The Impacts of Physician Documentation and Quality during Payment Transformation

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Today's Objectives

Attendees of this session will learn and understand the importance that clinical documentation in the physician office setting plays in an era of increasing exposure to contractual risk. With contracts and Medicare risk models continuing to evolve, the importance of obtaining the proper documentation in the ambulatory space is key for protecting revenue, both in the short and long term. A defined strategy to address these documentation components will help organizations ensure they are ready to tackle the shift from fee for service to value based care in the coming years.

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Setting the Stage on Payment Transformation

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Risk capture is critical in shift from volume to value

Population risk rating now underpins all Medicare risk programs

Medicare Advantage	Medicare Shared Savings	NextGen ACO	Comprehensive Primary Care+	MACRA Quality Payments (QPP)
Contract with local MA plans or launch owned MA plan	Choose from one of three tracks with progressively greater risk-sharing ≤75%	Choose between partial risk sharing (80–85%) or full performance risk	Choose from two tracks with progressing clinical and IT requirements	Proposed rule outlining specific payments for APM and MIPS tracks
40% of Medicare population will be MA by 2025	**85%** of population lives within an ACO territory	**64%** of commercial insurers are offering ACOs and shared risk programs	**57** payers and 2893 providers involved in 5-year program	**50%**[1] of CMS payments tied to risk models by 2018
Increases risk-adjusted capitated payments from CMS to health plan	MSSP benchmark revised downward if HCC risk score declines	3% HCC risk adjustment cap applied to each performance year	Determines risk-adjusted care management fees	Determines if bonus points ranging from 1–3 are awarded to providers in MIPS track

1. https://innovation.cms.gov/initiatives/Health-Care-Payment-Learning-and-Action-Network/.

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Slow path to risk has proven deceptive

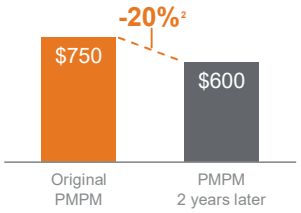
Slow-mover repercussions

Burch Health System[1]

Risk is a zero-sum game. Standing still means losing out to competitors.

Entered into several Medicare risk contracts, but did not make much investment across first few years

Started to see PMPM decline when competitors began investing in risk coding accuracy; began to make investments and improvements, but could not catch up



Cost containment: a challenging place to start

Spade Health[1]

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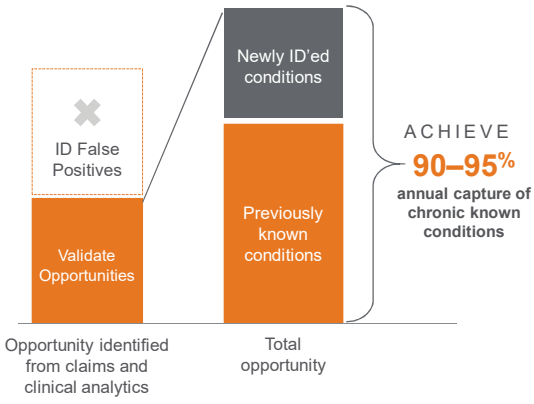
1. Pseudonym.
2. For just one at-risk population.

Enterprise-level metrics of success of quality and risk score accuracy efforts

RAF capture opportunity as augmented by problem list analysis



BENEFIT 1: Closing care gaps

Greater clarity on which patients require outreach, evaluation and management

BENEFIT 2: Achieve high utilization and provider engagement

Provide an integrated solution to identify and assist providers which they utilize 70% of the time or more

BENEFIT 3: Achieving optimal complexity score

Achieve 90–95% annual capture of chronic known conditions and associated appropriate care funding

BENEFIT 4: Increase opportunity size

Identify via reporting and analytics, investigate and identify more complete list of known conditions (increase 10–15%)

BENEFIT 5: Problem list hygiene

Improve maintenance of medical record both in accuracy and completeness

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Provider performance directly impacts health plans

CMS' Star Ratings System for Payers

Quality Measures Applied to Star Ratings

HEDIS[1]
- Better health outcomes through preventive measures
- Reduced administrative costs with accurate coding for services

CAHPS[2]
- Quality of health care experiences
- Opportunities to improve patient engagement

Patient Safety

Medication adherence to:
- Improve health and slow disease progression
- Reduce risk of hospital admissions and additional medical costs

HOS[3]
- Mental and physician health issues
- Fall risks, limitations in physician activity, and issues with bladder control (for example)

[1]Healthcare Effectiveness Data and Information Set
[2]Consumer Assessment of Healthcare Providers and Systems
[3]Health Outcomes Survey

Five-Star Ratings System

★★★★★ **Excellent**

★★★★ **Above Average**

Receives Quality Bonus Payments

★★★ Average

★★ Below Average

★ Poor

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Urgency to set an appropriate baseline

An 85-year-old MA patient comes in for a visit …

Symptoms
- Symptoms of UTI, reports mild claudication
- Tired, less energy, poor appetite, mild malnutrition
- Urinalysis performed shows white cells, leukocyte esterase and microalbuminuria

Medical history
- Stable diabetes mellitus (DM)
- Chronic kidney disease (CKD) stage 4 exacerbated by diabetes
- Stable left great toe amputation due to non-healing ulcer
- UTI with serum GFR 29
- BMI of 42

Care plan set
- Glipizide 5 mg b.i.d. for DM
- Cipro for UTI
- Ensure supplements for malnutrition
- Return to clinic (RTC) in 3 months
- Referral to nephrologist for CKD4
- Walking program for claudication

ONE PATIENT, THREE SCENARIOS

Date of service: June 29, 2018[1]

1 Capture basic demographics and primary reason for visit

85-year-old female
- ✓*UTI*

Total RAF	0.664
PMPM care funding	$531
Annual care funding	**$6,374**

2 Capture additional condition

85-year-old female
- ✓*Diabetes mellitus*
- ✓*UTI*

Total RAF	0.770
PMPM care funding	$616
Annual care funding	**$7,392**

3 Capture complete clinical information

85-year-old female
- ✓*Diabetes mellitus*
- ✓*UTI*
- ✓*CKD stage 4 due to diabetes*
- ✓*Mild degree malnutrition*
- ✓*H/O toe amputation*
- ✓*Morbid obesity*

Total RAF	2.320
PMPM care funding	$1,856
Annual care funding	**$22,272**

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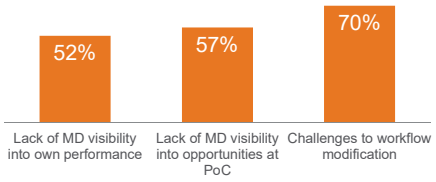
Many efforts to date helpful, but not sufficient

Among host of performance challenges, three rise to the top

- Unclear which patients require proactive outreach, scheduling
- Capacity limitations, conflicting priorities prohibit E/M scheduling
- Chronic care management opportunity obscured by reason for visit
- No incentive to close gaps
- High-risk patients not engaged in own care
- Lack of resources and tools for identifying next steps
- Unclear HCC documentation requirements and standards



Piecemeal efforts yield nominal results

Chart chasing | **Native functionality and chart reviews** | **Direct messaging**

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The Focus on Provider Documentation

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Pillars of Excellence Universal Across Care Settings

CDI Programs Best Practice Goals

Develop a defined purpose to drive program focus and generate organization-wide support

Construct a well-defined **team structure, CDI roles, and staffing model** to ensure high performance

Standardize day-to-day process flows to hardwire efficiency and minimize performance variation

Facilitate **strong relationships and rapport** to build engagement with providers and care team

Build **performance accountability** at individual and program levels with analytics and regular feedback to providers

Extend **CDI programming strategy across care continuum** to support outpatient documentation

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Conditions Ripe for Physician Office CDI

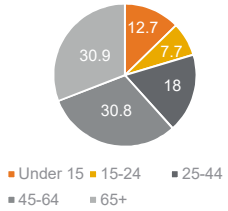
Physician Documentation Plays Important Role in Strategy Delivery

Demographics of Physician Office Visits A Motivating Factor

Physician/Patient Encounters, 2016

928.6M	Physician office visits
125.7M	Hospital outpatient visits
136.3M	Emergency department visits
51.4M	Inpatient surgical procedures

Office Visits, by Patient Age, 2015



Physicians Play an Increasingly Important Role in Strategy Delivery

49%

increase in percentage of physicians employed by hospitals, 2012-2015

Physician Office Documentation Impacts Key Strategic Imperatives

- Care delivery
- Care variation reduction
- Quality performance (MIPS/APMs, P4P)
- Medical necessity
- Accurate reimbursement

Source: National Center for Health Statistics, "National Ambulatory Medical Care Survey: 2015 State and National Summary Tables", CDC (2015); The Physician Foundation, "America's Physicians, Practice Patterns & Perspectives", Merritt Hawkins, (2016); Physician Advocacy Institute, "Physician Practice Acquisition Study: National and Regional Employment Changes" (2016); Financial Leadership Council interviews and analysis.

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Physician Office CDI Uncommon for a Reason

Inpatient CDI Model Not Exportable to the Physician Office Setting

Parameters of CDI Program Design, By Setting

	Type of Encounter	Window for Documentation	Technology Platform	Coding Framework	Oversight Responsibilities
Inpatient	Lower volume, higher payment per case	Multi-day stay	Unified	ICD-10	Hospital and system management
Physician Office	Higher volume, lower payment per case	~20 minute visit	Disparate	ICD-10, CPT, HCPCS	Physician enterprise
Key Differences that Prevent Scale	Need to prioritize subset of cases	Need to get information during shorter visit	Must capture data from multiple sources	Need unique coding knowledge	Greater physician involvement required

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Source: Financial Leadership Council interviews and analysis.

Multi-Disciplinary Approach Key to Success

Requires Coordination and Input

- EHR
- Scheduling
- Billing

→ IT/Informatics →

- Reporting
- Analytics

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Three Areas Emerge as Clear Targets

Assessing Physician Office CDI Opportunities

Important Strategic Considerations Involving Physician Office Documentation

1 Medicare Risk-Based Reimbursement

- Medicare total cost contracts
- Inpatient P4P
- Merit-based Incentive Payment System (MIPS)

2 Professional Fees

- Merit-based Incentive Payment System (MIPS)
- Advanced Payment Models (APMs)
- Evaluation and Management Coding (E&M)

3 Downstream Denials

- Medical necessity denials
- Technical denials

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Evaluating physician office CDI opportunities

Imperative elements to consider when designing program

A take-home worksheet to identify your areas of opportunity

Target areas	Aggregate size of opportunity[1]	Ease of inflection	Immediacy	Prioritization	Comments
Medicare total cost contracts					Biggest opportunity for anyone with significant volume of MA patients
E&M					Significant opportunity for systems with large employed groups
Denials					Opportunity dependent on denials performance
MIPS					Relatively small impact today, will increase over time, notably for hospital-owned practices
IP P4P					Implicated in risk-adjustment, but isolated reimbursement impact difficult to quantify


=Largest opportunity


=Easiest to inflect


=Most immediate impact


=Relative size of opportunity

1. Defined as the size of revenue stream multiplied by the size of the risk.

Source: Financial Leadership Council interviews and analysis.

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Risk is the clear path forward for all providers

Migrating beyond the “pilot phase” to intentional approach to risk*

Present

1

Renewed focus on hospital reimbursement

- Outcomes-focused pay-for-performance
- 2017 OPPS final rule site-neutral payments provision

2

Evolution of alternative payment model options

- Medicare Shared Savings Program (MSSP)
- Next Generation ACO (NGACO) model
- Comprehensive Primary Care Plus (CPC+)
- Bundled Payments for Care Improvement (BPCI) initiative
- Comprehensive Care for Joint Replacement (CJR) model
- Episode Payment Models (EPM)

3

Increased pressure on organizations to take risk

- Medicare Access and CHIP Reauthorization Act (MACRA)

*Front Health Care Advisory Board national research.

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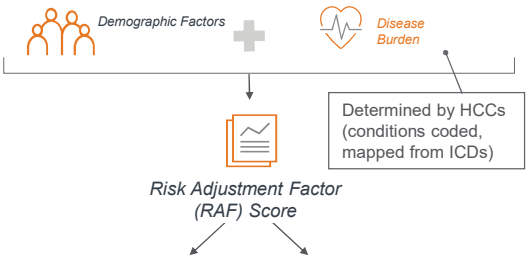
Why CDI Is Important for Risk-Adjusted Contracts

Risk-Adjustment Helps Capture True Population Risk Profile

Risk Adjustment In Brief

- Risk adjustment models are used to predict health care costs based on the relative actuarial risk of patients
- Accurate risk-adjusted payment relies on comprehensive medical record documentation and diagnosis coding
- Applied to providers to ensure performance-based payments adequately reflect patient complexity and risk
- Applied to health plans to mitigate the impacts of adverse selection and to stabilize premiums

Crucial to Success Payment Under Medicare Risk



Impacts Payment Under Medicare Risk Contracts

Adjust PMPM payments to **MA plans** and adjusts target benchmark for savings under **MSSP, NGACO**

Supports Care Management Activities

Offers clearer and fuller picture of patient health to enable better targeting of care management efforts

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Source: Financial Leadership Council interviews and analysis.

Critical foundation for delivering high-quality care

Identify overlooked conditions

Detect previously unknown or overlooked conditions to prevent unnecessary downstream risk for patients

Accurately stratify populations' risk

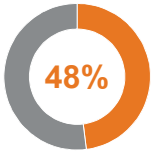
Correctly sort populations to better manage high-risk patients' cost and care

Actively close care gaps

HCC capture supports performance on 15 of 31 MSSP ACO measures[2]

Clinical intervention[1]

- Physician **alerted to aneurysm** patient had in 2010
- Physician had no previous knowledge of condition but was able to **order and now actively monitor condition going forward**



Almost half of MSSP ACO measures supported by HCCs

1. Optum customer example.
2. Advisory Board research.

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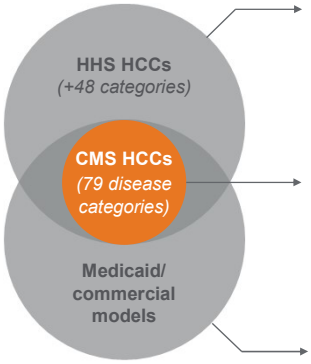
Risk scoring across populations

Building on the foundation of MA-HCC risk scoring



Publicly available risk model serving patients in ACA exchange plans

Publicly available risk model serving patients in Medicare risk programs (for example, MSSP, NGACO, CPC+) and Medicare Advantage plans

Variety of proprietary models (for example, CDPS, DxCG, ACG, ERG) serving Medicaid and Commercial patients

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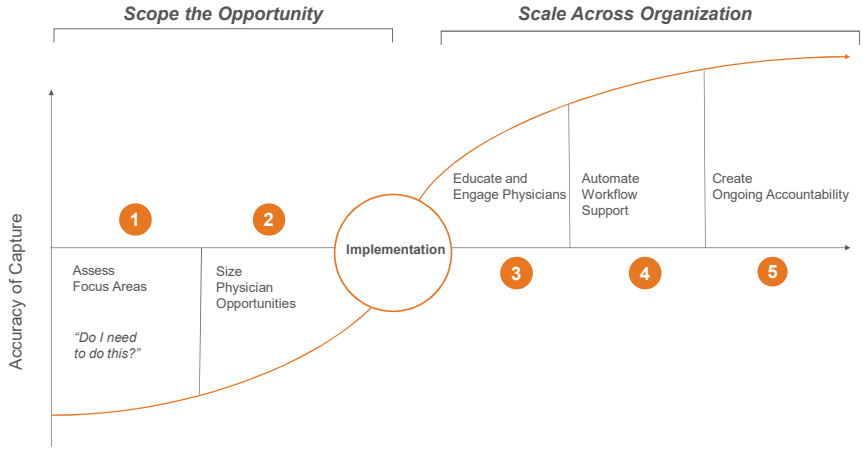
Building a Physician Office CDI Program

Five Steps Critical for Impactful Program Design

Blueprint for a Scalable Program



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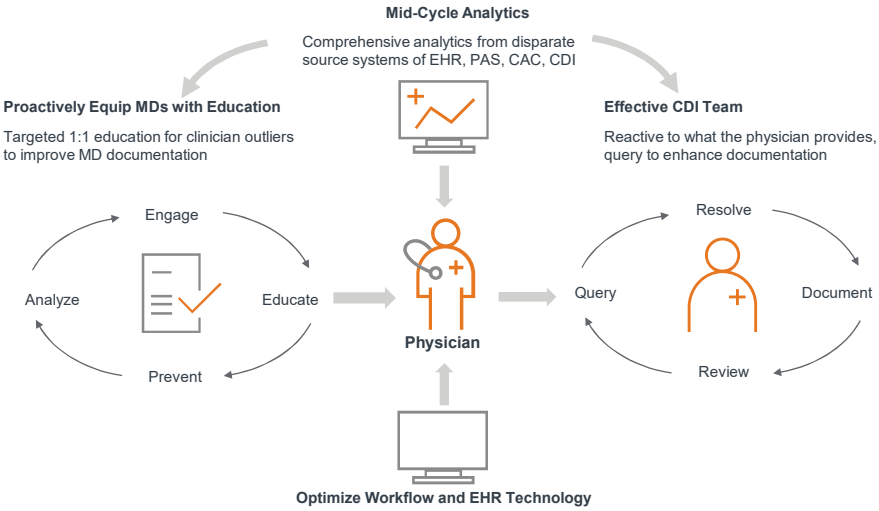
Sustainability Formula for Documentation Across the Continuum of Care



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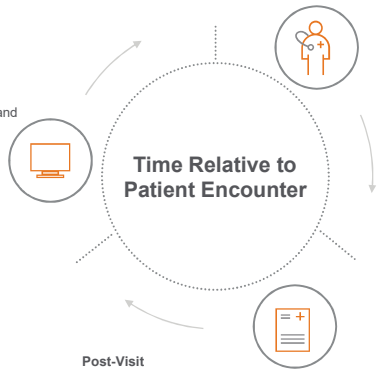
CDI Activities Relative to Patient Encounter

Pre-Visit
- Problem List Accuracy
- Suspect Condition Review
- Annual Wellness Visit Prep
- Health Maintenance Review and Prep
- Pre-Visit Questionnaires



During Visit
- Annual Wellness Visit completion
- Documentation workflow, methods, templates and efficiency
- Working at top of license
- Comprehensive ICD/HCC capture
- Health maintenance
- Accurate E&M selection
- Review of Longitudinal Plan of Care established by Care Manager

Post-Visit
- E&M Distribution and Profile Review
- Revenue and reimbursement accountability
- Denials management

Required Supporting Elements
- Risk Based Contracting
- Performance Analytics
- Patient Activation and Engagement
- Non Face-to-Face Care Management
- Provider Engagement

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Set Clear Documentation & Workflow Expectations

For Providers…

- ✓ Focus first on maximizing time with the patient
- ✓ Facilitate quick diagnosis code selection and streamlined, comprehensive documentation
- ✓ Ensure tools can be leveraged during visit – seamlessly integrating or improving workflow

For Clinical Staff…

- ✓ Decide which parts of the encounter that support staff can own (staff working to top of licensure)
- ✓ Provide outcomes of data mining exercises and tools for patient activation
- ✓ Maximize opportunities for comprehensive documentation before and after patient visit

For Ambulatory CDI Staff…

- ✓ Ensure regular communication routes with the providers
- ✓ Design ongoing education strategy
- ✓ Hardwire standard audits for code and diagnosis selection

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What Success Looks Like

Case Study from General Health's[1] Ambulatory CDI Program

	CDI Covers Practice Location	CDI Does not Cover Practice Location
Patient Population	23,805	17,603
Percent of MA/Next Gen Population	57.5%	42.5%
Avg. "Chronic" RAF Billed per Patient	0.355	0.307
Avg. "Chronic" RAF Potential per Patient	0.455	0.387

15.5%
Billed RAF per patient at CDI locations is 15.5% higher than non covered locations

17.4%
Potential RAF per patient at CDI locations is 17.4% higher than non covered locations

[1]Psuedonym

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