AMERICA'S PHYSICIAN GROUPS

# Understanding the 2020 Medicare Advantage Advance Notice – Part I

**Jennifer Carioto, FSA, MAAA**

Jennifer Carioto is a consulting actuary with the New York office of Milliman. She specializes in Medicare Advantage and Part D, and pharmaceutical consulting. She has assisted clients on and certified their Medicare Part C and D bid submissions.

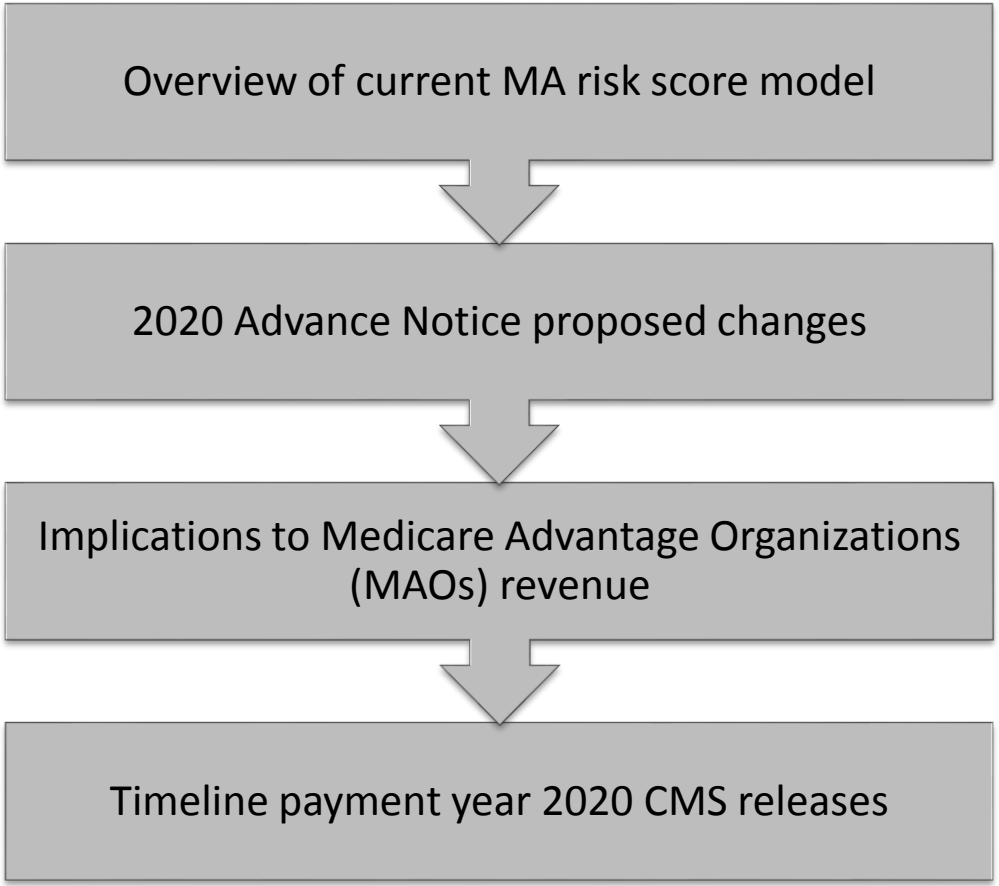
**Pamela Pelizzari, MPH**

Pamela is a senior healthcare consultant with the New York office of Milliman. She specializes in the development and management of episode-based payment methodologies. Prior to joining Milliman, Pamela served as a senior technical advisor at CMS.

**Margaret Peterson**

Margaret Peterson is the Director of Federal Affairs at APG. Previously, Margaret served on the health policy team for Senator Joni Ernst (R-IA), focusing on ACA reform and MACRA implementation.

# Agenda




AMERICA'S PHYSICIAN GROUPS

# Medicare Advantage Risk Adjustment

**Raw Risk Score = Patient Demographic Score + Health Status**

- CMS calculates factors for risk adjustment from Medicare Advantage and FFS claim data
- Plans submit claims experience and encounter data
- Prior year diagnoses are used for following year payments (i.e. 2018 dates of service determine 2019 CMS risk score and payment)

**CMS-HCC model (Hierarchical Condition Categories)**

- Demographic Score: Starting point is a demographic, Medicaid, originally disabled factor
  - New enrollees only have this factor
- Health Status: Use inpatient and ambulatory prior year ICD-9 diagnoses
- Raw Risk Scores are adjusted by FFS normalization and coding pattern differences to Payment Risk Scores

**RAPS and EDS overview**

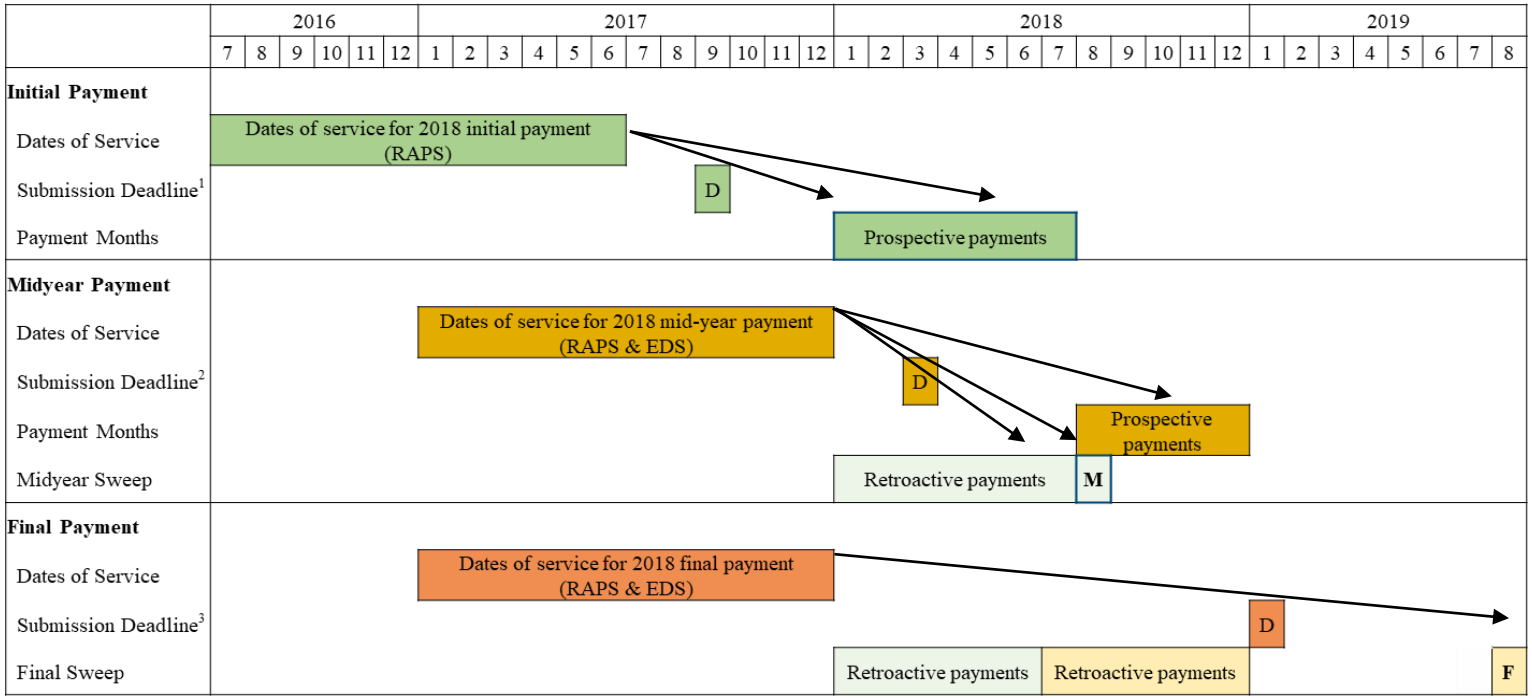
- Starting in 2008 CMS began effort to transition from Risk Adjustment Processing System (RAPS) to Encounter Data System (EDS)
- For payment year 2015 (2014 dates of service), EDS used as supplemental source of diagnoses to RAPS
- EDS transition began with payment year 2016 risk scores

# Patient demographic coefficient estimated separately for each segment

| Segment | Criteria |
|---|---|
| New enrollees | • Less than 12 months of Part B enrollment in the data collection year<br>• Only receive patient demographic coefficient; No health status coefficient applied |
| Community continuing enrollees | • With 12 months of Part B enrollment in the data collection year residing in the community (in the payment month)<br>• Six different segments: Aged/Disabled; Non-Dual/Full Dual/Partial Dual<br>  • Based on age as of February 1 of the payment year<br>  • Dual status based on the payment month |
| Institutional continuing enrollees | • In a long-term institutional facility (based on payment month) |

Community and institutional segments have the same age/sex variables and HCCs, with some differing interactions terms.

# 2018 Data Submission and Payment Timeline




[1] 9/1/17 is deadline to submit Jul 2016 – Jun 2017 dates of service diagnoses codes through RAPS to CMS for 2018 Initial Payment

[2] 3/2/18 is deadline to submit Jan 2017 – Dec 2017 dates of service diagnoses codes through EDS/RAPS to CMS for 2018 Midyear Payment

[3] 1/31/19 is deadline to submit Jan 2017 – Dec 2017 dates of service diagnoses codes through EDS/RAPS to CMS for 2018 Final Payment

**M** (Mid-year sweep) – additional payment in Aug 2018 to adjust prior 2018 payments, due to the diagnosis period being shifted forward by six months

**F** (Final sweep) – final true-up payment in Aug 2019 to adjust all 2018 payments, due to the run-out of diagnoses reporting*

* For PY 2017 RAPS submissions are due 5/4/2018 and EDS submissions are due 9/14/18, but that may not be the case for PY 2018

AMERICA'S PHYSICIAN GROUPS

# RAPS and EDS Methodology

**RAPS**

2016: 90%

2017: 75%

2018: 85%

2019: 75%

- MAOs filter diagnosis codes based on CMS guidance
- MAOs compile filtered diagnosis codes in RAPS files and submit to CMS
- CMS reviews RAPS files for duplicates/errors but does not verify validity of filtering logic or resulting list of diagnosis codes
  - CMS relies on Risk Adjustment Data Validation (RADV) audits to ensure submitted diagnosis codes are supported by patient charts

**EDS**

2016: 10%

2017: 25%

2018: 15%

2019: 25%

- MAO submits all unfiltered encounter data to CMS
- CMS applies filtering logic to extract valid diagnosis codes
- MAO needs to verify that data submitted is complete and accurate and that all appropriate diagnosis codes are being accepted for risk adjustment
  - CMS filtering may exclude diagnoses that were previously included in RAPS
  - Claims that are inconsistent with FFS coding standards may be excluded

# Reason for proposed changes

## Rule Overview

- 21st Century Cures Act
  - Account for the number of diseases or conditions a beneficiary may have, making an adjustment as the number increases
  - Three year phase-in period from 2019 to 2021, fully implemented by 2022
  - Include the additional factors for substance use disorder, mental health, and chronic kidney disease diagnoses (Already implemented in payment year 2019)
- EDS Transition

## Impact

- Improve risk adjustment by improving the accuracy of the predicted average costs of each risk score segment
- Improve prediction for high need beneficiaries with multiple chronic conditions
- EDS data can allow for improvements in quality measurement in MA by incorporating claims-based measure and comparing quality between MA and FFS Medicare programs

# What are the proposed changes in the Advance Notice?

## Rule Overview

- Encounter data-based (EDS) risk scores (50% weight)
  - Proposed Payment Condition Count (PCC) model
  - Using diagnoses from encounter data, FFS claims and RAPS inpatient records
- RAPS risk scores (50% weight)
  - 2017 CMS-HCC model (used for PY17 and PY18)
  - Using diagnoses from all RAPS records and FFS claims

## Impact

- Varies based on the EDS/RAPS and PCC/2017 CMS-HCC model weightings
- Varies by plan population mix – winners and losers vary based on the MAOs mix in the impacted populations
  - No impact to new enrollees
- Small changes in risk scores can have large impacts on plan reimbursement

# Impact of including condition counts

## Rule Overview – 2 Models

- Proposed Payment Condition Count (PCC) model
  - Coefficient added variable that counts the number of condition(s) a beneficiary has
  - Same model proposed in Part I of the 2019 Advance Notice, released December 27, 2017
- Alternative PCC model: Same as PCC model except includes 3 additional HCCs for Dementia and Pressure Ulcers

## Impact[1]

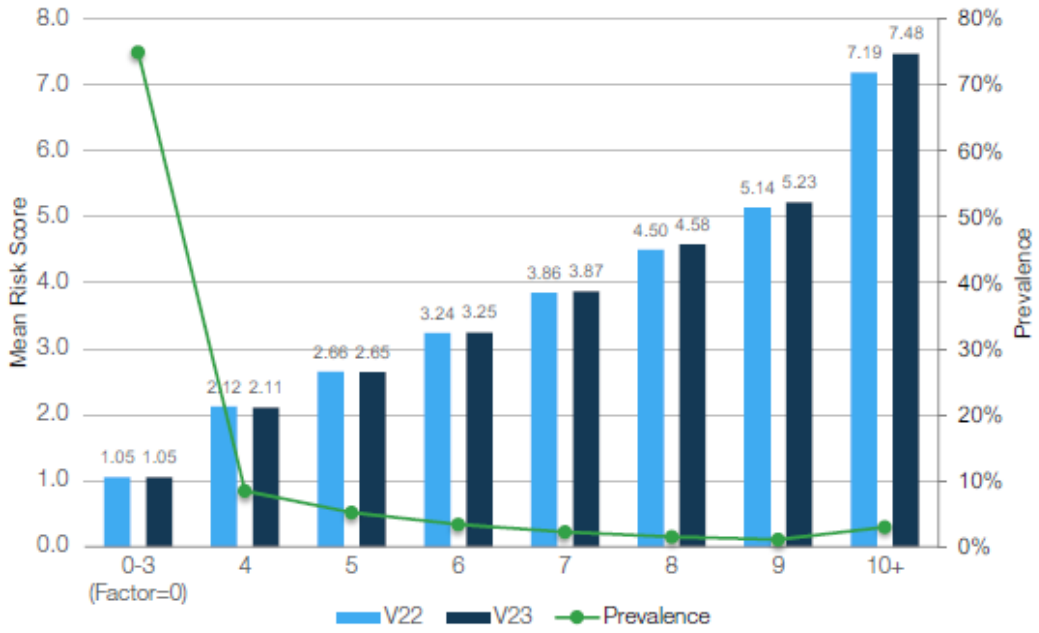
- Little impact on overall average risk scores but variation by beneficiary:
  - 0-3 HCCs: No impact
  - 4-5 HCCs: Slightly lower
  - 6+ HCCs: Slightly higher
    - 10+ HCCs: Largest impact (only 3% of population)
- Minimal impact by gender, age group, race/ethnicity, census region, plan type (HMO, PPO, POS), EGWPs
- CMS estimated 1.1% increase in MA individual plans average risk score[2] but Avalere estimated a 0.6% increase

[1] Source: https://avalere.com/wp-content/uploads/2018/10/Avalere-CMS-2019-HCC-Model-Impact-White-Paper.pdf

[2] Source: https://www.cms.gov/newsroom/fact-sheets/2019-medicare-advantage-part-i-advance-notice-risk-adjustment

# Risk score comparison of current vs proposed HCC model

## Average risk scores by risk score model and HCC counts




V22: Payment year 2019 HCC model
V23: Proposed Payment Conditions Count (PCC) model
Source: https://avalere.com/wp-content/uploads/2018/10/Avalere-CMS-2019-HCC-Model-Impact-White-Paper.pdf

AMERICA'S PHYSICIAN GROUPS

# Payment Condition Count (PCC) model considerations

## Rule Overview

- Started the count of conditions where the variable was positive and statistically significant in each segment; Capped the count variables at 10 conditions for each segment
  - Required count variables to increase monotonically
  - If the monotonicity requirement was violated the count variable was constrained to the next lowest count variable
  - Cap where sample size is too small (< 1,000 beneficiaries)
- Separate coefficients for seven segment types (excluding new enrollees)

## Impact

- Count floor (Between 4-6 depending on segment)
  - Helps to ensure stability between years
  - Encourages complete coding (avoids scenarios where reporting a diagnosis decreases the risk score)
- Count cap (10 for each segment)
  - Avoid wide swings in contract-level risk scores
  - Maintain meaningful cost prediction of the HCCs

# Impact of transition to EDS

## Rule Overview – EDS Transition

- Proposed 50% / 50% RAPS / EDS risk score model weighting
  - Transition to EDS began in 2016 and expected to be 100% EDS for 2022 (same year expected as full transition to PCC model)

## Impact

- Based on payment year 2017 risk scores, EDS risk scores are on average 2.5% lower than RAPS risk scores[1]
  - General enrollment plans: 2.2% lower
  - Special Needs Plans (SNPs): 5.2% lower
- Risk score comparison: 89% had same Part C, 9% RAPS higher, 2% EDS higher
- Revenue impact will grow in future as EDS becomes larger portion of risk score and for SNPs where EDS risk scores are much lower than RAPS risk scores

[1] Source: http://us.milliman.com/uploadedFiles/insight/2018/Medicare-RAPS-to-EDS-2017.pdf

# Range of EDS/RAPS risk score differences

# PY2017 Part C Risk Score Difference Percentiles (EDS vs RAPS)

| PLAN TYPE | 20TH | 40TH | 50TH | 60TH | 80TH |
|---|---|---|---|---|---|
| ALL PLANS | -6.2% | -3.3% | -2.5% | -2.0% | -0.8% |
| GENERAL ENROLLMENT | -5.6% | -2.5% | -2.2% | -1.8% | -0.6% |
| SNP | -6.6% | -5.6% | -5.2% | -3.2% | -1.7% |

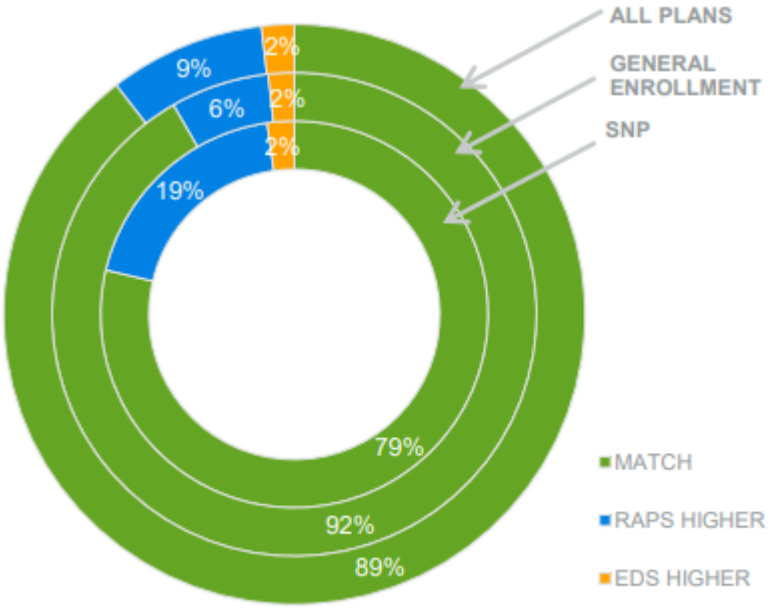
Note: Our analysis included non-ESRD/non-hospice members who were enrolled with the plan during the entire calendar year 2016.

[1] Source: http://us.milliman.com/uploadedFiles/insight/2018/Medicare-RAPS-to-EDS-2017.pdf

AMERICA'S PHYSICIAN GROUPS

# Comparison of EDS and RAPS Part C risk scores

## Member-level comparison of EDS and RAPS Part C risk scores by plan type




[1] Source: http://us.milliman.com/uploadedFiles/insight/2018/Medicare-RAPS-to-EDS-2017.pdf

AMERICA'S PHYSICIAN GROUPS

# MAOs best practices for EDS transition

## Analyzing and understanding the drivers of risk scores

- Reviewing differences between
  - EDS and RAPS risk scores
  - What is accepted by CMS and what MAOs independently calculate

## Developing targets and goals

- May include RAPS and EDS differences, submission timelines, acceptance rates and submission completeness

## Measure results

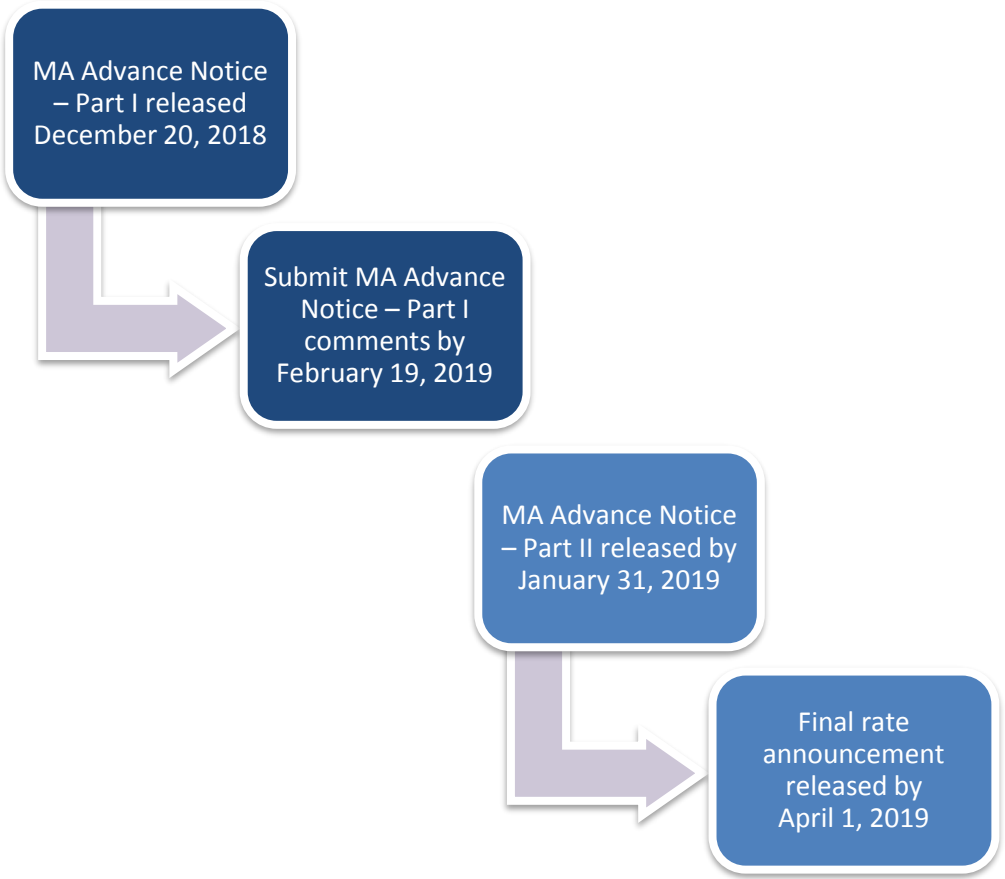
- Monitoring risk scores with each submission and providing timely and complete revenue reports to management
- Quantify and understand risk score results before submission deadlines

## Prioritizing issues and efforts that impact revenue

- Focus on over- and under-submissions that map to HCCs

AMERICA'S PHYSICIAN GROUPS

# Timeline of PY2020 CMS releases




AMERICA'S PHYSICIAN GROUPS

# Questions?


- **Jennifer Carioto**| Jennifer.carioto@milliman.com
- **Pamela Pelizzari**|Pamela.Pelizzari@milliman.com
- **Margaret Peterson** | mpeterson@apg.org