Track A:
Panel Discussion: Risk Bearing Organizations on the Value of a 360 Degree Approach to Risk Adjustment

Moderator:
Dr. Adele Towers, Senior Clinical Advisor
UPMC ENTERPRISES

Co-Panelists:
Donna Malone, CPC, CRC
Senior Manager, Risk Adjustment Coding, Quality Assurance & Provider Education
TUFTS HEALTH PLAN

Rebecca Welling, RHIT, CCS-P Director, Coding Compliance
PROVIDENCE HEALTH PLAN
Dr. Towers is the Senior Clinical Advisor for UPMC Enterprises. She is directly involved in the development of healthcare related technology, with emphasis on use of Natural Language Processing (NLP) for Risk Adjustment coding and use of Clinical Analytics to optimize clinical performance. Prior to this role, she has served as the Medical Director for Health Information Management at UPMC with responsibility for Clinical Documentation Improvement as well as inpatient coding denials and appeals. She has been on the faculty in the Division of Geriatric Medicine at the University of Pittsburgh for over 25 years, and continues to see patients at the Benedum Geriatric Center in UPMC. She is the former Medical Staff President at UPMC Presbyterian, and her prior positions have been as Vice Chair for Quality Improvement and Patient Safety for the Department of Medicine, Medical Director of UPMC Home Health, Medical Director of the Benedum Geriatric Center and Medical Director of Primary Care at the Western Psychiatric Institute and Clinic. Dr. Towers has presented the experience at UPMC with use of NLP for coding at multiple regional and national conferences.
**Donna Malone**, CPC, CRC and ICD-10 Trained, Manager: Risk Adjustment, HCC Coding and Quality Assurance at TUFTS HEALTH PLAN, will be speaking at our Boston event

Donna has been on the job with the Tufts Health Plan in their senior products division since August 2014, and is responsible for audit and coding review management, development and implementation of department and vendor policies and procedures, simulation RADV Audits for preparedness, coding team performance management and provider education development and management.

Additionally, Donna serves at the MassBay Community College in Framingham, where she has been an advisor / professor for nearly 10 years. Her specialty area is the Medical Coding Certificate and Medical Office Administration Program. Prior to Tufts Health Plan, Donna worked for Blue Cross Blue Shield of Massachusetts as an HCC Professional Audit III for four years. Earlier, she worked for AM B Care for 9 years and Maine Medical Center.
Rebecca Welling is the Director of Coding Compliance for Providence Health Plan, a not for profit Health insurance company serving 650,000 lives in the Pacific Northwest. Providence Health Plan is part of Providence Saint Joseph Health, the third largest nonprofit health system in the US with services in Alaska, California, Montana, New Mexico, Oregon, Texas and Washington State. Rebecca’s responsibilities include oversight of all risk adjustment programs pertinent to Medicare, Medicaid and ACA lines of business with focus on physician coding education, coder training and clinical documentation initiatives. Rebecca directs a team of highly trained HCC coders and educators that perform retrospective, prospective and RADV audits for all government related lines of business. This work entails a thorough understanding of financial implications associated with an efficient and ethical risk adjustment program. Rebecca also serves in a consultative role for Providence’s Accountable Care Organization as part of the Population Health division. In addition to risk adjustment work, Rebecca oversees payment policy creation, appeal resolution and detailed coding applications for the Health Plan.
Risk Bearing Organizations on the Value of a 360º Approach to Risk Adjustment

Panel Discussion Powered by Health Fidelity

Goals for Today’s Session

Insightful  Informative  Inspiring  Interactive
Session Participants

Rebecca Welling, RHIT, CCS-P
Director, Coding Compliance

- Revenues in excess of $1.45 billion
- 650,000 total members – 30% growth
- Multiple Lines of Business:
  - Medicare Advantage - 75K
  - Medicaid - 35K
  - Large Group - 160K
  - Small Group / ACA - 158K
  - Individual Self-funded ASO - 276K
  - Workers Comp

Session Participants

Donna Malone, CPC, CRC
Sr. Manager Enterprise Risk Adjustment Coding, Quality Assurance and Provider Education

- A nonprofit founded in 1979, Tufts Health Plan is committed to providing innovative, high-quality health care coverage.
- The plan offers an array of health management programs, which support evidence-based approaches to health and wellness.
- Tufts Health Plan is one of the few health plans in Massachusetts to participate in the commercial, Medicare and Medicaid/subsidized markets, offering coverage across the life span regardless of age or circumstance.
- With a Massachusetts HQ, Tufts also serves members in New Hampshire and Rhode Island.
A world-renowned health care provider and insurer, Pittsburgh-based UPMC is inventing new models of accountable, cost-effective, patient-centered care.

It provides $892 million a year in benefits to its communities, including to the region’s most vulnerable citizens.

The largest nongovernmental employer in PA, UPMC integrates:

- > 60,000 employees
- > 20 hospitals
- > 500 doctors’ offices and outpatient sites
- a 3-million-member health insurance division
- international and commercial operations

360º Approach to Risk Adjustment
360° Approach to Risk Adjustment

- Compliance
- Organizational Alignment
- Retrospective Review
- Data & Performance Management
- Data Acquisition
- Prospective Review
- Provider Engagement

360° Approach to Risk Adjustment

- Compliance
- Organizational Alignment
- Retrospective Review
- Data & Performance Management
- Data Acquisition
- Prospective Review
- Provider Engagement
Relationship - engagement and outreach tactics

- Methods for prioritizing physician contact
- Risk-sharing contract strategies
- Aligning incentives

Supporting programs
- Home health

Provider education tactics

- Coding training and ways to transfer risk adjustment best practice knowledge
- Technology portal for providers
- Sharing patient information

Process Safeguards

- Coding audits
- Real-time feedback loops
Data Acquisition

Technology adoption
- EHR integration for chart pulls
- Workflow tools

Analytics targeting
- Prioritization without needing to chart chase

Centralization and information sharing

Retrospective Review

Cost reduction maneuvers
- Efficiency improvements
- In-sourcing vs out-sourcing
- Technology and automation

Revenue capture
- NLP-enabled first or second-pass review
- Contract prioritization
Compliance and Measurement

Code validation programs
- Finding codes without substantiating evidence
- Frequently undocumented coding support for providers

Performance Management
- Operational controls and management reporting
- Quality processes and audits

Thank You
RaeAnn Grossman
Chief Sales & Marketing Officer

RaeAnn Grossman, Chief Sales and Marketing Officer at ArroHealth, is one of the nation's foremost experts on Medicare Advantage, Medicaid, and Commercial risk adjustment models, strategies implementation and integration. She is a thought leader in healthcare business strategy and product development. Her expertise extends to provider engagement, member outreach, HEDIS, STARS, QRS, analytic design, care impact, and best practices implementation. She has more than twenty years of professional experience in a wide variety of healthcare organizations including Health Plans, Medical Groups, Physician Hospital Organizations (PHOs), start-ups, Integrated Hospital Systems, and the Institute of Health Professionals Education.

RaeAnn has held executive positions encompassing her areas of expertise, which include: Hierarchical Condition Category (HCC) and Medicaid Risk Adjustment, network management, executive client relationship management, predictive modeling, reimbursement modeling and implementation, business development, strategic planning, Centers of Excellence execution, financial analysis, acute and chronic care pathway creation, and product development and marketing for healthcare companies.

Before joining ArroHealth, she held executive roles with Gorman Health Group, CenseoHealth and Optum. Over the past eight years, RaeAnn was one of the founders and principal investors in a first full-service HCC management company for Medicare Advantage, where she held the position of Chief Client Services Officer. Prior to that, RaeAnn worked as Health Net of Arizona's Vice President of Network Strategy and Development, Scottsdale PHO, and also at BCBSAZ. She holds an MS in health care planning from Florida State University.
Tim has over 15 years of professional experience in health care operations and regulatory risk management. A strategic and forward-thinking business executive, Tim has a proven track record of success in risk adjustment operations, coding and documentation programs, regulatory compliance, and consulting and business advisory services. Throughout his career, Tim has demonstrated effectiveness as a leader with an ability to build and coach teams that deliver integrated and optimal results.

In his current role as National Vice President for DaVita Medical Group (DMG), Tim is responsible for the national strategy, development, and implementation of programs focused on comprehensive health assessment and quality, coding documentation improvement, and revenue accuracy. In this capacity, Tim is responsible for the oversight of six geographic markets and a growing national infrastructure, focused on DMG’s Medicare Advantage patient population.

Previously, Tim served as the Compliance Officer for DMG, Vice President of Compliance for DaVita Kidney Care, and was a management consultant with PricewaterhouseCoopers’ Health Care Practice.
Gamification of Clinical Data for Risk Adjustment Purposes

2017 RISE Summit Nashville
March 6, 2017

Agenda

- Introductions
- Best Practices of the Industry
  - Data
  - Retrospective Strategies & Timing
  - Prospective Strategies & Timing
  - Use of Sweeps
- DMG Approach
  - Running it from a provider perspective
  - Prospective, Retrospective, Data Compilation
- Q&A
- Contact Information
Best Practices As Seen by ArroHealth

- Data & Analytics
  - Files & Innovative Sources Options
  - Where are Yields Going?

- What’s New in Retro?
  - Timing
  - Provider Type
  - 2LR and 3LR
  - Reviews on Sweeps

- What’s New in Pro?
  - In-Office
  - In-Home
  - Telemedicine
  - Concurrent review

DMG’s Provider Approach

- Data
- Prospective
- Retrospective
- Sharing Data with Health Plans
- Biggest Challenges
- Biggest Successes
- What to Change for 2017
Questions & Answers

Contact Us

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ArroHealth
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Tim Burke, National VP, Comprehensive Health Assessment Programs
DaVita Medical Group
tburke@healthcarepartners.com
The Impact of the Transition to ICD-10: A Real World Experience!

Olga Ziegler, Vice President, Revenue Program Management
HIGHMARK, INC.

Sean Creighton, BA, M.Sc, H.Dip, Senior Vice President, Risk Adjustment
VERSCEND
Olga Ziegler serves as Vice President of Revenue Program Management for Highmark Inc., which proudly offers Medicare Advantage and ACA health insurance coverage to over 450,000 members. Olga oversees the collection and submission of risk adjustment data to the Centers for Medicare and Medicaid Services (CMS) and is responsible for physician education and care gap closure programs. Before devoting her work to Highmark, Olga served as a Senior Managing Consultant in the Health Analytics practice at Berkley Research Group (BRG) where she specialized in providing advisory and analytical services to health care clients. Additionally, Olga is a Certified Risk Adjustment Coder (CRC) and has over 15 years in the managed care industry having worked for health care leaders including Universal Health Care and Coventry Health Care.

In her free time, Olga enjoys traveling and spending time with her family.
Sean Creighton, M.Sc, H.Dip  
Senior Vice President, Risk Adjustment  
Verscend

Sean provides overall leadership and subject-matter expertise related to risk adjustment for both the Medicare and commercial markets. He works with our product development and delivery teams to set priorities and develop world-class products that align with both our business and our clients’ needs.

Prior to Verscend, Sean worked at the Centers for Medicare & Medicaid Services (CMS) for 15 years, most recently as the deputy group director of the Payment Policy and Financial Management Group in the Center for Consumer Information and Insurance Oversight. While at CMS, he was responsible for payment policy and operations for both private Marketplace (ACA) and Medicare plans.

Sean holds a BA in European Studies from the University of Limerick and an MSc in Sociology from the London School of Economics. He has also taken advanced coursework at Indiana University Bloomington in sociology and statistics.
ICD-10 Implementation: What Have We Learned

RISE Nashville Summit
March 2017

Meet Your Presenters

Sean Creighton, M.Sc, H.Dip
Senior Vice President, Risk Adjustment

Olga Ziegler
Vice President, Revenue Program Management
Agenda

1. ICD-10 – “A Leap Forward in Care”

2. The First Year – Coders Experience

3. Risk Adjustment – Statistical and Financial Analysis
   1. How the Transition Affected Claims Diagnoses and Risk Scoring
   2. How the Transition Affected Revenue

4. Conclusions

Key ICD-10 Improvements – A leap forward in the definition of care

**Size** – 14,315+ codes numeric to 69,101 alphanumeric codes (January 1, 2010)

- 5 times more Dx codes and 9 times more procedure codes

**Specificity**

- Etiology, anatomic site, severity – as well as specify the encounter – initial, subsequent or sequelae.

**Expandability**

- Alphanumeric system allows for much more expandability for new diagnoses and procedures

**Laterality**

- Which knee did we operate on?

**Terminology**

- Updated for current practice and definition

**Combination Codes**

- Combination codes can eliminate problems with sequencing
Certain ICD-9 codes are related to many ICD-10 Codes - Others not so much

- Highest number of Equivalents
  - ICD9 V58,89 “Other specified aftercare”
  - Relates to 7,802 more-specific ICD-10s

- Count of Unique ICD10s so ratio is not exact because of repetition in range

* Based on 2017 CMS General Equivalency Mapping (GEM) Tables

Increase in Complexity from ICD-9 to ICD-10 Varies by Clinical Area

- Injuries: 3+: 563 (88%)
  - 1 or 2: 77

- Amputations
  - ICD-9 Codes with 3+ ICD-10 Equivalents
    - 4
  - ICD-9 Codes with 1-2 ICD-10 Equivalents
    - 11

- Complications
  - ICD-9 Codes with 3+ ICD-10 Equivalents
    - 8
  - ICD-9 Codes with 1-2 ICD-10 Equivalents
    - 25

- Diabetes
  - ICD-9 Codes with 3+ ICD-10 Equivalents
    - 8
  - ICD-9 Codes with 1-2 ICD-10 Equivalents
    - 62

- Musculoskeletal
  - ICD-9 Codes with 3+ ICD-10 Equivalents
    - 8
  - ICD-9 Codes with 1-2 ICD-10 Equivalents
    - 64

- Kidney disease
  - ICD-9 Codes with 3+ ICD-10 Equivalents
    - 4
  - ICD-9 Codes with 1-2 ICD-10 Equivalents
    - 24

- Artificial openings
  - ICD-9 Codes with 3+ ICD-10 Equivalents
    - 2
  - ICD-9 Codes with 1-2 ICD-10 Equivalents
    - 29

- Infections
  - ICD-9 Codes with 3+ ICD-10 Equivalents
    - 11
  - ICD-9 Codes with 1-2 ICD-10 Equivalents
    - 40

- Blood disorders
  - ICD-9 Codes with 3+ ICD-10 Equivalents
    - 21
  - ICD-9 Codes with 1-2 ICD-10 Equivalents
    - 86

- Lung disease
  - ICD-9 Codes with 3+ ICD-10 Equivalents
    - 13
  - ICD-9 Codes with 1-2 ICD-10 Equivalents
    - 97
Uneven Changes in Classification Complexity

From ICD-9 to ICD-10 the number of diagnosis codes increased by more than 360%
The increase in codes varies widely by clinical area, and one area actually lost codes

<table>
<thead>
<tr>
<th>Increase in Codes from ICD-9 to ICD-10 – Selected Clinical Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musculoskeletal and Connective Tissue Disorders: + 1,224%</td>
</tr>
<tr>
<td>Genital Conditions: + 34%</td>
</tr>
<tr>
<td>Injury, Poisoning: + 839%</td>
</tr>
<tr>
<td>Cardiovascular Disease: + 24%</td>
</tr>
<tr>
<td>Complications of Care: + 532%</td>
</tr>
<tr>
<td>Cognitive Disorders: + 24%</td>
</tr>
<tr>
<td>Screening / History: + 397%</td>
</tr>
<tr>
<td>Infections: -18%</td>
</tr>
</tbody>
</table>

Transition to ICD-10 in the Medicare HCC Models

ICD-9 Version: 3,033 Diagnosis Codes
ICD-10 Version: 9,494 Diagnosis Codes (3.1x Increase)

✓ About 0.06% of ICD-9 Codes In HCCs have > 10 ICD-10 Equivalents
✓ About 51% of ICD-9 Codes In HCCs have 1 or 2 ICD-10 Equivalents
✓ A Few Codes for Low-Frequency Medical Conditions **Dropped**
✓ A Few Codes for Low-Frequency Medical Conditions **Added**
Notes from the Field: A Survey of Coders

Coder Survey

- We conducted a survey of 100 RHIT certified coders to gauge experience with ICD-10 - the key results were interesting and consistent.
- A general theme is lack of documentation to capture codes and a desire among coders that providers get more training on documentation.
- Coders agreed that there has been a loss of productivity (53% of coders claim a loss of 5% or greater).
- Coders attribute loss of productivity to some specific factors:
  - Shifting between ICD-9 and ICD-10 documentation rules until PY2016 is completed.
  - More codes in various categories due to laterality etc.
  - Need to use alpha and numeric characters on the keyboard.
  - Ambiguity around assumed relationships between codes.
- In terms of items that helped with the transition, our coders pinpointed:
  - Software for code lookup.
  - Training on ICD-10 – workshops with specific training exercise and examples.
  - Creation of lists of commonly used codes.
Capturing active co-morbid conditions (i.e. inpatient codes)

Unspecified codes versus 'other' specified codes and when to use which one

The assumed relationship between diabetes and manifestations

Lack of documentation from the provider to capture a more specific code

What about ICD-10 codes have been particularly challenging?

Answered: 99 Skipped: 1

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of documentation from the provider to capture a more specific code</td>
<td>52.53% 52</td>
</tr>
<tr>
<td>The assumed relationships between diabetes and manifestations</td>
<td>26.26% 26</td>
</tr>
<tr>
<td>Unspecified codes versus 'other' specified codes and when to use which one</td>
<td>20.20% 20</td>
</tr>
<tr>
<td>Capturing active co-morbid conditions (i.e. inpatient codes)</td>
<td>1.01% 1</td>
</tr>
<tr>
<td>Total</td>
<td>99</td>
</tr>
</tbody>
</table>

Move directly to ICD 11

Earlier availability of testing tools/data for ICD 10

Advanced Training with coding exercises

Make sure the providers attend clinical documentation improvement classes

If you could change one thing about getting ready for ICD-10, what would it be?

Answered: 100 Skipped: 0

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Make sure the providers attend clinical documentation improvement classes</td>
<td>61.00% 61</td>
</tr>
<tr>
<td>Advanced training with coding exercises</td>
<td>32.00% 32</td>
</tr>
<tr>
<td>Earlier availability of testing tools/data for ICD 10</td>
<td>5.00% 5</td>
</tr>
<tr>
<td>Move directly to ICD 11</td>
<td>2.00% 2</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
</tr>
</tbody>
</table>
What is the largest challenge you face in coding ICD-10?

- Lack of clinical documentation in the medical record to support code capture: 42.00% (42 responses)
- Understanding the new assumed relationships between codes: 27.00% (27 responses)
- Loss of productivity: 21.00% (21 responses)
- Learning the new code values: 10.00% (10 responses)

Total: 100

What percent in productivity loss have you experienced now that ICD-10 codes are a year old?

- Moderate reduction 5-10%: 47.47% (47 responses)
- Slight reduction - less than 5%: 31.31% (31 responses)
- None – coding productivity is back to ICD 9 levels: 15.15% (15 responses)
- Large reduction - greater than 10%: 6.06% (6 responses)

Total: 99
What do you think has been the largest contributor to getting better at coding in ICD-10?

Answered: 99  Skipped: 1

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of coding software to help translate (i.e. Encoder Pro)</td>
<td>55.56%</td>
</tr>
<tr>
<td>ICD 10 focused diagnosis training with coding examples, internal or external</td>
<td>38.38%</td>
</tr>
<tr>
<td>Pop quizzes focused on specific areas of ICD 10 grey areas</td>
<td>4.04%</td>
</tr>
<tr>
<td>Mentoring with the QA or ICD 10 trainer on specific code relationships</td>
<td>2.02%</td>
</tr>
<tr>
<td>Total</td>
<td>99</td>
</tr>
</tbody>
</table>

Insights from Coders and Providers regarding transition from ICD-9 to ICD-10

- AAPC and AHIMA provided adequate preparation for ICD-10
- A number of physicians hired medical students / graduates during transition period to perform EMR documentation transcription, during patient visits, and to update Problem Lists
- Short-term coder productivity adverse impact due to:
  - Need to look-up codes in ICD-10 that most had memorized in ICD-9
  - Becoming familiar with differences and nuances of coding in ICD-10 vs ICD-9
  - Increased provider queries due to lack of specificity in documentation
  - Non-scientific survey estimated 50% productivity drop during first 3-6 months
- Provider documentation impact:
  - DM w/Complications (HCC 18)
    - ICD-10 allows the coder to assume a causative relationship between DM and all conditions listed under the sub-term “with” in the alphabetic index, unless the provider specifically links the complication to a cause other than DM
    - ICD-10 allows for a DM with Complications code to be assigned when provider states “DM poorly controlled / out of control / inadequately controlled” (does not apply to DM uncontrolled)
  - Major Depression (HCC 58): requires additional specificity in ICD-10 (e.g., episode: single, recurrent; severity: mild, moderate, severe)
ICD-10 Transition Impact on Risk Adjustment
An Examination of the Claims Statistics

Analysis – Early Data and Results
ICD-10 Impact Analysis – HCC Prevalence

Scope:
The analysis compared the average HCC Prevalence for 33 months prior to 10/1/15 ICD-10 transition date with the HCC Prevalence of 2015 Q4 ICD-10.

Observations:
• Net impact of analysis suggests HCC Prevalence for all HCCs result in a modest increase
• Increase driven primarily by HCC 18 - Diabetes with Chronic Complications
  • 23 HCCs were identified to have positive impact to HCC count
  • 16 HCCs were identified to have negative impact to HCC count

Consideration:
• The results were normalized for the HCC model changes (v12 vs v22) and population mix
• Further evaluation of ICD-10 impact to include 2016 data is warranted

ICD-10 Impact Analysis – HCC Prevalence

23 HCCs were identified to have significant (> 1σ) positive impact to HCC count

<table>
<thead>
<tr>
<th>HCC</th>
<th>HCC Description</th>
<th>2015 Q4</th>
<th>+/- 1</th>
<th>Impact Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>Diabetes with Chronic Complications</td>
<td>2.840%</td>
<td>0.234%</td>
<td>1.290% ☞ 3.501, 3.503</td>
</tr>
<tr>
<td>158</td>
<td>Pressure Ulcer of Skin with Full Thickness Skin Loss</td>
<td>0.078%</td>
<td>0.008%</td>
<td>0.115% ☞ 1.276, 102</td>
</tr>
<tr>
<td>154</td>
<td>Diabetic Ketoacidosis</td>
<td>0.149%</td>
<td>0.011%</td>
<td>0.254% ☞ 1.454, 286</td>
</tr>
<tr>
<td>22</td>
<td>Mortal Obesity</td>
<td>0.846%</td>
<td>0.142%</td>
<td>1.107% ☞ 3.348, 342</td>
</tr>
<tr>
<td>88</td>
<td>Angioedema</td>
<td>0.400%</td>
<td>0.073%</td>
<td>0.569% ☞ 3.134, 376</td>
</tr>
<tr>
<td>89</td>
<td>Acute Necrotizing Infarction</td>
<td>0.151%</td>
<td>0.014%</td>
<td>0.255% ☞ 1.262, 233</td>
</tr>
<tr>
<td>90</td>
<td>Specified Heart Arhythmias</td>
<td>4.620%</td>
<td>0.252%</td>
<td>4.966% ☞ 3.281, 272</td>
</tr>
<tr>
<td>157</td>
<td>Pressure Ulcer of Skin with Necrosis Through Muscle, Tendon, or Bone</td>
<td>0.033%</td>
<td>0.004%</td>
<td>0.047% ☞ 2.372, 31</td>
</tr>
<tr>
<td>103</td>
<td>Hemiplegia/Hemiparesis</td>
<td>0.192%</td>
<td>0.013%</td>
<td>0.230% ☞ 3.354, 83</td>
</tr>
<tr>
<td>35</td>
<td>Opioid/Glucal Dependence</td>
<td>0.134%</td>
<td>0.011%</td>
<td>0.170% ☞ 3.400, 67</td>
</tr>
<tr>
<td>117</td>
<td>Chronic Kidney Disease, Severe (Stage 4)</td>
<td>0.366%</td>
<td>0.029%</td>
<td>0.420% ☞ 3.214, 101</td>
</tr>
<tr>
<td>49</td>
<td>Severe Hematological Disorders</td>
<td>0.139%</td>
<td>0.007%</td>
<td>0.148% ☞ 1.083, 15</td>
</tr>
<tr>
<td>154</td>
<td>Esophageal Mucosal Degeneration</td>
<td>0.800%</td>
<td>0.069%</td>
<td>0.800% ☞ 3.319, 38</td>
</tr>
<tr>
<td>104</td>
<td>Monospecies, Other Paratonic Syndromes</td>
<td>0.023%</td>
<td>0.000%</td>
<td>0.037% ☞ 3.378, 15</td>
</tr>
<tr>
<td>122</td>
<td>Prostatic Oligospermia and Ovarian Oligospermia</td>
<td>0.135%</td>
<td>0.013%</td>
<td>0.157% ☞ 3.194, 23</td>
</tr>
<tr>
<td>6</td>
<td>Opportunistic infections</td>
<td>0.035%</td>
<td>0.004%</td>
<td>0.041% ☞ 1.420, 7</td>
</tr>
<tr>
<td>75</td>
<td>Myasthenia/Myoneural Disorders and Guillain-Barré Syndrome/Inflammatory and Toxic Neuropathy</td>
<td>0.146%</td>
<td>0.014%</td>
<td>0.162% ☞ 3.389, 6</td>
</tr>
<tr>
<td>78</td>
<td>Paediatric and Huntington’s Diseases</td>
<td>0.525%</td>
<td>0.031%</td>
<td>0.557% ☞ 3.659, 2</td>
</tr>
<tr>
<td>30</td>
<td>Cerebro-Vascular Disease/ Ischemic Damage</td>
<td>0.099%</td>
<td>0.005%</td>
<td>0.143% ☞ 3.148, 2</td>
</tr>
<tr>
<td>35</td>
<td>Nephrotic Syndrome</td>
<td>0.223%</td>
<td>0.019%</td>
<td>0.242% ☞ 1.288, 4</td>
</tr>
<tr>
<td>34</td>
<td>Chronic Pancreatitis</td>
<td>0.006%</td>
<td>0.000%</td>
<td>0.030% ☞ 3.273, 2</td>
</tr>
<tr>
<td>74</td>
<td>Central Pathy</td>
<td>0.017%</td>
<td>0.002%</td>
<td>0.020% ☞ 3.643, 1</td>
</tr>
<tr>
<td>10</td>
<td>Lymphoma and Other Cancers</td>
<td>0.590%</td>
<td>0.030%</td>
<td>0.620% ☞ 3.641, 0</td>
</tr>
</tbody>
</table>
ICD-10 Impact Analysis – HCC Prevalence

16 HCCs were identified to have significant (< -1σ) negative impact to HCC count

<table>
<thead>
<tr>
<th>HCC</th>
<th>HCC Description</th>
<th>2013 - Q3/2016</th>
<th>2016</th>
<th>Alt. 1</th>
<th>Impact Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Diabetes without Complication</td>
<td>0.014%</td>
<td>0.066%</td>
<td>0.002%</td>
<td>0.012%</td>
</tr>
<tr>
<td>161</td>
<td>Chronic Ulcer of Skin, Except Pressure Ulcer</td>
<td>0.651%</td>
<td>0.260%</td>
<td>0.557%</td>
<td>0.511%</td>
</tr>
<tr>
<td>100</td>
<td>Ischemic or Unspecified Stroke</td>
<td>0.023%</td>
<td>0.035%</td>
<td>0.481%</td>
<td>0.302%</td>
</tr>
<tr>
<td>87</td>
<td>Unstable Angina and Other Acute Ischemic Heart Disease</td>
<td>0.316%</td>
<td>0.016%</td>
<td>0.165%</td>
<td>0.246%</td>
</tr>
<tr>
<td>170</td>
<td>Hip Fracture/Dislocation</td>
<td>0.236%</td>
<td>0.013%</td>
<td>0.192%</td>
<td>0.425%</td>
</tr>
<tr>
<td>169</td>
<td>Vertebral Fractures without Spinal Cord Injury</td>
<td>0.219%</td>
<td>0.014%</td>
<td>0.152%</td>
<td>0.474%</td>
</tr>
<tr>
<td>54</td>
<td>Drug/Psychotic Psychosis</td>
<td>0.036%</td>
<td>0.034%</td>
<td>0.009%</td>
<td>0.402%</td>
</tr>
<tr>
<td>21</td>
<td>Protein-Calorie Malnutrition</td>
<td>0.235%</td>
<td>0.017%</td>
<td>0.205%</td>
<td>0.600%</td>
</tr>
<tr>
<td>33</td>
<td>Intestinal Obstruction/Perforation</td>
<td>0.020%</td>
<td>0.010%</td>
<td>0.174%</td>
<td>0.296%</td>
</tr>
<tr>
<td>57</td>
<td>Seizures</td>
<td>0.102%</td>
<td>0.017%</td>
<td>0.138%</td>
<td>0.407%</td>
</tr>
<tr>
<td>112</td>
<td>Fibrosis of Lung and Other Chronic Lung Disorders</td>
<td>0.364%</td>
<td>0.024%</td>
<td>0.333%</td>
<td>0.381%</td>
</tr>
<tr>
<td>173</td>
<td>Traumatic Imparations and Complications</td>
<td>0.035%</td>
<td>0.004%</td>
<td>0.023%</td>
<td>0.253%</td>
</tr>
<tr>
<td>114</td>
<td>Aspiration and Specified Bacterial Pneumonias</td>
<td>0.146%</td>
<td>0.019%</td>
<td>0.139%</td>
<td>0.541%</td>
</tr>
<tr>
<td>82</td>
<td>Respirator Dependence/Tracheostomy Status</td>
<td>0.046%</td>
<td>0.005%</td>
<td>0.042%</td>
<td>1.449%</td>
</tr>
<tr>
<td>39</td>
<td>Bone/Joint Muscle Infections/Infection</td>
<td>0.150%</td>
<td>0.091%</td>
<td>0.139%</td>
<td>0.475%</td>
</tr>
<tr>
<td>157</td>
<td>Major Head Injury</td>
<td>0.022%</td>
<td>0.006%</td>
<td>0.075%</td>
<td>0.152%</td>
</tr>
</tbody>
</table>

Largest (by a factor of 10) HCC Revenue Impact of the Transition to ICD-10

“Migration” from

HCC 19, Diabetes without Complication (HCC Coefficient = 0.113)

to

HCC 18 Diabetes with Chronic Complications (HCC Coefficient = 0.351)

- Under the ICD-10 coding guidelines, conditions that are commonly associated with diabetes (e.g., neuropathy) are assumed to be complications of diabetes unless the physician notes that the condition is NOT related to diabetes.
- Under ICD-9 coding guidelines, a diabetic complication code could be assigned only if the physician specifically stated that the condition was linked to the diabetes.
- This change greatly lowered the bar for coding HCC 18 on people with diabetes.

* Assumes that both the diabetes and the complicating condition are appropriately documented as currently in treatment.
Analysis – More Recent Data

Medicare Part C Claims and Coding

Data:

- 15 Quarters (Q1 2013 through Q3 2016) of Medicare Part C Claims Data, All Encounters Run-Out Through January 2017
- 950,000+ Medicare Part C Aged/Disabled Enrollees
Part C Risk Adjustment

How did the change in Medicare Part C diagnosis coding intensity impact:

• CCs
• HCCs
• Risk Adjustment Factors

Part C CCs, HCCs, and RAF Quarterly Overview

Key Points

• Q4 noted in black bullets
• 2013 Q3 to Q4 shows a modest decrease; 2014 a modest increase; 2015 a slightly higher increase
• Six month trend starting with Q4 is marginally higher after ICD-10 than in previous years.
• ICD-10 appears to have had a favorable impact on (H)CCs

Scale on left hand corresponds to CC/HCC Counts.
Scale on right corresponds to RAF Totals.
Claims Diagnoses Per Enrollee – First 4 Quarters of ICD-10 to prior year under ICD-9

Overall First ICD-10 Year Average Quarterly Diagnosis/Enrollee Increase: 7.2%

Risk Adjustment Factor Per 1,000 Claims Diagnoses

Overall First ICD-10 Year Average Quarterly RAF/1k Diagnoses Increase: 0.9%
CCs and New CCs
Per 1,000 Enrollees

<table>
<thead>
<tr>
<th>Quarter</th>
<th>CCs Increase</th>
<th>New CCs Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>+ 6.6%</td>
<td></td>
</tr>
<tr>
<td>Q2</td>
<td>+ 3.9%</td>
<td>+ 2.0%</td>
</tr>
<tr>
<td>Q3</td>
<td>+ 8.0%</td>
<td>+ 5.2%</td>
</tr>
<tr>
<td>Q4</td>
<td>+ 2.9%</td>
<td>+ 10.1%</td>
</tr>
</tbody>
</table>

Overall First ICD-10 Year
Average Quarterly CC Increase: 5.3%

Overall First ICD-10 Year
Average Quarterly New CC Increase: 5.0%

HCCs and New HCCs
Per 1,000 Enrollees

<table>
<thead>
<tr>
<th>Quarter</th>
<th>HCCs Increase</th>
<th>New HCCs Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>+7.7%</td>
<td></td>
</tr>
<tr>
<td>Q2</td>
<td>+ 5.2%</td>
<td>+ 1.4%</td>
</tr>
<tr>
<td>Q3</td>
<td>+ 9.4%</td>
<td>+ 4.2%</td>
</tr>
<tr>
<td>Q4</td>
<td>+ 2.7%</td>
<td>+ 10.5%</td>
</tr>
</tbody>
</table>

Overall First ICD-10 Year
Average Quarterly HCC Increase: 6.2%

Overall First ICD-10 Year
Average Quarterly New HCC Increase: 4.6%
RAFT and New RAF Per 1,000 Enrollees

Overall First ICD-10 Year Average Quarterly RAF Increase: 8.2%
- Q4 RAF: +5.4%
- Q3 RAF: -2.5%
- Q2 RAF: +7.1%
- Q1 RAF: +9.4%

Overall First ICD-10 Year Average Quarterly New RAF Increase: 5.5%
- Q4 New RAF: +11.2%
- Q3 New RAF: +4.6%
- Q2 New RAF: +2.5%
- Q1 New RAF: +11.2%

Part C ICD-10 Risk Impact Summary

<table>
<thead>
<tr>
<th></th>
<th>Q4 2014 vs. Q4 2015</th>
<th>Q1 2015 vs. Q1 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Claim Diagnoses Per Enrollee</td>
<td>+2.2%</td>
<td>+9.1%</td>
</tr>
<tr>
<td>Average RAF per Diagnosis</td>
<td>+3.1%</td>
<td>+0.3%</td>
</tr>
<tr>
<td>Average Newly Coded HCCs Per Enrollee</td>
<td>+10.5%</td>
<td>+7.7%</td>
</tr>
<tr>
<td>Average Newly Recognized Risk Adjustment Factor Per Enrollee</td>
<td>+11.2%</td>
<td>+9.4%</td>
</tr>
</tbody>
</table>
Top 5 Part C HCC “Bright Spots” and “Pain Points”

<table>
<thead>
<tr>
<th>Largest Part C HCC Prevalence Increases</th>
<th>Largest Part C HCC Prevalence Decreases</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Diabetes with Chronic Complications</td>
<td>1. Diabetes without Complication</td>
</tr>
<tr>
<td>2. Morbid Obesity</td>
<td>2. Specified Heart Arrhythmias</td>
</tr>
<tr>
<td>3. Major Depressive, Bipolar, and Paranoid Disorders</td>
<td>3. Congestive Heart Failure</td>
</tr>
<tr>
<td>4. Drug/Alcohol Dependence</td>
<td>4. Chronic Obstructive Pulmonary Disease</td>
</tr>
<tr>
<td>5. Acute Myocardial Infarction</td>
<td>5. Ischemic or Unspecified Stroke</td>
</tr>
</tbody>
</table>

Based on latest available ICD-9/ICD-10 quarters 1, 2, and 4 (i.e., 2015Q1 v. 2016Q1, 2015Q2 v. 2016Q2, 2014Q4 v. 2015Q4)

Other Factors Driving High Positive and Negative HCC Prevalence and Revenue Shifts

Universal Training of Coders in Lead-Up to ICD-10 Implementation
- All Coders, Regardless of Level of Experience, Have Received Unprecedented Amounts of Simultaneous Training

Clinical Documentation Improvement / Physician Awareness
- Increased Morbid Obesity Coding
  - Documentation Greatly Improved Due to Physician Awareness of ICD-10 Code Set Specificity
- Decreased Prevalence in Ischemic Stroke Coding
  - Follow-Up Care and Monitoring / History of Stroke Now More Clearly Distinguished from Acute Stroke Event

Improved Diagnosis Code Specificity with Regard to Episode of Care
- Decreased Hip Fracture Coding
  - Improvement of Coder Understanding/Awareness of Initial vs. Subsequent vs. Sequela Coding Options Probably Reduced Coding of Subsequent Care as the Acute Event
Other Factors Driving High Positive and Negative HCC Prevalence and Revenue Shifts

Improved Diagnosis Code Specificity with Regard to Episode of Care

- Decreased Hip Fracture Coding
  - Improvement of Coder Understanding/Awareness of Initial vs. Subsequent vs. Sequela Coding Options Probably Reduced Coding of Subsequent Care as the Acute Event

Better Specificity in Differentiating Acute vs. Chronic Coronary Disease

- Decreased Prevalence of Unstable Angina Pectoris and Increased Prevalence of ["Stable"] Angina Pectoris
  - Probably Due to Increased Coder Sophistication and Physician Documentation Improvement Reducing Incidents of Angina Being Improperly Coded as "Unstable"

Observations

- Use of coding tools help meet the challenges of providing high quality care, while maintaining compliance with CMS and other regulations related to documentation, coding and practice management
- The impact of the transition to ICD-10-CM in the Medicare Part C Aged/Disabled population appears to have been positive
- Coding of HCCs Varied by Clinical Area
  - There Was a Marked Shift from Uncomplicated to Chronically Complicated Diabetes
  - Anticipated Decreases in Coding of Injuries Were Seen
- Coding of HCC Chronic Conditions was Generally Improved / Coding Has Generally Trended Toward Higher-Risk Diagnoses Over Time
- Implementing tactics for both the provider and the coder will improve the plan’s opportunity to maximize risk/ revenue
- Using captured coder data can have a significant impact on the plans’ ability to improve the provider documentation
Thank You

Questions?
Risk Adjustment in State Medicaid Programs: Evolution and Developments Over 20 Years

John Kaelin, Senior Advisor
CENTENE

Richard Lieberman, Chief Data Scientist
MILE HIGH HEALTHCARE ANALYTICS
John J. Kaelin
Senior Advisor at Centene Corporation

February 2017

John Kaelin has diverse executive level experience in the health care industry spanning government, academia, U.S. based health insurers and recently health systems in the Middle East. In 2014, John moved to Abu Dhabi, the capital of the United Arab Emirates where he served as a special advisor to the government as it implements a mandatory health insurance program. When he returned to the U.S. in the spring of 2015, he joined Centene as a Senior Advisor for health financing and policy and is supporting its health plans on rate setting, risk adjustment and health insurance exchange issues. Previous positions include SVP for health reform at UnitedHealth Group and Executive Director of the University of Maryland’s Hilltop Institute where he supported that state’s efforts to implement managed care for Medicaid and a risk adjusted payment system. Earlier in his career, John served in New York State government where led the financing team in the development and implementation of New York’s first 1115 Medicaid managed care waiver in the mid 1990s.
Richard Lieberman is the founder and Chief Data Scientist of Mile High Healthcare Analytics. Mile High Healthcare Analytics provides strategic consulting and practical population-oriented analytics to health plans, Exchange issuers, ACOs, and risk-bearing provider groups. Mr. Lieberman is one of the nation’s leading experts on risk adjustment, quality measurement, and predictive analytics. Since 1991, he has been active in the design and implementation of risk adjustment models and risk-adjusted payment systems for commercial, Medicare, and Medicaid payers.

Mr. Lieberman possesses in-depth understanding of Medicare, Medicaid and Affordable Care Act statutes, regulations, and policies. He synthesizes these with insights obtained from the health services research literature, a background as a health care provider and clinical trials researcher, and from operational interactions with a variety of managed care entities. He applies this knowledge and experience to risk adjustment revenue optimization strategies, quality measurement/quality improvement activities, provider profiling, provider reimbursement strategies, and information systems design.
Risk Adjustment in State Medicaid Programs

Evolution and Developments Over 20 years
John J. Kaelin
Senior Advisor, Centene Corporation
RISE Event: March 2017

WHO WE ARE
St. Louis
based company founded in Milwaukee in 1984
30,500 employees
#124 on the Fortune 500 list
$40.6B revenue for 2016
$9.1 billion in cash and investments

WHAT WE DO
29 states
with government-sponsored healthcare programs
2 international markets
11.4 million members
includes 2.8 million TRICARE eligibles
~300 Product / Market Solutions

Medicaid (20 states)
Marketplace (11 states)
Medicare (12 states)
Corrections (8 states)
Context and Limitations

• The observations contained in the presentation represent the opinions of the author and not current or previous organizations.

• Beginning with my work at the University of Maryland Baltimore County’s (UMBC) health policy center (now Hilltop Institute), I have served in a variety of roles over the last 18+ plus years as an active participant in the risk adjustment process and evolution in Medicaid.

• The purpose of today’s panel discussion is to summarize how states operate their risk adjustment programs and engage our expert Richard Lieberman in a discussion of the lessons learned, implications of state operations of risk adjustment and views of the future.
Brief Background on Medicaid and Role of Health Plans

- Medicaid is jointly funded by the states and Federal government and administered by the states.
- Estimated total spending for Medicaid in 2014 is almost $500 billion
- Medicaid serves approximately 72 million people
- With the ACA’s optional Medicaid expansion as well as increased outreach and awareness in all states, more than 15 million have been added to Medicaid post ACA
- Managed care is now the dominant delivery model for Medicaid with over 75% of all eligibles enrolled in a managed care plan
- States are increasingly relying on managed care’s proven model to enroll more complex populations—those needing long term care services and those with intellectual disabilities

Medicaid and Risk Adjustment

- Risk adjusted payments are now the mainstream in publicly financed and subsidized health insurance programs
- Medicare Advantage, Medicare Part D, Marketplaces and Medicaid
- What’s not fully appreciated, is the role state Medicaid programs played in the widespread adoption of risk adjustment and important lessons learned by the early adopters
- Early adopting states include Maryland, Minnesota and Colorado dating back to 1997-98
State of the States : Risk Adjustment

- As we will see in the following state summaries, in a word, variation—models, prospective vs concurrent, populations covered, data sources and validation, administration and operation, frequency of updates and coding rules
- Unlike MA or the Marketplaces, there is no one single approach, grouper or set of business rules used by states to operate their risk adjustment programs
- These variations reflect, among other factors, state financing and program goals for their Medicaid managed care programs as well as the populations included for risk adjustment
- One important commonality is the heavy reliance of states on encounter data as the source of the coding.

Summary of States Using Risk Adjustment

- There is no up to date data base on each state’s policies for risk adjustment
- Presented in the next several slides are the authors’ summary based on working with select states, and publicly available information
- The reader is cautioned that the data may be out of date as state policies change, in some cases, significantly
- The grids are presented to show the extent which states are similar but also the significant variations in key implementation policies and will form the basis of the discussion on the pros and cons as well as implications of different policy choices with respect to risk adjustment implementation in Medicaid
### Brief Summary of States - DRAFT

*caution: state policies change so data are not necessarily up to date*

<table>
<thead>
<tr>
<th>State</th>
<th>Risk Adjustment System</th>
<th>Data Source</th>
<th>Key Policies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona</td>
<td>ERG</td>
<td>Health Plan encounters</td>
<td>Annual updates, phase in</td>
</tr>
<tr>
<td>California</td>
<td>MrX</td>
<td>Health Plan Rx encounters</td>
<td>Dx system under discussion</td>
</tr>
<tr>
<td>Delaware</td>
<td>CDPS Rx</td>
<td>Health Plan encounters</td>
<td>Semi annual updates</td>
</tr>
<tr>
<td>Florida</td>
<td>CDPS Rx</td>
<td>Health Plan encounters, initially legacy ffs</td>
<td>Qrtly updates, initially phased in</td>
</tr>
<tr>
<td>Illinois</td>
<td>CDPS Rx and MRX only (regions)</td>
<td>Health plan encounters, legacy FFS, special claims submission</td>
<td>Semi annual updates, retroactive application</td>
</tr>
<tr>
<td>Indiana</td>
<td>CDPS Rx</td>
<td>Health Plan encounters, legacy ffs</td>
<td>Semi annual updates</td>
</tr>
<tr>
<td>Louisiana</td>
<td>ACG</td>
<td>Health plan encounters</td>
<td>Annual updates</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>DXCG</td>
<td>APCD</td>
<td>Annual updates</td>
</tr>
</tbody>
</table>

### States - DRAFT

*caution: state policies change so data are not necessarily up to date*

<table>
<thead>
<tr>
<th>States</th>
<th>Risk Adjustment System</th>
<th>Data Source</th>
<th>Special Policies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kansas</td>
<td>CDPS</td>
<td>Health plan encounters</td>
<td>Initiated in 2015</td>
</tr>
<tr>
<td>Mississippi</td>
<td>CDPS Rx</td>
<td>Health Plan encounters</td>
<td></td>
</tr>
<tr>
<td>Maryland</td>
<td>ACG</td>
<td>Health plan encounters</td>
<td>Annual updates, initial encounter data completion adjustment</td>
</tr>
<tr>
<td>Michigan</td>
<td>CDPS Rx</td>
<td>Health plan encounters</td>
<td>Coding limit</td>
</tr>
<tr>
<td>New Jersey</td>
<td>CDPS Rx</td>
<td>Health Plan encounters</td>
<td>Semi annual updates</td>
</tr>
<tr>
<td>New York</td>
<td>CRG</td>
<td>Health plan encounters (including CPT)</td>
<td>Annual updates, initially phased in</td>
</tr>
<tr>
<td>Nevada</td>
<td>CDPS Rx</td>
<td>Health plan encounters</td>
<td>Semi annual updates</td>
</tr>
<tr>
<td>Missouri</td>
<td>CDPS Rx</td>
<td>Health plan encounters</td>
<td>Qrtly updates</td>
</tr>
</tbody>
</table>
Looking to the Future

- As states move to enroll more complex populations into managed care plans, existing diagnostic based risk adjusters may not be sufficient to adjust for variations among plans.

- Researchers and states are analyzing the important role that factors such as “Activities of Daily Living” (ADLs) play in explaining resource use and variation (see CHCS report “Developing Capitation Rates for Medicaid Managed Long-Term Services and Supports Programs: State Considerations, January 2016”).

- Work is underway to develop models and validation protocols for data derived from health assessments, determining how to standardize such information and ultimately tie them to encounters and claims for model development.
Discussion

• We will now turn to our expert Richard Lieberman to discuss some of the key issues and variations noted among the states in Medicaid risk adjustment:
  – Frequency of Updates
  – Choice of Grouper
  – Validation of data
  – Role of augmenting encounter data via medical record reviews
  – Risk adjustment in emerging delivery models, for example ACOs

• We will also ask Richard to weigh in on lessons learned in Medicaid and how they can be applied to other publicly funded insurance programs
Retrospective and Prospective Best Practices for Maximizing Results

Dr. Lerla Georgette Joseph, Chief Executive Officer
CENTRAL VIRGINIA COALITION OF HEALTH CARE PROVIDERS

Melanie Richey, Vice President of Quality
CENTAURI HEALTH SOLUTIONS

Dawn Carter, Director of Product Strategy
CENTAURI HEALTH SOLUTIONS

Krista Bowers, Senior Vice President
REGAL MEDICAL GROUP
As the CEO of Central Virginia Coalition of Health Care Providers (CVCHiP), Dr. Lerla Joseph, MD has 39 years of Internal Medicine experience and is affiliated with Bon Secours St Mary's Hospital and Bon Secours-Richmond Community Hospital in Richmond, VA. Dr. Joseph founded CVCHiP, which is a Medicare Shared Savings Program Track 1 Accountable Care Organization approved in December 2015. Its service area spans central and tidewater Virginia and northeast North Carolina. CVCHiP is made up principally of independent, small medical practices. It is physician-owned and physician-governed. CVCHiP offers a viable alternative to the small medical practice that desires to maintain autonomy and remain competitive in delivering value-based healthcare.
Melanie Richey, RN, Vice President of Quality, Centauri Health Solutions

As VP of Quality, Melanie Richey has more than 20 years of healthcare experience with deep expertise in quality management strategies, regulatory compliance, operations and product development. Ms. Richey’s experience includes a broad healthcare background across payers, providers and employer groups, commercial, Medicare and Indigent programs as well as care delivery re-design. As the former Senior Director, Quality Solutions for Verisk Health, Ms. Richey lead all aspects of quality management and improvement products for commercial, Medicaid, Medicare and QHP clients. Additionally, Ms. Richey launched and expanded a network model quality management program for Kaiser Permanente Colorado, where she oversaw risk adjustment, disease management, accreditation and regulatory compliance, wellness and P4P programs.
Dawn Carter Richey, Director of Product Strategy, Centauri Health Solutions

Dawn Carter, Director of Product Strategy has had a career in healthcare which spans more than 20 years. For more than two decades, Ms. Carter has actively developed revenue integrity and quality software solutions, with a focus on encounter management and risk adjustment solutions for Medicare Advantage, Medicaid and commercial health plans. Ms. Carter develops specializes in health plan and provider systems administration and healthcare applications. And, she is also a sought after and prolific industry speaker, author, blogger and subject matter expert in the area of claims, EDI management and risk adjustment, and teaches medical administration, billing and coding.
Krista Bowers, Senior Vice President of Operations, Regal Medical Group

Steeped with integrated health plan and practice group operations experience, Ms. Bowers currently oversees operations for San Fernando Valley, CA-based Regal Medical Group. Immediately before her appointment at Regal Medical Group, Ms. Bowers served as the Director of BDC Advisors, a healthcare strategy firm. Previously, Bowers served as a senior executive at two national health plans. At Anthem, (WellPoint), Ms. Bowers was responsible for leading the organization’s Medicare business division and Consumer Business marketing. Before Anthem, she spent five years at Health Net serving as Chief Medicare Officer, Western Region and Vice President, Corporate Marketing. Bowers publishes frequently on Medicare Advantage, Managed Medicaid and other topics related to population health management.
RISK ADJUSTMENT
RETROSPECTIVE AND PROSPECTIVE BEST PRACTICES FOR MAXIMIZING RESULTS

Dr. Lerla Georgette Joseph, CEO, Central Virginia Coalition of Health Care Providers

Melanie Richey, RN, BSN, MBA, VP, Quality
Centauri Health Solutions

Krista Bowers, BA, Senior VP, Regal Medical Group

Dawn Carter, BS, Director, Product Strategy
Centauri Health Solutions

Proprietary & confidential
2017 © Copyright Centauri Health Solutions

• 39 years of Internal Medicine experience
• Affiliated with Bon Secours St. Mary’s Hospital and Bon Secours-Richmond Community Hospital in Richmond, VA
• Internal Medicine, Howard University College of Medicine
• Doctor of Medicine (M.D.), Wake Forest University Graduate School
• B.S. Biology, Winston-Salem State University

• Senior Director, Quality Solutions, Verisk Health
• Director, Quality Management Program, Kaiser CO
• M.B.A., University of Phoenix
• B.S.N., Wright State University

• COO, BDC Advisors
• President, Medicare and Consumer Business, Anthem
• Chief Medicare Officer, Health Net Inc.
• B.A., University of California at Los Angeles

• Director, Product Analysis, Edfless, Inc.
• Product Manager, Verisk Health
• B.S., Business Administration, Strayer University
Risk Adjustment is a collaboration

RETROSPECTIVE AND PROSPECTIVE - MAXIMIZING RESULTS

Retrospective Basics

- What does it take to have a great working relationship with practice groups?
  - Priority in your company with designated leadership
  - Expertise in physician office management
  - Technical expertise specifically for HCC
RETROSPECTIVE AND PROSPECTIVE - MAXIMIZING RESULTS

Retrospective Basics

- Do you have an established best practice incentive program?
  - Do you provide plenty of incentive program options?
  - Which incentives work best?
  - How do you measure your incentive programs?

Prospective Basics

- Do you understand the member population of your practice group?
  - What does your data reveal about your members?
  - Do provider groups have access to the data they need to effectively engage and manage the members in their practice?
  - What tools and support are available to practice group partners?
  - Are you able to determine your program’s ROI?
RETROSPECTIVE AND PROSPECTIVE MAXIMIZING RESULTS

Prospective Basics

- Compliance
  - Practice group partners must have easy access to complete and accurate data
  - Geo Mapping: What's the highest membership for Hierarchical Condition Codes (HCC) stratification?
  - Determine your program's ROI

Questions?

Thank You
Risk Adjustment Strategies That Work

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As the CEO and President of MedXM, Sy brings a unique blend of business development in the medical industry dating back over twenty-five years. His significant background as an entrepreneur and experience in expanding distribution channels, instituting new technology platforms accompanied with developing strategic business and operational plans for new ventures has placed this company on the forefront of healthcare. It's his belief in patient education, prevention and early detection accompanied with technology creation, value and delivery that drives this company into this new era in healthcare.
Leverage risk adjustment as a competitive advantage with the following strategies:

- Take a Holistic Approach
- Stay Current on Federal Regulations
- Take a Member-Centric Approach
- Educate and Engage Providers
- Implement Quality Assurance & Prepare for RADV
Take a Holistic Approach to Risk Capturing

Offer In-Home Health Risk Assessments to Capture a Holistic View of Members

The Holistic Approach through HRA’s

- Allows for Integrative Medicine Model
  Treat the whole person, not just their disease.

- Allows for Care Management and Engagement
  Personalized service to address contextual factors in members’ lives
  i.e. Socioeconomic/psychosocial issues or concerns reported
  Gives members the support they need

- Promotes Prevention and Early Detection
  Avoid expensive interventions
  Avoid unnecessary emergency department visits
Stay Current on Federal Regulations

Risk Adjustment Updates

Medicare Risk Adjustment Update

Medicaid Risk Adjustment Update

Commercial Risk Adjustment Update
3 Ways to Take a Member Centric Approach to Risk Adjustment

Define Quality in Terms of Convenience
Reach Members Where it Counts, Everyone is Using Technology Today

Baby Boomers and seniors now spend more time online than watching television, according to a report by Ipsos and Google.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Seniors</th>
<th>Boomers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Watching TV</td>
<td>16.3</td>
<td>16.3</td>
</tr>
<tr>
<td>Going Online Outside of Home</td>
<td>4.8</td>
<td>4.7</td>
</tr>
<tr>
<td>Going Online at Home</td>
<td>13.9</td>
<td>14.8</td>
</tr>
<tr>
<td>Listening to the Radio</td>
<td>4.7</td>
<td>4.7</td>
</tr>
<tr>
<td>Reading a Magazine/Newspaper</td>
<td>3.1</td>
<td>2.2</td>
</tr>
<tr>
<td>Time Spent in an Average Week</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Online (NET) = 19hrs
Boomers/Seniors

Source: Reaching Today’s Boomers and Seniors Online, Ipsos and Google, 2013
Top 5 Sources to Learn About a Topic of Interest

Source: Reaching Today’s Boomers and Seniors Online, Ipsos and Google, 2013

- **INTERNET**: 80%
- **TV**: 65%
- **FRIENDS & FAMILY**: 77%
- **MAGAZINES & NEWSPAPERS**: 52%
- **BROCHURES & CATALOGS**: 36%

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52% of smartphone users gather health-related information on their phones.

Source: mobilemarketer.com/cms/news/research/15023.html

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Make Sure Your Site is Mobile Friendly
Create ways for health plan members to take control of the HRA experience through technology

- Online Appointment Scheduling and Rescheduling
- Text Message Appointment Reminders
- Email Appointment and Follow Up Reminders

OPTIMIZE COMMUNICATIONS

01 ELIMINATE CONFUSING JARGON
02 EXPLAIN THE ASSESSMENT IN AN EASY TO UNDERSTAND WAY
STOP BLINDLY SENDING DIRECT MAIL

Be strategic in your mailing efforts to save costs and improve response and success rates.

**Profiling**
- Know as much as you can about your existing members to learn your target audience and direct creative look, feel, and messaging.

**Modeling**
- Uses data to find similarities between those who have responded to you before and who is most likely not going to respond to your marketing.
- Mail to those in your target demographic and to only those people you know will respond.

1. Offer consulting services for costly tests and treatments.
2. The HRA can be used to help facilitate care between the member, primary care physician, and health plan.
3. Develop care management plans and teams to give members real-time responses.

Be a Facilitator of Care.
Risk Adjustment: A Member-Centric Approach To Achieving High-Value Collaboration

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MODA HEALTH

Mike Nemeth
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Nathan Trenholme is the Manager of Informatics and Quality Metrics at Moda Health, a multistate health plan covering over 1.2 million medical, dental, vision, and pharmacy lives in the Pacific Northwest. Nathan graduated from Oregon Health and Science University in 2010 with a Master’s in Public Health and has been applying his epidemiology and biostatistics skills, developing programs to improve health outcomes for Moda members. Working on HEDIS and quality metrics since 2010, Nathan seeks innovative solutions to support quality improvement across all product lines including Medicare, Commercial, Exchange, and Oregon’s Coordinated Care Organizations as part of the state Medicaid program. Nathan has participated in the development of new metrics and the curation of the measure set for the Oregon Medicaid program and is currently working to bring greater alignment in quality metrics for healthcare.
RISK ADJUSTMENT:
MEMBER-CENTRIC APPROACH TO ACHIEVING HIGH-VALUE COLLABORATION

Mike Nemeth, Director of Revenue Management Strategy, DST Health Solutions
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MANAGING DATA TO MANAGE RISK ADJUSTMENT AND QUALITY PERFORMANCE

BARRIERS TO COMPREHENSIVE PROGRAMS

- Disparate Data and Data Availability
- Decentralized Analytics
- Key Performance Indicators (Macro and Micro)
- Vendor Integration
- Organizational Awareness and Understanding
- Overlapping and Duplicative Activities
- Communication
BREAKING DOWN INTERNAL BARRIERS TO ACHIEVE COORDINATED MEMBER ACTIVITIES

Analytics can break down the barriers and drive alignment within an organization.

Quality
- HEDIS
- Provider Performance
- Care Outcomes

Risk Adjustment
- Prospective
- Concurrent
- Retrospective

Network
- Contracting
- Performance
- Incentives

Operations
- Campaign Management
- Member Engagement
- Provider Engagement
- Submissions

CENTRALIZED DATA – A SINGLE SOURCE FOR ANALYTICS

- A centralized set of data with a single analytics platform can guide a unified approach to managing revenue and is essential to fully leverage the investment in data.
- Viewing these revenue-focused processes as one allows health plans to increase data available for each process since information collected to support risk adjustment may also be used for quality performance, or vice versa.
- Holistic View – Member, Provider and Internal Programs
USING ANALYTICS TO DRIVE A MEMBER-CENTRIC APPROACH

Let the Data be your guide to identify who, when, and how to engage with a robust analytics program.

- Understand the Member First
- Develop a robust roadmap for member engagement
- Create awareness
- Avoid conflicting messages
- Minimize Redundancies
- Maximize Value
- Improve member experience

ACHIEVING CONSISTENT MESSAGING, BETWEEN PAYER AND PROVIDER

Centralized data and analytics supports improved collaboration with providers.

- Improved insight into provider performance
- Drives targeted education and better communication with provider and staff
- Provides Timely, Accurate, Transparent Data
- Enables Coordinated Touchpoints to
  - Manage Care and Conditions
  - Support data sharing of comprehensive member health status and care needs
- Maximizes integration opportunities via consolidated data set
- Improves member experience
IMPLICATIONS OF A DECENTRALIZED APPROACH

- Member and Provider Abrasion
- Increased Administrative Cost
- Redundant Internal Processes
- CMS Complaints
- Fragmented View of Member Coding and Care Gaps
- Unnecessary Touchpoints and False Positives
- Inconsistent Messages
- Credibility with Provider Community
- Creates Multiple Integration Points

ANALYTICS IS THE CORNERSTONE OF A REVENUE MANAGEMENT TOOLBOX

- Analytics and integrated data allow organizational and external insights into member level detail needed to support risk adjustment and quality performance activities
- Analytic capabilities and principles support mitigating risk associated with risk adjustment and quality programs
- Robust analytics can drive efficiency, value, and return for plans leveraging the information to its fullest capability
THANK YOU!