ADVALENT

# White Paper: New Risk Members and How to Impact Them

## Preparing Early

The key to success for any new or existing Medicare Advantage Organization (MAO) is largely built around the strength of your Risk Adjustment strategy and platform. The knowledge base and expertise within the organization and/or delegated RA vendor is paramount to understanding the complexities of submission, coding, membership variation, financial projections and timing. This white paper will examine the following in detail:

- When do MAOs receive payment?
- What members can be impacted?
- Why is it important to know where your membership came from?
- What strategies can be made to make earlier impacts?
- Why is the shape of Risk Adjustment changing rapidly?

## Risk Adjustment Payment

Each member within a MAO is risk adjusted per The Centers for Medicare and Medicaid Services (CMS) program. Every individual will be designated a risk score calculated based on diagnosis, demographics, and factor types. These payments make up almost all the plan's annual revenue. How they impact that revenue will be determined on the strategy and execution of their Risk Adjustment plan. Each new member or returning member can be impacted in different ways to reach the optimum risk score.

## New Members

New membership for the MAO can result in statistically lower risk scores due to differentiating factors. Members coming from a traditional Fee for Service (FFS) Medicare benefit will typically have a lower risk score. The reason for the lower score could be that there was a lack of incentive contracting for the physician and/or lack of education provided by the MAO plan for the physician around specific diagnosis capturing.

Nevertheless, members who opt to switch from another MAO plan will not necessarily have a better risk score. If a member has moved from a plan that has not built a robust Risk Adjustment program and/or failed to create efficient submission strategies, the new plan can still feel the negative effects of that member initially. However, due to a rule change from CMS in a Memo dated June 20, 2017, plans can submit retrospective diagnosis codes within a RAPS submission from a member who was enrolled with a different Parent Organization in order to adjust and accurately capture the new members' risk scores

The tables below and on page 2 demonstrate the differences between impacting new members for both situations.

- Figure 1.1 - Future Pay Year (PY) 2020 & 2021 FFS member entering the MAO market.
- Figure 1.2- Future PY2020 & 2021 for transitional MAO member

**Figure 1.1**

**Figure 1.2**


## Affecting Payment

There are three approaches to consider when receiving new membership which center around the different types of members. Let's look at the example of new membership for January 2020.

FFS Member

1. PY2020 Beginning RAF: Based on diagnosis from their FFS dates 7/1/18 through 6/30/19.
2. PY 2020 Mid-Year RAF: Based on diagnosis from 1/1/19 through 12/31/19 only FFS claims. Cannot retrospectively audit.
3. PY 2020 Final RAF: Based on diagnosis from 1/1/19 through 12/31/19 only FFS claims. Cannot retrospectively audit.
4. PY 2021 Beginning RAF: Based on diagnosis for RAPS/EDPS 7/1/19 through 6/30/20. This is the first instance the MAO can affect payment on these members.

MAO Member

1. PY2020 Beginning RAF: Based on diagnosis from their previous MAO submitted RAPS/EDPS within 7/1/18 through 6/30/19.
2. PY 2020 Mid-Year RAF: Based on diagnosis from their previous MAO submitted RAPS/EDPS within 1/1/19 through 12/31/19. Can retrospectively audit. These members for extra reimbursement based on CMS ruling.
3. PY 2020 Final RAF: Same ruling as Mid-Year payment for these members if new plan can have access to member chart information.
4. PY 2021 Beginning RAF: Based on diagnosis for RAPS/EDPS 7/1/19 through 6/30/20. This is the first instance the MAO can affect payment on these members.

New to Medicare Member

1. PY2020 Beginning RAF: Based on demographics only.
2. PY 2020 Mid-Year RAF: Based on demographics only.
3. PY 2020 Final RAF: Based on demographics only.
4. PY 2021 Beginning RAF: Based on diagnosis for RAPS/EDPS 7/1/19 through 6/30/20. This only applies if the member has had a full 12 months of Medicare eligibility. If the member became eligible any time after January, the "New Enrollee" flag can be active up to 24 months and the pan will continue to receive demographic payment.

## Strategy for Impact

Regardless of the different reimbursement rates and timing on these members, there are strategies that align to affect these members currently and in the future. Advalent's RISK360™ will allow payers and risk bearing providers to not only identify suspect conditions, but also assign the correct interventions for each HCC gap to address considering their propensity of closure during the required coverage periods. This allows for both prospective and retrospective tactics to align regardless of the new enrollee. This approach alone will generate a superior ROI with high predictability and drive sustainable financial improvements.

## Submission of Data

There is also the very important task of data submissions and how to accurately run various calculations and reconciliations for both payment and data compliance. The induction of Encounter Data Submission (EDPS) over the last few years has made it extremely important to have a strong submission platform to deal with the complexities that accompany EDPS submissions. Various blends and model versions have been released within the last few years which have created a heavy burden on payers to accurately project financial accruals. CMS has continued with their quest to place big changes in the model over the coming years.

Figure 2.1 below shows the current PY2019 blended RAF calculation and the two different HCC models and mappings used to determine a blended score. The composite model calculations and submissions are becoming progressively complicated with each new roll out as CMS transitions from a RAPS to EDPS world.

For PY2020 the EDPS execution risk increases once again with a heavier weight placed upon encounters and a new count variable model introduced. Figure 2.2 below explains the breakdown for the following year.

**Figure 2.1**

PY 2019

| DATA FEED | MODEL | BLEND | DATA | NORMALIZATION FACTORS |
|---|---|---|---|---|
| RAPS | 2017 - HCC Model V22 | 75% | RAPS & FFS | 1.041 |
| EDPS | 2019 - HCC Model (without count variables) V23 | 25% | ED + RAPS INPATIENT + FFS | 1.038 |

**Figure 2.2**

PY 2020

| DATA FEED | MODEL | BLEND | DATA | NORMALIZATION FACTORS |
|---|---|---|---|---|
| RAPS | 2017 - HCC Model V22 | 50% | RAPS & FFS | 1.075 |
| EDPS | 2020 - HCC Model (Alternative Payment Condition Count) V24 | 50% | ED + RAPS INPATIENT + FFS | 1.069 |

## Execution Risk Factors

The time to act is now. With an increasing transition to encounter data, health plans across the United States are focusing more time and energy into these submissions. Currently, error rates in submissions are ranging from 3%-15% within plans. These rates are increasingly worrying as EDPS still allows for RAPS Inpatient records to be calculated within encounter reimbursement blends, but that will not always be the case.

Advalent's Encounters Plus™ Risk Submissions platform is a HIPAA-compliant, cloud-based solution that encompasses RAPS, EDPS, Medicaid, EDGE and APCD risk adjusted submissions. It supports both inbound and outbound data validation, production workflows for error correction, and reporting alerts with revenue risk adjusted forecasting, as well as EDPS/RAPS reconciliation.

Contact Advalent today to discuss the future of Risk Adjustment and how we can help take your plan to the next level with our industry-leading Risk Adjustment solution platform.

# ADVALENT RISK360™

## Payment Improvement Solution

**Understand complete disease profile and care patterns for every member**
Analyze all available administrative and clinical datasets to assess the clinical profile of every member along with diagnosis and documentation gaps.

**Improve both clinical and financial performance**
Provide the right care to all members along while improving risk-adjusted reimbursement by integrating care/quality programs with Risk Adjustment.

**Promote provider awareness and payer-provider collaboration**
Generate sustainable clinical and financial improvements by engaging providers with the right programs (education, gap-closure etc.) at the point-of-care.

**Track provider coding/documentation patterns across all lines of business**
From under-coded to un-coded to un-assessed, identify all diagnosis (or HCC) gaps along with their payment improvement potential for all populations.

**Deploy high-ROI operational activities to address HCC gaps**
Continuously measure provider performance (as against the metrics and targets) during the benefit-years to offer proactive support

# ENCOUNTERS PLUS RISK SUBMISSIONS

Seamlessly submit for all lines of business through one easy-to-use interface

RAPS/EDPS

Medicaid

EDGE

APCD

+ Custom Submissions

**Exceptions and Workflows**
Automate exception identification and workflow assignment for quick resolution

**Custom Configurations**
Self-serve setup of any custom configuration

**Automatic Updates**
Track and manage updates to your encounter program, incorporating changes as configuration or updates

**Bulk Updates**
Flag & qualify records for updates using rules, allowing you to update using system oe 3rd party data. Audit information is tracked with every update

**Notifications**
Alert users of approaching deadlines, exceptions, urgent tasks, pending, and new work.

**Reports**
Clearly understand what is required for compliance. Analytical reports describe the impact of submission on risk and bottom-line

**Automated Submissions**

100% Success Rates

Dramatically more Efficient & Streamlined Submission Process

+ All Your Claims Receipts in One Place