



The Challenges and Opportunities for Optimizing HCC Risk Adjustment Processes



Introduction

Understanding a patient's risk is critically important to payers. A properly calculated risk score allows these organizations to make appropriate resources available to providers in order to deliver adequate patient care and financially plan for the future using predictive models that enable proper management of population health, underwriting, and rate calculation.

There are many different methods for approaching risk adjustment, each leveraging a variety of diagnostic and demographic data on patients. One of the most common approaches is hierarchical condition category (HCC) risk adjustment which uses a set of diagnostic codes from the Centers for Medicare & Medicaid Services (CMS) to adjust payments for Medicare Advantage (MA) beneficiaries and from the Department of Health and Human Services (HHS) for Affordable Care Act (ACA) beneficiaries.

This form of risk adjustment comprises a hierarchy of diseases created by CMS and HHS that are based on the severity and cost associated with the disease. An individual is assigned a risk score based on demographic information and severity and chronicity of the disease state, and that risk score is used to adjust the payment rate for each unique MA beneficiary. The risk scores for all beneficiaries are also pooled together to predict costs and resources needed to manage a health plan's member population.

CMS and HHS continuously re-evaluate their HCC risk adjustment methodology, modifying adjustment factors and adding new condition categories in order to determine risk scores with increased accuracy. But managing these ever-changing guidelines and

calculating risk scores for an entire population can pose a significant challenge for payers. The process is time and labor intensive and relies heavily on access to high-quality data, complete with accurate, standardized coding for optimal success.

Additionally, these risk scores are used outside of the payer's finance department. Predictive analytics and population health management strategies leverage risk scores to determine resource allocation, develop preventive programs, and conduct community outreach. An efficient and effective HCC risk adjustment strategy, therefore, fuels success across the entire payer organization.

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Methodology

To understand common challenges of HCC risk adjustment, Wolters Kluwer commissioned Xtelligent Healthcare Media to conduct a survey of Medicare Advantage plans. The survey set out to understand payer use of risk adjustment to achieve organizational goals and the tools leveraged to make the process more efficient and less laborious.

The survey yielded 119 qualified responses from senior-level or above employees at nearly 40 Medicare Advantage plans across the country. Results highlight the labor-intensive nature of risk adjustment, requiring involvement from numerous individuals and a variety of teams. While each organization may leverage different strategies and technologies to ease the process, the survey results indicate commonly shared challenges and opportunities to implement best practices in order to streamline risk adjustment processes and increase the accuracy of data to maximize reimbursement.

Current State of HCC Risk Adjustment

Payer organizations typically perform HCC risk adjustment in one of two ways — prospectively or retrospectively. Prospective risk adjustment uses historical claims to predict future risk while retrospective risk adjustment uses risk scores from the previous year to predict an individual's present risk.

Two patient examples help illustrate the relative efficacy of either approach: a healthy twenty-year-old patient who broke his leg, and an elderly woman with chronic heart disease. A prospective risk adjustment approach would be beneficial for the young man as his claims for the current year will be higher than the year previous; meanwhile, retrospective risk adjustment is likely more effective for the elderly woman as her claims from the preceding year will likely be similar to the current year given her chronic condition.

Survey results indicate that a majority of organizations, 56 percent, are using both prospective and retrospective risk adjustment. Because either risk

adjustment methodology can be useful depending on the member population, many organizations are using both. Only 18 percent of respondents are using prospective or retrospective HCC risk adjustment exclusively.

While organizations must report accurate data to CMS to receive appropriate reimbursement, survey results indicate there are many other uses for this data. Plans are using risk adjustment for population health analytics (58 percent), cost predictions (58 percent), required internal reporting (55 percent), informed decision-making on resource investment (50 percent), and longitudinal performance analysis (43 percent).

Fifty-six percent of organizations are using both prospective and retrospective risk adjustment, while only 18 percent are using prospective or retrospective HCC risk adjustment exclusively.

The variety of uses for risk adjustment means organizations must leverage both methods (retrospective and prospective) in order to meet their goals. However, using dual strategies increases the workload to calculate HCC risk scores which, in turn, can create challenges when optimizing strategies.

Challenge 1: HCC Risk Adjustment is Laborious

Because there are so many uses for HCC risk adjustment, organizations typically deploy teams of individuals solely dedicated to HCC risk adjustment in order to be most effective.

Survey results show that a majority of organizations are following this strategy. Fifty-one percent have a dedicated team internally responsible for handling HCC risk adjustment. These teams comprise a variety of individuals with unique skills and titles — analysts, IT managers, quality improvement directors, and operations staff — and can sometimes include dozens of individuals.

Half of the surveyed organizations have between ten and 30 individuals involved in HCC risk adjustment, while one-quarter report having over 30 individuals involved in the process. Even the 14 percent that outsource this work to a vendor still require





individuals within their own organization to manage the vendor relationships, renew contracts, and update organizational strategies.

In trying to quantify the time allocated to these efforts, most survey respondents report spending the bulk of their time on HCC risk adjustment. Two-thirds of respondents (67 percent) report spending more than 25 percent of their time on HCC risk adjustment. Organizations are spending a lot of time and resources on risk adjustment because the processes remain manual, laborious and, therefore, error prone. Simply adding more resources does not always solve their challenges.

Challenge 2: Risk Adjustment Teams Wear Many Hats

CMS requires the use of HCC risk adjustment to determine payment allocations to Medicare Advantage plans for managing beneficiaries. However, additionally, many plans rely on HCC risk scores when calculating budgets internally and across a variety of organizational goals.

Successful risk adjustment requires upstream and downstream implementation. Upstream, the focus is on understanding the ever-changing coding requirements for risk adjustment and working with providers to ensure proper documentation that in turn enables more efficient and effective risk score calculation. Downstream, the focus turns to quality assurance and population health analysis. To effectively manage the

risk adjustment process it requires a team of qualified personnel.

Considering that organizations use HCC risk adjustment for a variety of purposes, those involved in HCC risk adjustment must wear many hats.

Survey respondents report a variety of responsibilities involved in HCC risk adjustment:

- Provider education for optimizing EHR documentation (45 percent)
- Data quality assurance (42 percent)
- Population risk stratification and analytics (36 percent)
- Provider decision support (35 percent)
- ICD-10 coding for risk adjustment factor generation (34 percent)

Fifty-three percent believe risk adjustment would be improved by better documentation and data quality.

Thirty-nine percent of respondents note that risk adjustment efficiency would be improved by implementing more sophisticated software.

Some individuals are balancing both upstream and downstream work. Educating providers on proper documentation and keeping current with coding standards while also working on population health analysis and resource allocation. Such an approach can be overwhelming for one individual to manage alone. Even with teams dedicated to these tasks, payers must ensure that all team members understand their unique role in the HCC risk adjustment strategy.

Strategies that streamline the assessment process and optimize workflow will allow these teams to succeed. In fact, 26 percent of respondents said risk adjustment efficiency would be improved if there was a dedicated team assigned to risk adjustment.

Challenge 3: Data Quality Must Be Improved

There are multiple strategies for improving HCC risk adjustment to simplify the process for everyone involved. Only 14 percent of respondents are currently outsourcing the HCC risk adjustment process to a

vendor. Another 20 percent report partnering with a vendor for HCC risk adjustment, working collaboratively to ensure the risk scoring meets their need.

A majority, 53 percent, believe risk adjustment would be improved by better documentation and data quality. Yet achieving these improvements requires extensive training as providers must know which diseases to report and where to report this information. Providers must also be kept up to date on changing regulation and coding requirements. Poorly documented patient information translates to less reliable risk score calculations, risking inaccurate representation of their members health needs.

Yet data assurance can be a tedious process, requiring staff to parse through and update patient records. To

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help overcome these clinical documentation challenges, many organizations are leveraging advanced technology like, natural language processing (NLP). In fact, 39 percent of respondents note that risk adjustment efficiency would be improved by implementing more sophisticated software.

Natural Language Processing (NLP) allows coding efficiency to be streamlined, removing the need for dedicated health plan staff to follow up with providers in order to identify clinically relevant information found in a patient's medical record. Likewise, the technology can help automate risk score calculation, flagging members with specific codes and automatically

determining their risk based on diagnosis, gender, and age. When regulatory changes alter risk adjustment methodology, an intelligent software can eliminate the need to retrain internal teams and provider networks.

Many payers recognize the potential of NLP, with 20 percent already using the technology to aid in their risk adjustment efforts. More respondents, 33 percent, report they have plans to implement NLP solutions within the next three years. Only nine percent report having no plans to make NLP investments.

Automating HCC risk adjustment by leveraging NLP allows a health plan's HCC risk adjustment team to focus more on potential uses for risk scores and less on the process for calculating these risk scores. Recouped time can go toward quality improvement programs and population health management strategies that lead to improvements in the health and well-being of members.

So, while each Medicare Advantage plan leverages different strategies for HCC risk adjustment, a team-based approach can help the organization tackle a variety of tasks. And technology that streamlines and automates some of these tasks will allow plans to use risk adjustment beyond required reporting.

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The Health Language data quality portfolio includes the Reference Data Management solution, Interoperability and Data Normalization solution, and Clinical Natural Language Processing (cNLP) solution. By leveraging these solutions health plans can establish a single source of truth and foundation of quality data to effectively maximize reimbursement, manage risk, implement quality improvements, and engage with high cost, at risk member populations.

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