2010

Risk Adjustment User Group

Date: January 20, 2010

Payment

1. Q. How can plans identify a member with a default factor?

   A. The Monthly Membership Report (MMR) communicates the default factor in the Default Factor Code field.

   If the Default Risk Factor Code field is blank, check the RA Factor Type field to determine if the member is a new enrollee. If the member is a new enrollee they are identified as a new enrollee and not a default enrollee.

2. Q. How are the normalization and coding intensity factors applied?

   A. Normalization factor is applied first followed by the coding intensity factor.

3. Q. Will CMS expand the RAPS file layout in April 2010 to collect expanded data elements?

   A. No.

4. Q. When is the yearly attestation for risk adjustment?

   A Generally after the first of the year. CMS will send out letters notifying plans.

5. Q. Should plans not submit invalid diagnosis codes with the deletion of edit code 501?

   A. The submission of data is the plans responsibility. However, CMS will no longer report a 501 error on the file.

6. Q. If CMS is reporting an incorrect gender code on a beneficiary and the plan has contacted the beneficiary several times and requested the beneficiary to contact Social Security to update the record, and no update has occurred; what is the plan's next course of action?

   A. The Social Security Administration must update gender. CMS cannot change update gender information.

7. Q. Should plans flag beneficiaries who loose their Part B and are reinstated in the plan to ensure the RAPS data has not dropped for that year?

   A. RAPS data will not drop for the beneficiary. If the beneficiary is dropped and reinstated in the same year once the model is run the data is captured for the entire period.

8. Q. Should plans expect a change in the final payment for a beneficiary that turns 65years old in February of the year?

   A. Age for risk adjustment is determined by the age as of February 1st of the payment year.

9. Q. How are diagnosis codes that are associated with more than one HCC applied?

   A. The beneficiary will be assigned all applicable HCCs associated with the diagnosis.

10. Q. Has CMS selected plans to participate in the submission of deletes for 2005, 2006 and 2007?

    A. CMS will contact the appropriate plans after its review and analyst.