Auditing an ACO

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Written by

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Building a better working world

Should we audit the ACO?

Contents

Key takeaways

- ACOs do not run themselves and require auditing and monitoring
- Every ACO is different
- Appreciate the organization's *interest dynamic*
- How to start an Audit of an ACO
- Understand the results/impact of an ACO audit
- Examples of how to conduct a similar audit

Introduction of an ACO Audit

- What is an ACO?
  - Objectives of an Accountable Care Organization (ACO)
    - Allow providers (physicians, hospitals, other healthcare professionals, etc.) to work more effectively together, to lower costs and provide higher quality of care
    - Shift away from volume of services towards *value* and *outcomes* (healthcare quality measures and risk adjustment)
      - Right care at the right time (colonoscopies, breast cancer screenings, diabetes management, numerators/denominators, etc.)
      - Hierarchical Condition Categories (HCC), Risk Adjustment Factor (RAF)
      - Coding and Chart Abstraction
      - EMR/EHR
  - Medicare Shared Savings Program (MSSP)
    - Organizations can choose tracks that best fit the organization
    - Five year contracts
    - Capitated reimbursement adjusted based on quality measures and membership RAF score

MSSP-ACOs by the numbers

Shared Savings Program Fast Facts – As of January 1, 2021

CMS MEDICARE SHARED SAVINGS PROGRAM

SHARED SAVINGS PROGRAM INFORMATION

PROGRAM CHARACTERISTICS (as of January 1st of each year)

Performance Year	ACOs	Assigned Beneficiaries
2021	477	10.7 million
2020	517	11.2 million
2019	487	10.4 million
2018	561	10.5 million
2017	480	9.0 million
2016	433	7.7 million
2015	404	7.3 million
2014	338	4.9 million
2012/2013	220	3.2 million

PERFORMANCE YEAR (PY) RESULTS

Performance Year	Total Earned Shared Savings	Average Overall Quality Score
2019	$1.471 billion	92%
2018	$983 million	93%
2017	$799 million	92%
2016	$700 million	95%
2015	$645 million	91%
2014	$341 million	83%
2012/2013	$315 million	95%

2021 SHARED SAVINGS PROGRAM ACO INFORMATION

ACO TRACKS

	ACOs	Percent
One Sided (59% of ACOs)		
BASIC Track Levels A&B	163	34%
Track 1	119	25%
Two Sided (41% of ACOs)		
BASIC Track Levels C&D	31	6%
BASIC Track Level E*	69	14%
ENHANCED Track*	76	16%
Track 1+ Model*	17	4%
Track 2*	2	1%

*Qualifies as an Advanced Alternative Payment Model (APM)

ACOs BENEFICIARY ASSIGNMENT METHODOLOGY

	ACOs	Percent
Prospective	151	32%
Preliminary Prospective with Retrospective Reconciliation	326	68%

2021 MEDICARE BENEFICIARY DEMOGRAPHIC DISTRIBUTION

Enrollment Type	Beneficiary Person-Years	Percent
Aged Non-Dual	8,660,991	83%
Disabled	1,094,539	10%
Aged Dual	656,058	6%
End Stage Renal Disease (ESRD)	78,348	1%

ACO COMPOSITION

HIGH / LOW REVENUE ACOs

	ACOs	Percent
High Revenue	221	46%
Low Revenue	256	54%

Skilled Nursing Facility (SNF) AFFILIATES & SNF 3-DAY RULE WAIVER

ACOs approved for a SNF 3-Day Rule Waiver	118
Total number of SNF affiliates	1,775

ACO PARTICIPANT LIST COMPOSITION

Participant TINs	16,324
Physicians and non-Physicians	467,615
Hospitals	1,349
Federally Qualified Health Centers (FQHCs)	3,130
Rural Health Centers (RHCs)	1,397
Critical Access Hospitals	405

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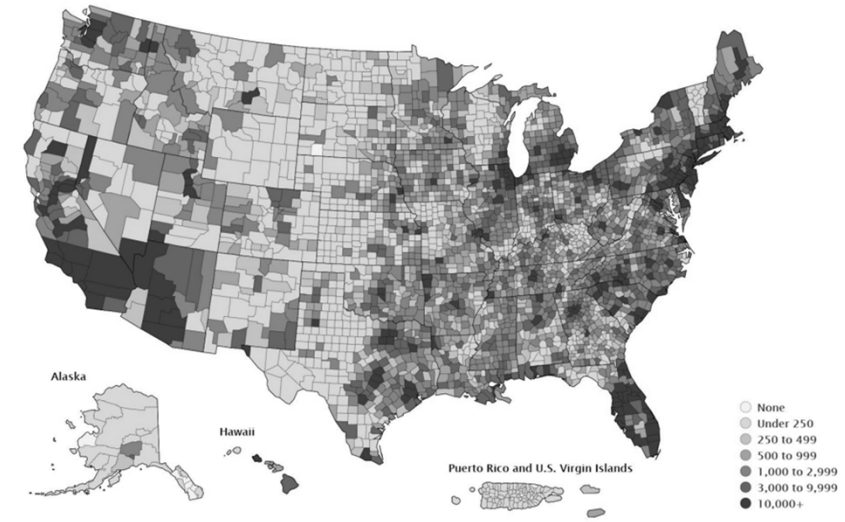
Shared Savings Program Fast Facts – As of January 1, 2021

CMS MEDICARE SHARED SAVINGS PROGRAM

Medicare Shared Savings Program ACO Assigned Beneficiary Population by County

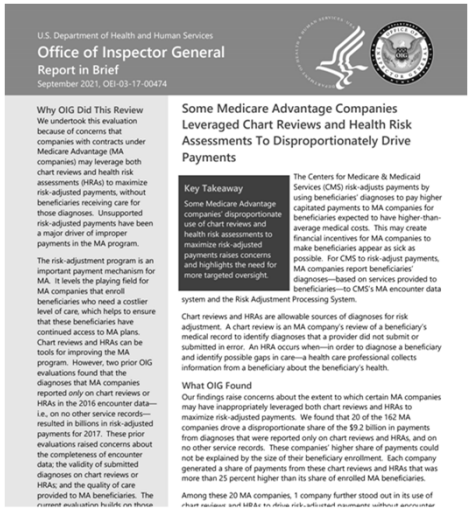


Why audit the ACO?

- Financial Risk
- False Claims Act Risk
- Better data better quality of care

US$9.2b

Office of Inspector General report of *Some Medicare Advantage Companies Leveraged Chart Reviews and Health Risk Assessments to Disproportionately Drive Payments*



U.S. Department of Health and Human Services

Office of Inspector General

Report in Brief

September 2021, OEI-03-17-00474

Why OIG Did This Review

We undertook this evaluation because of concerns that companies with contracts under Medicare Advantage (MA companies) may leverage both chart reviews and health risk assessments (HRAs) to maximize risk-adjusted payments, without beneficiaries receiving care for those diagnoses. Unsupported risk-adjusted payments have been a major driver of improper payments in the MA program.

The risk-adjustment program is an important payment mechanism for MA. It levels the playing field for MA companies that enroll beneficiaries who need a costlier level of care, which helps to ensure that these beneficiaries have continued access to MA plans. Chart reviews and HRAs can be tools for improving the MA program. However, two prior OIG evaluations found that the diagnoses that MA companies reported *only* on chart reviews or HRAs in the 2016 encounter data—i.e., on no other service records—resulted in billions in risk-adjusted payments for 2017. These prior evaluations raised concerns about the completeness of encounter data; the validity of submitted diagnoses on chart reviews or HRAs; and the quality of care provided to MA beneficiaries. The

Some Medicare Advantage Companies Leveraged Chart Reviews and Health Risk Assessments To Disproportionately Drive Payments

Key Takeaway

Some Medicare Advantage companies' disproportionate use of chart reviews and health risk assessments to maximize risk-adjusted payments raises concerns and highlights the need for more targeted oversight.

The Centers for Medicare & Medicaid Services (CMS) risk-adjusts payments by using beneficiaries' diagnoses to pay higher capitated payments to MA companies for beneficiaries expected to have higher-than-average medical costs. This may create financial incentives for MA companies to make beneficiaries appear as sick as possible. For CMS to risk-adjust payments, MA companies report beneficiaries' diagnoses—based on services provided to beneficiaries—to CMS's MA encounter data system and the Risk Adjustment Processing System.

Chart reviews and HRAs are allowable sources of diagnoses for risk adjustment. A chart review is an MA company's review of a beneficiary's medical record to identify diagnoses that a provider did not submit or submitted in error. An HRA occurs when—in order to diagnose a beneficiary and identify possible gaps in care—a health care professional collects information from a beneficiary about the beneficiary's health.

What OIG Found

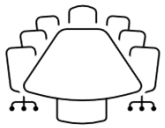
Our findings raise concerns about the extent to which certain MA companies may have inappropriately leveraged both chart reviews and HRAs to maximize risk-adjusted payments. We found that 20 of the 162 MA companies drove a disproportionate share of the $9.2 billion in payments from diagnoses that were reported only on chart reviews and HRAs, and on no other service records. These companies' higher share of payments could not be explained by the size of their beneficiary enrollment. Each company generated a share of payments from these chart reviews and HRAs that was more than 25 percent higher than its share of enrolled MA beneficiaries.

Among these 20 MA companies, 1 company further stood out in its use of

Deciding on an ACO audit
What are the risks and opportunities?

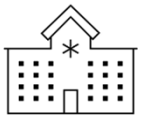
- What kind of governance is in place now, what was it in the past?
- Has the ACO ever been audited (Internal/External/Governmental Payer)?
- Have any risk assessments been performed revealing healthcare quality measures and HCC coding as a risk area?
- Have RAF scores seen a dramatic increase?
- Has your organization gone through acquisition, with an ACO agreement?
- Is the corporate structure of the ACO centralized, decentralized and/or practice based?
- Are there multiple different systems and technologies in use?

Interests Dynamic

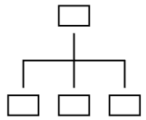


Board of Directors

Audit and Compliance



Providers



The Business

The Audit

Scoping and Objectives

- Peoples
- Processes
- Systems
- Technology
- Organizational Structure: Centralized vs. Decentralized
- Incentive Structures

Business Owners

- Practice leaders, Providers, IT, Risk Adjustment Department, Coding Managers, Chart Abstractors

Testing

Reporting

Communicating and Reporting the ACO Audit Results

- Define ACO audit terms
  - High, Medium, Low Risk and Process Improvement
  - Findings, Exceptions, Variances, Observations, Errors, Gaps, etc.
  - HCC, RAF, ICD-10, coefficients
  - Healthcare quality measures (Numerators & Denominators)
  - Coding and Chart Abstraction
  - EMR/EHR
- Recommendations and Management response involvement
  - Interest Dynamic
    - Know your environmental constraints
      - Know your resource constraints
      - Know your timing constraints

Board of Directors	Audit and Compliance	Providers	The Business

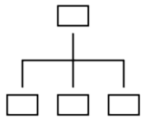
Accomplishing Objectives and Next Steps

- Did the audit address all items in the final scope?
- Did all findings have a recommendation?
- Did all recommendations have a reasonable management response?

If Yes…

…What's next to make for a meaningful ACO Audit?

- Go beyond updates to policies and procedures
- Think about leverage to nudge change (i.e., What are the parties to the ACO obligated (auditing and monitoring, training and educations, etc.?)
- Provide examples of best practice
- Transparency of audit results. Demonstrate value of the audit.



The ACO Audit Story

Understand the Organization

Tasks:

1) Documentation request
2) Policies and Procedures read through
3) Organization charts
4) Data requests

Interviews

Topics to discuss:

1) Roles & Responsibilities
2) Training & Education
3) Auditing & Monitoring
4) Systems, Technology and Reporting
5) Coding and Chart Abstraction

*Key Personnel – Practice leaders, Providers, IT, Risk Adjustment Department, Coding Managers, Chart Abstractors

Testing Risk Adjustment

1) Establish the scope and testing elements
2) Request relevant population
3) Test population
4) Hold variance discussion
5) Determine if an expanded sample or extrapolation is necessary

Testing Healthcare Quality Measures

1) Establish the scope and testing elements
2) Request relevant population
3) Test population
4) Hold variance discussion

Example of Testing HCC and Healthcare Quality Measures

Example HCCs

- HCC 1 (HIV)
- HCC 2 (Sepsis)
- HCC 8 (Metastatic CA)
- HCC 9 (Cancer)
- HCC 17 (DM w/ Coma)
- HCC 18 (DM w/ Complication)
- HCC 19 (DM w/o Complication)
- HCC 21 (Malnutrition)
- HCC 22 (Morbid Obesity)

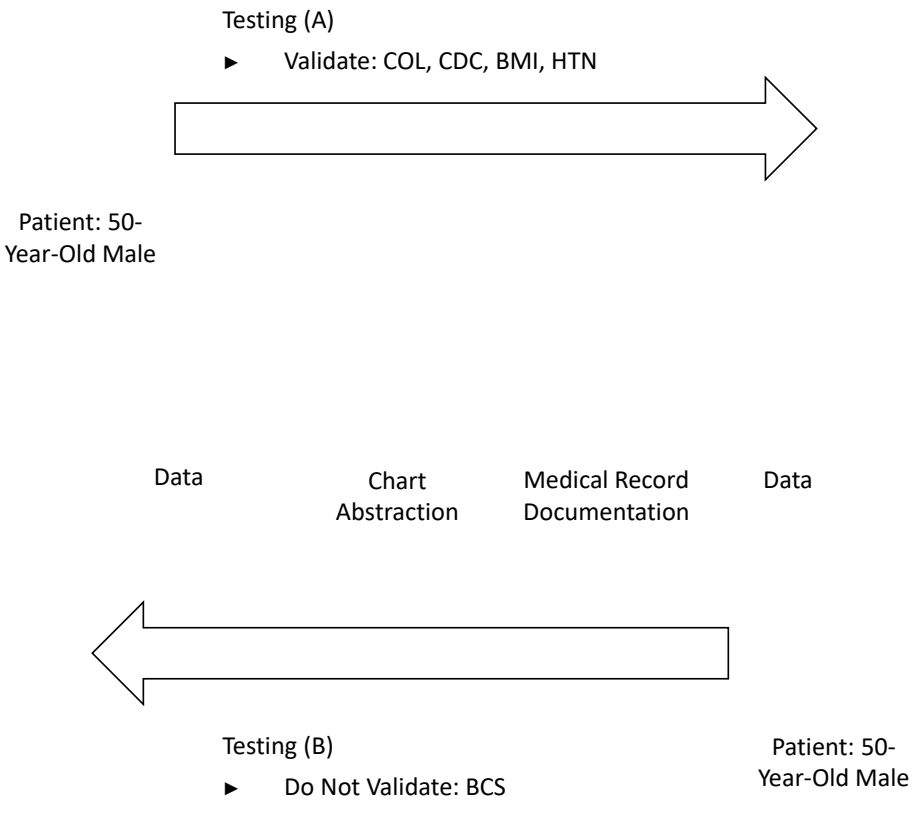
	Does EY agree with the submitted original RA diagnosis codes on the DOS?	Does EY agree with submitted original HCC on the DOS?	Does EY agree with the provider type according to CMS RA protocols for the encounter?	Is the document signed by the provider?	Pass/Fail
Yes (Pass)	58	61	75	75	58
No (Fail)	17	14	0	0	17
NA	2	2	2	2	2
Total:	77	77	77	77	77
					78%
			Adds	14	
			Revise	3	
			Delete	0	
			Total:	17	

Healthcare Quality Measures Testing

Providers

Measures

- Breast Cancer Screening (BCS)
- Colorectal Cancer Screening (COL)
- Comprehensive Diabetes Care (CDC)
- Vaccine (Influenza/Pneumococcal)
- BMI
- Hypertension management



Auditors

Testing (A)

- Appropriate inclusion (Denominator)
- Support for closure of a measure (Numerator)
- Data submission supports closure of the measures

Testing (B)

- Appropriate exclusion (Denominator)
- Measure appropriately not closed
- Data submission supports measure not applicable

Example: Auditing and Monitoring Plan

1. New Hire Quality Reviews:
   a. 100% of new providers and new coders would go through a 20 chart per month assessment, or until HCC coding accuracy of 95% accuracy is met.
   b. Once the provider or coder has consistently met the 95% accuracy rate, the provider or coder is released to the normal cadence of random auditing.
2. Random HCC Coding Reviews:
   a. Random sample selection of at least 10 encounters per year for all providers and coders.
   b. Random audits are conducted on a quarterly basis and reported at the practice and ACO level.
3. Focus Coding Reviews:
   a. Focus auditing selects a sample of 50 encounters on a risk-based approach identified from prior audits and/or third-party audit findings.
4. Audit the auditors:
   a. The auditors that conduct the new hire, random and focus auditing will be audited by the auditor QA or third party on a quarterly basis. A random sample of 10 encounters per auditor will be subject to this testing.

Soft skills matter

- The parties are engaged and want more.
- Work, Presentation and Transparency
- Enlightened Ostrich

Contact Us

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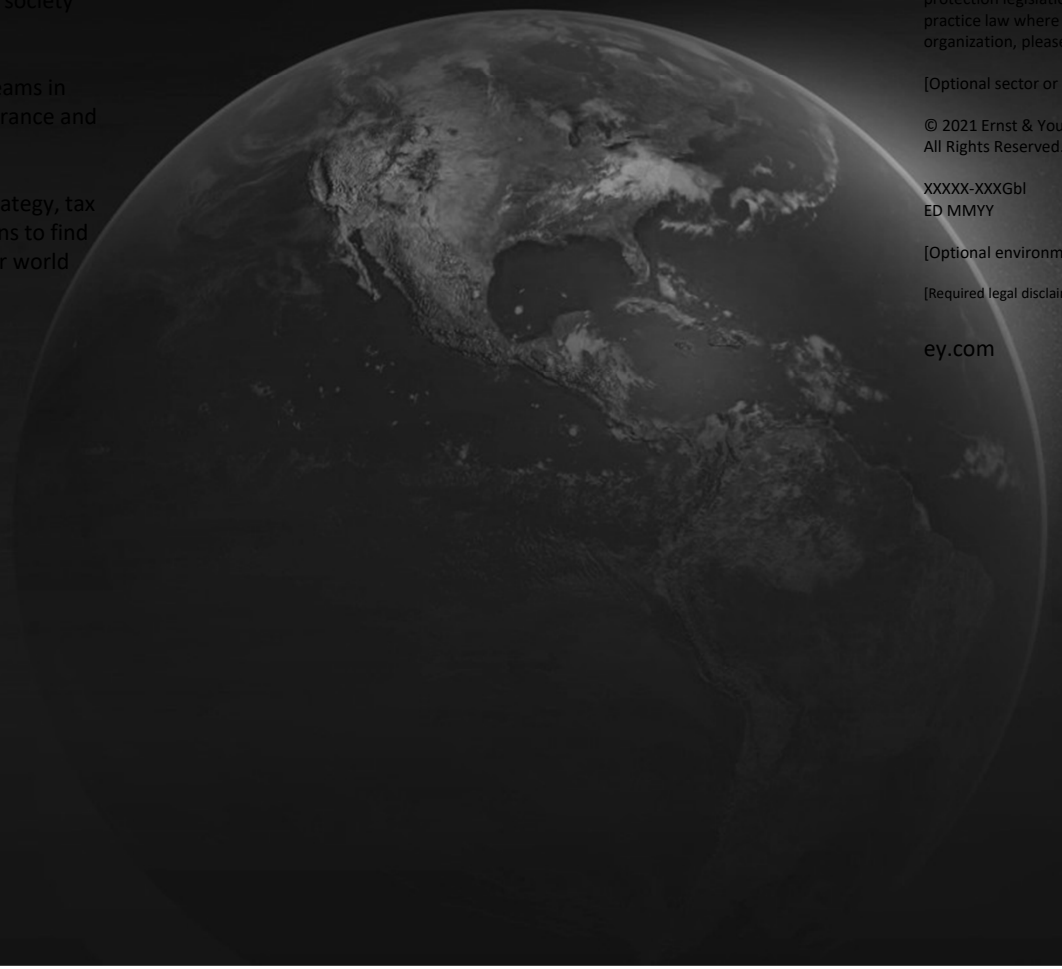

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