Moving To A Shared Risk Outpatient Performance Based Medicare Advantage Physician Payment Model

Presentation by

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The Impact of Reform

What will be the impact to our health system when this rule is modified?

“Pre existing conditions can no longer be screened for Insurance eligibility”.

EVERYTHING CHANGES!

Summary of Topics

- Medicare Reimbursement Trends
  - Risk Adjustment 101
  - Basic Calculation of Risk Adjustment Factors
  - Components Driving Payment
  - Sample Payment Calculations
- Connecting RAF, Quality & Reimbursement
  - Sample Scorecard
- HEDIS Stars Quality Measures
  - Sample STARS Report
- P4P Programs How they work
- Impact on Operations

A Clear Trend Toward Change

Congressional leaders' proposal would phase out Medicare fee-for-service

November 1, 2013 | By Zack Budryk

Read more: **Congressional leaders' proposal would phase out Medicare fee-for-service –** Plan aims to incentivize shared-savings programs and bundled services.

Commission: Phase out fee-for-service payment by 2020

Blended payment system said to improve care, cut costs

March 4, 2013 | By Julie Bird

Read more: **Stand-alone fee-for-service payment models should be phased out by the end of the decade** in favor of a blended payment system that would improve quality of care while reining in costs, according to a report issued today by the National Commission on Physician Payment Reform

Fee-for-service shift to new payment models a big change for docs

February 29, 2012 | By Debra Beaulieu

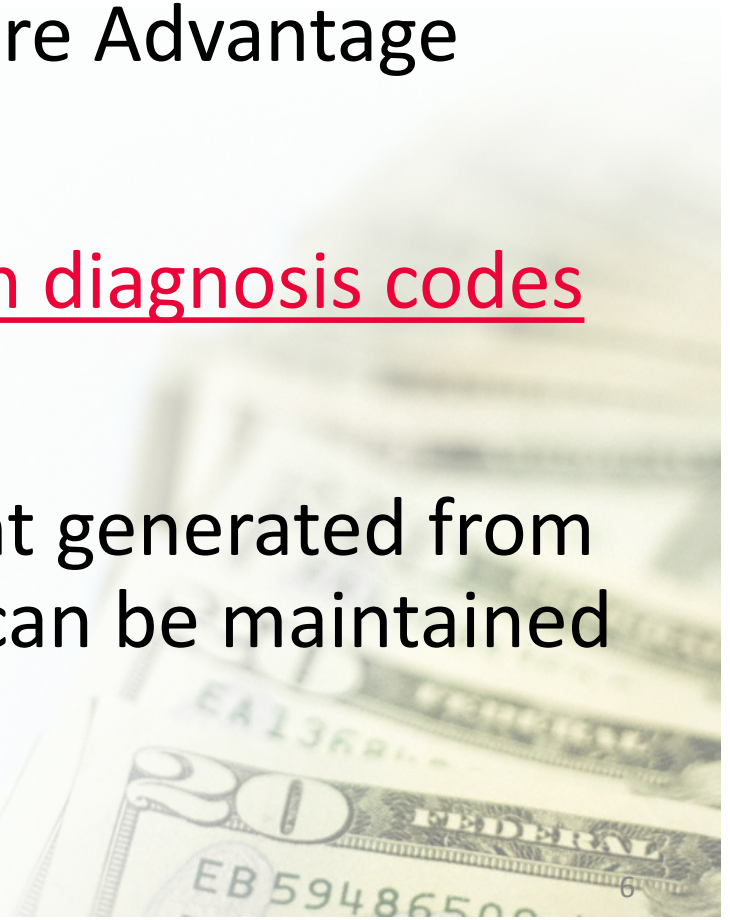
Read more: **If you're not already trying to navigate bundled payments, pay-for-performance, withholds and risk pools, capitation and shared savings, you will be soon.** Although many doctors still receive payments on a fee-for-service basis, there's no avoiding these radically different payment models. With an emphasis on lowering cost and improving quality,

The Future of Health Care…

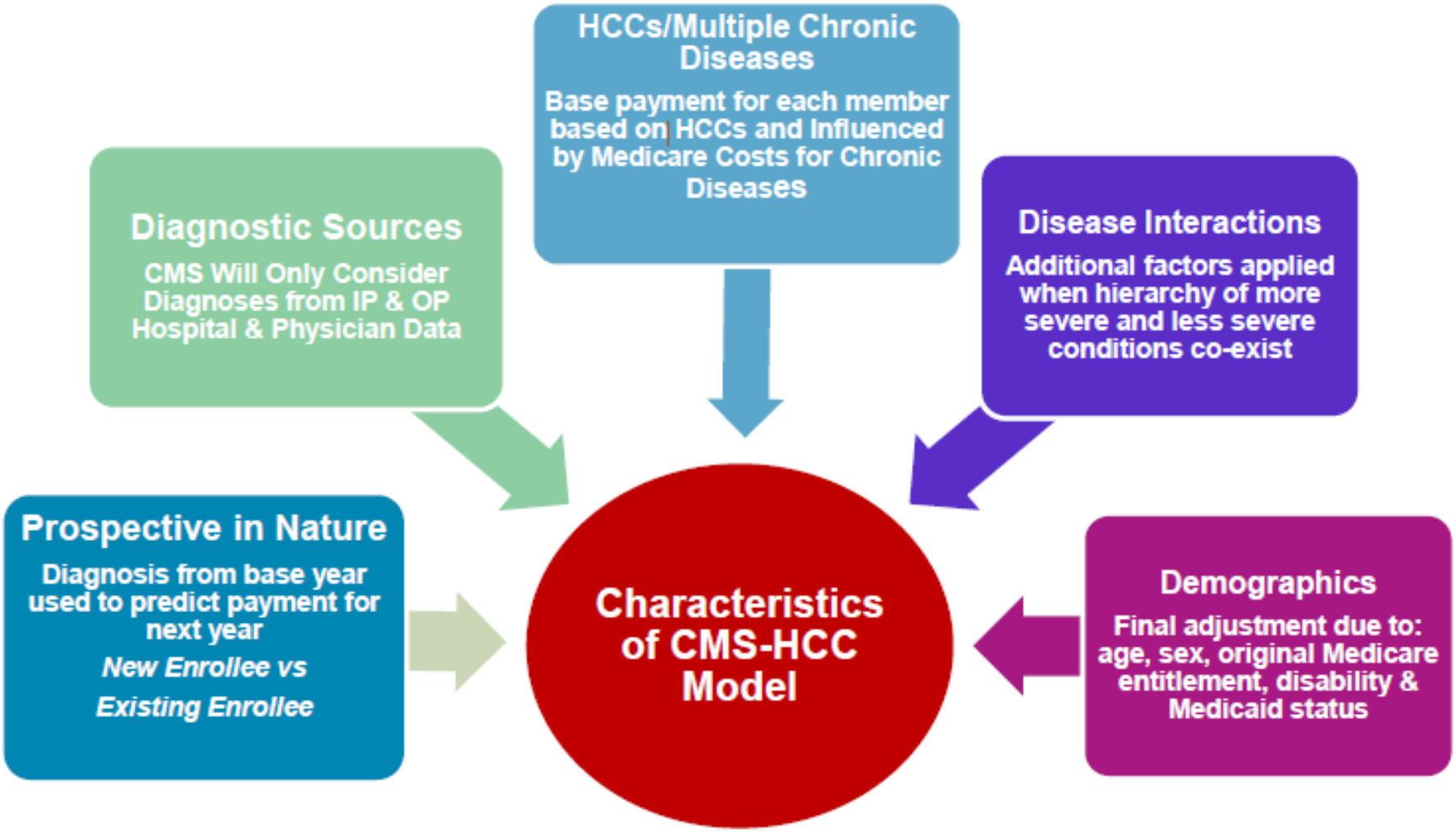
Schultz cartoon has been modified from the original.

The ABCs of Federal Reimbursement to the Health Plans

- Health plans are reimbursed based on the severity of disease for Medicare Advantage patients.
- Severity of disease is based on diagnosis codes submitted.
- The amount of reimbursement generated from CMS impacts what contracts can be maintained at today's level of payment.



RA 101 – Five Characteristics of CMS-HCC Model



Hierarchical Condition Category's (HCC)?

ICD-9 Diagnosis Code	ICD9-Description	CMS-HCC Model Category	CMS-HCC Model Calendar Year 2013 Payment
260	Kwashiorkor	21	Yes
261	Nutritional Marasmus	21	Yes
262	Oth Severe Malnutrition	21	Yes
2630	Malnutrition Mod Degree	21	Yes
2631	Malnutrition Mild Degree	21	Yes
2632	Arrest Devel D/T Malnutr	21	Yes
2638	Protein-Cal Malnutr Nec	21	Yes
2639	Protein-Cal Malnutr Nos	21	Yes
7994	Cachexia	21	Yes
4560	Esophag Varices W Bleed	25	Yes
4561	Esoph Varices W/O Bleed	25	Yes
45620	Bleed Esoph Var Oth Dis	25	Yes
45621	Esoph Varice Oth Dis Nos	25	Yes
5722	Hepatic Coma	25	Yes
5723	Portal Hypertension	25	Yes
5724	Hepatorenal Syndrome	25	Yes
5728	Oth Sequela, Chr Liv Dis	25	Yes
5712	Alcohol Cirrhosis Liver	26	Yes
5713	Alcohol Liver Damage Nos	26	Yes
5715	Cirrhosis Of Liver Nos	26	Yes
5716	Biliary Cirrhosis	26	Yes

Each ICD 9 has a HCC Risk Value

HCC 21 = .745

HCC 25 = 1.006

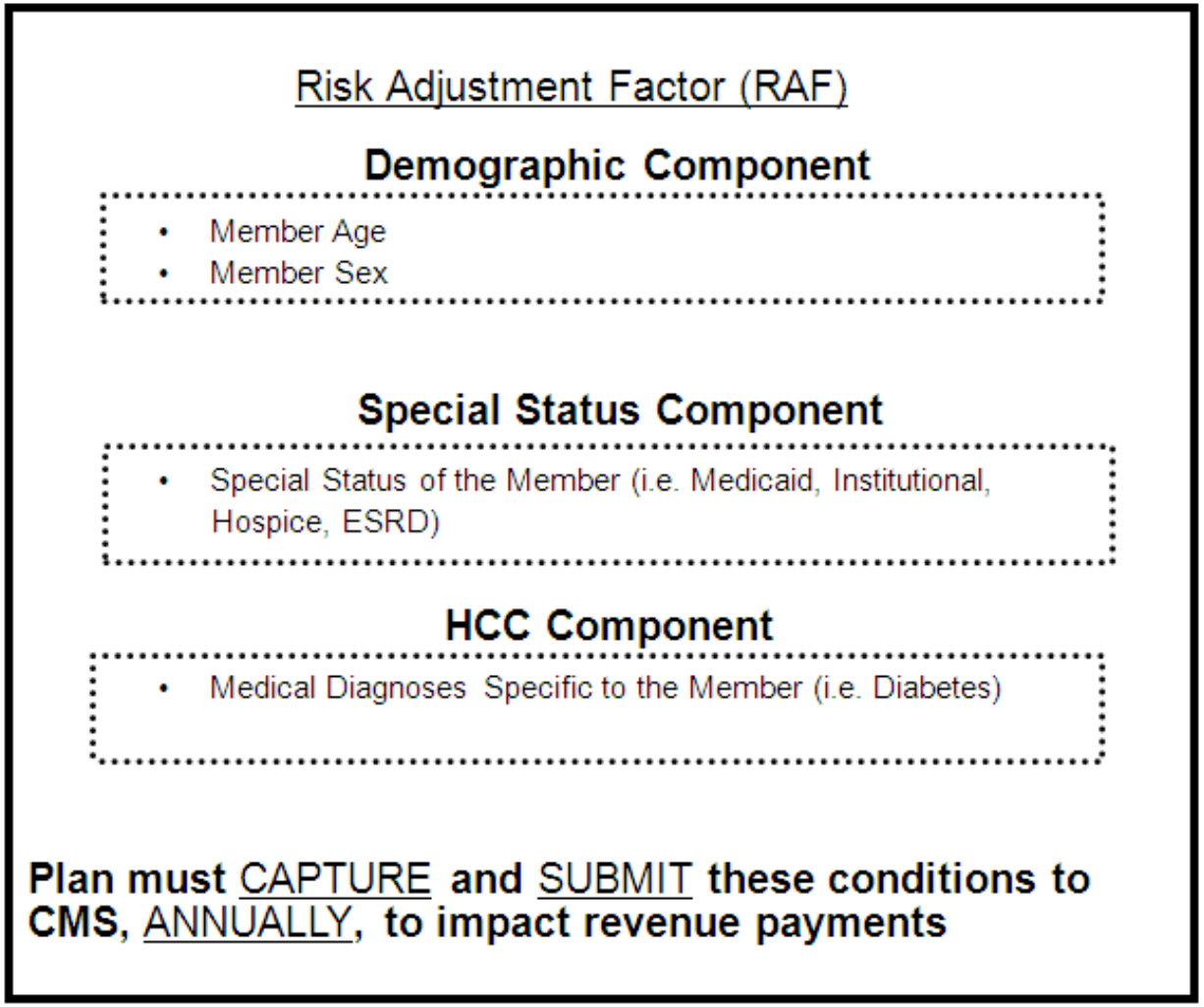
HCC 26 = .413

2013 - 70 disease categories; 2,916 diagnoses. A "risk factor" is assigned to each category.

2014 - 79 disease categories; 3,000+ diagnoses. A "risk factor" is assigned to each category.

RAF Calculation

Plan's monthly revenue payment from CMS is driven by a combination of where a member lives + age/sex + special status + medical diagnoses.



2013 RAF Coding Example

All conditions coded appropriately		Some conditions coded – low level of specificity		No conditions coded	
76 year old female	0.457	76 year old female	0.457	76 year old female	0.457
Medicaid eligible (aged)	0.179	Medicaid eligible (aged)	0.179	Medicaid eligible (aged)	0.179
Diabetes w/vascular complications (HCC 15)	0.508	Diabetes w/o complications (HCC 19)	0.162	No diabetes coded	X
Vascular disease w/complications (HCC 104)	0.610	Vascular disease w/o complications (HCC 105)	0.316	No vascular disease coded	X
CHF (HCC 80)	0.410	CHF not coded	X	CHF not coded	X
Disease Interaction (DM + CHF)	0.154	No Disease Interaction	X	No Disease Interaction	X
Total RAF	**2.318**	**Total RAF**	**1.114**	**Total RAF**	**0.636**

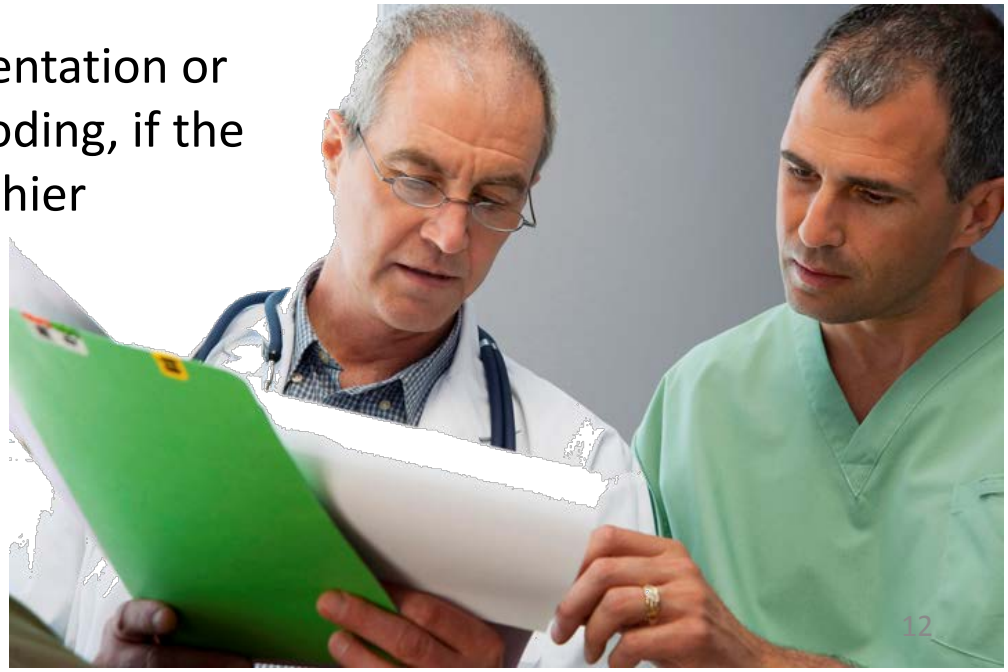
2013 RAF Coding Payment Example

All conditions coded appropriately		Some conditions coded – low level of specificity		No conditions coded	
Total RAF	2.318	Total RAF	1.114	Total RAF	0.636
County Medicare Rate* (Estimate)	$750	County Medicare Rate* (Estimate)	$750	County Medicare Rate* (Estimate)	$750
PMPM	$1,738	PMPM	$835	PMPM	$477
Annual Payment	$20,000	Annual Payment	$10,000	Annual Payment	$5,724
X 1000 Members	$20M	X 1000 Members	$10M	X 1000 Members	$5.7M

Interpreting Risk Adjustment Factor

- Risk adjustment factor or RAF score simply identifies patient health status
  - Lower RAF score indicates a healthier population

  OR
- A lower RAF score may also indicate the following issues
  - Lack of adequate chart documentation or complete, accurate ICD-9/10 coding, if the population is not actually healthier
  - Patients have not been seen
  - Poor quality of care.



Industry Trend

Blame game as insurers dump doctors

By Carl Campanile November 9, 2013

"We are working to collaborate with a more focused network of physicians to help us provide higher quality and more affordable health care coverage to meet the needs of our members, and help them get more from their health plan benefits".

Health Plans cut thousands of physicians from networks

By: Donna Marbury : NOV 19, 2013

Top healthcare insurance companies in the country are cutting at least 15% of physicians from networks due to "significant changes and pressures in the healthcare industry" by the end of 2014

Provider Scorecard - Key Indicators

Risk Adjustment Activities
2013 YTD Provider Progress Report

Client: **Medicare** Data Date: **9/3/2013**

Segment:

State:

Health System

Membership & MWOV

	2011	2012	2013
Members	3,829	3,719	4,318
MWOV %	4.4%	5.9%	11.5%
% HCC Recaptured	83.9%	81.4%	74.0%

Provider Scorecard - Key Indicators

Risk Adjustment Activities

2013 YTD Provider Progress Report

Client: **Medicare**

Segment:

State:

Data Date: **9/3/2013**

Health System

Prevalence [1]

Condition	2011	2012	2013	Literature Rate
CHF	-	11.2%	9.2%	16.8%
CKD Acute	-	13.1%	9.7%	38.1%
CKD Dialysis	-	1.2%	1.1%	1.3%
COPD	-	11.7%	8.8%	13.5%
Diab Wo Comp	-	15.2%	13.9%	11.2%
Diab Comp	-	8.5%	6.9%	15.4%
Diab Total	-	23.8%	21.0%	26.6%
Vascular	-	10.9%	7.7%	18.8%

Provider Scorecard - Key Indicators

Risk Adjustment Activities
2013 YTD Provider Progress Report

Client: **Medicare** Data Date: **9/3/2013**

Segment:

State:

Health System

Suspects

RAF Range	2011	2012	2013
0 To 0.999	797	915	1,202
1.000 To 1.999	155	219	306
2.000 To 2.999	28	28	45
3.000 To 3.999	5	3	10
>= 4.000	1	2	5
Total Suspects	986	1,167	1,568

Provider Scorecard - Key Indicators

Risk Adjustment Activities
2013 YTD Provider Progress Report

Client: **Medicare** Data Date: **9/3/2013**

Segment:

State:

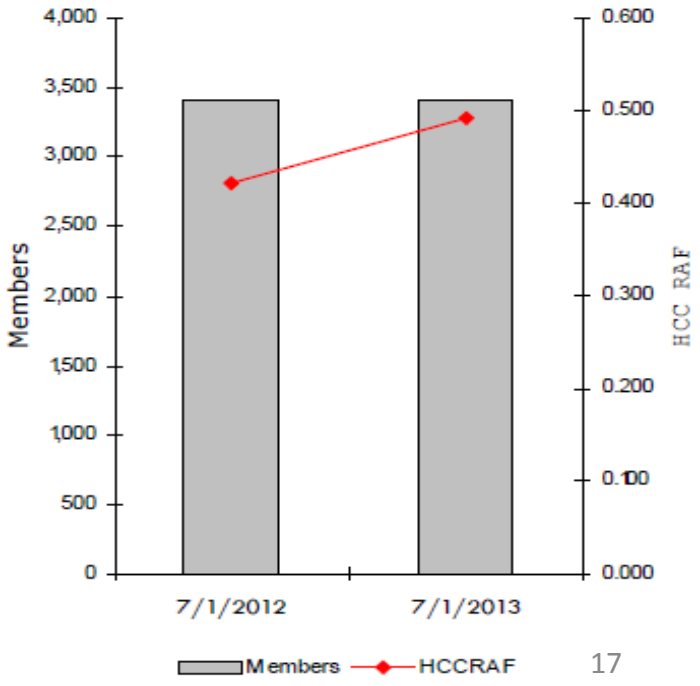
Health System

RAF Value

Date	Members[2]	RAF	HCC RAF
07/01/2013	4,292	0.907	0.449

Same Store RAF Value

Date	Members[2]	RAF	HCC RAF
07/01/2012	3,415	0.883	0.422
07/01/2013	3,415	0.951	0.492
Variance:		0.068	0.070



HEDIS Five Star Quality Rating System

The Five-Star Quality Rating System domains include:

DOMAINS	STAR MEASUREMENT GROUPING
Domain I	Staying Healthy: Screenings, Tests and Vaccines
Domain II	Managing Chronic (Long-Term) Conditions
Domain III	Plan Responsiveness and Care
Domain IV	Member Complaints, Problems Getting Services and Choosing to Leave the Plan
Domain V	Health Plan Customer Service

} Domains I, II and III impact clinical content

How Star Rating Domains Measure Clinical Care

Of the five Medicare Part C measurement groupings, Domains I, II and III have direct clinical content. Each of the measures in Domains I, II and III are sourced from nationally accepted Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, and Health Outcomes Survey (HOS) measurements.

HEDIS Five Star Provider Report

2013 STAR Rating Report - Your Clinic

Based on 2013 star methodology and HEDIS 2012

HEDIS data from 2011 dates of service with data collected 2012

StarID	Measure (red indicates not a star measure)	Star Weight	2 Star	3 Star	4 Star	5 star	Your Provider Group			
							Num	Den	Rate	Star
HEDIS ADMINISTRATIVE DATA MEASURES										
C01	Breast Cancer Screening	1	43	64	74	83	267	371	72	3
C05	Glaucoma Testing	1	54	62	70	74	1,536	2,281	67	3
C14	Osteoporosis Management	1	24	38	60	67	8	48	17	1
C20	Rheumatoid Arthritis Management	1	49	66	78	86	36	44	82	4
DM01	Access to Primary Care Doctor	0	NA	NA	NA	NA	3,701	3,883	95	0
C23	Plan All-Cause Readmissions**	3	17	13	11	3	46	389	11	4
HEDIS HYBRID DATA MEASURES		Expected & Observed Readmission Rates-->							*15.3%*	11.8%
C02	Colorectal Cancer Screening	1	35	51	58	67	22	35	63	4
C03	Cardiovascular Care – Cholesterol Screening	1	66	80	85	89	35	39	90	5
C04	Diabetes Care – Cholesterol Screening	1	69	81	85	90	38	40	95	5
C10	Adult BMI Assessment	1	25	50	61	80	30	34	88	5
C15	Diabetes Care – Eye Exam	1	47	54	64	81	33	40	83	5
C16	Diabetes Care – Kidney Disease Monitoring	1	78	82	85	90	39	40	98	5
C17	Diabetes Care – Blood Sugar Controlled	3	41	68	80	88	35	40	88	5
C18	Diabetes Care – Cholesterol Controlled	3	34	48	53	60	26	40	65	5
C19	Controlling Blood Pressure	3	43	53	63	70	25	31	81	5
HEDIS WEIGHTED AVERAGE							Weighted Average			4.41

HEDIS STAR Measure Example - Glaucoma

Glaucoma Screening

For CMS Star Reporting Year 2013

2013 Star Weight=1

Description: The percentage of Medicare Advantage plan members without a prior diagnosis, who received a glaucoma eye exam for early detection.

	Stars Threshold			
Performance	2 Star	3 Star	4 Stars	5 Stars
Benchmark	54	62	70	74

		Administrative Data Reported to CMS	
		All Group Totals	Your Provider Group
Current Results		65	67
Current Star		3	3
Variance from next level		5	3
Numerator - Administrative		11,706	1,536
Denominator- Administrative		17,878	2,281

Pay-for-performance Programs

Sample HEDIS P4P Measures:

- 12 HEDIS measures identified by CMS for 2013 (see below).

HEDIS Compliance Percentage Target:

- P4P programs set a level of compliance each HEDIS measure.
  The measures thresholds are typically set at or above the CMS 4-Star level.

	Measure	HEDIS Measure	HEDIS Compliance % Target
1	C01	Breast Cancer Screening	74%
2	C02	Colorectal Cancer Screening	58%
3	C03	Cardiovascular Care - Cholesterol Screening	85%
4	C04	Diabetes Care - Cholesterol Screening	85%
5	C05	Glaucoma Testing	70%
6	DMC12	Access to Primary Care Doctor Visits	85%
7	C14	Osteoporosis Mgt in women w/ fracture	60%
8	C15	Diabetes Care - Eye exam	64%
9	C16	Diabetes Care - Kidney disease monitoring	85%
10	C17	Diabetes Care - Blood sugar controlled	80%
11	C18	Diabetes Care - Cholesterol Controlled	53%
12	C20	Rheumatoid Arthritis Mgt	78%

Pay-for-performance Reimbursement Example

Performance Criteria:

– Physicians must achieve or exceed the HEDIS Compliance Percentage Target for at least six of the 12 HEDIS measures.

» In the event a physician has no customers identified as eligible for a particular HEDIS measure, that physician will be deemed to have met that measure.

Pay-for-performance Bonus:

- **Designed for providers to increase performance.**
- **Payment is based on a sliding scale and increases as more HEDIS Measure thresholds are met.**
- **Payment is earned as members are assessed.**

HEDIS Measure Thresholds met by provider	Payment for each customer in P4P Group
12	$100
11	$90
10	$80
9	$70
8	$60
7	$50
6	$40

Impact To Operations

- Risk Adjustment payments allow alternative care models such as medical home the flexibility to flourish.
- Groups engaging in shared risk models typically see increased revenue and costs in outpatient care and lower non-ambulatory admissions.
- Risk Adjustment models assume providers will perform with a higher level of accountability. Managing data to increase performance and lower risk is essential to success.
- Physician behavior is key to success. Consider:
  - Regular education to keep physicians up-to-date on current CMS guidelines for accepted documentation standards.
  - Building bonus incentives for good documentation into pay structures.
  - Use data and tools to help physicians perform.

Thank You. Questions?

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