CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Risk Adjustment Webinar

July 1, 2014

11:00 a.m. to
3:00 p.m. ET

Risk Adjustment Webinar

- Introduction
- Overview and Policy
- Operations Overview
- Operations Updates
- Risk Score Calculation
- Summary

Purpose

The purpose of this webinar is to provide information and resources related to:

- Risk Adjustment Policies
- Operations
- Risk Score Calculation

Note: This webinar only covers the Risk Adjustment Processing System (RAPS). It does not include information on the Encounter Data System (EDS).

Target Audience

The primary audience for this call includes:

- Medicare Advantage Organizations (MAOs) and Part D Plan (PDP) Sponsors
  - ✓Regional and Employer Group Health Plans
  - ✓Specialty Plans
  - ✓Medicare Medicaid Plans (*MMPs)

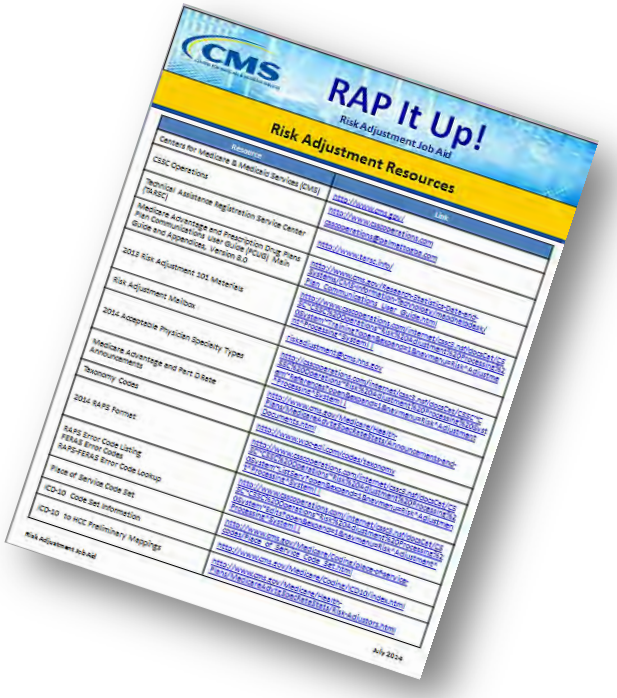
    *(*Webinar only covers Medicare information)*
- Programs for All Inclusive Care for the Elderly (PACE)
- Third Party Submitters

Agenda

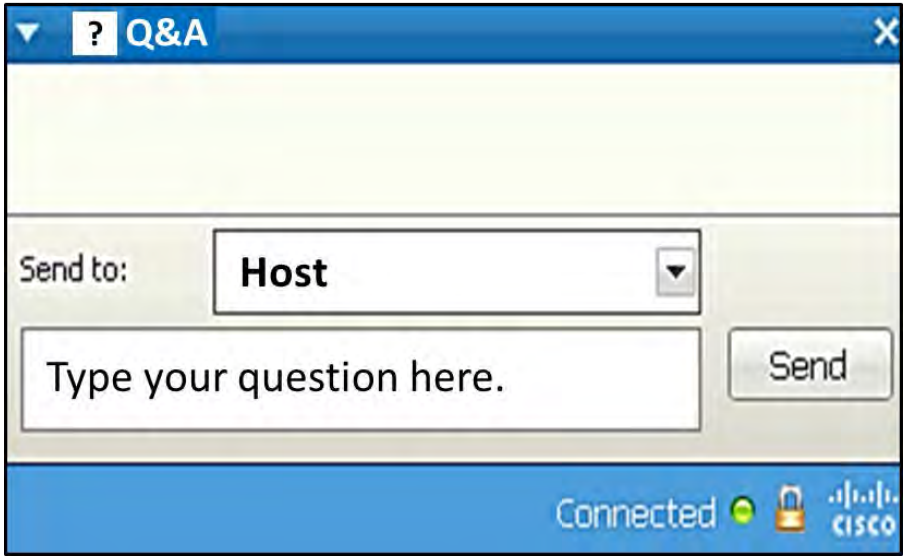
- Introduction
- Overview and Policy
- Operations Overview
- Operations Updates
- Risk Score Calculation
- Summary

Risk Adjustment Tools

- The materials provided in this training include:
  - ✓Job Aids
    - Provide handy tools for future reference
  - ✓Presentation Slides
    - Highlight the information covered during the session



Contact Information



To submit questions during the webinar

For questions regarding logistics or registration by phone, call **1-800-290-2910.**

After the webinar: riskadjustment@cms.hhs.gov

Polling Question Example

Please select your response to this question.

Today's training covers _____.

a) Encounter Data

b) Risk Adjustment

c) Prescription Drug Event

d) Payment

Risk Adjustment Webinar

Introduction | Overview and Policy | Operations Overview

Operations Updates | Risk Score Calculation | Summary

Learning Objectives

At the end of this module, participants will be able to:

- Explain the history and purpose of risk adjustment
- Identify at least five (5) risk adjustment model characteristics
- List the four main risk adjustment models

Risk Adjustment History

1997	• Balanced Budget Act (BBA)
2000	• Benefits Improvement and Protection Act (BIPA)
2003	• Medicare Prescription Drug, Improvement, and Modernization Act (MMA)
2004-2007	• Phase-in of Risk Adjustment

What is Risk Adjustment?

- Adjusts payments based on expected health care costs
- Promotes access and reduces adverse selection
- Utilizes multiple models to predict the costs of different benefits (for example, Parts C and D)
- Incorporates demographic and disease factors
- Uses diagnoses to predict the following year's costs

What is a 1.0 Risk Score?

- A 1.0 risk score represents average annual Medicare costs for an individual.
- A risk score higher than 1.0 means the individual is likely to incur costs higher than average.
- A risk score less than 1.0 means the individual will incur costs less than average.

What are the Risk Adjustment Models?

- CMS-HCC Models
- CMS-HCC PACE
- CMS-HCC ESRD
- Rx-HCC

Examples of CMS-HCC Model Segments:

- Aged/Disabled Community
- Aged/Disabled Institutional
- Aged/Disabled New Enrollee
- Aged/Disabled New Enrollee Chronic SNP

Risk Adjustment Model Characteristics

- Similar model characteristics for Part C and Part D
  - ✓ Selected Significant Disease (SSD) Model
  - ✓ Prospective Model
  - ✓ Site neutral
  - ✓ Diagnostic sources
  - ✓ Multiple chronic diseases considered
  - ✓ Disease interactions and hierarchies included
  - ✓ Demographic variables (e.g., age, sex, disabled status, and original reason for entitlement)

Risk Adjustment Model Characteristics, *continued*

- Model Characteristics Specific for Part C
  - ✓Medicaid eligibility
  - ✓Community-Based and Long-Term Institutionalized enrollees distinguished
  - ✓ESRD CMS-HCC Model

Risk Adjustment Model Characteristics, *continued*

- Age status
- Sex
- Disabled status
- Original Reason for Entitlement (OREC)
- Medicaid status
- Institutionalized status

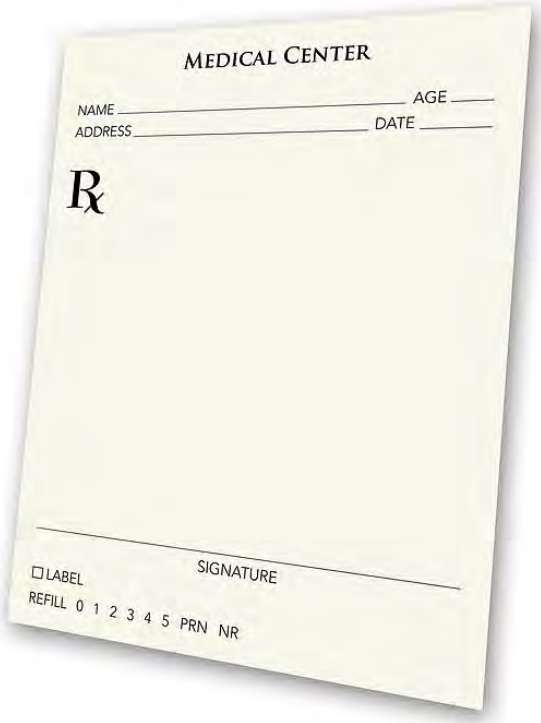
Risk Adjustment Model Characteristics, *continued*

Frailty add-on is used for:

- PACE
- Some FIDE-SNP plans

Risk Adjustment Model Characteristics for Part D

- Pre-2011 year
  - ✓Base Score
  - ✓Long-term Multiplier
  - ✓Low-income Multiplier
- Including and Post-2011
  - ✓Separate Model
  - ✓Segments for Low Income and LTI Beneficiaries



Diagnostic Characteristics

- Disease groups contain major diseases and are broadly organized into body systems.
- Disease groups are referred to as Hierarchical Condition Categories (HCCs).
- HCC assigned to a disease is determined by the ICD-9-CM diagnosis codes submitted during a data collection period.
- Only selected diagnoses are included in the risk adjustment models.

Hierarchical Condition Categories (HCCs)

- Payments are provided for only the most severe manifestation of a disease, even when diagnoses for less severe manifestations of a disease are also present for a beneficiary during a data collection period.

Example from 2014 CMS-HCC Model: Beneficiary has diabetes without complications (HCC19) and then progresses to diabetes with acute complications (HCC17). The costs of HCC19 are covered under HCC17, which is the more severe manifestation of the disease. Therefore, only HCC17 will be included in payment calculations.

Interactions

There are two types of interactions:

- Disease
  - ✓Disease combinations can increase an individual's medical costs.
  - ✓Combinations may be two or three diseases in an interaction.

    Example: Diabetes and congestive heart failure
- Disabled
  - ✓This is a combination of certain diseases and the disabled status of an enrollee.

    Example: Disabled status and opportunistic infection

An **interaction** is the combination of multiple diagnoses or a diagnosis with disabled status that results in an additional relative factor added to the risk score calculation.

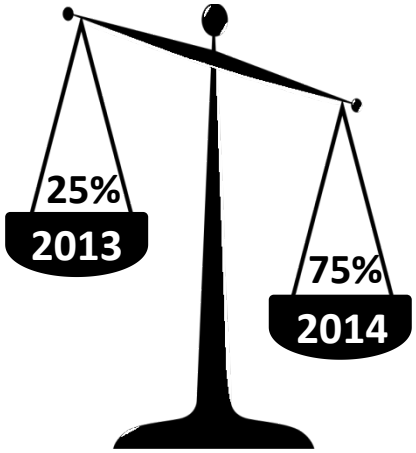
Part C Risk Adjustment Models for 2014 and 2015

- The Payment Years 2014 and 2015 risks scores are determined by first calculating the score using the 2013 CMS-HCC (V12) model, then calculating it using the 2014 CMS-HCC (V22) model, and then blending those two scores.
- Each risk score is adjusted with the PY 2015 normalization factor for each payment year.
- The risk score is also adjusted with the MA coding adjustment factor.

Part C Risk Adjustment Models for 2014 and 2015, *continued*

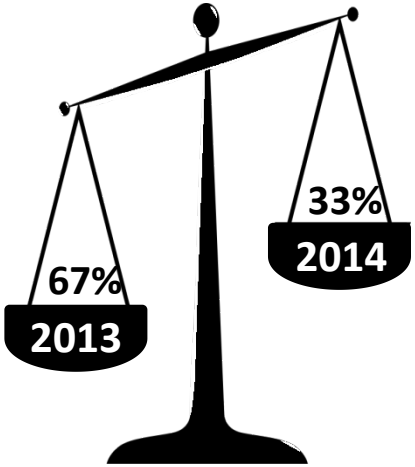
For Payment Year (PY) 2014 (2013 Dates of Service)

When blending, the 2013 CMS-HCC model risk scores are weighted at 25%, and the 2014 CMS-HCC model risk scores are weighted at 75%.



For Payment Year (PY) 2015 (2014 Dates of Service)

When blending, the 2013 CMS-HCC model risk scores are weighted at 67%, and the 2014 CMS-HCC model risk scores are weighted at 33%.



New Enrollee/Default RAFT Code

- New Enrollee Risk Adjustment Factor Type (RAFT) Code
  - ✓The Enrollee has less than 12 months of Medicare Part B in a data collection period.
  - ✓The risk score is generated by the Risk Adjustment System (RAS).
- Default Risk Factor Code
  - ✓Used when RAS does not calculate a score
  - ✓Entitlement is new and occurs after a model run.
  - ✓Change in status occurs between model runs.

Normalization

- Normalization adjusts for growth in risk scores year after year.
- Reasons for this include population trends and diagnostic coding between model estimation and payment year.

Coding Adjustment

- MA plan providers code differently than Fee-For-Service (FFS) providers.
- MA plan risk scores increase faster than FFS risk scores.
- The goal of the MA coding adjustment is 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).

Test Your Knowledge

What is the risk score for an “average” Medicare beneficiary?

a) 0.1

b) 1.0

c) 5.0

Test Your Knowledge

If you are considered a “New Enrollee” for risk adjustment, how long have you had Medicare Part B?

a) Less than 12 months in a data collection period

b) No Part B coverage at all

c) 12 consecutive months

Test Your Knowledge

How many different risk adjustment models did we discuss?

a) None

b) Four

c) Nine

Test Your Knowledge

Where are the normalization factors published?

a) On TARSC

b) On the CSSC website in the Training Materials

c) On the CMS.gov website in the Payment Announcement for each year

Questions

Risk Adjustment Webinar

Introduction | Overview and Policy | **Operations Overview**

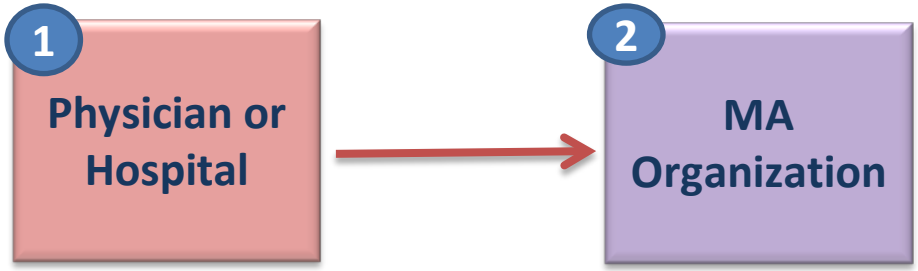
Operations Updates | Risk Score Calculation | Summary

Learning Objectives

At the end of this module, participants will be able to:

- Identify the sources for data collection
- Explain the requirements for submitting data to CMS
- Review the Risk Adjustment Processing System (RAPS) record layout
- Describe the error logic and reports

Data Collection



A physician documents a patient's visit in patient's medical record.

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

Data Collection, *continued*

- Sources of Risk Adjustment Data
- Data Elements
- Data Collection Formats

Data Collection Sources

- Hospital Inpatient
- Hospital Outpatient
- Physician Services

Data Collection
Covered and Non-Covered

Hospital Outpatient

Covered Facilities	Non-Covered Facilities*
• Short-term (general and specialty) Hospitals • Medical Assistance Facilities/Critical Access Hospitals • Community Mental Health Centers • Federally Qualified Health Centers • Religious Non-Medical Health Care Institutions • Long-term Hospitals • Rehabilitation Hospitals • Children's Hospitals • Psychiatric Hospitals • Rural Health Clinic (Free-standing and Provider-Based)	• Free-standing Ambulatory Surgical Centers (ASCs) • Home Health Care • Free-standing Renal Dialysis Facilities <u>Non-Covered Services</u> • Laboratory Services • Ambulance • Durable Medical Equipment • Prosthetics • Orthotics • Supplies • Radiology Services

*These are examples of non-covered facilities and are not a comprehensive list.

Data Collection Covered Entities

Hospital Outpatient Covered Entities Type

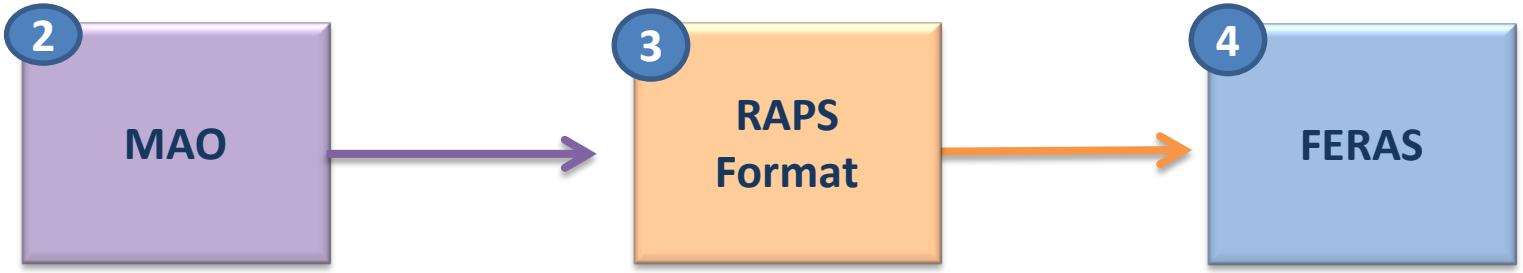
Type of Hospital Outpatient Facility	Taxonomy Code/ Type of Bill (TOB)
Short-term (General and Specialty) Hospital	282N00000X 273R00000X 273Y00000X
Medical Assistance Facilities/Critical Access Hospitals	282NC0060X
Community Mental Health Centers	TOB 76X
Federally Qualified Health Centers/Religious Non-Medical Health Care Institutions	TOB 73X for FQHC TOB 4XX for RNHCI
Long-term Hospitals	282E00000X
Rehabilitation Hospitals	283X00000X
Children's Hospitals	282NC2000X
Rural Health Clinics, Freestanding and Provider-Based	TOB 71X
Psychiatric Hospitals	283Q00000X

Types of facilities and taxonomy codes resource: http://www.wpc-edi.com/codes/taxonomy

RAPS Data Collection Minimum Data Elements

- HIC (Health Insurance Claim) Number
- Provider Type
- “From” Date of Service
- “Through” Date of Service
- Diagnosis Code

Submission



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.

Submission, *continued*

- Diagnoses
- Submission Schedule
- Formats
- Filtering
- Low Submissions
- Duplicate Submissions

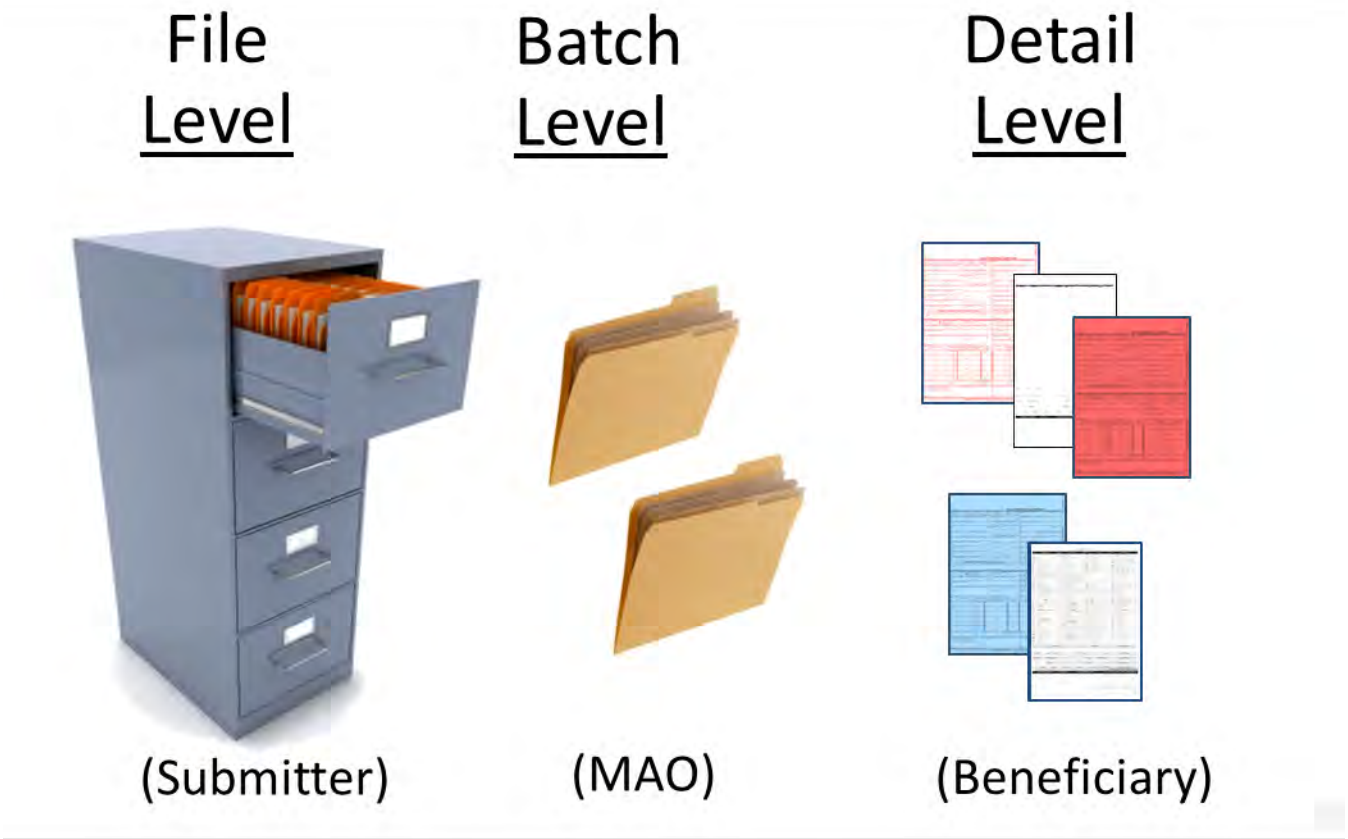
RAPS Submission Required Diagnoses

- All diagnoses submitted must meet risk adjustment rules.
- A beneficiary's diagnoses should be submitted at least once during a data collection year.

RAPS Submission Schedule

Payment Year	Model Run	Dates of Service	Timeframe
2015	Initial	7/1/2013 – 6/30/2014	September 2014
2015	Mid-year	1/1/2014 – 12/31/2014	March 2015
2015	Final	1/1/2014 – 12/31/2014	January 2016

Submission
RAPS Format File Logic



Submission RAPS Format

File Layout Record Types:

- AAA – File Header
- BBB – Batch Header
- CCC – Detail
- YYY – Batch Trailer
- ZZZ – File Trailer

AAA RECORD

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

BBB RECORD

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

CCC RECORD

FIELD NO.	FIELD NAME	POSITION	PICTURE	VALUE
1	RECORD-ID	1 – 3	X(3)	'CCC'
2	SEQ-NO	4 – 10	9(7)	Must begin with '0000001'
3	SEQ-ERROR-CODE	11 – 13	X(3)	SPACES
4	PATIENT-CONTROL-NO	14 – 53	X(40)	Optional
5	HIC-NO	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
9 – 15	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)	ICD-9 or ICD-10
9.5	DIAG-CLSTR-ERROR-1		X(3)	SPACES
9.6	DIAG-CLSTR-ERROR-2		X(3)	SPACES
16	CORRECTED-HIC-NO	413 – 437	X(25)	SPACES
17 – 18	RISK ASSESSMENT-CODE-CLUSTER (10 OCCURRENCES)	438 – 477		
17.0	RISK ASSESSMENT-CODE		X(1)	'A', 'B', or 'C'
17.1	RISK ASSESSMENT-CODE-ERROR		X(3)	SPACES
19	FILLER	478 - 512	X(35)	SPACES

YYY RECORD

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

ZZZ RECORD

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

Submission Diagnosis Cluster

- There are four provider type codes:
  - ✓ Hospital inpatient principal – 01
  - ✓ Hospital inpatient other – 02
  - ✓ Hospital outpatient – 10
  - ✓ Physician – 20
- A unique diagnosis cluster has at least one required element in the cluster that is different from another cluster previously accepted and stored for a beneficiary.

Submission
Diagnosis Cluster, *continued*

- From and through dates must be in CCYYMMDD format.
- Interim diagnoses are not permitted.
- Diagnosis codes must be diagnosed, documented, and submitted.
- Decimal is implied and should not be entered.

Submission Quick Facts

- The same submitter may transmit for several MAOs.
- More than one batch is allowed per H number.
- More than one detail record is allowed per HIC number.
- Once a cluster is submitted and stored, do not resubmit the cluster.

Filtering for RAPS Submissions

- MA organizations are required to filter risk adjustment data submitted to RAPS to ensure it only comes from acceptable hospital inpatient, hospital outpatient, and physician provider types.
  - ✓ Hospital inpatient data require admission and discharge dates of service from appropriate facilities.
  - ✓ Outpatient data require diagnoses from appropriate facilities and covered services contained on the CMS covered outpatient listings.
  - ✓ Physician data require visits with a professional listed on the CMS specialty list.
  - ✓ Diagnoses must result from a face-to-face encounter with an acceptable provider.

Submission Modifying Data

- Adding data
- Deleting data
- Correcting data

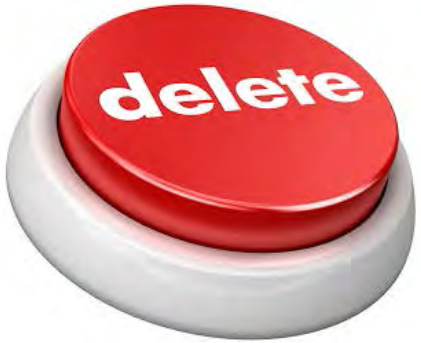
Incorrect clusters must be deleted from the system before correct cluster information can be added.

Submission
Deleting Diagnosis Clusters

- Remember:
  - ✓Only accepted diagnosis clusters may be deleted.
  - ✓Erroneously submitted clusters must be deleted.
- Steps to delete clusters:
  - ✓Verify diagnosis cluster was accepted.
  - ✓Select method for deleting cluster:
    - RAPS format – Submit correction using normal submission process with appropriate HIC number included.
    - DDE – Submit correction through DDE screens to the front-end system.
  - ✓Enter "D" in Delete Indicator field of diagnosis cluster.

Submission
Deleting Diagnosis Clusters, *continued*

- Steps to delete clusters, continued:
  - ✓ Delete the incorrect cluster through RAPS format or DDE screens.
    - "D" is entered into the appropriate field to designate the cluster that needs to be deleted.
  - ✓ If necessary, enter a cluster with the correct data.
  - ✓ Do not resubmit clusters for which modification is required.



Submission
MAO Deletion Responsibilities

- MA organizations must delete a diagnosis cluster when any data in that cluster are in error.
- When correcting data, MA organizations must submit a corrected cluster to replace the deleted one.
- MA organizations may submit corrections and deletions on the same record or in the same file.

Duplicate deletes in the same record on the same day cause system problems.

Submission
Direct Data Entry (DDE)

- DDE entries allow deletion of records for corrections even if another submission format was used.
- DDE screens automatically prevent the placement of incorrect data characters.

Submission Low

- Each quarter, plans should submit approximately 25% of the total expected data for the year for each provider type.
- Lower submission may indicate a data collection issue.

Submission Duplicate

- To identify and avoid duplicate diagnosis clusters:
  - ✓Review reports.
  - ✓Understand error resolution.
  - ✓Understand modifying data.
  - ✓Understand RAPS processing.

Submission
Improving Payment Accuracy

- On May 19, 2014, CMS issued a final rule revising the Medicare Advantage (MA) and Part D prescription drug benefit programs regulations to implement statutory requirements, improve program efficiencies, clarify program requirements, and improve payment accuracy for Contract Year (CY) 2015.
- The final regulation implements the Affordable Care Act (ACA) requirement that MA plans and Part D sponsors report and return identified Medicare overpayments.

Submission
Improving Payment Accuracy, *continued*

- After the final risk adjustment deadline for a payment year, MA organizations will be allowed to submit data to correct overpayments, but cannot submit diagnosis codes for additional payment.

- The provision codifies and clarifies rules regarding when Part D and MA plan sponsors must report and return overpayments.

Submission
Improving Payment Accuracy, *continued*

For a summary of the final provisions of these program changes and for the entire regulation, refer to:

CMS.gov Fact Sheet:
http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-05-19.html

CMS-4159-F Regulation:
https://s3.amazonaws.com/public-inspection.federalregister.gov/2014-12546.pdf

Test Your Knowledge

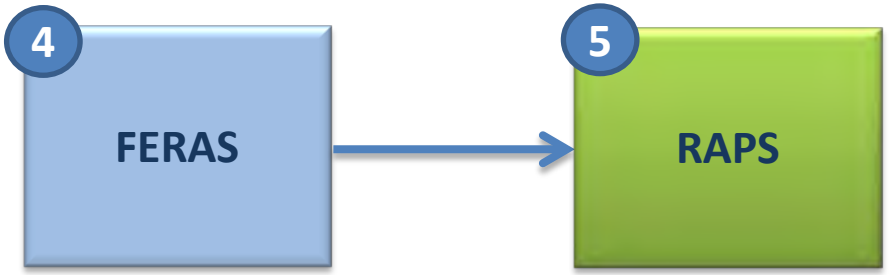
How often must MA organizations submit data for risk adjustment?

a) Weekly at a minimum

b) Annually at a minimum

c) Quarterly at a minimum

Errors and Reports



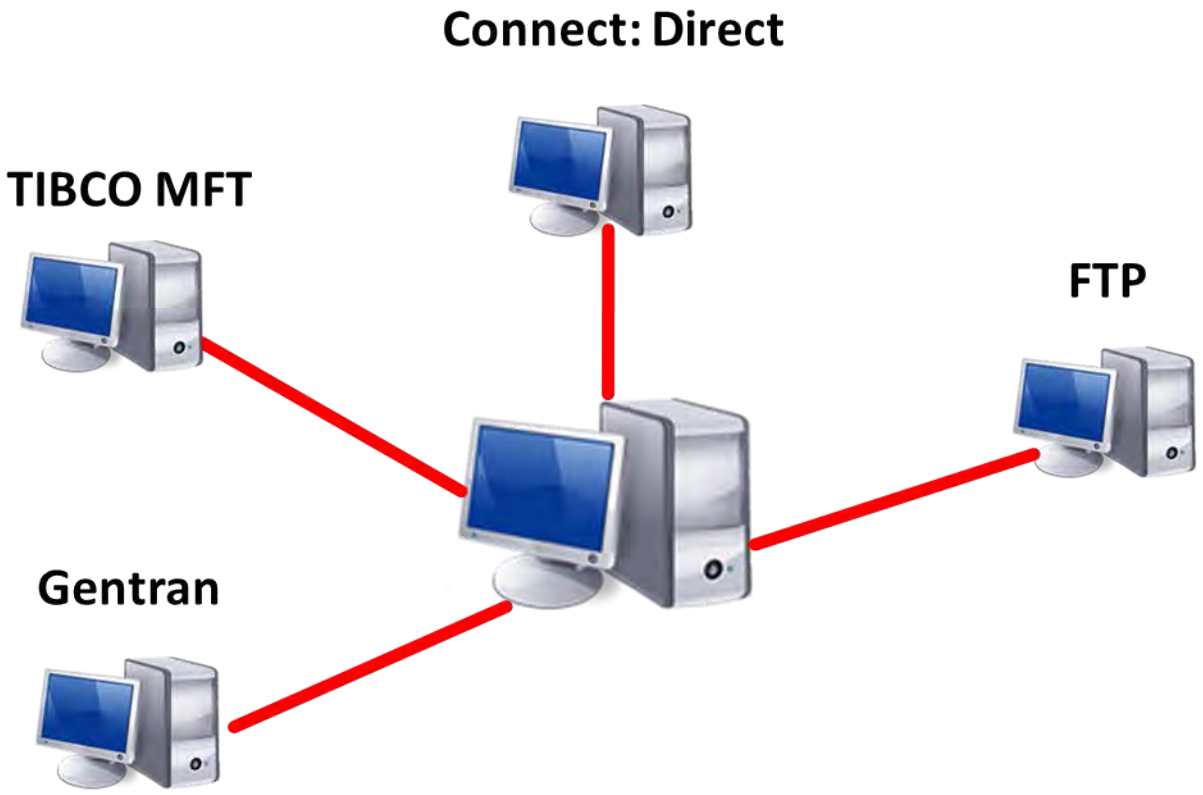
Data goes to Front–End Risk Adjustment System (FERAS) for processing where file-level data, batch-level data, and first and last detail records are checked.

After passing FERAS checks, file goes to CMS Risk Adjustment Processing System (RAPS) for detail editing.

Errors and Reports, *continued*

- Accessing Reports
- FERAS Edit Logic and Error Code Ranges
- FERAS Response Report
- RAPS Editing Rules and Error Codes
- RAPS Transaction Reports
- RAPS Management Reports

Accessing Reports



Reports Overview

Type	Report
FERAS	FERAS Response
RAPS Transaction	RAPS Return File
	RAPS Transaction Error Report
	RAPS Transaction Summary Report
	RAPS Duplicate Diagnosis Cluster Report
RAPS Management	RAPS Monthly Plan Activity Report
	RAPS Cumulative Plan Activity Report
	RAPS Monthly Error Frequency Report
	RAPS Quarterly Error Frequency Report

FERAS Edit Logic

Series	Explanation
100	File level errors on the AAA or ZZZ records
200	Batch level errors on the BBB or YYY records
300 & 400	Check performed on first and last CCC records

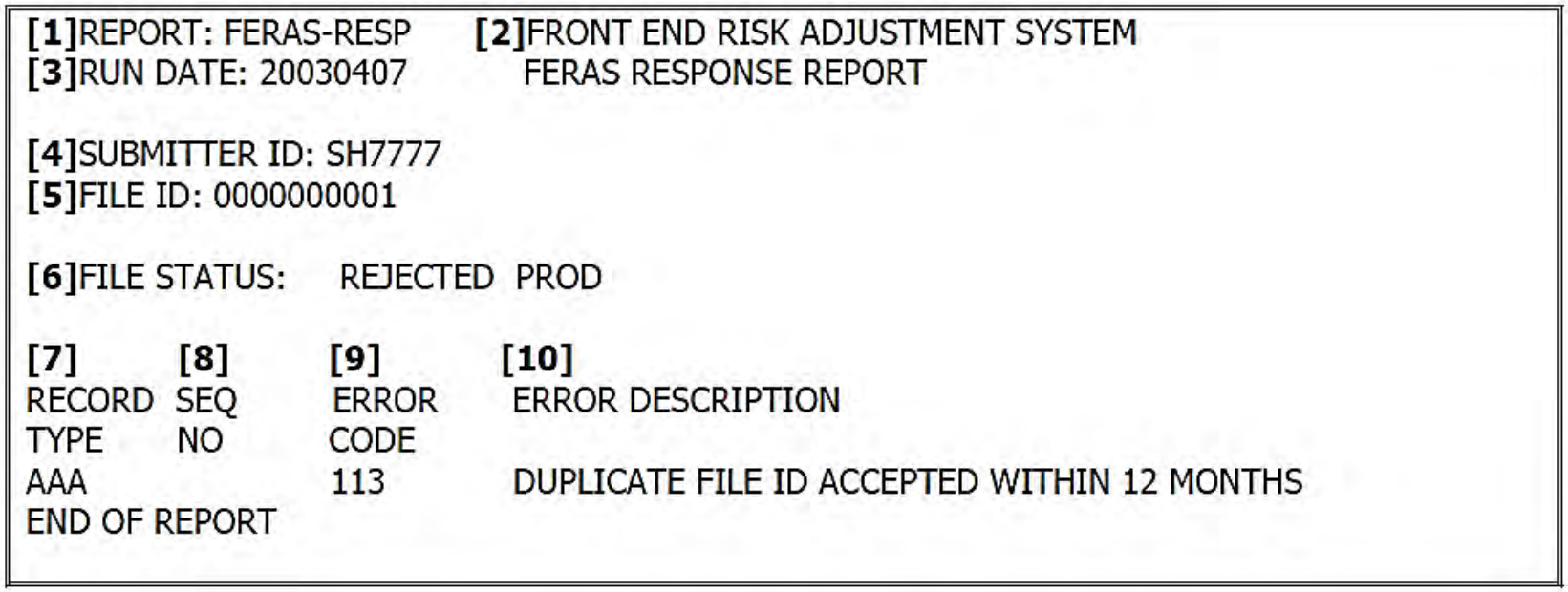
FERAS Error Code Ranges

100	101-125	→	AAA
	151-175	→	ZZZ
200	201-225	→	BBB
	251-275	→	YYY

FERAS Response Report

- The FERAS Response Report
  - ✓ Indicates the file is accepted into the system or rejected
  - ✓ Identifies reasons for rejection
  - ✓ Is provided in a report layout
  - ✓ Is received by FTP users the same business day
  - ✓ Is received by Connect:Direct, Gentran, and TIBCO users the next business day

Rejected FERAS Response Report



[1]REPORT: FERAS-RESP [2]FRONT END RISK ADJUSTMENT SYSTEM
[3]RUN DATE: 20030407 FERAS RESPONSE REPORT

[4]SUBMITTER ID: SH7777
[5]FILE ID: 0000000001

[6]FILE STATUS: REJECTED PROD

[7] RECORD TYPE	[8] SEQ NO	[9] ERROR CODE	[10] ERROR DESCRIPTION
AAA		113	DUPLICATE FILE ID ACCEPTED WITHIN 12 MONTHS

END OF REPORT

RAPS Editing Rules

- Field Validity and Integrity Edits
- Field-to-Field Edits
- Eligibility Edits
- Diagnosis Code Edits

RAPS Error Codes

Level	Series	Explanation of Errors and Consequences
Record	**300-349**	Record-level error - The record was bypassed and all editing was discontinued. No diagnosis clusters from this record were stored.
	350-399	Record-level error - All possible edits were performed, but no diagnosis clusters from this record were stored.
Cluster	**400-489**	Diagnosis cluster error - All possible diagnosis edits were performed, but the diagnosis cluster is not stored.
	490-499	Diagnosis delete error - Diagnosis was not deleted.
	500-599	Informational message, all edits were performed, diagnosis cluster was stored unless some other error is noted.

RAPS Transaction Reports

Report	Details
RAPS Return File	• 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	• 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	• Summarizes the disposition of diagnosis clusters • Report layout • Received the next business day after submission
RAPS Duplicate Diagnosis Cluster Report	• Identifies diagnosis clusters with 502-error message • Clusters accepted into system, but not stored • Report layout • Received the next business day after submission

RAPS Return File

- Uses for the RAPS Return File Format:
  - ✓ Identifies steps in the process where there may be data processing issues
  - ✓ Helps physicians and providers submit clean data in a timely manner
  - ✓ Confirms that the right data and the right amount of data is being submitted
  - ✓ Improves the quality and quantity of data submissions

RAPS Transaction Error Report

- Displays detail-level (CCC) record errors that occurred in RAPS
- Available in report layout only
- Received the next business day after submission

RAPS Transaction Summary Report

RISK ADJUSTMENT PROCESSING SYSTEM
TRANSACTION SUMMARY REPORT

[1]REPORT: RAPS001
[2]RUN DATE: 20030412 **[3]**TRANS DATE:20030411

[4]SUBMITTER ID SH7777 **[5]**PLAN ID: H7777 **[6]**FILE ID: 0000000001

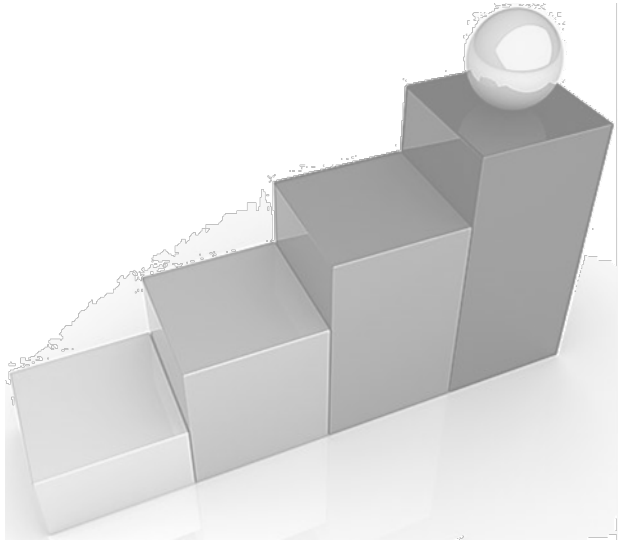
[7]PROVIDER TYPE	PRINCIPAL INPATIENT	OTHER INPATIENT	OUTPATIENT	PHYSICIAN	**[8]**UNIDENTIFIED	TOTAL
[9]TOTAL SUBMITTED	207	1,213	0	0	0	1,420
[10]TOTAL REJECTED	9	49	0	0	0	58
[11]TOTAL ACCEPTED	198	1,164	0	0	0	1,362
[12]TOTAL STORED	189	1,099	0	0	0	1,288
[13]TOTAL MODEL STORED	103	368	0	0	0	471
[14]TOTAL DELETE ACPTD	0	0	0	0	0	0
[15]TOTAL DELETE RJCTD	0	0	0	0	0	0

RAPS Duplicate Diagnosis Cluster Report

- Lists diagnosis clusters with 502-error information message
- Reflects clusters previously submitted and stored in the RAPS database with same:
  - ✓HIC number
  - ✓Provider type
  - ✓From and through dates
  - ✓Diagnosis
- Is received the next business day after submission

RAPS Resolution Steps

1. Determine the error level of the code to identify the nature of the problem.
2. Look up the error code and read the associated message.
3. Based on the error message, determine the next step.
4. Take steps to resolve the error.



RAPS Management Reports

Report	Details
RAPS Monthly Plan Activity Report	• Provides monthly summary of the status of submissions by submitter ID and plan number • Report layout • Available for download the second business day of the month, in months with activity
RAPS Cumulative Plan Activity Report	• Provides cumulative summary of the status of submissions by submitter ID and plan number • Report layout • Available for download the second business day of the month, in months with activity
RAPS Monthly Error Frequency Report	• Provides monthly summary of all errors associated with files submitted in test and production • Report layout • Available for download the second business day of the month
RAPS Quarterly Error Frequency Report	• Provides a quarterly summary of all errors on all file submissions within the 3-month quarter • Report layout • Available for download the second business day of the month following each quarter

RAPS Monthly Plan Activity Report

- Provides a summary of the status of submissions for a 1-month period
- Arrayed by provider type and month based on through date of service
- Reported by submitter ID and H number
- Allows tracking on a month-by-month basis for all diagnosis clusters submitted
- Available for download the second business day of the month

RAPS Cumulative Plan Activity Report

- Provides a cumulative summary of the status of submissions
- Report format similar to Monthly Plan Activity Report
- Service year “9999” indicates data have been rejected (not stored)
- Available for download by the end of the next processing day following submission

RAPS Error Frequency Reports

- Are received monthly and quarterly
  - ✓Monthly summary
  - ✓Three-month summary
- Summarize errors received in test and production
- Display frequencies for all errors received by provider type
- Provided in report layout
- Are available for download the second business day of the month/quarter

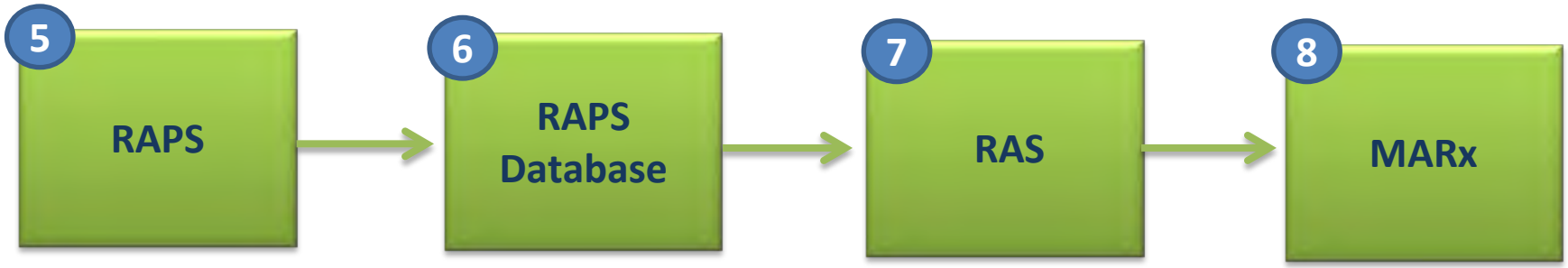
Correcting Rejected Data

- When submitting corrected data, rejected clusters are reflected in cumulative totals for the month and in total rejections.
- When a cluster is counted as stored, it remains part of the stored count on the Cumulative Plan Activity Report, even if it is deleted.
- Deleted clusters are included in total stored and total deleted.
- Reports can help identify internal processes affecting data collection and submission, as well as external issues affecting data collection.

Naming Conventions

Report Name	Mailbox Identification
FERAS Response Report	RSP#9999.RSP.FERAS_RESP_
RAPS Return File	RPT#9999.RPT.RAPS_RETURN_FLAT_
RAPS Transaction Error Report	RPT#9999.RPT.RAPS_ERROR_RPT_
RAPS Transaction Summary Report	RPT#9999.RPT.RAPS_SUMMARY_
RAPS Duplicate Diagnosis Cluster Report	RPT#9999.RPT.RAPS_DUPDX_RPT_
RAPS Monthly Plan Activity Report	RPT#9999.RPT.RAPS_MONTHLY_
RAPS Cumulative Plan Activity Report	RPT#9999.RPT.RAPS_CUMULATIVE_
RAPS Monthly Error Frequency Report	RPT#9999.RAPS_ERRFREQ_MNTH_
RAPS Quarterly Error Frequency Report	RPT#9999.RAPS_ERRFREQ_QTR_

RAPS Data Flow



After passing FERAS checks, file goes to CMS Risk Adjustment Processing System (RAPS) for detail editing.

The RAPS database stores all finalized diagnosis clusters.

Risk Adjustment System (RAS) executes risk adjustment models and calculates risk score.

Medicare Advantage Prescription Drug System (MARx) processes beneficiary-level payments and issues reports documenting data used in payment (MMR and MOR).

Test Your Knowledge

How many types of editing rules are there in the RAPS editing process?

a) Five

b) Four

c) It Depends

Test Your Knowledge

Why are there no 100 or 200 level error codes in RAPS?

a) Those levels are checked in FERAS.

b) Those levels are reserved for future use.

c) There are no such things as 100 and 200 level edits.

Test Your Knowledge

What RAPS Transaction Report comes in a flat file format?

a) RAPS Transaction Summary Report

b) RAPS Return File

c) RAPS Duplicate Diagnosis Cluster Report

Test Your Knowledge

In what order should the data on the RAPS Monthly and Cumulative Plan Activity reports be read?

a) In no particular order

b) Left to right

c) Left to right, and top to bottom

Questions

Break

Risk Adjustment Webinar

Introduction | Overview and Policy | Operations Overview

Operations Updates | Risk Score Calculation | Summary

Learning Objectives

At the end of this module, participants will be able to:

- Explain how risk assessment data is collected and reported in 2014
- Show how risk assessment data will be used in 2015
- Recognize that EDS diagnoses will be used for risk score calculation in 2015

2014 Risk Assessment Data Collection

- Beginning with 2014 dates of service, CMS instituted a new requirement for MA organizations to identify, in the diagnoses they submit to CMS, which diagnoses are from home visits.
- This data will enable CMS to evaluate how many diagnoses are identified in home visits and to assess what effect the home assessments have on the care provided to beneficiaries.

2014 Risk Assessment Data Collection, *continued*

- Effective for dates of service (DOS) starting 1/1/2014, 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

  *For information on the requirements for a First Annual Wellness Visit and Subsequent Annual Wellness Visit, see 42 CFR 410.15(a).

2014 Risk Assessment Data Collection, *continued*

- For risk adjustment purposes, a setting is clinical or non-clinical based on the place of service (POS).
- A setting is a POS, not a type of service or a type of provider.
- For purposes of MA risk adjustment, a non-clinical setting is a beneficiary's home, which is referenced as code 12, "Home," in the existing POS Codes for professional services located at: http://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html.
- Use risk assessment code A for diagnoses that come from clinical settings.
- Use risk assessment codes B and C for diagnoses that come from non-clinical settings, that is, the beneficiary's home.

Test Your Knowledge

If a diagnosis submitted for RAPS originates in a clinical setting, what code would be used in the Risk Assessment field?

- a) A
- b) B
- c) C

Test Your Knowledge

For the purposes of MA risk adjustment, what is a non-clinical setting?

a) A beneficiary's home, which is POS 12

b) A school or other public place

c) An outpatient facility

Using EDS Diagnoses for Risk Score Calculation

- CMS will continue using diagnoses submitted to RAPS, along with diagnoses from Fee For Service (FFS) providers for 2015 risk score calculations.
- Starting PY 2015 (DOS 2014), diagnoses for risk score calculation will also come from the Encounter Data System (EDS).
- Valid diagnoses from RAPS, FFS, and EDS will be used in equal measures with no weighting.

Questions

Risk Adjustment Webinar

Introduction | Overview and Policy | Operations Overview

Operations Updates | **Risk Score Calculation** | Summary

Risk Score Calculation Introduction

- Risk scores:
  - ✓ Measure individual beneficiaries' relative risk.
  - ✓ Are used to adjust payments and bids 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 coefficients associated with each beneficiary's demographic and disease factors.

Risk Score Calculation
New Beneficiary to Full Risk Score

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

Risk Score Calculation
New Beneficiary to Full Risk Score

- For purposes of risk adjustment, new enrollees are defined as newly eligible disabled or aged-in beneficiaries with less than 12 months of Medicare Part B entitlement during the data collection year, which is the same as the calendar year.
- A new enrollee will become a full-risk beneficiary after having 12 months of Medicare Part B entitlement in a data collection year.
- During the payment year, a new enrollee factor will also be assigned to any beneficiary whose risk score is not available. In this case, the beneficiary's correct risk score will be determined during the next reconciliation.

New Beneficiary to Full Risk Score Example

Ben Beneficiary turned 65 in October of 2013 and became entitled to Medicare. Ben opted to enroll in a Part C plan. He will be a "New Enrollee" until the 2015 mid-year risk score model run.

Model Run	Dates of Service	Ben's Status	Reason
2014 Initial	7/1/12 – 6/30/13	New Enrollee	Does not have 12 months of Medicare Part B entitlement
2014 Mid-year	1/1/13 – 12/31/13	New Enrollee	Does not have 12 months of Medicare Part B entitlement
2014 Final	1/1/13 – 12/31/13	New Enrollee	Does not have 12 months of Medicare Part B entitlement
2015 Initial	7/1/13 – 6/30/14	New Enrollee	Does not have 12 months of Medicare Part B entitlement
2015 Mid-year	1/1/14 – 12/31/14	Full Risk	Has 12 months of Medicare Part B entitlement

Risk Score Calculation
Blended Risk Score 2015

- For Payment Year (PY) 2015, risk scores will continue to be calculated using two models, but will be weighted differently than in PY 2014.
- For PY 2014, risk scores from the 2013 CMS-HCC model are weighted by 25%, and risk scores from the 2014 CMS-HCC model are weighted by 75%.
- For PY 2015, risk scores from the 2013 CMS-HCC model will be weighted by 67%, and risk scores from the 2014 CMS-HCC model will be weighted by 33%.

Risk Score Calculation for PY 2015

Portion of risk score from 2013 model + Portion of risk score from 2014 model = Blended 2015 Risk Score

Portion of risk score from 2013 model

[(raw risk score from 2013 model) / (PY 2015 normalization factor for the 2013 model)] X (1 – PY 2015 coding adjustment factor) X 67% = portion of the risk score from 2013 model

Portion of risk score from 2014 model

[(raw risk score from 2014 model) / (PY 2015 normalization factor for the 2014 model)] X (1 – PY 2015 coding adjustment factor) X 33% = portion of the risk score from 2014 model

Test Your Knowledge

In order to be considered “Full Risk,” a beneficiary must have _____.

a) Enrolled in Medicare Part B

b) 12 months of Medicare Part B

c) 12 consecutive months of Medicare coverage

Test Your Knowledge

For the PY 2015 blended risk score calculation, how are the risk scores from the 2013 and 2014 models weighted?

a) There is no weighting.

b) The risk scores from the 2013 model are weighted at 25%, and the scores from the 2014 model are weighted at 75%.

c) The risk scores from the 2013 model are weighted at 67%, and the scores from the 2014 model are weighted at 33%.

EX: Risk Score Calculation PY 2015

Portion of the risk score from 2013 model

1. Raw RS = Demographic Factors + Diagnostic Coefficients
   Example raw RS = 1.150
2. Normalized risk score = Raw RS /PY 2015 Normalization Factor for the 2013 model
   1.150 / 0.992 = 1.1592; Rounded = 1.159
3. MA coding adjusted risk score = Normalized Risk Score X (1 – PY 2015 Coding Adjustment Factor)
   1.159 X (1-0.0516) = 1.099; Rounded = 1.099
4. 2013 portion of the risk score = 2013 risk score X 67%
   1.099 X .67 = 0.73633

Portion of 2013 model risk score (rounded) = 0.736

EX: Risk Score Calculation PY 2015

Portion of the risk score from 2014 model

1. Raw RS= Demographic Factors + Diagnostic Coefficients
   Example raw RS = 1.117
2. Normalized risk score = Raw RS /PY 2015 Normalization Factor for the 2014 model
   1.117 / 0.978 = 1.1421; Rounded = 1.142
3. MA coding adjusted risk score = Normalized Risk Score X (1 – PY 2015 Coding Adjustment Factor)
   1.142 X (1-0.0516) = 1.0830; Rounded = 1.083
4. 2014 portion of the risk score = 2014 risk score X 33%
   1.083 X .33 = 0.357

Portion of the risk score from 2014 model = 0.357

EX: Risk Score Calculation PY 2015

Portion of the Risk Score from 2013 Model + Portion of the Risk Score from 2014 Model = Blended 2015 Risk Score

2013 Model Portion of the RS + 2014 Model Portion of the RS

0.736 **0.357**

PY 2015 Blended RS = **1.093**

Questions

Risk Adjustment Webinar

Introduction | Overview and Policy | Operations Overview

Operations Updates | Risk Score Calculation | **Summary**

Summary

- Risk Adjustment Overview and Policy
- Operations Overview
- Operations Updates
- Risk Score Calculation

Resources

Resource	Link
Centers for Medicare & Medicaid Services (CMS)	http://www.cms.gov/
CSSC Operations	http://www.csscoperations.com csscoperations@palmettogba.com
Technical Assistance Registration Service Center (TARSC)	http://www.tarsc.info/
Risk Adjustment Mailbox	riskadjustment@cms.hhs.gov

Resources, *continued*

Resource	Link
Medicare Managed Care Manual, Chapter 7 – Risk Adjustment	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html?DLPage=2&DLSort=0&DLSortDir=ascending
ICD-10 Code Set Information	http://www.cms.gov/Medicare/Coding/ICD10/index.html
ICD-10 to HCC Preliminary Mappings	http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html

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http://tarsc.info/

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- This information will assist CMS with meeting your training needs and enhancing your webinar participation experience.

YOUR FEEDBACK IS IMPORTANT!