The Coder’s Playbook for Success with Risk Adjustment Payment Methodologies

Angela Carmichael, MBA, RHIA, CDIP, CCS, CCS-P, CRC
Director, HIM & Risk Adjustment Consultant
J.A. Thomas & Associates /Nuance Communications
Agenda

• Risk Adjustment Fundamentals
• Overview of the top risk adjustment payment models:
  • CMS-HCCs & HHS-HCCs
• Pertinent Guidelines
• Common Challenges
• Potential Points of Breakdown
• Managing the Opportunities & Mitigating Compliance Risk
What is Risk Adjustment?

• An actuarial tool used to predict health care costs
• It includes adjustments that consider demographic information (age, sex, eligibility); and
• Captures the health status, severity or “disease burden” of each patient, or patient population, based on certain ICD-10-CM diagnosis codes reported on a claim, or submitted via RAPS or EDS format
• Various forms of risk adjustment methodologies
• For example: DRGs, CMS-HCCs, HHS-HCCs, CDPS, VBP, etc.
What are Hierarchical Condition Categories (HCCs)?

• HCCs are a form of Case Mix Index (CMI)
• This form of CMI applies to the patient for the calendar year across both inpatient and outpatient settings.
• HCCs are diagnostic categories that “bucket” patients into different "categories" based on demographics and the ICD-10-CM diagnosis codes
• The categories are designed to group patients that are not only *clinically* similar but follow similar *cost* patterns to predict future healthcare costs and allow for quality of care comparisons.
  – CMS HCCs are more predictive of readmissions and future costs than MS DRGs
Why is Risk Adjustment Important?

• It’s a necessary tool for Managed Care Programs
  • Account for changes in severity & case mix over time
  • Accurately set performance targets (quality & efficiency)
• It’s relevant
  • Risk adjustment is an important element in VBP
• It’s fair
  • Provide incentives to enroll high-cost individuals into managed care programs by ensuring health plans/ACOs have the resources needed to provide efficient and effective treatment
• It’s prominent
  • Risk adjustment payment methodologies are used across a variety of government (Federal & state) private & commercial insurance programs
• It’s here to stay!
How is Risk Adjustment Used?

• Payment methodology
  • For example:
  • CMS-HCCs set Per Member Per Month (PMPM) capitation payments to Managed Medicare plans
  • Used in combination with fee for service (FFS) to compensate Accountable Care Organizations (ACO) Medicare Shared Savings Programs (MSSP)

• Risk adjusts other payment models
  • HCCs mathematically reconcile the observed rate versus from the expected so that the quality of the care can be isolated and understood—an important element of Value Based Purchasing.
  • For example:
  • The five per capita cost measures included in the 2015 Value Modifier in Physician Quality Reporting System (PQRS)
  • Severity Of Illness (SOI) during the 90 days preceding the Medicare spending per beneficiary episode in Medicare Spending Per Beneficiary (MSPB)
How Prominent is Risk Adjustment?

• Risk adjustment payment methodologies are used across a variety of government (Federal & state) private & commercial insurance programs

• The Four Prominent Systems:
  – Ambulatory Care Groups (ACGs)
  – Chronic Illness and Disability Payment System (CDPS) (Managed Medicaid)
  – Diagnostic Cost Groups (DxCGs)
  – Hierarchical Condition Categories (HCCs)
    • CMS HCCs (Managed Medicare “Part C”)
    • HHS HCCs (Managed Commercial in Health Insurance Exchange)
    • RxHCCs (Prescription drug benefit “Part D”)
### CMS-HCCs (Medicare)
- **3 Programs:**
  - Medicare Advantage
  - Duals Demonstration
  - Medicare MSSP for ACOs
- **3 Models:**
  - Model 22 for CY 2015
  - Model 21 for PACE & ESRD
- **Budget/Payment Mechanism**
  - Funded by CMS
  - Applied to each individual
  - PMPM payment from CMS
  - Patient’s pay monthly premium
  - Medicare Advantage plans on average received about $9,900 per person in 2011.

### HHS-HCCs (Non-Medicare)
- **2 Programs**
  - Federal & State
    - Members offered direct & small group coverage on/off the Exchange
- **Federal Models: 15**
  - 3 populations (adult, child, infant) x 5 levels
- **Budget/Payment Mechanism**
  - Funded by members & supplemented by gov’t
  - Calculated for each member but applied in aggregate
  - State budget neutral; transfer of funds between Issuers within state
  - Redistributes premiums
Risk Adjusted Payment Models: Federal

**CMS-HCCs (Medicare)**
- ICD-10-CM codes: 9,548
- HCCs: 79
- HCC Range: 1-189
- Accepted Provider Types:
  - Specified by CMS
- Data Linkages:
  - Not tied to a particular procedure
  - MA: Claim-based, home assessments & retrospective review
  - ACO: Claim-based only

**HHS-HCCs (Non-Medicare)**
- ICD-10-CM codes: 7,768
- HCCs: 127
- HCC Range: 1-254
- Accepted Provider Types:
  - Specified by CMS
- Data Linkages:
  - Tied to 1 of 6,961 specific CPT/HCPCS procedures
  - Must be claim based

7,645 ICD-10-CM diagnoses are found in both methodologies
Key Characteristics of HCCs

- More than 1 HCC can be assigned per encounter
- No sequencing involved
- Not all diagnoses map to an HCC
- Procedures not included
- Various provider types & specialties documentation can be used for coding purposes
- Various settings involved
Center of Medicare & Medicaid
Hierarchical Condition Categories (CMS HCCs)
Diagnosis Sources: Provider Settings

Acceptable Provider Settings for CMS-HCCs
- Short-term (general & specialty) Hospitals
- Critical Access Hospitals
- Children’s Hospitals
- Long-term Hospitals
- Rehabilitation Hospitals
- Psychiatric Hospitals
- Religious Non-Medical Health Care Institutions
- Community Mental Health Centers
- Federally Qualified Health Centers
- Rural Health Clinic (Free-Standing & Provider-Based)

Non-Covered Settings: Hospital Inpatient Swing Beds, Free-standing Ambulatory Surgery Centers, Skilled Nursing Facilities, Intermediate Care Facilities, Respite Care, Hospice, Home Health Care, Free-standing Renal Dialysis Facilities

Non-Covered Services: Ambulance, Lab, Radiology, DME, Prosthetics, Orthotics, Supplies

Note: This is not an exhaustive list
Diagnosis Sources – Provider Types

• Diagnoses documented by select provider types are appropriate for coding and reporting for CMS HCC coding.
  • MD or DO
  • OD  Doctor of Optometry
  • DC  Doctor of Chiropractor
  • DDS Doctor of Dental Surgery
  • DO  Doctor of Osteopathy
  • DPM Doctor of Podiatry
• All Nurse Practitioners, Certified Nurse Specialists, CRNAs
• Physician’s Assistants
• Therapists; Speech, Physical, Occupational (except “respiratory”)
• Licensed Clinical Social Worker or Clinical Social Worker
• Certified Wound Care and/or Ostomy Nurse

Note: This is not an exhaustive list
Key Characteristics for Calculating Risk Scores

- Key characteristics for calculating individual risk scores (Published in the CMS Annual Rate Announcement)
  - Demographic Factors
    - Age, sex,
    - Eligibility status
      - Dual eligible (Medicare & Medicaid)
      - Current eligibility (Aged vs Disabled)
      - Original eligibility (Aged vs Disabled)
    - Sub model type (PACE, ESRD)
  - Living in the community or institutionalized (long term)
  - Chronic Disease Burden
    - ICD-10-CM diagnoses (think “complete, accurate & consistent”)
  - Disease Hierarchies (think “severity” &/or “specificity”)
  - Disease Interactions (think “complexity” & “completeness”)
Each Member (patient) has a Risk Adjustment Factor (RAF) Score

- Organization average RAF score similar to case mix
- = 1 a patient expected to use average resources
- < 1 a patient expected to use fewer resources
- > 1 a patient expected to utilize greater resources

Risk Adjustment Factor (RAF) spread: 0.118 - 2.4888
What type of conditions map to an CMS HCC?

- High cost medical condition (current cancer, heart disease, hip fracture)
  - Highest weighted: HIV, Sepsis, Opportunistic Infections & Cancers
- Acute, chronic, status codes, etiology & manifestation
  - Hip fracture, COPD, status amputation of great toe, diabetic neuropathy
- Common conditions, rare conditions, conditions that can be cured, non-curable, congenital and acquired, but ...
  - must be current & impact the encounter in terms of requiring either...
    - monitoring, evaluation, assessment or treatment
- Diagnoses are excluded from mapping when...
  - They do not predict future cost (e.g., appendicitis)
  - There is a high degree of discretion or variability in diagnosis, diagnostic coding, or treatment (e.g., symptoms, osteoarthritis)
- Diagnosis codes from lab, radiology and home health claims are not used because they are not reliable and may indicate rule-out diagnoses
Although HCCs reflect hierarchies among related disease categories, for unrelated diseases HCCs accumulate.

<table>
<thead>
<tr>
<th>Description</th>
<th>HCC</th>
<th>Weight</th>
<th>Cumulative Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>80 y.o. male, aged, community</td>
<td>Demographic</td>
<td>0.543</td>
<td>0.543</td>
</tr>
<tr>
<td>Unstable Angina</td>
<td>87</td>
<td>0.258</td>
<td>0.801</td>
</tr>
<tr>
<td>COPD</td>
<td>111</td>
<td>0.346</td>
<td>1.147</td>
</tr>
<tr>
<td>Primary malignant neo prostate</td>
<td>12</td>
<td>0.154</td>
<td>1.301</td>
</tr>
</tbody>
</table>

His predicted cost will reflect increments for all three diagnoses. So unlike DRGs, there may be several HCCs assigned to an individual culminating in a single risk score.
Disease Hierarchies

- Address Situations When:
  - Multiple levels of severity for a disease; or
  - Multiple conditions that are clinically related
    - Results in varying levels of associated costs for the same patient
    - Payment based only on most severe and costly manifestation of disease

<table>
<thead>
<tr>
<th>Description</th>
<th>HCC</th>
<th>Weight</th>
<th>Cumulative Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>76 y.o. female</td>
<td>Demographic</td>
<td>0.437</td>
<td>0.437</td>
</tr>
<tr>
<td>Dual Eligible</td>
<td>Demographic</td>
<td>0.151</td>
<td>0.588</td>
</tr>
<tr>
<td>DMII Uncomplicated—</td>
<td>19</td>
<td>0.118</td>
<td>0.706</td>
</tr>
<tr>
<td>DMII w/ acute complication</td>
<td>17</td>
<td>0.368</td>
<td>0.956</td>
</tr>
</tbody>
</table>
Disease Interactions

- Certain combinations of coexisting diagnoses for an individual can increase their medical costs. The CMS-HCC model recognizes these higher costs through incorporating payments for “disease interactions”.

<table>
<thead>
<tr>
<th>Description</th>
<th>HCC</th>
<th>Weight</th>
<th>Cumulative Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>76 y.o. female</td>
<td>Demographic</td>
<td>0.437</td>
<td>0.437</td>
</tr>
<tr>
<td>Dual eligible</td>
<td>Demographic</td>
<td>0.151</td>
<td>0.588</td>
</tr>
<tr>
<td>DMII w acute complication</td>
<td>17</td>
<td>0.368</td>
<td>0.956</td>
</tr>
<tr>
<td>CHF</td>
<td>80</td>
<td>0.368</td>
<td>1.324</td>
</tr>
<tr>
<td>Interaction DM + CHF</td>
<td>Disease Interaction</td>
<td>0.182</td>
<td>1.506</td>
</tr>
</tbody>
</table>

In this case, the plan receives payment for not only the RFs associated with DM & CHF, but also an add-on interaction RF of .182.
Report Each Mapping Condition at Least Once in the Calendar Year

• Each January starts a “clean slate”
• Each chronic—non-resolving diagnosis that maps would need to be reported at least once during the calendar year, on a claim denoting a face to face visit with an acceptable type of provider, in an acceptable setting.
• If not—we call this “falling off”
Why More Really is Better

• Even though each mapping diagnosis only needs to be reported once in the calendar year, during a RADV you are able to submit up to 5 DOS to support any 1 HCC.
• Even if the diagnosis is documented clearly & coded correctly—a medical record deficiency could make the encounter invalid
• Stack the deck in your favor!
• Your goal is to report each mapping diagnosis as often as it meets reporting guidelines
Step 1: Age, Sex, Demographics & Eligibility

Payment Year
2015

Determined by Date of Service

Birth Date (MM/DD/YYYY) or Age
06/01/1942

Gender
Male Female

Age & Gender

Demographic Risk Factors

Institutionalized or living in the Community?

Dual Eligible?

Current Medicare Eligibility due to
Aged Disabled

What drove Medicare Eligibility?

Original Medicare Eligibility due to Disability
Yes No
Step 2: Calculate Disease Burden

<table>
<thead>
<tr>
<th>Model</th>
<th>HCC</th>
<th>Description</th>
<th>Override</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>DX1</td>
<td>250.60</td>
<td>2014</td>
<td>18</td>
<td>DMII neuro nt st uncntrl</td>
</tr>
<tr>
<td>DX2</td>
<td>357.2</td>
<td>2014</td>
<td>18</td>
<td>Neuropathy in diabetes</td>
</tr>
<tr>
<td>DX3</td>
<td>428.32</td>
<td>2014</td>
<td>85</td>
<td>Chr diastolic hrt fail</td>
</tr>
<tr>
<td>DX4</td>
<td>492.8</td>
<td>2014</td>
<td>111</td>
<td>Emphysema NEC</td>
</tr>
<tr>
<td>DX5</td>
<td>427.31</td>
<td>2014</td>
<td>96</td>
<td>Atrial fibrillation</td>
</tr>
<tr>
<td>DX6</td>
<td>V85.41</td>
<td>2014</td>
<td>22</td>
<td>BMI 40.0-44.9, adult</td>
</tr>
<tr>
<td>DX7</td>
<td>278.01</td>
<td>2014</td>
<td>22</td>
<td>Morbid obesity</td>
</tr>
<tr>
<td>DX8</td>
<td>714.0</td>
<td>2014</td>
<td>40</td>
<td>Rheumatoid arthritis</td>
</tr>
<tr>
<td>DX9</td>
<td>707.15</td>
<td>2014</td>
<td>161</td>
<td>Ulcer other part of foot</td>
</tr>
<tr>
<td>DX10</td>
<td>296.30</td>
<td>2014</td>
<td>58</td>
<td>Recurr depr psychos-unsp</td>
</tr>
</tbody>
</table>

Best Practice: Document, code & bill every diagnosis that maps to an HCC/RxHCC each & every time it meets reporting criteria
Step 3: Calculate Total Risk Factor

3.771 = 2014 Total Risk Factor

Disease Interactions

2014 Demographic Risk Factor 0.348
2014 HCC Risk Factor 3.423
Interaction: CHF_COPD 0.259
Interaction: DIABETES_CHF 0.182
2014 Total Risk Factor 3.771
2014 RS Normalized w/Coding Intensity 3.655

-0.116
PERTINENT GUIDELINES
Pertinent Guidelines

• Payment Methodology
  • CMS HCCs, HHS HCCs, CDPS, etc.
  • Sub models
  • Rate year risk factors & mapping tables

• Code Sets
  • ICD-10-CM

• Official Coding Guidelines
  • Coding Conventions
  • Official Coding Guidelines published by the National Center for Health Statistics
  • Coding Clinic published by the American Hospital Association
COMMON CHALLENGES
Common Challenges

• Medical Record Administration Requirements
• Clinical Documentation Requirements
  • Mapping diagnoses
  • Clinical support for each mapping diagnosis
• Coding
• Billing / Reporting
• Compliance with all coding & methodology guidelines
Medical Record Requirements

• Two patient identifiers on each page of every document:
  • Example: Patient’s name, date of birth, medical record number
• Date of Service (complete Month/Day/Year & legible)
• Face-to-face encounter with acceptable type provider & setting
• Acceptable provider signature, with credential
• Legibility: Documentation, signature & credentials must be legible to the auditor validating the risk score
• Documentation should be clear, concise, consistent, complete and legible
What kind of documentation do we need?

- Diagnoses must be documented—there can be no assumptions
  - Coders cannot interpret labs
  - Coders cannot assume a diagnosis based on meds provided or orders
- Diagnoses must be documented to the highest level of specificity
  - Increases the likelihood of mapping (Example: Depression)
  - Increases the likelihood of the condition mapping to a higher weighted HCC (Example: Diabetes)
- Diagnoses must be documented in a part/section/document coders are permitted to code from
  - We can’t code current conditions from problem lists, medical history or super bills.
- Supporting clinical documentation for all reported diagnoses aka MEAT.....Monitor, Evaluate, Assess, Treatment
Where is the Meat?

Ensure “MEAT” is met

• M = Monitoring
• E = Evaluation
• A = Assess/Address
• T = Treatment

• Only 1 element of MEAT is required to support a diagnosis—not all 4
• 2 elements is better
• 3 elements is better still

M.E.A.T can be found in any section of the patient record
## MEAT for the Chronic Condition

<table>
<thead>
<tr>
<th>Monitor</th>
<th>Signs, symptoms, disease progression, disease regression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluate</td>
<td>Review of test results, medication effectiveness, response to treatment (&quot;stable&quot;, &quot;improving&quot;, &quot;exacerbation&quot;, &quot;worsening&quot;, &quot;poor&quot;)</td>
</tr>
<tr>
<td>Assess/Address</td>
<td>Ordering tests, discussion, review records, counseling</td>
</tr>
<tr>
<td>Treatment</td>
<td>Referral, medication(s), planned surgery, therapies, other modalities</td>
</tr>
</tbody>
</table>

**Example:**
- “CHF symptoms well controlled with Lasix and ACE inhibitor. Will continue current medications”
MANAGING THE OPPORTUNITIES &
MITIGATING COMPLIANCE RISK
Managing the Opportunities

Determine scope & depth of opportunity
• Varies based on patient population/insurance type

Medicare
• Does your organization offer their own provider sponsored Medicare Advantage Plan?
• Does your organization, or it’s employed providers, receive incentives from Health Plans with a Medicare Advantage Plan if they improve risk scores?
• Is your facility part of a Accountable Care Organization (ACO)?

Commercial Health Insurance Exchange Members
• Does your organization receive incentives from Health Plans within the Commercial HIE if they improve risk scores?

Medicaid
• Does your state utilize a risk adjustment methodology for Medicaid patients?
Mitigating Compliance Risk

• Health plans collect medical data used to calculate patient risk scores. But mistakes are common and trigger billions of dollars in “improper payments” every year, mostly overcharges.

• Risk Adjustment Data Validation (RADV) audits are utilized by the Centers for Medicare & Medicaid Services (CMS) to keep the industry honest.
Risk Adjustment Data Validation (RADV)

- National and Targeted Audits to validate HCCs
- Enrollees are sampled from selected contracts for the purpose of estimating payment error related to risk adjustment
- CMS will calculate each contract’s payment error based on the validation results
- Applicable to Medicare Advantage & Medicare Shared Savings Program for ACOs
- Regulated by: CMS
- Frequency: Annually
- Size: 30 plans with sample size of 201 members
- Financial Impact:
  - Payment recovery, if applicable
  - *Results may be extrapolated* against total enrollment
  - False Claims Act violation--Triple damages plus $5,500 to $11,000 per claim penalties
CMS HCC Data Validation Error Rates

- CMS HCC error rate approximately 33%
- RxHCC error rate approximately 25%
- OIG results indicate even higher error rates
- 2006 PY extrapolated results for overpayments indicated 3 billion in overpayments
- RACs have joined the party
Inpatient Setting

✓ Optimize the MS DRG assignment
✓ Ensure you are writing your typical SOI/ROM clarifications
  • Approximately 42% of CMS HCC diagnoses are CCs in MS DRGs
  • Approximately 16% of CMS HCC diagnoses are MCCs in MS DRGs
  • Approximately 42% of CMS HCC are not CCs/MCCs
    • These same diagnoses are often times either not documented or not coded/reported in the provider office setting
✓ Analyze the HCC tables to ensure you are capturing those conditions that map to an HCC but are not classified as CCs/MCCs
Outpatient Setting: Facility

ED, OBSV, OPSX

- Think beyond Medical Necessity
- Encourage documentation of all comorbid conditions
- Link manifestations to their etiology
- Ensure diagnosis coding is accurate, complete & consistent
- Ensure claim includes all coded diagnoses that are documented and meet the MEAT criteria
A Big
THANK YOU!

angela.carmichael@jathomas.com