Navigating the Model Matrix: 201 (Model, Track and Participant Selection)

The webinar will begin at 2:30 pm ET. Please make sure you are dialed in to the webinar on your telephone with the audio pin.

Agenda

1. Housekeeping and Introductions
2. Presentations:
   - Tradeoffs, Decision Points and Strategies for Dual Participation
   - ACO Perspectives
     - Direct Contracting
     - Primary Care First
     - Bundled Payments
3. Audience Q&A and follow-up

Housekeeping

1. Speakers will present for around 70 minutes

2. Q&A will take the remainder of the time
   - You can submit written questions using the Questions tab on your dashboard to the right of your screen at any time during the webinar
   - During the Q&A session, you can use the “raise hand” feature on your dashboard to ask a live question.
3. Webinar is being recorded
   - Slides and recording will be available on the NAACOS website within 24 hours. You will receive an email when they are available.

Speakers

	**Andrew Webster** Andrew is co-founder and lead actuary at Validate Health, the industry's only financial forecasting and optimization platform built exclusively for ACOs. He specializes in payer contract modeling (including MSSP, Next Gen, Medicare Advantage and commercial), forecasting shared savings under different decision scenarios and risk hedging strategies to lock in expected outcomes.
	**David Pittman** David is senior policy advisor at NAACOS where he assists the government affairs team in its legislative and regulatory affairs work, including its work around Direct Contracting. He also works on NAACOS's communications efforts.

Speakers

	**Glenn Abrahamsen** Glenn is Sr. Vice President of Business Analytics at Privia Health, where he oversees analytics and reporting in support of over 70 value-based care risk deals, across all lines-of-business, nationally. His prior experience includes companies such as Oxford Health Plans, Bristol-Myers Squibb and Pfizer, with prior leadership positions at Merck and Bausch Healthcare. Glenn earned a Ph.D. in Neuroscience from the State University of New York at Albany and was awarded a post-doctoral fellowship in Neuropharmacology at New York University Medical Center.
	**Margaret Senese** Margaret is Director of ACO Programs at Atrius Health where she leads the organization's participation in public payer ACOs, currently including the Next Generation ACO, Primary Care First, and the MassHealth Accountable Care Partnership Plan Medicaid ACO. She leads total medical expense performance management, staffing the medical expense performance management governance structure. Previously, Margaret led strategic grantmaking to community hospitals at the Massachusetts Health Policy Commission.
	**Jessica Walradt** Jessica leads advocacy, implementation and performance management for Northwestern Medicine's Value-Based Care portfolio. Prior to this, she led the Association of American Medical Colleges' policy, advocacy, and data analytic efforts on alternative payment models. She directly supported approximately 60 hospitals' and provider groups' efforts to implement Medicare bundled payment programs. Jessica holds an MS in Health Policy and Management from the Harvard School of Public Health and a BA in Political Science from the University of Richmond.

Three Provider/ACO Perspectives

	Atrius Health	Northwestern Medicine	PRIVIA HEALTH
GEOGRAPHY	Eastern Massachusetts	Northeastern Illinois	6 States (VA, MD, GA, FL, TX, TN) and DC
# PRACTICES/TINS	1	2 large NM-employed group practices; 50 independent practices	~6 (1 TIN per ACO/market area)
# EMRS	1	18	1
MEDICARE ACO	1 Next Gen ACO	1 MSSP Track 1 ACO	4 MSSP ACOs Track 1 (2); Basic C; Enhanced

Overview

- CMMI continues to release and refine payment models, especially in the wake of the COVID-19 PHE. As the number of models increase, so does the complexity of the Alternative Payment Model landscape.

- Overlap continues to be an issue for NAACOS members; understanding how these models interact and overlap is key

- Today's webinar will discuss key decision points for ACOs evaluating participation in these models, strategies for dual program participation, where permitted, and optimizing model, track and participant selection. Presenters will also discuss certain risk-and-reward tradeoffs between various models.

NAACOS Resources

- Stand-alone Direct Contracting webpage with CMS and NAACOS resources
  - In-depth analysis of Direct Contracting
- NAACOS Primary Care First webpage includes model news/information and resources
  - NAACOS Primary Care First Model Overview for ACOs
- NAACOS Bundled Payments webpage includes model news/information and resources
  - Understanding BPCI-A and MSSP Reconciliation
- NAACOS resource on voluntary kidney care models

Additional Charts and Resources

- Chart comparing Direct Contracting to other high-risk ACOs
- Chart on the overlap of CMMI models and ACOs
- NAACOS Medicare ACO-APM Overlap Chart

Navigating the Model Matrix: 201

Participant, Model and Track Selection

Andrew M. Webster, MS, ASA, MAAA
Chief Actuary at Validate Health
Actuarial Advisor to NAACOS
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David Portnoy
CTO/CDO at Validate Health
Computer simulations of CMS/CMMI programs
Formerly data interoperability lead at CMS/HHS
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Matrix 201 Picks Up from 101

✔ 101: What are our options?
201: How do we go about deciding?

Already Covered in 101

Across all models: MSSP, NGACO, GPDC

- Risk-Sharing Arrangements
- Savings/Losses Cap
- Stop/Loss Arrangement
- Payment Options
- Reconciliation
- Benchmarking methodology

	MSSP Enhanced	Next Gen	Direct Contracting - Professional	Direct Contracting - Global
MACRA	Advanced APM			
Risk-Sharing Arrangement	savings: 75% losses: 1 minus final sharing rate (40-70%)	2 options: - 80% or 100% shared savings/losses	50% shared savings/losses	100% shared savings/losses
Savings/Losses Cap	20% (savings) 15% (losses)	5% or 15% (selected by ACO)	Risk Bands: 50% for savings/losses < 5% 35% for savings/losses 5-10% 15% for savings/losses 10-15% 5% for savings/losses >15%	Risk Bands: 100% for savings/losses < 25% 50% for savings/losses 25-35% 25% for savings/losses 35-50% 10% for savings/losses > 50%

For GPDC

- DCE Types: Standard, New Entrant, High Needs
- Bene requirements
- Risk arrangements
- Benchmarking methodology
- Regional / national trend
- Risk adjustment
- Discount
- Quality Measures
- Benefit Enhancements

Slide courtesy of Dave Ault and NAACOS

How do we go about deciding?

Agenda

I. **Steps** in decision process

II. **Examples** of decision impact

III. **Optimizing** the decisions

IV. Proposed **schedule**

Regulatory Calendar by CMS Deadline

	MSSP	GPDC
Submit intent to apply	June 6	June 14
Participant selection: Addition (Non-binding and can remove later)	Aug 3*	Sep 10
Track selection decision & participant removal	Sep 10	Sep 16

* Decisions need to be made *before* shared savings *settlement* is available mid-August!

The Steps

for participant, model and track selection

Caution

Process simplified to be **sequential** for presentation purposes

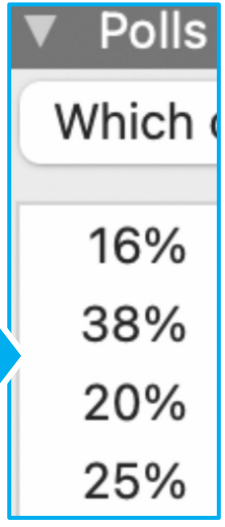
Steps should be in **parallel** as a constrained optimization model

Poll Question

Which of these describes your 2022 decisions?

1. Pathways with deferred GPDC
2. BASIC choosing between levels
3. BASIC jumping to ENHANCED
4. Next Gen deciding between MSSP and GPDC

NAACOS Poll Results 6/14/2021



Observations	
~40%	are interested in GPDC!
~40%	are staying within BASIC
20%	are interested in jumping BASIC to ENHANCED

4 steps in track and model selection lead you through key **questions**

Approach the track and model decisions systematically

What are our model & track options for next year?

Are we ready for a higher risk track based on history and trend?

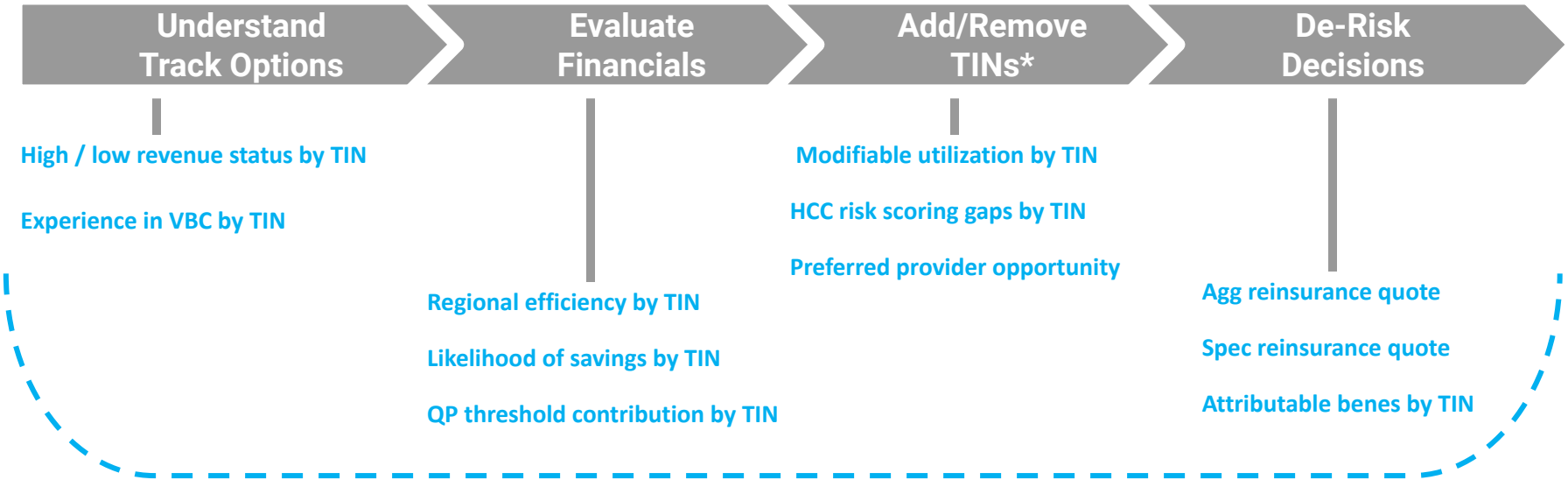
How should we add/remove participants based on performance & opportunity

How can we de-risk?

You're looking to answer key *questions* at each step

Optimal track and model decisions require TIN-level **metrics**

Instead of starting at ACO-level options,
go deeper and analyze TIN-level* metrics at each step



Using TIN-level *metrics* at each step

* Participants are TIN-NPI combination for GPDC and TIN for all other models

What are our track options next year?

Given your current track, your options for 2022 are…

⬇️ Current track in 2021	Avail for entering in 2022: BASIC A, B	BASIC C, D, E	ENHANCED	GPDC
Pathways				
BASIC – Low Rev	✔*	✔*	✔	✔**
BASIC – High Rev – Inexperienced	✔*	✔*	✔	✔**
BASIC – High Rev – Experienced	✘	✘	✔	✔**
ENHANCED	✘	✘	✔	✔**
Legacy MSSP				
Track 1	B only	✔	✔	✔**
Track 1+, 2, 3 – High Rev	✘	✘	✔	✔**
Track 1+, 2, 3 – Low Rev	✘	E only	✔	✔**
Next Gen / GPDC				
Low Rev	✘	E only	✔	✔
High Rev	✘	✘	✔	✔
New ACO in 2022	✔	✔	✔	✔**

* Can freeze at current Level or go up only

** If GPDC deferred application available

But moving analysis to TIN level metrics...

Opens more track options if you can modify either the:

- High revenue status
- Experienced status

	Avail for entering in 2022	
⬇️ Current track in 2021	BASIC A, B	BASIC C, D, E
Pathways		
BASIC – High Rev – Experienced	✘ → ✔	✘ → ✔
Legacy MSSP		
Track 1+, 2, 3 – High Rev	✘ → ✔	✘ → ✔
Next Gen / GPDC		
High Rev	✘ → ✔	✘ → ✔

To change high revenue or experienced status...

Look at the two related TIN-level metrics

High / low revenue status by TIN

Calculated as revenue vs benchmark by bene

- Change ACO from high to low revenue status
- Eliminate risk of flipping from low to high revenue status

Experience in value based care (VBC) by TIN

Calculated as % of panel or # of bene-years

... in MA HMO/PPO, MSSP, NGACO, etc.

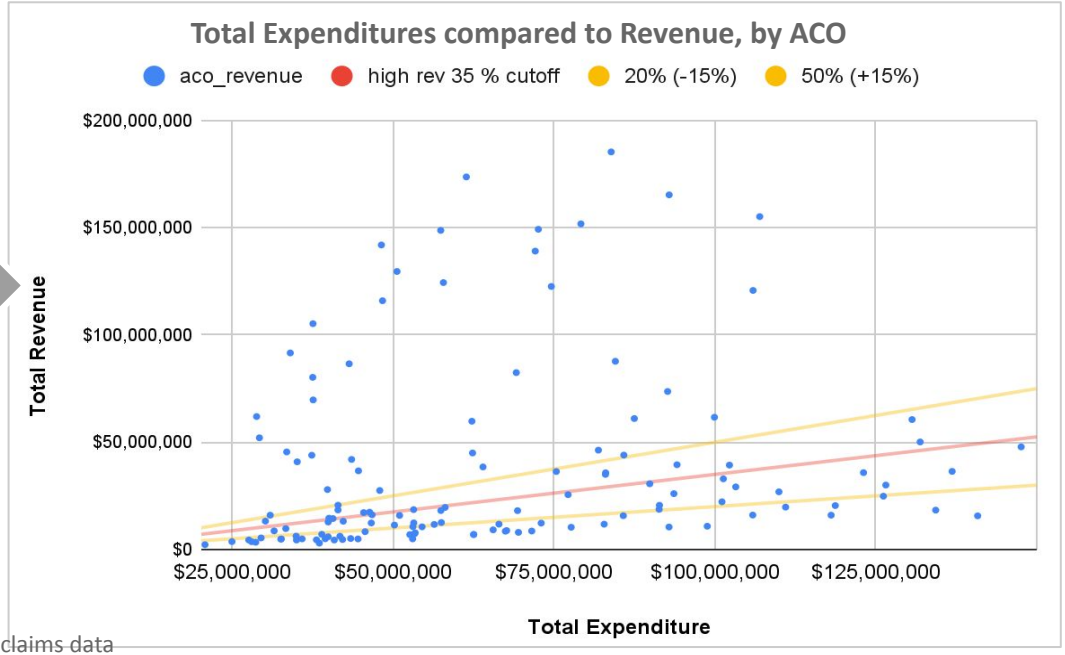
- Change ACO from experienced to inexperienced in risk
- Eliminate risk of flipping from inexperienced to experienced in risk
- For GPDC, determine if New Entrant requirements could be met

* Metrics for TINs outside your ACO require national FFS / MA claims data

High/Low revenue status across existing ACOs

- Many ACOs are already close to 35% threshold
- High rev ACOs can move to low rev with TIN addition/removal
- ACOs previously below the threshold risk flipping to high rev status with poor choice of TINs

25% of ACOs are within 15% of the high/low revenue threshold



* Metrics for TINs outside your ACO require national FFS / MA claims data

Evaluate financials for opportunity & risk readiness

We examine TIN-level metrics that drive financial history and trend

Regional efficiency by TIN

Calc PBPY for TIN vs region

...either by service or overall

- Reduce negative impact of regional adjustment
- Understand risk of COVID impact on rebased benchmark (Legacy MSSP and changing model)

Likelihood of savings by TIN

Based on benchmark trend between years

- Increase likelihood of ACO-level shared savings

QP threshold contribution by TIN

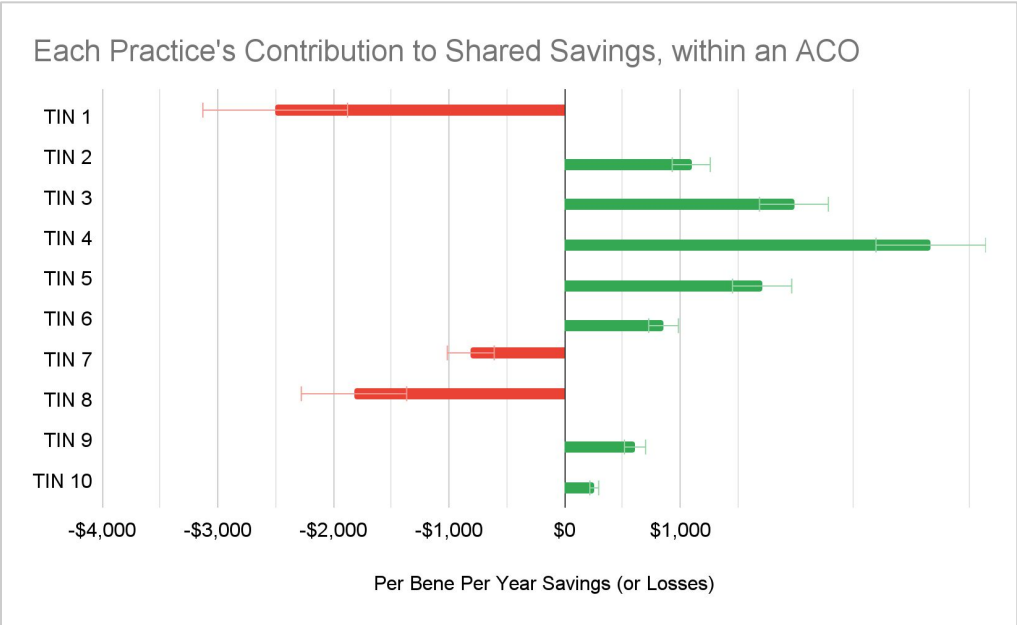
Calc bene count assignable vs assigned

- Drives AAPM bonus (BASIC E, ENHANCED, GPDC)

* Metrics for TINs outside your ACO require national FFS / MA claims data

Likelihood of shared savings by TIN has high variation

- Typically ACOs have high variation of financial impact across their TINs
- Simulate CMS Pathways/GPDC methodology to determine a TIN's actual financial contribution
- Leverage contribution across multiple years to improve sample size



* Metrics for TINs outside your ACO require national FFS / MA claims data

To select participants to add/remove...

We also examine TIN-level metrics based on **future** opportunity?

Modifiable utilization by TIN

Measure variance in utilization per disease cohort

- Choose TINs based on your ACO's existing strengths
- Bring in providers who can complement your ACO's capabilities

HCC risk scoring gaps by TIN

Calculate RAF improvement opportunity

- Modifiable opportunity with risk scores
- Up to 3% cap. Less coding intensity factor in GPDC

Preferred provider opportunity

Rank utilization & expenditures by PAC facility or specialist

- Determine 3-day SNF waiver (BASIC levels C-E and ENHANCED)
- Negotiate advanced payments (Prof DCE)
- Improve capitation (Global DCE)

* Metrics for TINs outside your ACO require national FFS / MA claims data

Use of revenue and experience status metrics in participant selection

The same metrics used to expand track and model options provide additional insights to add/remove TINs

High / low revenue status by TIN

Calculated as revenue vs benchmark by bene

Track / Model Selection

- Change ACO from high to low revenue status
- Eliminate risk of flipping from low to high revenue status

Participant Selection

- Impacts loss limit in BASIC Levels C-E and repayment mechanism in Level E / ENHANCED

Experience in value based care (VBC) by TIN

Calculated as % of panel or # of bene-years

... in MA HMO/PPO, MSSP, NGACO, etc.

Track / Model Selection

- Change ACO from experienced to inexperienced in risk
- Eliminate risk of flipping from inexperienced to experienced in risk
- For GPDC, determine if New Entrant requirements could be met

Participant Selection

- Readiness for new participant to enter a higher risk track based on risk level of prior experience

After participant selections overlay risk hedging options

Could include commercial agg or spec reinsurance, your own captive, or CMS offered stop loss

Growing the number of benes through TIN additions also helps PBPY risk exposure

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Agg reinsurance quote

Commercial carriers or captive

- Confidence to enter higher risk model, creating “synthetic” track
- In ENHANCED 15% of benchmark open to downside
- In GPDC 100% risk, up to 25% of benchmark

Spec reinsurance quote

CMS option, commercial or captive

- In GPDC de-risk large claimants, similar to truncation in Pathways
- CMS offered stop loss can be more costly, but is easier to administer

Attributable benes by TIN

Sum from attribution eligible visits

- Decrease PBPY risk exposure
- Bene count reduces MSR (BASIC levels A & B)

* Metrics for TINs outside your ACO require national FFS / MA claims data

The Examples

for participant, model and track selection

- CASE 1: BASIC option by converting to low revenue
- CASE 2: Level selection within BASIC
- CASE 3: BASIC vs ENHANCED
- CASE 4: GPDC vs Pathways

Converting from High to Low Revenue Status

The ACO's considerations and goals

- Wanted the option of BASIC tracks, but was high revenue
- ACO is close to 5k minimum bene threshold
- Facility-based TINs included, to satisfy certain quality waivers
  - ...but was adding revenue without the benefit of adding attributed benes
- A local specialist TIN had been included to help the specialist get 5% AAPM bonus

TIN	Person Years	Total Expenditure	Total Revenue	Rev to Expd %
TIN 1 (in ACO)	2695	$29,749,666	$3,450,961	11.6%
TIN 2 (in ACO)	2261	$23,433,235	$20,386,914	87.0%
TIN 3 (in ACO)	1638	$16,017,224	$2,562,756	16.0%
Specialist TIN 4 (in ACO)	79	$3,346,308	$9,035,031	270.0%
Facility TIN 5 (in ACO)	0	$0	$462,986,729	N/A
TIN 6 (possible addition)	442	$3,760,276	$135,370	3.6%
TIN 7 (possible addition)	565	$5,311,050	$191,198	3.6%
TIN 8 (possible addition)	458	$5,711,467	$205,613	3.6%

***Caution**: Case examples are for specific ACOs and should not be used to generalize

Converting from High to Low Revenue Status (cont)

Optimized solution using market data

- Removed TINs 4 & 5 (specialist and facility)
- Found 3 TINs to addusing market data to keep Rev to Expd < 35%
- Making these changes opened up the BASIC track options for this ACO.
- Reduce loss limit based on lower revenue

TIN Additions / Removals	Person Years	Total Expenditure	Total Revenue	Rev to Expd %
Before	6,673	$72,546,433	$498,422,391	687.0%
Drop Facility TIN 5	6,673	$72,546,433	$35,435,662	48.8%
Drop Facility TIN 5 & Specialist TIN 4	6,594	$69,200,126	$26,400,632	38.2%
Dropping TINs 4 & 5 Adding TINs 6-8	8,059	$83,982,919	$26,932,812	32.1%

*__Caution__: Case examples are for specific ACOs and should not be used to generalize

Simulate probability distribution of net savings for your ACO

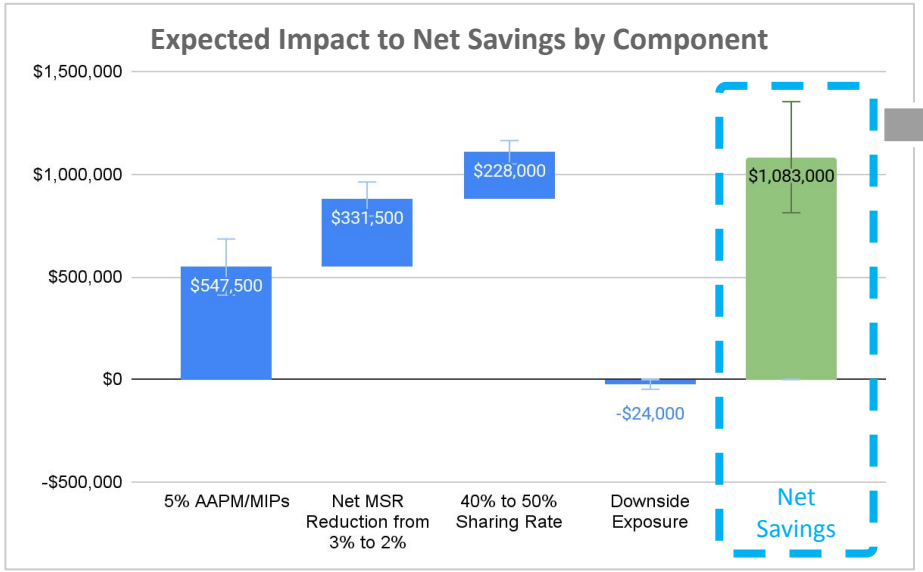
Generate outcomes for each model and track variant, along with probability of each

Probability	Gross Savings Band (% of Bench)	Avg Gross Savings w/in Band (% of Bench)	Total Net Shared Savings by MSSP Track ($)						
			BASIC Level B	BASIC Level C	BASIC Level D	BASIC Level E	ENHANCED	2% Aggregate Reinsurance	ENHANCED + 2% Aggr Reins
0.04%	<-10%	-13.4%	$0	-$442,064	-$884,128	-$1,768,257	-$7,689,751	$4,831,084	-$2,858,667
0.02%	-10% to -9%	-9.5%	$0	-$442,064	-$884,128	-$1,768,257	-$5,444,123	$2,810,019	-$2,634,104
0.03%	-9% to -8%	-8.5%	$0	-$442,064	-$884,128	-$1,768,257	-$4,867,664	$2,291,206	-$2,576,458
0.05%	-8% to -7%	-7.5%	$0	-$442,064	-$884,128	-$1,768,257	-$4,299,337	$1,779,711	-$2,519,626
0.10%	-7% to -6%	-6.5%	$0	-$442,064	-$884,128	-$1,768,257	-$3,716,825	$1,255,450	-$2,461,374
0.18%	-6% to -5%	-5.4%	$0	-$442,064	-$884,128	-$1,768,257	-$3,132,306	$729,383	-$2,402,923
0.35%	-5% to -4%	-4.4%	$0	-$442,064	-$884,128	-$1,768,257	-$2,559,946	$214,260	-$2,345,687
0.71%	-4% to -3%	-3.4%	$0	-$442,064	-$884,128	-$1,486,128	-$1,981,504	-$289,692	-$2,271,196
1.54%	-3% to -2%	-2.4%	$0	$0	$0	$0	$0	-$289,692	-$289,692
3.19%	-2% to -1%	-1.4%	$0	$0	$0	$0	$0	-$289,692	-$289,692
6.67%	-1% to 0%	-0.4%	$0	$0	$0	$0	$0	-$289,692	-$289,692
12.26%	0% to 1%	0.5%	$0	$0	$0	$0	$0	-$289,692	-$289,692
18.25%	1% to 2%	1.5%	$0	$0	$0	$0	$0	-$289,692	-$289,692
20.23%	2% to 3%	2.5%	$0	$0	$0	$0	$0	-$289,692	-$289,692
16.29%	3% to 4%	3.5%	$1,908,918	$2,386,147	$2,386,147	$2,386,147	$3,579,221	-$289,692	$3,289,529
10.06%	4% to 5%	4.5%	$2,449,469	$3,061,836	$3,061,836	$3,061,836	$4,592,754	-$289,692	$4,303,062
5.15%	5% to 6%	5.4%	$2,993,745	$3,742,182	$3,742,182	$3,742,182	$5,613,272	-$289,692	$5,323,580
2.50%	6% to 7%	6.4%	$3,541,695	$4,427,119	$4,427,119	$4,427,119	$6,640,679	-$289,692	$6,350,987
1.18%	7% to 8%	7.4%	$4,095,073	$5,118,841	$5,118,841	$5,118,841	$7,678,261	-$289,692	$7,388,569
0.56%	8% to 9%	8.4%	$4,641,703	$5,802,128	$5,802,128	$5,802,128	$8,703,193	-$289,692	$8,413,501
0.28%	9% to 10%	9.4%	$5,200,675	$6,500,844	$6,500,844	$6,500,844	$9,751,265	-$289,692	$9,461,573
0.35%	>10%	12.1%	$6,634,202	$8,292,752	$8,292,752	$8,292,752	$12,439,128	-$289,692	$12,149,436

***Caution**: Case examples are for specific ACOs and should not be used to generalize

Impact to net savings moving from Level B to E

- The ACO wanted to know what happens when they move from BASIC Level B to E
- Using weighted average probability distribution, we show the impact to net savings by component



The ACO would do better under Level E

- Upsides of AAPM, MSR reduction, sharing rate
- ...outweigh the small increase in downside exposure
- ...resulting in an expected $1.1M net savings increase vs Level B

Notes:

- Forecast shows +/- 25% range
- 5% AAPM bonus requires ACO-level QP thresholds

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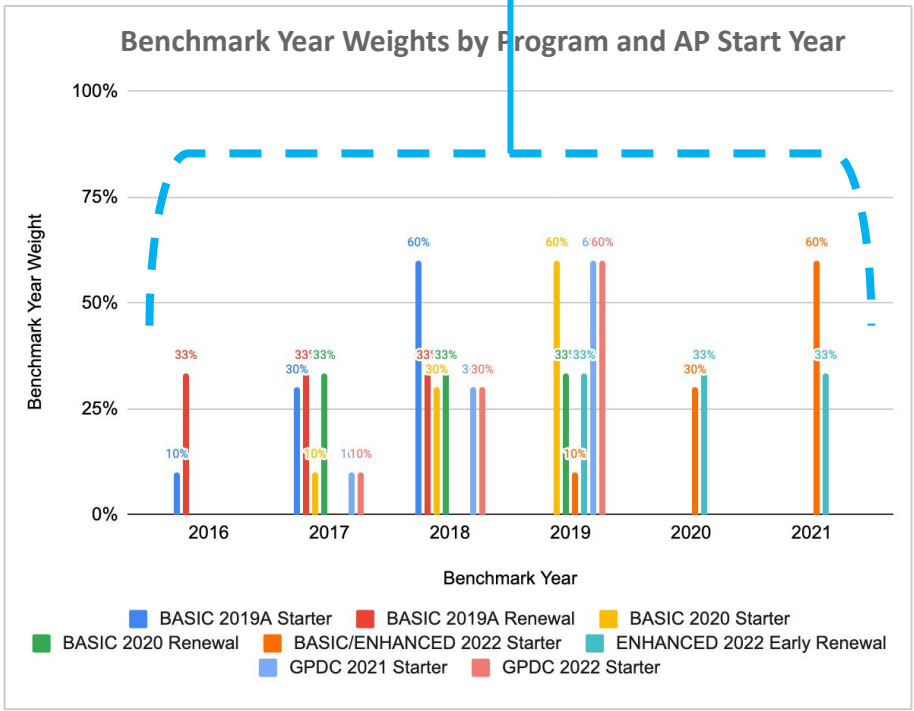
Select TINs strategically for your benchmark years

- For TINs you want to add, simulate each TIN's financial performance under the years and weights for available benchmark options available to your agreement periods

- Your options for rebasing your benchmark include:
  - Staying in your current contract, if existing benchmark is advantageous
  - Changing models (such as BASIC to ENHANCED), if a rebased benchmark is advantageous
  - Bifurcating your ACO into multiple contracts based on optimizing each TIN

- Identify cases where switching the TIN to your contract increases their benchmark

Review which benchmark years & weights are available to you



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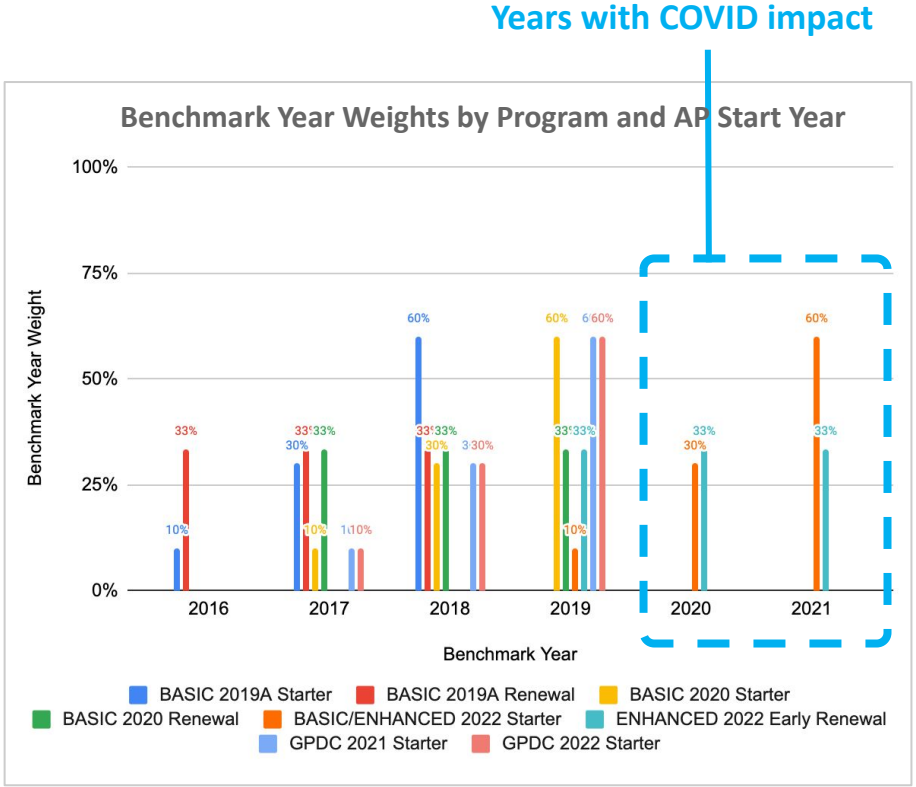
COVID impacts your benchmark if changing models

- Risk of unfavorable benchmark rebasing due to inclusion of 2020 and 2021

  66%-90% of benchmark would be based on COVID years

- Consideration for this ACO if switching from BASIC to ENHANCED

- Also impacts ACOs
  - New ACO
  - Renewing ACO (2018 starter)
  - Entering GPDC



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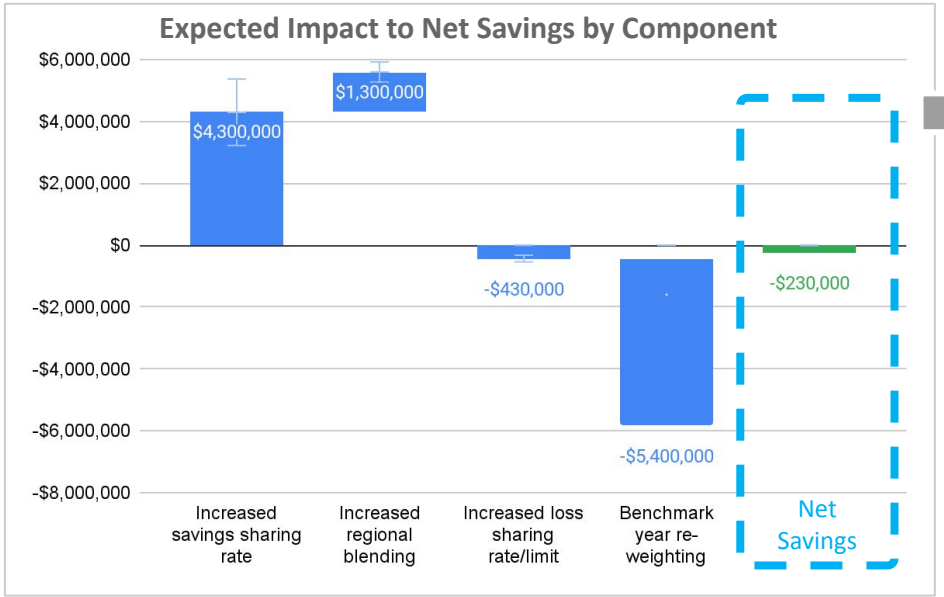
Impact to net savings moving from BASIC to ENHANCED

- The ACO wanted to know what happens when they move from BASIC to ENHANCED
- Using weighted average probability distribution, we show the impact to net savings by component



The ACO would do better staying in BASIC

- Upsides of increased savings rate and regional blending
- ...are outweighed by the increased loss sharing limit and benchmark re-weighting
- ...resulting in an expected $230K net savings decrease

Notes: Forecast shows +/- 25% range

***Caution**: Case examples are for specific ACOs and should not be used to generalize

CASE 4: GPDC vs Pathways*

Breakout for GPDC vs MSSP Pathways Decision

- Problem: An ACO's high-performing participant TIN is being recruited by a payer-owned MSO with a deferred GPDC option
  - MSO is offering higher incentives, made possible higher net savings opportunity GPDC
  - But MSO uses overly optimistic benchmark projections

- Current performance: Efficient network
  - Multi-year historical SS contribution for current participant list
  - Regionally efficient
  - Low rev status
  - High QP threshold

- Risk tolerance: Maximum aggregate self-insured loss of $3M

***Caution**: Case examples are for specific ACOs and should not be used to generalize

Evaluating Professional GPDC vs Basic E

Professional option of GPDC vs BASIC Level E has two issues:

- More downside exposure due to the symmetric sharing/loss rates
- Less upside due to the tiered sharing rate

Corridor	DC Professional	Pathways BASIC Level E
Savings Greater than 15%	5%	**50%** — Capped at 10% bench
Savings Between 10% and 15%	15%	
Savings Between 5% and 10%	35%	
Savings Less than 5%	50%	
MSR Selection (0-2%)	N/A (50%)	0%
Losses Less than 5%	50%	**30%** — Capped at 8% Medicare FFS revenue or 4% bench
Losses Between 5% and 10%	35%	
Losses Between 10% and 15%	15%	
Losses Greater than 15%	5%	

** Sharing rate (quality factors and discounts not included)

*Caution: Case examples are for specific ACOs and should not be used to generalize

Looking at Benchmarking Differences

Pathways and DC benchmark rates are comparable after adjustments

- Historical efficiency adjustment
- Retrospective trend adjustment: If retrospectively calculated trend is +/-1% different, CMS does not have to use the MA trend rates

Benchmark Prior to GPDC discount/quality/coding intensity factor (CIF)

	MSSP PBPY ($)	GPDC PBPY ($)	GPDC %
DC Ratebook PBPY ($)	N/A	$9,289	
Historical efficiency adjustment (Standard DCE only)	N/A	$511	-5.5%
Retrospective trend adjustment	N/A	$568	-5.8%
PBPY	$10,363	$10,368	

*__Caution__: Case examples are for specific ACOs and should not be used to generalize

Historical Efficiency Adjustment

- Effect of reweighting and benchmark years depends on TIN
  - Recent benchmark year weighting regardless of prior program participation
  - 2019A starter/renewals have different benchmark years

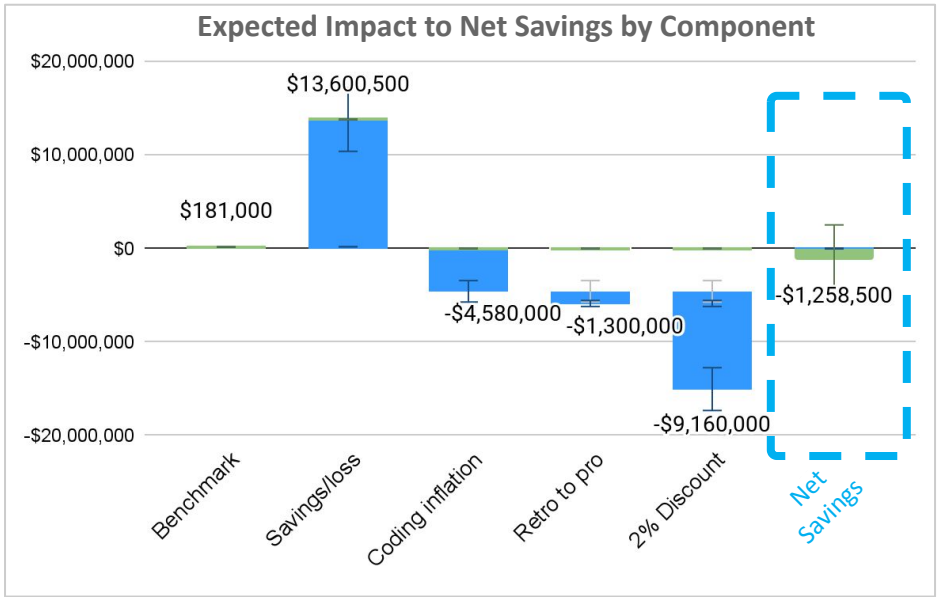
- Effect of benchmark year regional utilization and risk score trend on the Pathways benchmark
  - Low Pathways regional trend, then prefer GPDC e.g. rural glitch

	Pathways Trend	GPDC Trend
Population	National assignable and regional	National alignable
Regional Price	Y	Y
Regional Utilization	Y	N
Regional Risk score	Y	N

*Caution: Case examples are for specific ACOs and should not be used to generalize

Impact to net savings moving from Pathways to GPDC

- The ACO wanted to know what happens when they move from Pathways to GPDC
- Using weighted average probability distribution, we show the impact to net savings by component



The ACO would do better staying in Pathways

- Upsides of substantial increase in savings (and minor one in benchmark)
- ...are outweighed by the 2% discount, coding inflation and transition to prospective assignment
- ...resulting in an expected $1.2M net savings decrease

Notes: Forecast shows +/- 25% range

***Caution**: Case examples are for specific ACOs and should not be used to generalize

CASE 4: GPDC vs Pathways*

Differences in Net Savings Calculations

- Solution assuming all TINs are in the same Program/Track
  - Expected Net SS is greatest for ENHANCED followed by BASIC Level C
  - Loss exposure under GPDC Global and ENHANCED are significantly higher than BASIC

	BASIC Level B	BASIC Level C	BASIC Level D	BASIC Level E	ENHANCED	GPDC Global
Average Net SS (w/o 5% AAPM Bonus)	$5,782,697	$7,311,239	$7,273,665	$7,215,102	$8,067,340	$5,956,602
Average loss amount given a loss ($)	$0	-$523,138	-$1,046,275	-$1,861,648	-$4,494,145	-$7,619,612
Loss probability	0.0%	6.5%	6.5%	6.5%	9.6%	28.5%
Expected loss	$0	-$37,574	-$75,148	-$133,711	-$480,811	-$2,408,719

***Caution**: Case examples are for specific ACOs and should not be used to generalize

Required Risk Capital for GPDC

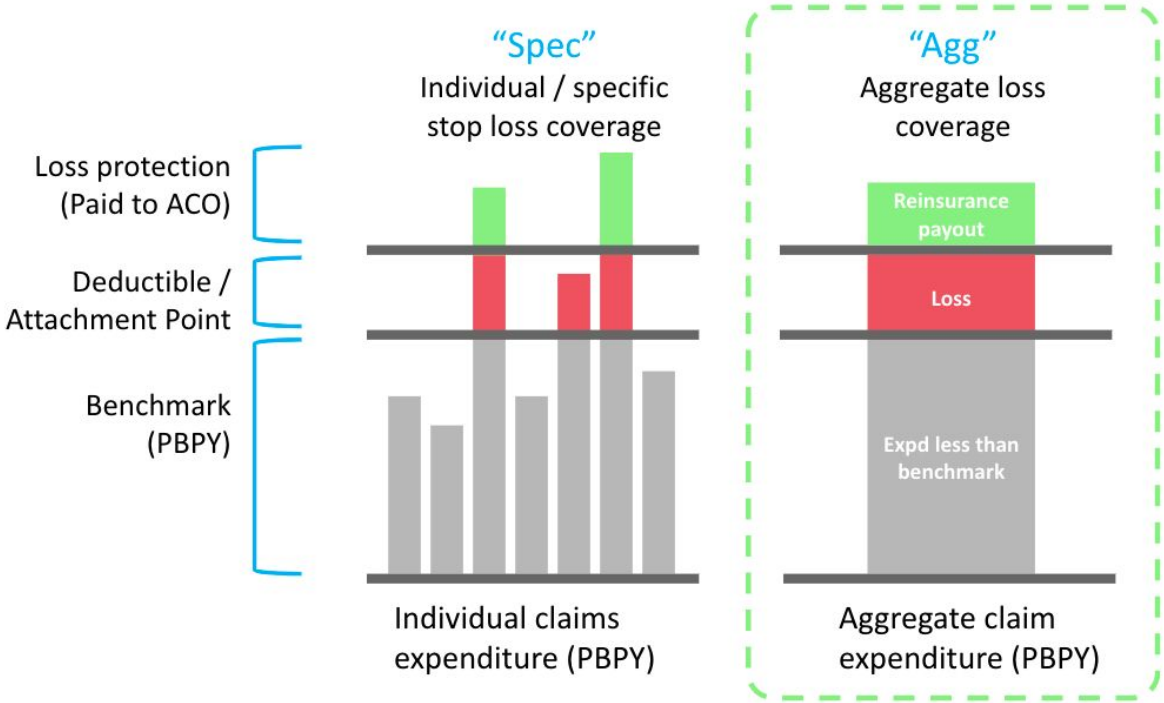
- Repayment mechanism amount is at least 2.5 to 6x higher in GPDC than Pathways depending on GPDC option
- Retention withhold can be financed through the repayment mechanism

Program	Track	RM Amount as % BM
Pathways	Repayment mechanism (Maximum)	1.0%
GPDC	Repayment mechanism - Professional - PCC - retention withhold	2.5%
GPDC	Repayment mechanism - Global - PCC - retention withhold	3.0%
GPDC	Repayment mechanism - Global - TCC - retention withhold	4.0%
GPDC	Repayment mechanism - Professional - PCC - retention guarantee	4.5%
GPDC	Repayment mechanism - Global - PCC - retention guarantee	5.0%
GPDC	Repayment mechanism - Global - TCC - retention guarantee	6.0%

*__Caution__: Case examples are for specific ACOs and should not be used to generalize

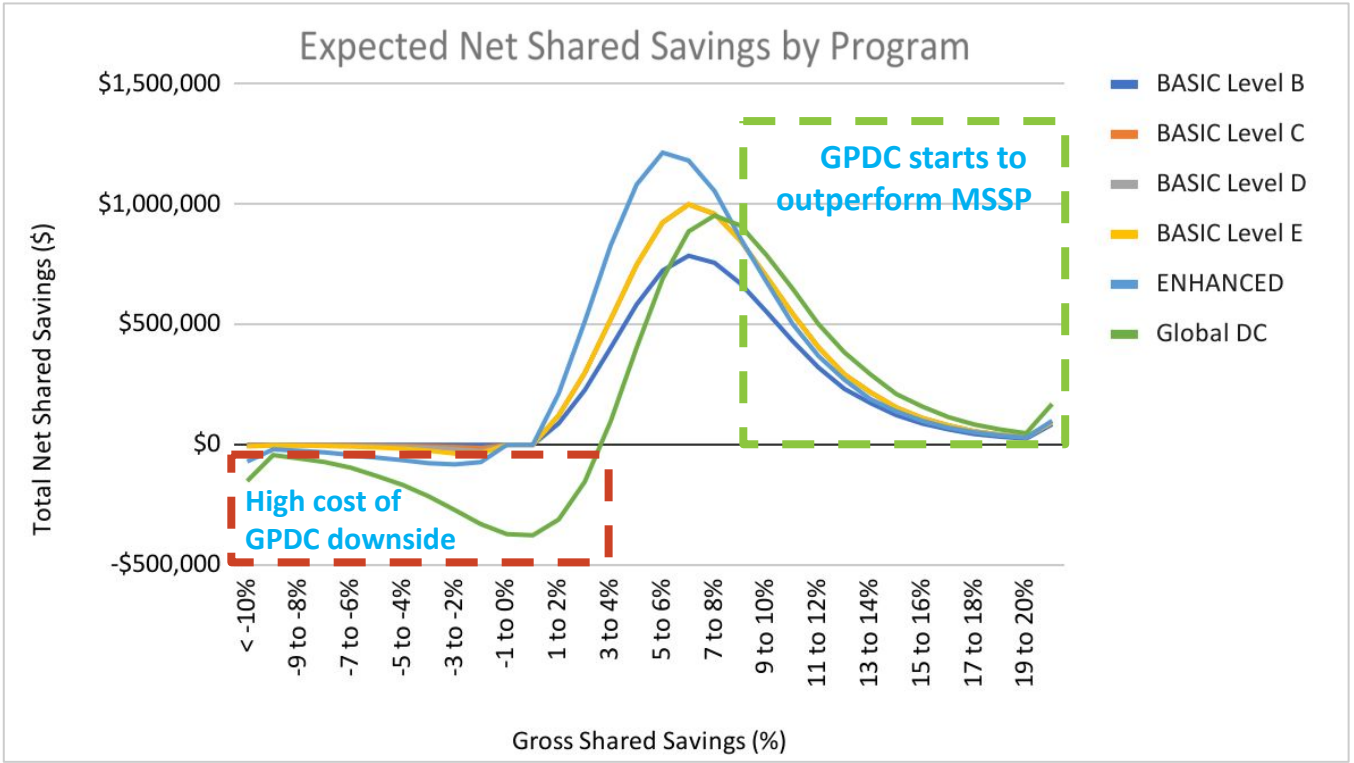
Side Note on Reinsurance Terminology

Examples in this presentation refer to aggregate (aka, “agg”) reinsurance contracts



Global DCE loss exposure vs Pathways

Visualizing that GPDC has the biggest downside and biggest upside compared to BASIC and ENHANCED

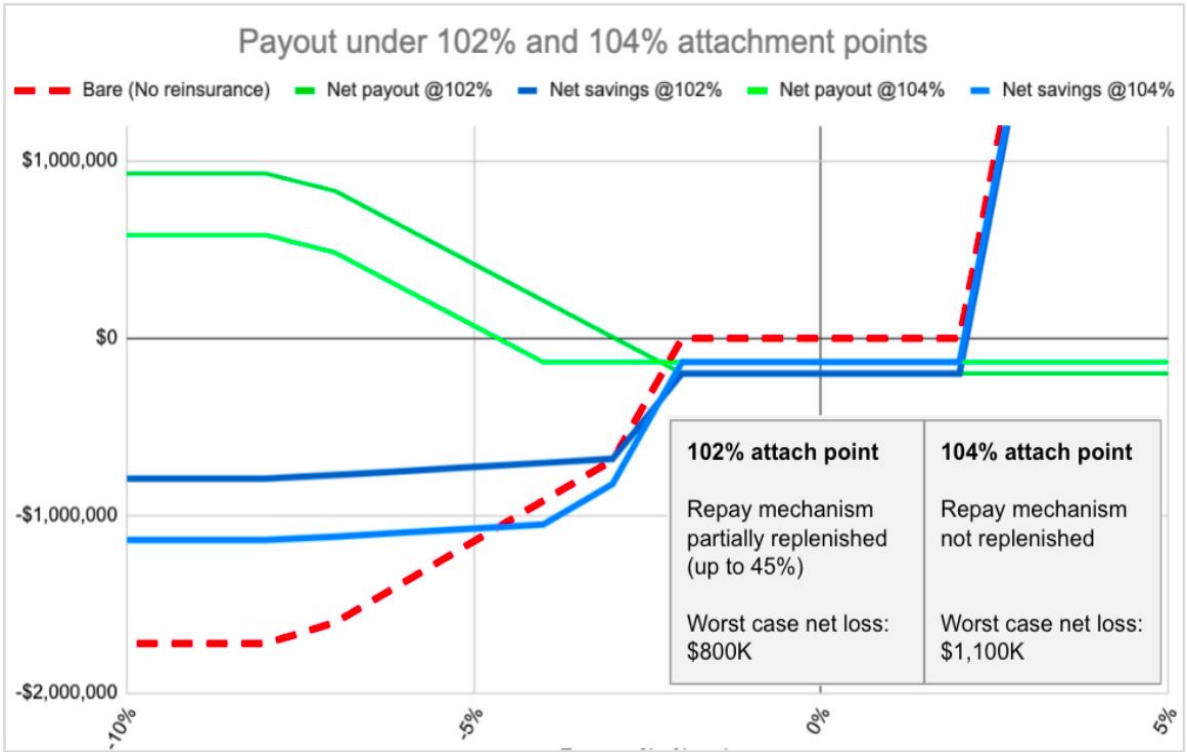


***Caution**: Case examples are for specific ACOs and should not be used to generalize

Creating "synthetic" tracks with agg reinsurance

Consider this option if...

- None of CMS/CMMI track options fit risk profile
- Risk aversion by participants
- Not enough reserves to cover losses



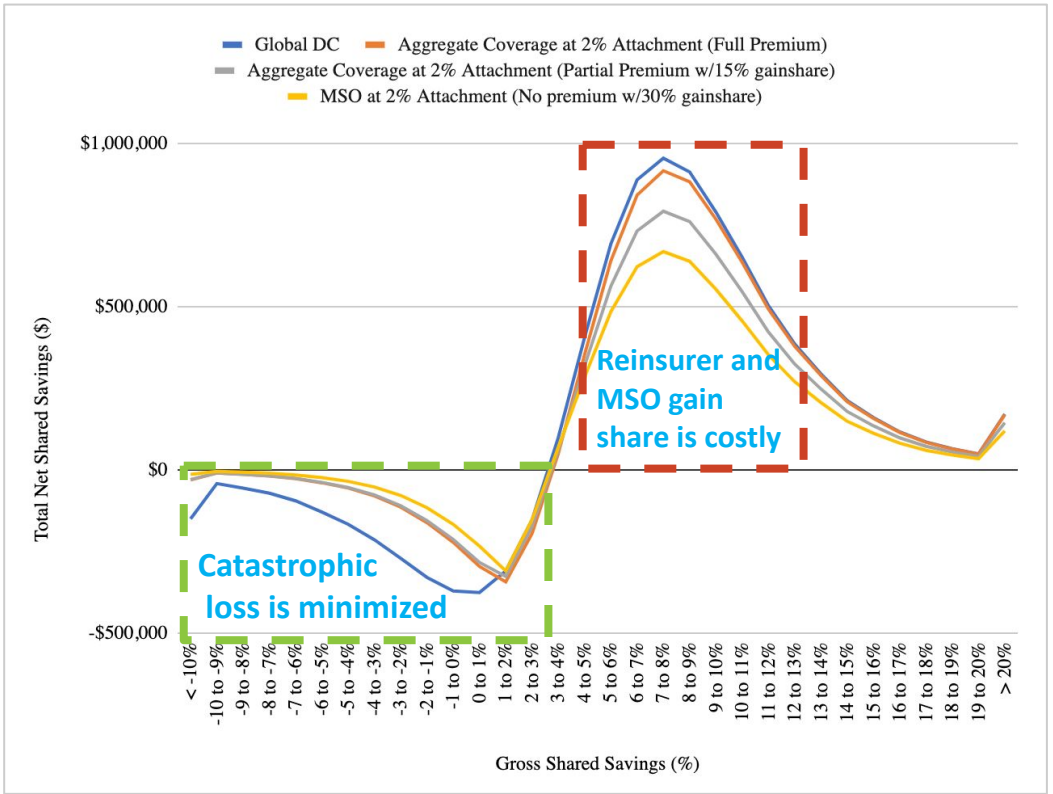
***Caution**: Case examples are for specific ACOs and should not be used to generalize

Example of "synthetic" tracks for global GPDC

Now the GPDC payout graph after overlaying aggregate reinsurance

For this ACO, GPDC with agg reinsurance is a more attractive option than joining an MSO

MSO	Most expensive (est. $710K)
Reinsurance w/ gainshare	Less expensive and more flexible than MSO (est. $520K)
Reinsurance full premium	Least expensive, assuming ACO can afford upfront premium (est. $110K)



*Caution: Case examples are for specific ACOs and should not be used to generalize

Optimizing: Combine all information

for participant, model and track selection

Using constrained optimization approach

- Although the process demonstrated was simplified to be sequential for presentation purposes
- ...the steps should be in parallel as a constrained optimization model
- The TIN level metrics described should be combined with constraints of CMS rules and regs into a single decision framework

TIN-level Metrics

TIN Name	Person years	Expenditures PBPY	Bench PBPY (1)	Revenue
TIN 1	376	$11,548	$12,764	$333,629
TIN 2	3,672	$9,848	$10,839	$1,225,085
TIN 4	705	$9,344	$9,937	$0
TIN 5	730	$9,442	$9,945	$0
TIN 6	414	$9,823	$10,260	$36,207,473
TIN 7	441	$9,626	$10,019	$127,176
TIN 8	934	$9,370	$9,739	$135,907
TIN 9	593	$9,327	$9,692	$683,688
TIN 10	3,620	$9,468	$9,825	$654,235

+

Constraints

Program	Constraint metric	Sign	Threshold
QP	QP patient count threshold	>	35%
QP	QP payment amount threshold	>	50%
MSSP	Low revenue	<	35%
MSSP	Minimum beneficiaries in all BY and PY	>	5000
MSSP	Experienced	>	50%

Constrained optimization could yield unexpected results

For example, it shows a potential hybrid track strategy...

- Low-performing high-risk TINs added to a BASIC Level E ACO
- High-performing low-risk TINs added to a Global DC
- Produces a total additional savings of $610K

					BASIC Level E		ENHANCED		GPDC Global		Hybrid	
TIN Name	Person years	Expenditures PBPY	Bench PBPY (1)	Gross SS Agg (Med)	Sharing Rate	Net SS Contribution*	Sharing Rate	Net SS Contribution*	Sharing Rate	Net SS Contribution*	Sharing Rate	Net SS Contribution*
TIN 1	376	$11,548	$12,764	$1,216	50%	$228,726	75%	$343,089	100%	$457,452	100%	$457,452
TIN 2	3,672	$9,848	$10,839	$991	50%	$1,819,364	75%	$2,729,047	100%	$3,638,729	100%	$3,638,729
TIN 4	705	$9,344	$9,937	$592	50%	$208,771	75%	$313,157	100%	$417,542	100%	$417,542
TIN 5	730	$9,442	$9,945	$503	50%	$183,462	75%	$275,192	100%	$366,923	100%	$366,923
TIN 6	414	$9,823	$10,260	$437	50%	$90,425	75%	$135,638	100%	$180,850	100%	$180,850
TIN 7	441	$9,626	$10,019	$393	50%	$86,555	75%	$129,833	100%	$173,111	100%	$173,111
TIN 8	934	$9,370	$9,739	$370	50%	$172,625	75%	$258,938	100%	$345,251	100%	$345,251
TIN 9	593	$9,327	$9,692	$365	50%	$108,120	75%	$162,180	100%	$216,240	100%	$216,240
TIN 10	3,620	$9,468	$9,825	$357	50%	$645,724	75%	$968,586	100%	$1,291,448	100%	$1,291,448
TIN 11	874	$9,344	$9,644	$299	50%	$130,897	75%	$196,345	100%	$261,794	100%	$261,794
TIN 12	1,344	$9,418	$9,693	$274	50%	$184,310	75%	$276,464	100%	$368,619	100%	$368,619
TIN 13	2,905	$9,729	$9,960	$231	50%	$335,188	75%	$502,781	100%	$670,375	100%	$670,375
TIN 14	348	$10,284	$10,495	$211	50%	$36,704	75%	$55,056	100%	$73,408	100%	$73,408
TIN 15	548	$9,594	$9,771	$177	50%	$48,419	75%	$72,628	100%	$96,837	100%	$96,837
TIN 16	1,528	$10,214	$10,385	$171	50%	$130,859	75%	$196,288	100%	$261,717	100%	$261,717
TIN 17	355	$9,783	$9,902	$119	50%	$21,144	75%	$31,716	100%	$42,287	100%	$42,287
TIN 18	417	$13,477	$13,518	$41	50%	$8,587	75%	$12,880	100%	$17,174	100%	$17,174
TIN 19	985	$9,879	$9,752	-$127	50%	-$62,690	75%	-$94,035	100%	-$125,380	30%	-$37,614
TIN 20	462	$11,983	$11,848	-$135	50%	-$31,109	75%	-$46,664	100%	-$62,218	30%	-$18,665
TIN 21	1,346	$11,751	$11,572	-$180	50%	-$121,030	75%	-$181,546	100%	-$242,061	30%	-$72,618
TIN 22	629	$11,138	$10,364	-$775	50%	-$243,491	75%	-$365,236	100%	-$486,981	30%	-$146,094
Total						$3,981,559		$5,972,339		$7,963,118		$8,604,767

(1) Benchmarks the same
(2) ACO overall earns SS

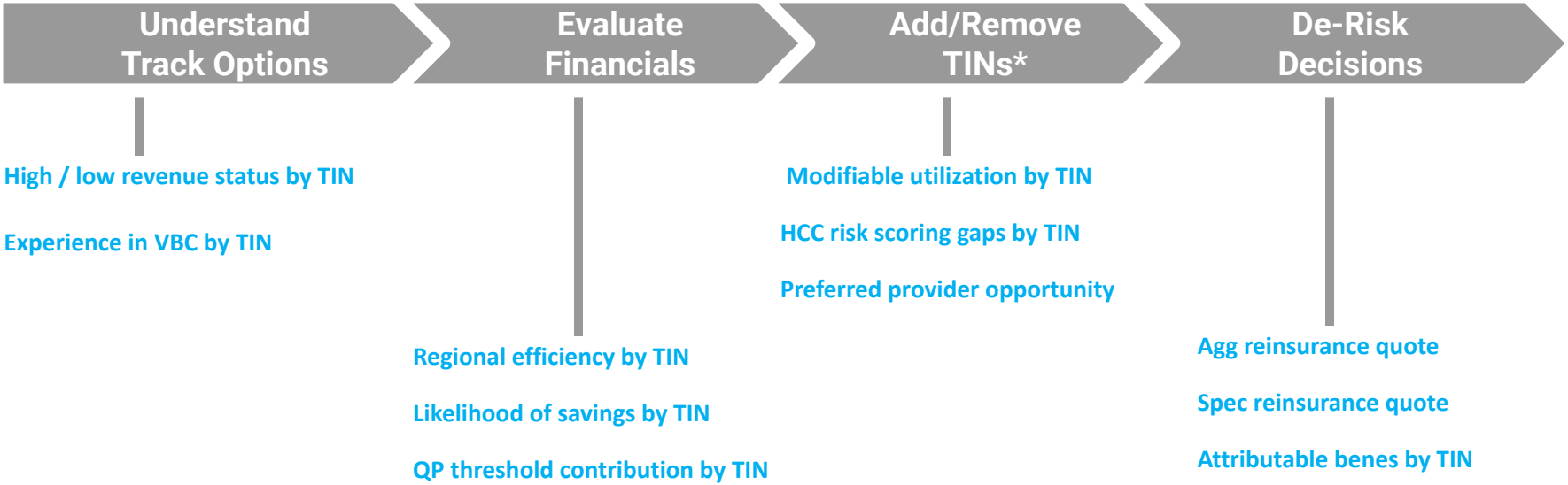
***Caution**: Case examples are for specific ACOs and should not be used to generalize

Wrapping up

for participant, model and track selection

For optimal track and model decisions...

Instead of starting at ACO-level options,
go deeper and analyze *TIN-level metrics* at each step



TIN-level metrics drive optimal ACO-level decisions

Relevance of TIN metrics discussed depend on model and track entered

	Metrics by TIN*	Entering Track in 2022			
		BASIC A, B	BASIC C, D, E	ENHANCED	GPDC
Understand Track Options	High / low revenue status by TIN	Y: Low rev if exper w/ risk	Y: Loss limit, repay mech	Y: Repayment mech	N
	Experience with VBC by TIN	N	Y	Y	Y: Standard vs New Entrant
Evaluate Financials	Regional efficiency by TIN	Y	Y	Y	Y: Arbitrage on GPDC ratebook
	Likelihood of savings by TIN	Y	Y	Y	Y
	QP threshold contribution by TIN	N: Not an advanced APM	Y (E only)	Y	Y
	Quality metrics by TIN	Y	Y	Y	Y
Add/Remove TINs	Modifiable utilization by TIN	Y	Y	Y	Y
	HCC risk-scoring gaps by TIN	Y	Y	Y	Y: Less coding intensity factor
	Preferred provider opportunity	N	Y: 3-day SNF waiver	Y: 3-day SNF waiver	Y: Adv. paym. (Prof DCE) Y: Capitation (Globe DCE)
De-Risk Decisions	Attributable benes by TIN	Y: "Variable" bene # drives MSR	Y	Y	Y
	Agg reinsurance quote Commercial carriers vs captive	N: Upside only	N: Downside too small	Y: 15% of bench open ended	Y: 100% risk up to 25% of bench
	Spec reinsurance quote CMS option, commercial or captive	N: Mandatory truncation in MSSP	N: Mandatory truncation in MSSP	N: Mandatory truncation in MSSP	Y: Optional CMS vs commercial

* Metrics for TINs outside your ACO require national FFS / MA claims data

Suggested 3–4 Month Schedule

1

June 2021 to CMS deadline

MSSP: Aug 3

Participant selection: Addition

Decision: Should the practice be added to the participant list?

- High-level pass, looking for specific reasons not to add by the CMS deadline
- Efficiency by service component compared to: Other participants, region, and competitors
- Identification of red flags: High nursing home procedures, high revenue, etc.
- Timing: Participant selection should be done before track selection

2

June to July 2021

Track selection preparation

Decision: Track selection both with and without added participant

- Contribution to loss limit
- Repayment mechanism increase
- Likelihood of high revenue status
- Impact of 5% AAPM bonus
- Impact of reinsurance, incl. partial premium financing

Considerations:

- May be impacted by TIN additions / removals
- May be impacted by reinsurance quote

3

June to July 2021

Reinsurance options

- Design coverage customized to track and risk tolerance
- Help procure non-binding quotes. Review quotes for cost effectiveness
- Assess partial premium financing options and timing of cash flows
- Provide payoff chart and efficient frontier for decision making

4

Aug 2021 to CMS deadlines

MSSP: Sep 10
GPDC: Sep 16

Track selection decision & participant removal

Decision: Should the practice be removed from the participant list?

- Deeper dive into what action might be needed to optimize their performance
- Analyze in conjunction with track selection and reinsurance quotes
- Apply reinsurance options to prior track selection analysis

Further Resources

Resources for participant, model and track selection

- NAACOS GPDC webinar series on
  - Standard
  - New Entrant
  - High Needs Population
- CMS Pathways Deadlines
- GPDC deadlines
- How shared savings by TIN is calculated and its uses throughout the year
- Case study on using reinsurance during track selection

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NAACOS – Navigating the Model Matrix

Glenn Abrahamsen, Ph.D.
Sr. VP Business Analytics

June 14, 2021

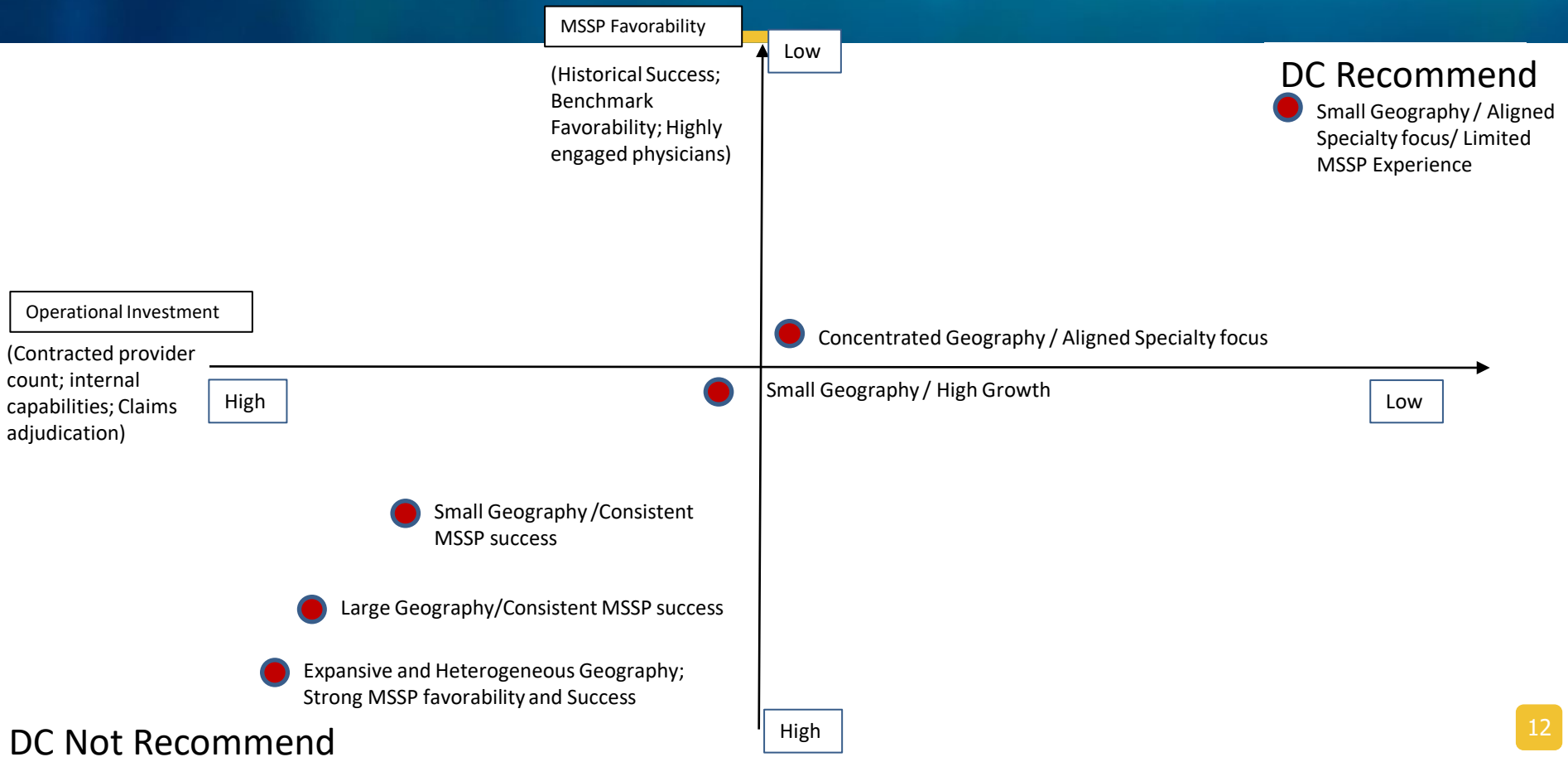
Privia: Situation assessments in advancing to risk

- Privia's history in MSSP dates back to 2014 with 4 current ACOs
  - Mid-Atlantic, GA, North Texas, Gulf Coast
- MSO is constantly evaluating new ACO opportunities
  - Considerable concurrent discussion about Direct Contracting
- Our basic process ensures team alignment in pursuing new/tracks programs:
  - MSO models opportunities/threats in all programs
  - Leadership aligns around opportunities/recommendations
  - Market-level physician board of directors votes on recommendations
  - MSO shares in VBC savings and losses with our physician partners

Direct Contracting (vs MSSP): Some Key considerations

- DC Global Model - 100% shared savings & TCC Capitation (vs choice PCC) create attractive revenue proposition
- Benchmark – Incorporates features of MSSP & MA
  - Mix of historical expenditures + regional expenditures (graduated increase from 35% to 50%)
  - Baseline fixed at 2017-2019 for duration of performance period
  - Prospective trend based on projected US Per Capita Cost (USPCC) growth trend & adjustment factors
  - 2%-5% discount to benchmark (fixed); 0% to 5% quality discount (performance based)
- DC Risk Adjustment – Limited opportunity Prospective HCC
  - Risk Adjustment Symmetrical Cap of +/- 3%
  - Retrospective Coding Intensity Factor on top of the cap
  - Versus MSSP: 3% lifetime cap vs benchmark
- Operational Investments – DC financial 'headwinds' necessitate significant additional investment in network/contracting infrastructure
  - Larger geographies more diffuse specialty/hospital concentration will require larger investment
  - Claims adjudication and/or outsourced partner
- Versus MSSP opportunities
  - Known benchmark attractiveness in key geographies
  - Experience/success in key geographies

Medicare FFS: Direct Contracting Geographic Mix



Guiding Management and Physicians through MSSP Risk-Track Selection

- Overview of Pathways and/or tracks
- Representative financial opportunity per track
  - Upside and downside
  - AAPM
- ACO size and experience/performance in VBC
  - Physician tenure in ACO
  - Quality
  - Operational performance measures (e.g. AWV rate, preventative care)
- Modeled benchmark attractiveness
  - HCC Trends
  - ACO efficiency: Regional Benchmarks

Illustrative guide on pathway economics to enable decision making

Track	Basic				Enhanced
Risk Level	A&B	C	D	E	ENHANCED
Shared Savings	40%	50%	50%	50%	75%
Max Shared Losses (w/MLR)	N/A	2% ACO Billing	4% ACO Billing	8% ACO Billing	15% Benchmark
2022 Attribution (fcst)	38,000	38,000	38,000	38,000	38,000
Benchmark 2022 PMPY (fcst):	$11,000	$11,000	$11,000	$11,000	$11,000
Benchmark 2022 (fcst):	$418,000,000	$418,000,000	$418,000,000	$418,000,000	$418,000,000
CMS Billing Revenue 2022 (fcst):	$25,080,000	$25,080,000	$25,080,000	$25,080,000	$25,080,000
Minimum Savings Rate/ Loss Rate	2.32%	2%	2%	2%	2%
Modeled Savings/Loss Rate*	5%	5%	5%	5%	5%
Quality Score	100%	100%	100%	100%	100%
MSO Gross Savings	**$8,360,000**	**$10,450,000**	**$10,450,000**	**$10,450,000**	**$15,675,000**
Gross Savings PMPY	**$220**	**$275**	**$275**	**$275**	**$413**
Max $ At Risk	$0	$501,600	$1,003,200	$2,006,400	$62,700,000
5 % Loss*	$0	$501,600	$1,003,200	$2,006,400	$8,360,000
AAPM Eligibility (5% Fee schedule)	$0	$0	$0	$1,254,000	$1,254,000
Loss Net of APM	**$0**	**$501,600**	**$1,003,200**	**$752,400**	**$7,106,000**
Net Loss PMPY	**$0**	**$13**	**$26**	**$20**	**$187**

** Enhanced modeled assuming 5% losses and 90% achieved quality (40% sharing)*

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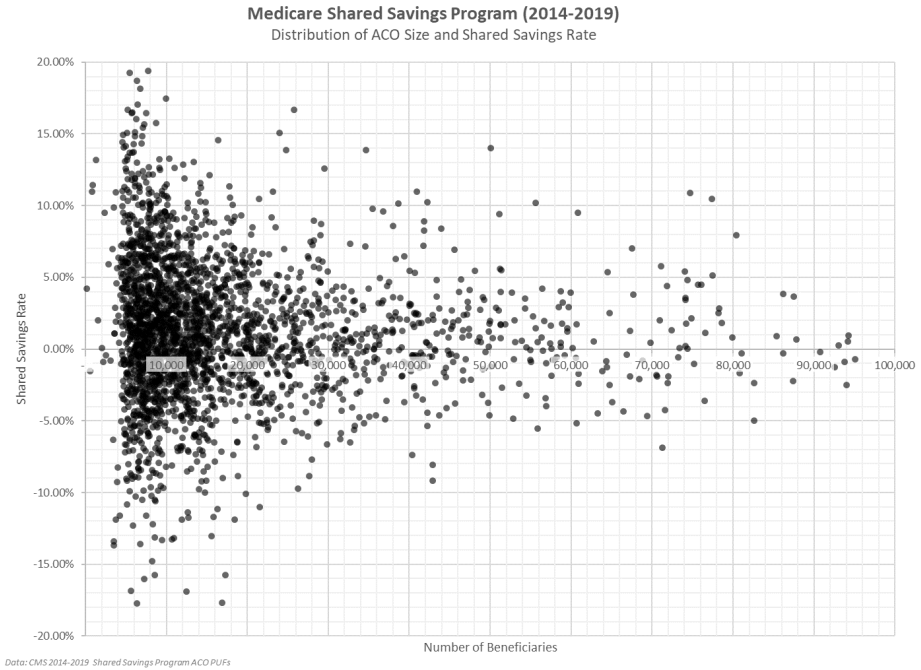
Note: Numbers are used for illustrative purposes only and do not reflect an actual Privia ACO

Size of the ACO doesn't bear a relationship to savings rate success, but does impact result variability



ACO Beneficiaries	ACOs	Average Savings Rate	Minimum ACO Rate (Losses)	Maximum ACO Rate (Savings)	Average Variation
(1) < 10K	1,037	1.7%	-31.8%	31.1%	6.1%
(2) 10K-20K	883	1.2%	-17.7%	22.3%	4.5%
(3) 20K-30K	324	0.7%	-11.0%	16.7%	3.9%
(4) 30K-40K	137	0.7%	-6.5%	13.9%	3.4%
(5) 40K-50K	108	0.8%	-9.2%	11.0%	3.5%
(6) 50K-60K	59	1.3%	-5.6%	14.0%	3.4%
(7) 60K-70K	26	-0.2%	-5.2%	9.5%	3.6%
(8) 70K-80K	33	1.8%	-6.9%	10.9%	3.8%
(9) GT 80K	45	1.3%	-5.0%	8.0%	2.4%

- ✓ Across all ACO sizes, average savings rates have historically been around 1%
- ✓ ACOs less than 20K are much more variable than above 20K

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Three year benchmark heavily influenced by HCC Trends

Benchmark Case #1: ACO with successive annual decline in HCC

ACO Case #1:	2019	2020	2021
Expenditures (incl Infl)	$ 10,000	$ 10,000	$ 10,000
HCC	1.11	1.05	1
Risk Ratio	0.90	0.95	1.00
Risk Adjusted Expenditures	$ 9,009	$ 9,524	$ 10,000

Benchmark			$ 9,511

Benchmark vs 2021 expenditures: -4.9%

Benchmark Case #2: ACO with successive annual increase in HCC

ACO Case #2:	2019	2020	2021
Expenditures (incl Infl)	$ 10,000	$ 10,000	$ 10,000
HCC	0.9	0.91	0.99
Risk Ratio	1.10	1.09	1.00
Risk Adjusted Expenditures	$ 11,000	$ 10,879	$ 10,000

Benchmark			$ 10,626

Benchmark vs 2021 expenditures: 6.3%

- Example #1: Expenditures being equal, a ~10% decline in HCC resulted in a benchmark close to 5% below 2021 expenditure run-rate
  - Benchmark 'Head-wind'
- Example #2: Expenditures being equal, a ~10% increase in HCC resulted in a benchmark more than 6% above 2021 expenditure run-rate
  - Benchmark 'Tail-wind'
- Benchmark HCC trends are 'uncapped'
- Privia uses both CCLF claims data and EMR billing data to monitor diagnostic trends in decision making
  - US HHS provides free SAS software that helps enable this practice
- To ensure continued diligence in documentation we also report on diagnostic 'recapture' and 'suspect medical conditions'

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Note: Numbers are used for illustrative purposes only and do not reflect an actual Privia ACO

ACO Efficiency: Regional Benchmark Estimation

	Illustrative ACO				Service Area				
County	Patients	HCC	PMPM	RA PMPM	Patients	HCC	PMPM	RA PMPM	Variance
County 1	6,434	0.85	$ 900	$ 1,063	105,291	0.95	$ 1,200	$ 1,263	-15.8%
County 2	2,614	0.88	$ 896	$ 1,015	3,553	0.85	$ 861	$ 1,010	0.6%
County 3	507	0.78	$ 893	$ 1,139	9,188	0.95	$ 1,208	$ 1,268	-10.2%
County 4	447	0.78	$ 636	$ 820	12,319	0.97	$ 1,138	$ 1,176	-30.3%
County 5	445	0.85	$ 682	$ 800	18,410	1.06	$ 1,182	$ 1,114	-28.2%
County 6	355	0.85	$ 882	$ 1,036	39,075	0.88	$ 1,036	$ 1,174	-11.7%
County 7	264	0.86	$ 885	$ 1,034	3,735	1.02	$ 1,124	$ 1,099	-5.9%
County 8	242	0.73	$ 733	$ 1,007	146,972	1.01	$ 1,312	$ 1,299	-22.4%
County 9	199	0.83	$ 736	$ 886	5,832	1.01	$ 1,297	$ 1,284	-31.0%
County 10	61	0.72	$ 922	$ 1,277	59,739	0.88	$ 1,107	$ 1,254	1.8%
Total	11,568	0.85	$ 873	$ 1,031	404,113	0.96	$ 1,206	$ 1,253	-17.7%

Total ACO RA PMPM:	$ 1,031
Service Area RA PMPM:	$ 1,191
Variance:	$ 160
35% of Variance	$ 56
Weighted Natl Average PMPM:*	$ 1,079
5% National Average PMPM	$ 54
Final Credit	$ 54
%Credit	5.2%

- Model suggest ACO expenditures are $160 less than Service Area
  - Service area is defined as counties weighted by ACO attribution
- Crediting 35% of the variance back to the ACO (subject to national limits) would increase the benchmark by 5.2% of historical spend ($54/$1,031)
- Key take-away: Regional benchmarking would represent a 5.2% tailwind

Note: Numbers are used for illustrative purposes only and do not reflect an actual Privia ACO

VBC Lessons Learned

- Physician growth impacted us in numerous ways:
  - Closely evaluate new provider profiles
  - Diverse Privia business model – must ensure VBC commitment early
  - Cavalier attitudes towards diagnostic documentation – target for training early
  - Re-basing impact on regional efficiency – key pathways to success variable
- Sustained focus with increasing contract obligations
  - Focus on tactics that have widespread influence, regardless of contract
    - AWV
    - HCC Coding
    - Quality
- Steerage difficult with open-access Medicare FFS product

Atrius Health

Medicare Model Options: Primary Care First

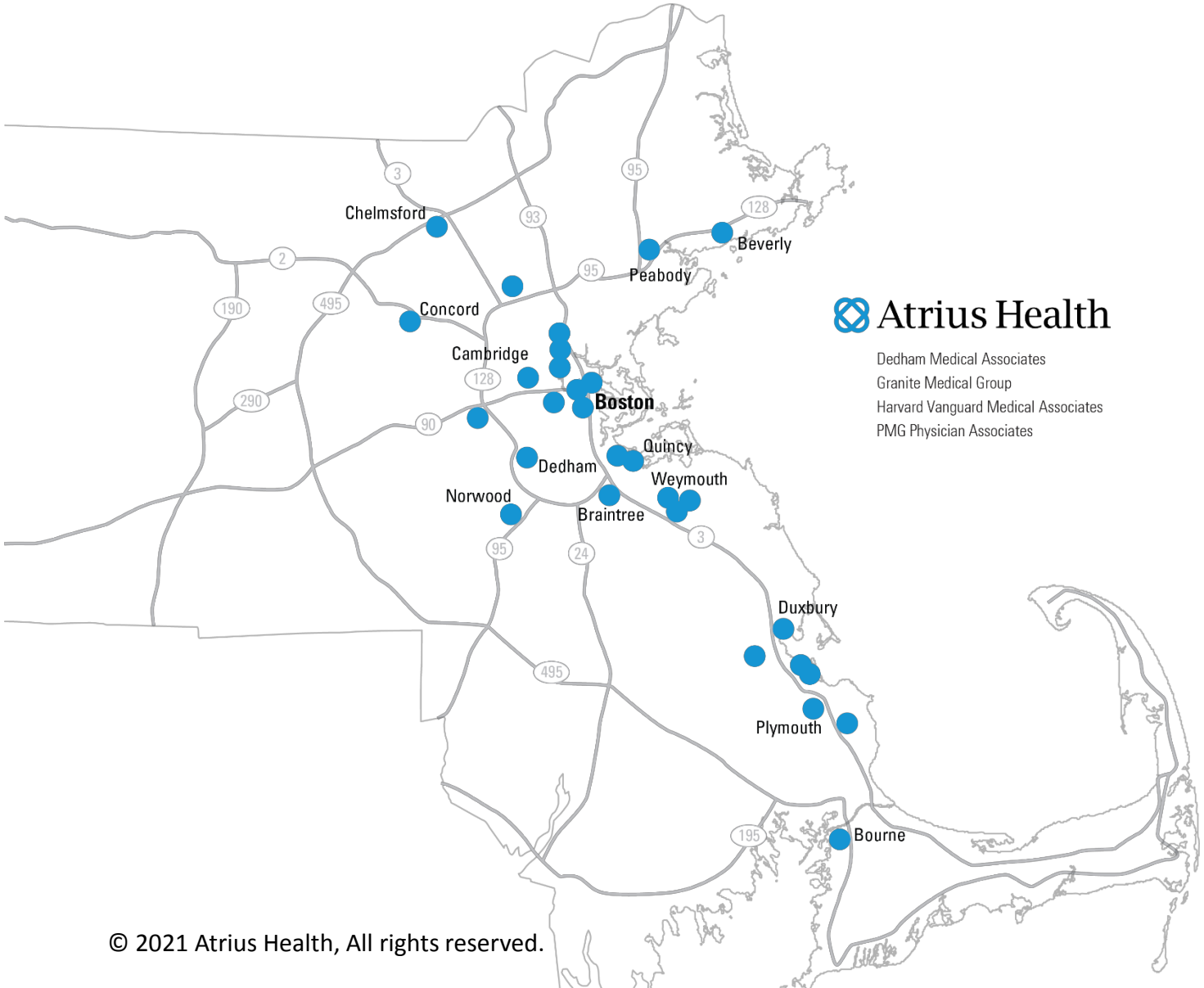
Margaret Senese, Director, ACO Programs

June 14, 2021

Atrius Health

Transforming care to improve lives

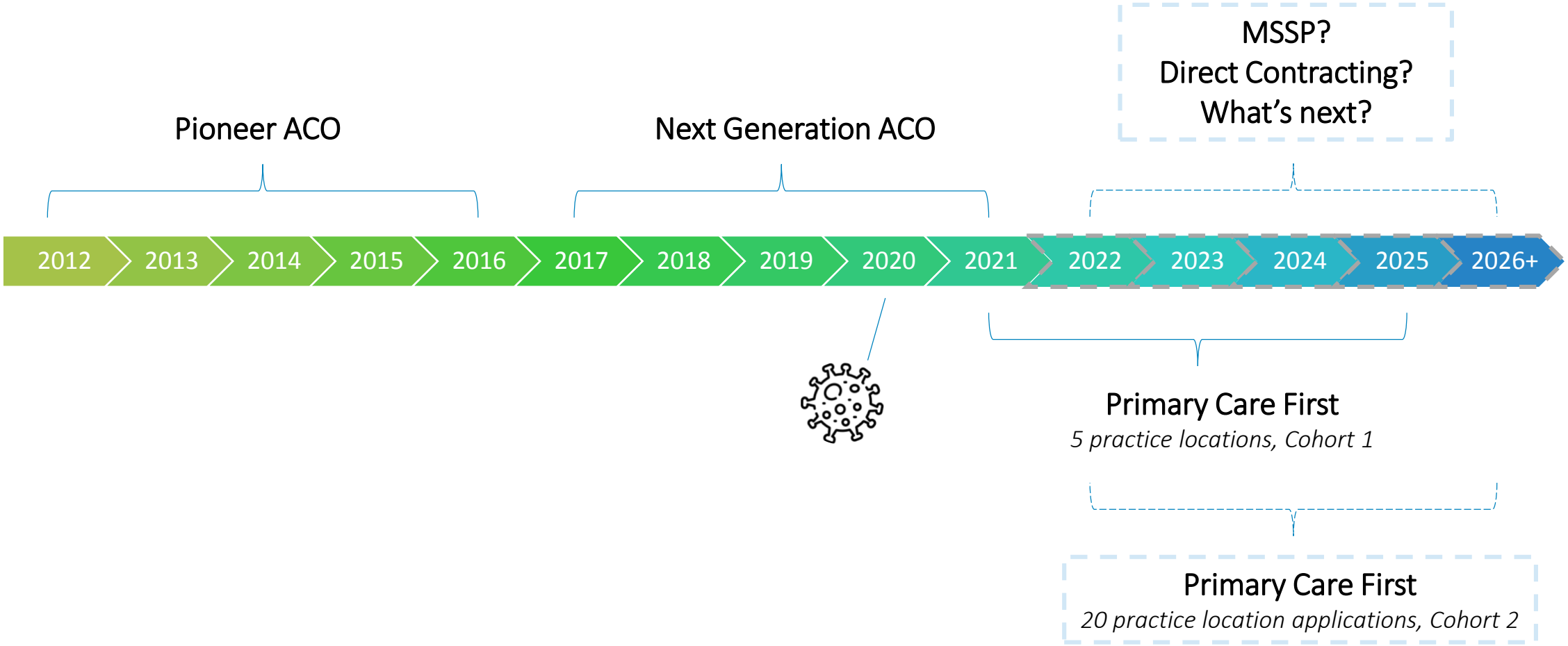
- 30 practice locations in eastern Massachusetts
- 1.8 million patient visits annually
- 705,000 adult and pediatric patients
- 660 physicians and primary care providers
- 4,800 employees
- $2B revenue



Care. About You.

Atrius Health

A strong history of accountable care leadership, with future decisions clouded in policy uncertainty and COVID benchmark impacts



Care. About You.

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So you applied to Primary Care First Cohort 2

1. Why participate?
   - Practice engagement
   - Financial upside
2. Evaluation recommendations
   - MSSP interaction
   - Leakage adjustment
   - Quality
   - Administrative effort and expense

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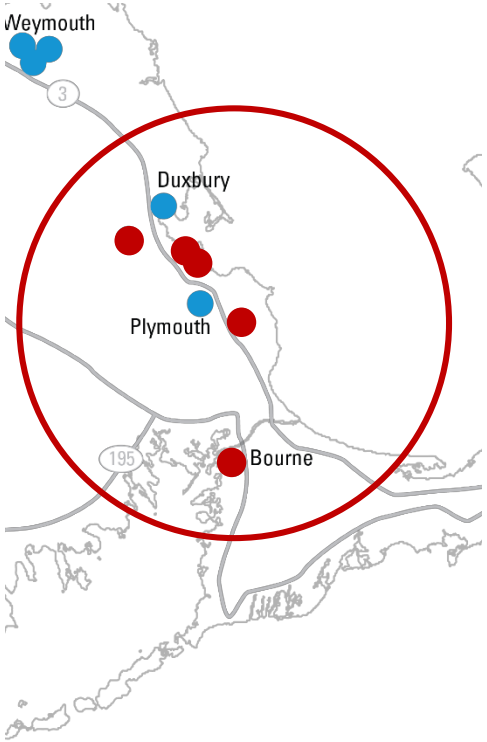
Our Primary Care First participation tests whether focused model participation bolsters local practice engagement

In 2021, Atrius Health begun piloting Primary Care First at five clinical locations, removing providers from NGACO. These locations are the most recent additions to Atrius Health, geographically separated from the core greater Boston service area, and small practices managed by a single local leadership team.



Note: Two other Plymouth-area practice locations do not provide adult primary care and are therefore excluded from PCF

The Team

Multi-disciplinary team includes primary care nursing, case management, operations, physician leadership, quality, and ACO representatives

The Focus

Local practice efforts focus on the fundamentals. The team aims to reduce acute hospital utilization, specifically reducing avoidable admissions and readmissions

The Strategy

The strategy is nursing-led, emphasizing (1) transitions of care – including discharge from home health services, (2) enhanced collaboration between primary care nursing and case management, and (3) operations tactics to ensure high-risk patients can be seen quickly when needed

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Participation can be advantageous compared to FFS base – especially for those also participating in MSSP

- PCF can be a financially beneficial model
  - Population-Based Payment is not adjusted for leakage or quality until second participation year, allowing time for readiness
- Under MSSP, PCF payments are included in the shared savings/losses calculation
  - With less than 100% risk in MSSP, this can be favorable overall
  - Depending on practice/ACO relationship and funds flow, this can be a positive or a negative
  - Magnitude depends on MSSP track/level

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Atrius Health

Evaluation: MSSP interaction

This is not MIPS advice!

- As discussed: PCF payments hit the MSSP benchmark
- PCF is a QPP Medical Home Model
  - Therefore, for larger practices ("50 eligible clinician limit"), PCF is not a substitute for more substantial risk participation
- No SNF waiver under PCF
- Recommendations
  1. Evaluate your PCF practice / ACO structure, funds flow, and interaction
  2. For those currently in MSSP but considering exiting, evaluate QPP / MIPS impact – and absence of SNF waiver

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Evaluation: Leakage adjustment

- PCF payments are adjusted for primary care leakage

$$Leakage\ Rate\ Adjustment = \frac{Number\ of\ Qualifying\ Visits\ and\ Services\ for\ Attributed\ Beneficiaries\ Outside\ PCF\ Practice}{Number\ of\ Qualifying\ Visits\ and\ Sevices\ for\ Attributed\ Beneficiaries}$$

Source: PRIMARY CARE FIRST: PAYMENT AND ATTRIBUTION METHODOLOGIES, Volume 1, Version 3

- Leakage does not take into account system approaches to access
  - E.g., regional evening/weekend sick care, cross-coverage reduces the payment
- Specialty NP/PA visits can count as leakage
  - E.g., post-op ortho PA visit *(taxonomy 363A00000X)*
- Recommendations
  1. Model primary care leakage using claims data
  2. Use a conservative primary care leakage figure in your PCF financial model, informed by your practice and system configuration
  3. Consider advocating for a more accurate methodology!

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Evaluation: Quality

- Quality gateway benchmarks are very reasonable (low), but performance is assessed at the site level
- Three measures are eCQMs; one measure reports via qualified registry or QCDR
- Recommendations:
  1. Assess baseline quality performance at the site level to spot outlier practices
  2. Assess your ability to report eQCMs (or your plans to develop this capacity) – and validate your EHR's ability to report eCQMs at the site level

Practice Risk Group 1-2
Quality Gateway Measures

1. HbA1c Poor Control
2. Controlling High BP
3. Colorectal Cancer Screening
4. Advance Care Plan
5. Patient Experience of Care Survey

Performance Based Adjustment Measure

- Acute Hospital Utilization

Source: PRIMARY CARE FIRST: PAYMENT AND ATTRIBUTION METHODOLOGIES, Volume 1, Version 3

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Evaluation: Administrative effort and expense

- Site-level participation requires site-level administration
  - E.g. keying in practitioner adds and terms separately for each location in the portal
- Required annual patient experience survey is also administered at the site level. This can add up.
- Quality reporting may require additional EHR, QDCR licenses
- Recommendations
  1. If contemplating multiple locations, ensure you have sufficient administrative support to scale the participation
  2. Assess expenses associated with program requirements

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Key messages

- Targeted, practice-specific model participation such as Primary Care First can be a promising practice engagement strategy
- ACOs that applied to PCF Cohort 2 should consider participating
- Diligence is needed:
  - MSSP interaction
  - Primary care leakage
  - Quality
  - Administrative expense and effort

Remember: one contract per site

Thank you

Margaret Senese

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Northwestern Medicine®

Lessons from Northwestern Medicine's Experience Implementing Alternative Payment Models

Bundled Payment vs. Shared Savings

Jessica Walradt

Northwestern Medicine®

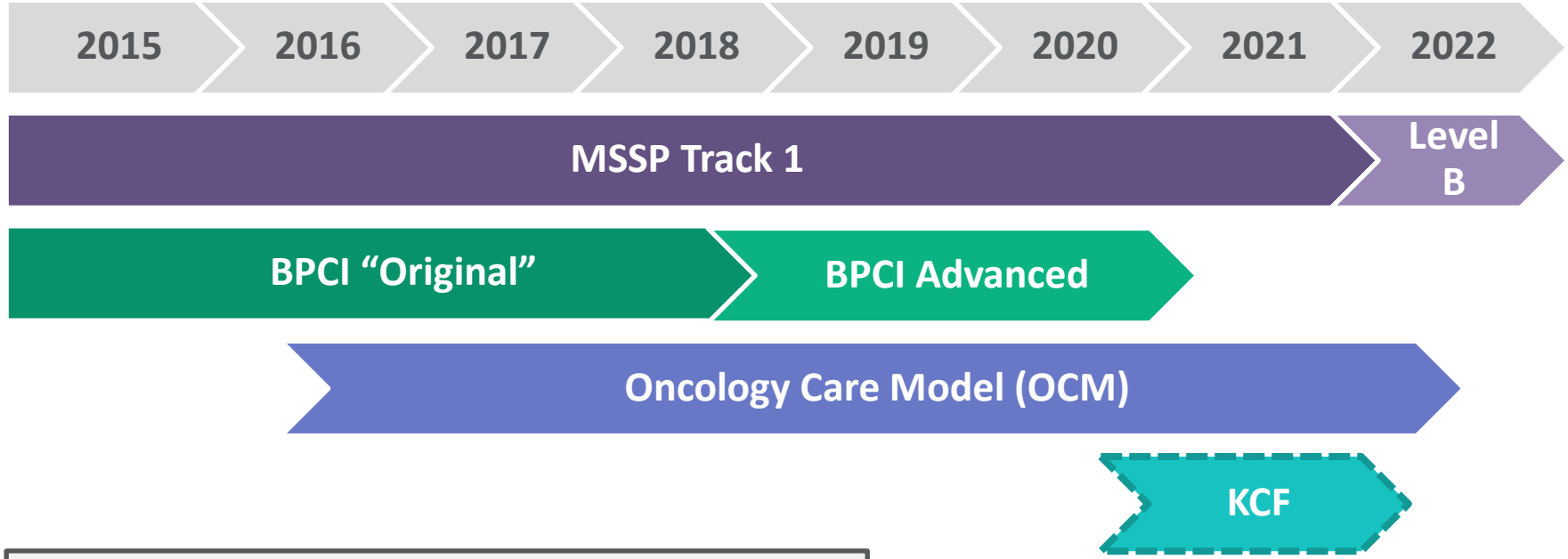
11 Hospitals

>2,500 employed physicians

1 Clinically Integrated Network (320 practices)

>3,200 Students & trainees

Timeline of Participation in Medicare* APMs



***NM Engages in Multiple Commercial VBC Contracts:**

- Medicare Advantage
- Shared Savings
- Self-insured for employees
- Pay-for-performance

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NM's Selected Clinical Episodes/Bundles

Clinical Condition	Duration	"Trigger" Event	Downside Risk?	Participant
Congestive Heart Failure (CHF)	30 days	Hospital Discharge (DRG-specific)	Yes	Hospital(s)
	90 days			
COPD	30 days			
Major Joint Replacement of the Lower Extremity	90 days			
Stroke				
Sepsis				
Cancer (all types)*	6 months (with ability to trigger subsequent 6-month episode)	Cancer diagnosis, E&M visit, + chemotherapy	No	Physician group practice

**Excludes certain small-volume cancers*

Bundled Payment Participation & Episode Selection Criteria

Category	Metric
Engagement	Active involvement of clinical champion
Financial Risk vs. Opportunity	**Volume:** Annual volumes exceed specified threshold
	Risk adjustment: Target price methodology adequately adjusts for factors beyond physician control
	Variance to Target: Target Price > Average Episode payment *(or tangible path to breakeven)*
	Variation: Low variation in episode payments
	Opportunity: % actionable **> 50%**
Operations	Possess analytic resources to identify patients
	Identified interventions to reduce unnecessary utilization

Bundled Payment: Benefits and Challenges

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Benefits of Bundled Payment Models
Engages specialists
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Access to “first dollar” savings
Lessons can be translated to other models

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Benefits of Bundled Payment Models

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- Access to “first dollar” savings
- Lessons can be translated to other models

Challenges of Bundled Payment Models

- Sub-optimal APM for certain condition/types & populations:
  - Hospital trigger may be “too late”
  - Difficult to determine optimal duration
- Volume too low to mitigate impact of random variation
- Difficult to adequately risk-adjust target price

Next Steps: Assessing Participation in Future APMs

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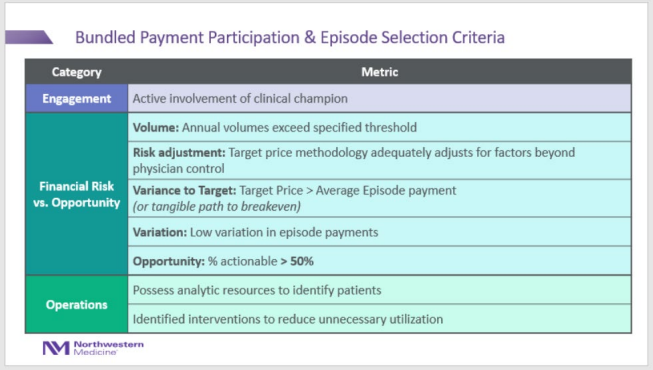
❑ Establish payer partner & model participation criteria



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Medicare Advantage | **ACOs** | **Prospective Payment**

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Medicare Advantage | **ACOs** | **Prospective Payment**

❑ Define & grade current competencies

Care Coordination Competency Assessment

Component	Optimal Attributes & Structure (What does an "A" look like?)	Current Grade
Scope		
Structure (Staffing & Leadership)		
Technology		
Other		

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- *Care Coordination*
- *Post-acute Network*
- *Analytics*
- *IT*
- *Clinical Documentation*
- *Patient outreach*

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Thank you!

Model Overlap

	Direct Contracting Model (DC)	
	Providers	Beneficiaries
MSSP	Participant Providers cannot particpate in MSSP (and vice-versa). Preferred Providers may participate in both models	Beneficairies aligned to a DCE will not be aligned to a MSSP ACO
Bundled Payments for Care Initiative - Advanced (BPCI-A)	Providers may participate in both DC and BPCI-A	DC beneficiaries cannot participate in BPCI-A (beneficiaries cannot trigger an episode)
Comprehensive Joint Replacement (CJR)	DC participants may be either CJR collaborators or collaborator agents	DC beneficiaries cannot participate in CJR (beneficiaries cannot trigger an episode)
Oncology Care Model (OCM)	Providers may participate in both DC and OCM	OCM beneficiaries are not excluded from participation in DC
Comprehensive ESRD Care Model (CEC)	DC Professionals cannot participate in both CEC and DC. DC Participants who are not primary care specialsts and DC Preferred Providers may participate in both CEC and DC.	CEC beneficiaries are excluded from participation in DC
Comprehensive Primary Care + (CPC+)	Providers cannot participate in both DC and CPC+	DC beneficiaries may not participate in CPC+. (DC has alignment preference over CPC+)
Primary Care First (PCF)	Providers cannot participate in both DC and PCF	DC beneficiaries may not participate in PCF. (DC has alignment preference over PCF).

Model Overlap

	Medicare Shared Savings Program (MSSP)	
	Providers	Beneficiaries
Direct Contracting	Participant Providers cannot participate in MSSP (and vice-versa). Preferred Providers may participate in both models	Beneficairies aligned to a DCE will not be aligned to a MSSP ACO
Bundled Payments for Care Initiative - Advanced (BPCI-A)	Providers may participate in both MSSP and BPCI-A.	(for Model Year 3, beginning 1/1/2020) MSSP beneficiaries can participate in BPCI-A regardless of MSSP track (beneficiaries can trigger an episode).
Comprehensive Joint Replacement (CJR)	MSSP participants may be either CJR collaborators or collaborator agents.	MSSP Track 3 beneficiaries are excluded from CJR (beneficiaries cannot trigger an episode); All other MSSP beneficiaries are included in CJR (beneficiaries can trigger an episode).
Oncology Care Model (OCM)	Providers may participate in both MSSP and OCM.	OCM beneficiaries are not excluded from participation in MSSP.
Comprehensive ESRD Care Model (CEC)	Providers (full TIN) cannot participate in both CEC and MSSP.	CEC beneficiaries are excluded from participation in MSSP.
Comprehensive Primary Care + (CPC+)	Providers can participate in both CPC+ and MSSP.	MSSP beneficiaries may participate in CPC+ regardless of MSSP track.
Primary Care First (PCF)	Providers can participate in both PCF and MSSP (any track).	MSSP beneficiaries may participate in PCF regardless of MSSP track.

Questions

If you did not get a chance to ask your question, or if you have additional questions in the future, please email advocacy@naacos.com