Today’s Presenter

Bradley Howard, MD

Dr. Howard is a Senior Vice President and Executive Medical Director that focuses on Electronic Health Record Optimization and leads the Optimization Service Line at Clinovations which accounts for $16 million in revenue. His main focus currently is on optimizing the capture of HCC conditions, maximizing the delivery of Medicare Annual Wellness Visits, and streamlining EHR workflows, particularly in Epic, to enhance provider efficiency and engagement. Prior to his current role, he was Senior System VP and CMIO for a complex metropolitan health system in Chicago. There he led the implementation and optimization of multiple EHR platforms, inpatient and ambulatory, to achieve Meaningful Use and Clinical Transformation. He was also a key resource in the creation of an Accountable Care Organization and clinically integrated network. He has also served as a Regional CMO, Regional CMIO, Hospital Medical Staff VP, and Emergency Department Medical Director.
1. Accurate Diagnosis Capture and Coding Basics

2. Medicare Risk Score Basics

3. Operational Considerations
What is risk adjustment?

Risk adjustment is a method used by CMS to evaluate the performance of solo practitioners and groups on the quality and cost of care they provide to their Medicare FFS beneficiaries.

• Addresses differences in beneficiary populations
  • For example, a clinic treating a large number of beneficiaries with multiple chronic conditions who could potentially perform worse on certain quality and cost measures
  • Utilizes the CMS-HCC risk adjustment model
    • A combination of demographic data and disease information through the assessment of 79 HCCs
    • The information from the current year is used to predict future year patient care costs
What are Hierarchical Condition Categories?

Hierarchical Condition Categories, or HCC, is a model introduced by CMS in 2004 to adjust capitation payments to private healthcare plans for the health expenditure risk for their enrollees

- Uses 79 HCC categories, correlated to diagnosis codes, to measure disease burden
- Diagnoses must be included on a claim within the calendar year to be considered active by CMS
  - Diagnoses reset January 1st of every year
- Used for the following CMS programs:
  - Medicare Advantage Plans
  - Medicare Shared Savings ACO
Risk is Becoming A Core Pillar of Our Business

Regardless of Payer Type, Risk on the Rise

- 45% Of physician MIPS payments tied to quality and clinical improvement
- 50% Of CMS Payments tied to risk models by 2018
- 64% Of commercial insurers are offering ACOs and shared risk programs
- 70% Of population lives within an ACO territory
- 85% Of Medicare population will be Medicare Advantage by 2025
- 40% Of Medicaid is in some form of risk contract
- 45% Of CMS Payments tied to risk models by 2018
- 50% Of commercial insurers are offering ACOs and shared risk programs
- 70% Of population lives within an ACO territory
- 85% Of Medicare population will be Medicare Advantage by 2025

Population Risk Rating Underpins Success in Shift to Pay-for-Value

Population risk rating – especially accurate HCC capture and documentation – is essential for gauging the complexity (cost) of a population and securing appropriate reimbursement for patients in the provider’s care.
Leaving Reimbursement on the Table

An 85-year-old MA patient comes in for a visit…

Symptoms
• Symptoms of UTI, reports mild claudication
• Tired, less energy, poor appetite, mild malnutrition
• Urinalysis performed shows white cells, leukocyte esterase, and microalbuminuria

Medical History
• Stable diabetes mellitus (DM)
• Chronic kidney disease (CKD) stage 4 exacerbated by diabetes
• Stable left great toe amputation due to non-healing ulcer
• UTI with serum GFR 29

One Patient, Three Scenarios

<table>
<thead>
<tr>
<th>Capture basic demographics</th>
<th>85-year-old Female</th>
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</thead>
<tbody>
<tr>
<td>Total RAF</td>
<td>0.677</td>
</tr>
<tr>
<td>PMPM Payment</td>
<td>$542</td>
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<tr>
<td>Annual Payment</td>
<td>$6,499</td>
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</table>

<table>
<thead>
<tr>
<th>Capture reason for most-recent visit</th>
<th>85-year-old Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes mellitus</td>
<td>✓</td>
</tr>
<tr>
<td>UTI</td>
<td>✓</td>
</tr>
<tr>
<td>CKD Stage 4 due to Diabetes</td>
<td>✓</td>
</tr>
<tr>
<td>Mild Degree Malnutrition</td>
<td>✓</td>
</tr>
<tr>
<td>H/O Toe Amputation</td>
<td>✓</td>
</tr>
<tr>
<td>PVD due to Diabetes</td>
<td>✓</td>
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<tr>
<td>Total RAF</td>
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<tr>
<td>PMPM Payment</td>
<td>$636</td>
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<td>Annual Payment</td>
<td>$7,632</td>
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<table>
<thead>
<tr>
<th>Capture complete clinical information</th>
<th>85-year-old Female</th>
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<tbody>
<tr>
<td>Diabetes mellitus</td>
<td>✓</td>
</tr>
<tr>
<td>UTI</td>
<td>✓</td>
</tr>
<tr>
<td>CKD Stage 4 due to Diabetes</td>
<td>✓</td>
</tr>
<tr>
<td>Mild Degree Malnutrition</td>
<td>✓</td>
</tr>
<tr>
<td>H/O Toe Amputation</td>
<td>✓</td>
</tr>
<tr>
<td>PVD due to Diabetes</td>
<td>✓</td>
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<tr>
<td>Total RAF</td>
<td>3.06</td>
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<tr>
<td>PMPM Payment</td>
<td>$2,448</td>
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<tr>
<td>Annual Payment</td>
<td>$29,376</td>
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</table>
Aligning on a Full Picture of Patient Health

Why Capturing Chronic Conditions Is Important

Electronic Health Records (EHR)

Center for Medicare and Medicaid Services (CMS)

Known Patient Conditions
- 85-year-old female
- Diabetes mellitus
- UTI
- CKD stage 4 due to diabetes
- Mild degree malnutrition
- H/O toe amputation
- PVD due to diabetes

Assumed Patient Healthcare Complexity Based on Billing Data
- 85-year-old female
- Diabetes mellitus
- UTI
- CKD stage 4 due to diabetes
- Mild degree malnutrition
- H/O toe amputation
- PVD due to diabetes

INFORMATION GAP
Incomplete view of patient's complexity

Complete documentation of patient's complexity results in CMS allocating the appropriate funds the following year to care for the patient.

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1. Accurate Diagnosis Capture and Coding Basics

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How is the risk score calculated?

Demographic Factors + Disease Factors + Interaction Factors = Raw RAF Score
Accounting for Demographics

Demographic Factors + Disease Factors + Interaction Factors = Raw RAF Score

**Age** as of February 1 of the payment year

**Sex** of the beneficiary

**Disabled Status** factor for community resident disabled beneficiaries under 65 years old

**Original Reason for Entitlement** factor for beneficiaries 65 years of age or older who were originally entitled to Medicare due to disability

**Medicaid Eligibility** factor for Medicaid status of the beneficiary
Calculating the Added Cost of Chronic Disease

Thousands of ICD-10 diagnosis codes map to 189 HCC categories
(Not every ICD-10 code or HCC category are used for each year or model)

Trumping logic ensures that diseases are not double counted. For example, HCC 18, Diabetes with Chronic Complication trumps HCC 19, Diabetes without Complication

Each HCC category has an associated RAF value. RAF values are added together to form the Disease Factor score

Demographic Factors + Disease Factors + Interaction Factors = Raw RAF Score
Interaction

Disease Interactions

- If the additive RAF score resulting from two diseases is not sufficient to fully document increased risk, an interaction term is added.

Example beneficiary:
- Diabetes HCC 19 = RAF .118
- CHF HCC 85 = RAF .368
- Raw RAF score = Demographic factors + .118 + .368 + .182 (Diabetes_CHF interaction)

Disease/Disabled Interactions

- For disabled beneficiaries, interaction terms apply for additional diseases.

Example beneficiary:
- Opportunistic Infection HCC 5 = RAF .440
- Originally Disabled
- Raw RAF score = Demographic factors + .440 + .451 (Disabled_HCC5 interaction)
1. Accurate Diagnosis Capture and Coding Basics
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Operational Considerations

**Coding Specificity**
- Important to code to the highest level of specificity possible
- A more accurate reflection of patients’ conditions
- Avoid potential for claim denial for unspecified diagnoses

**Accurate Documentation**
- Accurate and robust supporting documentation is required for all diagnoses submitted to CMS

**Problem List Maintenance**
- An up-to-date problem list is important for providing a clear picture of a patient’s conditions
- Can be used to remind providers to treat a patient’s condition that may not be the primary reason for the visit
Four Hallmarks of a Standout Performer

1. **Precision targeting through clinical data**
2. **Provider guidance embedded in EMR workflows**
3. **Programmatic team engagement**
4. **Continuous improvement cycle**

**Unified Through Strong Process**

The Right “People Approach”

The Right “Technology Approach”
Population Risk Rating a New Skill

Long-Term Success Requires Near-Term Precision

Securing Visits within Designated Rating Period

Complexity of Medicare patients is rated in E&M interactions with qualified providers in qualified care settings during calendar year

Maintaining an Accurate, Referenceable Record

Patients and conditions warranting management must be easy to identify, evaluate, and document within the medical record

Rebooting “Capture” Efforts Each Year

Consistent effort is required to maintain appropriate payment, which is reset regularly based on last-recorded complexity of population

HCCs captured and submitted by deadline(s) significantly impact payment amounts and cash flow for **up to two years**
## Top Five Missed Diagnoses

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Health System 1</th>
<th>Health System 2</th>
<th>Health System 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Morbid Obesity</strong></td>
<td>Rank: #1</td>
<td>Rank: #1</td>
<td>Rank: #1</td>
</tr>
<tr>
<td></td>
<td>Opportunity: 15%</td>
<td>Opportunity: 10%</td>
<td>Opportunity: 19%</td>
</tr>
<tr>
<td><strong>Diabetes with Chronic Compl.</strong></td>
<td>Rank: #2</td>
<td>Rank: #2</td>
<td>Rank: #2</td>
</tr>
<tr>
<td></td>
<td>Opportunity: 8%</td>
<td>Opportunity: 9%</td>
<td>Opportunity: 6%</td>
</tr>
<tr>
<td><strong>Atherosclerosis</strong></td>
<td>Rank: #3</td>
<td>Rank: #4</td>
<td>Rank: #3</td>
</tr>
<tr>
<td></td>
<td>Opportunity: 7%</td>
<td>Opportunity: 4%</td>
<td>Opportunity: 5%</td>
</tr>
<tr>
<td><strong>COPD</strong></td>
<td>Rank: #4</td>
<td>Rank: #3</td>
<td>Rank: #4</td>
</tr>
<tr>
<td></td>
<td>Opportunity: 5%</td>
<td>Opportunity: 5%</td>
<td>Opportunity: 5%</td>
</tr>
<tr>
<td><strong>Seizure Disorder</strong></td>
<td>Rank: #5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Opportunity: 4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Bipolar Disorder</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Opportunity: 2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CHF</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Opportunity: 2%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1) Rank of diagnosis as contributor to total RAF uncaptured
Questions for Q&A Hours?