Understanding Insurance Models For Risk Adjustment

For Healthcare Professionals

AAPC

Education provided by:

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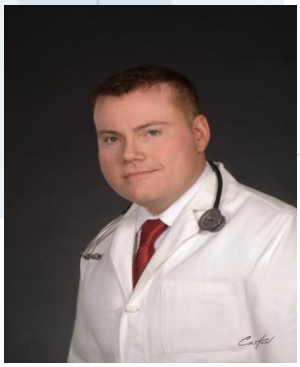

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Education | Network | Solutions

Insurance & Risk Adjustment

Course Objectives:

- Understand different insurance models
- Recognize how insurance models utilize risk adjustment
- Understand why risk adjustment models are being utilized
- Learn how risk adjustment models differ from Fee For Service and other traditional methods

What Does Managed Care Do?

- Patients enroll in a managed care plan that defines a specific benefit package (preventative services, primary care options, ER, hospitalization benefits, and/or pharmaceutical benefits)
- Patients typically choose a PCP (Primary Care Provider), who is often a gatekeeper and manager of the patient's care (usually manages consults with specialists and hospitalization)
  - Note that this is changing with the onset of "Hospitalists" offered by many hospitals to help manage inpatient care services

What Does Managed Care Do?

- MCO's (Managed Care Organizations oversee the utilization of benefits and services (that they are appropriate and needed, while monitoring cost and improving patient care)
  - This is a combination of managing health care delivery and the financial utilization of dollars across a population of patients sharing in the overall plan
- Providers are typically paid capitated rate (often monthly) for the care of these patients or are paid through a Fee For Service method

Methods of Coverage

- Traditional Insurance
- Government Programs
  - (Medicare, Medicaid, Tri-Care, CHIP)
- Health Maintenance Organizations
  - (HMO's)
- Preferred Provider Organizations
  - (PPO's)

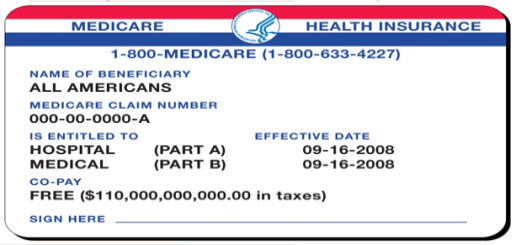
Coverage Options

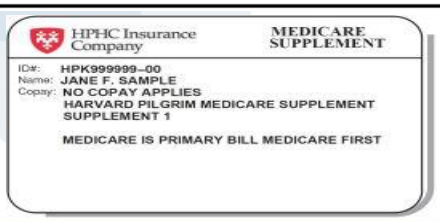
- Wrap Around Network = extended coverage for traveling patients or to increase coverage options from primary network
- High Deductible Plan = aka "Consumer Driven Health Plan (CDHP)" offers high deductibles to encourage patients to only use services when necessary and to shop around for the least expensive services

Administrative Organizations

- TPA = Third party administrator
- URO = Utilization Review Organization
- MSO = Managed Services Organization
- PPMC = Physician Practice Management Company

Medicare





Medicare

- **Part A – Hospital Insurance**
  - Medically necessary Hospital, Skilled Nursing Facility, Home Health and Hospice Care
- **Part B – Medical Insurance**
  - Medically necessary doctors services, preventative care, durable medical equipment (DME), hospital outpatient services, laboratory tests, x-rays, mental health care, and some home health and ambulance services

Medicare

- **Part C – Medicare Advantage**
  - MCO's through HMO's and PPO's provide Medicare benefits. May be offered at different pricing, includes all of Part A and B coverage, and may also get Part D benefits if chosen
- **Part D – Outpatient Prescription Drug Insurance**
  - Drug coverage provided by private insurance companies that have contracts with Medicare

PACE Program

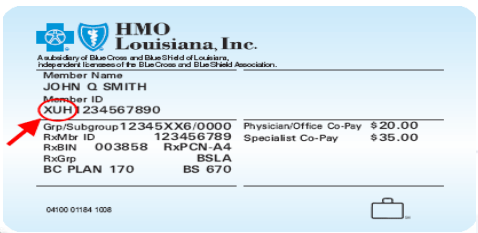
- PACE = Program of All-inclusive Care for the Elderly
  - Medicare and Medicaid Program
  - Meet needs in community instead of nursing home or other care facility
  - Care and services in the home and PACE centers
  - Must be:
    - 55 or older
    - Living in the service area of a PACE organization
    - In need of nursing home care (as deemed by state)
    - Able to live safely in the community with PACE help

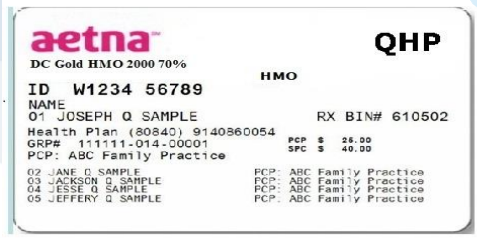
PPO

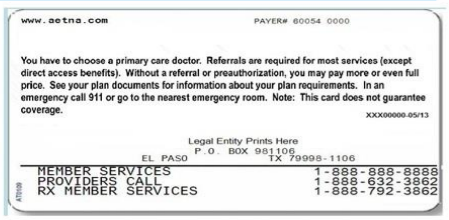
PPO

- Preferred Provider Organizations
  - (PPO's)
- Company contracts with health care providers to create a network and then lease the network to employer groups health plans (through TPA's)
- May be owned or operated by the TPA or operate independently
- TPA = Third Party Administrator, an entity that provides member services and claims processing

HMO







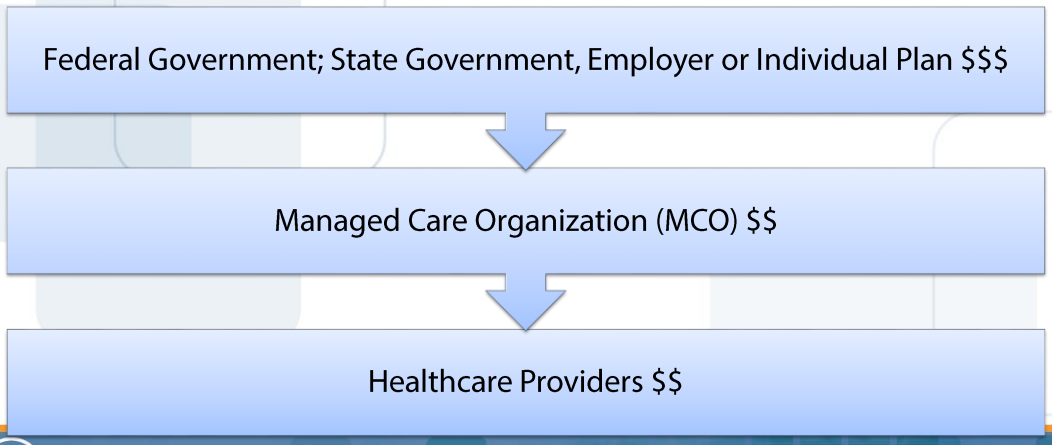
HMO Models

- **STAFF MODEL:** Physicians are salaried employees of the HMO
- **GROUP MODEL:** The HMO contracts with only one multispecialty or primacy care provider group
- **IPA MODEL:** An Independent Practice (or Provider) Association contracts with HMO's, PPO's, and others to provide care at a reduced rate. Providers have direct relationship to manage utilization of services
- **NETWORK MODEL:** HMO contracts with a variety of doctors to include individuals and group practices

Other Models

- **Exclusive Provider Organization (EPO):** Similar to a mix of HMO and PPO where patient is given a list of participating provider and may seek treatment without referrals
- **Point of Service (POS):** PCP acts a gatekeeper for referrals within the HMO, but patients may go out of network at a reduced reimbursement rate
- **Provider Sponsored Organization (PSO):** Possible next step in health care, system is owned and operated by a network of hospitals and physicians who can attend to any problems, no insurance middleman
- **Physician-Hospital Organizations:** like PSO's, part physician owned and part hospital owned

Organizational Flow



Capitation

- Payment of a fixed amount of money that is paid in advance, usually on a monthly rate, to the MCO to cover the delivery of all care and health services
  - PMPM = per member, per month
- Example: Agreed Rate of 800.00 PMPM
  - 1,000 members = 800,000.00 per month for care of all members **OR**
  - 1,000 members = 9,600,000.00 per year for care of all members
- The Problem? –Not all patients have the exact same costs….. Open to waste of health care dollars

Modified Capitation

- Keep current estimates of average costs PMPM, but attempt to narrow actual need or costs
- Based on known diagnoses
- The patient with multiple chronic conditions or diagnoses will cost more (and we know approximately how much exactly) than the patient with few problems or diagnoses
- This enables financial forecasting for the necessary funding toward the care of patients in the population group

= RISK ADJUSTMENT

Fee For Service Issues

- Fee For Service (FFS) pays providers a specific amount of money for a specific service rendered (by CPT® procedure code)
- FFS is the most commonly used method of reimbursement, but this is changing with risk adjustment
- FFS payments increase by increasing the number of services, tests, visits, procedures, and duplication of services

Fee For Service Issues

- Fee For Service (FFS) creates financial incentives:
  - To provide services which are reimbursed at higher rates
  - To invent new services that are billed at higher fees than gold-standard and less costly services
  - Encourages overuse and misuse of services
- FFS creates a DISINCENTIVE to:
  - Deliver services at a lower or fairer fee structure
  - Provide services that are not reimbursed (care coordination, treatment planning, web and e-visits, etc.

Fee For Service Issues

- Providers are reimbursed for what was done, with no insight to the quality of care provided
- Providers can be paid MORE in reimbursements for poor quality which causes added follow up visits, or additional treatments
- Many payment reform models are looking at ways to adjust payment for patient care based on the patient's need (by diagnosis code); and while including quality of care measures (attention to, and management of chronic conditions)

Pay For Performance

- CMS defines Pay for Performance (P4P) as:
  - "The use of payment methods and other incentives to encourage quality improvement and patient-focused, high-value care."
- Changes are already underway with HEDIS® measures and health plans that review other specific quality of care measures
- Combining reimbursement and financial planning based on what problems the patient has each year along with expected care needs helps to pinpoint a closer accurate payment toward quality care of chronic conditions

Population-based Medicine

- Managing chronic conditions across a population of people by treating all with a specific diagnosis with the same gold standards and preventative care measures
- Healthcare largely manages complications are they arise as opposed to attempting to prevent them
- Risk adjustment allows for knowledge of those in need of disease management

Medical Management

- Improve overall member health which will then reduce costs of care (preventative)
- Track HEDIS® quality measures
- Track days for inpatient stays
- Create policies for “medically necessary”
- Telephonic and other management of patient cases, often in areas such as:
  - Cardiology, COPD, Cancer, Transplant, etc.

Quality & Utilization Management

- Review and investigate quality initiatives and monitor health outcomes
- Analyze cost patterns and appropriate use of resources
- Meets cost projections while ensuring quality of care delivered
- These values are assisted through risk adjustment review of records to ensure quality is met for specific illnesses and to project utilization needs based on diagnoses

Risk Adjustment

- Enables changes to address quality of care for chronic illnesses
- Identifies Disease Management opportunities
- Identifies Quality of Care opportunities
- Identifies markers for Utilization

Risk Adjustment Models

Medicaid CDPS Model

CMS HCC Model

HHS HCC Model

Hybrid Models

Various Models in RA

There are various systems using Risk Adjustment beyond HCC for Medicare HMO plans. Some of these include:

Diagnosis based programs:

•Chronic Illness and Disability Payment Systems (CDPS) - Medicaid

•Hierarchical Co-Existing Conditions (HCC-C) - Medicare

•Diagnosis Related Groups (DRG) – Inpatient

•Adjusted Clinical Groups (ACG) – Outpatient

Prescription based programs:

•MedicaidRx (UCSD)

•RxGroups (DxCG)

•Hierarchial Co-Exisiting Conditions (HCC-D)

Some add: Patient Functional Abilities (ADL's)

History of CDPS Model

- Started in 1996 to tailor current risk adjustment models to better apply to Medicaid programs. Development started using claims from disabled beneficiaries information from the Disability Payment System (DPS) from Colorado, Michigan, Missouri, New York, and Ohio by Rick Kronick and associates
- Update in 2000 to include disabled and TANF (Temporary Assistance for Needy Families) beneficiaries from California, Georgia, and Tennessee. This upgraded program was then renamed the Chronic Illness and Disability Payment System (CDPS)
- In 2001, Todd Gilmer and associates developed the Medicaid Rx (MRX) using CDPS information. Based on combining from the Chronic Disease Score (CDS) developed by Von Korff and associates and the RxRisk model by Fishman and associates

History of CDPS Model

- In 2008, CDPS and MRX models were updated using Medicaid data from 44 states in 2001 and 2002. Another model was developed employing both diagnostic and pharmacy data called CDPS + Rx
- Data was supplied by CMS from Medicaid Analytic eXtract (MAX) data system. MAX data consists of patient-level data files with information on Medicaid eligibility, utilization of services, and payments for services

Stage 1 Groups in Major Categories (CDPS Model):

1) Psychiatric
2) Skeletal
3) Central Nervous System
4) Pulmonary
5) Gastrointestinal
6) Diabetes
7) Skin
8) Renal
9) Substance Abuse
10) Cancer
11) Developmental Disability
12) Genital
13) Metabolic
14) Pregnancy
15) Eye
16) Cerebrovascular
17) AIDS/ Infectious Disease
18) Hematological

Hierarchies in CDPS

CDPS Categories are Hierarchical within Major Categories:

For example: Cardiovascular Category: (4 levels)

- CARVH includes 3 Stage 1 groups and 7 diagnoses
- CARM includes 13 Stage 1 groups and 53 diagnoses
- CARL includes 26 Stage 1 groups and 314 diagnoses
- CAREL includes 2 Stage 1 groups and 35 diagnoses

VH (weight 2.037) = Very High: Heart transplants, valves, etc.

M (weight 0.805) = Medium: Heart attacks, etc.

L (weight 0.368) = Low: Heart disease, etc.

EL (weight 0.130) = Extra Low: Hypertension, etc.

* Credit only for most severe form/diagnosis in category. Each higher level takes all other lower diagnoses into consideration already.

Risk Adjustment is Spreading

- Risk Adjustment is a method of analysis using diagnoses for financial forecasting that has been growing in popularity in healthcare
- Medicaid plans began using Risk Adjustment modeling in 1996 and has continued to update that model
- Medicare Advantage Plans have been using the HCC/ Risk Adjustment model since 2004 and is expanding the program
- Commercial Plans are now required to have Risk Adjustment as a method to identify and plan for patients under the ACA

Hybrid RA Models

- Many commercial carriers will likely choose to utilize current established RA models, such as the HHS model
- They are permitted to create hybrid models combining the various models (CMS, HHS, Medicaid) and/or make their own additions or changes
- A study of the population of patients being served helps in creating hybrid models

Documented Diagnoses

- Risk adjustment is purely concentrated upon what patients have as current conditions instead of what was “done” or performed” on the patient
- Coders must understand that collecting all current diagnoses will affect payments as well as forecasting
- Diagnoses uncollected will be left with no dollars to manage those conditions

How ICD Codes Link to HCC Value

- Most of the ICD diagnosis codes which are in the models are chronic conditions
- Medicaid CDPS and HHS HCC Models recognize more codes
- Risk Adjustment is based on adjusting the estimated risk of each patient based on known diagnoses
- **Part C HCC** (HCC-C) are those diagnoses which are costly to manage from a medical perspective
- **Part D HCC** (HCC-D) are those diagnoses which are costly to manage from a prescription drug perspective
- Some diagnoses are both tough medically as well as costly for prescription drug management and therefore carry value in both models

Certified Coders Role

1. Find legible face-to face encounters with chronic conditions documented and signed by an acceptable provider
2. Include all Chronic Conditions that are part of the Medical Decision Making Process. This includes any chronic condition that is under current treatment whether it is the main reason for the visit or not. Past Medical History, Review Of Systems, Exam, Assessment & Plan are all portions of the record that may have valuable conditions documented
3. Any record within the calendar year works for the entire year, so if you do not find an acceptable first record, keep looking throughout the set

Questions/Feedback

Contact

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