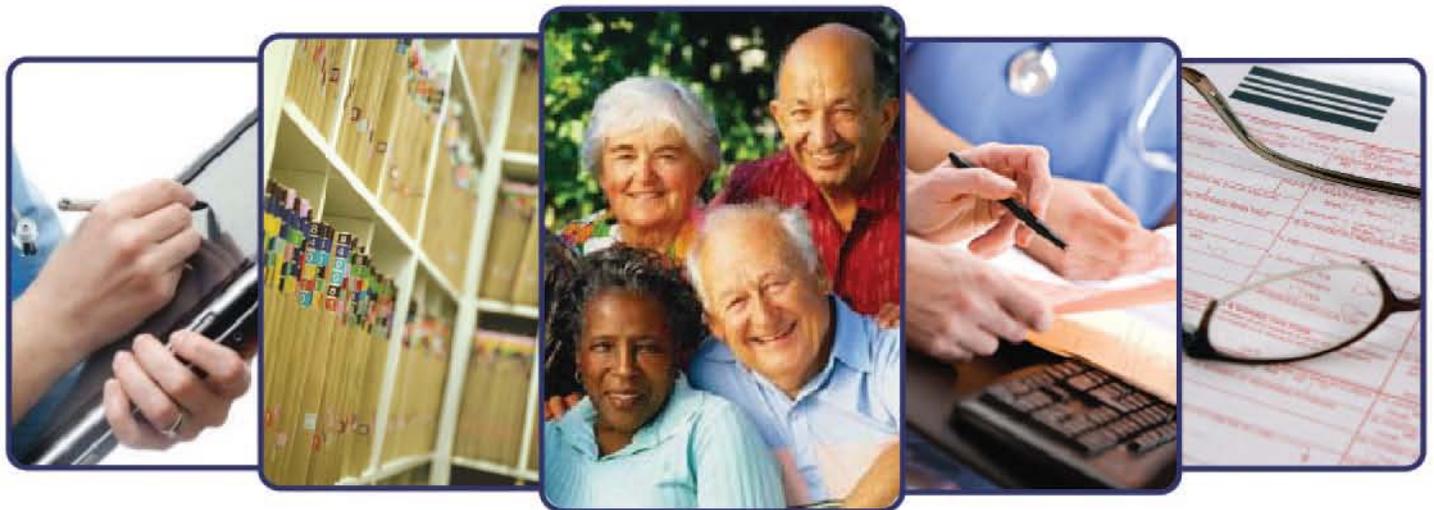


CMS

CENTERS for MEDICARE & MEDICAID SERVICES



Risk Adjustment Slide Presentations

2011 Regional IT Technical Assistance





2011 Regional IT Technical Assistance Risk Adjustment



Purpose

To provide participants with an understanding of changes to risk adjustment payment methodology, preparing your systems for changes to RAPS submissions, and reconciling your risk adjustment payment.

Technical Assistance Tools

- DRAFT Managed Care Manual Chapter 7- Risk Adjustment
 - On USB Provided
- PowerPoint Slides
 - Hard Copies Provided
- Job Aids
- Q & A Cards



Practice Example



Select your response to this question.
Today's training is located in?

1. Orlando
2. San Diego
3. Chicago
4. Not sure where I am or how I got here

Agenda Topics

Introduction

Risk Adjustment Methodology

RAPS ICD-10 Compliant Layout

Risk Adjustment Payment Reconciliation

Question and Answer Session

The session includes one 15-minute morning break.

Learning Objectives

- Understand risk adjustment methodology
- Review new RAPS Layout
- Apply the top ten risk adjustment payment tips
- Reconcile risk adjustment scores using reports

Common Terms

- FERAS
- RAPS
- MBD
- MARx
- RAS
- HPMS
- Common UI
- Relevant Diagnosis

Technical Assistance and Support



**Customer Service and Support
Center**

www.csscooperations.com

Risk Adjustment Payment Portal

www.askriskadjustment.com

**Technical Assistance Registration
Service Center**

www.tarsc.info



2011 Regional IT Technical Assistance Risk Adjustment



Objectives

- What is risk adjustment?
- How does CMS calculate risk scores?
- Why does it matter to health plans?

What is Risk Adjustment?

- Adjusts payment to health plans based on the expected health care costs of their enrollees
- Prospective
- Based on an individual's:
 - Diagnoses
 - Demographics
- Promotes access and reduces adverse selection

How the Model Works:

Introduction

- Uses diagnoses from the previous year and demographic information (e.g., age, gender, Medicaid status) to predict future costs
- Site neutral - e.g., inpatient and outpatient hospital costs are equally weighted
- Follows a set of core principles

What Is A 1.0 Risk Score?

- A 1.0 risk score represents average annual Medicare costs for an individual of \$7,463.14
- A risk score higher than 1.0 means the individual is likely to incur costs higher than \$7,463.14
- A risk score less than 1.0 means the individual will incur costs less than \$7,463.14

Meaning of Risk Scores

Examples:

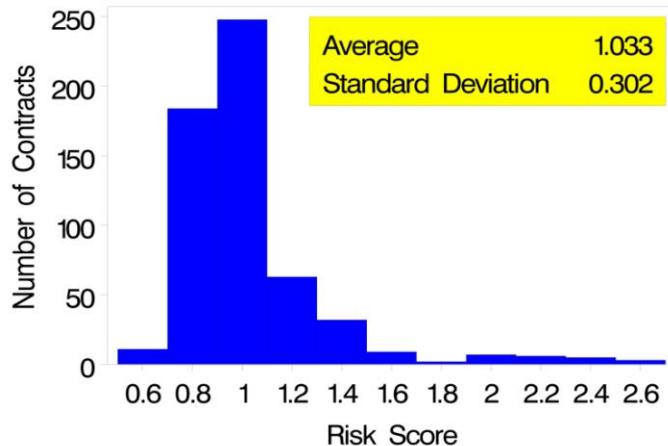
Average risk score of 1.0 means expected costs of \$7,463.14

Average risk score of 1.5 means expected costs of \$11,194.71 = \$ 7,463.14 * 1.5
(e.g. 50% more expensive than average)

Average risk score of 0.8 means expected costs of \$5,970.51 = \$ 7,463.14 * 0.8
(e.g., 20% less expensive than average)

What is Risk Adjustment?

Distribution of Risk Scores, June 2010



How the Model Works:

Disease and Demographic Groups

- Statistical model that measures incremental predicted costs associated with a person's age, gender, and diseases
- Predicted costs are heavily impacted by costs associated with chronic diseases
- Additive

How the Model Works: Hierarchies and Disease Interactions

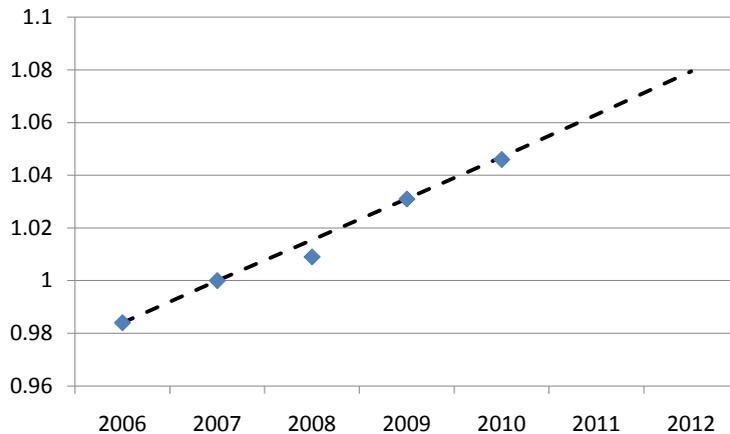
- Hierarchies
 - Address multiple levels of severity for a disease
 - Payment based on most severe manifestation of disease when less severe manifestations are also present
- Disease interactions
 - Model captures the combined effect of multiple unrelated conditions
 - Combined costs of two chronic diseases are greater than the sum of their individual costs

How the Model Works: Normalization

- Adjusts for growth in population trends diagnostic coding between model estimation and payment year
- Best thought of as an adjustment to the model denominator
 - Model denominator uses 2006 demographic data and diagnoses to predict 2007 costs
 - Model denominator must be estimated for 2012 costs in order to pay in 2012

Normalization Factor Calculation

Dotted Line Shows Projection to 2012



How the Model Works: MA Coding Differences Adjustment

- MA plan providers code differently than FFS providers
- MA plan risk scores increase faster than FFS risk scores
- MA coding adjustment goal to maintain MA risk scores at the level they would be if MA plans coded similarly to FFS providers (not necessarily a 1.0 average)

Part C Risk Adjuster Calculation: Example 1

	Payment Increment	Relative Factor
<u>Demographics:</u>		
Male, age 82, resides in community	\$4,455.49	0.597
<u>Diagnoses:</u>		
Diabetes w/o complications (HCC 19)	\$1,209.03	0.162
COPD (HCC 108)	\$2,977.79	0.399
Total Annual Pred. Spending	\$8,642.32	1.158
<u>Adjustments</u>		
Normalization factor (1.158/1.079)		1.073
Coding intensity (1.073*(1-0.0341))		1.036
Payment Risk Score		1.036

Part C Risk Adjuster Calculation: Example 2, Application of Hierarchy

	Payment Increment	Relative Factor
<u>Demographics:</u>		
Male, age 82, resides in community	\$4,455.49	0.597
Medicaid	\$1,238.88	0.166
<u>Diagnoses:</u>		
Diabetes w/complications (HCC 17)	\$2,530.00	0.339
Diabetes w/o complications (HCC 19)	-----	-----
COPD (HCC 108)	\$2,977.79	0.399
Total Annual Pred. Spending	\$9,963.28	1.501
<u>Adjustments</u>		
Normalization factor (1.501/1.079)		1.391
Coding intensity (1.391*(1-0.0341))		1.344
Payment Risk Score		1.344

Part C Risk Adjuster Calculation: Example 3, Disease Interaction (CHF and Diabetes)

	Payment Increment	Relative Factor
<u>Demographics:</u>		
Female, age 77, resides in community	\$3,410.65	0.457
<u>Diagnoses:</u>		
Diabetes w/complications (HCC 17)	\$2,530.00	0.339
CHF (HCC 80)	\$3,059.89	0.410
Diabetes & CHF Interaction	\$1,149.82	0.154
Total Annual Pred. Spending	\$10,150.36	1.360
<u>Adjustments</u>		
Normalization factor (1.360/1.079)		1.260
Coding intensity (1.260*(1-0.0341))		1.217
Payment Risk Score		1.217

Why Should We Care?

- Used to put all plans on the same footing
 - Standardize bids
 - Standardize rate book
- To pay plans accurately for the expected health care costs of the beneficiaries they enroll
- Pay appropriate and accurate payments for subpopulations with significant cost differences

Risk Adjustment in Bidding

- Plan derived costs for benefit package = \$1,000
- Plan estimated risk score for population = 1.25
- Standardized plan bid = \$800 ($\$1,000/1.25$)
- Plan actual risk score based on enrollment = 1.5
- Risk adjusted plan payment = standardized plan bid * actual risk score = \$1,200 ($\$800*1.5$)

Part D Risk Adjustment Model

- Part D model predicts prescription drug expenditures
- Used in bidding and to adjust direct subsidy payments for MA and PDPs
- Similar in structure to Part C model
- More diseases than Part C model (78 RxHCCs vs. 70 CMS-HCCs)
- Average predicted spending of \$1,107

Performance of RA Models

- Measured by comparing predicted payments to actual costs
- Predictive Ratio = (Predicted/Actual)
- Predictive Ratios separately for varying risk levels - deciles
- Part D model is performing very well across all levels of risk for both Regular and Low Income Subsidy beneficiaries

Performance of Part C Model vs. Demographic Model

Chronic Disease	Ratio of Predicted to Actual Costs	
	Part C Model (age, gender and diseases)	Demographic Model (e.g., age, gender only)
Diabetes	1.000	0.700
Heart Disease	1.000	0.503
Lung Disease	1.000	0.559
Cancer	1.000	0.617

Source: RTI International, Evaluation of the CMS-HCC model, Table 3-4
http://www.cms.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp

Performance of RA Models 2012 Part C Model

Sorted by Level of Predicted Spending	Ratio of Predicted to Actual Spending
Lowest 10%	0.892
Top 10%	0.999
Top 5%	0.983
Top 1%	0.941

Source: RTI International, Evaluation of the CMS-HCC model, Table 3-2
http://www.cms.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp

Conclusions

- **Consistency**
 - CMS approach uses risk adjustment for all types of plans
- **Flexibility**
 - Provides flexibility to ensure accurate payments to MA plans and PDPs; provides ability to develop other models as needed
- **Accuracy**
 - Improves our ability to pay correctly for both high and low cost persons

Information on Risk Adjustment Models and Risk Scores

- The updated CMS-HCC model is available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage
- The Part D risk adjustment model is available at http://www.cms.hhs.gov/DrugCoverageClaimsData/02_RxClaims_PaymentRiskAdjustment.asp#TopOfPage
- Comprehensive list of required ICD-9 Codes for Part C and D risk models is available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage

Contact

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- Melissa Evans
 - melissa.evans@cms.hhs.gov

Summary

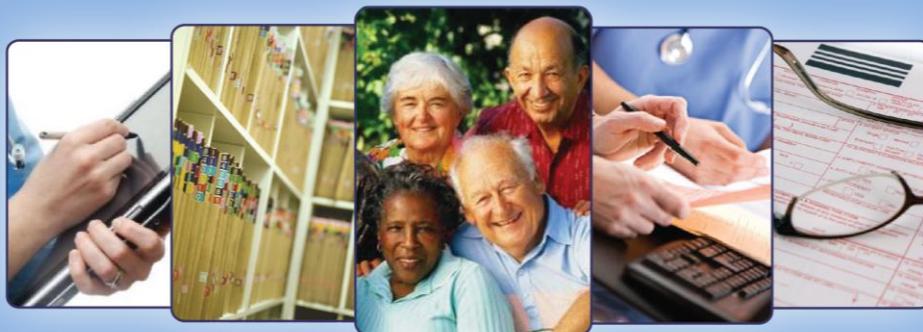
- Described risk adjustment
- Explained how CMS calculates risk scores
- Reviewed why it matters to health plans

Evaluation



Please take a moment to complete the evaluation form for the Risk Adjustment Methodology module.

Your Feedback is Important! Thank you!



2011 Regional IT Technical Assistance
Risk Adjustment



Purpose

To identify the RAPS ICD10 Compliant Layout and submission requirements to support the transition to the new RAPS layout.

Objectives

- Explain systems preparation for submission of new layout
- Examine the new RAPS ICD10 Compliant Layout
- Describe error messages associated with layout transition
- Discuss the submission of validation and production files
- Identify RAPS reports that provide plans with status of diagnosis cluster submitted
- Discuss compliance requirements

Submitter Requirements

- EDI Agreements
 - Required Signatures
- Submitter ID Application
 - Third Party Submitters
- Authorization Form

Steps in Preparing for Submitting Data

Step 1: Getting Started

Step 2: Security and Access

Step 3: Connectivity Setup

Step 4: Connectivity Testing

https://www.cms.gov/MAPDHelpDesk/downloads/PCUG_v5_3_111710_Appendices_With_Cover_Final.pdf

Final Rule 45 CFR Part 162

U.S. Department of Health and Human Services (HHS) released the final rule (45 CFR Part 162) mandating that all entities covered by the Health Insurance Portability and Accountability Act (HIPAA) must implement medical coding sets using the International Classification of Diseases, Tenth Revision (ICD10) on **October 1, 2013**

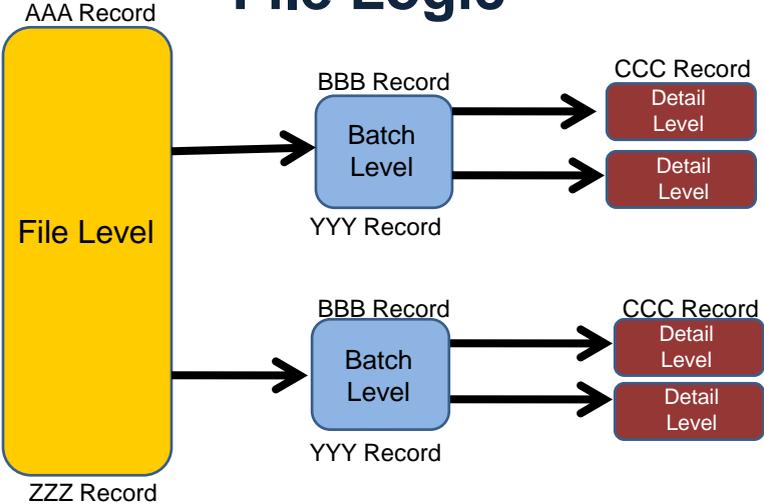
New RAPS Layout

- Changes effective January 2012
 - File Header Record Changes
 - Detail Record Changes
- Changes to RAPS error codes

Submitter Requirements for RAPS Validation Files

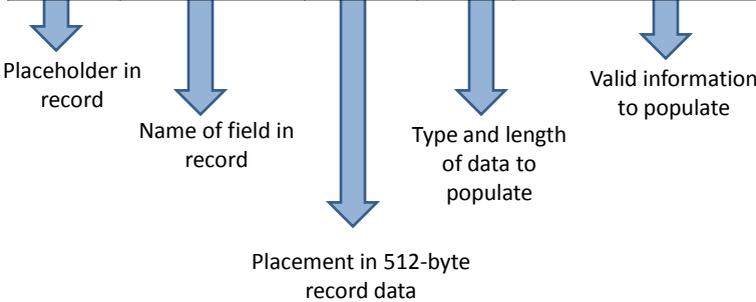
- Begin submitting test files by July 6, 2011
- All validation files submitted by September 15, 2011
- Plans should submit **no less than 10** records on a validation file
- Populate in the File Header Record
 - “Test” in field 5
 - “ICD9” in field 6

File Logic



RAPS File Layout Columns

FIELD NO	FIELD NAME	POSITION	PICTURE	VALUE
1	RECORD-ID	1-3	X(3)	'AAA'



RAPS Record Layout - AAA

File Header

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

Prior to January 2012 filler position 32-512, no File Diag-Type field

RAPS Record Layout - BBB

Batch Header

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

RAPS Record Layout - CCC

Detail Record

FIELD NO	FIELD NAME	POSITION	PICTURE	VALUE
1	RECORD-ID	1-3	X(3)	'CCC'
2	SEQUENCE NUMBER	4-10	9(7)	Must begin with '000001'
3	SEQUENCE NUMBER ERROR CODE	11-13	X(3)	SPACES
4	PATIENT CONTROL NUMBER	14-53	X(40)	Optional
5	HIC	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



RAPS Record Layout - CCC

Detail Record

FIELD NO	FIELD NAME	POSITION	PICTURE	VALUE
9-18	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)	ICD9 or ICD10
9.5	DIAG-CLSTR-ERROR-1		X(3)	SPACES
9.6	DIAG-CLSTR-ERROR-2		X(3)	SPACES
19	Corrected HICN	413 – 437	X(25)	SPACES
20	FILLER	438 - 512	X(75)	SPACES



Existing Versus New RAPS Layout CCC Detail Record

OLD FORMAT

FIELD NO	FIELD NAME	POSITION	PICTURE	VALUE
9.4	DIAGNOSIS-CODE		X(5)	ICD9
9.5	DC-FILLER		X(2)	FILLER – PLACE HOLDER FOR ICD10
9.6	DIAG-CLUSTER-ERROR 1		X(3)	SPACES
9.7	DIAG-CLUSTER-ERROR 2		X(3)	SPACES

Combined

NEW FORMAT (effective 01/2012)

FIELD NO	FIELD NAME	POSITION	PICTURE	VALUE
9.4	DIAGNOSIS-CODE		X(7)	ICD9 or ICD10
9.5	DIAG-CLUSTER-ERROR 1		X(3)	SPACES
9.6	DIAG-CLUSTER-ERROR 2		X(3)	SPACES

Renumbered



15

RAPS ICD-10 Compliant Layout

RAPS Record Layout - YYY

Batch Trailer

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



16

RAPS ICD-10 Compliant Layout

RAPS Record Layout - ZZZ

File Trailer

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

Scenario 1

Jane Doe visited her internist and was diagnosed with Chronic Obstructive Asthma (4932) and Lyme Disease (08881) on February 1, 2012.

What are you entering in field 6 of the AAA record?

1. ICD9
2. <blank>
3. ICD10

Scenario 1 (Continued)

How would you populate the diagnosis clusters?

Diagnosis Cluster 1		Diagnosis Cluster 2	
Provider Type	20	Provider Type	20
From Date	20120201	From Date	20120201
Thru Date	20120201	Thru Date	20120201
Delete Indicator	(1 space)	Delete Indicator	(1 space)
Dx Code	4932 (plus 3 spaces)	Dx Code	08881 (plus 2 spaces)
DxCluster Error-1	(3 spaces)	DxCluster Error-1	(3 spaces)
DxCluster Error-2	(3 spaces)	DxCluster Error-2	(3 spaces)

New RAPS Error Codes

- **(106)** - Missing/Invalid File-Diag-Indicator on AAA Record
- **(107)** - Submitter ID is not validated to send production data
- **(165)** - FERAS/RAPS EDI Agreement not on file
- **(177)** - ZZZ test file cannot exceed 3,000 CCC records
- **(227)** - ICD9/ICD10 file type in header does not match diagnosis code entered in detail record
- **(414)** - Service through date greater than 09/30/2013 for ICD9 diagnosis
- **(415)** - Service through date before than 10/1/2013 for ICD10 diagnosis

Scenario 2

You submitted data for beneficiary Mary Jones, 199999999A. Mary visited 2 primary care physicians, on September 1, 2013. The diagnosis codes rendered on the data collected are ICD9 codes 5733 (Hepatitis unspecified) and 2910 (alcohol withdrawal delirium).

Diagnosis Cluster 1		Diagnosis Cluster 2	
Provider Type	20	Provider Type	20
From Date	20130901	From Date	20130901
Thru Date	20130901	Thru Date	20130901
Delete Indicator	(1 space)	Delete Indicator	(1 space)
Dx Code	5733 (plus 3 spaces)	Dx Code	2910 (plus 3 spaces)
DxCluster Error-1	(3 spaces)	DxCluster Error-1	(3 spaces)
DxCluster Error-2	(3 spaces)	DxCluster Error-2	(3 spaces)

Scenario 2 (Continued)

What error code would you receive based on these diagnosis clusters?

1. 415
2. 414
3. Both
4. Neither

Submitting Diagnoses Codes

You have submitted diagnosis code 1830, malignant neoplasm of the ovary, for John Smith a 55 year old male. What error code will you receive?

1. 450
2. 453
3. 411

Deleted RAPS Error Codes

- **(166)** - Test file cannot exceed 3,000 CCC records
- **(306)** - Diagnosis code filler not equal to spaces
- **(350)** - Invalid patient-DOB on CCC record
- **(354)** - Patient DOB does not match with MBD DOB
- **(501)** - Valid diagnosis but not included in the current risk adjustment model during this service period

Scenario 3

You submitted data for beneficiary John Smith, 123456789A. John visited primary physician one on 11/10/11, and on the same day visited another physician for a second opinion, which was Salmonella Arthritis, ICD9 code 00323.

Based on this information how would you populate the fields in the RAPS File?

Scenario 3 (Continued)

Diagnosis Cluster 1		Diagnosis Cluster 2	
Provider Type	20	Provider Type	20
From Date	20111110	From Date	20111110
Thru Date	20111110	Thru Date	20111110
Delete Indicator	(1 space)	Delete Indicator	(1 space)
Dx Code	00323(plus 2 spaces)	Dx Code	00323(plus 2 spaces)
DxCluster Error-1	(3 spaces)	DxCluster Error-1	(3 spaces)
DxCluster Error-2	(3 spaces)	DxCluster Error-2	(3 spaces)

Duplicate Diagnosis Benchmark

- Duplicate diagnosis clusters share **all** of the same attributes of previously accepted and stored cluster
 - HIC Number
 - Provider Type
 - From and Through Dates
 - Diagnosis
- Error Code 502
- 5% Benchmark
- Possible Compliance Action

RAPS Transaction Reports

- RAPS Return File
- RAPS Transaction Error Summary Report
- RAPS Transaction Summary Report
- RAPS Duplicate Diagnosis Report

RAPS Transaction Reports

(Continued)

RAPS Reports	
RAPS Return File	<ul style="list-style-type: none"> • Contains the entire submitted transaction • Identifies 300-, 400-, and 500-level errors • Flat file layout • Received the next business day after submission
RAPS Transaction Error Report	<ul style="list-style-type: none"> • Communicates errors found in CCC records during processing • Displays only 300-, 400-, and 500-level error codes • Report layout • Received the next business day after submission
RAPS Transaction Summary Report	<ul style="list-style-type: none"> • Summarizes the disposition of diagnosis clusters • Report layout • Received the next business day after submission
RAPS Duplicate Diagnosis Cluster Report	<ul style="list-style-type: none"> • Identifies diagnosis clusters with 502-error message • Clusters accepted, but not stored • Report layout • Received the next business day after submission

Summary

- Explained the systems preparation for submission of new layout
- Examined the new RAPS ICD10 Compliant Layout
- Described error messages associated with layout transition
- Discussed the submission of validation and production files
- Identified RAPS reports that provide plans with status of diagnosis cluster submitted
- Discussed compliance requirements

Evaluation



Please take a moment to complete the evaluation form for the RAPS ICD-10 Compliant Layout module.

Your Feedback is Important! Thank you!



Risk Adjustment Payment Reconciliation



2011 Regional IT Technical Assistance Risk Adjustment



Purpose

To provide practical examples of payment reconciliation that allows plans a better understanding of the methods used to calculate risk scores and ultimately determine payment.



Objectives

- Identify the top ten payment calculation tips
- Illustrate the calculation of payment using practical examples
- Reconcile Model Output Report (MOR)
- Understand Monthly Membership Report (MMR) and data reported from various systems

Calculating Your Risk Scores



**Introducing the
Top Ten Tips!**

Top Ten Tips

1. Apply Normalization and Coding Intensity Factors
2. Round After Each Step
3. Understand Data Collection Period
4. Use LTI Coefficients for 90-Day or Greater Stays
5. Apply Hierarchy Logic & Interactions
6. Determine if New Enrollee or Full Risk Medicaid
7. Apply Correct Model
8. Apply Correct ESRD Phase
9. Understand LTI Trumps LI
10. Verify Payment Year and Eligibility When Reconciling Members Not Appearing on MMR

Tools Needed to Calculate Payment

- Payment Announcement that includes:
 - Demographic Factors
 - HCC Factors
 - Hierarchy Table
 - Normalization Factor
 - MA Coding Intensity Factor
- Model Diagnoses File
- Standardized Bid
- Medicare Managed Care Manual - Risk Adjustment Chapter

Steps in Calculating Payment

1. Calculate the Risk Adjustment Factor
2. Apply the Normalization and MA Coding Intensity Factors
3. Multiply a Risk Factor by Standardized Bid to determine Monthly Payment



Apply Normalization and Coding Intensity Factors

- When manually calculating the risk score, divide the raw risk score by the normalization factor and multiply by 1 minus the coding intensity factor
 - Normalization (raw risk score/normalization factor)
 - Coding Intensity (1 - Coding Intensity)
Example:
Risk Score = Raw Risk Score/1.079 (X) [1-0.0341]
- For SAS Programming
 - Default set to “1”; update to actual normalization factor (DF)



Round After Every Step

Step 1	Calculate raw risk score (round results)
Step 2	Divide raw risk score by FFS normalization factor (round results)
Step 3	Apply coding intensity (round results)



Scenario 1a

- 74-year old female
- Resides in the community
- Diagnoses submitted (4296 and 70710)
- Standardized bid = \$400
- County Intra-Service Area Adjustment (ISAR) Factor = .78
- Beneficiary premium = \$35

What is the final risk score? **1.053**

Scenario 1b

Monthly Payment

- Determine Plan-Specific County Rate (1.0 Standardized Bid x ISAR Factor)
- Multiply Plan-Specific County Rate by Risk Score
- Subtract Premium or Add Rebate

What is the total monthly payment for the beneficiary? **\$293.54**



Less than 12 Months of Medicare Part B is a New Enrollee

Rule:

- CMS identifies new enrollees as those beneficiaries that have less than 12 months of Medicare Part B enrollment during the data collection year.
- Data collection year:
 - Initial 2012 risk score is July 1, 2010 to June 30, 2011.
 - Mid-Year 2012 risk score is January 1, 2011 to December 31, 2011.
- Change in Risk Adjustment Factor Type (RAFT) Code not seen until Mid-Year model run.

Loss of Medicare Part B Coverage

- Lapse in Medicare Part B Coverage can affect
 - Full Risk Status
 - Period in New Enrollee Status
 - Identification as New Enrollee

Scenario 2

If a beneficiary turned 65 in October 2010, enrolled in Part B, and resides in the community, what would the factor code be for:

Initial 2011?

Midyear 2011?

Initial 2012?

Midyear 2012?

1. "E", "E", "E", "C"
2. "E", "C", "C", "C"
3. "E", "E", "C", "C"

Community vs. Institutional

- Short term institutionalized MA beneficiaries are included in the community population.

Community Residing

Institutional Residing

- Long-term institutionalized MA enrollees are individuals residing in a Medicare- certified nursing home for more than 90 days as identified using 90-day assessments in the Minimum Data Set (MDS).

Minimum Data Set (MDS)

- 90-Day Assessments Stored

MDS

RAS

- MDS Long Term Institutional File provides information to RAS to flag LTI

- MARx selects appropriate risk score and flag to calculate payment

MARx

LTI and MMR Fields

1. Part C LTI FLAG (field 20; position 67)
 - Institutionalized for at least 90 days as of the payment month.
 - CMS will turn on LTI for risk adjustment when a beneficiary has a reported 90-day assessment.
 - It continues to be populated until the beneficiary has a more than 14-day absence from the facility.
2. RA Factor Type Code (field 47; positions 189-90)
 - A value of "I" means that the enrollee has been institutionalized 90+ days as of the payment month.



Use LTI Coefficients for 90-day or Greater Stays

- 90-day stay is required for LTI status.
- Changing institutions does not reset the 90-day stay.
- If the transition from one facility to another is continuous or is interrupted for less than 14 days between stays, then the count continues.

Use LTI Coefficients for 90-day or Greater Stays (Continued)

Example:

A member is admitted to institution 1 on 2/2/10. On 8/3/10 the member is transferred to institution 2. The member then disenrolls from plan on 1/3/11. The member will remain LTI continuously through 1/3/11 if MDS assessments are completed every 90 days.



Apply Hierarchy Logic and Interactions

Hierarchies	If, Then – If an HCC is in a hierarchy, then the less severe HCC(s) drop off	<p>Example: HCC54 Schizophrenia HCC55 Major Depressive, Bipolar, and Paranoid Disorders</p> <p>Result: HCC55 not included in the risk score calculation because in hierarchy with HCC54</p>
Interactions	Disease and Disabled	<p>Example: HCC15 Diabetes with Renal or Peripheral Circulatory Manifestation (DM) HCC80 Congestive Heart Failure (CHF) INT1 DM_CHF</p> <p>Result: Both individual HCCs and Interaction are included in the risk score calculation</p>

Applying Hierarchies and Interactions

- Always check the hierarchy list to determine if HCCs are in a hierarchy and if any HCCs drop out of the calculation.
- After checking the hierarchy list, check the disabled and disease interactions to see if any apply.
- If interactions apply, then the beneficiary receives the individual HCCs and the interaction since the model is additive.



New Enrollee or Full Risk Determines Medicaid

- If a beneficiary has Medicaid status in the appropriate time period, the relative factor associated with Medicaid is included in the calculation of the beneficiary risk score.
- Full Risk vs. New Enrollee
 - New Enrollee beneficiaries must have a minimum of 1 month of Medicaid in the payment year.
 - Full Risk beneficiaries must have a minimum of 1 month of Medicaid in the Data Collection year (year prior to the payment year).
- Even if Medicaid appears in MARx, timing is important as to whether Medicaid applies. Medicaid must be time stamped as received in CMS systems prior to the calculation of risk scores for reconciliation in order to affect payment.

Checklist for Verifying Medicaid Status

-  Was the beneficiary full risk or a new enrollee?
-  When did the beneficiary have the Medicaid based on being full risk or a new enrollee?
 - In the payment year?
 - During the data collection year?
-  Was the Medicaid data submitted to CMS timely so that it could be included in the calculation?
-  Was the beneficiary enrolled in the plan during the payment year?



Apply the Correct Model

- CMS-HCC
 - Community, Long Term Institutional, New Enrollee
 - SAS Model - V1210F1P.sas
- CMS-ESRD
 - Dialysis (New Enrollee), Transplant, Functioning Graft
 - SAS Model - E1210D1P.sas
- RX HCC
 - Community Non-Low Income, Community Low Income, Institutional, New Enrollee LI, New Enrollee Non LI, New Enrollee Institutional
 - SAS Model - R0310I2P.sas

Apply the Correct Model

(Continued)

Example:

Jane Smith enrolled in Medicare Advantage plan Blue Moon on 12/15/09 when she turned 65. She is not disabled and does not have Medicaid. Jane was living at home until 3/10/10 when she went in to Green Garden Nursing Home. She was discharged on 5/20/10. She returned to Green Garden on 7/12/10 and was again discharged on 11/8/10. During this time, CMS received notification from MDS about her institutional status. She had to go back to Green Garden again on 11/15/10 and has remained there since. CMS has been receiving notification via MDS after each 90 day assessment.

Apply the Correct Model

(Continued)

Example (continued):

- The CMS-HCC New Enrollee Model will be used to calculate the 2010 Mid-year and 2011 Initial risk scores.
 - One full data collection year for Jane would be January to December 2010, so she is still a new enrollee during this time.
- The CMS-HCC Institutional model will be used to calculate the 2011 Mid-year risk score.
 - Based on the data collection year for Jane, the 90-day assessments, and the length of Jane's institutional stays, she would have Institutional status and be a full risk enrollee.

CMS-ESRD Model

- Model Segments
 - Dialysis
 - Transplant
 - Post-Graft/Functioning Graft
- MMR Reporting
 - Field 15, Position 62
 - “Y” following receipt of form 2728
 - Field 47, Positions 189-190
 - RAFT Assigned following Model Run



Apply Correct ESRD Phase

Consider all that apply:

- Dialysis (D)
- New Enrollee Dialysis (ED)
- New Enrollee Post Graft (E1 and E2)
- Graft (G1 and G2)
- Institutional Post Graft (I1 and I2)



LTI Trumps LI When Eligible for Both

RxHCC MODEL (2006-2010)

Multiplier	Description
LTI	<ul style="list-style-type: none">•Determined based on the payment year•90 days in institution•Factor 1.08 if beneficiary is 65 or older•Factor 1.21 if beneficiary is disabled and less than 65 years old
LIS	<ul style="list-style-type: none">•Determined during the payment year•Full subsidy (Factor 1.08)•Partial subsidy (Factor 1.05)

LTI Trumps LI When Eligible for Both (Continued)

RxHCC MODEL – EFFECTIVE 2011

- 5 Sets of Coefficients
 - Long Term Institutional (LTI)
 - Aged Low Income
 - Aged non-Low Income
 - Disabled Low Income
 - Disabled non-Low Income
- If beneficiary is both LTI and LI eligible, apply coefficients for LTI



Verify PY and Eligibility When Reconciling Members Not Appearing on MMR

Rules

- Pull correct information to calculate risk score by considering the following:
 - What payment year is being reconciled?
 - Know the difference between Payment Year and Dates of Service (Data Collection Period)
 - Was beneficiary enrolled in your plan anytime during the payment year?
 - If yes, and if there is a reconciliation payment, a reconciliation risk score will appear on the August MMR as Adjustment Reason Code (ARC) 25 (Part C) or ARC 37 (Part D); this is the beneficiary's risk score
 - If yes, and if there is not a reconciliation payment, the risk score for the members should be the same as the mid-year risk score and the plan can look at an MMR after July
 - If no, then there will not be a reconciliation payment for that payment year on the August MMR

Verify PY and Eligibility When Reconciling Members Not Appearing on MMR (Continued)

Rules (continued)

- What reports (month and year) are being used to calculate the risk scores? This can impact the calculation.
- Are you looking at the prospective risk score or a risk score with an Adjustment Reason Code?
 - Some members will have multiple lines on an MMR (e.g., blank ARC for prospective, 25 for Part C reconciliation, 37 for Part D reconciliation).
- Verify beneficiary's enrollment in Medicare Part B – ensure no lapses in coverage.
- Verify beneficiary enrolled in plan during payment year.

Scenario 3

Payment Year = 2008

HIC#	Last Name	First Initial	8/2009 MMR Reported Risk Score	ARC 25 (Y/N)	Reconciliation or Prospective Risk Score	Enrollment in Plan	Would plan receive 2008 Final Reconciliation Payment? Why?
123456789A	Doe	J	1.348	N ARC - blank	Prospective risk score	Disenrolled in 2/2007 and reenrolled in 1/2009	No Reenrolled in plan in 2009 which is why beneficiary appears on 8/2009 MMR for prospective payment Not in plan during 2008 payment year, therefore no reconciliation payment
998877665A	Blue	G	not on MMR			Disenrolled in 2/2007 DOD 5/30/2008	No Not in plan during 2008 payment year, therefore no reconciliation payment
001122334A	Green	B	1.182	Y Also ARC 37	Part C Reconciliation risk score Part D Reconciliation risk score	Disenrolled in 3/2007 and reenrolled in 1/2008	Yes Beneficiary reenrolled in plan in 2008, which means member was in plan in 2008 payment year Therefore, there is a reconciliation payment Not enrolled in 2009, so no prospective risk score on MMR
987654321B	Smith	J	not on MMR			Disenrolled in 4/2007	No Not in plan during 2008 payment year, which is why no reconciliation payment



MMR

***GROUP=H9999, CONTRACT=H9999
 RUN DATE:20051018
 PAYMENT MONTH:200601

MONTHLY MEMBERSHIP REPORT - NON DRUG
 PLAN (H9999) PBP (001) SEGMENT (000) CENTER INSURANCE

REBATES

BASIC PREMIUM	COST SHR REDUC	MAND SUPP BENEFIT	PART D SUPP BENEFIT	PART B BAS PRM REDUC	PART D BAS PRM REDUC
PART A \$0.00	I \$0.00	\$0.00	\$0.00	\$10.25	\$0.00
PART B \$0.00	I \$0.00	\$0.00	\$0.00	\$14.25	\$0.00

PAYMENTS ADJUSTMENT

CLAIM NUMBER	AGE	STATE	PP	MF	AD	SA	MTHS	DATES	LAG	FTYPE	PART A	PART B	TOTAL PAYMENT
00000000A	F 5959	33700					1 1	200601 200601	Y	D	\$2733.53	\$3900.59	\$6634.12
00000000A	F 8084	10050					1 1	200505 200705	Y		\$209.41	\$186.29	\$395.70

Health Status: H
 Adjustment Reason Code: B
 Part A, B, and Total Payments: \$2733.53, \$3900.59, \$6634.12

The information for J. Doe is reported as the following on the sample Non-Drug MMR:
 -Female
 -between the ages of 55-59
 -has a birth date of XXXXXXXX
 -has "Y" for ESRD (special status)
 -Part A and Part B RA Factors of 1.0280
 -Factor Type Code of D (for dialysis)
 -Part A payment amount of \$2733.53
 -Part B payment amount of \$3900.59
 -Total payment of \$6634.12



MOR

1***GROUP=H8888,CONTRACT=H8888,					
IRUN DATE: 20031219 RISK ADJUSTMENT MODEL OUTPUT REPORT					
PAGE: 1					
PAYMENT MONTH: 200401		PLAN: H8888 CHAMPION INSURANCE			
RAPMORP1					
0	LAST	FIRST	DATE OF		
HIC	NAME	NAME	I	BIRTH	SEX & AGE GROUP
123456789A	WOOD	CHARLES	W	XXXXXXX	Male75-79
123456789B	TREE	LILLIAN	L	XXXXXXX	Female75-79
111223333A	GRASS	ALBERT	A	XXXXXXX	Male 60-64
HCC DISEASE GROUPS:					
HCC019 Diabetes without Complication					
HCC080 Congestive Heart Failure					
HCC092 Specified Heart Arrhythmias					
INTERACTIONS: INTI01 DM_CHF					

Summary

- Identified the top ten payment calculation tips
- Illustrated the calculation of payment using practical examples
- Reconciled Model Output Report (MOR)
- Understand Monthly Membership Report (MMR) and data reported from various systems

Evaluation



Please take a moment
to complete the
evaluation form for the
Risk Adjustment
Payment
Reconciliation module.

Your Feedback is Important! Thank you!