

( E-BOOK #1 )

# Pulling Both Levers:

Part 1

A Four-Year Analysis  
of Medicare Cost and  
Risk Adjustment

(H<sub>F</sub>)  
HEALTH FIDELITY®

Value-based care is often treated as synonymous with cost reduction. CMS resources emphasize reduction in cost wherever possible. Even the terminology within alternate payment models, shared savings for example, emphasize that the benefits are around finding opportunities to save money and, therefore, reaping a financial benefit.

This paper unpacks the critical, and often overlooked, importance of effective risk adjustment in conjunction with medical expense reduction under value-based care. In it, readers will find a series of examples exploring the delta between risk score and cost, and their impact on total savings for organizations. To that end, in light of changes at CMS that have altered the pathways for ACOs, now is an optimal time to begin your journey into risk management. The hope is organizations can find their current circumstance in the examples and determine their best course of action for the future.

Anyone currently engaged in two-sided risk sharing already has a critical need to have accurate benchmarks at the start of a performance year, and organizations in “upside only” risk arrangements only stand to gain. Even organizations that have not taken on risk are still beholden to its calculations through MIPS. All of that established, what still may be novel for some readers is not that risk adjustment matters, but how much of an impact risk scores actually have on the financial health of an organization.



## The ACO Algorithm Simplified

While the challenges of controlling the variables can be complex, the equation that establishes benchmarks (and therefore results) is relatively straightforward:

$$((\text{Historical Expense} \times \text{Risk Adjustment}) - \text{Medical Expense}) \times \text{Quality}$$

Historical expenses are multiplied by risk adjustment factor. Medical expenses are subtracted from the product of the former and then multiplied by a quality score. Each element has its own impact and range of mobility modulating that impact, informing strategy.

Let's unpack each of these elements.

**Historical Expenses** aren't something that can be controlled within a given performance year. However, changes within a year do impact future benchmarking. This is why the best time to start addressing cost is "yesterday," but the second best is always, "right now."

**Risk Adjustment** is one of the "levers" that can be managed through accurate measurement of the covered population's disease burden. There is a misconception that the 3% risk cap, as applied to both Pathways to Success and NGACO, does not give organizations sufficient ability to enhance their benchmark and generate savings, since 3% is perceived as negligible. While true that the risk cap can only be increased 3% within an agreement period, risk adjustment has a significant impact on benchmarking which in turn, significantly affects overall revenue performance long-term (as this paper will demonstrate), as the gap between risk and cost reduction grows. As a result, risk adjustment shares the same urgency as cost: last year is ideal, right now is best. For provider organizations currently not actively engaged in risk adjustment, it's the easier "lever" to pull, before utilization management and cost reduction, therefore a logical first step. Finally, it only ever positively impacts patient care, as well as leading to a more accurate patient record (more thorough coding is a component of effective risk adjustment). This further impacts future treatment for the better.

### Risk Adjustment and Benchmarking

CMS uses the CMS Hierarchical Condition Category (CMS-HCC) to calculate risk scores. In the first year, this is based on medical history, and it updates each year, depending on documented conditions and care. The score acts as a multiplier, adjusted against other demographic factors calculated based on a patient's county. CMS then adds a flat dollar amount of growth to the risk-adjusted benchmark reimbursements.

If the continuously assigned population shows a decline in its CMS-HCC prospective risk scores, CMS will lower the risk score for this population. This is why risk adjustment is so critical under value-based care.

**((Historical Expense x Risk Adjustment) – Medical Expense) x Quality**

**Medical Expenses** are another relatively controllable “lever,” addressed through care managers, coordination of care, and general reduction in spend. This also often involves the definition of a high performing network within an organization. A common tactic is excluding high cost providers from the calculation, but that’s a selection bias that ultimately can do far more harm than good. In removing high cost providers, organizations are taking patients out of the calculation as well. Not only can this negatively impact a potentially higher risk score calculation reflecting care delivered, it’s not a patient-centric strategy for success; frankly, it’s gaming of the system. When risk adjustment is done correctly, it reflects the high risk/high cost patients, which is why the system exists in the first place.

**Quality** can be argued as a third lever, but quality only comes into play if an organization is successful in regard to the delta between risk and medical expense.

The diminishing returns of managing cost alone is why ACO directors and their teams have to look at trends across the years in their own individual scenarios. Managing just cost will create a short-term improvement because savings were generated within the year. However, that’s not an indicator of ongoing success. A better picture is the trend factors of risk adjustment performance against medical expenses. **Ideally, the delta between the two should grow**, with all other variations; delta steady, delta decreasing, or delta crossing; seen as opportunities to improve.

**Methodology**

We conducted a basic analysis of 2014-2018 MSSP Public Use Files (PUFs) and uncovered similar patterns that underscore the relationship between cost and risk benchmarks. The following charts show outcomes in performance year 1-2, based on benchmarks established in the prior two years (BY2-3).

When considering the following scenarios, note that benchmarks can be modified by changes in population, so the following analysis covers 2014-2018, to better illustrate the trends and smooth shorter-term variability.

In addition, the granularity is at the member level to control for any year-over-year population changes and calibrated per historical cost.

## Analysis

After reviewing the data gathered from the MSSP PUFs, four distinct archetypes emerged. **Scenario A**, where programs showed an increase in risk score that outpaced increases in cost (or even still showing a decrease), indicating accurate risk capture and effective cost management. **Scenario B**, where costs outpaced risk growth, indicating poor risk capture relative to the complexity of conditions driving cost, signaling a closing of the gap between risk (and therefore revenue) and cost. **Scenario C** represents cases in which risk score and cost decreased with a steady delta trending down. Finally, there was **scenario D**, in which risk score decreased and cost increased, leading to a crossed delta.

33 ACOs participated for the entire four year period, allowing for the following analysis of performance years 1 and 2 (PY1-2). Of those, category A represents 30%, category B is 55%, and category C is 9% of organizations analyzed. A small segment of organizations had their risk score decrease and their costs increase, this 6% represents category D. Selected organizations in scenarios A and B with static membership were selected as real examples that typified their category. Scenario C represents a worst case scenario.



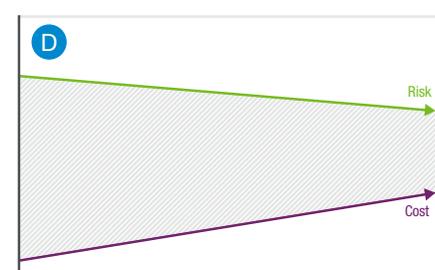
Increasing risk benchmark above cost



Can't control cost, inaccurate presentation of risk



Cost and risk going down. "Worst case"



Risk score decrease and their costs increase

### Scenario A - Increasing risk benchmark above cost

**Delta:** \$180.82 increase PMPY

**Impact:** \$16.5M Revenue increase on 92K population

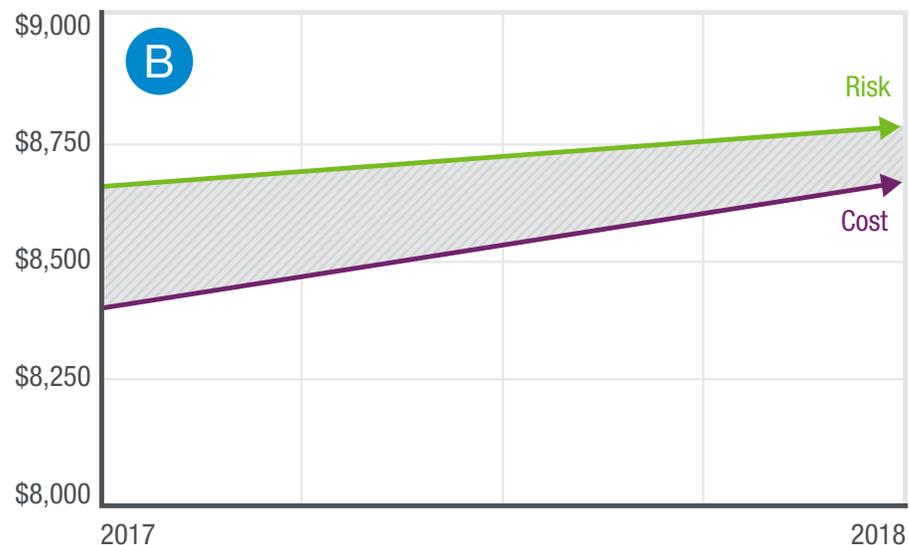
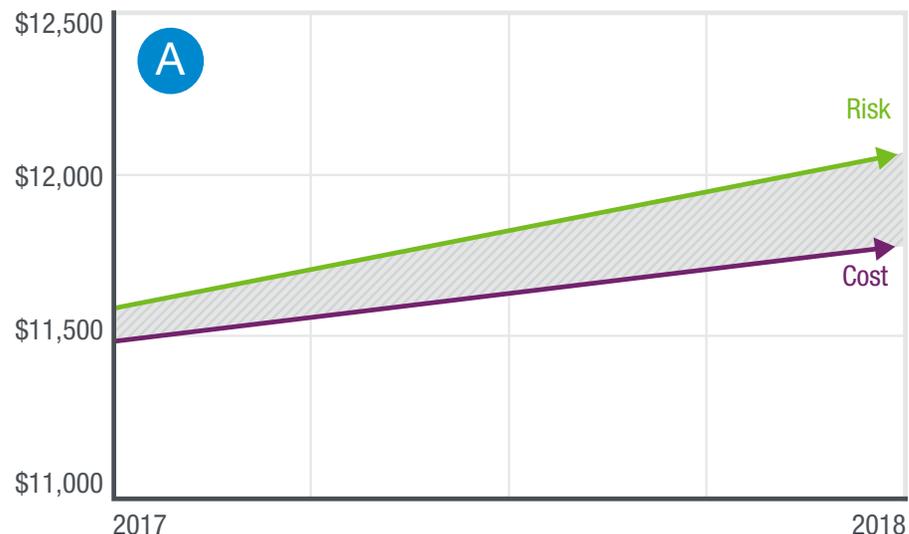
This is the ideal scenario. By improving risk score benchmarking above cost, the organization is insulating itself from any unanticipated rises in cost or revenue interruptions. It also maximizes the delta between risk and cost, which results in the most possible reward for taking on risk. In Scenario A, the delta between risk and cost benchmarks represents an increase of \$180 PMPY from 2017-2018 on a population of 92,000, or \$16.5m in revenue.

### Scenario B - Can't control cost, inaccurate presentation of risk

**Delta:** \$148.22 decrease PMPY

**Impact:** \$2.2M Revenue decrease on 15K population

Scenario B was the most common across the organizations analyzed. In this second blinded scenario, the organization cannot control its medical expenses, and does not have an accurate risk score for its populations. Costs increasing past the benchmark effectively eliminates any revenue from shared savings, a situation that could have been avoided if their risk scores were accurate, resulting in a larger delta for the rising costs to eat into. While that would still not be an ideal situation, it ensures revenue that can then be put back into care and time for organizations to stabilize costs. In Scenario B, the delta between risk and cost benchmarks represents a decrease of \$148 PMPY from 2017-2018 on a population of 15,000, or \$2.2m in lost revenue.

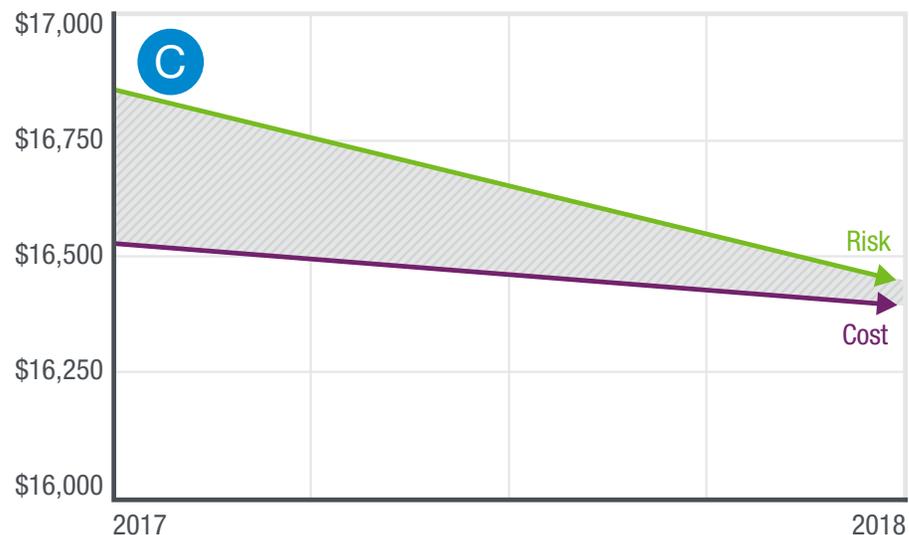


### Scenario C - Cost and risk going down. “Worst case”

**Delta:** \$283.29 decrease PMPY

**Impact:** \$7.6M Revenue decrease on 27K population

The third blinded analysis shows an organization in scenario C. Cost and risk score went down with a (relatively) static delta between the two. This can happen with population churn as higher risk patients either die or move to different, more specialized providers as needed as younger patients with fewer chronic conditions to manage join the population. However, independent of that, this should also be viewed as a “worst case” scenario or, more optimistically, the circumstance likely to experience the greatest possible benefit from improving its strategy. Organizations like this are still going to be subject to the increased requirements in cost savings under Pathways to Success. Launching a robust risk adjustment strategy in category C will still typically lead to the discovery that risk profiles are actually much higher, meaning organizations covering those populations have been losing revenue and putting themselves behind the curve. In light of that, any cost savings measures have only contributed to care delivery resource challenges. However, by addressing risk head on, organizations in this final scenario will start maintaining better relationships with their patients by providing more consistent care for the population they support; this is a natural side effect of engaging with risk more actively as a provider. This will also increase organizational access to shared savings much sooner. Finally, any provider organizations in this scenario would be preparing themselves for when the chronic conditions in the populations continue to advance over time, and/or facilitating any transition to two-sided risk through better benchmarking. In Scenario C, the delta between risk and cost benchmarks represents a decrease of \$283 PMPY from 2017-2018 on a population of 27,000, or \$7.6m in lost revenue.

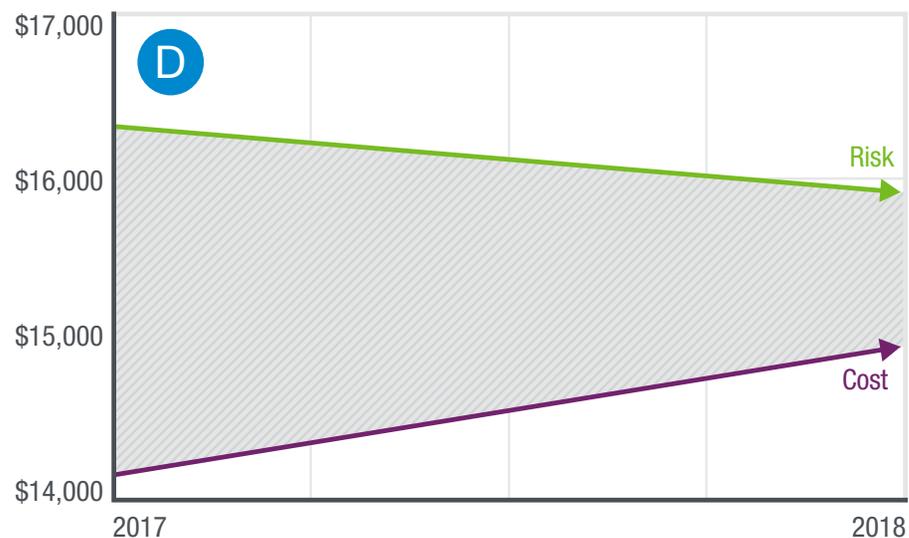


### Scenario D - Risk score decrease and their costs increase

**Delta:** \$1,102.08 decrease PMPY

**Impact:** \$17.6M Revenue decrease on 116K population

Finally, there's scenario D. Scenario D is included for the sake of thoroughness. A minority of organizations fell into this, in which risk score went down, and cost went up, rapidly accelerating the organization not to a closing delta, but signaling a crossed one in which revenue is actively being lost on each member, each year. While the circumstances are dire, they are also difficult to miss within an organization. Therefore, scenario C remains as the “worst case” because of the more subtle and common nature of what is going on between risk and cost, and what they signal down the line. In Scenario D, the delta between risk and cost benchmarks represents a decrease of \$1,102 PMPY from 2017-2018 on a population of 16,000, or \$17.6m in lost revenue.



# Conclusion

The overall takeaway is clear: isolating the effect of risk adjustment away from overall savings bears out that the performance health systems and clinically integrated networks want requires a positive change in the benchmark itself. Reduction of costs against prior benchmarks through better utilization management is simply not enough. As our current environment demonstrates, there's virtually no path to efficiency that can completely control costs; e.g. ACOs have minimal influence on drug prices or, as was illustrated in 2020, pandemics. This is what makes risk adjustment so critical to success. There is no question that cost reduction is certainly a critical outcome for MSSPs and NGACOs for Medicare spending. However, organizations overly focused on reducing cost are missing a crucial element of the formula baked into nearly any model under value-based care: capturing the most accurate, (and typically as a result, higher) risk score for patients and their respective populations. In the ACO equation, there are two levers. When performed effectively, risk adjustment should always outpace rising costs in top performing organizations, as it is an accurate reflection of the risk an organization is bearing.

The importance of managing cost and risk is only increasing. Pathways to Success is designed to pull more ACOs into two-sided risk, whether they want it or not. On the traditional glide path, ACOs are climbing one rung (taking on more risk) every single year. This increases the importance of being able to generate savings in a given year but having sustained improvements in savings leads to rapidly diminishing returns. Reducing cost alone is a job half done. Even with changes made by CMS in early 2020 around the COVID-19 pandemic allowing for a pause in the glide path, long term there is still a consistently dropping benchmark that trends forward to subsequent agreement periods with no real end. However, generating more revenue from properly documenting necessary care often already being delivered increases the delta between benchmark and actual cost, inherently creating more room for organizations to thrive.

A maximally improved risk score changes the benchmark, fully reflecting how sick patients actually are and therefore the full burden of care for a population placed on providers. In doing so, the delta between cost and revenue widens dramatically. It is in this way a risk adjustment program supports care and financial stability for an organization. Furthermore, the initial two goals of value-based care are approached with much more vigor: value is ensured through cost reduction, but care is further enabled through the incentive to treat, manage, and document the development of chronic conditions. The regular cadence of care required for a successful risk adjustment program ultimately results in better patient-physician relationships through more regular connections, and as a result, a better opportunity for care.

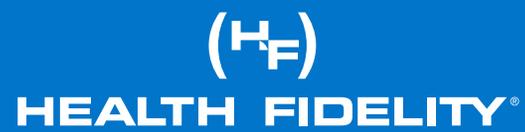
Every organization has its own unique challenges, whether it's rising costs outside of their control, decline in fee-for-service, reticent populations, or even staffing shortages. A robust risk adjustment program is, however, under nearly anyone's control, and can be a tremendous stabilizing factor both within the lines of business covered under value-based care, and for the organization as a whole. At the very least, measure these trends for your own organization using the equation we provided above, find where you are, and consider the next steps for you and your team.

If you have any questions, or want our specific insight on your own internal analysis, contact us today through [healthfidelity.com](https://healthfidelity.com)

---

## About Health Fidelity

Health Fidelity simplifies risk adjustment, offering risk-bearing organizations clear visibility into and control over the process. Through our NLP-powered solutions and expert advisory services, we uncover insights that enable better care plans and more complete revenue capture. The Lumanent™ suite gives our partners the confidence to pursue and ability to succeed in risk-sharing arrangements across MA, ACA, Medicaid, and ACO programs.



[healthfidelity.com](https://healthfidelity.com)