

A Patient Driven HCC Process

Why All the Buzz?

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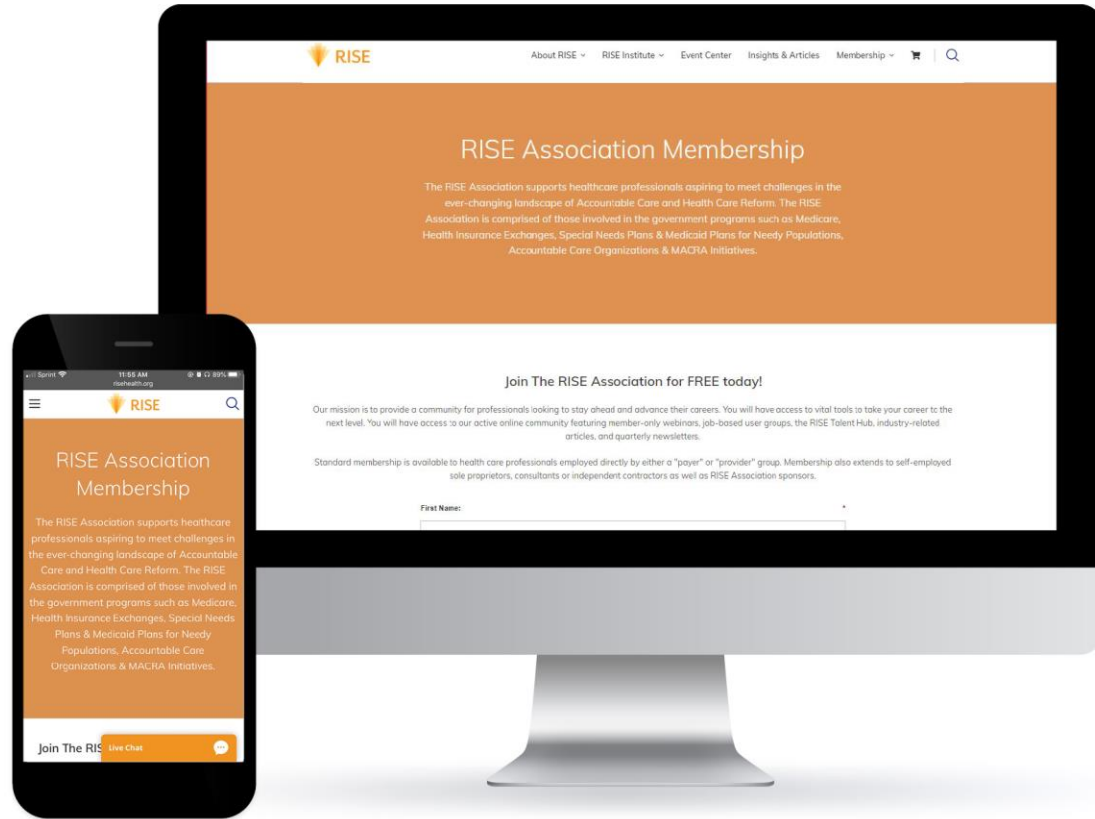
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Disclaimer

- This material is designed and provided to communicate information about clinical documentation, coding, and compliance in an educational format and manner.
- The author is not providing or offering legal advice but, rather, practical and useful information and tools to achieve compliant results in the area of clinical documentation, data quality, and coding.
- Every reasonable effort has been taken to ensure that the educational information provided is accurate and useful.
- Applying best practice solutions and achieving results will vary in each hospital/facility and clinical situation.

What are HCCs?

An HCC (Hierarchical Conditions Category) is a diagnosis code driven method used to apply cost grouping based risk adjustment in categorizing clinical condition groups and/or disease burden scale.

- Statistical regression-based model
- Diagnosis code(s) determine cost risk groupings
- Counts individual interactions between high burden diseases
- Predicts costs for an individual for the coming year
- Estimating the financial effect of disease burden on future costs
- Analyzes post acute care services following a hospitalization
- HHS HCC prospective cost analysis
- CMS HCC retrospective cost analysis
- CMS and HHS uses surrogate (non-clinical) and clinical variables to determine RAF score



Background and history – HCC models

CMS HCCs



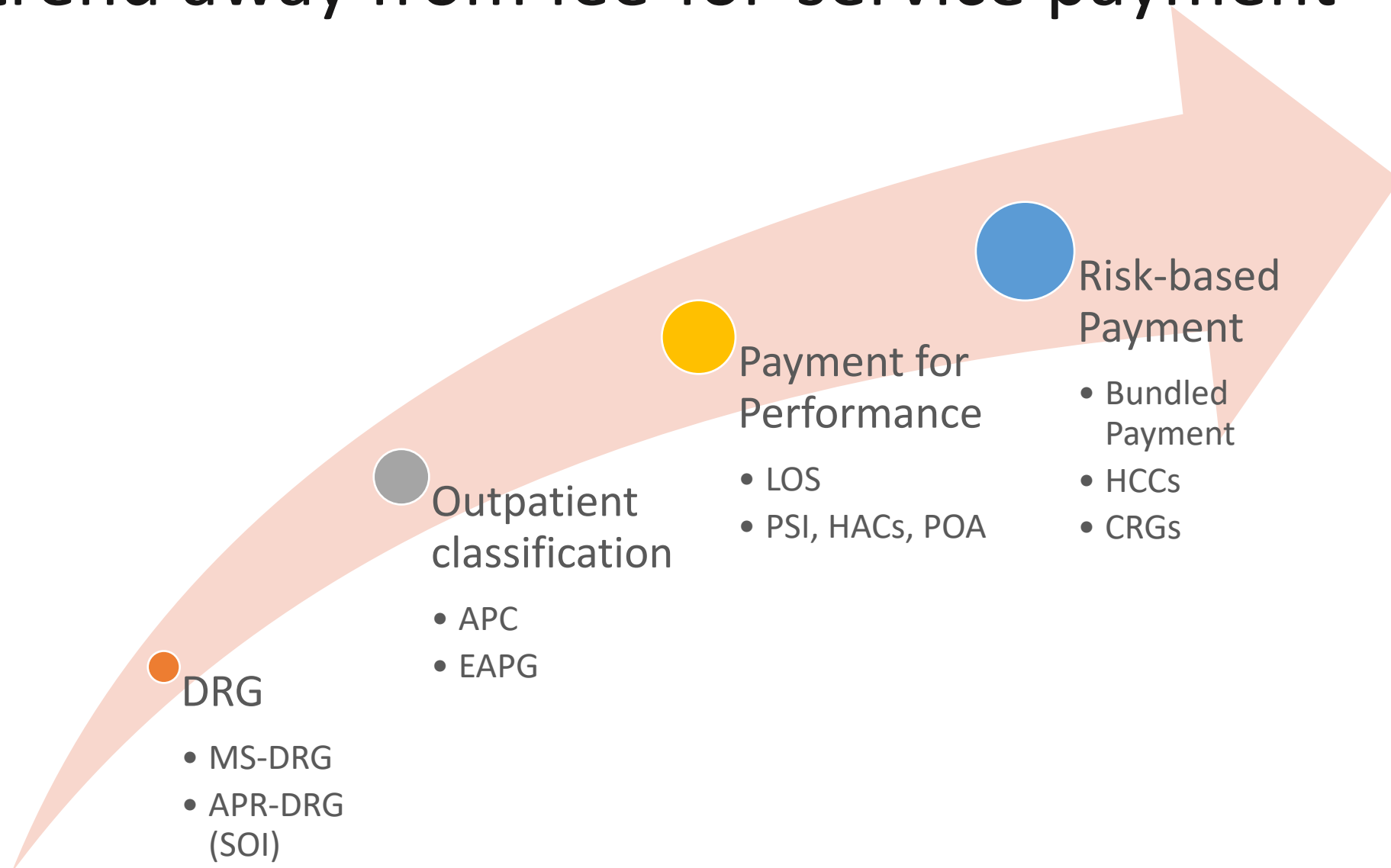
- Developed by CMS for risk adjustment of the Medicare Advantage Program (Medicare Part C)
- CMS also developed a CMS RX HCC model for risk adjustment of Medicare Part D population
- Based on aged population (over 65)
- Current year data predictive of future year risk

HHS HCCs (Commercial HCCs)

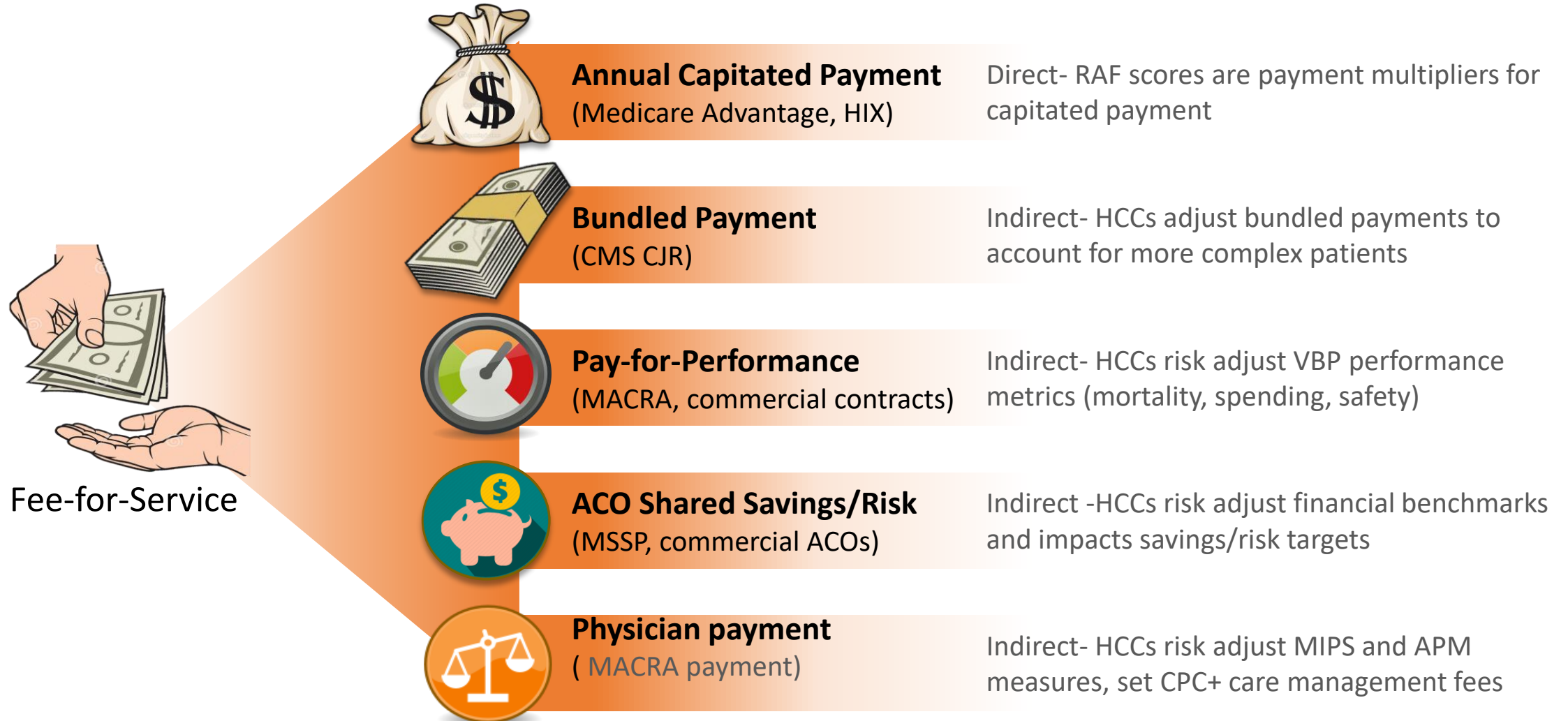


- Developed by the Department of Health and Human Services (HHS)
- Designed for the commercial payer population
- HHS-HCCs predict the sum of medical and drug spending
- Includes all ages
- Current year data used to predict current year risk

The trend away from fee-for-service payment



HCCs in multiple value-based payment programs

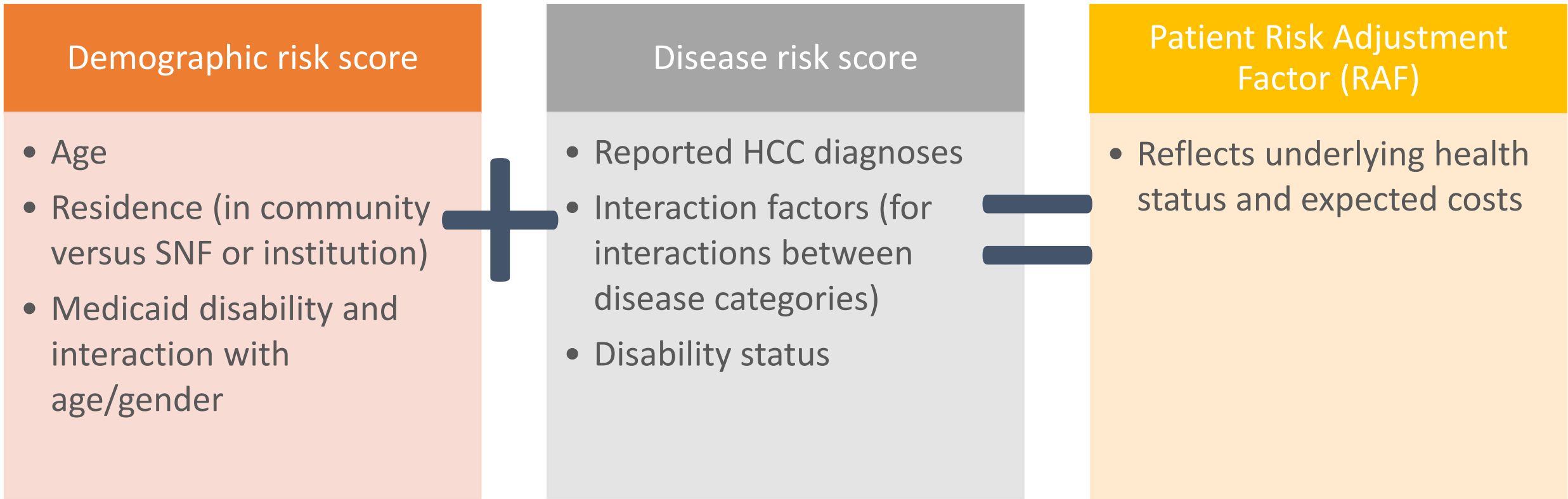


Why the buzz?

- An increasing number of provider organizations – hospital networks and physician practices – are entering into value-based contracts with their payers.
- It is estimated that by 2030 up to 40% of patients will participate in a Medicare Advantage risk-based plan... and the number will continue to grow!
- Providers establish a contract where they are paid a flat rate per patient; the amount paid to cover the annual patient care is **determined based on documentation and coding**.
- The need for capturing chronic conditions qualifying as an HCC is important for both ambulatory and inpatient providers:
 - Risk adjusted diagnoses can be captured regardless of place of service
 - Patient risk score is based on their health status across the care continuum

HCC RAF calculation

Total score of all relative factors related to one patient for a year (invisible to coder and provider until RAF score for next year is determined)



HCC Risk Adjustment Factor methodology example

- 78-year-old male, community based, managing chronic conditions

2019 Risk Adjustment Factor (RAF) Score Diagnoses documented/billed during visits in 2019	
Demographic score: 2019	0.466
HCC 18: Diabetes w/retinopathy	0.302
HCC 22: Morbid Obesity	0.250
HCC 40: Rheumatoid arthritis	0.401
HCC 85: Dilated cardiomyopathy	0.331
HCC 111: COPD	0.335
HCC Interaction Score: CHF—COPD	0.190
HCC Interaction Score: Diabetes—CHF	0.154
Total RAF Score	2.429

2020 Risk Adjustment Factor (RAF) Score Diagnoses documented/billed during visits in 2020	
Demographic score: 2020	0.466
HCC 18: Diabetes w/retinopathy	0.302
HCC 22: Morbid Obesity	0.250
Total RAF Score	1.018
2020 Missing RAF Score	1.411

Capitated Pay Per Member Per Month (PMPM):

- \$800 PMPM x 2.429 RAF = \$1943
- \$800 PMPM x 1.018 RAF = \$814

\$13,548
Annual

Common gaps and key steps in capturing HCCs



Face-to-face
patient visit

Visit Types

- Hospital inpatient and outpatient
- Physician / NPP (NP, PA, NW, CRNA)

Exclusions:

- Hospice
- SNF
- Home health
- Free-standing ASC

- Patients missing HCCs do not have visits scheduled
- No way to identify patients
- No easy process to schedule at-risk patient for a visit



Physician addresses and
diagnoses condition(s)

Providers

- Physicians
- NP, CRNA
- Psychologist/Psychiatrist

Services Excluded:

- DME
- Laboratory
- Diagnostic radiology

- Physician doesn't know what patient information is contained in disconnected EMRs
- Not all HCC-diagnoses are captured/documented

Claim

a1839
89j17
374b
980t

Dx coded and
itemized in claim

Requirements

- Each HCC diagnosis submitted in a claim once per calendar year
- Must be supported by documentation in visit note

- Physician documents an HCC-diagnosis but does not code for it
- Providers trained to code diagnoses for pro-fee billing, not HCC capture
- 80-90% of office visits coded by providers with no coder review

HCCs must be treated, documented, coded, and billed at some point across care settings

Common concerns for health systems

Capturing population's disease burden

- Struggle to accurately document and report each patient's entire disease burden
- Under-reporting means you don't get paid for the full cost it takes to keep patient healthy
- Does your data tell the entire story of your patient?

Staff understanding of HCC methodology

- Staff do not fully understand the HCC methodology
- Traditional DRG-focused documentation programs may not emphasize the entire disease burden
- Physicians, coding, and CDI may need additional training and policies
- RAF calculation may change the way coding and claims are submitted

Lack of CDI processes in physician office

- 80% of patient care occurs in the physician office
- Physician practices have limited documentation improvement practices
- Disparate systems create difficulty identifying a longitudinal care record
- Office-based physicians do not routinely document and code for full disease burden

Accurately predicting patient costs

- Struggle to accurately predict costs
- Provider Sponsored Health Plans and/or providers with risk-based agreements need to predict costs
- These providers are looking to risk stratify patient populations to help control costs

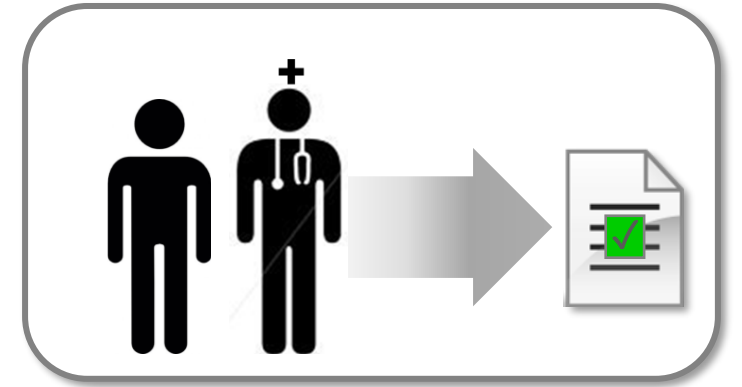
HCC documentation requirements

HCC diagnoses

- Must be captured in a face-to-face visit by physician or NPP
- Must be appropriately documented in the medical record
- Supporting clinical evidence for all diagnoses must be documented

M.E.A.T. criteria

- **Monitor** - Signs, symptoms, disease progression or regression
- **Evaluate** - Review of test results, medication effectiveness, response to treatment
i.e. “stable,” “improving,” “exacerbation,” “worsening,” “poor”
- **Assess** - Ordering tests, discussion, review records, counseling
- **Treat** - Referral, medication(s), planned surgery, therapies



KEY TAKEAWAY: Evidence of an HCC can be obtained from any qualified document/claim. It is important that provider documentation and billing be consistent across care continuum.

HCC documentation requirements

Complete and accurate documentation is a solid foundation for risk adjustment

Example of MEAT criteria for a patient with Diabetes Mellitus:

67-year-old female with 15-year history of Type 2 DM, taking Glucophage 500mg BID. Recent lab work shows an increase in A1C. Her last three A1C results show trending upward. Will increase her Glucophage, see her in 3 months, order placed for A1C.

Monitoring - 67-year-old female with 15-year history of Type 2 DM, taking Glucophage 500mg BID.

Evaluating - Recent lab work shows an increase in A1C.

Assessing - Her last three A1C results show trending upward.

Treating - Will increase her Glucophage, see her in 3 months, order placed for A1C.

Common HCC clarification opportunities



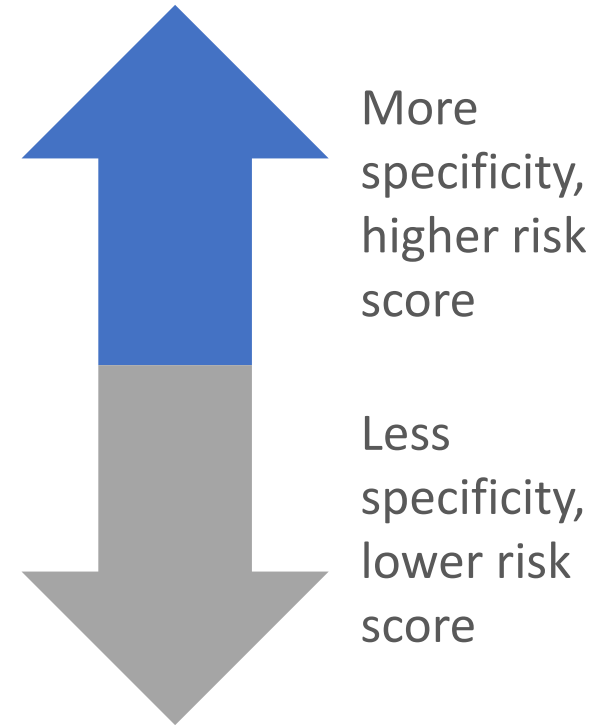
Top 10 Most Under-Documented HCCs

- > Amputations
- > Artificial openings
- > Asthma and pulmonary disease
- > Chronic skin ulcer
- > Congestive heart failure
- > Drug dependence
- > Metastatic cancers
- > Morbid obesity
- > Rheumatoid arthritis
- > Specific type of major depressive disorder

Source: 3M aggregated claims data

Goal for each patient

- Report all current diagnoses at the highest level of specificity based on physician documentation
- The more categories of diagnoses reported over a year creates a higher risk score
- Only one diagnosis per category is used in the risk score calculation
- ✓ If both angina and AMI are reported in one year, only the AMI is scored as it is a higher level of specificity within the Heart category



Time is the most precious resource we have

Delivering
high-quality care



EHR and
anything that
distracts from
**Interaction with
the Patient**

The (real) cost of technology in healthcare



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Right information at the right time

BEFORE THE VISIT



Surfaces reminders
in preparation for the visit.



Looks up information
such as prior notes or labs.



Jump-starts documentation
based on prior information.

DURING THE VISIT



Delivers critical insights
in a discrete fashion.



Performs time-sensitive tasks
such as order entry.



Detects important topics
from doctor-patient dialogue.

AFTER THE VISIT



Proposes next steps,
concrete and actionable.



Follows instructions
such as assessment & plan.



Captures documentation
in the EHR.

Conversational AI: Closing the Loop

Heart failure

Please consider specifying the **acuity** and **type**

- acute diastolic
- acute systolic
- chronic diastolic

drive **action**

3

Conversational AI Platform

Speech recognition
Real-time NLU
Clinical intelligence
Deep learning
Intent/context

1

capture clinical documentation

The patient has congestive **heart failure**. His history is significant for type 2 diabetes mellitus and **hypertension**. His current medications include Coumadin 6 mg once daily and **lisinopril 10 mg twice daily**.

2

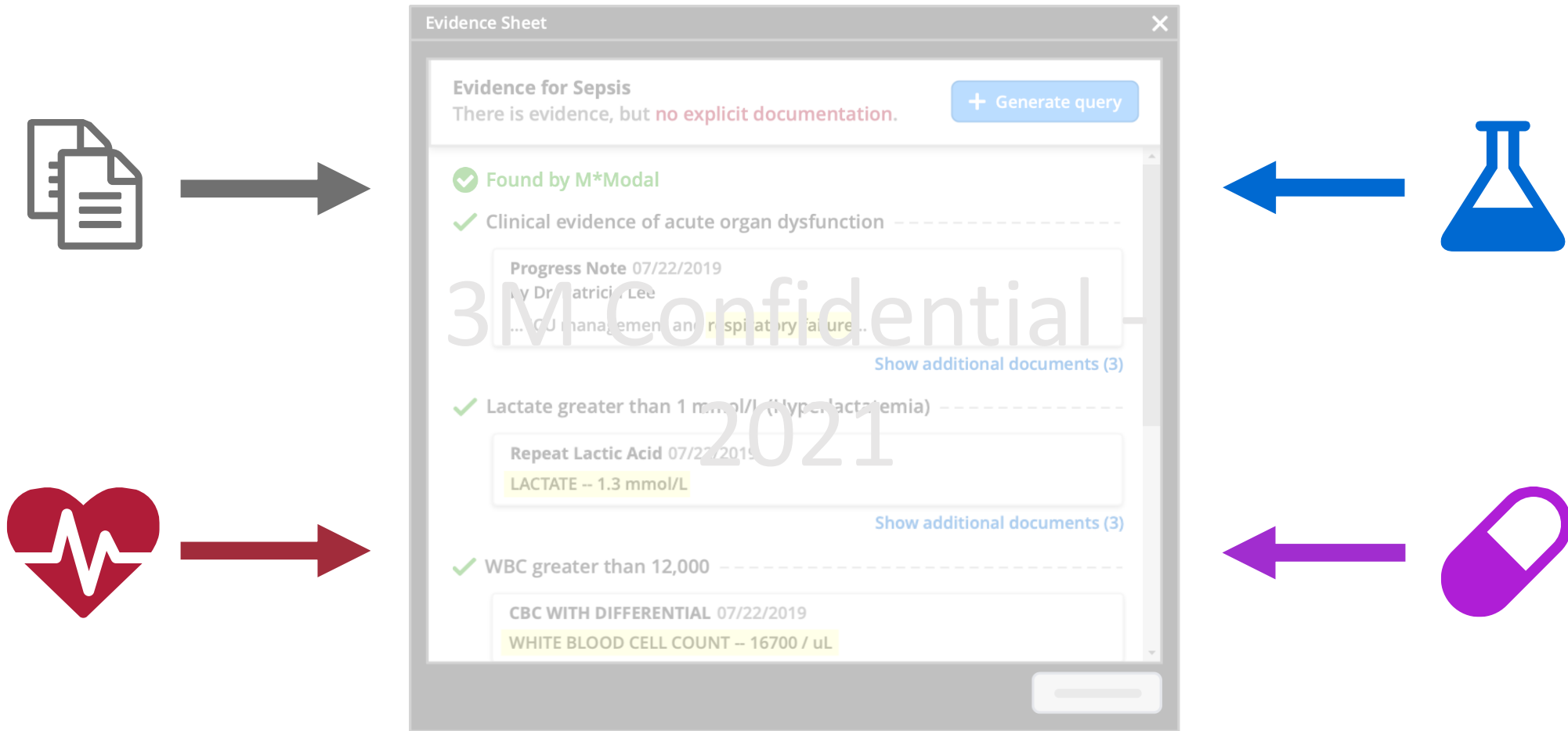
create **insight**



Structured and encoded CDA documents

Electronic Patient Record

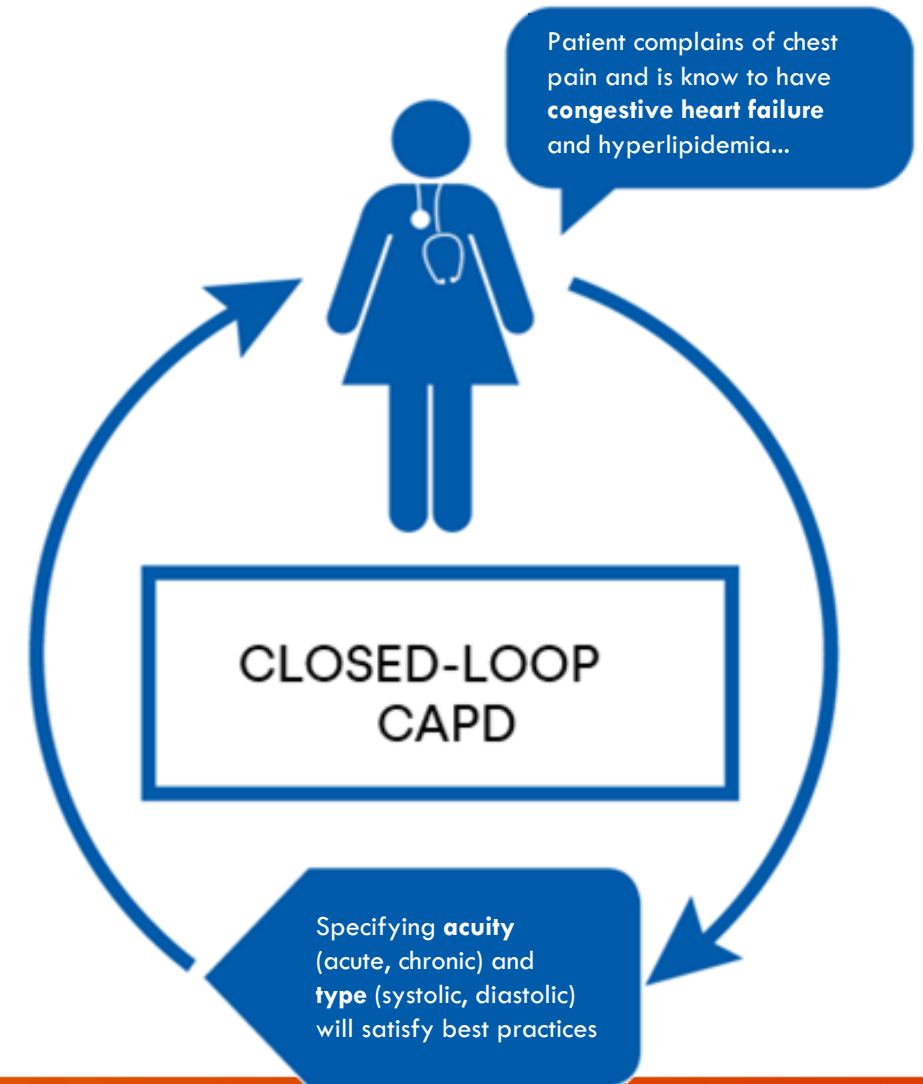
Explainable AI: Clinical Information Models



Real-time clinical intelligence at the point of care

Computer-Assisted Physician Documentation (CAPD)

- Real time feedback from clinical understanding platform
- Proactively encourages consistency and accuracy
- Closes care gaps, improves communication and compliance
- Personalize nudges for providers that are explainable and actionable



The power of



A comprehensive HCC program



Engage all stakeholders – Physicians, CDI, coding, quality, revenue cycle, population health – in order to define organizational goals and build support for a united front on how to build out a program to support “the shift from volume to value.”



Create a sustainable process across your network and risk contracts that reduces manual or disparate functions. Prioritize patients review based on the needs of all stakeholders and goals.



Move from retrospective analysis to proactive review and management that support enterprise scalability and improve the effectiveness of the program.



Operationalize data for continuous program improvement by targeting patients, physicians, and high-value HCCs. Focus on proxy measures and leading indicators.

What problem are we trying to solve?



Engage all stakeholders – Physicians, CDI, coding, quality, revenue cycle, population health – in order to define organizational goals and build support for a united front on how to build out a program to support “the shift from volume to value.”

“What diagnoses even count as HCCs? You have to make the coding work easier. My notes have all the necessary information, but the problem list is a mess.”

“Remind me what I need to review for my patient during the visit. Help me to get it right the first time.”

“Why can’t the computer tell me the correct ICD-10 codes based on my documentation?”

“Which patients have the greatest opportunity for HCC capture remaining this year? Our RAF scores do not reflect the actual population severity of illness.”

“We need a workflow to review patients before their visit... our retrospective review is not cutting it.”

“We’re building an OCDI program but don’t have the resources to cover our growing risk-based population.”

Problems → Goals → Process → Results



Create a sustainable process across your network and risk contracts that reduces manual or disparate functions. Prioritize patients review based on the needs of all stakeholders and goals.



Change within the healthcare landscape requires a better understanding of the patient complexity.



HCCs should provide a complete and accurate representation of patient burden of illness and chronic disease.



Document and code all patient chronic conditions annually

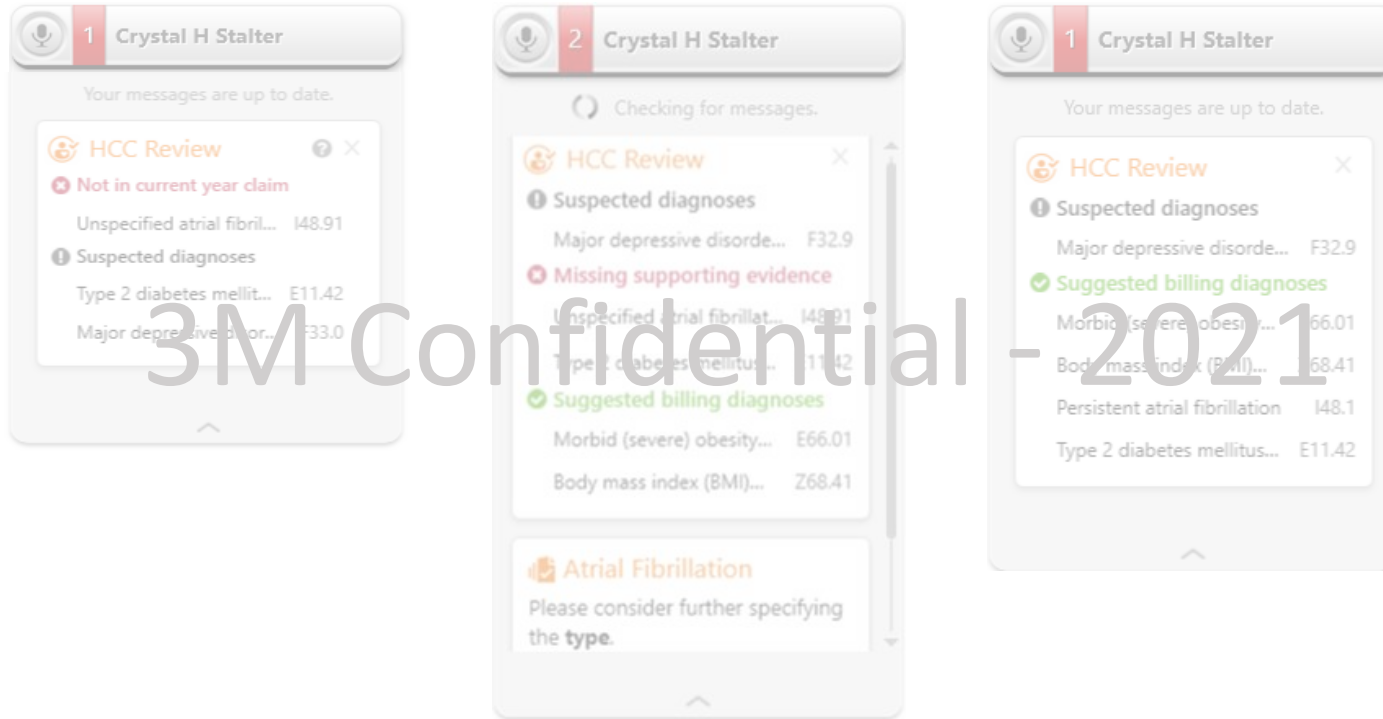


Predict health care resource utilization and drive improved population health outcomes



Ensure reimbursement appropriate for the actual level of care provided

Right information to right person at right time



Proactive Physician Engagement



- Automated, patient-specific, real-time feedback through industry leading CAPD
- Identifies and summarizes the most appropriate ICD-10 codes based on patient history and current documentation
- Ensure documentation compliance, billing accuracy, and appropriate patient severity of illness scores – the first time!
- Ability customize additional HCC and CDI actionable messages and EHR integrations

Right information to right person at right time



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Pre- and Post-Visit CDI Review



- Prioritized worklist based on RAF gaps, outpatient visit schedule, HCC opportunities
- NLU evidence sheets summarize findings from clinical documentation and claims in order to streamline longitudinal medical record reviews
- Workflow for sending automated provider notifications and reviewing compliance post-visit and before final billing
- Tools for follow-up and retrospective analysis by CDI, coding, quality, and population health

Operationalize data focused on proxy measures



Utilization Monitoring

CDS and provider scorecards, daily and weekly reports detailing activity in HCC Engage and HCC Collaborate to trend activity and monitor for those in need of retraining

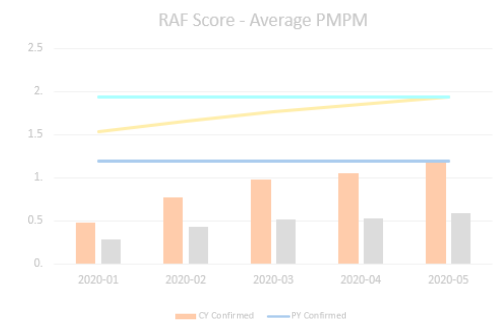
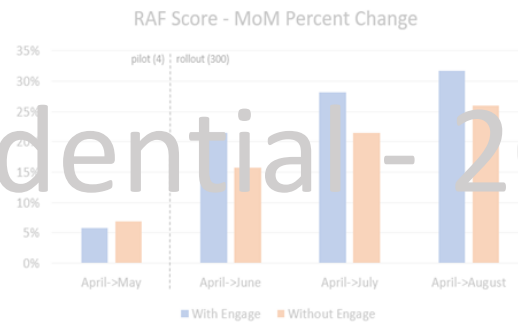
Action Reports

Detailed information focused on specific follow up opportunities to drive RAF capture, reconfirmation rate and audit risk mitigation

Outcomes Analysis

Monthly and year-over-year tracking of progress compared to baseline and trends in cohort groups (payer, provider, location)

DOB	GENDER	HCC	HCC DESCRIPTION	ICD-10	ICD-10 DESCRIPTION	RAF SCORE	DATA SOURCE
11/22/1936	F	19	Diabetes without chronic	E11.9	Diabetes Type II, unspec	0.121	claim
11/22/1936	F	96	Specified Heart Arrhythmias	I48.91	chronic atrial fibrillation	0.224	claim
11/22/1936	F	18	Diabetes with chronic complication	E11.42	type II diabetes with peripheral	0.441	claim
11/22/1936	F	58	Major Depressive, Bipolar and	F32.0	Major depressive disorder, single	0.271	documentation
11/22/1936	F	96	Specified Heart Arrhythmias	I48.91	chronic atrial fibrillation	0.224	documentation
11/22/1936	F	18	Diabetes with chronic complications	E11.42	type II diabetes with peripheral	0.441	claim
11/22/1936	F	87	Unstable angina and other Acute	I25.110	Coronary atherosclerosis	0.397	claim
1/1/1944	M	85	Congestive Heart Failure	I11.0	Hypertensive heart disease with	0.377	documentation
1/1/1944	M	11	Colorectal, Bladder and Other CA	C18.0	Malignant Neoplasm of Cecum	0.301	claim
1/1/1944	M	85	Congestive Heart Failure	I50.32	chronic diastolic heart failure	0.323	claim
1/1/1944	M	96	Specified Heart Arrhythmias	I48.2	chronic atrial fibrillation	0.268	claim
1/1/1944	M	75	Myesthenia Gravis	G62.82	diation-induced polyneuropathy	0.369	documentation
1/1/1944	M	85	Congestive Heart Failure	I50.32	chronic diastolic heart failure	0.191	claim
1/1/1944	M	11	Colorectal, Bladder and Other CA	C18.0	Malignant Neoplasm of Cecum	0.293	claim
3/17/1955	F	77	Multiple Sclerosis	G35	Multiple Sclerosis	0.441	claim
3/17/1955	F	135	Acute Renal Failure	N18.4	CKD Stage 4	0.422	claim

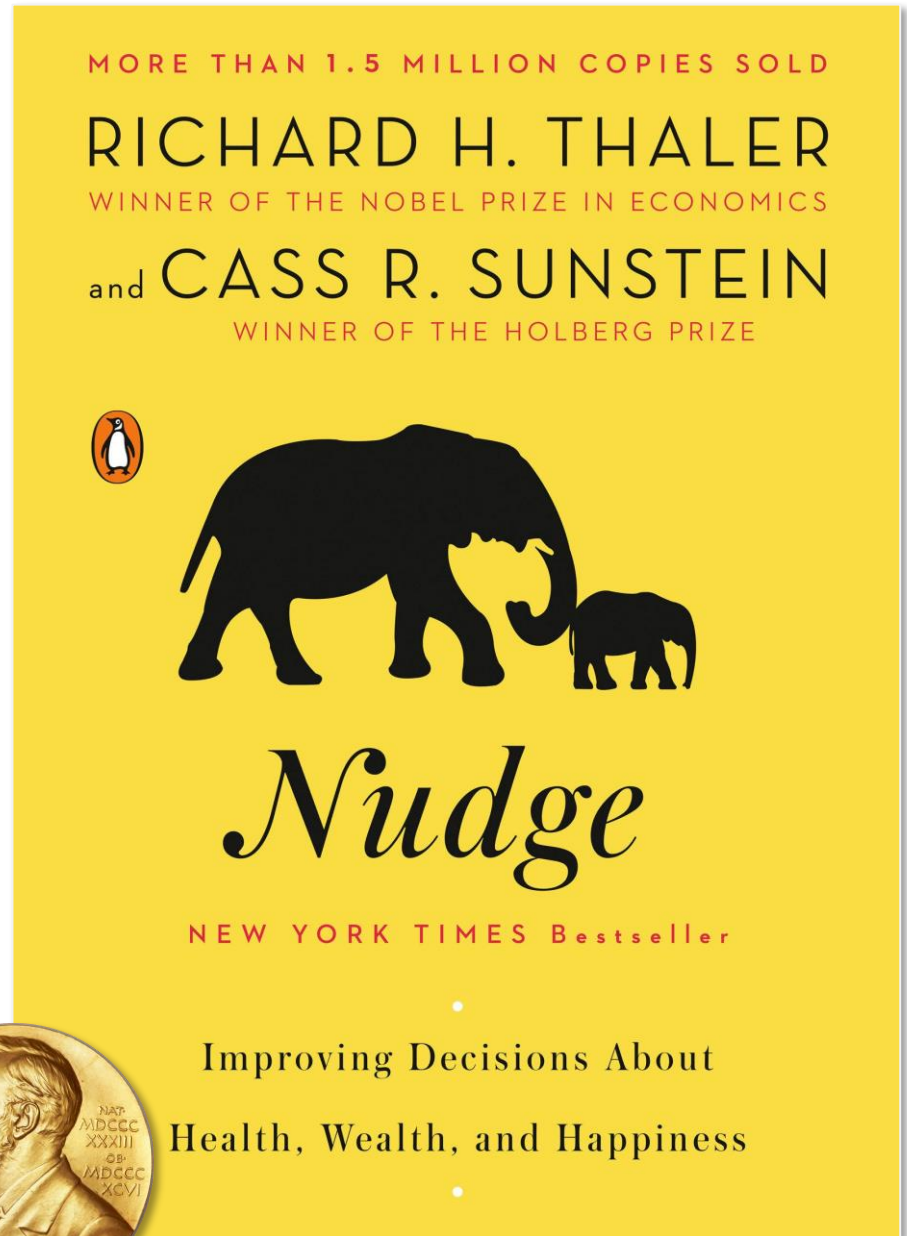


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Nudge Theory:

By presenting options with relevant information at the right time, **people make wiser decisions** without losing their freedom of choice.

A *nudge* [...] is any aspect of the choice architecture that *alters people's behavior in a predictable way without forbidding any options or significantly changing their economic incentives* [...] To count as a nudge, the intervention must be *cheap and easy to avoid*.



HCC Management: Leveraging technology and data to scale process and drive outcomes

Process	<ul style="list-style-type: none">OCDI review of the highest priority patients and HCC opportunitiesMake the longitudinal HCC chart review process efficient, automatedShift from retrospective analysis to proactive outreach and supportEnsure patient diagnosis are captured as specifically as possibleHighlight areas for ongoing improvement throughout the year
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Outcomes	<ul style="list-style-type: none">Reviews are completed timelier, with improved productivity and coverageImprove efficiency for physicians and CDI to close HCC gapsDrive data quality for improved care and communicationEnsure patient RAF scores are accurate and appropriateSupport the shift from acute response to chronic disease
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3M M*Modal HCC Management

3M M*Modal HCC Management is a technology driven solution that leverages artificial intelligence (AI) to uncover clinical insights that support appropriate risk adjustment. Integrated into a workflow for both physicians and outpatient clinical documentation integrity specialists, HCC Management provides –

- Proactive, real-time, automated provider feedback
- Prioritized patient chart review (pre- and post-visit)
- Detailed analytics for comprehensive analysis

This unique solution presents healthcare providers up-to-date visibility into the population, supporting the annual capture of HCC diagnoses, in order to accurately represents a patient's burden of illness across the care continuum.



3M M*Modal HCC Management

Goals

- ❑ **Save physicians and CDI time** – leverage technology to drive efficiency, reduce redundancy, and eliminate waste
- ❑ **Optimize program workflow** – ensure reviews focus on greatest opportunities to drive outcomes (clinical and financial)
- ❑ **Capture accurate RAF scores** – support the most appropriate risk-based reimbursement that represents actual burden of illness
- ❑ **Lead improvements in healthcare** – support the shift from volume (FFS) to value (pop health management)
- ❑ **Drive higher quality data capture** – enable improved patient care and communication with data that reflects care provided



THANK YOU

