A message from Neysa Guerino, Executive Director

It is hard to believe we are entering the second half of the year! Our network continues to improve its performance on delivering high quality care and meeting quality metrics in all of our value-based collaborations. Now is the time to take a look at your practice's performance and create a plan for the second half of the year to achieve success.

In our Medicare Advantage (MA) collaborations it is important that members with chronic disease are seen at least once in the first six months and again in the second six months. We also have a goal to complete an Annual Wellness Visit and/or a comprehensive physical exam on 85% of all MA members.

In the commercial collaborations we have set a target for participating practices to conduct physical exams on 60% of its members, utilizing the exam to close all gaps in care.

If you need assistance in developing your plan for success or prioritizing tasks do not hesitate to contact your CSMS-IPA resource. We are anxious to support you and welcome your recommendations on how we can assist you.

The Importance of Accurate and Complete Coding in a Value-Based Payment System

As the healthcare system continues to transform its payment system from one which is focused on volume to value, the need for more accurate and complete coding is increasingly important. The use of hierarchical condition categories (HCC), developed by Centers for Medicare and Medicaid Services (CMS) began in 2004 as a means of payment adjustment in capitated payment models based on risk. More recently, HCC are the risk adjustment methodology for Medicare to assess the overall level of medical complexity, or illness of burden to determine the payment rates for all Medicare beneficiaries in commercial Medicare Advantage plans. Both commercial and Medicaid plans are also using some form of risk adjustment methods to adjust payment based on overall burden of illness, but this article will focus primarily on the importance of accurate and complete coding for Medicare beneficiaries.
Providers are key to the appropriate and accurate coding of chronic conditions of their patients. In a value-based healthcare system, the provider becomes the main source of coding and documenting chronic conditions and Healthcare Effectiveness Data and Information Set (HEDIS) for quality patient outcomes.

Here are some key points to consider regarding appropriate documentation of a patients 'current chronic condition at the highest level of specificity:

1. All documentation of the patients overall chronic condition should be assessed yearly. All documentation should be accurate, valid and complete in their medical record and signed by the rendering physician.
2. Careful assessment of information in EHRs that auto-populate the patient's history, full exam and review of systems for each patient encounter. These types of systems require physicians to de-select manually the services not provided to ensure proper coding and billing. Clinical evaluation and findings should be documented for every patient encounter.
3. Document every active chronic condition and diagnosis and HEDIS measures with detailed information that supports the MEAT criteria of Monitored, Evaluated, Assessed and Treated.
   This helps to ensure that the patients' assessment of their current chronic conditions is captured should the patient not return for another visit in the year.

Since most physicians tend to focus on the patients' presenting diagnosis, they can often times omit other relevant conditions including chronic conditions. Based on 3M aggregated claims data, the 10 most under-documented HCCs include the following (1)

- 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

The goal is to capture the true medical complexity of each patient yearly to direct appropriate funding to adequately meet the clinical needs of each patient. The table below is an example of the HCC financial differences that appropriate coding and documentation can have on the risk adjustment of individual patients. These examples were taken from an article from the American Association of Family Practice. Click link to access the full article.
https://www.aafp.org/practicemanagement/payment/coding/hcc.html

***Example #1: A 68-year-old patient with type 2 diabetes with no complications, hypertension, and a body mass index (BMI) of 37.2**

ICD-10	Description	RAF
E11.9	Type 2 diabetes with no complications	
I10	Hypertension	
Z68.37	BMI of 37.2	
	Total Risk	0.000

***Example #2: A 68-year old patient with type 2 diabetes with diabetic polyneuropathy, hypertension, morbid obesity with a BMI of 37.2, and status post-left below knee amputation (BKA)**

ICD-10	Description	RAF
E11.42	Type 2 diabetes with diabetic polyneuropathy	0.0368
I10	Hypertension	
E66.01 & Z68.37	Morbid obesity with a BMI of 37.2	0.365
Z89.512	Status post-left BKA	0.779
	Total Optimized Risk	1.1808

***These are sample patients only, using 2017 CMS HCC model values and 2018 ICD-10 codes.**

In addition to the HCC coding used to assign risk scores to each patient, demographic factors such as age and gender are assigned to each patient to make up their overall risk adjustment factor (RAF). These RAF are used to predict the average costs for caring for patients based on their health status. A patient with minimal health conditions would require less costs than a patient with more complex chronic conditions.

Each January a patient's RAF needs to be evaluated again utilizing HCC coding with ICD-10 codes. Initially the patients demographics of age and gender will make up their baseline and it will be up to providers to assess the true medical severity of their patient population. The RAF assigned in one year, predicts the cost to manage the patient in the following year. Now is a great time to begin scheduling your patients for 2019 annual care visits. Your population health decision support tools like CareScreen® can help you assess the severity of your patient population by viewing the predicted RAF (pRAF) from 2018 HCC coding.

If you would like more information regarding HCC coding and documentation, please contact Rosemary Hokanson, CRC at rhokanson@csms-ipa.com

1. "The Role of HCCs in a Value-Based Payment System", HFM Magazine, October 2017

Please join our new
"Partners in Excellence Forum"
July 17, 2019 at 12:30 p.m. – 1:30 p.m.

This forum will serve as a communication venue for education, performance updates, and best practice sharing for all practices that participate in the CSMS-IPA payer collaborations.

We will continue to solicit your feedback so that this monthly forum will be valuable to you and your staff for continued success in our collaborations.

Together we can achieve our patient centered goals of improved quality and cost, while maintaining a positive experience for all.

If you have any suggestions on topics or speakers for our forum, please feel free to reach out to Rosemary Hokanson at rhokanson@csms-ipa.com. Thank you.

Our June Practice Manager Meetings

Thank you to all who attended our June Practice Manager Meetings! Our goal was to hold an event that was informative, provide an opportunity for you to network and share information with your colleagues and discuss your needs directly with our payor partners. Your attendance, participation and survey input made these meetings successful and will help guide our future meetings.

CALL TO ACTION

We Need Your Most Up to Date Provider Information

Has a new provider joined your practice - Doctor, Physician Assistant or APRN?
Have any of your providers recently moved or retired?

It is important we have currant and accurate information on your provider network to ensure patient attribution by our payer collaboration partners is optimal.

You may update providers in your practice by emailing or faxing a list of your current providers to Cindy Agosto cagosto@csms-ipa.com or fax 203-925-2652 or by downloading the VIP + MAP report in CareScreen® and completing the form. If you have any questions, please call Cindy at 203-225-1291. Thank you for your cooperation.

CTHealthLink

The CTHealthLink is an initiative aimed at providing physician practices with access to the expansive analytics and tools available in the physician-led, statewide health information exchange (HIE). Designed to help improve clinical outcomes, reduce inefficiencies, and positively impact patient safety, CTHealthLink is delivered in partnership with the Connecticut State Medical Society.

For more information: https://www.cthealthlink.com/Home.aspx