CMS 2016 Payment Model
Impact of Data Sources
Risk & Calibration

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- November 2015

2016 Model Discussion Items
- CMS-HCC Risk Adjustment Model for CY 2016
- Encounter Data as a Diagnosis Source
  - Filtering Logic
    - Physician
    - Inpatient
    - Outpatient
- Data Flow 90/10 PY 2016 Model
- Variance Impact - Payment
- RAPS / EDPS Variance
- What can you do?
- Questions

CMS-HCC Risk Adjustment
2016 ‘Blend’
CMS will blend RAPs and EDPS for 2016 risk score calculation
- CMS will continue to use the same risk adjustment model
  for PACE payments used from 2012 through 2015.

<table>
<thead>
<tr>
<th>PY 2015</th>
<th>PY 2016</th>
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<tbody>
<tr>
<td>‘Additive’</td>
<td>‘Blended’</td>
</tr>
<tr>
<td>Diagnosis from RAPs will be used for PY15</td>
<td>Diagnosis from RAPS will be at 90%, diagnosis from EDPS will be at 10%</td>
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<tr>
<td>Additional HCCs from EDPS - incorporated during 2015 Final Payment Calculation</td>
<td>CMS will incorporate the blend during the final settlement for PY 2016</td>
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Encounter Data Diagnosis Source

- CMS will continue to apply the MA coding difference factor to risk scores and will do so until they implement “risk adjustment using Medicare Advantage diagnostic, cost, and use data,” meaning until they have recalibrated the model using MA encounter data.

- According to CMS, since EDPS filtering logic does not change the definition of acceptable diagnoses or limit their submission
- CMS anticipates the risk scores calculated using encounter data will reflect the same coding trend as those calculated with RAPS-based diagnoses.

Filtering Logic: Professional

I. Filtering Professional Encounter Records (CPT based)
- Using the most recent version of an accepted professional encounter CMS will evaluate lines on an encounter data record to determine if the CPT/HCPCS codes are acceptable, based on the acceptable Medicare Code list.
- If there is at least one acceptable line on the record, CMS will use all the header diagnoses.
- If there are no acceptable service lines on the record, then CMS will not use any of the diagnoses for risk adjustment.

Filtering Logic: Inpatient

II. Filtering Institutional Inpatient Encounter Records
- CMS will use the Type of Bill Code to determine if an encounter is for services provided by a facility that is an acceptable source of diagnoses for risk adjustment.
- The acceptable institutional inpatient facility Type of Bill codes are 11x (Hospital Inpatient) and 41x (Religious Nonmedical Inpatient).
- CMS will take all header diagnoses from records where the Type of Bill Code equals one of these acceptable codes.
  - There is no CPT/HCPCS procedure screen for institutional inpatient bill type code.
III. Filtering Institutional Outpatient Encounter Records

- CMS will use the Type of Bill Codes to determine if an encounter is for services provided by a facility that is an acceptable source of diagnoses for risk adjustment.
- CMS will then evaluate lines (revenue centers) on an encounter data record to determine if the CPT/HCPCS codes are acceptable, based on the acceptable Medicare Code list.
  1. Type of Bill Code equals one of these acceptable codes,
  2. At least one acceptable CPT/HCPCS code on a service line.

90/10 PY 2016 Model

- Diagnoses from Claims/Encounter & Supplemental data
- Filtering using new CMS draft filtering logic
- Acceptable Ds that rollup to HCC
- Risk Score x 10%

- Filtering using the Health Plan’s RAPS filtering logic
- Acceptable Ds that rollup to HCC
- Risk Score x 90%

Variance Impact - Payment

- Total HCCs combined Claims and RAPS
- HCCs from claims EQUALS RAPS
  Payment = 100%
- HCCs from claims does NOT EQUAL RAPS
  Payment = 90% RAPS ONLY
  Payment = 10% CLAIMS ONLY
Data Source Impact on Recalibration

- If HCC from EDPS = HCC from RAPs
  - A blended data source will not impact payment
- Currently, base rates are calculated using FFS ‘cost’
- When CMS recalibrates using MAO ‘costs’
  - Completeness of claims records will drive base rates
- The completeness of EDPS is crucial to keeping appropriate base rates

RAPS / EDPS Variance

Initial Health Plan action items for RAPS / EDPS data files
- Check RAPS filtering logic to CMS DRAFT EPDS filtering logic
- If Variance, align RAPS with EDPS filtering logic

VARIANCE:
- If HCC is in both RAPS and EDPS – Congratulations!
  - If there is a variance:
    - RAPS (not EDPS) EDPS (not in RAPS)
      - Search EDPS rejects to see if in the reject file
      - Determine if on MAO-002
      - If none of above, research why not sent to CMS
      - Check completeness of RAPs data
      - Check filtering logic

What can you do?

- Risk Adjustment – RAPs & EDPS
  - Under/Over payment based on variance between RAPS & EDPS
  - Audit implications?
  - Work your rejects on both sides to avoid losing any % of payment
  - Work EDPS rejects from MAO-002 (avoid calibration impact)
  - Ensure additional diagnosis on EDPS are connected by ICN where possible
    - Additional diagnosis not linked may impact calibration negatively
- Variance
  - Determine any variance between RAPS and EDPS filtering
    - CMS filtering logic is currently ‘draft’
    - Submission variance can impact payment and calibration
    - Know what your EDI Vendors are doing
      - What error reports are they getting from the Plan, what error reports are you getting from them
      - Are they applying the correct filtering logic – have you reviewed their logic?
Questions?
Lessons learned:
The early adoption of ICD-10 in an HCC world

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ICD-10 deciding factors

- High-level decision was made to go live early with ICD-10. Dual coding in ICD-9 and ICD-10 began on April 1, 2015.
- Advantage of giving physicians and staff six more months to become familiar with ICD-10 and to identify any system issues prior to the October 1 deadline.
- Would allow for ICD-10 claims testing.
- Future lab orders and referrals that were generated now would already be ICD-10 compliant.
- Concerns about potential loss of HCC codes captured due to inadequate coding and documentation.

Physician frustrations

- Physicians are already frustrated and overwhelmed with electronic medical records, patient satisfaction surveys, Pay for Performance, Meaningful Use, increasing patient expectations, patient messaging, etc.
The physician mindset

- Most physicians have a big ego and don’t want to be told what to do.
- Resistant and slow to change. Creatures of habit.
- Older physicians may resist technological changes.
- Most physicians have anal-compulsive tendencies and want to do a thorough job.
- Physicians respond to the right incentives.

Our HCC program

- Director of Risk Adjustment Jessica Kwon, Pharm.D.
- HCC Coding Manager Daniela Culciar and Clinical RAF Educator Lidia Micile provide additional resources and education.
- Dedicated HCC-trained coders preview the charts prior to each senior appointment to identify documented conditions that have not yet been coded.
- Physician education and engagement are essential components to achieving success.
- Education occurs via bimonthly physician meetings, weekly facility meetings, email, 1-on-1 discussions.

HCC Enhancement Tool

- Developed an enhancement tool within our Electronic Medical Records system to identify past HCC codes that had not yet been documented during this calendar year.
- HCC Registry (LYNTY Box) where LYNTY stands for “Last Year, Not This Year.”
Launch of Dual Coding

- Educating physicians about the increased specificity of ICD-10 diagnosis codes.
- Updating templates with ICD-10 codes.
- Improving clinical documentation.
- Coders audited the notes and provided feedback.
- Simplifying the use of the diagnosis calculator.

Post ICD-10 Outcomes

- The ICD-10 transition on October 1 went smoothly.
- Our risk adjustment scores have steadily increased, without any dip in either April or October.
- Physician engagement with HCC program is rising.
- We continue to provide multiple opportunities for physicians to have their questions answered. The ideal way is a small group or individual session.
- It’s best to educate physicians about risk adjustment with small tidbits over time & to constantly repeat the message without sounding redundant.
- Most physicians are perfectionists and want to do a good job! Give them the tools to succeed!

Questions?

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ICD–10 Panel Discussion
The Perspective of the Coders and Providers

What Happened Before
October 1st – Coders for providers

› Coder were holding classes for providers and staff
› They were using email, etc. for tips
› They created handouts for distribution
› Coders used whatever they could to get the facts out about ICD–10

What Happened Before
October 1st – Coders for themselves

› Coders seemed to be ready for the change

› Certified coders action needed:
  • AAPC – retest
  • AHIMA – CEUs
What Happened Before October 1st—Providers

- A large percent of providers were slow to get ready
- Those that waited had a hard time finding code books as the 2015 were sold out
- Some ICD-10 code sets were not loaded early enough to do internal testing or the provider didn’t realize they had ICD-10 loaded in their system

What Happened October 1st

- NOT MUCH!
- Very few calls
- Possibly put billing off to the side to deal with later

What Happened After October 1st

- Only a few system errors
- Some date of service / code set errors
- Some calls verifying codes
  - Lack of confidence in finding ICD-10 codes
What Were the Provider Training Challenges

- Fear and anxiety
  - #1 issue
- Place holder concept
  - Hard concept to understand
    - Some code books put the X in the code and some did not
- No urgency to get ready

Conclusion

- The conversion was easier than expected
- We sat by the phones ready for a disaster
  - It never happened!
ICD-10 Code File Upload

- During the early stages we developed a project plan which included a test file upload in our test environment. The initial load allowed the plan to review the code display and identify possible issues.
- The Information Management, Medical Directors, and coders conducted an ICD-10 system analysis by reviewing all areas of the system analyzed to determine impact. Mainly to identify the risk and problem areas. There were approximately 30 Codes which overlapped ICD-9 and ICD-10 with different descriptions.

Clearing House / Vendors

- We reached out to our clearing house requesting their ICD-10 plan. We requested a outline of the business rules and edits in their system. If claims rejected at the front end we needed a way to identify providers with potential billing issues.
- Information compared to plan internal database edits.
- We worked with vendors supporting the provider portal to ensure authorizations and claims processed with ICD-10 would be successful during transfer back to our database.
Review of Claim/Auth Edits

- We reviewed there were 238 Codes which overlapped ICD-9 and ICD-10 with different descriptions. We found that we had to revisit systems to clearly identify code file versions, and to make sure our claims database accurately capture the correct code version.
- Once code files were updated to our system we

- Claims may not contain a combination of ICD-9 and ICD-10 codes.
- Claims must be submitted with ICD-10 codes if the date of discharge / date of service is on or after the ICD-10 compliance date of 10/1/2015.
- Claims must not be submitted with ICD-10 codes prior to compliance date of 10/1/2015.
- For some claims which span the ICD-10 compliance date, the admit date on the claim can be prior to the ICD-10 compliance date and the claim can still contain ICD-10 codes. For other claims which span the ICD-10 compliance date, a splitting of the claim into two separate claims is necessary. CMS has outlined guidance on which claims will need to be split in these claims processing documents (SE1325 and MM7492).
- CMS uses the “bill type” on an institutional claim for determining whether the claim should be split.