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DCE & ACO Toolkit for Taking Risk Webinar

November 13, 2020

Webinar Overview

01 Intro to Episource

02 Intro to ACOs

03 Intro to DCEs

04 Overview of DCE and ACO Challenges

05 Introducing the DCE/ACO Toolkit

06 Q&A

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Intro to Episource

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Episource is a technology-driven healthcare services firm building elegantly simple and innovative risk adjustment solutions.

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Intro to ACOs

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How ACOs Improve Patient Care and Reduce Cost

Key to CMS' push towards value-based care, ACOs have been improving quality of care and reducing costs since the program began in 2012.

Improving Care

- In the first three years of the program, ACOs improved their performance on 82% of quality measures.
- A 2017 report found that 98% of ACOs that were at least three years old either met or exceeded 81% of quality measures when compared to the average FFS program.

Reducing Cost

- Between 2013 and 2017, ACOs saved Medicare $3.53 billion.
- In 2018, ACOs saved Medicare $739 million after accounting for shared savings ($1.7 billion before shared savings).

How Benchmarks are Calculated

Each ACO's benchmark is unique and predetermined by multiple factors, including historical expenditures, regional factors, and patient population.

- Historical baseline expenditure is calculated: most recent year = 60 percent weighted; second most recent year = 30 percent weighted; least recent year = 10 percent weighted.
- The historical baseline is combined with the regional cost adjustment, which is capped at a 5% increase/decrease of expenditures.
- Trends and risk adjustment adjust the ACO benchmark at the end of the year.

Agreement Period ACO is Subject to Regional FFS Adjustment	Weight Used to Calculate Regional FFS Adjustment For ACOs Lower Spending Compared to Region	Weight Used to Calculate Regional FFS Adjustment For ACOs Higher Spending Compared to Region
First	35%	15%
Second	50%	25%
Third	50%	35%
Fourth and subsequent	50%	50%

ACO Risk Adjustment

Accurate RAF allows ACOs to properly manage patients and calculate benchmarks.

Pathways to Success

- CMS has a 3% risk adjustment cap on benchmark adjustment.
  - CMS will recalculate an ACOs average RAF annually.
  - CMS predicts that about 30% of ACOs will reach this cap every year.
- Accurate risk adjustment can determine the savings or loss shared with Medicare at the end of every performance year.

	NO BY3 TO PY1 RISK SCORE CHANGE		NEGATIVE BY3 TO PY1 RISK SCORE CHANGE	
	No coding accuracy improvement	With coding accuracy improvement	No coding accuracy improvement	With coding accuracy improvement
Risk Score, BY3	1.200	1.200	1.200	1.200
Risk Score, PY1	1.200	1.200	1.170	1.170
Risk Score, PY2	1.200	1.300	1.170	1.270
Change in Risk Score, BY3 to PY2	0.0%	8.3%	-2.5%	5.8%
Allowable Change in Risk Score, BY3 to PY2	0.0%	3.0%	-2.5%	3.0%
Value of Coding Accuracy Efforts		**3.0%**		**5.5%**

Source: Milliman Healthcare Analytics Blog

ACO Shared Savings Example

Scenario

- An ACO is on track D and was given an annual benchmark of $15 million dollars.
- It hits an average of 80% on its final quality score.
- While the minimum savings rate for that ACO is 2%, the ACO saved 4% ($600,000).
- The maximum savings rate for an ACO in track D is 50%.

Final Sharing Rate = Final Quality Score x Max Sharing Rate

Final Sharing Rate = 80% x 50% = 40%

40% x $600,000 = $240,000.

Example ACOs and Results

Optimus Healthcare Partners, LLC

- This ACO was on the Basic Track B (one-sided).
- Reported 3.9% in overall savings which equates to over $3.1 million in total savings for performance year 2019.

Palm Beach ACO

- This ACO was on the Enhanced Track (two-sided).
- Reported 5.5% in overall savings which equates to over $28 million in total savings for performance year 2019.

Advocate Physician Partners Accountable Care, Inc.

- This ACO was on the Basic Track E (two-sided).
- Reported 2.47% in overall savings which equates to over $16 million in total savings for performance year 2019.

Intro to DCEs

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DCEs: The Next Evolution of Risk-Sharing

- A Direct Contracting Entity (DCE) refers to a group of organizations that support a shift towards value-based care by sharing in savings and risk with Medicare.
- Direct Contracting models have been built from ACO models, including the Next Generation ACO Model and MSSP.
- The first optional implementation period will begin in October 2020; the first performance year will begin April 2021.
- Direct Contracting Entities are similar to ACOs in that they both support value-based and coordinated care. They differ from ACOs in terms of the requirements and levels of risk available.

	Level of Risk	Minimum # of Beneficiaries Required	Impact of Quality	Voluntary Alignment	Saving/ Loss Model	Payments	Risk Adjustment
DCE	50-100%	250-5,000 Beneficiaries (Glide Path)	Quality withholding 5% (Glide Path)	Yes; Is not considered in RA	1st dollar savings and losses; Risk Corridor	Prospective	Up to 3% for Standard and New Entrant; No cap on High Needs Pop.
ACO	Up to 75%	5,000 beneficiaries	Adjusts savings/loss	Yes	Minimum Savings Rate/ Minimum Loss Rate	Retrospective	Up to 3%

Types of DCEs

Standard DCEs

- Composed of organizations with experience serving Medicare beneficiaries, including:
  - Dual eligible members
  - Organizations with experience in another ACO program such as MSSP
  - Or new organizations consisting of FFS providers and suppliers
- Required to have a minimum of 5,000 beneficiaries prior to the first performance year.

New Entrant DCEs

- Composed of organizations with less than 50% of providers with Medicare FFS experience.
- Required to have a minimum of 1,000 beneficiaries prior to the first performance year.

High Needs Population DCEs

- Composed of organizations that serve Medicare FFS beneficiaries with high risk and complex needs, such as dual eligible Medicare beneficiaries.
- Requires a minimum of 250 beneficiaries prior to its first performance year. This minimum requirement increases every performance year.
- Beneficiaries must have: An HCC score greater than 3; or an HCC greater than 2 combined with 2 or more hospitalizations in the last year.

DCE Models

Professional

- 50% of all savings and losses are split between CMS and the DCE.
- CMS provides a monthly Primary Care Capitation (capitated and risk adjusted).

Global

- The DCE is 100% liable for all savings and losses.
- CMS offers monthly Total Care Capitation or Primary Care Capitation (capitated and risk adjusted).
- A discount of 2% is applied for PY 1 and 2 and increases by 1% each year (decreasing benchmark).
- Quality withhold is 5% and may be earned back by meeting performance requirements.
  - This is an exception for PY 1 and 2 (4% earned for reporting, 1% earned for performance.)

DCE Benchmarking

DCE benchmarking is determined by many factors, such as historical spending, patient population, and regional expenditures.

- The historical baseline is determined the same way as ACOs.
- The historical benchmark is blended with regional expenditure trends that are adjusted to reflect anticipated changes in Geographic Adjustment Factors.
- The regional adjustment cap is set at a 5% increase or 2% decrease of expenditures.

Phase-In Schedule for Regional Expenditures in Financial Benchmark

PY	Baseline Experience Weight	Regional Expenditures
PY1	65%	35%
PY2	65%	35%
PY3	60%	40%
PY4	55%	45%
PY5	50%	50%

How DCEs Reduce Cost

Benchmarks

- DCEs benchmarks are paid in the form of a monthly capitation rate.
- At the end of the year, the savings or loss is split with Medicare, depending on the program, risk corridor, and quality measure.

Model	Capitation	Description
Professional	Primary Care Capitation	A capitated, risk-adjusted monthly payment for enhanced primary care services
Global	Primary Care or Total Care Capitation	Primary Care (stated above) or Total Care, a capitated, risk-adjusted monthly payment for all services provide by DC participants and preferred providers with whom the DCE has an agreement

Source: CMS

Risk Corridors

- Risk corridors are factored into gross savings and losses as a percentage of the benchmark.
- This varies by model and essentially replaces a maximum savings or loss rate.
- The higher the savings or loss, the greater the shared portion of risk or savings assumed by CMS.

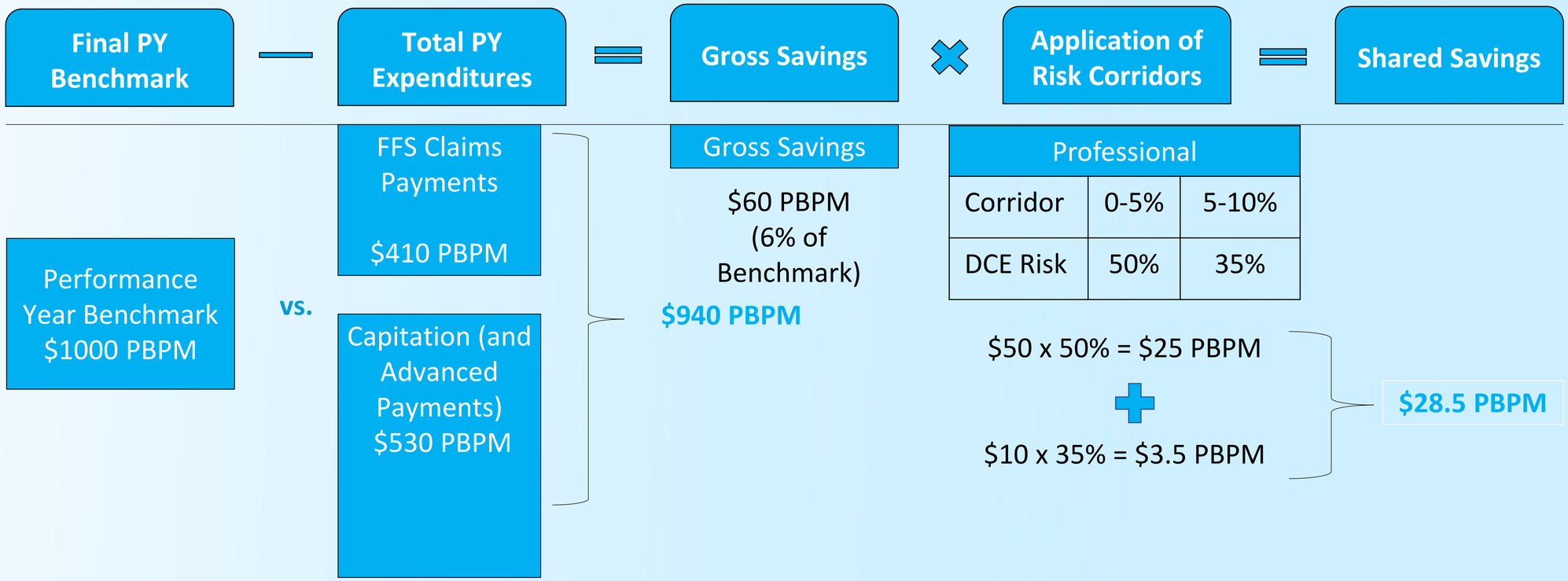
Professional Risk Corridor				
Gross Savings/ Losses	<5%	5-10%	10-15%	>15%
Savings/ Losses Rate	50%	35%	15%	5%

Source: CMS

Global Risk Corridor				
Gross Savings/ Losses	<25%	25-35%	35-50%	>50%
Savings/ Losses Rate	100%	50%	25%	10%

Source: CMS

DCE Example



Source: CMS

Overview of DCE and ACO Challenges

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DCE/ACO Challenges

Infrastructure Requirements

- **Complexity in data structure:** With 10+ separate files, CCLF file format is complicated. A robust, easy-to-digest data model is required to interpret data and incorporate various use cases and frequent changes in data format.
- **High cost of internal resources:** The infrastructure and analytic resources needed to handle, analyze, and store complex beneficiary, provider, and claims data can be costly to employ internally.

Leveraging Data

- **Data attribution and high patient churn:** Paired with lagging data from CMS' annual attribution list, high patient churn makes it difficult to know which beneficiaries are actually part of an ACO or DCE.
- **Challenges managing RA and benchmarking:** Interpreting claims data into HCCs and then RAF score is essential to understanding payment and cost structure but managing an RA calculation engine can be difficult.

Policy Challenges

- **Frequent changes in CMS guidelines:** CMS' policy guidelines can change from year to year, making them difficult to keep and comply with.

DCE/ACO Cost Management Checklist

To create a solid foundation to manage cost and ensure high-quality care, ACOs and DCEs will need to ask themselves the following questions:

- ✓ How up-to-date is my attribution List? Do I know who my beneficiaries are?
- ✓ Who are my high-needs, high-cost beneficiaries?
- ✓ What is my inpatient/outpatient/professional cost? What are the drivers of these costs?
- ✓ Where are patients utilizing inpatient/outpatient services outside of my ACO/DCE providers and preferred providers (network leakage)?
- ✓ What is my current risk score per member?
- ✓ What risk gaps do I need to close? How do I close them?
- ✓ Where do I stand against my benchmark?

Introducing the DCE/ACO Toolkit

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1. Know Who Your Patients Are

- Understanding patient attribution is one of the key factors of success for ACOs and DCEs.
- At Episource, we update our attribution lists monthly, based on the most recent data set, reflecting up-to-date patient-provider relations.

Monthly Attribution List

Member MBI	Member Name	Provider ID	Provider Name	Claim Amount	Step
1A898909303	John Doe	259284411	Jane Doe	90.37	1
1B717168221	John Doe	629689243	Jane Doe	1110.11	1
1C736402127	John Doe	759806971	Jane Doe	143.15	1
1A313765478	John Doe	471667586	Jane Doe	72.31	1
1B393460624	John Doe	683395468	Jane Doe	106.08	1
1C820439433	John Doe	323610595	Jane Doe	402.57	1
1A186169504	John Doe	126054736	Jane Doe	213.09	1
1B311901901	John Doe	675874616	Jane Doe	106.08	1
1C384453653	John Doe	263113328	Jane Doe	219.35	1
1A823449631	John Doe	387964907	Jane Doe	894.47	1
1B659670319	John Doe	673879505	Jane Doe	391.06	1
1C716838372	John Doe	483947493	Jane Doe	406.51	1
1A621695244	John Doe	475513009	Jane Doe	322.31	1
1B280624749	John Doe	864609084	Jane Doe	218.53	1
1C846139061	John Doe	387009247	Jane Doe	206.03	1
1A635428238	John Doe	412068140	Jane Doe	207.56	1
1B208203657	John Doe	764474423	Jane Doe	381.52	1

Attribution List

- On March 2020, attribution list is re-generated as CMS list is already outdated by a quarter.
- In the above chart, 81% of beneficiaries in our list are included in the CMS 2020 Prospective List.
- Between the CMS 2019 and 2020 List, only 71.6% of beneficiaries stayed in the same ACO (churn ratio of 28.4%).
- The difference can result from 1) lack of entire providers list, 2) missing claims or 3) voluntary assignment.

Example: Episource Attribution List as of Mar 20 vs. CMS list

	Episource List	CMS 2020 List	CMS 2019 List
Type	Retrospective	Prospective	Prospective
Generated as of	Mar 20	Dec 19	Nov 18
Claims-Based Assignment Window	Jan 19 – Dec 19	Oct 18 – Sep 19	Oct 17 – Sep 18
Total Population [A]	71K	78K	82K
Found in CMS 2020 List [B]	57K		59K
% Found in CMS 2020 List [B/A]	80.9%		71.6%
Found in CMS 2019 List [C]	49K	59K	
% Found in CMS 2019 List [C/A]	68.6%	75.4%	

Attribution List Use Cases

- Forecast upcoming prospective assignment before year end.
- Identify beneficiaries assigned to specific providers.
- Micro-focus beneficiaries assigned to providers at certain facilities or region.

Translate CCLF into Digestible and Timely Solutions

CCLF Data

- Using CCLF data, it is possible to understand what your patients are doing—and which patients are high-need, high-cost and therefore need to be managed more carefully.
- However, with 10+ different files, CCLF data is complex and hard to navigate.
- It's important to find a solution that can help you translate this information into timely and actionable strategies to target your members.

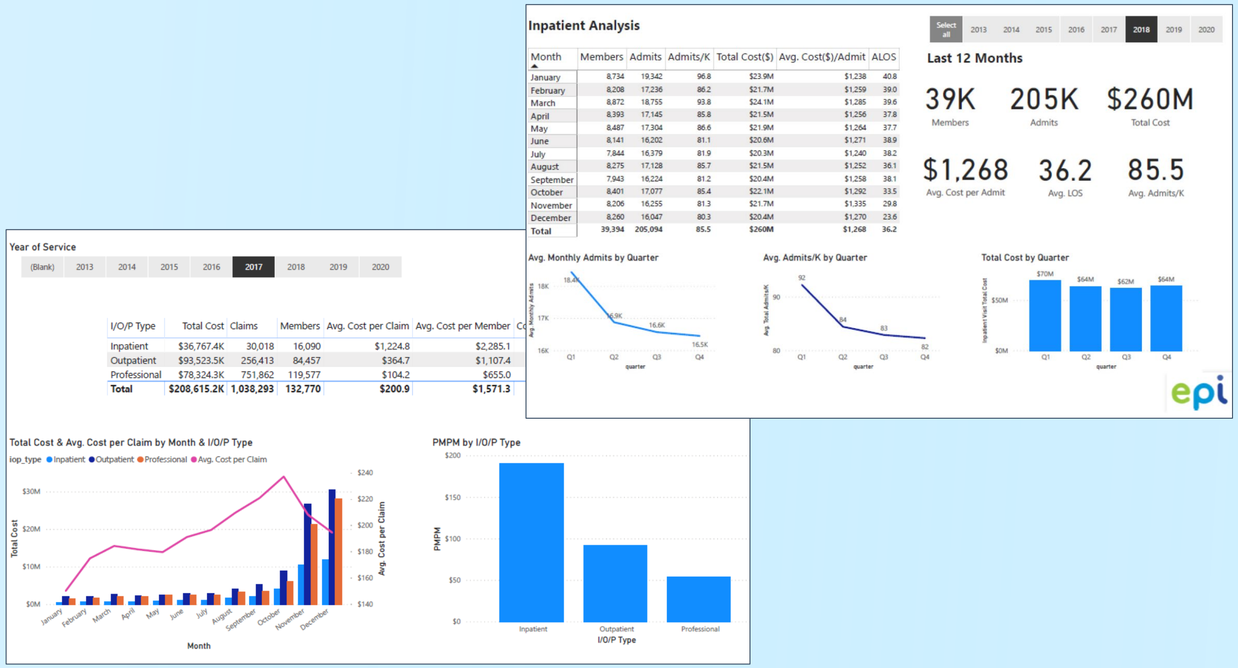
CCLF Files		Number of fields
CCLF1	Part A Claims Header File	37
CCLF2	Part A Claims Revenue Center Detail File	22
CCLF3	Part A Procedure Code File	12
CCLF4	Part A Diagnosis Code File	13
CCLF5	Part B Physicians File	49
CCLF6	Part B DME File	25
CCLF7	Part D File	21
CCLF8	Beneficiary Demographics File	31
CCLF9	Beneficiary XREF File	6
CCLFA	Part A Claims Benefit Enhancement and Demonstration Code File	17
CCLFB	Part B Claims Benefit Enhancement and Demonstration Code File	17

2. Know Who to Target and How

In order to make sure patients who are attributed to you stay attributed to you, and that you maintain a good mix of higher/lower comorbidities, it's important to understand which patients you need to target—and how to target them.

This can be done by analyzing:

- Claim type (inpatient/outpatient/professional)
- Provider/provider specialty
- Recently admitted/discharged patients
- Rx claims
- Utilization (inpatient/ER) analysis
- High-need, high-cost patients
- Beneficiary utilization to non-preferred providers (leakage)



3. Interoperability: ACOs and DCEs

Being able to connect to a data broker such as Carequality (data broker for Episource) or Commonwell (a participant of the Carequality network) will be critical to help ACOs and DCEs:

- Receive admit, transfer, and discharge data, (ADT) especially from providers who are not preferred (Manage Quality Measure ACO-08 as an example).
- Handle discharge transition management.
- Get clinical data, such as labs and Rx chart notes in advance of CCLF delivery (CMS claims data has some lag).
- Share data with other providers in the ACO/DCE who are participating or preferred.
- Determine leakage – utilization out of your preferred providers.
- Perform medication reconciliation
- Risk score capture immediately after service.
- Close quality gaps faster.
- Predict attribution based on primary care services out of ACO/DCE.
- Provider data blocking ONC rule begins enforcement in November 2020.

4. Benchmarking: The Importance of RA for ACOs

- Risk adjustment is only maxed out by 30% of ACOs annually**. There is a 3% upward only cap.**
- In the example below, only the aged/dual eligible cohort of beneficiaries are getting the upward adjustment to 1.030.
- The BY3 is the first step in the risk adjustment calculation.
- For BY1 and BY2, CMS determines the risk ratios of the ACO's BY3 risk score divided by the ACO's risk score for each benchmark year (BY1 and BY2) for each Medicare enrollment type.
- For example, the risk ratio applied to an ACO's BY1 aged/dual eligible expenditures is equal to the ACO's BY3 aged/dual eligible risk score divided by the ACO's BY1 aged/dual eligible risk score."

Table 4. *Hypothetical data on application of positive 3 percent cap on performance year to BY3 risk ratio*

MEDICARE ENROLLMENT TYPE	BY3 RENORMALIZED CMS-HCC RISK SCORE	PY RENORMALIZED CMS-HCC RISK SCORE	RISK RATIO BEFORE APPLYING CAP	FINAL RISK RATIO
ESRD	1.031	1.054	1.022	1.022
Disabled	1.123	1.074	0.956	0.956
Aged/dual eligible	0.987	1.046	1.060	1.030
Aged/non-dual eligible	1.025	1.001	0.977	0.977

Source: CMS

Benchmarking: RA Programs ACOs Should Focus On

- Capturing the correct HCCs for BY3 in the previous example will help lift BY1 and BY2 as well—unless it is already > 1.030.
- The key take-away: Getting your BY3 RAF up with a retro program and your PY1 with a prospective or concurrent review program will help you to maximize RAF opportunity and identify beneficiaries that are not being well documented.
  - This can make the difference between having savings and not.
- You should also use this opportunity to:
  - Identify beneficiaries who have lost their dual status and help them enroll.
  - Identify beneficiaries with Z codes in retro coding and prospective outreach (Z codes identify social needs)—again an opportunity to focus on beneficiaries with needs at the point of care.

BENEFICIARY TYPE	BY1 RENORMALIZED CMS-HCC RISK SCORE	BY3 RENORMALIZED CMS-HCC RISK SCORE	RISK RATIO BY3/PY (ONLY USED if GREATER THAN 1.03)	CAPPED RISK RATIO USED
Aged/dual eligible	1.05	1.010	0.958	1.019

Example: RA Programs Can Boost ACO Shared Savings

- This example uses a common benchmark and expense from the 2019 performance report.
- If 3% RAF lift cap is fully captured and benchmark is increased by 3%,
  -> additional Shared Savings up to $8.6 million (≈ $40 pbpm)

ACO A	SSP – Enhanced Track	Minimum Savings Rate: 2.5%
	18,000 Beneficiaries	Final Sharing Rate: 69% [75% x Quality Score (0.92)]

	Payment Year	3% increased benchmark, same expense
Total Benchmark [A]	$ 251 M	$ 258.5 M (3% ↑)
Total Expense [B]	$ 246 M	$ 246 M
Savings [C = A – B]	$ 5 M	$ 12.5 M
Savings Rate [C / A]	2.0%	4.8%
Minimum Savings Rate (2.5%) exceeded?	NO	YES
Shared Savings [C x Final Sharing Rate(49%)]	-	$ 8.6 M
Additional Shared Savings	**-**	**$ 8.6 M**

Benchmarking: RA for Standard DCEs

Table 4. Reference Population for Applying the Symmetric 3% Cap

Performance Year	Reference Year
IP–2020	NA
PY2–2022	2020
PY3–2023	2021[a]
PY4–2024	2022
PY5–2025	2023
PY6–2026	2024

- Both coding intensity factor (CIF) and normalization will be applied to the risk scores; normalization will come from the pool of all DCE cohorts (a subset of FFS) different than ACO where it comes from all FFS. The CIF will be driven entirely for two years from 2019RY because of COVID in 2020.
- The cap is 3% upside or **downside**—different than ACO where it's only upside.
- Once the cap ratio is applied the CIF is applied and this can further dial down the RAF in either direction. (Means 3% upside can never be achieved, but DCE participants can still focus on good coding and RAF capture which has value)

Source https://innovation.cms.gov/media/document/dc-riskadjustment

RA for Standard DCEs — Key Takeaways

- 2020 is being used as a reference year for 2022PY that makes it very important and DCEs need to benchmark this right away and review HCCs. (CIF is 2019 for two years)
- Focus should be on RAF optimization for 2021 through concurrent and prospective reviews (provider training, in home assessments, TH assessments, concurrent coding reviews)
- Retro program for PY2022 reviewing Reference Year 2020 DOS
- DCE program is very clear that they will audit charts to ensure it aligns with RA (TBD on the process from CMS)

BENEFICIARY TYPE	2019 RY NORMALIZED RAF	2021 PY NORMALIZED RAF	RISK RATIO RF1/PY2021	CAPPED RISK RATIO USED	CIF	APPLIED RISK SCORE PY2021
Aged/non-dual	0.987	1.030	1.044	1.030	1.010	1.020
Aged/dual eligible	1.050	1.010	0.958	1.019	1.020	1.000

Example: RA Programs Can Boost DCE Shared Savings

- This example uses a common benchmark and expense from the 2019 performance report.
- If 3% RAF lift cap is fully captured and benchmark is increased by 3%,
  -> additional Shared Savings up to $6 million (≈ $28 pbpm)

DCE A	Global DCE Model	18,000 Beneficiaries

	Payment Year	3% increased benchmark, same expense
Total Benchmark [A]	$ 251 M	$ 257 M (2.4% ↑) + 3% RAF lift x 0.8 CIF is assumed
Total Expense [B]	$ 246 M	$ 246 M
Savings [C = A – B]	$ 5 M	$ 11 M
Savings Rate [C / A]	2.0%	4.3%
Shared Savings [<5% Risk Corridor; 100% Savings Rate]	$ 5M	$ 11 M
Additional Shared Savings	**-**	**$ 6 M**

Benchmarking: RA for High-Needs Population

- Risk Adjustment for HNP DCE is similar to Standard: 2020 will be used as the Reference Year for 2022
    - Both coding intensity factor (CIF) and normalization will be applied to the Risk scores, normalization will come from the pool of all DCE cohorts (a subset of FFS) different than ACO where it comes from all FFS.
    - Concurrent new CMMI developed model (far more predictive of expense).
    - **No RA cap** because they are high needs.
- Once the risk ratio is applied the CIF is applied and this can further dial down the RAF in either direction. (Source: CMS)

RA for High-Needs Population — Key Takeaways

- Since 2020 is being used as a reference year that makes it very important and DCEs need to benchmark this right away and review HCCs.
- Focus should be on RAF optimization for 2021 through concurrent and prospective reviews (provider training, in home assessments, TH assessments, concurrent coding reviews).
- Retro programs for RY2020 and additional advanced coding audits.
- The DCE program is very clear that they will audit charts to ensure it aligns with RA (TBD on the process from CMS).

DCE/ACO Toolkit

Risk adjustment and quality platforms capable of analytics and services/workflow solutions to identify and close gaps in care while driving RAF lift.

- Member outreach, provider education, gap closure program, concurrent coding

BI Tool allowing you to navigate and drill down into your data, run focused analysis, and mine additional insights.

Data Storage to freely access, search, and download data with our secured, easy-to-use data storage lease.

Interoperability platform to get your data loaded far earlier than the CCLF, allowing you to connect your network and manage high-need, high-cost cost patients faster and more easily.

Benchmarking tool to help you identify your current and ongoing claims expense to your benchmark.

Q&A

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Keep in Touch!

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