



# Helping ACOs Decide Between ACO REACH and MSSP in 2023

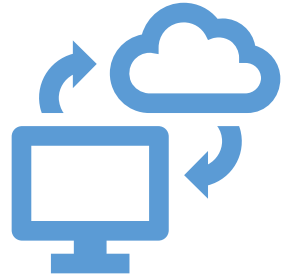


**August 23, 2022**  
**2:30 pm ET**

# Agenda.....

- Welcome and Introductions
- Policy Analysis
  - MSSP proposals in the 2023 Physician Fee Schedule
  - ACO REACH
- Empirical Analysis
- Benchmarking
- Question and Answer

# Housekeeping....



## Webinar is being recorded

The recording and slides will be available on the NAACOS website within 24 hours  
You will receive an email when they are available.



## We will take questions at the end of the program

At any time, please submit written questions using the **Questions tab** (not chat) on the dashboard to the right of your screen

# Speakers



**David Pittman**  
Senior Policy Advisor  
NAACOS



**Corey Rosenberg**  
ACO REACH Model Lead  
CMS Innovation Center



**Dave Ault**  
Counsel  
Ropes & Gray



**Andrew Webster**  
co-founder and lead actuary  
Validate Health

# Financial Methodology



- On July 27, CMMI released a [series of papers](#) that outline the financial methodology for ACO REACH
  - Little deviation from the financial specifications for GPDC and those changes already announced
  - CMMI did not include adjustments for the impacts of COVID-19 pandemic
- Changes include lowering of withholds and discounts, inclusion of health equity elements like benchmark adjustments, and risk adjustment changes
- Did NOT formalize how to score patients for its health equity benchmark adjustment
- NAACOS released two member resources summarizing the changes
  - [Summary of ACO REACH Financial Specifications](#)
  - ACO REACH [Financial Changes Coming](#) in 2023
- Still awaiting release of the quality paper which will have more details
- See NAACOS comparison matrix: [NAACOS MSSP vs. REACH ACO Comparison Chart](#)

# REACH Deadlines



<b>Sept 9</b>	<ul style="list-style-type: none"><li>• Deadline to certify Submitted PY2023 Provider Lists</li><li>• Deadline for PY2023 Core Service Area Submission</li><li>• Deadline for PY2023 ACO-level Risk Sharing Option selection</li><li>• Deadline for PY2023 ACO-level Capitation Payment Mechanism selection</li><li>• Preliminary deadline for PY2023 ACO-level Enhanced PCC Payment Percentage</li></ul>
<b>Sept 16</b>	<ul style="list-style-type: none"><li>• Preliminary Health Equity Plans Due</li></ul>
<b>Sept 30</b>	<ul style="list-style-type: none"><li>• PY2023 ACO-level Benefit Enhancement (BE) and Beneficiary Engagement Incentives (BEI)</li><li>• PY2023 BE/BEI Implementation Plans Due</li></ul>
<b>Oct 3</b>	<ul style="list-style-type: none"><li>• Deadline for PY2023 Provider-level Payment Mechanism elections</li></ul>
<b>Nov 18</b>	<ul style="list-style-type: none"><li>• PY2023 Provider-level Benefit Enhancement (BE) and Beneficiary Engagement Incentive (BEI)</li></ul>
<b>Dec 31</b>	<ul style="list-style-type: none"><li>• Deadline to elect PY2023 Prospective Plus Alignment</li><li>• Deadline to elect Provisional Reconciliation for PY2023</li><li>• Deadline to elect Signed Attestation-based Voluntary Alignment for PY2023</li></ul>

# Proposed MSSP Changes



- Allows more time before advancing to risk for certain ACOs
- Incorporates a prospectively projected administrative growth factor into a three-way blend with national and regional growth rates to update an ACO's historical benchmark for each performance year
- Account for an ACO's prior savings in rebased benchmarks
- Revise how CMS applies the existing 3 percent cap on HCC risk score
- Change the quality scoring approach to allow more ACOs to achieve some savings
- Add a health equity quality adjustment increase for ACOs serving high proportions of underserved beneficiaries
- Provide Advance Investment Payments to low revenue ACOs inexperienced with performance-based risk Medicare ACO initiatives. Comprised of two types of payments: a one-time upfront payment of \$250,000 and eight quarterly payments calculated per beneficiary for up to 10,000 beneficiaries. Limits the use of AIPs to investments in three specified categories: increased staffing, health care infrastructure, and the provision of accountable care for underserved beneficiaries, including SDOH strategies.

# MSSP vs. ACO REACH



	MSSP Enhanced	MSSP Enhanced (proposed PFS)	REACH – Professional	REACH – Global																									
<b>Policies to promote health equity</b>	A health equity quality adjustment		<ul style="list-style-type: none"> <li>ACO must develop and implement a Health Equity Plan that explains work to improve access to and quality of care for underserved communities</li> <li>A health equity benchmark adjustment will be applied at the beneficiary-level to increase benchmarks for ACOs that serve a higher proportion of underserved patients</li> <li>REACH ACOs are required to collect and report certain beneficiary-reported demographic and SDOH data for their aligned beneficiaries</li> <li>Application scores include the ACO's demonstrated ability to provide high quality care to underserved communities</li> </ul>																										
<b>Risk-sharing arrangement</b>	<ul style="list-style-type: none"> <li>Savings: 1st dollar savings at 75%</li> <li>Losses: 1st dollar losses at 40–75%</li> </ul>		<ul style="list-style-type: none"> <li>50% shared savings/losses</li> <li>1st dollar savings and losses</li> </ul>	<ul style="list-style-type: none"> <li>100% shared savings/losses</li> <li>1st dollar savings and losses</li> </ul>																									
<b>Discount or MSR/MLR</b>	Three options: <ul style="list-style-type: none"> <li>0% MSR/MLR</li> <li>Symmetrical MSR/MLR in a 0.5 percent increment between 0.5 and 2.0%</li> <li>Symmetrical MSR/MLR that varies based on the number of beneficiaries assigned to the ACO</li> </ul>		<ul style="list-style-type: none"> <li>No MSR/MLR</li> <li>No discount</li> </ul>	I. No MSR/MLR II. Discount applied to the PY benchmark <ul style="list-style-type: none"> <li>3% (PY 2023-2024)</li> <li>3.5% (PY 2025-2026)</li> </ul>																									
<b>Savings/Losses cap</b>	I. Savings: 20% of updated benchmark II. Losses: 15% of updated benchmark		For gross <u>savings/losses</u> : <table border="0"> <tr> <td>&lt; 5%</td> <td>50%</td> </tr> <tr> <td>5% - 10%</td> <td>35%</td> </tr> <tr> <td>10% - 15%</td> <td>15%</td> </tr> <tr> <td>15%</td> <td>5%</td> </tr> <tr> <td>&gt; 15%</td> <td></td> </tr> </table>	< 5%	50%	5% - 10%	35%	10% - 15%	15%	15%	5%	> 15%		Savings/ losses capped at: <table border="0"> <tr> <td>50%</td> </tr> <tr> <td>35%</td> </tr> <tr> <td>15%</td> </tr> <tr> <td>5%</td> </tr> </table>	50%	35%	15%	5%	For gross <u>savings/losses</u> : <table border="0"> <tr> <td>&lt; 25%</td> <td>100%</td> </tr> <tr> <td>25% - 35%</td> <td>50%</td> </tr> <tr> <td>35% - 50%</td> <td>25%</td> </tr> <tr> <td>50%</td> <td>10%</td> </tr> <tr> <td>&gt; 50%</td> <td></td> </tr> </table>	< 25%	100%	25% - 35%	50%	35% - 50%	25%	50%	10%	> 50%	
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# MSSP vs. ACO REACH



	MSSP Enhanced	MSSP Enhanced (proposed PFS)	REACH – Professional	REACH – Global
<b>Benchmark</b>	<p>CMS establishes and rebases benchmarks based on expenditures from three benchmark years leading up to an agreement period). CMS incorporates regional expenditures into benchmarks starting in an ACO's initial performance year. ACOs have a regional adjustment weight of 15% or 35% in their first agreement year. ACOs with spending higher than their region would receive the lower weight, and ACOs with spending lower than their region would receive the higher weight. If an ACO is considered a re-entering ACO, CMS will apply the regional adjustment weight that was used in the most recent agreement.</p>	<p>CMS will blend in an Administrative Growth Factor as a third component Savings will be added back for new agreement periods</p>	<p>Prospective blend of historical spending and adjusted Medicare Advantage Rate Book (established by CMS as the ACO REACH/KCC (Kidney Care Choices) Rate Book)</p> <p>I. For Standard ACOs using claims-based alignment: the baseline period will be a fixed 3-year period (2017, 2018, 2019)</p> <p>II. For Standard ACOs using voluntary alignment, New Entrant ACOs, and High Needs ACOs: CMS will only use regional expenditures through PY2024 and will incorporate historical expenditures beginning in PY2025</p> <p>III. A health equity benchmark adjustment will be applied to increase the benchmark for ACOs serving higher proportions of historically underserved communities (additional details in health equity section)</p>	

# MSSP vs. ACO REACH



	MSSP Enhanced	MSSP Enhanced (proposed PFS)	REACH – Professional	REACH – Global
<b>Risk adjustment</b>	<p>CMS uses an ACO's prospective HCC risk score to adjust the benchmark for changes in severity and case mix in the assigned beneficiary population between BY3 and the performance year. Positive adjustments in prospective HCC risk scores are subject to a cap of 3 percent for each agreement period.</p>	<p>CMS will apply an adjustment to the +/- 3% risk score growth cap for medically complex, high cost patients.</p>	<p>CMS will risk standardize the historical baseline by applying an ACO's risk score to each base year</p> <ol style="list-style-type: none"> <li>I. For Standard and New Entrant ACOs, CMS will use the CMS-HCC prospective risk adjustment model</li> <li>II. High-Needs Population ACOs use the CMMI-HCC concurrent risk adjustment model</li> <li>III. To control potential increases in coding intensity and risk score growth, CMS will use:               <ol style="list-style-type: none"> <li>A. Prospective estimated normalization factor, retrospectively adjusted</li> <li>B. Application of retrospective Coding Intensity Factor</li> <li>C. Application of ACO-level +/-3% risk score cap</li> </ol> </li> </ol> <p>Beginning in PY2024, CMS will modify the +/-3% cap to adopt a static reference year population and cap the ACO's risk score growth relative to demographic risk score growth</p>	

# MSSP vs. ACO REACH (policy overview)



	MSSP Enhanced	MSSP Enhanced (proposed PFS)	REACH – Professional	REACH – Global
<b>Payment options</b>	CMS makes all FFS payments		<p>Primary Care Capitation (PCC) ACO is paid a monthly capitated payment for estimated enhanced primary care expenditures</p> <p>I. Payment amount will generally equal 7% of TCOC</p> <p>II. Claims reduction is flexible through PY2024 and increases to 100% of primary care claims by PY2025</p> <p>III. CMS pays claims for all other services</p> <p>IV. May elect Advanced Payment for up to 100% of the benchmark, reconciled at the end of the PY (similar to the AIPBP payment mechanism in Next Gen)</p>	<p>PCC or Total Care Capitation (TCC)</p> <p>TCC:</p> <ul style="list-style-type: none"> <li>(TCC): 100% capitation for all Medicare Part A &amp; B services for aligned beneficiaries</li> </ul> <p>I. Providers submit claims but all payments go to the ACO</p> <p>II. Participant Providers required to take a 100% fee reduction to claims</p> <p>III. Optional fee reduction for preferred providers (1-100%)</p>

# MSSP vs. ACO REACH (policy overview)



	MSSP Enhanced	MSSP Enhanced (proposed PFS)	REACH – Professional	REACH – Global
<b>Quality measures</b>	<p>For years 2021 through 2024, ACOs in all tracks will have the option of reporting via the Web Interface (WI), reporting Advanced Performance Pathway (APP) measure set via eCQMs/MIPS CQMs, or both.</p> <p>Those which report both will be awarded the higher of the two scores.</p> <p>Those reporting WI will be scored on 10 total measures, including 7 WI quality measures, 2 administrative claims measures, and CAHPS for MIPS.</p> <p>Those reporting eCQMs/MIPS CQMs will be scored on 6 total measures, including 3 APP clinical quality measures, 2 administrative claims measures, and CAHPS for MIPS. Note that CMS may suppress certain measures in certain performance years due to issues establishing a benchmark, or other measure issues.</p>		<p>I. Standard and New Entrant ACOs will be assessed on 4 measures, 3 administrative claims measures and the ACO CAHPS Survey</p> <p>II. For High Needs ACOs, the Timely Follow-Up measure is replaced with Days at Home for Patients with Complex, Chronic Conditions</p>	
<b>Reporting requirements</b>	<p>In order to be eligible to earn shared savings, an ACO must meet or exceed the 30th percentile among all MIPS quality performance category scores in 2021-2023 and meet or exceed the 40th percentile each year after. If an ACO meets this minimum standard, it will share in the maximum shared savings rate prescribed in a particular track, regardless of its final quality score.</p>	<p>Sliding scale for quality performance (no longer “all or nothing”)</p>	<p>I. CMS will withhold 2% of ACO's benchmark that can be earned back through quality scores</p> <p>II. ½ of the withhold is tied to the CI/SEP threshold: if the ACO meets the threshold, multiply the total quality score by 2% to determine how much of the withhold is earned back (multiply by 1% if threshold not met)</p> <p>III. CMS will also employ a "High Performers Pool" funded by quality withholds</p> <p>IV. Application of CI/SEP and High Performers Pool will begin in PY2024 for ACOs beginning model participation in PY2023</p>	

# MSSP vs. ACO REACH (policy overview)



	MSSP Enhanced	MSSP Enhanced (proposed PFS)	REACH – Professional	REACH – Global
<b>SNF 3-day rule</b>	Open to ACOs who use either prospective assignment or preliminary prospective assignment with retrospective reconciliation. CMS will waive its three-star quality rating requirement for providers furnishing SNF services under swing bed arrangements.		<ul style="list-style-type: none"> <li>For prospectively assigned beneficiaries that receive otherwise covered post-hospital extended care services by an eligible SNF</li> <li>SNF must have a quality rating of 3+ stars</li> <li>SNFs must be either Participant or Preferred Providers</li> <li>ACOs may be asked to describe how the SNFs can carry out proposed coordination activities</li> </ul>	
<b>Telehealth</b>	Waives geographic and originating site requirements. This provision is applicable only to ACOs under two-sided models who have elected prospective assignment.		Waives geographic and originating site requirements	
<b>Beneficiary Incentive Program</b>	ACOs can establish a CMS-approved beneficiary incentive program to provide incentive payments to eligible beneficiaries who receive qualifying primary care services. Through this program, ACOs may provide limited “cash equivalent” incentive payments to qualifying patients. The beneficiary incentive program is available to two-sided risk ACOs with preliminary prospective assignment with retrospective reconciliation or prospective assignment starting July 1, 2019.		ACOs may provide in-kind items or services to beneficiaries, including blood pressure monitors to patients with hypertension, vouchers for over-the-counter medications, transportation vouchers, wellness program memberships, among other things	
<b>Other benefit enhancements</b>	Not permitted	Not permitted	I. Cost sharing support for Part B services II. Care management home visits III. Chronic Disease Management Reward Program IV. Provision of home health services to beneficiaries who are not “homebound” for certain conditions V. Nurse Practitioner Services Benefit—allows NPs to certify that a patient is eligible for home health services, certify the need for hospice care and for diabetic shoes, order and supervise cardiac rehab, establish, review, and sign home infusion therapy care plans, and refer patients for medical nutrition therapy	In addition to what Professional ACOs are allowed, CMS allows Global ACOs to waive the requirement that beneficiaries who elect the Medicare Hospice Benefit give up their right to receive curative care as a condition of electing the hospice benefit  I. Allows nurse practitioners to assume more responsibilities without physician supervision

# REACH vs MSSP: Decision Factors



- **Regional competition:** Are you in a REACH-concentrated area of the country
- **Capitation:** Is it attractive to your participants? Are you foregoing PCF? Would you utilize price discounts?
- **Benefit enhancements:** Would you utilize the additional benefit enhancements?
- **Health equity:** What %-ile ADI are you? What is the impact to your benchmark?
- **Risk adjustment:** Do you have an HCC gap recapture program in place to overcome the coding intensity factor (CIF)?
- **Ratebook:** Is your region made up of outlier counties?



# PY 2022: Market Share.....

By Org Type

- **56% Provider**
- 23% Payer
- 22% Venture/MSO

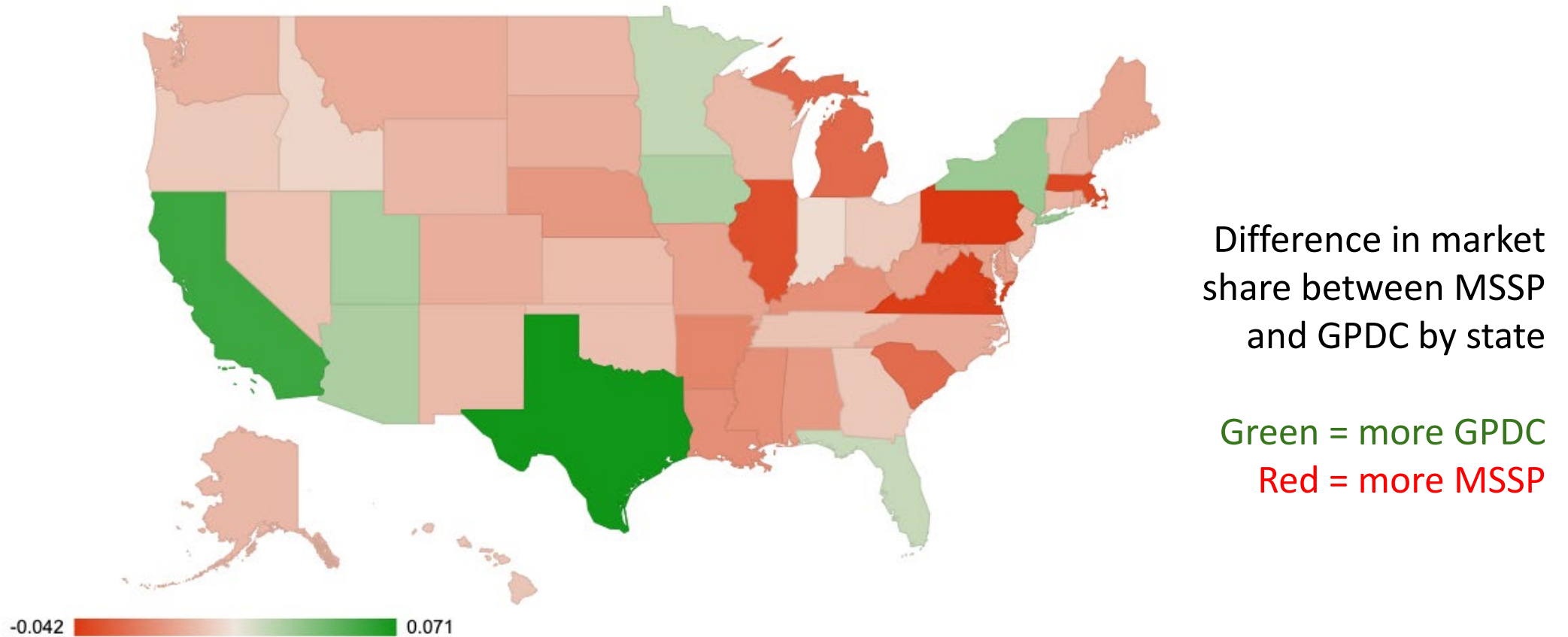
Top 10 DCEs make up **50%** of the market

Top 3 academic health systems make up **20%** of the DCE market

DCE Name	Organization type	% of All Aligned Beneficiaries
UT Southwestern	Provider	9.5%
Clover Health	Payer	8.4%
UnityPoint	Provider	6.7%
Sutter Preferred	Provider	5.4%
Agilon (8 DCEs)	Venture	5.0%
Humana (2 DCEs)	Payer	3.4%
VillageMD (5 DCEs)	Venture	3.2%
Indiana University	Provider	3.1%
Asaar Medical, LLC	MSO	3.1%
Intermountain (2 DCEs)	Provider	2.8%
Total		50.5%



# PY 2022: GPDC vs MSSP by Bene State



Source: VH Market data as of May, 2022



# PY 2022: GPDC vs MSSP by Bene County

% of all MSSP Benes	% of all REACH Benes	% MSSP - % REACH	State	County
2.1%	0.4%	-1.7%	Illinois	Cook
1.0%	0.2%	-0.9%	Massachusetts	Middlesex
<b>0.8%</b>	<b>0.1%</b>	<b>-0.6%</b>	<b>California</b>	<b>San Diego</b>
0.7%	0.0%	-0.6%	Washington	King
0.6%	0.0%	-0.6%	Illinois	DuPage
0.6%	0.1%	-0.6%	Massachusetts	Essex
0.5%	0.0%	-0.5%	Massachusetts	Norfolk
0.5%	0.0%	-0.5%	Massachusetts	Bristol
<b>0.6%</b>	<b>0.1%</b>	<b>-0.5%</b>	<b>Florida</b>	<b>Lee</b>
0.4%	0.0%	-0.4%	Massachusetts	Plymouth

% of all MSSP Benes	% of all REACH Benes	% MSSP - % REACH	State	County
0.4%	3.2%	2.8%	Texas	Dallas
1.0%	3.6%	2.7%	Arizona	Maricopa
0.3%	2.2%	1.9%	Texas	Tarrant
0.1%	1.6%	1.5%	Minnesota	Hennepin
<b>0.1%</b>	<b>1.5%</b>	<b>1.4%</b>	<b>Wisconsin</b>	<b>Dane</b>
0.2%	1.6%	1.4%	Florida	Lake
<b>0.1%</b>	<b>1.4%</b>	<b>1.3%</b>	<b>North Carolina</b>	<b>Guilford</b>
0.5%	1.7%	1.2%	California	Los Angeles
0.1%	1.3%	1.2%	Texas	Denton
0.2%	1.3%	1.1%	Texas	Collin

Source: VH Market data as of May, 2022



# GPDC shared savings vs MSSP/NGACO

Performance Year	Period covered	Data as of	ACO/DCE Count	Avg. aligned beneficiaries across all ACO/DCEs	Total dollars under risk across all ACO/DCEs (cumulative YTD)	Average reduction in spending compared to benchmark	Standard Deviation
<b>MSSP</b>							
PY 2019/A	Jan-Dec 2019	8/1/2020	475	9,997,705	\$92,820,036,141	2.1%	4.6%
PY 2020	Jan-Dec 2020	8/1/2021	513	10,614,589	\$110,962,952,924	3.7%	4.6%
<b>NextGen</b>							
PY 2019	Jan-Dec 2019	8/1/2020	41	1,338,233	\$16,138,440,167	3.2%	3.4%
PY 2020	Jan-Dec 2020	8/1/2021	37	1,081,233	\$11,488,506,050	5.6%	4.2%
<b>REACH</b>							
PY 2021	Apr-Dec 2021	5/1/2022	53	338,938	\$3,514,813,246	1.7%	10.1%
PY 2022	Jan-Mar 2022, YTD	5/1/2022	99	1,768,708	\$5,749,697,246	4.5%	8.8%

Source: [Quarterly Summary of Quality Performance, Financial Performance, and Model Payments](#) (Aug, 2022)



# Capitation: Gain/Loss to date

Payment mechanism	2021 % DCEs	2022 % DCEs
No capitation	32%	0%
Primary care capitation (PCC)	47%	73%
Advanced payment option (APO)	12%	19%
Total care capitation (TCC)	21%	27%

- Nearly **1/3rd** of DCEs in PY 2021 choose no capitation
- Nearly **3/4ths** of DCEs in PY 2022 are professional care capitation (PCC) only
- About **1/4th** of DCEs under PCC utilize price discounts (APO)

# GPDC Shared Savings vs MSSP/NGACO

Period covered	Data as of	DCE Count	Average % of Performance Year Benchmark paid via capitation	Preliminary % of capitation payments spent on Medicare Covered Services
<b>PY 2021</b>				
Apr-Jun 2021	January, 2022	36	2.5%	91.4%
Apr-Sep 2021	January, 2022	36	2.5%	90.3%
Apr-Dec 2021	May, 2022	36	2.5%	90.8%
<b>PY 2022</b>				
Jan-Mar 2021	May, 2022	99	3.5%	Available in Fall 2022 (pending full claims runout)

Source: [Quarterly Summary of Quality Performance, Financial Performance, and Model Payments](#) (Aug, 2022)

# Benefit Enhancements (BE)

BE	MSSP	GPDC	REACH
3-Day SNF Waiver	Y	Y (44%)	Y
Telehealth	N	Y (16%)	Y
Post Discharge Home Health Visits	N	Y (3%)	Y
Care Management Home Visits	N	Y (2%)	Y
Homebound Home Health Waiver	N	Y (37%)	Y
Concurrent Care for Beneficiaries that Elect Medicare Hospice Benefit	N	Y (29%)	Y
Nurse Practitioner Services Benefit Enhancement	N	N	Y

# Benchmarking: REACH vs MSSP Matrix



Section	REACH	MSSP (Current)	MSSP (Proposed)
Historical baseline expenditures	<ul style="list-style-type: none"> <li>- Fixed Baseline Years 2017-2019 (PY1-PY6)</li> <li>- 10/30/60 Credibility weighting</li> </ul>	<ul style="list-style-type: none"> <li>- 3 years prior to start year</li> <li>- Equal weighting if after first agreement period</li> </ul>	Same as current MSSP
Benchmark trend	<ul style="list-style-type: none"> <li>- Adjusted USPCC prospective trend</li> <li>- Geographic Adjustment Factor trend</li> </ul>	- 2-way blend between national retrospective trend and regional retrospective trend	- 3-way blend taking into account 1/3 USPCC prospective trend
<b>Health equity adjustment</b>	Benchmark adjustment from -\$6 PMPM to \$30 PMPM	N/A	Request for information on how to incorporate
<b>Risk adjustment</b>	<ul style="list-style-type: none"> <li>- Symmetric +/- 3% cap indexed to change in demographic-only risk</li> <li>- Coding intensity factor (CIF)</li> </ul>	- +3% cap	<ul style="list-style-type: none"> <li>- +3% cap indexed to change in demographic-only risk score</li> <li>- Capped in aggregate</li> </ul>
<b>Regional benchmarking</b>	<ul style="list-style-type: none"> <li>- Faster regional blending schedule</li> <li>- 3-year regional rate calculation</li> <li>- Annual rebasing</li> <li>- Geographic Adjustment Factor trend</li> <li>- Asymmetric 5%/2% regional caps</li> </ul>	- +/- 5% regional cap	<ul style="list-style-type: none"> <li>- +5% /-1.5% regional caps</li> <li>- Negative regional adjustment factor offset further based on % Medicaid and risk score</li> </ul>
Discounts/quality withhold	<ul style="list-style-type: none"> <li>- Gradually increasing discount (Global only) between 3% to 3.5%</li> <li>- 2% quality withhold</li> </ul>	<ul style="list-style-type: none"> <li>- No discount</li> <li>- Savings not prorated by quality for PY 2021/22</li> </ul>	- Quality proration re-introduced in PY 2023 and later



# Health Equity Benchmark Adjustment (HEBA)

- Each beneficiary in the PY 2023 all-aligned population is ranked according to Area deprivation index (ADI) and % Medicaid

For each beneficiary aligned to a given ACO, a beneficiary-month level benchmark adjustment is calculated based on these percentile scores. This benchmark adjustment is calculated dependent on each beneficiary's percentile score as follows:

$$\text{Adjustment}_b = \begin{cases} \$30 & \text{if percentile}_b > 90 \\ \$ - 6 & \text{if percentile}_b \leq 50 \\ \text{else } 0 & \end{cases}$$



# Health Equity Benchmark Adjustment

- Health equity benchmark is added to the benchmark at the end

**Figure 4.11: Calculation of Benchmark Expenditure after Health Equity Benchmark Adjustment**

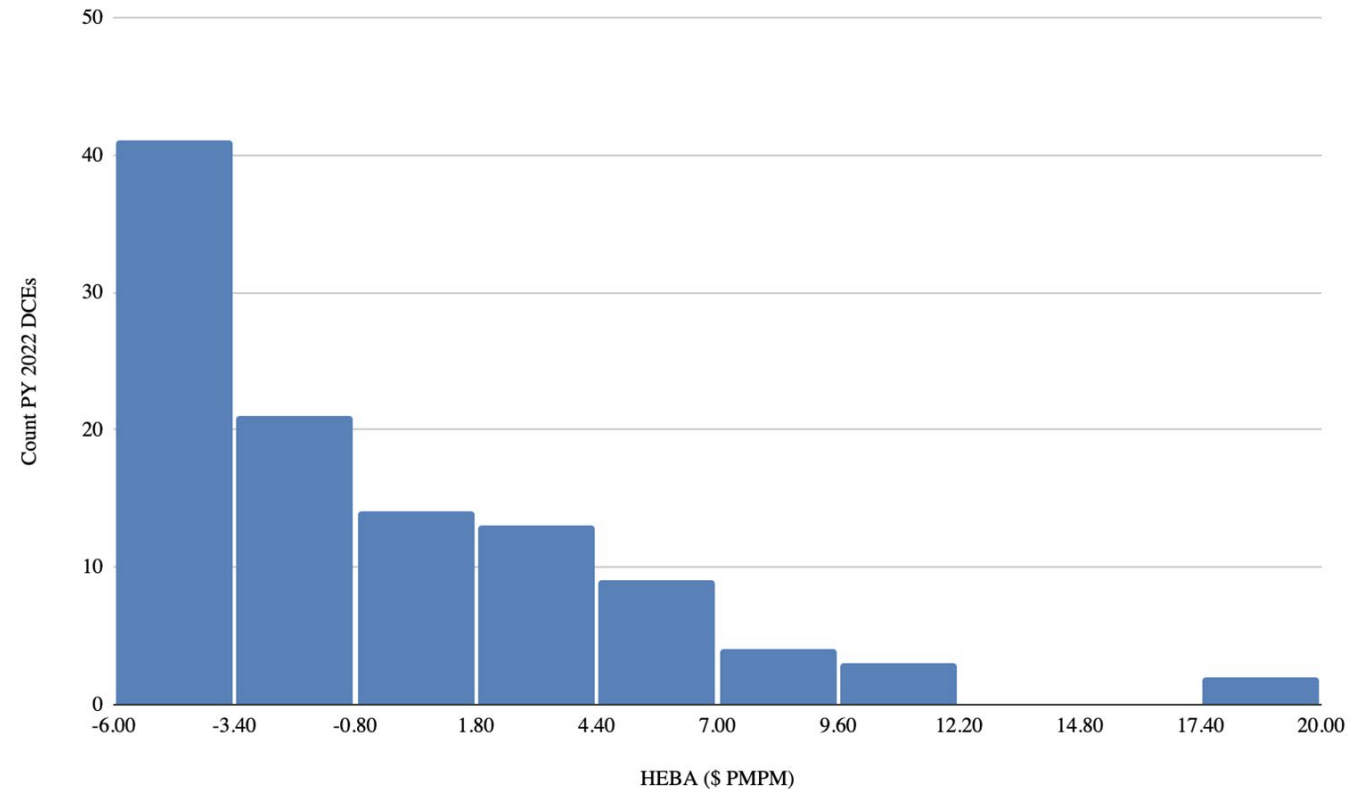
		Benchmark to which Experience Accrues		TOTAL
		AD	ESRD	
<b>ACO Benchmark Expenditure</b>				
12.	EQUALS: Benchmark before Discount or Quality Withhold	\$41,092.11	\$0.00	\$41,092.11
13.	TIMES: Retrospective Trend Adjustment	1.0000	1.0000	
14.	Benchmark Expenditure for All Aligned Beneficiaries	\$37,258,806.89	\$2,076,780.07	\$39,335,586.96
15.	LESS: Discount			\$0.00
16.	LESS: Retention Withhold			(\$786,711.74)
17.	EQUALS: Benchmark Expenditure after Discount & Retention Withhold			\$38,548,875.22
18.	LESS: Quality Withhold			(\$786,711.74)
19.	PLUS: Earned Quality Withhold			\$786,711.74
20.	EQUALS: Benchmark Expenditure after Earned Quality			\$38,548,875.22
21.	PLUS: Health Equity Benchmark Adjustment			\$96,372.19
22.	EQUALS: Benchmark Expenditure after Health Equity Benchmark Adjustment			\$38,645,247.41



# HEBA: Distribution by DCE

- Simulated HEBA ranges from -\$6 PMPM to \$20 PMPM
- Skewed to left to lower values (negative for **2/3rds** of DCEs)

Distribution of HEBA (\$ PMPM)





# HEBA: Outlier DCEs

- Top 10 DCEs who benefit still have a % of their population <50-ile
- Both urban low-income (e.g. Detroit) and rural (e.g. South east Ohio) lead to higher HEBA
- \$30 PMPM theoretical maximum still not attained (Note: -\$6 PMPM theoretical minimum is still attained by at least 14 DCEs)

	% Benes <50th Percentile	% Benes >90th Percentile	HEBA PMPM
Renovis Health LLC	14%	69%	\$20
Ohio DCE - SEOH, Inc.	2%	62%	\$19
Giatros Health	14%	42%	\$12
The MetroHealth System dba Collaborative Care Partners	15%	41%	\$12
Triad HealthCare Network, LLC.	5%	34%	\$10
Oak Street Health Medicare Partners LLC	17%	34%	\$9
Capital Caring Advanced Illness Services	13%	32%	\$9
Alegis Care Services LLC	26%	30%	\$7
Indiana University Health ACO, Inc.	10%	27%	\$7
Ohio DCE - Akron, Inc.	4%	21%	<sup>26</sup> \$6



# Risk Adjustment Matrix

Risk Adjustment Step	REACH	MSSP (Current)	MSSP (Proposed)
<b>Normalization</b>	Y	Y	Y
<b>Risk Score Floor</b>	Y (demographic-only change in risk score adjusted)	N	N
<b>Risk Score Ceiling</b>	<ul style="list-style-type: none"> <li>- 3% indexed to demographic-only change in risk score</li> <li>- Done in aggregate for aged and disabled enrollment types</li> </ul>	<ul style="list-style-type: none"> <li>- Static 3%</li> <li>- Done separately by enrollment type</li> </ul>	<ul style="list-style-type: none"> <li>- 3% indexed to demographic-only change in risk score</li> <li>- Done in aggregate across all enrollment types</li> </ul>
<b>Retrospective coding intensity factor (CIF)</b>	Y	N	N



# Demographic-only Risk Score Adj Caps

- +/- 3% Symmetric cap shifts by change in demographic-only risk score
- Helps the REACH ACO if the demographic-only risk score increase 2%
- Hurts the REACH ACO if the demographic-only risk score decreases -2%
- Examples
  - Higher mix of age-ins in PY => Caps shift downward -2% based on age
  - Hired new geriatricians in PY => Caps shift upward 2% based on age

**Table 5. Illustration of HCC risk score cap for PY2024**

Demographic risk score			2024 HCC risk score growth cap		HCC risk score pre-application of the cap			Final 2024 capped HCC risk score (post-cap)	
2022 risk score	2024 risk score	Growth rate	Floor	Ceiling	2022 risk score	2024 risk score	Growth rate	Growth rate	2024 risk score
1.00	1.02	2.0%	2% - 3% = <b>(1%)</b>	2% + 3% = <b>5%</b>	1.00	1.04	4.0%	<b>4.0%</b>	<b>1.04</b>
1.00	1.00	0.0%	0% - 3% = <b>(3%)</b>	0% + 3% = <b>3%</b>	1.00	1.04	4.0%	<b>3.0%</b>	<b>1.03</b>
1.00	0.98	(2.0%)	(2%) - 3% = <b>(5%)</b>	(2%) + 3% = <b>1%</b>	1.00	1.04	4.0%	<b>1.0%</b>	<b>1.01</b>



# Risk Adjustment: ACO-specific Cap

- Simulation of 513 MSSP ACOs in PY 2020
- Application of an ACO-specific 3% upper risk ratio cap in aggregate versus separate
- Separate capping disproportionately affects more vulnerable populations
- REACH risk scoring also (mostly) in aggregate

Enrollment Type	Number of Separately capped ACOs MSSP (current)	% Separately capped ACOs MSSP (current)	Number of Aggregate capped ACOs MSSP (proposed)
All	251	49%	<b>7</b>
ESRD	102	20%	<b>7</b>
Disabled	113	22%	<b>7</b>
Aged Dual	122	24%	<b>7</b>
Aged non-Dual	85	17%	<b>7</b>



# CIF: Final for PY 2021.....

- Final PY 2021 over a 2-year horizon (reference year is 2019)
- Your REACH ACO risk score accuracy is graded relative to all other REACH ACOs aligned beneficiaries

## Final Risk Score Coding Intensity Factor

Risk Score Parameters					
	Observed CY2021 (through Q3)	Observed CY2021 (through Q4)	Observed CY2021 - Final (S1)	Observed CY2021 - Final (S2)	<u>Suggested Impact</u>
<b>Coding Intensity Factors</b>					
Prospective A&D CIF	1.0094	<b>1.0024</b>	<b>1.002543</b>	<b>1.002502</b>	← <b>~0.2502% reduction</b>
Prospective ESRD CIF	1.0083	<b>1.006</b>	<b>1.006383</b>	<b>1.006299</b>	← <b>~0.6299% reduction</b>
Concurrent A&D CIF	N/A	<b>N/A</b>	<b>1</b>	<b>1</b>	

# CIF: Example Impact.....

Claims Aligned	2019	PY 2021
Raw Risk Score	1.400	1.500
Normalization Factor	1.137	1.176
Normalized Risk Score	1.231	1.275
PY Risk Score Floor (0.97 X RY normalized risk score)		1.194
PY Risk Score Ceiling (1.03 X RY normalized risk score)		1.268
PY Capped Risk Score		1.268
CIF		1.0025
PY Benchmark Risk Score		1.265
Eligible months		120,000
Benchmark PBPM		\$1,000
Total benchmark w/o CIF		\$152,170,769
Total benchmark w/ CIF		\$151,791,291
Difference in total benchmark due to CIF		\$379,478



# REACH Ratebook vs MSSP

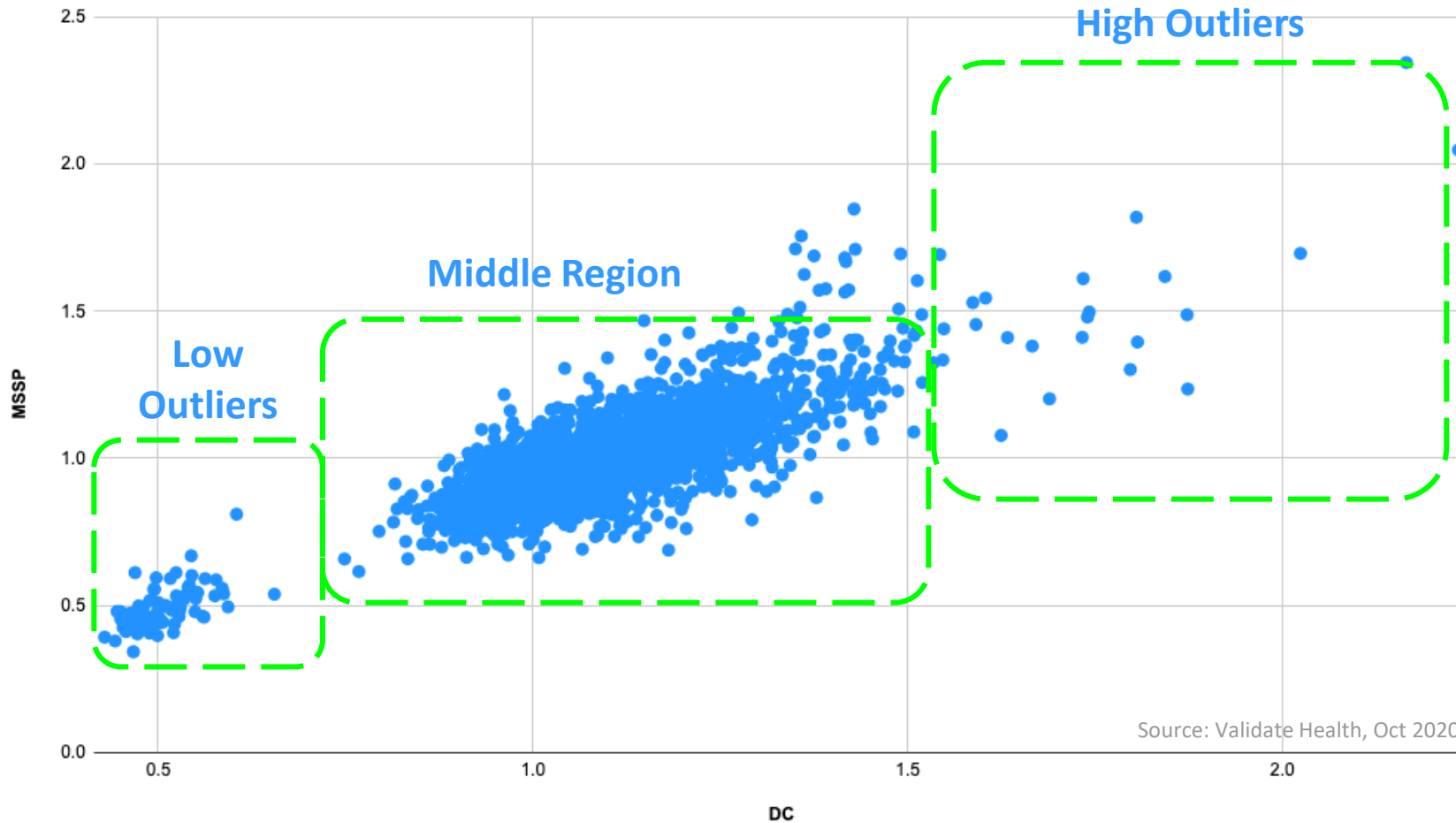
The DC ratebook has lower volatility versus the MSSP regional rates

- Credibility-weighted **three base years** (instead of one base year under MSSP)
- Credibility adjustment: The REACH financial methodology uses a credibility adjustment that blends counties with less than 1,000 beneficiaries with CBSA or state-level rate
- Risk scores use the same model as the payment year (no model version skew)

# Regional Benchmarking: MSSP vs. DC – County Relative Cost Index (Non-ESRD)



MSSP vs. DC - County Relative Cost Index (Non-ESRD)



\* MSSP uses 2018 expenditures relative cost index and REACH uses 2019 risk-standardized expenditures. The 2023 refreshed analysis will be available upon request.

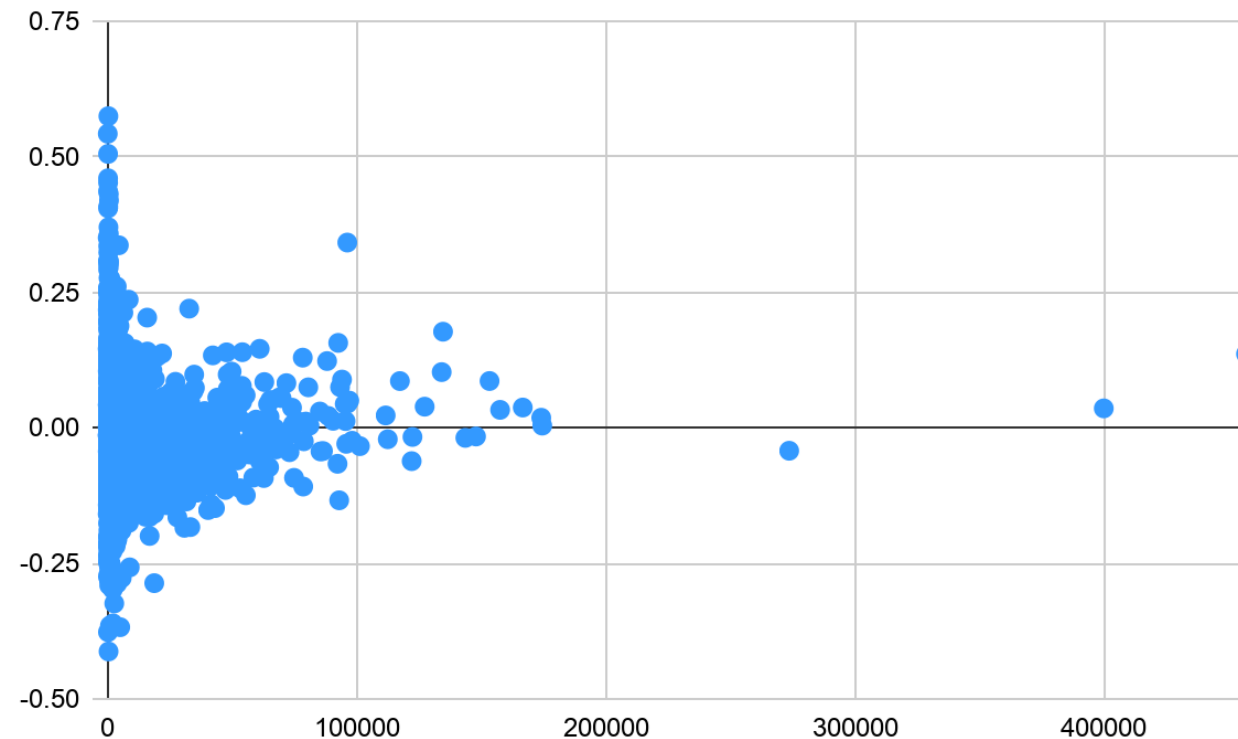


# Regional Benchmarking: Regions

- Low outliers: Puerto Rico and a few counties in AZ, NM, TX
- High outliers: Mainly rural counties in AK, KS, NE with very few beneficiaries (non-credible)
- Middle region
  - Error is proportional to the number of person years in the county; There may be single year variability
  - Positive error means that the MSSP regional rate is more favorable than what would be expected given the REACH regional rate

# Regional Benchmarking: Middle Region

- Error is proportional to the number of person years in the county
- Positive error means that the MSSP benchmark is more favorable than what would be expected given the REACH ratebook rate
- Whether the MSSP or REACH ratebook is more favorable is ACO-specific



# Summary of Decision Factors



- **Regional competition:** Are you in a REACH-concentrated area of the country
- **Capitation:** Is it attractive to your participants? Are you foregoing PCF? Would you utilize price discounts?
- **Benefit enhancements:** Would you utilize the additional benefit enhancements?
- **Health equity:** What %-ile ADI are you? What is the impact to your benchmark?
- **Risk adjustment:** Do you have an HCC gap recapture program in place to overcome the coding intensity factor (CIF)?
- **Ratebook:** Is your region made up of outlier counties?

# *Questions?*



# Thank you!



Please email [advocacy@naacos.com](mailto:advocacy@naacos.com) with additional comments and questions.

# *Appendix*



# Appendix: Credibility Adjustment



- The DC financial methodology uses a credibility adjustment that blends counties with less than 1,000 beneficiaries with CBSA or state-level rate
- This leads to a higher stability versus the MSSP regional adjustment (which is only based on BY3 and is not credibility adjusted.)
- If you're an ACO across smaller counties then the DC year-over-year stability in the regional benchmark could be attractive.

# Appendix: Credibility Adjustment



- 2,725 counties are fully credible in 2020
- 496 counties are partially credible in 2020
- Counties with at least 10 partially credible counties along with the average credibility factor are shown in the table

Name	Count of Counties with Partial Credibility	Average Partial Credibility Factor
TEXAS	72	69%
PUERTO RICO	64	58%
KANSAS	39	77%
NEBRASKA	39	66%
S. DAKOTA	39	71%
N. DAKOTA	32	70%
GEORGIA	28	76%
MONTANA	24	67%
COLORADO	21	73%
MINNESOTA	20	83%
ALASKA	19	70%
IDAHO	10	77%

# Appendix: VA/DOD Adjustments



- Adjusts for health care services received by dual-eligible military retirees and veterans outside of Medicare, under the Department of Defense's (DoD) TRICARE health program, or the Veterans Health Administration's health care system.

Low coordination with Military plans (Increases Medicare rates)				High coordination with Military plans (Decreases Medicare rates)			
Enrollment Used for	Military Adjustment Ratio	County Name	State Name	Enrollment Used for	Military Adjustment Ratio	County Name	State Name
5120	111.9%	SAGadahoc	MAINE	579	96.4%	CIDRA	PUERTO RICO
3121	110.7%	MEADE	S. DAKOTA	705	96.4%	DECATUR	KANSAS
516	110.7%	NIOBRARA	WYOMING	130	96.2%	KENT	TEXAS
474	110.6%	ISABELA	PUERTO RICO	411	96.2%	SANBORN	S. DAKOTA
208	110.3%	RED LAKE	MINNESOTA	204	95.6%	WEBSTER	GEORGIA
274	109.4%	NARANJITO	PUERTO RICO	207	95.5%	SULLY	S. DAKOTA
654	109.3%	FLORENCE	WISCONSIN	186	94.2%	HINSDALE	COLORADO
19	109.3%	KING	TEXAS	74	94.1%	MC PHERSON	NEBRASKA
106	108.8%	ZIEBACH	S. DAKOTA	50	93.9%	CULEBRA	PUERTO RICO
619	108.4%	BRISTOL BAY BOROUGH	ALASKA	172	93.0%	PATILLAS	PUERTO RICO
239	108.4%	CEIBA	PUERTO RICO	90	93.0%	HAYES	NEBRASKA
1445	108.2%	BUTTE	S. DAKOTA	71	92.5%	BILLINGS	N. DAKOTA
256	108.1%	RIO GRANDE	PUERTO RICO	60	92.5%	SLOPE	N. DAKOTA
5085	108.0%	CARTER	TENNESSEE	358	91.9%	CULBERSON	TEXAS
1919	107.8%	BRAXTON	W. VIRGINIA	225	91.5%	PENUELAS	PUERTO RICO
174	107.7%	HARDING	NEW MEXICO	35	91.4%	KENEDY	TEXAS

# Appendix: Zero Claims Adjustment



- A percent adjustment applied to the Puerto Rico MA rates to reflect the prevalence of zero-dollar-claimants enrolled in FFS
- It was a 4.7% increase to rates in 2020

Enrollment Used for	County	State	Zero Claims
Credibility	Name	Name	Adjustmnt
13468	SAN JUAN	PUERTO RICO	0.047
4088	BAYAMON	PUERTO RICO	0.047
2876	GUAYNABO	PUERTO RICO	0.047
2846	CAROLINA	PUERTO RICO	0.047
2749	PONCE	PUERTO RICO	0.047
2718	CAGUAS	PUERTO RICO	0.047
1539	ARECIBO	PUERTO RICO	0.047
1535	MAYAGUEZ	PUERTO RICO	0.047
1047	AGUADILLA	PUERTO RICO	0.047
1040	CATANO	PUERTO RICO	0.047
1001	HUMACAO	PUERTO RICO	0.047
937	CAYEY	PUERTO RICO	0.047
909	TRUJILLO ALTO	PUERTO RICO	0.047
819	MANATI	PUERTO RICO	0.047
818	CABO ROJO	PUERTO RICO	0.047
761	VEGA BAJA	PUERTO RICO	0.047
638	FAJARDO	PUERTO RICO	0.047
595	LAS PIEDRAS	PUERTO RICO	0.047
579	CIDRA	PUERTO RICO	0.047
572	TOA ALTA	PUERTO RICO	0.047
555	LOIZA	PUERTO RICO	0.047
546	SAN GERMAN	PUERTO RICO	0.047

# Appendix: Regional Rate Baseline Adjustment



	Baseline Experience			Three Year-Benchmark
	CY2017	CY2018	CY2019	
<b>DCE Aligned Beneficiary Experience</b>				
1 Aligned Beneficiaries				
2 ... Claims Aligned	6,277	6,307	6,414	
3 Eligible Months				
4 ... Claims Aligned	69,042	69,378	70,551	
<b>5 DCE Claims Aligned Beneficiary Claims &amp; Claims Reductions</b>				
6 Non-DCE Provider Claim Payments & Claims Reductions	\$32,034,345.07	\$33,036,067.79	\$34,467,102.52	
7 PLUS: Participant Provider Claim Payments & Claims Reductions	\$11,722,245.23	\$11,924,634.11	\$12,612,741.12	
8 PLUS: Preferred Provider Claim Payments & Claims Reductions	\$17,944,490.46	\$18,349,268.21	\$18,725,482.24	
9 EQUALS: Total DCE Claims Aligned Beneficiary Expenditure	\$61,701,080.76	\$63,309,970.11	\$65,805,325.89	
10 TIMES: Prospective Adjusted FFS USPPC Trend	1.101	1.061	1.049	
11 EQUALS: Prospective Trended Total DCE Aligned Beneficiary Expenditure	\$67,917,003.24	\$67,183,079.10	\$69,061,398.44	
12 DIVIDED BY: Eligible Months	69,042	69,378	70,551	
13 EQUALS: Claim-based Expenditure PBPM	\$983.71	\$968.36	\$978.88	
14 DIVIDED BY: DCE Risk Score	1.232	1.208	1.201	
15 EQUALS: DCE Trended Risk-Standardized Baseline Expenditure	\$798.43	\$801.85	\$815.27	
16 TIMES: GAF-Adjusted Prospective Trend	0.997	1.011	1.039	
17 EQUALS: DCE Risk-Standardized, GAF-Adjusted Baseline Expenditure	\$796.04	\$810.78	\$847.13	\$831.12
18 DCE Regional Rate based on DC/KCC Rate Book	\$858.88	\$858.31	\$858.66	\$858.58
19 Blend Percentage (% historical)				65%
20 Blended Benchmark (before applying ceiling/floor)				\$840.73
21 Difference between Blended Benchmark and DCE Baseline				\$9.61
22 Ceiling on Blended Benchmark Adjustment				\$41.66
23 Floor on Blended Benchmark Adjustment				(\$16.66)
24 Blended Benchmark				\$840.73
<b>25 DCE Regional Rate Baseline Adjustment</b>				<b>0.979</b>

Source: Direct Contracting Model Global and Professional Options: Financial Companion to Operating Guide  
 Overview: Standard DCE Figure A.3: Calculation of A&D Benchmark for Claims-Aligned Beneficiaries

# Appendix: Regional Rate Baseline Adjustment



(6-9) Use paid claims from three sources; Non-DCE, DCE participants, DCE preferred

Add back any payment reductions. For 2017 through 2019 those will be from other programs (such as NextGen PBP/AIPBP). When voluntary aligned beneficiaries use historical benchmarking in PY5/6, these will include DC payment reductions from capitation and Advanced Payment Option (APO).

	Baseline Experience		
	CY2017	CY2018	CY2019
6 Non-DCE Provider Claim Payments & Claims Reductions	\$32,034,345.07	\$33,036,067.79	\$34,467,102.52
7 PLUS: Participant Provider Claim Payments & Claims Reductions	\$11,722,245.23	\$11,924,634.11	\$12,612,741.12
8 PLUS: Preferred Provider Claim Payments & Claims Reductions	\$17,944,490.46	\$18,349,268.21	\$18,725,482.24
9 EQUALS: Total DCE Claims Aligned Beneficiary Expenditure	\$61,701,080.76	\$63,309,970.11	\$65,805,325.89

(10-11) Trend to the performance year (e.g. PY 2021) using adjusted USPCC trend

	Baseline Experience		
	CY2017	CY2018	CY2019
9 EQUALS: Total DCE Claims Aligned Beneficiary Expenditure	\$61,701,080.76	\$63,309,970.11	\$65,805,325.89
10 TIMES: Prospective Adjusted FFS USPCC Trend	1.101	1.061	1.049
11 EQUALS: Prospective Trended Total DCE Aligned Beneficiary Expenditure	\$67,917,003.24	\$67,183,079.10	\$69,061,398.44

Source: Direct Contracting Model Global and Professional Options: Financial Companion to Operating Guide Overview: Standard DCE  
 Figure 2.2: Historical Baseline Expenditure and Figure 2.3: Application of Prospective Trend

# Appendix: Regional Rate Baseline Adjustment



(12-13) Divide by eligible months to convert to a PBPM rate

(14-15) Divide by the normalized DCE risk score to risk standardize expenditures to 1.0 (No cap or coding intensity factor is applied)

(16-17) Multiply by the geographic adjustment factor (GAF) trend

	CY2017	CY2018	CY2019
11 EQUALS: Prospective Trended Total DCE Aligned Beneficiary Expenditure	\$67,917,003.24	\$67,183,079.10	\$69,061,398.44
12 DIVIDED BY: Eligible Months	69,042	69,378	70,551
13 EQUALS: Claim-based Expenditure PBPM	\$983.71	\$968.36	\$978.88
14 DIVIDED BY: DCE Risk Score	1.232	1.208	1.201
15 EQUALS: DCE Trended Risk-Standardized Baseline Expenditure	\$798.43	\$801.85	\$815.27
16 TIMES: GAF-Adjusted Prospective Trend	0.997	1.011	1.039
17 EQUALS: DCE Risk-Standardized, GAF-Adjusted Baseline Expenditure	\$796.04	\$810.78	\$847.13

Source: Direct Contracting Model Global and Professional Options: Financial Companion to Operating Guide Overview: Standard DCE  
 Figure 2.4: Standardization of Baseline Expenditure

# Appendix: Regional Baseline Rate Adjustment



(17) Credibility weight the DCE PBPM by 10/30/60 for 2017 through 2019

	CY2017	CY2018	CY2019	Three Year-Benchmark
17 EQUALS: DCE Risk-Standardized, GAF-Adjusted Baseline Expenditure	\$796.04	\$810.78	\$847.13	\$831.12

(18) Credibility weight the county rates 10/30/60. They are already risk standardized and trended through the national conversion factor.

	CY2017	CY2018	CY2019	Three Year-Benchmark
18 DCE Regional Rate based on DC/KCC Rate Book	\$858.88	\$858.31	\$858.66	\$858.58

Source: Direct Contracting Model Global and Professional Options: Financial Companion to Operating Guide Overview: Standard DCE  
 Figure 2.5: Historical Baseline (3-Year Average) and Figure 2.6: Regional Rate for Claims-Aligned Beneficiaries

# Appendix: Geographic Adjustment Factors



- County-level factors used for historical and regional benchmark components
- Familiar from the NextGen program
- A form of price-standardization to remove the effect of regional price changes
- Calculated as the ratio of the CY PBPM repriced to PY-1 pricing rules vs CY pricing rules (by county)
- Reprices the following services:
  - Inpatient claims paid under Prospective Payment Systems e.g. Area Wage Indices (AWI)
  - Outpatient claims paid under the Hospital Outpatient Prospective Payment System (HOPPS)
  - Skilled Nursing Facility claims paid under the SNF Prospective Payment System
  - Home Health claims paid under the HHA Prospective Payment System
  - Hospice claims
  - Physician claims paid under the Physician Fee Schedule e.g. Geographic Practice Cost Index (GPCIs)
  - Claims paid under the Renal Dialysis Prospective Payment System

# Appendix: Regional Baseline Rate Adjustment



(19-20) Blend with the county rate depending on the performance year blend percentage

(21) Calculate the difference between the county rate and the DCE rate

(22-24) Apply 5% ceiling and 2% floor (as a percentage of PY USGCC)

(25) Divide by the county rate to get a DCE regional rate baseline adjustment or the percentage historical benchmark out of regional benchmark

	Three Year-Benchmark
17 EQUALS: DCE Risk-Standardized, GAF-Adjusted Baseline Expenditure	\$831.12
18 DCE Regional Rate based on DC/KCC Rate Book	\$858.58
19 Blend Percentage (% historical)	65%
20 Blended Benchmark (before applying ceiling/floor)	\$840.73
21 Difference between Blended Benchmark and DCE Baseline	\$9.61
22 Ceiling on Blended Benchmark Adjustment	\$41.66
23 Floor on Blended Benchmark Adjustment	(\$16.66)
24 Blended Benchmark	\$840.73
25 <b>DCE Regional Rate Baseline Adjustment</b>	<b>0.979</b>

Source: Direct Contracting Model Global and Professional Options: Financial Companion to Operating Guide Overview: Standard DCE  
 Figure 2.7: Blended Benchmark