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CENTER FOR MEDICARE
MEDICARE PLAN PAYMENT GROUP

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TO: All Medicare Advantage Organizations, Medicare-Medicaid Plans, and Demonstrations

FROM: Cheri Rice, Director
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SUBJECT: 2017 CMS-HCC Risk Adjustment Model Implementation

As described in the 2017 Advance Notice and Rate Announcement, CMS has revised the CMS-HCC model used to pay for beneficiaries enrolled in Medicare Advantage plans and certain demonstrations (including the MMPs). CMS is currently working to make system changes for payments beginning in January 2017.

This memo (and the forthcoming System Release memos) describes how we are initially implementing this model. We invite comment on this approach to operationalize the new model, and we will take into account industry comment as we contemplate any future modifications to this approach. If you wish to submit comments, please submit them to RiskAdjustment@cms.hhs.gov, with the subject heading "2017 CMS-HCC Risk Adjustment Model Implementation." Comments submitted by July 29, 2016 will be considered as we determine whether to make changes in the coming year.

I. 2017 CMS-HCC model segment selection:

The revised CMS-HCC model will have eight mutually exclusive segments, including: six community segments (Full Benefit Dual Aged, Full Benefit Dual Disabled, Partial Benefit Dual Aged, Partial Benefit Dual Disabled, Non-Dual Aged, and Non-Dual Disabled), a long term institutional (LTI) segment, and a new enrollee segment. The logic for determining whether a beneficiary is a new enrollee, or whether to use either an LTI or a community risk score remains the same as previously defined. For full risk beneficiaries at final reconciliation, CMS will continue to apply either an LTI or a community risk score on a month-by-month basis (for more info, please reference the Medicare Managed Care Manual, Chapter 7 – Risk Adjustment). With this revised model, if a beneficiary has a community status for a payment month, CMS will apply one of six community scores, depending on each beneficiary's aged versus disabled status for the year, and their dual status for the month.

II. Determining the appropriate community score to apply for a month:

Throughout the payment year, when we calculate a month's payment, the beneficiary's dual status for that month is not yet known. In order to choose a dual status to use for each month's payment throughout the year, we will use a prior month's dual status. We will use one "anchor month" for the months prior to the mid-year risk score update, and a more recent "anchor month" for the months starting with the mid-year update. Unlike with the mid-year risk score update that incorporates updated diagnosis data, we will use the updated anchor month on a prospective basis only, i.e., we will not make adjustments to prior months' payment amounts using the updated anchor month.

Specifically, we will use the following months as "anchor months" throughout the payment year to determine which community risk score to apply.

- Medicaid status in October of the year prior to the payment year will be used as the anchor month for prospective payments in January – July; and
- Medicaid status in May of the payment year will be used as the anchor month for prospective payments in August – December.

That is for 2017, the beneficiary's Medicaid status as of October 2016 will be used for payments for January through July of 2017 and their Medicaid status as of May 2017 will be used for payments for August through December of 2017.

At final reconciliation, we will use the beneficiary's Medicaid status of the actual payment month to determine the risk score for beneficiaries in community status.

Because our research indicates that most beneficiaries who are full dual remain in this status for all or most of a year, we concluded that the approach outlined above is the best way to minimize both the potential to generate multiple adjustment records for an enrollee throughout a year, and the amount of revenue that is paid or netted out of payment at final reconciliation.

CMS will continue to determine a beneficiary's aged versus disabled status for an entire payment year; age is determined as of February 1st for a payment year for most beneficiaries.

After final reconciliation, we will annually review any retroactive changes in Medicaid status made. We will provide information on the timing of these updates in the future.

III. Data sources:

As we stated in the 2017 Advance Notice/Rate Announcement process, CMS will be using three sources of Medicaid status for risk adjustment, beginning in PY2017: the MMA State files, the Point of Sale data, and the monthly Medicaid file that the Commonwealth of Puerto Rico submits to CMS. We will identify full benefit dual status for a month using dual status codes 02, 04, and 08, or presence on the Puerto Rico file to indicate full dual status. We will identify partial benefit dual status for a month using dual codes 01, 03, 05, or 06. We will identify non-duals as those who are not a full benefit dual or a partial benefit dual for a month.

IV. Reports

a. Monthly Membership Report (MMR) data fields:

On the MMR report, the following fields will be modified for use with the new model, starting with January 2017 payment. Note that field numbers can change, so you may want to rely on the field name for reference.

- New RAF Factor Type Codes (Field 47). The following new Factor Type codes will be added as possible values.
    - CF = Community Full Dual
    - CP = Community Partial Dual
    - CN = Community Non-Dual
- Adjustment Reason Code at final reconciliation. At final reconciliation, changes in monthly risk scores will continue to fall under Adjustment Reason Code (ARC) 25, "Part C Risk Adjustment Factor Change/Recon."
- Current Medicaid Status (Field 38): This field is currently not related to the Medicaid status reflected in the risk score, and is provided for information purposes only. Starting in 2017, this field will refer to the Medicaid status in the month that was used to determine the community risk score (or that would have been used to determine the community risk score, in cases where the beneficiaries is a new enrollee or LTI for the payment month). Specifically, this field will reflect the Medicaid status in either the October or May anchor month (throughout a payment year) or the actual monthly status at final reconciliation.
- Medicaid Dual Status Code (Field 83): As it does today, this field will be populated in parallel with the "Current Medicaid Status" field, but will provide the Dual Status Code used to determine whether a beneficiary is full, partial, or non-dual (or that would have been use to determine the community risk score, in cases where the beneficiaries is a new enrollee or LTI for the payment month).
- Future change to "Medicaid Indicator" (Field 21): This field currently indicates when the risk score of the beneficiary reflects Medicaid status in the appropriate period (e.g., the data collection year for full risk beneficiaries). Because Medicaid in the data collection period will no longer be relevant for the risk score of community beneficiaries, CMS is planning to leave this field blank for community beneficiaries in early 2017.

b. Additional reporting updates:

In order to support plans' revenue tracking, CMS is developing reporting changes that will provide additional information on beneficiaries' dual status. In early 2017, CMS will update:

- The Marx UI Medicaid status module– In addition to providing information on monthly Medicaid status codes, we will add "full benefit" and "partial benefit" dual status designations.
- We are also developing a new report that will let plans know their enrollees' actual monthly Medicaid status for a payment year. We envision sending an initial report in the latter part of 2017 – once there is sufficient and stable monthly data to make the report informative -- and a final report after 2017 is over.

Addendum: Risk Scores changes that can occur for Payment Year 2017

January 2017	• Risk score used is the initial risk score • Community versus LTI status is based on the data collection period • Medicaid status (full, partial, or non-dual) is based on status in October 2016
August 2017	• Anchor month used to determine Medicaid status is changed from October 2016 to May 2017. • Mid-year risk scores are applied in payment. • LTI/community status is updated, based on the data collection period. • A beneficiary's risk score will change if: o Their mid-year risk score differs from their initial risk score. If this is the case, the mid-year risk score is used from August through the end of the year, and payments for January – July are adjusted. o A beneficiary's Medicaid status has changed between October 2017 and May 2018. The new Medicaid status is used for August – December payments; we will not adjust payments for January – July with the updated Medicaid status. o Their community/LTI status has changed.
July 2018	• Final reconciliation for payment year 2017 takes place. • Final risk scores are applied in payment • LTI/community status is determined on a month-by-month basis • Medicaid status for each month is used to determine which community risk score to apply in payment. • A beneficiary's risk score will change if o Their risk score changed from mid-year 2017 to final 2017 o Their monthly Medicaid status changed between the anchor month in use for a month and the status for the actual payment month determined. o Their LTI/community status changed for a month.