Provider guide to Medicare Advantage and ACA risk adjustment

Maximizing efficiency in documenting and capturing patient conditions

What is risk adjustment and why is it important?

Risk adjustment is a payment model used by the Centers for Medicare and Medicaid Services (CMS) to predict future health care expenditures of individuals based on diagnoses and demographics. This model predicts health care costs based on the actuarial risk of enrollees, which is established based on chronic conditions, age, race, socioeconomic status and gender. The goal of risk adjustment is to mitigate the impact on insurers with higher-risk populations, ensure patients with varying degrees of health conditions have access to affordable health care and provide providers with improved understanding of patient health status and potential conditions.

How can providers help?

Providers play a key role in our reporting to CMS through documentation and accurate coding for Medicare and ACA risk adjustment by taking the following steps:

- **Coding:** Code all diagnosis codes on a claim every year. Submitting all ICD-10 codes on a claim reduces the potential amount of medical record retrieval.
- **Medical records:** Make sure all medical records include accurate, complete and up-to-date information, including clinical notes and test results. Risk adjustment relies on diagnosis coding, so all chronic, acute and status conditions should be documented during each face-to-face encounter. Document how each condition is assessed, monitored and treated. In accordance with CMS guidelines, all entries must be properly dated and include a valid signature with credentials.
- **Patient assessment**: Use the annual wellness visit to review, update and document all active health conditions for ACA and Medicare Advantage (MA) members. Accurate coding and documentation is essential for proper risk adjustment. Tools like patient assessment forms help identify suspected conditions that should be addressed and coded if present. Diagnoses must be submitted on valid claims to be captured.
- **Diagnosis codes:** Providers should become familiar with risk adjustment practices and use accurate ICD-10 codes that reflect each patient's current health conditions with the highest level of specificity. All encounters should be coded accurately and submitted to the health plan to support proper risk adjustment.
- **Best practices for risk adjustment documentation:**
  - Conduct annual wellness visits early in the year to allow greater opportunity to address all chronic conditions.
  - Ensure the patient's name and date of birth is documented on each page of the medical record.
  - Use clear language and provide complete details. Avoid using acronyms.
  - Include updates on assessment and treatment for each diagnosis. For example: assessment = improving or treatment plan = continue medication.
  - Reaffirm chronic conditions and ask about other conditions reflected in past visit notes.
  - Verify the physician signature, credentials and date are all included to authenticate the medical record.
  - Confirm that claims are tied to an encounter and complete details are included. When in doubt, document!
  - Verify that medication explicitly ties to treatment plans.
  - Link related conditions using words such as "due to," "with" or "diabetic."

Frequently asked questions

Review the following frequently asked questions and reach out to our Risk Adjustment team at risk.adjustment@bcbsks.com if you need additional information.

1. **What are my responsibilities as a provider in the risk adjustment process?**
   Providers are responsible for accurately documenting and coding all relevant chronic and acute conditions at least once per calendar year. Use specific ICD-10 codes to ensure each diagnosis is supported by clinical evidence of monitoring, evaluation, assessment or treatment.
2. **We don't have the staff to produce the large number of medical records being requested from multiple health plans. What are my other options?** Blue Cross Blue Shield of Kansas (BCBSKS) understands your concern and suggests granting us external access to your EMR system or providing permission to come on site so that we can retrieve medical records with less effort from your staff.
3. **What if another provider primarily manages specific conditions of the patient?** Providers should document and code all conditions influencing their clinical decision-making, even if the patient sees another provider to manage the condition.
4. **What kind of visits are eligible for risk adjustment data capture?**
   Face-to-face visits such as office visits, annual wellness visits and inpatient encounters are eligible.
5. **What is the difference between Medicare Advantage and ACA risk adjustment?**
   - Medicare Advantage (MA) risk adjustment uses CMS hierarchical condition category (HCC) model with data from the prior year to establish a patient-level risk score to capitated payments from CMS to MA plans.
   - ACA Risk Adjustment uses the Health and Human Services (HHS)-HCC model with data from the current benefit year to determine transfer payments between plans in the same market.
6. **What is a risk adjustment audit and why does it happen?**
   Risk adjustment audits are required by CMS and HHS to ensure diagnosis codes submitted by providers are accurate and supported by medical records. These audits help verify the health status of patients is documented correctly, which affects health plan payments under Medicare Advantage and ACA programs.
7. **I received a request for medical records and want to know why?**
   The audit request letter confirms Blue Cross Blue Shield of Kansas will conduct risk adjustment audits as required by HHS and CMS. Medical records are being requested from your provider(s) based on the diagnosis code selected for the patients, as defined by HHS and CMS. As an insurance company that offers Medicare Advantage plans and marketplace plans for individuals and small groups, we are required to audit the chronic conditions mapped to those specific diagnosis codes for those specific patients to ensure they are being documented accurately.
8. **Do the results of this audit change payment I received from submitting the claim?**
   No, this audit doesn't affect payments received by the provider from BCBSKS. This audit is solely a review of the diagnosis codes submitted on the claim.
9. **Why won't our practice be reimbursed for processing medical record requests?**
   Records should be supplied at no cost based on your contractual agreement with BCBSKS. Your office manager should have complete information regarding your contract. If you need additional information, reach out to your provider representative or the Risk Adjustment team at risk.adjustment@bcbsks.com