



Risky Business:

What Every Healthcare Finance Leader Should Know
Before Taking On Risk

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Presenter



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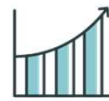


A Quick Primer on Value Based Care

Value Based Care

Is a system in which reimbursement is driven by quality of care and patient outcomes.

It is...



Not driven by volume, use, or "heads in beds"



About full continuum performance



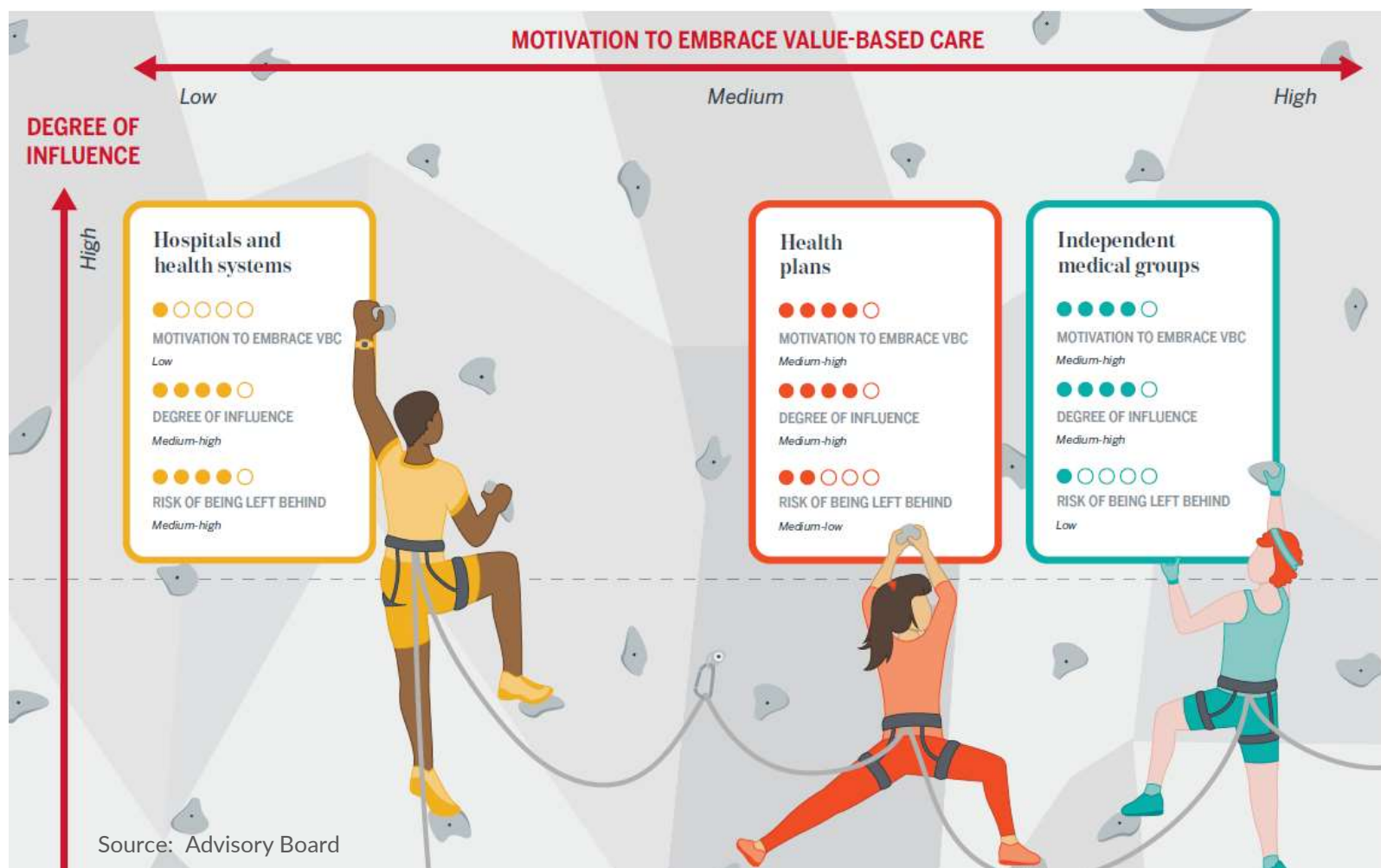
Focused on Prevention



Payment is based on expected cost of care

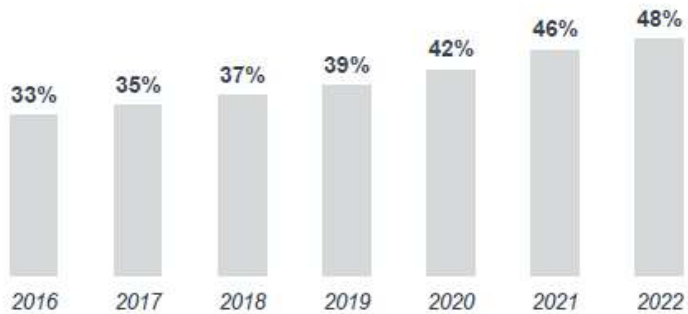
Value Based Care is Risk Based Care

The Climb to Value Based Care

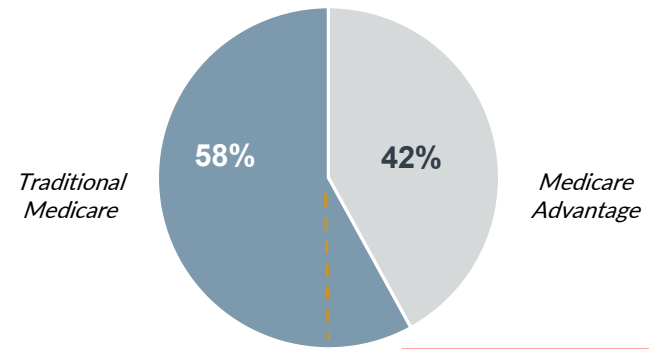


Why Make the Climb?

Medicare Advantage penetration rate steadily increasing



MA projected to overtake traditional Medicare by 2030



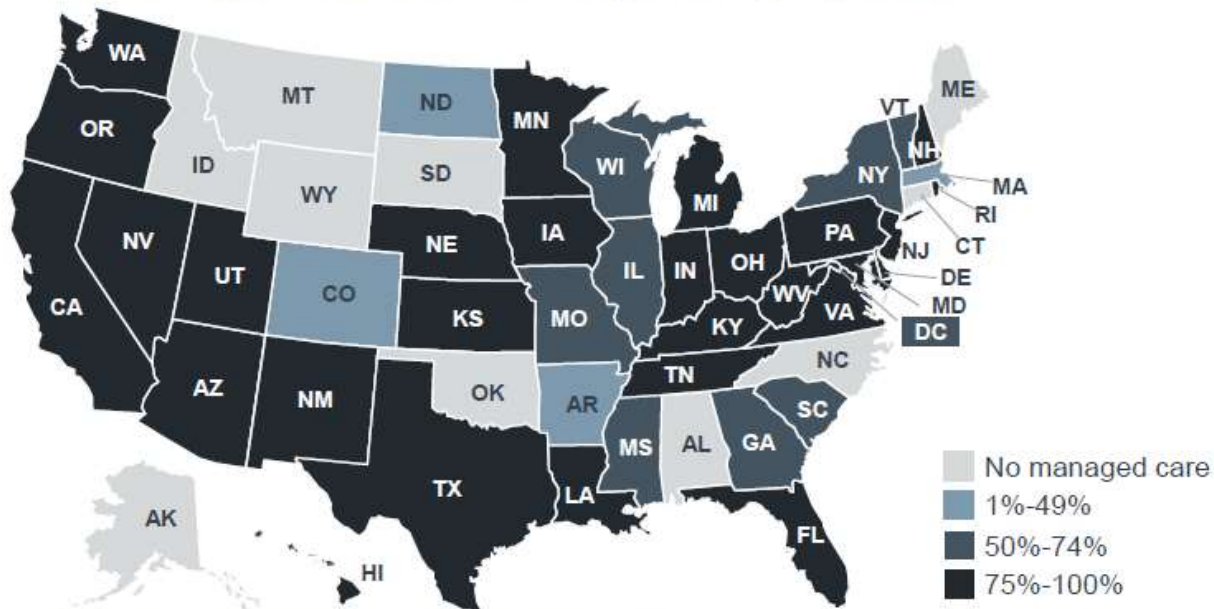
MA Overtook Medicare on April 24, 2023.
Six Full Years Ahead of Predictions

Source: 2023 Advisory Board

Source: Freed M, Damino A, Neuman T, "A Dozen Facts About Medicare Advantage in 2020," KFF, April 2020; Jacobson G, Freed M, Damico A, Neuman T, "Medicare Advantage 2020 Spotlight: First Look" KFF, October 2019; Freed M, et al., "Medicare Advantage in 2021: Enrollment Update and Key Trends", KFF, June 2021; "Health Care Spending and the Medicare Program, Medpac, July 2020.

Climbing Further...

Percent of Medicaid beneficiaries in managed care¹ by state in CY2020



68 million
Medicaid beneficiaries enrolled in managed care plans

72%
of Medicaid members are enrolled in managed care nationally

1. The number and percentage of Medicaid beneficiaries in managed care reported here excludes those who are enrolled in a Financial Alignment Initiative Medicare-Medicaid Plan as their only form of managed care. This is the primary model in states like North Carolina, Oklahoma, Alabama, Maine, Montana, and South Dakota.

Source: "Managed Care Enrollment Summary", Medicaid, Medicaid.gov.



The “Nuts and Bolts” of Value and Risk Based Reimbursement

Risk Reimbursement at a High Level



Foundational Premise: Patient and/or Procedural volumes do not drive reimbursement

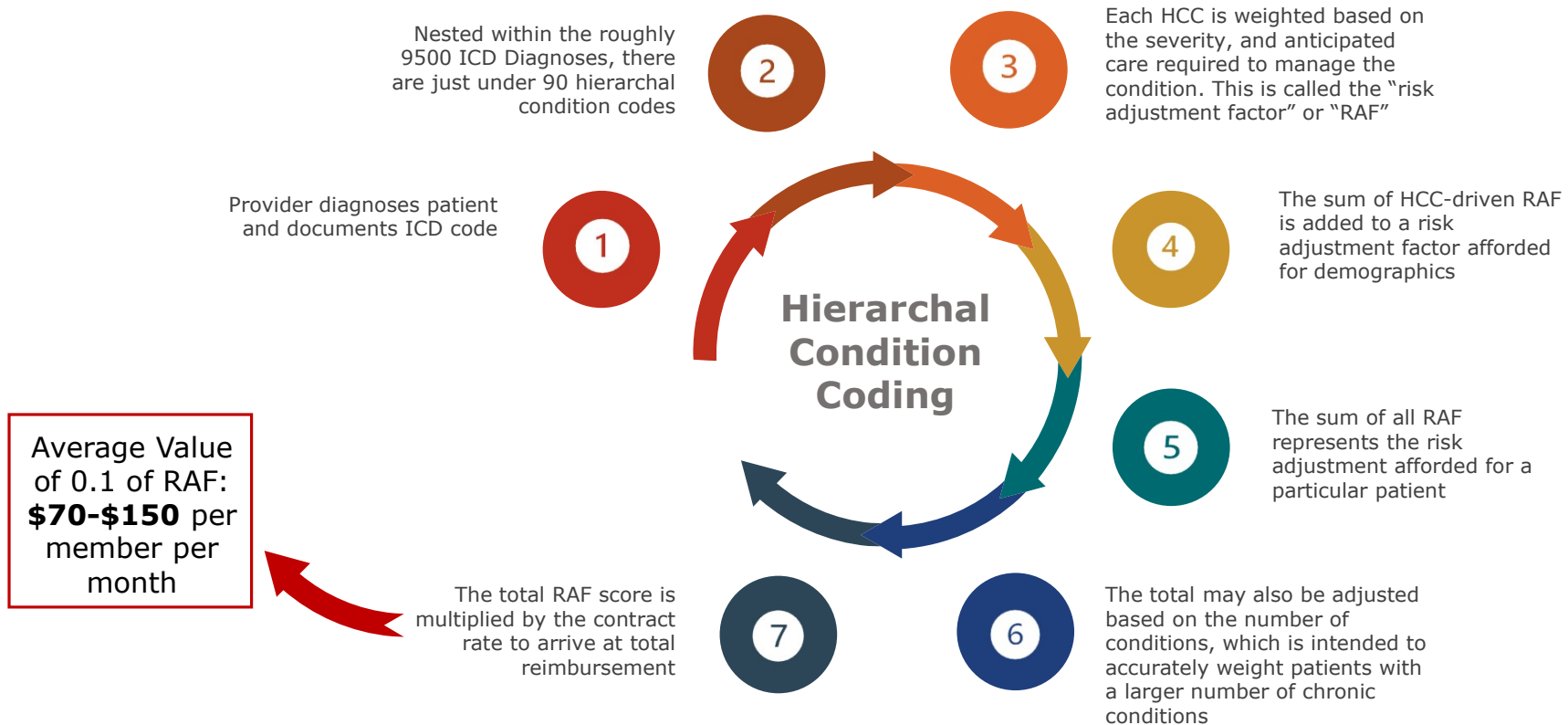
Payment is made for the *expected* cost of care per member per month ("pmpm")

Expected cost of care is risk adjusted using Hierarchal Condition Codes (HCC's) based on specific patient conditions and basic demographic profile

The calculation of the patient's weighted disease specific risk is called the risk adjustment factor (RAF)

In simplest form, RAF is multiplied by the payment rate to arrive at the reimbursement

Hierarchal Condition Coding





Making a diagnosis is not enough to claim the HCC You must document a plan for management

M

Monitor signs and symptoms, disease progression, further regression, etc.

E

Evaluate tests and diagnostics, effectivity of meds or therapies prescribed, and overall response to treatment

A

Assess by ordering tests, evaluations, diagnostics, or records

T

Treat with medications, therapies or other treatment

A Tale of Two Clinics...

Clinic A

Condition	Risk Adjustment Factor (RAF)
78 year old male living in community	0.460
Height/weight: 217 pounds. No BMI calculated, "obese"	0
Diabetes with Circulatory Impairment	0.302
Multiple late-stage wounds on right foot, documentation shows "pressure ulcer"	0
Congestive Heart Failure	0.331
No assessment of psychosocial condition	0
Total RAF	1.093
Sample Medicare Advantage Payment	\$14,776 annually

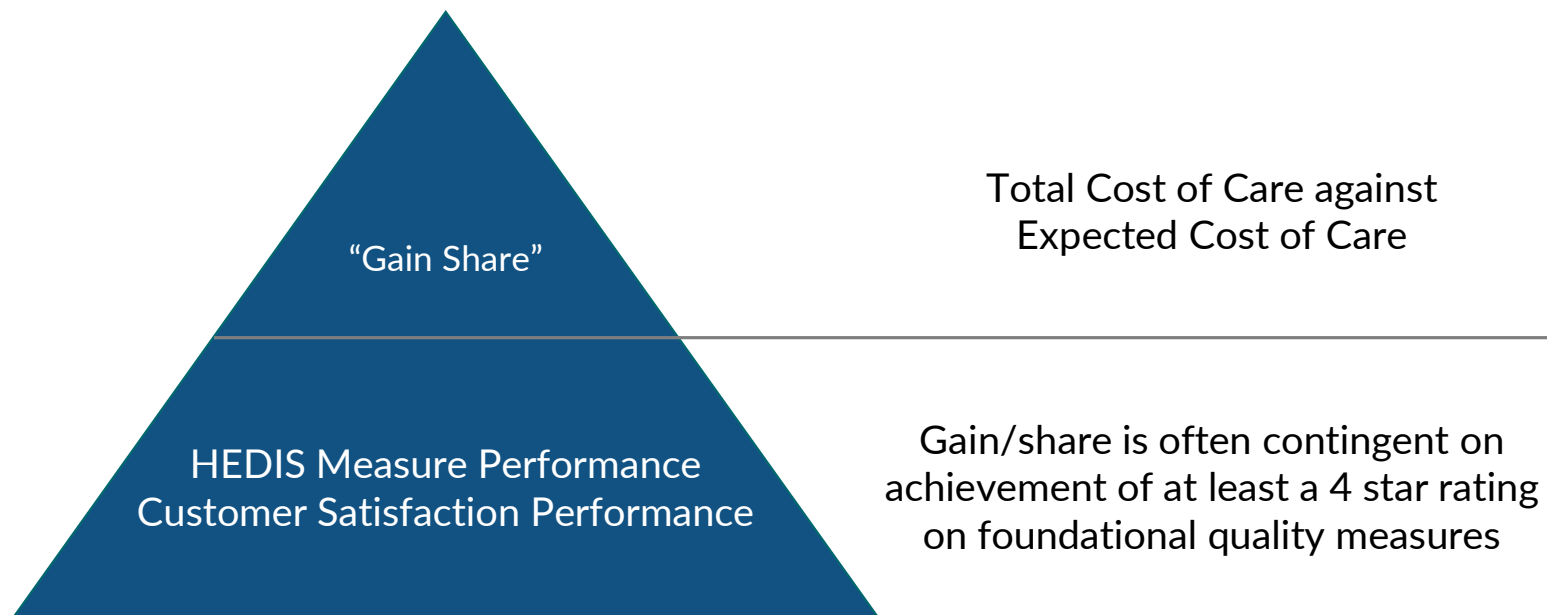
Clinic B

Condition	Risk Adjustment Factor (RAF)
78 year old male living in community	0.460
Height/weight: "5 feet tall, 217 pounds, BMI 41"	0.250
Diabetes with Circulatory Impairment	0.302
Multiple chronic late-stage wounds on right foot, staged and documented individually	0.515
Congestive Heart Failure	0.331
Major Depression as a result of condition impact (PHQ-9)	0.309
Total RAF	2.167
Sample Medicare Advantage Payment	\$28,548 annually

+\$13,772 as a result of value based operational focus

** Sample simplified for exemplar purposes only, using 2020 risk adjustment modeling and exemplar payment rate.

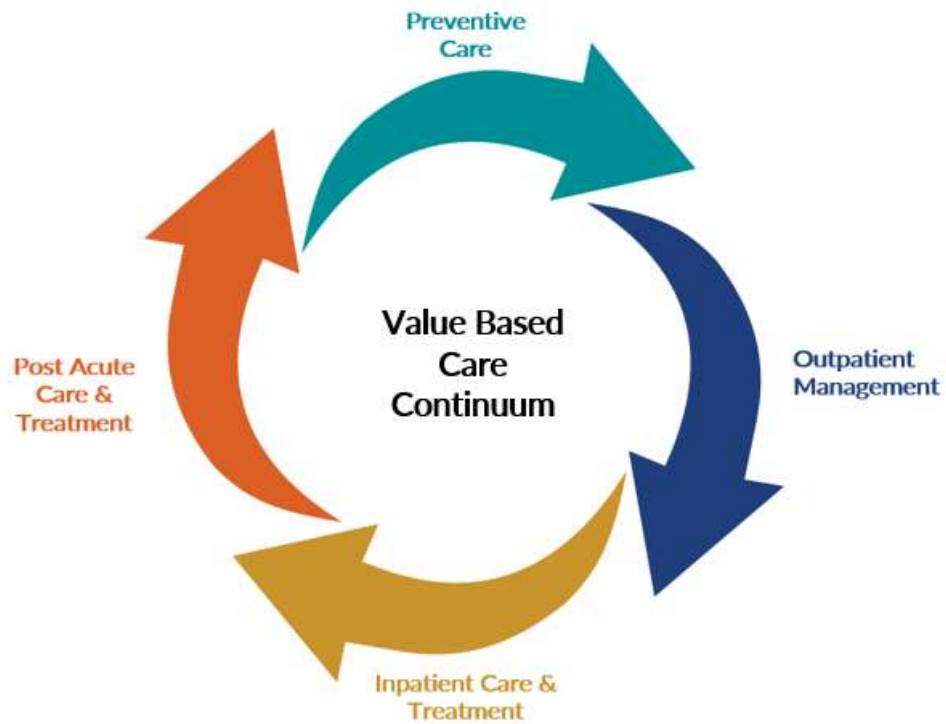
Payment on a Risk Platform





Winning or Losing in Value and Risk Based Agreements: The Must Haves

You Must Know and Leverage the Full Continuum



Providers Must be “All In”



Providers Must

- Understand (in detail) how it works
- Believe in the value
- Help drive the evidence-based care behind it

Primary Care Operations Must Run Efficiently



Visit capacity optimized: Must see the right patients at the right frequency to identify and manage conditions

Top of License: Every member of the staff plays a role in risk capture and condition management

Visit Outcomes: Operational protocols must support evidence-based care pathways to capture and manage risk

Electronic Health Record Optimized: Your record must support the protocols and the documentation for RAF capture

Everyone in the office must understand RAF and why it is important to care and reimbursement

Measuring Ambulatory Efficiency

Visit Capacity & Scheduling

- Annual Wellness Visits Completed (%)
- Call Time to Visit
- No Show/Cancel Rate

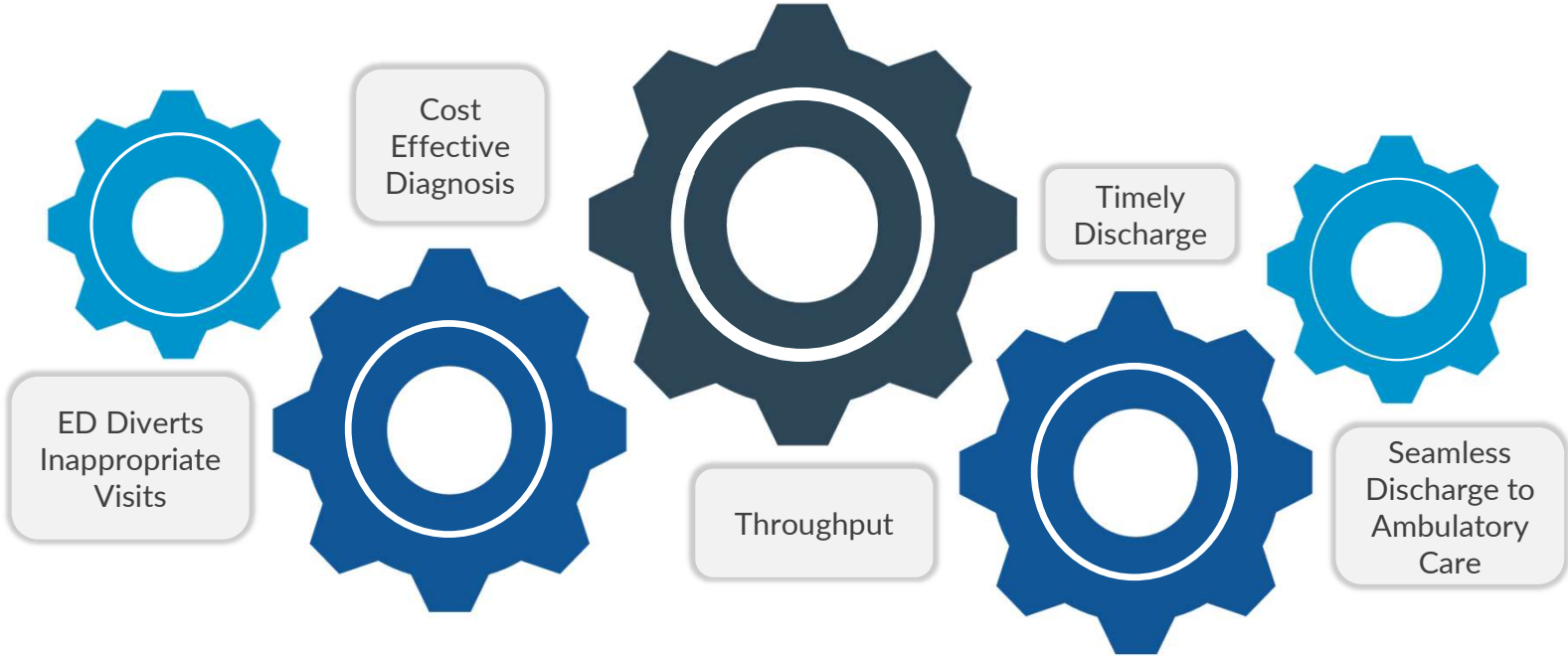
HCC Capture and Accuracy

- Coding Accuracy
- HCC Capture v. Benchmarks
- HEDIS measures

Chronic Condition Management

- Monthly Interactions
- ED Utilization Rate
- Acute Utilization Rate
- Med Adherence Rates

Acute Care Must Run on Value

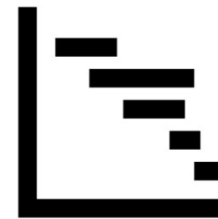


Analytics Must Support The Enterprise

You can't afford to have a bad day and learn about it months later



Analytics staff must understand value based care and the operations that support it



If you can't produce analytics to the provider level on a monthly basis (ideally a weekly basis), you need an overhaul



Efficiency is doing things right.
Effectiveness is doing the right things.

-Peter Drucker

Contact your presenter



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Thank you for attending