

Risk Adjustment and Coding

Introduction to Risk Adjustment and Why it Matters



What is risk adjustment?

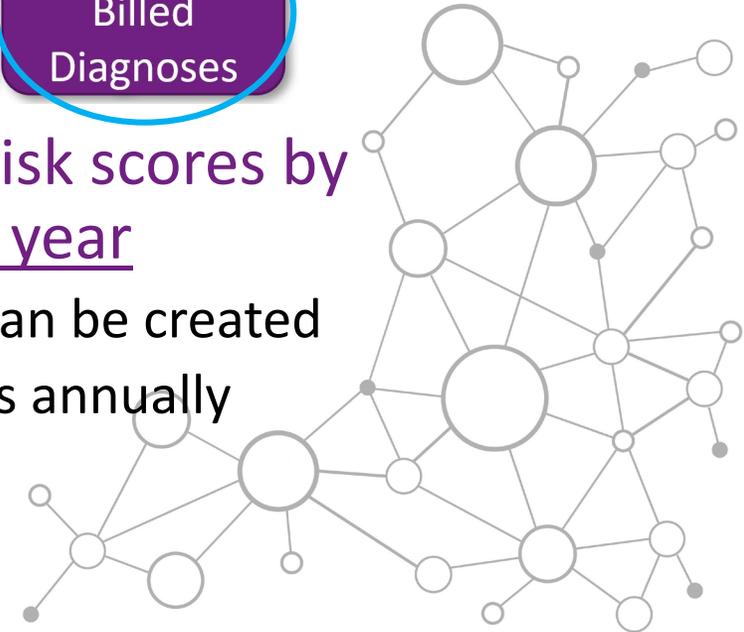
➤ **Risk adjustment** is a calculation of how complex our patients are. It is used by payors to estimate or predict the future healthcare costs of that patient population, and therefore plays a role in how our medical cost budgets are set.

➤ A patient's **Risk Adjustment Factor (RAF)** is based on six components:



➤ Providers play an important role in ensuring accurate risk scores by **documenting and coding ALL chronic conditions every year**

- Risk scores reset every January 1st so a new annual budget can be created
- HCC % is used as an indicator of how well we code conditions annually

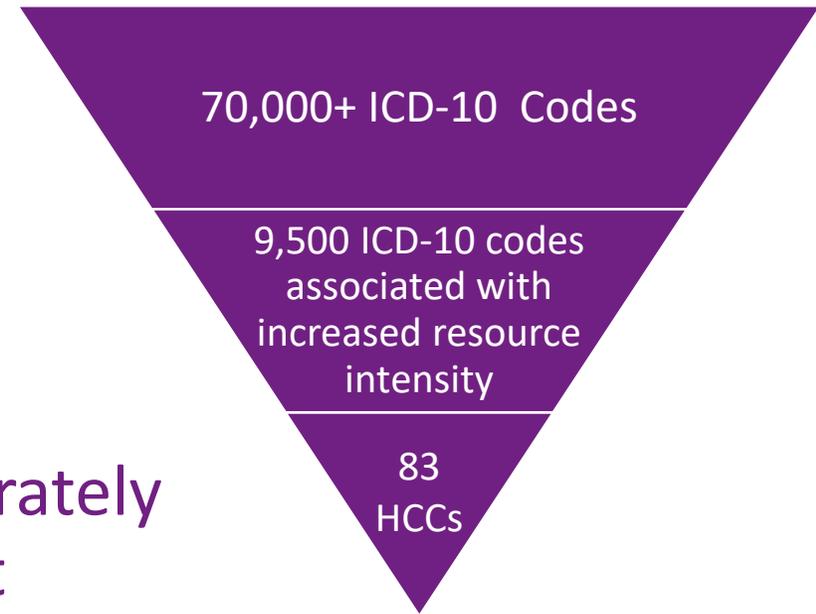


From ICD-10s to HCCs to RAF...

➤ Chronic conditions are grouped into Hierarchical Condition Categories (**HCCs**), each with a weight that contributes to a patient's **RAF**

- They are grouped by similar conditions that would require similar resource and cost needs

➤ Coding to the highest specificity is crucial to accurately capture the correct HCC and its associated weight



ICD-10 Code	Code Description	HCC	Weight
E11.9	Type 2 diabetes mellitus without complications	19	.106
E11.65	Type 2 diabetes mellitus with hyperglycemia	18	.307

Improvement in documentation for a single diagnosis can lead to nearly triple the HCC weight for this condition



Capturing the full medical complexity:

Member A		
Example 1 - All Conditions Coded	Example 2 - Some Conditions Coded	Example 3 - No Conditions Coded
Demographics	Demographics	Demographics
Female, 73 FB Dual, Aged 0.511	Female, 73 FB Dual, Aged 0.511	Female, 73 FB Dual, Aged 0.511
HCCs	HCCs	HCCs
HCC 17 - Diabetes w chronic complications 0.346	HCC 19 - Diabetes w/o complications 0.097	
HCC 85 - Congestive Heart Failure 0.355	HCC 22 - Morbid Obesity 0.41	
HCC 22 - Morbid Obesity 0.41		
HCC 189 - Amputation Status 0.787		
Interactions	Interactions	Interactions
CHF - Diabetes Group 0.205		
RAF 2.614	RAF 1.018	RAF 0.511

In addition to capturing the highest specificity, providers need to document and code ALL conditions each year. In this example, Member A's risk score is 5x greater when all conditions are captured compared to none.



Why does risk adjustment matter?

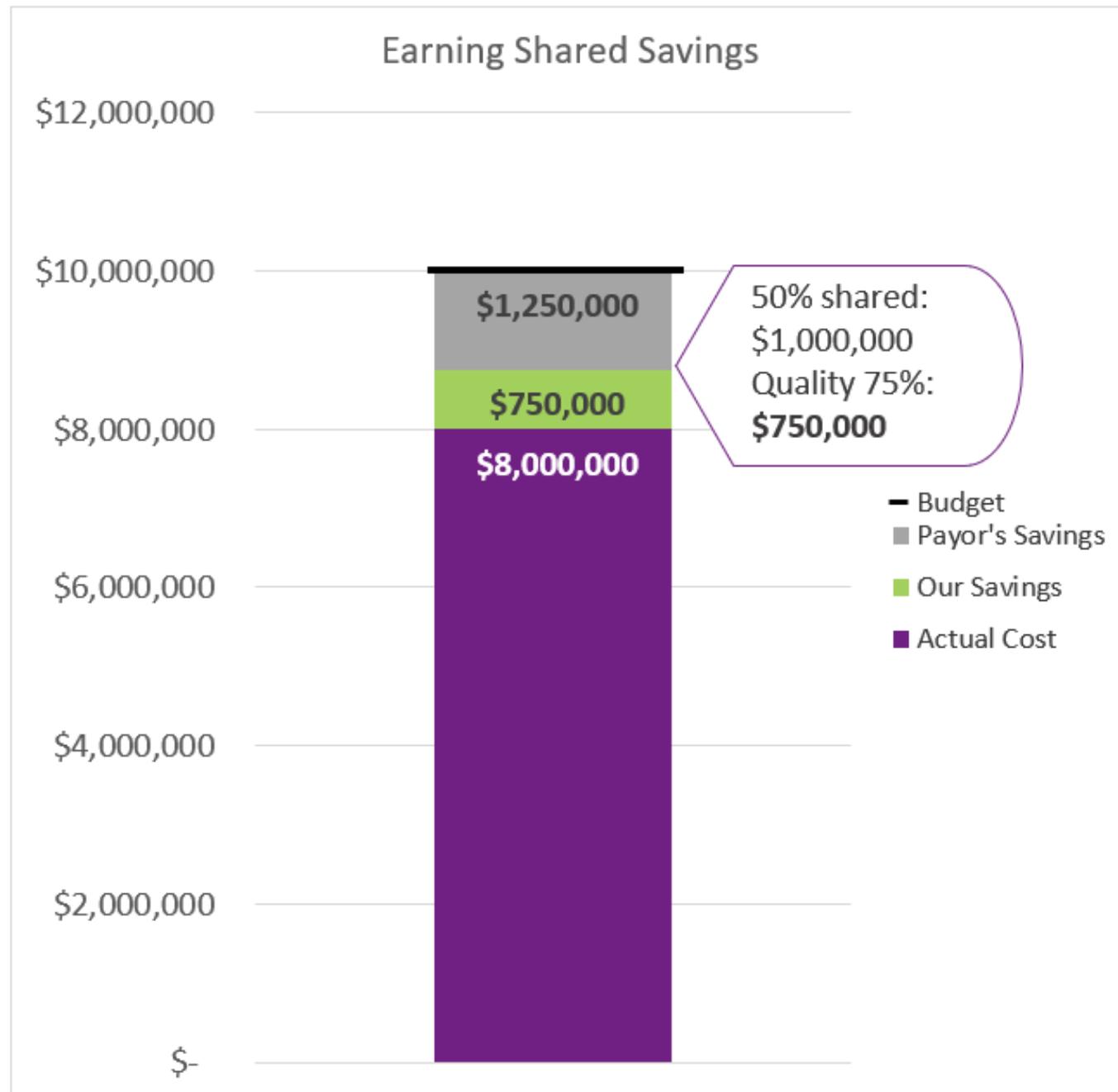
- In our value contracts, a payor will set our medical cost budget based on historical costs and by applying the Risk Adjustment Factor
 - Increased medical complexity, payors expect increase spending
 - Lower risk, healthier populations, payors expect less spending
- Errors in risk adjustment will lead to errors in medical cost budgets
 - Failure to code all conditions, or the severity of conditions, could make our patients *appear* healthier than they are, leading to lower budgets
- To be successful in our value contracts, our actual costs of care must come in under budget. This generates a surplus (shared savings) that is paid back to our network providers



Example of how we earn shared savings in a value-based contract –

Baseline performance

- \$10 million budget
- \$8 million actual costs
- \$2 million surplus -
 - Payor splits 50/50, quality score applied, our earnings are \$750,000

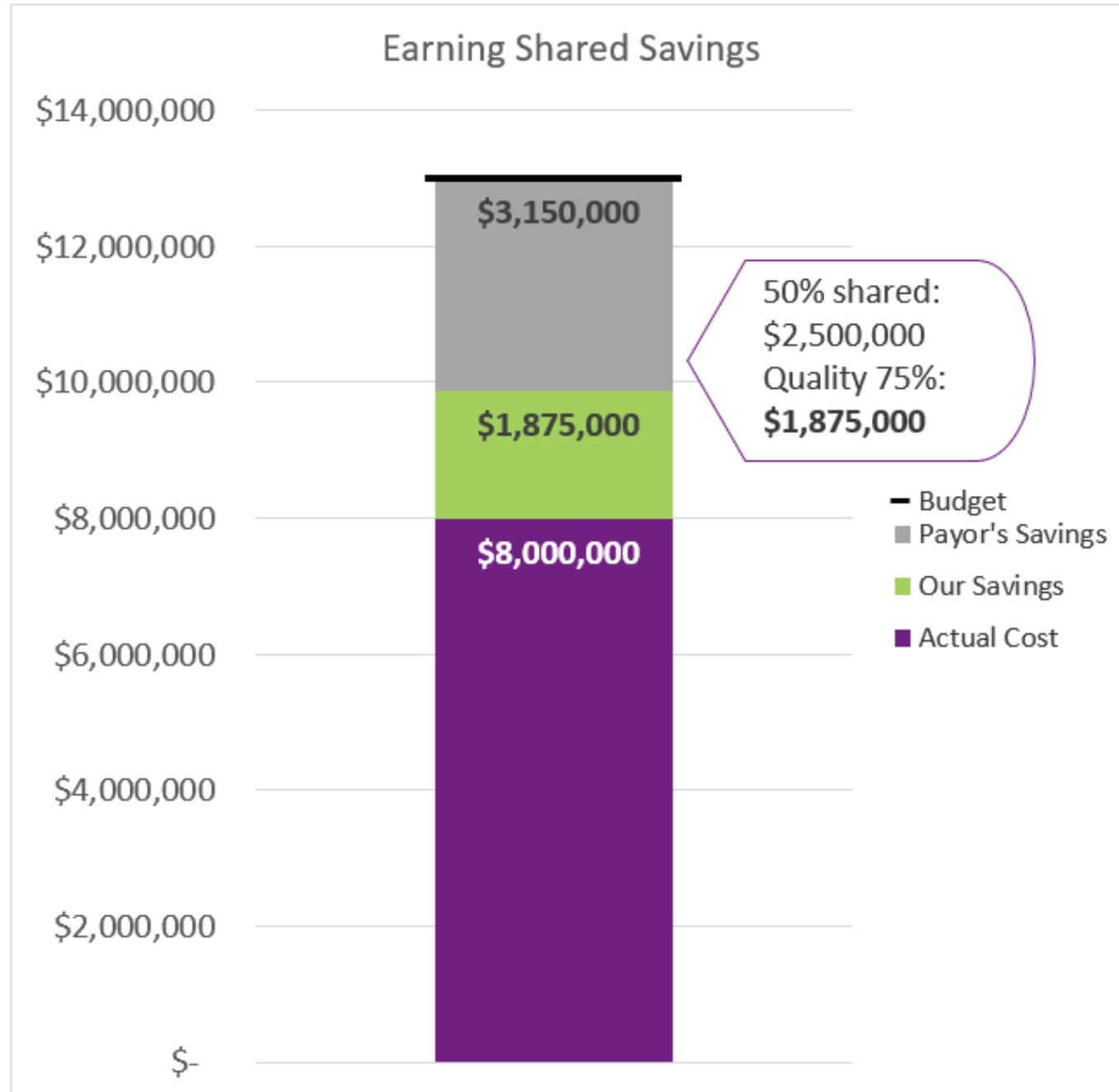


Accurate HCC coding increases risk score



Medical budget increases to \$13million

- \$13 million budget
- \$8 million actual
- \$5 million surplus -
 - Payor splits 50/50, quality score applied, our earnings are \$1,875,000



All else equal, earned share increases by over \$1million