Sustainability Under Value Based Payments and Population Health Management – It Starts With Documentation

October 16, 2017
Session Objectives

• Provide perspective and market observations on VBP/PHM initiatives
• Outline requirements to harmonize VBP/PHM initiatives
• Highlight the importance of medical record accuracy in VBP/PHM
  – “Accurate” MS-DRG assignment does not necessarily equate to appropriate VBP/PHM performance
  – Appropriate portrayal of patient acuity requires focus beyond traditional financial performance metrics
  – Patient acuity spans the care continuum and requires connectivity across care settings for appropriate care coordination
• Describe a process to analyze medical record accuracy and improve care plan activities
Our Observations
The Current State of Population Health Management
(Market Observations)

- Important but siloed organizational initiatives
- Lack of alignment and engagement
- Lack of clarity regarding definition, vision and strategy
- Undefined investment goals and ROI expectations
- Limited commitment to economic and clinical transformation
Population Health Management Requires Intense Focus On Data... But Is Your Data Complete and Correct?

- Data is used across a number of VBC/PHM initiatives
- Clinical Documentation Improvement efforts largely exist to enhance/protect revenue
- Clinical data is the foundation for VBC/PHM analytics efforts
- Clinical data also inform Clinical Transformation efforts
- These uses require expanded focus for CDI efforts
Performance Under VBP/APM
Case Mix Index is not the Complete Picture

CASE MIX INDEX PERFORMANCE

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Hospital A</td>
<td>Hospital B</td>
<td>Hospital C</td>
<td>SAMPLE Hospital</td>
<td>Linear (SAMPLE Hospital)</td>
</tr>
<tr>
<td>1.38</td>
<td>1.35</td>
<td>1.42</td>
<td>1.45</td>
<td>1.51</td>
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<tr>
<td>1.73</td>
<td>1.70</td>
<td>1.74</td>
<td>1.80</td>
<td>1.86</td>
</tr>
</tbody>
</table>
CMS reports inpatient CMI increased 4.7% between 2011 and 2016
  
  But \( \frac{1}{3} \) of hospitals still lost money on operations in 2015

CMI is derived from the *relative weight associated with the MS-DRG*

Fewer cases are being paid under the Inpatient Prospective Payment System (IPPS) methodology resulting in lower revenue
Prevalence of Understated Patient Acuity

In our experience, grouping under an APR-DRG reveals 20-30% of cases contain an understatement of acuity in Severity of Illness (SOI) and Risk of Mortality (ROM) due to the lack of coding documented diagnoses and/or querying based on clinical indicators that support additional relevant diagnoses.

- Patient acuity directly:
  - Impacts expected readmission and mortality rates AND
  - Influences organizational ranking in mandatory quality programs where performance (observed) is comparative to other organizations
Because those diagnoses classified as CCs and MCCs do not typically capture the impact of multiple chronic conditions and the MS-DRG doesn’t reflect the interaction among diagnoses, organizations must understand **Risk Adjustment** as part of their CDI activities.

- CMS uses the **Hierarchical Condition Category (HCC) methodology** to risk adjust the patient’s clinical status at the time of the indexed admission for most outcome measures.
- **Patient Safety Indicators (PSI’s)** use a different but similar methodology for risk adjustment.
- All of these methodologies are impacted by the **totality of reported diagnoses (i.e., your claims)** and their specificity requiring a more comprehensive CDI review process than just the MS-DRG assignment.
Appropriate Portrayal of Patient Acuity
The Risk Adjustment Blind Spot Magnified

ICD-10-CM Codes
Classified as a CC or MCC

93%
7%

ICD-10-CM Codes Not a CC or MCC
ICD 10 Codes which are CC’s and/or MCC’s

Distribution of ICD-10-CM Codes
Impacting Risk Adjustment*

60%
40%

CC or MCC  Non-CC or MCC

*Estimates using GEMS Mapping
# Diagnosis Coding Depth Matters

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>DIAGNOSIS</th>
<th>ICD-10 CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amputation Status, Lower Limb</td>
<td>Status amputation, toes, foot, ankle below/above knee</td>
<td>Z89.411-619</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>CHF</td>
<td>I50.9</td>
</tr>
<tr>
<td></td>
<td>Pulmonary Heart Disease</td>
<td>I27.9</td>
</tr>
<tr>
<td>COPD</td>
<td>COPD</td>
<td>J44.9</td>
</tr>
<tr>
<td></td>
<td>Emphysema</td>
<td>J43.9</td>
</tr>
<tr>
<td></td>
<td>Chronic Bronchitis</td>
<td>J42</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Diabetes, uncontrolled</td>
<td>E11.65</td>
</tr>
<tr>
<td>Major Depressive Disorders</td>
<td>Major Depression</td>
<td>F32.9</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>Schizophrenia</td>
<td>F20.9</td>
</tr>
<tr>
<td>Vascular Diseases</td>
<td>Peripheral Vascular Disease</td>
<td>I73.9</td>
</tr>
<tr>
<td></td>
<td>Aortic Atherosclerosis</td>
<td>I70.0</td>
</tr>
<tr>
<td></td>
<td>Aortic Aneurysm</td>
<td>I71.9</td>
</tr>
<tr>
<td></td>
<td>Abdominal Aortic Aneurysm</td>
<td>I73.9</td>
</tr>
<tr>
<td>History of CABG</td>
<td>Presence of coronary bypass graft</td>
<td>Z95.1</td>
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</table>

Diagnosis codes having the Greatest Impact on Risk Adjusted Reimbursement (Mortality & Readmissions) that are **NOT** classified as a CC or MCC under MS-DRG Methodology.
Potential Financial Implications
## Value Based Payments – Example Impacts

<table>
<thead>
<tr>
<th></th>
<th>HOSPITAL A</th>
<th>HOSPITAL B</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HVBP</strong></td>
<td>Base rate increased by 2.00%</td>
<td>Base rate decreased by 2.00%</td>
</tr>
<tr>
<td></td>
<td>$5,000 x factor = $5,100</td>
<td>$5,000 x factor = $4,900</td>
</tr>
<tr>
<td><strong>HRRP</strong></td>
<td>No Adjustment</td>
<td>Base rate decreased by 3.00%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$5,000 x factor = $4,850</td>
</tr>
<tr>
<td><strong>Revised Base Rate</strong></td>
<td>$5,100</td>
<td>$4,750</td>
</tr>
<tr>
<td></td>
<td>DRG 872 w/RW of 1.0283</td>
<td>DRG 872 w/RW of 1.0283</td>
</tr>
<tr>
<td></td>
<td>$5,244 after adjustments</td>
<td>$4,884 after adjustments</td>
</tr>
<tr>
<td><strong>HACRP</strong></td>
<td>No HACRP penalty</td>
<td>HACRP penalty of 1.00%</td>
</tr>
<tr>
<td></td>
<td>Total incentive = gain of $102</td>
<td>= adjusted payment of $4,836</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total penalties = loss of $306</td>
</tr>
</tbody>
</table>

If 5,000 discharges, gain = $.5M

If 5,000 discharges, loss = $1.53M
Root Causes of Poor Performance in Mandatory Payment Reform Programs

Clinical Variability
Deviation from established best practices in disease management and/or care delivery resulting in poor patient outcomes.

Clinical Documentation
Documentation that lacks sufficient detail to accurately portray the acuity of the patient - either through gaps in documentation or lack of required specificity for accurate coding.

Coding
Coding that is inaccurate or incomplete resulting in erroneous or deficient claims data.
Small Numbers Make for Large Problems

- A total of 7 cases made the difference.
- A review of the documentation and coding revealed 6 cases with coding errors.
- **ALL 7 CASES** had secondary diagnoses (ex. Anemia, COPD) documented but not coded. These diagnoses may have raised the risk profile resulting in a higher number of EXPECTED HACs and/or excluded some cases from the denominator.

### HAC PERFORMANCE SCORE

<table>
<thead>
<tr>
<th>FISCAL YEAR</th>
<th>BENCHMARK</th>
<th>SCORE</th>
<th>PENALTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>7.00</td>
<td>7.70</td>
<td>$2,300,000</td>
</tr>
<tr>
<td>2016</td>
<td>6.75</td>
<td>8.25</td>
<td>$2,350,000</td>
</tr>
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</table>

FISCAL YEAR BENCHMARK SCORE PENALTY

<table>
<thead>
<tr>
<th>FY 2015</th>
<th>7.7</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2016</td>
<td>8.25</td>
</tr>
</tbody>
</table>

No Penalty  Penalty
HCCs and Risk Adjustment Span the Care Continuum
Clinical Documentation Integrity and the Patient

Clinical documentation is at the core of caring for patients. Goal is to have clinical documentation that best reflects the patient’s conditions across the continuum of care.
What are Hierarchical Condition Categories and Why Do They Matter?

• HCC’s are similar to a Case Mix Index
  o Used to group patients into clinically similar categories that follow like-cost patterns based upon ICD-10 Diagnosis Codes.

• HCC’s are a payment model
  o CMS-HCC’s set Per Member per Month capitation for Managed Care Plans.
  o Used in combination with Fee-for-Service to compensate ACO’s.

• HCC’s are used to risk-adjust cost and quality measures for VBP
  o Medicare Part A: 30 Day All Cause Hospital Readmissions.
  o Medicare Part B: Per Capita Costs for Beneficiaries with Specific Conditions.
    • The measure of beneficiary risk is based upon the CMS-HCC risk score based upon 12 months of medical history gleaned from claims data.

• HCC’s are used for the Medicare Spend Per Beneficiary
  o Severity of Illness is measured using 79 HCC indicators derived from the beneficiary’s claims during the 90 days prior to the start of the episode. This accounts for 25% of the total performance score in HVBP.
Diagnoses That Map to an HCC have a Tendency to “Fall Off” the Claim History

• Each condition must be reported at least once per calendar year.
  o Each January resets the slate.

• Diagnoses that “Fall Off” due so because:
  o They are chronic and stable and may not be consuming the most intense resources or medical decision making thus are neglected in documentation.
  o The provider may not have had a face-to-face encounter with the patient to capture the information in the calendar year.
  o The diagnoses may be documented but not be specific enough in the documentation to qualify as an HCC. Ex. Anxiety.

• Capturing of all clinical diagnoses is critically important to risk-adjust the patient population accurately across the entire continuum. This requires:
  o A systematic approach.
  o An educated healthcare team, including providers.
  o Technology and tools to support the “human integrators”.
RAF Scores: A Continuum Perspective

• The national average Risk Adjustment score for Medicare Beneficiaries is 1.013.
• It is important to be able to use data analytics to identify where your opportunities are:
  o Compare the aggregate risk score of members of your provider-sponsored Medicare Advantage Plan or Accountable Care Organization to the national average.
  o Compare individual members enrolled in an ACO or Medicare Advantage Plan within a practice.
  o Compare individual providers within same specialties or within same practices.
  o Compare year over year HCC’s to see which conditions are “falling off” in order to recapture them.
A key step to managing patient health is to identify those patients that need services

- Based on claims data, patient looked fairly healthy with conditions totaling .714 in risk score.
- Clinical Indicators and documentation demonstrated a very different picture.
  - Over 100% sicker than the claims data demonstrates.
- Capturing appropriate severity helps ensure appropriate resources and care.

<table>
<thead>
<tr>
<th>Condition</th>
<th>HCC #</th>
<th>Actual Claims Data</th>
<th>Possible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morbid Obesity</td>
<td>22</td>
<td>0</td>
<td>.365</td>
</tr>
<tr>
<td>COPD</td>
<td>111</td>
<td>.346</td>
<td>.346</td>
</tr>
<tr>
<td>Diabetes w/ other complications</td>
<td>18</td>
<td>.368</td>
<td>.368</td>
</tr>
<tr>
<td>Amputation status, other toes</td>
<td>189</td>
<td>0</td>
<td>.779</td>
</tr>
<tr>
<td>Peripheral Vascular Disease</td>
<td>108</td>
<td>0</td>
<td>.299</td>
</tr>
<tr>
<td>Sum of condition risk scores</td>
<td>.714</td>
<td>2.157</td>
<td></td>
</tr>
</tbody>
</table>
Population Health Management: An Integrated Approach
Using an Integrated Approach to VBC/PHM

- Technology & Analytics
- Economic Sustainability
- Clinical Innovation & Transformation
Capabilities of an Integrated Platform

• Actionable Data & Decision-Making Analytics
• Patient Stratification, Utilization Analysis & Risk Profiling
• Clinical Programs Focused on Opportunities
• Integration & Accountability Across the Continuum
• Alignment of Care Initiatives and Wellness Programs
• Patient-Specific Engagement and Incentives
• Care-Enabling Tools In the Home
Benefits of an Integrated Approach to Population Health Management

- Thoughtful and Deliberate Response to Market Forces
- Meaningfully Positive Community and Patient Clinical Impacts
- Organizational Preparedness and Transformation Agility
- Committed Governance and Collaborative Culture
- Responsible Confidence in Economic Portfolio Transition
- Alignment of Mission and Strategy with Pursuit of Triple Aim Objectives
Thank you!