Welcome! The webinar will begin shortly.

For audio: Use your computer mic and speakers or call (631) 992-3221 and enter code 157-476-305.

To ask questions: Use the chat function
Next Month’s Webinar

MIPS Reporting in 2018: What to Expect & How To Prepare

Presenters:
Gail Mazzone
Rachel Crowe

Tuesday, March 20, Noon
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Today’s Presenters

Karen Waycott, CPC, PCMH CCE
Program Manager, Advanced Primary Care
MaineHealth

Brett Loffredo, MD
Director, Provider Revenue Cycle Initiatives
Maine Medical Partners
But First . . .

Jeffrey Aalberg, MD
Chief Medical Officer
MaineHealth ACO
Annual Wellness Visits can impact care coordination, safety and reliability, engagement and loyalty.

Good clinical documentation will improve communication, increase recognition of comorbid conditions that are responsive to treatment, validate the care that was provided and show compliance with quality and safety guidelines.

Help prevent or delay onset of chronic disease, lessen associated complications, reduce functional limitations and help to lower cost of treating chronic disease.

Older adults who obtain preventive services and practice health behaviors are more likely to stay healthy and functionally independent.

Completion of an Annual Wellness Visit yearly aligns with the incentives created by CMS, to clearly document the severity of illness of our patients.
Why is this important?

They intend to continue living in their current homes for the next five to ten years!

“I have a strong sense of purpose and passion about my life and my future.”

2012, AARP The US of Aging Survey
Aging in the United States

The U.S. population 65+ is now the largest in terms of size and percent.

By 2011, 38M American’s age 65+

By 2050, it will more than double 76M+

The group grew at a faster rate than the total population between 2000 and 2010.
It’s a conversation …

“Physicians often don't have time to discuss important topics such as home safety, how to take medications, implementing advance directives and reviewing the family support system”
## Quality Improvement when AWV Occurs

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>With AWV</th>
<th>No AWV</th>
</tr>
</thead>
<tbody>
<tr>
<td>DM - Hba1c &gt;9 (18-75)</td>
<td>8%</td>
<td>13%</td>
</tr>
<tr>
<td>DM - eye Exam (18-75)</td>
<td>71%</td>
<td>60%</td>
</tr>
<tr>
<td>HTN - BP Control - BP &lt;140/90 (18-85)</td>
<td>74%</td>
<td>70%</td>
</tr>
<tr>
<td>Colon Cancer (50-75)</td>
<td>82%</td>
<td>71%</td>
</tr>
<tr>
<td>Falls Assess (65+)</td>
<td>95%</td>
<td>89%</td>
</tr>
<tr>
<td>PHQ9 Screening w/o Dx Depression (18+)</td>
<td>95%</td>
<td>83%</td>
</tr>
<tr>
<td>Tobacco Composite (18+)</td>
<td>98%</td>
<td>95%</td>
</tr>
<tr>
<td>Adult Weight Screening (18+)</td>
<td>99%</td>
<td>98%</td>
</tr>
<tr>
<td>Breast Cancer (50-74)</td>
<td>83%</td>
<td>71%</td>
</tr>
</tbody>
</table>

Wellness visits improve screening rates and thus serve to reduce cancer burden.

*Fabian, et al, 2017, Journal of Primary Care & Community Health Vol.8*
Only half of those that meet criteria are diagnosed.
SMHC Cognitive Screening Pilot

- Mini Cog Screening performed on all patients during AWV visit

22% of Patients with positive Mini-Cog results

60% Referred for MoCA

Montreal Cognitive Assessment
Fatal Falls

- Falls #1 cause of fatal injuries in 65+ population
- 27,000 (2014)
- 50% due to Traumatic Brain Injury
- Deaths have risen sharply over the past decade!
- 169 of our Maine neighbors 65+ died from a fall in 2015
• **25%** adults 65+ report a fall each year
• Less than **½ talk** to their health care provider about this

CDC, 2016 28.7% reported a fall
Advance Care Planning

37% of people have some sort of advance care plan

MH ACO Palliative Care: system wide initiative to improve rate of Advance Directives

ACP required component of Annual Wellness Visits

Check for resources in your region who are trained to assist patients in completing Advance Directives
Making Medicare Wellness Visits Work

Core Care Team Approach

Population health – proactive outreach

Clerical Support – Identify and schedule visit

Clinical Support – Pre-visit planning w/ standing orders, Health Risk Assessment (HRA), Update Care Team, perform depression, fall risk and cognitive screenings, safety questions and advanced directives

Provider – Creates personal care plan based on HRA and Screenings
Resources, Guidelines and Protocols

Includes “Best Practice” workflows to support Care Team Model

Mainehealth.org/awv

Medicare Wellness Visit

Medicare beneficiaries are eligible for an Annual Wellness Visit that focuses on establishing and maintaining a personalized prevention plan. Unlike the physical exam, the Medicare Wellness Visit is an opportunity for the provider and the patient to have a conversation about important topics such as home safety, health risks, advance directives and developing a care plan.

A beneficiary is eligible for his or her first Annual Wellness Visit if he or she:

- has had Medicare Part B coverage for at least 12 months, and
- has not received either an Initial Preventive Physical Examination (IPPE or “Welcome to Medicare” visit) within the past 12 months.

See Comparing Types of Medicare Wellness Visits for details.

After the first Annual Wellness Visit, beneficiaries are eligible for subsequent Annual Wellness Visits every 12 months.

Information and Materials for the Healthcare Team

- Office Resources
- Patient Documents
- Training Videos
- References and Resources
Questions?

Chat us your questions and we’ll answer them at the end of the presentation.
The AWV is an excellent opportunity to assess the health risk of your patients.

This health risk assessment is accomplished through accurately documenting and coding all of your patients relevant diagnoses.

CMS uses some of these diagnosis codes (HCCs) to generate a risk score for our patient population, and that score determines reimbursement from federal programs.

CMS risk adjustment determines how sick a population is. The sicker the population (from their perspective), the more resources the government provides to care for those patients.

Because Medicare payments are designed essentially to be a “zero sum game”, if we are not capturing the risk of our population, funding to provide care for our patients will go elsewhere.
Why is Risk Adjustment Important?

**Quality**
Quality scores are risk-adjusted. If we document comorbidities accurately, our quality measures improve commensurately.

**Reimbursement**
Risk adjustment affects our reimbursement for all Medicare patients (MA, MSSP, MACRA)

**Panel Adjustment|Panel Management**
In the future, we will adjust our panels through risk scores to better allocate resources, including physician panel sizes
Capturing Patient Complexity Will Only Get More Important

Currently, Nearly a Third of Medicare Beneficiaries Enrolled in MA and Growing...

Percent Medicare Beneficiaries in MA, 2015

- 31%

...And CMS Has Set Aggressive Broader Targets for Transition to Risk, Value

- By 2018, expected percent of all Medicare payments tied to risk: 50%
- By 2018, expected percent of all fee-for-service Medicare payments tied to value: 90%

16.8 million Medicare beneficiaries enrolled in MA as of March 2015

Other Benefits to Enhancing Documentation Compliance

- Sets a foundation for population health and comprehensive look across care settings
- Offers helpful insight into the health of your patient panel
- Provides advantage for providers wanting to engage commercial payers in risk


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1) Includes alternative payment models built on fee-for-service architecture and population-based payment models.
2) Includes fee-for-service models with a link to quality in addition to those under the alternative payment or population-based payment models.
What is Risk Adjustment for CMS?  
The Goal is to Reflect Actuarial Burden of Plan Enrollees

**Risk Adjustment In Brief**

- Risk adjustment models are used to predict health care costs based on the relative actuarial risk of risk-based plan enrollees
- Accurate risk adjustment payment relies on comprehensive medical record documentation and diagnosis coding
- Risk adjustment was mandated under the ACA to mitigate the impacts of potential adverse selection and to stabilize premiums

**Risk Adjustment Calculation**

- **Demographic Factors**
- **Health Factors**
- **Marginal Contribution to Total Risk**

What is a Risk Score?

- **Risk Adjustment**: CMS reimburses Medicare Advantage (MA) plans based on the health status of their members. Risk Adjustment was implemented to pay MA plans more accurately for the “predicted health cost” expenditures based on Risk Adjustment Factor (RAF). The same risk adjustment methodology applies to the MSSP and MIPS, and affects quality-based reimbursement under these programs.

- **HCC - Hierarchical Condition Categories**: 79 Categories of medical conditions that map to a corresponding group of 9,500 ICD-10 diagnosis codes, pertains to ambulatory care and inpatient care.

- **RAF - Risk Adjustment Factor**: this is the risk score that is assigned to a Medicare beneficiary. The RAF is based on health conditions the beneficiary may have (specifically, those that fall within HCC categories), as well as demographic factors such as Medicaid status, gender, aged/disabled status, and whether a beneficiary lives in the community or an institution. The RAF is as relative measure of the probable costs to meet the healthcare needs of the beneficiary. **

** DEFINITION CAME FROM AAPC
Example: Impact of Diagnosis Coding

**SITUATION:**
76 Year Old Female who is both Medicare and Medicaid eligible with Diabetes, Vascular Conditions and CHF.

Assume patient has $19,000 dollars in medical expenses for services that you and your facilities (hospitals, labs, specialist) receive for providing care to this individual.

How does coding accuracy impact diagnosis and quality?
### Example: Impact of Diagnosis Coding
**Same Patient – Three Scenarios**

<table>
<thead>
<tr>
<th></th>
<th>No Conditions Coded (Patient seen for acute visits only)</th>
<th>Some Conditions Coded with Poor Specificity (Most Common)</th>
<th>All Conditions Coded Appropriately (Ideal State)</th>
</tr>
</thead>
<tbody>
<tr>
<td>76 year female</td>
<td>0.468</td>
<td>76 year female</td>
<td>0.468</td>
</tr>
<tr>
<td>Medicaid eligible</td>
<td>0.177</td>
<td>Medicaid eligible</td>
<td>0.177</td>
</tr>
<tr>
<td>Diabetes not Coded</td>
<td>DM w/o CC (HCC 19)</td>
<td>DM w/ vascular CC (HCC 15)</td>
<td>0.608</td>
</tr>
<tr>
<td>Vascular disease not Coded</td>
<td>Vascular Disease w/o CC (HCC 105)</td>
<td>Vascular Disease w/ CC (HCC 104)</td>
<td>0.645</td>
</tr>
<tr>
<td>CHF not Coded</td>
<td>CHF not Coded</td>
<td>CHF (HCC80)</td>
<td>0.395</td>
</tr>
<tr>
<td>No Disease Interaction</td>
<td>No Disease Interaction</td>
<td>Disease Interaction</td>
<td>0.204</td>
</tr>
<tr>
<td>Total RAF</td>
<td>0.645</td>
<td>Total RAF</td>
<td>1.15</td>
</tr>
<tr>
<td>PMPM Payment</td>
<td>$484</td>
<td>PMPM Payment</td>
<td>$863</td>
</tr>
<tr>
<td>Annual CMS Payment to Plan to Care for Patient</td>
<td>$5,805</td>
<td>Annual CMS Payment to Plan to Care for Same Patient</td>
<td>$10,350</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Annual CMS Payment to Plan to Care for Same Patient</td>
</tr>
</tbody>
</table>

MaineHealth Accountable Care Organization
Documenting and Coding to the highest level of specificity allows CMS to see the patient as you see them.
CMS Risk Adjustment and Quality Go Together

HCC model is about patient care

The focus of HCC is on early diagnosis, treatment, and documentation of disease and conditions

Helps to properly identify risk of individuals in a population, ensure that dollars are available for disease management programs, and pay for predicted healthcare cost of those members

Improvement in risk adjusted revenue translates to appropriate revenue from CMS available to support ongoing care and programs

This additional documentation can identify patients who can be well served through additional case management/care management services and programs
Illustration of importance of documentation on Shared Savings Arrangements:

Hypothetical patient with $7,165.39 in Medical expenses in one year

- In the Scenario of Poor Coding: Medical Expense is 217% of Revenue
  - Patient portrayed as relatively healthy, actual spending is not justified (not all diagnoses documented, use of ‘unspecified’ codes)

- In the Scenario of Good Coding: Medical Expense is 135% of Revenue
  - Patient portrayed as having a moderate illness burden, actual spending more in line with expectation but still seeming high, may not have captured disease interactions

- In the Scenario of Best Coding: Medical Expense is 85% of Revenue
  - Illness burden accurately portrayed, includes all conditions impacting medical decision making, complexity increased through documentation of disease interactions – accurate, specific, complete documentation
Annual Reset

- Health status is calculated by CMS for each calendar year to determine payer capitation.
- All diagnoses need to be re-evaluated, documented and billed for each year (no matter how permanent or chronic)

This ensures that the physician and hospital are appropriately credited for the complexity of each case.
Data Example of Challenge with HCC Drops

Percent of a Delivery System’s patients who in 2012 had the following condition and had it restated in the subsequent years.
Top HCC Risk Adjustment Errors to Look Out For

**Documentation Errors**
- Medical record does not contain legible signature, authentication
- Discrepancy exists between diagnosis codes and written description
- Does not indicate that diagnosis is being monitored, evaluated, addressed, or treated (MEAT)

**Coding Errors**
- Highest degree of specificity was not assigned the most precise ICD-10 codes to fully explain the narrative description of the symptom or diagnosis in chart
- “History of” coding used when the condition is still active

**Errors Associated with Chronic, Active Conditions**
- Chronic or coexisting conditions not documented or left out of clinical documentation
- A link or causal relationship is missing with failure to report a mandatory manifestation code

**Example Documentation Errors**
- Documenting depressive disorder (311) but coding major depressive affective disorder (296.20)
- Documenting “very obese”, not “morbidly obese”

**Example Coding Errors**
- Coding “Asthma” (493.90), not “Chronic Obstructive Asthma” (492.20)
- Coding for “history of” COPD”, not “COPD controlled w/Advair”

**Example Chronic, Active Conditions That Should Be Coded Once Per Year**
- Diabetes
- HIV
- Amputations
- CHF
- Transplants
- COPD

Common Examples of missed HCC’s:

- Hemiplegia, paraplegia, quadriplegia
- Amputation status
- Diabetic complications, +/- insulin use
- CKD Stage III and IV (diabetes and its manifestations)
- “Ostomy” status
- Morbid obesity
- CAD, CHF (systolic, diastolic, acute, chronic)
- Dialysis status; transplant status; respiratory failure
- Active cancer sites and metastatic cancer sites “not history of”
- Alcoholism in remission (drug and alcohol dependencies)
- Depression, major psychiatric disorders
What can the Care Teams do?

- Recognize that seeing all Medicare patients annually is critical to our success. The AWV is an excellent vehicle to accomplish this.
- If you have EPIC, use its functionality to help you
  - Use Health Maintenance to see when the patient is due for their Wellness Visit. If they haven’t had one, schedule one as their next visit!
- When seeing a new patient on Medicare, take the opportunity to update their problem list and submit their diagnoses at that first visit.
- Use the AWV to update all chronic conditions annually
- Enlist the care team to help us succeed
Questions?