Managing the Burden of HCC and HEDIS Reporting: A Lesson in Streamlining

BY OMID B. TOLOUI

Chart audit review is an intensive and expensive process that costs Medicare Advantage (MA) plans millions of dollars each year. Today, innovations and improvements in review processes are streamlining these audits, thereby increasing the value of the data collected and reducing the expenses associated with documentation review.

Extracting large cross-sections of medical records and clinical data between June and November (the traditional “off-season” for both activities) each year helps health plans capture robust data in less time and at lower costs. This facilitates improved hierarchical condition categories (HCC) and Healthcare Effectiveness Data and Information Set (HEDIS) documentation.

Defining the Burden

A few months ago, all MA insurers welcomed new members into their risk pools as the open enrollment period came to an end. Virtually all of these new enrollees entered into their health plan with incomplete medical histories and potential gaps in care.

In some cases, the health plans were able to fill in numerous gaps in care with instantaneous queries of databases maintained by technologically-advanced providers. In other cases, much of the member data remained a mystery for a few more weeks while review nurses visited the members’ primary care physicians and manually extracted cross-sections of paper medical records.

This burden is not exclusive to new health plan subpopulations. Members who have been with a health plan for a year or longer also bring complex histories and the associated risks into the plans—and these health plans do not always possess complete immunization records, cancer screenings, medications, and other key records from which to properly treat these members.

Gaps in HEDIS related measures and hierarchical condition categories (HCC) documentation exist among long-standing health plan members, too. Refining this data helps MA insurers improve their revenue stream, manage their quality improvement strategies, and curtail their overall member risk.

While health plans continuously gather documentation about their members, the efforts ramp up before sweeps dates and prior to HEDIS reporting deadlines. Between the months of February and May, MA plans engage in the traditional HEDIS chart abstraction period to close data gaps, resolve false positives, define risks and gain a more accurate understanding of the care being delivered to member populations.

These audits often require specially trained chart auditors to immerse themselves in examining approximately 80 percent of members’ charts to substantiate the health plan’s progress on the prominent 75 HEDIS measures. Capturing all of that needed documentation for thousands of members is a tall order.

Within this early stage of HEDIS chart review, the data captured can be extremely beneficial to revenue cycle professionals as this information can provide them insight into hybrid rates throughout the year.

However, this early HEDIS extraction process is not where the greatest opportunity for substantial streamlining exists. The large cycle of chart audit reviews,
which begin in June and extend through November, offer more extensive cost-cutting opportunities. The month of June ushers in a focused emphasis on HCC-driven reimbursement reconciliations.

Approximately 65 percent of a health plan’s MA member population’s charts necessitate review to identify gaps in care. Armies of documentation specialists, driven by the revenue cycle management and compliance function of the health plan, often lead this charge. They dive into databases, review scanned documentation, and enter health care facilities in search of data that will complete the reimbursement picture on a member-by-member basis.

During these same months, HEDIS-related reviews are beginning anew for the next round of quality improvement scoring. Driven by quality assurance leaders and medical directors, these deeper chart reviews often scan more sections of member charts compared to HCC reviews.

Unfortunately, because the medical and quality review departments’ goals are different from those of their revenue cycle counterparts, there has traditionally been limited coordination or attempts to capture data together.

### Reducing Redundancy

All too often, when health plan reviewers begin to extract medical records and associated data relevant to HCC-driven reimbursement, they overlook the opportunity to collect critical HEDIS-rate improvement documentation at the same time.

While the data gathering objectives for HEDIS versus HCC documentation are somewhat different, there is no reason why both sets of data requirements cannot be satisfied in many of the same physician office stopovers, visits to centralized record repositories, or within the same electronic queries.

Progressive health plans—and the professional firms that assist them—are now gathering sweeping data sets during these June-November chart reviews. Reviewers scan entire charts where overlap exists between HCC suspect and HEDIS measure gaps.

This only makes sense considering the sheer volume of data that needs to be gathered. Traditionally, as health plans have conducted separate chart review for HEDIS and HCC measures, the burden was multiplied by returning to the same charts in search of additional data—a significant proportion of which was already gathered in an earlier query.

This redundant activity is largely unnecessary, and insurers are recognizing the chance to eliminate many of these expenses. The opportunity to improve upon these strategies from an operational and financial standpoint is explained in detail below.

### No Care Gap, No Reporting Burden?

Fixing gaps in care is the main driver of chart reviews. Not every member chart requires reviewing—and knowing which charts not to pull for reviewing purposes creates a substantial source of savings for health plans.

The predictive technology and artificial intelligence developed with leading health insurers in recent years rules out members who need no intervention. With these measures in place, health plans can save valuable time and money by avoiding examining these members’ charts.

The same technology that identifies members devoid of care gaps also identifies members’ records that are incomplete. Within the average health plan, approximately 65 percent of MA members have one or more HEDIS-related gaps in care, according to records gathered by their health plan.

Within that 65 percent of members, most member records also contain HCC information gaps. Therefore, it makes sense to capture both the HEDIS and HCC documentation at the same time and from the same extraction sessions.

Does this mean the remaining 35 percent of members with no detected HEDIS-related gaps are automatically excluded from any chart review? No, because approximately 60 percent of this group still has HCC-related gaps, this subset represents members whose charts must be reviewed.

Some health plans are taking advantage of robust HEDIS quality data analytics coupled with actionable HCC risk adjustment data and creating analytics engines that precisely identify and group plan members according to their likely gaps in care.

For example, an examination of a 30,000-member health plan reveals that 20,000 members’ HCC risk profiles were incomplete and then flagged for chart review by the analytics engine. However, further analysis reveals that of the other 10,000 members with complete HCC profiles, 6,000 had HEDIS-related care gaps. As a result, those charts would also be scheduled for review.

Through a coordinated effort, streamlined strategies are put into place to efficiently capture data profiles that satisfy both the HCC and HEDIS requirements. The analytics engine directed the reviewers to the right charts, and the vast majority of the HEDIS- and HCC-related data were gathered concurrently during one-time physician office visits.

### Lesson in Logistics

A deeper analysis of the above-mentioned group of 6,000 members with HEDIS-related care gaps reveals that reviewers are already scheduled to visit physician offices for 4,000 of those charts for HCC purposes. Close attention to logistical planning prevents hundreds of re-visits and saves tens of thousands of dollars for the health plan.

### Importance of a Robust Analytics Engine

Current technology allows MA plans to accurately identify members with HEDIS-related gaps in care and potential discrepancies in HCC capture. In addition, refined data analytics engines are sensitive enough to analyze multiple independent factors and to identify small pieces of documentation that serve as hints for underlying gaps in care or undiscovered care conditions.

Technology is not only a boon in our ability to identify care and documentation gaps, but it also accelerates the process of retrieving the requisite documentation. There will always be a need for manual documentation gathering in physicians’ offices and other health care facilities.

However, most health plans have cut costs associated with documentation retrieval for electronic data cap-
Experts have found that it is much easier for electronic medical records to provide broad documentation that satisfies the needs of utilization review, quality assurance, compliance, revenue cycle management and all other aspects that influence HEDIS and HCC reporting within a health plan.

**Medicare Stars Improvement, Too**

Certainly, the work of continually gathering member data is a burden to all health plans. However, there are also benefits for health plans that execute HEDIS and HCC reporting capably. HEDIS measures exist to drive quality improvement, and streamlining reporting activities can bolster that process.

When health plans cut costs associated with data retrieval, they can redirect resources to catalyze more dynamic interventions that drive improved HEDIS results. More efficient chart review allows medical care managers to quickly identify members with care gaps and increases the odds that the interventions will improve HEDIS scores by year’s end.

Improved HEDIS scores boost Medicare Star ratings. Not only do higher Medicare Star ratings result in additional revenue from the Centers for Medicare & Medicaid Services, but they also help health plans grow in size by appearing more attractive to potential new members.

**Peace of Precision**

Health plans that have invested in processes, information systems, and partnerships to enhance the precision of their member data enjoy the security of receiving complete revenue that sufficiently offsets the costs of care to their members. They also benefit from accurate risk profiles, which better anticipate claims expenses over time.

Moreover, accurate HCC reporting reduces the risk of unsatisfactory federal compliance audit outcomes and their tendency to result in costly penalties and tiresome litigation.