HOW PROVIDERS & HEALTH PLANS CAN COLLABORATE TO MAXIMIZE REVENUE & QUALITY

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Educational Webinar Series

ATTAC CONSULTING GROUP

ABOUT US

Founded in 2003, ATTAC Consulting Group is recognized as a premier national consulting and auditing firm serving insurers, managed care and provider organizations on issues related to:

- Medicare Advantage
- Medicare Part D
- Medicaid
- Duals Programs
- ACOs
- Health Exchange (ACA) products

We specialize in:

- Risk Adjustment for Medicare Advantage, ACA Plans, Medicaid Plans & Risk-bearing Provider Groups
- Regulatory Compliance
- Medicaid Bids
- Provider Access Surveys
- Provider Network Development
- Operational Excellence, Business Transformation & Systems

SPEAKER INTRODUCTIONS

Charles Baker
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AGENDA

- What provider organizations should know about the latest trends in Star ratings, HEDIS measures and risk adjustment
- Risk adjustment exposure for health plans and providers
- How provider organizations can collaborate on quality initiatives to strengthen relationships with health plans
- Infrastructure and capabilities that provider organizations should develop to position themselves as valuable partners to health plans and enhance ACO results

POLLING QUESTION #1

- **How familiar are you with quality & risk-related requirements (e.g. HEDIS, medication compliance) for Managed Care Orgs (MCOs) & Accountable Care Orgs (ACOs)? (Select one)**
  - **Very**
  - **Moderately**
  - **Not at all**

WHAT PROVIDER ORGS SHOULD KNOW ABOUT TRENDS IN STAR RATINGS & RISK ADJUSTMENT

- Changes in updated 2024 CMS Star Ratings and Risk Adjustment modeling puts more pressure on quality of care to drive down total cost of care
- Providers are being held more accountable for complete and accurate documentation
- Increased focus on health equity and SDoH measures

FOCUS ON THE PATIENT

Quality, Quality, Quality

WHAT PROVIDER ORGS SHOULD KNOW ABOUT TRENDS IN STAR RATINGS & RISK ADJUSTMENT

- **The average performance for 2024 Star Ratings declined by approx. 0.25 stars from previous year**
  - **Controlling blood pressure measure weighting increased to triple-weight**
  - **Plan all-cause readmission returned to ratings**
  - **Added transitions of care and retired stand-alone medication reconciliation post-discharge measure**
  - **Added follow-up after ED visit for people with high-risk multiple chronic conditions**
- **Implementation of Health Equity Index**
  - **Understanding SDoH impacts and ZCode documentation for social risk factors**

WHAT PROVIDER ORGS SHOULD KNOW ABOUT TRENDS IN HEDIS & RISK ADJUSTMENT

- HEDIS measures tie providers and health plans together to improve quality and total cost care
  - Focus on equity: HEDIS is placing a greater emphasis on equity, aiming to close care gaps and make care more equitable across diverse patient populations
- Understanding HHS-HCC and CMS-HCC models is crucial for providers to ensure accurate coding and documentation, which directly impact reimbursement
  - Given CMS's recent final rules and changes in Risk Adjustment methodology, accuracy is crucial; documentation must show complete/accurate record of each patient’s medical history and face-to-face encounters with physicians
  - M.E.A.T. (Monitoring, Evaluation, Assessment, Treatment)

RISK ADJUSTMENT EXPOSURE FOR HEALTH PLANS & PROVIDERS

- Health plans rely on providers for Risk Adjustment and quality initiatives, which have significant impact on plan revenue, resources and compliance. Plans need providers to:
  - See the member
  - Understand and address potential gaps in diagnosis or care
  - Properly document encounter (diagnosis / services provided)
  - Follow-up with members
- Providers contract with health plans for member flow, rate structure protection, contractual terms, past performance/reputation of plan
- This symbiotic relationship enables both to successfully provide healthcare services; but when issues arise, both will likely be impacted

OFFICE OF INSPECTOR GENERAL AUDITS

- **The OIG is actively auditing Medicare Advantage plans targeting Dx codes considered at high risk of being miscoded for Risk Adjustment purposes**
- **Between February 2021 & November 2023, the OIG issued reports for 31 health plans**
  - **Audits covered contract years 2015, 2016, 2017, 2018**
  - **Overpayment for sampled data = $10.4M covering 4,227 member years**
  - **Extrapolated overpayment estimate of more than $581M**
- **OIG audits are continuing and the financial risk to plans is increasing through the extrapolation rule**

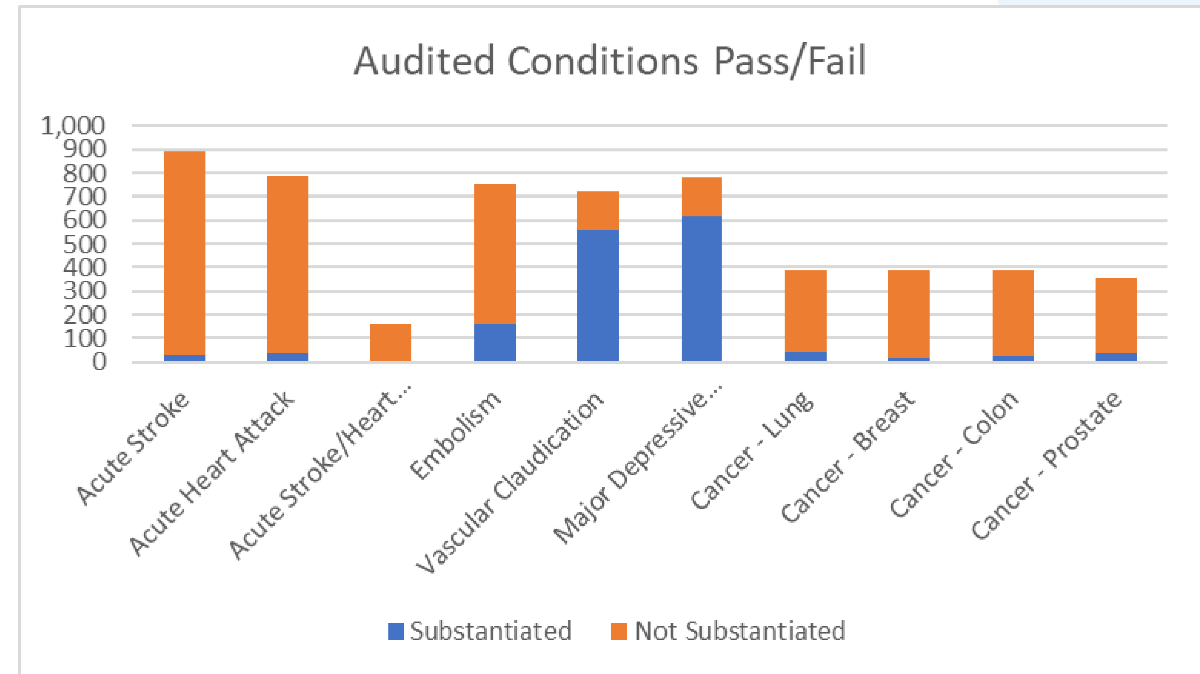
OIG audits analyze standard CMS Risk Adjustment files already in its possession to identify plans for audit based on observed data patterns

OIG AUDITS | TARGETED CONDITIONS

- Generally, the OIG is evaluating:
  - Acute stroke and/or acute heart attack in single Dx in physician office setting and/or with no hospitalization
  - Major depressive disorder, embolism – single Dx with no corresponding appropriate Rx therapy
  - Vascular claudication – single Dx with no other in prior Dx (two years) and Rx for neurogenic claudication
  - Cancers – single Dx with no treatment +/- 6-month window

OFFICE OF INSPECTOR GENERAL AUDITS

- Reported an aggregate substantiation (pass) rate of 26.5%
- Samples were selected from a universe of more than 165,000 suspect cases
- 1,538 out of 5,636 substantiated across the 10 condition scenarios
- More than 72% of audited cases failed to be validated
- Factoring out major depressive disorder & vascular claudication, more than 91% of sampled cases failed to be validated

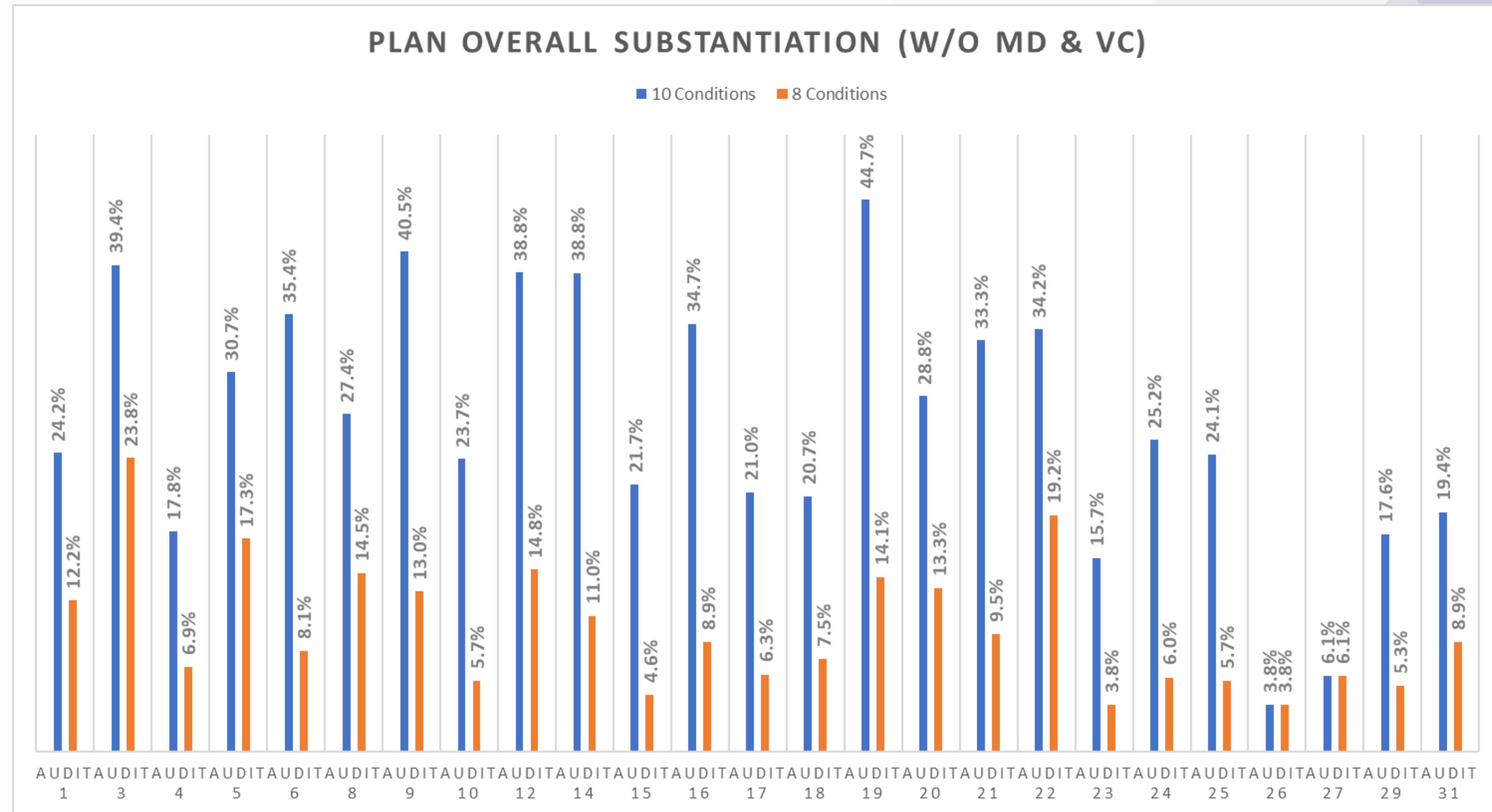


OIG AUDIT FINDINGS | CURRENT AUDITS

Without major depressive & vascular claudication * substantiation rates ranged from 3.8% to 23.8%

The best performing plan was able to substantiate 1 out of 4 sample cases

***Note – In the most recent audits, the OIG dropped review of major depressive disorder & vascular claudication**



OIG AUDIT IMPLICATIONS FOR PROVIDERS IN VALUE-BASED & RISK-SHARING CONTRACTS

- As the OIG and CMS pursue reimbursement, this can have implications to providers under value-based agreements with health plans
  - Flow-down or pass-thru provisions: If MCOs are required to reimburse CMS for improperly claimed payments, MCOs may pass impact to attributed providers; this could apply to capitation payments, quality payments, and possibly liquidated damages clauses
  - Overpayments have been alleged up to 8 years after payment; this requires *reserves* for any financial exposure

OIG AUDIT IMPLICATIONS FOR PROVIDERS IN VALUE-BASED & RISK-SHARING CONTRACTS

- Methods to Mitigate
  - Administrative
    - Establish methods to detect and address these and similar outlier cases
    - Establish tools to measure patient compliance with care plans
  - Health plan collaboration
    - Review contracts for audit-related clauses
    - Determine approach to collaborate with plans in event of audit findings
    - Proactively collaborate with health plan to identify and address suspect cases
  - Quality of care
    - Follow-up with members on care plans
    - Medication adherence follow-up
    - Access or scheduling issues

POLLING QUESTION #2

- **How confident are you in understanding the impacts of risk adjustment on your organization? (Select one)**
  - **Very**
  - **Moderately**
  - **Not at all**

HOW PROVIDER ORGS CAN COLLABORATE ON QUALITY INITIATIVES TO STRENGTHEN RELATIONSHIPS WITH HEALTH PLANS

- **Mutual Objectives and Joint Governance**
  - Establishing mutual objectives is crucial; clearly defining a road map for success via metrics and data enables providers to focus on key performance indicators
  - Joint governance structures, like steering committees, can be set up to develop operating rules, roles, and scope of collaboration
- **Communication and Expectation-setting**
  - Clear Communication: Set expectations about what's needed from health plan for physicians to be successful
  - Request Support: Includes technical support, data feeds, staff augmentation and support, and analytics/reporting

HOW PROVIDER ORGS CAN COLLABORATE ON QUALITY INITIATIVES TO STRENGTHEN RELATIONSHIPS WITH HEALTH PLANS

- Data Exchange and Collaboration
  - Sharing clinical and claims data allows both parties to access and mine intelligence, moving towards collaborative management of individual patients and populations
  - Successful collaboration relies on leadership and reimbursement realignment, a thorough operating model, and integrated data systems for Risk Adjustment

HOW PROVIDER ORGS CAN COLLABORATE ON QUALITY INITIATIVES TO STRENGTHEN RELATIONSHIPS WITH HEALTH PLANS

- **Enhance Coordination and Care Management**
  - **Leverage technology for collaborative care management, using software with interface features accessible to both internal team members and external providers; this fosters full collaboration and improves patient healthcare journeys**
  - **Optimize roles and responsibilities: Understand and optimize roles of care management team members including utilization reviewers, care managers, social workers, and administrative staff**

POLLING QUESTION #3

- What are the top challenges you face to establish/maintain a contractual relationship between a health plan & provider organization? (Select all that apply)
  - Finding the right decision maker
  - Demonstrating value-add your org brings to the table
  - Agreeing on reimbursement terms
  - Understanding contractual obligations (claims, quality, authorization guidelines)
  - Other

INFRASTRUCTURE & CAPABILITIES PROVIDER ORGS SHOULD DEVELOP TO BE POSITIONED AS VALUABLE PARTNERS TO HEALTH PLANS & ENHANCE ACO RESULTS

- Quality, Quality, Quality
- Provider Data Accuracy and Maintenance
- Network Adequacy and Coverage
- Access and Availability
- Communications and Engagement
- Value-based Reimbursement and Reasonable Contract Terms – look at the opportunity (incentives/penalties)

INFRASTRUCTURE & CAPABILITIES PROVIDER ORGS SHOULD DEVELOP TO BE POSITIONED AS VALUABLE PARTNERS TO HEALTH PLANS & ENHANCE ACO RESULTS

Quality Management
Health plan and ACO measures vary

Data Management
Health plan and ACO data needs vary

Practice Management
Staff communications and training

Community Engagement
SDoH, community-based, home and community-based providers

Data Integration
Know how you're performing

QUESTIONS

Please send questions via webinar control box or contact us directly

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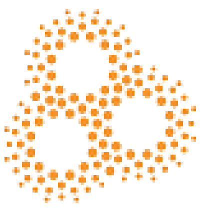

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