ABCs of Medicare Advantage

by J. (Jeannette) Stacey Hernandez, CCS-P

Although most Medicare beneficiaries receive their health coverage through the traditional Medicare Part A and B fee-for-service programs, more and more beneficiaries are enrolling in Medicare Part C, referred to as Medicare Advantage (MA), to manage their healthcare costs.

By June 2008 more than 8 million Medicare beneficiaries, roughly 18 percent, were enrolled in MA plans.[1] This number is expected to grow due to lower out-of-pocket costs and increased plan choices, such as PPOs and private fee-for-service plans. Employers who provide group retiree coverage also find MA plans attractive.

This article provides key information for HIM professionals involved with the coding and operational aspects of MA provider plans.

The Medicare Advantage Model

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 included a provision that changed Medicare+Choice into the MA program. The MA program was created to expand the options available under private plans in Medicare. Examples of approved MA plans administered by private healthcare organizations at local and regional levels include:

- Coordinated Care Plan, which includes HMOs, HMO-POS plans, PPOs, provider-sponsored organizations, and special needs plans
- Private Fee-for-Service Plan
- Medical Savings Account Plan

In 2004 the Centers for Medicare and Medicaid Services (CMS) adopted the CMS-Hierarchical Condition Category Risk Adjustment (CMS-HCC RA) payment model. The ultimate goal of the model was to adopt a clinically sound risk adjustment model to improve payment accuracy. For example, the model promotes fair payments to MA organizations that reward efficiency and encourage excellent care for their chronically ill member population.

The model adjusts per-beneficiary capitation payments with a risk adjustment methodology using diagnoses to measure relative risk due to health status. In the past this was calculated using demographic characteristics such as age, sex, and Medicaid eligibility. The new model uses select ICD-9-CM diagnostic codes to define disease groups, referred to as hierarchical condition categories, or HCCs.

ICD-9-CM diagnostic codes map to clinically related hierarchical condition groups, which are broadly organized into body systems. The ICD-9-CM diagnosis codes within each HCC disease category are related both clinically and in cost to the fee-for-service Medicare program.

The diagnostic conditions within each HCC are assigned a weight, which multiplied by a payment factor results in a payment amount to the MA organization. The payment factor is unique to each MA organization, based in part on its bid. The total HCC payment is based on the MA organization's bid amount and the MA beneficiary's actual risk score.

The CMS-HCC RA model is both additive and hierarchical. The weights of unrelated or distinct conditions are added together. But as the model's name implies, it is a hierarchical model based on serious and chronic diseases, which are predictive of increased healthcare costs in the next year.

Hierarchies in the model provide payment for only the most severe manifestation of a disease. When more than one condition in a hierarchy is reported, only the most heavily weighted diagnosis will be assigned and used in the calculation of the patient's

risk score during the data collection year.

If a condition is likely to lead to additional healthcare costs in the next year it is included in the model. The most common hierarchy is diabetes, which is shown in the table below.

The CMS-HCC model also includes disease interaction payments. These payments recognize that when certain diseases are present together (e.g., diabetes and congestive heart failure), they have added potential costs that are not fully accounted for by simply adding the category weights together. An additional payment factor is added for these interactions.

This model is prospective, which under MA means past diagnosis implies future cost. For example, ICD-9-CM diagnostic data collected in a base year (e.g., 2008) will be used to predict expenditures and payment in the following year (e.g., 2009). A diagnosis must be substantiated and submitted once per calendar year in order to affect payment. Payment for diagnoses is never automatically carried over into the next year. This makes submission of all pertinent diagnoses critical to funding an MA member's healthcare costs.

In addition to diagnostic codes, the CMS-HCC model employs five demographic factors in calculating the risk score: age, sex, Medicaid status, disability, and original reason for Medicare entitlement (i.e., disability). In CY 2007 the transition from demographic-only to risk-adjusted payments was complete, and CMS payments to MA organizations were fully risk-adjusted for the first time.

In order to further improve MA organization payments, CMS developed four separate models based on different Medicare patient population cost trends. The CMS-HCC models used to calculate MA plan risk scores include a community model, a long-term institutional model for members in skilled nursing facilities more than 100 days, an end-stage renal disease model, and a new enrollee model. The new enrollee model is unique from the other models in that it is not disease based.

Key HIM Contributions for MA Success

HIM professionals can take the following steps to assist in collecting and submitting accurate MA CMS-HCC RA data and ensure MA provider partner compliance.

Understand the MA Provider Agreement

HIM professionals should request a copy of their provider's MA provider agreement and learn the HIM coding and documentation requirements, the applicable CMS-HCC models, and release of information compliance expectations. This knowledge will position the MA provider to succeed in critical aspects of the contractual agreement requirements.

For example, CMS requires that risk adjustment data from the MA organization be complete and accurate. MA organizations *must* obtain these data from MA providers, and CMS allows MA organizations to require these data in their MA provider contracts, which may contain financial penalties for noncompliance.

Promote Accurate Diagnostic Coding and Data Collection

The MA organization must report all MA beneficiary ICD-9-CM diagnosis codes relevant for the CMS-HCC risk adjustment model at least once per enrollee in the organization's data collection period. Accurate CMS-HCC classification is dependent on the MA organization's ability to obtain and report accurate MA provider diagnostic information to CMS. Although this sounds simple, challenges have been identified from both a coding and operational perspective.

CMS uses MA beneficiary administrative claims data reported by hospital inpatient, hospital outpatient, and physician office MA providers and submitted by MA organizations. The required data collection from the appropriate risk adjustment sources and formats is critical for MA program data integrity and appropriate risk-adjusted payment. Accurate payments to MA organizations help ensure that their MA providers are paid appropriately for the services they provide to MA beneficiaries.

MA organizations and CMS data validation studies have identified concerns with the quality of diagnostic reporting from physician office providers. The CMS data validation process ensures risk-adjusted accuracy and payment integrity. Error rates appear to be high. Individual audit results shared among providers and health plans indicate a raw error rate of about 60

percent when reviewing diagnostic coding data from physician office providers, which represent approximately 80 percent of MA data submitted to CMS. This only heightens the critical need for physician office providers to accurately report diagnostic coded data for their MA members.

MA organizations are able to improve the error rate, because CMS allows MA plans to search for the "one best medical record" to support a diagnosis code in the audit year. However, this medical record review process is labor intensive for both the MA organization and MA provider partner. Currently, the average overall error rate for data validation from all MA providers is approximately 35 percent in the pilot project, the only data CMS has published to date.[2]

Coding professionals play a critical role in physician coding and documentation education in the hospital setting. This relationship provides an opportunity to advocate diagnostic coding and documentation education related to MA provider plans. However, regardless of the provider setting, coding professionals who succeed in delivering fundamental physician ICD-9-CM diagnostic coding training will have a tremendous positive impact in the critical need to report diagnostic coded data that accurately reflect MA beneficiaries' health profiles.

This year CMS implemented an additional audit initiative to continue validating diagnostic coding practices submitted to CMS by MA plans. CMS intends to review information from medical records and make contract-wide adjustment to payments based on the findings. In prior years, CMS contractors have audited medical records for 6,000 MA beneficiaries. CMS's current audit covers 60,000 MA beneficiaries.

Although CMS has indicated in its announcement of 2009 rates that it will extrapolate overpayments, how this will be accomplished and what appeals will be available are still under development. It is possible that CMS will use these data to set national error benchmarks and apply the extrapolation to error rates above the national benchmarks.

CMS-HCC RA Hierarchy for Diabetes

The payment model is hierachical, based on serious and chronic diseases, which are predictive of increased healthcare costs in the following year. The most common heirarchy is diabetes, shown here.

CMS HCC Model Category Number	Description	Weight
15	Diabetes with Renal or Peripheral Circulatory Manifestations	.508
16	Diabetes with Neurologic or Other Specified Manifestations	.408
17	Diabetes with Acute Complications	.339
18	Diabetes with Ophthalmologic or Unspecified Manifestations	.259
19	Diabetes without Complications	.162

Support MA Organization Release of Information Requests

HIM professionals are uniquely positioned to assist MA providers in understanding and complying with MA organization medical record documentation requests. When MA providers receive MA member medical record requests, HIM professionals can be relatively certain the MA organization is being audited by CMS (i.e., in a data validation study) or the MA organization is requesting additional information for MA payment methodology purposes.

Because of system limitations on the number of diagnoses that can be submitted, MA organizations sometimes ask for coding abstracts in order to capture diagnosis codes that could not be submitted through the normal submission process. In any case, HIM professionals should expect such requests to address the need, purpose, and regulatory basis for the release.

The purpose of the release should be clear. If this is not the case, HIM professionals should contact the MA health plan employee listed on the request. As for any HIPAA concerns, the MA member data requests fall under health plan operations and payment.

For example, as noted earlier, MA organizations must obtain all existing coded diagnoses for each MA beneficiary in order to calculate an appropriate risk adjustment score. Often the chronically ill MA member population has more diagnoses than are allowed to be reported on healthcare claim data. Under the CMS-HCC RA model, patients with risk-adjustable diagnoses are reimbursed at a rate intended to fund their healthcare costs in the next calendar year. Therefore, it is clear why MA organizations need to request additional MA member health information pertaining to diagnosis documentation in order to capture all applicable chronic diseases and conditions.

In an effort to decrease the burden on MA provider partners, most MA organizations limit requests and generally request the coding abstract when the maximum number of reportable diagnoses is reached on healthcare claim data. MA organizations also strive to limit these types of requests to instances where it is likely that the additional applicable diagnosis data are available.

Developing a collaborative relationship with the MA organization's risk adjustment staff will assist in determining when the MA organization anticipates submitting high volume MA member medical record requests. It is valuable to determine if the MA organization practices concurrent or retrospective MA member data collection and audit reviews.

Coding professionals who actively demonstrate MA plan knowledge, provide complete and accurate MA risk adjustment coded data, and commit to promoting physician coding education not only provide key contributions at the MA provider and MA organization level, they also contribute in strengthening the MA program at a national level.

Notes

1. Gold, Marsha. "Medicare Advantage in 2008." June 2008. Henry J. Kaiser Family Foundation. Available online at www.kff.org/medicare/upload/7775.pdf.
2. Centers for Medicare and Medicaid Services. "Medicare Advantage Risk Adjustment Data Validation CMS-HCC Pilot Study: Report to Medicare Advantage Organizations." July 2004.

Resources

Centers for Medicare and Medicaid Services. "Announcement of Calendar Year (CY) 2009 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies." April 7, 2008. Available online at www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2009.pdf.

Electronic Code of Federal Regulations. 42 CFR 422.310 (d)(3) and 42 CFR 422. Available online at http://ecfr.gpoaccess.gov.

Medicare Payment Advisory Commission. "The Medicare Advantage Program and MedPAC Recommendations." June 28, 2007. Available online at www.medpac.gov/documents/062807_Housebudget_MedPAC_testimony_MA.pdf.

J. (Jeannette) Stacey Hernandez (SHernandez@scanhealthplan.com) is HCC tools and development manager of SCAN Health Plan.

Article citation:
Hernandez, Jeannette. "ABCs of Medicare Advantage" *Journal of AHIMA* 79, no.11 (November 2008): 82-84.