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PART OF SIGNIFY HEALTH

Risk Calculations in Monthly Claims Analysis and Comparison

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Presenters

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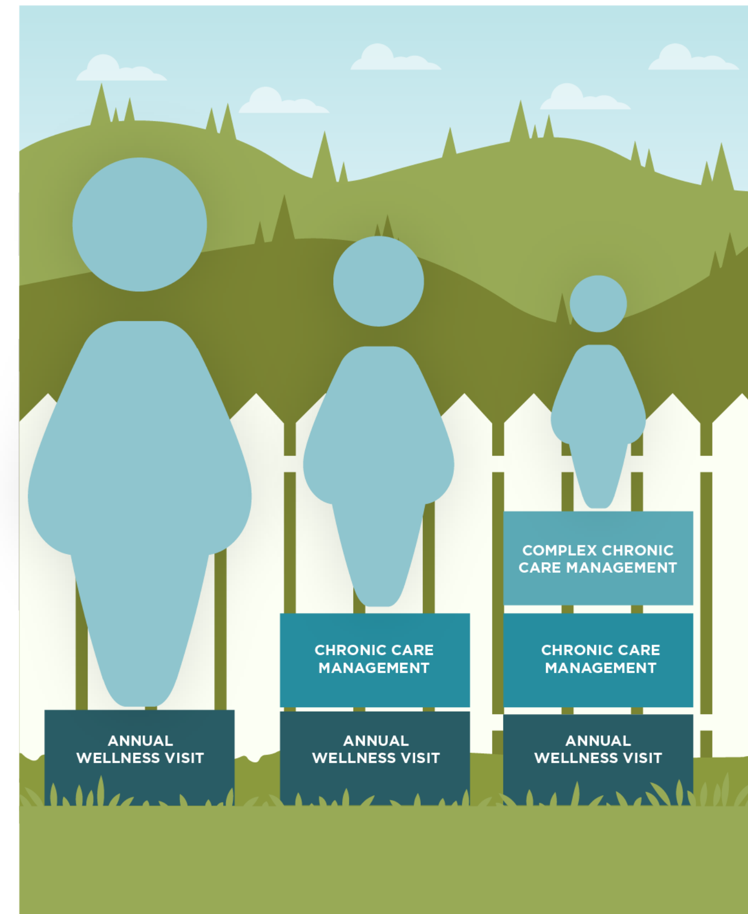
Session Outline

- What is risk stratification and why is it important?
- What is HCC?
- What are the drawbacks of HCC?
- How can other risk scores help bridge this gap?
- Capturing the complexity of your patient panel
- Point-of-Care workflows
- Wrap Up and Questions

What Are Risk Scores?

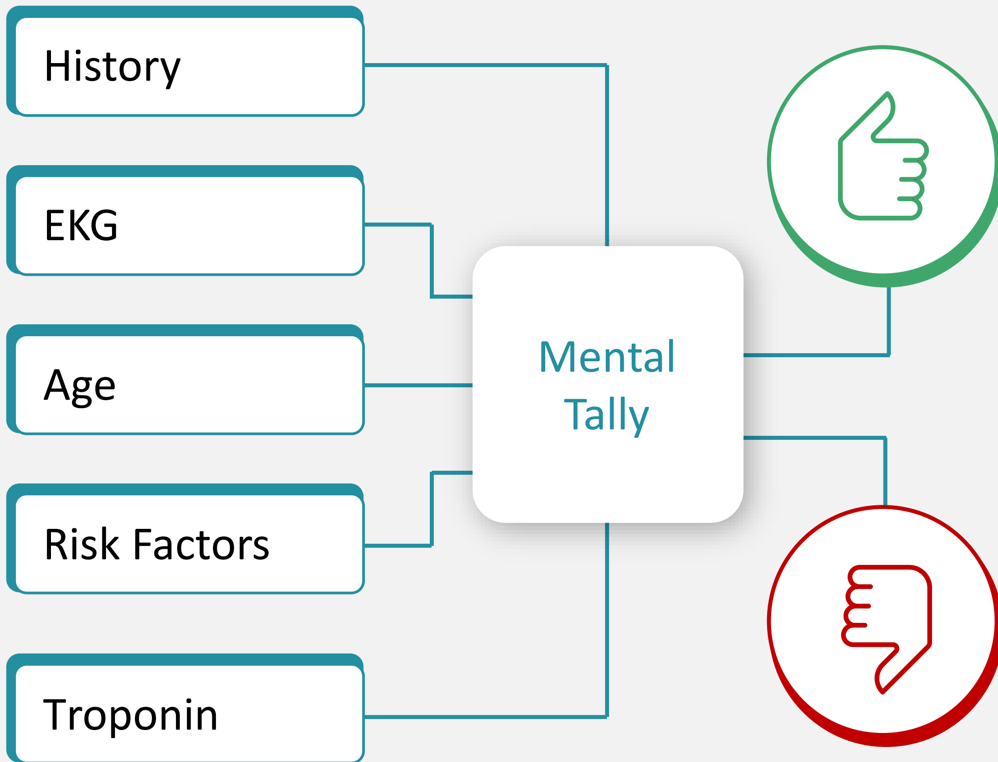
Why Do You Need Risk Stratification?

QUALITY CARE

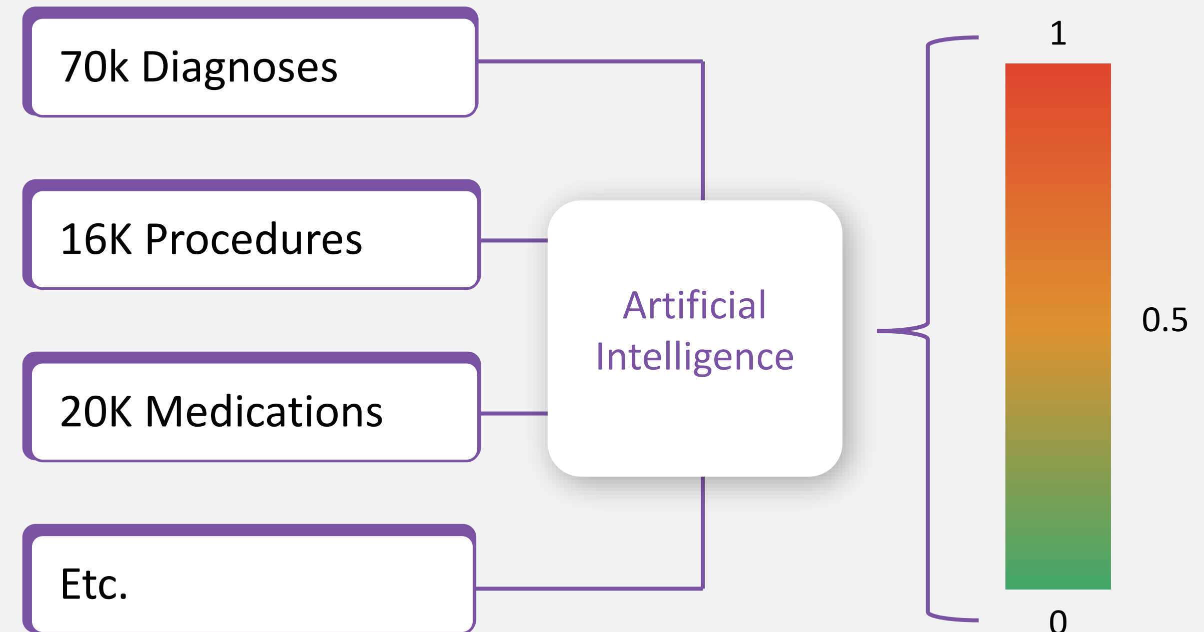


Calculating Risk

Patient Level



Population Level



Examples Of Risk Scores

HCC Basics

Risk score used by CMS to predict future costs for a patient

Diagnoses from year 1 used to calculate HCC score for year 2

Conditions need to be recoded annually

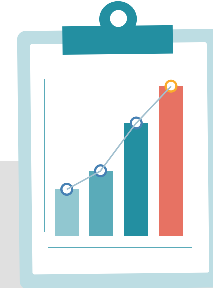
ACO benchmarks adjusted based on change in HCC score from benchmark year to performance year

Normalized so the national average
for each enrollment type is 1.0

ACOs and Risk Adjustment

Shared Savings Program ACOs are groups of doctors, hospitals, and other health care providers who join together to provide high-quality care to Medicare beneficiaries to ensure patients receive the right care at the right time.

When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, the ACO may be eligible to share in the savings it achieves for the Medicare program.



At the end of the performance year, an ACO’s benchmark is adjusted based on the change in risk score from the final benchmark year to the current performance year.

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Calculating HCC

Condition	RAF
Congestive Heart Failure	0.331
Chronic Kidney Disease (Stage 3)	0.069
Congestive Heart Failure + Renal Interaction	0.156
Major Depressive Disorder	0.309
72-Year-Old Male	0.395
Total	1.26

HCC Downsides

Annual recording makes it difficult to know a patient's risk at the moment

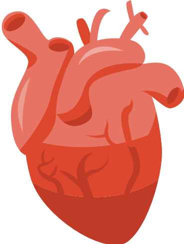
A patient's initial diagnosis will not count towards their risk score until the following year

Lag in CMS reporting

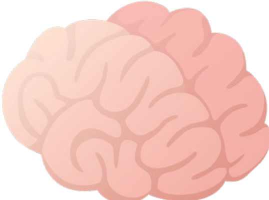
Most recent CMS rosters contain risk scores calculated using 2019 claims

Claims and demographics based only

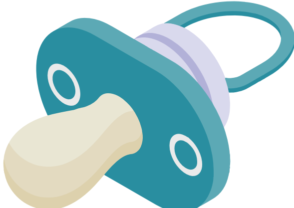
Other Examples of Risk Scores



HEART Score



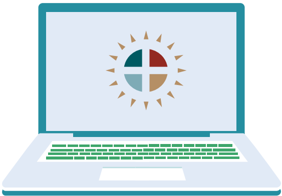
Glasgow Coma Scale



APGAR Score

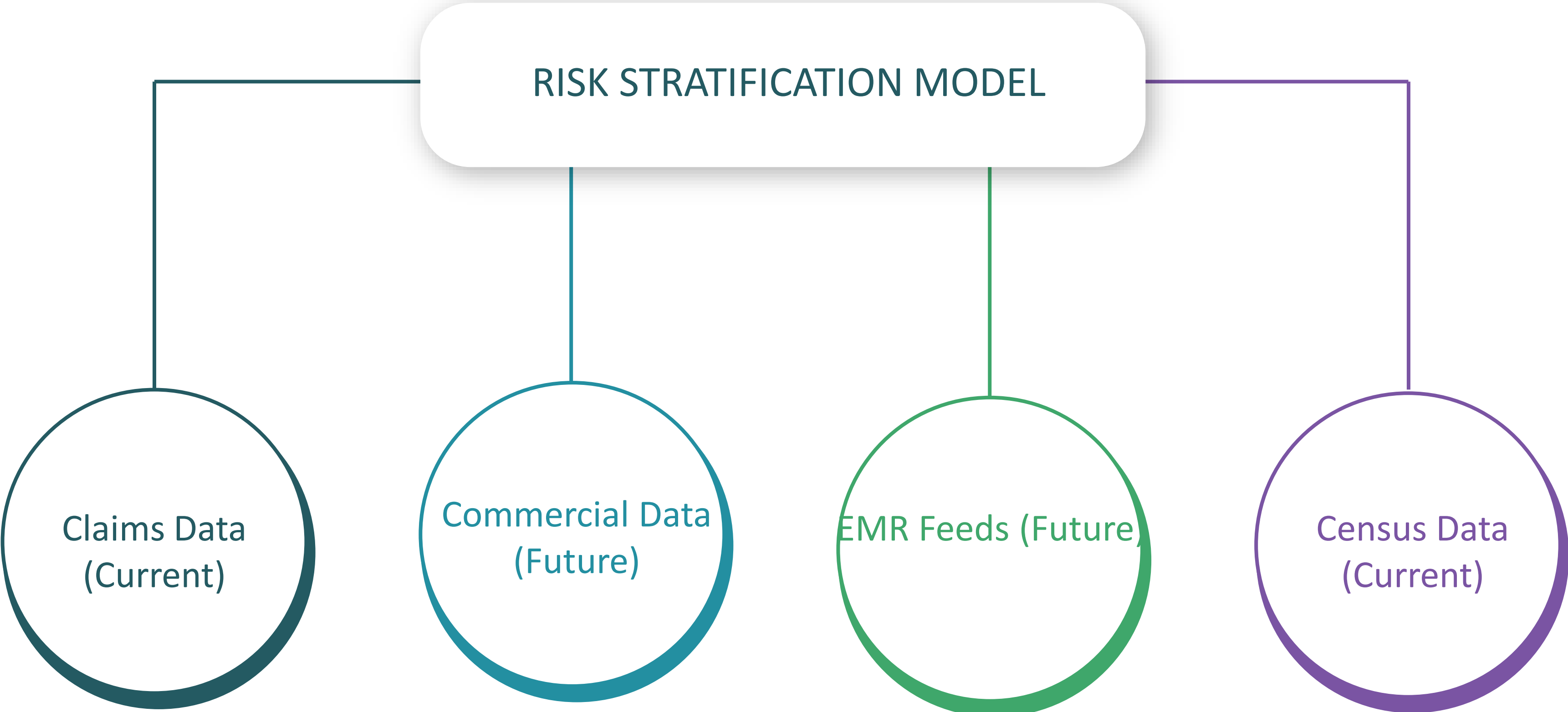
Milliman MARA

John’s Hopkins ACG



Caravan Risk Level

Data Sources



Importance of Different Risk Scores

CMS-HCC	Proprietary Risk Models
Used in end of year reconciliation	Can be built to serve your organization’s needs
How CMS views your patient’s disease burden	Can pull in any data source you choose
Optimize internal workflows and patient outreach	Can be leveraged to target patient outreach and programs
Optimize your organization’s coding	Can accurately measure a patient’s current disease burden

Caravan Health Provider Tools

HCC Patient Facesheet

Lavalais, Nela

Provider (Attributed)
Agim Hupfer

74y, Female | Born: 2/13/1948
MBI: XXXXXX7829

Projected Risk: **Medium**

CHRONIC CODING OPPORTUNITIES

Open Gaps **1.218**

Last year 1.821

This year 0.363 1.581

0.331	**Congestive Heart Failure**	
	I42.8 - Other cardiomyopathies	Paxton, Elena, 12/22/21
	I50.23 - Acute on chronic systolic (congestive) heart failure	Paxton, Elena, 12/22/21
0.309	**Major Depressive, Bipolar, and Paranoid Disorders**	
	F33.0 - Major depressive disorder, recurrent, mild	Brosz, Marcelline, 01/31/21
0.268	**Specified Heart Arrhythmias**	
	I49.5 - Sick sinus syndrome	Molden, Suzanna, 08/29/20
0.069	**Chronic Kidney Disease, Moderate (Stage 3)**	
	N18.32 - Chronic kidney disease, stage 3b	Sybilla, Lelia, 08/23/21

DISEASE INTERACTIONS

+0.156	**Congestive Heart Failure + Renal Group**
+0.085	**Congestive Heart Failure + Specified Heart Arrhythmias**

ACUTE CODING OPPORTUNITIES

0.435	**Acute Renal Failure**	
	N17.9 - Acute kidney failure, unspecified	Saller, Larry, 09/26/20
0.282	**Cardio-Respiratory Failure and Shock**	
	R57.0 - Cardiogenic shock	Saller, Larry, 09/26/20

HCC Dashboard

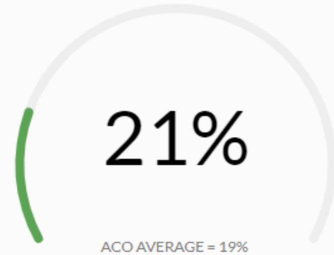
Impact of Chronic Conditions

62 chronic conditions

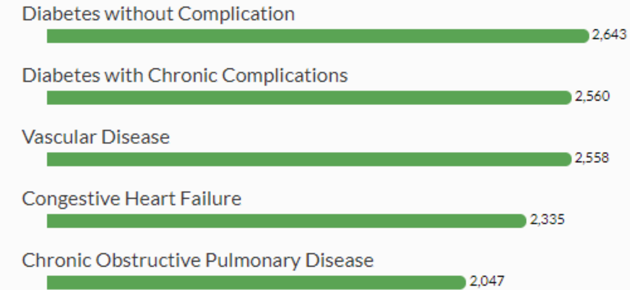
Data updated as of Mar 30, 2022

View Clinicians | View Patients

Annual Closure Rate ⓘ



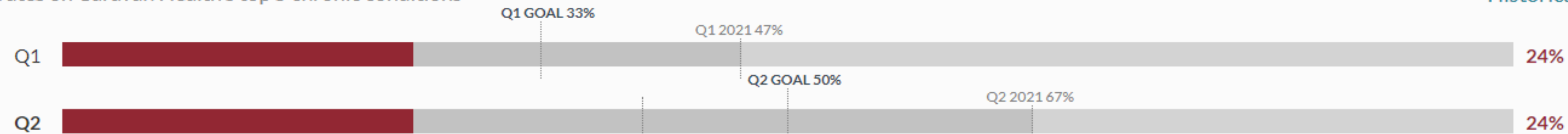
Top Coding Opportunities ⓘ



Quarterly Milestones ⓘ

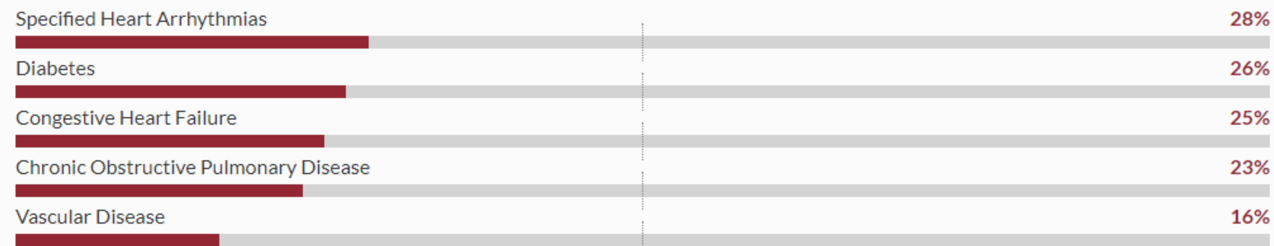
Closure rates on Caravan Health's top 5 chronic conditions

Historical Quarterly Milestones



REMEDIATION

Current Quarter Details ⓘ



GOAL = 50%

HCC Dashboard contd.

PRACTICE NAME	CLINICIAN	NPI	SPECIALTY	PATIENT COUNT	HCC CLOSURE GAPS ↓	OVERALL HCC CLOSURE RATE
TANO COUNTY HOSPITAL				2427	4449	22%
BUCCO REGIONAL HOSPIT...				1567	3241	19%
Brick Life Hospital				546	1016	23%
BAZO Internists				400	870	22%
WIERTZEMA Partners				433	763	20%

MBI	NAME 1 ↑	DATE OF BIRTH 2 ↑	CLINICIAN	CLINICIAN NPI	CLINICIAN SPECIALTY	RAF SCORE (YTD)	TOTAL GAP WEIGHT	HCC CLOSURE GAPS	OVERALL HCC CLOSU...
XXXXXX5356	AALDERS, Azariya	11/15/1969	DELORA LANGLIN...	XXXXXX364	Family practice	0.293	0.607	3	0%
XXXXXX3347	AANERUD, STERN	10/20/1951	NANI BOTTARI	XXXXXX292	Internal medicine	0.37	2.395	6	0%
XXXXXX7426	AANERUD, Satine	01/19/1939	CHRYSA DILLS	XXXXXX754	Internal medicine	0.496	0.225	1	75%

Proprietary Risk Score Programs

Care Management

Higher risk patients would be contacted first with more frequent outreach attempts.

Disease Management Programs

Higher risk patients will more frequently assessed for and qualify for programs.

AWV/Annual Patient Visits

Higher risk patients will be prioritized for appointments.

Same Day/Post-Discharge Visits

Higher risk patients would be triaged first for same day and post-discharge appointments.

Quality Outreach

Higher risk patients will receive more frequent contacts and contacts through more outreach mediums (portal, phone, email, etc.).

Capturing the Complexity of Your Patient Panel

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Documentation Guidelines

Paint a clear picture of the patient’s condition.

Avoid “history of” which implies condition is no longer being treated.

Medicare’s guidelines state, “Code all documented conditions which coexist at the time of the visit that require or affect patient care or treatment.”

The treatment plan should link conditions to medications.

“Upcoding” is fraud: DO NOT code conditions that were previously treated, but no longer exist.

If Conditions Are Stable, Make it Clear

Instead of Documenting…	Document this and use codes for these dx:
History of COPD	COPD controlled with Advair, no exacerbations in xx timeframe.
History of HTN	HTN well controlled on current regimen. Labs ordered due to diuretic use.
History of DM	DM with neuropathy controlled, continue current regimen, educated on proper foot care.
History of CHF	CHF well compensated on current regimen.

HCC Score Calculation

Poor Specificity and Coding	RAF	Better Specificity / Coding	RAF	Coder Query Workflow Completed	RAF
72-Year-old Male	0.395	72-Year-old Male	0.395	72-Year-old Male	0.395
Paroxysmal AFIB (I48.0)	0.286	Paroxysmal AFIB (I48.0)	0.286	Paroxysmal AFIB (I48.0)	0.286
Depression (F32.A)	No HCC	Major Depressive Disorder (F32.9)	No HCC	Major Depressive Disorder, recurrent (F33.9)	0.309
Neuropathy (G62.9)	No HCC	Neuropathy (G62.9)	No HCC	Type 2 DM w/ diabetic neuropathy (E11.40)	0.302
Diabetes (E11.9)	0.105	Diabetes (E11.9)	0.105	-----	--
Amputation L. 5th toe (not coded)	0	Amputation L. 5th toe (Z89.422)	0.519	Amputation L. 5th toe (Z89.422)	0.519
Sleep Apnea (not coded)	0	Sleep Apnea (G47.30)	No HCC	Morbid obesity with alveolar hypoventilation (E66.2)	0.250
COPD (not coded)	0	COPD (J44.9)	0.335	COPD (J44.9)	0.335
Total RAF	0.786	Total RAF	1.640	Total RAF	2.396
Expected Total Cost of Care	$10,825	Expected Total Cost of Care	$27,874	Expected Total Cost of Care	$40,810

Values are illustrative and not intended to match currently published rates

Point-of-Care Workflows

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Focus Areas for HCC Workflows

Pre-Visit

Identifying HCCs
for recapture

- Identify patients not seen in office (HCC VIP Cohort)
- Utilize Facesheet
- Pre-visit planning
- Clean-up Problem Lists

Point-of-Care

Accurate documentation and coding
of all chronic HCCs

- Team-based documentation
- Materials and tools for complete and accurate documentation and code capture
- Utilize Facesheet
- Utilize EMR tools (alerts/flags/short list)

Post-Visit

Audits, coding,
and queries

- Perform provider queries
- QA or monitoring process
- Audits
- Ongoing education

Top-of-License Team-Based Care

Annual Wellness Visits

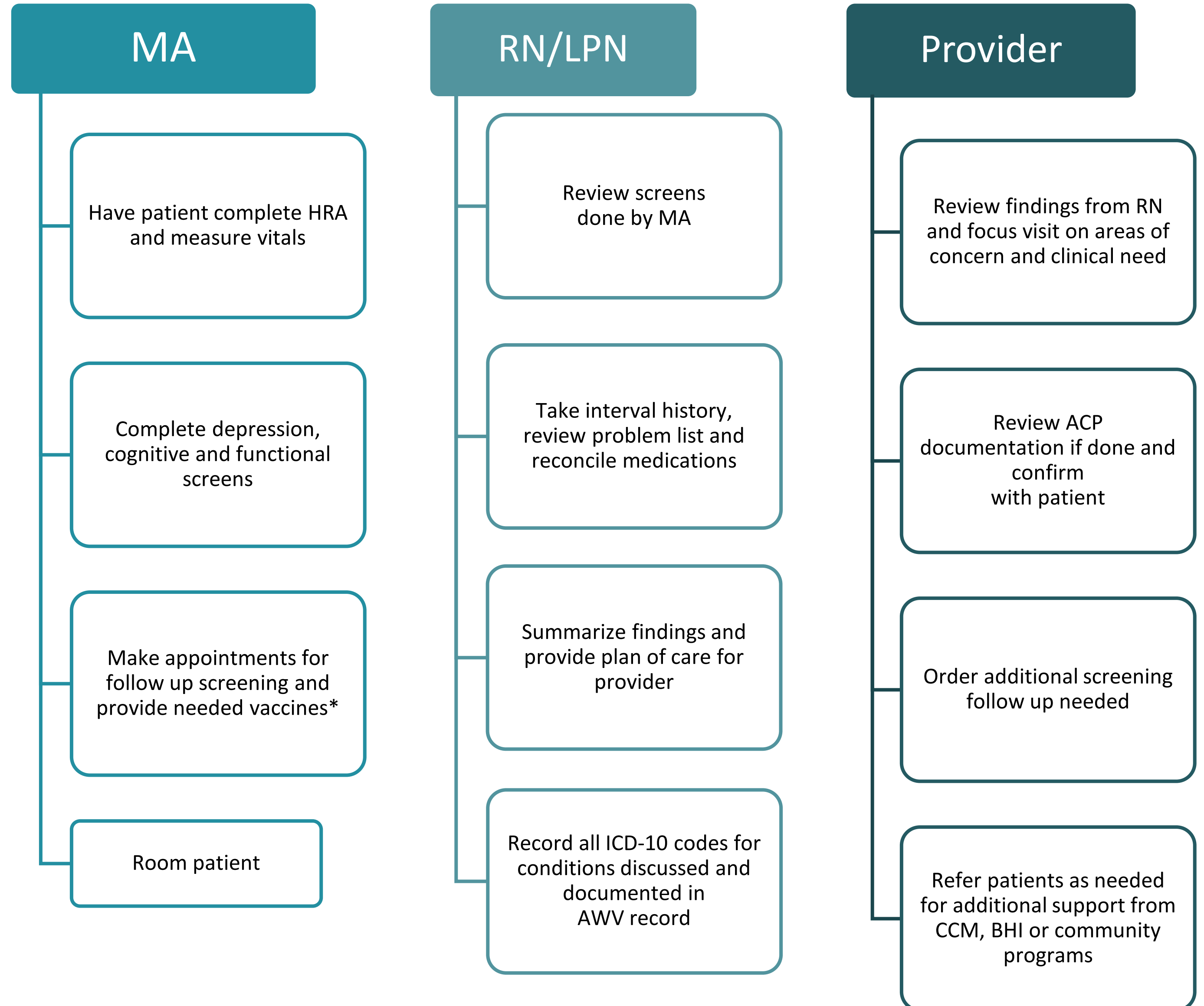
A medical professional* or a team of such medical professionals working under the *direct* supervision of a physician or non-physician practitioner.

*Medical Professionals include:

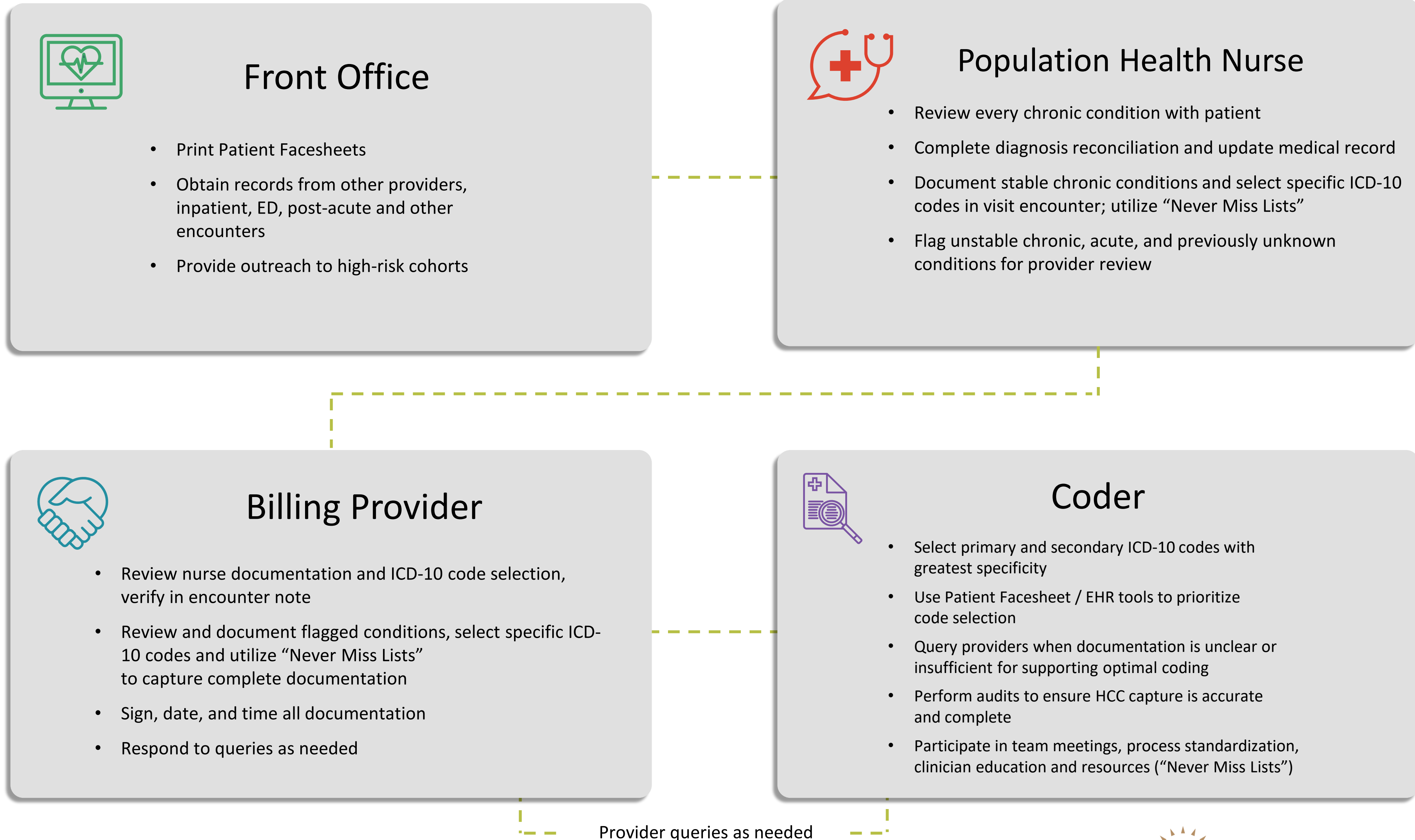
State laws may vary on scope of practice for a given license.

Suggested AWV Workflows

- Customize this workflow to fit with POD staffing
- *If standing orders are in place and scope of practice allows

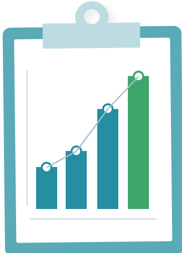


Sample Team-Based Responsibilities



Wrap Up and Questions

Importance of risk scoring



Difference between HCC and other risk scores

Taking the data and operationalizing it

QUESTIONS?

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Thank You

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