Operationalizing Value Based Revenue Cycle – Navigating the Change from CMS-HCC v24 to v28

Maria Alexander, Mount Sinai Health System
Henish Bhansali, Duly Health and Care
Kyle Campbell, Castell
Wilson Gabbard, Advocate Health

Operationalizing Value Based Revenue Cycle – Navigating the Change from CMS-HCC v24 to v28

Learning Objectives Outline

a. Overview of Risk Adjustment
    a. The basics and the population health impact
    b. The alignment between MA, MSSP, ACA, and Commercial
b. Review the changes between v24 and v28
    a. Where do you focus?
    b. Reading the tea leaves of what this means for ACOs
c. Understand what you can do to respond
    a. Deploy your technology updates
    b. Analyze your data
    c. Transform your operations
d. Tying it all together

Maria Alexander, VP of Population Health Operations, Mt. Sinai Health

Maria is the Vice President of Population Health Operations for Mount Sinai Health System, where she provides overall executive oversight for operational, administrative, clinical, and financial areas of population health and clinical integration operations.

Her team is responsible for creating, maintaining, and optimizing population health infrastructure in support of value-based care principles supporting the more than 460,000 patients who are a part of Mount Sinai's value-based care and performance-based contracts.

Prior to joining Mount Sinai in 2018, Ms. Alexander spent six years at the Centers for Medicare & Medicaid Services (CMS), most recently as a division director in Innovation Center. During her time at CMS, she helped develop the Pioneer ACO Model, the Comprehensive ESRD Care Model and worked on several initiatives focused on dual eligible populations. Ms. Alexander holds a BA from Tufts University.

Mount Sinai Health System

43,000+
Employees

7,400+
Physicians

8 Hospitals
3,919 Beds

1
Leading Medical School
Icahn School of Medicine at Mount Sinai

2,600+
Residents and Fellows

1
Renowned Nursing School
Mount Sinai Phillips School of Nursing

5,000
Alumni

4.2M
Patient Visits Annually

$11.3B
Revenue Annually

410+
Network Outpatient Practices

As of Feb 2023

Mount Sinai Health Partners: Clinically Integrated Network

~ 4,300
faculty physicians

~ 1,200
committed affiliated physicians

Over 400
Mount Sinai outpatient practices

Committed to a vision of **transforming healthcare in New York** toward value-based care and population health

Dozens of
Community-based organization collaborators

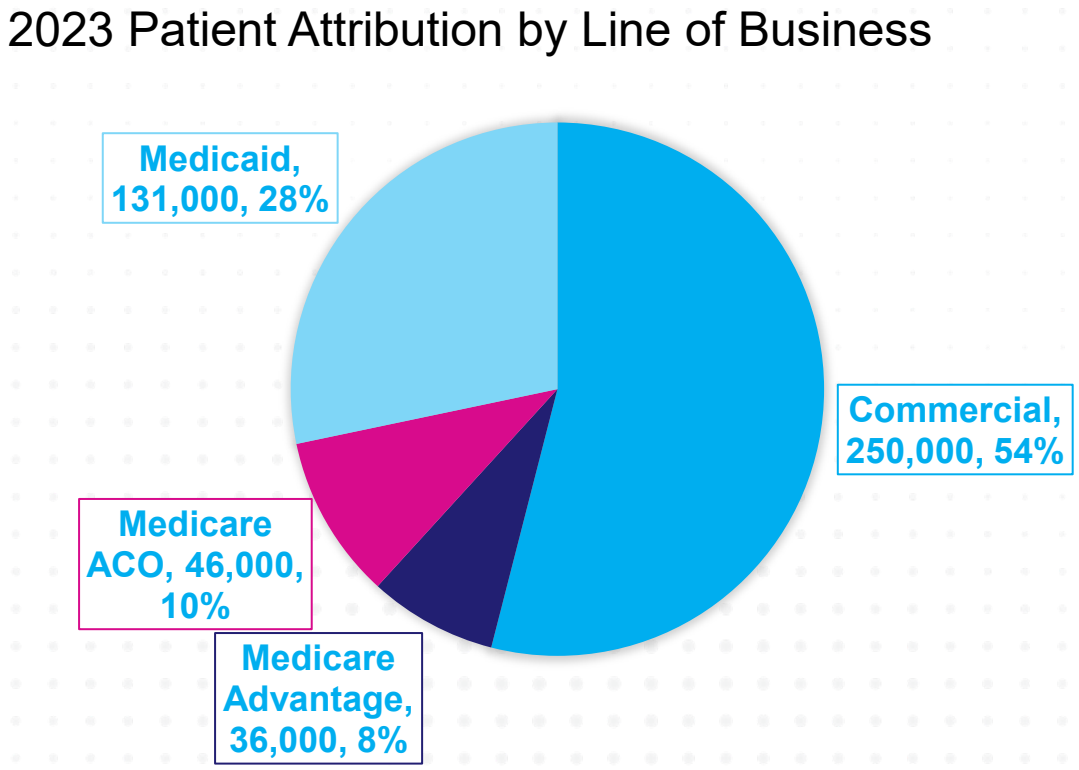
8 hospitals
spanning Manhattan, Brooklyn, Queens, & Long Island

45 skilled nursing
facilities that collaborate with our network

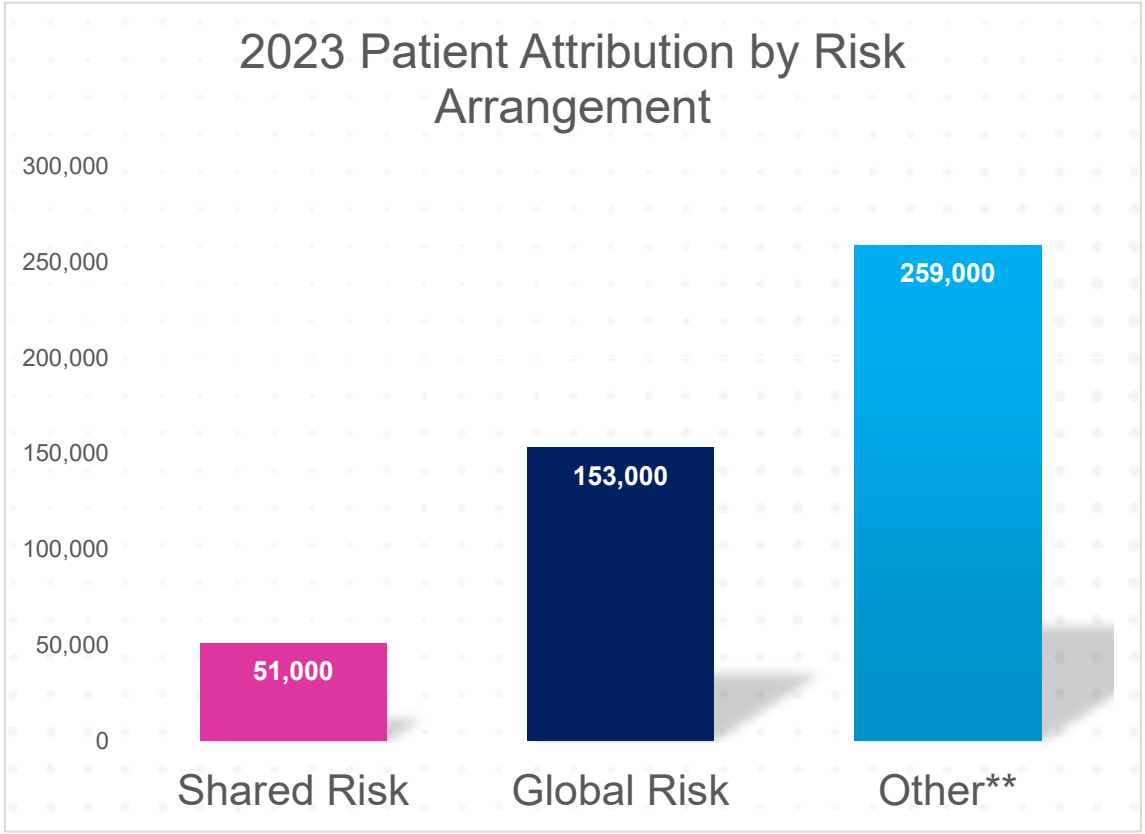
Geographic access and coverage across **the 5 boroughs, Long Island & beyond**

Integration with **ASCs & FQHCs** across New York City

Over 460,000 Lives in Value-Based Contracts



Risk Distribution of Lives in Value-Based Contracts*



*Mount Sinai manages $4.2 billion in total medical cost for these attributed lives

**Other includes Pay for Performance, Shared Savings, Upside Only

Kyle Campbell, Director of Risk Adjustment, Castell

Kyle is the risk adjustment director at Castell, bringing over 18 years of coding expertise to the forefront of healthcare innovation.

Castell, a leading healthcare organization, that oversees multiple ACOs, including the Rocky Mountain Accountable Health Network. Castell also helps manage multiple Medicare Advantage, commercial and healthcare exchange risk contracts.

Prior to joining Castell in 2019, Mr. Campbell spent 14 years in progressively responsible roles within Castell's parent company Intermountain Health, most recently leading consulting and auditing. Mr. Campbell holds a Bachelor of Science in Business Management from Columbia College and a Masters degree in Public Administration from Brigham Young University.

Castell At A Glance

CASTELL

Intermountain Health's Population Health Platform Company

5 states

~1.2 Million
lives under management

~$5 Billion
in value-based care arrangements

~550
employees

Advanced data & analytics platform

860
employed providers

840
affiliate providers

Multi payer value-based relationships

Full spectrum of valuebased care arrangements

Medicare Shared Savings	Medicare Direct Contracting	Medicare Advantage	Managed Medicaid	Individual ACA	Commercial

Henish Bhansali, MD, SVP of Medicare Advantage, Duly Health and Care

Henish is a physician executive in Medicare Advantage (MA) and a practicing internist. He joined Duly Health and Care in 2021 as their SVP of MA, overseeing care model design and delivery, TCC management, HEDIS, payor relationships, documentation and MA expansion.

Prior to Duly, he was Oak Street's Senior Medical Director and VP of Care Navigation leading clinical strategy for diagnostic and specialty care for 100K+ patients across 20 states. Prior to Oak Street, he led primary care education of over 50 internal medicine residents annually as an Associate Program Director with the University of Chicago for five years.

Dr. Bhansali trained in internal medicine and was Chief Resident at Washington University (WU)-Barnes Jewish Hospital (BJH). Post-residency, he directed BJH's readmission reduction program and WU's Global Health Program. His current focus is on improving the MA care model and he is pursuing a masters of public policy from the University of Chicago. He is a fellow of the American College of Physicians, a member of the AOA Medical Honor Society and is board certified in both internal and obesity medicine.

A diversified mix of value-based care and fee for service

1,100+ Primary care and Specialty physicians providing coordination across the health and care continuum

Purpose-driven holistic health and care model with an unrivaled end to end patient experience

Multi-pronged scalable growth model

30,000 MA Global Risk Lives with significant potential to grow

Personalized patient navigation built through an omni-channel approach

Physician-aligned model proactively managing patient health, increasing access to comprehensive care

Diversified payor mix

duly AT A GLANCE

900+
Physicians

6,000+
Team Members

1 million+
Total Patients

50+
Specialties

150+
Locations

90
Patient Trust Score

227,000+
Telehealth Visits

Wilson Gabbard, VP of Quality and Condition Management, Advocate Health

Wilson joined Advocate in 2020 where he is responsible for CIN and medical group quality across over 1.3M value based members and risk adjustment strategy for over $3 billion in system risk-based revenue. This includes responsibility for operationalizing programs for a portfolio of joint-ventures, fully delegated capitation, upside/downside risk, shared savings and pay for performance contracts.

Previously, he spent seven years leading population health operations for UNC Health Care where he was responsible for strategy and operations during its transition from fee-for-service to value-based reimbursement. The UNC population health services team grew from two to over 200 team members during his seven-year tenure.

Prior to joining UNC, he led regional operations for primary and specialty care practices and regional emergency and hospitalist service lines for Vidant Medical Group. Mr. Gabbard received his Bachelor and Master of Business Administration degrees from Morehead State University and is a Fellow of the American College of Healthcare Executives (FACHE).

ADVOCATE HEALTH

NEARLY	NEARLY	MORE THAN	NEARLY	NEARLY	MORE THAN		
6M	**150K**	**21K**	**42K**	**$5B**	**1K**	**67**	**$27B+**
UNIQUE PATIENTS	TEAMMATES	PHYSICIANS	NURSES	COMMUNITY BENEFIT	SITES OF CARE	HOSPITALS	REVENUE

AdvocateAuroraHealth

- **2.9M** unique patients
- **77K** teammates
- **10K** physicians
- **22K** nurses
- **$2.4B** in community benefit
- **500+** sites of care
- **27** hospitals
- **$14B+** in annual revenue

Atrium Health

- **2.9M** unique patients
- **73K** teammates
- **11K** physicians
- **20K** nurses
- **$2.46B** in community benefi
- **500+** sites of care
- **40** hospitals
- **$13B+** in annual revenue

MAGNET RECOGNIZED · 2018-20 TOP HOSPITAL FOR DIVERSITY · LGBTQ+ HEALTHCARE EQUALITY LEADER · Modern Healthcare Best Places to Work 2021 · 2022 Practice Greenhealth SYSTEM FOR CHANGE AWARD · American Hospital Association Quest for Quality Prize · Forbes 2022 AMERICA'S BEST-IN-STATE EMPLOYERS · 100 Top Hospitals · AMERICA'S MOST LOVED WORKPLACES · Equity of Care AWARD

Advocate Health has a long history with value-based care, and partners with 13,000+ physicians in 12 ACOs & CINs

13,000+
Participating Physicians in our CINs

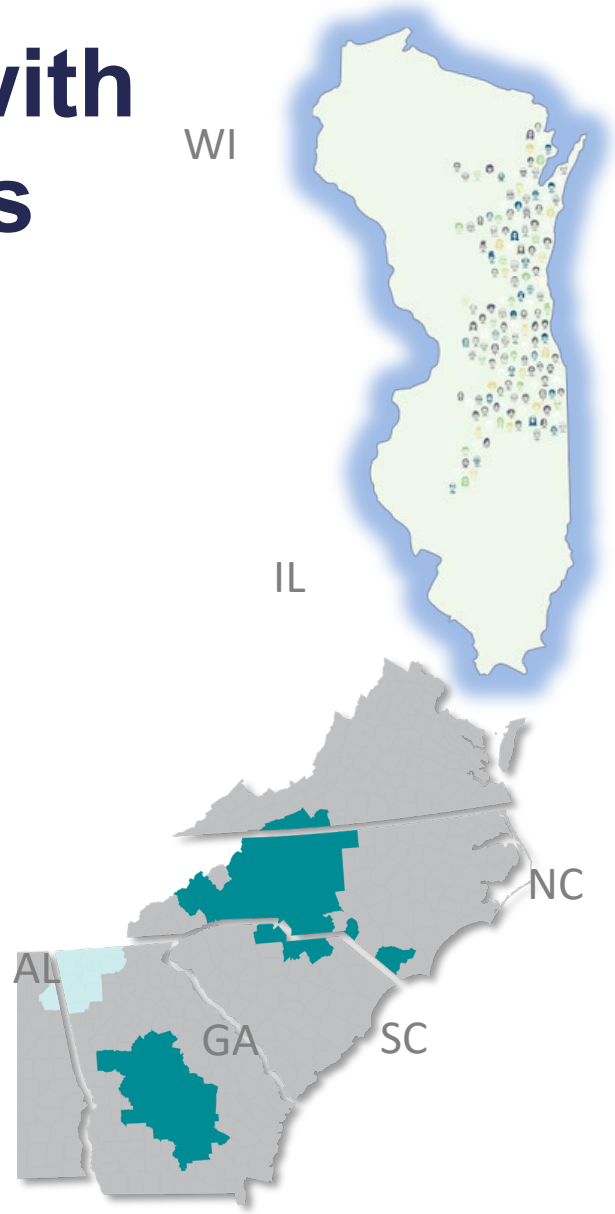
2.2 M
Total Managed Lives

73
Hospital Organizations Part of our CINs

108
Unique Value Contracts Across All ACOs/CINs

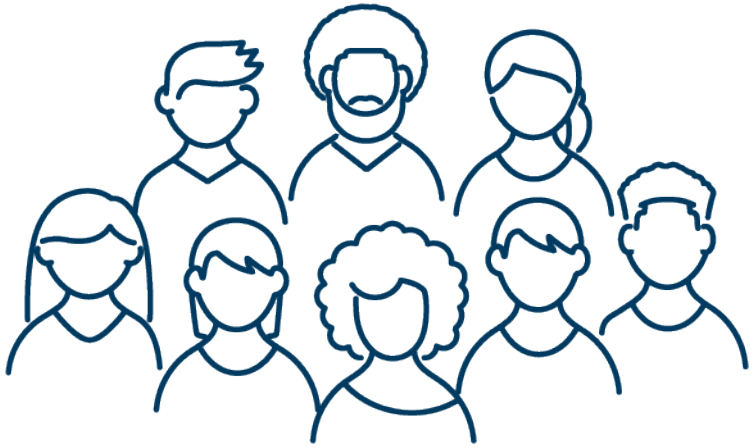
$1.2 B
Annual managed Capitation revenue

$1.4 B
Paid Out in Value payments



Our Midwest Value Based Population

Caring for 1.3 million lives
in 40+ contracts



- Commercial Shared Savings **577K lives**
- Commercial HMO **221K lives**
- Medicare Shared Savings Program **171K lives**
- Medicare Advantage **106k lives**
- Advocate Aurora Team Members **106K lives**
- Managed Medicaid **87K lives**
- Medicare Bundles **10K lives**

Question #1

How would you rate your knowledge of risk adjustment?

a. Just learning about it

b. Understand the basics

c. Beyond the basics but less than expert

d. Significant understanding and operational

Overview of Risk Adjustment

Condition Management and Documentation Fundamentals

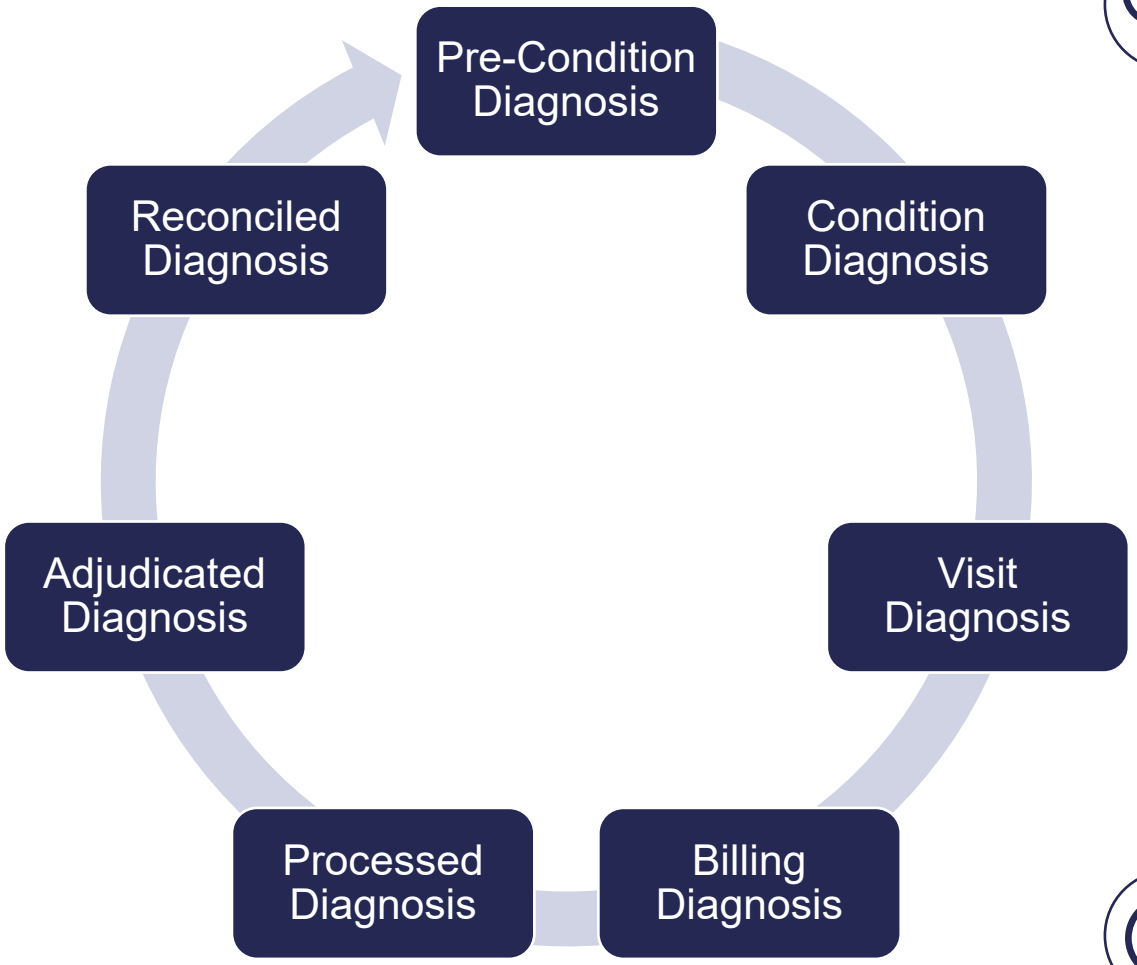
1. Risk Adjustment is a Population Health fundamental
    - Ensure that patients and their conditions are not lost to care
    - Helps ensure that chronic conditions are well cared for and can help reduce condition exacerbation

2. wRVUs and CPT coding are to fee-for service as risk adjustment is to value based care

3. Our goal is not for clinicians to be expert coders but rather to support them being expert caregivers. We need to make it easy for them to do the right thing, for the right patient, at the right time.

4. All programs should be focused on completeness and accuracy to improve member outcomes
    - OIG/DOJ focus on risk adjustment compliance
    - Develop strong legal and compliance partnerships to oversee and audit programs

Chronic Condition Lifecycle



- Pre-Condition Diagnosis: To identify specificity opportunity or suspect conditions. Leverages clinical and billing data, supplemental data from payers and others i.e. Quest, LabCorp, Surescripts.
- Condition Diagnosis: Based on provider clinical judgement often driven based on pertinent clinical findings and or lab values.
- Visit Diagnosis: Supported by condition specificity documentation following correct coding guidelines. Documentation follows MEAT criteria.
- Billing Diagnosis: Validated by coding review or through coding query. Avoiding auto claims truncation at 4 or 12 diagnoses.
- Processed Diagnosis: Flowing through claims processing and submitted to TPA/payer.
- Adjudicated Diagnosis: Reconciled on CCLF or MAO-002/4.
- Reconciled Diagnosis: Returned financial benchmark or revenue reporting. Reconciled on MMR and MOR from CMS. Retrospectively evaluated through NLP with corrections processed through ASM or corrected claims submission.

Risk Adjustment – MSSP vs. MA

Both MA and MSSP rely on the same model for risk adjustment but the way it is applied to financial targets differs between the programs

Characteristic/Application	MSSP	MA
Model Used	Prospective HCC Model	Prospective HCC Model
Ability to Submit Supplemental Retrospective Data	No	Yes
Limits on risk score growth	Yes – risk ratio cannot exceed 1.03	No*
Effect on Financial Target	Risk ratio (change in risk scores from BY3→PY) multiplied by benchmark	Risk scores multiplied by bid to get capitated rate
Level at which adjustment is applied	Member level risk scores aggregated to Beneficiary type	Member level adjustment applied to capitated rate

Notes:

- *Although there are no limits on MA risk score growth comparable to the 3% cap in MSSP, CMS does include coding intensity factor adjustments at plan level and conducts audits
- In both MA and MSSP, uncharacteristic growth in risk scores can be considered a red flag and result in audit. All coding must accurately reflect the true acuity of the patient.
- The GPDC/ACO Reach Model uses a somewhat different risk adjustment approach, including use of concurrent risk scores for High Needs ACOs. For details on risk adjustment methodology for ACO Reach, visit: https://innovation.cms.gov/innovation-models/aco-reach

MA Risk Adjustment Example – Impact on Capitated Rate and/or Target

Example: Aged/Non-dual member with varying risk scores

Bid rate - monthly	Risk Score (demographic + dx)	Member Months	Annual Capitated Rate to Plan	MLR	ACO/IPA Target
$780	0.95	11.2	$8,299	85%	$7,054
$780	1.0	11.2	$8,736	85%	$7,426
$780	1.5	11.2	$13,104	85%	$11,138
$780	2.0	11.2	$17,472	85%	$14,851

Notes:

- Bid rate, risk scores, member months, MLR/ACO Target are purely for illustrative purposes.
- Example does not account for quality adjustment or coding intensity factors under MA.

MSSP Risk Adjustment Example – Impact on Benchmark

Because MSSP benchmarks are largely based on the ACO's own historical expenditures, the risk adjustment methodology seeks to update the benchmark based on the *change* in risk scores from BY3 to PY.

Example: ACO population with same historical benchmark but varied PY risk scores

Historical Benchmark (PBPY)	Updated Benchmark (before risk adjustment)	BY3 Risk Score (normalized)	PY Risk Score (normalized)	Risk Ratio	Capped Risk Ratio	Risk Adjusted Updated ark	Impact after risk adjustment
$13,500	$13,900	1.15	1.09	0.95	**0.95**	$13,175	-$725
$13,500	$13,900	1.15	1.15	1.00	**1.00**	$13,900	$0
$13,500	$13,900	1.15	1.17	1.02	**1.02**	$14,142	$242
$13,500	$13,900	1.15	1.3	1.13	**1.03**	$14,317	$417

Not capped

Capped

Notes:

- All figures are for illustrative purposes.
- For Agreement periods starting prior to 2024, Risk ratios are calculated and caps are applied at the beneficiary type le ment periods starting in 2024 or later, risk ratios are capped at the aggregate level.
- In MSSP, risk scores are normalized for each specific beneficiary eligibility type. For example, an ESRD risk score of 1.0 means that the ACO's ESRD population is expected to have average total costs relative to other ESRD patients (not relative to *all* Medicare patients)
- Risk scores are normalized for the given year. In other words, a risk score of 1.0 in the PY could represent different acuity level, expected spending than a risk score of 1.0 in a Benchmark Year 3.

Question #2

How does risk adjustment stack up against other operational priorities? (Please rank the following priorities from high to low)

a. Risk Adjustment – ensuring completeness and accuracy of data and benchmarks
b. Quality – ensuring superior quality performance and reporting
c. Growth – executing value-based agreements and growing/retaining lives under management
d. Utilization – driving appropriate utilization of health care resources through the care team model
e. Infrastructure – managing infrastructure expense

Transitioning from v24 to v28

Going from v24 to v28

What, When, & Why?

What?

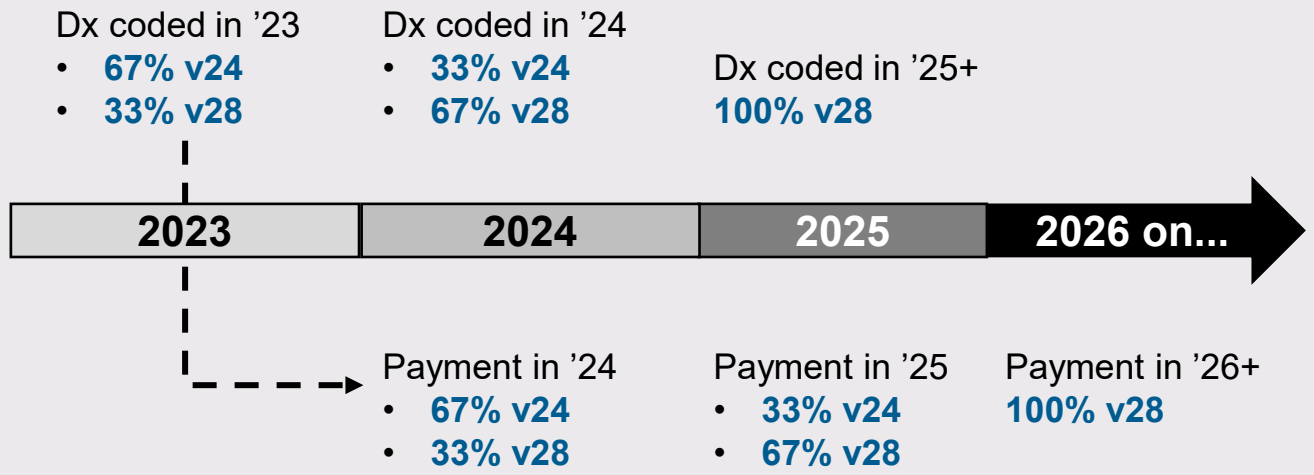
Meaningful overhaul of the CMS-HCC risk adjustment model

- Removes weight from ~2k ICD-10 codes
- Adds 200+ risk-bearing ICD-10s & 29 HCCs
- Changes weights of numerous HCCs
- (Minor) changes to demographic weights, interaction factors, and 4/5+ HCCs
- Updated benchmark (’14 / ’15 to ’18 / ’19)

CMS predicts a **2.2% decrease** in ’24 plan payments as a result. Prior to the final notice and intro of the 3-year blend, industry analyses and CMS estimated similar levels of impact.

When?

Now! *Beginning Jan. 1, 2023*
B/c Dx documented in 2023 = risk scores in 2024…



Why?

- Reduce **discretionary coding** (Principle 10) – 75 codes
- Improve **prediction of future costs** (Principle 2) - predictive power for every decile of risk for ages > 65 went up; remove weight from codes that **don’t predict costs** (e.g., sub. encounters, complications from medical care)
  - Combinations of the 2 – *constraining diabetes HCCs*
- Moving from ICD-9 to HCC mappings to **ICD-10 mappings**

Source: Aledade – NAACOs Spring Conference

CMS 2024 Payment Model
Diabetes Coefficients by Hierarchical Condition

HCC	Description Label	Community, NonDual, Aged	Community, NonDual, Disabled	Community, FBDual, Aged	Community, FBDual, Disabled	Community, PBDual, Aged	Community, PBDual, Disabled	Institutional
HCC 36	Diabetes with Severe Acute Complications	0.166	0.191	0.186	0.235	0.166	0.21	0.28
HCC 37	Diabetes with Chronic Complications	0.166	0.191	0.186	0.235	0.166	0.21	0.28
HCC 38	Diabetes with Glycemic, Unspecified, or No Complications	0.166	0.191	0.186	0.235	0.166	0.21	0.28

Condition coefficients are identical across all populations and diabetic HCCs.

Source: Norwood Consulting Analysis of 2024 CMS Final Rule

CMS Proposed 2024 Payment Model
Conditions with Largest Potential Care Funding Increase

Description Label	V24 HCC	V28 HCC	2023 Weight	2024 Weight	Percentage Change	Estimated Patients with Condition per 10k Lives	Estimated Impact per 10k Lives
CKD, Severe (Stage 4)	137	327	0.289	0.514	78%	100	**$222,750**
Multiple Sclerosis	77	198	0.423	0.647	53%	58	**$128,621**
Intestinal Obstruction/ Perforation	33	78	0.219	0.326	49%	111	**$117,582**
Artificial Openings for Feeding or Elimination	188	463	0.534	0.673	26%	85	**$116,969**
Exudative Macular Degeneration	124	300	0.521	0.596	14%	142	**$105,435**

$691k per 10,000 Lives

While these conditions are all seen infrequently (<1.5% of patients), the significance of the weight changes means these could have a disproportionate impact on funding. Care funding assumes a $9,900 PMPY funding for a 1.00 risk adjustment factor patient.

Source: Norwood Consulting Analysis of 2024 CMS Final Rule

CMS Proposed 2024 Payment Model
Conditions Completely Removed from the Model

Description Label	Diagnoses That Mapped to HCC	2023 Weight	Estimated Patients with Condition per 10k Lives	Estimated Impact per 10k Lives*
21-Protein-Calorie Malnutrition	10	0.455	226	**$1,018,017**
88-Angina Pectoris	36	0.135	415	**$554,648**
134-Dialysis Status*	50	0.435	21	**$90,437**
135-Acute Renal Failure*	5	0.435	467	**$2,011,136**
176-Complications of Specified Implanted Device or Graft	325	0.582	131	**$754,796**

$4.4M per 10,000 Lives

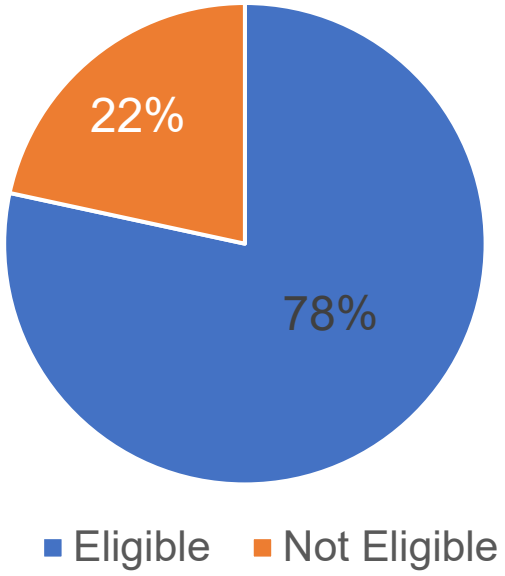
Removal of these conditions may have a noticeable impact on overall care funding. The removal of these conditions from the model allows for weights to be shifted elsewhere, but also contribute to the expected fall in risk scores. *Impact doesn't account for underlying condition if condition trumped another category.

Source: Norwood Consulting Analysis of 2024 CMS Final Rule

CMS Proposed 2024 Payment Model
Sample Organizational Impact

Chronic Conditions Eligible for Recapture

2023 -> 2024 Payment Year



Projected Change in Prevalence Rate

2024 Payment Year

HCC Category	PY2023 Prevalence	Projected Decrease
23- Other Significant Endocrine and Metabolic Disorders	4.7%	-92%
108- Vascular Disease	14.6%	-90%
48- Coagulation Defects, Oth Hematological Disorders	5.6%	-78%
47- Disorders of Immunity	2.5%	-65%
40- RA and Inflammatory Connective Tissue	9.9%	-51%
59- Major Depressive Disorder	13.9%	-47%

$1,456 Per Member Per Year

The amount of value lost from the recapture of chronic conditions that no longer risk adjust in payment year 2024. This must be offset by other conditions still eligible for capture and net new conditions.

Source: Norwood Consulting Analysis of 2024 CMS Final Rule

CMS 2024 Payment Announcement

CMS Risk Model Evolution

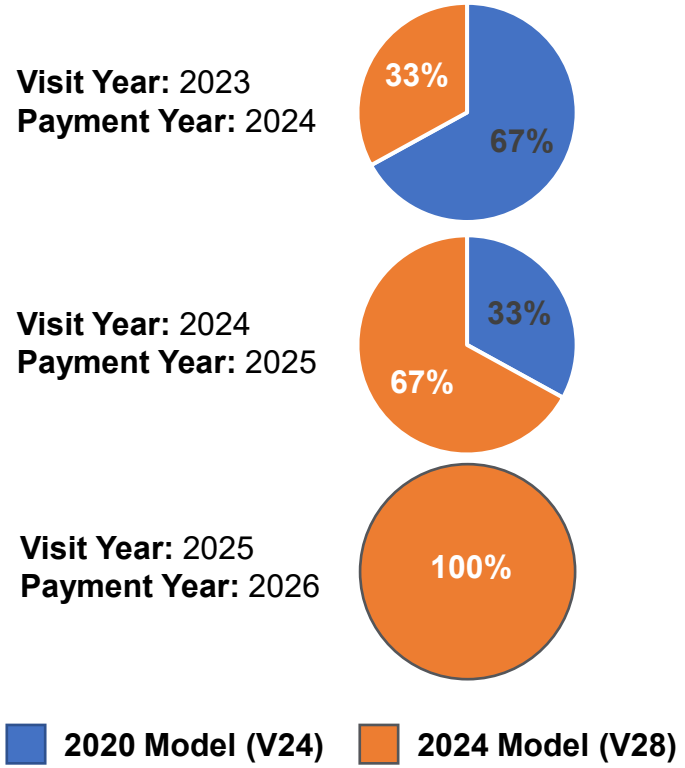
2020 to 2024 Model Key Differences

2020 Model (V24)
-Risk Adjustable DXs: 9,797
-Risk Adjustable HCCs: 86

2024 Model (V28)
-Risk Adjustable DXs: 7,720
-Risk Adjustable HCCs: 115

Risk Model Blend

2024-2026 Payment Years



-2.16% or $7.62B

While the total Medicare Part C payments will go up, risk adjustment impacts from the model changes in 2024 are estimated to cost MA organizations $7.62B. This is down from initial estimates of -3.12% or $11B

Source: Norwood Consulting Analysis of 2024 CMS Final Rule

Question #3

If any, what risk adjustment programs do you already have in place? (Please select all that apply).

a. Engagement efforts – clinician and operational education on how to ensure completeness and accuracy of documentation
b. Point of care tools – decision support within the EMR
c. Value based compensation – tied to panel size or risk adjustment metrics
d. Analytics – performance management tools, natural language processing, or care gap suspecting

Operational Best Practices Panel Conversation

Complete Documentation of Patient Complexity

Pre-Visit, Point of Care, and Pre-Bill teams working in tandem to fully capture complexity of care.

Pre-Visit

Establish a sustainable ***pre-visit*** process to support the identification of highly probable care gaps.

Point of Care

Pre-Bill

Close coding gaps ***prior*** to submitting the claim leveraging NLP powered review of 100% of encounters before claim submission.

1. Identify the **PATIENT** accounts with upcoming scheduled visits to be reviewed
2. Identify the **GAPS** that need to be addressed
3. Have the **PROVIDER** see the patient to address the gaps without abrasion
4. Ensure that **CONDITIONS** are properly documented according to MEAT criteria
5. Put the documented conditions on the **CLAIM** and bill for it

- Add team to Outpatient CDI **WORKFLOW** for simple, integrated access
- Display clinical **EVIDENCE** to reveal why a suspect condition was identified using additional data sources (claims, unstructured data, etc..)
- Allow team to easily **DOCUMENT** their care gap assessment and notify providers
- Integrate highly probable suspect condition into provider **WORKFLOW** and ensure sufficient **RECONCILIATION** processes.
- **ADD** documented diagnosis codes to the bill and/or **REMOVE** codes that are unsubstantiated
- Leverage NLP to **INCREASE** review productivity, accuracy and efficiency

Question #4

If anything, what are you going to do differently? (Please select all that apply).

a. Better understand the financial implications risk adjustment plays in my contractual performance

b. Explore deploying new programs to support completeness and accuracy

c. Expand existing programs to support completeness and accuracy

Question #5

When has your vendor committed to updating your technology tools for v28?

a. Already deployed
b. Before the start of Q4 2023
c. Before the start of Q1 2024
d. After Q1 2024
e. Unknown