WNRAR Frequently Asked Questions

Please review carefully and send any questions or comments to: WNRARSupport@wakely.com.

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1. General Questions

1.1 WNRAR Results

1. **Will aggregate results be reported by rating area?**
   - Reporting will **not** be at the rating area level of detail. The calculations will use the rating area factors, but this information will be in an embedded calculation rather than provided in specific reporting breakdowns.
   - If we provided rating area level detail, we would likely be sharing issuer-specific information in some instances. Two scenarios in which this could occur include:
     - There is only one issuer in a particular rating area within a state.
     - There are only two issuers in a particular rating area, allowing those issuers to back into each other's score.

1.2 Software Requirements

1. **What type of SQL software should we be using?**
   - Please use Microsoft SQL 2005 or newer. If you are using an older version of SQL and are experiencing errors running the code, please send an email to WNRARSupport@wakely.com as soon as possible.

1.3 Risk Scores

1. **Does the WNRAR methodology account for new HCC risk weights released by CMS each year?**
   - Yes, Wakely updates the HCC risk weights each year as appropriate. For submissions pertaining to 2023, results are based on the final 2023 HCC risk weights, which can be found here: https://www.cms.gov/files/document/2023-benefit-year-final-hhs-risk-adjustment-model-coefficients.pdf. In all 2023 WNRAR runs, Wakely is rescoring data using the final 2024 risk model, labeled as Version 8 in WNRAR results. The final 2024 HCC risk weights can be found here: https://www.cms.gov/files/document/cms-9899-f-patient-protection-final.pdf. Beginning in the 202312 WNRAR run, Wakely is rescoring data using the proposed 2025 risk model, labeled as Version 9 in WNRAR results. The proposed 2025 HCC risk weights can be found here: https://www.cms.gov/files/document/cms-9895-p-patient-protection-final.pdf
2. **Are there any differences between how WNRAR and CMS calculate risk scores? If so, please explain.**

- A complete list of differences is available in Section 4.6 of the written report that accompanies each set of WNRAR results released. Please contact WNRAR Support at WNRARSupport@wakely.com if you need the latest report.

2. Enrollment Data Questions

2.1 Eligibility File Format

1. **Can we submit monthly enrollment data, *i.e.*, one line of enrollment for each member for each month?**
   - Yes, as long as they do not have different values in other enrollment fields (Date of Birth, Gender, Metal Tier, etc.), the WNRAR code will recognize this and combine adjacent but otherwise identical enrollment records.
2. **Our state expanded the definition of small group to include groups of size 51-100. How should I format my small group data?**
   - In your state, please include all ACA, grandfathered, and non-grandfathered pre-ACA groups of size 2-100, and flag them as Small Group (XSG). For example, say that a non-grandfathered group of size 51-100 entered the ACA small group market on its renewal date of 3/1/2023. Then please format the members in this group as follows:
     - Enrollment Record #1: 1/1/2023 – 2/28/2023, GRP1: [STATE]-XSG-NGF
     - Enrollment Record #2: 3/1/2023 – 12/31/2023, GRP1: [STATE]-XSG-ACA

2.2 Member Inclusion Criteria

1. **Should Medicare (Primary) members be included?**
   - We can find no guidance indicating that any ACA-compliant individual or small group enrollment is ineligible for risk adjustment. Therefore, please include all such members in your input data. See REGTAP FAQ #3551.
2. **Should we be reporting our "suspended members" (*i.e.*, members that have been suspended for non-payment of premium and are in a grace period, who will be retroactively cancelled if they do not pay before their grace period expires?)**
   - Please report data for such members.
3. **Should we exclude terminated members that had only Pre-ACA eligibility?**
   - No. Please include such members if they meet the other requirements outlined in the WNRAR Participation Guide for inclusion in your samples.

2.3 Member and Subscriber IDs

1. **Does the Member ID (MBR_ID) need to be de-identified when preparing the data?**
   - No, since Wakely does **not** receive any member-level data (including the member identifier), MBR_ID does not need to be de-identified, as it will only stay within each participant's local systems. If you do de-identify your member identifier, be sure to apply the same identifier to the enrollee's information in the claims files, so the WNRAR code can correctly match up members with their claims.
2. **Do Subscriber IDs need to map to Enrollee IDs, or do they only need to map (potentially) to other Subscriber IDs?**
   - Subscriber IDs need to map to Enrollee IDs. For example, if an enrollee is listed as a dependent, then the enrollee's Subscriber ID must map to another enrollee's Enrollee ID who is indicated as a Subscriber in the Subscriber Indicator field. If an enrollee is indicated as a Subscriber, then that member's Subscriber ID may be left blank.

2.4 Metal Tiers

1. **How should we set metal tier for pre-ACA data? Is there a default metal tier we should be using?**
   - Participants should use a reasonable method to develop AV estimates for their plans. A good approach is to use the Federal AV calculator as most issuers have already run their existing plans through the calculator and are therefore able to leverage that work and apply those metal tiers to the data. Plans may also use the simplified tool Wakely distributed as part of the Phase II Simulation in order to determine the metallic tiers. The cutoff range for each metal tier is explained in the WNRAR Participation Guide. Participants should not default their plans to a specific metal tier.

2.5 Premiums

1. **Is the Premium Amount a monthly amount?**
   - Yes. The Premium Amount represents the total family's monthly premium, reported only in the Subscriber's row(s). Please note that you will only need to populate the family's monthly Premium Amount for the Subscriber during his/her ACA-compliant enrollment span.
2. **How should we report partial month premiums?**

- The EDGE Server requirements specify that partial-month enrollments are to be indicated on their own lines, but our code has no such requirement; either way will work fine.

3. **How should we report premium changes?**
   - We need multiple enrollment lines if the family's monthly premium (reported at the Subscriber level) changes mid-year, *e.g.*, if the family composition or plan changes. A break in enrollment (for example, enrollment in January and March, but not February) is another scenario that would require multiple enrollment lines.
4. **Do we need to report premiums for pre-ACA subscribers?**
   - No. You may leave these blank.
5. **How do we handle premiums for child-only plans?**
   - In child-only plans, one child should be considered the subscriber, so attach premiums to that child's record.
6. **Should we include the impact of premium credits in our submission?**
   - Yes. Per the Fact Sheet released on August 25th, 2020[1], please use the actual premium amounts billed to enrollees for the 2023 benefit year (i.e. include all premium credits) in your WNRAR submission. Some issuers have reported that they only offered a premium credit for one month earlier in the year and do not plan to offer any additional premium credits after the cutoff for the current WNRAR run. In this case, please report the expected annualized average premium in your WNRAR submission. If the year-to-date premiums are used, the full-year estimated premiums in the WNRAR results will be understated because no premium discounts will be given after the cutoff for the current WNRAR run.

2.6 Rating Area

1. **What information do we use to set Rating Area for ACA-compliant plans?**
   - Per CMS guidance (http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/qa_hmr.html):
     - Individual Market: Use the Subscriber's residence. In the case when a Subscriber moves to a different state and maintains coverage, we believe that the member will remain in the original state's risk pool until renewal and should be assigned the Rating Area that was used to determine his or her premium. For example, if a member lives in Colorado Rating Area 1 and obtains a policy there, and then moves to Utah Rating Area 2 with no change in coverage, then the member

[1] https://www.cms.gov/files/document/cciio-premium-reductions-fact-sheet.pdf

should be continue to be assigned to Rating Area 1 (and have a GRP1 value beginning with CO-IND).

- Small Group Market: Use the small group employer's address.

2. Do we need to set Rating Area for pre-ACA members?

- No. If you like, you can set Rating Area to '0'.

2.7 CSR Indicator

1. Is the WNRAR code using the new CSR Indicator specifications that are included in the CMS DIY documentation published on Oct 19, 2015?

- No, we have **not** changed the CSR indicator definition since we began collecting it in 2014. Please keep using the same numbering that we used in prior runs. See the WNRAR Participation Guide for detailed instructions.

2. Is there specific logic I can use to set the CSR value when preparing my eligibility input file?

- The 16-digit Plan ID should be used to set CSR, as the last 2 digits represents the plan's CSR Variant. Generic SQL and SAS code follows – you will need to modify the logic as necessary to account for the actual variable names in your data set and their formats. **NOTE:** In the Massachusetts individual market, ConnectorCare plans should all be set to "1" – this applies to Plan IDs with CSR Variants "04" (73% AV Silver Plan Variation), "05" (87% AV Silver Plan Variation) and "06" (94% AV Silver Plan Variation). In the Colorado individual market, enrollees in Colorado OmniSalud Plans/Silver Enhanced Off-Exchange Plans receiving a state subsidy should have their CSR value set to "1" – as per CMS instruction for Benefit Year 2023.
  - SQL

```
CSR = CASE      WHEN RIGHT([Plan ID],2)= '00' THEN '0a'
                WHEN  RIGHT([Plan ID],2)= '01' THEN '0b'
                WHEN  RIGHT([Plan ID],2)= '03' THEN '8'
                WHEN  RIGHT([Plan ID],2) in ('32','36','35','42') THEN '9'
                WHEN  RIGHT([Plan ID],2) in ('30','41') THEN '10'
                WHEN  RIGHT([Plan ID],2)= '04' THEN '3'
                WHEN  RIGHT([Plan ID],2)= '05' THEN '2'
                WHEN  RIGHT([Plan ID],2)= '06' THEN '1'
                WHEN  RIGHT([Plan ID],2)= '02' THEN
                CASE    WHEN [Metal Tier] = 'PLATINUM' THEN '4'
                        WHEN [Metal Tier] = 'GOLD' THEN '5'
                        WHEN [Metal Tier] = 'SILVER' THEN '6'
                        WHEN [Metal Tier] = 'BRONZE' THEN '7'
                        ELSE ''
                        END
        ELSE    '0b'
```

```
END
```

- SAS

```
PROC SQL;
UPDATE DIRECTORY.TABLE
SET CSR = CASE  WHEN SUBSTR(PLAN_ID,15,2) ='00' THEN '0a'
                WHEN SUBSTR(PLAN_ID,15,2) = '01' THEN '0b'
                WHEN SUBSTR(PLAN_ID,15,2) = '03' THEN '8'
                WHEN SUBSTR(PLAN_ID,15,2) IN ('32','36', '35','42') THEN '9'
                WHEN SUBSTR(PLAN_ID,15,2) IN ('30','41') THEN '10'
                WHEN SUBSTR(PLAN_ID,15,2) = '04' THEN '3'
                WHEN SUBSTR(PLAN_ID,15,2) = '05' THEN '2'
                WHEN SUBSTR(PLAN_ID,15,2) = '06' THEN '1'
                WHEN SUBSTR(PLAN_ID,15,2) = '02' THEN
                CASE    WHEN Metal_Tier = 'PLATINUM' THEN '4'
                        WHEN Metal_Tier = 'GOLD' THEN '5'
                        WHEN Metal_Tier = 'SILVER' THEN '6'
                        WHEN Metal_Tier = 'BRONZE' THEN '7'
                        ELSE ''
                        END
        ELSE    '0b'
        END ;
QUIT;
```

2.8 New Member Indicator

1. How should we identify a "new member" to populate the New Member Indicator field?

- Individual Market: This is a member who is new to the plan as of the current plan year and is not renewing from a pre-ACA plan. As a working definition, a new member is someone who was not enrolled with the issuer in any business block at any point during a prior plan year. For example, a member should be identified as new in 2023 if (s)he was not enrolled in any business block with the issuer at any time on or before 12/31/2022.
  - For individual plans, the New Member Indicator should be set at the Subscriber (i.e., contract) level.
- Small Group Market: For small group plans, set New Member Indicator at the small group level. For example, if a small group existed in 2022, then all subscribers and dependents of this small group will be considered "existing" in 2023, even if there are new employees added.

2.9 Renewal Date

1. **Should the Renewal Date field be populated the same way for both Pre-ACA and Post-ACA enrollees?**
    - Post-ACA plan – If a member is enrolled in an ACA-approved plan at any time during the current plan year, the WNRAR code sets the Renewal Date to the earliest date of ACA enrollment in the year, regardless of how you populated Renewal Data in your eligibility input file.
    - Pre-ACA plan – If the member is only enrolled in a Pre-ACA plan, then we use the Renewal Date value provided in your eligibility input file. Please see Question 2.9.2 below for more details on how to populate the Renewal Date.
2. **Please provide more information on populating Renewal Date.**
    - Member renews during WNRAR experience window: If a member has renewed into a plan as of the last day in the experience window for which you are reporting data (*e.g.*, 7/31/2023 for the Jan-Jul run), then the Renewal Date field should be set to occur in 2024. For example, if a member has renewed into a plan on 3/1/2023, then the renewal date field should be set to 3/1/2024 (and **not** 3/1/2023).
    - Member renews after WNRAR experience window: If a member has **not** renewed into a plan as of the last day in the experience window for which you are reporting data (e.g. **not** on or before 7/31/2023 for the Jan-Jul run), then the renewal date field should be set to occur in 2023 after the last day of the data window. For example, if a member's last renewal date is 12/1/2022, then the renewal date field should be set to 12/1/2023 (in 2023 instead of 2024).
3. **What impact does the Renewal Data field have, if any, on risk score results?**
    - The Renewal Date will not affect risk scores in most versions of the results, as it is meaningful only for pre-ACA members. It will affect pre-ACA members in Version 7, and it will have a small impact for members with pre and post-ACA eligibility in Version 1, Version 5, and Version 8.

2.10 Pre-ACA Plan Considerations

1. **Are all pre-ACA policies "transitional"?**
    - Not necessarily. Here is how we think about the data:
        - Total Member Months (MM) = Pre-ACA MM + Post-ACA MM
        - Pre-ACA MM = Continuation or Transitional MM (*i.e.*, members utilizing the "keep your plan" legislation) + grandfathered Pre-ACA MM
2. **How should we identify pre-ACA Sole Proprietors prior to ACA policy renewal?**

- Please include them in Individual, unless they renewed into an ACA small group policy, in which case please identify them as small group.

2.11 Enrollment Duration Factor

1. How is Enrollment Duration Factor (EDF) calculated for members with dual coverage?

- EDF for members with dual coverage is calculated based on the guidance released by CMS on October 31, 2017[2]. This guidance specifies that a member's enrollment is to be aggregated within a HIOS Issuer ID, with overlapping enrollment periods counted only once. For example, consider a member with four enrollment spans within a single HIOS Issuer ID: 1/1/2023 – 2/28/2023 and 4/1/2023 – 5/31/2023 in the individual market; and 2/1/2023 – 4/30/2023 and 7/1/2023 – 7/31/2023 in the small group market. In this case, the EDF for all four spans will be based on 182 enrolled days. (There are 182 days in January, February, March, April, May, and July.) 182 enrolled days corresponds to the six month EDF.[3]

2. Which members receive an Enrollment Duration Factor (EDF)?

- Only adults (aged 21 and older) who meet the enrollment duration and HCC criteria receive an EDF.

2.12 Non-Binary Gender

1. How should non-binary gender enrollees be assigned a gender?

- If the same member is listed with a different gender in different enrollment segments, that member will be treated as two different members, and their risk score will be calculated separately. To avoid overrepresentation of that member within the same plan, we ask that you use their latest enrollment record's gender.

3. Medical Claims Data Questions

3.1 Medical Input File Format

1. Should I use claims header or claim line detail records?

- The code can work with either claim line detail or header records as long as diagnosis and CPT information is not truncated and each claim line detail record has the same Claim ID.

[2] https://www.regtap.info/uploads/library/DDC_Slides_EDGE25MR_103117_5CR_103117.pdf (EDF guidance begins on page 29)
[3] https://www.regtap.info/uploads/library/DDC_Slides_EDGE25MR_103117_5CR_103117.pdf, see page 31

2. **What if we don't have the resources to assign HIOS IDs to our claim records?**
   - In this case, please simply include a field called GRP2 in your medical and pharmacy claims files, and leave the field NULL or blank. Our codes will attempt to assign HIOS IDs to claims based on the HIOS IDs from the corresponding enrollment records.

3.2 Medical Claims Inclusion Criteria

1. **Should we exclude any claims in our data preparation?**
   - Please refer to the WNRAR Participation Guide for details on preparing the medical claim input file. The SQL and SAS codes will perform the risk adjustment exclusions by Procedure Code and Bill Type – please do **not** perform these exclusions yourself.
   - Per EDGE Server specifications, individual service lines that are denied or reversed may be included if at least one line in the header claim has a positive allowed amount. [4]
2. **Should we include behavioral claims?**
   - Yes. Behavioral (*i.e.* mental health) claims are to be treated the same as medical claims, and should be included.
3. **Should we include vision and dental claims in our submission?**
   - This depends on the type of plan that pays the claims. Vision and dental claims covered under ACA-compliant major medical plans should be included. Claims from stand-alone dental or stand-alone vision plans should **not** be included. See REGTAP FAQ #7389 and #7260.
4. **Should we include supplemental claims?**
   - No, not in the medical claims input file. Issuers with supplemental diagnoses are now required to submit a separate supplemental claims input file. Please see Section 4 below for additional questions regarding the separate supplemental diagnosis file.
5. **Do we need to include pharmacy data?**
   - No, not in the medical claims input file. Issuers are now required to submit a separate pharmacy claims input file. See Section 5 below regarding pharmacy claims data questions for more details.

3.3 Cross-Year Claims

1. **How are claims that begin in the prior year and end in the current year treated in the WNRAR code?**
   - The logic is as follows:

[4] EDGE Server Business Rules 7.0, Section 7.14
https://www.regtap.info/uploads/library/DDC_ESBR_V07_081817_5CR_082417.pdf

- If [Date of Service – From] and [Date of Service – To] are in the current year, then the programs will fully ignore the Statement Covers dates when filtering.
- Otherwise, claims with [Statement Covers From] in the prior year and [Statement Covers Through] in the current year are included for members who have coverage as of January 1st of the current year.

3.4 Procedure Codes

1. **What if my claim header has over six procedure codes and only PR1-PR6 are allowed in the medical input file?**
   - We recommend using claim line detail information if it is possible for your claims to have more than six procedure codes, as this will help ensure all CPT codes are captured. For example, if you have 50 professional claim lines, all belonging to a single claim with a Claim Header ID of "110", then include all 50 lines with "110" in the Claim Header ID field in the INP_DX (medical claim input) file. This allows us to capture all CPT codes within the confines of the PR1 – PR6 fields. By comparison, if only six of the potentially 50 CPT codes are captured by only using the claim header record, then an important CPT code may be excluded. This could dramatically impact the member's risk score if the excluded CPT code makes one or more diagnosis codes associated with the claim allowable per the HHS risk adjustment logic.
2. **Should the PR1-PR6 fields include ICD-10-CM procedure codes?**
   - No. The HHS logic only uses the 5-digit HCPCS and CPT codes.
3. **Which procedure codes are being used to determine which claims are allowable for risk scoring?**
   - Wakely always strives to include the most current list of allowable HCPCS and CPT codes in the WNRAR code, revising based on information provided in CMS SAS DIY software, EDGE Server maintenance release documentation, etc.

3.5 Diagnosis Codes

1. **Do WNRAR codes accept ICD-10 diagnosis codes?**
   - Per CMS guidance, the code accepts ICD-10 diagnosis codes for claims with dates of service on or after October 1, 2015. See: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/ICD-10-Guidance-8-13-15.pdf
2. **What if my claim header record has more than 25 diagnosis codes?**
   - For claims with more than 25 diagnosis codes, please replicate the claim record (all fields except diagnosis ([DX1] – [DX25]) and procedure code ([PR1] – [PR6]) fields must be identical) and put the additional codes on the second line.

4. Supplemental Claims Data Questions

1. How should we submit supplemental claims?

- Beginning with the 201712R run, participants with supplemental diagnoses **are required** to include supplemental diagnoses in a separate file. This allows us to explicitly identify when issuers have included their supplemental claims in their WNRAR submissions.

5. Pharmacy Claims Data Questions

1. Is submitting pharmacy claims data required?

- Yes, pharmacy data is included in the 2018 and future risk models and is now required in all submissions.