Digital Operations

Creating a Data Strategy for Unified Risk-Adjusted Payments

Taking a holistic approach to addressing tighter Medicare data requirements and new risk models will help payers optimize data accuracy for risk-adjusted payments as well as improved operations, patient health and regulatory compliance.

Executive Summary

Managing risk-adjusted payments requires better data than ever. Payers who don't report frequently enough or whose encounter data fails submission through Centers for Medicare & Medicaid Services (CMS) systems risk penalties for inadequate data submissions. Payers whose submissions are not appropriately filtered could face making repayments to CMS, fail an audit and even risk legal trouble. From a patient care perspective, bad data submitted to CMS could mean a plan doesn't identify members

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with complex and/or chronic conditions that must be carefully managed for optimal health outcomes.

Payers must build successful and safe risk adjustment management strategies on optimized data accuracy. Accurate data is necessary not only to meet CMS's stringent reporting requirements but also to succeed in value-based contracting, care coordination and chronic disease management, population health outreach and administering social determinants of health (SDoH) programs. Collecting the right data at the right times and locations requires payers to choreograph and execute an intricate dance. The dance partners should include internal health plan departments such as quality assurance/HEDIS, provider contracting, IT and claims, plus external constituents such as providers and healthcare systems, and a variety of regulatory agencies.

Payers can also better adapt to regulatory shifts when they have accurate data. Possible regulatory changes include implementation of the recurring CMS proposal to extrapolate risk adjustment audit results for repayment across the entire plan population vs. the findings of only the sampled population, which could cost payers millions of dollars in repayments and penalties. Another possible change is new CMS benefits, such as reimbursements for nonmedical services for chronically ill patients. Managing the multiple touchpoints now related to risk-adjusted payments requires payers to take a unified, holistic approach to managing risk adjustment data and reporting.

This unified approach requires broader thinking about risk adjustment. It should encompass a strategy for improving data integrity, optimizing the timing of risk adjustment activities to coordinate with other health plan outreach efforts, coordinating risk adjustment and HEDIS reporting requirements, and addressing SDoH and care gaps.

This white paper discusses key components of risk adjustment and how payers can design a strategy and incorporate technology that addresses them holistically. Creating a strategy that unifies complementary data and efforts across multiple functions will help payers improve outcomes, ensure they collect and submit appropriate data both for risk adjustment and population health management efforts, comply with all regulations and be continually ready to pass a CMS risk adjustment audit.

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Managing the current risk in risk-adjusted payments

Risk-adjusted payments help ensure that payers receive appropriate payment for the health acuity of members in their Medicare Advantage plans. CMS calculates risk-adjusted payments via a risk-scoring formula based on member diagnostic and encounter data. The current risk adjustment model categorizes ICD-10-CM diagnostic codes into hierarchical condition categories (HCCs). CMS assigns these codes based on data payers submit through its Risk Adjustment Payment System (RAPS) and Encounter Data Processing System (EDPS). Different HCCs are weighted according to the prevalent costs associated with caring for the underlying condition and contribute different values to a plan member's risk score.[1] Capturing accurate ICD-10 codes documented during face-to-face encounters with appropriate providers is key to reporting accurate HCC data and appropriate risk-adjusted payments. In our experience, on average, payers miss approximately 30% of their reimbursement value because of inadequate HCC capture and documentation.

CMS requires plans and providers to submit "complete, truthful and accurate diagnosis reporting" and plans must maintain medical record documentation to support the HCC. To validate the data, CMS selects many plans each year for targeted Risk Adjustment Data Validation (RADV) audits. A single payer may have multiple plans audited.

In its most recent proposed rule, CMS suggests that "risk adjustment discrepancies can be aggregated to determine an overall level of payment error" and further, that payment error "for a sample of contract enrollees can be extrapolated to calculate a contract-level payment error estimate."[2] In other words, instead of simply collecting overpayments on the audited records, CMS would apply the error rate to all members in a plan to calculate repayments. The extrapolation concept is not new; CMS has persistently proposed it over the past several years.

Estimates indicate CMS made $14.35 billion in improper payments in FY 2017.[3] CMS noted in its draft rule that its proposed new audit process would save $1 billion in 2020 "due to collection from the industry of money improperly paid." The agency estimates it will save $381 million annually in following years by avoiding improper payments to insurers.[4]

While CMS did not include this audit methodology in its final letter,[5] the agency made clear it intends to take steps to reduce overpayment to Medicare Advantage plans. Further, the Office of the Inspector General (OIG) and the Department of Justice (DoJ) also are auditing plans. As a result of a DoJ investigation, one Medicare Advantage provider paid $270 million for submitting inaccurate information that led to Medicare overpayments.[6] Another health system, accused of inflating risk scores, paid $30 million without admitting culpability.[7]

These examples underscore that CMS and other government agencies clearly intend to curb overpayments. Yet payers certainly should pursue all the risk-adjusted payments due to them. Success is being fully compliant with CMS regulations while capturing all appropriate HCC codes. Accomplishing that requires payers to create a risk-adjusted payment strategy that encompasses optimized data accuracy, business and clinical objectives, other compliance and quality programs, and industry payment trends.

Unified encounter and risk adjustment process flow

Payers must develop broad, holistic risk adjustment management strategies to optimize data accuracy. Quality assurance/HEDIS, provider contracting, IT, claims and provider activities must be coordinated with the risk adjustment workflow to ensure the right data is captured at optimal times and locations. Applying automation and AI tools streamlines the workflow and creates insights to apply to initiatives like population health and social determinants as well as risk-adjusted payments.

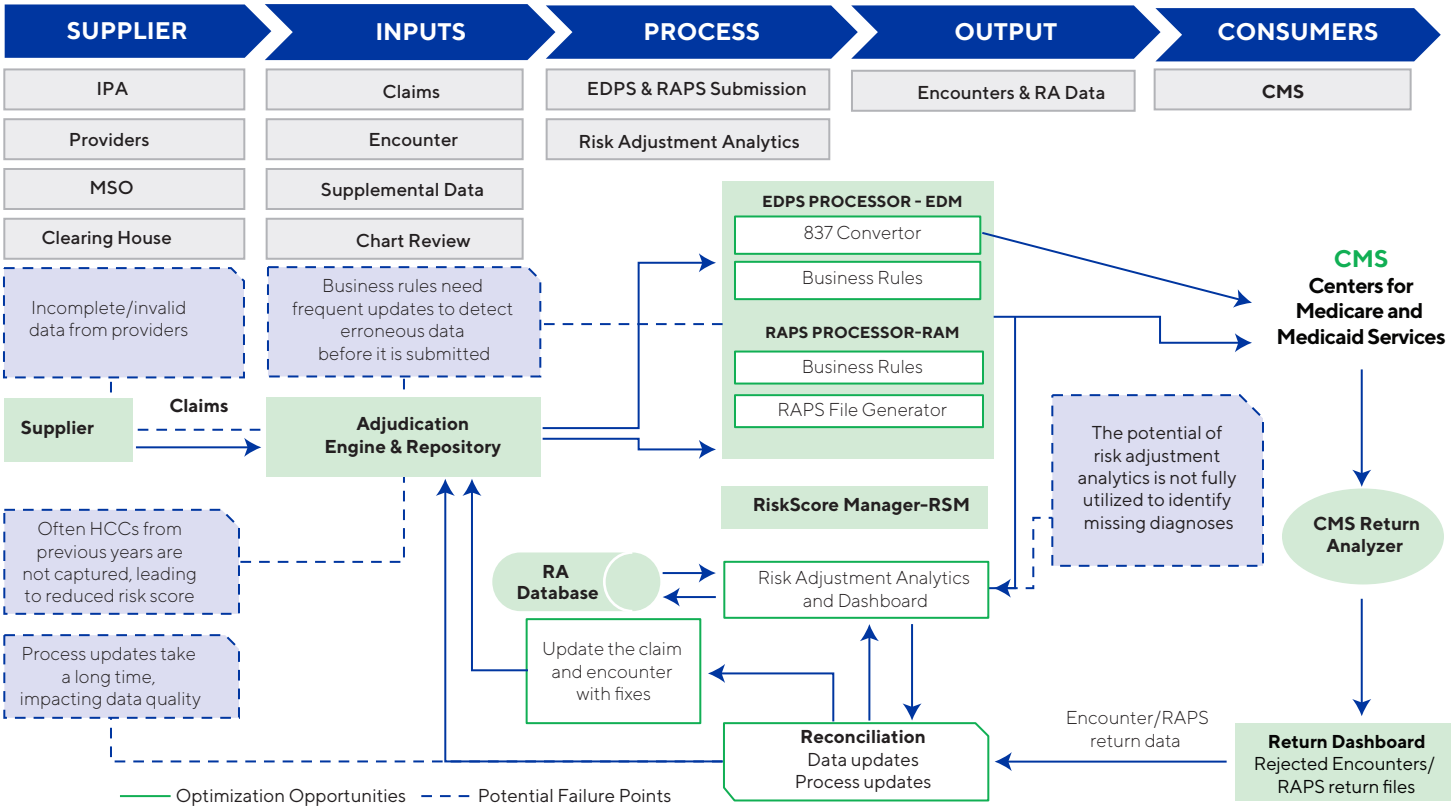

Figure 1

The risk areas

A holistic risk adjustment strategy must address key areas that affect how well a plan captures data necessary to support Medicare risk-adjusted payments. This ensures health plans are optimizing revenue accuracy. It also helps them maintain readiness to meet the challenge of a CMS RADV audit. These audits are unpredictable and intense, with tight submission deadlines. Pulling risk adjustment teams off current projects to address the RADV may help a plan pass the audit – while risking the delay or loss of adjustment revenue for the current payment year. Creating a holistic risk-adjusted payment strategy and implementing it with modern tools, from robotic process automation (RPA) to artificial intelligence (AI) and natural language processing (NLP), enables plans to consistently gather and analyze required data to improve a variety of complementary operations, such as quality assurance, in addition to being RADV audit-ready.

The strategy must tackle the following key areas.

Data integrity

Health plans have long struggled with data submission for risk adjustment. This is true both for the CMS RAPS filtering logic as well as encounter submissions to the CMS EDPS. We often work with payer clients convinced they are submitting clean data, only to have submissions rejected.

While health plans ultimately are responsible for making accurate and complete submissions, collecting most of the required data is beyond a payer's control. Improperly coded medical records, lack of two patient identifiers on each page of a record, electronic signatures that don't match the CMS configuration rules, illegible signatures – any of these can lead to a rejected risk-adjusted submission, and all of these are the responsibility of the provider.

Claims data is the basis for most risk adjustment submissions. Rules about data accuracy and completeness are likely to become more stringent based on the Medicare Payment Advisory Commission's (MedPAC) proposal that CMS withhold a percentage of monthly payments to health plans that submit inaccurate or incomplete data. This proposal recommends including encounter data in audit activities. Whether this means expanded RADV audits or a separate set of audits remains to be determined. If CMS adopts the MedPAC proposal, that could disrupt revenue streams and increase the regulatory burden, requiring health plans to be ready to respond to yet another type of CMS audit as early as 2021.[8]

This is one key reason a payer's IT, claims and provider network organizations must closely coordinate their activities. For example, after the payer's provider network organization writes a capitated contract for a large provider group, the provider group stops submitting claims in favor of submitting encounters less frequently. The EDI team within IT sees the periodic encounter data and so isn't concerned about the nearly 100% drop in submitted claims from this provider group. However, the delay in encounter data means the

Current Medicare encounter data challenges

The claims data on which risk-adjusted and encounter submissions are based often contains seemingly small errors that nonetheless result in rejected submissions. Digital automation tools can help identify and rectify these more efficiently.

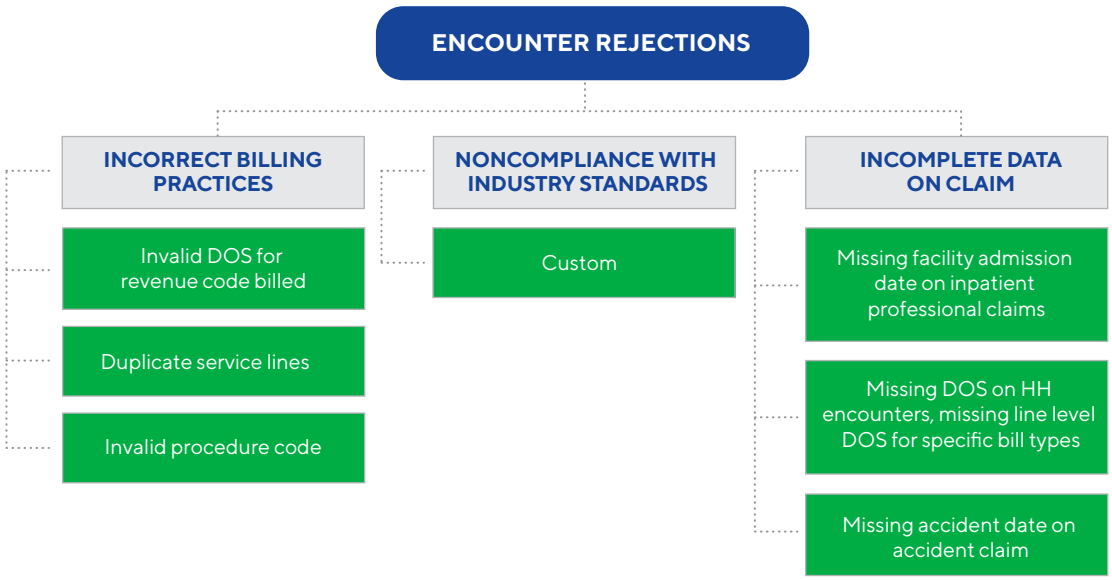

Figure 2

Lack of timely data submissions could also cause the payer to miss a mid-cycle sweep and disrupt its revenue cycle. Working as a unified payer team at the initiation of the capitated contract could have prevented the disruption by ensuring that good quality data continues to flow for risk adjustment HEDIS, population health management analytics, and other data uses.

risk adjustment team doesn't have timely and complete information to perform analytics. The team can't submit timely and accurate data to CMS without claims or complete encounter data. The encounters the provider group submits must be tested to ensure they capture all the CMS-required submission information. A sharp drop in the number of encounters submitted could raise red flags with CMS. Lack of timely data submissions could also cause the payer to miss a mid-cycle sweep and disrupt its revenue cycle. Working as a unified payer team at the initiation of the capitated contract could have prevented the disruption by ensuring that good quality data continues to flow for risk adjustment HEDIS, population health management analytics, and other data uses.

Medical record retrieval challenges

Retrieving records requires tracking down record locations, which are often different than the office locations and payment/billing locations already captured in provider data management systems. This is often time-intensive and -sensitive, so many payers hire third parties to retrieve and code medical records. Some providers refuse to provide records, even though risk adjustment medical record review falls squarely in the HIPAA guidelines for sharing personal health information due to treatment, payment and operations. Providers may cite sensitivity of diagnoses in their refusal; others want a specific release approval from the patient; and others may charge prohibitively high fees for pulling the records, which could also be considered an "information and data blocking" violation under the new CMS and the Office of National Coordinator (ONC) Interoperability Ruleset.

Nonetheless, it is vital to obtain records and verify they support the HCC codes. Relying on claims data alone will almost certainly guarantee rejected submissions. Many risk-adjusted conditions have complex coding requirements. HIV/AIDS and specific mental health conditions are among the most highly weighted risk adjustment conditions. CMS also has added many substance abuse and previously excluded mental health diagnoses to its HCC model in recent years. All of these are among the most miscoded diagnoses in the industry. Supporting documentation for these diagnoses can be difficult to obtain, but it is critical to do so from both a reporting and an audit-risk perspective.

As plans obtain records, coordinating and centrally storing these for review and use by multiple departments will save time and money, and improve

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provider relations. Risk adjustment analytics and NLP can comb through this central data repository and help identify HCC diagnoses as well as helpful patterns for appeals, medical necessity reviews and quality functions.

CMS and ONC have proposed data interoperability rules that would enable payers to tap provider medical records data directly using the HL7 clinical data set standards and the Fast Healthcare Interoperability Resources (FHIR) protocol. That data could be extracted directly to a payer repository; once there, software bots could crawl it to identify risk-adjustment conditions in near real time.

Current risk adjustment challenges

Challenges in retrieving supporting medical records and then coding to meet CMS requirements often result in missing hierarchical condition categories (HCCs). In addition to hurting risk scores, incomplete or inaccurate HCC data may also reflect payers not identifying members with complex chronic conditions for care coordination, high utilizer and population health management initiatives.

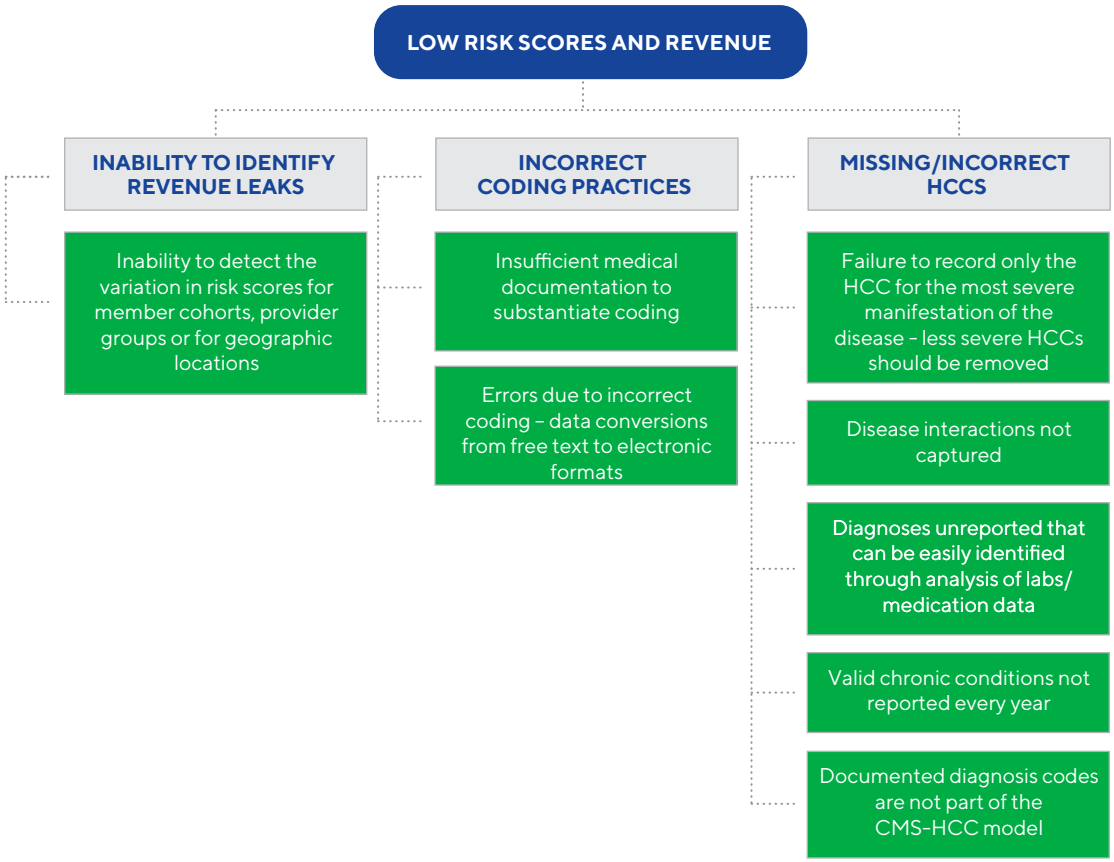

Figure 3

Medical record coding challenges

Reviewers should always begin with the end in mind (i.e., what is coded today needs to be able to pass an RADV audit in the future). That said, it can be difficult to know exactly what an RADV reviewer will be looking for five to six years from now. CMS just released guidelines for RADV reviewers this year[9] that apply to medical records produced in 2014 – before the industry had converted to ICD-10-CM. In short, CMS wrote the rules after the risk adjustment activities concluded. A payer's coding team must use the appropriate version of the *Official ICD-10-CM Guidelines for Coding and Reporting* for medical records currently under review and document their use so auditors in the future can understand the coders' actions.

Before coding, determine whether the medical record meets submission criteria: type of visit, location, performed by an acceptable provider. Then each record must be checked to see that it meets CMS guidelines. This means ensuring date of service and patient identifiers appear on every page and that the record is legibly signed and dated. Concrete items, such as date and identifier, are easily verified but others, like legibility, are relative. RPA can verify objective information, reducing the amount of time needed for document review.

Diagnoses must be assigned according to the *Official ICD-10-CM Guidelines for Coding and Reporting*.[10] These are standard guidelines, but they are not black and white. In brief, coders must also be current on interpretations of how to apply codes as published quarterly in the *Coding Clinic for ICD-10-CM and ICD-10-PCS* publication. CMS considers this an official source of coding information and it should be used when the classification and the guidelines don't provide direction.[11]

Coding guidelines often are granular. Whether a diagnosis is under- or over-coded, failure to correctly code based on documentation in the medical record will always result in a failed claim on audit. The ICD-10-CM codes for Major Depressive Disorder, F320-F325, are an example. These codes all fall into HCC 58. However, these codes must be supported with specific documentation criteria when used. If the documentation just says "depression" without listing the criteria, the coder must choose a nonspecific code – which is not on the HCC model.

Another is diabetes. A code may indicate a causal relationship between diabetes and a complication, such as kidney disease. The underlying medical record must provide evidence for that relationship, versus a patient presenting with diabetes and kidney disease that is unrelated to the diabetes. A coder may have mistakenly assumed a causal relationship and miscoded the claim in error.

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Risk adjustment submission and score forecast

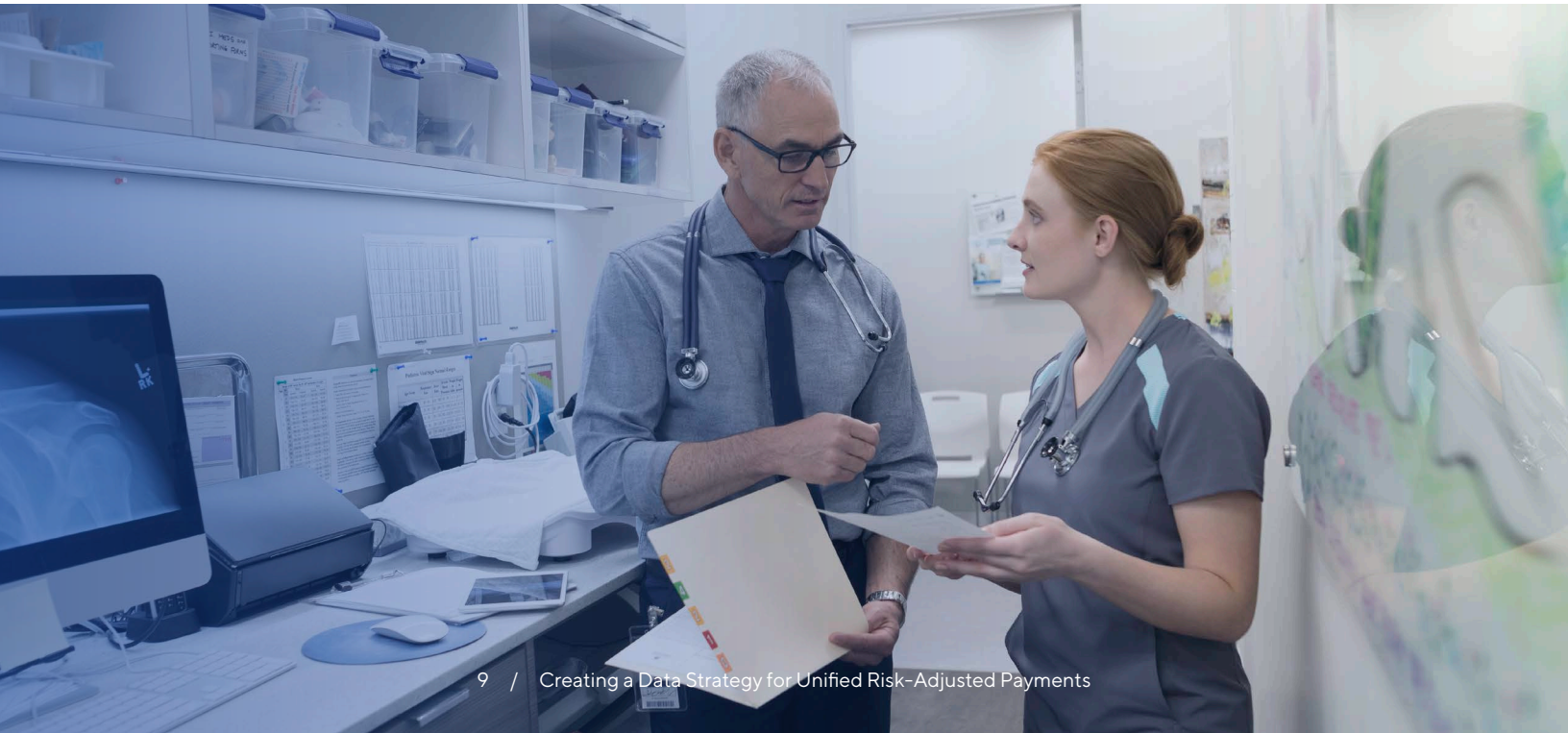
Filtering logic for RAPS is complicated. Payers must ensure their filtering logic captures CMS required data, only from encounters that prove an acceptable type of service as well as provider type, date of service, etc. The filtering logic must determine what is acceptable to submit for risk adjustment frequently based on only submitted claims data instead of the underlying medical record. Mistakes can be made, for example, when an office visit (appropriate for risk adjustment) occurs on the same claim as a lab test (not appropriate for risk adjustment). While there are "pointers" to pair the diagnoses to the appropriate service line, this can be complicated. Care must be taken not to report diagnoses through RAPS that were only supported by the lab test and not documented within the office visit.

Dealing with RAPS and EDPS error reports can be time-consuming. The formats for each are very different, yet often draw from the same sources. An error might originate with CMS, the provider or the health plan submission. A claim might appear to be appropriate to submit, but would fail a CMS audit when the medical record is reviewed and shows the place of service was actually an ambulatory care center, not the in-patient hospital the claim indicated. CMS errors could include errors in membership on the original CMS file. Even errors such as reported gender can cause a gender-specific ICD-10-CM code to be rejected. Decoding the mistake and fixing the root cause is required to prevent submitting unacceptable or incorrect data, which could result in revenue leakage or raise audit flags.

Manually calculating future risk scores and risk score opportunities is tedious and complicated. Automating this process gets answers about bottom-line implications to the finance team more quickly. It also helps payers adjust outreach strategies faster.

Choreographing the timing of risk adjustment operations

While the CMS measurement period for risk-adjusted payments is a calendar year, risk adjustment activities can occur up to 2¼ years after the actual date of service! Knowing when to perform which type of risk adjustment activities is critical to ensuring all appropriate data has been reported, any inappropriate data has been deleted and the plan is ready for RADV if selected.



Increased benefits mean increased costs. Payers should consider addressing SDoH factors to improve overall population health even while taking steps to ensure they report all risk-adjustable conditions.

Plans often overlook coordinating risk adjustment activities with internal quality and HEDIS teams. Some risk adjustment diagnoses also have associated HEDIS measures, such as diabetes and hypertension. If a diagnosis is showing for risk adjustment outreach, it may not yet be flagged for HEDIS. If not properly coordinated, performing an outreach to close the risk adjustment gap could inadvertently create a HEDIS gap. That gap could then affect accreditation or STAR ratings and hurt revenues. So as patients are identified with diabetes, conducting the hemoglobin A1c test should be considered as part of the standard clinical strategy to gather the data needed for both risk-adjusted payment support as well as HEDIS.

Prospective risk adjustment

Prospective risk adjustment can be a powerful tool. First, providers conducting prospective examinations are well-trained in risk adjustment and generally produce better documentation to support the claim. Second, health plans always receive the actual medical record for any prospective services done on their behalf, eliminating the need to retrieve records in the future. Providers performing prospective evaluations also get a peek into the patient's living conditions, and sometimes can alert the health plan or even local agencies about unsafe conditions or medical emergencies.

There can also be challenges associated with prospective risk adjustment activities. Some patients consider it invasive to have a provider come to their home to perform a medical examination. Other patients are grateful for the visit because they have difficulty getting out of the house. In rural populations or in high crime areas it can be difficult to find nurse practitioners to perform the assessments. Some patients require assessments that cannot easily be performed in home settings because of lack of equipment. Frequently there is little to no medical history for a provider to review in the form of an existing medical chart, and some members may struggle to accurately convey their medical history. CMS has also expressed concerns about prospective risk adjustment activities for many years because they often lack follow-up care.

Payers must consider many factors when developing a prospective risk adjustment strategy. These include logistics, safety of patient and staff, and intervention type. At all times, they must ensure good patient care is at the forefront of these assessments. Prioritizing continuation of care of any newly identified chronic conditions must be paramount to any prospective program.

Incorporate emerging trends into holistic risk adjustment strategies

CMS is revising its risk model to incorporate requirements of the 21st Century Cures Act and take into greater account multiple existing conditions in a single member.[12] In addition, CMS will reimburse health plans that offer supplemental nonmedical benefits (housecleaning, meal prep, grocery shopping, etc.) to chronically ill members to address SDoH.[13] Additional modalities for treatment of chronic pain will also be covered in 2020.

SDoHs continue to gain recognition as powerful health influencers. The American Medical Association, in cooperation with UnitedHealthcare, has proposed the addition of 23 ICD-10-CM SDoH reporting codes.[14] If added, these proposed codes are likely to influence HEDIS reporting as well as risk adjustment, and these will no doubt also need to be supported by the underlying medical record. Educational programs to encourage their

Risk adjustment process: High-level process flow

A central records data repository, synchronized internal activities and automation, intelligent OCR documents and NLP tools enable payers to streamline risk-adjusted process flows to reduce time and cost while improving data accuracy and availability to the business.

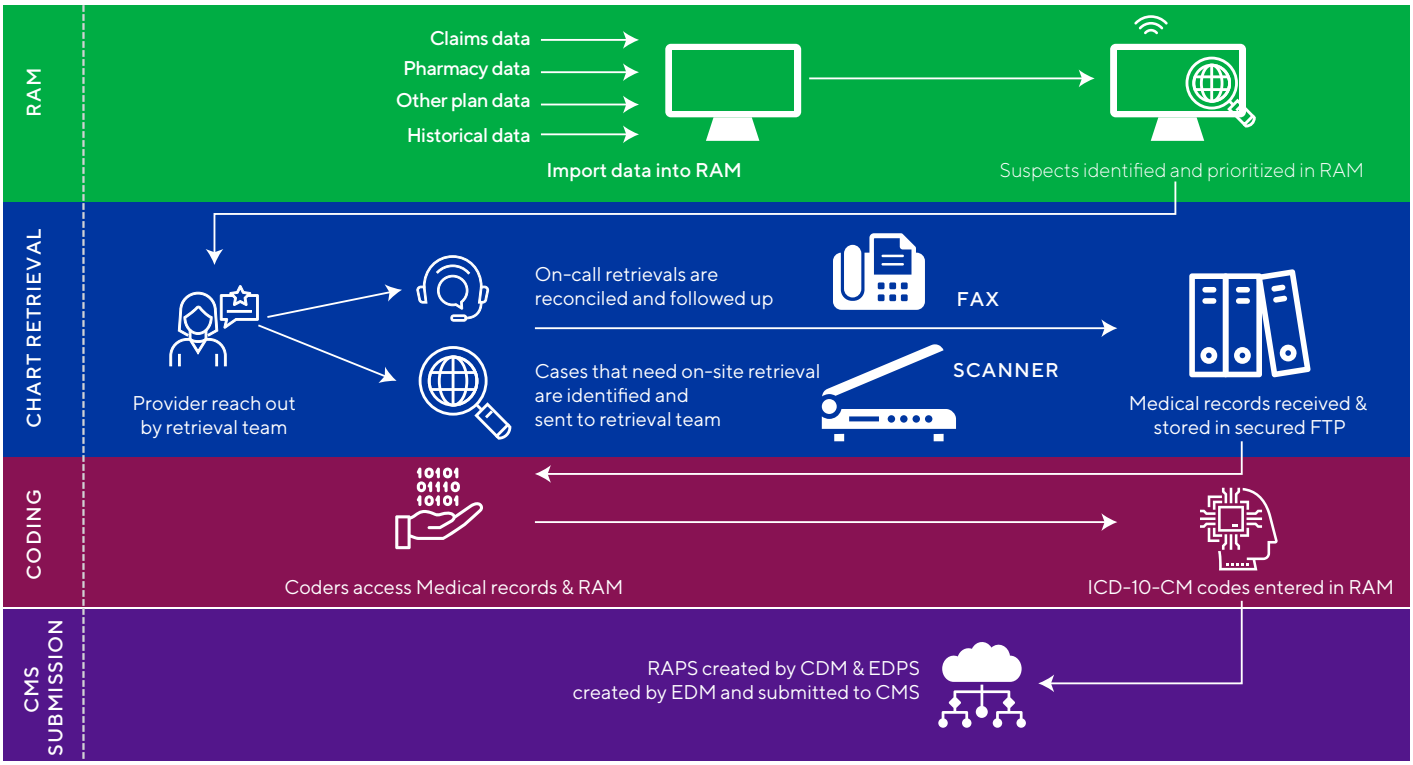


Figure 4

appropriate use may be considered, both to enrich the data being reported to CMS and to mitigate inappropriate use which could create an audit risk.

Increased benefits mean increased costs. Payers should consider addressing SDoH factors to improve overall population health even while taking steps to ensure they report all risk-adjustable conditions.

Payers that optimize their risk adjustment strategies using a wider lens and broader capabilities will collect more comprehensive and accurate data to create business and clinical efficiencies that reduce costs and improve outcomes.

Unifying risk-adjusted payment management: Laying a foundation

While CMS risk-adjusted submissions remain strictly defined, it's clear multiple factors contribute to a member's health conditions and potential HCC codes. Payers that optimize their risk adjustment strategies using a wider lens and broader capabilities will collect more comprehensive and accurate data to create business and clinical efficiencies that reduce costs and improve outcomes.

Key elements of a unified risk adjustment strategy include:

- **Create a centralized document repository.** The repository is the foundation for most of the optimization activities that follow. Medical records all should be stored in one repository accessible to all appropriate users across the payer organization. Metadata should clearly identify the contents of each record for easy retrieval, whether by humans or software agents. Paper records can be converted to optical character recognition (OCR) files to make their data readable. Analytics tools can leverage multiple types of data from the repository and other sources to help identify and collect risk adjustment data. Tools can use claims data to identify diagnoses that may indicate the presence of other HCC codes, or identify members with chronic HCCs reported in earlier years but not in a current payment year.
- **Synchronize timing of internal complementary activities.** Coordinating activities to collect data required for multiple purposes at one time saves time and money and avoids irritating members with multiple contacts. New member welcome activities can incorporate HCC screening, which will also help identify conditions for future HEDIS reporting. Analytics can help the timing of risk adjustment and care management activities within an experience year: if a patient with a prospective risk-adjusted condition typically has an annual check-up in May, it is not cost-effective to schedule an in-home visit in late February. Analytics can flag that patient so the payer can pull the required data from the physician records after the visit.
- **Invest in next-generation automation and intelligent tools.** Intelligent OCR, NLP and machine learning tools increasingly will automate labor-intensive processes, such as preparing EDPS and RAPS submissions,

medical record retrieval, medical record coding and review, and analysis of RAPS return files to understand submission errors. Some of these functions may be available as-a-service, enabling payers to gain next-generation capabilities on a cost-effective subscription basis.

- **Build forward-looking capabilities.** Payers can use their experience to anticipate future risk adjustment scores and forecast revenues. The data also can be mined to predict population health trends, identify potential high utilizers and address their issues and identify SDoH. Payers gathering and tracking member SDoH data trends now will be equipped to respond quickly as CMS incorporates more of these into its risk models.
- **Create an RADV audit action plan.** The plan should detail how the payer will quickly retrieve and report required data, tasks that will be streamlined with the single data repository and automation tools. Educating internal associates about overall risk adjustment activities as well as plan-specific actions is key to ensuring the plan works as expected.

Creating an implementation plan and roadmap are the first phases of developing a unified risk adjustment strategy. Payers can begin with these steps:

- **Identify key stakeholders.** These can vary by payer and should include at minimum: medical management, HEDIS and quality teams, customer service, provider network management, finance, IT, and claims and encounters teams. Think outside the siloes!
- **Identify all the current systems for RAPS and EDPS submissions and analytics.** Document the current steps of the submissions process, plus underlying tools and architecture.
- **Identify all users of medical records at your health plan.** Find out where those medical records are currently stored and what they're used for. Start the conversation about how to begin to centralize these medical records so they're accessible to all departments that need to use them.

These activities will help payers begin to create a unified data strategy to benefit risk adjustment as well as other health plan stakeholders. Then they can begin defining their business requirements with an eye toward using risk adjustment activities and data to augment and coordinate related business and clinical functions, and vice versa. That will create a solid foundation for enhanced compliance, optimal revenue management and enhanced quality of care.

Endnotes

1 www.federalregister.gov/d/2018-23599/p-562.

2 www.federalregister.gov/d/2018-23599/p-558.

3 www.federalregister.gov/d/2018-23599/p-563.

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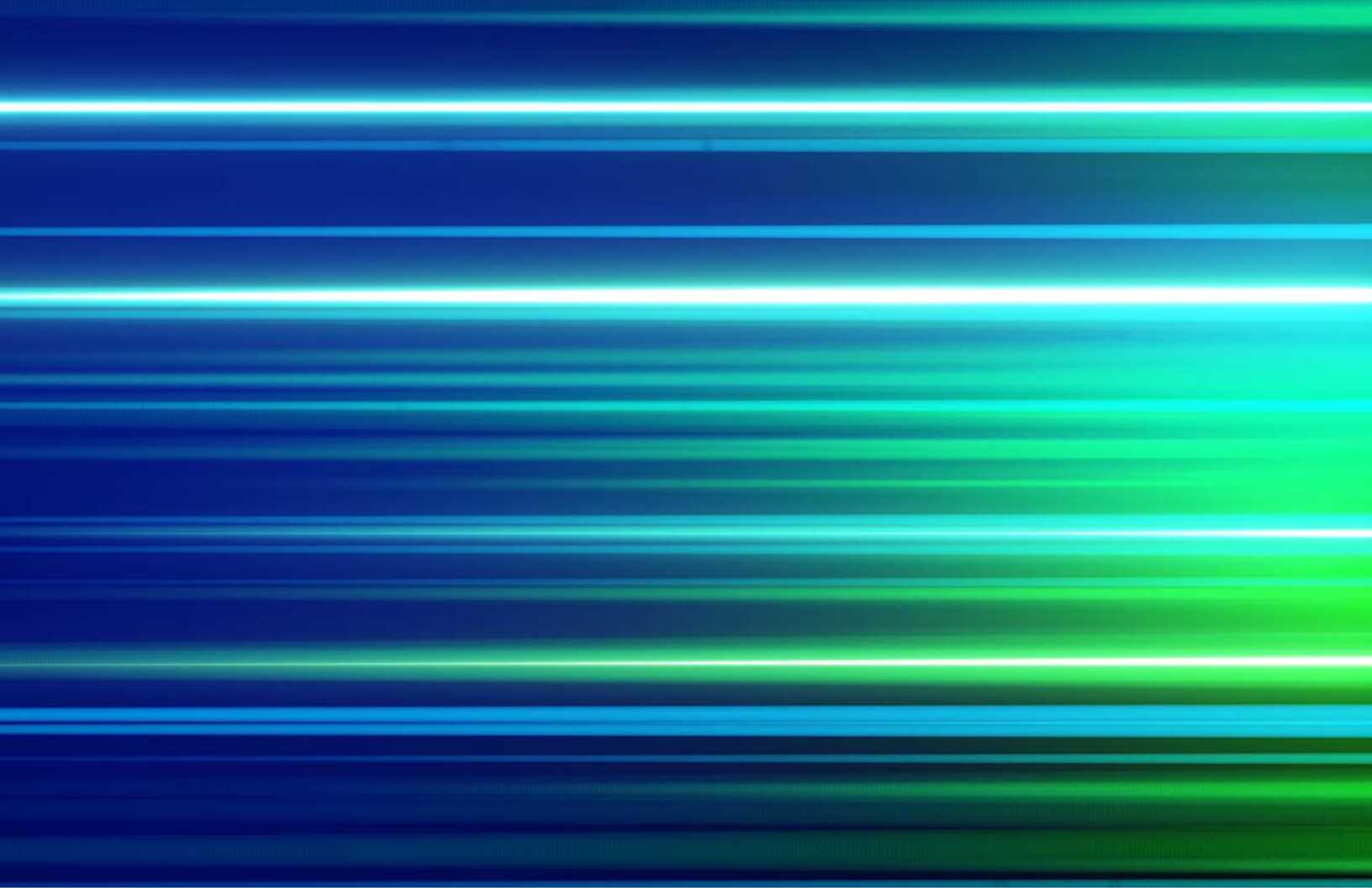

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