CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Risk Adjustment for EDS & RAPS User Group

Thursday

November 17, 2016

2:00 p.m. – 3:00 p.m. ET

Introduction

Session Guidelines

- This is a one hour User Group session for MAOs and other entities submitting data to the Encounter Data System (EDS) and the Risk Adjustment Processing System (RAPS)
- There will be opportunities to submit questions via the session Q&A feature
- For questions regarding content of this User Group, submit inquiries to CMS at: EncounterData@cms.hhs.gov or RiskAdjustment@cms.hhs.gov
- Today's User Group slides are posted on the CSSC Operations website under Medicare Encounter Data>User Group and Risk Adjustment Processing System>User Group. The Q&As will be posted in the coming weeks at the same location
- Please refer to http://tarsc.info for the most up to date details regarding training opportunities

Upcoming User Group Calls

- CMS plans to hold monthly User Group calls to address topics related to risk adjustment data (EDS and RAPS data submissions)
  - There will be no December 2016 User Group call
  - CMS plans to hold the next User Group Call in January 2017
- The topics and 2017 dates for future webinar sessions will be posted on http://tarsc.info

Agenda

- Introduction
- CMS Updates
- Refinements to MAO-004 Reports
- Review Topics
  - RAPS Overview & Submission Guidelines
  - EDS Overview & Submission Guidelines
  - Submission Timelines
  - Risk Adjustment Model Overview
  - Blended Risk Score Calculations
  - Beneficiary Status Determination – Resources
- Q&A Session

CMS Updates

Submitting HIPPS Codes on Skilled Nursing Facility (SNF) and Home Health Agency (HHA)Encounter Data Records

- When the MAOs submit encounter data records to report SNF and HHA encounters to CMS, they must include the Health Insurance Prospective Payment System (HIPPS) code.
- **SNF**: Include the HIPPS code on the encounter from the OBRA admission assessment
  - When no Admission assessment was completed during the MA-covered stay, MAOs shall follow the guidance outlined in the December 4, 2014 HPMS memo entitled 'Additional Guidance Regarding Submission of Health Insurance Prospective Payment System (HIPPS) Codes to Encounter Data System'
  - Applicable SNF Institutional Inpatient facilities include non-Critical Access Hospitals facilities with Type of Bills (TOBs) such as 18X Hospital Swing Beds and 21X Skilled Nursing Inpatient (Medicare Part A)
  - HIPPS codes are not applicable for SNF institutional outpatient encounters

Submitting HIPPS Codes on SNF and HHA Encounter Data Records (continued)

- **HHA**: Include the HIPPS code on the encounter from the Outcome and Assessment Information Set (OASIS) Start of Care Assessment
  - CMS encourages MAOs to submit the HIPPS codes from any completed assessments when available from the providers
  - Applicable HHA Institutional encounters include TOB 32X (Home Health Inpatient Part B Services under a Plan of Treatment)
  - HIPPS codes are not applicable on Type of Bill (TOB) 034X (e.g., the MAO is providing supplemental benefits)
- CMS' guidance is related to plan submission of HIPPS codes to the Encounter Data System, and not the contractual financial arrangement and billing requirements plans have for providers

Submitting HIPPS Codes on SNF and HHA Encounter Data Records (continued)

SNF Encounter Data Records	HHA Encounter Data Records
TOB = 18X or 21	TOB = 32X
Claim From Date of Service (DOS) is equal to or greater than 07/01/2014 Revenue Code = 0022	Claim From DOS is equal to or greater than 07/01/2014 Revenue Code = 0023
Claim From DOS is equal to or greater than 07/01/2014 Revenue Code = 0022	Claim From DOS is equal to or greater than 07/01/2014 Revenue Code = 0023

ICD-10 Updates

- **Fiscal Year (FY) 2017 ICD-10 Codes**
  - CMS is evaluating the new FY 2017 ICD-10 codes for risk adjustment
  - An updated diagnosis to Hierarchical Condition Code (HCC) crosswalk and risk adjustment model software package will be published on the Risk Adjustment webpage (https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html) once the mappings are finalized
  - Updated mappings will be posted before the end of the year
- **Payment Year (PY) 2016 & PY 2017 Mapping Correction**
  - The final PY 2016 and mid-year 2017 model runs will include a correction to the mapping of two ICD-10 diagnosis codes
    - Diagnosis codes B180 and B181 will be correctly mapped to RxHCC 55 instead of RxHCC 54

Terminating Contracts

- All MA, Cost Plans, and certain demonstrations with non-renewing contracts effective on or before January 1, 2017 are required to submit risk adjustment data and attestations to CMS for the non-renewing contracts. Risk adjustment data includes both Risk Adjustment Processing System (RAPS) and Encounter Data Processing System (EDPS) data.
- The submission deadlines for terminating contracts are typically shorter than those for continuing contracts.

Refinements to the MAO-004 Report

Technical Refinements to the MAO-004 Report

- On October 22-24, 2016, CMS distributed Phase II MAO-004 Reports. These reports were for months starting January 2014, and replaced earlier versions of the reports.
- Working with MAO's and submitters, CMS has discovered the need for a few additional technical refinements to the MAO-004 report. These changes will account for:
  - CPT/HCPC codes on each record (and not between original, replacement, and chart review records)
  - Replacement and Void records submitted out of sequence
  - Interim and non '1', '7', or '8' claim frequency codes

Technical Refinements to the MAO-004 Report (continued)

- Because of the unique nature of encounter data, CMS is creating two categories that identify diagnoses as:
  - Add or delete – this category indicates whether a diagnoses has been reported on an accepted record or deleted, regardless of whether it's risk adjustment allowable.
  - Allow or disallow – this category indicates whether a diagnoses is risk adjustment allowable, based on the Type of Bill or HCPCS code.

Technical Refinements to the MAO-004 Report Scenarios

Scenario 1: Disallowed Replacement

In March 2016, Happy Health Plan submitted an original encounter ICN 1234 with ICD-10 diagnoses AAA, BBB, CCC. **Encounter 1234** was accepted into EDS and it **passes** the CMS filtering logic. Happy Health Plan receives an MAO-004 report indicating AAA, BBB, and CCC are added. In October 2016, a replacement encounter data record with ICN 9393 reporting ICD-10 diagnoses AAA, BBB, GGG was submitted for the original encounter with ICN 1234. The **replacement encounter 9393 does not pass** the CMS filtering logic because there are no allowable HCPCs on the replacement encounter.

In this scenario, AAA, BBB, and GGG are added, but are not risk adjustment eligible.
March 2016 MAO-004 report for ICN 1234: AAA*0*A* BBB*0*A* CCC*0*A*
October 2016 MAO-004 report for ICN 9393: GGG*0*A*CCC*0*D
In the future, CMS will report that– AAA, BBB, and GGG are "disallowed."

Technical Refinements to the MAO-004 Report Scenarios (continued)

- AAA & BBB were on the original encounter and have already been reported as an “Add”, so AAA & BBB would not be reported again on the October 2016 Report MAO-004. However, the diagnoses on the replacement record do not pass the filtering logic, so AAA & BBB are no longer allowable, i.e., they are no longer risk adjustment eligible. In the future, CMS will report diagnoses in this circumstance as “disallowed.”
- GGG was not on the original encounter, so it is reported as an “Add” on the October 2016 MAO-004 report. However, GGG is not risk adjustment eligible, since the replacement record does not pass the CMS filtering logic. In the future, in addition to reporting diagnoses in these circumstances as adds, CMS will also report that they are “disallowed.”
- CCC was on the original, and has been reported on the MAO-004 Report before as an “Add.” However, it is not on replacement. The October 2016 MAO-004 reports CCC as a “Delete.”

Technical Refinements to the MAO-004 Report Scenarios (continued)

Scenario 2: Allowed Replacement

In March 2016, Happy Health Plan submitted an original encounter ICN 1456 with ICD-10 diagnoses AAA, BBB, CCC. **Encounter 1456** was accepted into EDS and **does not pass** the CMS filtering logic. Happy Health Plan does not receive an MAO-004 report for this submission. In October 2016, a replacement encounter data record with ICN 9789 reporting ICD-10 diagnoses AAA, BBB, GGG was submitted for the original encounter with ICN 1456. **Replacement encounter 9789 passes** the CMS filtering logic.

In this scenario, AAA, BBB, & GGG are added, and are risk adjustment eligible.
In the future, CMS will report that -- the diagnoses on 1456 (AAA, BBB, CCC) are adds, but disallowed.
October 2016 Report for ICN 9789: GGG*0*A*CCC*0*D
In the future, CMS will report that – AAA and BBB are now allowed diagnoses

Technical Refinements to the MAO-004 Report Scenarios (continued)

- AAA & BBB were considered as “Adds” on the original encounter 1456, but currently they would not be reported on an MAO-004 report since the encounter 1456 did not pass the CMS filtering logic. AAA and BBB are still not reported on the October 2016 Report since they were previously considered “Adds”. However, because AAA & BBB are on the replacement encounter that passes the filtering logic, they are now considered risk adjustment eligible.
- GGG was not on the original encounter, therefore it is a new “Add.” It is reported as an “Add” on the October 2016 MAO-004 report. In the future, CMS will also note that it is allowable.
- CCC was on the original encounter 1456 as an “Add”, but currently would not be reported. In the future, a diagnoses in this circumstance will be reported as allowable, but since CCC is not on the replacement, the October 2016 MAO-004 reports CCC as a “Delete”.

Technical Refinements to the MAO-004 Report Scenarios (continued)

Scenario 3: Disallowed Linked Chart Review

In March 2016, Happy Health Plan submitted an original encounter ICN 2425 with ICD-10 diagnoses AAA, BBB, CCC. **Encounter 2425** was accepted into EDS and it **passes** the CMS filtering logic. Happy Health Plan receives a MAO-004 report indicating AAA, BBB, and CCC are added as risk adjustment eligible. In June 2016, a **chart review record with ICN 6554 linked to ICN 2425** and reporting ICD-10 diagnoses AAA and DDD, was submitted and accepted, but does not **does not pass** the CMS filtering logic because there are no allowable HCPCs on the linked chart review record.

In this scenario, AAA, BBB, CCC, and DDD are added, AAA, BBB, and CCC are risk adjustment eligible.
March 2016 MAO-004 report for ICN 2425: AAA*0*A* BBB*0*A* CCC*0*A*
June 2016 MAO-004 report for ICN 6554: DDD*0*A*
In the future CMS will report that – DDD is not allowable (i.e., DDD is not risk adjustment eligible).

Technical Refinements to the MAO-004 Report Scenarios (continued)

- AAA was on the original encounter, and since it was reported before as an “Add”, AAA will not be reported on the June MAO-004 report for the chart review record.
- DDD was not on the original encounter, it is currently reported as an “Add” on the June MAO-004 report, since the original encounter was allowed. However, DDD should not be considered risk adjustment eligible since the linked chart review record does not pass the CMS filtering logic.

Technical Refinements to the MAO-004 Report Scenarios (continued)

Scenario 4: Allowed Linked Chart Review

In March 2016, Happy Health Plan submitted an original encounter ICN 2425 with ICD-10 diagnoses AAA, BBB, CCC. **Encounter 2425** was accepted into EDS and **does not pass** the CMS filtering logic. Since the encounter did not pass the CMS filtering logic, Happy Health Plan does not receive a MAO-004 report indicating AAA, BBB, and CCC are added. In June 2016, **a chart review record with ICN 6554 linked to ICN 2425** reporting ICD-10 diagnoses AAA and DDD, was submitted and accepted. Chart review 6554 **passes** the CMS filtering logic.

In this scenario, AAA, BBB, CCC, and DDD are added, AAA and DDD are risk adjustment eligible.
June 2016 MAO-004 report for ICN 6554: DDD*0*A*
In the future CMS will report that – BBB and CCC are added, but not allowable for risk adjustment.

Technical Refinements to the MAO-004 Report Scenarios (continued)

- AAA was on the original encounter, and since it was reported before as an “Add”, AAA will not be reported on the June MAO-004 report for the chart review record.
- DDD was not on the original encounter, it is reported as an “Add” on the June MAO-004 report.

Technical Refinements to the MAO-004 Report Scenarios (continued)

Scenario 5: Out of Sequence Replacement Submission

In March 2016, Happy Health Plan submitted an original encounter ICN 1234 with ICD-10 diagnoses AAA, BBB, and CCC. **Encounter 1234** was accepted into EDS and it **passes** the CMS filtering logic. In May 2016, Happy Health Plan submitted a chart review record that received ICN 4568 and was linked to the original encounter record with ICN 1234. **Linked chart review 4568** record **passes** the CMS filtering logic and ICD-10 diagnosis code YYY is reported as an "Add." The following month a replacement encounter record was submitted for the original encounter with ICN 1234 and receives ICN 7876. **Replacement encounter 7876 passes** the CMS filtering logic and reports ICD-10 diagnosis codes AAA and EEE.

In this scenario, AAA, EEE, and YYY are risk adjustment eligible.
March 2016 MAO-004 report for ICN 1234: AAA*0*A* BBB*0*A* CCC*0*A*
May 2016 MAO-004 report for ICN 4568: YYY*0*A*
June 2016 MAO-004 report for ICN 7876: EEE*0*A*BBB*0*D*CCC*0*D*YYY*0*D*
In the future, CMS will not report YYY as a delete.

Technical Refinements to the MAO-004 Report Scenarios (continued)

- Since AAA was on the original encounter and was previously reported as an “Add,” AAA will not be reported again on the MAO-004 report for the replacement.
- EEE was not on the original encounter, but was reported on the replacement encounter. EEE will be reported as an “Add”
- YYY was not reported on the replacement encounter, so YYY currently will be reported as a delete. However, since YYY passed the CMS filtering logic and the chart review record was not replaced, YYY should still be considered as risk adjustment eligible.
- BBB and CCC were on the original, and has been reported on the MAO-004 Report for the original encounter as an “Add.” However, they are not on the replacement. The MAO-004 will report BBB and CCC as “Delete”.

Technical Refinements to the MAO-004 Report Scenarios (continued)

Scenario 6: Out of Sequence Void Submission

In March 2016, Happy Health Plan submitted an original encounter ICN 1234 with ICD-10 diagnoses AAA, BBB, and CCC. **Encounter 1234** was accepted into EDS and it **passes** the CMS filtering logic. In July 2016, Happy Health Plan submitted a chart review record that received ICN 5568 and was linked to the original encounter record with ICN 1234. **Linked chart review 5568 passes** the CMS filtering logic and ICD-10 diagnosis code YYY is reported as an "Add." The following month a **void encounter record with ICN 8988** was submitted and **accepted** for the original encounter with ICN 1234.

In this scenario, YYY is risk adjustment eligible.
March 2016 MAO-004 report for ICN 1234: AAA*0*A* BBB*0*A* CCC*0*A*
July 2016 MAO-004 report for ICN 5568: YYY*0*A*
August 2016 MAO-004 report for ICN 8988:
AAA*0*D*BBB*0*D*CCC*0*D*YYY*0*D
In the future, CMS will not report YYY as a delete.

Technical Refinements to the MAO-004 Report Scenarios (continued)

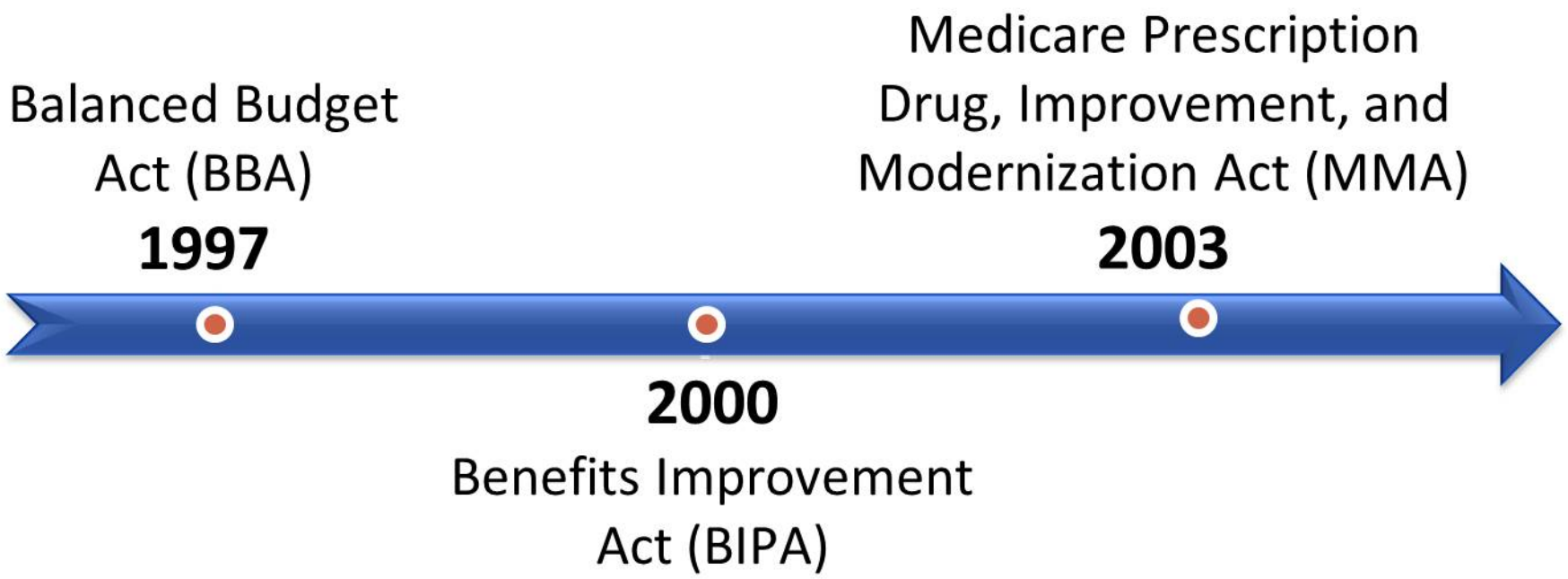
- AAA, BBB, and CCC were on the original, and have been reported on the MAO-004 Report as “Add.” The void encounter deletes AAA, BBB, and CCC. The MAO-004 will correctly report AAA, BBB, and CCC as “Delete”.
- The linked chart review containing YYY was not voided by void encounter, but YYY will currently be reported as a delete. However, since YYY passed the CMS filtering logic and the chart review record was not voided, YYY should still be considered as risk adjustment eligible.

RAPS Overview & Submission Guidelines

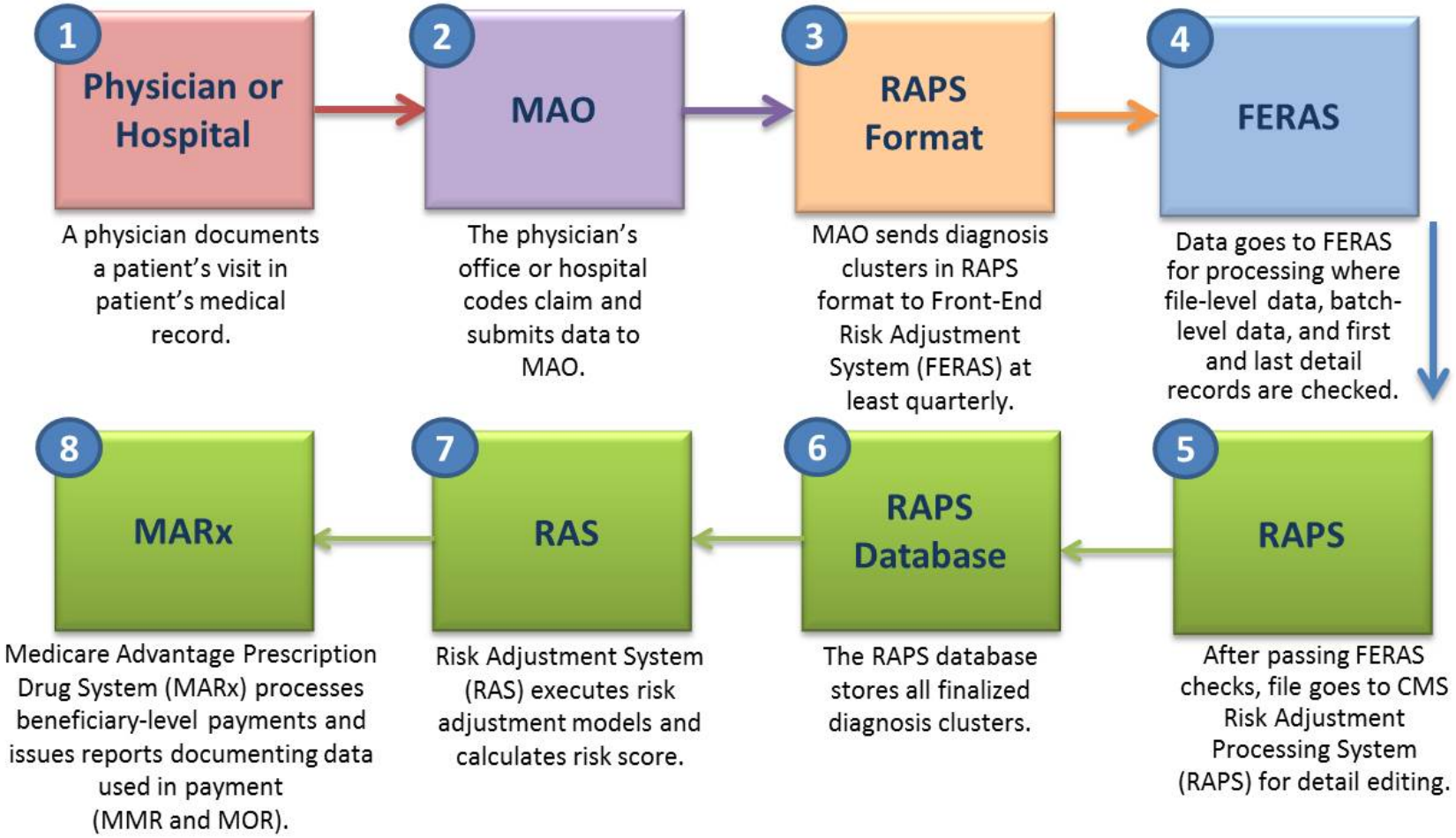
Risk Adjustment

Risk Adjustment:

- Method used to adjust bidding and payments
- Derived from enrollee's health status and demographic characteristics



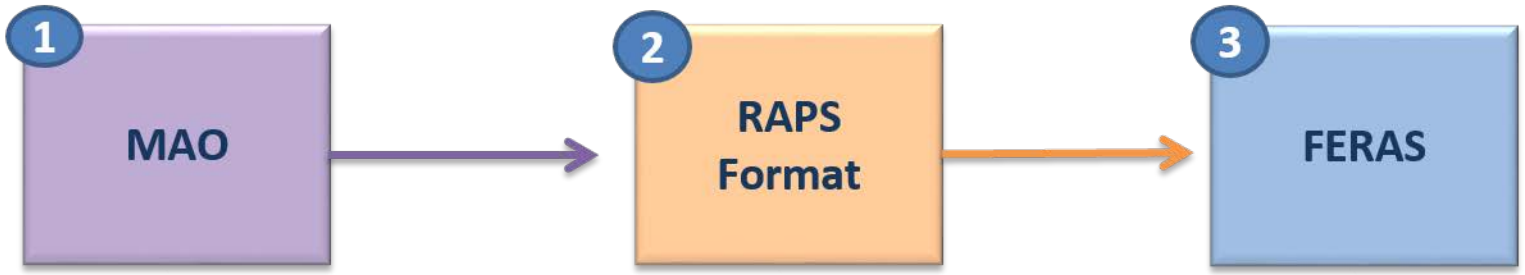
Risk Adjustment Processing System Overview: Process Flow



RAPS Overview: Required Minimum Data Elements for Submission

- Health Insurance Claim Number (HICN)
- Acceptable Provider Type
- “From” Date of Service (DOS)
- “Through” Date of Service
- Diagnosis Code (ICD-10)

RAPS Overview: Submission Flow & Frequency



The physician's office or hospital codes claim and submits data to MAO.

MAO sends diagnosis clusters in RAPS format to Front-End Risk Adjustment System (FERAS) at least quarterly.

Data goes to FERAS for processing where file-level data, batch-level data, and first and last detail records are checked.

EDS Overview & Submission Guidelines

EDS Overview

- 42 CFR Section 422.310(d)(1):
  - MAOs must submit data, in accordance with CMS instructions, to characterize the context and purposes of items and services provided to their enrollees by a provider, supplier, physician, or other practitioner
  - This includes comprehensive data equivalent to Medicare FFS claims data (encounter data) or data in abbreviated format

EDS Overview

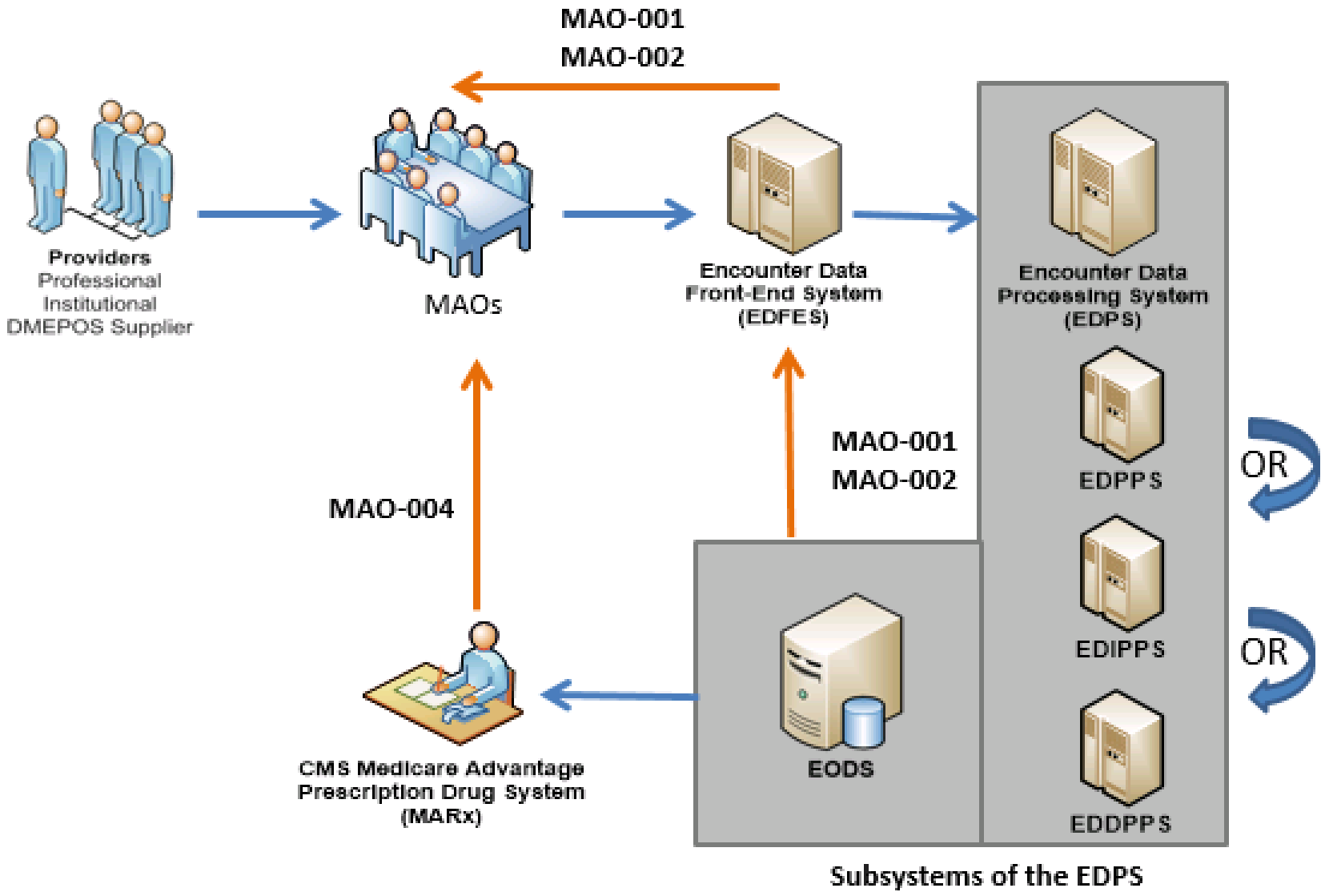
- CMS may use risk adjustment data obtained from MA organizations:
  - To determine the risk adjustment factors used to adjust payments
  - To update risk adjustment models
  - To calculate Medicare Disproportionate Share Hospital (DSH) percentages
  - To conduct quality review and improvement activities
  - For Medicare coverage purposes
  - To conduct evaluation and other analysis to support Medicare program, public health initiatives, and health care-related research
  - For activities to support the administration of the Medicare program
  - For activities conducted to support program integrity
  - For purposes permitted by other laws

EDS Overview: Submission Frequency

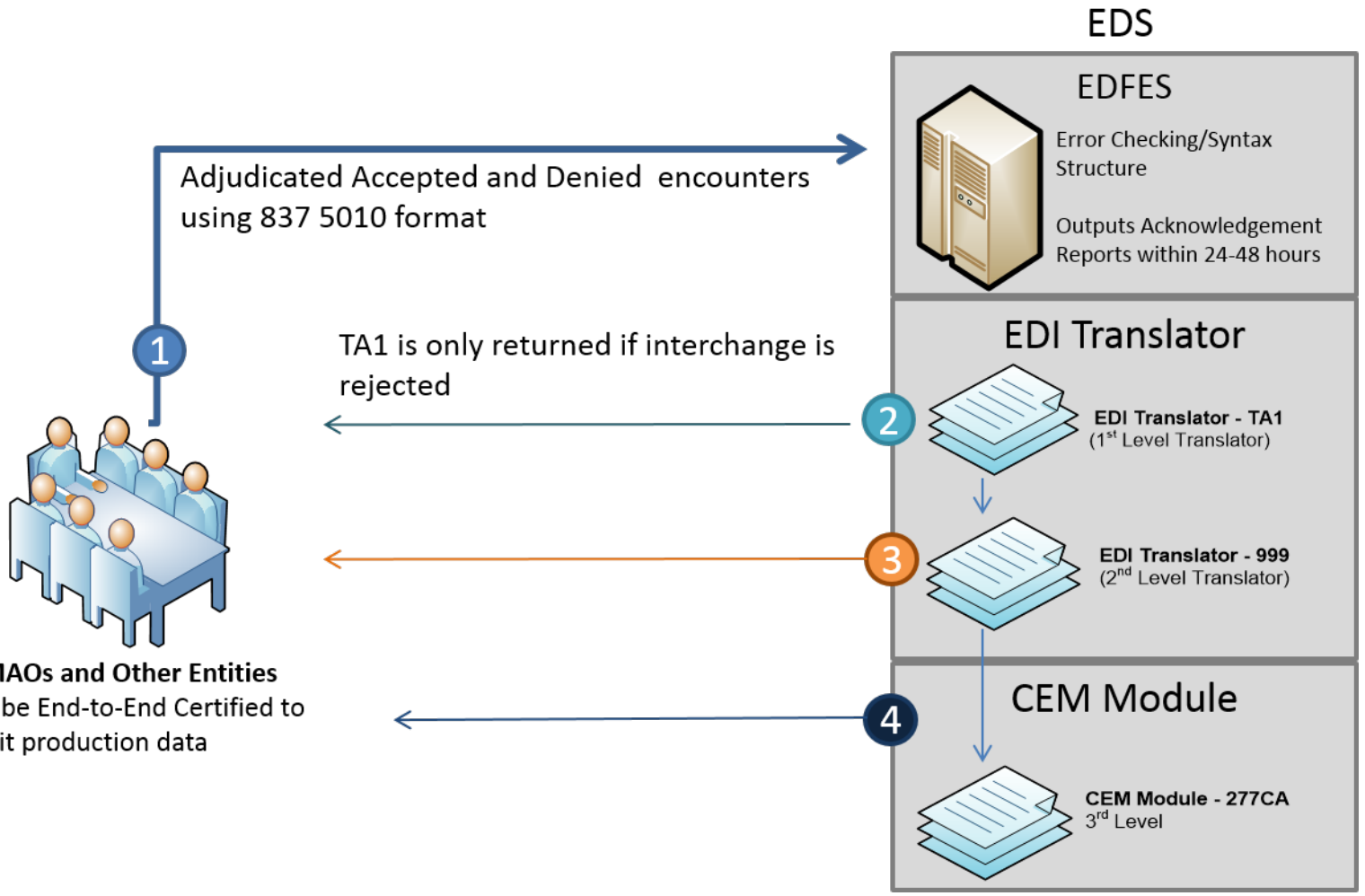
- MAOs are required to submit encounter data on a frequency based on the contract's enrollment size
- All encounter data must be submitted in the ANSI X12 837 format

Number of Medicare Enrollees	Minimum Submission Frequency
Greater than 100,000	Weekly
50,000 – 100,000	Bi-weekly
Less than 50,000	Monthly

EDS Overview: Process Flow



EDFES Submission Overview



EDPS Submission Overview

Adjudicated Accepted and Denied encounters using 837 5010 format

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MAOs and Other Entities

- Must be End-to-End Certified to submit production data

EDFES

Error Checking/Syntax Structure

Outputs Acknowledgement Reports within 24-48 hours

EDPS

EDPS
Processes and edits encounters according to logic for system module

Checks encounter data for logic and business rules

Submission Timelines

2016, 2017, 2018 Risk Adjustment Payment Run Submission Deadlines

Risk Score Run	Dates of Service	Risk Adjustment Data Deadline for Submission
2017 Initial (RAPS)	07/01/15 – 06/30/16	Friday, 09/09/2016
2016 Final Run (RAPS and EDS)	01/01/15 – 12/31/15	Tuesday, 01/31/2017
2017 Mid-Year (RAP and EDS)	01/01/16 – 12/31/16	Friday, 03/03/2017
2018 Initial (RAPS and EDS)	07/01/16 – 06/30/17	Friday, 09/08/2017

Risk Adjustment Model Overview

Risk Adjustment Model Overview

- From 2004-2016, the Centers for Medicare & Medicaid Services Hierarchical Condition Categories (CMS-HCC) model has included separate risk scores for new enrollees, long-term institutional beneficiaries, and community beneficiaries
  - CMS-HCC Model
  - CMS-HCC PACE Model
  - CMS-HCC ESRD Model
  - RxHCC Model

Hierarchical Condition Categories (HCCs)

- All diagnosis codes are mapped to a Hierarchical Condition Category (HCC)
- Only HCCs which predict Medicare costs are included on the CMS-HCC model
- Hierarchies are applied to the HCCs and allows the CMS-HCC model to apply the most severe HCCs to a beneficiary's risk score

Risk Score Calculation Overview

- Risk scores:
  - Measure individual beneficiaries' relative risks
  - Are used to adjust payments based on the health status (diagnostic data) and demographic characteristics (such as age and sex) of an enrollee
- The CMS-HCC risk adjustment models are used to calculate risk scores, which predict individual beneficiaries' health care expenditures, relative to the average beneficiary
- Individual risk scores are calculated by adding the relative factors associated with each beneficiary's demographic and disease factors

Risk Score Calculation Overview (continued)

Risk Adjustment Model Variables and Adjustments	
Demographic Variables: • Age / Sex • Originally Disabled	There are relative factors associated with each demographic variable.
Disease Variables: • Disease Hierarchical Condition Categories (HCCs) • Disease / Disabled Interactions	CMS uses diagnoses submitted by plans and FFS providers to assign HCCs and interactions for each beneficiary. There are relative factors associated with each HCC and interaction.
Sum of Factors ***Demographic + Disease*** *The relative factors for all of the demographic variables, HCCs and interactions are added together. The result is the raw risk score.*	
• **Normalized Score**	A normalization factor is applied to keep the average FFS risk score at 1.0.
• **MA Coding Pattern Adjusted Score**	A coding pattern adjustment is applied to account for differential coding patterns between MA and FFS.
Final product is the payment risk score	

2017 Adjustments to Risk Scores

2017 MA Coding Pattern Adjustment:
For PY 2017, CMS will implement an MA coding pattern difference adjustment of ***5.66%.***

2017 Normalization Factors:

Model	Factor
Revised CMS-HCC model	0.998
PACE model	1.051
ESRD dialysis model	0.994
ESRD functioning graft model	1.051
Recalibrated RxHCC model	0.976

Part C – Example ICD-10 to HCC Mapping

- Example of ICD-10 diagnosis mapping to the 2016 CMS-HCC Model:

John Doe visits his physician and is diagnosed with diabetes mellitus due to underlying condition with other diabetic kidney complication (E0829). The provider submits diagnosis code E0829 to the MAO.

The MAO submits the diagnosis code to EDS on an encounter data record. Upon applying the filtering methodology, CMS determines that E0829 is a risk adjustment eligible diagnosis code and, in risk score calculation, is mapped to HCC-18.

Part D – Example ICD-10 to HCC Mapping

- Example of ICD-10 diagnosis mapping to the RxHCC Model:

Jane Doe visits her physician and is diagnosed with diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema (E08329), for which medication is needed. The provider submits diagnosis code E08329 to the MAO.

The MAO submits the diagnosis code to EDS on an encounter data record. Upon applying the filtering methodology, CMS determines that E08329 is a risk adjustment eligible diagnosis code and, in risk score calculation, is mapped to RxHCC-241.

New Beneficiary to Full Risk Score

- During the payment year, CMS assigns a new enrollee factor to any beneficiary who does not have enough diagnoses to support a risk score
- Operationally, CMS identifies new enrollees as those beneficiaries with less than 12 months of Medicare Part B during the data collection year

New Beneficiary to Full Risk Score Example

- A beneficiary ages in to Medicare when they turn 65 on October 3, 2015. The beneficiary opting to enroll in a Part C plan will be a "New Enrollee" until the 2017 Mid-year risk score model run.

Model Run	DOS in data collection period	Beneficiary's Status	Reason
2016 Mid-year	1/1/15 – 12/31/15	New Enrollee	Does not have 12 months of Medicare Part B entitlement in data collection period
2016 Final	1/1/15 – 12/31/15	New Enrollee	Does not have 12 months of Medicare Part B entitlement in data collection period
2017 Initial	7/1/15 – 6/30/16	New Enrollee	Does not have 12 months of Medicare Part B entitlement in data collection period
2017 Mid-year	1/1/16 – 12/31/16	Full Risk	Has 12 months of Medicare Part B entitlement in data collection period

Blended Risk Score Calculations

Payment Year 2017 Blended Risk Score Calculation

- In PY 2017, CMS will continue calculating risk scores by blending two risk scores:
  - The risk score calculated using diagnoses RAPS and Fee for Service (FFS)
  - The risk score calculated using diagnoses from the EDS and FFS

Risk Score Calculation for PY 2017

For PY 2017, risk scores will be calculated independently and then blended:

- **Portion of risk score from 75% RAPS & FFS**
  - [(raw risk score from RAPS + FFS diagnoses) / (PY 2017 normalization factor)] X (1 – PY 2017 coding adjustment factor) X 75% = portion of the risk score from RAPS and FFS
- **Portion of risk score from 25% EDS & FFS**
  - [(raw risk score from EDS + FFS diagnoses) / (PY 2017 normalization factor)] X (1 – PY 2017 coding adjustment factor) X 25% = portion of the risk score from EDS and FFS
- **Blended risk score** = RAPS and FFS portion of the risk score + the EDS and FFS portion of the risk score

CMS-HCC Risk Model
Example Risk Score Calculation for PY 2017

Demographics	RAPS and FFS	EDS and FFS
Male, Age 82 (aged), FB-Dual, Community	0.816	0.816
Diagnoses:		
Diabetes w/o complications (HCC-19)	0.097	0.097
COPD (HCC-111)	0.422	0.422
Total Raw Risk Score (Demographic Factors + Diagnostic factors)	1.335	1.335

CMS-HCC Risk Model
Example Risk Score Calculation for PY 2017 (continued)

Demographics	RAPS and FFS	EDS and FFS
Total Raw Risk Score	1.335	1.335
Adjustments:		
Normalization factor (0.998)	1.335/0.998 = 1.338	1.335/0.998 = 1.338
Coding differences (5.66%)	1.338 X (1- 0.0566) = 1.26	1.338 X (1- 0.0566) = 1.26
Blending of the Risk Scores	1.26 X 0.75 = 0.945	1.26 X 0.25 = 0.315
Payment Risk Score	**0.945 + 0.315 = 1.26**	

Using EDS Diagnoses for Risk Score Calculation

- ***For PY 2016 (DOS 2015)***, CMS will blend the risk scores:
  - Portion of risk score from 90% RAPS & FFS diagnoses +
  - Portion of risk score from 10% EDS and FFS diagnoses =
  - Blended 2016 risk score

- ***For PY 2017(DOS 2016)***, CMS will blend the risk scores:
  - Portion of risk score from 75% RAPS & FFS diagnoses +
  - Portion of risk score from 25% EDS and FFS diagnoses =
  - Blended 2017 risk score

- ***Programs of All-Inclusive Care for the Elderly (PACE) Organizations:*** for PY 2016 & PY 2017 risk score calculations, CMS will continue to use the same method as used for PY 2015, which is to use diagnoses from RAPS, FFS, and ED in equal measure (with no weighting)

Beneficiary Status Determination – Resources

MARx Reports – Monthly Membership Report (MMR) and Monthly Output Report (MOR)

- The Medicare Advantage Prescription Drug (MARx) system generates reports, which include the Part C and Part D MORs and the MMR
- The MMR contains demographic and payment data, and is available in both a formatted report layout and a data file format
- The MOR contains diagnosis data that is used in the model. Currently, this data comes from Fee for Service (FFS), RAPS, and EDS submissions

MARx Reports - MMR and MOR (continued)

- The MMR and MOR contain information which will help MAOs determine different beneficiary statuses

Demographic/ Diagnostic Information	Description	MMR	MOR
Sex	Male or Female	√	√
Age/RA Age Group	Age as of February 1st of payment year, with the exception of beneficiaries who recently aged into Medicare and may have been 64 on February 1st. These beneficiaries are treated as 65.	√	√
Medicaid and Disabled	Beneficiary is disabled and also entitled to Medicaid.	N/A	√

MARx Reports - MMR and MOR (continued)

Demographic/ Diagnostic Information	Description	MMR	MOR
Medicaid	The Medicaid factor is applied to full risk beneficiaries if they have one or more months of Medicaid status in the data collection year (through payment year 2016) and for new enrollees when they have one or more months of Medicaid in the payment year.	√	N/A
Originally Disabled	Beneficiary's original Medicare entitlement was due to disability (and they are now aged).	N/A	√
Hospice	MAOs are not paid risk payments for the months when their enrollees are in hospice. Risk score on the MMR will be zero (0.000).	√	N/A
Default Risk Factor Code	Assigned for new enrollment in Medicare after the model run, change in status (i.e., new to ESRD), a change in HIC number, or in rare cases when there is a lapse in Part B coverage). Used when RAFT code unavailable. Not used at final.	√	N/A
Risk Adjustment Factor Type (RAFT) Code or Part D RA Factor Type Code	Communicates which type of risk score was used to calculate the risk score for a beneficiary.	√	N/A

MARx Reports - MMR and MOR (continued)

Demographic/ Diagnostic Information	Description	MMR	MOR
Frailty Factor (if applicable)	Flag indicates if beneficiary receives additional factor because of enrollment in PACE or other qualifying FIDE SNP and qualifies for frailty.	√	N/A
Original Reason for Entitlement Code (OREC)	A number that represents the beneficiary's reason for entitlement to Medicare. 0 = due to age, 1 = disability, 2 = ESRD, 3 = disability and current ESRD, and 9 = none of the above.	√	N/A
Part C Long Term Institutional (LTI)	An LTI risk score was used in payment. The LTI status is based upon 90 day or longer stays in an institutional setting.	√	N/A
HCC / RxHCCs	HCCs or RxHCCs applicable to a beneficiary and used in calculating the risk score for initial, mid-year, or final reconciliation payments. RAS applies the hierarchies prior to generating the MOR, so that only the most severe condition of a disease appears on the report.	N/A	√
Interactions	Applicable disease or disabled interactions reported on the MOR.	N/A	√

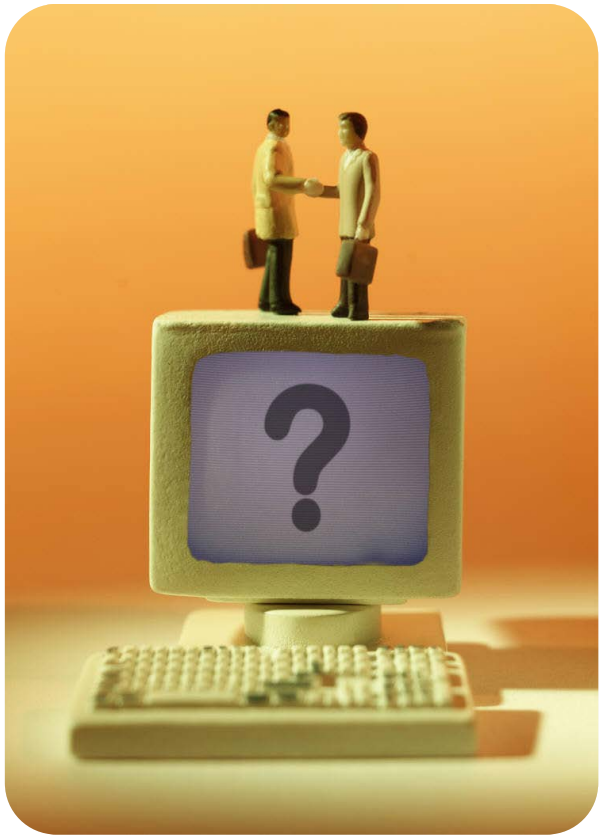
Determining Dual Status Starting Payment Year 2017

- CMS defines dual status as follows:
  - ***Full benefit dual eligible***: eligible for full Medicaid benefits under title XIX of the Social Security Act (SSA). Include those who have Medicaid benefits only, or who are also eligible as Qualified Medicare Beneficiaries (QMBs) or Specified Low Income Medicare Beneficiaries (SLMBs)
    - Dual status codes 02, 04, 08, or presence on the monthly Puerto Rico file
  - ***Partial benefit dual eligible***: eligible only as QMBs, SLMBs, and under other categories of beneficiaries who are not eligible for full Medicaid benefits under title XIX
    - Dual status code 01, 03, 05, or 06
  - ***Non dual eligible***: Neither full benefit dual or partial benefit dual eligible

Determining Dual Status (continued)

- MAOs can use the Monthly Membership Report (MMR) and the Monthly Output Report (MOR) to determine if a beneficiary is dual status
- CMS will use Medicaid data from three (3) sources:
  - Medicare Modernization Act (MMA) state files
  - Point of Sale (POS) data
  - Monthly Medicaid file that the Commonwealth of Puerto Rico submits to CMS

Questions & Answers



Closing Remarks

Commonly Used Acronyms

Acronym	Definition
ANSI	American National Standards Institute
CEM	Common Edits and Enhancements Module
CFR	Code of Federal Regulations
CPT	Current Procedural Terminology
DOS	Date(s) of Service
EDDPPS	Encounter Data DME Processing and Pricing Sub-System
EDFES	Encounter Data Front-End System
EDIPPS	Encounter Data Institutional Processing and Pricing Sub-System
EDPPPS	Encounter Data Professional Processing and Pricing Sub-System
EDPS	Encounter Data Processing System

Commonly Used Acronyms (continued)

Acronym	Definition
EDR	Encounter Data Record
EDS	Encounter Data System
EODS	Encounter Operational Data Store
FERAS	Front-End Risk Adjustment System
FFS	Fee-for-Service
FTP	File Transfer Protocol
HCC	Hierarchical Condition Category
HCPCS	Healthcare Common Procedure Coding System
HH	Home Health
HIPPS	Health Insurance Prospective Payment System

Commonly Used Acronyms (continued)

Acronym	Definition
ICN	Internal Control Number
MAOs	Medicare Advantage Organizations
MARx	Medicare Advantage Prescription Drug System
MMR	Monthly Membership Report
MOR	Monthly Output Report
NPI	National Provider Identifier
PY	Payment Year
RAPS	Risk Adjustment Processing System

Resources

Resource	Resource Link
Centers for Medicare & Medicaid Services (CMS)	http://www.cms.gov
Customer Support and Service Center (CSSC) Operations	http://www.csscoperations.com csscoperations@palmettogba.com
Encounter Data Mailbox	encounterdata@cms.hhs.gov
Risk Adjustment Mailbox	riskadjustment@cms.hhs.gov
Technical Assistance Registration Service Center (TARSC)	http://www.tarsc.info/
Washington Publishing Company	http://www.wpc-edi.com/content/view/817/1
Medicare Advantage and Prescription Drug Plans Communications User Guide	http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelpdesk/Plan_Communications_User_Guide.html

Resources (continued)

Resource	Link
CMS 5010 Edit Spreadsheet	https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/
RAPS Error Code Listing and RAPS-FERAS Error Code Lookup	http://www.csscoperations.com/internet/cssc3.nsf/docsCat/CSSC~CSSC%20Operations~Risk%20Adjustment%20Processing%20System~Edits?open&expand=1&navmenu=Risk^Adjustment^Processing^System||
EDFES Edit Code Lookup	https://apps.csscoperations.com/errorcode/EDFS_ErrorCodeLookup
EDPS Error Code Look-up Tool	http://www.csscoperations.com/internet/cssc3.nsf/DocsCat/CSSC~CSSC%20Operations~Medicare%20Encounter%20Data~Edits~97JL942432?open&navmenu=Medicare^Encounter^Data|||

Contact Us

- Additional questions may also be submitted following the webinar to:

EncounterData@cms.hhs.gov

or

RiskAdjustment@cms.hhs.gov

- Questions submitted to other CMS mailboxes will be forwarded to the risk adjustment or encounter data mailboxes as appropriate

Evaluation

A formal request for evaluation feedback will be sent at the conclusion of this session.

Please take a moment to note any feedback you wish to give concerning this session.

Your Feedback is Important.

Thank You!

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