Winning in Risk Adjustment
Five Steps for Health Plan Executives to Boost Coding Accuracy and Efficiency
Executive Summary

As the healthcare industry continues to shift from volume-based to value-based reimbursement, health plans are moving to change the way they do business. Recognizing that the cost of and incentives associated with traditional fee-for-service care are unsustainable, they are expanding their risk-based contracting efforts and seeking out more innovative ways to help providers deliver better care at a lower cost. For these payer organizations, accurate and timely risk adjustment is crucial to their success, as it has a direct impact on both plan revenue and care quality.

The stakes are high and will only continue to grow. In today’s highly regulated, competitive and increasingly quality-focused market, payers must look to technology for cost-effective ways to expand their risk adjustment strategies.

This white paper outlines the risk adjustment challenges health plans face and how technology-enabled data analytics can help plans tackle the problem and master risk adjustment through five proven steps for improved coding efficiency, productivity and accuracy.

A Changing Marketplace

The Center for Medicare & Medicaid Services’ (CMS) goal to tie 50 percent of traditional fee-for-service Medicare payments to quality or value through alternative payment models—such as Accountable Care Organizations (ACO)—by the end of 2018 has drastically changed the Medicare Advantage insurance marketplace. Healthcare consulting firm Leavitt Partners predicts that by 2020, anywhere from 41 million to more than 176 million patients will be covered by a value-based contract delivered through an ACO, with MACRA payments responsible for 37 million of those\(^1\). Similarly, the passage of the Affordable Care Act (ACA) has touched off a dramatic shift toward value-based care in the commercial health plan market.

Payers in both markets are responding to the increasing demand for higher quality and more affordable care by veering away from simply paying for treatment to supporting prevention and wellness efforts through value-based care and population health management initiatives. Payers surveyed in a recent national research study commissioned by McKesson\(^2\) estimated that 42 percent of their payments will be tied to value-based reimbursement models in the next two years, up from 32 percent currently. That number rises to 54 percent of payments tied to value-based reimbursement arrangements in five years. Goodbye fee-for-service care, hello value-based, risk-adjusted care.

Payers expect the majority of their reimbursements will be tied to value-based payment arrangements by 2020.
With value-based reimbursement and alternative payment models quickly becoming industry mainstays, risk adjustment, which compensates payers based on the health of their member population, is now a key compensation mechanism for both Medicare Advantage and commercial exchange payers. An effective risk adjustment program is critical to ensuring that payers receive accurate reimbursements and transfer payments. It is also the key to providing the complete picture of member health needed to support better care delivery, generate cost savings and improve quality ratings.

Mistakes in risk-based contracting can be costly. For commercial health plans that are taking on the higher risk of sicker, costlier patients, inaccurate risk adjustment can lead to serious revenue shortfalls. They may set premiums too low to cover the actual cost of care or set low risk scores that prevent them from qualifying for transfer payments. On the flip side, insurers that overestimate risk can set premiums too high, putting them in danger of losing healthier members to more affordable plans.

The risk adjustment performance of Medicare Advantage payers, who are covering an older population that tends to require more care, directly impacts their reimbursement from CMS. CMS reimburses plans based on the health status of their membership. Sicker members require costlier care, so it’s critical for payers to find and document all chronic conditions and statuses through accurate risk-adjusted coding.

Additionally, the Medicare Advantage market is highly regulated, and health plans are facing greater audit risk. CMS announced that it is considering changes to the risk adjustment audit program in 2017 that would expand audits to 100 percent of plans. In this atmosphere of increased scrutiny, it will be more important than ever for payers to utilize solutions that not only find and close coding gaps but also mitigate compliance risk by providing accurate evidence and clear supporting documentation for every claimed code.

**Three Big Challenges of Risk Adjustment**

1. **Manual Processes** — Traditional risk adjustment processes are highly manual and inefficient. Trained coders—either in-house, contracted, or outsourced (or some combination of the three)—must comb through reams of charts to analyze claims to find undocumented HCC codes and determine risk scores. It is an expensive and time-consuming process that hinders coder productivity and too often results in costly errors and missed codes. Adding to the burden is the likelihood that coding methodologies will continue to increase in sophistication, making the conversion from ICD-9 to ICD-10 seem like a walk in the park.

2. **More Enrollees and More Data** — There’s no doubt that both the Affordable Care Act and the aging baby boomer population have created a huge increase in the number of enrollees flowing into many health plan membership rolls. As of January 31, 2016, an estimated 12.7 million people signed up for insurance through the ACA, up from 7.3 million enrollees in 2014. In 2016, Medicare Advantage enrollment grew to nearly 19 million, continuing a steady increase of about one million people every year.
This flow of new members has benefitted some private insurers. Between 2010 and 2014, revenues of private insurers increased 45 percent to approximately $375 billion, while operating profit increased 65 percent to $21 billion. However, this increase in covered lives also brings challenges. Medicare Advantage patients are older and may tend to need more care, increasing the complexity and cost of treatment. Many of the new exchange enrollees have never been insured, so information on their health status is unknown, making it difficult for payers to anticipate cost and correctly determine risk scores. Additionally, many are sicker and more expensive to treat than anticipated, while fewer younger, healthier people who would help offset that cost have signed up for coverage.

For example, in 2015, the Blue Cross Blue Shield Association (BCBSA) reported that the rates of diabetes in its overall membership jumped from 235 per 10,000 prior to 2014 to 456 per 10,000 after the ACA took effect. Rates of members with hepatitis C increased 140 percent, while those with HIV spiked to 242 percent. All in all, BCBS plans saw their average monthly spending per member increase from $436 to $569.
As the shift to value-based care continues and payers boost their risk-based contracting, coders employing manual risk adjustment processes will find it increasingly difficult to review the flood of patient records efficiently and accurately. They will simply not be able to keep up with the ever-expanding demand. Payers could respond by vastly expanding their coding staff—provided enough qualified people can be found—but it is an expensive proposition that may not be viable at a time when margins are thin and the need to keep costs down is acute. If not properly addressed, this combination of more members covered by value-based payment models, more patient files, and an overburdened coding staff relying on manual coding and chart review processes could have a ruinous effect on a plan's risk adjustment performance; any increase in missed codes will lead to incorrect risk scores, which will in turn negatively affect quality scores and reimbursement rates.

3. **Structured v. Unstructured Data** — Health plans are experts at collecting and reviewing patient charts, but effective risk adjustment requires more detail than what claims data alone provides. According to IDC Health Insights, an estimated 80 percent of patient information is stored in unstructured formats\(^6\) such as free-text care plans, historical chart notes and specialist reports. This type of clinical data is critical for providing a more complete patient risk profile for increased risk score and revenue accuracy. However, retrieving the data can be difficult and can further slow the review process. Plans often must ask providers for the records—a process sometimes called a “chart chase”—who then send them via fax or through the mail. Or they send staff to the provider’s office to collect the data. It’s an inefficient, expensive process that exacerbates the already time-consuming, manual chart review. Without technology enablement, as patient volume grows, so will the problem.

### Technology Best Practices: Five Steps for Addressing Risk Adjustment with More Accurate and Efficient Coding

Effectively addressing the challenges of risk adjustment starts with improving coder productivity and accuracy. Payers should leverage the new breed of sophisticated data analytics available and ensure their professional coding staff—whether made up of in-house, remote contractors, or outsourced to a third-party vendor—has the tools and capabilities that support best practices for high accuracy coding:
1. **Automate the Chart Review Process** — Utilizing automated technology will help streamline the risk adjustment process by reducing the need for the “chart chase” and eliminating inefficient, time-consuming, manual chart reviews. These technology-driven data analytics tools give coders the ability to process a higher volume of patient charts with more accuracy for increased efficiency. Tools that are integrated into the coder’s workflow and feature an intuitive, easy-to-use interface allow coders to review more charts per hour, often dramatically increasing productivity. Health plans that leverage these tools can more easily respond to growing enrollment and expand their risk adjustment programs without the high costs associated with increasing their coder workforce.

2. **Comprehensively Review Patient Data** — Finding and identifying chronic conditions is essential to improving patient care, controlling costs, and obtaining accurate risk scores and reimbursements—three critical components of successful risk adjustment programs. New technology, such as natural language processing (NLP), advanced semantic ontologies and machine-learning clinical rules engines, can collect and analyze large amounts of disparate patient data, including the valuable 80 percent of unstructured data hidden in consult notes, radiology reports, specialist charts, etc. Finding and documenting these missed conditions can have a significant effect on risk scores and reimbursement rates and can make the difference between receiving or paying out transfer payments. Implementing these powerful, automated analytics tools gives coders a more complete look at all patient data, allowing them to efficiently and accurately uncover missed HCC conditions and close documentation gaps without having to manually comb through reams of clinical data.

3. **Track and Manage Coder Workflow and Financial Reports** — Today’s professional coder workforce is more distributed than ever, usually consisting of some combination of in-office staff, work-from-home staff and/or outsourced coders through a third-party vendor. To expedite the risk adjustment process, coder managers should have a simple and effective way to assign projects, check in on coder progress and evaluate productivity. These analytics and reporting capabilities can also track the financial impact of risk, giving both managers and health plan CFOs valuable insight into the effectiveness of their risk adjustment program so they can learn where there are opportunities for improvement.

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**High accuracy risk-adjusted coding provides the complete picture of member health that payers need to succeed in value-based care.**
4. **Improve Provider Engagement** — In addition to improving retrospective coding, plans should also incorporate a prospective approach by ensuring that providers follow coding and documentation best practices at the point of care. Analytics and reports that can pinpoint provider coding patterns are essential tools for assisting payers in their provider outreach and clinical documentation improvement initiatives. Taking this prospective approach increases coding accuracy and completeness, helping providers identify and appropriately treat their high-risk patients. It also reduces the retrospective coding burden for increased efficiency and productivity. Plans will see more accurate reimbursements or transfer payments and can deliver higher quality care and improved patient outcomes for their members. These tools can also help payers forge a closer bond with providers by reducing the administrative burden on physicians. Providing coding analytics tools that are embedded into the physician-patient workflow will deliver accurate reimbursement and give physicians more time to spend with patients, thereby helping to alleviate one of their chief pain points.

5. **Be Audit Ready** — In early 2016, CMS signaled its intention to significantly increase Medicare Advantage RADV audits in the 2017 plan year, making it more critical than ever for health plans to have complete, detailed evidence for every condition coded. Automated analytics tools can provide coders with documented evidence to support their coding recommendations and a clear line of sight between the patient record and claimed codes. This not only increases coder productivity by speeding up the reconciliation process but can also make a big difference in mitigating any financial impact of a CMS audit.

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### The Cold, Hard Impacts of Inaccurate Coding

**Scenario 1: What Was Coded**

<table>
<thead>
<tr>
<th>Condition</th>
<th>ICD-10 Code</th>
<th>HCC Risk Score</th>
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</thead>
<tbody>
<tr>
<td>Diabetes Mellitus with diabetic nephropathy</td>
<td>E11.21</td>
<td>0.368</td>
</tr>
<tr>
<td>Peripheral Vascular Disease, unspecified</td>
<td>I73.9</td>
<td>0.299</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease, unspecified</td>
<td>J44.9</td>
<td>0.346</td>
</tr>
</tbody>
</table>

**RAF Score: 1.013**  
**Total Payment: $10,130**

**Scenario 2: What Should Have Been Coded**

<table>
<thead>
<tr>
<th>Condition</th>
<th>ICD-10 Code</th>
<th>HCC Risk Score</th>
</tr>
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<tbody>
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<tr>
<td>Chronic Obstructive Pulmonary Disease, unspecified</td>
<td>J44.9</td>
<td>0.346</td>
</tr>
<tr>
<td>Sick Sinus Syndrome</td>
<td>I49.5</td>
<td>0.295</td>
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<tr>
<td>Chronic Viral Hepatitis C</td>
<td>B18.2</td>
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<tr>
<td>BMI 40.0–44.9, adult</td>
<td>Z68.41</td>
<td>0.365</td>
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**RAF Score: 1.924**  
**Total Payment: $19,240**

*Source: Data based on a Talix customer’s experience*
Automating the coder workflow can significantly improve a health plan’s risk adjustment performance, but doing it is not as simple as just flipping a switch. It is a process that requires commitment (financial and time), planning and collaboration across several departments and among various vendors. Health plan executives in charge of the process should put together a strong implementation team that includes internal IT staff, their EHR vendor and members of their coding staff. Once in place, there’s an initial tuning period during which coders adapt to using the tool and get comfortable with reviewing the suspect conditions and associated evidence and learning to trust recommendations. The technology partner should also be optimizing the tool for the coding staff during this period by fine-tuning it to account for coding patterns and the organization’s internal coding guidelines and regulations. During the tuning process, a high-quality tool will generally go through two or three iterations, and some challenges are to be expected. But at the end of the day, the process is essential to the overall success of the implementation as coders go through a learning curve, experiment and adapt to the new system.

Boosting Coder Productivity: A Case Study

In 2016, a large payer coding organization set out to find an automated tool to help improve the risk adjustment process for its health plan customers, which would include more accurately identifying codes, improving coder productivity and providing risk mitigation. After canvassing the market for risk adjustment software solutions, the organization decided to implement Coding InSight by Talix based on the tool’s excellent performance in accuracy and productivity during a competitive bake-off. The team relied heavily on input from its coding staff, who preferred Coding InSight by a wide margin.

Within two days of implementing Coding InSight, coders more than doubled their productivity—an improvement of 135 percent.

Coding InSight leverages advanced natural language processing technology, a clinical rules database and a vast medical taxonomy to analyze member data from disparate sources and accurately identify missed or inaccurate HCC codes. It conveniently presents code recommendations and relevant evidence within the chart. As a result, coders are able to streamline chart review by improving efficiency and accuracy.
The impact of implementing Coding InSight at this payer coding organization has been considerable. At the outset of the program, the organization initially set a target expectation of a 20 percent improvement in productivity over its baseline. By just the second day, its coders more than doubled their productivity, increasing the number of charts reviewed from approximately two charts per hour before using Coding InSight to more than five charts per hour after—an improvement of 135 percent. They expect this number to increase even further as the coders gain more experience using the tool. This increased productivity enables the company to save considerable cost while delivering successfully managed member care and ensuring appropriate reimbursement.

<table>
<thead>
<tr>
<th>Metric</th>
<th>Baseline</th>
<th>Day Two</th>
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<tbody>
<tr>
<td># Charts Reviewed/hour</td>
<td>2.18</td>
<td>5.12</td>
</tr>
<tr>
<td>Percent Improvement</td>
<td>20% (target)</td>
<td>135% (actual)</td>
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**Conclusion**

Value-based care—and risk adjustment—are here to stay. Health plans that want to be competitive in this changing market must be able to deliver both high quality and affordable care to their members. There’s no doubt that the rapidly transforming face of the U.S. healthcare industry is creating a challenging environment. One important way payers can successfully meet these challenges is by instituting an accurate risk adjustment program that leverages an automated data analytics solution. This cutting-edge technology increases coder productivity and accuracy so health plans can improve quality ratings and realize more accurate reimbursements or transfer payments while staying true to their mission of delivering better care and improved member health.

**About Talix**

Talix provides healthcare coding solutions to help providers, payers and accountable care organizations address the challenges of value-based healthcare and risk-based contracts. Its SaaS applications leverage patient data analytics to turn structured and unstructured health data into actionable insights that drive improved coding efficiency and accuracy, leading to better patient outcomes and reduced costs. For more information, please visit [www.talix.com](http://www.talix.com).
References


