Leveraging Data to Inform Value-Based Care

Payers have long used hierarchical condition categories (HCCs)—a risk-adjustment method that is the basis for reimbursing Medicare Advantage plans—to prospectively estimate the costs of caring for their member populations. More recently, healthcare providers looking to embrace value-based care and other risk-based payment models are also starting to use HCCs to get a better handle on projected care costs so they can assume appropriate amounts of risk. In this executive roundtable, sponsored by 3M Health Information Systems, several healthcare executives discuss the role of HCCs and other metrics in facilitating value-based care and offer specific strategies for consideration.

How far along is your organization in its value-based care journey?

Ladd Udy: Mercyhealth has had a provider-based HMO as part of our integrated delivery system for more than 20 years. If you look at it that way, we are already on the path to value-based care with our traditional HMO product. That said, most of our contracts are still fee-for-service and some have pay-for-performance or other quality-based incentives built in. I would say we are in the middle of the pack as far as value-based care is concerned, and we have a lot of experience behind us to help with the transition.

Gary Brock: We recently merged two health systems: Baylor Health System and Scott & White. Our Health Texas Provider Network is a fully integrated physician company in the legacy Baylor Health System, and our Scott & White clinic physicians are part of the legacy Scott & White Health System. All of these physicians are employed and are now part of our quality alliance, which has been in existence for more than five years. We also have non-employed, preferred network physicians who participate in the quality alliance. Plus, we have the Scott & White health plan. Combined, that’s a total of 4,500 physicians who are helping develop best practices, clinical protocols, and care pathways to measure outcomes and promote a population health management approach. Our quality alliance network serves close to 300,000 lives, including our own employees and individuals in third-party payer commercial contracts. In addition, we have about 85,000 lives in Medicare Advantage and the Medicare Shared Savings Program (MSSP).

Phillip Oravetz: I would say Ochsner Health System is ahead of the curve, with about a third of our 600,000 lives in value-based arrangements. We’re a full-risk capitation organization within Medicare Advantage; we participate in the MSSP; we are self-insured as an employer, which is a risk business; and we have a variety of value-based programs with just about every commercial insurer.

PARTICIPANTS IN THE HFMA EXECUTIVE ROUNDTABLE

Gary Brock is executive vice president and chief integrated delivery network officer at Baylor Scott & White Health in Dallas.

Phillip Oravetz, MD, is medical director of accountable care at Ochsner Health System in New Orleans.

Ladd Udy is director of population health and accountable care at Mercyhealth in Rockford, Ill.

Donna Smith is project manager for 3M Health Information Systems in Murray, Utah.
How does your organization use hierarchical condition categories (HCCs) to determine the costs of managing a patient population? What are the benefits of doing this?

Donna Smith: HCCs help accurately report the story of a patient’s chronic disease burden. If a patient has a higher disease burden, he or she is going to need more care than somebody who doesn’t, and that care will cost more. Conversely, if patients are less sick than others, the hospital is going to be offered less money to take care of them. The problem comes when your patient population is sicker than average, and you don’t reflect that appropriately. I met an outpatient physician revenue manager at a top-ranked inpatient hospital who was upset after an insurance company reviewed the organization’s data and concluded its patients weren’t very sick. This hospital’s inpatient clinical documentation showed the opposite: Patients were much more ill than average. It turns out that the patients the insurance company reviewed were being seen primarily as outpatients, and the HCC data weren’t being captured properly. Hospitals need to get a handle on how to optimize HCC data across all their care settings so they can position themselves more accurately.

Additionally, HCCs are important because as more hospitals buy physician practices, they become responsible for how physicians document, code, and bill for the care they provide. Traditionally, hospital health information teams haven’t reviewed coded data from outpatient physician offices because that’s not been the hospital’s area of expertise. However, this lack of review can now have an adverse effect on the revenue cycle, especially if the outpatient data aren’t being captured properly.

Brock: The risk-adjustment factors are obviously critical for us to make sure that we are precisely reporting our patients’ conditions and are ultimately getting paid for the care and services we provide. Are we where we need to be? By no means, but it is a huge area of focus right now, particularly in our existing Medicare Advantage contracts. A lot of our attention is directed toward educating and re-educating our physicians.

Oravetz: HCCs are a linchpin of our fully capitated Medicare Advantage program and form the basis of our care management program. We are looking at the 3 to 5 percent of any population—Medicare, Medicare Advantage, employee, or commercial—on which we spend a disproportionate share of dollars. These are the patients we need to identify and help.

Udy: We are still relatively new to using HCCs, and we aren’t yet at the point where we use them to model out predictive costs, although we would like to eventually get there. Instead, we are using risk as the proxy for cost. Our primary effort is to focus further upstream on the data inputs and ensure risk-scoring accuracy by improving our medical documentation, particularly in the ambulatory setting. Like many other facilities, our documentation-improvement efforts to date have largely centered around acute encounters rather than on the entire care experience. However, there is far more volume in the ambulatory care environment, and so we are starting to work on that area.

As risk-based arrangements emphasize the importance of wellness and preventive care, we are starting to shift our practices to be more proactive. For example, a patient’s annual wellness visit is the ideal time to capture his or her whole health status, looking at chronic conditions—as well as acute ones—and updating the information to factor into the HCC model. This prepares provider organizations for risk-based contracting by ensuring benchmark accuracy, as well as giving them an opportunity to risk stratify their populations.

Are there other types of metrics that help you assess care costs and determine acceptable risk levels? If so, what are they and why are they valuable?

Udy: We always pay attention to what The Joint Commission and the Centers for Medicare & Medicaid Services (CMS) are doing and lean heavily on those quality measures in assessing our performance. On the ambulatory side, we tend to focus on CMS’s 34 ACO measures because they overlap with the physician quality reporting system (PQRS) measures and a lot of our other efforts around quality and meaningful use (MU) compliance.

As for risk adjustment, there are measures that can be used aside from HCCs. Some of these are proprietary models, whereas others are specific to the electronic health record (EHR) an organization uses. These may be general risk scores or gap scores, which are calculated based on how many care gaps exist and what preventive care is missing. Some providers are more comfortable using these tools because they are part of the EHR with which they are already familiar. However, there are caveats. With our EHR, for instance, it does not generate the risk score using an academically proven method. Also, this risk score will only draw from the data coming from the EHR; it will not look at claims data or factor in all the care that patients have had from external providers. As you can see, there are limitations.
Even the HCC model itself is limited because it depends on how good the data input is and how accurate the resulting risk score is. In reality, there is no perfect solution. An organization might feel that one method is better than another based on a specific goal it is trying to reach. For example, we use a certain type of risk score, which is a predictor of readmission or death within 30 days of discharge, for our transitional care management program. This makes sense because when you are trying to reduce readmissions, you can’t wait for claims data, because that can take 30 days or more to come in from payers.

**Brock:** We have one platform as our data aggregation tool, and then we use a separate analytics tool that sits on top of the platform that allows us to segment our members according to risk profiles. We are able to identify patients in the top 5 percent risk category and then the next 15 percent who are the highest-rising risk. Once we stratify these patients, we align our resources around them accordingly.

Some of the other metrics we review are admissions per thousand; 30-day readmission rates; appropriate site of care—which includes getting more patients who shouldn’t been seen in the emergency department into after-hours or urgent care—and formulary management, including higher generic utilization rates and standardization around antibiotic therapy. Over the past three years, we’ve delivered more than $30 million in shared savings in our own Baylor Scott & White employee and beneficiary health plan program. We also look at quality metrics for specific chronic disease states, adult preventive care measures, and patient satisfaction.

Keeping patients in network is also key—nearly 80 percent of the medical dollars being spent are currently within our quality alliance network. The more care we provide in network, the more we can collect the right data to better manage patient care along the continuum.

**Smith:** Many hospitals concentrate on quality metrics because value-based metrics are often tied to quality. Yet, organizations should be cautious because you can’t determine if you have a quality problem unless you are sure your data are being reported correctly. When an organization examines data about infections, or lacerations, or hemorrhages, how does it know which of these were hospital-caused or not? The answer is in the codes used to classify these events. As such, the accuracy and completeness of the coding and the reporting are critical. I think that is where people need to start.

**Udy:** We educated providers on what this HCC model is, how it works, and how it affects us by bringing in a certified coder and a physician as guest speakers. Next, we made HCCs more visible to physicians as a part of their normal workflow. For example, if a patient presents at the clinic with a condition that hasn’t been assessed in the past year, the physician receives a pop-up alert in our EHR, prompting him or her to assess and document the condition. Once that is captured in the system as an encounter diagnosis, the alert won’t pop up again for another year. Clinic nurses also see these alerts when they review a patient’s record for overdue preventive care.

In addition, we introduced within our EHR a new column in the diagnosis search box—something our physicians use regularly—that shows which conditions get a risk adjustment. We put in a “yes” or “no” next to each condition listed in the column. This helps remind the physicians to be more specific if they are initially going to put down a generic diagnosis. Some of our providers have actually told us that they are surprised to learn which conditions get an adjustment and which ones don’t, so we know they are seeing this.

In the future, we plan to shore up our reporting to see who is bypassing these alerts and target additional education efforts to them. We also want to incorporate risk-adjustment coding more strongly into the pre-visit planning process used by the clinic nurses. This way, when the nurses review the charts before the patient encounter, they can know what to talk about with the provider, including what the provider needs to discuss with the patient.

**Oravetz:** We, too, developed a robust and advanced program by building tools into our EHR that make it easier for doctors to document their HCCs. One program is a scorecard of sorts that uses colored dots...
to show which diagnoses have to be addressed for the current calendar year. On Jan. 1, all the dots appear black, but as patients are seen during the course of the year, and as more conditions are documented into the system, more of the dots turn green. The doctors love it, and by the end of the year, we can easily see in the system which patients don’t have the right documentation and go back and correct that.

Second, we’ve built templates for our nurse practitioners who perform the annual, hour-long patient health risk assessment, enabling us to dig deep into the patient’s health history. That program has been successful as well.

Smith: Some organizations are hiring more coders to capture HCC data at the physician-management level. Others are hiring nurses to do chart reviews prior to a patient being seen by the physician and write reminder notes on which conditions to include on the claim or bill. Yet, this is expensive, and it can be tough to find good coders. What I hear is that physicians want some kind of technology or software to help them accurately capture and report this information on an individual patient basis.

Could you share some lessons learned with other organizations looking to start using HCCs and other metrics to enable value-based care?

Smith: Regardless of care setting, it’s important to get a complete picture of what is going on with the patient through coding. Let’s say a physician visits an ICU patient who is put on a ventilator and the coder later indicates respiratory failure on the claim as the diagnosis, thinking that Medicare won’t reimburse for the ventilator otherwise. However, patients may be put on ventilators for other reasons, such as following a bypass procedure. Consequently, a post-operative respiratory failure diagnosis is not only inaccurate, it’s a quality mark against the hospital. That is the kind of thing organizations must pay attention to.

Udy: As a first step, I would recommend doing a thorough internal assessment to find out how much HCC coding or lack thereof may be affecting you already. We did the assessment just by looking closely at our risk contracts.

I would also stress that it takes time to make improvements, so it is good to start sooner rather than later. If you are not going to take on major risk for a few years, this is less urgent, but if you are already in a capitated arrangement, and you don’t have a good handle on your HCC coding, then this would rank very high on the urgency scale.

Oravetz: You shouldn’t be going into value-based programs unless you have a good claims and clinical data set because if you don’t have all the information, any risk model you use is going to be less than effective. Moreover, because you will never have enough resources to manage your entire population, you have to narrow your focus to those patients where you can have the biggest impact.

We are entering the era of Big Data in health care. All of these models are starting to incorporate a lot of behavioral, psychosocial, demographic, and other elements that extend our predictive capacity. Social media, retail, banking, and countless other industries do it already; it’s time we get up to speed in health care. Think about it this way: Our health system has research that says that the No. 1 thing that determines why a heart failure patient is readmitted to a hospital is that he or she lives alone. With that kind of knowledge, we should be able to make an intervention before discharge. I think we are on the verge of determining a whole new set of indicators to help patients get better care, and that’s very exciting.