Track B
Special Panel – Lessons Learned from 4 & 5 Star Plans

Moderator:
Kim Browning, Executive Vice President
COGNISIGHT

Panelists:
Michael Turrell, Chief Executive Officer
ULTIMATE HEALTH PLANS

Colleen Walsh, Associate Vice President, Clinical Affairs and Quality Improvement
UPMC

Suriya Grima, Senior Director of Medicare Strategy and Growth
BLUE CROSS BLUE SHIELD OF MICHIGAN
Kim Browning
Executive Vice President
kbrowning@cognisight.com
585.662.4215

As Executive Vice President at Cognisight, Kim is responsible for corporate operations, compliance, and product development. She has more than 20 year’s experience in health care business and technology, including software development, sales and marketing, strategic planning, and management.

Kim’s particular expertise lies in health care operations and P&L accountability of Medicare and Medicaid lines of businesses. She has held leadership positions with health care plans and developed proprietary software solutions in the risk adjustment arena. Under Kim’s leadership, Excellus BCBS was ranked #1 in New York State and tied for #2 in the nation by US News & World Report in 2009 for Medicaid contractors.

Kim is a graduate of SUNY Buffalo where she received her BS in both Business Studies and Business Administration. She also holds several post graduate certifications, including: Certified Project Management Professional, Certified Healthcare Consultant and most recently, Certified Healthcare Reform Specialist.
Mr. Turrell is the founding Chief Executive Officer of Ultimate Health Plans, a Medicare Advantage Health Plan North of Tampa. Prior to starting Ultimate Health Plans, Mr. Turrell spent 15 plus years in Compliance, Legal and the fight against fraud, waste and abuse. Mr. Turrell was a principal at Brandt and Evans LLC after holding executive positions at Fortune 500 companies such as Wellpoint and Wellcare plus additional small and midsize companies. Mr. Turrell received his BA from Boston University and his Juris Doctor from Chapman University School of Law.
Colleen Walsh is the Associate Vice President of Quality Performance and Clinical Regulatory Affairs at UPMC Health Plan. Colleen has over 35 years of experience in managing quality strategy and outcomes, both at the hospital and managed care arenas. At UPMC Health Plan, Colleen is responsible for eleven different products for HEDIS and NCQA accreditation, quality for all products, CMS stars, provider credentialing, and provider quality oversight.
Part I:
Michael Turrell
Chief Executive Officer

Part II:
Colleen Walsh
AVP, Clinical Affairs & Quality Improvement

Part III:
Suriya Grima
Sr. Director, Medicare Strategy & Growth

Moderator:
Kim Browning
Executive Vice President

Learning Objectives

- Practical, ongoing steps taken to reach Stars’ highest level and remain there
- Making the difficult climb to the top
  - How we identified and targeted specific areas of focus
- How quality teams worked with other departments to reach performance objectives
  - What you must know about working together to move the most challenging measures
- Creating a plan of attack
  - How to accurately assess your existing performance in order to institute a cohesive, strategic approach to achieving high-level Stars outcomes
- Keeping track and staying ahead of changes to the methodology, shifting measures, and resulting initiatives to ensure high performance
Three Perspectives

- Managing the member experience scores
- Provider integration to achieve results
- Managing out of network/state to achieve results

HEDIS & the Member Experience
Michael Turrell
Chief Executive Officer
Ultimate Health Plans
Be Member Centric *Not Measure Centric*

- Start with the prospective member – proselytize in marketing
- Communicate in detail with member about Stars, why the measurement and what’s in it for them

Create an army of members seeking their:
- Eye exam
- Colorectal cancer screening
- Breast cancer screening
- Flu shots
- Conversations about falls and bladder control

Enlist members in root cause analysis
- Help identify special populations and appropriate approach
- Help identify barriers
- Help identify best communication methods
- Help identify bad actors (from staff to providers)

How We Educated Members About Stars

**Help Ultimate Reach 5 Stars**
- Medicare uses information from member satisfaction surveys, plans, and health care providers to give overall performance star ratings to plans.
- A plan can get a rating between 1 and 5 stars. A 5-star rating is considered excellent.
- These ratings help you compare plans based on quality and performance. The ratings are updated each fall and can change each year.

**Why are 5 Stars Important?**
- Bonus payments have to be used to improve the plan’s quality and benefit offerings for Members
- New members can join a 5-Star plan year-round (not just October – December)
- This plan got Medicare’s highest rating (5 stars)

**Where Does the Info Come From?**
- Surveys of our Members. You will receive it in the mail – CAHPS & HOS
- Call Center Monitoring – CMS test calls
- HEDIS – Your medical record and claims
- Prescription Drug Event – when you fill your prescriptions
- Other CMS data (i.e. audits, complaints, etc.)
Coordinate, Coordinate, Coordinate

- Kill many birds with one stone by consolidating interventions
  - QIP
  - CCIP
  - Stars
  - Risk Adjustment
  - D-SNP Assessments
- Each member interaction should be leveraged
- Don’t overload providers with multiple burdens.
Collaborating with Nurses and Physicians in Member Engagement

- Reward delivery systems for progress
- PAM (Patient Activation Measure) model and CS-PAM
- Match staff to appropriate members
- Smart benefit design
- Preferred networks
- Increase volume for practices that engage

Why Drive Volume to Engaged Docs?

CS-PAM and Self-Management Behaviors Among Primary Care Providers

* Significant difference p<0.05
Leverage Provider-Member Trust

- Provider and staff already have a relationship with member
- They’ve already gotten to the “Yes”
- Coordinate member engagement campaigns with providers
- Live person calls better than IVR – Can we leverage provider office familiarity?
- Letters and materials from PROVIDER
- Preventive care checklists, signage and education

Preventive Care Checklists and Education
Preventive Care
Checklists and Education

Signage and Member Education
At Your Appointment Today, Ask Me About:
• Whether the flu vaccine is right for you
• Whether we should schedule a test for osteoporosis screening

And While We’re At It... Let’s Talk About:
• Concerns about urine leakage. We can manage it!
• Your level of physical activity
• Could you be at risk for falling?
Provider Integration

Colleen Walsh
AVP Quality Performance & Clinical Regulatory Affairs
UPMC Health Plan

UPMC Health System

• Premier health system in Western Pennsylvania and renowned medical academic center.

• Integrated Delivery Health and Finance System

• Over 2.8 million members

• Medicare HMO  4.5 Stars
• Medicare PPO  4.5 Stars
• Special Needs Plan  4.0 Stars
UPMC is data driven and is committed to high standards of care. **Collaboration with our physicians** and member engagement is critical to achieve total care coordination for our members.

**Network Provider Program Integration**

- Incentive cost sharing initiative with our providers –
  - Cost savings on utilization measures; readmissions, diagnostics, consultants, generic medication use
  - Percent of cost savings shared with providers
  - HOWEVER, to receive any cost sharing providers must hit a quality threshold which is closing gaps in care related to HEDIS measures – sets target for overall Star score
  - Plan Downside risk going forward
• Practice Based Care Managers in PCP offices coordinate closing gaps in care

• View daily “Tracking Board” for member discharges and ER visits – care coordination

• Transition Coordinators at high volume hospitals facilitate safe discharge and follow-up with PCP, ideally within 5 days

• Engage member in “Prescription for Wellness” program

• Engage member in mobile events – convenience to member

Prescription for Wellness – Notable Visit for Member

Physician writes a patient an order (prescription) for Wellness
• What is important to patient
  • Losing weight
  • Stop smoking
  • Diabetes and wants to get HbA1c in control
  • Hypertension and wants to get BP in control

Physician writes prescription to join HP Clinical programs – sends automated referral
Mobile Van – Notable visit for Member

- Mobile events at physician office and community centers, housing high rises, member retention meetings – Health Plan manages
- Members invited with gaps in care
- Labs drawn, retinal eye exam, colorectal screening kits distributed, Adult BMI and BP done and gets into chart, osteoporosis screening.
- Preventive – no member copayment
- Diabetes educators present
- Pharmacist, medication reviews

PCMH Summary through 2016

<table>
<thead>
<tr>
<th>Category</th>
<th>Total Population</th>
<th>Active Sites</th>
<th>Total Physicians</th>
<th>Shared Savings Sites</th>
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<tr>
<td>CM</td>
<td>223,702</td>
<td>495</td>
<td>1259</td>
<td>23</td>
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<tr>
<td>MA</td>
<td>140,269</td>
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<tr>
<td>MC</td>
<td>73,287</td>
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<tr>
<td>SNP</td>
<td>11,440</td>
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<tr>
<td>CHP</td>
<td>9,832</td>
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<td></td>
<td></td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>458,530</strong></td>
<td><strong>495</strong></td>
<td><strong>1259</strong></td>
<td><strong>23</strong></td>
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</table>
Network Provider Program Integration

- Dedicated Quality, Clinical and Financial team, visits providers at least quarterly
- Monthly member gaps in care provided
- Ongoing education on measures, thresholds and what the health plan is doing to assist success
- Ad hoc reports as needed:
  - What methods does the provider use to close colorectal cancer screening gaps - % colonoscopy, % sigmoid, % Fit kits
  - If member not on a DMARD medication and diagnosis of RA, which of these members did the PCP render the diagnosis of RA
  - Current star and rate and number needed to reach next star level
- Discussion of display measures to present to shared savings incentive providers – diabetes and statin use metric one year display then counts in shared savings program next year

Quality Dashboard SS vs RON

<table>
<thead>
<tr>
<th>CMS Star Measure</th>
<th>Shared Saving</th>
<th>Rest of Network</th>
<th>Difference</th>
<th>Significance</th>
<th>4 Star</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Screening</td>
<td>74%</td>
<td>69%</td>
<td>5%</td>
<td>**</td>
<td>&gt;=74%</td>
<td></td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>67%</td>
<td>53%</td>
<td>14%</td>
<td>**</td>
<td>&gt;=71%</td>
<td></td>
</tr>
<tr>
<td>Osteoporosis Management in Women</td>
<td>49%</td>
<td>42%</td>
<td>7%</td>
<td>*</td>
<td>&gt;=51%</td>
<td></td>
</tr>
<tr>
<td>Diabetes Care: Eye Exam</td>
<td>70%</td>
<td>62%</td>
<td>8%</td>
<td>**</td>
<td>&gt;=75%</td>
<td></td>
</tr>
<tr>
<td>Diabetes Care: Kidney Disease Monitoring</td>
<td>95%</td>
<td>85%</td>
<td>6%</td>
<td>**</td>
<td>&gt;=53%</td>
<td></td>
</tr>
<tr>
<td>Rheumatoid Arthritis Management</td>
<td>77%</td>
<td>74%</td>
<td>3%</td>
<td></td>
<td>&gt;=82%</td>
<td></td>
</tr>
<tr>
<td>Plan All-Cause Readmissions *</td>
<td>9%</td>
<td>9%</td>
<td>0%</td>
<td></td>
<td>&lt;=9%</td>
<td></td>
</tr>
<tr>
<td>High Risk Medication *</td>
<td>6%</td>
<td>6%</td>
<td>0%</td>
<td></td>
<td>&lt;=8%</td>
<td></td>
</tr>
<tr>
<td>Part D Adherence for Diabetes Medication</td>
<td>85%</td>
<td>84%</td>
<td>1%</td>
<td></td>
<td>&gt;=75%</td>
<td></td>
</tr>
<tr>
<td>Part D Adherence for Hypertension Medications</td>
<td>87%</td>
<td>86%</td>
<td>1%</td>
<td>**</td>
<td>&gt;=77%</td>
<td></td>
</tr>
<tr>
<td>Part D Adherence for Cholesterol Medications</td>
<td>83%</td>
<td>81%</td>
<td>2%</td>
<td>**</td>
<td>&gt;=73%</td>
<td></td>
</tr>
</tbody>
</table>

* Lower Rate is Better
** Statistically significant P < 0.01
* Statistically significant P < 0.05

▲ SS Rate Exceeds RON, 4 Star Goal not met
▲ SS Rate Exceeds RON, 4 Star Goal met
Part Three

Managing Out of Network/State to Achieve Results

Suriya Grima  
*Senior Director of Medicare Strategy & Growth*  
Blue Cross Blue Shield of Michigan
BCBSM Star Program Overview

Topics

1. BCBSM Product Overview
2. Star Improvement Strategy Process
3. Case Study: Out of State Clinical Improvement

BCBSM Membership and Performance Overview

Even with membership growth upwards of 120k members over 4 years, BCBSM’s PPO product maintains a 4 Star rating, while the HMO product maintains a 4.5 Star rating.

BCBSM PPO Product

<table>
<thead>
<tr>
<th>Membership (in 000s)</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michigan</td>
<td>253</td>
<td>305</td>
<td>329</td>
<td>351</td>
</tr>
<tr>
<td>Out of State</td>
<td>217</td>
<td>255</td>
<td>272</td>
<td>285</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4 Star</td>
<td>4 Star</td>
<td>4 Star</td>
<td>TBD (Oct 17)</td>
<td></td>
</tr>
</tbody>
</table>

BCBSM HMO Product

<table>
<thead>
<tr>
<th>Membership (in 000s)</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michigan</td>
<td>54</td>
<td>63</td>
<td>72</td>
<td>79</td>
</tr>
<tr>
<td>Out of State</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4.5 Star</td>
<td>4.5 Star</td>
<td>4.5 Star</td>
<td>TBD (Oct 17)</td>
<td></td>
</tr>
</tbody>
</table>
Key Differentiators of the BCBSM Stars Program

BCBSM has a robust program to manage and improve Star performance, which is grounded in advanced analytics and comprehensive reporting.

Key Program Differentiators

1. Demonstrated success in Stars
   - BCBSM achieved at least four Stars on all MA plans for 2012–2015 measurement years (2014–2017 Star ratings) and has left no Star bonus money on the table

2. Robust predictive modeling
   - Projections for Stars scores are highly accurate: for 2015 measurement year (2017 Star rating), final scores were within 5% of projections

3. Broad suite of offerings with customization options
   - Initiative improvement landscape includes more than 30 initiatives for Stars alone

4. Data-driven strategy
   - All aspects of strategy setting process are anchored in sophisticated analysis

5. Comprehensive and detailed reporting
   - Performance is tracked in real-time with monthly reporting readouts

BCBSM’s Strategy and Performance Management Approach

The overall Star Quality Improvement strategy is developed through a collaborative process, beginning with annual strategy development and followed by initiative execution and performance management.

<table>
<thead>
<tr>
<th>Strategy Development</th>
<th>Implementation and Performance Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish Baseline and Set Goals</td>
<td>Build Initiative Portfolio</td>
</tr>
<tr>
<td>• Analyze historical performance</td>
<td>• Identify areas that drive greatest impact against goals</td>
</tr>
<tr>
<td>• Benchmark competitor performance</td>
<td>• Build initiative portfolio</td>
</tr>
<tr>
<td>• Set 2-year aggregate goals</td>
<td>• Develop high-level implementation timeline for all initiatives in the portfolio</td>
</tr>
<tr>
<td>• Set 1-year measure-level goals</td>
<td>• Socialize goals with other key partners</td>
</tr>
</tbody>
</table>
BCBSM’s Star Quality Improvement Strategy

BCBSM’s annual Star Quality improvement strategy process reviews current and historical performance, industry trends and past initiative performance to develop an initiative portfolio focused on improving Star quality performance.

Star Strategy Activities
- Providing an overview of competitive landscape and local dynamics
- Setting goals for each measure (monthly & year-end) and two-year overall Star goals
- Identifying an initiative portfolio customized to BCBSM performance, including executive timeline

Star Quality Improvement Strategy Outputs

BCBSM’s Quality Monitoring & Performance Management Process

BCBSM’s Star Quality monitoring and management process measures, monitors and communicates initiative and overall Star performance to key stakeholders.

Star Quality Monitoring Activities
- Collecting monthly performance data for each measure
- Reviewing trends and performance to project year-end results at the measure level
- Operating a robust Monte Carlo simulation to provide an overall Star rating projection monthly
- Developing initiative design document that includes an initiative overview, timeline, and detailed design
- Monthly initiative monitoring of key implementation dates prior to launch, and monthly monitoring of key performance indicators and impact post-launch

Monitoring Reports – Overall Star Rating

Monitoring Reports – Initiative Management
Case Study: Out of State Clinical Improvement

Through in-depth analysis, it was identified that clinical Star performance for members who reside out of state (OOS) is much lower than in-state and the top opportunity for improvement is within Indiana.

<table>
<thead>
<tr>
<th>State</th>
<th>Members</th>
<th>% of Total Out of State Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Florida</td>
<td>15,842</td>
<td>23.9%</td>
</tr>
<tr>
<td>Indiana</td>
<td>15,028</td>
<td>22.7%</td>
</tr>
<tr>
<td>All Other</td>
<td>35,318</td>
<td>53.4%</td>
</tr>
<tr>
<td>Total OOS</td>
<td>66,188</td>
<td>-</td>
</tr>
</tbody>
</table>

- The quality gap closure rate for BCBSM members in Michigan is significantly higher than for members who reside outside of Michigan
- Although members who reside outside of Michigan represent 20% of the population, the low performance impacts clinical Star performance
- Florida and Indiana represent just under 50% of the OOS membership
- The remainder of the membership is spread across 41 states
- The overall gap closure rate in Florida is higher than the BCBSM OOS average and significantly higher than in Indiana
- Indiana is identified as a key opportunity area for clinical improvement

Case Study: Out of State Clinical Improvement Solution

To impact clinical quality performance in Indiana, the Provider Engagement Coordination (PEC) program was deployed in 2016 for 19 practices to improve clinical Star performance and risk coding accuracy.

The PEC program is a national solution for risk adjustment and Star quality outcomes that utilizes a highly collaborative and interactive approach with physicians

- A provider engagement coordinator is embedded in each targeted office to act as liaison between the physician and BCBSM
- A sophisticated proprietary algorithm identifies patient conditions and Star gaps
- A team of physicians and certified coders review the medical record of the member and produce a single page alert document of potential risk coding and Star gaps
- The provider engagement coordinator provides the single page alert to the provider prior to the member visiting the office. The provider then has an easy, comprehensive reference for the member’s visit, allowing for more efficient and effective code identification and capture
- The physicians and certified coders review the medical record after the member’s visit and code all conditions for submission to CMS
Case Study: Out of State Clinical Improvement Results

In order to assess the performance of the PEC program in Indiana, a comparison of YTD quality gap closure rates for the PEC program practices were compared to non-PEC practices in Indiana.

**Quality Gap Closure Rates**

PEC vs non-PEC Practices

<table>
<thead>
<tr>
<th></th>
<th>2015 Nov YTD</th>
<th>2016 Nov YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PEC</strong></td>
<td>52.5%</td>
<td>68.9%</td>
</tr>
<tr>
<td><strong>Non-PEC</strong></td>
<td>46.2%</td>
<td>51.9%</td>
</tr>
</tbody>
</table>

Overall Quality Gap Closure Rate

- PEC practices experienced higher year over year clinical gap closure improvement than the control group
- First-year program results showed significant improvement (>20%) across Adult BMI Assessment and Diabetes – Blood Sugar Control and modest improvement (<20%) across all other clinical Star measures
- PEC program results in the first year are typically significant, depending on the starting point of the physician community, as it is focused on education and medical record review
  - The PEC program in a mature market will typically show a 5% gap closure improvement year over year as the program enables physicians to address member gaps at the point of care

Key Program Highlights

**Quality gap closure rate includes the following measures:** Breast Cancer Screening, Colorectal Cancer Screening, Adult BMI Assessment, Diabetes Care – Eye Exam, Diabetes Care – Kidney Disease Monitoring, Diabetes Care – Blood Sugar Controlled.
Closing Stars/HEDIS Measures and Maximizing Risk Performance using Mobile Clinics

Moderator:
Ray Ekbatani, Chief Administrative Officer
HEALTHFAIR

Co-Panelists:
James Metcalf DO, MBA, Medical Director
OPTUMCARE

Manuel Gaidola, HIA, CPC, Director, Medicare Revenue Operations
MARTIN’S POINT HEALTH CARE
Closing Star/HEDIS Measures and Maximizing Risk Performance using Mobile Clinics

Our Speakers

- **James Metcalf, DO, MBA**
  - Medical Director
  - OptumCare Utah

- **Manuel Gaidola, HIA, CPC**
  - Director, Medicare Revenue Operations
  - Martin's Point Health Care

- **Ray Ekbatani**
  - Chief Administrative Officer
  - HealthFair
Topics Of Discussion

- Can appropriately targeted testing identify disease burden and reduce audit risks?
- Is it possible to close more than 25 Star/HEDIS measures during a single visit?
- Can mobile clinics improve access and member engagement?
- Are your prospective assessment programs integrated with primary care?
- Do member incentives really increase member engagement?

Industry Challenges

- Large portion of members are not engaging
  - Not comfortable with home assessment
  - Do not go to PCP unless they are sick
  - Access to services not always convenient
- Lack of coding experience and consistency for providers
  - Missed coding opportunities
  - Poor documentation
- Missed Star and HCC gaps
  - Members don’t complete follow up testing
  - Limited availability of testing during patient encounters
Can appropriately targeted testing identify disease burden and reduce audit risks?

James Metcalf, DO, MBA
Medical Director
OptumCare Utah

Limitations For Capturing Diagnostic Data During An Assessment

OFFICE & HOME ASSESSMENT
- Annual Wellness Visit
- Medication Review
- Gait/Cognitive Analysis
- Depression Screening
- Blood Pressure
- Vaccinations
- Basic Vision

BLOOD TESTS

LABORATORY

OPHTHALMOLOGIST

MAMMOGRAM

CARDIOLOGIST

FOLLOW UP OFFICE VISIT
- Provider develops patient care plan with limited data
Leveraging Clinical Data To Enhance Documentation and Reduce Audit Risk

- We cannot effectively “Evaluate” or “Assess” some chronic conditions without additional clinical data (M.E.A.T)
  - Example:
    - Congestive Heart Failure (CHF) - Echocardiogram/EKG
    - Chronic Obstructive Pulmonary Disorder (COPD) – Spirometry
    - Peripheral Vascular Disease (PVD) – ABI/LEAD

- Many common chronic conditions are not recaptured or missed altogether due to limited diagnostic information

- Providers and payers should support evidenced based testing when clinically indicated to help assessment and evaluation of chronic conditions
Is it possible to close more than 25 Star/HEDIS measures during a single visit?

Stars Impact (Part C)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Open Gaps</th>
<th>Star Rating - Pre Visit</th>
<th>Closed</th>
<th>Star Rating - Post Visit</th>
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</thead>
<tbody>
<tr>
<td>Breast Cancer Screening</td>
<td>1955</td>
<td>2</td>
<td>1564</td>
<td>5</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>4773</td>
<td>3</td>
<td>1910</td>
<td>5</td>
</tr>
<tr>
<td>Annual Flu Vaccine</td>
<td>2880</td>
<td>3</td>
<td>2549</td>
<td>5</td>
</tr>
<tr>
<td>Improving or Maintaining Physical Health</td>
<td>-</td>
<td>-</td>
<td>9277</td>
<td>5</td>
</tr>
<tr>
<td>Improving or Maintaining Mental Health</td>
<td>-</td>
<td>-</td>
<td>9277</td>
<td>5</td>
</tr>
<tr>
<td>Monitoring Physical Activity</td>
<td>-</td>
<td>-</td>
<td>9277</td>
<td>5</td>
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<tr>
<td>Adult BMI Assessment</td>
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<td>1056</td>
<td>5</td>
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<td>Care for Older Adults – Medication Review</td>
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<td>9277</td>
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<tr>
<td>Care for Older Adults – Functional Status Assessment</td>
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<td>9277</td>
<td>5</td>
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<tr>
<td>Care for Older Adults – Pain Assessment</td>
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<td>-</td>
<td>9277</td>
<td>5</td>
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<tr>
<td>Osteoporosis Management in Women who had a Fracture</td>
<td>92</td>
<td>3</td>
<td>83</td>
<td>5</td>
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<tr>
<td>Diabetes Care – Eye Exam</td>
<td>1805</td>
<td>2</td>
<td>1711</td>
<td>5</td>
</tr>
<tr>
<td>Diabetes Care – Kidney Disease Monitoring</td>
<td>1440</td>
<td>3</td>
<td>1278</td>
<td>5</td>
</tr>
<tr>
<td>Diabetes Care – Blood Sugar Controlled</td>
<td>863</td>
<td>3</td>
<td>370</td>
<td>4</td>
</tr>
<tr>
<td>Controlling Blood Pressure</td>
<td>2202</td>
<td>3</td>
<td>816</td>
<td>4</td>
</tr>
<tr>
<td>Reducing the Risk of Falling</td>
<td>-</td>
<td>-</td>
<td>9277</td>
<td>5</td>
</tr>
</tbody>
</table>

*Captured during AWV
Benefits From Our Mobile Program

- Increases convenience by delivering healthcare to the member’s neighborhood
- Gives members who decline home or PCP visits another option to access care
- Multi-specialty services create a “one stop shop”, increasing the value of each visit
- Closes a higher number of quality and care gaps compared to other encounters
- Specialized providers, diagnostics, and assessment technology deliver improved coding/documentation

Can mobile clinics improve access and member engagement?

Manuel Gaidola, HIA, CPC
Director, Medicare Revenue Operations
Martin’s Point Health Care
A Multi-Pronged Approach

Market: Maine

Who Was Targeted:
- ~20,000 non-compliant members
- Were not engaging with PCP or home visits
- Existing gaps in care (Star & HCC’s)

Mobile Clinic Engagement Rate: 48%

Participant surveys showed 98% satisfaction rate
- “Convenience” was the primary benefit seen by members
Can mobile assessments enhance the quality of care delivered by primary care?

Comprehensive Services On Mobile Clinic

**MOBILE MEDICAL CENTER**
- Annual Wellness Visit
- Medication Review
- Gait/Cognitive Analysis
- Depression Screening
- Blood Pressure
- Vaccinations
- Basic Vision
- DRE
- Mammography
- EKG
- Spirometry
- Echocardiogram
- Ankle Brachial Index
- LEAD
- Abdominal Aneurysm Ultrasound
- Carotid Artery Ultrasound
- Phlebotomy Services

**FOLLOW UP OFFICE VISIT**
- Provider has single report with all findings from which to direct patient care.
Supporting Primary Care

- Engages patients who may not otherwise access care
- Identifies conditions that may have gone unchecked or undiagnosed
- Provides comprehensive clinical data for creating an improved patient care plan
- Physicians have more time to focus on treatment
- Assists providers by helping reach quality and coding goals

Do member incentives really impact engagement?

Ray Ekbatani
Chief Administrative Officer
HealthFair
Rewards/Incentives Requirements*

- CMS recognizes overall goal for RI programs is for enrollees to engage in their health
- Old RI requirements capped at $10 per occurrence and no more than $50 per year
- Medicare removed the dollar value cap on recent call letter, now tied to value of services
- All enrollees must be eligible
- Cannot offer “cash” or “monetary rebates”
- Offered in connection with entire service or activity

*42 CFR §422.134.

Case Studies
Incentives vs No Incentives

- **Case Study 1:**
  - Arizona Market
    - Year 1: No incentive offered – 27% engagement rate
    - Year 2: $25 gift card – 35% engagement rate

- **Case Study 2:**
  - Florida/South Carolina Markets (ACA Program)
    - Plan A: No incentive offered – 22% engagement rate
    - Plan B: $25 gift card – 38% engagement rate

- **Case Study 3:**
  - Texas Market
    - Plan A: No incentive offered – 30% engagement rate
    - Plan B: $25 gift card – 42% engagement rate
Rewards/Incentives Programs

- HealthFair data shows over 30% higher engagement with programs that offer incentives
- Focus group surveys concluded that $50 value would have the highest impact at lowest cost
- Incentives offered during visit are more attractive and can help improve show/completion rate
- When considering impact to quality and care, benefits far outweigh cost of incentive programs

Conclusion

- Mobile clinics can provide another option for members to access care and achieve higher engagement rates
- Take advantage of all opportunities to close HEDIS/Star gaps during your prospective encounters
- Increasing access to appropriately targeted testing can help recapture and identify new conditions
- A properly structured incentive program can have a significant impact on member engagement
- Prospective assessments can enhance patient care when properly coordinated with primary care
Building a Year Around Quality Improvement Strategy

Sarah Bellefleur, Director, Network Quality Network Management
SCAN HEALTH PLAN

Akash Patel, Chief Executive Officer
ADVANTMED

Dr. Scott Howell, Senior Executive
HERITAGE PROVIDER NETWORK
Sarah Bellefleur joined SCAN Health Plan in 2003 and has held a variety of quality improvement positions within the organization. She has been responsible for developing and implementing Special Needs Plans and other programs that serve vulnerable populations, notably the frail elderly and persons living with chronic illness. In her current role as the Director of Network Quality, she leads integration and collaboration efforts with providers, vendors, and research partners, as well as actively manages 5-Star initiatives and incentive plans aimed at improving health care delivery and quality outcomes.

Sarah holds master’s degrees in Social Work, Health Care Administration and Holistic Nutrition.
Akash Patel founded Advantmed in 2005 to address the increasing need for managed care organizations to optimize revenue and improve clinical quality outcomes. His company is committed to strengthening the health of the healthcare industry – one organization, one provider and one member at a time.

Prior to launching Advantmed, Akash served as Chief Financial Officer for various organizations in industries as varied as consumer electronics to BPO. His background and work experience paved the way for the cutting-edge technology Advantmed utilizes to increase program accuracy and efficiencies, while his formal education as a CPA has him mindful on the dollars and cents of the ROI of his client’s business needs.

In addition to his responsibilities at Advantmed, Akash sits on the board of directors of Aluratek, a consumer electronic company. He holds a Bachelor of Arts degree in Business from California Polytechnic State University of Pomona and is a Certified Public Account (CPA) in the State of California.
Dr. Scott Howell, is a senior advisor at Heritage Development Organization for national expansion through joint ventures, mergers / acquisitions and identifying enterprise-wide clinical solutions. Previously, Dr. Howell was the National Senior Medical Director and Chief Medical Officer for Network and Population Health at OptumInsight responsible for risk adjustment, quality performance, networks, predictive modeling and clinical consulting. Prior to Optum, Dr. Howell was the Regional Chief Medical Officer (RCMO) for the Northeast Region of AmeriChoice, Inc. focusing on the Medicaid and Dual SNPs populations. Prior to United Healthcare, Dr Howell was the Medical Director for Managed Care at the AIDS Healthcare Foundation, the first HIV SNP in the nation, along with responsibility for international consulting in Russia, Ukraine, Guatemala, Honduras and Haiti. Dr. Howell was the lead scientific advisor to Management Sciences for Health the prime contractor for PEPFAR in Haiti.

Dr. Howell is board certified in Family Practice, Preventative Medicine and Public Health and Addiction Medicine and has been in medicine for over 25 years.

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Dr. Howell has served the military for 23 years and his current reserve assignment is with the Office of Secretary of Defense (OSD) at the Department of Defense Inspector General (DoDIG) concentrating on the Wounded Warrior Program, BioAssurity, and Ebola Outbreak Assessment.

Dr. Howell has published peer-reviewed articles in both disciplines finance and medicine.
Building a Year Around Quality Improvement Strategies
Sarah Bellefleur
SCAN® Health Plan
03/07/2017

About SCAN

- MAPD in California (Medicare and Medi-Cal only)
- Started by seniors 40 years ago
- Currently 4-Star Plan (4.5 in 2016)
- Non-Profit Mission: Keep seniors healthy & independent
- 180,000 members in 12 counties (15% SNP)
Health Plan & Provider Strategies

1. Creating a Culture of Quality
   - Accessibility
     - “Coffee with Chris”
     - Legacy Team

2. Leveraging Data & Analytics

3. Aligning Incentives

Creating a Culture of Quality at the Health Plan

C-Suite Accessibility
- “Coffee with Chris”
- Legacy Team

Senior Representation
- Senior & Peer Advocates

Employee Engagement
- Customer Experience
- Focus Groups
Creating a Culture of Quality with Provider Partners

Education & Training
- 5-Star Webinars
- Office Staff Training

Tools
- 5-Star Pocket Cards
- Laminated Best Practices

Peer Engagement
- Round-Tables
- Recognition
- Feedback

Leveraging Data & Analytics at the Health Plan

Prioritization
- Ranking the network, on every measure
- Agree on the “Top 3”
- Aligning the message across ALL departments

Qualitative Data
- Development of “Provider Profiles”
- Minimize duplication

Continuous Monitoring
- YOY trends
- Early detection and prevention
Leveraging Data & Analytics with Provider Partners

**Actionable Reports**
- Quantify results (i.e., 10 more members = 4 Stars)
- Top performing vs bottom
- Health Check Records

**Prioritization**
- The power of the “Top 3”
- Identify priorities of other plans

**Identify Motivation**
- Incentive $  
- Prestige  
- Partnership/Branding

Aligning Incentives at the Health Plan

**Individual & Team Accountability**
- Development Plans & Performance all tie to Vision/Mission

**Healthy Competition**
- “Reach for the Stars” contest  
- Customer Experience Submissions

**Share Successes**
- All employees received Star Bonus’  
- Recognition

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Aligning Incentives with Provider Partners

**Communication**
- Monthly PIP reports
- Monthly meetings
- Maximum payout vs YTD
- Predictive scores

**5-Star “Plus”**
- Other Quality Measures
- Incentivize behaviors & interventions
- Invest in Programs (Provider to Home)

**Improvement Focus**
- Gateway measures (5-Star 101)
- Modified for low-volume providers
- Bonus “kicker”
- Contractual thresholds
Building A Year Around Quality Improvement Strategy

Integration Risk Adjustment, Quality & Care Management

Member

Prospective Risk Adjustment

Prospective Analytics

Prospective Interventions

Retrospective Risk Adjustment

Retrospective Analytics

Retrospective Interventions

Care Management

Care Analytics

Care Intervention

Quality & RX Improvement

Quality Analytics

Quality Interventions
Integration: Where Are We Going?

- Integration Between Lines of Business
  - Medicare
  - Medicaid
    - Fully integrated duals
  - Affordable Care Act (ACA)

- Integration Between Lines of Operations
  - Risk Adjustment
  - Quality / STARS / HEDIS®
  - Care Coordination / Disease Management
  - Compliance / Audit
    - Quality of reporting and execution
    - Accuracy of documentation and execution

Integration: Where Are We Going?

- Integration Between Stakeholders
  - Government
    - Medicare
    - Medicaid
    - ACA (individual / small group)
  - Providers
    - Contracting consistency and aligned incentives
    - Training
    - Tools
    - Information / feedback loop
  - Patients
    - Awareness / brand / one relationship
    - Social barriers
    - Logistical barriers (transportation)
Sample Flight Plan

Holistic programs drive results across the population:

- **Q1/Q2 - Focus on new members and members w/o visits**
  - Member Engagement
  - Preventative screening measures & education
  - Health risk assessments
  - HEDIS® gap closures

- **Q3/Q4 - Focus on Closing high value gaps in data/care**
  - Medical record review
  - Urgent HEDIS® gap closures
  - Renewal reminders
  - In home program

### Key initiatives on the pathway to integration

- **Q4 2016**
  - **STEP 1**
    - Supplemental Abstraction of Risk Adjustment Charts

- **Q3 & Q4 2017**
  - **STEP 3**
    - Member Engagement

- **Q3 & Q4 2018**
  - **STEP 5**
    - Full Integration

- **Q1 & Q2 2017**
  - **STEP 2**
    - Partial Retrieval & Abstraction for HEDIS

- **Q1 & Q2 2018**
  - **STEP 4**
    - HEDIS® Audit, Monthly Gap Reports, & MRR
Why Engage Members Now?

Benefits For Plans
- Fill the gaps in your data
- Identify barriers to care
- Great referral source for care management programs
- Reduce acute utilization and ER visits
- Reduce readmission rates
- Increase retention rates, keep more members each year
- Measure the effectiveness of health management resources

Benefits For Members
- Reduce healthcare costs
- Supplements treatment plan
- Identifies correct use of PCP vs. specialist
- Trusted resources and access to information specific to their conditions & behaviors
- Educational tips for healthy living and a higher quality of life

Engagement Results: HEDIS® Measures

Measure Compliance

- A1C Test
  - Members with No HEDIS Outreach: 58%
  - Members with at least 1 HEDIS Outreach: 82%
  - Fully Engaged Members: 85%

- LDL Test
  - Members with No HEDIS Outreach: 56%
  - Members with at least 1 HEDIS Outreach: 74%
  - Fully Engaged Members: 85%

- Eye Exam
  - Members with No HEDIS Outreach: 37%
  - Members with at least 1 HEDIS Outreach: 44%
  - Fully Engaged Members: 51%

- Kidney Test
  - Members with No HEDIS Outreach: 63%
  - Members with at least 1 HEDIS Outreach: 85%
  - Fully Engaged Members: 88%
Engagement Results: Acute Utilization

Utilization Statistics

<table>
<thead>
<tr>
<th></th>
<th>Members with No HEDIS Outreach</th>
<th>Members with at least 1 HEDIS Outreach</th>
<th>Fully Engaged Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP Visits</td>
<td>4.22</td>
<td>4.91</td>
<td>5.2</td>
</tr>
<tr>
<td>Specialist Visits</td>
<td>2.46</td>
<td>2.5</td>
<td>2.88</td>
</tr>
<tr>
<td>Hospital Days</td>
<td>1.62</td>
<td>1.58</td>
<td>1.39</td>
</tr>
<tr>
<td>ER Visits</td>
<td>1.26</td>
<td>1.02</td>
<td>0.96</td>
</tr>
</tbody>
</table>

Measuring Engagement Levels

HEDIS® Gap Closures Engagement Levels

- No Engagement: 8%
- Engaged - Appt Set: 19%
- Engaged - No Need for PCP: 13%
- Partially Engaged: 14%
- Minimally Engaged - VOI: 46%
Quality Optimization: Recent impact from collaborative client effort

As an example of the potential impact of our efforts, Advantmed recently worked in collaboration with another Puerto Rico based MA plan with a goal of significantly improving quality scores. For our part, Advantmed deployed our CQRO™ (Continuous Quality and Risk Optimization) strategies which included:

- Thorough analysis of all claims / encounter data, labs, pharmacy MMR and MOR files
- Health Risk Assessments (telephonic and in-home)
- Abstraction of HEDIS data from medical records retrieved for Fall and Jan sweeps RA
- Member engagement to drive PCP visits for wellness exams and identified service gap closure
- Provider care gap reports
- Monthly monitoring of HEDIS rates driving prospective interventions

Executing these programs in collaboration with our plan partner, we were (through joint effort) able to achieve the net results you see in the table to the right:

<table>
<thead>
<tr>
<th>ID</th>
<th>Measure</th>
<th>2015</th>
<th>2016</th>
<th>Net</th>
</tr>
</thead>
<tbody>
<tr>
<td>C01</td>
<td>Breast Cancer Screening</td>
<td>74%</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>C02</td>
<td>Colorectal Cancer Screening</td>
<td>65%</td>
<td>68%</td>
<td></td>
</tr>
<tr>
<td>C07</td>
<td>Adult BMI Assessment</td>
<td>75%</td>
<td>83%</td>
<td></td>
</tr>
<tr>
<td>C09</td>
<td>COA - Medication Review</td>
<td>58%</td>
<td>51%</td>
<td></td>
</tr>
<tr>
<td>C10</td>
<td>COA - Functional Status</td>
<td>82%</td>
<td>91%</td>
<td></td>
</tr>
<tr>
<td>C11</td>
<td>COA - Pain Screening</td>
<td>82%</td>
<td>92%</td>
<td></td>
</tr>
<tr>
<td>C12</td>
<td>OnMC</td>
<td>24%</td>
<td>26%</td>
<td></td>
</tr>
<tr>
<td>C13</td>
<td>CDC - Eye Exam</td>
<td>64%</td>
<td>68%</td>
<td></td>
</tr>
<tr>
<td>C14</td>
<td>CDC - Kidney Disease Monitoring</td>
<td>91%</td>
<td>99%</td>
<td></td>
</tr>
<tr>
<td>C15</td>
<td>CDC - Blood Sugar Controlled</td>
<td>34%</td>
<td>54%</td>
<td></td>
</tr>
<tr>
<td>C16</td>
<td>Controlling Blood Pressure</td>
<td>41%</td>
<td>43%</td>
<td></td>
</tr>
<tr>
<td>C17</td>
<td>ART</td>
<td>64%</td>
<td>72%</td>
<td></td>
</tr>
<tr>
<td>C19</td>
<td>Plan All Cause Readmissions</td>
<td>96%</td>
<td>92%</td>
<td></td>
</tr>
</tbody>
</table>

Key Takeaways

- Team Sport – Play it like one
- Communication is the catalyst that drives results
- Technology is a piece but not the entire solution
- Look externally as soon as possible
Sir William Osler

- “One of the first duties of physicians is to educate the masses not to take medicines”
- “It is much more important to know what sort of a patient has a disease than what sort of disease a patient has...”
- A good physician treats the disease; the great physician treats the patient who has the disease”
Year Round Quality

• Table top review of previous year to determine reason for non-compliance of measures, members and providers
  – Too busy chasing next year’s benchmark for strategy
  – Integrate approach pharmacy, network and medical management, claims and IT into discussion for solutions
    • Is the formulary STARs favorable; What is the Part D denial rate?
    • Are the right pharmacies/providers in the network?
    • Are claims processing correctly?

• There is a perception with STARs measure all beneficiaries are the same
• In fact, there is significant heterogeneity amongst beneficiaries within an MA population
• Different levels of human capacity to close quality gaps
  – Disease Burden: Major Depression, Protein Calorie Malnutrition, Hemiplegia, Active Cancer Treatment
  – Transportation, Care Giver Status, Living Alone
    • Social Determinants to closing gaps
Quadruple Aim

• The Triple Aim
  – enhancing patient experience,
  – improving population health, and
  – reducing costs—is widely accepted as a compass to optimize health system performance.

• Quadruple Aim
  – Burnout is associated with lower patient satisfaction, reduced health outcomes, and it may increase costs.
  – Burnout thus imperils the Triple Aim
  – Improving the work life of health care providers, including clinicians and staff

Bodenheimer, T., Christine Sinsky, C. Annals of Family Practice, From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider
Interplay of Star Ratings Performance and Compliance Initiatives

Osato F. Chitou, Esq., MPH, *Medicare Compliance Officer*
GATEWAY HEALTH
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.
INTERPLAY OF STAR RATINGS PERFORMANCE AND COMPLIANCE INITIATIVES

Osato F. Chitou, Esq., MPH
Medicare Compliance Officer

The Foundation

Plans should utilize an approach that encompasses cross-departmental initiatives and incentive programs around member and provider coordination of care and retention to maximize Star Ratings efforts.
Ensuring Interplay

<table>
<thead>
<tr>
<th>Direct connection with Plan membership</th>
<th>Program Development that focuses on Care Coordination and Quality Improvement.</th>
<th>Member and Provider engagement</th>
<th>Reliance on Data Analytics</th>
<th>Stakeholder Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome Call Campaigns</td>
<td>Health Risk Assessment</td>
<td>Member Incentive Programs</td>
<td>Star measures and key performance dashboards for internal and external data trending analysis &amp; summary reports</td>
<td>Star Ratings Program Employee Trainings</td>
</tr>
<tr>
<td>New Member / Benefits Orientations - Member Seminars</td>
<td>MTM Program</td>
<td>Provider Office Staff Incentives</td>
<td>Annual data/survey analytics summaries (HEDIS/CAHPS/HOS)*</td>
<td>Business interviews and KPI assessments</td>
</tr>
<tr>
<td>Birthday Cards w/Annual Wellness Visit/Physical Reminders</td>
<td>Medication Adherence Initiatives</td>
<td>Outreach for Stars/HEDIS/HC</td>
<td>Routine reporting to senior leadership</td>
<td>Clinical-focused Workgroups</td>
</tr>
<tr>
<td>Quarterly Member Newsletters</td>
<td>Post-discharge &amp; Readmission Prevention Programs</td>
<td></td>
<td></td>
<td>Regular updates to senior leadership &amp; Board</td>
</tr>
<tr>
<td></td>
<td>Care Management Programs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Quality Improvement Projects</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chronic Condition Improvement</td>
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</tbody>
</table>

Management Program Oversight

- Stars program success starts at the top with Senior leadership effectively communicating the legitimacy of the program.

- **It is imperative that it is Cross-functional** - consisting of representatives from key business areas including Compliance established to routinely assess business initiatives (clinical and administrative), determine effectiveness and recommend improvements.

- **Internal and external feedback** through surveys and call center activities in addition to other qualitative data such as appeals and grievances trending.

- **Ongoing progress of performance activities** reported to senior leadership (e.g. Operations, Quality and Compliance Committees, Board of Directors) on a regular basis.
The Compliance Perspective

Medicare Compliance Officers interact with and impact Star ratings across the spectrum of the Compliance Officers' responsibilities:

- Star Measure Performance
- Process Integrity
- Data Submission
- Performance Monitoring
- Risk Assessment and Audit Workplan Development

Compliance oversees activities that can influence performance for specific Star Measures

- Plan makes timely decisions about appeals
- Call Center – Foreign Language Interpreter and TTY availability
- Beneficiary Access and Performance Problems
- Complaints about the Health Plan/Drug Plan
- Customer Service
- Getting Appointments and Care Quickly
Star Measure Process and Data Integrity

Compliance is responsible for monitoring processes to confirm accuracy of data provided to CMS

- Erroneous data submission to CMS
- Potential Reduction of Ratings

Medicare Compliance Officers can take specific actions to monitor and manage performance

- Identify and Monitor Stars-related risks
- Work in concert with business owners to determine initiatives and interventions
- Monitor anticipated Star Measures performance
- Anticipate future Star Ratings
- Monitor Display Measures for anticipated future performance
RADV, RAC, and Recent Enforcement Actions: The Changing Landscape of Risk Adjustment Compliance

Moderator:
Biggs Cannon, Senior Managing Director
FTI CONSULTING

Panelists:
Dr. Scott Howell, DO
HERITAGE PROVIDER NETWORK

Daniel Meron, Partner
LATHAM AND WATKINS

Wayne Gibson, Senior Managing Director
FTI CONSULTING
Biggs Cannon is a Senior Managing Director in the Health Solutions practice at FTI Consulting. He is based in Washington D.C.

Mr. Cannon has worked with managed care organizations, retail pharmacies, pharmaceutical companies, and government agencies where his areas of expertise include data compliance and process improvement, advanced database development and maintenance, advanced data querying and analysis, data mining and manipulation, quantitative analysis, project management and general litigation support.

Mr. Cannon has worked extensively with Medicare Advantage plans, helping identify potential compliance concerns while supporting and educating internal resources on appropriate ways to remediate identified issues. He has lead the identification, reconciliation and reprocessing of Medicare Advantage submissions to CMS as well as the quantification of potential repayments related to those reprocessed submissions. He has also led process improvement initiatives for these plans to put compliant policies and procedures in place in these organizations going forward.

Mr. Cannon has also worked with payor owned physician groups to support their Medicare Advantage submissions and help maximize their financial return. He has led efforts to review physician charts and determine historical risk within groups as well as provided guidance on steps to minimize risk going forward. He has also led efforts to identify erroneous submissions, assess solutions to remediate correctable submissions and calculate potential risk adjustment factor (“RAF”) lift related to the remediation efforts.

Mr. Cannon has supported several major managed care organizations, retail pharmacies and pharmaceutical companies through complex litigations and disclosures involving intensive data collection and analysis. During these engagements he has worked with various members within the client organizations to gather systems information, identify and collect key data elements, and perform analysis on this data using various platforms.

Mr. Cannon holds an MBA along with a BS in Neuroscience from The College of William & Mary.
Dr. Scott Howell, is a senior advisor at Heritage Development Organization for national expansion through joint ventures, mergers / acquisitions and identifying enterprise-wide clinical solutions. Previously, Dr. Howell was the National Senior Medical Director and Chief Medical Officer for Network and Population Health at OptumInsight responsible for risk adjustment, quality performance, networks, predictive modeling and clinical consulting. Prior to Optum, Dr. Howell was the Regional Chief Medical Officer (RCMO) for the Northeast Region of Americhoice, Inc. focusing on the Medicaid and Dual SNPs populations. Prior to United Healthcare, Dr Howell was the Medical Director for Managed Care at the AIDS Healthcare Foundation, the first HIV SNP in the nation, along with responsibility for international consulting in Russia, Ukraine, Guatemala, Honduras and Haiti. Dr. Howell was the lead scientific advisor to Management Sciences for Health the prime contractor for PEPFAR in Haiti.

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Dr. Howell has published peer-reviewed articles in both disciplines finance and medicine.
Daniel Meron is Global Co-chair of Latham & Watkins’ Healthcare & Life Sciences Practice, as well as Co-chair of the firm’s Healthcare Services & Providers Industry Group. He is in the Litigation & Trial Department of the firm’s Washington, D.C. office and is also a member of the Supreme Court & Appellate Practice.

Mr. Meron has deep regulatory, investigatory and litigation experience across a broad range of healthcare and life sciences matters, from product approval, exclusivity determinations and promotional regulation by the US Food and Drug Administration (FDA) to coverage and reimbursement regulation by the Centers for Medicare & Medicaid Services (CMS), including fraud and abuse and white collar enforcement investigations and litigation. Mr. Meron focuses his practice on providing sophisticated counseling and advocacy (regulatory, investigative and litigation) to members of the pharmaceutical, biotech and medical device industries. He also represents providers.

Mr. Meron is consistently recognized as one of the leading healthcare lawyers in the country, most recently as a “Health MVP” by Law 360 (2016). He has been repeatedly named a leading lawyer by The Legal 500 US and Chambers USA, in which sources applaud him for his “quality, reliable advice in time-sensitive situations.” In addition, Legal Media Group — a part of Euromoney Institutional Investor PLC — has identified Mr. Meron as one of the “stars” in the area of government investigations and fraud & abuse (2013-2016) and Nightingale’s Healthcare News named him one of the top 10 outstanding healthcare fraud and compliance lawyers.

Mr. Meron joined Latham from the United States Department of Health and Human Services (HHS), where he served as General Counsel from 2006 to 2007. At HHS, he supervised the work of approximately 500 lawyers and was heavily involved in advising the HHS’s leadership on sensitive and high priority matters involving all of the key statutes and regulations that HHS enforces, including the Food, Drug and Cosmetic Act and the Medicare and Medicaid statutes, as well as the federal Anti-Kickback Statute. As General Counsel, Mr. Meron worked closely with the Office of Inspector General in coordinating positions on enforcement matters relating to FDA and CMS statutes and regulations. During his time at HHS, Mr. Meron also served as a senior policy advisor to Secretary Mike Leavitt on the Secretary’s healthcare transparency initiative.

Prior to his service at HHS, Mr. Meron was the Principal Deputy Assistant Attorney General for the Civil Division of the US Department of Justice (DOJ), where he supervised approximately 735 lawyers litigating thousands of cases. His duties as Principal Deputy included oversight of the Division’s healthcare civil fraud (False Claims Act) and off-label promotion prosecutions, as well as defense of FDA and CMS regulations, policies and reimbursement decisions.

Prior to joining the DOJ, Mr. Meron was an appellate and regulatory litigation partner in the Washington, D.C. office of another international law firm.

Mr. Meron has argued approximately 15 cases in the US federal courts of appeals, including two appeals en banc, has argued numerous dispositive motions in the federal district courts and has led or co-led a number of trials, including a US$40 million dollar arbitration that ended in complete victory for his client.

Mr. Meron served as a law clerk to Justice Anthony M. Kennedy of the US Supreme Court and to Judge Laurence H. Silberman of the US Court of Appeals for the D.C. Circuit.
Wayne Gibson is a Senior Managing Director at FTI Consulting and is based in Washington, DC. He is part of the Health Solutions segment. He has 20 years of experience applying economic and financial modeling, data-intensive analysis, and complex claims analyses across numerous industries and in a variety of operational, dispute and compliance matters.

He has assisted health plans, providers, pharmaceutical manufacturers and PBMs with in a variety of matter types including operational improvement and compliance consulting, nationwide class-action litigation, Medicare and Medicaid false claims and sales and marketing investigations, investigations by other government agencies, and arbitration matters. Significant types of matters Mr. Gibson has worked on include:

Risk Adjustment Operational Improvement and Compliance Assessments – assisted Medicare Advantage plans, ACA exchange-based plans, trading partners/vendors, and providers under risk contracts in an end to end assessment and redesign of work flows and data flows, policies and procedures, controls, reporting and forecasting related to their Medicare Advantage and risk adjusted populations. Has also performed reviews of systems and programming logic used to filter encounters to assess compliance with Medicare Advantage and Managed Medicaid requirements. Has worked with clients to develop and implement interim and ‘bridge’ applications that provided added functionality in managing populations subject to risk adjustment. Has supported plans in RADV and other regulatory reviews. Has assisted in contractual disputes regarding payments from health plans to provider groups under shared risk agreements.

Medicare and Medicaid Investigations – assisted a variety of clients including health plans, pharmaceutical manufacturers, institutional providers, diagnostic lab testing companies, and their outside counsel in responding to governmental investigations and in conducting internal investigations related to Medicaid and Medicare false claims and fraud and abuse issues as well as how these issues may impact statutory and SEC reporting. These investigations encompass issues such as reimbursement, pricing, Medical Loss Ratios and cost reporting, and sales and marketing. As part of these investigations has assisted clients and their counsel in discussions with the DOJ, OIG, state Medicaid and regulatory agencies, and the SEC.

Compliance and Operational Reviews – assisted a variety of clients with compliance reviews related to Medicare Advantage, Fee for Service Medicare and Medicaid programs. He has also performed other contractually-mandated reviews, and operational assessments of controls, data and information systems, and relationships with third parties/sub-contractors.

Litigation and Commercial Disputes (Healthcare and Other Industries) – assisted a variety of clients and their outside counsel in defense of nationwide class-action matters, federal and state court litigation,
international arbitration, and arbitration and mediation matters. Has developed and submitted expert reports on damages in a number of forums and has testified in arbitrations.
RADV, RAC, and Recent Enforcement Actions: The Changing Landscape of Risk Adjustment Compliance

RISE CONFERENCE, NASHVILLE, TN
March 2017

Presenters

Moderator

• Biggs Cannon
  • Senior Managing Director, FTI Consulting

Panel Members

• Dr. Scott Howell
  • Senior Executive, Heritage Provider Network

• Wayne Gibson
  • Senior Managing Director, FTI Consulting

• Daniel Meron
  • Partner, Latham & Watkins, LLP
Medical Group Compliance

Scott C Howell, DO, MPH&TM, CPE
Senior Executive, Heritage Provider Network

Sir William Osler

“No human being is constituted to know the truth, the whole truth and nothing but the truth; and even the best of men must be content with fragments, with partial glimpses, never the full fruition”
Medical Group Compliance

• Large integrated delegated medical groups have their own risk adjustment departments
  – Well defined process of concurrent coder review
    • Most primary care physicians capitated
    • Completeness of encounter submission
  – In-house retrospective chart review - specialists
  – Medical chart reviews for additional suspects
  – Evidence-based chronic disease screening programs
  – Some have developed NLP for chart review recognition

Medical Group Compliance

• How much risk are delegated medical groups to RADV audits?
  – Every year more membership is assigned to medical groups with percent of premium contracts
  – Health plan has RADV audit exposure; how will this be attributed to medical groups?
    • If medical groups have above average compliance programs why should they have exposure to plan RADV?
    • Medical Groups have less capital to weather significant premium ‘clawbacks’
Meet the New Boss...Same as the Old Boss?

Past experience with RADV:

- CMS RADV (Contract) - 2007-37 Audits, $14M
  Targeted: 30 Plans, No Extrapolation

- CMS RADV (National) – Annual Sample of Beneficiaries
  2013 Improper Payment Rate 3.4%

- OIG RADV
Meet the New Boss...Same as the Old Boss?

RADV Today:

- CMS RADV – 2011 (30), 2012 (30)
  
  *Still Targeted, Extrapolation, FFS Adjuster*

- ACA RADV
  
  *Every Issuer, Enrollment Validation, Plans Incur Cost*

RADV Tomorrow:

- RAC Expanded to MA (No Timeline)
  
  *‘Traditional’ RADV*

  *Condition-specific RADV*

- ACA RADV (ACA?)
Meet the New Boss...Same as the Old Boss?

Keys:

- Sound internal validation processes
- Potential differences in validation rules
- Record retrieval and review process (has a big impact)
- Ability to model potential impact
Recent Legal Developments Related to Risk Adjustment Data

- Plans' obligations to investigate the validity of their diagnosis codes has recently been the subject of litigation.
  - **Swoben**: the government has intervened in a case alleging that MA plans have deliberately avoided the detection of unsupported diagnosis codes in bad faith. The Ninth Circuit recognized potential FCA liability for a health plan that deliberately structured its review in bad faith to avoid the identification of unsupported diagnosis codes.
  - **Burwell**: MA plans have sued the government under the APA, claiming that a rule governing the identification of overpayments violates the statutory mandate of actuarial equivalence for risk adjustment data. Litigation is pending.

Issues and Ramifications

- MA plans’ obligations to identify over coding is not yet clearly defined.

- Existence and scope of reasonable diligence unclear and subject to litigation.

- Potential ramifications of Swoben, Burwell et al.
RADV, RAC, and Recent Enforcement Actions: The Changing Landscape of Risk Adjustment Compliance

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Aligning Your Legal, Compliance and Risk Adjustment Initiatives – Taking A Collaborative Approach

Ryan Dodson, Director, Risk Adjustment
FIRST CHOICE MEDICAL GROUP

David Meyer, Vice President, Risk Adjustment, Encounters, Coding and Audit
SCAN HEALTH PLAN
Ryan C. Dodson  
Director of Risk Management, First Choice Medical Group

His background is in management and operational processes for 15 years and in risk adjustment for 8 years. His experience in risk adjustment has been demonstrated in helping providers in southern California raise their RAF scores through better chart documentation and chart audits. Mr. Dodson helped coordinate a 10,000 member group raising their RAF average from a .959 to a 1.4 in a 3 year period. Ryan ensures that the group is documenting correctly according to CMS guidelines, and not submitting erroneous diagnoses. He demonstrates an excellent team attitude and can be counted on as a go to resource on projects. Providers and administrators appreciate his passion and straightforward approach in training on the risk adjustment model. Recently Ryan helped a small population move their score up 75% in a 5 month period through chart reviews and provider training. Ryan is currently working on helping various groups within southern California raise their RAF score through chart review and provider trainings. Ryan can be counted on to set up an operational product that will assist provider groups and health plans raise their scores on various size groups.


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.
Risk Adjustment, Legal & Compliance

David Meyer
VP Informatics, SCAN Health Plan
RISE: 11/11/2016

Compliance & Legal
A bit About SCAN:

- Founded in 1977
- Nation’s 4th largest not-for-profit MAPD
- ~170K Mbrs – all senior business
- 4.5 in 2014 => 4.0 in 2015 => 4.5 in 2016 => 4.0 in 2017

<table>
<thead>
<tr>
<th>Age Groups of SCAN Members</th>
<th>&lt;65</th>
<th>65-69</th>
<th>70-74</th>
<th>75-79</th>
<th>80-84</th>
<th>85-99</th>
<th>100+</th>
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<tbody>
<tr>
<td>SCAN has 203 members who are centenarians</td>
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Member Satisfaction

- These are the numbers that matter most: How do our members rate us?
- 97.4% of SCAN members are satisfied overall with the SCAN program
- 92.3% of members say that SCAN has helped them manage their health
- 85.8% of members say that SCAN has improved their ability to live independently
A bit about Health Care Informatics Team: A Key SCAN Advantage

All Impacted by Legal and compliance

Coding
QI
RA
STARS
HEDIS

My GC (slightly tongue in cheek)

• “If in doubt, check with me.”
• “Even if not in doubt, check with me.”
• “No sloppy emails...about anything.”
• “Simple clear messages to everyone.”
• “If in doubt, make the choice you assume a regulator would want you to.”
• “And check with me about that.”
The environment we find ourselves in...

Wisdom of the Simpsons

Donald Trump (R)  
Electoral Votes 279  
59,704,886 Popular Votes
The Skinny from SCAN’s Washington Team

3 Big Themes for Healthcare:
• Repeal and replacing Obamacare,
• Tax reform,
• Medicaid and potentially Medicare reform

The Good News:
• House Ways and Means (MA friendly)
• Sen Schumer (Senate Minority Leader – MA fan)

SCAN “tea leaves” (Contract & Rev)

• Plan exists: We estimate about ~ 280 contracts by 2018
• Increasing difficulty to maintain / improve STARS & revenue outlook
  – (note CMS position on CQI)
• Grassley Letter => Implications
  – Increasing role / frequency of Audits with existing and new players
  – Just re-elected in 2016
Links:

- Grassley Letters (June 2016):

- Yates Memo:
  [https://www.justice.gov/dag/file/769036/download](https://www.justice.gov/dag/file/769036/download)

- Center for Public Integrity:

Quality Driver?? Case in Point...

Enrollment in Medicare Advantage Contracts, by Contracts’ Star Quality Rating, 2013-2015

- 2013:
  - 7% 5 Stars
  - 14% 4.5 Stars
  - 37% 4 Stars
  - 20% 3.5 Stars
  - 4% 3 Stars
  - 4% No rating

- 2014:
  - 8% 5 Stars
  - 24% 4.5 Stars
  - 32% 4 Stars
  - 13% 3.5 Stars
  - 2% 3 Stars
  - 1% No rating

- 2015:
  - 8% 5 Stars
  - 21% 4.5 Stars
  - 32% 4 Stars
  - 8% 3.5 Stars
  - 6% 3 Stars
  - 2% No rating
But what is REALLY going on…

The RFI

- CMS issued RFI
  [https://www.fbo.gov/index?s=opportunity&mode=form&id=83f1ec085c52a81a6a6ce7cba3fbc5d&tab=core&cview=0](https://www.fbo.gov/index?s=opportunity&mode=form&id=83f1ec085c52a81a6a6ce7cba3fbc5d&tab=core&cview=0).

- CMS looking for 1 + Recovery Audit Contractor (RAC) for:
  - Incorporating RACs into RADV audit process
  - Add targeted Audits on high-error diagnoses reported but not subject to a RADV for the same payment year

- CMS noted that the agency is required by law to use RACs
RAC RFI Points of Interest:

• Payment made to the RAC only from amounts recovered (page 1)
• Audits would be called “RADVs” & CMS would like to eventually conduct one for each health plan each year. (page 2)
• RADVs would be either random or Dx focused
• The entire selected record is reviewed (page 6)
• Not clear if this would replace the current RADV program, or be a supplement

RAC RFI Points of Interest: (cont)

• Record selection would be based on a statistically valid random sample (page 6)
• The number of records will be determined by CMS based on: (page 8)
  – The number of audited contracts
  – The sampling methodology
  – CMS’ rules regarding the number or records will be based on multiple factors, including the CMS-HCCs in a focused audit
RAC RFI Points of Interest: (cont)

- CMS controls the development of a Coder Guidance Document (page 7)
- A panel of coders may be convened to discuss and resolve problematic coding issues
- **Condition Specific RADV Audits** will be conducted for a subset of MA contracts not subject to a Comprehensive Audit for any given payment year (page 15)

RAC RFI Points of Interest: (cont)

- Similar to current RADVs in that there is an Lead Contractor and a Secondary Review Contractor. (page 4)
- CMS controls the development of the Coder Guidance Document…but it appears that the RAC must write their own. (page 22)
- There is no indication of how soon CMS will be making a decisions on next steps.
Some More Other “Stuff”:

- Kwashiorkor & other “almost” never events
  - AMIs Office Setting
  - Single instances of cancer
- Phase in of EDS
  - Err rates range from ~3% to 15%
  - Driving Delta: Logic differences, Error’d Data, Missing data
  - What if your HP doesn’t have a delta…

The Audit Players…
LEGAL & COMPLIANCE
Reality…

- Compliance & Legal will either be a house guest or an intrusive Voyeur. Either way, they are in.
- HP BOD expects at least a verification role

Possible Roles in a RADV:
- Proactive general review of plan
- Point of escalation for physicians not providing chart attestations
- Role on QA'ing CDAT load

Some RA Controls at SCAN:

1. “Never Events” (audits => filters)
2. Education on concern issues
   - CMS generated notices on specific issues
   - Results of a SCAN audit
3. Conservative “stake in the ground” for coding – 100% focus on ICD guidelines
4. List of contingencies identified and vetted to maintain day-to-day and audit operations.
5. Executive group oversight (CQOC)
Good luck!
Compliance, Encounter Data, SNP Plans, and Your Bottom Line

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

I. Why compliance with HRA and ICP requirements is necessary to ensure improved outcomes for SNP beneficiaries and will directly impact your bottom line

II. How SNP Plans can utilize encounter data to better coordinate care for SNP beneficiaries

III. Criticality of communicating your plans SNP MOC requirements to all stakeholders

IV. Tips for effectively auditing and monitoring your plans MOC performance metrics
I. Why compliance with HRA and ICP requirements is necessary to ensure improved outcomes for SNP beneficiaries and will directly impact your bottom line

The Medicare Modernization Act of 2003 (MMA) established an MA CCP specifically designed to provide targeted care to individuals with special needs.

In the MMA, Congress identified “special needs individuals” as:

1) institutionalized individuals;
2) dual eligibles; and/or
3) individuals with severe or disabling chronic conditions, as specified by CMS.

HRA & ICP Requirements

The quality and content of the Health Risk Assessment should identify the medical, functional, cognitive, psychosocial and mental health needs of each SNP beneficiary.

The content of, and methods used to conduct the HRA have a direct effect on the development of the Individualized Care Plan. The ICP

- ensures that the member’s needs and preferences are addressed.
- is updated/revised at minimum, annually or when the member’s health status changes through ongoing member evaluation and coordination of services and benefits.
- is communicated to the member and/or caregiver and shared with the PCP/providers
Impact of Timely Completion of HRA and ICP

Completing an initial Health Risk Assessment (and annual reassessments) with the member, coupled with developing the Individualized Care Plan with the member, PCP and an Interdisciplinary Care Team (ICT) ensures:

- That the member’s healthcare needs and information is shared across appropriate healthcare staff and facilities, as needed
- That there is a coordinated delivery of services and specialized benefits that meet the member’s needs
- That members are assisted with care transitions

SNP Compliance and Bottom Line Impact

HRA & ICP completion

Proactive Member Interventions

Improved Health Outcomes

Improved Health Outcomes
II. How SNP Plans Can utilize encounter data to better coordinate care for SNP beneficiaries

MA encounter data is more comprehensive than RAPS data because they include information that originates from a wider range of provider types.

This significantly expands the scope of sources for diagnosis and other information. In addition to physicians and hospital inpatient and outpatient facilities, many other provider types including ambulance providers, clinical laboratories, durable medical equipment suppliers, home health providers, mental health providers, rehabilitation facilities, and skilled nursing facilities report encounter data.

These data metrics can subsequently be utilized to understand your population and coordinate care.

III. Criticality of communicating your plans SNP MOC requirements to all stakeholders

Define Stakeholders of your SNP MOC:
- Members
- Providers
- Community Based Providers
- Care Management Team

Why requirements must be communicated:
- Facilitates collaboration in the development of the ICP
- Encourages the member to continue treatment established in the care plan
II. Monitoring & Auditing your MOC Performance Metrics

- Managing your plan's data and the collection process is a critical part of performance improvement. The essential components of this are:
  - collecting, tracking, analyzing, interpreting and acting on what the data presents
- Present the gaps in data/metric findings to your executive sponsor for the MOC.
- Focus on evidence-based measures that your plan is able to collect
- Focus on adherence to evidence-based guidelines in order to drive better provider practices.
  - This also helps guide your benchmarks and insight into where you stand relative to other national and state goals.
- Ensure that metrics can be mapped or reported by the current care management system. Prioritizing work with meaningful data leads to improved outcomes

Questions

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