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Webinar:

Risk Adjustment in Value-Based Contracts

The Need to Know Information for Health Plans and Providers

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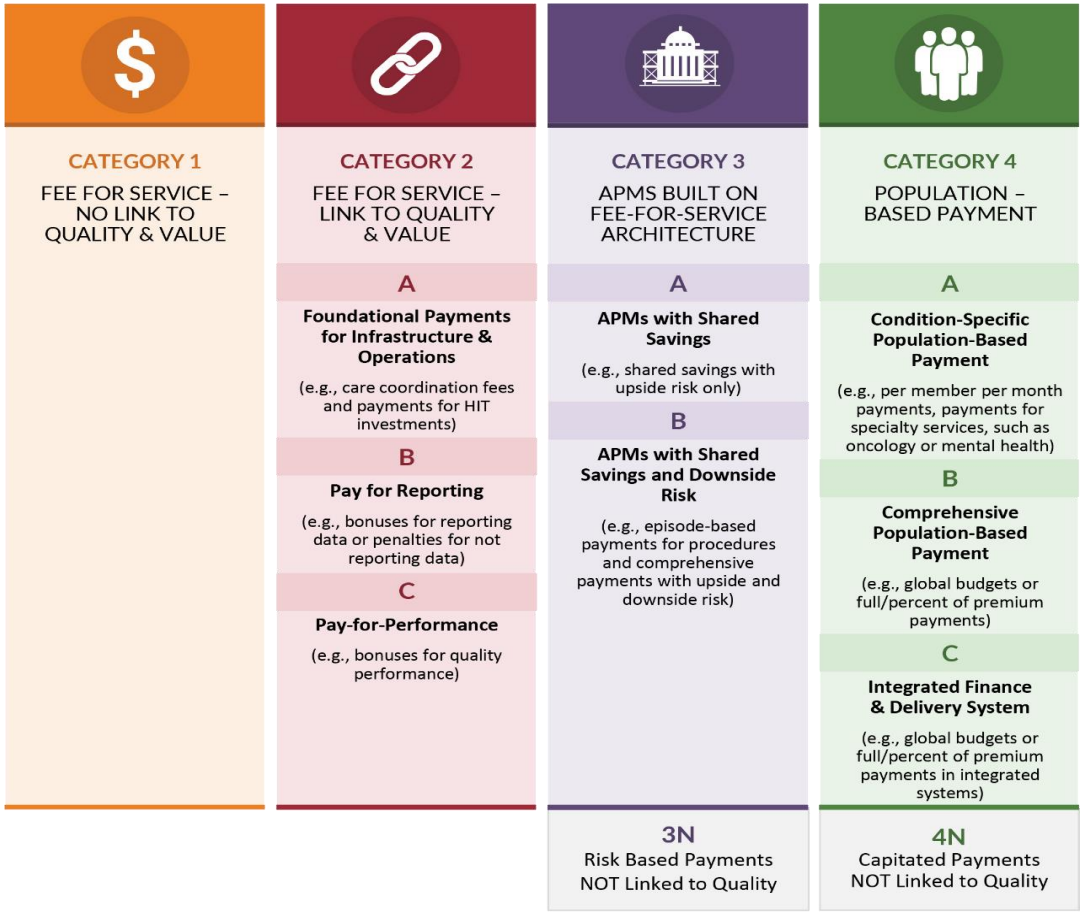
Today's Topics

- Overview of Value-Based Payment (VBP) Models
- Current State of VBP Model Adoption
- Analysis of Risk Adjustment in Value-Based Contracts from Different Perspectives
  - Provider, Health Plan, and Government
  - Challenges/ Opportunities
- Best Practices for Implementation
- Future Adoption of VBP Models
- Q&A

Overview VBP Models/ Contracts

- Currently there is a lack of standardization across all payer's Value-Based Payment models or Alternative Payment Models
- Contributes immensely to provider burden
- HCP-LAN has created categories for payment models that helps standardize and create structure
- Can be used as a foundation when implementing APMs



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Current State of VBP/ APM Adoption

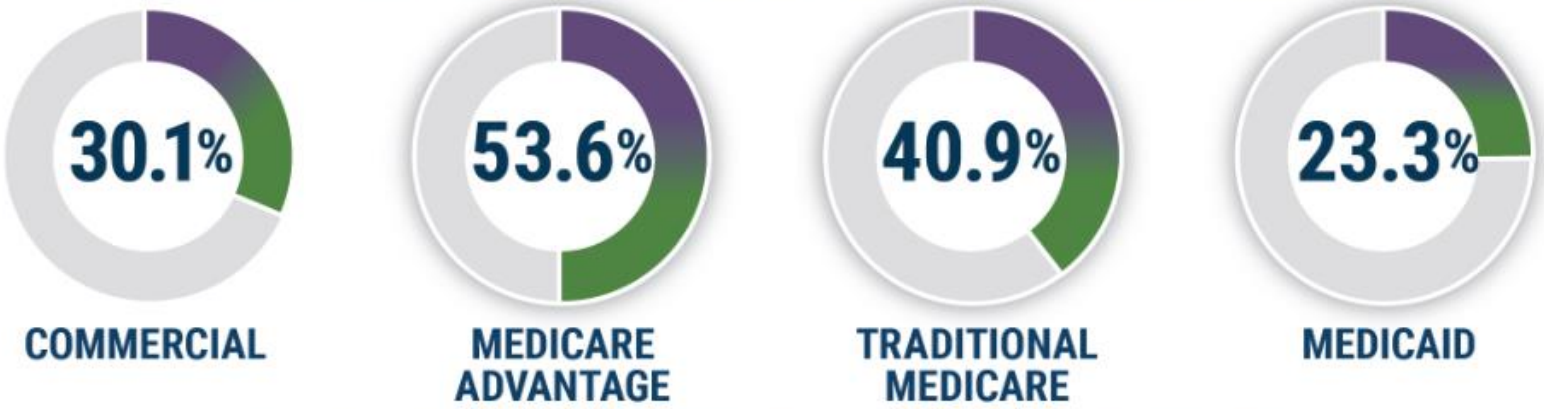
LAN 2018 APM Measurement Results

Read the APM Measurement Report

In **2018,**

35.8% of U.S. health care payments, representing approximately **226.5 million** Americans and **77%** of the covered population, flowed through Categories 3&4 models.

In each market, Categories 3&4 payments accounted for:

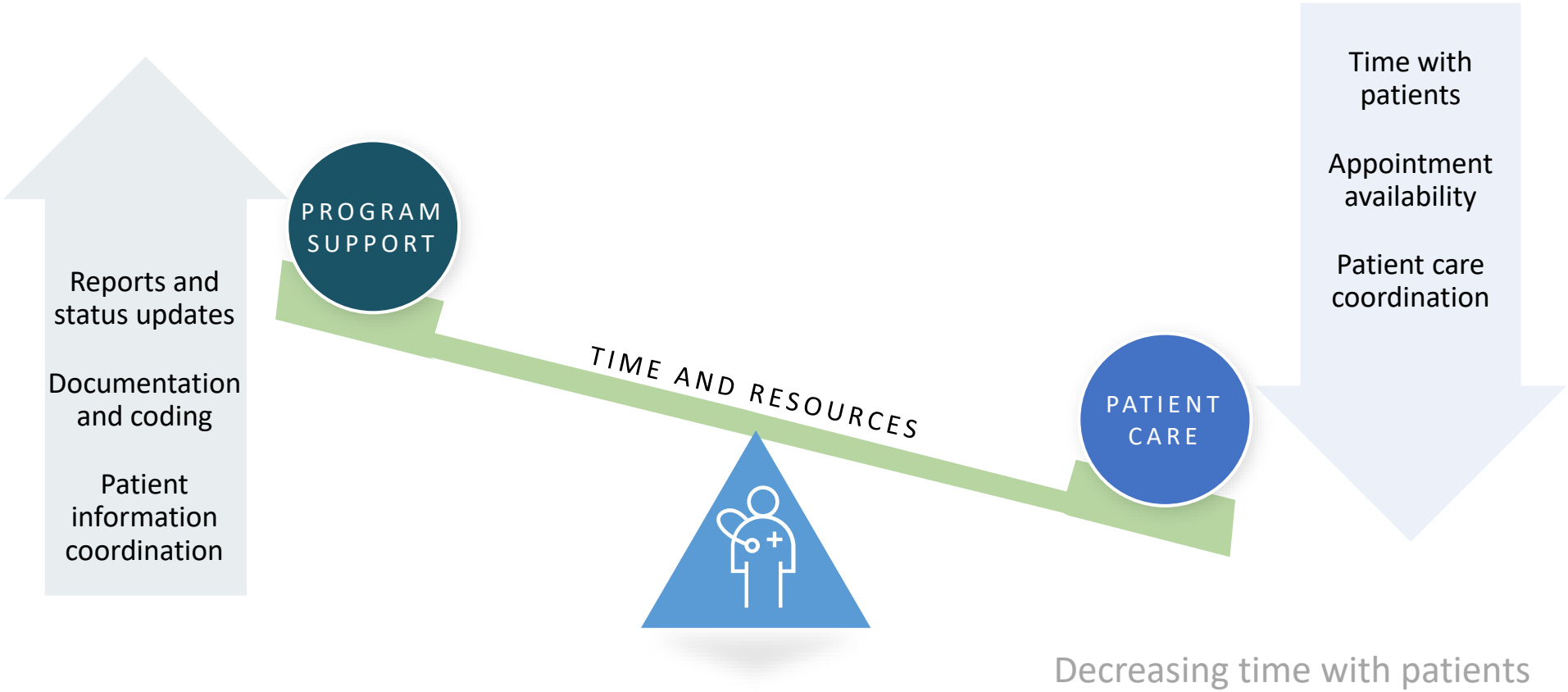


Representativeness of covered lives: Commercial - 61%; Medicare Advantage - 67%; Traditional Medicare - 100%; Medicaid - 51%

HCPLAN Health Care Payment Learning & Action Network

Challenges/ Opportunities

Increasing provider burden related to risk and quality programs.



Decreasing time with patients and care coordination

Risk Adjustment in Federal Models

- 2018 Pathways to Success regulation finally allow for MSSP patients' risk scores to increase over time (cap 3% increase)
- MIPS has improved its Cost Category to include episode-based cost measures, which account for Medicare Part A and Part B spending around a clinically cohesive set of medical services rendered to treat a given medical condition
  - CMS has developed risk adjustment methods incorporated in the cost measures that account for patient characteristics that can influence spending outside of the control of the clinician
- MIPS complex patient bonus, which applies at the final score to adjust for patient complexity
  - Based on the physician's attributed beneficiaries' average HCC risk score and the proportion of dually eligible patients
- Medicare Advantage: as we saw a few slides ago – 53.6% of MA payments fall into APM Category 3 & 4 (Pop. based payments etc.)

Risk Adjustment from Private Payer Perspective

- With a common goal in mind of providing the best quality outcomes to members/ patients, payers are in a position to incentivize providers to demonstrate better quality outcomes
- As a result the healthcare market is seeing an increase in providers moving or being pushed toward value-based care programs to share in the rewards of quality care
- Providers are entering into VBP with payers for all lines of business and utilizing different reward models:
  - Meeting established Medical Loss Ratio
  - Outperforming budgeted Medical Trend

Risk Adjustment from Provider Perspective

- Provider groups want to enter into value-based models however they don't always have the infrastructure to take on the additional data and requirements
- Providers can be immediately challenged by the metrics of these programs and demonstrating performance as they try to organize around this model
  - Adoption of EMRs and sharing data
  - Waves of spreadsheets and data to interpret
  - New payment models and incentives to track towards
- Providers may require infrastructure payments initially to obtain the right resources and systems to operate in the value-based program world

Best Practices for Implementation

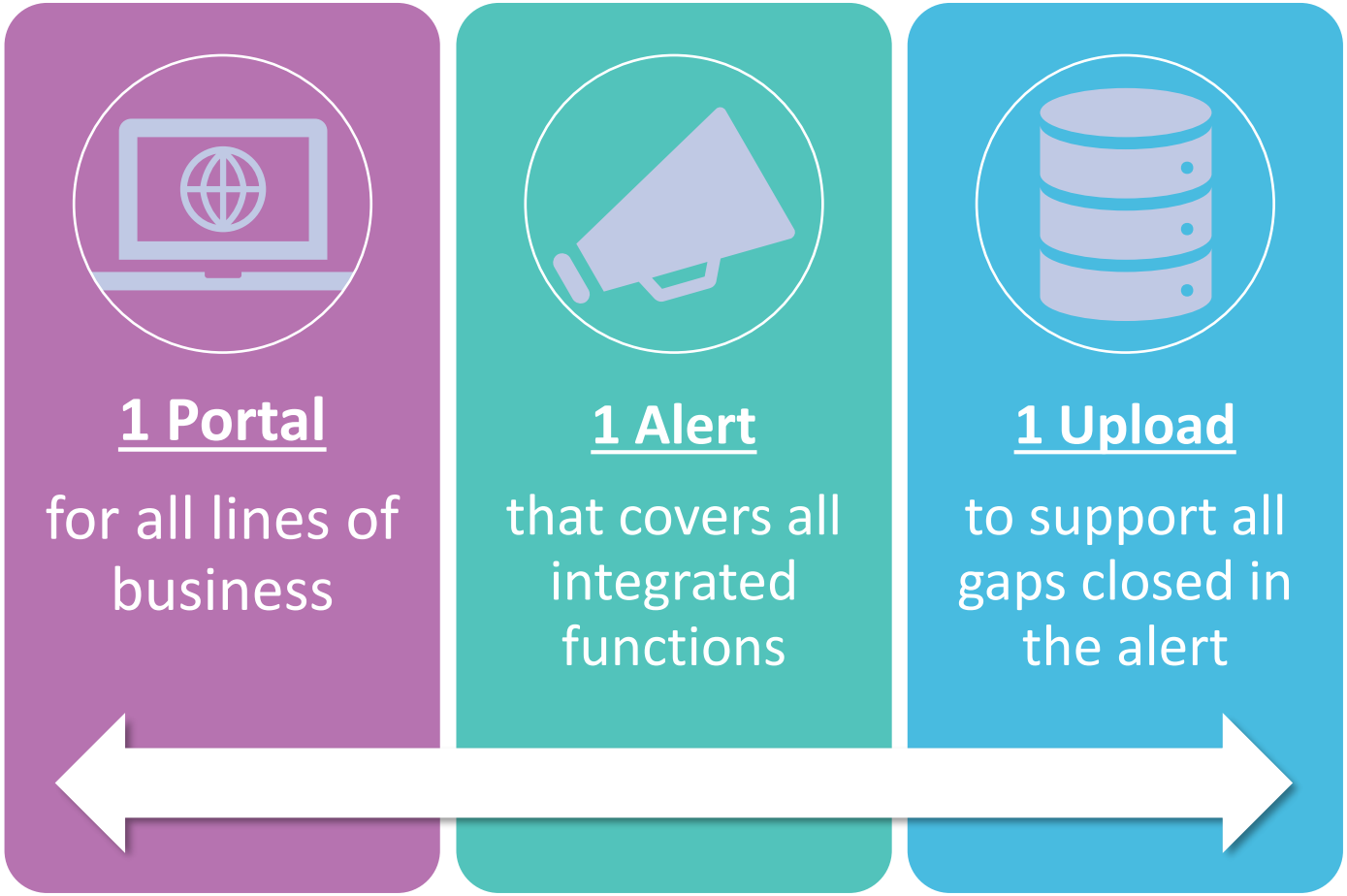
In order to avoid costly errors when transitioning to a VBP model, we implemented the following additional provider support:

- Provide timely and accurate analytics, which are critical to all Risk and Quality gap closure activities – both with vendors and providers
- Use Pulse8 as an analytics vendor – they determine all our vendor and provider intervention programs and lists
- These analytics are scanned throughout the year so that we can shift members between programs where necessary
  - e.g. Initially drive a member to an in-office assessment program. After 6 months, if the member has not visited their physician, move them to an in-home or mobile assessment
- Share internal analytics with provider so they can take action

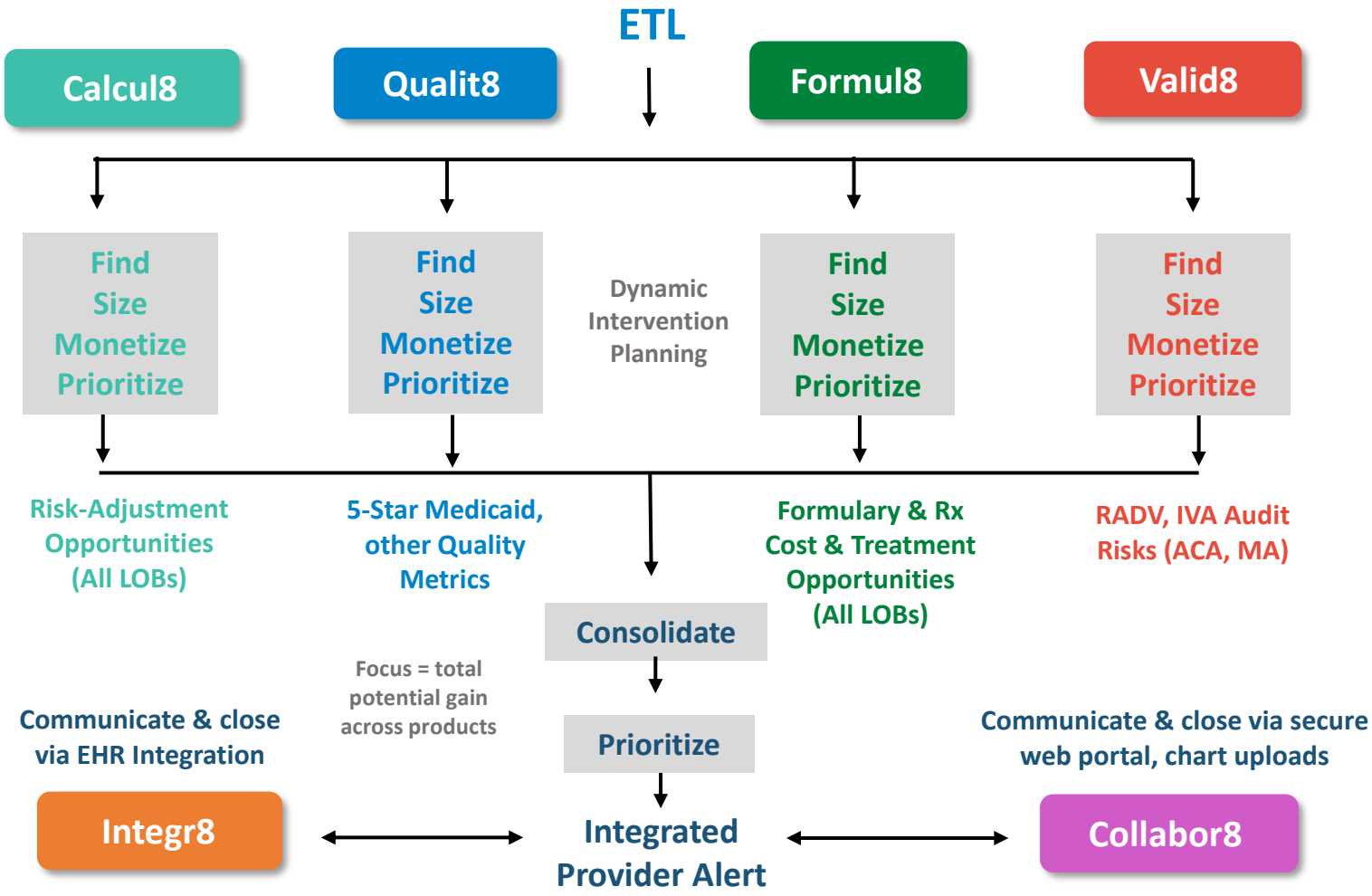
Sense and Respond Strategy for Analytics

- Broaden and deepen your data: more & better data = better results!
  - Clean what you have – ID gaps and fill – Link what you have
- Mine and model: Dynamic Intervention Planning to focus and optimize efforts
- Tailor your touches
  - When, how, and where are as critical as the type of intervention
  - "Mass-customize" the type, objective, and tone to what's most apt to trigger a change
- Unblind with science
  - Learn by testing multiple approaches. Six-Sigma techniques can be a big help
- "Nudge" wherever you can: often a call, email, or text is all that's needed
- Learn and apply from your outcomes

The Strategy of One



“Integrated” Organization = Integrated Alerts!



Benefits of Such Integration

- **Completeness**
  - All actionable opportunities in one place. No hunting pages of charts or EMR screens
  - Use integrated alert in treatment room to ensure all areas are covered during the consultation
- **Convenience**: Office staff can decide the best way to proceed depending on the member's history
  - Retrospective: If the member had a recent visit, then pull and upload chart
  - Prospective: If overdue for visit, use alerts to prioritize scheduling
- **Context**: Provider sees the full picture, with each area informing the others. Easy to prioritize
- **Compliance**: Easy to learn and efficient to use means faster and more closures of care gaps
- **Cash**
  - Rapid resolution improves clarity and precision of revenue forecasts
  - Enhances MA cashflow
  - Lowers chart retrieval and coding costs

Payer/ Provider Collaboration Case Study

Challenge:

- VBP providers had their own risk adjustment programs in place however they were not achieving the necessary results to achieve their VBP targets
- They lacked effective analytics

Solution:

- We partnered with Pulse8 to generate specific provider group-level analytics for chart review and in-home assessment programs, and they were supplied to our provider groups and used for program execution
- These providers realized a significant improvement in their risk scores over the next payment year

Payer/ Provider Collaboration

- The success of the VBP is dependent on effective and efficient collaboration between the payer and provider
- In addition to the sharing of reports, open risk adjustment gaps, and analytics, the provider needs to engage with Payer Risk Adjustment programs or develop their own
- Close coordination of Risk Adjustment programs will ensure the quality RA outcomes necessary to succeed in the VBP

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Reports and status updates

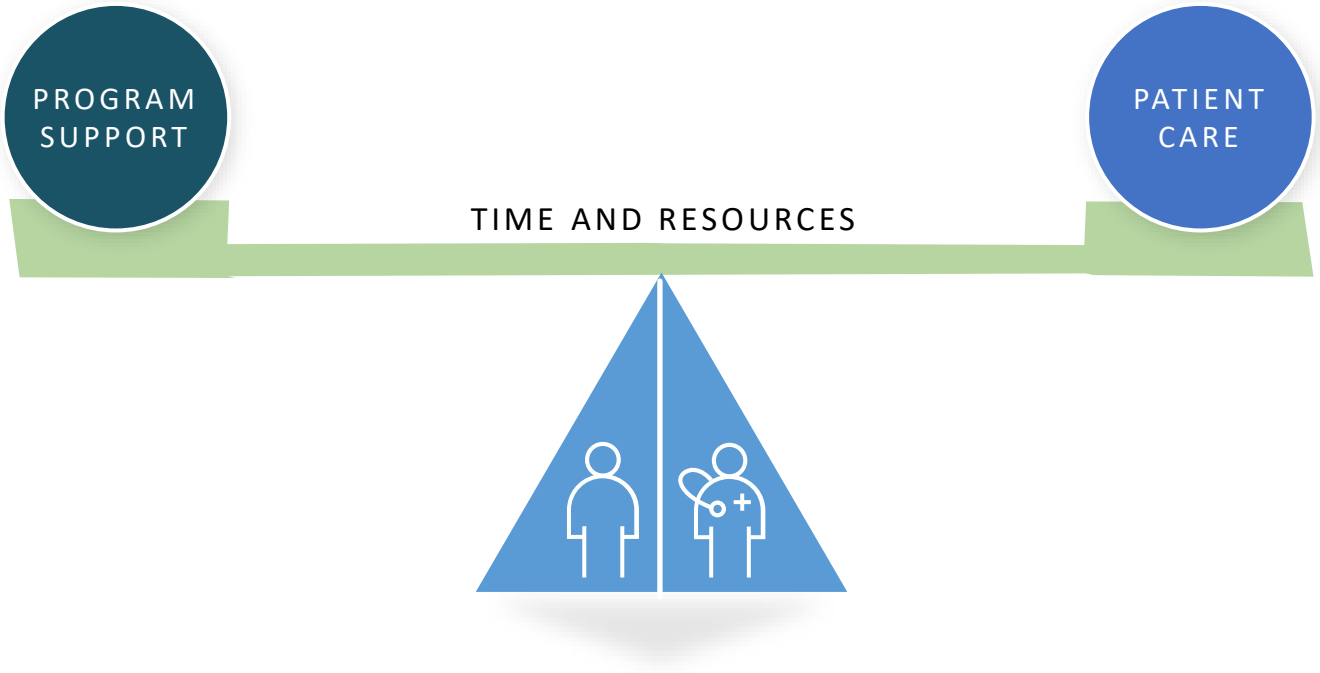
Patient information coordination

Documentation and coding

Appointment availability

Patient care coordination

Time with patients



Payers can help providers by tailoring their approach based on their needs.

Q&A

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EVERY NUMBER IS A LIFE.