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The end of chart chase: How payers are rethinking risk adjustment

Executive Summary

Becker's Healthcare, in collaboration with InterSystems, hosted four leaders to discuss how payers are moving toward a more proactive, clinical-first approach to risk adjustment. Key insights from the discussion focused on:

- Why retrospective chart chase is becoming increasingly unsustainable.
- How an explosion in CMS audit activity is changing the economics of risk adjustment.
- The rationale for and benefits of a clinical-first approach to risk adjustment.
- Why provider engagement is foundational to a clinical first approach.
- The role of real-time clinical data in improving documentation and reducing operational burden.

Introduction

Risk adjustment strategies built on retrospective chart chase are not just inefficient, they can be risky and increasingly leave organizations financially exposed. As CMS expands Risk Adjustment Data Validation (RADV) audits, payers must rethink how risk is captured and when it's validated and acted on.

Clinical-first risk adjustment uses timely, authenticated clinical information and provider workflows to improve documentation and validation closer to the point of care, rather than relying primarily on retrospective chart retrieval.

Risk adjustment historically

Risk adjustment processes were initially created to infrequently and retrospectively validate a handful of codes. John Murtha, health plan executive at InterSystems, described these historical processes as adequate in validating a few codes, but frequently breaking down around timing and scale.

In terms of timing, the encounter has already happened. The provider completed the documentation, the claim has been submitted and processed and the health plan is no longer influencing the process. Then, when an audit arises, the provider must retrospectively reconstruct everything that happened, which is difficult, especially when the review reaches back several years.

Why the current model is breaking down

In addition to the retrospective nature of RADV audits, CMS is now pursuing audits at massive scale. "Last year CMS asked for 300,000 charts," Mr. Murtha said. "This year they are asking for five times that amount and they're making organizations manually go through them."

> "The last six years of payment are being audited in the next 13 months."
>
> – John Murtha, health plan executive, InterSystems

Lisa Purnell, director of risk adjustment at Community Health Choice agreed that "CMS has moved the goalposts," and asserted that this situation is untenable for organizations.

> "Retrospective review is the most expensive way to fix yesterday's problems. It drains operations, destabilizes revenue and does nothing for members."
>
> – Lisa Purnell, director of risk adjustment, Community Health Choice

WHY TODAY'S MODEL IS BREAKING DOWN	WHY IT MATTERS
RADV Audits	CMS is auditing six years of Medicare Advantage payments within a compressed timeframe.
Extrapolation Risk	Audit findings may now be projected across the entire member population, significantly increasing financial exposure.
HCC Model Evolution	Migration to HCC Version 28 places greater emphasis on complete, accurate clinical documentation.
Margin Pressure	Health plans face increasing operational costs while managing tighter financial margins.
Provider Fatigue	Retrospective chart requests create administrative burden and strain provider relationships.

Moving documentation upstream

According to Mr. Murtha, much of the industry continues to rely on incremental improvements to retrospective processes. He argued that approach falls short of addressing the magnitude of today's compliance and documentation challenges.

"The issue is whether your operating model can withstand continuous audit scrutiny at an enterprise scale," Mr. Murtha said. "There's so much risk. The amount of risk and the cost to put the operations in place to withstand these changes is unsustainable.

That realization is prompting some organizations to rethink the entire risk adjustment process. Rather than continuing to optimize retrospective workflows, leaders are shifting their focus upstream to improve documentation and capture accurate clinical information at the point of care.

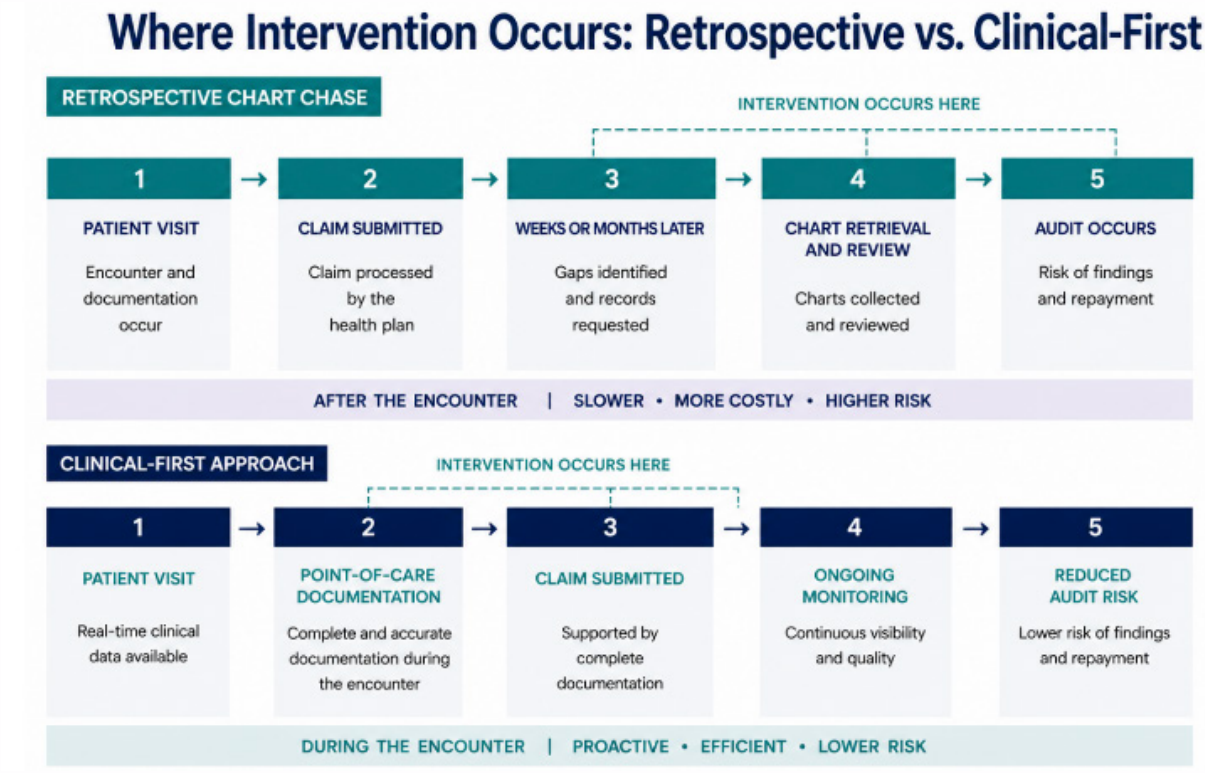
"Process improvement tweaks and tighter vendor oversight aren't enough anymore. They're solving problems that don't exist," Ms. Purnell said. "Every gap you close on the back end highlights a failure at the point of care. If we are able to document and capture everything at the point of care, it's going to make it easier."

Benefits of a proactive, clinical-first approach

What is needed is to shift from retrospective to prospective risk adjustment through a "clinical-first" approach that involves gathering and documenting necessary information at the point of care.

Operationally, the key is to build data capture and documentation into provider workflows at the time of care. This gathers necessary information upfront and eliminates the need to go back retrospectively, observed Mark Dabney, director of risk adjustment at Community Health Plan of Washington.

> "Building it [proactive risk adjustment] into providers' workflows, you see stronger provider engagement."
>
> – Mark Dabney, director of risk adjustment, Community Health Plan of Washington



Jonathan Masoudi, MD, chief medical officer at Clear Spring Healthcare sees the solution as a "tech fix." "We've got great AI tools," he said. "We should be implementing them alongside the provider, almost like decision-support tools, where the AI tool evaluates the documentation, looks at the conditions being addressed and reminds the provider if any information is missing." This will remove risks from audits, remove costs due to having to look back at charts and improve relationships with providers.

Clinically, proactively and consistently gathering information at the point of care will improve quality, especially for patients with chronic conditions.

> "The answer to everything is higher-quality healthcare. If you do that, everything else works out."
>
> — Jonathan Masoudi, MD, chief medical officer, Clear Spring Healthcare

Proactively gathering information at the time of care has financial advantages of decreasing audit exposure and operational costs by reducing the need to go back and manually review charts. It may also help providers increase revenue by more accurately capturing coding information about the clinical services provided.

Changing attitudes and incentives

For Dr. Masoudi, it starts with culture and communication and how organizations view and discuss risk adjustment within the context of clinical care. "You don't have to talk about risk adjustment. You talk about how you address chronic problems. That is much more palatable to physicians," Dr. Masoudi said.

Collaboration and aligned incentives are equally critical. Better coordination on risk adjustment is needed between payers and providers, as well as across the functions of risk adjustment, quality and care management. Greater alignment of incentives can also help providers buy into and support changes in risk adjustment processes.

Incorporating real-time data

Another important practice is incorporating real-time data sources, like continuity of care documents (CCDs) and admission, discharge and transfer (ADT) feeds to support risk adjustment at the time it is documented. "Providers need data in front of them at the time of the encounter," Ms. Purnell said.

Mr. Murtha shared examples of how CCDs and ADT feeds are being used – and the benefits of using these data sources.

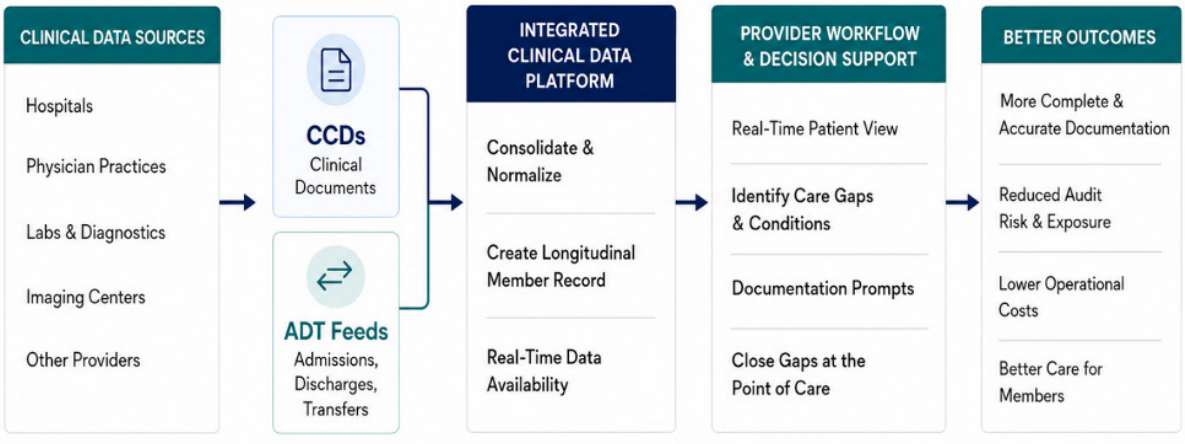
> "CCDs are being used for risk adjustment. They're authenticated, saved and pass an RADV. That gets providers away from chart chase."
>
> – John Murtha, health plan executive at InterSystems

Regarding ADT feeds, Mr. Murtha explained that a plan may work based on an absence of claims. If a plan does not see an expected prescription claim, it may indicate that the member has not filled the medication. An ADT event can provide an earlier signal that allows the care team to investigate and intervene.

"With ADTs, you get a very early signal," he said. The plan can then have care managers call patients, schedule appointments and close care gaps.

Ms. Purnell suggested that organizations start small, test different workflows and gradually build provider engagement. Most importantly, organizations need to start looking at their processes now to avoid long-term impact in the future.

How CCDs and ADT Feeds Enable Earlier Clinical Intervention



CCDs and ADT feeds provide **timely clinical information**, enabling providers to **act earlier, document more completely**, and **reduce retrospective work.**

Practical suggestions for getting started in transitioning to clinical-first risk adjustment

In addition to discussing the challenges with risk adjustment and the benefits of a clinical-first approach, these industry experts offered practical recommendations for making this transition.

- Shift conversations from coding compliance to patient care quality.
- Strengthen provider partnerships through education and aligned incentives.
- Bring clinical and coding teams closer together.
- Introduce CCDs, ADT feeds and point-of-care clinical data into provider workflows.
- Measure reductions in retrospective chart retrieval as prospective workflows mature.
- Get started now. Start small, test different workflows, gradually build provider engagement.

Why waiting increases financial risk

The panelists, from very different organizations, are experiencing similar challenges and arrived at similar conclusions, which include:

- Retrospective-only workflows are becoming increasingly difficult to sustain at the massive scale now required.
- Incremental process improvements alone are unlikely to address today's regulatory environment.
- A proactive, clinical-first approach has clinical, operational and financial advantages.
- Provider engagement is foundational.
- Earlier access to clinical information creates better operational and clinical outcomes.

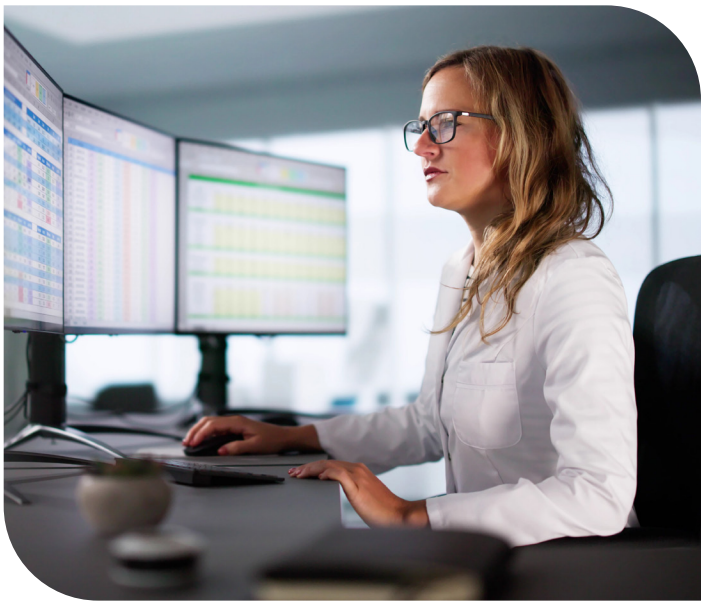
Ultimately, this discussion isn't simply about improving risk adjustment. It raises a broader strategic question: *How can health plans create trusted clinical evidence once and enable it to support multiple operational decisions across the enterprise?*

Organizations that answer that question won't just improve risk adjustment. They'll establish a reusable clinical evidence foundation that supports quality measurement, care management, utilization management, provider collaboration, regulatory compliance, and future AI-enabled workflows. Rather than solving one business problem at a time, they create an enterprise asset that delivers value across the organization.

Lastly, there was consensus that waiting is not an option – and action is needed now. The panelists agreed that organizations that begin this transition now will be better positioned to navigate increasing audit scrutiny while simultaneously building the clinical data foundation required for the next generation of healthcare operations. Waiting is no longer a neutral decision, it delays both financial resilience today and organizational capability for the future.

> "The more that we delay in making these changes, we risk losing millions of dollars in revenue and having enormous RADV exposure. Waiting is not neutral; it is financially punitive. We need to be more proactive and not delay."
>
> – Lisa Purnell, director of risk adjustment, Community Health Choice

Organizations that begin the transition today to a proactive, clinical-first approach will be better positioned to navigate increasing audit scrutiny while supporting higher-quality patient care in a financially beneficial way.



The Four Pillars of Clinical-First Risk Adjustment Success

PILLAR	WHAT LEADING ORGANIZATIONS DO	BUSINESS IMPACT
Providers *Engage. Educate. Empower.*	Educate providers on why risk adjustment matters, align documentation with quality measures and patient outcomes, and reinforce desired behaviors through incentives, feedback, and embedded workflows.	Stronger provider engagement, more complete documentation, improved collaboration, and better clinical outcomes.
Data & Interoperability *Complete. Connected. Current.*	Integrate clinical data from multiple sources (CCDs, ADTs, EHRs), enable interoperability across care settings, and create a longitudinal view of each member to support timely decision-making.	Earlier clinical insight, reduced reliance on retrospective chart chase, improved documentation quality, and a stronger foundation for clinical and operational workflows.
Workflow Intelligence *Intelligent. Embedded. Actionable.*	Deliver AI-assisted decision support within provider workflows, surface EHR-integrated alerts and documentation prompts, and provide real-time documentation and coding support before the encounter closes.	Earlier condition capture, reduced administrative burden, improved coding accuracy, and more efficient clinical workflows.
Enterprise Value *Financial Integrity. Better Care.*	Measure reductions in retrospective chart retrieval while transitioning toward prospective, clinical-first workflows that align risk adjustment, quality, care management, and clinical operations.	Lower audit and extrapolation risk, improved RAF accuracy, stronger financial performance, sustainable growth, and better member outcomes.

Learn more

- **Watch the full webinar.**
- **Schedule a strategy session.** Connect with John Murtha, health plan executive at InterSystems, to discuss how organizations are approaching the transition from retrospective chart chase to a more clinical-first risk adjustment strategy.