Value-Based Payments Under Medicare and Medicaid
LeadingAge New York Financial Managers Conference

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Health Dimensions Group

Value-Based Payments (VBP) Under Medicare and Medicaid

- Defining Value-Based Purchasing
- Medicare Alternative Payment Models
- NY’s Value-Based Roadmap
Value-based purchasing refers to a broad set of performance-based payment strategies that link financial incentives to providers’ performance on a set of defined measures.

Attributed to Mark Twain...

“If you don't like the weather in New England now, just wait a few minutes.”

Same could be said about value-based purchasing!
Value-Based Payment Links Quality and Risk on a Continuum

- Value-Based Payment Thrives on Scale: Which Can Be Challenging to Obtain
  - Risk aversion can drive down scale of VBP and lead to unintended vulnerability
  - Increasing VBP volume diversifies risk and makes it easier to achieve critical mass
Medicare Alternative Payment Methods

IMPACT Act for Post-Acute
Physician Proposed Rule
Accountable Care
Bundling

Medicare Continues to March Towards Its Goals for Alternative Payment Models (APMs)

APM Goals for Medicare Fee-for-Service Program

2016 Goal Met in March
Alternative Payment & Service Models: Expansion Likely After Evaluation

- Centers for Medicare & Medicaid Services (CMS) Innovation Center is testing 25+ major payment & service delivery models and other initiatives under authority of Affordable Care Act
- Each model will be comprehensively evaluated and could be expanded if certified by the CMS Actuary to be effective at:
  - Improving quality without increasing spending; or
  - Reducing spending while maintaining quality of care
- Other payers likely to follow suit as CMS expands APMs

Wholesale expansion of Medicare APMs does not require an Act of Congress

Physician Payment Rule Provides Framework to Drive Advanced APMs

MACRA of 2015 ("Physician Fix")

- Provides automatic 5% lump sum bonus to physicians (starting 2019) who receive significant portion of their revenue from "Advanced Alternative Payment Models" (APMs); OR
- Rewards or penalizes physicians by up to +/- 9% depending on their Merit-based Incentive Payment System (MIPS) score

Intent is drive physicians to value-based behavior through multiple pathways
IMPACT Act Drives Changes for Post-Acute: Value-Based Payments and Much More

Bi-partisan statute enacted in 2014 requires:
- Development of uniform quality and resource measures
- Core set of assessment items across settings
- Detailed timelines and objectives

IMPACT Act is intended to facilitate:
- Interoperable, reusable core data set
- Creation of site-neutral payment policies
- Value-based payment approaches
- Improved care transitions and hospital discharge planning

SNF & HHA Value-Based Purchasing: Both Will Affect Payments by 2018

<table>
<thead>
<tr>
<th>SNF VBP</th>
<th>HHA VBP</th>
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<tbody>
<tr>
<td>Will lead to rewards and penalties initially based on “30-day potentially preventable hospital readmission measure”&lt;br&gt;• Confidential reporting first, then incorporated into payments&lt;br&gt;• INTERACT is becoming de facto industry standard suite of tools for readmissions prevention</td>
<td>New mandatory program in 9 states* where HHAs get up to +/- 3% payment adjustment based on relative scores&lt;br&gt;• Payment adjustment eventually ramps up to +/- 8%&lt;br&gt;• Scoring based on process and outcome measures, including new advance care planning measure</td>
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Both programs will have process to reward IMPROVEMENT versus ATTAINMENT in measures

*States are: Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington
Continued Growth in Medicare ACOs: However, Only 5% Are at Two-sided Risk

- CMS announced 100 new Medicare Shared Savings ACOs for 2016 (89 new in 2015)
  - Total of 434 Medicare Shared Savings Program (MSSP) ACOs
  - 21 Next Generation ACOs, with another round coming
- CMS also recently proposed further adjustments to ACO benchmarking methods, designed to move away from historical data to regional benchmarks
  - Would reward historically efficient regions

First LTPAC-Sponsored Medicare ACO: Genesis HealthCare Dives In

- Effective January 1, 2016, program targets long-term care residents in 113 Genesis facilities in 4 states (PA, NJ, MD, WV)
- Genesis expects to have 16,000 LTC residents (and some post-acute patients) attributed to the ACO based on obtaining plurality of primary care physician (PCP) visits while residents/patients are seen in the SNF
  - Genesis Physician Services (GPS) providers make approximately 500,000 visits to their LTPAC patients annually, driving attribution
  - Strategy will include after-hours visits, supplemented by telemedicine

Source: Genesis HealthCare website, accessed May 19, 2016
Medicare Advantage Is Growing Nationally

Medicare Advantage (MA) penetration grew by more than 30% in the last 5 years

Most growth is concentrated in 15 states...48 counties that have more than 25,000 Medicare-eligible persons and greater than 50% MA penetration: Wisconsin is a high penetration state

Despite enrollment growth, MA remains a “black box” to many post-acute providers due to small scale by a specific plan for any given provider and frequently non-competitive markets

Source: HDG analysis of CMS.gov files as February 2015

Medicare Advantage Plans Will Become Next Frontier for VBP

- **Value-Based Insurance Design** (VBID): September 1, 2015, CMS announced that MA plans in 7 states* will be offered flexibility in benefit design (reduce cost sharing or offer extra benefits) so beneficiaries with certain chronic conditions can be incentivized to pursue high-value treatments

- As MA penetration grows, plans will increasingly copy value-based payment initiatives
  - Medicare Advantage plans accorded significant payment flexibility under federal law
  - Special Needs Plans (SNPs) likely to be early adopters of VBP

Engaging Medicare Advantage plans with alternative payment approaches will become increasingly common

*Arizona, Indiana, Iowa, Massachusetts, Oregon, Pennsylvania, and Tennessee
Health Plans Are Now Implementing Large-Scale Shared Savings Programs

- Accountable cost and quality arrangement (ACQA)—ACO look-alike
- Mechanism to organize physicians and operate across payers (e.g., Medicare Advantage and commercial plans)

Bundling
Episodic Payment Models Growing
Medicare Episodic Payment Timeline

- **Voluntary Bundled Payments for Care Improvement (BPCI)**
  - Round 1 sign-up in 2012; Round 2 sign-up in 2014

- **Mandatory Comprehensive Joint Replacement Model (CJR)**
  - Proposed July 2015; implemented in 67 markets April 1, 2016
  - Proposal to add Surgical Hip & Femur Fracture Treatment (SHFFT) for July 2017 implementation

- **Mandatory Advancing Care Coordination Proposed Rule**
  - Proposed July 2016 for implementation in 98 markets July 2017
  - Two new mandatory cardiac bundles: heart attack and bypass surgery, now called Episode Payment Models (EPM)
  - Cardiac rehab incentive payments

- **Voluntary BPCI 2.0 intended for CY 2018**

### Comparison of Key Features Between Voluntary BPCI & Mandatory CJR/EPMs

<table>
<thead>
<tr>
<th>Domain</th>
<th>Voluntary BPCI</th>
<th>Mandatory CJR/EPMs</th>
</tr>
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<tbody>
<tr>
<td>Participation</td>
<td>Voluntary for awardees</td>
<td>Mandatory for hospitals</td>
</tr>
<tr>
<td>Scope</td>
<td>Up to 48 MS-DRG families</td>
<td>Specific DRGs</td>
</tr>
<tr>
<td>Length of bundle</td>
<td>30, 60, or 90 days</td>
<td>90 days</td>
</tr>
<tr>
<td>Target price</td>
<td>Own historical data (2009–2012 trended)</td>
<td>Phase-in to trended regional prices</td>
</tr>
<tr>
<td>Reconciliation</td>
<td>Quarterly</td>
<td>Annual</td>
</tr>
<tr>
<td>Risk</td>
<td>Immediate two-sided risk</td>
<td>Phase-in two-sided risk</td>
</tr>
<tr>
<td>Quality linkage</td>
<td>Indirect</td>
<td>Potential for gains linked directly to quality scores</td>
</tr>
<tr>
<td>Waivers</td>
<td>Certain waivers allowed</td>
<td>Certain waivers allowed with model-specific tweaks</td>
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Policy on Gainsharing Is Evolving

- Gainsharing in Medicare bundling currently executed through waivers of fraud, waste & abuse laws
- So far, most gainsharing activity in bundling is limited to hospitals and physicians
- Policy on gainsharing is rapidly evolving as alternate payment approaches flourish and may become more widespread

Process of Gainsharing Can Vary Depending on VBP Model

- **Medicare Shared Savings Program (Medicare ACOs)**
  - Various waivers of FW&A laws for ACO participants finalized in 2015
  - Waivers are self-executing, after ACO certifies that gainsharing is *bona fide* arrangement related to purposes of ACO

- **Bundled Payments for Care Improvement (BPCI)**
  - At-risk bundler includes description of gainsharing arrangement in implementation protocol approved by CMS
  - Bundler executes formal agreement with gainsharers and sends list of provider numbers to CMS for program integrity screening

- **Comprehensive Care for Joint Replacement (CJR) Model**
  - *CJR collaborators* must be Medicare providers participating in the care redesign; can share both upside and downside risk (as well as internally derived cost savings) up to certain limits
NY’s Value-Based Payment Roadmap

Integrating Value-Based Payments with Managed Care

NY’s Medicaid VBP Roadmap: Emphasis on Shared Savings Model

• New York State’s VBP Roadmap approved by CMS in July 2015: VBP goals will be embedded into Medicaid managed care contracts

• Statewide goal: 80% to 90% of Medicaid payments be captured in at least Level 1 VBPs in 5 years

  – L1 means some linkage to quality with the opportunity for upside shared savings

• 35%–70% of total payments to be captured in Level 2+

  – L2 means linkage to quality; with both upside & downside shared risk

• VBP Roadmap just completed its first annual update
Understanding Shared Savings: Attribution and Benchmarks Are Key

- **Benchmarks** for VBP arrangements are created by measuring key metrics of attributed patients in base period.
- Benchmarks are risk-adjusted to account for differences in case load, further adjusted by value modifiers to account for variation in initial performance levels and trended for inflation.
- During the performance period, quality measures and costs will be compared to target metrics and, depending on the arrangement, savings will be shared or payments due.

Risk-adjusted Target Benchmarks Will Be Established by the State for Use by MCOs

- Calculated by State as input for VBP Contractor – MCO negotiations.
- Calculated by State and paid to MCO through rate adjustments.
- 3 Years Weighted Baseline: Historic claims data, Risk Adjustment, Growth Trend.
- Target Baseline Performance Adjustment.
- Efficiency & quality adjustments account for differences in starting points.
- Efficiency Modifier.
- Quality Modifier.
- Stimulus Adjustment designed to motivate increased risk.
- Target Budget.

Relationship of VBP Level to Quality

Enforced by Guidelines and MCO Contract Review

<table>
<thead>
<tr>
<th>Quality Targets % Met</th>
<th>Level 1 VBP Upside only</th>
<th>Level 2 VBP Upside and downside When actual costs &lt; budgeted costs</th>
<th>Level 2 VBP Upside and downside When actual costs &gt; budgeted costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥ 50% of Quality Targets Met</td>
<td>50% of savings returned to VBP contractors</td>
<td>Up to 90% of savings returned to VBP contractors</td>
<td>VBP contractors responsible for up to 50% of losses</td>
</tr>
<tr>
<td>&lt; 50% of Quality Targets Met</td>
<td>Between 10%–50% of savings returned to VBP contractors (sliding scale in proportion with % of quality targets met)</td>
<td>Between 10%–90% of savings returned to VBP contractors (sliding scale in proportion with % of quality targets met)</td>
<td>VBP contractors responsible for 50%–90% of losses (sliding scale in proportion with % of quality targets met)</td>
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<tr>
<td>Quality Worsens</td>
<td>No savings returned to VBP contractors</td>
<td>No savings returned to VBP contractors</td>
<td>VBP contractors responsible for up to 90% of losses</td>
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Options Under Discussion for MLTC Population As Part of Roadmap Update

Initial VPB

- Home care organization that can employ innovative care models to delay or prevent nursing home admissions and reduce avoidable hospitalizations
- Nursing home organization willing to engage in P4P around reducing avoidable hospitalizations, step down/return to community programs, and possible other key quality measures

Future VPB

- Arrangements with more flexible continuum of services to meet individual needs
- Opportunities for alignment with Medicare may be available

Outstanding issues include: necessity for Intermediaries to aggregate smaller agencies; integration with Medicare

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Source: A Path Towards VBP, Annual Update, NYSDOH, June 2016

Source: MLTC Clinical Advisory Group Meeting #4, April 18, 2016

August 31, 2016
Next Step for MLTC Population: VBP Pilots

Continually looking for organizations that are:

- Motivated
- Forward thinking
- Focused on member care quality

**Summer 2016**
- Potential pilot participation engagement

**Fall 2016**
- Pilot planning

**TBD**
- Medicare data enhancement capabilities

**Quarter 1 2017**
- Pilot launch

Source: MLTC Clinical Advisory Group Meeting #4, April 18, 2016

Thank You!

Any Additional Questions?
For More Information

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Health Dimensions Group: What We Do

Strategic Consulting
- Strategic planning and positioning
- Health care continuum alignments
- Market growth strategies
- PACE development
- Bundling implementation
- Senior service line development
- Post-acute medicine development

Operational and Performance Improvement
- Clinical
- Financial and billing
- Regulatory compliance
- Reimbursement advisory
- Transaction advisory
- Business office support
- Operations re-engineering

Management Solutions
- Strategic planning and positioning
- Turnaround management
- Transitional leadership
- Full-service management
- Acquisitions & divestiture
- Interim management
HOSPITALITY
STEWARDSHIP
INTEGRITY
RESPECT
HUMOR
Value Based Purchasing
MJHS’s Approach as a Provider & a Payer

Jay Gormley
Chief Strategy & Planning Officer, MJHS

MJHS Today
• An integrated not-for-profit health system
• Comprised of 11 corporations in 4 business:
  • Home & Community Based Services
    – CHHA
    – LHCSA
    – Care Management
  • Hospice & Palliative Care
  • Facility Based Care
    – Housing
  • Health Plans (Elderplan)
• $1.1B in annual revenues
• Serves over 55,000 New Yorkers each year
• Serves all 5 boroughs of New York City, Westchester, Nassau & Suffolk counties, plus some upstate managed care
• Main corporate office in Brooklyn with satellite locations in:
  • Manhattan,
  • Rochester, NY &
  • Nassau County
What is Value?

Value = \frac{Quality}{Cost}

What is Value?

Value = \frac{Perceived Quality}{Cost}
The Four Underlying Concepts of Cost Containment Through Payment Reform

1. Global Payment
2. ACO Shared Savings Program
3. Medical Home
4. Bundled Payment

5. Hospital-Physician Gainsharing
6. Payment for Coordination
7. Hospital P4P
8. Payment Adjustment for Readmissions
9. Payment Adjustment for Hospital Acquired Conditions
10. Physician P4P
11. Payment for Shared Decision Making

Eleven Payment Reform Models

- **Global Payment**
  - A single per-member per-month payment is made for all services delivered to a patient, with payment adjustments based on measured performance and patient risk.

- **ACO Shared Savings Program**
  - Groups of providers (known as accountable care organizations [ACOs]) that voluntarily assume responsibility for the care of a population of patients share payer savings if they meet quality and cost performance benchmarks.

- **Medical Home**
  - A physician practice or other provider is eligible to receive additional payments if medical home criteria are met. Payment may include calculations based on quality and cost performance using a P4P-like mechanism.

- **Bundled Payment**
  - A single “bundled” payment, which may include multiple providers in multiple care settings, is made for services delivered during an episode of care related to a medical condition or procedure.

- **Hospital-Physician Gainsharing**
  - Hospitals are permitted to provide payments to physicians that represent a share of savings resulting from collaborative efforts between the hospital and physicians to improve quality and efficiency.


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Eleven Payment Reform Models

- **Payment for Coordination**
  - Payments are made to providers furnishing care coordination services that integrate care between providers.

- **Hospital P4P**
  - Hospitals receive differential payments for meeting or missing performance benchmarks.

- **Payment Adjustment for Readmissions**
  - Payments to hospitals are adjusted based on the rate of potentially avoidable readmissions.

- **Payment Adjustment for Hospital Acquired Conditions**
  - Hospitals with high rates of hospital-acquired conditions are subject to a payment penalty, or treatment of hospital-acquired conditions or serious reportable events is not reimbursed.

- **Physician P4P**
  - Physicians receive differential payments for meeting or missing performance benchmarks.

- **Payment for Shared Decision Making**
  - Payment is made for the provision of shared decision making services.

Five Strategies for Optimal Provider Payer Relationships for VBP

1. Define the win
   - Where are we going?
   - Who benefits?

2. Communicate change at all levels
   - If it's not business as usual, then it's not business as usual

3. Don't dress up a quality program as a cost savings
   - And visa versa

4. Don't believe our data at first glance
   - And visa versa (you're stinks too)

5. Use the right technique for the right population

MJHS’s Approach

- **BPCI Model 2 (Bundling)**
  - Total cost of care approach for Medicare spend
  - All costs for Post acute and Acute Medicare spend of DRG defined groups are put into a budget
  - MJHS has targets but no Risk Share

- **CJR (Bundling)**
  - Total cost of care approach for Medicare spend
  - All costs for Post acute and Acute Medicare spend for lower ortho are put in to a budget
  - MJHS has targets but no Risk Share

- **Palliative Care (Capitation, Shared Savings & P4P)**
  - High Touch Model
    - High Capitation with extensive risk share and/or bonus payments
  - Practice Support Model for DSRIP, ACOs and IPAs

- **Homecare Capitation**
## MJHS’s Approach

- **MA Post Acute Care Bundle**
  - Case Rate for services for DRG defined conditions
    - i.e. "Flat Rate" or "Episodic"
  - Full upside down side shared Risk for 90 days
  - Varying Levels of Risk inclusion
    - Who holds what risk? (Hospital vs RHCF vs CHHA vs MD)
    - And for what?:
      - Post acute Utilization
        - Level of Care
        - Setting (RHCF vs CHHA)
        - Length of Stay
      - Acute Utilization (Readmits)
  - Require use of a Narrow Network

## Elderplan’s Approach

- **I-SNP Model (Total Cost of Care)**
  - Total cost of care approach for Medicare spend
  - All costs for Medicare spend of Long Term RHCF residents are put in to a budget
  - Capitation & Administrative Fee

- **IPA (physician led) Model (Shared Savings)**
  - Total cost of care approach for Medicare spend
  - All costs for Medicare spend for members in community are put in to a medical budget

- **I-SNP Model (Capitation & P4P)**
  - All SNF & MD Part A & B services are capitated
  - Bonus/Penalty for quality metrics

- **MLTCP (Shared Savings)**
  - Former Lombardi programs, Budget Based
  - Administrative Fee

- **MLTCP (P4P)**
Thank You!

Questions?

Feel free to reach out

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Understanding and Preparing for Episodic Reimbursement: Value Based Payments (VBP) and Bundled Payments

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Discussion Topics

- Commonly used terms and titles
- Bundled Payments (BPCI)
- Keys to Success
- Comprehensive Care for Joint Replacement (CCJR)
- Risk Structure
- Value Based Purchasing (VBP)
- Facility identity
- Identifying Facility specific costs and potential data resources
- Know the Metrics / Know your Metrics
- Communication
Commonly used terms and titles

- Fee-for-service
- Bundled Payments
- Bundled Payment for Care Improvement (BPCI)
- Value Based Purchasing (VBP)
- Comprehensive Care for Joint Replacement (CCJR)
- Potentially avoidable hospitalizations (PAH)
- Downstream provider

Bundled Payments

- Providers paid a set fee for an “episode of care”
  - Rewards for improved coordination, quality and efficiency
- Up front savings to CMS
  - No waiting period to assess if providers met targets
- HHS via the ACA recognizes 10 conditions
  - Chronic, acute, surgical and medical
Bundled Payments (continued)

- **Model 1** includes only hospitalization services for all Medicare severity diagnosis – related groups (DRGs). Medicare pays traditional FFS, less a negotiated discount and participants can enter into gain sharing arrangements with other providers.

- **Model 2** includes inpatient hospitalization and post-discharge services. Medicare pays expected amount less negotiated discount. (SNF related). Continued FFS payments but recoupment can occur if target is not met.

- **Model 3** includes only post-discharge services and paid same as Model 2. (SNF related). Continued FFS payments but recoupment can occur if target is not met.

- **Model 4** includes the inpatient hospitalization, physician and related readmission services. For this model Medicare reimburses a prospective determined amount. Providers submit “no-pay” claims, and are paid by the hospital out of the bundle payment.

Bundled Payments (Continued)

- Akin to DSRIP, in that it is hospital administered
- SNF’s not eligible for Model #1
- SNF’s eligible for Models 2,3,4
  - 48 clinical episodes
    - For example: Amputation, Cardiac Arrhythmia, Cellulitis, Chest Pain
**Keys to Success**

- Assess and integrate technology commensurate with Facility needs
- Solidify and maintain relationships
  - Hospital(s), MCO’s, other Care Partners
- Develop and monitor meaningful key metrics
- As known and available, compare your metrics to those of your competitors
- Identify Facility strengths and weaknesses
  - Patient satisfaction

**Comprehensive Care for Joint Replacement (CCJR)**

- Starts 4/1/2016 and ends 3/31/2021
- DRG’s for hip and knee replacements, DRG 469 and 470
- Episode analysis:
  - Hospitalization and 90 days post acute care discharge
  - All Medicare Part A and B services
  - Skilled nursing facility
  - Independent out-patient rehabilitation
  - Durable medical equipment (DME)
  - Medicare Part B reimbursable drugs
  - Hospice
Risk Structure
Hospital has financial risk and responsibility
  •Providers paid on a fee-for-service basis
  •Target prices established for hospital based on prior 3 years data
  •Target prices include “system discount”, the CMS savings
  •Pricing:
    •Years 1 and 2:
      •2/3 hospital specific, 1/3 regional pricing
    •Year 3:
      •1/3 hospital specific, 2/3 regional pricing
    •Years 4 and 5:
      •100% regional pricing

Financial Link to Quality
•Hospitals must meet minimum threshold for 3 quality metrics to be eligible for bonus
•Know your quality metrics and targets
  –Re-hospitalization rate during SNF stay and after SNF discharge
  –Rate of discharge to community
  –Length of stay
  –Improved function
  –Satisfaction score
•Maintain at minimum, a 3 star rating
•Reconciliation payments capped at 20% of target prices
•Year 1: no responsibility
•Year 2: Capped at 10% of target prices
•Years 3 – 5: Capped at 20%
Value Based Purchasing (VBP)

• Successor to DSRIP (Medicaid)
• To deliver patient centric, high quality and efficient care at a lower cost
  – Financial viability
  – Payment incentives
  – Accountability
  – Effectiveness
  – Access
  – Smooth transitions between levels of care

Facility Identity

• Self Evaluation
  – Strengths and weaknesses
• Specialization
• Community perception
  – Hospitals
  – Physicians
  – Community population
Identifying Facility Specific Costs: Potential Data Resources

• Medicare and Medicaid cost reports
• Internal facility reports
• Vendor historical data
• Available “public information” about neighboring providers
• Information available through trade organizations

Know the Metrics / Know your Metrics

• Cost per patient category
  – Key to successful negotiations
  – Length of stay
• Hospital re-admission rate
  – Potentially avoidable hospitalizations (PAH)
• Patient acuity versus staffing
• Medical staffing
  – Mid-level providers
  – General availability of medical resources
Communication

• Staff training and ongoing communication service delivery changes
• Vendors
  • Apprise vendors of when bills should be sent to the Facility versus other 3rd party payers
• Patients and Families
  • Apprise patients and or families of costs which they may be responsible to pay
• Ongoing communication with MCOs
• Ongoing communication with Hospitals and other care partners

Lessons learned

• Know your metrics
• Identify your specialties
• Technology
• Identify strengths and weaknesses or vulnerabilities
  • Bolster weaknesses, i.e. medical coverage
• Understand quality measures and work to implement, maintain, or improve scores
• Communicate with “Partners” to assess performance and satisfaction
  • MCO / Hospitals/ Downstream Providers, etc.
• Patient satisfaction