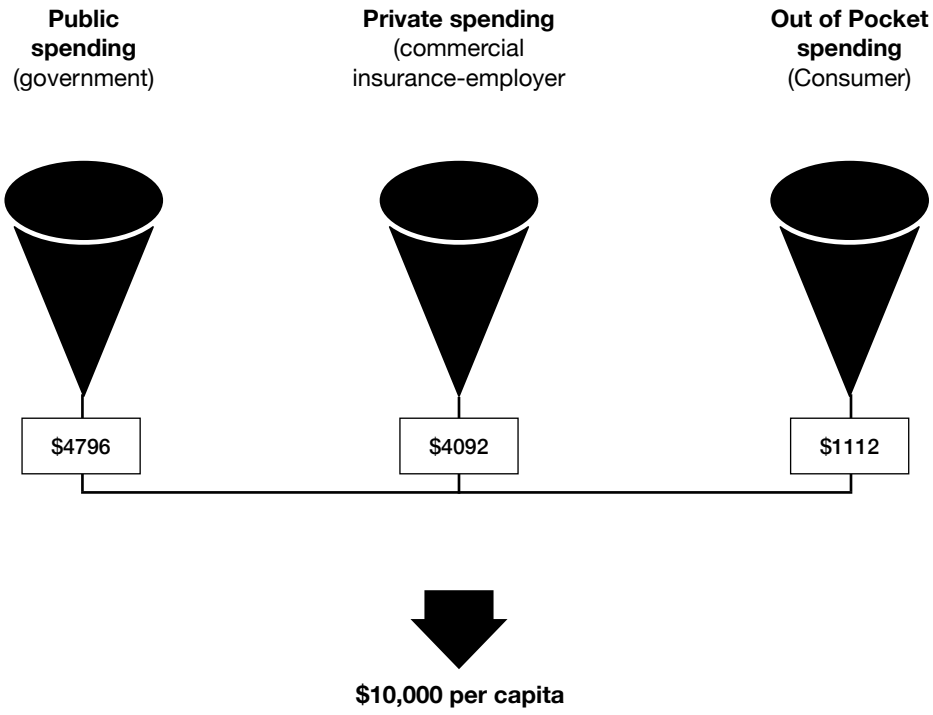
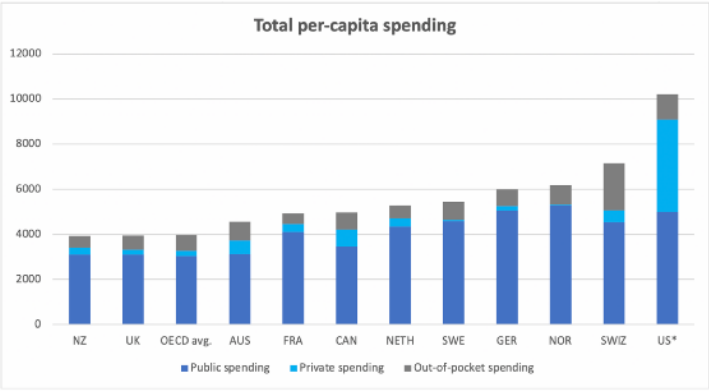
Business Curriculum Basics: Learn the ABC's

Who pays for Health Care?

Before we talk about the need for health care reform for cost and quality, let's answer a basic question. Who pays for health care in the United States?

Think about payment for US health care as coming from **three buckets:**





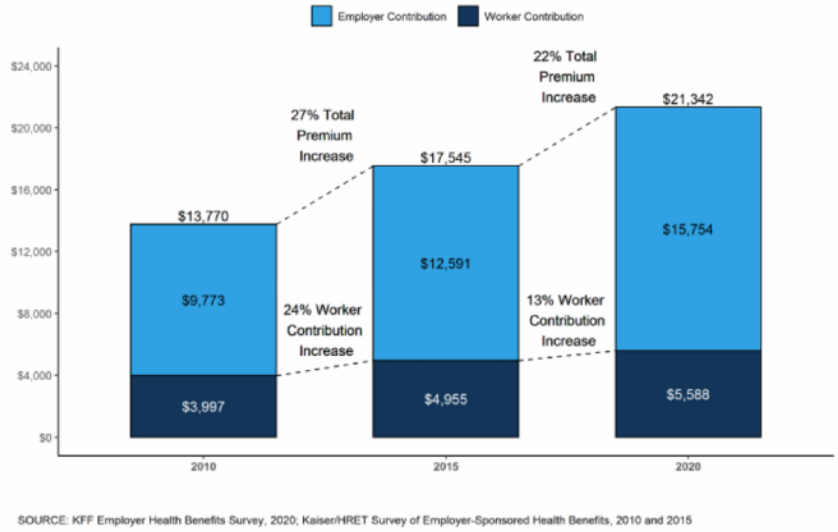
Source: https://www.commonwealthfund.org/publications/issue-briefs/2020/jan/us-health-care-global-perspective-2019

Per capita health spending in the US exceeds **$10,000**, more than 2x higher than in Australia, France, Canada, New Zealand and the UK. While US public spending on health care is about the same as the others[1], at **$4092** per capita US **private spending** is more than 5X higher than Canada- the second highest private spender. (In Sweden and Norway, private spending made up < $100 per capita). As a share of total spending, private spending is much larger in the US (40%) than in any other country (range 0.3%-15%).

In 2019 the average US resident paid **$1112 out of pocket** for health care (premiums, copays, prescription drugs, health insurance

[1] Organization for Economic Cooperation and Development (OECD) comparisons of investment in health care by industrialized nations

Figure A
Average Annual Worker and Employer Premium Contributions for Family Coverage, 2010, 2015, and 2020



SOURCE: KFF Employer Health Benefits Survey, 2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010 and 2015

Source: https://www.kff.org/health-costs/report/2020-employer-health-benefits-survey/

deductibles). Only the Swiss pay more, while residents of France and New Zealand pay less than half of what Americans spend.[2]

New payment models promoted over the past ten years by CMS (Center for Medicaid and Medicare Services) have resulted in multiple government programs that may be flattening the curve of escalating costs, although not yet confirmed.

The Kaiser Family Foundation reports an average **annual cost of health insurance** for a family of four as **$4819 for the employer** contribution and **$1619 for employee** contributions with a total insurance cost of **$6438 in 2000**. The **2020 total is $21,342** (> 3x higher). Inflation over that time represents only $2400 of the $15,000 increase.

This increase in health care costs is not sustainable. New ways to reduce costs while maintaining a focus on quality of outcomes were sought and make up the center of healthcare reform.

What about healthcare quality? Doesn't high cost correspond with better quality?

Healthcare quality in the United States is lower than other first world nations in chronic disease, maternal health, infant mortality. This is because we do not prioritize healthcare for all citizens. Instead, we use income, ability to work, and social determinants to decide who *deserves* to have medical care. States retain an enormous amount of control over which of their citizens receive health care and at what cost.

One example of this is maternal health. For every 100,000 women who give birth in Germany, fewer than 4 die. In Canada, the figure is 8; in the UK, a bit fewer than 9. **In the US, the number is 24.** In 2020, 861 women died because of pregnancy or childbirth. That may not sound like a lot, but according to the National Academies of Sciences, Engineering, and Medicine, for every death, an estimated 70 other women barely survive. This means that in 2020, an additional 60,270 women in the US suffered life-threatening medical complications, many of which could've been prevented if they'd had better access to care. Ranked against other countries by the World Bank, the quality of maternal health care in America is no better than in Latvia, Moldova, and Oman. And it doesn't touch on one of the biggest risk factors of all: *where someone lives.*

[2] Kaminski, M. Population Health Learning Network. April 19, 2021

According to data from the Centers for Disease Control and Prevention, the maternal mortality rate in cities is about 18 deaths per 100,000 births. In rural counties, that figure is 29, roughly on par with Syria. Babies are more likely to die, too. Insufficient prenatal care is linked to a greater likelihood of preterm birth, the leading cause of infant death in the US. Because most rural hospitals in America don't have a working maternity ward, women travel longer distances to give birth, putting them at greater risk of delivering on the side of the highway or at home without a medical professional. The CDC estimates that infant mortality rates are 20% higher in rural areas than in large urban ones. [3]

What construct is being used to improve healthcare quality and reduce cost?

The Triple Aim: Compass for Health System Improvement

The IHI (Institute for Healthcare Improvement) **Triple Aim** is a framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance while advancing in three dimensions:

- Improving the **patient experience** of care (including quality and satisfaction)
    - Best expressed by the **6 aims of care** to close the quality gap introduced by the IOM's 2001 *Crossing the Quality Chasm:* (All care must be: **Patient-Centered, Safe, Timely, Efficient, Effective, and Equitable**)
- Improving the **health of populations**
- Reducing the **per capita cost** of health care

We can view the Triple Aim as a compass to optimize health system performance. It's important for physicians entering the work force to understand how this compass helps health administrators and leaders shape the mission of their institutions and how they as physicians can further it in tangible ways.

The Quadruple Aim: One factor that affects all elements of the Triple Aim

From 2014 the medical community became increasingly aware of widespread **burnout** (42% of physicians) and dissatisfaction among the health care workforce as they became more motivated to improve quality. Burnout is associated with **lower** patient satisfaction, **reduced** health outcomes, and **increased** costs. Burnout *imperils* the Triple Aim. Bodenheimer and Sinsky recommended expanding the Triple Aim to the **Quadruple Aim**, adding the goal of **improving the work life of health care providers**,

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[3] Centers for Disease Control data, as reported in Bloomberg Businessweek, August4, 2022: A Very Dangerous Place to Be Pregnant Is Getting Even Scarier

including clinicians and staff.[4] Physicians and health workforce workers are motivated by being able to provide high quality care (as opposed to incentives). To do that, they need to be able to utilize team documentation, pre-visit planning, nursing support with preventative screening Adequate staffing (4.25 FTE, or Full Time Equivalent workers per physician) is necessary to allow a care team to perform each of these functions in a Patient Centered primary care office.

Understanding Value-Based Models of Care

ABC's of Medical Reimbursement

ACA

Affordable Care Act
The comprehensive health care reform law enacted in March 2010 (sometimes known as ACA, PPACA, or "Obamacare").
The law has 3 primary goals:

- Make affordable health insurance available to more people. The law provides consumers with subsidies ("premium tax credits") that lower costs for households with incomes between 100% and 400% of the federal poverty level.
- Expand the Medicaid program to cover all adults with income below 138% of the federal poverty level. (Not all states have expanded their Medicaid programs.)
- Support innovative medical care delivery methods designed to lower the costs of health care generally.

There are three other things about ACA that were important:

- Created the individual mandate for coverage (later repealed by Congress)
- Set a minimum standard for insurance coverage by definition. (Include pregnancy, behavioral health, addiction)
- Mandated coverage of pre-existing conditions. (Before 2010, insurance coverages would not cover any conditions diagnosed earlier, or their costs.)

Has the ACA been successful in accomplishing its goals?

- A health survey of the US Centers for Disease Control and Prevention conducted in June 2020 noted that the proportion of individuals without health insurance in states that did not expand their Medicaid program (14 states; in 2022, 12 states remain: WY, TX, SD, WI, MISS, TN, AL, GA, NC, SC, KA and FL) **was nearly twice that of those in states that did expand Medicaid (17.1% vs 9.1%).** Low-income Black, Latino and Native American adults were disproportionately affected (12%, 22%, 28)

ACO

Accountable Care Organization
An Accountable Care Organization is a healthcare organization that ties provider reimbursements to quality metrics and reductions in the cost of care. ACOs in the United States are formed from a group of coordinated health-care practitioners. They use alternative payment models, normally, capitation.

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[4] Bodenheimer, Sinksy. From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider. Ann FM. www.annfammed.org Vol 12, No. 6. Nov/Dec 2014 pp 573-576.

APM

Alternative payment model

A *value-based care payment model* that addresses quality by using incentives for providers to advance coordination and efficiency of care, while also improving quality and outcomes, all (hopefully at a lower cost. *Bundled payment* is an example of an alternative payment model.

Bundled Payment

Bundled payments represent one form of alternative payment models (APMs) that are designed to move toward value-based care by incentivizing providers to advance coordination and efficiency of care while also improving quality and outcomes at lower costs. With bundled payments, the total allowable acute and/or post-acute expenditures (target price) for an episode of care are predetermined. Participant providers share in any losses or savings that result from the difference between this target price and actual costs.

Bundled payments, also known as episode payment models (EPMs), require participant providers to assume risk, as they must cover costs that go above the target price for an episode of care including those that arise from complications and hospital readmissions. On the upside, providers share in the savings if they keep costs below the target price while maintaining quality standards. Bundled payments are showing significant promise in improving care quality while at the same time bringing costs down. (NEJM Catalyst Series)

CMS

Centers for Medicare and Medicaid Services. A federal agency within the United States Department of Health and Human Services that administers the Medicare program and works in partnership with State governments to administer Medicaid, the Children's Health Insurance Program (CHIP) and health insurance portability standards.

CMS has other responsibilities, including the administrative simplification standards from the Health Insurance Portability and Accountability Act of 1996 (HIPAA), quality standards in long-term care facilities (more commonly referred to as nursing homes) through its survey and certification process, clinical laboratory quality standards under the Clinical Laboratory Improvement Amendments, and oversight of HealthCare.gov. CMS was previously known as the Health Care Financing Administration (HCFA) until 2001.

CMS 2021 Rule

Center for Medicare and Medicaid Services Medicare Physician Fee Schedule 2021 Rule

The Centers for Medicare and Medicaid Services (CMS) issued the final rule for Calendar Year 2021 Medicare Physicians Fee Schedule. It determines how much physicians get paid for delivering services furnished under the PFS starting January 1, 2021.

As a result of a statutory requirement that the PFS remain budget neutral adjustments must be made to the conversion factor if changes to the RVU (RVUs), which determine physician reimbursement, result in changes of more than $20 million. The conversion factor for CY (calendar year) 2021 was reduced by $3.68 leading to a conversion factor of $32.41.

This year's rule seeks to aid clinicians by reducing the E/M (Evaluation and Management) documentation burden through a streamlined reporting process that emphasis medical decision making. Monitoring chronic disease continues to be important using the prior MEAT approach.

A new category of Telehealth includes more than 60 services to the Medicare telehealth list. Some benefits are covered only as long as there is a public declaration of an emergency due to the pandemic and will expire after it is withdrawn.

HCC: Hierarchal Condition Categories

The Hierarchical Condition Categories (HCC) is a risk-adjustment model Medicaid created in 1997 and started using it in 2004. With the introduction of the Medicare Advantage Plans and its requirement of RAF reimbursement scores, the HCC has become more popular.

The HCC payment system uses ICD-10 codes and demographics to generate a risk adjustment factor (RAF) score which identifies patients that require a higher cost to care and is based on the diagnosis codes billed in the previous review period.

HCCs help CMS to reimburse Medicare Advantage plans based on their members' health. HCCs pays accurately for the predicted patient cost expenditures.

Medicare

Medicare is a health insurance program for

- People age 65 or older
- People under age 65 with certain disabilities
- People of all ages with End-Stage Renal Diseases) permanent kidney failure requiring dialysis or kidney transplant)

Medicare has different parts that help cover specific services:

Medicare Part A (Hospital Insurance)

- Inpatient care in a hospital
- Skilled nursing facility care (not custodial or long term care)
- Hospice care
- Some home health care

Beneficiaries must meet certain conditions to get these benefits. Most people don't pay a premium for Part A because they or a spouse already paid for it through their payroll taxes while working.

Part B (Medical Insurance)

- Doctors' services and outpatient care
- Some Physical and Occupational therapy
- Some home health care

Part B helps pay for these covered services and supplies when they are medically necessary. Most people pay a monthly premium for Part B.

Medicare Part D (Prescription Drug Coverage)

- Medicare prescription drug coverage is available to everyone with Medicare.
- People must join a plan approved by Medicare that offers Medicare drug coverage.

Most people pay a monthly premium for Part D. Those in a coordinated care Medicare Advantage plan receive prescription drug coverage.

MA: Medicare Advantage Plans

Originally called M+C, Medicare Advantage Plans were renamed under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). Medicare Advantage Plans are a type of Medicare health plan offered by a private company that contracts with Medicare to provide all your Part A and Part B benefits. Most Medicare Advantage Plans also offer prescription drug coverage. If you're enrolled in a Medicare Advantage Plan, most Medicare services are covered through the plan; Medicare services aren't paid for by Original Medicare.

PCMH: Patient Centered Medical Home

The Patient-Centered Medical Home (PCMH) is a care delivery model whereby patient treatment is coordinated through their primary care physician to ensure they receive the necessary care when and where they need it, in a manner they can understand.
The objective is to have a centralized setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. (ACP)

RVU: Relative Value Units

Medicare uses a physician fee schedule to determine payments for over 7500 physician services. The fee for each service depends on its **relative value units (RVUs)** which rank on a common scale the resources used to provide each service. These resources include the physician's work, the expenses of the physician practice, and professional liability insurance.

To determine the Medicare fee, a services's RVU's are multiplied by a dollar conversion factor.

Physician work RVUs account for the time, technical skill and effort, mental effort and judgment, and stress to provide a service. There are also Practice expense RVUs and Professional liability insurance RVUs.

Physical Work RVU's Example: The work RVU's for a diagnostic colonoscopy are more than twice the work RVUs for an intermediate office visit because the colonoscopy requires more physician time and effort than the visit. A diagnostic colonoscopy is estimated to require 75 minutes of physician time, which includes 30 minutes to prepare for the procedure and 15 minutes after the procedure. The time actually performing the colonoscopy- termed the intra-service time- is estimated to be 30 minutes. In contrast, an intermediate office visit is estimated to take about 40 minutes of physician time. This is comprised of 5 minutes before and 10 minutes after seeing the patient, and 25 minutes of intra-service time for the office visit to reface the higher skill and effort and associated stress of providing the procedure.

Using HCC and Problem-Based Charting to Optimize Reimbursement

What is HCC Coding?

HCC scores have been used since 2004 by Medicare to adjust payments based on the risk level of the enrollee. This has resulted in Medicare paying a higher monthly capitation fee for patients with higher HCC scores as these require more resources and disease intervention.

The role of the ACA is to ensure that patients get affordable health coverage regardless of the number of visits. However, there is no consecutive plan that everyone can follow. So, what is HCC in medical terms and what is HCC healthcare?

The Hierarchical Condition Categories (HCC) is a risk-adjustment model that has existed for many years. With the introduction of the Medicare Advantage Plans and its requirement of RAF reimbursement scores, the HCC has become more popular.

At the moment, every coding leader and the commercial payer is talking about HCC.
It is clear that proper HCC medical coding and documentation is critical in ACOs, MA, and HVBP. In order to ensure HCC codes and documentation compliance, CMS checks health plans using targeted and random audits.

The HCC payment system uses ICD-10 codes and demographics to generate a **risk adjustment factor (RAF)** score which identifies patients that require a higher cost to care and is based on the diagnosis codes billed in the previous review period. So as to better understand HCC, you should have a fundamental understanding of Risk Adjustment and in order to better understand risk adjustment, you should understand HCC.

Risk Adjustment Coding, Its Relationship to HCC and Its Importance

In the Risk Adjustment model, the diagnosis and patient demographics help determine the patient's risk score. The risk score is a relative measure of how costly the patient is likely to be. What does HCC mean after a diagnosis? Usually, healthy patients have a lower than average risk adjustment factor. This ensures that the insurance premium gets transferred from healthy patients to patients with an RAF score that is below average. In this payment model, two different patients in the same practice may pay different amounts for the services they receive. Payment depends on a number of factors that determine the level of risk required to maintain the patient's health.

The combination of the ACA market reforms and the RAF programs means that insurance companies focus on offering high-quality health plans at reasonable prices.

Why HCC is Important for Medical Practitioners and Patients?

Basically, HCCs help CMS to reimburse Medicare Advantage plans based on their members' health. HCCs pays accurately for the predicted patient cost expenditures.

How?

By adjusting payments according to the health status and demographics of the patient. This is what we refer to as Medicare HCC codes.

Where does the risk assessment data come from?

The risk assessment data is based on the diagnosis information collected from medical records that are collected from physician offices, outpatient data and hospital inpatient visits.

Just to be clear, HCC is not a new idea. Medicaid created this model in 1997 and started using it in 2004. The HCC is so successful at predicting the use of resources and because the general trend to follow CMS direction, we expect that HCC is the model that commercial payers will use soon.

How Disease Classification Works in HCC Coding Guidelines

How does HCC Classify Diseases?

In the HCC, conditions, and diseases are based on body systems or other similar diseases. The main HCC categories are bipolar disorders, pulmonary disease, diabetes, congestive heart failure, rheumatoid arthritis, prostate & breast cancer and specified heart arrhythmias.

It is typical for patients to be assigned at least one category of diseases because of a combination of demographic information and risk factors that can represent more than one form of illness.

This risk adjustment identifies the patients that are in need of disease management. As such, it establishes the financial allotment offered by CMS towards each patient's annual care.

The new model is referred to as CMS-HCC and is **based on chronic health conditions**. Doctors must give thorough reports on the risk adjustment of each patient and based on the documentation of clinical medical record from face-to-face encounters. Consequently, the RAF cannot be entirely determined by the patient's test results or medical history.

Each specific diagnosis helps in determining the RAF and the overall score helps in calculating the payer reimbursement and predict potential future costs associated with each patient.

Why Understanding the MEAT Framework is Important in Accomplishing HCC Coding

Healthcare providers need to be aware of the importance of medical records in mitigating the risk of audits and remaining compliant. This means that the doctors should have been exposed to some HCC coding examples in the past.

To ensure that diagnosis captures the accurate HCC code, healthcare providers should adhere to the M.E.A.T criteria.

M.E.A.T stands for monitoring, evaluating, assessing and treatment and is one of the most critical and basic requirements of proper and compliant documentation, especially in medical complexity. M.E.A.T is defined as:

- **Monitor**: signs, symptoms, disease progression, and disease regression
- **Evaluate**: test results, medication effectiveness, and response to treatment
- **Assess**: ordering tests, discussion, review records, and counseling
- **Treat**: medications, therapies, and other modalities

Here's why this is important…

Documentation without M.E.A.T. to substantiate the diagnosis is likely to be rejected by CMS due to lack of evidence. To adhere to M.E.A.T., providers should:

1. Evaluate and document all conditions during each encounter.
2. Ensure a proper progress note with the HPI, physical exam and medical decision-making process.
3. Document each diagnosis in an assessment and care plan
4. Ensure that each diagnosis provides evidence that the provider is monitoring, evaluating, assessing and treating the condition.

These four factors establish the presence of a diagnosis during an encounter and ensure proper documentation.
Healthcare providers would do well to remember the following:

- Code to the highest level of specificity

- Maintain HCCs from a prior health plan if relevant
- Ensure comprehensive documentation:
- Perform chart reviews
- Ensure consistent HCC capture
- Stay up-to-date on coding

If physicians understand the MEAT framework, they can accomplish HCC. It is important that every healthcare provider documents all relevant chronic conditions while offering the patient's care.
Now:

It remains imperative for coders to ensure that each patient's medical record is accurate and that all factors like the supporting documentation for each condition are completed in totality.

Diagnoses can be made on each documented condition. Moreover, the documentation should show that the condition is monitored and evaluated. Each diagnosis requires a plan and an assessment.

It is also vital to justify the health status of the patient. All chronic conditions require close monitoring and reporting at least once every month.

This is the truth about HCC:

Reporting the complete picture of the risk adjustment factor through HCC increases the accuracy of the patient's score, lowering the need to ask for medical records or to audit the claims issued by the healthcare provider.

If correctly implemented, the HCC streamlines the process of creating claims resulting in fast reimbursements. Therefore, the HCC is a great equalizer. Before the rise of the risk adjustment model, reimbursement was solely based on demographic factors.

Costs may vary widely among patients. As such, risk adjustment can be used to evaluate patients on an equal scale. This creates many new opportunities for providers and coders and promises to increase the effectiveness of reimbursements.

How to put this educational module into practice

Here are two steps you should take today to implement what you have learned about Healthcare Reimbursement in this module.

Step One: look at your last five progress notes and use Problem List to update diagnoses to HCC codes for Chronic conditions.

Now that you understand how CMS uses HCC specific coding to predict your individual billing coefficient for RVUs and payment, you will want to develop some skill in using HCC codes. Along with accepting the diagnoses EPIC offers to substitute when you open a patient's chart for the first time this year, you can also make changes yourself.

1. Open a patient chart in Chart Review.
2. Navigate to Problem List.
3. To Change and replace any *chronic disease* ICD codes in your active list with their HCC counterparts, select the diagnosis you need to change. Now click on *Change Dx* and select a diagnosis that is marked "HCC".
4. Be sure to select HCC codes whenever possible going forward.
5. Accept the offered diagnoses at least once a year in a note. You can comment on these very briefly to satisfy the documentation requirement: "Stable, Monitored by (lab, history, etc.), Evaluated, Treated."

Step Two: While you are in Problem List, use Assessment/Treatment documentation to improve your note efficiency and reduce documentation time.

1. Open a patient chart in Chart Review.

2. Navigate to Problem List.
3. Select an active Problem that is a chronic condition. Open the Assessment/Plan documentation box (*not the Overview box*)
4. Use the MEAT (Monitor-Evaluate-Assess-Treat) outline to update information that already informs your treatment of this condition. For example, Systolic Heart Failure MEAT might include: **Monitor**: Condition is **Stable**, followed with Shaub (cardiology) BMP yearly.. **Evaluate**: EF=45% on 7-1-22. Assess: No dyspnea, ankle edema, weight gain; adherent to current medication. **Treat**: continue beta blocker, diuretic.
5. When you use the smart phrase to create a IMC ambulatory note, each Problem List item with A/P detail will populate in your note, satisfying CMS documentation and saving you time: Review it carefully to be sure no updates are needed.

Problem List Tips: Make sure pertinent Problem List information is current before using the smart phrase to start (create) your note.

Resolve any diagnoses no longer active.

References

1. MedConverge web site at:
https://www.medconverge.com/2017/08/22/hcc-coding-tips-the-importance-of-m-e-a-t/

This informational website carries many CMS links and standards. It is intended to support a medical billing and coding service but the information is organized well to share it with other learners.

2. Centers for Medicare and Medicaid Services (CMS) at cms.gov

3. National Health Policy Forum at nhpf.org