Overview of the Risk Adjustment Process

Purpose of Risk Adjustment

Risk Adjustment was created in effort to appropriately pay Medicare Advantage Organizations (MAOs) for care provided to members based on the health status of the members. Each member receives a risk score from the Centers for Medicare and Medicaid Services (CMS) based on submitted claims and encounter data. Risk adjustment is used to pay MAOs more accurately for the predicted health cost expenditures of members by adjusting payments based on demographic factors and presence of disease conditions.

Data Submission Requirements

There are specific rules that govern MAO plan submission of data which are used in Risk Adjustment Scoring. Important considerations include:

- All diagnoses codes submitted must be documented during a “face to face” encounter and be clearly documented in the medical record
- MAOs may only use data from hospital inpatient facilities, hospital outpatient facilities, and physicians
- MAOs must follow ICD 10 coding guidelines
- MAOs must submit at least once for each member during the plan year and must ensure data is accurate
  - If after submission it is discovered that submitted data does not meet CMS requirements, the MAO must delete the previously submitted data
- CMS sends reports back after submission which must be reconciled and changes tracked

Risk Score Calculation

CMS calculates risk scores based on multiple criteria including demographic factors, enrollee status, and disease variables. Currently CMS is using two separate models and blends them to produce a final score. The two models are:

- CMS Hierarchical Condition Category (HCC) model, revised for 2017 PY
- Encounter Data System (EDS) model

In payment year (PY) 2017, CMS will blend two risk scores to produce a final score.

- 75% of the score comes from the HCC model
- 25% of the score comes from the EDS model

CMS is phasing out the CMS HCC model, replacing it with the EDS model. CMS believes the EDS model will supply more accurate and complete data. They will also use the encounter data for assessing quality, complexity, and effectiveness of care provided.
Physician Role

Physician data is critical for accurate risk adjustment. Physicians are the primary source of data for the risk adjustment score. Ensuring that the members have an **annual wellness exam and/or comprehensive preventive exam** is a crucial component in the risk adjustment process. This visit provides the opportunity to discuss current issues with the member and accurately document the complexity of current disease states. Think about using the **MEAT** acronym for documentation during each visit. This will help ensure the documentation will be adequate to meet the parameters of the CMS Risk Adjustment Data Validation (RADV) audit.

- **Monitor** – what conditions does the member have that require monitoring?
- **Evaluate** – what conditions are being evaluated? What complications are being evaluated?
- **Assess/ Address** – what conditions or complications are being assessed or addressed?
- **Treatment** – What treatment is new or ongoing for a condition? Is the treatment effective? What conditions are the treatment plans addressing?

VHP would like all new members to have their wellness exam within three months of becoming a member. This enables earlier management and documentation of conditions for the risk adjustment scoring. Because the wellness exams are so important, VHP has incentivized the visit for both the provider and the member. Providers potentially have the opportunity to be incentivized two ways for this visit above the contracted fee for service:

- Incentive for completion of the exam to include the list of assessments requested by VHP
  - The incentive is higher if the exam is completed earlier in the year
- There is an additional incentive for complete and accurate documentation along with accurate coding of the member’s current conditions and status on claims

There are some best practices and guidelines that will help with medical record documentation, and coding. Here are some that will help you stay compliant:

- Every visit within the medical record needs to contain a legible credentialed signature and date
  - Sign the documentation and include the patient’s name, date of birth, and date of service on every page of the medical record form
- Make sure your electronic health record (EHR) is authenticated or electronically signed
- The highest degree of specificity needs to be documented so the most precise ICD-10 codes may be assigned
- Make sure that the diagnosis codes being applied to the claim, have supportive documentation provided within the medical record
- Remember the MEAT acronym during a patient exam if diagnoses are being monitored, evaluated, assessed/addressed, or treated (MEAT), they can be coded and billed on the claim
- Status Codes and Chronic conditions need to be documented at minimum of once per year
- Visits are required to be face to face
- Conditions need to be in an assessment, and plan of action for follow up
- When writing medications, connect them to the diagnoses they treat
- Remember to always link casual relationships of diseases and their manifestations
Example: Diabetes with neuropathy, retinopathy, nephropathy

- Make sure the current conditions stay current, by using these words, stable, exacerbated, or referring the patient for the diagnosis
- Make sure history is historical by using healed, old, removed, or no longer being treated
- Arrows (←↑→↓) and or abbreviations are not an approved form of documentation for chart reviewers to use, please write out any abnormal labs that could be captured as diagnosis
  - Example: ↑ cholesterol should be elevated cholesterol or LDL value or XX
- Super Bills are not a good practice for billing, codes circled or written cannot be used
  - Coding requires a written diagnosis
- Remember to chart pressure ulcers along with the location and stage of the ulcer
- Drug and/or alcohol use instead of dependence is an important differentiating diagnosis for coding
- Outpatient Providers: If the following words/phrases are used with any diagnosis, that diagnosis will not be permitted to be coded and billed
  - Probable, Possible, Presumed, Likely, Suspect, Rule-out, Questionable, or any other uncertainty of the condition

The diagnoses tell a story about your patient from beginning to end, clear, concise, consistent, and complete documentation can only bring success to you as a part of our Risk Adjustment Program at VHP.

### HCC Financial Difference in Coding and Documentation Improvement

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Factor</th>
<th>Criteria</th>
<th>Factor</th>
<th>Criteria</th>
<th>Factor</th>
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<tbody>
<tr>
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<td>Conditions Coded with Poor and Incomplete Specificity</td>
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<td>Everything Coded Appropriately (Reviewed for Risk Adjustment)</td>
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<td>82 Year-old Female</td>
<td>.557</td>
<td>82 Year-old Female</td>
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<td>Medicaid Eligible</td>
<td>.179</td>
<td>Medicaid Eligible</td>
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<tr>
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<td>DM with Vascular Manifestations</td>
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<td>Vascular Disease (no complication)</td>
<td>.410</td>
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<td>Vascular Disease (no complication)</td>
<td>.299</td>
<td>ChF coded</td>
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<td>CHF coded</td>
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<td>No CHF Coded</td>
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<td>+ Disease Interaction = Bonus Factor (DM &amp; CHF)</td>
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<td>Per Member Per Month Payment (PMPM)</td>
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<td>Patient Total Risk Score</td>
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<td>Patient Total RAF</td>
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Audit Processes

Accurate documentation is critical in the delivery of high quality clinical care. Data validation ensures the integrity of you the provider, your place of employment, and the profession. Through the VHP audit process we will help you and your staff gain more knowledge of correct coding and documentation, which will in turn, bring more accurate financial revenue for your practice, and most important provide continuity of care to our patients so they receive the care they deserve. In addition to the official CMS RADV audit, VHP will conduct monthly audits for a multitude of different members including those who are high risk and/or have complex conditions.

Starting in late February, VHP will be requesting access to records for members who have had their annual wellness visit during the previous month. It will be important to appoint a contact person in your office for communication. We will provide a record review list to your contact person which will include the member names, identification numbers, dates of birth, and known dates of service. Additionally, we will request last year’s records for comparison of chronic conditions.

The purpose of the audit is multipurpose:

- To validate that all incentive items were covered in the annual wellness visit (see VHP Incentive Payment Plan for PCPs)
- To evaluate that the medical record documentation supports submitted diagnoses codes on claims present and past
- To determine if the member’s chronic conditions documented last year are addressed in the assessment and care plan for the current year

VHP employs a Certified Risk Adjustment Coding Auditor who will be reviewing medical records. Records may be securely faxed to the VHP office or the auditor may visit the office to abstract the data based on office preference. If you prefer the auditor to come on site, please note that if you are using electronic health records then, access will need to be granted in order to complete the audit. If you need any information from our staff to have temporary access granted, please feel free to reach out. Our contact information is listed below. Take into consideration the time frame it takes if access is needed, so that you can stay within the receipt of request days so you will still be eligible for the VHP incentive. We request that records be made available within 15 days of receipt of the request. VHP will maintain confidentiality and follow all rules related to protecting private information.

Important note:
During the CMS RADV audits, participation is mandatory and on a time sensitive schedule. Provider offices failing to meet the CMS requirements may be subject to VHP administrative actions including corrective action plans and possible termination from the network.
Risk Adjustment Incentives

VHP will encourage participation in the VHP *Clinical Documentation Improvement Strategy through* use of incentives for accuracy in coding and documentation and their participation in the VHP program. Incentives include:

- Timely access to records for data validation
  - Number of records made available to VHP within **15 days of request**
- Accuracy with audit
  - Member audits performed by the plan on high risk patients that are **100% complete** in medical record documentation and coding (no requests needed for data addendums)
  - This will be audited only after completion of the annual comprehensive / preventable exam
- Collaborative efforts in **submitting appropriate data edits** and addendums which were discovered in medical record review
  - 100% completion of requested addendums within 60 days of notice

Incentives will be paid on a quarterly basis in conjunction with the VHP Provider Incentive Program for Stars Improvement.

Provider Office Reports and Dashboard

VHP will provide a quarterly report in a dashboard format to each provider and group. The report will contain the following:

- Projected risk score by member for those assigned to the practice based on currently submitted claims and encounter data
- A list of members that may have risk gaps
- Summary of incentives earned to date

Access to a Certified Risk Adjustment Coding Auditor

VHP provides access for questions, education, and assistance to a Certified Risk Adjustment Coding Auditor. Please use the contact information below for assistance.

Concurrent Stars Measure Data Collection

In addition to conducting chart audits for risk adjustment, the auditor will also collect data for the VHP Stars Management Program. By completing both audits at the same time, we feel the process will be more efficient for both the office and VHP. Here is the list of **Stars Measures** that will be reviewed during the audit:

- Date of breast cancer screening
- Date and type of colorectal cancer screening
- Vaccination status for both influenza and pneumonia
• BMI assessment
• Diagnosis of Diabetes and care inclusive of each of these:
  o Most recent A1c level
  o Evidence of kidney disease monitoring
  o Dilated eye exam
  o Medications to include statin therapy
  o Most recent blood pressure
• Diagnosis of Rheumatoid Arthritis and review of medications for treatment
• Listing of all current acute conditions
• Listing of chronic conditions from the member history
• List of all conditions coded at the annual wellness visit and/or any other visits within the year
  (HCC coding purposes, matching to the member history)
• Listing of all medications including any documentation of barriers to medication adherence

Questions or Comments?
Please feel free to contact VHP with any questions or comments regarding our efforts to ensure safe,
quality care for our members.

Dr. Josh Bennett
Interim Chief Medical Officer
Jbennett@vibrahealthplan.com
717-510-6205

Ali Mullikin
Stars Improvement Consultant
Amullikin@vibrahealthplan.com
717-510-6263

Karen Snyder, RN, MSN
Director of Quality
Ksnyder@vibrahealthplan.com
717-510-6229

LaShawn Hall
Certified Risk Adjustment Analyst
Lhall@vibrahealthplan.com
717-510-6230

References:
