Risk Evolution Task Force Webinar
October 7, 2021

RISK EVOLUTION
TASK FORCE
AMERICA'S PHYSICIAN GROUPS

We know that asking clinicians to take on this risk and shoulder the burden of America's health is not easy.

The Risk Evolution Task Force was formed to ensure APG members and the wider physician communities have access to the education, support, and resources necessary to both be successful in current risk models and prepare for the next iteration of risk models to come.

Housekeeping

- Type questions in the Q & A box
- This webinar will be recorded
- Links to the recording and slides will be sent to registrations
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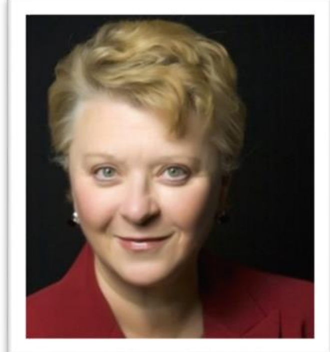
RETF Leadership

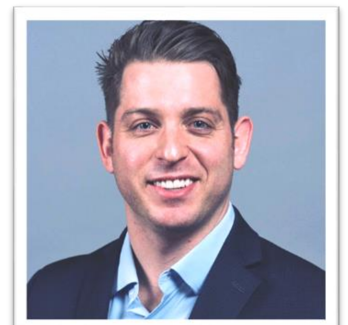
Melanie Matthews

Aneesh Chopra



Valinda Rutledge

Maria Alexander



Rick Goddard

Speakers

Andrea Osborne
SVP, ACO Operations
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Eric Becker
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Medicare Innovation Model
Strategy
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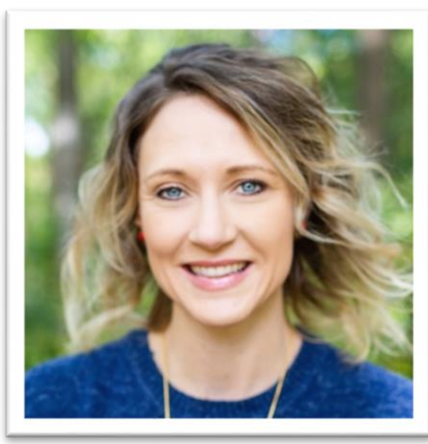

Ashley Ridlon
Vice President of Health Policy
Evolent Health

Agenda

- Welcome and Introductions- Melanie Matthews and Maria Alexander
- Part I in a New Series on Pathways to the Enhanced Track- Rick Goddard
- Update on MSSP Quality- Maria Alexander, Melanie Matthews, and Ashley Ridlon
- Benchmarks Update- Aneesh Chopra
- Direct Contracting Update- Eric Becker and Andrea Osborne
- Update on APG Advocacy Activities- Valinda Rutledge
- Q&A

Part I in a New Series on Pathways to the Enhanced Track
Rick Goddard

Pathways to Success (MSSP) Enhanced

Session 1: Concepts & Methodology

Risk Evolution Task Force: Pathways Enhanced Series

Two-part series to cover the considerations for this program as organizations prepare for PY 2022 and beyond

Session 1: Concepts & Methodology (10/7)

Program Overview

Taking on “Enhanced” Risk

Session 2: Execution (11/18)

High Performing Network Development

Medical Cost Management

Leveraging the Levers Available in Enhanced

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Pathways to Success Enhanced: The Why

Few Programs Available

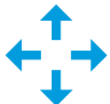
For performance year 2022, there are only a few programs available for providers to take a greater degree of risk/reward and total cost of care accountability within the Traditional Medicare population

- Next Gen ACO has been sunsetted and participants can only participate in Pathways Enhanced or Direct Contracting (DC) if they applied in June 2021
- For those graduating from Pathways to Success Basic: These participants, either through optional or mandatory progression, have options to move into Enhanced or DC

Market Influence

Medicare models continue to be a major influence on local market referral patterns, market share, and eligibility for quality payment program APM coverage.

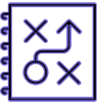
With the entrance of non-provider conveners with Direct Contracting, the Medicare market could shift to those with tightly aligned relationships



The Track of Opportunity

Pathways to Success, also known as MSSP, is now into its 10th year in existence. As a permanent model, ran by CMS (not CMMI), it has evolved into a finely tuned methodology and comfortable downside risk trajectory in an open-access population.

Pathways Enhanced, as the most upside/downside risk in the program, offers the most opportunity for experienced organizations to capitalize on the program’s strengths



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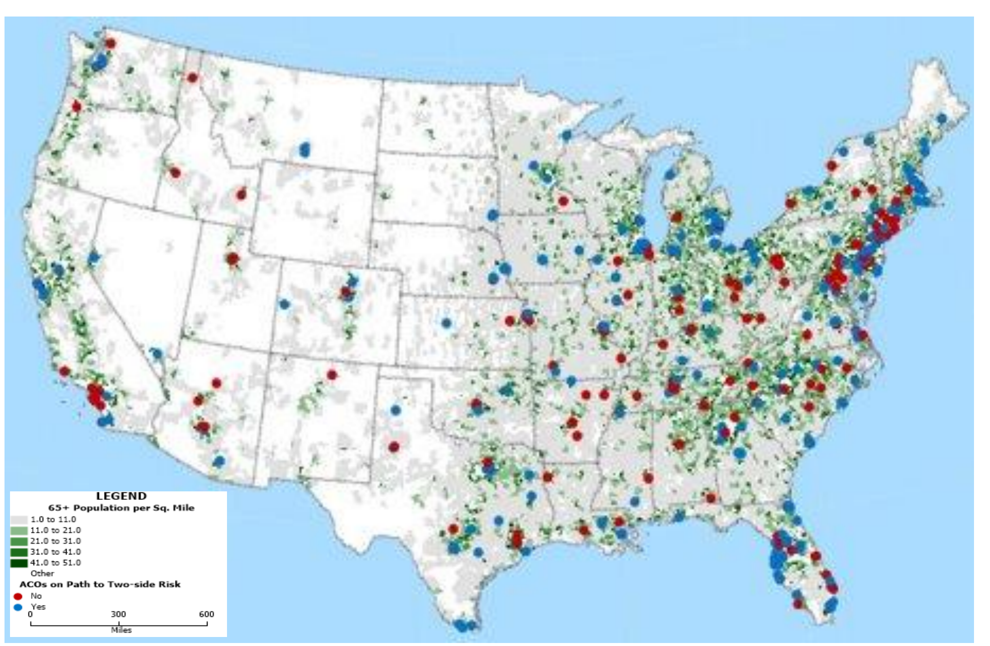
New Models Require Commitment to Two-sided Risk with Significant Share of Entities Destined to Accept Risk in 2022

2020 Pathways ACO Distribution x Senior Population



- Approximately 60% of ACOs participating in the 2020 Pathways performance year were destined to progress to a two-sided risk model
- Organizations considering entry into Pathways to Success will be required to take downside risk within one or two years of entering the program
- Pathways offers two participation options (BASIC Track E and ENHANCED Track) that qualify as an Advanced APM under the Quality Payment Program (QPP)

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Introduction

Program Overview

- ACO Participation Options
- Beneficiary Assignment Methodology
- Benchmark: Calculation Overview
- Benchmark: Regional/National Performance Adjustments
- Benchmark: Growth Rate and Risk Adjustment
- Minimum Savings/Loss Rate Selection
- Quality & Impact at Reconciliation
- Quality Payment Program Considerations

Taking on "Enhanced" Risk

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Pathways to Success Overview

Introduced in 2019, Pathways to Success was an enhancement to MSSP, moves ACOs toward risk faster, with longer 5-year contracts (compared to traditional MSSP 3-year contracts)

Increased emphasis on an ACO's performance compared to their local markets

CMS offers ACOs greater ability to shape participation terms, presenting ACOs with more choices than before

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ACO Participation Options: BASIC and ENHANCED

Standard Glide Path

		BASIC Track				ENHANCED Track
		Level A / B	Level C	Level D	Level E	
Shared Savings Rate		Up to 40% (based on quality)	Up to 50% (based on quality)	Up to 50% (based on quality)	Up to 50% (based on quality)	Up to 75% (based on quality)
Maximum Savings		Up to 10% of updated benchmark	Up to 10% of updated benchmark	Up to 10% of updated benchmark	Up to 10% of updated benchmark	Up to 20% of updated benchmark
Shared Loss Rate		N/A	30%	30%	30%	1 minus sharing rate (between 40-75%)
Maximum Loss	**% Part A&B Revenue**	N/A	Not to exceed 2%	Not to exceed 4%	Not to exceed rev set by QPP (8%)	N/A
	% Updated Benchmark	N/A	Capped at 1%	Capped at 2%	Capped at 1% higher than nominal amount standard (4%)	Capped at 15%
QPP APM Status		MIPS APM	MIPS APM	MIPS APM	Advanced APM	Advanced APM
Beneficiary Incentives		No	Yes	Yes	Yes	Yes
Expanded Telehealth		N/A	Yes, w/ prospective assignment	Yes, w/ prospective assignment	Yes, w/ prospective assignment	Yes, w/ prospective assignme nt
3-Day SNF Waiver		N/A	Yes	Yes	Yes	Yes

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Beneficiary Assignment Methodology

Before the start of a performance year (PY), an ACO may elect beneficiary assignment methodology related to its participation in the Program. Elections become effective at the start of the applicable PY and for the subsequent years of the agreement period, unless superseded by a later election in accordance with CFR 425.226. Methodology elections can switch annually.

PRELIMINARY PROSPECTIVE (Retrospective)

1. Assigned beneficiaries in a preliminary manner at the beginning of a PY based on most recent data available.
2. Assignment updated quarterly based on the most recent 12 months of data.
3. In determining final assignment for a BY or PY, CMS excludes services furnished during the BY or PY that are billed through the TIN of an ACO participant that is an

PROSPECTIVE

1. Medicare beneficiaries are assigned to an ACO at the beginning of each BY or PY based on the beneficiary's use of primary care services in the most recent 12 months for which data are available.
2. Beneficiaries that are prospectively assigned to an ACO will remain assigned to the ACO at the end of the BY or PY unless they meet any of the exclusion criteria.

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Beneficiary Assignment: Key Considerations

Factor	Description	ACO Characteristics	Prelim Prospective (Retrospective)	Prospective
ACO Size	Smaller ACOs tend to favor retrospective assignment as beneficiary counts tend to be lower under prospective	<10,000 Lives	✓	
ACO Market Competition	ACOs electing prospective assignment methodology will maintain precedence over ACOs with retrospective assignment	ACOs in the region have elected prospective		✓
Local Medicare Enrollment Growth	Prospective assignment methodology does not consider assigning new Medicare enrolls ("age-ins")	> 5% Medicare CAGR > 30% MA penetration	✓	
Executing Med. Mgmt. Programs	Prospective assignment allows for early identification of assigned beneficiaries for risk identification and stratification	ACO with significant experience (> 3 years) could leverage historical beneficiary lists in absence of prospective	✓	✓
Member Churn Rate	ACOs experiencing high member churn tend to favor retrospective, which ensures ACO isn't financially responsible for care delivered outside of the ACO	Average "churn rate" of 25%	✓	
Beneficiary Engagement	ACO experiencing low assigned beneficiary engagement or annual visit turnout may favor retrospective	Established Members Not Seen (30%)	✓	

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Benchmark: Calculation Overview

STEP 1
Calculate historical expenditures for beneficiaries that would have been assigned through the benchmark years (BY) by beneficiary type:

- BY1: 2017
- BY2: 2018
- BY3: 2019

STEP 2
Trend forward the expenditures for BY1 & BY2 to BY3 using a blend of national and regional growth rates

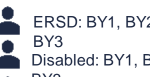
STEP 3
Adjust expenditures for changes in severity and case mix using CMS-HCC risk

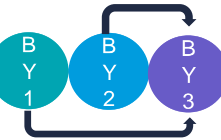
STEP 4
Restate BY1 and BY2 trended and risk adjusted expenditures using BY3 proportions of ESRD, disabled, aged/dual eligible and aged/non-dual beneficiaries

STEP 5
Blend benchmark expenditures applying an equal weight of approximately 33%

STEP 6
Adjust the historical benchmark based on the ACO's regional service area expenditures

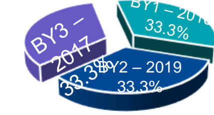
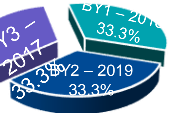
STEP 7
Historical benchmark is further adjusted at the time of reconciliation for a performance year to account for changes in severity and case mix of the ACO's assigned beneficiary population


ERSD: BY1, BY2, BY3
Disabled: BY1, BY2, BY3
Aged/Duals: BY1, BY2, BY3
Aged/Non-Dual: By1, BY2, BY3



CMS-HCC Risk Scores

ERSD	X	BY3 Proportion
Disabled	X	BY3 Proportion
Aged/ Dual-Eligible	X	BY3 Proportion
Aged/Non-Dual Eligible	X	BY3 Proportion

Regional Expenditures

CMS-HCC Risk Scores

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Benchmark: Regional & National Performance Adjustments

While CMS attempts to reduce the polarizing effects of regional adjustments, CMS incorporated a benchmark adjustment based on the ACO's expenditures compared to the regional service area.

REGIONAL ADJUSTMENT WEIGHT

Agreement Period	Lower Spending Relative to Region (efficient ACO)	Higher Spending Relative to Region (inefficient ACO)
1	35%	15%
2	50%	25%
3	50%	35%
4	50%	50%
5	50%	50%

MAX ADJUSTMENT – ILLUSTRATIVE EXAMPLE

			MAX ADJUSTMENT – PY1
Beneficiary Type	BY3: Regional Expenditures	BY3: National Expenditures	5% of National Assignable FFS Expenditure
ESRD	$105,132	$86,425	$86,425
Disabled	$12,646	$11.756	$11.756
Aged/Dual	$19,762	$18,118	$18,118
Aged/Non-Dual	$12,316	$10706	$10706

Regional vs. National Adjustments

Regional benchmarks incorporated in **all** agreement **periods**

Regional benchmark **maximum weight** set at **50%**; ramp to 50% variable based on ACO's regional efficiency

Cap amount of adjustment based on percent of **national FFS expenditures at 5%**

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Benchmark: Growth Rate & Risk Adjustment Overview

Benchmarks are rebased less frequently in Pathways to Success due to an extension to the agreement period length (3-5 years). However, annually, blended growth rates and risk adjustment factors are calculated and used to update an ACO's benchmark.

Growth Rate Methodology

Calculated based on **blend of regional and national** trends

Increased weight on national as ACO gains more regional market share

National Trend Weight:
ACO's market share within service Area

Regional Growth Trend Weight:
1 – National Trend Weight

ACO's service area market share determines the blending weights

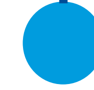
Risk Adjustment

Updated methodology for **annual risk adjustment** of **newly assigned** and **continuously assigned** beneficiaries

Allow for **adjustments over the length of the agreement period** to reflect changes in health status of up to **+3%**

The final rule **does not cap negative adjustments** to risk score

CMS projects that roughly **30% of ACOs** will reach the **risk adjustment cap**



+3% Risk Adjustment cap to the renormalized benchmark every Agreement Period (5 Years)

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Minimum Saving & Loss Rate Selection

Prior to entering a two-sided arrangement of the BASIC track, the ACO must select the MSR/MLR.

Minimum Savings/Loss Rate Options

1. **Zero percent** MSR/MLR
2. Symmetrical MSR/MLR in **0.5% increments** between 0.5 and 2.0%
3. Symmetrical MSR/MLR that **varies** based on the **number** of **assigned beneficiaries**

ACO Hurdles
Illustrative Examples of $80M in Benchmark Premium

Option		Minimum Savings/Losses %	Minimum Savings/Losses $[2]
(1)	**Zero**	0%	N/A
(2)	**Symmetrical**	0.5%	$ 400-500K
		1.0%	$ 800-900K
		1.5%	$ 1.0-1.5M
		2.0%	$ 1.5-2.0M
(3)	**Variable**[1]	3.2%	$ 2.5-3.0M

1) Assumes that the CMS associates ACO's MSR/MLR to a "high" designation with 7,000-7,999 assigned beneficiaries
2) Example Benchmark Expenditures = $80M assuming 6,900 assigned lives

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Quality & Impact at Reconciliation

First Generation MSSP Participants – reframe your understanding of quality impact to your reconciliation due to changes that started in PY2021 – **It is now a pass/fail for shared savings eligibility**

PY 2022 Participants

Achieve a quality performance score that is **equivalent to or higher than the 30th percentile across all MIPS Quality performance category scores**, excluding entities/providers eligible for facility-based scoring

PY 2023 Participants

Achieve a quality performance score that is **equivalent to or higher than the 40th percentile across all MIPS Quality performance category scores**, excluding entities/providers eligible for facility-based scoring

The ACO Quality Performance Standard: The quality performance standard what the ACO must meet in order to be eligible to receive shared savings for a performance year. An ACO will not qualify to share in savings in any year it fails to meet the quality performance standard. It also affects shared loss percentage range in Enhanced

Designation of quality performance: For all ACOs, except those that are in the first year of the program (pay for reporting), CMS designates the quality performance standard as the ACO reporting quality data via the APM Performance Pathway (APP) reporting site, according to the method of submission established by CMS and if an ACO does not report any of the three measures it is actively required to report and does not field a CAHPS for MIPS survey via the APP, the ACO will not meet the quality performance standard.

Quality Payment Program Considerations for 2022

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is a bipartisan legislation signed into law on April 16, 2015, which created the Quality Payment Program (QPP).

Quality Payment Program (QPP)

Repeals the Sustainable Growth

Rewards for value over volume

Streamlines quality programs under MIPS

Bonus payments for advanced APMs

MERIT-BASED PAYMENT SYSTEM (MIPS)

MIPS APM: Non-AAPMs and AAPMs that do not meet payment/patient threshold required for AAPM bonus

ASSESSMENT CRITERIA

Improvement Activities

Cost

Promotes Interoperability

Quality

Final MIPS Score

Medicare Part B Payment Adjustments +/- 9%

ADVANCED ALTERNATIVE PAYMENT MODELS (AAPMs)

AAPMs: Pathways Basic E or Enhanced Track; Primary Care First; Direct Contracting

Qualifying AAPM Participant (QP)?

No

Yes

Annual Bonus: 5% Medicare Part B Payments (until 2024*)

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* 5% AAPM incentive bonus will be distributed to eligible clinicians (designated as “Qualified Participants” or “QP” by CMS) from 2019-2015; starting in 2025 AAPM “QP” will be eligible for 0.75% increase to their Part B fee schedule and AAPM clinicians who are designated as “partially qualified participants” will be eligible for 0.25% increase to their Part B fee schedule. The last program performance eligibility year is PY 2022 unless Congress extends it.

Introduction

Program Overview

Taking on “Enhanced” Risk

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Emphasis on the Enhanced Track for Pathways

		BASIC Track				ENHANCED Track
		Level A / B	Level C	Level D	Level E	
Shared Savings Rate		Up to 40% (based on quality)	Up to 50% (based on quality)	Up to 50% (based on quality)	Up to 50% (based on quality)	Up to 75% (based on quality)
Maximum Savings		Up to 10% of updated benchmark	Up to 10% of updated benchmark	Up to 10% of updated benchmark	Up to 10% of updated benchmark	Up to 20% of updated benchmark
Shared Loss Rate		N/A	30%	30%	30%	1 minus sharing rate (between 40-75%)
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	% Updated Benchmark	N/A	Capped at 1%	Capped at 2%	Capped at 1% higher than nominal amount standard (4%)	Capped at 15%
QPP APM Status		MIPS APM	MIPS APM	MIPS APM	Advanced APM	Advanced APM
Beneficiary Incentives		No	Yes	Yes	Yes	Yes
Expanded Telehealth		N/A	Yes, w/ prospective assignment	Yes, w/ prospective assignment	Yes, w/ prospective assignment	Yes, w/ prospective assignment
3-Day SNF Waiver		N/A	Yes	Yes	Yes	Yes

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ACO Financial Opportunity & Exposure

ILLUSTRATIV E XAMPLE

As an ACO progresses towards increased levels of financial risk (i.e., Basic E), there is an opportunity to forgo participating in MIPS (Quality Payment Program) and capture an incremental financial bonus via qualifying as an advanced APM.

Glide Path	Pathways to Success Track/Level	Max Losses: % of Part A&B FFS Rev[1]	Max Losses: % of Benchmark[2]	Max Gains: % of Benchmark[2]	QPP Incentive (Incentive Bonus/Penalty as % of FFS Part B Revenue[3]): MIPS	QPP Incentive: AAPM[4]
	Basic A	N/A	N/A	N/A	+ / - 9% ($4.0-4.5M)	N/A
Entry Level CY2022	Basic B	N/A	N/A	10% ($20-25M)		
Next Level CY2023	Basic C	2% ($3.0-3.5M)	1% ($2-3M)	10% ($20-25M)		
CY2024	Basic D	4% ($6.0-6.5M)	2% ($4-5M)	10% ($20-25M)		
CY2025 & CY2026	Basic E	8% ($12-13M)	4% ($8-10M)	10% ($20-25M)	N/A	+ 5% ($2.0-2.5M)
	Enhanced	N/A	15% ($35-40M)	20% ($45-50M)		

MSSP Pathways to Success Model | Quality Payment Program (QPP) Incentive

GLIDE PATH

2022 is last eligibility year unless Congress extends AAPM bonus

1. Traditional Medicare Parts A&B Revenue = ~$160M
2. PY1 Benchmark Expenditure = ~$220M assuming 23k assigned lives
3. Traditional Medicare Part B Revenue = ~$50M
4. AAPM = Advance Alternative Payment Model; Quality Payment Program (APP) incentive bonus for AAPM designation is offered until 2024

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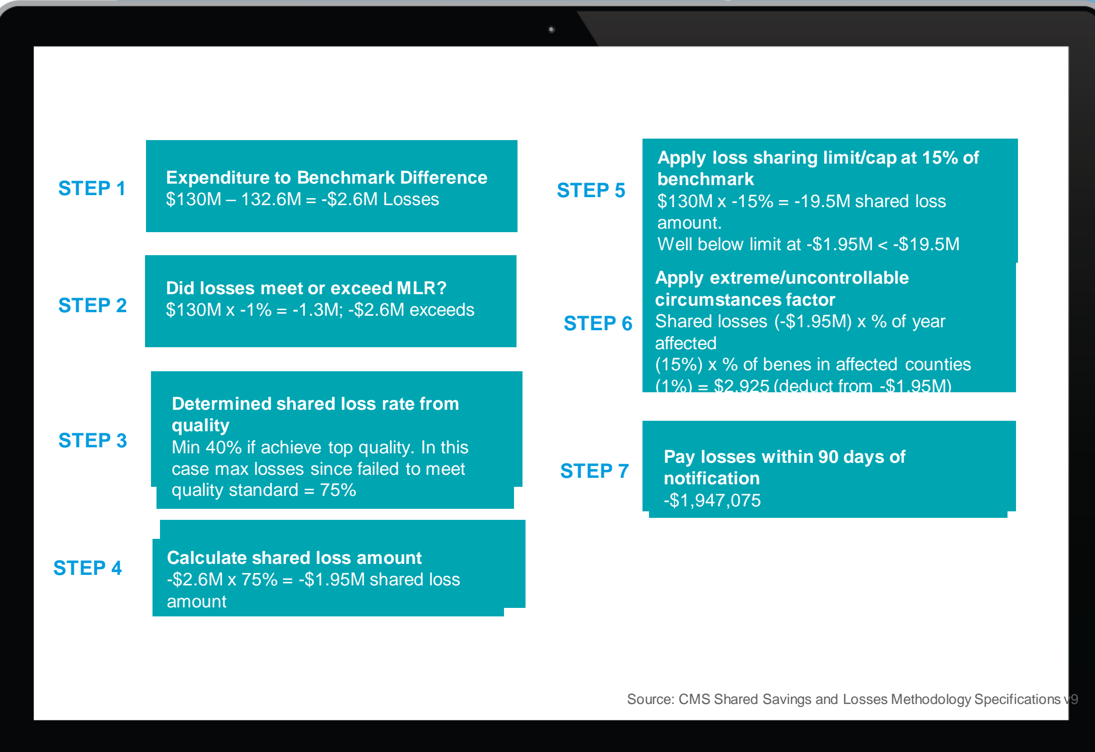
Enhanced Track Reconciliation Losses Example

Assumptions

- MLR: **1%**
- Performance year assigned beneficiaries: **16,000**
- Total Updated benchmark expenditures: **$130M**
- Total performance year expenditures: **$132.6M**
- Quality performance: ACO **failed** to meet quality performance standard
- Max sharing rate: **75%**
- Shared loss rate: between **40% - 75%**
- Loss sharing limit: **15%**



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Summary of Considerations for ACOs Approaching Enhanced

- ✓ Understand the Pathways track selection implications to QPP compliance via Advanced APM or MIPS APM along with the associated financial risk
- ✓ Understand your risk tolerance for taking up to 15% of benchmark losses. Consider reinsurance options.
- ✓ Timing and implications of early termination

- ✓ Know whether your ACO is regionally efficient or not
- ✓ Monitor your region to understand how changes in it will affect your performance
- ✓ Be aware of your patients' risk scores – the more accurate the risk score the more accurate the ACO's benchmark

- ✓ Consider between prospective or retrospective (preliminary prospective) beneficiary assignment and how it fits your ACO and market characteristics
- ✓ Determine strategically your election of a minimum savings/loss rate, if at all.
- ✓ Leverage the offered waivers: SNF 3-day waiver, telehealth expansion, and beneficiary incentive program

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MSSP Quality Changes

Maria Alexander, Melanie Matthews, and Ashley Ridlon

MSSP Quality Measurement and Scoring: PY2021 and Beyond

Proposed rule will be finalized this fall; information subject to change

CMS is moving forward with their alignment of MSSP Quality Scoring and MIPS Quality Scoring into the **APM Performance Pathway**.

- Beginning in 2021, ACOs report under the APM Performance Pathway for MIPS and that performance is used for both MIPS and MSSP
  - The measure set and scoring methodology are the same for MIPS and MSSP.
- **PY2021 (and proposed for 2022)**
  - ACOs can choose to report either 10 measures under Web Interface (WI) Reporting or 3 eCQM/MIPS CQMs
  - ACOs also assessed on 2 claims-based measures and CAHPS for MIPS Survey
- **PY2022 and beyond –** further phase-in of eCQMs/MIPS CQM reporting (covered later in deck)

MSSP Quality Measurement – PY2021

	Option 1	Option 2
ACO Reported measures	10* via Web Interface measures	3 via eCQM (EHR)/MIPS CQMs (Registry)
Patient Population for ACO Reported measures	Sample of patients attributed to ACO	**All Payer** Must report on 70% of population eligible for measure
Claims-based	2 measures	
Patient Experience	CAHPS for MIPS Survey (10 measures aggregated to 1 score)	

- Scoring methodology under MSSP now consistent with MIPS:
  - Does not use domains
  - Each measure worth 10 points; performance rate within decile factors into score
  - CAHPS scored as one measure instead of 10 separate measures
- *3 of the WI measures do not have benchmarks and will not be scored; they must still be reported.
- CAHPS for MIPS Survey uses same measures as CAHPS for ACOs but scoring is different

Option 1

Measure Title	Collection Type	Submitter Type
CAHPS for MIPS	CAHPS for MIPS Survey	Third Party Intermediary (Press Ganey)
Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups	Administrative Claims	N/A
Risk Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions for ACOs	Administrative Claims	N/A
Diabetes: Hemoglobin A1c (HbA1c) Poor Control	CMS Web Interface	ACO
Preventive Care and Screening: Screening for Depression and Follow-up Plan*	CMS Web Interface	ACO
Controlling High Blood Pressure	CMS Web Interface	ACO
Falls: Screening for Future Fall Risk	CMS Web Interface	ACO
Preventive Care and Screening: Influenza Immunization	CMS Web Interface	ACO
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	CMS Web Interface	ACO
Colorectal Cancer Screening	CMS Web Interface	ACO
Breast Cancer Screening	CMS Web Interface	ACO
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease*	CMS Web Interface	ACO
Depression Remission at Twelve Months*	CMS Web Interface	ACO

*We note that Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (Quality ID# 438); Depression Remission at Twelve Months (Quality ID# 370), and Preventive Care and Screening: Screening for Depression and Follow-up Plan (Quality ID# 134) do not have benchmarks and are therefore not scored; they are, however, required to be reported in order to complete the Web Interface dataset.
* ACOs will have the option to report via Web Interface for the 2021 MIPS Performance year only.

Option 2

Measure Title	Collection Type	Submitter Type
CAHPS for MIPS	CAHPS for MIPS Survey	Third Party Intermediary
Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups	Administrative Claims	N/A
Risk Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions for ACOs	Administrative Claims	N/A
Diabetes: Hemoglobin A1c (HbA1c) Poor Control	eCQM/MIPS CQM	ACO/Third Party Intermediary
Preventive Care and Screening: Screening for Depression and Follow-up Plan	eCQM/MIPS CQM	ACO/Third Party Intermediary
Controlling High Blood Pressure	eCQM/MIPS CQM	ACO/Third Party Intermediary

+ We note that Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (Quality ID# 438); Depression Remission at Twelve Months (Quality ID# 370), and Preventive Care and Screening: Screening for Depression and Follow-up Plan (Quality ID# 134) do not have benchmarks and are therefore not scored; they are, however, required to be reported in order to complete the Web Interface dataset.
* ACOs will have the option to report via Web Interface for the 2021 MIPS Performance year only.

Measure Scoring and Effect on Shared Savings

	Previous MSSP Approach	APM Performance Pathway (APP) Approach (Effective PY2021)
Weighting	4 equally weighted domains; different number of measures in each domain so not all measures weighted equally	All measures weighted equally
Scoring per measure	Up to 2 pts based on decile; no adjustment based on distance from decile (same score within decile)	Up to **10 pts per measure** based on decile; distance from decile included in score (e.g., a performance rate of 78% earns more points than a performance rate of 75%)
Quality Performance Standard/Minimum Attainment Level	Must score above 30th percentile benchmark for at least one measure within each of 4 domains	Quality score must be equal to or higher than the **30th percentile* across all MIPS Quality performance scores**
Effect on Shared Savings	Final Quality Score x Max Sharing Rate	If quality performance standards are met → ACO shares in savings at max sharing rate.

For PY 2021, ACOs impacted by Extreme and Uncontrollable Circumstances (ALL) get higher of their score or 30th percentile score if they report, or 30th percentile score if they do not report due to EUC impact during the PY or reporting period.

*This now proposed to increase to 40th percentile in 2024

MSSP 2021 Quality Benchmarks

- Under APP, ACOs will be scored using MIPS benchmarks, which are specific to the reporting method
  - **Exception:** Web Interface reporters will continue to use MSSP benchmarks
  - CMS will continue to use historical benchmarks for 2021 (not performance year benchmarks)
- **As the reporting mechanism changes, the benchmark and score may change.**

Measure	Collection Type	Decile 3 (or lower)	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Points Awarded		**3-3.9**	**4-4.9**	**5-5.9**	**6-6.9**	**7-7.9**	**8-8.9**	**9-9.9**	**10**
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	WI	>70	70 - 60.01	60 - 50.01	50 - 40.01	40 - 30.01	30 - 20.01	20 - 10.01	<=10
	MIPS CQM	90.69 - 72.52	72.51 - 55.18	55.17 - 41.99	41.98 - 32.57	32.56 - 25.49	25.48 - 19.16	19.15 - 12.88	<=12.87
	eCQM	90.50 - 69.43	69.42 - 53.61	53.6 - 42.12	42.11 - 34.07	34.06 - 28.33	28.32 - 23.57	23.56 - 19.11	<=19.1
Controlling High Blood Pressure	WI	<30	30 - 39.99	40 - 49.99	50 - 59.99	60 - 69.99	70 - 79.99	80 - 89.99	>= 90
	MIPS CQM	20 - 29.99	30 - 39.99	40 - 49.99	50 - 59.99	60 - 69.99	70 - 79.99	80 - 89.99	>= 90
	eCQM	51.69 - 57.07	57.08 - 61.32	61.33 - 64.79	64.8 - 68.44	68.45 - 72.03	72.04 - 76.35	76.36 - 82.37	>= 82.38

MSSP Quality Measurement – PY2022 and Beyond

Proposals: Extend Web Interface Reporting option for ACOs; Create incentives for ACOs to report via eCQM

	PY 2022		PY 2023		PY 2024 and beyond
	Option 1	Option 2	Option 1	Option 2	
ACO Reported measures	10 via Web Interface measures	3 via eCQM/ MIPS CQMs	• 10 via Web Interface measures • 1 via eCQM/MIPS CQM (on all payer)	3 via eCQM/ MIPS CQMs	3 via eCQM/ MIPS CQMs
Patient Population for ACO Reported measures	Sample of patients attributed to ACO	All Payer	Sample of patients attributed to ACO	All Payer	All Payer
Claims-based	2 measures				
Patient Experience	CAHPS for MIPS Survey (10 measures aggregated to 1 score)				

- **PY 2022 and PY 2023:** If an ACO selects option 2 and achieves a quality performance score ≥30th percentile of the performance benchmark on at least one measure in the APP measure set, ACO is eligible for shared savings
- If ACO reports both Option 1 and Option 2, receives the ***higher of the two scores***.

Concerns We Continue to Weigh in On

- General approach of tying Medicare shared savings to all-payer reporting
  - Accuracy concerns
  - Equity concerns
  - Privacy law concerns
- General approach of comparing ACO quality performance to MIPS reporters
  - Setting a minimum threshold off of target that is not known in advance and “grading on a curve” when performance is clustered at the top
- Lack of clear guidance on measure aggregation process, detail measure file specifications and time for validation testing for data integrity and accuracy
- Significant cost of turning on eCQM modules, when it should already be enabled in 2015 CEHRT

Benchmarking Highlights
Aneesh Chopra

Data Metrics & Benchmarking

Purpose: To provide benchmarking to APG members across a core set of quality & utilization measures that align with risk model success

Current Established Measures:

- PMPY by category (IP, OP, Part B, SNF, HH)
- IP admits per 1k and % of IP admits that come in through the ED
- % of avoidable ED visits
- SNF stays per 1k and average length of stay
- Part B spend across subcategories

Actively soliciting stakeholder input of APG Risk Evolution Task Force members to refine and augment measures

CareJourney Benchmarks Derived from CMS Data

Benchmark Data:

To create these benchmarks, CareJourney is using data through Q4 2020.

	MEDICARE FFS
Description	100% fully linked Part A, B, D claims
Total Lives	~60M
Linked & Longitudinal	✓
Time Frame	2010 - Present
Refresh Frequency	Quarterly*

The RETF Cohort:

Primary Care Alliance, LLC
Christiana Care Quality Partners ACO, LLC
Caravan Health ACO 17 LLC
CHESS Value, LLC
V120 CHESS NextGen,LLC.
Asian American Accountable Care Organization, LLC
Beacon Health Partners, LLP
CHS Physician Partners ACO II LLC
Accountable Care Coalition of Southeast Texas Inc.
Accountable Care Coalition of Southeast Wisconsin, LLC
Mid-Atlantic Collaborative Care, LLC
Hudson Accountable Care, LLC
QHI ACO, LLC
Accountable Care Coalition of Tennessee, LLC
Accountable Care Coalition of Northeast Georgia, LLC
Accountable Care Coalition of Southeast Partners, LLC
Accountable Care Coalition of Georgia, LLC.
Commonwealth Primary Care ACO
Triad HealthCare Network LLC
The Accountable Care Organization, Ltd.
Physicians ACO, LLC
Intermountain Accountable Care, LLC
KentuckyOne Health Partners, LLC
New York Medical Partners ACO, LLC
Mount Sinai Care, LLC
MSHP ACO, LLC
Caribbean Accountable Care, LLC
Prisma Health Upstate Network, LLC
Ochsner Accountable Care Network, LLC
NW Momentum Health Partners ACO,LLC
MultiCare Connected Care, LLC
Genuine Health ACO LLC
Prisma Health Midlands Network, LLC
Privia Quality Network, LLC
PQN - Georgia, LLC
Privia Quality Network Gulf Coast II, LLC
PQN - Central Texas, LLC
South Texas ACO Clinical Partners LLC
Health Alliance ACO, LLC
DOCACO GULF COAST, LLC
CALIFORNIA CLINICAL PARTNERS ACO, LLC
Texoma Clinical Partners ACO, LLC
Silver State ACO LLC
Texas Panhandle Clinical Partners ACO LLC
Prospect ACO Northeast LLC
Health Connect Partners, LLC
Ohio Integrated Care Providers, LLC
Coastal One Health Partners, LLC
UT Southwestern Accountable Care Network
Trinity Health ACO Inc.
Torrance Memorial Integrated Physicians, LLC
Healthcare Solutions Network, LLC
VillageMD Chicago ACO, LLC
VillageMD New Hampshire ACO, LLC
Primaria ACO, LLC
Medical Clinic of North Texas PLLC

The metrics coded up in this deliverable will be based on 2019 Q4 beneficiary to ACO roster.

RETF Trending Over Time Relative to Non-RETF ACOs

RETF ACOs see a **lower Total PMPY** in comparison to non-RETF ACOs in 2020, driven by **lower IP, OP, and PAC utilization and spend**.

	RETF ACOs 2017	RETF ACOs 2018	RETF ACOs 2019	RETF ACOs 2020	Non RETF ACOs 2020	RETF vs Non RETF	RETF YOY Trend (2019 to 2020)
PMPY	**$ 11,647**	**$ 11,561**	**$ 12,030**	**$ 11,219**	**$ 11,930**	**-6%**	**-7%**
IP PMPY	$ 4,087	$ 4,012	$ 4,115	$ 3,563	$ 4,100	-13%	-13%
OP PMPY	$ 2,126	$ 2,267	$ 2,329	$ 2,251	$ 2,469	-9%	-3%
Part B PMPY	$ 3,502	$ 3,549	$ 3,801	$ 3,395	$ 3,369	1%	-12%
SNF PMPY	$ 797	$ 685	$ 692	$ 743	$ 824	-10%	6%
HHA PMPY	$ 611	$ 552	$ 573	$ 474	$ 543	-13%	-18%
Hospice PMPY	$ 299	$ 252	$ 261	$ 290	$ 329	-12%	9%
IP Admits Per 1K	244.66	226.47	225.21	168.87	198.82	-15%	-28%
SNF Admits Per 1K	102.94	86.94	83.27	66.52	86.65	-23%	-19%
% Avoidable ED	31%	31%	31%	27.40%	26.90%	2%	-13%
% Admits From ED	68%	67%	67%	62%	68%	-9%	-7%

Spotlight on Part B Spend

	RETF ACOs 2019	Non RETF ACOs 2019	RETF ACOs 2020	Non RETF ACOs 2020
PMPY	$12,030	$12,057	$11,219	$11,930
IP PMPY	$4,115	$4,131	$3,563	$4,100
OP PMPY	$2,329	$2,495	$2,251	$2,469
Part B PMPY	$3,801	$3,576	$3,395	$3,369
SNF PMPY	$692	$743	$743	$824
HHA PMPY	$573	$562	$474	$543
Hospice PMPY	$261	$267	$290	$329
IP Admits Per 1K	225.21	213.42	168.87	198.82
SNF Admits Per 1K	83.27	62.18	66.52	86.65
% Avoidable ED	31%	33%	27%	27%
% Admits from ED	67%	70%	62%	68%

Although Part B spend decreased from 2019 to 2020, RETF members consistently observe higher Part B PMPY compared to non RETF members.

SNF and hospice spend increased from 2019 to 2020. Non RETF members observe higher SNF and hospice PMPYs compared to RETF members.

RETF Part B Spend Breakdown

Across RETF ACOs in 2020, CareJourney sees **higher Part B PMPYs** being driven by **drugs** and **procedures.**

	RETF ACOs 2017	RETF ACOs 2018	RETF ACOs 2019	RETF ACOs 2020	Non RETF ACOs 2020	RETF vs Non RETF	RETF YOY Trend (2019 to 2020)
Part B PMPY	**$ 3,502**	**$ 3,549**	**$ 3,801**	**$ 3,395**	**$ 3,369**	**1%**	**-12%**
Part B Ambulance PMPY	$ 145	$ 132	$ 134	$ 134	$ 133	-1%	0%
Part B DME PMPY	$ 6	$ 4	$ 4	$ 4	$ 4	-18%	-6%
Part B Drugs PMPY	$ 421	$ 510	$ 571	$ 803	$ 586	27%	29%
Part B E&M PMPY	$ 1,216	$ 1,176	$ 1,239	$ 908	$ 1,095	-21%	-36%
Part B Imaging PMPY	$ 305	$ 297	$ 323	$ 242	$ 252	-4%	-33%
Part B Other PMPY	$ 91	$ 90	$ 89	$ 87	$ 90	-3%	-2%
Part B Procedures PMPY	$ 947	$ 959	$ 1,047	$ 905	$ 866	4%	-16%
Part B Test PMPY	$ 374	$ 363	$ 395	$ 310	$ 339	-9%	-27%

Top RETF ACOs with the Lowest Total Cost (2020)

Top 10% for the **lowest PMPY** across the RETF also have the **lowest IP PMPY**.

ACO Name	Avg PMPY	Avg IP PMPY	Avg OP PMPY	Avg Part B PMPY	Avg SNF PMPY	Avg HHA PMPY	Avg Hospice PMPY
Diamondbacks	**$ 7,567**	**$ 1,954**	**$ 1,429**	$ 3,291	$ 161	**$ 321**	**$ 128**
Sabres	**$ 7,910**	**$ 2,466**	**$ 1,421**	$ 3,334	**$ 92**	**$ 315**	**$ 135**
Braves	**$ 8,076**	**$ 2,211**	$ 2,380	**$ 2,652**	**$ 233**	**$ 213**	**$ 157**
Hornets	**$ 8,796**	**$ 2,654**	$ 2,475	$ 2,514	$ 332	$ 351	$ 175
Cavaliers	**$ 9,260**	**$ 2,661**	$ 2,488	$ 2,724	$ 320	$ 436	$ 306

These ACOs are the top 5 RETF ACOs for **lowest IP PMPY** as well.

BOLD indicates ACOs that also ranked in top 10% in these respective spend categories.

Top RETF ACOs with the Highest COVID-19 Vaccination Rates

	Vaccinated_Benes	Enrolled_Benes	Percent_Vaccinated
Warriors	21,794	48,375	45%
Heat	15,542	36,378	43%
76ers	26,768	64,541	41%
Bulls	35,891	87,177	41%
Celtics	17,190	43,255	40%

CareJourney JumpStart on COVID-19 vaccination trends!

Benchmarking Performance Quintiles

	Savings per Capita
Top Performer	$1,141
2	$614
3	$396
4	$189
Worst Performer	$(281)

CareJourney JumpStart on 2020 ACO Success coming soon!

2020 ACO Results: Overview

Nationwide
2020 ACO Savings
$2,283,724,790
Avg Savings: $4,451,705
Min Savings: $0
Max Savings: $54,320,998

Nationwide
2020 ACO Benes
10,614,589
Avg Benes: 20,691
Min Benes: 3,418
Max Benes: 161,364
2020 ACOs: 513

Nationwide
2020 ACO PMPY
$10,537
2019 PMPY: $9,499
2019A PMPY:$5,839

ACO Counties by DCI Quintile

Avg. DCI Quintile
1.000 5.000

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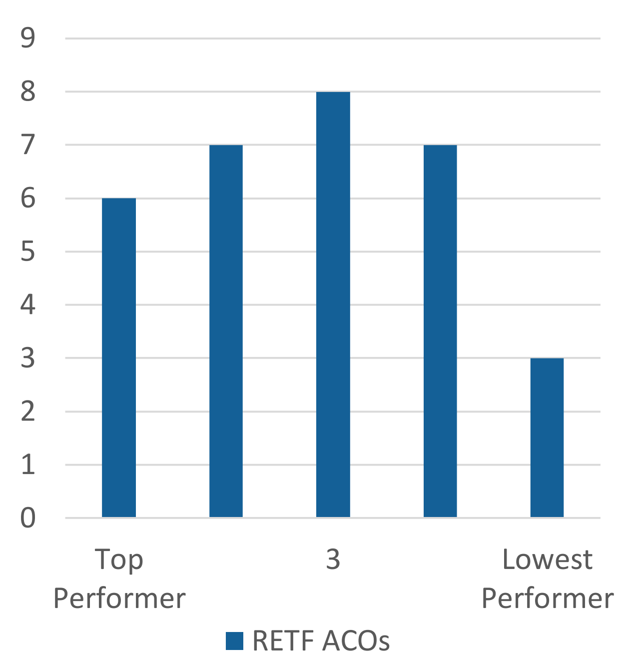
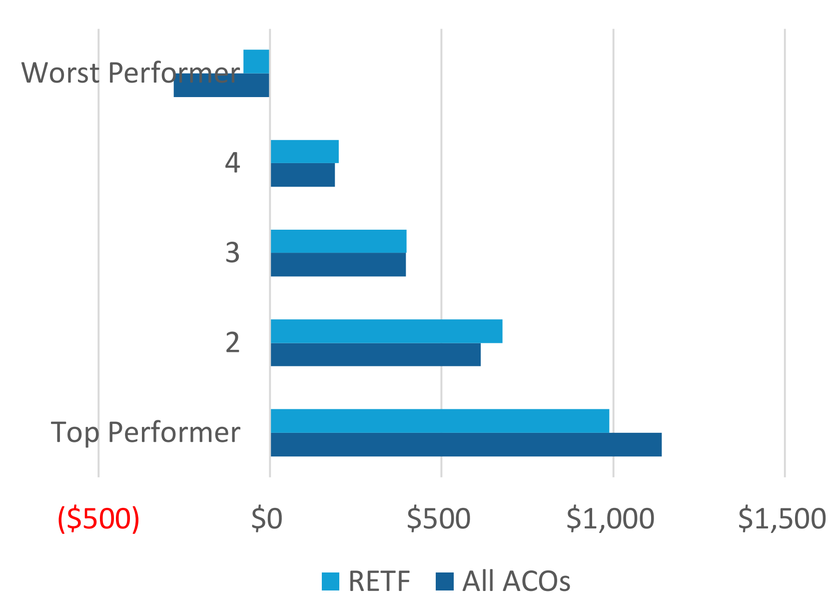
ACO Summary

ACO ID	ACO Name	Avg. Generated Savings (2020)	Avg. Total Assigned Beneficiaries (2020)	Avg. Bene % (2019 to 2020)	Avg. Pmpy (2020)	Avoidable Visits	Emergent Avoidable Visits	Avg. Percent Awv Compliant	Frailty Frail Elderly Cnt
A1001	Palm Beach Accountable Care Or..	$54,320,998	80,864	5.9%	$11,182	17,369	3,230	59.0%	17,483
A3834	Steward National Care Network, ..	$51,533,448	161,364	456.1%	$11,080	47,996	9,772	41.4%	31,176
A2542	Baylor Scott & White Quality Alli..	$47,128,684	129,866	-0.4%	$9,919	35,768	6,544	51.5%	21,036
A4641	Mass General Brigham ACO, LLC	$46,711,743	126,420	3.7%	$11,088	40,302	6,550	32.0%	21,483

RETF 2020 MSSP ACO Performance Quintiles



Count of RETF MSSP ACOs



RETF vs All ACOs: Savings per Capita

RETF 2020 MSSP ACO Performance Quintiles

Top Quintile of RETF MSSP ACOs see **higher PMPYs in Part B and PAC**.

	RETF MSSP ACO 2020 Quintiles				
	1	2	3	4	5
Savings per Capita	$ 988	$ 677	$ 397	$ 200	$ (278)
Diff Benchmark - Expenditures	$ 23,352,940	$ 20,482,454	$ 19,304,839	$ 5,721,677	$ (822,584)
Avg DCI	2.17	1.48	2.09	1.99	2.55
Risk Adjusted PMPY	$ 14,158	$ 12,262	$ 11,677	$ 10,686	$ 12,247
Total PMPY	$ 12,652	$ 12,728	$ 10,941	$ 10,966	$ 11,826
IP PMPY	$ 4,385	$ 4,581	$ 3,052	$ 3,482	$ 3,719
OP PMPY	$ 2,354	$ 2,291	$ 2,484	$ 2,276	$ 2,957
Part B PMPY	$ 3,790	$ 3,944	$ 3,278	$ 3,507	$ 3,465
SNF PMPY	$ 707	$ 928	$ 600	$ 608	$ 669
HHA PMPY	$ 787	$ 499	$ 479	$ 517	$ 412
Hospice PMPY	$ 315	$ 213	$ 261	$ 289	$ 303
IP Admits per 1K	210	200	175	172	168
SNF Admits per 1K	64	76	54	65	68
% Avoidable ED	26.9%	26.6%	27.9%	27.2%	27.2%

ACOs are quintiled on savings per capita based on their benchmark minus expenditures.

Direct Contracting Update
Eric Becker and Andrea Osborne
(verbal presentation)

Update on APG Advocacy Activities
Valinda Rutledge

Advocacy Updates

- Outreach
  - White House
  - HHS
  - CMS
  - CMMI
  - Congressional
- Topics
  - MA
  - Direct Contracting
  - MSSP

APG 2021 Priorities

Strengthening Medicare Advantage	Increase Mvmt to Value	Lowering Healthcare Costs
• Incentives for MA plans to push budget-based prospective payment downstream to the physician group level • Continue to support innovative providers amidst the public health emergency	• Continue to move toward budget-based prospective payment model • Increase the amount of risk and number of patients taken on by providers and organizations	• Drug Pricing Reform • Moving Care to Lower Cost Settings • Ensure parity and make permanent for reimbursement of telehealth services for services in the home and outside the designated rural areas

Closing comments

2021 RETF Meeting Schedule

Meetings are schedule by webex at 12pm ET

Thursday, November 18
Thursday, December 2

Questions?

- Valinda Rutledge: vrutledge@apg.org
- Melanie Matthews: melaniem@pswipa.com
- Maria Alexander - Maria.Alexander@mountsinai.org
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- Andrea Osborne - aosborne@villagemd.com
- Eric Becker: eric.becker@agilonhealth.com
- Ashley Ridlon - ARidlon@evolenthealth.com

ANNUAL CONFERENCE 21

DECEMBER 9 – 11

Marriott Marquis San Diego Marina, San Diego, CA

EMERGING FROM THE PANDEMIC: THE PATH FORWARD