The ROI of Outpatient CDI

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Presented By

Carol Ann Hudson, RN, is a registered nurse with over 30 years of experience in population health, informatics, regulatory programs, nursing, and practice management. She is currently the AVP of quality and clinical operations in population health at Lifepoint Health. The population health team is responsible for Lifepoint's portfolio of accountable care organizations and clinically integrated networks (AdvantagePoint Health Alliance), along with other value-based initiatives. Hudson brings her clinical experience to the team to help the networks, facilities, and providers improve clinical health outcomes of their assigned patient populations by promoting quality, care coordination, and patient engagement. Hudson has three teams doing care navigation, ambulatory CDI, and annual wellness visits. In addition, her team leads the quality reporting for all eight networks.

Jason Jobes, MSPA, oversees all solution partnerships and delivery for Norwood's healthcare partners. These partnerships focus on bringing health to hospitals' bottom lines, improving performance across the revenue cycle and value-based care terrains. During his career, Jobes has delivered over $500 million in return on investment for partners. Jobes holds a bachelor's degree in economics from The University of Hawaii at Hilo and obtained his master's degree in predictive analytics from Northwestern University in Evanston, Illinois. He is passionate about making healthcare better and more affordable, particularly for those who may not be able to pay for or access it.

Learning Objectives

At the completion of this educational activity, the learner will be able to:

- Define the current state of outpatient (OP) CDI adoption and points of resistance
- Describe the financial impact of OP CDI initiatives including risk adjustment factor (RAF)
- Recognize and understand the barriers to overcome in creating an OP CDI program

The Basics of Value Based Care and the Reimbursement Landscape

Defining Value-Based Care

Fee-For-Service

Fee-for-service contracts compensate healthcare organizations for each service rendered and there are generally no quality, cost, or outcome expectations. What this means is that organizations increase revenue by increasing the volume of care provided. There is little incentive to control healthcare utilization.

Value-Based Care Contracts

Value-based care contracts come in multiple forms but at their core they seek to share cost savings, incentivize high quality outcomes, and drive lower healthcare utilization. Providers are paid a certain amount for each patient encounter but can earn additional revenue through metrics defined in the contract. The goal is to create incentives across the healthcare continuum for high-quality, low-cost care.

The Concept of Medical Loss Ratios (MLR)

Health plans must annually calculate their medical loss ratio. This ratio reflects the percent of all premiums that are paid for claims. The lower the ratio, the more controlled costs are relative to the premium collected. This can be an indicator of overall performance but is by no means an absolute metric.

MLR Calculation

$$\text{MLR Ratio} = \frac{\text{Medical Claims Expense}}{\text{Total Premiums Received}}$$

Profit Calculation

$$\text{Profit} = \text{Premiums} - \text{Expenses}$$

To improve medical loss ratios, an organization must do at least one of the following :

1) **Decrease Medical Claims**: To do this, organizations must either decrease the volume of services being provided or decrease the cost per patient encounter.
2) **Increase Total Premiums**: To do this, organizations must capture all appropriate conditions. The capture of these conditions will impact risk scores and therefore increase risk adjusted premiums.

What Drives Total Premiums Received

In its simplest form, annual premiums received are calculated monthly and then aggregated across the 12-month period. The calculation uses the number of member months, the per member per month (PMPM) payment, and the RAF score. It is important to note that this is calculated at the patient level and added up but for illustrative purposes this is done in aggregate for the entire year below.

Eligible Population Member Months ✖ Per Member Per Month Payment ✖ Total RAF Score for all Patients = Total Premiums

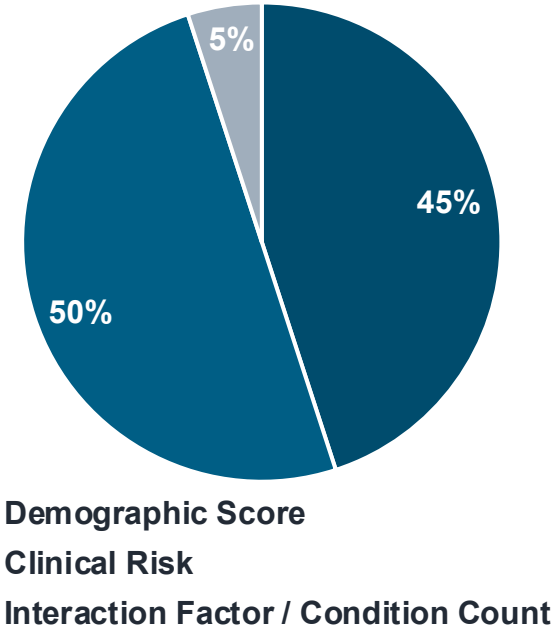
	Member Months	PMPM	RAF Score	Premiums
Baseline	125,000	$800.00	1.00	$100,000,000
Scenario #2	125,000	$800.00	1.10	$110,000,000
Difference	0	0	0.10	$10,000,000

Breaking Down How Risk Scores Are Calculated

The CMS-HCC model is calibrated so that the average Medicare patient has a 1.00 risk score. The risk score has multiple components to it including the patient's demographics, the clinical conditions captured for the patient, and additional complexity drives such as the interaction factor and the count of hierarchical condition categories (HCC).

Approximate Risk Score Breakdown

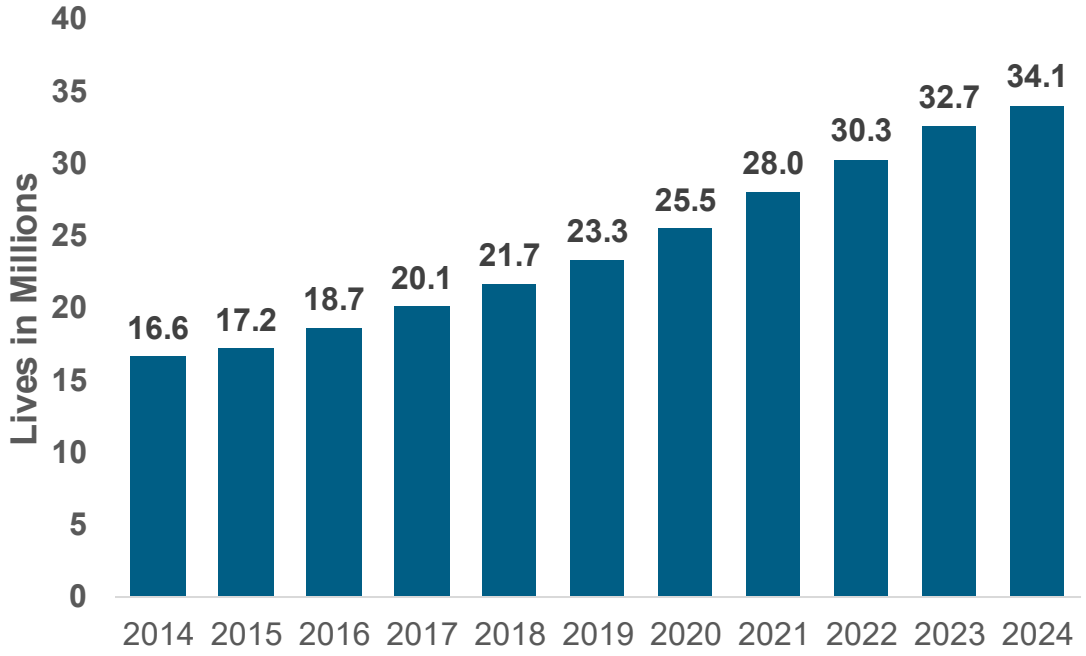
1.00 Medicare Patient



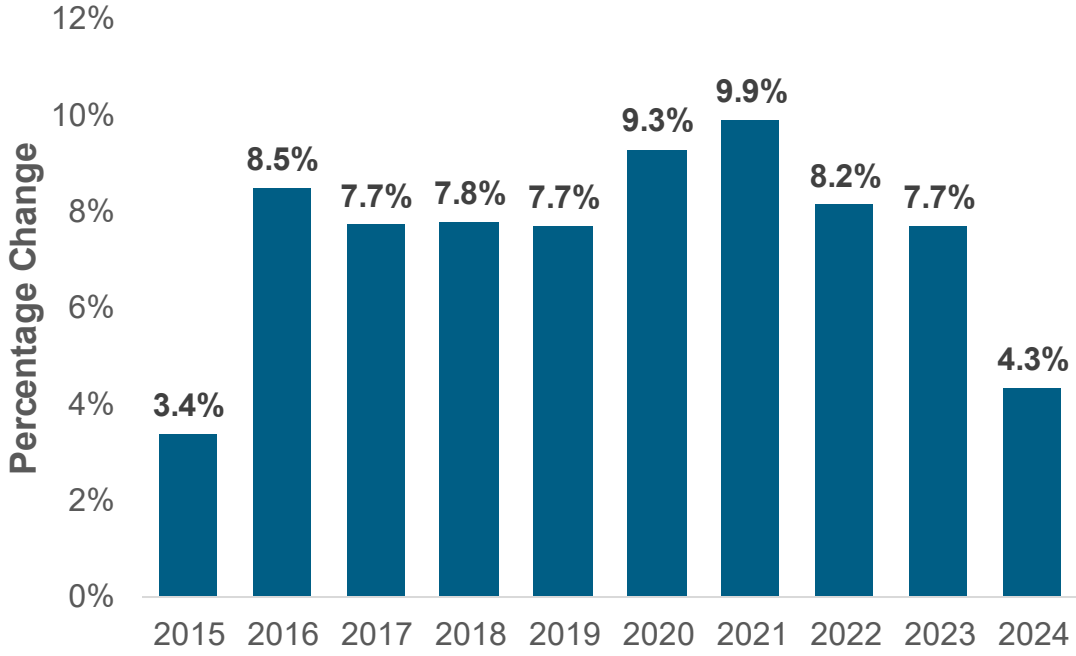
Score Component	Comments on Component
Demographic RAF	A patient's age and sex is used to generate a score for their demographics. If no conditions are captured the entire year, this will represent the patient's entire RAF score.
Clinical RAF	This is driven by the HCCs captured for the patient. Many organizations focus on the chronic conditions, those that are long-term and often not subject to resolution. These conditions often are the subject of recapture and outpatient CDI programs. Approximately 80% of clinical RAF is associated with chronic conditions.
Interaction Factor	The simultaneous presence of some conditions adds extra complexity to patient care and the expected resource consumption. When the conditions appear, an interaction bonus is calculated and increased the patient's score.
Condition Count	Patients with 5 or more conditions will receive an additional increase in RAF given the expected increase in resource consumption for these more highly complex patients.

A Look at the Medicare Advantage Landscape

Total Medicare Advantage Lives
Annually – Year Ending December



Annual MA Enrollment Growth Rate
Annually – Year Ending December



67 Million

As of December 2024, there are over 67 million Medicare beneficiaries. While risk scores are normalized each year, if left unchecked a 0.01 increase in risk score would equate to over $6 billion in extra revenue.

Source: : https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data

Program Structure and Return on Investment- The Lifepoint Health Story

AdvantagePoint - 40+ Hospitals | 2,300+ Providers Participating in CIN/ACO

Northwest
- 10+ primary care or specialty independent practices
- 4 non-LifePoint hospitals and employed practices
- 3 LifePoint hospitals and employed practices (excluding Castleview and Ashley Valley)

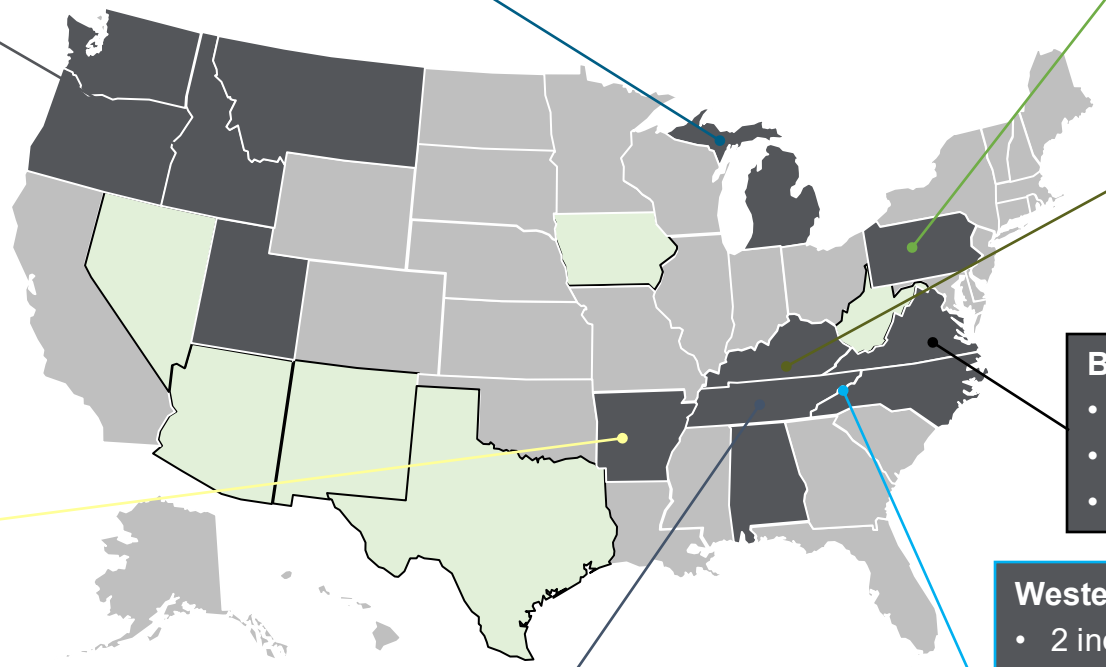
Great Lakes
- 25+ independent provider groups | 1 independent FQHC
- 2 non-LifePoint hospitals and employed practices
- 3 LifePoint hospitals and employed physician groups

Laurel Highlands
- 25+ independent provider groups
- 4 LifePoint hospitals and employed practices (Conemaugh)

Commonwealth
- 2 independent practices (primary care & nephrology)
- 9 LifePoint hospitals and employed practices
- Included Scion facilities until 2025

Blue Ridge
- 15+ independent provider groups
- 1 independent FQHC
- 6 LifePoint hospitals and employed practices

Hot Springs
- 3 primary care or oncology independent practices
- 3 LifePoint hospitals and employed practices



Current Markets

Potential future expansion

Tennessee Valley
- 2 independent practices (primary care & nephrology)
- 7 LifePoint hospitals and employed practices

Western North Carolina
- 2 independent specialty provider groups
- 5 LifePoint hospitals and employed practices
- Now includes entire state, **including Central Carolina, Maria Parham, Person, and Wilson** who had previously participated with Duke

Why Outpatient CDI and the Return on Investment Concept

The AdvantagePoint “Why”:

Capturing the care of your patients is our priority. Ensuring optimal patient outcomes necessitates identifying or inventorying patients' illness burdens and addressing conditions annually. As part of our clinically integrated network, ACOs are expected to understand the needs of their patient population, encourage enhanced patient outcomes and steward costs. Achieving improved patient outcomes despite higher disease burdens carries additional financial incentives to be reinvested into resource allocation such as new equipment, services, and locations. OP CDI will help to fulfill AdvantagePoint’s mission by identifying the true complexity of populations. Accurate and compliant condition capture ensures treated conditions are properly reimbursed by CMS and payers.

Risk score accuracy and appropriately depicting a patient’s illness burden

Provider awareness to enhance care management

Aligning documentation and coding to drive compliant billing

Our Outpatient CDI Journey: A Continuous Evolution

2021
- Assess and develop a plan for risk score accuracy

2022
- Initial at the elbow support for providers
- Retrospective review and rebilled claims

2023
- Focused on building the pre-encounter workflows
- Initially deployed post-encounter workflows driven by natural language processing (NLP)

2024
- Expanded pre-encounter workflows to new markets
- Launched pre-encounter NLP suspects

2025
- Continued expansion across the networks
- Expand to additional practices in each network

A Patient Example of How Condition Capture Matters

A patient schedules an office visit for a prescription refill. Her care has been inconsistent as it is November, and this is the patient's first trip to her provider all year. Below are conditions that are noted on the problem list. Like relative weights, HCC weights can be multiplied by a factor to get the potential financial impact.

Condition	HCC Category (v28)	HCC Weight (v28)[1]	Care Funding
E11620- Type 2 diabetes mellitus with diabetic dermatitis	37- Diabetes with Chronic Complications	0.166	$1,594
J449- Chronic obstructive pulmonary disease, unspecified	111- COPD, Interstitial Lung Disorders, and Other Chronic Lung Disorders	0.319	$3,062
I270- Primary pulmonary hypertension	226- Heart Failure, Except End-Stage and Acute	0.360	$3,456
N1831- Chronic kidney disease, stage 3a	329- Chronic Kidney Disease, Moderate (Stage 3, Except 3B)	0.127	$1,219
Interaction Factors Based on Conditions Above	• Diabetes + Heart Failure • Heart Failure + Chronic Lung Disorder • Heart Failure + Kidney	• 0.112 • 0.078 • 0.176	• $1,075 • $749 • $1,690
	Total- Assuming All Conditions Captured	1.338	$12,845

Sources: 1) https://www.cms.gov/files/document/2024-advance-notice-pdf.pdf | 2) Care Funding: Assumes $9,600 per point of RAF

Multiple Opportunities to Capture Complexity and ROI

How to Impact an HCC Throughout its Life Cycle

Used with permission from Edifecs

Like Inpatient, a Lot Must Happen for Value To Be Realized

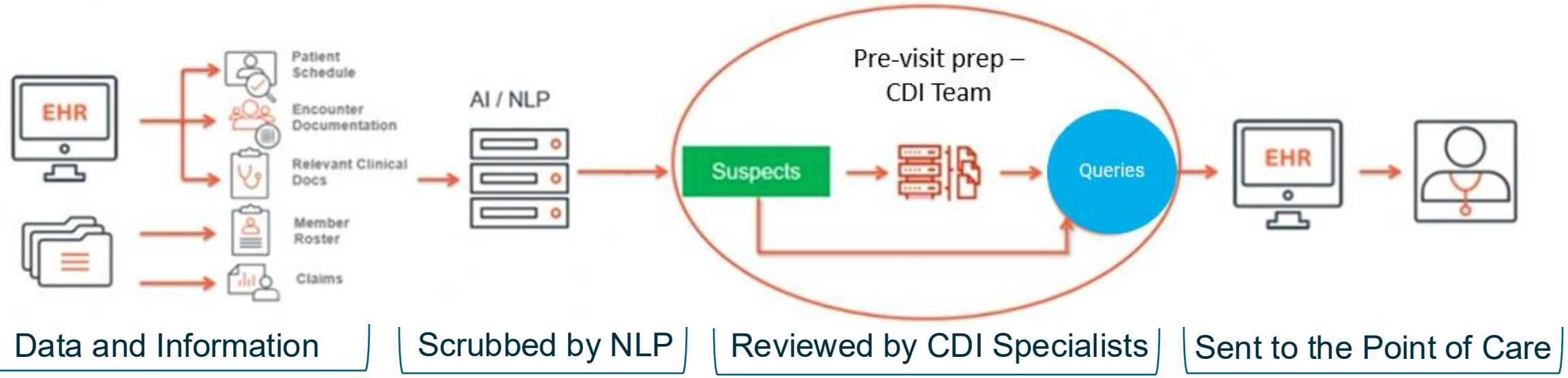
Eligible Population Member Months ✖ Total RAF Score for all Patients ✖ Per Member Per Month Payment = Total Premiums

Pre-Encounter Review	Identify / Send Clarifications	Providers Respond at the Point of Care	Documentation / Coding Alignment
20 Reviews per Day	10 Queries Per Day	50% Response Rate	80% Accuracy

Impact:
1 FTE may review 20 visits per day but impact will be driven from what is found, what is responded to, and what is documented. The above example would result in 4 HCCs captured after 20 reviews.

An Overview of Data and Information Flow

CDI Pre-Encounter Workflow Enabled with AI/NLP



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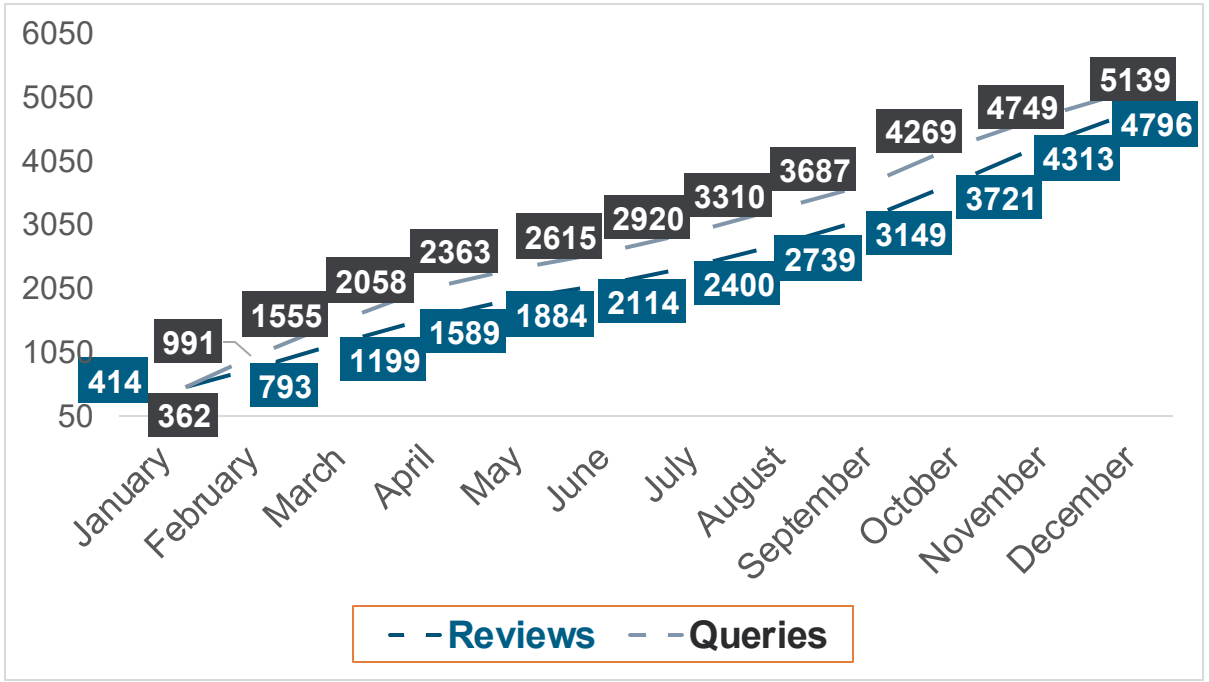
Measuring the Pre-Encounter Process: Volumes and Value

Before Patient Visits

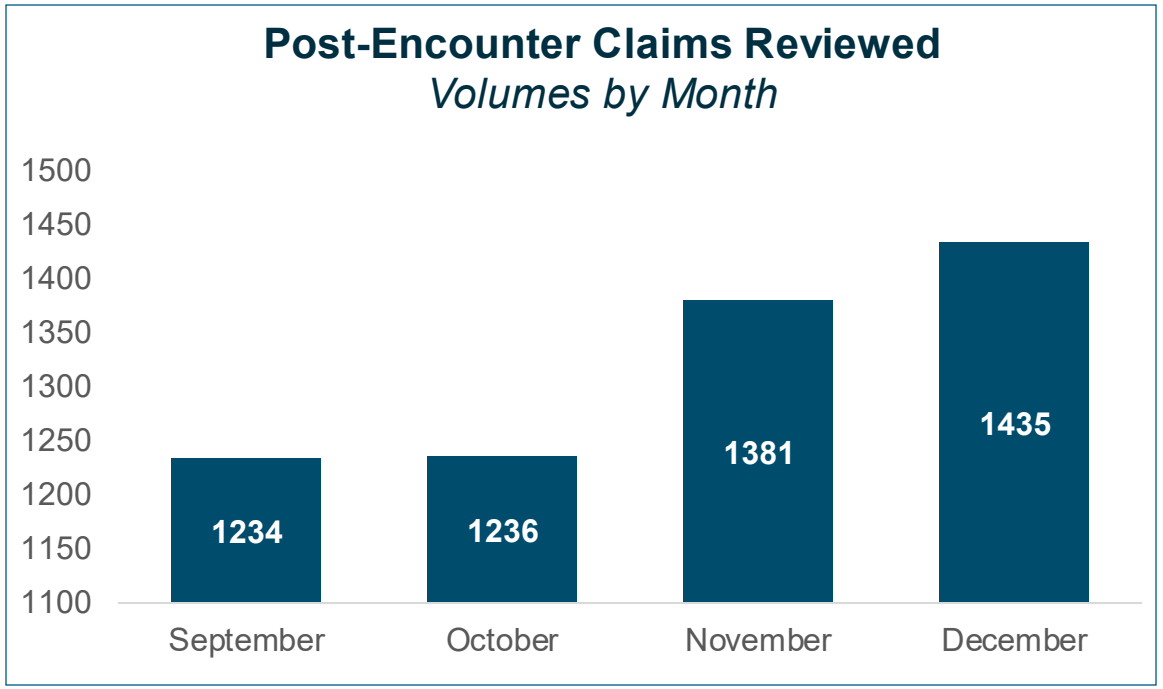
About 1-3 days before a patient's scheduled annual wellness visit, the pre-visit team will review 2-3 years of medical records (including labs, diagnostic imaging and consultations) for clinical conditions lacking specificity or support. Potential opportunities surfaced by our technology partners will be validated or dismissed if resolved or unsupported.

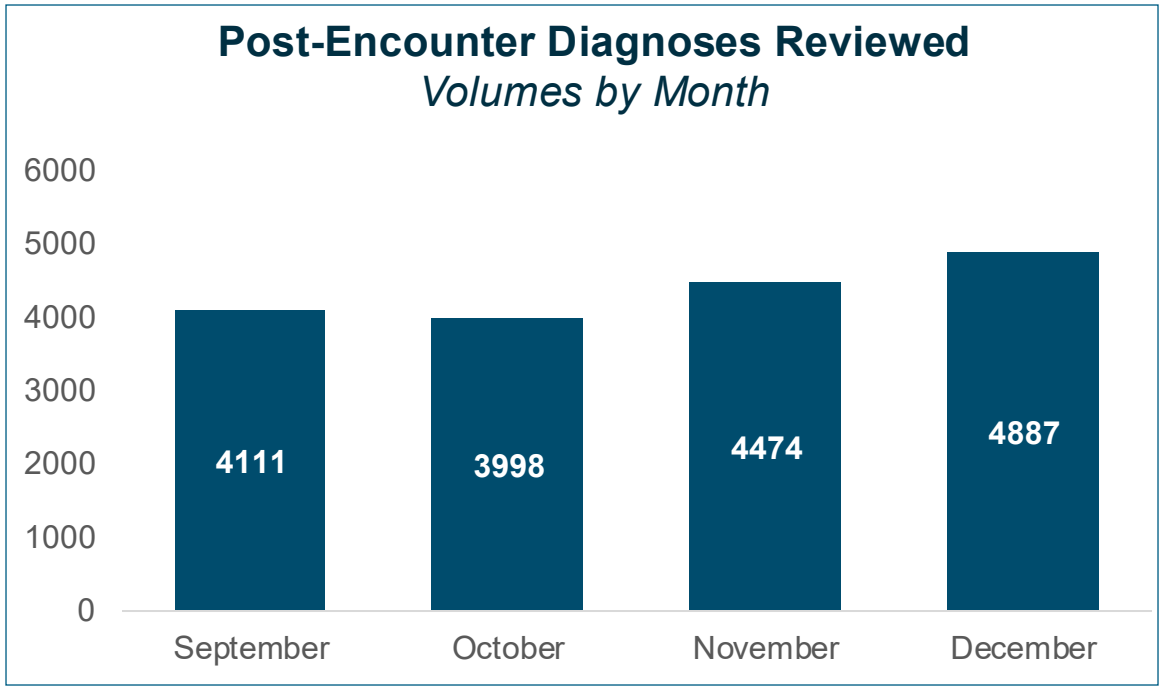
Pre-Encounter Reviews and Queries
Calendar Year 2024



Post-Encounter and Retrospective Workflows

Post-Encounter Metrics and Value Creation





2024 Metrics of Success:

–68,108 HCCs surfaced by the NLP powered software
--11% of suggested HCCs were added
–13,628 total conditions added, including conditions without risk value

Mitigating Compliance Risk Is Also ROI

Pre-Encounter

Specialists are not only expected to review records for net new conditions and clarifying current clinical conditions, they are also expected to review the record for clinical conditions that are no longer clinically valid.

Decreasing Over Capture Risk:
Hundreds of conditions for historical, acute conditions (e.g., stroke, heart attacks, and old cancers) were reviewed and prevented from being prompted at the point of care

Post-Encounter

The post-encounter process seeks to align documentation and coding. This is done by both evaluating conditions documented but not coded as well as removing codes that were coded but lacked supporting documentation.

Risk Mitigated:
18,786 conditions, both risk eligible and non-risk eligible have been removed from encounters due to insufficient documentation

Returning to the ROI Concept: An Example of Performance

Due to the sensitive nature of financial performance, the example used below is both illustrative and can be used for you to determine your potential impact.

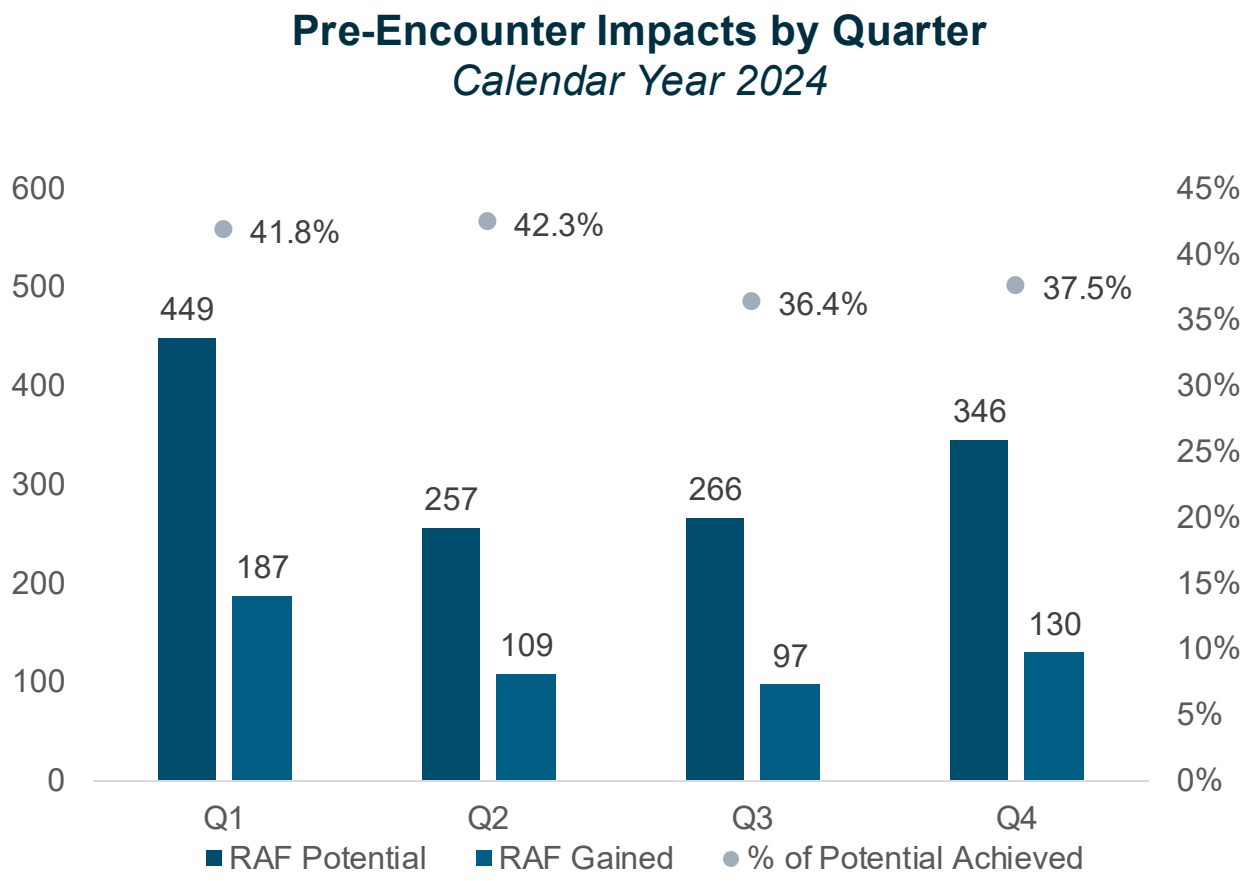
Pre-Encounter

Metric	Value
RAF Potential Identified per Review	0.27
RAF Captured per Review	0.11
Percent of RAF Potential Captured	40%
Impact per Review[1]	$272

Post-Encounter

Metric	Value
RAF Potential Identified per Review	0.31
RAF Captured per Review	0.06
Percent of RAF Potential Captured	20%
Impact per Review[1]	$154

Total ROI Depends on Contract and Investment Costs



Key Investment Considerations

When calculating return on overall investment, there are a few things to consider:

- Program build and start-up cost
- Human capital (production / supervisors / management)
- Educator time/FTEs for provider support
- Technology investments (initial / recurring) inside the EHR and additional technologies

Barriers To Achieving Stronger ROI

Chart Coverage Rates

Provider Response Rates

Cancelled / Rescheduled / No-Show Patients

Sufficient Documentation to Bill Code

Key Considerations for Your Outpatient Program

Other Considerations and Value Opportunities for OP CDI ROI

Annual Wellness Visits

- AWVs are often a prime appointment type for review
- Organizations find that due to CDI reviews, there is an increased emphasis in scheduling AWVs
- Past reviews have also shown that patients with an AWV have higher risk score accuracy than those without an AWV

Quality Outcomes

- OP CDI is dependent upon patient visits. Mature organizations see their patients more often to ensure risk and quality are addressed
- Higher AWV completion rates have been shown to increased HEDIS scores

Leveraging Technology

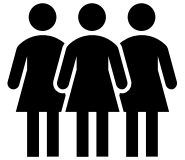
- Human capital can't reach 100% of records. At some point to achieve scale and efficiency technology may be needed.
- Organizations should maximize tools within the EHR first
- NLP should be considered to supplement and enhance the human review process (pre/post/retro)

Payer-Partner Relationship

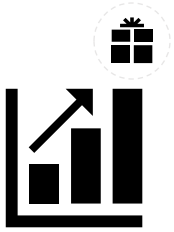
- Payers can be a tremendous resource for data. This can include historical claims information and suspect conditions
- Some payers will provide educational information to clinicians and review specialists
- You need to ensure you understand the reimbursement structure for each plan.

Key Decision Points for an Outpatient Program: Lessons Learned

Understanding Contractual Risk and the Value Proposition



Who / How Will You Do the Work



Provider Engagement and Incentives

Organizational Support and Alignment

Wrapping Up

Key Takeaways from Today

OP CDI Can Drive Tremendous Value – But It Is Complex

- With the continued shift from volume to value there is an increasing need to get the professional medical record complete and accurate
- You should consider processes before the visit, at the point of care, after the visit, and retrospectively
- Don't underestimate provider engagement, IT partnership, or data analytics in building a successful program

ROI Calculations are Imperfect But Don't Let That Stop You

- Tracking RAF across a lot of data is complex and requires data expertise
- 1 point of RAF can be worth more than 1 point of relative weights depending on your risk arrangement. Don't leave millions on the table
- Consider ROI calculations to be as much science as it is math. Strive to be directionally accurate but don't die on a hill attempting to be actuarially precise

Value Exists in Risk Score Accuracy – That Includes Revenue Protection

- The OIG says that nearly 10% of all Medicare Advantage revenue isn't supported by documentation in the record
- In 2024, the OIG identified $231M in overpayments across just 9 reviews. Protecting revenue is just as important as maximizing revenue.
- Compliance is a non-negotiable.

Thank you! Questions?

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