Risk Adjustment Methodologies

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Definitions

- Risk:
  - “a situation involving exposure to danger”
- Adjustment:
  - “a small alteration or movement made to achieve a desired fit, appearance, or result”
- Risk Adjustment
  - “a statistical process that considers the underlying health status and health spending of patients when examining their healthcare ***outcomes*** or healthcare ***costs***.” -- AHIMA
- The risk we are discussing concerns both cost and outcomes!
- The data must be analyzed for improvements and to better the odds!

H.I.M.'s Role

- Data Governance
  - Accurate coding
    - Most appropriate first-listed/principal diagnosis
    - All appropriate secondary diagnoses
    - Correct p.o.a. indicators
  - Quality documentation
    - Complete
    - Consistent
    - Timely

H.I.M.'s Role

- In this case, we go against that golden rule of Coding where we ***never assume***
- Here we ***always assume*** there will be risk
  - Regardless of patient setting
  - Regardless of patient status
  - Regardless of payer
- And we should always assume this risk can be adjusted to lessen the blow of any less than optimal circumstance through quality documentation and complete and accurate coding!
- Tell the patient's complete story!

Models Used to Adjust Healthcare Data

- CMS' Value-Based Purchasing Programs
  - Logistic Regression Model
  - Maintained by:
    - The National Healthcare Safety Network
    - Centers for Disease Control and Prevention
- U.S. News Rankings
  - Using 3M's APR-DRGs
    - Severity of Illness
    - Risk of Mortality

Models Used to Adjust Healthcare Data

- Health Plan Prescription Rates
  - Through the RxHCCs
- Medicare Advantage Contract Rates
  - CMS HCCs
- Affordable Care Act Health Plan Premiums
  - Health and Human Services HCCs
- Clinical Risk Groups
  - Developed by 3M
  - New York State Medicaid Programs

H.I.M.'s Role

- A pattern of focusing on the current "buzz" or "hot topic" -- currently the HCCs
- Had we been doing what we should be doing right along, this would not be an issue
- Should always have been capturing all relative diagnoses for all patients in all settings and ensuring their inclusion on the claim
- CDI programs should have been striving for genuinely ***improved*** documentation that reflected and strongly supported the patient's true and complete clinical picture

Inpatient Risk and Adjustment

- Does the patient truly qualify as inpatient?
- The wrong patient status immediately invites risk
- A shared problem requiring interdepartmental collaboration --
  - Patient Access
  - Case Management
    - Two-Midnight Rule
    - Condition Code 44
  - Clinical Documentation Improvement
    - Working DRG
    - Does the documentation support an inpatient stay?
  - Nursing Staff

Inpatient Risk and Adjustment

- Patient Safety Indicators
  - Does documentation suggest ***inclusion***?
  - Does documentation suggest possible ***exclusion***?
  - Is CDI aware and looking concurrently?
  - Is Quality involved or even aware?
- Quality Measures
  - Through inappropriate querying
- Clinical Pathways
  - Through inappropriate querying
- Length of Stay
  - Does the documentation support?
  - The Two-Midnight Rule
    - "A remarkable recovery!"
  - The longer the patient stays, the greater the risk!

Inpatient Risk and Adjustment

- Present on Admission
  - “Y”, “N”, “U”, “W”, exempt from p.o.a.
  - Only applies to inpatient
  - An indicator of “Y” if present at the time of inpatient admission
    - When the M.D. order was written!
  - If admitted through an outpatient setting becomes confusing
  - Auditing of p.o.a. will often show poor results for accuracy
    - Opportunity for coder education
  - Assigning the incorrect indicator can wreak havoc with risk!
  - An indicator of “N” that should have been “Y” creates needless risk
  - Indicator “W” is overlooked and underused!

Inpatient Risk and Adjustment

- Severity of Illness
  - “The extent of physiologic decomposition or organ system loss of function”
  - Specific to APR-DRG
  - Connecticut uses APR-DRG to reimburse for Medicaid patients
  - Effective at showing just how sick your patients truly are!
  - For the most part, looks at all secondary diagnoses for an overall score:
    - Minor
    - Moderate
    - Major
    - Extreme
  - Just a good practice to get into regardless of payer!
  - With MS-DRGs it would be a CC or MCC showing severity

Inpatient Risk and Adjustment

- Risk of Mortality
  - “the likelihood of dying”
  - Again, specific to APR-DRGs
  - Will clearly show just how likely the patient is to die on this admission!
  - For the most part, looks at all secondary diagnoses for an overall score:
    - Minor
    - Moderate
    - Major
    - Extreme
  - Again, a good practice to get into since these secondary diagnoses may exclude the patient from a PSI or other measure

Inpatient Risk and Adjustment

- Would you want to have a patient expire with an SOI and ROM of minor?
- SOI and ROM provide not only an accurate evaluation of resource use, but of expected outcomes as well
- There is also the risk of how things appear and public image:
  - Healthgrades
  - Leapfrog
- Impossible to retrospectively correct!

Inpatient Risk and Adjustment

- So very many moving parts!
  - Readmissions
  - HACs
  - All of the other “potentially avoidable” measures creating risk
- And these are all in constant flux!
- The agencies responsible are still not sure of how to proceed or what data or methodology to use
- Your data could be being run and adjusted for risk in ways yet unknown to you?
  - Commercial payers for better contract negotiations might run data through 3M’s CRG
- Wise to cover all bases all the time! Why leave anything to chance!

Inpatient Risk and Adjustment

- Social Determinants of Health (SDOH)
  - Healthcare's new best friend!
  - Socioeconomic risk factors that can impact patient outcomes
  - Also serves the outpatient setting well
  - At the March Coordination & Maintenance Committee Meeting --
  - An industry first—the CMO of United Health Care asking for new ICD-10 codes:

"UHC believes expanding the ICD-10-CM code set would allow for population health improvement, along with the opportunity for National Committee for Quality Assurance (NCQA) to expand HEDIS measurements around social barrier identification and assistance in the future. Today, capturing SDOH barriers appear to vary widely throughout the industry, rendering it a fragmented, inconsistent way of both capturing and using this information."

Inpatient Risk and Adjustment

- Z59.41 Lack of adequate food
- Z91.110 Patient's noncompliance with dietary regimen due to financial hardship
- Z56.84 Unemployed but not seeking work
- Z59.61 Unable to pay for prescriptions
- Z59.64 Unable to pay for transportation for medical appointments or prescriptions
- Z60.82 Inadequate social interaction – limited to once or twice a week

Inpatient Risk and Adjustment

- Social Determinants of Health (SDOH)
  - Can explain a readmission
  - Can explain unexpected or unfavorable outcomes
  - Can explain an extended length of stay – including social admissions
  - Ensure these make their way to the actual claim!
    - 12 diagnosis codes for the 837P (professional)
    - 25 diagnosis codes for the 837I (institution)
- An overzealous CDI department!
  - Querying retrospectively for conditions not adequately documented or followed in the chart
  - Gained an MCC, also gained a PSI!
  - Often with Quality unaware!

Inpatient Risk and Adjustment

- Not staying true to the H.I.M. cause of **Data Governance**!
- H.I.M. creates all the data used throughout healthcare including risk adjustment through coding
- CDI assures the completeness and integrity of the data that supports those assigned codes
- H.I.M. then governs that data throughout its life!
- If all of this happens, ***appropriate*** reimbursement will follow!
  - Fewer missed opportunities
  - Fewer denials

Outpatient Risk and Adjustment

- Secondary diagnoses inherent to the encounter should ***always*** have been reported on the claim to tell the complete patient story!
- *"Code all documented conditions, which coexist at the time of the visit that require or affect patient care or treatment."*
- Not just because of HCCs!
- Haste makes waste – "Just get the bills dropped!"
  - The DNFB!!!
  - Coding Benchmarks
  - Coder Productivity
- May not have captured some valuable data to potentially be used in some risk adjustment methodology

Outpatient Risk and Adjustment

- Lack of CDI for outpatient
  - No one knows quite where or how to begin
- Rarely an outpatient query unless it affects payment!
  - Lacking medical necessity
- Consider education for the physician practices and other outpatient services
  - Community physicians doing same-day surgery in the O.R.
- Be proactive!
  - Measures keep expanding in all patient settings
  - The need to adjust for risk will also expand

Outpatient Risk and Adjustment

- Outpatient data are currently adjusted for risk using the Hierarchical Condition Categories (HCCs)
- Designed to predict the health spending for a specific patient population
- Risk actually equals the level of expected healthcare spending
- Both healthcare plans ***and*** healthcare facilities use these models
  - A collaborative effort!
- There are actually two HCC Models currently in use!

Outpatient Risk and Adjustment

- Each has unique characteristics to address the different patient populations for their intended use
  - CMS-HCCs for 65 and older and those with disabilities (similar to MS-DRGs)
  - HHS-HCCs intended for all ages (similar to APR-DRGs)
- Similar in both purpose and in structure
- The goal of each is to accurately predict the future costs for individual patients
- The CMS-HCC model is prospective
  - Data is collected in a ***base year*** to determine costs for the following year
    - Often referred to as the "prediction year"
- The HHS-HCC model, on the other hand, is concurrent
  - Uses the current year's health events to predict future expenditures

Outpatient Risk and Adjustment

- The premise behind both HCC models is to look at how demographics and diagnoses relate to expenditures
- The specific demographic and health data elements vary between the two
- But each uses the data to determine a risk adjustment factor (RAF)
- The RAF is a relative measure used to predict the expenditure level of a given patient

Risk Adjustment Factor

- The median, or the RAF established for the “average” patient is set at 1.0
- Healthier patients would have a below average RAF < 1.0
- Sicker patients would have a higher than average RAF > 1.0
- A RAF score can never be a negative number
- The RAF serves as a mechanism to differentiate the expected resource consumption of patients with varying health statuses

Risk Adjustment Factor

- CMS-HCCs focus on long-term chronic conditions
  - Diabetes
  - COPD
  - CHF
- CMS-HCCs actually exclude acute illnesses and injuries
- HHS-HCCs consider both chronic and acute conditions
  - Maternity care
  - Low birth weight
  - Organ transplants

Risk Adjustment Factor

- Each HCC has an associated value called the ***relative factor***
  - Similar to the relative weights assigned to MS-DRGs
- These relative factors contribute to the patient's RAF
- Each patient can have no, one or many HCCs impacting the RAF score
- The RAF score is calculated each calendar year
  - Encourages traditional managed care concepts:
    - Continuity of care
    - Disease management
    - Case management

Structure for the HCC Models

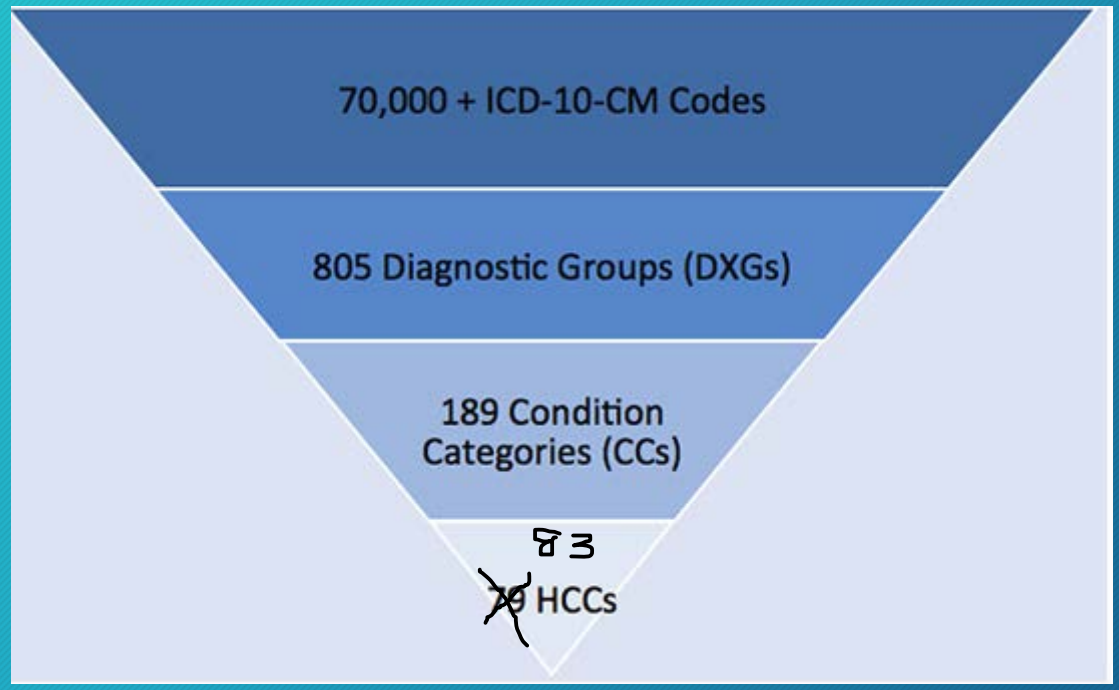
- Demographic data elements are straightforward –
  - Age
  - Gender
  - Other factors specific to the population
    - Institutional Status (CMS-HCCs)
    - Financial Status (HHS-HCCs)

- Diagnosis data elements are complex –
  - First organized by body systems or disease processes called **Diagnostic Groups**
  - Next the conditions in each Diagnostic Group are organized into **Condition Categories**

Structure for the HCC Models

- ICD-10-CM codes are ***ranked*** into these Condition Categories with similar cost patterns and hence the term ***hierarchical***
- The logic involved is a hierarchy based on cost
- Like a funnel or inverted triangle with all of the ICD-10-CM codes at the top and at the bottom are the final HCCs
- Of the more than 70,000 ICD-10-CM codes only around 9,500 actually map to one of the 79 CMS-HCCs (might have increased for 2019)
- More than 200 HHS-HCCs

CMS-HCC Model Structure



Four New CMS-HCCs for 2019

- HCC 56: Drug Abuse, Uncomplicated, Except Cannabis
- HCC 58: Reactive and Unspecified Diagnoses
- HCC 60: Personality Disorders
- HCC: Chronic Kidney Disease, Moderate (Stage 3)

- Bringing the total now to 83 in 2019

Side-By-Side Comparison of the Two

CMS-HCC	HHS-HCC
Used by CMS to pay Medicare Advantage plans for enrollees	Used by CMS to pay health insurers in Affordable Care Act marketplace
Base year (current year) diagnoses determine next year's rates	Uses current year diagnosis coding to set risk payments in current year
Developed for >65 year olds and disabled patients of all ages	Developed for all age patients
Pediatrics and obstetrics diagnosis codes are not assigned risk values	Includes categories for infants, children and adults, and includes obstetrical diagnoses
Does not include drug costs	Includes drug costs
Model used by many software programs, integrated into EMR systems.	Model less well known by medical practices
Rule making: proposal at the end of December, final rates in April	Payment to health insurers for caring for sicker patients in ACA.

Three Basic Steps

#1 Validation of medical record eligibility

- Patient identification in the record
- Provider is eligible
  - Medical Doctor (MD)
  - Nurse Practitioner (NP)
  - Physician Assistant (PA)

  } Non-eligible clinicians include registered nurses (RNs) and medical assistants (MAs)

- The record has been authenticated

Three Basic Steps

#2 Assignment of all appropriate ICD-10-CM codes

- Continuous review throughout the year to ensure all conditions have been considered and abstracted by the end of the year

#3 Submission of ICD-10-CM codes to CMS or HHS for reporting

- Sequencing matters!
- Work with EHR vendors, clearinghouses, IT and the health plans to ensure maximum reporting opportunities
- Include checking the claims when auditing!

Documentation Best Practices

- Always document to the highest degree of specificity
- Document all cause-and-effect relationships
- Link any complications or manifestations of a disease process
- Include all current diagnoses in the medical-decision making for every visit
- Only use “history of” when the condition no longer exists
- Must support not only the presence of a condition, but also the provider’s assessment or plan to manage that condition

Coding Best Practices

- Define internal policies for risk adjustment coding
- Always consistent with the *ICD-10-CM Official Guidelines for Coding and Reporting*
- In keeping with any advice from the American Hospital Association's *Coding Clinic for ICD-10-CM/PCS*
- If the patient receives treatment or care, chronic conditions should continue to be reported on an ongoing basis (i.e. every encounter)
- Any and all diagnoses receiving management or care during an encounter should be reported

Coding Best Practices

- Conditions no longer active should not be coded! (i.e. removed from Problem List)
- Report ***history of*** or ***status*** codes if relevant and impacting current treatment or care
- The entire medical record can be used to report diagnosis codes
- The HCC coding professionals should have an overview of the HCC/RAF methodology with a basic understanding
- Familiarity with clinical indicators (testing, medications, etc.)
- Familiarity with audit requirements for the HCCs

Coding Best Practices

- Coding both the etiology and the manifestation
  - Oftentimes both qualify as an HCC
- Excludes 1 Notes
  - Could code something that should not have been and results in an HCC
- Excludes 2 Notes
  - Could miss reporting another code that might be an HCC
- History of malignancy verses active cancer
  - Active cancers are often exclusions from PSIs and are HCCs or CCs for IPF-PPS
- Correct 7th character for injury and poisoning codes
  - For some, the initial encounter counts as an HCC
- Code specificity
  - That added layer of granularity just might make it an HCC

Coding Best Practices

Section III. Reporting Additional Diagnoses

GENERAL RULES FOR OTHER (ADDITIONAL) DIAGNOSES

For reporting purposes the definition for “other diagnoses” is interpreted as additional conditions that affect patient care in terms of requiring: clinical evaluation; or therapeutic treatment; or diagnostic procedures; or extended length of hospital stay; or increased nursing care and/or monitoring.

Coding Best Practices

The UHDDS item #11-b defines Other Diagnoses as --

"all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded."

Coding Best Practices

- Some organizations use the “MEAT” approach to assigning secondary diagnoses:

  - **M**onitoring
  - **E**valuation
  - **A**ssessment
  - **T**reatment

Coding Best Practices

- Others use “TAMPER™”:
  - **T**reatment
  - **A**ssessment
  - **M**onitor/Medicare
  - **P**lan
  - **E**valuate
  - Referral

Effective Management

- Data Analytics are crucial!
- Data Sources
  - Disease Registries
  - CMS Chronic Conditions Prevalence Data
  - The facility's claims data – imperative!
    - Ensure all diagnoses making their way to the claim
    - Failed medical necessity for certain tests or drugs
    - Anomalies
      - A diagnosis reported but without the expected testing and treatment being charged
      - Charges without the expected diagnoses

Effective Management

- CMS has a formal audit program to monitor health plan compliance with HCC reporting regulations
- The Risk Adjustment Data Validation (RADV)
  - Ensure health plans receive appropriate risk adjustment based on patient health status
  - Review documentation
  - Ensures reporting guidelines are followed
- The results of these audits should be analyzed and communicated up to leadership
  - Patterns of aberrant coding practice
  - Documentation insufficiencies

Effective Management

- Conduct a mock RADV
- Best time of year is the 3rd quarter
- Results can be used before the end of the calendar year
- And always remember to check those claims!!! ☺

Contact Information

Thank you!

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