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Providers Taking Medicare Advantage Risk: Financial Forecast Playbook

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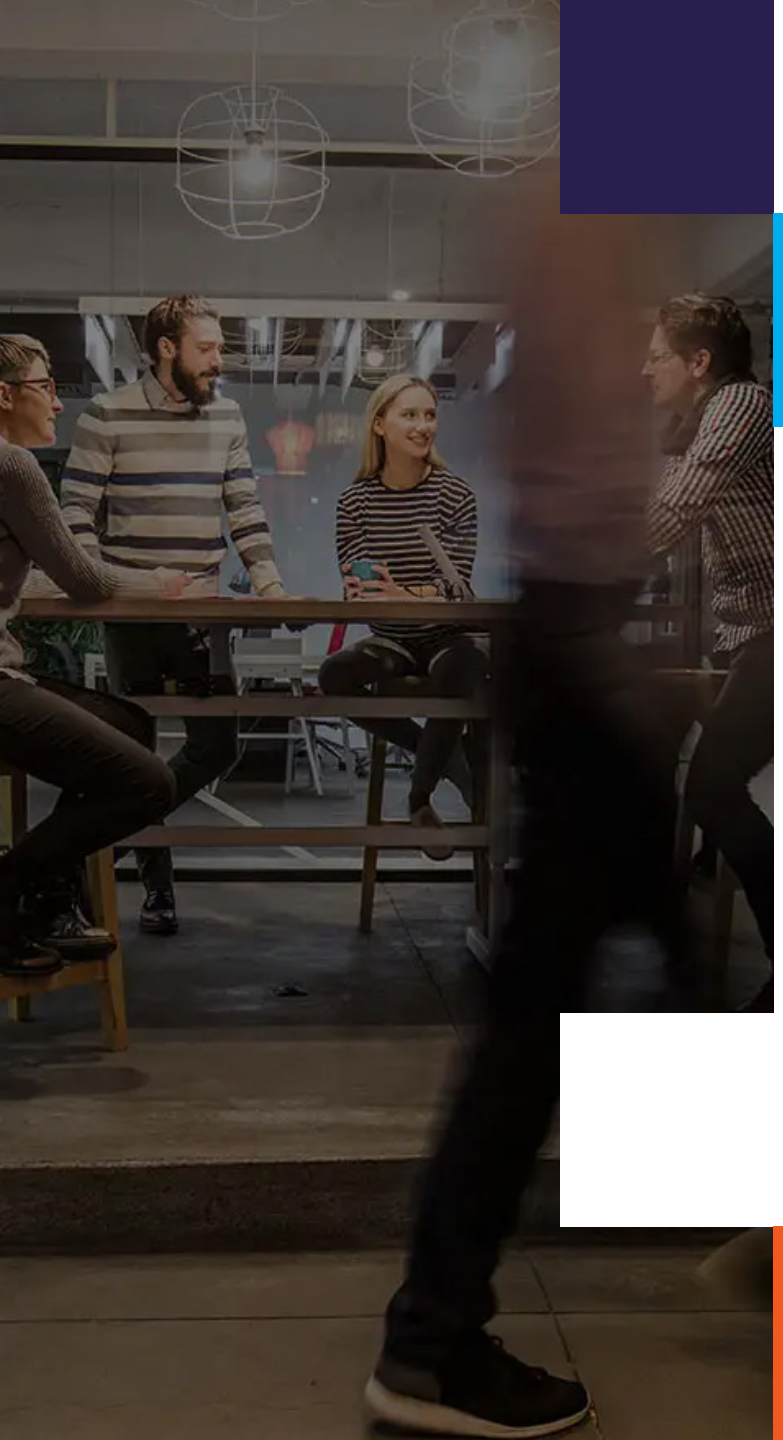

FINANCIAL FORECAST PLAYBOOK

For Clinically Integrated Networks (CINs), Independent Physician Associations (IPAs), and other independent physician groups (providers), the shift toward value-based care (VBC) in Medicare Advantage (MA) represents both an opportunity and a challenge. While risk-sharing arrangements offer the potential for significant financial upside, they also demand sophisticated financial management capabilities. The monthly financial close process serves as the foundation for successful risk management. This playbook outlines the essential components of a reliable close process, from data infrastructure to forecasting methodologies, equipping providers with the tools needed to monitor their risk-based contracts.

MONTHLY FINANCIAL REPORTING

The ultimate shared savings or loss from a risk-based contract is typically reconciled six to nine months (or more) after the end of the performance year. Waiting for this final reconciliation is not an option for providers taking significant risk in MA. Estimates should be developed on a monthly or quarterly basis to help inform the leadership team with setting budgets, hiring staff, making decisions on care management programs, and evaluating existing programs and underperforming contracts.

Developing this monthly process can be a daunting task. Shared savings aren't distributed evenly throughout the year. Calculating a gain or loss for a specific month or a year-to-date period requires extensive data analysis and careful actuarial assumptions. Once you have the year-to-date view, you then need to project that estimate to the full year.

The remainder of this guide outlines the steps to developing a successful monthly financial forecast process.

"Monthly financial reporting is like doing a puzzle, except you can't look at the picture on the box and you don't have all the pieces."

DATA INFRASTRUCTURE

The initial step, and arguably the most difficult for providers, is the development of a robust data infrastructure. Each payer partner typically provides multiple data sources, often in non-standard formats and with various levels of detail, often on a lagged timing basis. The sources of data could include medical claims, prescription drug claims, attribution, revenue, risk scores, and summary financials. Organizing and standardizing this data can be an immense task. A provider's ability to comprehend and manage insurance risk within a value-based contract hinges on its capacity to organize data effectively.

The first consideration is your team's technical capabilities. Managing MA data requires specialized knowledge of CMS reports, healthcare data systems, medical diagnosis coding, and analytics. Your team must be able to build these systems and maintain and upgrade them as the environment changes. This isn't just about having a few skilled individuals—it's about having enough depth of expertise to sustain these systems long-term.

The second, and equally important, consideration is opportunity cost. Even if your team possesses the necessary technical skills, you must evaluate whether managing data infrastructure is the best use of their talents. For example, your skilled staff members could instead be using their expertise to analyze results, improve clinical care programs, or develop new strategies. This consideration often proves decisive—many organizations with capable technical teams still choose to outsource the management of data infrastructure because they want their experts focused on using the data rather than managing it.

If either of these considerations raises doubts, partnering with established vendors may be an option worth exploring. These partnerships can take different forms depending on your comfort level and expertise. Some organizations outsource their entire data infrastructure, while others keep their basic systems in-house but rely on partners for advanced analytics.

The key is choosing an approach that lets your team spend more time using information to improve performance and less time wrestling with technical details and reconciliations.

Wakely Analytics Healthcare Operation Optimization (WAHOO)

features an organized datamart developed by data engineers, online dashboard technology, actuarial-backed reporting, and wrap-around consulting services all designed to help providers manage financial and operational performance. Provider WAHOO is a more flexible and scalable solution than other population health platforms and offers a significantly shorter onboarding process.

What Can my Data do for Me?

With a solid data infrastructure, you should have access to the data elements needed for a monthly financial forecast including medical and prescription drug claims, revenue, risk scores, and membership information. If you find your team is spending excessive time manipulating data, you may need to go back and revisit the data infrastructure to make sure you are processing and summarizing the data in a way that supports all downstream data requirements.

DATA ANALYSIS

Effective forecasting requires understanding historical patterns, adjusting for anticipated pattern changes, and scenario testing results. Experience studies analyzing historical patterns like incurred but not reported (IBNR) claims, claims seasonality, revenue seasonality, and risk score accruals are the next step to a successful financial forecast.

IBNR Analysis

IBNR analyses are experience studies that should be done each month as part of the monthly close process. IBNR estimates the claims that have occurred but are not yet in the system. There are a few methods for estimating IBNR, with the most common using historical patterns from previous months.

Let's say you are closing the monthly financials for May. May would be "month one". The IBNR study would go back and look at historical patterns to see the total dollar amount for claims that were incurred and paid in month one compared to what was incurred in month one and paid in all months. In a simplified example, if 20% of inpatient claims are historically incurred and paid in month one, and the total paid and incurred in May was $1,000,000, then the full estimate for incurred in May and paid in **all months** is $5,000,000 = ($1,000,000 / 20%).

Developing IBNR can get complicated quickly demonstrated by the considerations outlined below.

- At which level of service category granularity (e.g., Inpatient, Outpatient, Professional, Pharmacy) should the reserves be developed? Each service category typically has different completion patterns. This level of granularity should be considered hand in hand with the credibility of the data.
- Each payer partner adjudicates claims independently so historical patterns will be different.
- How much credibility should be applied to the first three months?
- In the previous example, now that I have June data, how do I go back, and re-estimate May based on the new data?

Providers taking MA risk are at a particular disadvantage because of the lag time between when a claim is incurred and when the claim comes through the provider's data warehouse. The payer partner typically sends over a monthly claims feed, which could take three to four weeks to process and deliver to the provider. These raw files then need to be processed by the provider's internal or external data teams, which could take another three to four weeks. Considering the delivery and processing time, data could be six to eight weeks old before the initial estimates can be developed.

In addition, for most providers, alternative data sources are needed to support IBNR estimates. Electronic Health Record (EHR) data can be leveraged for real time estimates. Admit, Discharge and Transfer (ADT) feeds along with historical data can be studied to estimate a cost for an inpatient claim where there is a known discharge but no record. CMS's Interoperability and Prior Authorization Final Rule (CMS-0057-F) will allow providers and payers to exchange data much quicker and in a standardized format.

SEASONALITY

Seasonality studies on claims, revenue, risk score, and membership also should be developed to create a full year financial forecast. Seasonality studies review historical patterns to help predict future periods and should be reviewed on an annual basis. When there are significant program changes (e.g., Inflation Reduction Act) historical patterns may not be reliable and additional modeling will be needed.

Claims Seasonality Example:

As members reach their deductible or maximum out of pocket (MOOP), the provider's liability goes up. The provider's liability in January is typically lower than October. Other factors like flu season cause spikes in claims in the fall and winter. Members utilize more services on weekdays, so even the number of weekdays in a month can impact how many claims are incurred. Having 23 weekdays vs. 24 could be a big difference (23 / 24 = 0.958). These historical patterns can and should be captured to accurately adjust your financial forecast.

When is Experience Data not enough?

Sometimes the available historical experience can be a limiting factor, specifically related to credibility and consistency.

Full credibility represents the number of members needed so that the change in healthcare expenditures can be reasonably attributed to the provider group's performance and not caused by the random fluctuation in healthcare claims. Credibility can help to answer questions like: was the 1% decrease in claims because of the new clinical initiatives or because of an external factor?

Each time you slice the data, you lose some credibility, and as your lives under risk contracts grow the consistency of the population changes.

Manual data can help bridge these gaps. Manual data can be developed by combining and normalizing experience data, or by looking at external manual data sources.

Credibility issues come into play when

You want to look at financial performance at too granular of a level. Maybe you want to look at financial results by region, clinic, or population (e.g., splitting out DSNP members). When you start looking at more granular levels, you lose credibility.

Data consistency comes into play when

Your risk contracts are growing significantly, so historical data is not representative of the current population. For example, if you have 5,000 lives under risk contracts in 2024 and 12,000 in 2025, the historical experience in 2024 may not be representative of the new population in 2025.

DEVELOPING MANUAL DATA

Aggregating data that has similarities is an option for developing a manual data source. For example, if you have two payer contracts in Atlanta, GA, you could combine them to create an Atlanta, GA, experience manual. When you open a new clinic or sign a new risk deal with Payer Three in Atlanta, you could use the Atlanta, GA experience manual as a substitute until actual experience is available and credible.

Payer partners may also be a source for manual data. As part of their reporting packages, payers may provide a benchmark that shows all the payer's members in Atlanta or all members in Georgia. This can be used to support seasonality assumptions and may also be a source for benchmarking KPIs.

Having a trusted data partner can also be a good source of manual data

Wakely maintains several proprietary MA data sets and has access to CMS's Virtual Research Data Center (VRDC). The VRDC data includes the 100% MA encounter data and 100% Medicare FFS expenditures data. Access to these robust data sets allows manual data to be developed specifically for each contract's underlying experience.

ADJUSTMENTS FOR KNOWN CHANGES

Sometimes we know things won't match historical patterns. Perhaps a key contract will go from a 3.5 Star Rating to 4.0, so there will be a significant increase in revenue and perhaps enhancements in benefits. Or a new discharge planning initiative with timely follow up protocol was implemented. The historical data should be adjusted for these new changes and the financial forecast should reflect these impacts. If the new discharge planning initiative was implemented in January, actual experience through May would already have the impact baked in, but the projected claims for June - December would need to be adjusted.

RISK ADJUSTMENT ACCRUALS

Providers taking risk in MA struggle with estimating risk scores for the current plan year. MA risk scores are prospective. Risk scores for the current year are based on the diagnosis for claims incurred in the prior year. As an example, risk scores for payment year 2025 used diagnosis claims incurred in 2024. Risk score data provided by payer partners are often from the CMS Monthly Membership Report (MMR) files and don't include an estimate of the midyear or final risk score. With limited data and resources, a provider is expected to estimate the full year risk scores based on MMR files, which can be a nearly impossible task.

Wakely has a robust process to estimate risk scores. We identify three cohorts of members and then estimate a range of completion factors based on a large database of historical risk score completion data by cohort.

THE THREE MEMBER COHORTS ARE:

1.
The member was enrolled with the provider for all 12 months of the diagnosis year.

2.
The member was enrolled with the provider for between 1 and 11 months of the diagnosis year.

3.
The member was not enrolled with provider at all during the diagnosis year and is a new member in the payment year.

"Individually, each of these adjustments, studies or considerations are easy to understand. The real challenge is understanding them in aggregate and how changes in one impact others."

RELYING ON YOUR PAYER PARTNER

There is an unequal distribution of data between providers taking risk and their payer partners. The payer partners have teams of actuaries and financial analysts. There are teams for developing the MA BPTs, monitoring trend, and developing IBNR. They are your partners and generally are willing to help but as a provider, knowing the right questions to ask is half the battle.

At Wakely, we have over 100 actuaries and consultants who develop MA BPTs for over 40 health plans.

We know how MA payers think because our experts are in the room each year helping the key stakeholders make decisions. We use this expertise to help providers request the right information which in turn helps manage their risk.

FORECAST MODEL

Now that you have your data in the right format and you have all your studies developed, let's talk about your forecast model.

Is your financial forecast a cyborg bolting together years of ad-hoc analysis? Do you need three full time employees with advanced degrees to update the model each month? Does modeling out a new trend scenario take one minute or one day? Your model should be fast, flexible, and easy to use. If your finance team needs to paste data into excel and build out their own reports, your model isn't flexible enough nor has it incorporated all stakeholders needs.

After you close the books for May and update your full year forecast, you should be able to explain what the key drivers of change are from the April close. How much did your IBNR re-state? What caused the changes in inpatient expenditures, and will those changes persist for the rest of the year?

Once you have developed a best estimate for all assumptions, you should understand the variance on each assumption by completing scenario testing on the results. A $30 million shared savings estimate in November is more reliable than a $30 million estimate in April due to having more data. You may want to consider communicating financial results in ranges to capture the potential variability in the results. For example, "The 30th to 70th percentile estimate of shared savings is $20-40 million."

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Zach Davis FSA, MAAA, joined Wakely Consulting Group, LLC as a Senior Consulting Actuary in 2023. He has a wide range of actuarial experience helping both payers and providers manage risk. His current focus is helping ACOs manage insurance risk from their value based contracts in the MSSP, ACO Reach, Medicare Advantage and commercial markets.

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