3M Science. Applied to Life.™

Intelligent solutions for a value-based world

HCCs: The next chapter – Integrating coding, quality and CDI to develop your HCC program across the continuum.

November 15, 2018

Agenda

- Introduction to HCCs
- Risk adjustment factors and impacts of missing HCCs
- Gaps in capturing missing HCCs
- Expanding your CDI program into the OP and Professional setting
- Performing an assessment of current state
- Developing the HCC Program
- Implementing technologies

In the News

Becker's Healthcare: Hospital Review | ASC Review | Spine Review | Clinical | Health IT & CIO | CFO | Dental Review | 1.800.417.2035 | Email Us

BECKER'S HOSPITAL REVIEW

athenahealth stop bringing patients home. 74% same-day encounter close rate. Free up

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CMS says it will recoup $1B in improper Medicare payments by 2020

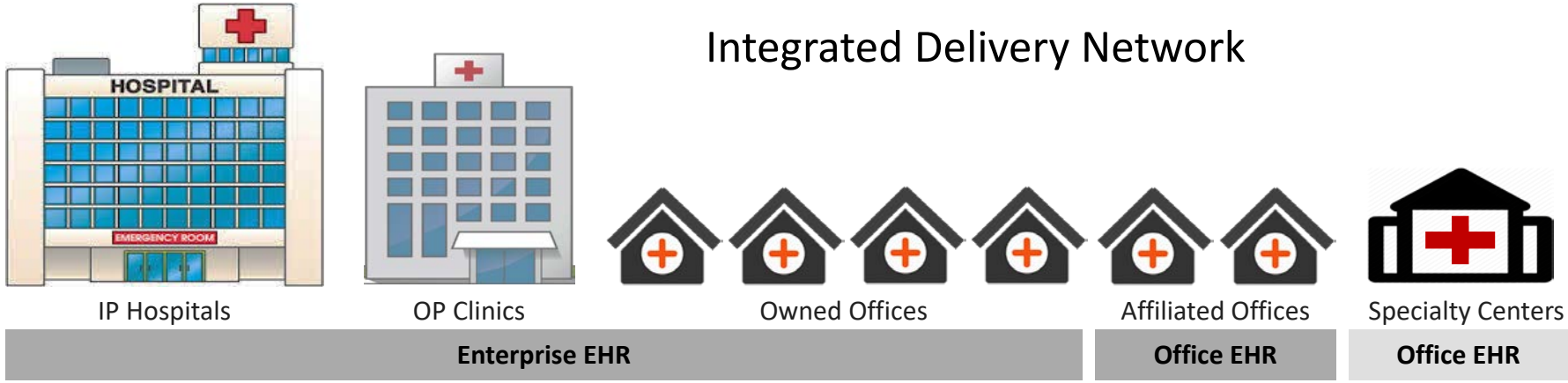
Written by Morgan Haefner | October 31, 2018 | Print | Email

CMS said it is poised to claw back $1 billion from Medicare Advantage organizations by 2020 through widespread audits, according to a proposed rule.

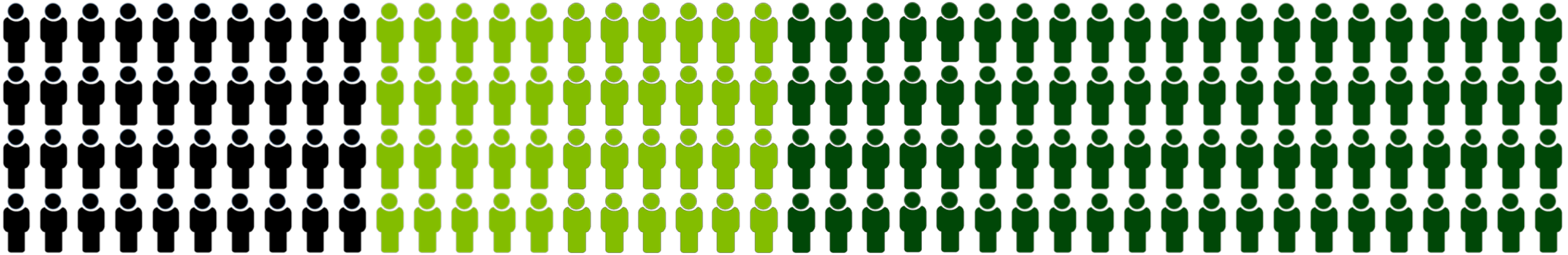
In the news

- The audits target Medicare Advantage health plans
- Risk Adjustment Data Validation Audits – RADV – New Acronym
- These audits confirm that MA organizations self-reported risk adjustment data, or diagnosis codes used to depict how sick beneficiaries are, match medical documentation,
- Estimated to recoup 1$ billion dollars I in improper payments by 2020.

Shift to value-based reimbursement



Health System Patient Population



Fee-for-service ← 75% tied to quality* ← 50% reimbursement based on value*

*CMS targets for 2018

HCC Definition

Hierarchical Condition Categories is a payment methodology based on risk and used by CMS to adjust Medicare Advantage health plan payments at the patient level.

Two patients in the same community can have a different payment rate based on several factors relating the to amount of risk or work it takes to maintain the health of a patient. Used by insurance companies to determine future medical needs for the next year.

Example: if a person is diagnosed with diabetes in one year, the money that will need to be set aside for the patient for he next year changes from before they were diagnosed as a diabetic. Sicker patients cost more to care for.

Risk Adjustment to Deliver Better Patient Care

The focus on HCCs is on early diagnosis, treatment, documentation and coding of diseases.

Keeping patients well and out of the hospital.

Keeping medical costs down and leading to better patient care

Risk Adjustment: CMS and Commercial HHS HCCs

- Developed by CMS for risk adjustment of the Medicare Advantage Program (Medicare Part C)
- CMS also developed a CMS RX HCC model for risk adjustment of Medicare Part D population
- Based on aged population (over 65)

- Developed by the Department of Health and Human Services (HHS)
- Designed for the commercial payer population
- HHS-HCCs predict the sum of medical and drug spending
- Includes all ages

Medicare Advantage vs. Health and Human Services HCCs

- MA HCCs, implemented in 2004 for people that are eligible for Medicare and is their HMO product.
- HHS HCCs are set up exactly like MA HCCs – same categories and hierarchies but include all decades of life. Created under the Affordable Care Act, they are intended for uninsured that not eligible for Medicare via the Health Exchanges
- In addition to the ICD-10 diagnosis codes in the MA HCCs, pregnancy and newborn conditions and codes are added.
- Asthma is also added because it more severely affects patients in the first three decades of life.
- As providers move into value based care, there must be an agnostic approach to documenting for HCCs for patients across all decades of life.

HCCs in multiple value-based payment programs

Preparing for a mix of models

Fee-for-Service

Annual Capitated Payment
(Medicare Advantage, HIX)

RAF scores are payment multipliers for capitated payment

Bundled Payment
(CMS CJR)

HCCs adjust bundled payments to account for more complex patients

Pay-for-Performance
(MACRA, commercial contracts)

HCCs risk adjust VBP performance metrics (mortality, spending, safety)

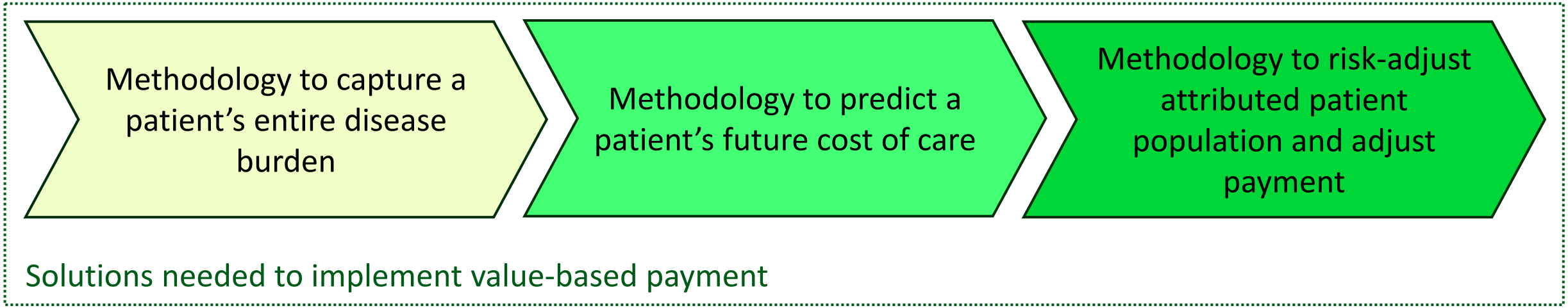
ACO Shared Savings/Risk
(MSSP, commercial ACOs)

HCCs risk adjust financial benchmarks and impacts savings/risk targets

Medical Homes
(CMS CPC+, commercial PCMHs)

RAF for a physician's patient panel determines care management fee

Value-based reimbursement changes the game

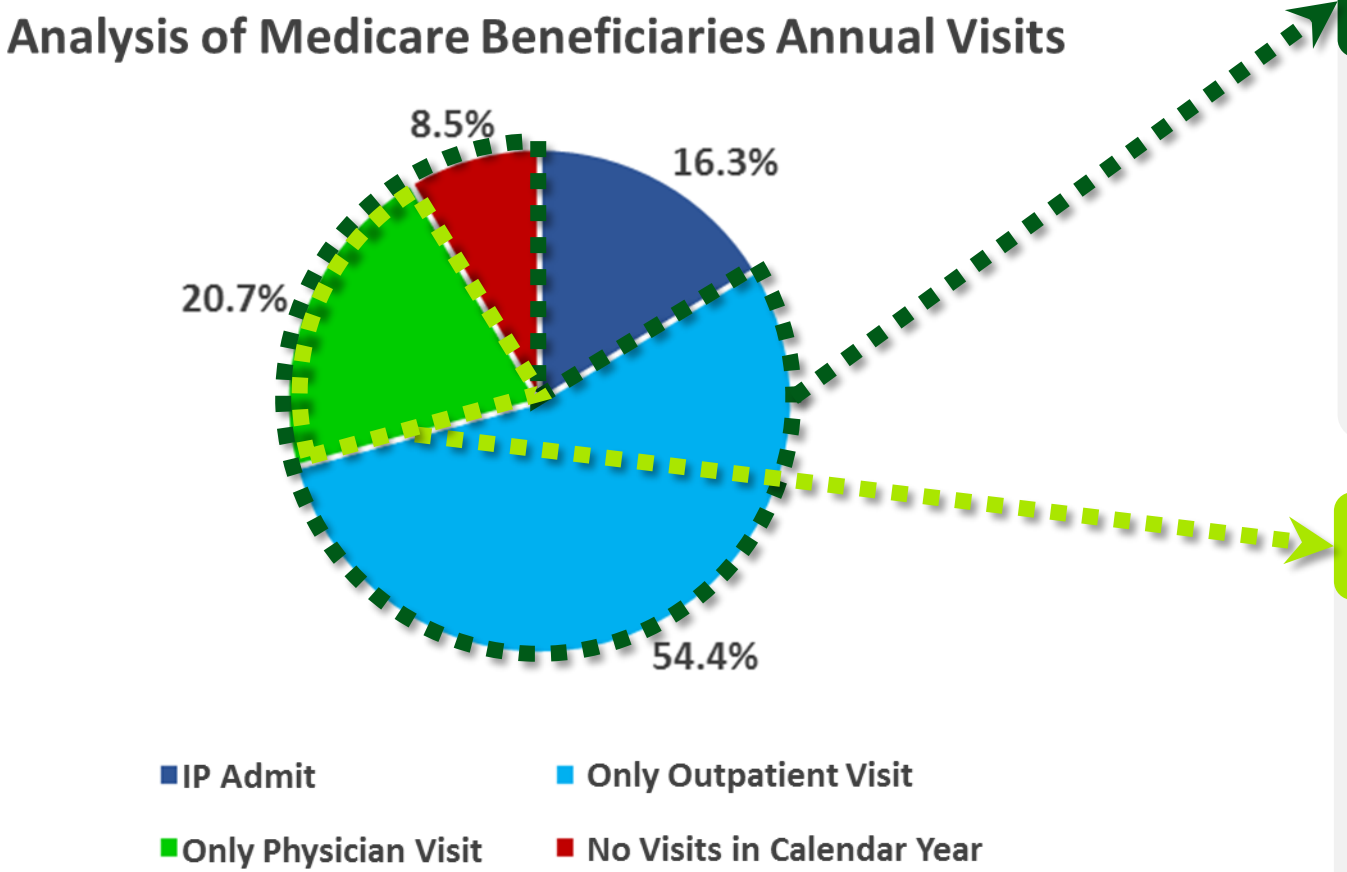


Hierarchical Condition Categories (HCCs)

HCC

CMS-HCC risk adjustment model is prospective with a base year of demographic information combined with major medical conditions to predict Medicare expenditures/risk in the next year.

HCC gaps across a population



*IP admission patients may have also had a physician office or outpatient visit as well in the calendar year
**Patient receiving outpatient care or physician visits had no other visit types in the calendar year

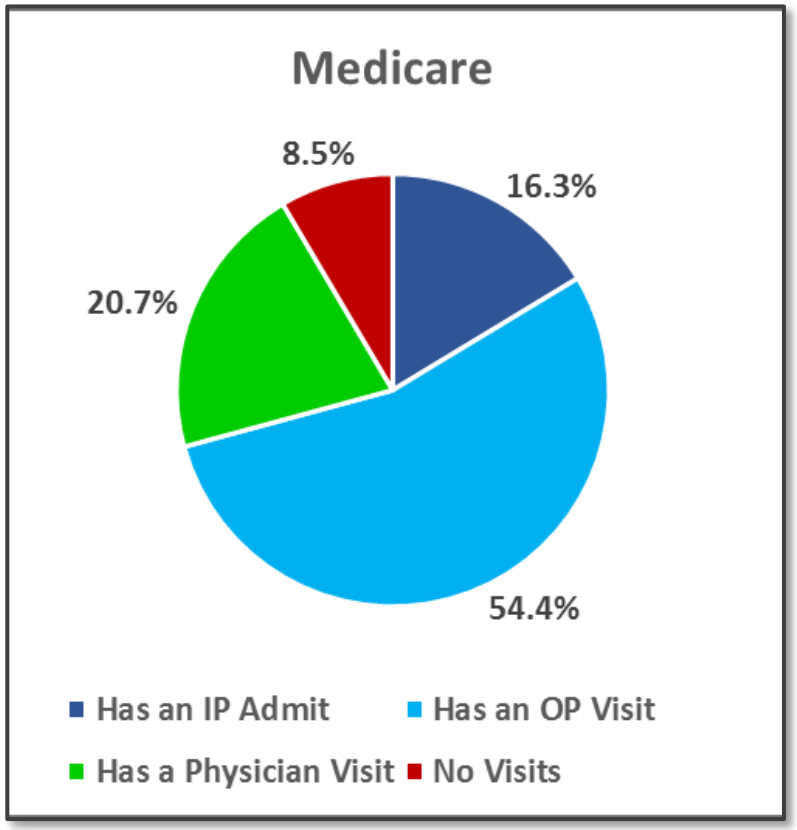
Outside the Hospital

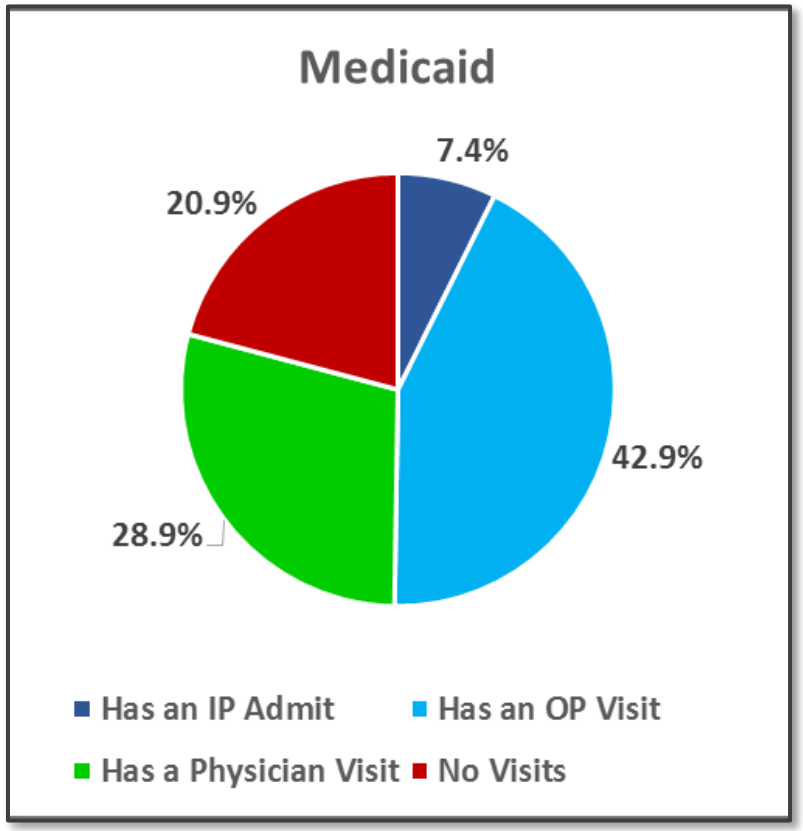
- CDI programs today focus on IP acute admissions
- Little to no documentation review and physician guidance in OP or office settings
- Automated tools can guide physicians to capture HCC diagnoses

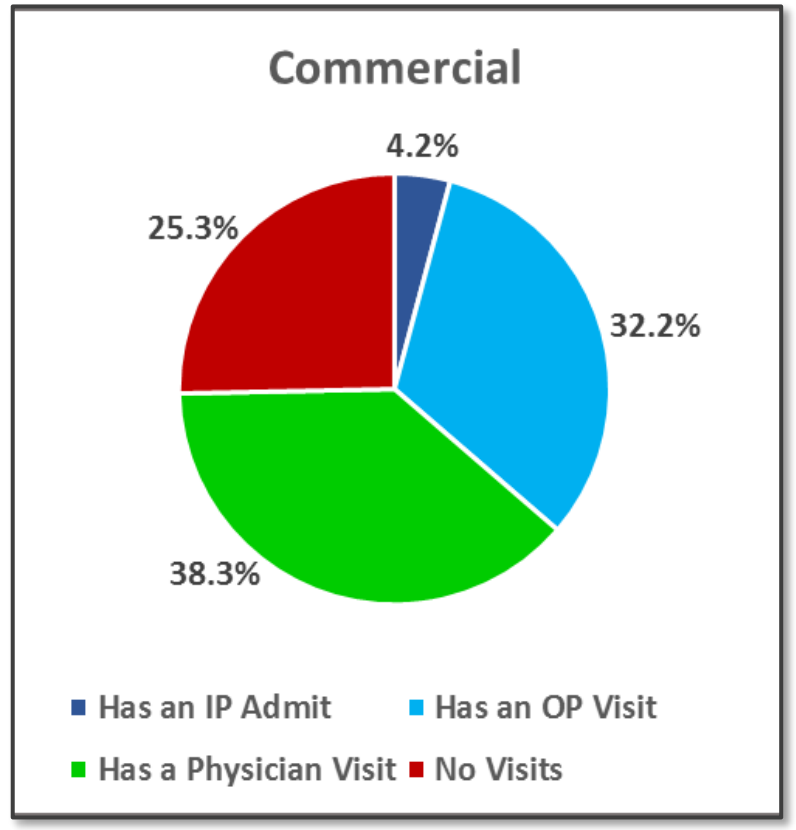
Physician Office

- 80-90% of office visits are coded by providers with no coder review
- Physicians focus on CPT not complete diagnosis billing
- Computer-assisted coding can aid complete HCC diagnosis coding

Multi-Client Patient Visit Analysis



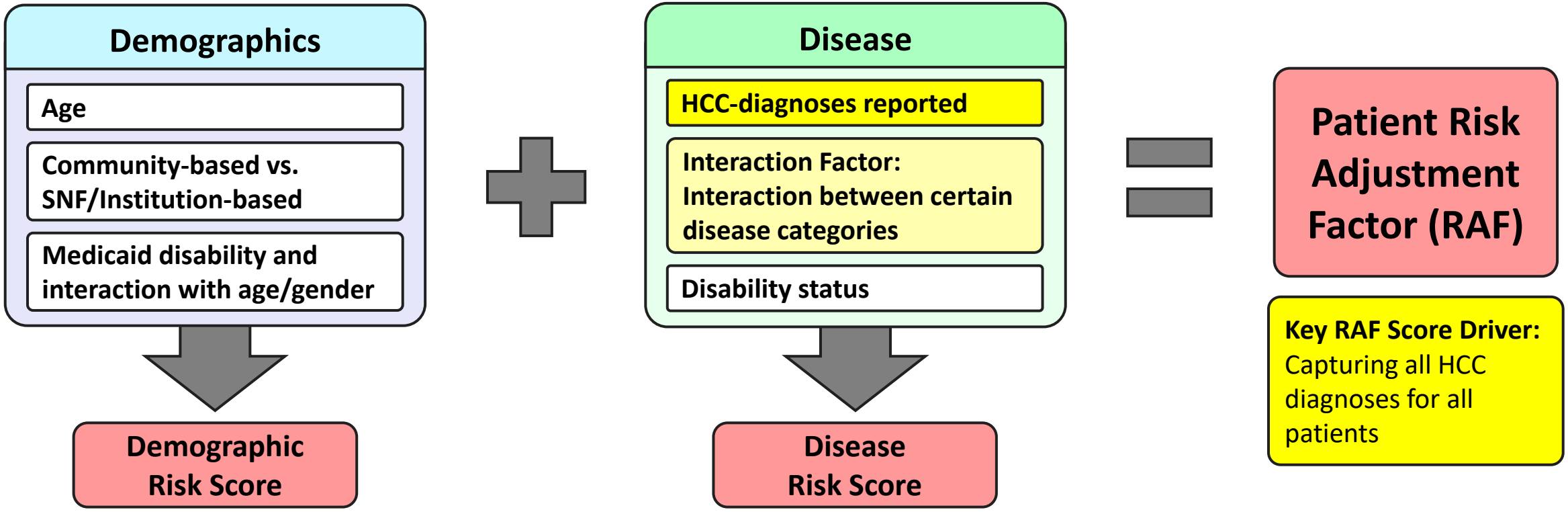




HCCs also used in Medicaid and many Commercial Payer plans

HCC and RAF (Risk Adjustment Factor) Calculations

Total score of all relative factors related to one patient for a total year derived from a combination of the two scores



Background and Overview
Ideal state: HCC diagnoses drive RAF scores

Paul Smith, 78-year-old male, community based, managing chronic conditions

2016 Risk Adjustment Factor (RAF) Score Diagnoses documented/billed during visits in 2016	
Demographic score: 2016	0.442
HCC 18: Diabetes w/retinopathy	0.368
HCC 22: Morbid Obesity	0.365
HCC 40: Rheumatoid arthritis	0.374
HCC 85: Dilated cardiomyopathy	0.368
HCC 111: COPD	0.346
HCC Interaction Score: CHF—COPD	0.259
HCC Interaction Score: Diabetes—CHF	0.182
Total RAF Score	2.704

2017 Risk Adjustment Factor (RAF) Score Diagnoses documented/billed during visits in 2017	
Demographic score: 2017	0.466
HCC 18: Diabetes w/retinopathy	0.318
HCC 22: Morbid Obesity	0.273
Total RAF Score	1.057
2016 Missing RAF Score	1.647

Capitated Pay Per Member Per Month (PMPM):

- $800 PMPM x 2.704 RAF = $2,163
- $800 PMPM x 1.057 RAF = $846

-$15,804 Annual

**Example of payment made to Medicare Advantage payer based on $800 PMPM base rate*

RAF Scores → Drive Value-Based Reimbursement

2015

$800 Baseline PMPM	X	**2.704** Individual RAF Score	=	**$2,163** Individual PMPM

2016

$800 Baseline PMPM	X	**1.057** Individual RAF Score	=	**$846** Individual PMPM

$15,804

Missed Annual Payment 2017

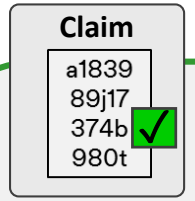
*Assumes capitated program is based on negotiated $800 per member per month agreement

Physician documentation and coding

Annual physical for Paul Smith, a 78-year-old male, living at home

The physician documents:

"Mr. Smith is here for his annual physical. He is a 78 y/o male with continued morbid obesity and diabetes with retinopathy. Current meds are still being taken as directed…"



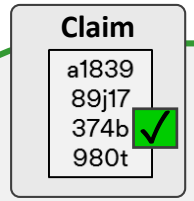
And codes:

E&M level	**99213**
Diabetes w/retinopathy	E11.319
Morbid Obesity	E66.01

HCCs require more detailed documentation and coding

Ideal documentation:

"Mr. Smith is here for his annual physical. He is a 78 y/o male with continued morbid obesity and diabetes with retinopathy. Current meds are still being taken as directed…
…rheumatoid arthritis…
.dilated cardiomyopathy…
…
… and COPD…"



Optimal coding:

E&M level	**99214**
Diabetes w/retinopathy	E11.319
Morbid obesity	E66.01
Rheumatoid arthritis	M06.9
Dilated cardiomyopathy	I42.0
COPD	J44.9

About 90% of office visits are coded by providers with *no coder review.* Will providers document and code complex diagnoses correctly?

CHF – HCC Example

Sample of 46 ICD-10 CHF-related diagnoses that map to CMS-HCC #85

CMS-HCC Category	HCC Description	Community RAF	ICD-10 Diagnosis Code	ICD-10 Description
85	**Congestive Heart Failure (CHF)**	**0.368**	I5020	Unspecified systolic (congestive) heart failure
			I5021	Acute systolic (congestive) heart failure
			I5022	Chronic systolic (congestive) heart failure
			I5023	Acute on chronic systolic (congestive) heart failure
			I5030	Unspecified diastolic (congestive) heart failure
			I5031	Acute diastolic (congestive) heart failure
			I5032	Chronic diastolic (congestive) heart failure
			I5033	Acute on chronic diastolic (congestive) heart failure
			I5040	Unspecified combined systolic (congestive) and diastolic (congestive) heart failure
			I5041	Acute combined systolic (congestive) and diastolic (congestive) heart failure
			I5042	Chronic combined systolic (congestive) and diastolic (congestive) heart failure

How specificity impacts CMS HCCs and RAF scores

Specificity Impact	Diagnoses		Examples
DOES NOT impact the HCC/RAF	1. Secondary cancers 2. Malnutrition 3. Hepatic failure 4. Cirrhosis 5. Chronic hepatitis 6. Osteomyelitis 7. Osteonecrosis 8. Rheumatoid arthritis	9. Schizophrenia 10. Epilepsy 11. Resp. failure 12. Atrial fib/flutter 13. COPD 14. Emphysema 15. Heart failure	• Severe / Moderate / Mild / Unspecified Malnutrition all under HCC 21 • Twenty-seven ICD-10 codes related to respiratory failure HCC 84 o Acute / Chronic / Acute and Chronic / Unspecified Respiratory Failure
DOES impact the HCC/RAF	1. Diabetes 2. Angina 3. Pneumonia 4. Renal failure unspecified 5. Chronic kidney disease unspecified 6. Pressure ulcer unspecified		• Chronic kidney disease: o Stages 1, 2 and 3 are not HCCs o Stage 4 and Stage 5 are HCCs • Different HCCs for diabetes with: o Acute complications (HCC 17) o Chronic complications (HCC 18) o Without complications (HCC 19)

The most critical factors is ensuring providers are aware of the full historical HCC diagnosis list

How HCCs affect providers

Stratifies patient populations based on disease burden and disability status

Provides apples-to-apples comparison of resources needed to safely manage patients in acute and chronic settings

Used to set Medicare resource consumption and payment adjustment:

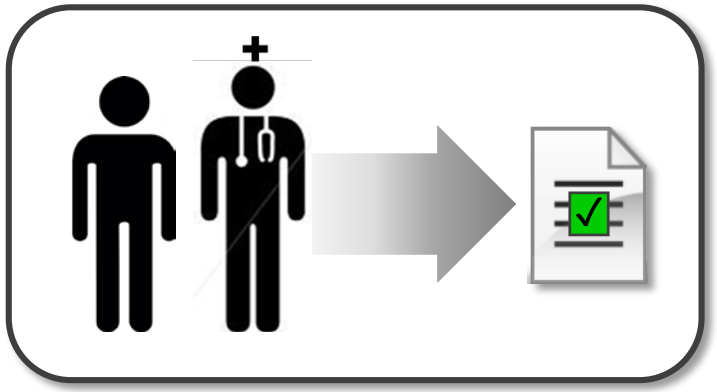
- For Hospital Value Based Purchasing (VBP)
- As a part of the Total Performance Score for Merit-Based Incentive Payment System (MIPS), beginning in 2018
- As the risk adjustment determining the CPC+ monthly case management fee (from $6 to $30)
- As a measure of resource use for Accountable Care Organizations which are Alternate Payment Model (APM) programs

Risk-adjusts provider costs, which may exclude them from a commercial health plan network due to excessive cost of care compared to peers

HCC Documentation Requirements

HCC Diagnoses

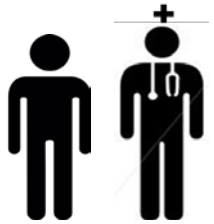
- Must be captured in a face to face visit – MEAT criteria (monitor, evaluate, assess and treat).
- Must be appropriately documented in the medical record with date and provider signature
- Must be appropriately captured on the bill.



Specific reporting rules:

- ✓ Chronic diseases can be reported as long as they receive treatment and care
- ✓ Diagnoses resolved or no longer treated should not be listed
- ✓ Diagnoses that receive care and management during the visit can be reported
- ✓ Be careful using diagnoses on problem lists that have been resolved
  - ➢ Lack of updated, maintained EHR problem lists make patient histories challenging to clearly discern

Common gaps and key steps in capturing HCCs



Face-to-face patient visit

Visit Types
- Hospital inpatient and outpatient
- Physician office

Exclusions:
- Hospice
- SNF
- Home health
- Free-standing ASC

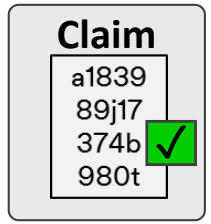
- Patients missing HCCs do not have visits scheduled
- No way to identify patients
- No easy process to schedule at-risk patient for a visit

Physician addresses and diagnoses condition(s)

Providers
- Physicians
- NP, CRNA
- Psychologist/Psychiatrist

Services Excluded:
- DME
- Laboratory
- Diagnostic radiology

- Physician doesn't know what patient information is contained in disconnected EMRs
- Not all HCC-diagnoses are captured/documented



Dx coded and itemized in claim

Requirements
- Each HCC diagnosis submitted in a claim once per calendar year
- Must be supported by documentation in visit note

- Physician documents an HCC-diagnosis but does not code for it
- Providers trained to code diagnoses to support pro-fee billing not for HCC capture

HCCs must be treated, documented, coded, and billed at some point across care settings

CMS 1500 Professional Billing Form

3M 360 Professional makes sure that all fields on the form are completed correctly

Patient Info

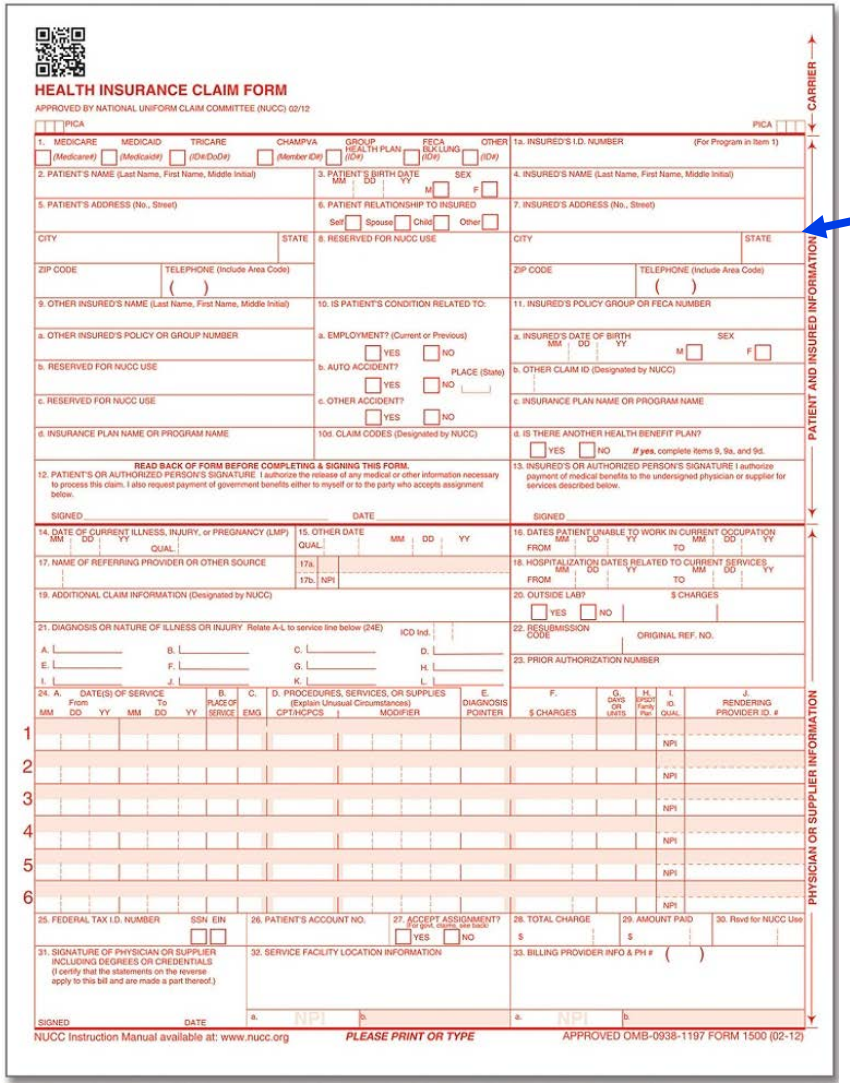
Insurance Info

Referring Provider

Dx Codes

CPT codes with dates, place of service, modifiers, and pointers to diagnosis codes above, charges, and billing provider (up to 6)

Facility Info

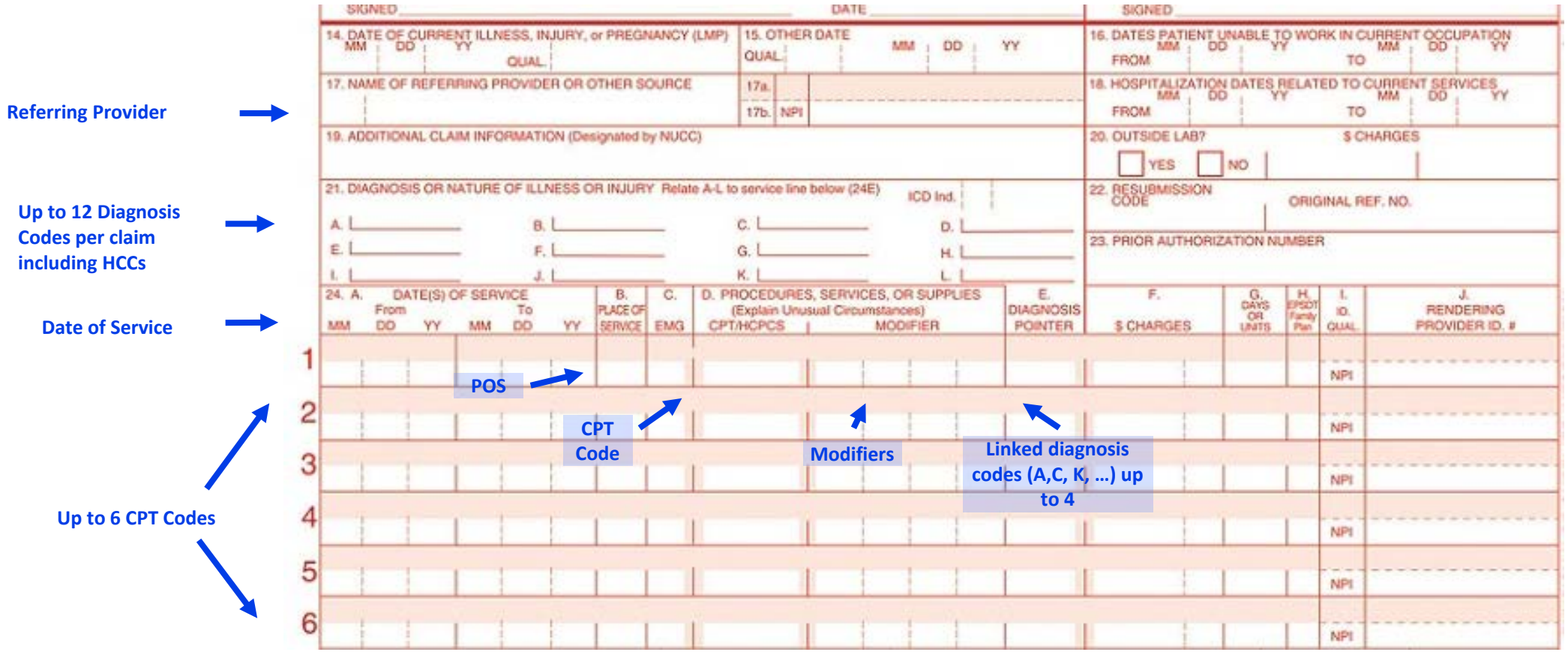


CMS 1500 Professional Billing Form

3M 360 Professional makes sure that all fields on the form are completed correctly

One per Provider

Multiple Procedures per provider



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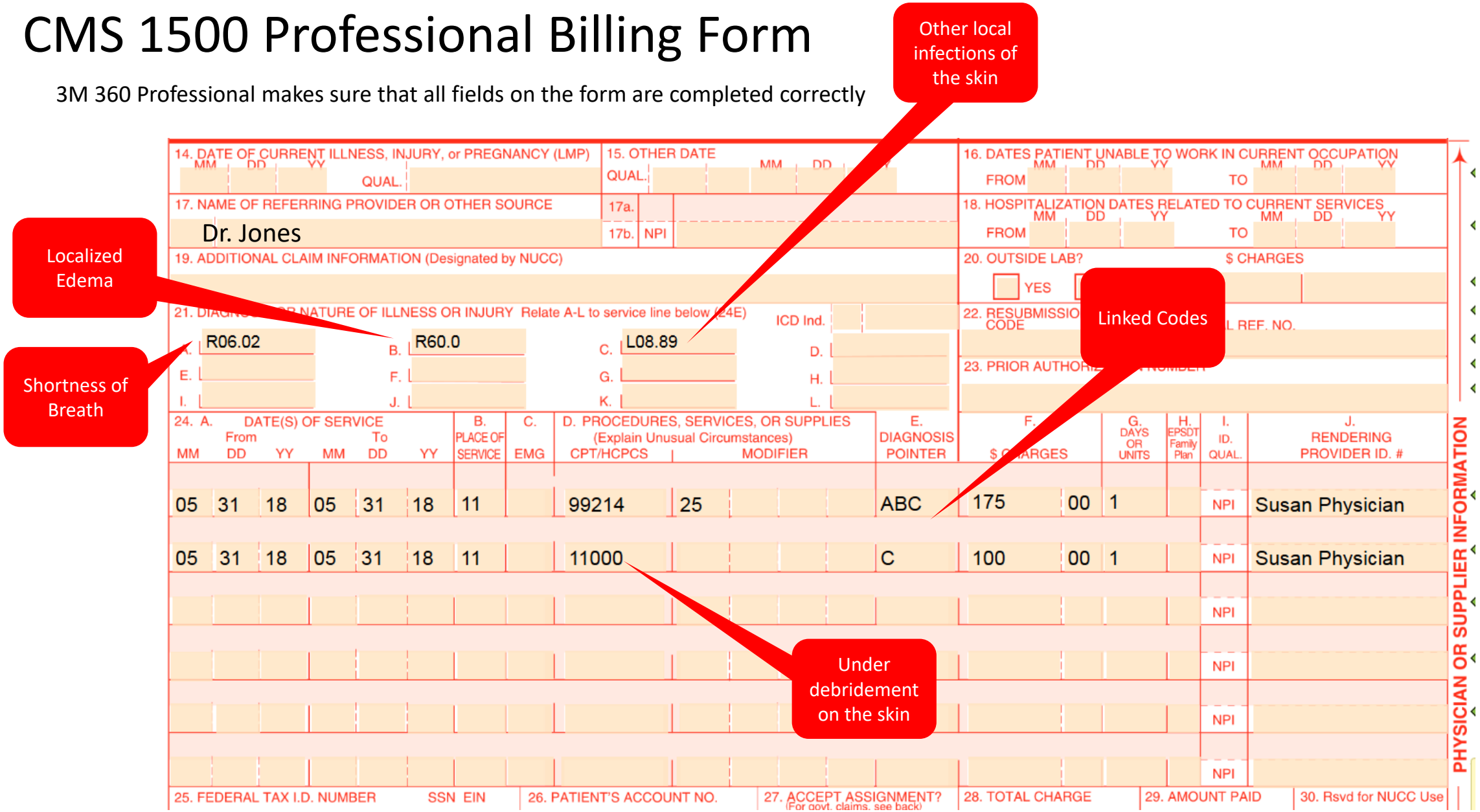


Undercoding HCCs… Why it Might Happen

- Providers are having to do their own coding in EMR systems and EMRs are always changing.
- Providers don’t know coding guidelines and HCC guidelines.
- Reimbursement never depended on ICD-10 codes before.
- Providers are not aware of the documentation guidelines.
  - Diagnosis is not specific enough therefore it does not risk adjust.
  - Too many one word diagnoses such as bronchitis, renal disease, hepatitis.
  - Documentation must say chronic bronchitis, stage 4 renal disease, chronic hepatitis C.

Top 10 Most Under-documented HCCs

- Amputations
- Artificial Openings
- Asthma and pulmonary disease
- Chronic skin ulcer
- Congestive heart failure
- Drug dependence
- Metastatic cancers
- Morbid obesity
- Rheumatoid Arthritis
- Specific type of major depressive order

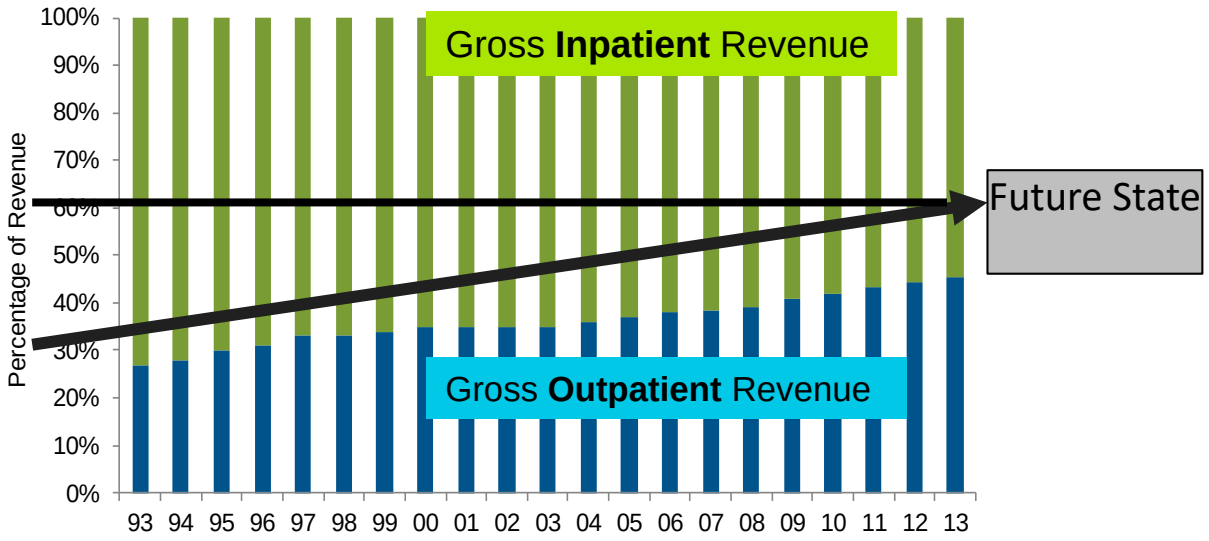
Source: 3M aggregated claims data

Outpatient and Professional CDI to Improve HCC Capture

- Leveraging and expand your existing CDI program to Outpatient and Professional CDI – it’s not just about HCCs
- Perform an assessment
- Educate providers across the continuum of care on HCCs and improving documentation
- Implement technology
- Monitor and measure improvement

What Customers Have Told Us About Outpatient CDI

- A significant portion of existing revenue comes from outpatient services and is expected to increase by at least 25% over the next 3 years
- Only 5% have an existing OP CDI program
- 56% participants will invest in an OP CDI program in the next few years
- Most participants need help starting a program



Clinical Documentation Improvement Program - Outpatient

What is driving the trend to move services to the outpatient setting?

- Technological advances
- To lower the cost of healthcare
- To capture HCC's

Questions related to outpatient claim scrubbing:

- What does it cost to get paid for outpatient services?
- What are the claim denial volumes?
- How much rework (number of claims) are being re-processing each day?
- How long does it take to be reimbursed from:
  - Original claim to payment or denial
  - Resubmitted claim to payment
- How much staff is involved in this process?
- How much time is invested in making sure charge information gets to the bill correctly?
- How often is information reprocessed because the root cause of the problem is not identified and corrected?

Reasons an organization needs OP or PS CDI

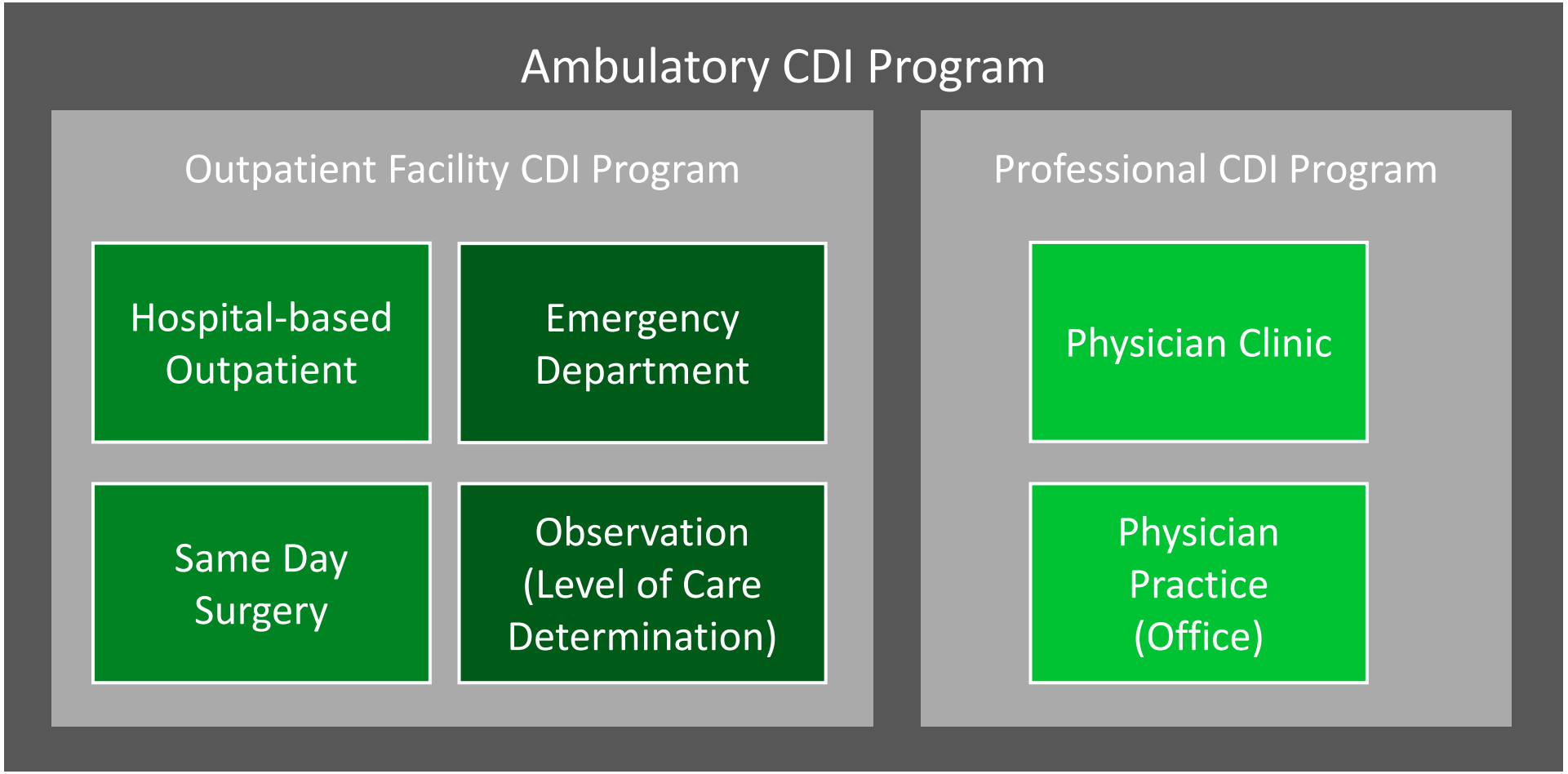
Reasons

- Missed medical necessity
- Documentation may not represent the patient care delivered
- Physician documentation may lead to undercoding or overcoding (missing HCC's)
- Issues documenting in the EHR
- Need more documentation on surgical procedures
- Charge entry clerks are coding
- Participation in Medicare Advantage, MACRA, MIPS, ACO's

Challenges

- Other priorities
- No resources
- Disparate departments involved
- No metrics to measure the need
- Cost benefit and return on investment

3M CDI for ambulatory settings



CDI for Ambulatory Settings

- Ambulatory CDI needs to be broader in both setting and scope than IP CDI
- Needs to include all ambulatory and professional sites of service
  - Emergency Department
  - Observation
  - Physician Clinic
  - Physician Practices
- Focus on:
  - Documentation, coding and billing of HCC diagnosis
  - Monitoring the Risk Adjustment Factor
  - Addressing gaps in care
- Requires 2-3 years of complete claims data
  - SPARCS

Ambulatory CDI – Documentation Review

Ambulatory CDI:

- Chart reviews, audits, workflow/process improvement and education

- Education Goals
  - Coding accuracy
  - Charge Capture
  - Medical Necessity
  - Site of Service Determination
  - HCC Documentation
  - Claims Submission, and
  - Denials Management

Ambulatory CDI comparison to inpatient

Four ways the setting changes CDI activities

	Outpatient and Professional	Inpatient
Timing	Fast pace in minutes and hours before discharge	Encounter spans days, allowing for concurrent CDI
Objective	Priority on charge capture and reducing rework and denials	Focus on comorbid conditions, SOI, and case mix
Code sets for payment	Payment is usually based on procedures (CPT and APC). . .	Payment varies based on diagnosis coding (ICD-10-CM)
Payment reform	. . . Although HCC-based physician pay puts attention on chronic conditions	Attention to POA, PSIs, other quality measures

3M Outpatient and Professional CDI Programs

Three phases

Identify process gaps, policy change requirements, ineffective practices, and inefficient workflow

- Data analysis
- Record review
- Onsite interviews and shadowing
- Recommendations

Work with key stakeholders to integrate new policies, processes, education and tools

- Onsite follow-up visits
- Implement best practices and process improvements
- Classroom training for CDI staff and peer-to-peer physician education
- Quality measures and HCCs
- Reports and program oversight

Measure and monitor progress; review with key stakeholders to ensure goals are achieved and to validate and sustain success

- Onsite follow-up visits
- Post-implementation audits
- Performance monitoring
- Retraining as needed

Clinical Documentation Improvement Program-Professional

Questions related to professional billing:

- How are the E/M levels and procedure codes assigned:
  - Coder?
  - Providers?
  - Superbill?
- Is the provider documentation routinely reviewed to support coding?
- Are E/M levels graphed for trend provider utilization?
- How are physicians made aware of missing HCC's?
- What impact do they believe HCCs will have on their reimbursement, if any?

Next steps to developing an HCC Program

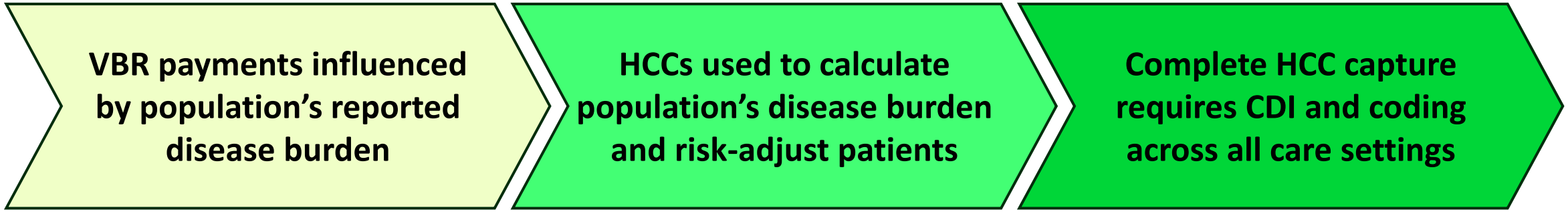
- Establish an HCC oversight committee
- Involve all departments/functions that touch HCC data capture
- Assess current state including accuracy of diagnosis capture
- Educate on details regarding HCCs based on role
- Develop an HCC Program – Collaborative effort between Coding and Clinical/operational
- Identify software needs to automate and enhance HCC program
- Monitor data capture accuracy and determine solutions for identified issues

Customer Questions

CFO, VP Rev Cycle	• What percentage of the payer mix is based on HCCs? • How much difference does a one percent increase in overall RAF have on your bottom line?
CMO, CMIO, Physicians	• **How do you identify HCC gaps in care?** • **Do you know which patients in your panel have conditions not yet treated and documented this year?**
VP of Quality, Compliance	• How well do your hospitals and medical groups perform in public reports on mortality, complications and efficiency? • Have clinicians been trained in compliant documentation and coding for HCCs? • Medical office personnel as well as hospital staff?
HIM and CDI Directors	• **Are outpatient HIM and CDI teams trained for HCC specificity?** • **How do your teams collaborate to track HCCs?** • **What is your provider query response rate? Has this gone up or down due to specificity requirements for HCCs?**

Value-Based Reimbursement Changes the Game

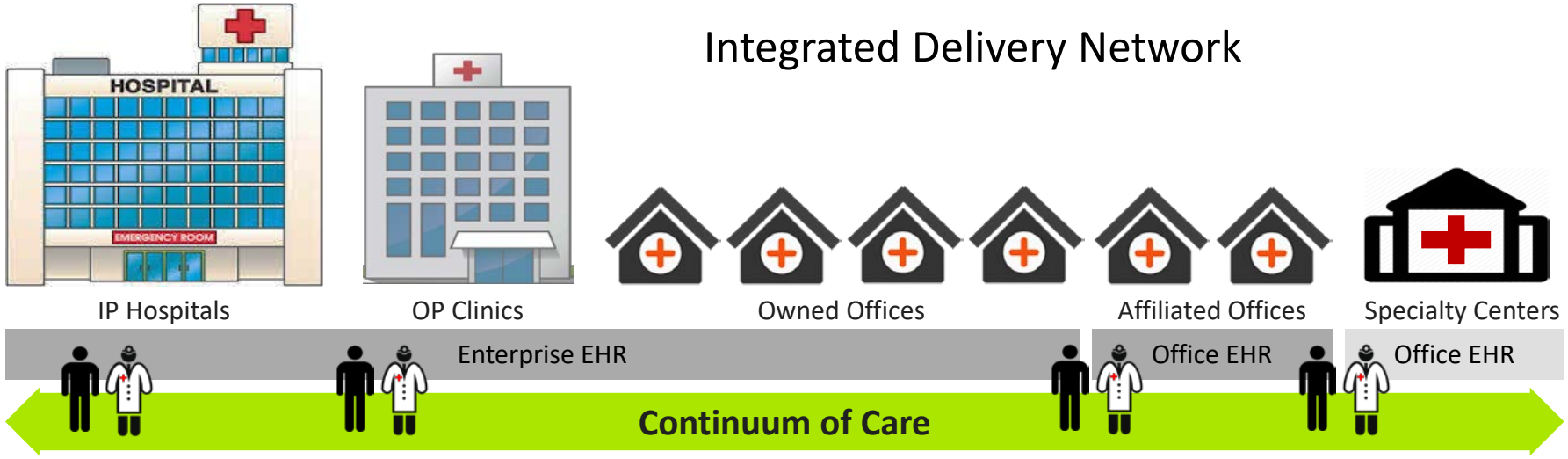
Health care systems need to capture HCC-diagnoses across all care settings



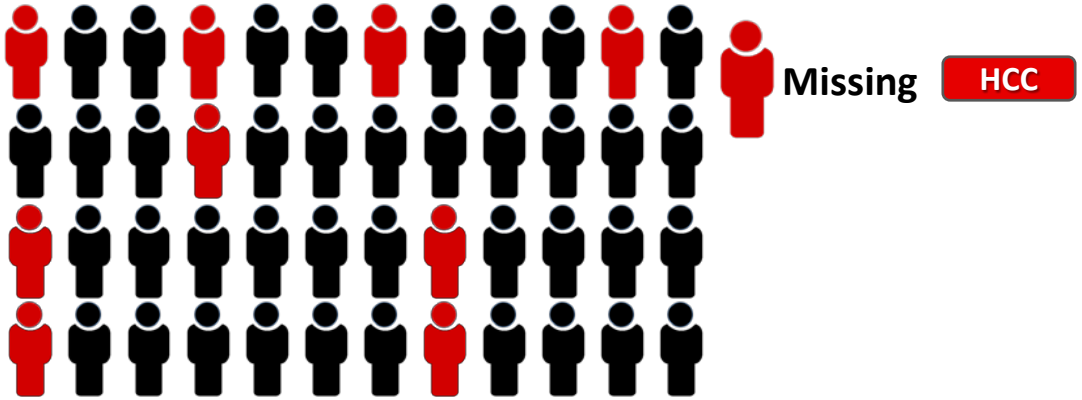
New tools, processes and training required to ensure financial success in value-based reimbursement models

HCC coding review and staff education	Population HCC/RAF gap analysis	Care coordination and scheduling	OP/office CDI-based patient review	Physician HCC-diagnosis guidance	Complete, accurate coding in OP/office

Technology to capture HCCs across an IDN



Patients Attributed to the IDN



Providers should be able to:

- ✓ Identify patients with missing HCCs, lower RAF
- ✓ Bridge EMRs for a patient profile across care settings
- ✓ Alert PCPs at the point of care about undocumented diagnoses
- ✓ Prioritize high-risk patients needing to be scheduled
- ✓ Coordinate care using case tracking tools
- ✓ Calculate the potential increase in RAF for capturing complete HCCs

Benefits of the HCC Program

- Improved capture of diagnoses across the continuum of care (longitudinal record)
- Improved coding accuracy through complete and specific clinical documentation
- Appropriate capture and reporting of HCCs
- Extensive education is provided across the IDN on the need for accurate reporting of a complete diagnosis picture of each individual patient on inpatient, outpatient and professional services claims data

When the HCC Program is Combined with Technology

- Near real-time patient alerting
- Interoperable data and workflows
- Linking insight across the continuum of care through the electronic health record (EHR)
- Analytics based on longitudinal assessments utilizing administrative data

Thank you

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