Today’s Presenters

- Paula Murray  
  Educator, Provider Services

- Lara Adelberger  
  STARS Clinical Coordinator
Risk Adjustment, Quality Measures, and Care of Older Adults

April 27, 2017
Agenda

- **Risk Adjustment**
  - What is RA, why do we need it
  - What are HCCs and RAFs
  - Looking ahead in 2017
  - Tips for success

- **Getting a Jump on Quality**
  - STARs: Medicare Advantage Quality
  - Diabetes Incentive Program
  - Dual Special Needs
  - Medication Management
  - Cozeva

- **Success in Performance**
  - New Reporting Codes
  - Success Strategies
  - Payment Transformation
Risk Adjustment
Terminology

- **CMS** - Centers for Medicare & Medicaid Services
- **HCC** (Hierarchical Condition Categories) - Groupings of specific ICD10 codes that roll up into a similar condition category.
- **RxHCC** - Some HCC codes adjust risk due to prescription burden of disease
- **MA** (Medicare Advantage) - A method of helping CMS budget for the cost of caring for populations of patients
- **RA** – Risk Adjustment
- **RAF** (Risk Adjustment Factor) - A coefficient that adds together reported ICD-10 codes & demographics to create the risk profile of a Medicare member.
What is Risk Adjustment?

**Risk Adjustment** is a process that CMS uses to reimburse Medicare Advantage plans based on the health status of members. This ensures that CMS pays plans appropriately for members’ predicted health costs based on demographics and health status.
Why do we need risk adjustment?

- To accurately reflect the health of our membership
- Greater disease burden = higher risk adjustment score
- Healthier patient = lower risk adjustment score
Hierarchical Condition Categories
HCC Background

- Introduced in 2004
- Used by CMS for determining capitated payments for the MA and other Medicare programs
- Allows payments to be risk-adjusted based on patient complexity
- Uses a patient’s documented 12-month diagnostic coding history to predict future financial utilization and risk
- Creates a RAF “score” that reflects his or her complexity
- This score is then multiplied by a base rate to set the per-member-per-month (PMPM) capitated reimbursement for the next period of coverage

69,000+ Total ICD-10 Codes

9,505 ICD-10s in Risk Adjustment

79 HCCs
What is an HCC code?

- The HCC model is comprised of over 9,000 ICD-10 codes that typically represent costly, chronic diseases such as:

  - Diabetes
  - Chronic kidney disease
  - Congestive heart failure
  - Chronic obstructive pulmonary disease
  - Malignant neoplasms
  - Some acute conditions (MI, CVA, hip fx)
# HCC Table

<table>
<thead>
<tr>
<th>Source</th>
<th>Description</th>
<th>RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCC 1</td>
<td>HIV/AIDS</td>
<td>0.470</td>
</tr>
<tr>
<td>HCC 2</td>
<td>Septicemia, Sepsis, Systemic Inflammatory</td>
<td>0.535</td>
</tr>
<tr>
<td></td>
<td>Response Syndrome/Shock</td>
<td></td>
</tr>
<tr>
<td>HCC 6</td>
<td>Opportunistic Infections</td>
<td>0.440</td>
</tr>
<tr>
<td>HCC 8</td>
<td>Metastatic Cancer and Acute Leukemia</td>
<td>2.484</td>
</tr>
<tr>
<td>HCC 9</td>
<td>Lung and Other Severe Cancers</td>
<td>0.973</td>
</tr>
<tr>
<td>HCC 10</td>
<td>Lymphoma and Other Cancers</td>
<td>0.672</td>
</tr>
<tr>
<td>HCC 11</td>
<td>Colorectal, Bladder, and Other Cancers</td>
<td>0.317</td>
</tr>
<tr>
<td>HCC 12</td>
<td>Breast, Prostate, and Other Cancers and Tumors</td>
<td>0.154</td>
</tr>
<tr>
<td>HCC 17</td>
<td>Diabetes with Acute Complications</td>
<td>0.368</td>
</tr>
<tr>
<td>HCC 18</td>
<td>Diabetes with Chronic Complications</td>
<td>0.368</td>
</tr>
<tr>
<td>HCC 19</td>
<td>Diabetes without Complication</td>
<td>0.118</td>
</tr>
<tr>
<td>HCC 21</td>
<td>Protein-Calorie Malnutrition</td>
<td>0.713</td>
</tr>
<tr>
<td>HCC 22</td>
<td>Morbid Obesity</td>
<td>0.365</td>
</tr>
<tr>
<td>HCC 23</td>
<td>Other Significant Endocrine and Metabolic</td>
<td>0.245</td>
</tr>
<tr>
<td></td>
<td>Disorders</td>
<td></td>
</tr>
<tr>
<td>HCC 27</td>
<td>End-Stage Liver Disease</td>
<td>0.923</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Source</th>
<th>Description</th>
<th>RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCC 55</td>
<td>Drug/Alcohol Dependence</td>
<td>0.420</td>
</tr>
<tr>
<td>HCC 57</td>
<td>Schizophrenia</td>
<td>0.490</td>
</tr>
<tr>
<td>HCC 58</td>
<td>Major Depressive, Bipolar, and Paranoid Disorders</td>
<td>0.330</td>
</tr>
<tr>
<td>HCC 70</td>
<td>Quadriplegia</td>
<td>1.234</td>
</tr>
<tr>
<td>HCC 71</td>
<td>Paraplegia</td>
<td>1.052</td>
</tr>
<tr>
<td>HCC 72</td>
<td>Spinal Cord Disorders/Injuries</td>
<td>0.509</td>
</tr>
<tr>
<td>HCC 73</td>
<td>Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease</td>
<td>0.958</td>
</tr>
<tr>
<td>HCC 74</td>
<td>Cerebral Palsy</td>
<td>0.045</td>
</tr>
<tr>
<td>HCC 75</td>
<td>Myasthenia Gravis/Myoneural Disorders and Guillain-Barr Syndrome/Inflammatory and Toxic Neuropathy</td>
<td>0.408</td>
</tr>
<tr>
<td>HCC 76</td>
<td>Muscular Dystrophy</td>
<td>0.565</td>
</tr>
<tr>
<td>HCC 77</td>
<td>Multiple Sclerosis</td>
<td>0.556</td>
</tr>
<tr>
<td>HCC 78</td>
<td>Parkinson's and Huntington's Diseases</td>
<td>0.691</td>
</tr>
<tr>
<td>HCC 79</td>
<td>Seizure Disorders and Convulsions</td>
<td>0.284</td>
</tr>
<tr>
<td>HCC 80</td>
<td>Coma, Brain Compression/Anoxic Damage</td>
<td>0.570</td>
</tr>
<tr>
<td>HCC 82</td>
<td>Respirator Dependence/Tracheostomy Status</td>
<td>1.520</td>
</tr>
</tbody>
</table>
Risk Adjustment Factor (RAF)

- What affects the Risk Score?
  - Enrollee health status
  - Demographic characteristics
  - Accurate documentation
  - Coded HCCs

- Health Status is determined based on the following methodology:
  - Physicians use diagnosis codes to document health status
  - Each HCC Model Category relates to a “Relative Factor” or Health Risk Score
How Does Risk Adjustment Work?

- Physicians diagnose and report their patients’ conditions
- Physicians do not assign a RAF score
- CMS adjusts payments based on expected costs
- Risk scores are reset each year
## Risk Adjustment Coding Example #1

<table>
<thead>
<tr>
<th>Condition</th>
<th>ICD-10 Code</th>
<th>ICD-10-CM Description</th>
<th>Risk</th>
<th>HCC Risk Adjustment Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>E11.9</td>
<td>Type 2 diabetes mellitus without complications</td>
<td>Less Risk</td>
<td>0.118</td>
</tr>
<tr>
<td></td>
<td>E11.21</td>
<td>Type 2 diabetes with diabetic nephropathy</td>
<td>Higher Risk</td>
<td>0.368</td>
</tr>
<tr>
<td>Hypertension</td>
<td>I10</td>
<td>Essential (primary) hypertension</td>
<td>Less Risk</td>
<td>0.000</td>
</tr>
<tr>
<td></td>
<td>I12.0</td>
<td>Hypertensive chronic kidney disease</td>
<td>Higher Risk</td>
<td>0.224</td>
</tr>
</tbody>
</table>
# Risk Adjustment Coding Example #2

<table>
<thead>
<tr>
<th>No conditions coded</th>
<th>Some conditions coded</th>
<th>All chronic conditions coded</th>
</tr>
</thead>
<tbody>
<tr>
<td>76 year old female</td>
<td>0.442</td>
<td>0.442</td>
</tr>
<tr>
<td>Medicaid eligible</td>
<td>0.151</td>
<td>0.151</td>
</tr>
<tr>
<td>DM with complications</td>
<td>X</td>
<td>DM w/o complications</td>
</tr>
<tr>
<td>Vascular disease</td>
<td>X</td>
<td>Vascular disease</td>
</tr>
<tr>
<td>CHF</td>
<td>X</td>
<td>CHF</td>
</tr>
<tr>
<td>Disease interaction (DM+CHF)</td>
<td>X</td>
<td>Disease interaction (DM+CHF)</td>
</tr>
<tr>
<td>Total RAF</td>
<td>0.593</td>
<td>Total RAF</td>
</tr>
</tbody>
</table>

| 0.442  | 0.118  | 0.368  |
| 0.299  | 0.368  | 0.182  |
| 0.593  | 0.711  | 1.810  |

5/12/2017
Why Is Risk Adjustment Important?

- CMS uses RA to make appropriate payments for patients’ expected medical costs
- Coding correctly for MA patients can mean an increase in payment of 2-3 times the base amount
- Medical record documentation and accurate coding are critical to assess risk and ensure proper payment
- Risk Adjustment allows physicians and payers to effectively manage their patients’ health care
- Accurate coding helps identify high-risk patients
How Does Risk Adjustment Affect You?

Physicians treat patients who are on plans that are funded through risk adjustment models.

Providers document and code diagnoses accurately and to the highest level of specificity.

Documentation & coding establishes the complexity and workload of their patient panel.

Documentation and diagnoses become the basis for funding and reimbursement.

Proper coding = proper resources.
Why code accurately?

- **Accurate, timely claims** + **Accurate codes** = **Correct payment**
- **Inaccurate claims** + **Less specific codes** = **Less payment**
Characteristics of the HCC Model

- HCCs/Multiple Chronic Diseases
- Diagnostic Sources
- Disease Interactions
- Prospective in Nature
- Demographics

Characteristics of CMS-HCC Model
How HCCs affect an MA Plan

- The CMS model is cumulative

- Patients can have multiple HCC categories assigned to them to indicate multiple chronic conditions

- Some categories supersede other categories, which comprise the hierarchy within the categories
RxHCCs

- RxHCCs cover many diagnoses which are not covered in the HCC
- Almost all HCC diagnoses are also RxHCC codes but all RxHCC are NOT also HCC
- Rx HCC’s complement the reimbursement for managing patients with illnesses that may not be as complex or costly as HCC diagnoses, but qualify for additional reimbursement to the health plans due to increased medication costs
What Does The Future Hold?

Healthcare is rapidly changing

More patients are affected than just Medicare

Documentation & coding will increasingly drive reimbursement and quality measures

Risk adjustment is used for ACA and Medicaid
How Do We Improve?

- HMSA to help physicians, coders, office staff stay up to date on best practices and HCCs
- Reporting a complete picture of RAF increases the accuracy of the risk score and reduces the need to request medical records or audit providers’ claims
- HCC streamlines the process of creating clean claims and allows for efficient reimbursement
HMSA and Risk Adjustment

Retrospective  Prospective
HMSA and Risk Adjustment - Retrospective

- **Review**: Ensure accuracy of chart reviews
- **Analyze**: Report chart review findings to providers
- **Educate**: Provide training & education on RA basics
- **Improve**: Conduct performance management reviews
- **Align**: Improve & maximize RA scores of MA plans
HMSA and Risk Adjustment - Prospective

- Education & Administrative Resources
- Communications & Outreach
- Training
- Incentives
- Reporting & Analysis

Risk Adjustment
Formula For Success
Best Practice: See Each Patient Every Year

Factors that can affect a patient’s diagnostic picture

- Patient with chronic conditions not monitored = chronic conditions not treated
- Patient seen infrequently for other problems, without updating and documenting chronic conditions
- Not seeing PCP annually
Documentation Tips

- Commonly used by providers to mean the condition is part of the patient’s history, ‘h/o’ or ‘s/p’ is indicative to coders of a past condition and cannot be coded as active disease.
- Documentation must indicate a treatment plan for each diagnosis, such as ‘refer to cardiologist’, or ‘observation for exacerbation or worsening’ and an assessment, such as ‘stable’, ‘worsening’, ‘not responding to treatment’
- Remember to use linking terms like ‘due to’ or ‘secondary to’ to describe relationships between diseases and manifestations
Linking Words

- Linking words create relationship between diseases and manifestations
- Assures coders of a cause and effect between disease and manifestation, as we cannot assume (except in hypertensive renal disease)
- Appropriate terms:
  - Due to
  - Secondary to
  - Use of associative suffix ‘ic’ or ‘ive’ (diabetic ulcer or hypertensive heart disease)
Coding and Clinical Documentation Improvement

- Non-specific codes can dramatically (and negatively) impact reimbursement under new payment models
- It is critical that documentation and diagnosis coding accurately reflect the acuity of the patient’s condition known and present at the time of the encounter
- Use of an unspecified code may be appropriate in some cases, and should be assigned when the documentation does not reflect a higher level of specificity. However, providers should identify scenarios where specificity appears to be under-documented or miscoded.
- Clinical documentation improvement and coding proficiency go hand-in-hand in supporting this critical initiative.
Plan Now for the Future

- Historically, fee-for-service reimbursement has placed emphasis on the CPT and HCPCS procedural service codes for professional claims instead of ICD diagnosis codes.
- With the rise of value-based reimbursement models and the focus on risk and outcomes, now is the time to focus on accurate ICD-10 diagnosis coding and documentation.
- This allows providers to accurately reflect how their patients are categorized by payers and how their future reimbursements are determined.
Tips and Tricks to Improve the Use of ICD-10 Codes

- **Learn** current ICD-10 coding guidelines and conventions to ensure that the correct codes are being applied.

- **Code** from the medical record documentation. Do not rely on General Equivalency Mapping (GEMs) or other crosswalk tools to assign ICD-10 codes.

- **Perform** documentation reviews to validate that the correct ICD-10 code is being assigned, and engage in provider documentation training on code selection.

- **Monitor** coder productivity and quality.
Documentation Strategy

- All encounters must contain:
  - Patient Name & DOB on every page
  - Date of Service
  - Signature of provider + credentials
  - Compliant signatures (authenticated electronic signatures or original signatures-typed or stamped signatures not acceptable)
  - Document to highest specificity (“Benign Hypertension” vs “HTN”)
  - All diagnoses must include an assessment and treatment plan - lists are not sufficient!
MEAT in Your Documentation

Monitor

- Signs, symptoms, disease progression, disease regression

Evaluate

- Test results, medication effectiveness, response to treatment

Assess/Address

- Ordering tests, discussion, review records, counseling

Treatment

- Medications, therapies, other modalities
Tips for Success in HCC coding

- Capture HCCs at least once every 12 months
- Ensure the diagnosis code(s) being billed match your documentation
- Be mindful of M.E.A.T.
- Use linking statements or document causal relationships for manifestation codes
- Review specialist documentation
Questions?
Stars:
Coding for Quality
CMS asks: “How Good is Your MA Plan?"

- Inform beneficiaries as they choose a plan
- Encourage evidence-based practices
- Improve health & well-being
Stars: What gets scored?

- Preventative Screenings
- Chronic Disease Care
- Dual Eligible Member Care
- Care Coordination
- Medication Management
Why code for quality metrics?

- Reduce HEDIS medical record collections
- Increase quality scores and payments for Payment Transformation and Pay for Quality
- Increase cost of care payments for Payment Transformation and MACRA
- Get credit for the work you do
CODE TO CLOSE CARE GAPS
Care for Older Adults: Dual Special Need

- Once per calendar year
- Four part assessment:
  - Medication Review
  - Functional Status Assessment
  - Pain Assessment
  - Advance Care Planning
- COA form available with coding and checklist assessments

- Complete the assessments
- Add completed form to your medical record
- File a claim
Medication Reconciliation Post Discharge

Hospital Discharge

30 day window – Medication Reconciliation

Document in chart: Discharge medications were reviewed and reconciled with pre-admit medications.

Document on claim (CPT II code 1111F)

Forms available on provider portal
Rheumatoid Arthritis

- Z87.30: Patient reported or personal history of RA, History of RA in remission
CODE FOR BURDEN OF ILLNESS
Hospital Readmissions

- Risk scores and accurate coding affect risk-adjusted measures
- Populations with a higher burden of illness have higher expected admissions (and readmissions)
Potentially Preventable Complications

- Hospitalizations related to:
  - Diabetes
  - Diabetes-related amputations
  - COPD
  - Asthma

- Hypertension
- Heart Failure
- Bacterial pneumonia
- Urinary Tract Infection
- Cellulitis
- Pressure ulcer

- Metric is scored on observed hospitalizations vs. expected
- Code to highest level of specificity
Take Home Thoughts

- Use CPT II codes to report quality care
- Code burden of illness to the highest specificity
- Need a guide to helpful codes for quality measures?
  - Quick Reference Guide “Coding for Medicare Star Ratings”
  - Payment Transformation coding guide
Success in Performance Measures
Important Reminders about Reporting Measures

- All codes on claims submitted to HMSA, whether claim line is “approved” or “denied,” are captured for numerator credit in Cozeva
- Some CPT codes used in reporting may trigger member copayments
- Please consider coding options that will minimize impact on your patients
Reminders about Benefits

- Some performance measures are recognized as Affordable Care Act (ACA) preventive services that have no member copayment when a specific combination of procedure code and diagnosis code is billed.
- Check on HHIN to determine if member has a commercial HMSA ACA-compliant plan.
  - On HHIN, look under Special Instructions heading for text: “This is a Non-Grandfathered – Patient Protection and Affordable Care Act (PPACA) Compliant Plan.”
  - HHIN displays ACA benefits under “Routine Preventive Care” for HMO plans, and under “Preventive Services” for PPO and ACA Individual HMO Metallic plans.
Sharecare RealAge Assessment  

- Commercial members 18 and older who complete Sharecare RealAge assessment at least once during the measurement year. Gauges how fast you’re aging based on lifestyle and medical history.
- Replaces Well-Being 5
- More information to be provided. Explore at https://www.sharecare.com/static/realage-test
Pediatric Measures and Due Dates  New!

- Birthday rule: Measures with due dates determined by child’s birthday
  - Well-child visits before age 15 months (birthday plus 90 days)
  - Childhood immunizations – second birthday
  - Developmental screenings – before the child’s first, second or third birthday

- Calendar-year rule: Measures that count only if completed in that calendar year
  - Well-child visits in third to sixth years of life – any visit during the measurement year will count (can be before or after birthday), but at least 9 months since previous well-child visit
  - Adolescent well-care – any visit during the measurement year will count but at least 9 months since previous well-care visit
Early-Borns and Late-Borns

- Well-child visits in third to sixth years need to be completed in the calendar year for PCP to receive numerator credit

Examples:
- Kawika turns 6 in January 15, 2017. Although his parents prefer a well-child visit before Christmas 2016, he needs to wait until January 2017 for the well-child visit to count for numerator credit for calendar year 2017.

- Kuulei turns 6 on December 28, 2017. Visit should be scheduled before end of 2017. If the well-visit occurs in January 2018, the visit will not count for numerator credit because Kuulei turns 7 in 2018.
Aging into Measures

- **Calendar-year view**: Cozeva displays all members who are eligible for a measure if they will be the qualifying age as of December 31

Example:

- Immunizations for adolescents required for members by their 13\textsuperscript{th} birthday

- Cozeva populates measure registry with all members born in year 2004 as the denominator. Patients are 12 at the beginning of the year and 13 at the end of the year.

- When required shots (meningococcal and Tdap) are given by child’s 13\textsuperscript{th} birthday, PCPs receive numerator credit
Success Strategies: Pediatrics

<table>
<thead>
<tr>
<th>Children</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn through age 15 months</td>
<td>Well-child visits in the first 15 months</td>
</tr>
<tr>
<td>By age 2 birthday</td>
<td>Childhood immunizations by age 2</td>
</tr>
<tr>
<td>By age 1 birthday</td>
<td>Developmental screening in first 3 years of life, annual</td>
</tr>
<tr>
<td>By age 2 birthday</td>
<td></td>
</tr>
<tr>
<td>By age 3 birthday</td>
<td></td>
</tr>
<tr>
<td>Age 3 to 17</td>
<td>CSHCN Screener, every 3 years</td>
</tr>
<tr>
<td>Age 3 to 17</td>
<td>Weight assessment and counseling for nutrition and physical activity</td>
</tr>
<tr>
<td>Age 3, 4, 5 and 6</td>
<td>Well-child visit annually</td>
</tr>
<tr>
<td>Birth to age 20, per state EPSDT schedule (QUEST Integration)</td>
<td>EPSDT form submission</td>
</tr>
</tbody>
</table>
# Success Strategies: Pediatrics

<table>
<thead>
<tr>
<th>Children</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages 12 to 21</td>
<td>Adolescent well-care visit</td>
</tr>
<tr>
<td>Ages 12 to 17</td>
<td>Screening for symptoms of clinical depression and anxiety [Patient Health Questionnaire-2, -4, -9, -Adolescents]</td>
</tr>
<tr>
<td>By age 13 birthday</td>
<td>Immunization for adolescents</td>
</tr>
<tr>
<td>All patients, with each visit</td>
<td>Patient Experience survey</td>
</tr>
<tr>
<td>All patients</td>
<td>Check on well-being of all patients in panel at least once a year [annual patient survey administered to sample of patients]</td>
</tr>
</tbody>
</table>
## Success Strategies: Adults

<table>
<thead>
<tr>
<th>Adults</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages 18 and older</td>
<td>Flu vaccine</td>
</tr>
<tr>
<td>Ages 18 and older</td>
<td>Tobacco cessation and follow-up</td>
</tr>
<tr>
<td>Ages 18 and older</td>
<td>Screening for symptoms of clinical depression and anxiety</td>
</tr>
<tr>
<td>Ages 18 and older</td>
<td>RealAge assessment completed</td>
</tr>
<tr>
<td>Ages 18 to 74</td>
<td>Body mass index assessment</td>
</tr>
<tr>
<td>Ages 18 to 75</td>
<td>All 4 diabetes measures</td>
</tr>
<tr>
<td>Ages 18 to 85</td>
<td>Controlling blood pressure</td>
</tr>
<tr>
<td>Women ages 24 to 64</td>
<td>Cervical cancer screening</td>
</tr>
<tr>
<td>Women ages 52 to 74</td>
<td>Breast cancer screening</td>
</tr>
<tr>
<td>Ages 51 to 75</td>
<td>Colorectal cancer screening</td>
</tr>
</tbody>
</table>
## Success Strategies: Adults

<table>
<thead>
<tr>
<th>Adults</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages 65 and older</td>
<td>Advance care planning</td>
</tr>
<tr>
<td>Ages 65 and older</td>
<td>Review of chronic conditions</td>
</tr>
<tr>
<td>All patients</td>
<td>Check on well-being of all patients in panel at least once a year</td>
</tr>
<tr>
<td></td>
<td>[annual patient survey administered to sample of patients]</td>
</tr>
</tbody>
</table>
Success Strategies – Office Workflows

Pre-visit Planning:

- Review schedule of future visits and check Cozeva for any outstanding care gaps
  - Flag gaps on face sheet, encounter forms, superbill, or EMR alerts, etc.
  - Medicare patients with RCCs, print patient’s RCC list from Cozeva
  - Check for any reports from specialists that may need to be addressed (e.g. colorectal, breast, cervical screenings, etc.)
Success Strategies – Office Workflows

Patient Check-In/In-take:

- **Clinical Depression & Anxiety Screener** (age 18 and older) PHQ 4
- **Patient Assessment/Chief Complaints/Vitals** (HT, WT, BMI, BP, TEMP, etc)
  - If BP reading is too high (above 139/89), repeat BP
  - Document appropriate codes for BMI & BP
- **Tobacco Screening** (age 18 and over)
  - Ask about smoking status
  - Document in medical record and appropriate codes for smoking status
Success Strategies – Office Workflows

Patient Check-In/Intake (con’t)

- **Care Gaps** (Breast Screening, Cervical Screening, Colorectal Screening, & Diabetes Care)
  - If patient completed any of screenings and there are no results in file, have the patient sign a Release of Information Form to request records.
- **Flu Vaccine** (age 18 and over) *Seasonal
- **Advance Care Planning** (age 65 and older)
  - Only if physician wants this to occur, may vary per office. Most physicians would rather go over with the patient themselves.
  - POLST information and documents can be found at [http://kokuamau.org/](http://kokuamau.org/)
Success Strategies – Office Workflow

Patient Roomed with Physician:

- Medicare Patients with RCC
  - Documentation of M.E.A.T.
  - Code at the highest level of specificity for each attested condition
  - If disconfirming, enter text for Disconfirm in Cozeva.
- Advance Care Planning (age 65 and older)
  - Document discussion and code appropriately
- Adolescent Well Care Visit (age 12-21)
  - Medical record evidence of all of the following is required:
    - Health and development history (physical and mental)
    - Physical Exam
    - Health education/anticipatory guidance
Success Strategies – Office Workflow

Patient Check-Out:

- Schedule next visit, tests, procedures, if applicable. Provide the patient with the information.
- Assist patient with referrals/specialist appointments
- Collect co-pay

Copays are due prior to services rendered. Please present your Photo I.D. and insurance card at time of check-in. Thank You!
2017: A Transition Year

- Staggered starts for Payment Transformation
  - **January 1, 2017** – PCPs in identified Physician Organizations will move fully into Payment Transformation (global monthly payment + new measures), joining the 2016 pilot
  - **April 1, 2017** – Some PCPs begin global monthly payment, but remain on Pay for Quality measures through 2017
  - **July 1, 2017** – Last group of PCPs begins global monthly payment, but remain on Pay for Quality measures through 2017

*Expectation that most PCPs will move to Payment Transformation payment and metrics by 2018*
PCPs in Transition to Payment Transformation

- Payment Transformation (Pilot, April 2016)
- Payment Transformation (January 2017)
- Payment Transformation (April 2017)
- Payment Transformation (July 2017)
Important Announcements

▪ In 2017, global monthly payment will be made on or about the 15th of the month, with patient attribution from one month earlier

▪ **New!** Engagement measure to build PCP’s profile on Sharecare find-a-provider application

▪ **New!** Performance measure – Well-Being 5 being replaced by Sharecare RealAge Assessment

▪ Report to Provider will give more information about processing of each claim; will make account reconciliation easier

**Coming! PO training sessions and webinars**
Important Announcements

- Supplemental data (commercial, QUEST Integration and Akamai Advantage) for **January 2017 class ONLY** must be entered into Cozeva by Dec. 31, 2016
- Cozeva Pay for Quality view will be locked down for transition to Payment Transformation-only view for January 2017
- **All other PCPs** have regular deadlines for submitting supplemental data:
  - Jan. 31, 2017 for commercial, QUEST Integration and Akamai Advantage measures
  - Dec. 31, 2016 for Review of Chronic Conditions
Payment Transformation Transition

- PCPs starting in **April or July** will remain on Pay for Quality program (rolling 12 months, quarterly payment). Will use familiar Cozeva dashboard
- Will also have “sneak peek” of Payment Transformation Cozeva dashboard
- **All PCPs** will work on 2 Physician Organization quality measures on the Payment Transformation dashboard

<table>
<thead>
<tr>
<th>Starting Date</th>
<th>Cozeva View</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2017</td>
<td>Only <strong>Payment Transformation</strong> view</td>
</tr>
<tr>
<td>April 2017</td>
<td>Pay for Quality and Payment Transformation views; Will be scored on <strong>Pay for Quality</strong> measures</td>
</tr>
<tr>
<td>July 2017</td>
<td></td>
</tr>
</tbody>
</table>
Q&A

Questions will be taken through the Chat function.

Thank you for your attendance!
Please fax us your evaluation form.