PRIVIA HEALTH

Introduction to Risk Adjustment: Medicare Advantage Value Based Care

Agenda

At the end of this session participants will have a better understanding of:

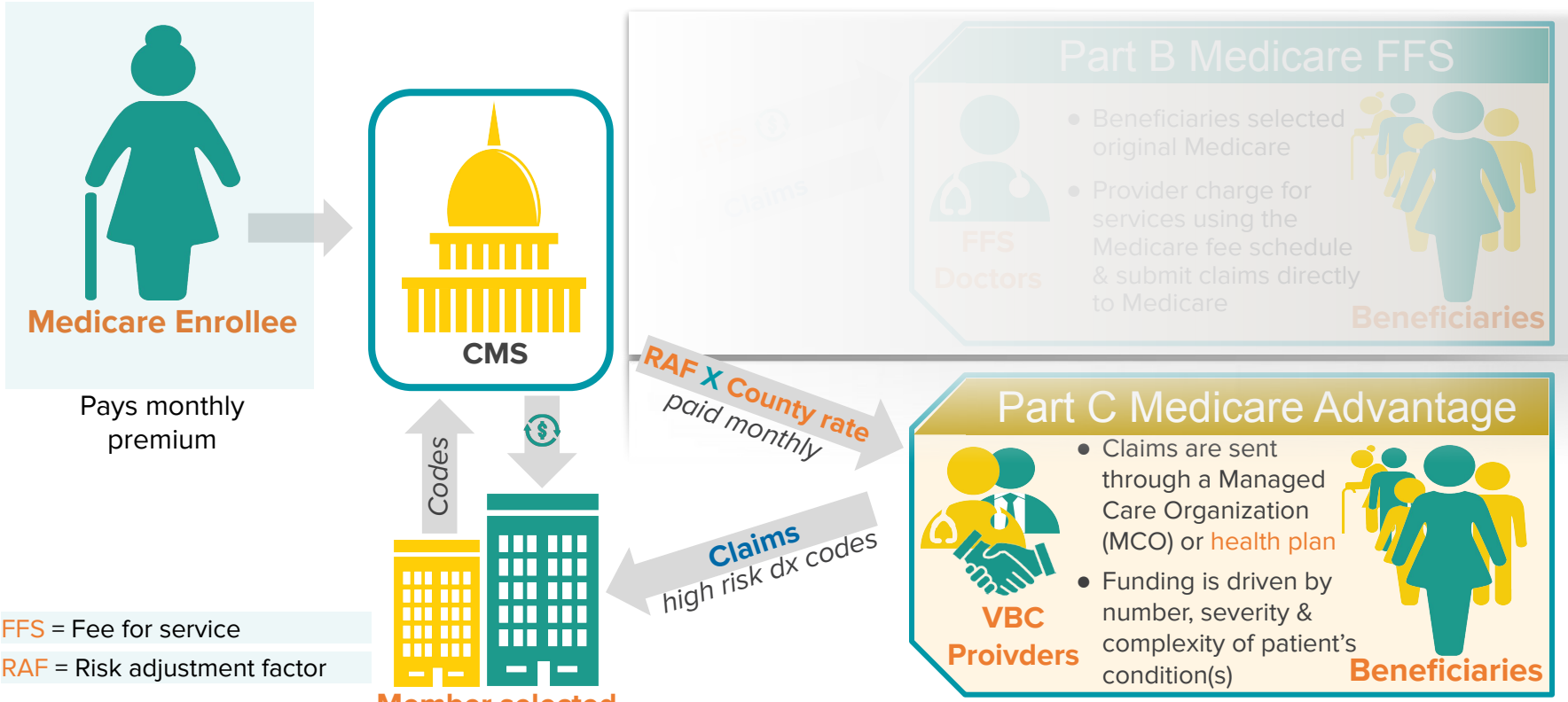
Medicare Advantage risk adjustment model and process

- Original Medicare vs. Medicare Advantage
- Funding for value-based care programs
- Discuss risk adjustment factor calculation
- Define the MEAT acronym for documentation
- Discuss benefits to correct diagnosis Coding
- Risk Adjustment process review and documentation tips

Diagnosis codes that are bolded in **black** represent fully reportable codes that risk-adjust in the CMS-HCC risk adjustment model

Original Medicare (OM) vs. Medicare Advantage (MA)

Enrollees are offered options



FFS = Fee for service

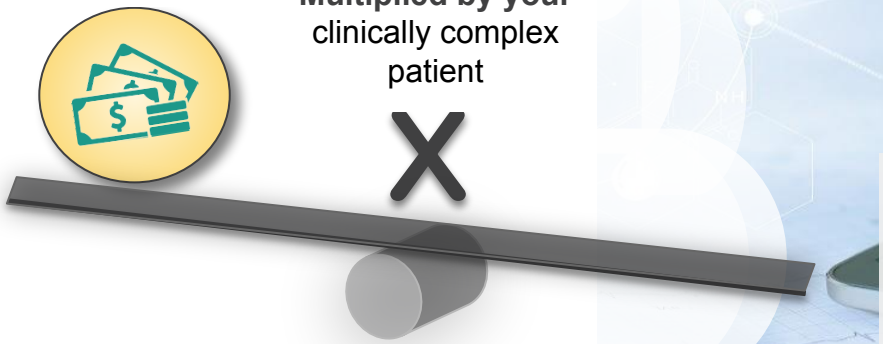
RAF = Risk adjustment factor

The Funding for Value Based Care (VBC) Programs

- **Based on** each patient's overall illness burden, which is directly proportional to diagnosis coding (accuracy and specificity)

Plan base PMPM payment

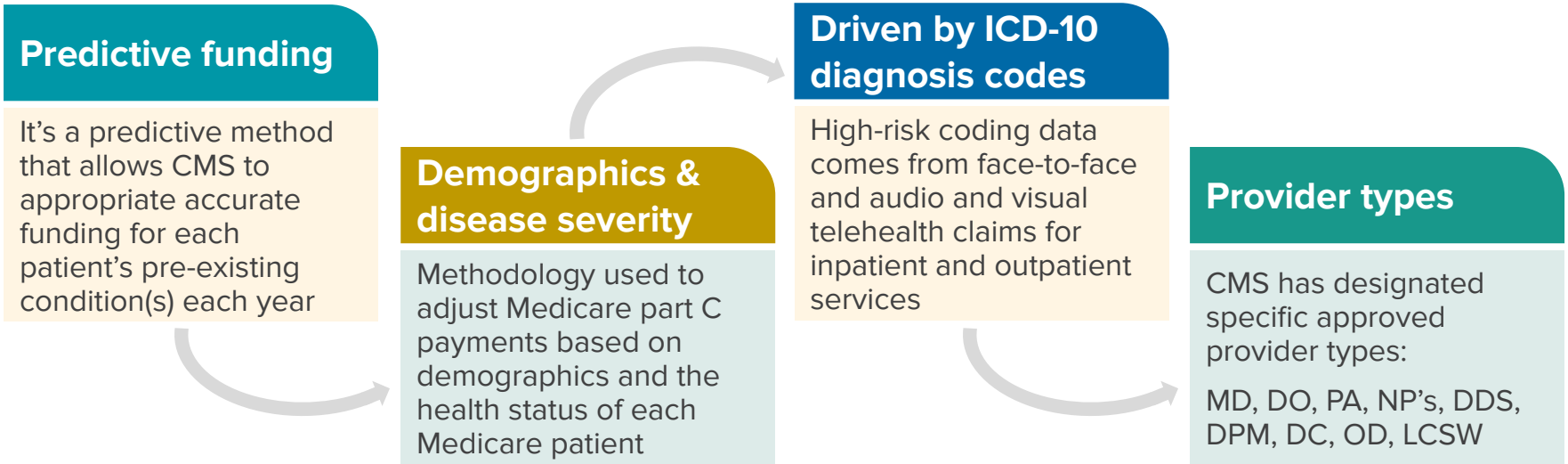
Multiplied by your clinically complex patient



- **Validation:** Based on documented assessment and/or treatment of complex needs with appropriate diagnosis codes
- **Equates to:** More equitable funding to support high-risk medical resource utilization.

What is Risk Adjustment (RA)

- Funding is determined based on severity and specificity of high risk diagnoses
- Pre-existing Conditions must be assessed or addressed year-over-year



The Medicare Advantage Risk Adjustment Model

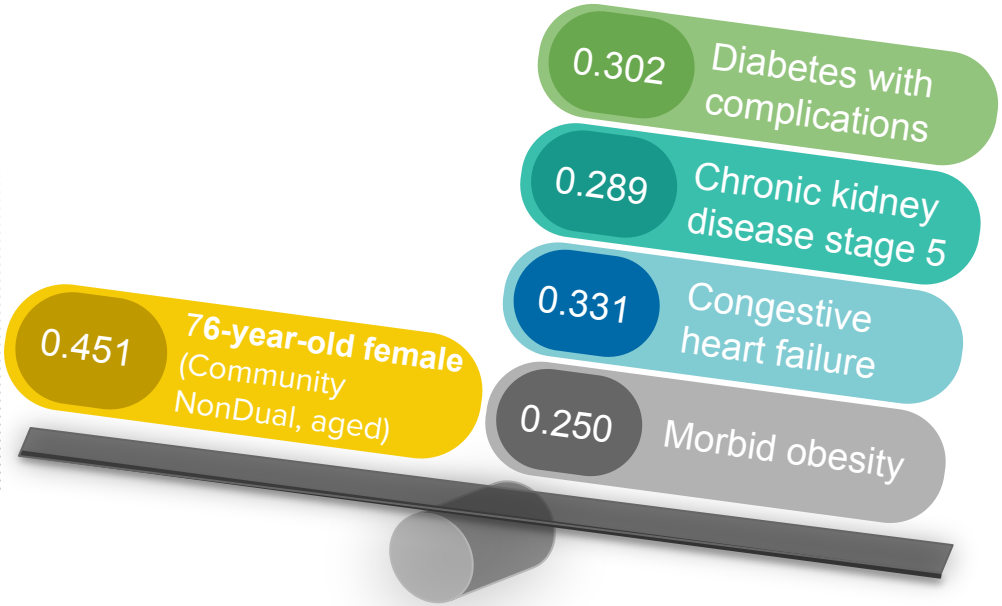
- It's additive by adding all the qualifying diagnosis submitted to CMS in throughout the calendar year starting on Jan 1st
- It's predictive in that codes reported this year determine funding for the following year, and sets cost targets for the patient population
- Has 86 Hierarchical condition categories (HCCs)
- Has over 9,500 diagnosis codes that fall into the 86 HCCs
- CMS resets all patient RAF scores on Jan 1 of each year

Risk Adjustment RAF Example

Patient status

Demographics (age, sex)

High-risk Conditions



Impact of Accurate vs. Inaccurate RAF Coding

(Represents Community, NonDual Aged Eligibility)

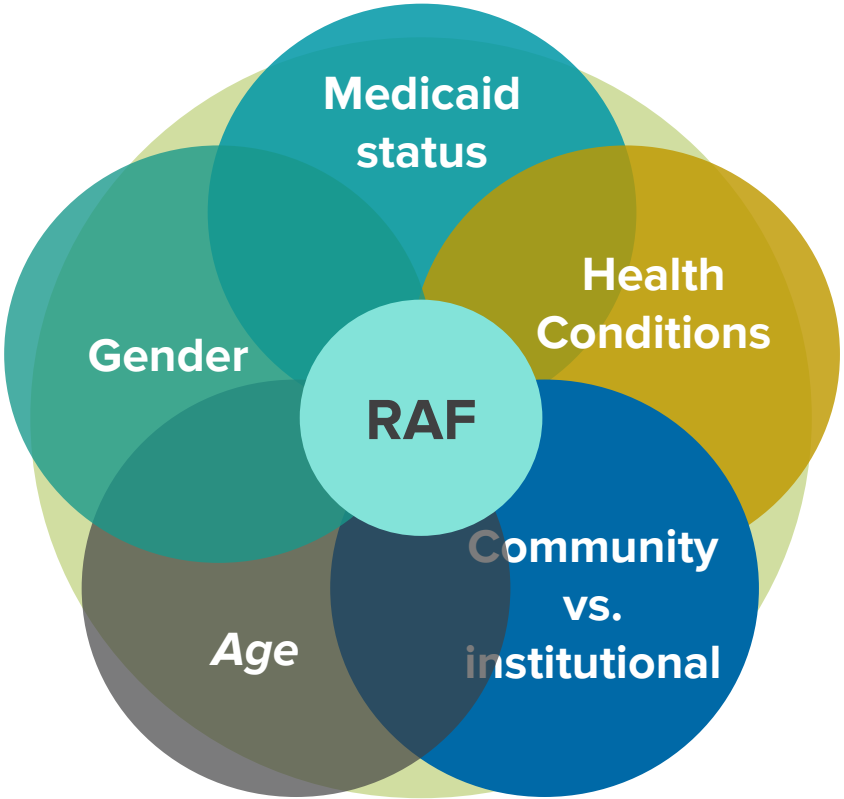
No conditions documented & coded (No encounters or lack of documentation and coding)	
76-year-old female	**0.451**
DM	—
CKD	—
CHF	—
Morbid obesity	—
Total RAF	**0.451**

Some conditions documented & coded (Encounters not assessed to the highest level of specificity)	
76-year-old female	**0.451**
DM w/o complications (HCC 19)	**0.105**
CKD unspecified (no HCC)	—
CHF	—
Morbid obesity	—
Total RAF	**0.556**

All conditions documented & coded (Encounters are assessed to the highest level of specificity)	
76-year-old female	**0.451**
DM w/ complication (HCC 18)	**0.302**
CKD stage 5 (HCC 136)	**0.289**
CHF (HCC 85)	**0.331**
Morbid obesity (HCC 22)	**0.250**
★ 4 condition payment (HCCs)	**0.006**
★ Disease interaction (CHF+DM)	**0.121**
★ Disease interaction (CHF+Renal)	**0.156**
Total RAF	**1.906**

Risk Adjustment Factor (RAF)

Includes multiple parameters



Accurate & specific diagnosis HCC code capture

Accurate funding

Polling Question

Value-based care (VBC) programs are utilized to classify high risk patients to forecast anticipated health costs.

Which of the following is also correct about VBC?

A. Adjusts payments each calendar year based on diagnosis codes submitted to the patients participating health plan

B. Helps place sicker patient populations into an appropriate risk category based on higher medical needs and expected resource utilization

✓ C. Both A and B apply

What is a Risk Adjustment Factor (RAF) Score?

Demographics

- Age
- Gender
- SNF Status
- Community enrollment
  - Nondual aged
  - Nondual disabled
  - Full benefit dual aged
  - Full benefit dual disabled
  - Partial benefit dual aged
  - Partial benefit dual disabled
  - Institutional factor

Risk Adjustment Factor

=

Demographics

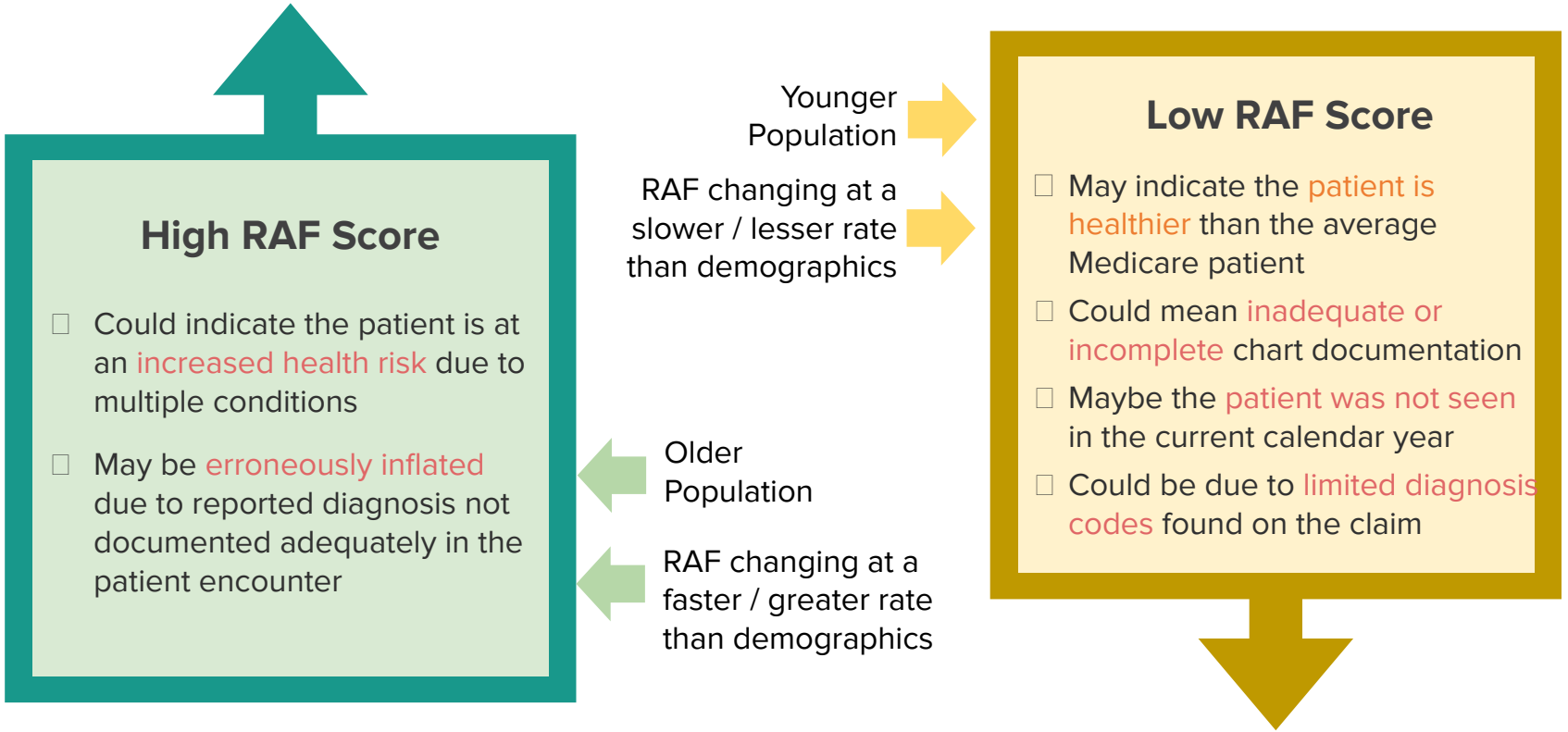
+

Condition HCCs

HCC RAF diagnoses

- High risk diagnoses that map to an HCC and coded with supporting documentation are submitted through claims.
- RAF values are assigned to each HCC to generate more funding for expected medical resource utilization
- Improving coding intensity can impact accurate funding

Interpreting the Risk Adjustment Factor (RAF)



Polling Question

Value-based care programs utilize high risk diagnosis codes that carry a Risk Adjustment Factor (RAF) value

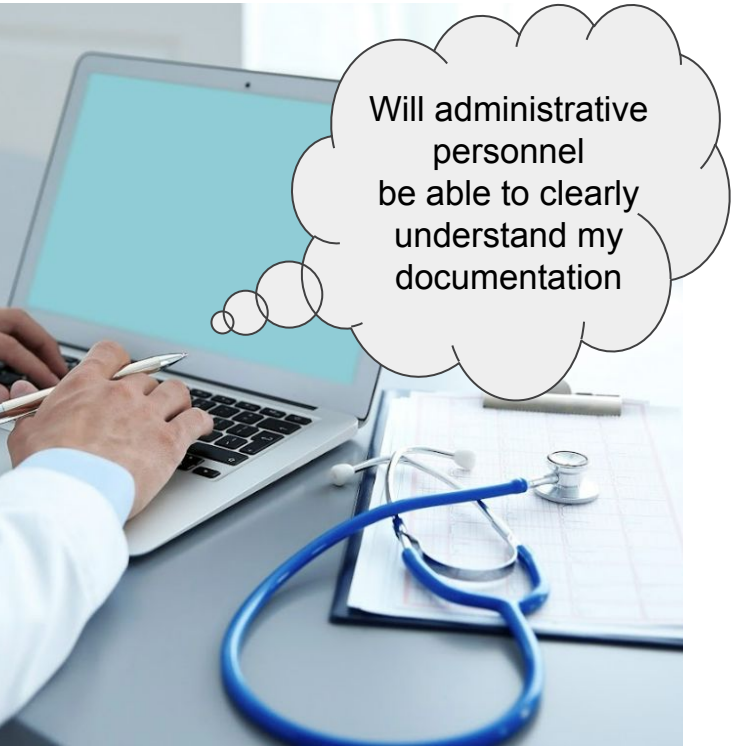
Which of the following is also correct regarding RAF?

A. HCC RAF scoring is progress note dependent, which is calibrated based on high-risk condition diagnosis codes submitted through claims data and supported with clinical documentation

B. HCC RAF score is added to the patient demographic RAF score for a cumulative total score

C. Both A and B apply

Clinical Documentation Improvement Efforts



ICD-10-CM guidelines for outpatient services

- Assign ICD-10-CM codes for the reason of the encounter
  - Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care, treatment, or management.
- Document and code all chronic conditions problem pertinent for each encounter
  - Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).

Risk Adjustment Documentation Needs "MEAT"

Monitoring

- Symptoms
- Disease progression/regression
- Ordering of tests
- Referencing labs/other tests

"Uncontrolled DM2, A1C is 9.2, repeat in 1 month"

Evaluating

- Test results
- Medication effectiveness
- Response to treatment
- Physical exam findings

"Abnormal heart rhythm EKG ordered, follow up in 3 weeks"

Assessing

- Discussion and/or counseling
- Review conditions (status, severity)
- Referrals for specialists if relevant

Screening bloodwork shows A1C of 8, patient is new onset DM2"

Treating

- Stop or start medications
- Diagnostic and/or therapeutic plan
- Patient education and/or follow up schedule

"COPD, start DuoNeb & Symbicort"

Non-specific documentation

A **74-year-old female** presents today for routine follow up of diabetes [illegible]
History of **vascular disease** and **coronary artery disease**

Vital Signs: BP 135/80; Ht 5'10"; Wt 245 lbs; **BMI: 36.13**; HR 56/min; RR: 16/min; T: 98.1F; O2Sat: 97%

History/Exam: states 4-5 days ago began to develop an **ulcer** on left [illegible]
0.5 x 0.2 cm lesion with yellow fibrinous tissue at base with red margins. Pt using OTC Neosporin. Mild infection with localized cellulitis, Rx: cephalexin 500[illegible]

Assessment/Plan:

E11.65 Hyperglycemia- diabetes poorly controlled – A1C 8.3% [illegible]
trying to eat a well balanced diet.

L97.929 Non-pressure chronic ulcer, unspecified art of left lo[illegible]y

Unspecified with vague description

BMI not linked to a condition

Ulcer severity & complexity not documented

Not all problem pertinent conditions assessed or addressed

Specific documentation with M.E.A.T.

A **74-year-old female** presents today for routine follow up of
History of (**I73.9**) **peripheral vascular disease** and (I25.10) **native coronary artery disease**

Vital Signs: BP 135/80; Ht 5'10"; Wt 245 lbs; (Z68.36) **BMI: 36.13**;
T: 98.1F; O2Sat: 97%

History/Exam: states 4-5 days ago began to develop **a diabetic ulcer stage II** on left lower extremity. 1 x 0.5 x 0.2 cm lesion with yellow fibrinous tissue at bas red margins. Pt using OTC Neosporin. Mild infection with localized cellulitis, R

Assessment/Plan:

E11.65 Hyperglycemia- diabetes poorly c A1C 8.3%.

E11.622 Type 2 diabetes mellitus **with other skin ulcer**

L97.921 Non-pressure chronic ulcer, unspecified part of left lov

E66.01 Morbid obesity– advised patient to modify excessive calorie intake.

Conditions are specified

BMI is linked to severe obesity condition

Ulcer severity & comorbidity is documented

Problem pertinent conditions assessed or addressed

Benefits to Correct ICD-10-CM Coding

Improves resource utilization

- Allows the payers to obtain the correct funding that aligns with the patients disease burden

Reduces need for prior authorizations

- Preauthorization of medical services, tests, supplies, and medications may be easier and faster to obtain

Validates Evaluation & Management code selection

- 2 or more stable chronic conditions with Rx management qualify for moderate level complexity of problems addressed

Improve quality of care

- Helps reduce complex health conditions, which may prevent conditions from deteriorating to the point of needing emergency care.

Polling Question

If a patient presents with an acute complaint, it is important to include all problem pertinent diagnoses in the assessment & plan

Which is correct?

A. Additional risk weight can be added to the total RAF for the patient based on number of conditions the patient has

B. Additional CMS-HCC risk adjusted conditions can be captured

C. Both A and B apply

CMS Risk Adjustment

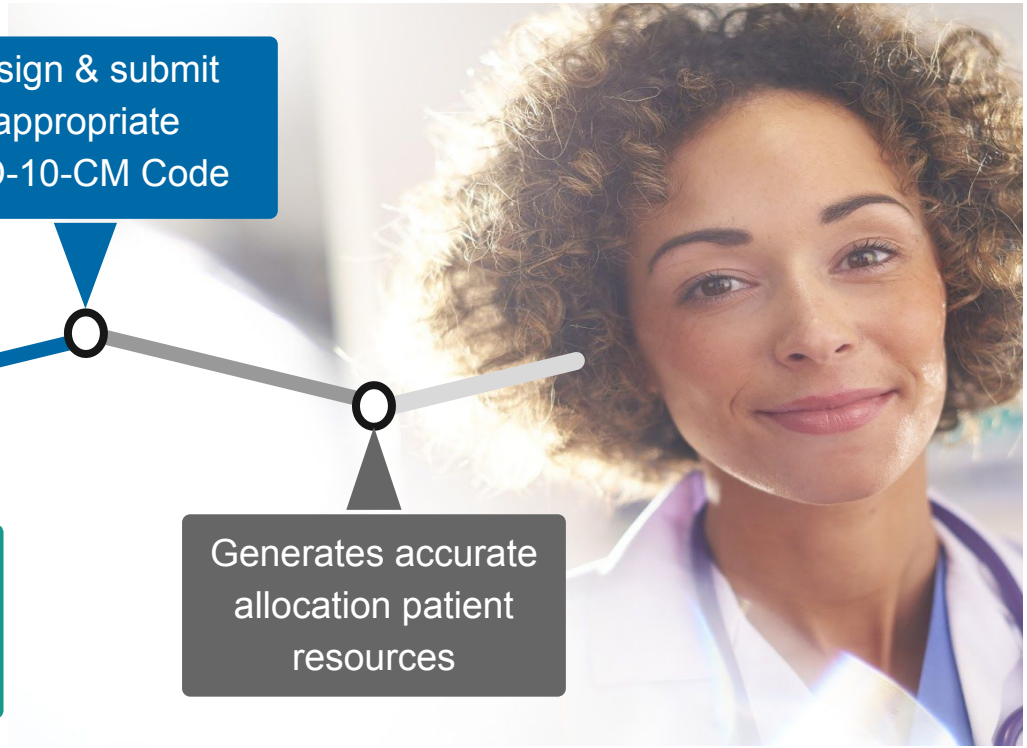
Process Review

In person or telehealth visit (audio-visual)

Provider must document specificity of conditions

Assign & submit appropriate ICD-10-CM Code

Generates accurate allocation patient resources



Guidelines for Risk Adjustment Documentation & Coding

- **Risk adjusted codes** - are acceptable only from face-to-face or audio-visual telehealth visits

- **Document cognitive work** - to support diagnoses, which cannot be reported directly from diagnostic tests results without professional interpretation, or a medication lists without an assessment.

- **Be complete** - code all documented coexisting conditions affecting patient care

- **Be concise** - include a reason for the encounter or telehealth visit

- **Be logical** - with documentation supporting assessment and or active treatment, evaluation and/or management with a clinical rationale

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Thank you for your participation

For more information on coding and documentation you can:

- **Visit Privia University for risk adjustment E-learning videos**

  or

- **Reach out to:**
  national-ra-team@priviahealth.com
  Or the Population Health team