MEDICARE ADVANTAGE ORGANIZATION REVENUE PROJECTION AND MANAGEMENT

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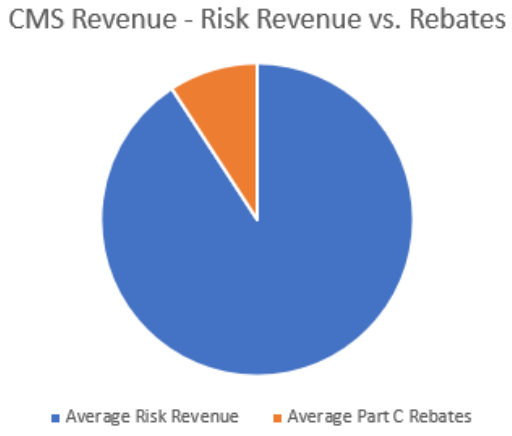
Revenue Projection and Management

Medicare Advantage (MA) plan revenue is determined via a complex set of plan filings (bids) and data submissions that typically spans three (3) calendar years from diagnosis period to final data submission ("sweep"). The revenue that Medicare Advantage Organizations (MAOs) ultimately recognize is determined by required submissions to the Centers for Medicare & Medicaid Services (CMS) that occur before, during, and after the payment year. This complex programmatic structure drives unique challenges and opportunities for Medicare Advantage Organizations in ensuring accurate revenue budgeting and management processes. This paper provides a brief overview of the key determinants of MA revenue and a suggested approach to managing the risk adjustment revenue management cycle.

MA Revenue Components

On a monthly basis, MAOs receive a capitation amount (per member per month (PMPM) basis) for their enrolled members. The capitation amount is intended to cover member medical benefit costs as well as plan administrative costs and margin. A large portion of the capitation amount is determined well ahead of each plan year via the annual MA bidding process. The bid process involves the submission of plan design details ("plan benefit package"), member premiums, and actuarially certified estimates of plan costs. The remaining portion of the capitation amount, mainly the MA risk adjustment, evolves throughout and beyond the



MA risk revenue accounts majority of MA revenue from CMS, compared to plan rebates.[1]

[1] Based on CMS Medicare Advantage 2021 Part C payment data; not weighted by membership

plan year based on continuous diagnostic data submissions by the MA plan.

The following table presents key components that determine MA capitation rates and revenue, including key data sources and timing. The column named "Status in Payment Year" describes whether the per-capita value of the component would be fixed or still evolve during the payment year. Some of the fixed items are determined by other mechanisms (such as the MA county benchmark and plan star rating); others are determined at the time of bid (such as the standardized bid and plan rebates).

Table 1. MA Revenue Components

Type	Brief Description	Timing of when Final During Revenue Cycle	Status in Payment Year
MA County Benchmark	County-level MA rates determined by CMS	April of Plan Year – 1	Frozen
MAO Star Rating	Contract-level quality performance	October of Plan Year -2	Frozen
MAO Risk Adjustment Factor	Member-level, based on demographic and diagnosis information	June of Plan Year + 1[2]	Evolving
Plan Standardized Bid	Plan-specific bid (for average risk Medicare beneficiary). This is the basis to which risk adjustment factors are applied	August of Plan Year – 1	Frozen
Plan Rebates	Component of MAO revenue determined by bid process which covers supplemental benefits and premium buy-downs	August of Plan Year – 1	Frozen
Plan Member Premium	Plan premium paid by members	August of Plan Year – 1	Frozen
Part D Revenue Items	Component of MAO revenue resulting from Part D bid process (occurs in concert with MA bid process)	Mostly August of Plan Year - 1[3]	Mix

Acknowledging that each revenue component involves sufficient complexity to merit its own paper, this paper will focus mainly on the risk adjustment component for Part C revenue for a general enrollment population. The evolution of the final risk adjustment revenue spans multiple years and deserves a rigorous projection and tracking system to ensure revenue accuracy. While similar timing concepts apply

[2] In recent years, due to the pandemic, CMS has extended the deadline for finalizing risk scores.

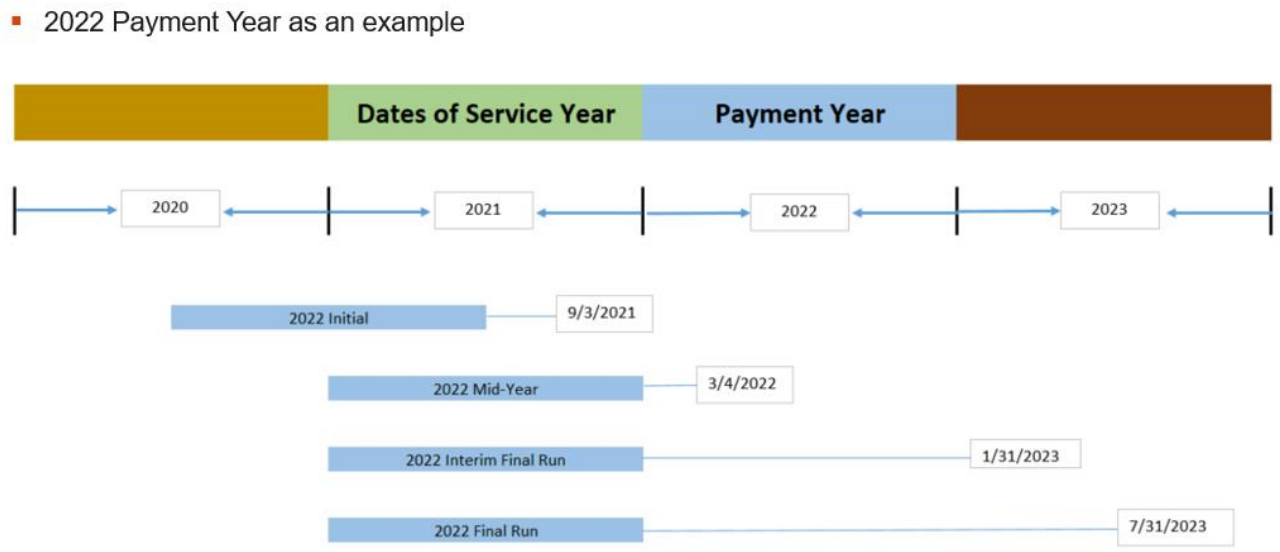
[3] There are components of Part D revenue that will be finalized well past the Plan Year as well.

on the Part D side, given that MA revenue comprises the large majority of MA plan revenue, we focus on Part C revenue in this paper.

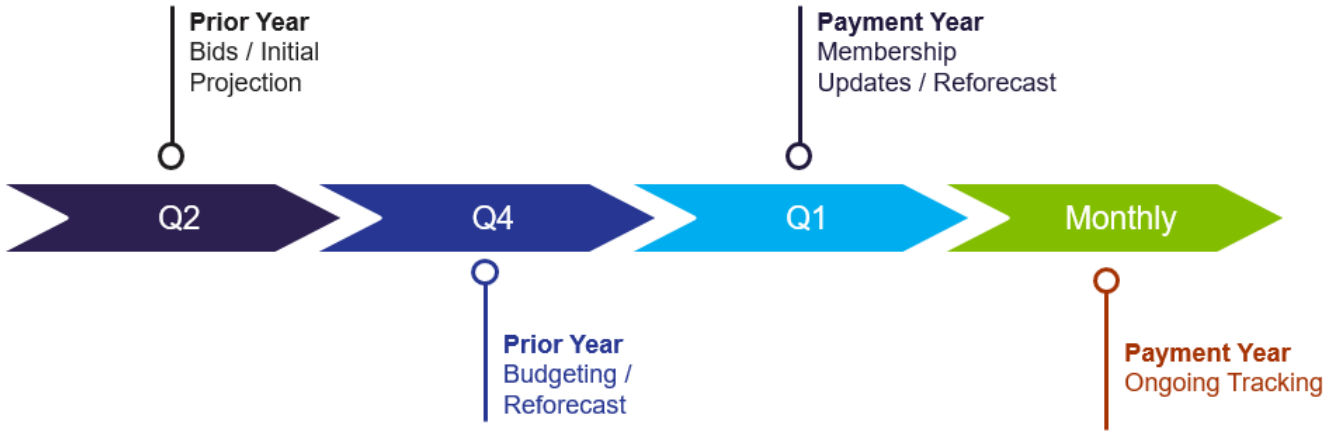
MA Risk Adjustment and Revenue Management Cycle

Risk adjustment is an important aspect of MA revenue projection and management. The CMS-Hierarchical Condition Categories (HCC) model is a prospective model that uses the beneficiaries' demographic information as well as diagnostic information from the prior year to calculate their risk scores used for payment in the current year. Since its inception, the CMS-HCC model has gone through numerous updates, though the core concept and structure have stayed the same. Diagnoses under the International Classification of Diseases, Tenth Revision (ICD-10, previously ICD-9) are grouped with other clinically similar diagnosis codes. These groupings are then mapped into hierarchical condition categories (HCCs) based on clinical characteristics, severity, and cost implications. Coefficients for HCCs, as well as demographic factors (such as age group, gender etc.), are estimated by regressing the total expenditure for Medicare Part A and part B benefits for each Medicare beneficiary onto their HCCs and demographic factors. In recent years, a factor that accounts for the total number of conditions has been added to the HCC model too. For risk adjustment purposes, to determine a MAO member's risk score, their diagnoses are collected and mapped into HCCs, along with their demographic and condition count factors. The coefficients are summed up to form the member's risk score.

There are various data sweep points as CMS incorporates diagnosis data submitted by MAOs into monthly plan payments. The data sweeps (initial, mid-year, final) predate CMS updating the risk score information (and resulting capitation rates) disseminated to MAOs. Using the 2022 payment year as an example, the following figure provides an illustration of the data submission and sweep timeframe.



Due to the design of MA risk adjustment and timing of the data sweeps, it is best practice for MAOs to conduct revenue accrual activities on a regular basis for accurate tracking and timely feedback. Besides the regular accrual process, below are a few typical points in time when revenue forecasting and reforecasting activities should take place for a given payment year:



The relevance of each point in time is explained in the following sections.

Q2 of the Prior Year

The second quarter of the year preceding the payment year is when majority of the MA bidding activities take place. MA bids determine several key components of the plan's revenue, including the standardized bid amount and MA rebate amounts. Plan risk scores are an integral component of MA bids. Under- or over-projecting bid risk score can drive significant ramifications for plan financial performance.

Due to the lack of detailed risk adjustment data available at the time of bid submission and considering that the plan does not know which members will enroll (or reenroll) for the payment year, many project assumptions are needed. MAOs typically use the risk adjustment experience from the most recent complete year available (called the base year), which is two years before the payment year, to project risk scores for the payment year. Various potential changes need to be accounted for between the base year and projection year, including but not limited to population mix changes, morbidity changes, provider network and vendor changes, plan operational changes, and changes in the CMS-HCC model parameters.

Upon completion of the bid process, the following revenue components are tentatively (pending CMS bid approval) locked in standardized bid (varies by plan and county), plan rebates, and member premium. The projected risk score reflected in the bids drives these particular revenue components. It is fair to think of these items as "frozen" at the bid risk score. Even if the MAO ends up enrolling members with a materially different morbidity profile from that which was projected at the time of bid, there is no opportunity to update the aforementioned components. On the other hand, the actual risk score in the payment year will determine the ultimate "risk revenue" of the plan.

Q3/Q4 of the Prior Year

The third or fourth quarter is typically when MAOs develop and finalize financial budgets for the payment year. MA plan revenue is of course an essential budget element. Bids typically receive formal approval from CMS in September, at which point the following items are determined with finality:

- Standardized bid at the plan and county level
- MA rebate amount per member per month at the plan level

The following information are still unknown and need to rely on assumptions for revenue determination:

- Plan membership
- Member risk scores

Plan membership includes the number of members, as well as the morbidity mix of its members. Membership changes (e.g. what portion of the current plan members are going to stay with the plan next year or lapse, the risk profile of members the plan will newly attract next year, etc.) are key drivers of plan risk scores.

Plans may determine membership assumptions based on available data and by member cohorts, including:

- Current members that will continue into the next year.
    - This cohort may be further divided by member duration (how long the member has been enrolled in the plan)
    - Historical member duration patterns can be studied to derive lapse rate by duration.
- New members joining from other MAOs or FFS each year.
    - Plan benefit information and marketing strategies need to be considered in anticipating new membership.
- New to Medicare members
    - For age-in members, their initial risk scores are typically lower than the plan average.
    - The mix of age-ins will have an impact on overall risk score.

For an established plan that is not implementing significant benefit or service area changes, the majority of a plan's members will typically be continuing members from the current year. For these members, diagnosis data is available and can be used to calculate member-level risk scores for the projection year. However, the diagnoses data would not be complete, and a completion factor based on previous years' experience and current operational initiatives should be developed to "complete" the risk score projection for this population cohort.

For new members, historical risk scores for comparable cohorts could be leveraged in gauging the cohort risk score for the projection year. If a plan is rapidly growing and attracting new members, demographic information from the plan's service areas as well as the plan's marketing strategy needs to be taken into consideration to anticipate the new member risk profile.

Q1 of the Payment Year

This is a typical time frame for plans to conduct reforecast activities and update the financial outlook for the year. There is significant new information from the CMS Monthly Membership Report (MMR) that warrants a reforecast:

- Membership: although membership will change throughout the year, the Q1 MMRs provide the basis and subsequent changes are typically less dramatic
- Initial risk score: this is based on the lag year.

A reforecast in Q1 of the payment year should incorporate the following information and provide the following key insights:

Mid-year Adjustment Amount

- For continuing members, diagnoses data submitted through current can be used and the risk sores can be calculated based on the CMS-HCC model, which will help provide a more accurate estimate of the mid-year adjustment amount.

Full-year Risk Score and Revenue

- With the base membership from the Q1 MMR files, membership seasonality can reasonably be applied to the different cohorts of members and monthly membership can be projected out for the whole year, which will help refine membership mix and the projected full-year risk scores and revenue. Typically, we observe a decreasing ultimate risk score by month for a stable population, as older members with high-risk scores expire over the course of the year and are replaced by new enrollees that have lower risk scores.

The following table shows the CMS schedule of risk score runs:

Risk Score Run	Dates of Service	Deadline for Submission of Risk Adjustment Data	Anticipated Payment Month
2022 Final Run	1/1/2021 – 12/31/2021	Monday, 7/31/2023	November 2023
2024 Initial	7/1/2022 – 6/30/2023	Friday, 9/1/2023	January 2024
2023 Final Run	1/1/2022 – 12/31/2022	Wednesday, 1/31/2024	TBD
2024 Mid-Year	1/1/2023 – 12/31/2023	Friday, 3/1/2024	TBD
2025 Initial	7/1/2023 – 6/30/2024	Friday, 9/6/2024	January 2025

2024 Final Run	1/1/2023 – 12/31/2023	Friday, 1/31/2025	TBD

We recommend conducting a Q1 reforecast when more data (e.g. the February MMR, more MAO004 files) becomes available. We are frequently asked about the timing of a Q1 reforecast. Depending on organization needs, February or March would be a reasonable timing for a Q1 reforecast.

Pros and Cons of Conducting a Reforecast in February

Pros	Drawbacks
▪ The February MMRs provide key payment membership information that was missing in the Q3/Q4 forecast. • Provides an earlier view of an updated revenue outlook	▪ Mid-year sweep deadline is usually in early March. ▪ A reforecast in February would not have the complete MAO004 files underlying the mid-year risk scores

Alternatively, the plan can wait until mid-to-late March for a reforecast. By that time, plans would have all the risk adjustment data submitted through the mid-year sweep deadline and the mid-year adjustment estimates will be more accurate.

Ongoing Tracking

It is best practice from our experience to conduct regularly (e.g. monthly or quarterly) revenue accrual and reforecast. New information available each month include:

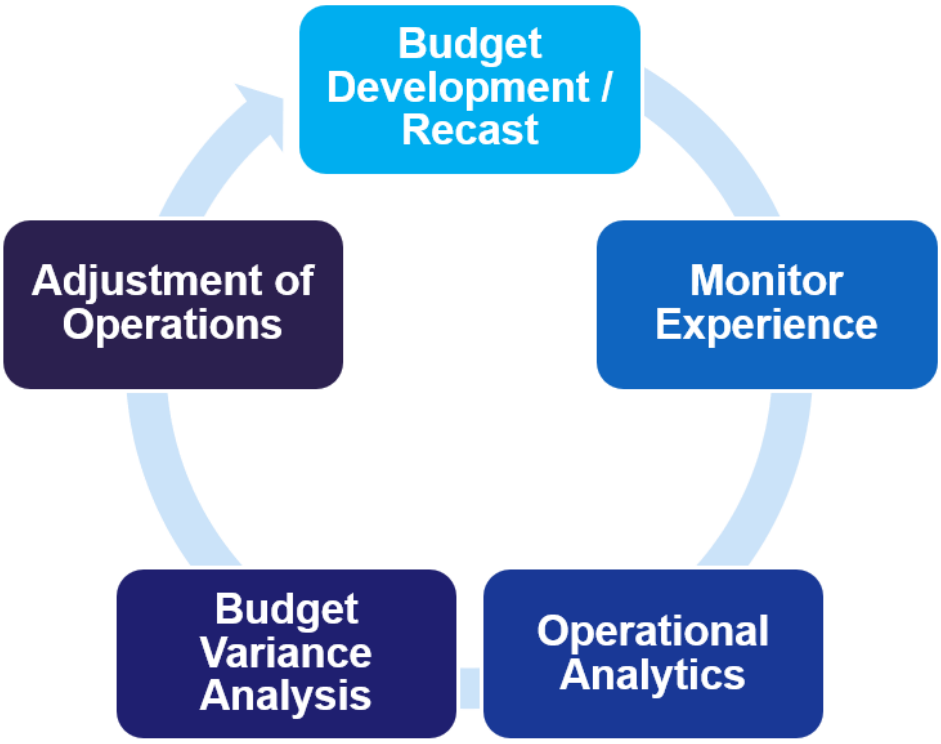
- Diagnoses collected/submitted during the month.
- Monthly membership changes

Many MAOs conduct monthly revenue accrual to fulfill financial reporting, track the revenue performance against budget, and monitor the impact of operational initiatives. Such information may help to evaluate ongoing operations and inform strategy adjustment when necessary. Besides regular risk score and revenue calculations, the following metrics can be tracked on a regular cadence to inform risk adjustment operations:

- Number of HCCs per member
- Incremental risk adjustment returns by initiative.
- Suspected HCC gaps
- HCC gap closure

Below is a figure to illustrate a typical revenue management cycle. Monthly revenue accrual and tracking help to close the feedback loop and iterations, as well as inform operational activities to ensure revenue accuracy. Without a rigorous and frequent tracking system, MAOs may not be able to detect potential operational issues that impact revenue on a timely basis, thus missing the opportunity to pivot and optimize revenue accuracy.

Figure 1. Revenue Management Cycle



In our experience, many MAOs conduct reforecasts on a monthly basis and others do so on a less frequent basis. A more frequent cadence of reforecasts provides a faster feedback loop and allows for more timely incorporation of emerging information that can lead to operational adjustments. On the other hand, a more frequent cadence adds to administrative burden and increases variation in revenue tracking. MAOs should weigh the benefit and costs of the frequency and timing of conducting a reforecast and consider their business needs in making their decisions.

Conclusion

Medicare Advantage revenue determination is complicated. MAOs benefit from revenue projection and management on a regular basis to optimize results. There are key points in time when revenue projection activities are most effective based on information as it becomes or will become available to the plan. Besides regular tracking, MAOs should plan major forecast and reforecast activities around those time periods.

Please contact the authors with any questions or to follow up on any of the concepts presented here.

OUR STORY

Five decades. Wakely began in 1969 and eventually evolved into several successful divisions. In 1999, the actuarial arm became the current-day Wakely Consulting Group, LLC, which specializes in providing actuarial expertise in the healthcare industry. Today, there are few healthcare topics our actuaries cannot tackle.

Wakely is now a subsidiary of Health Management Associates. HMA is an independent, national research and consulting firm specializing in publicly funded healthcare and human services policy, programs, financing, and evaluation. We serve government, public and private providers, health systems, health plans, community-based organizations, institutional investors, foundations, and associations. Every client matters. Every client gets our best. With more than 20 offices and over 400 multidisciplinary consultants coast to coast, our expertise, our services, and our team are always within client reach.

Broad healthcare knowledge. Wakely is experienced in all facets of the healthcare industry, from carriers to providers to governmental agencies. Our employees excel at providing solutions to parties across the spectrum.

Your advocate. Our actuarial experts and policy analysts continually monitor and analyze potential changes to inform our clients' strategies – and propel their success.

Our Vision: To partner with clients to drive business growth, accelerate success, and propel the health care industry forward.

Our Mission: We empower our unique team to serve as trusted advisors with a foundation of robust data, advanced analytics, and a comprehensive understanding of the health care industry.

Learn more about Wakely Consulting Group at www.wakely.com