RISK ADJUSTMENT – THE EARLY WARNING SYSTEMS
AGENDA

- Where can we find early detectors of a possible member that can have one or more HCC be found?
- What tools do we need to have an early warning system?
- Do claims really tell the Risk Adjustment Story?
- Is Enrollment/Eligibility a driving factor of your true risk score?
- When can too much data be too much data?
WHAT IS RISK ADJUSTMENT?
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- Risk Adjustment (RA) is the payment methodology that the Centers for Medicare and Medicaid (CMS) uses to pay Medicare Advantage (MA) plans for taking financial risk and administering benefits to MA members.

- The methodology takes into consideration the member’s demographic data (age, sex, Medicaid status, etc), as well as their health risk, based off of diagnostic data.

Of the 15,000+ diagnosis codes, only about 3,100 are relevant to the Part C payment model.
Example #1

Maria is 65 – has Rheumatoid Arthritis but is otherwise healthy. She is not low income

Female age 65-69 = .312
Rheumatoid Arthritis HCC 40 = .423

**Total Unadjusted Risk Score = .735**
(Sum of the total Risk Score Factors before Coding intensity)

Capitation Rate for New York

\[ \$790.52 \times .735 = \$581.03 \]

\( -$33.91 \)
(Reduction of payment after the 2018 Coding Intensity Adjustment of -5.91% that reduces the risk score to .692)

**Final Risk Score Payment**

\$547.04

Example #2

Philip is 88 – has diabetes, macular degeneration, lung cancer and is depressed, low income and is Dual Eligible

Male Age 85-89 = 1.009

Philip is 88 – has diabetes, macular degeneration, lung cancer and is depressed, low income and is Dual Eligible
Diabetes with chronic complications HCC 18 = .346
Lung Cancer HCC 9 = .973
Major Depressive Disorder HCC 58 = .444
Exudative Macular Degeneration HCC 124 = .278

**Total Unadjusted Risk Score = 3.050**
(Sum of the total Risk Score Factors before Coding intensity)

Capitation Rate for New York

\[ \$790.52 \times 3.050 = \$2,411.09 \]

\( -$142.30 \)
(Reduction of payment after the 2018 Coding Intensity Adjustment of -5.91% that reduces the risk score to 2.870)

**Final Risk Score Payment**

\$2,268.79
DATA CHECKLIST

Data Sources
- **Claims** – as up-to-date as possible to ensure chasing with a purpose
- **Provider Information** – more on this later
- **Member Data**
  - Accurate eligibility information
  - HRAs
  - Plan website data
  - Smartphone Apps
- **Laboratory Data** - highlights conditions and helps with gaps
- **Pharmacy Data** - highlights conditions, comorbidities, and inferred conditions
- **Intervention Data**
  - IHAs feeding Retrospective
  - In-Office feeding Quality
  - Retrospective feeding Education

Non-Traditional Data Elements
- Dosage/Refill information
- Provider Specialty
- Disease Management

Data Levers to Consider
- Confidence Ranges
- Condition-Level Data
- Confidence-Adjusted Impacts
- Provider Cooperation Levels
- Provider Location Options
- Geographic Options
- Co-morbidity Combinations
- Historical Patterns
Where can we find early detectors of a possible member that can have one or more HCC be found?

- Enrollment Data – Enrollment Data will have designations if the individual is ESRD or Aged and Blind
- ADT – Admission/Discharge and Transition – Notices for a hospital Inpatient Stay
- EMR – Electronic Medical Records
- Audits

But What About????????????

- Utilization Review Application? It captures data at the time of or before a service is performed.
Is Enrollment/Eligibility a driving factor of your true risk score?

✓ Is your Plan reconciling all of your MMR and TRRs?

✓ What does your Plan do with discrepancies?

✓ How do you capture demographics about each member?

✓ Does your system capture previous risk scores and have the ability to reconcile month over month?

✓ How does your plan make changes that were reported by the member?

✓ Are you submissions supporting changes month over month?

✓ Are you current with all of your reconciliation processes?

✓ Can you system target members who have only been on your plan for a short period of time?
Do claims really tell the Risk Adjustment Story?

✓ Are claims processes right the first time?
✓ What is your claims backlog?
✓ What is your first pass adjudication Rates
✓ How many claims contains supplemental data or need to be reprocessed?
✓ How tightly coupled is your claims system to your authorization system?

What happens when your claims do not contain the data needed for Risk Adjustment?

✓ How do you ensure an amputee has this diagnosis captured year over year?
✓ How do you factor for members who have been on your plan only a short period of time?
✓ How do you ensure that members who do not have claims history are in fact healthy and have not HCC Factors?
Provider scorecards are important, but how have you quantified past interactions with providers, groups, and facilities? Which activities worked?

Which locations won’t play ball without additional compensation?

What kind of additional value, if any, have past activities from that location produced?

What providers have received education or training on risk adjustment and which ones are new to the practice?

What are the current incentives? Are contractual elements in place with that provider or group?
When can too much data be too much data? Do you have Analysis Paralyses? Jonas to add a few more examples.

✓ Have you ever felt like you were trying to find a needle in a hay stack looking for one diagnosis?

✓ Has your organization been through a CMS Audit and as you look across the sea of data you realize that you have just taken every tree from Sherwood forest to product your audit results?

✓ Have you every asked your IT Team to run a data comparison of your HCC Risk Scores from previous years and compare to this year, only to find that program has now been running since last week and it is still not completed?

✓ Does your team know what are the key component of the Risk Adjustment Eco System?
Simple rules are easy to design but don’t bring in nuanced elements of healthcare.

Many Americans have a cycle to their healthcare. *Identify their patterns of behavior and adjust your expectations.*

Provider behaviors are even more reliable than members’ behaviors. *Evaluate their coding patterns.*

When did you last evaluate the performance of your rule set? Who evaluated them?

How transparent are your vendors in proving their rules are evaluated and updated?

What is the yield of those rule sets (by condition) over time? If you aren’t averaging above $400/chart in Medicare and $250/chart in ACA, your rules need a major overhaul.
What tools do we need to have an early warning system? (Merge Data Points)

- Risk Adjustment Score Application
- Analytics based Utilization Management System
- Continual Analytics – Run Early and Run Often – Agreed upon Frequency
- Data Eco System
- Strong Enrollment Application
- Advanced Claims System
- Intelligent Utilization Management and Case/Management System
- Staff who understand the complex HCC and Risk Adjustment Rules and Guidelines

Let’s start with a checklist of things to ask your vendor or internal team:

- What data elements do you need? Critical vs non-critical
- How quickly can you map the data needed from your data warehouse?
- What frequency do you plan to run analytics on your population?
- How much time do you need to review a suspect list once produced? Who?
- Should you consider merging multiple initiatives?
- What unique things about your population, leadership, or organization should you think about in presenting findings, impacts, and reporting?
2018 TRENDS

Coordinate Your Activities
- Earlier Retrospective activities
- Multi-faceted approaches to chart reviews
- Limited IHA activities, Increased Provider activities

Fill Data Gaps
- More interactions with the data warehouse team
- Lab Results, Rx Frequency, SmartPhone App Usage, DM
- Using historical behavior patterns

Demand Report Transparency
- Location-based information
- Real-time tracking
- Excel is out, Tableau/PowerBI are in
THOUGHTS ON THIS STATEMENT?

For 2019 CMS will use the updated CMS-HCC model without count variables for the blended risk score calculation. Therefore, for 2019 CMS will calculate risk scores as proposed, but with the updated CMS-HCC model without count variables. Specifically, CMS will blend 75% of the risk score calculated with the 2017 CMS-HCC model, using diagnoses from RAPS and FFS, summed with 25% of the risk score calculated with the updated CMS-HCC model without count variables, using diagnoses from encounter data, RAPS inpatient records, and FFS.

RxHCC Risk Adjustment Model will not implement the updated model in 2019. They will continue to use the RxHCC model used in 2018, as published in the 2018 Rate Announcement.

CMS will calculate 2019 risk scores by adding 25% of the risk score calculated using encounter data (supplemented with RAPS inpatient data) and FFS diagnoses with 75% of the risk score calculated using RAPS and FFS diagnoses.

ESRD model gets its first update since 2012.

Does it resonate within your organization?

What does your organization see as new trends for 2018/2019?

What are you planning for?
Is your organization leading a quest toward a Risk Adjusted Healthcare Ecosystem?

- Plans need to be actively engaged in identifying and documenting beneficiary health conditions in order to initiate early intervention and slow disease progression.
- Plans need to emphasize preventive services and primary care. Primary care teams coordinate care for beneficiaries and work to ensure proper screening and disease management particularly for those with chronic conditions.
- Plans offer services specifically designed to help beneficiaries with chronic conditions stay as healthy and active as possible. Through robust health information technology platforms and programs that coordinate care for beneficiaries who have multiple health conditions, Plans need to work even harder to ensure that chronically ill beneficiaries receive the most clinically appropriate care.
- Data needs will continue to become more advanced and the focus of understanding the EDI transactions may result in plans losing millions of dollars in payments due to error reports that have not been reconciled or data that has fallen into the data gap abyss.
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