Medicare Advantage Risk Adjustment

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Medicare Advantage Risk Adjustment

What is risk adjustment?

- Risk adjustment is method used by the Centers for Medicare & Medicaid Services (CMS) to account for the overall health and expected medical costs of each individual enrolled in a Medicare Advantage (MA) plan.

- CMS uses this method to pay MA plans on a capitated basis for medical care and separately for prescription drug benefits per beneficiary.

- Risk adjustment accounts for beneficiary differences by adjusting these capitated payments (*more or less*) to the MA plan. Payments reflect the specific characteristics of each enrolled beneficiary, including demographics, Medicaid eligibility, and health status.
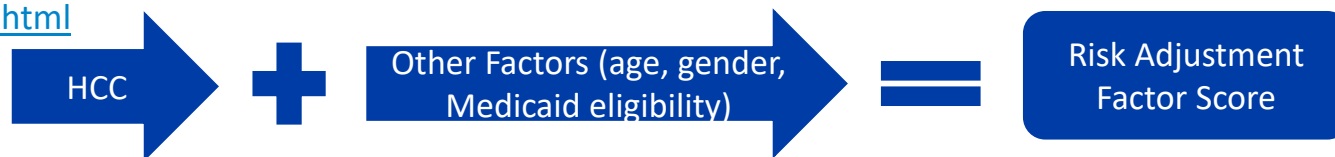
Why is risk adjustment done?

- To accurately reflect the health of each MA plan's membership.

- To ensure MA the plans have adequate resources to reimburse providers treating MA beneficiaries.

- So MA plans can rely on predictable and actuarially sound payments from CMS in order to provide enough resources to treat and manage all beneficiaries.

What methodology is used for risk adjustment?

- CMS uses a disease model to determine a risk "score" for each member. The model takes individual diagnosis codes and combines them into broader diagnosis groups, which are then refined into **Hierarchical Condition Categories (HCCs)**. HCCs, together with demographic factors such as age and gender, are used to predict beneficiaries' total care costs.

- This system is prospective, which means it uses a beneficiary's diagnoses from one year to calculate a risk adjustment factor used to establish a payment for the following year.

- Each January starts a "clean slate" for HCCs. A non-resolving chronic condition diagnosis (such as diabetes) must be reported on a claim denoting a face-to-face visit with an acceptable type of provider, in an acceptable setting, at least once during the calendar year. If it is not reported this is called "falling off".

Understanding Hierarchical Condition Categories (HCCs)

- Implemented by CMS in 2003.

- Measures the disease burden that includes 86 HCC categories, which are groups of clinically related diagnosis (ICD-10) codes with similar cost implications.

- The HCC model is made up of 10,000+ ICD-10 codes that typically represent costly, **chronic** diseases such as:

  - ✓ Diabetes
  - ✓ Chronic kidney disease
  - ✓ Congestive heart failure

  - ✓ Chronic obstructive pulmonary disease
  - ✓ Malignant neoplasms
  - ✓ Some acute conditions (MI, CVA, hip fracture)

- ICD 10 to HCC Crosswalk resource: https://www.nber.org/data/icd-hcc-crosswalk-icd-rxhcc-crosswalk.html

HCC ➔ **+** Other Factors (age, gender, Medicaid eligibility) ➔ **=** Risk Adjustment Factor Score

Percent of Co-Morbidities

Figure 15: Co-morbidity among Chronic Conditions for Medicare Fee-for-Service Beneficiaries : 2018
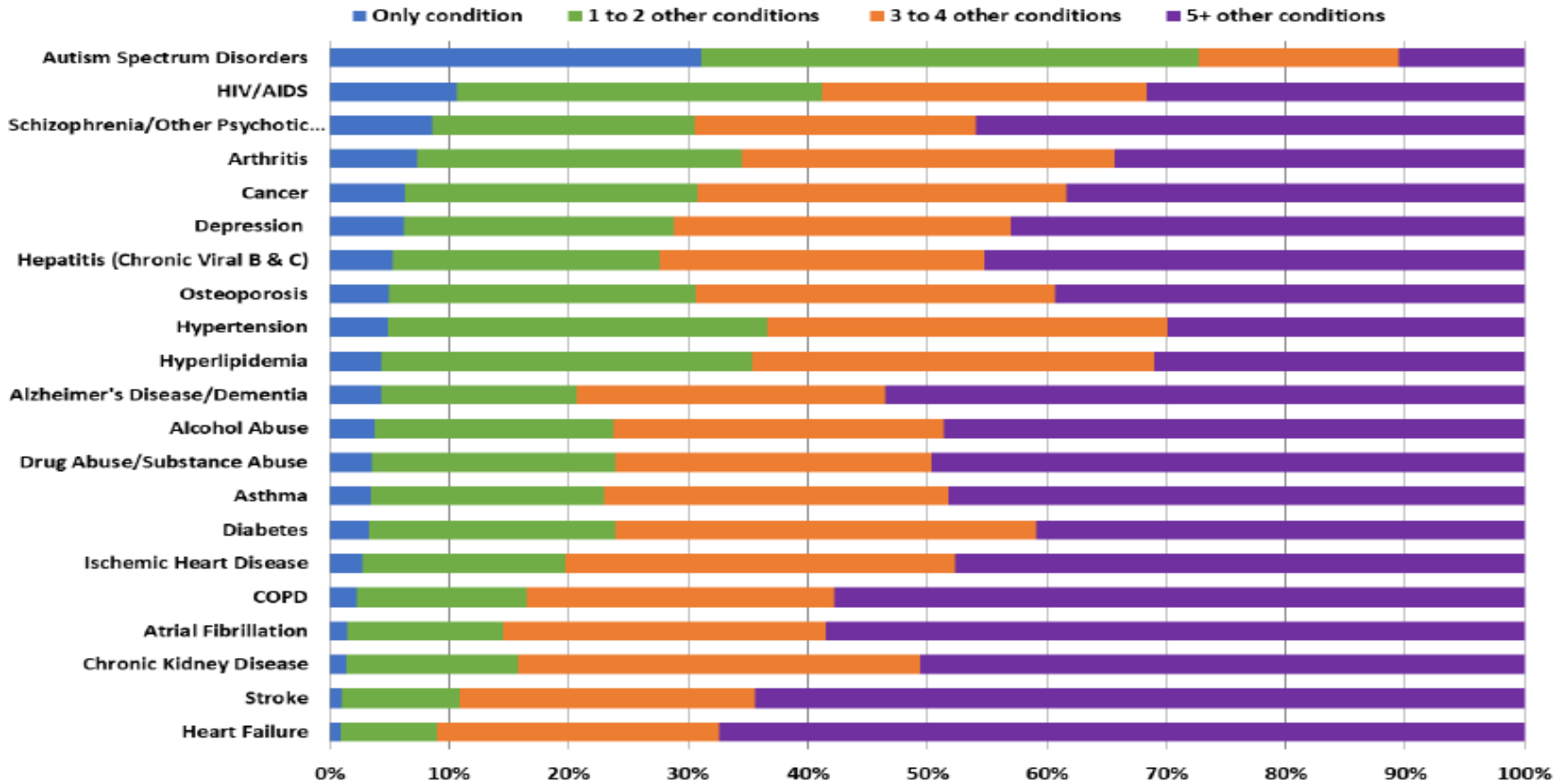
*Example: Heart failure – Only = 1%, 1 to 2 = 9%, 3 to 4 = 26%, 5+ = 64%

How can this help beneficiaries?

Risk adjustment is much more than a regulatory requirement. It actually improves quality of care in several ways. Accurate identification of patient health status allows us to:

- Understand patient needs, so new programs and interventions can be developed.

- Identify high-risk patients for disease and intervention management programs.

- Ensure that chronically ill beneficiaries receive the most clinically appropriate care.

- Integrate clinical efforts with clinics and provide more robust data.

Who in the provider's office influences HCC coding?
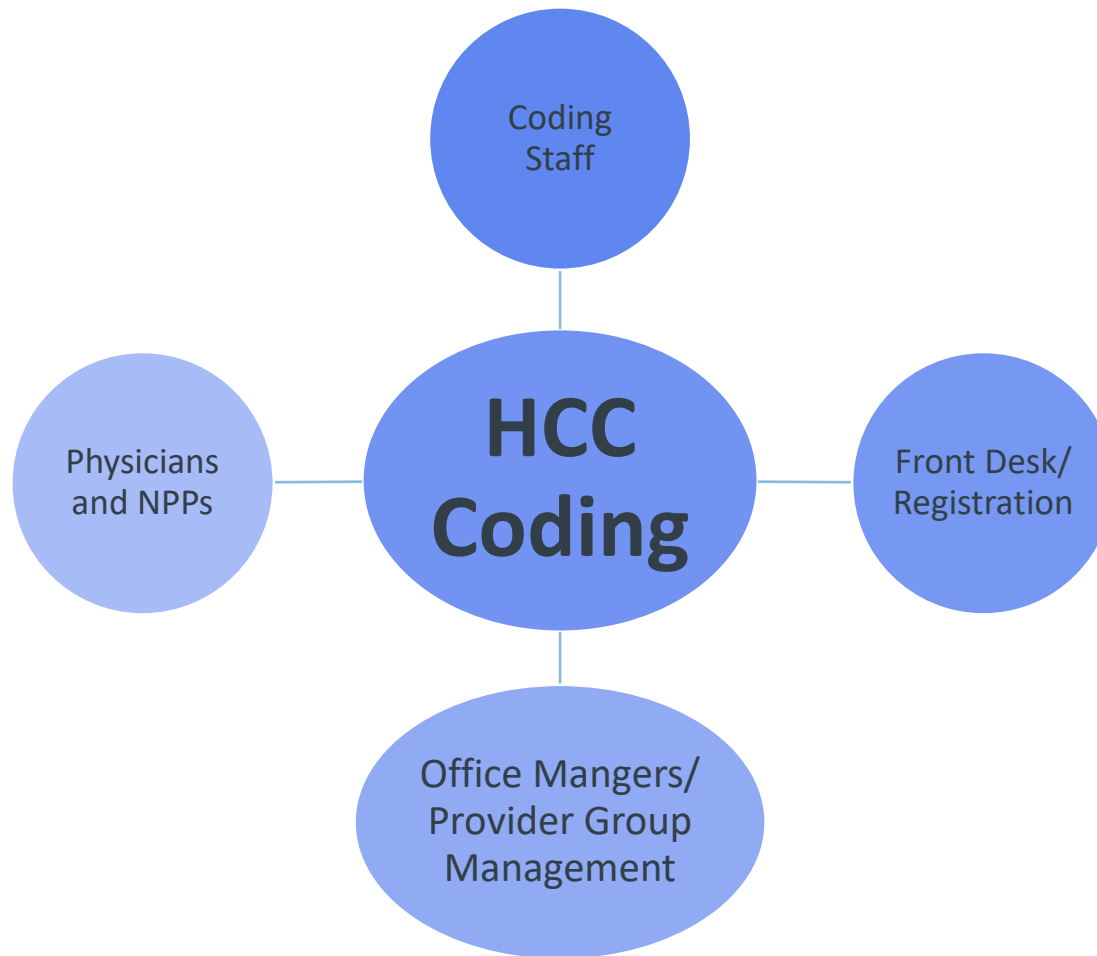
How can provider's help?

To comply with CMS regulations, provide the best and most efficient service to your patients, and receive appropriate reimbursements, here are some steps you can take:

- **Master HCC coding** - Providers should become familiar with the principals of risk adjustment and the impact it has on the health care system.

- **Understand your patient population** – If you serve Medicare patients, it's more than likely many of them have been diagnosed with diabetes, vascular disease, or one or more of the other most common HCC diagnoses. Take a look at your patients and determine who belongs in what diagnosis category.

- **Capture comorbidities** - Because risk adjustment is dependent on diagnosis coding, it is very important that all chronic, acute, and status conditions are documented during each face-to-face encounter.

- **Focus on accuracy** - All diagnosis codes should be coded to the highest specificity and all encounters should be submitted to the health plan.

How can provider's help (cont.)?

- **Medical Records** -
  - ✓ Document clearly and concisely how the conditions coded were assessed, monitored, or treated, or how they affected the patient's care or your medical decision-making during the visit.
  - ✓ Make sure all medical record entries have a valid signature with credentials (e.g., "M.D.,") and dates for each encounter per CMS guidelines.
  - ✓ Become familiar with standard coding principals for your specialty and make sure that all reported diagnosis codes are clearly supported in the medical record to protect from audits and potential fraud.

- **Report every year** – The CMS risk adjustment model is built on reviewing a previous year's health status to predict the following year's health expenses. That means physicians and practices must report their information every year. Get in the habit of using HCC codes and submitting accurate information in a timely fashion.

★ **Medicare Annual Wellness Visit** ★

Documentation Requirements – MEAT vs TAMPER

MEAT

- Monitor – signs, symptoms, disease progression/regression

- Evaluate – test results, medication effectiveness, response to treatment

- Assess – ordering tests, discussion, review of records, counseling, refer to another provider

- Treat – medications, therapies, other modalities

TAMPER

- Treat – medications, therapies, other modalities

- Assess – ordering tests, discussion, review of records, counseling

- Monitor – signs, symptoms, disease progression/regression

- Plan – what is being done about the patient's condition

- Evaluate – test results, medication effectiveness, response to treatment

- Refer – sending the patient to another provider for treatment of the condition

**At least <u>one</u> element of MEAT/TAMPER must be documented
for each coded condition to qualify for HCC**

Key Points for Documentation

Diagnosis(es) must be:

- Reported at least once each year
- Captured in a face-to-face setting
  - Telehealth by video qualifies
  - Telehealth by audio only does not qualify
- Documented in the health record with appropriate identification, date, and provider signature

Examples:

- OK to capture:
  - Acute conditions that receive care and management during the encounter
  - Chronic conditions, as long as there is continued treatment and care
- Not OK to capture:
  - Conditions that have resolved or are no longer receiving treatment

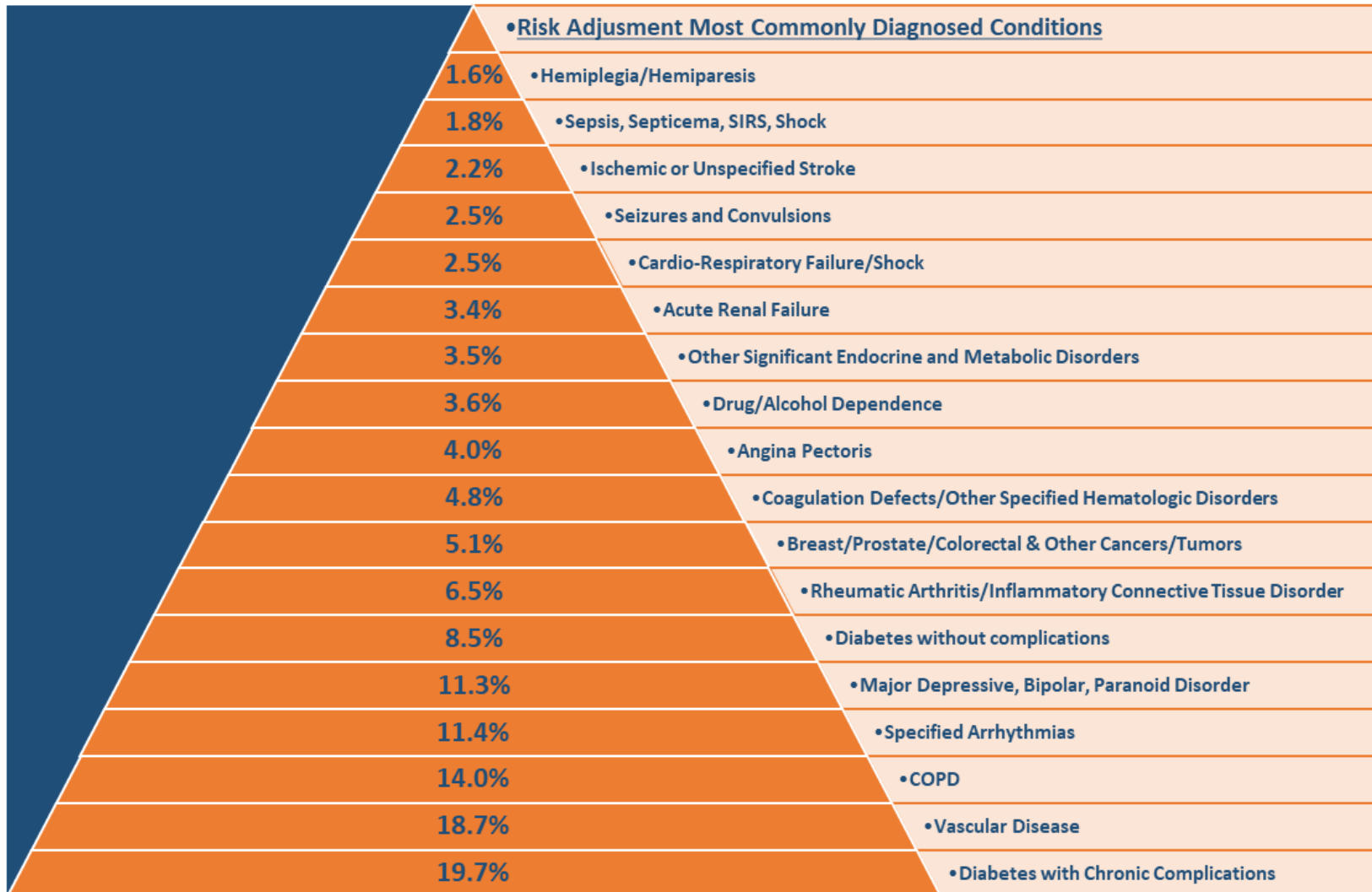# Risk Adjustment Most Commonly Missed Conditions

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- Diabetes **without** complications

- Depression

- Unspecified conditions

- Status conditions – T.O.A.D conditions

  - Transplant

  - Ostomy

  - Amputation

  - Dialysis

Risk Adjustment Common Errors

Common errors in high-risk diagnoses that are reported, but not validated in medical documentation:

- Cancer – Codes as Active/Current vs. History of

- Acute Stroke in outpatient setting vs. History of with residual effects

- Acute Heart Attack in outpatient setting vs. Old Myocardial Infarction

- Embolism – No current medication or treatment documented

- Behavioral Health - Major Depressive Disorder – Over coding with no current treatment or medication documented

- **Mis-keyed diagnosis codes** - ICD-9 diagnosis code 250.00 Diabetes Without Complication transposed as diagnosis code 205.00 Metastatic Cancer and Acute Leukemia

Risk Adjustment Most Commonly Diagnosed Conditions

•**Risk Adjusment Most Commonly Diagnosed Conditions**

1.6%	•Hemiplegia/Hemiparesis
1.8%	•Sepsis, Septicema, SIRS, Shock
2.2%	•Ischemic or Unspecified Stroke
2.5%	•Seizures and Convulsions
2.5%	•Cardio-Respiratory Failure/Shock
3.4%	•Acute Renal Failure
3.5%	•Other Significant Endocrine and Metabolic Disorders
3.6%	•Drug/Alcohol Dependence
4.0%	•Angina Pectoris
4.8%	•Coagulation Defects/Other Specified Hematologic Disorders
5.1%	•Breast/Prostate/Colorectal & Other Cancers/Tumors
6.5%	•Rheumatic Arthritis/Inflammatory Connective Tissue Disorder
8.5%	•Diabetes without complications
11.3%	•Major Depressive, Bipolar, Paranoid Disorder
11.4%	•Specified Arrhythmias
14.0%	•COPD
18.7%	•Vascular Disease
19.7%	•Diabetes with Chronic Complications

Risk Adjustment Data Validation (RADV) Audits

RADV audits ensure that health plans are not overstating how sick patients are in order to receive a higher risk-adjusted payment. The audits check to see if HCC codes submitted by MA plans are supported by the member's medical record.

- RADV audits *validate the accuracy of diagnoses* submitted by MA plans.

- Medicare and Medicaid require annual RADV audits.

- If you treated a member whose name appears in a RADV audit, you provide the requested medical records to the MA plan.

- **Success = accurate chart notes to support every chronic condition reported.**

- **Average error rate nationally is 20–30%.**

Medicare Advantage Plans are Here to Stay

- 26+ million Medicare beneficiaries are in a MA plan nationwide (42%)

- This number will increase over time partly because MA plans:

  ➢ Focus on preventive care and early intervention and are incentivized to provide high-value care to keep beneficiaries healthy and minimize disease progression.

  ➢ Develop innovative models, such as care and disease management programs.

  ➢ Address chronic diseases by encouraging providers to identify, manage, and treat chronic illness in innovative cost-effective ways, producing high-quality outcomes.

  ➢ Experience a more clinically appropriate use of health care services than beneficiaries in Fee-for-Service (FFS) Medicare. For example, MA beneficiaries:

    ✓ Experience lower incidence of emergency services, hospital admissions and readmissions, and receive fewer hip and knee replacements.

    ✓ Are 20% more likely to have an annual preventive care visit, have improved PCP services and higher rates of screening and outcome metrics for chronic diseases.

Why Risk Adjustment is Here to Stay

- MA plans are here to stay.

- Healthcare industry is moving from a fee-for-service to a pay-per-performance system – Value-based contracting.

- Is also being used under ACA and Medicaid – so it affects more than just Medicare patients.

- Documentation and coding will increasingly drive reimbursement, quality measures, and medical home models.

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