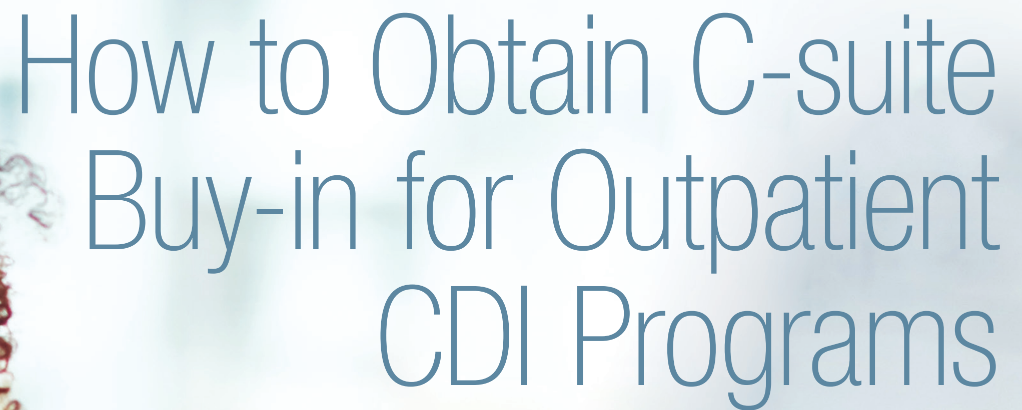


# How to Obtain C-suite Buy-in for Outpatient CDI Programs

By James P. Fee, MD, CCS, CCDS; Sonia Trepina; and Rachel Phillips, RHIA, CCS, CCDS



Copyright ©2018 by the American Health Information Management Association. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, photocopying, recording or otherwise without prior permission from the publisher.

IN AN ERA of risk-adjusted payments, organizations—particularly those embarking on the journey toward becoming an Accountable Care Organization (ACO)—are turning their attention from inpatient to outpatient clinical documentation improvement (CDI) with a focus on the accurate capture of hierarchical condition categories (HCC). This is also true for organizations participating in other types of alternative payment models, those with a large volume of patients who have Medicare Advantage coverage, and those with a significant number of pay-for-value contracts.

Health information management (HIM) professionals understand the importance of HCC capture, but they need to explain the concept to the C-suite before the organization can launch a full-blown outpatient CDI effort. The sooner HIM obtains buy-in, the better. Why? ACOs participating in the Medicare Shared Savings Program (MSSP) must achieve a target percentage less than the budget or benchmark to potentially obtain a shared savings based upon quality performance. For MSSP track 1, the target is 2.5 percent.

Cost reduction or utilization management is often the first strategy that organizations employ to meet the target rather than optimizing HCC risk scores to raise the benchmark or budget. If historical risk-adjusted data does not portray true population risk, the ACO's viability can be compromised. Not preparing in advance equates to three years of incorrect budgeting. For example, at $700 per member per month for a population of 8,500 patients, a 6.9 percent increase in the RAF score equates to approximately $4.9 million. Early C-suite buy-in is therefore critical. See Figure 1 on page 26 for a HCC/risk adjustment financial impact example.

## Create an Outpatient CDI 'Value Proposition' Team

In reality, no single individual can easily make the case for outpatient CDI. It takes a team of experts to demonstrate why outpatient CDI is necessary to improve value-based payments. In many organizations, this team includes the following:

1. **HIM—either the HIM director, HIM manager, or CDI manager.** HIM professionals understand the impact of clinical documentation and coding on payment, quality, profiling, and patient care. They possess an in-depth knowledge of ICD-10-CM/PCS coding guidelines and classifications systems, and they can identify clinical indicators that help support queries. They also know what auditors look for when auditing (e.g., current vs. history of cancer, conditions for which there is no evidence of treatment or evaluation, or capturing stroke instead of sequela codes).

   What they bring to the table: HIM can explain how the organization can create a compliant outpatient CDI program that focuses on accurate documentation and coding.
2. **Physician champion.** As with any CDI effort, physician support is critical. For outpatient CDI, consider partnering with a physician who is interested in clinical integration or population health management. A primary care physician (PCP) is a logical choice. That's because PCPs tend to be the physicians who most often identify, address, and document a variety of HCCs that ultimately affect risk adjustment payment methodologies. If the PCP has shared-savings contracts or participates in Medicare Advantage programs, he or she may already be well aware of the importance of HCCs and Medicare risk adjustment factor (RAF) scores. If not, they may need education on how diagnosis codes drive physician reimbursement under value-based payment. This is a sharp contrast from fee-for-service payments driven by CPT codes.

   What they bring to the table: With education and awareness, a physician champion can explain the clinical importance of HCC capture to hospital and health system leaders, and ultimately help obtain buy-in from other physicians.
3. **Director or vice president of quality (hospital and/or ambulatory).** This individual should possess an in-depth knowledge of various outpatient quality- and value-based reimbursement programs that are driven by HCCs. If an organization doesn't have someone in this role, the re-

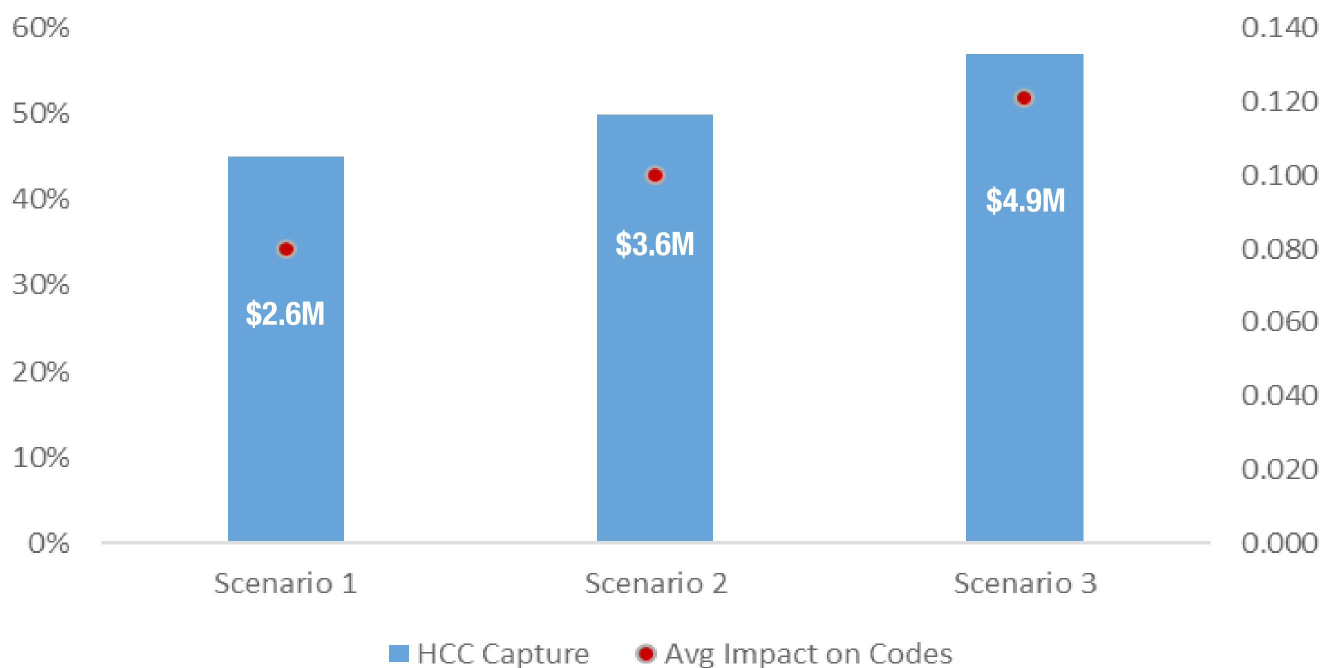
Copyright ©2018 by the American Health Information Management Association. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, photocopying, recording or otherwise without prior permission from the publisher.

## Figure 1: HCC/Risk Adjustment Financial Impact Example

IF A CONTRACT was for $700 per member/per month (PMPM) with a risk score increase of 6.9 percent, then the projected gross impact would be $4.9M (Scenario 3) if results of 57 percent HCC opportunity across 8,500 members continues through the year. Note: Requires information regarding contract details.

Based on 1.0 benchmark RAF and $700 PMPM. Gross revenue impact captures both revenue at risk for not capturing conditions that were previously captured and new revenue for capture of new conditions. Net impact is based on contract terms.

**GROSS REVENUE IMPACT BASED ON FINDINGS AND EXTRAPOLATION TO 8,500 MEMBERS**




sponsibility may fall on HIM to obtain this knowledge if they don't already possess it.

What they bring to the table: A hospital director or vice president of quality can explain how HCCs and condition categories affect hospital quality measures. An ambulatory director or vice president of quality can explain how these same codes affect ambulatory quality programs.

4. **IT/project manager.** An IT-savvy project manager can help the organization capitalize on electronic health record (EHR) technology as it ventures into outpatient CDI. For example, he or she can activate HCC registries to identify patients with gaps in diagnoses and risk scores, build physician-specific diagnosis preference lists that include common HCCs, redesign workflows to maximize efficiencies, and develop IT tools to help physicians capture HCCs more easily. In some cases, the manager of ambulatory quality or HIM director may be able to serve in this role.

What they bring to the table: An IT/project manager can help leverage technology and explain the logistics of executing the outpatient CDI program and how the EHR will enable a return on investment.

### Focus on What Matters Most to the C-suite

The C-suite doesn't need to know all of the intricacies of RAF score calculations. Instead, deliver a high-level message that conveys how outpatient documentation affects inpatient reimbursement. They need to understand that HCCs included on outpatient claims for face-to-face visits affect hospital risk-adjusted value-based payments. This is important because inpatient documentation of HCCs and condition categories are sometimes lacking. When calculating population risk, the Centers for Medicare and Medicaid Services (CMS) looks back at outpatient claims over a 12-month period prior to the inpatient admission. Outpatient claims can fill in the gap, allowing organizations to get credit for HCC and condition category capture.

The C-suite also needs to understand that some HCCs and condition categories don't risk adjust and positively impact the readmission reduction program or bundled payment programs unless providers document them *before* an inpatient admission. Examples include chronic kidney disease (stages four and five), diabetes and associated complications, and hemiplegia. This is something that members of the C-suite must understand because it reiterates the importance of outpatient CDI.

 Copyright ©2018 by the American Health Information Management Association. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, photocopying, recording or otherwise without prior permission from the publisher.

## Know the Potential ROI

With inpatient CDI and DRG-based payments, there's a more immediate and apparent return on investment. With outpatient CDI, the return on investment will differ depending on the type of ACO or value-based contract. It may also take at least a year to fully reap financial rewards.

Still, the C-suite will want to understand the potential financial impact of outpatient CDI efforts. Use a hypothetical example, similar to the one displayed in Figure 2 on page 28, that demonstrates how specified HCCs can greatly affect the Medicare Advantage per member per month payment. Combine this data with how much it costs to care for the patient, and it becomes apparent that without coding any chronic conditions organizations actually lose money under these types of risk-adjusted contracts.

Present the C-suite with these other benefits of outpatient CDI:

- **Appropriate physician payments under MIPS.** Beginning this year, cost data counts toward each physician's MIPS final score. HCCs help justify why costs may be higher to care for certain patients.
- **Improved 30-day mortality metrics.** As CDI programs focus on inpatient clinical validation, they may notice a decrease in their expected mortality rate. HCC and condition category capture in the outpatient setting can help offset this decrease. Ideally, the expected mortality rate will be noticeably higher than the actual mortality rate. When the gap between the two begins to close, HCCs may be able to widen it.
- **More streamlined revenue cycle processes across multiple settings.** As lines of communication open between inpatient and outpatient settings, operational silos begin to fade. This can lead to greater efficiency overall.
- **Potential for better outcomes and lower costs.** HCC capture is all about population health management—managing chronic conditions that could otherwise lead to costly hospitalizations.

## Use Facility-specific Data to Build Your Case

Baseline metrics are critical for any CDI program because they help demonstrate the need for outpatient CDI, and they'll serve as a point of comparison as efforts get underway. Medicare Advantage plans may be able to provide organizations with HCC capture rates. However, organizations must keep in mind that this data may not be completely accurate, or it may even be falsely elevated if documentation doesn't clinically support the HCCs.

For the most accurate baseline data, organizations should analyze their 837 or UB claims data to identify current HCC capture. If an organization doesn't have an internal data analytics team that's able to do this, it may want to consider working with a consultant. The following are several questions to consider when analyzing the claims data:

1. What patient population is included in the advanced alternative payment model in which we're participating?

Copyright ©2018 by the American Health Information Management Association. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, photocopying, recording or otherwise without prior permission from the publisher.

## Figure 2: HCC Financial Impact in Coding and Documentation Improvement—CMS Payment to Medicare Advantage Payer

| No Conditions Reported (Demographics Only) | | Some Conditions Reported | | All Conditions Reported Appropriately | |
|---|---|---|---|---|---|
| **Status/Condition** | **Weight** | **Status/Condition** | **Weight** | **Status/Condition** | **Weight** |
| 80-year-old female | .557 | 80-year-old female | .557 | 80-year-old female | .557 |
| Medicaid Eligible | .179 | Medicaid Eligible | .179 | Medicaid Eligible | .179 |
| | | Diabetes (without manifestations) | .118 | Diabetes with CKD | .368 |
| | | CKD Stage 4 | .224 | CKD Stage 4 | .224 |
| | | History of CVA | | Hemiparesis following CVA | .581 |
| | | Heart failure not coded | | Heart Failure | .368 |
| | | | | + Disease Interaction = Bonus Factor (DM & CHF) | .154 |
| **Total RAF** | .736 | **Total RAF** | 1.078 | **Total RAF** | 2.431 |
| PMPM Base Payment | $800 | PMPM Base Payment | $800 | PMPM Base Payment | $800 |
| Per Member Per Month Payment | $589 | Per Member Per Month Payment | $862 | Per Member Per Month Payment | $1,945 |
| Annual Payment | $7,068 | Annual Payment | $10,349 | Annual Payment | $23,337.60 |

2. What HCCs do we currently capture for this population?
3. How does this capture rate compare with national benchmarks?
4. What is the financial impact of an improved HCC capture rate that's on par with national averages?
5. How will an outpatient CDI program enable better HCC capture? With an outpatient program, clinical documentation specialists can focus on supporting capture of diagnoses that connect to an HCC. This approach can be done in a variety of ways, but regardless of the approach the accuracy and possible increase in HCC capture will lead to more accurate and improved risk scores. It is possible for organizations to improve RAF scores by 15 percent or more even with limited resources, as the authors of this article have seen demonstrated at various healthcare facilities. For example, this was the case at Lakeland Health, a healthcare organization based in southwest Michigan, who saw a 15 percent increase in RAF scores the first year they expanded CDI into the ambulatory setting with limited resources.

### Other Tips to Consider

When obtaining C-suite buy-in for outpatient CDI, HIM professionals can also use these strategies:

1. Leverage the value of your inpatient CDI program. How has your inpatient CDI program affected quality metrics, revenue, and utilization management? This can help establish a "proof of concept" for outpatient CDI.
2. Offer to perform an outpatient HCC pilot program. Using experienced inpatient CDI specialists and coders, focus on documentation improvement for target populations (e.g., patients with diabetes or obesity). Once you're able to make a significant impact on RAF scores, continue to expand your efforts.
3. Conduct a patient-centered chart review on the outpatient side to determine the extent to which HCCs are under-documented. These findings can support recommendations for moving inpatient CDI programs into the outpatient setting.

Using these strategies, it doesn't usually take leadership long to realize the value proposition for outpatient CDI. The necessity of HCC capture—and its impact on ACO success—becomes crystal clear. To ensure long-term viability, however, HIM must be at the table to share their critical knowledge of the financial and compliance aspects of outpatient CDI.

*James P. Fee (James.fee@enjoincdi.com) is CEO and Sonia Trepina (Sonia.trepina@enjoincdi.com) is director of ambulatory CDI services at Enjoin. Rachel Phillips (RHPHILLIPS@LakelandHealth.org) is manager of coding and CDI at Lakeland Health.*