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WHITE PAPER

The APM's Guide to Risk Adjustment Success

This guide provides ACOs with an introduction to risk adjustment for Medicare Alternative Payment Models (APMs), including an overview of the CMS HCC model and key factors/KPIs for risk adjustment success.

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How to Use This Guide

This guide is designed to be a foundational reference for ACOs for Medicare risk adjustment within CMS APM. It provides an introduction to risk adjustment for APMs, an overview of the CMS HCC model used in APMs, key factors for risk adjustment success, and evaluation criteria to help APM risk adjustment programs improve over time.

Each of APM entity's financial reimbursement is tied to performance against quality, cost, and experience of care based on the risk burden of its eligible Medicare population. CMS continues to authorize Alternative Payment Models (APMs) to increase risk-sharing payment with providers that include: Medicare Shared Savings Programs (MSSP), Next Generation ACOs (NGACO), Direct Contracting Entity (DCE), and others.

While many provider groups have experience with performance-based contracts, CMS's risk adjustment process may be less familiar. However, in order to protect benchmark performance and thrive under the different organizations, risk adjustment expertise must be developed.

An Introduction to Risk Adjustment for APMs

Risk adjustment (RA) is a method used by CMS and HHS to adjust healthcare payments to reflect the demographics and ongoing needs of a patient population. The goal is to ensure that organizations who serve needier patients receive additional funds to cover their higher cost of care.

Each patient covered under government programs such as Medicare, Medicare Advantage, and the Affordable Care Act receives a risk score called a **Risk Adjustment Factor (RAF)**. This score is factored into the benchmark payments for Medicare and Medicare Advantage organizations, and is based on a patient's eligibility status, demographic factors,

Risk Adjustment Factor Calculation Example

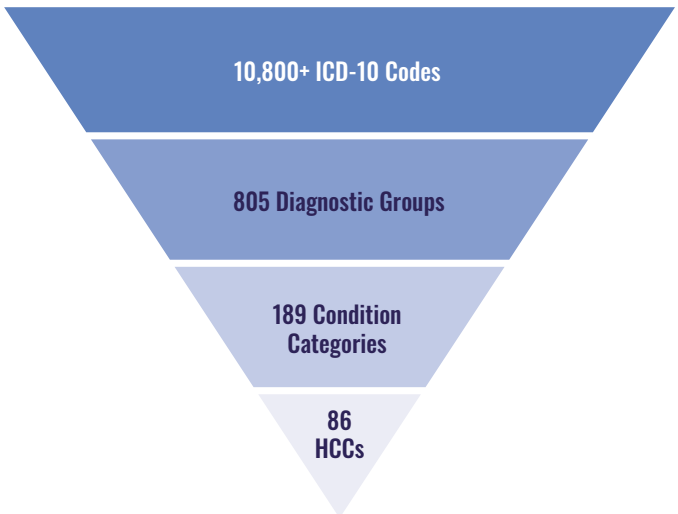
Condition	ICD-10 Code	CMS Risk Score	Demographic Risk Score	Total RAF Score
Diabetes Mellitus w/ Renal Manifestations	250.40	0.508		
UTI	599.0	0		
Diabetic Nephropathy	583.81	0 (Trumped by CKD Stage 3)		
CKD Stage 3	585.3	0.368		
Mild Degree Malnutrition	263.1	0.856		
Old MI	412.0	0.244		
BKA Status	V49.75	0.678		
Total		**3.050**	**0.44**	**3.094**

AN INTRODUCTION TO RISK ADJUSTMENT FOR APMs:

Alternative Payment Models (APMs)

APMs for ACOs and DCEs use the CMS Hierarchical Condition Category (HCC)[1] risk adjustment model to calculate RAF value for a covered population. There are 86 HCCs for Medicare and Medicare Advantage programs, which are comprised of ICD codes. ICDs are mapped into **diagnostic groups** that represent a specific medical condition. Diagnostic groups are then rolled up into **condition categories** that describe a set of related diseases. **Hierarchies** are used for related condition categories to ensure only the most severe manifestation of a disease is coded within a category. Each HCC has an associated value that is summed up in a patient's overall RAF score.

FIGURE 1
Hierarchy of codes used in the CMS HCC risk adjustment model.



Most recently, CMS has limited the risk-adjustment portion of the benchmark increase to 3% for both MSSP and DCE with Claim Based Alignment, but there is no limit on the downside adjustment.

Organizations need to continue to manage their risk adjustment bench-mark and use analytic insights to support activities that contribute to their overall member risk management strategy, including annual wellness visit (AWV) campaigns, provider education programs, and care management.

Unlike the Medicare Advantage risk adjustment program, which allows for supplemental code submissions, Medicare APMs must submit all supported condition codes to CMS via medical and pharmacy claims within one year of the encounter date of service. CMS uses these condition codes to risk-adjust the covered patient population[2] at the end of each performance year. Using this updated population risk, Medicare rebases each ACO's historical benchmark to capture changes between the benchmark years and the performance year. This updated benchmark is then compared to the performance year expenditures to deter-mine shared savings or losses.

Source:

1 https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors

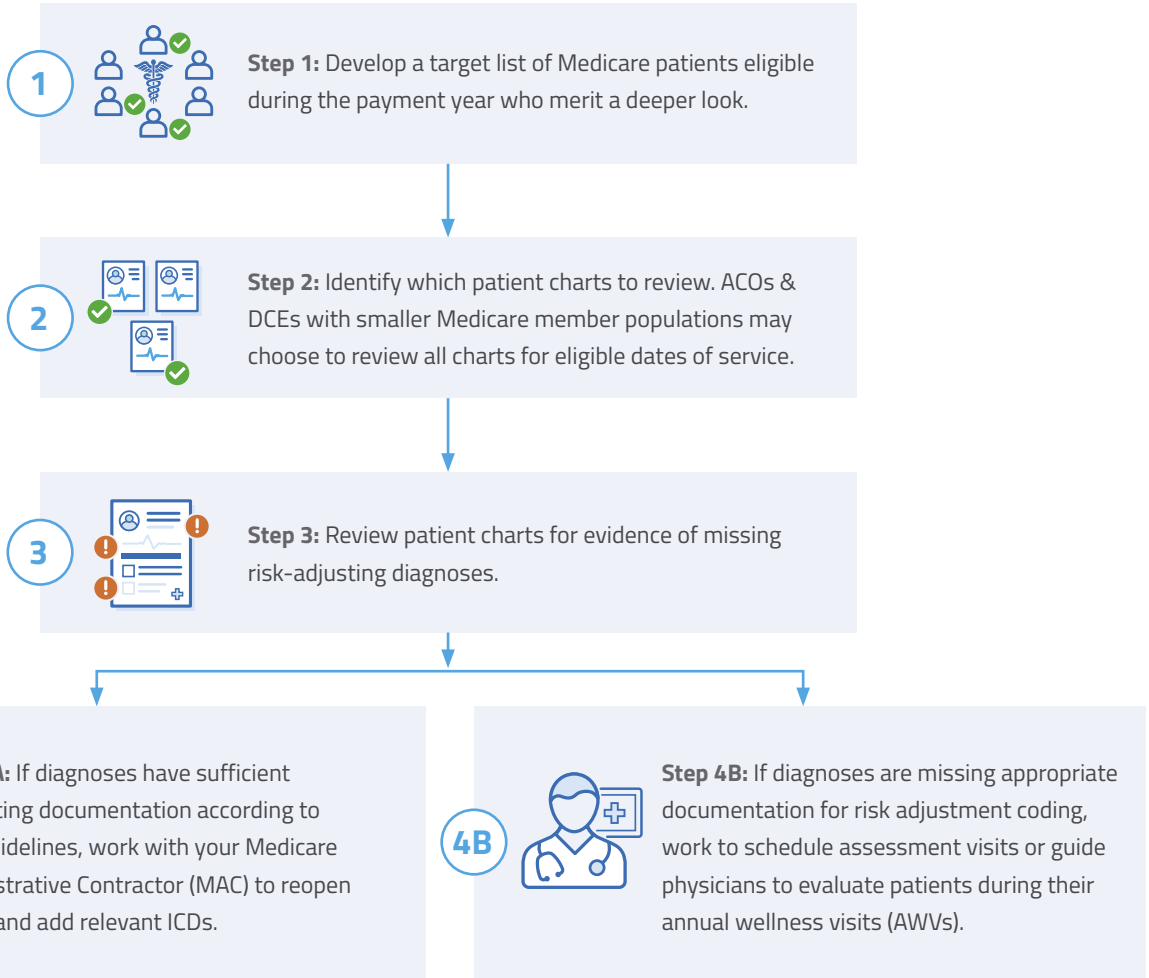
2 https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/Shared-Savings-Losses-Assignment-Spec-V7.pdf

AN INTRODUCTION TO RISK ADJUSTMENT FOR APMs:

Risk Adjustment Coding Process

Risk adjustment coding is the process of reviewing clinical documents for evidence of supported risk-adjusting diagnoses that describe the patient's health needs. In most cases, HCC codes are additive for each patient, so the more codes found, the higher the patient's risk score.

All diagnosis codes for risk-adjusting conditions must be captured on Medicare encounter claims. Here's how the coding process works:



Running a Successful Risk Adjustment Program

Team Members

APM risk adjustment programs require a few key elements to be successful.

Your organization needs a number of people in place to perform essential risk adjustment activities, including:

A coding manager to oversee coder assignments and performance

One or more **medical coders** trained in HCC coding to perform chart reviews

A **data specialist** who can help your coders access the right records for review

An **operational liaison** to work with your MAC on claims corrections

A **member outreach representative** who can work to schedule patient visits to close risk adjustment documentation & coding gaps

RUNNING A SUCCESSFUL
RISK ADJUSTMENT PROGRAM:

Coding Guidelines

Coding guidelines provide a framework for patient chart reviews to ensure that risk-adjusting diagnosis codes are accurately assigned according to regulations.

There are two primary sets of guidelines applied to HCC coding: **ICD-10 coding guidelines**, which govern clinical diagnosis codes, and **Risk Adjustment Diagnosis Validation (RADV) guidelines**, which govern administrative and documentation requirements for hierarchical condition categories (HCCs).

While ICD-10 guidelines are fairly straightforward, RADV guidelines are more open to interpretation. Many organizations use the **MEAT framework** to assess whether documentation supports risk adjustment coding.

M **M**onitoring: Has the patient been evaluated for the condition?

E **E**valuation: What is the current status of the patient's condition?

A **A**ssessment: What did the physician do to further evaluate the condition?

T **T**reatment: What is the care plan for the condition based on the physician's assessment?

Some additional documentation best practices from AHIMA[1] include:

- Documenting all cause-and-effect relationships.
- Clearly linking complications or manifestations of a disease process.
- Including all current diagnoses as part of the medical decision-making process and documenting them in the note for every visit.
- Only documenting diagnoses as "history of" or "past medical history (PMH)" when they are resolved.

Resources

In addition to having a strong team to drive risk adjustment strategy and oversee the work, you'll also need financial resources to devote to your efforts. Internal headcount, vendor coding support, and technology investments will require a dedicated budget.

Tip: Most ACOs and DCEs performing HCC coding create their own set of internal coding guidelines that provide instructions and clarification for common scenarios that arise during chart reviews. Your organization should develop a tailored set of guidelines that reflect your preferences and population.

Source: 1 https://bok.ahima.org/doc?oid=302516#.Xoi24C2ZOCV

RUNNING A SUCCESSFUL
RISK ADJUSTMENT PROGRAM:

Analytics & Technology

Without the right analytic capabilities and technology solutions in place, it will be difficult to scale your risk adjustment program. Some of the risk adjustment areas of focus that can be optimized with analytics and technology include:

Condition suspects and recaptures:
Using advanced metrics to identify Medicare members who may have risk-adjusting conditions, physicians can assess patients appropriately at the point of care and properly document & code conditions before the initial claims submission.

Chart retrieval:
Using sophisticated analytics to understand which patients to pull charts for and which servicing providers are most likely to have appropriate supporting documentation ensures retrospective chart reviewers don't waste time reading documents with no evidence.

Chart reviews:
Using an AI-powered coding & QA platform can cut down on coding time, improve accuracy, and provide a record of coder decisions to support compliance requests.

Claims coding audits:
Using an AI-powered audit solution can help your team quickly review submitted risk-adjusting codes on claims and validate supporting evidence in linked encounter notes, identifying areas for provider training and improvement.

Annual wellness visit outreach:
Using analytics to help identify patients with suspected chronic conditions that need to be evaluated, your organization can prioritize outreach for annual wellness visit campaigns to ensure patients with the most severe health needs are being appropriately managed.

Evaluating Your APMs and DCEs Risk Adjustment Performance

Whether your APM is just starting out with risk adjustment or has a few years' experience, it's important to step back at the end of each performance period and assess your program's impact and opportunities for improvement.

While risk adjustment program evaluation criteria varies across APMs and DCEs depending on activity, goals, and sophistication, there are some common performance indicators to consider when developing your review plan:

Physician Documentation & Coding

KPIs:

- % of claims with unsupported ICDs (individual provider and group)
- # of confirmed condition suspects / recaptures (if running prospective programs)
- # of documentation gaps closed during the reporting year
- YoY average RAF value per member

Retrospective Chart Reviews

KPIs:

- # of net-new HCCs missing on submitted claims
- # of charts reviewed per hour (coding & QA)
- % agreement rate between QA reviewers and coders
- % of charts reviewed with no evidence supporting HCCs

Patient Outreach

KPIs:

- % of high-risk patients who came in for their AWV
- % of responses from patients who received targeted outreach for an assessment visit to close condition coding gaps

Claims Corrections

KPIs:

- % of claims with missing ICDs found during retrospective reviews
- # of clerical errors fixed with MAC during the reporting year
- Aggregate RAF value of ICDs updated with MAC

AI-Powered Risk Adjustment for Medicare ACOs

Protecting your APM benchmark requires accurate claims coding. Apixio's risk adjustment solutions for ACOs and DCEs use AI to surface valuable insights about patient conditions, streamlining the risk adjustment coding process and ensuring your Medicare claims contain accurate, well-supported ICD codes.

Our Solutions:

APIXIO | HCC Identifier

Our market-leading risk adjustment coding & QA solution that helps ACOs accurately and efficiently captu e conditions documented in patient charts on encounter claims.

APIXIO | HCC Auditor

Our risk adjustment auditing and compliance solution that helps reviewers quickly and thoroughly identify potentially unsupported HCCs on submitted.

APIXIO | Care View Pre-Visit & Care Analytics

Our AI algorithms curate text and coded data to produce enriched clinical summaries and helpful tips and predictions, all of which are available in the clinical setting via workflow embedded applications.

Visit our website to learn how Apixio can help you get the most out of your APM risk adjustment program efforts for your ACOs and DCEs.

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