Transforming Healthcare
A Clarkson Company

Breaking down claims data

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Who are Transforming Healthcare?

A Clarkson Regional Health Services Company

We

- *Provide insight and analytics to Think ACO*
- *Focus on Insight and actionable data*
- *Have Data and Analytic functions*
- *Have helped other ACOs in our Region*

Agenda

Breaking down claims data

(MSSP, ACO REACH, MA)

- Where it goes wrong
- Which questions can be answered
- Which cannot?
- How to use Claims Data in the real world?

Where it goes wrong

Getting the latest version of events

Claim Adjustment Type Code CLM_ADJSMT_TYPE_CD 0 – Original Claim 1 – Cancellation Claim 2 – Adjustment Claim

Building Blocks

Original Claim	Original Claim Cancellation Claim	Original Claim Cancellation Claim Adjustment Claim

} Same Effective Date

These can be repeated multiple times, as claims get (re)submitted, cancelled and adjusted, (re)submitted and cancelled etc

Claims can get reprocessed causing changes to the data i.e. an Adjustment Claim → Original Claim
Beneficiary ID numbers can change

I have found using the Natural Key for that table, with the latest version of claims gives consistent results.

Where it goes wrong

XREF file – using the Patients' current MBI consistently

As part of the load process we find the most recent MBI and update all previous entries in all tables.

Setting this standard avoids

- Duplication of the patient
- Difficulty in linking to ALR, BEUR files
- Data Validation issues

Issues

Dates as 9999-12-31

2 MBIs at the same time

Instilling Data Confidence by transparent comprehensive answers

Where it goes wrong

knowing the denominator

	Assignment Type	Assignment Labal	Assignment Window	Lookback for newly Assigned
MSSP	Prospective Assignment	All Assigned Beneficiaries	Offset Window ending 3 Months propr to PY	36 Months
	Retrospective Reconcilliation	All Assignable Beneficiaries	The PY	36 Months
ACO Reach	All ACO Type	All Aligned Beneficiaries	2 Alignment Years ending 6 Months prior to PY	36 Months

To generate Hospital Discharges per 1,000 Person Years (or any rate)

Numerator - Count the number of Discharges from hospital in the period

Denominator - For every month in the period how many beneficiaries are we getting data on?
(whether they had a service or not)

The same issue applies to calculating total average expenditures per beneficiary. It is a weighted mean.

Sum of Dollars / Number of Person Years (whether dollars were spent in PY or not)
[Attribution window is not the same for the PY in all ACOs]

Questions - Answered or Not
Attribution

I don't know of a good way to link NPI/TIN to the ACO Participant List with its participants legal business name.

If you don't know which Providers / TIN are in an ACO, you cannot run a comprehensive attribution algorithm.

You can get close, if

- you know your local market well
  - The participant TINs of the ACOs are know, but are the NPI on the roster?
- you are looking at a specific beneficiary
  - What is the sum of allowed for PQEM/ PCS ACO PCP APP for each NPI/ TIN
- you are looking at a specific situation.
  - How many beneficiaries in the ACO did not see an ACO Physician?
  - How many beneficiaries are we gaining losing approximately due to wound care APPs?

ACO REACH – PQEM Primary Care Qualified Evaluation & Management
MSSP - PCS ACO PCP APP – Primary Care Service with an ACO Primary Care Physician or Advance Practice Practitioner

Questions - Answered or Not
What is a beneficiaries current HCC Risk Score

You probably cannot answer this 100% accurately always as the HCC Risk Scores get renormalized every year

There are different models, HCC RAF score can change annually.
The models are based on

- Age
- Gender
- Entitlement original/ current
  - full or partial benefits if Dual
  - new or continuing enrollee
- Diagnosis
- Count of condition categories
- Interaction between conditions
- Community or institutional

All this without discussing the change from V24 to V28

You can however track trends easily by building just one model or simplifying that.

Mean National Assignable Risk Scores Used to Renormalize Beneficiary Risk Scores

Renormalization Risk Pool	Year 2023	2024	2025
Aged/Dual	1.704	1.682	1.878
Aged/Non-Dual	1.004	1.003	1.122
Disabled	1.206	1.194	1.330
ESRD	1.021	1.028	1.088

Ex Covid Episodes

Questions - Answered or Not
Gaps in Care / Expenditure

Gaps in Care

If you have data for the beneficiary, you can see if or when there was a CPT code paid (mammogram, colorectal cancer screen, A1C) for a corresponding gap in care. Knowing the date and which clinic to request a report from is a great first step.

CPTII codes (when available) may help supplement vitals or results e.g. BP / A1C but are not comprehensively available.
Exclusion criteria may be found in claims data.

Expenditure

CCLF Data does not include any claims that identify alcohol and substance abuse treatment information.

You cannot accurately recreate the CMS reports. Use the BEUR file to validate.

MEDICAL HOME NETWORK

Breaking Down Claims Data in Medicare:
What You Can and Can't Do With Claims…and How to Overcome The Gaps!

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Our Mission: Transform Care and Build Healthier Communities

Medical Home Network creates community-based systems of care that succeed under value-based care

2009
Founded by Comer Family Foundation to serve Chicago's most vulnerable

2012
Established MHNConnect, proprietary care management platform

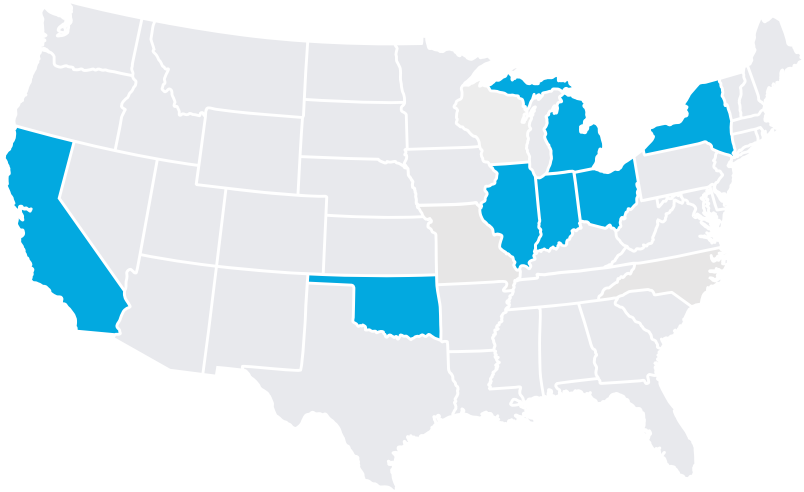
2014-2015
MHN ACO: Established first provider-owned Medicaid ACO in Illinois, one of the highest performing in the U.S. First NCQA delegated Medicaid ACO for Care Management.

2019
Expanded geographically to scale & replicate our proven model

2022-2023
Approval of Medical Home Network REACH ACO and Medical Home Network Health Alliance ACO for MSSP in 2024

80+
FQHCs

Impacting
300,000+
lives



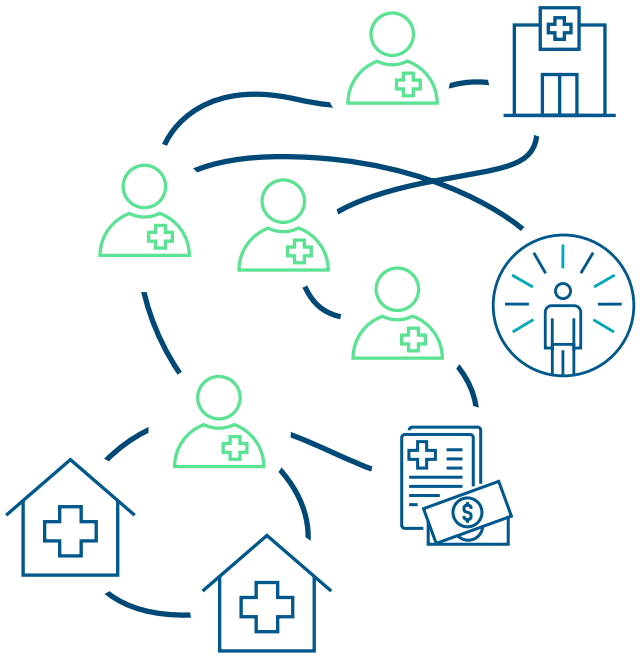
2024
Today

MHN is in seven states impacting over 300,000 Medicare, Medicaid and the uninsured lives.

What We Do: Value-based Care Achievement

With a focus on Community Health Centers, MHN creates integrated systems of whole person care

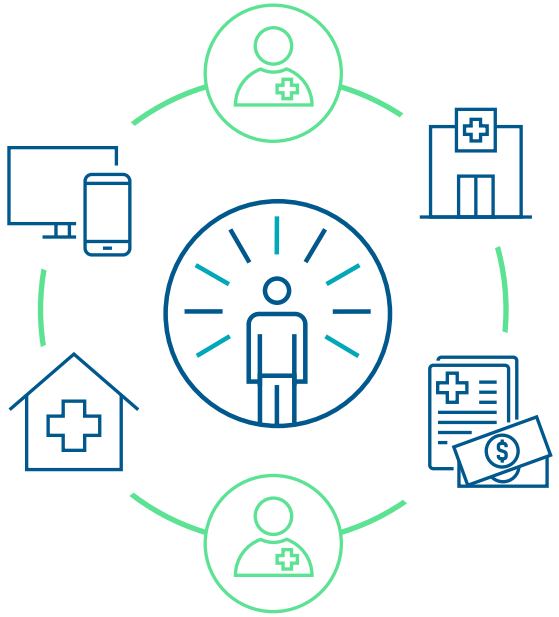
Current State



A disconnected, inefficient safety net where stakeholders act independently

- Fragmented & disjointed
- Reactive care model
- Incomplete patient view

Future State



A clinically integrated & digitally connected safety net network

- Proactive care coordination
- System of care supporting medical, behavioral & social needs
- Seamless data integration with 360-degree patient view

What we will talk through

- Claims – primary use cases
- Gaps for primary use cases
- Questions + discussion

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A little bit about me

- Readmissions at Barnes/Wash U
- Caring for 4,000 Medicaid and undocumented patients
- Taking full risk in East Garfield Park
- 2 Million patients, 90K in VBC
- MHN

Primary Use Cases

Primary Use Cases

- Utilization
- Financial performance + fraud, waste, and abuse (FWA)
- Population health <> risk stratification <> coordination
- Risk-adjustment
- Quality gaps – All for REACH, some for MA and MSSP
- Network optimization

Gaps

2024 With Our Key Partner

- **Priorities**
  - Based on **trends –** quality, outcomes, documentation, **cost category** – key KPIs
  - **CHC specific**

	ALIGNED PATIENTS	PMPM							PMPM
	TOTAL	CAT - 1	CAT - 2	CAT - 3	CAT - 4	CAT - 5	CAT - 6	CAT - 7	PMPM
CIN TOTAL	**13,300**	**$320**	**$70**	**$260**	**$80**	**$50**	**$40**	**$240**	**$1,060**
FQ1	3,000	$340	$70	$310	$60	$50	$40	$230	$1,120
FQ2	1,400	$340	$80	$170	$140	$50	$50	$270	$1,100
FQ3	1,300	$270	$60	$220	$100	$30	$30	$190	$910
FQ4	1,100	$260	$30	$260	$60	$30	$30	$190	$870
FQ5	1,100	$310	$150	$320	$70	$20	$50	$330	$1,240
FQ6	1,000	$390	$150	$310	$80	$40	$30	$310	$1,310
FQ7	1,000	$390	$80	$300	$80	$40	$40	$300	$1,240
FQ8	800	$270	$70	$250	$50	$30	$40	$180	$890
FQ9	700	$230	$10	$200	$80	$70	$40	$190	$830
FQ10	500	$290	$40	$160	$180	$60	$40	$190	$950

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Utilization is Retrospective

1. Quicker – BCDA +/- Authorizations (MA)
2. ADT → ED visits + transitions
3. EHR, HIE → real-time clinical data, root cause (Rx., SDoH, ER triage (avoidable), CM (appt., lab, imaging follow-ups))
4. RPM – both early detection and management

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Financial Performance + FWA

- Processing lag → authorizations; provider billing feeds + encounters; RCM (unbilled/denied)

- Rx.
  - PBM feeds → cost tracking and formulary changes
  - Med adherence → quality + high-risk pts.

- Emerging high-cost patients → predictive analytics

- Correct IBNR, RTA, CIF, etc. <> partnering w/actuarial firm

- FWA alerts → trends + BCDA + index new codes + sectors

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Population Health

- Claims is primary source → predictive analytics for future utilization, EOL, readmissions
- Clinical → labs, Rx. (filled vs. prescribed), RPM → substantial improvement
- Coordination
  - SDoH → useful in addition to dual status
  - ADT
  - Rx (PDC/MPR): med adherence + polypharmacy

Chronic Kidney Disease – Caring for Patients

Health Center	Total Patients	Total CKD Patients	No CKD Dx		Appt in 2024		Filled	Prescribed	None	CKD Stage 4 &5: Nephrology Visits Year to Date			
			CKD #	CKD %						Stage 4	No Appt.	Stage 5	No Appt.
FQHC 1	2940	480	170	35%	90	53%	49%	27%	24%	30	17	1	0
FQHC 2	1360	220	120	55%	70	58%	45%	35%	19%	10	7	4	1
FQHC 3	1280	150	110	73%	30	27%	43%	37%	20%	10	9	1	0
FQHC 4	1080	160	110	69%	50	45%	50%	31%	19%	10	4	1	1
FQHC 5	1000	140	50	36%	20	40%	55%	28%	17%	10	4	2	0
FQHC 6	940	210	110	52%	60	55%	56%	22%	22%	10	3	3	1
FQHC 7	910	190	110	58%	50	45%	48%	35%	17%	20	11	0	-
FQHC 8	720	70	20	29%	10	50%	50%	18%	32%	10	2	3	0
FQHC 9	670	120	50	42%	20	40%	41%	22%	37%	10	4	0	-
FQHC 10	470	110	50	45%	30	60%	28%	33%	39%	10	5	2	1
FQHC 11	290	60	30	50%	10	33%	29%	45%	26%	10	4	3	3
FQHC 12	260	30	10	33%	0	0%	62%	15%	23%	0	1	1	1
FQHC 13	250	40	20	50%	10	50%	39%	33%	28%	0	2	0	-
FQHC 14	220	40	20	50%	10	50%	24%	29%	47%	0	0	0	-
FQHC 15	110	20	10	50%	0	0%	45%	27%	27%	0	2	1	0
FQHC 16	100	10	0	0%	0	-	33%	67%	0%	0	0	2	0
Total	12,600	2,040	1,010	50%	450	45%	46%	30%	23%	120	75	24	8

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Addressing SDoH

Our Health Risk Assessments Accurately Predict Risk and Addresse the Rising Risk

37.4%

reduction in total social risk factors

The presence of even one social risk factor dramatically increases a patient's cost & utilization*

Social Risk factors

89% Completion rate of a proven screening assessment

42% Difficulty making appointments	**36%** Constrained mobility (Appt or Pharmacy)	**56%** Untreated depression
48% Untreated substance use disorder	**49%** Food, housing or clothing insecurity	**46%** Homelessness
73% Difficulty paying for medication	**32%** Feeling unsafe at home	**62%** Refused smoking cessation

Sources: Jones A, Lemak CH, Lulias C, Burkard T, McDowell B, et al. (2027) Predictive Value of Screening for Addressable Social Risk Favors. J Community Med Public Health Care 4: 030

Our Results: Medicaid & Medicare Outcomes

- ↑37% **PCP Visits**
- ↓37% **SDOH Resolved**
- ↓11% **Readmissions**
- $120M **Shared Savings over 6 Years**
- 84% **Health Risk Assessment Completion Rate**
- ↓42% **Admissions** per 1,000
- ↑82% **Post-ER follow-up** within 7 days
- 96% **Quality Score**
- ↓69% **SDOH resolved**
- ↓10% **1-year Medical Expenses Reduction**
  1 market 104% to 92% MLR
- 60% **Health Risk Assessment Completion Rate (Year 1)**
- 100% **Health Equity Data Reporting (HEDR) bonus**
- $15.9M **Net Shared Savings for PY2022 & 2023**
  62 FQHCs

Risk-adjustment

1. Claims → YoY recapture → usually 90-95% if accurate the first time
2. Clinical data → CHF, COPD, CKD + uncaptured
3. Rx data → suspecting
4. Other structured/non-structured data → HRA (pt. reported) QHIN, EMR, partner

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Quality Gaps – Hybrid Measures

1. Clinical performance → HTN, DM (A1c, eye exam), Osteoporosis, etc.

2. Screenings → CRC, functional status, etc.

3. Solving for this → EMR access/chart chase +/- purchasing data on marketplace

EMR or QHIN is Essential

Network Optimization

- Claims OK, missing outcomes:
  - Outcomes registries: complications, readmissions, recovery metrics
  - Other ratings: NPS, CAHPS, LeapFrog, Medicare Compare
  - Bundled episodic costs
- Risk of patient – medical and SDoH
- Partnership attributes
- Regional variance, AMC

THANK YOU!

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