

Introduction to Risk Adjustment Programs for Medicare Advantage and the Affordable Care Act (Commercial Health Insurance Exchange)

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Overview of Risk Adjustment

- + Risk Adjustment (RA) is a process for compensating health plans that acquire a member population with less than average health. Risk Scores are used to predict healthcare costs based on the relative actuarial risk of enrollees in risk-covered plans.
- + The purpose of RA is to minimize the incentive for health plans to select enrollees based on their health status – and - to encourage insurance-market competition based on quality improvements and efficiency; mitigating the impact of potential adverse selection¹ and stabilizing premiums.
 - The Federal government (Centers for Medicare and Medicaid Services (CMS)) is responsible for operating risk-adjustment models for Medicare Advantage plans.
 - Either the state and/or federal government (Department of Health & Human Services) will be responsible for operating commercial risk-adjustment models for Accountable Care Act plans.

1. Adverse selection occurs when a larger proportion of persons with poorer health status enroll in specific plans or insurance options, while a larger proportion of persons with better health status enroll in other plans or insurance options. Plans with a subpopulation with higher-than-average costs are adversely selected.

Source: HHS Risk Adjustment Model, May 7, 2012 (Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services, Department of Health & Human Services) <http://cciio.cms.gov/resources/files/fm-1c-risk-adj-model.pdf>



Overview of Risk Adjustment

- + Risk Adjustment recognizes each health plan enrollee based upon their individual Hierarchical Condition Category (HCC):
 - Disease groups are organized into body systems, referred to as HCC's
 - Include both diseases and demographic factors (coefficients)
 - Cumulative models allow a patient to be assigned to more than one category

Comparison of Models

	Medicare Advantage	Commercial
Population Profile	Concentrated, high cost population with pervasive health issues	Large, highly diverse population with more isolated health issues and includes small group and individual plans
Member Engagement	Population easier to engage due to frequency of medical incidence and lifestyle demands	Difficult to engage due to high lifestyle demands and sporadic medical incidence
Data Source	Medical claims submitted to insurers with ability to supplement with medical chart data	Medical claims submitted to insurers with ability to supplement with chart data
HCCs*	Represent a measure of each member's health status only	Represent a combination of member's health status and choice of benefit plan



Overview of Risk Adjustment

+ Risk Adjustment focuses on four key areas:

Clinical Training

- Training for physicians and clinicians about risk adjustment basics for documentation and coding requirements

Clinical Outreach

- Encounters with providers in order to address and capture diagnoses missing from claims data
- Outreach to members with chronic conditions not yet seen in the calendar year

Auditing & Monitoring

- Review encounters for accurate diagnosis coding supported by the medical record
- Concurrent and retrospective chart review/data mining to identify diagnoses documented but not coded
- External claims audits to ensure appropriate capture of diagnoses

Quality & Monitoring

- Ensure that all appropriate diagnoses are submitted by providers and identified in health plan reporting



Medical Records Needed for Risk Adjustment

- + Risk Scores are based on diagnosis codes found on claims, and patients' medical records serve as proof to support the diagnosis codes reported.
- + BCBSNC needs to request medical records from providers because the records are necessary to:
 - Support accurate risk scores
 - Close gaps in medical record documentation
 - Support government audits
 - Support Medicare Advantage Star rating measures



Risk Adjustment Importance to Members and Providers

- + Risk Adjustment helps support delivery of high quality care:
 - Detect and treat chronic diseases earlier
 - Complete and accurate documentation, coding, and capture are key to ensuring the overall disease burden is understood and reported
- + Risk Adjustment drives ability to maintain affordability:
 - Accurate reporting substantiates the overall complexity of care providers provide, and directly impacts affordability in the marketplace to both our member and groups by stabilizing premiums
 - ❖ Old school: Affordability was measured by per member per month (PMPM) costs
 - ❖ New school: Affordability incorporates the ability to better care for the overall disease burden of the member in relationship to the PMPM cost and risk



Provider Participation is Critical

Risk adjustment relies on providers to perform accurate medical record documentation and coding practices in order to capture the complete risk profile of each individual patient.

Financial Health

Accurate medical records and diagnosis code capture on claims & encounter data the “first time” helps reduce the administrative burden of adjusting claims. For providers involved in risk-sharing arrangements, it also ensures more accurate payments and reflection based on the severity of illness burden.

Opportunities to Improve Care

Accurate risk capture improves high-risk patient identification and the ability to reach out / engage patients in disease and care management programs and care prevention initiatives. It also helps in the endeavor to identify practice patterns and reduce variation when clinically appropriate.

Complete coding supplied by providers closes the loop



Coding Gaps for Prevalent Conditions

- + Complete and accurate coding of the most common conditions can have a significant impact on risk capture due to their prevalence. A few of the prevalent conditions that are often not monitored, evaluated, assessed or treated and coded on an annual basis are:
 - Asthma
 - Osteoporosis
 - Hearing loss
 - Psychiatric diagnosis: e.g. major depression, bipolar disorder
 - Vascular conditions: cardiac or cerebral
 - These conditions can have a significant impact on risk capture due to their prevalence



Coding Gaps for High Risk and Rare Conditions

- + Many high risk patients with multiple conditions are often seen by a specialist for the most severe or symptomatic condition. However, analysis shows significant coding gaps for these relatively rare conditions, which often require specialty care, may be lost to care for other conditions:
 - Extremely or Very Low Birth weight Neonates
 - Respirator Dependence, Tracheotomy status
 - Hemophilia, Cystic Fibrosis
 - Bone Marrow and Solid Organ Transplant
 - Severe Head Trauma
 - Protein-Calorie Malnutrition



Accurate Medical Record Documentation and Coding

- Medical coding of patient encounters is only as good as the underlying medical record documentation

Best Practices in Medical Record Documentation

- Documentation needs to be sufficient to support and substantiate coding for claims or encounter data
- Diagnoses cannot be inferred from physician orders, nursing notes, or lab or diagnostic test results; diagnoses need to be in the medical record
- Chronic conditions need to be reported every calendar year (e.g., leg amputation status must be reported each year)
- Each diagnosis needs to conform to the ICD-9 coding guidelines until transition to ICD-10
- Medical records needs to be legible, signed, credentialed and dated by the physician
- Patient's name and date of service need to appear on all pages of the record
- Treatment and reason for level of care need to be clearly documented; chronic conditions that potentially affect the treatment choices considered should be documented

Best Practices in Medical Coding

Accuracy

Specificity

Thoroughness

Consistency



Common Coding and Documentation Errors

- + Medical record documentation does not indicate that all diagnoses are being **M**onitored, **E**valuated, **A**ssessed or **T**reated (MEAT) [e.g. status of cancer or cancer treatment]
- + The highest level of specificity is not used (e.g. an unspecified arrhythmia is coded rather than the specific type of arrhythmia)
- + Chronic conditions are not documented and coded as chronic (e.g. hepatitis, renal insufficiency, bronchitis, etc..)
- + Chronic conditions or status codes aren't documented in the medical record at least once per year (e.g. transplant status, amputation status and paraplegia)



Risk Adjustment Issues and Concerns

Additional Information

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