Focus on Population Health CDI Generates ACO Shared Savings

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COST CONTAINMENT. IT'S a concept that accountable care organizations (ACOs) cite frequently as they strive for shared savings. This makes sense because expenditures drive cost thresholds. If an ACO meets all quality benchmarks—and the cost of caring for its attributed population is below that threshold in accordance with its minimum savings rate (MSR)—then the ACO shares a defined percentage of the savings. Taking steps to address cost outliers, reduce hospital admissions and readmissions through preventive care, and prevent system leakage for attributed patients should therefore theoretically put the ACO on a path for financial success. So why do the majority of ACOs fail to realize shared savings payments?

To answer this question, an ACO must examine whether its costs make sense given the severity of its attributed patient population. When costs remain high despite robust reduction strategies, perhaps costs aren't the problem. The real problem could be the way in which providers document the patient story. Costs typically correlate with chronic disease burden and disease interactions. Does physician documentation portray this risk? Oftentimes not. This is where population health clinical documentation improvement (CDI) can help.

Timing is Important

Unfortunately, many ACOs make the mistake of focusing exclusively on cost containment when their strategy should instead be twofold: Reduce costs *and* improve documentation, thereby increasing the accuracy of expected population risk. It's easy to get derailed with costs because they're a tangible target for improvement. Another reason ACOs forget about documentation is that they're focused on all of the steps necessary to form the legal entity itself—forming a legal structure to receive and distribute shared savings payments, considering tax status, raising capital for staffing and IT systems, and more. It's a huge undertaking, and inevitably something will be overlooked. In most cases, that "something" is the documentation—even though it's the single most important element that helps payers understand the complexity and morbidity of the population the ACO serves.

Best practice is to involve CDI from the beginning, and ideally before an ACO is formed. This is because an ACO's

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benchmark is based on its historical performance—more specifically, its population risk adjustment factor defined by hierarchical condition categories (HCCs). For Medicare Shared Savings Program (MSSP) ACOs, this threshold remains in place for a minimum of five years with a potential risk score growth of three percent during that timeframe. However, per the "Pathways to Success" final rule, there is no defined limit on risk score decreases over the agreement period. Documentation must accurately reflect disease complexity because this information translates to medical codes that convey the financial resources the ACO needs to function properly.

If an ACO isn't able to communicate the resources it needs to effectively serve its population, it could face years of insufficient reimbursement. Interestingly, a recent survey of 43 Track 1 MSSP ACOs conducted by the National Association of ACOs prior to the release of the Centers for Medicare and Medicaid Services' (CMS) Pathways to Success final rule found that 71 percent of these entities will likely leave the MSSP as a result of assuming risk in a two-sided model.[1] Could subpar documentation be one reason why? Quite possibly. These ACOs may not be able to sustain the care they provide because their documentation doesn't justify their costs. Creating a population health CDI program can help solve this issue and others for an ACO.

Justifying the Need for Population Health CDI

Obtaining executive-level buy-in is the first step in creating a population health CDI program because it ensures there will be resources dedicated to the effort. However, demonstrating an immediate return on investment (ROI) can be challenging because ACO reimbursement is based on retrospective data. Even if an ACO improves its risk adjustment factor (RAF) scores in the short-term, it won't see a potential increase in its benchmark immediately, as is realized in inpatient or fee-for-service models. Even then, the ACO would still need to contain costs and meet quality metrics to drive a shared savings payment. Instead, health information management (HIM) professionals can articulate the following to hospital executives:

1. While adding dollars to the ACO benchmark does not mean we have improved our bottom line, it does make it easier for the organization to meet the MSR.
2. By improving our organization's outpatient documentation, we'll also improve our inpatient documentation specificity. This will help with prior authorizations, cost justification, medical necessity, risk adjustment for hospital-centric outcome measures, star ratings, and more.
3. By improving our organization's outpatient documentation, we can reduce denials in our system-owned physician practices.
4. Having complete, accurate, and detailed provider documentation is key to ensuring patient safety and providing consistent quality care. This documentation also informs payers and system leaders when making strategic business decisions (e.g., whether to participate in a bundled payment model).

Forming a Population Health CDI Team, Strategy

A population health CDI team should exist at the corporate level and include the following individuals:

- Ambulatory coding and/or CDI director
- Executive director of HIM
- Hospital coding and/or CDI director
- Operations directors
- Project manager
- Vice president and/or manager of population health and chief transformation officer

The team should also include at least one physician champion. Depending on the size of the ACO, multiple physician champions may be necessary. However, rather than strive to assign a physician champion for each specialty or region, focus on finding the right individual for the role. A physician champion should be someone who is enthusiastic about CDI, respected by their peers, influential within the medical community, and whose documentation can serve as a model for others.

Together, a population health CDI team can answer the following strategy-related questions:

- What HCCs will we target, and why?
- What HCCs have not yet been captured in the current year? Are we able to capture these HCCs during *and* before each visit? For example, can nurses and medical assistants obtain and present pre-visit planning information to physicians before they meet with patients so physicians can monitor, evaluate, assess, or treat the conditions during the visit? Can we incorporate point-of-care technology into the provider workflow to assist with this process?
- How will we streamline CDI efforts across disparate providers to prevent physician burnout and improve physician satisfaction and engagement? For example, how can we align messaging from CDI, coders, care coordinators, compliance, legal, and others to reduce the documentation burden as much as possible? Can we leverage our inpatient CDI program in any way? In many cases, targeted diagnoses will overlap.
- How will we provide ongoing education to all physicians, including those working in independent practices? How will we track new providers who are onboarded into the ACO so they don't fall through the cracks?
- How can we work with IT to develop documentation tools that integrate easily into physician workflows?
- How will we continually measure and communicate the ROI of our program?

Understanding Baseline Documentation

Identifying the quality of baseline documentation enables an ACO to track its progress and identify high-risk areas to target

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Six Ways in Which CDI Efforts Support Population Health Initiatives

THE EARLIER AN ACO establishes a population health CDI program, the better. However, ACOs can also benefit from CDI efforts at any point in their journeys. Consider the following six ways in which population health CDI supports ACO success:

1. **Understanding costs.** Accurate documentation translates to accurate data. Without data, organizations can't justify costs.
2. **Reducing patient leakage.** Accurate documentation drives the data that helps organizations identify opportunities for new patient services, new contractual relationships, and other changes necessary to retain patients within the ACO by improving patient access and the care experience.
3. **Maximizing pay-for-performance reimbursement.** Accurate documentation helps providers close gaps in care, thereby driving better outcomes through preventive medicine and an avoidance of "never events" and hospital-acquired conditions.
4. **Reducing utilization.** Accurate documentation helps organizations reduce costly hospitalizations, emergency department visits, and 30-day readmissions.
5. **Supporting chronic disease management.** Accurate documentation enables organizations to target and engage high-risk patients with meaningful interventions.
6. **Predicting individual patient health.** Accurate documentation supports accurate data analytics—the ability to predict outcomes based on the number and severity of a patient's comorbid conditions. Organizations can then target these individuals with early interventions.

through education.

Reviewing Medicare claims data is a valuable first step. CMS provides robust, claims-level information about each ACO's attributed beneficiaries. This information includes beneficiary-level Medicare claims for hospital services, physician services, post-acute care, and other covered Medicare services. An ACO can use this data to evaluate beneficiary cost across the continuum of care. CMS also provides the following:

- Monthly claims and claims line feed files for assigned beneficiaries
- Quarterly reports (including an updated ACO benchmark and list of attributed beneficiaries)
- Expenditure/utilization reports

However, it's not easy to extrapolate these results to determine where educational resources are best spent. An external vendor with data analytics expertise can help an ACO normalize, organize, and understand its data so it can refine the focus of its population health CDI program on certain specialties, practices, or physicians. A vendor can also help articulate the impact of CDI efforts (i.e., how much do we anticipate the RAF score has moved?).

Using Data Analytics to Drive the Program

Where can an ACO have the biggest financial impact across the entire system? Based on the data, it may be better to focus on one high-impact diagnosis (e.g., diabetes without complications) rather than several lower-impact ones. However, an ACO must be cautious when using data. Partnering with practice managers and others in operations (e.g., care coordinators and physician advisors) can help CDI specialists identify whether they should target certain providers as early adopters or for ongoing CDI interventions. For example, if data analytics identifies that an endocrinologist continually forgets to document body habitus to support the body mass index and morbid obesity diagnosis, it might not make sense to engage this provider as an early adopter if the practice manager states that the physician typically resists CDI efforts. When targeting interventions, it's important to ask these questions:

- How far does the provider's RAF scores deviate from expected scores?
- How large is the provider's patient panel?
- Is the effort required to convince the provider to support CDI worth the anticipated benefit?
- Is the provider participating in other initiatives/projects that may limit their ability to focus on CDI?

Providing Ongoing Physician Education

The success of a population health CDI program depends largely on an ACO's ability to provide ongoing physician education. All physicians, including primary care providers and specialists, should strive to capture HCCs that are pertinent to the current encounter. Be sure to include the ACO's independent providers in HCC education. Explain to physicians that a RAF score is assigned to a patient—not a provider. As patients move throughout the ACO receiving care in multiple settings, each physician must do his or her part to capture the HCCs that cumulatively affect this patient-specific score. Establish a baseline average RAF score for each physician, provide education regarding HCC capture, remeasure the average RAF score, and then provide additional education as needed.

Linking Documentation with Patient Engagement

Population health CDI programs are unique in that they include an element of patient engagement that's typically absent from inpatient CDI programs. That's because population health is all about managing the continuum of care rather than an isolated inpatient admission. To truly enable population health management, patients must be empowered throughout their healthcare journey to make healthy choices, participate in preventive screenings, and stay out of high-cost settings. ACOs that ultimately improve the health of their populations are those that can identify high-risk patients (both from a clinical perspective and based on their social determinants of health) and target them with tailored

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Five Population Health CDI Best Practices

1. Create a corporate-level CDI team with executive sponsorship.
2. Identify at least one physician champion who can engage all providers, including those working in independent practices.
3. Launch a CDI program as soon as possible while forming an ACO.
4. Let data analytics combined with operational insights drive the direction of your program.
5. Understand baseline documentation before launching the CDI program.

interventions to improve outcomes. How can ACOs identify these patients? Coded data based on clinical documentation. CDI plays an important role in obtaining this documentation.

Articulating Benefits of Population Health CDI

As with any CDI effort, it is important to continually articulate the benefits of the program to ensure continued executive sponsorship and physician buy-in. In addition to revenue accuracy, focus on changes in RAF scores over time, improvements in provider engagement and satisfaction, and improvements in patient safety.

Note

1. National Association of ACOs. Medicare Shared Savings Program Track 1 ACOs survey results. Press release. May 2, 2018. www.naacos.com/press-release-may-2-2018.

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