AFFORDABLE CARE ACT
RISK ADJUSTMENT
OVERVIEW
Gain knowledge of the Premium Stabilization programs referred to as the three “Rs”– Risk Adjustment, Reinsurance and Risk Corridors
Provide an overview of risk adjustment methodology defined in the Affordable Care Act
Understand the impact of coding and documentation on risk assessment
The Affordable Care Act implemented three programs to stabilize health care premiums to help ensure that every American has access to high-quality, affordable health insurance.

Program 1: Risk Adjustment - this is a permanent program. The methodology is based on the premise that plan premiums should reflect the differences in the plan benefits, quality and efficiency, **not the health status of the enrolled population.**

Goal of risk adjustment is to compensate health plans for the differences in the enrollee health mix.

It is budget neutral and funds are transferred from plans with lower risk enrollees to plans with higher risk enrollees in a State market.
Program 2: **Transitional Reinsurance** is a temporary program that will expire after 2016. The program is designed to reduce the costs of high-risk enrollees and ensure market stability for the first three years of the ACA.

- All health plans (traditional and self insured) contribute funds to the HHS reinsurance program on an annual basis. Contribution rate is $63/enrollee in 2014.
- Either HHS or the State can run the program.
- Reinsurance payments are determined by medical costs incurred by the individual and not based on diagnosis.
- Payments will never exceed contributions and are calculated annually based on a formula.
Program 3 – Risk Corridor – this is a temporary program that will expire after 2016. This program protects health plans from uncertainty in rate setting from 2014-2016 due to lack of data in first three years of ACA.

Administered by HHS

HHS calculates a target amount of revenue for each plan according to the premiums collected less the plan’s allowable administrative expenses.

HHS calculates the plan’s allowable costs incurred through claims and costs associated with improving quality and implementing technology.

If plan’s costs are more than revenue as specified by a formula, HHS will pay a certain percentage to plan. If plan’s revenue is more than costs, plan must pay HHS based on a formula.
What is Risk Adjustment?

Â Risk Adjustment is a process to predict health care costs for enrollees of a health plan and balances the risk between other health plans in the same market within a State.

Â The theory is: the sicker the patient-the more expensive they are to treat.

Â Accurate risk scores are dependent on the specificity of ICD-9 CM codes reported on encounters and claims.

Â Without risk adjustment, plans that enroll a higher proportion of high-risk enrollees would have to charge a higher average premium (across all of their enrollees) to be financially viable.
The standards for the risk adjustment program are established under Regulations at 45 CFR Part 153.

The Centers for Medicare & Medicaid Services (CMS) is the entity responsible for implementing the HHS Risk adjustment program under the ACA.

HHS Risk Adjustment is adapted from Medicare Advantage risk adjustment model.

HHS Risk Adjustment is a concurrent model—meaning current year information is used to predict current year costs.

HHS Risk Adjustment is only applicable to non-grandfathered individual and small group plans inside and outside of the Marketplace (Exchange). There are 15 risk models based on age and plan metal levels (Platinum, Gold, Silver and Bronze).
RISK SCORE MODELS

- **Infant (Age 0-1)**
  - Platinum
  - Gold
  - Silver
  - Bronze
  - Catastrophic*

- **Child (Age 2-20)**
  - Platinum
  - Gold
  - Silver
  - Bronze
  - Catastrophic*

- **Adult (Age 21+)**
  - Platinum
  - Gold
  - Silver
  - Bronze
  - Catastrophic*

*Individual Market only*
Risk Adjustment Factor (RAF) is a sum of multiple factors that determine the health risk of an enrollee. It is also called the Risk Score and is calculated for each enrollee and then summarized for all enrollees at the plan level (Plan Level Risk Score).

Components required to calculate enrollee risk score are:

1. Verification that individual or small group plan qualifies
2. Verification that enrollee has an active enrollment during the measurement period
3. Qualifying diagnosis code and CPT-4/HCPCS code combination on medical claims/encounters.
4. Diagnosis code filtered for Age and Sex parameters
5. **Mapping the correct Hierarchical Condition Category (HCC)**
6. Application of severity/maturity interactions
7. Application of Demographic factor
8. Application of CSR (Cost Savings Reduction factor)
A Hierarchical Condition Category is a grouping of similar condition categories (CCs) based on disease. Only the most severe manifestation of the disease is coded.

Condition Category (CC) is a grouping of similar diagnosis codes into diseases that are related clinically and with respect to cost.

HHS-HCC methodology for the ACA plans is similar to the CMS-HCC methodology used for Medicare Advantage plans. There are 3,518 individual ICD-9-CM codes that map to 127 HCCs. Mostly chronic conditions, but some acute illnesses are included. The CMS-HCC Model has 70 HCCs with 3519 ICD-9-CM codes.
Not all ICD-9-CM codes are used for Risk Adjustment. Codes that best predict the cost of services are used. Excluded codes are those that are vague (e.g., signs and symptoms), medically insignificant (e.g., muscle strain), definitively treated (e.g., appendicitis), or discretionary in medical treatment or coding (e.g., osteoarthritis)

All diagnosis codes are assigned to a condition category CC (1 to 1 mapping except for a handful of codes that are mapped to two categories: 40403, 40413, 40493, 74100, 74101, 74102, 74103)

Condition Categories are mapped to Hierarchical Condition Categories (HCCs). Most CCs are mapped to one HCC. However, if there are related CCs, an hierarchy is required. The HCC with the highest severity is used and the other HCCs are dropped.

Non related HCCs are added together to determine total risk of the enrollee along with other factors (age, sex, interactions and grouped HCCs)
EXAMPLES OF HCCs

<table>
<thead>
<tr>
<th>Diabetes with Chronic Complications - HCC 20</th>
<th>Amputation Status, Lower Limb/Amputation Complications – HCC 254</th>
</tr>
</thead>
<tbody>
<tr>
<td>24940 Sec DM renl nt st uncntr</td>
<td>V4970 Status amput lwr Imb NOS</td>
</tr>
<tr>
<td>24941 Sec DM renal uncontrld</td>
<td>V4971 Status amput great toe</td>
</tr>
<tr>
<td>24950 Sec DM ophth nt st uncn</td>
<td>V4972 Status amput othr toe(s)</td>
</tr>
<tr>
<td>24951 Sec DM ophth uncontrld</td>
<td>V4973 Status amput foot</td>
</tr>
<tr>
<td>24960 Sec DM neuro nt st uncn</td>
<td>V4974 Status amput ankle</td>
</tr>
<tr>
<td>24961 Sec DM neuro uncontrld</td>
<td>V4975 Status amput below knee</td>
</tr>
<tr>
<td>24970 Sec DM circ nt st uncntr</td>
<td>V4976 Status amput above knee</td>
</tr>
<tr>
<td>24971 Sec DM circ uncontrld</td>
<td>V4977 Status amput hip</td>
</tr>
</tbody>
</table>

Enrollee Info: Adult Male, Age 35, Platinum Plan
Diagnosis Codes: 51901, 03812, 49382, 72886, 7991, 33181
1. Apply Age/Sex filters on dx codes - Dx 33181 is excluded (patient is too old for this dx)
2. Map Condition Categories:
   51901 \(\text{CC125}\); 03812 \(\text{CC2}\); 49382 \(\text{CC161}\); 72886 \(\text{CC54}\); 7991- \(\text{CC126}\)
3. Map Hierarchical Condition Codes:
   CC125 and CC126 \(\text{HCC125}\) (drop CC126)
   CC2 \(\text{HCC2}\); CC161- \(\text{HCC161}\), CC54- \(\text{HCC54}\)
4. Apply Interactions, Demographic Factor to get subtotal enrollee risk score for plan metal level and multiply by CSR factor for Total Risk Score:
   \[\text{HCC 125} \times 40.054; \text{HCC2} \times 13.696; \text{HCC54} = 0; \text{HCC161} = 0\]
   \[\text{G03} \times 7.878; \text{G15} \times 1.098, \text{Severity} \times 2.498; \text{Dem} \times .413\]
   \[40.054+13.696+0+0+7.878+1.098+2.498+.413 = 65.637\]
   \[65.637 \times \text{CSR Factor of 1.0} = 65.637 \text{Total Risk Score}\]
Plan Level Risk Score (PLRS) is the overall level of risk associated for each plan – it is the average enrollee risk score. Each enrollee’s risk score is multiplied by the number of member months for that enrollee in the plan. This amount is summarized for all enrollees of the health plan. This amount is divided by the sum of all billable enrollees multiplied by the number of months that billable members are enrolled in plan.

Once the plan risk score is calculated, a payment transfer formula is used to determine payments and charges assigned to each plan within a market.

Transfers are intended to bridge the gap between a plan’s actual revenue and what its revenue would be in the absence of risk selection.

Transfers will be calculated by June 30, 2015
Risk Adjustment Validation Audit is the process of validating the integrity and quality of the data used for risk adjustment.

All Health Plans must engage an independent auditor to conduct validation audits starting in the Fall of 2015 for 2014 data. Sample size includes 200 enrollees per issuer.

CMS will select a subsample of the independent auditor results and perform a second validation.

2014 and 2015 data will be audited but not adjusted.

2016 data used for risk adjustment will be reviewed and adjusted upon audit findings.
Chief Complaint: 58 year old male, c/o ear ache, R ear. ï Gold Plan

ROS (Review of Systems): pain in ear x 2 days. Ear feel plugged. Denies sore throat or fever.

PFSH (Past, Family, Social History): 1 year post MI-stable, no chest pain. Stable DM with neuropathy, reviewed home meter results. R BKA (Right below knee amputation) site without complications.

Observation: R TM (Temporal Membrane) red and fluid filled; Lungs- CTA; CV- RRR (Regular rate and rhythm; Skin warm day and intact; Eyes-PERRLA (Pupils Equal Round and Reactive to Light and Accomodation); Numbness in tingling in foot and hands remains unchanged.

Assessment/Plan: Continue on Novalog and Lyrica for DM and neuropathy; ABX for Otitis Media. RTC in 3 days if no improvement. Scheduled for routine check up in 3 months.
Coding Example One: What is commonly reported to the health plan by health care providers:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Code</th>
<th>HCC Code</th>
<th>Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Mellitus</td>
<td>250.00</td>
<td>HCC 21 - G01</td>
<td>1.199</td>
</tr>
<tr>
<td>Otitis Media</td>
<td>382.9</td>
<td>No HCC</td>
<td>0.000</td>
</tr>
<tr>
<td>Age/Sex Factor</td>
<td></td>
<td></td>
<td>0.736</td>
</tr>
<tr>
<td>No Severity Factors</td>
<td></td>
<td></td>
<td>0.000</td>
</tr>
<tr>
<td>Subtotal</td>
<td></td>
<td></td>
<td>1.935</td>
</tr>
<tr>
<td>CSR Factor 1.07</td>
<td></td>
<td></td>
<td>x1.070</td>
</tr>
<tr>
<td><strong>Total Risk Score</strong></td>
<td></td>
<td></td>
<td><strong>2.070</strong></td>
</tr>
</tbody>
</table>

Coding Example Two: What can be coded and reported to the health plan by providers:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Code</th>
<th>HCC Code</th>
<th>Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Otitis Media</td>
<td>382.9</td>
<td>No HCC</td>
<td>0.000</td>
</tr>
<tr>
<td>DM with Neuro</td>
<td>250.60</td>
<td>HCC 20 - G01</td>
<td>1.199</td>
</tr>
<tr>
<td>Neuropathy in DM</td>
<td>357.2</td>
<td>HCC 20</td>
<td>0.000</td>
</tr>
<tr>
<td>Long term Insulin use</td>
<td>V58.67</td>
<td>HCC 21 (included in HCC20)</td>
<td></td>
</tr>
<tr>
<td>Old MI</td>
<td>412</td>
<td>No HCC</td>
<td>0.000</td>
</tr>
<tr>
<td>BKA status</td>
<td>V49.75</td>
<td>HCC 254</td>
<td>9.937</td>
</tr>
<tr>
<td>No Severity factor</td>
<td></td>
<td></td>
<td>0.000</td>
</tr>
<tr>
<td>Subtotal</td>
<td></td>
<td></td>
<td>11.872</td>
</tr>
<tr>
<td>CSR Factor 1.07</td>
<td></td>
<td></td>
<td>x 1.070</td>
</tr>
<tr>
<td><strong>Total Risk Score</strong></td>
<td></td>
<td></td>
<td><strong>12.703</strong></td>
</tr>
</tbody>
</table>
ACCURATE CODING - WHY IT MATTERS - CONTINUED

- Accurate coding makes a difference ᵃ 613% increase for this mocked up scenario.

- The increase in enrollee risk score will increase the plan level risk score and provide a more accurate estimate of the amount of $ required to take care of the enrollee in the calendar year.

- Accurate documentation and coding or lack thereof can have a substantial impact on the health plan and providers.
ACCURATE CODING - WHY IT MATTERS - CONTINUED

- Improves quality of care
- Improves coordination of care
- Increases probability of receiving health plan incentives
- Improves performance in risk and value based contracts
- Improves opportunity to participate in narrow provider networks
- Reduces audit risk
- Future methodology for health plan contracting
- Provides health plan with greater resources to assist providers
CODING AND DOCUMENTATION REQUIREMENTS

- Patient’s name and DOS must appear on all pages of the record.

- Encounter must be face-to-face.

- Conditions reported on the claim must be documented in the medical record and the documentation must support that the condition was monitored, evaluated, assessed or treated.
Entry must have health provider’s signature, credential and date.

Remember to document and code ostomies and amputation status.

Document and code to the highest level of specificity.
### CODING AND DOCUMENTATION OF OSTOMIES AND AMPUTATIONS

<table>
<thead>
<tr>
<th>Verbiage</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>... having problems managing colostomy, not able to change her bag because of her arthritis. Stoma pink...</td>
<td>V55.3</td>
</tr>
<tr>
<td>S/P colostomy, stable</td>
<td></td>
</tr>
<tr>
<td>... prosthesis fitting well. Skin on L leg old amputation site warm, dry and intact.....</td>
<td>V49.75</td>
</tr>
<tr>
<td>S/P Left BKA, stable</td>
<td></td>
</tr>
</tbody>
</table>
**History Of**

- Means that the patient no longer has the condition
- Or is no longer being treated for the condition
- Exception being amputations and ostomies
  - Code with the appropriate V code when attention is given to the artificial opening and/or the amputated limb
### EXAMPLES OF “HISTORY OF”

- **Not** Ṣ_history Ofọọ ṣọtọ ṣọtọ. ṣọtọ ṣọtọ. with illness or illness being treated

<table>
<thead>
<tr>
<th>Verbiage</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>H/O of COPD, well controlled with Advair</td>
<td>496</td>
</tr>
<tr>
<td>H/O Breast Cancer, mastectomy 3 months ago, continues with radiation treatment</td>
<td>174.9</td>
</tr>
</tbody>
</table>

- Ṣ_history Of Ṣọtọ ṣọtọ. ṣọtọ ṣọtọ no longer with illness or being treated for illness

<table>
<thead>
<tr>
<th>Verbiage</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>H/O Breast Cancer, 2 year survivor. Mammogram up to date. No longer follows up with oncologist. No lumps felt on exam of remaining breast.....</td>
<td>V10.3</td>
</tr>
<tr>
<td>.....history of colon cancer 5 years ago......</td>
<td>V10.05</td>
</tr>
</tbody>
</table>
In a physician or OP setting - do not code probable, suspected, possible, rule-out conditions

Instead code the condition to the signs and symptoms

<table>
<thead>
<tr>
<th>Documentation</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pt. has lower right quadrant abdominal pain, with nausea and vomiting.</td>
<td>Abd pain, RLQ – 789.03</td>
</tr>
<tr>
<td>Assessment: Possible appendicitis. Sent patient to the ER</td>
<td>Nausea and Vomiting – 787.01</td>
</tr>
<tr>
<td></td>
<td>Do not code appendicitis</td>
</tr>
</tbody>
</table>
Is your documentation sufficient to fund the care of your sicker patients?

Why it matters:
- accurate documentation and coding bring the correct amount of risk adjustment dollars to the health plan, giving you the provider - more resources to manage your patient population with targeted case management, population health management and assistance from the health plan
CHOOSING DIAGNOSIS CODES

- If the health care provider does not select his/her own codes, a joint effort with the health care provider and the coder assures accurate and complete documentation and coding.

- Annual code changes are effective October 1 through September 30 of the following year. Updates are usually automatic with an electronic record. With paper records, purchase a new ICD-9-CM book yearly.

- Always code to the highest level of specificity.
Calendar year is the reporting period

- Data extracted from claims (both UB and 1500)
  - FACE-to-FACE visit from the provider

- Data submitted to government

- Government communicates information back to Health Plan
Report all ICD-9-CM codes addressed at the time of the face-to-face visit.

Document all clinical findings in the medical record, it is the proof that supports the diagnosis codes reported.
Document the members health conditions/status in the medical record.

Accurate documentation and coding bring the correct amount of risk adjustment dollars to the health plan, giving you the provider - more resources to manage your patient population with targeted case management, population health management and assistance from the health plan.

Address all chronic conditions at least annually - being sure to code for all illnesses addressed at the face-to-face visit.

Code to the highest level of specificity.

If the patient has an ostomy or an amputation, be sure to code for those when you address them during your office visit.
For questions

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