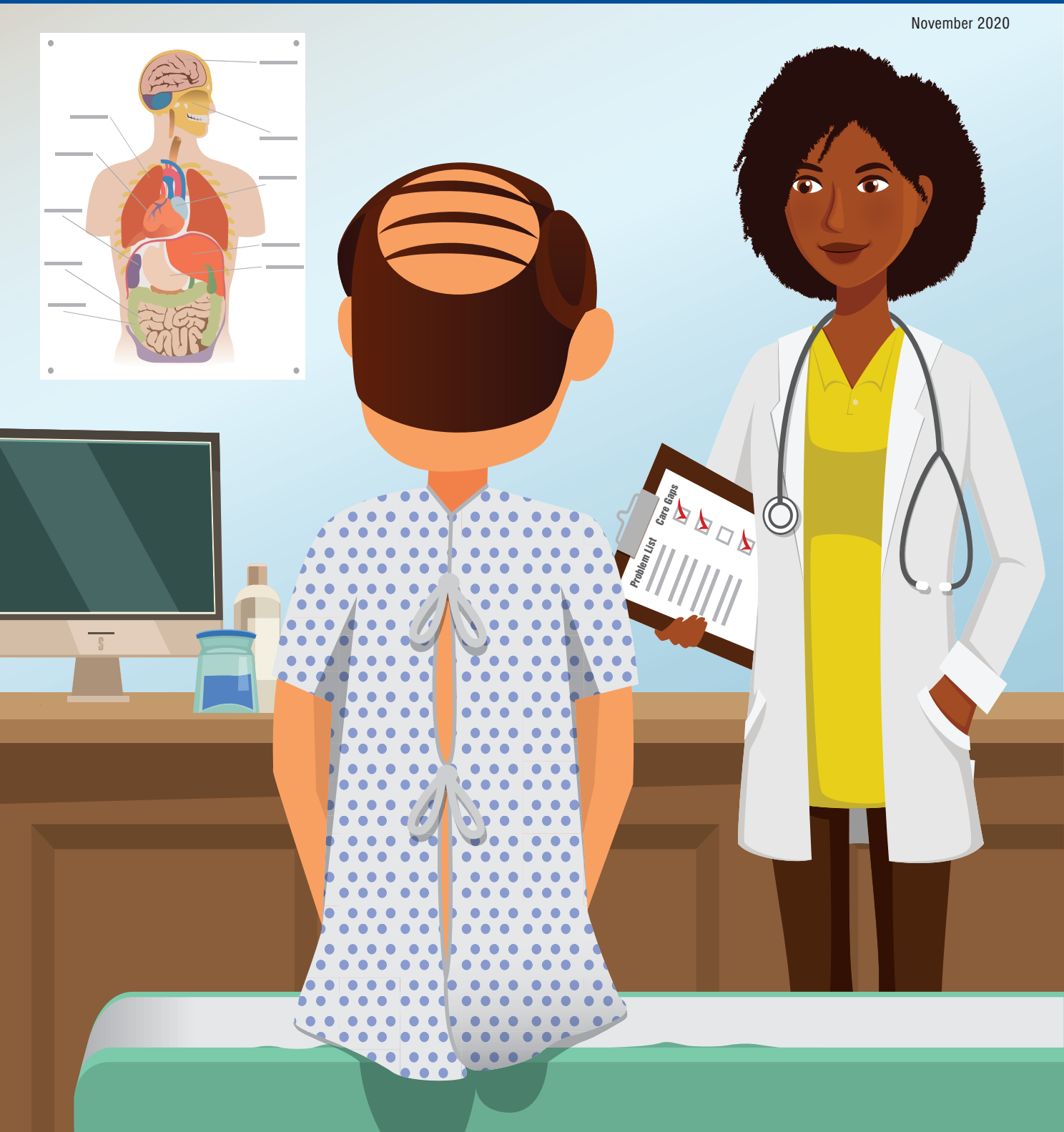
FROM THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

UNDERSTANDING AND IMPROVING RISK ADJUSTMENT IN TEAM-BASED CARE

November 2020



AAFP

Predicting Health Care Costs

Risk adjustment is an actuarial tool to predict health care costs. Hierarchical condition category (HCC) coding is a risk-adjustment model created by the Centers for Medicare & Medicaid Services (CMS) to estimate future health care costs for patients.

The ICD-10 coding system classifies the diagnoses, signs, and symptoms that physicians and other health care professionals use to code and bill for health care services. There are more than 70,000 ICD-10 codes, with more than 9,700 mapped to an HCC.[1,2]

CMS maps an ICD-10 code to exactly one HCC to assign risk scores to patients.[3] Not all ICD-10 codes map to an HCC. Payers assign patients a risk-adjustment factor (RAF) using HCC scores and demographic factors, such as age and gender, which factor into the calculation. Put more simply, a diagnosis gets an HCC score, while a patient receives a RAF made up of HCC scores. Algorithms then allow payers to use a patient's RAF to predict costs.[4] Typically, higher costs would be predicted for sicker patients and lower costs for healthier patients.[3,4]

For most payers, a risk score of 1.000 is an average patient. Medicare calculates a beneficiary's RAF on an annual basis or cost per beneficiary per year. For example, if the RAF for your patient is 1.000, Medicare would expect to spend $10,000 on that patient. If your patient had an RAF of 1.100, Medicare would expect to spend $11,000 ($10,000 x 1.100). This method of cost prediction is used by the Medicare and Medicare Advantage programs.

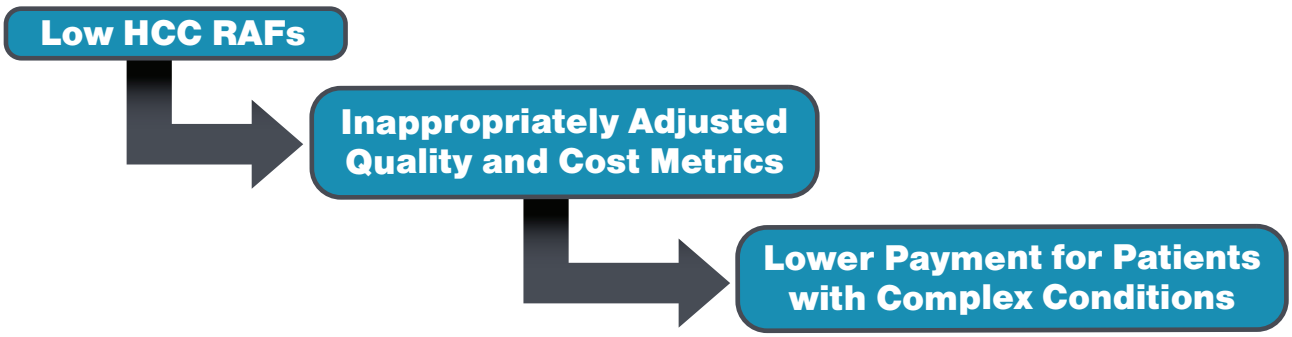
Commercial payers sometimes use Clinical Risk Groups (CRG) to predict cost.[5] In one Midwest area for one payer, a CRG of 1.0 equals $450 per patient per month (PMPM), or $5,400 annually per patient. A CRG of 1.1 for this payer equals $495 PMPM, or $5,940 annually.

Risk Adjustment in Value-based Payment (VBP)

Risk adjustment has taken root in value-based payment (VBP) contracts. HCC coding explains patient complexity and paints a picture of the whole patient. In addition to predicting health care resource utilization, RAFs are used to risk adjust quality and cost metrics.

In a VBP arrangement, if the RAFs for patients attributed to a practice are inaccurate, there are downstream effects.

Downstream Effects of Inaccurate RAFs



Accounting for differences in patient complexity means your quality and cost performance can be more appropriately measured. This leads to better compensation. For example, in the Center for Medicare & Medicaid Innovation's CMMI's new Primary Care First (PCF) model, practices receive a risk-adjusted population-based payment (PBP) based on the average HCC RAF of all attributed beneficiaries. The difference in revenue to a practice with an average HCC RAF of 1.190 compared to 1.210 for 300 attributed beneficiaries is more than $60,000 annually. Many commercial payers have also begun offering risk-adjusted contracts with partial- and/or full-capitation options.

Example of Monthly and Yearly Primary Care First Population-based Payment

Patient Group	Monthly Primary Care First Population-based Payment	Yearly Primary Care First Population-based Payment
Group 1 (HCC <1.2)	$28 PMPM x 300 = $8,400	$100,800
Group 2 (HCC 1.2-1.5)	$45 PMPM x 300 = $13,500	$162,000

Strategies for Success

Finding success in the VBP environment requires a commitment to appropriate coding, proper diagnosis, and effectively using data. However, the payoff for your practice can be immense by increasing your revenue and improving patient care and staff satisfaction. Use the following strategies to thrive in VBP and risk-adjustment models.

Schedule more frequent primary care touches

If the care for your patients is thorough and focuses on prevention, the chance of patients visiting a hospital (i.e., emergency room or inpatient) is much lower. This care can occur through many modalities, including physician, nursing, or integrated behavioral health visits; clinical pharmacy appointments for patients on five or more prescriptions; and/or appointments with a social worker. Increased primary care touches provide multiple opportunities to accurately capture diagnoses to ensure adequate payment in risk-adjusted payment arrangements.

Code appropriately with supporting documentation

Many physicians were trained to code for evaluation and management (E/M) services, but they received little information on HCC coding. With the implementation of ICD-10, this problem was magnified with more than 9,700 ICD-10 codes being assigned an HCC weight. Coding is a team sport and includes the physician, coder, certified medical assistant, nurse, and any other team members in contact with the patient. While only physicians and clinicians can make a diagnosis, the whole care team can ensure it is documented appropriately. Educating the care team about HCC coding and recording the appropriate diagnosis is fundamental to success in a VBP program.

Use the data available to you

Depending on your electronic health record (EHR), you can pull data on certain diagnoses during the past two to three years and determine if all lifelong diagnoses are recorded (e.g., below knee amputation [BKA]). You can review all patients on anti-estrogen or anti-androgen medication to make sure they have a cancer diagnosis, if appropriate. While certain cancers (e.g., prostate, breast, colon) do not have an associated HCC if the patient is not being treated for that condition, other cancer diagnoses, such as melanoma and lymphoma, stay with the patient for life. You can look at all patients with a body mass index (BMI) >40 kg per m^2 to see if they have a morbid obesity diagnosis. Data from your EHR or a health information exchange (HIE) can help you appropriately code your patients' conditions. Once you have identified patients with lifelong or current diagnoses that need to be accounted for during the present year, your care team can reach out to schedule an appointment to close any existing care/quality gaps or for an Annual Wellness Visit (AWV).

Utilize the Annual Wellness Visit for Medicare patients

There are certain times when recording all the diagnoses of a patient is appropriate. For Medicare patients, this occurs at an AWV. A retrospective study of accountable care organizations (ACOs) in one national network of independent practices examined the impact of the AWV on quality and cost for patients who had an initial AWV and those who never had an AWV. Over an 11-month period, the AWV was associated with a $38 PMPM decrease in costs ($456 annually) for all patients and a savings of $81 PMPM ($972 annually) for patients in the top HCC risk quartile.[6] This suggests the AWV is an opportunity to provide high-quality care, contain costs, and ensure patient care occurs in the primary care setting.

Understand the nuances of diagnoses

Certain diagnoses, such as an acute myocardial infarction, are transient and can only be coded for a short period of time. Other diagnoses, such as a BKA, are for a lifetime. Some diagnoses are long term but not lifelong, such as when a person is on an anti-estrogen medication for breast cancer. This patient is considered to have a breast cancer diagnosis until the medication is stopped. If there is no sign of breast cancer, the diagnosis then becomes a history of breast cancer with no associated HCC score. Increased specificity in diagnosis, when clinically appropriate, can sometimes lead to increased HCC scores, as with a diagnosis of diabetes with complications. Some diagnoses are size- or grade-dependent, such as skin ulcers or cancers. Every appropriate diagnosis must be addressed and recorded at least once a year and sometimes twice a year for some commercial payers. If a patient has had a BKA, but it was not recorded in a given year, the payer may assume the leg grew back, which clearly is not possible.

Foster a culture of ownership and autonomy with your care team

In the past, the physician was directing or providing nearly all the care for the patient. More recently, the primary care physician directs a more diverse care team working at the top of their training to care for a population of patients. This requires several actions by the care team. The team must have data for the whole population and use these data to proactively reach out to patients to close care gaps and identify patients who may need increased care management and coordination services. The team must focus on the needs of their whole population, continually monitoring quality and safety. Additionally, the care team can ensure the problem list is current, including new diagnoses by specialists and hospitalizations, as this can be a useful tool when monitoring HCC capture throughout the year.

Bringing Value to Your Patients and Practice

Family medicine is the one medical specialty that cares for a population for a lifetime and family physicians are trained in the importance of behavioral and mental health, family dynamics, and social determinants of health (SDoH). Under fee-for-service (FFS) payment, family physicians and their care teams are not compensated for the value they bring to their population. Understanding and appropriately using HCC coding, while providing sophisticated primary care, will improve your patient panel's health and satisfaction, and appropriately compensate you for the savings your team provides. This accomplishes the quadruple aim of health care: better health of the population, better patient satisfaction, lower total cost of care, and better primary care team satisfaction.

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