Alternative Payment Models and Risk Readiness

An In-Depth Analysis of the CMS “Pathways to Success” Final Rule

HealthPOINT Compass PTN TCPI Learning Community
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Background and Disclosures

• Practiced full scope, rural Family Medicine in Harlan, Iowa for 16 years, serving as Medical Director, championed our practice’s participation in the TransforMED NDP from 2006-2008.
• Worked for Accountable Care Associates MSO in 2014-15, as CMO and national Medical Director; work with MSSP ACOs, Medicare Advantage, commercial and full risk contracts
• Involved in organized medicine – AMA, IAFP and AAFP leadership; currently serve on the AAFP Commission on Quality and Practice
• Founding President and Board Chair of Heartland Rural Physician Alliance, an IPA created in 2012 which brings together physicians, practices and hospitals across Iowa to thrive in the changing healthcare environment
• Serving as Board Chair and CMO of Heartland Physicians ACO since 2015.
• CEO and CMO of MedLink Advantage, a healthcare consulting and ACO management firm founded in 2015 to organize and manage ACOs made up of independent physicians, practices and hospitals. Provide consulting services for healthcare organizations of all types – physicians, clinic groups, hospitals, healthcare systems, ACOs, IPAs, associations, CME companies, and healthcare technology firms.
• Serve as Board Chair for the Interstate Postgraduate Medical Association (IPMA), a 101-year old nonprofit focusing on transformative physician education.
• Serve as physician faculty support for TCPI, SIM, HIIN and other projects run by the Iowa Healthcare Collaborative and Compass PTN
Educational Objectives

• Discuss the drivers of Value-Based Purchasing (VBP) change and the resulting opportunities and challenges
• Describe the three key concepts for maintaining practice viability during the transition to VBP
• Examine how to appropriately maximize FFS revenue and MIPS Scoring while preparing for VBP
• Discuss how to align practice-level efforts aimed at improving the quality of care while also addressing cost
• Identify how to position your practice or organization for VBP and when/how to consider participation in Alternative Payment Models
While I greatly enjoy ACO development and management, practice transformation, and healthcare consulting, as I work in those worlds this is where my heart will always be...
Five Underlying Social Drivers of Healthcare Changes

1. Unsustainable costs
2. Lifestyle illnesses (think SDH)
3. High concentrations of care/cost (top 1% of patients = 30% of cost)
4. Care misalignment (poor coordination, silos, wrong/unneeded care, etc.)
5. Digital health (behind other industries but catching up)

http://digitalhealthage.com/5-trends-changing-healthcare/
National Policy Driver

The Triple Aim is Better Care, Smarter Spending, and Healthier People.

The Quadruple Aim adds...Improved Clinician Experience
The Major Underlying Healthcare Payment Trend: Value-based Payment

Value = \frac{Quality}{Cost}

Quality = \text{(Outcomes, Safety, Service)}
CMS Goals for Payment Reform

Current State

Category 1
- Fee for Service
- No Link to Quality & Value

Category 2
- Fee for Service
- Link to Quality & Value

Category 3
- APMs Built on Fee-for-Service Architecture

Category 4
- Population-Based Payment

Future State

Category 1
- Fee for Service
- No Link to Quality & Value

Category 2
- Fee for Service
- Link to Quality & Value

Category 3
- APMs Built on Fee-for-Service Architecture

Category 4
- Population-Based Payment
Do our patients understand this transition to value-based payment? Well, I recently received this meme...

_Before I do anything I ask myself, "Would an idiot do this?" And if the answer is yes I do not do that thing._

_That's why I don't pay as much to hospitals w/ high rates of preventable readmissions, complications & infections._
Positioning for Success in Value-Based Healthcare

The degree of VBP success achieved is in large part determined by the degree to which we understand and actively manage these three factors using a thoughtful, balanced approach.

- **Quality** – Improve
- **Cost** – Lower
- **Risk** – Manage
Quality – Key Concepts

- APMs measure quality –
  - MSSP ACOs measure 31 quality metrics (decreasing to 24 in 2019) in 4 domains – some each from claims, quality reporting from EHR, and patient surveys
- Higher quality can often mean lower cost – look for these opportunities for synergy
- Some QI efforts/strategies align well with FFS revenue streams, and that’s a good thing...
  - AWV, TCM, CCM, etc.
  - f/u visits
  - Colonoscopy/mammograms
  - Immunizations
- This is a team sport – much quality work is not physician work
- Will build on previous/current PCMH work
Cost – Key Concepts

• Much APM/ACO work is (rightly) directed at cost
• Have to work to get comfortable discussing cost
  • Not natural for many providers – feels wrong to focus here
  • However, high cost patients are often (maybe even usually) those that need our attention and expertise the most
• Claims/cost data isn’t perfect….but that’s ok
  • Gives us new insights into patients/populations
  • We are good at pattern recognition – start to use those skills here
• Understand your patient population and practice dynamics
  • Many cost buckets are relatively universal – ER, Admissions, SNF, etc.
  • The drivers of these may vary remarkably between practices/communities
• While we cannot fully control healthcare costs, we do have direct and indirect impact on a large portion of those costs, whether we like it or not…
Risk – Key Concepts

• Essential to educate physicians/practices on Risk Adjustment
• Is often the least understood of the key three, but in many ways one of the most important
  • New knowledge and skills
• Each ACO contract is different which regards to risk adjustment
  • Understand the differences
  • Look for areas of alignment and focus there
• Key understanding is that what we code directly affects the insurers risk adjustment for our ACO patients
  • This did not matter in the same way in FFS
  • Has great impact in ACO efforts, and is nearly completely in our control, unlike some aspects of quality and cost
• Risk Adjustment = Appropriately documenting the complexity of the patient and the care provided
The Key Three

- VBP/ACO SUCCESS
- QUALITY
- COST
- RISK
Aligning Quality with Cost - QI

- **Important concept:** Higher quality care most often means lower cost
  - look for these opportunities for synergy between quality and cost

- **Many Quality Improvement (QI) efforts/strategies align quite well with FFS revenue streams (and that’s a good thing...)**
  - AWV, TCM, CCM, etc.
  - f/u visits
  - Colonoscopy/mammograms
  - Immunizations
Aligning Quality with Cost - QI

• Quality is a team sport – much quality work in a practice is not physician work
• Include as many hooks as possible to engage providers and staff fully in QI efforts
  • Look at QI as skill building for entire practice team
  • Give CME/CEU for all participants
  • Give MOC Part IV credit for physicians
• Recognition/praise – celebrate wins!
  • Posters
  • Awards
  • Contests
  • Parties/celebrations
Aligning Quality with Cost - MIPS

• The CMS Quality Payment Program and MIPS scores directly tie quality and cost to physician/practice payment in an increasingly meaningful (and possibly painful for some) way

• Important questions to ask about MIPS:
  • Did you report OK for 2017? If not, why?
    • What was your score?
    • What was your resulting payment adjustment?
  • How has your reporting gone in 2018?
  • Do you know what changes occurred in the 2019 program?
  • Where are the best opportunities for improvement/maximizing your MIPS score for this year and moving forward?
<table>
<thead>
<tr>
<th>Category</th>
<th>PY 2017</th>
<th>PY 2018</th>
<th>PY 2019 and beyond</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>60%</td>
<td>50%</td>
<td>35%</td>
</tr>
<tr>
<td>Cost</td>
<td>NA</td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
</tbody>
</table>

CMS has invoked its statutory flexibility to not score the cost category in the first year. However, that category will increase quickly in subsequent years.
“With respect to positive MIPS adjustment factors...the Secretary shall increase or decrease such adjustment factors by a scaling factor in order to ensure that the budget neutrality requirement...is met”
MIPS: Incentives and Penalties

Exceptional performance threshold (2019 – 2024 only)

Performance Threshold (Determined annually)

25 percent of performance threshold

Exceptional performance bonus (>7%)

Positive adjustment on sliding scale (0 up to 7%)

Negative adjustment on sliding scale (0 to -7%)

Maximum Negative Adjustment (-7%)

MIPS Final Score

Set at 3 for 2017
Set at 15 for 2018
Set at 30 for 2019

70 in 2017/18
75 in 2019

100
Aligning Quality with Cost – VBP

What does this quality and cost work look like when you transition to a value-based purchasing contract like an ACO:

**GOAL: Reducing ER visits** – but how does this happen?

- Better data on who has been in ER
  - Claims data, ACO reports, ADT feeds, direct communication from ERs, etc.
- Better processes in the office –
  - empower nurse/care coordinator
  - standard procedures and expectations on f/u calls and appts.
  - better CDM protocols and f/u
  - identifying high utilizers of ER and targeting strategies to their needs
- Better communication with patients
  - Communicate practice capabilities, expectations
  - “Call first” campaigns
  - May need to address culture issues – practice and community
- Practice/Community solutions
  - Extended hours for clinic/walk-in clinic availability
  - Use of extenders to address some needs – Paramedics to check on pts
  - after hours call-in lines separate from the ER, etc.
How discussing value-based payment, ACOs, and MIPS can make many feel... \textbf{Don't give in!}
What we as physicians and healthcare professionals are used to thinking about:
What we are now asked to increasingly become comfortable with:
So here’s what that starts to look like…
What is an Accountable Care Organization (ACO)?

• A set of health care providers—including primary care physicians, specialists, and hospitals—that work together collaboratively and accept collective accountability for the cost and quality of care delivered to a defined population of patients.

• The ACO has a contract with a payer, such as CMS, a commercial payer, or Medicaid, that:
  • Defines the quality measures the ACO practices will be responsible for delivering.
  • Sets a benchmark – the cost of care expected for the patients (beneficiaries) in the ACO.
  • Defines the benefits the ACO is eligible for if the cost falls below the benchmark, usually a percentage of the savings achieved over the benchmark (upside), as well as any potential payback required if costs run higher than the benchmark (downside risk).
Why Participate in an APM/ACO?

- Shared Savings – access to these revenue streams while continuing FFS or current payment model, including cost-based reimbursement
- Quality score education, QI training, improvement efforts – important in ACO work, better patient care, can give market advantages
- Data – access to claims data and risk adjustment data
  - Claims data – new insights on patients populations, costs, local healthcare market, opportunities for improved care and improved revenue
  - Risk adjustment data – essential to understand well if participating in an APM. Can bring short and long-term value to practice in VBP world
- MIPS scoring advantages under MACRA – APMs/ACOs get significant MIPS scoring advantages and can maximize MACRA fee increases
- 5% Bonus payment/MIPS exclusion for Advanced APMs
- Support – ACO work is not the same as FFS clinical care, so support is needed to function well in an ACO
Why Participate in an APM/ACO?

• Education on details of how ACOs and Pay for Value functions – providers, staff and administrators all need to learn about the transition to VBP
• Learning Collaboratives – chance to learn alongside other leaders, providers and practices
• Best practices – Gain insights from those who have experience in these models locally, regionally, and nationally
• Networking – connect with others in similar roles with similar concerns. New support networks develop.
• Contracting advantages – Plant your flag in the ground. Once organized as an ACO, you have significantly improved leverage to negotiate in the pay-for-value space
Barriers

• **Cost** – Is joining an APM/ACO worth an upfront investment?
  • Know the costs – direct and indirect
  • Consider what participation might do to improve revenue, therefore offsetting or overshadowing any costs
    • AWV, TCM, CCM, improved Chronic care, prevention, immunizations...
    • Shared savings potential
  • Consider what new opportunities participation can bring
    • Better connections with employers, payer benefits, marketing advantages, new patients, etc.

• **Time/Staff** – what are the opportunity costs?
  • Know what your responsibilities will be to perform in the APM/ACO
    • Reporting, quality work, efforts addressing costs, etc.
  • Decide if this time/work will benefit your practice in tangible ways – most ACO practices find themselves becoming more organized, more efficient, working better as teams, able to make changes effectively, etc.

• **Risk** – Is there downside risk? If so, is it acceptable?
  • Often, participating earlier means the chance to learn the ropes before downside risk becomes a part of the APM/ACO equation
When are ready to join an APM?

• If you are asking the question, then you probably are...
• The most important factor is the **willingness** to:
  • Look at new data – claims, utilization, risk, quality
  • Think about and organize around how to improve the care you provide
  • Collaborate with others – teach and learn together
  • Dedicate time/resources – especially important to identify a physician champion if at all possible!
• You don’t have to have it all together and be a highly-functional, high-performing practice up front (most aren’t even close!)
• APM/ACO work is the pathway not the destination
How do you join an APM/ACO?

• Consider the options of ACOs to join.
  • MSSP - Check out the CMS website for APMs in your area. All MSSPs are required by CMS to have a public reporting page that details participants, leadership, contact information, shared savings and quality results, etc.
  • Commercial - Contact your major payers and inquire about ACO/APM options.
  • Medicaid – explore the state Medicaid and/or MCO websites and reach out
• Important distinctions when considering APM/ACO options
  • Health system-led vs. physician-led/independent
  • Upside only vs. downside risk ACO contract
How do you join an APM/ACO?

- Some more detailed questions to ask whenever considering an opportunity
  - Who else is in the ACO?
  - Who is the leadership/on the Board of Directors?
  - How are decisions made?
  - What quality metrics will I be accountable for?
  - What are the upfront costs?
  - What are the indirect costs?
  - What support/data/technology will I receive? How? When?
  - What education is provided to physicians/administrators/staff?
  - How are any savings distributed?
  - How are any potential losses shared/covered?
- Timing
  - Most ACOs operate on a calendar year basis, with sign-up for the next year occurring sometime between June-September, depending on the payer
CMS Final MSSP Rule: Pathways to Success

• On December 21, 2018, CMS released the final MSSP ACO rule, dubbed the Pathways to Success, making sweeping and significant changes to the Medicare Shared Savings ACO Program
  • The rule can be accessed [here](#) and CMS also released a related [factsheet](#)
• The rule’s release follows months of advocacy efforts led by a wide variety of healthcare stakeholders since CMS issued their proposed rule in August 2018
• CMS also addressed several final ACO policies for 2019 in the 2019 Medicare Physician Fee Schedule rule
  • The rule can be accessed [here](#) along with the CMS [factsheet](#)
  • MedLink also provided a summary of the ACO provisions in this [resource](#)
Opportunities

• More gradual ramp up of risk in new Basic Track
• Efforts to promote program stability and predictability through use of 5-year agreements
• Makes T1+ equivalent permanent part of MSSP
• Implementation of expanded waivers and beneficiary incentives at lower levels of risk
• Allows ACOs to choose assignment methodology annually regardless of risk
• Removes ACO measure 11 (CEHRT use), replacing with an attestation
• Benchmarking changes (benefits many ACOs)
Challenges

• Shortens shared savings only timeframe for many new ACOs (from the current 6 years permitted to 2-3 years)
• Requires the move to downside risk
• New termination policies based on spending above a certain threshold (related to MSR/MLR) for 2 or more years
• CMS establishes a distinction between high/low revenue ACOs and requires more risk sooner from high revenue ACOs, though CMS did raise the threshold to be considered a high revenue ACO
• While risk scores can now rise, CMS sets a risk adjustment cap of 3% across 5 years and removes the cap on downward adjustments
New Program Structure

<table>
<thead>
<tr>
<th>BASIC Track</th>
<th>Level A</th>
<th>Level B</th>
<th>Level C</th>
<th>Level D</th>
<th>Level E</th>
<th>ENHANCED Track</th>
</tr>
</thead>
<tbody>
<tr>
<td>40% sharing rate</td>
<td>40% sharing rate</td>
<td>50% sharing rate</td>
<td>50% sharing rate</td>
<td>50% sharing rate</td>
<td>50% sharing rate</td>
<td>75% sharing rate</td>
</tr>
<tr>
<td>Upside only</td>
<td>Upside only</td>
<td>1st dollar losses at 30%, not to exceed 2% of revenue capped at 1% of BM</td>
<td>1st dollar losses at 30%, not to exceed 4% of revenue capped at 2% of BM</td>
<td>1st dollar losses at 30%, not to exceed 8% of FFS revenue capped at 4% of BM</td>
<td>1st dollar losses 40-75% and not to exceed 15% of BM</td>
<td></td>
</tr>
</tbody>
</table>

MIPS APM | MIPS APM | MIPS APM | MIPS APM | Advanced APM | Advanced APM |

* Agreement Period 5 years (increase from current 3 years)
2020 MSSP Application Timeline

- Notice of Intent to Apply for new ACOs will be due in May
- New ACO applications will be due by July 28
- MSSP ACO Practice sign up for these ACOs (either new or existing) will occur between June-September

Therefore, **practices interested in joining an MSSP ACO for 2020 will have the following opportunity to do so:**

- June - September 2019 for the January 1, 2020 start date.
- For those that don’t join then, the next opportunity to join an MSSP would be in Summer 2020 for a January 1, 2021 start date.
- **All MSSP ACOs will be required by CMS to move to downside risk by at least year three, so it is important for practices to consider getting experience in an ACO early, while still in upside-only years.**
Positioning for Value-based Purchasing

- Working on appropriately maximizing FFS, while concurrently building out a practice or organization’s knowledge base, skill set, and trained people around quality, cost and risk is a wise transition strategy.
Positioning for Value-based Purchasing

- What are some of the benefits of ACO participation instead of just participating in FFS and reporting under MIPS?
  - MIPS Alternative Payment Model
    - Preferential MIPS scoring – can add significant value to CMS payment

**Shared Savings Program (All Tracks) under the APM Scoring Standard**

<table>
<thead>
<tr>
<th>REPORTING REQUIREMENT</th>
<th>PERFORMANCE SCORE</th>
<th>WEIGHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ No additional reporting necessary. ACOs submit quality measures to the CMS Web Interface on behalf of their participating MIPS eligible clinicians.</td>
<td>✓ The MIPS quality performance category requirements and benchmarks will be used to score quality at the ACO level.</td>
<td>50%</td>
</tr>
<tr>
<td>✓ MIPS eligible clinicians will not be assessed on cost.</td>
<td>✓ N/A</td>
<td>0%</td>
</tr>
<tr>
<td>✓ No additional reporting necessary.</td>
<td>✓ CMS will assign a 100% score to each APM Entity group based on the activities required of participants in the Shared Savings Program.</td>
<td>20%</td>
</tr>
<tr>
<td>✓ Each ACO participant TIN in the ACO submits under this category according to MIPS reporting requirements.</td>
<td>✓ All of the ACO participant TIN scores will be aggregated as a weighted average based on the number of MIPS eligible clinicians in each TIN to yield one APM Entity group score.</td>
<td>30%</td>
</tr>
</tbody>
</table>
Positioning for Value-based Purchasing

- What are some of the benefits of ACO participation instead of just participating in FFS and reporting under MIPS?
  - Advanced Alternative Payment Model
    - Not subject to MIPS reporting
    - Bonus payment – 5% of Part B
    - Higher fee schedule update to 0.75% from 2026 onward

### 2018 Primary Care Advanced APMs

- Shared Savings Program (Tracks 1+, 2 & 3)
- Next Generation ACO Model
- Comprehensive Primary Care Plus (CPC+)
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)
- AAPMs announce as approved
Risk – where does it fit in and why should we care?

- Increasingly healthcare providers are being told we need to take on more risk. The term **risk** can be used to mean a variety of things:
  - **Risk management**, traditionally used to describe malpractice/legal risks and the subsequent efforts to minimize this type of risk exposure
  - **Contractual risk**, usually discussed in terms of upside/downside risk in an ACO or other VBP contract; may also include defined risk corridors
  - **Risk scoring**, or a calculation of actuarial risk, when looking at potential future healthcare costs of differing demographic groups and healthcare conditions or disease states
  - **Risk adjustment**, process where payers use the above risk scoring to determine and set estimates for medical spending in a defined population; therefore, benchmarks or budgets are set in an ACO or other value-based payment contract.

- We don’t need to fear the term risk, but we do need to understand what is meant when it is used, and how risk and risk adjustment work in the value-based payment world.
- Let’s explore risk scoring and risk adjustment in more detail...
Risk Adjustment

- Payers use risk adjustment to set budgets/benchmarks, which then can be used to determine payments/shared savings.
- Many types of risk adjustment methodologies exist:
  - CMS uses HCC codes to determine Risk-Adjusted Factor (RAF) scores.
  - Commercial payers use methodologies such as Diagnostic Related Groups (DRGs).
- The idea of risk adjustment is to as accurately as possible predict the future healthcare costs of individuals and populations by looking at factors such as age, gender, and the presence/absence of specific medical diagnoses/conditions.
- This risk adjustment is nearly exclusively performed using a combination of demographic data and claims-based diagnoses.

- Let’s compare coding and payment in the more familiar world of Fee For Service to how coding-driven risk adjustment can affect payment under value-based payment arrangements. We’ll dive deeper into the CMS HCC methodology.
No margin, no mission!

-Sister Irene Kraus, Daughters of Charity
How Things Work in Fee For Service
Think about the coding system we are used to in FFS

• Coding is how we communicate with the insurance company about how much work we have done.
• If we are not very accurate, we are essentially telling the insurer that we are doing less work than we actually are
• This translates into less payment, sometimes MUCH less payment
General Types of Coders in Fee For Service

- **Under-coders**
  - 50% 99212; 50% 99213

- **Lazy coders**
  - almost all 99213

- **“More Appropriate” coders**
  - 10% 99212, 58% 99213, 32% 99214
## Effects of Appropriate Coding on Income

<table>
<thead>
<tr>
<th>Code</th>
<th>99212 - $52.75</th>
<th>99213 - $88.85</th>
<th>99214 - $121.62</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under-coder</td>
<td>Lazy</td>
<td>Correct</td>
<td></td>
</tr>
<tr>
<td>Collections</td>
<td>$255,559</td>
<td>$320,712</td>
<td>$345,534</td>
</tr>
<tr>
<td>Overhead</td>
<td>$175,000</td>
<td>$175,000</td>
<td>$175,000</td>
</tr>
<tr>
<td>Net Income</td>
<td>$80,559</td>
<td>$145,712</td>
<td>$170,534</td>
</tr>
</tbody>
</table>
How Things Work in Value-Based Payment (ACOs)

Hierarchical Condition Category (HCC) Fundamentals
Our coding affects the ACO via Risk Adjustment by affecting the ACO Budget

• ACO Budgets, referred to as Benchmarks
  • are the costs projected by the payer to care for the ACO’s panel of patients
  • are risk-adjusted based on burden of disease of each patient to account for more complex patients being expected to cost more to care for based on actuarial assessments

• CMS, BCBS, etc. can only determine this burden of disease based on our diagnosis coding on the claims we submit

• Therefore, if you don’t code it…. the patients don’t have it!
  • And therefore, from the insurer (CMS, Wellmark) perspective, they expect the costs needed to care for these patients to be lower
CMS Payment Formula

CMS approved base rate \( \times \) Risk Adjusted Factor (RAF) score

(\textit{factors associated with HCCs} + \textit{factors associated with member’s demographics})

= \textit{ACO Budget/Benchmark for that patient}
Characteristics of the HCC model

- **Diagnostic Sources**: CMS will only consider diagnoses from IP & OP Hospital & Physician Data.
- **Prospective in Nature**: Diagnosis from base year used to predict payment for next year. *New Enrollee vs Existing Enrollee*.
- **HCCs/Multiple Chronic Diseases**: Base payment for each member based on HCCs and influenced by Medicare Costs for Chronic Diseases.
- **Disease Interactions**: Additional factors applied when hierarchy of more severe and less severe conditions co-exist.
- **Demographics**: Final adjustment due to: age, sex, original Medicare entitlement, disability & Medicaid status.
Hierarchical Condition Categories (HCCs)

What is an HCC?
- A category of medical conditions that map to a corresponding group of ICD-10 diagnosis codes

*Over 8,800 ICD-10 codes map to one of 79 HCCs*
# Risk Adjustment 101
## Example of HCC and ICD code mapping

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
<th>CMS-HCC Model Category V22</th>
<th>CMS-HCC Model for 2016 Payment Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>E40</td>
<td>Kwashiorkor</td>
<td>21</td>
<td>Yes</td>
</tr>
<tr>
<td>E41</td>
<td>Nutritional marasmus</td>
<td>21</td>
<td>Yes</td>
</tr>
<tr>
<td>E42</td>
<td>Marasmic kwashiorkor</td>
<td>21</td>
<td>Yes</td>
</tr>
<tr>
<td>E43</td>
<td>Unspecified severe protein-calorie malnutrition</td>
<td>21</td>
<td>Yes</td>
</tr>
<tr>
<td>E440</td>
<td>Moderate protein-calorie malnutrition</td>
<td>21</td>
<td>Yes</td>
</tr>
<tr>
<td>E441</td>
<td>Mild protein-calorie malnutrition</td>
<td>21</td>
<td>Yes</td>
</tr>
<tr>
<td>E45</td>
<td>Retarded development following protein-calorie malnutrition</td>
<td>21</td>
<td>Yes</td>
</tr>
<tr>
<td>E46</td>
<td>Unspecified protein-calorie malnutrition</td>
<td>21</td>
<td>Yes</td>
</tr>
<tr>
<td>E550</td>
<td>Rickets, active</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>E640</td>
<td>Sequelae of protein-calorie malnutrition</td>
<td>21</td>
<td>Yes</td>
</tr>
<tr>
<td>E6601</td>
<td>Morbid (severe) obesity due to excess calories</td>
<td>22</td>
<td>Yes</td>
</tr>
<tr>
<td>E662</td>
<td>Morbid (severe) obesity with alveolar hypoventilation</td>
<td>22</td>
<td>Yes</td>
</tr>
<tr>
<td>E700</td>
<td>Classical phenylketonuria</td>
<td>23</td>
<td>Yes</td>
</tr>
<tr>
<td>E701</td>
<td>Other hyperphenylalaninemas</td>
<td>23</td>
<td>Yes</td>
</tr>
<tr>
<td>E7020</td>
<td>Disorder of tyrosine metabolism, unspecified</td>
<td>23</td>
<td>Yes</td>
</tr>
<tr>
<td>E7021</td>
<td>Tyrosinemia</td>
<td>23</td>
<td>Yes</td>
</tr>
<tr>
<td>E7029</td>
<td>Other disorders of tyrosine metabolism</td>
<td>23</td>
<td>Yes</td>
</tr>
<tr>
<td>E7030</td>
<td>Albinism, unspecified</td>
<td>23</td>
<td>Yes</td>
</tr>
<tr>
<td>E70310</td>
<td>X-linked ocular albinism</td>
<td>23</td>
<td>Yes</td>
</tr>
<tr>
<td>E70311</td>
<td>Autosomal recessive ocular albinism</td>
<td>23</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Hierarchical Condition Categories

• Whenever **any condition from a given category** is documented in a given year, the member receives “credit” for that category, and the appropriate value is added to the Risk Adjustment Factor (RAF) score.

• Categories carry different weight (value), with more serious conditions having higher values.

• In the hierarchy, certain categories “outrank” others— that is, a patient diagnosis from certain categories brings a higher value to the RAF score than other categories.
## HCC RAF Score Examples

<table>
<thead>
<tr>
<th>HCC Code</th>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCC8</td>
<td>Metastatic Cancer and Acute Leukemia</td>
<td>2.484</td>
</tr>
<tr>
<td>HCC9</td>
<td>Lung and Other Severe Cancers</td>
<td>0.973</td>
</tr>
<tr>
<td>HCC10</td>
<td>Lymphoma and Other Cancers</td>
<td>0.672</td>
</tr>
<tr>
<td>HCC11</td>
<td>Colorectal, Bladder, and Other Cancers</td>
<td>0.317</td>
</tr>
<tr>
<td>HCC12</td>
<td>Breast, Prostate, and Other Cancer and Tumors</td>
<td>0.154</td>
</tr>
<tr>
<td>HCC17</td>
<td>Diabetes with Acute Complications</td>
<td>0.368</td>
</tr>
<tr>
<td>HCC18</td>
<td>Diabetes with Chronic Complications</td>
<td>0.368</td>
</tr>
<tr>
<td>HCC19</td>
<td>Diabetes without Complications</td>
<td>0.118</td>
</tr>
</tbody>
</table>
HCC and Disease Interactions

- CMS pays additionally for the presence of two identified conditions where the cost is greater than just their additive effects. In these instances, there is additional reimbursement when the following conditions co-exist:

  - Sepsis and Cardiorespiratory Failure **0.214
  - Cancer and Immune Disorders **0.947
  - Diabetes and CHF **0.182
  - CHF and COPD **0.259
  - CHF and Renal Disease **0.317
  - COPD and Cardiorespiratory Failure **0.456
Diagnoses Used in CMS-HCC Risk Scores

- The diagnoses used to calculate risk scores for beneficiaries are collected from claims.

- Diagnoses from the following settings/providers are used:
  - Hospital inpatient
  - Hospital outpatient
  - Physician
  - Clinically-trained non-physician (e.g., clinical psychologist)

- The CMS-HCC model counts only the most severe manifestation among related conditions.
RxHCC’s

- Rx HCC’s complement the reimbursement for managing patients with illnesses that may not be as complex or costly as HCC diagnoses, but qualify for additional reimbursement due to increased medication costs.

- As a general rule, almost all HCC diagnoses are also RxHCC codes but all RxHCCs are NOT also HCCs.

- Here are some examples of diagnoses which are not HCC but are RxHCC codes:
  - Hypertension is not an HCC
  - Osteoporosis is another common illness that is an RxHCC
  - CAD in itself is not a medical HCC, but it is an RxHCC. Because CAD is a general term, it is imperative that if the patient has angina or an old MI, the chronic problem list should include angina or old MI as they are HCC Diagnoses.
Risk Adjustment Factor Score

• These HCCs determine the risk adjustment for that patient
• Each CMS ACO Member (Patient) has a Risk Adjustment Factor (RAF) score calculated by CMS
  • RAF = 1 - a patient that is expected to use the average amount of resources
  • RAF < 1 – a patient that is expected to use less than the average amount of resources
  • RAF > 1 – a patient that is expected to use more than the average amount of resources
Let’s look at a few examples of how risk adjustment works in the real world
# Risk Adjustment

## A Case Study of coding effects

An 81 year old male patient had the following conditions coded:

<table>
<thead>
<tr>
<th>Year</th>
<th>Condition</th>
<th>RAF Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>Age/Gender</td>
<td>0.683</td>
</tr>
<tr>
<td></td>
<td>Chronic Atrial Fibrillation (HCC 96)</td>
<td>0.268</td>
</tr>
<tr>
<td></td>
<td>Type 2 Diabetes Mellitus with foot ulcer (HCC 18)</td>
<td>0.318</td>
</tr>
<tr>
<td></td>
<td>Non pressure Chronic Ulcer R foot (HCC 161)</td>
<td>0.535</td>
</tr>
<tr>
<td></td>
<td><strong>Total RAF Score</strong></td>
<td><strong>1.804</strong></td>
</tr>
<tr>
<td>2016</td>
<td>Age/Gender</td>
<td>0.683</td>
</tr>
<tr>
<td></td>
<td>Chronic Osteomyelitis L foot (HCC 39)</td>
<td>0.425</td>
</tr>
<tr>
<td></td>
<td>Spinal Enthesopathy, lumbosacral (HCC 40)</td>
<td>0.423</td>
</tr>
<tr>
<td></td>
<td><strong>Total RAF Score</strong></td>
<td><strong>1.531</strong></td>
</tr>
</tbody>
</table>

If the Diabetes and Chronic Afib had been coded in 2016, the RAF score would have been (appropriately)

\[ 2.117 \times 9,200 = 19,476.40 \text{ (}$5391.20 \text{ increase)} \]

Result of risk adjustment on this patient’s budget for the next year:

\[ 1.531 \times 9,200 = 14,085.20 \]
\[ 2.117 \times 9,200 = 19,476.40 \text{ (}$5391.20 \text{ increase)} \]
Risk Adjustment
A Case Study of coding effects

An 93 year old female patient had the following conditions coded and subsequent RAF score:

2015
- Age/Gender = 0.692
- CVA (HCC 100) = 0.317
- Type 2 Diabetes Mellitus w/o compl. (HCC 19) = 0.118
- Total RAF Score = 1.127

2016
- Age/Gender = 0.692
- COPD, unspecified (HCC 111) = 0.328
- Total RAF Score = 1.02

If the Diabetes and CVA had also been coded in 2016, the RAF score would have been (appropriately) = 1.455

Result of risk adjustment on this patient’s budget for the next year:
- 1.020 X $9,200 = $9,384.00
- 1.455 X $9,200 = $13,386.00 ($4,002 increase)
## Risk Adjustment

### A Case Study of coding effects

A 86 year old female patient had the following conditions coded and subsequent RAF score:

<table>
<thead>
<tr>
<th>Year</th>
<th>Condition</th>
<th>RAF Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>Age/Gender</td>
<td>0.692</td>
</tr>
<tr>
<td></td>
<td>Angina pectoris (HCC 88)</td>
<td>0.141</td>
</tr>
<tr>
<td></td>
<td>PVD NOS (HCC 108)</td>
<td>0.476</td>
</tr>
<tr>
<td></td>
<td>Intermediate Coronary Failure (HCC135)</td>
<td>0.299</td>
</tr>
<tr>
<td></td>
<td>Acute Kidney Failure (HCC 87)</td>
<td>0.258</td>
</tr>
<tr>
<td></td>
<td>Thrombocytopenia NOS (HCC 48)</td>
<td>0.252</td>
</tr>
<tr>
<td></td>
<td>Deep Phlebitis, Leg NEC (HCC 108)</td>
<td>0.299</td>
</tr>
<tr>
<td></td>
<td>Sinoatrial Node Dysfunction (HCC 96)</td>
<td>0.268</td>
</tr>
<tr>
<td></td>
<td><strong>Total RAF Score</strong></td>
<td><strong>2.386</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Condition</th>
<th>RAF Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>Age/Gender</td>
<td>0.692</td>
</tr>
<tr>
<td></td>
<td>Sick Sinus Syndrome (HCC 96)</td>
<td>0.268</td>
</tr>
<tr>
<td></td>
<td><strong>Total RAF Score</strong></td>
<td><strong>0.960</strong></td>
</tr>
</tbody>
</table>

Result of risk adjustment on this patient’s budget for the next year:

\[
\begin{align*}
2.386 \times \$9,200 &= \$21,951.20 \\
0.960 \times \$9,200 &= \$8,832 \\
\text{Difference} &= \$13,119.20
\end{align*}
\]
Risk Adjustment 101 Pearls
Common missing or incomplete diagnoses

• Diabetes
  • Type 1 or Type 2
  • Controlled or uncontrolled
  • Manifestations (neuropathy, nephropathy, etc.)
• Major depression vs. depression
• Chronic Renal Failure – stage 2, 3, 4, etc.
• Angina Pectoris
• Breast, Prostate, Colorectal Cancers coded as “history of” rather than active dx
• Drug or alcohol dependency
Risk Adjustment 101 Pearls
Document Status Conditions

- Transplants
- HIV
- Dialysis
- Ventilators
- Amputations
- Artificial openings for feedings

- Must reflect active conditions that require treatment or influence medical decision making
Important Points of Interest

• CMS wipes the slate clean every year and starts over with demographics
  • so need to code diagnoses on claims each year, not just have the diagnosis listed in the EHR

• Must submit diagnoses at least once during the year
  • optimum is twice a year based on the timing and methodology of calculations of risk scores by CMS

• Improved risk adjustment translates into more accurate, usually higher ACO benchmarks/budgets
  • therefore a higher likelihood of shared savings

• However, this depends entirely on complete and accurate documentation
  • It’s not difficult and it’s worth your time!
The best way to predict your future is to create it

— Peter Drucker
Summary thoughts on APMs

• Find an APM whose culture/goals match the best with the culture/goals of your practice or organization
• While shared savings can be a big incentive, it is more important to also look at APM/ACO work as your practice’s path forward as the healthcare system undergoes some foundational changes. Therefore consider which APM/ACOs are going to:
  • Help you take the best care of your patients/community
  • Equip you to succeed in our changing system – long-term skills and success, as well as short-term improvement
  • Offer the best support in terms of data, education, practice/QI support, networking opportunities, engagement of providers, etc.
An Excellent Educational Opportunity to Prepare Physician Leaders

- Ascent Physician Leadership program
  - To prepare physician leaders to lead through the opportunities and challenges presented by today’s healthcare world
  - Beginning with session on June 28-29, 2019 in Denver with ongoing, rolling enrollment
  - [www.ascentphysicianleadership.org](http://www.ascentphysicianleadership.org) for more information
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Today’s healthcare environment is constantly changing. Physician leaders are needed to lead the transformation of healthcare to new models yet these leaders are faced with competing demands as they work to improve patient outcomes and manage costs. Ascent Physician Leadership offers an exciting, dynamic physician leadership program aimed at professional and personal development in a supportive peer group environment.

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LEARNING REDEFINED

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Questions Encouraged

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712-579-1911