The Future of Risk Adjustment: Moving Beyond Chart Chase

An On-Demand Webinar | Becker's Healthcare x InterSystems

About This Webinar

The pressure on health plans to modernize risk adjustment has never been greater. CMS is auditing six years of Medicare Advantage payments in a compressed window. Extrapolation risk is back on the table. Margins are tightening. And the retrospective chart chase model that has defined risk adjustment operations for decades is cracking under the weight of a regulatory environment it was never designed to handle.

In this 53-minute on-demand session, Becker's Healthcare brought together four health plan leaders and clinical executives for a candid, experience-driven conversation about where the current model is failing, what the financial and operational stakes are for plans that delay, and what a clinical-first approach to risk adjustment actually looks like when it's working. The result is one of the most practical and direct discussions available on the topic — grounded in real operational experience, not theory.

Featured Panelists

Lisa Parnell — Director of Risk Adjustment, Community Health Choice A regional health plan leader navigating the shift from retrospective workflows toward proactive, point-of-care risk capture in a resource-constrained environment.

Mark Dabney — Director of Risk Adjustment, Community Health Plan of Washington Leads risk adjustment strategy for a not-for-profit plan covering Medicare, Medicaid, and ACA populations, with deep expertise in FQHC provider engagement, coding education, and value-based care alignment.

Dr. John Mazzutti — Chief Medical Officer, Clear Spring Healthcare A former urologist and Permanente Medical Group leader who brings a physician-first perspective to the intersection of clinical quality, provider culture, and risk adjustment accuracy.

John Murtha — Health Plan Executive, InterSystems A health plan operations and clinical data interoperability strategist with a national view of how organizations are — and are not — making the transition to prospective risk adjustment models.

Moderated by Lucas Vos, Becker's Healthcare

Webinar Summary

The session opens with a telling exercise: each panelist is asked for a single word to describe how health plans are approaching risk adjustment today. The answers — *exposed*, *cautious*, *careful* — set the tone for everything that follows.

The first third of the conversation diagnoses the core problem. Retrospective chart chase, the panelists agree, was designed for a world where a plan needed to retrospectively validate a handful of codes per member and close a few documentation gaps. It was never designed to reconstruct clinical history at scale, defend coding accuracy across six simultaneous audit years, or absorb the financial shock of extrapolation. That world is now the reality, and the mismatch between the old model and the new environment is where the exposure lives.

Lisa Parnell puts it plainly: retrospective review is the most expensive way to fix yesterday's problems. It destabilizes revenue, drains operations, and does nothing for the member currently sitting in front of a provider. Mark Dabney surfaces the provider relationship damage that retrospective review causes — asking FQHCs to retrieve charts from 2019 and 2020, years many clinics barely survived, strains trust and undermines the collaborative relationships that sustainable risk adjustment depends on. Dr. Mazzutti

introduces a less-discussed dimension: chart chase is not always additive. It also surfaces codes that should not have been submitted, meaning the exercise does not reliably produce revenue upside.

John Murtha provides the macro context that sharpens the urgency: the HCC model has moved from version 24 to version 28, CMS has resumed RADV audits after a four-year pause, and the legal battle over extrapolation — which would project audit findings from a sample across an entire member population — is ongoing. His summary is one of the most quotable moments in the session: *"The last six years of payment are being audited in the next 13 months."*

The middle section examines why incremental fixes are not enough. The panel agrees: tighter vendor management, faster chart retrieval, and improved coding audits are improvements to a model that is fundamentally misaligned with the regulatory environment. Every gap closed on the back end, as Lisa notes, now highlights a failure at the point of care. John Murtha draws a sharp distinction between interoperability and workflow — getting more clinical data is not the same as acting on it at the moment it matters. What changes the outcome is the timing of when data enters a workflow and influences what happens with the patient.

The discussion of the clinical-first alternative is where the session becomes most practically useful. Dr. Mazzutti outlines the approach with unusual clarity: stop talking about risk adjustment coding with providers entirely. Start talking about ensuring that every chronic condition a patient has is addressed and documented at every encounter. The reframe — from compliance exercise to quality care — is what makes provider engagement possible. Alongside this cultural shift, he describes the technology layer: AI-assisted decision support embedded in the provider workflow, surfacing unaddressed conditions and documentation gaps in real time, before the encounter closes.

Lisa Parnell adds the structural dimension: clinical and coding need to be interwoven, not running on parallel tracks. Risk adjustment documentation is storytelling — telling the complete, accurate, high-specificity story of a patient's conditions at the point of care. Mark Dabney emphasizes the educational foundation: providers who understand *why* risk adjustment matters — how it connects to their patient panel's care quality, to the plan's financial health, and to the sustainability of the value-based partnership — are fundamentally different partners than providers who receive coding checklists in the mail.

The conversation then turns to the data infrastructure that enables this shift: Continuity of Care Documents (CCDs), ADT feeds, and EHR-integrated alerts. CCDs are certified, RDV-compliant, and can dramatically reduce retrospective chart retrieval when deployed systematically. ADT feeds give care managers early signals — before claims process — allowing outbound outreach that improves care coordination and generates better documentation naturally. Leading plans, John Murtha notes, are already measuring how much their retrospective chart chase activity has been displaced by CCD and ADT-based workflows, quantifying the operational cost savings and using them to build the internal business case for further investment.

The final segment addresses financial risk at the enterprise level. The panel is direct: RADV exposure with extrapolation is not a compliance matter — it is a business continuity issue. A small number of coding errors across a small number of members can now produce plan-wide revenue impact measured in percentage points of margin. John Murtha ties this to the wave of Medicare Advantage market exits in recent years, including Cigna's sale of its MA book, pointing to the operational unsustainability of keeping pace with CMS changes without a fundamentally different workflow architecture.

The session closes with forward-looking recommendations. All four panelists converge on the same starting point: provider partnership, education, and incentive alignment come first. Technology and data infrastructure amplify what is built on that human foundation — they do not replace it. The overarching message, captured best by Dr. Mazzutti, is one of elegant simplicity: *"The answer to everything is higher-quality healthcare. And if you do that, everything else works out."*

Key Learnings

1. The retrospective model was designed for a different regulatory era — and that era is over. Chart chase worked when RADV audits were infrequent, extrapolation was limited, and only a fraction of codes needed retrospective validation. Today's environment — simultaneous multi-year audits, HCC model recalibration, and extrapolation risk — has outpaced the model entirely.

2. Timing is the central failure point of retrospective risk adjustment. Once a claim has moved, the plan can no longer influence the system — only reconstruct it. Every retrospective process starts from a

position of lost opportunity. Moving the point of influence upstream, to the encounter itself, is the only structural fix.

3. Incremental improvements to a broken model do not change the underlying risk. Faster chart retrieval, tighter vendor oversight, and improved back-end auditing are optimizations of a process that is itself misaligned. They reduce operational friction but leave the financial and audit exposure intact.

4. Clinical-first risk adjustment requires a language shift, not just a workflow shift. Providers do not engage with coding compliance the way they engage with patient care quality. Reframing risk adjustment conversations around comprehensive chronic condition management — eliminating the coding vocabulary entirely in provider-facing communications — is what enables sustainable engagement.

5. Provider incentive alignment is a prerequisite, not a nice-to-have. Without financial incentives tied to documentation completeness and capture accuracy, provider behavior will not change regardless of education investment. Value-based contract structures must reflect what the plan is asking providers to do.

6. CCDs are an underutilized, audit-ready asset. Continuity of Care Documents are certified for risk adjustment, pass RADV review, and can displace significant volumes of retrospective chart retrieval when systematically deployed. Most plans are not measuring their CCD utilization — and therefore cannot optimize it.

7. ADT feeds change when care management can act, not just what it knows. Admission/discharge/transfer data provides clinical signals before claims process, enabling care managers to reach patients at medically relevant moments. Plans using ADTs to drive care manager outreach are seeing better care coordination outcomes and earlier documentation capture.

8. RADV extrapolation converts individual coding errors into enterprise-scale financial risk. With extrapolation, a coding error rate found in an audit sample is projected across the full member population. Small margin errors become large revenue clawbacks. This is a board-level risk issue, not a compliance department issue.

9. Provider-sponsored MA plans have a structural advantage in this environment. When the medical group and health plan are organizationally aligned — as at Kaiser Permanente or in Cleveland Clinic's emerging model — incentives, workflows, and documentation standards can be synchronized in ways that are structurally difficult for traditional payer-provider relationships.

10. The shift to clinical-first is an enterprise transformation. Risk adjustment, quality, care management, clinical leadership, and IT must converge around the same clinical signals and the same patient-first workflows. Organizations that treat this as a risk adjustment department initiative will not achieve the scale of change the environment requires.

Key Takeaways

- **Waiting is not a neutral position.** Every year of delay compounds RADV audit exposure across multiple payment years. Lisa Parnell's framing is precise: *"Waiting isn't neutral — it's a financial punitive action."*
- **The earliest possible signal is the most valuable one.** Whether that signal is a CCD, an ADT notification, a care gap flag, or a pre-encounter alert, identifying and acting on clinical information earlier in the care cycle is the defining characteristic of a modern risk adjustment program.
- **Talk to providers in their language, not yours.** The plans making the most progress on clinical-first risk adjustment are the ones that have stopped leading with coding terminology and started leading with patient care quality. This is both a communication strategy and a cultural stance.
- **Build the business case from measurable displacement.** Track how much retrospective chart retrieval is being replaced by CCD-based capture, ADT-driven outreach, or point-of-care decision support. That displacement metric is your internal proof of concept — and your CFO's business case for further investment.
- **Provider partnership is the foundation everything else is built on.** Technology, data feeds, and workflow redesign all amplify what is possible when providers are genuinely engaged. They cannot substitute for that engagement.

- **Frame this for leadership as operational sustainability, not compliance.** The plans that are exiting Medicare Advantage are doing so because their operating model cannot withstand continuous audit scrutiny at enterprise scale. That is the conversation that needs to happen in the boardroom.

Questions This Webinar Answers

On the current state of risk adjustment:

- Why is retrospective chart chase no longer adequate for today's regulatory environment?
- What specific CMS changes — RADV resumption, HCC v28 migration, extrapolation — have changed the financial calculus for Medicare Advantage plans?
- What does it actually cost, operationally and financially, to stay on a retrospective-only risk adjustment path?
- Where does the retrospective model break down most visibly — and why?

On financial and audit risk:

- What is the real dollar exposure for plans that delay modernizing their risk adjustment programs?
- How does extrapolation transform individual coding errors into enterprise-scale financial risk?
- How should RADV exposure be framed for CFOs and boards — and why is this a business continuity issue, not a compliance issue?
- What happened to plans that couldn't keep pace with CMS operational changes, and what does that signal for market participants?

On the clinical-first alternative:

- What does a clinical-first approach to risk adjustment actually look like in practice?
- How do you talk to providers about risk adjustment without talking about risk adjustment?
- What role does AI-assisted decision support play at the point of care, and what does it need to do to be effective?
- How do you integrate risk adjustment, quality, and care management into a single clinical signal?

On provider engagement:

- How do you engage providers — particularly FQHCs and independent practices — in risk adjustment education without damaging the relationship?
- What does provider incentive alignment look like, and why is it non-negotiable?
- How do provider-sponsored MA plans approach this differently — and what can traditional plans learn from them?

On data and technology:

- How should plans use CCDs and ADT feeds to move risk capture upstream?
- What is the difference between interoperability and workflow — and why does it matter for risk adjustment outcomes?
- How do leading plans measure the operational impact of CCD and ADT utilization?
- What does a bidirectional EHR integration look like for risk adjustment workflows, and where is it most valuable?

On getting started:

- What is the single most important first step for a plan that is still primarily retrospective?
- What are leading plans doing today that positions them ahead of the next audit cycle?
- How do you build the internal business case for moving from retrospective to prospective risk adjustment?
- What does a realistic 6–18 month roadmap for this transition look like?

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