



Outsized Impact of Risk Adjustment on MSSP and REACH ACOs



March 24, 2022 3:00 pm

Agenda.....



1. Housekeeping Items
2. Presenter Introductions
3. Presentation Overview
4. Audience Q&A and follow-up

Housekeeping.....

1. Speakers will present for around 45 minutes
2. Q&A will take the remainder of the time
 - You can submit written questions using the Questions tab on your dashboard to the right of your screen at any time during the webinar
 - During the Q&A session, you can use the “raise hand” feature on your dashboard to ask a live question.
3. Webinar is being recorded
 - Slides and recording will be available on the NAACOS website within the next few days.

Speakers



Andrew Webster, actuarial advisor to National Association of ACOs
Andrew Webster MS, ASA, MAAA, is co-founder and lead actuary at Validate Health, the industry's only financial forecasting and optimization platform built exclusively for ACOs. He specializes in payer contract modeling (including MSSP, Next Gen, Medicare Advantage and commercial), forecasting shared savings under different decision scenarios and risk hedging strategies to lock in expected outcomes. He also serves in a consulting role for NAACOS, quantifying the financial impact of policy changes and designing methodologies for analyzing nationwide datasets. He can be reached at andrew.webster@validatehealth.com.



Jeffrey Cumplido, MD, MPH,
Dr. Cumplido graduated from Tufts University's MD/MPH program. He completed his residency in the General Internal Medicine Program and was Chief Resident at Warrant Alpert School of Medicine at Brown University. He is currently an Associate Medical Director at Coastal Medical and supports Coastal's RAF Audit Program.

Presentation Overview

Outsized Impact of Risk Adjustment on MSSP and REACH ACOs

- I. Overview of CMS-HCC Risk Scoring
- II. Application to ACO Benchmarking
- III. HCC Accuracy Improvement
- IV. Case Study: Coastal Medical
- V. Q & A



Overview of CMS-HCC Risk Scoring

HCC risk scoring



- HCCs group chronic and acute conditions for calculating the risk score of a patient
 - RAF = **R**isk **A**djustment **F**actor
 - Normalized to 1.0 average chronic illness burden nationwide
 - Reset annually for every condition
- HCC model types
 - Concurrent model for GPDC/REACH High Needs Population otherwise prospective
 - Model versions/Clinical revision
 - MSSP model version can be different between performance and benchmark years
 - Major clinical revision of the ESRD model is expected for PY 2023

HCC = Hierarchical Condition Categories

HCCs have origins in MA Program

Based on ICD-10 diagnoses: Risk Adjustment | CMS

- **Not all claims trigger an HCC (e.g. audio-only telehealth visits)**

HCC Risk Adjustment Factor (RAF) Calculation Example



Risk marker	Incremental prediction	Relative risk factor
Female, age 75–79	\$3,409	0.457
Acute myocardial infarction (HCC 81)	\$2,681	0.359
Angina pectoris (HCC 83) ¹	\$0	—
Chronic obstructive pulmonary disease (HCC 108)	\$2,975	0.399
Renal failure (HCC 131)	\$2,745	0.368
Chest pain (HCC 166) ²	\$0	—
Ankle sprain (HCC 162) ²	\$0	—
Total	\$11,810	1.583

HCC Application to ACO Benchmarking

High-level risk adjustment steps

- Normalization/Renormalization
 - Ensures that a given year has an average risk score of 1.0
 - Sets a baseline moving target for maintaining risk scores
- Capping
 - Ensures that a specific ACO/DCE doesn't have outlier risk growth
 - Sets a minimal goal for coding accuracy improvement during the performance year
- Coding intensity factor (CIF)
 - Ensures that the overall change in risk score is budget neutral to CMS
 - Adds additional market pressure for maintaining risk scores

Comparison of application steps across models

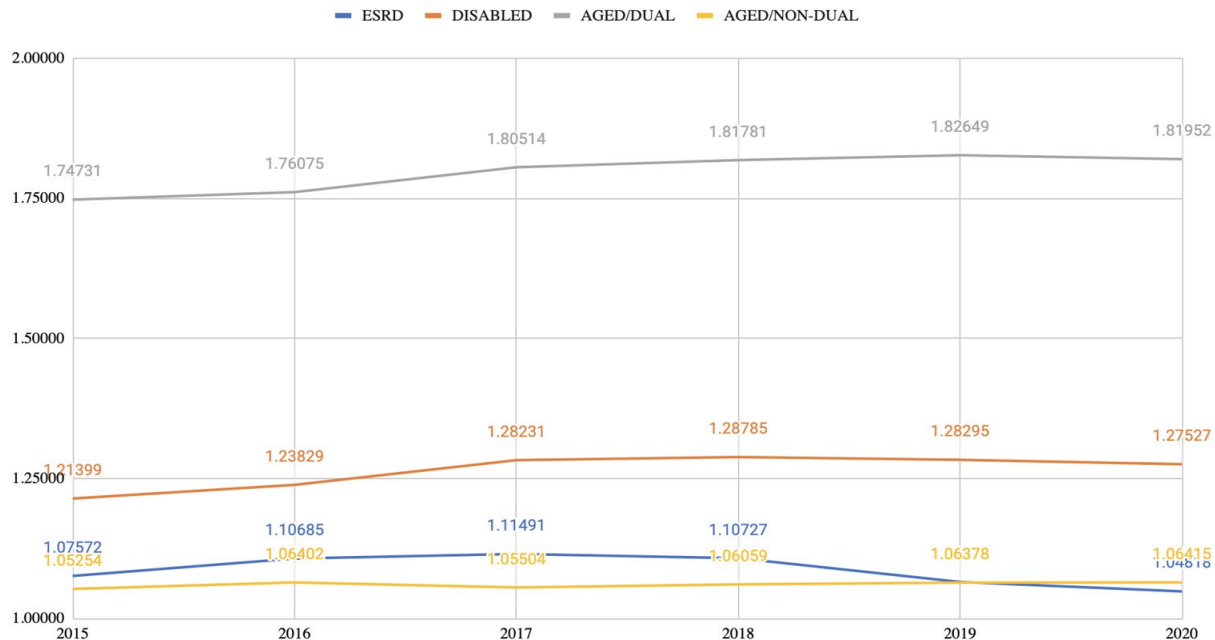


Step	GPDC/REACH	Example	MSSP	Example
1) Normalization/ Renormalization	<ul style="list-style-type: none"> - Raw risk scores are normalized to the all alignable population - Prospective normalization with retrospective reconciliation - Based on all DC alignment eligible beneficiaries 	Raw score: 1.12 Normalization factor: 1.1 Normalized Risk Score = $1.12 / 1.1 = 1.018$	Normalization factors are determined annually on a retrospective basis	Raw score: 1.12 Renormalization factor: 1.06 Renormalized Risk Score = $1.12 / 1.06 = 1.057$
2) Capping	<ul style="list-style-type: none"> - Symmetric +/- 3% risk growth (ratio) caps are calculated and applied to claims-aligned beneficiaries only. Risk growth caps are demographic-adjusted for REACH. - Relative to a rolling reference year in GPDC and static reference year in REACH - Applied after final normalization 	Score 2021: 1.018 Score 2023: 1.050 Capped score = $1.018 \times 1.03 = 1.048$	<ul style="list-style-type: none"> - 3% risk growth ceiling applied to all assigned beneficiaries - Static BY3 reference year 	Score 2018: 1.018 Score 2024: 1.050 Capped score = $1.018 \times 1.03 = 1.048$
3) Coding Intensity Factor (CIF)	<ul style="list-style-type: none"> - Calculated on and applied to claims-aligned beneficiaries only - At the national level by A/D and ESRD - After capping; Retrospectively determined - Divided by risk score growth of PY vs 2019 reference year 	Score 2023: 1.06 Score 2019: 1.0 CIF = $1.0 / 1.06 = 0.943$ Score = $1.06 \times 0.943 = 0.999$	Not applied	N/A

Normalization/Renormalization



- Ensures that the national assignable/alignable population risk score is 1.0 in each year
- Generally increasing (except for 2020)
- Continuous coding accuracy improvement is needed to keep pace with national change in risk score



Capping



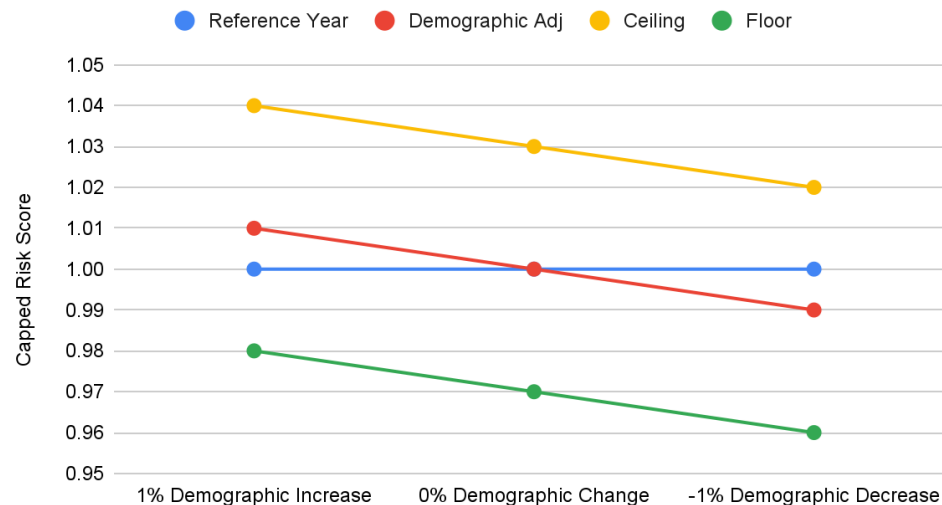
- % of MSSP ACOs capped by years from the reference year
- At least one enrollment type is capped more often than not
- Percentage of ACOs capped increases as number of years from the reference year increases

Years from Reference Year	Number ACOs	Count Any Enrollment Type Capped	% Any Enrollment Type Capped	Count Aged Dual Capped	% Aged Dual Capped	Count Aged non-dual capped	% Aged non-dual capped	Count Disabled Capped	% Disabled Capped	Count ESRD Capped	% ESRD Capped
1	772	521	67%	264	34%	95	12%	203	26%	212	27%
2	711	496	70%	270	38%	136	19%	203	29%	181	25%
3	551	422	77%	231	42%	159	29%	182	33%	133	24%

Demographic-adjusted cap (REACH-only)

- +/- 3% Symmetric cap shifts by change in demographic-only risk score
- Examples
 - Higher mix of age-ins in PY => Caps shift downward 1% based on age
 - Hired new geriatricians in PY => Caps shift upward 1% based on age

Reference Year, Ceiling and Floor



Coding Intensity Factor (CIF): Empirical Estimation



- Simulation of CIF after capping
- A/D CIF of **+0.05% (PY1) to -0.57% (PY3) change to benchmark**
- CIF reference year is fixed to 2019 whereas the cap reference year is rebased annually (except for PY1)

Enrollment Type	2016*	2017	% change vs BY3	CIF PY1	2018	% change vs BY3	CIF PY2	2019	% change vs BY3	CIF PY3
Non-ESRD (A/D)	1.029	1.028	99.95%	100.05%	1.030	100.19%	99.81%	1.034	100.57%	99.43%
ESRD	1.019	1.022	100.23%	99.77%	1.022	100.23%	99.77%	1.017	99.76%	100.24%

Source: Validate Health, Oct 2020

For the 205 MSSP ACOs in 2019-A PY having 2018 BY3

* This analysis does not remove risk scores for voluntarily aligned beneficiaries

** Assigned beneficiaries was used as an approximation to person years

*** BY1 and BY2 used BY3 assignment since assignment for BY1 and BY2 was not available

Timing of change in risk score matters



- Year in which the risk score is changed impacts multiple performance years
- PY 1-2 only positively impacts, PY 3-5 can positively or negatively impact
- Actual impact depends strongly on ACO-specific risk score, regional efficiency and shared savings performance

	Agreement period 1 performance year					Agreement period 2 performance year					
Year in which risk score changed	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	Overall
2020 (PY1)	+										+
2021 (PY2)		+									+
2022 (PY3)			+			-	-	-	-	-	+/-
2023 (PY4)				+		-	-	-	-	-	+/-
2024 (PY5)					+	+/-	+/-	+/-	+/-	+/-	+/-

Advocacy issues around risk adjustment



- Rural glitch
 - Including the ACO in the region
 - Artificially capping the ACO risk score but not the regional risk score
- Model version skew
 - A consistent CMS-HCC model isn't necessarily used in benchmark and performance years introducing shared savings estimation error
- Measuring HCC coding accuracy
 - Identifying accurate vs inappropriate HCC coding
 - Recommendations on CMS audit procedures

See [2022 Physician Fee schedule](#) for more information

HCC Accuracy Improvement

Disclaimer



The authors support fair and accurate ICD-10 medical coding based supporting physician documentation. The acts of coding diagnoses that are not fully supported or artificially increasing the coded severity of a given diagnosis without clinical evidence i.e. “up-coding” are highly discouraged. These acts are fraudulent and have associated financial penalties and reputational risks that outweigh any short-term financial gains for your ACO/DCE.

HCC accuracy terminology



Lookback period

- The prior years used to identify previously coded HCCs

Open HCC gap

- An HCC that was captured in the lookback period but not the current coding year

Dismissed HCC

- A dismissed condition is an HCC that was recorded in the lookback period but is no longer clinically appropriate

Closed HCC gap

- Face-to-face visit with the patient during the current coding year and appropriately recorded the HCC or if it should be dismissed

New HCC

- An HCC that was recorded in the current year but not in the lookback period

Missed Opportunity

- A missed opportunity is when a physician had an appointment with a patient with an HCC gap and didn't close the gap

HCC accuracy terminology (Ctd.)



Chronic vs. Acute

- 2021 CMS-HCC prevalence
 - Average **chronic** prevalence of 10,966 per 10,000 MSSP assigned benes
 - Average **acute** prevalence of 9,210 per 10,000 MSSP assigned benes
- 2021 average weight
 - Average **chronic** weight per HCC is 0.306
 - Average **acute** weight per HCC is 0.343

Top Acute

HCC	HCC Name	Freq per 10k	Lift
HCC108	Vascular Disease	1,520	438
HCC96	Specified Heart Arrhythmias	1,586	425
HCC8	Metastatic Cancer and Acute Leukemia	102	272
HCC135	Acute Renal Failure	403	175
HCC9	Lung and Other Severe Cancers	118	121

Top Chronic

HCC	HCC Name	Freq per 10k	Lift
HCC18	Diabetes with Chronic Complications	1,796.4	542.5
HCC111	Chronic Obstructive Pulmonary Disease	1,233.9	413.4
HCC85	Congestive Heart Failure	1,210.4	400.6
HCC40	Rheumatoid Arthritis and Inflammatory	773.6	325.7
HCC59	Major Depressive, Bipolar, and Paranoid	983.8	304.0

Methods for accuracy improvement



- Prioritization of HCC Gap closure based on:
 - Gap Closure Likelihood
 - Chronic vs acute
 - Beneficiaries with Greatest Lift
 - HCC lift in risk score (**Frequency x Weight**)
- Improving documentation at provider/TIN level
 - Focus on both primary and specialists
 - Provider incentive programs
- Chart Review/Audit
 - Updating codes that might be unspecified
 - Focus on accuracy and discouragement of upcoding
- Opportunity for care management
 - Encourage patients to meet with physician
 - Improve access to preventative care/AWVs

NOTE:

Providers must have face-to-face visits with patients to close HCC gaps. This is important because some patients might not have come in for a visit recently.

- This was especially the case during COVID - patients postponed care
- This is an opportunity for care management

Poll Question - T/F

HCC accuracy improvement should only be focused on in the last half of the year

HCC Gap Prioritization

Likelihood



MBI	
Bene Name	
Date of Birth	
Sex	
Last Visit	
Last AWV	
PCP TIN	
PCP TIN Name	
PCP NPI	
PCP NPI Name	
Priority 1 HCC	<p>HCC Group: Rheumatoid Arthritis and Inflammatory Connective Tissue Disease Past Coded HCC Number, Name, Weight: hcc40 - Rheumatoid Arthritis and Inflammatory Connective Tissue Disease - 0.421 Current Coded HCC Number, Name, Weight: None - None - 0 Most Recently Coded DX: M3500 - Sicca syndrome, unspecified Most Recently Coded Visit Info: TIN: NPI: Claim Date: CPT: 99203 Setting: Professional Related Part D Drugs: - CICLOSPORIN Related Part B: None</p>
Priority 2 HCC	<p>HCC Group: Acute Renal Failure Chronic Kidney Disease, Moderate (Stage 3) Chronic Kidney Disease, Severe (Stage 4) Chronic Kidney Disease, Stage 5 Dialysis Status Past Coded HCC Number, Name, Weight: hcc138 - Chronic Kidney Disease, Moderate (Stage 3) - 0.069 Current Coded HCC Number, Name, Weight: None - None - 0 Most Recently Coded DX: N183 - Chronic kidney disease, stage 3 (moderate) Most Recently Coded Visit Info: TIN: NPI: Claim Date: CPT: 99214 Setting: Professional Related Part D Drugs: None Related Part B: None</p>

Very High

- Chronic condition
- Coded last year
- Have Part D or Part B services in the coding year associated with the condition

High

- Chronic condition
- Coded last year

Medium

- Chronic condition
- Coded 2 years ago

Poll Question - T/F

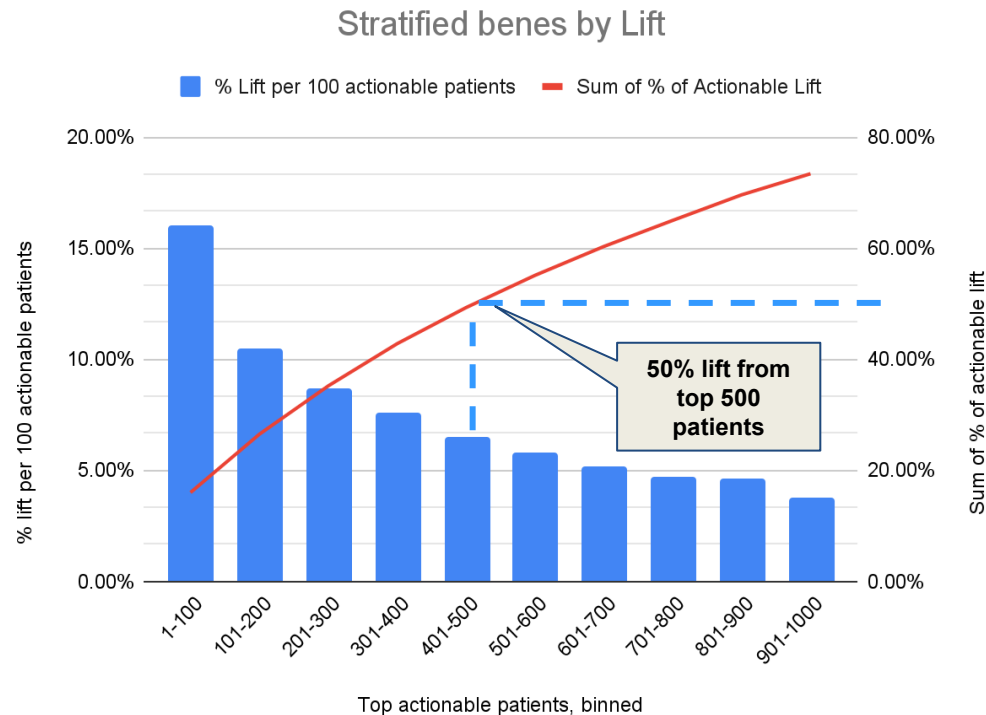
All HCC gaps need to be closed annually for HCC coding accuracy to yield a benefit

Beneficiary Prioritization

Diminishing Returns



- **Stratifies** benes by cohorts of 100
- Illustrates need to focus on highest impact benes, due to **diminishing returns**
- Opportunity: Closing gaps on **500 patients** yields...
- e.g. **4.7% per year or \$22M over 5-year** increase to benchmark, applied across all years of the next agreement period – Not limited to 3% improvement
- Reminder of the 3% limit, by focusing on a few actionable you can get there more quickly



Condition Prioritization

Top HCCs to focus on



It's possible to hit the **3% cap** for next PY by prioritizing which HCCs to focus on

Example quantifying top 5 Most impactful Chronic HCC codes

- Only Chronic HCCs codes are taken into account
- The top 5 conditions make up over **60%** of the **lift**

HCC Code	HCC Name	# of HCC gaps	Cum. % of HCC RAF	Risk score lift	PY Risk score	PY Risk ratio	PY Bench PBPY	Increase Bench PBPY	Increase Bench Agg
hcc58	Major Depressive, Bipolar, and Paranoid Disorders	363	18%	0.0120	1.054	101.1%	\$9,595	\$109	\$1,318,664
hcc18	Diabetes with Chronic Complications	289	32%	0.0106	1.065	102.2%	\$9,692	\$206	\$2,489,400
hcc85	Congestive Heart Failure	214	42%	0.0079	1.072	102.9%	\$9,764	\$278	\$3,356,313
hcc111	Chronic Obstructive Pulmonary Disease	210	52%	0.0073	1.080	103.6%	\$9,771	\$285	\$3,441,141
hcc40	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	194	62%	0.0073	1.087	104.3%	\$9,771	\$285	\$3,441,141

Provider prioritization



1) Identify outliers in risk ratio

	2020						
TIN ID	BY Risk Score	PY Risk Score	Risk Ratio	Updated Benchmark PBPY	Shared Savings PBPY	Shared Savings Total	
TIN-1	0.97	0.86	0.889	\$7,253	-\$2,361	-\$3,438,126	
TIN-2	1.00	1.01	1.009	\$12,242	-\$2,789	-\$6,755,343	
TIN-3	0.98	1.00	1.018	\$11,427	-\$2,455	-\$4,114,673	
TIN-4	0.96	0.92	0.953	\$8,109	\$105	\$158,219	
TIN-5	0.97	0.99	1.016	\$10,167	\$1,620	\$716,147	
TIN-6	0.97	0.98	1.008	\$11,084	\$1,812	\$21,594,759	
All TINs						\$8,160,983	

*Only aged non-dual enrollment type shown for brevity

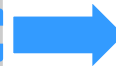
Provider prioritization



2) Observe open HCC gaps driving risk ratios

It may be more actionable to drill down to NPI level

	2020				
TIN ID	HCC Gaps Open Count	HCC Gaps Open Ratio	HCC Gaps Closed Count	HCC Gaps Closed Ratio	HCC Gaps Beneficiary Count
TIN-1	247	43%	327	37%	874
TIN-2	221	30%	506	70%	727
TIN-3	140	28%	363	72%	503
TIN-4	146	32%	306	68%	452
TIN-5	42	32%	91	68%	133
TIN-6	1,161	32%	2,415	68%	3,576
All TINs	2,257		4,008		6,265



HCC Gaps for Providers under TIN1			
Provider Name	Gaps Open Ratio	Gaps Closed Ratio	Beneficiary Count
NPI1	18%	82%	88
NPI2	19%	81%	77
NPI3	34%	66%	39
NPI4	15%	85%	64
NPI5	38%	62%	9
NPI6	50%	50%	83
NPI7	10%	90%	109

*Only aged non-dual enrollment type shown for brevity

Provider prioritization



3) Calculate financial impact of better accuracy

TIN ID	BY Risk Score	PY Risk Score	Risk Ratio	Updated Benchmark PBPY	Shared Savings PBPY	Shared Savings Total
TIN-1	0.97	0.86	1.000	\$8,163	-\$1,451	-\$2,113,308
TIN-2	1.00	1.01	1.009	\$12,242	-\$2,789	-\$6,755,343
TIN-3	0.98	1.00	1.018	\$11,427	-\$2,455	-\$4,114,673
TIN-4	0.96	0.92	0.953	\$8,109	\$105	\$158,219
TIN-5	0.97	0.99	1.016	\$10,167	\$1,620	\$716,147
TIN-6	0.97	0.98	1.008	\$11,084	\$1,812	\$21,594,759
All TINs						\$9,485,801

\$1.3M improvement in savings

*Only aged non-dual enrollment type shown for brevity

Poll Question - T/F

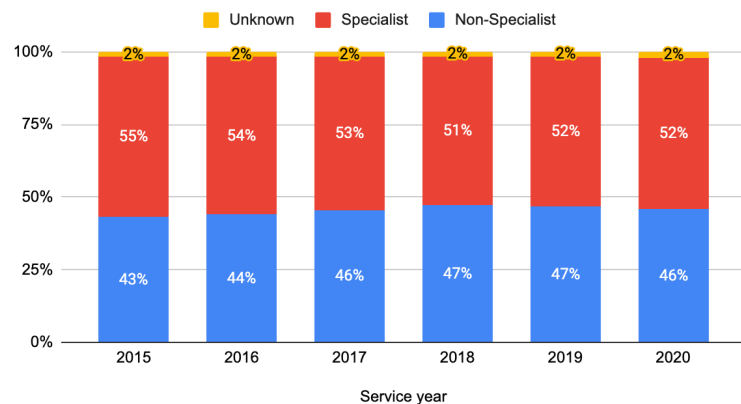
Primary care providers are mainly responsible for HCC documentation and coding

Engage specialists in HCC accuracy improvement efforts



Over **50%** of HCC risk adjustment factor (RAF) is captured by specialists
 Certain HCCs are specialist “heavy”(coded **>60%** of the time by a specialist)

HCC Weight by Specialist Designation by Year



HCC Code	HCC Description	Specialist	Specialist (%)
HCC124	Exudative Macular Degeneration		99%
HCC122	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage		90%
HCC055	Substance Use Disorder, Moderate/Severe, or Substance Use with Complications		88%
HCC083	Respiratory Arrest		86%
HCC012	Breast, Prostate, and Other Cancers and Tumors		69%
HCC106	Atherosclerosis of the Extremities with Ulceration or Gangrene		69%
HCC186	Major Organ Transplant or Replacement Status		67%
HCC110	Cystic Fibrosis		67%
HCC008	Metastatic Cancer and Acute Leukemia		67%
HCC136	Chronic Kidney Disease, Stage 5		66%
HCC176	Complications of Specified Implanted Device or Graft		66%
HCC011	Colorectal, Bladder, and Other Cancers		65%
HCC167	Major Head Injury		65%
HCC134	Dialysis Status		65%
HCC010	Lymphoma and Other Cancers		64%
HCC099	Cerebral Hemorrhage		64%
HCC009	Lung and Other Severe Cancers		63%
HCC023	Other Significant Endocrine and Metabolic Disorders		62%
HCC072	Spinal Cord Disorders/Injuries		61%
HCC006	Opportunistic Infections		61%

Case Study: Coastal Medical



Jeffrey Cumplido, MD, MPH, graduated from Tufts University's MD/MPH program. He completed his residency in the General Internal Medicine Program and was Chief Resident at Warren Alpert School of Medicine at Brown University. He is currently an Associate Medical Director at Coastal Medical and supports Coastal's RAF Audit Program.

Coastal Medical – Providence, RI

- Primary care centric ACO
 - 13 Adult/Family Medicine Practices
 - 4 Pediatric Practices
 - 3 Specialty Practices (2 Cardiology, 1 Pulmonology)
 - Urgent Care

- 120,000 attributed patients

Previously physician-owned, now an affiliate of the Lifespan Health System in Rhode Island

Risk Adjustment Program Overview

- Centralized, cross-payer program
 - 9 Risk Adjustment trained coders
- Clinician-centric
- Pre-visit chart audits for point of care recommendations
 - All Medicare/Medicare Advantage patients
 - RAF Handbook – Labs, diagnostic imaging, consultant notes
- Structured communication/organization of recommendations
- Payer-specific initiatives

Pre-visit Audit Example

Risk Adjusted codes must be coded annually. The following code(s) have not been billed in the current year. Please consider at the upcoming visit:

- *I70.0 Atherosclerosis of aorta (See CT Chest-RIH 5/2/17)*

The following code(s) have been billed in the current year:

- *E11.22 Type 2 diabetes mellitus with diabetic chronic kidney disease;*
- *N18.32 Stage 3b chronic kidney disease;*
- *Z79.4 Long term (current) use of insulin;*
- *I48.0 Intermittent atrial fibrillation;*
- *I50.9 Heart failure, unspecified;*
- *E11.69 Type 2 diabetes mellitus with other specified complication (we also recommend I25.10 CAD to identify complication).*

These codes were specifically chosen as they increase the accuracy of the RAF score and appear to also be supported by prior notes, documents, labs. Please review and adjust if necessary. You must ADD the STATUS of the condition in the progress note after seeing the patient, and confirm problems selected are correct.

Risk Adjustment Communication

Subjective:

Chief Complaint(s): ▼

- Comprehensive
- MA: obtain/perform PHQ9 and CAGE-AID-QA AF
- Clinician: consider colorectal ca screening QSA AS. DM A1C, DM Eye exam, DM Foot exam-QA AF
- Please pull over RAF Codes from the Problem List to this Office Note, see telephone encounter (3/9/22) for details of RAF Audit

HPI: ▼

! Current Medication:

Medical History:

Allergies/Intolerance:

Recommended diagnosis codes are organized in the problem list to facilitate transfer

Claim diagnosis limits

- Barrier for claims with expansive problem lists
- Challenging to verify what has been processed on the payer side
- Prior to submitting claim, diagnosis codes in the “Assessment” are ranked according to RAF by the audit team.

Tech-based solutions

- Our EMR vendor has a platform, but we do not currently use this.
- Our parent organization utilizes a separate EMR, which also has a RAF platform which we are in the process of learning more about.

We recognize the competing interests a clinician has during a patient encounter. Our program is labor intensive but keeps the physician workflow in mind.

- Decreases sole-dependence on clinician
 - Clinician only does what they need to do
- Process allows us to track utilization and develop customized feedback

Payer-Specific Initiatives

- Partner with MA plans to identify and capture potential risk adjusting diagnosis codes
 - Mutual goal of improving the accuracy of our RAF codes
- Contractual agreement with payer tied to reviewing a predetermined percentage of suspect condition list
- Application of claims-based and EMR based logic to payer generated reports
 - Targeted approach to working lists
 - Increased yield of capturing actionable opportunities

Example: Top 20 conditions make up 80% of risk score lift

Rank	HCC Name	Chronic	Total Lift	Incremental % Lift	Cumulative % Lift
1	Reactive and Unspecified Psychosis	N	184.3	12%	12%
2	Diabetes with Chronic Complications	Y	156.4	10%	22%
3	Vascular Disease	N	114.0	7%	29%
4	Morbid Obesity	Y	101.8	6%	35%
5	Chronic Obstructive Pulmonary Disease	Y	97.1	6%	41%
6	Major Depressive, Bipolar, and Paranoid	Y	82.5	5%	46%
7	Metastatic Cancer and Acute Leukemia	N	77.1	5%	51%
8	Congestive Heart Failure	Y	59.6	4%	55%
9	Other Significant Endocrine and Metabolic	N	53.2	3%	58%
10	Diabetes without Complication	Y	49.5	3%	62%
11	Rheumatoid Arthritis and Inflammatory	Y	48.8	3%	65%
12	Specified Heart Arrhythmias	N	42.3	3%	67%
13	Acute Renal Failure	N	38.3	2%	70%
14	Schizophrenia	Y	37.2	2%	72%
15	Coagulation Defects and Other Specific	N	33.0	2%	74%
16	Disorders of Immunity	N	20.6	1%	76%
17	Chronic Kidney Disease, Moderate (Stage 3)	Y	18.6	1%	77%
18	Complications of Specified Implanted Devices	N	18.0	1%	78%
19	Atherosclerosis of the Extremities with	N	17.9	1%	79%
20	Parkinson's and Huntington's Disease	Y	16.4	1%	80%

Specific Initiatives

Condition	Coastal HCC accuracy Workflow
Obesity	<ul style="list-style-type: none"> ● MAs enter BMI code, height and weight required at all visits ● Morbid obesity recommended by audit team and organized into problem list.
Chronic Kidney Disease (CKD)	Look for historical EGFR < 60
Atherosclerosis of aorta	Review radiologic imaging reports within a couple years
Diabetes	Link diabetic complications (e.g. HCC 122 Proliferative Diabetic Retinopathy and Vitreous Hemorrhage)
Pacemakers	Coding the underlying native rhythm
Atrial fibrillation	Code secondary hypercoagulable state
ESRD on dialysis or cirrhosis	<ul style="list-style-type: none"> ● Capture end stage organ disease ● Code immunocompromised state (HCC 47 - Disorders of Immunity)

Measuring HCC accuracy improvement

- Acute vs chronic
- New vs continuous
- Coastal-only coding vs all-provider coding
- 1-3% increase in RAF corresponds to \$0.5 - \$1.5MM per year for one MA plan

Enrollment	Age 65	Chronic Acute	Beneficiary Count			Average RAF (CSTL-only rendering providers)			% Change in RAF (CSTL-only rendering providers)		Average RAF (All rendering providers)			% Change in RAF (All rendering providers)	
			2018	2019	2020	2018	2019	2020	2019	2020	2018	2019	2020	2019	2020
New	No	Acute	449	324	481	0.628	0.591	0.458	-6%	-22%	1.430	1.213	0.741	-15%	-39%
New	No	Chronic	590	527	752	0.574	0.512	0.440	-11%	-14%	0.863	0.757	0.560	-12%	-26%
New	Yes	Acute	5	19	54	1.235	0.375	0.360	-70%	-4%	0.749	0.405	0.578	-46%	43%
New	Yes	Chronic	13	33	106	0.617	0.370	0.429	-40%	16%	0.727	0.438	0.500	-40%	14%
Continuous	No	Acute	1,963	2,286	2,274	0.435	0.456	0.495	5%	9%	0.672	0.745	0.849	11%	14%
Continuous	No	Chronic	2,904	3,299	3,261	0.451	0.464	0.470	3%	1%	0.591	0.611	0.623	3%	2%
Continuous	Yes	Acute	58	34	8	0.414	0.412	0.825	-1%	100%	0.443	0.561	1.136	27%	102%
Continuous	Yes	Chronic	96	73	18	0.396	0.471	0.531	19%	13%	0.473	0.590	0.649	25%	10%

Questions ?

Appendix

Regulatory Calendar by CMS Deadline



	MSSP	REACH
Submit intent to apply	June 7	N/A
Submit application	June 29	Apr 22
Implementation Period PY23 (IP3 - optional)	N/A	Aug 1
Participant selection: Addition (Non-binding and can remove later)	Aug 4*	Sep 10*
Track selection decision & participant removal	Sep 9	Sep 16*

- * Decisions need to be made *before shared savings settlement* is available mid-August!
- * Estimate, based on 2021 GPDC calendar.

Comparison Between HCC Model Types



Concurrent Model

- Same coding collection year as the risk measurement year
- Acute conditions contribute more than chronic conditions
- Trade-offs
 - (+) Increased overall accuracy
 - R^2 for concurrent: 0.4911
 - R^2 for prospective: 0.1245
 - (+) Can immediately start calculating risk scores for new enrollees
 - (-) Less predictability
 - (-) Longer reporting lag

Prospective											
2020				2021				2022			
Dates of Service				Performance Year				Payment Year			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

Concurrent							
2021				2022			
Performance Year /Dates of Service				Payment Year			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

Reminders



1. NAACOS Spring Conference April 27-29 in Baltimore
2. Learning Lab on Specialist Engagement and Incentives:
Kicking off April 27th in Baltimore
3. Upcoming ACO Reach Webinar: Part 2, April 4th from 3:00 to 4:00 pm ET
 - Information to sign up for these events found in this week's Issue of the NAACOS Newsletter and on our website calendar of events.