RHP Insight Education Curriculum

2024 Curriculum

# Defining Hierarchical Condition Categories (HCCs) in Primary Care

Nick Ulmer, MD CPC FAAFP

# Value-Based Arrangement Education

The following is required reading as introduction to this educational session.  Please pause the slides as you need to allow time to read this information

# Value-Based Arrangement Education

This presentation follows our prior correspondence and meetings regarding the new value-based incentive component of the 2024 SRHS Primary Care Compensation Model. The Value-Based Incentive is detailed in the 2024 Primary Care Physician Employment agreement (Exhibit A-6).

Spartanburg Regional Healthcare System has created a Value-Based Enterprise with employed primary care physicians. Through the Value-Based Enterprise, the parties will collaborate to achieve goals for patients in the district service area. These goals include coordinating and managing care, improving the quality of care, and transition in healthcare delivery and payment to mechanisms based on the quality of care and control of cost of care.

The Value-Based Enterprise will achieve these goals through the Value-Based Activities described in the Value-Based Incentive portion of the Physician Employment Agreement. These activities include successful completion of diagnosis code training and accurate diagnosis code utilization as measured through educational chart reviews and other activities.

# Value-Based Arrangement Education (cont.)

Appropriate, accurate, and specific diagnosis code utilization is a core component of medical documentation and care coordination. Proper and accurate utilization of diagnosis codes strengthen the medical documentation and ensures the patient's conditions are fully memorialized in the medical record. These activities enhance both quality of care and efforts to coordinate and manage care of patients for the District. This training module is intended to provide additional training background and resources for accurate diagnosis code utilization.

The Value-Based Enterprise reflects a collaborative process, created by regulatory agencies. MGC, and conjunction with RHP and the Districts Compliance Department, will oversee, monitor and administer the Value-Based Enterprise's activities. Exhibit A-6 of your Physician Employment Agreement describes the governance and operation of the value-based efforts.

# Value-Based Arrangement Education (cont.)

As SRHS moves into value-based clinical arrangements, the importance of documentation accuracy cannot be overstated. Previous provider educational chart reviews have shown opportunities to better align clinical thought-work with chronic condition documentation of medical necessity in our encounters. The intent of this education is to help educate providers to be more "clinically correct" in the written expression of our work with the patients we care for.

# Objectives

- Be able to define optimal clinical “documentation”, “redocumentation”, and “risk scores”
- Explain the 2024 HCC transition from Version 24 to Version 28
- State the financial possibilities associated with optimal performance in this area

# Why the fuss over documentation….?

- Insurance companies ("health plans") collect premiums ($$$) from financial entities/beneficiaries to help pay for healthcare services
  - Self insured (like a large employer) or governmental or corporate
- Payouts to providers (physicians, NPPs, hospitals, facilities, etc.) for care
- Care needs to be authorized as "medically necessary" which is determined by the documentation of the patient's condition. "Think in ink" to state the issues and then capture the condition diagnosis to the highest level of significance ("pneumonia" vs "cough")
- Poor documentation or care that is not medically necessary (based on evidenced-base medicine guidelines) can be denied with cost shifted to the patient if delivered
- People change … so documentation must continually be updated

# Why the fuss over documentation (*Medicare Advantage*)?

- Funds flow into the MA organization from CMS based on their work, quality, and scope
  - Scope:  certain areas of country (economically stressed, rural, urban, etc.)
  - Quality:  incentivized to be a "4 or 5 Star vs. 2 Star"

# 2024 Stars/ACO Quality Metrics

| Measure | Program | | Star Category & Weight | | Thresholds 10/17/2023 | |
|---|---|---|---|---|---|---|
| | Stars | ACO | Part C or D? | Weight | 4 Star | 5 Star |
| Care for Older Adults - Medication Review | ✓ | | C | 1 | 93% | 98% |
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| Follow-Up After ED Visit for MCC | ✓ | | C | 1 | 60% | 68% |
| Plan All-Cause Readmissions | ✓ | | C | 1 | 10% | 8% |
| Osteoporosis Management in Women w/ Fracture | ✓ | | C | 1 | 55% | 71% |
| Kidney Health Evaluation for Patients with Diabetes | ✓ | | C | 1 | TBD | TBD |
| Statin Use in Persons with Diabetes | ✓ | | D | 1 | 88% | 92% |
| Diabetes Care - Eye Exam | ✓ | | C | 1 | 73% | 81% |
| Diabetes Care - Blood Sugar Controlled | ✓ | ✓ | C | 3 | 80% | 87% |
| Breast Cancer Screening | ✓ | ✓ | C | 1 | 71% | 79% |
| Colorectal Cancer Screening | ✓ | ✓ | C | 1 | 71% | 80% |
| Controlling Blood Pressure | ✓ | ✓ | C | 3 | 74% | 82% |
| Statin Therapy for Cardiovascular Disease | ✓ | ✓ | C | 1 | 86% | 90% |
| Reducing the Risk of Falling | | ✓ | | | | |
| Depression Screening | | ✓ | | | | |
| Influenza Immunization | | ✓ | | | | |
| Tobacco Screening and Cessation Intervention | | ✓ | | | | |

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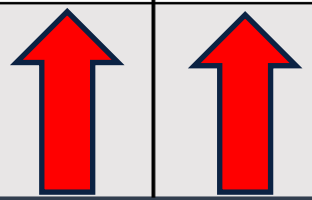

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  - Work: Work product is displayed by our documentation of codes (E&M codes, CPT procedures, diagnosis codes, etc.) → the written words of the provider show "work"
    - MA plans through "open enrollment" gain patients to care for. No cherry picking allowed … no way to know how sick those on the MA Plan panel are
    - Diagnoses and the documentation to support the diagnosis severity has a "weight" – sicker people have a higher weight – a way to standardize the risk in caring for patients
      - The "weight" has economics tied to it (not directly to providers, but in big picture, so downstream)
      - Capture of the right diagnosis (Heart Failure has higher clinical weight than chest pain)
      - Conditions are tied to clinical outcomes and tie in to Stars Quality Measures

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# Why the fuss over documentation (*Medicare Advantage*)?

- **Documentation**
  - Shows the medical necessity for payment
  - Shows our work, shows the clinical weight, shows the quality link
  - With the appropriate diagnosis, appropriate financial weight can be assigned to fund the care, so that sicker people won't "break the bank"
    - The "Risk Score" or "Risk Adjustment Factor" or "RAF Score"

# Risk Adjustment

- *Risk adjustment* is a method of adjusting payments to health plans or individual providers to account for the differences in expected health costs of individuals.
- The process accounts for known health conditions which allows for comparison of "wellness" among patients.
  - Diagnosis codes are used to determine potential risk
  - Used to predict cost of care and quality of care

**The process starts over every year on January 1st**

# ICD-10-CM Diagnoses: HCC Basics

- All clinical conditions that affect the patient are to be assigned each year as CMS does an annual "clearing of the slate" for each patient …must redocument !!!!
  - "The leg does not grow back".. eGFR of 35 in December …The urostomy/PEG …RA …home $O_2$ …
- "history of" means the condition is gone. "History of COPD, stable on budesonide/formorterol" means they had COPD in the past, but not now…
- Multiple chronic conditions with resultant elevated HCC risk score, but only one 99213 office visit all year
- The diagnoses are additive to get the HCC score
  - So if it is clinically pertinent, make sure that the diagnosis is "active" (on the bill) at least once a year (MWV is best time)
- If seen but not in diagnosis, no credit. BMI 40+ → is an HCC risk score. But needs to be A/P.
- But, not all diagnosis codes are linked to HCCs
  - For 2024, the HCCs are redefined/removed/added …
  - Redefined because not as impactful, removed as they didn't point to added cost, added because data said so

# Risk Adjustment Calculation

- Average patient of average health — RAF = 1.0
- Healthy patient — RAF < 1.0
- Patient with multiple illnesses — RAF > 1.0
  - *$$ is assigned to these numbers, adjusted yearly, "threshold"*

*~$10,402 = 1.0 for this example ($10,000 for all examples)*

- Higher risk scores would positively impact

Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for MA (p137)

# Risk Adjustment and **YOU**

## Used to evaluate and compare YOU to your peers

Higher risk scores translate into higher premiums paid by payor (CMS, etc.) to a contracted entity (ACO, Health Plan, etc.) for the patient's care.

- Looking at the quality measures of the patients attributed to YOU, the risk score (higher is sicker) allows a more complete picture of high-quality patient care
- Looking at the total cost of care for the patients attributed to YOU, the risk score (higher is sicker) allows a more complete picture of managing the patient's care
- Likewise, lower risk scores associated with high cost may indicate a provider being a poor clinical manager - or having a poor ability to document the clinical picture.

- "Clinical Risk" through correct documentation is foundational to value-based care and to show "my patients are sicker" and "I have high quality"

# Risk Adjustment and **YOU**

- CMS uses risk adjustment when calculating the relative performance of a Medicare-enrolled provider on such metrics as:
  - Per capita costs for Medicare patients attributed to the provider
  - Per capita costs for Medicare patients with specific conditions
    - Diabetes, COPD, CAD, CHF
  - Medicare Spending Per Beneficiary (MSPB)

# MSPB metric

- Publicly reported, price standardized, risk adjusted measure.  Tied to individual clinicians by NPI/TIN
- 3 days before IP “index” admission to 30 days after discharge for a **m**edicare-**s**pending-**p**er-**b**eneficiary inpatient episode of care
- All Medicare Part A and Part B services provided
  - Costs associated with the hospital stay, SNF, Home Health, Hospice Care, DME, physician and other supplies
- Risk adjustment by diagnosis coding (higher risk should spend more)
- Encourages transparency, shared with hospitals before it is posted on Hospital Compare website

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    - Diabetes, COPD, CAD, CHF
  - Medicare Spending Per Beneficiary (MSPB)
  - All-cause hospital readmissions
  - MSSP ACO uses HCCs to set ACO baseline finances

# Why the fuss over documentation (*Medicare Advantage*)?

- **Documentation**
- The "**Risk Score**" or "**Risk Adjustment Factor**"
  - Provides a view into the clinical complexity of the patient
  - Allows a way to impact other quality measures so the clinical complexity isn't harmful
    - MSBP, Readmissions, Total cost of care for certain conditions, etc.
  - Revenue enhancing on payor side (and can downstream help with shared savings)

# The Hierarchical Condition Category (HCC)

- HCC is an acronym for Hierarchical Condition Category
  - Risk-adjustment model originally designed to estimate future health care costs for patients. Relies on ICD-10 coding to assign risk scores to patients.
  - Higher risk = sicker → more costly to care for (and harder to achieve quality scores)
  - HCC is "mapped" to a group of diagnoses and grouped into a hierarchy
- Two primary HCC systems: CMS-HCC and HHS-HCC
  - HHS-HCC is used for managed commercial plans (wide age range)
  - CMS-HCC is used with Medicare Advantage (senior heavy)
- Demographic factors are linked into calculation with conditions (age, gender, socioeconomic factors, disability, etc.)

Pinson&Tang 2022 CDI Pocket Guide, p49..

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# The 2024 CMS HCC Revamp (01.2024)

- In 2024, the HCC "Version 28" replaces the previous model, "version 24", 3-year phase-in (33% new model this year, 67% old)
- Now with ICD-10 (was I-9). Recalibrated, updated diagnosis/cost data
- Deleted diagnoses (2294) that don't map to payment HCC, added 268 new that previously were not risk adjusted.
  - Of 268 new, 95 are in perinatal period, 17 others are congenital (42% not MA)
  - Deleted didn't predict cost, small numbers, were not as specified as others
  - Renamed and updated the weights/RAF values
- Total number of HCCs increased from 86 →115.
- Constraining: related HCCs given the same coefficients. Net-Net less.

Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for MA (p137)

# 2024 HCC Constraining: Diabetes

- Diabetic disorders in V24 had different HCC weights – without complications (0.105) and with complications (0.302).
- In V28, the DMII without complications (E11.9) has the same RAF score as DMII with complications (E11.8).
  - DMII w/o (E11.9) has a higher RAF now than before (0.105 → 0.166), but DMII w (E11.8) is lower now (0.302 → 0.166) – "constrained"

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- The other condition where "constraining" occurs in V28 is in Heart Failure.
- Don't worry about the RAF, just capture the clinical condition completely to the highest level of specificity

# The HCC Hierarchy

- Diseases "roll up" into a hierarchy
  - Chronic Hepatitis →
  - 0.185 →

# The HCC Hierarchy

- Diseases "roll up" into a hierarchy
  - Chronic Hepatitis → Cirrhosis →
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# Disease State: End Stage Liver Disease

| Chronic Hepatitis | → Cirrhosis | → End-Stage Liver Dz/Failure |
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# Disease State: End Stage Liver Disease

Chronic Hepatitis → Cirrhosis → End-Stage Liver Dz/Failure

0.185 → 0.447 → 0.962

**$1850** **$4470**

**$9620**

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# V28 still has disease interactions

- Capture all pertinent conditions at each visit you are managing.
- "Disease Interactions" are added HCC risk weights when co-morbid conditions exist in a patient that you show in your documentation you are managing
- If you document in the A/P, the specific condition weight gets applied, PLUS a disease interaction weight gets added on
  - HF + Diabetes (0.112)
  - HF + Chr Lung D/O (0.078)
  - HF + Chr Kid Dz (0.176)
  - HF + Card Arrhyth (0.077)

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  - Didn't predict cost, small numbers, diagnoses were not as specified as others
  - Renamed and updated the weights/RAF values
- Constraining: related HCCs given the same coefficients. Net-Net less.
- MA plan coding was higher than Traditional Medicare, expected MA impact would be a revenue loss -3.12% ($11B)

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# Why the fuss over documentation (*Medicare Advantage*)?

- **Documentation**
- **"Risk Score"/"Risk Adjustment Factor"**
- **ReDocumentation**

# The new buzzword in CDI…

- **Redocumentation**
  - Get the right clinical diagnosis to the correct severity and then support that in the medical record
  - Recapture it EVERY year – if still being managed
    - The leg does not grow back, but the stroke may have resolved … or the DVT now may be absent, etc.
  - The "clearing of the risk score" at year end makes this an every-year event
  - What is a good redocumentation goal….? Ask you payors to run your report (if your EMR cannot) and then have them benchmark you. No CMS norms.
    - This is not a liability and can be shared as a best practice for the region

# When to update HCC Diagnoses

- As patients come in for post-acute office visits
  - After ED or medical hospital admissions
  - Even with elective surgeries, new conditions could present
- Medicare Wellness Visits
- First visit of the New Year

# Key Areas *Not* to Miss (Yearly)

- Amputations (AKA, BKA, toes) and how it affects functional state
- BMI, especially 40+ with a plan to address
- Asthma and pulmonary conditions (esp chronic respiratory failure – Home $O_2$)
- CHF: specifying type (systolic or diastolic) and condition (acute/chronic)
- Ostomy:  urostomy, cystostomy, tracheostomy, ileostomy, gastrostomy with a status/condition
- Transplanted organs:  heart, liver, lung, pancreas, bone marrow (not kidney!) and status
- Functional quadriplegia:  complete inability to move due to disability (not neuro)
- Stage III, IV, and V kidney disease
- Rheumatoid Arthritis

# Key Areas *Not* to Miss (Yearly)

- Amputations (AKA, BKA, toes) and how it affects functional state
- ***BMI, especially 40+ with a plan to address***
- ***Asthma and pulmonary conditions (esp chronic respiratory failure – Home $O_2$)***
- ***CHF: specifying type (systolic or diastolic) and condition (acute/chronic)***
- Ostomy:  urostomy, cystostomy, tracheostomy, ileostomy, gastrostomy with a status/condition
- Transplanted organs:  heart, liver, lung, pancreas, bone marrow (not kidney!) and status
- Functional quadriplegia:  complete inability to move due to disability (not neuro)
- ***Stage III,*** IV, and V kidney disease ***(silent disease)***
- Rheumatoid Arthritis

# What are the most OVERdocumented HCCs…?

- Surgically corrected conditions (AAA repair)
- Malnutrition that is now not
- Strokes that are not acute
- Embolic diseases (DVT) – unless acute or with ulcer… caution!
- Vascular diseases (abnormal ABI, no treatment/symptoms noted)
- Cancers that are no longer (thyroid cancer post removal)
- CKD (stage III from last year, that for this year is Stage II)

# Where are significant shifts with V28 HCCs…?

- Vascular diseases
  - Atherosclerotic disease with intermittent claudication is now not risk adjusted, only the rest pain PAD – native or bypass
  - Thoracic/Abd Aorta, Renal artery aneurysm risk only if ruptured
- ASCVD
  - Cardiomyopathy due to drugs, no risk now; other c-myopathies OK
  - Angina pectoris is only risk adjusted if unstable
  - SVT is no longer risk adjusted but all other abnormal rhythms are
- Pulmonary
  - Added severe persistent asthma
- Renal
  - Transitory dialysis and acute renal failure have no RAF

# Closing comments

- Clinically Correct Documentation to Capture Severity…
- KEY in the Ambulatory
  - Capturing the highest degree of clinical specificity increases our risk score
  - Risk is tied to revenues and when quality scores are reported, our "grade" can be impacted
  - Redocument the conditions EACH year (make a plan – MWV, etc. to close the gap)
- OUR JOB: Be CLINICALLY CORRECT in our documentation capture and in our medical management of the patients we care for

# Defining HCCs in Primary Care

- Thanks for taking this session!
- Post-test is next– Good Luck!


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# Defining Hierarchical Condition Categories (HCCs) in Primary Care

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