AVAILITY WHITE PAPER

RISK ADJUSTMENT:
A Roadmap to Success

Availity®

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INTRODUCTION

"Big Data" holds tremendous promise for the health care industry as it transitions from fee-for-service to value-based care models. With technology advancements and the increased volume of health care data that's collected, many believe we are close to finding better ways to measure value and assess risk within patient populations. But for health plans and their providers, this promise has not yet been realized. They face significant challenges in their efforts to accurately predict costs and improve healthcare delivery.

Deceptive Simplicity

The shift to value-based care gained momentum with the passage of the Affordable Care Act (ACA) in 2010. Under its reforms, health plans are expected to improve the timeliness and accuracy of healthcare information for accurate coding, enhancing member care coordination, and optimizing collaboration between physicians and medical groups.[1] An important stabilization feature of the ACA (and Medicaid Managed Care and Medicare Advantage) is risk adjustment, which compensates health plans based on the underlying health status of their member populations. Risk adjustment also protects health plans from a so-called "death spiral," where premium increases cause healthy or low-risk populations to abandon the marketplace, leaving insurers with primarily high-cost, high-risk populations.

Health plans have used risk adjustment for years, traditionally on the basis of age and gender. Today, it is an important component of value-based care models, in which health plans and providers are compensated for the quality of care they deliver, rather than individual services. However, the values assigned to new risk adjustment models are much more precise, and include the direct costs of primary care services and management of chronic conditions, as well as the indirect costs of care coordination.

The more precise these risk adjustment models are, the more important it is to have accurate and timely data.[2] However, the existing processes for collecting, storing, and analyzing this data are not where they need to be.

Roadmap to Success

This AVAILITY white paper will outline some of the primary challenges of **Risk Adjustment** and present health plans with potential solutions.

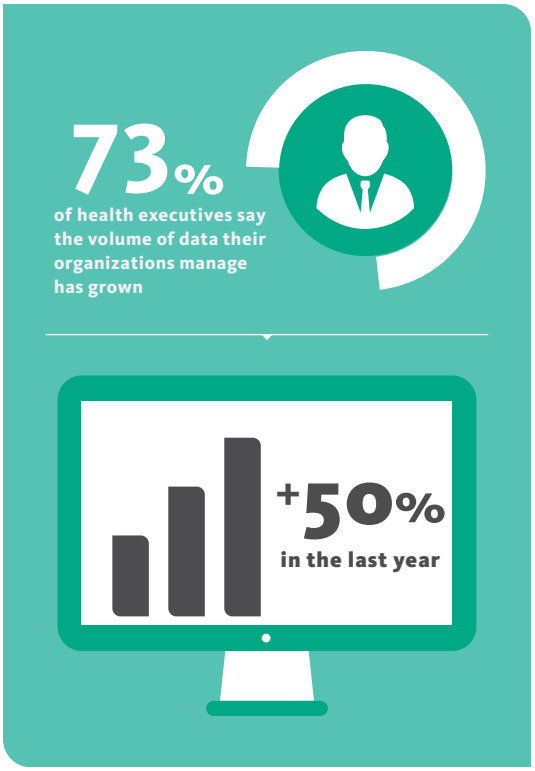
With the transition to value-based care models, health plans and providers are increasingly being compensated for the quality of care they deliver, rather than the individual services.

RESOLVING RISK ADJUSTMENT CHALLENGES

Shattering Data Silos

Within a health plan organization, there are typically multiple departments responsible for collecting provider data for different purposes. The **Risk Adjustment** department reviews claims and related charts to ensure accurate reimbursement, while **Care Management** identifies potential gaps in care and conditions. Another department is responsible for **HEDIS** and **STARS** quality measurements. Once data is captured, however, it's maintained within these individual departments, rather than being centrally stored and accessible across the health plan. These information silos represent one of the greatest obstacles to maximizing the use of information and enhancing collaboration with providers.

In order for risk adjustment to work, health plans must figure out how to streamline data collection, leverage data for different needs, and improve sharing capabilities.



Provider Collaboration

The health plan's organizational silos are not only inefficient, but they can be disruptive to providers who must field multiple requests—via phone call, fax, and in-office visits—from health plan employees looking for access to the same patient medical records for different purposes. Providers often have to dedicate significant financial and administrative resources to respond to these duplicate requests, which is a source of frustration for them.

Because providers represent a critical source of patient information, it's important for health plans to assess the tools and resources they use to engage with them. Implementing data-capture technology represents an opportunity to collect more timely, higher-quality data in a less intrusive way, while opening up deeper collaboration between the provider and the health plan.

Accurate Medical Record Collection

Another challenge for health plans and their provider networks is the Risk Adjustment Data Validation (RADV) audit. Conducted by the Centers for Medicare & Medicaid Services (CMS), RADV audits ensure that health plans are not overstating how sick patients are in order to receive a higher risk-adjusted payment. The audits check to see if Hierarchical Condition Category (HCC) codes submitted by Medicare Advantage and ACA health plans are supported by the member's medical record.

When health plans are selected for a RADV audit, they must submit the health records for members included in the audit. Once again, providers are on the receiving end of multiple requests for documentation that support the coding—a process often referred to as "chart chase." Given the time-sensitive nature of the audit, it's common for health plans to send staff to provider offices to gather the data.

The risk of RADV audits underscores why it's so important for health plans to streamline collection of provider data. Not only is sending staff out to collect information inefficient and expensive, but health plans may also have to refund the government if the provider documentation is incomplete or incorrect. By identifying and closing administrative gaps early in the claims process, health plans can minimize these costs.

Vendor Solutions

With so many different departments requesting information from the provider network, health plans need a digital, scalable, enterprise-wide solution that:

- Works seamlessly over existing systems within health plans and provider practices;
- Ensures data accuracy and eliminates the inefficiencies and frustrations associated with current workflows; and
- Is able to pull components for HEDIS, STARS, and Care Management alongside risk adjustment and bundle them.

Health plans should rely on a vendor partner that can seamlessly manage enterprise-wide workflows from both the health plan and the provider, capture all the data necessary for proper risk adjustment, and turn that data into measurable, proven results.

THE ROAD AHEAD

Risk adjustment is here to stay. To receive accurate, favorable reimbursement from the federal government, health plans must optimize their risk adjustment processes. Because risk adjustment is just one of many health care reform initiatives, many health plans will rely on vendors to streamline the process, allowing them to focus on the core aspects of their business.

Revenue Program Management

One large, single-state health plan worked with Availity to provide Revenue Program Management (RPM), which offers digital payer-provider collaboration to support risk adjustment.

Availity RPM's capabilities include helping providers prioritize patient outreach and the scheduling of comprehensive annual wellness visits. This streamlines the entry and submission of comprehensive quality and risk assessments and improves the electronic upload of medical record attachments, including assessments and attestations.

Within five months of deployment, user adoption of Availity RPM was eight times faster than the adoption of the client's previous tool. This success can be attributed to the fact that Availity RPM exists within the provider's workflow. RPM also gave the health plan a revenue lift of $1,560 per-assessed member per year. When compared with the previous tool using the same number of completed assessments, RPM provided the client an opportunity to more than double its revenue. With new innovative technologies and streamlined processes, the health plan is tackling issues like provider satisfaction, transparency, documentation accuracy, and EMR data extraction. The result is superior performance.

x8

FASTER ADOPTION BY PROVIDERS

$1,560

REVENUE LIFT PER-ASSESSED MEMBER PER YEAR

2.3x

DOUBLE THE REVENUE WITH THE SAME AMOUNT OF ASSESSMENTS

[1]The Henry J. Kaiser Family Foundation. Explaining health care reform: risk adjustment, reinsurance, and risk corridors. January 22, 2014. Retrieved from: http://kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors.

[2] Nielsen, M., Gibson, A., Buelt, L., Grundy, P., Grumbach, K. "The Patient-Centered Medical Home's Impact on Cost and Quality," January 2015. Patient-Centered Primary Care Collaborative. Retrieved from: http://assets.fiercemarkets.net/public/healthcare/pcpcc-2015-evidence-report.pdf

About Availity

As an industry-leading, HITRUST-certified health care information technology company, Availity serves an extensive network of health plans, providers, and technology partners nationwide through a suite of dynamic products built on a powerful, intelligent platform. Availity integrates and manages the clinical, administrative, and financial data needed to fuel real-time coordination between providers, health plans, and patients in a growing value-based care environment. Facilitating over 7 million transactions daily, Availity's ability to provide accurate, timely, and relevant information is vital to the financial success of its clients. For more information, including an online demonstration, please visit www.availity.com or call 1.800.AVAILITY (282.4548).

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