Chairpersons’ Opening Remarks

Nathan Goldstein, Chief Strategy Officer
CENSEOHEALTH

Kevin Healy, Senior Vice President, Payer Solutions
OPTUM

Introduced by: Kevin Mowll, Executive Director
RISE (Resource Initiative & Society for Education)
Nathan Goldstein

Chief Strategy Officer

Nathan Goldstein is passionate about improving healthcare quality. As Chief Strategy Officer he is responsible for identifying and developing new ways health insurance plans and healthcare organizations can leverage in-home diagnostic and care expertise to drive improved health outcomes for beneficiaries.

Before joining CenseoHealth, Goldstein served as CEO of Gorman Health Group where he brought the industry’s leading Medicare consulting firm into the health reform era by developing new practices and software products, doubling the company’s client base. In addition to Goldstein’s focus on Medicare Star Ratings and risk adjustment, teams led by Goldstein developed software to improve client’s revenue management, compliance and business strategy, and forecasting. During this time, he was also a founding member of the first full-service risk adjustment management company serving the managed care industry.

Goldstein is a nationally known speaker and presents at numerous industry events each year on topics including health reform, reimagining the healthcare service model and innovations in clinical practice.

Before entering healthcare, Goldstein’s communications company had clients including presidential candidates, members of the U.S. Congress, network news anchors, Fortune 500 CEOs and one infamous Gonzo journalist. He specialized in writing on healthcare related topics, and, on behalf of his clients, his writings have been syndicated in over 100 newspapers nationwide.
Kevin M. Healy – Senior Vice President
Optum

Kevin Healy is the Senior Vice President of Sales for Optum focusing on Risk Adjustment, Stars, HEDIS, Quality measures, Complex Care management and Data Analytics. Kevin has held this position for over six years. Kevin came to Optum through its acquisition of INSPIRIS, at the time, the leading in home care/care management and in home Medicare assessments organization where he was the Chief Development Officer. Prior to joining INSPIRIS, Kevin was the Senior Vice President of Sales for Warm Health (now part of Change Health). Kevin also served as Managing Director of Social Service Coordinators (Now Change Health) and Vice President of Sales for Healthcare Dimensions and the SilverSneakers Fitness program. Kevin and his family live in Scottsdale, Arizona.
Kevin Mowll, Executive Director
The RISE Association

Kevin Mowll is responsible for building and driving the RISE association, creating a better value for members, creating education and training, industry collaboration, as well as expanding and enhancing our conference offerings.

Prior to joining RISE, Kevin was Vice President for Senior Products with the Tufts Health Plan in Boston. He was responsible for sales, marketing, product development, business performance and strategic planning for the strategic business unit that had annual revenues of $1 B. Kevin has a diverse background and an expertise in Medicare health plans. His expertise centers on:

- Consumer-driven product design and value segmentation
- Growth-oriented product development and implementation
- Market-based sales strategy and execution
- Strategic planning and business development
- Optimization of sales channel distribution models

Earlier, Kevin was the Vice President, Medicare Products, for Capital District Physicians’ Health Plan in Albany, New York, when the Medicare Advantage membership grew from 12,000 to 30,000, including both individual and group retiree business. This growth was achieved through product portfolio and geographic expansion, development of the sales and distribution system and other strategic initiatives. Originally, from Southern California, Kevin worked for both PacifiCare Health Plans and CIGNA Healthplans. At PacifiCare (acquired in 2005 by United Healthcare), Kevin led the development and launch of multiple products and conducted service area expansions for health plans, led a multi-functional national franchise team for start-up Medicare health plans, and ran the California business unit provider network management department. At CIGNA, Kevin was the healthcare center administrator of staff model offices in Long Beach and Torrance, California, as well as regional manager, and Regional Director for IPA model plan development.

A speaker at national conferences on Medicare Advantage business themes, Kevin has also chaired several events. He founded a professional social networking group on LinkedIn called Medicare Advantage Healthplan Colleagues, focused on educating and sharing best practices by developing a virtual community with shared interests and concerns. The group attracted over 18,000 members from across the country.

Kevin is married and has three adult children, and now lives in the Santa Barbara area in California.
Keynote Address - Politics: From the Top and the Inside and Its Impact on the Healthcare Landscape

Howard Fineman, *NBC/MSNBC Political Analyst, Global Editorial Director of The Huffington Post Media Group & Bestselling Author*
NBC/MSNBC Political Analyst, Global Editorial Director of The Huffington Post Media Group & Bestselling Author

A true Washington insider, Howard Fineman is widely respected throughout the news industry for his knowledge of the political landscape. As Global Editorial Director of The Huffington Post Media Group, he helps shape its overall coverage, an editorial vision that has contributed to HuffPo becoming the leading U.S. news site on the Internet.

Fineman appears regularly on MSNBC's Hardball with Chris Matthews, Last Word with Lawrence O'Donnell and Morning Joe, as well as NBC’s Today Show and ESPN Radio's Tony Kornheiser Show.


With an impressive and expansive career that includes interviewing and writing about every major presidential candidate since 1984 and reporting from across the country and around the world, Fineman has established himself as one of the leading journalists in Washington. His work has earned him numerous honors, including from National Magazine, American Bar Association and Sigma Delta Chi (journalism fraternity); an Alumni Award from the Columbia Journalism School; and honorary degrees from his alma maters, Colgate University and University of Louisville Brandeis School of Law.

A popular keynote speaker, Fineman delivers insight with approachability and candor as he clarifies the day's most complicated political issues, drawing on his sharp journalistic instincts to produce an enlightening presentation for all audiences.
Jeffrey D. Grant, Director, Payment Policy & Financial Management Group, Center for Consumer Information and Insurance Oversight
CENTERS FOR MEDICARE & MEDICAID SERVICES
Jeff Grant has worked on ACA financial programs since July 2010, first in the Office of Consumer Information and Insurance Oversight, and now in CCIIO. He has been a key senior leader in the implementation of health insurance marketplaces and associated financial provisions, advising staff and management on policy development, payment methodology, and operational implementation. As the original marketplace financial team member, Jeff has provided strategic and technical direction for financial programs that impact the individual and small group private insurance markets, including premium tax credits, cost sharing reductions, user fees, reinsurance, risk adjustment, and risk corridors.

Jeff has over 22 years of experience in Federal health insurance programs, previously having led the development of the systems and operations to implement Medicare Advantage risk adjustment and Medicare Part D payment reconciliation. Jeff previously served Senior Vice President for Client Services at Health Risk Partners, LLC, where he supported clients on risk adjustment and enrollment and payment reconciliation. He is a retired Naval Reservist with 22 years of service.
ACA Risk Adjustment Updates

Jeff Grant, MPA
March 6, 2017

A New Administration Arrives

“It is imperative for the executive branch to ensure that the law is being efficiently implemented, take all actions consistent with law to minimize the unwarranted economic and regulatory burdens of the Act, and prepare to afford the States more flexibility and control to create a more free and open healthcare market.”

President Donald J. Trump
Executive Order Minimizing the Economic Burden of the Patient Protection and Affordable Care Act
January 20, 2017
February 15, 2017 CMS released a proposed rule on ACA market stabilization

Rule is intended to:
- Stabilize the individual market, including the Marketplace
- Improve the risk pool in the individual market
- Provide more flexibility to states and insurers
- Give patients access to more coverage options

Comments are due by 5 PM EST March 7

Proposed Market Stabilization Rule

Expands pre-enrollment verification related to special enrollment periods in Marketplaces on Healthcare.gov platform, and modifies the parameters of some special enrollment periods

Allows an issuer to collect premiums for prior unpaid coverage from the same issuer before enrolling a patient in the next year’s plan

Expands the de minimis range used for determining the level of coverage

Defers to the states’ reviews to assess issuer network adequacy

Shortens the upcoming annual open enrollment period for the individual market

Did not propose any payment changes for 2018

Provisions of the Proposed Rule
Making Risk Adjustment Better

- Our group’s mission is simple: Pay right, pay on time, every time!
  - For risk adjustment, we want to ensure the transfers represent the most accurate reflection of the relative risk each issuer has assumed in a market
    - In policy, we work to ensure the model accurately reflects risk and that transfers are appropriately sized based on risk
    - In operations, we strive for earlier EDGE data submissions, allowing more time to assess data quality to eliminate surprises and potential sources of payment inaccuracy
    - We want risk adjustment data validation (HHS-RADV) to be strong enough to ensure a thorough assessment of submitted data but simple enough to pass if an issuer’s data accurately reflects risk

2018 Payment Notice

- Revamped HHS HCC model through public process involving consultation, white paper, public meeting, and notice and comment rulemaking
- Model enhancements including inclusion of prescription drugs, enrollment duration factors, and creation of high cost risk pool
- Removal of 14% administrative costs from the statewide average premium in transfers, reducing the overall magnitude of transfers
- Provision to obtain masked EDGE enrollee and claims data to inform future model recalibrations
2015 Program Year Operations

- 837 EDGE servers, up from 775 for 2014
- More issuers met submission standards, and achieved them far earlier than for 2014
- First time CMS released interim risk adjustment data, with 21 states receiving information
- Fewer default charges and for a much lower value than in 2014

HHS-RADV Pilot

- Conducted pilot year of HHS-RADV in 2016, with 470 issuers and 19 independent validation audit (IVA) entities participating
- First time CMS has validated enrollee and claims data from issuer systems in a RADV process
- CMS hosted an IVA lessons learned conference in January and follow-up call with medical record coders in February
- Obtained written issuer feedback on ways to improve
- CMS will issue updated protocols prior to starting this year's RADV cycle
2017 Outlook: EDGE Operations

• Baseline data submission process updated to include an attestation from the financial management component of an issuer, improving the accuracy of baseline data
• EDGE submission deadlines were similar to last year, with the exception of an earlier deadline for the first three quarters of data (mid-December vs. early January)
• This schedule adjustment improved early submission results:
  – Issuers met data quantity thresholds at record rates
  – CMS performed data outlier analysis in December, with the first outlier notifications going out before January 1
  – Multiple data quality issues were remedied prior to the interim risk adjustment scores being run
• Many more states will receive interim scores this year

Future of EDGE

• Moving toward multi-year processing model
• Improving CMS ability to load and update issuer plan reference data on EDGE servers
• Issuers and TPAs need to move from a submission model to a complete data management model
  – Know what has been submitted and accepted
  – Improve capacity to update data through void and replace process
  – Manage rejected data so that it can be corrected and resubmitted
Your Role in Helping Reach Our Goal

• “Pay right, pay on time, every time” is not a CMS responsibility alone
• Payment accuracy and timeliness depends upon issuers and their TPAs raising their own success levels
  1. Regularize data submissions
  2. Meet or beat all interim deadlines
  3. Improve data management, focusing on error correction and updating accepted claims
  4. Build in checks and audits to ensure data quality
  5. Forecast results and compare EDGE to forecasts

HTTPS://WWW.REGTAP.INFO/
Featured Address: The Future of Healthcare is Now

Ceci Connolly, President and Chief Executive Officer
ALLIANCE OF COMMUNITY HEALTH PLANS
Ceci Connolly, a nationally-recognized healthcare leader, is president and CEO of the Alliance of Community Health Plans. She spent 25 years in the journalism field and is a well-respected author and TV commentator. As the Washington Post's former chief health correspondent, she chronicled President Obama's drive for sweeping healthcare reform. Connolly is co-author of LANDMARK: The Inside Story of America's New Health Care Law and What It Means for Us All.

In her current role, she works with some of the most innovative executives in the health sector to provide high-quality, affordable care to all. She is a leading thinker in the disruptive forces reshaping our health system and has been a trusted adviser to c-suite executives. Well-versed in a variety of areas pertinent to business today, she is an expert on communications, leadership coaching, crisis management and the Washington regulatory process.

A highly sought-after speaker, Connolly has the unique ability to translate complex subjects for audiences at all levels. Her breadth of experience as a healthcare adviser and as a political reporter both here and abroad enables her to speak authoritatively on a range of subjects including politics, health care, journalism, and what it takes to be a successful woman in the male-dominated worlds of Washington and Latin America.

She is the first non-physician to receive the prestigious Mayo Clinic Plummer Society award for promoting deeper understanding of science and medicine, and is a founding member of Women of Impact (WOI) for Healthcare.
FEATURED PANEL: IMPACT OF THE NEW ADMINISTRATION ACROSS THE HEALTHCARE SPECTRUM

Moderator:
Nathan Goldstein, Chief Strategy Officer
CENSEOHEALTH

Panelists:
Osato F. Chitou, Esq., MPH, Medicare Compliance Officer
GATEWAY HEALTH

Krista Drobac, Partner
SIRONA STRATEGIES

Rafael Gonzalez, Esq., President
FLAGSHIP SERVICES GROUP, LLC

Ana Handshuh, Vice President, Managed Care Services
ULTIMATE HEALTH PLANS

David Meyer, Vice President, Risk Adjustment, Encounters, Coding and Audit
SCAN HEALTH PLAN
Nathan Goldstein

Chief Strategy Officer

Nathan Goldstein is passionate about improving healthcare quality. As Chief Strategy Officer he is responsible for identifying and developing new ways health insurance plans and healthcare organizations can leverage in-home diagnostic and care expertise to drive improved health outcomes for beneficiaries.

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Osato F. Chitou, Esq., MPH
Ms. Chitou currently serves as the Director of Medicare Compliance for Amida Care, a not for profit health plan in New York founded by several community based organizations. Ms. Chitou is well versed in the industry having served as Director of Legal & Regulatory Affairs for CarePoint Health Plans, a startup Medicare Advantage plan in Hudson County NJ, as well as served as compliance officer for Newark Beth Israel Medical Center, a 669-bed regional care teaching hospital. Additionally, Ms. Chitou also served as a legal specialist charged with overseeing Managed Care Organizations (MCOs) New Jersey market entry and exit including MCO applications, close-out activities, and procurement cycles at the NJ Department of Human Services. Ms. Chitou was also an associate in the Healthcare & Healthcare Privacy practice groups at Moses & Singer LLP. While there, her areas of concentration included state and federal health privacy issues and regulatory compliance with HIPAA and HITECH. Osato was a freelance writer for The National Jurist and appeared as a featured guest on the award winning talk show Good Evening Ghana. She is also an adjunct professor at Rutgers School of Public Affairs and Administration and has taught the following courses: Law and Public Health, Leadership and Diversity, and Healthcare Management. Additionally, she serves as President-Elect on the Board of Trustees of the Alumni Association for Rutgers School of Law-Newark, as well as on the Executive Board of Directors for the New Jersey Women Lawyers Association and is Co-Diversity Officer. Ms. Chitou is admitted to practice law in New York and New Jersey.
Rafael Gonzalez, Esq.
President
Flagship Services Group, LLC
11755 E. Peakview Avenue, Suite 200
Englewood, CO 80111
Website: www.flagshipservicesgroup.com
Email: rgonzalez@flagshipsgi.com
Phone: 813.967.7598

Rafael graduated from Miami Senior High School in 1983. While at Miami High, Rafael won several local, state, and national awards, including the prestigious Miami Herald Silver Knight. After graduating from Miami High, he obtained a Bachelor’s of Science degree from the University of Florida in 1987. While at UF, Rafael received numerous scholarships and served in various leadership roles in a number of state and national organizations.

After graduating from UF, Rafael earned his Jurisprudence Doctorate degree from the Florida State University in 1990. During law school, Rafael interned for Rep. Lincoln Diaz Balart at the Florida House of Representatives. He also clerked for Judge Charles McClure at the Florida 2nd Circuit Court, Judge James Joanas at the Florida 1st District Court of Appeal, and Justice Gerald Kogan at the Florida Supreme Court.

After graduating from FSU, Rafael practiced social security disability, workers’ compensation, and personal injury law in Tampa, Florida from 1990 to 2005. He then served as corporate counsel for FCCI Insurance in Sarasota, Florida from 2005 to 2008. He then served as Chief Executive Officer of The Center for Lien Resolution, The Center for Medicare Set Aside Administration and The Center for Special Needs Trusts Administration in Clearwater, Florida from 2008 to 2011. Rafael then served as Vice President of Medicare & Medicaid Compliance for Gould & Lamb in Bradenton, Florida from 2011 to 2014. He then served as Vice President of Strategic Solutions at PMSI/Helios/Optum/UnitedHealthcare in Tampa, Florida from 2014 to 2016. Rafael presently serves as President of Flagship Services Group in Denver, Colorado.

Over the last 30 years, Rafael has published over 250 articles, book chapters, and books, including his series on Workers’ Compensation, Social Security Disability, and Medicare Set Asides.

Over the last 25 years, Rafael has also taught workers’ compensation social security disability, Medicare, and Medicaid at the FSU College of Law, Stetson University College of Law, USF Department of Vocational Rehabilitation, USF Department of Occupational Medicine, USF College of Public Health, and the University of Tampa.

Over the last 20 years, Rafael has lectured over 500 times on a national basis on the history, substance, and legislative composition of the US workers’ compensation system, the federal social security disability system, and the interplay between Medicare and Medicaid, including the Medicare Secondary Payer Act and Affordable Care Act’s requirements affecting both. He is considered one of the country’s preeminent experts in the areas of Mandatory Insurer Reporting, Conditional Payments Resolution, Medicare Set Asides, and Special Needs Trusts.

Due to his expertise in these areas, he has been actively engaged in the workers’ compensation, social security, and Medicare/Medicaid legislative process at both the state and federal levels. Since 1993, Rafael has attended hearings, testified before legislative committees, testified before executive commissions, drafted, reviewed, amended, and provided opinions on proposed legislation, and served as a consultant to legislative and congressional staff on these substantive areas.

After meeting at UF in 1983, Rafael and Lisa were married in 1988. They have two boys, Alex and Andres. Lisa teaches kindergarten at Brandon Academy, Alex studies game design at the University of Central Florida and Andres plays basketball for Bell Creek Academy High School.
Ana Handshuh, Principal at CAT5 Strategies, is a government programs executive with expertise in creating and implementing corporate programs for the healthcare industry. Her background includes Quality, Core Measures, Care Management, Benefit Design and Bid Submission, Accreditation, Regulatory Compliance, Revenue Management, Communications, Community-based Care Management Programs and Technology Integration. Ms. Handshuh currently serves on the Board of the Resource Initiative and Society for Education (RISE), the preeminent national professional association dedicated to managed and accountable care financing and delivery. She is a sought-after speaker on the national healthcare circuit in the areas of Quality, Star Ratings, Care Management, Member and Provider Engagement, and Revenue Management. Her recent consultancy roles have included assisting organizations create programs to address the unmet care management needs in the highest risk strata of membership, document their processes and procedures, achieve accreditation status, design and submit government program bids, institute corporate-wide programs and create communications strategies and materials. She possesses sophisticated business acumen with the ability to build consensus with cross-functional groups to accomplish corporate goals. Ms. Handshuh served as the Vice President of Managed Care Services at Central Florida Inpatient Medicine (CFIM). In this role, she provided leadership and strategy on CFIM projects and collaborations with physicians, risk entities, hospital health care systems, and health plans. CFIM is the largest Hospitalist group in Central Florida, with 70 providers discharging over 50,000 patients annually from multiple hospitals across two health care delivery systems and 24 skilled nursing facilities. At CFIM Ms. Handshuh previously served as the Vice President of Operations. Prior to those assignments, she worked with Precision Healthcare Systems as their Vice President of Quality Improvement. In that capacity, she led the IPA’s Quality efforts and collaborated with payers on implementing programs to move the needle on Quality and Star Rating initiatives. Ms. Handshuh also served as the Director of Corporate Program Development at Physicians United Plan. In this role, she led the Quality Management and Corporate Communications departments and spearheaded the development of innovative integrated technology solutions to drive business excellence and Star Rating achievement initiatives. For the past fifteen years Ms. Handshuh has taken an active role in redefining and implementing changes that have led to improvements and greater efficiency within Government programs and healthcare delivery. Prior to joining Physicians United Plan Ms. Handshuh was the founder of I-Six Creative. Under Ms. Handshuh’s vision and leadership, I-Six Creative provided expertise in the areas of managed Medicare benefit design, MSO/IPA operations, provider network strategy, new market launches, technology integration, corporate communications and quality improvement.


Previously, Dave served as an independent consultant to healthplans, was Corporate VP, Operations (Revenue and Quality) at InnovaCare Health. He has also performed as Sr. Consultant, Risk Adjustment and Health Plan Operations for Dynamic Healthcare Systems, and in other roles with healthplans.
SPECIAL CMS ADDRESS: RADV UPDATE

Kelly Drury, Deputy Director, Division of Risk Adjustment Operations
CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)
Kelly Drury serves as the Deputy Director of the Division of Risk Adjustment Operations in the Payment Policy and Financial Management Group at the Center for Consumer Information & Insurance Oversight (CCIIO) within the Centers for Medicare & Medicaid Services (CMS). Since joining CCIIO in May 2012, Kelly has focused mainly on risk adjustment policy. Prior to CCIIO, Kelly worked on home health payment policy in the Center for Medicare and in financial services at Legg Mason. Kelly has an undergraduate degree from the University of Maryland and an MBA in finance and management from Johns Hopkins University.
HHS-Operated Risk Adjustment Data Validation (HHS-RADV)

Risk Adjustment Overview

- **What**: A budget neutral program that transfers funds from plans with lower risk enrollees to plans with higher risk enrollees in a state market risk pool
- **Who participates**: Affordable Care Act-compliant non-grandfathered individual and small group market plans, inside and outside the Marketplace
- **How**: Criteria and methods developed by the Secretary of HHS, in consultation with states and issuers
Purpose of HHS-RADV

To promote confidence in risk adjustment payment transfers by ensuring the integrity and quality of data provided from issuers operating in state markets under the HHS-operated risk adjustment program

HHS-RADV Authority

- CMS requires states, or HHS on behalf of states, to validate a statistically valid sample of data for all issuers that submit for risk adjustment every year and allows states, or HHS on behalf of states, to adjust average actuarial risk for each plan based on the found error rate and adjust payments and charges based on the changes to average actuarial risk
- The 2015 Payment Notice detailed the methodology and issuer requirements for the initial years of the program
Key Components:
• CMS selects a statistically valid sample of enrollment and medical claims data submitted to the issuer’s External Data Gathering Environment (EDGE) server.
• Data validation of the selected sample is conducted by an initial validation audit (IVA) auditor (IVA entity) selected by the issuer and reviewed by CMS.
• CMS selects a second validation auditor to validate a subsample of the original IVA sample.
• CMS establishes an issuer-level error rate based on data validation results.

Key Components (continued):
• CMS applies the error rate to each issuer’s risk adjustment covered plan average liability risk score (PLRS) to produce an error estimate.
• CMS provides an HHS-RADV appeals process for issuers.
• CMS adjusts the PLRS for issuers’ risk adjustment covered plans based on errors discovered as a result of data validation.
HHS-RADV Processes

1. Sample Selection
2. IVA/IRR
3. SVA
4. Error Estimation
5. Appeals
6. Payment Adjustments

2015 Pilot Year HHS-RADV
### 2015 Pilot Year Goals

- To acclimate issuers to the requirements of the HHS-RADV process
- To inform HHS of process improvements that would make the HHS-RADV program more efficient in ensuring that risk adjustment transfers were accurate

### 2015 Pilot Year Challenges

- The audit tool used for the pilot year was complicated and cumbersome
- IVA entities have indicated that some requirements were overly burdensome or incongruous with the goal of the program
  - Examples: state credentials for providers, tracking types of provider credentials, claims review
Lessons Learned & Process Improvements

2016 HHS-RADV Refinements

• We have held two sessions with IVA entities and medical coders to gather feedback on improvements for 2016 benefit year HHS-RADV
• We have also taken a full week to internally “LEAN” this process in an effort to provide more value for issuers, IVA entities, and CMS, while reducing wasteful processes
• CMS has developed a timeline for 2016 HHS-RADV that provides issuers and IVA entities additional time for medical record retrieval

• Issuers and IVA entities experienced widespread issues obtaining medical records in the pilot year

• CMS will be releasing the IVA sample 1-2 months earlier, and simultaneously to issuers and IVA entities so that the IVA can begin

• Concurrent submission of the inter-rater reliability (IRR) results with the IVA results
# 2016 Benefit Year HHS-RADV Timeline

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
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<tbody>
<tr>
<td>February 15, 2017</td>
<td>HHS-RADV trainings begin</td>
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<tr>
<td>February 2017 – April 28, 2017</td>
<td>Issuers contractually selects an IVA Entity</td>
</tr>
<tr>
<td>March – April, 2017</td>
<td>Issuers designate their Senior Officials, Request Exemption, Register in the Audit Tool</td>
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<tr>
<td>March 7 – 28, 2017</td>
<td>IVA Entities elects to participate in RADV using a web form (Deadline: March 28, 2017)</td>
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<tr>
<td>April 17 – 28, 2017</td>
<td>Issuers designates IVA entity selection for CMS review/acceptance in the Audit tool (Deadline: April 28, 2017)</td>
</tr>
<tr>
<td>May 1, 2017</td>
<td>2016 benefit year risk adjustment EDGE server data submission deadline</td>
</tr>
<tr>
<td>May 2017</td>
<td>HHS-RADV 2016 Benefit Year Protocols released</td>
</tr>
<tr>
<td>May 2017</td>
<td>1. CMS pushes RADV sampling command to EDGE servers</td>
</tr>
<tr>
<td></td>
<td>2. Reports are provided to CMS for validation. Reports are NOT available to issuers</td>
</tr>
<tr>
<td></td>
<td>3. Sample released to issuers, after CMS validation</td>
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<tr>
<td></td>
<td>4. 15 day RADV sample discrepancy window opens</td>
</tr>
<tr>
<td>June 2017 – January 8, 2018</td>
<td>IVA is conducted</td>
</tr>
<tr>
<td>January 8, 2018</td>
<td>Package 1 and IRR submissions are due</td>
</tr>
<tr>
<td>January 8, 2018</td>
<td>CMS releases the SVA subsample to IVA entities</td>
</tr>
<tr>
<td>January 18, 2018</td>
<td>IVA entity submits SVA subsample to CMS</td>
</tr>
<tr>
<td>January 2018 – April 2018</td>
<td>SVA is conducted</td>
</tr>
<tr>
<td>May 2018 – June 2018</td>
<td>CMS releases 2016 RADV error rates to issuers</td>
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**HHS-RADV Audit Tool**

- The HHS-RADV audit tool is an automated system CMS implemented for the 2015 pilot year to facilitate HHS-RADV processes
- The audit tool serves as the means of submission for all related RADV activities (IVA entity designation, inter-rater reliability (IRR) submission, IVA results submission, etc.)
- Issuers, the IVA entity and the second validation audit (SVA) entity are registered in the audit tool

**Audit Tool Proposed Improvements**

- Redaction of medical records to be automated
- Simplification of the audit matrix to only specific data elements required for IVA results
- IVA entities may provide IVA results in a data file rather than Excel
In the pilot year, 470 issuers participated in HHS-RADV, and 347 issuers were excluded from being required to perform an IVA for 2015 HHS-RADV:

- Excluded issuers at or below 12,000 billable member months or issuers exiting the market in the 2016 benefit year.

In the 2018 Payment Notice, CMS implemented a materiality threshold of $15 million in total premiums, beginning for the 2017 benefit year HHS-RADV program.

Issuers that are at or below this threshold for the 2017 benefit year of risk adjustment will be randomly selected to be required to conduct an IVA for 2017 benefit year HHS-RADV.
Outreach

• Many diagnoses in the pilot year of HHS-RADV were unsupported due to missing medical records

• In addition to extending the IVA window to allow additional time, we will be leveraging Medicare provider communications to have more substantive outreach to providers to make them aware of the HHS-RADV requirements

• We are also actively working on an approach for mental and behavioral health records in states with very stringent privacy laws

State Credentials of Providers

• CMS had required that IVA entities demonstrate that the providers of the risk adjustment eligible diagnoses be credentialed in the applicable state, including the type of credentials

• For 2016 HHS-RADV, CMS is eliminating this requirement, as we do not believe demonstrating this is necessary for the IVA audit

• The issuer is responsible for ensuring that only qualified providers receive reimbursement for services; RADV will not evaluate the appropriateness of that determination
Demographic and Enrollment Data

- CMS had required the validation of all sampled enrollees’ demographic and enrollment data for 2015 HHS-RADV.
- Many IVA entities voiced the challenges of slight errors for date of birth, or the cumbersome and time-consuming review of enrollments, especially in situations with dual enrollments or missing end dates.
- For 2016 HHS-RADV, we will allow a subsample and are evaluating the size of a subsample of enrollees in the IVA sample for demographics and enrollment validation.

Premiums

- Because premiums are a key component of risk adjustment transfers, we believe they warrant validation in ensuring the integrity of risk adjustment payments.
- For 2015 HHS-RADV, CMS required IVA entities to map the amount being charged to the enrollee and show a screenshot that maps to this amount.
- IVA entities encountered challenges linking EDGE premium values to what was billed to each enrollee, since there was no reconciliation back to the source billing system.
- CMS is evaluating how best to allow for a simplified but validating look at issuer premiums.
### IVA Changes

**Plan ID**
- Similarly to premiums, because the plan ID validates the plan’s metal level (and CSR variant, if applicable), it is another component of risk adjustment transfers.
- For 2015 HHS-RADV, CMS required IVA entities to validate the plan ID of sampled enrollees’ plans.
- IVA entities encountered challenges mapping the CMS-issued plan ID to an issuer’s source system, which often did not exist or was unavailable to the IVA entity.
- For 2016 HHS-RADV, in addition to using a subsample for validating enrollment data elements, CMS is evaluating how to help clarify appropriate procedures to help simplify this process.

**Rating Area**
- Rating area is another important component of risk adjustment transfers, as transfers are calculated at the rating area level.
- For 2015 HHS-RADV, CMS required IVA entities to obtain work papers from issuers that explained how they determined an enrollee’s rating area.
- IVA entities encountered challenges deciphering these guidelines and found the level of effort associated with this requirement to be quite large.
- For 2016 HHS-RADV, CMS is evaluating how to help clarify appropriate procedures to help simplify this process.
Medical Record Submissions

- Given some of the constraints of the audit tool for 2015 HHS-RADV, these issues were exacerbated by medical record submissions beyond what we would require for validation of an enrollee’s diagnoses.
- Medical records were submitted that were tens of thousands of pages long.
- For 2016 HHS-RADV, CMS will be explicitly detailing the elements of the medical records that IVA entities should abstract for diagnosis validation:
  - For example, we will not require the submission of discharge instructions, photos, flow sheets, physician orders, nurse notes, lab results, or the medical administration record (MAR).

Removing requirements to validate lower priority elements

- Service code modifiers:
  - IVA entities expressed that not only are service code modifiers difficult to map, but they are also not available for inpatient services – we will remove this requirement.
- Claims:
  - Medical records are the source of diagnoses and IVA entities expressed that the level of effort for claims review was overly burdensome – we will remove this requirement.
• CMS is still determining the timing of the 2015 benefit year HHS-RADV pilot report, as the SVA is still in progress

• As we progress with the SVA results, we will update issuers on when they can expect their issuer-specific 2015 HHS-RADV results
Next Steps

• New audit tool is a step in the right direction of increased automation, better organization, user intuitiveness, and less burden

• Ramping up outreach to providers to ensure they are aware of the HHS-RADV requirements

• Working with new issuers and IVA entities to ensure they have a smooth first year in the program

• Continuing to hold weekly webinars for issuers and IVA entities

• Actively refining the HHS-RADV Protocols to better serve issuers and IVA entities as a manual for all HHS-RADV requirements and process examples – we continually welcome feedback on how this document can best serve our stakeholders
Questions?
John Lumpkin, MD, MPH, is the senior vice president. He is responsible for the overall planning, budgeting, staffing, management, and evaluation of the Robert Wood Johnson Foundation’s efforts aimed at ensuring that all children grow up at a healthy weight, ensuring that all Americans have access to stable and affordable health care coverage, advancing change leadership, and creating a health care system that provides the best possible care at a reasonable cost.

Before joining the Foundation in April 2003, Lumpkin served as director of the Illinois Department of Public Health for 12 years. During his more than 17 years with the department, he served as acting director and prior to that as associate director. Before joining the Foundation in April 2003, Lumpkin served as director of the Illinois Department of Public Health for 12 years. During his more than 17 years with the department, he served as acting director and prior to that as associate director.

Lumpkin has participated directly in the health and health care system, first practicing emergency medicine and teaching medical students and residents at the University of Chicago and Northwestern University. He is the past chairman of the board of directors of the Robert Wood Johnson University Hospital, the major teaching hospital of Rutgers University in New Brunswick. After earning his MPH in 1985, he began caring for the more than 12 million people of Illinois as the first African-American director of the state public health agency with more than 1,300 employees in seven regional offices, three laboratories, and locations in Springfield and Chicago. He led improvements to programs dealing with women’s and men’s health, information and technology, emergency and bioterrorism preparedness, infectious disease prevention and control, immunization, local health department coverage, and the state’s laboratory services.

Lumpkin is a member of the National Academies of Medicine and a fellow of the American College of Emergency Physicians and the American College of Medical Informatics. He has been chairman of the National Committee on Vital and Health Statistics, and served on the U.S. Department of Agriculture’s Council on Maternal, Infant and Fetal Nutrition, the advisory committee to the director of the U.S. Centers for Disease Control and Prevention, and the National Institute of Medicine's Committee on Assuring the Health of the Public in the 21st Century. He has served on the boards of directors for the Public Health Foundation and National Quality Forum, as president of the Illinois College of Emergency Physicians and the Society of Teachers of Emergency Medicine, and as speaker and board of director’s member of the American College of Emergency Physicians. He has received the Arthur McCormack Excellence and Dedication in Public Health Award from the Association of State and Territorial Health Officials (ASTHO), the Jonas Salk Health Leadership Award, and the Leadership in Public Health Award from the Illinois Public Health Association. Lumpkin also has been the recipient of the Bill B. Smiley Award, Alan Donaldson Award, African American History Maker, and Public Health Worker of the Year of the Illinois Public Health Association. He is the author of numerous journal articles and book chapters.
Lumpkin earned his MD and BMS degrees from Northwestern University Medical School and his MPH from the University of Illinois School of Public Health. He was the first African-American trained in emergency medicine in the country after completing his residency at the University of Chicago. He has served on the faculty of the University of Chicago, Northwestern University, and University of Illinois at Chicago.

Lumpkin and his wife Mary S. Blanks, MD, a health care mediator, reside in the Princeton area. They have two adult children.
Building a Culture of Health

John R. Lumpkin, MD, MPH, FAAN
Senior Vice President
Robert Wood Johnson Foundation

American Health Care Act Repeal

- Individual and employer mandate
- Small business tax credit – 2020
- Bronze-Silver-Gold-Platinum -2020
- (no change to essential health benefit)
- Prevention and Public Health fund – 2019
- Health insurer, pharm and device taxes
- Delay “Cadillac Tax” - 2025
American Health Care Act

- Age range to 1-5
- Continuous coverage
- New advanceable tax credit – 2020
  - $2K - $4K
- Medicaid Reforms including cap – 2020
- $15 Billion Patient and State Stability Fund
- No repeal of CMMI or MACRA

American Health Care Act

- No CBO score’
- SP predicts as many as 10 Million uninsured
Predictions

■ There will be a bill
■ Costs remain an diving issue
■ Coordinated care is better than uncoordinated care
■ Challenges and opportunities

We can’t solve problems by using the same kind of thinking we used when we created them.
France II

Preussens
Building a Culture of Health

- Clinical
- Clinical Population Health
- Community Population Health
We have the best clinical science in the world...

The best health care in the world?

Health Care Spending
1980–2011

Source: OECD Health Data 2013.
Hospital Discharges
per 1,000 Population, 2011

GER  NOR*  DEN*  SWIZ  FR  SWE*  AUS*  OECD Median  NZ  UK  US*  NETH  JPN  CAN*
244  175  172  170  169  163  159  159  147  136  125  122  111  82

* 2010.
Source: Commonwealth Fund from OECD Health Data 2013.

Average Annual Physician Visits
per Capita, 2011

JPN*  GER  CAN*  FR  AUS  NETH  OECD Median  NOR**  UK**  DEN*  US**  SWE
13.1  9.7  7.4  6.8  6.7  6.6  6.6  5.2  5.0  4.6  4.1  3.0

* 2010.
** 2009.
Source: Commonwealth Fund from OECD Health Data 2013.
We have the best clinical science in the world…
Do we have the best health in the world?
The U.S. has the lowest life expectancy at birth among OECD comparable countries

*Life expectancy at birth in years, 2011*

<table>
<thead>
<tr>
<th>Country</th>
<th>Life Expectancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switzerland</td>
<td>83</td>
</tr>
<tr>
<td>Japan</td>
<td>82</td>
</tr>
<tr>
<td>France</td>
<td>83</td>
</tr>
<tr>
<td>Australia</td>
<td>82</td>
</tr>
<tr>
<td>Sweden</td>
<td>82</td>
</tr>
<tr>
<td>Comparable Country Average</td>
<td>82</td>
</tr>
<tr>
<td>Canada</td>
<td>81</td>
</tr>
<tr>
<td>Netherlands</td>
<td>81</td>
</tr>
<tr>
<td>Austria</td>
<td>82</td>
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<td>United Kingdom</td>
<td>82</td>
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<td>Germany</td>
<td>82</td>
</tr>
<tr>
<td>Belgium</td>
<td>82</td>
</tr>
<tr>
<td>United States</td>
<td>79</td>
</tr>
</tbody>
</table>


*Peterson-Kaiser Health System Tracker*
Health and Social Spending as a Percent of GDP

Notes: GDP refers to gross domestic product.

---

U.S. life expectancy declines for the first time since 1993

By Lenny Bernstein  December 8, 2016

Life expectancy at selected ages, by sex (CDC/NCHS/HHS/NVSS)
71% of those 17 to 24 are ineligible to serve in the military.

Culture

Learned and shared behavior of a community of interacting human beings

— Useem & Useem: Human Organizations 1963
We, as a nation, will strive together to build a Culture of Health enabling all in our diverse society to lead healthier lives, now and for generations to come.
what is a culture of health?
Being healthy and staying healthy is an esteemed social value.

Health of the population guides public and private decision-making.
geography and demographics do not serve as barriers to good health.

individuals, businesses and governments work collectively to foster healthy communities and lifestyles.
the economy is less burdened by excessive and unwarranted health care spending

we are all supported to make proactive choices that will improve our health.
Teens Today Have Less Sex Than Their Parents Did

New data show dramatic decreases in teen sexual activity over the last 25 years.

By Kimberly Leonard | Staff Writer  July 22, 2015, at 12:51 a.m.
we will only be able to succeed if we take chances and consider completely new approaches and ways of thinking
In the past, the benefits of modern medical science have not been enjoyed by our citizens with any degree of equality. Nor are they today. Nor will they be in the future – unless government is bold enough to do something about it. – Harry Truman
TRENTON, NEW JERSEY

Short Distances to Large Gaps in Health

Follow the discussion
#CloseHealthGaps

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Equality

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The choices one makes are determined by the choices one has.

Risa Lavizzo-Mourey
CULTURE OF HEALTH ACTION FRAMEWORK

MAKING HEALTH A SHARED VALUE

FOSTERING CROSS-SECTOR COLLABORATION TO IMPROVE WELL-BEING

IMPROVED POPULATION HEALTH, WELL-BEING AND EQUITY

CREATING HEALTHIER MORE EQUITABLE COMMUNITIES

STRENGTHENING INTEGRATION OF HEALTH SERVICES AND SYSTEMS

MAKING HEALTH A SHARED VALUE

DRIVERS

MINDSET AND EXPECTATIONS

SENSE OF COMMUNITY

CIVIC ENGAGEMENT
What is the most important thing we can do to improve health?
This is how Randee writes in September.

This is how Jose writes in September.

**Math**
K Assessment

Date: September

I can write my name:  

Jose

I can count to:  5

I can write my numbers 0 through 20:

0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20

Randee Madelbaum veteran Kindergarten Teacher – Freehold, NJ
Universal Preschool

- 41 states fund
- 9 states serve more than half 4-year-olds
- Florida, Georgia, Oklahoma
CULTURE OF HEALTH ACTION FRAMEWORK

- Making Health a Shared Value
- Fostering Cross-Sector Collaboration to Improve Well-Being
- Improved Population Health, Well-Being and Equity
- Creating Healthier More Equitable Communities
- Strengthening Integration of Health Services and Systems
- Equity

ACTION AREA 2: Fostering Cross-Sector Collaboration to Improve Well-Being

Drivers
- Number and Quality of Partnerships
- Investment in Cross-Sector Collaboration
- Policies That Support Collaboration
Current smoking among adults aged ≥18 years by census tract, Nashville, TN, 2014
Obesity among adults aged ≥18 years by census tract, Nashville, TN, 2014

High blood pressure among adults aged ≥18 years by census tract, Nashville, TN, 2013
Current lack of health insurance among adults aged 18-64 years by census tract, Nashville, TN, 2014

Up to date on a core set of clinical preventive services (flu shot past year, pneumococcal shot ever, colorectal cancer screening) among men aged ≥65 years by census tract, Nashville, TN, 2014
Physical health not good for $\geq 14$ days among adults aged $\geq 18$ years by census tract, Nashville, TN, 2014

NASHVILLE Health

Hypertension, or high blood pressure, is a leading cause of heart disease and stroke. Concentrating on this health issue, which contributes to many others, is critical to improving health in Nashville.

31 PERCENT OF NASHVILLIANS ARE OBSESE, COMPARED TO 34.9 PERCENT NATIONALLY
(RWJF County Health Rankings; Centers for Disease Control and Prevention)

MORE THAN 1 IN 4 NASHVILLIANS ARE PHYSICALLY INACTIVE, COMPARED TO 1 IN 5 AMONG TOP-PERFORMING CITIES
(RWJF County Health Rankings)

IN 2013, 23 PERCENT OF NASHVILLE DEATHS WERE DUE TO HEART DISEASE
(Centers for Disease Control)
MAKING HEALTH A SHARED VALUE

OUTCOME IMPROVED POPULATION HEALTH, WELL-BEING AND EQUITY

CREATING HEALTHIER MORE EQUITABLE COMMUNITIES

STRENGTHENING INTEGRATION OF HEALTH SERVICES AND SYSTEMS
MAKING HEALTH A SHARED VALUE

OUTCOME
IMPROVED POPULATION HEALTH, WELL-BEING AND EQUITY

CREATING HEALTHIER MORE EQUITABLE COMMUNITIES

STRENGTHENING INTEGRATION OF HEALTH SERVICES AND SYSTEMS

EQUITY

FOSTERING CROSS-SECTOR COLLABORATION TO IMPROVE WELL-BEING

CULTURE OF HEALTH ACTION FRAMEWORK

STRENGTHENING INTEGRATION OF HEALTH SERVICES AND SYSTEMS

ACTION AREA

4

DRIVERS

ACCESS

CONSUMER EXPERIENCE AND QUALITY

BALANCE AND INTEGRATION
CULTURE OF HEALTH ACTION FRAMEWORK

- Making health a shared value
- Fostering cross-sector collaboration to improve well-being
- Outcome: Improved population health, well-being and equity
- Creating healthier, more equitable communities
- Strengthening integration of health services and systems

Outcome: Improved population health, well-being, and equity

Outcome Areas:
- Enhanced individual and community well-being
- Managed chronic disease and reduced toxic stress
- Reduced health care costs
“Money would be better spent in maintaining health in infancy and childhood than in building hospitals to alleviate disease. It is much cheaper to promote health than to maintain people in sickness.”

--Florence Nightingale, 1894

Health is more than Health Care
How People Spend Their Time

- Clinical visit - 60
- Sports and exercise – 7,008
- Shopping – 15,770
- Eating and drinking – 27,360
- Watching TV – 93,600
- Working-120,000

Health happens where we live, learn, work, and play
Building a Culture of Health

- Clinical
Building a Culture of Health

- Clinical
- Clinical Population Health
Building a Culture of Health

- Clinical
- Clinical Population Health
- Community Population Health
WHAT COULD YOU DO TO END CHILD POVERTY?
Help us create a better future for Cincinnati's children.
childpoverty@uwgc.org

CHILDHOOD POVERTY

boom
We, as a nation, will strive together to build a Culture of Health enabling all in our diverse society to lead healthier lives, now and for generations to come.
Bobbie Knickman joined CCIIO in the fall of 2012 as a technical advisor for risk adjustment operations. She was a senior member of the EDGE server implementation team working on business requirements, technical implementation, training and outreach. In September 2015, Bobbie became the Director of the Division of Risk Adjustment Operations.

Bobbie started her career at CMS in 1999. Prior to joining CCIIO, she worked on various Medicare programs including Medicare Advantage risk adjustment, implementation of the MMA Critical Care Improvement Program (CCIP) pilot, Part D, and Medicare Part C and Part D program integrity and fraud detection.
Planning for Future EDGE Submissions:
ACA Benefit Year 2017 and Beyond

Bobbie Knickman
RISE Annual
Summit –
Nashville, TN
March 8, 2017

Agenda

- Overview
- Proposed Timeline
- Data management plan
- Evaluating the Plan
- Achieving good outcomes
- Multiple year submissions
- Reminders
Overview: 2017

- Now is the time to start thinking about your 2017 benefit year (BY) EDGE data
- 2017 BY will be our 4th year
- Each year we have been able to move up deadlines
- We are proposing to start receiving 2017 BY data in early July

2017 Proposed Timeline

- July 2017: Start submitting 2017 BY data to the EDGE server
  - Monitor 2017 BY errors and submit voids or replacements
- October 2017:
  - Reference data for 2017 BY is updated
  - Submission of 2017 BY baseline data
  - CMS will start checking for initial submissions
- November 2017: Goal should be to have 75% of enrollment and claims data submitted
- December 2017: CMS starts checking quantity and quality measures
2017 Proposed Timeline (cont’d)

- **January 2018:** 2017 BY quantity and quality continues
  - Continue to monitor 2017 BY errors and fixes (submit voids or replacements)
- **February 2018:** Interim RA data for 2017 BY year is finalized
  - Continue monitoring 2017 BY errors and fixes
- **March 2018:** Interim RA transfer reports are released
  - Continue monitoring 2017 BY errors and fixes

2017 Proposed Timeline (cont’d)

- **April 2018:** All data submitted for 2017 BY
  - Finalize 2017 BY data
- **May 2018:** Discrepancy period
- **June 2018:** CMS finalizes 2017 BY Risk Adjustment Report
2018 and Beyond

- Start transitioning to continuous submission
- This means viewing 2018 BY as a transitional year from benefit year data submission to the continuous model
- Requires a holistic data management approach
- The ultimate goal is submitting data as you have issued payment or created an encounter record

2018 and Beyond (cont’d)

- Moving up the timeline will allow for earlier submission of data and more data
- CMS will be able to assess the data earlier
- The goal is to deal with final run out of claims as early as possible
- More data for interim RA reports
- Earlier submission of plan data and baseline data
- Around May/June 2018, CMS will start looking at the 2018 BY data and reaching out
Quantity & Quality

- Minimum quantity threshold: CMS expects all issuers to meet a quantity threshold of 90% of both reported enrollment and claims baseline
- After reaching the quantity threshold, the focus should be on quality

Quantity & Quality (cont’d)

<table>
<thead>
<tr>
<th>Current Data Quality/Sufficiency Evaluation Metrics</th>
<th>Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of all enrollees with at least one (1) Hierarchical Condition Category (HCC)</td>
<td>Risk Adjustment</td>
</tr>
<tr>
<td>Average number of conditions per enrollee with at least one (1) HCC</td>
<td>Risk Adjustment</td>
</tr>
<tr>
<td>Issuer average risk score</td>
<td>Risk Adjustment</td>
</tr>
<tr>
<td>Average number of diagnosis codes per medical claim</td>
<td>Risk Adjustment</td>
</tr>
<tr>
<td>Average premium per member per month</td>
<td>Risk Adjustment</td>
</tr>
<tr>
<td>Average number of medical claims per enrollee</td>
<td>EDGE Claims/Enrollment</td>
</tr>
<tr>
<td>Percent of enrollees without claims</td>
<td>EDGE Claims/Enrollment</td>
</tr>
<tr>
<td>Percent of medical claims that are institutional claims</td>
<td>EDGE Claims/Enrollment</td>
</tr>
<tr>
<td>Average number of pharmacy claims per enrollee</td>
<td>EDGE Claims/Enrollment</td>
</tr>
</tbody>
</table>
Remember . . .

- CMS does not have the same knowledge that issuers have of their own data and CMS cannot detect data quality anomalies that fall within the normal distribution of data (i.e. data that is not an outlier)
- Issuers are responsible for ensuring the completeness and accuracy of all data submitted
- Issuers should develop processes to assess their own EDGE data

Data Management Plan

- Have a data management plan: Good data relies on process improvements
- Is the plan working?
- Validate and analyze the results
- Achieve efficient and effective outcomes
Data Management Plan (cont’d)

- Don’t have a silo approach
- Risk adjustment touches many parts of your organization
  - Financial
  - Medical record review/audit
  - Care management
  - Data
- Remember to coordinate

Components of a Good Data Management Plan

- Develop a schedule and stick to it
  - Decide on frequency of submissions – daily or weekly
- Identify and resolve problems quickly
- Complex problems should have the right people working on a solution
- Prioritize high impact data
- Utilize medical record review
- Document what worked and what did not
Problem Resolution

- Is it an inpatient claim?
  - Resolving an inpatient claim is important; more diagnoses are likely to be in the model
- Is the diagnosis unique (not previously submitted, regardless of source)?
- Is the claim orphaned (no corresponding enrollment period)?
  - Consideration: resolve an orphaned claim if the diagnosis contributes to the risk score

General Suggested Guidance

- Ensure all enrollment records are accepted
- Ensure enrollee claims are accepted
- Monitor the Enrollee (Without) Claims Detail (ECD) Report
- Execute suggested EDGE server database queries
General Suggested Guidance (cont’d)

- High cost enrollees that don’t have RA diagnoses may require more research
- Inpatient medical records are a good source of additional diagnoses
- Submit supplemental diagnoses
- Developing a plan for medical record review will help with evaluating the quality of the data

Specific Guidance for Risk Adjustment Data

- Ensure Supplemental Diagnosis Codes (adds and deletes) are accepted
- Monitor the Risk Adjustment Claim Selection Detail (RACSD) Report
- Monitor the RA Risk Score Detail (RARSD) Report
- Review the Risk Adjustment Transfer Elements Extract (RATEE) Report for accuracy
Monitor RARSD Report

- Using the HHS DIY Risk Adjustment software to perform projections and make sure that EDGE risk scores are aligning with expectations
- If an enrollee does not appear in the RARSD Report, or has a lower than expected risk score, issuers should:
  - Confirm the enrollee’s enrollment has been accepted on the EDGE server
  - Identify what RA diagnosis codes were not included in the RARSD Report and then validate that the claims with these Diagnosis Codes were:
    - Submitted to and accepted by the EDGE server
    - Identified as RA-eligible in the RARSD Report

Review the RATEE Report for Accuracy

- The RATEE Report includes all the issuer’s inputs into the RA transfer formula
- Issuers should review the RATEE Report to ensure that the information from the RARSD Report results in an accurate PLRS for each plan in a rating area
- Other important components of the RATEE Report that should be validated include: billable member months, subscriber months, allowable rating factor (ARF) and plan average premium
Validating Results & Analyzing Data

- Make sure you are consistently checking your results
- Develop your own predictive model for checking results
  - HHS DIY Risk Adjustment software is a good place to start
- Make sure your EDGE server reports are showing the same results
- Look for trends and patterns in rejected data
- If there is a problem that is consistently observed, then contact CMS and your FM representative as early as possible (EDGE_Server_Data@cms.hhs.gov)

Evaluating the Plan

- Is the plan working?
  - Identify inefficient processes and decide if corrective action is needed
- Are more resources needed?
- Identify gaps
Achieving Good Outcomes

- Your independent results are now matching the EDGE server results
- Your improvement processes are yielding timely submissions
- You know and understand your quantity and quality measures

Multiple Year Submissions

- After 2018 BY, this should be the norm
- Core competencies:
  - Check data based on analytics
  - Submit based on receipt of data
  - Rapid turnaround of rejected data
  - Timely voids and replacements
Reminders: Prepare and Communicate

- Prepare for a Disaster
  - Back up your data frequently and save it to an external storage area in the event you need to restore your server or a prior version of your data

- Communicate with CMS
  - Respond to CMS outreach related to quantity and quality promptly
    - Delayed responses will result in escalation to CEOs
  - Contact EDGE_Server_Data@cms.hhs.gov early and as often as needed for assistance including policy questions, technical support and understanding reports

QUESTIONS?
SPECIAL LIVE FOCUS GROUP: MEDICARE ADVANTAGE MEMBERS SHARE FEEDBACK

Facilitated by:
Linda M. Lynch, M.Ed., PRC, Performance Improvement Consultant
SPH ANALYTICS
Consulting Services Bio

LINDA LYNCH, M.Ed., PRC
Performance Improvement Consultant

SUMMARY:
Linda Lynch leads SPH Analytics’ Consulting Services team in her role as Performance Improvement Consultant.

Linda and her team assist organizations in understanding their survey results, member feedback, and healthcare data to identify improvement opportunities and appropriate next steps for improving quality and performance. Linda provides support and guidance to implement process enhancements and strategic initiatives to improve performance and increase scores and ratings.

BACKGROUND/EXPERIENCE:
Linda has almost 30 years of experience in healthcare market research and in driving health plan quality improvement initiatives.

Prior to joining SPH Analytics, Linda served as Director of Market Research and Strategy at Blue Cross Blue Shield of Massachusetts for 16 years where she was responsible for leading and developing corporate market research. Linda led the Commercial HMO and PPO CAHPS projects, MCAHPS for HMO, PPO PDP, and Provider Satisfaction research, where she also facilitated and participated in internal cross-functional teams to assure the survey results were used for health plan quality improvement efforts and to maximize CMS Star Ratings.

Linda has been involved in research initiatives and speaking at research conferences to help educate organizations and offer solutions for improving plan performance.

She has also served as Vice President at First Market Research in Boston, a national full-service market research firm with a large healthcare client base.

Linda joined SPH Analytics (formerly The Myers Group) in 2012 where she has served on the company’s Client Relations Team working directly with healthcare clients to understand their market research information needs, develops surveys to achieve their objectives, review/interpret survey results, and help identify action and improvement opportunities.

EDUCATION AND AFFILIATIONS:
- Master of Education, University of Delaware
- Bachelor of Science in Business Education, University of Delaware
- Professional Researcher Certification, Marketing Research Association
- Member of Marketing Research Association and American Association of Public Opinion Researchers

CONTACT INFORMATION: Linda Lynch, Performance Improvement Consultant
SPH Analytics
llynch@themyersgroup.net
770-978-3173 x1351
SPECIAL LIVE FOCUS GROUP:
MEDICARE ADVANTAGE MEMBERS SHARE FEEDBACK

RISE Conference
March 2017

Moderated By:
Linda M. Lynch, M.Ed., PRC
Performance Improvement Consultant
SPH Analytics

Agenda

1. Feedback from Medicare Advantage Members
2. Questions from the Audience
3. Thank You to Participants
Medicare Advantage
Members Share Feedback

Questions from the Audience

Linda M. Lynch, M.Ed., PRC
Performance Improvement Consultant
SPH Analytics
linda.lynch@sphanalytics.com
(770) 978-3173, ext. 1351
Thank You to Participants

Linda M. Lynch, M.Ed., PRC
Performance Improvement Consultant
SPH Analytics
linda.lynch@sphanalytics.com
(770) 978-3173, ext. 1351