Managed Healthcare® EXECUTIVE

Ten ways Medicare Advantage plans improve risk adjustment success

December 19, 2016
By Sean Creighton

Medicare plans need to be on top of their entire risk adjustment game in 2017 and beyond, starting with understanding CMS rule change impacts, identifying and documenting all members with potentially underreported conditions, and submitting accurate data to CMS.

There are two main areas of risk adjustment where plans could potentially fall down:

1. Identifying and documenting the accurate illness burden of as many members as possible.

Plans may not be getting fully or accurately reimbursed relative to the risk of their populations. When running analytics on a client's population to look for the possibility of undiagnosed or underdiagnosed conditions, results show 50% to 60% more revenue per chart than those identified by clients themselves. In addition, CMS has segmented its eligibility status into six specific categories to account for the historical challenge of appropriately reporting the risk of plans' dual-eligible populations with appropriate predictive ratios. This means plans with a higher concentration of partial-duals and non-duals should realize a payment reduction—it has been estimated about a 0.6% risk score decrease, on average, for Medicare Advantage plans. Finding more members

with underreported conditions could offset this predicted decrease or even turn it around.

2. Closely monitoring encounter data submissions in relation to RAPS data submissions.

For 2017, CMS is changing the weighting to 75% Risk Adjustment Processing System (RAPS) data and 25 percent Encounter Data Processing System (EDS) data, with a full phase in to 100% EDS data occurring in Payment Year (PY) 2020. Based on experience with health plan clients, I expect that the move to a 25% weight on EDS submissions will have a negative impact on risk scores, ranging widely from -0.3% to -1.5%. During the transition to 100% EDS risk score calculations, plans must manage two data streams. With encounter data impacting risk scores since 2016, plans must better monitor their encounter submissions for completeness to avoid a negative effect on their revenue. Research has shown that plans that are more engaged in the monitoring of their encounter data are missing less of their claims in the encounter data system. These plans will see less of an impact to their risk scores in PY 2017.

Ten tips to manage the risk adjustment process

Successfully addressing these two focus areas for Medicare risk adjustment can be daunting. Here are 10 tips to better manage the risk adjustment process from A to Z:

1. Know what to expect from the latest rules.

CMS provides advance notice to inform plans on what they should do to prepare for an upcoming risk adjustment program. Understanding the latest program updates in advance and developing a strategy in response position a plan more favorably when it comes to obtaining appropriate funding.

2. Stay involved and communicate with CMS.

Before implementing new policies, CMS often sends out proposals with a request for public comment. CMS has historically shown that it pays close attention to these comments. Responding to these requests helps keep CMS aware of how its policies

affect your plan. Often the highlights of the public comments are released, which is a great way to learn about how other plans are reacting to proposed CMS changes.

3. Conduct outreach early.

Encourage members to visit their primary care providers. Educate providers on Medicare risk adjustment, as well as the recommendations for prospective health assessments. This will allow you to view members' health in detail early in the year, including their Hierarchical Condition Category (HCC) and non-HCC conditions, HEDIS measures, and particular care gaps to help you identify members who should be enrolled in disease management programs.

4. Get to know your population.

The key to a successful risk adjustment program is fully understanding your population:

- How sick are they?
- What conditions will you need to anticipate and care for?
- Which patients have the highest risk?

By using suspect analytics, organizations can better identify, prioritize, and reach members with the highest probability of having undocumented conditions. An informed, prioritized list of patients will help drive your strategy to retrospectively find and document conditions for consideration in your risk-adjusted payment formula, as well as undertake prospective health assessment outreach.

5. Be strategic about suspecting.

Suspect analytics will also help you avoid chasing members with less risk. The ideal time to start suspecting is between February and April of each payment year. Identify target members, conduct prospective outreach and/or retrospective medical record retrieval and review, and document new or undocumented conditions in time for the final CMS sweep, which typically occurs at the end of January in the following year.

6. Seek peak efficiency when executing medical record retrieval.

The most certain way to validate and document potential conditions is through a patient's medical record. In many cases, a provider may note the existence of a condition in a patient's chart but not bill for anything specific to that condition in the claim. For example, if a patient is seen for an acute event such as a cut or wound related to an accident, the doctor may note that the patient suffers from diabetes. However, because the patient is not being seen or treated for diabetes during that visit, no claim detail regarding the condition would be submitted. The actual record, however, can be used as documentation.

When retrieving medical records from provider offices, minimize provider abrasion and unnecessary effort by being as efficient as possible. Consolidate multiple member chart requests, track all office staff details and prior requests, and have a means of imaging and indexing the inevitable paper records. Consider two waves of retrieval, with the first wave starting around April to get ahead of the game, and the second wave taking place after CMS updates its risk profiles for each member by refreshing the risk score calculation in August. This refresh may add or remove HCCs to and from payment calculations.

7. Code accurately, and capture all relevant data.

Accurate and complete coding should be your seasonal risk adjustment mantra. Be sure to capture all diagnosis and HCC data when coding. The accuracy rate is important. Even a slight variation in accuracy, when extrapolated across an entire population, can make a huge difference in revenue and an even bigger difference should you be audited. Emphasize accuracy among your team of coders, or take advantage of a vendor's expertise in this area. Coding activities typically start around June, depending on how early you start your first wave of retrievals, and can continue through January until CMS's final sweep of data from your prior payment year.

8. Compile, scrub, and triple-check your data.

Conduct multiple quality assurance reviews and audits throughout the process to ensure the highest level of quality and accuracy prior to submission to CMS. The recent transition to ICD-10 may present additional challenges with data quality as providers are working to adapt to new coding procedures. If you've planned for and completed your suspecting, record retrieval, and coding processes early enough, you should be compiling and scrubbing data in January through March.

9. Ensure that data is successfully submitted on time, in the correct format.
The introduction of EDS data into risk score calculations, and therefore risk-adjusted payments, has the potential to drastically change MA revenue. For 2016, EDS will account for only 10% of risk-adjusted payments. However, this portion will increase rapidly as CMS moves toward its eventual goal of discontinuing RAPS submissions.

Medicare Advantage programs have already begun to analyze the impact of EDS on their revenue and are focusing more on monitoring their EDS submissions. Plans must understand the difference between RAPS and EDS submissions. System edits, claims filtering, and supplemental requirements are just a few examples of potential variances between the two systems. Developing a sound transition plan will be crucial to maintain risk-adjusted revenue over the next few years.

10. Reconcile any errors, and analyze your final reports.
Each year is a new opportunity to secure appropriate funding for your population. The final step should be to reconcile any errors, analyze your final data, and look at ways to improve your submissions.

Sean Creighton is senior vice president of risk adjustment at Verscend Technologies.