# Medicare Risk and Quality: 2021 Year in Review + 2022 Planning

**December 2021**

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# VNSNY CHOICE Medicare Star Rating


**Note 4.5 STARs Rating for 2022**

# 2021
# NEW MEDICARE PLAN BENEFITS

# New 2021
# Member Incentive Program

Members can earn financial rewards in 2021

for completing quality screenings:


- Breast Cancer Screening (BCS)
- Colorectal Cancer Screening (COL)
- Comprehensive Diabetes Care (CDC)
  - CDC – Retinal Eye Exam
  - CDC – HgA1c test
- Controlling Blood Pressure (CBP)
- Statin Therapy for Patients with Cardiovascular Disease - Received (SPC)
- Annual Wellness Visit (AWV); (all members eligible)
- Influenza vaccine (all members eligible)

# THIS IS WHERE YOU BELONG

In the home you love.
In the community you know.
In the health plan designed for you.

If you need help to safely live at home, it's no longer necessary to have separate Medicare and Medicaid plans to cover all of your benefits. VNSNY CHOICE Total combines Medicare and Medicaid Long-Term Care plans for people who need ongoing help with daily activities, such as bathing, cooking, dressing and walking.
**Benefits include:**

- **$0 plan premiums**
- **$0 co-pays for medical care****
- **$0 for unlimited transportation to medical appointments**
- **$0 for skilled nursing, personal care services, rehabilitation therapy and more**
- **Consumer Directed Personal Assistance Services (CDPAS)**

You can also keep your doctors, specialists and home health aide!***

## Total's New Benefits in 2021

Total has several new benefits to help you live safely in the comfort of your own home, where you belong.

## Below are some benefits you can expect from VNSNY CHOICE Total

| 2021 Benefits Overview | | |
|---|---|---|
| Monthly plan premium | $0 | |
| Medicare Parts A & B services (including doctors, hospitals, clinics, labs) | $0 | |
| Medicare Part D services (brand name and generic prescription drugs) | $0** | |
| Over-the-counter (OTC) and grocery items | Up to $1,584/year ($132 per month) | NEW |
| Acupuncture | Up to 30 visits for $0 | NEW |
| Eye Exam/Eyeglasses | $0 for routine eye exam, $300/year for eyeglasses (frames and lens) and contacts | NEW |
| Telehealth service | $0 | NEW |
| Dental | $0 for preventitive and comprehensive care | |
| Transportation | Unlimited to medical appointments (to plan-approved locations) | |
| Long-term services and supports (including Home Health Aide, nursing and social work) | $0 | |
| Physical therapy | 40 sessions/year^ | |
| Social Day Care | $0 | |
| Worldwide coverage | Up to $50,000/year for emergency services and urgent care | |

**Depending on Medicaid eligibility. ***As long as the provider is in the network. ^As covered by Medicaid.

**Call 1-866-783-1444 (TTY: 711)**
October 1 – March 31: 8 am – 8 pm, 7 days a week, April 1 – September 30: 8 am – 8 pm, Monday – Friday

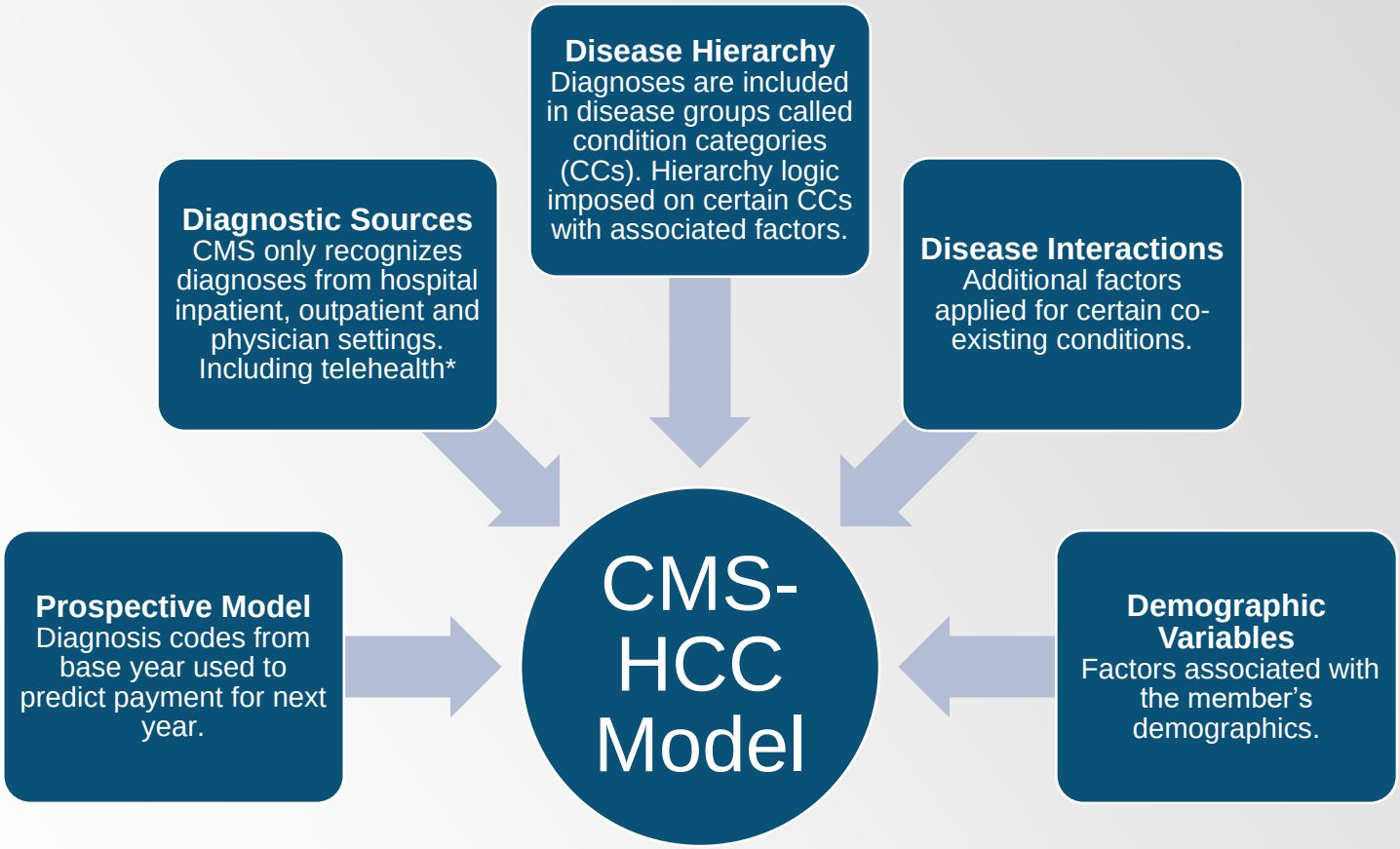
**Or visit vnsnychoice.org or call your CHOICE Representative**

# Objectives

- Engage providers in the benefits of annual risk adjustment
- Reduce medical record requests across payers
  - Strategies to close quality gaps in care electronically with CPT II + Exclusion codes
- Ensure documentation standards compliance
- Implement workflows to meet HEDIS Transitions of Care (TRC) and TCM code requirements
- Key Takeaways for effectively closing out the 2021 year and planning for the year 2020 ahead

# Annual Medicare Risk Adjustment

# Hierarchal Condition Category (HCC) Model




*Diagnoses from telehealth claims are Risk Adjustment eligible only when both audio and visual components are used during the encounter.

# Risk Score Calculation

**Demographic Factors** (associated with age, sex, disabled status, original entitlement reason, and Medicaid eligibility)

+

**Health Status** (associated with chronic conditions included in CMS-HCC Model)

=

## Member's Risk Score

# The Risk Score

Each member is assigned a risk score which measures their relative illness risk. These risk scores are used to adjust payments for each beneficiary's expected expenditures. Simply put, they create the budget for care.

Higher risk scores represent members with a greater than average burden of illness.

Lower risk scores, if coded correctly, represent members with a lower-than-average burden of illness.

**BUT**

They could also indicate incomplete HCC coding and/or supporting documentation for patients with a higher illness burden.

# HCC Risk Adjustment: Why is Code Specificity and Frailty Score important?

| No Conditions Coded | RAF | Some Conditions Coded | RAF | All Conditions Coded | RAF |
|---|---|---|---|---|---|
| 76-year-old female | 0.468 | 76-year-old female | 0.468 | 76-year-old female | 0.468 |
| Medicaid eligible | 0.177 | Medicaid eligible | 0.177 | Medicaid eligible | 0.177 |
| Diabetes not coded | 0 | Diabetes no complications | 0.118 | Diabetes w/vascular complications | 0.368 |
| Vascular disease not coded | 0 | Vascular disease no complications | 0.299 | Vascular disease w/ complications | 0.41 |
| CHF not coded | 0 | CHF not coded | 0 | CHF coded | 0.368 |
| No disease interaction | 0 | No disease interaction | 0 | Disease Interaction Bonus RAF (DM +CHF) | 0.182 |
| Patient Total RAF | **0.645** | Patient Total RAF | **1.062** | Patient Total RAF | **1.973** |
| **Yearly Reserve for Care** | **$5,418** | **Yearly Reserve for Care** | **$8,921** | **Yearly Reserve for Care** | **$16,573** |
| **No ADLs for Plan-wide Frailty Score** | **-0.093** | **0-2 ADLs for Plan-wide Frailty Score** | **+0.105** | **5-6 ADLs for Plan-wide Frailty Score** | **+0.420** |

**An inaccurate Plan-wide frailty score can negatively impact the resources/budget for a member's care.**

**Note:** For illustration purposes only. Should not be used for financial inference.

# Engaging Providers in the Benefits of Annual Medicare Risk Adjustment

***Scheduling annual wellness visits allows time to address all quality measure and HCC gaps.***

# The Provider Role in Risk Adjustment

**Providers can help ensure the integrity of data used in calculating risk:**

- ✓ **A comprehensive health status for each patient**
  - Best addressed during an annual wellness visit (AWV)
- ✓ **Medical record documentation sufficient to support ICD-10-CM coding**
  - Monitoring/Evaluating/Assessment/Treatment (“MEAT”) standards
- ✓ **Accurate and complete ICD-10-CM coding for every patient, every time**
  - Update problem and medication lists, review of all consult notes, lab/procedure results, discharge summaries
- ✓ **Coding to the highest level of specificity for claim submission**
  - Ensuring that as diseases progress, complications and comorbidities are captured in coding annually. (CHOICE can provide member’s historical diagnoses that can be leveraged during their AWV.)

**Remember:** Each January 1, the member’s risk score is reset for a new year, and next year’s budget for their care is rebuilt with this year’s claims.

# AWV: Gap Closing Workflows

## Pre-visit Planning

- **Flag chart prior to AWV**
  - **Updates/changes in diagnoses/HCCs**
    - Specialty consult notes (e.g., new vascular complications)
    - Lab/test results (e.g., CAD on angioplasty report)
    - Discharge plans (e.g., new CHF diagnosis)
  - **Time to update problem and medication lists**
    - All previous diagnoses, procedures/surgeries e.g., amputations, CABG
  - **Quality Measure gaps in care to be addressed**
    - Close gaps with **CPT/CPT II Codes** and prevent medical record requests
    - CHOICE provides monthly member specific GIC reports and can provide historical dx information to assist in completing Risk Adjustment
    - CHOICE can assist with CM scheduling AWV
- **Evaluate for exclusion criteria**
  - To remove member from quality measure for Frailty and Advanced Illness or ICD10 diagnoses (e.g., bilateral mastectomy)

# Documentation Standards for Risk Adjustment/HCC Coding

**NOTE**: A list of diagnoses, or past medical history is not acceptable or valid per official coding guidelines, as it does not meet the **definition** of an assessment or treatment plan:

- **Assessment:** a skilled evaluation of the patient and/or relevant health information (e.g., lab results) to appraise conditions, disorders, and/or a patient's overall state
- **Treatment Plan:** follows an analytical process of patient/health information to establish a course of care

**Telehealth**: Must document in the provider visit note that both audio and visual technology was used during the encounter for HCC updates

- The documentation must include:
  - the start/stop times of the medical visit.
  - the virtual visit site/location, i.e., use modifiers (e.g.; mod 95) as needed to indicate virtual visits vs. in office site.
  - the encounter type as audio-video, e.g., “Audio-Visual AV telehealth visit”

# Electronic Quality Measure Gap Closing: CPT/CPT II + Exclusion codes

# CPT II + Exclusion Codes Close Gaps in Care with Claims

- **Category II codes** provide clinical details, e.g., lab values, usually included in evaluation and management or clinical services and are not associated with any relative value. **Category II codes** are billed with a $0 **billable** charge amount.
  - These codes provide clinical data that can close gaps via claims/administratively to prevent the need for medical record review.
- **Exclusion Codes** ensure that members with diagnoses that make them inappropriate for quality measure inclusion are removed from measure reporting. These diagnoses need to be coded each year.
  - Example: ensure members with a history of bilateral mastectomy have their condition coded each year so that they don't fall into the breast cancer screening measure.

# Takeaway: Actions for Gap Closure

Complete (mammography, colonoscopy) and compliant (HgA1c) test results may be securely faxed to VNSNY CHOICE at 646-640-2862 or call your Provider Service rep to arrange secure FTP.

| Measure Name | CPT/CPT II Codes | Exclusion Codes |
|---|---|---|
| **Medication Reconciliation Post Discharge** | ▪ **Within 7 days post-discharge: 99496**<br>▪ **Between 8-14 days: 99495**<br>▪ **Between 15-30 days: 1111F** | N/A |
| **Comprehensive Diabetes Care – Blood Sugar Controlled** | **3044F (<7.0%); 3046F (>9.0%); 3051F (≥7.0% - <8.0%); 3052F (≥8.0 – ≤9.0%)** | Advanced Illness + Frailty codes |
| **Controlling Blood Pressure** | **3074F (S<130); 3075F (S = 130-139); 3077F (S> 140); 3078F (D<80); 3079F (D = 80-89); 3080F (D≥ 90)** | Advanced Illness + Frailty codes |
| **Care for Older Adults – Medication Review** | **Medication Review CPT II 1160F & Medication List CPT II 1159F both CPT codes required on same claim** | N/A |
| **Colorectal Cancer Screening** | N/A | Colon cancer diagnosis or Advanced Illness + Frailty codes |
| **Breast Cancer Screening** | N/A | Bilateral mastectomy diagnosis or Advanced Illness + Frailty codes |
| **Medication Adherence for Hypertension** | N/A | N/A |
| **Medication Adherence for Cholesterol** | N/A | Intolerance diagnoses (myalgia, myositis, myopathy, rhabdomyolysis) or Advanced Illness + Frailty codes |

# Documentation Standards: Annual Medicare Risk Adjustment

# Risk Adjustment Diagnostic Sources

The Centers for Medicare & Medicaid Services (CMS) requires that Medicare Advantage (MA) organizations collect and submit risk adjustment data from:

- Hospital inpatient facilities
- Hospital outpatient facilities
- Physicians
- Telehealth encounters*

From a risk adjustment perspective, treatment within the current year is evidence of diagnoses. Documentation support is evidence that service billed was provided.

*Diagnoses from telehealth claims are risk adjustment eligible only when both audio and visual components are used during the encounter.

# EHR Copy and Paste Best Practices-Reminder

Carrying existing information forward may be appropriate when the copied information is:

- Based on external and independently verifiable sources, such as basic demographic information that is stable over time
- Clearly and easily distinguished from original information, such as automatic summaries that populate data fields that are clearly identified as nonoriginal and cannot be mistaken for original information
- Not actually rendered as part of the record until after a re-authentication process and auditable for identifying actual origination

All imported documentation should be edited by the practitioner to ensure that only accurate and medically necessary imported documentation remains in the documentation of the patient encounter.

# Documentation
# Standards for Medicare Medical Records

**Medical Records from providers should contain**:

1. Enrollee name and date of birth for every record received. All pages of every record are for the correct enrollee.
2. Date of service is clearly documented. The provider type, specialty, and face-to-face requirement is clearly documented.
3. Acceptable physician/practitioner authentication comes in the form of handwritten signatures and electronic signatures. Stamped signatures are not acceptable.

# Transitions of Care

## TRC + TCM WORKFLOWS FOR SUCCESS

# Medicare Payers Report
# Four HEDIS Transitions of Care Quality Measures

1) **Notification of Inpatient Admission**: must be documented in medical record within 2 calendar days

2) **Receipt of Discharge Information**: must be documented in medical record within 2 calendar days

3) **Patient Engagement after Discharge**: claim or medical record documentation within 30 days

4) **Medication Reconciliation Post-discharge**: TCM claims (7-14 days post-discharge); CPT II code or medical record documentation (within 30 days post-discharge)

# TCM Services & Visits Description:

**TCM Visit Within 7 Days Post-Discharge: CPT Code 99496**

- Medical record documentation must include:
  - Communication (direct contact, telephone, electronic/email) with the patient and/or caregiver within **two business** days of discharge
  - Medical decision making of **high complexity** during the service period
  - Face-to-face visit (in-office or **video telehealth**) within seven calendar days of discharge:
    - Includes medication reconciliation and discharge summary review
    - Assistance in scheduling referrals, tests, and follow-up care

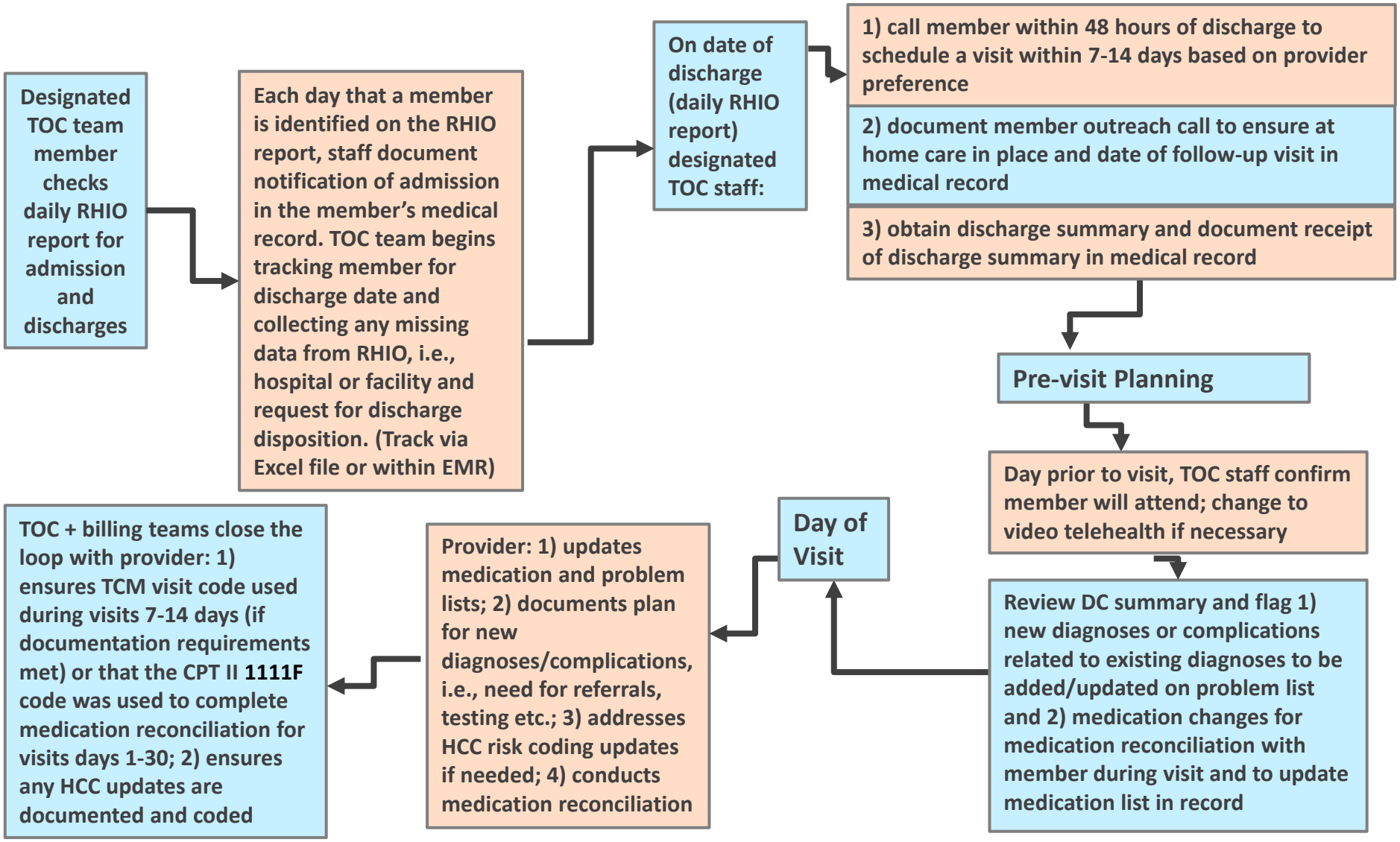
**TCM Visit Within 14 Days Post-Discharge: CPT Code 99495**

- Medical record documentation must include:
  - Communication (direct contact, telephone, electronic/email) with the patient and/or caregiver within **two business** days of discharge
  - Medical decision making of **at least moderate complexity** during the service period
  - Face-to-face visit (in-office or **video telehealth**) within 14 calendar days of discharge:
    - Includes medication reconciliation and discharge summary review
    - Assistance in scheduling referrals, tests, and follow-up care

# TRC QM Measures (4 rates reported) + TCM Services & Visits Workflows – Summary Details

| HEDIS TRC Quality Measure | Documentation/Workflow | CPT TCM/CPT II Codes |
|---|---|---|
| Notification of Inpatient Admission | • TOC Staff check daily RHIO report<br>• Document call to member within 48 hours post-discharge<br>• Schedule visit (in-person or video telehealth) within 7-14 days<br>• Document receipt of inpatient notification in medical record on the day of admission or within the 2 following calendar days | • NA (must be documented in the medical record) Incudes EDTs and shared EMRs |
| Receipt of Discharge Information | • Obtain and document receipt of the discharge summary report in the medical record on the day of discharge or within the 2 following calendar days; includes the "instructions for patient care post discharge" | • NA (must be documented in the medical record) |
| Patient Engagement after Inpatient Discharge | • Ensure that TCM documentation requirements are met<br>• Do not include patient engagement on date of discharge | • Within 7 days post-DC: CPT 99496 (TCM)<br>• Days 8-14 post-DC: CPT 99495 (TCM)<br>• Days 15-30 post-DC: appropriate visit code |
| Medication Reconciliation Post-Discharge (MRP) | • Documentation must include reference to the discharge medications and the current medication list in the medical record; can be on the date of discharge through 30 days post discharge | • Within 7 days post-DC: CPT 99496 (TCM)<br>• Days 8-14 post-DC: CPT 99495 (TCM)<br>• Days 1-30 post-DC: CPT II 1111F (if TCM codes are not used) |

# Takeaway: Transitions of Care Suggested Workflows



# 2021 Quarter 4 Close Out

# Screenings and Annual Wellness Visits 2021

1. Provider should schedule all members with HCC + Quality Measure gaps in care for an in-office or telehealth visit to address open gaps by December 31st
    1. **Note**: members with lab gaps (COL, Nephropathy, CCS, HbA1c/HgA1c) or Mammography screenings may need to come in office to complete those screenings
    2. **Reminder** our Quality Department can coordinate in-home labs for COL, Nephropathy, HbA1c/HgA1c for homebound members.
    **Email: QualityManagement@vnsny.org**

2. Member Engagement:
    1. Reminder: Annual Wellness Visit scheduling for any members not seen in the last 12 months by December 31st.
    2. If members require transportation for in office visits, or if you're having difficulty scheduling members, our Care Management team can assist with arrangements. Call **1-866-783-0222**

# Medical Records Collection

1. **Supplemental Chart Collection activities are underway**
    1. Provider offices may receive calls, or fax requests for medical records and/or EMR files to close data gaps for MY 2021 services completed and not included in administrative data (claims, labs feeds)
    2. Responding to Supplemental Chart Collection requests now may reduce Medical Record requests and administrative burden for the provider office during the HEDIS Season (February – May 2022)
    3. **All supplemental data records/files are due to VNSNY CHOICE by January 7th, 2022, for 2021 dates of service.**
2. HEDIS Medical Record Review season will start in February 2022 – CHOICE is partnering with the vendor Cotiviti to obtain medical records to support HEDIS data collections. Provider offices may start to receive calls from Cotiviti as early as December 2021 to schedule onsite chart collection.
    1. **Note**: If providers prefer to work directly with CHOICE for medical record collections, please contact the Quality Management Department – Chantal.Louisma@vnsny.org

# Thank You

## Reminder: It's flu season!

## CHOICE Care Management can assist with scheduling vaccinations

# Thank you!


SURVEY

# CHOICE Contacts

- Risk + Quality topics webinar registrations
- Individual practice education on your topic choice
- Information on individual practice gaps in care reports or EMR data sharing

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Sheila.Spiezio@vnsny.org
**Cell: 347-413-2875**

# Visit the VNSNY CHOICE Provider Website!

**vnsnychoice.org/for-health-professionals-overview**

- Guideline and Policy Updates
- Provider Toolkit
  - **All CY 2021 Provider Education Presentations are available here**
- Claims, Billing, and Payments
- Credentialing

**Link to telehealth coding guidance:**
vnsnychoice.org/wp-content/uploads/2020/09/CHOICE-Quality-HEDIS-Telehealth-Updates.pdf

# References and Resources

## CMS References

**Centers for Medicare & Medicaid Services (CMS) Risk Adjustment**

- www.cms.gov/Medicare/Health-Plns/MedicareAdvtgSpecRateStats/Risk-Adjustors

**Medicare Managed Care Manual 100-16, Chapter 7 – Risk Adjustment**

- www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c07.pdf

**Customer Service and Support Center (CSSC) Operations- Risk Adjustment Processing System**

- www.csscoperations.com/internet/csscw3.nsf/T/Encounter%20and%20Risk%20Adjustment%20Program%20(Part%20C)

## Risk Adjustment Resources

**ICD-10-CM Official Guidelines for Coding and Reporting**

- www.cms.gov/files/document/2021-coding-guidelines-updated-12162020.pdf

**ICD10 HCC Model Mappings**

- www.cms.gov/medicarehealth-plansmedicareadvtgspecratestatsrisk-adjustors/2021-model-softwareicd-10-mappings