Introduction to Commercial (Affordable Care Act) Risk Adjustment

Risk Adjustment 101

Commercial Risk Adjustment

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What is Risk Adjustment?

CMS HHS

- The Department of Health and Human Services' (HHS), Centers for Medicare & Medicaid Services (CMS) uses a **Hierarchical Condition Category (HCC) risk adjustment model to calculate risk scores for each member**. The model ranks diagnoses into categories that represent conditions with similar cost patterns.

Model

- The model is structured so insurers with sicker-than-average members receive compensation to help pay for the higher cost of care. This allows CMS to reimburse plans based on the actual costs of care for each individual beneficiary, rather than to apply an average across all members.
- CMS assesses payments or charges to insurers annually based on whether the cost of caring for their membership is above or below average.

Simplified Terms

- Risk adjustment is a methodology used by HHS/CMS used to compare the health risk of populations enrolled in health plans to determine appropriate reimbursement.
- It helps identify the need for disease management interventions, close quality care gaps, and ensure appropriate payment. It benefits patients, providers, and health plans.

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Benefits of Risk Adjustment

Improve Patient Safety and Satisfaction

Complete and Accurate Patient Health Profile

Prioritize Patient Needs and Necessary Resources

Focus on Continuous Quality and Efficiency Improvement

Risk Adjustment Population

Medicare Advantage (Part C)

CMS – HCC Risk Adjustment Model

Commercial: ACA Individual and

ACA Small Group

HHS – HCC Risk Adjustment Model (includes newborns, pediatrics, labor & delivery, etc.)

Federal Employee Plan

Mid & Large Employer Group Plans

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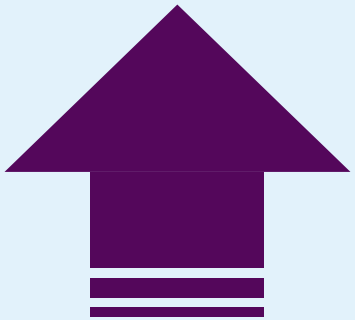
What a Risk Score Represents:



Higher risk scores represent patients with a greater than average burden of illness. These are generally tied to:

- Chronic conditions such as diabetes, rheumatoid arthritis, and HIV
- Older/higher risk population

Lower risk scores represent a healthier population, but ***may*** also falsely indicate a healthier population due to:

- Inadequate or incomplete chart documentation
- Incomplete or inaccurate diagnosis coding

- Approximately **80%** of **Medicare Advantage** patients have a chronic condition
- About **22%** of **ACA** patients have an HCC

Most common conditions prevalent in ACA population: diabetes, asthma/chronic obstructive pulmonary disease, major depression, and heart disease

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Breaking it down…

For instance, suppose a member is enrolled in an **ACA Individual Under 65 (IU65) silver plan.**

- A claim was submitted for a 42-year-old female. This claim may receive a risk score of 0.281, if no chronic conditions were reported.
- However, if the claim also reported the patient's diagnosis of chronic viral hepatitis C (HCC37.1), an additional risk of 0.490 would be credited.

SCENARIO 1 No Conditions Coded		SCENARIO 2 All Conditions Coded Appropriately	
42-year-old female in an IU65 Silver Plan	0.281	42-year-old female in an IU65 Silver Plan	0.281
Chronic viral hepatitis not coded		Chronic viral hepatitis C (HCC 37.1)	0.490
Risk Score	0.281	Risk Score	0.771
**Based on 2023 Wakely Simulations and only applicable for 2023 payment year.*			

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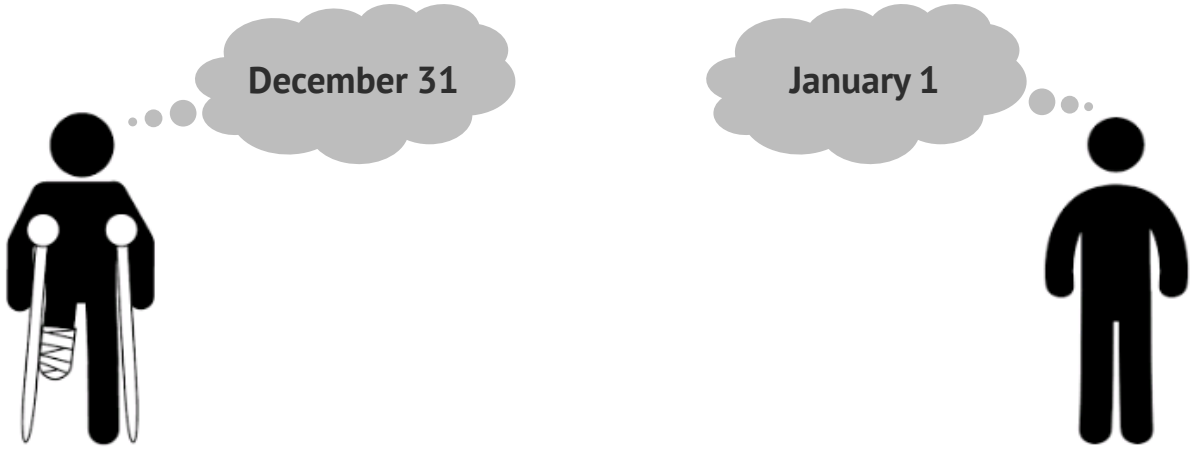
Additional Facts

- The diagnosis codes reported on claims determine a member's disease burden and risk score, so Risk Adjustment relies on physicians to perform accurate medical record documentation and coding practices to capture the complete risk profile of each individual patient.
- Chronic conditions must be captured and reported once per calendar year in a face-to-face encounter with a physician.
- 141 hierarchical condition categories (HCCs) for the Commercial Risk (ACA) Adjustment Model
- 11,326 + diagnosis codes fall in 141 HCCs for the Commercial (ACA) Risk Adjustment Model
- **For Commercial (ACA) Risk Adjustment, risk adjustment credit is only counted on paid claims.**

❖ Each year on January 1, the Risk Adjustment slate is wiped clean. All Medicare and ACA members are considered completely healthy until diagnosis codes are reported on claims.



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The Provider's Role

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The Provider's Role

Face-to-Face Visit

- Physician evaluates patients at least once a year.

Medical Record

- Physician documents the patient visit including:
  - ➢Reason for visit
  - ➢Physical exam
  - ➢Medication review & reconciliation
  - ➢Medical diagnosis and conclusions
  - ➢Treatment plan

Diagnosis Code

- Code to the greatest degree of specificity.
- Note that claim diagnosis codes and the medical record should mirror each other.
- Diagnosis codes within the medical record should include a written description.
- Documentation should support all ICD-10 codes.

Claim Submission

- Submit claim in accordance with Florida Blue processes.
- Submit the first 12 diagnosis codes on the primary claim.
- Then submit a supplement (second) zero-dollar or penny claim for encounters with more than 12 diagnosis codes with the additional codes.

Accurate, complete **Monitoring**, **Evaluation**, **Assessment, and Treatment** (**MEAT)** documentation of Chronic Condition diagnoses by clinicians is an essential component of the risk adjustment and HCC process. Most chronic conditions match to an HCC.

Most organizations use the MEAT criteria for their documentation practices. As well as ICD-10-CM diagnosis coding and HCC assignments.

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Medical Record Documentation

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Why accurate documentation and coding is important for Risk Adjustment

1. Improves medical record documentation
2. Places patients into appropriate risk category for expected resource utilization
3. Improves Quality (HEDIS and Stars)
4. Early intervention slows progression of disease
5. Ensures monitoring of complex conditions reducing the need for emergency care

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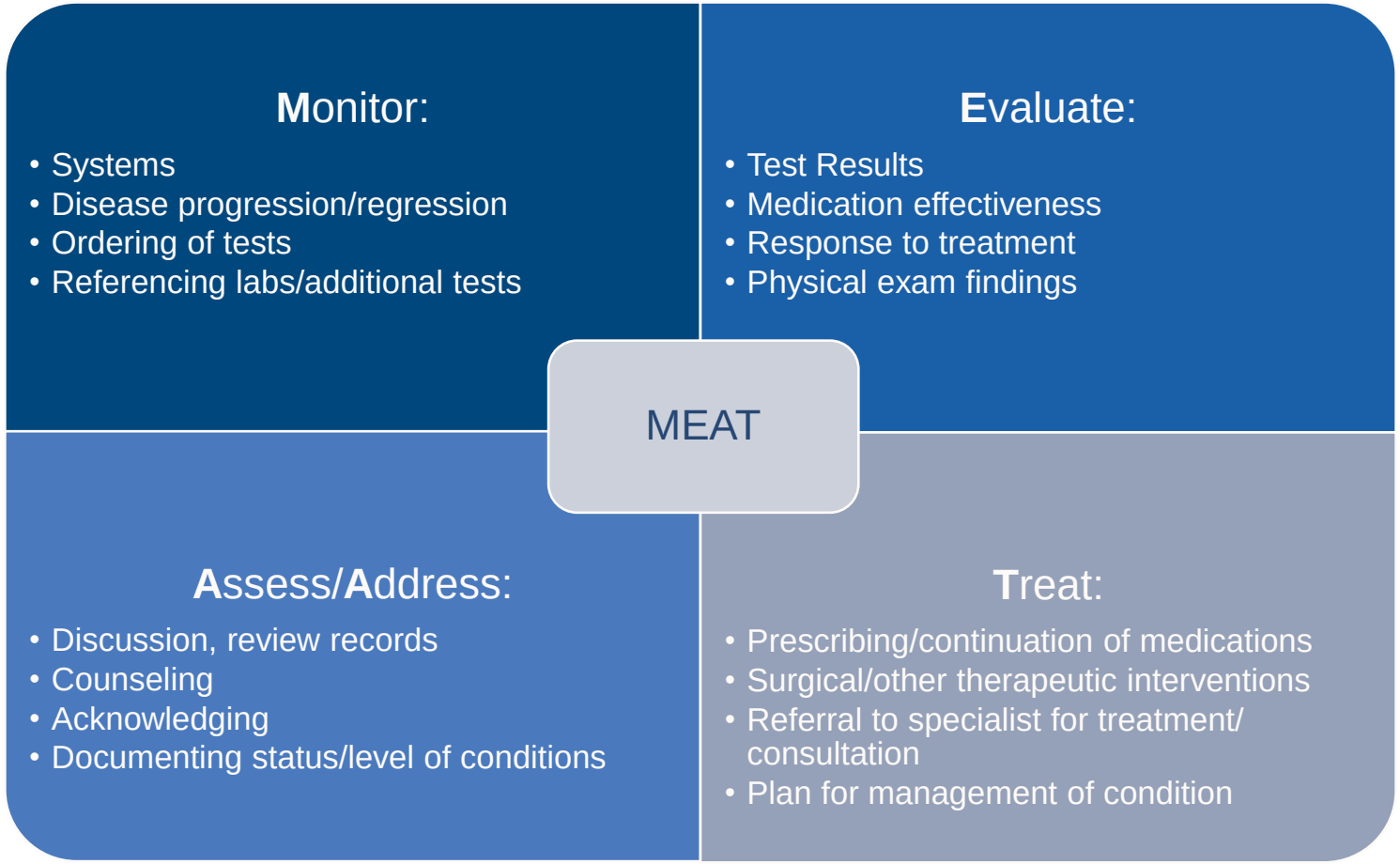
Best Practices - Documentation

- Most organizations use the MEAT criteria – **Monitoring**, **Evaluation**, **Assessment, and Treatment** for their documentation practices. As well as ICD-10-CM diagnosis coding and HCC assignments.
- Accurate, complete **MEAT** documentation of chronic condition diagnoses by clinicians is an essential component of the risk adjustment and HCC process. Most chronic conditions match to an HCC.
- To support an HCC, documentation must support the presence of the disease/ condition. Additionally, it must also include the clinical provider's assessment and/or plan for management of the disease/condition.



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Examples of MEAT

MEAT	Support	Disease Example	Documentation Examples
Monitor	• Symptoms • Disease progression/regression • Ordering of tests • Referencing labs/other tests	Chronic Heart Failure DJD, Hip Hyperlipidemia	Stable. Will continue same dose of Lasix and ACE inhibitor. Pain Controlled with current medication, Lipid profile ordered,
Evaluate	• Test results • Medication effectiveness • Response to treatment • Physical exam findings	Type 2 Diabetes Decubitus Ulcer	BS log and A1c results of 7.5% reviewed with the patient from lab work June 4, 2024. Relay wound measurement in exam.
Assess/ Address	• Discussion, review records • Counseling • Acknowledging • Documenting status/level of condition	Peripheral Neuropathy Ulcerative Colitis	Decreased sensation of BLE by monofilament test. Stable. Managed by Dr. Smith.
Treat	• Prescribing/continuation of medications • Surgical/other therapeutic interventions • Referral to specialist for treatment/consultation • Plan for management of condition	Tobacco Abuse GERD	Advised on risks; smoking cessation counseling. No complaints. Symptoms controlled on current medication.

Medical Record Documentation Helpful Tips

All chronic conditions must be documented yearly as diagnoses do not carry over each year.
Code condition as many times as patient receives care and treatment for the condition. Do not code for conditions previously treated and no longer exist.
If condition is being monitored and treated by a specialist, code condition and status. Example: Patient on Coumadin for atrial fibrillation. Followed by Dr. Hill.
Document and code status conditions at least once a year (i.e., transplant status, amputation status, dialysis status, chemotherapy status, artificial opening status/maintenance).
Do not code unconfirmed diagnoses such as probable, possible, suspected, and working diagnosis.
Be sure diagnosis codes billed are consistent with medical record documentation. Except you cannot just state I10 only with no description, you must document the word hypertension.

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Common Diagnosis Coding Errors

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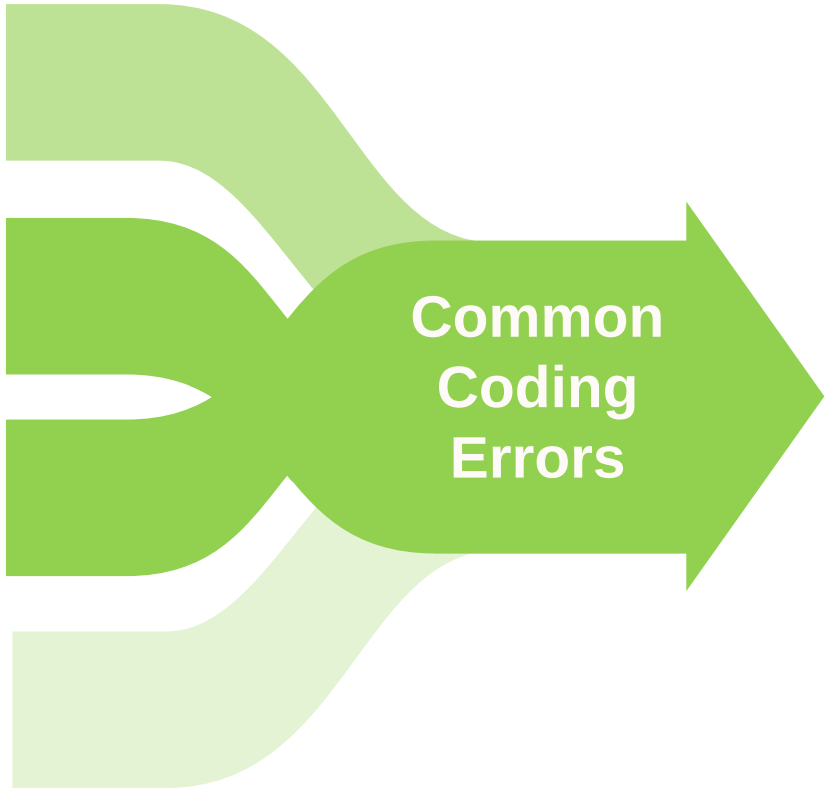

Common Coding Errors

Medical record does not contain a legible signature.
Electronic medical record (EMR) was unauthenticated (not electronically signed).
Coding a condition as current when it is “History Of”.
Highest degree of specificity was not assigned the most precise ICD-10 to fully explain the narrative description of the symptom or diagnosis in the medical chart.
Documentation does not indicate the diagnosis is being monitored, evaluated, assessed/addressed, or treated (MEAT).
Status of cancer is unclear. Treatment is not documented.
Chronic conditions, such as hepatitis or renal insufficiency, are not documented as chronic.
Lack of specificity (e.g., an unspecified arrhythmia is coded rather than the specific type of arrhythmia).
Chronic conditions or status codes are not documented in the medical record at least once per year.
A link or causal relationship is missing for a diabetic complication, or there is a failure to report a mandatory manifestation code.

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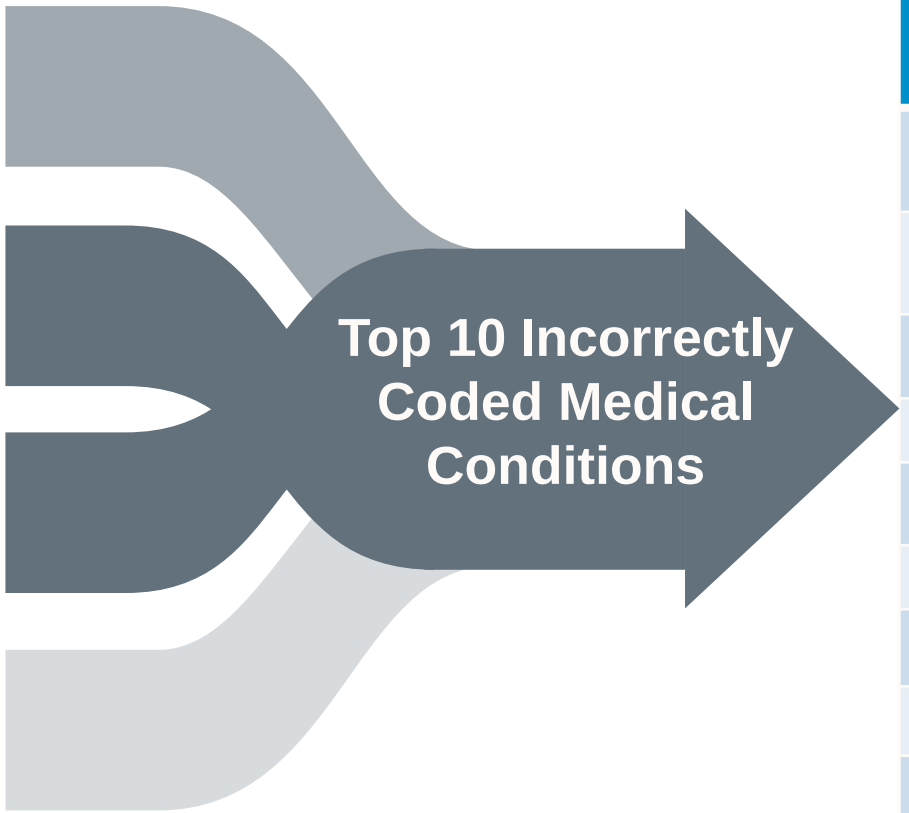

Top Ten Incorrectly Coded Medical Conditions Found in Florida Blue Provider Quality Audits

Diabetes Mellitus (with/without complications)
Asthma
Congestive Heart Failure
Respiratory
Autoimmune Disorders (RA, LUPUS, etc.)
HIV/AIDS
Cancer
Heart Arrhythmias
Major Depressive/Bipolar Disorder
Seizure Disorders and Convulsions

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Commercial Risk Adjustment Case Example

Date of Service/Visit: 01/01/2024

Mr. Johns presents today with a known history of HIV dementia and urinary incontinence. According to his brother, Mr. Johns had a nap around 4 p.m. and stated he witnessed the patient shaking shortly after he woke up. He developed loss of consciousness approximately lasting three minutes. There is no previous history of seizure documented. He denies any prior episodes like this. The patient was somewhat confused but is now trying to improve back to baseline. Mr. Johns also has a previous history of a CVA and is dependent on his brother for routine activities of daily living. He uses a motorized wheelchair and persists on smoking one pack of cigarettes a day.

Past Medical History: HIV diagnosed 20 years ago, HIV dementia, urinary incontinence, NIDDM, PVD, hypertension, and CVA w/ hemiparesis (right-sided)

Medication: Stribild, Losartan, Detrol, Metoprolol, Aricept, Actos, Cilostazol

Surgical History: Cervical fusion, L BKA

Allergies: NKDA

Social History: Currently smokes one pack per day of cigarettes

Review of Systems: A detailed 14-point review of systems ascertained but is negative other than described above.

Vital Signs: BP-180/90, HR-80, R-18, Temp-98.6°

Physical Examination: There is no aphasia. There is paucity of verbal output. He blinks to visual threat bilaterally. Facial sensation intact. Muscle facial expression intact. Hearing intact. Palate and uvula are midline and elevated symmetrically. Tongue is strong without weakness or wasting. Diminished pulse in RLE. Motor, strength is 2/5 in the RU & RLE and 5/5 in the LUE. L BKA. Right side hemiparesis 2/2 CVA. He does not ambulate at this time.

Assessment

1. R/o seizure d/o
2. HIV dementia, mild - continue Stribild and Aricept
3. HTN - continue Losartan and Metoprolol
4. Urinary incontinence - continue Detrol

Plan:

At this time, we will order carotid Doppler studies and check orthostatic vitals. For now, I will wait before starting him on any anticonvulsant unless his EEG is abnormal, or his imaging studies show evidence of underlying involvement. Follow up with endo for DM and the cardiologist for PVD. Continue with Cilostazol.

Electronically Signed by: John K. Smith, M.D.

Commercial Risk Adjustment Case Example (continued)

Typically Submitted ICD-10-CM Codes for the Office Visit		
ICD-10-CM Code	**Condition**	**HCC**
B20	Human Immunodeficiency Virus (HIV)	HCC 1
I10	Hypertension	Does not risk adjust
R32	Urinary Incontinence	Does not risk adjust

Opportunities for Additional Risk Adjustment Code Reporting		
ICD-10-CM Code	**Condition**	**HCC**
F02.A0	Dementia, mild, in other diseases classified elsewhere	Does not risk adjust
E11.51	Diabetes with peripheral vascular disease	HCC 20
I69.351	CVA with right-sided hemiparesis	HCC 150
Z89.512	Left below the knee amputation (L BKA)	HCC 254
F17.210	Smoker, cigarettes	Does not risk adjust
Z99.3	Dependence on wheelchair	Does not risk adjust
Z79.02	Current use of antithrombotic/antiplatelets (Cilostazol)	Does not risk adjust

Coding Tips for Acute Stroke

Coding acute strokes accurately requires the documentation to note the following:

1. Acute Ischemic Stroke (**ICD-10 code I63.*) should not be coded from an outpatient setting** because confirmation of the diagnosis should be determined by diagnostics studies, such as non-contrast brain CT or brain MRI, which would be ordered in an emergency room and/or inpatient setting.

2. ICD-10 Code Category I63.* generally requires causation and location of the stroke.
   a. Non-specific and should be avoided during an inpatient setting. **ICD-10 codes I63.8 and I63.9 should not be used in an outpatient setting** where site and cause should be determined by diagnostic testing.

3. Unconfirmed Stoke Diagnoses in outpatient setting: Do not code diagnoses documented as probably, suspected, likely, questionable, possible, still to be ruled out, or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reasons for the visit.

4. History of Stroke (ICD-10 code Z86.73)
   a. The patient is seen in the outpatient setting after a confirmed diagnosis of a stroke, currently not experiencing CVA and shows no residual deficits.
   b. A diagnosis of a transient ischemic attack (TIA) was made and has been resolved.

5. Code Sequela of cerebrovascular disease/stroke (ICD-10 code I69*) anytime post diagnosis of any condition classifiable to ICD-10 codes I60 – I67.*
   a. Providers must link the deficit with the stroke to be able to comply with the sequela code.
   b. Use codes from category I69 to specify the residual condition and the affected side of the patient (dominate or non-dominate).

6. Transient ischemic attack (TIA)
   a. When a TIA is diagnosed, a separate code is used (G45.9). This can be referred to as a “mini stroke” but should be considered separate from coding for a cerebral infarct.

* Notates ICD-10 code has an extension such as 163.001. etc.

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Supplemental Claims Process

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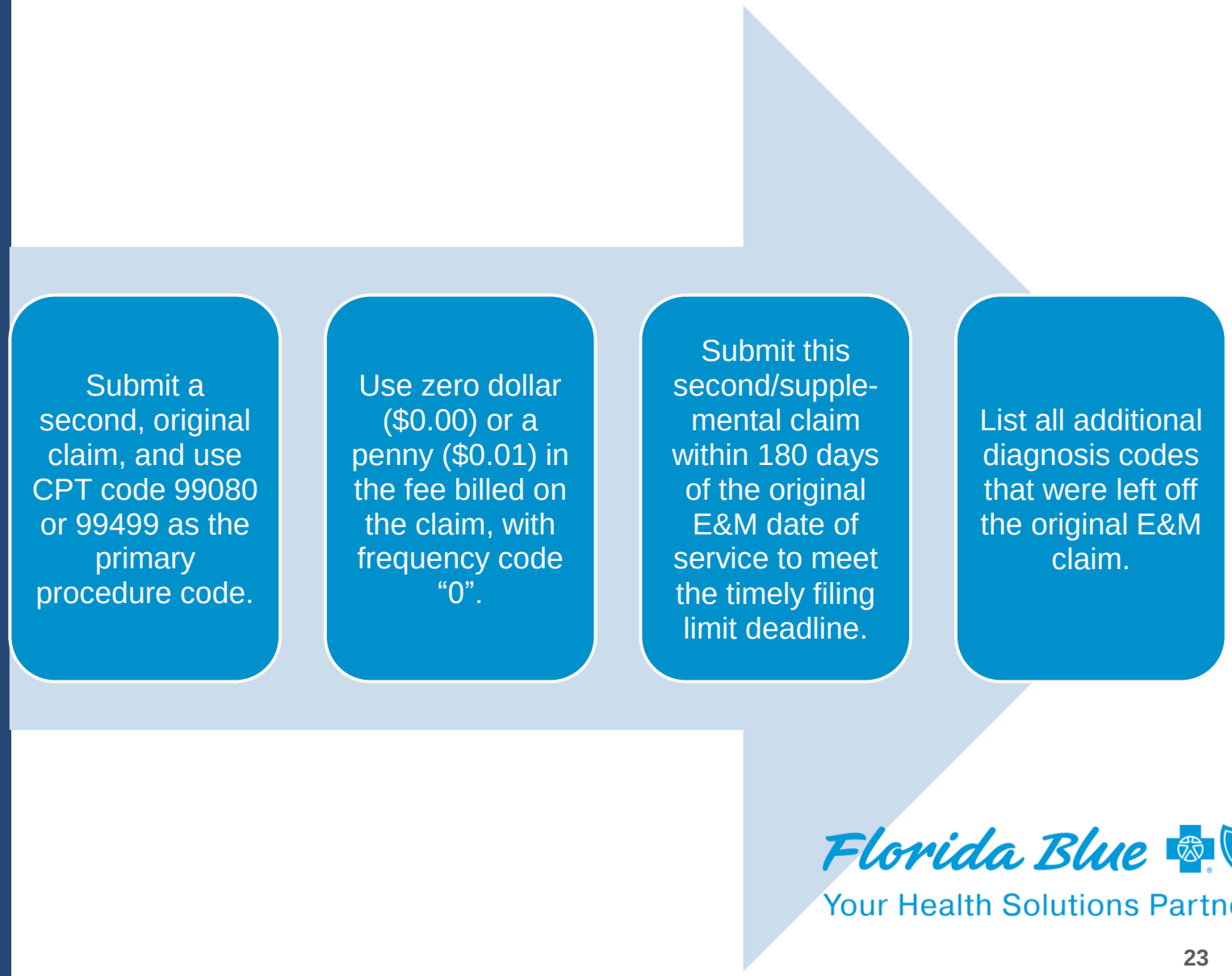
Supplemental (Second) Claims Process

- Medical claims have a maximum diagnosis count per submission.
- Professional/outpatient claims are capped at 12 diagnosis codes.
- Institutional/inpatient claims are capped at 24 diagnosis codes.

When a patient has more than the capped number of diagnosis codes referenced above, the provider must submit a supplemental (second) claim to report the additional diagnosis codes.



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How Can Florida Blue Help?

Current Training Offered:

- Top Conditions Series:
  - Asthma
  - Autoimmune disease
  - Cancer
  - Chronic heart failure (CHF)
  - Chronic obstructive pulmonary disease (COPD)
  - Diabetes mellitus
  - Heart arrhythmia
  - Human immunodeficiency virus (HIV)
  - Major depression & bipolar disorders
  - Seizure disorders
- Supplemental Claims Submission
- ProviderVista Provider Portal

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Florida Blue's Commercial Risk Adjustment Provider Educators are available for additional training, education, and support.

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Thank You!

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