

MAXIMIZING FINANCIAL PERFORMANCE UNDER VALUE- BASED CARE

A SPOTLIGHT ON CONTRACTING AND RISK ADJUSTMENT
THURSDAY, JUNE 8, 2023 | 1:00 PM - 2:00 PM EST

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Educational Webinar Series

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MAXIMIZING FINANCIAL PERFORMANCE UNDER VALUE-BASED CARE

A spotlight on contracting and risk adjustment

- In this session, learn about the three layers to adaptive VBC transformation:
1. Incorporating data infused goals in contract design
 2. Enhanced visibility into all VBC programs through real-time performance management
 3. Shifting risk adjustment upstream prospectively and with automation

INTRODUCING YOUR SPEAKERS

Experienced Partner Trusted by over 300 Leading Healthcare Organizations



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Mike Pattwell

Principal Business
Advisor



1050+
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TODAY'S VALUE-BASED CARE MODELS

Healthcare is at a tipping point in its transition to value-based care



BY 2030
100%
OF MEDICARE & MAJORITY OF MEDICAID BENEFICIARIES IN ACCOUNTABLE CARE



Medicare has designed a range of VBC programs

- Medicare Shared Savings Program (MSSP)
- Pioneer ACOs and Next Generation ACO
- ACO REACH Professional & Global (pka Direct Contracting)

For Medicaid, States use different terminology in referring to their Medicaid VBC initiatives – some examples

- PPS now HERO
- Collaborative Care Organizations (CCO)
- Medicaid ACO

CMS' recent strategic refresh intends for all Medicare beneficiaries and the vast majority of Medicaid beneficiaries to be in accountable, coordinated care relationships by 2030, and aims to support similar growth among commercially insured populations.

TODAY'S WEBINAR

Focusing on Provider Organizations providing value-based care today

QUESTION 1

Are you generating good results in value-based care models but you want to enhance your position in the future?

QUESTION 2

Are you preparing for newer value-based care models (downside risk, episodes of care, full capitation, etc.)?

QUESTION 3

Any concern that you may be leaving dollars on table? Do you need to advance your clinical coding with automation to address RAF challenges?

Understand how to be successful within all Value-Based Care contracts and what is required to build a strong data foundation with operational infrastructure utilizing automation.

VALUE-BASED CARE & RISK

VALUE-BASED CARE MODELS & RISK

Providers moving to advanced value-based care models is a process that takes time, effort and data

Category 1	Category 2	Category 3	Category 4
<p>Fee for Service</p> <p>No link to quality or value</p>	<p>Care Coordination Payments</p> <p>Helps cover new admin expenses.</p> <p>PROVIDER RISK</p>	<p>Shared Savings</p> <p>Participate in more complex arrangements.</p> <p>PROVIDER RISK</p>	<p>Condition-based Payments</p> <p>Helps cover new admin expenses.</p> <p>PROVIDER RISK</p>
	<p>Pay for Reporting</p> <p>Incentivize providers to report regular updates.</p> <p>PROVIDER RISK</p>	<p>Shared Risk</p> <p>Incentivize with some gains offset by shared risk.</p> <p>PROVIDER RISK</p>	<p>Partial Capitation</p> <p>Fully manage certain members, services, or LOBs.</p> <p>PROVIDER RISK</p>
	<p>Pay for Performance</p> <p>Incentivize providers to improve outcomes.</p> <p>PROVIDER RISK</p>	<p>Episodes of Care</p> <p>Incentivize with some gains.</p> <p>PROVIDER RISK</p>	<p>Full Capitation</p> <p>Full population risk for all assigned members.</p> <p>PROVIDER RISK</p>

Familiar

Feels Risky,
Complex

Adapted from the Health Care Payment Learning & Action Network Alternative Payment Model Framework

SUCCESSING IN VALUE-BASED CARE

Managing your population's health while mitigating the risks

Population Health

- Patient Engagement
- Patient Stratification
- Chronic Disease Management
- Clinical Integration
- Care Gaps
- Quality Measures







Financial Risk

- Pair Risk Adjustment with Payment & Regulatory Incentives Beyond Risk Coding
- Health Equity
- Provider Transparency

PROVIDER MATURITY MATRIX

Business sophistication level requirements for advancing models and taking on risk

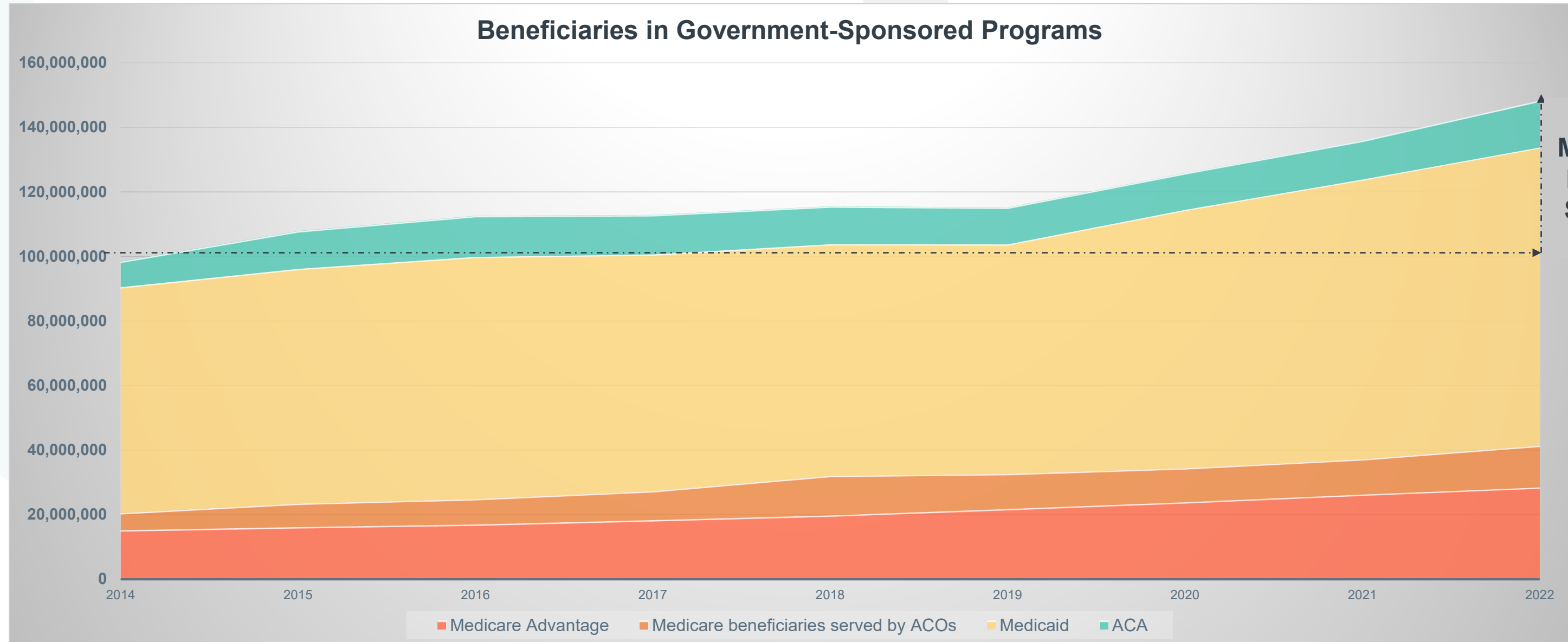
Payment Model	Examples	Technology	Operations	Data Excellence	Care Coordination	Risk Analytics
Category 1 	Fee for Service No link to quality or value	Basic	Basic	Basic	Basic	Basic
Category 2 	Care Coordination Payments Pay for Reporting Pay for Performance	Intermediate	Intermediate	Basic	Basic	Basic
Category 3 	Shared Savings Shared Risk Episodes of Care	Advanced	Advanced	Intermediate	Intermediate	Intermediate
Category 4 	Condition-Based Payments Partial Capitation Full Capitation	Advanced	Advanced	Advanced	Advanced	Advanced

Capabilities

Basic
 Intermediate
 Advanced

MARKET GROWTH & STRATEGIES OF HIGH- PERFORMING PROVIDERS

MARKET GROWTH BEYOND FFS



~50 Million Lives Since 2014

MA continues to grow: More than doubling over the past decade to **28M lives** + Medicare ACOs have grown to **cover over 13M lives** + State Medicaid VBC Through 1115 Waivers and DSRIP + Exchange (ACA) grew by **8%** in 2022 (YoY)

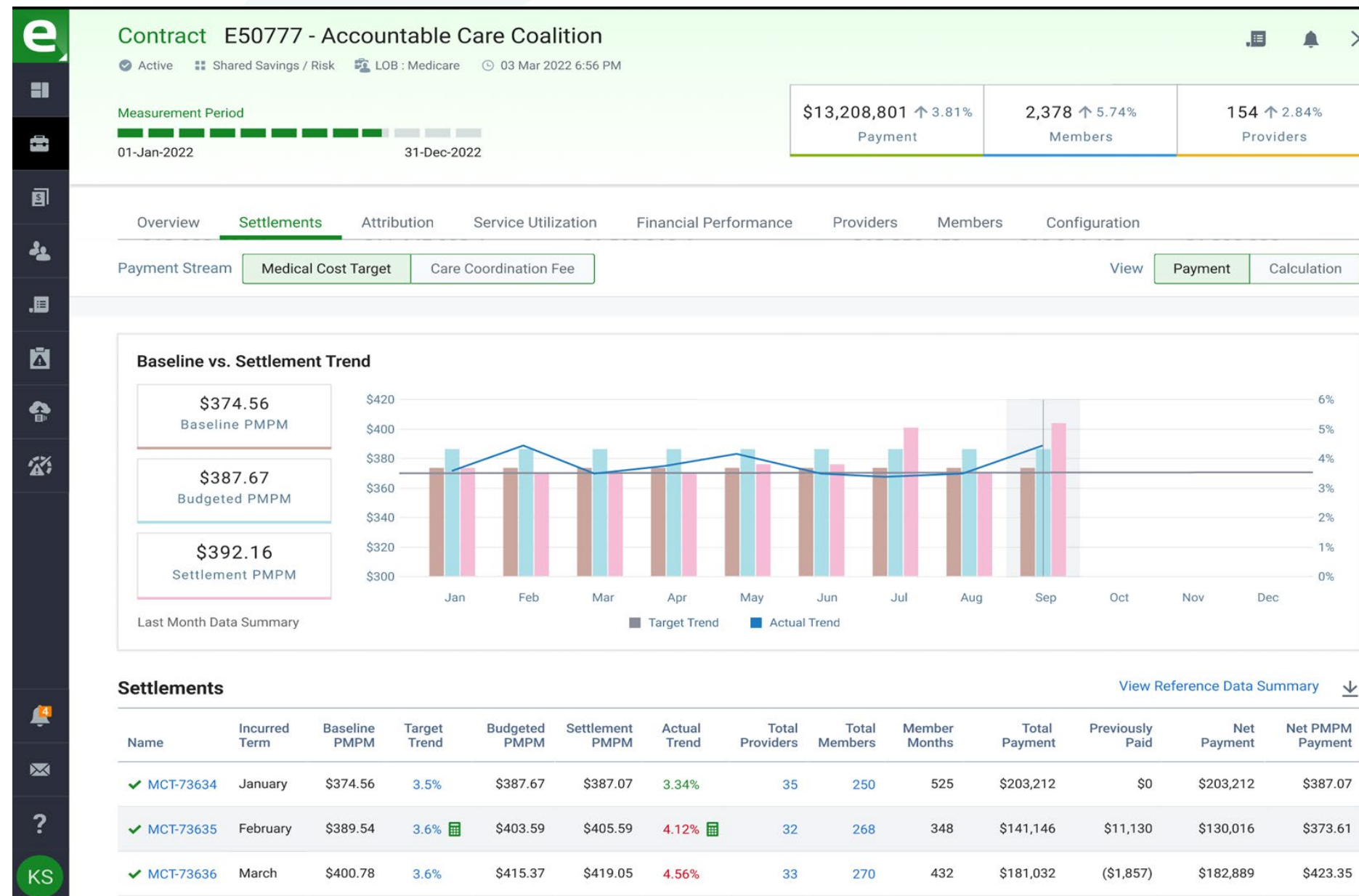
Source: <https://www.cms.gov>

TOP 3 INITIATIVES OF HIGHEST PERFORMING PROVIDERS



#1: Value-Based Care Contract Administration Excellence

- **Orchestrate and automate** all operational and analytical components of value-based programs
- **Utilize technology** with AI and NLP
- **Comprehensive patient profiles** to providers at the point of care
- **Provider education and training**
- **Increase specificity** of coding

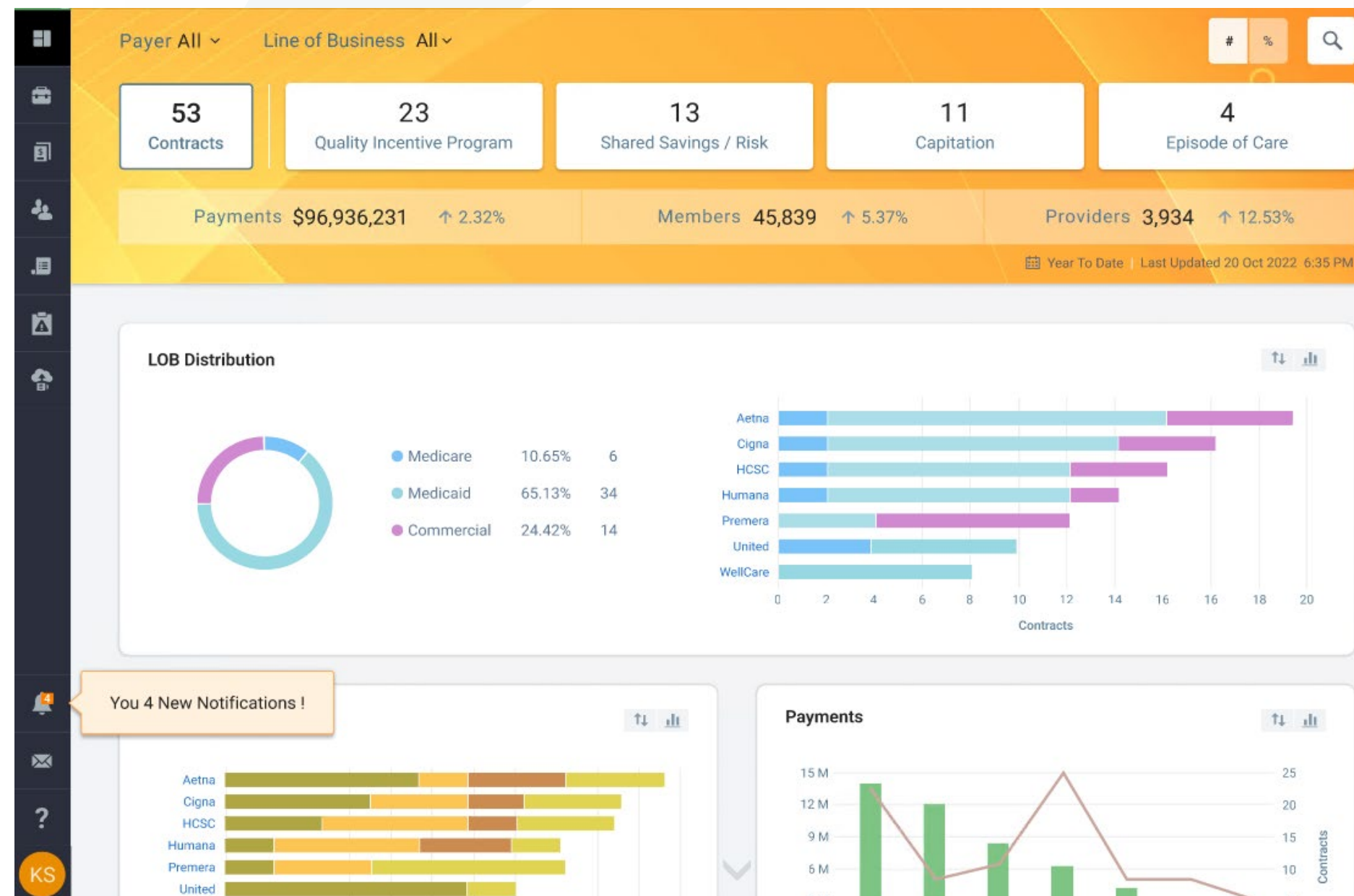


TOP 3 INITIATIVES OF HIGHEST PERFORMING PROVIDERS



#2: Real-Time Performance Management

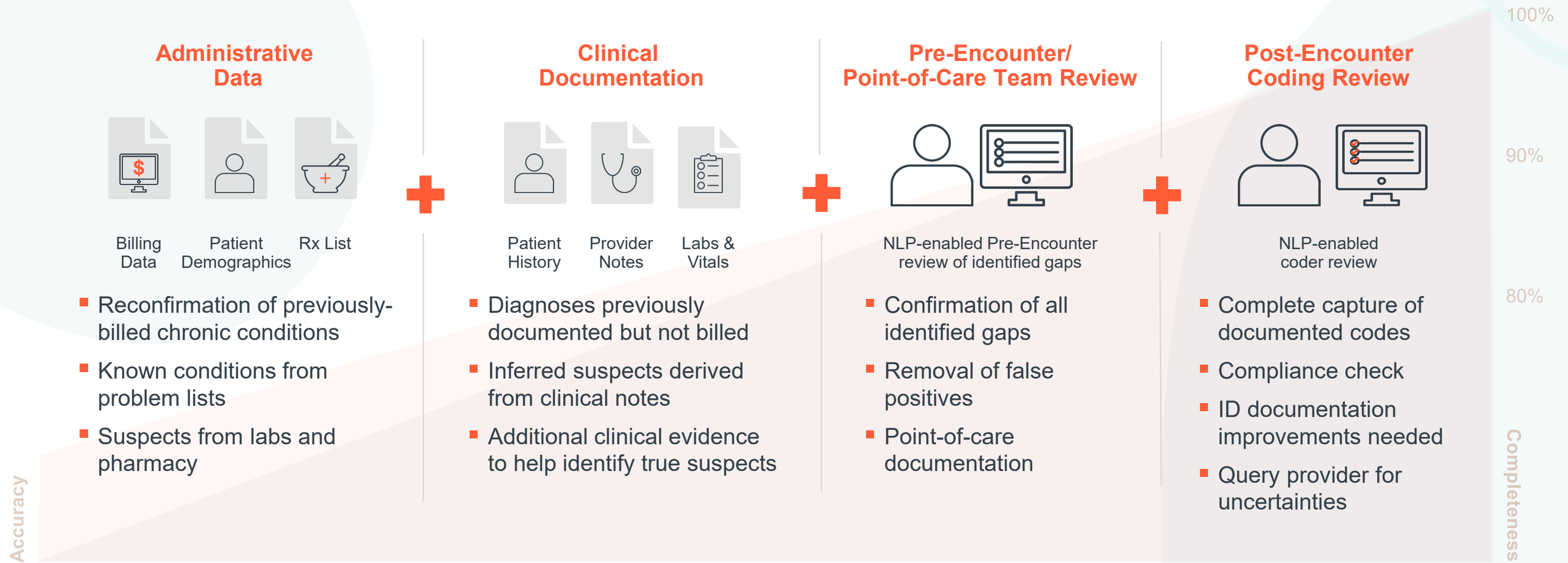
- **Improve visibility** of beneficiary outcomes, provider performance, or interactions with community-based organizations
- **Course correct** with near real-time insight into financial, quality, risk, and contractual performance



TOP 3 INITIATIVES OF HIGHEST PERFORMING PROVIDERS



#3: Drive Risk Adjustment Efficiency Upstream

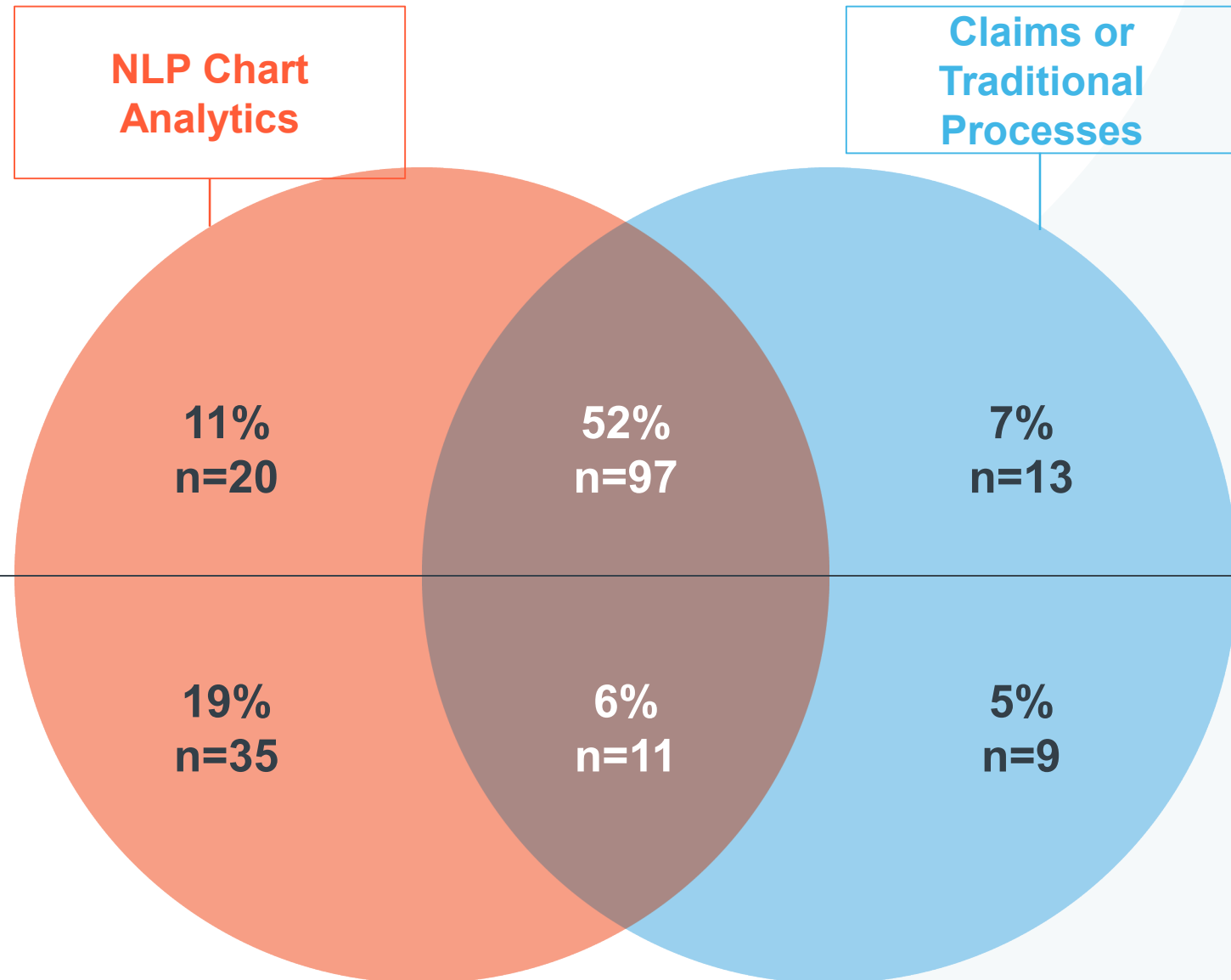


NLP-ENABLED SUSPECTING

Delivering better suspects that traditional processes

NLP can increase the average number of suspects per patient by **40%** compared to claims-only suspecting algorithms.

Chronic Conditions
Suspect Conditions



CMS HCC V24 VS. V28 RISK ADJUSTMENT

→ Changes to Hierarchical Condition Categories (HCCs)

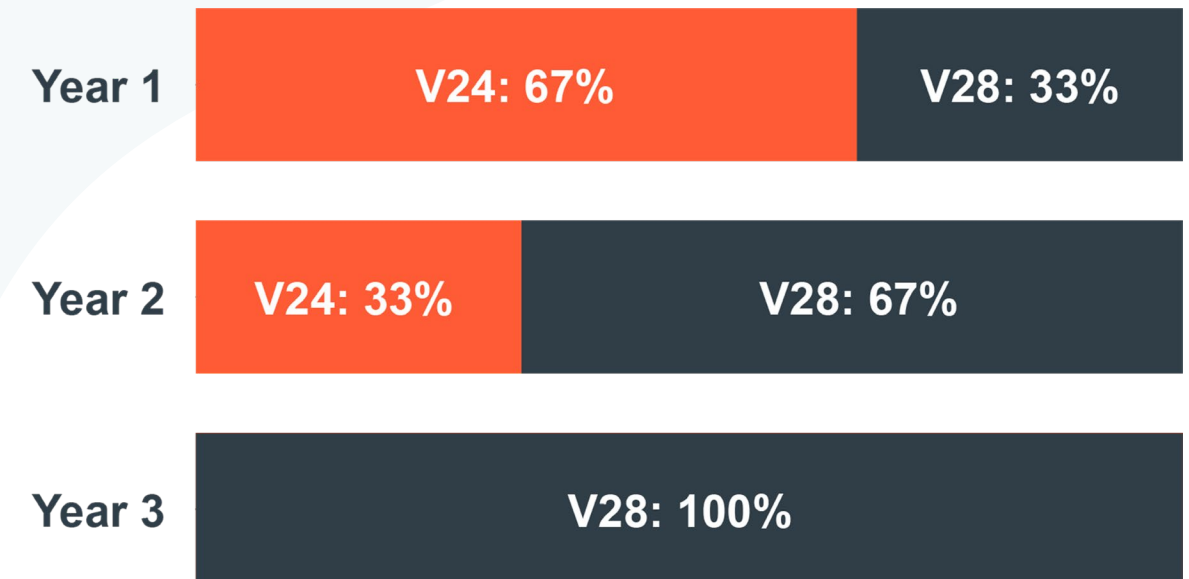
- Naming and numbering
- Coefficient Values

→ Expanded number of HCCs

- V24 – 86 HCCs
- V28 – 115 HCCs

→ Changes to the ICD-10-CM code to HCC mappings

- V24: 9,797 diagnosis codes
 - Removed 2,236 dx codes that will no longer map to a payment
 - + Added 209 dx codes that did not map to a payment CMS-HCC in V24
- V28: 7,770 diagnosis codes



Ensuring accurate and compliant coding will continue to be crucial for success

CMS RATIONALE OF CHANGES

CMS stated the rationale used to remove diagnosis considered the following:

- The inability of the condition to predict costs



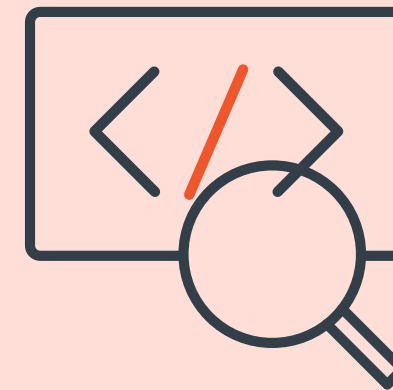
- The conditions in which coefficients were small or thought to be insignificant



- The conditions that were uncommonly seen



- The conditions with "well-specified" diagnostic coding criteria



CMS RATE ANNOUNCEMENT

Taking Action

PROVIDER

- Utilize technology in the form of AI and NLP
 - Provide comprehensive patient profiles to providers at the point of care
- Increase provider education and training
- Improve clinical documentation to drive increased specificity of coding



PAYER

- Utilize technology in the form of AI and NLP
 - Increase productive for chart reviews and claims validation
- Reassess expensive interventions (IHAs) for incremental value and compliance
- Provide support to provider partner so they can focus on improving health



ELEVATING VBC FINANCIAL PERFORMANCE

Edifecs' strategic approach provides data-driven insights *and* tools to drive better outcomes.

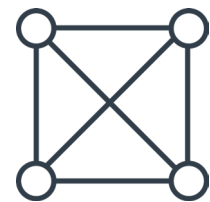
Current State

Contracting

- Limited modeling and design
- Disadvantaged in negotiations

APM Revenue

- Claims-centric
- Funding gaps from deficient data inputs and incomplete coding



INFORMED CONTRACT DEVELOPMENT

- Integrate clinical risk and SDoH datasets
- "What if" modeling and design
- Set performance expectations



REAL-TIME PERFORMANCE MANAGEMENT

- Orchestrate and automate
- Course correct
- Mitigate financial risk



PROSPECTIVE RISK ADJUSTMENT

- NLP and AI-derived insights
- Identify, diagnose, and code all current conditions
- Identify resolved conditions upstream

Future State

- Greater revenue integrity
- Enhanced visibility and control of value-based contracts
- APM program scalability
- Confidence to accelerate into downside risk

ABOUT EDIFECS

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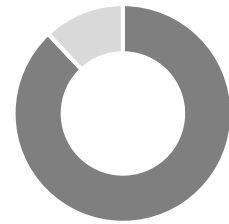


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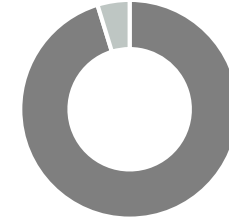


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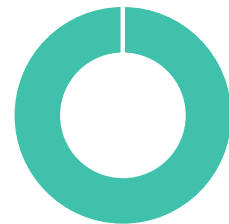
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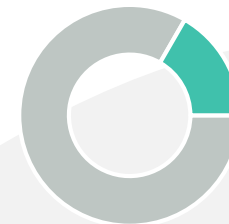
88%
U.S. Lives processed via
Edifecs platform



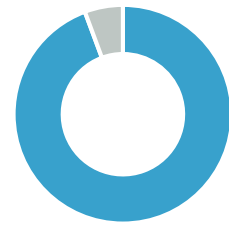
NLP Recall **>95%**



100%
National Health Plans



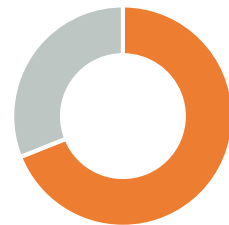
Increase RAF:
5%-20%



94%
BCBS Covered Lives



>25% increase in
suspected conditions



70%
State Medicaid Programs



1 HCC for every
2-5 patients analyzed



40%
Top Health Systems
by Revenue



Proven technologies
and models, not
conceptual untested ideas

Q & A

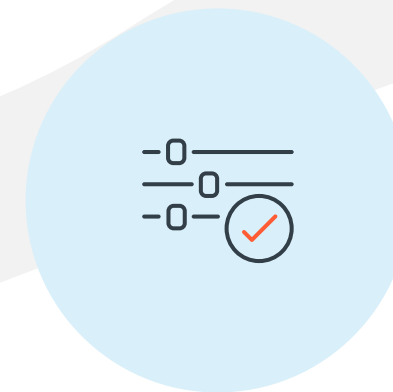
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To learn more or to schedule a consult with our national thought leaders on best practices to optimize your value-based payment or risk adjustment programs, please contact:



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THANK YOU!