Clinicians’ Role in Medicare and Medicaid Payment – An Overview of Clinical Data Elements and Trends

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Objectives

• Medicaid Payments
  • Upper Payment Limit
  • Monthly capitation rate
• Medicare Payment Model (Parts A, B and D)
  • Risk Adjustment methodology
  • Recent PDAC Data
  • Changes in 2016
• Encounter Data Reporting
  • Background
  • Current requirements
  • What’s coming
How Does PACE Get Paid?

MEDICAID PAYMENT
– Monthly Capitated payment.
– Rate reviewed and renewed yearly
– Payment Calculation differs by State
– Payment must be below the Medicaid Upper Payment Limit (UPL)
– Not Risk Adjusted (except to some degree in NY and WI)
– Accounts for 50-60% of PACE Revenue
How Does PACE Get Paid?

MEDICARE PAYMENT

- Monthly Capitated Payment for A&B
- Risk Adjusted by Participant
- Amount Changes Yearly
- Accounts for 40-50% of PACE Revenue
- Part D payment by Bidding Process
  - Only partially Risk Adjusted
CMS Hierarchical Condition Category

(“CMS-HCC Model”)

Groups similar serious chronic medical conditions with similar costs of treatment into Hierarchical Condition Categories (HCCs), each with a “Risk Score”

A similar model, known as Rx-HCC, for Part D

RA methodology has two inputs:
- Demographics
- Diagnoses

One output = HCCs (driving risk scores)
Big Picture of Risk Adjustment

• RA is a mathematical model designed for more accurate payments to Medicare Advantage, PACE and other capitated health plans

• Based upon health status of enrollees rather than demographic data alone.

• Designed to predict illness costs covered by Parts A and B (Part C)

• Payments tend to be higher for sicker members and lower for more healthy members
Medicare Risk Adjustment Components

- County Benchmark Payment Rate
- Participant’s HCC Risk Score
- Normalization Factor
- MA Coding Intensity Adjustment
- Frailty Adjuster

Note: Frailty Adjustor not applied to LTI or ESRD
County benchmark payment rates CY2016

County payment rates are the greater of:
– prior year’s rates trended forward (using MA Growth rate)
– average per capita fee-for-service payment amounts

Payment rates vary significantly across counties, e.g., in 2016 (rounded):
– Miami, FL (Dade county): $1418
– New Orleans, LA (Orleans county): $1212
– Oakland, CA (Alameda county): $1028
– Pittsburgh, PA (Allegheny county): $913
– Portland, OR (Multnomah county): $871
– Big Stone Gap, VA (Wise county): $786
Risk Score Components
Average Risk Score in PACE ~ 2.536

- **Demographic Component: ~0.75** (range ~0.4 - 1)
  - Gender, Age
  - How entered Medicare (disabled or age)
  - Medicaid status (at least 1 month eligible in collection year)

- **Frailty Factor: ~0.15** (range ~0.01 to .25)
  - Based on self-reported ADL dependency
  - HOS-M

- **HCC Component: ~1.6** (range ~0 to 8)
Frailty Factor/Adjustment

- HCC model poorly predicts medical expenditures in the frail elderly with multiple co-morbidities
- Applies only to PACE Programs and Fully Integrated Dual Eligible Special Needs Plans
- Added to the revised HCC
  - NOT added to Long-Term Institutional
  - NOT added to ESRD participants

<table>
<thead>
<tr>
<th>ADL Dependencies</th>
<th>Non-Medicaid</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>-0.074</td>
<td>-0.156</td>
</tr>
<tr>
<td>1-2</td>
<td>0.143</td>
<td>0.0</td>
</tr>
<tr>
<td>3-4</td>
<td>0.278</td>
<td>0.195</td>
</tr>
<tr>
<td>5-6</td>
<td>0.278</td>
<td>0.446</td>
</tr>
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</table>
## Examples of HCCs

<table>
<thead>
<tr>
<th>HCC</th>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>HIV/AIDS</td>
<td>0.492</td>
</tr>
<tr>
<td>2</td>
<td>Septicemia, Sepsis, SIRS/Shock</td>
<td>0.520</td>
</tr>
<tr>
<td>8</td>
<td>Metastatic Cancer and Acute Leukemia</td>
<td>2.425</td>
</tr>
<tr>
<td>12</td>
<td>Breast, Prostate, and Other Cancers and Tumors</td>
<td>0.180</td>
</tr>
<tr>
<td>18</td>
<td>Diabetes with Chronic Complications</td>
<td>0.344</td>
</tr>
<tr>
<td>19</td>
<td>Diabetes without Complication</td>
<td>0.124</td>
</tr>
<tr>
<td>21</td>
<td>Protein-Calorie Malnutrition</td>
<td>0.653</td>
</tr>
<tr>
<td>22</td>
<td>Morbid Obesity</td>
<td>0.342</td>
</tr>
<tr>
<td>55</td>
<td>Drug/Alcohol Dependence</td>
<td>0.358</td>
</tr>
<tr>
<td>57</td>
<td>Schizophrenia</td>
<td>0.471</td>
</tr>
<tr>
<td>58</td>
<td>Major Depressive, Bipolar, and Paranoid Disorders</td>
<td>0.318</td>
</tr>
<tr>
<td>75</td>
<td>Polyneuropathy</td>
<td>0.281</td>
</tr>
<tr>
<td>108</td>
<td>Vascular Disease</td>
<td>0.288</td>
</tr>
<tr>
<td>138</td>
<td>Chronic Kidney Disease, Moderate (Stage 3)</td>
<td>0.227</td>
</tr>
</tbody>
</table>
HCC Model Characteristics

• **Hierarchical**
  • Payment based on more severe form of disease when less severe form is also present in reporting period (e.g., PVD vs PVD w/ complications)

• **Interactive**
  • When certain diseases coexist, the model assigns additional payment to recognize higher morbidity and costs than just adding the separate conditions

• **Additive**
  • When unrelated diseases co-exist, the risk factors are added together
The CMS HCC Model is Prospective

• Risk Adjustment System uses CURRENT demographic information and diagnoses to predict FUTURE medical expenses.

• Ultimately, payment in a given year is based on diagnoses submitted the PREVIOUS year.

• ICD-10 codes submitted for dates of service in CY 2016 will be basis of payment in CY 2017
## Multiple Versions of HCC Models

<table>
<thead>
<tr>
<th>MODEL</th>
<th>DESCRIPTION</th>
<th>SEGMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS-HCC (Version 22)</td>
<td>MA Plans serving those who qualify for Medicare by age or Disability</td>
<td>Aged/Disabled Community&lt;br&gt;Aged/Disabled Institutional&lt;br&gt;Aged/Disabled New enrollee&lt;br&gt;Aged/disabled New enrollee C-SNP (&quot;N.E.&quot;)</td>
</tr>
<tr>
<td>CMS-HCC PACE (Version 21)</td>
<td>Version 21 includes additions and deletions and revisions of HCC's.</td>
<td>Age/ Disabled Community&lt;br&gt;Aged/Disabled Institutional&lt;br&gt;Aged/Disabled New Enrollee</td>
</tr>
<tr>
<td>CMS-HCC ESRD</td>
<td>Uses Version 21 since 2012. Different Payment rates based on phase of ESRD: Dialysis, Transplant (mo 1-3), Functioning Graph (mo 4-9, and 9 mo. And greater</td>
<td>ESRD Dialysis&lt;br&gt;ESRD Dialysis New Enrollee&lt;br&gt;ESRD Transplant&lt;br&gt;ESRD Functioning Graft –Com&lt;br&gt;ESRD Functioning Graft-Instit.&lt;br&gt;ESRD Functioning Graft N.E.</td>
</tr>
<tr>
<td>Rx-HCC MODEL</td>
<td>Similar to CMS-HCC. Different diseases predict different cost compared to Med A&amp;B</td>
<td>Models for Age vs. Disabled, low income status, Institutional &amp; N.E. status</td>
</tr>
</tbody>
</table>
HCC Model Variants

• **New Enrollees (to Medicare)**
  • Current PACE Participant who turns 65
  • CMS has no previous encounter data/claims
  • Therefore cannot use HCC Model for payment
  • Use heavily weighted Demographic factors

• **Community vs Long Term Institutional (LTI)**
  • Any given disease is less costly in LTI vs. Community
  • Therefore different coefficients Community vs. LTI
  • Determined in the Payment Year not Collection Year
  • > 90 Day stay. Continues until 14 days post discharge
Example of the HCC Model

- 78 year old AA woman, Lives independently in 2-story row home for past 50 years
- Bi-polar daughter who lives in home with her along with her 2 children (one with autism)
- Recurrent utility crisis due to poor money management
- Oxygen dependent
- Held and personally catered annual block party
- Multiple cats with fleas
- Personal goal to survive to 80th birthday
Example of the HCC Model

### Problem List

- J44.9 COPD
- J96.10 Respiratory Failure, Hypoxic with O₂
- G47.33 Sleep Apnea
- I73.9 PVD
- N18.3 CKD 3
- I13.0 HTN w/CKD and HF
- I27.89 Pulmonary Htn
- I50.30 Diastolic CHF
- I48.2 Atrial Fibrillation
- G30.9 Polyneuropathy
- M10.00 Gout
- D63.8 Anemia
- H47.819 Cervical spondylosis
- F33.9 Major Depression, mild, recurrent
- H26.9 Cataract
- K21.9 GERD
- H919.0 Hearing loss

### CMS-HCC – V.21

1. **111**: Chronic Obstructive Pulmonary Disease
2. **84**: Cardio-Respiratory Failure & Shock
3. **108**: Vascular Disease
4. **138**: Chronic Kidney Disease Stage 3
5. **139**: CKD Stage 1,2 or Unspecified
6. **85**: Congestive Heart Failure
7. **96**: Specified Heart Arrhythmias
8. **75**: Polyneuropathy
9. **58**: Major Depressive, Bipolar, Paranoid
<table>
<thead>
<tr>
<th>FACTOR</th>
<th>DESCRIPTION</th>
<th>RISK SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female 75-79</td>
<td>Demographic</td>
<td>0.428</td>
</tr>
<tr>
<td>Medicaid Female Aged</td>
<td>Demographic</td>
<td>0.213</td>
</tr>
<tr>
<td>Originally Disabled</td>
<td>Demographic</td>
<td>0.000</td>
</tr>
<tr>
<td>HCC 58</td>
<td>Major Depressive, Bipolar, Paranoia</td>
<td>0.318</td>
</tr>
<tr>
<td>HCC 75</td>
<td>Polyneuropathy</td>
<td>0.281</td>
</tr>
<tr>
<td>HCC 85</td>
<td>Heart Failure</td>
<td>0.361</td>
</tr>
<tr>
<td>HCC 96</td>
<td>Specified Heart Arrhythmias</td>
<td>0.276</td>
</tr>
<tr>
<td>HCC 108</td>
<td>Vascular Disease</td>
<td>0.288</td>
</tr>
<tr>
<td>HCC 138</td>
<td>Chronic Kidney Disease Stage 3</td>
<td>0.227</td>
</tr>
<tr>
<td>INTERACTION</td>
<td>COPD &amp; Chronic Respiratory Failure</td>
<td>0.420</td>
</tr>
<tr>
<td>INTERACTION</td>
<td>COPD &amp; Heart Failure</td>
<td>0.255</td>
</tr>
<tr>
<td>INTERACTION</td>
<td>Heart Failure &amp; CKD</td>
<td>0.201</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>3.268</td>
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<tr>
<td>Normalization Factor</td>
<td></td>
<td>1.042</td>
</tr>
<tr>
<td>MA Coding Factor</td>
<td>(1 - 0.0541)</td>
<td>2.967</td>
</tr>
<tr>
<td></td>
<td>Multiply by 0.9459</td>
<td></td>
</tr>
<tr>
<td>FRAILTY FACTOR</td>
<td></td>
<td>0.114</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.081</td>
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</table>
Normalization Factor

• Gradual change in cost per diagnosis between the Model Year Denominator estimation and the payment year.
  • Population Changes
  • Diagnostic Coding changes

• Re-equilibrates the payment year so that the average HCC Score remains 1.00

• The 2016 normalization factor = 1.042
Coding Adjustment

- CMS uses Fee for Service (FFS) data to calibrate CMS-HCC.

- Accounts for differences in coding and operational practices in FFS versus MA and PACE Plans (submit more diagnoses)

- Or….Accounts for growth in MA Plans compared to FFS above what is captured by the Normalization Factor

- ESRD and Transplant Models are exempt

- Coding Adjustment for 2016 = 5.41%

  \[1 - 0.0541 = 0.9459\]
Sample PACE Payment Calculation

- AHCC Risk Score = 2.967
- Frailty Adjuster (FA) = 0.114
- PACE County Payment Rate (PCPR) = $864.45

Therefore

\[ \text{Payment} = (2.967 + 0.114) \times \$864.45 = 2,663.27/\text{mo} \]

*Thereafter subject to the 2% Sequestration withhold*
Sources of diagnosis codes?

CMS recognizes three sources:

1. CMS Certified Hospital In-Patient
   > 24 Hours Stay

2. CMS Certified Hospital Out-Patient
   Not Lab, Diagnostic Imaging or other Testing

3. “Physician” claims
   Face to Face Visit (except Anatomic Pathology)
Sources of diagnosis codes

Codes are extracted from External Sources:
• Hospital Claims: UB-04
• Physician Claims: CMS 1500

Claims extracted from Internal Sources:
• Encounters within the PACE Program

ALL must be supported by Documentation
“Physician” can be the following

- Clinical Psychologist
- Licensed Clinical Social Worker
- Nurse Practitioner
- Occupational Therapist
- Optometrist
- Oral Surgery
- Physical Therapist
- Physician Assistant
- Podiatrist
- Medical or surgical specialty

- Speech/Language Pathologist
- Audiologist
- Certified Clinical Nurse Specialist
- Certified Nurse Midwife
- Certified Registered Nurse Anesthetist
- Chiropractor
- “Unknown” Specialty
### Unacceptable Outpatient Sources of Diagnosis Data

- Skilled Nursing Facilities (MDS)
- Swing Bed Units of Acute Care Hospitals
- Intermediate Care Facilities
- Respite Care
- Hospice Facilities
- Laboratory Services
- Radiology Services
- Ambulance
- DME
- Prosthetic/Orthotics
- Freestanding Surgical Centers
- Dialysis Centers
- Physician Telephone Consults
Onboarding New Participants

- Optimize intake process to ensure all diagnoses for new participants are documented and submitted in a timely manner

- Scrub for diagnoses from
  - Old records
  - PT, OT, RN, SW, Home care assessments
  - Model Output Report (MOR) – what CMS has on record
  - Fresh H&P by PCP

- Maintain a Master Problem List!
Distribution of Most Prevalent HCCs for the Top 20% Most Costly PACE Participants: August 2015
Who are Enrollees with ESRD?

– For the purpose of payment, “ESRD beneficiaries” means beneficiaries with ESRD, whether entitled to Medicare because of ESRD, disability, or age, and includes beneficiaries in dialysis, transplant, and post-transplant functioning graft statuses.
The ESRD CMS-HCC model differs significantly from the CMS-HCC risk adjustment model used for payment for non-ESRD enrollees.

The ESRD model is a three-part model that distinguishes payments for:

- dialysis patients
- patients receiving kidney transplants
- beneficiaries with functioning kidney grafts
Average ESRD PMPM in PACE

<table>
<thead>
<tr>
<th>Year</th>
<th>Dialysis</th>
<th>Functioning Graft</th>
<th>MSP-Transplant/Dialysis</th>
</tr>
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<tbody>
<tr>
<td>2011</td>
<td>$8,174</td>
<td>$3,365</td>
<td>$1,568</td>
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<tr>
<td>2012</td>
<td>$9,254</td>
<td>$3,121</td>
<td>$1,602</td>
</tr>
<tr>
<td>2013</td>
<td>$8,638</td>
<td>$3,227</td>
<td>$1,391</td>
</tr>
<tr>
<td>2014</td>
<td>$8,562</td>
<td>$3,391</td>
<td>$2,482</td>
</tr>
<tr>
<td>2015</td>
<td>$8,682</td>
<td>$3,708</td>
<td>$2,482</td>
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</table>
All Type ESRD vs Total PACE Enrollment 2011-2015

All ESRD Types

<table>
<thead>
<tr>
<th>Year</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>411</td>
<td>484</td>
<td>530</td>
<td>662</td>
<td>745</td>
</tr>
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</table>

Total PACE population

<table>
<thead>
<tr>
<th>Year</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>22788</td>
<td>25443</td>
<td>28255</td>
<td>31654</td>
<td>34413</td>
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</table>
PACE Medication Regulations
(Before Part D)

• Payment for PACE Rx came from Medicaid Capitation Payment.
• Some drug payment could be attributed to Medicare Part A or B
• There was no accounting or reconciliation between actual drug spending and Medicaid capitation or Medicare Part B amounts.
PACE Medication Regulations
(Under Part D)

• All PACE participants must receive Part D coverage from their PACE organization; all PACE enrollees must enroll in Part D

• If PACE participants enroll in a PDP or MA-PD, they will automatically disenroll from their PACE organization

• New PACE enrollees will be disenrolled from a PDP or MA-PD upon enrollment in PACE; this can happen throughout the year
What Does Part D Cover?

- A drug that may be dispensed only upon a prescription;
- A drug that is being used for a medically-accepted indication; and
- Is one of the following:
  - A drug described in §§1927(k)(2)(A)(i) through (iii) of the Social Security Act
  - A biological product described in §§1927(k)(2)(B)(i) through (iii) of the SSA
  - Insulin
  - Medical supplies associated with delivery of insulin
  - A vaccine licensed under §351 of the Public Health Service Act and its administration (does not include all vaccines)
What Part D Does Not Cover

1. Drugs covered under Medicare Parts A or B
2. Over the counter medications
3. Agents used for anorexia, weight loss, or weight gain
4. Agents used for cosmetic purposes
5. Agents used for symptomatic relief of cough and colds
6. Most prescription vitamins and mineral products
7. Agents used for treatment of sexual dysfunction

*Drugs excluded by Part D may still be included in Medicaid*
Managing Part D Medications

Formularies
Not used by most PACE organizations
  Requires a comprehensive formulary to be developed and submitted
  Requires a Pharmacy and Therapeutics (P&T) Committee
Preferred drug lists or other means of directing prescribers is not allowed without a formulary.
Plan can provide education on drug efficacy.
Part D Payment

Part D Bid
Actuarially determined average cost of caring for an average Medicare beneficiary in your plan. Includes administrative costs and profit margin

Risk Adjustment
Bid Amount Multiplied times Part D risk score and determined through RxHCC model

Reconciliation
Reconciliation with submitted Prescription Drug Event (PDE) data in the summer of the following year.
## Risk Corridor Reconciliation

<table>
<thead>
<tr>
<th>Risk Corridor</th>
<th>PACE Share</th>
<th>CMS Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;10.0%</td>
<td>20% of Loss</td>
<td>80% of Loss</td>
</tr>
<tr>
<td>5.0% - 10.0%</td>
<td>50% of Loss</td>
<td>50% of Loss</td>
</tr>
<tr>
<td>0% - 5.0%</td>
<td>100% of Loss</td>
<td>0% of Loss</td>
</tr>
<tr>
<td>-5.0% - 0%</td>
<td>100% of Gain</td>
<td>0% of Gain</td>
</tr>
<tr>
<td>-10.0% - -5.0%</td>
<td>50% of Gain</td>
<td>50% of Gain</td>
</tr>
<tr>
<td>≤ -10.0%</td>
<td>20% of Gain</td>
<td>80% of Gain</td>
</tr>
</tbody>
</table>

* Risk Corridor Reconciliation / AARCC = Risk Corridor %
Risk Corridor Reconciliation
**Risk Corridor Example**

PACE ABC **AARCC** -- $1,000,000 for year
(Plan received $980,000 because of sequester)

PACE ABC **Total Drug Spending** $1,200,000

Risk Corridor Reconciliation
$1,000,000 - $1,200,000 = -$200,000

Risk corridors for this plan
5% loss - $50,000 -- All ABC PACE
5-10% loss – $50,000 ($25,000 ABC PACE + $25,000 CMS)
Over 10% - $100,000 ($20,000 ABC PACE + $80,000 CMS)

ABC Overspent its target by $200,000. CMS will pay an additional $105,000 to the plan.
Who is Paying? (Examples)

Part D - Most prescription drugs
Part A - Part A stays in a skilled nursing facility
Part B - Some physician administered drugs, some vaccinations and infusions
Medicaid - Other drugs not covered by Medicare
Encounter Reporting Update

• Currently there are 2 drivers:

• **Federal** – CMS continues to devise ways to adjust the current payment model

• **States** – Trending towards full Managed Care for Medicaid (i.e. New York, California, Wisconsin, Kansas)
What is Encounter Reporting?

Since 2005, CMS required PACE organizations (POs), Medicare Advantage Plans and Special Needs Plans to submit Dx codes to calculate risk adjusted payments.

In 2013, CMS implemented a requirement that PACE, MA and SNPs submit encounter data. Two big problems for POs:

1. Service encounters are to be submitted to CMS in the form of health care claims (basis for how they pay provider bills). POs are uniquely challenged as majority of PACE services are rendered by employees rather than contract providers (ergo, no claims generated to submit)

2. PACE programs focus on providing person centered care by offering services not covered under traditional Medicare fee-for-service and Medicaid, many encounter codes simply do not fully explain the depth, breadth and intensity of services provided to participants.
What is encounter data?

- Encounter data is record of medically-related service rendered by provider to a participant enrolled with a capitated contractor. Is focal point linking, administrative clinical and financial information.

- Encounter data covers people who have health insurance and includes information about both their eligibility and their health care claims.

- It offers details about an insured person’s engagement with the health care system, including such “encounters” as clinic visits or drug prescriptions.

- Information showing use of provider services by enrollees is used to develop cost profiles of groups of enrollees to guide decisions about or provide justification for the maintenance or adjustment of premiums.
Why Report Encounter Data?

• Encounter reporting data from “plans” could be used as an alternative to fee-for-service data as the basis for calculating capitated payments to PACE, Medicare Advantage and Special Needs Plans.

• CMS intends to use this data to more accurately calculate risk adjusted payments that are in alignment with Medicare spending for similar individuals.

• NPA does not have a clear nor accurate understanding of the specific nature by which encounter data will be used to impact payments.
How is encounter data used to calculate payments?

- CMS requires encounter data to assist in calculating risk adjusted payments to adjust for inconsistencies between the diagnostic characteristics of Medicare beneficiaries enrolled in POs, MA Plans and SNPs vs. beneficiaries in Medicare fee-for-service (whose costs are the basis for calculating risk adjusted payments).

- **Goal:** more accurately calculate capitated payments to reflect spending in Medicare fee-for-service.

- It is not fully clear as yet how CMS will use the data in calculating further payments. However, it seems likely that one possibility is that they will adjust payments for various disease groups based on service intensity and related costs based on encounter data.
What are Current Rules for PACE?

- Recognizing the disproportionate difficulty for POs to gather and submit encounter data for all services rendered to participants, CMS required that in 2013 POs only send encounter data for services from which they have claims.
- NPA interprets this as requiring POs to submit to CMS any claims data received for services, typically from hospitals and medical specialists.
- CMS is not currently requiring PACE Organizations to submit encounters for services for which a claim is not collected.
- CMS is targeting 2016 to collect encounters for which a claim is not collected and will be providing more information at a later date regarding the submission of encounters for these other services.
Why should my program begin increasing the volume of EDR data submitted to CMS?

• POs need to begin efforts to understand and put in place strategies for collecting and reporting comprehensive encounter data to CMS.

• Also, in consideration of the potential for CMS to suspend the Risk Adjusted Payment System (RAPS) into which POs submit the vast majority of diagnostic data needed for calculating Medicare risk adjusted payment, NPA believes it is imperative that POs begin submitting a greater volume of encounter data as the basis for reporting participants diagnoses.

• Therefore, and as early as 2017, claims (encounter data) could be on the only basis for which to submit diagnoses.
How is NPA supporting PACE Encounter Data Reporting?

- In addition to extensive comments to and interactions with CMS on EDR related issues, NPA has been working with an EDR workgroup of PACE professionals and outside experts to develop a collection of resources to assist POs in this coding effort.

- A superbill is an itemized form for healthcare providers to capture rendered services and is the main data source for the creation of a healthcare claim. Over a two year period, NPA organized a tool kit of encounter reporting superbill resources.
  - Professional superbills for physicians, nurses, social workers, dieticians, and PT/OT professionals
  - Home Care superbill
  - Care Coordination superbill
  - Day Center service superbill

- NPA has also engaged in strategic partnerships with 2 firms with PACE experience that assist POs in converting internal and contract service encounters into 837X/V5010 HIPAA compliant claims that are submitted to CMS.
Where are NPA coding resources located?

- When finalized, all Professional and Paraprofessional Superbills will be distributed to the membership organizations and also posted to the NPA website for future use.

- NPA is also recording the webinars which members can access on the NPA website at their convenience.

- NPA will also be making available on its website an encounter reporting primer which will contain a brief 3-5 page summary and guide as well as a set of slides to be used for internal PO staff training.
Questions and Answers