Provider Level Data Analytics that Drive Key Performance Indicators for Direct Contracting Entities

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The Global and Professional Direct Contracting (GPDC) model is the Center for Medicare and Medicaid Innovation (CMMI)'s recent model for value-based care in the Medicare market. Direct Contracting Entities (DCEs) often partner with several providers or provider groups in operating the GPDC model. This whitepaper explains the needs for DCEs to track performance at the provider levels and explores the data analytics needed to enable provider level performance reporting and management.

Background

The GPDC model was introduced by CMMI in early 2019. It leverages lessons learned from other CMMI value-based programs, such as the Medicare Shared Savings Program (MSSP) for Accountable Care Organizations (ACO), the Next Generation ACO model and the Pioneer ACO model. With building blocks from previous programs,ss GPDC furthers provider involvement by allowing participants to take on more financial risk and including additional flexibilities for the entities. GPDC is the Center for Medicare and Medicaid Services (CMS)'s latest initiative in value-based payment arrangements and is set for testing over a six-year period (2021 – 2026).

In 2022, the GPDC Model will be operating in its second Performance Year (PY2022)[1]. For Direct Contracting Entities (DCEs) that have been operating since the implementation period (starting October 1, 2020) or the first performance period (starting April 1, 2021), early performance results from their first performance year are evolving.

Throughout each performance year, DCEs receive a wealth of information from CMS including aligned membership, financial reports, claim level detail and quality information. Among the various data elements and reports provided, an important financial report is the quarterly benchmark report (QBR) which provides the key components of the DCE's annual benchmark as well as estimated financial settlement as of the reporting period.

The CMS quarterly benchmark report contains key performance metrics at the DCE level. While this report provides DCEs pertinent, financial information to the overall entity, we frequently hear the need of tracking and reporting of financial components at a more granular level. For example, reporting at the provider group level is a common "measuring unit" for a DCE. Physicians within a group or practice commonly perform under shared strategies and operations, and sometimes similar patient profiles. A similar report to the DCE benchmark report, but provided at the provider group level, would provide

[1] For organizations that deferred their start date to January 1, 2022, it will be their first Performance Year.

significantly more actionable data for the DCEs to identify drivers of success and areas of focus to direct its operational resources for performance improvement amongst its provider groups to help identify those performing poorly and those performing more effectively.

In this white paper, we discuss provider group level data analytics that can provide additional insights to the DCE's overall financial performance. When developed and tracked at a layer deeper, these metrics show the contribution of individual provider groups and identify improvement opportunities. We explore provider level data analytics in the following three areas: benchmark development, medical expenditures and settlement surplus/loss outcomes.

Case Study

To demonstrate the potential problem with tracking DCE financial performance solely at the aggregate level, we will use the following hypothetical example. All numbers are for illustrative purposes only.

For purposes of this hypothetical example, DCE "X" has the following parameters:

- Contains three participant provider groups driving alignment
- PY2021 was their first Performance Year

Table 1 below shows a simplified summary of DCE X's financial performance in 2021, with key data entries taken out of the DCE X's financial settlement tab of the benchmark report.

Table 1: Sample 2021 Financial Performance

	DCE
Regional Rate	$1,000
Baseline Adjustment	0.990
Adjusted Regional Rate	$990
Performance Year Risk Score	1.09
Benchmark Before Discount or Quality Withhold	$1,079
Total Cost of Care	$969
Gross Savings / Loss	$110

In this example, DCE X's management is developing strategies to be deployed in 2022 to drive more favorable performance. With the partnership amongst the three participant provider groups, DCE X would like to identify different areas of focus for each group according to their individual strengths and weaknesses. To effectively identify each group's strengths and weaknesses, the DCE's management needs a breakdown of the provider group's key metrics. The following summary is prepared based on available data provided by CMS.

Table 2: Sample Initial 2021 Provider Level Financial Performance

	Provider Group A	Provider Group B	Provider Group C	DCE
Member Months	30%	60%	10%	**100%**
Regional Rate	NA	NA	NA	**$1,000**
Baseline Adjustment	NA	NA	NA	**0.990**
Adjusted Regional Rate	NA	NA	NA	**$990**
Performance Year Risk Score	1.050	1.100	1.150	**1.090**
Benchmark Before Discount or Quality Withhold	$1,040	$1,089	$1,139	**$1,079**
Total Cost of Care	$948	$968	$1,038	**$969**
Gross Savings / Loss	$92	$121	$100	**$110**

As seen in Table 2 above, the provider group level analytics start to shed some light on each individual group's contribution to the overall financial performance of the DCE. As part of the GPDC data sharing, CMS provides the medical expenditures and risk scores at the beneficiary level. Such information is able to be rolled up to the provider group level based on aligned members. In later sections within this paper we will discuss considerations and adjustments necessary for rolling up medical expenditures and risk scores.

On the benchmark side, the methodology for determining the DCE benchmark is a convoluted myriad of steps that involves a look-back period going back multiple years to determine historical performance of the DCE's participant providers. The benchmark methodology is further complicated given that the data shared by CMS does not allow for the DCEs to capture the contribution of individual providers or provider group's to the overall benchmark. In the simple example in Table 2 above, we used the DCE-level benchmark parameters to allocate the DCE benchmark to the provider group level. From Table 2, one may conclude that Provider Group B is outperforming the other groups and Provider Groups A and C lag behind the DCE overall performance.

Suppose we had access to the same financial reporting at the provider group level as is provided at the overall DCE level. With this more detailed financial data, we repeat the above analysis, but with provider group-level benchmarks calculated with specific regional rate baseline adjustments based on their own attributed patients in the base years.

Table 3: Sample More Detailed 2021 Provider Level Financial Performance

	Provider Group A	Provider Group B	Provider Group C	DCE
MLR on the surface	30%	60%	10%	**100%**
Regional Rate	$1,000	$1,000	$1,000	**$1,000**
Baseline Adjustment	0.950	1.000	1.050	**0.990**
Adjusted Regional Rate	$950	$1,000	$1,050	**$990**
Performance Year Risk Score	1.050	1.100	1.150	**1.090**
Benchmark Before Discount or Quality Withhold	998	1100	1208	**$1,080**
Total Cost of Care	$948	$968	$1,038	**$969**
Gross Savings / Loss	$50	$132	$169	**$111**
	Provider Group A	Provider Group B	Provider Group C	**DCE**
MLR on the surface	30%	60%	10%	**100%**
Regional Rate	$1,000	$1,000	$1,000	**$1,000**
Baseline Adjustment	95%	100%	105%	**0.990**
Adjusted Regional Rate	$950	$1,000	$1,050	**$990**
Performance Year Risk Score	1.050	1.100	1.150	**1.090**
Benchmark Before Discount or Quality Withhold	$998	$1,100	$1,208	**$1,080**
Total Cost of Care	$948	$968	$1,038	**$969**
Gross Savings / Loss	$50	$132	$169	**$111**

It becomes clear that while Provider Group B remains a solid contributor to overall savings, provider Group C's performance is no longer below the DCE's overall performance, but rather emerges as a performance leader. In contrast, Provider Group A's performance continues to decline in this view suggesting Provider Group A requires the most urgent need for improvement.

The remaining sections of this white paper will address in more detail the key components of provider group level data analytics within the following three categories: benchmark, medical expenditures and gross savings / loss.

Key considerations and limitations will also be presented.

Benchmark Development

The DCE benchmark is the amount the DCE's performance year expenditures are compared against in order to determine the DCE's savings or losses. The benchmark is calculated from a performance year ratebook developed by CMS and then further adjusted to reflect the regional and member demographic specific make-up of the DCE. The DCE benchmarking methodology is described in full in a CMS released document - Global and Professional Direct Contracting Model Financial Operating Guide: Overview[2].

The DCE's participant providers and their aligned members' historical medical expenditures, over a large time span (i.e. as far back as Calendar Year 2014), contribute significantly toward the DCE's performance year benchmark. Simply speaking, performance year savings or losses are generated partially by comparing the current costs with the providers' historical cost levels, and partially by comparing against the DCE's regional rates as found in the ratebook released by CMS for each performance year.

Currently, CMS only provides the benchmark at the DCE level separated out for Aged & Disabled vs. ESRD beneficiaries. Being able to break down the DCE benchmark to the provider group level can help provide more insights and achieve several advantages including:

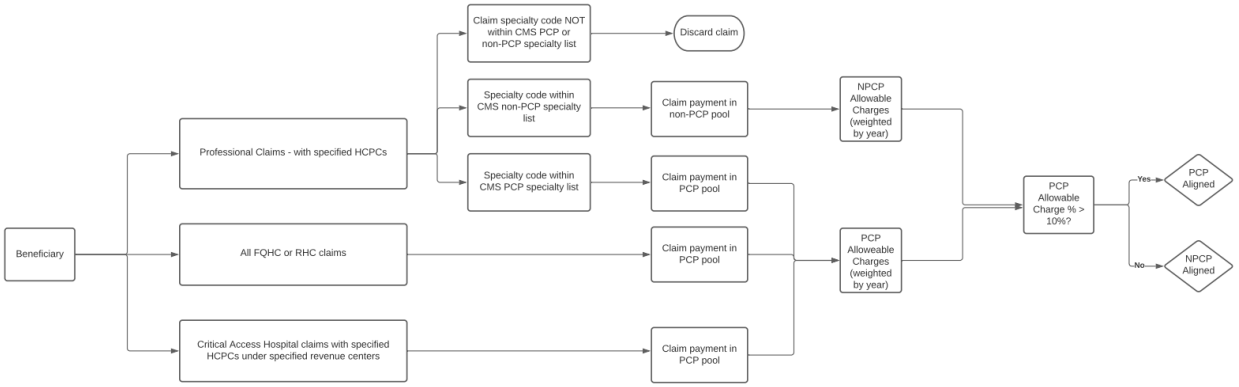
- Allowing for more accurate reporting of the provider group's performance by capturing the provider group's historical contribution to the DCE benchmark
- Helping with financial projection at a more granular level by knowing the provider group's historical performance
- Further providing insights for the DCE management as they determine future expansion strategies and evaluate new provider groups

In order to obtain the benchmark at the provider group level, one key component necessary is the regional rate baseline adjustment factor for claims-aligned beneficiaries. The regional rate baseline adjustment is a factor that's applied to the DCE's regional rate, to account for the claims-aligned population portion of the benchmark. This factor is derived based on the DCE's participant provider list and the claim payments for their claims-aligned beneficiaries during the base years (CY 2017 – 2019). The claims-aligned beneficiaries for the base years are determined using the same alignment algorithms as the performance years, which requires a two-year look-back period starting as early as July 2014.

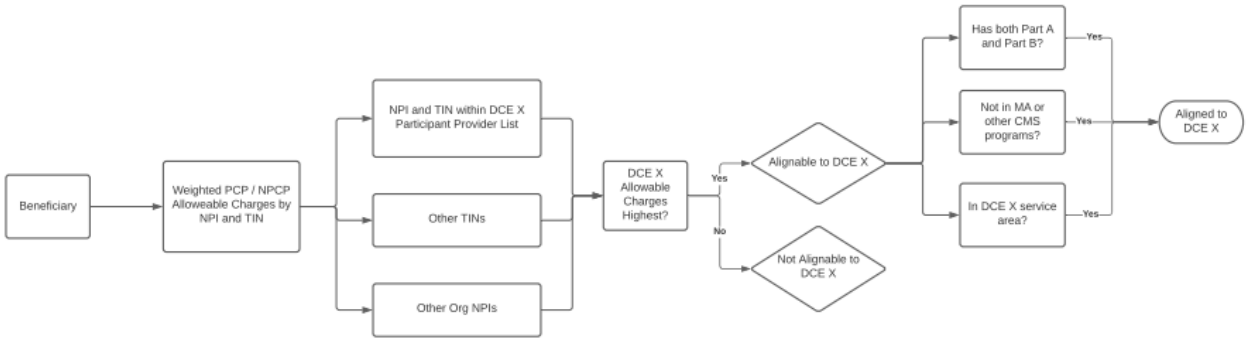
[2] https://innovation.cms.gov/media/document/gpdc-py2022-fin-op-guide-ovw

The following flow charts illustrate our understanding of the CMS alignment process of beneficiaries to a DCE.

Step 1: Determining the Alignment Track

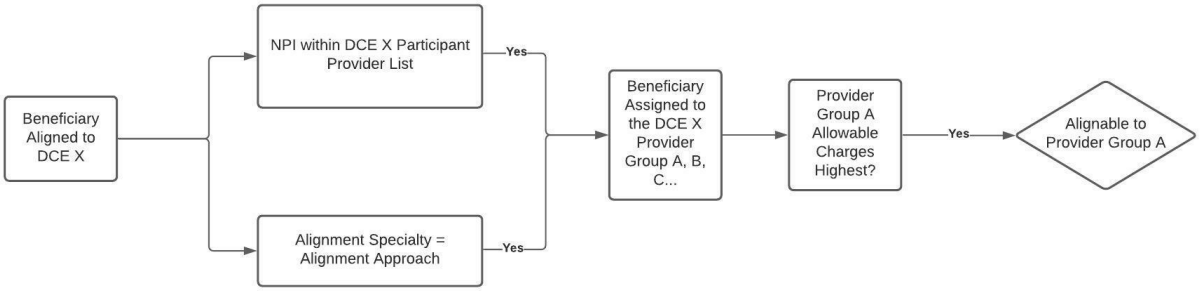


Step 2: Determining DCE Alignment



If the provider and beneficiary data is available, the DCE can take a step further and attribute each aligned beneficiary to a provider group. Similar logic could be used by comparing the allowable charges for PQEM services among the beneficiary's provider groups. The beneficiary can be aligned to the provider or provider group with the plurality of PQEM services (determined by the highest allowable charge).

Step 3: Determining Provider Group Alignment



Once the provider group level alignment is available for all three base years, claims payment and risk score data can be obtained for aligned beneficiaries. These data elements will enable the DCE to

calculate all parameters and obtain the benchmark at the provider group level in a similar manner as determining the DCE benchmark.

The base year claims and risk score data analytics for provider groups can also be used for evaluating prospective participant providers as the DCE expands.

Decomposing the DCE benchmark to the provider group level as described above requires access to the Medicare research identifiable data (RIF) with Medicare enrollment and claims over a number of years.

Medical Expenditures

Fee For Service Expenditures

Above we have discussed the methodology for developing the claims target (DCE benchmark) within the Direct Contracting program at the provider group level. The second piece found within the financial settlement that'll drive shared savings or losses is the medical expenses. These expenses include both the Fee For Service (FFS) payments made by CMS and the at risk part of the capitation the DCE will receive each month to pay for services covered under the capitation.

Unlike the DCE benchmark, which is provided by CMS at the DCE aggregate level, main components of the medical expenditures are provided at the member or provider level. This enables the DCEs to conveniently develop provider group-level medical expenditures. However, there are nuances related to the medical expenditures and we will address them below.

The FFS claim line data is provided to DCEs via the CCLF (Claim and Claim Line Feed) data. This is a standardized data feed from CMS containing all FFS professional, institutional, and prescription drug program services rendered to aligned beneficiaries during the prior month.

While the CCLF claims detail will provide each DCE with effective and actionable data in order to estimate the FFS expenditures at the provider group level, it's important to understand the following expenditures are excluded from these feeds:

1) Members who have opted-out of sharing their claim line detail

2) Substance Abuse claims

Both of these exclusions will lower the overall expenditure the DCE is responsible for each performance year, and in turn, the medical expenditures attributed to the provider groups. This difference will need to be accounted for when estimating shared savings/losses. If any provider group has a disproportionate amount of claims falling under the exclusions, medical expenditures from the CCLF for such group will not represent the group's true financial performance. DCEs need to pay attention to the distribution of exclusions and make appropriate adjustment when developing provider group-level medical expenditures from the CCLF data.

Another important aspect to the overall FFS expenditures is the incurred but not paid (IBNP) portion of claims. Since the CCLF data is lagged, DCEs are often dealing with incomplete claims data and need to make an estimate the IBNP. Provider groups may submit claims and be paid at different speeds. A set

of universal IBNP estimates may not be appropriate for individual provider groups. The DCE should evaluate the need to develop provider group specific IBNP estimates to complete their medical expenditures.

Large Claims and Stop Loss

DCEs have the option of purchasing specific stop loss through CMS or private reinsurers. The stop loss option through CMS is calculated with each quarterly benchmark report. When calculating the provider level medical expenditures, the DCE should consider how to deal with large claims and stop loss recoveries at the member level. Due to the high frequency and low severity nature of such claims, it may be appropriate to exclude them when calculating provider level medical expenditures. Excluding such claims will ensure the provider level performance not be skewed by random fluctuation of outliers.

Capitation Expenditures

Another piece of the expenditures is the capitation. The capitation the DCE receives is used to pay for the services to the participant and preferred providers that fall under specified primary case services. The services covered under the capitation come through the FFS CCLF data as zero-paid claims, and the capitation amounts are the DCE's expenditures for these services. Since the DCE's participant and preferred providers can select their own percentage of FFS reductions for the capitation amount, it is important that the actual provider-level capitation be reflected when developing provider level capitation expenditures.

With the above components and adjustments, provider group-level medical expenditures can be determined.

Shared Savings / Losses

With the provider group level benchmarks and medical expenditures developed, the DCE can calculate the savings / losses at the provider group level. In short, the shared savings / losses is calculated as the difference between the DCE/Provider group's benchmark and their overall expenditures as discussed in prior sections. Given both the benchmark and the expenditures are calculated specifically for each provider, the DCE may use the provider group-level savings / losses to assess the performance of the provider groups and their contribution to the DCE's overall profitability. Below we lay out the following considerations when measuring the provider group-level savings / losses.

Credibility

As many know, there is inherent volatility in medical expenditures across different populations. Such volatility is greater over a smaller population or shorter time. The DCE should consider the provider group's patient panel size when studying provider group-level profitability. For a smaller provider practice, exceptional savings or losses for one performance period alone may not be a good indicator of future performance. The DCE and provider group need to go beyond this single metric and exam the root causes for performance management.

Risk corridor

The risk corridor allows the DCE to share savings / losses with CMS and provides a risk mitigation mechanism for the DCE. Some DCEs may consider a similar arrangement with the provider groups. The

size of the provider group and credibility needs to be considered in setting up such arrangements. The DCEs should also be aware that when the risk corridor is applied at the provider group level, the resulting shared savings / losses may not add up to the DCE level sharing savings / losses with the CMS. That may lead to additional savings / losses for the DCE. We discuss this topic in more detail further along in this white paper.

Additional Considerations

In addition to the considerations for developing provider level analytics, below we have outlined additional considerations for provider level financial reporting.

Risk Score Cap/Floor

Within the Direct Contracting program, a 3% cap/floor is applied to the performance year risk scores. This cap is developed by comparing a reference year (RY) population's risk score (typically two years prior to the performance year) to the performance year population's risk score, after normalization. If the normalized PY risk score increased from that the RY risk score by more than 3%, the PY risk score is capped to the RY risk score with a 3% increase. Similarly, if the normalized PY risk score decreased from that the RY risk score by more than 3%, the PY risk score is capped to the RY risk score with a 3% decrease. This calculation is done at the overall DCE level

As part of provider level reporting, different provider groups might have different results from the three percent cap/floor. It's not uncommon for the overall DCE to not trigger the three percent cap, but at the provider level there are some provider groups that do trigger the three percent cap. This will create a slight discrepancy between the aggregate DCE risk score and the rolled up provider level risk score, but it will allow the DCE management to understand which providers are having a larger impact to the risk score than others.

Quality Measures

In a similar fashion to the risk score cap/floor, the DCE is provided an overall quality score that determines a percentage of the "at risk" portion of the benchmark that the DCE will earn back. For 2021 and 2022, majority of the quality component will be pay-for-reporting (vs. pay-for-performance) which means the quality component has little impact to the overall benchmark. However, starting in 2023, up to five percent of the benchmark will be "at-risk" and can only be earned back through meeting quality thresholds.

This component is another area where the overall DCE might be provided with one score, but at the provider level, the results might differ more drastically. One provider might be performing exceptionally, while another is underperforming. Calculating the quality measures at the provider level will help identify which providers are contributing to earning back the "at-risk" portion of the benchmark and which providers are causing the DCE to lose some of that benchmark revenue. These measures are predominantly HEDIS measures that can be calculated from the CCLF claims data provided by CMS to the different organizations.

DCE Aggregate vs. Provider Level Rolled Up

As mentioned briefly above, it is important to note that the overall DCE aggregate results might vary from a provider level view rolled up. We mentioned above how the risk score cap could be applied at the

provider group level and while the overall DCE wasn't impacted, the rolled-up provider level view might have some providers that were impacted. This will cause a discrepancy between the reported DCE results over what is created through a provider level roll-up.

While this difference may present challenges in accounting for provider level financial components, it actually provides more insight into the overall impact that provider could be having on the DCE.

Patient Panel Change

The GPDC benchmarking methodology places a heavy weight in the DCE's participating providers' historical performance on medical costs and risk scores. These components form a significant portion of the DCE's performance year benchmark. If a provider's patient panel changes significantly from the base years and performance years, there could be a mismatch between the benchmark and performance year expenditures and the financial outcome may not represent the provider's true performance. Such mismatch may be partially, but not fully accounted for by the risk standardization mechanism built into GPDC benchmarking. For this reason, it again emphasizes the importance of being to view the provider's historical experience that contributed to the benchmark, as described in the Benchmark Development section.

Conclusion

The GPDC model provides an opportunity for Direct Contracting Entities to take on higher financial risk for potentially higher rewards. The DCE's participant providers are crucial partners to achieve the program's intended goals of improving health outcome and lowering healthcare costs. In order to drive performance as a whole, DCEs should deploy provider-level data analytics. Such analytics should reflect the provider's real performance, identify problem areas, and provide information upon which the providers can act.

Please contact Ivy Dong at ivy.dong@wakely.com, Brad Heywood at brad.heywood@wakely.com with any questions or to follow up on any of the concepts presented here.

OUR STORY

Five decades. Wakely began in 1969 and eventually evolved into several successful divisions. In 1999, the actuarial arm became the current-day Wakely Consulting Group, LLC, which specializes in providing actuarial expertise in the healthcare industry. Today, there are few healthcare topics our actuaries cannot tackle.

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