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

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 in improper payments by 2020.
Shift to value-based reimbursement

Fee-for-service $\rightarrow$ 75% tied to quality$^*$ $\rightarrow$ 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

- **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

- Methodology to capture a patient’s entire disease burden
- Methodology to predict a patient’s future cost of care
- Methodology to risk-adjust attributed patient population and adjust payment

Solutions needed to implement value-based payment

Hierarchical Condition Categories (HCCs)

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

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

Analysis of Medicare Beneficiaries Annual Visits

- 54.4% IP Admit
- 20.7% Only Outpatient Visit
- 8.5% Only Physician Visit
- 16.3% No Visits in Calendar Year

*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
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

Demographics

<table>
<thead>
<tr>
<th></th>
<th>Risk Score</th>
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<tbody>
<tr>
<td>Age</td>
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<tr>
<td>Community-based vs. SNF/Institution-based</td>
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<tr>
<td>Medicaid disability and interaction with age/gender</td>
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</table>

Disease

<table>
<thead>
<tr>
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<th>Risk Score</th>
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<tbody>
<tr>
<td>HCC-diagnoses reported</td>
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</tr>
<tr>
<td>Interaction Factor: Interaction between certain disease categories</td>
<td></td>
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<tr>
<td>Disability status</td>
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</table>

Patient Risk Adjustment Factor (RAF)

Key RAF Score Driver: Capturing all HCC diagnoses for all patients
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

<table>
<thead>
<tr>
<th>Demographic score: 2016</th>
<th>0.442</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCC 18: Diabetes w/retinopathy</td>
<td>0.368</td>
</tr>
<tr>
<td>HCC 22: Morbid Obesity</td>
<td>0.365</td>
</tr>
<tr>
<td>HCC 40: Rheumatoid arthritis</td>
<td>0.374</td>
</tr>
<tr>
<td>HCC 85: Dilated cardiomyopathy</td>
<td>0.368</td>
</tr>
<tr>
<td>HCC 111: COPD</td>
<td>0.346</td>
</tr>
<tr>
<td>HCC Interaction Score: CHF—COPD</td>
<td>0.259</td>
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<tr>
<td>HCC Interaction Score: Diabetes—CHF</td>
<td>0.182</td>
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<tr>
<td>Total RAF Score</td>
<td>2.704</td>
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</table>

2017 Risk Adjustment Factor (RAF) Score
Diagnoses documented/billed during visits in 2017

<table>
<thead>
<tr>
<th>Demographic score: 2017</th>
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<tr>
<td>HCC 18: Diabetes w/retinopathy</td>
<td>0.318</td>
</tr>
<tr>
<td>HCC 22: Morbid Obesity</td>
<td>0.273</td>
</tr>
<tr>
<td>Total RAF Score</td>
<td>1.057</td>
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</table>

2016 Missing RAF Score 1.647

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

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

×

2.704
Individual RAF Score

= 

$2,163
Individual PMPM

2016

$800
Baseline PMPM

×

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:

<table>
<thead>
<tr>
<th>E&amp;M level</th>
<th>99213</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes w/retinopathy</td>
<td>E11.319</td>
</tr>
<tr>
<td>Morbid Obesity</td>
<td>E66.01</td>
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</table>
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:

<table>
<thead>
<tr>
<th>E&amp;M level</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Diabetes w/retinopathy</td>
<td>E11.31 9</td>
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<tr>
<td>Morbid obesity</td>
<td>E66.01</td>
</tr>
<tr>
<td>Rheumatoid arthritis</td>
<td>M06.9</td>
</tr>
<tr>
<td>Dilated cardiomyopathy</td>
<td>I42.0</td>
</tr>
<tr>
<td>COPD</td>
<td>J44.9</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>CMS-HCC Category</th>
<th>HCC Description</th>
<th>Community RAF</th>
<th>ICD-10 Diagnosis Code</th>
<th>ICD-10 Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>85</td>
<td>Congestive Heart Failure (CHF)</td>
<td>0.368</td>
<td>I5020</td>
<td>Unspecified systolic (congestive) heart failure</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>I5021</td>
<td>Acute systolic (congestive) heart failure</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>I5022</td>
<td>Chronic systolic (congestive) heart failure</td>
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<td></td>
<td></td>
<td></td>
<td>I5023</td>
<td>Acute on chronic systolic (congestive) heart failure</td>
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<td></td>
<td></td>
<td></td>
<td>I5030</td>
<td>Unspecified diastolic (congestive) heart failure</td>
</tr>
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<td></td>
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<td></td>
<td>I5031</td>
<td>Acute diastolic (congestive) heart failure</td>
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<td></td>
<td></td>
<td>I5032</td>
<td>Chronic diastolic (congestive) heart failure</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>I5033</td>
<td>Acute on chronic diastolic (congestive) heart failure</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>I5040</td>
<td>Unspecified combined systolic (congestive) and diastolic (congestive) heart failure</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>I5041</td>
<td>Acute combined systolic (congestive) and diastolic (congestive) heart failure</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>I5042</td>
<td>Chronic combined systolic (congestive) and diastolic (congestive) heart failure</td>
</tr>
</tbody>
</table>
# How specificity impacts CMS HCCs and RAF scores

<table>
<thead>
<tr>
<th>Specificity Impact</th>
<th>Diagnoses</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DOES impact the HCC/RAF</strong></td>
<td>1. Diabetes 2. Angina 3. Pneumonia 4. Renal failure unspecified 5. Chronic kidney disease unspecified 6. Pressure ulcer unspecified</td>
<td>• 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)</td>
</tr>
</tbody>
</table>

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

**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

**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

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

**Claim**
- 1839
- 8917
- 374b
- 980t

**Dx coded and itemized in claim**

**Physician addresses and diagnoses condition(s)**

**Face-to-face patient visit**

**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

3M Confidential – for customer's internal review only.
Further use or disclosure requires prior approval from 3M.
CMS 1500 Professional Billing Form

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

**Localized Edema**

**Shortness of Breath**

**Other local infections of the skin**

**Linked Codes**

**Under debridement on the skin**
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
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

Ambulatory CDI Program

Outpatient Facility CDI Program
- Hospital-based Outpatient
- Same Day Surgery
- Emergency Department
- Observation (Level of Care Determination)

Professional CDI Program
- Physician Clinic
- Physician Practice (Office)
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

<table>
<thead>
<tr>
<th>Timing</th>
<th>Outpatient and Professional</th>
<th>Inpatient</th>
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<tbody>
<tr>
<td></td>
<td>Fast pace in minutes and hours before discharge</td>
<td>Encounter spans days, allowing for concurrent CDI</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objective</th>
<th>Outpatient and Professional</th>
<th>Inpatient</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Priority on charge capture and reducing rework and denials</td>
<td>Focus on comorbid conditions, SOI, and case mix</td>
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</table>

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<thead>
<tr>
<th>Code sets for payment</th>
<th>Outpatient and Professional</th>
<th>Inpatient</th>
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<tbody>
<tr>
<td></td>
<td>Payment is usually based on procedures (CPT and APC) . . .</td>
<td>Payment varies based on diagnosis coding (ICD-10-CM)</td>
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</table>

<table>
<thead>
<tr>
<th>Payment reform</th>
<th>Outpatient and Professional</th>
<th>Inpatient</th>
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<tbody>
<tr>
<td></td>
<td>. . . Although HCC-based physician pay puts attention on chronic conditions</td>
<td>Attention to POA, PSIs, other quality measures</td>
</tr>
</tbody>
</table>
3M Outpatient and Professional CDI Programs

Three phases

**Assess**
- Identify process gaps, policy change requirements, ineffective practices, and inefficient workflow
  - Data analysis
  - Record review
  - Onsite interviews and shadowing
  - Recommendations

**Implement**
- 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

**Sustain**
- 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

VBR payments influenced by population’s reported disease burden

HCCs used to calculate population’s disease burden and risk-adjust patients

Complete HCC capture requires CDI and coding 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

Integrated Delivery Network

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

Patients Attributed to the IDN
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

Phil Goyeau
Revenue Cycle Solution Sales Executive
Northeast Region

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