



# Encounter Data Improvement Initiative- Why Go There Again?

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# MACRA and Alternate Payments mean encounter data will be front and center

## Goals

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2016

30%

In 2016, at least 30% of U.S. health care payments are linked to quality and value through APMs

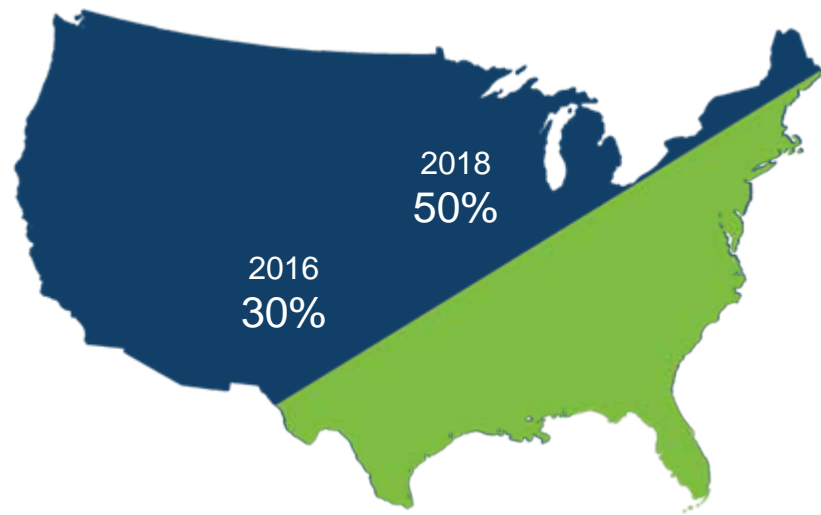
2018

50%

In 2018, at least 50% of U.S. health care payments are so linked.

These payment reforms are expected to demonstrate better outcomes and lower costs for patients.

## Adoption of Alternative Payment Models (APMs)



*Better Care, Smarter Spending, Healthier People*

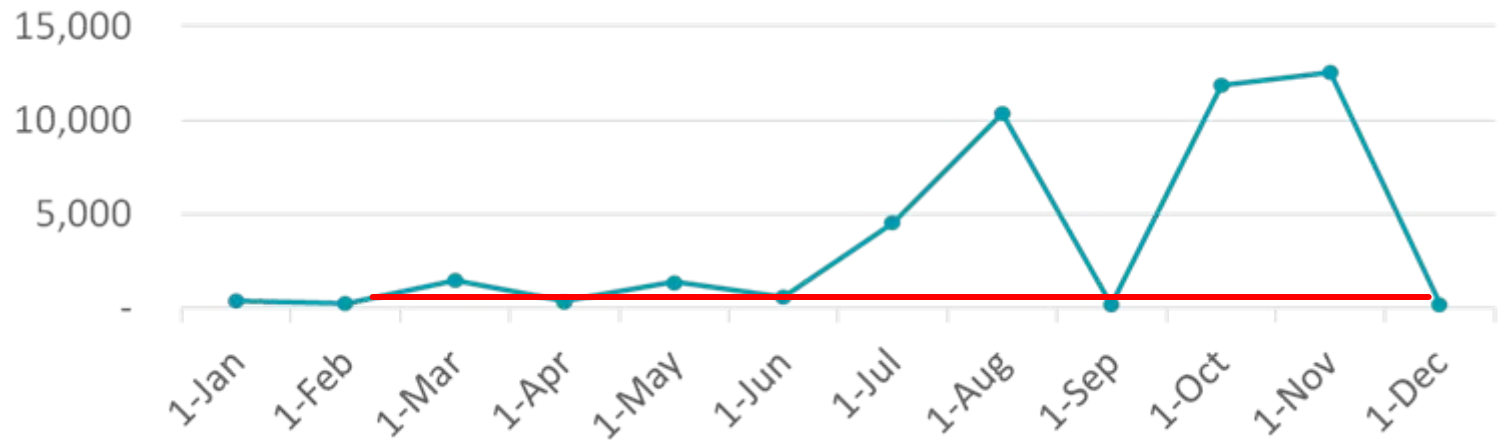
# APM Framework At-A-Glance

The framework situates existing and potential APMs into a series of categories.

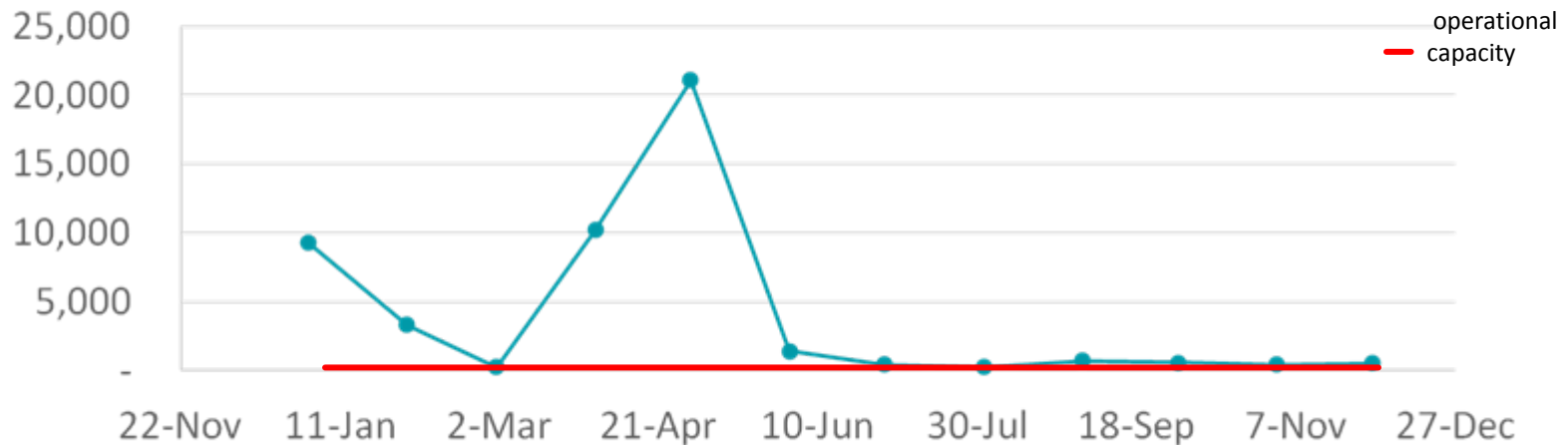


# Encounter Data-Physician Organization Realities

2013 edits  
volume ➡



2014 edits  
volume ➡

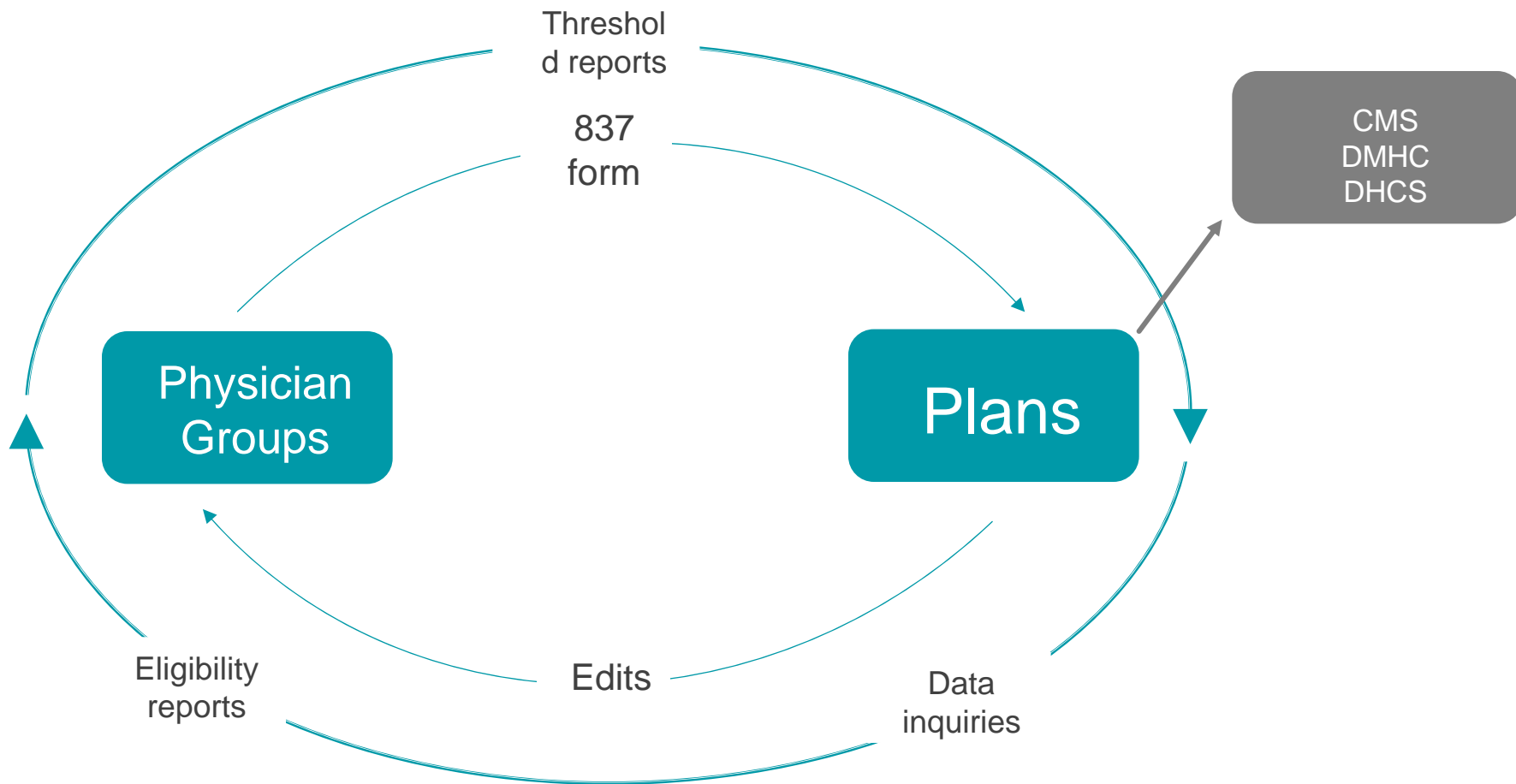


# Encounter Data-Health Plan Reality (new)

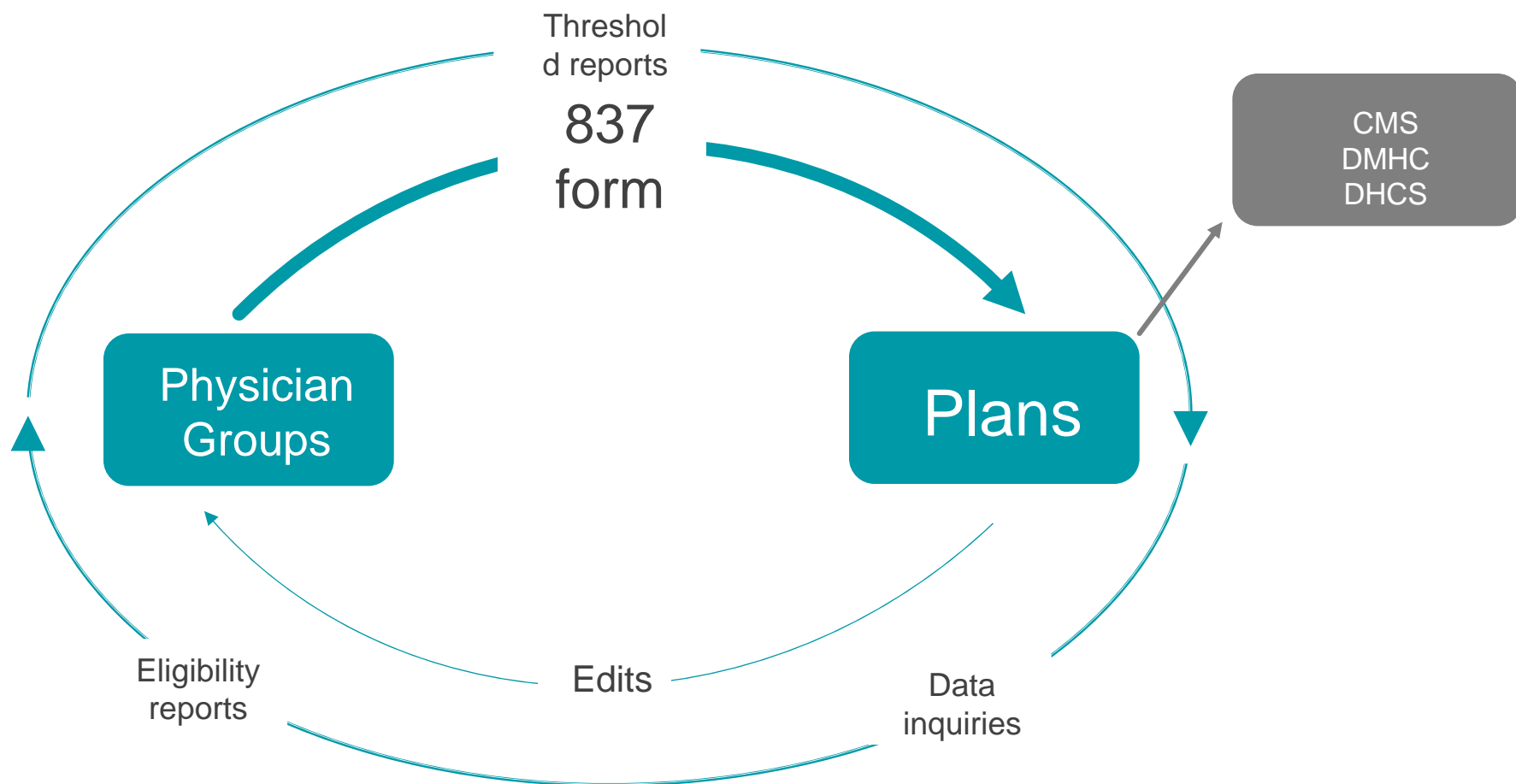
CALIFORNIA PLAN	HHS RISK ADJUSTMENT TRANSFER AMOUNT (INDIVIDUAL MARKET, INCLUDING CATASTROPHIC)	HHS RISK ADJUSTMENT TRANSFERS AMOUNT (SMALL GROUP MARKET)
1		(\$23,489,767)
2	(\$181,692,588)	\$23,364,910
3	\$135,212,707	\$13,755,875
4	\$17,743,436	
5	\$53,801,059	(\$1,149,328)
6	(\$100,186,993)	(\$3,718,210)
7	\$98,811,448	(\$6,119,362)
8	\$10,432,568	(\$953,791)
9		(\$2,215,283)
10	\$2,576,272	\$884,572

Source: CMS SUMMARY REPORT ON TRANSITIONAL REINSURANCE PAYMENTS AND PERMANENT RISK ADJUSTMENT TRANSFERS FOR THE 2014 BENEFIT YEAR

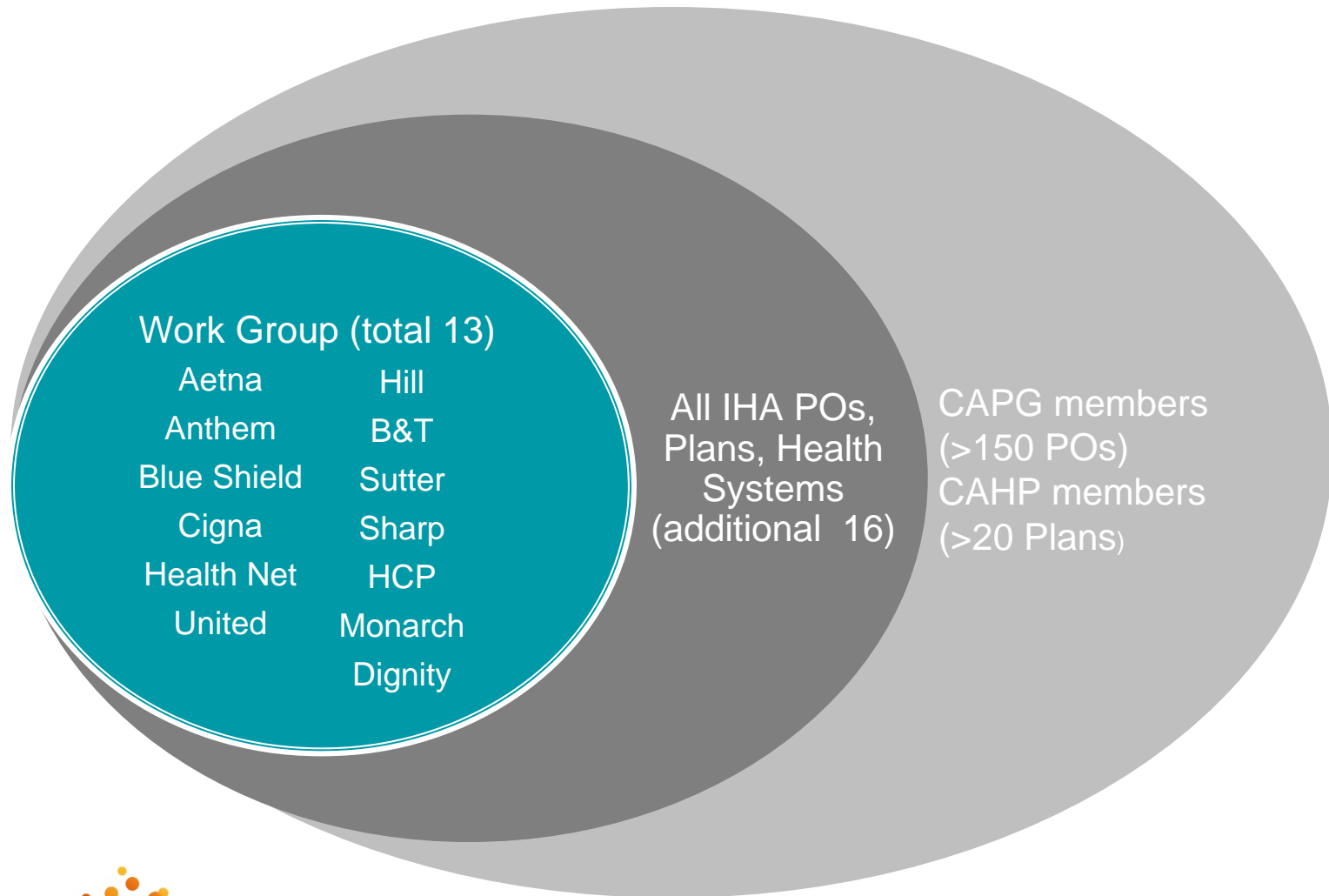
# Encounter data submission process flow



# Different requirements across plans for 837 submission create significant complexity for POs



# Phase 1 : 837 Standardization Roll Out





# 837 Data elements- where we started

	Plan 1	Plan 2	Plan 3	Plan 4	Plan 5	Plan 6	PO 1	PO 2	PO 3	PO 4	PO 5	PO 6
Organization/Issue												
Patient Amount Paid (AMT*F5 - 837P)												
Patient Estimated Paid (AMT*F3 - 837I)												
Frequency Code (Replacement Claim(CLM_05_03)												
Original Claim (If frequency code = 7 REF*F8_02)												
Frequency Code (Void Claim CLM_05_03)												
Original Claim (If frequency code = 8 REF*F8_02)												
Out of Network Flag												
Payer Paid (AMT*DI)												
Repriced Allowed Amount (HCP*10)												
IPA Paid AMT (SVD_02)												
Claim Adjustment Group Code (CAS01)												
Patient Paid Amount (CAS02)												
Remit Date (DTP*573)												



In agreement on interpretation



Pending approval

# 837 Data elements- after first meeting in Nov

Organization/ Issue	P1	P2	P3	P4	P5	PO1	PO2	PO3	PO4	PO5	PO6
1											
2											
3											
4											
5											
6											
7	NEED ACA CLARIFICATION OF TERMS AND INTENT										
8											
9											
10											
11											
12											
13											



In agreement on interpretation



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# 837 Data elements- Current- “Go Green”

	P1	P2	P3	P4	P5	P6	P01	PO2	PO3	PO4	PO5	PO6
Organization/Issue												
Patient Amount Paid (AMT*F5 - 837P)												
Patient Estimated Paid (AMT*F3 - 837I)												
Frequency Code (Replacement Claim(CLM_05_03)												
Original Claim (If frequency code = 7 REF*F8_02)												
Frequency Code (Void Claim CLM_05_03)												
Original Claim (If frequency code = 8 REF*F8_02)												
Out of Network Flag												
Payer Paid (AMT*DI)												
Repriced Allowed Amount (HCP*10)												
IPA Paid AMT (SVD_02)												
Claim Adjustment Group Code (CAS01)												
Patient Paid Amount (CAS02)												
Remit Date (DTP*573)												

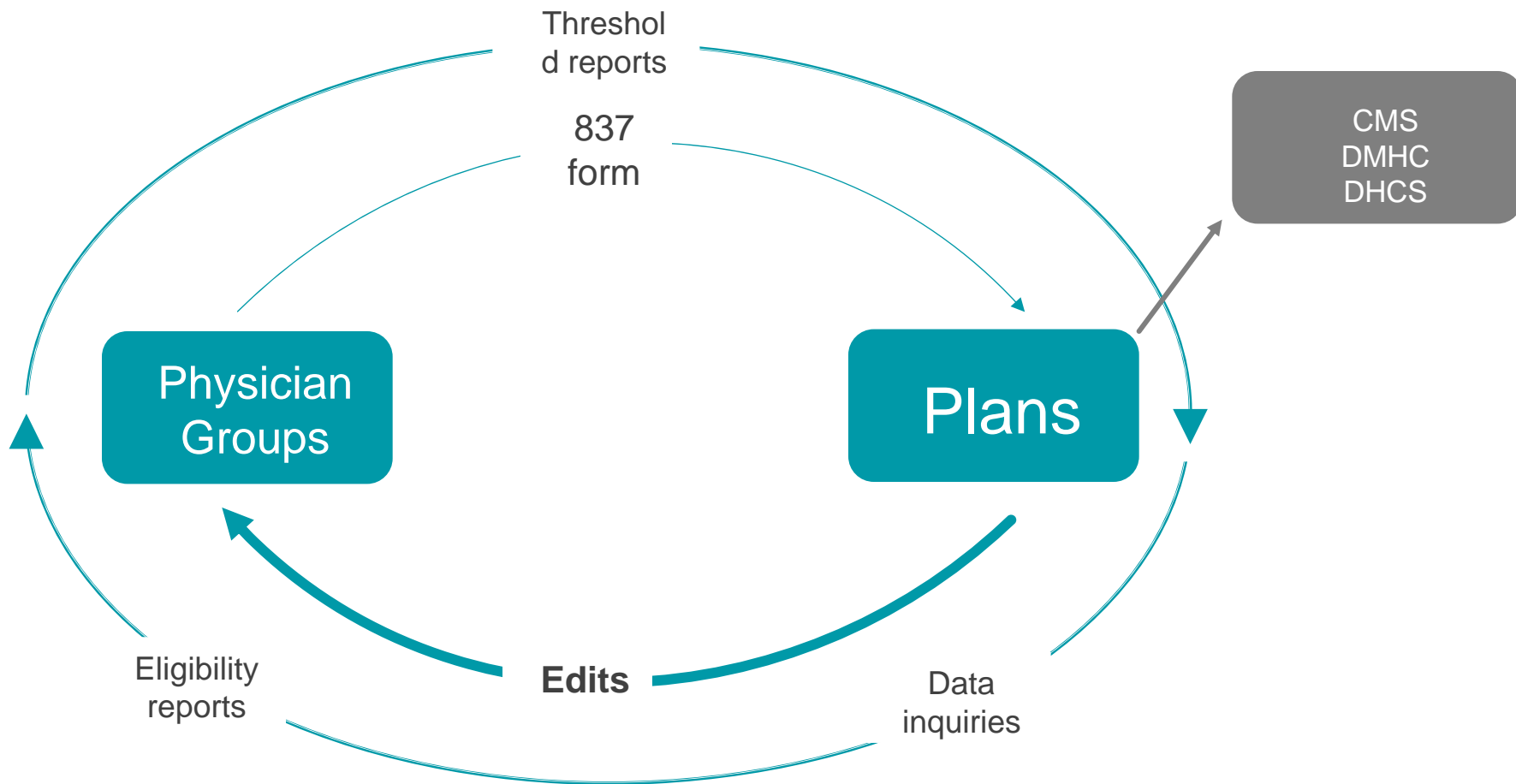


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# Next phase- Edit reports



# Panelists

- **Stacey Hrountas, CEO Sharp Rees-Stealy Medical Centers**
- **Jeff Burnich, MD, SVP Medical and Market Networks, Sutter Medical Network**
- **Martha Smith, Chief Program Officer, Dual Eligible Demonstration, Health Net of California**