The Importance of Risk Adjustment Across All Populations

Terry L Mills, MD, MMM, CPE, FAAFP Senior Vice President & Chief Medical Officer, CommunityCare Saturday August 27, 2022













- I have no disclosures to make in regard to this topic or any commercial products referenced.
- · No pharmaceuticals will be discussed
- All references to "improving" or "optimizing" risk factors in every context refers to the billing provider being accurate and comprehensive to the extent appropriate for the patient and encounter in question. At no time am I suggesting, overtly or implicitly, that any provider attempt to code diagnoses not appropriate to the patient and encounter in question, or otherwise attempt to manipulate a risk adjustment system on an individual or population level.

≫



Objectives

- 1. Describe the interrelationship of value-based care and risk adjustment
- 2. Understand the concepts and inputs used in risk adjustment.
- 3. Begin applying risk adjustment concepts in practice to improve your documented quality and cost of care.

×







Primary Care is Being Disrupted

Change is Uncomfortable

We Can Flourish in a New Paradigm







Progression to Alternative and Value-Based Payment: 2020

	Traditional fee-for- service	Fee-for-service linked to quality and value	Shared savings and bundles	Population-based payment
Medicare	38.00%	4.00%	36.20%	21.80%
Advantage	-10 pts	+1.5 pts	-3 pts	+11.5 pts
Original	15.00%	42.20%	37.80%	5.00%
Medicare	+4.5 pts	-9 pts	+5 pts	+0.5 pts
Medicaid	59.00%	5.50%	29.10%	6.40%
	-8.8 pts	-1.7 pts	+8.3 pts	+2.2 pts
Commercial	51.50%	13.00%	32.10%	3.40%
	-4 pts	-2.2 pts	+5.5 pts	+1.7 pts
All-payer	39.30%	19.80%	34.20%	6.70%
	-1.7 pts	-5.6 pts	+4.4 pts	+2.5 pts

https://hcp-lan.org/workproducts/apm-discussion-2018.pdf

Progression to Alternative and Value-Based Payment: 2020

	Traditional fee-for- service	Fee-for-service linked to quality and value	Shared savings and bundles	Population-based payment
Medicare	38.00%	4.00%	36.20%	21.80%
Advantage	-10 pts	+1.5 pts	-3 pts	+11.5 pts
Original	15.00%	42.20%	37.80%	5.00%
Medicare	+4.5 pts	-9 pts	+5 pts	+0.5 pts
Medicaid	59.00%	5.50%	29.10%	6.40%
	-8.8 pts	-1.7 pts	+8.3 pts	+2.2 pts
Commercial	51.50%	13.00%	32.10%	3.40%
	-4 pts	-2.2 pts	+5.5 pts	+1.7 pts
All-payer	39.30%	19.80%	34.20%	6.70%
	-1.7 pts	-5.6 pts	+4.4 pts	+2.5 pts

https://hcp-lan.org/workproducts/apm-discussion-2018.pdf



Innovation Center Strategic Objective Drive Accountable Care Aim: Increase the number of people in a care relationship with accountability for quality and total cost of care. Measuring Progress: • All Medicare beneficiaries with Parts A and B will be in a c relationship with accountability for quality and total cost 2030. • The vast majority of Medicaid beneficiaries will be in a car quality and total cost of care by 2030.	1: ACCOUNTABLE CARE ACCOUNTABLE CARE ACCOUNTA
--	--



Fundamental Realignment in Payment Systems

- Complete repudiation of the underlying concept of the RBRVS system that payment should be proportional to the cost of the inputs. Or is even related.
- New and building payment concept is this: payment should be related to the broad outcomes of your care, building from an individual patient to a population level.
- This is Value Based Care, in multiple flavors from simplest quality bonus to most complete population payment model.
- This involves measurement of both outcomes (quality of care) and utilization (cost of care).
- Both quality and costs are impacted & adjusted by Risk Adjustment.
- Risk adjustment is not perfect... it is just better than the next best system.

۰.	
	~
۰,	0
	×.

ᆋ



"Value" is in the eye of the beholder









The 3 Critical Concepts Underlying All Value Based Care

- 1. Attribution
- 2. Measurement and Metrics
- 3. Risk Adjustment
 - Concurrent
 - Prospective

≍

Attribution is Everything









Metrics & Measurement are Something



Nationally Standardized Core Measure Sets • ACO / PCMH / PC C Behavioral Health ore Quality Measures Cardiology Collaborative Gastroenterology • HIV & Hepatitis (ahpm) AAOS C AMERICAN CONLECT AAFP aetna AHIP x Medical Oncology Neurology MACP ų, ACOG -Anthem AMA ⊧ aga = OBGYN • Orthopedics Pediatrics 0 OP ●17世田..... OV Burleun opervita+ Asco == Chill Smarchage Cerner https://www.qualityforum.org/CQMC_Core_Sets.aspx 35





Risk Adjustment is the rest of Everything





Interrelated Concepts of "Risk"

- Risk factor = the individual building blocks of a score, at an individual level
- **Risk score** = the individual patient's calculated risk; or a population's average risk
- **Risk stratification** = the use of risk scores to divide and focus on certain populations
- **Risk adjustment** = the management of individual and population levels of risk scores; the use of population average risk scores for myriad purposes

×

Using Motivational Interviewing to Promote Healthy Weight # 18 Beating the Prior Au (i).es HCC Goding, Ruk Adjustmen and Physician Income Nortant Masseging: A Simple Test to Ingrave Teamwork and Wait Times 18 Optimion Is Direct Privary Care the Solution to Our Health Care Crisis⁵ 12 Opinian in Dafama of Direct Primary Care Couling & Decomposition ICO-10 Changes - Screening for Depression - More

Family Practice Management

Helping Patients Change Behavior ...

**

.

•

.

.

.

ice Pearls er Guesters Bafor die Visk in Pateris Akmit Delays The Last Word Practical Ways to Improve Medication Automation

EARN 5 CME CREDITS to the pair of www.aafp.arg/h

AMPANCAN ACADEMISTOR VAMILY PHYSICIANS

- MARA Milliman Advanced Risk Adjusters
- CMS-HCC Hierarchical Condition Classifications (Medicare)
- HHS-HCC (ACA Exchange Plans)
- CDPS Chronic Illness and Disability Payment System (Medicaid)
- DRG Diagnosis Related Groups (Inpatient)
- ACG Johns Hopkins Adjusted Clinical Groups (Outpatient)
- CRG 3M Clinical Risk Groups

ᆋ











A LOWER RISK SCORE

 Healthier population or person with lower costs of care

OR

- Wrongly suggests a healthier population due to:
 - Patients who were not seen
 - Incomplete or inaccurate coding

A HIGHER RISK SCORE

• More ill, more expensive, population or person with higher costs of care

OR

- Wrongly suggest a sicker population due to:
 - Reported Dx not documented
 - Over documenting (copy/paste)
 - Over coding (incorrect coding)

≫

82-year-old male	0.543	82-year-old male	0.543	82-year-old male	0.543
Medicaid Eligible	0.177	Medicaid Eligible	0.177	Medicaid Eligible	0.177
Diabetes – Not Coded	N/A	Diabetes (HCC 19)	0.118	Diabetes with Renal Disease	0.368
Rheumatoid Arthritis	N/A	Rheumatoid Arthritis	0.374	(HCC 18)	
				Rheumatoid	0.374
Heart Failure (HCC	N/A	Heart Failure (HCC	N/A		
85)		85) – Not Coded		Heart Failure (HCC	0.368
CKD IV – Not Coded	N/A	CKD IV- Not Coded	N/A	85)	
		OND IV- NOL COULCU	N/A	CKD IV (HCC 137)	0.224
No Disease	N/A	No Disease	N/A	Disease	0.182;
Interaction		Interaction		Interaction (HCC	0.317
Risk Adjustment	0.72	Risk Adjustment	<u> </u>	18 + HCC 85; HCC	
Factor		Factor		85 + HCC 137)	
Anticipated	\$6679.15	Anticipated	\$11.242.8	Risk Adjustment	2.553
Expenditures		Expenditures	3	Factor	
				Anticipated	\$23,682.2
				Expenditures	9
×					



Risk Adjustment Impact in Value Based Care

- Shared savings expense/savings are risk adjusted
- Episode bundle expense are risk adjusted
- MSSPs both upside and upside/downside models; quality and cost risk adjusted
- ACO REACH model outcomes and costs risk adjusted (including SDoH)
- CMMI models like CPCI, CPC+, Primary Care First cost and quality risk adjusted
- ACA Exchange individual and small group plans community health plan true-up is risk adjustment driven
- Managed Medicaid revenue impacted by risk; cost and quality risk adjusted
- Medicare Advantage revenue impacted by risk score; cost and quality risk adjusted

**

Fee For Service	Value Based Care
CPT coding (E&M, procedures) drives revenue Physician's time was spent counting bullets for coding; now E&M coding related to clock time or MDM Inherent drive is to take care of the presenting problem only, do more things, and move fast	 Risk adjustment drives revenue Care Coordination fees Quality bonuses Shared Savings Value based payment Physician's time is spent on accurate & complete diagnoses Inherent drive is to be complete, comprehensive, and anticipate



- 1. To accurately stratify each individual patient
 - Make comparisons between patients
 - · Know where to focus time, resources, and care management
 - Predict future outcomes and costs
- 2. To stratify a population
 - Make comparisons between populations
 - Combine with known costs and define value (predicted vs actual costs = savings)
- 3. To operate practices
 - Allocation of staff
 - Physician compensation

≍



Concurrent Model

METHOD: uses this year's claims history to calculate risk of now.

- 1. Measures what an individual's typically risk would be based upon condition profile compared to average MARA population
- 2. Differentiate health status among individuals; align resources
- Retrospective analysis individual or group's expected expenditures compared to actual costs (which are known)

Prospective Model

METHOD: uses claims history to predict a 12-month projection immediately following the assessment period (this year to predict next year)

- Identify patients who are expected to be high cost, or likely to be hospitalize in the future (may or may not be expensive now)
- 2. Analysis of future cost projections health plan budgets and payments
- 3. Renewal underwriting

×



Example: Ca	alculation of	Expected	Costs
-------------	---------------	----------	-------

	Member 1	Member 2
HCC Score	0.87	1.6
Average MA pmpm costs	\$1,080	\$1,080
Observed costs	\$1,000	\$1,300
Expected costs	\$940	\$1,728
O/E	1.064	0.752
	6%	-25%

*



Comparison Across Risk Mod<u>els</u>

R2 = percent of variation explained by the model (equivalent to Pearson's Correlation Coefficient)

MAE = mean absolute error; a measure how close a prediction is to the outcome

> https://www.soa.org/resources/research -reports/2016/2016-accuracy-claimsbased-risk-scoring-models/

	R-Squared		MAE	
	Uncensored	Censored at \$250k	Uncensored	Censored at \$250k
Diagnosis-Only	Models		a - 41	
ACG System	44.1%	52.4%	75.3%	73.3%
CDPS	24.2%	30.0%	92.5%	90,6%
DxCG	52.6%	61.0%	67.6%	65.0%
HHS-HCC	41.3%	45.2%	86.8%	85.5%
MARA	52.7%	62.6%	64.0%	61.8%
Truven	52.6%	62.7%	64.9%	61.6%
Wakely	43.2%	51.0%	76,5%	74.3%
Pharmacy-Only	Models			
DxCG	29.6%	38.4%	83.0%	80.8%
MARA	30.1%	40.1%	81.8%	79.6%
MedicaidRx	12.9%	18.0%	100.3%	98.3%
Wakely	19.9%	28.8%	91.4%	89.2%
Diagnosis-and-P	Pharmacy Models			
ACG System	45.9%	56.4%	70.0%	67.6%
CDPS-MRx	25.6%	32.4%	90.0%	88.1%
CRG	41.0%	49.3%	78.2%	76,2%
MARA	55.4%	66.7%	57.9%	55.6%
Wakely	44.3%	54.2%	73.8%	71,3%

















Build a Program to Address Highest Risk Patients



*

How Can I Do Better?

- 1. Know the programs and patients in your practice impacted by risk adjustment default is to assume that most or all are!
- 2. Address risk scores through accurate, comprehensive coding
- 3. Remember the things that you may not be actively managing but impact your thoughts and MDM all the time
 - Ostomies, amputations, dialysis, etc.
- 4. See every patient every year! • Reset January 1
- 5. Build a program to address your highest risk patients.



**



