Risk Adjustment Webinar Q&A Documentation

Questions and Answers – July 1, 2014

Q1: Can a beneficiary have a disabled status for risk adjustment if the member was originally enrolled due to age?

A1: If the beneficiary was originally enrolled due to age, they would not have the disabled status for risk adjustment. The disabled status is for community residents who were originally entitled to Medicare because they were disabled and under the age of 65.

Q2: Why aren't diagnoses from Skilled Nursing Facilities' (SNF) claims or Home Health acceptable for Risk Adjustment Processing System (RAPS) submissions?

A2: Diagnoses from a variety of services, including SNFs, are not used to calculate risk scores because they are considered not as reliable as the preferred sources -- hospital inpatient, hospital outpatient and selected clinician records. Other types of records add little new diagnostic information. Because CMS calibrates the model using the same methodology we use to calculate risk sores, the risk scores are calculated correctly. However, diagnoses from patients in a SNF are acceptable if they are obtained from a stand-alone visit from an acceptable risk adjustment specialty, as listed on Acceptable Physician Specialty Types for 2014 Payment Year (2013 Dates of Service) Risk Adjustment Data Submission, available at http://www.csscoperations.com/internet/cssc3.nsf/files/Acceptable%20Physician%20Specialty%20Types%20Effective%202014.doc/$FIle/Acceptable%20Physician%20Specialty%20Types%20Effective%202014.doc

Q3: Does the RAPS duplicate diagnosis check include the Risk Assessment codes when detecting duplicate diagnosis clusters?

A3: The Risk Assessment field is not used to detect duplicate diagnosis clusters.

Q4: Which payment runs include data with dates of service from July 1, 2013 through December 31, 2013?

A4: The dates of service for a payment year's initial risk score calculation overlap the dates of service from the previous payment year's midyear and final model runs. For example, dates of service from July 1, 2013 through June 30, 2014 are used for the payment year (PY) 2015 initial risk score calculations. Dates of service from January 1, 2013 through December 31, 2013 were used for the PY 2014 midyear and final risk score calculations. Therefore, diagnoses from the dates of service in the question, July 1, 2013 through December 31, 2013, are included in the PY 2014 midyear, the PY 2014 final, and the initial PY 2015 risk score calculations.

Q5: Is the Risk Assessment field a required field for all RAPS submissions?

A5: Effective for dates of service (DOS) starting January 1, 2014, plans must populate the Risk Assessment field for all risk adjustment data submitted to RAPS. The Risk Assessment field must contain one of these values:

A - Diagnosis code from a clinical setting

B - Diagnosis code from a non-clinical setting originating in a visit that meets all requirements for First Annual Wellness Visit or Subsequent Annual Wellness Visit

C - Diagnosis code from non-clinical setting originating in a visit that does not meet all requirements for a First Annual Wellness Visit or Subsequent Annual Wellness Visit

Q6: If an Annual Wellness Visit (AWV) occurs in a physician's office, would the Risk Assessment field be populated with "A" for all diagnoses captured during that visit?

A6: Populate the Risk Assessment field with an "A" for all diagnoses originating in a clinical setting.

Q7: What does "CC" mean in the date format CCYYMMDD?

A7: The "CC" in the date format CCYYMMDD stands for the century. For example, using the date October 15, 2014 in CCYYMMDD format (20141015), the "CC" is 20, the "YY" is 14, the "MM" is 10, and the "DD" is 15.

Q8: How does a plan delete a record from RAPS?

A8: In order to delete a record from RAPS, a plan should resubmit the original diagnosis, and populate the delete indicator field in the diagnosis cluster in the RAPS file with "D."

Q9: Once an ICD-9 diagnosis code has been submitted and accepted into RAPS, should plans continue to submit the same diagnosis code for each different date of service (DOS)?

A9: Plans are required to submit all ICD-9-CM diagnosis codes that meet the requirements for RAPS submission for each beneficiary. Plans are also required to submit unique diagnoses for each beneficiary at least once during the risk adjustment data collection period.

Q10: What is a diagnosis cluster?

A10: A diagnosis cluster contains the core information regarding each diagnosis submitted by a Medicare Advantage Organization (MAO). The following components are included in the cluster:

- Provider Type
- From Date
- Through Date
- Delete Indicator
- Diagnosis Code

Q11: How can a plan determine which diagnosis clusters were accepted by RAPS?

A11: Plans can refer to the RAPS Return File which provides the disposition of the diagnosis clusters and identifies if they are accepted or if there is an error.

Q12: Are ICD-10 codes currently accepted in RAPS submissions?

A12: ICD-10 codes are not currently accepted in RAPS submissions. As detailed in the *2015 Announcement of Calendar Year (CY) 2015 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter*, after the enactment of the *Protecting Access to Medicare Act of 2014*, which delayed the adoption of ICD-10 as the standard code for sets, CMS will not begin using ICD-10 on October 1, 2014. Therefore, plans should continue to submit ICD-9 diagnoses through September 30, 2015. The U.S. Department of Health and Human Services (HHS) issued a rule finalizing Oct. 1, 2015 as the new compliance date for health care providers, health plans, and health care clearinghouses to transition to ICD-10, the tenth revision of the International Classification of Diseases.

Q13: Do the place of service (POS) codes apply to PACE?

A13: The Medicare Advantage (MA) enrollee risk assessment code requirement applies to all entities that submit RAPS data to CMS.

Q14: Where can plans obtain the coefficient values for each HCC model?

A14: Coefficients for the risk adjustment models can be found in the Annual Rate Announcements at http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html. For detailed information on locating these values in the announcements, refer to page nine of the *July 1, 2014 Risk Adjustment Webinar Job Aids* located on CSSC at http://www.csscoperations.com/internet/cssc3.nsf/docsCat/CSSC~CSSC%20Operations~Risk%20Adjustment%20Processing%20System~Training?open&expand=1&navmenu=Risk%5eAdjustment%5eProcessing%5eSystem||.

Q15: What HCC model years will CMS use to calculate the PY 2016 risk scores?

A15: Changes to risk adjustment methodology for the 2016 payment year will be proposed in February 2015, and will be finalized in April 2015.

Q16: How will submissions from the Risk Adjustment Processing System (RAPS) and the Encounter Data Processing System (EDPS) be used to calculate risk scores for Payment Year (PY) 2015?

A16: When calculating risk scores for PY 2015, CMS will extract all diagnoses that meet their risk adjustment criteria from the Encounter Data System (EDS), Medicare Fee-for-Service (FFS), and RAPS. CMS will use all of these diagnoses in equal measure to calculate risk scores. Once diagnoses from all sources have been gathered, a master file of diagnoses for each beneficiary will be created, from which risk scores will be calculated. Since Encounter Data will not be included in the initial 2015 risk score, CMS will use diagnoses from RAPS with dates of service from July 1, 2013 through June 30, 2014 in the initial risk score run.

Q17: If a beneficiary was previously enrolled in Medicare Fee-for-service (FFS) and then changed to a Medicare Advantage plan, will that beneficiary have a New Enrollee status or a Full Risk status?

A17: New enrollee status is determined based on the number of months a beneficiary is enrolled in Part B in the data collection period, not where they were enrolled. If a beneficiary has 12 months of Part B in the data collection period, then they are full risk, and their risk score will incorporate diagnoses from whatever source has submitted them in the data collection year, whether it was FFS, MA, or both.