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Forward Thinking

White Paper

Navigating RA Workflows for Utilization Reimbursement and Performance Outcomes

Medical record retrieval is a necessary evil for most payers and risk-bearing entities. It is governed by archaic processes that have been unchanged for nearly four decades. However, certain watershed events over the past few years have impacted retrievals and may start to improve the front intake of medical records.

While the risk adjustment (RA) process is slowly catching up to become more efficient, there are a number of ways that payers can improve their workflows and provider relationships. These improvements not only result in better outcomes for payers but they help improve patient care.

This whitepaper will delve into the issues surrounding compliant risk adjustment workflows and ways payers and risk-bearing entities can improve their data retrieval.

Limitations of Traditional RA Workflows

Here at GeBBS Healthcare Solutions, we have numerous conversations with payers about their risk adjustment workflows. Many feel like medical record retrieval projects are just like throwing everything in the air and hoping things land correctly. They have to sort through ICD-10 codes that are buried, unstructured, and disjointed with incomplete histories. When was the last time you felt confident your chart reviews included records from all out of network claims?

While payers take established approaches and develop programs to capture more accurate codes, many still feel like it is a shotgun response where they must go after everything. Add to that the individual providers that use their specific technologies, and payers are forced to retrieve records from nearly a dozen systems. Plus, they often have to turn to manual practices since providers don't want payers entering into their systems and making any

changes. This is due to the fact that payers think of themselves and what they need, while providers need to cover all data documentation/data feeds for auditing purposes.

The three main pain points that payers run into with risk adjustment are inefficient data retrieval, inaccurate coding, and lack of provider participation in providing access to medical documentation (including of all diagnoses assessed during a patients visit), retrieval and follow-up.

Inefficient Data Retrieval

Data retrieval is a critical tool for retrospective and prospective risk adjustment. Unfortunately, outdated processes bog down most data retrieval processes.

The methods of data retrieval have not changed significantly since the 1980s. Payers are forced to handle various data across the spectrum: structured, unstructured, etc. It can be challenging to gather and organize all the necessary data. Other than specific financial sectors, healthcare stands alone in its dependence on fax machines to send critical information.

Providers are becoming more comfortable with data and knowledgeable about how they need to code. However, it's a practice-by-practice, provider-by-provider initiative with no broad and easy step for increasing education.

When payers request medical records from providers, it takes time and resources to hunt through the limited data that has been retrieved. Because medical record retrieval depends on manual processes, it is also prone to human error that limits the number of charts that can be reviewed.

Getting access to data is also challenging. There are plenty of new technologies and multiple data-keeping systems, with everyone rushing in with their unique solution. The sheer number of options is overwhelming for physicians, slowing them down and making it more challenging for payers to get the necessary documentation.

Inaccurate Coding

For a long time, coding the diagnosis was not something for which payers paid. It was about the services performed and if it was appropriate for the diagnosis. The shift to risk adjustment has changed that, but providers have struggled to keep up with these changes and inefficient workflows.

Most diagnoses have to be recaptured from claims (looking back a period of standard 3 years) and a portion of clinical data from the primary care provider's (PCP) electronic health record (EHR). Payers sometimes rely on hierarchical condition (or

HCC) coding tools, but most only analyze internal data within EHR. This is especially problematic for value-based coders who need clinical understanding beyond fee-for-service.

There have been huge strides, such as submitting claims electronically and standardizing them through portals. However, diagnosis data and charts don't come through portals.

Many risk adjustment models, such as Medicare Advantage, that come through on the claims are not the same as what is in the chart. For example, the chart may include lab results, vital signs, and pertinent information from the client that the provider may not necessarily put in the claims. This lack of added detail can make getting everyone on the same page challenging to ensure the best possible care for patients.

Lack of Provider Participation in Record Retrieval and Follow-up

One of the significant issues that payers run into is provider participation in the medical retrieval process. Payers struggle to get the necessary documentation, proper notes, and thorough patient follow-up. Usually, this is because providers are too focused on "acute" patient problems at the time of a visit and not on managing their overall chronic conditions. This results in providers becoming overwhelmed, disorganized, or uneducated about the latest coding changes to be active participants in the risk adjustment process.

Since providers want to get paid based on the services provided but documenting accurate diagnoses for the patient demonstrates to CMS the utilization of resources and how sick the population for your plan is. Without documentation, CMS has no way to identify the specific diseases which are contributing to high utilization costs. Now that nearly all funding mechanisms for risk-adjusted government programs have ICD-10 coding, providers must understand the value of the diagnosis to the system.

Payers and providers should collectively go after the goal of making the information about the patient — and their different dimensions — available. If it's going to be

available to providers and payers, it has to be portable. In an ideal world, payers and associated providers would have access to the information that is pertinent to them. However, it can be difficult for everyone to quickly access the data that is most important to them.

Ensuring that the most important information is most readily available is currently a challenge for aligning with physicians. For example, if a patient has stroke and is at the hospital, the documentation is important to understand and document the 'history of' diagnosis for appropriate follow up and care management.

Many physicians struggle with the ability to zoom in and out from a time perspective on the chart. Ultimately, they are not acting on a person but on the immediate issues associated with that person. For example, if a patient with uncontrolled Type 2 diabetes has a sore throat, the PCP will treat it but forget to document that they recommended sugar-free throat lozenges.

Understanding the patient's history and all relevant diagnosis is critical through standardized documentation that objectively describes the patient.

The ability to find information will only become more complex as electronic medical records (EMR) contain more patient data than ever. Current estimates suggest that just one patient generates as much as 80 megabytes annually in EMR data. It can be challenging for providers to sift through all of this data to find what is essential for the patient at that moment.

Provider participation has only gotten more complicated after the pandemic and the rise in telehealth. Providers and payers have learned new technology rules, sets, and processes that can assist with things like when patients move and don't take their medical records with them, online health assessments require audio and visual in many cases, and everything needs to be documented correctly.

Getting providers aligned with the workflow process entails keeping problems front and center where the provider and payer can act on them. However, the current model can keep vital information buried and make sharing medical data with payers cumbersome. This information disconnect makes it challenging to share with payers and other providers. It not only makes it more difficult for payers and providers, but it also keeps the healthcare system from being able to provide the most optimal care.

Steps to Improve Risk Adjustment and Data Retrieval

While the current risk adjustment model has issues with archaic and cumbersome processes and workflows, there are steps payers and risk-bearing entities can take to improve their processes. Multiple strategies can help payers retrieve critical documentation, encourage provider participation, and ensure that patients receive the best care and follow-up.

Key Strategies for a Better Risk Adjustment Workflow

Efficient medical record retrievals amplify an optimal compliance-driven risk adjustment. These retrievals are critical for risk-bearing entities — both retrospective and prospective. The right workflow strategy will enable payers to get all the necessary data to provide better patient care and ensure proper documentation.

Some of the key strategies to a better risk adjustment workflow include:

Work towards implementing a more prospective process. During the pandemic, health plans — especially with Medicare Advantage risk adjustment — had an excess of cash. Payers were getting premium capture, but most patients could not go to the doctor.

One study showed that 15% of consumers with employee-sponsored insurance said they deferred some care during 2020 due to COVID. However, by the end of 2020,

going into 2021, there was a large influx of patients getting the services they were previously missing. To compensate for the rise in costs, risk-bearing entities sought to get more data and risk adjustable codes retrospectively. For example, with the COVID, the healthcare advancement of telehealth services provided additional opportunity to document and capture risk adjustable codes through audio and visual platforms.

Now in 2022, many risk-bearing entities are looking to looking to document the current acuity status of the patient, as well as document all related chronic conditions, from a prospective standpoint to ensure that patients in the future get better care and recovery. Payers can implement more tools, such as algorithms and artificial intelligence (AI), to make prospective processes possible. It also helps create better outcomes for the patient, better recovery, better return for their provider in terms of efficiency, and better results for the payer.

Retrieve all clinical data across the care continuum. The drawback of separating medical records from charts is that payers lack some of the critical information they need to provide care. For example, risk-bearing entities may pay claims on pharmaceuticals, but without all the data on care, they cannot check on medication adherence. They cannot ensure proper patient follow-up and that the medication meets their needs.

Likewise, payers must have access to all clinical data, including chart data that is not necessarily on the health record. Getting all the information ensures that risk-bearing entities can provide optimal care and have all the pertinent diagnoses.

Employ NLP as one of the tools to identify diagnoses. Human error is a significant problem when coders look over hundreds of pages. They can miss critical diagnoses and data that may indicate the presence of an undiagnosed chronic condition. Natural language processing (NLP) uses artificial intelligence (AI) to help eliminate human error so that payers can access all the information that is used more effectively.

NLP is not an answer in and of itself and does not eliminate the need for coders. However, it is a valuable tool in the workflow process to ensure that nothing is missed. It can identify both submission-ready diagnoses and clinical data that could suggest the presence of an undiagnosed chronic condition.

Top Tips to Encourage Provider Participation in Documentation

Provider participation in proper documentation comes down to time, quality, and relevance. If documentation can be done in such a way to make it faster to get what is needed, everyone will embrace that. Improving provider participation, then, is about ensuring that payers are not overwhelming medical groups and doctors and

that they are providing them with the information and seamless processes to make their jobs easier.

Traditional payer and provider communication often leaves the provider with more work than they can handle. Payers provide medical groups with a list of suspect conditions and give them access to all of them, both large and small. It leaves providers unable to handle the workload and unsure whether it is necessary to follow up with each patient.

Now, payers are working to enable medical groups to take action, such as giving the original medical record for when the diagnosis was documented to the provider assigned to the patient. Preventative visits are one way to avoid overwhelming doctors with everything they need to assess while providing optimal patient care.

Some steps that payers could take to improve provider participation in documentation and proper patient follow-up include:

- Curate conditions for consideration before sending them to the provider. It will help avoid overload and false positives that leave them overwhelmed and frustrated.
- Use a system to track both confirmed and denied diagnoses in real-time.
- Push diagnoses directly into the EHR-enabled electronic submission alone isn't enough to encourage participation. Offer incentives per diagnosis evaluated, regardless of disposition.
- Encourage providers to capture all the relevant diagnoses during encounters. The information can include providing a notification upon each encounter and the ability to quickly assess and validate the source of GAP suggestions and push documentation back to EHR.
- Allow providers to put notes on top of the record in EMR. It's not a database for which physicians are legally responsible, but it still provides payers with the workflow of ideas on a shared screen.
- Make the EMR bi-directional so that payers can access it immediately. This step makes interoperability possible, which is significant for better coding and care.

Many payers want providers to perform specific actions and fill out paperwork precisely. However, people only do what makes sense for their situation, whether it's because of time, money, or legal constraints. That is why it is critical that payers make it easy for providers to participate in prospective risk adjustment.

Engage with Patients Regularly

Recently, there has been a shift towards involving payers from the beginning with annual wellness visits. Experts realize that while wellness visits alone are not enough, this participation allows PCPs to identify issues and needs and capture the information for coordinating care. It is a critical opportunity for payers to follow up with patients and coordinate various types of care to ensure they see physicians complying with treatment plans and getting more involved.

Through wellness visits, documentation falls into a better place and is no longer just about risk adjustment. It is critical documentation so that the next person who picks up the case file or gets a reminder can see their condition, whether they are still receiving the best care, and follow up with the patient. It becomes more than financials: it's about better care for the patient.

Patient engagement is more than just the actual encounter, whether online or in-person. Many provider groups do a good job getting their members seen but struggle with proper documentation of their conditions. That cuts across both quality and risk when the documentation isn't there. It can result in missing tests and diagnoses when they don't have a workflow in place to help them.

To overcome this deficit, it's critical to get the patient care coordinator involved to:

- Check-in with patients regularly and ensure they are seen at least once per calendar year, as well as schedule visits in advanced.
- Call to verify risk gaps before encounters and schedule screenings accordingly.
- Prepare for an annual wellness visit to minimize provider time. Ensure that pertinent information is easy to access in the patient record so providers don't have to read through pages of history to understand the issues they face now.
- Enroll patients in chronic care management and remote patient monitoring programs.
- Check to ensure medication adherence.

These steps in care coordination are especially crucial with the recent change in risk adjustment scores. Dementia and certain skin diagnoses are just a couple of examples of meaningful risk adjustment scores that have changed in recent years.

When providers don't document these correctly, it can mean thousands of dollars in lost premiums.

For example, if a physician sees small amounts of atrophy on a CT scan of an older and frail patient, they may fail to write it down because it is expected. However, this makes a significant difference in a value-based program. It means that the insurer can have money to do remote monitoring and visit the patient.

It is challenging for providers because even two years ago, that type of documentation didn't matter, but it is critical now. Payers need to be aware of this sudden change for physicians and help educate them on why it is crucial.

Implementing Innovative Risk Adjustment Strategies Can Make the Difference

Compliance-driven risk adjustment faces a number of hurdles. The traditional workflow processes are outdated and challenging for risk-bearing entities and providers. As a result, payers struggle to get the documentation they need when retrieving medical records, and providers are unaware that they should be documenting diagnoses and treatments.

There are ways that payers can overcome these hurdles to be faster, more effective, and provide better returns and patient outcomes. Enhancing provider education and participation and having the right tools to improve coding will help them get the results they need without frustrating providers. For example, GeBBS Healthcare Solutions offers a notable technology platform that is based on compliance-driven risk adjustment powered by amplified retrievals, with health information exchange (HIE) interoperability integrated into EMRs. iCode Risk Adjustment is designed to streamline workflow and improve productivity and quality.

The right partner will help you implement your strategy and reach your goals. However, creating the right tools to improve workflow in-house is expensive and time-consuming. In most cases, partnering with a third-party vendor can be a more efficient and effective solution.

The right expert will help you get further down the road and provide you with the in-depth expertise to fix your processes and start getting the returns and outcomes that will benefit your business and patients. Contact one of our experts today at gebbs.com to learn more about how the right tools are critical for your payer strategy.

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