The Importance of Risk Adjustment in Value Based Care Contracts

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Presented By

- **Jason Jobes, MSPA,** is the senior vice president (SVP) of Norwood Solutions in Saint Amant, Louisiana. As SVP, Jobes oversees all consulting and managed services partnerships and delivery for Norwood's healthcare partners. These partnerships focus on creating economic sustainability for the healthcare ecosystem through improved performance across the revenue cycle and value-based care terrains. Across his consulting career, Jobes has delivered over $425 million dollars in return on investment for partners. A sample of performance results include: $16.82 million dollar case mix index improvement at a four-hospital system in the Midwest; 37% increase in charts reviewed per FTE per day through process redesign at a large hospital in the southeast; 27% improvement in hieratical condition category (HCC) scores for a large health system on the west coast; 19% reduction in denials for a system in the Northeast; 22% improvement in worked RVUs per provider for a medical group in the south. Jobes holds a Bachelor of Arts from The University of Hawai'i Hilo, where he graduated Summa Cum Laude with a degree in economics with a minor in business administration. He also obtained his master's in science of predictive analytics from Northwestern University in Evanston, Illinois. Jobes has also served five terms as a member of the national Malcolm Baldrige Board of Examiners.

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Learning Outcomes

- At the completion of this educational activity, the learner will be able to:
  - Explain the current state of value-based care and the importance of risk adjustment
  - Apply best practice techniques to succeed in capturing chronic conditions in the ambulatory space
  - Assess current patient complexity relative to state and local comparisons

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The Basics of Value Based Care Contracts

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Defining Value Based Care

Fee for Service

Fee for service contracts compensate healthcare organizations for each service rendered and there are generally no quality, cost, or outcome expectations. What this means is that organizations increase revenue by increasing the volume of care provided. There is little incentive to control healthcare utilization.

Value Based Care Contracts

Value based care contracts come in multiple forms but at their core they seek to share cost savings, incentivize high quality outcomes, and drive lower healthcare utilization. Providers are paid a certain amount for each patient encounter but can earn additional revenue through metrics defined in the contract. The goal is to create incentives across the healthcare continuum for high-quality, low-cost care.
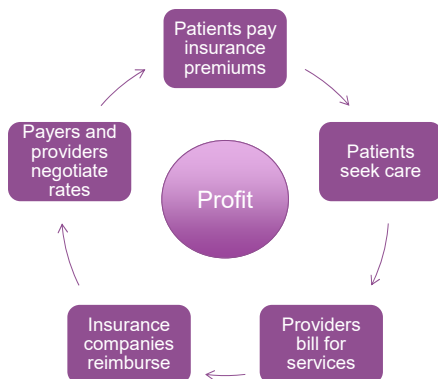
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Why the Shift From Volume to Value?

- Economic profit is a driver of most, if not all, private businesses. To derive a profit, an organization must make more in revenue than it spends in expenses. If profits are low, the business needs to either increase revenue by charging more for each item it sells or sell more of those items. Alternatively, they can decrease costs by lowering how much each product costs.

Simplified Economic Model

- Patients pay insurance premiums
- Patients seek care
- Providers bill for services
- Insurance companies reimburse
- Payers and providers negotiate rates
- Profit

The Economics Aren't Sustainable

Price Changes: January 2000 to December 2022
Selected US Consumer Goods and Services, Wages

MORE EXPENSIVE
- Hospital Services (227.2%)
- College Tuition and Fees (181.2%)
- College Textbooks (163.7%)
- Medical Care Services (132.3%)
- Childcare and Nursery School (123.1%)
- Average Hourly Wages (104.1%)
- Food and Beverages (89.7%)
- Housing (87.1%)

Overall Inflation (76.1%)

- New Cars (24.1%)
- Household Furnishings/Operations (12.5%)
- Clothing (-2.2%)
- Cellphone Services (-39.5%)

MORE AFFORDABLE
- Computer Software (-71.7%)
- Toys (-72.3%)
- TVs (-97.7%)

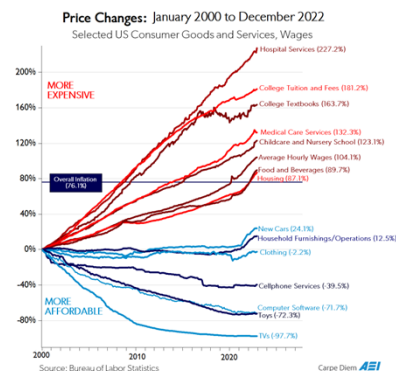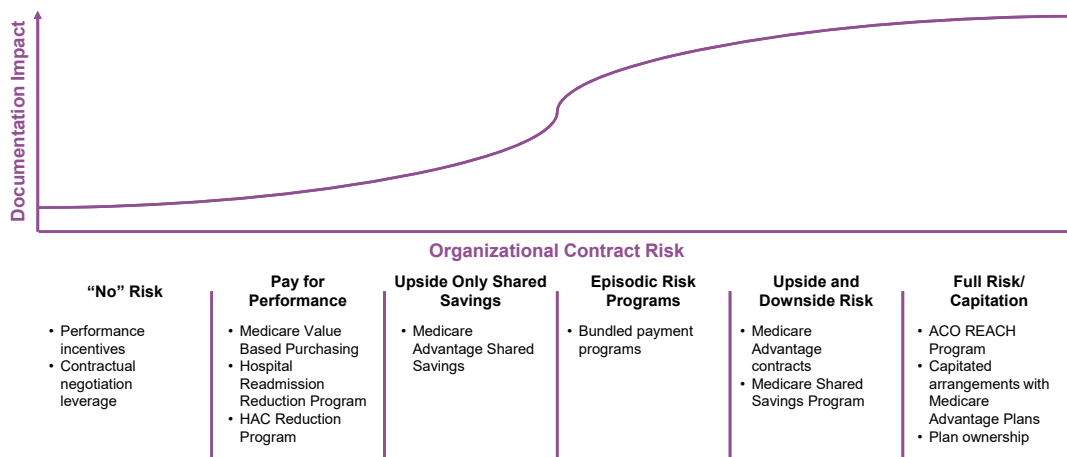Source: Bureau of Labor Statistics

Carpe Diem AEI

Image Source: https://twitter.com/Mark_J_Perry/status/1616903822118649858/photo/1

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The Medicare Risk Spectrum

- Organizations will always exist somewhere on the risk spectrum. In every contract there is both explicit and implicit risk. Documentation always matters but its importance grows, sometimes exponentially, as the organization takes on more advanced payment models.
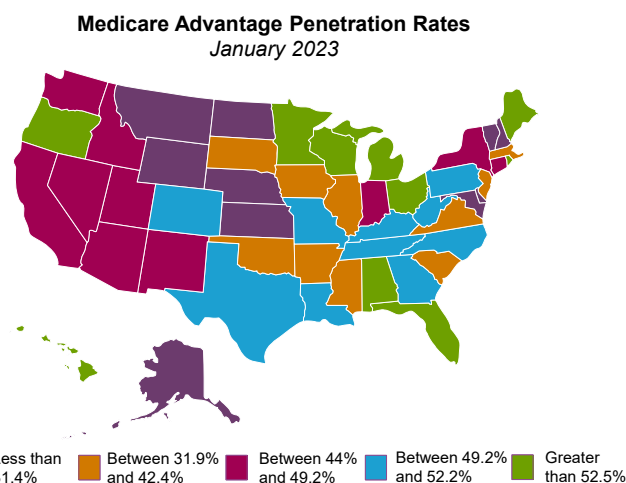

Organizational Contract Risk

"No" Risk	Pay for Performance	Upside Only Shared Savings	Episodic Risk Programs	Upside and Downside Risk	Full Risk/ Capitation
• Performance incentives • Contractual negotiation leverage	• Medicare Value Based Purchasing • Hospital Readmission Reduction Program • HAC Reduction Program	• Medicare Advantage Shared Savings	• Bundled payment programs	• Medicare Advantage contracts • Medicare Shared Savings Program	• ACO REACH Program • Capitated arrangements with Medicare Advantage Plans • Plan ownership

Documentation Impact (y-axis)

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A Look at the Medicare Advantage Landscape

- MA enrollment as of January 2023:
  - The overall enrollment is 30.1 million lives
  - The eligible population is 64.1 million lives
  - Approximately 47% of all Medicare beneficiaries have enrolled in MA plans
- Five Medicare population growth rates:
  - The eligible Medicare population has increased by 6.67 million lives, or 11.6%
  - Overall MA enrollment has increased 9.8 million lives or 48%
  - Overall, the percent of patients in MA plans has increased from 35.4% to 47% in just 5 years

Medicare Advantage Penetration Rates
January 2023

| Less than 31.4% | Between 31.9% and 42.4% | Between 44% and 49.2% | Between 49.2% and 52.2% | Greater than 52.5% |

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Medical Loss Ratio (MLR)

- Health plans must annually calculate their medical loss ratio. This ratio reflects the percent of all premiums that are paid for claims. The lower the ratio, the more controlled costs are relative to the premium collected. This can be an indicator of overall performance but is by no means an absolute metric.

MLR Calculation

$$\text{MCR Ratio} = \frac{\text{Medical Claims Expense}}{\text{Total Premiums Received}}$$

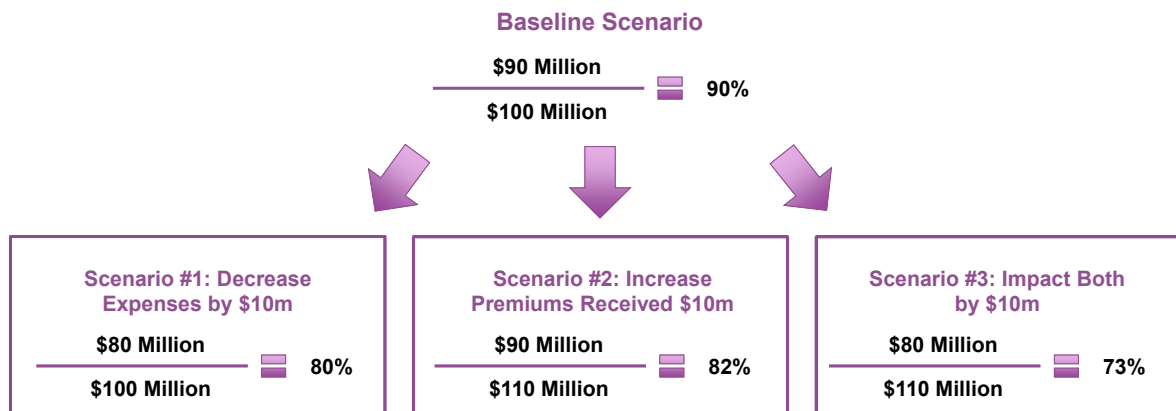To improve medical loss ratios, an organization must do at least one of the following two items:
1) Decrease medical claims: To do this, organizations must either decrease the volume of services being provided or decrease the cost per patient encounter.
2) Increase total premiums: To do this, organizations must capture all appropriate conditions. The capture of these conditions will impact risk scores and therefore increase risk adjusted premiums.

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The Math Behind Improving Medical Loss Ratios

- Remember, in its simplest form, to improve the medical loss ratio either the claims must decrease, the premiums must increase, or both can occur.
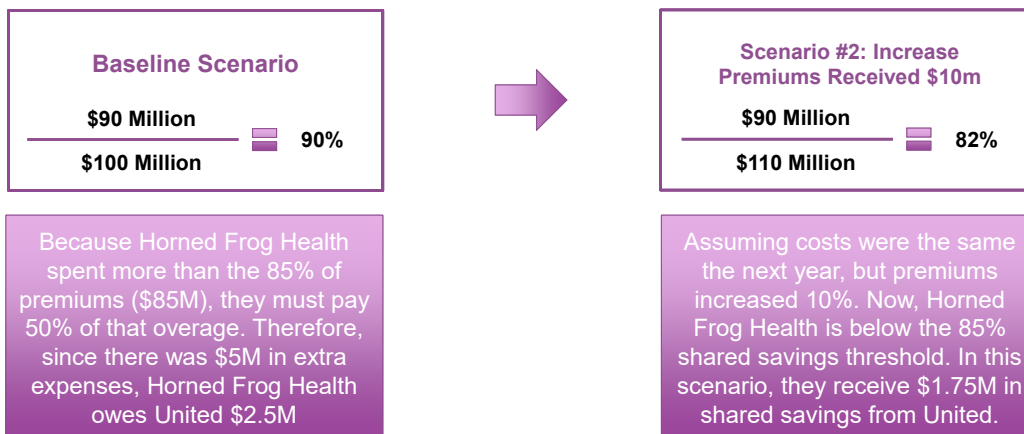
Baseline Scenario

$$\frac{\$90 \text{ Million}}{\$100 \text{ Million}} = 90\%$$

Scenario #1: Decrease Expenses by $10m

$$\frac{\$80 \text{ Million}}{\$100 \text{ Million}} = 80\%$$

Scenario #2: Increase Premiums Received $10m

$$\frac{\$90 \text{ Million}}{\$110 \text{ Million}} = 82\%$$

Scenario #3: Impact Both by $10m

$$\frac{\$80 \text{ Million}}{\$110 \text{ Million}} = 73\%$$

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Let's Take Scenario #2 and Convert to Real Impact

- Horned Frog Health, a fictious health system in Fort Worth, Texas, has entered a shared savings arrangement with United Healthcare for its Medicare Advantage patients. The organization receives 50% of savings below an 85% MLR and must pay 50% of the overage if the MLR is above 85%.

Baseline Scenario

$$\frac{\$90 \text{ Million}}{\$100 \text{ Million}} = 90\%$$

Scenario #2: Increase Premiums Received $10m

$$\frac{\$90 \text{ Million}}{\$110 \text{ Million}} = 82\%$$

Because Horned Frog Health spent more than the 85% of premiums ($85M), they must pay 50% of that overage. Therefore, since there was $5M in extra expenses, Horned Frog Health owes United $2.5M

Assuming costs were the same the next year, but premiums increased 10%. Now, Horned Frog Health is below the 85% shared savings threshold. In this scenario, they receive $1.75M in shared savings from United.

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So, What Drives Total Premiums Received?

- In its simplest form, annual premiums received are calculated monthly and then aggregated across the 12-month period. The calculation uses the number of member months, the per member per month (PMPM) payment, and the risk adjustment factor (RAF) score. It is important to note that this is calculated at the patient level and added up but for illustrative purposes this is done in aggregate for the entire year below.

Eligible Population Member Months ✖ Per Member Per Month Payment ✖ Total RAF Score for all Patients ▬ Total Premiums

	Member Months	PMPM	RAF Score	Premiums
Baseline	125,000	$800.00	1.00	$100,000,000
Scenario #2	125,000	$800.00	1.10	$110,000,000
Difference	0	0	0.10	$10,000,000

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A Patient Example of the Importance of Condition Capture

- An 85-year-old Medicare Advantage patient comes in for a visit …
- **Symptoms**
  - Symptoms of urinary tract infection (UTI), reports mild claudication
  - Tired, less energy, poor appetite, mild malnutrition
  - Urinalysis performed shows white cells, leukocyte esterase and microalbuminuria
- **Medical history**
  - Stable diabetes mellitus (DM)
  - Chronic kidney disease (CKD) stage 4 exacerbated by diabetes
  - Stable left great toe amputation due to non-healing ulcer
  - UTI with serum GFR 29
  - Body mass index (BMI) of 42
- **Care plan set**
  - Glipizide 5 mg b.i.d. for DM
  - Cipro for UTI
  - Ensure supplements for malnutrition
  - Return to clinic (RTC) in three months
  - Referral to nephrologist for CKD stage 4
  - Walking program for claudication

ONE PATIENT, THREE SCENARIOS
Date of service: June 29, 2018

1 **Capture basic demographics and primary reason for visit**

85-year-old female
✓ *UTI*

Total RAF	0.664
PMPM care funding	$531
Annual care funding	**$6,374**

2 **Capture additional condition**

85-year-old female
✓ *Diabetes mellitus*
✓ *UTI*

Total RAF	0.770
PMPM care funding	$616
Annual care funding	**$7,392**

3 **Capture complete clinical information**

85-year-old female
✓ *Diabetes mellitus*
✓ *UTI*
✓ *CKD stage 4 due to diabetes*
✓ *Mild degree malnutrition*
✓ *H/O toe amputation*
✓ *Morbid obesity*

Total RAF	2.320
PMPM care funding	$1,856
Annual care funding	**$22,272**

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Best Practices for Accurate Risk Adjustment

The Recipe for Success

The Winning Formula

- Know Your Patients
- See Your Patients
- Capture RAF
- Capture 90% of Complexity
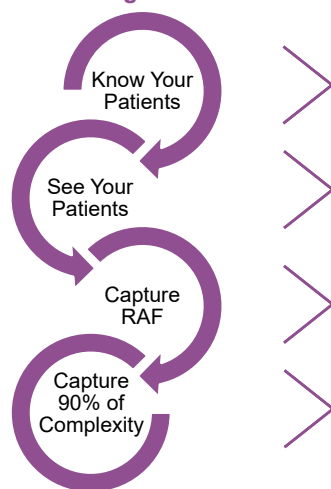
To Succeed You Must…

Know who your patients are, what risk program they are in, and what clinical conditions they have.

See your patients at least annually. Best practice organizations see their patients multiple times per year.

Have processes in place to alert clinicians to known and suspected conditions and empower them to capture them.

Aggressively monitor process and outcome metrics to ensure that patient complexity is fully captured.

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Know Your Patients

- Success in value-based care contracts begin by having a clear understanding of who is in your patient population and what conditions they have. Knowing those patients, their complexity, and when they join your risk panel is vital to accurately depicting the complexity of the patient population.

Pre-Encounter Reviews

- Evaluate suspect conditions
- Add, update, or resolve the problem list (if allowed)
- Send queries to be evaluated during the patient visit.

Consistent Roster Assessment

- Obtain patient rosters on a regular basis; monthly is preferred
- Determine new patients
- Don't rush to saying "that is not our patient"

New Patient Outreach

- Identify new patients and determine if they aged into a population or are net new
- Reach out to newly rostered patients within 60 days for an appointment
- Encourage patients new to the organization to bring their medical records to their next appointment

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Know Your Patient Case Study

- The facility below uses a seven FTE CDI team who performed nearly 28K chart reviews in for 11K unique patients. Their approach to chart reviews and physician partnership have paid off with incredibly strong quantifiable results.

Sample Health System CDI Impact

	CDI Performed at Least One Patient Review	CDI Did Not Perform at Least One Patient Review
Patient Population	11,110	41,877
Percent of Population	21%	79%
Average Chronic Condition RAF Billed per Patient	0.563	0.430
Average Chronic Condition RAF Potential per Patient	0.600	0.500
Percent of Chronic Condition RAF Captured	92.25%	86.14%

30.7%
Billed chronic condition RAF per patient for patients with a review was 30.7% higher than those not receiving a review

22.1%
Potential chronic condition RAF per patient for patients with a review was 22.1% higher than those not receiving a review

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See Your Patients

- Once you know who your patients are, it is imperative that they be seen. Risk adjustment can only be captured in face-to-face visits and telehealth audio/video visits. Have a strong process to ensure patients are scheduled at least annually, preferably by their primary care provider, is essential to success.

Annual Wellness Visits

- Conduct a welcome to Medicare visit for net new patients
- Continue to drive attribution by leveraging this visit
- Address all known and suspected conditions in one visit

Schedule Patients for Follow-up Visits

- Never let a patient walk out with no scheduled appointments
- Align follow-up with known disease conditions
- Best practice for patients with chronic conditions is to address them two times per year (once in before June and once from July–December)

Outreach to No Show and Cancelled Visit Patients

- Create a process to quickly identify patients who no show or cancel appointments
- Reach out to patients within 72 hours to reschedule patients
- Partner with scheduling to help enable patients to be rescheduled in lieu of cancelled

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Annual Wellness Case Study

- Annual wellness visits can be a fantastic opportunity to assess, and where appropriate capture, chronic conditions. The case study below shows an organization that, while lagging behind best practice levels of AWVs, has been able to have a significant impact on overall premiums received.

2020 Risk Performance for AWV Patients
In-Scope Lives

Metric	Patient Did Not Have an AWV	Patient Had an AWV
Total patients	24,503	5,748
Percent of patients	81%	19%
Average chronic condition RAF billed per patient	0.28	0.38
Average chronic condition RAF billed per patient	0.36	0.40
Percent of chronic condition RAF captured	78%	95%
Percent of patients with cRAF that have all cRAF captured	66%	92%

92%
Patients with an annual wellness visit had 92% of their chronic condition risk adjustment value captured

35.7%
Patients with an annual wellness visit had 35.7% more chronic condition RAF captured than patients without an AWV.

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Accurately Capture Patient Complexity

- It isn't good enough to just see patients, to be successful clinicians must document and code for the conditions their patients have. Given the burdens of managing patient volumes, this is often a challenge and things are unintentionally overlooked. Ensuring a strong, collaborative approach, supported by technology often helps minimize missed opportunities.

Collaboration with Clinicians

- Conduct a welcome to Medicare visit for net new patients
- Continue to drive attribution by leveraging this visit
- Address all known and suspected conditions in one visit

Technology Where Practical

- Never let a patient walk out with no scheduled appointments
- Align follow-up with known disease conditions
- Best practice for patients with chronic conditions is to address them two times per year (once in before June and once from July–December)

Robust Audits

- Create a process to quickly identify patients who no show or cancel appointments
- Reach out to patients within 72 hours to reschedule patients
- Partner with scheduling to help enable patients to be rescheduled in lieu of cancelled

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The Importance of Auditing Records

- Over the last decade, there has been an increased emphasis on audits to validate the sufficiency of documentation for risk adjustable conditions. The Risk Adjustment Data Validation (RADV) audits have been a driver of False Claims Act suits. An early 2023 ruling will expand the impact that these audits will have on MA plans.

Sample Audit Impact Stories from 2021–2023

One nationwide health system has been the target of a suit for approximately $1B of over payments for MA patients	A system in California settled a false claims act for $90M for allegedly capturing conditions not full supported	In 2021, Humana settled with the OIG for nearly $200 million in MA overpayments

https://kslawemail.com/128/8398/uploads/1434000-1434776-doj-(002).pdf
https://www.justice.gov/opa/press-release/file/1428656/download
https://www.healthcaredive.com/news/humana-nets-nearly-200m-in-overpayments-oig-audit-finds/598709/

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Evaluating Performance Relative to Others
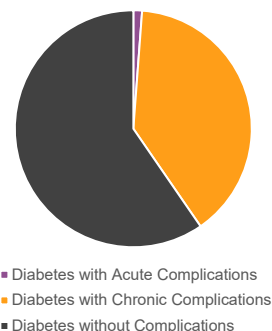
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Prevalence Data

- One way to compare performance is to look at prevalence data. This will allow an organization to compare the percentage of its patients with a given condition to that of the nation. This can allow an organization to see if its patients have more or less of a given condition than the nation.

CMS HCC Prevalence Rate
2021 Report to Congress

HCC Category	HCC Name	Patients in Sample with Condition	Sample Prevalence Rate
17	DM with acute complications	83,346	0.30%
18	DM with chronic complications	2,785,407	9.87%
19	DM without complications	4,235,412	15.00%
85	Congestive heart failure (CHF)	3,111,271	11.02%
86	Acute myocardial infarction (MI)	273,381	0.97%
108	Vascular disease	3,453,434	12.23%
111	Chronic obstructive pulmonary disease (COPD)	2,013,836	7.13%

It is imperative to note that local and regional factors will influence local comparisons. Information should be used directionally and not as an absolute.

Relative Diabetes Prevalence
2021 Report to Congress

- Diabetes with Acute Complications
- Diabetes with Chronic Complications
- Diabetes without Complications

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CMS Data Portal

- On a monthly basis, CMS publishes a series of data points that can be leveraged to learn about market share, population growth, and payer performance. While it won't provide other system information, it can be used to understand the shifting landscape.

- Sample reports to review include:
  - MA state/county penetration
  - MA HEDIS public use files
  - Monthly enrollment by contract, plan, state, and county

Chicago Metro Area MA Enrollment
2018-2023

County Name	January 2018 MA Enrollees	January 2023 MA Enrollees	January 2023 MA Eligible Enrollees	January 2023 MA Penetration	5-Year Enrollee Growth Rate
Cook	219,452	312,877	844,870	37%	43%
DuPage	33,915	52,468	170,647	31%	55%
Will	24,044	38,032	113,086	34%	58%
Kane	17,994	27,502	85,642	32%	53%
McHenry	7,033	15,585	58,147	27%	122%
Kankakee	4,436	6,191	22,298	28%	40%
Kendall	3,387	5,414	18,022	30%	60%
DeKalb	3,321	4,089	16,875	24%	23%
Grundy	1,094	2,144	9,509	23%	96%

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MSSP/ACO Data Availability

- Annually, data is released on Medicare shared savings plans and other Medicare-based ACO program performance. The table below identifies the top 10 organizations with the most savings in the past two years. The average risk score in 2021 was 1.29. By comparison, the risk score for the bottom 10 (not shown) was 1.13.

NextGen ACO Performance: Top 10 Organizations with the Most Shared Savings
Performance Years 2020 and 2021

NextGen ACO Name	2020 Risk Score	2020 Savings	2021 Risk Score	2021 Savings	2-Year Savings
APA ACO, Inc.	1.59	$21,799,261	1.52	$48,841,361	$70,640,622
St. Luke's Clinic Coordinated Care, LTD	1.22	$25,679,914	1.19	$18,965,114	$44,645,029
CareMount ACO	1.22	$32,000,823	1.19	$10,513,935	$42,514,758
Trinity Health ACO, Inc.	1.24	$23,112,358	1.20	$15,974,587	$39,086,945
UT Southwestern Accountable Care Network	1.22	$30,945,618	1.18	$8,084,378	$39,029,996
Accountable Care Coalition of Southeast Texas	1.38	$30,338,720	1.39	$8,226,336	$38,565,056
Indiana University Health	1.25	$32,455,540	1.20	$3,693,847	$36,149,387
Reliant Medical Group, Inc	1.34	$19,314,854	1.32	$15,780,913	$35,095,767
Carilion Clinic Medicare Shared Savings	1.19	$18,179,526	1.15	$16,569,337	$34,748,862
Primary Care Alliance	1.48	$15,665,681	1.51	$18,158,504	$33,824,185

https://www.cms.gov/research-statistics-data-systems/next-generation-aco-model-ngaco-public-use-files

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Payers

- Obtaining data from payer partners is often more challenging. The best payer partners, however, want to ensure a win-win scenario. As such, organizations should explore what resources exist and work with payers to create additional local or regional benchmarking opportunities.
- Sample reports that payers can provider:
  - CMS Model Output Report (MOR): This will show what patients have which specific HCCs. This can be used for internal prevalence rate purposes and can be segmented by condition, provider, and clinic locations.
  - Monthly Membership Report (MMR): This report can provide a list of what patients are on your roster and the risk score for each patient.
- Additional side-by-side comparisons you should consider asking your payer to provide:
  - Percentage of patients without a visit this calendar year
  - Total RAF score
  - Prevalence of key conditions (e.g., COPD, diabetes, heart failure, vascular disease, etc.)
  - Annual wellness visit percentage

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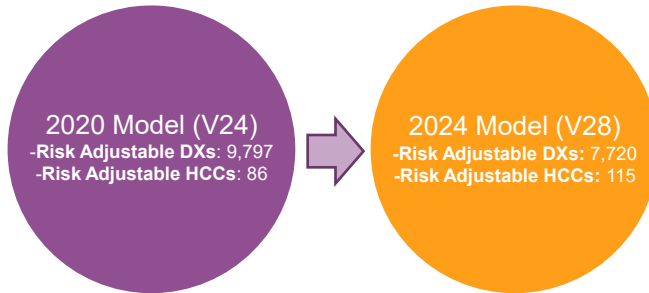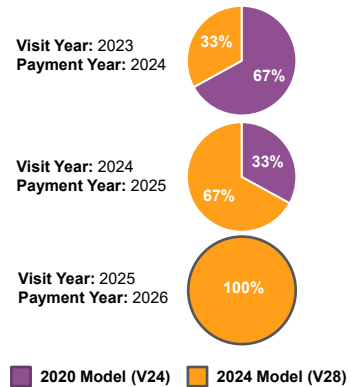
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Wrap Up

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Recapping Our Learning Outcomes

- Hopefully now you can:
  - Explain the current state of value-based care and the importance of risk adjustment
  - Apply best practice techniques to succeed in capturing chronic conditions in the ambulatory space
  - Assess current patient complexity relative to state and local comparisons

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Thank you. Questions?

Jason@Norwood.com

In order to receive your continuing education certificate(s) for this program, you must complete the online evaluation. The link can be found in the continuing education section of the program guide.

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