



HOW TO ACE THE ACO BENCHMARK CHANGES – DO YOUR HOMEWORK AND COVER ALL THE BASES

This paper sheds light on several factors that led to a significant drop in the ACO benchmarks for 2020, like COVID spend exclusion and the changes in the benchmark calculation methodology. ACOs faced a considerable challenge in maintaining and increasing savings which negatively impacted their bottom line. This paper also outlines the technological solution ACOs today need to tackle the challenges in the future.

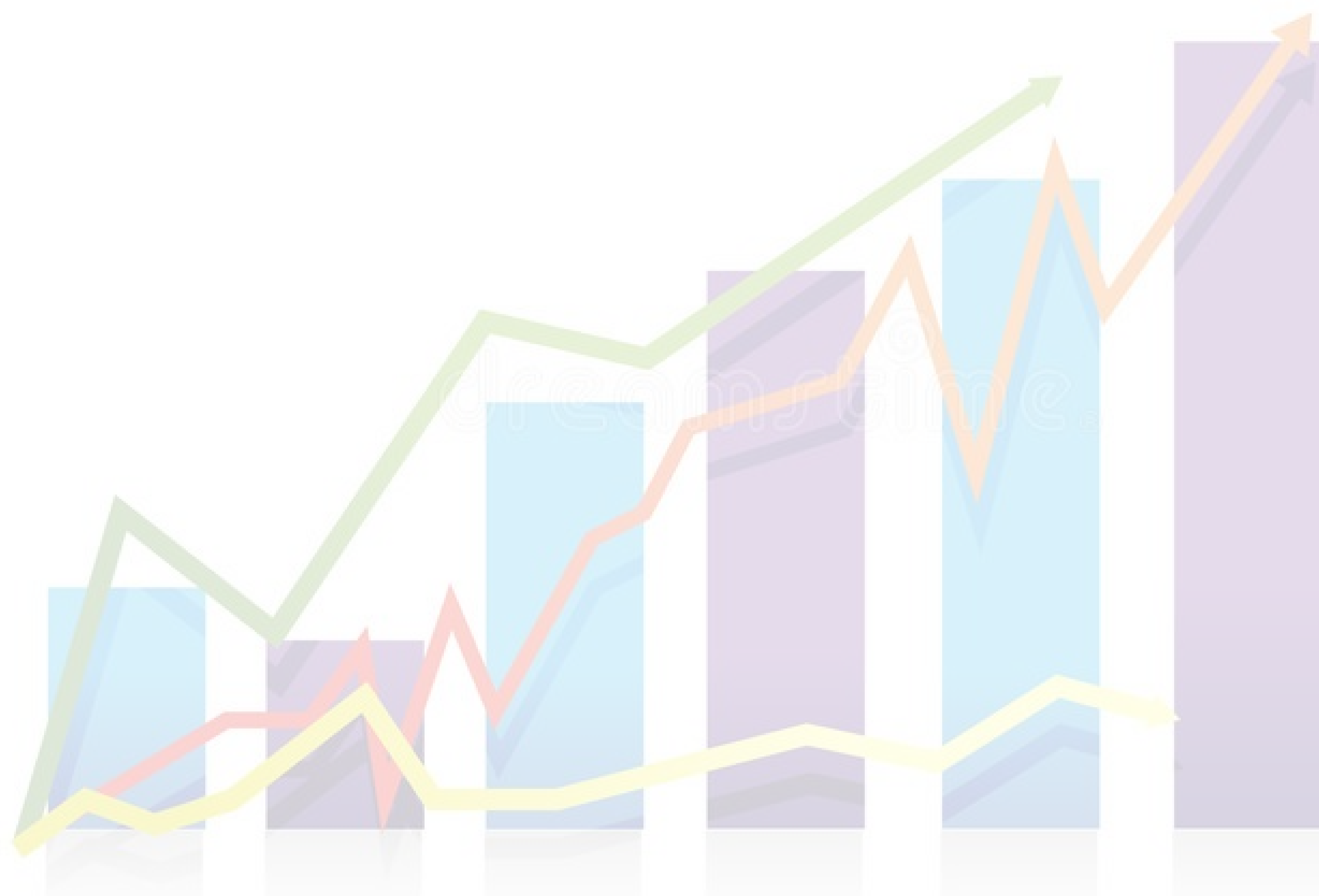
Benchmark Changes for ACOs in 2020:

Considering the latest updates for ACOs, all stakeholder discussions revolve around the significant drop in the benchmarks. Combination of a couple reasons attributed to this significant decrease. They include a change in the ACO benchmark calculation methodology and the public health emergency due to a major hit by a pandemic.

- ◆ What factors contributed to the decline in ACO Benchmarks in 2020?
- ◆ How did the change in ACO Benchmarks impact RAF and Savings?
- ◆ How can the blockades faced by ACOs be smoothed out?

What factors contributed to the decline in ACO Benchmarks in 2020?

One of the core reasons behind the significant drop in ACO benchmarks is the [National Assignable FFS Growth Increment](#) being replaced with [National Blended Update Factor](#). This change in the calculation methodology along with the COVID IP exclusion dragged down the national as well as regional trends as compared to previous BYs (Benchmark Years). To quote an example, the cost for an ACO saw a 6% decrease. What remained was done by the inclusion of telehealth codes in primary care services. This jolted the attribution process at the time of reconciliation, swinging a lot of anticipated [assigned beneficiaries](#) to the [assignable \(unassigned\) beneficiaries](#) bucket. Relevant stats reveal that an ACO had to suffer a USD 900 per beneficiary decrease at the time of reconciliation.



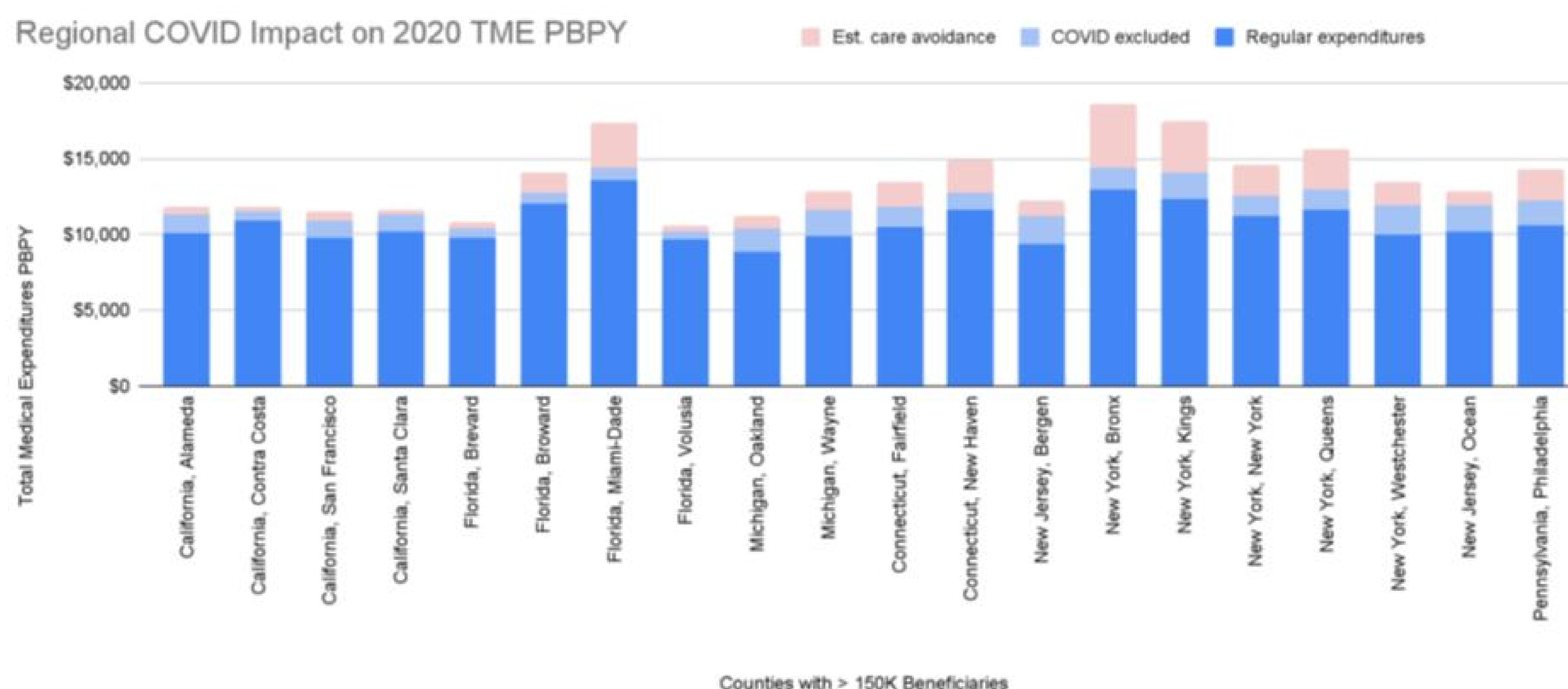
How did the Change in ACO Benchmarks Calculation Impact RAF and Savings?

Covid-19 IP exclusion disrupted the benchmark calculation at regional and national levels as the person years, expenditures, and risk scores were removed. As historical benchmarks are used to determine the latest one, the exclusion brought down the expenditure and the [Risk Adjustment Factor \(RAF\)](#). Consequently, haphazard changes were seen that only suited the ACOs having a greater spend during the months when Covid-19 cases spiked. This exclusion brought down the expenditures, inversely increasing the savings. Therefore, impact on the RAF and Savings can be broken down into a couple of factors:

- ◆ Covid-19 Care Avoidance Adversely Affecting Regional Trends
- ◆ Expenditure Reduction Accumulating in a Handful ACOs

How did Covid-19 Care Avoidance Impact Regional Trends?

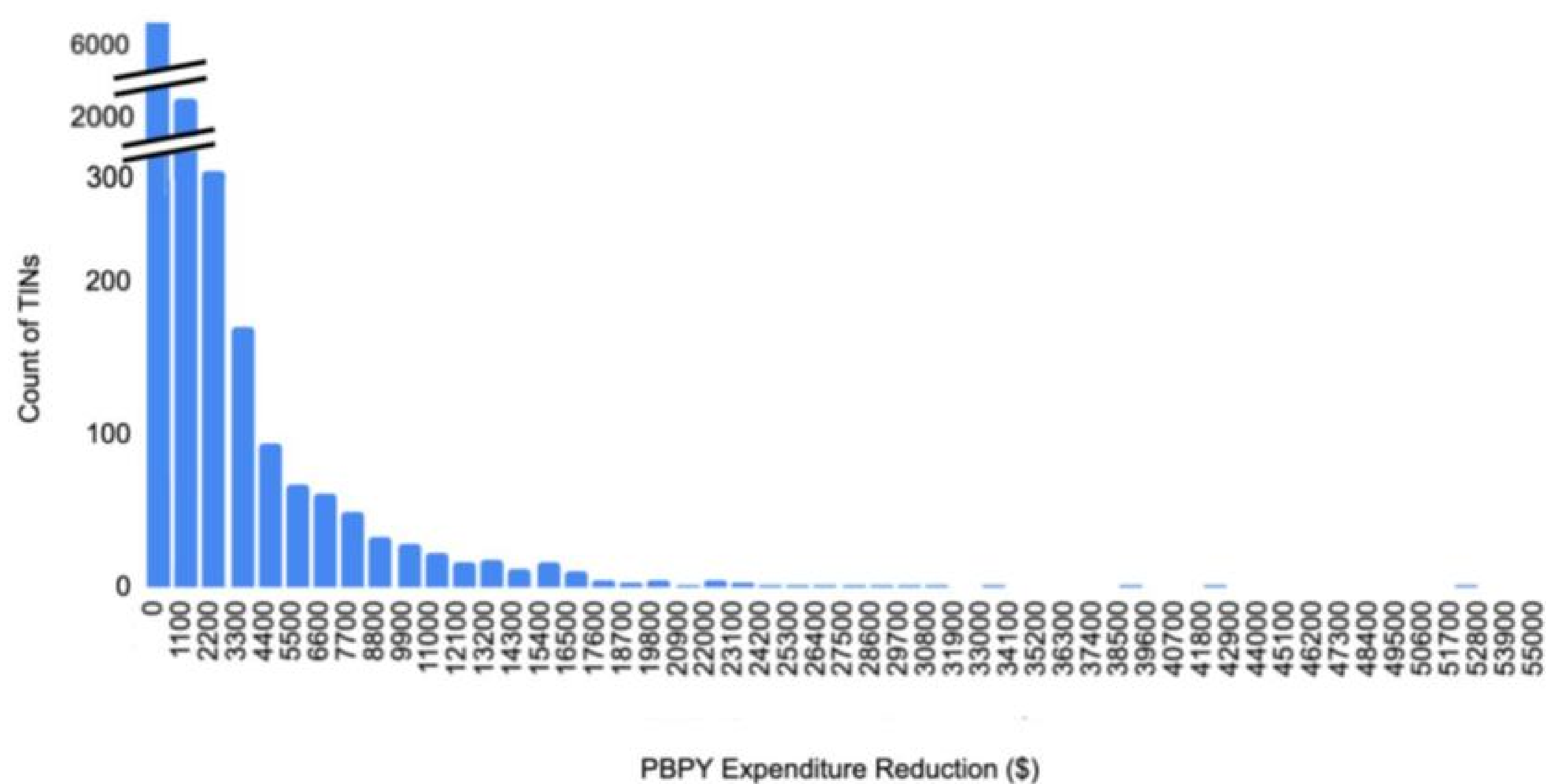
CoVid-19 care avoidance brought the regional trends down by a considerable extent. This is because the expenditure on elective procedures was already down due to the pandemic. When compared to the historical benchmarks, a significant decrease was seen in all regions across the country. The following image highlights the regional CoVid-19 impact for the year 2020:



Expenditure Reduction Accumulating in a Handful ACOs

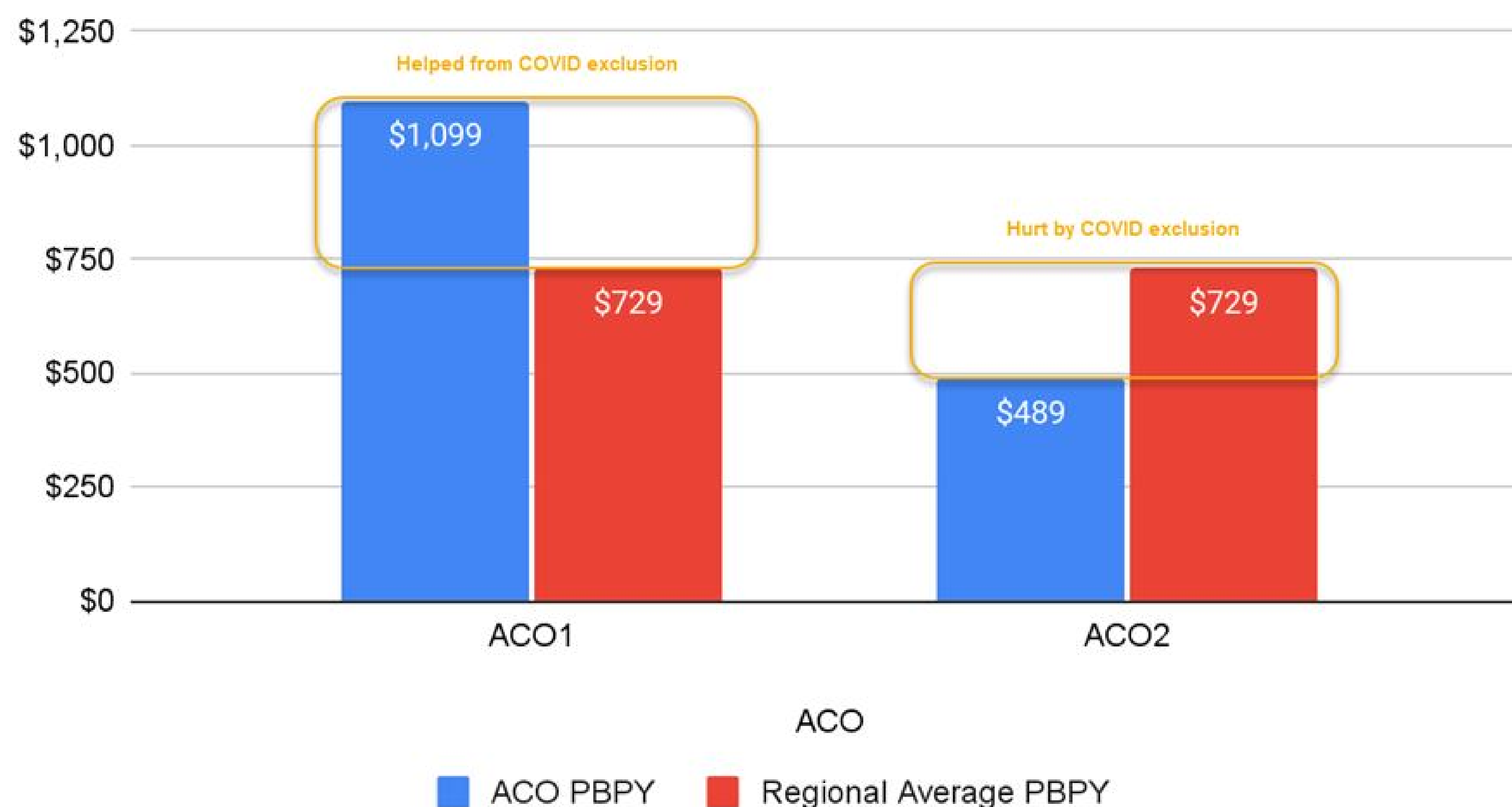
Spending in the Covid-19 peak months only served a minority of ACOs. This is because this expenditure turned out to be directly proportional to the savings for an ACO at the end. However, a Covid-19 related expenditure drop of USD 3000 to USD 50000 accumulated in 10% of the ACOs. The following image highlights the PBPY expenditure reduction from Covid-19 inpatient exclusion:

PBPY Expenditure Reduction from Inpatient COVID Exclusion



Where this exclusion served a few ACOs (~10%), it harmed the majority that had significantly lower spend in the pandemic-struck months.

CMS's COVID Exclusion on ACO Expenditures



This calls for a solution to exit this vicious cycle brewing from an unprecedented health emergency. So, what is the way out?

The Way Out

Persivia has been helping ACOs move towards a unified digital platform – CareSpace®, that harnesses the power of AI to aggregate data and drive insights from it and give complete control to all stakeholders to sift through the data lake. Our NLP capability has shown promising results in improving coding and risk scores. Also, the platform is equipped with dashboards for quality, cost, and utilization analysis and supports multi-channel communication among all stakeholders.

The timing and informational gaps in the release of updated benchmarks from CMS left the ACOs unprepared for any unforeseen circumstances. ACOs must take a proactive approach to counter the challenges that may arise in the future and should have the technological infrastructure in place to be more resilient in uncertain situations.

Development of Sophisticated AI Models

With the help of next-generation technological capability, ACOs can leverage interactive dashboards to predict outcomes based on historical trends to ensure that the savings see an upward trend always.

Leveraging Market Data

ACOs must keep track of the updated benchmarks & historical trends to identify regional trends on time. Monitor market data will provide a better insight into the provision of primary care services & the relevant attribution process.

HCC Risk Adjustment Optimization

AI-driven risk adjustment program that uncovers the hidden codes in unstructured notes and combines them with structured data to equip providers with missed/dropped codes and opportunities at the point of care can prove to be a game-changer for ACOs

Tweaking Beneficiary Attribution

Telehealth code included in the primary care services during the Covid times should be modified to help swing the risk score and benchmarks in the right direction for the ACOs.

Performance Forecasting

A technology platform that uses AI to present meaningful performance stats for ACOs as well as provide an overview of where things are going in the current Benchmark Year can help ACOs meet their defined targets.

Conclusion

A consistent risk adjustment methodology/version for benchmark and performance periods by CMS would be the best bet. In case of a pandemic situation, the timely release of the updated benchmarks by CMS would allow the ACOs to fine-tune their performance evaluation methods.

But the need of the hour is a comprehensive technological solution across the board that helps ACOs build a data repository along with an analytic platform.

CareSpace's single platform architecture allows any coding and care improvement opportunities identified by the system to be delivered directly to the provider's desktop in real time. Combining EHR, claims, ADT and SDOH data CareSpace provides a clinical and analytics infrastructure that is unrivaled in the industry and provides significant, demonstrated ability to:

- ◆ Improve operational efficiency
- ◆ Boost revenue generation and
- ◆ Enhance organizational resilience

Contact us today to know how our platform makes you more resilient and saves you from potential losses due to any rules changes in the future.

McLaren Health Generation \$34 Million In Savings With The Help Of Carespace®

We have been working with numerous ACOs to transform their care delivery model and help them make the most of the value-based care contracts.

Learn how we turned around the table for McLaren health. Download our case study

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Appendix A: Key Definitions & Calculation Methodologies

National Assignable FFS Growth Increment = (PY Expenditure) – (BY3 OACT National Assignable FFS Expenditure)

National Blended Update Factor = (National Expenditure Trend & Update Factor * National Weightage Factor) + (Regional Expenditure Trend & Update Factor * Regional Weightage Factor)

Assignable Beneficiary: A Medicare fee-for-service beneficiary who received at least one primary care service during the Performance Year from a Medicare-enrolled physician who is a primary care physician.

Assigned Beneficiary: A beneficiary assigned to an ACO for the current performance year who received a primary care service or was assigned to any other ACO participant during the 12-month assigned period.

Risk Adjustment Factor: A numeric value assigned to each enrollee in a risk adjustment program each year on the basis of demographics and conditions (HCCs).

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