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ACO REACH Program

Health Equity Adjustment under ACO REACH Program

The Innovation arm of the Center for Medicare and Medicaid Services (CMS) announced Accountable Care Organization Realizing Equity, Access, and Community Health Model, or ACO REACH, a new program that will replace the Global and Professional Direct Contracting Program effective January 1, 2023. The goals behind ACO REACH are to create a program that is primarily provider focused, requiring that participating physicians make up 75% of the ACO's governing body, and to put a greater focus on improving health equity within the Medicare program.

While much of the new ACO REACH program resembles the prior Direct Contracting model, there are several substantive changes in the financial and operational aspects of the program. A summary of the changes can be found in this [white paper](#) published by Wakely previously. Among the new financial program parameters, one key change is the health equity adjustment which will be applied to the performance benchmark. In this whitepaper, we will discuss the methodology of the health equity adjustment, as well as Wakely's analysis of the potential geographic-specific financial impact of this adjustment based on the Medicare 100% Research Identifiable File (RIF) data.

ACO REACH Health Equity Adjustment

Why it matters: Health equity is becoming a focal point as health insurers and risk-taking providers are recognizing health disparities amongst beneficiary populations related to where they live and work. Social determinants of health, or conditions in the places where people live and work, can include a wide range of factors such as availability of transportation to the doctor's office, or even proximity of grocery stores to the beneficiary's home. Wide disparities across the nation can lead to beneficiaries having different health outcomes simply due to their region of residence and access to healthcare. To combat these disparities, CMMI is adjusting the benchmark under the ACO REACH program to help support ACOs serving populations that are deemed under-served¹.

¹ <https://innovation.cms.gov/media/document/aco-reach-rfa>

How it works: To help quantify a region's underserved population, CMMI is relying upon the Area Deprivation Index (ADI) released by the University of Wisconsin². This index provides a score of 0 - 99 for each census block group (region) which represents a detailed, granular geographic location across the nation. With this index, CMMI will calculate an adjustment to the individual beneficiary's benchmark by taking the following steps:

- 1) Each beneficiary is given a score from 0 – 99 based on their census block group and according to the ADI
- 2) If a beneficiary is dual-eligible, meaning they qualify for both Medicare and Medicaid, the beneficiary will receive an extra 25-point bump (i.e. if a beneficiary was in a region with a score of 60 and is dual-eligible, then their overall score would be $60 + 25 = 85$)
- 3) All beneficiaries in the ACO REACH program receive a score and are subsequently ranked from highest to lowest based upon their score
- 4) Beneficiaries with scores in the top decile (highest 10%) will receive a \$30 PMPM increase to their benchmark
- 5) Beneficiaries with scores in the bottom 50% of all members will receive a \$6 PMPM decrease to their benchmark

In the end, the ACO may have beneficiaries with a \$30 PMPM increase to their benchmark, no adjustment to their benchmark, and a \$6 PMPM decrease to their benchmark. Given this adjustment will be made at the individual beneficiary level, the overall adjustment to the ACOs benchmark will be based on the weighted average of the beneficiary-level adjustments.

Data and Methodology

In order to determine the beneficiary-level health equity adjustment described above, data on the universe of the ACO REACH population are necessary. Such data will not be available until after all REACH ACOs have been finalized and the performance year has begun. Even then, participant providers and beneficiary-level information for determining the deciles will not be made public. It may not be possible for any ACOs or external entities to calculate the ACO-specific health equity adjustment precisely. We intend to simulate the potential impact using currently available information to provide directional guidance for ACOs considering the REACH program.

Simulating the ACO REACH health equity adjustment requires having information for ACO REACH beneficiaries' residence and dual eligible status. Absent such data, our methodology was to calculate an average health equity score for each county (represented by the Federal Information Process Standard

² <https://www.neighborhoodatlas.medicine.wisc.edu/>

or FIPS code) and then analyze the health equity score distribution for all counties based on the county-level eligible beneficiaries. This would provide directional guidance to existing and prospective ACOs as they assess the potential impact of the health equity adjustment on their benchmarks and financial outcome.

Area Deprivation Index (ADI): The ADI score system to be used for ACO REACH is developed by the research team at the University of Wisconsin-Madison at the census block level. The census blocks can be viewed as neighborhoods and the ADI is a ranking of the socioeconomic disadvantage of the neighborhood relative to the nation. A census block group with a ranking of 1 indicates the lowest level of economic disadvantage whereas a group with an ADI of 100 indicates the highest level of disadvantage for that neighborhood. Using the census block-level population distribution for age 65 published by the US Census data³, we calculated the weighted average ADI at the state and county FIPS level for population aged 65 and above.

Dual Status: The 100% RIF data contains detailed enrollment and claim experience of the entire Medicare FFS population for historical years. We used the Dual_Stus_CD field in the Master Beneficiary Summary File (MBSF) Base data to identify each member’s dual status based on the following criteria. The code values are shown in the appendix.

Table 1: Dual Status Code Values in 100% Research Identifiable Data

	Dual_Stus_CD
Dual Status	01, 02, 03, 04, 05, 06, 08
Non Dual	NA, 00,09, 99

Using the CMS 100% RIF data, we obtained the dual status of each FFS beneficiary for the 2019 calendar year, and calculated the percentage of dual eligible beneficiaries at the state and county FIPS level. Since each dual eligible beneficiary would receive 25 points toward the health equity factor, we multiplied 25 by the percentage of dual eligible population to arrive at an average number of points for dual eligible for each state and county combination.

Composite Score and Ranking: For each state and county FIPS, we then calculated the composite health equity score by adding up the average ADI and the average dual eligible point increase. We then ranked the state and county FIPS based on the weighted average composite score at the county level.

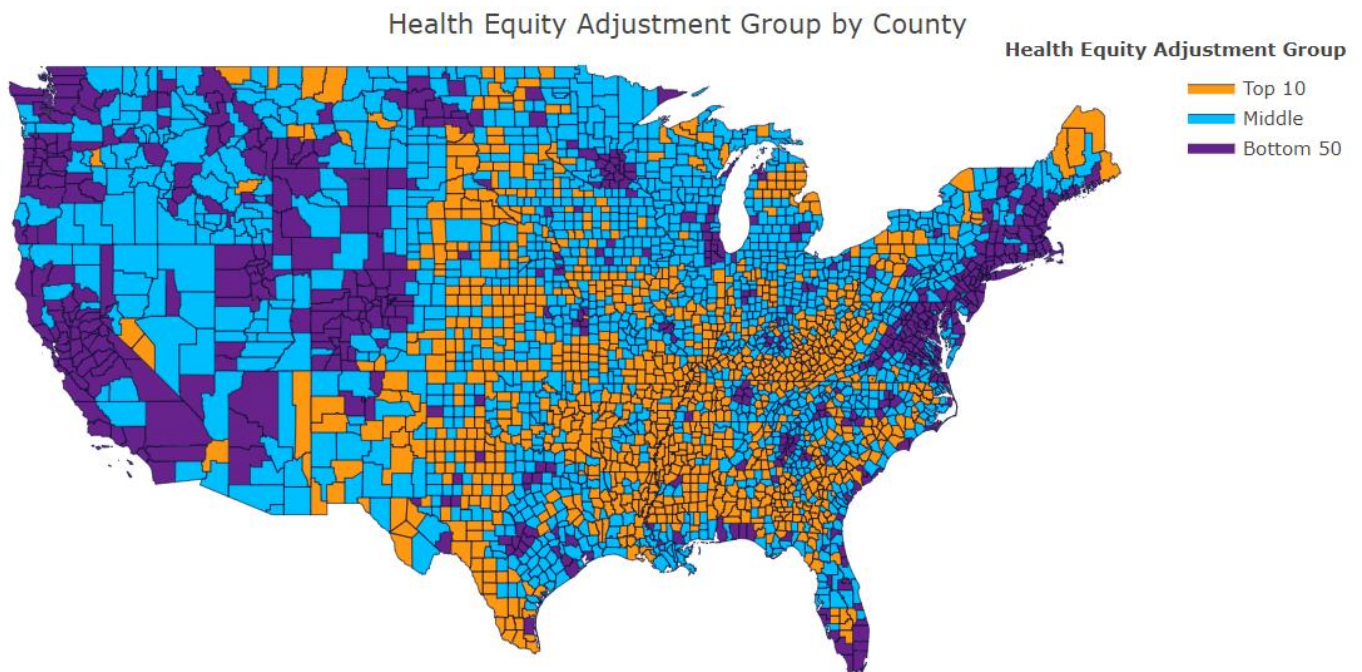
³ <https://www.census.gov/data/developers/data-sets/planning-database.html>

Key Findings

Health Equity Score by County

The following map shows at the county level, the overall health equity score in relation to the national deciles for the Medicare payment. Counties highlighted in orange have a membership distribution such that on average, that county would fall under the top decile.

- Borden County (TX), Teton County (WY), San Mateo County (CA) showed the lowest average health equity adjustment (least under-served)
- Wolfe County (KY), Starr County (TX), Lee County (KY) showed the highest average equity adjustment (most under-served)⁴
- Los Angeles County (CA) and Cook County (IL) were the counties with the highest number of Medicare FFS beneficiaries in the dataset. Both counties fell into the bottom five deciles indicative of a less disadvantaged/under-served population.



⁴ For this portion of our analysis, we focused on counties with 1000 or more Medicare FFS beneficiaries and excluded those not meeting this threshold.

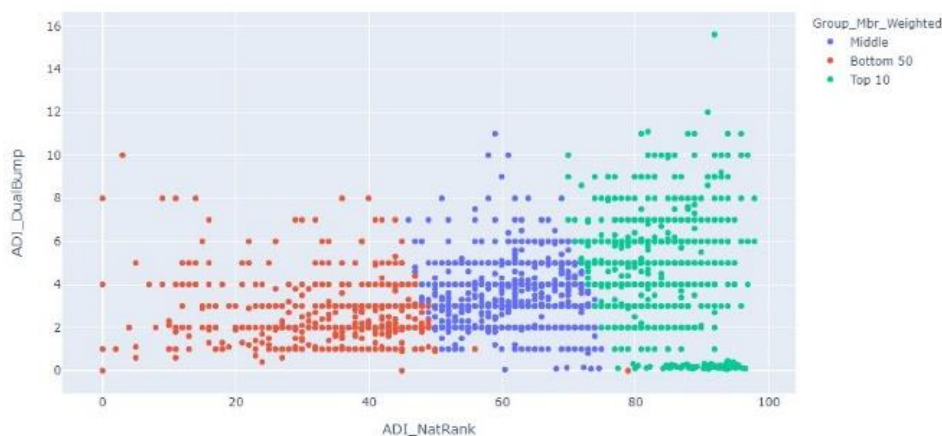
Additional Observations on Health Equity Score

- County scores ranged from 0-98 prior to the addition of 25-point bump for dual eligible members in the county; the range was 0-107 after additional bump from dual eligible members
- Total of 3,219 unique FIP county codes (includes counties, municipalities, boroughs, etc.)
 - 1,150 counties and county equivalents were in the top decile (i.e. highest level of disadvantage)
 - 594 counties and county equivalents were in the bottom 5 deciles (i.e. lower level of disadvantage)
- Approximately 4.2 million beneficiaries reside in counties that are in the top decile.

Dual Eligible and ADI Rank

In compiling the data, we observed a weak correlation between dual eligible status and the ADI ranking. Fifty percent of the total Medicare beneficiary population resides in the bottom 5-decile counties, while 48% of dual eligible members reside in the bottom 5-deciles counties. Approximately fourteen percent of the dual eligible beneficiaries reside in counties within the top decile compared to only ten percent of the overall Medicare beneficiary population. We plotted the counties' ADI ranking and dual status adjustment below. The graph shows that the county data points are somewhat evenly distributed, without a strong pattern, but there is a slight positive correlation between the two metrics (as ADI ranking increases, average dual status bump increases).

As demonstrated in the graph below, counties with the highest ADI ranking (most disadvantaged) are on the far right of the x-axis. The y-axis shows the additional health equity adjustment for a dual eligible member; a higher value on the y-axis represents a higher proportion of dual eligible members residing in that county. For example, the grouping of green data points on the bottom of the graph towards the far right indicates counties with high ADI ranking (high-level of disadvantage) but with a low proportion of dual eligible members.



Considerations and Limitations

Our analysis uses a state and county FIPS as the measuring unit and the average ADI and dual score at the FIPS level as the composite health equity score. We also used the Medicare FFS 100% RIF data and the US census total 65+ population as our basis for this analysis. This approach intends to provide a high-level view of the potential relative ranking of the counties, and a proxy of the potential health equity adjustment for ACO REACH benchmarks based on geography. This approach has a number of limitations.

First of all, the health equity adjustment will be determined based on the ACO REACH program participants, instead of the entire Medicare FFS population. The ACO REACH program participants would be a sample of the FFS population and may not resemble the characteristics (such as geography or demographics) of the total population.

Secondly, the ranking of the composite health equity scores will be based on those of individual beneficiaries, instead of the county average health equity scores. Depending on the participating ACOs and their attributed membership, the distribution of the individual beneficiary health equity scores may deviate materially from that of the county-level scores.

With the limitations stated, we intend for this analysis to shed light on the regional differences in terms of health equity and provide directional guidance on potential benchmark impact of the newly proposed health equity adjustment as ACOs looking to engage with ACO REACH.

Conclusion

The ACO REACH program seeks to advance health equity by testing an innovative payment approach to better support care delivery and coordination for patients in underserved communities (through the health equity adjustment to the performance year benchmark). REACH ACOs serving underserved communities will benefit from this adjustment and receive additional funding to improve the quality of care and outcomes for their aligned beneficiaries. While CMMI's estimates suggest marginal impact of this adjustment to most ACOs, results may vary by individual ACO and it is important for program participants to understand the potential financial impact based on their specific population.

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Appendix

Dual Status code values from the 100% RIF data.

Code	Code value
NA	Non-Medicaid
00	Not Medicare enrolled for the month
01	Qualified Medicare Beneficiary (QMB)-only
02	QMB and full Medicaid coverage, including prescription drugs
03	Specified Low-Income Medicare Beneficiary (SLMB)-only
04	SLMB and full Medicaid coverage, including prescription drugs
05	Qualified Disabled Working Individual (QDWI)
06	Qualifying individuals (QI)
08	Other dual eligible (not QMB, SLMB, QDWI, or QI) with full Medicaid coverage, including prescription drugs
09	Other dual eligible, but without Medicaid coverage
99	Unknown