Medicare Risk Adjustment (MRA)
RAF-HCC 101
Objectives

- Provide Overview of Medicare Risk Adjustment (MRA)
- Identify the role of Health Care Providers in the Medicare Risk Adjustment process
- Provide medical record documentation guidelines
Background - MRA

- The Centers for Medicare & Medicaid Services (CMS) Risk Adjustment Model ensures adequate resources to care for our high-risk Medicare Advantage members
- Mandated by the Balance Budget Act (BBA) of 1997
- Prior to Risk Adjustment, payments to MA plans derived principally from demographic information (age, gender, county of residence, Medicaid eligibility, etc.)
Background – MRA

- MRA Model ensures adequate resources to care for our high-risk Medicare Advantage members.
- MRA Model utilizes a reimbursement method commonly referred to as Risk Adjustment Factor-Hierarchical Condition Categories (RAF-HCC) to adjust capitation payments to health plans.
Reimbursement Model
ICD-9 to ICD-10 transition

- October 1, 2015
- Data collection year for risk scores used for Payment Year 2016 would use diagnoses from the prior calendar year (CY2015)
- CMS will use the following when calculating PY2016 risk scores
  - ICD-9 codes were used for dates of service: January 1, 2015–September 30, 2015
  - ICD-10 codes are used for dates of service: October 1, 2015–December 31, 2015
Reimbursement Model RAF-HCC

- 2014 Model - 79 HCC’s and over 8830 ICD-10 Diagnosis codes that currently risk adjustment

- 2016 Payment Year model is based on 100% of the 2014 CMS-HCC model mappings known as V22.
Reimbursement Model RAF-HCC

The RAF score identifies the members health status and drives reimbursement.

Lower RAF score indicates healthier population

Lower RAF score may also indicate the following issues:

- Lack of adequate chart documentation
- Lack of complete and accurate ICD10 coding
- Patients have not been seen

Healthier Population
Reimbursement Model RAF-HCC

- Clinical encounter data is submitted to CMS by Health Plans or their Business Associates (BA) throughout the year

- Final submission for 2014 Dates of Service (DOS) due by the January 31, 2016.
What are the role of providers?

- Providers must report the ICD-10-CM diagnosis codes to the highest level of specificity
- This requires accurate and complete medical record documentation
- Accurate diagnosis code reporting and complete clinical documentation increases the accuracy of a patient’s RAF score
How it works

Each member is assigned a Risk Adjustment Factor (RAF)

- RAF is a numeric value assigned by CMS to identify the health status of a patient
Table 1. 2014 CMS-HCC Model Relative Factors for Community and Institutional Beneficiaries

<table>
<thead>
<tr>
<th>Disease Coefficients</th>
<th>Description Label</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCC1</td>
<td>HIV/AIDS</td>
<td>0.470</td>
<td>1.904</td>
</tr>
<tr>
<td>HCC2</td>
<td>Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock</td>
<td>0.535</td>
<td>0.575</td>
</tr>
<tr>
<td>HCC6</td>
<td>Opportunistic Infections</td>
<td>0.440</td>
<td>0.344</td>
</tr>
<tr>
<td>HCC8</td>
<td>Metastatic Cancer and Acute Leukemia</td>
<td>2.484</td>
<td>1.203</td>
</tr>
<tr>
<td>HCC9</td>
<td>Lung and Other Severe Cancers</td>
<td>0.973</td>
<td>0.674</td>
</tr>
<tr>
<td>HCC10</td>
<td>Lymphoma and Other Cancers</td>
<td>0.672</td>
<td>0.412</td>
</tr>
<tr>
<td>HCC11</td>
<td>Colorectal, Bladder, and Other Cancers</td>
<td>0.317</td>
<td>0.296</td>
</tr>
<tr>
<td>HCC12</td>
<td>Breast, Prostate, and Other Cancers and Tumors</td>
<td>0.154</td>
<td>0.198</td>
</tr>
<tr>
<td>HCC17</td>
<td>Diabetes with Acute Complications</td>
<td>0.368</td>
<td>0.474</td>
</tr>
<tr>
<td>HCC18</td>
<td>Diabetes with Chronic Complications</td>
<td>0.368</td>
<td>0.474</td>
</tr>
<tr>
<td>HCC19</td>
<td>Diabetes without Complication</td>
<td>0.118</td>
<td>0.182</td>
</tr>
<tr>
<td>HCC21</td>
<td>Protein-Calorie Malnutrition</td>
<td>0.713</td>
<td>0.399</td>
</tr>
<tr>
<td>HCC22</td>
<td>Morbid Obesity</td>
<td>0.365</td>
<td>0.579</td>
</tr>
</tbody>
</table>

[Complete 2014 CMS-HCC Model]
How it works

RAF scores are made up of the following criteria for each member:

• Demographic information including age and sex
• Medicaid status and if the patient was eligible for Medicare due to a disability
• Chronic conditions and a number of disease interactions
How it works

If two or more ICD-10-CM conditions are mapped to the same HCC category, will result in payment for only one and will be to the highest specificity code.
How it works

- Each diagnostic code falls into one Diagnosis Group and codes are grouped into Condition Categories

  DX A   
  DX B   
  DX C   
  HCC (A) → Risk Score → Reimbursement

  DX D   
  DX E   
  HCC (B) → Risk Score → Reimbursement

- CMS designed the equation so that the average Medicare FFS patient has the score of **1.00**
Examples of Diagnosis to HCC Mapping

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-10-CM</th>
<th>HCC</th>
<th>Risk Score</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes with Ophthalmologic Manifestation</td>
<td>E11.39</td>
<td>18</td>
<td>.368</td>
<td>$</td>
</tr>
<tr>
<td>Diabetes with Neurological Manifestation</td>
<td></td>
<td>18</td>
<td>.368</td>
<td></td>
</tr>
<tr>
<td>Diabetes with Circulatory Manifestation</td>
<td></td>
<td>18</td>
<td>.368</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-10-CM</th>
<th>HCC</th>
<th>Risk Score</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcoholism</td>
<td></td>
<td>55</td>
<td>0.420</td>
<td>$</td>
</tr>
<tr>
<td>Drug Dependence</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
How it works

Related codes from different categories will result in payment for only the most severe manifestation of a disease.

Example, an individual with diabetes that progresses over a year from having no complications (HCC19) to having acute complications (HCC17) would trigger the payments for HCC17 but not for HCC19.
How it works

Disease Interaction 2014 Model Community: Examples:

• Cancer and Immune Disorders
• Congestive Heart Failure and COPD
• Congestive Heart Failure and Renal Disease
• COPD and Cardiorespiratory Failure
• Sepsis and Cardiorespiratory Failure
• Artificial Openings and Pressure Ulcer
Documentation
Documentation Guidelines

Documentation And Coding Guidelines
It’s the Law!

Mandated by HIPAA
Documentation Guidelines

Per the ICD-10-CM Official Guidelines for Coding & Reporting:

- Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care, treatment or management.
Documentation Guidelines

• Do not code conditions that were previously treated and no longer exist.

• However, history codes may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.
Documentation Guidelines

- Patient’s name (on each page)
- DOS (on each page)
- A face-to-face visit
- Patient’s condition(s) must be documented
- Monitor, Evaluate, Address, Treatment (MEAT)
- Acceptable provider signature with credentials and date of authentication
Provider’s Role

• Documentation should demonstrate complete and concise picture of the patient’s condition

• Treatment /Plan should link conditions to medications

• Document all conditions that co-exist at the time of the visit and how they impact current care/treatment
Provider’s Role

• Providers must report the ICD-CM diagnosis codes to the highest level of specificity

• Excellent documentation is reflective of the “thought process” of provider when treating patients

• **Accurate** diagnosis code reporting and complete clinical documentation increases the accuracy of a patient’s RAF score
Coder’s Role

• When in doubt, query the provider, do not assume

• Know the ICD-10-CM Official Guidelines for Coding and Reporting results in accurate and complete coding
Why is complete documentation important?

- ICD10 Hepatitis C, unspecified (No HCC)
- ICD10 Hepatitis C, acute (No HCC)
- ICD10 Hepatitis C, chronic (HCC-29)
Why is complete documentation important?

• When a primary malignancy has been previously excised or eradicated from its site and/or there is no further treatment directed to that site and there is no evidence of any existing primary malignancy, a code from Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy.
Why is complete documentation important?

History of CA Vs. Current CA

• History codes should NOT be assigned if a prophylactic drug is given as part of current cancer treatment.

• In this case, the current cancer code should be assigned.

(AHA Coding Clinic, Fourth Quarter 2008 Page: 156-160)
M.E.A.T.

In order for CMS to make the payment, documentation submitted must be from a face-to-face visit and must indicate how the provider is treating, managing or addressing the chronic conditions.

<table>
<thead>
<tr>
<th>Language Samples:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment</td>
</tr>
<tr>
<td>Stable</td>
</tr>
<tr>
<td>Improved</td>
</tr>
<tr>
<td>Tolerating Meds</td>
</tr>
<tr>
<td>Deteriorating</td>
</tr>
<tr>
<td>Uncontrolled</td>
</tr>
</tbody>
</table>

Example of Acceptable Language

Ex: Diabetes type 2, stable well controlled on meds
Ex: COPD Stable on Advair
M.E.A.T.

- **Monitor:** B/P reading 120/80; HgbA1c 5.5; last lipid panel was within normal limits
- **Evaluate:** stump well healed, ostomy site w/o infection appears clean & dry
- **Address:** stable; controlled, worsening; unchanged, uncontrolled
- **Treatment:** taking Fosamax for osteoporosis; taking tamoxifen for breast cancer “treatment”, DM controlled on insulin
Acceptable Sources of Data

CMS only accepts diagnosis codes submitted from specific sources:

- Inpatient hospitalization
- Outpatient hospital services
- Physician office visits (Face-to-Face)
Excluded Sources of Data

- SNF
- Hospice
- Nursing Homes
- Lab
- Radiology
- Ambulance
- DME
- Ambulatory Surgery Centers
Unconfirmed Diagnoses

• Probable
• Suspected
• Questionable
• Rule Out
• Working

Condition(s) should be coded to the highest degree of certainty that is known at the time of the visit, such as symptoms, signs, abnormal test results, or other reasons for the visit.
Medical Record Documentation

Accurate coding begins with complete documentation.

- Consistent
- Concise
- Complete
- Clear
- Legible
Outcomes

Medicare Risk Adjustment supports achievement of “Triple Aim”

- Cost effective Care
- Quality Outcomes
- Patient Satisfaction
Purpose

- MRA is intended to redirect money away from MAO that would cherry-pick the healthier enrollees

- MRA is a way to provide MAO that care for the sickest patients the resources to do so
Purpose

• The ultimate purpose of the CMS-HCC payment model is to promote fair payments to MAOs that reward efficiency and encourage excellent care for the chronically ill.
Our Mission

Our non-profit mission is:

• We exist to make a difference in people’s lives through excellent patient care.
References

  

- ICD-9-CM Official Guidelines for Coding and Reporting
  

- ICD-9-CM HCC model mappings
  
Contact Information

Our goal is to help simplify and support accurate, complete, concise documentation and coding.

We are happy to help you!

Please contact us with any additional questions or comments

RAFOps@bannerhealth.com