Value-Based Care and Risk Adjustment *The New Disrupters in the Revenue Cycle*

Presented By:

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HIM, Coding, and Compliance

Leader* | *Mentor* | *Strategist

ABOUT ME

- Davenport University; B.S., Health Information Management
  - RHIA and CCS Certified; Preparing for CHDA Exam – Summer 2019
- Consultant - HIM, Coding, and Compliance
  - Exam Prep via AHIMA Mentor Match
- AHIMA volunteer since 2016 – Engage Community Facilitator
  - 2017 Chair Engage Advisory Committee
- AHIMA Contractor: HIM PE and IG Teams, Certification and Webinars
  - Program Manager, AHIMA-Approved ICD-10 Trainer Ambassador Program
  - Facilitator – AHIMA Train-the-Trainer; IG, CDI, Data Analytics, and Revenue Cycle
- Passionate about health and fitness; NASM-CPT
  - Love running, swimming, kettlebell training, and boxing
  - Favorite thing to do is go to the driving range with my dad

Today's Objectives

- What is Value-Based Care and the History of VBC
- Transition from Fee-for-Service to value based contracting, P4P programs, and population health management programs
- Introduction to Quality Payment Programs and new Alternative Payment Models (APMs)
- The impact of VBC and risk adjustment on coding and reimbursement
- How VBC is disrupting the revenue cycle and challenging the status quo of the current healthcare business model
- VBC - Healthcare Policy 2020 and Medicare for All

HISTORY OF VALUE-BASED CARE

The Long Road to Value-Based Care

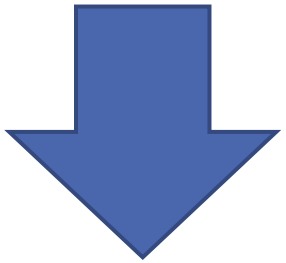
- **2004 - President George W. Bush**
  - President's Health Information Technology Plan - 100 million dollar investment in HIT
  - Create secure, fully electronic health records to promote quality, safety, and efficiency
  - Every American would be able to access their medical records electronically by the year 2014

- **2009 - President Barack Obama**
  - Signed The Health Information Technology for Economic and Clinical Health Act (HITECH)
  - Part of ARRA and ACA
  - Implementation of "Meaningful Use" and Certified Health Information Technology

https://georgewbush-whitehouse.archives.gov/infocus/technology/economic_policy200404/chap3.html

What is VBC?

- Transition from traditional fee-for-service/capitation to P4P
- Fee-for-service (FFS)
  - Retrospective payment - after healthcare services are provided
  - Based on QUANTITY and VOLUME: # of healthcare services provided
  - Encounter is paid for separately and each service provided is unbundled
  - Increases healthcare costs and utilization = poor health outcomes



- Pay For Performance (P4P)
  - Prospective payment – Payments calculated prior to healthcare services rendered
  - Reimbursed based on VALUE - measuring health outcomes compared to cost
  - Increased safety, quality, and efficiency
  - Lowers healthcare costs and decreases utilization
  - Improved health outcomes of patient populations

Quantity vs. Quality = VALUE

https://catalyst.nejm.org/what-is-value-based-healthcare/

Fee-For-Service = Skyrocketing Healthcare Costs and Improper Medicare Payments

- Fee-For-Service (FFS) Care Delivery Model
  - Leads to over utilization, duplicative tests, and medically unnecessary services
  - No financial incentives and/or penalties to increase quality
  - Care becomes fragmented / care gaps in the healthcare continuum
  - Result = over burdened healthcare system with no incentives to
    - Meet performance measures
    - Improve health outcomes for individual and populations
- $23.2B in Improper Payments for Medicare Fee-For-Service Programs
- Medicaid fee-for-service programs improperly paid $4.3B

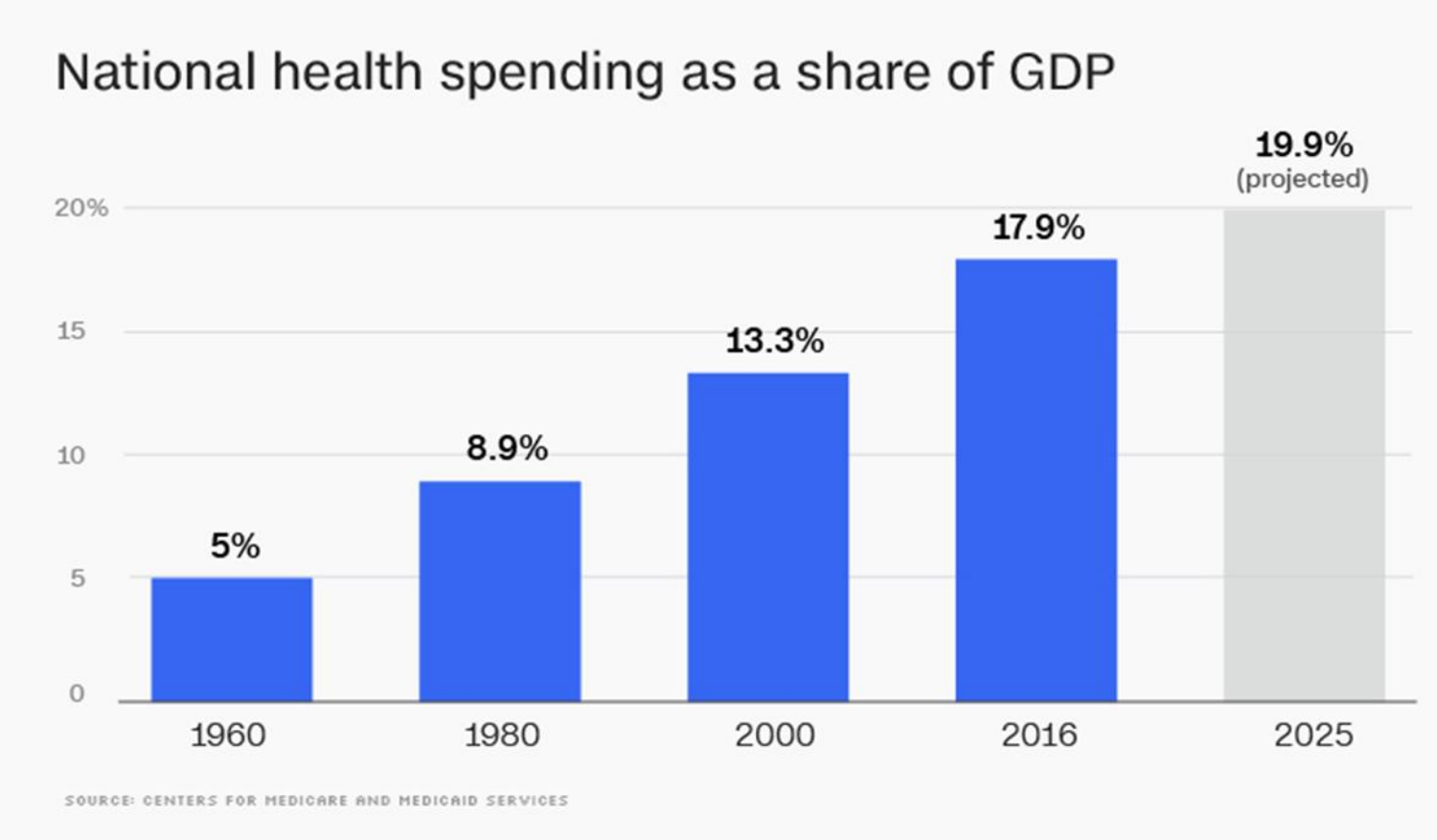
http://www.insight-txcin.org/post/what-is-fee-for-service

Year	Spending (Billions)	Cost Per Person	Event
1965	$41.90	$209	LBJ started Medicare
1966	$46.10	$228	Vietnam War
1973	$102.80	$474	Gold standard ended.
1974	$116.50	$534	ERISA / Wage-price
1984	$405.00	$1,692	Tax hike/higher defense
1987	$516.50	$2,099	Black Monday
1989	$644.80	$2,571	S&L crisis
1996	$1,074.40	$3,964	Welfare reform
1997	$1,135.50	$4,147	Balanced Budget Act
1998	$1,202.00	$4,345	LTCM crisis
2001	$1,486.80	$5,220	9/11 attacks
2002	$1,629.20	$5,668	War on Terror
2003	$1,768.20	$6,098	Medicare Modernization
2005	$2,024.20	$6,855	Bankruptcy Act
2008	$2,399.10	$7,897	Recession slowed
2010	$2,598.80	$8,412	ACA signed
2011	$2,689.30	$8,644	Debt crisis
2012	$2,797.30	$8,924	Fiscal cliff
2013	$2,879.00	$9,121	ACA taxes
2014	$3,026.20	$9,515	Exchanges opened
2017	$3,492.10	$10,739	Drug costs rose just

National Healthcare Spending and Major Events 1965 -2017

https://www.thebalance.com/causes-of-rising-healthcare-costs-4064878

Healthcare Spending and GDP



- CMS Office of the Actuary Projections of National Health Expenditures 2018-2027
  - $6.0 Trillion by 2027
  - Drivers of healthcare spending:
    - growth income and employment
    - Baby boomers aging - Medicare
    - increase in medical services and goods; 2.5% 2018- 2027, up from 1.1% from 2014-2017

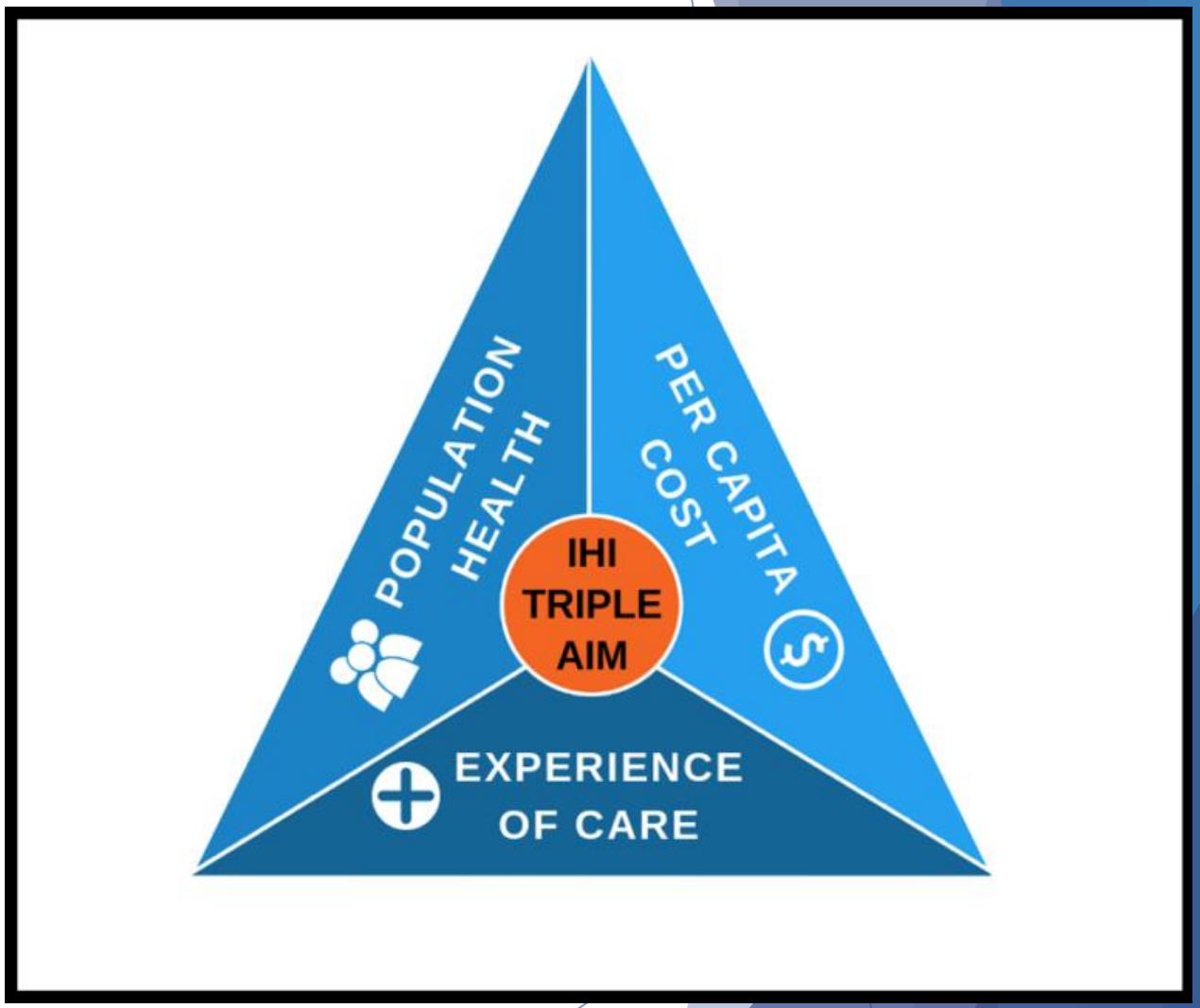
https://money.cnn.com/2018/01/30/news/economy/health-care-costs-eating-the-economy/index.html

https://www.cms.gov/newsroom/press-releases/cms-office-actuary-releases-2018-2027-projections-national-health-expenditures

Shift from Volume to Value
Focus on Quality, Safety, Cost, and Outcomes

Triple Aim – CMS and IHI

- Experience of Care (Quality/Satisfaction)
- Reduce per capita cost of care
- Improve the health of populations
  - Focuses individuals and families, primary care services, and cost controls, and integration of services
- Quadruple Aim adds the goal of improving the experience of providing care with focus on provider retention and engagement



http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx

Accountable Care Organizations (ACOs) and Population Health

- VBC + Population Health = patient-driven and patient-centric care
- Paved the way for P4P and implementation of population health programs
- Healthcare organizations are partnering with physician led accountable care organizations (ACOs)
  - "ACOs are groups of clinicians, hospitals and other health care providers who come together voluntarily to give coordinated high-quality care a designated group of patients."
  - The ACO model is used by both private and public payers who contract with the ACO's to provide care to health plan members

https://healthpayerintelligence.com/news/value-based-care-drives-progress-in-population-health-management

Patient-Centered Medical Homes (PCMH)

- Healthcare organizations and ACO's form patient-centered medical homes (PCMH) to drive primary care initiatives
  - Combines primary care practices and other clinical specialists across the care continuum for IDS
  - Focus of care delivery is promoting better health and improved outcomes for populations based on best practices and EBM
  - individualized approach to care coordination
  - Care plans that takes into account the specific needs of each patient.

- Population Health Management - Imperative for optimal reimbursement in risk-based contracting
  - PCMH recognition - National Committee for Quality Assurance (NCQA); HEDIS core measures
  - Requires project management, predictive analytics, and health informatics in reporting and performance measures for quality and safety
  - ACOs that participate in PCMH receive financial incentives for meeting and exceeding standards and share in the savings of providing quality care

https://www.healthaffairs.org/do/10.1377/hblog20180905.807827/full/

Joint Principles of PCMH
Five Pillars of Coordinated Care

- Taking the whole patient into account by delivering comprehensive physical and behavioral healthcare through a team-based network of providers
- Developing meaningful relationships with patients, caregivers, and family members that take into account the patient's cultural values and preferences, as well his or her socioeconomic experiences
- Employing coordinated, data-driven care strategies fueled by electronic health record (EHR) use, health information exchange (HIE), data analytics, and population health management tools
- Ensuring care access by expanding office hours, employing telehealth or other remote communications technologies, offering same-day appointments for pressing needs, and educating patients about alternative care sites for emergencies
- Placing a premium on care quality and patient safety by leveraging clinical decision support technologies, clinical guidelines, and alerts that flag potential gaps in care

https://healthitanalytics.com/features/breaking-down-the-basics-of-the-patient-centered-medical-home

From Fee-for-Service to Value-Based Care

- Value Based Contracting = evolution of healthcare delivery
  - Transforms reimbursement methodologies that improves quality and safety
  - Outcomes and Indication based pricing
    - Provides accountability, tracks performance outcomes, and allows for innovations in the use of new medical technologies
  - New payment models improve clinical outcomes, decrease costs, and enhance the patient's experience
- Aligns the goals of providers, payers, patients, and employers
  - Win-win for payers and providers who are receptive to financial incentives
  - Patients and providers share in the savings

https://consultant.uhc.com/assets/vbc_overview_flier.pdf

Value-Based Contracting - Health Plans for State Employees and Private Sector Employees

- States recognize CMS push for VBC and want better value for their “buck”
  - Montana, North Carolina, and Oregon - using “Medicare’s hammer” on hospital bills to contain costs and cut down on increasing health care premiums
- North Carolina will pay providers Medicare rates + 82% = savings of $258M
  - NC State Treasurer, Dale Folwell, 60M in savings on healthcare premiums for state health plan members
- Lead to disruption in the health insurance market, should the private sector take notice of the cost savings

https://www.npr.org/sections/health-shots/2019/03/20/704640661/health-plans-for-state-employees-use-medicares-hammer-on-hospital-bills

Transforming VBC - Quality Payment Programs and Alternative Payment Models

Meaningful Use – The Mother of MACRA/MIPS

- ARRA and HITECH - "Meaningful Use" of Certified Electronic Health Records
  - CMS and ONC - goal of fully electronic and interoperable health records
  - Increase efficiency, quality, and safety through meaningful use of certified EHR technology(i.e. e-prescribing)

- MU - 3 stages with core objectives, measures, and standards
  - Financial incentives for meeting performance standards – No penalties
  - Migrated towards downward payments and financial penalties; difficulty in meeting standards

- 5 Pillars of MU
  1. Improving quality, safety, efficiency, and reducing health disparities
  2. Engage patients and families in their health
  3. Improve care coordination
  4. Improve population and public health
  5. Ensure adequate privacy and security protection for personal health information

https://www.cdc.gov/ehrmeaningfuluse/introduction.html

Medicare Access and CHIP Reauthorization Act (MACRA)

- MACRA legislation released by CMS in 2015
  - Quality Payment Program (QPP)
  - Repealed the Sustainable Growth Rate (SGR) for Medicare Part B
  - New methodologies to reimburse physicians of Medicare Beneficiaries
- QPP Rewards clinicians for value over volume
  - Participate in either Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs)
    - Focus on quality of care, effectiveness, and population health
    - provides bonus payments for providers who are eligible to participate in alternative payment models (APMs)
    - Simplifies and streamlines QPPs through MIPS and APMs
    - **GOAL - 90% of CMS payments linked to value-based care and 50% under APMs by 2018**

https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/value-based-programs/macra-mips-and-apms/macra-mips-and-apms.html

Merit-Based Incentive Payments System (MIPS)

- MACRA streamlines the QPP
  - Creates MIPS and APMs which reward value and outcomes
  - Eligible providers must meet volume threshold based on allowed charges for under MFPS and # of Part B beneficiaries that were provided services under MFPS
- Four Performance Categories
  - 1) Quality (Replaced PQRS) – Addresses quality of care delivered and CMS performance measures
  - 2) Promoting Interoperability (Replaced MU) - Focus on patient engagement, exchange of electronic health information using certified electronic health record technology (CEHRT)
  - 3) Improvement Activities (formerly Advancing Care Information) - Assesses care coordination, care processes, patient engagement in care, and access to care
  - 4) Cost (Replaces VBM) - cost of the care provided based on Medicare claims. Utilizes cost measures to assess total cost of care for the year or during a hospital stay

https://qpp.cms.gov/mips/overview

Alternative Advanced Payment Models

- Alternative Payment Models (APMS)
  - Provides added incentive payments for high-quality and cost-efficient care
  - APMs apply to specific clinical conditions, care episodes, or a population
- MIPS APMs
  - MIPS eligible clinicians participating in the APM on their CMS-approved participation list
- Advanced APMs
  - QPP track that offers a 5 percent incentive for achieving threshold levels of payments or patients through Advanced APMs
  - Providers are eligible if they do not meet the threshold for payments or patients sufficient to become a Qualifying APM Participant (QP)
- All-Payer/Other-Payer Option
  - 2019 - eligible clinicians can become Qualifying Alternative Payment Model Participant (QPs)
  - Must participate in a combo of Advanced APMs with Medicare and Other-Payer Advanced APMs

https://qpp.cms.gov/apms/overview

Medicare Physician Fee Schedule (MPFS)

- 1992 - CMS implements Medicare Physician Fee Schedule (MPFS)
  - Decrease healthcare spending
  - Reimburse providers on a service's resource costs and not historical charges
- Reimbursed based on fee schedule utilizing the resource-based relative value scale (RBRVS)
  - The rate at which a physician is based is based on resource costs relative to other services
- RBRVS utilizes RVUs which are used to calculate Medicare payments, create budgets, measure productivity, and allocate expenses
    - Payment rates are set utilizing three criteria
      - Physician work (time and intensity)
      - Practice expenses
      - Malpractice costs

https://revcycleintelligence.com/news/amp/aligning-the-medicare-physician-fee-schedule-with-value

Medicare Shared Savings Program (MSSP)

- Largest push towards transitioning the US healthcare system value based care
- 561 participating ACOs; Serves 10.5 million beneficiaries
  - Amounts to 1/3 of traditional Medicare beneficiaries with Part A and Part B coverage
- ACOs provide care to a defined population of Medicare beneficiaries
- Must meet annual spending target or “benchmark” and quality thresholds
- ACOs that spend less than the target can share the savings with the government
- In comparison to providers that do not participate in MSSP, ACOs have shown greater quality of care to Medicare patients, achieving savings relative to the benchmark

https://www.healthaffairs.org/do/10.1377/hblog20180906.711463/full/

Value-Based Insurance Design

- CMS is testing a new service delivery model – VBID
  - Improves quality of care for Medicare Advantage beneficiaries
  - Better coordination between patients' hospice providers and their other clinicians
  - Increased Patient Engagement
  - 2021 VBID model allows MA plans to offer Medicare's hospice benefit
- VBID is available to participating organizations for CY 2020 who are
  - Value-Based Insurance Design by Condition, Socioeconomic Status or both
  - Rewards and Incentives
  - Telehealth Networks
  - Wellness and Health Care Planning

https://innovation.cms.gov/initiatives/VBID

Other Care Models
Oncology Model of Care (OMOC)

- Human = Oncology Model of Care (OMOC)
  - Utilizes integrated treatments for MA and commercial members
  - Improved patient experiences and health outcomes for cancer patients
  - Reimbursed for quality and cost
    - inpatient admissions, emergency department visits, medical and pharmacy drugs, radiology, laboratory and pathology services

https://www.fiercehealthcare.com/payer/humana-launches-value-based-model-for-cancer-patients

Other Care Models – CMS Next Generation ACO Model

- initiative for ACOs that have had success at managing population health
  - Assume higher levels of financial risk; greater rewards than Pioneer Model and MSSP
  - Increased financial incentives and added tools for patient engagement and care management to lower costs and improve outcomes for Medicare FFS

- Core Principles – CMS Next Generation ACO Fact Sheet
  - Protect FFS beneficiaries' freedom to seek covered items and services from the Medicare-enrolled providers and suppliers of their choice
  - Engage beneficiaries in their care through benefit enhancements designed to improve the patient experience and reward seeking appropriate care from providers and suppliers participating in ACOs
  - Create a financial model with long-term sustainability
  - Utilize a prospectively-set benchmark that: (1) rewards quality; (2) rewards both improvement in and attainment of efficiency; and (3) ultimately transitions away from using an ACO's recent expenditures for purposes of setting and updating the benchmark
  - Mitigate fluctuations in aligned beneficiary populations and respect beneficiary preferences by supplementing a prospective claims-based alignment process with a voluntary process
  - Smooth ACO cash flow and support investment in care improvement capabilities through alternative payment mechanisms

https://www.modernhealthcare.com/safety-quality/next-generation-aco-participants-2019-drop-41

Other Care Models - Prescription Drug Value-Based Contracting

- New pricing strategy to reduce prescription drug spending; links to outcomes
- Pros = Patients can access innovative new drugs quickly
  - Insurers include new, expensive drugs in their formularies
  - If drug is ineffective in treating patients, the insurer can recoup costs
  - Insurers want the most effective drugs; weed out new drugs that don't improve outcomes
- **Cons** = Patients unlikely to see any difference in out-of-pocket costs
  - Rates negotiated between insurance carriers/pharmaceutical companies
  - If a drug doesn't work, pharmaceutical company gives insurer a refund/rebate
    - The patient is NOT refunded their portion
  - Assessing drug effectiveness and refunds take years
  - No evidence exists of measurable difference in drug costs

https://revcycleintelligence.com/news/cms-targets-value-based-purchasing-drug-costs-to-reduce-spending

Value-Based Care and QPP Works!
Cigna Case Study and Report

- 3.6 million Cigna commercial customers receive VBC- 85% through Medicare Advantage (MA)
- Cigna 50.5 percent alternative payment arrangements - $600 million in savings 2013-2017
  - 240+ primary care provider organizations; 500+ hospital facilities
  - 270+ specialist programs in 6 disciplines; 245+ Episodes of Care programs
  - 90% of Cigna customers in top 40 markets - 15 miles of 3+ participating PCPs
  - Cigna ACO's quality performance is 11 % better than the market
    - 92 % of providers meet or exceed quality benchmarks
  - Scott Josephs, MD CMO at Cigna "Focus on quality and affordability enabled the company to exceed it's 50 percent alternative payment goal, offering more value for our customers' and clients' health care dollars. This is a critical milestone as we work to accelerate the pace of change in health care delivery in the United States. Our commitment to value-based care and alternative payment models is driving better health outcomes, increased affordability and improved patient experience for the people we serve."

https://www.businesswire.com/news/home/20190207005236/en/Cigna-Transition-Value-Based-Health-Care-Results-600

Value-Based Care
Coding and Reimbursement

Risk Adjustment

- Implemented by CMS in 2004 as a payment model to adjust for risk of mortality (ROM) and severity of illness (SOI)
  - Actuarial tool that accounts for the costs of providing long-term care for patients with chronic illness
  - Reimbursement methodology used mainly by Medicare Advantage (MA) providers, but starting to infiltrate commercial health plans
- Controversial due to conflicting standards from competing organizations
  - Compliance issues concerning MA providers- incentive to artificially increase SOI and ROM as higher risk scores receive bigger payments
  - UnitedHealthcare allegedly used non-compliant risk adjustment policies to increase payments it received from CMS for providing care to beneficiaries of MA plans

https://journal.ahima.org/2018/09/26/hccs-and-risk-adjustment-never-a-coding-issue-always-a-documentation-issue/

Coding for Risk – Hierarchical Condition Category (HCCs)

- Similar to case mix index and DRGs
  - Patients are grouped into categories based on disease burden and resource
  - Weighted in a similar way to DRGs and are assigned a coefficient

- HCCs document chronic illness over time
  - Levels the risk of caring for sicker patient populations with multiple chronic conditions Ensures that physicians are adequately reimbursed for providing long-term care
  - Provides incentive to take on more complex patient cases

- Assigning an HCC requires compliance with MEAT
  - Monitoring, Evaluation, Assess/Address, and Treatment
  - At least one element of MEAT is required
  - Look back period of 1 year

https://journal.ahima.org/2018/09/26/hccs-and-risk-adjustment-never-a-coding-issue-always-a-documentation-issue/

Tracking SDOH with ICD-10

- Healthy People 2020: "Create social and physical environments that promote good health for all."
- SDOH impact 80% of health outcomes
- SDOH linked to over 50% in hospital readmissions

https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

CMS, AMA, and UnitedHealthcare SDOH Initiative

- CMS to reimburse for services that promote the SDOH
  - Meal delivery, transportation to the grocery store, nutrition services, coverage for non-emergency medical transportation, and expanded diabetes education in outpatient programs and community health facilities
  - Telehealth services - essential for individuals with disabilities, to address social cohesion and isolation

- The AMA is partnering with UnitedHealthcare, who has already been working with NCQA, in an effort to create 23 new ICD-10 codes that will address SDOH and social barriers of care. Adoption of these codes could begin in 2020.

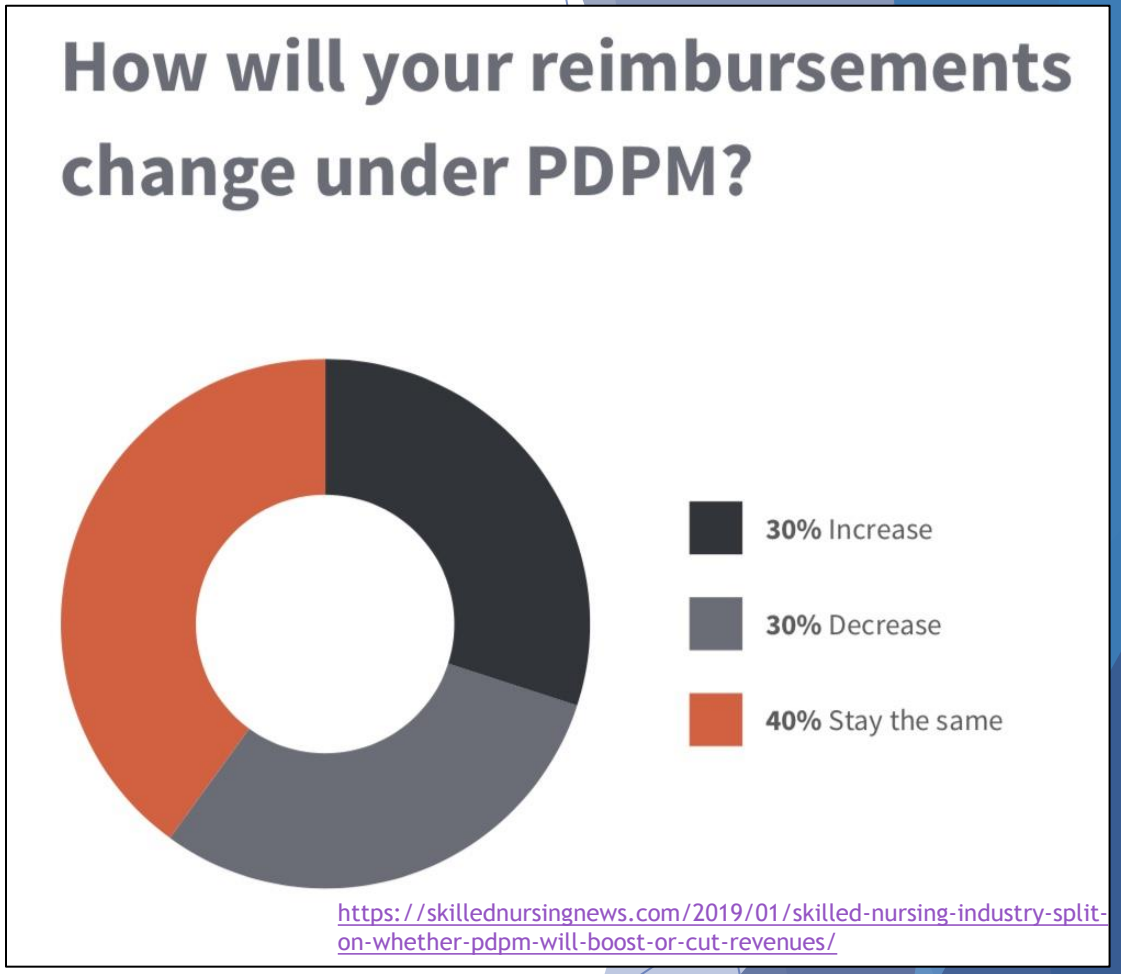
- AHA has already recognized the use of the ICD-10 Z codes from non-clinical documentation to collect data on the psychosocial and socioeconomic stressors to track behavioral healthcare outcomes

https://www.icd10monitor.com/social-determinants-of-health-in-the-news

SNFs – Value-Based Purchasing and PDPM

- SNFs - Patient Driven Payment Model
  - Patient condition, NOT therapy minutes determines payment
  - Reimbursed based on assigned ICD-10 codes
  - Survey of 400 respondents - 63% stated greater emphasis on coding
- Mitigating Risk
  - Will it promote value?
  - Decreased revenues or increase in reimbursement?
  - Lead to Mergers and Acquisitions?
  - Michele Kastenholz - Director at HDG

    "We believe that there will be an evolution in practice for therapy. It happened under RUGs. We were incentivized to adapt to the payment structure."



https://skillednursingnews.com/2019/01/skilled-nursing-industry-split-on-whether-pdpm-will-boost-or-cut-revenues/

https://skillednursingnews.com/2019/01/icd-10-coding-will-be-crucial-under-pdpm-but-snfs-dont-need-to-become-experts/

2021 CMS Changes to CPT E/M Coding

- AMA CPT E/M changes specific to Office or Other Outpatient Services (99201-99205 and 99211-99215)
  - Deletion of 99201
  - New guidelines specific to 99202-99215
  - Changes in component scoring for both new and established patient codes (99202-99215)
  - Changes to the medical decision-making table
  - Changes to the typical times associated with each E/M code (99202-99215)
- Changes in Component Scoring
  - Documentation of history and physical
    - Number of body areas and/or organ systems examined and documented will not be used to determine the level of service.
  - Medical decision making (MDM) or total time will determine level of service
  - Medical necessity for the level of service must be identified within the documentation

https://www.findacode.com/news/cpt-announces-2021-e-m-changes.html

VBC – What is the Role of the Coder?

- Coding no longer just about abstracting codes and submitting claims
  - Optimal reimbursement places Increased importance on CC/MCC capture rate and compliant queries; accurately assign ICD-10 Codes
  - New E/M guidelines will require new documentation strategies that comply while also optimizing reimbursement
  - Participation and support of CDI programs to enhance integrity of the documentation to accurately assess quality of care and tell the patient story through care continuum
  - Adjusting for ROM and SOI to ensure adequate reimbursement for more complex cases
- Acquire skills in project management, data analytics, and health informatics
  - PCMH and population health programs
  - CDI programs
  - Research, predictive analytics, and data modeling

Revenue Cycle Disruption
Challenging the Status Quo of the Current Healthcare Business Model

Upside Risk and Downside Risk - Alternative Payment Models

- APMs have their own financial risk structure and models: Two Types
- **Upside Risk – One Sided**
  - Track One of MSSP - providers who reduce healthcare costs below their benchmarks receive a percentage of the difference between actual and budgeted costs = shared savings
    - If costs go over - do not receive any shared savings, but not financially penalized
- **Downside Risk –Two Sided**
  - Providers that exceed costs must refund payers a portion of the difference, (i.e. Next Generation ACO)
  - Losses are shared but also allow for higher shared savings
- **Other Risk Structures - Bundled Payments**
  - Providers are given incentives to take on more financial risk. In bundled payment models
  - Reimbursed a set price for episodes of care
    - Providers see cost savings by lowering the cost of care
    - Could stand to lose difference between actual and budgeted costs

https://revcycleintelligence.com/news/examining-the-role-of-financial-risk-in-value-based-care

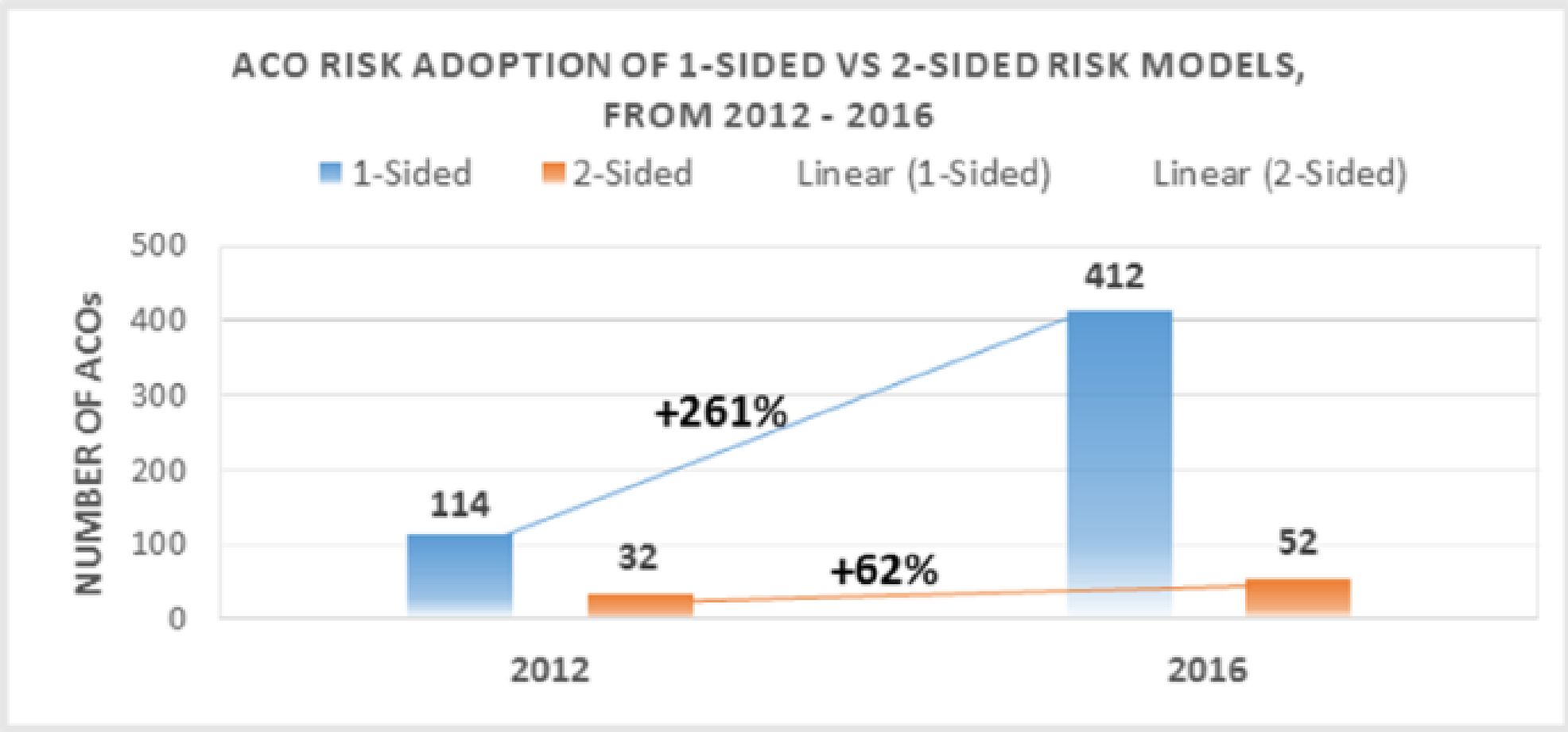
Gaining Buy-In for VBC from Major Stakeholders

Research Study: 87% of Hospital CFOs are NOT Prepared for Value-Based Reimbursement!!!

- 160 healthcare organizations, hospitals, and providers surveyed
- Not prepared financially for constant changes in evolving healthcare markets
  - Includes changes in care delivery methods and value-based reimbursements
- Only 13% of the Hospital CFOs are being prepared for new payment processes and VBC reimbursement.
- 23% of the CFOs are prepared and are confident they can mitigate risk and impact of VBC and shared Risk
- Getting buy-in from strategic leadership at major health an uphill battle
- Executives surveyed say it will take 3-5 years to tackle upside/downside shared risk

http://www.mcatx.com/shocking-87-of-hospital-cfos-are-not-prepared-for-value-based-reimbursement/

ACO Adoption of One-Sided and Two-Sided Risk 2012 -2016



Source: NAACOS

https://revcycleintelligence.com/features/exploring-two-sided-financial-risk-in-alternative-payment-models

Strategies to Manage Increased Financial Risk

- Leveraging strategic partnerships to mitigate risk in a two-sided environment
  - Decrease variations in delivery of care through benchmarking quality and performance
  - Assess the true cost of care; account for direct/indirect costs, overhead, and value of care coordination by providers
  - Redesign care delivery and data models for improved management of patient care and care transitions
  - Utilize partnerships to access additional capital, infrastructure, and resources
  - Create a plan that manages high-risk populations to reduce ER visits
  - Create a plan to prevent hospital admissions and readmissions

https://www.medicaleconomics.com/health-law-and-policy/strategies-manage-risk-value-based-payment-environment

Value-Based Care and Politics 2020 and Beyond

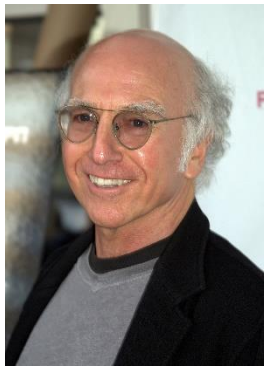
The Major Players and Key Figures

All Images curtesy of Common Creative License

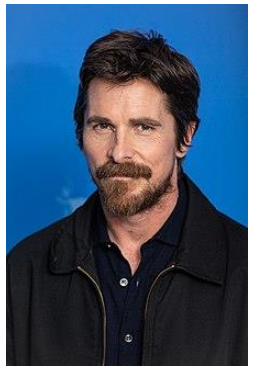
MEDICARE FOR ALL – THE MOVIE
Directed by Adam McKay (The Big Short and Vice)

Alexandria Ocasio Cortez (aka AOC)
Played by J. Lo

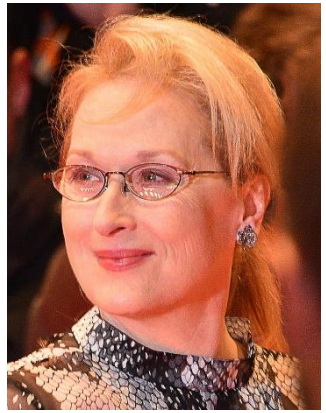
Kamala Harris
Played by Kerry Washington



Bernie Sanders
Played by Larry David



Joe Biden
Played by Christian Bale



Elizabeth Warren
Played by Meryl Streep

Seema Verma
Played by Selma Hayek

Donald Trump
Played by Alec Baldwin

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Medicare For All – The Script

- **AOC** - "$21 T of Pentagon financial transactions "could not be traced, documented, or explained. $21T in Pentagon accounting errors. Medicare for All costs ~$32T. That means 66% of Medicare for All could have been funded already by the Pentagon. And that's before our premiums."
- **Bernie Sanders -** "The current debate over Medicare for All really has nothing to do with health care, everything to do with greed and profiteering. It is about whether we continue a dysfunctional system."
- **Kamala Harris -** Publicly supported Bernie Sanders plan at Town Hall that eliminates private health insurance. She lambasted insurance company paperwork and delays; "Let's eliminate all of that. Let's move on."
- **Elizabeth Warren -** "Affordable Healthcare for every American, and there are different ways to get there."
- **Joe Biden -** Has remained silent. Has not endorsed Medicare for All plan, nor disavowed it. He has supported single payer in the past.
- **CMS Administrator, Seema Verma** "This year's scariest Halloween costume goes to – Medicare for All."
- **Donald Trump** - "Open enrollment starts today on lower-priced Medicare Advantage plans so loved by our great seniors. Crazy Bernie and his band of Congressional Dems will outlaw these plans. Disaster!"

Medicare For All – Future of VBC or Collapse of the US Healthcare System?

FOR

- Creates a single-payer health system based on an already existing federal program that is relatively successful
- Abolishes private health insurers
  - Big Insurance may be culprit in the rise of healthcare premiums, HDHP, gaps in coverage and access to services
  - Promotes initiatives of VBC and can expand upon new payment models

AGAINST

- *New York Times* April 21, 2019: "Hospitals Stand to Lose Billions Under 'Medicare for All'
  - Knee Replacement: Medicare will pay a hospital $17k. The same hospital can as much as $37k, for patient on private health insurance
  - Gallbladder surgery: Medicare will pay hospital $4.2k. The same hospital would get $7.4k from private health insurer
- Eliminating private health insurance would result in a decrease of 40 percent in payments to hospitals.
- Policy experts predict that struggling hospitals in rural and underserved areas may have to close overnight

https://www.nytimes.com/2019/04/21/health/medicare-for-all-hospitals.html

Let's Review What We've Learned!

- VBC - transformation of healthcare reimbursement away from traditional Fee-For-Service
  - reign in healthcare spending and Increase the quality, efficiency, and safety of care
  - Payment is based on value and quality of care provided, not quantity and volume of services provided.

- VBC began around the inception of the ACA when healthcare organizations began to form ACOs and implement population health initiatives through Patient Centered Medical Homes

  - Legislation enacted through MACRA created QPPs and instituting new reimbursement methodologies and financial incentives.
  - Reimbursed for meeting standards and improving healthcare outcomes and performance measures.

- Reimbursement and Coding VBC initiatives
  - Integration of SDOH and implementation of new ICD-10 codes to track
  - Risk adjustment and HCCs will continue to be a major force in reimbursement methodology for MA plans, but commercial insurers

- As healthcare organizations take on increased risk, risk management strategies will be imperative for revenue cycle management to ensure optimal reimbursement and compliance with performance measures

THANK YOU! QUESTIONS?

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https://www.linkedin.com/in/kristenpiccirillo/

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