Risk-Adjustment, Quality and Reimbursement: Revenue Streams in the ERA of Medicare Advantage, MACRA, and MIPS

March 2019
Topics

- Risk-based Reimbursement: a Brief History
- Quality and Reimbursement: More History
- MACRA and MIPS: an overview
- aCDI and HCCs: Why do We Care?
- HCC Introduction
- Ambulatory Clinical Documentation Improvement (aCDI) Introduction
- A Strategic Approach to aCDI/Risk-based Contracts
- EMR and Other Tools
CMS developed a claims-based risk-adjustment model in 2004. Since then, it has become their principal mechanism to measure the acuity of patient populations. CMS uses these risk scores (RAF scores) to adjust reimbursement to health systems, and to adjust scores on related quality metrics.

The difference in reimbursement to organizations that do a best-in-class job with risk capture and ambulatory coding and documentation, compared with their peers, is staggering, especially in Medicare Advantage.

Since CMS has adopted this methodology, commercial payers have followed suit. Most commercial payers now have claims-based risk-adjustment schema that are similar to that of CMS.

The financial sustainability, quality performance, and competitiveness of a health system rely on performance in this space.

When health care systems do a best-in-class job at capturing the risk of their patients, patients get improved care because of greater availability of resources.
Quality and Reimbursement: More History

• We can trace the modern pursuit of quality and value in health care in part to Don Berwick/IHI’s seminal piece *Crossing the Quality Chasm*, from 2001, and Berwick et al’s exposition of the “Triple Aim” in 2008, later expanded to the quadruple aim


  - (Berwick DM, Nolan TW, Whittington J. *The Triple Aim: Care, health, and cost.* Health Affairs. 2008 May/June;27(3):759-769)
The Quadruple AIM:

- Improving the patient experience
- Improving the health of populations
- Reducing the per capita cost of healthcare
- Improving the experience of providing care
What are the CMS Quality Programs?

- MACRA
- MIPS
- End-Stage Renal Disease Quality Incentive Program
- Hospital Value-Based Purchasing Program
- Hospital Readmission Reduction Program
- Value Modifier Program (also called the Physician Value-Based Modifier or PVBM)
- Hospital Acquired Conditions Reduction Program
- Skilled Nursing Facility Value-Based Program
- Home Health Value Based Program
What is MACRA?

• The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is a bipartisan legislation signed into law on April 16, 2015.

• MACRA created the Quality Payment Program that:
  - Repeals the Sustainable Growth Rate formula
  - Changes the way that Medicare rewards clinicians for value over volume
  - Streamlines multiple quality programs under the new Merit Based Incentive Payments System (MIPS)
  - Gives bonus payments for participation in eligible alternative payment models (APMs)

What is MIPS?

• One of two options in the Quality Payment Program (QPP) that replace the sustainable growth rate in Medicare fee-for-service payment. The other option is the Advanced Alternative Payment Mechanism (AAPM)

• The option remains to continue operating with fee-for-service reimbursement

• This program calibrates payments according to performance in four broad categories (risk-adjusted categories emboldened):
  - Quality—based on the Physician Quality Reporting System (PQRS)
  - **Cost** — **based on the Value-based Payment Modifier (VBPM)**
  - Promoting Interoperability—based on the Medicare EHR Incentive Program (Meaningful Use)
  - Improvement Activities—a new category

Source: https://www.aafp.org/practice-management/payment/medicare-payment/mips.html
MIPS Payment Timeline

Quality Key Points:

- Quality is a critical component of performance in CMS contracts
- Many CMS quality measures are risk-adjusted in some fashion
- Commercial insurers have modeled their quality requirements after CMS
- One cannot hope to perform well on risk-based contracts without attending to quality
- We cannot neglect quality in the long run to improve performance in risk capture. We must perform well in both simultaneously.
Why is Risk Adjustment Important to Us?

**Reimbursement**
Risk adjustment affects our reimbursement for MACRA/MIPS, MSSP and Medicare Advantage patients. Commercial payers are following suit. Good performance on aCDI can be make-or-break for healthcare systems.

**Patient Care**
To focus limited population health, care management, and other resources on our sickest patients, we need to be able to represent their severity of illness accurately. Accurate problem-list management leads to more efficient care in this setting, as well as in transitions-of-care.

**Quality**
Many quality scores are risk-adjusted. If our patients appear healthier than they really are, our overall quality scores suffer.

**Panel Adjustment | Panel Management**
In the future, we will risk-adjust our patient panels, to better allocate physician resources.
HCCs and Risk Adjustment: an Introduction

- **HCCs are Hierarchical Condition Categories** – in brief, diagnoses that, when submitted on an appropriate claim, are used to attribute a risk score to a patient.

- The summary risk score for a patient or population is a **RAF score, or Risk Adjustment Factor score**

- These scores reset annually according to the calendar year

- Specific conditions for an encounter must be met in order for an HCC to count toward a patient’s RAF score

- If these conditions are not met, CMS can impose **draconian financial penalties** on institutions
What is Risk Adjustment for CMS?

The Goal is to Reflect Health Care Resource Burden of Medicare Patients

**Risk Adjustment In Brief**
- Accurate risk adjustment relies on comprehensive medical record documentation and diagnosis coding in all care settings
- Risk adjustment was mandated under the ACA to mitigate the impacts of potential adverse selection and to stabilize payments
- Risk adjustment models are used to adjust for patient clinical differences when scoring quality measures and reimbursements

**Risk Adjustment Calculation**

- Demographic Factors
- Health Factors
- Total Risk Score
Overview – CMS Risk Adjustment Model

Medicare Advantage plans are paid on a prospective per capita basis

• Payment is risk adjusted according to health status of members
  - Aims to predict medical expenditures of each member
  - Plan is responsible for all care delivered during the period
• Model converts health status into a risk score
  - Risk score adjusts negotiated base payment

Payers are pressing providers to participate in risk sharing arrangements
Risk Adjustment Structure

Hierarchical Condition Category (HCC)

- HCCs are a grouping of clinically related diagnoses (ICD-10-CM codes) with similar cost implications
- Only those diagnoses that map to an HCC are used in risk score calculation

- Source: [https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html](https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html)
Risk Scores Reset each December 31 at Midnight (Happy New Year!)

- Health status (as measured by the RAF score) is calculated for each calendar year.
- All diagnoses need to be re-evaluated, documented and billed each year (no matter how permanent or chronic)
- You must assess each problem (even if briefly) in your note in addition to designating as a visit diagnosis.
- This ensures that the physician and hospital are appropriately credited for the complexity of each case.
Case Study: Medical Record Example (Fictional)

DOS: 02/24/16
Justin Tyme, DOB: 01/04/1950

Chief Complaint & HPI
Medicare Wellness Visit, 66 yr. old male here for annual wellness visit with known history of diabetes, neuropathy, and major depression.

Past Medical History
DM, Neuropathy, MDD, Congestive Heart Failure, Traumatic toe amputation (2011)

ROS
As noted in HPI, all other systems negative

Vitals
Ht 64 in, Wt 240 lbs, BMI: 42.5

Exam
General appearance: Patient is obese, ENMT: Normal, Abdomen: No abdominal tenderness, and Musculoskeletal: Foot exam reveals decreased sensation, great toe amputation

Assessment/Plan
1. Medical Screening Exam- preventive care discussed
2. DM II- stable, continue current treatment plan
3. Neuropathy- stable, continue current treatment plan
4. Major Depression- stable, continue treatment plan

Electronically signed by: Phil N. Good, MD on 02/24/16
## Case Study: Code Assignments with Risk Factor Impact

### Code assignments based on conditions documented in case study

<table>
<thead>
<tr>
<th>Condition</th>
<th>I-10</th>
<th>HCC</th>
<th>Factor*</th>
</tr>
</thead>
<tbody>
<tr>
<td>66 year old, male</td>
<td></td>
<td></td>
<td>0.288</td>
</tr>
<tr>
<td>Medical Screening</td>
<td>Z13.9</td>
<td>n/a</td>
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<tr>
<td>DM uncomplicated</td>
<td>E11.9</td>
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<td>0.118</td>
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<tr>
<td>Neuropathy</td>
<td>G62.9</td>
<td>n/a</td>
<td>--</td>
</tr>
<tr>
<td>Major Depression</td>
<td>F32.9</td>
<td>n/a</td>
<td>--</td>
</tr>
<tr>
<td>Obesity</td>
<td>E66.9</td>
<td>n/a</td>
<td>--</td>
</tr>
<tr>
<td>BMI 42.5</td>
<td>Z68.41</td>
<td>22</td>
<td>0.365</td>
</tr>
<tr>
<td>Great Toe Amputation</td>
<td>Z89.419</td>
<td>189</td>
<td>0.779</td>
</tr>
</tbody>
</table>

### Code assignments based on more specific documentation (illustrative purposes only)

<table>
<thead>
<tr>
<th>Condition</th>
<th>I-10</th>
<th>HCC</th>
<th>Factor*</th>
</tr>
</thead>
<tbody>
<tr>
<td>66 year old, male</td>
<td></td>
<td></td>
<td>0.288</td>
</tr>
<tr>
<td>Medical Screening</td>
<td>Z13.9</td>
<td>n/a</td>
<td>--</td>
</tr>
<tr>
<td>Diabetic Neuropathy</td>
<td>E11.40</td>
<td>18</td>
<td>0.368</td>
</tr>
<tr>
<td>Major Depression, Mild</td>
<td>F32.0</td>
<td>58</td>
<td>0.330</td>
</tr>
<tr>
<td>Marbid Obesity</td>
<td>E66.01</td>
<td>22</td>
<td>0.365</td>
</tr>
<tr>
<td>BMI 42.5</td>
<td>Z68.41</td>
<td>22</td>
<td>above</td>
</tr>
<tr>
<td>Left Great Toe Amputation</td>
<td>Z89.412</td>
<td>189</td>
<td>0.779</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>I50.9</td>
<td>85</td>
<td>0.368</td>
</tr>
<tr>
<td>+ Disease interaction factor with DM &amp; CHF</td>
<td></td>
<td></td>
<td>0.182</td>
</tr>
</tbody>
</table>

Risk Factor/Score: 1.55

*Factors based on 2014 CMS-HCC Model for Community Beneficiaries

Risk Factor/Score: 2.68
As this Medicare Advantage plan payment example illustrates, payers are motivated to manage risk scores – they look to providers to participate in this effort.
Accurately Represent the Health of Your Patients

**PROVIDER VIEW**
RAF SCORE 2.497

**CMS VIEW**
RAF SCORE 0.645

- Documenting and coding to the highest level of specificity allows payers like CMS to see the patient as you see them.

RAF = Risk Adjustment Factor. Reflects the likelihood of future utilization of health care services.
Ambulatory Clinical Documentation Improvement (aCDI)
What are the Components of a Successful aCDI Program?

- **SEE ALL MEDICARE PATIENTS AND ADDRESS ALL CARE GAPS ANNUALLY**
- **Iterative provider education** about aCDI
  - Include discipline-specific content
  - Start with the basics and work toward “doctorate level” knowledge base
- **EMR-based POC support**
  - Tools to identify gaps in care at the POC
  - Tools for pre-visit planning and real-time support from content experts
- **Population/division/practice/individual level performance metrics** that are real-time and transparently displayed
- **Coding and documentation experts** to review documentation and billing, and to educate providers
- **Reward structures** in place to promote this work.
- Use of the data generated through aCDI to drive population health and care management investments, to control the cost of care
- Improve performance drives **contract negotiation** among payers.

MaineHealth
Improve Coding Using HCC Guidelines

- **Valid HCC Documentation Requires Three (3) Elements:**
  - Diagnosis = Face to Face Visit
  - Status or Condition = Stable condition, worsening, labs or tests ordered, medications adjusted
  - Plan of Action = COPD, Stable, continue current medications
- Must evaluate **each** diagnosis on Progress Note
- Can **not** refer to Problem List as Documentation
- A diagnosis passes CMS audit if includes M.E.A.T
  - **M**onitor—signs, symptoms, disease progression, disease regression
  - **E**valuate—test results, medication effectiveness, response to treatment
  - **A**ssess/Address—ordering tests, discussion, review records, counseling
  - **T**reat—medications, therapies, other modalities
Reminder: Replace ‘history of’ with ‘higher degree of specificity’

- “History of” indicates a condition no longer exists
  - Should not be used for chronic conditions receiving current treatment
  - Instead, include current status, dates, treatment:

<table>
<thead>
<tr>
<th>Instead of Documenting….</th>
<th>Document This….</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of Diabetes</td>
<td>Patient with DM since 2009</td>
</tr>
<tr>
<td>History of CHF, meds Lasix</td>
<td>Compensated CHF, stable on Lasix</td>
</tr>
<tr>
<td>History of COPD, meds Advair</td>
<td>COPD controlled with Advair, PFT ordered, refer to Pulmonary</td>
</tr>
</tbody>
</table>

- Do not code non-definitive conditions: Probable, Possible, Questionable, Rule Out
- Code the condition to the highest degree of specificity: Signs/symptoms, Abnormal test results, other reason for visit.
1 element required per DX code; more is better

These factors help providers to establish the presence of a diagnosis during an encounter (“if it wasn’t documented, it doesn’t exist”)

Review problem list, document as ‘current’ or ‘active’

Do not use ‘history of’ for chronic conditions unless is fully resolved. Instead use ‘stable...
Some of the top Hierarchical conditions (HCC*) weighted by prevalence that is suggested to focus on could include:

<table>
<thead>
<tr>
<th>1. DM with Comp</th>
<th>6. Rheumatoid Arthritis</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Specified Heart Arrhythmias</td>
<td>7. Major Depression</td>
</tr>
<tr>
<td>3. COPD</td>
<td>8. Metastatic Cancers</td>
</tr>
<tr>
<td>5. CHF</td>
<td>10. Amputations</td>
</tr>
</tbody>
</table>

*HCC - Hierarchical Condition Categories, CMS identified 79 Categories of medical conditions that map to a corresponding group of 9,500 ICD-10 diagnosis codes, pertains to ambulatory care and inpatient care.

** National Association of ACOs (NAACOS) suggest focusing on top 9 HCCs by weighted prevalence- MHACO has been following these HCCs and have added amputations.
• **Document anything that impacts your medical decision making** to reflect the complexity and level of care provided.
• Documentation improves care, coverage, costs and compliance.
• other commonly lost conditions: substance/alcohol abuse, AIDS or HIV, mental health severity and status
Reminder: ‘Acute’ becomes ‘Old’ after 4 weeks

- Acute MI – I22.9 for only 4 weeks after diagnosis is made
  So every visit within 4 weeks the correct code is I22.9
- If a patient is seen 4 weeks after an acute MI, and has no
  continued anginal symptoms, the correct code is I25.2
  (recent MI, old MI, or history of MI)
Strategies for HCC Capture through aCDI
Strategies for aCDI:

• Build knowledge base among all providers about the importance of aCDI
• Garner support among leadership at the system and local level
• Identify local champions to move this work forward
• Get other components of the “tool box” into the hands of providers
• Develop meaningful informatics for leadership, and for providers in-the-trenches
• Deploy Population Health and other resources to ensure all Medicare patients are seen annually
• Create and promote meaningful incentives for providers to do this work. Create the space for them to do best-in-class work
• Use your successes in this space to negotiate contracts that reflect that you are a top performer in aCDI
More Specifically:

• Patients must be seen **annually** in a **face-to-face visit** by an **authorized provider** (MD, DO, NP, PA, some others).
  - So, you have to be able to track who has been seen in a calendar year, or more importantly, who has not been seen. **Those who have not been seen need to be brought in by the end of the calendar year.**

• All relevant HCC codes must be submitted for that visit, or for a series of several sequential visits
  - So, the ability to identify **HCCs not coded** at the point of care becomes critical

• The submission of those codes must coincide with **adequate documentation**

• Robust **auditing capacity** should be build to ensure compliance with CMS requirements, and to identify members of the workforce who would benefit from additional education

• **Comparative performance statistics** are a reliable motivator of physician performance, especially when tied to financial incentives.
How Can an EMR Help?

- Best Practice Advisory: Passive (Plan section of Navigator)
- Add the Refresh print group as a Sidebar report (above Problem List print group) – AMB with HCC
- Add Refresh report as a Snapshot report
- Add HCC Score Gap to multi – provider schedule
- Add HCC gap score to patient banner
MaineHealth ACO Priorities

Achieve the Quality Top 10
Focus on the 10 highest-impact quality measures

Manage Utilization & Costs
Reduce ED visits and avoidable admissions/readmissions

Accurately Represent the Health of Patients
Improve clinical documentation in the ambulatory setting
Arcadia data: examples of current capabilities and current state
## Current State

### Global Stats

<table>
<thead>
<tr>
<th>Region</th>
<th>Total Members</th>
<th>Total RAF Per Mbr</th>
<th>% RAF Coded</th>
<th>% Coding Gap</th>
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<td>81%</td>
<td>19%</td>
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<td>19%</td>
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<td>Filter...</td>
<td>98</td>
<td>1.76</td>
<td>79%</td>
<td>21%</td>
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49,341 members
1.17 avg RAF
81% coded
# How Sick are Our Patients?

Comparison: FM vs. IM Practice

2017 Total Risk

<table>
<thead>
<tr>
<th></th>
<th>Family Medicine</th>
<th></th>
<th>Internal Medicine</th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Total Members</td>
<td>Total RAF</td>
<td>Total Members</td>
<td>Total RAF</td>
</tr>
<tr>
<td></td>
<td>1,102</td>
<td>1.09</td>
<td>1,472</td>
<td>1.15</td>
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Arcadia: November 27, 2018
### How Sick are Our Patients?

#### 2018 Documentation – IM v. FM Providers

<table>
<thead>
<tr>
<th>Total Members</th>
<th>Total RAF Per Mbr</th>
<th>RAF Not Coded Per Mbr</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>2.72</td>
<td>0.24</td>
</tr>
<tr>
<td>118</td>
<td>1.33</td>
<td>0.37</td>
</tr>
<tr>
<td>13</td>
<td>1.33</td>
<td>0.32</td>
</tr>
<tr>
<td>366</td>
<td>1.25</td>
<td>0.26</td>
</tr>
<tr>
<td>231</td>
<td>1.23</td>
<td>0.24</td>
</tr>
<tr>
<td>78</td>
<td>1.22</td>
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</tr>
<tr>
<td>306</td>
<td>1.18</td>
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</tr>
<tr>
<td>200</td>
<td>1.17</td>
<td>0.19</td>
</tr>
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<td>29</td>
<td>1.15</td>
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<tr>
<td>85</td>
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<td>159</td>
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<td>292</td>
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<td>136</td>
<td>0.89</td>
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<td>167</td>
<td>0.88</td>
<td>0.19</td>
</tr>
<tr>
<td>1</td>
<td>0.66</td>
<td>0.26</td>
</tr>
</tbody>
</table>

**Family Med Providers**

**IM Providers**
How Sick are Our Patients?
2017 Clinical Documentation:
MaineHealth ACO Employed Regions

Medicare & Medicare Advantage Patients

RAF (Risk Adjustment Factor)
- Demographics
+ Documented Health Conditions

RAF reflects the likelihood of future utilization of health care services (aka, Risk Score)

RAF = 1 = person is average risk
RAF = 2 = person is TWICE as likely to use health care services in future than the average person
Parting Thoughts:

• “Any health care funding plan that is just, equitable, civilized and humane must, must redistribute wealth from the richer among us to the poorer and the less fortunate. Excellent health care is by definition redistributational.” (Don Berwick)
Questions?