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Risk Adjustment in 2027:

What's **Changing** and What to Do **Now**

Subbu Ramalingam & Michael Lesnik
Industry Experts & Leadership Team

VBCExhibitHall.com
Educational Webinar Series

Your Speakers Today

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About Inferscience

Dr. Sunil Nihalani

Founder & Practicing Physician

Clinical Impact: Focused on **improving real-world clinical workflows** and reducing provider burden.

Proven Experience: **10+ years** advancing risk adjustment accuracy across value-based care organizations.

National Reach: Supporting risk and quality programs for **2M+ patient lives nationwide**.

Smart Technology: EHR-embedded AI delivering real-time, **encounter-linked HCC** and quality insights at the point of care.

Core Pillars: Improving **documentation integrity, RAF accuracy**, and audit readiness.

What You Will Walk Away With Today

- **The 2027 Rate Notice:** **Key Changes** and the market **forces driving them**
- **CY 2027 Final Rule:** **Strategic implications** for your risk adjustment model
- **Documentation Tightening:** Why retrospective strategies are **losing ground**
- **HCC Coding Strategies:** Navigating the **four paths to risk management** in 2027
- **"Getting It Right":** Lessons from **10 years** and **2M+ lives**

What the 2027 CMS Rate Notice Actually Means

NET RATE INCREASE

+2.48%

Advance notice proposed +0.09% - entire swing drive by CMS retaining 2024 risk adjustment model

DOLLAR IMPACT

$13B+

Above 2026 Levels

EFFECTIVE GROWTH RATE

5.33%

Revised upward from 4.97% driven by the inclusion of Original Medicare program experience data through Q4 2025

CODING PATTERN ADJUSTMENT

5.9%

Held at statutory minimum, sustained downward pressure on effective risk scores continues

STRATEGIC IMPLICATIONS

The favorable rate reflects a model decision, not a shift in CMS's direction on risk adjustment oversight. The coding adjustment signals that pressure on coding accuracy continues regardless of the rate outcome. **CMS was explicit that future model updates remain on the agenda.** Organizations should use this window to strengthen encounter-based documentation practices.

Unlinked Chart Review Exclusion

Effective CY 2027, diagnoses from chart review records not tied to a specific encounter will not count for risk adjustment.

Major Impact

This accounts for the single largest driver of the proposed 1.78% risk score reduction.

Revenue Risk

Retrospective chart reviews not linked to encounters place your revenue at risk.

The Exception

Unlinked chart reviews still count for MA-to-MA switches, but not for new Original Medicare enrollees.

CMS Visibility

CMS now sees the gap between coded data and encounter-linked records via expanded access.

POLL: Chart Review

Which of the following encounter-based strategies is your organization currently prioritizing to address unlinked chart review risk?

A. Pre-visit coder workflow

B. Point-of-care EMR alerts

C. Post-visit / concurrent coding review

D. We are not yet prioritizing any of these

The RADV and Audit Environment

RADV Enforcement Is Expanding

CMS and OIG are signaling zero tolerance for unsupported diagnoses. The audit environment is getting materially more aggressive.

Scope & Frequency

RADV audits are expanding in both scope and frequency across the industry.

Evidence Standard

The bar is rising: diagnoses require clear clinical evidence, not just code presence.

Data Access

CMS has expanded encounter data access, increasing visibility into documentation gaps.

Proactive Action

Identify gaps with precision analytics and fix them before the audit window closes.

Stars Changes: Why This Matters for Clinician Burden

Fewer Measures, Higher Stakes on Clinical Outcomes

11

Measures removed
(2028–2029 Stars)

1

New behavioral measure
(Depression Screening)

$18.56B

Trust Fund impact
(Stars, 2027–2036)

- **11 measures removed:** mostly operational compliance metrics where 94–97% of plans scored identically
- Removal **amplifies the weight** of clinical and experience measures
- Clinical measures now carry **more mathematical weight per measure** than at any prior point in Stars history
- **More clinical weight = more clinician burden**. Point-of-care tools are **how you reduce it**

POLL: 2027

What is your organization doing to prepare for the 2027 year of risk adjustment?

A. Adding technology

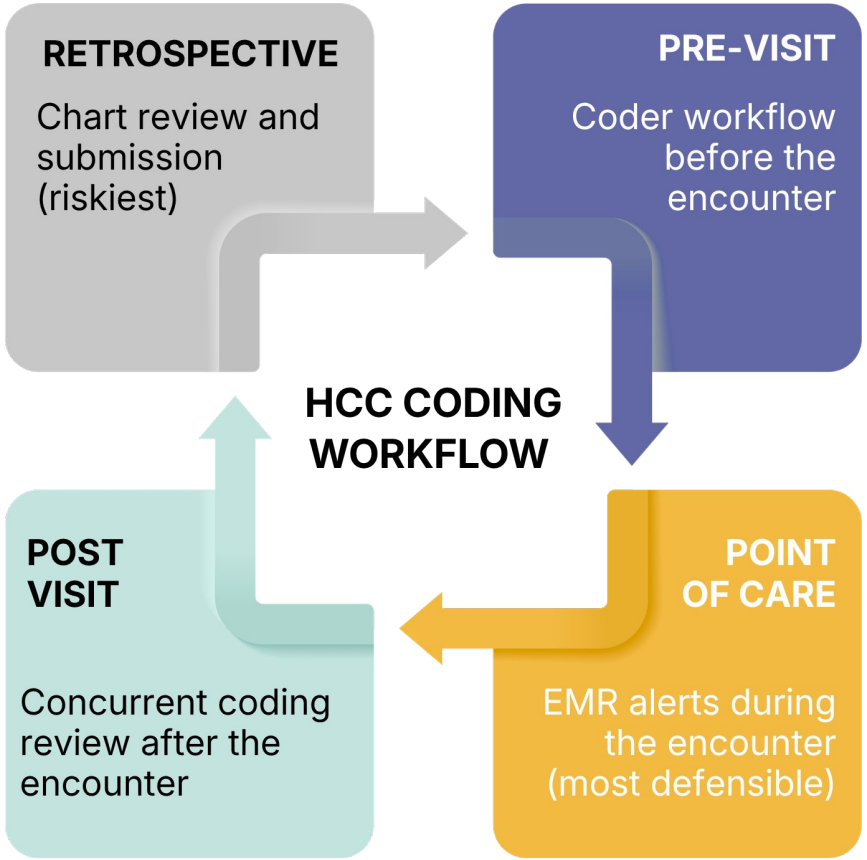
B. Adding coders / CDI personnel

C. Ramping up provider education

D. The same thing we did in 2026

E. Something Else

The Four HCC Coding Strategies



Strategy 1: Pre-Visit Coder Workflow

1

TRIGGER

Patient appointment scheduled

A visit is booked in the EHR, the signal that starts the pre-visit workflow automatically

2

AUTOMATED

Technology runs automated chart review

AI scans the patient's full clinical history (diagnoses, labs, meds, notes) for HCC documentation opportunities.

3

AI OUTPUT

HCC suspects surfaced

Conditions flagged and ranked by clinical evidence, recapture priority, and risk score impact.

4

HUMAN REVIEW

Coder reviews and filters

Clinical coder removes anything not appropriate. Human judgment stays in the loop before the provider sees anything.

5

DELIVERY

Curated suspect list delivered to provider

A clean, prioritized list lands in the provider's EHR before the patient walks in, ready to address at the point of care.

Encounter-linked. Defensible.

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Strategy 1: Pre-Visit Coder Workflow

The Opportunity: Strategic Impact

The pre-visit window is where technology has the biggest impact. Automation surfaces HCC suspects, which are then human-validated to provide the clinician with a curated, accurate list.

What to Get Right

- **Human Quality Gate:**
  Technology does the heavy lift, but the coder ensures every suspect is clinically defensible.
- **Curated Focus:**
  A coder may filter three suspects down to two; the goal is accuracy over volume.
- **Actionable Data:**
  The provider receives the right information for the encounter, not an overwhelming data dump.

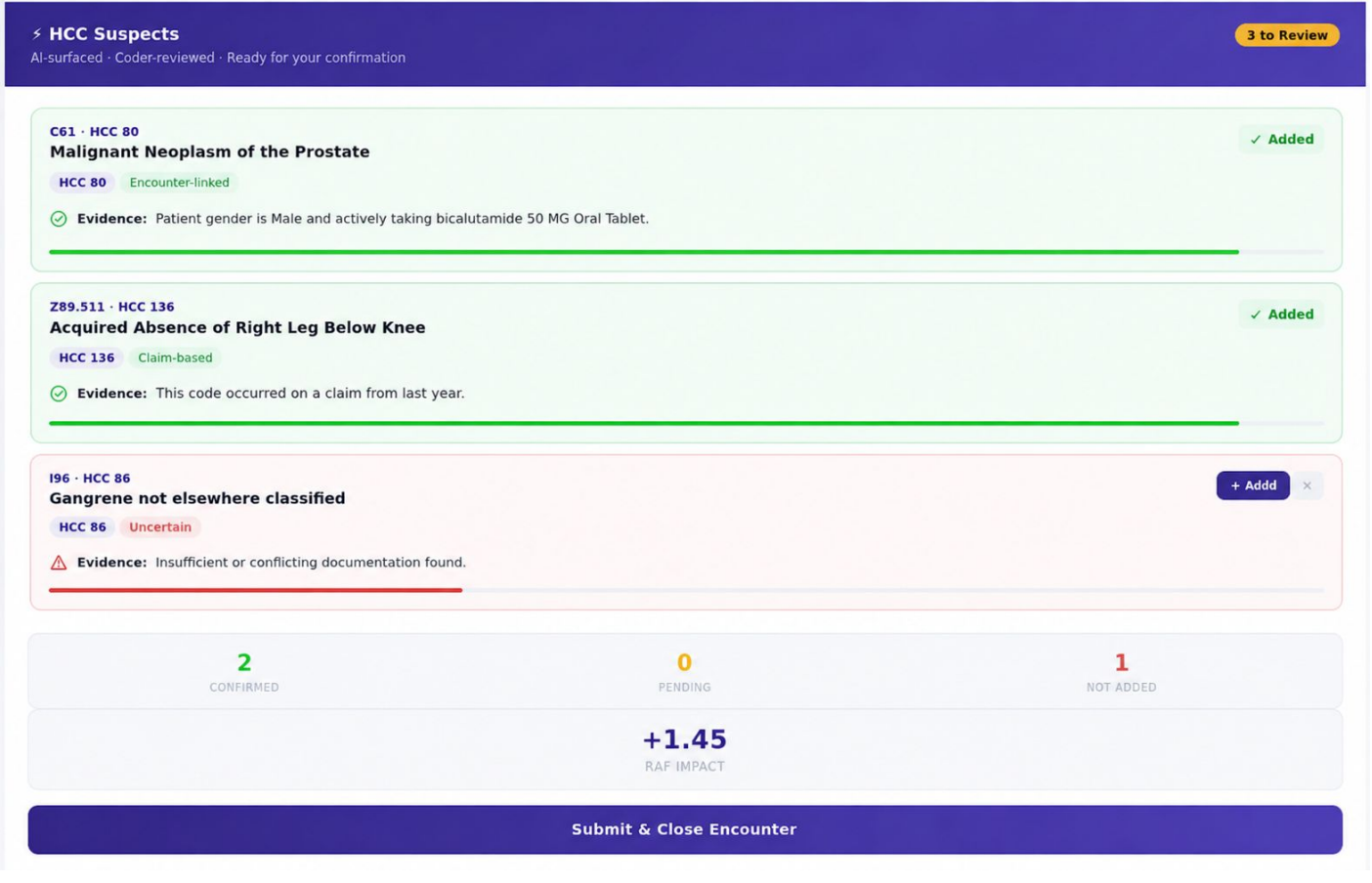
Mitigating Unlinked Review Risk

The Direct Path:
Addressing pre-surfaced suspects during the visit ensures documentation is encounter-linked by definition.

Audit Defense Strategy:

This workflow proactively moves away from the risks associated with unlinked retrospective submissions.

Strategy 2: Point of Care EMR Alerts



Strategy 2: Point of Care EMR Alerts

The Opportunity: Real-Time Action

EMR alerts surface curated suspects during the encounter, allowing for documentation and coding at the moment of care—the gold standard for defensibility.

What to Get Right

- **Actionable, Not Noisy:** Avoid "alert fatigue" by ensuring alerts are high-value and non-repetitive.
- **Curated Lists:** Display only pre-visit validated suspects, not a raw data dump.
- **Clinical Support:** Documentation must reflect active treatment, monitoring, or assessment.
- **Data Alignment:** Encounter and coding dates must tie up perfectly for RADV.

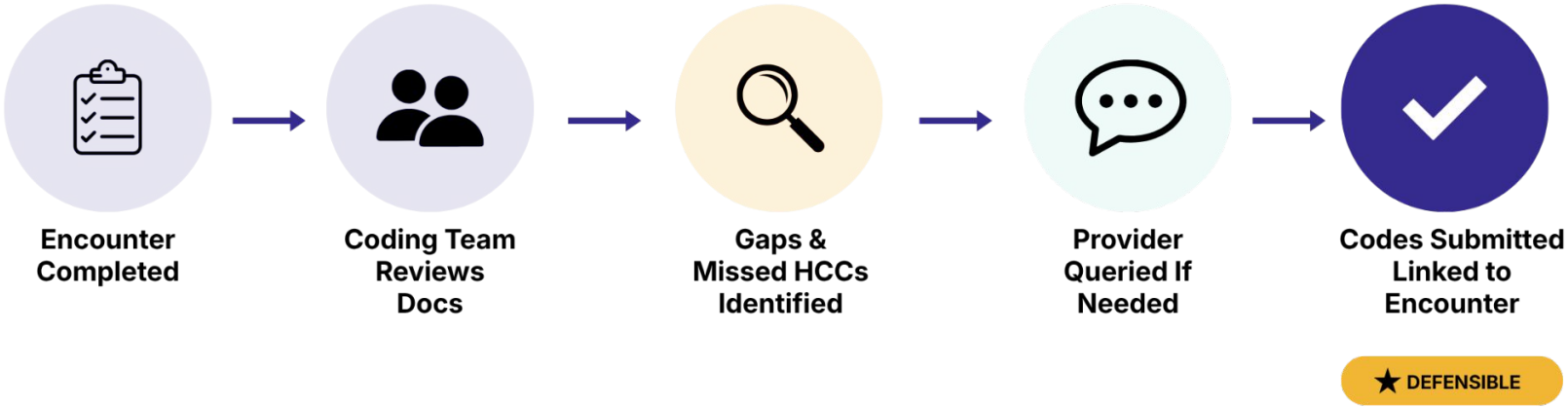
Mitigating Unlinked Review Risk

The Gold Standard: Conditions coded during a face-to-face encounter are encounter-linked by definition.

Defensibility Advantage:

This workflow creates contemporaneous evidence that withstands RADV audits better than any retrospective method.

Strategy 3: Post-Visit/Concurrent Coding Review



Strategy 3: Post-Visit/Concurrent Coding Review

The Opportunity: The Safety Net

Post-visit review catches what fell through — while the encounter is still fresh and linkable, ensuring no conditions are missed even with strong pre-visit workflows.

What to Get Right

- **Real-time Review:** Must happen near-real-time, not months later.
- **Gap Analysis:** Identify where diagnoses fall off (providers or EDI processes).
- **Process Remediation:** Develop new processes to prevent recurrence in real-time.
- **Second-Level Review:** Implement robust checks across all vendor/internal processes.

Mitigating Unlinked Review Risk

The Defensible Standard: As long as review is tied to a specific encounter and resolved while documentation is current, it remains **RADV-defensible**.

The Danger Zone:

Avoid "retrospective" review conducted months later, disconnected from the original encounter.

POLL: Post-Visit

When your coding team conducts post-visit review, how quickly does it typically happen after the encounter closes?

A. Within 24–48 hours

B. Within the same week

C. Within the same month

D. It varies — sometimes months later

What “Getting It Right” Actually Looks Like

It Takes All Three Steps: Getting it right means using all three strategies together. Everything must be linked to an encounter.

Patterns: 10 Years & 2M+ Lives

- Single-strategy reliance leads to underperformance in risk score accuracy.
- High performance requires a coordinated pre-visit, point of care, and post-visit pipeline.
- Defensible documentation is the ultimate output for RADV audit readiness.

Defensible Practice in Action

- Document active treatment, monitoring, or clinical management in the current year.
- Ensure encounter data and coding date line up cleanly.
- Maintain a chain of custody from suspect identification to provider submission, supported by MEAT documentation

Integrated Action Roadmap

Now: Before June 1

- Audit unlinked chart review usage and risk-eligible diagnosis percentages
- Model revenue impact for CY2027
- Coordinate with your payer(s) on RADV audit support to protect resources from unlinked chart reviews

Q3 2026

- Begin encounter-based HCC documentation training
- Validate documentation and identify coding gaps
- Implement second-level coding review processes

Q4 2026 / AEP

- Build 30-day care coordination workflows
- Develop targeted risk and quality plans for new members
- Finalize operational budgets for 2027–2028

2027 and Beyond

- Monitor CMS model rulemaking for future shifts
- Establish permanent encounter-based infrastructure
- Sustain consistency to maximize Stars Historical Reward

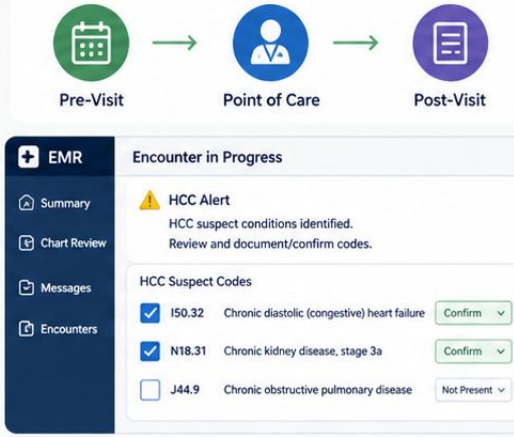
Three Things to Prioritize Now

1 Quantify your unlinked CRR exposure.

Risk-Eligible Diagnoses

Unlinked Diagnoses by Category

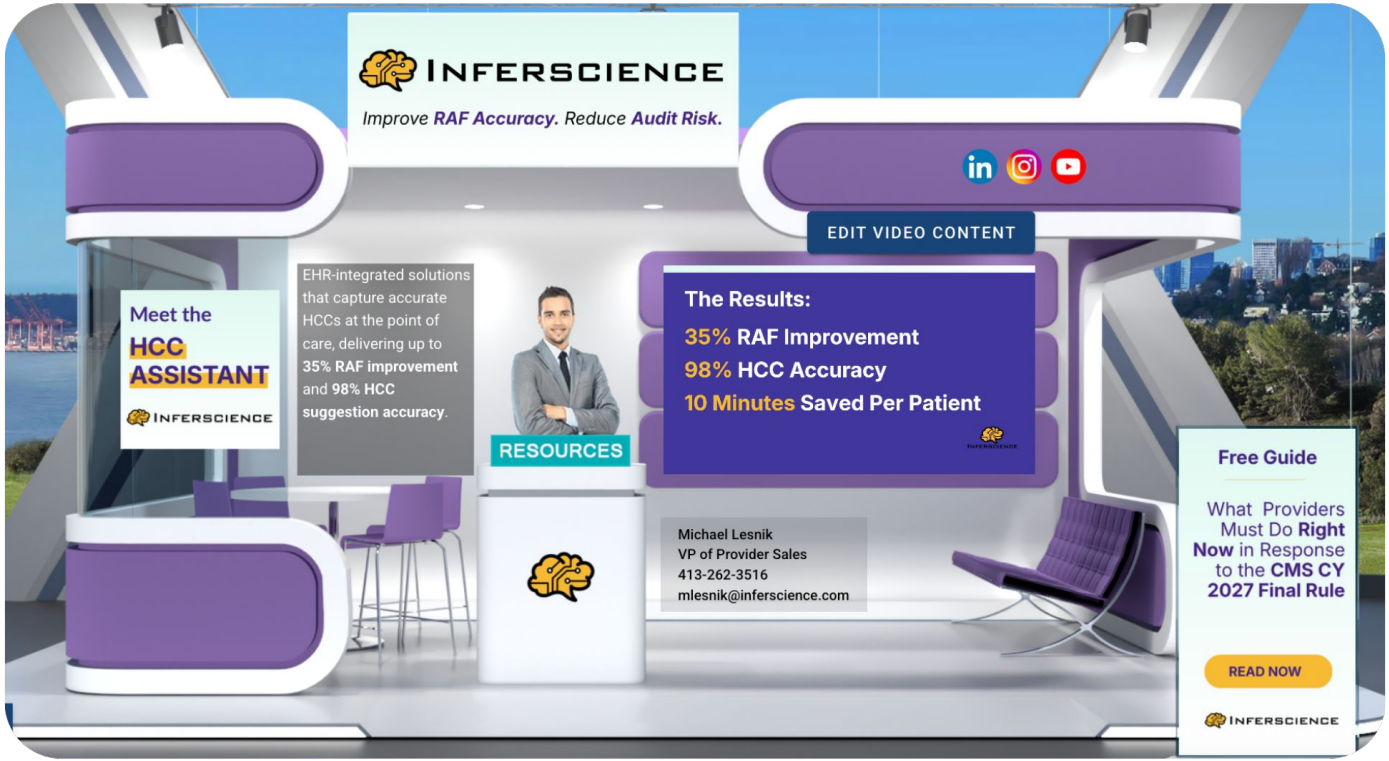
2 Build prospective workflows — don't just plan them.



3 Treat every chart as if it will be audited.

Q&A

Stop By Our VBC Exhibit Hall Booth



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