Risk Adjustment in Medicare Advantage Program and Beyond

Understand the Impacts of Hierarchical Condition Category (HCC) and Risk Adjustment Factor (RAF)

Fall Summit – November 12th, 2015

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Learning Objectives

- Understand HCC and RAF, HCC risk scoring methodology and their impacts on Medicare Advantage and other programs
- Appreciate the importance of physician documentation, coding and risk scoring on reimbursement
- Realize the necessity of integration of HCC risk adjustment with scheduling, contracting, HIM, EHRs, and clinical operations
- Identify and implement actionable decision supporting tools for monitor and enhance your organization’s HCC and RAF performance
- Be aware of the Certification of Monthly Enrollment and Payment Data, and succeed in mandatory compliance Medicare RADV audits for HCC/RAF
Table of Contents

I. Introduction to Medicare Advantage

II. Risk Adjustment – HCC and RAF

III. Requirements for Success
   a. Documentation and Coding
   b. Resources – knowledge experts and decision support tools
Not Just Medicare Advantage
Programs using HCC for Risk Adjustment

Medicare
  • Medicare Advantage
  • Medicare via the Value Based Modifier in 2015 and 2016
  • Medicare Shared Savings Plans – use year 2 risk adjustment for years 4-6 targets

Managed Medicaid Plans

Exchange Plans
I. Introduction to Medicare Advantage
Medicare Part A, B, C & D

- **Part A**
  - IP hospital, IP SNF care, IP care in religious non-medical healthcare facility, home health, and hospice

- **Part B**
  - Doctor services, office visits, screenings, therapies, preventive services, OP hospital, emergency care, ambulance, medical/surgical supplies, and durable medical equipment

- **Part C – Medicare Advantage**
  - A managed care plan includes Part A & B services
  - Additional services

- **Part D**
  - Pharmacy benefits
  - Includes plans with varying out-of-pocket expenses
# Medicare Advantage Product Types

<table>
<thead>
<tr>
<th>HMO</th>
<th>PPO</th>
<th>PFFS</th>
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</table>
| • Requires use of network providers, with exception of Emergency and Urgent Care | • Choice of network and non-network providers  
• Higher out-of-pocket expenses for non-network services | • No network requirements  
• Providers are “deemed”  
• Deemed providers must accept plan and reimbursement terms |
Figure 1
Medicare Advantage Market Share of Five Firms Reported to Be Discussing Mergers

Total Medicare Advantage Enrollment, 2015 = 16.8 Million

NOTE: BlueCross BlueShield excludes Blue Cross and Blue Shield plans operated by Anthem.
Medicare Advantage Projected Growth

What is the future outlook for Medicare Advantage?

Actual and projected enrollment (in millions)

- Actual
- Projected


2013 Enrollment Projections

CBO

OACT

2010 Enrollment Projections (Post-ACA)

NOTE: CBO is Congressional Budget Office; OACT is CMS Office of the Actuary.
Medicare Beneficiaries as a Percent of Total Population

Source: The Henry J. Kaiser Family Foundation, 2012
http://kff.org/medicare/state-indicator/medicare-beneficiaries-as-of-total-pop
Medicare Advantage Enrollees as a Percent of Total Medicare Population

Source: The Henry J. Kaiser Family Foundation, 2015
http://kff.org/medicare/state-indicator/enrollees-as-a-of-total-medicare-population/

IL - 18%
Roadmap to Risk

Healthcare organizations must prepare for an increase in financial risk.

Change in Reimbursement Structure
Physician Reimbursement Evolution

Reimbursement
- Volume-based Fee For Service
- Value-Based FFS + Quality Incentives

Clinical Documentation
- Audit
- Audit, Care Coordination, Risk Factor

Billing and Collection
- Procedures CPTs
- Procedures + Diagnosis CPTs + ICDs

Financial Management
- Revenue and data reporting
- Active Management of population data and optimize revenue incentives
II. Risk Adjustment – HCC and RAF
Risk Adjustment Background

Prior to 2003
- Payments to health plan were based on demographics – gender, age, county, etc.

2003
- Medicare Risk Adjustment (MRA) was established in 2003
- Mandated by the Balanced Budget Act of 1997
- Phased in over a five year period
Risks Adjustment

- CMS-HCC (Hierarchical Condition Category) model used to measuring “Risk Adjustment”
- The HCC model accounts for differences in expected health costs of individual patients
- Enrollees’ demographic characteristics and prior year diagnoses (HCC) are used to prospectively predict
  - Medicare Part C “capitation” payments
  - Medicare Part A and Part B fee-for-service RAF scores
Demographic Characteristics

- 24 age-sex criteria
  - male age 80-84
- Medicaid dual eligible status
  - By sex and aged vs. disabled entitlement
- Disabled status
  - Current disabled:
    - Separate age/sex and Medicaid factors
    - Selected diagnoses have different risk weights
  - Current aged, originally entitled to Medicare by disability
    - Separate factor by sex
Hierarchical Condition Category (HCC)

- A group of ICD-9/10 diagnosis codes map to a corresponding category of chronic conditions.
- The diagnoses within each category are clinically related in terms of cost to the Medicare program.
- Diagnoses codes **must** be from Medicare-approved facilities and providers.
  - Hospital Inpatient and Outpatient
  - Physician
  - Clinically-trained non-physician, e.g. clinical psychologist
- Each condition **must** be reported once per calendar year.
HCC and ICD Mapping

18,000 ICD-9 Codes
3,000 Assigned to HCC
87 HCCs

141,000 ICD-10 Codes
8,600 Assigned to HCC
87 HCCs
**HCC Groupings**

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<th>ICD-9 Description</th>
<th>CMS-HCC Model Category</th>
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<td>4561</td>
<td>Esophag Varies W/O Bleed</td>
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<td>45620</td>
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<td>45621</td>
<td>Esoph Var Oth Dis Nos</td>
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<td>5724</td>
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<td>5728</td>
<td>Other Sequela, Chr Liv Dis</td>
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<tr>
<td>5712</td>
<td>Alcohol Cirrhosis Liver</td>
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<tr>
<td>5713</td>
<td>Alcohol Liver Damage Nos</td>
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<td>5715</td>
<td>Cirrhosis of Liver Nos</td>
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<td>5716</td>
<td>Biliary Cirrhosis</td>
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**Severity**

The most severe diagnosis within each HCC, each diagnosis should be specifically documented and addressed.

**Additive**

Based on the sum of all Chronic Conditions in different HCCs.

**Interactivity**

Some diagnoses also include interactive factor, i.e. COPD+CHF, diabetes+CHF.
A final scoring calculation is assigned to a patient to assess risk,

- “Capitation” payment is calculated for Part C
- Value measurement for Part A and Part B

RAF = CMS approved base rate + HCCs + factors associated with member’s demographics
Progress Note:

80-year old morbidly obese female seen today for chronic cough with COPD, diagnosed with Peripheral Vascular Disease (PVD) in 2011

- Morbid Obesity discussed weight lose program, patient would like to start Weight Watchers, BMI of 43
- PVD with diminished pulses legs and feet, continue Coumadin
- COPD on home oxygen

<table>
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<tr>
<th>HCC</th>
<th>HCC Category</th>
<th>Risk Score</th>
<th>Payment</th>
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<td>Female, age 80-84</td>
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<td>111</td>
<td>Chronic Obstructive Pulmonary Disease</td>
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<td>108</td>
<td>Vascular Disease</td>
<td>.299</td>
<td>$3,100.00</td>
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<td>22</td>
<td>Morbid Obesity</td>
<td>.355</td>
<td>$3,800.00</td>
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<td><strong>Total</strong></td>
<td><strong>1.358</strong></td>
<td><strong>$14,700.00</strong></td>
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</table>

Payments based on northern California rates and rounded to the nearest hundredth
Why Take Risk?

True or False?

• My organization has contracts to manage Medicare Advantage patients, but we don’t have to worry about risk because we are paid fee-for-service?

False
Why Take Risk?

*Why take risk when the providers are reimbursed fee-for-service?*

The Obama administration unveiled a plan to control health costs by moving the $2.9 trillion U.S. health systems away from costly fee-for-service medicine, beginning with the Medicare program for the elderly and disabled.

**2015** - About **20%** of Medicare payments, $72 billion, currently go to providers with cost-saving business models.

**End of 2016** - The administration's goals would be phased in by first increasing the participation of alternative care models to **30%** of Medicare payments.

**End of 2018** - Health and Human Services Secretary Sylvia Burwell proposed that **50%** of traditional Medicare annual payments would go to providers that participate in payment models which emphasize cost containment and quality of care.
Chronic Conditions

Two thirds of Medicare Beneficiaries have multiple chronic conditions

- 32% have 0 - 1 chronic conditions
- 32% have 2 - 3 chronic conditions
- 23% have 4 - 5 chronic conditions
- 14% have 6+ chronic conditions

Percentage of Medicare FFS Beneficiaries by Number of Physician Office Visits and Number of Chronic Conditions: 2010

- 3 chronic conditions, 6 visits/year

- 16% of All FFS Beneficiaries
- 34% of 0 to 1 visits
- 7% of 2 to 3 visits
- 7% of 4 to 5 visits
- 8% of 6+ visits

30% of All FFS Beneficiaries have 3 chronic conditions and visit 1 to 5 times per year.
Risk Reimbursement

Medicare Advantage Enrollee Reimbursement *“Ballpark Math”*

Medicare pays $16,000 (approximation for illustration purpose only) per year for a 80-year old female with 3 HCCs.

Assume a scenario in which insurance, hospital and physician group entered into a contract to manage the health of this enrollee.
Fee-for-Service vs. Risk Reimbursement

For Illustration Only:
**99213: Level-3 office visit**

- Part B fee schedule - $72.81
- Provider contract – 103% of Medicare fee schedule - $75.00
III. Requirements for Success
   a. Documentation and Coding
   b. Resources – knowledge experts and decision support tools
Foundation of Success

- Actionable Decision Support Tools
- Clear Strategic Vision
- Contract Management
- Active Financial Management
- Supportive Leadership
- Integrated EHR
- HCC Certified Coders/Auditors
- Education & Training
- Engaged Providers
- IT Support
Encounter data—CMS oversight of data integrity

We will review the extent to which **MA encounter data reflecting the items and services provided to MA plan enrollees are complete and consistent** and are verified for accuracy by CMS...
Challenges for Providers

- Not familiar with ICD-9/10 requirements
- Not familiar with CMS coding guidelines
- 60% of the time providers choose incorrect diagnosis codes
- Providers miss more than 40% of active HCC conditions
- 30% of submitted HCC codes will not pass Medicare’s validation process because of insufficient documentation

**CMS recommends 95% provider documentation accuracy.**
Chronic Conditions should be:
- Documented in your encounter
- Include a statement regarding the status or plan
- Captured in the billing portion of your encounter

When Chronic Conditions are addressed documented, and captured in your encounter:
- Patients receive better care
- Reimbursement supports care provided
- Regulatory compliance and guidelines are met
HCC data is pulled from diagnosis data and reported on claims from physician offices, hospital, and outpatient settings

- Excluded data source from SNF, Dialysis, Hospice, Clinical Lab, Diagnostic Radiology, Ambulance, DME

Must be the result of a face-to-face visit, and include any coexisting conditions.

Must be performed by a Medicare approved provider

- MD, DO, DPM, DC, OD, NP, PA, LCSW, CNS, Nurse-midwives
Medical Record Requirements

- Encounter **must** be based on a face-to-face visit, and submitted at least once per year
- ICD-9/10 code can be assigned to each condition documented on the record
- Documentation **must** show that condition was monitored, evaluated, assessed or treated (MEAT)
- Physician’s signature, credentials and DOS **must** appear on the record
- Patient’s name and DOS **must** appear on all pages of the record (hardcopy audit support documentation are requested by CMS)
Coding Guidelines

- Medical record must support codes reported on the claim or encounter form
- Provider should document and code to the highest level of specificity
- Provider must report all diagnoses, and not just primary diagnosis that impact the patient’s MEAT (how many diagnosis codes does your EHR system submit?)
Does your organization have the resources required to track and trend HCC status and present actionable reporting?

- Are the reports “real-time”, or from last quarter?
- Do the reports have the flexibility to both summarize based organizational structure, i.e. location, group, division, etc., and drill down to patient level?
- Capability to pinpoint areas of improvements and monitor progress?
Does your organization have the resources required to convert ICD 9/10 codes into HCC and RAF calculations resulting in anticipated reimbursements?
## Integrated Healthcare Medical Foundation

### HCC/RAF Dashboard

#### HCC Capture Rate YTD through Nov 2015
85% CY 2015 Goal

<table>
<thead>
<tr>
<th>Division</th>
<th>Total HCC’s</th>
<th>HCC’s Captured</th>
<th>HCC Capture Rate</th>
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<tr>
<td>North</td>
<td>964</td>
<td>867</td>
<td>89.94%</td>
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<tr>
<td>South</td>
<td>5,858</td>
<td>4,814</td>
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<tr>
<td>East</td>
<td>3,582</td>
<td>3,055</td>
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<tr>
<td>West</td>
<td>1,691</td>
<td>1,429</td>
<td>84.51%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12,095</strong></td>
<td><strong>10,165</strong></td>
<td><strong>84.04%</strong></td>
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</table>

#### Data Mining New HCC’s

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Identified</th>
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<tbody>
<tr>
<td>Chronic Kidney Disease, Severe (Stage 4)</td>
<td>24</td>
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<tr>
<td>Chronic Kidney Disease, Stage 5</td>
<td>0</td>
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<tr>
<td>Coagulation Defects and Other Specified Hematological Disorders</td>
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<td>Diabetes with Chronic Complications</td>
<td>115</td>
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<td>Morbid Obesity</td>
<td>40</td>
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<tr>
<td>Rheumatoid Arthritis and Inflammatory Connective Tissue Disease</td>
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<tr>
<td>Vascular Disease</td>
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</table>

#### Division Avg. RAF HCC

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<th>Division</th>
<th>Avg. HCC</th>
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<td>0.438</td>
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<td>0.332</td>
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#### Clinician Opportunity

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<th>Clinician Opportunity</th>
<th>Div.</th>
<th>#Pats</th>
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<td>Baker MD, Robert</td>
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<td>Welby MD, Robert</td>
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<td>Godard MD, James</td>
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</table>

#### Monthly Average HCC RAF Score

![Monthly Average HCC RAF Score Chart](image)

#### Monthly Patients With HCC Rate

![Monthly Patients With HCC Rate Chart](image)

#### HCC Monthly Recapture Rate

![HCC Monthly Recapture Rate Chart](image)
### Patient Summary

<table>
<thead>
<tr>
<th>Div.</th>
<th>Provider name</th>
<th>Total Patient Count</th>
<th>Number of Patients with no Encounter HCC's</th>
<th>Number of Patients with no Problem List HCC's</th>
<th>Percent of Patients with no Encounter HCC's</th>
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**DIVISION SUMMARY**

| Total | 597 | 284 | 217 | 60.00% |

### Diagnosis Summary

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<th>DX Code</th>
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<th>HCC Version</th>
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<td>FOLLOW-UP EXAMINATION FOLLOWING UNSPECIFIED SURGERY</td>
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<td>V17.00</td>
<td>ROUTINE MEDICAL EXAM</td>
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Auditing Resource Requirements

Does your organization have the tools to track all your compliance activity?
CEOs and CFOs responsible for Medicare Advantage plans must certify monthly that the data submitted is accurate and complete.

TO: ALL Medicare Advantage Organizations and Demonstrations, PACE Organizations and Part D Plans

SUBJECT: CERTIFICATION OF MONTHLY ENROLLMENT AND PAYMENT DATA

Under the Medicare Advantage (MA) program requirements (42 CFR 422.502(l)), MA organizations must submit monthly attestations of enrollment information related to payment from the Centers for Medicare and Medicaid Services (CMS). This requirement is also described in the MA coordinated care plan (CCP) contract, which all participating MA organizations offering such a plan have signed. The requirement for Part D Plans to submit the monthly attestation of the enrollment information related to payment from the CMS is included in the Medicare Prescription Drug Benefit program requirements (42 CFR 423.505(k)(2)).
CMS uses RADV audits to validate the accuracy of HCCs submitted by MA health plans. This validation occurs after data has been submitted to CMS and *payments have been made*. Starting with the 2011 RADV audit, CMS will apply the results of the audit to the revenue for *all* members on the contract, not just the ones in the audit sample.

Providers that have submitted HCCs for Medicare Part C beneficiaries and whose names appear on a RADV audit are required by CMS to participate in the audit.

Record must document that the condition was monitored, evaluated, addressed/assessed or treated.
Discussion

Improving the Health of Populations
Contact Information

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(408) 300 - 8596
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Medicare Advantage Organizations and Demonstrations, PACE Organizations, and Prescription Drug Plans (PDP), (hereafter referred to as “Organizations”) are to complete and submit the attached form, “Certification of Monthly Enrollment and Payment Data”, to CMS each month. In this form the Organization certifies, through the signature of its chief executive officer (CEO) or chief financial officer (CFO) or an individual delegated with the authority to sign on behalf of one of these officers and who reports directly to such officer, that, based on best knowledge, information, and belief, the enrollment information submitted to CMS is accurate, complete, and truthful. In addition, this certifies that the items submitted by the Organizations are accurately reflected in the reports provided by CMS and that those which are not accurate have been submitted to the CMS’ Retroactive Adjustment Processing Contractor for correction.

CMS provides the following information to assist Organizations in complying with the monthly enrollment certification requirements.

Certification of Data Submitted by the Organization: Item 1 of the “Certification of Monthly Enrollment and Payment Data” requires the Organization to certify the accuracy of new data that the Organization has submitted to CMS. This includes new enrollments, disenrollments, including changes in Plan Benefit Packages, as well as those beneficiaries who have met the qualifying institutional period or Medicaid coverage periods, as appropriate.

Certification of Information from CMS Reports: Item 2 of the “Certification of Monthly Enrollment and Payment Data” requires the organization to certify the accuracy of CMS’
monthly reports including the Monthly Membership Detail and Transaction Reply Report. To comply with the requirement of Item 2, the Organization must review these reports and document any discrepancies it finds between the report and the Organization’s records. Organizations will follow the existing procedures for submitting corrections of discrepancies to IntegriGuard following the procedures for retroactive adjustments.

*Organizations should not send retroactive adjustments with the certification form as they will not be processed.*

**Multiple Plans:** Organizations offering multiple contracts are to submit one form for all plans combined. The organization must indicate in the appropriate space the contract numbers (H numbers, R numbers and/or S numbers) which the Organization offers and for which the Organization is certifying.

**Timing:** The “Certification of Monthly Enrollment and Payment Data” requires the MA organization’s CEO/CFO to attest to the accuracy, completeness, and truthfulness of two types of enrollment information: 1) the data the Organization has reported to CMS in a given month and 2) the data contained in CMS’ monthly membership report. Organizations must notify CMS of any request for corrections within 45 days of the date the report becomes available to the Organization. Therefore, the certification for each month’s data will be due to CMS within 45 days of the date the reports become available for that month’s data. For example the certification of data in the February 1 payment is due on March 13, 2006. This is 45 days after the monthly reports for the February 1 payments were available, which was January 25, 2006.

The schedule for Organizations to submit certification of Monthly Enrollment and Payment data is included on the MARx Monthly Schedule for each calendar year (For example: the MARx Schedule shows “Attestation due on February 6, 2006, and states that ”Certification of Enrollment for December 22, 2005 report”. Any delay in the posting of the Monthly report will result in CMS adjusting the certification form due date accordingly.

**Mailing Address / Point of Contact:** Please send completed enrollment certification forms to:

IntegriGuard  
Attn: Attestations  
2121 North 117th Avenue, Suite 200  
Omaha, Nebraska 68114  
Phone: 402-955-2781

Please direct questions about this process to your Division of Payment Operations Representative per Appendix B of the Plan Communications User’s Guide.
CERTIFICATION OF MONTHLY ENROLLMENT AND PAYMENT DATA

Pursuant to the contract(s) between the Centers for Medicare and Medicaid Services (CMS), and ______________________________ (name of Medicare Advantage Organizations and Demonstrations, PACE Organizations, Medicare Part D Organizations and PACE Organizations (hereafter referred to as Organizations) governing the operation of the following contracts _____________________________ (H number, R number and or S number), the Organization hereby requests payment under the contract, and in doing so, makes the following certifications concerning CMS payments to the Organization.

The Organization acknowledges that the information described below directly affects the calculation of CMS payments to the Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution. This certification shall not be considered a waiver of the Organization’s right to seek payment adjustments from CMS based on information or data which does not become available until after the date the Organization submits this certification.

1. The Organization has reported to CMS for applications received in the month of __________________ (month and year) all new enrollments and disenrollments, as well as those beneficiaries who have met the qualifying institutional period and Medicaid period with respect to the above-stated Organizations. Based on best knowledge, information, and belief, all information submitted to CMS in this report is accurate, complete, and truthful.

2. The Organization has reviewed the CMS monthly membership report and transaction reply listing for the month of __________________ (month and year) for the above-stated Organizations and has submitted requests to IntegriGuard, under separate cover, for retroactive adjustments to correct payment data when the Organization has more accurate information. This may include enrollment status, Institutional status, Medicaid status, and State and County Code related to a specific beneficiary. Based on best knowledge, information, and belief, all information submitted to CMS or IntegriGuard is accurate, complete, and truthful.

In addition, for those portions of the monthly membership report and the reply listing to which the Organization raises no objection, the Organization, through the certifying CEO/CFO, will be deemed to have attested, based on best knowledge, information, and belief, to their accuracy, completeness, and truthfulness.

________________________________________
NAME:
TITLE:
On behalf of ________________________________
(Organization)