Executive Summary:

The New Normal – Tackling the Future of Risk Adjustment and Technology

March 2021
Introduction

RISE and GeBBS hosted a two-hour think tank with hand-picked executives from payer, providers, health systems, and other innovators at RISE National 2021 in March to brainstorm practical and compliant technology innovations that will impact the future of health care.

The session, conducted over Zoom, was open only to invited participants and was facilitated by Timothy Burke, Chief Compliance Officer, Radiology Partners and Former National VP Medicare Risk Adjustment and Coding and Gabe Stein, Executive Vice President, GeBBS.

Participants included:

- Jessica Columbus, AVP Stars & Risk Adjustment, Apex Health Solutions
- Peter Davidson, CEO, Windstone Health Services
- Elizabeth Haynes, Director, Risk Adjustment and Stars Govt Programs, Blue Cross Blue Shield of Kansas City
- Jeslie Jacob, Divisional Vice President, Provider Performance | Provider Analytics, Reporting and Connectivity, Blue Cross Blue Shield of Illinois

- Frank Micciche, Vice President of Public Policy and External Relations, NCQA
- Renee Parrish-Moorefield, Sr. Director, Risk Adjustment, Florida Blue Medicare
- Paula Sing, Sr. Director, Florida Blue Medicare
- Thomas Twentyman, Associate Director Risk Adjustment, AIDS Healthcare Foundation
- Naz Urooj, Vice President of Risk Adjustment, Fresenius Health Partners
- Josh Weisbrod, Vice President of Risk Adjustment, Network Health

Objective

To discuss the future of risk-adjustment programs and how 2020 changed processes and technology to drive quality outcomes.

Discussion

The COVID-19 pandemic posed a lot of challenges in 2020. But in some ways, it was also an opportunity.

One participant said her organization was closing in on a 35 percent home assessment completion rate when COVID hit, and the focus turned to telehealth. “During that transition, we quickly realized this was going to be a long-term benefit and we really needed to get our ducks in a row,” she said.

“We also have some other care programs that we offer for our members, and we quickly identified those programs that weren't aligned to our in-home health assessment or telehealth program. So, we circled back with our partners at the company to make sure that the codes they're using are risk-adjustment eligible and that the codes that the practitioners use are risk-adjustment eligible. That's a very similar program to an in-home assessment. We wanted to make sure that we could all capitalize on that visit. Because, as we know, you may only get one visit. So, we're trying to make sure we capture as much as we can. We circled the troops together to identify any visits with our members to make sure that we can use the right clinicians and the right codes to make sure they're all risk-adjustable or risk-eligible.”

The pandemic made it difficult to stay focused on risk-adjustment goals and expectations and maintain chart procurement, even for organizations with access to providers’ EMRs. But that didn’t stop risk-adjustment teams from continuing their work. “We modified our EMR strategy. We went after as many records as we could,” one participant said**.**

“We had to make sure that we were engaged, that we were collaborating with our partners, and that we were making sure that anything that we or anyone else in the organization were doing had a strong risk-adjustment focus,” said another.

Some participants said they maintained their programs—but others were happy to report they exceeded them. “We procured more charts last year than we ever have in the history of risk adjustment,” one participant noted.

Meanwhile, technologies are boosting risk-adjustment productivity and effectiveness, helping with data acquisition, documentation, back-end analysis, and reporting.

Creating a ‘content central’

Records indexing using a central repository is a common goal. Properly indexing and making the data easier to search using analytics and artificial intelligence-powered data mining to increase effectiveness is the next step forward.

One attendee said the journey for a central repository that the risk-adjustment team could access started two years ago. “We wanted to get all of those records together. We found that they were several different departments that were storing their records in different locations. So, we spent two years just getting everybody to make sure that their records were all in what we call content central, which is our content document storage repository area.”

The project collects the day’s records each night and puts them in a PDF format. From there, they go to a natural language processing vendor for coding. All that data gets stored and indexed in the central repository. The program also does a duplicate record check every day as historical data—about two year’s worth—is loaded into the repository.

“Last year we were able to get 22 percent of our medical records via our content repository. And that saved us on vendor cost, plus an average of six to eight weeks in procuring those records. Our coders are able to start coding on day two versus waiting six to eight weeks to get those records back from the chart procurement vendor.”

Bonuses helped incentivize providers to send data electronically. “Because there is a bonus and there is an eventual requirement to make it mandatory, now is the time to go out and get those records.”

Tips:

- Use a provider interoperability team to approach high-priority providers to explain why your organization needs the data, incentives, and looming information-sharing requirements.
- Several participants recommended the OnBase document management system. “We would use it for medical records, obviously, but it's all about the indexing,” one said.

Sharing and acting upon data

When it comes to storing and sharing data in a scalable, bidirectional way and using it to close care gaps, automation is key.

“We're working to expand our collection aperture so that we're getting as much directly from the system-to-system connectivity, as opposed to manual work,” one participant said. **“**One of the things that we're hoping to do with our Epic EHR is to close the loop and get the right information at the right place at the right time.”

Here, again, payers saw the opportunities among the many COVID challenges.

“We took a step back and said, ‘It's not just about getting the records. It's about making sure that the clinical information that we're looking for is there.’ So, building those prospective programs to reduce the retrospective programs on the backend you obviously have to continue them to catch up, but in terms of getting this information in front of the providers in a meaningful manner and helping them take a step back and revisit their workflows, COVID was a good time to do that.”

During a two-month shutdown in a state that saw a later wave of COVID than others did, one organization used the time to really examine clinical information flow to physicians—not only from their own organization but from all payers. They pushed providers to “think comprehensively” across the care continuum about processes and support staff to provide quality care to patients, identify gaps in care, especially for members with chronic conditions, and to capture the record of that care.

“We built a prospective programs team that works collaboratively with the provider groups and helps them to set up processes. They probably saved a couple million dollars in consulting fees,” the participant who shared that example said. “It's supporting them and pushing dollars back into their pocket so that they can continue to build and grow.”

Tips:

- Narrow the scope of provider education to focus on major risk-adjustment pain points to help overwhelmed physicians. One participant said plans for big education efforts had to be scaled back to basics. “It was really just knocking at their doors, looking at their claims data and risk scores one-on-one, and showing them the opportunities.”
- Ask physicians what alerts they need or want to see in the health record is another good strategy. EHR vendors must design systems that providers like to work in to maximize the chance they’ll look at and respond to alerts.
- Add incentives that allow practices to hire support staff to scrub charts before the physician even enters the exam room and to help with documentation.
- Close the loop by making data actionable. “If you don't have a way to follow up or interact with the provider or the physician, you're not going to get as much out of it. And that's where payers and providers can start really linking those two together,” one

participant said. “If we just throw money into technology without other components, it’s just money down the tubes,” said another. “It’s just not going to meet the needs.”

- Consider doing some of the work yourself. One participant’s organization preps charts, “spoon-feeds” providers the gaps, and then checks to ensure they’re documenting visits properly. They also review workloads and processes. “We're basically doing practice transformation consulting.” And it’s paid off: “Last year, out of all the programs we did prospectively, our CDI program came out with the highest ROI.”

Direct-to-member technology

Plans are also using technology to reach out to and engage members. One participant’s organization has a member onboarding portal with information about in-home assessments, educational webinars, and details about the plan’s benefits and rewards program, for example.

Another organization took its quality initiatives to the streets—literally. “We did mobile visits the last couple of years, using a bus and went out to meet people where they're at. We were really focused on Star measures and closing quality gaps to get those scores up a notch or two.” The buses are now being used as COVID vaccine sites, but the program was successful enough that the organization will consider relaunching the program post-pandemic.

To help with virtual visits, one organization launched a device-on-demand program, mailing out iPads with cellular capabilities that members can use to complete pre-visit assessments and, if they don’t have access to the internet, the virtual visit itself. The device is locked for any other purpose and members mail it back in a prepaid envelope after their visit. The plan has completed close to 1,000 member encounters and expects to continue the program post-pandemic.

Another mobile device program helped deal with social isolation by sending a 17-inch tablet to help at-risk members, mostly enrolled in Medicare Advantage, communicate with family, and conduct simple tasks like checking the news and weather. “It doesn't help with the in-home assessments yet, but in theory it could.”

AI, natural language processing

Technology can help payers streamline and get the most out of chart reviews and obtain data that can help providers close gaps in care.

“We've moved to NLP with a vendor's help,” one attendee said. “One of the things that we may want to do in the future is use it for the purpose of weeding out records to review.” Meanwhile, they’ve found value every time they run charts through two times—first with a coder and second through the NLP technology. It’s also possible to run charts through two different NLP programs.

“Coders are humans. And sometimes it's the coder missed something or thought the documentation criteria wasn't appropriate to capture it. So, we look into why codes are deleted

by some coders and why they're accepted by others and try to achieve greater consistency. We aim for 95 percent and we've found that with our NLP it's around 92 to 93 percent."

Tips:

- An NLP platform's taxonomy is critical to the process. One program may pick up on a code while another will not.
- Any AI and NLP product is only as good as its algorithms and experience. Look at how many records a platform has processed and what types of records they use when evaluating vendors.
- Expect errors. "We used to find a lot of errors in terms of the documentation and what the NLP is actually picking up," one participant said. "One of the things that we had to tell the provider is that they have to train the NLP." When a program suggests a code, physicians still have to pay attention and correct any errors.

The good news: Both patients and providers are getting much more comfortable with all of these technologies, tools, and apps, participants agreed.

About GeBBS

GeBBS Healthcare Solutions is a KLAS rated leading provider of Revenue Cycle Management (RCM) services and Risk Adjustment solutions. GeBBS' innovative technology, combined with over 9,500-strong global workforce, helps clients improve financial performance, adhere to compliance, and enhance the patient experience. Headquartered in Los Angeles, CA, GeBBS is backed by ChrysCapital, one of the premier private equity funds based out of India. GeBBS has won numerous accolades for its medical coding outsourcing and medical billing outsourcing, including being ranked in Modern Healthcare's Top 10 Largest RCM Firms, Black Book Market Research's Top 20 RCM Outsourcing Services, and Inc. 5000's fastest growing private companies in the U.S. For more information, please visit http://www.gebbs.com.

About RISE

RISE is the premier community for health care professionals who aspire to meet the extraordinary challenges posed by the emerging landscape of accountable care and government health care reform. Recognized industry wide as the number one source for information on risk adjustment and quality improvement within health care, RISE strives to serve the community on four fronts: networking, education, industry intelligence, and career development.