Mitigate the Risk in Risk Adjustment:

It Takes a Team!

HCC Risk Adjustment – What is it?

- A payment methodology that uses demographics and diagnostic information to predict a per participant, per month (PM/PM) rate reflecting the complexity of care and required treatment

- The intended purpose is to promote wellness and reimburse appropriately for the risk assumed by the organization responsible for the cost of care of the Medicare Advantage eligible enrollee or PACE participant

What are the demographics considered in Risk Adjustment?

- Age
- Gender
- Disability status
- Medicaid Status
- Institutional/Community Status
- Frailty

What are the diagnostics considered in Risk Adjustment?

- Not every condition/diagnosis that a participant has is associated with “risk”
- To be considered for risk adjustment, a condition must be included in the HCC Model—Hierarchical Condition Categories
- The health status of your PACE Organization’s participants (…as long as CMS is made aware of that health status!*)*

CMS Hierarchical Disease Categories

Table 11. List of Disease Hierarchies for the Revised CMS-HCC Model (PACE 6/6/11)

DISEASE HIERARCHIES		
Hierarchical Condition Category (HCC)	If the Disease Group is Listed in this column…	…Then drop the HCC(s) listed in this column
	Hierarchical Condition Category (HCC) LABEL	
8	Metastatic Cancer and Acute Leukemia	9,10,11,12
9	Lung and Other Severe Cancers	10,11,12
10	Lymphoma and Other Cancers	11,12
11	Colorectal, Bladder, and Other Cancers	12
17	Diabetes with Acute Complications	18,19
18	Diabetes with Chronic Complications	19
27	End-Stage Liver Disease	28,29,80
28	Cirrhosis of Liver	29
46	Severe Hematological Disorders	48
51	Dementia With Complications	52
54	Drug/Alcohol Psychosis	55
57	Schizophrenia	58
70	Quadriplegia	71,72,103,104,169
71	Paraplegia	72,104,169
72	Spinal Cord Disorders/Injuries	169
82	Respirator Dependence/Tracheostomy Status	83,84
83	Respiratory Arrest	84
86	Acute Myocardial Infarction	87,88
87	Unstable Angina and Other Acute Ischemic Heart Disease	88
99	Cerebral Hemorrhage	100
103	Hemiplegia/Hemiparesis	104
106	Atherosclerosis of the Extremities with Ulceration or Gangrene	107,108,161,189
107	Vascular Disease with Complications	108
110	Cystic Fibrosis	111,112
111	Chronic Obstructive Pulmonary Disease	112
114	Aspiration and Specified Bacterial Pneumonias	115
134	Dialysis Status	135,136,137,138,139,140,141
135	Acute Renal Failure	136,137,138,139,140,141
136	Chronic Kidney Disease, Stage 5	137,138,139,140,141
137	Chronic Kidney Disease, Severe (Stage 4)	138,139,140,141
138	Chronic Kidney Disease, Moderate (Stage 3)	139,140,141
139	Chronic Kidney Disease, Mild or Unspecified (Stages 1-2 or Unspecified)	140,141
140	Unspecified Renal Failure	141
157	Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone	158,159,160,161
158	Pressure Ulcer of Skin with Full Thickness Skin Loss	159,160,161
159	Pressure Ulcer of Skin with Partial Thickness Skin Loss	160,161
160	Pressure Pre-Ulcer Skin Changes or Unspecified Stage	161
166	Severe Head Injury	80,167

How Payments are Made with a Disease Hierarchy EXAMPLE: If a beneficiary triggers HCCs 140 (Unspecified Renal Failure) and 141 (Nephritis), then HCC 141 will be dropped. In other words, payment will always be associated with the HCC in column 1, if a HCC in column 3 also occurs during the same collection period. Therefore, the organization's payment will be based on HCC 140 rather than HCC 141.

This is what a Disease Category looks like…

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135	Acute Renal Failure	136,137,138,139,140,141
136	Chronic Kidney Disease, Stage 5	137,138,139,140,141
137	Chronic Kidney Disease, Severe (Stage 4)	138,139,140,141
138	Chronic Kidney Disease, Moderate (Stage 3)	139,140,141
139	Chronic Kidney Disease, Mild or Unspecified (Stages 1-2 or Unspecified)	140,141
140	Unspecified Renal Failure	141

Basis of the CMS HCC Model

- Diagnostic categories should be clinically meaningful
- They should predict medical expenditures
- They should have adequate sample sizes in the population
- Hierarchies should characterize illness levels and accumulate unrelated disease processes
- Encourage specific coding
- Not reward or penalize coding proliferation
- Categorization must be consistent

Basic Rules

- Risk-based entities MUST submit all existing participant diagnoses that affect risk adjustment annually
- These diagnoses MUST be code-able according to Official Coding Guidelines
- Diagnoses submitted for risk adjustment MUST be supported by the medical record of the patient
- The existence of a disease state is what creates risk, not the treatment

HCC Basics for PACE

- 8,939 diagnoses for ICD-10
- 87 HCC categories
- Risk factor is attached to each HCC
- Each qualifying HCC only counts once annually
- Risk score is based on cumulative HCCs per individual (and their particular demographics)
- Documentation must support each HCC annually according to Official Coding Guidelines and CMS interpretation and guidance

How do you make CMS aware of the health status of your participants?

Ensure that:

- Participant demographic information is accurate and current
- Participant past medical history is on site, reviewed, and addressed at the pre-enrollment history and physical
- Provider documentation is thorough, accurate, and code-able
- Coding is thorough and accurate
- Codes are submitted to CMS (in a timely manner)
- Codes are accepted by CMS

If a diagnosis was not accepted, figure out why—backtrack to fix it and resubmit

Take advantage of the reports that CMS creates every month

Do You Need A Coder?

- Yes, but the coder can only code what the documentation supports, and only what they have the background and experience to code
  - This is outpatient and physician coding
  - This is not inpatient coding
- If you leave all the coding and the understanding of CMS rules up to your coder, the unintended impact is that you are leaving some important cash flow and revenue decisions up to your coder
- They didn't ask for that responsibility and you probably didn't intend it

Or Should You Just Train Your Care Providers To The HCCs?

- Good documentation (and coding) is all inclusive and not just HCC related
- Coders are trained to code what care providers specifically write, and most good, experienced coders are trained to code for billing purposes (CPT and DRG) – ICD-10 codes are different
- Documenting completely and coding completely for the HCCs is important for payment
- Coding everything is important for reporting
- Documenting everything is essential for quality care

What Can a Coder Do?

- A coder can only code what is written by a provider
- A coder cannot diagnose, interpret, translate, or intuit
- A coder needs to stay current and educated re: constantly changing codes and rules and guidelines

What Can Providers do?

- Problem list – keep it updated and correct
- Repeat all diagnoses that have not resolved annually; sign and date everything, every time
- Communicate/Clarify "specialty" diagnoses at IDT meetings
- If a chronic disease exists, document it specifically annually– may seem redundant, but it's required
- Review, sign, and update your pre-admission physicals AGAIN, on admission and AT LEAST annually thereafter
- Seems silly, but when you review a lab– sign and date it, document what the information is telling you in a note, or link lab back to original encounter note

When Documenting, Words Matter

In PACE, unconfirmed or inconclusive diagnoses should not be submitted for risk adjustment… PACE is considered an outpatient setting

- Possible
- Probable
- Suspected
- Likely
- Questionable
- Appears to be
- Rule Out
- Working Diagnosis of
- Consistent with
- Compatible with
- Comparable with
- Suspicion of

Understanding the CMS Calendar

Everyone—Coding staff, Clinical staff, Finance staff, and IT staff, need to have a basic understanding of how the submission and reimbursement calendar works.

It’s complicated…

Basically, the earlier you get your data submitted relative to the cutoff dates for risk score calculations, the earlier you will receive your risk adjusted premium payments.

Understanding the CMS Calendar

PMPM rate is by calendar date

- One year's cumulative diagnoses create the next year's risk score
- Rate is adjusted twice per year – January and July
- January 1 is an interim rate PMPM (2017)
  - Based on 12 months of diagnoses submitted
  - Submissions with service dates between July 1, 2015- June 30, 2016 (submitted by the September 2016 deadline)
- July 1 is an actual rate PMPM (2017)
  - Based on 12 months of diagnoses submitted
  - Submissions with service dates between January 1 – December 31, 2016 (submitted by the March 2017 deadline)

RATES and Dates – 2017 Members

2017 Rate is determined by diagnoses confirmed in the medical record during 2016 calendar year and accepted for reimbursement by CMS

New Medicare Enrollees have a flat rate for 18 months—so a new member in January 2017 will not have a change in risk score until July 1, 2018

New PO Participant rates Will NOT be impacted by your PACE organization prior to January 2018; all 2017 payments are based on prior plan submission

Recurring Members	Diagnoses confirmed by 2016 medical record	
New Enrollees	Flat Rate 1/1/2017 – 7/1/2018	*NO IMPACT*
New Participants	Adjusted Rate from Prior Plan	*NO IMPACT* until Jan 2018

CMS Risk Adjustment Submission Calendar

Risk Score Run	Dates of Service	Deadline for Submission of RAPS
2017 Initial (January)	7/1/2015 – 6/30/2016	Friday, 9/9/2016
2016 Final	1/1/2015 - 12/31/2015	Tuesday, 1/31/2017
2017 Mid Year (July)	1/1/2016 – 12/31/2016	Friday, 3/3/2017

What is a RAPS Cluster?

```
AAAPH12343329723495201509O8PRODICD10
BBB0000001P1111
CCC0000001                                     456789123A                20201510112015101l
N184
YYY0000002P22220000001
ZZZPH12343329723495000000l
```

Basics:

- HICN
- Provider Type
- From Date
- Thru Date
- Diagnosis Code

A RAPS file can contain as little as one cluster

What Reports Should be Viewed EVERY MONTH?

Reporting Naming Conventions

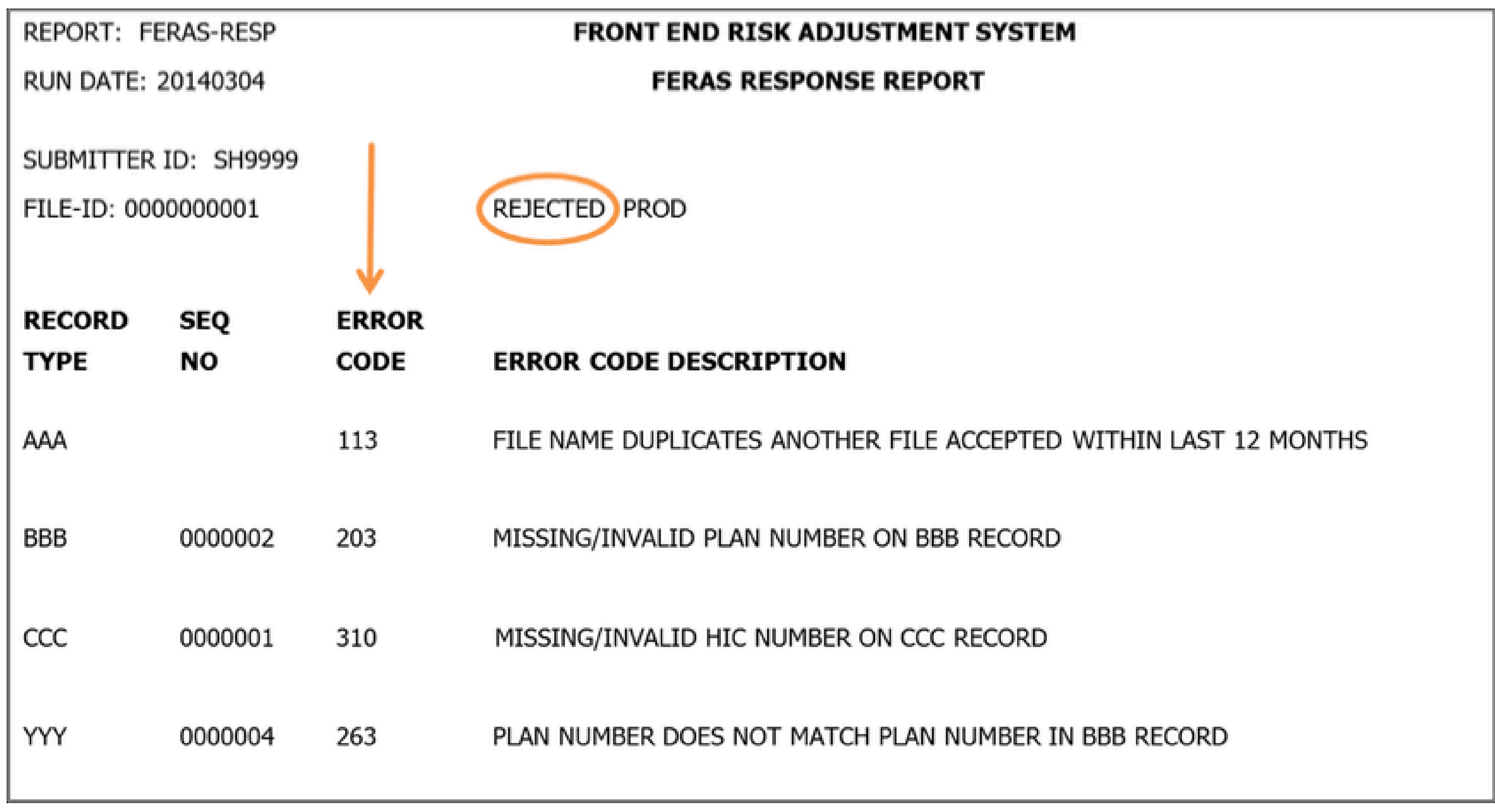
Mailbox Identification	Report Name
RSP#9999.RSP.FERAS_RESP_	FERAS Response Report
RPT#9999.RPT.RAPS_RETURN_FLAT	RAPS Return File
RPT#9999.RPT.RAPS_ERRORRPT_	RAPS Transaction Error Report
RPT#9999.RPT.RAPS_SUMMARY_	RAPS Transaction Summary Report
RPT#9999.RPT.RAPS_DUPDX_RPT_	RAPS Duplicate Diagnosis Cluster Report
RPT#9999.RPT.RAPS_MONTHLY_	RAPS Monthly Plan Activity Report
RPT#9999.RPT.RAPS_CUMULATIVE_	RAPS Cumulative Plan Activity Report
RPT#9999.RAPS_ERRFREQ_MNTH_	RAPS Monthly Error Frequency Report
RPT#9999.RAPS_ERRFREQ_QTR_	RAPS Quarterly Error Frequency Report

FERAS:
Front End Risk Adjustment System

FERAS Response Report

- Indicates if a file is accepted or rejected
- Identifies the reason for rejection
- SFTP users receive this report the same business day of submission
- Direct Connect or Gentran users receive this report the next business day after submission

FERAS Response Report - Example


REPORT: FERAS-RESP

RUN DATE: 20140304

FRONT END RISK ADJUSTMENT SYSTEM

FERAS RESPONSE REPORT

SUBMITTER ID: SH9999

FILE-ID: 0000000001

REJECTED PROD

RECORD TYPE	SEQ NO	ERROR CODE	ERROR CODE DESCRIPTION
AAA		113	FILE NAME DUPLICATES ANOTHER FILE ACCEPTED WITHIN LAST 12 MONTHS
BBB	0000002	203	MISSING/INVALID PLAN NUMBER ON BBB RECORD
CCC	0000001	310	MISSING/INVALID HIC NUMBER ON CCC RECORD
YYY	0000004	263	PLAN NUMBER DOES NOT MATCH PLAN NUMBER IN BBB RECORD

RAPS Return File

- Contains the entire submitted transaction
- Generated in response to RAPS file submission
- Identifies errors specific to line item transactions
- A flat file layout for easy download into Excel

RAPS Returns - Example

```
AAAPH12343329723495 20150908PRODICD10
BBB0000001P1111
CCC0000001            111111111A      2020151109 20151109 I252
CCC0000002            111111111A      2020151109 20151109 A065
CCC0000003            111111111A      2020151109 20151109 E11641  408409
CCC0000004            111111114A      2020151025 20151025 E168
CCC0000005            111111114A      2020151025 20151025 E1101
CCC0000006            111111114A      2020151025 20151025 E1165
CCC0000007            111111115A      2020151222 20151222 F2089
CCC0000008            111111115A      2020151222 20151222 A202
CCC0000009            111111116A      2020151130 20151130 I509
YYY0000002P2220000001
ZZZPH123433297234950000001
```

20 – Physician
20151130 – From Date of Service
20151130 – Through Date of Service
I509 – Congestive heart failure, unspecified ICD-10

RAPS Transaction Error Report

- Communicates errors found in CCC records during processing
- Displays only 300, 400, and 500 level error codes
- Report layout

RAPS Error Report - Example

```
1REPORT   : RAPS002  **ICD10**                  RISK ADJUSTMENT PROCESSING SYSTEM                                      PAGE:        1
 RUN DATE : 20151106                                 TRANSACTION ERROR REPORT                                    TRANS DATE: 20151108
0SUBMITTER ID   SH1234    FILE ID: 0000001283    PLAN ID: H8000    BATCH NUMBER: 0000001
0SEQ     SEQ  PATIENT CONTROL  HIC          HIC          DOB PRVD FROM     THRU     DEL DGNS    DGNS DGNS MAEA MAEA CORRECTED
         ERR  NUMBER           NUMBER       ERR  DOB     ERR TYPE DATE     DATE     IND CODE    ERR1 ERR2 CD   ERR  HIC


 0000015                                    310                 20  20151017 20151018     E11331             A
              12342E00074

 0000021                                    310                 20  20150908 20150909     H4011X1            A
              15678E00253

 0000022                                    310                 20  20151004 20151005     E1165              A
              19874E00331                                       20  20151004 20151005     H2513              A
0                                              ************  END OF FILE ************
```

RAPS Error Resolution Steps

- Determine the error level of the code to identify nature of the problem
- Look up the error code
- Determine course of action
- Resolve all errors in a timely manner

RAPS Duplicate Diagnoses Cluster Report

- Identifies diagnosis clusters with 502 error message (duplicate)
- These clusters were accepted into the system, but were not stored in the RAPS database
- Report layout

RAPS Monthly Plan Activity Report

Provides monthly summary of the status of submission by Submitter ID and Plan Number

RAPS Cumulative Plan Activity Report

- Provides cumulative summary of the status of submissions by Submitter ID and Plan Number
- Available in data file format and flat format
- One available each month if RAPS have been submitted in the month prior

RAPS CPAR - Example

1REPORT: RAPM0020 **ICD10** CMS RAPS ADMINISTRATION PAGE: 1
RUN DATE: 20160501 RAPS CUMULATIVE PLAN ACTIVITY REPORT SERVICE YEAR: 2015
PLAN NO: H1234 FOR PERIOD ENDING APRIL 30, 2016

PROVIDER TYPE/TOTALS	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	TOTAL
PRINCIPAL INPATIENT							
TOTAL SUBMITTED	0	0	0	0	1	0	1
TOTAL REJECTED	0	0	0	0	0	0	0
TOTAL ACCEPTED	0	0	0	0	1	0	1
TOTAL STORED	0	0	0	0	1	0	1
TOTAL MODEL STORED	0	0	0	0	1	0	1
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OTHER INPATIENT							
TOTAL SUBMITTED	0	0	0	0	9	0	9
TOTAL REJECTED	0	0	0	0	0	0	0
TOTAL ACCEPTED	0	0	0	0	9	0	9
TOTAL STORED	0	0	0	0	9	0	9
TOTAL MODEL STORED	0	0	0	0	4	0	4
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
OUTPATIENT							
TOTAL SUBMITTED	0	0	0	11	6	12	29
TOTAL REJECTED	0	0	0	0	0	0	0
TOTAL ACCEPTED	0	0	0	11	6	12	29
TOTAL STORED	0	0	0	11	6	12	29
TOTAL MODEL STORED	0	0	0	11	6	11	28
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0
PHYSICIAN							
TOTAL SUBMITTED	0	29	56	185	254	196	720
TOTAL REJECTED	0	29	56	9	19	22	135
TOTAL ACCEPTED	0	0	0	176	235	174	585
TOTAL STORED	0	0	0	176	235	174	585
TOTAL MODEL STORED	0	0	0	100	141	65	306
TOTAL DELE ACPTD	0	0	0	0	0	0	0
TOTAL DELE RJCTD	0	0	0	0	0	0	0

RAPS Error Frequency Report

2 Reports-Monthly & Quarterly

Provides a summary of all errors associated with files submitted in test or production within a month or a quarter

Model Output Report (MOR)

- The Part C MOR is provided in the "data file" format and the "report" format
- There will be one such report for each plan for each month
- The filename will contain the string "HCCMODD"

Model Output Report - Example

```
1RUN DATE: 20160415                     RISK ADJUSTMENT MODEL OUTPUT REPORT                                                PAGE:     1
 PAYMENT MONTH: 201605                  PLAN: H9999 A HEALTH PLAN FROM A PLACE                                                RAPMOSDA
0             LAST             FIRST                                                        DATE OF
 HIC          NAME             NAME             I                                           BIRTH    SEX & AGE GROUP  ESRD
 ------------ --------------- --------------- -                                             -------- ---------------  ----

 012345678A   SMITH            JOHN          A                                              19430505 Male70-74        N
 V21 HCC DISEASE GROUPS: HCC018 Diabetes with Chronic Complications

 987654321A   JOHNSON          STEVE         B                                              19230505 Male90-94        N
 Medicaid Male Aged (Age>=65)
 Medicaid
 V21 HCC DISEASE GROUPS: HCC012 Breast, Prostate, and Other Cancers and Tumors
                         HCC048 Coagulation Defects and Other Specified Hematological Disorders
                         HCC085 Congestive Heart Failure
                         HCC111 Chronic Obstructive Pulmonary Disease
                         HCC138 Chronic Kidney Disease, Moderate (Stage 3)
                         HCC169 Vertebral Fractures without Spinal Cord Injury
 V21 INTERACTIONS:       INTI03 CHF_COPD
                         INTI12 CHF_RENAL
```

Monthly Membership Report (MMR)

- The Part C MOR is provided in the “data file” format and the “report” format
- There is one such report for each plan for each month
- The filename will contain the string “MONMEMD”

Monthly Membership Report - Example

```
1RUN DATE:20160515                              MONTHLY MEMBERSHIP REPORT - NON DRUG                                PAGE:         1
 PAYMENT MONTH:201606                     PLAN(H9999) PBP(001) SEGMENT(000) A HEALTH PLAN FROM A PLACE
0                             --------------------------------------------- REBATES --------------------------------------------
            BASIC PREMIUM | COST SHR REDUC   MAND SUPP BENEFIT  PART D SUPP BENEFIT    PART B BAS PRM REDUC   PART D BAS PRM REDUC
     PART A      $0.00    |       $0.00              $0.00              $0.00                  $0.00                  $0.00
     PART B      $0.00    |       $0.00              $0.00              $0.00                  $0.00                  $0.00
0             S                -----------  FLAGS  ------------   ----------------------- PAYMENTS/ADJUSTMENTS ----------------------
 CLAIM        E AGE  STATE       P P         M F   A D   S   C MTHS     PAYMENT DATE      LAG    FTYPE----FACTORS--------     AMOUNT
 NUMBER       X GRP  CNTY        A A H E I   C R O D E E O   M A B       START   END                  FRAILTY-SCORE    MSP        MSP
 ------------ - ---- -----     O R R O S N N A A R D F G U M C ---- --- ------------------------------------------------------------------
    SURNAME F    DMG  BIRTH     O T T S R S H I I E O A H R S A PIP  ADJ
            I    RA   DATE      A A B P D T C D L C N U P C P I DCG  REA  FCTR-A  FCTR-B      PART A      PART B      TOTAL PAYMENT
 ------------ - ---- -----     - - - - - - - - - - - - - - - - ---- ------------------------------------------------------------------
 123456789A   F 6569 12345                                     1 1      201606 201606      Y       E     0.1660                 $0.00
    SMITH   A    6565 19470505    Y Y           Y 0      B   Y           0.6150  0.6150    $260.00     $250.00           $510.00
 987654321A   F 6569 17860                                     1 1      201606 201606      Y       C     0.1660                 $0.00
    JONES   B    6569 19440505    Y Y           Y 0 Y    B   Y           2.5250  2.5250   $1000.00    $1020.00          $2020.00
```

But why does this matter to me? I just want to provide good health care!

- There is a “disconnect” between how clinicians document to provide good care, how coders are trained, and what CMS expects non-clinicians (coders) to pull from a chart to submit for reimbursement
- Your PACE organization needs to be appropriately reimbursed for the risk it is taking on in order to continue to provide that good health care

Over Time…

Ongoing efforts of every department in your program will maintain the right level of reimbursement, ensuring that you are receiving appropriate payment in a timely manner for the risk that you are taking.

Develop a TEAM - Based Risk Adjustment Strategy

Risk Adjustment should be an integrated approach between

- Coding Staff
- Clinical Staff
- Finance/Administrative Staff

CentraCare Results

- August 1 2016 Risk Score: 2.434
- January 1, 2017 Interim Risk Score: 2.495
- Change in Risk Score: 0.061
- Budgeted 2017 Member months: 3,668
- Base Rate: $871.07
- Annual 2017 Effect: $194,900.00

Questions ?

Resources

http://www.cms.gov information regarding risk adjustment, announcements, documents, special reports, coding, encounter data.

http://www.cdc.gov/nchs/icd/icd10cm.htm information regarding ICD-10 coding, updates, etc…

http://www.csscoperations.com gateway to Medicare Advantage and Prescription Drug Programs. Information regarding risk adjustment, encounter data, data submission & reporting. Links to CMS instructions, training materials.

2013 National Technical Assistance Risk Adjustment 101 Participant Guide This is a 36 page overview/primer of the risk adjustment process.

Presenter Contact Info

Eileen Black, RN, Client Services Manager, DxID
eblack@Dx-ID.com

Alexandria Lueth, CPA, Chief Executive Officer, CentraCare   a.lueth@mycentracare.com

Thank you!