Best Practices and Actionable Tools for Improving Risk Adjustment & Achieving Exceptional Quality Performance

MARCH 25-27, 2015
GAYLORD OPRYLAND RESORT

KEYNOTE ADDRESS
BILL FRIST, MD
U.S. SENATOR (R-TN) 1995-2007;
SENATE MAJORITY LEADER 2003-2007;
Chairman, HOPE THROUGH HEALING HANDS

FEATURED PRESENTER
THOMAS E. HUTCHINSON,
Strategic Advisor, EBG ADVISORS, INC.; Formerly
Director of the Medicare Plan Payment Group, CENTERS
FOR MEDICARE & MEDICAID SERVICES

TO REGISTER: CALL 866-676-7689 OR VISIT US AT WWW.HEALTHCARE-CONFERENCES.COM
### Top Reasons to Attend

- **Special Opening Keynote presentation by Senator Bill Frist, MD (R-TN, 1995-2007; Senate Majority Leader 2003-2007) on The Future of Healthcare Reform**
- **Featured presentation - Tom Hutchinson, Strategic Advisor-EBG Advisors, Inc. and former CMS Director of the Medicare Plan Payment Group will examine the 45 Day Notice, payment policy and the direction of risk adjustment**
- **Introducing an expanded program with three pre-conference workshops and four tracks over two days, providing the rare opportunity to customize your ideal learning experience**
- **Over 30 sessions of expert-led case studies, presentations, panel discussions, and roundtables on quality, MA/Commercial/Medicaid, risk adjustment, data, care management, compliance, policy and so much more!**
- **Ample networking opportunities to share ideas with old friends and develop new industry contacts in risk adjustment, quality and revenue optimization**
- **A dynamic speaking faculty comprised of the industry’s best and brightest in risk adjustment, payment policy, audit preparation, Stars/quality, care management and performance analytics – all in one location**
- **The latest on Health Exchange marketplace enrollment trends, risk adjustment and quality measurement**
- **Two unique 75-min. roundtable sessions featuring innovative technologies and solution providers versed in risk adjustment optimization, boosting quality performance, and streamlined data management**

### About the Venue

Nashville’s premier hotel, the Gaylord Opryland Resort & Convention Center, offers RISE attendees all the excitement and energy of Music City under one spectacular roof. Beneath its climate-controlled signature glass atriums and nestled in a bend of the meandering Cumberland River is an extraordinary selection of dining, shopping and recreation options that create the perfect conference and networking setting. Enjoy the 9 amazing acres of indoor gardens, cascading waterfalls and indoor river. Within this lush landscape, you will discover remodeled guest rooms and suites, a completely redesigned Cascades lobby featuring a VIP check-in area, and a 20,000 square foot spa and fitness center. Located mere minutes from the airport a lush, tropical oasis await you. The property boasts over 15 restaurants and bars, make your reservations and get ready to network.

RISE has a block of rooms reserved at a $179/night rate. We urge you to reserve your rooms without delay. Based on the popularity of the conference we expect the hotel room block will sell out rapidly. Once the block is sold out rates will be at the hotel’s discretion. Please do not delay, book your room today!

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### Who Should Attend?

Leaders and Senior Management from Medicare Advantage Health Plans, Commercial Plans, Provider Groups, Pharmacy Benefit Managers, Prescription Drug Plans, and Medicaid Plans, with responsibilities in the following areas:

- Risk Adjustment and HCC Management
- Star Ratings and Quality Improvement
- HEDIS/CAHPS/HOS
- Provider Engagement and Education
- Member Engagement and Education
- Product Development and Plan Strategy
- Medicare and Government Programs
- Part D
- Operations
- Data Management/Performance Analytics
- Revenue Management/Financial Performance
- ROI and Value Assessment
- Performance Improvement
- Accountable Care
- Care Coordination
- Compliance/Regulatory Affairs

### Team Discounts

- Three people will receive 10% off
- Four people will receive 15% off
- Five people or more will receive 20% off

In order to secure a group discount, all delegates must place their registrations at the same time. Group discounts cannot be issued retroactively. For more information, please contact Whitney Betts at 704-341-2445 or email her at wbetts@healthcare-conferences.com for any group registrations.

### Refunds and Cancellations

For information regarding refund, complaint and/or program cancellation policies, please visit our website: [https://www.healthcare-conferences.com/thefineprint.aspx](https://www.healthcare-conferences.com/thefineprint.aspx)

### Important Information

**Venue Details**

Gaylord Opryland Resort
2800 Opryland Drive
Nashville, Tennessee 37214
615-889-1000

We have a limited number of hotel rooms reserved for the conference. The negotiated room rate of $179 per night will expire on March 3, 2015 although we expect the block to sell out prior to this date. To ensure you receive a room at the negotiated rate book well before the expiration date. Upon sell out of the block room rate and availability will be at the hotel’s discretion.

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### Conference Organizers

Healthcare Education Associates is a division of Financial Research Associates, LLC. HEA is a resource for the healthcare and pharmaceutical communities to improve their businesses by providing access to timely and focused business information and networking opportunities in topical areas. Offering highly targeted conferences, Healthcare Education Associates positions itself as a preferred resource for executives and managers seeking cutting-edge information on the next wave of business opportunities. Backed with over 26 years of combined conference industry experience, the producers of HEA conferences assist healthcare professionals, actuaries, attorneys, consultants, researchers and government representatives in their professional endeavors. For more information on upcoming events, visit us online: [www.healthcare-conferences.com](http://www.healthcare-conferences.com)

RISE (Resource Initiative & Society for Education) Vision:

To build a community and an educational system that promotes successful careers for professionals who aim to advance the quality, cost and availability of health care.

RISE provides:

- A forum to build professional identity and a network of colleagues
- A platform to capture and share knowledge and insights
- A venue to develop and share benchmarks and document best practices
- Career track development support
- A channel for building alliances, partnerships and affiliations that fulfill the vision

RISE (Resource Initiative & Society for Education) Mission:

RISE is the first national association totally dedicated to enabling healthcare professionals working in organizations and aspiring to meet the challenges of the emerging landscape of accountable care and health care reform. We strive to serve our members on four fronts: Education, Industry Intelligence, Networking and Career Development. To learn more about RISE and to join, visit us online: [risehealth.org](http://risehealth.org)

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“Diverse topics; great opportunities for networking.”

Donna Blythe, HIGHMARK BLUE CROSS BLUE SHIELD
WORKSHOP A
Mini Boot Camp: Risk Adjustment 101
If you are new to healthcare, or risk adjustment specifically, HCC coding, risk models, and payment accuracy may seem like a complex maze. This workshop will provide a comprehensive overview of the nuts and bolts of risk adjustment, providing a solid backdrop to your RISE Nashville learning experience.

- Introduction to RA -
  - MA vs. Commercial vs. Medicaid
- How does it work?
  - How it ties to payment
- The Quality/RA connection
- Diagnosis codes
- Technologies and software

Moderator:
Jason Rose, Chief Strategic Development Officer
INovalon
Hiro Arai, ASA, MAAA, Staff Actuary, Assistant Actuary, Risk Analytics
Blue Cross Blue Shield of North Carolina
Jessica Smith, Director, Risk Management Operations
Blue Cross Blue Shield of Minnesota

WORKSHOP B
Data Intensive: Risk Adjustment Analytics - Operating with Clarity
This interactive workshop will provide you with data analytic ideas that will help you operate a successful risk adjustment business unit. We will demonstrate how to make use all the data you’ve captured through the years and show you how to overcome some deficiencies and complexities of health plan data. Be sure to bring your data issues and questions to get the most out of this session.

In this workshop, we will:
- Tackle what a data analyst needs to know, such as basic concepts of health information management, medical classification and coding schemes, data cleansing, how to integrate outside resources, master data management, basic statistics and data presentation strategies, and stakeholder reporting
- Explore the nuances of risk adjustment calculations and how healthy respect for these nuances assures the authenticity of risk adjustment information
- Review a set of reports that a business unit needs to have, then discuss to how read and decipher the reports, what to do if you see discrepancies and how to drill down and take action
- Examine quality measurement topics such as continuous enrollment vectors, the impact of how inpatient episodes of care are constructed, the impact of provider specialty reporting and other relevant topics

Tam Pham, Vice President of Product and Strategy
Peak Risk Adjustment Solutions
Gary Gau, Actuarial Predictive Modeling Lead
Florida Blue

WORKSHOP C
HCC Coding Clinic: Accuracy, Chart Review and Staff/Provider Training
- Educating providers on accurate HCC documentation
- Getting physicians to write things in the chart and on the bill
- Demonstrating that coding accuracy is the root of risk adjustment
- Novel approaches to screening for coding inaccuracies
- Coding for complex diagnoses
- How to configure your EMR to get better quality diagnoses
- Claims review vs. chart audit
  - Conducting fail-proof chart audits
  - Claims validations and identifying new codes
- ICD-10 readiness -
  - Why impact on revenue is not the only issue
  - Are providers ready?
  - What is the impact on revenue – does it mean lower reimbursement?
- Coding to specificity-mitigating the impact on health plan revenue

James Taylor, MD, Medical Director, Revenue Cycle
Kaiser Permanente
Timothy Buxton, Director, Coding Services
Episource LLC

4:00 – 6:00
PRE-CONFERENCE REGISTRATION AND OPENING NIGHT COCKTAIL RECEPTION sponsored by
1:30 – 2:15 DYNAMIC INTERVENTION PLANNING: REDUCING WASTE IN RISK ADJUSTMENT
• How can “natural HCC gap closures” be predicted?
• How much money can health plans save by being more efficient and strategic in their documentation efforts?
• How will static and inefficient interventions be transformed using dynamic intervention planning?
• How many visits close as the result of future visits rather than through interventions?
• What new innovative solutions will replace legacy intervention techniques?

Moderator:
Alan Stine, Chief Technology Officer
EBSI | LEPRECHAUN

Co-Panelists:
John Criswell, Chief Executive Officer
PULSE
Hiro Arai, ASA, MAAA, Staff Actuary,
Assistant Actuary, Risk Analytics
BLUE CROSS BLUE SHIELD OF NORTH CAROLINA

2:20 – 3:05 ADDRESSING THE DARK SIDE OF RISK ADJUSTMENT: STEPS TO IDENTIFY YOUR RADV RISK FROM OVER-CODED DIAGNOSES AND FIXING THIS EXPOSURE CONCURRENTLY
• The fundamentals of RADV: Over-coding and mis-coding
• Legal and financial risks of not operationalizing an effective RADV intervention strategy
• How to identify and intervene on over-coded and mis-coded claims
• How to prioritize efforts in sorting through millions of claims
• How to mitigate RADV risk going forward

Sy Zahedi, President & Chief Executive Officer
MEDXM

Munish Khaneja, MD, MPH, VP Medical Management and Pharmacy Operations
EMBLEM HEALTH, INC.

3:05 – 3:20 AFTERNOON NETWORKING BREAK
**3:20 – 4:05 Navigating the Tenuous Future of the In-Home Assessment**
- What direction is CMS taking in the in-home assessment?
- A case study in taking a proactive approach to member and provider engagement
- What are viable alternatives?
- Doing more than confirming diagnosis

**Dr. Kevin Kearns, Chief Medical Officer**

**Anthem Blue Cross and Blue Shield**

**3:20 – 4:05 Connecting Quality and Stars with Risk Adjustment for a Comprehensive Approach**
- Rising medical costs, affordability pressure, new reimbursement models, increased regulatory requirements, and public reporting of quality metrics, have shifted how plans view the importance of a quality focus. This session will explore how organizational structure, analytics, and member and provider engagement can work together within an integrated framework to drive results.
  - Increase information available to physicians at point-of-service
  - Improve quality scores
  - Increase revenue potential

**Speaker TBA**

**Optum**

**3:20 – 4:05 Solving the Conundrum: Making the Member Engagement + Care Management Connection**
- Why you must first engage your members before realizing care management results, i.e. reducing unnecessary treatments
- Using the data to understand your members including communication preferences, cultural and socio-economic differences
- Improving the process of identifying the high utilizers vs. less engaged members
- Engaging members in new and different ways

Sarah Martin, Assistant Vice President, Product and Member Engagement

**Blue Cross Blue Shield of South Carolina**

**Jan Reed, Director, Community Outreach**

**Molina Healthcare**

**Robert H. Thompson, Vice President, Community Health Engagement**

**Excellus Blue Cross Blue Shield**

**3:20 – 4:05 Improving Risk Adjustment Results: Best Practices from the Front Lines**
- This Q&A-style session will feature a panel of experts from two health plans discussing key challenges in Risk Adjustment, and new best practices for improving results. The discussion will focus on:
  - The use of analytics to optimize coding compliance, data submissions, and program evaluation
  - Ideas for improving internal processes, team training, and provider education
  - Strategies for improving communication and coordination across departments and health plans
  - How to leverage quality team resources for improving risk adjustment programs
  - Key challenges to overcome in both Medicare and Commercial risk adjustment

**Moderator:**

Marilyn Garry, Senior Director, Product Management

**Verisk Health**

**Co-Panelists:**

Susan L. Waterman, Risk Adjustment Manager

**Scott & White Health Plan**

**Kimberly Reid, AVP of Risk Adjustment**

**Molina Healthcare**

**4:10 – 5:30 “Choose Your Own Adventure” Roundtables - Select from a variety of presentations spotlighting healthcare’s most influential technology and solution gurus presenting tools to elevate your plan’s initiatives**

Pull up a chair and settle in for this unique opportunity to select three interactive, speed-dating type presentations featuring the latest technologies and solutions for boosting your plan’s risk, quality and data management endeavors. A bell will ring three times within this special 80 minute session, alerting you to transition to the next roundtable of your choice.

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<th>Roundtable A: Member and Provider Coordination to Improve Outcomes</th>
<th>Roundtable I: Claims Confidence Testing and Chart Validation</th>
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<td>Advance Health</td>
<td>MedSave</td>
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<td><strong>Roundtable B:</strong> A Plan-Provider Partnership for Better Risk Adjustment Data Collection: Electronic Medical Record Request &amp; Delivery</td>
<td><strong>Roundtable J:</strong> Provider Engagement Strategies for Improved Quality and Risk Scores</td>
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<td><strong>Roundtable C:</strong> Advanced Analytics Drives Improved Targeting</td>
<td><strong>Roundtable K:</strong> Optimizing Patient Care and Revenue Through Your Quality and Documentation Efforts</td>
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<td>Peak Risk Adjustment Solutions</td>
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<td><strong>Roundtable D:</strong> Continuous Quality Revenue Optimization: Moving the Needle</td>
<td><strong>Roundtable L:</strong> Shooting for the Stars: Aligning Financial and Quality Goals</td>
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<td><strong>Roundtable E:</strong> TPRP: Are You Funding or Feasting On Your Competitors?</td>
<td><strong>Roundtable M:</strong> Demonstration of ePASS®, An Analytically Driven Point-of-Care Decision-Support Tool</td>
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<td><strong>Roundtable F:</strong> Detecting PAD, One of the Top 10 Most Costly Under-Reported Chronic Conditions</td>
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<td><strong>Roundtable G:</strong> Personalized Primary Care: Transforming the Patient Experience for Improved Outcomes</td>
<td><strong>Roundtable O:</strong> RADV Analytics to Protect (and Even Enhance) Your Bottom Line</td>
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<td>Censeo Health</td>
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<td><strong>Roundtable H:</strong> How Health Plans Are Using an Integrated Approach to Risk Adjustment and Quality Management to Improve Outcomes</td>
<td><strong>Roundtable P:</strong> Learn About the Only Patented Computer-Assisted HCC Risk Adjustment Service, Which Has Yielded Significant Second Pass Coding Results for Large Health Plans in 6 to 8 Weeks</td>
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## 7:45 – 9:00  BREAKFAST sponsored by  Leprechaun

## 7:45 – 9:00  MORNING ROUNDTABLES

Grab a mimosa, a cup of joe and a sweet treat and continue the roundtable fun. Select three sessions for these speed-dating type presentations spotlighting new technologies and solutions for supporting your plan’s risk management, quality performance and data analytics endeavors. A bell will ring three times within this lively 75 minute session, alerting you when it’s time to transition to the next roundtable of your choice.

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<td>Improving Star Ratings through Automation of HEDIS Care Gap and Supplemental Data Collections</td>
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<td>ROUNDTABLE B</td>
<td>It’s Not Too Late: Launching an Effective 2015 HRA Strategy</td>
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<td>ROUNDTABLE C</td>
<td>Knights of the Round Table Discussion: The Story Behind Legendary Engagement Solutions</td>
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<td>Guarantee a 4 Star Part D Rating, and Achieve Health Outcomes</td>
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<td>ROUNDTABLE E</td>
<td>Audit Proof Your Risk Adjustment</td>
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<td>Global Chart Repository: Managing Records Across the Enterprise</td>
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<td>Compliance and Follow-Up Care: Care Management &amp; the Home Assessment</td>
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<td>ROUNDTABLE I</td>
<td>Product Demo on Risk Adjustment</td>
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<td>ROUNDTABLE J</td>
<td>Optimize Risk Adjustment: Will Your Competitors Say Thank You When You Write Them a Check?</td>
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<tr>
<td>ROUNDTABLE K</td>
<td>Creating the Best Chase and Retrieval Strategy for Retrospective Programs - Medicare Advantage vs. Marketplace</td>
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## 9:05 – 9:15  CHAIRPERSON’S RECAP OF DAY ONE

Nathan Goldstein, Chief Strategy Officer  CENSEO HEALTH

## 9:15 - 10:10  FEATURED SESSION: (RE) FOCUSING ON THE MEMBER

- Let’s bring it back to why we are all here – the member, the patient
- Making the cultural shift – ensuring your organization keeps the member in front view
- What are patients/members really trying to tell us?

Nancy Davenport-Ennis, Founder and Chairman of the Board  PATIENT ADVOCATE FOUNDATION AND NATIONAL PATIENT ADVOCATE FOUNDATION

Carol Matyka, Advocate  NATIONAL BREAST CANCER COALITION

## 10:10 – 10:30  MORNING NETWORKING BREAK

sponsored by  ECS

"The information given is always up-to-date and gives plans a whole picture view of our business."

Megan Lombardi, BLUE CROSS BLUE SHIELD OF WESTERN NEW YORK

## 10:30 – 11:30  SYNERGY PANEL: PROVIDER & HEALTH PLAN COLLABORATION – REALIZING THE POWER OF THIS ALIGNMENT

- Working with physicians to get members into the office – moving beyond documentation discussion and into action
- How do you overcome the "non-employed" challenge? Connecting with and incentivizing physicians when they are not employed by your plan
- How can you get in front of providers and actually keep them engaged when they have such limited time?
- Shift the paradigm and the cost savings will follow – looking beyond revenue into actual care improvement
- How can we collaborate to make sense of the data and actually put it to work?

**Co-Panelists:**
- Raymond L. Chan, MD, MBA, Corporate Medical Director  SCAN HEALTH PLAN
- Scott Flinn, MD, Medical Director  ARCH HEALTH PARTNERS
- Debra Wallace, Integrated Care Program Director  FALLON HEALTH

## 11:30 - 12:45  NETWORKING LUNCHEON

sponsored by  Cognisight

**CPE CREDITS**

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The recommended CPE credit for this course is 12 credits for conference only and 15.5 credits for the conference and workshop in the following field(s) of study: SPECIALIZED KNOWLEDGE AND APPLICATIONS

For more information, visit our website:  [https://www.healthcare-conferences.com/thefineprint.aspx](https://www.healthcare-conferences.com/thefineprint.aspx)

Conference – 12 Credits  Pre-Con 3 Credits
12 credits for conference only - Maximum of 15 credits per person (with workshop)

RISE will be applying for AHIMA and AAPC credits for this event. Once approved, we will announce the number of credit hours on the conference website. Please check periodically.

## RISE ATTENDEE BREAKDOWN

- Quality & Care Mgmt: 22%
- Strategy & Business Mgmt: 19%
- Audit/Compliance: 10%
- Risk & Revenue: 43%
- Operations/Informatics: 6%

**RISE ATTENDEE BREAKDOWN**

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FRIDAY, MARCH 27, 2015

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### Track A: Commercial Risk Adjustment & Quality

**12:45-1:30** Retrospective Analysis: The Health Exchange Marketplace in 2015
- What population actually emerged in the exchanges?
- What revelations have emerged from the marketplace?
- Initial feedback from the field

RaeAnn Grossman, Chief Sales & Marketing Officer, MEDSAVE USA

Gabe Medley, Manager, Risk Adjustment Programs, Actuarial Services, HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY

### Track B: Compliance, Audit-Prep & Legal

**12:45-1:30** CMS Program Audit-Preparedness
- Strengthening your compliance training, communication and documentation
- Evaluating your internal vs. external resources from a compliance POV
- What does risk adjustment mean to compliance?
- Looking ahead at 2016-17 through a compliance lens
- Managing your FDRs

Moderator:
- Dan Weinrieb, Senior Vice President, Risk Adjustment, GORMAN HEALTH GROUP

Co-Presenters:
- Dawn Jadin, Manager, Regulatory Compliance Audits - Audit Management, UNITEDHEALTHCARE
- Rachel Haltiwanger, Delegate Oversight and Finance Compliance Officer, UNITEDHEALTHCARE

### Track C: Medicaid Risk Adjustment & Case Management

**12:45-1:30** Integrating High-Risk Member Care with Risk Adjusted Revenue for Medicaid Members and Dual Eligibles
- Taking a holistic approach to integrated programs in high-risk population management can provide true value to members, and the plans and providers serving them. Join us as we discuss how to:
  - Identify opportunities for care quality improvement and RA revenue and find members at highest risk for avoidable adverse medical events
  - Initiate a comprehensive field-based longitudinal care program to fulfill member care needs
  - Ensure complete and accurate condition documentation to secure revenue under Medicaid and Medicare RA models
  - Coordinate quality improvement, complex care management, comprehensive assessments for dually eligible members, medication adherence support and revenue improvement into one balanced program
  - Engage your health plan provider networks in pursuit of these objectives

Andrew Walsh, Chief Marketing Officer, POPHEALTHCARE
  - Matt Cowley, Chief Executive Officer, PHOENIX HEALTH PLAN

### Track D: Case Studies & Topics on the Rise

**12:45-1:30** Establishing a Member Advisory Group for Your Health Plan
- How do you establish a Member Advisory Board that will have true impact on improvement?
- How do you empower your Member Advisory Group to influence change?
- What have health plans accomplished with their Member Advisory Group?
- Really listening to members/patients – implementing changes based on this valuable voice

William Dean, JD, MSW, Delivery System & Consumer Engagement Manager, Community Catalyst

### 1:30 - 1:50 Afternoon Networking Break

**1:50 - 2:35** Using Analytics to Refine Your Commercial Risk Performance
- How did analytics help plans affect year one performance?
- What types of analytics can drive changes in risk scores?
- What operational resources are required to effectively use analytics?
- How can plans leverage analytics beyond risk adjustment?

Lisa DiSalvo, Senior Director of Product Development, ALTEGRA HEALTH
  - Nick Liguori, Chief Operating Officer, HEALTH REPUBLIC INSURANCE, NEW YORK

**1:50 - 2:35** The Provider-Health Plan Audit Connection
- Although HEDIS and Medicare Risk Adjustment audits are seasonal and only 20 percent of all medical record requests, they hit providers at various times and often with very short completion timeframes. Record requests can be in the thousands, depending on the facility size and number of plans they participate with.
  - Understand the provider pain points around seasonal chart data collection
  - Learn how providers can institute a solution for fast, accurate chart turn-around that meets the goals of both providers and health plans
  - Discuss practical steps to streamline chart requests and release the requests electronically to ensure deadlines are met

Jeannie Hennum, Vice President of Sales, HealthPort ChartSecure
  - Elizabeth Beer, Director, Managed Care, ALBERT EINSTEIN HEALTHCARE NETWORK

**1:50 - 2:35** Tactical Solutions to Risk Adjustment Collaboration Across Lines of Business
- Leaders from each line of business will discuss where Medicare, Medicaid and Commercial risk adjustment program operations intersect.
  - Identification of advantages/disadvantages/barriers to collaborating between lines of business
  - Sharing of medical records amongst provider networks
  - Coordinating provider communications and provider education
  - Aligning incentive programs

Camie Welch, Director Medicare Risk Adjustment Programs, WELLPOINT ANTHEM, INC.
  - Jennifer Creighton, Director Medicaid Risk Adjustment Programs, WELLPOINT ANTHEM, INC.
  - Jake Brown, Director Commercial Risk Adjustment Programs, WELLPOINT ANTHEM, INC.

**1:50 - 2:35** New Optimization Tools to Reduce Uncertainty forRisk-Based Products
- Optimization in pre-bid preparation and risk management
- Managing and optimizing plan performance once members have enrolled
- Optimization of networks for risk-based products

Rick Valentine, Managing Director, Business Intelligence Strategy, DST HEALTH SOLUTIONS
  - Terry Chesser, Principal US ADVISORS, INC.
2:40 - 3:25 PRIMARY CARE’S EXTREME MAKEOVER
At the heart of our efforts to help our members live healthier lives is our strategy to deliver informed and inspired primary care. Yet primary care, as traditionally thought of, is stretched past its breaking point. How will strategies need to change as primary care enters its next phase: telemedicine, ambulatory, retail and self-directed? How can we use these new tools to reach un-engaged members or those with access issues? Learn how to solve today’s problems with tomorrow’s leading strategies.
Moderator:
Nathan Goldstein, Chief Strategy Officer, CENSEO HEALTH
Panelists:
Speakers TBA

2:40 - 3:25 MEDICARE PART C CONDITIONAL PAYMENTS: AN UPDATE ON MA PLANS’ REIMBURSEMENT RIGHTS
Are MA plan private carriers considered secondary payers? If so, are they entitled to the same recovery rights the Federal government has, i.e. the ability to seek double damages when primary payers deny responsibility for payment of such medical bills? In this session, you will –
• Learn about the Federal regulations guiding MA plans’ reimbursement rights
• Gain an understanding of CMS position regarding MA organization subrogation rights
• Hear about case law decided by the various Federal district courts and circuit courts around the US, interpreting such statutory and regulatory provisions
Rafael Gonzalez, Vice President, Strategic Solutions, Settlement Solutions

2:40 - 3:25 CARE MANAGEMENT TAILED TO THE MEDICAID POPULATIONS
• Identifying members with high, impactful needs who can benefit most from care management
• Using trusted evidence-based guidelines to drive clinical & quality of care interventions.
• Addressing members’ complex needs using a high touch community-based approach to promote their optimal health and wellness
• Leveraging community resources to act as a bridge between the formal health care system and the members we serve
Howard Shaps, MD, MBA, Medical Director, Kentucky Market WELLCARE HEALTH PLANS, INC.

2:40 - 3:25 NO HCC LEFT BEHIND
Healthcare continues to be plagued by an incentive mismatch with MCOs reimbursed on a risk adjusted population basis and providers reimbursed via fee-for-service, reducing provider visibility into how their data submissions affect risk scores, CMS or state Medicaid payments and ultimately funds available for care. Risk scores, HCCs and quality scores are also affected by transition point gaps within the encounter lifecycle contributing to data loss, negatively impacting payments. Finally, ICD-10 could change which HCCs get coded based upon provider coding behavior. This session will explore how health plans can:
• Enhance provider engagement to improve coding accuracy
• Achieve end-to-end encounter visibility across all lines of business
• Employ strategies to mitigate data quality issues (including ICD-10 data) using proactive analyses and predictive modeling
Moderator:
Dawn Carter, Director Product Management, EDIFECS
Panelists:
Vik Anantha, Vice President, Financial Management, EDIFECS
Stephen Tenaglio, Senior Actuary of Reserves and Financial Forecasting, INDEPENDENCE BLUE CROSS

3:25 – 3:45 CONFERENCE ROUND-UP
In this unique re-cap session, join your colleagues one last time before heading home to discuss key take-aways, highlights and lessons learned from this exceptional event that will truly impact your respective organizations, and ultimately, the dynamic landscape of healthcare as a whole.

3:45 CONFERENCE CONCLUDES

PLATINUM SPONSORS

Optum is a health services company with more than 35,000 people dedicated to making the health system work better for everyone. Our solutions and services are used at nearly every point in the health care system, from provider selection to diagnosis and treatment, and from network management, administration and payments to the innovation of better medications, therapies and procedures. Our clients and partners include those who promote wellness, treat patients, pay for care, conduct research and develop, manage and deliver medications. With them, Optum is helping to improve the delivery, quality and cost effectiveness of health care.

MedSave USA is a full-service provider of Risk Adjustment services, offering a suite of Analytics, Record Retrieval, Prospective Home Assessments, and Coding products. These services are offered on a unique and proprietary technology platform that is designed for excellence in results, quality, and transparency. MedSave recognizes the importance of performance in these critical endeavors and provides the most and the deepest performance guarantees in the industry. We financially guarantee success in yield, timing, ROI, provider satisfaction, accuracy, quality and more. Further, we provide full transparency into all that we do for clients; allowing them to adapt quickly and maximize financial and clinical results. This includes unfiltered access to back-end systems, enabling clients to see – in real time – the smallest details of their projects’ status. MedSave serves most of the top national health plans as well as many regional and local plans.

Pulse8 is the only cutting-edge healthcare analytics and technology company that delivers an unprecedented view into risk adjustment enabling health plans to achieve the highest financial impact in the Commercial Health Exchanges, Medicare Advantage and Medicaid markets. Pulse8 is revolutionizing risk adjustment through innovative and unique products to ensure its clients outperform competitors. Utilizing transparent and flexible business intelligence tools, Pulse8 offers real-time visibility into member and provider activities so our clients can apply the most cost-effective and appropriate intervention. For additional company information, or to schedule a demonstration, contact Scott Fillault at 732.570.9095 or scott.fillault@pulse8.com. Please visit www.Pulse8.com and follow Pulse8 on twitter @Pulse8News for timely risk adjustment, analytics and industry updates.

CenseoHealth’s nationwide network of mobile physicians is bringing back the house call. Whether addressing the needs of the housebound, the disengaged or members in need of transitional care, home visits yield unique insights into the lifestyles of our members and patients. These insights fuel analytics using data not available in a traditional healthcare data set to drive smarter interventions and better outcomes. We call it care anywhere. Discover how our in-home physician program can improve your organization’s clinical outcomes at censeohealth.com

Matrix Medical Network. Quality, care and access are three constant pillars in the rapidly changing health care market. Capturing comprehensive diagnoses are key components of those pillars. And Matrix Medical Network, with the largest national network of Nurse Practitioners, is the leader in identifying gaps in care, medication compliance, social needs and safety issues in an environment where the member is most comfortable—in the home or skilled nursing facility. Because our leading health risk assessments evaluate the whole person, member satisfaction averages above 98 percent and the results change lives. But Matrix doesn’t stop at just assessments. Our expanded analytical and clinical capabilities are helping health plans across the country get ready for the next wave of health care reform. We help health plans change lives one member at a time.

HealthPort ChartSecure™ leverages HealthPort’s position as the authority on the compliant exchange of protected health information to offer health plans a uniquely effective model for medical record retrieval. HealthPort ChartSecure supports Medicaid and Medicare risk adjustment programs, and quality measurement and improvement programs such as HEDIS® and CMS Star Ratings. HealthPort® combines a staff of over 4,000 HIPAA-trained release of information specialists with HealthPort Connex™, the largest, most secure distribution network in the industry. HealthPort ChartSecure provides electronic request and delivery of medical records in ways that eliminate the request burden and improve the relationships for both providers and plans.
Peak focuses on delivering Risk Adjustment and Quality Solutions to provide our clients with full service and customized options that give you the ability to choose services which best meet your needs. Peak provides top quality staff, a state-of-the-art technology workflow, chart reviews, in-home assessments and chart retrieval specific to your needs. With Peak as your partner, you will receive quality, timely results from a caring team of professionals that will guide you through the challenges of this ever changing industry.

RecordFlow is an emerging industry leader who is focused on providing best in class, cost effective Revenue and Quality solutions for our health plan customers. Our robust technology suite and our team’s expertise and strong focus on operational excellence allow our clients the confidence to focus on their core business while knowing that their project is getting done right, the first time. We partner with health plans to satisfy their and Revenue and Quality objectives including:

- Medicare Risk Adjustment
- Commercial Risk Adjustment
- STAR Ratings
- Member Outreach
- ACO Quality Review
- HEDIS MRR
- Commercial QRS Review
- RADV / Data Validation
- Record Retrieval

Founded in 2005, RecordFlow is privately held and headquartered in Orange County, CA. Our mission is to help our clients increase revenues and reduce costs, without compromising quality.

DST Health Solutions, LLC, delivers contemporary healthcare technology and service solutions that enable clients to thrive in a complex, rapidly evolving market. Providing business solutions developed from a unique blend of industry experience, technological expertise, and service excellence, we assist our clients in improving efficiencies while also effectively managing the processes, information, and products that directly impact quality outcomes. Our portfolio of services and solutions, which includes enterprise payer platforms, population health management analytics, care management, and business process outsourcing solutions, are designed to assist clients in successfully managing their most important business functions while facilitating strategic and financial growth. We specifically support commercial, individual, and government-sponsored health plans, health insurance marketplaces, and healthcare providers in achieving the goal of affording the best possible care to their members each and every day. DST Health Solutions, LLC, is a wholly-owned subsidiary of DST Systems, Inc.

The FloChec® System Provides In-office Detection of Vascular Disease
With increasing focus on managing risk in an HCC (Hierarchical Condition Categories) environment and the need for accurate patient risk stratification, early identification of patients with vascular disease is critical. The FloChec® System helps primary care physicians identify additional patients under HCC 108 - Vascular Disease, which can add up to 0.3 to the Risk Adjusted Factor (RAF), resulting in 30% higher monthly payments.

FloChec testing can play an important role in improved patient care and financial performance by allowing earlier identification of PAD patients.

Edifecs is a leader in developing innovative, cost-cutting solutions to transform the global healthcare marketplace. Since 1996, Edifecs has provided technology that automates many administrative functions in order to trim waste and reduce costs as well as increase revenues, collaboration and operational performance. Customers who have benefited include healthcare providers, insurers, pharmacy benefit management companies, and other trading partners. More than 350 healthcare customers today use Edifecs solutions to simplify and unify financial, clinical and administrative transactions. They also use Edifecs technology to automate manual business processes (e.g., enrollment, claims and payments management) and to support compliance for HIPAA, Operating Rules and ICD-10 mandates. In addition, Edifecs develops supply chain management solutions to support worldwide customers in non-healthcare industry segments. Edifecs is based in Bellevue, WA, with operations internationally. Learn more about us at edifecs.com.

It’s premier solution is the HCC Optimizer, the only Risk Adjustment solution that combines computer advanced text mining and expert third party coder review, to deliver accurate and timely results at a lower cost for Medicare Advantage plans.

Advance Health is dedicated to assisting health insurance companies navigate the challenges of the current and future environment by helping members lead healthy and productive lives.

Advance Health offers prospective health risk assessment, readmission prevention and care management services. Our providers capture data about members using our proprietary iPad application. Electronic capture means data needed for a prospective campaign, HEDIS capture or care management initiatives are available almost instantly in a searchable database. We partner with our clients to offer real-time reporting and transparency into our operations.

Verisk Health is transforming the business of healthcare by providing data services, analytics, and advanced technologies that answer the industry’s most complex challenges. With a focus on reducing risk across all domains of healthcare, our solution suite is designed to help organizations better understand the health and risk of their populations to improve quality, reduce costs, ensure payment accuracy, and support compliance.

Verisk Health currently serves more than 220 health plans, including regional and national plans with commercial, Medicare, Medicare Advantage, and Medicaid lives. Combining expert insight with innovative technology, the Verisk Health suite empowers you to make better healthcare decisions. Solutions include:

- Risk-adjustment to optimize reimbursement for Medicare Advantage plans
- Solutions to drive compliance, revenue optimization and quality improvement
- Population Health Management to help contain costs, improve quality, and inform decisions.
- Clinical, analytical and technical expertise for fraud monitoring and claims accuracy

The core of every Verisk Health solution is fueled by the technological know-how, clinical genius, and analytical vision of our experts. We aggregate data, design models, and review billions of claims and over 100 million medical records to ensure your risk is mitigated, your data is validated, and your payments and reimbursements are accurate. From this foundation, we develop custom solutions to drive performance and achieve long-term measurable results—giving you access to a base of intelligence unlike any other.

PopHealthCare offers groundbreaking programs in high-risk population management that drive rapid, large, and demonstrable improvements in member quality of life and satisfaction, while helping its partnering health organizations realize appropriately enhanced revenues, enhanced quality scores, and reduced medical costs. With decades of experience, PopHealthCare is led by a team of long-standing leaders in health care analytics, field-based high-risk population care delivery, quality improvement, and both prospective and retrospective risk adjustment services. PopHealthCare has designed its high impact services to meet the needs of local, regional and national health plans and provider organizations and currently partners with over 30 health plans across the U.S. and in Puerto Rico.

Altegra Health is a national provider of technology-enabled, end-to-end payment solutions providing health plans and other risk-bearing organizations with the data they need to expertly manage member care and ensure appropriate reimbursement. The power of Altegra Health’s advanced analytics and supporting interventions enables healthcare organizations to elevate care quality, optimize financial performance, and enhance the member experience.
Inovalon is a leading technology company that combines advanced data analytics with highly targeted interventions to achieve meaningful impact in clinical and quality outcomes, utilization, and financial performance across the healthcare landscape. Inovalon’s unique achievement of value is delivered through the effective progression of Turning Data into Insight, and Insight into Action®. Large proprietary datasets, advanced integration technologies, sophisticated predictive analytics, and deep subject matter expertise deliver a seamless, end-to-end platform of technology and nationwide operations that bring the benefits of big data and large-scale analytics to the point of care. Driven by data, Inovalon uniquely identifies gaps in care, quality, data integrity, and financial performance – while also bringing to bear the unique capabilities to resolve them. Touching more than 540,000 physicians, 220,000 clinical facilities, and more than 140 million Americans, this differentiating combination provides a powerful solution suite that drives high-value impact, improving quality and economics for health plans, ACOs, hospitals, physicians, patients, and researchers.

“Patient Care and Understanding is our focus”

Mobile Medical Examination Services, Inc. “MEDXM” was founded in 1990. Our mission is to provide the most qualified Medical Doctors and other Mid-Level Medical Professionals, equipped with the latest medical devices and diagnostic equipment to our clients. We have built a vast network of medical professionals throughout the USA. From the start, our growth has been fueled by an insistence of quality and service. We provide a vast array of medical services in the privacy of the client’s home. We pride ourselves in making a difference and serving a purpose with your member’s wellbeing. MEDXM would like to be a part of your efficient, proactive and sound management strategy and help your plan realize better financial performance.

Centauri Health Solutions improves member outcomes and financial performance for health plans and at-risk providers by supporting initiatives in Risk Adjustment, RADV Risk Mitigation, HEDIS, Star Ratings, and Care Gap Management.

Our consultative approach delivers compliant end-to-end solutions that leverage clinically-rich data analytics, workflow software tools, and other technology and service resources. We identify risk adjustment gaps, care and quality gaps, and support the closure of those gaps to benefit our clients and their members. We know from experience that data alone is not enough – the combination of data, experience, and execution is required to improve outcomes in today’s environment.

Centauri’s core leadership team is comprised of seasoned healthcare executives from managed care organizations, pharmacy benefit managers and HCIT companies. They understand from personal experience the challenges facing today’s health system – and have set out to resolve them in a better way for their clients and their members / patients.

Centauri partners with respected Medicare Advantage, Managed Medicaid and Health Insurance Exchange plans, as well as at-risk provider groups to answer critical business questions such as whether they are impacting the members who are the most at-risk, how much financial exposure they may face due to RADV audit and compliance risk, and whether they are optimally utilizing their scarce resources.

Risk Adjustment | RADV Risk Mitigation | HEDIS | Star Ratings | Care Gap Management

ComplexCare Solutions, Inc. is a national care management and assessment company. CCS’ services drive quality health outcomes, high member satisfaction, lower costs, and appropriate reimbursement. Through CCS’ deep collaboration with the health plan’s care management team, CCS has a strong ROI record in lower readmissions and improved STAR measures. We extend the reach of the health plan’s care management departments into the member’s home to develop care plans, implement interventions, and strengthen or initiate the member’s PCP relationship.

Cognisight is a leading health care solutions provider, specializing in risk adjustment services for Medicare Advantage, Medicaid Managed Care, PACE plans, and issuers on and off the Health Insurance Exchange. Born out of the Greater Rochester Independent Practice Association (GRIPA), a member organization comprised of nearly 1,000 physicians, we know providers and plans because we are providers and plan leaders. At Cognisight our mission is simple: capture the most accurate and complete information to help ensure our clients have the best information to care for their members. As HCC risk adjustment experts, we enable our clients to improve the quality of health care they deliver while maximizing efficiency and assuring accurate revenue. Our continuum of comprehensive risk adjustment services include:

- Analytics
- Retrospective/Concurrent Chart Reviews
- Health Risk Assessments
- Risk Adjustment Data Validation (RADV/IVRA)
- Risk Verification
- Provider & Coder Training

For more information please visit Cognisight.com, email info@Cognisight.com, or call (877) 271-1657.

Your Home Advantage, Inc. (YHA) is leading the way in Clinical Outcomes and Member Health by bridging the gap between the physicians’ office and the patients’ home. Our services include, Health Risk Assessments, Annual Wellness Visits, Chronic Care Program, Chart Reviews, and Data Analytics. YHA’s Health Risk Assessments are conducted by MRA trained clinicians to clarify current health status and identify opportunities for intervention, which facilitates PCP follow up, as recommended by CMS. Our Chronic Care program enables an in-home delivery model to promote patient self-management and education through a personalized care plan. The program includes social services, RN Case Management, as well as 24-hour access to a YHA clinician. Providing comprehensive Chart Reviews, a customized program can better impact HCC management as well as identify clinical opportunities, and necessitate physician involvement. For more information please visit www.homeadvantageinc.com, or contact Dr. Martin Santiago, CMO, at MSantiago@homeadvantageinc.com.

Dynamic Healthcare Systems, Inc. is a strategic business partner to Health Plans participating in government-sponsored programs. Our comprehensive solutions address the following business areas of a Health Plan’s operations: Enrollment processing, MSP/COB, Correspondence/Fulfillment, Plan Reconciliation, Risk Adjustment Analytics/Data Submission, Encounter Data Processing, PDE Data Management/Audit, and Member Premium Billing Processing.

Gorman Health Group, LLC (GHG) is a leading consulting and software solutions firm specializing in government health programs, including Medicare managed care, Medicaid and Health Insurance Exchange opportunities. For nearly 20 years, our unparalleled teams of subject-matter experts, former health plan executives and seasoned healthcare regulators have provided strategic, operational, financial, and clinical services to the industry, across a full spectrum of business needs. Further, our software solutions have continued to place efficient and compliant operations within our client’s reach. Find out more at www.gormanhealthgroup.com.

Alegis Care is a national company that provides direct patient care, comprehensive health assessments, chronic care management, SNFist, and value-based purchasing services. Alegis Care has over 19 years of experience. Our physicians provide chronic care management resulting in successfully reducing MLR, admissions, readmissions and increasing STAR and HEDIS ratings.

Our program is made up of face-to-face interactions with members in their homes or wherever they reside. We provide services to Medicare Advantage/Medicaid and 55% of the members we service daily are dual eligible. For additional information, please contact Michael Doherty, Senior Vice President of Sales, at 954.648.4773 or mdoherty@alegiscare.com.
ECS is the nation's largest and most secure provider of medical record retrieval services. ECS processes 3,000,000+ medical records retrieval requests from 65,000+ physician offices annually. ECS's 2,500+ onsite retrieval personnel and 350+ person call center leverage the industry’s most proven and robust technology platform, ChartFinder, to ensure customer and provider satisfaction throughout the retrieval process. In addition to retrieving paper and electronic medical records for Risk Adjustment (Commercial, Medicare, Medicaid), HEDIS and RADV audits, ECS can distribute and retrieve any document from any provider office at any time.

Health Data Vision, Inc. provides a Software-as-a-Service platform addressing the critical and rapidly changing needs around clinical data collection and analytics. Solutions and services address the increasingly co-dependent functions of Quality (HEDIS), Medicare Advantage 5-STAR, Risk Adjustment and Care Management, as well as strategic Revenue Optimization for Payers and ACOs.

Health Data Vision, Inc. offers new and flexible approaches for Payers and Providers alike. Innovation and automation span everything from Medical Records retrieval, chart abstraction and coding, to audit preparation and audit defense. The scalability of HDVI's platform allows payers and providers to complete their critical initiatives with the flexibility to meet their needs and circumstances, while leveraging technology and best practices to achieve outstanding results. HDVI’s patent-pending, process-centric approach provides unprecedented quality control and audit response features, as well as real-time analytics on clinical and project metrics—all critical components for success in the newly emerging healthcare landscape.

Health Data Vision, Inc. has offices in California and Massachusetts, with clients throughout the United States.

Blue Health Intelligence (BHI) is the nation’s premiere health intelligence resource, delivering data-driven insights resulting in healthier lives and more affordable access to safe, effective care.

As an analytic center of excellence, we create leading-edge tools like Xchange Advisor. This solution improves risk-score accuracy by targeting the most impactful members and providers for diagnosis capture, prospective engagement and improvements. Your benefit is greater control, transparency and flexibility to manage goals, streamline operations, and address local challenges. The power to BHI’s insights is accessing healthcare claims data from more than 140 million lives nationwide, collected over nine years, in a safe, HIPAA-compliant and secure database. The resulting conformed, reliable data set has the broadest, deepest pool of integrated medical and pharmacy claims, reflecting medical utilization in every ZIP code.

Blue Health Intelligence is an LLC and independent licensee of the Blue Cross and Blue Shield Association. For more information, visit www.bluehealthintelligence.com

For over 100 years, MIB has been the industry standard for assessing applicant risk in 450 North American life and health insurance companies. To help our members adapt to healthcare reform, MIB introduces HealthRisk ID, an innovative service that lets insurers sort through the undifferentiated mass of new enrollees, identifying those with “qualified medical conditions” to fast-track into risk adjustment workflows. And, HealthRisk ID spots those individuals who can immediately benefit from disease management and wellness programs.

HealthRisk ID informs through diagnosed medical conditions, lab test results, physical exams, self-admitted health information and tobacco use so health plans can be proactive with their risk assessment practices. Learn more at the MIB booth or visit: www.mibgroup.com/healthriskID.

Epsiose is a leading services provider for chart reviews and quality measure abstraction for Medicare Advantage, Commercial/ HIX, Medicaid health plans, and ACOs across the United States.

Using an integrated global delivery methodology, with onshore and offshore Medical Professionals, Clinicians, and Certified Coders, Epsiose is able to provide extensive and quality Medical Record Review Services with significant cost savings to increase ROI on organizations’ Risk Adjustment and Government affiliated Programs. We began by providing medical coding solutions to both provider and payer organizations. Over the last five years we have expanded our core service offerings to include: RADV/IVA Audit Support, Home Health Assessments, HEDIS Abstraction, ACO GPRO reporting, and medical record retrieval. Our vision is to provide health information exchange solutions that allow healthcare organizations to safely and efficiently manage member-centric data, quality of care initiatives, member intervention and risk adjustment programs in Medicare, Medicaid, Commercial and Health Insurance Exchanges.

Health Dialog is a leader in population health management solutions. The company works with the nation’s largest third-party payers, employers and providers – as well as Health Dialog’s parent company, Rite Aid – to improve the health and wellness of their members, employees, patients and customers while reducing costs and improving performance in key quality measures, such as NCQA’s HEDIS and CMS’ Stars ratings. Health Dialog’s unique capabilities include data analytics, a multi-media coaching platform, and a 24/7 nurse line.

For more information, visit www.healthdialog.com.

PointRight is the industry-standard analytics leader that enable healthcare providers and payers to measure risk, quality of care, rehospitalization, compliance and reimbursement accuracy. Using some of the largest and best databases in the industry, PointRight’s nationally recognized clinical staff, researchers, and technologists expertly translate data from multiple sources into actionable information and insight. Founded in 1995, PointRight is the leader in analytics for post-acute care, with over 40 million Minimum Data Set (MDS) patient assessments from SNFs nationwide. The PointRight Pulse™ analytics suite helps prevent high-cost events, such as pressure ulcers and falls, while also delivering these benefits:

- Mortality prediction for hospice/palliative care placement
- Reduced readmissions
- Acute-to-SNF matching
- Medicare risk adjustment for SNF-based members
- Medicaid rebalancing
- Long-term services and support analytics

Visit www.pointright.com or call 781.457.5900.

SILVER SPONSORS

For over 100 years, MIB has been the industry standard for assessing applicant risk in 450 North American life and health insurance companies. To help our members adapt to healthcare reform, MIB introduces HealthRisk ID, an innovative service that lets insurers sort through the undifferentiated mass of new enrollees, identifying those with “qualified medical conditions” to fast-track into risk adjustment workflows. And, HealthRisk ID spots those individuals who can immediately benefit from disease management and wellness programs.

HealthRisk ID informs through diagnosed medical conditions, lab test results, physical exams, self-admitted health information and tobacco use so health plans can be proactive with their risk assessment practices. Learn more at the MIB booth or visit: www.mibgroup.com/healthriskID.

AE & Associates, LLC, is a premier healthcare staffing, auditing, consulting and education firm with 11+ years experience in providing quality medical records coding services, as well as chart scanning. We guarantee a 95% accuracy rate in medical coding, staff physician auditing the auditors, we understand and implement CMS guidelines and specialized in Hierarchical Condition Categories. www.aeandassociatesllc.com.

Services
- HCC Risk Adjustment Retrospective and Prospective Chart Reviews - correct coding to the highest specificity, based on the provider documentation, to maximize risk scores
- Coder education on HCC Risk Adjustment criteria for coding and documentation
- Physician education on documentation and coding for HCC Risk Adjustment
- Mock RADV audits
Healthtel is a member engagement company that applies a proven approach focused on exceptional design and execution of flexible engagement systems. We design dynamic member experiences that meet business objectives and drive results. We get it right by using proven communication channels to create individual conversations and experiences with the people you want to reach. Each result-driven communication experience builds upon itself... continuously improving to meet your objectives. We are here for one reason: to lead our clients to better results. To learn more visit us at www.healthtel.net.

Bloom is an insurance services company with a focus on compliance, experienced staff, technology and a desire to produce custom solutions that meet our clients’ business needs. Since 2007, Bloom has participated in 55 million+ conversations about insurance, submitted over 160,000 applications for insurance, and set over 110,000 home visits for field agents. With nearly three dozen insurance carrier clients and an investment in technology available only at Bloom, we have a turnkey operation and management infrastructure that is capable of executing so seamlessly, it is as if we were part of your organization.

Carenet partners with leading Medicare Advantage health plans across the country. By teaming consumer marketing and clinical expertise with progressive technology, our Medicare Star Advantage solution increases member engagement and helps optimize revenue, manage risk, reduce costs, sustain growth and improve star ratings. By proactively connecting with members throughout the year to complete HRAs, schedule HEDIS screenings and annual provider visits, increase medication adherence and conduct annual surveys, we deliver the results MA Plans need to thrive.

Indegene Healthcare, is a leading integrated provider of end-to-end Risk Adjustment, HEDIS/STARs rating improvement, and provider engagement solutions. With over 1200+ healthcare experts across the globe, Indegene brings its rich clinical expertise, proprietary analytics models, education outreach, and training capabilities that enable payers and providers to thrive by driving better business and health outcomes. Leveraging its strong intellectual property and innovation capabilities, Indegene deploys a portfolio of next-generation platforms in quality improvement, risk adjustment, and provider engagement to drive integrated outcomes and business success for its clients.

Allscripts (NASDAQ: MDRX) delivers the insights that healthcare providers require to generate world-class outcomes. The company’s Electronic Health Record, practice management and other clinical, revenue cycle, connectivity and information solutions create a Connected Community of Health™ for physicians, hospitals and post-acute organizations. To learn more about Allscripts, please visit www.allscripts.com.

Bloom provides quality, risk and compliance solutions using our BenchMark Software-as-a-Service platform. Some of the top health plans use our platform for an aggregate network of over 375,000 providers. Avoir’s Star Module helps payers improve their HEDIS metrics and Part C Star Ratings via an automated, online communication process between the plan and the provider. This allows plans to quickly and efficiently engage providers by identifying the gaps in care for each member and giving them easy-to-view reports and tools. Providers give on-line feedback on each item for a closed loop process that helps improve and protect your rating by addressing all gaps in care. This solution also provides a complete audit trail of all activities which complies with CMS and NCOA guidelines. Please visit www.avior.com for more information.

Indegene is a member engagement company that applies a proven approach focused on exceptional design and execution of flexible engagement systems. We design dynamic member experiences that meet business objectives and drive results. We get it right by using proven communication channels to create individual conversations and experiences with the people you want to reach. Each result-driven communication experience builds upon itself... continuously improving to meet your objectives. We are here for one reason: to lead our clients to better results. To learn more visit us at www.avior.com.
Since 1985, Medical Data Exchange (MDX) has been serving the Healthcare Industry by creating systems that process healthcare fiscal and clinical data. MDX provides a suite of products consisting of MAX II (hospital claims system), AXIS Physician Practice Management, VChart (EHR), AXIS IPA Management (IPA/MSO/TPA management system), HCC Manager (risk adjustment), P4P, and integrated Case Management systems to support hospitals, health plans and physician organizations. Our systematic applications assist healthcare organizations to move toward integrated healthcare data management in order to optimize quality of care and cost-effective models of care management. For more information call MDX Business Development at (562) 256-3800.

Predilytics is a healthcare information technology company that helps drive decisions that improve population health, quality of care, and business performance. Using patented machine learning analytic tools, we identify opportunities at an individual consumer level, prioritize them based on receptivity to engagement, and identify actions to realize the greatest value.

Looking for Healthcare Providers?
PPR TMG is the leading recruitment organization partnering with risk adjustment organizations and health plans that need healthcare professionals to perform prospective health risk assessments.

We hire your Health Providers so you don’t have too.
PPR TMG will recruit, hire and manage your healthcare providers allowing for quicker starts and the ability to flex your staff up or down based on your project needs. Most importantly, we eliminate your recruiting costs and the hassles of managing healthcare professionals.

We can Manage it All!
No more hiring costs, employees, payroll or benefits management.

Health Solutions Plus (HSP) is a U.S. based leading provider of payer software solutions that solves federally sponsored program business problems by automating processes and supplying the tools to enable adherence to stringent, complicated and changing CMS and state standards. The HSP Payer Suite is an Enterprise payer platform that incorporates core claims, customer service reporting, eligibility, document management and fulfillment into a single system that supports your Medicare, Medicaid and Dual Eligible lines of business, helping you to streamline your operations and differentiate your organization in the market. The HSP Payer Suite will provide you with the tools to optimize risk adjustment reimbursement and improve STAR ratings and Quality Measurements. The HSP Payer Suite ensures your readiness for government program requirements with analytics and customizable workflow processes built into the solution.

For more information visit us at the HSP booth or our website at www.hspweb.com or contact us at 800.244.8718.

Clear Vision Information Systems, Inc. is a risk adjustment and HEDIS/Stars solutions company that balances care, quality and revenue optimization for Medicare Advantage health plans and provider groups. Clear Vision provides an integrated mix of risk adjustment analytics and continuity-of-care strategies tailored to the individual needs of each client. The easy-to-implement, high-impact software and services Clear Vision delivers results in improved risk scores and measurable return on investment. Our product offerings and services include:

- Risk Adjustment Analytics
- HEDIS and Stars Tracking
- Inpatient Data Pursuit
- Patient and Provider Outreach,
- Coding and Data Collection
- CMS-Rejected Diagnosis Tracking and Correction

Our decades of experience at the forefront of Medicare policy translate into a deep understanding of the business processes, risk adjustment strategies and best practices that improve care and optimize revenue.

Clear Vision is headquartered in Westlake Village, California and serves clients nationwide. Please contact us at www.cvinfosys.com or toll-free at 888-778-9899.

RelayHealth Pharmacy Solutions (RHPS) connects more than 50,000 retail pharmacies to health plans, government agencies and pharmaceutical manufacturers. With the industry’s most reliable and scalable network, RHPS supports retail pharmacies’ efforts to improve medication accessibility and adherence and deliver value-added, cost effective clinical services that improve patient health and outcomes. To learn more, visit relayhealth.com, call 888.743.8735 or email pharmacy.connections@relayhealth.com.

Vatica Health offers analytic services, member engagement programs, wellness networks, and cloud-based technology to maximize the penetration and value of Annual Wellness Visits (AWVs) delivered in a clinical setting. We enable providers to streamline the delivery of AWVs for all Medicare beneficiaries and automate the capture of HCC codes and quality measures for Medicare Advantage health plans and Medicare ACOs. Our comprehensive solutions produce attractive returns and can be implemented quickly on a large scale.

Synaptic Advisory Partners offers innovative care management and care coordination applications built on the world’s leading CRM platform, Salesforce.com. Our flagship solution, SynapseTM, provides healthcare organizations with an easy way to identify at-risk individuals within a population, schedule visits with providers in the home and clinic, assess the health and needs of the population using a smart assessments engine, and create personalized care plans.
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Payments must be received no later than March 18, 2015

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INCOMPLETE MAILING INFORMATION: If you are receiving multiple mailings, have updated information or would like to be removed from our database, please fax our database team at 704-341-2641 or call 704-341-2387. Please keep in mind that amendments can take up to 8 weeks.

Best Practices and Actionable Tools for Improving Risk Adjustment & Achieving Exceptional Quality Performance

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