

Medicare Advantage risk score primer: What you need to know about diagnoses supporting risk scores and revenue payment timing

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Risk scores are a crucial area of focus for successful Medicare Advantage (MA) plans because changes in risk scores directly affect plan revenue. However, risk scores are complex and are influenced by many factors, which can be confusing to those who are new to MA risk score development. This article will answer the following questions:

- What time period of diagnoses supports risk scores?
- When are revenue payments made?
- Who submits diagnoses used to create risk scores?
- Why is member retention critical for the success of a Medicare Advantage organization (MAO)?

MA revenue payments are risk-adjusted

The Centers for Medicare and Medicaid Services (CMS) risk-adjusts MA revenue payments to MAOs by member-specific risk scores. The primary goal of risk adjustment is to create a market where plans and providers compete on quality and efficiency, not risk selection. MAOs submit diagnoses to CMS to create member risk scores, which are then used to calculate member-specific revenue payments. These risk-adjusted amounts typically make up the majority of a plan's revenue.

Diagnosis submission and revenue payment timing are on detailed schedules

Risk-adjusted revenue payments for a given plan year are based on diagnoses submitted for the prior plan year. Using the 2018 bid year as an example, final 2018 risk scores are based on calendar year (CY) 2017 diagnoses. The initial payments for 2018 are paid before all diagnoses are due for 2017, so payments are first paid prospectively using diagnoses from an earlier time period (in this example, July 2016 through June 2017) and then retroactively adjusted based on CY 2017 diagnoses to true up any payment discrepancies. The figures below illustrate this timing.

PROSPECTIVE PAYMENTS

Figure 1 contains a timeline of prospective payments and the diagnosis dates of service on which they are based.

- CMS makes prospective payments for January 2018 through July 2018 based on July 2016 through June 2017 diagnoses submitted through mid-September 2017.
- CMS makes prospective payments for August 2018 through December 2018 based on January 2017 through December 2017 diagnoses submitted through early March 2018.

FIGURE 1: PROSPECTIVE PAYMENTS - 2018 RISK SCORES

	2016		2017				2018			
	JULY-SEPT	OCT-DEC	JAN-MAR	APR-JUNE	JULY-SEPT	OCT-DEC	JAN-MAR	APR-JUNE	JULY-SEPT	OCT-DEC
JAN-JUL INITIAL PAYMENT										
DATES OF SERVICE	Dates of Service for 2018 Jan-July Risk Scores									
SUBMISSION DEADLINE					X					
PAYMENT MONTHS							Prospective Payments			
AUG-DEC INITIAL PAYMENT										
DATES OF SERVICE			Dates of Service for 2018 Aug-Dec Risk Scores							
SUBMISSION DEADLINE							X			
PAYMENT MONTHS									Prospective Payments	

FIGURE 2: RETROACTIVE PAYMENTS - 2018 RISK SCORES

	2017				2018				2019		
	JAN-MAR	APR-JUNE	JULY-SEPT	OCT-DEC	JAN-MAR	APR-JUNE	JULY-SEPT	OCT-DEC	JAN-MAR	APR-JUNE	JULY-SEPT
MIDYEAR PAYMENT											
DATES OF SERVICE	Dates of Service for 2018 Midyear Risk Scores										
SUBMISSION DEADLINE					X						
PAYMENT MONTHS							X				
FINAL PAYMENT											
DATES OF SERVICE	Dates of Service for 2018 Final Risk Scores										
SUBMISSION DEADLINE									X		
PAYMENT MONTHS											X

RETROACTIVE PAYMENTS

Figure 2 contains a timeline of retroactive payments. All payments are based on diagnoses from January 2017 through December 2017.

- CMS makes retroactive payments for January 2018 through July 2018 in August 2018. These retroactive payments are based on CY 2017 diagnoses submitted through March 2018. This is also called the midyear sweep payment.
- CMS makes the final retroactive payments for January 2018 through December 2018 in July 2019. These retroactive payments are based on CY 2017 diagnoses submitted through January 2019. This is also called the final sweep payment.

Payments in 2018 are initially paid based on a time period that includes 2016 diagnoses. However, through retroactive adjustments, the final 2018 payments to the plan are ultimately based only on CY 2017 diagnoses. If the risk scores based on CY 2017 diagnoses are higher than risk scores used for initial payment, the MAO will receive additional revenue. If the risk scores based on CY 2017 diagnoses are lower than risk scores used for initial payment, the MAO will be required to return a portion of the initial revenue. Ultimately, the diagnoses for the prior year control the risk scores, and thus the revenue, in the following year.

The timing of payments and diagnosis submission dates shown in the figures above are based on historical practice. Though not typical, these dates can be modified by CMS. Therefore, MAOs should monitor announcements released by CMS for adjustments to these dates. Please refer to the Medicare Managed Care Manual, Chapter 7 – Risk Adjustment, for more information.¹

Control of the diagnoses from the prior year varies by member source

As discussed above, risk scores are based on diagnoses from the prior year. If an MAO wants to determine who controls a member's current risk score, and thus the MAO's current revenue, the MAO should examine who enrolled that member in the prior year.

The four primary sources of membership for MA plans include:

1. Existing MA members within the MAO
2. Members transitioning from other MAOs
3. Members converting from traditional fee for service (FFS)
4. Members who age into Medicare

1. Existing MA members within the MAO: For a member who remains in the MA plan from one year to the next, the MAO that influences the member's risk score receives the revenue for that member the next year. If an MAO wants to optimize its revenue, the MAO should carefully review the submitted diagnosis codes for the prior year and submit any missing diagnosis codes to CMS. To remain compliant, the MAO must also remove any inappropriate codes. "Late" submission of diagnoses is permitted as long as they are submitted within the required time period described above. Retaining these members is paramount to success. A significant MAO investment is required to submit complete and accurate risk score information, and the return on that investment is quickly diminished if members select another MAO or traditional FFS Medicare during open enrollment.

2. Members transitioning from other MAOs: In contrast, risk scores for members who come from another MA plan are initially determined by the prior MAO. The new MA plan is subject to the diagnosis submission efforts, also known as coding efforts, of the prior MA plan. If the prior MAO invested substantial effort to ensure that the member was coded properly and then the member changes MAOs, the new MAO

¹ CMS. Medicare Managed Care Manual: Chapter 7 – Risk Adjustment. Retrieved August 19, 2017, from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c07.pdf>.

will receive the increased revenue the next year. Conversely, if the prior MAO did not put much effort into capturing and submitting a member's diagnosis codes, the payment may be insufficient. However, per its June 20, 2017, memo,² CMS specifies that "organizations are able to submit diagnosis codes to RAPS [risk adjustment processing system] for years when a beneficiary was enrolled in a plan of a different parent organization (but not if the beneficiary was in Fee-for-Service Medicare the year before)." Thus, the new MAO has an opportunity to provide diagnosis information that the prior MAO did not submit.

3. Members converting from traditional FFS: Members who come from traditional FFS typically have lower risk scores than MA members. This is not necessarily because members from FFS have fewer diagnoses but instead because MAOs educate their providers on the importance of proper and complete diagnosis coding. In some cases, MAOs agree to pay incentives to providers, which are in part based on appropriate risk score coding; these agreements financially incentivize providers to submit complete and accurate diagnoses. Aside from Medicare demonstrations such as the Medicare Shared Savings Program (MSSP), traditional FFS physicians are paid by the services performed and not how completely the members are coded. These members usually have the largest potential for improvement in their risk scores. However, just like members coming from other MA plans, the effort the plan puts into submitting member diagnoses will not affect the payment for that member until the following year.

4. Members who age into Medicare: Members who age into Medicare do not receive risk scores based on their diagnoses information until they have a full calendar year of Medicare eligibility. Until that time, a member receives a default new enrollee risk score. This means a member who turned 65 in February 2017 will receive this default risk score for 2017 and 2018. The member's 2019 risk score will be based on diagnoses submitted by the MAO in 2018. In this case, a plan may need to wait nearly two years to receive a payment based on the member's specific diagnoses.

Retention is key to realizing a return on a risk score investment

Increasing risk scores through appropriate diagnosis coding and submission requires significant effort from the MAO, which does not translate into an actual increased revenue payment until roughly a year later. Even if the MAO has a long-term strategy to improve risk scores, members can leave the

plan and the gains from any risk score improvement investment by the MAO will be realized by another MAO (or not at all). MAOs must be focused on retaining members to help reduce the likelihood that the MAO will lose these optimally coded members to competitors. Retention is important to MAOs for many reasons, not the least of which is reaping the significant rewards of efforts to properly code member diagnoses.

Please note that the opinions stated in this article are those of the authors and do not represent the viewpoint of Milliman.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Brad Piper and Hillary Millican are members of the American Academy of Actuaries and meet the qualification standards for sharing the information in this article. To the best of their knowledge and belief, this information is complete and accurate. They relied on CMS for select information contained in this paper.

This information is intended to discuss fundamental MA risk score concepts including dates of service of diagnoses that support risk scores, revenue payment timing, and which organization submits diagnoses for each member type. This information highlights select areas and is not an exhaustive discussion of MA risk scores or payments. This information may not be appropriate, and should not be used, for other purposes. Milliman does not intend to benefit and assumes no duty of liability to parties who receive this information. Any recipient of this information should engage qualified professionals for advice appropriate to its own specific needs.

For additional information on risk scores, please visit <http://www.milliman.com/insight/healthcare/>.

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² CMS memo dated June 20, 2017, Subject: RAPS Submission of Data Collection Year Diagnosis Codes.