Track C
Optimizing Care and Outcomes Across Episodes of Care

Dr. Robert London, Senior Medical Director
WELLCARE HEALTH PLANS, INC.

Dr. Kevin Kearns, Chief Medical Officer
ADVANCE HEALTH
Dr. Robert S. London is the senior medical director for South Carolina. He is responsible for overseeing the medical services and quality results for WellCare of South Carolina. In this role, London provides medical leadership for the effective care integration of pharmacy operations, utilization/case/disease management activities and quality improvement activities. He reports to Kathy Warner, WellCare’s state leader for South Carolina. In addition to his market role, Dr. London leads a number of corporate projects involving informatics, medical management, and IT related subjects.
Bio: Kevin Kearns, M.D. is a Board Certified Internist with a diverse background in medical management, clinical practice, managed care and academic medicine. Prior to joining Advance Health, Dr. Kearns served as Corporate Vice President and Senior Medical Director at Universal American, where he developed and implemented medical management strategies to enhance the Healthy Collaboration Model for the Medicare Advantage membership. Previously, Dr. Kearns held senior positions at UPMC Health Plan and Coventry Health Care of Delaware. Dr. Kearns received his undergraduate degree in Biology from St. Joseph University and completed medical school at the Pennsylvania State University College of Medicine. Dr. Kearns completed his internship in Internal Medicine at the University of Maryland and his residency at Thomas Jefferson University Hospital.
Why In-Person Care Management?

“In-person care management was the most effective intervention across all five diseases... (it) is the best intervention to use to generate cost savings and improve clinical outcomes.”

- **Savings per patient; impact of in-person care management on COPD cost:** $13,000
- **Decrease in hospital utilization attributed to in-person care management:** 16%
- **Reduction in CHF hospital readmissions within 6 months through in-person care management; others failed to see a difference when telephonic interventions were applied:** 74%
- **Increase in routine visits when in-person care management was employed:** 39%

Who to Target and Why

On a national level, 96% of expenditures are for medical services, while only 4% are directed to preventive care*

Target high utilizers in partnership with health plan
  • Members where the system isn't working
  • Members where you can realistically make a difference

Top 5% of people annually spend $47,000 on average
  • Example of 1,000 member cohort
  • Target of reducing pre-intervention spend by 20%

Why the Home

Coaching/Care Transition Management

Understand Safety & Support Issues

Proactive Identification, Prompt Information Forwarding

Medication Reconciliation

Family and Patient Education

Chronic Condition Care Coordination

Member Activation and Engagement

Nurse Practitioners have the training, judgement, and licensure to prescribe, treat, and focus on primary/preventive care.


** Source: Agency for Healthcare Research & Quality, Medical Expenditure Panel Survey, Household Component, 2014

Care Management Overview

Identify High Risk Cohort

Comprehensive Assessment
60-75 minute initial visit in the home or facility

Risk Stratification*
*Based on assessment findings, client provided claims and supplemental data

High  Moderate

Program Components

Collaboration / communication across episodes of care and healthcare settings

Recurring home visits, plus ongoing telephonic care coordination

Comprehensive risk identification and care coordination; outcomes and care optimized via performance monitoring

Clinical Team

Care plans in coordination with member’s health team; engage member and caregivers to achieve goals
Readmission Prevention Program

- Pre-discharge risk assessment to identify key risk factors that can lead to unnecessary hospital readmissions; schedules the post-discharge home visit
- NP uses assessment for documentation and decision support; data sent to clients and providers
- Members are assigned to care management staff for possible follow-up or intervention by the provider

Client Reported Outcomes
- Program was 15% cheaper vs. internal health plan program
- Program provided 5x ROI
  - ROI doesn’t include revenue for risk adjustment HCC capture or STARS bonus

![Graph showing 61% reduction in readmissions]

Confidential & Proprietary
Hypertension

- Most common condition in Medicare enrollees (58%)
- Single largest risk factor for cardiovascular disease mortality, 45% of all CVD deaths
- $42.9 billion medical spend in 2010
- 2/3 of seniors with hypertension have multiple chronic conditions

- 25% of seniors are treated, but not controlled
- Control can reduce unnecessary utilization and future risk of MI, CAD, stroke, CHF, and ESRD by 30%

Plan Conditions & High Risk Status

Addressing Hypertension

Assessment application identifies high risk cohort to trigger program

- Cohorts
  - Care management program (high risk)
  - Plan care management program (low/moderate risk)

A 10mmHg lower systolic blood pressure (SBP), or 5mmHg lower diastolic blood pressure (DBP), is associated with an approximately 20–25% lower risk of coronary heart disease (CHD) and an approximately 40% lower risk of stroke.

Results:
- **85%** Engagement for high-risk, least adherent population of chronic condition management
- **73%** of members sustained BP goal of 140/90 or less


Diabetes in America

Cost of diagnosed diabetes has risen to $245 billion in 2012 from $174 billion in 2007, a 41% increase

- 29.1 Million Americans have diabetes
- $1 in $3 Medicare dollars is spent caring for people with diabetes
- 86 Million Americans have prediabetes
- $322 Billion in healthcare dollars is spent caring for people with diabetes
- $1 in $5 is spent caring for people with diabetes

Source: American Diabetes Association: Economic Costs of Diabetes in the U.S. in 2012

Confidential & Proprietary
Addressing Diabetes

- Designed to address rising costs and fragmented care within chronic diabetes management
- Proactively target members who benefit from an in-home visit
- Standardized functional assessment with risk scores

Program Results

- 39% at A1C goal (vs 0 for control group)
- 82% at LDL goal (vs 0 for control group)

Program Results

Gaps in Care Closure

- Colonoscopy: 68% improvement
- Dexta Scan: 79% improvement
- FOBT: 80% improvement

Total Number of RX per group

- Control: 12,815
- Treatment: 13,928

Total Number of Office visits

- Control: 10,461
- Treatment: 11,555

Inpatient Admission Cost

- Control: $2,211,816
- Treatment: $1,940,553
SNF-ist Program

• Some hospital transfers, ER visits, observation stays, hospital admissions, and readmissions are “avoidable,” “preventable,” or “unnecessary”

• CMS study in Georgia - Expert ratings on potentially avoidable hospitalizations suggest up to 68% of hospitalizations are avoidable¹

¹ Ouslander et al: J Amer Ger Soc 58: 627-635, 2010

Impact on Residents

“Going to the emergency department can actually be somewhat traumatic for a nursing home patient. They're waiting a long time, sometimes in the hallway with a lot of commotion, and it's definitely not a comfortable environment. And these are patients who are going to be sensitive to different environment, in terms of delirium. If a visit to the ED can be avoided, it should be.”

-Renee Hsia, MD
Emergency Department Physician at the University of California San Francisco Department of Emergency Medicine.
Impact on Residents

Hospital transfers in this population frequently result in:

- Increased Cognitive and Functional Decline
- Iatrogenic Disease/Complications
  - Delirium, falls, incontinence, and/or nosocomial infections
- Adverse Drug Events
- Death

Ouslander, Weinberg, & Phillips, 2000; Pedone et al., 2005

Components of Plan

- Actively engage member and family caregivers to focus on achieving personalized care goals
- Collaboration / communication across episodes of care and in planning for future transitions (e.g., end-of-life palliative care)
- EMR optimizes care and outcomes via performance monitoring and continuous quality improvement
- Develop care pathways for resident clinical presentations

Nurse Practitioner
SNF-ist Results

33% decrease in admits / 1K (pre-program vs. program)

<table>
<thead>
<tr>
<th>Top Admission Reasons-All Markets</th>
<th>%</th>
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<tbody>
<tr>
<td>Mental Health</td>
<td>22%</td>
</tr>
<tr>
<td>Respiratory Related</td>
<td>18%</td>
</tr>
<tr>
<td>UTI/Renal Related</td>
<td>15%</td>
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</table>

< 30 Day Readmission Rates - ABC Plan

< 30 Day Readmission Rates - XYZ Plan
The Radical Primary Care Model that Led to what CMS Called “The Most Successful Demonstration in Medicare History”

Dr. Damien Doyle, Medical Director
JOHNS HOPKINS HEALTHCARE MEDICARE ADVANTAGE

Kevin P. Murphy, Chief Executive Officer
PRINCIPIUMHEALTH

Steven Counsell, Chief Medical Officer
PRINCIPIUMHEALTH
Dr. Doyle is a board-certified Family Practice and Geriatrics physician. He completed his undergraduate and medical school training at the University of Wisconsin – Madison before pursuing a Family Medicine residency at the University of North Carolina Chapel Hill program in Greensboro and a Geriatrics Fellowship at Wake Forest University in Winston-Salem, North Carolina. After moving to the Washington DC area in 2001, he was in private practice in Northern Virginia for several years before moving to the Hebrew Home of Greater Washington in 2003. He directed the outpatient clinics and assisted living facility at Hebrew Home until 2008 when he assumed the role of Medical Director of the Hebrew Home campus. In 2011 he became Medical Director of Evercare MidAtlantic (now Optum Health) overseeing care of enrollees in over 65 facilities in Maryland, Washington DC and Virginia in addition to a large and growing community based program. In September of 2015 he moved to Johns Hopkins HealthCare LLC to help implement and oversee the new Medicare Advantage MD program. He continues to see geriatrics patients at the Landow House Assisted Living Facility of Hebrew Home.

Dr. Doyle has been involved in numerous advanced care protocols and has served on the regional boards of the American Geriatrics Society and the American Medical Directors Association. He has been involved in numerous state-wide initiatives including the Governor’s task force on Health Information Exchange, the Maryland Medical Orders for Life Sustaining Treatments and the Transitions in Care Initiative. He was a clinical professor of Geriatrics at both Georgetown University and the George Washington School of Medicine and actively involved in the training of Geriatrics professionals. His main areas of interest include Geriatric Psychiatry issues, quality of life measures and improvement in transitions of care outcomes.
Kevin Murphy co-founded Principium Health in June 2016 as a sister company to CenseoHealth, and has served as its Chief Executive Officer since inception. As CEO, Kevin is responsible for the strategic direction of Principium, delivering cost and quality improvements for managed care organizations and improved health outcomes for the highest-risk patient demographics. Prior to Principium, Kevin served as Chief Operating Officer of U.S. Medical Management and Visiting Physicians Association, where he transformed the nation’s largest house call practice from a 17-year-old fee-for-service delivery model into the most successful value-based medical practice to date.
Steven R. Counsell, M.D.
Chief Medical Officer

Dr. Counsell is Board Certified in internal and geriatric medicine and is Immediate Past President and Chairman of the Board of Directors for the American Geriatrics Society. Prior to joining Principium Health, he served as the Mary Elizabeth Mitchell Professor and Chair in Geriatrics at Indiana University (IU) School of Medicine and Founding Director of the IU Geriatrics program.
The Radical Primary Care Model that Led to What CMS Called “The Most Successful Demonstration in Medicare History”

Dr. Damien Doyle, Medical Director, JOHNS HOPKINS HEALTHCARE MEDICARE ADVANTAGE
Dr. Steve Counsell, Chief Medical Officer, PRINCIPiUM HEALTH
Kevin P. Murphy, Chief Executive Officer, PRINCIPiUM HEALTH

Today’s Panel

Dr. Damien Doyle
Medical Director
JOHNS HOPKINS HEALTHCARE MEDICARE ADVANTAGE

Dr. Steve Counsell
Chief Medical Officer
PRINCIPiUM HEALTH

Moderator

Kevin P. Murphy
Chief Executive Officer
PRINCIPiUM HEALTH
The Cost Curve Challenge

BACKGROUND

- 5 percent of beneficiaries accounted for 39 percent of annual Medicare FFS spending in 2011
- Within the these beneficiaries -43 percent are persistently high spenders

BACKGROUND

- Constraints of health care system
  - Alignment of incentives
  - Average panel size of primary care physician is 2,300

- Failure to address the root causes of cost inflation among frail elderly
  - Episodic care
  - Care coordination limitations
  - Geriatric conditions
  - Health literacy
  - Social determinants of health
What Is Independence at Home?

- A Demonstration conducted by the Center for Medicare & Medicaid Innovation as part of the Affordable Care Act.
- A partnership between CMS and medical practices to test the effectiveness of delivering comprehensive primary care services at home.
- IAH provides chronically ill patients with a complete range of primary care services in the home setting.

Independence at Home: Results

- 17 practices participated in the IAH demonstration
- During its first year, the program saved more than $25 million, or an average of $3,070 per beneficiary, according to CMS
- CMS awarded incentive payments of $11.7 million to nine participating practices that reduced Medicare expenditures and met quality goals during the first demonstration performance year
- Top performing house-call practices saved over $11,400 per beneficiary
Principium Health Model: Best Practices from IAH Success

- Physician-driven, in-home, multi-disciplinary care team model
- High-touch support team, locally deployed
- Social Services support team and fully integrated community-based services
- Palliative Care, community based with integrated Hospice Clinical Educator
- Proprietary Mobile Technology
- 24/7 Call Center response to urgent escalations
- Transitions of Care Program

Panel Discussion

HOME-BASED CARE MODEL
Panel Question

With 5 percent of Medicare Patients driving more than 40 percent of a health plan’s total cost, can you share your thoughts on why office-based primary care may not be as effective as a house call model in addressing these patients?

Panel Question

How do the patient and caregiver respond to the shift to the home?
Panel Question

- What role do geriatric care principles play in home-based care?

Panel Question

- What data can you share about best practices for the composition of the clinical team?
Panel Question

- What is the key to curing social barriers to care?

Panel Question

- What are the key performance indicators in measuring house call performance?
Panel Question

What happens when you export this model to managed care?

Questions?

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Kevin P. Murphy
Chief Executive Officer
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Improving the Performance of a Delivery Network: Tools, Resources and Strategies To Improve Quality, Cost And Satisfaction.

Ryan Dodson, CRC, Director, Risk Adjustment
FIRST CHOICE MEDICAL GROUP

Dr. Gary Piefer, Chief Medical Officer
WHITEGLOVE HEALTH
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 straight forward 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.
Dr. Gary Piefer is a noted healthcare leader and innovator with a breadth of experience in highly effective medical management, physician leadership, medical practice transformation, team building and change leadership. Dr. Piefer is responsible for clinical strategy, product development and supports client management. Previously, he served as a Chief Medical Officer and held other senior management positions with responsibility for transforming medical management and physician practice operations, as well as the design, development and implementation of a chronic care delivery model focused on integration and care coordination. He has also guided the development of complex case management and quality improvement programs for the management of chronic disease. In addition, Dr. Piefer has extensive experience in governmental programs and ACO development and management.

Dr. Piefer is a graduate of the University of Houston College of Pharmacy, The University of Texas Medical School at Houston, and The University of Texas at Dallas School of Management. He is currently a Fellow with the American Academy of Family Physicians and American College of Physician Executives. He has served in several capacities at the local and state level for the Texas Academy of Family Physicians and speaks regularly to organizations regarding the critical competencies required to develop, lead and govern a successful physician enterprise entering the arena of value-based care.
IMPROVING THE PERFORMANCE OF A DELIVERY NETWORK

RYAN C. DODSON, CRC

How engaged is your network?
CREATING STRATEGIC TEAM SOLUTIONS TO IMPROVE WORKFLOW

Develop a team of strong individuals

- Provider Liaisons
- Provider Trainers
- Data Analyst/Informatics
- Auditors
- Scanners

DEVELOPING A PAYER/PROVIDER RELATIONSHIP

- Develop a strong relationship with Office Manager/Staff. Stay relevant and visible with regular communications
- Minimize the time impact on the providers
- Keep it Simple.
  - Provider’s offices are getting busier each day and the administrative duties are frustrating many providers.
  - Coordinate with other departments so providers are not getting multiple requests for the same data.
PROVIDE FEEDBACK ON DIAGNOSTIC CODING

• Use Chart scanning to do audits of provider records for additional HCC/5 Star/HEDIS capture
• Obtain/Use a data mining program to help analyze claim data for provider summaries and score cards.
• Provide scorecards weekly/monthly/quarterly depending on panel size.
• Engage a vendor to visit those members who are remote or do not regularly use their PCP office.

CASE STUDIES OF AN IMPROVED NETWORK AND IMPACT ON RAF SCORE

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IMPROVING COST

- Predictive modeling to improve patient care
- Proactive case management
- Reduce Hospitalizations

CONTACT INFO

Ryan C. Dodson, CRC
RYANDODSON@OUTLOOK.COM
CELL: 661-747-1386
11th Annual RISE Nashville Summit

Improving the Performance of a Delivery Network: Tools, Resources and Strategies to Improve Quality and Satisfaction

Gary Piefer, MD, MS, FACPE, FAAFP
Chief Medical Officer - WhiteGlove Health

Ryan Dodson, CRC
Director Risk Adjustment - First Choice Medical Group

Agenda

• Tools to assist in building your network
• Strategies to improve performance
• Case Study
Building and Evaluating Your Network

Network adequacy
• Geography
• Specialty

Performance
• Splitters
• Cost

Maintenance

Developing an Aligned Network

Alignment: High level Overview
Performance: Details on Selected Providers

M3: Dashboards

- 2a Cost
- 2b Utilization
- 2c Volume/Market Share
- 2d Risk Variation

Performance: Details on Selected Providers

M4: Dashboards

- 2e Quality Metrics

Option 3: Create up to 5 HEDIS Measures for PCP (Recommended)

5 HEDIS Measures
Strategies to Improve Performance

Reframe the Solutions

Teach reliability science
- Reliable execution of processes drive outcomes
- Note that vigilance and hard work are not sustainable improvement strategies
- Recognize human factors contributing to defect rates
- Simplify – reduce process steps

Involving the physicians in the development of the solution
- Ownership versus Buy-in
- Identify, avoid and remove non-value added work
- Lead with “why”

Case Study

Ryan Dodson, CRC
Director Risk Adjustment - First Choice Medical Group
Improving the Performance of a Delivery Network

How Engaged is Your Network?
Strategic Team Solutions to Improve Workflow

Develop a Team of Strong Individuals
- Provider Liaisons
- Provider Trainers
- Data Analyst/Informatics
- Auditors
- Scanners

Developing a Payer/Provider Relationship

Develop a strong relationship with Office Manager/Staff
- Stay relevant and visible with regular communications

Minimize the time impact on the providers

Keep it Simple.
- Provider’s offices are getting busier each day and the administrative duties are frustrating many providers.
- Coordinate with other departments so providers are not getting multiple requests for the same data.
Provide Feedback on Diagnostic Coding

- **Use Chart Scanning** to do audits of provider records for additional HCC/5 Star/ HEDIS capture
- **Obtain/Use a Data Mining Program** to help analyze claim data for provider summaries and score cards
- **Provide Scorecards** weekly/monthly/quarterly depending on panel size
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### CASE Study - Improved Network & Impact on RAF Score

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Improving Cost

Predictive modeling to improve patient care
• Proactive case management
• Reduce Hospitalizations

Contact Information

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661-747-1386

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Wrap Up & Next Steps
Tom Peterson brings more than 25 years of experience in healthcare. Prior to joining the SCIO team, Tom was CEO and co-founder of Clear Vision Information Systems (acquired by SCIO® in 2016), which designed software and services to optimize care and revenue for plans and providers across the country. Tom brings a unique perspective to revenue and care optimization having held positions at major health plans including Blue Shield of California and Blue Cross of California, as well as providers such as Cedars-Sinai Medical Center. His extensive background in clinical data related to risk adjustment, system design and analysis, provider outreach and training program development led to his involvement in the Industry Collaboration Effort (ICE), the development of training forums and best-practice presentations on risk adjustment for the industry. In his role with SCIO, Tom leads the operations in Westlake Village, California overseeing the strategic direction and IT innovation to ensure growth and alignment with evolving industry needs.
BETTER TOGETHER:
Fostering Payer-Provider Collaboration to Improve Risk Adjustment & Quality Programs

Kristen Connulty, Sr. Program Manager, Enterprise Risk Adjustment
Tufts Health Plan

Tom Peterson, Executive Vice President, Risk Adjustment
SCIO Health Analytics

March 7, 2017 | 11:20AM - 12:05PM

AGENDA

1. KNOW EACH OTHER
   - Understanding the Spectrum of Providers Involved
   - Data Transparency & Assess the Current State

2. BUILD CONSENSUS
   - Setting Joint Goals & Creating a Plan
   - Role of the Physician Champion

3. WORK SMARTER (NOT HARDER)
   - Streamline to Avoid Abrasion
   - The Three "Rights"
   - Ongoing Education

4. CONTINUAL FINE TUNING
   - Measuring Progress
   - Feedback Loops
   - Celebrating Success

5. Q&A
START BY UNDERSTANDING THE PROVIDERS YOU WORK WITH

Risk Adjustment Sophistication

Use of Technology

Human Capital

ASSESSING THE CURRENT STATE VIA DATA TRANSPARENCY

**Global Issues**
- Provider to Health Plan Data Transfer Completeness and Accuracy
- Handling EDPS Data
- Aligning Incentives

**Provider-Specific Concerns**
- Profiling Provider Groups and Physicians
- Low Scores ≠ Bad Doctors
- Root Causes Analysis: Comparing Revenue to Expense Trends

**Members With Gaps**
- Creating Suspect Lists Based on HCC and Quality Measure Gaps
EXAMPLE GLOBAL ISSUE: RAPS/EDPS PROCESSING DIFFERENCES

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<tr>
<th>Estimate</th>
<th>Actual</th>
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<tr>
<td>RAPS Members with HCG:</td>
<td>84.6%</td>
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<tr>
<td>RAPS Members without HCG:</td>
<td>15.4%</td>
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<tr>
<td>EDPS Members with HCG:</td>
<td>70.3%</td>
</tr>
<tr>
<td>EDPS Members without HCG:</td>
<td>29.7%</td>
</tr>
<tr>
<td>MAO4 Members with HCG:</td>
<td>0.0%</td>
</tr>
<tr>
<td>MAO4 Members without HCG:</td>
<td>100.0%</td>
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48.8%

AGENDA

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4. CONTINUAL FINE TUNING
   Measuring Progress
   Feedback Loops
   Celebrating Success

5. Q&A
COMMON RISK ADJUSTMENT CHALLENGES

Clinical Care Gaps
Year End Crunch Tactics
Incorrect Coding
Missing HCCs
Measuring Impact of Programs
Lack of Data Transparency
Data Drop Off
Collecting Data
Insufficient Staffing
Risk Adjustment Factor Scores
HEDIS, Stars & P4P Quality Scores

BALANCING RETROSPECTIVE AND PROSPECTIVE TACTICS

Retrospective
Prospective

Invest resources here!
Build into business processes
Information sharing & transparency is critical
Integrate initiatives (e.g., risk and quality)

Use selectively - Avoid duplication
Share criteria, results, & feedback

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Setting Achievable Goals

- Develop goals alongside provider group leadership
- Be “SMART”: Specific, Measurable, Assignable, Realistic, Time-Bound
- Use two comparisons: year-over-year and against a benchmark
- Mix quantitative-leaning goals (eg, RAF score increase) with qualitative-leaning goals (eg, attend risk adjustment education sessions)

### Beginner:
- **Member Visits:** Reduce percentage of members without an office visit to <20% in the next payment year. Led by patient engagement.
- **Recapture Rate:** Over the next year, 5% improvement in documenting previously reported HCCs for Dr. Smith.

### Intermediate:
- **Prevalence:** 10% increase in members documented in 2 key HCCs (CHF and COPD). Led by risk adjustment department at the health plan.

### Advanced:
- **RAPS & EDPS:** Attain RAPS/EDPS HCC capture discrepancy of within 5% by the final EDPS submission date. Led by the IT department

— Arthur Ashe

“Start where you are. Use what you have. Do what you can.”
**Case Study**

**PARTNERING WITH A RANGE OF PROVIDERS**

**Organization Profile**

65,000+ Member Medicare Advantage Health Plan

**Goal**

- Optimize revenue and quality by collaborating with providers to:
  - Identify members with chronic gaps in care
  - Identify low performing providers who may need additional risk adjustment support and education
  - Deliver actionable information to provider groups in a consistent format

**Solution**

- Developed a three-pronged approach based on the provider sophistication/volume:
  1. High volume providers: Full access to risk adjustment analytics
  2. Low volume providers: Share health assessment tool reports
  3. Outlier providers: Risk Adjustment 101 education

**Results**

- Annual revenue potential of $24 million per month
- Successfully closed 38% of gaps for members with chronic conditions in the first year.

---

**Case Study**

**Dx CODE DELETE % OVER TIME**

While the audits for this group varied in size year-over-year, with Year 2 being the largest, over a three year period we’ve seen decreasing trends in the rates of deletes for the Cancer, MI, and Diabetes HCCs.
DEVELOPING A PHYSICIAN CHAMPION

• Role:
  – Liaison between the health plan and provider group who promotes and implements changes to achieve jointly developed goals.
  – Oftentimes they interface with multiple departments (e.g., care management and risk adjustment)

• Who to Target?
  – Clinical Provider Group Leaders (preference towards those with a financial background/interest)
  – Medical Directors are a good place to start

• Signing Them Up:
  – Aim for representation from all in network groups
  – Consider contractual language requesting a good faith effort of participation

• Keeping Champions Engaged:
  – Monthly Meetings at the Health Plan
    • Includes a presentation on emerging topics (e.g., ICD-10)
    • Offer CME credits for some presentations
    • Opportunity to voice satisfaction/concerns with programs/solutions/EMRs
    • Opportunity to network, share best practices, and build relationships
  – Individual Meetings As Needed

ENSURING YOUR PHYSICIAN CHAMPIONS SUCCEED

Five Common Reasons Physician Champions Fail (Becker's Hospital Review)

1. Champion lacks a formal job title or description
2. Champion doesn’t have the proper support and mentorship
3. Failure to address the conflict between clinical workload and physician champion duties
4. Champions don’t have a say in decision-making
5. Poorly selected physician champion

AGENDA

1. KNOW EACH OTHER
   Understanding the Spectrum of Providers Involved
   Data Transparency & Assess the Current State

2. BUILD CONSENSUS
   Setting Joint Goals & Creating a Plan
   Role of the Physician Champion

3. WORK SMARTER (NOT HARDER)
   The Three “Rights”
   Streamline to Avoid Abrasion
   Ongoing Education

4. CONTINUAL FINE TUNING
   Measuring Progress
   Feedback Loops
   Celebrating Success

5. Q&A

THE THREE “RIGHTS”

Engaging the right person (member or provider) with the right information at the right time(s)

<table>
<thead>
<tr>
<th>Pre-Encounter</th>
<th>Point of Care</th>
<th>Post Encounter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member does not visit provider</td>
<td>Provider does not diagnose and document condition</td>
<td>Coding / billing process failures</td>
</tr>
<tr>
<td>• Insufficient provider education and engagement</td>
<td>• Provider unaware of care and diagnosis gaps</td>
<td>• MOCs not submitted to CMS</td>
</tr>
<tr>
<td>• Lack of patient activation</td>
<td>• Provider unaware of documentation requirements</td>
<td></td>
</tr>
<tr>
<td>• Member has difficulty accessing provider (contacting, scheduling, visiting)</td>
<td>• Physician incentives not aligned or tracked</td>
<td></td>
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</table>

Root Causes

<table>
<thead>
<tr>
<th>Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>• MWV Report Report</td>
</tr>
<tr>
<td>• In-Home Assessments</td>
</tr>
<tr>
<td>• Suspect Conditions Report</td>
</tr>
<tr>
<td>• Provider Documentation Training</td>
</tr>
<tr>
<td>• Chart Review</td>
</tr>
<tr>
<td>• ASM Process</td>
</tr>
<tr>
<td>• Data Quality Initiatives</td>
</tr>
<tr>
<td>• Data Reconciliations</td>
</tr>
<tr>
<td>• Coding error</td>
</tr>
<tr>
<td>• EMR limitation on number of diagnosis fields</td>
</tr>
<tr>
<td>• Claims truncation of additional diagnosis</td>
</tr>
<tr>
<td>• Data warehouse limits</td>
</tr>
<tr>
<td>• Server / submission errors</td>
</tr>
</tbody>
</table>
AN INTEGRATED PLATFORM SUPPORTING A RANGE OF PLANS & PROVIDERS

Sophisticated processes in place to optimize outcomes
Newer to risk bearing contracts

One Platform to Manage Medicare Risk Adjustment

Flexibility to Engage Providers in Various Stages of the Risk-Bearing Readiness Continuum

Risk Adjustment 101 – Provider in-service and education
Outsourced patient and provider engagement for gap closure
Sharing reports and suspect lists in the right format
Portal for CMS and claims data transparency
EHR Integration and real-time integration

Gain Efficiencies: Integrate Risk Adjustment & Quality Improvement Activities

Revenue QUALITY Of Care

Accurate Medicare Advantage Risk Scores
Ensure That CMS Reimbursement is Commensurate With the Expected Costs

Improved Quality Measures
Ensure that Conditions are Identified and Treated Each Year
ANALYTICS DRIVING ENGAGEMENT

<table>
<thead>
<tr>
<th>Date: 04/18</th>
<th>Scope: Group</th>
<th>Provider Group</th>
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<tbody>
<tr>
<td>Internal Procedure</td>
<td>External Procedure</td>
<td></td>
</tr>
<tr>
<td>198-403</td>
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<tr>
<td>198-403</td>
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<td></td>
</tr>
<tr>
<td>198-403</td>
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</table>

Diagnosis and HCC History for Member 3008 - MBR3008

<table>
<thead>
<tr>
<th>HCC Code</th>
<th>EXP Code</th>
<th>Diagnosis and Procedures</th>
<th>Date of Service</th>
</tr>
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<tbody>
<tr>
<td>198</td>
<td>403</td>
<td>Code 198-403</td>
<td>2016-01-01</td>
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<td>403</td>
<td>Code 198-403</td>
<td>2016-02-01</td>
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<td>198</td>
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<td>Code 198-403</td>
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<tr>
<td>198</td>
<td>403</td>
<td>Code 198-403</td>
<td>2016-04-01</td>
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HEDIS Measures

<table>
<thead>
<tr>
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<th>EXP Code</th>
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<td>Code 198-403</td>
<td>2016-01-01</td>
</tr>
<tr>
<td>198</td>
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<tr>
<td>198</td>
<td>403</td>
<td>Code 198-403</td>
<td>2016-04-01</td>
</tr>
</tbody>
</table>

PARTICIPATING IN ONGOING EDUCATION

Tip! It’s okay to start small - don’t try and boil the ocean right away.

Internally Developed Training
- Provider Coder “Bootcamps”
- Organizations
  - AHIP
  - CMS
  - Industry Collaborative Effort (ICE)
- Events
  - Rise Nashville
  - RISE West
  - Vendor Webinars

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AGENDA

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   Celebrating Success

5. Q&A

MEASURING PROGRESS

An important part of a well-run risk adjustment program is measuring results.

Set Year-End and Interim Goals
Set a year end goal and break it into monthly/quarterly milestones.

Create a Balanced Scorecard
Your risk adjustment dashboard should reflect all aspects of the program - RAF results, initiative return on investment, provider engagement/satisfaction, and auditing results.

Watch Monthly Results and Trends Over Time
Important trends might include quarterly RAF scores, RAF trends by provider group/PCP/geography, year over year adjustments and program costs.
MEASURING PROGRESS

Measure ROI
Be sure to note the impact of initiatives on year over year trends.

Communicate Top to Bottom
Share progress/results with all levels of the organization to ensure data transparency and increase engagement

Celebrate Success
A successful risk adjustment program takes a village!
Recognize key contributors to the initiatives.

Special Recognition
Recognize providers that have demonstrated the most significant improvement in care gap closures.

EXAMPLE: PROVIDER RAF SCORE LEADERBOARD

<table>
<thead>
<tr>
<th>RANK</th>
<th>SCORE</th>
<th>NAME</th>
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<tbody>
<tr>
<td>1ST</td>
<td>10000</td>
<td>BOB</td>
</tr>
<tr>
<td>2ND</td>
<td>10000</td>
<td>JHC</td>
</tr>
<tr>
<td>3RD</td>
<td>10000</td>
<td>SKT</td>
</tr>
<tr>
<td>4TH</td>
<td>10000</td>
<td>TBS</td>
</tr>
<tr>
<td>5TH</td>
<td>10000</td>
<td>MMN</td>
</tr>
<tr>
<td>6TH</td>
<td>10000</td>
<td>WJC</td>
</tr>
<tr>
<td>7TH</td>
<td>10000</td>
<td>SUV</td>
</tr>
<tr>
<td>8TH</td>
<td>10000</td>
<td>WHO</td>
</tr>
<tr>
<td>9TH</td>
<td>10000</td>
<td>TRN</td>
</tr>
<tr>
<td>10TH</td>
<td>10000</td>
<td>JAC</td>
</tr>
</tbody>
</table>

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BUILDING EFFECTIVE FEEDBACK LOOPS

• **Examples:**
  - Standing meetings (based on interest from groups)
  - Formal Post-Program Debrief
    • Share Results, ROI, Discuss Improvements for Next Year
  - Provider Forums
  - Newsletters

• **Best Practices:**
  - Nothing beats face-to-face meetings
  - Put it on the calendar!
  - Know Your Audience (Decision Makers vs. Staff)
    • Make sure audience matches agenda
    • Anticipate topics that may arise

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5. **Q&A**
Once We Understand; Change Results.

Thank You!
A Physician Organization’s Perspective on MACRA

Jennifer Pereur, Director, Government Programs
HILL PHYSICIANS MEDICAL GROUP
Jennifer Pereur – Biography

Jennifer Pereur is the Director of Government Programs for Hill Physicians Medical Group, an independent practice association (IPA) in Northern California. The group consists of over 3,000 contracted physicians who provide care to 300,000 managed care members. Jennifer oversees both the Medicare and Medicaid lines of business. Her primary focus since establishing the department in 2011, has been improving the accuracy of Medicare Advantage risk scores. Jennifer has 10 years of prior experience in Network Management at Hill Physicians. She has an extensive background in value-based physician payments, including the development of physician profiles and reporting metrics. Jennifer took time away from her work at Hill Physicians to lead the client support team at MedeAnalytics. In her role there as the Director of Payer Services, she worked with health plans to integrate analytics into their utilization management and cost containment decision making process. Using the MedeAnalytics platform, she developed dashboards that helped payers and providers collaborate on their shared performance goals. Jennifer has an MBA from St. Mary’s College and currently sits on the Practice Improvement Program (PIP) Advisor’s Committee for the San Francisco Health Plan.
MACRA Overview
RISE Nashville Summit
March 2017

Jennifer Pereur, Director of Government Programs
Hill Physicians Medical Group

What is MACRA?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is a bipartisan legislation signed into law on April 16, 2015. The law seeks to accomplish 4 things:

1. Repeal the Sustainable Growth Rate (SGR) formula
2. Shift Medicare payments away from volume and toward value
3. Streamline the multiple quality programs under one new Merit-Based Incentive Payments System (MIPS)
4. Reward participation in eligible alternative payment models (APMs)

Starting in 2019 . . .

*CMS estimates that 43-47% of physicians will fall into the MIPS track and 5-8% will qualify for APM

45%*
Of physicians

6%*
Of physicians
MIPS: Performance Category Scoring

2017 MIPS Performance

- Quality (60%)
- Advancing Care Information (25%)
- Improvement Activities (15%)

Pick Your Pace Option for MIPS

- Don’t Participate
- Submit Something
- Submit a Partial Year
- Submit a Full Year

Not participating in the Quality Payment Program:
If you don’t send in any 2017 data, then you receive a negative 4% payment adjustment.

Test:
If you submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity for any point in 2017), you can avoid a downward payment adjustment.

Partial:
If you submit 90 days of 2017 data to Medicare, you may earn a neutral or small positive payment adjustment.

Full:
If you submit a full year of 2017 data to Medicare, you may earn a moderate positive payment adjustment.
APM Track: Qualifying Participants

- You must have a certain % of your patients or payments through an Advanced APM.
- QPs will:
  - Be excluded from MIPS
  - Receive a 5% lump sum bonus

Bonus applies in 2019-2024: then QPs receive higher fee schedule updates starting in 2025.

Financial Impact of MIPS vs. APM

<table>
<thead>
<tr>
<th>Year</th>
<th>Fee Schedule</th>
<th>MIPS Max Adjustment</th>
<th>QP in Advanced APM</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>+0.5% each year</td>
<td>No change</td>
<td>+5% bonus (excluded from MIPS)</td>
</tr>
<tr>
<td>2017</td>
<td>+0.5% each year</td>
<td>No change</td>
<td>+5% bonus (excluded from MIPS)</td>
</tr>
<tr>
<td>2018</td>
<td>+0.5% each year</td>
<td>No change</td>
<td>+5% bonus (excluded from MIPS)</td>
</tr>
<tr>
<td>2019</td>
<td>+0.5% each year</td>
<td>No change</td>
<td>+5% bonus (excluded from MIPS)</td>
</tr>
<tr>
<td>2020</td>
<td>+0.5% each year</td>
<td>No change</td>
<td>+5% bonus (excluded from MIPS)</td>
</tr>
<tr>
<td>2021</td>
<td>+0.5% each year</td>
<td>No change</td>
<td>+5% bonus (excluded from MIPS)</td>
</tr>
<tr>
<td>2022</td>
<td>+0.5% each year</td>
<td>No change</td>
<td>+5% bonus (excluded from MIPS)</td>
</tr>
<tr>
<td>2023</td>
<td>+0.5% each year</td>
<td>No change</td>
<td>+5% bonus (excluded from MIPS)</td>
</tr>
<tr>
<td>2024</td>
<td>+0.5% each year</td>
<td>No change</td>
<td>+5% bonus (excluded from MIPS)</td>
</tr>
<tr>
<td>2025</td>
<td>+0.5% each year</td>
<td>No change</td>
<td>+5% bonus (excluded from MIPS)</td>
</tr>
<tr>
<td>2026 &amp; on</td>
<td>+0.25% or 0.75%</td>
<td>No change</td>
<td>+5% bonus (excluded from MIPS)</td>
</tr>
</tbody>
</table>
Case Study 1: Dr. Phil

“Excluded from MIPS Strategy” . . . for now

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Medicare FFS Billing</td>
<td>$20,000</td>
<td>$31,000</td>
<td>$35,000</td>
<td>$40,000</td>
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<tr>
<td>99213 – Sample</td>
<td>$76.71</td>
<td>$77.09</td>
<td>$77.48</td>
<td>$77.48</td>
</tr>
<tr>
<td>% Impact – MIPS</td>
<td>No Impact</td>
<td>No Impact</td>
<td>No Impact</td>
<td>No Impact</td>
</tr>
<tr>
<td>Annual $$ Impact</td>
<td>No Impact</td>
<td>No Impact</td>
<td>No Impact</td>
<td>No Impact</td>
</tr>
</tbody>
</table>

Eligible Providers:
- In 2017 and 2018: physician, physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist
- Starting in 2019: physical and occupational therapists, speech-language pathologists, audiologists, nurse midwives, clinical social workers, clinical psychologists, and dietitians/nutritional professionals

Exclusions:
1) First year participating in Medicare Part B
2) <$30,000 allowed billing and/or <100 Medicare patients
3) Significant participation in Advanced APM

Case Study 2: Dr. Oz

“Do Nothing Strategy”
aka “MACRA Will Be Repealed”

✓ Did not report on any measure in 2017.
✓ Did not report on any measure in 2018.

<table>
<thead>
<tr>
<th></th>
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<tr>
<td>Medicare FFS Billing</td>
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<td>$250,000</td>
<td>$250,000</td>
<td>$250,000</td>
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<tr>
<td>99213 – Sample</td>
<td>$76.71</td>
<td>$77.09</td>
<td>$77.48</td>
<td>$77.48</td>
</tr>
<tr>
<td>% Impact – MIPS</td>
<td>-4%</td>
<td>-5%</td>
<td></td>
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<tr>
<td>Annual $$ Impact</td>
<td>-$10,000</td>
<td>-$12,500</td>
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</table>
Case Study 3: Dr. Howser

“All In Strategy”

- Full reporting on all measures in 2017. Exceptional performer bonus earned.
- Full reporting on all measures in 2018. Exceptional performer bonus earned.

<table>
<thead>
<tr>
<th></th>
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<th></th>
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</thead>
<tbody>
<tr>
<td>Medicare FFS Billing</td>
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<td>$250,000</td>
<td>$250,000</td>
<td>$250,000</td>
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<tr>
<td>99213 – Sample</td>
<td>$76.71</td>
<td>$77.09</td>
<td>$77.46</td>
<td>$77.48</td>
</tr>
<tr>
<td>% Impact – MIPS</td>
<td></td>
<td></td>
<td>+4% plus extra</td>
<td>+5% plus extra</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1.5% exceptional performer</td>
<td>3% exceptional performer</td>
</tr>
<tr>
<td>Annual $$$ Impact</td>
<td>+$13,750</td>
<td></td>
<td>+$20,000</td>
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</table>

Case Study 4: Dr. Jemison

“Advanced APM Strategy”

- Joined a Next Generation ACO as a participating provider starting in 2017.
- Met both payment and patient requirements for “significant” participation.

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
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<td>$76.71</td>
<td>$77.09</td>
<td>$77.48</td>
<td>$77.48</td>
</tr>
<tr>
<td>% Impact – APM</td>
<td></td>
<td></td>
<td>+5% bonus paid at year-end</td>
<td>+5% bonus paid at year-end</td>
</tr>
<tr>
<td>Annual $$$ Impact</td>
<td>+$7,500</td>
<td></td>
<td>+$7,500</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>+shared savings from NGACO</td>
<td>+shared savings from NGACO</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>+No MIPS reporting burden</td>
<td>+No MIPS reporting burden</td>
</tr>
</tbody>
</table>
## Hill Physicians Strategy: APM

**Advanced APM:**
Hill Physicians is proud to be one of 45 groups in the 2017 Next Generation ACO Model.

## Hill Physicians Strategy: MIPS

<table>
<thead>
<tr>
<th>Specialties</th>
<th>Measurement Areas</th>
<th>Programs</th>
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<tbody>
<tr>
<td>Primary Care</td>
<td>Utilization (Admits/K, ED/K, Readmission Rate)</td>
<td>Primary Care P4P</td>
</tr>
<tr>
<td>Cardiology</td>
<td>% Generic</td>
<td>Specialty Bonus</td>
</tr>
<tr>
<td>Pulmonology</td>
<td>Patient Experience</td>
<td>California Statewide P4P</td>
</tr>
<tr>
<td>Orthopedic Surgery</td>
<td>Clinical</td>
<td>CMS Star</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>HCC Recapture Rate</td>
<td>Health Plan Performance Programs</td>
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<tr>
<td>Nephrology</td>
<td></td>
<td></td>
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<tr>
<td>Obstetrics and Gynecology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hematology and Oncology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastroenterology</td>
<td></td>
<td></td>
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<tr>
<td>General Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rheumatology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ophthalmology and Retinal Specialists</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Our job is to connect the dots and be efficient:
- Does a measure span multiple lines of business and quality programs?
- Can we focus physicians on the biggest areas of opportunity?
- Is measurement easy?

**MIPS Success**
- **Network Stability**
- **Greater Engagement**
Questions/Feedback?

For more information:
qpp.cms.gov

Jennifer Pereur
Hill Physicians Medical Group
jennifer.pereur@hpmg.com
The Speed of Transformation: Preparing for the Value-Based Contracting Models of Tomorrow

Monica Deadwiler, Senior Manager Strategic Projects
CLEVELAND CLINIC

David Mauzey, Director of Value-Based Care
OPTUM
David Mauzey is the General Manager of Optum’s value based care & provider network administrative platforms. These solutions and services include a network administration platform, as well as, valued based contract and bundle payment administration solutions. David has spent over 20 years working in the network administration space helping to implement the efficient solution to evolving network administration programs. With the emerging alternative payment models initiatives, the focus has been on implementing solutions that manage modeling, implementing, contract and payment associated with value based contracts and bundle payment.
The Three Futures: Preparing Your Organization for the Changes in Healthcare Over the Next 5 Years

Molly T. Turco, Director of Policy & Research
BETTER MEDICARE ALLIANCE

Caroline Pearson, Senior Vice President of Policy and Strategy
INOVALON

Elizabeth Carpenter, Senior Vice President, Policy Practice
INOVALON
Molly T. Turco, MPH

Director of Policy and Research, Better Medicare Alliance

Molly T. Turco is Director of Policy and Research at Better Medicare Alliance (BMA), a Medicare Advantage advocacy alliance. Turco is a former senior healthcare policy analyst for Marwood Group, a healthcare-focused advisory and consulting firm, where she specialized in Medicare Advantage and implementation of the Affordable Care Act. Turco’s experience also includes work as a healthcare policy researcher in the State of Vermont Office of the Health Reform Director, within the University of Pennsylvania Health System as part of a Chronic Care Initiative, and on research projects at Dartmouth-Hitchcock Medical Center and Geisel School of Medicine at Dartmouth. Turco holds a Master of Public Health (MPH) from the Dartmouth Institute for Health Policy & Clinical Practice and a BA from Middlebury College.
Caroline Pearson
Caroline Pearson is the Senior Vice President for Policy and Strategy at Avalere Health, a strategic advisory firm located in Washington DC that works with Fortune 500 healthcare companies to solve complex business and policy problems. In her role, Caroline oversees the firm's content generation across consulting services, research products, and public visibility. She previously led Avalere's Health Reform & Policy Practice. In Caroline’s twelve years at the firm, she has focused on implementation of the Affordable Care Act (ACA), prescription drug pricing, and public and private insurance benefit design. She is regularly quoted in national and trade press and is a frequent presenter to audiences seeking to understand the health policy landscape. In 2009, Caroline contributed to a report, led by Senators Tom Daschle and Bob Dole at the Bipartisan Policy Center, which advanced a comprehensive, bipartisan health reform proposal. She graduated Magna Cum Laude from Harvard University with a B.A. in Government.
Elizabeth Carpenter
Elizabeth Carpenter is a Senior Vice President at Avalere Health, where she leads the Policy Practice. Specifically, Elizabeth focuses on implementation of the Affordable Care Act, trends in commercial insurance, drug pricing policy, and the impact of politics on the policy landscape. Prior to joining Avalere, Elizabeth was a Senior Advisor in the Health Policy practice at McKenna Long & Aldridge LLP and the Associate Policy Director for the Health Policy Program at the New America Foundation. Previously, she served on both the legislative and campaign staffs of Senator Lincoln Chafee (RI). Elizabeth has a BA in Political Science from Brown University.
Today’s Discussion

- **Future One – Capped Spending**
  - Government Efforts to Limit Healthcare Cost Growth
- **Future Two – Not Your Parents’ Insurance**
  - Evolving benefit design and the role of consumers in healthcare
- **Future Three – The Pursuit of Value**
  - Aligning incentives in alternative payment models
Future Policy Changes Will Prioritize Capped Spending and Increased Flexibility

CONGRESS IS LIKELY TO PURSUE REFORMS THAT SEEK TO:

- **Cap federal healthcare spending and cost growth**
- **Limit spending through Medicaid block grants at the state or per capita level**
- **Offer more flexibility to states**
- **Grant states additional flexibilities to design and administer Medicaid programs**
While Lowering Federal Spending, Medicaid Block Grants Can Cause Large State Budget Shortfalls

- Medicaid Spending: Current Law Compared to Block Grant
- Medicaid Spending: Current Law Compared to Per Capita Cap

Funding Gap

Billions

- Total Medicaid Federal and State
- Federal Medicaid Current Law
- Federal Medicaid Block Grant, CPI + Pop
- Federal Medicaid Per Capita Cap, CPI

CPI: Consumer Price Index for all items; Pop: Population growth.

Simulation assumes Medicaid funding policies start in 2001 (using 2000 as the base year for Federal spending levels) and that States do not alter enrollment or benefits. Projections for Medicaid enrollment, Medicaid spending, and CPI are from CMS 2016 Medicaid Actuarial Report. Medicaid spending projections assume that the Affordable Care Act (ACA) Medicaid expansion is not repealed. The per capita cap simulation does not adjust for types of Medicaid enrollees (i.e. child, adult, aged, disabled).

Both Block Grants and Per Capita Caps Can Generate Substantial Federal Savings in Medicaid

- If implemented in 2018, 5-year federal savings would be about $150B under a block grant or $110B under a per capita cap

Projected Annual Reduction in Federal Medicaid Spending Under a Block Grant vs. Per Capita Cap

Billions

- Block Grant, CPI + Population
- Per Capita Cap, CPI

CPI: Consumer Price Index for all items

Simulations assume Medicaid funding policies start in 2018 (using 2017 as the base year for federal spending levels) and that States do not alter enrollment or benefits. Projections for Medicaid enrollment, Medicaid spending, and CPI are from CMS 2016 Medicaid Actuarial Report. Medicaid spending projections assume the Affordable Care Act (ACA) Medicaid expansion is not repealed. The per capita cap simulation does not adjust for types of Medicaid enrollees (i.e. child, adult, aged, disabled).
Medicare Premium Support Generally Implies a Shift from Defined Benefit to Defined Contribution

<table>
<thead>
<tr>
<th>Current Medicare Program</th>
<th>Medicare Premium Support</th>
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<tbody>
<tr>
<td>• A defined benefit, established by federal statute, dictates the richness of benefits</td>
<td>• A defined contribution from the federal government applies</td>
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<tr>
<td>• Federal reimbursement is linked to services provided to beneficiaries</td>
<td>directly toward an individual’s purchase of health insurance</td>
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Future Two – Not Your Parents’ Insurance
Exchange Deductibles Are Generally Higher than Those in Employer Coverage

**AVERAGE COMBINED DEDUCTIBLES FOR EXCHANGE PLANS, BY METAL LEVEL, 2017**

Bronze: $6,014  
Silver: $3,703  
Gold: $1,051  
Platinum: $110  
Employer: $1,478*


Cost-Sharing Is Particularly High for Specialty Drugs

**PRESCRIPTION DRUG COST SHARING ON SPECIALTY TIER, IN EXCHANGE PLANS, 2017**

Bronze: 40%  
Silver: 26%  
Gold: 24%  
Platinum: 27%

Source: Avalere PlanScape®, a proprietary analysis of exchange plan features, December 2016. Avalere analyzed data from the FFE Individual Landscape release October 2016 and the California and New York state exchange websites.

Note: Instances in which values were one percent or below were excluded from the graphic display. Notably, the FFE landscape file forces plans into four tiers of data which excludes some cost-sharing detail. When plans indicated “no charge” in the FFE Landscape file, Avalere assigned the plan to 0 percent coinsurance or 0 percent copay depending on which cost-sharing type was most prevalent for the specified benefit. For Tier 4 Avalere used 0 percent coinsurance. Avalere did not include health plans in which there was no cost sharing across service categories or that had deductibles that were equal to the out-of-pocket maximum.
Employer Plans Have Tightened Formulary Controls, Mirroring Exchange and Part D Benefits

![Graph showing utilization management for single-source drugs in 22 classes, 2014-2016.]

**Note:** Coverage is weighted according to unique plan-state combinations. Sample includes all silver plans offered in 50 states and the District of Columbia. Source: Avalere Health PlanScape®, a proprietary analysis of exchange plan features, April 2016. This analysis is based on data collected by Managed Markets Insight & Technology, LLC.

UM: Utilization Management

Consumers Are Increasingly in a Decision-Making Role for Healthcare

![Diagram showing consumer experience with user-friendly website, drug information, educational resources, provider information, sorting & filtering options, and out-of-pocket estimation tools.]

Consumer Experience
Payers Driving Towards Payment Models That Shift Risk to Providers

Accountable Care Organizations (ACOs) have proliferated across payer types, although the highest enrollment is in commercial ACOs.

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<thead>
<tr>
<th></th>
<th>Number</th>
<th>Payer Type</th>
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<tbody>
<tr>
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<td>Commercial ACOs</td>
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<td>Medicare ACOs</td>
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<tr>
<td></td>
<td>69</td>
<td>Medicaid ACOs</td>
</tr>
</tbody>
</table>
CMMI Accelerated Payment and Delivery Reform in Public Programs

Under Trump Administration, CMMI could modify some demos, but shift toward value-based payments will continue.

Implementation of the Medicare Quality Payment Program will likely move forward as planned.

Payment Reforms Demand Increased Focus on Quality, Value, and Care Optimization

**Quality Measurement**
Ensure quality measure development focus on filling gap areas and creating measures that are meaningful to patients.

**Value Demonstration**
Assess products and services on holistic value, including product performance and improved outcomes for patients.

**Optimal Setting**
Select best setting of care to improve outcomes and reduce costs.

**Example:**
Qualified Clinical Data Registries (QCDRs)

**Example:**
Outcomes-based contracts

**Example:**
Post-acute care optimization
For Additional Questions…

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