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translating risk into revenue strategies for risk-adjusted markets

A health system's financial success under payment contracts that include some sort of risk adjustment depends largely on the extent that its physicians can accurately and completely document and code their patients' conditions and treatments.

AT A GLANCE

- > As a result of the healthcare industry's shift to value-based care, an increasing percentage of the payment providers receive for delivering care is risk-adjusted.
- > To effectively negotiate a risk-adjusted contract with a health plan, a health system must be able to demonstrate that it is fully capable of accurately documenting and coding its patient care.
- > Developing this capability requires identifying and eliminating deficiencies occurring at three key phases a health system's care processes: prior to the patient encounter, at the point of care, and at the time of billing.

Health plans are undergoing a period of financial transformation as their revenue increasingly reflects the concept of risk adjustment in addition to underwritten premiums collected. In turn, risk adjustment may appear in contracts as a primary component of a value-based payment arrangement or in the form of additional incentive payments for complete and accurate coding and documentation.

Risk adjustment is a financial mechanism to align payments received by health plans with the risk of the populations they are managing. Although each market (e.g., Medicare Advantage [MA] and the health insurance marketplaces established under the Affordable Care Act [ACA]) has its own risk-adjustment model, every model is predicated on encounter-based diagnostic information that corresponds to hierarchical condition categories (HCCs) to calculate risk.^a

With these models, accurate payment ultimately depends on encounter documentation and the substantiation of the submitted coding within the medical record. Thus, the ability of physicians to completely and accurately code patient conditions has a direct impact on both the provider's and the health plan's bottom lines.

a. HCCs are pre-defined condition categories that correlate to a collection of ICD-10 codes (e.g., HCC10—Lymphoma and Other Cancers). Each HCC is assigned a different risk weight associated with the severity and cost of managing the condition. HCCs are added to each member's demographic risk score to determine the member's overall risk score, which then makes it possible to determine the overall risk of the health plan's population.

Health systems that understand the underlying principles of risk adjustment and can prove that they can consistently provide complete and accurate documentation enjoy a strategic advantage in negotiations with health plans.

Achieving this strategic advantage requires health systems to take control of their own workflow and not be solely reliant on numerous health plans to push data and requests in a variety of formats that tax different parts of the organization.

Risk Adjustment Is Here to Stay

Between existing risk-adjusted markets and the growth in alternative payment models (APMs), an increasing percentage of the payment a provider receives for care delivery to its patient population is risk-adjusted. Government data indicate that more than 90 million Americans are insured in risk-adjusted, government-regulated products.^b Moreover, the U.S. Department of Health & Human Services (HHS), as part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), set a goal of tying 50 percent of traditional, or fee-for-service, Medicare payments to quality or value through APMs, such as accountable care organizations (ACOs) or bundled payment arrangements, by the end of 2018.^c The government's continued push toward value-based payment models is driving health plans to adopt similar models in the commercial market, further expanding the risk-adjusted population.

Financial Implications of Risk Adjustment

Ineffective documentation can have a profound financial impact on a plan's and a health system's bottom line. At an individual member level, for instance, the failure to document a single risk-adjusted condition can translate to thousands of dollars in lost revenue, and to the extent

that the same omission occurs across a health system's overall patient population, the financial impact on the health system could potentially amount to millions of dollars.

Consider, for example, that a 72-year-old patient presents with rheumatoid arthritis and colorectal cancer. For this scenario, let's say the health plan's risk-adjusted annual payment for these two conditions, if they are coded correctly, will be \$12,643. But if the patient is coded only for colorectal cancer, the risk-adjusted annual payment by the health plan is \$9,600, which represents a loss of \$3,043 in risk-adjusted premium as a result of the incomplete coding. Closing documentation gaps can have a significant financial impact when applied across a health system's entire risk-adjusted patient population. For example, in the previously described scenario, a 10 percent increase in risk documentation accuracy and completeness for a health system with 20,000 patients translates to \$8 million to \$10 million in additional risk-adjusted revenue.

This example provides just a glimpse at the potential financial implications of risk-adjusted contracts. Each market (e.g., MA, ACA insurance marketplaces, managed Medicaid) employs different risk models, each comprising different HCCs with various risk weights or financial values. It is important that provider organizations understand the financial implications of each risk-adjusted model and its continually changing nuances to be able to set priorities among patient care strategies, forecast financials, and quantify the financial return and overall effectiveness of improved coding efforts.

Challenges of Achieving Complete and Accurate Documentation

The challenge for health systems is to develop comprehensive solutions to address process deficiencies potentially existing at various points in the care continuum—including during the pre-encounter phase, at the point of care, and during the billing process—that ultimately can pose a barrier to complete and accurate documentation and coding.

b. Centers for Medicare & Medicaid Services (CMS), Medicare Advantage monthly enrollment, July 2016; Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026*, March 2016; CMS, *Medicaid Managed Care Enrollment and Program Characteristics, 2014*, Medicaid.gov, Spring 2016.

c. HHS, "Better, Smarter, Healthier: In Historic Announcement, HHS Sets Clear Goals and Timeline for Shifting Medicare Reimbursements From Volume to Value," news release, Jan. 26, 2015.

During the pre-encounter phase, for example, accurate documentation and coding can be impeded by:

- > Ineffective targeting of patients for risk measures
- > Limited patient histories that make it difficult to establish priorities among health plan members
- > A lack of engagement of patients with their primary care physicians

At the point of care, challenges can occur if, for example:

- > The physician is unable to access the patient's complete history
- > The patient is not evaluated for all existing chronic conditions
- > There is a lack of appropriate specificity about the patient's condition
- > There is a lack of proper documentation in the medical record

Examples of obstacles that can be encountered at the time of billing include:

- > Improper coding in the medical record to ensure claims reflect all evaluated and documented diagnoses
- > Truncation of diagnosis codes within the billing information because of system limitations in the fields for entering diagnostic information
- > Government business rules that prevent the record from being accepted^d

To close the gaps created by such process deficiencies, health plans primarily rely on retrospective chart reviews and in-home assessments. But each of these approaches presents its own challenges. Chart reviews offer no clinical benefit and are administratively taxing for physician offices. And although in-home assessments provide clinical value for home-bound patients,

they tend to be overly applied to a health plan's membership and ultimately direct revenue away from the patient's physician and toward in-home assessment vendors.

In general, the solutions that health plans have tended to employ have been developed with little to no input from health systems, with the result that they tend to deviate from the workflows of health systems' physicians, resulting in low adoption rates. Each health plan also tends to develop solutions with requirements specific to its own members, making it necessary for a health system to adopt multiple solutions—one for each health plan—or work multiple disparate lists to address its entire risk-adjusted population.

A more clinically beneficial approach for health plans that also increases the physicians' revenue is to develop strategies for increasing members' level of engagement with their primary care physicians or engaged specialist, who can then completely and accurately document all conditions.

A health system also can develop its own approach for improving documentation for risk adjustment where health plans are required to adapt their processes to the health system's approach, not the other way around. Such an effort involves implementing basic strategies that connect with existing workflows and systems to address failure points across the pre-encounter, point-of-care, and billing phases by developing improved workflows for effectively identifying, evaluating and documenting patient conditions.

Pre-Encounter Opportunities

Health systems can take the following steps to improve data processes during the pre-encounter period.

Integrate clinical data with claims data. Physicians have insight into health plan members that is not necessarily reflected in a health plan's claim data, especially where new plan members have been with the medical group longer than with the health plan. Data reflecting physicians' prior

d. Each risk model has defined parameters for which encounters are acceptable. Consider the following example: A provider performs a comprehensive new-patient evaluation and then orders an electrocardiogram (EKG), finding that the patient has congestive heart failure (CHF). The CHF diagnosis would be recognized for payment if it were coded on the Medicare Advantage claim for the new-member evaluation, but the diagnosis would not be recognized if it were coded only on the EKG claim because EKGs are not deemed scoreable under the Medicare Advantage Encounter Data Processing System risk-adjustment model.

By developing centralized capabilities to identify risk and close coding gaps through standard processes, a health system can focus its expertise and maintain constant improvement cycles.

experience with patients can provide a deeper insight into patients' conditions prior to encounters.

Look across plans to set priorities among areas of focus for patient care efforts. Taking control of the data enables health systems to prioritize efforts across health plans.

Allow physicians to take the lead on patient engagement. Physician-led efforts to engage patients are consistently seen as more successful than health-plan-led efforts, because of the relationships patients develop with their physicians. Moreover, physicians can optimize their efforts by capitalizing on the appointment scheduling system, which can enable them to identify patients who are already scheduled so they can focus their efforts on those patients who have not been seen recently in their offices.

Point-of-Care Opportunities

Steps that health systems can take to optimize processes for risk adjustment during care processes include the following.

Deliver actionable insights through current workflows. Embedding information into current physician workflows highlighting potential documentation gaps specific to each patient can promote higher adoption rates (e.g., embedding messages within currently leveraged electronic health record [EHR] applications).

Standardize physician efforts across health plan patients. By consolidating data for all health plans,

health systems can deliver actionable insights to physicians in a standard and consistent way that eliminates the variance in data and formats among different health plans.

Counsel patients with confirmed conditions. Such patients should routinely receive thorough counseling about the importance of regular visits and care management.

Assign staff to perform post-visit follow-up. Such follow-up should seek to ensure patients comply with treatment plans and are satisfied with the care team.

Opportunities at the Time of Billing

Deficiencies in documenting evaluated conditions can be addressed during billing processes in the following ways.

Evaluate current billing practices. The focus of such an evaluation should be to ensure current billing practices emphasize complete and accurate diagnosis coding and that current billing system does not truncate diagnoses.

Utilize revenue cycle processes and technologies. Natural language processing, for example, can be used to identify discrepancies between documented conditions in the EHR and coded conditions on the bill.

Independently audit charts. Audits should be performed to check for coding completeness and accuracy.

Invest in the process. By establishing best-in-class diagnosis submission practices, health systems can ensure risk-adjusted payments align with the clinical evaluations performed and reduce the administrative burden of retrospective chart reviews performed by the health plan.

Such remediation steps can be viewed as an outgrowth of the organization's existing revenue cycle coding efforts, but they are focused specifically on identifying and capturing HCCs, reporting and documenting diagnoses, managing

processes, and communicating with payers in a way that supports the development of an effective risk-adjustment strategy.

Evolving Risk-Adjustment Strategies

Risk adjustment is fertile ground for payers and providers to move beyond the discussion of unit price in contractual agreements. The parties have a shared interest in coding risk accurately and completely to ensure that payment for population risk is commensurate with the underlying actuarial risk.

Yet risk adjustment has long been wrongly perceived to be exclusively a “payer issue.” Because payers have long understood the mechanics of risk adjustment, and have been the direct beneficiaries of and contributors to the financial aspects of the process, they have shouldered responsibility of pursuing coding opportunities on their own unilaterally. Lack of alignment between payers and providers has contributed to inefficient workflows and neglected or missed opportunities to capture HCC codes.

With the healthcare industry’s movement toward value-based payment, as demonstrated by MACRA and other regulatory initiatives, as well as industry adoption of APMs, the time has come to reframe risk adjustment as a shared opportunity to promote better coding and workflows to achieve revenue integrity, cost savings, and quality improvement. Provider organizations should develop their approach to risk adjustment by employing the following tactics.

Viewing risk adjustment as a key aspect of managed care negotiations to ensure revenue integrity.

Provider organizations should assess and financially value the activities involved in chart pulls and audits and in scheduling and performing home or office-based visits to assess patient risk. Payment related to these activities should be based purely on completeness and accuracy of coding, with an awareness that any connection with the level of coding could trigger legal or compliance issues around upcoding.

As coding processes improve and mature, downstream revenue integrity benefits will be accrued related to actuarial risk measurement of attributed populations in APMs, rebasing of cost and quality targets in risk contracts, and enhanced forecasting of final bonus payments. Further, the growing subset of provider organizations that sponsor their own health plans will receive direct economic benefit through risk-adjustment programs that enhance or redistribute premiums based on risk scores.

Reducing unnecessary costs by streamlining risk coding requests.

Today, such requests are likely to be sent by various payers directly to different parts of a health system, including clinician offices, the billing department, and payer relations, where they are likely to be prioritized for follow-up. The challenges around the risk-coding workflow parallel the challenges of claims denials management that have plagued business offices for many years: multiple codes and processes from payers, absence of policies and procedures around follow-up, the need to involve multiple departments/parties in the documentation review, and a lack of transparency into the downstream financial impact of direct efforts around follow-up.

By developing centralized capabilities to identify risk and close coding gaps through standard processes, a health system can focus its expertise and maintain constant improvement cycles. Having a proficient centralized staff can enable an organization to reduce its total number of FTEs dedicated to risk capture.

Understanding the ancillary benefits of complete and accurate coding.

A well-functioning risk-coding program can contribute to early identification of patients that have suspected, but undocumented or inaccurately documented clinical risk. Indeed, such a program should be part of clinical quality improvement (QI) and predictive analytics initiatives.

Today, many QI or predictive analytics programs focus on patient groups with conditions like

asthma or diabetes, which constitute too small of a proportion of the total population to be as effective as they could be. Health systems also all too often rely entirely on their own EHR data, which includes only encounters that have taken place within their organizations, or on the claims data provided by their payer partners, which typically relate only to those populations with documented conditions within a 12-month period, or during the period that the members were enrolled with the specific health plan.

A well-functioning risk-coding program aggregates claims from multiple payers to look for undocumented or inaccurately documented conditions across time periods and carriers based on algorithms that look for clues about the underlying patient condition in historical evidence of related encounters or demographic indicators. By including such patients, QI and predictive-analytics-driven interventions provide a better insight into a health system's full patient population by accounting for patients with previously documented conditions and for patients with suspected conditions that can be confirmed through a chart review and follow-up examination.

Next Steps

Provider organizations have the potential for significant gains in revenue integrity, cost reduction, and quality improvement through enhanced risk-adjustment partnership efforts. The historical characterization of risk adjustment as a payer issue should give way to strategic collaborations between payers and providers.

To be able to participate in such a collaborative effort, provider organizations should take the following steps:

- > Build knowledge and education on the risk-adjustment process and its influence on payer economics.
- > Catalogue managed care contracts with a risk-adjustment component (e.g., MA, ACA exchange, managed Medicaid, and commercial APMs).

- > Construct a comprehensive financial model of the revenue impact of accurate coding weighed against the workflow costs required to ensure accurate coding.
- > Formulate a centralized risk-coding approach that streamlines workflows and proactively pursues coding opportunities.
- > Discuss collaborative risk-coding models with payer partners and payment incentives for participation.
- > Devise approaches for sharing incentives internally to reward participation in risk-coding activities.
- > Perform routine audits to evaluate the completeness and accuracy of physician coding.

These tactics can enable a provider organization to realize the potential value of accurate and complete documentation and coding in promoting financial success under risk-adjusted arrangements. Such efforts not only contribute to improved revenue integrity, cost savings, and enhanced quality but also can help a health system prepare for the next stage of value-based payment, where success will depend on having the ability to calculate the full actuarial risk of enrolled populations. ■

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