HCCs and Star-Ratings: An IPA’s Successful Approach to Revenue Integrity

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Agenda

• Introduction

• HCCs (Hierarchical Condition Categories)
  – Diagnosis coding
  – Physician documentation

• Five Star Ratings
  – Award quality-based payments to Medicare Advantage plans

• St. Joseph Hospital Affiliated Physicians’ (SJHAP) approach
  – Best practices for successful physician documentation and performance improvement

• Kaiser Permanente Colorado’s approach
Introduction

• Focus on measurements of evidence-based medicine outcomes

• Likely transition of fee-for-service payment model to reflect severity of illness and medical practice outcomes

• The impact of physician documentation and diagnosis coding practices will increase exponentially with the implementation of HCCs and Star-Ratings programs
HCC’s
Medicare Advantage - Risk Adjustment

- 13.1 million people, 27% of all Medicare beneficiaries are enrolled in Medicare Advantage - Risk Adjusted plans

- HCC model categorizes diagnosis codes into disease groups that are similar
  - Clinically
  - Financially

- Payments are higher for sicker members and lower for more healthy members
This really doesn’t impact me...

EXHIBIT 2
Share of Medicare Beneficiaries Enrolled in Medicare Advantage Plans, by State, 2012

National Average, 2012 = 27%

NOTE: Includes cost and demonstration plans, and enrollees in Special Needs Plans as well as other Medicare Advantage plans.
HCC’s

• Certain ICD-9-CM diagnosis codes are used as to determine severity of illness, risk, and resource utilization

• HCCs classify
  – Disease processes
    • Infections
    • Cancers
  – Specific body systems e.g.,
    • Endocrine
    • Cardiac/Circulatory
    • Pulmonary
    • Renal
HCC’s

• Each HCC possesses a risk adjusted factor (RAF) that is used to determine payment
• One Medicare Advantage enrollee may have multiple HCCs; some of which have compounded payment value
• HCC model heavily influenced by costs associated with chronic disease
HCC distribution: 72,000 Patients
## HCC’s - Examples

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>I-9 code</th>
<th>HCC</th>
<th>RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>COPD</td>
<td>496</td>
<td>096</td>
<td>0.399</td>
</tr>
<tr>
<td>CHF</td>
<td>428.0</td>
<td>080</td>
<td>0.41</td>
</tr>
<tr>
<td>Rheumatoid arthritis</td>
<td>714.0</td>
<td>038</td>
<td>0.346</td>
</tr>
<tr>
<td><strong>Diabetes mellitus</strong></td>
<td>250.00</td>
<td>019</td>
<td>0.162</td>
</tr>
<tr>
<td>Neuropathy</td>
<td>356.9</td>
<td>0.71</td>
<td>0.327</td>
</tr>
<tr>
<td>CVA</td>
<td>436</td>
<td>096</td>
<td>0.265</td>
</tr>
<tr>
<td>Hemiplegia</td>
<td>438.21</td>
<td>100</td>
<td>0.437</td>
</tr>
<tr>
<td>CA breast</td>
<td>174.9</td>
<td>010</td>
<td>0.208</td>
</tr>
<tr>
<td>CA colon</td>
<td>153.9</td>
<td>010</td>
<td>0.208</td>
</tr>
<tr>
<td>Colostomy</td>
<td>V44.3</td>
<td>176</td>
<td>0.662</td>
</tr>
</tbody>
</table>
HCC’s – Physician Documentation

• HCC RAF scores are tabulated yearly
  o The physician must examine the patient each year and compliantly document the status of all chronic and acute conditions
  o Compliant documentation requirements include:
    • Signature
    • Date
    • Patient name
    • Legibility
HCC’s – Physician Documentation

• The physician must show evidence that the patient’s condition(s) were
  • Monitored
  • Evaluated
  • Assessed
  • Treated
HCC’s

- Sites of patient encounter
  - Physician office visits
  - Emergency Department encounters
  - Hospital Outpatient encounters
  - Hospital inpatient admissions
    - Short-term (general and specialty) Hospitals
    - Religious Non-Medical Health Care Institutions (formerly Christian Science Sanatoria)
    - Long-term Hospitals
    - Rehabilitation Hospitals
    - Children’s Hospitals
    - Psychiatric Hospitals
    - Medical Assistance Facilities/ Critical Access Hospitals
### RADV – The Risks of Risk

- CMS actively involved in Risk Adjustment Data Validation (RADV) to ensure
  - Documentation supports ICD-9 diagnosis code submission
    - MEAT
    - Documentation requirements
  - Correct code has been reported
- Retraction of HCC payment shall result
Star Ratings Program
Star Rating Program Truly, P4P

• Health reform law of 2010 established the application of Star Ratings to be used to award quality-based payments to Medicare Advantage plans

• Measures Medicare Advantage health plans on a scale of 1 - 5 stars.
The Star quality ratings consist of over 50 measures found in five (5) distinct rating systems including:

- HEDIS (Healthcare Effectiveness Data and Information Set),
- CAHPS (Consumer Assessment of Healthcare Providers and Systems),
- CMS (Centers for Medicare and Medicaid Services),
- HOS (Health Outcomes Survey), and
Star Rating Program

• The overall score covers 36 different topics:

<table>
<thead>
<tr>
<th>Summary Rating of Health Plan Quality (What is this?)</th>
<th>3 out of 5 stars</th>
</tr>
</thead>
<tbody>
<tr>
<td>View previous ratings for these plans</td>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>+ Show Information</td>
<td></td>
</tr>
<tr>
<td>Staying Healthy: Screenings, Tests and Vaccines</td>
<td>⭐⭐⭐⭐</td>
</tr>
<tr>
<td>Click to view data sources</td>
<td>3 out of 5 stars</td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>+ Show Information</td>
<td></td>
</tr>
<tr>
<td>Managing Chronic (Long Term) Conditions</td>
<td>⭐⭐⭐⭐</td>
</tr>
<tr>
<td>Click to view data sources</td>
<td>3 out of 5 stars</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>+ Show Information</td>
<td></td>
</tr>
<tr>
<td>Ratings of Health Plan Responsiveness and Care</td>
<td>⭐⭐⭐⭐</td>
</tr>
<tr>
<td>Click to view data sources</td>
<td>3 out of 5 stars</td>
</tr>
<tr>
<td>View how these plans compare to Original Medicare</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>+ Show Information</td>
<td></td>
</tr>
<tr>
<td>Health Plan Members’ Complaints, Appeals, and Choosing to Leave the Health Plan</td>
<td>⭐⭐⭐⭐⭐</td>
</tr>
<tr>
<td>Click to view data sources</td>
<td>4 out of 5 stars</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>+ Show Information</td>
<td></td>
</tr>
<tr>
<td>Health Plan’s Telephone Customer Service</td>
<td>⭐⭐⭐</td>
</tr>
<tr>
<td>Click to view data sources</td>
<td>3 out of 5 stars</td>
</tr>
</tbody>
</table>
Star Rating Program

• Evidence based on claims
  – At least One Primary Care doctor Visit in the Last Year
  – Breast Cancer Screening
  – Colorectal Cancer Screening
  – Cholesterol Screening for Patients with Diabetes
  – Cholesterol Screening for Patients with Heart Disease
  – Glaucoma Testing
  – Osteoporosis Testing
  – Monitoring of Patients Taking Long-term Medications
Star Rating Program

• Evidence based on survey (CAHPS or HOS)
  – Annual Flu Vaccine
  – Pneumonia Vaccine
  – Improving or Maintaining Physical Health – patient perception
  – Improving or Maintaining Mental Health
  – Monitoring Physical Activity - conversation with physician
Managing Chronic Conditions

- Evidence based on claims
  - Osteoporosis Management
  - Diabetes Care: Eye Exam
  - Diabetes Care: Kidney Disease
  - Diabetes Care: Blood Sugar Controlled
  - Diabetes Care: Cholesterol Controlled
  - Controlling Blood Pressure
  - Rheumatoid Arthritis Management
  - Testing to Confirm COPD
Managing Chronic Conditions

• Evidence based on survey (HOS)
  – Improving Bladder Control
  – Reducing the Risk of Falling
Star Rating Program

Financial Impact

- High-quality plans rewarded with increased payment, low-quality plans penalized
- Quality Bonus of up to 5%
  - 2012 = 1.5% bonus
  - 2013 = 3% bonus
  - 2014 = 5% bonus
  - May result in increased payment of $50/member per month
- 20% plans currently qualify
  - Must have four (4) stars to qualify for bonus
Star Rating Program
Financial Impact

- Rebate incentives based number of stars
  - 10% of plans qualify for highest level (70%) – 4-5 stars
  - 60% of plans qualify for lowest level (50%) – 3 stars
  - Plans with less than 3 stars require corrective action
Star Rating Program
Financial Impact

• Fee for services moving to P4P/quality model using ACO, physician and hospital reporting/data

• Managing Chronic Conditions may be the greatest challenge
  – Getting physicians to understand scope of documentation and coding needs
  – Infrastructure practices including scheduling patient visits
  – Different approach based on structure
  – Health plan and provider (e.g. Kaiser)
  – Medical group
  – Independent Physician Association (IPA) Bonus if measures are met?
Star Rating Program:
2013 Ratings

Group Health Plan Inc: *Minnesota and Wisconsin*

Group Health Cooperative: *Washington state*

Gundersen Lutheran Health System Inc: *Wisconsin*

Baystate Health Inc.'s Health New England: *Massachusetts*

Kaiser Foundation Health Plans:
- California
- Hawaii
- Colorado
- Oregon/Washington,
- Ohio
- Mid-Atlantic region.

*Nine Medicare Advantage Plans Receive Five-Star Ratings in 2012, CMS Data Show* Wednesday, October 19, 2011

found at: http://www.bna.com/nine-medicare-advantage-n12884903928/
POP QUIZ: Name the only Medicare Advantage Program in the Nation to get a 5 Star rating for the past 3 years.

ANSWER: Kaiser Permanente: Colorado Region
Proposed Changes to 2014: Examples

- Medication Therapy Management (MTM) program measures related to comprehensive medication reviews (CMR) (Part D) – Grievance rate per 1,000 enrollees (Part C and D)

- Serious reportable adverse events (Part C) – would include SRAEs and HACs

- SNP Care Management Measure (Part C SNPs)
The SJHAP Experience
The SJHAP Philosophy

The Goal of the 5 Star Program at St. Joseph’s is to ensure that members receive a complete and comprehensive health assessment at least once per year that includes a focus on both preventive screenings and chronic care evaluation and management.
The SJHAP Challenges

- Altruistic goals
- IPA network model
- Extensive senior panel
- Multiple Medicare Advantage plan contracts
- No common EHR platform
- Capitation environment does not promote encounter submissions
The SJHAP Process for Improvement

• Experience with IHA P4P measures extremely beneficial
• Patient Registry = ASCENDER
• Concentration on particular measures
• Engage the senior patients
• Passport to Wellness
• Host Senior health fairs w/screenings
The SJHAP Process for Improvement

- Marketing / informational collateral material in MD offices
- Incentivize the MD office staff
- Educate MDs via email, fax, live during PCP meetings held quarterly
- Small steps = success stories
- Utilize Patient Education Dept.
- AUDIT – AUDIT - AUDIT
The SJHAP Results/Experience

• Rankings with 3 MA plans >3 Stars
• Improved Patient Satisfaction scores
• Use of HQPAF tools improves data capture
• Greater number of seniors seen annually for physical
• MDs expanded their use of screening tools
The KPCO Experience
The KPCO Challenges

- Altruistic goals
- Network Model is expanding with our need to care for groups across the state of Colorado
- 72,000 Medicare Advantage Members
- 68,000 on same EMR platform
- Encounter Diagnoses ≠ Audited Diagnoses
- Full Data Encounter Required for Diagnosis Capture
- Limits number of diagnoses
- We now have to process 4,000+ internal claims/day
The KPCO Process for Improvement

- Medicare Refresh
- Deleted Diagnosis Reconciliation
- Data Mining
  - “Depression 311” on Antidepressant
  - History of Breast Cancer on Tamoxifen
- EMR tools to capture appropriate documentation
- CDI: doctor to doctor discussions and queries
The KPCO Results/Experience

Proactive Assessment of Total Health & Wellness to Add Active Years for Seniors

- Proactive, interdisciplinary, regional outreach program to screen and address Geriatric issues
- Significant improvements in quality metrics for falls and urinary incontinence
- Implemented novel strategies for capturing and automatically scoring the Medicare total health assessment (THA)
**PATHWAAY for Seniors Workflows**

**Prior to office visit**

Initiate THA collection via KP.org or IVR when the visit is scheduled.

**In Clinic**

Provider reviews PPP letter and QST note, acts on the information and/or encourages follow-up with appropriate health care staff.

**Prior to Office Visit**

THA responses scored, PPP letter created in Health Connect, and positive triggers referred to support team.

**In Clinic**

Staff in clinic see message on schedule to "print PPP" and any other pre-visit needs (Orthostatic BP, PVR, Adv Directive book, etc.)
Case Example: “Trifecta Ted”

95 yr old Man

THA completed

**Positive for falls, UI, & PHQ2

Visit:
- Orthostatics (coded)
- Decreased Propranolol
- D/C tamsulosin
- Start finasteride
- Noted neg UA
- Emphasized fall prevention

SAC Phone Outreach:
- Vit D done, B12 ordered
- Check orthostatic BP at visit
- Declined falls class
- PHQ 9 = 7; self-help info mailed
- UA Ordered, Info/video mailed

Pharmacy Review Suggestions
- Drop propranolol dose
- Assure tamsulosin QHS

CHART REVIEW:
PLANNED CARE QST
### Positive triggers for referral: Nutrition, Falls, UI, Mood, Pain, or Frailty

N=7896 (20% KP.org, 75% IVR, 5% HC)*

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>Any Positive</td>
<td>67%</td>
</tr>
<tr>
<td>1</td>
<td>32%</td>
</tr>
<tr>
<td>2</td>
<td>21%</td>
</tr>
<tr>
<td>3+</td>
<td>14%</td>
</tr>
<tr>
<td>High Risk Nutrition Screen (6+)</td>
<td>6%</td>
</tr>
<tr>
<td>Fall Risk</td>
<td>40%</td>
</tr>
<tr>
<td>Urinary Incontinence</td>
<td>38%</td>
</tr>
<tr>
<td>Mood Screen Positive (PHQ2 and/or GAD2)</td>
<td>11%</td>
</tr>
<tr>
<td>Pain Interfering with Function</td>
<td>9%</td>
</tr>
<tr>
<td>Frailty</td>
<td>7%</td>
</tr>
</tbody>
</table>

*Low percentage of KP.org data collection related to technical problem where KP.org not offered for >4wks following KPCO HC upgrade; prior work shows about 50% complete via KP.org and 50% via IVR*
KPCO PATHWAAY Lessons Learned

• KP.org and IVR are optimal methods of THA collection
• Patients consider the THA to be an added value
• Multidisciplinary approach is crucial
• Prescreening improves provider satisfaction
• Persistent communication is needed for cultural change at the clinic level
Putting It All Together

• Clinical documentation improvement
  – Historic focus on inpatient/hospital documentation for DRG purposes
  – Future for all points of service as emphasis on coded data and physician documentation will impact financial viability for payers and providers

• And don’t forget about I-10!
Questions?
Proactive Assessment of Total Health & Wellness to Add Active Years for Seniors

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