Risk Adjustment in Medicare Advantage Plans

What is risk adjustment?
Risk adjustment is a process that the Centers for Medicare & Medicaid Services (CMS) uses to reimburse Medicare Advantage (MA) plans based on the health status of members.

Risk adjustment ensures that CMS pays plans appropriately for members’ predicted health costs based on demographics (age and gender) and health status (claims data).

How does risk adjustment work?
In the risk adjustment and Hierarchical Condition Category (HCC) payment model, physicians must diagnose and report their patients’ conditions (e.g., acute, co-existing, and chronic). It’s important to note that the physician does NOT assign a score. The physician reports on the diagnosis and the risk adjustment factors are already designated for the HCC. HCCs are groups of clinically related diagnoses (ICD-10 codes) with similar cost implications.

CMS uses the risk score to adjust payment for a patient’s expected costs. Specific documentation of risk scores results in more accurate reimbursement. The patient’s risk score is reset on January 1 of each year for a new year of claims data.

Why is risk adjustment important?
CMS uses risk adjustment to make appropriate payments for patients with differences in expected medical costs. Medical record documentation and accurate coding are critical to assess risk and ensure proper payment.

The goal of HCC is to allow physicians and payers like HMSA to effectively manage their patients’ health care by allowing for appropriate resources and responses. Accurate risk capture also helps identify high-risk patients, which allows physicians to encourage them to participate in disease and care management programs and prevention initiatives.

Who is affected by risk adjustment?
Providers whose payment is tied to the amount of money the MA plan receives for a specific patient have an aligned interest with the plan to document each patient’s proper condition. When patients are coded properly, the proper revenue is distributed to the health plan to provide the resources needed to care for the patient, including physicians. Additionally, future payment methods to providers will align and correlate to the risk of their patient panel, therefore, HMSA is helping providers prepare for the future.

Risk adjustment also relies on physicians to maintain accurate medical records to capture a comprehensive health status and complete risk profile of their patients.

When will HMSA implement a new risk adjustment plan?
In the past, HMSA conducted chart reviews to validate and capture the appropriate risk adjustment factor. In 2017, HMSA will supplement chart reviews with reporting and analysis, educational and administrative resources, and outreach and communication to help physician organizations, providers, and office staff to improve coding.

How can we improve risk adjustment?
HMSA’s solution is to help physicians, coders, and office staffs stay up to date on best practices and HCCs. Since most of the burden in documenting the risk adjustment factor (RAF) is placed on the provider, having knowledgeable coders will ensure that appropriate diagnosis codes are reported with complete clinical documentation.

Reporting a complete picture of the RAF increases the accuracy of the risk score and reduces the need to request medical records or audit providers’ claims. When done correctly, HCC streamlines the process of creating “clean” claims and allows efficient reimbursements.

Questions? Email us at MedicareRiskAdj@hmsa.com
### RETROSPECTIVE STRATEGY

HMSA will focus on improving the risk scores of patients whose claims and charts were previously submitted and written. Retrospective chart review will continue for previously submitted claims where there’s opportunity to improve the accuracy. Results will be communicated back to the provider, so HMSA can provide effective feedback, education, and training.

- **Conduct chart reviews**: Ensure accuracy of completed chart reviews and that accurate risk scores are submitted to CMS.
- **Analyze & report results**: Report chart review findings to providers. Show gap opportunities and financial variance between risk scores based on claims submitted vs. risk scores after chart reviews.
- **Educate & train**: Provide training and education on RA basics to physicians, coders, and office staff.
- **Improve risk scores**: Conduct performance management reviews with providers to improve accuracy and buy-in of submitting properly coded claims.
- **Align revenue**: Improve and maximize RA scores of MA plans to align revenues with the patients’ role.

Chart reviews validate that risk conditions applicable to the patient are captured in the progress notes with assessment and treatment options. Increased coding accuracy and specificity helps health plans and providers identify patients who may benefit from disease and care management programs.

### PROSPECTIVE STRATEGY

HMSA will focus on training and educating physician organizations, providers, and office staff to improve the risk adjustment accuracy of claims submitted. HMSA will concentrate on these key areas:

- Customizing and optimizing educational and administrative resources for providers and their staffs.
- Creating a training program to provide ongoing education on coding and documentation.
- Presenting provider performance report cards with comparison to peer results and gap closure opportunities.
- Creating an incentive program to encourage providers to code more accurately.
- Providing ongoing communication and outreach to RA stakeholders with periodic provider office visits and performance updates.

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