Risk Adjustment Coding &: It's Impact on ACO Performance

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continuum® HEALTH

Better Business. Better Care.

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INTRODUCING TODAY'S PRESENTERS

Dan Fabius, DO, FACP

VP, Clinical Informatics

Dr. Fabius supports Continuum's clinical transformation efforts through data analysis and workflow optimization. In collaboration with the analytics team, Dr. Fabius leverages data from Continuum's physician network to develop comprehensive metrics and actionable insights that are meaningful for providers. He also interfaces with the care coordination team to create comprehensive care management plans for the most complex patients. In addition to his role at Continuum, Dr. Fabius is currently a practicing physician at Riverside Medical Group in Haddon Heights, NJ. Dr. Fabius is board certified in internal medicine and clinical informatics.

Bryan Wellens

VP, Integrated Care & Value-Based Intelligence

Mr. Wellens oversees population health operations and administration of government and commercially sponsored value-based programs. He develops data-driven strategies in collaboration with key leaders, stakeholders and clients, delivering actionable, patient-centered information that helps improve the patient experience, increase quality, and reduce overall costs of care. Throughout his career, Mr. Wellens has driven breakthrough results and has been publicly recognized by *South Jersey Biz Magazine* as a member of the "Top 20 Under 40" and was featured as one of the publication's "Man of the Year" profiles in 2013.

CONTINUUM: BETTER BUSINESS. BETTER CARE.

PURPOSE:

Continuum Health is a healthcare management firm that makes the business of healthcare work more efficiently and effectively for the stakeholders who matter most – providers, payers and patients.

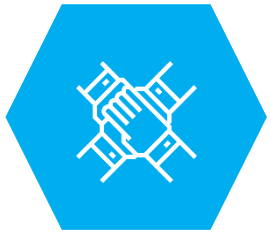
PROMISES:

IMPROVE

Improving financial performance **so providers have more options**

OPTIMIZE

Optimizing and transforming practice operations **to help providers thrive**



BUILD

Building strong payer and provider partnerships **to drive better care & reduce costs**

ACTIVATE

Activating and scaling new payment and delivery models **to meet the growing demand for value-based care**

HELP

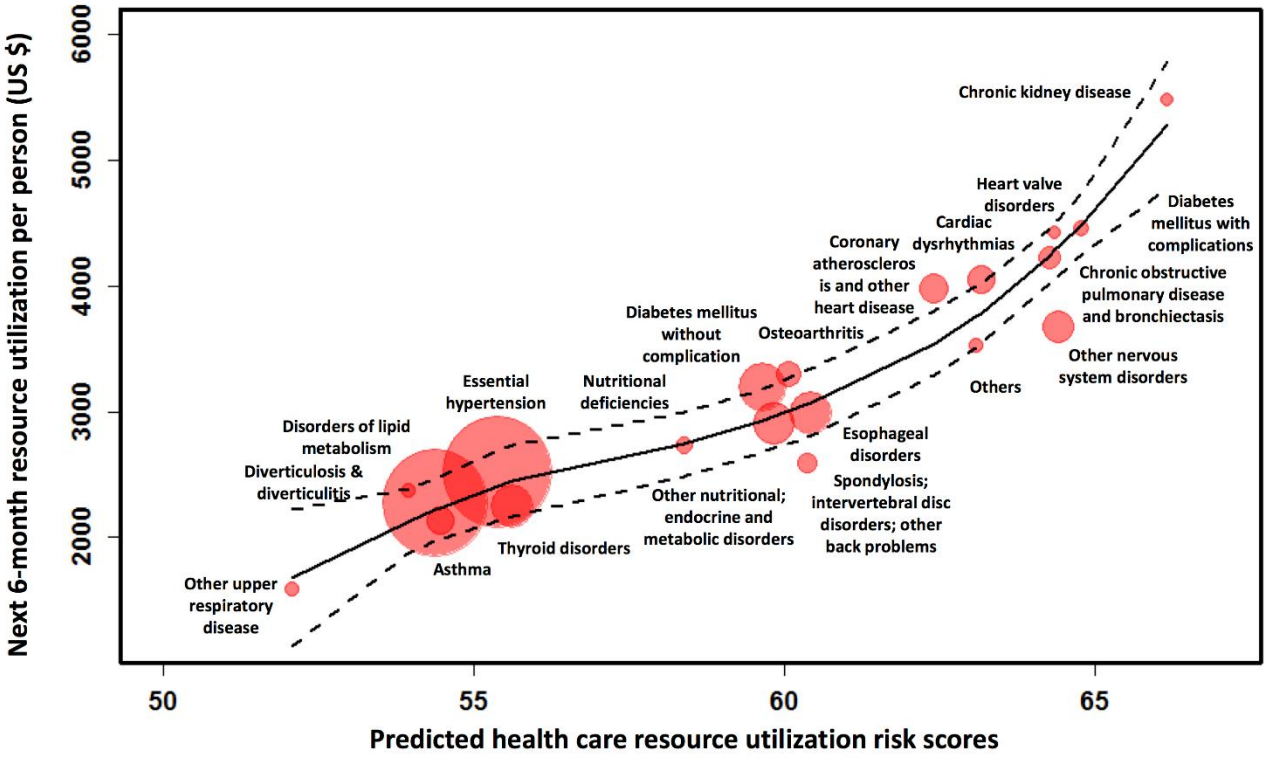
Enabling providers to spend more time with patients and **improve the health of their populations**

WHAT IS RISK ADJUSTMENT?

- A process used by CMS and other payers to evaluate the severity of a patient's condition and predict future costs based on patient demographics and diagnosis documentation.
- Health conditions are identified via ICD-10 diagnoses that are submitted by providers on incoming claims.
- Of the 70,000+ ICD-10 codes, more than 9,000 map to 79 Hierarchical Condition Category (HCC) codes in the CMS risk adjustment model; HCCs allow CMS to establish condition severity in a simpler way.

ESTABLISHING RISK SCORES

- Using demographic and diagnosis data, CMS creates "benchmarks" or "risk scores" for each patient; the sicker the patient, the higher the expected cost of care. Providers are evaluated based on their ability to manage the overall cost of care relative to each patient's risk score.



Source: Online Prediction of Health Care Utilization in the Next Six Months Based on Electronic Health Record Information: A Cohort and Validation Study J Med Internet Res 2015;17(9):e219

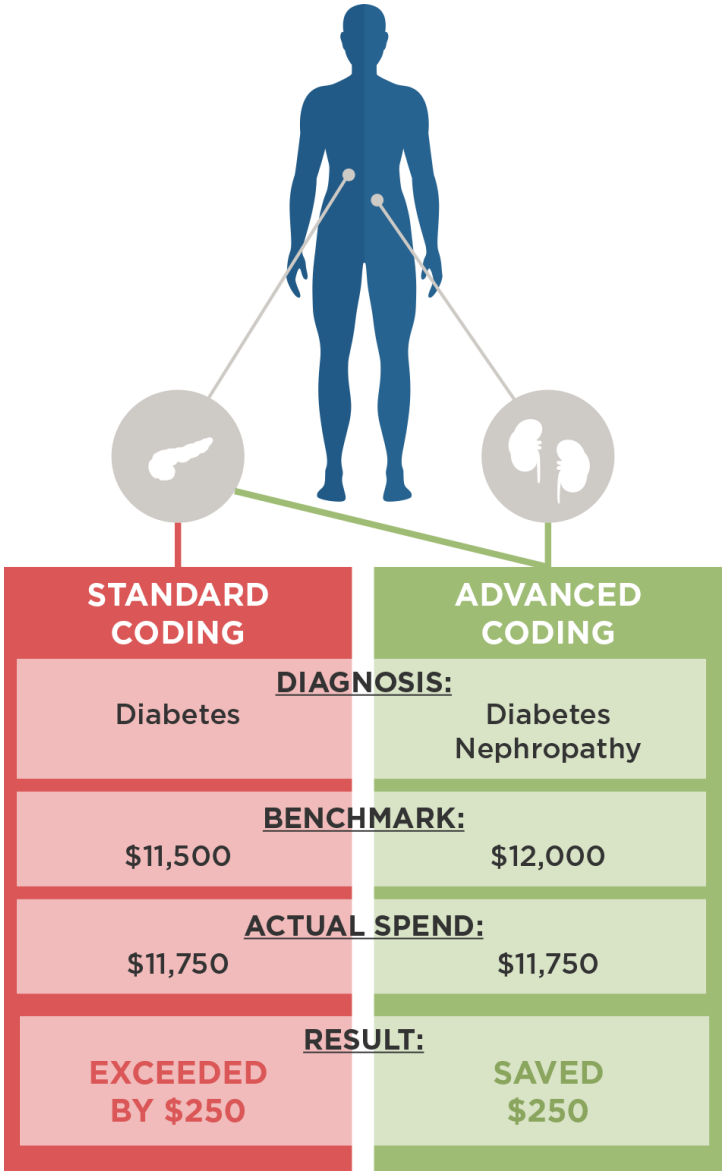
WHY IS RISK ADJUSTMENT IMPORTANT?

- **Risk scores significantly impact payments and opportunity for shared savings**
  - Selecting the appropriate ICD-10 code matters, because certain codes directly correlate to a disease category.
  - By properly identifying all diagnoses with greater specificity, providers create a more detailed picture of each patient's health status and improve the practice's overall risk score accuracy. Accurate documentation relies on comprehensive, face-to-face health assessments of patients.

No Conditions Coded (Demographics Only)		Some Conditions Coded (Claims Data Only)		All Conditions Coded (Chart Review by Certified Coder)	
76 year old female	.468	76 year old female	.468	76 year old female	.468
Medicaid Eligible	.177	Medicaid Eligible	.177	Medicaid Eligible	.177
DM Not Coded		DM (no manifestations)	.118	DM with Vascular Manifestations	.368
Vascular Disease not coded		Vascular Disease without complication	.299	Vascular Disease with complication	.41
CHF not coded		CHF not coded		CHF coded	.368
No interaction		No interaction		+ Disease Interaction bonus RAF (DM + CHF)	.182
Patient Total RAF	.645	Patient Total RAF	1.062	Patient Total RAF	1.973
PMPM Payment for Care	$452	PMPM Payment for Care	$743	PMPM Payment for Care	$1,381
Yearly Reserve for Care	$ 5,418	Yearly Reserve for Care	$8,921	Yearly Reserve for Care	$16,573

RISK ADJUSTMENT CODING EXAMPLE

- Sam's physician reports a diagnosis of diabetes, but does not report Sam's nephropathy. The payer assigns a risk factor for diabetes and a spending benchmark of $11,500.
- If Sam's physician had reported both diabetes ***with*** nephropathy, the payer would have assigned a higher risk factor and an annual spending benchmark of $12,000.
- Sam's actual cost of care was $11,750. Since Sam's physician ***only*** reported diabetes, cost of care exceeded the benchmark by $250. However, if both diagnoses had been reported, Sam's cost of care would have been below the benchmark, and his doctor would have been recognized by the payer as ***saving*** $250.
- If a practice has 500 patients with similar DX, that could be a cost savings of **$125,000.**



FOUR-STEP APPROACH TO RISK ADJUSTMENT CODING

STEP ONE: START WITH CODING EDUCATION

- Provide HCC education for both attributed providers and staff
  - Include education on code gaps (last year vs. this year)

ICD10	Diagnosis Description	HCC_Code	HCC_Description
D12.5	Benign neoplasm of sigmoid colon-D12.5		
D50.9	Iron deficiency anemia, unspecified-D50.9		
D69.3	Immune thrombocytopenic purpura	48	Coagulation Defects and Other Specified Hematological Disorders
E03.9	Hypothyroidism, unspecified-E03.9		
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy	18	Diabetes with Chronic Complications
E11.8	Type 2 diabetes mellitus with unspecified complications	18	Diabetes with Chronic Complications
E11.9	Type 2 diabetes mellitus without complications	19	Diabetes without Complication
E66.01	Morbid (severe) obesity due to excess calories	22	Morbid Obesity
E66.8	Other obesity-E66.8		
E66.9	Obesity, unspecified-E66.9		
F41.9	Anxiety disorder, unspecified-F41.9		
F32.9	Major depressive disorder, single episode, unspecified-F32.9		
F33.9	Major depressive disorder, recurrent, unspecified	58	Major Depressive, Bipolar, and Paranoid Disorders
I48.1	Persistent atrial fibrillation	96	Specified Heart Arrhythmias
I48.91	Unspecified atrial fibrillation	96	Specified Heart Arrhythmias
I50.30	Unspecified diastolic (congestive) heart failure	85	Congestive Heart Failure
J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation	111	Chronic Obstructive Pulmonary Disease
I25.5	Ischemic cardiomyopathy-I25.5		
I42.8	Other cardiomyopathies	85	Congestive Heart Failure
N18.3	Chronic kidney disease, stage 3 (moderate)-N18.3		
N18.4	Chronic kidney disease, stage 4 (severe)	137	Chronic Kidney Disease, Severe (Stage 4)

HCC EXAMPLES THAT PAY OFF

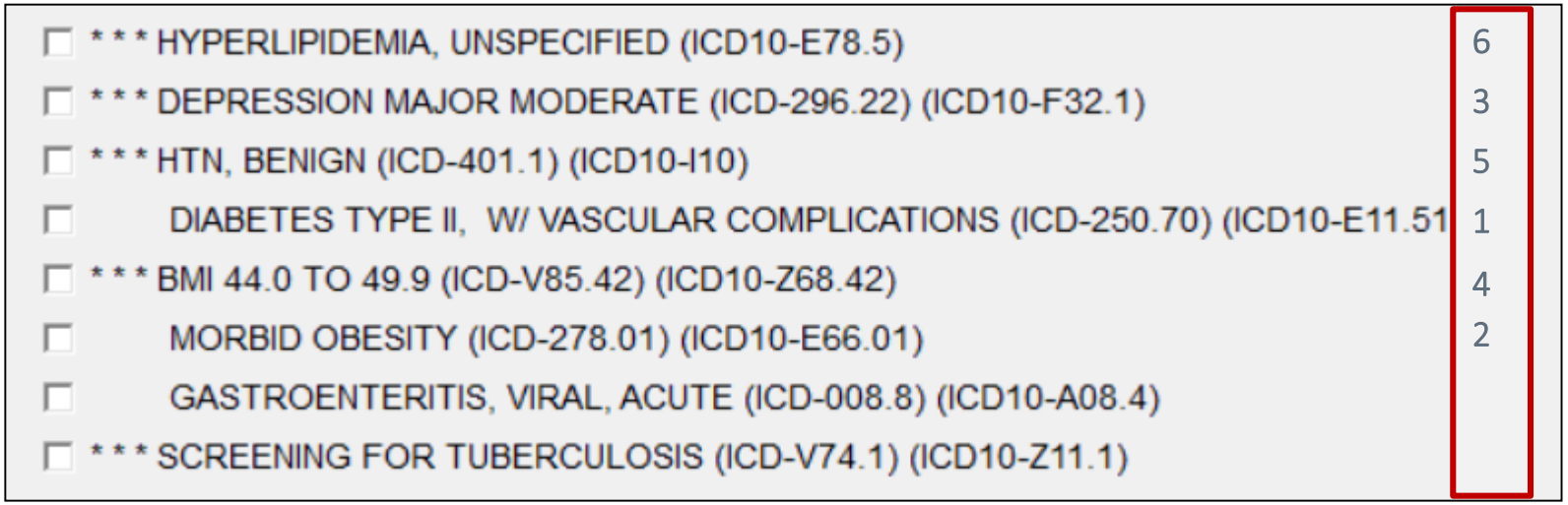
- There are numerous opportunities to improve risk scores by coding more appropriately

Condition	HCC Implication
Diabetes	• Document if patient also has vascular disease because you will receive credit for two disease categories
Depression	• Generally the least specified code; F32.9 used frequently but does not map to HCC. • F32.9 and Pregnancy do not map to HCC.
Morbid Obesity	• E66.01 is the only code that maps to HCC
Substance Abuse	• Includes any person who is currently (or) has previously abused substances and is currently in remission

- You must take actions to treat each disorder on an annual basis when documenting. If you don't document every year, you won't get credit in some models.
- Per CMS' proposed rule, you will only be able to adjust the practice risk score by +/- 3%

STEP TWO: ASSESS CLAIMS; KNOW CUT-OFFS

- Scrub your claims before submitting to ensure appropriate coding
- Understand the various cut-offs associated with documentation
  - Have you prioritized the order of your diagnoses in your claim after the primary diagnosis?
  - Are your physicians prioritizing the codes?



  - What does your EMR limit?
  - What is your RCM team cutting off?
  - What is your Clearinghouse cutting off?
- Don't lose an opportunity to appropriately evaluate your patients

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STEP THREE: WORK WITH REFERRAL NETWORK

- Educate your referral providers to better leverage the network.
- Don't limit yourself to providers within your ACO – anyone who sees your patients impacts risk adjustment
- Incentivize specialists to attend education workshops on this topic
  - Consider including them in your shared savings distribution plan

Order Date	Order Description	Order Authorizing User	Specialist Full Name
1/3/2017	Radiology Referral	King MD Susan	Radiology South Jersey-
1/3/2017	Ortho Referral	Peters PA-C Tom	Khan MD Maj
1/9/2017	Ortho Referral	Lambert PAC Joseph	Joint Institute Cooper Bone and
1/10/2017	Radiology Referral	Highsmith PA-C Paul	Radiology South Jersey-
1/6/2017	Radiology Referral	Highsmith PA-C Paul	SJRA-Rt 73
1/3/2017	Radiology Referral	King MD Susan	Radiology South Jersey-
1/4/2017	Surgical Consult Referral	Highsmith PA-C Paul	Roark MD Richard
1/16/2017	Infectious Disease Referral	Smith MSN APN Maryann	Thompson DO Judith
1/23/2017	Dermatology Referral	Lambert PAC Joseph	Smith, MD Grace
1/16/2017	Cardiology Referral	Highsmith PA-C Paul	Our Lady of Lourdes Cardi
1/23/2017	GI Referral	Lambert PAC Joseph	Jasper, DO John

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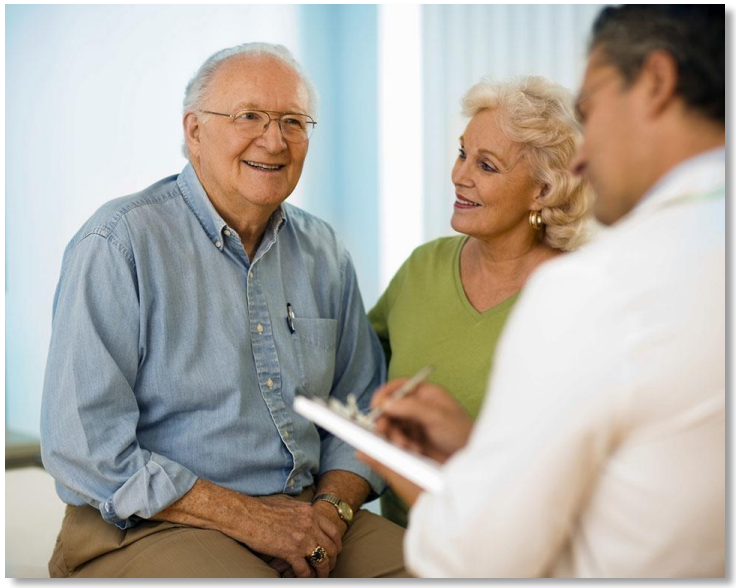
STEP FOUR: ENGAGE PATIENTS

- None of the previous steps will have an impact on risk adjustment if the provider is not engaging with the patient.
- If only 70% of your patients see you, you'll be impacted…you must get 100% of your patients in for a wellness visit.
- Create outreach campaigns to drive well visit appointments:
  - Social Media Posts
  - Letter or Email Alerts
  - Staff phone calls or care coordination support



7 TAKEAWAY TIPS

– Strong documentation will help you improve both quality of care and revenue capture from Medicare and other value-based payer programs. Remember these best practices to meet the challenge:

- ✓ Document and submit yearly; create thorough encounter notes
- ✓ Document active, chronic diseases using MEAT (Monitor, Evaluate, Assess, Treat)
- ✓ Use specific ICD-10 codes; learn the ICD-10-to-HCC crosswalks
- ✓ Assess claims before submitting; know your cut-offs
- ✓ Educate all providers in the ACO network
- ✓ Work with your referral network including those outside the ACO
- ✓ Engage 100% of your Medicare patients

QUESTION & ANSWER SESSION

ACCESS THE RECORDING:

www.ACOExhibitHall.com

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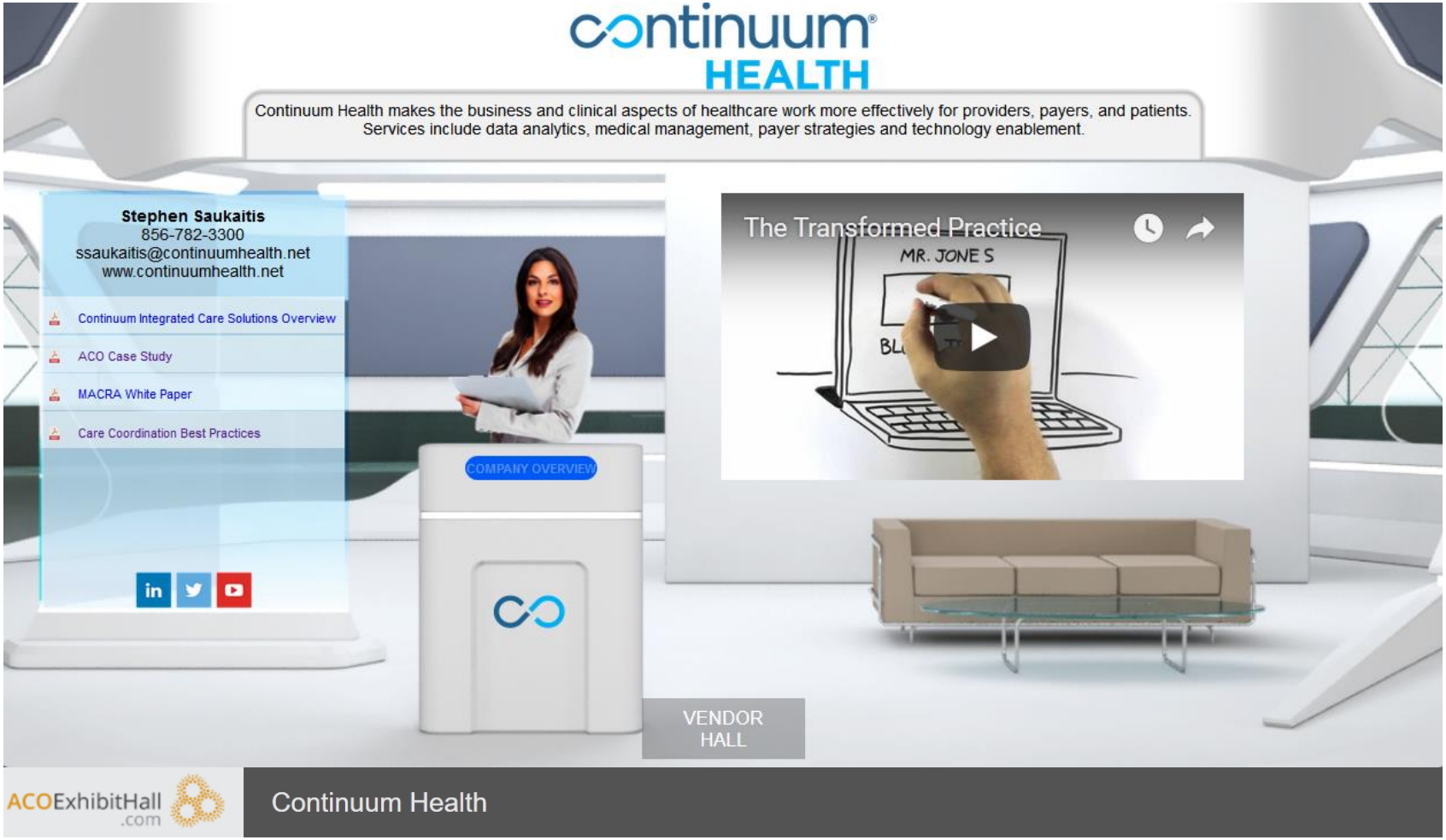

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