Objectives

- Introduce key ACA provisions and ACA Risk Adjustment
- Provide a high level understanding of the differences and similarities between ACA risk adjustment and Medicare risk adjustment
- Illustrate how ACA risk adjustment will impact your under 65 patient panel
Key ACA Changes

- **Individual Mandate** requires most Americans to obtain health insurance or face a tax penalty.

- **Guarantee Issue** requires that health plans accept all employer groups and individuals who apply for coverage.

- Health plans can no longer create coverage exclusions for **pre-existing conditions**.

- ACA creates three **risk-spreading programs to mitigate** for adverse selection and stabilize premiums in the individual and small group markets.

- Plans issued in the small group and individual markets beginning in 2014 must **include coverage for Essential Health Benefits (EHB)**, determined by the state’s benchmark plan.

- **Federal MLR** rules require plans to spend at least 80% or 85% of premiums on medical costs.

- **Review by the Department of Insurance** is required on all products, with stricter rules on premium increases.
Impact to Stakeholders

Changes created by ACA have implications to the key stakeholders in the healthcare delivery system: Members, Providers, and Health Plans

**Member**
- Changes in premiums
- Changes in benefits
- More outreach from health plans in regards to managing overall health

**Provider**
- Growing focus on regular comprehensive patient evaluation /documentation
- Increased involvement in member engagement /care planning
- Increased emphasis on accurate /complete diagnostic coding practices
- Increased audit /chart review requirements

**Health Plan**
- Increased importance of documenting the diagnostic attributes of the population
- Growing need for tighter relationships with providers (sharing patient health needs)
- Growing focus on health and wellness
- Retooling of infrastructure and underwriting practices
ACA Impact at a Glance

- Increase the number of Americans with health insurance
- Promote patient disease and medical management
- Encourage insurers to compete on the basis of price, efficiency, and quality - not on attracting the healthiest enrollees and deterring those in poorer health.
ACA Risk Adjustment

A mechanism to protect insurers against adverse selection by transferring funds from plans with relatively lower-risk enrollees to plans with relatively higher-risk enrollees

- Creates a balance between health plans based on the health characteristics of their members, so plans have no incentive to select or avoid members based on health status
- Hierarchical Condition Category (HCC) Model*: groups ICD-9 codes into medical condition categories and are associate with a risk value used to calculate member risk scores. Risk score accuracy is driven by the complete and accurate capture of ICD-9 codes.
- A plan’s average member risk score is compared to the average market risk within the state to generate the plan’s overall relative risk score.

*Two commercial HCC models: Federal and Massachusetts. All states other than MA use Federal Model
### ACA v/s Medicare Advantage Risk Adjustment

Both programs use Hierarchical Condition Category models for risk adjustment and require complete and accurate coding, however there are key differences that impact the response by plans and providers.

<table>
<thead>
<tr>
<th></th>
<th>Medicare Advantage</th>
<th>ACA – Risk Adjusted Products</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population Profile</strong></td>
<td>Concentrated, high cost population with pervasive health issues</td>
<td>Large, highly diverse population with more isolated health issues</td>
</tr>
<tr>
<td><strong>Member Engagement</strong></td>
<td>Population easier to engage due to frequency of medical incidence and lifestyle demands</td>
<td>Difficult to engage due to high lifestyle demands and sporadic medical incidence</td>
</tr>
<tr>
<td><strong>Transfer Payment Funds</strong></td>
<td>Generally results in increased payment to plan with retrospective upward adjustments</td>
<td>Transfer payment between plans creating winners and losers financially</td>
</tr>
<tr>
<td><strong>Dataset</strong></td>
<td>Retrospective model</td>
<td>Concurrent model</td>
</tr>
<tr>
<td><strong>Data Source</strong></td>
<td>Medical Claims submitted to insurers with ability to supplement with medical chart data</td>
<td>Medical Claims submitted to insurers with ability to supplement with chart data. Mass. model will ONLY accept medical claims.</td>
</tr>
</tbody>
</table>
Provider Impact: Key Coding Takeaways

*Risk Adjustment will create an increased importance of complete and accurate coding by providers and billing staff*

- All condition(s) must be *documented* on the medical record and *transmitted* to the health insurance carrier via claims submission process.
- Medical record must show that condition was monitored, evaluated, assessed or treated (MEAT).
- All chronic conditions must be assessed and reported no less than once a year.
- Conditions should be documented and coded to the highest level of specificity.
- Use V codes to document health status conditions in notes (amputation status, transplant status, dialysis, HIV status, and artificial opening such as colostomy and ileostomy).
- ‘History of’ means the patient no longer has the condition - Frequent documentation errors regarding use of history of:
  - Coding a past condition as active
  - Coding history of when condition is still active
ACA Risk Adjustment Case Study

- 45 year old Hispanic male, who was last seen 2 1/2 years ago. Marked inflammation of the nasal mucosa, pharynx and conjunctiva. Headache, severe generalized myalgia, fever and chills noted, Prostration. Presents with a low grade fever, 72 hours duration, has minimal nasal secretions and reports malaise and fatigue. Patient is negative for current year flu immunization. Clear To Auscultation bilateral, absence of wheezing, rhonchi and crackles. Weight has increased by 22 pounds since last visit, BMI currently 35, HTN WNL, received in-patient treatment for Bi-polar disorder 4 years ago.

- PMH: Stable Hypertension (HTN), Obese, stable, Sleep apnea, non compliant with C-PAP.

- Plan: 1. Influenza, 2. Obesity, 100 mg Metoprolol b.i.d. & 10 mg Lisinopril b.i.d. for HTN, refer to pulmonologist for sleep study, refer to psychiatrist for counseling and medications
ACA Case Study: Coding

Scenario A – Represents coding focus on only current problems.

Scenario B – Represents members total health status. Supports focus on regular comprehensive patient evaluation and documentation.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Scenario A</th>
<th>Scenario B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza</td>
<td>487</td>
<td>487</td>
</tr>
<tr>
<td>Obesity</td>
<td>278.0</td>
<td>278.0</td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
<td>401</td>
</tr>
<tr>
<td>Sleep Apnea</td>
<td></td>
<td>327.23</td>
</tr>
<tr>
<td>Bi-polar Disorder</td>
<td></td>
<td>296.0</td>
</tr>
</tbody>
</table>
Common Coding Errors

- Medical record documentation does not indicate that all diagnoses are being monitored, evaluated, assessed/addressed, or treated (MEAT).
- The status of cancer is unclear in the medical record. Treatment is not documented.
- Chronic conditions are not documented as chronic (e.g. hepatitis or renal insufficiency)
- The highest level of specificity is not used (e.g. an unspecified arrhythmia is coded rather than the specific type of arrhythmia).
- Chronic conditions or status codes aren’t documented in the medical record at least once per year. Common missed conditions include transplant status, amputation status, and paraplegia.

Source: AAPC (American Academy of Professional Coders). Top 10 MA Risk Adjustment Coding Errors
Complete and accurate coding of the most common conditions can have a significant impact on risk capture due to their prevalence

Most Frequent Conditions:

- Asthma
- Osteoporosis
- Hearing Loss
- Psychiatric diagnosis; e.g. Major Depression, Bipolar Disorders
- Vascular Conditions; cardiac or cerebral
Coding Gaps by Condition

Analytics show significant coding gaps for relatively rare conditions that often require specialty care

Less common, but of note:

- Extremely and or Very Low Birthweight Neonates
- Respirator Dependence, Tracheotomy status
- Hemophilia, Cystic Fibrosis
- Bone Marrow and Solid Organ Transplant
- Severe Head Trauma
- Protein-Calorie Malnutrition
Closing the Gap Together

Harvard Pilgrim will be working with physicians to close the coding gap. Coding gaps will occur:
- Owing to the fact a patient may be lost to care for any number of reasons.
- Because members may not see their physician each year or seek services for all their chronic conditions.

Harvard Pilgrim and Providers need to work together as:
- Only a **physician** can **document** a diagnosis in the medical record.
- **Provider billing offices** are the **transmitter** of those diagnoses via medical claims to health plans.
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References


- Center of Budget and Policy Priorities, Edwin Park,”*Ensuring Effective Risk Adjustment*,” May 18, 2011