EXPANDING PHYSICIAN SERVICES UNDER THE AFFORDABLE CARE ACT

The Provider Perspective

Peter Winston
Executive Vice President

HOPE IS NOT A STRATEGY BUT WE’VE BEEN DOWN THIS ROAD BEFORE
How many times have we heard that the sky is falling every time a new program is implemented?
TANF

• Temporary Aid to Needy Families
• Major conversion of most TANF members occurred back in the mid-1990s with the implementation of Medi-Cal managed care:
  – The Two-Plan Model
  – Geographic Managed Care (GMC)
  – County Organized Health Systems (COHS)
• Fully 50% of all Medi-Cal beneficiaries were converted
• SynerMed groups currently represent 600,000 beneficiaries

SPD

• Seniors and Persons with Disabilities
• In 2011-12, SPDs were added as a new mandatory Medi-Cal managed care population
• Statewide, over 427,000 affected
  – SynerMed groups currently represent 56,000

SCHIP

• State Children’s Health Insurance Program
  – Also called “Healthy Families”
• Program closed in 2013
• 860,000+ children affected
  – SynerMed groups had 42,000
• The program may have gone away, but the membership did not
• Moved to Medi-Cal managed care
  – New aid categories
Rural Expansion

- California continues to focus on managed care as the panacea to cure all financial woes
- 26 rural counties – mostly in northern California
- 300,000 beneficiaries affected
- 8 counties creating a super-CDHS (County Organized Health System) with Partnership HealthPlan
- 2 awardees in other counties
  - Anthem Blue Cross
  - California Health & Wellness (CHW) / Centene

The DUALS CCI

- The Coordinated Care Initiative pilot targets over 400,000 Medi-Medi beneficiaries in 8 counties
  - LA County maxes out at 200,000
- Mandatory enrollment into managed care for Medi-Cal benefits
- Members receive medical, behavioral, LTSS, home and community-based services thru a single plan
- Pathology is similar to the SPD population
HOPE IS NOT A STRATEGY

IT IS STRICTLY A PAYMENT TRANSITION FROM UNCOORDINATED CARE TO COORDINATED CARE
OMG – What Else?

- Fee Schedules
  - Increasing PCP E&M FFS rates from Medi-Cal to Medicare
  - Retro to Jan 1, 2013
  - Money not yet flowing
  - And you still need to factor in 10% rate cuts

- ICD-10 Implementation (Oct 2014)
  - It’s not going away
  - It’s not going to be delayed again
  - Make sure your billing system vendor is ready

- Continued EHR Implementation
  - Do you yet have “meaningful use”? 

Covered California

Alliance UCD Health
Anthem Blue Cross
Contra Costa Health Plan
CCHP of California
Pacific Permanente
Western Health Advantage
Molina Healthcare
Valle County Health Care Plan
blue of California
L.A. Care
Addressing the Challenges

• You do so by giving the traditional providers who already take care of these communities the additional tools to make change happen

• And you do it with technology

• Even if you have to drag the provider kicking and screaming into the 21st century

It’s All About Engagement
Communication is Key
AGENDA

- Present an overview of risk adjustment methodology
- Describe the HHS-HCC risk adjustment model for small-group/individual issuers
- Compare and contrast with Medicare-Advantage risk adjustment
- Explain how the Exchanges will maintain payment integrity
- Highlight clinical and administrative challenges
- Revenue optimization for small-group/individual issuers

RICHARD LIEBERMAN

- One of the nation’s leading experts on financial modeling and risk adjustment in the managed care industry
- Combines unique expertise in provider profiling, risk adjustment, case-mix measurement, and provider reimbursement strategies
- Actively involved in the development of risk adjustment systems for over 20 years
  - Johns Hopkins ACG Development Team, 1991-2005
  - Designed the risk-adjusted payment system for Maryland Medicaid
- Designer of the PeakAnalytics decision support platform that presents quality metrics, HEDIS, medical management metrics, and risk adjustment on the same platform
SUMMARY OF 3 R’s BY MARKET

<table>
<thead>
<tr>
<th>Sold within Exchange</th>
<th>Sold Outside Exchange</th>
<th>Who Administers</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACA Provision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>Small Group</td>
<td>State or HHS</td>
</tr>
<tr>
<td>Small Group</td>
<td>Grant-Fathered</td>
<td>Federal Run</td>
</tr>
<tr>
<td>Group</td>
<td>State Run Exchange</td>
<td></td>
</tr>
<tr>
<td>State Run Exchange</td>
<td>Federal Run Exchange</td>
<td></td>
</tr>
<tr>
<td>Risk Adjustment</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Reinsurance</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk Corridor</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

*State can decide to administer or allow HHS to administer. If HHS administers, all parameters will be federal.

RISK ADJUSTMENT MODELS

- Risk adjustment models organize diagnosis codes, and sometimes prescription drug claims, into discrete categories
  - Relatively homogenous with respect to cost and utilization
  - Category groupings need to be clinically meaningful to minimize opportunities for gaming or discretionary coding
  - Condition categories should have adequate sample sizes

KEY CHARACTERISTICS OF RISK ADJUSTMENT MODELS

- Most models are additive: Each category (groups of diagnosis codes) is assigned a weight, which when added together comprise the risk score for a particular member
  - CMS-HCCs (Medicare), HHS-HCCs (small-group/individual) and most Medicaid risk adjustment models (CDPS, DCGs, MedicaidRx, etc.) are all additive linear models
  - The Johns Hopkins ACG System, used by several Medicaid programs, is not additive (tree-based). CRGs, used by New York State Medicaid is also a non-additive model
KEY CHARACTERISTICS OF RISK ADJUSTMENT MODELS (CONT’D)

- Payment weights can either be prospective or concurrent
  - Prospective models use categories derived from prior period data to predict cost/utilization in a future period
  - Lag between risk assessment period and payment year
  - Concurrent models use categories from a period to explain cost/utilization in the same period
- Risk scores are always assigned to individual members
  - Risk scores and payments are not always synonymous
- Risk scores reset every year
  - Often the most difficult concept to explain, particularly to clinicians

RISK ADJUSTMENT METHODOLOGY

- Understanding the risk adjustment model is only the beginning
- The risk adjustment methodology incorporates
  - The risk adjustment model
  - Calculation of plan average actuarial risk (for Medicaid and Exchanges only)
  - Calculation of payments and charges
  - Risk adjustment data collection approach
  - The schedule for the risk adjustment program
  - Payment integrity provisions
RISK ADJUSTMENT METHODOLOGY (CONT’D)

- Sponsors that have adopted risk adjustment have designed their methodologies very differently:
  - Medicare Advantage: Assigns risk scores to individual members and pays for each member individually
  - Medicaid: Most states pay at the plan level with a multi-year lag; others for each member individually
  - Health Benefit Exchanges: Will pay at the plan level, with no payment lag

INDIVIDUAL VS. GROUP-LEVEL PAYMENT

- Medicare-Advantage determines risk-adjusted payment at the individual member level
  - Every member has their own risk score and carries with them if they change plans from one year to the next
- Exchange risk adjustment calculates an average risk score for the entire cohort of members who enroll in a plan
  - Average risk scores are specific to the metal level
  - Weighted by months of enrollment
  - Far more short-term enrollees than in Medicare-Advantage

AFFORDABLE CARE ACT VS. MEDICARE RISK ADJUSTMENT

<table>
<thead>
<tr>
<th>Category</th>
<th>ACA Risk Adjustment</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Benefits</td>
<td>Benefit tiers based on actuarial value; benefit structure varies within tiers</td>
<td>Plans provide, at a minimum, Medicare benefits</td>
</tr>
<tr>
<td>Plan-level premiums</td>
<td>Can vary based on age, geography and family size of subscriber unit</td>
<td>Uniform plan premiums</td>
</tr>
<tr>
<td>Monetary basis for transfers</td>
<td>Based on premiums seen in market</td>
<td>Standardized bid</td>
</tr>
<tr>
<td>Transfer of funds</td>
<td>Charges assessed at issuer level; lower risk plans are charged and higher risk issuers make payments after the benefit year</td>
<td>Prospective payment adjustments (up or down) to individual standardized bid</td>
</tr>
<tr>
<td>Budget</td>
<td>Budget-neutral</td>
<td>Not budget-neutral</td>
</tr>
</tbody>
</table>
### AFFORDABLE CARE ACT VS. MEDICAID RISK ADJUSTMENT

<table>
<thead>
<tr>
<th>Category</th>
<th>ACA Risk Adjustment</th>
<th>Medicaid Risk Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Benefits</td>
<td>Benefit tiers based on actuarial value; benefit structure varies within tiers.</td>
<td>Plans provide, at a minimum, federally or state-mandated benefits.</td>
</tr>
<tr>
<td>Plan-level premiums</td>
<td>Premiums paid by enrollees can vary based on age, tobacco use, geography and family size.</td>
<td>Premiums paid to plans typically vary by eligibility category, age, gender, and geographic area.</td>
</tr>
<tr>
<td>Model estimation</td>
<td>Concurrent</td>
<td>Prospective or concurrent (more states use concurrent).</td>
</tr>
<tr>
<td>Lag Period</td>
<td>None</td>
<td>Typically 1 – 2 years.</td>
</tr>
<tr>
<td>Transfer of funds</td>
<td>Charges assessed at issuer level; lower risk plans are charged and higher risk issuers make payments after the benefit year.</td>
<td>Prospective adjustment for relative risk based on historical plan-level average; a few states employ individual level risk adjustment.</td>
</tr>
<tr>
<td>Budget</td>
<td>Budget-neutral</td>
<td>Budget-neutral</td>
</tr>
</tbody>
</table>

### SUMMARY OF RISK ADJUSTMENT PROCESS TIMELINE

- **2013**
  - Throughout: Technical Requirements Released
  - Operations Implementation Specifications for Data Storage Issued
- **2014**
  - March 2014: Final HHS Payment Notice
  - June 30, 2014: Data Storage deadline
- **2015**
  - April 30, 2015: Reinsurance and Risk Adjustment data submission deadline
  - June 26, 2015: Payments and charges for implementation for Benefit year 2014
RISK ADJUSTMENT MODEL CHARACTERISTICS

- Derived from the Diagnostic Cost Group (DCG) model
  - Medicare HCCs and DHHS-HCCs are both progeny of the DCG model
  - DCGs were originally developed by researchers from Brandeis University and Boston University
- The HHHS-HCC model has 127 HCC categories
- Separate models for adults, children and infants
- The structure of the HCC model is the same across the four metal levels (the catastrophic health plan is a fifth “metal level”)
  - Coefficients (payment weights) vary by metal level
  - State-specific adjusters will be applied to the model coefficients

MORE RISK ADJUSTMENT MODEL CHARACTERISTICS

- The single HHHS-HCC risk adjustment model predicts medical and pharmacy costs
  - No separate model for pharmacy costs
  - Medicare-Advantage HCCs predict only medical costs
    - Separate RxHCC Model predicts pharmacy costs

MORE RISK ADJUSTMENT MODEL CHARACTERISTICS

- Expected members with an HCC
  - 19 percent of adults
  - 9 percent of children
  - 45 percent of infants
- In Peak’s experience, these rates are a bit high
- HHHS estimated these values using the Truven Analytics Marketscan database, which is mostly derived from large-group experience
HHS-HCC DIAGNOSES SHARED BY MEDICARE HCCs

• HIV/AIDS
• Malignant neoplasms
• ESRD/chronic renal failure
• Acute or Chronic Pancreatitis
• Diabetes, acute/chronic/uncomplicated
• MI, unstable angina, arrhythmias, and CHF
• CVA and intracranial hemorrhage, hemiplegia, monoplegia
• COPD/CF
• Cardio-respiratory failure
• Inflammatory Bowel Disease

HHS-HCC DIAGNOSES SHARED BY MEDICARE HCCs (CONT’D)

• Severe and persistent mental illness: psychosis, personality disorders, major depression, drug dependence
• Seizure disorders
• Traumatic spinal cord lesions, quadriplegia, and paraplegia
• Multiple sclerosis
• Bone, Joint, and Muscle Infections/Necrosis, Necrotizing Fasciitis, Chronic skin ulcers
• Opportunistic infections
• Protein-calorie malnutrition

CONDITIONS SPECIFIC TO THE HHS-HCCs

• Pregnancy/miscarriage
• Asthma
• Congenital Disorders
• Significant Endocrine Disorders
• Organ transplants
• Blood disorders: Aplastic anemia, hemolytic diseases, sickle cell, etc
CONDITIONS SPECIFIC TO THE HHS-HCCs (CONT’D)

• SLE, Autoimmune Disorders, Immunodeficiencies
• CNS Infections
• Acute Liver Failure/Disease
• Peritonitis, GI Perforation, Necrotizing Enterocolitis
• Intestinal Obstruction
• Coagulation Defects and Other Specified Hematological Disorders
• Select Pathological Fractures

CONDITIONS SPECIFIC TO THE HHS-HCCs (CONT’D)

• Reactive and Unspecified Psychosis, Delusional Disorders
• Anorexia/Bulimia Nervosa
• Autistic Disorder, Pervasive Developmental Disorders
• Cerebral Palsy, Except Quadriplegic
• Select Neurological Disorders
• Muscular Dystrophy

CONDITIONS SPECIFIC TO THE HHS-HCCs (CONT’D)

• Select Heart Disorders: Assistive Device/Artificial Heart, Heart Infection/Inflammation
• Cerebral Aneurysm and Arteriovenous Malformation
• Atherosclerosis of the Extremities with Ulceration or Gangrene
• Lung Transplant Status/Complications, Fibrosis of Lung and Other Lung Disorders
ROLE OF DEMOGRAPHIC CHARACTERISTICS

- Demographic categories are incorporated into the HHS-HCCs
  - 18 categories for adults (ages 21+)
    - 9 age cells in 5-year increments
  - 8 categories for children
    - 2-4, 5-9, 10-14, 15-20
    - Infants are ages 0 and 1
  - Age is determined as of last day of member’s enrollment in contract year

RISK ADJUSTMENT FOR INFANTS

- The infant model utilizes a mutually-exclusive groups approach in which infants are assigned a maturity category (by gestation and birth weight) and a severity category.
  - There are 5 maturity categories:
    - Extremely Immature
    - Immature
    - Premature/Multiples;
    - Term
    - Age 1

RISK ADJUSTMENT FOR INFANTS (CONT’D)

- There are 5 severity categories based on the clinical severity and associated costs of the nonmaturity HCCs:
  - Severity Level 1 (Lowest Severity) to Severity Level 5 (Highest Severity)
  - The 5 maturity categories and 5 severity categories are used to create 25 mutually-exclusive interaction terms
  - An infant who has HCCs in more than one severity category would be assigned to the highest of those severity categories
  - An infant who has no HCCs or only a newborn maturity HCC would be assigned to Severity Level 1 (Lowest)
EXCHANGE RISK SCORES ARE NORMALIZED TO THE STATE-WIDE AVERAGE

- In Medicare-Advantage, risk scores are purely individual, only related to the entire Medicare population of 49 million beneficiaries
- In Exchange risk adjustment, plan-level risk scores are compared to other plans in the same state, within metal level
- Medicaid risk adjustment tends to work like small-group/individual market risk adjustment, with standardization to a plan-wide average
  - Standardization typically occurs at sub-state regions
RISK ADJUSTMENT OPERATIONS

- HHS will be using a distributed approach for risk adjustment
  - Issuer will run HHS risk adjustment software using enrollee data on its own server and report back enrollee risk scores to HHS. The issuers will calculate enrollee level risk scores
  - States electing to run risk adjustment may also use a distributed approach, or they may request detailed data and calculate risk scores

RISK ADJUSTMENT MODEL & METHODOLOGY (MEDICARE & MEDICAID)

Risk Adjustment Administrator (CMS or State Medicaid)
- Medical Claim Data
- Pharmacy Data
- Eligibility Data

RISK ADJUSTMENT MODEL & METHODOLOGY (EXCHANGES)

Risk Adjustment Administrator (Exchange)
- Issuers' Edge Server
- Medical Claim Data
- Pharmacy Data
- Eligibility Data

De-identified Risk Assessment Scores/Prevalence Data

PHI
DATA REQUIRED FOR RISK SCORE CALCULATIONS

- ICD-9-CM diagnosis codes
- CPT-4/HCPCS
- Bill types
- Acceptable source of data
  - Claims
  - Encounters
- Paid claims only? “…diagnoses reported on institutional and medical claims that result in final payment action or encounters that result in final accepted status.”

PAYMENT TRANSFER FORMULA

COMPONENTS OF THE PAYMENT TRANSFER FORMULA

- Plan average risk scores; member month-weighted average of individual enrollee risk scores
- State average premium
- The issuer’s metal level AV
- Allowable rating factor
- Issuer’s induced demand factor
- Issuer’s geographic cost factor
BASIC FORM OF THE PAYMENT TRANSFER CALCULATION

\[
\text{Adjusted Plan Risk Score} \times \text{Baseline Premium} = \text{Payment Transfer}
\]

- Difference Between Plan Liability and Average Risk Pool Liability
- Positive Transfers Are Payments
- Negative Transfers Are Charges

RISK ADJUSTMENT AT THE PLAN LEVEL

- Plan 1: Average Risk Score = 0.9
- Plan 2: Average Risk Score = 1.1
- Exchange

Average pmpm premium = $400
Plan A pays Plan B: $40 pmpm

MAINTAINING PAYMENT INTEGRITY
MAINTAINING PAYMENT INTEGRITY

- Every issuer of a product in the small-group/individual market will be audited every year.
- Comprehensive audits are necessary because of the relative nature of the risk scores across all issuers in a state.
- Issuers will hire their own, Initial Validation Auditors to conduct the RADV audit.
- CMS will audit the IVA auditors using Secondary Validation Auditors.
- Financial impacts of audits will not be applied retroactively.

RISK ADJUSTMENT AUDITS IN THE SMALL-GROUP/INDIVIDUAL MARKET

- Audit program to look like Medicare Advantage (RADV).
  - BUT, every issuer gets audited every year!
  - RADV audits are state-specific.
  - Approximately 300 members will be audited each year per issuer.
- Audit results are extrapolated to all members and applied to a future year’s revenue.
- No financial sanctions for 2014 and 2015 contract years.

PROPOSED DATA VALIDATION PROCESS SETUP AND IMPLEMENTATION TIMELINE FOR BENEFIT YEAR 2014

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>March 2015: Issuers provide Auditor Information to HHS</td>
</tr>
<tr>
<td></td>
<td>July-November 2015: Initial data validation of Auditor Sample</td>
</tr>
<tr>
<td></td>
<td>April-May 2015: HHS findings and processing of appeals</td>
</tr>
<tr>
<td>2016</td>
<td>April-June 2016: Selection of Audit Sample, Issuer/Auditor Training &amp; Distribution of Sample to Issuers</td>
</tr>
<tr>
<td></td>
<td>December 2015: HHS oversight of Data Validation Audit Sample</td>
</tr>
<tr>
<td></td>
<td>June 2016: Estimate Risk Scores and Stimulate Payment Adjustment</td>
</tr>
</tbody>
</table>
REINSURANCE AND RISK CORRIDORS

REINSURANCE PARAMETERS

• Reinsurance available for the first three contract years
• $60,000 attachment point
• 20 percent co-insurance from $60,001 - $250,000 per member per year
• National reinsurance cap of $250,000
  • Issuers can purchase private reinsurance for liability above $250,000
• CMS will charge issuers $5.25 pmpm for reinsurance

ISSUER PARTICIPATION IN HEALTH INSURANCE EXCHANGES

CLINICAL AND ADMINISTRATIVE CHALLENGES
QUALITY IMPROVEMENT AND REPORTING
FEDERAL GUIDANCE AND RULES: FEDERALLY- FACILITATED EXCHANGE

<table>
<thead>
<tr>
<th>Certification Year</th>
<th>QHP Issuers without existing accreditation</th>
<th>QHP Issuers with existing Commercial, Medicaid accreditation for the state</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1 (2013)</td>
<td>Schedule accreditation review</td>
<td>Attest that accredited policies and procedures are comparable to Exchange (not all the same)</td>
</tr>
<tr>
<td>Years 2 and 3 (2014-2015)</td>
<td>Be accredited for Exchange product (policies and procedures)</td>
<td>Attest that accredited policies and procedures comparable to Exchange</td>
</tr>
<tr>
<td>Year 4 (2016)</td>
<td>Exchange product is accredited, data, performance data submitted</td>
<td></td>
</tr>
</tbody>
</table>

CLINICAL MANAGEMENT CHALLENGES

- Lack of information about risk status/disease burden of potential enrollees
- Pent up demand for services from previously uninsured
- Inherent inefficiencies of “care as usual” system
- Lack of care coordination and vertical integration
- Firmly entrenched provider practice patterns
- Concurrent risk adjustment methodology
  - Educating providers will be a challenge
  - Getting members into care

CLINICAL MANAGEMENT STRATEGIES

- Timely identification and assimilation of high risk members:
  - Establish effective screening programs to identify:
    - Those needing earlier practitioner appointments
    - Those requiring comprehensive assessment and care planning
  - Anticipate/plan for pent-up demand for routine and preventive services
  - Pre-existing conditions for previously uninsured population; those with significant chronic conditions and/or disabilities
CLINICAL MANAGEMENT STRATEGIES
- Provider engagement strategies
  - Develop/share tools and resources to manage sick members attracted to guaranteed issue products
- Reimbursement methods:
  - Move away from FFS toward more bundled payments
  - Compensate for care coordination activities
  - Incentivize preferred practice patterns
  - Gather comparative performance data
  - Identify and reward high performing providers/practitioners
  - Include clinical, utilization, cost and service measures

ISSUER ACTIONS TO PREPARE FOR 3-R’s

ACTIONS FOR PAYERS INTENDING TO OPERATE IN SMALL-GROUP/INDIVIDUAL MARKETS
- Risk adjustment readiness assessment
  - Does every diagnosis code make it from the claims system to the data warehouse and ultimately to the edge server?
  - Diagnosis code filtering process
  - Mother/baby claims require special attention
  - Implications of ICD-10 cutover on 10/1/2014
- Estimate risk scores in current small-group/individual markets
  - Historical data from guaranteed issue markets is sufficient
  - Medicaid experience used as a proxy for subsidy-eligible population
ACTIONS FOR ISSUERS INTENDING TO OPERATE IN SMALL-GROUP/INDIVIDUAL MARKETS (CONT’D)

• Assess medical record documentation
  • Peak’s work on small-group data using Rx data as a predictor indicates substantial opportunities for risk score optimization
  • Given 100% chance of RADV audit, unsubstantiated diagnosis coding creates risk for adverse payment integrity audits

• Prepare for edge server
  • Ability to map every member to a single longitudinally-stable blinded member ID, that can be mapped back to the issuers’ systems at all times
  • Edge server assumes that all claims represent discrete episodes of care, not just paid claims

ACTIONS FOR ISSUERS INTENDING TO OPERATE IN SMALL-GROUP/INDIVIDUAL MARKETS (CONT’D)

• Provider education
  • This can be done!
  • Providers will be more receptive than previously assumed
  • Integrate with quality improvement
  • Create incentive programs around clinical documentation quality, risk score accuracy, and quality improvement
  • Network selection has to be based on provider willingness to submit data and comply with risk adjustment and quality paradigms

COMPONENTS OF A RISK ADJUSTMENT READINESS ASSESSMENT

• Ascertaining readiness requires more than ascertaining the ability to collect diagnosis code data into an online operational data store
  • Requires the assessment of provider’s coding and documentation acumen

• Conduct interviews with key operational managers throughout the enterprise, including claims processing department(s), provider relations, IT and medical informatics, network management, contracting, quality measurement and care management
COMPONENTS OF A RISK ADJUSTMENT READINESS ASSESSMENT

• Identify a limited number of providers to interview about their coding and documentation practices and to assess how their EMRs or paper medical records are used to collect and longitudinally track key morbidities necessary to calculation of an accurate risk score

• Analyze samples of claims data from selected target markets.
  • Determine if there is underreporting of diagnosis codes that will produce an underestimate of actual risk
  • Ascertain audit risk by assessing the prevalence of unsubstantiated diagnoses

2014 ACTIONS FOR PAYERS OPERATING IN RISK ADJUSTED PROGRAMS

• Revenue maximization will be a sprint, not a jog!
  • All morbidity data must be collected by April 30th

• Promote access to care by every enrollee
  • Maximize the number of substantiated diagnosis codes
  • All chronic illnesses must be documented
  • Care avoidance may be as significant as pent-up demand

• Guard against incorporating diagnosis codes into the risk adjustment calculation that are not substantiated by the medical record

• Ensure quality metrics are measured

SECRETS FOR SUCCESS

• Assure that you are capturing comprehensive data that documents the individual’s risk burden

• Aggressively manage care toward improved clinical outcomes
  • Case management of high comorbidity members
  • Actively engage with practitioners to enhance data capture, to effectively manage care and to improve the care experience for patients

• Focus on key dimensions of service to patients
TANDEM RISK SCORE STRATEGIES FOR MEDICAID AND EXCHANGES

- Seamless plan and provider education on risk adjustment
  - Providers shouldn’t be burdened with the complexities of multiple models in use in a particular state
  - Provider strategies under diagnosis-based risk adjustment do not vary by model or methodology
  - Risk mitigation strategies
- Provider report cards that tabulate resource consumption, quality and clinical documentation quality
  - 2013 is the time to assess the network on these dimensions

2014 ACTIVITIES TO MAXIMIZE REVENUE IN EXCHANGE MARKETS

- Software to estimate risk scores in real time
  - Re-estimate monthly or quarterly as part of IBNR process
- Telephone HRAs to screen members for:
  - Case management referrals
  - In-home prospective assessments
  - Retrospective medical record reviews
  - Provider notifications and access facilitation
- Retrospective medical record review
- Population of data on edge servers and risk score calculation
- Mock audits prior to hiring an Initial Validation Auditor

CONTACT INFORMATION

If Peak can assist you with a readiness assessment, analytical decision-support, or program design strategies, please do not hesitate to contact us:

Richard Lieberman
EVP, Plan Strategy
Peak Health Solutions
rlieberman@peakhs.com
Tel: 858-207-3373

Vijay Prabhakar
Vice President of Sales, Payor Solutions
Peak Health Solutions
vprabhakar@peakhs.com
Tel: 858-361-4801