Risk Adjustment and Reinsurance Discrepancy Reports & Data Quality Analysis Reports

January 29, 2015

Health Insurance Marketplace Program Training Series

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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Agenda

- Session Guidelines
- Session Purpose
- Informal Discrepancy Reporting
- Data Quality Analysis Report (DQAR) Overview
- DQAR Response
- Questions
- Closing Remarks

Session Guidelines

- This is a 90-minute webinar session.
  - Please note, we will conduct a user group on the same subject next week.
- Frequently Asked Questions (FAQs) will be posted in the coming weeks.
- For questions regarding content, please submit inquiries at https://www.regtap.info/
- For questions regarding logistics and registration, please contact the Registrar at: (800) 257-9520

Intended Audience

- Issuers of Marketplace and Non-Marketplace plans, in states where the Department of Health and Human Services (HHS) operates the Risk Adjustment (RA) and Reinsurance (RI) Programs
- Third Party Administrators (TPAs) and Support Vendors
- Amazon and On-Premise External Data Gathering Environment (EDGE) server issuers (Marketplace and Non-Marketplace)

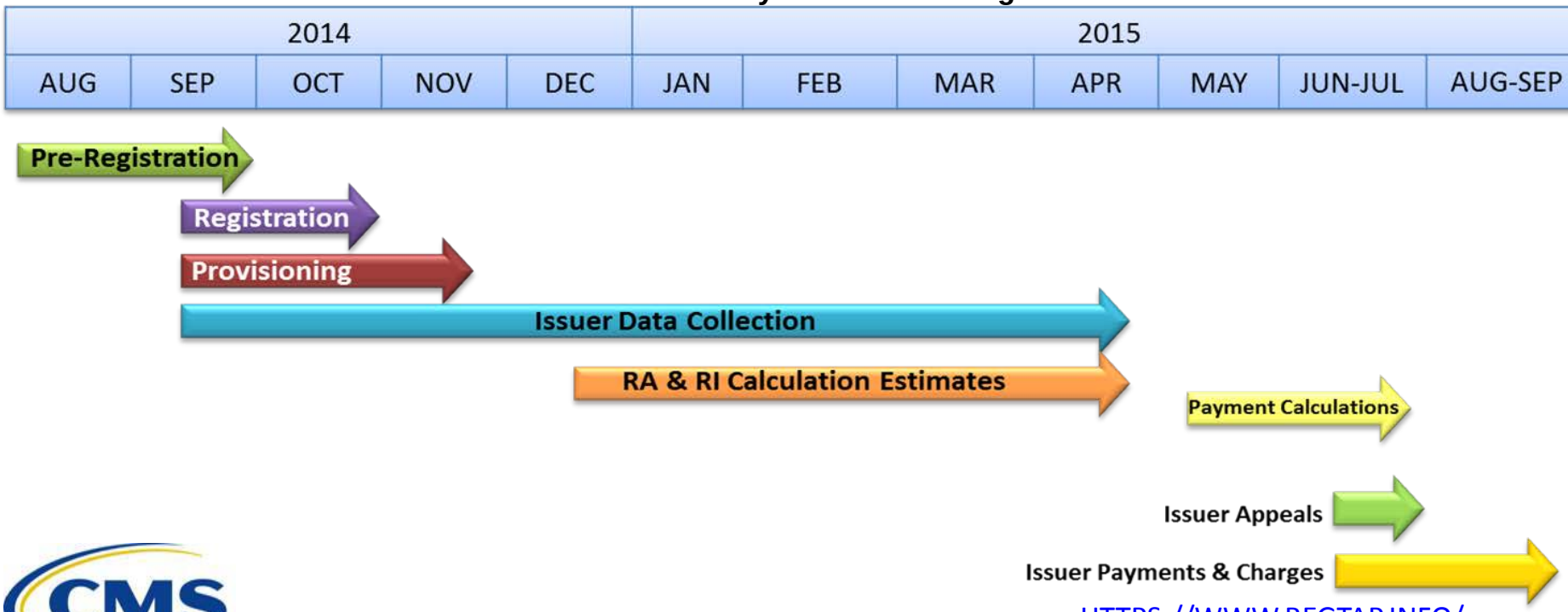
Purpose

- This session will provide guidance specific to informal discrepancy reporting for EDGE-generated reports.
- Additionally, we will share information on the Data Quality Analysis Reports (DQARs) that are distributed to issuers, which provide data summaries and metrics.

Risk Adjustment & Reinsurance Programs Timeline

Key Implementation Dates:

- **EDGE Pre-Registration**: 8/7/14 – 9/26/14
- **EDGE Registration:** 9/27/14 – 10/20/14
- **EDGE Provisioning:** 9/27/14 – 11/21/14
- **Data Collection:** 9/27/14 – 4/30/15
- **Risk Adjustment Risk Score & Reinsurance Estimates:** 12/19/14 – 4/30/15
- **Payment Calculations:** 5/1/15 – 6/30/15
- **Payment Report to Issuers:** 6/30/15
- **Issuer Appeals** 7/1/15 – 7/31/15
- **Issuer Reinsurance Payments & Risk Adjustment Payments and Charges**: 7/1/15 – 9/30/15



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Informal Discrepancy Reporting

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Informal vs Formal Discrepancy Reporting

- **Informal**: CMS is initiating an informal discrepancy reporting process to enable early feedback, address any errors in the reports, and prepare for the discrepancy process.
- **Formal**: In the future, all issuers will be required to email their agreement with the outbound reports, or submit a formal discrepancy report about the outbound report with which they don't agree.

Report Types

- When the RI and RA calculations are executed, the EDGE server will generate the following outbound reports:
  - RA Claim Selection (Detail & Summary)
  - RA Risk Score (Detail & Summary)
  - RA Transfer Elements Extract
  - RA Data Validation Population Summary Statistics
  - Reinsurance Calculation (Detail & Summary)

Informal Discrepancy Reporting Procedures

- All issuers should review the outbound reports that are generated each time the monthly program calculations are executed.
  - o Review the reports and confirm that the data in the reports are correctly calculated per CMS's established RA and RI calculation methodologies.
  - o Determine if the reports are consistent with the underlying claims and enrollment data stored within the issuers' EDGE server's data tables.

When to send an Informal Discrepancy Report

- Issuers should submit an informal discrepancy report to CMS if:
  - The derived values in the report are incorrectly calculated or are inconsistent with the established CMS RA and RI methodologies;
  - Accepted claims and enrollment data were incorrectly excluded from the calculations; or
  - The calculated values are understated because of claims and enrollment records that were incorrectly rejected during the file processing edit checks.

Additional Informal Discrepancy Reporting Details

- Discrepancy reporting should be based on findings in the outbound reports.
  - o Issuers may include data from other reports generated as part of the discrepancy reporting documentation provided to CMS.
- The report schedule for the 2014 Benefit Year will run from December 2014 through May 2015 and is subject to change.
  - o Issuers will be notified of the specific date as each run approaches.

Where to Report

- All informal discrepancy reports must be submitted to RARIpaymentoperations@cms.hhs.gov.
- **Note:** Issuers must **NOT** submit this information to REGTAP or the CMS helpdesk.

Email Requirements

- When submitting an informal discrepancy report, include the phrase “Discrepancy Report,” the name of the outbound report, and date of the run in the subject line.
- For example, “Discrepancy Report: RA Claim Selection Detail Report 01/16/2015.”
- Include the Issuer ID and links to any open, related remedy tickets in the body.

Removing Personally Identifiable Information

- The issuer must remove Personally Identifiable Information (PII) from any information or document submitted to RARIpaymentoperations@cms.hhs.gov.
  - It is the issuer's responsibility to de-identify any enrollee-level data sent to CMS.
  - Issuers should not include names or addresses on any information being submitted as source supporting data to identify the discrepancy.
- Issuers should submit the minimum amount of data necessary to demonstrate the discrepancy.

Additional Report Information

- Issuers identifying discrepancies are required to provide documentation that demonstrates potential deficiencies, including de-identified data that shows both the input and outputs of the RA and RI calculations.
- Issuers may have to provide de-identified
  - Input source claims and enrollment data;
  - Evidence of system acceptance and assessment of the information;
  - Corresponding RA and/or RI output calculation estimate reports; or
  - Individual enrollee level data.

CMS Review

- CMS will validate the discrepancy report to ensure it contains the proper information and comes from a valid issuer.
- Any discrepancy report containing PII will be rejected by CMS.

Resolving Discrepancies

- For all program reports occurring in January, February and April, CMS encourages issuers to review all calculation estimates and communicate potential discrepancies to CMS as soon as possible, to ensure proper resolution of potential errors in a timely fashion prior to calculation of final program payments.

Discrepancy Resolution

- CMS will review all discrepancies identified by issuers and will make a determination on whether an error exists, based on the evidence submitted by the issuer along with any other relevant data.
  - As needed CMS may follow-up to request additional information from issuers for further clarification to resolve potential discrepancies.

Discrepancy Resolution (continued)

- CMS will provide direct responses to issuers regarding a determination on the potential discrepancies, and where necessary, information on how confirmed discrepancies will be remediated.
- Remediated discrepancies can be observed in a future calculation estimate report or as part of the final program calculation report.

Data Quality Analysis Reports (DQARs)

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Data Quality Analysis Reports (DQARs)

- After monthly reinsurance and risk adjustment payment estimates are generated, CMS will send issuers a DQAR.
- These reports are separate from the EDGE Server Outbound Reports and provide issuers with technical summary metrics related to their Risk Adjustment risk score and Reinsurance calculation estimates.
  - The DQAR also identifies potential technical data problems.
- CMS may require follow-up with issuers and confirmation of findings based on data summaries in the DQAR.

Data Quality Analysis Reports (DQARs) (continued)

- The initial DQAR will focus on high level file processing metrics. For example:
  - The report will indicate the number of submitted and accepted files, which aids in determining if the necessary claims and enrollment data is present to run the risk adjustment risk score and reinsurance calculations.
  - The reports will indicate if issuers have submitted data for all of their plans and whether the data submitted includes claims and enrollments for all months in the benefit year.

Data Quality Analysis Reports (DQARs) (continued)

- Future reports will include metrics that assess the reasonableness of the underlying enrollment, claims, and RA and RI data used in issuers' Risk Adjustment risk score and Reinsurance calculations.
  - The reports will identify issuers that had unsuccessful monthly risk adjustment risk score and reinsurance calculation runs (issuers never executed the calculation script, or the script was executed and generated an error).
  - Risk Adjustment metrics may include types of claims, types of volumes of claims selected for risk adjustment, and analysis of claim exclusion from risk adjustment.
  - Reinsurance metrics may include the total amount of reinsurance payments per issuer, the average number of reinsurance payment per enrollee, and the number of enrollees receiving reinsurance payments.
- CMS will run outlier analyses at the issuer level and these analyses will be based on where issuers' data fall within their state's distribution.

Sample DQAR – Section 1

Issuer XXXXXX Data Quality Analysis Report (DQAR)

Data as of 01/20/2015

File Submission Summary

	Enrollee	Medical	Pharmacy	Supplemental	Total
Files Accepted	1	0	0	0	1
Files Rejected	0	0	0	0	0
Total Files Submitted	1	0	0	0	1
File Rejection Rate	0%	NA	NA	NA	0%
Records Accepted (Claims Summary Report)	5,190	0	0	0	5,190
Records Rejected	253	0	0	0	253
Total Records Submitted	5,443	0	0	0	5,443
Record Rejection Rate	5%	NA	NA	NA	5%
# of Plan IDs with submitted Records	63	0	0	0	63

- The DQAR provides a summary of the files that have been submitted on the EDGE server as of the date listed in the report.

Sample DQAR – Section 2

Claims by Plan-Year Month

Month	Medical	Pharmacy	Supplemental
Total	0	0	0
Dec-14	0	0	0
Nov-14	0	0	0
Oct-14	0	0	0
Sep-14	0	0	0
Aug-14	0	0	0
Jul-14	0	0	0
Jun-14	0	0	0
May-14	0	0	0
Apr-14	0	0	0
Mar-14	0	0	0
Feb-14	0	0	0
Jan-14	0	0	0

- This table provides a listing of the number of claims on the EDGE server by month.
  - In this example, no claims have been loaded to the server.

Sample DQAR – Section 3

List of Plans in EDGE Plan Reference Data Table without Records in EDGE Server

Plans without Records
XXXXXOR044000604
XXXXXOR044000602
XXXXXOR044000603
XXXXXOR044000606
XXXXXOR044000605
XXXXXOR044000601
XXXXXOR039000103
XXXXXOR039000102
XXXXXOR044001700
XXXXXOR044000400
XXXXXOR044000801
XXXXXOR044000805
XXXXXOR044000802
XXXXXOR044000804
XXXXXOR044000803

- This table lists the Plans in the EDGE Plan Reference Data Table that do not currently have records in the EDGE server.

Reviewing your DQAR

- Upon receipt of your DQAR, open the attached excel spreadsheet.
- The DQAR is broken into three (3) sections:
  - A count of medical files CMS has received to date and the record rejection rates for each file type. The rejection rate is cumulative based on all of the records that you have submitted to your server to date.
  - A table showing claims from the 2014 Plan Year broken down by month.
  - A table listing the plans for your Issuer ID that are included in your EDGE server plan reference data, but currently have no submitted claims or enrollment records.

Sample Response – Section 1

Data Quality Analysis Report (DQAR) Response Template

Report 1

INSTRUCTIONS FOR COMPLETION

The DQAR Response Template provides questions to Issuers that assist CMS in ensuring that EDGE servers are reporting records data correctly. This Response Template should be used in conjunction with the review of the DQAR provided by CMS. Each item should be completed prior to returning the Response Template to CMS. Response Templates should be submitted to RARIPaymentOperations@cms.hhs.gov.

Date Completed:	

ISSUER IDENTIFICATION	
Issuer ID	
Issuer Name	
Issuer's Parent Company Name	
If "Other", Parent Company Name	
Issuer Technical Contact (ITC)	
ITC Email	
ITC Telephone	

FOLLOW-UP ITEM #1

To establish a base line of the total number of claims and enrollment records that your organization will submit for the 2014 plan year, CMS is requesting an estimate of the total enrollment records and claims records that your organization will submit for 2014. In this estimate, Issuers should not count void or replacement claims as part of their claims totals. CMS acknowledges that Issuers are still adjudicating claims for 2014. Issuers should provide their best current estimate based on total paid claims for 2014. CMS will ask for revised claims and enrollment totals at a later point during the 2014 EDGE Server Data collection period. **All Issuers are required to complete this section.**

Estimate the number of RECORDs you expect to report for 2014 EDGE Server Data Collection	
Enrollee Records	
Medical Claim Records	
Pharmacy Claim Records	

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Required Issuer Response

- All issuers will be asked to estimate the total enrollment records and claims records that will be submitted for the 2014 Coverage Year.
  - o Issuers should not count void or replacement claims as part of their claims totals.
  - o CMS acknowledges that issuers are still adjudicating claims for 2014.
- CMS will ask for revised claims and enrollment totals at a later point during the 2014 EDGE server data collection period.

Sample Response – Section 2

FOLLOW-UP ITEM #2

In the DQAR, the first table titled "File Submission Summary" shows the count of Enrollee, Medical, Pharmacy, and Supplemental files that have been accepted on your EDGE server. **For those Issuers with NO accepted Enrollee, Medical Claim, or Pharmacy Claim files in the File Submission Summary table on the DQAR**, please confirm that you will be submitting the data prior to the next monthly payment calculation on February 12, 2015. Additionally, please provide an explanation if you are experiencing technical difficulties with sending the files. Issuers with NO "Accepted Files" for Enrollees, Medical Claims, or Pharmacy Claims are required to complete this section.

Type	Do you plan to submit data before 02/12/2015?	Provide an explanation if data will be submitted after 02/12/2015	If you are experiencing technical difficulties, provide a summary of the issue.
Enrollee Files			
Medical Claim Files			
Pharmacy Claim Files			

No Enrollee/Medical/Pharmacy Files

- For those issuers that do not have any enrollee, medical, or pharmacy files submitted to their servers, please confirm that you will be sending the data prior to the next monthly payment calculation on February 12, 2015.
  - In your response please let CMS know if you are encountering any technical issues that would prevent you from submitting by this date.

Sample Response – Section 3

FOLLOW-UP ITEM #3

In the DQAR, the List of Plans in the third table titled "List of Plans in EDGE Reference Table Without Records on the EDGE server" provides plan IDs that are included in your plan reference table data but currently do not have any submitted claims or enrollment data. If the table indicates that you are missing data for any of the plans, please confirm that you will submit data for these plans prior to the next monthly round of payment calculations on February 12, 2015. If not, provide a justification for why these plans are not included in 2014. Permissible exemptions include: plans with no active enrollment for the 2014 plan year and plans that meet one or more reporting exemptions provided in CMS regulations (Grandfathered plans, transitional plans and plans that do not meet market reform rules http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf).

Are there additional plans for which you have not yet provided data but plan to?	
Are you working with CMS to add these plans to the Reference Table?	

Issuers with data missing for plans in the EDGE Reference Table are required to complete this section.

Please copy and paste all of the plans listed in the third table below and provide information about the status of data for these plans.		
Plans without records	**Will data be uploaded by 2/12/2015?**	**Reason, if Other**

Plans Without Records

- If the third table indicates that you are missing data for any of the plans, indicate in the response template that you will be submitting data for these plans prior to the next monthly round of payment calculations on February 12, 2015 or provide a justification for explaining why they will be exempt from the 2014 Coverage Year.
- Permissible exemptions include:
  - Plans with no active enrollment for the 2014 Coverage Year; or
  - Plans that meet one (1) or more reporting exemptions provided in CMS regulations (grandfathered plans, transitional plans and plans that do not meet market reform rules).

Submitting Responses

- All responses must be submitted to RARIPaymentoperations@cms.hhs.gov.
- Response is due no later than February 10, 2015.
- The subject of the email should be **Response: DQAR 1**.
- **Note:** issuers must **NOT** submit this information to REGTAP or the CMS helpdesk.

Next Steps

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Next Steps: Training Sessions

- CMS will continue to support Stakeholders through the RA/RI payment calculation estimate process by hosting webinar and user group sessions.
- CMS will update issuers once the discrepancy reporting submission process is finalized.

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Locating Documents in REGTAP

Stakeholders can access additional documents at https://www.REGTAP.info in the REGTAP Library.

Under Program Area, select 'Reinsurance' or 'Risk Adjustment'

Questions?

To submit questions by phone:

- *dial '14' on your phone's keypad*
  - *dial '13' to withdraw your question*

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Resources

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Resources

Resource	Resource Link
U.S. Department of Health & Human Services	http://www.hhs.gov/
Centers for Medicare & Medicaid Services (CMS)	http://www.cms.gov/
The Center for Consumer Information & Insurance Oversight (CCIIO) web page	http://www.cms.gov/cciio
Consumer website on Health Reform	http://www.healthcare.gov/
Registration for Technical Assistance Portal (REGTAP) - presentations, FAQs	https://www.REGTAP.info
Do-It-Yourself (DIY) Software	http://www.cms.gov/cciio/Resources/Regulations-and-Guidance/index.html#Premium_Stabilization Programs http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/DIY-instructions-5-20-14.pdf

Resources (continued)

Resource	Resource Link
Patient Protection and Affordable Care Act (ACA)	http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/content-detail.html
Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment under the ACA	http://www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17609.pdf
HHS Notice of Benefit and Payment Parameters for 2014 and Amendments to the HHS Notice of Benefit and Payment Parameters for 2014	http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf
HHS Notice of Benefit and Payment Parameters for 2015 and Amendments to the HHS Notice of Benefit and Payment Parameters for 2015	http://www.gpo.gov/fdsys/pkg/FR-2014-03-11/pdf/2014-05052.pdf

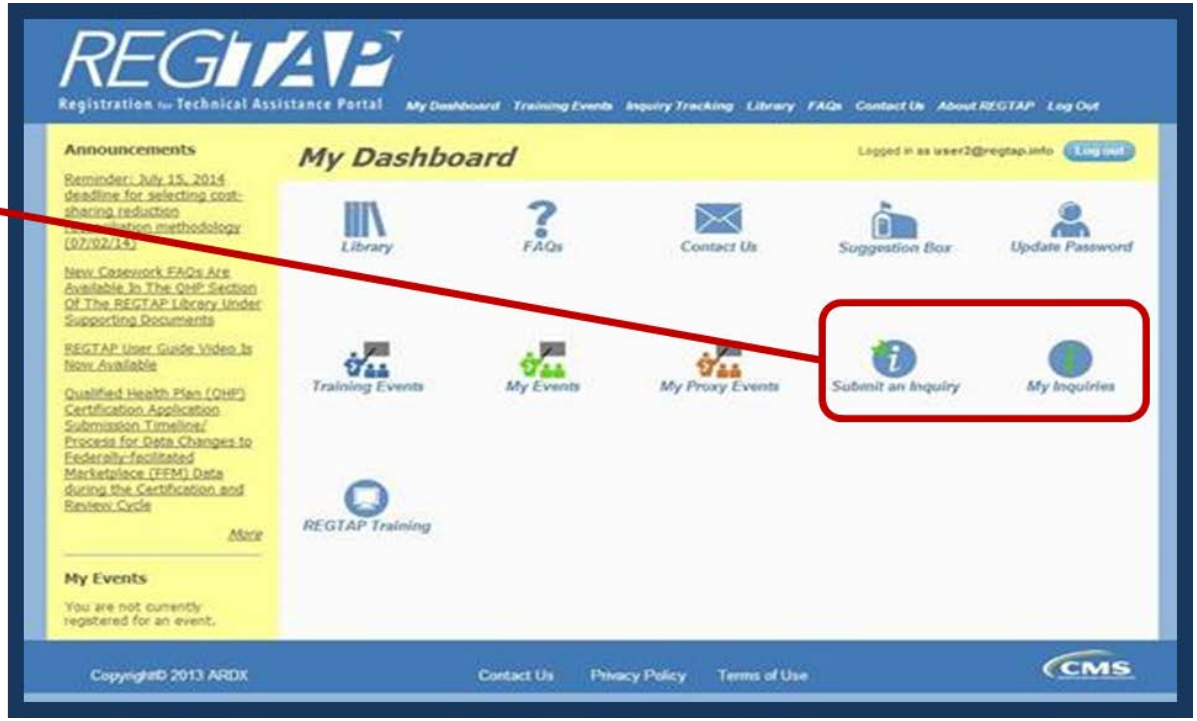
Resources (continued)

Resource	Resource Link
Standards Related to Reinsurance, Risk Corridors and Risk Adjustment under the ACA	http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6594.pdf
Program Integrity: Exchange, Premium Stabilization Programs, and Market Standards; Amendments to the HHS Notice of Benefit and Payment Parameters for 2014	http://www.gpo.gov/fdsys/pkg/FR-2013-10-30/pdf/2013-25326.pdf
Health Insurance Market Rules, Rate Review Final Rule	http://www.gpo.gov/fdsys/pkg/FR-2013-02-27/pdf/2013-04335.pdf

Inquiry Tracking and Management System (ITMS)

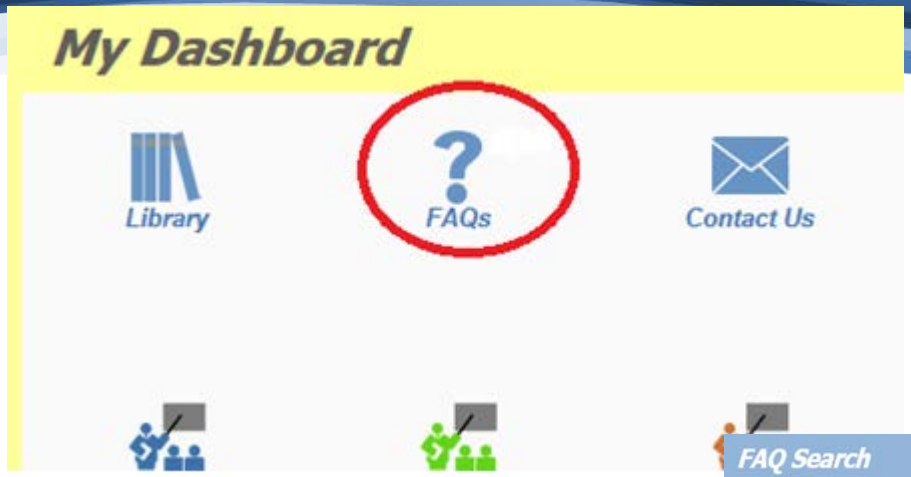
Stakeholders can submit inquiries to https://www.REGTAP.info through ITMS.

Select ‘Submit an Inquiry’ from My Dashboard.

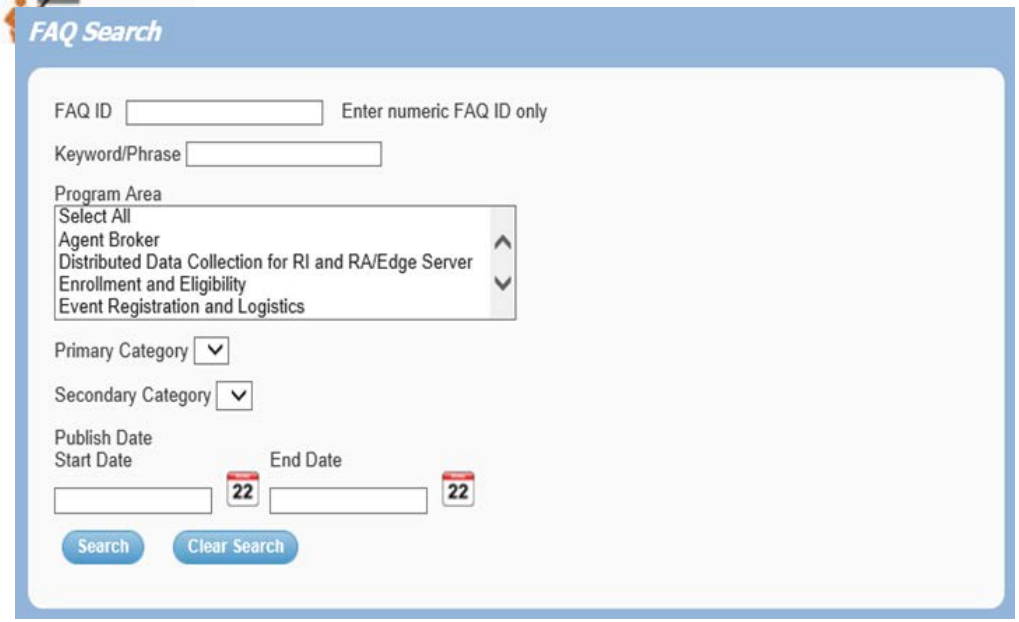


Note: Enter only one (1) question per submission.

FAQ Database on REGTAP



The FAQs Database allows users to search FAQs by FAQ ID, Keyword/Phrase, Program Area, Primary and Secondary categories, and Publish Date.



The FAQs Database is available at https://www.REGTAP.info

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Closing Remarks

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