NAACOS National Association of ACOs WEBINAR

Audit-Defensible AI

Risk Adjustment in **the Age of Expanded RADV**

Kevin Hill, PhD
Chief Innovation Officer

Dr. Terrell Bacchus, MD
Chief Medical Officer

presented by keebler

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Terrell Bacchus, MD

Founding CMO @ Keebler Health
Ex-CMO @ ConvenientMD
Ex-Chief Clinical Officer @ ChenMed

Born & Raised in Toronto, Canada

- Family Medicine Physician
- Chief Clinical Officer
- Chief Medical Officer



Things I Like To Do: Growing Carolina Reapers, 3D Printing, Working on Cars, Family Trips



Kevin Hill, PhD

Co-Founder & Chief Innovation Officer

Denver wanna-be native. PhD Neuroscience.

Series of startup, large and small. My professional roles have spanned data science, data engineering, and ML. I started doing health tech because there was so much data and no person could manager it all themselves

Things I like to do: backcountry skiing, video games, wrangling children, cooking



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AI-native vs AI-enabled

AI-NATIVE

LLMs unlocked speed & scale by removing sequencing altogether

Model Goal:
"What Did Terrell Do Wrong?"

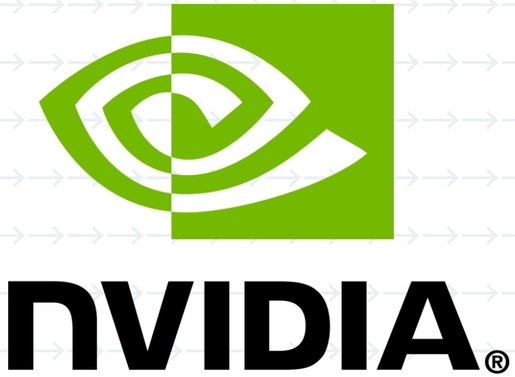
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Input:
With his daughter's lunch money, on a beautiful Sunday afternoon, Terrell bought new sneakers.

Attention:

daughter's lunch money

Terrell bought new sneakers.



Output:
Got it! Terrell stole from his daughter.

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The focal question **has changed.**

Not: Can AI find more HCCs?

Now: ***Can you defend the ones you submitted—three years later?***

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Audit exposure has **changed.**

2023

RADV Final Rule

Extrapolated recoveries, reaching back to 2018. No FFS Adjuster

2025

The net widened

Every MA contract became subject. Larger record samples.

2026

More exacting enforcement

Accelerated audits. More scrutiny of coding practices.

In brief: More audits. More exposure. Less tolerance.

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These four tests are familiar.
What's new is that someone is checking.

	CHART A	CHART B
Face-to-face provenance	✓ treating provider, at the visit	✗ addendum, months later
MEAT	✓ eGFR trend followed, med adjusted	✗ on the problem list, never assessed
Specificity & linkage	✓ "CKD 3a due to T2DM" — at time of care	✗ causality added downstream
Reproducibility	✓ evidence, confirmer, timestamp	✗ model version no longer exists

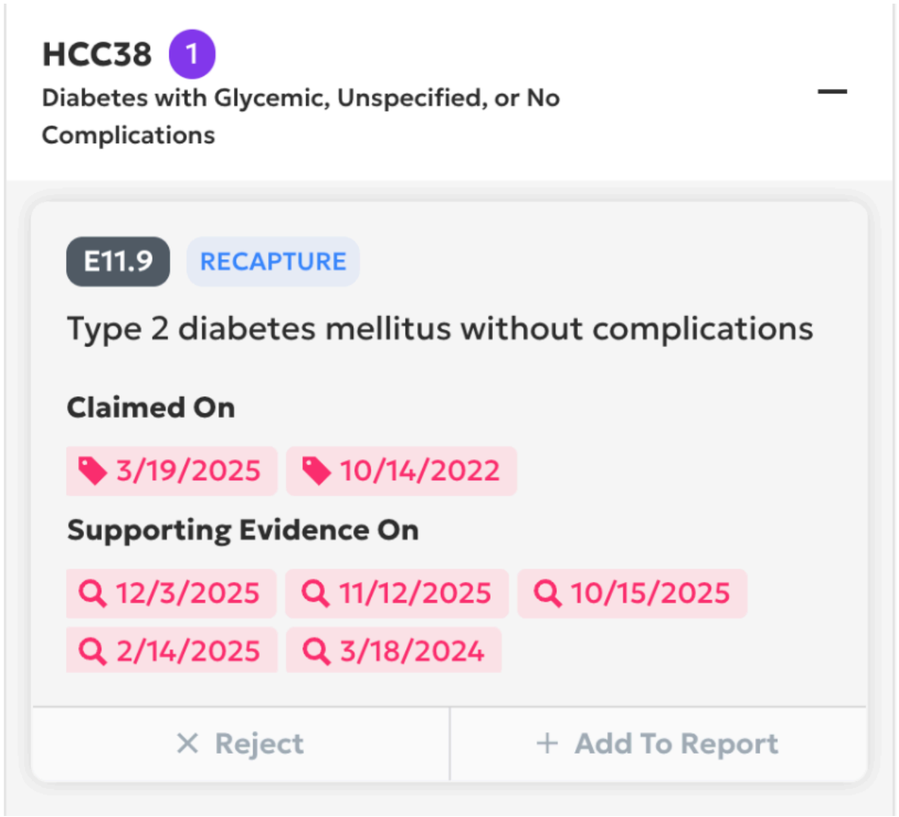
But, Keebler
“We’re an ACO!”

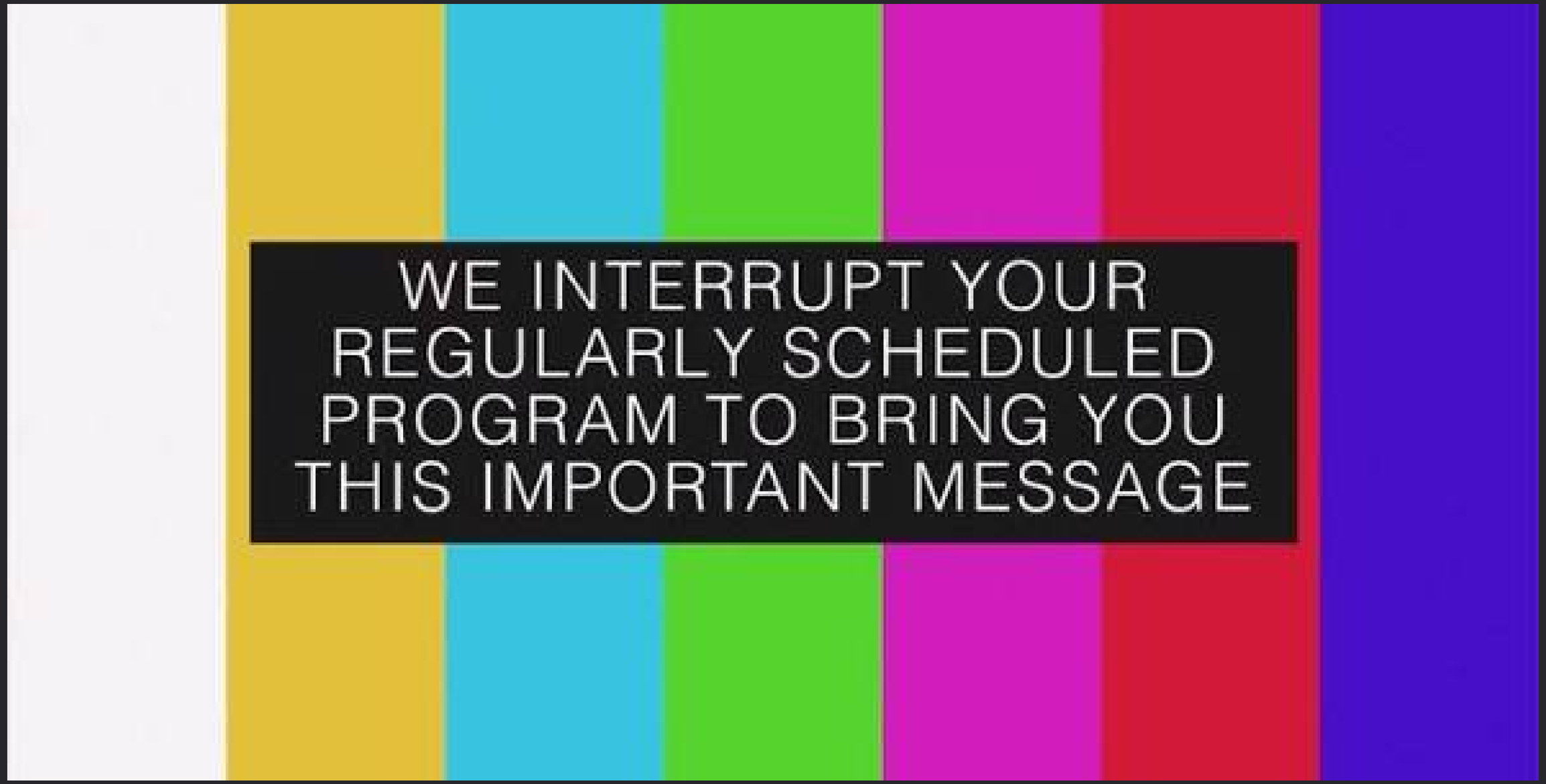
Your risk scores feed your benchmark.

MSSP **REACH** **LEAD**

Tightened the logic,
not loosened it.

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WE INTERRUPT YOUR
REGULARLY SCHEDULED
PROGRAM TO BRING YOU
THIS IMPORTANT MESSAGE

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Now that we have your attention,

let’s make it make sense.

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One deleted code is never **one deleted code.**



The sample becomes the multiplier.

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2023

Two charts.
Same code.

CHART A

E11.22

Type 2 diabetes with diabetic CKD.

Chart A survives.

CHART B

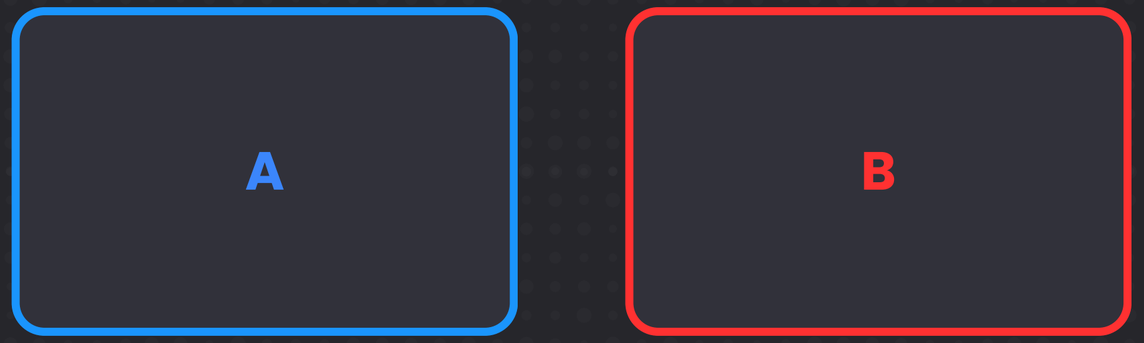
E11.22

Type 2 diabetes with diabetic CKD.

Chart B multiplies against you.

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Both charts were touched by AI.



The difference was **the architecture behind the technology.**

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AI TOUCHED CHART A

- evidence travels with the flag and is clearly linked to the source
- decisions enabled at the point of care
- flags removals, not just additions
- immutable audit trail

AI ALSO TOUCHED CHART B

- auto-coded, unconfirmed
- “trust the model” mantra
- add-only, tuned to RAF lift
- linkage manufactured after the fact
- black box of machine mystery logic

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Every pattern on that list manifested as a feature.

When the incentives are focused only on addition, the tools follow suit.

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The best audit defense isn't a legal strategy.
It's in the architecture itself.

If you don't build capture and defense as the same workflow you may learn later that you've built neither.

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Questions to consider when reviewing audit tools

1. Show me the evidence chain for one code, end to end
2. What percentage of your suggestions get rejected by clinicians, and is that rate healthy or suspicious?
3. Does your tool ever recommend removing codes?
4. What's your model governance: documentation, monitoring, update controls?
5. Which one of my teams can utilize this tooling?

Thank you!

Have more questions?

Scan to schedule a demo

or visit **keebler.health**

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