

WNRAR 2023 Participation Guide

The Wakely National Risk Adjustment Reporting Project

202312 Run

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

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1. Timeline

Proposed Schedule

Description	Service Dates	Paid Through	Output Uploaded to Website ¹	Results from Wakely ²
1 st Qtr 2023	1/1/2023 – 4/30/2023	4/30/2023	5/31/2023	6/15/2023
2 nd Qtr 2023	1/1/2023 – 7/31/2023	7/31/2023	8/31/2023	9/15/2023
3 rd Qtr 2023	1/1/2023 – 10/31/2023	10/31/2023	11/30/2023	12/15/2023
RADV IVA Survey ³			January 2024	February 2024
Year End 2023 I	1/1/2023 – 12/31/2023	12/31/2023	1/31/2024	2/15/2024
RATEE Report ⁴			May 2024	May 2024
Year End 2023 II	1/1/2023 – 12/31/2023	4/30/2024 ⁵	5/31/2024	6/15/2024

2. Preparing the Data (2023 Jan-Dec Run)

IMPORTANT CHANGES IN 2023

- In the 202310 run, the project codes were updated to align with the 2023 DIY tables released by CMS on August 22, 2023.⁶ The codes also align with Global Reference Data Files released on REGTAP on December 21, 2023.⁷
- Starting in the 202304 run, the output summary file generated from the project codes has a total of 317 columns.

¹ [WakelyRiskReporting.com](https://www.wakely.com/risk-reporting). See Section 3 below for details on uploading summary output.

² The actual timing of results in a given state and market (individual / small group) varies as results can only be released once all participants have submitted data that has passed certain high level reasonability checks.

³ For the 2022 BY RADV IVA Survey, Wakely will send participating issuers project codes in January 2024, which extract aggregated data from the issuers' 2022 EDGE files and 2022 RADV IVA Findings Report. This summary data will be used by Wakely to calculate issuer and market error rates. We plan to collect the summary files in mid-January 2024 and release results in early February 2024.

⁴ The RATEE report will use issuers' final RATEE results to calculate market averages and report back estimated risk transfers. We expect to collect issuers' RATEE results as soon as they are available in May 2024 and release results back within 5-7 business days after collection.

⁵ Date subject to change based on CMS guidance.

⁶ The 2023 DIY tables released by CMS on August 17, 2023 can be found here: <https://www.cms.gov/files/document/cy2023-diy-tables-08172023.xlsx>

⁷ The 2023 Global Reference Data Files released on REGTAP on December 21, 2023, can be found here: https://regtap.cms.gov/reg_library_openfile.php?id=5044&type=

2.1 General Guidelines

1. Please use data for claims incurred (i.e., start-date) from **January 1, 2023 to December 31, 2023**, and paid through (i.e., with paid date no later than) **December 31, 2023**. Data for members that were eligible for any time during the incurred period are to be included (i.e., this includes termed members and members that had no claims).
2. We recommend that you create a single set of Enrollment, Medical, Pharmacy and Supplemental Diagnosis files for all of the markets (i.e., states, small group/individual) in which you are participating. This will save you a lot of time in preparing and uploading results, as you will be developing and uploading one set of files instead of multiple sets of files for each state/market/issuer).
3. No detailed claim data, protected health information (PHI) or member-level data is sent to Wakely as part of this project. Only the summarized aggregate-level output is submitted, as described below.

2.2 Preparing the Enrollment file

1. Member inclusion criteria: Please include all effectuated members in your individual and small group business, both active and terminated, subject to the following criteria:
 - a. Members expected to enroll in ACA-compliant plans: As a general rule, please include all members that are expected to enroll in ACA-compliant plans in **2023**. All continuation (i.e., subject to 'keep your plan' legislation of November 2013) members are to be included. For example, if you have association business with groups of size 2-50 that are expected to transition into small group coverage in **2023**, please include this data.
 - b. Terminated Pre-ACA only members: Please include Pre-ACA only members (i.e., members that have no ACA-compliant eligibility) that terminate coverage before the end of the data window if they meet the other requirements for inclusion in your samples. Please contact us at WNRARSupport@Wakely.com to discuss any state-specific questions.
 - c. Association Business:
 - Treatment of association business may need to vary by state. If state rules are clear that individuals or small groups that are part of an association may remain in the association and not be part of the respective risk pool for risk adjustment, please exclude that business from the risk adjustment reporting submission. If state rules are clear that these individuals or small groups will be included in the risk adjustment pool, please include this business in the risk adjustment reporting project. If state rules are **not** clear and you believe there is uncertainty on how these policies will be treated, please exclude this business from the project.
 - For each state and market for which you are participating in the project and that have a material number of covered lives within association business, please indicate how you handled association business. If we see any inconsistencies across issuers, we will reach out to discuss a consistent approach.
 - d. Conversion policies: Conversion policies should not be included in the individual market submission. However, if your conversion policies are in an ACA-compliant plan, please

- include them under the appropriate market, consistent with your EDGE server submission.
- e. Hospital-only plans: Enrollees in hospital-only plans or other limited benefit plans should be excluded.
 - f. Student health plans: Student health plans are not subject to risk adjustment. Therefore, please exclude these plans from the data.
 - g. Grandfathered and non-grandfathered plans: Please include all grandfathered and non-grandfathered policies and flag them appropriately as defined in the [GRP1] specification below.
 - h. State assignment: Please use the state in which a plan was filed and approved as the basis for assigning enrollees into a state risk pool.
 - i. Sole proprietors: Please include sole proprietors in the individual risk pool if they are in pre-ACA policies. If they have renewed into an ACA-compliant plan, please include them in their respective ACA risk pool.
 - j. Suspended members (i.e., members in a grace period): Include suspended members who are currently in a grace period, including those in their 2nd or 3rd months.
2. File structuring: The HHS model uses metal-tier based risk scoring, and it is possible that an individual may be enrolled in more than one plan in a given year. Please provide a separate record for each plan enrollment for any given enrollee. For example, if an enrollee was enrolled from January through July in a Silver plan, and then enrolled from August through December in a Gold plan, please provide two separate records with the appropriate [Enrollment Start Date] and [Enrollment End Date] to reflect the enrollment periods in each plan.
 3. Data fields to include:
 - a. **[Unique Enrollee ID]** {text field, max length 80}: Member Identifier. Please do **not** include null or blank values. The identifier must be consistent with that used for the claims files. The information should not be truncated (i.e., if your member identifier is 10 digits long, then the width of this field should at least be 10 digits).
 - b. **[Enrollee DOB]** {date field}: This is a date field which identifies the enrollee's date of birth. It will be used, along with enrollment dates, to calculate an enrollee's age.
 - **Note**: If an enrollee has more than one enrollment record and the birthdates do not match, the birthdates will be reassigned to the earliest date.
 - c. **[Enrollee Gender]** {text field}: 'M' or 'F', where 'M' is male and 'F' is female. Please do **not** include any null values or blanks (i.e., all records should include a gender). A value of 'U' will be allowed for infants aged 0 – they will be defaulted to female for risk-scoring purposes.
 - d. **[Subscriber Indicator]** {text field}: 'S' or '' (blank), where 'S' indicates that the enrollee is the subscriber on the plan represented by the present HIOS Plan ID, and '' (blank) indicates that this enrollee is a dependent on that plan.
 - **Note**: For child-only plans, treat one child as the subscriber. See note under Premium Amount below.
 - e. **[Subscriber ID]** {text field}: This is the [Unique Enrollee ID] of the subscriber on this enrollee's plan. If the present enrollee is the subscriber, this field may be left blank.
 - f. **[GRP1]** {text field}: Please indicate the state using the appropriate 2-letter abbreviation, e.g., CO for Colorado; the market using values **IND** (for Individual) and **XSG** (for small groups, including Small Groups with 51-100 employees that are now ACA eligible in the

CA, CO and NY markets); and the plan type using **GRF** (for Pre-ACA grandfathered), **NGF** (for pre-ACA non-grandfathered) and **ACA** (for ACA-compliant records). The format must be State Abbreviation-Market Segment Value-Plan Type.

- For example, Colorado Individual grandfathered business would be indicated by 'CO-IND-GRF' and Colorado Small Group ACA business would be indicated by 'CO-XSG-ACA'. If a member has two separate records for being in a pre-ACA enrollment span and another in an ACA-compliant enrollment span, GRP1 should be used to differentiate the type of enrollment span.
- g. **[GRP2]** {text field}: Please use the five-digit HIOS Issuer ID.
- h. **[Metal Tier]** {text field}: Indicate the metal level of the plan in which the person is enrolled. Valid inputs are 'Catastrophic', 'Bronze', 'Silver', 'Gold', and 'Platinum'. For Pre-ACA plans, please estimate metal tier based on the following rules:
- Actuarial value between 0 and 67: **Bronze**
 - Actuarial value between 68 and 77: **Silver**
 - Actuarial value between 78 and 87: **Gold**
 - Actuarial value > 88: **Platinum**
- i. **[CSR]**⁸ {text field}: This is the Cost-Sharing Reduction tier, defined as follows:
- '1' : 94% AV Silver Plan Variation
 - **Note:** All ConnectorCare plans in the Massachusetts individual market should be set to '1' regardless whether the plan variant identifies the plan as a 94%, 87% or 73% AV Silver Plan Variation. This aligns with the 2017 NBPP requiring ConnectorCare plans to be treated as Medicaid alternative plans and given a CSR adjustment of 1.12.⁹
 - **Note:** All enrollees receiving state subsidies for "Colorado OmniSalud Plans/Silver Enhanced Off-Exchange" plans in the Colorado individual market should be set to '1'. Per CMS instructions, these enrollees will receive a CSR adjustment of 1.12.
 - '2' : 87% AV Silver Plan Variation
 - '3' : 73% AV Silver Plan Variation
 - '4' : Zero Cost-Sharing Plan Variation of Platinum Level QHP
 - '5' : Zero Cost-Sharing Plan Variation of Gold Level QHP
 - '6' : Zero Cost-Sharing Plan Variation of Silver Level QHP
 - '7' : Zero Cost-Sharing Plan Variation of Bronze Level QHP
 - '8' : Limited Cost-Sharing Plan Variation
 - '9' : Premium Assistance Medicaid Alternative, 94% AV Silver Plan Variation
 - '10' : Premium Assistance Medicaid Alternative, Zero Cost-Sharing Plan Variation of Silver Level QHP
 - '0a' : Off-exchange eligibility with no or unknown CSR.
 - **Note:** Pre-ACA enrollment records should default to this value.
 - '0b' : On-exchange eligibility with no or unknown CSR.

⁸ Note that the CMS DIY SAS software released October 19, 2015 changed the specifications on this field. For the sake of simplicity, we are retaining the prior specifications for this field.

⁹ <https://www.federalregister.gov/documents/2016/03/08/2016-04439/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2017>

- j. **[Plan ID]** {text field, max length 16}: This is the plan’s HIOS ID from the EDGE Server. The format is: HIOS Issuer ID + State Code + HIOS Product ID + HIOS Component ID + CSR Variant. For non-ACA-compliant plans, please set this to a unique identifier that links related enrollment records and distinguishes unrelated records. For example, if an enrollee has double-coverage under Pre-ACA plans, please ensure that the respective Plan IDs are distinct; if the enrollee has two enrollment records for the same coverage for January and February, then these records should have the same Plan ID.
- k. **[Enrollment Start Date]** {date field}: This is a date field which indicates the beginning of an enrollee’s enrollment in the plan specified by the other information in the input line. This date should be in **2023**.
 - **Note:** Dates unpopulated or prior to **2023** will be set to **1/1/2023**. Enrollment start dates subsequent to the corresponding [Enrollment End Date] will be set to the [Enrollment End Date].
- l. **[Enrollment End Date]** {date field}: This is a date field which specifies **the final day of enrollment** in the plan. Example: For a member enrolled through August, [Enrollment End Date] should be set to 8/31/2022. The field should **not** be left blank.
 - **Note:** Dates unpopulated or falling later than the final requested enrollment date (e.g., **Dec 31, 2023 for the Jan-Dec run**) will be set to that final date.
- m. **[Premium Amount]** {float}: This is the monthly premium amount for the subscriber. This field should be positive and non-zero for subscribers, and zero for non-subscribers.
 - **NOTE:** This field should be populated for child-only plans, on the subscriber record for the plan.
- n. **[Rating Area]** {integer}: This is the numeric (1 – xx) CMS-implemented 2019 geographic Rating Area ID as shown here: <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-gra.html>
 - For example, the Denver, CO rating area is ‘3’ per the document above.
 - For Pre-ACA policies, you may set all Rating Areas to 0.
- o. **[Renewal Date]** {date field}: The future renewal date in which either a small group or individual comes up for renewal. The renewal date should always fall after the member’s [Enrollment End Date].
- p. **[New Member Indicator]** {text field}: ‘Y’ or ‘N’, where ‘Y’ indicates that this enrollee was not in any of your business blocks on or before **12/31/2022** and is new in **2023**.
 - **Note:** For small group plans, set at the small group level. For example, if a small group was covered in 2021, then all members of this small group will be considered “not new” in 2022 and thereafter, even if new employees are added to the group.

2.3 Preparing the Medical (Diagnosis) File

1. **Paid claims:** Please use the latest and greatest information on a claim, **except for** any diagnoses added or deleted through the claim coding remediation process **if** you are submitting a separate supplemental diagnosis file (see [Section 2.4](#) below).
2. **Denied claims:**

- a. Denied or reversed claims, in general: Regardless of plan type, do **not** include denied claims or reversed claims that do not accurately reflect the diagnosis history of a patient.
 - b. ACA claims: All denied or reversed ACA claims should be excluded. Per EDGE Server specifications, individual service lines that were denied or reversed can be included if some line in the header claim has a positive allowed amount.¹⁰
 - c. Pre-ACA claims:
 - Denied claims with a legitimate diagnosis – for example, claims denied due to reaching an annual or lifetime max – should be included.
 - Denied claims due to pre-existing conditions should be included, since they reflect a more complete and accurate picture of morbidity for an individual.
3. Data fields to include:
- a. **[Unique Enrollee ID]** {text field, max length 80}: Member identifier (consistent with that on the INP_ELIG file).
 - b. **[GRP2]** {text field}: Please use the five-digit HIOS Issuer ID of the plan that paid the claim. This value must align with the GRP2 value on the member’s enrollment record.
 - c. **[Form Type]** {text field}: Set the value to ‘I’ for an institutional setting or the value ‘P’ for a professional setting. Please do not include any null values or blanks (i.e., all records should include a Form Type).
 - d. **[Claim ID]** {text field, max length 80}: This field uniquely identifies Claim Header records. This field is important because the HHS Exclusion logic looks for allowable CPT/HCPCS codes at the header level, not the claim line level. Therefore if this field is not populated correctly, the HHS Exclusion logic may not get applied consistently.
 - **Note:** In the case of records where the [Claim ID] is left blank, we apply a modified version of the logic that looks at all the CPT/HCPCS codes that are coded on a given day for a given member.
 - e. **[Bill Type]** {text field}: This field should follow the standard bill type code format of three digits, with no leading zeroes. For example, Bill Type 111 is associated with Hospital-Inpatient-Admit Through Discharge Claim whereas Bill Type 131 is Hospital-Outpatient-Admit Through Discharge Claim.
 - f. **[Diagnosis Code Qualifier]** {text field}: ‘1’ or ‘2’, where ‘1’ indicates ICD-9-CM codes and ‘2’ indicates ICD-10-CM codes are used in the DX fields. Since it is 2021, we expect all diagnosis codes to be in ICD-10 format and the Diagnosis Code Qualifier field to be set equal to ‘2’.
 - g. **[DX1] – [DX25]** {text field}: ICD9-CM or ICD-10-CM diagnosis code, fully specified (i.e., up to 5 digits for ICD9-CM and up to 7 digits for ICD10-CM). Do **not** include decimals. Format as text, including any leading zeroes. Include all available diagnoses per encounter (i.e., DX1-DX25) in one row.
 - **Note:** For claims with more than 25 diagnosis codes, please replicate the claim record (all non-DX and non-PR fields must be identical) and put the additional codes on the second line.
 - h. **[Statement Covers From]** {date field}: For inpatient claims, this is the admission date. For other claims, this can be set to [Date of Service – From].

¹⁰ See Section 7.14 FFS and Capitated Cla [081817_SCR_082417.pdf](#)

- **Note:** Since the code uses the service dates in order to select the window for gathering diagnoses, if there are any invalid (or missing) dates or dates outside the experience window (e.g., Jan 1, 2023 – Dec 31, 2023 for the Jan-Dec run), the codes drop those claims from the processing files and they will not be used for risk scoring.
- i. **[Statement Covers Through]**¹¹ {date field}: For inpatient claims, this is the discharge date. For other claims, this can be set to [Date of Service – To].
 - **Note:** For a 2021 inpatient claim that ended in 2022, the Statement Covers Through date must be in 2022 for the claim to be considered in the 2022 risk adjustment scoring.
- j. **[Date Paid]** {date field}: This is the date on which a claim is paid. This date must be present on all claims.
 - **Note:** Since the code uses the paid dates in order to select the window for gathering diagnoses, if there are any invalid (or missing) dates or dates outside of the payment window (e.g., Jan 1, 2023 – Dec 31, 2023 for the Jan-Dec run), the codes drop those claims from the processing files and they will not be used for risk scoring.
- k. **[Date of Service - From]** {date field}: This is the date of service on which the service began.
 - **Note:** Since the code uses the service dates in order to select the window for gathering diagnoses, if there are any invalid (or missing) dates or dates outside the experience window (e.g., Jan 1, 2023 – Dec 31, 2023 for the Jan-Dec run), the codes drop those claims from the processing files and they will not be used for risk scoring.
- l. **[Date of Service - To]** {date field}: This is the date of service on which the service ended.
- m. **[PR1] – [PR6]** {text field}: These fields are to be populated with standard procedure codes (CPT, HCPCS) as published by the American Medical Association. They must be formatted as text, including any leading zeroes.
 - **Note:** For claims with more than 6 procedure codes, please replicate the claim record (all non-DX and non-PR fields must be identical) and put the additional codes on the second line.

2.4 Preparing the Supplemental Diagnosis file

1. We are now asking participants to include supplemental diagnoses in a separate input file. We understand that participants are unlikely to have any supplemental diagnoses until later in the year. You are **not** required to create a supplemental diagnosis input file for the Jan-Dec run if you do not have supplemental diagnoses.
 - a. When preparing your file, be sure to only include supplemental diagnoses (both adds and deletes that are still valid (i.e., were not later voided). For example, if a diagnosis was deleted on 2/15/2023 and that deletion was later voided on 3/4/2023, exclude the deleted diagnosis transaction from your input file.
2. Data Fields to include:

¹¹ Inpatient claims with a [Statement Covers Through] date between 1/1/2023 and 12/31/2023 are eligible for risk adjustment in 2022 and should be included. This includes claims with a [Statement Covers From] date prior to 1/1/2023.

- a. **[Unique Enrollee ID]** {text field, max length 80}: Member identifier (consistent with that on the INP_ELIG file).
- b. **[Claim ID]** {text field}: A Claim Header ID, used to link this record to a record in the diagnosis file. This record will have no impact if they do not map to a record in the diagnosis file.
- c. **[DX]** {text field}: This is the supplemental ICD10 diagnosis code to be added or deleted from the specified claim in the diagnosis file.
- d. **[AddDeleteCode]** {text field}: Indicates that the specified supplemental DX code is to be added (“A”) or deleted (“D”) from the specified claim. Valid values: “A” and “D”

2.5 Preparing the Pharmacy file

1. We are now asking participants to include a pharmacy data input file. Please include all paid pharmacy claims for the members in your enrollment input file.
2. Data Fields to include:
 - a. **[Unique Enrollee ID]** {text field, max length 80}: Member identifier (consistent with that on the INP_ELIG file).
 - b. **[GRP2]** {text field}: Please use the five-digit HIOS Issuer ID of the plan that paid the claim.
 - c. **[NDC]** {text field}: The 11-digit National Drug Code, with no spaces, periods, hyphens, or other formatting .
 - d. **[Date of Service]** {date field}: This is the date on which the prescription was filled. This field is required on all records.
 - e. **[Date Paid]** {date field}: This is the date of service on which the claim is paid. This date must be present on all claims. This field is required on all records.

3. Running the Model

Step 0: Run 00_WNRAR – Load Test Tables.sql

1. The model requires an eligibility table and a medical claims (diagnosis) table in order to run. Accompanying this guide and the model are ‘test’ input (eligibility and medical) files, such that the user can see how the model runs out of the box. This first code in the sequence is designed to help load these test tables.
2. Please specify a database in which to run the model and create tables. The default database name is **Wakely_Risk_Reporting**.
3. In order to run this code, all of the text files in Step 0.5 below need to be placed in a location such as “**C:\SQL_BulkInsert\WNRAR Sample Inputs**”. If you change this location, then please edit the code in the USER INPUTS section (right below the contact information) to reflect the new location.
4. While the manner to load files above is easiest, in case it fails you may load the tables using another method (using SQL import/export wizard, or MS Access, for example).
5. List of text files to upload:
 - a. INP_ELIG_TEST_2023

- b. INP_DX_TEST_2023
- c. INP_DX_SUPP_TEST_2023
- d. INP_RX_TEST_2023

Step 1: Run 01_WNRAR – Load Mandatory Tables.sql

1. The model uses several data tables (listed below) in order to run. This step of code in the sequence loads all of the mandatory tables needed in order for the code to work properly. Note that no text tables accompany this step – all the necessary data for the tables is located within the SQL code.
2. Please specify a database in which to run the model and create tables. The default database name is **Wakely_Risk_Reporting**.
3. List of files relevant to the **2023 Jan-Dec run** that are loaded:
 - a. MANDATORY_CHECKS
 - b. WNRAR_HHS_TABLE3_2023
 - c. WNRAR_HHS_TABLE3_ICD10
 - d. WNRAR_HHS_WEIGHTS_2023
 - e. WNRAR_HHS_WEIGHTS_2024
 - f. **WNRAR_HHS_RX_MAPPING**
 - g. **WNRAR_HHS_HCPCS_RX_MAPPING¹²**
 - h. WNRAR_HHS_PROC_INCLUSION_2023

Step 2: Run 02_WNRAR – Eligibility Inputs.sql

1. This step processes your eligibility input file in preparation for scoring. For this step to run successfully, you must prepare an eligibility input file for your data in a format identical to the test files (see [Section 2.2](#) above).
2. This code will collate the member-level premium information into a table format (in a file called **PREMIUM_WORKSHEET**), which you can review for its reasonability. If you would prefer to populate the Premium Template by hand from your organization’s internal data, please do so and use the Premium template (an Excel file included in the code package).
3. Please specify a database in which to run the model and create tables. The default database name is **Wakely_Risk_Reporting**.
4. In order to run this code, you need to point the code to your data input files. For example, if you created an input file named “Input Eligibility 2023”, then you can edit the code in the USER INPUTS section in following manner:

Change: `SET @ELIG_FILENAME = 'INP_ELIG_TEST_2023'`
 To: `SET @ELIG_FILENAME = 'Input Eligibility 2023'`

¹² The pharmacy condition logic is updated to align with the NDC to RXC and HCPCS to RXC mappings in the Global Reference Data Files released on REGTAP on December 21, 2023.

5. Validation Checks: If the code runs successfully, you will see a small table of high-level data checks appear in the Results window. You will see a variety of metrics describing the validity of your data. The most important one is “% Dropped”: this is the percent of the input rows that have invalid or missing information. The various “Dropped Categories” describe the types of missing information, and the STAT field will state the number of rows with the corresponding error as the primary error. We recommend that you carefully review your eligibility data to minimize the % Dropped to be 0% or at least below 2%. Other checks include:
- a. **Code Version: [Date]**: This allows Wakely to confirm that the most recent code version was used.
 - b. **# of rows in [your Eligibility file]**: This is the number of rows in the Eligibility file indicated by @ELIG_FILENAME.
 - c. **# of input rows, after removing duplicates**: This is the total eligibility in the INP_ELIG file – completely identical rows have been removed. In the Eligibility file you created, there should not be any rows that are identical across all values.
 - d. **# of distinct Subscriber+Plan ID combinations**: This is the number of distinct combinations of Subscriber+Plan ID
 - e. **Average Family size (when consisting of more than one person)**: This average family (Subscriber + Dependents) size, among those with more than one member.
 - f. **# of distinct MBR_IDs**: This is the number of distinct member identifiers in the input file. This may differ from the number of rows in INP_ELIG if, for example, a member switches metal tier or has non-adjacent enrollment spans.
 - g. **Average Eligibility**: This is the average number of eligible months per unique enrollment record (i.e., per row) in the INP_ELIG file.
 - h. **Total Eligibility in INP_ELIG**: This is the sum of the eligible months in the INP_ELIG file.
 - i. **Total Billable Eligibility in INP_ELIG (Passed Validity Checks)**: This is the number of valid eligible months attributed to billable members. In general, a member is considered billable if he or she is aged 21 or older or among the three oldest family members younger than 21. Please see the programming notes in the latest WNRAR run’s final report documentation for more details.
 - j. **Total Non-Subscriber Eligibility in INP_ELIG (ACA)**: This is the number of valid eligible months attributed to non-subscribers in Post-ACA policies.
 - k. **Total Subscriber Eligibility in INP_ELIG (ACA)**: This is the number of valid eligible months attributed to subscribers in Post-ACA policies.
 - l. **Total New Member Eligibility in INP_ELIG (Passed Validity Checks)**: This is the number of valid eligible months attributed to New Members.
 - m. **Total ACA Eligibility in INP_ELIG (Passed Validity Checks)**: This is the number of valid eligible months attributed to Post-ACA policies
 - n. **Total GRF Eligibility in INP_ELIG (Passed Validity Checks)**: This is the number of valid eligible months attributed to Pre-ACA grandfathered policies
 - o. **Total NGF Eligibility in INP_ELIG (Passed Validity Checks)**: This is the number of valid eligible months attributed to Pre-ACA non-grandfathered policies
 - p. **Total Dropped Eligibility**: This is the total eligibility that is dropped due to reasons below. The ratio of this to the total eligibility should be close to 0% -- otherwise, it means that there are deficiencies in your input data that are causing eligibility to be dropped.

“Dropped” here means that those members are not processed by the scoring code, and their summarized results are not transmitted to Wakely.

- Reasons for dropped eligibility include:
 - **# Rows: Dropped: Invalid Age:** Calculated age is negative, missing, or over 150 (i.e., DOB is invalid)
 - **# Rows: Dropped: Invalid Gender:** Gender is not in ‘M’ or ‘F’
 - **# Rows: Dropped: Invalid Metal:** Metal value is not in (‘Platinum’, ‘Gold’, ‘Silver’, ‘Bronze’, ‘Catastrophic’)
 - **# Rows: Dropped: No MBR_ID:** Member identifier is NULL or blank
 - **# Rows: Dropped: Invalid CSR:** CSR value is invalid and not in 0-10
 - **# Rows: Dropped: Invalid Member Type Indicator:** Record indicator is not in (‘GRF’, ‘NGF’, ‘ACA’)
- q. **# of members that lie in more than one PLAN_ID+GRP1+METAL+CSR_INDICATOR:** This is the number of enrollees that have more than one enrollment record, when grouping by [Unique Enrollee ID], [Plan ID], GRP1, [Metal Tier], and CSR. Such records are not necessarily erroneous.
- r. **# of members that lie in more than one STATE+GRP2:** This is the number of enrollees that have more than one enrollment record, when grouping by STATE and GRP2. Such records are not necessarily erroneous.
- s. **# of members with more than [maximum number of months in enrollment window for data run] average month(s) of eligibility:** This is the number of members who are collectively enrolled for more than the maximum possible number of average months in the enrollment window for the data run. If the enrollee’s records are accurate, then this indicates double-coverage for that enrollee.
- t. **# of valid duplicate member months:** This is the number of member months in which enrollees have double coverage.
- u. **Average monthly premium (for ACA business):** This is average monthly premium (PMPM) for Post-ACA business.
- v. **% of Enrollee IDs that terminate (have no enrollment on end of run period):** This proportion assesses the reasonability of enrollment dates.
- w. **# of Enrollee IDs that terminate and are Pre-ACA only:** These members terminate and have no Post-ACA enrollment. Wakely will exclude these members from the results.
- x. **# of Enrollee IDs that have both Pre-ACA and Post-ACA eligibility:** These are members that have both Pre- and Post-ACA eligibility, and so either renewed into an ACA plan in the reporting window or were flagged as having double coverage in a Pre-ACA and Post-ACA plan in the reporting window.
- y. **Warnings:** The checks produce warnings where the eligibility may not be dropped outright, however the data may be invalid. When we receive files that raise such warnings, we reach out to the participants to get further clarification. Reasons that trigger warnings include:
 - **# Rows: Warning: Nonzero CSR applied to non-individual business (CSR set to zero):** CSR adjustments apply only to individual business. Nonzero CSR values for small group members will be set to zero.
 - **# Rows: Warning: Dependent maps to Subscriber with zero Premium:** In the premium worksheet, these members will be left out of the member month totals.

- **# Rows: Warning: Subscribers with Monthly Premium < \$100 or > \$1500:** This is not necessarily an error, but we expect very few plans to lie at these extremes.
- **# Rows: Warning: Out-of-order Enrollment Start and End dates:** Enrollment start date is after the enrollment end date. In this case the code sets it to the enrollment end date.
- **# Rows: Warning: Invalid Enrollment End Dates (set to [maximum End Date in window]):** Enrollment End date is after the valid enrollment window for the data run (e.g., after Dec 31, 2023, for the Jan-Dec run). The date is re-set to the maximum allowed end date (e.g., Dec 31, 2023 for the Jan-Dec run).
- **# Rows: Warning: Invalid Enrollment End Dates (set to 1/1/2023):** Enrollment end date is before 2023 (or is NULL or blank), and is re-set to 1/1/2023. These members will effectively get no eligibility.
- **# Rows: Warning: Invalid Enrollment Start Dates (set to [day after the maximum allowed Date in the window]):** Enrollment Start Date is after the valid enrollment window for the data run (e.g., after Dec 31, 2023, for the Jan-Dec run). The date is re-set to the day after the maximum allowed date (e.g., Jan 1, 2023 for Jan-Dec run).
- **# Rows: Warning: DOB after Enrollment Start Date:** Date of Birth is after Enrollment Start Date.
- **# Rows: Warning: DOB out of range:** Date of Birth is before 1/1/1800 or after the final valid date of enrollment in this data run.
- **# Rows: Warning: Members with multiple enrollments and differing DOBs:** This counts the number of INP_ELIG rows whose MBR_IDs appear more than once in INP_ELIG, and which are also associated with more than one distinct date of birth.
- **# Rows: Warning: Invalid Market:** The market is not set to 'IND' (individual) or 'XSG' (small group). For information on how to set this indicator, review [Section 2.2.3.f](#).
- **# Rows: Warning: Invalid State:** The two-character state abbreviation used is not a valid state. For information on how to set this indicator, review [Section 2.2.3.f](#).
- **# Rows: Warning: Invalid Subscriber Indicator:** The Subscriber Indicator is something other than 'S' or '' (blank).
- **# Rows: Warning: Invalid Plan ID:** The Plan ID is empty or NULL.
- **# Rows: Warning: Invalid Rating Area:** Each state has a certain number of Rating Areas, always numbered from 1 to xx. This checks that the listed Rating Area is a valid value in the listed state.¹³
- **# Rows: Warning: Invalid New Member Indicator:** The New Member Indicator is something other than 'Y' or 'N'.
- **# Rows: Warning: Misapplied CSR Indicator:** Each CSR value (except '0') is valid only for a single Metal Tier. This warning occurs when a CSR value is misapplied. See the CSR definition in [Section 2.2.3.i](#).
- **# Rows: Warning: Subscriber with <= zero premium:** Indicates a subscriber with no (positive) premium.
 - **Note:** This applies only to ACA members.

¹³ For details, see <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-gra.html>.

- **# Rows: Warning: Non-subscriber with non-zero premium:** Indicates a non-subscriber with a non-zero premium; only subscribers are supposed to have premiums.
 - **Note:** This applies only to ACA members.
- **# Rows: Warning: Subscriber ID not found in INP_ELIG:** Indicates a dependent whose Subscriber ID does not map to a Unique Enrollee ID in INP_ELIG.
- **# Rows: Warning: Misapplied Subscriber Indicator:** Checks that Subscriber Indicator, Subscriber ID, and Unique Enrollee ID are consistent.
- **# Rows: Warning: Members with multiple subscribers:** Indicates that a member is associated with more than one Subscriber (i.e., necessarily through multiple enrollment records).

Step 3a: Run 03a_WNRAR – Medical Inputs.sql

1. This step processes your INP_DX (medical claims input) file in preparation for scoring. The purpose of this code is to create flags for claims that are allowed in the risk adjustment reporting, as well as to format the data for processing. Wakely applies several HHS exclusions based on the data you have created. For more details on these exclusions, please contact the support team at WNRARSupport@wakely.com.
2. For this step to run successfully, you must prepare a medical claims input file for your data in a format identical to the test files (see [Section 2.3](#) above).
3. Please specify a database in which to run the model and create tables. The default database name is **Wakely_Risk_Reporting**.
4. In order to run this code, you need to point the code to your data input files. For example, if you created an input file named “Input Claims 2023”, then you can edit the code in the USER INPUTS section in the following manner:

Change: `SET @ELIGDX_FILENAME = 'INP_DX_TEST_2023'`
 To: `SET @ELIGDX_FILENAME = 'Input Claims 2023'`

5. **Validation Checks:** If the code runs successfully, you will see a small table of high-level data checks appear in the Results window. Please carefully review the checks. These include:
 - a. **Code Version: [Date]:** This allows Wakely to confirm that the most recent code version was used.
 - b. **# of rows of raw input that pass cross-check (have valid dates):** This is the number of claim input lines that lie within the data window and meet the criteria for inclusion (i.e., are not dropped for any Dropped Claim reason specified below).
 - c. **# Rows: Statement Covers From date in 2022 and Statement Covers Through date in 2023:** This is the number of claim lines that spans over 2022 and 2023.
 - d. **Average number of claim lines per Claim ID:** This provides a check on the Claim ID assignment.
 - e. **Claimant Ratio (before HHS Exclusions):** This is provided to help illustrate the impact of exclusions. For a full-year run, there will be considerable variability, but we expect market-wide values to be above 50%, averaging 60-70%. Partial year runs will produce

considerably smaller claimant ratios. Values abnormally high or low may indicate data issues. Please contact the support team at WNRARSupport@wakely.com in order to discuss.

- f. **Out-of-Range Dropped Claims:** Claims dropped upfront for certain “out-of-range” reasons are moved to a file on your server called INP_DX_DROPPED. The [DROPPED_REASON] field indicates why each claim was deleted.
- **DELETED: Dates missing or outside of data window:** This is the number of claim lines, split by [Form Type] that are dropped for lying outside of the experience window (e.g., Jan 1, 2023 – Dec 31, 2023 for the Jan-Dec run).
 - **DELETED: Incurred outside of valid enrollment span:** This is the number of claim lines, split by [Form Type], that are dropped for incurring outside of a member’s valid enrollment span.
 - **DELETED: Phantom claim lines:** This is the number of claim lines whose [MBR_ID] does not exist in the enrollment file.
 - **DELETED: Claim GRP2 <> Enrollment GRP2:** This is the number of claim lines dropped because the [GRP2] value associated with the claim does not match the member’s [GRP2] value in the eligibility input file.
- g. **# of records with invalid category:** Claims that are not dropped upfront for being out-of-range, but are otherwise excluded for other reasons are listed below. These excluded claims are identified as such in a file on your server called INP_DX_EXCL. The [DROPPED_REASON] field indicates why each claim was excluded.
- **Dropped: Invalid Form Type:** [Form Type] is other than ‘I’ or ‘P’.
 - **Dropped: Institutional claim with empty Bill Type:** Claim line with [Form Type] of ‘I’ and no [Bill Type] value.
- h. **Warnings:** The checks produce warnings where the medical records may not be dropped outright, however the data may be invalid. When we receive files that raise such warnings, we reach out to the participants to get further clarification. Reasons that trigger warnings include:
- **Claim lines that lie outside of enrollment span:** Claim lines whose [Date of Service – From] lie outside of the member’s valid enrollment period.
 - **Paid Date earlier than DOS:** Indicates the Paid Date falls prior to the claim’s dates of service (either date of service [Date of Service – From] or [Date of Service – To]).
 - **DOS – To prior to DOS – From:** Indicates the dates of service are reversed, with [Date of Service – To] falling before [Date of Service – From].
 - **Empty Claim ID:** Indicates an empty claim header ID.
 - **Institutional claim with non-empty Bill not in accepted list (Disallowed):** This is not necessarily an error, but provides a direct check on the [Bill Type] formatting. It indicates a valid institutional claim with disallowed Bill Type.
 - **Professional claim with non-empty Bill Type:** Indicates a professional claim with non-empty [Bill Type]. Provides a check on [Form Type] assignment.
 - **Outpatient institutional claim with unequal DOS – To and DOS – From dates:** This is not necessarily an error. Provides a general date check on outpatient claims.
- i. **Max Paid Date:** This is the most recent claims paid date included in your valid claims. It is provided as a data validation check to ensure you included claims up through the experience window for the run. If the date exceeds the data window for the run, you

can expect the results reported for the “DELETED: Dates missing or outside of data window” check to be higher.

- j. **% of diagnoses with disallowed reason code:** Summarizes the results of the HHS exclusion logic. The code shows the percentage% of diagnoses (technically, the percentage% of the records grouped by member identifier, diagnosis code, and HHS exclusion reason flag) that are excluded due to various reasons, such as those explained below:
 - **Disallowed Reason Code = 0:** Allowed for risk adjustment purposes. This value should be higher than 50%, and typically in the 70-85% range. If the value is too low, then too many diagnoses may be getting excluded and therefore the calculated risk score may be lower than it should be. Likely reasons for getting a value here that is too low may include:
 - CPT/HCPCS codes are missing or incorrectly formatted.
 - [Bill Type] codes are missing or incorrectly formatted.
 - [Form Type] values are missing or incorrectly assigned.
 - Claim header identifiers are inaccurate.
 - **Disallowed Reason Code = 1:** Institutional claim with missing or unacceptable [Bill Type].
 - **Disallowed Reason Code = 2:** Institutional outpatient claim with no allowable CPT/HCPCS code or [Bill Type].
 - **Disallowed Reason Code = 3:** Professional claim with no allowable CPT/HCPCS code.
 - **Disallowed Reason Code = 4:** Invalid Form Type
- k. **% of diagnoses not mapped to HCCs_ICD10:** This is the percentage of unique MBR_ID+DX pairs that do not map to HCC conditions. Reasonable range: 92% and below.
- l. **Average number of unique DX codes per claimant:** This is the number of unique diagnosis codes per claimant. It is offered as a data validity check. For a full-year run, there will be significant variability, but values above 7.0 are likely to be reasonable. Partial year runs will produce considerably smaller metrics.
- m. **% of Claim lines with Form Type:** Split by [Form Type], the distribution of claim rows assigned as ‘I’ or ‘P’ is provided to help diagnose data issues.

Step 3b: Run 03b_WNRAR – Supplemental Diagnosis Inputs.sql

NOTE: Only run this code if you have prepared a supplemental diagnosis input file. Otherwise, skip Step 3b and proceed to the next step.

1. This step processes your INP_DX_SUPP (supplemental diagnosis input) file in preparation for scoring. The purpose of this code is to record diagnosis code modifications to claims already reported in the medical claim input file and perform validation checks to pinpoint possible errors.

2. For this step to run successfully, you must prepare a supplemental diagnosis input file for your data in a format identical to the test files (see [Section 2.4](#) above).
3. Please specify a database in which to run the model and create tables. The default database name is **Wakely_Risk_Reporting**.
4. In order to run this code, you need to point the code to your data input files. For example, if you created an input file named “Input Supp DX 2023”, then you can edit the code in the USER INPUTS section in the following manner:

Change: `SET @SUPP_FileName = 'INP_DX_SUPP_TEST_2023'`
 To: `SET @ SUPP_FileName = 'Input Supp DX 2023'`

5. Validation Checks: If the code runs successfully, you will see a small table of high-level data checks appear in the Results window. Please carefully review the checks. These include:
 - a. **Code Version: [Date]**: This allows Wakely to confirm that the most recent code version was used.
 - b. **# Rows: Total raw claim input rows**: This provides a total count of rows in your file.
 - c. **# Rows: Total formatted input rows**: This is the total count of distinct rows in your file, after formatting all values to remove extra spaces – completely identical rows have been removed. In the supplemental diagnoses input file you created, there should not be any rows that are identical across all values.
 - d. **Dropped Rows**: Rows dropped upfront for failing cross checks against records in the medical claims input file. These rows are moved to a file on your server called INP_DX_SUPP_DROPPED. The [DROPPED_REASON] field indicates why each row was excluded.
 - **# Rows: Dropped: Member not found in INP_DX**: This is the number of rows dropped because the [MBR_ID] value listed in the supplemental diagnosis file does not exist in the medical claims input (INP_DX) file.
 - **# Rows: Dropped: Claim ID not found in INP_DX**: This is the number of rows dropped because the [CLAIM_ID] value listed in the supplemental diagnosis file does not exist in the medical claims input (INP_DX) file.
 - **# Rows: Dropped: Deleted DX not found in INP_DX**: This is the number of rows dropped because the [DX] value listed in the supplemental diagnosis file does not exist for in the medical claims input (INP_DX) file for the Claim ID specified.
 - e. **% of records that map to CC**: This is the percentage of unique [MBR_ID]+[CLAIM_ID]+[DX] pairs that map to HCC conditions, after removing duplicate rows and dropping invalid records. It is offered as a data validity check. The percentage should increase from run to run throughout the plan year.
 - f. **Total Number of distinct DX codes**: This provides a total count of distinct diagnosis codes included in your file, after removing duplicate rows and dropping invalid records.
 - g. **Average number of distinct DX codes per supplemental claimant**: This is the number of unique diagnosis codes per claimant, after removing duplicate rows and dropping invalid records. It is offered as a data validity check. The average should increase from run to run throughout the plan year.

- h. **% of lines with AddDeleteCode:** Split by [AddDeleteCode], the distribution of claim rows assigned as 'A' or 'D', after removing duplicate rows and dropping invalid records. It is provided to help diagnose data issues and should sum to 100%.

Step 3c: Run 03c_WNRAR – Pharmacy Inputs.sql

NOTE: Pharmacy data is required in all 2023 submissions.

1. This step processes your INP_RX (pharmacy claims input) file in preparation for scoring. The purpose of this code is to create flags for pharmacy claims that **may be** allowed in the risk adjustment reporting, as well as to format the data for processing. Wakely applies several HHS exclusions based on the data you have created. For more details on these exclusions, please contact the support team at WNRARSupport@wakely.com.
2. For this step to run successfully, you must prepare a pharmacy input file for your data in a format identical to the test files (see [Section 2.5](#) above).
3. Please specify a database in which to run the model and create tables. The default database name is **Wakely_Risk_Reporting**.
4. In order to run this code, you need to point the code to your data input files. For example, if you created an input file named "Input RX 2023", then you can edit the code in the USER INPUTS section in the following manner:

Change: `SET @RX_FileName = 'INP_RX_TEST_2023'`

To: `SET @RX_FileName = 'Input RX 2023'`

5. **Validation Checks:** If the code runs successfully, you will see a small table of high-level data checks appear in the Results window. Please carefully review the checks. These include:
 - a. **Code Version: [Date]:** This allows Wakely to confirm that the most recent code version was used.
 - b. **# Rows: Total raw pharmacy input rows:** This provides a total count of rows in your file.
 - c. **# Rows: Total formatted pharmacy input rows:** This is the total count of distinct rows in your file, after formatting all values to remove extra spaces – completely identical rows have been removed. In the pharmacy claims input file you created, there should not be any rows that are identical across all values.
 - d. **Dropped Rows:** Rows dropped upfront for certain "out-of-range" reasons or for failing cross checks against the eligibility input file are moved to a file on your server called INP_RX_DROPPED. The [DROPPED_REASON] field indicates why each row was deleted.
 - **DELETED: Dates missing or outside of data window:** This is the number of pharmacy claim lines that are dropped for lying outside of the experience window (e.g., Jan 1, 2023 – Dec 31, 2023 for the Jan-Dec run).
 - **DELETED: Incurred outside of valid enrollment span:** This is the number of pharmacy claim lines that are dropped for incurring outside of a member's valid enrollment span.
 - **DELETED: Phantom claim:** This is the number of claim lines whose [MBR_ID] does not exist in the eligibility input file.

- **DELETED: NDC not mapped to RXC:** This is the number of claim lines whose [NDC] value do not map to any RXC categories.
- e. **Max Paid Date:** This is the most recent pharmacy claims paid date included in your valid claims. It is provided as a data validation check to ensure you included claims up through the experience window for the run (e.g., Jan 1, 2023 – Dec 31, 2023 for the Jan-Dec run). If the date exceeds the data window for the run, you can expect the results reported for the “DELETED: Dates missing or outside of data window” check to be higher.
- i. **Claimant Ratio % (after filtering):** This is the percentage of unique members in your eligibility input file with at least one pharmacy claim. The average should increase from run to run throughout the plan year.
- j. **Average number of unique NDCs per claimant:** This is the number of unique NDCs per claimant, after removing duplicate rows and invalid records. It is offered as a data validity check. The average should increase from run to run throughout the plan year.

Step 4: Run 04_WNRAR – Scoring.sql

This is the main code that runs the WNRAR scoring model (after steps 0 through 3 have been performed). Follow the steps below:

1. In the USER INPUTS section of the code, please specify a database in which to run the model and create tables. The default database name is **Wakely_Risk_Reporting**.
2. In the USER INPUTS section of the code, please specify a name for your output tables. The default table name is ‘MyOutput’.

Step 5: Run 05_WNRAR – 2024 Prevalence.sql

This code runs the WNRAR scoring model based on the proposed 2024 HHS model (after steps 0 through 4 have been performed) and produces the output needed for the risk reporting project. We are collecting the information needed for the proposed 2024 HHS model, so we can calculate risk adjustment transfer estimates under the proposed 2024 HHS model. Follow the steps below:

1. In the USER INPUTS section of the code, please specify a database in which to run the model and create tables. The default database name is **Wakely_Risk_Reporting**.
2. In the USER INPUTS section of the code, please specify a name for your output tables. The default table name is ‘MyOutput’.
3. After you run the code, a table **WNRAR_OUT_SUM_[@MyOutput: User-defined string]_202312** will be created. This output is to be uploaded to WakelyRiskReporting.com (see [Step 6](#) below).

Step 6: Run 06_WNRAR – CFG Lite.sql

This code produces summary data from the WNRAR_OUT_SUM_[@MyOutput] table that is used to populate the Checking File Lite workbook – a workbook that provides high-level summary detail for issuers to review the accuracy and completeness before issuers’ official WNRAR submission to the Wakely team. This step is not required, but may be helpful if an issuer would like to review their WNRAR submission before sending it to the Wakely team. If you would like to run this code, please follow the steps below:

1. In the USER INPUTS section of the code, please specify the database in which your WNRAR_OUT_SUM_[@MyOutput] table is saved. The default database name is **Wakely_Risk_Reporting**.
2. In the USER INPUTS section of the code, please specify the name of your WNRAR_OUT_SUM_[@MyOutput] table. The default table name is ‘WNRAR_OUT_SUM_MyOutput’.
3. After you run the code, a table **CFGLite_202312** will be created. This output may be pasted into the “Paste Tables” tab in the Checking File Lite workbook to review your summarized data.

Step 7: Upload Results to WakelyRiskReporting.com

After the model results are reviewed in Step 5 (or after Step 6 if you choose to use the Checking File Lite workbook), please upload the output to WakelyRiskReporting.com. Following are the steps.

1. Copy the WNRAR_OUT_SUM_[@MyOutput] **202312** table (created in step 5 above, and shown in the SQL window), and save the table as a **tab-delimited** text file. **Please copy the headers as well.** Do not enclose any data within quotes.
 - a. You may copy / paste directly from the SQL window into a text file, depending on the size of your file, or use the SQL export utility.
 - b. Please name your upload file as follows: “**WNRAR_RUN202312_Upload_[Suffix]**”. The [Suffix] can be a date or any other text to help you keep track of versions. The “**RUN202312**” specifies that this data is for the experience window ending at the end of **Dec 2023**.
2. Zip the tab-delimited **WNRAR_OUT_SUM**. If you populated the Premium Template by hand, make sure to zip it with WNRAR_OUT_SUM. This will shrink the file considerably, allowing for an easier upload.
 - a. **Note:** While the transfer is through a secure HTTPS process, for additional security, **please encrypt the zipped file using the password provided by Wakely**. Please contact us at WNRARSupport@wakely.com for your organization-specific password.
3. Login to your account on WakelyRiskReporting.com
 - a. If you have not registered with the site, please register first. There should be a single registration per issuer (in order to have a single folder where you upload data and access results).
 - b. Go to the ‘Data & Results’ page.
 - c. Upload the file to your secure folder.

4. Notify the support team that you have loaded your data by emailing the support team at WNRARSupport@wakely.com.