MILLIMAN ISSUE BRIEF

Why accurate claims coding for MSSP ACOs has become increasingly important

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The regional adjustment to the benchmarks of renewing Medicare Shared Savings Program (MSSP) accountable care organizations (ACOs) highlights the need for complete and accurate diagnosis coding.

The Centers for Medicare and Medicaid Services (CMS) changed the benchmark methodology for ACOs entering a renewal (second or subsequent) MSSP agreement period in 2017 and thereafter. The 2017 methodology introduced a regional adjustment, whereby the ACO's benchmark is updated based on whether the ACO's historical expenditures are higher or lower than regional expenditures on a risk-adjusted basis. Because the risk adjustment depends on the ACO's benchmark period risk scores, accurate and complete diagnosis coding during the benchmark period has a significant influence on the calculation of ACO benchmarks for renewals in 2017 and thereafter.

CMS uses benchmark year 3 (BY3) risk scores for the calculation of the regional adjustment, scores that are based on diagnoses (Dx) from BY2 claims. For agreements that begin in 2020, the year 2019 will be considered BY3 and Hierarchical Condition Category (HCC) risk scores will be based on diagnoses from 2018 claims. Likewise for MSSP agreement periods that begin in 2021, the year 2020 will be considered BY3 and HCC risk scores will be based on diagnoses from 2019 claims. Figure 1 shows the years for various agreement periods.

FIGURE 1: CLAIMS DIAGNOSIS YEARS USED IN RISK ADJUSTMENT

AGREEMENT START YEAR	BENCHMARK YEAR 3 (BY3)	CLAIMS DX YEAR FOR BY3 RISK SCORE
2019	2018	2017
2020	2019	2018
2021	2020	2019

As a result of this staging by year, MSSP organizations with renewals in 2020 and later need to be working this year (2018) and on an ongoing basis to ensure accurate and complete diagnosis coding.

In this issue brief, we explain how BY3 risk scores impact the benchmark calculation for MSSP renewals, present an overview of the prior and new MSSP benchmark calculations, and illustrate how the change can affect an ACO's benchmark under various scenarios.

MSSP overview

MSSP ACOs earn shared savings from CMS when the performance year expenditures for their assigned Medicare fee-for-service (FFS) population are lower than the updated historical benchmark expenditures (their financial benchmark). Furthermore, under downside risk agreements (Tracks 1+, 2, and 3), they may need to share losses with CMS if their performance expenditures are greater than their financial benchmarks. All else being equal, an ACO benefits from having a higher financial benchmark.

The historical benchmark period (the basis for the financial benchmark) spans three base years (BY1, BY2, and BY3) with the third year (BY3) occurring the year prior to the first performance year (PY) of a three-year agreement period (PY1, PY2, and PY3). The aggregate historical benchmark expenditures are updated for changes in the ACO's membership mix by enrollment type, Medicare cost trends, and changes in the ACO's risk scores between BY3 and the performance year. The risk score adjustments are generally capped at 1.000 and therefore ACOs seldom benefit from risk score gains between BY3 and the performance year.

Risk scores are calculated using the CMS-HCC risk adjustment system, the same system CMS uses for Medicare Advantage (MA). CMS-HCC risk adjustment uses the health status of a beneficiary in one year to predict costs in the following year. Diagnosis codes from claims are used to identify serious or chronic illness and a risk score is assigned based on these identified conditions and other demographic details (including age, gender, Medicaid eligibility, and aged/disabled status). As an alternative to

the coding intensity adjustment made in MA, ACO risk scores are normalized to the national ACO-assignable population.

Risk adjustment for first agreements (and pre-2017 renewals)

For ACOs in their first agreement periods, or in an agreement that renewed prior to 2017, CMS uses risk adjustment in two instances within the calculation of the financial benchmark. Each instance uses the change in the normalized risk score rather than the risk score itself.

In the first use of risk adjustment, BY1 and BY2 expenditures are updated to BY3 risk levels as part of the calculation of the three-year weighted historical benchmark. If an ACO's risk score in BY3 is higher relative to BY1 or BY2, then the BY1 and BY2 expenditures are both adjusted upward, increasing the ACO's benchmark. Conversely, a BY3 risk score that is lower than BY1 or BY2 will result in a reduction to the benchmark. There are no caps or other restrictions on this risk adjustment.

In the second use of risk adjustment, the change in risk score between BY3 and the performance year (a gap of between one and three years) is used to update the historical benchmark expenditures before comparison to the performance year. There is a cap on this adjustment that precludes most upward adjustments but allows for full downward adjustments. As a result, an ACO that has a larger portion of higher-risk beneficiaries attributed to its population over time, or that improves the accuracy of diagnosis coding for its ACO members, will not receive an upward adjustment to its benchmark. In contrast, an ACO with a population whose overall risk decreases in the performance years, or does not keep up with the national trend in diagnosis coding during the performance years, will have its benchmark reduced.

Because of the cap, upward adjustments are at most small. CMS compares "continuously assigned" beneficiaries in the performance year to the BY3 "continuously assigned" beneficiaries and caps the risk score increase at 1.00 plus the change in the demographic component of the risk scores. CMS includes any beneficiary for whom the ACO provided any primary care services during the prior year as "continuously assigned," even if that beneficiary did not meet ACO attribution criteria. Such beneficiaries often make up 80% or more of an ACO's assigned population. The remaining beneficiaries are truly new to the ACO and changes in their risk scores between BY3 and the performance year are not capped.

In both instances of risk adjustment, an ACO is only advantaged or disadvantaged based on how its risk score grows relative to the national trend in diagnosis coding (aka, risk adjustment "creep"—approximately 2% per year between 2013 and 2016 as reported in ACO settlement reports). ACOs are not rewarded for accurate and complete diagnosis coding or penalized for a lack thereof.

Figure 2 illustrates an ACO benchmark calculation under three different benchmark year risk score scenarios for an ACO in its first agreement period. While risk score trend impacts the benchmark (Scenario 1 vs. Scenario 2), the absolute value of the risk factors do not impact the benchmark (Scenario 2 vs. Scenario 3).

FIGURE 2: ACO FIRST AGREEMENT

SIMPLIFIED CALCULATION OF BENCHMARK1

Scenario	ACO BY1	ACO BY2	ACO BY3	Region BY3	Benchmark (3)	Benchmark vs. Scen 1
All Scenarios						
ACO PBPY Exp (2)	$10,000	$10,200	$10,404	n/a		
National Trend		2.0%	2.0%	n/a		
Weights	10%	30%	60%	n/a		
Normalized Risk Scores *(Scenarios 2 and 3 increasing 1% per year)*						
Scenario 1	1.000	1.000	1.000	n/a	$10,404	
Scenario 2	0.950	0.960	0.969	n/a	$10,456	100.5%
Scenario 3	1.050	1.061	1.071	n/a	$10,456	100.5%
Conclusion	**Risk score trend has some impact (Scenario 1 vs. 2); Risk score level has no impact (Scenario 2 vs. 3)**					

(1) Actual benchmark calculation is by enrollment type

(2) ACO Per Beneficiary Per Year Expenditures (PBPY), increasing 2% a year

(3) CMS MSSP Specifications versions 5 (2017) and 6 (2018)

Risk adjustment for renewals

Per the CMS ACO list, more than 200 ACOs may renew in 2019 and an additional 160 may renew in 2020. These renewing ACOs will be subject to the regional adjustment.

For renewals in 2017 and later, the regional adjustment is the third instance where risk adjustment is utilized by CMS when developing a financial benchmark. Unlike the first two instances, the regional adjustment relies on the absolute value of the ACO's risk score, specifically the ACO's BY3 risk score.

Under the renewal methodology, CMS continues to calculate historical benchmarks as described above, but then adjusts these benchmarks based on the difference between the ACO's aggregate benchmark expenditures and BY3 regional expenditures, where regional expenditures are risk-adjusted to the ACO's BY3 risk score. The ACO gets an upward adjustment to its benchmark if its BY3 expenditures are less than regional risk-adjusted expenditures and a downward adjustment if its BY3 expenditures are greater than regional risk-adjusted expenditures.

Because the regional adjustment depends on the BY3 population's risk score, accurate and complete diagnosis coding in the year prior to BY3 becomes particularly critical.

ACOs in their first renewal agreements with the regional adjustment receive a benchmark adjustment of 35% of the difference between their BY3 expenditures and the regional risk-adjusted expenditures if their BY3 expenditures are lower. The percentage rises to 70% for second and third renewal agreements. The adjustment penalty for having expenditures higher than regional risk-adjusted expenditures is less, but still significant, ranging from 25% for the first agreement subject to regionalization up to 50% and 70% for second and third agreements, respectively. Overall, the regional adjustment to the benchmark becomes more impactful each renewal period. Figure 3 demonstrates the renewal ACO benchmark calculation for the same three benchmark year risk score scenarios shown in Figure 1 above. The ACO with low risk scores (Scenario 2) is disadvantaged at renewal compared to the ACO with higher risk scores (Scenario 3).

FIGURE 3: ACO SECOND AGREEMENT/FIRST RENEWAL (2017+)

SIMPLIFIED CALCULATION OF BENCHMARK1

Scenario	ACO BY1	ACO BY2	ACO BY3	Region BY3	Benchmark (3)	Benchmark vs. Scen 1, 1st Agree
All Scenarios						
ACO PBPY Exp (2)	$10,000	$10,200	$10,404	$10,400		
Regional Trend		2.0%	2.0%	n/a		
Weights	33%	33%	33%	n/a		
Normalized Risk Scores *(Scenarios 2 and 3 increasing 1% per year)*						
Scenario 1	1.000	1.000	1.000	1.000	$10,403	100.0%
Scenario 2	0.950	0.960	0.969	1.000	$10,401	100.0%
Scenario 3	1.050	1.061	1.071	1.000	$10,729	103.1%
Conclusion	**The ACO with the low risk score is disadvantaged at renewal compared to the ACO with a high risk score (Scenario 2 vs. 3)**					

(1) Actual benchmark calculation is by enrollment type

(2) ACO Per Beneficiary Per Year Expenditures (PBPY), increasing 2% a year

(3) CMS MSSP Specifications versions 5 (2017) and 6 (2018)

Finally, we note that renewals use a risk-adjusted regional trend adjustment, and therefore more accurate and complete diagnosis coding is less advantageous to ACOs that dominate their regions compared to ACOs with lesser dominance, due to the risk factor increase being negated by the ACO's contribution to the regional trend adjustment.

Strategies for comprehensive diagnosis coding

The increased significance of risk adjustment in the calculation of an ACO's renewal benchmarks accentuates the continued need for accurate and complete condition coding by providers.

An ACO can identify potential coding gaps by examining its Claim and Claim Line Feed (CCLF) files. Two claims-based approaches to identify gaps include:

1. Analysis of Part D prescription drug usage to identify indicated HCC conditions that are not coded in Part A or B medical claims.
2. Analysis of chronic conditions that are not persistently coded in the Part A and B medical claims from one year to the next.

Milliman has tools to assist with identifying coding gaps.

Conclusion

MSSP ACOs anticipating renewals in 2020 need to be working this year (2018) to ensure accurate and complete coding. Similarly, 2019 is the critical year for 2021 renewals. ACOs will then want to examine coding insufficiencies and implement corrective strategies to avoid being disadvantaged for their next renewal.

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