



Direct Contracting's Financial Details: New Entrant DCEs



The webinar will begin at 2:00 pm ET. Please make sure you are dialed in to the webinar on your telephone with the audio pin.

Agenda.....



1. Housekeeping and Introductions
2. Presentations:
 - Policy Details
 - Modeling and Analysis
 - New Entrant DCE Perspective
3. Audience Q&A and follow-up

Housekeeping.....

1. Speakers will present for around 60 minutes
2. Q&A will take the remainder of the time
 - You can submit written questions using the Questions tab on your dashboard to the right of your screen at any time during the webinar
 - During the Q&A session, you can use the “raise hand” feature on your dashboard to ask a live question. Please make sure you have dialed in on the telephone and used your audio pin to connect so that we can hear you clearly.
3. Webinar is being recorded
 - Slides and recording will be available on the NAACOS website within 24 hours. You will receive an email when they are available.

Speakers



Dave Ault

Dave is counsel at Faegre Drinker Biddle & Reath LLP where he advises clients on a range of CMS issues including those related to value-based payment. Dave regularly draws on his extensive experience at HHS and CMS, including his tenure leading the Next Generation ACO Model and working as part of the Medicare Shared Savings Program leadership team.



Andrew Webster

Andrew is co-founder and lead actuary at Validate Health, the industry's only financial forecasting and optimization platform built exclusively for ACOs. He specializes in payer contract modeling (including MSSP, Next Gen, Medicare Advantage and commercial), forecasting shared savings under different decision scenarios and risk hedging strategies to lock in expected outcomes.



Nathan Lohmeyer

Nathan is Vice President, Integrated Kidney Care & Government Programs at DaVita where he is the national leader for integrated care innovation, business development, operations and public policy for Government value-based care programs, including Medicare Advantage ESRD Chronic Special Needs Plans (C-SNPs) and ESRD Seamless Care Organizations (ESCOs).

NAACOS Direct Contracting Taskforce



Created last fall to help educate members on and advocate for positive changes on the Direct Contracting Model.

- Stand-alone [webpage](#) with CMS and NAACOS resources
- [Frequently Asked Questions](#) on Direct Contracting
- In-depth [analysis](#) of Direct Contracting
- [Chart](#) comparing Direct Contracting to other high-risk ACOs
- [Chart](#) on the overlap of CMMI models and ACOs
- Hosted several webinars, town halls and learning discussions
- **NEW! [Summary of Direct Contracting Financial Specifications](#)**

Future NAACOS Advocacy



- NAACOS continues to meet with CMMI on shaping Direct Contracting
- Examples of formal letters we've written
 - NAACOS [urges](#) announced plans for the future of the Direct Contracting Model
 - NAACOS [calls for changes to Direct Contracting](#) and seeks more information
- NAACOS submits feedback on new [Geographic](#) and [Professional and Global](#) Options of Direct Contracting Models from the CMS Innovation Center
- We plan to address concerns with financial specifications with CMMI
 - In setting benchmarks, CMS should give greater weight to the least recent year
 - CMS should add shared savings earned by a DCE back in the PY benchmark
 - CMS should give more weight to the regional rates for all DCEs
 - CMS should expand the concurrent risk adjustment model beyond the High Needs Population DCEs
- ***What else concerns or excites you about this model?***
- **Reach out to DirectContracting@naacos.com**

Upcoming Events



Today is the second in a series of October webinars on Direct Contracting's financial details.

Direct Contracting's Financial Details: High Needs Population DCEs

- Thursday, October 29th
- 2 pm - 3:15 pm ET
- **Participation is free for NAACOS ACO and Direct Contracting Taskforce members. [Register Now!](#)**

Available on-demand: Direct Contracting's Financial Details: Standard DCEs

- Slides and recording are [available here](#)

Direct Contracting Model Updates

- In mid-September, CMMI released 8 papers containing the financial methodology for Direct Contracting
- The papers included details on:
 - Benchmarking, including the adjusted MA rate book (called the DC/KCC Rate Book) and Risk Adjustment
 - Capitation and Advance Payment
- Model extended through 2026 to offer five complete years for all participants
 - CMS will apply a “seasonality adjustment” to PY1 benchmarks to account for the shortened, nine-month performance period (April 1 – December 31, 2021)

Two Model Options

Professional Option

- Shared Savings/Losses: 50%
- Capitation: Primary Care Capitation (up to 7% capitation) → Basic + Enhanced
- Advanced Payment
 - May elect Advanced Payment for non-capitated claims
 - Reconciled at the end of each PY (similar to the Population-Based Payment mechanism in NextGen)

Global Option

- Shared Savings/Losses: 100%
- Capitation: DCE chooses Primary Care Capitation or Total Care Capitation (100% capitation)

- Participant Providers must agree to capitation
- Capitated payments are not reconciled against actual expenditures
- The model will qualify as an AAPM

Either model option is available to each of the three types of DCEs.

Note: In the future, CMS may offer a third model option, the “Geographic Option,” where a DCE would assume financial risk for the entire population of a particular geographic area.

Changes to Primary Care Capitation

- DCEs not required to participate in capitation in PY 1
- Glide path with increasing capitation minimums

Payment Mechanism	Participant Providers	Preferred Providers
TCC	100% claims reduction	Optional
PCC	* For primary care claims only PY1: optional PY2: min 5% PY3: min 10% PY4: min 20% PY5: 100% PY6: 100%	Optional
APO	Optional	Optional

Financial Methodology - Benchmarking

Benchmarking will follow a **5-step process** (similar to NextGen)

Calculation of historical baseline
expenditures

Trending the historical baseline
expenditures forward

Risk adjustment

Blending the historical baseline
expenditures with regional
expenditures

Applying the discount, quality
withhold, and retention withhold

Calculation of historical baseline expenditures

- Historical baseline expenditures NOT used for PY1-4.
- CMS will only use regional expenditures for PY1-4
 - CMS will add in historical baseline expenditures for PY5-6.
 - The baseline will be a weighted 3-year base period:
 - PY5 (2021, 2022, 2023)
 - PY6 (2022, 2023, 2024)

** A New Entrant DCE with more than 3,000 aligned beneficiaries will be treated as a Standard DCE*

3. Blending the historical baseline expenditures with regional expenditures

Adjusted MA Rate Book = DC/KCC Rate Book.

Notable differences:

- Uses only DCE-eligible benes
- 3 base years (not 5), 1-year interval between base year 3 and PY
- Include hospice care and IME; removes uncompensated care
- No quartile adjustment

Applying the discount, quality withhold, and retention withhold

Discount

- Applies only to Global DCEs (No discount for Professional DCEs)
- Applied to the PY benchmark

Performance Year	Discount
PY1-2	2%
PY3	3%
PY4	4%
PY5/6	5%

TCC Withhold

- For TCC DCEs only
- To account for spillage

Quality Withhold

- Applied to PY benchmark
- Quality withhold = 5% of benchmark
- DCE can earn back based on quality performance
- Amounts not earned back fund a High Performers Pool

Retention Withhold

- Applied to PY1 benchmark only
- Retention withhold = 2% of benchmark
- DCE will earn back if stays in model for at least 2 years

Calculation of historical baseline expenditures

- Historical baseline expenditures NOT used for PY1-4.
- CMS will only use regional expenditures for PY1-4
 - CMS will add in historical baseline expenditures for PY5-6.
 - The baseline will be a 3-year base period:
 - PY5 (2021, 2022, 2023)
 - PY6 (2022, 2023, 2024)

Trending the historical baseline expenditures forward

- CMS will prospectively trend forward the historical baseline using the projected US Per Capita Cost (USPCC) growth trend and the ESRD USPCC growth trend
- CMS will trend to reflect the anticipated impact of changes in the regional FFS Geographic Adjustment Factors (GAFs)

Risk adjustment

For **New Entrant DCEs** CMS will use the existing CMS-HCC A&D model and CMS-HCC ESRD risk adjustment model

CMMI will use a 4-step risk adjustment process:

1. Prospective estimated normalization
2. Normalization correction adjustment factor
3. Risk score cap (symmetric 3% cap on DCE-level risk score grow (per PY))
4. Retrospective Coding Intensity Factor (CIF)

Blending the historical baseline expenditures with regional expenditures

- Using an “Adjusted MA Rate Book” to blend regional expenditures with aligned beneficiary historical expenditures

<u>Performance Year</u>	<u>Historical Baseline Expenditures</u>	<u>Regional Expenditures</u>
PY5	55%	45%
PY6	50%	50%

- Limits on adjustment resulting from blending in regional expenditures:
 - Upward adjustment capped at 5% of the FFS USPCC for the PY
 - Downward adjustment capped at 2% of the FFS USPCC for the PY

Applying the discount, quality withhold, and retention withhold

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Standard DCE: Recap



1. Calculation of Regional Rate Baseline Adjustment (historical benchmark)
2. PY1 Seasonality Adjustment (Also applies to New Entrant DCEs; See issue in the appendix)
3. 2022 Program selection: MSSP vs DC
 - Average value of lower 3% risk ratio cap (\$200k PBPY) is less than cost for upper 3% risk ratio cap (\$500k PBPY)
 - Up to PY3 0.6% decrease in benchmark due to the coding intensity factor (CIF) values (from Pathways 2019-A performance)
 - DC ratebook vs MSSP regional rates (PY 2018, PY 2019 data released)

New Entrant DCE Agenda

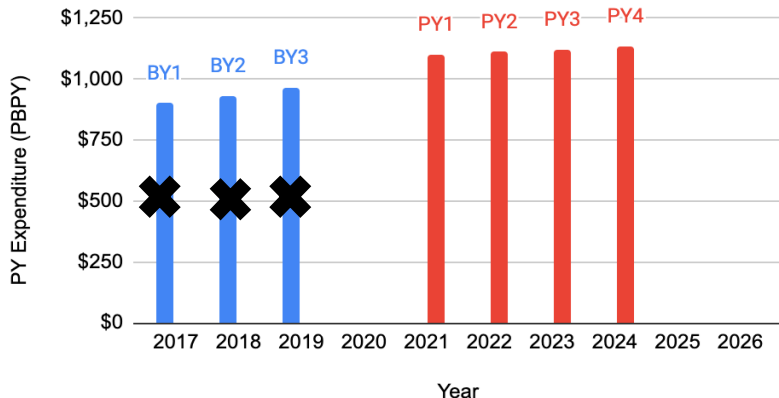


1. New Entrant DCE benchmark calculation
2. Differences between MA and DC risk adjustment methodologies
3. Differences between MA and DC regional benchmarks

New Entrant Benchmark

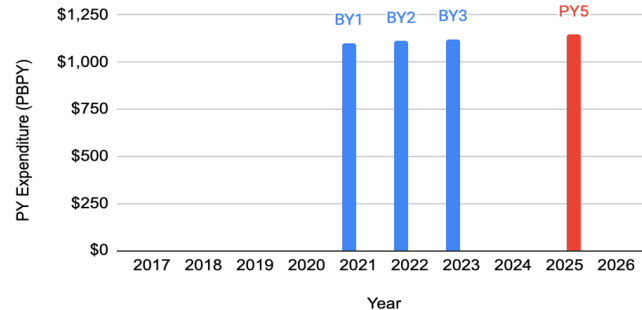


PY1-4 (BY 2017-2019)

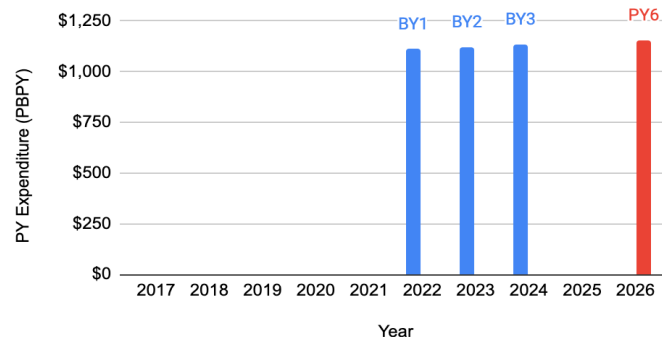


✖ If < 3,000 aligned beneficiaries then unable to calculate a historical PBPY. (This can change in PY1-4 based on participant list changes.)

PY5 (BY2021-2023)



PY6 (BY2022-2024)



New Entrant Benchmark



		Benchmark to which Experience Accrues
		AD
DCE Benchmark Expenditure		
1.	Claims-Based Alignment	
2.	DCE Regional Rate based on DC/KCC Rate Book	\$812.92
3.	TIMES: DCE Regional Rate Baseline Adjustment	1.000
4.	TIMES: PY Risk Score	1.102
5.	TIMES: PY Eligible Months	69,657
6.	EQUALS: Benchmark before Discount or Quality Withhold	\$62,385,095.84
7. Voluntary Alignment		
8.	DCE Regional Rate based on DC/KCC Rate Book	\$815.99
9.	TIMES: DCE Regional Rate Baseline Adjustment	1.000
10.	TIMES: Risk Score	1.017
11.	TIMES: Eligible Months	31,208
12.	EQUALS: Benchmark before Discount or Quality Withhold	\$25,901,638.49

Source: Financial Companion to Operating Guide Overview: New Entrant DCE

Figure 2.1: A&D Benchmark Calculation

New Entrant Benchmark



Regional Risk
Standardized
Rate PBPM
\$812.92
PBPM



Capped and
CIF-Adjusted
PY Risk Score
1.102



Benchmark
PBPM before
Discount or
Quality
Withhold
\$895.84 PBPM

5% Quality Withhold

2-5% Discount

Benchmark
PBPM after
Discount or
Quality
Withhold
\$833.13 PBPM

New Entrant PY Risk Score



Step	Goal	DC	DC Example	MA	MA Example
Normalization	Ensures that a given year has an average risk score of 1.0	<ul style="list-style-type: none"> - Raw risk scores are normalized to the all alignable population - Prospective normalization with retrospective reconciliation - Based on all DC alignment eligible beneficiaries 	Raw score: 1.12 Normalization factor: 1.1 Normalized Risk Score = $1.12 / 1.1 = 1.018$	Normalization factors are determined annually on a prospective basis	Raw score: 1.12 Normalization factor: 1.06 Normalized Risk Score = $1.12 / 1.06 = 1.057$
Capping	Ensures that a specific DCE doesn't have outlier risk growth/ratio	<ul style="list-style-type: none"> - Symmetric +/- 3% risk growth (ratio) caps are calculated and applied to claims-aligned beneficiaries only - Relative to a rolling reference year - Applied after final normalization 	Score 2021: 1.018 Score 2023: 1.05 Capped score = $1.018 \times 1.03 = 1.048$	No plan-specific risk adjustment caps are applied	N/A
Coding Intensity Factor (CIF)	Ensures that the overall change in risk score is budget neutral	<ul style="list-style-type: none"> - Calculated on and applied to claims-aligned beneficiaries only - At the national level by A/D and ESRD - After capping; Retrospectively determined - Divided by risk score growth of PY vs 2019 reference year 	Score 2023: 1.06 Score 2019: 1.0 CIF = $1.0 / 1.06 = 0.943$ Score = $1.06 \times 0.943 = 0.999$	A prospectively determined coding intensity adjustment applied each year	Score 2023: 1.057 Coding Intensity: 6.1% Score = $1.057 \times (1 - 0.061) = 0.992$

PY Risk Scores for Voluntary Alignment



2021 - PY1												2022 - PY2												2023 - PY3																							
Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec												
PY2 Alignment Year 2																																															
PY3 Alignment Year 1												PY3 Alignment Year 2																																			
Bene A			E&M			E&M			E&M			E&M			E&M			E&M			E&M			E&M			E&M			E&M			E&M			E&M											
			Voluntarily Aligned						Claims Aligned						Claims Aligned						Claims Aligned						Claims Aligned						Claims Aligned														
Bene B			E&M			E&M			E&M			E&M			E&M			E&M			E&M			E&M			E&M			E&M			E&M			E&M			E&M								
			Voluntarily Aligned						Voluntarily Aligned						Voluntarily Aligned						Voluntarily Aligned						Claims Aligned						Claims Aligned						Claims Aligned								

- Voluntarily-aligned beneficiaries are likely to become claims-aligned beneficiaries in one or two performance years
- Bene A** has E&M visits starting in April of 2021 leading to 2022 claims-based alignment (and capping/CIF)
- Bene B** has E&M visits starting in July of 2021 and if voluntarily aligned again in 2022 (Potential loophole)
 - Avoids 2022 capping/CIF (despite control over HCC coding in 2021)

CIF: Empirical Estimation



- Simulation of ESRD/Non-ESRD CIFs after capping
- A/D CIF of **+0.05% (PY1) to -0.57% (PY3) change to benchmark**
- CIF reference year is fixed to 2019 whereas the cap reference year is rebased annually (except for PY1)

Enrollment Type	2016*	2017	% change vs BY3	CIF PY1	2018	% change vs BY3	CIF PY2	2019	% change vs BY3	CIF PY3
Non-ESRD (A/D)	1.029	1.028	99.95%	100.05%	1.030	100.19%	99.81%	1.034	100.57%	99.43%
ESRD	1.019	1.022	100.23%	99.77%	1.022	100.23%	99.77%	1.017	99.76%	100.24%

For the 205 MSSP ACOs in 2019-A PY having 2018 BY3

* This analysis does not remove risk scores for voluntarily aligned beneficiaries

** Assigned beneficiaries was used as an approximation to person years

*** BY1 and BY2 used BY3 assignment since assignment for BY1 and BY2 was not available

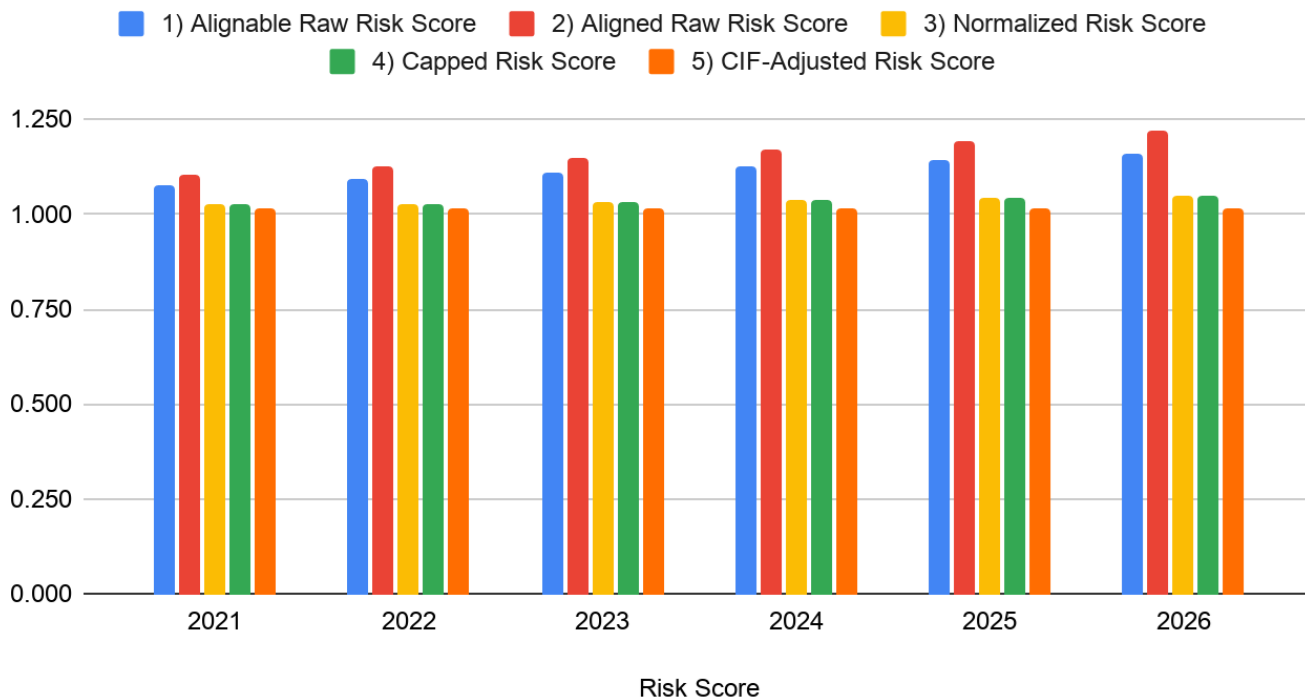
Source: Validate Health, Oct 2020

CIF: Demographic Maturation Issue



- 2% annual CMS-HCC risk score increase
- 1% annual demographic-only risk score increase
- No capping
- **CIF-adjusted risk score is flat**

PY 2021, 2022, 2023, 2024, 2025 and 2026



The CIF demographic maturation issue was first raised by Mike Barrett at Collaborative Health Systems (CHS)
Assumes that 50% of the alignable population is not aligned and that their risk scores increase at the demographic-only rate

CIF: Demographic Maturation Issue



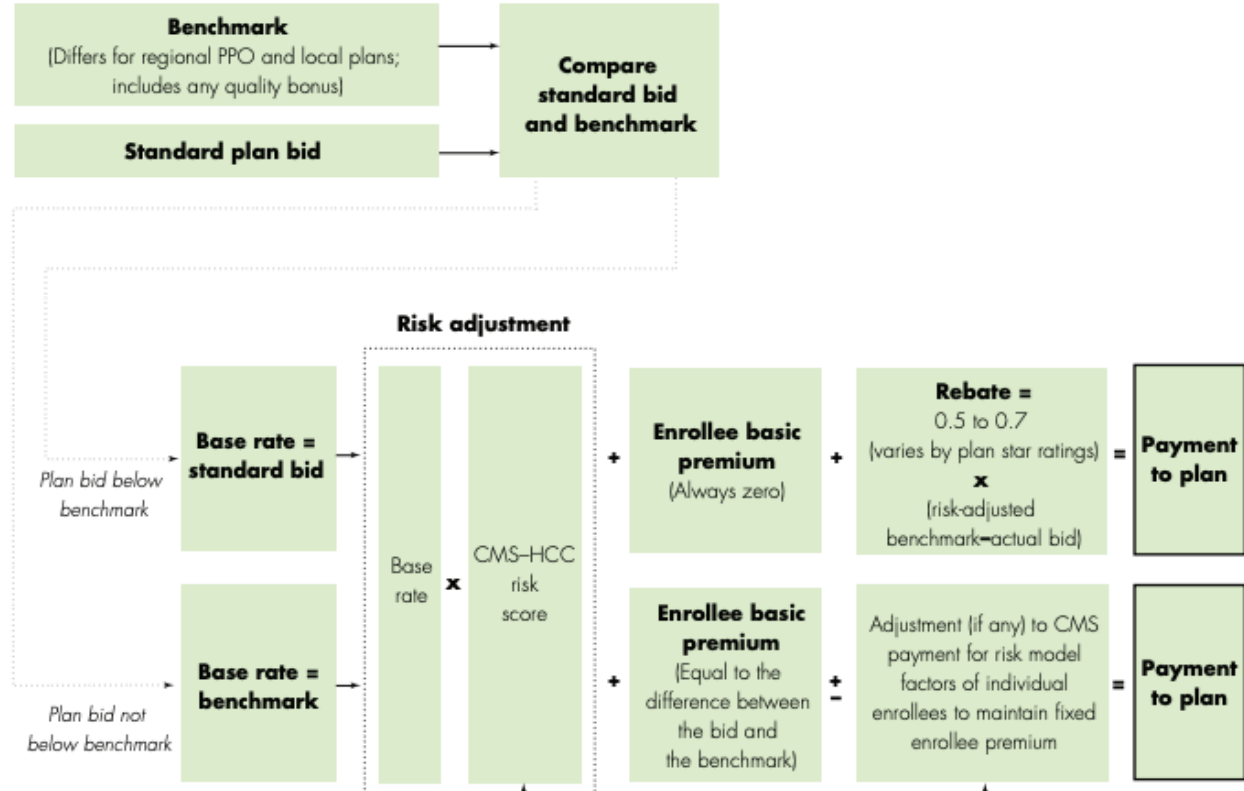
- One possible solution is to allow the demographic-only change in risk score
- This solution could be an improvement or not depending on the population
- It would remove risk due to demographic changes

Prospective Trend					
	CY2014	CY2015	CY2016	CY2017	CY2018
Aged & Disabled Benchmark					
Simple Age/Sex Risk Score	1.0000	0.9975	0.9950	0.9925	0.9900
HCC-based Raw Risk Score ¹	1.1297	1.1321	1.1605	1.1731	1.1880
... trend ratio from 2014	1.0000	1.0021	1.0272	1.0384	1.0515
Coding Factor	1.0000	1.0046	1.0324	1.0462	1.0621
ESRD Benchmark¹					
Simple Age/Sex Risk Score	1.0000	0.9975	0.9950	0.9925	0.9900
HCC-based Raw Risk Score ¹	1.1163	1.1209	1.1395	1.1747	1.1948
... trend ratio from 2014	1.0000	1.0041	1.0208	1.0523	1.0703
Coding Factor	1.0000	1.0046	1.0324	1.0462	1.0621

Source: The PY3S2 (2018 final) NextGen Settlement

Role of the MA Ratebook in MA

- The MA regional benchmark sets an upper “target” for plan revenue
- MA plan revenue can be lower than the regional benchmark



DC vs MA Ratebook

- County rating; No competitive bidding process as a New Entrant DCE
- A lot of differences between the DC and MA ratebook
 - DC alignable population versus MA enrolled beneficiaries
 - Base years used/Lag
 - STARS bonuses
 - Quartile adjustments
 - Educational payments (IME/GME)
 - Uncompensated Care Payments (UCP)
 - Hospice expenditures
- How financially significant are those differences?

DC vs MA Ratebook



Provision	DC Goal	DC	MA
Base years used/Lag	Use multiple years to boost credibility for small counties. Use the most recent data available.	- 2017-2019 used for PY1 2021 DC - Rebased one year forward each year	- 2014-2018 used for 2021 - Rebased one year forward each year
STARS bonuses	Replace the STARS bonus with DC quality measures	Removed	Included
Quartile adjustments	Avoid artificial redistribution of regional rates under DC	Removed	Included
Educational payments (IME/GME)	Ensure consistency with Medicare FFS claims (although could be removed)	IME included GME removed	IME phased out GME removed
Uncompensated Care Payments (UCP)	Remove risk due to network increasing or decreasing uncompensated care	Removed	Included
Hospice expenditures	Traditionally covered by Medicare FFS	Included	Removed (except for Value-based Insurance Design (VBID) plans)

Source: DC/KCC Rate Book Development

Appendix Table 1. Comparison between MA Rate Book and DC/KCC Rate Book construction

MA Ratebook: Quartile Adjustments

- **Goal:** Redistribute the regional rates to reduce variation and subsidize counties having a lower rate by the counties with higher rates
- Rank counties from highest to lowest based upon their 2020 average per capita FFS rate
- Rates are placed into four quartiles
- An “applicable percentage” is applied to the regional rate

Table II-1. FFS Quartile Assignment

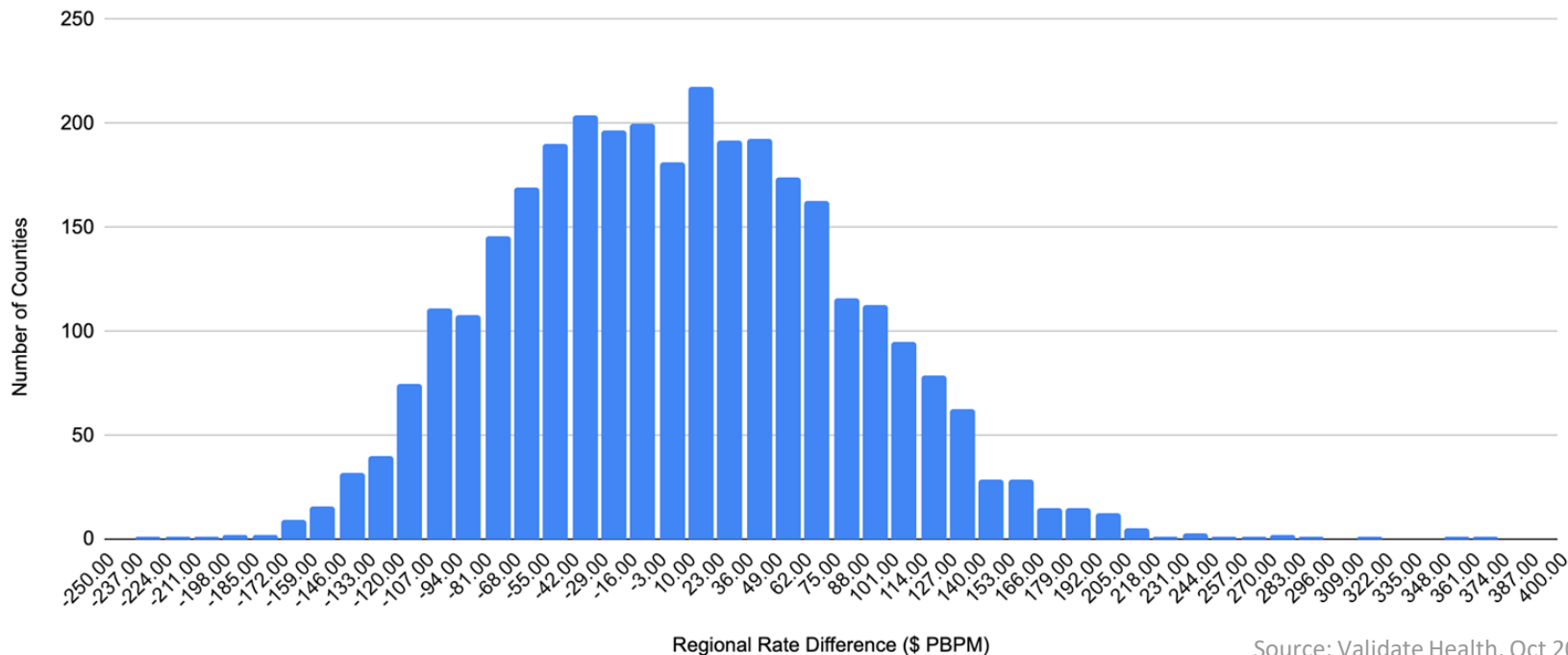
Quartile	Applicable Percentage
4 th (highest)	95%
3 rd	100%
2 nd	107.5%
1 st (lowest)	115%

DC vs MA Rate Difference

- Average difference of \$6 PBPM/\$72 PBPY (per county unweighted)
- DC rates are higher on average than the MA rate (for 0% STARS Bonus)
- Wide variation in the difference between
 - Bottom 25% of counties have a DC rate that is \$594 PBPY lower than the MA rate
 - Top 25% of counties have a DC rate that is \$695 PBPY higher than the MA rate

DC vs MA Rates

DC Regional Rate vs MA Regional Rate (\$ PBPM)



Source: Validate Health, Oct 2020

DC vs MA Ratebook: Regression Analysis

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- **Goal:** Rank the sources of differences between the MA and DC ratebook based on financial impact to the benchmark
 - Would your benchmark (revenue) be higher or lower under DC than in MA?
 - Which program should you participate in? In which counties?
- Explained the difference between the DC and MA county rates
- Used 0% Bonus 2021 Rate to remove effect of STARS
 - Further analysis is needed if you are a highly rated STARS plan considering DC.
- Not weighted by person years

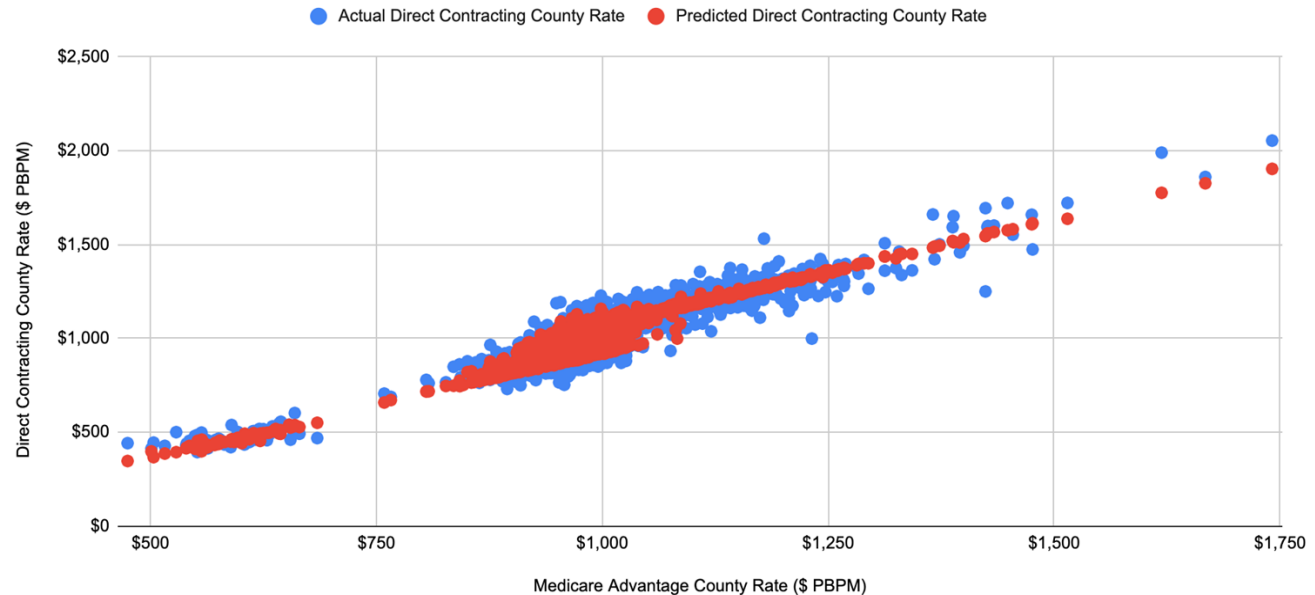
DC vs MA Ratebook: Regression Analysis

- Variables **included**
 - Graduate Medical Education (GME)/Indirect Medical Education (IME)
 - Kidney Acquisition Costs (KAC)
 - Average Geographic Adjustment (AGA)
 - Credibility Factor (See Appendix)
 - Quartile adjustments (Applicable Percentages)
- Variables **not yet included**
 - STARS bonus
 - Hospice rates
 - Medicare FFS eligibility and DC alignment differences (e.g. Parts A or B versus Parts A and B)

DC vs MA Ratebook: All Variables

- Full model has a high 67% R-squared
- All variables are significant (except for Graduate Medical Education (GME))

Actual versus Predicted Direct Contracting County Rate (Full Model)

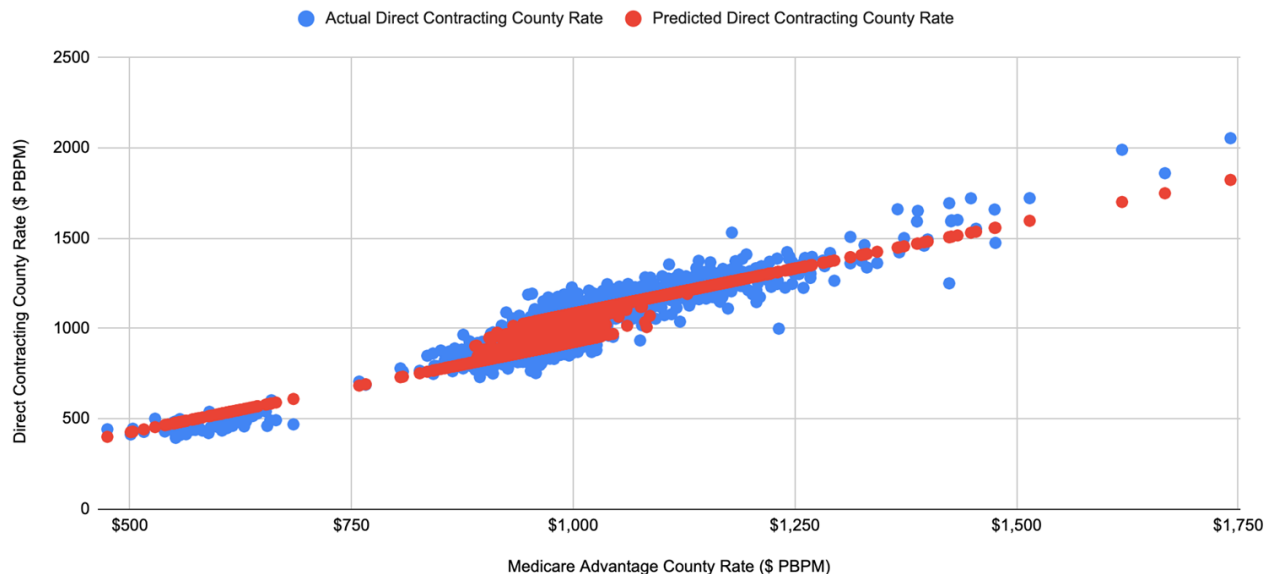


Source: Validate Health, Oct 2020

DC vs MA Ratebook: Only the Quartile Adj.

- A model with just the quartile adjustment has a 62.5% R-squared
- Quartile adjustment is highly significant
- Its exclusion in the DC program could benefit MA plans

Actual versus Predicted Direct Contracting County Rate (Quartile Only)



Source: Validate Health, Oct 2020

New Entrant DCE Takeaways

1. New Entrant DCEs should be careful about which providers are added as participants to maintain <3,000 threshold and avoid the regional rate baseline adjustment
2. Risk score caps and CIF are costly to the benchmark
3. Voluntarily aligned beneficiaries avoid risk score caps and CIF. It is unclear if voluntarily aligned beneficiaries can avoid an additional year of capping and CIF by focusing on July and later E&M
4. There is wide variation in county rates between the DC and MA ratebook. MA plans penalized by quartile adjustments may want to look closer at DC.

New Entrant Direct Contracting Innovation & Outlook

Nathan Lohmeyer
Vice President, Integrated Kidney Care & Government Programs

October 21, 2020

New Entrant DCE Opportunity

**Unique Patient
Benefits**

**Continued
Innovation**

**Public / Private
Collaboration**

New Entrant Considerations

- Utilize the implementation period on-ramp
 - Voluntary and claims based alignment allows for early insights
 - Growth strategy that marries operational strengths with risk management
- Know thy benchmark
 - Recreate the CMMI funding and discounts to understand the biggest swing factors
 - Financial methodology raises concerns of adequate funding, varies from MA
 - Quality score unknowns must be calibrated with operations cost / performance assumptions
- Focus on the biggest medical cost drivers
 - Clinically avoidable, frequent, high cost occurrences e.g. inpatient utilization
 - Leverage medical cost analytics and reporting to identify areas of opportunity

Questions.....



Appendix: Seasonality Adjustment Issue

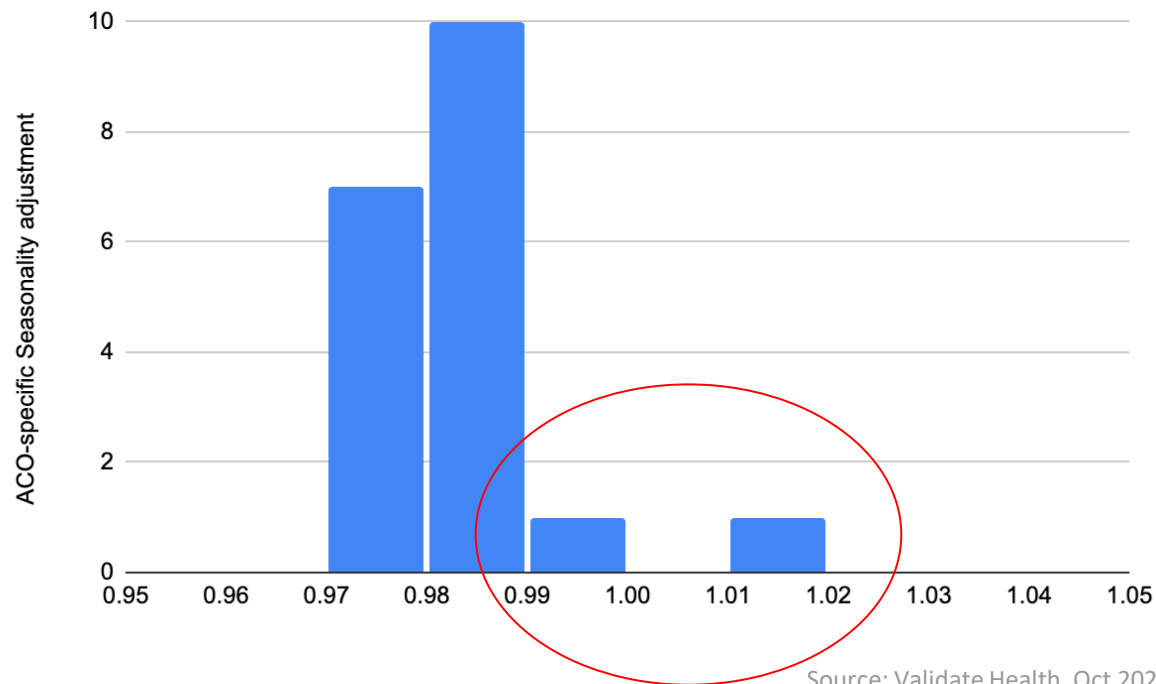
- The difference between a per-ACO seasonality adjustment versus national seasonality adjustment was analyzed
 - PBPY expenditures between Q1 and full year were used to estimate seasonality factors
- A national reference population of Medicare FFS beneficiaries eligible for the DC Model were used:
 - MSSP ACOs under prospective assignment only
 - 2019 Performance year only
 - A sample of 86 MSSP ACOs as of Q1, 79 ACOs as of final settlement
 - Percentiles were compared between Q1 and final

Appendix: Seasonality Adjustment Issue (Ctd.)



- Some ACOs have a large difference between National Seasonality Adjustment of 96.8% and ACO-specific seasonality adjustment
- The difference ranges from 0.2% and 4.5% of benchmark
- One possible solution: Develop regional or DCE-specific seasonality adjustments

ACO-specific Seasonality adjustment



Source: Validate Health, Oct 2020

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%