The Medicare Advantage V28 Transition

What we've learned in year 1

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Educational Webinar Series

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Presenter

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- 13 years in healthcare
- Actuarial work
- Provider engagement
- Risk adjustment leadership for vendors and health plans

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Outline

- Medicare Risk Adjustment primer
- What is V28 and how did we get here?
- How do our old strategies work in the new world?
- What is the data telling us about appropriate strategies?

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Polling Question

Medicare risk adjustment primer

Ted is a 66-year-old male with no chronic conditions

Risk score ~0.250

CMS analyzes their FFS data and finds:

1. Across all Medicare FFS lives, the average cost to provide benefits is $800 per month
2. For males between 65 and 70 with no chronic conditions, the cost is about 25% of the average or $200 per month

If Ted enrolls in Medicare Advantage, CMS will provide the MAO* with up to $200 per month to cover his care.

The objective of this program is to incentivize the MAO to take care of Ted for *less than* $200 per month.
Any savings generated will be split between CMS and the **member** in the form of richer benefits from the MAO.

*MAO = Medicare Advantage Organization

Medicare risk adjustment primer

A physician finds Ted has peripheral vascular disease (I739)

New risk score ~0.500

CMS analyzes their FFS data and finds:

1. People with diagnoses in the vascular disease category typically cost an additional $200 per month
2. In turn, the new expected cost to care for Ted is $400 per month

If Ted enrolls in Medicare Advantage, CMS will now provide the MAO with up to $400 per month to cover his care.

Prior to V28, the expected cost of care was based on CMS' analysis of FFS members that were diagnosed with vascular disease.

Risk Adjustment Theory vs Reality

If MAOs can better manage the cost of care for patients, this approach makes sense.

- Total cost of the program is reduced
- Members get richer benefits with less out-of-pocket costs

In practice, what's happening is

- the MAO is managing the cost
- ***and*** finding far more people with vascular disease

CMS wants to reward MAOs for ***managing*** the care of patients, not simply identifying them
V28 attempts to solve for this

V28 Overview

Rather than using FFS members, CMS is now using MA data to estimate expected costs.

The outcome critical to our discussion today is

For conditions prone to be under-diagnosed in FFS (or diagnosed at a higher rate in MA) the risk impact has been greatly reduced or removed altogether

For a deeper dive into the changes in V28, see our previous webinar here

Polling Question

V28 Market Disruptions

Range of impacts to overall risk score

MA plans often run at a 3% margin. If this reduction can't be mitigated, it will result in a combination of:

- Higher member-paid premiums
- Reduction in supplemental benefits
- Reduction in overall admin costs (including vendors)

How can this be mitigated?

Legacy Strategies

Medical Record Retrieval & Review

Historically, these initiatives increase plan risk by between 2% and 5%

In the V28 model, the impact of these programs is reducing by 10% to 30%

Example - Health plan with ~20K members

- Performed MRR on 2022 DOS and generated $6.5M
- In the V28 model, this same project would have been worth $5M
- The cost of the project was ~$1M
- This represents a 27.3% drop in net ROI

In-Home Assessments

Historically, these initiatives increase plan risk by between 1% and 5%

In the V28 model, the impact of these programs is reducing by 20% to 50%+

Example - Health plan with ~15K members

- Small scale IHA project in 2022 DOS generated ~$650K
- In the V28 model, this same project would have been worth $300K
- The cost of the project was ~$100K
- This represents a 63.6% drop in net ROI

Recommendations on legacy strategies

These strategies are **still valuable**, but they have less leverage. We recommend you augment these programs by:

1. Being more targeted. Find partners that will help reduce costs without impacting revenue.
2. Consider how these programs fit into your long-term strategies.

Unfortunately, this will not be enough to mitigate the drop in revenue for most.

So, our analytics team went on an adventure to try to find what strategies would work.

Differential Diagnoses

Top 20 most prevalent dx being dropped in V28

DxCode	DxDescription	Disease Category	V24 HCC	Prevalence per K
I700	Atherosclerosis of aorta	Vascular	108	193.6
I739	Peripheral vascular disease, unspecified	Vascular	108	111.6
D692	Other nonthrombocytopenic purpura	Blood	48	77.3
D696	Thrombocytopenia, unspecified	Blood	48	43.2
F330	Major depressive disorder, recurrent, mild	Psychiatric	59	38.2
D6869	Other thrombophilia	Blood	48	35.0
I209	Angina pectoris, unspecified	Heart	88	34.8
G319	Degenerative disease of nervous system, unspecified	Cognitive	52	32.9
M461	Sacroiliitis, not elsewhere classified	Musculoskeletal	40	26.9
I471	Supraventricular tachycardia	Heart	96	24.2
F320	Major depressive disorder, single episode, mild	Psychiatric	59	24.2
I779	Disorder of arteries and arterioles, unspecified	Vascular	108	23.8
F339	Major depressive disorder, recurrent, unspecified	Psychiatric	59	23.5
I25119	Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris	Heart	88	23.4
N2581	Secondary hyperparathyroidism of renal origin	Metabolic	23	22.1
I77810	Thoracic aortic ectasia	Vascular	108	21.2
E213	Hyperparathyroidism, unspecified	Metabolic	23	20.2
I25118	Atherosclerotic heart disease of native coronary artery with other forms of angina pectoris	Heart	88	17.8
G63	Polyneuropathy in diseases classified elsewhere	Neurological	75	17.3
E7211	Homocystinuria	Metabolic	23	16.5

Closing gaps by more efficient means

The ideal, most efficient way to close a gap is for the member's PCP to document that condition during an annual visit. But this doesn't happen to an alarming extent.

Why do seemingly so many HCC gaps go undocumented in a year of service?

Chronic Recapture Rate Analysis

Methodology: Using MAO-004s identify chronic conditions captured in 2021 DOS and indicated which diseases were redocumented in 2022.

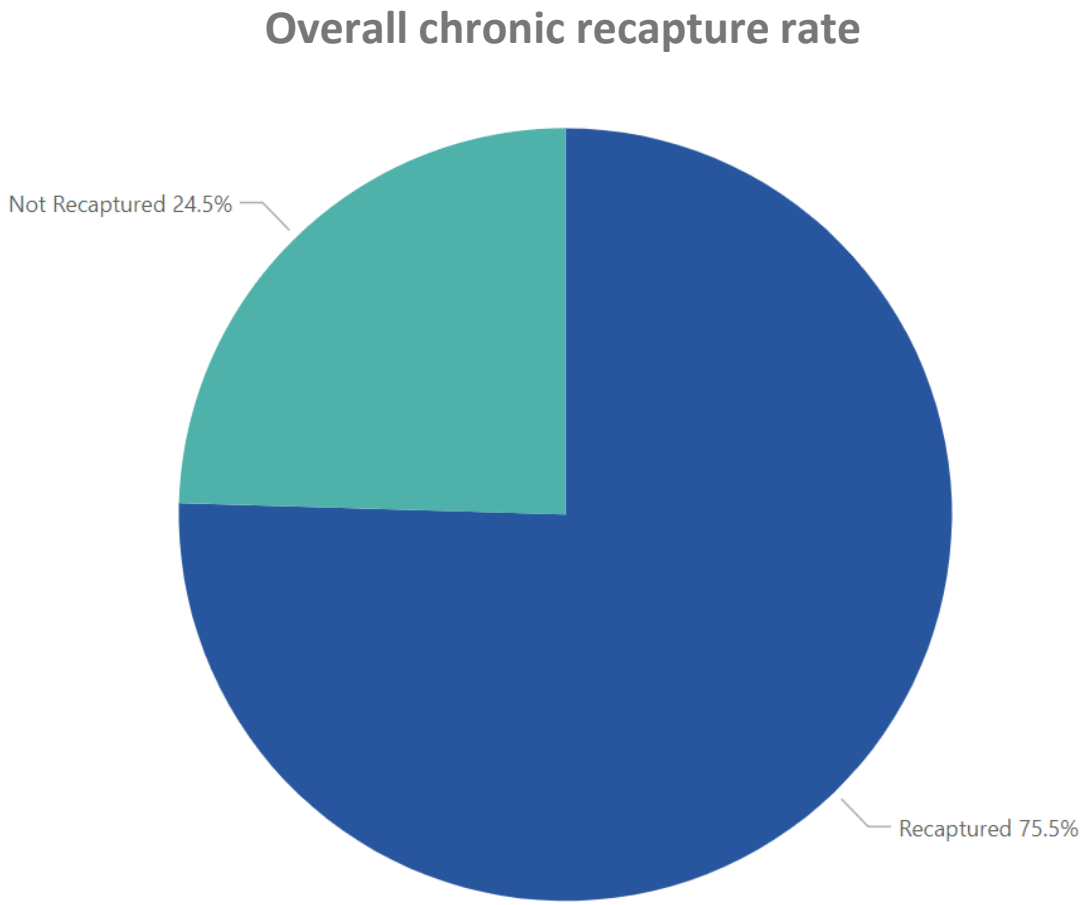
- Chronic indicator determined at the dx-level with a conservative approach
- If *any* condition in the same hierarchy family is documented, consider it recaptured
- Only include members enrolled for the full 24 months of 2021 & 2022

Our research question:

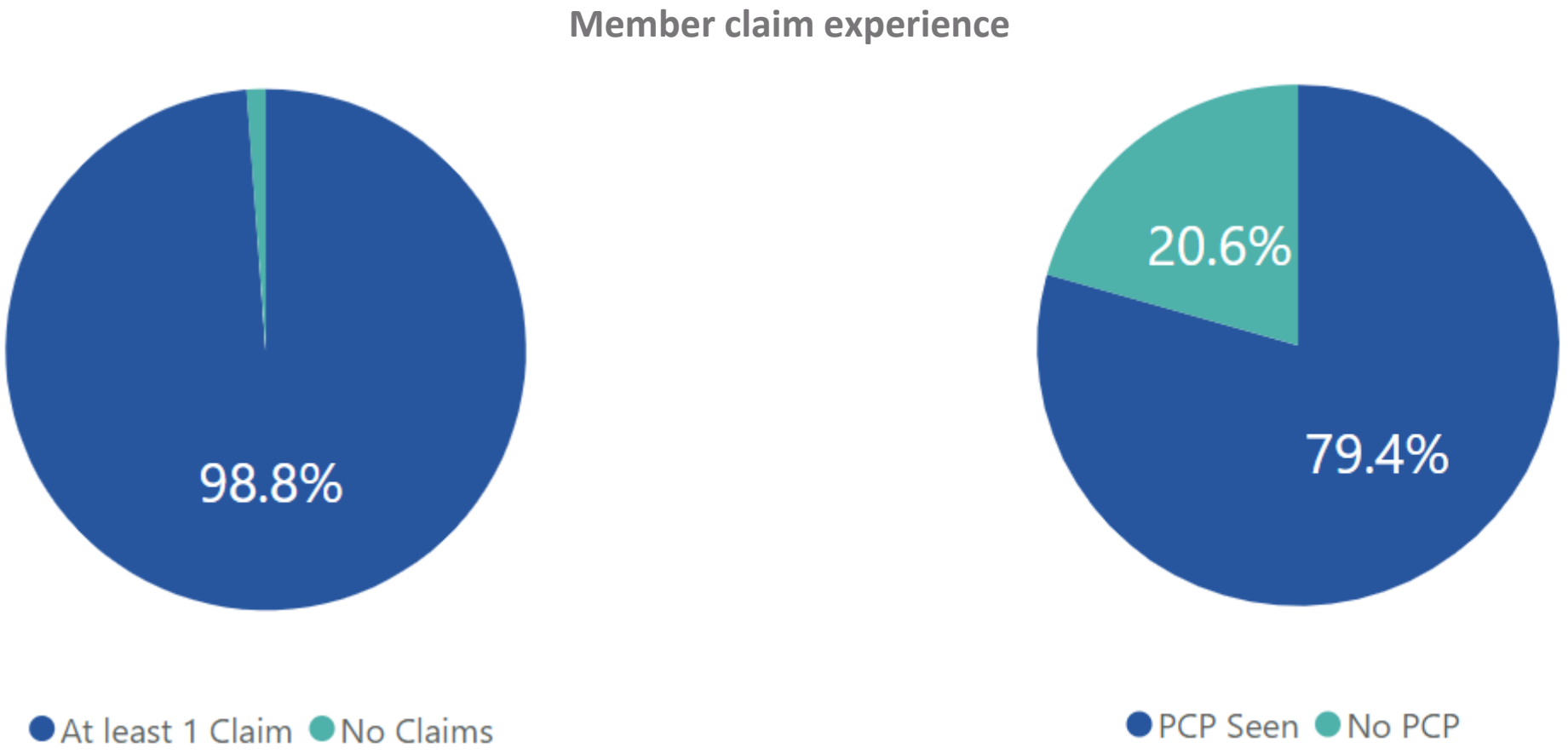
What utilization patterns are associated with higher/lower recapture rates?

Overall findings

1 out of 4
MA members seemingly went an entire year without that diagnosis being documented

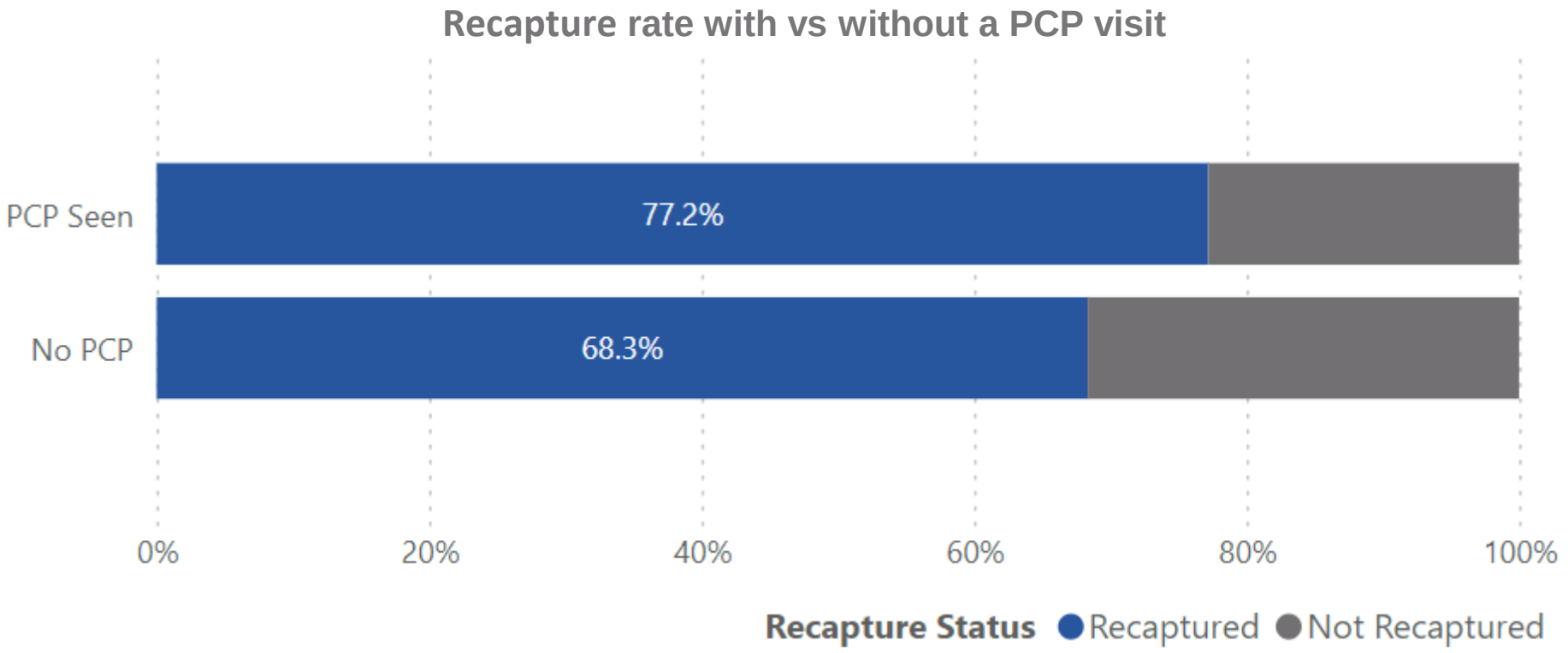


Q1: Are these patients not seeing a provider?



- Only includes risk-adjustable claims per CMS guidelines
- Only considers members w/chronic dx & 12 months enrollment

Q2: Do they need to see their PCP?

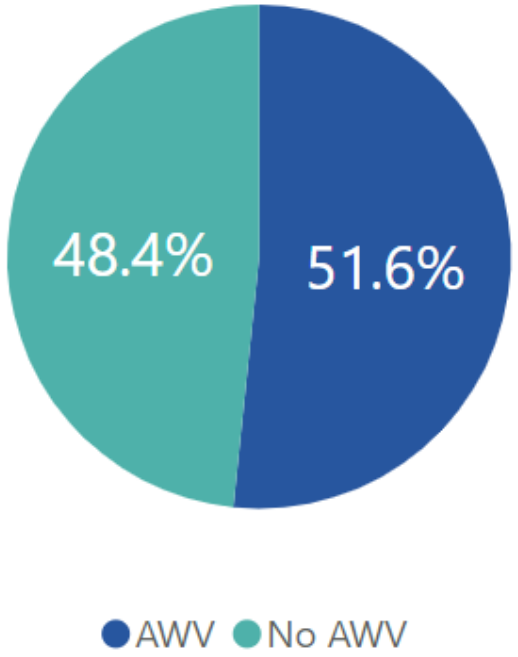


Context

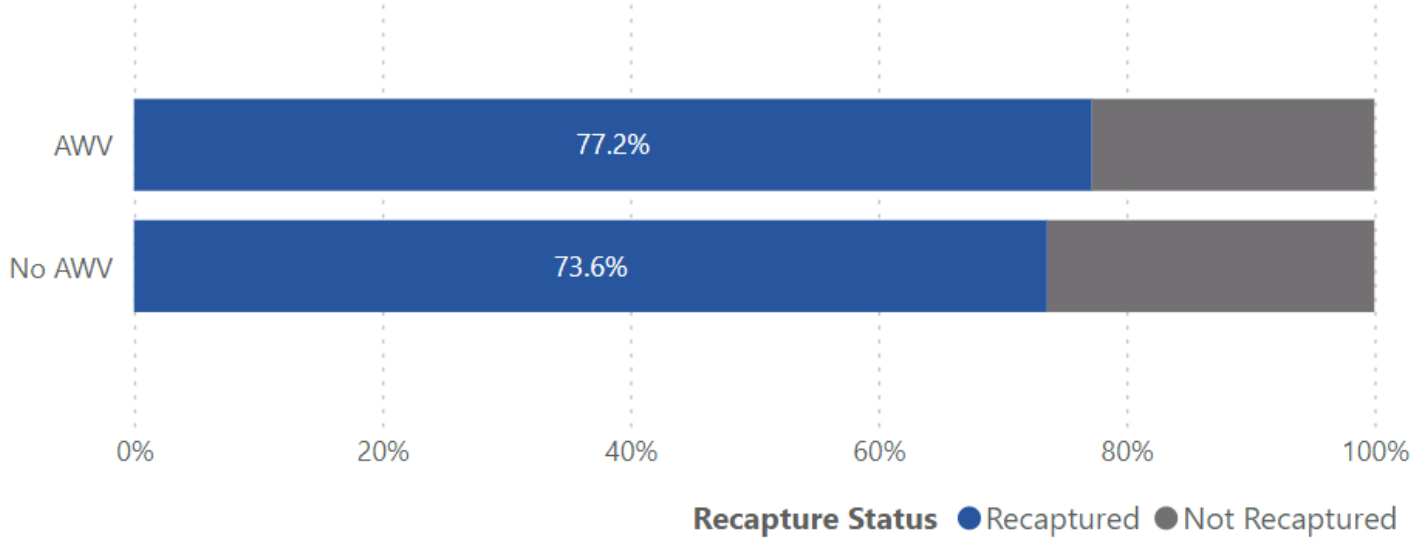
- The financial impact of going from V24 to V28 on this population is a reduction of $54.80 PMPM
- Moving the "No PCP" population up to the "PCP Seen" population's recapture rate would increase RA rev by $8.12 PMPM

Q3: Are they not having the right type of visit?

Count of Members by AWV Status



Recapture rate with vs without an AWV



Context

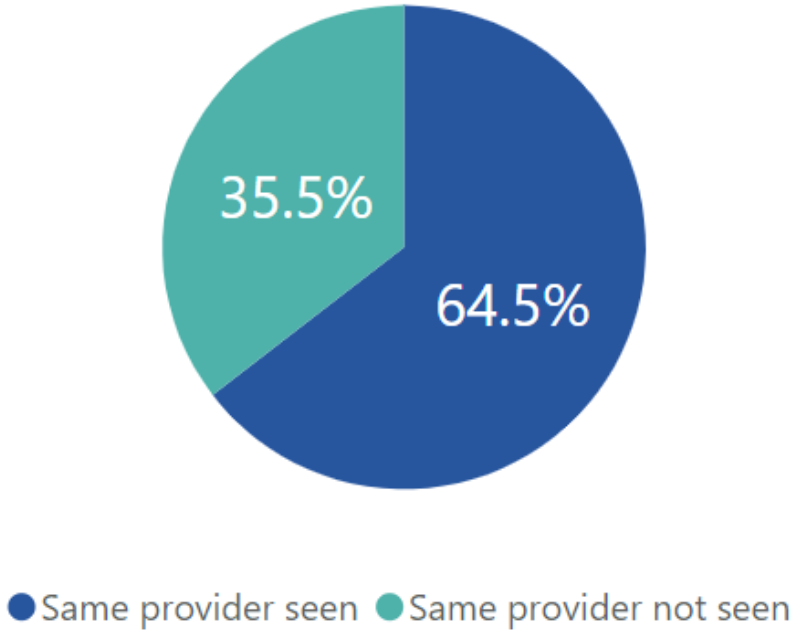
- The financial impact of going from V24 to V28 on this population is a reduction of $54.80 PMPM
- Moving the "No AWV" population up to the AWV population's recapture rate would increase RA rev by $8.20 PMPM

Why aren’t AWVs having higher success?

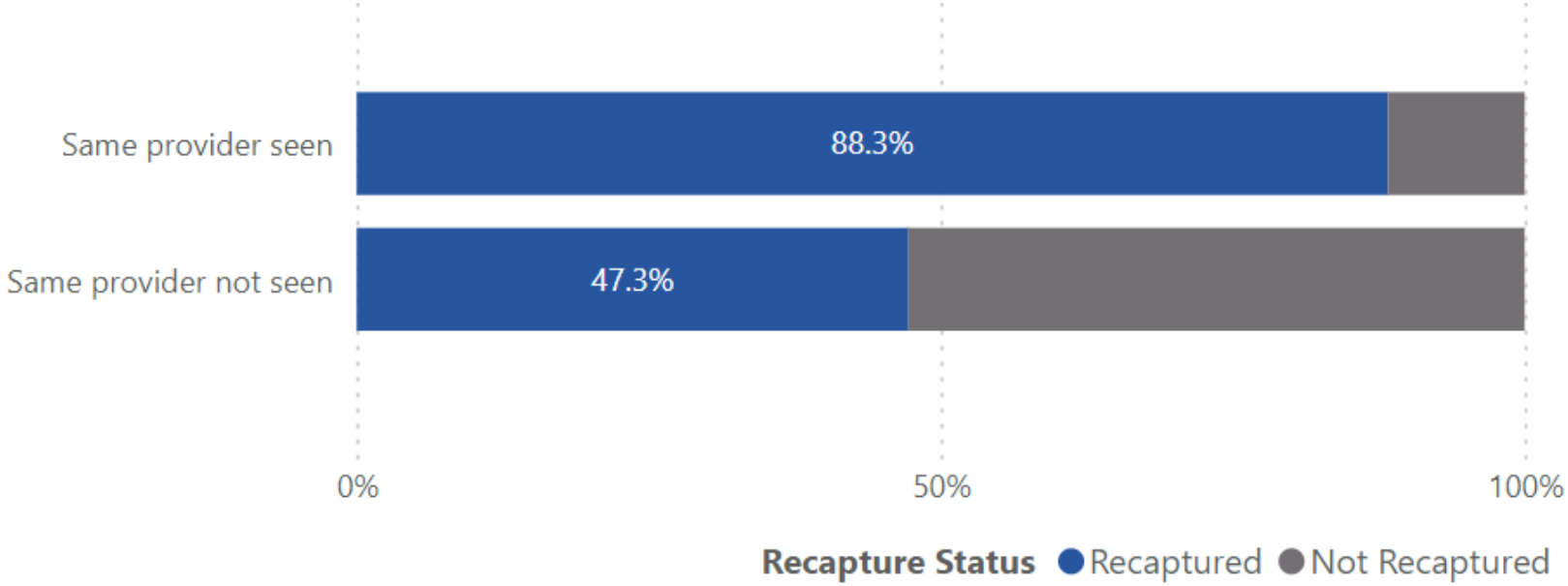
1. The condition was misdiagnosed and/or has resolved
2. Providers are not coders
3. The provider doing the assessment is
    a) not being thorough
    b) not aware of the condition
    c) not comfortable making the diagnosis

Q4: Are they seeing the right provider?

Count of Member-HCCs who had a visit w/ the provider who last diagnosed them



Recapture rate with vs without a visit to the same provider



Context

- The financial impact of going from V24 to V28 on this population is a reduction of $54.80 PMPM
- Moving everyone* to the “Same provider seen” group would increase RA rev by $60.47 PMPM

*Note: easier said than done, but we did see similar results seeing the same provider group or specialty

Conclusions & Recommendations

- **Identify the "right" provider for a patient to visit -** *specialist, provider, group most likely to manage or have knowledge of the condition*
- **Remove barriers for patients to have specialist visits -** *transportation, referral management, scheduling, cost-sharing, care navigation/management*
- **Work on solutions that give the PCP the information they need to properly document the condition –** *pre-visit prep, access to charts & clinical details, interoperability, disease management*

Lastly,

- You will *always* need to support this process from a coding and CDI perspective
- It should not be lost on anyone that these recommendations align with best-care practices. This is a future-proof strategy.

Q&A

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