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An Edifecs eBook

Risk Optimization Toolkit

Whether your organization is just moving into value-based care, already on the path to **downside risk**, or **ready to optimize every angle**, this **eBook can offer valuable insights.** Inside, you'll find:

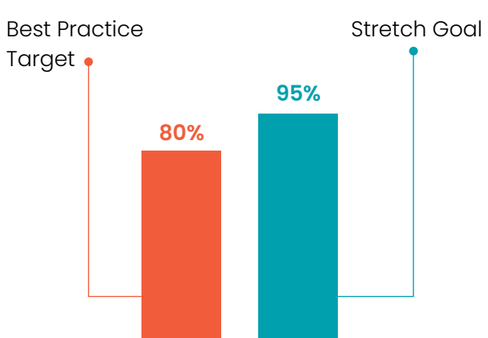
1. **Best-in-class performance metrics**
2. **The expertise required to succeed**
3. **Key considerations when evaluating risk adjustment tools**
4. **How to establish more effective risk adjustment processes**

This information will give you the context you need to start moving forward confidently to better support patient outcomes while ensuring appropriate and compliant reimbursement.

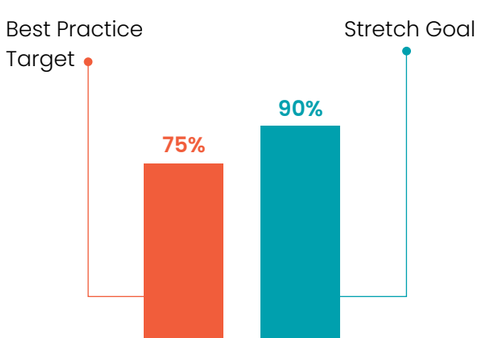
Best-in-class Metrics for Risk Adjustment Performance

To understand how much an organization can gain from more robust risk adjustment, knowing what to look for and why is crucial. Under risk adjustment, there are key performance measures that must be quantified and closely monitored, year-over-year, to gain a better understanding of organizational strengths and weaknesses.

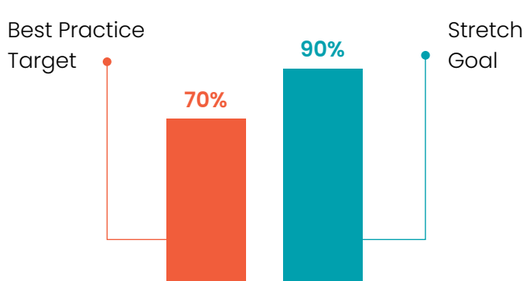
Recapture Rate is the rate at which previously confirmed conditions are re-confirmed each year. The industry average is around 80%, with a stretch goal of 95%.



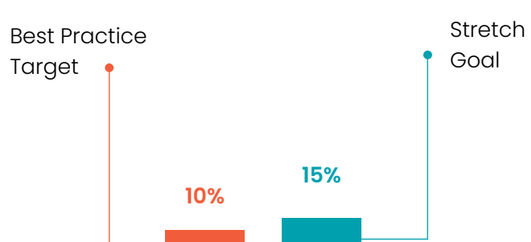
CCV Rate covers the percentage of visits that qualify as a comprehensive care visit (CCV): any visit where half or more of a patient's known or suspected chronic medical conditions are addressed, appropriately documented and correctly coded for the encounter. CCV Rate can therefore be used to measure the efficacy of provider efforts. The standard CCV goal for robust risk adjustment is around 75%, with a recommended stretch goal of 90%.



Annual Wellness Visits are a type of CCVs but should still be tracked independently due to their value in determining care needs and managing chronic conditions. Annual wellness visits serve as optimal opportunity to reconfirm and update the severity of extant chronic conditions and identify new diagnoses. The industry average is 70% total coverage in this area, while meeting the 90% stretch goal can have a significant impact on risk. Annual wellness visits are a valuable tool when used for eligible patients in instances where enrollment and coverage is changing.



New Condition Capture can significantly impact year-over-year RAF, as net-new diagnoses increase the risk score for a given patient. New Condition capture is especially crucial in ensuring patients are engaged in disease management programs and other programs to drive improved health management and outcomes. 10% is the industry average, with 15% as an optimized stretch goal.



General industry standards for ICD-10-CM coding accuracy, at a minimum, should be 95% and the corresponding HCC level accuracy should be 98%. These rates are most effectively achieved with educated Clinicians, supported by Clinical Documentation Integrity (CDI) staff and continuously trained and technologically equipped coders.

For organizations with established risk adjustment programs that may include the use of technology or planning to do so in the near future, we also recommend closely monitoring the following data points. There is no single best practice, as these data points are highly dependent on the organization itself, their patients or lives covered, available resources, data quality, education, and other factors.

QA Benchmarking built using two-way (code addition and redaction) functionality and workflows. The most successful risk adjustment programs are not explicitly additive to overall risk score when it comes to codes, although that is typically the larger total impact. A normalized redaction workflow removing codes at the point of care or retrospectively after submission ensures the risk profiles for patients and populations is complete and accurate. This means not only painting the most accurate possible picture of the care required while ensuring appropriate reimbursement, but also the removal of accidental "upcoding" or codes that are unsupported by clinical documentation. Not only does this improve reimbursement accuracy, but also helps insulate organizations against CMS audits, which can not only result in lost revenue through corrected errors, but significant fines and, in some cases, legal costs.

Charts per Hour, also known as RAF capture rate, is a useful metric that is susceptible to misinterpretation. The charts per hour rate can give high-level insights into a team's efficiency, as well as reveal changes in complexity that do not necessarily even out over large populations, which could indicate a need for technological refinement, additional provider training, etc.

Coding Throughput Coding Throughput is a valuable metric for understanding the total volume of charts and codes that have been evaluated and processed. It can be enhance by Natural Language Processing (NLP), which identifies opportunities and efficiently presents them for validation. Coding throughput is particularly useful as a means of comparing workflow changes and technology upgrades.

Broad Insights, Better Outcomes

Data analytics of performance metrics for a given population, provides insights to help inform short- and long-term decision making in risk adjustment operations; however, we recommend adopting them across all lines of business. Not only will organizational returns improve incrementally, but the more an organization has internalized its risk adjustment processes, the more accurate risk capture is; this, in turn, leads to more complete reimbursement and supports more accurate projections of future cash flows/revenues to aid care improvement initiatives.

Applied Expertise

As risk adjustment continues to be recognized as an avenue to support care and revenue, recognizing the value of human expertise is critical. An organization with the best clinically-focused NLP on the market must remember that AI tools ultimately don't make decisions—care teams and coders do. Risk adjustment technology is not meant to reduce labor costs by automating functions previously performed by humans; rather, it is intended to amplify the reach of humans by parsing massive volumes of data to allow for better-informed decisions.

For payers, this can include first, second, and even third "QA" passes on retrospective reviews of codes to maximize compliance and accuracy and therefore revenue. For health plans making long-term decisions about in- and outsourced coding, there are similar advantages.

For example, lower-cost **offshore coding** that trades knowledge and expertise for total chart volume may benefit more from NLP-powered decision support at a higher level. This lowers costs by enabling outsourced teams to focus on more impactful decision-making with pre-highlighted evidence around the coding opportunities themselves.

At the same time, **in-house coding** operations benefit from the inverse: fewer coders can still process a much higher volume of records if the NLP engine is pre-identifying opportunities within populations for review, while using their expertise to consider more complex coding. Greater synergy between clinicians and staff is another opportunity with bringing coding in-house. In this regard, in-house and outsourced coding still have their strengths and weaknesses, but the gulf between the two is reduced, letting organizations zero in directly on their priorities without sacrificing as much and at a more accessible cost.

For providers already undertaking risk adjustment of some kind, ownership of risk adjustment tasks can vary depending on how and why the initiatives were launched. While typically initiated by financial departments, the wider impact of effective risk adjustment on care—especially with prospective, pre-encounter approaches—means the financial side is more closely tied to clinical outcomes. The answer may be a clinical review specialist with expertise that blends coding and clinical knowledge.

The CRS is an ideal example of how a focus on risk adjustment can create new opportunities in functions and expertise, while also creating a substantial revenue lift, improving documentation quality, and impacting care. The combination of clinical knowledge and coding insight is ideal for pre-vetting suspected conditions prior to an encounter.

In all instances, it comes down to uplifting organizational talent with new technology workflows while simultaneously supporting efficient and quality-focused value-based care.

Tools for the Talent

Effective risk adjustment in value-based care requires the right technology that works with your team—not against it—and empowers your experts to do their job to the limits of their licenses and qualifications. Regardless of which risk adjustment solutions you pursue, the underlying technology must include:

- **Advanced NLP/AI capabilities** 80% of the relevant data needed to adjust for risk is unstructured, usually in the provider's notes, requiring a human or NLP engine to parse and make use of it. Data from claims, clinical narratives, pharmacy, labs, etc., being "piped" through an NLP engine also helps support the centralization and standardization of information. Through the addition of a new data set, the application of NLP to that data, and the centralization of that data, new opportunities can be discovered and acted upon. By extension, the insights derived from risk adjustment activities can be redistributed in the form of both business intelligence and clinical analytics across other departments.
- **Prioritized interoperability standards** to allow clinical data from the EHR to flow into any risk adjustment solution and vice versa. Through access to data, the technology can identify opportunities and make recommendations to coding experts while simultaneously providing necessary evidence for human validation, either within or adjacent to the EHR.
- **A universal workflow across departments and lines of business** that maximizes the skills of coders or, in the case of a pre-encounter solution, a clinical review specialist. This continuity not only improves risk-based outcomes across the board, it also helps whenever additional support may be needed for a specific population depending on the time of year and/or submission deadline.
- **Payer-and EMR-agnostic data feeds** to ensure that working with multiple payer partners for different populations does not present a barrier to adoption and still allows for maximum impact.
- **Chart Retrieval** to address the vulnerabilities and costs associated with a largely manual chart retrieval process. Automating chart retrieval through FHIR enabled chart extraction helps reduce these vulnerabilities—often at a reduced cost, depending on volume. The use of analytics can also help organizations predict which segments of the population (and therefore provider networks) are most likely to have documented risk conditions and quantify the expected value of conditions likely to be found.

Along the patient care continuum, there are three key opportunities to deploy technology to support risk capture:

Prospectively identifying conditions for reconfirmation or highly likely new diagnoses, augmenting any current programs with an otherwise-inaccessible unstructured dataset. Prospective risk opportunity identification is often implemented before or during the patient encounter by provider organizations, but there are ways for payers to do so as well with analytic dashboards.

Concurrently coding at or after the encounter but prior to submission. This is an ideal approach for Medicaid risk adjustment in states that have rules barring retrospective review. It can be done exclusively by risk-bearing provider organizations or in concert with payer partners.

Retrospective reviews are performed by both payers and providers attempting to identify opportunities to code substantiated conditions or delete codes that are no longer supported. They are often performed in concert with sweeps deadlines..

Risk Adjustment Process Maturity

Risk adjustment exists on a continuum of process maturity. At one end of the continuum is zero participation; at the other is upside (sharing savings) and downside risk (sharing cost overages). The largest opportunities in both revenue and patient record accuracy come from engaging in any process of risk capture. Because most risk contracts start "upside only," this creates a great incentive to initiate programs, reap rewards, and find a new stable foundation upon which to build.

Effective risk adjustment programs at any level tend to offer a significant enough increase (or protection) of revenue to fund themselves as well as multiple additional programs. These subsequent programs lead to incremental revenue lift, allowing for greater impact to the funding of care. The deeper an organization goes, the more these returns begin to diminish, but only relative to that early larger ROI.

At a minimum, early education for provider teams is critical to success. Those on the front line of care will have varying levels of understanding of how the complete capture of risk-adjustable conditions can impact the quality of life of their patients as well as the financial health of their institution. Providers are more likely to embrace risk adjustment-focused workflows when the relationship between risk capture, patient record accuracy, and care funding is clearly understood. However, it is critical that these programs only minimally impact time spent on patient care. This is why we often recommend provider organizations begin with a post-encounter solution: providers themselves are virtually uninvolved, but still benefit from better-quality records.

When considering whether to move into value-based care, many organizations view risk adjustment as a lesser element to consider, over-emphasizing the reduction in cost to appreciably earn a piece of shared savings. While the reduction in costs is a fundamental element of value-based care, it is important to remember that it is only one of two levers—and the other is risk management. A more complete and accurate risk adjustment factor for patients and populations, identification of providers who care for the sickest populations, and a consideration of the costs of that program and what it means to engage are arguably as impactful as reducing costs, if not more so.

Complete and accurate risk benchmarking is always higher when risk capture is a priority.

A more accurate benchmark means the high-water mark against which the reduction in cost is measured is higher, leading to a greater share of revenue for organizations bearing that risk.

A robust risk adjustment program that incentivizes better monitoring and management of chronic conditions and includes analytics and insights, provider engagement, and ongoing integration into associated care programs always leads to better care for patients.

This, in turn, also further reduces costs: more visits means better management and fewer acute incidences of chronic conditions—which is the backbone of risk adjustment and, ultimately, the goal of value-based care.

Next Steps

Supported by the right technology, organizational alignment, and ongoing management, a robust risk adjustment strategy can bring risk-bearing organizations and their patients from surviving to thriving under value-based care. But without the right partner, this evolution can still seem like a tall task.

If your organization is looking to improve risk adjustment performance, Edifecs offers a modular suite of risk adjustment solutions designed to meet your goals—whatever they may be.

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About Edifecs

Edifecs is a leading **healthcare technology company** with the mission to improve **healthcare outcomes, reduce costs, and accelerate innovation**. We do this by harnessing all clinical data and eliminating a siloed vendor framework in order to simplify financial, administrative, and compliance initiatives while providing **transparency into value-based care performance.**

Corporate Headquarters
Bellevue, Washington State
1756 114th Avenue SE
Bellevue, WA 98004
Main: (425) 435-2000