Outpatient efforts: What your primary care physicians need to know about CDI

by Trey La Charité, MD

The field of CDI traditionally focused on the inpatient environment. However, as healthcare reform gains momentum, that view has dramatically changed. Wise organizations have already seen the writing on the wall and know that CDI is equally important for outpatient providers.

Unfortunately, even though primary care physicians (PCP) need CDI expertise, many remain unaware of how the medical landscape around them has changed, and many more simply do not believe that their practice has to change. If the PCPs in your network are reticent, the following information might persuade them to embrace the changes necessary to implement CDI principles in their practices.

Consumer pressures

The two basic reasons for expanding CDI efforts to the outpatient arena are the same as those that influenced our inpatient efforts: Will patients want to see our providers for their medical care? and Will they be allowed to see our providers?

When prospective patients search for a new PCP, they will choose the one who has better performance metrics readily available from online reviews and data resources—they will want to see the better-rated doctor.

Increasingly, insurance carriers (or employers paying for the health insurance) steer new patients to a particular group of PCPs based on those same performance metrics—they won’t be allowed to see a provider deemed inferior. If a patient wants to see a physician outside his or her insurance carrier’s network, that patient will have to pay to do so.

As with inpatient CDI, providers achieving equivalent or superior performance metrics and outcomes on patients who are clearly sicker than their competition will be rewarded by both of these mechanisms. Providers that do not achieve favorable results will experience reduced patient volumes. Therefore, the goal of CDI in the outpatient environment remains the same: to make sure that the patient’s medical record accurately reflects the severity of the illness treated by the physician.

However, there is a less widely known reason for our PCPs to embrace outpatient CDI efforts. While not a new phenomenon, utilization justification may be the most important factor in determining a PCP’s success. All insurance carriers (Medicare, Medicaid, and commercial) monitor the practice patterns of every PCP in their network. While carriers certainly care about the obvious performance metrics, such as the percentage of mammograms completed on eligible beneficiaries or the average hemoglobin glycosylated test (HbA1c) of the diabetic beneficiaries in a practice, they are particularly concerned with cost-effectiveness. The carriers want to see that a PCP spends an appropriate amount of the limited healthcare dollars available on the patients in his or her charge.

What does “appropriate” mean? The obvious answer is that it depends on how sick the patient is.

Cost-effectiveness is measured by a simple formula: the amount of money spent on a given beneficiary for a given calendar year divided by the amount of money that was expected to be spent on that beneficiary for that calendar year. Expressed as a percentage, this utilization ratio, also known as the Medical Expense Ratio or Medical Loss Ratio, is perhaps the single most important yardstick by which PCPs are judged.

The amount of money spent on a patient for a given calendar year is easily and accurately obtainable by the carriers from their claims data. Calculating the amount of money that was expected to be spent on a beneficiary for a given calendar year varies by carrier. Regardless of carrier, though, the calculation is documentation dependent: The more accurately a provider reports a patient’s (or patient population’s) severity of illness, the higher the
amount of money the carrier will expect the provider to need to treat that patient or population.

While Medicare’s hierarchical condition categories (HCC) system is the most widely known methodology for obtaining this forecast, every carrier has a similar system. Explaining HCCs is beyond the scope of this article; however, I suggest that your PCPs learn and incorporate the system’s intricacies into their documentation patterns. If they can master HCCs, they will likely obtain high marks regarding their publically reported quality data as well as within their various payers’ risk stratification methods.

What should a PCP’s utilization ratio actually be? With the passage of the Affordable Care Act, insurance carriers became obligated to spend no less than 80% (individual and small group plans) to 85% (large group plans) of collected premiums on actual medical care for their beneficiaries. This means that out of every dollar collected, $0.80 to $0.85 must go to medical services and benefits for a carrier’s patients, leaving only $0.15 to $0.20 for the administrative costs of the carrier and its potential profit margin. Therefore, since most of our PCPs will be dealing with large group plans, a utilization ratio somewhere around 85% should be the PCP’s goal.

Hypothetical case in point

Let’s assume that PCP A’s utilization ratio is 110% for a given year. This means the insurance carrier would have spent $1.10 on PCP A’s patients for every $1.00 it collected, making that PCP look expensive. However, if PCP B’s utilization ratio were only 86%, the insurance carrier would have spent only $0.86 for every $1.00 collected, potentially generating a little profit. Assuming equal patient outcomes, PCP B looks more cost-efficient.

For PCP A to improve (i.e., decrease) his utilization ratio, he must either reduce the amount of money spent on his patients or increase the amount of money that was expected to be spent on his patients. Reducing the amount of money PCP A spends means ordering fewer lab tests and/or radiological studies, making fewer specialist referrals, or seeing his patients less frequently in the office. However, increasing the amount of money expected to be spent on his patients merely requires accurately portraying within the medical record how sick the patients really are.

The first strategy requires the PCP to change his practice patterns; the second strategy requires only a change in documentation patterns. Needless to say, suggesting that a colleague limit or reduce patient care is not a strategy or conversation I intend to pursue. Going forward, denominator management is the clear choice.

Insurer options

What will an insurance carrier do if a PCP’s utilization ratio stays consistently high? First, the carrier can drop certain carrier-specific care designations for the expensive providers from its network websites. Alternatively, if the carrier employs a ranking system (such as adding a variable number of stars next to each provider’s name, with a higher number of stars indicating a better provider), it may reduce the expensive provider’s number of stars in relation to his or her peers. When presented with more than one choice, a prospective patient will select a PCP that has the carrier-specific care designation or that has the most stars.

As yet another option, the carrier can charge higher copays to see the expensive providers. Again, when presented with two options, prospective patients are more likely to choose the one that costs less.

Lastly, insurance carriers can invoke what I call the “death penalty.” They can completely drop or exclude the expensive-appearing PCP from one or all of their network products. Rest assured that any of these will result in fewer patients being steered towards your PCPs’ offices.

Traditional word-of-mouth referrals will continue to dwindle as technologically savvy patients do their homework on the Internet. These patients will choose their PCP based on the information and data they discover. Therefore, a PCP’s documentation is paramount in ensuring a flow of new patients. Ultimately, your organization’s future may depend on what the publicly reported information and data says about your PCP network. A reduction in patients for PCPs means a reduction in referrals for your hospital—and empty hospital beds result in closed hospital doors.

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