

A CODERS GUIDE TO VALUE BASED PAYMENT MODELS

Kari L. John, RHIT, CPC, CRC, CPMA, CEMA



DISCLAIMER

This presentation is for educational purposes only. Nothing in this presentation constitutes legal or medical practice advice. The opinions expressed in this presentation and on the following slides are solely those of the presenter(s).

AGENDA



What are Value Based Agreements



Agreements VS Programs



Coding Hot Points

Risk Strategy
HCC & Other ICD-10 Models
CPT II

VYOND

SAINT LUKE'S HEALTH SYSTEM

WHAT ARE VALUE BASED AGREEMENTS

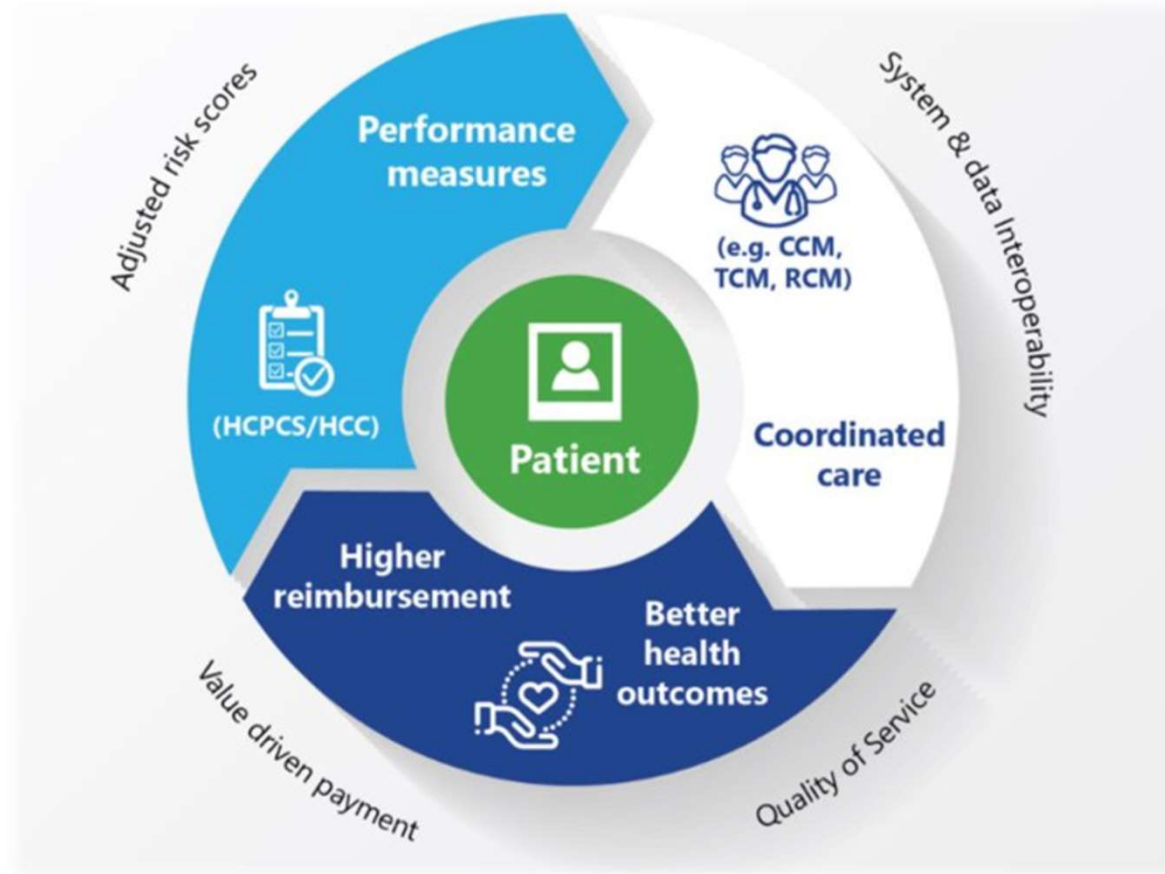


Image: www.acehealthcaresolutions.com/value-based-care-model-benefits

HCC CODING & PAYMENT MODELS

Risk Adjustment Payment Models

- Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000

The 21st Century Cures Act

- Focus (not all encompassing):
 - Number of diseases or conditions a patient has had
 - Utilizing 2 years of Diagnostic Data
 - Evaluation of Mental Health and Substance use disorders
 - Evaluation of CKD
 - Evaluation of Payment rates for ESRD
- Several Types of payment models

SO, WHAT DOES
THIS MEAN??

Trend:

Healthier patients
equals less cost

Better outcomes

Better
preventative
measure controls



HCC coding & Coding
accuracy is every
specialties responsibility



KEY FOCUS AREAS

- Star Level
- Risk Adjustment Factor (RAF)
- Utilization
- Preventive Care
- Social Determinants of Health

AGREEMENT VS PROGRAM

AGREEMENT

Negotiated Incentives:

Care Coordination Fee (CCF)
or Infrastructure support
payment
Quality Incentive
Financial Incentive (Shared
Savings Component)

Other Important Contractual Components:

Attributed population
Claims data sharing
Favorable benefit design
Consolidate quality measures
Stop loss / outlier protection
Upside/Downside % (Risk)

PROGRAM

No Contractual
obligation, but there
may be program
minimum standards
to be eligible to
participate

TYPES OF PAYER PARTICIPATION

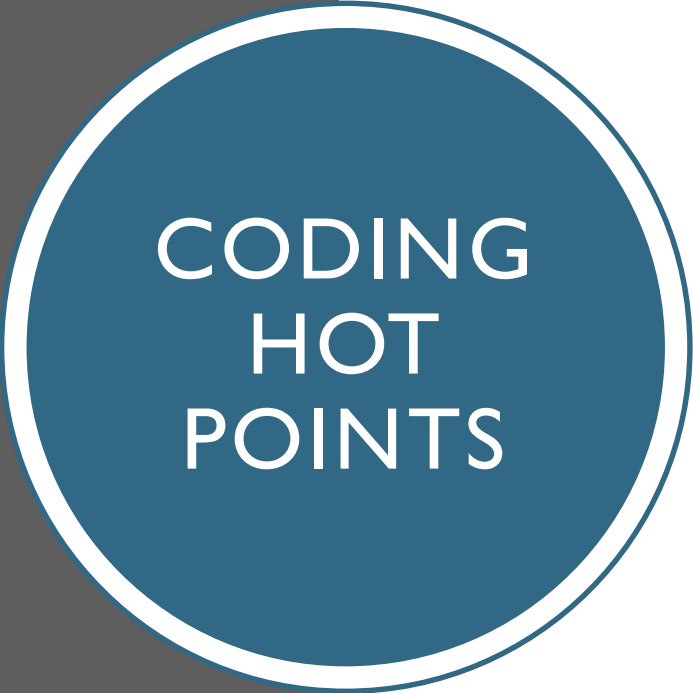
CMS
(Primary
Care First)

Medicare
Advantage

Commercial

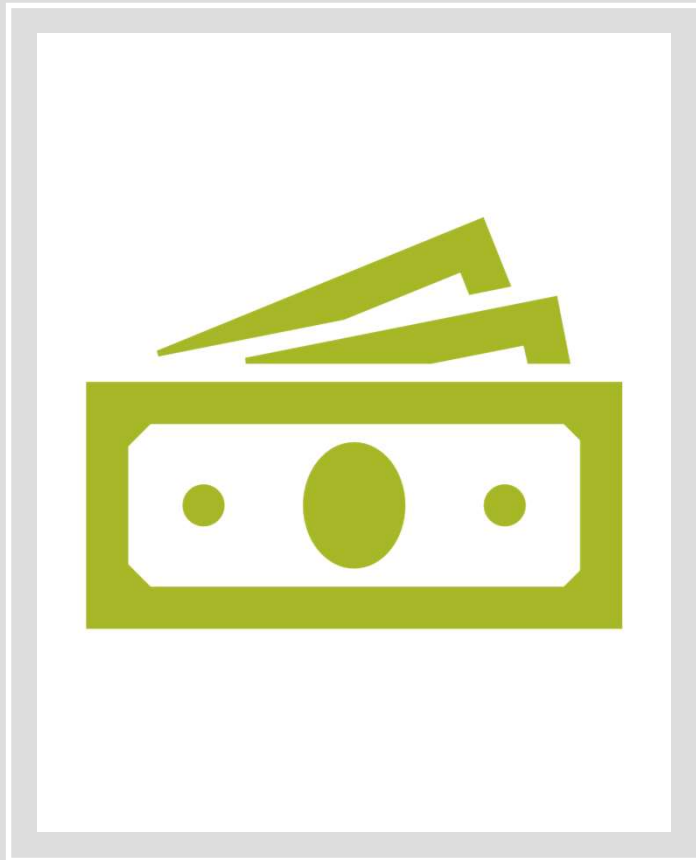
Accountable
Care
Organization

Medicaid



CODING HOT POINTS

- How does coding effect these agreements?
- What are the benefits?
 - Data
 - Improving reporting & data capabilities
 - Population Management
 - High Cost/High Risk Utilizers
 - Identifying Intervention using data analytics
 - MLR Incentive:
 - “Upside”
 - Below a target is a “surplus” to be shared
 - “Downside”
 - Above the target is a “Deficit” which may be shared responsibility



MLR SURPLUS EXAMPLE

- How sick is your patient = \$\$\$\$\$
- Minus (-)
- How much did it cost to take care of your patient = \$\$\$
- Surplus Total= \$\$
- Entity and payer share in savings \$/\$

SAMPLE MLR EXPENSE REPORT

How sick is your patient?

- ICD-10-CM
- HCC



Revenue

CMS Premium	\$926.89
Member Premium	\$6.72
<i>Gross Premium</i>	<i>\$933.61</i>

CMS Part D Risk Sharing Settlement	\$3.26
Less: HIF ACA Adjustment ¹	(\$23.62)
Less: PCORI ACA Adjustment ²	(\$0.21)
<i>Net Prem</i>	<i>\$913.04</i>

What was the patient's medical cost?

- Claims
- CPT II Codes



Expenses

Hospital IP	\$280.69
Hospital OP	\$178.10
Total Hospital	\$458.79

Part B Pharm	-
Part D Pharm	-
Part D adjustments	-
<i>Net Pharm</i>	<i>\$61.82</i>

Physician	\$221.50
Other/ Cap ³	\$1.00
<i>Total Medical Expenses</i>	<i>\$743.11</i>

Did manage your patient and keep costs reasonable?

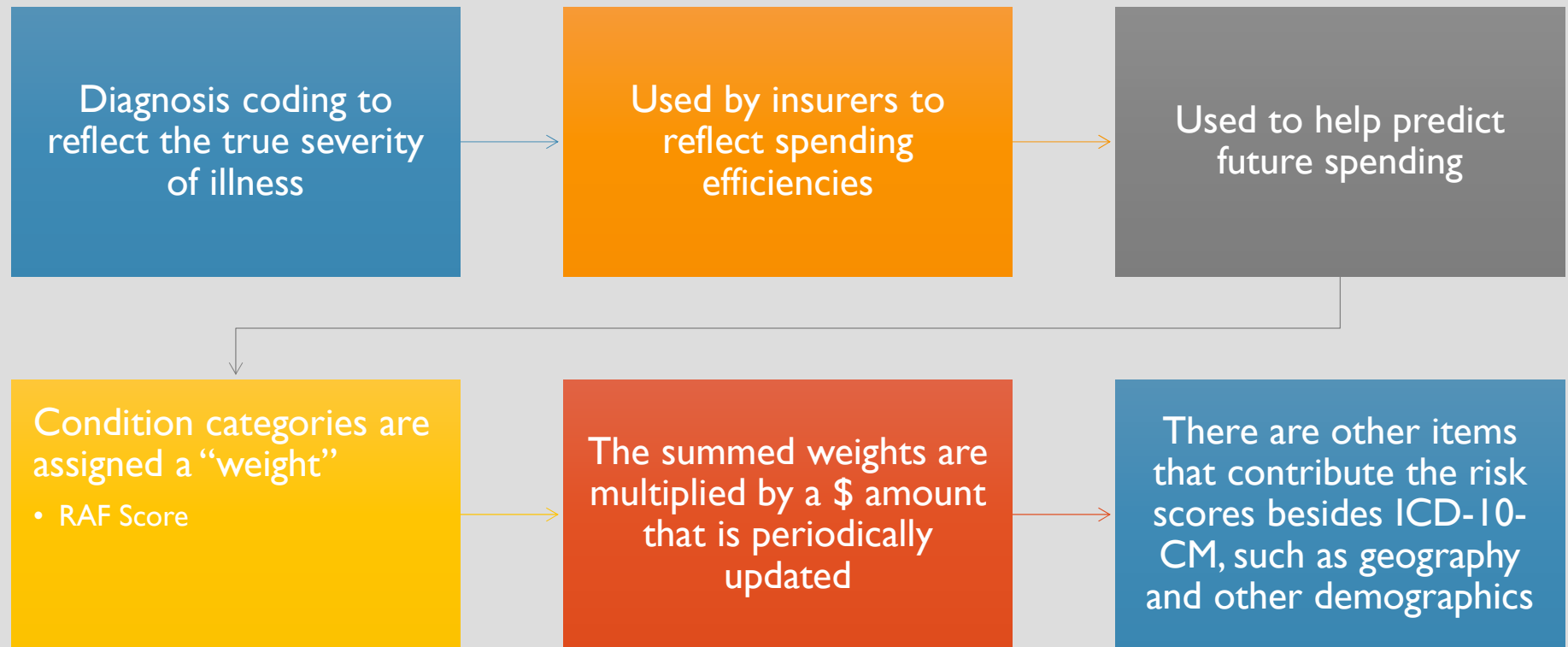
$$MLR = \frac{\text{Expenses}}{\text{Revenue}}$$



MLR

<u>Combined C & D</u>	<u>81.4%</u>
---------------------------	--------------


HCC CODING & RISK ADJUSTMENT





68 y/o F w/ DM, HTN		
ICD-10	DESCRIPTION	RAF
	Demographics (Female, 68 y/o)	0.323
E11.9	Type 2 Diabetes, unspecified, without mention of complications	0.105
I10	Hypertension	0
		TOTAL RISK SCORE:0.428

68 y/o F with unstable DMII with diabetic polyneuropathy, controlled hypertension, and morbid obesity with a BMI of 40.0		
ICD-10	DESCRIPTION	RAF
	Demographics (Female, 68 y/o)	0.323
E11.42	Type 2 diabetes with diabetic polyneuropathy	0.302
I10	Hypertension	0
E66.01	Morbid obesity	0.250
Z68.41	BMI of 40.0	0
		TOTAL RISK SCORE:0.875



TYPES OF RISK ADJUSTMENT MODELS

HCC: Hierarchical Condition Category

- Primarily used in Medicare & Medicare Advantage Structures

CDPS: Chronic Illness and Disability Payment System

MARA: Milliman Advanced Risk Adjusters

- Primarily in Commercial & ACO Structures

CRG: Clinical Risk Groups

CPT II CODING



Do you have quality opportunities via claims

- Submission by claims gives data transparency reducing the burden of medical record submission
- Some have incentive dollars tied to utilization of CPT II coding



Supporting Documentation

- EHR check points
- Even though you may not be getting “paid” via claim there are “incentives” to some of these submissions.
- Your organization should still have compliance check points to ensure documentation supports any code that is going out on a claim



Check with your payer

- Some clearinghouses/EDI's/Payers will not accept \$0.00 claims
- Its important to verify how to submit this supplemental data so you don't cause downstream effects in denials

QUALITY MEASURES/GAP CLOSURES

Medical Attention
for Nephropathy
(3060F-3062F, 4010F)

Social
Determinants of
Health Screenings
(G9919/G9920)

Advanced Care
Planning
(1123F/1124F)

Medication
Reconciliation
(1111F)

Functional Status
Assessments
(1170F)

Diabetic Eye
Exams (2023F-
2024F, 2033F, 2026F)

Controlling Blood Pressure

Systolic

3074F <130mmHG

3075F 130 to 139mmHG

3077F >140mmHG

Diastolic

3078F <80mmHG

3079F 80-89mmHG

3080F >90mmHG

Blood Sugar Control (last A1C)

3044F <7.0%

3051F ≥7.00% and <8.00%

3052F ≥8.0% and ≤9.0%

3046F >9.0%

OTHER CONSIDERATIONS

- Understand your Numerator/Denominator Criteria
 - Are there Place of Service Restrictions?
 - Are these services allowed to be done via telehealth?
 - In order to get credit do you have to submit these CPT II codes with an E/M?
 - What are the documentation requirements?

TAKEAWAYS

Teamwork

- Coding, clinical, operational.....it takes a village

Understand your organizations bandwidth

Be payer agnostic

Develop priorities