MSSP Benchmark Report Trends and Implications

May 3, 2022
2 PM

Housekeeping

1. Speakers will present for around 45 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 ask a question via the Question tab on your dashboard to ask a question.
3. Webinar is being recorded
   - Slides and recording will be available on the NAACOS website within the next few days.

Speakers

	**Melody Danko-Holsomback, MSN, CRNP, NAACOS** Melody is the Vice President of Education, where she leads NAACOS' education on value-based care and supports members' educational needs. She has more than 28 years of practical experience in nursing, 21 of which have been within Geisinger Health as a nurse, nurse practitioner, IT and various ACO roles including CAO of Keystone ACO She has served as a member of the NAACOS Quality Committee, the National Quality Forum Measure-Loop-Feedback Committee, Health Care Transformation Task Force committees and board, and is a Days-at-Home Technical Expert Panelist. Melody attended Ohio University for her BSN and Wilkes University for her MSN as an Adult-Gerontology Primary Care Nurse Practitioner
	**Michael Sarli, MHA, MS, Mercy** Michael is currently serving as Vice President of Population Health Economics at Mercy (headquarters in St. Louis). He has 15 years of experience in healthcare spanning physician practice operations, population health, CMS MSSP ACO and value-based contracts in Medicare Advantage and commercial. Michael received his Master's in Health Outcomes Research and a Master's in Health Administration from Saint Louis University. He currently lives in St. Louis with wife and two children

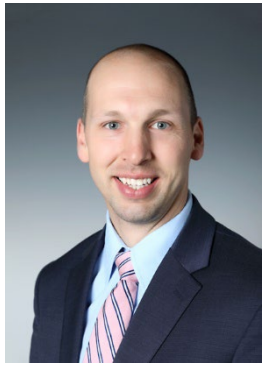
Speakers

Colleen Norris, FSA, MAAA, Milliman

Colleen Norris is a consulting actuary with Milliman located in Denver. Colleen has worked for many years in providing analytical and strategic support to ACOs and other organizations engaging in new models provider risk sharing. Her main interest is in helping ACOs deploy a variety of strategies to help manage and mitigate financial risk, use data to understand what is happening with their patients and improve care, and most importantly get properly compensated for the good work that they do. She has extensive experience helping organizations navigate and succeed in MSSP, ACO REACH (and predecessor programs), and commercial arrangements. Colleen is a Fellow with the Society of Actuaries and a Member of the American Academy of Actuaries.

Matthew Smith, FSA, MAAA, Milliman

Matthew Smith is a consulting actuary with Milliman in Phoenix. Matthew is an expert in Medicare issues and has worked with numerous Medicare Advantage plan sponsors on the plan design and pricing of their bids, as well as CMS bid and financial audits and feasibility studies. He has also worked with ACO clients on risk settlement validation, contract negotiations, and internal benchmark development, and served a range of clients on projects such as M&A due diligence, insurance license and federal or state funding grant applications.



Brent Jensen, FSA, MAAA, Milliman

Brent Jensen is a Principal and consulting actuary with Milliman. Brent's consulting experience covers a wide range of health actuarial projects. He leads projects covering ACO programs, risk sharing arrangements and related contracting, financial forecasting, pro forma projections, and bundled payment analyses. He is an expert in the various ACO programs, especially direct contracting and ACO REACH and works with clients to evaluate various CMS programs and tracks. He also does a variety of different types of work for his clients which include ACOs, insurance companies, hospitals and physician groups, and employers.

A Look into MSSP Benchmark Report Trends and Implications

Mike Sarli
Vice President
Population Health Economics
Mercy ACO

Colleen Norris, FSA, MAAA
Matthew Smith, FSA, MAAA
Brent Jensen, FSA, MAAA
Milliman, Inc.

Does your preliminary benchmark look a little different than you expected?

Let’s figure out the future of your benchmark

…since it might change a lot by the time you get your final historical benchmark report.

Agenda

1. What makes the preliminary benchmarks “preliminary”?
2. Should you expect big adjustments between the preliminary and final benchmark? Why the adjustments to the preliminary benchmark may be particularly pronounced for new / renewing ACOs in 2022.
3. What information is available to understand more about how the benchmark will be adjusted.
4. Mercy ACOs experience with the preliminary benchmark, and how it is being understood.
5. Timing for ACO’s to receive the final historical benchmark, and how to interpret Q1 reports.

What makes the preliminary benchmark “preliminary”?

What makes the preliminary benchmarks "preliminary"?

Placeholders in the preliminary benchmark

Cells in yellow are where values in the preliminary benchmark report are essentially placeholders.

All values are for illustration purposes only.

		BY1	BY2	BY3	Composite
	Per Capita Expenditures	$11,000	$10,200	$11,200	
x	Trend to BY3	1.020	1.000	1.000	
x	Risk Adjust to BY3	0.980	1.000	1.000	
=	**Historical Benchmarks before Regional Adjustment**	$10,996	$10,200	$11,200	$10,799
+	Regional Adjustment				$123
=	**Regionally Adjusted Historical Benchmark**				$10,922

That's a lot of yellow!

How far off might the preliminary values be from final values?

How might trend change between the interim and final benchmark reports?

What makes the preliminary benchmarks "preliminary"?

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+	Regional Adjustment				$123
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The fact that we don't have BY3 regional, or national expenditures means that the values trending BY1 to BY3 and BY2 to BY3 are effectively placeholders.

Preliminary Trend

Everyone will have received a build-up of their preliminary trend in Table 2.

Table 2 Trend Factor Determination Table of Contents			
	BY1	**BY2**	**BY3**
[A] OACT National Assignable FFS Per Capita Expenditures ($)			
ESRD	87,911	84,662	84,662
Disabled	12,340	11,885	11,885
Aged/dual	18,593	18,676	18,676
Aged/non-dual	10,977	10,071	10,071
[B] National Expenditure Trend Factor			
ESRD	0.963	1.000	1.000
Disabled	0.963	1.000	1.000
Aged/dual	1.004	1.000	1.000
Aged/non-dual	0.918	1.000	1.000
[C] Risk-Adjusted Regional Per Capita Expenditures ($)			
ESRD	80,146	78,207	78,201
Disabled	10,770	10,299	10,299
Aged/dual	17,313	17,248	17,244
Aged/non-dual	9,658	8,879	8,883
[D] Regional Expenditure Trend Factor			
ESRD	0.976	1.000	1.000
Disabled	0.956	1.000	1.000
Aged/dual	0.996	1.000	1.000
Aged/non-dual	0.920	1.000	1.000

You will notice that BY2 and BY3 values are identical. CMS used the BY2 values as a placeholder.

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CMS also used BY2 values as a placeholder for the regional component. The only reason values are not identical is due to any differences in county-level weighting between BY2 and BY3.

(See Note [C] in Table 2 of the Preliminary Benchmark)

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The reason this is such a problem is that in almost all cases, expenditures increased notably between 2020 (BY2) and 2021 (BY3).

Trend – where can you find better information?

For renewing ACOs *without significant changes* in the geographic footprint, Q4 QEXPU reports are a valuable source of information.

	All MSSP ACOs[2]	National Assignable FFS[3]
Total Expenditures by Assigned Beneficiary Medicare Enrollment Type, Excluding COVID-19 Episodes[5]		
Total	10,791	12,294
End Stage Renal Disease	80,183	87,466
Disabled	10,662	12,179
Aged/Dual	15,587	18,896
Aged/Non-Dual	9,978	10,777

National Assignable - See Table 1A

There will be adjustments between these, and the final numbers used in the OACT trend. Still, this is a more reasonable proxy than BY2 values.

Regional Expenditures - See Table 2A

These numbers are not risk adjusted. While this is better than using BY2 as an estimate, risk adjustment has the potential to change these values.

Table 2A
Medicare Shared Savings Program
Regional Expenditures Report, Excluding COVID-19 Episodes
2021 Quarter 4 Report
Table of Contents

	Benchmark Year 3	Q1, Excluding COVID-19 Episodes	Q2, Excluding COVID-19 Episodes	Q3, Excluding COVID-19 Episodes	Q4, Excluding COVID-19 Episodes
Regional Expenditures ($)[1]					
ESRD	76,300	76,600	77,900	77,900	79,700
Disabled	10,500	10,900	11,400	11,400	11,600
Aged/dual	17,600	19,400	19,800	19,400	19,200
Aged/non-dual	9,500	9,400	10,000	10,000	10,400

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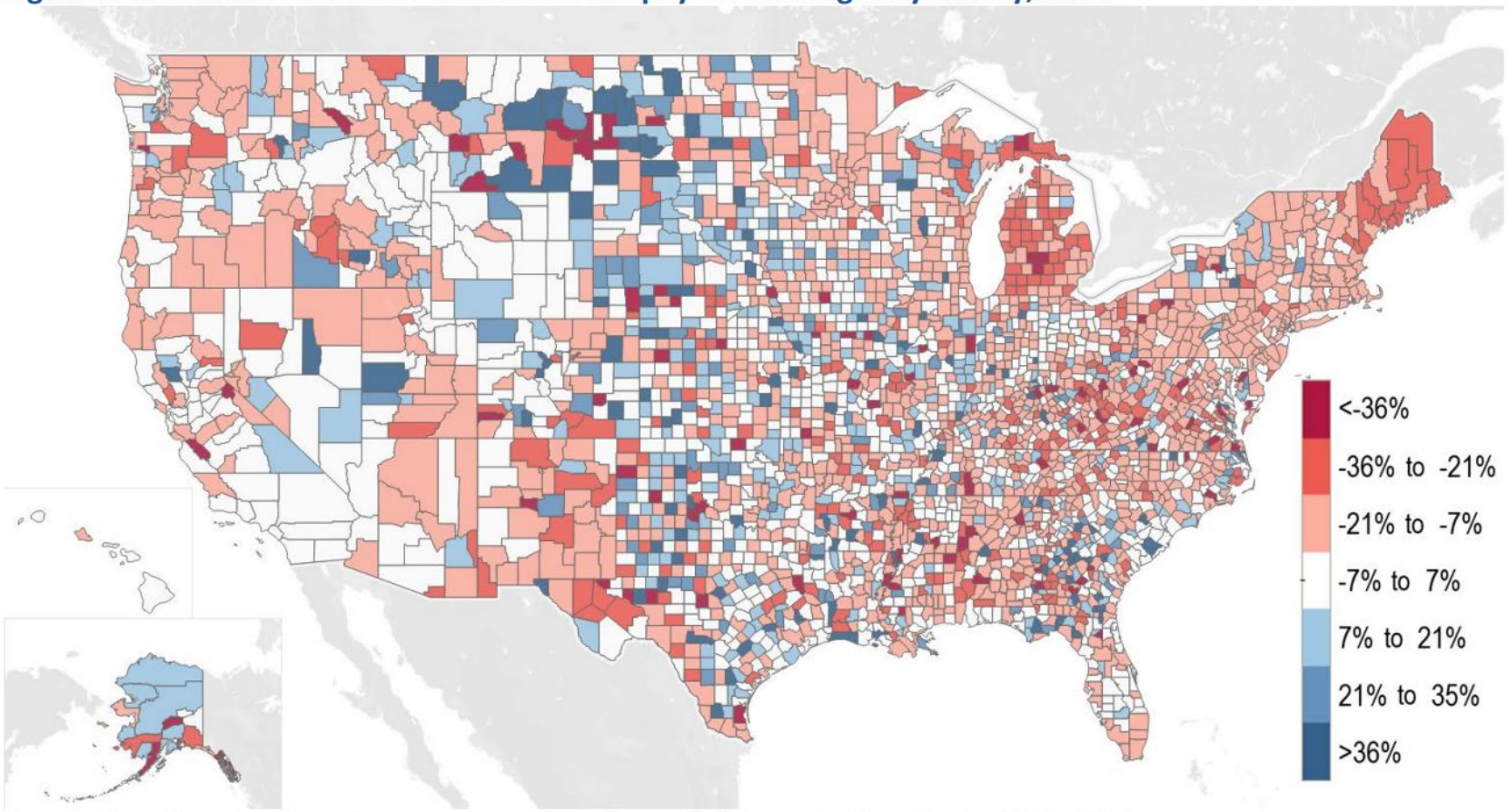
Disabled	10,500	10,900	11,400	11,400	11,600
Aged/dual	17,600	19,400	19,800	19,400	19,200
Aged/non-dual	9,500	9,400	10,000	10,000	10,400

The key caveat here the renormalized regional risk score may have also moved up or down relative to BY2.

Trend – change in Y-O-Y expenditures

Ratio of 2020 to 2019 cumulative year to date Medicare fee-for-service payments, by county

Figure 5. Cumulative Medicare fee-for-service payment changes by county, 2020



Source: Data from Medicare's common working file as of claims submitted by April 23, 2021

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https://aspe.hhs.gov/sites/default/files/documents/fc9316ab391e6b6a18fde3e8fca68685/medicare-ffs-utilization-spending-ib.pdf, figure 5

Trend – How to think about regional trend?

Cells in blue are from the preliminary benchmark report

Cells in yellow are from the 2021 Q4 QEXPU

All values are for illustration purposes only.

		BY1	BY2	BY3
	Regional Expenditures	$11,000	$10,200	$11,200
x	Risk Adjustment to Regional Expenditures	N/A	N/A	???
=	Risk Adjusted Regional Expenditures	$11,000	$10,200	$11,200
	Regional Trend	1.018	1.098	1.000
	National Assignable Expenditures	$10,800	$10,300	$11,000
	National Assignable Trend	1.019	1.068	1.000
x	Weight given to Regional Trend	80%	80%	80%
	Blended Trend	1.018	1.092	1.000

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The BY1 and BY2 values from the preliminary benchmark report are already risk adjusted, but the BY3 estimate from the QEXPU is not normalized.

We don't need to worry about risk adjustment for the national assignable expenditures.

Trend – How to think about regional trend?

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x	Weight given to Regional Trend	80%	80%	80%
	Blended Trend	1.018	1.092	1.000

If the raw regional trend increased more than the national assignable trend, it is possible (but not certain) that the regional risk score also increased at a higher rate than the national assignable values.

If regional trend is higher than national trend, you may want to moderate the adjustment for conservatism.

Trend – How to think about regional trend?

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… but really, it is going to be difficult to get a sense of the change in regional risk scores with any precision before CMS releases the final benchmark reports.

How might risk adjustment change between the interim and final benchmark reports?

Preliminary Risk Adjustment

Calculate Historical Benchmark	BY1	BY2	BY3
[C] CMS-HCC Risk Score			
ESRD	1.037	1.042	1.042
Disabled	1.036	1.038	1.038
Aged/dual	1.116	1.089	1.089
Aged/non-dual	1.083	1.075	1.075
[D] CMS-HCC Risk Ratio			
ESRD	1.005	1.000	1.000
Disabled	1.002	1.000	1.000
Aged/dual	0.976	1.000	1.000
Aged/non-dual	0.993	1.000	1.000

BY2 is set to BY3

Preliminary Risk Adjustment

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ESRD	1.037	1.042	1.042
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BY2 is set to BY3

Which means that the risk ratios for BY1 and BY2 are not correct.

Risk Adjustment – where can you find better information?

For renewing ACOs, the information available from CMS is extremely limited

Parameters	For ACOs Under Preliminary Prospective Assignment	For ACOs Under Prospective Assignment
Claims-Based Beneficiary Assignment Window	01/01/2021 - 12/31/2021	10/01/2019 - 09/30/2020
MSSP ACO Report Period	01/01/2021 - 12/31/2021	01/01/2021 - 12/31/2021
Voluntary Alignment End Date	09/30/2020	09/30/2020
ALR Table 1-1: Claims Processed as of	01/07/2022	10/23/2020
ALR Table 1-2, 1-3, 1-4: Claims Processed as of	01/07/2022	01/07/2022
CMS-HCCs and CMS-HCC risk scores shown in this report	01/01/2020 - 12/31/2020	01/01/2020 - 12/31/2020
CMS-HCCs and CMS-HCC risk scores shown in this report are based on diagnoses from	01/01/2019 - 12/31/2019	01/01/2019 - 12/31/2019
CMS-HCC Version used in this report	V24	V24
Demographic risk scores shown in this report	01/01/2020 - 12/31/2020	01/01/2020 - 12/31/2020
Performance Year Participant List on which Report is Based	2021	2021
Date Produced	01/12/2022	01/12/2022

You will notice that in your 2021 Q4 ALR reports, in the ***ALRParameters.xlsx*** file, that the risk scores for the members in the report are 2020 risk scores, based on 2019 diagnoses.

… so not very helpful for understanding your 2021 risk score.

Risk Adjustment – where can you find better information?

Pseudo-analyses using risk scores generated by other systems

- Obtain risk scores for the ACO population calculated in your data warehouse, by your EHR vendor, etc.
- Determine if the scores are concurrent or prospective. If concurrent, remember to adjust accordingly. (i.e., a 2019 concurrent risk score corresponds to a 2020 MSSP risks score.)
- Determine if any normalization has been applied to the risk scores. It will be necessary to make sure that normalization is comparable between MSSP values and system-generated values.
- Compare the ratio of MSSP risk scores to system-generated risk scores for at least 2 years. Estimate 2021 risk score for MSSP, which is based on 2020 diagnoses.

Limitations to this approach

- *Material changes to the ACO roster during the time period from 2018 – 2020 will cause this approach to fail.*
- *Inability to determine if any normalization has been applied to system-generated risk scores.*
- *Changes in risk score model used by the system during the time period in question.*
- *Limitations on how precisely 2021 MSSP renormalization factors can be estimated.*

Risk Ratio Leveraging

Low Risk Score in BY3

		BY1	BY2	BY3
		2019	*2020*	*2021*
	Per Capita Expenditures	$10,000	$9,500	$10,200
	Risk Score *after normalization*	1.000	1.000	0.960
x	Risk Ratio	0.960	0.960	1.000
	Blended regional / national expenditures	$10,000	$9,500	$10,200
x	Blended Regional / National Trend	1.020	1.074	1.000
	Trended expenditures	**$9,792**	**$9,792**	**$10,200**
	Historical Benchmark	**$9,928**		

A lower risk score in BY3 has the effect of depressing the risk ratios in BY1 and BY2, leading to lower trended expenditures for those years and a lower historical benchmark.

High Risk Score in BY3

		BY1	BY2	BY3
		2019	*2020*	*2021*
	Per Capita Expenditures	$10,000	$9,500	$10,200
	Risk Score *after normalization*	1.000	1.000	1.040
x	Risk Ratio	1.040	1.040	1.000
	Blended regional / national expenditures	$10,000	$9,500	$10,200
x	Blended Regional / National Trend	1.020	1.074	1.000
	Trended expenditures	**$10,608**	**$10,608**	**$10,200**
	Historical Benchmark	**$10,472**		

A higher risk score in BY3 has the effect of raising the risk ratios in BY1 and BY2, leading to higher trended expenditures for those years and a higher historical benchmark

Risk Ratio Leveraging

Low Risk Score in BY1 or BY2

		BY1 2020	BY2 2021	BY3 2022
	Per Capita Expenditures	$9,500	$10,200	$10,200
	Risk Score *after normalization*	1.000	0.960	1.000
x	Risk Ratio	1.000	1.042	1.000
	Blended regional / national expenditures	$9,500	$10,200	$10,200
x	Blended Regional / National Trend	1.074	1.000	1.000
	Trended expenditures	**$10,200**	**$10,625**	**$10,200**
	Historical Benchmark	**$10,342**		

A lower risk score in BY2 has the effect of raising the risk ratio in BY2, leading to higher trended expenditures for that year and a higher historical benchmark.

High Risk Score in BY1 or BY2

		BY1 2020	BY2 2021	BY3 2022
	Per Capita Expenditures	$9,500	$10,200	$10,200
	Risk Score *after normalization*	1.000	1.040	1.000
x	Risk Ratio	1.000	0.962	1.000
	Blended regional / national expenditures	$9,500	$10,200	$10,200
x	Blended Regional / National Trend	1.074	1.000	1.000
	Trended expenditures	**$10,200**	**$9,808**	**$10,200**
	Historical Benchmark	**$10,069**		

A higher risk score in BY2 has the effect of lowering the risk ratio in BY2, leading to lower trended expenditures for that year and a higher lower benchmark

Regional Adjustment

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+	Regional Adjustment				$123
=	**Regionally Adjusted Historical Benchmark**				$10,922

In a nutshell, the regional adjustment is a portion of the difference between your ACO's BY3 expenditures and the regions BY3 expenditures.

Regional Adjustment

Cells in yellow are significantly influenced by BY2 placeholders in the preliminary report.

	BY3 Risk-Adjusted Regional Expenditures
x	ACO BY3 RS / Reg. BY3 RS
	BY3 Adjusted Reg exp
-	Historical Benchmark
	Difference
x	Weight
	Regional Adjustment

This is a simplified build-up of how the regional adjustment is calculated
(ignoring for a moment the caps on regional adjustment).

The challenge is that by the time we get to the regional adjustment calculation, assumptions are extremely compounded.

Regional Adjustment

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	BY3 Risk-Adjusted Regional Expenditures
x	ACO BY3 RS / Reg. BY3 RS
	BY3 Adjusted Reg exp
-	Historical Benchmark
	Difference
x	Weight
	Regional Adjustment

Reasonable estimate of BY3 regional expenditures from QEXPU if there are no material changes to the provider list, but the values are not risk adjusted.

Regional Adjustment

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	BY3 Risk-Adjusted Regional Expenditures
x	ACO BY3 RS / Reg. BY3 RS
	BY3 Adjusted Reg exp
-	Historical Benchmark
	Difference
x	Weight
	Regional Adjustment

Unless you have special access to analyses from the 100% data, this is likely a guess.

Regional Adjustment

Cells in yellow are significantly influenced by BY2 placeholders in the preliminary report.

	BY3 Risk-Adjusted Regional Expenditures
x	ACO BY3 RS / Reg. BY3 RS
	BY3 Adjusted Reg exp
-	Historical Benchmark
	Difference
x	Weight
	Regional Adjustment

Can be estimated, but is leveraged on several uncertain assumptions.

Regional Adjustment

Cells in yellow are significantly influenced by BY2 placeholders in the preliminary report.

	BY3 Risk-Adjusted Regional Expenditures
x	ACO BY3 RS / Reg. BY3 RS
	BY3 Adjusted Reg exp
-	Historical Benchmark
	Difference
x	Weight
	Regional Adjustment

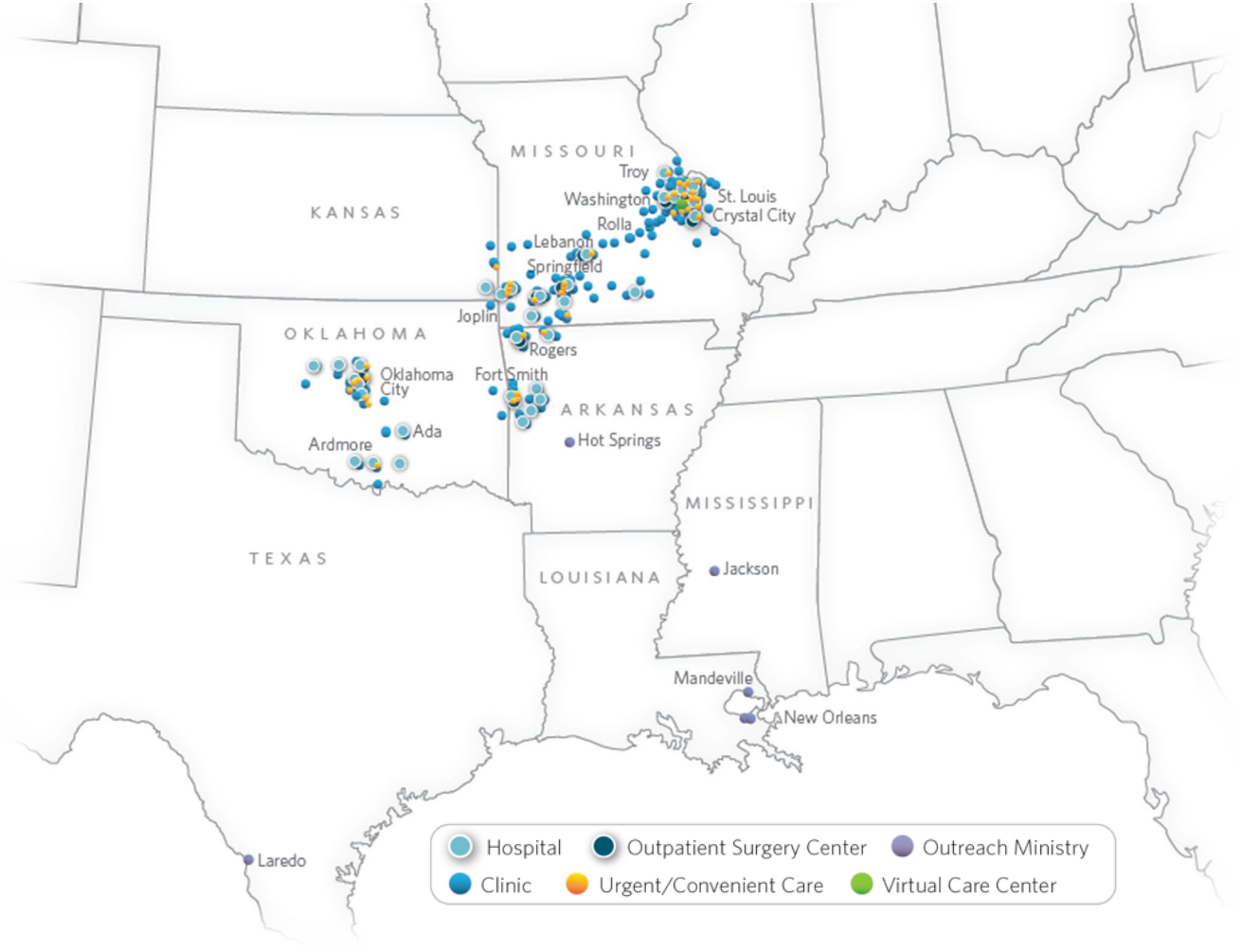
You can certainly estimate the regional adjustment, but be aware of the drivers of uncertainty in the estimate.

Other reasons an ACO's expenditures and / or risk score might differ from regional averages

- The facilities and providers associated with an ACO, or providing care for an ACO's patients, may have resumed normal levels of care earlier or later than the area at large.
- An ACO's success rate at implementing telehealth may have been above or below average for an area. Success can be determined not only by the ability to launch a platform, but also the ability of beneficiaries to access it successfully which can be influenced by age, internet access, and social factors.
- Differences in social factors for assigned beneficiaries that may cause those patients to return to care at a different rate than the wider area.
- An ACO's ability to "catch up" with getting patients in for primary care visits in the 2nd half of the year.

About Mercy

Headquartered in St. Louis, Mercy is one of the largest Catholic health systems in the US, serving millions each year over a multi-state footprint through touchpoints including outreach ministries and virtual care.



Hospitals & Ambulatory Sites

- 28 acute care hospitals
- 4 heart hospitals
- 3 rehab hospitals
- 2 children's hospitals
- 2 orthopedic hospitals
- 1 virtual care command center
- 903 physician practices
- 345 clinic locations
- 12 outpatient surgery centers
- 35 urgent care sites
- 29 convenient care centers

Medical Staff & Co-workers

42,000+ co-workers including:

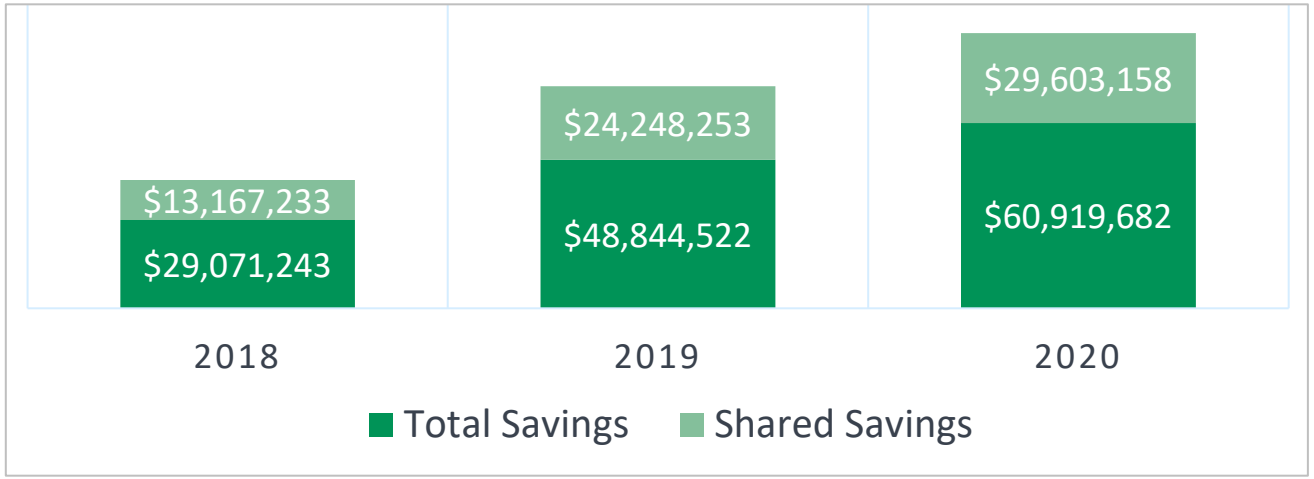
- 2,400+ integrated physicians
- 1,600+ integrated advanced practitioners

Utilization FY20

- 3,131 staffed beds
- 25,006 births
- 164,212 surgeries
- 185,212 inpatient discharges
- 10,854,002 clinic and outpatient visits
- 677,240 ED visits

Mercy ACO

Shared Savings and Total Savings



Quality and Shared Savings Rate

CY	Quality Score	Shared Savings Rate
2018	92.43%	46.2%
2019	99.29%	49.6%
2020	97.19%	48.6%

Key Facts about 2020 ACO

- 3rd largest ACO based on attributed lives
- 7th in total savings
- 9th in total shared savings

Mercy ACO: Functional Areas

DOCUMENTATION & CODING	QUALITY	MEDICAL MANAGEMENT	MEMBERSHIP & GROWTH	VALUE-BASED CONTRACT PERFORMANCE	HIGH FUNCTIONING PRIMARY CARE TEAMS
Standardize reporting of suspected and known condition data Education and best practice sharing Optimize technology and risk coding team	Deliver standard reports to providers Leverage technology and conduct patient outreach to engage patients in closing care gaps	Unnecessary emergency department avoidance Proactive high risk patient management Post-acute care optimization Appropriate criteria-based utilization and site of care Chronic disease management	Patient empanelment Network integrity Market analyses	Complete place of service, physician, longitudinal referral reporting and insights Establish framework for managing risk contacts Connect FFS and Value based revenue activities to population health operations	Access analyses Relationship between access and inappropriate ED utilization Meeting the patient how s/he wants to receive care Workflow analyses Physician compensation model evolution

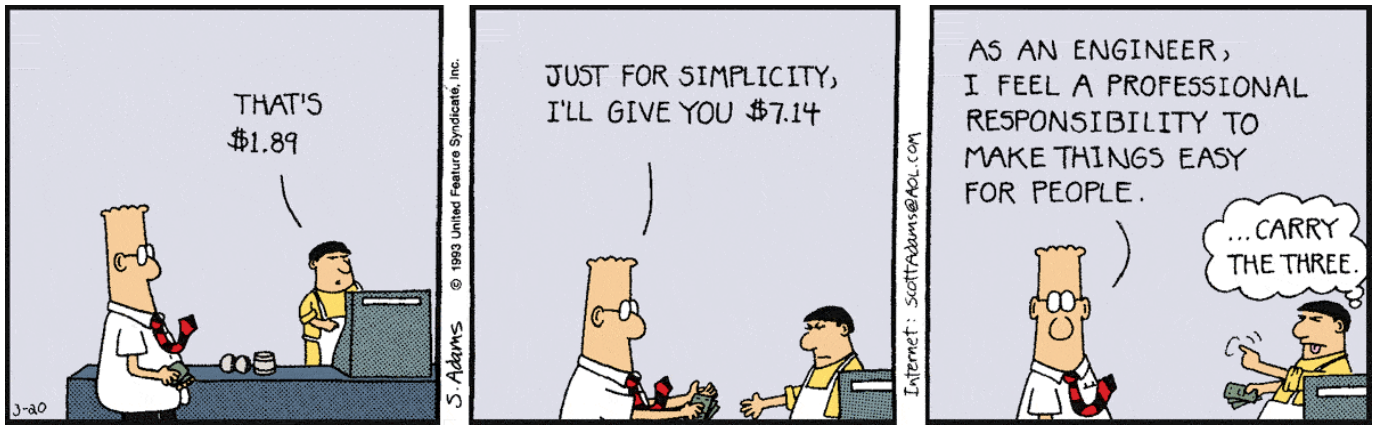
Mercy ACO: Functional Areas - Measures

DOCUMENTATION & CODING	QUALITY	MEDICAL MANAGEMENT	MEMBERSHIP & GROWTH	VALUE-BASED CONTRACT PERFORMANCE	HIGH FUNCTIONING PRIMARY CARE TEAMS
Prevalence of disease Coding gap closure rate (recapture)	HEDIS/ACO STARS Patient Experience	ED/1,000 IP/1,000 SNF/1,000 Emergent and non-emergent Rate of utilization outside of organization Utilization by CHF, DM and COPD	Panel change quarter over quarter Attributed member annual visit	Medical Expense or Loss Ratio % of shared savings Incentive performance	Patient rooming metrics PCP visits/1,000

Mercy ACO: Key Points

- Primary care compensation moving from RVU to value, and empanelment is key component
- Primary care empanelment and continuous outreach drives annual visit
- Annual visit with patient = 65% increase in care gap and care plan closure
- Workflows within electronic health record allow gaps to be closed
- Ability to measure use of workflow across the care team to identify opportunity for training and education
- Electronic health record registry for HCC provides proxy to forecast performance YoY

So, what does this all mean?



… and how does it impact the benchmark?

What can you expect from your final benchmark?

	Per Capita Expenditures
x	Trend to BY3
x	Risk Adjust to BY3
=	**Historical Benchmarks before Regional Adjustment**
+	Regional Adjustment
=	**Regionally Adjusted Historical Benchmark**

Almost certain to improve, despite risk adjustment causing some uncertainty in the exact trend calculation.

What can you expect from your final benchmark?

	Per Capita Expenditures
x	Trend to BY3
x	Risk Adjust to BY3
=	**Historical Benchmarks before Regional Adjustment**
+	Regional Adjustment
=	**Regionally Adjusted Historical Benchmark**

If an ACO's level of coding accuracy was able to outpace national assignable trends, the ACO is likely to see a bump in relative risk scores in BY3.

What can you expect from your final benchmark?

	Per Capita Expenditures
x	Trend to BY3
x	Risk Adjust to BY3
=	**Historical Benchmarks before Regional Adjustment**
+	Regional Adjustment
=	**Regionally Adjusted Historical Benchmark**

Difficult to judge due to compounded assumptions.

Timeline for Q1 reports and final benchmark

MEDICARE SHARED SAVINGS PROGRAM

2022 SHARED SAVINGS PROGRAM REPORT SCHEDULE

Table 1. 2022 Shared Savings Program report schedule for January 2022 participating ACOs

MONTH[1]	CMS REPORT	REPORT RECIPIENTS & NOTES:
Monthly	Performance Year (PY) 2022 Claim and Claim Line Feed (CCLF) files	▪ Made available to ACOs participating for Performance Year (PY) 2022. ▪ Beneficiary and provider-identifiable claims data.
February	PY 2021 Quarter 4 Report Package	▪ Made available to ACOs that participated in PY 2021. ▪ Contains: Assignment List Report; Assignment Summary Report; Aggregate Expenditure/Utilization Report; Beneficiary Expenditure Utilization Report; Non-Claims Based Payment File
March	PY 2021 Quarter 4 Opioid Measures Report	▪ Made available to ACOs that participated in PY 2021.
March	PY 2022 Preliminary Historical Benchmark Report	▪ Made available to ACOs entering an agreement period on January 1, 2022.
March	PY 2022 Adjusted Historical Benchmark Report	▪ Only ACOs that made modifications to their certified ACO Participant List or changed their assignment methodology between PY 2021 and PY 2022 will receive adjusted historical benchmarks.
May	PY 2022 Quarter 1 Report Package	▪ Made available to ACOs participating in PY 2022. ▪ Contains: Assignment List Report; Assignment Summary Report; Aggregate Expenditure/Utilization Report; Beneficiary Expenditure Utilization Report; Non-Claims Based Payment File
June	PY 2022 Quarter 1 Opioid Measures Report	▪ Made available to ACOs participating in PY 2022.
June	PY 2022 Final Historical Benchmark Reports	▪ Made available to ACOs entering an agreement period on January 1, 2022. ▪ Report packages contains the Final Historical Benchmark Report and the Assignment List Report, Assignment Summary Report, Aggregate Expenditure/Utilization Report, Beneficiary Expenditure Utilization Report, Non-Claims Based Payments Data Files.
August	PY 2021 SSP Feedback Report (Annual Quality Report)	▪ Made available to ACOs that participated in PY 2021.
August	PY 2021 Financial Reconciliation Package	▪ Made available to ACOs reconciled for PY 2021. ▪ Contains: Financial Reconciliation Settlement report and Assignment List Report, Assignment Summary Report, Aggregate Expenditure/Utilization Report, Beneficiary Expenditure and Utilization Report; Non-Claims Based Payment File, and ACO Quality Performance Report.

Contact Information and Caveats

Contact Information

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QUESTIONS?

Reminders

This boot camp will provide an opportunity to learn from ACO's with demonstrated success in harnessing data to drive positive performance outcomes.

Boot camp faculty will present how they use data to drive these processes. We will include breakout sessions that take a deeper look into technical questions around benchmarking, dashboards, claims and coding data.

Some examples include:

- Creating dashboards to support the needs of leadership, providers, and staff
- Using claims data for risk calculation
- Thinking through data resource needs for population health strategy and outcome tracking
- Understanding how to assess year over year population trends using claims and EMR data
- Evaluating specialist performance in ACOs

Register Now!

Thank you!