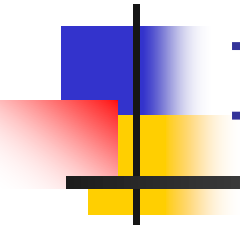
CY2011 Actuarial Bid Training



Introduction

CMS Office of the Actuary

April 2010

CY2011 Highlights

Health reform

New bid quality/compliance initiative

Risk score development

Training overview

- Training program has a different focus
- Includes two components to the training
  - What's New and Points of Emphasis for CY2011
  - Background material
    - Introduction to Bidding and BPT 101
    - Intermediate Topics

Other Resources

Call Letter
Advance Notice
Rate Announcement
Bid Instructions

Office of the Actuary (OACT) mailbox: actuarial-bids@cms.hhs.gov

OACT weekly actuarial user group calls

CY2011 Actuarial Bid Training

Impact of Health Care Reform on MA and Part D Bids

CMS Office of the Actuary

April 2010

In this session . . .

This session will cover:

- provisions of the health care reform bills affecting MA and Part D bids for CY2011,
- pricing considerations, and
- changes to the Part D BPT.

MA Provisions

- Benchmarks frozen at 2010 levels
- New benefit requirement
  - Cost sharing cannot exceed A/B cost sharing for chemotherapy administration, renal dialysis services and skilled nursing care
- No new pricing considerations

Part D Provisions

- Coverage in the Gap
  - Generic Drugs
    - Cost sharing reduced to 93%
  - Brand Drugs
    - Cost sharing reduced to 50%
    - Pharmaceutical manufacturers provide 50% discount at point-of-sale
    - 100% of negotiated allowed cost counts toward TrOOP

Part D Provisions (cont.)

Low-Income Premium Subsidy Amounts

- Same approach as CY2010 demonstration
- Will be calculated using the Part D premiums for MA-PD plans before they have been reduced by any applicable MA A/B rebates

Income-Related Part D Premium

- Direct subsidy will be reduced by the amount of the increased income-related premium

Pricing Considerations

Guidelines that apply to all bids:

- Use "Other Change" components of utilization and unit cost trend factors to reflect changes from base period to contract year
- CMS Specialty drugs guideline unchanged
- TrOOP threshold of $4,550 unchanged; point at which the member reaches catastrophic coverage changes, even for DS coverage
- Reflect impact on LIS Cost Sharing PMPM and Federal Reinsurance PMPM on Worksheet 3

Pricing Considerations (cont.)

Guideline for AE, BA and EA plans:

- Report members in the same claims interval for both DS and AE, BA or EA coverages

Guideline for EA plans:

- "Enhanced" gap coverage includes standard and additional – partial or full – gap coverage
- Above and beyond required DS coverage

Changes to the Part D BPT

Worksheet 3

- Capture amounts for generic coverage in the gap
- Calculate impact of generic coverage on cost sharing, gap and plan liability

Changes to the Part D BPT (cont.)

- Worksheets 3 and 4
  - Updated "catastrophic" labels to remove references to a dollar amount
- Worksheet 5
  - Updated standard benefit gap formulas

Questions?

CY2011 MA Bid Instructions

CY2011 Part D Bid Instructions

CY2011 BPT Technical Instructions

OACT mailbox: actuarial-bids@cms.gov

OACT weekly actuarial user group calls

CY2011 Actuarial Bid Training

What's New for CY2011 Medicare Advantage and Part D

CMS Office of the Actuary

April 2010

In this session...

Summary of common changes to CY2011 Medicare Advantage and Part D bid instructions

- New requirements
- Clarifications based on actuarial user group calls and feedback from industry, bid reviewers and bid auditors

Base Period Experience

MA and Part D BPTs collect actual base period revenue and expenses

- Account for final risk adjustment reconciliation payment
- Gross of user fees
- Earned premium basis
- Include Part D premiums only in Part D BPT

Base Period Experience (cont.)

- MA base period revenue
  - Includes MA rebates for A/B mandatory supplemental benefits
  - Excludes MA rebates to buy down Part B and Part D premiums
- Part D base period revenue
  - Excludes risk-sharing payments
- See the "What's New – MA" training session

Plan Experience (cont.)

- Plan Terminations and Enrollment Shifts
  - Data aggregation limited to cross-walks within and between contracts
- Override for partial credibility
  - 0% for ≤ 20% CMS credibility
  - 100% for ≥ 90% CMS credibility
- See Intermediate Bidding Topics training session

Gain/Loss

Gain/Loss Supporting Documentation

- Plan sponsor's corporate margin and any change in the prior two years
- For bids with negative margins—
  - Year-by-year numeric business plan
- For bids with negative margins in prior years—
  - Numerical comparison of gain/loss margin to original business plan

Non-benefit

- Non-benefit expenses
  - Cost of lobbying activities must be excluded from administrative activities
  - See Related Party Agreements training session for clarifications in related party instructions

Risk Score

Risk Score pricing considerations updated

See Risk Score training session

Appendices A&B

- Appendix A, Actuarial Certification
  - ASOP#41 replaces ASOP#31 (same requirement to provide documentation "with sufficient clarity" for an "appraisal of the reasonableness of the actuary's work")
- Appendix B, Supporting Documentation
  - See the Quality Initiative, Documentation and Resubmission training session

Questions?

- "Bidding Resources" in Introduction to bid instructions
  - CY 2011 Call Letter, payment announcements, and technical instructions
  - OACT mailbox: actuarial-bids@cms.hhs.gov
  - OACT weekly actuarial user group calls

CY2011 Actuarial Bid Training

What's New for CY2011 Medicare Advantage

CMS Office of the Actuary

April 2010

In this session…

Review key changes to the Contract Year (CY) 2011 Medicare Advantage (MA) Bid Pricing Tool (BPT) and instructions since last year

May be helpful to have the BPT in front of you while watching this presentation

CY2011 Changes

- Two-Year Look-Back (2YRLB) Form eliminated
  - Some of the information formerly collected on the 2YRLB will now be collected on MA BPT Worksheet 1

MA Worksheet 1

- Section I General Information
  - Line 14 "SNP Type" field added
    - Only used by Special Needs Plans
    - Options are: Institutional, Dual-Eligible, and Chronic or Disabling Condition
  - Line 9 "Enrollee Type" field pre-populated for RPPO plans with "A/B"

MA Worksheet 1 (cont.)

- Section II Base Period Information
  - Line 1 "Incurred Dates" pre-populated with January 1st though December 31st for two years prior to the contract period
    - 1/1/2009 – 12/31/2009 for CY2011
  - Line 5 "Plans in Base"
    - Expanded to eight lines for data entry
    - Report members months (rather than percentages)

MA Worksheet 1 (cont.)

- Section III Base Period Data
  - Column (d) "Net PMPM" added
  - Column (e) "Cost Sharing" added
    - The allowed and cost sharing amounts on Worksheet 1 must reflect the full level of plan cost sharing in the plan benefit package (PBP)
      - Even for dual-eligible enrollees that are not liable for full plan cost sharing

MA Worksheet 1 (cont.)

- Section IV Projection Assumptions
  - Column (o) "Other Factor" added as a second column for entering Unit Cost Adjustments
    - If used, describe in Section V

MA Worksheet 1 (cont.)

- Section VI, Base Period Summary
  - New section added for CY2011
  - Actual MA revenue and expenses for the base period
  - Must be completed in total dollars
    - Not reported in PMPMs
  - Include all beneficiaries
    - Include ESRD and hospice

MA Worksheet 1 (cont.)

- Section VI, Base Period Summary (cont.)
  - Include the same plans identified in Section II Line 5 “Plans in Base”
  - Exclude Optional Supplemental benefits
  - Exclude Part D

MA Worksheet 1 (cont.)

- Section VI New fields added
  - Line 1 CMS Revenue
  - Line 2 Premium Revenue
  - Line 3 Total Revenue
    - Line 3b Subset Revenue (ESRD and hospice)

MA Worksheet 1 (cont.)

- Section VI New fields added (cont.)
  - Line 4 Net Medical Expenses
    - Line 4b Subset Net Medical Expenses (ESRD and hospice)
  - Lines 5a - e Non-Benefit Expenses
  - Line 6 Gain/Loss Margin
  - Line 7 Percentage of Revenue

MA Worksheet 1 (cont.)

Section VI Example

1 CMS Revenue	$21,023,032.71	Non-benefit expenses:		Gain/Loss Margin	$368,003.02
2 Premium Revenue	$0.00	5a Marketing & Sales	$792,324.65		
3 Total Revenue	$21,023,032.71	5b Direct Administration	$850,825.77	Percent of Revenue:	
3b Subset Revenue	$167,142.60	5c Indirect Administration	$365,309.06	7a Net Medical Expenses	88.7%
4 Net Medical Expense	$18,646,570.21	5d Net Cost of Private Reins.	$0.00	7b Non-Benefit Expenses	9.6%
4b Subset Net Medical	$176,239.71	5e Total Non-Benefit Expenses	$2,008,459.48	7c Gain/Loss Margin	1.8%

MA Worksheet 2

- Column (h) "Projected Allowed PMPM" formulas revised
  - To include new "Other Factor" Unit Cost Adjustment (column (o) of Worksheet 1)
- Column (o) "Blended Allowed PMPM" formulas revised
  - Requires data entry in column (e) "Utilization Type"

MA Worksheet 2 (cont.)

- Column (q) “DE# Allowed PMPM” default formulas removed
  - User must now enter DE# Allowed PMPM in this column

MA Worksheet 3

- Column (l) "Total In-Network Cost Sharing PMPM" formulas revised
  - Requires data entry in column (e) "Measurement Unit Code" (ex: "Coin" for coinsurance)
- New field "Actual combined plan level deductible" added to footer
  - To better match PBP entries

MA Worksheet 6

- In Section IIB, line 3 was removed
  - This field formerly captured a Yes/No indicator regarding whether the plan intended to fully buy-down the Part B premium
    - CMS can use the Rebate amount allocated to Part B premium buydown as this indicator

MA Worksheet 7 and MSA Worksheet 5

- A "Package Description" field has been added for each Optional Supplemental Benefit package
  - Description must match the description entered in the PBP
  - OSB packages must be entered in the same order as the PBP entries

DE# Definition

- Special Case for defining DE#
  - Based on enrollment data posted in HPMS under "Risk Adjustment"
  - If total dual-eligible beneficiaries < 10% of total beneficiaries, then
  - The certifying actuary may consider QMB and QMB+ to represent the entire DE# population

DE#

If actuary sets projected allowed costs equal (DE#<10% or DE#>90%)

- DE#, non-DE# and total projected risk scores (WS5, Sect.II) must be equal
- Cost sharing utilization must be based on total plan experience (DE#>90%) or non-DE# experience (DE#<10%)
- New option to enter zero for DE# Medicaid Cost Sharing (WS4, Sect. IIB, column k)

MSP

- Projected MSP adjustment
  - Based on plan payment data excluding MA rebates
    - HPMS memos dated 1/12/2010 and 1/25/2010
  - Consistent with development of projected allowed costs
  - Any adjustment to projected allowed costs allowed only for additional savings

Appendix E, Rebate Reallocation & Premium Rounding

- New section G for LIPSA
  - Examples of options for returning to target LIPSA

Bid Instructions

See the MA bid instructions for—

- Clarifications based on actuarial user group calls and feedback from industry, bid reviewers and bid auditors
- Other changes to the CY2011 MA BPT

Questions?

- "Bidding Resources" in Introduction to bid instructions
  - CY 2011 Call Letter, payment announcements, and technical instructions
  - OACT mailbox: actuarial-bids@cms.hhs.gov
  - OACT weekly actuarial user group calls

CY2011 Actuarial Bid Training

Considerations for Part D Bids in CY2011

CMS Office of the Actuary

April 2010

In this session . . .

This session will cover:

- policy updates,
- supporting documentation, and
- changes to the Part D BPT.

National Average Monthly Bid Amount Calculation

The calculation of the 2011 benchmarks will be fully enrollment weighted using 2010 enrollments applied to the 2011 bids.

Impact of the Weighted Methodology

The following table illustrates the impact of the weighted enrollment methodology using enrollment as of June 2009 and February 2010.

The left side of the table shows the actual 2010 benchmarks calculated based on June 2009 enrollment.

The right side shows the 2010 benchmarks recalculated using February 2010 enrollment.

Impact of the Weighted Methodology (cont.)

	Enrollment Weighted Approach	
	June 2009 Enrollment	February 2010 Enrollment
National average monthly bid amount	$88.33	$86.96
Base beneficiary premium	$31.94	$31.34
Direct subsidy	$56.39	$55.62

LIS Benchmark Premium Amounts

For CY2011, the LIS benchmarks will again be weighted based on 100% of the LIS enrollments.

The impact of the weighted LIS enrollment methodology for two enrollment periods – June 2009 and February 2010 – are included in the Instructions.

Part D Reinsurance Payment Demonstration

Reinsurance payment demonstration ended in CY2010.

The payment demonstration options will not be allowed in CY2011.

Prescription Drug Event Data

- Considerations
  - Development of PDE from claims data
  - Timing of adjustments and deletions
  - Rejected and resubmitted PDEs
  - Plan-to-Plan transactions
  - Over-the-Counter drugs

Supporting Documentation

Appendix B in the "Instructions for Completing the Medicare Prescription Drug Bid Pricing Tool for CY2011" contains all of the documentation requirements.

All required documentation must be uploaded into HPMS with the initial bid submission, on or before June 7, 2010.

Supporting Documentation (cont.)

- Trend Projection Factor Development
  - Must be uploaded with the initial bid submission
- Mapping of Allowed Costs, Effective Cost Sharing and Script Counts from Formulary to Type of Drug Categories
  - Worksheet 2 and Worksheet 6

Changes to the Part D BPT

References to the Part D Reinsurance Payment Demo have been removed from all worksheets.

Worksheet 1

- Reimbursement for Federal Reinsurance per Member: Changed cell M31 to an input field.

Changes to the Part D BPT (cont.)

Worksheet 3

Network Pricing: Removed heading and drop-down box in cells C12 and D12.

Worksheet 5

Type of Gap Coverage: Removed "partial-limited monetary value" option from drop-down box in cell M33.

Questions?

CY2011 Part D Bid Instructions

CY2011 BPT Technical Instructions

OACT mailbox: actuarial-bids@cms.hhs.gov

OACT weekly actuarial user group calls

CY2011 Actuarial Bid Training

Quality Initiative, Supporting Documentation & Resubmissions

CMS Office of the Actuary

April 2010

In this session . . .

This session will cover:

- Quality initiative on professional conduct
- Supporting documentation
- Resubmissions

Quality Initiative on Professional Conduct

Objective: Improve upon accuracy and efficiency in bid-related work

- bid submission
- desk review
- bid audit

Quality Initiative on Professional Conduct (cont.)

OACT will:

- Track areas of bid performance
- Share information with compliance groups
  - May lead to compliance action against plan

Evaluation of Professional Conduct

Was the bid prepared in accord with?

- Code of Conduct
- ASOPs
- CMS Guidance
  - Laws, Regulations, etc.
  - Bid Instructions
  - CMS-OACT User Group Calls

Expectations on Professional Conduct

Bids must be complete, accurate, well documented, peer-reviewed, and adhere to all of CMS's bid instructions and guidance

Actuaries must provide reviewers with all requested data in a timely fashion and be knowledgeable about the bids they have certified

Professional Conduct Compliance Areas of Emphasis

- Instructions
- Documentation
- Responsiveness
- Bid errors
- Knowledge/Expertise

Professional Conduct Compliance Actions

Compliance actions could include:

- Phone calls
- Notice of Non-compliance
- Warning letters
- Corrective Action Plans (CAPs)
- Other actions, such as marketing and enrollment limitations

Supporting Documentation Requirements

Plan sponsors must:

- Upload substantiation to support the development of the bid with the June bid submission
- Prepare to provide additional support upon request throughout the bid desk review

What is CMS looking for? Compliance with ASOP No. 41

In accordance with Section 3.3.3, materials provided must be written "with sufficient clarity that another actuary qualified in the same practice area could make an objective appraisal of the reasonableness of the actuary's work."

Compliance with ASOP No. 41?

More rationale and detail

Fully explain the development, assumptions of the BPT

Break out all intermediate steps (ex: adjustments made during risk score development)

Excel files with formulas and data intact (not PDF files)

Compliance with ASOP No. 41? (cont.)

- Include all required elements of the product narrative
- Upload bid-specific information and memos
  - Should include all necessary information about that bid
  - Not include extraneous information applicable to other bids

Resubmissions

- Create re-work for sponsors and CMS
- Should not be the result of inadequate peer review or not reading the instructions
- Preventing resubmissions is worth the effort

Common Causes of Resubmissions

- Inconsistencies between the BPT and the Plan Benefit Package (PBP)
- Failure to correct flagged data validations
- Utilization not match across worksheets
- Failure to price minor supplemental benefits like World Wide Emergent services

Preventing Resubmissions

Adhere to ASOP #41

Pay attention to details

Check for BPT to PBP consistency issues

Review cost sharing descriptions in BPT

Correct every error, even when there is no impact to bid values

Preventing Resubmissions (cont.)

- Avoid carelessness (ex: uploading the incorrect files repeatedly)
- Establish communication among PBP and BPT preparers during bid development
- Check the accuracy of every upload
- Peer review

Questions?

CY2011 MA and MSA Bid Instructions

CY2011 Part D Bid Instructions

CY2011 BPT Technical Instructions

OACT mailbox: actuarial-bids@cms.hhs.gov

OACT weekly actuarial user group calls

CY2011 Actuarial Bid Training

Related-Party Agreements

CMS Office of the Actuary

April 2010

In this session . . .

This session on Related-Party (RP) Agreements will cover:

- Objective
- Requirements
- Guidance on completing the BPT

CMS' Related-Party Guidance

Objective – demonstrate that operating results and financial positions are not significantly different from what would have been achieved without the relationship

Related-Party Guidance Objective (cont.)

The bid must reflect the actual revenue requirements of the plan

CMS requires sponsors to provide the full disclosure of and support for the actual costs of the RP services

When Does Related-Party Guidance Apply?

Requirements apply to all Medicare Advantage and Part D sponsors that enter into any type of service agreement involving a parent company and subsidiary, or between subsidiaries of a common parent

Requirements for Sponsor's with Related- Party Agreements

- Disclose every related-party agreement at bid submission
- Prepare the bid pricing tool (BPT) in accord with CMS guidance
  - Develop and support the gain/loss and non-benefit expense of the RP organization in accord with CMS guidance

Two Approaches to Preparing the Bid Pricing Tool

- Two methods for pricing RP agreements in the BPT
  - Actual costs
  - Comparable fees
- Always acceptable to use the actual cost method
- Demonstrating comparable fees is an option in limited circumstances

Actual Cost Method for Preparing the Bid Pricing Tool

- Develop the BPT without recognizing the independence of the RP organization
  - Develop and report the gain/loss and non-benefit expense of the RP organization as those of the sponsor
    - Report admin of RP as that of sponsor
    - Report gain/loss of RP as that of sponsor

Optional Approach: Demonstrate Sponsor's Fees are Comparable

- When the sponsor's RP organization has a comparable agreement with an unrelated party:
  - Option to demonstrate that sponsor's fees are comparable to the fees in agreements between the sponsor's RP organization and other unrelated parties of similar size and market position

Demonstrating that Sponsor's Fees are Comparable (cont.)

- Analysis must meet the objective of guidance
- "Comparable?"
  - Clearly show that operating results, financial positions are not significantly different from what would have been achieved in the absence of the relationship

Demonstrating that Sponsor's Fees are Comparable (cont.)

When preparing the BPT, sponsors must:

- Recognize the independence of the subcontracted RP organization
- Allocate all administrative costs in the RP agreement to non-benefit expense

Supporting Documentation on Related-Party Agreements

Sponsors must:

- Substantiate all RP information presented in the BPT, including information held by the RP organization
- Arrange for the required disclosures to CMS in their RP agreements

Proprietary Concerns

CMS can have separate contact with both the sponsor and the subcontracted related party

- Pre-arranged by the sponsor and RP

Sponsors interested in this must request it and identify a point of contact at the RP at the time of bid submission

Questions?

CY2010 MA and MSA Bid Instructions

CY2010 Part D Bid Instructions

CY2010 BPT Technical Instructions

OACT mailbox: actuarial-bids@cms.hhs.gov

OACT weekly actuarial user group calls

CY2011 Actuarial Bid Training

Risk Score Development

CMS Office of the Actuary

April 2010

Session Outline

New Model for PD

Risk data to be provided by CMS

Risk Score Adjustments

Preferred Methodology

Alternate Methodologies

HCC Risk Adjustment Models

MA

Same CMS-HCC risk model to be used for CY2011 payments as was used for 2009 and 2010

- 2004 diagnoses were used to predict 2005 expenditures
- Denominator is the predicted Medicare FFS per capita cost for 2007 (denominator year)

PD

Updated Rx-HCC risk model to be used for CY2011 payments

- 2007 diagnoses were used to predict 2008 expenditures
- Denominator was the predicted per capita cost for 2008 (denominator year)

Risk Adjustment Model Details

Advance Notice at

http://www.cms.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2011.pdf

Final Rate Announcement at

http://www.cms.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2011.pdf

Risk Data to be Provided by CMS

Plan Level Data

Beneficiary Level File

Plan Level Data

MA and PD

July 2009 cohort with retro adjustments

- Enrollment and status

CY2011 model risk scores

MA file same categories of enrollees as last year

PD file new categories of enrollees aligning with new model

Technical notes will be released with the data providing other details

Beneficiary Level File

MA and PD

12 months of 2009 retro adjusted enrollment

12 months of status information

Old and new model risk scores for PD only

No model change for MA in CY2011

Adjustments to Project from CMS Provided Risk Scores

Plan-specific coding trend	(MA & PD)
Population changes	(MA & PD)
MA coding pattern adj	(MA only)
Normalization	(MA & PD)
Frailty Factor, if applicable	(MA only)
Missing diagnosis adjustment (plan sponsor sourced data only)	(PD only)

Missing Diagnosis Adjustment

Part D risk scores for MA-PD provided by CMS do not include diagnoses mapped to RxHCCs for which ICD-9 codes have not been collected from plan sponsors

CMS will provide an adjustment factor in the technical notes that accompany the beneficiary level files

Does not apply to PDPs

Plan Specific Coding Trend

- Represents the diagnosis coding of each individual plan
- Measured from the starting point of the projection to the contract year
  - If using CMS provided data, would be 2009 to 2011

Population Change

Represents changes in the make-up of the population enrolled in the plan

MA Coding Pattern Adjustment

Reflects the differential in diagnosis coding patterns between MA and FFS

If MA coding pattern adj = 3.41%* , then adjustment to risk score is multiplication by (1-.0341)

Does not apply to PD

* assumption from the Advance Notice; see Final Notice for updates

Normalization Factor

- Brings average risk score back to a 1.0 in years subsequent to the denominator year
  - CMS-HCC model = 1.031 *
  - Rx-HCC model = 1.029 *
  - Note that the above factors are preliminary
  - See Final Rate Announcement for updates to factors
- Divide projected risk score by normalization factor

* assumption from the Advance Notice; see Final Notice for updates

Frailty Factor

Only applies to PACE organizations

May affect some SNP organizations in 2011

See Final 2011 Rate Announcement

Is additive

Does not apply to PD

MA Preferred Methodology for Projecting Risk Scores

- Begin with the Risk Score data provided by CMS
  - Plan Level or Beneficiary Level data
- Apply Adjustments
  - Plan specific coding trend
  - Population changes
  - MA coding pattern adjustment
  - Normalization Factor
  - Frailty Factor, if applicable

PD Preferred Methodology for Projecting Risk Scores

- Begin with the Risk Score data provided by CMS
  - Plan Level or Beneficiary Level data
- Apply Adjustments
  - Missing diagnosis adjustment for MA-PD only
  - Plan specific coding trend
  - Population changes
  - Normalization Factor

Alternative Methodology Adjustment Considerations

- Converting to raw risk score
- Transition from lagged to non-lagged diagnosis data
- Transition from incomplete to complete diagnosis data
- Seasonality adjustment
- Risk model adjustment

Conversion to Raw Factor

Consideration if starting point is Monthly Membership Report (MMR)

- For example, CY2010 MMR risk score is normalized and for MA includes the coding intensity adjustment
- To convert an MA risk score from a CY2010 MMR, multiply by 1.041 and divide by (1-.0341)

Example Assumptions

March 2010 and July 2009 cohorts assumed equal

2011 PD Missing Diagnosis Adjustment = 1.010

Plan specific coding trend is 2.0% annually

Population change = 1.0%

2011 MA Coding Pattern Difference = 3.41% *

2011 MA Normalization factor = 1.031 *

2011 PD Normalization factor = 1.029 *

2011 Frailty Adjustment Factor = .008

* assumption from the Advance Notice; see Final Notice for updates

Risk Score Example

RISK SCORE PROJECTION		
	MA Preferred	**PD Preferred**
A **Starting Risk Score Provided by CMS**	1.0500	1.0400
B **Covert to Raw - Remove Normalization (multiply)**		
C **Covert to Raw - Remove MA Coding Pattern Adj (divide)**		
D **Transition from Lagged to non-lagged diagnosis data**		
E **Incomplete reporting of diagnosis data**		
F **Seasonality**		
G **Risk Model Adjustment**		
H **Missing Diagnosis Adjustment**		1.0100
I **Plan Specific coding Trend at 2.0% annually**	1.0404	1.0404
J **Population change**	1.0010	1.0010
K **MA Coding pattern differences (1-3.41%)**	0.9659	
L **Normalization Factor ***	1.0310	1.0290
M **Frailty factor (additive)**	0.0080	
Final Risk Score [(A * B / C * D * E * F * G * H * I * J * K) / L] + M	**1.0325**	**1.0631**

Documentation

- Must clearly show the method used to develop the risk score
- Must support each adjustment factor
- Must show that the methodology is consistent with the preferred method
- Must not roll multiple adjustments together and call them “trend” or “normalization”
- Must state the reason the alternative method was used