All-CIN Physician WebEx

Quality Health Alliance
Mercy Accountable Care
Delaware Care Collaboration

November 11, 2020
6:00pm - 7:30pm
Reflection

“Our nation owes a debt to its fallen heroes that we can never fully repay.”

- Barack Obama
Trinity Health Mid-Atlantic (THMA) Clinically Integrated Network (CIN)

Regional News

Quality Health Alliance – St. Mary Medical Center
Mercy Accountable Care – Legacy Mercy Health System
Delaware Care Collaboration – St. Francis Hospital
THMA CIN Physician / Executive Leadership Team

Dan Bair
Regional Executive Director
THMA CIN

Dr. Sharon Carney
Regional Chief Clinical Officer
THMA

Dr. Benjamin Chack
President
Quality Health Alliance

Dr. Robert Monteleone
Medical Director
Delaware Care Collaboration

Dr. Wayne Miller
Medical Director
Mercy Accountable Care

Dr. Naomi McMackin
Medical Director
Quality Health Alliance
Welcome New THMA CIN Regional Directors

Brittany Danoski
Regional Director for Population Health

Mark Lewis
Regional Director for Data/Analytics
New THMA Regional Newsletter Publication

Trinity Health Mid-Atlantic
Network NEWS

October 2020

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THMA CIN Value-Based Agreements 2020

THMA* CIN VALUE-BASED AGREEMENTS

- 25% Medicare Advantage
- 25% Commercial
- 22% Medicaid
- 18% Medicare
- 9% Trinity Colleagues

THMA ATTRIBUTION PROFILE

- Risk Medicare: 20,252
- Non Risk Commercial: 19,085
- Non Risk Medicare Advantage: 11,217
- Non Risk Medicare: 7,877
- Non Risk Trinity Health Colleagues: 3,910
- Risk Medicare Advantage: 1,237

*represents QHA, MAC, and DCC as of June 2020
Medicare Shared Savings Program (MSSP) 2019 Participation Year Results

Trinity Health Integrated Care Delaware Care Collaboration
Medicare Shared Savings Program (MSSP) PY 2019 Results

- Trinity Health Integrated Care (THIC)

Savings Generated = $19.8 M

Savings Earned = $13.7 M

Quality Score = 92%
Savings Rate = 2.9%
Medicare Shared Savings Program (MSSP) PY 2019 Results

• Delaware Care Collaboration (DCC)

Savings Generated = $4.9 M

Savings Earned = 0$

Quality Score = 92%
Savings Rate = 2.2%
MSSP 2020 – COVID-19 Implications

• CMS Public Health Emergency (PHE) extended through January 20, 2021;

• MSSP 2020 Quality Metrics:
  - ACOs are accountable to participate in a CMS ACO Quality Measures Audit (GPRO) for the 2020 participation year;
  - CMS preliminary rule indicates ACOs can use the better of the 2019 or 2020 score for the 2020 participation year – NOT FINAL;

• What does this mean for Trinity Health Integrated Care (QHA & MAC) and Delaware Care Collaboration?
MSSP 2020 – COVID-19 Implications

• Trinity Health Integrated Care (THIC)
  - NO downside financial risk for 2020 participation year;
  - Entitlement to all shared savings earned in 2020 participation year;

• Delaware Care Collaboration (DCC)
  - NO progression to downside risk for 2021 participation year;
  - Entitlement to all share savings earned in 2020 participation year;
THMA CIN Quality and Care Coordination Updates

• Quality
  - 2019 GPRO Performance
  - 2021 ACO Proposed Quality Measures

• Practice Transformation
  - COVID19 & Flu

• Care Coordination
  - Advanced Care Planning COVID19
## GPRO Results 2019- DCC

### 2019 Quality Performance Report (includes 2019 and 2019-A)

**DELAWARE CARE COLLABORATION DCC LLC**

<table>
<thead>
<tr>
<th>ACO</th>
<th>Measure</th>
<th>Measure Name</th>
<th>Numerator</th>
<th>Denominator</th>
<th>DCC 2019 %Rate</th>
<th>ACO National Mean %Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>DCC</td>
<td>CARE-2</td>
<td>Falls Screening</td>
<td>282</td>
<td>301</td>
<td>93.69%</td>
<td>84.04%</td>
</tr>
<tr>
<td>DCC</td>
<td>DM-2</td>
<td>HbA1c Poor Control</td>
<td>40</td>
<td>296</td>
<td>13.51%</td>
<td>13.88%</td>
</tr>
<tr>
<td>DCC</td>
<td>HTN-2</td>
<td>Controlling High BP</td>
<td>242</td>
<td>300</td>
<td>80.67%</td>
<td>75.04%</td>
</tr>
<tr>
<td>DCC</td>
<td>MH-1</td>
<td>Depression Remission 12m</td>
<td>5</td>
<td>64</td>
<td>7.81%</td>
<td>13.58%</td>
</tr>
<tr>
<td>DCC</td>
<td>PREV-10</td>
<td>Tobacco Use (Screen/Cessation)</td>
<td>21</td>
<td>25</td>
<td>84.00%</td>
<td>78.04%</td>
</tr>
<tr>
<td>DCC</td>
<td>PREV-12</td>
<td>Depression Screening</td>
<td>267</td>
<td>295</td>
<td>90.51%</td>
<td>70.40%</td>
</tr>
<tr>
<td>DCC</td>
<td>PREV-13</td>
<td>Statin Therapy CVD</td>
<td>263</td>
<td>294</td>
<td>89.46%</td>
<td>82.17%</td>
</tr>
<tr>
<td>DCC</td>
<td>PREV-5</td>
<td>BrCa Screening</td>
<td>233</td>
<td>298</td>
<td>78.19%</td>
<td>73.84%</td>
</tr>
<tr>
<td>DCC</td>
<td>PREV-6</td>
<td>CRC Screening</td>
<td>232</td>
<td>300</td>
<td>77.33%</td>
<td>70.76%</td>
</tr>
<tr>
<td>DCC</td>
<td>PREV-7</td>
<td>Flu Immunization</td>
<td>222</td>
<td>250</td>
<td>88.80%</td>
<td>74.77%</td>
</tr>
</tbody>
</table>
GPRO Results 2019 - DCC Improvements

DCC Notable Improvements

- Falls Screening: 93.69%
- Depression Screening: 90.51%
- Controlling High BP: 80.41%

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# GPRO Results 2019 - QHA & MAC

<table>
<thead>
<tr>
<th>ACO</th>
<th>Chapter</th>
<th>Measure</th>
<th>Measure Name</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>THIC</td>
<td>Langhorne</td>
<td>CARE-2</td>
<td>Falls Screening</td>
<td>120</td>
<td>122</td>
<td>98.36%</td>
</tr>
<tr>
<td>THIC</td>
<td>Langhorne</td>
<td>DM-2</td>
<td>HbA1c Poor Control</td>
<td>22</td>
<td>125</td>
<td>17.60%</td>
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<tr>
<td>THIC</td>
<td>Langhorne</td>
<td>HTN-2</td>
<td>Controlling High BP</td>
<td>106</td>
<td>128</td>
<td>82.81%</td>
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<tr>
<td>THIC</td>
<td>Langhorne</td>
<td>MH-1</td>
<td>Depression Remission</td>
<td>1</td>
<td>13</td>
<td>7.69%</td>
</tr>
<tr>
<td>THIC</td>
<td>Langhorne</td>
<td>PREV-10</td>
<td>Tobacco Use (Screen/Cessation)</td>
<td>7</td>
<td>7</td>
<td>100.00%</td>
</tr>
<tr>
<td>THIC</td>
<td>Langhorne</td>
<td>PREV-12</td>
<td>Depression Screening</td>
<td>97</td>
<td>120</td>
<td>80.83%</td>
</tr>
<tr>
<td>THIC</td>
<td>Langhorne</td>
<td>PREV-13</td>
<td>Statin Thearpy, CVD</td>
<td>153</td>
<td>159</td>
<td>96.23%</td>
</tr>
<tr>
<td>THIC</td>
<td>Langhorne</td>
<td>PREV-5</td>
<td>BrCa Screening</td>
<td>123</td>
<td>145</td>
<td>84.83%</td>
</tr>
<tr>
<td>THIC</td>
<td>Langhorne</td>
<td>PREV-6</td>
<td>CRC Screening</td>
<td>123</td>
<td>145</td>
<td>84.83%</td>
</tr>
<tr>
<td>THIC</td>
<td>Langhorne</td>
<td>PREV-7</td>
<td>Flu Immunization</td>
<td>96</td>
<td>119</td>
<td>80.67%</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>ACO</th>
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<th>Measure</th>
<th>Measure Name</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>THIC</td>
<td>SEPA</td>
<td>CARE-2</td>
<td>Falls Screening</td>
<td>43</td>
<td>52</td>
<td>82.69%</td>
</tr>
<tr>
<td>THIC</td>
<td>SEPA</td>
<td>DM-2</td>
<td>HbA1c Poor Control</td>
<td>19</td>
<td>65</td>
<td>29.23%</td>
</tr>
<tr>
<td>THIC</td>
<td>SEPA</td>
<td>HTN-2</td>
<td>Controlling High BP</td>
<td>50</td>
<td>68</td>
<td>73.53%</td>
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<tr>
<td>THIC</td>
<td>SEPA</td>
<td>MH-1</td>
<td>Depression Remission</td>
<td>0</td>
<td>4</td>
<td>0.00%</td>
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<tr>
<td>THIC</td>
<td>SEPA</td>
<td>PREV-10</td>
<td>Tobacco Use (Screen/Cessation)</td>
<td>7</td>
<td>7</td>
<td>100.00%</td>
</tr>
<tr>
<td>THIC</td>
<td>SEPA</td>
<td>PREV-12</td>
<td>Depression Screening</td>
<td>42</td>
<td>60</td>
<td>70.00%</td>
</tr>
<tr>
<td>THIC</td>
<td>SEPA</td>
<td>PREV-13</td>
<td>Statin Thearpy, CVD</td>
<td>66</td>
<td>79</td>
<td>83.54%</td>
</tr>
<tr>
<td>THIC</td>
<td>SEPA</td>
<td>PREV-5</td>
<td>BrCa Screening</td>
<td>47</td>
<td>70</td>
<td>67.14%</td>
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<tr>
<td>THIC</td>
<td>SEPA</td>
<td>PREV-6</td>
<td>CRC Screening</td>
<td>30</td>
<td>56</td>
<td>53.57%</td>
</tr>
<tr>
<td>THIC</td>
<td>SEPA</td>
<td>PREV-7</td>
<td>Flu Immunization</td>
<td>39</td>
<td>54</td>
<td>72.22%</td>
</tr>
</tbody>
</table>
GPRO Results 2019- QHA & MAC Improvements

**QHA Noteable Improvements**

- Falls Screening: 2018 vs 2019
- Controlling High BP: 2018 vs 2019
- Tobacco Use (Screen/Cessation): 2018 vs 2019
- Statin Therapy, CVD: 2018 vs 2019

**MAC Noteable Improvements**

- Falls Screening: 2018 vs 2019
- Controlling High BP: 2018 vs 2019
- Tobacco Use (Screen/Cessation): 2018 vs 2019
- Depression Screening: 2018 vs 2019
## Proposed Quality Changes for PY2021

<table>
<thead>
<tr>
<th>Measure #</th>
<th>Measure Title</th>
<th>Collection Type</th>
<th>Submitter Type</th>
<th>Meaningful Measure Area</th>
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</thead>
<tbody>
<tr>
<td>Quality ID # 321</td>
<td>CAHPS for MIPS</td>
<td>CAHPS for MIPS Survey</td>
<td>Third Party Intermediary</td>
<td>Patient’s Experience</td>
</tr>
<tr>
<td>Quality ID # 001</td>
<td>Diabetes: Hemoglobin A1c (HbA1c) Poor Control</td>
<td>eCQM/MIPS CQM</td>
<td>APM Entity/Third Party Intermediary</td>
<td>Mgt. of Chronic Conditions</td>
</tr>
<tr>
<td>Quality ID # 134</td>
<td>Preventive Care and Screening: Screening for Depression and Follow-up Plan</td>
<td>eCQM/MIPS CQM</td>
<td>APM Entity/Third Party Intermediary</td>
<td>Treatment of Mental Health</td>
</tr>
<tr>
<td>Quality ID # 236</td>
<td>Controlling High Blood Pressure</td>
<td>eCQM/MIPS CQM</td>
<td>APM Entity/Third Party Intermediary</td>
<td>Mgt. of Chronic Conditions</td>
</tr>
<tr>
<td>Measure # TBD</td>
<td>Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups</td>
<td>Administrative Claims</td>
<td>N/A</td>
<td>Admissions &amp; Readmissions</td>
</tr>
<tr>
<td>Measure # TBD</td>
<td>Risk Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions for ACOs</td>
<td>Administrative Claims</td>
<td>N/A</td>
<td>Admissions &amp; Readmissions</td>
</tr>
</tbody>
</table>
# CPT II Codes for CMS 2021 Quality Measures

## Diabetes Hemoglobin A1c

<table>
<thead>
<tr>
<th>HbA1c level</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 7.0%</td>
<td>3044F</td>
</tr>
<tr>
<td>≥ but &lt; 8</td>
<td>3051F</td>
</tr>
<tr>
<td>8 – 9</td>
<td>3052F</td>
</tr>
<tr>
<td>&gt; 9</td>
<td>3046F</td>
</tr>
</tbody>
</table>

## Screening for Depression

<table>
<thead>
<tr>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>3725F</td>
</tr>
</tbody>
</table>

## Controlling High Blood Pressure

<table>
<thead>
<tr>
<th>Systolic</th>
<th>Code</th>
<th>Diastolic</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 130</td>
<td>3074F</td>
<td>&lt; 80</td>
<td>3078F</td>
</tr>
<tr>
<td>between 130-139</td>
<td>3075F</td>
<td>between 80-89</td>
<td>3079F</td>
</tr>
<tr>
<td>≥ 140</td>
<td>3077F</td>
<td>≥ 90</td>
<td>3080F</td>
</tr>
</tbody>
</table>
COVID19 + Flu
COVID-19 Early Warning Monitoring System Dashboard

Updated on 11/6/2020

Pennsylvania

+2,503
Confirmed cases (diff.)

124.8
Incidence rate per 100,000 (curr.)

6.9%
PCR percent positivity (curr.)

+264.8
Avg. daily hospitalizations (diff.)

+14.6
Avg. daily ventilators (diff.)

0.9%
Hosp. visits due to COVID (curr.)

diff. - difference between the most recent 7-day period and the previous 7-day period.
curr. - most recent 7-day period

Most recent 7-day period: October 30 - November 5
Previous 7-day period: October 23 - October 29

For detailed county progress hover over the metric.

¹https://www.health.pa.gov/topics/disease/coronavirus/Pages/Monitoring-Dashboard.aspx
Comparison of PA Influenza Cases in Current Season to the Eight Previous Seasons

¹https://www.health.pa.gov/topics/disease/Flu/Pages/2020-21-Flu.aspx
## COVID19 vs Flu

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Coronavirus (COVID-19)</th>
<th>Influenza (FLU)</th>
<th>Cold</th>
<th>Seasonal Allergies</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Symptoms range from mild to severe</td>
<td>Abrupt onset of symptoms</td>
<td>Gradual onset of symptoms</td>
<td>Symptoms improve or worsen depending on environment</td>
</tr>
<tr>
<td>Fever</td>
<td>Often</td>
<td>Often</td>
<td>Rare</td>
<td>Sometimes</td>
</tr>
<tr>
<td>Fatigue</td>
<td>Sometimes</td>
<td>Sometimes</td>
<td>Sometimes</td>
<td>Often</td>
</tr>
<tr>
<td>Cough</td>
<td>Often (usually dry)</td>
<td>Often (usually dry)</td>
<td>Mild</td>
<td>Often</td>
</tr>
<tr>
<td>Sneezing</td>
<td>No</td>
<td>No</td>
<td>Often</td>
<td>Often</td>
</tr>
<tr>
<td>Aches &amp; Pains</td>
<td>Sometimes</td>
<td>Often</td>
<td>Often</td>
<td>No</td>
</tr>
<tr>
<td>Runny or Stuffy Nose</td>
<td>Rare</td>
<td>Sometimes</td>
<td>Often</td>
<td>Often</td>
</tr>
<tr>
<td>Sore throat</td>
<td>Sometimes</td>
<td>Sometimes</td>
<td>Often</td>
<td>No</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Rare</td>
<td>Sometimes in Children</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Headaches</td>
<td>Sometimes</td>
<td>Often</td>
<td>Rare</td>
<td>Sometimes</td>
</tr>
<tr>
<td>Shortness of breath/</td>
<td></td>
<td>Rare</td>
<td>Rare</td>
<td>Rare</td>
</tr>
<tr>
<td>Difficulty breathing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of taste and smell</td>
<td>Often</td>
<td>Rare</td>
<td>Rare</td>
<td>Rare</td>
</tr>
</tbody>
</table>
Flu/COVID19 Testing Algorithm

1. Patient presents with Flu/COVID Symptoms
   - Acute COVID19 infection in previous 3 months?
     - Yes
       - Flu prevalent in the community?
         - Yes
           - Test for Flu
         - No
           - Consider alternative diagnosis
     - No
       - Flu prevalent in the community?
         - Yes
           - Test for Flu/COVID19
         - No
           - Test for COVID19

Note: Please follow your local/state requirements for testing if they are more stringent
• **Patient Collateral** developed to help patients seek care in appropriate setting based off symptoms (➔)

• Partner with your patients to **mitigate** community spread

• Focus on inappropriate ED visits for **ambulatory conditions & chronic disease management** to prevent future inpatient admissions

• Ensure office access for same day/next day visits and education to patients to **call your office** for help deciding where to seek care.
COVID Alert PA app

- App uses anonymous Bluetooth low technology to know when your phone is within 6 feet of another phone with the app for 15 minutes or more.
- When an app user confirms a positive COVID-19 test result in the app, it will check to see if it matches any of the anonymous Bluetooth close contact interactions your phone has had over the last 14 days.
- If there is a match, COVID Alert PA may send an alert after taking into account the date, duration of exposure, and the Bluetooth signal strength.
THMA CIN Regional Care Coordination Leadership Team
THMA CIN Care Coordination Leadership Team

Christine Falcone, MHA, BSN, RN, CPHQ
Vice President of Quality, Safety, and Care Transformation

Rhonda Meredith, BSN, RN, CCM, Director of ACO Care Coordination, Delaware Care Collaboration

Allison Patzek, MSN, RN, CCRN-K
Director of Ambulatory Care Coordination, North Region

Tanya Vogel, MSN, RN
Director of Acute and Ambulatory Care Integration
- Ensure patients receive the care they want, aligning the care that is delivered with patients’ values and goals.
- Know that patients most likely to develop severe illness will be older and have greater burden of chronic illness.
- Have the relationships with patients and families while hospitalist/intensivists are tasked with urgent decisions in a crisis.
- Best understand how visitor restrictions create communication challenges with patients and their loved ones.

¹The Importance of Addressing Advance Care Planning and Decisions About Do-Not-Resuscitate Orders During Novel Coronavirus 2019 (COVID-19)
J. Randall Curtis, MD, MPH, Division of Pulmonary, Critical Care, and Sleep Medicine, University of Washington, Seattle; and Cambia Palliative Care Center of Excellence, University of Washington, Seattle
Erin K. Kross, MD, Division of Pulmonary, Critical Care, and Sleep Medicine, University of Washington, Seattle; and Cambia Palliative Care Center of Excellence, University of Washington, Seattle
Renee D. Stapleton, MD, PhD
Larner College of Medicine, Division of Pulmonary and Critical Care Medicine, University of Vermont, Burlington
Advance Care Planning During COVID 19

• Ambulatory Care Managers have been trained in ACP and Serious Illness conversation
• ACP quality measure for BPCI-A
• Newsletter contains education on documentation and coding opportunities

¹The Importance of Addressing Advance Care Planning and Decisions About Do-Not-Resuscitate Orders During Novel Coronavirus 2019 (COVID-19)
J. Randall Curtis, MD, MPH, Division of Pulmonary, Critical Care, and Sleep Medicine, University of Washington, Seattle; and Cambia Palliative Care Center of Excellence, University of Washington, Seattle
Erin K. Kross, MD, Division of Pulmonary, Critical Care, and Sleep Medicine, University of Washington, Seattle; and Cambia Palliative Care Center of Excellence, University of Washington, Seattle
Renee D. Stapleton, MD, PhD
Larner College of Medicine, Division of Pulmonary and Critical Care Medicine, University of Vermont, Burlington
Guidance Regarding Best Practices for Prescription Medication and Refill Requests and Prescribing of Chronic Regimens of Controlled Substances

Presented by Dr. Robert Monteleone
Medical Director of Delaware Care Collaboration

Development of Guidance in part by:
Kristina Mazzie, PharmD
Population Health Pharmacist
Mercy Accountable Care
Summary of Guidance for Refill and Prescription Requests

Education
▪ Informing and educating staff and patients of the refill policy should be a priority

Process of Patient Prescription and Refill Requests
▪ Refills should be requested at patient’s office visit or via office refill line during normal business hours
▪ Ninety-day supplies should be prescribed whenever possible
▪ Prescribing should primarily be performed electronically
▪ Requests should be checked at least twice a day

Denial of Patient Prescription and Refill Requests*
▪ Reasons would include:
  1. not being seen by provider in last 6 months
  2. if request is for a medication not previously prescribed by provider
▪ If an appointment is needed, it should be scheduled for patient within 72hrs of request

* Exceptions to this policy are allowable per provider on a case by case basis.
Summary of Guidance for Prescribing of Chronic Regimens of Controlled Substances

New Patients, Initiation of Therapy and Controlled Substance Agreements
- New patients are required to give informed consent and submit their prior health records
- Opioid Risk Assessment and urine drug screen should be performed
- Controlled substance agreements are required for regimens >7 days

Usage of Prescription Drug Monitoring Program (PDMP)
- Prescribers must continue to query the PDMP before therapy initiation and for every therapy renewal
- Prescribers must be registered with the PDMP in each state they are licensed to practice

Clinician Guided Monitoring for Continuation of Therapy
- Periodic fluid drug screens should be completed at least every 12 months in PA and every 6 months in DE
- Patients should be available for monitoring requests within 24hrs
Summary of Guidance for Prescribing of Chronic Regimens of Controlled Substances

Procedure for Handling of Prescription Refills and/or Renewal Requests

- Patients should be seen once every 3 months by telehealth or in-person visit before renewal is approved.
- At the patient’s office visit, a prescription for CII medications can only be written for a thirty-day supply.
- CIII-CV prescriptions can be written for up to a ninety-day supply.
- Prescription renewal requests for CII medications should be requested by the patient for the 2nd and 3rd prescriptions by phone to the office staff or via refill phone extension.

Discontinuation and Tapering of Ongoing Therapy

- Tapering should not occur at a rate greater than 25% per week, in order to minimize serious risk of withdrawal.

Monitoring of Clinician Compliance with Prescribing, and Patient Surveillance

- Random audits of compliance should be performed by the compliance department or the network’s corporate staff.
Clinical Condition Documentation/
Hierarchical Condition Category (HCC)
Coding

Wayne G. Miller, D.O., M.P.H.
Medical Director
Mercy Accountable Care
Importance of Focusing on Clinical Condition Documentation (CCD) Education

• The move from FFS to Value-Based Care makes it increasingly important for providers to properly document the disease burden of their patients.

• CCD educational efforts are geared toward helping assure that the codes being used on claims help payers accurately risk adjust patients.

• This will result in both more accurate forecasting of benchmarks in CMS shared savings programs and more accurate reimbursement in Medicare Advantage and other commercial programs.
What do you see?
How many lives are we talking about for our Clinically Integrated Network?

Approximately 28,000 Attributed Medicare Patients
Risk Adjustment Factor (RAF) and Methodologies
CMS-HCC model

- 70,000 ICD-10 Codes (Conditions)
- 9,500 ICD-10 codes require increased costs to manage
- Conditions grouped into Hierarchical Condition Categories (HCC)
  - Similar conditions
  - Similar resource needs

70,000 ICD-10 Codes (Conditions)

9,500 ICD-10 Codes with increased resource intensity

86 HCCs
## CMS-HCC model

<table>
<thead>
<tr>
<th>ICD-10-CM codes</th>
<th>HCC category description</th>
<th>HCC</th>
<th>Disease Hierarchy</th>
</tr>
</thead>
<tbody>
<tr>
<td>E08.0-, E08.1-, E08.641, E09.0-, E09.1-, E09.641, E10.1-, E10.641, E11.0-, E11.1-, E11.641, E13.0-, E13.1-, E13.641</td>
<td>Diabetes with acute complications</td>
<td>17</td>
<td>18, 19</td>
</tr>
<tr>
<td>E08.9, E09.9, E10.9, E11.9, E13.9, Z79.4</td>
<td>Diabetes without complication</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>I85., K70.41, K71.11, K72.01-K72.91, K76.6, K76.7, K76.81</td>
<td>End-stage liver disease</td>
<td>27</td>
<td>28, 29, 80</td>
</tr>
<tr>
<td>K70.30-K70.9, K74.3-K74.69</td>
<td>Cirrhosis of liver</td>
<td>28</td>
<td>29</td>
</tr>
<tr>
<td>B18., K73., K75.4</td>
<td>Chronic hepatitis</td>
<td>29</td>
<td></td>
</tr>
</tbody>
</table>
How is risk score (RAF) calculated?

Baseline Patient Demographics + HCCs Coded with Weights = PATIENT RISK SCORE (RAF)

RAF: Risk Adjustment Factor; HCC: Hierarchical Condition Categories
Where does each patient stand?

**Risk Score**

- **< 1**
  - Costs **LESS** to provide proper care to these patients

- **= 1**
  - **AVERAGE** cost to care for these patients

- **> 1**
  - Costs **MORE** to give proper care for these patients

*Important to note that CMS rebases what “1” is every year based on all Medicare beneficiaries and their risk score*
Patient Comparison

66 Years Old
Female
HTN
Below Average RAF

87 Years Old
Male
CHF + DM
Above Average RAF
Providers want to provide the best care for their patients.

Providers want to properly document the disease burden of their patients.

Providers are not specifically trained in diagnostic coding.
Documentation Elements
The sooner, the better

**Yearly**- Document chronic conditions at least once annually

**Linkage**- clarify any complications that relate to chronic conditions

**MEAT**- add supporting documentation for each chronic condition assessed

Excellent Documentation
The documentation done in 2020 directly impacts 2021

2020 Risk Score Set by 2019 Diagnoses

2021 Risk Score Set by 2020 Diagnoses

The work we do today directly impacts next year’s risk score and reimbursement

HCCs must be reconfirmed on an annual basis
Medical complications can result from a long-standing, under-controlled primary condition. In these cases, the complication is assumed to have resulted from the primary condition. The patient's encounter diagnosis should reflect the connection between the primary and secondary conditions.

The most common assumed relationship are:

- Diabetes with complications
- Hypertension with heart failure or kidney failure
Remember this acronym

**Monitor**

**Evaluate**

**Assess/Address**

**Treat**

**MEAT** is an easy acronym for remembering what suffices as supporting documentation.

Only one of the elements needs to be present for a coded condition.
<table>
<thead>
<tr>
<th>Essential Concepts</th>
<th>What is MEAT?</th>
</tr>
</thead>
</table>
| **Monitor**        | • How is the individual doing?  
|                    | • Are there any signs or symptoms?  
|                    | • Conceptually represents ongoing surveillance of the condition(s) |
| **Evaluate**       | • What is the current state of the condition?  
|                    | • What is the provider’s judgement of the condition currently?  
|                    | • For example: *the review of results or the treatment outcomes*. |
| **Access**         | • How will the conditions(s) be evaluated or estimated?  
|                    | • For example: *documentation of prior records review, counseling, or ordering further studies* |
| **Treat**          | • What care is being offered or what is being done to help the patient with the condition(s)?  
|                    | • For example: *medication, diagnostic study, or therapeutic service*. |
What are acceptable locations for MEAT documentation?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔ History of present illness</td>
<td>X Past medical history</td>
</tr>
<tr>
<td>✔ Review of symptoms</td>
<td>X Surgical history</td>
</tr>
<tr>
<td>✔ Physical exam</td>
<td>X Problem list</td>
</tr>
<tr>
<td>✔ Assessment</td>
<td>X Medication list</td>
</tr>
<tr>
<td>✔ Plan</td>
<td></td>
</tr>
<tr>
<td>✔ Treatment</td>
<td></td>
</tr>
</tbody>
</table>
Assessment and Plan with Opportunities

- Type 2 Diabetes with retinopathy - refill meds and continue follow up with Ophthalmologist, Dr. Smith. Diabetic retinopathy education is provided.
- Hypertension - controlled, continue meds
- Recurrent depression, mild - Stable on citalopram, symptoms are improving
- Morbid obesity - Diet and exercise information given and discussed
Assessment and Plan with Opportunities

• Congestive heart failure, diastolic, chronic- this is not due to hypertension. Patient is tracking salt intake and has quit smoking.
• Hypertensive chronic kidney disease-patient is compliant with ACE inhibitor and has been referred to nephrology with new diagnosis of stage 5 CKD.
• History of breast cancer-patient had a double mastectomy and is currently completed all treatment. Originally diagnosed in 1995.
It all boils down to this!

<table>
<thead>
<tr>
<th>Clinical Factor</th>
<th>Weight</th>
<th>Clinical Factor</th>
<th>Weight</th>
<th>Clinical Factor</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>76 year old female</td>
<td>0.468</td>
<td>76 year old female</td>
<td>0.468</td>
<td>76 year old female</td>
<td>0.468</td>
</tr>
<tr>
<td>Medicaid Eligible</td>
<td>0.177</td>
<td>Medicaid Eligible</td>
<td>0.177</td>
<td>Medicaid Eligible</td>
<td>0.177</td>
</tr>
<tr>
<td>DM not coded</td>
<td>0</td>
<td>DM, type 2</td>
<td>0.121</td>
<td>DM with CKD</td>
<td>0.667</td>
</tr>
<tr>
<td>CKD not coded</td>
<td>0</td>
<td>CKD, stage 4</td>
<td>0.23</td>
<td>CKD, stage 4</td>
<td>0.23</td>
</tr>
<tr>
<td>Use of insulin not coded</td>
<td>0</td>
<td>Use of insulin not coded</td>
<td>0</td>
<td>Long term use of insulin</td>
<td>0.121</td>
</tr>
<tr>
<td>COPD not coded</td>
<td>0</td>
<td>COPD not coded</td>
<td>0</td>
<td>COPD</td>
<td>0.355</td>
</tr>
<tr>
<td>Interaction of COPD + DM</td>
<td>0</td>
<td>Interaction of COPD + DM</td>
<td>0</td>
<td>Interaction of COPD + DM</td>
<td>0.204</td>
</tr>
<tr>
<td>Total Risk Adjustment Factor</td>
<td>0.645</td>
<td>Total Risk Adjustment Factor</td>
<td>0.996</td>
<td>Total Risk Adjustment Factor</td>
<td>2.222</td>
</tr>
<tr>
<td>PMPM Spending Budget</td>
<td>$484</td>
<td>PMPM Spending Budget</td>
<td>$747</td>
<td>PMPM Spending Budget</td>
<td>$1,667</td>
</tr>
<tr>
<td>Annual Expected Cost of Care</td>
<td>~$6K</td>
<td>Annual Expected Cost of Care</td>
<td>~$9K</td>
<td>Annual Expected Cost of Care</td>
<td>~$20K</td>
</tr>
</tbody>
</table>

This is what the payer believes it should cost annually to care for a patient with a score of 2.2 compared to a patient with a score of 0.64. Same patient, $14,000 difference based on accurate and complete coding.
The Essential Eight

- Diabetes
- Depression
- BMI and Nutritional Status
- Congestive Heart Failure Chronic
- Chronic Kidney Disease
- Neoplasms
- Obstructive Pulmonary Disease
- Vascular Disease
BMI & Nutritional Status

**BMI Status**
- You can diagnose Obesity based upon BMI
- You can diagnose Cachexia based upon BMI

**Nutritional Status**
- You can diagnose morbid obesity related to excessive calorie intake
- You can diagnose protein-calorie malnutrition

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>HCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>E66.01</td>
<td>Morbid (severe) obesity due to excess calories</td>
<td>22</td>
</tr>
<tr>
<td>Z68.41-Z69.45</td>
<td>BMI &gt; 40</td>
<td>22</td>
</tr>
<tr>
<td>R64</td>
<td>Cachexia</td>
<td>21</td>
</tr>
<tr>
<td>E43-E46</td>
<td>Protein-calorie malnutrition</td>
<td>21</td>
</tr>
</tbody>
</table>
Chronic Statuses Illustrate Full Picture

If these conditions are still present they need to be coded at least once EVERY year.
Use of Comprehensive Care Visit (CCV) forms

• CCVs assist in achieving an accurate risk score by listing opportunities to:
  - Revalidate chronic active conditions for the current year
  - Reject resolved conditions or incorrect diagnoses
  - Document conditions with status codes for the current year
  - Use more specific language for certain diagnoses and/or link to other conditions by, e.g., “due to”
  - Add new chronic active conditions diagnosed in other settings
Keys to Success

- Address Chronic Conditions *once a year*
- Better to see patients sooner in the year
- Give a full picture of patient
Adjournment