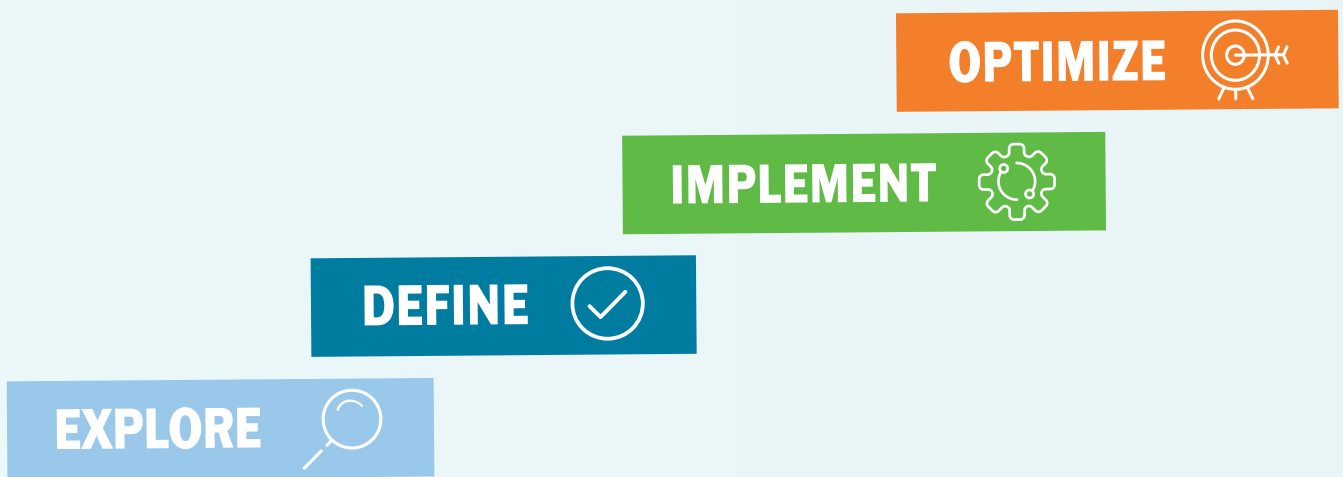


# Where are you in managing your risk-adjusted population?



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**UASi**

United Audit Systems Inc.

Numerous drivers, including federal and state initiatives, a rapidly aging population, and rising incidence of chronic disease, are propelling a movement toward value-based healthcare (VBC). In many healthcare arenas, VBC models are already found particularly in Medicare Advantage (MA) plans, but also in health maintenance organizations (HMOs), medical homes, accountable care organizations, and other types of plans.

The growth of MA plans has been considerable. A KFF analysis found that in 2021, more than 26 million people were enrolled in a Medicare Advantage plan, accounting for 42 percent of the total Medicare population. And more growth is on the way. (Source: kff.org) In 2021 the Centers for Medicare and Medicaid (CMS) Innovation declared that “The vast majority of Medicaid beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030.” (Source: innovation.cms.gov)

VBC has its benefits: lower costs and better outcomes for patients as well as increased patient satisfaction rates and care efficiencies for providers, an NEJM analysis notes (Source: catalyst.nejm.org). For society at large, there is also the benefit of overall reduced healthcare spending and better health for more people. For providers, VBC plans can also be a reliable revenue stream and can help practices acquire resources to improve patient outcomes (Medical Economics). But with benefits come a downside as financial risk is passed from payers to providers.

To bypass the risk, provider organizations need to master the challenges of managing populations and have a solid strategy to assess risks and increase revenue. UASI's unique maturity model and con-

sulting solutions can put your organization on the path to success.

## Understanding HCCs and RAFs

The big difference between VBC and other forms of reimbursement is that VBC puts the focus on the patient, not the encounter--and on improving health while containing costs. One form of VBC, risk-adjusted models, focus specifically on managing chronic--not acute--conditions. The goal is to create a ‘whole picture’ of the patient, including their risk factors, any chronic health conditions, and demographic factors to optimize care, ultimately improving quality and reducing costs in a more efficient way. This is different than the fee-for-service model, where reimbursement is based on the services physicians provide.

Documenting these factors, with the right processes and methodologies in place, is a critical part of the process. The work begins with understanding hierarchical condition categories (HCCs) and Risk Adjustment Factor (RAF) scores.

HCCs are used to calculate payments for patients insured by MA plans, accountable care organizations (ACOs),

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some Affordable Care Act (ACA) plans, and others. Insurance companies use HCC codes to assign patients a RAF score to predict or estimate the costs of their care. CMS uses the score to adjust capitation payments made to MA plans.

A RAF score is calculated every year for each patient and can impact an organization's allocated reimbursement. A high RAF score reflects the patients who need the most care and resources. RAF scores can also be averaged for defined patient populations in a healthcare organization.

Healthcare organizations must take steps to ensure they are getting the right reimbursement for high-risk patients. Poor understanding of RAF scores and failure to manage this process can negatively impact an organization's reimbursement. Mastering HCCs and RAF scores should be a priority for healthcare finance leaders who want to ensure that their facilities are getting reimbursed appropriately for the care they provide and that they are taking advantage of the financial incentives available to them.

**To avoid RAF pitfalls, providers should take steps, including but not limited to:**

- Identifying the populations they are serving and determining opportunities to optimize
- Using data analytics appropriately to understand high-risk populations and the care they are receiving
- Ensuring that high-risk patients' care is documented and managed appropriately
- Implementing processes to make sure patient populations are identified and documented every year
- Putting disease and chronic care management programs in place to help specific patient groups manage their conditions and improve their health

## Common Problems

The need to master HCCs and RAF scores may not be on every healthcare executive's radar. It is not uncommon for healthcare organizations to discover problems with their scores. What is more, they may struggle to determine the cause of the problem, such as:

**Documentation:** The link between HCC codes, RAF scores, and reimbursement puts added focus on documentation. Care given to patients needs to be accurate and timely as well as complete to reflect the patient's whole health picture. Accurate documentation can affect a provider's reimbursement as well as quality scores.

**Administrative Burden:** In many organizations, the work of documentation and code assignment of HCCs falls to the provider. Incomplete documentation can result in an overwhelming number of queries about the content of the record, creating an unwelcome administrative burden.

**Wrong Tools:** Methodologies and approaches that work for fee-for-service or prospective payment reimbursement are insufficient to address risk-based models. It can be difficult to find the right tools to calculate HCCs, as they are patient-based and not encounter-based. Using the right data analytics tools and understanding the results is critical. Even the best electronic health record (EHR) systems may not be able to do it all.

For organizations struggling with HCCs and RAF scores, it is important to assess the current state, develop a road map, and build a robust program to effectively manage the risk-adjusted population. Even a small number of sick patients can have a substantial financial impact.

## Case Study 1:

Ensuring chronic health conditions are appropriately documented every year can have a significant effect on an organization's reimbursement. In this case study, we look at an ACO that had no grasp on its RAF scores. UASI analyzed the data and identified the top HCC opportunities. The HCC 22 RAF opportunity was one of the most significant for the client.

- In an ACO, 1,500 of the patients have a BMI greater than 40
- Five hundred of these patients had a claim with E66.01, the ICD-10-CM code for morbid obesity, during a calendar year
- The remaining 1,000 patients did not have morbid obesity coded in the calendar year

Looking at the RAF weight for HCC 22 and the CMS annual base rate, we can see reimbursement that the organization has missed out on:

Patient with potential missed HCCs	RAF weight for HCC 22	CMS annual base rate	
1000	X 0.250	X \$9366	= \$2,341,500

## Case Study 2:

An organization suspected its RAF scores were low and wanted to compare to existing benchmarks and identify opportunities to improve. They needed help deciding whether to implement a CDI program and if so, where to begin.

### UASI:

- Performed a focused risk assessment of the provider's outpatient documentation and HCC coding
- Explored current documentation and identified HCC opportunities
- Defined an outpatient CDI process to address identified documentation gaps, tailored to the organization's specific goals and opportunity

### The Outcome:

UASI identified an opportunity to improve the average RAF score by +0.436. For every 0.1 improvement in RAF, an increase of \$1 million is expected (based on a population of 10,000 lives). This average RAF score improvement more than justified the establishment of a CDI program.

## Case Study 3:

A UASI client had a risk-adjusted patient population of 100,000. They've had an HCC CDI program in place for a few years and are doing a great job with compliant documentation/coding and HCC recapture. They came to UASI with concerns about patients they were treating/managing for chronic diseases that perhaps had never been coded/reported.

### UASI:

- Analyzed the organization's risk-adjusted patient population, applying specific search criteria to stratify the population and identify data patterns indicative of commonly missed chronic conditions (using both clinical and claims data)
- Used these criteria to identify cases for focused chart reviews
- Reviewed more than 2,500 targeted patients and identified corrections in documentation and coding that represented over \$4 million in missed HCC opportunities

### The Outcome:

Of this opportunity, the client was able to realize more than 15 percent of the \$4 million total (\$600,000) before the end of the calendar year. That is a return on investment of \$5 for every \$1 spent on the effort.

## The UASI Solution

To support providers, UASI has developed a maturity model that provides an initial benchmark to determine how close an organization is to being “fully optimized” in addressing its risk-adjusted population. The model provides tools for leading discussions and creating a roadmap of next steps.

Once next steps are determined, UASI's real-time solution for calculating, monitoring, and auditing population health data (outcomes) will help you to monitor organizational vital signs to succeed in risk-based reimbursement. UASI's actionable guidance and best practices can support providers looking to improve or implement their HCC coding, training physicians, pre-visit advising, and ultimately reducing administrative burden on clinicians.

The four levels of the maturity model include:

**Explore:** Understanding how well an organization's data reflects its population and where the opportunities to improve may be.

**Define:** Identifying the biggest opportunities, understanding what patient populations should be prioritized and what actions can be taken right now and understanding what people, tools, and processes are needed.

**Implement:** Identifying the steps needed to establish a program and making sure that an organization is properly compensated and sustainable into the future.

**Optimize:** Monitoring the program, understanding what is working,

sharpening focus, and closing the loop to correlate quality and patient outcomes.

UASI can help you answer questions like:

1. What key priorities, training, and key performance indicators (KPIs) should be established in a holistic VBC program?
2. What people, processes, and tools are needed to accommodate risk-based approaches?

3. How can we target efforts on high-risk patients and population management strategies?
4. How can we optimize RAF scores compared to benchmarks?
5. How can we identify trends to optimize and continuously improve?



**Learn more about managing your risk-adjusted population and take the 3-Minute Checkup.**

[uasolutions.com/hcc-risk-adjusted-checkup-1](https://uasolutions.com/hcc-risk-adjusted-checkup-1)

## About UASI

UASI is a leading national provider of revenue cycle solutions that help healthcare organizations receive proper reimbursement for the care they provide. With nearly 40 years of experience in coding, clinical documentation integrity (CDI), and revenue integrity solutions, UASI staff members are the industry's most experienced and credentialed professionals. UASI offers full-service consulting to identify inaccuracies and strategic solutions to drive coding and documentation quality improvements.

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