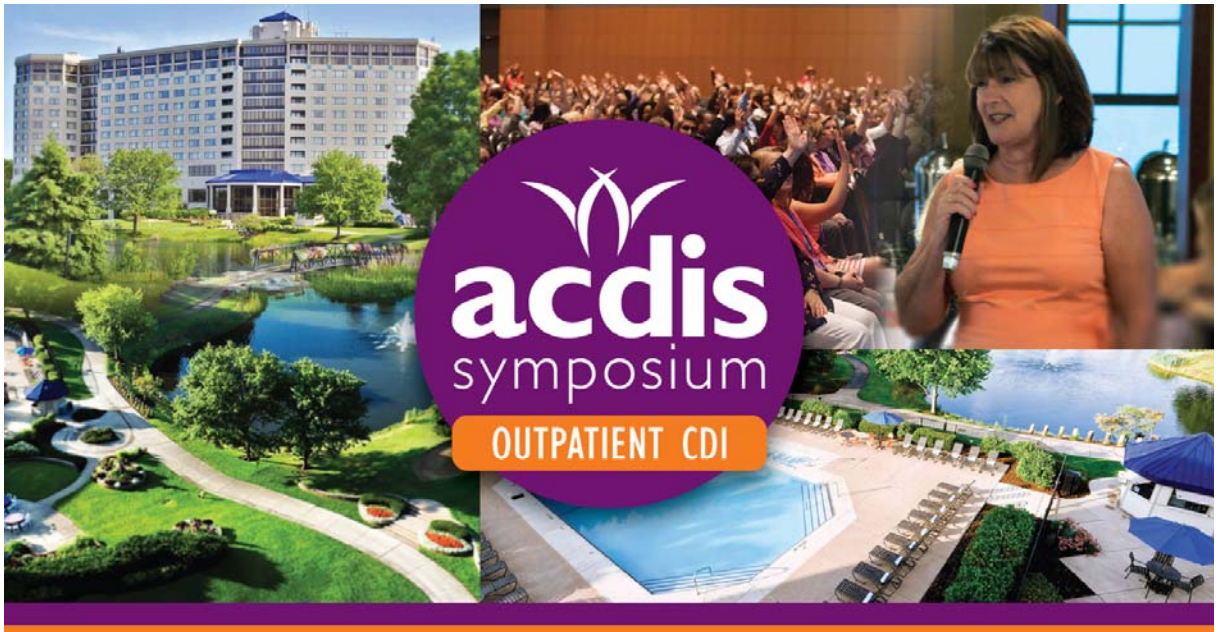

HCCs and Pay for Performance

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Program Notes for CDI Outpatient Workshop Series

- Workshop materials and recordings
  - Copies of the slides for all programs in this workshop series can be downloaded at the link below. The workshop recordings will be posted to the same location on a rolling basis within a few days of a program:
  - https://acdis.org/2017-outpatient-cdi-workshop
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Learning Objectives

- At the completion of this educational activity, the learner will be able to:
  - Discuss the different payment models for providers
  - Understand the HCC payment and risk adjustment methodologies for Medicare patients
  - Identify the outpatient CDI focus areas for the highest return on investment
  - Describe the differences between inpatient and outpatient coding and documentation requirements

Agenda

- Payment models
- How HCCs impact hospitals, physicians and health plans
- Outpatient CDI and focus areas for the highest return on investment
- Coding, documentation, and clinical validation requirements for outpatient

Affordable Care Act 2010

- Improve healthcare quality and patient safety and reduce the growth of healthcare costs
- Pay for value rather than fee-for-service performed regardless of quality
- CMS goal by 2018:
  - 90% of payments tied to quality
  - 50% of payments tied to Alternative Payment Models

Payment Models

1. Fee for service:
   - Inpatient DRG
   - APCs for hospital ambulatory care
   - CPT® codes for physician services
2. Value-based: Fee for service with incentives and/or penalties based on certain quality and cost measures
   - CMS pay-for-performance programs
   - Alternative Payment Models (APM): Medicare Shared Savings Program, bundled payments
3. Capitation: Full risk – capped annual payment to cover all healthcare expenses for a patient

Medicare Insurance

Part A Part B	Hospital insurance Medical insurance	Traditional
Part C	Medicare Advantage	Private health plans
Part D	Prescription drug coverage	Prescription drugs

Part C – Medicare Advantage

- Almost 1/3 of Medicare beneficiaries receive their Medicare health benefits through private healthcare plans or Medicare Advantage
- CMS pays participating health plans a monthly capitation payment based on CMS-HCCs
- Health plans pay providers a fee for service (inpatient DRG, CPT code, etc.)

CMS Payment to Health Plans: CMS-HCCs

- Each Medicare Advantage member is assigned a Risk Adjustment Factor (RAF) based on
  - Demographic factors (age, disability, Medicaid eligibility)
  - Diagnostic data (inpatient and outpatient)
- Medicare pays the insurer/health plan for each patient on each individual's calculated risk score
- RAF payment methodology also used by ACA plans (HHS-HCCs) and certain Medicaid plans

CMS Payment to Health Plans: CMS-HCCs

RAF Calculation Example

	HCC	Weight
75 year old male		0.437
Medicaid eligible		0.177
Diabetic nephropathy E0821	18	0.368
Pneumonia J189	--	0.0
Acute respiratory failure J9600	84	0.329
Pulmonary hypertension I272	85	0.368
Total RAF		1.679
Annual payment		$15,111

Estimated RAF based on CMS-HCC coefficients for community beneficiaries; $750 PMPM rate.

Payment to Providers

Medicare Advantage patient

- Health plans pay providers (hospitals and physicians) based on fee-for-service
  - Very few providers are paid by capitation

Traditional Medicare patient

- Medicare pays providers based on fee-for-service
  - Payment adjustments based on quality and cost measures

The Impact of HCCs

- **Directly** impact payment to health plans
  - HCC diagnoses directly affect the capitated payment a health plan receives for each of its Medicare Advantage members
- **Indirectly** impact payment to providers
  - HCC diagnoses are used to risk-adjust certain quality and cost measures

CMS P4P Measures Risk Adjusted With HCCs

Program	# of Risk-Adjusted Measures	Incentive/ Penalty
Value-Based Purchasing	6 of 21	+2% to -2%
Readmissions Reduction	7 of 7	Up to -3%
HAC Reduction	1 of 7	-1%
Value Modifier	~ 50%	+32 to -2%
Merit-based Incentive Payment System (MIPS)	Very few	+4% to -4%

Readmission Rates

Measure	Number of Eligible Discharges at Your Hospital	Number of Readmissions of Your Hospital's Eligible Discharges	Predicted Readmission Rate	Expected Readmission Rate	Excess Readmission Ratio	National Observed Readmission Rate
AMI	1,094	211	18.7%	16.7%	1.1171	16.6%
COPD	1,160	270	22.8%	20.8%	1.0920	20.0%
HF	2,262	486	21.5%	21.8%	0.9859	21.9%
Pneumonia	2,649	570	21.2%	17.8%	1.1872	17.2%
CABG	358	68	17.7%	15.5%	1.1368	14.2%
THA/TKA	1,157	80	6.4%	4.9%	1.3195	4.5%

Payment penalty – up to 3%

Medicare Spending Per Beneficiary

FY 2017 Performance Period Totals		
MSPB Amount (Numerator)	Median MSPB Amount (Denominator)	MSPB Measure
$20,779.08	$20,473.32	1.014935

Focus on CMS-HCC Diagnoses: Inpatient and Outpatient

- Each program currently uses different versions of the condition categories for risk adjustment
  - Each measure includes its own set of HCCs for risk adjustment
  - Risk adjustment coefficients, scoring methodologies, and performance periods vary by measure
- Using just CMS-HCCs should capture at least 90% of the risk adjustment for all these programs

Expanding CDI to Outpatient

Expanding CDI to Outpatient

2016 ACDIS Outpatient CDI White Paper:

1. Emergency department
2. Observation services
3. Ambulatory clinics: Primary care, infusion, diagnostic, ambulatory surgery
4. Evaluation and Management (E/M) services
5. CMS-HCCs

Inpatient vs. Physician Practice

Inpatient

- Long visit
- Payment based on diagnosis/DRG
- Inpatient coding guidelines
  - Uncertain diagnoses can be coded
- Documentation requirements
  - Meet secondary diagnosis guideline

Physician practice

- Short visit
- Payment based on E/M level, not diagnosis
- Outpatient coding guidelines
  - Uncertain diagnoses cannot be coded
- Documentation requirements
  - Must be **relevant** to encounter and **addressed** during the visit

Official Coding Guidelines

- **Inpatient**
  OCG Section III – Definition of additional diagnosis: clinical evaluation, treatment, diagnostic procedures, increased nursing care/monitoring, or extended LOS.

- **Outpatient**
  OCG Section IV – Documented condition must be directly "relevant" to or "affect" the specific encounter. The term "addressed" best describes this requirement.

Official Coding Guidelines

- IV.I: "Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient **receives treatment and care for the condition(s)**."
- IV.J: "Code all documented conditions that coexist at the time of the encounter/visit, and **require or affect patient care treatment or management**."

Clinical Validation

- Widely used and generally accepted industry standard "MEAT"
  - **M**onitoring – signs, symptoms, disease progression, disease regression
  - **E**valuating – test results, medication effectiveness, response to treatment
  - **A**ssessing/addressing – ordering tests, discussion, review record, counseling
  - **T**reating – referral, medications, planned surgery, therapies, other modalities

Clinical Validation

- Misinterpretation and misapplication of MEAT are common and have resulted in compliance audits and regulatory penalties
- Examples:
  - Physician states in the record a condition is being "monitored" without actually performing any specific monitoring activities
  - Diagnosis associated with a medication without managing it in some way assumes "treatment"

Clinical Validation – Relevance Criteria

- *Outpatient CDI Pocket Guide: Focusing on HCCs*
- Identify what documentation to expect and where it should be found
- Parallels and compliments the E/M Key Components to also improve physician documentation of level of service
  - History
  - Physical Exam
  - Medical Decision-Making

Clinical Validation – Relevance Criteria

1. **History**: Specifically asking about the condition and any relevant signs or symptoms
2. **Examination**: Documentation of the presence or absence of specific findings related to the condition, not just a general statement about body area or organ system examined
3. **Evaluation**:
   - Diagnostic studies (ordering, reviewing, or interpreting) – lab, imaging, EKG, EEG, PFTs, other studies pertinent to the condition
   - Review and summary of other records
   - Referral for evaluation of the condition

Clinical Validation – Relevance Criteria

4. **Treatment** includes:
   - Medication: Administration during visit, initiation of new medication, adjustment of current medication or consideration of it, or a decision that current medications and doses are sufficient and will be continued – not just refilling an existing prescription
   - Equipment (DME) and supplies: Provided, ordered, or modified
   - Referral for treatment of a condition
   - Performing a procedure
5. **Discussion:** Documentation of the nature of conversations or counseling about the condition with patient, family, caregivers, other providers – not just documentation of "discussed"

Key Chronic Diagnoses

- Abdominal aortic aneurysm, aortic atherosclerosis
- Alcohol/drug abuse, dependence
- Amputation status
- Cardiac dysrhythmia
- Cardiomyopathy
- Chronic kidney disease
- Chronic respiratory failure
- COPD
- Depression
- Diabetic complications
- Heart failure
- Morbid obesity/BMI
- Paralysis (plegia/paresis)
- Malnutrition
- Neoplasms
- Pulmonary hypertension and heart disease
- Skin ulcers

Abdominal Aortic Aneurysm (AAA)

HCC 108 Vascular Disease 0.299

Diagnosis: Dilation of the aorta technically > 3.0 cm. Includes abdominal aortic aneurysm (most common) and thoracic (ascending, arch, descending) aorta.

Often an incidental finding on chest x-ray, lumbar spine x-ray and would not be coded unless significance documented and subsequently addressed.

Abdominal Aortic Aneurysm (AAA)

HCC 108 Vascular Disease 0.299

1. **History**:
   - Any unusual symptoms of chest, abdominal, back, flank, or lower extremity pain, or suggestive of thromboembolism attributable to aneurysm
   - Symptoms associated with exacerbation of underlying vasculitis or infection

2. **Exam**:
   - Aortic pulsation (impulse) on abdominal exam or abdominal bruits
   - Initial assessment of body areas for findings of a causative vasculitis or infection

3. **Evaluation**:
   - US of aorta, CXR, or lateral lumbar x-ray specifically for calcification or enlargement
   - Aortography
   - Vascular surgery referral
   - Initial testing for a causative vasculitis or infection

Abdominal Aortic Aneurysm (AAA)

HCC 108 Vascular Disease 0.299

4. **Treatment**:
   - Surveillance with US: Recommended every 6 mo. to 3 years depending on size
   - Aneurysm/ectasia –
     - Initiation of medical treatment (e.g., antiplatelet agents including ASA, statin therapy) are not recommended as specific treatment and do not represent treatment for aortic aneurysm
     - Initiation or adjustment of medications for causative vasculitis or infection
   - Blood pressure control is important for aneurysm but not specifically for it

5. **Discussion**:
   - Implications like risks, consequences, outcomes, mortality, complications, and important symptoms
   - Medications and side effects
   - Evaluation and/or results
   - Other treatment or management and the associated risks/benefits, side effects, or complications including procedures

Diabetic Hyperlipidemia

HCC 18 Diabetes with Chronic Complications 0.368

Unique characteristics are **hypertriglyceridemia with low HDL cholesterol**. LDL cholesterol is not particularly elevated.

- Pancreatitis is a well-recognized consequence of uncontrolled hypertriglyceridemia

Indicators:

- Triglyceride (TG) level (fasting) > 200 mg/dL
- Severe > 500 mg/dL – sometimes reaching several thousand with "lipemic (cloudy) serum"
- HDL cholesterol < 40 mg/dL

Diabetic Hyperlipidemia

HCC 18 Diabetes with Chronic Complications 0.368

1. **Evaluation**: Lipid profile

2. **Treatment**:
   - Low fat, diabetic diet; avoid alcohol
   - Fibrates: Gemfibrozil (Lopid) and fenofibrate (multiple brand names) – also increase HDL
   - Niacin (vitamin B3) in high doses ≥ 1,500 mg/dL – also increase HDL and decrease LDL
   - Omega-3 fatty acids (fish oils) in high doses ≥ 4 gm/d
   - Statin drugs (e.g., Lipitor)
     - Primarily for hypercholesterolemia (elevated LDL)
     - High doses for modest elevation of TG
     - Not recommended for severe hypertriglyceridemia (> 1,000 mg/dL)

Diabetic Hyperlipidemia

HCC 18 Diabetes with Chronic Complications 0.368

3. **Discussion**: Implications, complications like pancreatitis, lifestyle modifications including low carb diet, strict blood sugar control, medications and side effects.

In Summary

- HCC diagnoses directly affect capitated payments to a health plan for its Medicare Advantage members
- For providers, HCC diagnoses are used to risk-adjust quality and cost measures that can affect payment
- The vast majority of HCC diagnoses that drive risk adjustment are generated by the primary care provider
- When expanding CDI to the physician practice, be sure to understand the outpatient coding guidelines and apply clinical validation "relevance" criteria for accuracy and compliance

Thank you. Questions?

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To submit a question, go to the questions window located on the right side of your screen. Type your question into the box at the bottom then click the "Send" button.

Conclusion

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Thank You!

The next program in the
Outpatient CDI Workshop series,

Outpatient Query Practices:
Building Compliant Queries,

will be broadcast live on
Wednesday, October 25 at 1 p.m. ET.