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Bringing Clarity to the Complexity of Quality, Risk and Cost

White Paper
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Achieving Success in Risk Adjustment and Quality Incentives

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Kathy Ormsby, CPC, CPCO
Director, Risk Management and Analytics

Introduction

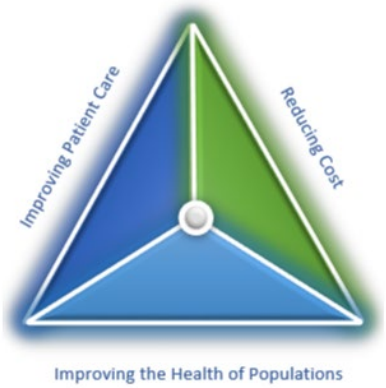
Because of significant demographic changes in the US population, coupled with an unsustainable level of healthcare spending, the US Government's Medicare program is transitioning to a pay model intended to drive improved quality of care while better controlling and reducing costs with the anticipated result of improved health of the population. Consider the following trends:

- The median age of the US population increased to 38.1 years in 2017 from 32.9 years in 1990, a 15.8% increase.
- Approximately 65,000 people enroll in Medicare each month per a recent AARP report.
- Per capita healthcare spending in the US was $10,224 in 2017 vs. $2,843 in 1990. Per capita healthcare spending in other developed (comparable) countries was $5,280 in 2017.
- Total healthcare spending in the US was almost 18% of GDP in 2017 vs. 12.8% in 1990, a 39% increase in healthcare's share of GDP.
- The average age of death in the US was 78.7 years in 2017 vs. 75.2 in 1990.

Due to the demographic and spending changes noted, Medicare has adopted a pay for performance plan as part of its offered programs designed to control overall healthcare spending. The plan incorporates the reporting of quality metrics along with a comprehensive calculation of patient and population risk scores that are included in the Medicare reimbursement determination. Ultimately all providers with Medicare patients will participate in this pay for performance plan.

These value-based programs support Medicare's triple aim which reward healthcare providers with incentives for quality care. These programs were designed to:

1. Improve patient care
2. Improve the health of populations
3. Reduce cost



This paper describes the risk adjustment model and quality incentives used by CMS (Centers for Medicare and Medicaid Services) and how providers should properly manage that process to ensure proper and adequate payment from Medicare.

Risk Adjustment Overview and Purpose

The Risk Adjustment Factor is a statistical calculation that scores the underlying health status and is a factor in the determination of spending for an individual patient. The primary goal of the risk adjustment methodology is to provide appropriate funding to health plans and organizations to cover the expense of patient care and to discourage health plans from selectively enrolling healthier patients. CMS uses this method to calculate and adjust capitated payments to Medicare Advantage plans (Part C) and Medicaid HMOs (Health Maintenance Organizations). CMS relies on accurate risk adjustment diagnosis data or ICD-10-CM codes to ensure payments made to the MA organization reflect the true healthcare risk of its beneficiaries*.

*For more information regarding proper risk adjustment submission see the qrcAnalytics Compliance White Paper.

Quality Initiatives Overview and Purpose

CMS implemented quality initiatives to assure and support that the quality of healthcare provided is improving the healthcare value of its beneficiaries. The CMS quality programs address care provided across the care continuum and encourage improvement of quality through various payment incentives. These incentives increase transparency through public reporting of results. The results are made public to allow beneficiaries to evaluate the quality of specific organizations. This enables the beneficiaries to make better informed decisions and choices about where and how to receive their health care.

Healthcare organizations submit quality incentive data on several diagnosis dimensions, including diabetes, eye exams, blood pressure tests, glucose levels, foot care, screenings, age-appropriate test, and smoking cessations. Organizations earn points when specific measures are achieved. This translates to recognition and financial incentives as long as the specific patient population meets or exceeds standards of care.

As quality initiatives become more value-based and pay-for-performance reimbursement models become more prevalent, healthcare organizations and providers need to understand the basics of risk adjustment methodologies and quality incentives. It is imperative that healthcare organizations learn how to effectively manage their populations while providing more efficient care for complex patients during routine patient visits.

Risk Adjustment and Quality Initiatives Improve Patient Care

When medical documentation is not accurate and lacks the specificity needed to assign the most appropriate ICD-10 diagnosis codes, organizations stand to lose appropriate reimbursement in a performance-based, risk adjustment payment model. If a chronic condition is not documented yearly, the diagnosis disappears (referred to as a "missed recapture") and will not be included in the calculation thereby lowering the risk adjustment score and, in turn reducing reimbursement. Accurate documentation and diagnosis coding depict a complete medical picture of the patient allowing for improvement in patient care. Statistics indicate that 1/3 of the chronic conditions for specific patients that are captured and submitted to CMS in one year will not be captured and submitted the second year. How does this affect patient care? Those patients with undocumented chronic conditions from missed recaptures are not getting consistent care. This inconsistent care provokes the possibility of poor patient outcomes. Healthcare organizations that are equipped to manage their populations and incorporate their learned data as described below, into a more efficient visit, not only improves and ensures appropriate care for their patients but also supports more appropriate reimbursement to better manage specific populations.

Example: A severely obese patient appears in the office for the management of diabetes. The physician documents, addresses and submits diabetes but does not document or address morbid obesity. Diabetes is managed and treated, and the appropriate quality tests are ordered, however morbid obesity is not documented, addressed or submitted. The organization just lost approximately $3000.00 for not managing morbid obesity and this patient leaves with no plan for weight management.

Efficient Office Visits Improve Care, Revenue and Patient Satisfaction

Competitive pressure in healthcare is forcing organizations to re-evaluate the way they provide care. Patients are now more informed and have more control regarding how and where they receive healthcare. The old way of receiving reimbursement has changed. Organizations are no longer reimbursed based on how often they see patients but rather the quality of that visit as it relates to the demographics and the

management of the chronic conditions including accurate and complete diagnosis codes for the patient. These changes force healthcare organizations to become more efficient and at the same time improve the patient experience. So how can organizations stay afloat in this ever-changing sea of healthcare?

Healthcare organizations should utilize an actionable data platform

1. *Know your patient and provider mix:*

Part of becoming more efficient is to know the provider and patient population. Knowing the patient mix and having the ability to track and observe the flow of patients can help in the understanding of cost and risk associated with the provider's population. Knowing this valuable information will help identify:

- Gaps in care
  - Patients that have not been seen in the calendar year
  - Patients with outstanding quality metrics i.e., age-based screenings, exams, medication & vaccines
  - Specific conditions that have not been managed or treated
  - Over or under use of medication
  - Over or under utilization of routine and preventative visits

Identifying providers that are expending too many resources without efficiency will enable management and practitioners to:

- Extend education to those providers who are over or underutilizing visits
- Adjust process to better utilize resources
- Balance quality, risk and cost associated to the specific provider and patient

Healthcare organizations that utilize actionable data analytics ultimately improve care, patient satisfaction and receive appropriate revenue to support the quality care that is provided.

2. *Use scheduling data to improve efficiency:*

To ensure that each patient's quality measures and risk adjustment conditions have been addressed during the time frame allowed, organizations should monitor and track each patient's visits. The scheduling department or call center should receive an updated list at least monthly and have a clear understanding why this process is essential. Monitoring visits ensures that:

- Patients are seen at least yearly
- Conditions are monitored and treated appropriately
- Specific organizational goals are tracked accordingly
  - An organization may have a set goal of at least 90% of the adult population as having received an AWV (Annual Wellness Visit)
  - The AWV provides an annual opportunity to monitor and capture chronic conditions at no cost to the patient and can be used to identify unaddressed quality measures and risk adjustment conditions

3. *Use patient specific data during the visit*

According to a study by "The American Journal of Managed Care", the outpatient visit grew longer over the period from 1993 through 2010 (1). The study confirms that outpatient office visits continue to get longer over time. The visit lengths are getting longer, and mounting pressure demands the provider to improve the overall patient experience AND protect financial security. Providers are stretched. Focusing on the quality of the office visit may be key in taking the weight off the provider. If the quality of the visit encompasses the identified measures and risk adjustment conditions, the patient may only require one visit during the year versus several to manage only the chief complaint. Office visits have always been a critical access point for the patient and provider interaction. Using this access to ensure that all conditions are monitored, and quality measures are addressed is imperative. The question is how is this achieved? The answer lies in the data. Organizations that have access to patient specific and historical data are better at managing financial security, meeting quality metrics, improving risk adjustment scores and achieving better patient satisfaction. The specific patient data that providers should use are:

- Historical diagnoses*
- Historical and current procedures *
- Immunizations and medications *
- Unresolved quality measures
- Problem list
- Suspect logic

*Obtained from all involved provider organizations for each patient

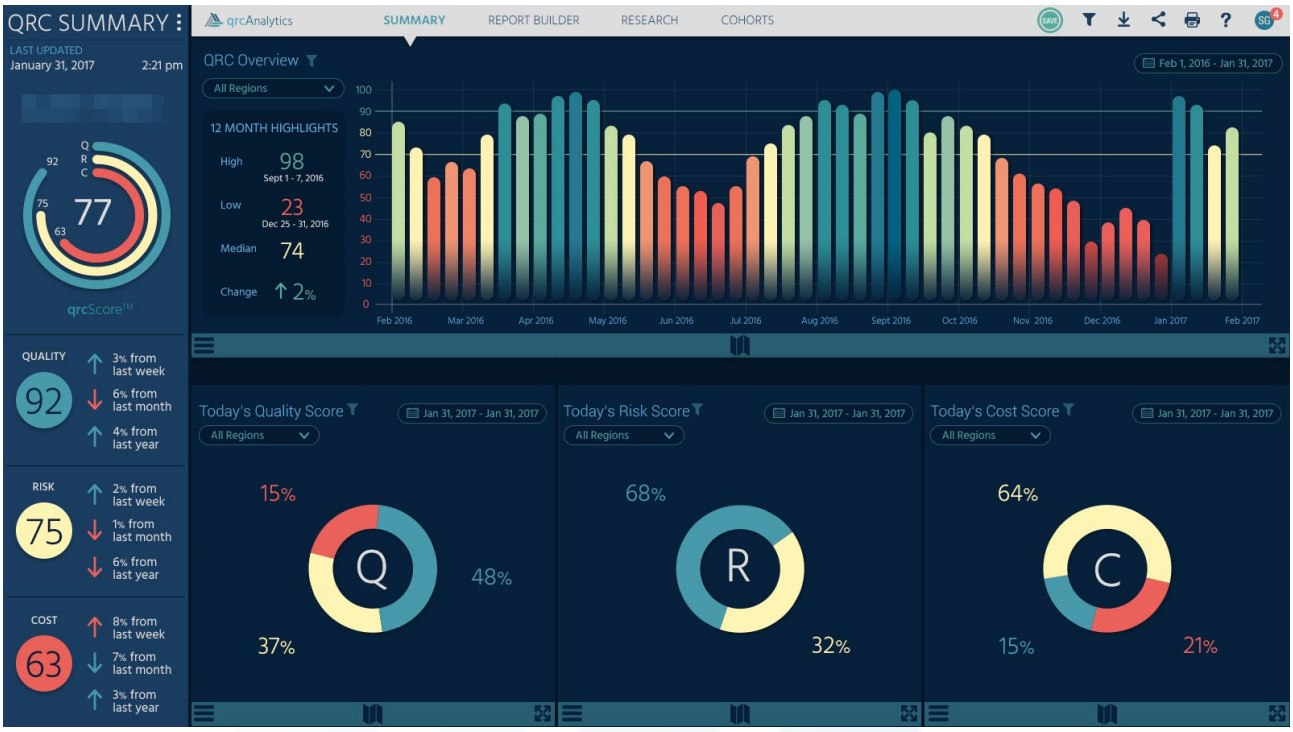
(1)*https://www.ajmc.com/journals/issue/2014/2014-vol20-n10/the-duration-of-office-visits-in-the-united-states-1993-to-2010*

4. *Monitor your organization's performance*

If you can't measure it, you can't improve it. – *Peter Drucker*

An organization's success is first defined by specific goals; proof of its success is then provided by tracking those specific, measurable metrics. Organizations must be able to identify all opportunities for improving quality, reducing cost and have processes in place that validate process success. Measuring provider efficiency is key for the organization's success**.** Studies show that the use of an analytics platform that incorporates summarization dashboards is effective in ensuring optimum quality care at an efficient cost. Those dashboards that allow drill downs into specific patient data provide data that is actionable to accomplish an organization's quality goals.

Dashboard example:



5. *Beware of hidden costs*

Having a robust collection of real-time data has compound benefits. In utilizing actionable data, organizations can validate all the actions and insights noted above and also monitor for inefficiencies in care that otherwise may have been missed. Organizations should use data analytics to identify hidden costs and repeated procedures that drain the financial state of the organization, such as:

- Excessive cancer screenings
- Imaging overuse on low back pain
- Dispensing antibiotics without clinical proof
- Repeating unnecessary medical office visits

Conclusion:

An organizational structure that supports quality and risk by utilizing best practices as outlined here and based on having detailed knowledge of patients, providers and health patterns is positioned for success. Analyzing data and taking proper actions can mean the difference between success and failure. Statistics show that when best practices are followed, organizations come out on top compared to their peers and are more financially balanced.

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About qrcAnalytics:

Who can help your organization design and implement a pay-for-performance and quality program that ties in with the risk adjustment models?	qrcAnalytics has the experience and know-how to assist your organization in developing pay-for-performance and quality programs that tie in with the risk adjustment models. We pride ourselves on our ability to translate complicated and sometimes confusing rules and regulations into practical straightforward strategies.
Who are the qrcAnalytics subject matter experts?	Our integrated delivery team includes experienced certified auditors and trainers, a regulatory subject matter expert specialist, data analysts, process improvement professionals, and IT specialists in medical informatics.
What specific services does qrcAnalytics provide?	Our services include: MA Plan development ROI analysis Gap analysis Clinicians & coder training Workflow design Coding & auditing tools Supportive technologies Coding processes Compliance reviews Training plans And more

qrcAnalytics is a healthcare technology company with a state-of-the-art analytics platform designed to improve healthcare delivery, providing insights from coding results, clinical documentation, administrative data, and clinical outcomes. qrcAnalytics leverages proprietary algorithms that aid clinicians, coders, and the entire risk adjustment program to more accurately and efficiently perform responsibilities supporting clinical risk management.

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A Healthcare Analytics Company |*Bringing Clarity to the Complexity of Quality, Risk and Cost*

5201 Great America Parkway
Suite 320
Santa Clara, CA 95054
630.474.0880

qrc-analytics.com