The Summer of Risk Adjustment Love

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We are a network of health care professionals addressing the challenges posed by the emerging landscape of value-based care and government health care reform.

OUR MISSION

Our mission is to provide a community for like-minded professionals to come together for networking, education, and industry collaboration to stay ahead and advance their careers.

ONE ASSOCIATION

THREE COMMUNITIES

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Agenda

1

Where Are We & Where Are We Going?

- Current state of risk adjustment analytics and associated problems
- Next-generation risk adjustment analytics barriers
- Your old partner is your new partner

2

Overcoming Barriers, Use Cases & Best Practices

- Health plan example
- Risk-bearing organization example
- Provider engagement best practices

3

Value and the Path Forward

- Operationalizing next-gen risk adjustment
- Value and next steps

4

Q & A

- Let the experts answer your questions!

Where are we &
Where are we going?

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Analytics In Risk Adjustment

Business Norms

Risk Analytics Opportunities

Suspecting

Identify missing and mis-coded diagnosis codes

Targeting

Identify the best intervention or medical record to close documentation / care gaps

Interventions

Identify diagnostic conditions documented in progress notes

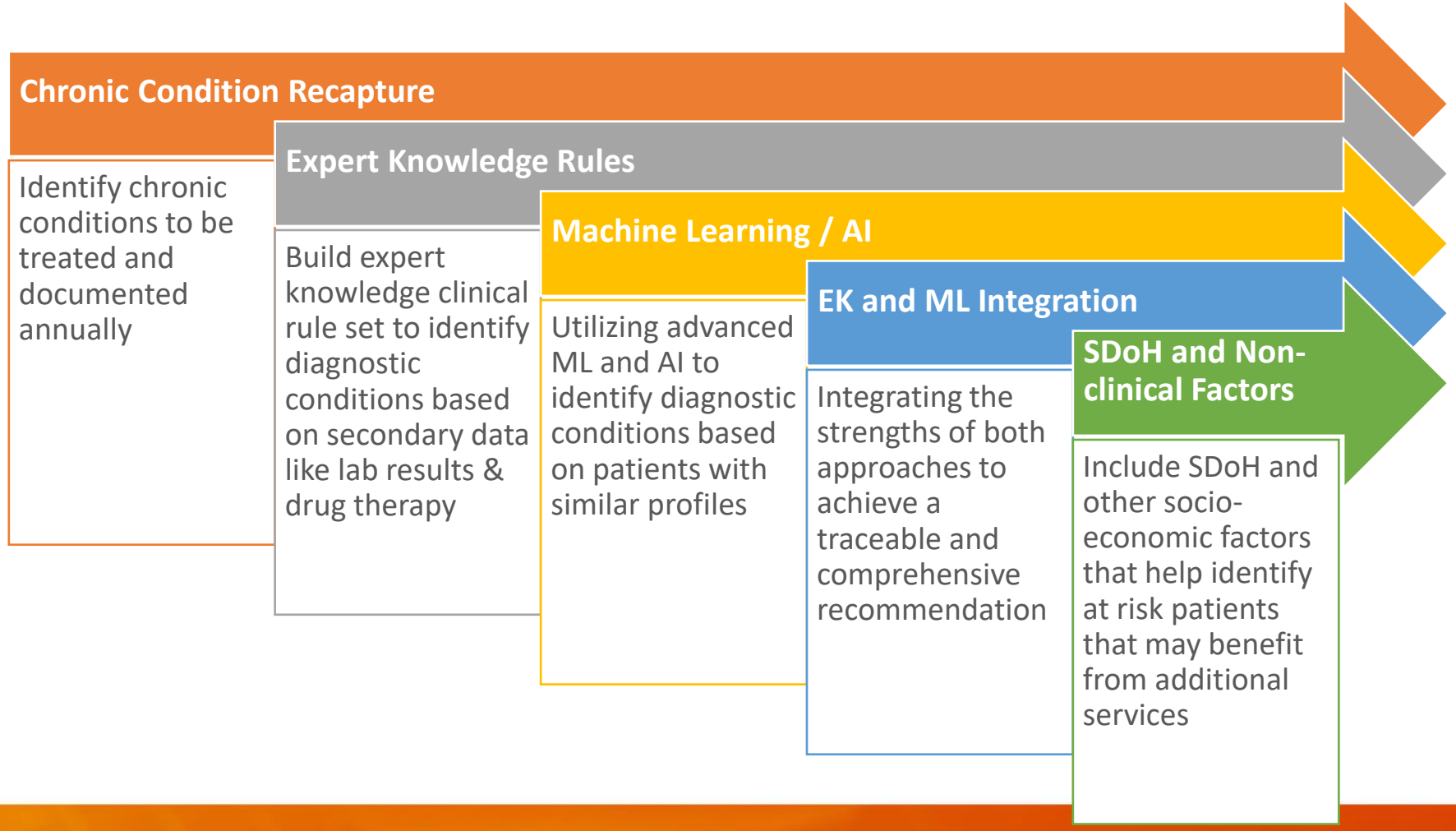
Submissions

Link chart reviews to existing medical claims

Interventions

Identify the best intervention or medical record to close documentation / care gaps

Analytics In Risk Adjustment Suspecting Evolution



Innovative Market Trends

Cloud Computing (SaaS)	AI and Machine Learning	Robotic Process Automation (RPA)	Interoperability (FHIR)
			
• 85% of enterprise organizations will be using cloud services for business-critical functions – Gartner • Driving the shift from analog and physical assets to digital assets	• ML mimics the brain's ability to review information and make recommendations • 40% of firms expect to increase investment in AI/ML in 2021 • NLP unlocking 80% of clinical information	• Automates manual operational processes that are repetitive and prone to error • 69% of data processing and 64% of data collection operations can potentially be automated	• Loosely couple payers, providers and systems using a standard semantic data interface • Government mandated to implement…market requirement

Barriers to Next-Gen RA Analytics

Interoperability and Quality of Data	• FHIR and other government mandated interfaces are unlocking data that is traditionally stored in proprietary formats. Does not adjust for data bias.
Technical Debt and Legacy Systems	• Sunk capital costs in equipment, systems and propitiatory applications • Innovation requires new skills and a change in culture
Innovating an entire ecosystem (one bite at a time)	• Moving from proprietary to standard data formats • Change management – people
Culture of Innovation	• Innovation requires new skills, change in culture and the way problems are solved

Your Old Partner is Your New Partner

Payers and Providers are Integrating Care

- Payers contract with networks to deliver care to patients
- Staff models and Integrated Delivery Systems blur care models
- Payers deliver care though retail and mobile clinics

Aligning Incentives between Payers and Providers

- Value-based care aligns the goals of the payer with the actions of the provider
- Transparency to payment models and metrics build trust

Delivery of Care Systems Shift

- Telemedicine, in-home and retail and mobile clinics shift primary care to new models
- AI and drone delivery innovations will drive just-in time medicine

Healthcare Benefits Redesigned

- SDoH are shown to drive health outcomes
- Plans are expanding health benefits to include housing, food, internet access, etc.

How It Works – Transactional Risk Analytics

Step 1

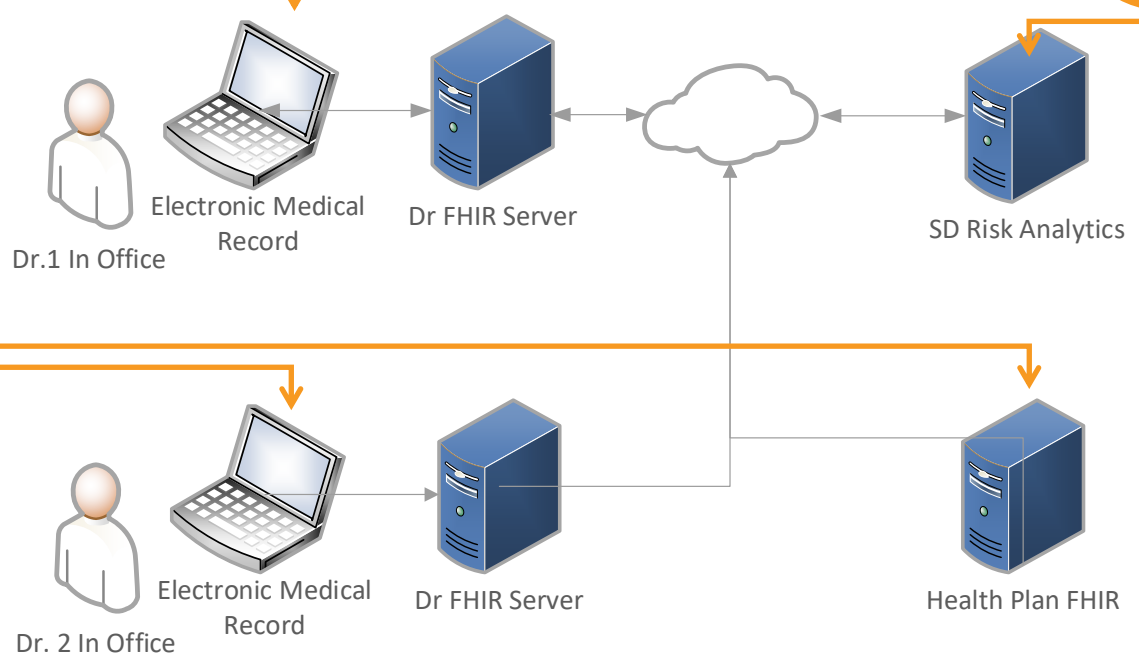
Dr.1 requests updated patient information from the plan and Drs in the care team using an EMR/FHIR request

Step 2

Dr.2's FHIR server and the plan will send the requested information to Dr.1 on demand

Step 3

Risk analytics service will update the risk suspects and targeting for Dr.1 based on the updated information before and after the visit



Overcoming Barriers, Use Cases & Best Practices

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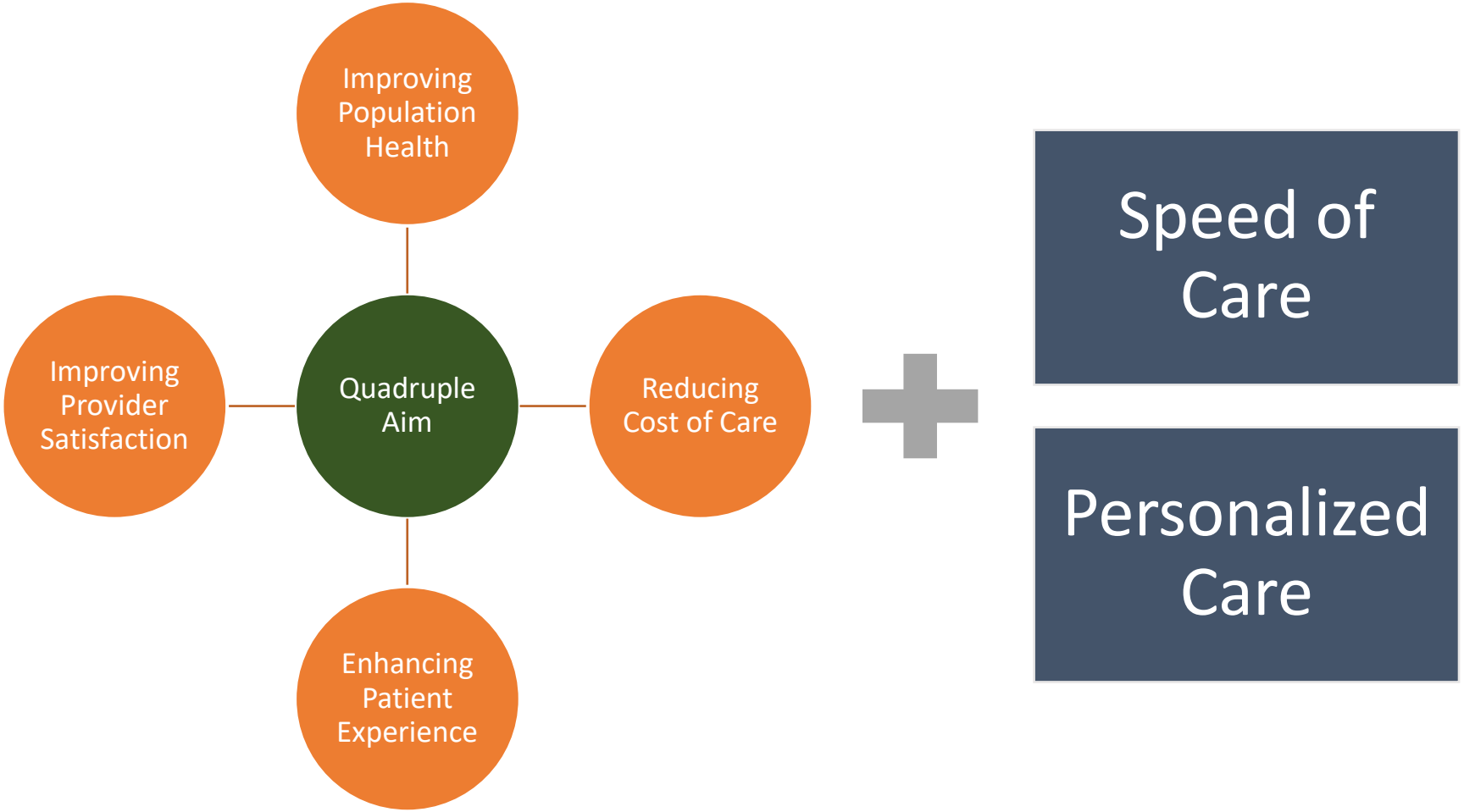
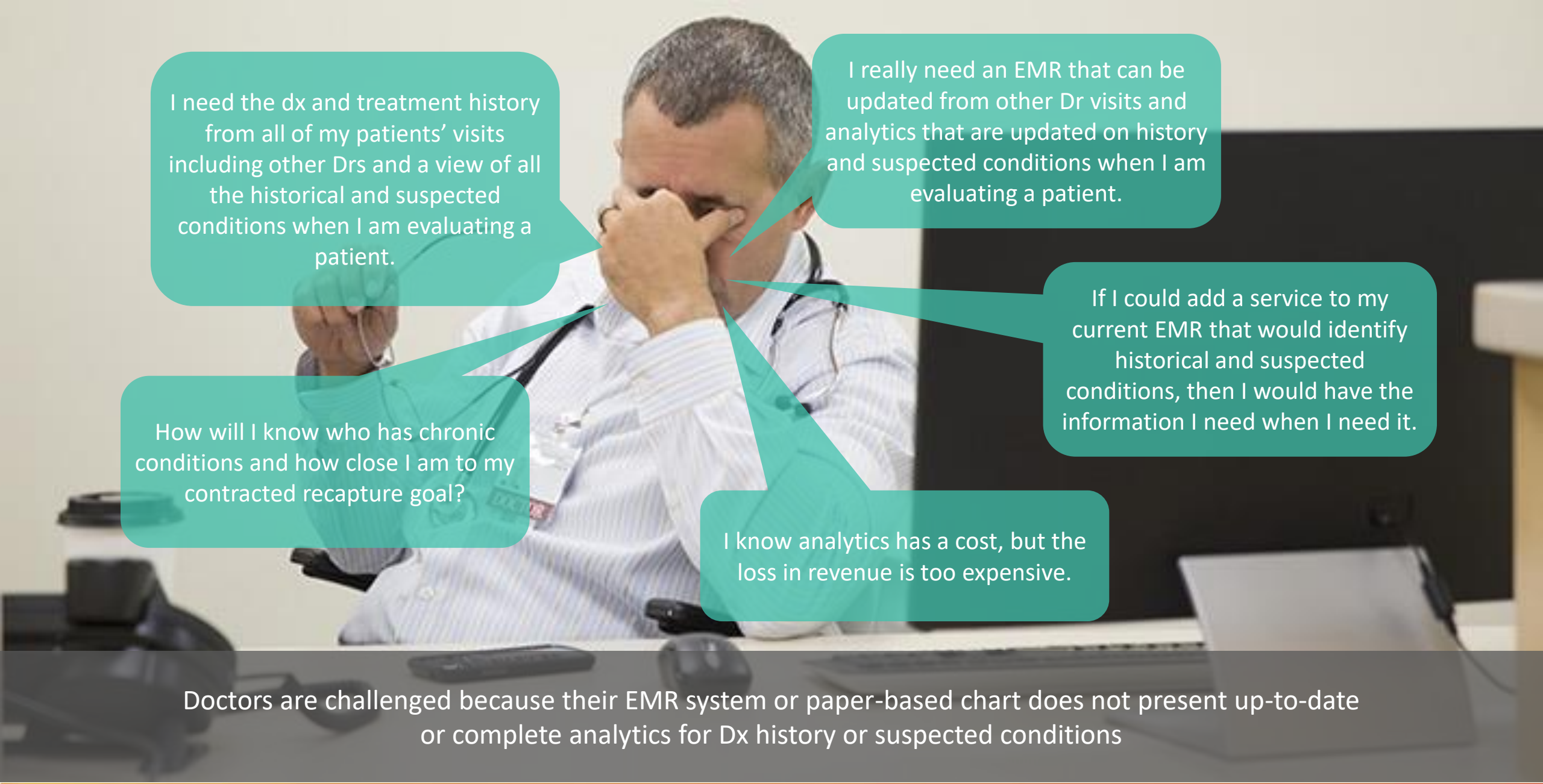
Next-Gen Analytics Impact and Outcomes



Plans are entering into value-based contracts with providers,
but the details for evaluation/verification are still a work in progress

Today, many doctors rely on patient memory and feedback for some of the follow up feedback. Additionally, doctors often don't have a complete history of chronic historical and suspected conditions when evaluating patients – leading to incomplete evaluations and treatment plans.



Doctors are challenged because their EMR system or paper-based chart does not present up-to-date or complete analytics for Dx history or suspected conditions

Because the doctor has access to current and complete information and analytics, they will be able to improve the care delivered, improve the patient experience and reduce the cost of care by avoiding duplication of services

MANAGERIAL

Value-Based Contracting Innovated Medicare Advantage Healthcare Delivery and Improved Survival

Aloke K. Mandal, MD, PhD; Gene K. Tagomori, BSc; Randell V. Felix, BSc; and Scott C. Howell, DO, MPH&TM

In caring for traditional Medicare beneficiaries, primary care physicians will need to transform their clinical practice and assume more fiduciary risk. CMS recently published "new policies to address and incentivize participation in alternative payment models" (APMs).[1] An APM broadly can be defined as any reimbursement model other than strict fee-for-service (FFS). Currently, 30% of traditional FFS Medicare is reimbursed through APMs, with the goal of 50% involvement by 2018.[1,2] Clinicians who want to become qualifying APM participants can expect to "bear more than a nominal amount of risk for monetary losses."[3] Through APMs and increasing risk assumption, these new policies aspire to promulgate high-value healthcare, as defined by "better care, smarter spending, and healthier people."[1,2] Whether FFS divestiture in favor of APMs and increasing capitation can generate cost efficiencies and also improve clinical outcomes remains debatable.[4,5]

Medicare Advantage (MA) provides an alternative to traditional FFS Medicare. It has been a commercial success, accounting for 17.5 million (30.6%) of all Medicare enrollees and $204.7 billion (28.9%) of Medicare's 2017 gross spending budget.[6,7] Because it is regulated by its own federal statutes,[8] MA is classified as an "Other Payer APM" and excluded from CMS' Proposed Rule for Medicare FFS.[1] For over a decade, MA has used the CMS Hierarchical Condition Categories (CMS-HCC) payment model to reimburse private plans (Medicare Advantage Organizations [MAOs]) with prospective, monthly, risk-adjusted or health-based capitated payments for the care of MA enrollees. The value of subsidizing MA often has been challenged.[9,10] Consequently, on October 3, 2016, CMS' Innovation Center (CMMI) announced its Medicare Advantage Value-Based Insurance Design (VBID) model to test whether new initiatives can "improve health outcomes and lower expenditures for Medicare Advantage enrollees."[11]

CMS adopted the CMS-HCC payment model with the concept that MAO recompense should reflect the disease and related cost burdens of the pertinent population and, thus, fundamentally changed how MAOs are reimbursed.[12-15] In return for providing healthcare benefits to MA enrollees during the calendar year (CY),

ABSTRACT

OBJECTIVES: In Medicare Advantage (MA) with its CMS Hierarchical Condition Categories (CMS-HCC) payment model, CMS reimburses private plans (Medicare Advantage Organizations [MAOs]) with prospective, monthly, health-based or risk-adjusted, capitated payments. The effect of this payment methodology on healthcare delivery remains debatable. How value-based contracting generates cost efficiencies and improves clinical outcomes in MA is studied.

STUDY DESIGN: A difference in contracting arrangements between an MAO and 2 provider groups facilitated an intervention-control, preintervention-postintervention, difference-in-differences approach among statistically similar, elderly, community-dwelling MA enrollees within one metropolitan statistical area.

METHODS: Starting in 2009, for intervention-group MA enrollees, the MAO and a provider group agreed to full-risk capitation combined with a revenue gainshare. The gainshare was based on increases in the Risk Adjustment Factor (RAF), which modified the CMS-HCC payments. For the control group, the MAO continued to reimburse another provider group through fee-for-service. RAF, utilization, and survival were followed until December 31, 2012.

RESULTS: The intervention group's mean RAF increased significantly ($P < .001$), estimating $2,519,544 per 1000 members of additional revenue. The intervention increased office-based visits ($P < .001$). Emergency department visits ($P < .001$) and inpatient hospital admissions ($P = .002$) decreased. This change in utilization saved $2,071,293 per 1000 enrollees. By intensifying office-based care for these MA enrollees with multiple comorbidities, a 6% survival benefit with a 32.8% lower hazard of death ($P < .001$) was achieved.

CONCLUSIONS: Value-based contracting can drive utilization patterns and improve clinical outcomes among chronically ill, elderly MA members.

Am J Manag Care. 2017;23(2):e41-e49

Why Does Risk Adjustment Matter?

How does contractual design affect care management outcomes?

- Two clinics 2–19 miles from each other
- Both accredited as Patient-Centered Primary Care

Medical Group Structure: Capitated vs FFS
Methodologies Employed:

- Propensity Score
- Nearest Neighbor Matching
- Randomization Inference (Permutation Testing)
- Pre-Intervention/Post-Intervention
- Difference-in-Differences Analysis

Value and the Path Forward

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Operationalizing Next-Gen Risk Adjustment Analytics – Key Issues

Data Integration and Quality

- Investing in industry-adopted interoperability initiatives like FHIR – active participant in innovations

HIPAA and Patient Privacy and Access to Information

- Ensuring HIPAA privacy and security are enforced
- Develop and adopt patient consent workflows and systems

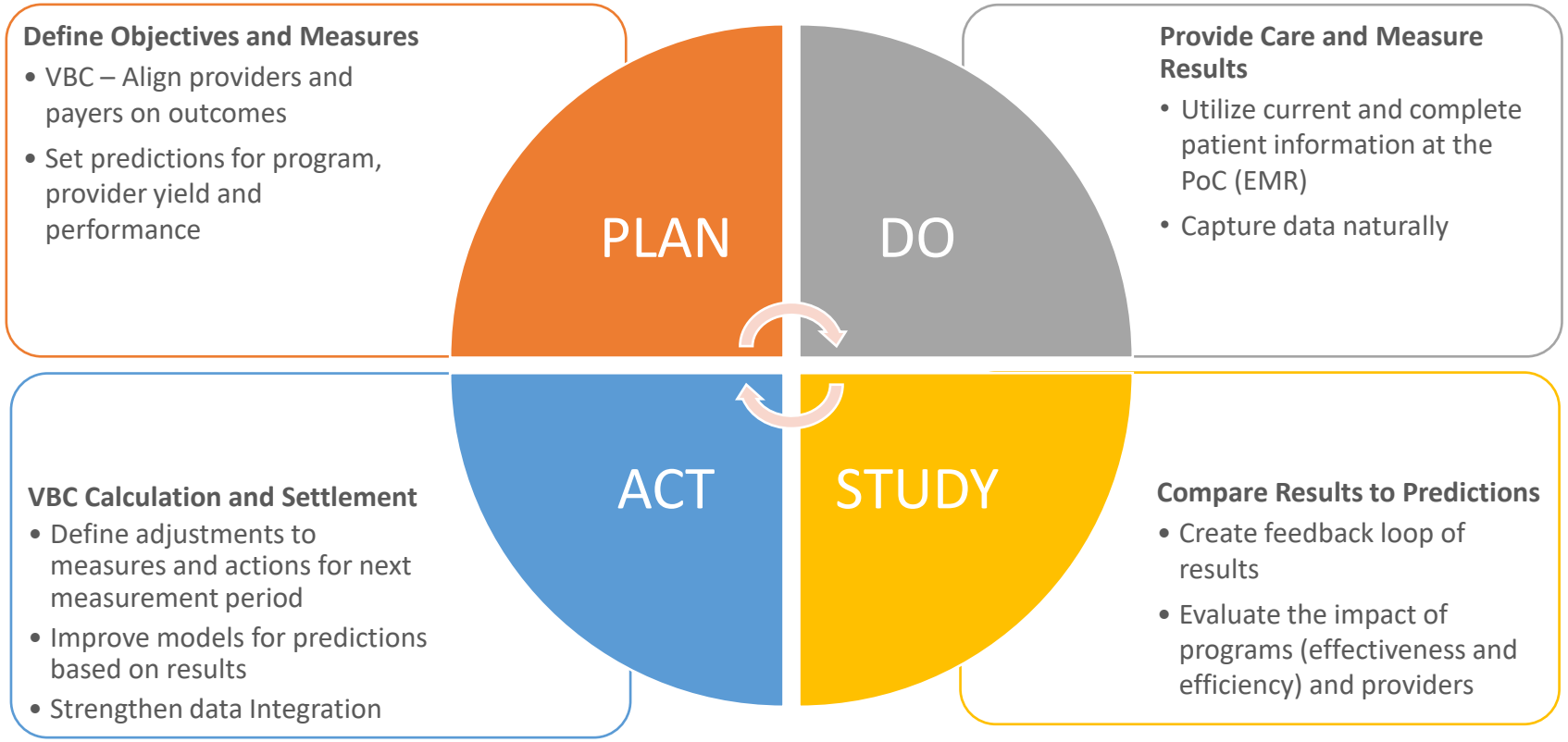
Emerging skills and capabilities

- ML/AI development and deployment
- SaaS development and integration (CI/CD)

Unintentional Bias in AI/ML Models

- Prevent known bias where possible
- Mitigate bias risk by combining with expert knowledge
- Disclose known bias in model development and training

Continuous Improvement – Next-Generation Analytics



How to Innovate Next-Gen Analytics

PEOPLE

- Invest in emerging skills (AI/ML, SaaS, CI/CD)
- Create a culture of INNOVATION (fail fast / fix fast)

PROCESS

- Develop a process for continuous improvement in risk and quality analytics
- Moving from risk and quality projects to ongoing processes

TECHNOLOGY

- Commit to leading-edge technology and standards backed by industry
- Health IT is moving to a SaaS ecosystem – understanding how your business thrives in a SaaS market

Innovators in Encounter Processing

Encounter Management Solution Profile

Serving more than **60 Million lives** through our 43+ encounter customers

Substantial Submission Footprint

1.4B encounter submissions annually across Medicare Advantage, Managed Medicaid and the Marketplace

Scalability & Performance

Supports clients as large as 7.2M members; Single instance supports over 24 LOBs; process up to 4M encounter submissions per week

Submission Accuracy

Achieved very high submission compliance and protect revenue accuracy for our customers

Market Leader

Overall, ~32% of encounters submitted to CMS are generated by our system

Key Differentiators

- CMS/ACA/State OOTB modular approach
- Prioritized exception workflows
- Intuitive operational dashboards
- Impactful data visibility

Q & A

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THANK YOU