

Risk Adjustment and CDI Through a Population Health Lens

Jessica Vaughn, DNP, RN, CCDS, CCDS-O, CRC

Director of Operations, Condition Management and Documentation
Advocate Health
Downers Grove, IL

Wilson Gabbard, MBA, FACHE

Vice President, Quality and Condition Management
Advocate Health
Downers Grove, IL



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Presented By



- **Jessica Vaughn, DNP, RN, CCDS, CCDS-O, CRC**, is the director of operations, condition management and documentation, at Advocate Health in Downers Grove, Illinois. A nurse of 26 years, Vaughn has 12 years of CDI experience in both inpatient and ambulatory settings. She joined Advocate Health in 2022, where she leads a large multidisciplinary team focused on ambulatory CDI for risk adjustment and quality gap closure, as well as teams focused on population health initiatives including patient outreach, comprehensive care, and revenue cycle management. She is a leader in the industry, having previously created and led ambulatory CDI initiatives for Atrium Health Wake Forest Baptist in Winston-Salem, North Carolina, and Norwood in Austin, Texas. She has spoken at multiple conferences, authored articles, received ACDIS' Professional Achievement Award and helped write both the original study guide and the initial CCDS-O certification exam. She has held clinical certifications in oncology, chemo and biotherapy, and AHIMA's approved ICD-10 CM/PCS trainer. Vaughn completed her doctor of nursing practice in executive leadership at Duke University and believes in empowering interprofessional teams to improve patient care.

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Presented By



- **Wilson Gabbard, MBA, FACHE**, is the vice president of quality and condition management for Advocate Health, the fifth largest not-for-profit, integrated health system in the United States and a national leader in population health. He joined Advocate in 2020 where he is responsible for the clinically integrated network and medical group quality for more than 1.3M value-based lives and risk adjustment strategy for over \$3 billion in system risk-based revenue. His responsibilities include operationalizing programs for a portfolio of joint-ventures, fully delegated capitation, upside/downside risk, shared savings and pay for performance contracts. Previously, Gabbard spent seven years leading population health operations for UNC Health Care where he was responsible for strategy and operations during their transition from fee-for-service to value-based reimbursement. The UNC population health services team grew from two to over 200 team members during his seven-year tenure. Prior to joining UNC, he led regional operations for primary and specialty care practices and regional emergency and hospitalist service lines for Vidant Medical Group. Gabbard received his Bachelor and Master of Business Administration degrees from Morehead State University and is a Fellow of the American College of Healthcare Executives (FACHE).

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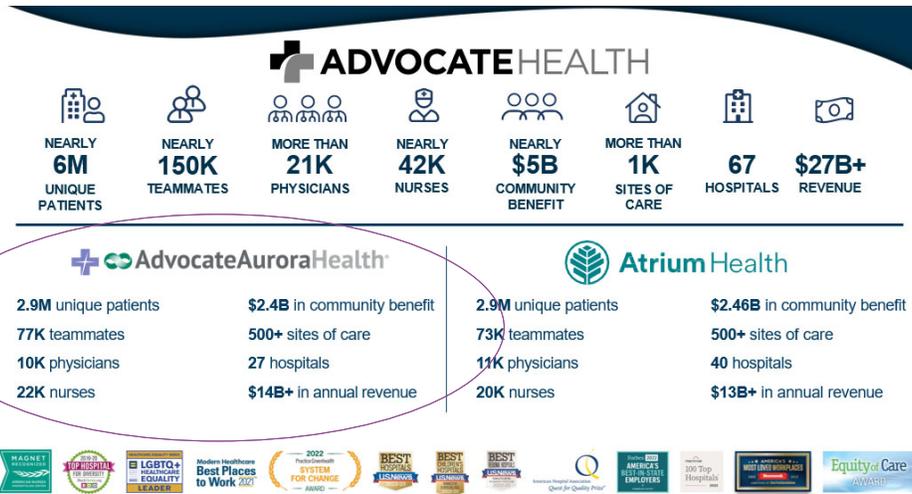
Learning Outcomes

- At the completion of this educational activity, the learner will be able to:
 - Define risk adjustment and why it's important to population health services, value-based care, and patient care programs.
 - Describe how core teams, focusing on patient care and the full revenue cycle can collaborate to affect risk adjustment accurately and compliantly.
 - Understand data and KPIs to identify and close care gaps using prospective, concurrent, and retrospective CDI and coding workflows across a matrixed system.

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Who Is Advocate Health?



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BY THE NUMBERS



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Our Population

Caring for 1.3 million lives
in 40+ value-based contracts



Commercial
Shared Savings
577K lives



Commercial
HMO
221K lives



Medicare Shared
Savings Program
171K lives



Medicare
Advantage
106k lives



Advocate Aurora
Team Members
106K lives



Managed
Medicaid
87K lives



Medicare
Bundles
10K lives

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Raise Your Hand - Question #1

- How would you rate your understanding of risk adjustment?
 - I am just learning about it.
 - I understand the basics.
 - I know more than the basics but I'm no expert.
 - I am the BOMB.com! (hint: significant understanding)

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Defining Risk Adjustment

- A mathematical formula that attempts to “level the playing field” so that people with higher healthcare risks (conditions that typically incur high costs to insure) are **not denied insurance**, and so all beneficiaries do not incur higher premiums.
 - **Protect** the less fortunate
 - **Protect** healthcare access for all
 - By **predicting** the expected outcomes of populations

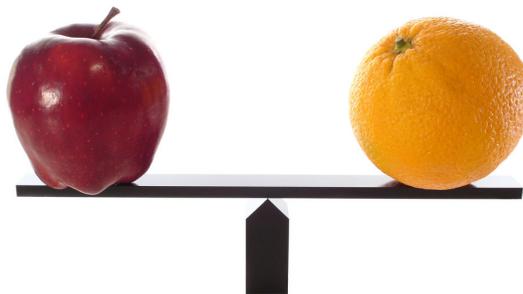
$$y_i = \beta_0 + \beta_1 x_{i1} + \beta_2 x_{i2} + \dots + \beta_p x_{ip} + \varepsilon_i$$

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/Risk-Adjustment.pdf>

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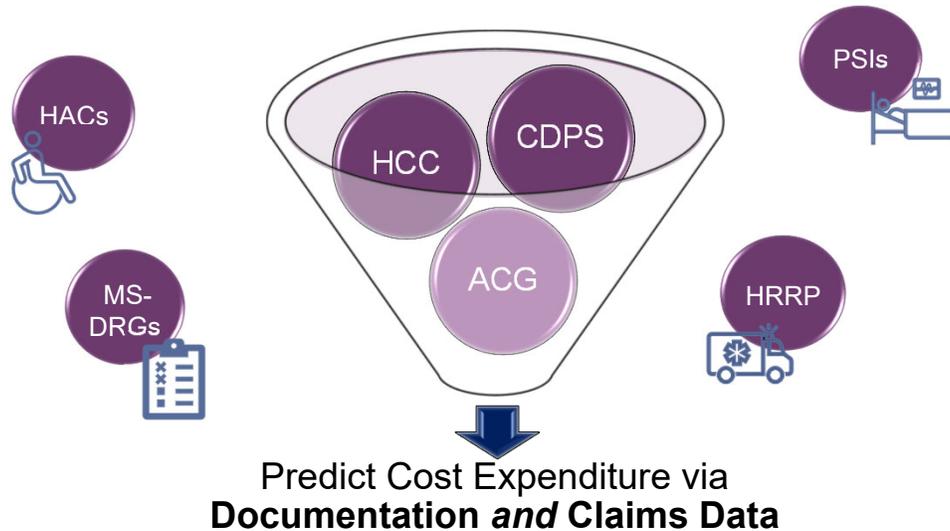
A Picture of Risk Adjustment



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Risk Adjustment Models



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Risk Adjustment Differs with Payment Model

- The risk adjustment model enacted under the Affordable Care Act (ACA) is budget neutral.
 - When in a “risk” contract, the insurer with a greater volume of healthy beneficiaries must contribute to a set of funds to help insurers with a greater volume of high-risk (sicker) beneficiaries.
 - Typically based upon demographic data and **ICD-10 diagnoses** to determine a risk score
- Medicare Advantage (MA) in general is not budget neutral.
 - Private insurances contract with CMS to receive funds and must prove they “deserve” it.

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Condition Management and Documentation (CMD) Fundamentals

- Risk adjustment is a population health fundamental!
 - Ensures that patients and their conditions are not lost to care.
 - Helps ensure that chronic conditions are well cared for and can help reduce condition exacerbation.
- wRVUs and CPT coding are to fee-for-service as risk adjustment is to value-based care.
- Our goal is not for clinicians to be expert coders but rather to support them being expert caregivers. We need to make it easy for them to do the right thing, for the right patient, at the right time.
- All programs should focus on completeness and accuracy to improve patient outcomes.
 - OIG/DOJ focus on risk adjustment compliance.
 - Develop strong legal and compliance partnerships to oversee and audit programs.

Generic Health Estimated Value Case Medicare Advantage (CMS Model)

Inputs and assumptions

Population size and growth

- 1,000 Medicare Advantage (MA) members
- Assume 500% annual growth in covered lives

Risk and reimbursement

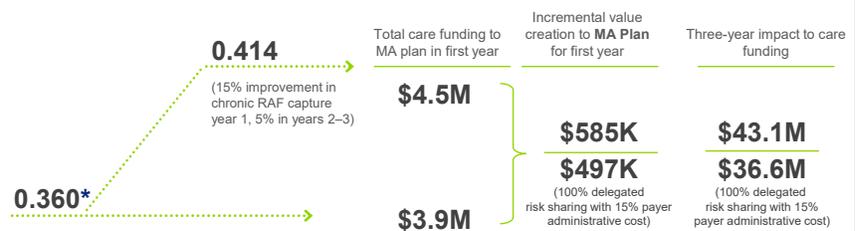
- Assume current premium for MA is \$985 PMPM
- Assumes 100% delegated risk sharing after typical 15% payer administrative cost*

Risk Score implications

- Assume a 0.90 total RAF, chronic RAF estimated to be 40% of total RAF
- Chronic RAF conservative improvement estimated at 15% in first year, 5% in each subsequent year

* Assumed baseline chronic RAF capture.

Projected financial opportunity:



DOS Year	Year 1	Year 2	Year 3
Number of lives	1,000	6,000	36,000
cRAF Portion of total RAF	0.414	0.435	0.456
Incremental value creation to health system with 100% risk sharing and 15% payer administrative cost	\$497,327	\$4,127,810	\$31,973,121

Case Study: Refresh of ROI Calculation for Timing

Inputs and Assumptions:

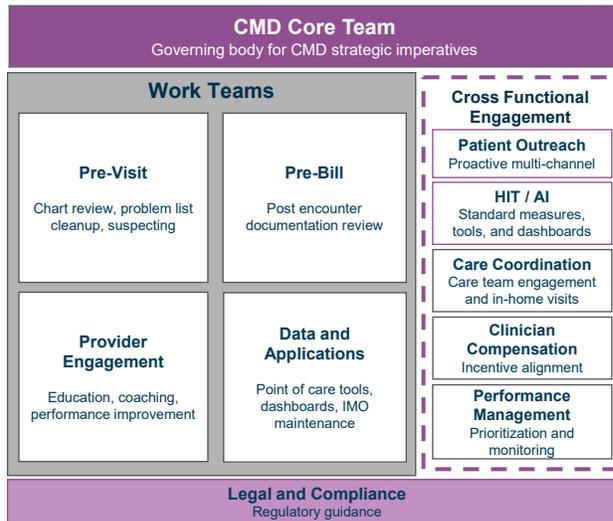
- Population Size & Growth**
 - 5,023 MSSP members, assume 5% annual growth in covered lives
 - 9,200 MSSP beneficiaries with no growth projected in financials
- Risk & Reimbursement**
 - MA: Current premium for MA is \$800 PMPM
 - MA: Assume a 50% delegated Risk Sharing agreement signed beginning 2023 with first year PMPM aligned with 2022 capture rate
- HCC Implications**
 - MA: Assume a .710 Starting Total RAF, chronic RAF estimated to be 40% of Total RAF
 - MA: Chronic RAF conservative improvement estimated at an adjusted 7.5% increase in the five months of 2022, 2023 assumes the full 15% increase, with 5% increases in 2024, 2025, and 2026. cRAF scores are held constant in the final year, 2027
 - MSSP: Assume that Generic Health is achieving the 3% growth cap on MSSP population each year

Risk Program	2022 (five months)	2023	2024	2025	2026	2027 (seven months)
Number of covered lives	5,023	5,274	5,538	5,815	6,105	6,411
Chronic RAF portion of total RAF	0.305	0.351	0.369	0.387	0.406	0.427
MSSP revenue value created	\$1,900,000	\$2,000,000	\$2,100,000	\$2,200,000	\$2,300,000	\$2,400,000
Medicare Advantage value created (50% risk sharing)	\$213,980	\$1,557,024	\$2,062,624	\$2,637,349	\$3,289,148	\$2,562,528
Timing of value realization	\$0	\$2,113,980	\$3,557,024	\$4,162,624	\$4,837,349	\$5,589,148
Cash flow timing	\$0	\$0	\$2,113,980	\$3,557,024	\$4,162,624	\$4,837,349

Period of value creation by increased capture

Governance Structure

Purpose: Define and implement condition management and documentation (CMD) strategy for AAH. Establish strategic mandates, identify measures for success, and support core team in outcome accountability.



Short Term Goal

Swift decision-making from clinical and operational leadership on initiatives and performance that impacts CMD program goals and development

Long Term Goal

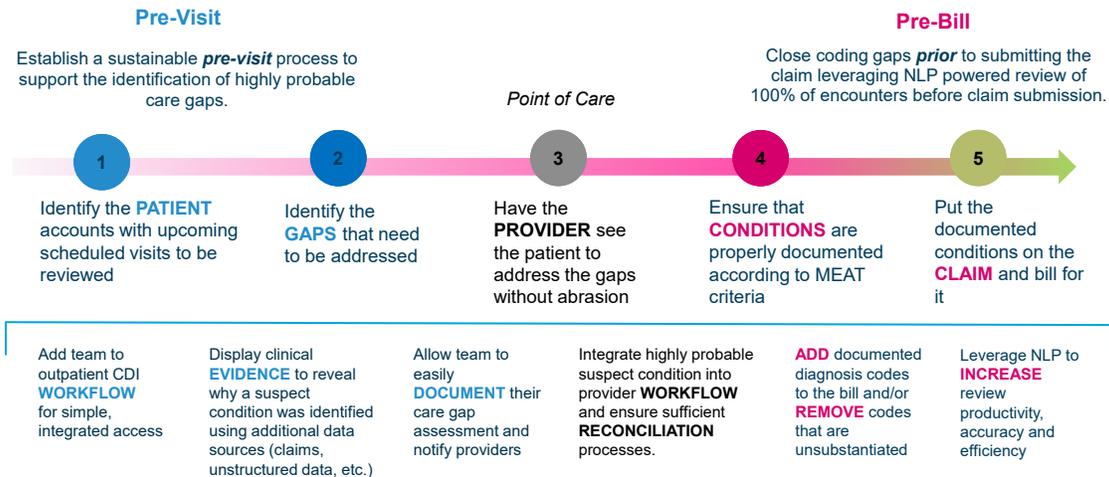
Development and continued optimization of best-in-class CMD program to drive optimal chronic disease management, complete, and accurate documentation.

Key Priorities

- 85% chronic condition refresh rate
- 95% completeness and accuracy rate
- 80% MWV rate
- 92% senior wellness PCP visit rate
- Monitor plan risk score performance

Complete Documentation of Patient Complexity

Pre-visit, point of care, and pre-bill teams working in tandem to fully capture complexity of care.



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Outreach

Partner with outreach/employer products to outreach to patients in need of an annual visit and follow-up to support care gap closure, chronic conditions, and re-engage value-based lives with their primary practice.

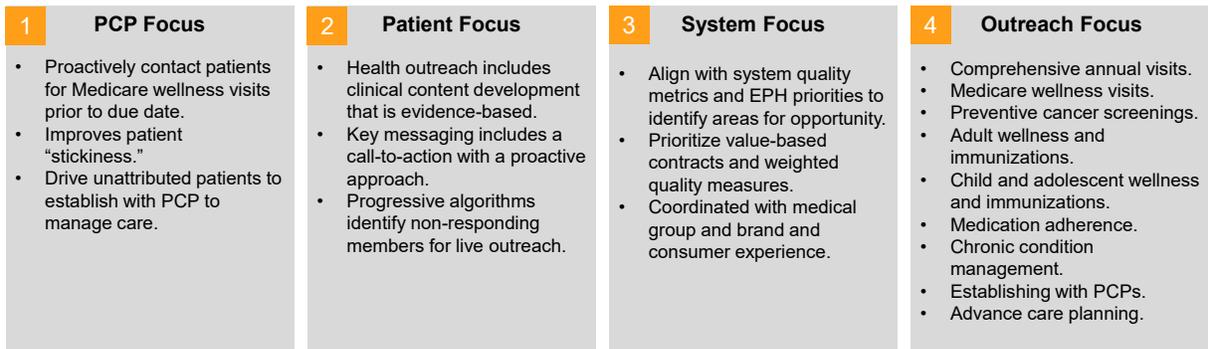


1,598,214 patient interventions

- Medicare Advantage
- MSSP/ACO
- Commercial/Medicaid



15.9 – Outreach FTEs
2 - Leaders



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Engagement Program

Engages clinicians, care teams, and leaders through ongoing education, coaching, performance improvement, tool development, and accountability to drive success.



12 FTE
Engagement Team

1 – Manager
1 – Project Coordinator for auditing, projects, orientation materials, clinical staff resource
10 – Consultants for enterprise development and training of education tools and process improvement.

1 Education and Coaching

- Tip sheets for EHR tools.
- Specialty-specific approach.
- Case studies and disease specific tip sheets.
- Monthly newsletters.
- Orientation of new clinicians and leaders.
- 1:1, web-based, on-demand, and group training sessions.

2 Performance Improvement

Top opportunity providers where chronic conditions are not being managed, standard PDSA processes utilized.



3 Engagement Tools

Proactively engage providers coming up for maintenance of their certification and CME opportunities for primary care and specialists.

Incentive and required/highly encouraged education requirements.

Clinician champions.

4 Risk Adjusted Appointment Times

Adjust clinician schedule templates for long and short appointments based on the severity of illness of the patient.

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Pre-Visit Planning and Advanced Suspecting

Prior to a patient's scheduled encounter, the pre-visit process will review the accuracy of a patient's problem list, diagnostic results, and prior billed conditions **from both internal and external data sources**.



17 FTEs
Pre-Visit Planning Nurses

2 lead RNs for high risk reviews, projects, clinical staff resource, work queue support

15 RNs for enterprise pre-visit chart reviews for upcoming appointments

1 Worklist

PVP RNs use work queues based on upcoming appointments.

- Upcoming visit within seven days.
- Visit with a PCP.
- Prioritize based on risk of readmission.

2 Chart Review

Review chart for evidence of active and suspect conditions that have yet to be addressed in the calendar year:

- Progress notes
- Specialist/hospital notes
- Radiology
- Labs

3 Problem List

Review problem list for accuracy.

Protocol approved for CMD RNs to add/edit 17 conditions in the problem list.

PVP RNs work top of license in problem list maintenance, therefore allowing providers more time to focus on quality patient care.

4 Chart Prep

Curate suspect conditions in Epic BPA for provider's final review.

Provider Benefit: Simplifies chart prep to increase efficiency and effectiveness during patient visit.

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Point of Care Tools

Tools are available to help identify care gaps and support clinicians in identifying conditions.



+1k PCPs
Utilizing point of care solutions

50+ homegrown suspect clinical algorithms
 • +90% acceptance rate
 Three dedicated analysts and one project manager

1 Panel Management

Dashboards and reports allow clinicians to identify patients who may be lost to care.

- Identifies Medicare wellness visit completion rates.
- Identifies patients with open care gaps.
- Identifies conditions that have not been reevaluated.

2 Schedule Identification

Identification of patients with open care gaps from clinician's daily schedule.

- Health maintenance
- Chronic conditions
- Suspected care gaps

3 Visit Navigation

Condition assessment and planning in native EHR tools.

- Ensures problem lists are well maintained and conditions are well managed.
- Highly confident (+90% accuracy) suspect algorithms support top of license practice.

4 Visit Closure

Identify care gaps that may be unaddressed before chart closure.

- Ensures conditions are well managed.
- Promotes safe handoffs in care across specialties.

Provider Benefit: Reduces pre-bill queries.

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Comprehensive Annual Visits (CAV)

Partners with continuing health to provide annual visits in the patient's home to support care gap closure, reevaluate chronic conditions and re-engage value-based lives with their primary practice.



721 CAV Visits Completed
 • Medicare Advantage
 • MSSP



3 advance practice clinicians dedicated to complete CAV visits
 1 pre-visit planning FTE

1 CAV Overview

The program is a key strategy put in place to support care coordination and gap closure.

CAV visits are intended to engage patients unwilling or unable to engage in our traditional care model and those who have remaining care gaps through typical care team engagement.

2 Pre-Visit and CAV Visit

Thorough pre-visit planning helps the APCs determine the equipment needed to complete the necessary point of care screenings (i.e., BP, A1c, spirometry, retinal eye exam).

During the visit meaningful conversations take place, which allow us to identify social determinants and close gaps.

3 Care Gaps Addressed*

885 chronic conditions have been evaluated and 1,001 care gaps have been closed.

675 patients have been re-engaged to a primary practice.

4 Services for Older Adults*

Provide additional services for older adults by completing additional assessments that resulted in ~501 total practice hours saved. These include:

- 641 advance care planning
- 497 functional status assessments
- 666 medication reviews
- 652 pain assessments

*Period: 11-21-21 to 12-5-22

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Pre-Bill Review

Partner with revenue cycle to identify and address gaps in complete coding, following a patient encounter.



330k members

- Medicare Advantage
- MSSP
- Commercial



20 Coding FTEs

dedicated to risk adjustment coding

<p>1 NLP Review</p> <p>Leverage natural language processing (NLP) technology to ensure missing diagnoses and incomplete documentation are corrected prior to the claim submission.</p>	<p>2 Work Queue</p> <p>Work queues generated by NLP and prioritized by date of service for coders to review completed encounters.</p>	<p>3 Chart Review</p> <p>Encounters and billed diagnoses are reviewed for proper coding of all documented chronic conditions.</p> <p>Addition – documentation supports condition not coded.</p> <p>Deletion – condition coded that is unsubstantiated in the documentation.</p>	<p>4 Conditions Billed</p> <p>Coder adds and/or removes diagnoses to or from the bill as appropriate.</p> <p>Once conditions are properly documented on the claim, it is billed.</p>
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CMD Analytics & Intelligence

Partners with our analytics intelligence team to address analytic needs for CMD, leadership, and related CMD governance work teams to create outcomes reports and outreach lists.



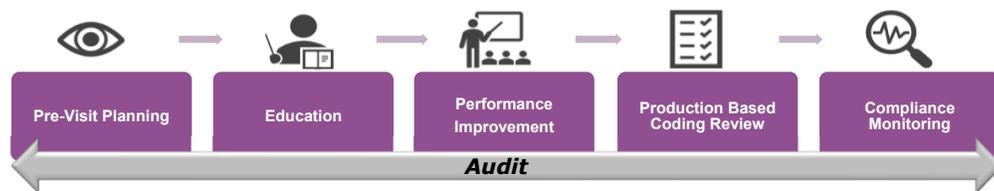
1 Project Manager
3 Analysts

Project manages enhancement requests and break fixes in addition to trouble shooting, testing, and producing requested reports from Cerner, Power BI, and Epic databases and tools.

<p>1 Claims Analytics</p> <ul style="list-style-type: none"> • Claims based. • Enterprise-wide interactive dashboards for leadership. • Point of care patient lists for aligned contracts. • Supports CI metrics for APP. 	<p>2 Business Intelligence</p> <ul style="list-style-type: none"> • Epic clinician interactive leadership dashboards . • Employed and Epic Connect aligned monthly outcomes reports and patient lists using Epic point of care information. • Enterprise-wide year-over-year trending reports for KPIs 	<p>3 EHR Tools</p> <p>Employed and Epic Connect point of care analytics</p> <ul style="list-style-type: none"> • Slicer Dicer reports. • Caboodle SSRS reports. • Patient lists for outreach. • IMO loads and annual risk model updates. • Grouper updates. • Power BI dashboards. 	<p>4 Ad-hoc Reports</p> <p>Additional reporting to observe trends in:</p> <ul style="list-style-type: none"> • Suppression of conditions. • Usage of point of care tools. • Conditions lifecycle monitoring. • Pre-visit team outcomes. • Monitor attribution, payer onboarding, enrollment file loads from RME, Tapestry into Epic and Cerner.
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Takeaways

- **Develop processes** that support accuracy and completeness.
 - Pre-visit planning process to avoid coding conflicts and alert fatigue.
 - Education process to promote complete and accurate coding.
 - Performance improvement activities to distill trends and review results.
 - Coding review process to capture possible over/under coding prior to claim submission.
 - Compliance monitoring process to identify coding patterns/trends and remediation opportunities.
 - Annual audit process including action plan.



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Thank you. Questions?

jessica.vaughn@aah.org, wilson.gabbard@aah.org

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