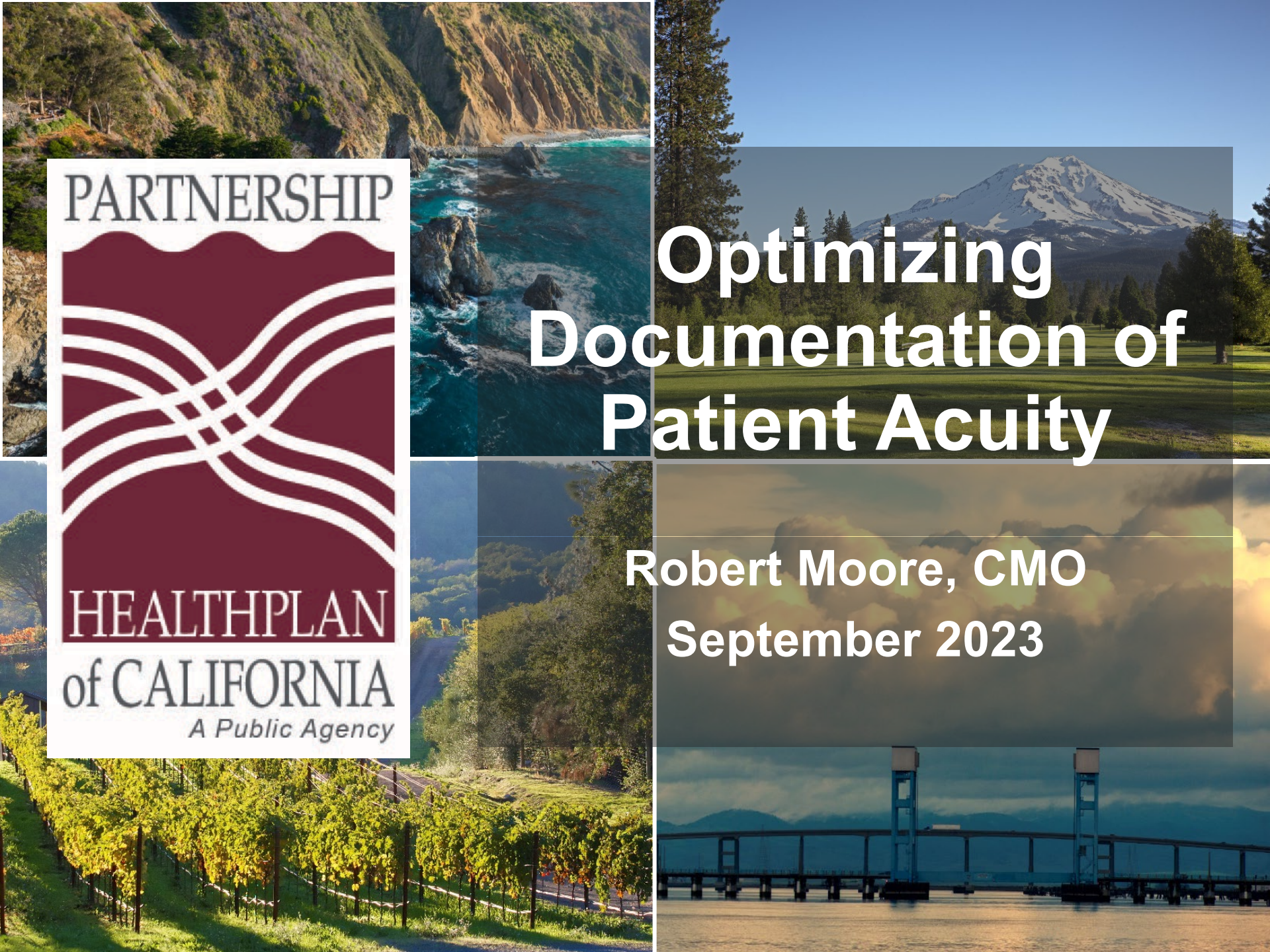


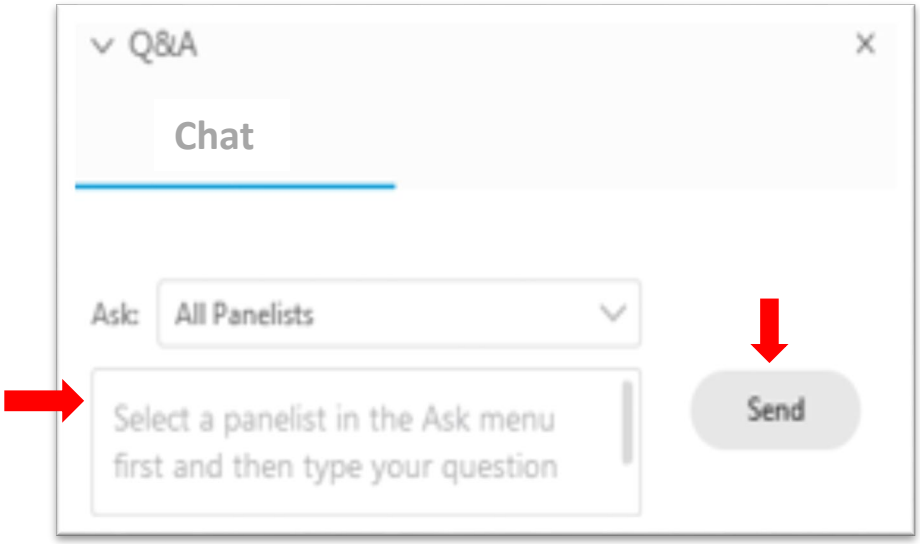
Optimizing Documentation of Patient Acuity

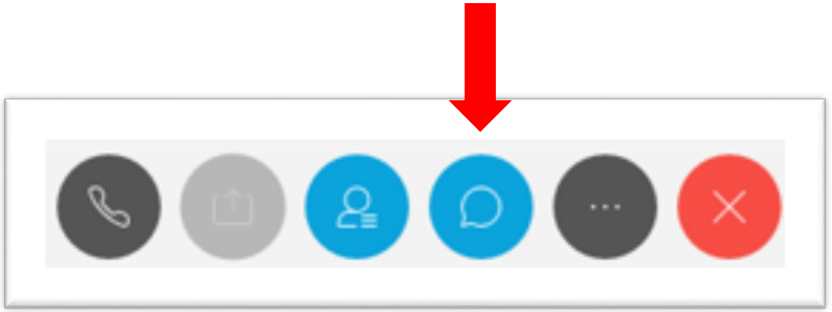
Robert Moore, CMO

September 2023

Housekeeping

- This webinar will be recorded
- All participants have been muted to eliminate any possible noise interference/distraction
- Time is put aside for questions at the end of the webinar
- If you have a question, please type your question in the chat box and address to all panelists





What We'll Cover

- PCP QIP equity adjustment: how acuity adjustment fits in
- Measuring patient acuity
- Recommendations and best practices

Equity Adjustment Methodology

- **Why Equity Adjustment?**
- **Big Picture**
- **Components of Adjustment**

Why Equity Adjust the QIP?

- Previously, dollars going into the pool for the PCP QIP were only dependent on assigned Partnership patients with primary Medi-Cal coverage
  - There was no adjustment in payment amount for the complexity of the patient, the degree of socio-demographic stress, the difficulty in recruiting high quality staff, or the baseline resources of the PCP
- Equity adjustment is intended to make the PCP QIP payment more fair, while not reducing motivation to strive for high quality

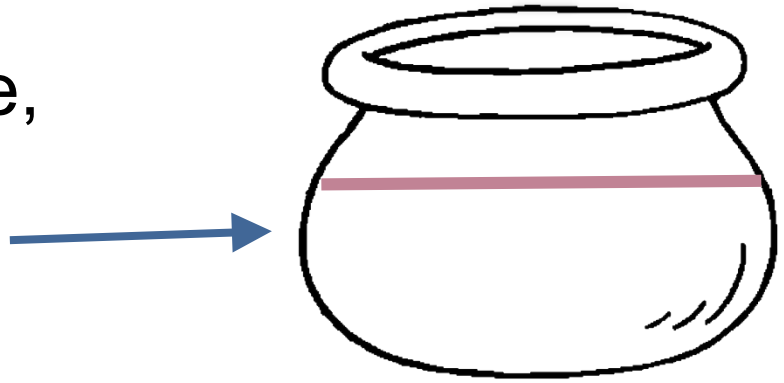
Rate Methodology Changes

How DHCS will pay managed care plans starting in 2024:

- Rates will be adjusted based on estimated patient acuity, as calculated from encounter claims data
- Substantial new quality withhold for patient experience/clinical quality

Basic Principles Approved for 2023 Equity Adjustment

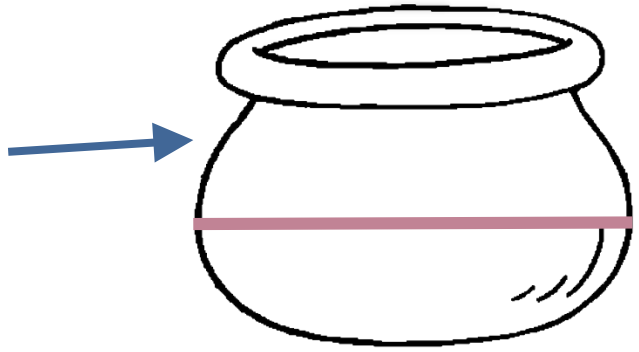
- Adjust the dollars at stake, starting at a minimum amount of $4 PMPM, increasing depending on adjustments



Multiplied by the score on Core Measure Set (0-100%)

- No adjustment for target thresholds or measures

- The amount earned will still depend on quality of care provided.



Previous Method of Allocating Dollars to Pool

- Dollars available for PCP QIP was set at $9.25 PMPM for members capitated or assigned to a PCP
- Of this amount in 2022, 62% of funds were earned (weighted average), or about $5.75 PMPM

Process Used to Determine Adjustment Methods

- Goals:
  - Fairness
  - Simplicity
  - Understandability
- Incentivize discretionary energy to improve quality metrics and avoid unintended negative consequences
- Stakeholder input of early ideas
- Last year, actual data to test validity of options was used
- Structured to **not** have an overall increase in total PCP QIP budget
- Took into account new DHCS rate methodology
- 2023 is a pilot year; we will modify in future based on what we learn

Components of Upward Adjustments Summary

- Gateway
  - Must have at least 100 assigned members as of December 1, 2023
- Core adjustments
  - Acuity of patient panel
  - Socio-demographic risk, at patient level, rolled up to PCP site level
  - Site difficulty in recruiting PCP physicians
  - Lower than average baseline per visit resources available to PCP
- Disaster Adjustment
  - Site closed and unusable due to external factor, such as fire, earthquake, flood, etc. for at least five consecutive days in the year

Relative Weight of Core Adjustments

Percentage Weight	Equity Adjustment Factor
40%	Acuity Adjustment (2 components
20%	Socio-demographic risk factors
20%	Difficulty in Recruiting PCPs (2 components)
20%	Below Average Resources

Estimated Site PMPM

- We are distributing an estimated PMPM for each PCP site, using 2021 or 2022 data, depending on the measure
- These are being distributed to parent organizations to assist with budgeting and to be a baseline for the acuity measure, which is amenable to change due to coding behavior
- Final adjustment factors for 2023 will be based upon updated data, the most recent available – estimated date of final calculation is March 2024 for Payment in May, 2024

Key Takeaway

We recommend immediately focusing energy on improving acuity adjustment (as well as on quality performance)

Acuity Adjustment

- High Level Overview
- Rationale
- Key Messages
- Further Resources

Poll

What is your experience with **acuity adjustment**? (select all that are true)

1. Never heard of it
2. Heard of it, but never used it
3. Using it to adjust patient panel size
4. Using it for adjusting PCP clinician pay
5. Using it to optimize MediCare ACO revenue
6. Using it to estimate case management workload
7. Using it for some other purpose

Patient Acuity

- Broadly: Patient Acuity is a description of how sick a person is at the present time.

- Common **medical** use of “acute” has a different meaning than the **actuarial** use of the term.

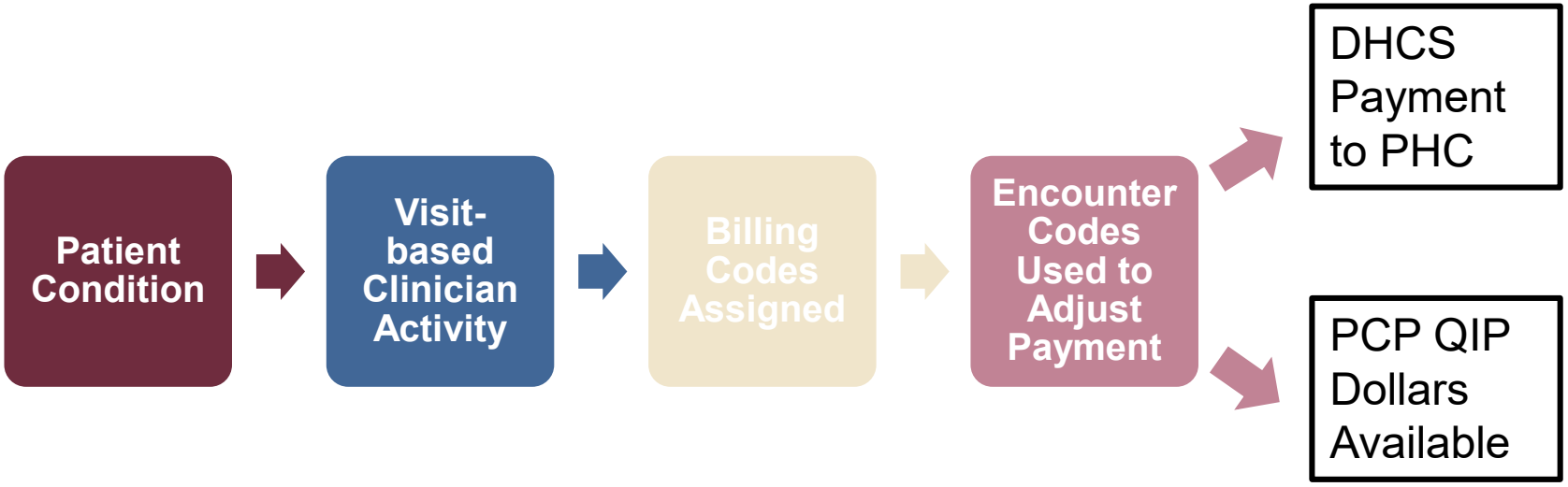
- Medical: “Acutely ill” may imply a severity of illness (e.g. needing more intensive level of care), or may be used more to apply to newness of symptoms and condition as contrasted with “chronic symptoms” or “chronic diseases”

Patient Acuity

- Patient Acuity may also be interpreted in other ways:
  - Actuarial: How much medical resources has a given patient utilized in the recent past?
  - Predictive: What is the likelihood that a patient's ongoing illness continues to incur high medical expenses in the future?
  - Operational: How much energy is a given patient taking from the medical team, compared to other patients?

Aligning Partnership and PCP Incentives

- Acuity as an estimate of PCP work: If your patients are sicker, they will be worth more dollars at stake in the PCP QIP
- Acuity as an estimate of Partnership risk: If Partnership members have more acuity, that patient will generate a higher rate from DHCS



Acuity: How Much PCP Work?

- Acuity is calculated based on claims data received, which in turn depends on:
  - How severely and chronically ill the patient is
  - How much the patient sought care
  - How well the provider captured all relevant diagnosis codes
- The latter two factors can be improved upon with discretionary clinician attention, systems of support, and education on billing processes

Estimating How Much Clinician Work Needed

. . . to care for their patient panel.

- Why?
  - To weigh more complex patients higher in empanelment systems (fairness)
  - To assign additional dollars in capitation or other arrangements to account for the additional work some patients require

- How?
  - There is no agreed upon methodology for linking codes to work
  - Since workload is more difficult to measure on a patient-level, predictive analytic techniques are less exact than they are for predicting future cost.

Approximating PCP Workload: Options

- Use the actuarial acuity as an approximation
  - No new system to validate
  - Impacting it is understood, but is complex
  - Relatively complex, so typical front line clinician doesn't understand it, and thus is less likely to think it unfair
- Weigh patients with certain conditions more heavily
  - Use a few conditions well recognized to take more work (Diabetes, CHF) and also the age of the patient
  - More understandable, but still feels fairer than no adjustment
- Measure the drivers which are impacting acuity calculation
  - Easier to understand than the complex actuarial calculation
  - Link between coding practices and acuity calculations become obvious

Measuring the Drivers for Acuity

- Two key drivers/associations of acuity levels, with other factors being constant, are:
  - Average number of diagnoses per claim
  - Number of assigned patients with at least one encounter
- These numbers are easily calculated both by the health plan and by PCPs
- These measures are easy to convey to clinical staff, making interventions and dashboards easier to develop
- This methodology will be analyzed and adjustments made for future years (weighting of diagnosis codes)

Acuity Adjustment: Two Components

- Half of dollars in the acuity adjustment will be awarded based on the aid code-adjusted average number of diagnosis codes per encounter submitted by the provider

Diagnosis Codes

- The other half of dollars in the acuity adjustment will be awarded based on the percentage of assigned patients who are seen at least once in the measurement year

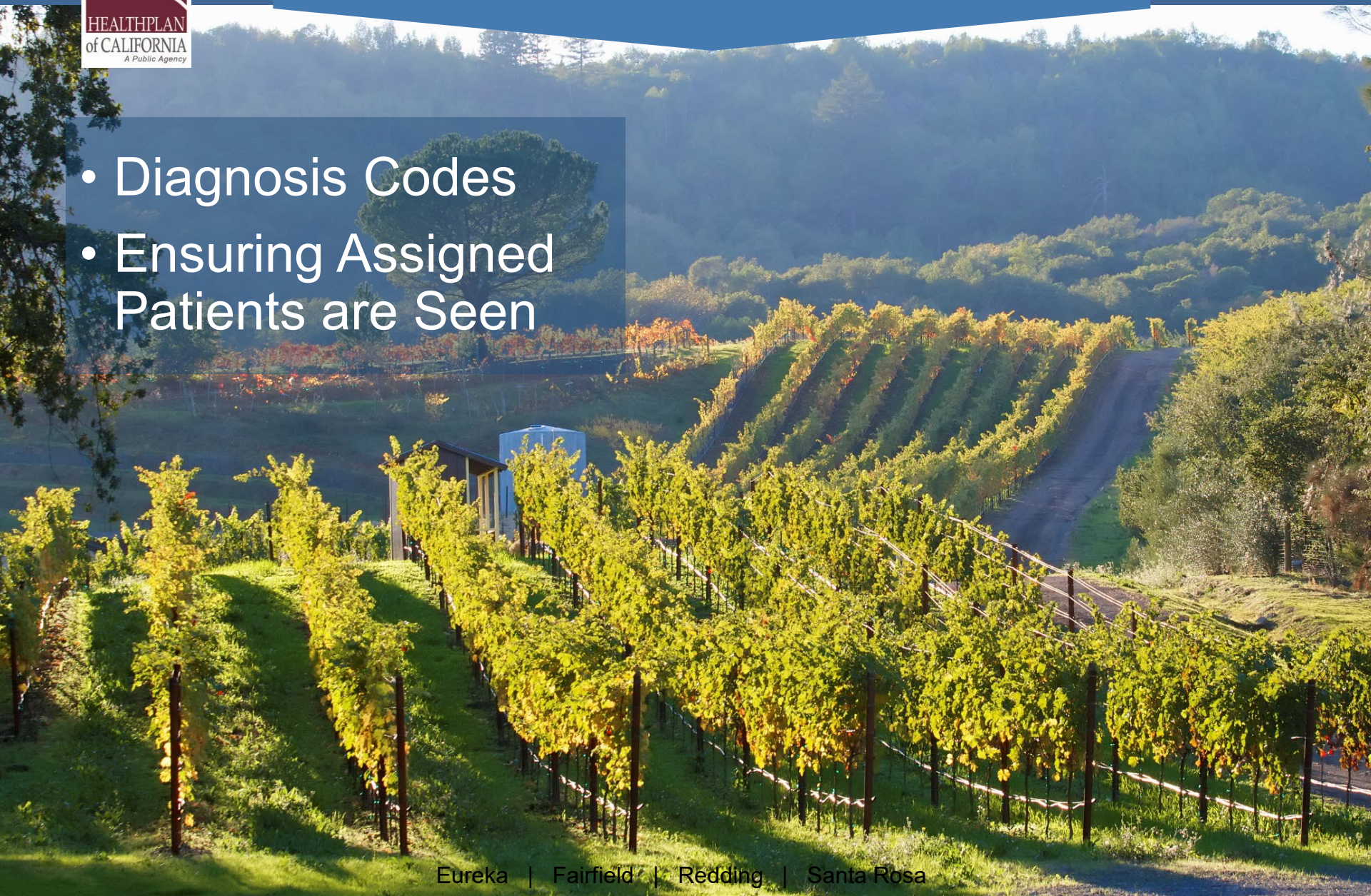
Health Care Engagement

Acuity Adjustment: Two Components

- For both measures, an upper target threshold (above which the maximum dollars are allocated) and lower baseline threshold (below which no dollars are allocated) are established at approximately the 90th percentile and 10th percentile, respectively.
  - Between these values, increased acuity scores will lead to a higher supplemental PMPM.

Description	Zero Adjustment	Max Adjustment	Adjustment Method	Data Source
Acuity: Number of Diagnoses	<2.5 diagnoses /encounter	>4 diagnoses/ encounter	Continuous	PHC Claims Data for PHC. Denominator – claims/PCP site
Acuity: Non-utilizer Rate	>20%	<10%	Continuous	PHC Claims data (all providers); Denominator=assigned patients with some utilization in past 2 years

Recommendations and Best Practices



- Diagnosis Codes
- Ensuring Assigned Patients are Seen

Best Practices for Diagnosis Codes

- Ensure billing system allows for collection and submission of **at least** 4 diagnosis codes.
- Claims review of encounters for inappropriate low number of diagnosis codes
- If time allows in a visit, clinician would review and update the patient's problem list
  - If a previous problem is addressed at a visit, document the medical decision-making or counseling provided on that problem
  - Include it on the list of diagnoses that were covered at that clinical visit (to be sent in with the claim)

Additional Dx Code Recommendations

- Where possible, choose a more specific ICD 10 code, instead of a more general code.
  - Less specific: Diabetes Mellitus E11.8
  - More specific: Diabetes with macrovascular complications E11.59
  - Less specific: COVID U07.1
  - More specific: COVID-19 Pneumonia: U12.82

- Sometimes additional codes are used for co-morbidities or conditions influencing health status
  - One Diagnosis: DM with hypoglycemia without coma E11.649
  - Additional Diagnoses: Stage 4 renal dz: N18.4; DM foot ulcer Z86.31

Additional DX Code Recommendations

- Use coding for social determinants of health
  - Homelessness: Z59.0
  - Inadequate Housing: Z59.1
  - Other problems related to housing: Z59.8
  - Personal history of unspecified abuse in childhood: Z62.819
  - Disruption of family by separation and divorce: Z63.5
  - Dependent relative, needing care at home: Z63.6
  - Problems related to release from prison: Z65.2

- For full list see APL 21-009: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-009.pdf

Additional Dx Code Recommendations

- Add BMI code based on patient weight

CONDITION	ICD-10-CM DIAGNOSIS CODES	CODE DESCRIPTION
Obesity	E66.01	Morbid (severe) obesity due to excess calories
	E66.09	Other obesity due to excess calories
	E66.8	Other obesity
BMI	Z68.35	Body mass index (BMI) 35.0-35.9, adult
	Z68.36	Body mass index (BMI) 36.0-36.9, adult
	Z68.37	Body mass index (BMI) 37.0-37.9, adult
	Z68.38	Body mass index (BMI) 38.0-38.9, adult
	Z68.39	Body mass index (BMI) 39.0-39.9, adult
	Z68.41	Body mass index (BMI) 40.0-44.9, adult
	Z68.42	Body mass index (BMI) 45.0-49.9, adult
	Z68.43	Body mass index (BMI) 50-59.9 , adult
	Z68.44	Body mass index (BMI) 60.0-69.9, adult
	Z68.45	Body mass index (BMI) 70 or greater, adult

Other Strategies?

Please enter other strategies for increasing diagnosis coding into the Chat

Percent of Patients Seen

- All in-person and virtual visits count
- Denominator for this measure is patients who were seen in the prior year or the current year – this removes patients that have never been seen or never want to be seen.
- However, don't give up on patients who haven't been seen in a while. Bringing in a long-lost patient will count for numerator and denominator, boosting the score
- Assuming that on their prior visit, their contact information was updated, the PCP is more likely to be able to reach this population

Align With Other Clinical Quality Measures!

- Prioritize well child visits: First outreach to those who need an annual visit anyway are children up to age 20
- Ensure regular visits for those with diabetes, asthma, and other chronic diseases
  - Diabetes experts recommend at least quarterly visits for all those with diabetes
- For patients with hypertension, whose last BP was not under control, bring them in to re-measure their blood pressure, reinforce lifestyle modification, and adjust medication if needed
  - Repeat visits (in person or virtual) until BP under control
  - Consider ordering a home BP monitor, to facilitate virtual visits for hypertension
- Persons with a cervix due for cervical cancer screening

Other Strategies?

Please enter other strategies for decreasing unengaged members into the Chat

Coding Resources

- ICD 10 codes are produced by the American Medical Association
- CMS course on ICD-10-CM coding:
  - https://www.cms.gov/Outreach-and-Education/MLN/WBT/MLN6447308-ICD-10-CM/icd10cm/index.html
- American Health Information Management Association coding practices for risk adjustment
  - https://bok.ahima.org/doc?oid=302516
- Medi-Cal website: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/manual

Other News

- Health Equity Practice Transformation Grants
  - **Funding**: $700M initiative
  - **Goal:** to improve primary care for Medi-Cal recipients by:
    - Advancing health equity
    - Reducing COVID-19 care disparities
    - Investing in up-stream care models to address health and wellness
    - Fund practice transformation

Learn More at Upcoming Webinar

- Partnership Webinar on the EPT program
  - Date: Tuesday, October 3, 2023
  - Time: Noon – 1 p.m.

- Please register at the link provided below.
  - https://partnershiphp.webex.com/weblink/register/r70ef88b7600831449l776dc862f2657c

Questions

Direct number for Partnership's Claims resolution questions or challenges: (530) 999-6868

PCP QIP Team: qip@partnershiphp.org