What is Medicare risk adjustment?

Under the Medicare Advantage (MA) program, MA Organizations (MAO) are paid a set premium to cover the costs of healthcare services provided by their plans. The Centers for Medicare & Medicaid Services (CMS) uses demographic and disease data for each member to determine the individual premium. The amount of the premium does not vary based on actual use of healthcare services. This payment system, known as Medicare risk adjustment (MRA), allows CMS to adjust its premium payments to MA organizations based on the expected healthcare costs of its members.

The role of the MA plan, physicians and other healthcare providers

Diagnosis data from physicians and other healthcare providers is used to determine whether an individual member suffers from certain diseases that are expected to lead to higher healthcare costs for that member. CMS requires all health plans to submit Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant 837 claims transactions to CMS for MRA. All diagnoses submitted for risk-adjusted payment must meet the following criteria:

- They must be documented in a medical record based on the following criteria during a face-to-face encounter with an acceptable provider type, such as physician, inpatient hospital facility, outpatient hospital facility, etc.
- They must be assigned based on dates of service within the relevant data collection period.
- They must be coded in accordance with standard industry guidelines, International Classification of Diseases, 10th Revision (ICD-10)
- They must not be based solely on laboratory or other diagnostic tests, such as radiology reports.

MA plans must annually attest that, based on their best knowledge, information and belief, all risk adjustment information submitted to CMS is accurate, complete and truthful. As part of the provider participation agreement, physicians and other healthcare providers attest to the accuracy of the data, including diagnosis codes, submitted to CarePlus Health Plans®. Physicians and other healthcare providers are responsible for maintaining an accurate and

complete medical record for each Medicare patient and must alert CarePlus to any erroneous data that has been submitted and follow the procedures for correcting such data. Physicians and healthcare providers are responsible for participating in any CarePlus medical record reviews or audits related to documentation and coding, such as the provider data validation documentation and coding review.

In addition to facilitating payment accuracy as well as good medical record documentation and coding practices, MRA also helps ensure that MA plan members receive the care they need for their health conditions and that they are able to take advantage of disease management and other programs available through their MA plans. To improve medical record documentation and coding practices, physicians and other healthcare providers should consider the following suggestions:

- Providers should use an electronic health records system.
- Providers should confirm that all diagnosis codes are included in the claim submission. For professional services, physicians and other healthcare providers should have the capacity to submit 12 diagnosis codes.
- Providers should ensure procedure and diagnosis codes on the form are current when using a superbill, encounter sheet or checkout form.
- Providers should submit full and accurate documentation and ascertain that diagnoses are supported.
- Providers should purchase and use updated coding books or software each year and ensure the practice management system is kept updated.
- Providers should use a certified coder or health information management professional for coding and billing functions.

For more information, please contact your CarePlus representative. Thank you.