10 tips for a successful commercial risk adjustment program

As ACA Marketplace enrollment continues to grow, health plans can leverage proven best practices to optimize the impact and compliance of their commercial risk adjustment programs.

Cotiviti has translated over 25 years of experience into top tactics for Qualified Health Plans (QHPs) looking to better understand and prepare for the commercial risk adjustment process this year. Our expertise has led to consistent high-quality results, including high retrieval rates and >98% coding accuracy across our commercial risk adjustment clients in 2023.

Read this checklist to learn more about our recommendations and lessons learned.

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1. **Stay up to date on regulatory and maintenance changes—and understand the impact.**
2. **Confirm plan data for accuracy.**
3. **Conduct outreach early to minimize administrative expense.**
4. **Understand your members.**
5. **Retrieve medical records efficiently.**
6. **Code accurately and capture all relevant data.**
7. **Compile, scrub, and triple-check your data.**
8. **Ensure data is successfully submitted on time, in the correct format.**
9. **Leverage analytics to educate providers.**
10. **Reconcile any errors, and analyze your final reports.**

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1 Stay up to date on regulatory and maintenance changes—and understand the impact.

REGTAP provides advance maintenance notices to help inform plans on what they should do to prepare for an upcoming risk adjustment program. Knowing what to expect and how best to prepare will position your plan favorably. A vendor that continually monitors and interprets the latest payment model updates can alleviate the burden of combing through notices yourself and will offer the expertise to help you plan your risk adjustment strategy.

2 Confirm plan data for accuracy.

Many plans struggle with data reconciliation from one department to another, and these challenges are compounded by the sheer number of departments in a health plan that contribute to the data flow in a risk adjustment program. Conducting an assurance review of plan data on EDGE prior to the submission year will reduce data inconsistencies and ensure data and member accuracy. The team overseeing the submissions process should have deep, cross-functional expertise and broad knowledge of the entire process to identify leakage and resolve issues that can occur at any point. In addition, monthly stakeholder meetings with finance, claims processing, underwriting, and risk adjustment operations will help align all departments to a similar goal.

3 Conduct outreach early to minimize administrative expense.

Encourage members to visit their primary care providers, and educate providers on commercial risk adjustment as well as recommendations for members who are disengaged from their wellness plan. Ensuring that members visit their providers annually allows issuers to view their health in detail early in the year, including their HCC and non-HCC conditions, HEDIS® review measures, and disease and case management cues. This, in turn, helps identify members who should be enrolled in health and wellness programs. Telehealth and in-home assessments can also help provders assess the wellness of their members and close condition gaps.

4 Understand your members.

What conditions will you need to anticipate and care for? Which members have the highest risk? Which engagement methods do they respond to? Suspect analytics can help organizations better identify, prioritize, and reach members with the highest probability of having undocumented conditions. An informed, prioritized list of patients, in turn, helps drive your strategy to retrospectively find and document conditions for consideration in your risk-adjusted payment formula. Suspect analytics will also help you avoid chasing members carrying less risk. The ideal time to start suspecting is November and December, as you can review as many claims as possible and still have enough time to find conditions for the current submission year.

5 Retrieve medical records efficiently.

The most certain way to validate and document potential conditions is through a patient's medical record. In many cases, a provider may note the existence of a condition in a patient's chart but not bill for anything specific to that condition in the claim. For example, if a patient is seen for a routine well visit, the doctor may note that the patient suffers from diabetes. However, because the patient is not being seen or treated for diabetes during that visit, the provider does not submit any claim detail regarding the condition. The actual record, however, can be used as documentation.

When retrieving medical records from provider offices, minimize provider abrasion and unnecessary effort by streamlining your approach. Leverage digital data retrieval, consolidate multiple member chart requests across officers and lines of business, track all office staff details and prior requests, and index paper records for audit purposes. Begin retrieval once your suspecting efforts are complete, ideally in December.

6 Code accurately and capture all relevant data.

Accurate and complete coding should be your seasonal risk adjustment mantra. Be sure to capture all diagnosis and HCC data when coding. The accuracy rate is important—even a slight variation, when extrapolated across an entire population, can make a significant difference in revenue and impact HHS Risk Adjustment Data Validation (HRADV) audit results. Work with your team of coders to improve accuracy, or take advantage of a vendor's expertise in this area. Coding activities typically start around January and February and continue right up until the final deadline. To maintain a high accuracy rate, independently audit both coders and vendors to ensure effective quality improvement processes are in place.

7 Compile, scrub, and triple-check your data.

It's critical to quality-check your coding data for accuracy. In fact, we recommend that you conduct multiple quality assurance reviews and audits throughout the process to ensure the highest level of quality and accuracy prior to submission to the Centers for Medicare & Medicaid Services (CMS). Partnering with an expert vendor, health plans can strengthen independent overview and improve accuracy to respond to increased compliance scrutiny and best prepare for annual audits. The submission of accurate baseline data creates a solid foundation for understanding your acceptance rate and submission goals. The quantity and quality measurements that CMS uses to evaluate submissions are very important in tracking and understanding your members' utilization year over year.

8 Ensure data is successfully submitted on time, in the correct format.

You can work directly with CMS to submit your data, or you can work with a vendor that offers a secure data environment, also known as an EDGE server. A smooth process should allow you to submit more than 98% of your enrollment and claims data by early March, with final submission typically by the end of Apri.

9 Leverage analytics to educate providers.

Each year is a new opportunity to secure appropriate funding for your population. Take a proactive approach to provider education to reduce administrative costs later in the process. Using data from the previous year, review all clinical coding errors and submitted deletes to understand where providers are struggling, then build your provider education program around these issues. Offering providers financial incentives to improve their coding and billing accuracy can also assist in reducing submission errors found during HRADV.

10 Reconcile any errors, and analyze your final reports.

Your final step should be to reconcile and prioritize any errors, analyze your final data, and identify ways to improve your submissions in a "lessons learned" session with all stakeholders. Reviewing your CMS reports with key stakeholders can help shed light on opportunities for improvement, which can ultimately lead to improved assessment of population risk and thus more appropriate funding.

Learn how Cotiviti's Risk Adjustment solutions enable health plans to optimize risk-associated revenue capture as well as compliance.

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