Introduction

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
  o On USB Provided
• PowerPoint Slides
  o 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.csscoperation.com

Risk Adjustment Payment Portal
www.askriskadjustment.com

Technical Assistance Registration Service Center
www.tarcs.info
Risk Adjustment Methodology

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:
  o Diagnoses
  o 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

Number of Contracts

Risk Score

Average 1.033
Standard Deviation 0.302

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

Risk Adjustment Methodology

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

**Demographics:**
- Male, age 82, resides in community: $4,455.49, 0.597

**Diagnoses:**
- 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

**Adjustments:**
- Normalization factor (1.158/1.079): 1.073
- Coding intensity: 1.036

**Payment Risk Score:** 1.036

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

**Demographics:**
- Male, age 82, resides in community: $4,455.49, 0.597
- Medicaid: $1,238.88, 0.166

**Diagnoses:**
- Diabetes w/complications (HCC 17): $2,530.00, 0.339
- Diabetes w/o complications (HCC 19): $2,493.84, 0.325
- COPD (HCC 108): $2,977.79, 0.399

**Total Annual Pred. Spending:** $9,963.28, 1.501

**Adjustments:**
- Normalization factor (1.501/1.079): 1.391
- Coding intensity: 1.344

**Payment Risk Score:** 1.344
Part C Risk Adjuster Calculation:
Example 3, Disease Interaction
(CHF and Diabetes)

<table>
<thead>
<tr>
<th>Demographics:</th>
<th>Payment Increment</th>
<th>Relative Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female, age 77, resides in community</td>
<td>$3,410.65</td>
<td>0.457</td>
</tr>
</tbody>
</table>

Diagnoses:
- 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

Adjustments
- 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

<table>
<thead>
<tr>
<th>Chronic Disease</th>
<th>Ratio of Predicted to Actual Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Part C Model (age, gender and diseases)</td>
</tr>
<tr>
<td>Diabetes</td>
<td>1.000</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>1.000</td>
</tr>
<tr>
<td>Lung Disease</td>
<td>1.000</td>
</tr>
<tr>
<td>Cancer</td>
<td>1.000</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Sorted by Level of Predicted Spending</th>
<th>Ratio of Predicted to Actual Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lowest 10%</td>
<td>0.892</td>
</tr>
<tr>
<td>Top 10%</td>
<td>0.999</td>
</tr>
<tr>
<td>Top 5%</td>
<td>0.983</td>
</tr>
<tr>
<td>Top 1%</td>
<td>0.941</td>
</tr>
</tbody>
</table>

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

Conclusions

• Consistency
  o CMS approach uses risk adjustment for all types of plans

• Flexibility
  o Provides flexibility to ensure accurate payments to MA plans and PDPs; provides ability to develop other models as needed

• Accuracy
  o 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

• Sean Creighton
  o Director - Division of Risk Adjustment & Payment Policy
  o sean.creighton@cms.hhs.gov

• Tom Kornfield
  o thomas.kornfield3@cms.hhs.gov

• Melissa Evans
  o 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!
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
  o Required Signatures
• Submitter ID Application
  o 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
RAPS File Logic

File Level

AAA Record

BBB Record

Batch Level

YYY Record

BBB Record

Batch Level

YYY Record

CCC Record

Detail Level

Detail Level

Detail Level

Detail Level

AAA Record

ZZZ Record

RAPS File Layout Columns

<table>
<thead>
<tr>
<th>FIELD NO</th>
<th>FIELD NAME</th>
<th>POSITION</th>
<th>PICTURE</th>
<th>VALUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>RECORD-ID</td>
<td>1-3</td>
<td>X(3)</td>
<td>'AAA'</td>
</tr>
</tbody>
</table>

- Placeholder in record
- Name of field in record
- Type and length of data to populate
- Valid information to populate
- Placement in 512-byte record data
### RAPS Record Layout - AAA

**File Header**

<table>
<thead>
<tr>
<th>FIELD NO</th>
<th>FIELD NAME</th>
<th>POSITION</th>
<th>PICTURE</th>
<th>VALUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>RECORD-ID</td>
<td>1-3</td>
<td>X(3)</td>
<td>‘AAA’</td>
</tr>
<tr>
<td>2</td>
<td>SUBMITTER-ID</td>
<td>4-9</td>
<td>X(6)</td>
<td>‘Shnnnn’</td>
</tr>
<tr>
<td>3</td>
<td>FILE-ID</td>
<td>10-19</td>
<td>X(10)</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>TRANSACTION–DATE</td>
<td>20-27</td>
<td>9(8)</td>
<td>‘CCYMMDD’</td>
</tr>
<tr>
<td>5</td>
<td>PROD-TEST-IND</td>
<td>28-31</td>
<td>X(4)</td>
<td>‘PROD’ or ‘TEST’ or ‘CERT’</td>
</tr>
<tr>
<td>6</td>
<td>FILE-DIAG-TYPE</td>
<td>32-36</td>
<td>X(5)</td>
<td>‘ICD9’ or ‘ICD10’</td>
</tr>
<tr>
<td>7</td>
<td>FILLER</td>
<td>37-512</td>
<td>X(476)</td>
<td>SPACES</td>
</tr>
</tbody>
</table>

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

### RAPS Record Layout - BBB

**Batch Header**

<table>
<thead>
<tr>
<th>FIELD NO</th>
<th>FIELD NAME</th>
<th>POSITION</th>
<th>PICTURE</th>
<th>VALUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>RECORD-ID</td>
<td>1-3</td>
<td>X(3)</td>
<td>‘BBB’</td>
</tr>
<tr>
<td>2</td>
<td>SEQUENCE NUMBER</td>
<td>4-10</td>
<td>9(7)</td>
<td>Must begin with ‘0000001’</td>
</tr>
<tr>
<td>3</td>
<td>PLAN NUMBER</td>
<td>11-15</td>
<td>X(5)</td>
<td>‘Hnnnn’</td>
</tr>
<tr>
<td>4</td>
<td>FILLER</td>
<td>16-512</td>
<td>X(497)</td>
<td>SPACES</td>
</tr>
</tbody>
</table>
### RAPS Record Layout - CCC

#### Detail Record

<table>
<thead>
<tr>
<th>FIELD NO</th>
<th>FIELD NAME</th>
<th>POSITION</th>
<th>PICTURE</th>
<th>VALUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>RECORD-ID</td>
<td>1-3</td>
<td>X(3)</td>
<td>‘CCC’</td>
</tr>
<tr>
<td>2</td>
<td>SEQUENCE NUMBER</td>
<td>4-10</td>
<td>9(7)</td>
<td>Must begin with ‘0000001’</td>
</tr>
<tr>
<td>3</td>
<td>SEQUENCE NUMBER ERROR CODE</td>
<td>11-13</td>
<td>X(3)</td>
<td>SPACES</td>
</tr>
<tr>
<td>4</td>
<td>PATIENT CONTROL NUMBER</td>
<td>14-53</td>
<td>X(40)</td>
<td>Optional</td>
</tr>
<tr>
<td>5</td>
<td>HIC</td>
<td>54-78</td>
<td>X(25)</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>HIC ERROR CODE</td>
<td>79-81</td>
<td>X(3)</td>
<td>SPACES</td>
</tr>
<tr>
<td>7</td>
<td>PATIENT DOB</td>
<td>82-89</td>
<td>X(8)</td>
<td>‘CCYYMMDD’</td>
</tr>
<tr>
<td>8</td>
<td>DOB ERROR CODE</td>
<td>90-92</td>
<td>X(3)</td>
<td>SPACES</td>
</tr>
</tbody>
</table>

### RAPS Record Layout - CCC

#### Detail Record

<table>
<thead>
<tr>
<th>FIELD NO</th>
<th>FIELD NAME</th>
<th>POSITION</th>
<th>PICTURE</th>
<th>VALUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>9-18</td>
<td>DIAGNOSIS-CLUSTER (10 OCCURRENCES)</td>
<td>93 – 412</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.0</td>
<td>PROVIDER-TYPE</td>
<td>X(2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.1</td>
<td>FROM-DATE</td>
<td>9(8)</td>
<td></td>
<td>‘CCYYMMDD’</td>
</tr>
<tr>
<td>9.2</td>
<td>THRU-DATE</td>
<td>9(8)</td>
<td></td>
<td>‘CCYYMMDD’</td>
</tr>
<tr>
<td>9.3</td>
<td>DELETE-IND</td>
<td>X(1)</td>
<td></td>
<td>SPACE or ‘D’</td>
</tr>
<tr>
<td>9.4</td>
<td>DIAGNOSIS-CODE</td>
<td>X(7)</td>
<td></td>
<td>ICD9 or ICD10</td>
</tr>
<tr>
<td>9.5</td>
<td>DIAG-CLSTR-ERROR-1</td>
<td>X(3)</td>
<td></td>
<td>SPACES</td>
</tr>
<tr>
<td>9.6</td>
<td>DIAG-CLSTR-ERROR-2</td>
<td>X(3)</td>
<td></td>
<td>SPACES</td>
</tr>
<tr>
<td>19</td>
<td>Corrected HICN</td>
<td>413 – 437</td>
<td>X(25)</td>
<td>SPACES</td>
</tr>
<tr>
<td>20</td>
<td>FILLER</td>
<td>438 - 512</td>
<td>X(75)</td>
<td>SPACES</td>
</tr>
</tbody>
</table>
## Existing Versus New RAPS Layout

### CCC Detail Record

#### OLD FORMAT

<table>
<thead>
<tr>
<th>FIELD NO</th>
<th>FIELD NAME</th>
<th>POSITION</th>
<th>PICTURE</th>
<th>VALUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.4</td>
<td>DIAGNOSIS-CODE</td>
<td>X(5)</td>
<td>ICD9</td>
<td></td>
</tr>
<tr>
<td>9.5</td>
<td>DC-FILLER</td>
<td>X(2)</td>
<td>FILLER</td>
<td>PLACE HOLDER FOR ICD10</td>
</tr>
<tr>
<td>9.6</td>
<td>DIAG-CLUSTER-ERROR 1</td>
<td>X(3)</td>
<td>SPACES</td>
<td></td>
</tr>
<tr>
<td>9.7</td>
<td>DIAG-CLUSTER-ERROR 2</td>
<td>X(3)</td>
<td>SPACES</td>
<td></td>
</tr>
</tbody>
</table>

#### NEW FORMAT (effective 01/2012)

<table>
<thead>
<tr>
<th>FIELD NO</th>
<th>FIELD NAME</th>
<th>POSITION</th>
<th>PICTURE</th>
<th>VALUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.4</td>
<td>DIAGNOSIS-CODE</td>
<td>X(7)</td>
<td>ICD9 or ICD10</td>
<td></td>
</tr>
<tr>
<td>9.5</td>
<td>DIAG-CLUSTER-ERROR 1</td>
<td>X(3)</td>
<td>SPACES</td>
<td></td>
</tr>
<tr>
<td>9.6</td>
<td>DIAG-CLUSTER-ERROR 2</td>
<td>X(3)</td>
<td>SPACES</td>
<td></td>
</tr>
</tbody>
</table>

### Combined

#### Renumbered

### RAPS Record Layout - YYY

#### Batch Trailer

<table>
<thead>
<tr>
<th>FIELD NO</th>
<th>FIELD NAME</th>
<th>POSITION</th>
<th>PICTURE</th>
<th>VALUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>RECORD-ID</td>
<td>1-3</td>
<td>X(3)</td>
<td>‘YYY’</td>
</tr>
<tr>
<td>2</td>
<td>SEQUENCE NUMBER</td>
<td>4-10</td>
<td>9(7)</td>
<td>Must begin with ‘0000001’</td>
</tr>
<tr>
<td>3</td>
<td>PLAN NUMBER</td>
<td>11-15</td>
<td>X(5)</td>
<td>‘Hnnnn’</td>
</tr>
<tr>
<td>4</td>
<td>CCC RECORD TOTAL</td>
<td>16-22</td>
<td>9(7)</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>FILLER</td>
<td>23-512</td>
<td>X(490)</td>
<td>SPACES</td>
</tr>
</tbody>
</table>
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?

<table>
<thead>
<tr>
<th>Diagnosis Cluster 1</th>
<th>Diagnosis Cluster 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Type</td>
<td>20</td>
</tr>
<tr>
<td>From Date</td>
<td>20120201</td>
</tr>
<tr>
<td>Thru Date</td>
<td>20120201</td>
</tr>
<tr>
<td>Delete Indicator</td>
<td>(1 space)</td>
</tr>
<tr>
<td>Dx Code</td>
<td>4932 (plus 3 spaces)</td>
</tr>
<tr>
<td>DxCluster Error-1</td>
<td>(3 spaces)</td>
</tr>
<tr>
<td>DxCluster Error-2</td>
<td>(3 spaces)</td>
</tr>
</tbody>
</table>

| Provider Type       | 20                  |
| From Date           | 20120201            |
| Thru Date           | 20120201            |
| Delete Indicator    | (1 space)           |
| Dx Code             | 08881 (plus 2 spaces)|
| DxCluster Error-1   | (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).

<table>
<thead>
<tr>
<th>Diagnosis Cluster 1</th>
<th>Diagnosis Cluster 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Type</td>
<td>20</td>
</tr>
<tr>
<td>From Date</td>
<td>20130901</td>
</tr>
<tr>
<td>Thru Date</td>
<td>20130901</td>
</tr>
<tr>
<td>Delete Indicator</td>
<td>(1 space)</td>
</tr>
<tr>
<td>Dx Code</td>
<td>5733 (plus 3 spaces)</td>
</tr>
<tr>
<td>DxCluster Error-1</td>
<td>(3 spaces)</td>
</tr>
<tr>
<td>DxCluster Error-2</td>
<td>(3 spaces)</td>
</tr>
<tr>
<td>Provider Type</td>
<td>20</td>
</tr>
<tr>
<td>From Date</td>
<td>20130901</td>
</tr>
<tr>
<td>Thru Date</td>
<td>20130901</td>
</tr>
<tr>
<td>Delete Indicator</td>
<td>(1 space)</td>
</tr>
<tr>
<td>Dx Code</td>
<td>2910 (plus 3 spaces)</td>
</tr>
<tr>
<td>DxCluster Error-1</td>
<td>(3 spaces)</td>
</tr>
<tr>
<td>DxCluster Error-2</td>
<td>(3 spaces)</td>
</tr>
</tbody>
</table>

### 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?

<table>
<thead>
<tr>
<th>Diagnosis Cluster 1</th>
<th>Diagnosis Cluster 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Type</td>
<td>20</td>
</tr>
<tr>
<td>From Date</td>
<td>20111110</td>
</tr>
<tr>
<td>Thru Date</td>
<td>20111110</td>
</tr>
<tr>
<td>Delete Indicator</td>
<td>(1 space)</td>
</tr>
<tr>
<td>Dx Code</td>
<td>00323 (plus 2 spaces)</td>
</tr>
<tr>
<td>DxCluster Error-1</td>
<td>(3 spaces)</td>
</tr>
<tr>
<td>DxCluster Error-2</td>
<td>(3 spaces)</td>
</tr>
</tbody>
</table>
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)

<table>
<thead>
<tr>
<th>RAPS Reports</th>
<th>Contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>RAPS Return File</td>
<td>• Contains the entire submitted transaction</td>
</tr>
<tr>
<td></td>
<td>• Identifies 300-, 400-, and 500-level errors</td>
</tr>
<tr>
<td></td>
<td>• Flat file layout</td>
</tr>
<tr>
<td></td>
<td>• Received the next business day after submission</td>
</tr>
<tr>
<td>RAPS Transaction Error Report</td>
<td>• Communicates errors found in CCC records during processing</td>
</tr>
<tr>
<td></td>
<td>• Displays only 300-, 400-, and 500-level error codes</td>
</tr>
<tr>
<td></td>
<td>• Report layout</td>
</tr>
<tr>
<td></td>
<td>• Received the next business day after submission</td>
</tr>
<tr>
<td>RAPS Transaction Summary Report</td>
<td>• Summarizes the disposition of diagnosis clusters</td>
</tr>
<tr>
<td></td>
<td>• Report layout</td>
</tr>
<tr>
<td></td>
<td>• Received the next business day after submission</td>
</tr>
<tr>
<td>RAPS Duplicate Diagnosis Cluster Report</td>
<td>• Identifies diagnosis clusters with 502-error message</td>
</tr>
<tr>
<td></td>
<td>• Clusters accepted, but not stored</td>
</tr>
<tr>
<td></td>
<td>• Report layout</td>
</tr>
<tr>
<td></td>
<td>• Received the next business day after submission</td>
</tr>
</tbody>
</table>

**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!*
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

TIP 1

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

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>Calculate raw risk score <em>(round results)</em></td>
</tr>
<tr>
<td>Step 2</td>
<td>Divide raw risk score by FFS normalization factor <em>(round results)</em></td>
</tr>
<tr>
<td>Step 3</td>
<td>Apply coding intensity <em>(round results)</em></td>
</tr>
</tbody>
</table>

### 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?

Community vs. Institutional

- Short term institutionalized MA beneficiaries are included in the community population.
- 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 Long Term Institutional File provides information to RAS to flag LTI
- MARx selects appropriate risk score and flag to calculate payment
LTI and MMR Fields

1. Part C LTI FLAG (field 20; position 67)
   o Institutionalized for at least 90 days as of the payment month.
   o CMS will turn on LTI for risk adjustment when a beneficiary has a reported 90-day assessment.
   o 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)
   o 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

<table>
<thead>
<tr>
<th>Hierarchies</th>
<th>If, Then – If an HCC is in a hierarchy, then the less severe HCC(s) drop off</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example</td>
<td>HCC54 Schizophrenia</td>
</tr>
<tr>
<td></td>
<td>HCC55 Major Depressive, Bipolar, and Paranoid Disorders</td>
</tr>
<tr>
<td>Result</td>
<td>HCC55 not included in the risk score calculation because in hierarchy with HCC54</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Interactions</th>
<th>Disease and Disabled</th>
<th>Example:</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCC15 Diabetes with Renal or Peripheral Circulatory Manifestation (DM)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCC80 Congestive Heart Failure (CHF)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>INT1 DM_CHF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Result</td>
<td>Both individual HCCs and Interaction are included in the risk score calculation</td>
<td></td>
</tr>
</tbody>
</table>
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?
  o In the payment year?
  o 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
  o Community, Long Term Institutional, New Enrollee
  o SAS Model - V1210F1P.sas

• CMS-ESRD
  o Dialysis (New Enrollee), Transplant, Functioning Graft
  o SAS Model - E1210D1P.sas

• RX HCC
  o Community Non-Low Income, Community Low Income, Institutional, New Enrollee LI, New Enrollee Non LI, New Enrollee Institutional
  o 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
  o Dialysis
  o Transplant
  o Post-Graft/Functioning Graft

• MMR Reporting
  o Field 15, Position 62
    – “Y” following receipt of form 2728
  o 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)

<table>
<thead>
<tr>
<th>Multiplier</th>
<th>Description</th>
</tr>
</thead>
</table>
| LTI        | • 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        | • 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  
  o Long Term Institutional (LTI)  
  o Aged Low Income  
  o Aged non-Low Income  
  o Disabled Low Income  
  o 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:
  o What payment year is being reconciled?
    – Know the difference between Payment Year and Dates of Service (Data Collection Period)
  o 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?
  o 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

<table>
<thead>
<tr>
<th>HIC#</th>
<th>Last Name</th>
<th>First Initial</th>
<th>8/2009 MMR Reported Risk Score</th>
<th>ARC 25 (Y/N)</th>
<th>Reconciliation or Prospective Risk Score</th>
<th>Enrollment in Plan</th>
<th>Would plan receive 2008 Final Reconciliation Payment? Why?</th>
</tr>
</thead>
<tbody>
<tr>
<td>123456789A</td>
<td>Doe</td>
<td>J</td>
<td>1.348</td>
<td>N</td>
<td>Prospective risk score</td>
<td>Disenrolled in 2/2007 and reenrolled in 1/2009</td>
<td>No</td>
</tr>
<tr>
<td>998876543A</td>
<td>Blue</td>
<td>G</td>
<td>not on MMR</td>
<td></td>
<td></td>
<td>Disenrolled in 2/2007 DOD 5/30/2008</td>
<td>No</td>
</tr>
<tr>
<td>987654321B</td>
<td>Smith</td>
<td>J</td>
<td>not on MMR</td>
<td></td>
<td></td>
<td>Disenrolled in 4/2007</td>
<td>No</td>
</tr>
</tbody>
</table>

---

**Non-Drug**

The information for J. Doe is reported as the following on the sample Non-Drug MMR:
- **Gender:** 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**

---

**Risk Adjustment Payment Reconciliation**

---

**Risk Adjustment Factors and Factor Type Code**

---

**Health Status**

- Adjustment Reason Code
  - Part A, B, and Total Payments

---

**Adjustment Reason Code**

- **Part A, B, and Total Payments**
MOR

1***GROUP=H8888,CONTRACT=H8888,  
1RUN 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  XXXXXXXX Male60-64  
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
Please take a moment to complete the evaluation form for the Risk Adjustment Payment Reconciliation module.

*Your Feedback is Important! Thank you!*