2007/08 Risk Adjustment User Group

March 2008 Questions & Answers

Date: March 12, 2008

Payment Issues

Payment Models

1. Q: Is the effective date October 1 or January 1 for diagnoses added to the payment model?

   A: The effective date for diagnoses added to the model is October 1.

2. Q: Where is the formula for calculating the risk scores for payment located?

   A: CMS makes available a free SAS software program on the CMS website at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage. The plans supply demographic and diagnosis information for each beneficiary and the software calculates the scores. Plans can also find the coefficients for the model in the annual payment notices.

3. Q: How do plans manually calculate the risk adjustment factors for the RxHCC model in order to tie to the factors provided on the MMR?

   A: If the plan wishes to validate its Part D score:

   1) Calculate the Part D risk score

   2) Multiply the result by the Long-Term Institutional (LTI) or Low Income Subsidy (LIS) multiplier, if appropriate

   3) Divide by the Part D Normalization Factor for 2008.

4. Q: Does CMS keep the valid diagnoses not included in the payment calculation of the model to track trends to determine if they fall into a category?

   A: Yes, the diagnoses are stored in the risk adjustment processing system database. CMS does not tell plans whether to submit only relevant diagnoses (those included in the model for calculation of payment) or all valid diagnoses. The model includes two sets of required diagnoses, diagnoses that CMS requires to create a history to determine impacts and to make changes to the system, and diagnoses that are required for one of the payment models; CMS-HCC, ESRD, or RxHCC.

5. Q: What is the schedule for implementing ICD-10?

   A: CMS anticipates implementing ICD-10 coding in 2011 or 2012.

6. Q: Can plans see the diagnoses stored and model stored counts at the payment calculation website?

   A: No. Plans may review their stored and model stored diagnoses counts on their RAPS Return File. Please be aware that if the diagnosis is valid, but not relevant to the model, a 501 informational error will appear on the return file.

Submission Schedules

1. Q: Is the data collection period June 20, 2007 through July 1, 2008 or June 30, 2007 through July 1, 2008?

   A: The data collection period begins with June 30, 2007 and is through July 1, 2008.

2. Q: Do you know whom to contact for information about the status of the rescheduled reconciliation for Social HMOs?

   A: Contact Henry Bachofer in ODI at henry.bachofer@cms.hhs.gov.

3. Q: Is there a different submission deadline for ESRD data?
   A: The submission deadline for data for the Part C ESRD model data is the same as for the Part C CMS-HCC and Part D RxHCC models.

4. Q: Please clarify if data submitted after the submission deadline and prior to the sweep date is included in the sweep.
   A: Yes. Typically, the sweep date is 2 weeks after the deadline and will include data submitted until that time. However, the sweep date is an arbitrary date that is set based on CMS operational necessity and is subject to change if the CMS data center needs to process the data earlier than originally scheduled in order to make the payment adjustments on time. Therefore, plans should submit data according to the deadlines on the published submission schedule to ensure that the data is included.

Data Submission

1. Q: Can plans submit valid diagnoses from a denied or unpaid claim?
   A: If the diagnosis is from an acceptable data source and the medical record documentation supports the diagnosis, the plan can submit the data.

Reports

1. Q: Will an adjustment code appear on the Monthly Membership Report (MMR) for the ESRD 2005 payment?
   A: Yes, an Adjustment Reason Code 25 (Part C Risk Adjustment Factor Change/Recon) will appear in the adjustment field on the report.

2. Q: What does a blank in the risk adjuster type code on the MMR indicate for a beneficiary?

A: The primary reason is that a beneficiary is a new enrollee and will receive the default new enrollee factor; the MMR may show a “Y” or a “1” indicating a default factor for a new enrollee. Other possible explanations are the reporting of reconciliation may cause the factor not to appear in the field or when a beneficiary moves from the CMS-HCC model to the ESRD model.