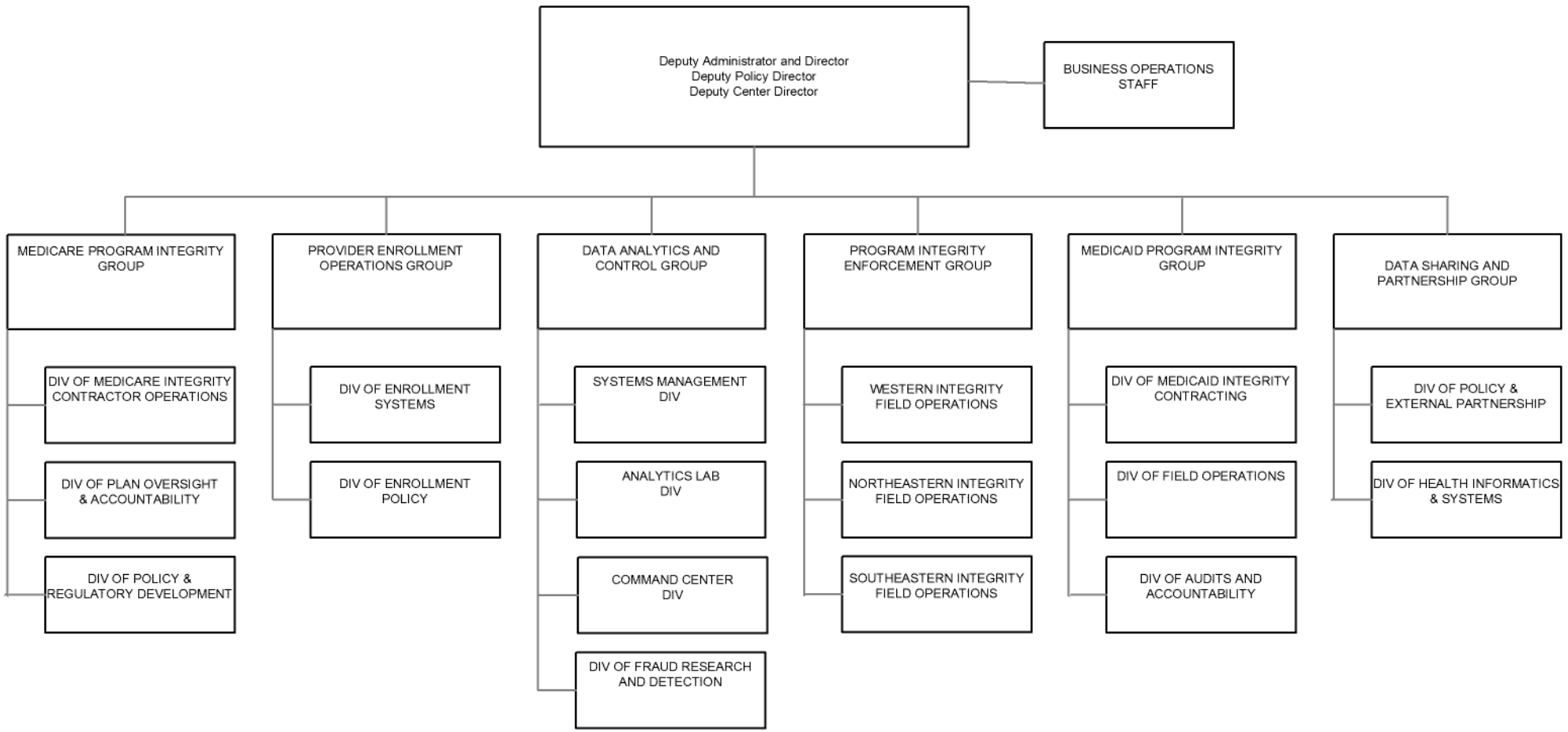


EXHIBIT 13

Document Produced in Native Format

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Program Integrity



Organizational Overview

April 6, 2017

Center for Program Integrity (CPI)

Jonathan Morse, Acting Director
Jonathan Morse, Deputy Director
George Mills, Deputy Director

- **Created**: Department of Health and Human Services (HHS) Secretary created CPI to align Medicare and Medicaid activities in March 2010.
- **Allocated FTEs**: 493.5
- **Current Organization**:
  - 8 Groups
  - 24 Divisions, including four field offices
- **Budget**: 20 funding sources totaling $1.3 billion
- **Work**: Serves as CMS' focal point for all national and statewide Medicare and Medicaid program integrity functions and the establishment of an integrated and coordinated national framework for program integrity-related policies and procedures

CPI Guiding Principles

- Prevent fraud, waste, abuse, and other improper payments
- Reduce provider burden while maintaining consistency in processes and oversight
- Assess risk at individual provider, supplier, health plan, or other key stakeholder level
- Implement interventions commensurate with risk
- Rationalize contractor use to gain operational efficiencies and better outcomes
- Increase transparency through outreach, education, strategic communications, data releases, and partnerships
- Address program integrity early in program development and mature over time

Provider Compliance Group (PCG)

Melanie Combs-Dyer, Director
Connie Leonard, Deputy Director

- **PCG Front Office**
  - Prior Authorization/Pre-Claim Review (PCR) programs
  - Improve documentation requirements

- **Division of Medical Review and Education**
  - Oversees the Medical Review Department of the Medicare Administrative Contractors (MACs)
  - Oversees the Supplemental Medical Review Contractor (SMRC)
  - Oversees targeted small sample review and education to improve provider compliance ("Probe and Educate")

- **Division of Recovery Audit Operations**
  - Oversees five Medicare Fee-for-Service (FFS) Recovery Audit Contractors (RAC)
  - Oversees RAC Validation Contractor claim reviews
  - Manages the RAC Data Warehouse

- **Division of Compliance Projects and Demonstrations**
  - Conducts Self Audit with Validation and Extrapolation Pilot
  - Electronic Submission of Medical Documentation (esMD) and Interoperability
  - Contributes to the Program Integrity Manual

Governance Management Group (GMG)

Mary G. Greene, M.D., Director
Clint Eisenhower, Deputy Director

- **Division of Vulnerability Governance**
  - Facilitates Program Integrity Board comprised of CMS Center Directors and Deputies
  - Identifies, tracks and makes recommendations for program vulnerabilities
  - Developing risk-based analysis of provider compliance with existing Medicare requirements
  - Leads CMS-wide opioids initiative in collaboration with Center for Clinical Standards and Quality (CCSQ)

- **Division of Performance and Oversight**
  - Leads strategic planning and innovation
  - Tracks performance measurement and writes Reports to Congress
  - Develops and monitors improper payments Corrective Action Plans
  - Implements Government Accountability Office (GAO) Fraud Risk Management Framework
  - Manages congressional correspondence, clearance, and GAO and Office of Inspector General (OIG) audit responses

- **Division of Policy and Regulation**
  - Develops program integrity regulations and policies
  - Modifies and maintains Program Integrity Manual

- **State Liaison Staff**
  - Manages the Medicaid Integrity Institute (MII)
  - Provides state-level Medicaid program integrity technical assistance and communications
  - Fosters federal and state stakeholder input and collaboration to mitigate program integrity vulnerabilities

Data Sharing and Partnership Group (DSPG)

Merri-Ellen James, Director

Jennifer Dupee, Deputy Director

- **Division of Stakeholder Engagement and Outreach**
  - Develops customized outreach materials and methods to enable diverse stakeholders to gain information and make informed decisions about CPI initiatives
  - Collaborates with external stakeholders, including relevant federal and state agencies, physicians and clinical staff, hospitals, healthcare industry, private payers, associations, clinical and analytic experts, beneficiaries, and other stakeholders affected by program integrity-related activities to ensure program integrity priorities are effectively communicated, understood, and applied by stakeholders

- **Division of Data and Informatics**
  - Oversees the Open Payments program, a statutorily-mandated national disclosure program that promotes transparency and accountability in the healthcare industry by making financial relationships between drug, medical supply, biological, and device manufacturers and physicians and teaching hospitals available to the public
  - Oversees the Healthcare Fraud Prevention Partnership (HFPP), a voluntary, public-private partnership between the federal government, state agencies, law enforcement, private health insurance plans, employer organizations, and healthcare anti-fraud associations to identify and reduce fraud, waste, and abuse across the healthcare sector

Investigations and Audits Group (IAG)

Mark Majestic, Director

Lori Bellan and Peter Leonis, Deputy Directors

- **Division of Plan Oversight and Accountability**
  - Partners with CMS components to provide program integrity oversight of Medicare Advantage and Prescription Drug Plans
  - Provides technical oversight of the Parts C/D program integrity contractor (National Benefit Integrity Medicare Drug Integrity Contractors – NBI MEDIC)

- **Division of State Program Integrity**
  - Provides oversight and conducts state program integrity reviews

- **Division of Provider Investigations and Audits**
  - Develops regional and national investigative strategies
  - Serves as Business Function Leads for CMS program integrity contractors
  - Provides audits and investigations technical assistance to Medicaid state program integrity components
  - Approval authority for Medicare payment suspensions
  - Serves as law enforcement liaison and provides oversight of the Zone Restriction process

- **Four Divisions of Field Operations (North, South, East, and West)**
  - Supports IAG national strategies and investigative processes for Medicare and Medicaid
  - Conducts regional program integrity activities in Medicare and Medicaid

Contract Management Group (CMG)

Craig Gillespie, Director
Desiree Wheeler, Deputy Director

- **Division of Acquisition Strategies and Planning**
  - Oversees Medicare and Medicaid Program Integrity Contractors
  - Manages the Unified Program Integrity Contractor (UPIC) acquisition (pre-award) process – consolidation of Medicare and Medicaid investigation and audit work
  - Issues contract/task order awards

- **Division of Contract Management**
  - Provides daily contractor oversight
  - Manages contract modifications
  - Executes option years
  - Provides technical direction
  - Manages contractor invoice payments and award fee disbursements

- **Division of Contractor Performance and Assessment**
  - Develops, coordinates, and completes contractor performance evaluations
  - Develops contractor award fee plans and completes contractor award fee assessments

Data, Analytics, and Systems Group (DASG)

Raymond Wedgeworth, Director
Kathy Wolf, Deputy Director

- **Division of Modeling and Analytics**
  - Provides statistical and data analysis for program integrity
  - Identifies emerging fraud trends through data mining and other advanced analytical techniques
  - Leads model and edit development for the Fraud Prevention System (FPS), a predictive analytics system for Medicare claims

- **Division of Systems Management**
  - Manages system development and enhancements in support of information gathering and analysis to detect fraud and abuse
  - Implements data management technologies and strategies to support analysis to identify fraud, waste, and abuse
  - Maintains Fraud Prevention, Provider Enrollment, and Unified Case Management (UCM) systems

- **Division of Outcomes and Measurement**
  - Develops sound methodologies for calculating outcome measures and return on investment (ROI) for Medicare and Medicaid Programs Program Integrity Manual Development

Provider Enrollment and Oversight Group (PEOG)

Zabeen Chong, Director

Charles Schalm, Deputy Director

- **Division of Enrollment Operations**
  - Oversees the Medicare Administrative Contractor (MAC) provider enrollment operations
  - Develops Medicaid provider enrollment sub-regulatory guidance and provides technical assistance to states
  - Revalidates the enrollment of over two million providers

- **Division of Enrollment Systems**
  - Oversees and develops Medicare provider enrollment systems
  - Collaborates and develops partnerships with the provider and healthcare community
  - Helps state Medicaid agencies leverage Medicare data for Medicaid enrollment and screening

- **Division of Enforcement Actions**
  - Analyzes and implements Medicare administrative actions (revocations and deactivations)
  - Assists providers with no previous history of non-compliance in Medicare and Medicaid in achieving enrollment compliance for violations not deemed detrimental to the program

- **Division of Compliance and Appeals**
  - Reviews and renders decisions on corrective action plans and appeals for providers who are denied or revoked from the Medicare program
  - Identifies and mitigates Medicare provider enrollment vulnerabilities

Business Services Group (BSG)

Teresa Krause, Director
Lisa Jarvis-Durham, Deputy Director

- Works closely with the Office of Financial Management (OFM)
- Coordinates with all CPI groups for funding needs
- Responsible for managing and distributing $1.3+ billion in 20 funding sources
- Responsible for formulation of budget to the Department of Health and Human Services (HHS), Office of Management and Budget (OMB), and Congressional Justification
- Responsible for execution of current year funds
- Responsible for the integrated time and attendance system, travel system, hiring, facilities management, and training for CPI

Reducing Provider Burden

CPI is working to reduce provider burden through operational efficiencies, data transparency, risk-based intervention, systems enhancements, documentation improvement, and provider education. Sample initiatives include:

- **Integrity Continuum** – Aimed at improving provider compliance with Medicare requirements through risk-based interventions, such as outlier identification followed by education. Projects include assessing risk at the individual provider level to target interventions (*e.g.,* self-audit, probe and education, *etc.*); coordinating contractor activities to reduce duplication and expedite escalation and de-escalation of interventions; and consolidating provider portal entry points and enabling visibility into their current and historic billings and CMS audit activities.

- **Provider Enrollment Chain Ownership System (PECOS) Redesign** – New procurement will streamline the provider interface and enable us to assist states with enrolling Medicaid providers. The system supports the Medicare provider and supplier enrollment process by allowing registered users to securely and electronically submit and manage Medicare enrollment information.

Reducing Provider Burden

- **Documentation Improvement Initiative** – This program aims to consolidate documentation requirements into a centralized resource to avoid inconsistencies in requirements scattered across manuals, local coverage determinations, and other guidance documents. A centralized resource would also ease management of the requirements, including periodically identifying those that may no longer be needed.

- **Outreach and Education** – CMS provides education, outreach and training to stakeholders (providers, beneficiaries, plan sponsors, private plans, law enforcement, states, and others).

- **Probe and Educate** – CMS' probe and educate medical review strategy involves completing a small sample of medical reviews on certain providers and then offering individualized education as appropriate to promote provider understanding and compliance with program requirements.

- **Program Integrity Institute** – CMS plans to create an institute to train Medicare contractors and staff on policies and procedures, helping to ensure that all reviewers are basing their review of claims on the same interpretation. In addition, training will target known trends and problem areas.

EXHIBIT 14

From: Smith, Jonathan (CMS/CM) <Jonathan.Smith@cms.hhs.gov>
Sent: Friday, February 15, 2013 3:22 PM
To: Maldonado, Gloria M. (CMS/CMHPO) <Gloria.Maldonado@cms.hhs.gov>
Cc: Paul, Rebecca (CMS/CM) <REBECCA.PAUL@CMS.HHS.GOV>; Harlow, Jennifer A. (CMS/CM) <Jennifer.Harlow@cms.hhs.gov>; Chaudhuri, Ilina (CMS/CM) <Ilina.Chaudhuri@cms.hhs.gov>; Kornfield, Thomas (CMS/CM) <Thomas.Kornfield@cms.hhs.gov>
Subject: Org charts for Liza's review
Attach: Scanned_document_15-02-2013_10-07-31.pdf; ReorgChartV5.docx; dpv 1 09 13 orgchart v4.pdf; RADV org chart v8_1092013.pdf

---

Gloria,

Here are the org charts that we will review in the interview.

Thanks,

Jonathan

>-----Original Message-----
>From: jonathan.smith3@cms.hhs.gov [mailto:jonathan.smith3@cms.hhs.gov]
>Sent: Friday, February 15, 2013 10:08 AM
>To: Smith, Jonathan (CMS/CM)
>Subject: Scanned document 15-02-2013 10:07:31
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>PDF sent from Oce printer
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>
>
>Oce VarioPrint 1065: COC1-09-01-OCE
>(Oce VarioPrint)
>15-02-2013 10:07:31

US-DOJ-KAISER-00049747

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

APPROVED LEADERSHIP
As of February 1, 2013
*** Acting**
****Reports to Office of Enterprise Management**

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Anita Pinder, Dep. Dir.

MEDICARE OMBUDSMAN GROUP

OFFICE OF PUBLIC ENGAGEMENT
Teresa Niño, Director
Charlotte Newman , Dep. Dir.

TRIBAL AFFAIRS GROUP

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Michele Patrick, Dep. Dir.
Mary Wallace, Dep. Dir.

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Lauren Aronson, Director
Jennifer Boulanger, Dep. Dir.

FEDERAL COORDINATED HEALTH CARE OFFICE
Melanie Bella, Director
Cheryl Powell, Dep. Dir.

OFFICE OF MINORITY HEALTH
Cara V. James, Director
Vacant, Dep. Dir.

Marilyn Tavenner
ACTING ADMINISTRATOR

Jonathan Blum
ACTING PRINCIPAL DEPUTY ADMINISTRATOR

Marilyn Tavenner
CHIEF OPERATING OFFICER

Aryana Khalid
CHIEF OF STAFF

Michelle Snyder
DEPUTY CHIEF OPERATING OFFICER

OFFICE OF THE ACTUARY
Paul Spitalnic, Chief Actuary*

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Kathleen Cantwell, Director
Olen Clyboum, Dep. Dir.

CENTER FOR CLINICAL STANDARDS AND QUALITY
Patrick Conway, M.D., Director & CMS Chief Medical Officer
Wesley Perich, Dep. Dir.
Shari Ling, M.D., Dep. Chief Medical Officer

CENTER FOR STRATEGIC PLANNING
Michelle Snyder
Deputy Administrator and Director*

Vacant
Deputy Center Director

OPERATIONS
Michelle Snyder
Deputy Chief Operating Officer

OAGM—Daniel Kane, Director

OFM--Deborah Taylor, Director & Chief Financial Officer

OIS--Tony Trenkle, Director & CMS Chief Information Officer

OOM—James Weber, Director

CFMFFSO--Nanette Foster Reilly, Consortium Administrator

CMCHO--Jackie Garner, Consortium Administrator

CMHPO--James T. Kerr, Consortium Administrator

CQISCO—James Randolph Farris, M.D., Consortium Admin.

OEM—David Nelson, Director*

***OEP-Sandra Kraft, Director*

***OESS-Robert Tagalicod, Director*

***OEB-Marc Wynne, Director**

***OIPDA-Niall Brennan, Director*

CENTER FOR MEDICARE

Jonathan Blum
Deputy Administrator and Director

Liz Richter
Deputy Center Director

Tim Love
Deputy Center Director

CENTER FOR MEDICAID AND CHIP SERVICES

Cindy Mann
Deputy Administrator and Director

Julie Boughn
Deputy Center Director

Penny Thompson
Deputy Center Director

CENTER FOR PROGRAM INTEGRITY

Peter Budetti
Deputy Administrator and Director

Ted Doolittle
Deputy Policy Director

Elisabeth Handley
Deputy Center Director

CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT

Gary Cohen
Deputy Administrator and Director

Chiquita Brooks-Lasure
Deputy Center & Policy Director

Jim Kerr
Deputy Center & Operations Director*

CENTER FOR MEDICARE AND MEDICAID INNOVATION

Richard Gilfillan, M.D.
Director

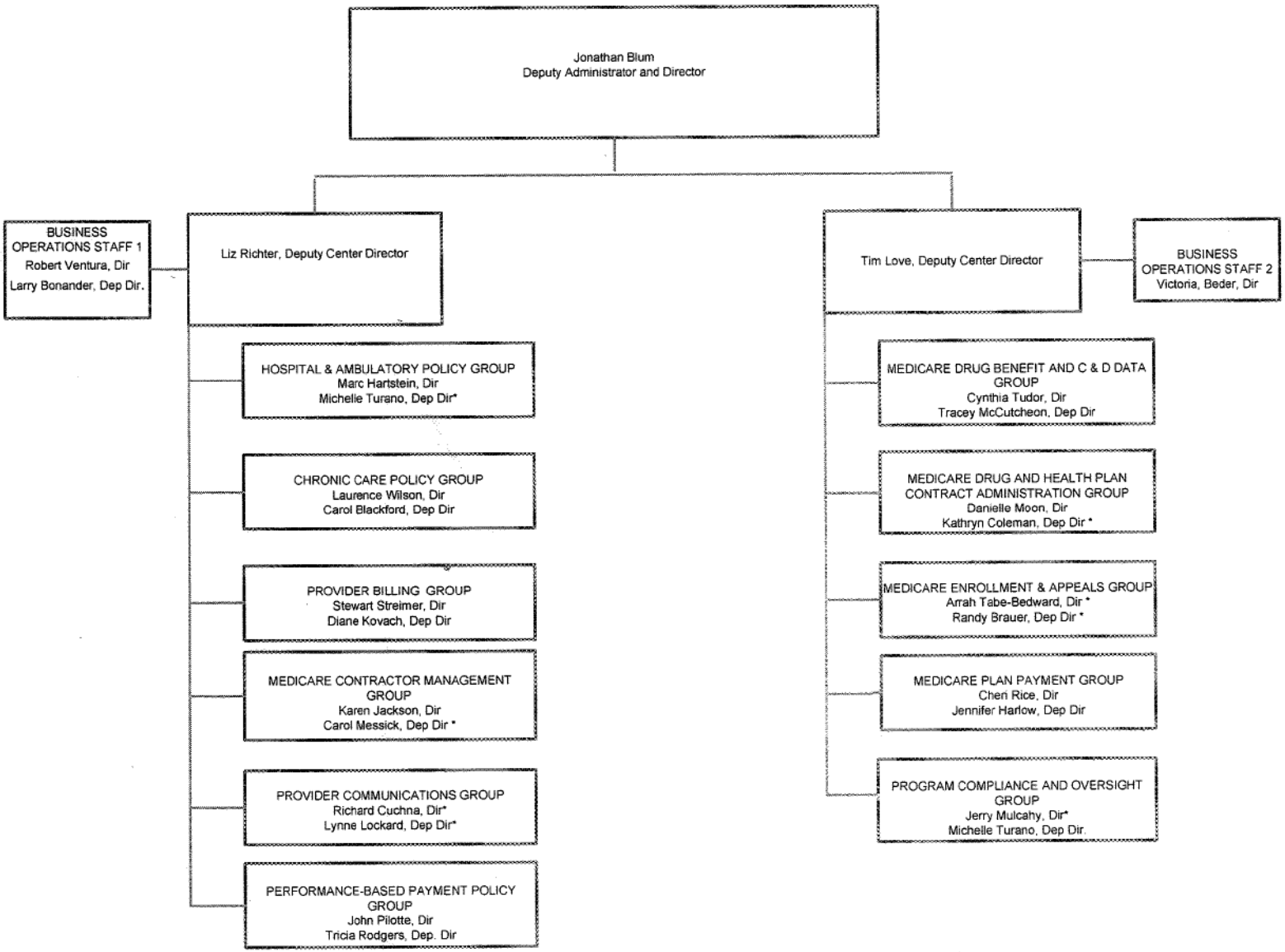
Sean Cavanaugh
Deputy Director

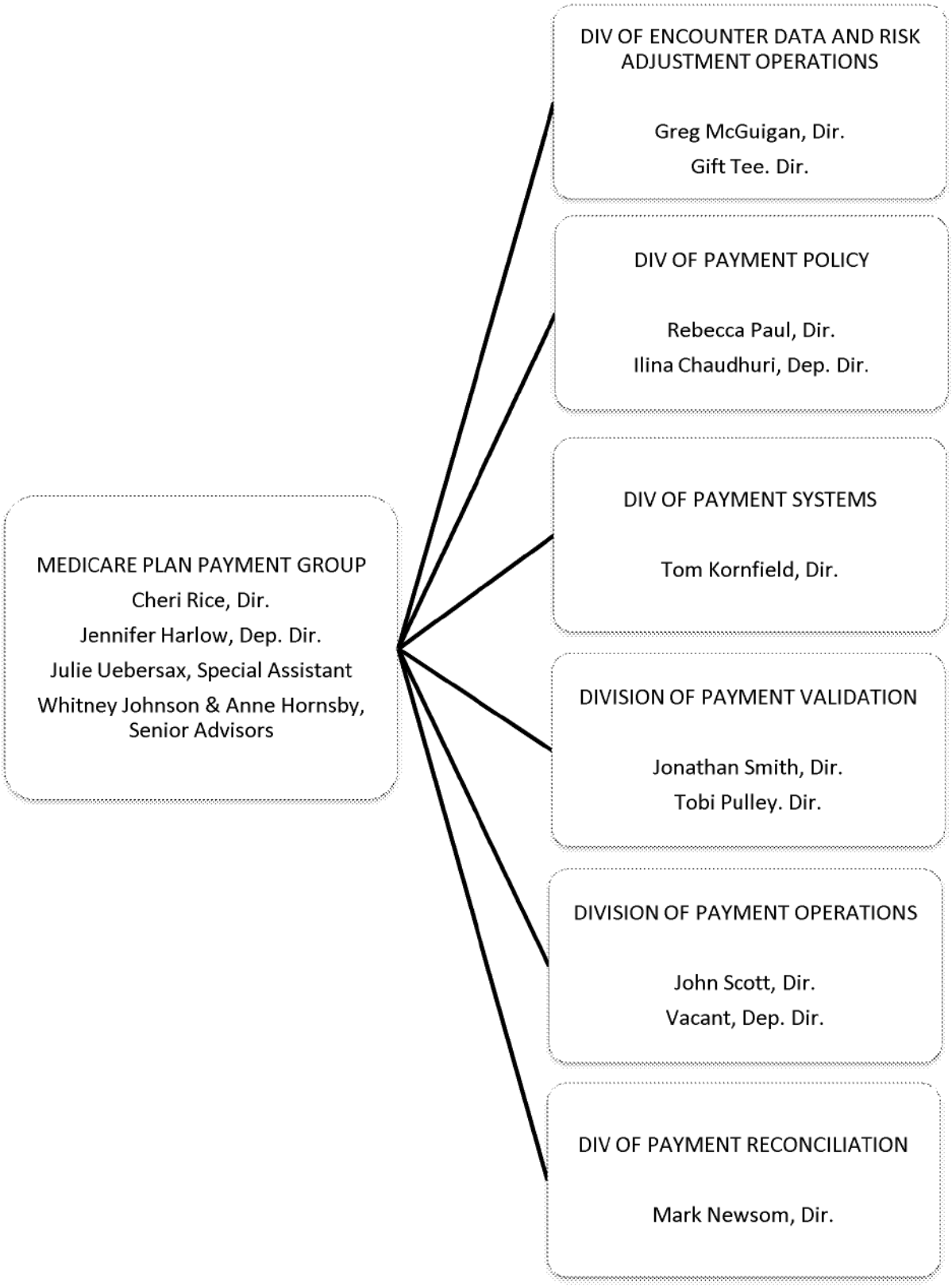
Thomas Reilly
Deputy Director

US-DOJ-KAISER-00049748

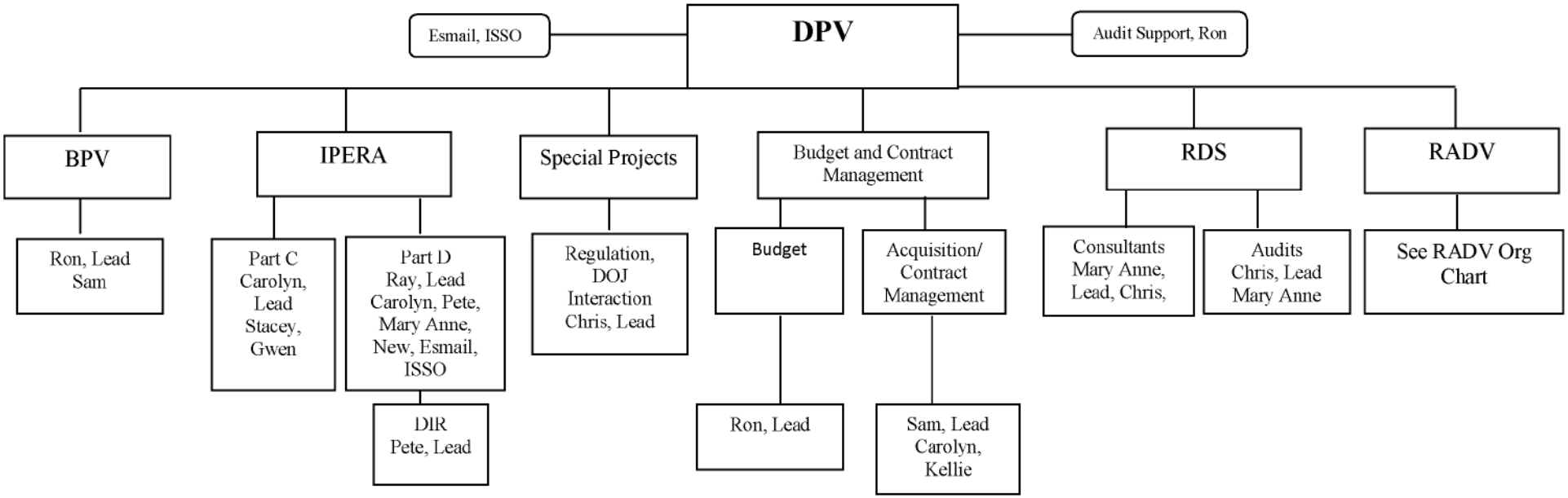
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE

APPROVED LEADERSHIP
As of February 1, 2013
***Acting**



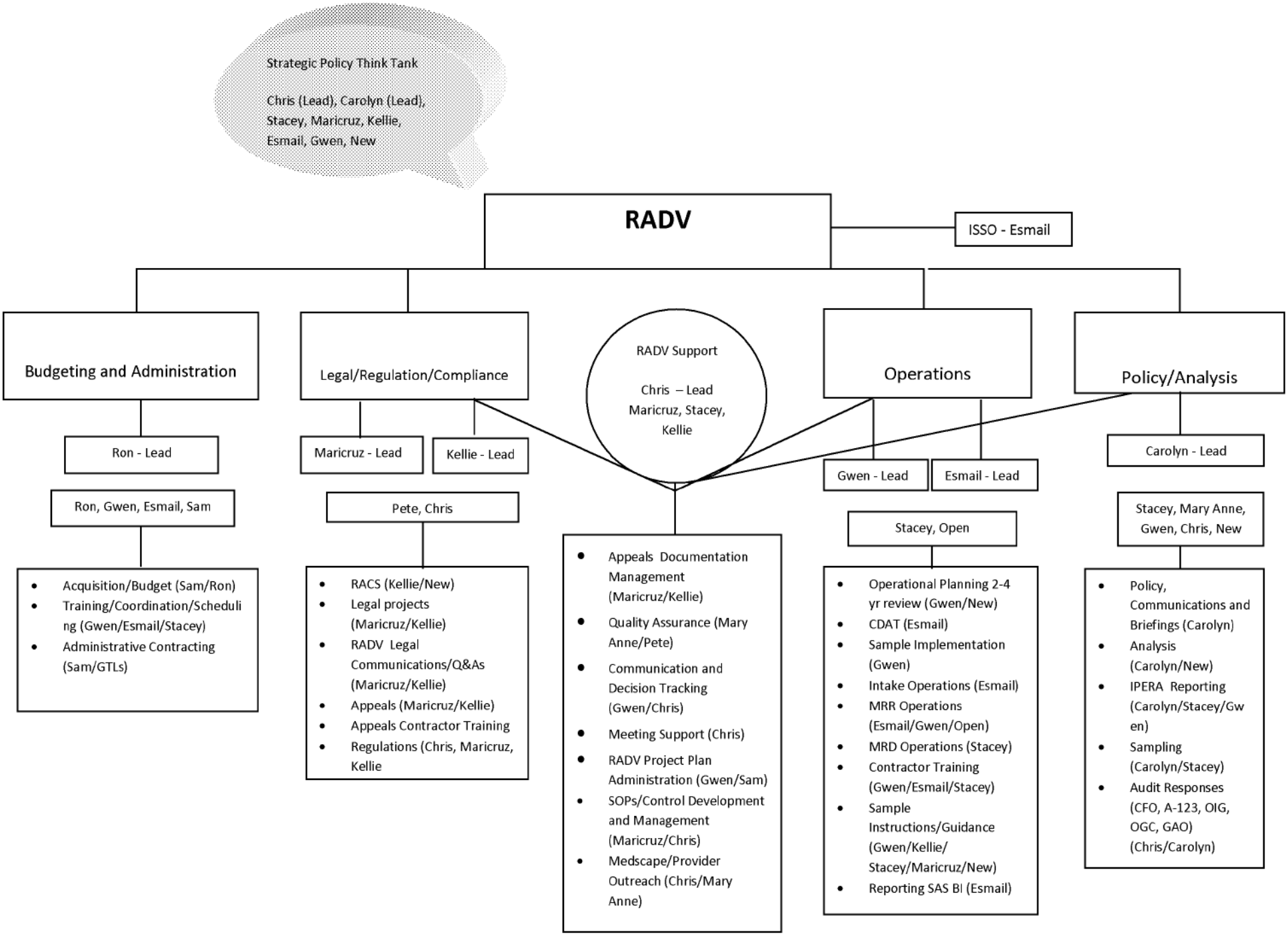

MEDICARE PLAN PAYMENT GROUP
Cheri Rice, Dir.
Jennifer Harlow, Dep. Dir.
Julie Uebersax, Special Assistant
Whitney Johnson & Anne Hornsby, Senior Advisors
DIV OF ENCOUNTER DATA AND RISK ADJUSTMENT OPERATIONS
Greg McGuigan, Dir.
Gift Tee. Dir.
DIV OF PAYMENT POLICY
Rebecca Paul, Dir.
Ilina Chaudhuri, Dep. Dir.
DIV OF PAYMENT SYSTEMS
Tom Kornfield, Dir.
DIVISION OF PAYMENT VALIDATION
Jonathan Smith, Dir.
Tobi Pulley. Dir.
DIVISION OF PAYMENT OPERATIONS
John Scott, Dir.
Vacant, Dep. Dir.
DIV OF PAYMENT RECONCILIATION
Mark Newsom, Dir.

DIVISION OF PAYMENT VALIDATION
MEDICARE PLAN PAYMENT GROUP
CENTER FOR MEDICARE
CMS
Organization Chart



1/9/2013
v.4.

US-DOJ-KAISER-00049750



US-DOJ-KAISER-00049751

EXHIBIT 15

Message

From: Beder, Victoria M. (CMS/CM) [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=F0211E55DDDD4FA4A4CF3D0928CBD55C-B139]
Sent: 1/5/2017 9:02:02 PM
To: Rice, Cheri M. (CMS/CM) [/o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=320f389b49d743e5b27fffd308c3225c-R14L]; Harlow, Jennifer A. (CMS/CM) [/o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=8ca0a20d92d84d598a12b1a4ab2d71e5-H111]
CC: Deming, Nicole M. (CMS/CM) [/o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=880b32a325ec4360bbda7a8c6880dbc6-D2EI]; Darden-Hill, Sabrina Y. (CMS/CM) [/o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=226fdb67989042aa8ea789ebae8d41c6-PC48]; Feaster, Simone E. (CMS/CM) [/o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=555d32d47ec64bfc81ab6bd54e6bb28e-D24K]
Subject: FW: CM & CPI Approved Reorganization--121416
Attachments: Memo--CM - CPI--121416.pdf; Org Summary Sheet--CM - CPI--121416.pdf; FCHKA--Functional Statement--CM - CPI--121416.pdf; ATT44505

Importance: High

fyi

From: Deluca, Terri G. (CMS/OHC)
Sent: Thursday, January 5, 2017 3:49 PM
To: Cavanaugh, Sean (CMS/CM) <Sean.Cavanaugh@cms.hhs.gov>; Agrawal, Shantanu (CMS/CPI) <Shantanu.Agrawal@cms.hhs.gov>
Cc: Richter, Elizabeth (CMS/CM) <elizabeth.richter@cms.hhs.gov>; Tudor, Cynthia G. (CMS/CM) <cynthia.tudor@cms.hhs.gov>; Morse, Jonathan D. (CMS/CPI) <Jonathan.Morse@cms.hhs.gov>; Mills, George G. (CMS/CPI) <george.mills@cms.hhs.gov>; Anderson, Kelly M. (CMS/OHC) <Kelly.Anderson1@cms.hhs.gov>; Barron, Michael J. (CMS/OHC) <michael.barron@cms.hhs.gov>; Bohuslav, Christine R. (CMS/OFM) <Christine.Bohuslav@cms.hhs.gov>; Botterill, Julie M. (CMS/OFM) <Julie.Botterill@cms.hhs.gov>; Bovell, Stephanie M. (CMS/OHC) <stephanie.bovell@cms.hhs.gov>; Bryant-Ricketts, Faraja (CMS/OSSO) <faraja.bryantricketts@cms.hhs.gov>; Cascio, Dolores D. (CMS/OHC) <Dolores.Cascio@cms.hhs.gov>; Christ, Jill R. (CMS/OHC) <Jill.Christ@cms.hhs.gov>; Clark, Jerry (CMS/OHC) <Jerry.Clark@cms.hhs.gov>; CMS AID <AID@cms.hhs.gov>; Coleman, Renee L. (CMS/OHC) <Renee.Coleman@cms.hhs.gov>; Dion, Joseph (CMS/OHC) <Joseph.Dion@cms.hhs.gov>; Eckenrode, Anona (CMS/OSSO) <Anona.Eckenrode@CMS.hhs.gov>; Fletcher, Regina B. (CMS/OHC) <Regina.Fletcher@cms.hhs.gov>; Fraczkowski, Melissa A. (CMS/OHC) <Melissa.Fraczkowski@cms.hhs.gov>; Garner, Jillian C. (CMS/OFM) <Jillian.Garner@cms.hhs.gov>; Giberson, Scott F. (CMS/OHC) <Scott.Giberson@cms.hhs.gov>; Gordon, Erin M. (CMS/OC) <Erin.Gordon@cms.hhs.gov>; Haller, Raven Y. (CMS/OC) <Raven.Haller@cms.hhs.gov>; Handley, Elisabeth (CMS/OHC) <elisabeth.handley1@cms.hhs.gov>; Harrison, TaRhonda L.(CMS/OHC) <Tarhonda.Harrison@cms.hhs.gov>; Huza, Christopher M. (CMS/OSSO) <Christopher.Huza@cms.hhs.gov>; Little, Cheryl L. (CMS/OFM) <Cheryl.Little@cms.hhs.gov>; Loftus, Janet M. (CMS/OFM) <Janet.Loftus@cms.hhs.gov>; Lunsford, Lee (CMS/OEOCR) <lee.lunsford@cms.hhs.gov>; Lyles, Johnalyn (CMS/OHC) <Johnalyn.Lyles1@cms.hhs.gov>; Magnotta, David M. (CMS/OHC) <David.Magnotta@cms.hhs.gov>; Milihram, Suzanne (CMS/OFM) <Suzanne.Milihram@cms.hhs.gov>; Oh, Kathy J. (CMS/OHC) <Kathy.Oh@cms.hhs.gov>; Odowd, Donna M. (CMS/OHC) <donfyina.odowd@cms.hhs.gov>; Pleines, Kurt W. (CMS/OFM) <Kurt.Pleines@cms.hhs.gov>; Porter, Angela K. (CMS/OHC) <Angela.Porter@cms.hhs.gov>; Presco, Kimberly D. (CMS/OHC) <Kimberly.Presco@cms.hhs.gov>; Reed, Angela (CMS/OHC) <angela.reed@cms.hhs.gov>; Sanders, Melvin J. (CMS/OC) <Melvin.Sanders@cms.hhs.gov>; Scott, Latrina L. (CMS/OEOCR) <Latrina.Scott@cms.hhs.gov>; Sheahin, Michelle R. (CMS/OFM) <Michelle.Sheahin@cms.hhs.gov>; Sheil, Jean K. (CMS/CQISCO) <jean.sheil@cms.hhs.gov>; Tucker, Tony R. (CMS/OSORA) <Tony.Tucker@cms.hhs.gov>; Vaughn, Katherine L. (CMS/OHC) <Katherine.Vaughn@cms.hhs.gov>; Walekar-Hempstead, Andrea (CMS/OHC) <Andrea.Walekar-Hempstead@cms.hhs.gov>; Williamson, Alexander (CMS/OFM) <Alexander.Williamson@cms.hhs.gov>; Beder, Victoria M. (CMS/CM) <Victoria.Beder@cms.hhs.gov>;

Grant, Monica (CMS/CPI) <Monica.Grant@cms.hhs.gov>; Jarvis-Durham, Lisa (CMS/CPI) <Lisa.Jarvis-Durham@cms.hhs.gov>
Subject: CM & CPI Approved Reorganization--121416
Importance: High

Good afternoon. The reorganization for the Center for Medicare (CM) and Center for Program Integrity (CPI) was approved on December 14. Attached, for your records, is a copy of the approved memo (3 pages), organizational summary sheet (1 page), and functional statement (1 page). The functional statement will be available on the intranet within 3 – 5 business days. The organizational structures for CM and CPI have not changed. The organization charts remain the same.


Memo--CM - CPI--121416.pdf


Org Summary Sheet--CM - CPI-...


FCHKA--Functio... Statement--CM - ...

Both the administrative and program delegation of authorities will be reviewed for any impact, and if needed, updated accordingly. Until such time, all current authorities remain in effect.

Feel free to contact me if you have any questions.

Thank you in advance.

Terri DeLuca
Lead Management Analyst & CMS Principal Delegation Control Officer
DPOP/WMG/OHC
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
Mail Stop: C5-17-16; Location: C5-16-14
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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE

TO: Deputy Chief Operating Officer

THRU: David Magnotta /s/
Director, Workforce Management Group (OHC)

FROM: Sean Cavanaugh /s/
Deputy Administrator and Director
Center for Medicare

SUBJECT: Request to Reorganize the Center for Medicare and Center for Program Integrity -- DECISION

ISSUE

Your approval is requested to realign the Risk Adjustment Data Validation (RAD-V) function and employees from the Division of Payment Validation (DPV), Medicare Plan Payment Group (MPPG), Center for Medicare (CM) to the Division of Plan Oversight and Accountability (DPOA), Investigations and Audits Group (IAG), Center for Program Integrity.

Attached is the organizational summary sheet.

BACKGROUND

MPPG/CM is responsible for developing and improving all bidding and payment policies related to the Medicare Prescription Drug Benefit and the Medicare Advantage (MA) program for the individual and employer sponsored group market, including rules regarding how plans are to structure their bids, bid review criteria, benchmark computations, use of beneficiary rebates, development and refinement of risk adjustors, low income subsidy, reinsurance, risk sharing, and the MA regional stabilization fund. It also directs all operations, policy, and research related to risk adjustment of payments to MA Organizations and Prescription Drug Plans, and collects encounter data from Medicare Advantage plans to: describe Medicare Advantage beneficiary health care encounters and recalibrate risk adjustment model factors; validate Medicare utilization and expenditures; conduct geographic acuity studies; evaluate managed care cost and utilization trend information; and monitor performance.

MPPG consists of DPV, Division of Payment Operations, Division of Payment Reconciliation, Division of Payment Policy, Division of Encounter Data and Risk Adjustment Operations, and the Division of Payment Systems.

IAG/CPI is responsible for providing technical guidance on all Medicare and Medicaid program integrity (PI) enforcement activities; develops an integrated and coordinated national framework for PI investigations and audit policy and procedures across the Medicare and Medicaid Programs and capitalizes on economies of scale and whenever possible and feasible. It also oversees and coordinates the operations of the CPI Medicare and Medicaid field offices.

IAG is currently comprised of the Division of Plan Oversight and Accountability (DPOA), Division of State Program Integrity, Division of Provider Investigations and Audits, Divisions of Field Operations – North, South, East, and West.

ORGANIZATION AND STAFFING CHANGES

The RAD-V function and three employees will realign from DPV, MPPG, CM to DPOA, IAG, CPI, and will be an expansion of the auditing process related to MA plans because DPOA is the focal point for fraud, waste, and abuse oversight for MA plans. In addition, to create consistencies in the oversight and auditing process for the MA program and align with the Recovery Audit Contractors' program for MA.

There will be no impact on employee grade levels, changes in classification series, or assignment of duties. No employee is losing a job due to these improvements in the organizational structure and there will be no change in pay or benefits. Employees' commuting duty stations will also be unchanged.

CPI will still maintain its current 14/15 and full-time equivalent (FTE) ceilings. CM will decrease its 14/15 ceiling by one and FTE ceilings by three.

The overall functional statements for CPI, IAG, DPOA will not change because the current functional statements are written broad enough to include the addition of the RAD-V function. A minor change will be made to the functional statement for DPV in MPPG/CM. The organizational structures in both CM and CPI remain the same and have not changed.

DELEGATIONS OF AUTHORITY

All delegations and re-delegations of authority made to officials and employees of affected organizational components will continue in them or their successor organization pending further re-delegation, provided they are consistent with this proposed reorganization. Until such time, all delegations of authority remain in effect.

RECOMMENDATION

I recommend approval of the proposed reorganization in CM and CPI based on the above analysis. Please indicate your approval or disapproval of the proposed change on the **DECISION** line below.

DECISION

Approve: x Disapprove: _____ Date: 12/14/2016

Signature: /s/
Karen Jackson
Deputy Chief Operating Officer

Attachment:
Organizational Summary Sheet

ORGANIZATIONAL SUMMARY SHEET

Centers for Medicare & Medicaid Services

Center for Medicare
Medicare Plan Payment Group

Component with Revised Functional Statement

FCHKA	Division of Payment Validation

Date: December 14, 2016

Centers for Medicare & Medicaid Services
Office of the Administrator
Center for Medicare
Medicare Plan Payment Group

Division of Payment Validation
(FCHKA)

- Validates monthly payments at the beneficiary level for Part C and Part D prior to payment authorization. Coordinates with staff in the Office of Information Services and CMS contractors to access and analyze monthly payment files. Maintains, expands and/or revises as necessary payment validation analyses and protocols. Maintains history of payment validation findings for audit purposes. Documents and implements internal controls relating to payment validation functions. Responds to annual audit requirements.

- Identifies and analyzes payment system issues relating to payment error. Tracks and monitors payment issues over time and works with the Medicare Advantage Prescription Drug System contractors and other CMS contractors to clarify and resolve problems. Validates proposed solutions to ensure the integrity of proposed payment adjustments and software fixes.

- Develops error rates for Part C and Part D relating to prospective payments and final payment reconciliation. Improves error rate design and estimates error rates on a routine annual basis in response to Improper Payments Information Act reporting requirements. Coordinates estimate development and reporting with HHS and the Office of Management and Budget.

- Designs and implements sampling frames to allow for national payment error estimates in risk adjustment. Pulls and reviews medical records relating to Part C payments. Conducts quality assurance of medical record review findings. Manages and coordinates multiple contractors to implement the review process.

- Reviews and assesses plan requests for retro enrollment, disenrollment, and other status changes. Upon review, allows appropriate changes to be implemented.

- Reviews and validates plan submissions relating to direct and indirect remuneration. Uses outlier analyses, comparisons with quarterly reporting and other descriptive statistics to identify plan sponsors with rebate and payment anomalies.

- Develops and coordinates accrual estimates for financial statements as appropriate.

EXHIBIT 16

Document Produced in Native Format

Risk Adjustment Data Validation (RADV) Coder Training







Calendar Year (CY) 2010

February 22, 2012

Centers for Medicare & Medicaid Services (CMS)

Risk Adjustment Data Validation (RADV) Coder Training

Introductions

Agenda

- RADV Team Roles and Responsibilities
- Risk Adjustment Overview
- Risk Adjustment Data Validation Overview
- Intake Overview
- Medical Record Review Coding Process
- Questions

RADV Team Roles & Responsibilities

- **Review RADV Roles**
- **Methods of Communication**
- **Security**

Centers for Medicare & Medicaid Services (CMS)

Cheri Rice, Director, Medicare Plan Payment Group (MPPG)	Jennifer Harlow, Director, Div. of Payment Validation (DPV)	Mary Bonner, RADV Team Lead	Ashley Franzel, RADV Team Lead
Jonathan Smith, Technical Advisor	Maricruz Bonfante, IMRRC & PAC COTR	Stacey Deiter, IMRRC COTR	Kellie Gombeski, IMRRC COTR
Carolyn Kapustij, LAC COTR	Pete Castellano, ICC COTR	Samuel Jenkins, LAC COTR	Ray Mierwald, Alternate LAC COTR
	Esmail Essajee, ISSO	Ronald Thompson, TDPS COTR	

Lead Analytic Contractor (LAC)

- Coordinates overall analytic approach and process
- Produces composite Part C payment error estimate (reported by the end of each fiscal year)
- Helps develop sampling plan
- Ensures data integrity
- Evaluates IRR analyses
- Calculates payment error estimates
- CDAT data export requests/receipts
- Quality Assurance of CDAT reports

Intake Medical Record Review Contractor (IMRRC)

- Requests, receives, and tracks submissions from MA contracts
  - Electronic CMS-HCC Coversheet containing uploaded Medical Record File (CMS-Generated Attestation [if applicable] and Medical Record)
- Conducts Administrative Intake and Senior Evaluation
- Offers Intake Technical Assistance
- Act as a point of contact between CMS and audited MA contracts

Medical Record Review Contractor (MRRC)

Conducts medical record review using CDAT, by using certified ICD-9-CM coders to abstract diagnosis

Independent Coding Contractor (ICC)

- Drafts training materials and standard procedural guidance for RADV coders
- Communicates with CMS to provide understanding of coding issues that may impact policy decisions
- Participates as a procedural advisor during medical record review

Payment Appeals Contractor (PAC)

- Serves as a liaison between CMS, its contractors, and the CMS Hearings Office to coordinate, prepare and manage documentation requested for hearings
- Conducts internal audit of the RADV process
- Independently recalculates RADV payment error calculation
- Assists CMS with Control Briefings

Methods of Communication

- CMS and RADV Contractors
  - Meetings
  - Email
  - CDAT Repository
- CMS CORs must be involved for all communications among contractors
- RADV is a confidential project – information must not be shared
- All communications with MA contracts are cleared with CMS before distribution.

Security – Your role

- **Both PHI (Personal Health Information) and PII (Personally Identifiable Information) are part of RADV data**
  - **Do NOT transfer medical records via email**
  - **Do NOT email an enrollee name or HICN**
  - **Do NOT leave a voice message with an enrollee name or HICN**
  - **Do NOT download a medical record onto your computer**
  - **Do NOT send screen shots containing PHI/PII**
- **Follow the security policy defined in your contract if you suspect a data breach has occurred**

Questions



Risk Adjustment Data Validation (RADV) Coder Training

Risk Adjustment Overview

Risk Adjustment (RA)

- Used to adjust CMS' payments to Medicare Part C MA contracts based on health status and demographics of their Medicare members
- Makes appropriate and accurate payments for subpopulations with significant cost differences
- Protects beneficiary access to care, reduces adverse selection

Risk Adjustment – How it Works

- **CMS develops prospective risk adjustment models for Part C**
  - **Diagnoses from year 1 used to predict average spending for Medicare fee-for-service populations in year 2**
  - **Models contain approximately 3,500 diagnosis codes**
- **Models include components for:**
  - **Demographics (age, sex, Medicaid status, original reason for Medicare entitlement)**
  - **Disease groupings referred to as CMS hierarchical condition categories (CMS-HCC)**
  - **CMS-HCCs represent the disease component of the enrollee risk scores**

Creation of a Risk Adjustment Model

- **Condition Categories**
  - **ICD-9 codes are clustered into related Condition Categories (CCs)**
  - **Contains diagnoses clinically related and with similar Medicare predicted cost implications**
  - **Relates to well-specified medical conditions**
- **Hierarchy logic is imposed on certain CCs to account for hierarchical costs for the conditions (thus HCCs)**
  - **Condition categories have relative risk factors assigned based on the predicted costs:**
  - **Risk factors represent marginal predicted costs, relative to the average Medicare beneficiary**

CMS Risk Adjustment Models

- **Two Part C CMS-HCC models developed for non-ESRD enrollees with 12 months of Medicare Part B during the data reporting period (i.e., full risk beneficiaries)**
  - **Community: based on enrollees with less than 90 days in an institution**
  - **Long-Term Institutional: based on enrollees with 90+ days in an institution**
- **New enrollee model used for enrollees who are new to Medicare, or with less than 12 months of Medicare Part B**

Risk Adjustment Data Reporting and Risk Score Calculation

- MA contracts submit diagnosis data to CMS
  - Enrollee diagnoses from dates of service within the data collection period
- Risk scores are calculated for:
  - Every Medicare beneficiary
    - ICD-9-CM codes from FFS claims and data submitted from plans (risk scores data can derive from plan submitted data and FFS claims data)
  - A specific beneficiary
    - Identify model (community, institutional, new enrollee, ESRD)
    - Identify risk factors within model which apply (1 or more)
    - Enrollee risk score = sum of all risk factors

Disease Groups in the Part C Model

Community and Long-Term Institution Models

70 risk factors for disease groups (HCCs)

30 risk factors for demographic characteristics

11 risk factors for special categories

*Unique costs patterns were found for the special categories

- demographic-disease combinations
- disease combinations

Calculating Risk Adjustment Portion

Example: Mrs. Jones is 83 and resides in her Baltimore home. She was determined to be eligible for Medicaid effective September last year, and has been a member of Silver Health plan for several years. The health plan also offers additional vision and dental benefits. Her plan submitted 2 diagnostic codes with dates of service during last year:

- **41011, Ami Anterior Wall, Init**
- **80851, Fracture Of Ilium-Open**

Calculating Risk Adjustment Portion

- **Sum the following factors:**
  Base Factors Mrs. Jones
  - **83 year old female**
  - **Non-Institutionalized**
  - **Medicaid**
- **Risk Factors**
  - **HCC81**
  - **HCC158**

	Risk Adjustment Factors
Base (female 80-84)	0.544
Medicaid Female, aged	0.179
HCC81	0.359
HCC158	0.429
Total	1.511

Note: normalization factor is applied to the beneficiary's total risk score prior to payment.

Calculate Payment

- **Apply risk score(s) to payment using basic Part C formula**

  [Base payment rate * enrollee risk score] + additional payment amount if plan offers additional benefits

  - **base payment rate = $932 per member per month**
  - **beneficiary risk score = 1.511**
  - **additional payment amount of $32 for additional benefits.**
- **CMS' monthly payment to Silver Health plan for Mrs. Jones:**

  ($932 * 1.511) + $32 = $1,440.25

Questions



Risk Adjustment Data Validation (RADV) Overview

RADV Purpose

To measure the extent to which inaccurate MA contract-reported risk adjustment data impact CMS-HCC assignments and payment.

RADV Goals

- **Legislative/regulatory mandates to:**
  - **Validate CMS-HCC data submitted by MA contracts for risk adjusted payments**
  - **Report payment error**
    - **In accordance with IPIA as amended by IPERA**
    - **To conduct contract-level payment adjustments**
- **Conduct medical record review to validate the accuracy of diagnosis/CMS-HCC data submitted by Part C - MA contracts for payment**

RADV Guiding Principal

- **MA contract-submitted risk adjustment diagnosis must be:**
  - **Based on clinical medical record documentation from a face-to-face encounter (patient and provider)**
  - **Coded in accordance with the *ICD-9-CM Guidelines for Coding and Reporting***
  - **Assigned based on dates of service within the data collection period**
  - **Submitted to the MA contract by:**
    - **RA provider type**
    - **RA physician data source**

RADV Process Overview

Step 1	• Sampling
Step 2	• Medical Record Request
Step 3	• Medical Record Receipt
Step 4	• Medical Record Review
Step 5	• Medical Record Review Findings and Medical Record Dispute
Step 6	• Final Audit Report of Findings and Appeals

Risk Adjustment Data Validation (RADV) Coder Training

Intake Overview

Intake

The Intake Medical Record Review Contractor (IMRRC) uses CDAT to facilitate the request and receipt of medical record files from MA contracts

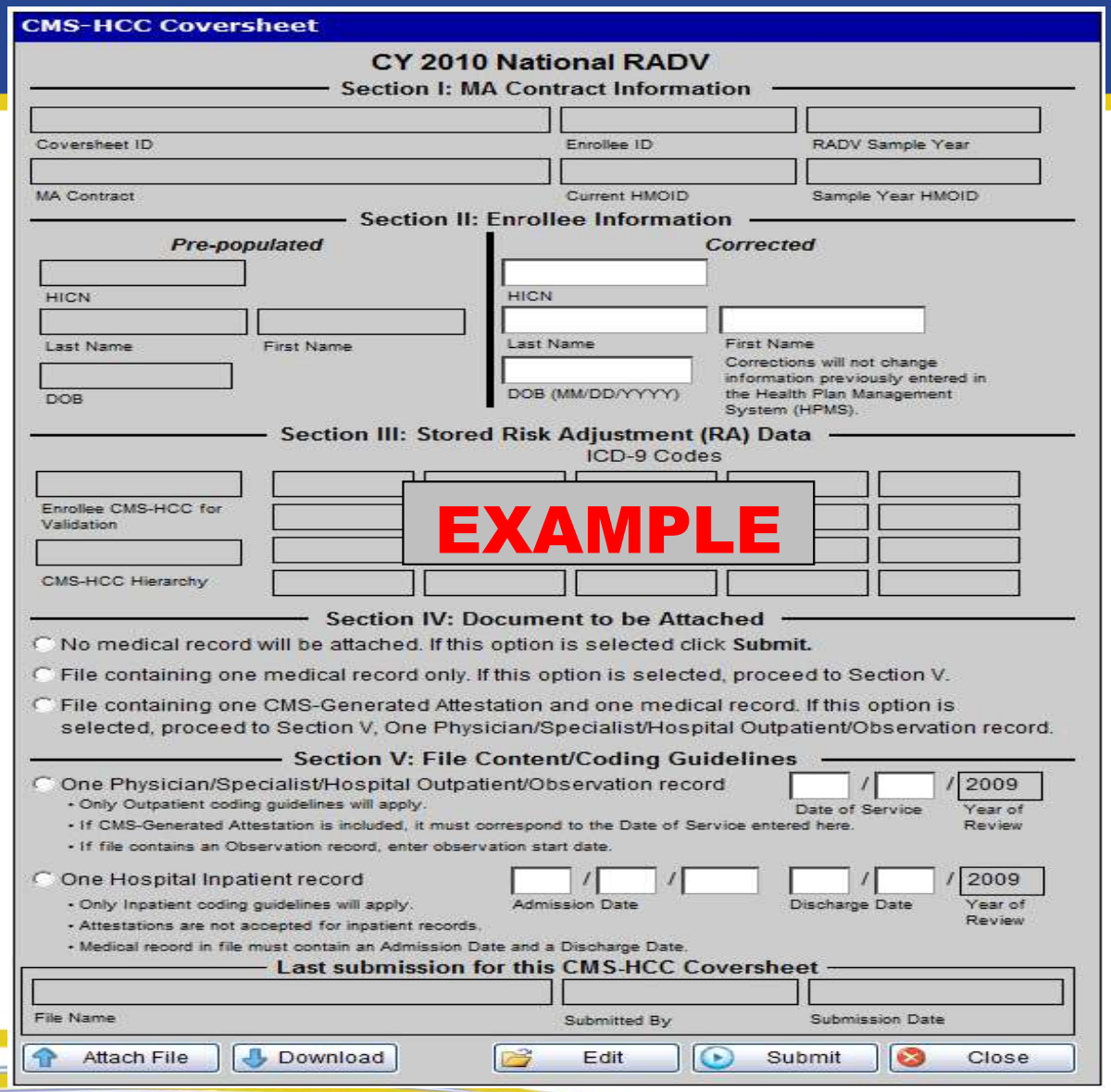
Intake: Notification and Medical Record Request

- MA contracts are notified of selection
- Each MA contract is required to:
  - Identify points of contact
  - Gain CDAT access
  - Download CMS instructions
  - Request medical records from providers
  - Download encrypted file with contract-specific data (includes enrollee CMS-HCCs)
  - Upload medical record file via CMS-HCC Coversheet

Intake: Instructions and Data

- MA contracts access CDAT in order to download CMS instructions and MA contract-specific data
- Access is limited to CDAT users identified by the MA contracts
- Data is encrypted

Intake: CMS-HCC Coversheet



CMS-HCC Coversheet

CY 2010 National RADV

Section I: MA Contract Information

Coversheet ID | Enrollee ID | RADV Sample Year

MA Contract | Current HMOID | Sample Year HMOID

Section II: Enrollee Information

Pre-populated

HICN

Last Name | First Name

DOB

Corrected

HICN

Last Name | First Name

DOB (MM/DD/YYYY)

Corrections will not change information previously entered in the Health Plan Management System (HPMS).

Section III: Stored Risk Adjustment (RA) Data

ICD-9 Codes

Enrollee CMS-HCC for Validation

CMS-HCC Hierarchy

EXAMPLE

Section IV: Document to be Attached

- No medical record will be attached. If this option is selected click **Submit.**
- File containing one medical record only. If this option is selected, proceed to Section V.
- File containing one CMS-Generated Attestation and one medical record. If this option is selected, proceed to Section V, One Physician/Specialist/Hospital Outpatient/Observation record.

Section V: File Content/Coding Guidelines

- One Physician/Specialist/Hospital Outpatient/Observation record
  - Only Outpatient coding guidelines will apply.
  - If CMS-Generated Attestation is included, it must correspond to the Date of Service entered here.
  - If file contains an Observation record, enter observation start date.

  Date of Service / Year of Review (2009)
- One Hospital Inpatient record
  - Only Inpatient coding guidelines will apply.
  - Attestations are not accepted for inpatient records.
  - Medical record in file must contain an Admission Date and a Discharge Date.

  Admission Date | Discharge Date | Year of Review (2009)

Last submission for this CMS-HCC Coversheet

File Name | Submitted By | Submission Date

Attach File | Download | Edit | Submit | Close

Intake: CMS-Generated Attestation

Physician/Practitioner Medical Record Attestation
Medicare Advantage
Calendar Year (CY) 2010 National Risk Adjustment Data Validation (RADV)

I. Enrollee Information

Last Name: JONES
First Name: MARY
Date of Birth: 1/12/1926
Medicare Health Insurance Claim Number (HICN): 123456789A
MA Contract Name: SILVERHEALTH
Current Contract ID: H0070

Example – Fictitious Data

II. Attestation Statement - (to be completed by Physician)

I, _____ , hereby attest that the medical record entry
(print or type full name of the physician/practitioner)

for _____ accurately reflects signatures/notations that I made in my capacity as
(Date of Service: mm/dd/2009)

_____ when I treated/diagnosed the above listed Medicare beneficiary.
(insert provider credentials: e.g., M.D.)

I do hereby attest that this information is true, accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil or criminal liability.

_____
Signature

_____
Signature Date (mm/dd/yyyy)

Intake Evaluation

Administrative Intake Evaluation

- Submission Review

Senior Evaluation

- Confirm Administrative Intake findings
- Address documentation suitability for review
- Confirm or establish a date of service and provider type that will remain fixed as the record proceeds to medical review.

Intake Evaluation

- **INV1 Is the beneficiary correct?**
- **INV2 Is the document signed?**
- **INV3 Does the name on the medical record match the name on the coversheet?**
- **INV4 Is the date on the record within the data collection period?**
- **INV5 Is the document submitted from a valid provider type?**
- **INV6 Is the record complete (i.e., is there sufficient data to assign ICD-9 codes)? For CY2010 National, the I-SE will indicate Yes (valid) for this INV check**
- **INV7 Are you able to confirm an acceptable credential/specialty?**

Questions



Risk Adjustment Data Validation (RADV) Coder Training

Medical Record Review Coding Process

Medical Record Review

- **Certified ICD-9-CM coders review medical records to validate the sampled CMS-HCC(s)**
  - **Confirm identification data in CDAT matches medical record file being reviewed**
  - **Coders determine reportable diagnoses from the records and assigns ICD-9-CM codes**
  - **CDAT maps the ICD-9-CM codes to CMS-HCCs**

Medical Record Review

- **Inter-rater reliability (IRR) is used to measure coder consistency and accuracy**

Medical Record Review

Risk Adjustment Discrepancies

- Documentation does not support the diagnosis information for the enrollee CMS-HCC used for payment

Discrepancies may result in revisions to the risk scores used for payment



Most Common Discrepancy Types

- **Coding**
  - Abstracted diagnosis code does not support payment CMS-HCC
- **Invalid**
  - Unacceptable provider or physician specialty
  - No signature
  - Record outside data collection period
- **Missing**
  - No medical record submitted to support CMS-HCC
  - Insufficient information to code a diagnosis

Pre-coding Steps

- Records forwarded to the coder have been deemed valid for coding with regard to provider type, RA source, signatures, and dates.
- The Date of Service for review is the date CDAT show, and this date is the date of service selected by the Intake Senior Evaluator.
- Coders verify record matches identifying information in CDAT
- If for any reason the date, provider type, record source, or enrollee on the record significantly disagree with the CDAT data- notify supervisor.
- Assume unsigned outpatient & physician records have been checked for presence of a valid attestation and code the record.

Primary Coding

Primary Coders access their CDAT inbox & select a record to code

At the Coding Screen coders:

- **View the medical record**
- **Access encoder tool to research, add, modify, or delete ICD-9-CM codes**
- **View diagnosis codes entered in encoder tool when they are transferred back to CDAT**
- **Escalate medical record to senior coder for further analysis and enter reason for escalation. Use history tab for returned escalations**
- **Either return a record back to their inbox for later completion or submit coding for the next level of review**

Senior Coding

- **Senior coders do all of the primary coder functions and are able to:**
  - **View the CMS-HCC Coversheet**
  - **View primary coder's abstraction results**
  - **View primary and senior coder similarities and discrepancies in coding**
  - **Provide feedback as applicable for escalated cases and issues with established policies**
  - **Escalate record to ICC for unusual documentation or related policy questions**
- **Primary and senior entries are saved**
- **Use the history tab for escalation returns**
- **Finalize coding to the database**

Guidance to Coders

- **Post Intake Version Overview**
  - **Signature issues**
  - **Date issues**
  - **Provider and record type issues**
  - **Enrollee issues**
  - **Documentation issues**

Guidance to Coders

- **Signatures**
  - **Electronic examples**
  - **Typed but not authenticated**
  - **Signature stamps**
  - **Legibility**
- **Dates acceptable for 2009**
- **Provider and Record Types**
- **Enrollee issues**
- **Documentation Issues**

New and Revised Codes for 2009 Dates of Service

Effective 10/1/2008

- Secondary diabetes 249.xx HCC 15-19
- Functional quadraplegia 780.72 HCC 67
- Malignant pleural effusion 511.81 no HCC
  - Change from 197.2 HCC 7
- Healed pathological fracture V13.51 no HCC
- Healing pathological fracture V54.2 no HCC
  - Newly diagnosed pathological fx remains 733.1x
  - Vertebrae HCC 157, Femur HCC 158
- Pressure ulcer stages 707.2x HCC 148
- Dialysis non-compliance V45.12 HCC 130

New and Revised Codes & Clarifications for 2009 Dates of service

Effective October 1, 2009

- **DVT and Thrombophlebitis 453.4x, .5x, .7x, .8x HCC 105**
- **Postoperative hyperglycemia not a complication**
- **Diabetes mellitus with loss of protective sensation 250.6x HCC 16**
- **Hypoxia with other respiratory conditions 799.02 HCC 79**
- **Catheterization with UTI 996.64 HCC 164 vs UTI with Cystostomy status V44.50 or Attention to V55.5 HCC 176**
- **Moderate protein malnutrition 260, 263.9 HCC 21**
- **Multilobar pneumonia 481 HCC 112, 482.x HCC 111 vs 486 no HCC**
- **Anemia due to chemo, cancer 285.22, 285.3 vs 284.89 HCC 44**
- **Chronic pulmonary embolism 416.2 HCC 104**

Medical Record Review

- Sources of Reportable Conditions
  - Problem lists
  - SNF physician
  - Orders
  - Nurse specialists
- Unacceptable sources
  - Claim forms
  - Code lists without narrative

Medical Record Review

- **Inpatient**
  - **Sources for reportable conditions**
    - **Attending, consultants, other physicians**
      - **Potential issues with discharge summaries and H & P reports**
    - **Anesthesiologists and operative notes**
    - **Emergency department team notes**
  - **Sources not acceptable**
    - **Ancillary department findings-PT, OT**
    - **Code lists, DRG attestation forms**

Medical Record Review

- **Hospital Outpatient**
  - **Sources for reportable conditions**
    - **Attending, consultants, other physicians**
    - **Anesthesiologists and operative notes**
    - **Emergency department team notes**
    - **Ancillary department findings-PT, OT**
  - **Sources not acceptable**
    - **Code lists, charge forms**
    - **Clinic notes from non acceptable specialties**
    - **Uncertain conditions**

Medical Record Review

- **Physician and Professional**
  - **Sources for reportable conditions**
    - Physician office notes
    - Nurse intake on same date
    - Ancillary data referred to in notes
    - Testing interpretation/consultation
  - **Sources not acceptable**
    - Patient generated data
    - Prior encounters
    - Rule out, working diagnoses

Encoder Use, Edits, and References

- Edits for accurate coding
- Using both the index and tabular
  - Double check encoder outcome is what you intended
- Direct entry vs using code book
  - Avoid memory mix ups (CHF/COPD) (438/483) (496/486)
- Rechecking/reviewing final list before submitting

Encoder Use, Edits, and References

- **References include:**
  - **Official Guidelines**
  - **Coding Clinic**
  - **Abbreviation List**
  - **Medical terminology**
  - **Lab references**
  - **Drug index**

Comments & Escalation Situations

- **Assistance/advice**
  - **When to ask, Who to ask**
  - **Identifying cause of issue: system, training, or human error**
- **Add written comments for codes that relate to HCC assignment**
  - **When making a decision between two acceptable codes**
  - **When using a reference**
  - **When using a document source other than DS & HP**
- **Comments will be available for dispute process**
  - **Use professional language, grammar, limited abbreviations, source, reference, dates**

Coding Manager/Supervisor Role

- Ongoing guidance and training
- Identification of trends
- Management reports
- Keep current with coding resources and encoder enhancements
- Coder Guidance feedback to CMS and ICC

Reset, Reassign, Reallocate

- **RESET: For use after a coded medical record has been submitted.**
- **REALLOCATE: For use before a medical record has started coding.**
- **REASSIGN: For use on medical record opened and saved, but not submitted. Coder escalates and escalation senior coder will reassign to a different coder.**

An ICD-9 code entered by one coder is not provided to another coder when a medical record is reset, reallocated or reassigned.

Primary to Senior Review

Records to be forwarded to Senior Coder for review

- 100% of discrepant records
- 100% of records with additional HCCs
- 5% of non-discrepant and those with no additional HCCs
- 100% of records for Primary Coder not meeting the inter-rater reliability (IRR) threshold

Key Controls/Signoffs

- Project Managers tasked with asserting that certain activities/deliverables are complete

- Intake and Medical Record Review are part of one signoff which must be completed before proceeding to the next phase of the audit

Questions



EXHIBIT 17

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CMS CY 2011 Contract-Level Risk Adjustment Data Validation Medicare Advantage Contract Training (Module I)



February 11, 2014
2:00 p.m. - 4:00 p.m. ET

Participant Dial in #:

1-855-679-2204

This presentation was updated to reflect the actual dates of notifications and trainings

Agenda – Module I

- Welcome
- RADV Team Members
- RADV Terminology
- CMS RADV Contractors
- MA Contract Teleconference/Webinars
- Objectives
- RADV Policy/Overview
  - What is RADV?
  - What is Risk Adjustment?
  - Payment Error Calculation Methodology
- RADV Audit Process Overview
- MA Contract Selection and Preparation of Medical Record Files
- MA Contract Access and Submission to CDAT

US-DOJ-KAISER-00040127

Welcome

- Introductions
  - Cheri Rice
    - Director, Medicare Plan Payment Group
  - Jonathan Smith
    - Director, Division of Payment Validation
  - Tobi Pulley
    - Deputy Director, Division of Payment Validation

US-DOJ-KAISER-00040128

CMS Risk Adjustment Data Validation (RADV) Team Members

- Kellie Gombeski
- Carolyn Kapustij
- Esmail Essajee
- Rebecca Walden
- Joanne Davis
- LuAnn Piccione
- Chris Eisenberg
- Peter Castellano
- Jeanette James

US-DOJ-KAISER-00040129

RADV Terminology

- CY – Calendar Year
- CON – Contract-Level
- CMS – Centers for Medicare & Medicaid Services
- CDAT – Central Data Abstraction Tool
- HCC – Hierarchical Condition Category
- INV – Invalid

US-DOJ-KAISER-00040130

RADV Terminology (Cont.)

- ICD-9 – International Classification of Disease, Ninth Revision
- MA – Medicare Advantage
- MRR – Medical Record Review
- PHI – Protected Health Information
- PII – Personally Identifiable Information
- RADV – Risk Adjustment Data Validation

US-DOJ-KAISER-00040131

CMS RADV Contractors

- MRRCs – Medical Record Review Contractors
- LAC – Lead Analytic Contractor
- ICC – Independent Coding Consultant
- CDAT – Central Data Abstraction Tool Contractor
- ISC – Independent Statistical Consultant
- TDPS – Technical Data Processing Support Contractor
- C&QC – Communications & Quality Control Contractor
- IV&V – Independent Verification & Validation Contractor

RADV Contractors – CDAT Contractor

- Implements the information technology processes necessary to support the RADV project goals.
- Provides technical support to all CDAT users.
- Demonstrates system design and development.
- Assists in operations and maintenance.
- Provides technical support to health plans and RADV contractors.
- Maintains system security and compliance.

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MA Contract Teleconference/Webinars

Key Dates

- November 5, 2013 - CY 2011 Contract-Level RADV Notification Letter
- February 11, 2014 - CY 2011 Contract-Level RADV MA Contract Teleconference/Webinar (Module I)
- April 8, 2014 - CY 2011 Contract-Level RADV MA Contract Teleconference/Webinar (Module II)

Objectives

- To provide information and overview of RADV team and training regarding:
  - CMS RADV Policy
  - Risk Adjustment
  - Payment Error Calculation
  - Responding to CMS RADV Contract-Level Audits for CY 2011
  - Accessing the Plan Portal Library and Encrypted Enrollee Data Package
  - Preparing and Submitting Medical Records for RADV

RADV Policy

- RADV validates diagnoses submitted for payment.
- RADV is a corrective action initiated by CMS to help reduce the Part C error rate.
- CMS is legislatively mandated to risk adjust Medicare Part C payments, validate the payments (diagnoses), and report a payment error.

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RADV Policy (Cont.)

- The goal of RADV is to identify all discrepancies by comparing risk adjustment diagnosis data submitted by MA contracts for payment against what the MA contracts provided during medical record submission.

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RADV Policy (Cont.)

- MA contract-submitted risk adjustment diagnoses must be:
  - Based on the clinical medical record documentation from a face-to-face encounter (patient and provider),
  - Coded in accordance with the ICD-9-CM Official Guidelines for Coding and Reporting, and
  - Assigned based on dates of service within the data collection period.

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RADV Policy (Cont.)

- Risk adjustment diagnoses must be submitted to the MA contracts by acceptable:
  - Risk adjustment provider type
  - Risk adjustment provider data source
  - Risk adjustment physician specialty types

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RADV Policy (Cont.)

- The CY 2011 contract-level RADV is being conducted in accordance with 42 CFR 422.310.
- Subsection 422.310(e) requires MA contracts, providers, and practitioners to submit accurate medical records for the validation of risk adjustment data as required by CMS.

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RADV Policy (Cont.)

- CON 11 RADV audit will use CY 2010 data.
- Enrollees will be sampled from each MA contract for the purpose of estimating payment error related to risk adjustment.
- CMS' sampling frame and medical records review findings will be used to estimate a contract-level payment error and associated payment adjustments for an established contract population.

RADV Policy (Cont.)

- MA contracts selected for CON 11 will initially have four (4) weeks to request and prepare medical record files.
- After that time, MA contracts will have an additional 16 weeks to submit medical record documentation into a secure online portal called the Central Data Abstraction Tool (CDAT).

PART C Risk Adjustment Model

- The Part C CMS-HCC model is used to pay plans for non-ESRD enrollees (with 12 months of Medicare Part B coverage during the data reporting period- i.e., full risk beneficiaries). There are three (3) possible scores produced by the model:
  - Community: Based on enrollees with less than 90 days in an institution.
  - Long-Term Institutional: Based on enrollees with 90+ days in an institution.
  - New Enrollee: Used for enrollees who are new to Medicare. This is operationalized as beneficiaries with less than 12 months of Medicare Part B coverage.

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Risk Adjustment – How It Works

- CMS develops prospective risk adjustment models for Part C:
  - Diagnoses from Year 1 are used to predict average spending for Medicare fee-for-service populations in Year 2.
  - Models contain approximately 2,910 diagnosis codes. This is the number of diagnoses mapping to HCCs.
- Models include components for:
  - Demographics (Age, Sex, Medicaid Status, Original Reason for Medicare Entitlement); and
  - Disease groupings referred to as HCCs;
    - HCCs represent the disease component of the enrollee risk scores.

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Creation of A Risk Adjustment Model

- Condition Categories (CCs)
  - ICD-9-CM codes are clustered into related CCs.
  - Contain diagnoses clinically related and with similar Medicare predicted cost implications.
  - Relate to well-specified medical conditions.
    - Hierarchy logic is imposed on certain CCs to account for hierarchical costs for the conditions (thus HCCs).
    - CCs have relative risk factors assigned based on the predicted costs.
    - Risk factors represent marginal predicted costs, relative to the average Medicare beneficiary.

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Reporting and Risk Score Calculation

- MA contracts submit diagnosis data to CMS:
  - Enrollee diagnoses from dates of service within the data collection period.
- Risk scores are calculated for:
  - Every Medicare beneficiary
    - ICD-9-CM codes from Fee-for-Service (FFS) claims and data submitted from plans (risk scores data can derive from plan submitted data and FFS claims data).
  - A specific beneficiary
    - Identify model (community, institutional, new enrollee, End Stage Renal Disease (ESRD));
    - Identify risk factors within model which apply (One (1) or more);
    - Enrollee risk score = Sum of all relative and frailty factors.

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Types of CMS-HCCs

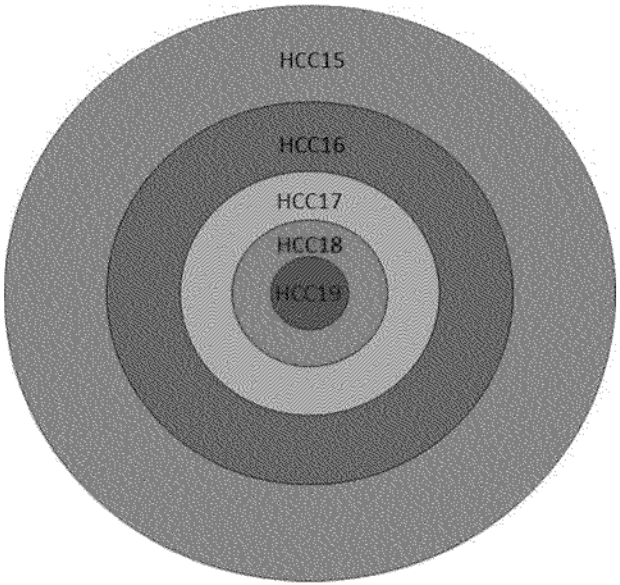
- Non-hierarchical
- Hierarchical
  - Traditional Hierarchies (Diabetes)
  - Hybrid or Complex Hierarchies (Spinal Conditions)

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Traditional Hierarchy

Illustration of Diabetes Hierarchy

HCC	Description	Relative Rank	Community and Institutional Relative Factors	Institutional Relative Factors
HCC15	Diabetes with Renal or Peripheral Circulatory Manifestation	1 (Most Severe)	0.508	0.459
HCC16	Diabetes with Neurologic or Other Specified Manifestation	2	0.408	0.459
HCC17	Diabetes with Acute Complications	3	0.339	0.459
HCC18	Diabetes with Ophthalmologic or Unspecified Manifestation	4	0.259	0.459
HCC19	Diabetes without Complication	5 (Least Severe)	0.162	0.248

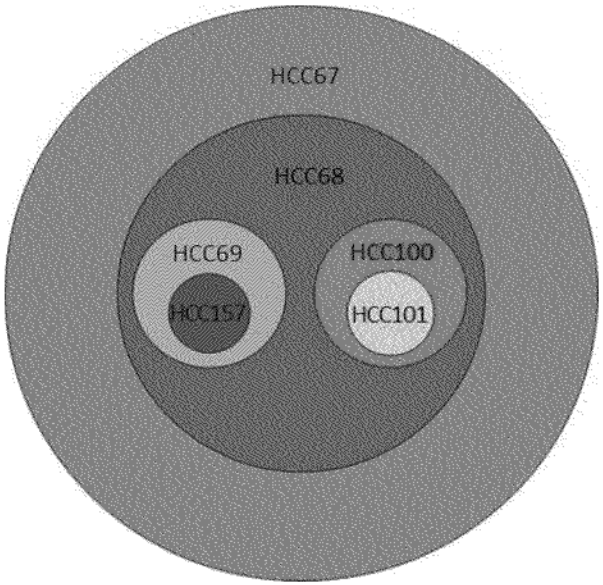


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Hybrid/Complex Hierarchy

Illustration of Hybrid Hierarchy with Spinal Conditions

HCC	Description	Community and Institutional Relative Factors	Institutional Relative Factor
HCC67	Quadriplegia, Other Extensive Paralysis	1.011	0.434
HCC68	Paraplegia	0.993	0.434
HCC69	Spinal Cord Disorders/Injuries	0.558	0.225
HCC100	Hemiplegia/Hemiparesis	0.437	0.039
HCC101	Cerebral Palsy and Other Paralytic Syndromes	0.180	0.000
HCC157	Vertebral Fractures without Spinal Cord Injury	0.443	0.161



Example of Calculating a Risk Adjustment Score

- Example: Mrs. Jones is 83 and resides in her Baltimore home. She was determined to be eligible for Medicaid effective September last year (2012), and has been a member of Silver Health Plan for several years. The MA contract also offers additional vision and dental benefits. Her MA contract submitted two (2) diagnostic codes with dates of service during last year:
  - 41011, AMI (Acute Myocardial Infarction)
  - 808.51, Fracture Of Ilium

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Calculating a Risk Adjustment Score (Cont.)

- Sum the following relative factors:
  - Model variables for Mrs. Jones:
    - 83-year old female
    - Non-institutionalized
    - Medicaid
  - Disease Coefficients:
    - HCC81
    - HCC158

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Example of Payment Calculation

- Apply risk score(s) to payment using basic Part C formula:

  [Base payment rate * enrollee risk score] + additional payment amount if MA contract offers certain supplemental benefits

  - Base payment rate = $932 per member per month
  - Beneficiary risk score = 1.511
  - Additional payment amount of $32 for supplemental benefits
  - CMS' monthly payment to Silver Health Plan for Mrs. Jones:
    ($932 * 1.511) + $32 = $1,440.25

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Helpful Resources on Risk Adjustment and Risk Scores

- The following link will take you to the Medicare Advantage (MA) Advance Notices of Methodological Changes, announcements issued for MA rates, and special reports:

  https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/

Payment Error Calculation Methodology

- On February 24, 2012, CMS released the Notice of Final Payment Error Calculation Methodology for Part C Medicare-Advantage RADV Contract-Level Audits.
  - Notice available at: http://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/PaymentValidation.html/

Payment Error Calculation Methodology (Cont.)

- The CON 11 RADV audit will utilize the February 24, 2012 payment error calculation methodology published by CMS.
- A fee-for-service adjuster will apply to the payment recovery amounts.

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RADV Audit Process

- Overview
- Sampling
- MA Contract Selection and Preparation of Medical Record Files
- MA Contract Access and Submission to CDAT

RADV Audit Process - Sampling

- Step 1: Select MA contracts eligible for RADV audits
  - Active contracts that received risk adjusted payments.
  - All audited CMS-HCCs that contributed to the CY 2011 risk adjusted payment will be reviewed.

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RADV Audit Process – Sampling (Cont.)

- Step 2: Select enrollees eligible for sampling
  - Selection based on enrollment data for January of the payment year.
  - Eligible enrollees:
    - 12 months of Part B during data collection year (i.e. full risk).
    - Continuously enrolled in the same contract from January of the data collection year through January of the payment year.

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RADV Audit Process – Sampling (Cont.)

- Eligible enrollees:
  - Non-ESRD status (no payment made based on the ESRD-HCC Model) from January of the data collection year through January of the payment year.
  - No hospice status (resulting in one (1) year or more eliminated monthly risk-adjusted payments) from January of the collection year through January of the payment year.

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RADV Audit Process – Sampling (Cont.)

- Eligible enrollees:
  - All audited CMS-HCCs for selected enrollees will be reviewed.
    - At least one (1) CMS-HCC assigned resulting in a positive risk-adjustment payment amount for payment year 2011
      - CMS will review all CMS-HCCs for selected enrollees
    - Not selected for the National 2011 RADV audit

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RADV Audit Process – Sampling (Cont.)

- CMS will select 201 enrollees from the contract's RADV eligible population.
- Stratified, random sample
  - 67 in each stratum
- Sampling weights
  - Enrollee sample weight is computed as the total number of enrollees in the stratum divided by the number of enrollees sampled from that stratum (N/n).
    - For RADV contract-level samples, n= 67

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RADV Audit Process –Selection and Preparation of Medical Record Files

- MA contracts must contact hospitals and practitioners that provided services to the enrollees.
- Enrollees data selected for the CON 11 RADV is now available on CDAT for download by MA contracts.
- MA contracts must first prepare medical record files for submission.
- CMS has provided guidance for contacting hospitals and providers in the CY 2011 Contract-Level RADV CMS Preliminary Instructions (Module I).

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RADV Audit Process –Selection and Preparation of Medical Record Files (Cont.)

- Effective with the CON 11 RADV audit, CMS will allow audited MA contracts to submit up to five (5) medical records for each audited CMS-HCC.
- CMS will consider individual hardship requests for extraordinary circumstances upon submission of a justification from a MA contract.

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RADV Audit Process –Selection and Preparation of Medical Record Files (Cont.)

- For the CON 11 RADV audit, MA contracts must adhere to the RADV rules and provide documentation as prescribed in CMS' instructions.
- MA contracts must use CDAT to facilitate the CON 11 RADV process.
- Submitting a CMS-Generated Attestation is voluntary.
- If a CMS-Generated Attestation is submitted, it must be the first page submitted with the PDF medical record file.

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RADV Audit Process –Selection and Preparation of Medical Record Files (Cont.)

- Each MA contract must create one (1) electronic medical record file containing PDF images of one (1) CMS-Generated Attestation (if applicable), with the related corresponding medical record to validate the audited CMS-HCC.
- Each medical record must be labeled using the Enrollee ID and the CMS-HCC(s) for medical record(s) being submitted.
- Each medical record must contain the CMS-Generated Attestation (if applicable) and the supporting medical record.

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RADV Audit Process –Selection and Preparation of Medical Record Files (Cont.)

- After the medical record has been prepared, MA contracts will access CDAT, complete the CMS Medical Record Coversheet and upload the prepared medical record file.
- When MA contracts are ready to submit medical record files, they must confirm the following:
  - The medical record matches the File Content selection that the MA contract will make on the CMS Medical Record Coversheet.
  - The medical record contained in the file corresponds with the CMS Medical Coversheet being submitted.
  - The file does not contain multiple medical records.
  - All attached images are legible.

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RADV Audit Process –Selection and Preparation of Medical Record Files (Cont.)

- MA contracts must take reasonable steps to ensure that sensitive information are not disclosed during the medical record preparation and submission process.
- Both PII and PHI are part of RADV data.

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RADV Audit Process –Selection and Preparation of Medical Record Files (Cont.)

- Below are examples of the following information:
  - PII
    - Variables
      - Health Insurance Claim Numbers
      - Gender
      - Date of Birth
  - PHI
    - Data
    - Documents

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RADV Audit Process –Selection and Preparation of Medical Record Files (Cont.)

- Below are examples of exposed PII or PHI:
  - Information sent through email: This is a security violation and considered a data breach.
  - Information left in a voicemail: It is acceptable to communicate via telephone, but not acceptable to leave a message containing PII/PHI.
  - Information burned to a CD without encryption and CMS approval.

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RADV Audit Process –Selection and Preparation of Medical Record Files (Cont.)

- To mitigate any risks of exposure, MA contracts must:
  - Analyze documents to remove PII/PHI.
  - Obtain approval from leadership prior to sharing with other team members.
  - Do not email a medical record within your local network or to parties outside of the network.
  - Immediately report any suspected exposure to your Medicare Compliance Officer and your leadership.

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MA Contract Access and Submission to CDAT

- CDAT staff will validate the medical record documentation to determine if the submitted medical record:
  - Is either inaccessible due to password protection or encryption.
  - Is an Invalid PDF File Format.
  - Does not allow page rotations.
  - Does not allow pages to be deleted.
  - Does not allow merging with the CMS Medical Record Coversheet PDF.
  - Contains binders, bookmarks, or either embedded containers or an unidentifiable issue encountered with the medical record.

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MA Contract Access and Submission to CDAT (Cont.)

- CDAT will not accept any records that contain the issues identified.
- MA contracts are encouraged to review the file format validation issue and resolve any issues prior to the submission deadline.
- CMS will cover the medical record submission process in more detail in the next training.

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MA Contract Access and Submission to CDAT (Cont.)

- After this training, CMS will email MA contracts the encrypted passwords and the enrollee data specific to each MA contract.
- On April 2, 2014, CMS is scheduled to provide training to MA contracts regarding the medical record submission process.

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MA Contract Access and Submission to CDAT (Cont.)

- Next, CMS' CDAT Contractor will provide a demonstration of CDAT, the system through which data related to RADV audits are transferred.
- Using CDAT, MA contracts will:
  - Access enrollee data.
  - Complete CMS related documents.
  - Prepare medical records.
  - Submit medical records.

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CDAT Demonstration

Questions



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Conclusion

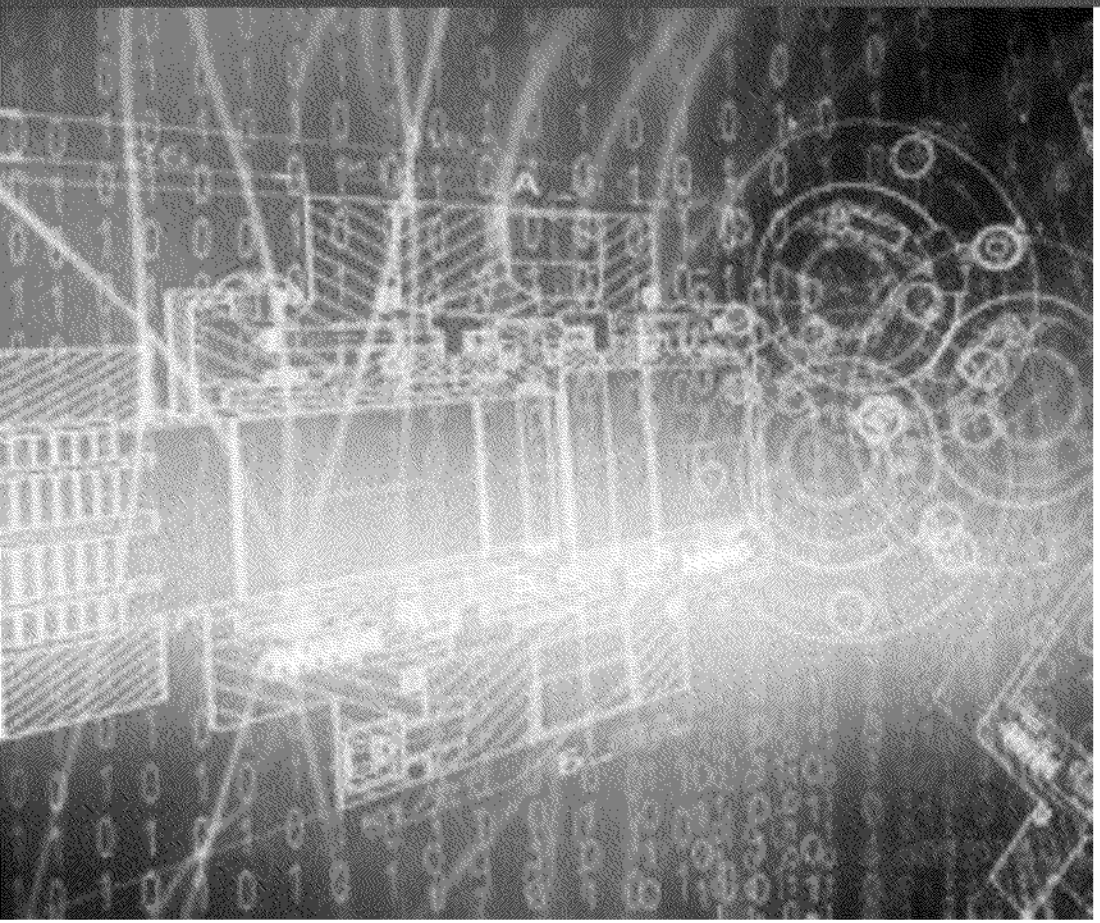
- Thank you for your participation in Module I! We look forward to speaking with you soon.
- If there are any questions that you have after the conclusion of this training, please contact CMS at radv@cms.hhs.gov with "CON 11 RADV" in the subject line.

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EXHIBIT 18

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CY 2014 National Risk Adjustment Data Validation (RADV) Partner Training



CMS

March 10, 2016

1:00 – 4:00 ET

Agenda:

- Risk Adjustment Data Validation (RADV) Purpose
- Risk Adjustment Overview
- RADV Roles & Responsibilities
- RADV Security and Repository
- RADV Sampling
- RADV Medical Record Request

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Agenda

- RADV Medical Record Intake
- RADV Medical Record Review
- RADV Payment Error Estimate & Report of Finding
- RADV Contractor & Coder Training

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Objectives

- Provide the purpose of RADV
- Share RADV goals
- Identify the RADV team and contractor roles and responsibilities
- Provide an overview of risk adjustment
- Identify the RADV processes

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Terminology

- RADV commonly used terminology
  - C&QC: Communications and Quality Control Contractor
  - CDAT: Central Data Abstraction Tool
  - CMS-HCC: Centers for Medicare & Medicaid Services Hierarchical Condition Category Model
  - ICC: Independent Coding Consultant
  - ICD-9-CM: International Classification of Diseases-9th Revision-Clinical Modification

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Terminology (cont.)

- RADV commonly used terminology
  - IMRRC: Intake Medical Record Review Contractor
  - IRR: Inter-rater reliability
  - ISC: Independent Statistical Consultant
  - IV&V: Independent Verification & Validation Contractor
  - MA: Medicare Advantage

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Terminology (cont.)

- RADV commonly used terminology
  - MCO: Medicare Compliance Officer
  - MRRC: Medical Record Review Contractor
  - PM: Project Manager
  - POC: Point of Contact for MA Organization
  - TDPS: Technical Data Processing Support Contractor

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Why RADV?

Legislative/regulatory mandates require CMS to . . .

1. Risk adjust Part C payments

2. Validate payments (diagnoses)

3. Report payment error on the
   - National Level (Improper Payment Information Act 2002 (IPIA), as amended by Improper Payment Elimination and Recovery Act 2010 (IPERA), as amended by Improper Payments Elimination and Recovery Improvement Act 2012 (IPERIA)

RADV Regulation

42 CFR §422.310 Risk adjustment data.

"(e) Validation of risk adjustment data. MA Organizations and their providers and practitioners will be required to submit a sample of medical records for the validation of risk adjustment data as required by CMS. There may be penalties for submission of false data."

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RADV Guiding Principal

- MA Organizations-submitting risk adjustment diagnoses must be:
  - Based on clinical medical record documentation from a face-to-face encounter (patient and provider)
  - Coded in accordance with the ICD-9-CM Guidelines for Coding and Reporting
  - Assigned based on dates of service within the data collection period (usually 12 months)
  - Submitted to the MA Organizations by:
    - Risk Adjustment (RA) provider type
    - RA physician data source

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Data Validation Purpose

- To measure the extent to which inaccurate risk adjustment data impacts CMS-HCC assignments and the associated payment for MA beneficiaries.

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RADV Goals

- Identify all discrepancies by comparing risk adjustment diagnosis data submitted by MA Organizations for payment against what MA Organizations provided during medical record review.
- Compute a risk adjustment error (RAE) estimate for the Medicare Part C program
- Report the RAE in compliance with program reporting requirements IPIA 2002, as amended by IPERA 2010, as amended by IPERIA 2012.

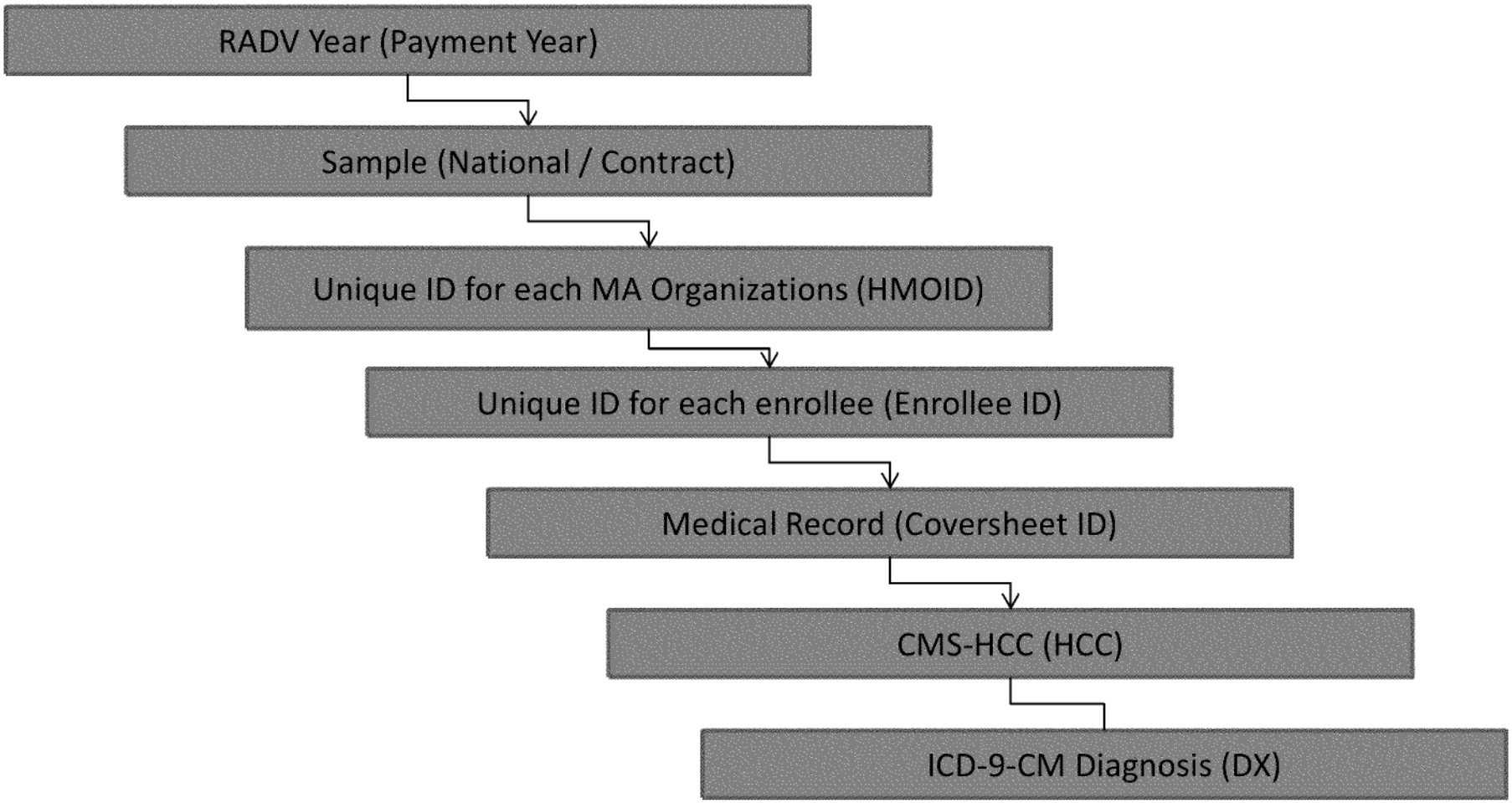
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Most Common Error Types

Incomplete Medical Record	**These payment errors represent medical records that were submitted for validation, but lacked sufficient clinical information to assign at least one ICD-9 code, and no other medical record for the enrollee supported the CMS-HCC**
Missing and / or Illegible Physician / Practitioner Signature and/or Credential	These payment errors represent medical records that were submitted and deemed invalid because the physician /practitioner signature and /or credentials were either missing or illegible
Coding Discrepancy	These payment errors represent medical records that were reviewed, but abstracted diagnosis codes did not support the CMS-HCC selected for validation, and no other medical record submitted for the enrollee supported the CMS-HCC
Missing	These payment errors represent CMS-HCCs for which the MA Organization submitted no medical record documentation, and no other submitted medical record supported the enrollee CMS-HCCs.
Other Invalid	These payment errors represent CMS-HCCs that were discrepant because the submitted medical records were invalid due to one or more of the following reasons: 1) incorrect beneficiary; 2) name on record and name on coversheet did not match; 3) date(s) of service were outside the data collection period; and 4) invalid risk adjustment provider type (e.g., SNF).

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RADV Core Data Elements (Units of Analysis)



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RADV Process

Step 1
- Sampling

Step 2
- Medical Record Request

Step 3
- Medical Record Intake

Step 4
- Medical Record Review

Step 5
- Payment Error Estimate

Step 6
- Report of Findings

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Risk Adjustment Overview



NAT 14

RADV Partner Training

Risk Adjustment

- Calculates risk score for each beneficiary
- Risk score is used to adjust CMS' payments to Medicare Part C MA Organizations based on health status and demographic characteristics of their enrollees.
- Makes appropriate and accurate payments for enrollees with differences in expected costs.

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Risk Adjustment
The CMS-HCC Model

- Prospective model
  - Calibrated using fee-for-service claims data
  - One year's claims data is used to predict the following year's expenditures
- Model variables
  - Demographics
    - Age
    - Gender
    - Medicaid status
  - Disease
    - CMS Hierarchical Condition Categories (CMS-HCC)
  - Blended Risk Score: 2013 and 2014 CMS-HCC Models are used for NAT14

Diagnosis Groupings

- Condition Categories
  - CMS-HCC Model contain approximately 3,100 diagnosis codes
  - ICD-9-CM codes are clustered into related Condition Categories (CCs)
    - Contains diagnoses clinically related and with similar Medicare predicted cost implications
    - Relates to well-specified medical conditions
  - Hierarchy logic is imposed on certain CCs to account for hierarchical costs for the conditions (thus CMS-HCCs)
  - Condition categories have relative risk factors assigned based on the predicted costs:
    - Risk factors represent marginal predicted costs, relative to the average Medicare beneficiary

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Types of CMS-HCCs

- Non-hierarchical
- Hierarchical
  - Traditional hierarchies (diabetes)
  - Hybrid or complex hierarchies (spinal conditions)

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Hierarchy example: 2013 CMS-HCC Model

- Diabetes hierarchy in the 2013 CMS-HCC model, with five disease groups:
  - CMS-HCC 15 Diabetes with Renal Manifestations or Peripheral Circulatory Manifestation
  - CMS-HCC 16 Diabetes with Neurologic or Other Specified Manifestation
  - CMS-HCC 17 Diabetes with Acute Complications
  - CMS-HCC 18 Diabetes with Ophthalmologic or Unspecified Manifestations
  - CMS-HCC 19 Diabetes Without Complication

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Hierarchy example: 2014 CMS-HCC Model

- Diabetes hierarchy in the 2014 CMS-HCC model, with three disease groups:
  - CMS-HCC 17 Diabetes with Acute Complications
  - CMS-HCC 18 Diabetes with Chronic Complications
  - CMS-HCC 19 Diabetes Without Complication

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CMS Risk Adjustment Models

- Two Part C CMS-HCC models developed for non-ESRD enrollees with 12 months of Medicare Part B during the data reporting period (i.e., full risk beneficiaries)
  - Community: based on enrollees with less than 90 days in an institution
  - Long-Term Institutional: based on enrollees with 90+ days in an institution
- New enrollee model used for enrollees who are new to Medicare, or with less than 12 months of Medicare Part B

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RADV Reporting and Risk Score Calculation

- MA Organizations submit diagnosis data to CMS
  - Enrollee diagnoses from dates of service within the data collection period
- Risk scores are calculated for:
  - Every Medicare beneficiary
    - ICD-9-CM codes from FFS claims and data submitted from plans (risk scores data can derive from plan submitted data and FFS claims data)
  - A specific beneficiary
    - Identify model (community, institutional, new enrollee, ESRD)
    - Identify risk factors within model which apply (1 or more)
    - Enrollee risk score = sum of all risk factors

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Comparison of 2013 and 2014 CMS-HCC models

- Same 30 demographic categories for both models
- New CMS-HCCs were added and existing CMS-HCCs were split in 2014 model
- Increase from 70 CMS-HCCs in 2013 model to 79 CMS-HCCs in 2014 model
- Additional interactions for 2014 community and institutional models
- Blended risk scores and payments
  - 25% from 2013 model and 75% from 2014 model

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Calculating Risk Adjustment Portion

Example: Mrs. Jones is 83 and resides in her Baltimore home. She was determined to be eligible for Medicaid effective September last year, and has been a member of Silver Health plan for several years. The MA Organization also offers additional vision and dental benefits. Her MA Organization submitted 2 diagnostic codes with dates of service during last year:

- 41011, Ami Anterior Wall, Init
- 80851, Fracture Of Ilium-Open

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Calculating Risk Adjustment Portion (cont.)

- Sum the following factors for each model:

  Base factors for Mrs. Jones
  - 83 year old female
  - Non-institutionalized
  - Medicaid
- HCC Risk Factors

	2013 Model Risk Adjustment Factors	2014 Model Risk Adjustment Factors
Base (female 80-84)	0.525	0.543
Medicaid female, aged	0.202	0.151
2013 HCC81, 2014 HCC 86	0.294	0.275
2013 HCC158, 2014 HCC 170	0.435	0.446
Total	1.456	1.415

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Calculate Blended Risk Score

- Calculate blended risk score

  [0.25 * enrollee risk score from 2013 model] + [0.75 * enrollee risk score from 2014 model]

  - Enrollee risk score from 2013 model = 1.456
  - Enrollee risk score from 2014 model = 1.415
- Blended risk score equals:

  (0.25 * 1.456) + (0.75 * 1.415) = 1.425

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Calculate Payment

- Apply blended risk score(s) to payment using basic Part C formula

  [Base payment rate * enrollee risk score] + additional payment amount if MA Organization offers additional benefits

  - Base payment rate = $932 per member per month
  - Beneficiary risk score = 1.425
  - Additional payment amount of $32 for additional benefits.
- CMS' monthly payment to Silver Health plan for Mrs. Jones:

($932 * 1.425) + $32 = $1,360.10

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Helpful Resources on Risk Adjustment and Risk Scores

- Updated CMS-HCC model - CMS publishes the list of hierarchies each time we recalibrate the CMS-HCC risk adjustment model. The following link will take you to the list from the 2014 Announcement:

https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/downloads/Announcement2014.pdf

Helpful Resources on Risk Adjustment and Risk Scores (cont.)

A link to view the Risk model diagnosis codes is available on the CMS website. To view the Risk model diagnosis codes go to: https://www.cms.gov/MedicareAdvtgSpecRateStats/06a_Risk_adjustment_prior.asp#TopOfPage

Once on the page click on “Risk adjustment” under the “Medicare Advantage – Rates Statistics” heading, then click on the applicable link to open a zip-file.

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RADV Team Roles & Responsibilities



NAT 14
RADV Partner Training

Roles and Responsibilities

- RADV Team/Contractors
- Interdependencies of each role
- Methods & Form of communication

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CMS MPPG RADV Team

Centers for Medicare & Medicaid Services (CMS), Center for Medicare (CM)

- Cheri Rice – Director, Medicare Plan Payment Group (MPPG)
- Jennifer Harlow – Deputy Director, Medicare Plan Payment Group (MPPG)
- Ilina Chaudhuri – Director, Division of Payment Validation (DPV), Medicare Plan Payment Group (MPPG)

CMS MPPG RADV Team

Carolyn Kapustij
Joanne Davis
Kellie Simons
Sue Billet
David Winchell
LuAnn Piccione
Esmail Essajee

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Communications & Quality Assurance Contractor (C&QC)

- Acts as point of contact with MA Organizations during RADV activity
- Maintains email boxes for all RADV activity
- Conducts quality assurance of communications
- Distributes CMS communications to MA Organizations

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Intake Medical Record Review Contractor (IMRRC)

- Conducts intake evaluation of medical record files to determine
  - Accuracy of submission
  - Medical record validity
  - Attestation validity, if necessary

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Medical Record Review Contractor (MRRC)

- Conducts medical record review using certified ICD-9-CM coders to review medical records to abstract diagnoses
- Implements internal IRR processes

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Lead Analytic Contractor (LAC)

- Coordinates overall analytic approach and process
- Produces composite Part C payment error estimate (reported by the end of each fiscal year)
- Helps develop sampling plan to select MA Organizations, enrollees and CMS-HCCs
- Facilitates data communications
- Ensures data integrity
- Evaluates IRR analyses
- Calculates payment error estimates
- CDAT development of reports
- CDAT data export requests/receipts
- Resolution of data discrepancies
- Quality Assurance of CDAT reports

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Centralize Data Abstraction Tool (CDAT) Contractor

- The CDAT contractor maintains CDAT, the secure online system used by
  - MA Organizations to download data and upload medical record documentation
  - IMRRC to perform intake review of the medical record documentation
  - MRRCs to perform abstraction of the diagnoses within the medical record documentation
  - C&QC to document communications with the MA Organizations
  - LAC to provide reports to CMS and other users
  - CMS to analyze the results of the reviews conducted by the IMRRC and MRRCs.
  - Other RADV contractors to exchange data

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Technical Data Processing Support Contractor (TDPS)

- Uses sampling specifications to:
  - Identify the MA Organizations populations eligible to be sampled
  - Select MA Organizations and enrollees into samples
- Checks LAC's derivation of final medical record review CMS-HCCs from coding results
- Creates dataset of actual payment data used to compare to post-validation estimated payment data

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Independent Coding Consultant (ICC)

- Drafts training materials and standard procedural guidance for RADV coders
- Communicates with CMS to provide understanding of coding issues that may impact policy decisions
- Participates as a procedural advisor during intake and medical record review

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Independent Verification & Validation (IV&V) Contractor

- Verifies and confirms that RADV business and information technology systems meet CMS requirements.
- Conducts independent testing and validation of CDAT prior to all releases.
- Conducts 1/3 of annual assessment audits.
- Ensures system is Federal Information Security Management Act (FISMA), CMS-OIS, and 508 compliant.

Independent Statistical Consultant (ISC)

- Performs independent payment error re-calculations.
- Serves as an independent consultant for RADV sampling and other statistical issues.

Methods & Form of Communication

- Communication Rules
  - The CMS Contracting Officer Representative (COR) or Government Technical Lead (GTL) must be a party to all communications (whether by telephone, email or otherwise)
  - The RADV Project is confidential – the information must not be shared
  - All communications with MA Organizations shall be cleared by CMS before distribution.

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Security and Repository



NAT 14
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Security – Sensitive Information

- Both PHI (Personal Health Information) and PII (Personally Identifiable Information) are part of RADV data
- PII
  - Variables
    - Health Insurance Claim Numbers (CHIC, HICNO, RRBHIC, OHIC, HIC_MOD)
    - Gender (GENDER, SEX, SEX_MOD)
    - Date of Birth (DOB, DOB_MOD)

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Security – Sensitive Information (cont.)

- Both PHI and PII are part of the RADV data, cont.
- PHI
  - Data
    - Any datasets with the variables listed above
    - Any datasets with the variables listed above merged with health information (diagnoses, HCCs, personal demographics)
  - Documents
    - Medical Records (pdf or image files)

Security – Key Guidelines

- Some examples of PII or PHI exposure are when it is:
  - Sent through e-mail: this is a security violation and is considered a data breach
  - Left as a voicemail: it is okay to communicate live via phone but do not leave a message containing PHI/PII info
  - Burned to a CD without a) encryption AND b) CMS approval

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Security – Key Guidelines (cont.)

- Documents need to be scrubbed (cleaned of all personal information) and approved by leadership prior to sharing with other team members
- Under no circumstances should a medical record be emailed within your local network or to parties outside of the network
- Report any suspected exposure to your CMS COR and your leadership immediately so that the data breach plan can be executed if required

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Security – Transferring Data

- Any information containing PHI/PII
  - Information should be uploaded to the CDAT Repository in a password protected and encrypted executable using SecureZip
  - Location of the file and the password to the file must be sent in separate e-mails

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Security – Golden Rule

Golden Rule: When in doubt: ask first, send later. Always use a "better safe than sorry" approach.

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CDAT Repository

- https://sprepo.cms.radvcdat.com
  - Used by CMS and RADV Contractors
    - Exchange data
    - Store RADV internal and external project related communications and materials
  - Folder access is controlled by CDAT Administrator

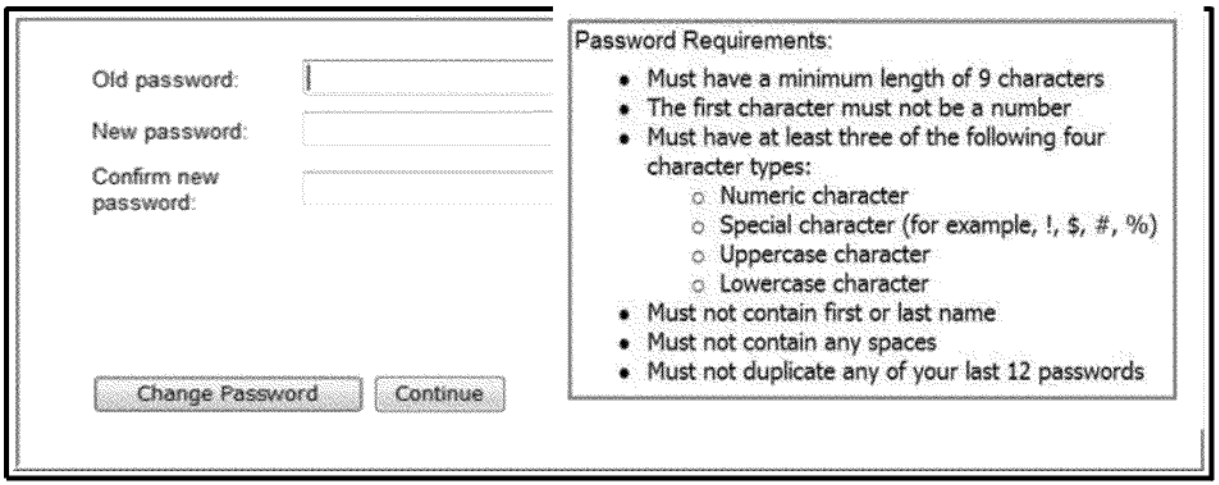
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CDAT Security Requirements

To change password, check the box on the logon



Passwords must meet criteria below, including **nine character minimum length**



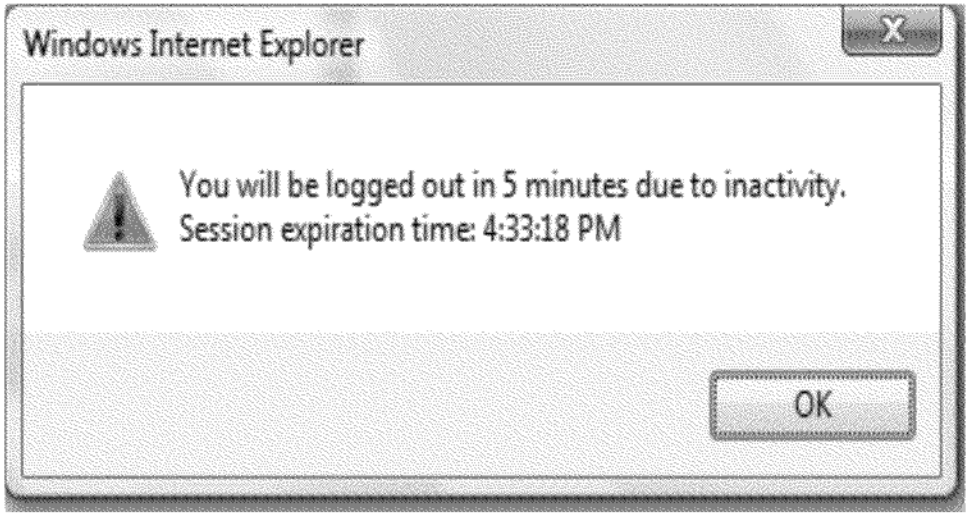
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CDAT Security Requirements (cont.)

Timeout Feature

- After 1 hour and 55 minutes of inactivity, the following warning message will appear
- Users will be logged out of CDAT after 2 hours of inactivity

If OK button is clicked, the clock "starts over" and session continues.



Users are required to comply with CMS requirements for desktop timeout security

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Sampling



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Sampling Overview

- Two types of samples:
  - National sample
  - Contract-Level sample
- Sampling specification designed to:
  - Define eligible MA Organizations
  - Define eligible enrollees from MA Organizations
- Eligible enrollees are randomly selected into the national sample or into selected MA Organizations for contract sample
- All CMS-HCCs are reviewed for each selected enrollee

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Sample Design

National Sample

- Define eligible contracts
- Define eligible enrollees
- Randomly select eligible enrollees from eligible contracts
- Select all CMS-HCCs from the randomly selected enrollees
- Estimate national level payment error

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Sampling Eligibility

- 2014 RADV enrollee eligibility for national sample, for example:
  - Have 12 months of Medicare Part A in 2013
  - Have 12 months of Medicare Part B in 2013 (i.e., full risk)
  - Are enrolled in an eligible MA Organization in January 2014 and were continuously enrolled in that same MA Organization for all of 2013.
  - Have at least one ICD-9-CM diagnosis code mapping to a CMS-HCC
  - Do not have particular exclusion criteria

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Sampling Stratification

- Samples use a stratified sampling method
  - All eligible enrollees (population)
    - Ranked from lowest to highest risk scores by cumulative risk score. Divided into equal thirds to establish low, medium, high
  - Sample
    - Equal number of enrollees randomly selected from each stratum
  - Weights
    - Enrollee sample weight computed as the total number of enrollees in eligible population stratum divided by the number of enrollees sampled from that stratum (N/n)

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Medical Record Request



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Medical Record Request

- The Contractor Process
  - C&QC distributes CMS message notifying MA Organizations of selection for RADV and requirements for participation
  - CDAT team provides CDAT accounts to MA Organizations users
  - LAC prepares data to be posted on CDAT Plan Portal
  - CDAT develops CDAT user instructions
  - CDAT posts instructions on CDAT Plan Library
  - CDAT posts data on the CDAT Plan Portal
  - CDAT teams train MA Organizations and provides technical support
  - CDAT generates reports to track MA Organizations response rates

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Medical Record Request

- When selected for RADV, MA Organizations
  - Identify contacts/CDAT users for the RADV
  - Participate in training about RADV and also CDAT use
  - Download data from CDAT
  - Request medical records and attestations from MA providers
  - Submit medical record files to CMS via CDAT

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Instructions

- MA Organizations must send medical record to support the CMS-HCC identified in the sample
  - MA Organizations submit the medical record electronically in PDF form via CDAT
  - The medical record must correspond to individual pre-populated Medical Record Coversheet that is loaded onto CDAT

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CDAT Plan Portal Library

- A library within CDAT for MA Organizations containing
  - Important documents supplied by CMS
    - Initial notification
    - Instructions documents
    - CDAT Troubleshooting Guide
    - CDAT Access deck
- Important messages to MA Organizations from CMS
  - Reminder of the early submission deadline & final submission deadline

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HIPAA Fact Sheet and Provider Letters

- HIPAA document provides:
  - Reference to Health Insurance Portability and Accountability (HIPAA) Code of Federal Regulations (CFR)
  - A web link to the HIPAA regulations
  - Additional CFR references
- Provider letters
  - CMS letter to providers to explain the RADV process

MA Organization Support

- CMS encourages MA Organizations to communicate via email for the purpose of tracking
  - C&QC Role: tracks non-technical CDAT issues via CDAT Correspondence Log
- CDAT Contractor tracks technical issues via the CDAT Correspondence Log
  - CDAT Support Role

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Submissions Period

- Medical Records submissions for MA Organizations selected for NAT14 RADV will start on February 25, 2016
  - Early Submission Deadline - April 21, 2016 at 11:59 PM
  - Regular Submission Deadline - June 20, 2016 at 11:59 PM

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Submissions

- Medical records submitted into CDAT from February 25, 2016 – April 21, 2016 shall receive feedback on the validity of submitted medical records via CDAT.
  - Guidance will be provided on the validity of submitted medical records or CMS-Generated Attestations
  - MA Organizations can correct or submit a new medical record file on or before the submission deadline, June 20, 2016

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Submissions (cont.)

- Regular Submissions
  - Through June 20, 2016 – MA Organizations continue to obtain and submit medical records to CDAT
  - 11:59 p.m. ET, June 20, 2016 – Medical records submission deadline
  - MA Organizations will also receive three Interim Findings Reports. (dates will be based on submissions)

Correspondence Log

- The Correspondence Log
  - Allows the C&QC and CDAT Support Team to identify the reason the correspondence exists
  - Allows for the C&QC and CDAT Support Team to log communications with MA Organization Point of Contact
  - Allows CMS and its contractors to contribute to the discussion thread

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Medical Record Intake Process



NAT 14
RADV Partner Training

Intake Overview

- The IMRRC uses CDAT to conduct Intake
  - Submission Review
  - Senior Evaluation
  - Confirm Invalid
  - Activity Tracking

Intake Overview (cont.)

- Other roles in Intake:
  - Escalation Intake Senior Evaluator
  - Physician Reviewer
  - QA Panel

- A CMS Coversheet or medical record file may be flagged for the following during the Intake process:
  - Early submission feedback before the early submission deadline
  - Technical assistance for records received after the early submission deadline

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Medical Record File Intake

- Within CDAT, the IMRRC also
  - Enters comments regarding the coversheet, medical record and attestation.
  - Uses the early submission feedback report and technical assistance report to identify and manage medical record issues and technical assistance cases.

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Medical Record File Intake – Submission Review

- Submission Review
  - Organize record file before it moves through CDAT
  - View image of the submitted medical record file
  - Pages can be
    - Reoriented
    - Removed, if data breech
    - Reordered (if attestation is in the wrong place)

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Medical Record File Intake – Senior Evaluation

- The IMRRC Sr. Evaluator
  - Reviews the Coversheet Validation Tab
    - Compares the information on the medical record with the information displayed in the screen as entered by the MA CDAT user
    - According to CMS instruction, may revise information entered by the MA CDAT user
    - Indicates if the medical record file submitted and the Medical Record Coversheet was completed according to CMS instruction
    - Indicates if the medical record supplied by the MA Organization is an electronic health record
    - Determines if the CMS-Generated Attestation, if supplied, is valid

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Medical Record File Intake – Senior Evaluation

- The IMRRC Sr. Evaluator
  - Answers each of the INV questions
    - "No" requires a comment
- Valid and invalid medical records move forward to abstraction
  - Important data can be captured
  - Invalid records will not be used to calculate payment error

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Medical Record File Intake – Senior Evaluation

- INV Questions
  - Question 1 (INV1) = Does the medical record correctly identify the sampled beneficiary?
  - Question 2 (INV2) = Is the medical record signed?
  - Question 3 (INV3) = Is the name on the medical record an acceptable variance of the name of the sampled beneficiary?
  - Question 4 (INV4) = Is there a date on the medical record?

  (For the National Sample ONLY, Senior Evaluator must answer INV 4 based on entry by the MA Organization CDAT user and the medical record submitted, but failure of this INV will not stop the Medical Record from proceeding to coding).
  - Question 5 (INV5) = Is the medical record from a valid source?

Medical Record File Intake – Senior Evaluation

- INV Questions
  - Question 7 (INV7) = Are you able to confirm an acceptable credential/specialty?
  - Question 14 (INV 14) = Is the date on the medical record within the data collection period?
  - Question 15 (INV15) = Does the Provider Type of the medical record match the Provider Type selected on the Medical Record Coversheet?

    (For the National Sample ONLY, Senior Evaluator must answer INV 15 based on entry by the MA Organization CDAT user and the medical record submitted, but failure of this INV will not stop the Medical Record from proceeding to coding).
  - Question 19 (INV19) = Is the medical record free of issues requiring TA so that abstraction can be performed?
  - Question 20 (INV20) = Is the record free from invalid issues not otherwise addressed through existing INV checks?

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Medical Record File Intake – Confirm Invalid

- I-IVC Sr. Coder
  - Reviews submissions deemed invalid at Senior Evaluation
  - Reviews the submission using the same process and INV checks as the Sr. Evaluator at Senior Evaluation step

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Medical Record Review



NAT 14
RADV Partner Training

Medical Record Review

- Process Overview
  - Baseline IRR established for all coders
    - New for NAT14, coders who achieved a 95 % IRR on previous National Samples will not be required to go through the IRR process again
    - Only new coders and those who have not previously achieved 95% IRR in the National sample will go through the first 25 process.
  - Primary Coders receive records to code
  - All records go to Senior Coders for repeat coding
  - Escalation as required
  - Ongoing IRR
  - Final coding results passed to LAC to begin analysis

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MRRC Roles

- All Coders
  - Are certified as Registered Health – Information Administrator (RHIA), Registered Health Information Technician (RHIT), or Certified Coding Specialist (CCS)
  - Have experience in conducting medical record review and data abstraction
  - Have experience in coding and general acute hospital (inpatient and outpatient), multi-specialty physician office or health maintenance organization (HMO) by applying ICD-9-CM coding guidelines (for both inpatient and outpatient/physician settings) and related Official Coding Clinic.

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MRRC Roles

- Senior coders
  - Are certified as Registered Health Information Administrator (RHIA), or Registered Health Information Technician (RHIT), or CCS (Certified Coding Specialist)
  - Have significant experience in leading and/or supervising personnel in abstracting and ICD-9 coding of general acute hospital (inpatient and outpatient) and physician medical records by applying ICD-9-CM Coding Guidelines for inpatient and outpatient settings and related Official Coding Clinic.
  - Perform a lead role and/or train health information management (HIM) medical record coders
  - Possess knowledge and skills to serve as "Master Coder" (i.e., gold standard) for all coding projects.

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Abstraction Workflow

- National sample
  - Initial validation contractor (IVC)/ Secondary validation contractor (SVC)
    - IVC and SVC perform review of 100% of valid and invalid medical records
      - Audited HCCs
      - Additional HCCs must have IVC/SVC agreement
  - MA Organizations cannot dispute findings

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Abstraction in CDAT

- MRRCs use CDAT to
  - View medical record
  - Access encoder for coding resources and also to select ICD-9 codes to be assigned based on diagnoses that appear in the medical record
  - Submit ICD-9 code(s) selected in the encoder, which are then populated in CDAT and mapped to corresponding CMS-HCCs
  - Confirm coding selection and submit abstraction results

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Abstraction in CDAT

- Inpatient/Outpatient Guidelines
- Validity of records in abstraction
- Invalid record coding
- Resetting records

Abstraction in CDAT

- CDAT allows for:
  - Secure communication that can be easily tracked between coders, escalation Sr. Coders, the QA Panel, and physician reviewer
  - Comments to be entered and available to subsequent MRRC users and for reporting
  - Coder discretion on record validity

- Tracks all actions performed

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End of Abstraction

- No records remain to be coded
- Final IRR
- Data is available to LAC

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Payment Error Estimate



NAT 14

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Payment Error Calculation Overview

Payment error calculation steps:

- Receive notification that abstraction is complete
- Identify CMS-HCCs based on abstracted diagnoses
- Select highest CMS-HCC in hierarchies
- Select highest CMS-HCC among IVC/SVC results (national sample)
- Calculate validated enrollee-level payment amounts
- Calculate difference between original (RAPS) and validated payment amounts
- Extrapolate payment amounts to population

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Types of Payment Errors

- Payment error types
  - CMS Overpayments
    - CMS-HCCs not validated (unconfirmed)
    - Lower level hierarchical CMS-HCC validated
  - CMS Underpayments
    - Higher level hierarchical CMS-HCC found
    - Additional CMS-HCCs

Report of Findings

- National Sample
  - Reports at national level

    www.paymentaccuracy.gov

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RADV Contractor & Coder Training



NAT 14

RADV Partner Training

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Risk Adjustment Data Validation (RADV) Contractor and Coder Training

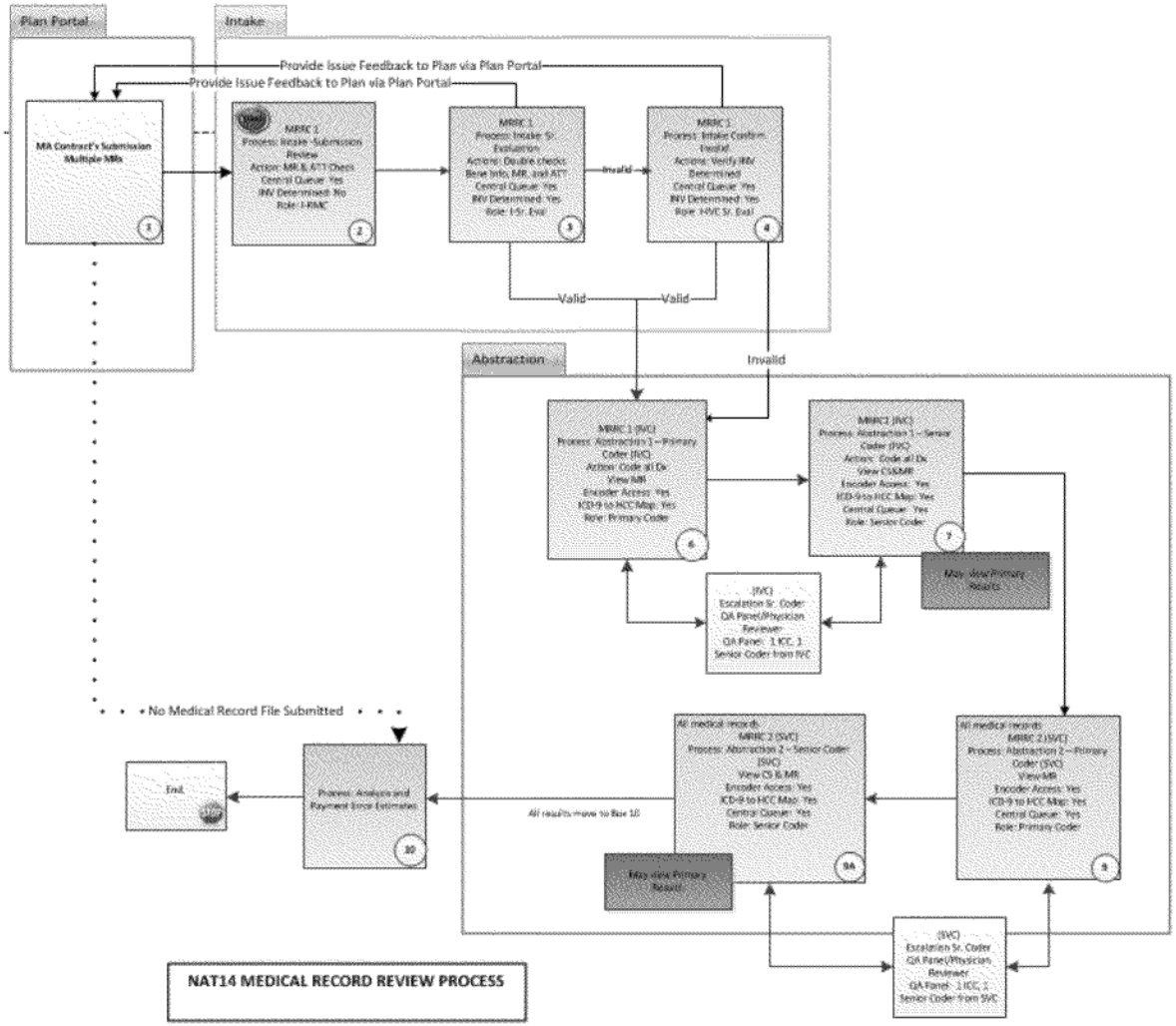
Recap Medical Record Review Coding Process

- Intake confirms/corrects name, date, provider type, and invalid designation when applicable
- From Intake all records go to abstraction
  - Medical record goes through primary and senior review
    - Codes assigned for both valid and invalid records to extent possible
  - Each MRRC team gets same set of records

– Differences from CON12 Process

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National 2014 Workflow



NAT14 MEDICAL RECORD REVIEW PROCESS

Abstraction

- Code and abstract record for all reportable ICD-9-CM
- If otherwise valid record has no conditions documented, then mark “No ICD-9”
- If record can not be coded due to another issue, then escalate to QA panel with comment
- CDAT and 3M encoder procedures map to HCC
- Verify entries

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MRR Intake Process and Coder Guidance

- Includes all steps in MRR process
  - Administrative intake
  - Intake validity assignment
  - Technical Assistance or Early Submission Feedback
  - Escalation Issues
  - Post Intake MRR
  - Coding

MRR Intake and Coder Guidance

- Signatures
  - Electronic examples
  - Typed but not authenticated
  - Legibility
- Dates acceptable for NAT14
  - 2013 Dates of Service
- Provider and Record Types
- Enrollee issues
- Documentation Issues

Medical Record Review

- Sources of Reportable Conditions
  - Problem lists
  - SNF physician
  - Orders
  - Nurse specialists
- Unacceptable sources
  - Claim forms
  - Code lists without narrative

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Medical Record Review

- Inpatient
  - Sources for reportable conditions
    - Attending, consultants, other physicians
      - Potential issues with discharge summaries and H & P reports
    - Anesthesiologists and operative notes
    - Emergency department team notes
  - Sources not acceptable
    - Ancillary department findings-PT, OT
    - Code lists, DRG attestation forms

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Medical Record Review

- Hospital Outpatient
  - Sources for reportable conditions
    - Attending, consultants, other physicians
    - Anesthesiologists and operative notes
    - Emergency department team notes
    - Ancillary department findings-PT, OT
  - Sources not acceptable
    - Code lists, charge forms
    - Clinic notes from non acceptable specialties
    - Uncertain conditions

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Medical Record Review

- Physician and Professional
  - Sources for reportable conditions
    - Physician office notes
    - Nurse intake on same date
    - Ancillary data referred to in notes
    - Testing interpretation/consultation
  - Sources not acceptable
    - Patient generated data
    - Prior encounters
    - Rule out, working diagnoses

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Encoder Use, Edits, and References

- Edits for accurate coding
- Using both the index and tabular
  - Double check encoder outcome is what you intended
- Direct entry vs using code book
  - Avoid memory mix ups (CHF/COPD) (438/483) (496/486)
- Rechecking/reviewing final list before submitting

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Encoder Use, Edits, and References

- References include:
  - Official Guidelines
  - Coding Clinic
  - Medical Dictionary
  - Lab references
  - Drug index
- Do not quote from unofficial references

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MRR Intake and Coder Guidance

Updates for Nat 14

- INV 4- Is there a date on the medical record?
  - Some discharge summaries without discharge date may be acceptable if admission date is present and within 2013
- Coversheet prepopulated with 2013
- QA Panel editor may research names, credentials and provider for questionable INV7 and attestation validity
- Note extraneous documents and missing pages in non-compliant comment. Extraneous documents may be moved to back of record
- Attestation validity comments should include provider name
- Health Risk Assessment forms- evaluate who is completing the form
- Query form evaluation- check for date of completion
- PHI Protocol updated

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Specific Coding Reference for Some HCCs

- Updated with PY 2014 model diagnoses
- No ICD-9-CM Updates on 10/1/13
- Updates from AHA Coding Clinic for 2013 dates of service
- Review Coding References
- RADV notes

Specific Coding Reference for Some HCCs

Common Medicare Conditions in New PY14 model

- Sarcoidosis 135, Bronchiectasis 494.x, Asbestosis 501, Pulm fibrosis 515
  - Many related chronic lung disorders HCC 112
- Thrombocytopenia 287.5, Sickle-cell trait 282.5
  - Many related blood disorders HCC 48
- Hyperparathyroidism 252.00
  - Many related endocrine disorders HCC 23
- Morbid obesity 278.01/BMI over 40 V85.41-45 HCC 22
- Diabetic eye conditions 362.01, 362.03-07, 366.41 HCC 18
- Exudative (wet) macular degeneration 362.52 HCC 124
- Rheumatic heart failure 398.91 HCC 85
- Venous stasis (varicose veins) with ulcer 454.0 HCC 107
- Sepsis, SIRS 995.90, 995.91-.92 HCC 2

Comments & Escalation Situations

- Assistance/advice
  - When to ask, Who to ask
  - Identifying cause of issue: system, training, or human error
- Add written comments for codes that relate to HCC assignment
  - When making a decision between two acceptable codes
  - When using a reference
  - When using a document source other than DS & HP
  - If a record is deemed valid in intake, but cannot be coded due to RADV or coding rules that make coding invalid

Communicating Updates

- MRRC internal training
- QA Panel Members report back to MRRC
- CDAT Team Library
- Coder Discussion Journal
  - Entries by QA Panel Editor
  - Notifies MRRCs of input or review needed
- Weekly MRRC status meetings
- Intake and Coder Guidance updated
  - Announcement by Emails to CMS and MRRCs

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Thank You

Thank you for joining us today!

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EXHIBIT 19

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

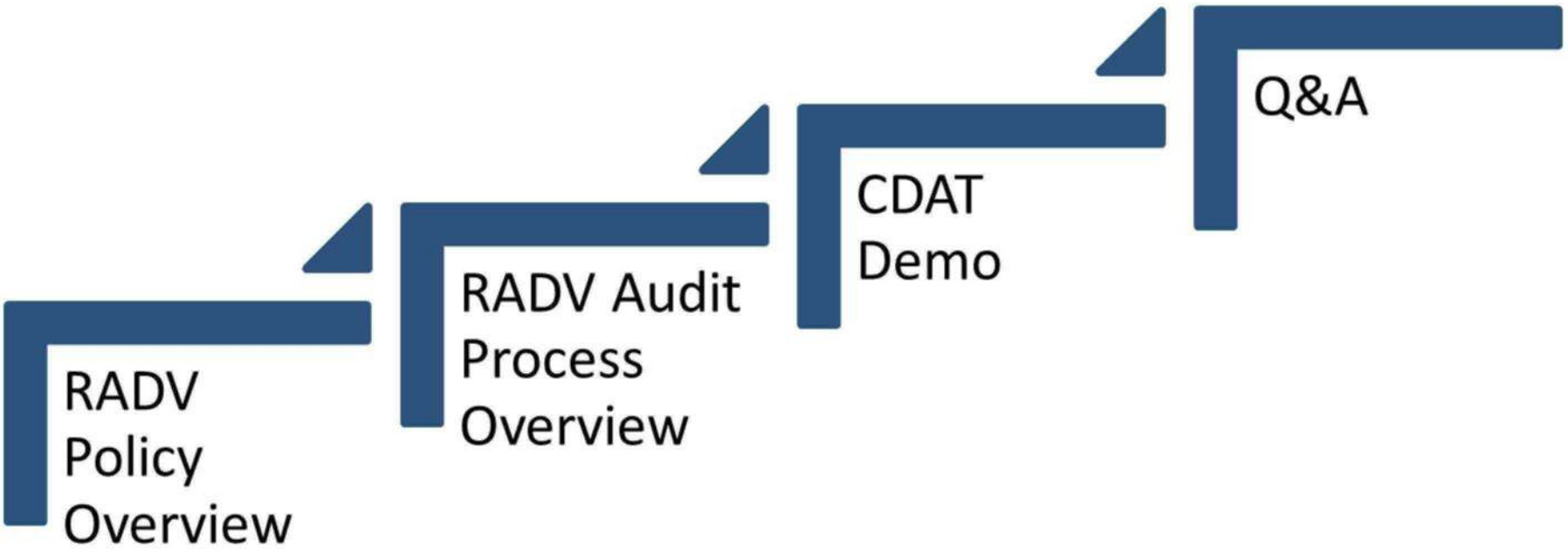
CON13 RADV MA Organization Training



Tuesday, September 13, 2016

1:00–4:00 p.m. ET

Agenda Highlights



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Welcome and Introductions



Medicare Plan Payment Group (MPPG)

Cheri Rice – Director, MPPG

Jennifer Harlow – Deputy Director, MPPG

Ilina Chaudhuri – Director, Division of Payment Validation (DPV), MPPG

Kellie Simons – Deputy Director, DPV, MPPG

MPPG RADV Team

Sue Billet	Carolyn Kapustij
Joanne Davis	LuAnn Piccione
Esmail Essajee	David Winchell

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RADV Terminology

Term	Definition
CY	Calendar Year
CON13 RADV	CY 2013 Contract-Level RADV
CMS	Centers for Medicare & Medicaid Services
CDAT	Central Data Abstraction Tool
HCC	Hierarchical Condition Category
INV	Invalid

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RADV Terminology (continued)

Term	Definition
ICD-9-CM	International Classification of Diseases, Ninth Revision, Clinical Modification
MA	Medicare Advantage
MRR	Medical Record Review
PHI	Protected Health Information
PII	Personally Identifiable Information
RADV	Risk Adjustment Data Validation

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CMS RADV Contractors

Term	Definition
MRRC	Medical Record Review Contractor
LAC	Lead Analytic Contractor
ICC	Independent Coding Consultant
CDAT	Central Data Abstraction Tool
ISC	Independent Statistical Consultant
TDPS	Technical Data Processing Support Contractor
C&QC	Communications & Quality Control Contractor
IV&V	Independent Verification & Validation Contractor

CDAT Contractor

- Implements information technology processes necessary to support RADV project goals
- Demonstrates system design and development
- Assists in operations and maintenance
- Provides technical support to MA Organizations and other RADV contractors
- Maintains system security and compliance

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Activity to Date

- May 6, 2016 – Notification of Selection
- August 30, 2016 – Point of Contact (POC) Template submission deadline
- September 7, 2016 – Documents available on CDAT Plan Portal Library:
  - CON13 RADV *CMS Submission Instructions* and Appendices
  - CON13 RADV *Hardship Exception Request Form*
  - CON13 RADV *POC Request Package*
  - *CDAT Access* Slide Deck
  - *CDAT Troubleshooting Guide*
  - Slide Deck for today's teleconference

RADV Policy Overview

- What is RADV?
- What is Risk Adjustment?
- How is the Payment Error Determined for RADV?

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RADV Policy

- CMS is legislatively mandated to risk adjust Medicare Part C payments, validate the payments (diagnoses), and report a Part C payment error rate.
- RADV is CMS' primary strategy to address the Part C error rate.
- RADV validates diagnoses submitted for payment.

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RADV Policy (continued)

- The goal of RADV is to identify all discrepancies by comparing risk adjustment diagnosis data submitted by an MA Organization for payment against what the MA Organization provided during medical record submission.

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RADV Policy (continued)

- MA Organization-submitted risk adjustment diagnoses must be:
  - Based on the clinical medical record documentation from a face-to-face encounter between patient and physician/practitioner.
  - Coded in accordance with the *ICD-9-CM Official Guidelines for Coding and Reporting.*
  - Assigned based on dates of service within the data collection period.

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RADV Policy (continued)

- Risk adjustment diagnoses submitted to CMS by MA Organizations must be from an acceptable:
  - Risk adjustment provider type (Physician, Hospital Inpatient, or Hospital Outpatient)
  - Risk adjustment data source
  - Risk adjustment physician specialty type (see Appendix 3 of the *CMS Submission Instructions* for a list of acceptable specialties)

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RADV Policy (continued)

- This CON13 RADV audit is being conducted in accordance with 42 CFR §422.310.
- Subsection 422.310(e) requires MA Organizations, providers, and practitioners to submit medical records to validate risk adjustment data as required by CMS.

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RADV Policy (continued)

- This CON13 RADV audit will use data from CY 2012 dates of service.
- Enrollees will be sampled from each MA contract for the purpose of estimating payment error related to risk adjustment.
- CMS' sampling frame and medical records review findings will be used to estimate a contract-level payment error and associated payment adjustments for an established contract population.

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RADV Policy (continued)

- MA Organizations selected for CON13 will have 20 weeks from September 14, 2016, to:
  1. Request medical records from providers.
  2. Prepare medical record files.
  3. Submit the files via a secure online portal called the Central Data Abstraction Tool (CDAT).
- Medical record file submission is available in CDAT from the beginning of the 20-week period.

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Part C Risk Adjustment Model

- The Part C CMS-HCC model is used to pay plans for non-ESRD enrollees (with 12 months of Medicare Part B coverage during the data reporting period [i.e., full risk beneficiaries]). There are three (3) possible scores produced by the model:
  - **Community**: Based on enrollees with less than 90 days in an institution
  - **Long-Term Institutional**: Based on enrollees with 90+ days in an institution
  - **New Enrollee**: Used for enrollees who are new to Medicare; operationalized as beneficiaries with less than 12 months of Medicare Part B coverage

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Risk Adjustment – How It Works

- CMS develops prospective risk adjustment models for Part C:
  - Diagnoses from Year 1 are used to predict average spending for Medicare fee-for-service populations in Year 2.
  - Models contain approximately 2,938 diagnosis codes. This is the number of diagnoses mapping to CMS-HCCs.
- Models include components for:
  - Demographics (Age, Sex, Medicaid Status, Original Reason for Medicare Entitlement)
  - Disease groupings referred to as CMS-HCCs
    - CMS-HCCs represent the disease component of the enrollee risk scores.

Creating the Risk Adjustment Model

- Condition Categories (CCs):
  - ICD-9-CM codes are clustered into related CCs
  - Contain diagnoses clinically related and with similar Medicare predicted cost implications
  - Relate to well-specified medical conditions
    - Hierarchy logic is imposed on certain CCs to account for hierarchical costs for the conditions (thus "HCCs").
    - CCs have relative risk factors assigned based on the predicted costs.
    - Risk factors represent marginal predicted costs, relative to the average Medicare beneficiary.

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Reporting and Risk Score Calculation

- MA Organizations submit diagnosis data to CMS:
  - Enrollee diagnoses from dates of service within the data collection period.
- Risk scores are calculated for:
  - Every Medicare beneficiary
    - ICD-9-CM codes from Fee-for-Service (FFS) claims and data submitted from plans (risk score data can derive from plan submitted data and FFS claims data).
  - A specific beneficiary
    - Identify model (community, institutional, new enrollee, End Stage Renal Disease [ESRD]).
    - Identify risk factors within model which apply (one [1] or more).
    - Enrollee risk score = Sum of all relative and frailty factors.

Types of CMS-HCCs

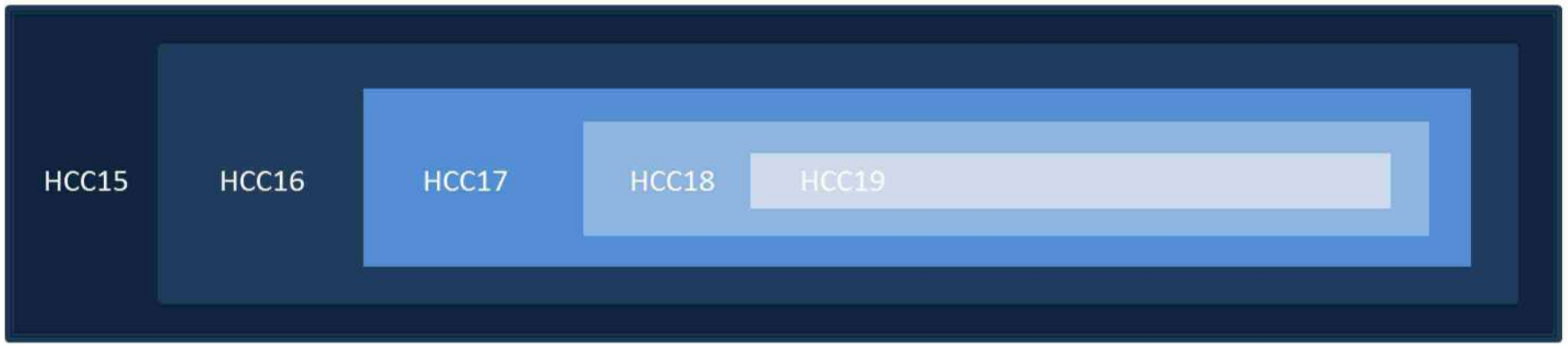
- Non-hierarchical
- Hierarchical
  - Traditional Hierarchies (Diabetes)
  - Hybrid or Complex Hierarchies (Spinal Conditions)

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Traditional Hierarchy – Diabetes

CMS-HCC	Description	Relative Rank*	Community Factor	Institutional Factor
HCC15	Diabetes with Renal or Peripheral Circulatory Manifestation	1	0.371	0.413
HCC16	Diabetes with Neurologic or Other Specified Manifestation	2	0.371	0.413
HCC17	Diabetes with Acute Complications	3	0.371	0.413
HCC18	Diabetes with Ophthalmologic or Unspecified Manifestation	4	0.371	0.413
HCC19	Diabetes without Complication	5	0.127	0.173

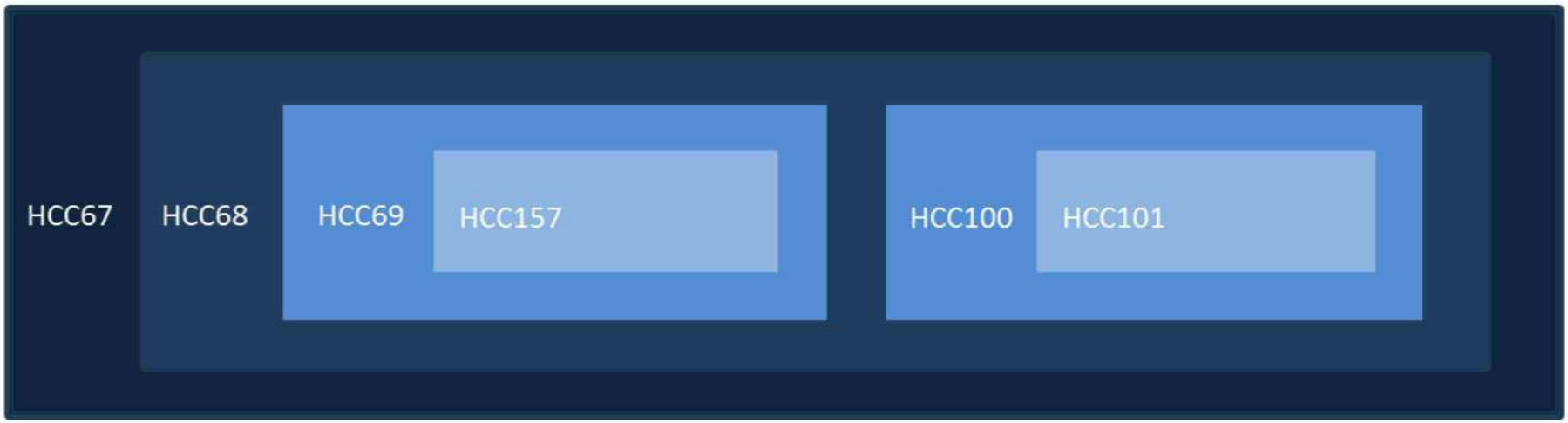
* 1 is most severe, 5 is least severe.



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Hybrid/Complex Hierarchy – Spinal Conditions

CMS-HCC	Description	Community Factor	Institutional Factor
HCC67	Quadriplegia, Other Extensive Paralysis	1.147	0.518
HCC68	Paraplegia	1.061	0.480
HCC69	Spinal Cord Disorders/Injuries	0.491	0.238
HCC100	Hemiplegia/Hemiparesis	0.534	0.069
HCC101	Cerebral Palsy and Other Paralytic Syndromes	0.131	–
HCC157	Vertebral Fractures without Spinal Cord Injury	0.467	0.154



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Calculating a Risk Adjustment Score

- **Example:** Mrs. Jones is 83 and resides in Baltimore. She was determined to be eligible for Medicaid effective September 2012 and has been a member of Silver Health Plan for several years. The MA contract also offers additional vision and dental benefits. Her MA Organization submitted two (2) diagnostic codes with dates of service during last year:
  1. 410.11 – AMI (Acute Myocardial Infarction)
  2. 808.51 – Open Fracture Of Ilium

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Calculating a Risk Adjustment Score (continued)

- Sum the following relative factors:
  - Model variables for Mrs. Jones:
    - 83-year old female
    - Non-institutionalized
    - Medicaid
  - Disease Coefficients:
    - HCC81
    - HCC158

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Example of Payment Calculation

- Apply risk score(s) to payment using the basic Part C formula:

  [Base payment rate * enrollee risk score] + additional payment amount if MA contract offers certain supplemental benefits

  - Base payment rate = $932 per member per month
  - Beneficiary risk score = 1.511
  - Additional payment amount of $32 for supplemental benefits
  - CMS' monthly payment to Silver Health Plan for Mrs. Jones:
    ($932 * 1.511) + $32 = $1,440.25

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Helpful Resources on Risk Adjustment and Risk Scores

- Medicare Advantage (MA) Advance Notices of Methodological Changes, announcements issued for MA rates, and special reports are available at:

  https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/

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Payment Error Calculation Methodology

- On February 24, 2012, CMS released the Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage RADV Contract-Level Audits, available at:

  https://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/Downloads/radvmethodology.pdf

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RADV Audit Process Overview

- Sampling
- Enrollee Data Package
- Requesting Medical Records
- Selecting Medical Records
- CMS-Generated Attestations
- Hardship Exception Requests
- Preparing Medical Record Files
- Submitting Medical Record Files
- Ranking Medical Records in CDAT
- Receipt and Review of Medical Records

Sampling

- Step 1: Select MA contracts eligible for RADV audits
  - Active contracts that received risk-adjusted payments.
  - All audited CMS-HCCs that contributed to the CY 2013 risk-adjusted payment will be reviewed.

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Sampling (continued)

- Step 2: Select enrollees eligible for sampling
  - Selection based on enrollment data for January of the payment year.
  - Eligible enrollees:
    - 12 months of Part B during data collection year (i.e., full risk).
    - Continuously enrolled in the same contract from January of the data collection year through January of the payment year.

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Sampling (continued)

- Eligible enrollees:
  - Non-ESRD status (no payment made based on the ESRD-HCC Model) from January of the data collection year through January of the payment year.
  - No hospice status (resulting in one (1) or more eliminated monthly risk-adjusted payments) from January of the collection year through January of the payment year.

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Sampling (continued)

- Eligible enrollees:
  - All audited CMS-HCCs for selected enrollees will be reviewed.
    - At least one (1) CMS-HCC assigned resulting in a positive risk-adjustment payment amount for payment year 2013.
      - CMS will review all CMS-HCCs for selected enrollees.
    - Not selected for the National 2013 RADV audit.

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Sampling (continued)

- 201 enrollees selected from the contract's RADV-eligible population
- Stratified, random sample
  - 67 in each stratum
- Sampling weights
  - Enrollee sample weight is computed as the total number of enrollees in the stratum divided by the number of enrollees sampled from that stratum (N/n).
    - For RADV contract-level samples, n= 67.

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Enrollee Data Package

- Sampling Specifications
  - Define how HMOIDs, enrollees, and their respective CMS-HCCs are selected.
  - Specify the methods and CMS data systems to identify CMS-HCCs for which MA Organizations received payment.
- Initial Data Steps
  - Diagnoses obtained from the CMS system are run through the CMS-HCC model.
    - Highest manifestation of disease(s) for each enrollee.
    - All diagnoses mapping to the CMS-HCC.
- Forms Populated for Distribution
  - Enrollee Lists (XLS)
  - Enrollee List Data Dictionary (DOCX)
  - CMS-Generated Attestations (PDF)

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Enrollee Data Package – Enrollee List

- CMS-HCC-level documentation containing enrollee information in Microsoft Excel format
- Majority of data elements in the enrollee list are also present on the Medical Record Coversheet within CDAT
- Contains supplemental HIC information (Railroad Board Health Insurance Claim Number) to cross-reference against the Monthly Membership Report (MMR)
- Each observation is based on unique CMS-HCCs for an enrollee

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Enrollee Data Package – Enrollee List Data Dictionary

- Description of each data element present in the enrollee list
- Listed in the same order in which the variables appear in the enrollee list
- Three (3) columns in the data dictionary:
  - Column 1 – the order in which the variable appears
  - Column 2 – descriptive label of the variable
  - Column 3 – definition of the variable

Enrollee Data Package – Enrollee List Data Dictionary (continued)

- Can be used in conjunction with the enrollee list if details are needed about a specific variable
- Variable groupings:
  - HMOID
  - Enrollee
  - Risk adjustment

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Medical Record Request Requirements

MA Organizations must:

1. Review the CON13 RADV Enrollee List.
2. Request medical records and attestations for CMS-HCCs using provider letters (required), HIPAA References, and CMS-Generated Attestations (if applicable).
3. Have physician/practitioners complete CMS-Generated Attestations (if applicable).
4. Select the corresponding medical records for submission.
5. Submit all selected medical records and accompanying Coversheets to CDAT by the deadline of **February 7, 2017**.

Medical Record Request Requirements (continued)

- Medical records:
  - Documentation of a single face-to-face encounter with a physician/practitioner.
  - Not the enrollee's entire year's worth of medical records for the data collection period beginning January 1, 2012 through December 31, 2012.
- Types of medical records:
  - Physician/Hospital Outpatient
    - A specific date of service (e.g., May 5, 2012).
  - Hospital Inpatient
    - A specific admission beginning on the admission date through the discharge date (e.g., August 23, 2012 through September 12, 2012).
    - If the admission date is in 2011, the discharge date must be in 2012 to be accepted. If the discharge date is in 2011, you cannot submit the record as a Hospital Inpatient provider type.
      - Likewise, if the admission date is in 2012 the discharge date must also be in 2012; you cannot submit the record as Hospital Inpatient if the discharge date is in 2013.

Medical Record Request Requirements (continued)

- You may only use the Provider Letters and HIPAA References provided with the *CMS Submission Instructions*:
  - When requesting medical records from providers
  - **Only for the purposes of this CON13 RADV**

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Medical Record Request Requirements – PHI/PII

- When requesting medical records from providers:
  - Limit disclosure of enrollee identifiable health information to minimal information necessary to accomplish the intended purpose of this request.
  - Only send specific enrollee health condition information to the providers responsible for rendering/treating the enrollee for those conditions.
  - Instruct providers to send medical records to your MA Organization.
    - Providers should not send any medical records directly to CMS or CDAT Support. Only your MA contract's confirmed points of contact may upload medical records to CDAT.

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Medical Record Request Requirements – PHI/PII (continued)

- Below are examples of the following information:
  - PHI
    - Data
    - Documents
  - PII
    - Health Insurance Claim Numbers
    - Gender
    - Date of Birth

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Medical Record Request Requirements – PHI/PII (continued)

- Below are examples of exposed PHI or PII:
  - Information sent through email: This is a security violation and is considered a data breach
  - Information left in a voicemail: It is acceptable to communicate PHI/PII via telephone but *not* acceptable to leave a message containing PHI/PII
  - Information copied to a CD/DVD/flash drive/ external hard drive without encryption and CMS approval

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Medical Record Request Requirements – PHI/PII (continued)

- To mitigate any risks of exposure, your MA Organization must:
  - Analyze documents to identify and remove PHI/PII.
  - Obtain approval from leadership prior to sharing with other team members.
  - Avoid emailing medical records within your local network or to parties outside of the network.
  - Avoid capturing and emailing CDAT screenshots to CDAT Support or any other party.
  - Immediately report any suspected exposure to your Medicare Compliance Officer and your leadership.

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Medical Record Request Best Practices

- Designate a point of contact within your MA Organization for providers to contact if they have questions about your medical record request. Be sure to include this person's name and contact information on all medical record requests you send to providers.
- Identify a contact person at the hospital or physician's office prior to sending the request for medical records.

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Medical Record Request Best Practices (continued)

- Confirm receipt of the medical record request with the provider's office. This is especially important if faxing the medical record request, since fax cover sheets often become separated from the other pages.
- Maintain communications with the providers throughout the request period.
- Periodically remind providers to send medical records to your MA Organization before the Submission Deadline.

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Selecting Medical Records

- At a minimum, medical records must meet the following requirements to avoid a discrepant finding:
  - Acceptable risk adjustment provider type (Physician, Hospital Inpatient, Hospital Outpatient) and physician specialty (see list in Appendix 3 of *CMS Submission Instructions*)
  - Dates of service within the data collection period
    - January 1, 2012 through December 31, 2012
  - Contain valid signatures and credentials
    - If missing, use CMS-Generated Attestation
  - Correct beneficiary

US-DOJ-KAISER-00098373

Selecting Medical Records (continued)

- CMS-HCC Hierarchies:
  - If supporting medical record documentation for the enrollee CMS-HCC cannot be provided, medical record documentation supporting another CMS-HCC within the same hierarchy may be submitted under the same coversheet.

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Selecting Medical Records (continued)

- For example, in the case of the diabetes hierarchy, with five (5) disease groups:

Group	Description
HCC15	Diabetes with Renal or Peripheral Circulatory Manifestation
HCC16	Diabetes with Neurologic or Other Specified Manifestation
HCC17	Diabetes with Acute Complications
HCC18	Diabetes with Ophthalmologic or Unspecified Manifestation
HCC19	Diabetes without Complication

- Coversheet identifies CMS-HCC 16 for validation.
- If documentation for CMS-HCC 16 was missing, documentation could be submitted for CMS-HCC 15, CMS- HCC 17, CMS-HCC 18, or CMS-HCC 19.

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Selecting Medical Records (continued)

- MA Organizations may select and submit one (1) or multiple unique medical records to support a single audited CMS-HCC.
- You may also select and submit a single record to validate multiple CMS-HCCs.
- A separate Coversheet must be completed in CDAT for each unique medical record submitted.
- Select and submit medical records to support each of the enrollee's audited CMS-HCCs up to a maximum medical record allowance of five (5) times the total number of audited CMS-HCCs (e.g., if an enrollee has five (5) audited CMS-HCCs, you may select and submit a maximum of 5*5 = 25 medical records).
- CMS will review each submitted medical record to validate the CMS-HCC(s) indicated on the attached Coversheet.

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Selecting Medical Records (continued)

- It is important to submit a medical record for every audited CMS-HCC because missing medical records can contribute significantly to payment error calculations.
- If you have a medical record that you believe does not support the exact CMS-HCC being validated and there is no viable substitute record, we encourage you to still submit the medical record for review.

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Selecting Medical Records – Checklist

- Use the checklist in Appendix 2 of the *CMS Submission Instructions*:
  - Enrollee name correct – use correction area if different
  - Date of Service in 2012
  - Provider type, face-to face visit and specialty/credential evident
  - Signature/authentication evident
  - Attestation from correct physician/practitioner
  - Legible
  - Active diagnosis documented, not just a code number

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Selecting Medical Records – Name

- **Page 50 of *CMS Submission Instructions***: "If any of the enrollee demographic information on the medical record documentation differs from that supplied in the **Pre-populated** column, enter differences in the **Corrected** (right) column."

- Reminders:
  - Make sure the medical record name matches *exactly* the Coversheet name. If it does not, use the corrected column. This does not "correct" the name in the Medicare database but informs the reviewers of a nickname, newly married/divorced name, middle name used as first name, typo, etc.
  - If the reviewer can not match the enrollee name sufficiently, the record will be marked invalid and will not be further reviewed.

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Selecting Medical Records – Name

- Reminders:
  - Be sure to check that you have not attached the medical record to the Coversheet of a different enrollee in the sample. If the medical record is for the wrong enrollee, it will not be reviewed and you will have no notification of the error.
  - If one or more pages of an attached medical record are for an enrollee not in the RADV audit sample, this is considered a PHI/PII breach: the entire submission will be deemed invalid and removed from CDAT and will not be reviewed.
  - Check your submissions carefully!

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Selecting Medical Records – Provider Type

- **Pages 26–33**
  - Inpatient Records: Must have discharge date documented. Submit the discharge summary and other pertinent sections where RA physician or practitioners describe diagnoses history, testing, management, treatment, and conclusions.
  - Outpatient Records: Observation, Emergency Department (ED) "holds" may have multiple dates, enter admit date (usually the ED registration date).
  - Physician: Must be face-to-face (except for pathologist); no telephonic or nurse only encounters.
  - Physician/Practitioner Specialty/Credential – validated in multiple record locations whenever possible since often illegible if hand-written.

US-DOJ-KAISER-00098381

Selecting Medical Records – Date

- **Page 29**: "If a medical record is missing a **date of service**, the medical record will be deemed invalid and will result in an error determination under the CMS RADV medical record review process."

  Reminder:
  - *A dictation date is not defined as a date of service. Include medical record documentation that supports the full encounter date of service (month/day/year) including both admission and discharge dates for Coversheets marked as inpatient provider types.*

- **Page 31**: "All medical record entries must be complete and must be authenticated and **dated** promptly by the provider who is responsible for ordering, providing or evaluating the service furnished."

  Clarification:
  - *For purposes of RADV, "promptly" is defined as within 180 calendar days of the encounter. Electronic signatures or EMR authentication dated greater than 180 calendar days from the encounter must include a valid CMS-Generated Attestation in order for review to continue.*

US-DOJ-KAISER-00098382

Selecting Medical Records – Authentication

- **Page 30**: "MA Organizations must ensure that the provider of services for face-to-face encounters is appropriately identified on medical records **via signature and physician specialty credentials**."
- **Page 30**: "Transcribed Reports – Electronic signatures are an acceptable form of medical record authentication so long as the system requires the provider to authenticate the signature at the end of each note."
- **Page 30**: "Electronic Medical Records – Electronic point of service type medical record entries are typically considered authenticated at login since the physician/practitioner is directly entering the content into a template and populating from other sections of the EMR....Since EMR formats differ, the presence and significance to RADV of a signature authentication statement and a date in a signature line depends on the structure of the EMR."
- **Page 31**: "The author of **each entry** must be identified and authenticate his or her entry."

Reminders:

- *Use the CMS-Generated Attestation for medical records with undated electronic signatures such as those used to sign dictated reports after review of the transcription. A transcriptionist's entry of the provider name is not acceptable authentication.*
- *Each entry in an EMR must include authentication. In EMRs, authentication by the provider name and credential with the electronic date stamp of the entry is acceptable. Do not submit unsigned encounter reports by one physician imported into an authenticated EMR from another physician.*

US-DOJ-KAISER-00098383

CMS-Generated Attestations

- What is the purpose of a CMS-Generated Attestation?
  - CMS-Generated Attestations may be used to address problematic or missing signatures and/or credentials on Physician and Hospital Outpatient medical records only.
    - If an attestation is needed to validate a missing signature/credential on a Physician/Hospital Outpatient record and one is not submitted, a payment error will result.
  - CMS-Generated Attestations are voluntary.
  - CMS-Generated Attestations are simple to complete and submit, but they must meet CMS requirements.

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CMS-Generated Attestations – Format

- Attestation contains two (2) sections:
  I. Enrollee Demographic Information (pre-populated)
     - Name
     - DOB
     - HICN
     - MA Contract Name
     - Contract ID (E-, H-, or R-Number)
  II. Attestation Statement
     - To be completed by physician/practitioner

US-DOJ-KAISER-00098385

CMS-Generated Attestations – Validity

- CMS-Generated Attestations are reviewed for validity and may be deemed invalid because of the following:
  - Date of service on CMS-Generated Attestation does not match date of service on Medical Record
  - Unacceptable Credentials
  - Attestation Incomplete
  - Attestation Altered (Changes to any pre-populated information)
  - Incorrect Enrollee
  - Signed by a person other than the treating physician/practitioner who created the original record
  - Submitted for a Hospital Inpatient record
  - Attestation is not a CMS-Generated Attestation
  - Other

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Using CMS-Generated Attestations (continued)

- To use a CMS-Generated Attestation (if applicable):
  1. Check CMS-Generated Attestation to be sure it is completed according to CMS requirements.
  2. If it does not meet CMS requirements, decide whether to request that physician/practitioner complete another CMS-Generated Attestation.
  3. Create a PDF medical record file containing, first, the CMS-Generated Attestation (if applicable) and, second, a medical record.
  4. Submit the file by attaching it to a Medical Record Coversheet in CDAT.
- If a physician/practitioner submits medical records without signatures and/or credentials for more than one (1) medical record, you must obtain and submit individual CMS-Generated Attestations corresponding to each medical record and date of service.

CMS-Generated Attestations – Reminders

- Only allowed for Physician and Hospital Outpatient medical records.
- Pre-printed information must ***not*** be altered or edited.
- May only be signed by the physician/practitioner whose medical record is being submitted.
- Complete all blanks indicated.
- Attestation and medical record dates of service must match.
- MA Organizations are given one (1) CMS-Generated Attestation per enrollee in the Enrollee Data Package. If more than one (1) attestation is needed, print multiple copies.
- Must ***not*** use MA Organization-Generated Attestations.

US-DOJ-KAISER-00098388

Hardship Exception Requests

- CMS will consider individual hardship exception requests if there are extraordinary circumstances that may prevent your MA Organization from meeting RADV audit requirements.
  - If your MA Organization believes such circumstances exist, submit a *Hardship Exception Request Form* (available on the CDAT Plan Portal Library) to CMS as soon as possible and no later than **January 10, 2017**.

US-DOJ-KAISER-00098389

Preparing Medical Record Files

- Preparation Steps:
  1. Select medical records that support each enrollee's audited CMS-HCCs.
  2. Create an individual medical record file in PDF format for each medical record to be submitted, including the CMS-Generated Attestation if applicable.
  3. Complete the Medical Record Coversheet within CDAT for each medical record file.

US-DOJ-KAISER-00098390

Preparing Medical Record Files (continued)

- PDF medical record file should contain:
  - 1st: CMS-Generated Attestation (if applicable)
  - 2nd: Supporting Medical Record
- Can only contain one (1) CMS-Generated Attestation and one (1) medical record

US-DOJ-KAISER-00098391

Preparing Medical Record Files – Naming

How to name the PDF Medical Record File:

123456_78(5)



Enrollee ID is composed of six (6) numbers followed by an underscore, followed by two (2) numbers (i.e., 123456_78).

HCC is displayed in parentheses. It is not necessary to include "HCC" or leading zeros in the file name.

US-DOJ-KAISER-00098392

Preparing Medical Record Files – Naming

How to name the PDF Medical Record File for multiple CMS-HCCs:

123456_78(1_2_3)

Enrollee ID is composed of six numbers followed by an underscore, followed by two numbers
(e.g., 123456_78)

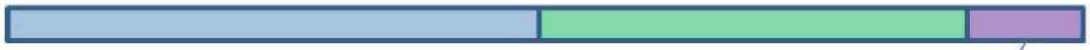
HCCs are displayed in parentheses, separating each with an underscore. It is not necessary to include "HCC" or leading zeros in the file name

US-DOJ-KAISER-00098393

Preparing Medical Record Files – Naming

How to name PDF Medical Record Files when the enrollee and CMS-HCCs are the same and multiple files are being submitted:

123456_78(15_131)v#



Enrollee ID CMS-HCCs

File Name Suffix

File 1: 123456_78(15_131)
File 2: 123456_78(15_131)v2
File 3: 123456_78(15_131)v3
File 4: 123456_78(15_131)v4

US-DOJ-KAISER-00098394

Preparing Medical Record Files (continued)

- Do not submit extraneous documents (e.g., business cards, adhesive notes, coding/clinical evaluations, coding documents).
- Do not write on or mark the medical records.
- Do not highlight the medical records.
- Do not submit electronic medical record system "screen shots" in lieu of a medical record.

US-DOJ-KAISER-00098395

Preparing Medical Record Files (continued)

- Each sampled enrollee has one or more audited CMS-HCCs, and each audited CMS-HCCs should be supported by at least one submitted medical record.
- One (1) medical record may support one or multiple audited CMS-HCCs.
- You may also submit multiple medical records to support a single audited CMS-HCC.

US-DOJ-KAISER-00098396

Preparing Medical Record Files (continued)

- Once a medical record file has been prepared, you may access CDAT to complete the Medical Record Coversheet and upload the prepared medical record file.
- When your MA Organization is ready to upload a medical record file, you must confirm the following:
  - The medical record contained in the file matches the File Content selection that your MA Organization indicates on the Medical Record Coversheet.
  - The medical record contained in the file corresponds to the other information on the Medical Record Coversheet being submitted.
  - The file does not contain multiple medical records.
  - All attached images are legible.

US-DOJ-KAISER-00098397

Submitting Medical Record Files

1. Label the PDF medical record file according to the file naming convention just reviewed.
2. Review medical record file for accuracy prior to upload.
3. Log in to CDAT to complete the Medical Record Coversheet and upload medical record file prior to the Submission Deadline of **February 7, 2017**.
4. Download and view the file that your MA Organization uploaded to CDAT.

US-DOJ-KAISER-00098398

Submitting Medical Record Files (continued)

- CDAT will validate each submitted medical record file to determine if it:
  - Is either inaccessible due to password protection or encryption
  - Is in an invalid file format
  - Does not allow page rotations
  - Does not allow pages to be deleted
  - Does not allow merging with the CMS Medical Record Coversheet PDF
  - Contains binders, bookmarks, or embedded containers
  - Has any other unidentifiable issue

US-DOJ-KAISER-00098399

Submitting Medical Record Files (continued)

- CDAT will not accept any records that contain the issues previously identified.
- MA Organizations are encouraged to review the *File Format Issue* column in CDAT and resolve any issues prior to the Submission Deadline.
- Tomorrow morning CMS will email the MA Organization's Points of Contact the passwords needed to access the CDAT Enrollee Data Package specific to their selected MA contract(s).

US-DOJ-KAISER-00098400

Submitting Medical Record Files: Medical Record Coversheets

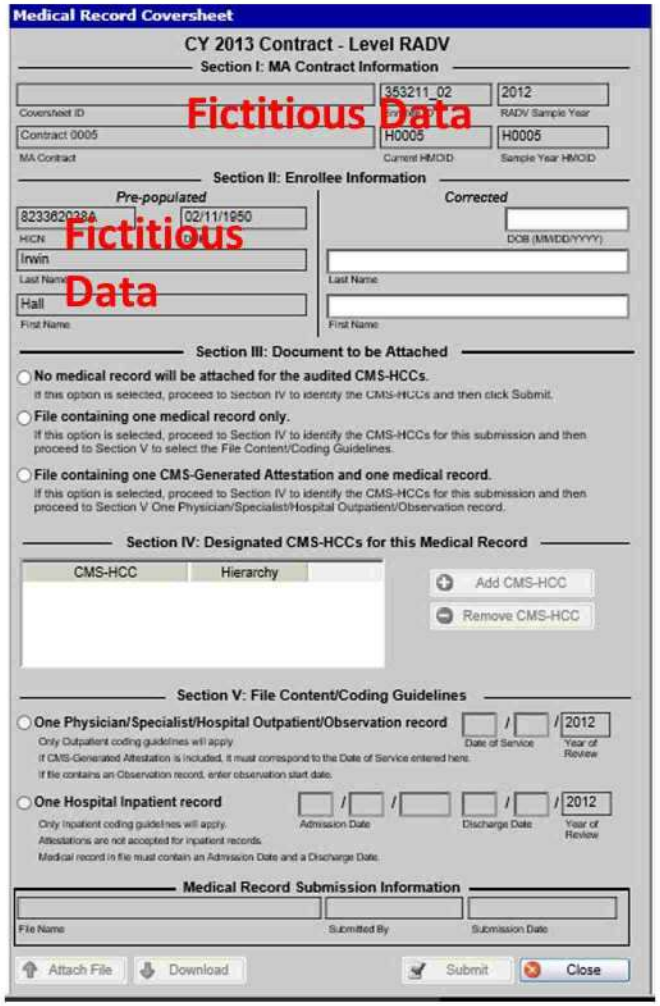
- What is the purpose of the Medical Record Coversheet?
  - Track and monitor the submission of medical records.
  - Confirm the record belongs to the enrollee.
  - Identify the CMS-HCC(s) under review.
  - Identify the documentation (i.e., medical record and attestation) to be considered for review.
  - Define which ICD-9-CM coding guidelines should apply (Inpatient or Outpatient).
  - Define the date of service to be reviewed.

Submitting Medical Record Files: Medical Record Coversheets (continued)

- The Medical Record Coversheet in CDAT contains five (5) sections:
  - I. **MA Contract Information** (pre-populated)
  - II. **Enrollee Information** (pre-populated)
  - III. **Document to be Attached** (input provided by MA Organization)
  - IV. **Designated CMS-HCCs for this Medical Record** (input provided by MA Organization)
  - V. **File Content/Coding Guidelines** (input provided by MA Organization)

US-DOJ-KAISER-00098402

Submitting Medical Record Files: Medical Record Coversheets (continued)



US-DOJ-KAISER-00098403

Submitting Medical Record Files: Medical Record Coversheets (continued)

- Submit a Medical Record Coversheet for every audited CMS-HCC for the enrollee.
- A single Medical Record Coversheet can be submitted for multiple audited CMS-HCCs.
- You may also submit multiple Coversheets for a single audited CMS-HCC.
- Verify that the medical record submitted corresponds to the enrollee identified on the Coversheet.
  - Submitting a record for the wrong enrollee will constitute a PHI/PII breach.

US-DOJ-KAISER-00098404

Receipt and Review of Medical Records

- Accurately completed Medical Record Coversheets will facilitate an optimal medical record review outcome.
- The specific documentation, ICD-9-CM guidelines, provider type and dates of service identified and selected for review may result in coding decisions that have a direct impact on the medical record review results and payment error estimate.

US-DOJ-KAISER-00098405

Receipt and Review of Medical Records (continued)

- Medical Records are reviewed to determine if they are valid for RADV purposes.
- Reasons a medical record be invalid include:

Code	Description
INV1	Wrong enrollee/No name
INV2	Missing signature
INV3	Name variation
INV4	Date missing
INV5	Invalid source
INV7	Unacceptable credential/specialty
INV14	Date outside data collection period
INV15	Provider type mismatch
INV17	Unacceptable medical record documentation
INV20	Other

US-DOJ-KAISER-00098406

Receipt and Review of Medical Records (continued)

- RADV coders will review the acceptable date of service (Physician/Hospital Outpatient records) or range of dates (Hospital Inpatient records) within the data collection year.
- All coding discrepancies are confirmed using independent coders.
- Coders will abstract all reportable ICD-9-CM codes within acceptable date(s) of service in the data collection year.

Ranking Medical Records in CDAT

- Medical records are ranked by MA Organizations in CDAT at the enrollee level.
- All diagnoses will be abstracted from the valid priority medical record that supports the CMS-HCC under review (except in hierarchy situations).
- Priority is based on the order in which your MA Organization ranks medical records in CDAT.

US-DOJ-KAISER-00098408

Ranking Medical Records in CDAT (continued)

- In a non-hierarchy case, if an audited CMS-HCC is confirmed, then the highest-ranked valid medical record that confirms the audited CMS-HCC moves forward for review for additional diagnoses ("additionals").
  - Example: Mary Johns – five (5) medical records are submitted for CMS-HCC 21 (*this assumes all records are valid*).
    - Medical record ranked #1 confirms no CMS-HCC
    - Medical record ranked #2 confirms CMS-HCC 16
    - Medical record ranked #3 confirms no CMS-HCC
    - Medical record ranked #4 confirms CMS-HCC 21
    - Medical record ranked #5 confirms CMS-HCC 21
  - Because the medical record ranked #4 is valid and confirms the audited CMS-HCC, it will move forward for review. The other records will not move forward.

US-DOJ-KAISER-00098409

Ranking Medical Records in CDAT (continued)

- In a hierarchy case, if the audited CMS-HCC or a higher manifestation of the audited CMS-HCC is found then the valid medical record with the highest manifestation of that CMS-HCC moves forward for review for additionals.
  - Example: John Smith – five (5) medical records are submitted for HCC 17 (*this assumes all records are valid*).
    - Medical record ranked #1 confirms CMS-HCC 17
    - Medical records ranked #2 & #3 confirm no CMS-HCC
    - Medical record ranked #4 confirms CMS-HCC 15
    - Medical record ranked #5 confirms CMS-HCC 80
  - Because the medical record ranked #4 is valid and confirms the highest manifestation of the audited CMS-HCC, it will move forward for review. The other records will not move forward.

US-DOJ-KAISER-00098410

Ranking Medical Records in CDAT (continued)

- Alternatively, if in a hierarchy case only a *lower* manifestation of the audited CMS-HCC is found then no medical records will move forward for review for additionals.
  - Example: John Doe – five (5) medical records are submitted for CMS-HCC 15 (*this assumes all records are valid*).
    - Medical record ranked #1 confirms CMS-HCC 19
    - Medical record ranked #2 & #3 confirm no CMS-HCC
    - Medical record ranked #4 confirms CMS-HCC 16
    - Medical record ranked #5 confirms CMS-HCC 80
  - No ranked medical records will move forward for review since all are either discrepant or confirmed lower.

US-DOJ-KAISER-00098411

CDAT Demonstration

- Next, CMS' CDAT Contractor will provide a demonstration of CDAT, the system through which data related to RADV audits is transferred.
- Using CDAT, MA Organizations will:
  - Access enrollee data and pre-populated CMS-Generated Attestations.
  - View and download CMS-provided documents.
  - Complete Coversheets and submit medical record files.

US-DOJ-KAISER-00098412

CDAT Demonstration

US-DOJ-KAISER-00098413

CMS Submission Instructions

- CON13 RADV *CMS Submission Instructions* contents:
  - **Introduction**
  - **Chapter 1: General CMS Requirements**
    - RADV Background
    - CON13 RADV Requirements
  - **Chapter 2: Accessing CDAT Instructions**
    - CDAT Overview
    - CDAT Access
    - Logging In to CDAT (Citrix)
    - Logging In to CDAT (Non-Citrix)
    - Using the Plan Portal Library
    - The CDAT Enrollee Data Package

US-DOJ-KAISER-00098414

CMS Submission Instructions (continued)

- **Chapter 3: Medical Record File Preparation Instructions**
  - Requesting Medical Records From Providers
  - Medical Record Selection Criteria
  - CMS-Generated Attestations
  - Preparing the Medical Record File
  - Ranking Medical Records in CDAT
  - Checking the Medical Record File Before Submission

CMS Submission Instructions (continued)

- **Chapter 4: CDAT User Submission Instructions**
  - CMS Requirements to Submit Documentation
  - Accessing the Plan Portal to Complete the Medical Record Coversheet and Attach the Medical Record File
  - Changing the Rank of a Medical Record Coversheet Submission
  - Updating a Finalized Enrollee
  - Correcting File Format Issues
  - Removing a Medical Record Coversheet Submission
  - Reminders

US-DOJ-KAISER-00098416

CMS Submission Instructions (continued)

- **Appendices**
  - Appendix 1a: HIPAA References
  - Appendix 1b: Physician/Practitioner Letter
  - Appendix 1c: Hospital Letter
  - Appendix 2: RADV Medical Record Guidance
  - Appendix 3: Reference Materials: CMS-HCCs and Physician Specialties
  - Appendix 4: Sample CMS-Generated Attestation Form
  - Appendix 5: RADV Terminology

US-DOJ-KAISER-00098417

Next Steps

1. Download *CMS Submission Instructions* and Appendices from CDAT Plan Portal Library.
2. Download Enrollee Data Package from CDAT.
3. Review *CMS Submission Instructions* and note deadlines.
4. Request medical record documentation from providers.
5. Prepare medical record files.
6. Complete Medical Record Coversheets in CDAT.
7. Upload medical record files and rank submissions within CDAT.
8. Check uploaded files.
9. Download completed Medical Record Coversheets and uploaded medical record files from CDAT.

US-DOJ-KAISER-00098418

Contact Information

The CDAT Support Team and the CMS RADV Team are available to provide assistance throughout this process.

- Email is the most effective means of communication.
- For CDAT-related questions please email radvCON13@radvcdat.com with subject "CDAT Support." Support hours are 9:00 a.m. to 6:00 p.m. ET.
- All questions related to RADV policies and procedures should be directed to CMS at radv@cms.hhs.gov with subject "CON13 RADV." Responses will be provided during normal business hours.

Final Reminders

- Share this slide deck with others in your MA Organization working on CON13 RADV (e.g., those selecting medical records for submission).
- Do not send PHI/PII to the RADV@CMS or radvCON13@RADVCDAT mailboxes.
  - Use the RADV Enrollee ID or Coversheet ID when communicating about a specific enrollee or submission
- When requesting records from providers, be sure to include the appropriate CMS letter and your contact information.

US-DOJ-KAISER-00098420

Final Reminders (continued)

- Double check your medical record file for errors before you upload and submit. Ensure that:
  - There is only one medical record in the medical record file.
  - The medical record is for the enrollee identified on the Medical Record Coversheet.
  - The medical record file does not contain medical records for more than one enrollee mixed together.
- Be sure to submit early in the submission window in order to be able to view and re-rank your submissions prior to the Submission Deadline.

US-DOJ-KAISER-00098421

Q&A



Thank You

- Thank you for your participation!
- If you have any further questions about CMS RADV policy, please contact CMS at radv@cms.hhs.gov with subject "CON13 RADV."

US-DOJ-KAISER-00098423

EXHIBIT 20

U.S. Department of Justice

Civil Division

JAY:PLH:LAOberembt
DJ No. 46-11-3388

(202) 305-8586

Washington, DC 20530

March 15, 2023

VIA EMAIL

Stephen Sullivan, Esq.
O'Melveny & Myers LLP
400 South Hope Street
18th Floor
Los Angeles, CA 90071-2899

Re: *United States ex rel. Osinek v. Kaiser Permanente*, Case No. 3:13-cv-03891-EMC – Defendants' Request for Consent to Conduct Early Rule 30(b)(6) Deposition of United States on Organizational Topics

Dear Mr. Sullivan:

We are writing in response to your March 8, 2023 email, regarding Kaiser's proposed "initial" Rule 30(b)(6) deposition. Your email contains several mischaracterizations, which are addressed below.

First, Kaiser has not actually served a Rule 30(b)(6) Notice on the United States. On October 10, 2022, Kaiser wrote a letter to the United States proposing that it be permitted to take more than one Rule 30(b)(6) deposition of the United States: a "foundational" Rule 30(b)(6) deposition to start and an additional Rule 30(b)(6) deposition in the future. Kaiser sought the United States' "consent" for the first foundational deposition and attached a notice. The notice, which sought testimony related to over 125 "Standards," was not accompanied by a certificate of service and was not served on all parties to this action.

In our response to Kaiser's October 10, 2022 letter, the United States declined to consent to Kaiser's proposal. U.S. Oct. 20, 2022 Ltr. In doing so, we did not object to the deposition in isolation, but specifically to the proposal that Kaiser be permitted to take *two* Rule 30(b)(6) depositions. Had Kaiser actually served the Rule 30(b)(6) notice, the United States would have responded to the notice with objections and the parties would have met and conferred about the matters under examination. If Kaiser serves a Rule 30(b)(6) notice in the future, the United States will respond accordingly. What the United States will not agree to, however, is Kaiser's unwarranted proposal to take two Rule 30(b)(6) depositions.

As we explained in our October 20, 2022 letter, there is no support for Kaiser's proposal. *Id.* at 1. Numerous courts, including Judge Chen, have found that only one Rule 30(b)(6) deposition is permitted absent leave of court. *See Blackwell v. City & Cty. of San Francisco*, No. C-07-4629 SBA (EMC), 2010 WL 2608330, at *1 (N.D. Cal. June 25, 2010). And Kaiser has never cited a case in which a court granted leave for a "foundational" Rule 30(b)(6) deposition in addition to a subsequent Rule 30(b)(6) deposition on the merits.

Second, Kaiser mischaracterizes the discovery that has occurred in this case, which undermines Kaiser's stated reason for requesting a separate "foundational" Rule 30(b)(6) deposition. The United States has produced substantial organizational information responsive to Kaiser's First and Second Requests for Production ("RFPs"). For example, Kaiser's Request for Production No. 126 asked for documents sufficient to identify CMS employees within each of the following groups from January 1, 2010 to present: the Center for Program Integrity; Medicare Parts C and D Oversight and Enforcement Group; the Medicare Plan Payment Group; and the Offices of the Administrator, Acting Administrator, Director, Acting Director, and Deputy Directors of Medicare. The United States has provided organizational information for each of these groups, for each year, from 2010-2021, including CMS' organizational charts for each year and (because these charts do not show all lower-level employees) many additional group-specific directories. Contrary to your statement in the letter, these productions (updated directories) enable Kaiser to determine how personnel changed over time. In addition, after receiving Kaiser's Second Requests for Production, we produced functional statements and other documents describing the roles and responsibilities of certain groups and sub-groups at CMS,[1] as well as overviews of various HHS processes.[2]

While we have not yet produced documents from the CDC, we are actively working to collect, review, and produce these documents. In our March 10, 2023 email, we stated that we anticipate completing our production of documents responsive to the November 2022 agreement by mid-June; this will include relevant documents from the CDC. We further note that the recent production by the AHA in response to Kaiser's third-party subpoena contains much of the same information that Kaiser now seeks from the United States. The AHA production includes agendas and minutes from the Coding Clinic's Editorial Advisory Board Meetings for each year from 2000-2022. These agendas identify the individuals at the CDC who participated in these meetings and sat on the Board. Thus, even without our production, Kaiser is able to identify individuals at the CDC likely to have information responsive to Kaiser's current discovery requests, undercutting Kaiser's stated need for a "foundational" Rule 30(b)(6) deposition.

Finally, Kaiser claims that we "agreed" to produce documents in response to the Second Set of RFPs in 30 days. That is not correct. Kaiser served the Second Set of RFPs on December 15, 2022 (over a month-and-a-half after the Rule 30(b)(6) meet and confer) and the United States responded with Responses & Objections ("R&Os") 30 days later, as required. We objected to

[1] *See, e.g.*, US-DOJ-KAISER-00065160; US-DOJ-KAISER-00067249; US-DOJ-KAISER-00051007.

[2] *See, e.*g., US-DOJ-KAISER-00049881; US-DOJ-KAISER-00064913; US-DOJ-KAISER-00053387.

various aspects of the 19 RFPs, which sought documents related to 70 different and often irrelevant Standards, and offered a number of compromises. We have not heard back from Kaiser or had any conversations about the scope of the 19 RFPs. Please confirm whether we are now in agreement on our proposed responses to the 19 RFPs, as described in our R&Os.

* * * * * *

We look forward to the March 20 meet and confer to discuss these issues. In order to have a productive conversation, it would be helpful to better understand what will be discussed at the meet and confer. Specifically, please clarify in advance whether the discussion will be limited to Kaiser's proposed motion for leave to take two Rule 30(b)(6) depositions or also include other topics, such as Kaiser's Second Set of RFPs. If it will include other topics, such as Kaiser's Second Set of RFPs, please send us a list of the specific items you would like to discuss.

Sincerely,

Laurie A. Oberembt

Laurie A. Oberembt
Senior Trial Counsel

Cc: Assistant U.S. Attorney Shiwon Choe (N.D. Cal.)
Assistant U.S. Attorney David Moskowitz (D. Colo.)
Assistant U.S. Attorney David DeVito (N.D. Cal.)