

Risk adjustment in healthcare

Essentials that all providers should know.

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Most healthcare providers have not been intimately involved or even aware of the risk adjustment methodologies used in common Pay-for-Performance risk contracts, such as Medicare Advantage (MA) and Medicare Shared Savings Programs (MSSP). This, however, will need to change as the Medicare Access and CHIP Reauthorization Act (MACRA) and its Quality Payment Programs (QPPs) roll out. Both quality and cost performance metrics used in MACRA QPPs are to be risk adjusted using the same methodology currently used for MA and the MSSPs. Consequently, the MACRA QPPs will affect a much larger number of providers than either MA or MSSP.

The basics: Risk adjustment methodologies

While the purpose of this paper is not to delve deeply into the risk adjustment methodologies commonly used in healthcare, it is important that providers understand the basic mechanisms at work in these models.

The common risk adjustment methods today make use of Hierarchical Condition Categories (HCCs) to further define and predict the risks associated with any individual patient. HCCs represent clinical conditions (e.g., diabetes, hypertension, stroke, heart failure) that have a significant impact on a patient's clinical complexity and risk for further healthcare-related needs and services. While most HCCs are chronic conditions, others are acute conditions and/or procedures (e.g., transplant surgery and amputations). Providers need to be aware that even though HCCs describe chronic conditions, they must be captured annually to be used in the risk adjustment process.

Once HCCs are identified and documented appropriately in the medical record, healthcare providers must account for them in the risk adjustment model. The term addressed is somewhat nebulous, but a handy mnemonic, M.E.A.T., can be used to remember the various ways in which the HCC can be addressed on an annual basis.

M = Monitored. For instance, a diabetic patient's blood sugars, hemoglobin A1C level, renal function, and eye exam may be monitored to determine the progression or lack of progression of the diabetic disease process.

E = Evaluated. A patient with a stroke may be evaluated for risk factors leading to the stroke event (e.g., hypercholesterolemia, atrial fibrillation or hypertension).

A = Assessed. The provider may document that a specific condition (HCC) is progressing, regressing or perhaps even resolving, making it no longer a factor in the patient's risk profile.

T = Treated. Here, it is important to document that a condition is addressed through either medical, surgical or behavioral treatments.

A final step in the risk adjustment process is that each of the HCCs identified for a certain patient population is given a weighted score, and then the cumulative scores are used to determine a population's risk adjustment factor (RAF) score.

In brief, the capture of HCCs and the calculation of RAF score give providers the opportunity to prove what many have historically claimed—that their patients are sicker and their conditions are more complicated than most. Quite simply, providers are now asked to prove this claim, and knowing how to document HCCs to ensure that risk adjustment is done accurately is the best way to do so.

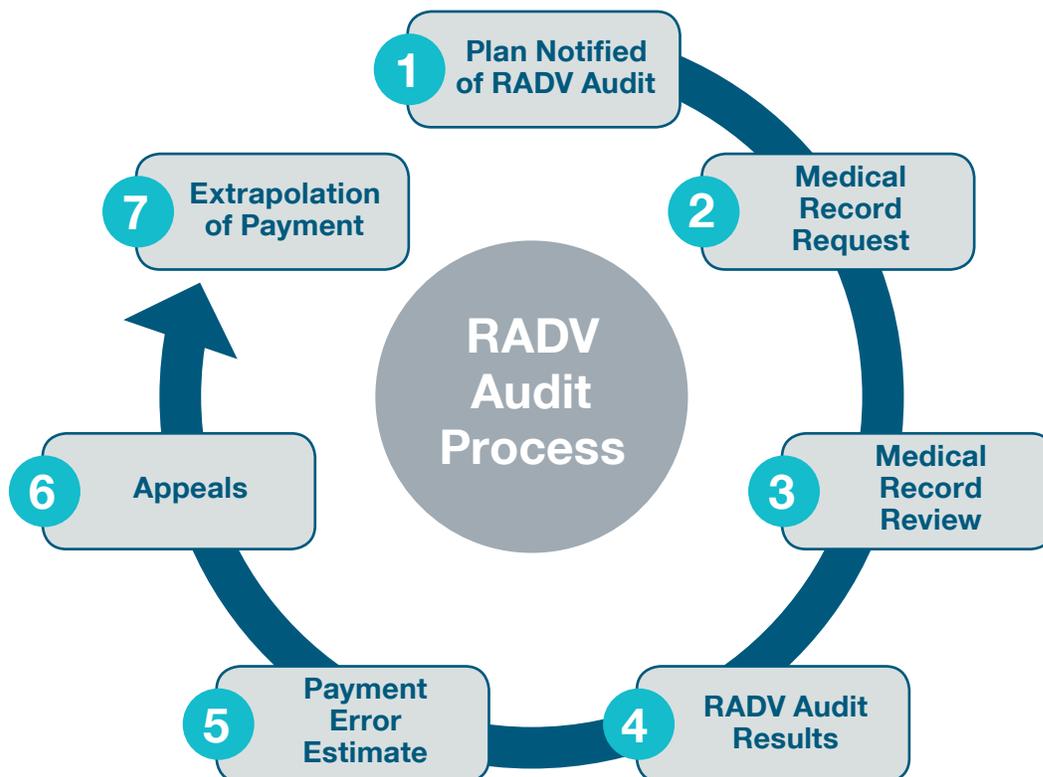
Risk-adjusted scoring

The mathematics of how things like RAF scores affect payments are not as important as the understanding of several key facts surrounding the ways these scores are used in common pay-for-performance programs (e.g., MA, MACRA and MSSP).

Basically, the RAF score is a representation of provider's performance as quality or cost metrics are compared to those of other providers in similar situations based on the claims and supporting documentation.

Risk adjustment audits

CMS performs risk adjustment data validation (RADV) to verify the accuracy of the HCC capture process. Providers who are unfamiliar with this process, such as those who plan on participating in MACRA but who have not previously participated in MA, should be familiar with the process outlined below.



Providers should especially note that overpayments may be identified through this process and that they may be required to return these dollars to CMS. The risk related to RADV makes it even more important for participants in programs like MACRA's QPPs to have a reliable and accurate process for capturing HCCs.

Clinical documentation and risk adjustment

Most providers are familiar with the fact that professional coders speak their own language, and often this language does not directly translate into the clinical language that most physicians and other providers use. The same is true for clinical documentation related to risk adjustment. Documentation related to how an HCC is addressed (monitored, evaluated, assessed and/or treated) must be documented annually, as the slate is wiped clean every year and a patient's RAF score resets. Failure to document in a way that allows HCCs to be captured or recaptured leaves providers—who are intent on demonstrating the average complexity or severity of illness of the patients they serve—short.

Supporting risk adjustment through technology

The other feature of clinical documentation and coding that most providers are well aware of is that they are time-consuming processes that require a wealth of knowledge far outside of what most providers can manage. After all, there are over 9,000 ICD-10 codes that are grouped into multiple HCC groupings, each of which requires certain additional elements to accurately code. For example, simply documenting that a patient is diabetic in the medical record is inadequate for the purposes of HCC capture. Instead, documentation must also indicate whether the patient is a type I or type II diabetic, whether the diabetes is controlled or uncontrolled, whether the diabetes is progressing and involving other organ systems (e.g., the eyes, as in diabetic retinopathy, or the kidneys, as in diabetic nephropathy), and how the diabetes is being treated—with diet, oral agents or insulin.

Most providers, unless prompted to fill in the gaps in their clinical documentation, will not remember to do so in a reliable fashion. Thankfully, artificial intelligence (AI) systems and natural language processing (NLP) can be combined with in-workflow guides to make this happen in a reliable manner. For instance, a provider might have medical records for a patient containing possible or historical conditions that map to HCCs that have not been captured and utilized to contribute to the patient's current-year RAF score. Providers can use NLP systems to "read" those historical records, even if the records are in free-text; identify the possible HCCs (or quality opportunities); prompt them (using AI algorithms) to conduct a review of systems; and document how the clinical condition is addressed efficiently, so that it can be accounted for in risk adjustment scoring and improve care coordination and quality.

One common way providers use this technology is to create a list of all possible conditions and corresponding HCCs that need to be evaluated, addressed and documented (as appropriate) at the time of a patient's annual wellness visit. By combining the annual wellness visit with a vigorous search for chronic conditions that map to HCCs, providers will find that many of these conditions can qualify the patient for enrollment in a chronic care management program (CCM). This program, consisting of the staff of physicians, disease managers, health coaches and others, can provide more systematic disease management, perhaps even by telephone, which CMS will now reimburse.

The technology also can search through the provider's patient community to identify those at highest risk and proactively schedule them for their annual wellness visit or efficiently triage known conditions during other office visits. Doing so helps reduce gaps in care while taking a more holistic and

methodical approach to scheduling patients throughout the year, avoiding the rush in the last quarter to update patient records for proper risk adjustment, as well as capitalizing on the limited number of visits patients present in any given year.

Risk adjustment example

Consider the example of a 67-year-old female who visits her primary care physician's office for an annual wellness visit. Prior to her visit, her medical records from the previous year are processed by an AI-powered system that "reads" these files, extracting the following possible HCCs, quality and gaps in care opportunities: diabetes mellitus, hypertension, and heart failure. The physician is then prompted to address these conditions by conducting an exam and review of systems, while further documenting and defining the status, type, testing and/or treatment plan for each condition. That is, diabetes mellitus might be further documented as diabetes mellitus type II with associated nephropathy and neuropathy, controlled, as evidenced by a hemoglobin A1C of 6, with insulin therapy. Finally, because the patient has two or more chronic conditions, she is referred to a chronic care management program, and an RN from the practice contacts the patient each month to update her symptoms and blood sugar readings, and to discuss any issues she is having with her diabetes. When she returns in a year for her next annual wellness visit, the process repeats, and she continues to be closely followed and expertly managed for her chronic conditions.

In the example above, the patient's appropriately documented HCCs (diabetes mellitus type II, chronic systemic hypertension and chronic systolic heart failure) are all captured and reflected to her provider's RAF score. This score is then used to adjust the provider's quality or cost performance measures in programs such as MA or MSSP. If the provider's average costs per Medicare beneficiary are nominally higher than those of the physician peer group and the patient has a high RAF score, the incremental payment may be adjusted to account for the fact that the provider is caring for a population with more clinical complexity and a higher severity of illness. In other words, this provider should consume more resources than a provider serving a population with a lower RAF score.

Application of RAF scores

Increasingly, healthcare reimbursement is more value-based; providers are no longer simply paid on a fee-for-service basis, where payments are based on services rendered. Instead, value-based reimbursement combines outcomes with process measures to gauge a provider's performance and the value provided to the patient. Those who provide higher value are then reimbursed more per unit of service than those who produce lower value.

Risk-adjusted reimbursement seeks to address both quality and cost performance, but variables beyond the provider's control can dramatically affect reimbursement. Those providers whose patients are demonstrably more complex and difficult to manage must have their performance scores adjusted to account for this variability and thus ensure direct, peer-to-peer comparisons.

A risk adjustment methodology is an essential component of any well-designed pay-for-performance, value-based reimbursement model.

Furthermore, providers should have a good understanding of how these systems work in their Value-Based Reimbursement contracts and work diligently to make sure they are conducting patient exams, treating appropriate conditions, and documenting in a manner that fully reflects the disease state and care provided to receive full credit. This is not “gaming” the system, but understanding the system helps ensure that credit is given where credit is due. Elderly patients may have multiple medical problems, complex illnesses, and a history of complications (including behavioral health issues) that make their management more difficult. Providers whose patients are elderly need to know that their performance is not directly compared to that of a provider whose patients are all young, healthy and compliant with their care plans.

Failure to appropriately and accurately risk-adjust performance can lead to negative consequences such as “cherry picking” of patients or even providers exiting payment plans, such as Medicare, where payments are based on non-risk-adjusted performance metrics or where risk adjustment methodologies are not trusted by the providers.

Conclusion

As value-based, pay-for-performance reimbursement models such as MACRA QPPs become pervasive, providers must understand the basics of risk adjustment methodologies and learn how to effectively manage populations, more efficiently care for complex patients during routine and annual wellness visits or maintenance follow-ups, and document the essential elements in the medical record that allow their performance to be fairly compared with others performing similar services. Today, tools and technologies are available to help support providers with required clinical documentation for accurate and appropriate risk adjustment.

About Risk Adjustment Professional Services Partner

Coker Group, a national healthcare advisory firm, has developed a close relationship with Nuance regarding next-generation quality and risk adjustment healthcare solutions. Coker’s collaboration with Nuance helps organizations improve their providers’ ambulatory clinical documentation and risk adjustment. With thirty years of experience in healthcare consulting, Coker has extensive expertise in workflow design, change management, and incentive planning for all types of provider organizations.

The combination of Coker’s advisory services and Nuance’s innovative technology offers unparalleled support to providers, who face many challenges inherent in the healthcare industry.

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