### Introduction

The rapid adoption of new payment models across the United States health care system presents profound challenges and opportunities for primary care. The success of this transformation requires highly committed, well-informed, and engaged primary care providers that effectively embrace the underlying principles of population health. One opportunity for primary care providers to enhance their performance involves the accuracy of the risk adjustment that applies to their patients. Over the past 15 years, there has been rapid growth in the number of Americans enrolled in health plans that incorporate risk adjustment into their payment methodologies, including Medicare, Medicaid, state and federal Health Insurance Exchange products, and commercial health plans. In addition, risk adjustment will play an important role in the quality and cost measures used by Medicare as part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

This article focuses on the risk adjustment methodology used by Medicare Advantage (MA) plans, which are private insurance options offered under Medicare Part C. This is important for primary care providers for several reasons. First, enrollment in Medicare Advantage plans has tripled to 17.6 million beneficiaries from 2004 to 2016. Approximately 31% of all Medicare beneficiaries are enrolled in one of these plans. These plans receive monthly, capitated, risk-adjusted payments from Medicare based on Hierarchical Condition Category (HCC) codes. These codes, which represent a select group of almost 9,000 ICD 10 diagnoses, estimate the likelihood of patients utilizing health care resources in the future. The HCC codes are given different numerical weights, with higher values indicating greater illness complexity. These codes are also used to severity adjust CMS’s quality and cost measures, making accurate risk adjustment a prerequisite for proper outcome measurement.

The majority of these HCC codes are submitted by primary care providers, and must be submitted once each calendar year, based on face-to-face encounters between patients and either physicians or a limited number of other care providers, such as nurse practitioners and physician assistants. The visits may occur in the outpatient office, the emergency department, or during an inpatient stay. Each HCC code must be supported by a specific diagnosis and its associated status and plan both clearly documented in the medical record. Several sources can be used to complete the proper clinical documentation for this coding model. These include hospital data (inpatient and outpatient services), diagnostic reports, as well as records from other medical services (physical therapy, occupational therapy and pathology).

Each Medicare beneficiary is assigned a total Risk Adjustment Factor (RAF) score that is comprised of a demographic RAF and an HCC RAF. The demographic RAF is based on age, gender, and a limited number of other factors, such as Medicaid enrollment and the presence of disability. The HCC RAF is the numerical sum of the individual RAF assigned to select acute and chronic medical conditions they experience. The total RAF from one year determines the payment made by Medicare during the subsequent year. Improvements in the accuracy of HCC coding can lead to large increases in HCC RAF scores that greatly influence reimbursement and the accuracy of risk adjustment. The accompanying table demonstrates the significant impact of more specific and comprehensive coding on the total RAF, using a patient with type 2 diabetes mellitus and common comorbid disorders as an example.

Prior experience indicates that certain disease categories represent more frequent opportunities to improve coding, including cardiovascular, pulmonary, endocrine, renal, hematologic, oncologic, nutritional, and behavioral health disorders.

A variety of approaches are used by payers and providers to improve their HCC coding. For example, health plans often hire intermediaries to analyze claims and clinical data in order to identify patients with significant coding opportunities and perform outreach to physicians to get them to submit the desired documentation. In some instances, payers are reaching out to patients directly, including arranging home visits to address potential coding opportunities. Medical groups can utilize information provided by payers or derived from their electronic medical records and practice management systems to identify coding opportunities. These can be converted into patient-specific coding alerts that offer guidance to physicians at the point of care. Some electronic medical continued on page 2
SHARE

HEALTH POLICY CORNER
continued from page 1

SHARE records have embedded processes that facilitate accurate HCC coding. Provider groups have also hired personnel with expertise in coding to assist physicians and numerous companies offer coding services to assist practices in these efforts. Performance measures related to clinical documentation quality improvement can be used to measure and track improvements over time. Some payers and provider organizations provide financial incentives for physicians to submit the more appropriately specific documentation.

Efforts to improve the accuracy of HCC coding and risk adjustment have several potential advantages, including the following:

- an enhancement in the engagement of providers to build comprehensive patient profiles and maintain accurate problem lists;
- an increased physician understanding of risk levels within their medical panels;
- a reduction of diagnostic gaps; and
- an encouragement of regular visits by patients to the medical practice.

These risks scores can identify patients who would benefit from more intensive care management interventions, allowing organizations to proactively plan and deploy the practice resources across different practice sites. More accurate risk adjustment allows medical groups to highlight the quality care they provide and identify opportunities to further improve the services they deliver.

However, on the downside, to improve the specificity and comprehensiveness of coding present challenges for primary care physicians. Identifying the correct code and providing the appropriate documentation requires focused effort by physicians who may already be beleaguered by other clinical and administrative demands. At times, it may be difficult for primary care physicians to code at the desired degree of specificity, particularly when specialists do not share the same medical record or important elements of care are delivered at other institutions. To avoid creating and perpetuating inaccuracies in the medical record, physicians must only code to the level of specificity that is supported by the available clinical data.

It is important to recognize that primary care providers traditionally have not received sufficient training in past or current health care payment systems. The consequence of this educational gap is that many primary care providers have a limited understanding of coding guidelines and the restrictions placed upon the billing personnel reviewing their medical records. This lack of focus on payment systems and coding creates a significant degree of reluctance among some primary care

continued on page 3

<table>
<thead>
<tr>
<th>ICD 10 Code</th>
<th>RAF*</th>
<th>ICD 10 Code</th>
<th>RAF*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographic RAF</td>
<td>0.395</td>
<td>Demographic RAF</td>
<td>0.395</td>
</tr>
<tr>
<td>E11.9: Type 2 diabetes mellitus without complications</td>
<td>0.104</td>
<td>E11.22: Type 2 diabetes mellitus with diabetic chronic kidney disease</td>
<td>0.318</td>
</tr>
<tr>
<td>N18.9 Chronic kidney disease, unspecified</td>
<td>0.000</td>
<td>N18.4: Chronic kidney disease, stage 4</td>
<td>0.237</td>
</tr>
<tr>
<td>E66.9: Obesity unspecified</td>
<td>0.000</td>
<td>E66.01: Morbid Obesity</td>
<td>0.273</td>
</tr>
<tr>
<td>F32.8: Other depressive episodes</td>
<td>0.000</td>
<td>F32.1: Major depressive illness, single episode, moderately severe</td>
<td>0.395</td>
</tr>
<tr>
<td>I25.9 Chronic ischemic heart disease, unspecified</td>
<td>0.000</td>
<td>I25.119: Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris</td>
<td>0.140</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>0.499</td>
<td><strong>Total</strong></td>
<td>1.758</td>
</tr>
</tbody>
</table>

**Payment Year 2017, Average Total RAF FFS Medicare is 1.000**
providers to engage in efforts to improve risk assessment.

Submitting HCC codes with higher value that are not medically appropriate or supported by required clinical documentation violates coding rules and may be considered upcoding. CMS performs Risk Adjustment Data Validation (RADV) audits to confirm the accuracy of coding and to detect fraudulent behavior. The risk scores of patients enrolled in Medicare Advantage plans has been estimated to be 6.4% higher than those in traditional Medicare. This likely reflects providers attempting to document more accurately so their risk scores accurately reflect the medical complexity of their patients. Some have viewed this difference as unwarranted upcoding.

Conclusion

Primary care physicians are uniquely positioned to drive improvements in risk adjustment. This is a required core competency as our health systems transform and adopt value based payment models. Efforts to educate PCPs about HCC coding and the risk adjustment methods used by other payers should be prioritized and clinicians encouraged to develop improved approaches to accurately capture relevant data using processes that improve care and mitigate bureaucratic busy work. This content should be included in the population health curriculum for medical residents, so they leave residency with the necessary knowledge and experience. Current information technology, data analytic tools, and employees with expertise in risk adjustment must be deployed to assist practices in their efforts to enhance the accuracy of clinical documentation and coding. Engaged and knowledgeable primary care physicians will augment the integrity of the medical record and improve the accuracy of risk adjustment leading to more appropriate severity-adjusted reimbursement, more accurate performance results on quality and cost, and more effective outreach to high risk patients who will benefit from more intensive disease management approaches.

References