Additional Information/Resources

FirstChoice VIP CARE PLUS by Select Health of South Carolina | Healthy Connections PRIME

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?

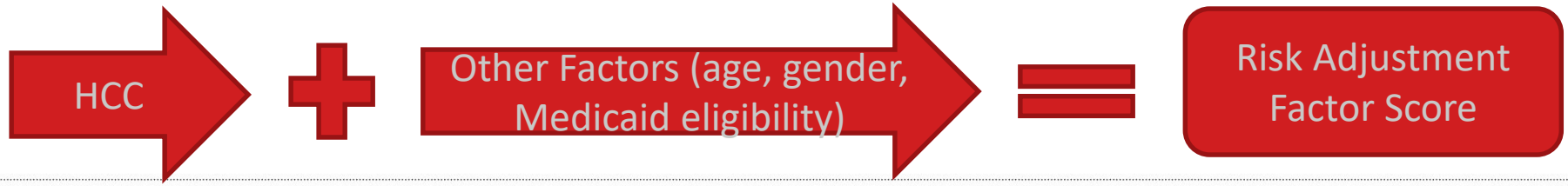
- CMS uses a disease model to determine a risk "score" for each member. The model takes individual diagnosis codes and combines them into broader diagnosis groups, which are then refined into **Hierarchical Condition Categories (HCCs)**. HCCs, together with demographic factors such as age and gender,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

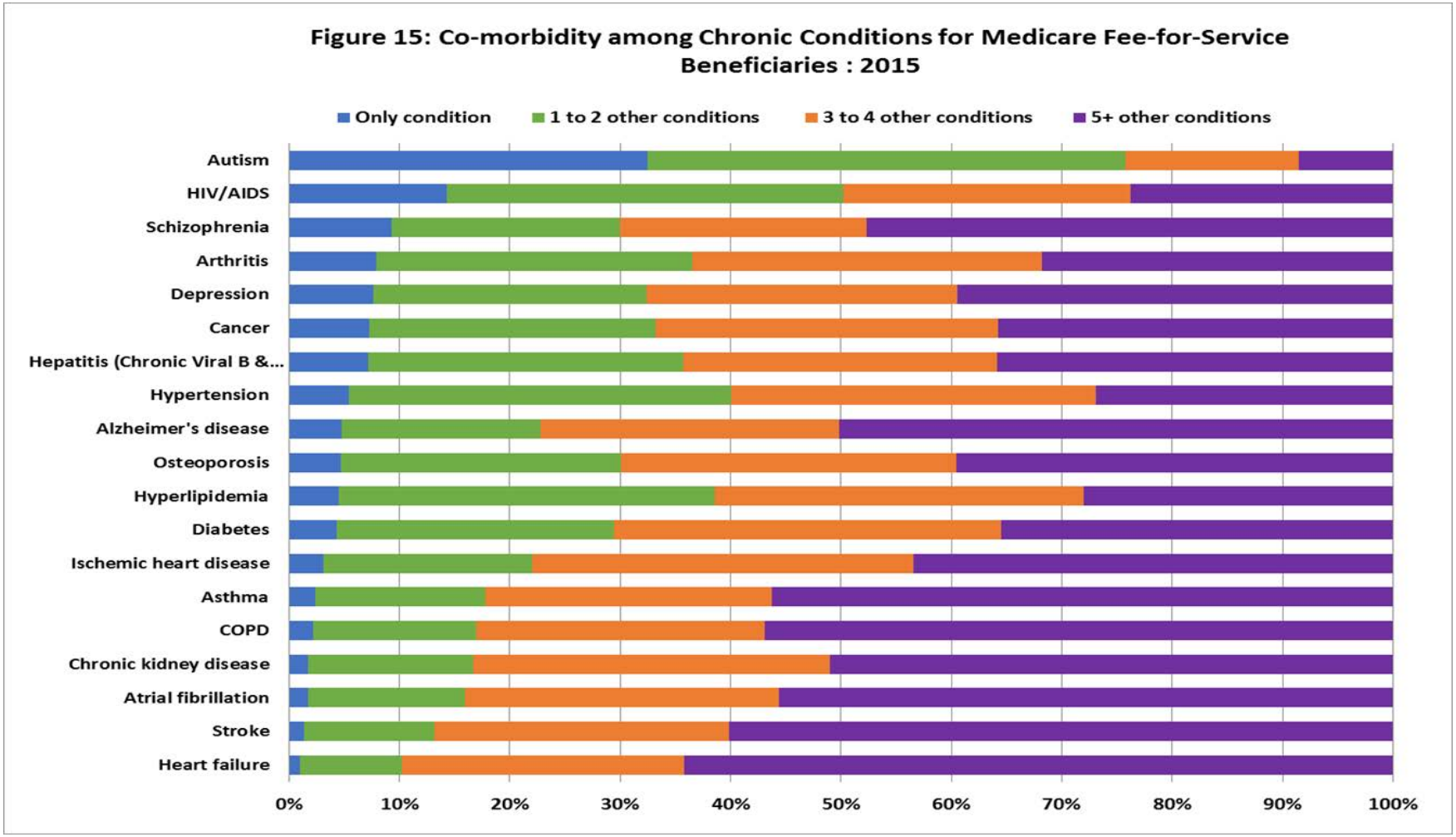
- Implemented by CMS in 2003.
- Measures the disease burden that includes 79 HCC categories, which are groups of clinically related diagnosis (ICD-10) codes with similar cost implications.
- The HCC model is made up of 10,000+ ICD-10 codes that typically represent costly, **chronic** diseases such as:

  - ✓ 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



Percent of Co-Morbidities



*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.

How can provider's help?

To comply with CMS regulations, provide the best and most efficient service to your patients, and receive the reimbursements you deserve, 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** ★

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

- 21.5 million Medicare beneficiaries are in a MA plan nationwide (34%)
- 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.

Pharmacy - High Risk Drugs for the Elderly

Are your providers prescribing high-risk medications for your patients over age 65?

High-risk medications are those identified by American Geriatric Society (AGS) Beers Criteria which tend to cause adverse drug events in older adults due to their pharmacologic properties and the physiologic changes of aging.

Prescription drug use by the elderly can often result in adverse drug events that contribute to:

- ✓ Hospitalization
- ✓ Increased duration of illness
- ✓ Nursing home placement
- ✓ Falls and fractures.

Potentially inappropriate medications continue to be prescribed for and taken by older adults despite the recognition of increased likelihood of adverse drug events and evidence of poor outcomes in elderly patients. First Choice VIP Care Plus would like to work with providers to find safer alternatives for our members over age 65. Please contact the member's care coordinator at **1-888-978-0862**, option 5, and we will be glad to assist you.

A printable pocket guide of these medications is also available from AGS at:

Beers Criteria Printable Pocketcard - American Geriatrics Society

Advance Directives

The advance directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under South Carolina state law, relating to providing health care when an individual is incapacitated.

Advance Directive — Member Rights

Member rights under federal law:

- To decide what medical care they want to receive, if in the future they are unable to make their wishes known.
- To choose an individual to act on their behalf to make health care decisions in the event they are unable to make these decisions on their own.

Advance Directives — Provider Responsibilities

Provider's responsibilities:

- Discuss and offer to assist with facilitation of advance directives for individuals.*
- Maintain written policies and procedures concerning advance directives with respect to all adults receiving care.

* Must be in compliance with 42 C.F.R. 489.100.

Advance Directives — Provider Responsibilities (cont.)

- Information regarding advance directives must be furnished by providers and/or organizations as required by federal regulations:
  - **Hospital** — At the time of the individual's admission as an inpatient.
  - **Skilled nursing facility** — At the time of the individual's admission as a resident.
  - **Home health agency** — In advance of the individual coming under the care of the agency or at the time of the first home visit, as long as the information is furnished before care is provided.

Advance Directives — Provider Responsibilities (cont.)

- **Personal care services** — In advance of the individual coming under the care of the personal care services provider or at the time of the first home visit, as long as the information is furnished before care is provided.
- **Hospice program** — At the time of initial receipt of hospice care by the individual from the program.

Report suspected fraud, waste or abuse to First Choice VIP Care Plus

Providers who suspect that a First Choice VIP Care Plus provider, employee or member is committing fraud, waste or abuse should notify the First Choice VIP Care Plus Special Investigative Unit as follows:

By phone: 1-866-833-9718
By U.S. mail:

First Choice VIP Care Plus Special Investigative Unit
200 Stevens Drive
Philadelphia, PA 19113

Reports may also be sent directly to the U.S. Department of Health and Human Services one of the following ways:

By calling 1-877-7SAFERX (772-3379)
Online at hhstips@oig.hhs.gov
Information may be left anonymously.

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