

September 29, 2022

Re: E.O. 12866 Aledade Meeting on the CY 2023 Physician Fee Schedule Final Rule

To Whom It May Concern:

Thank you for the opportunity to discuss the substantial revisions to the Medicare Shared Savings Program (MSSP) that CMS proposed in the CY 2023 Physician Fee Schedule. We thank the Administration for its continued commitment to value-based care and MSSP. There are important proposals in this NPRM that will help MSSP grow and thrive and bring us closer to the goals of increasing access to accountable care, improving health equity, and improving the alignment of MSSP with other value-based efforts. Our full comments are available as [CMS-2022-0113-21649](https://www.regulations.gov/comment/CMS-2022-0113-21649)<sup>1</sup>. With our time today, we are focused on three bodies of evidence we developed in response to the proposed rule, and its impact on public policy.

## Regionalization

**Finding:** From 2015 to 2020, region trends differed significantly and reliably from national trends.<sup>2</sup>

**Impact:** CMS is proposing a benchmarking trend factor called ACPT, which is a national projection with no regionalization for one-third of the benchmark update regardless of how much an ACO impacts its market. This will create “winning” areas of the country and “losing” areas of the country where savings will not be dependent on ACO performance.

**Solution:** We, along with most of the ACO community, support the first step towards projected trends, administrative benchmarking. To take this first step, we recommend that the final rule incorporate ACPT in the current two-way blend based on the ACO’s market share. The ACO is responsible for the proportion of the variation between regional and national trends it affects and we take the first step towards administrative benchmarking.

## No Evidence of Beneficiary Selection

**Finding:** A comprehensive literature review found no evidence that ACOs attempt to lose assignment for beneficiaries with higher costs. Literature suggests that ACOs see their healthier patients at higher rates than the reference population, but there is no evidence that they see their sicker patients less.

**Impact:** CMS put forward concern of beneficiary selection as a reason to continue its policy of rewarding ACOs in areas with abundant health care providers with more savings than ACOs who operate in health professional shortage areas. By including ACO beneficiaries in regional trend updates, ACOs are discouraged from going to areas where a shortage of health care providers will drive up their market share thus ratcheting down their regional trend updates through their own efforts. The economic model for dropping costly beneficiaries exists both when an ACO’s beneficiaries are included in regional trends and when they are excluded. We believe that we do

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<sup>1</sup> <https://www.regulations.gov/comment/CMS-2022-0113-21649>

<sup>2</sup> This remains true even if 2020 is excluded due to COVID

not see adverse beneficiary selection today because it is against the professional standards of the health care profession and incredibly difficult to operationalize. Both of those things will remain true if an ACO's beneficiaries are removed from its regional trend calculations.

**Solution:** Removing the ACO's beneficiaries from its regional trends is imperative to advancing health equity. The Administration's equity goals are clearly laid out. However, the only meaningful economic incentives related to equity in MSSP run expressly counter to those goals. The policy of including the ACO's beneficiaries mathematically drives more savings to ACOs in areas with abundant health care providers where they can have a lower market share. On risk scores, the application of the risk score cap to the ACO, but not the region, drives ACOs out of counties where beneficiaries are getting older and sicker. The Administration can eliminate these inequitable policies, confident that all research shows the ACOs do not engage in the type of adverse beneficiary selection that CMS outlined in the proposal.

## eCQMs Will Generate Inaccurate and Inequitable Quality Report Cards

**Finding:** Sampling a population and supplementing eCQMs with chart review will always lead to a more accurate report of the quality provided to beneficiaries. Moving to an all-site, all-patient, all-clinician, and all-payer quality measurements introduce high levels of variation between ACOs and between Original Medicare and Medicare Advantage. Furthermore, Medicare quality policy and payment policy become misaligned.

**Impact:** While there are other efforts enabled by eCQMs, reporting on the quality of outcomes is not the strongest use of eCQMs. The use of eCQMs also does not align with Medicare Advantage. The exclusive use of eCQMs and the resulting aggregation required vastly increases the administrative burden of running an ACO. In an example of payment policy misalignment, every visit for a diabetic patient in every setting requires an A1C lab. Will CMS view it as justified if a sprained wrist 99213 becomes a 99214 with tests just to comply with quality measure specifications? In even more direct conflict, CMS only pays for one depression screening a year. It is implausible that every health care provider that the beneficiary sees in a year will have access to that one depression screening.

**Solution:** CMS should keep quality reporting focused on beneficiaries with whom the ACO has longitudinal relationships with as demonstrated by assignment to the ACO. CMS should continue to incentivize the use of eCQMs as they enable interventions. However, reporting should retain the accuracy provided by sampling.

Sincerely,

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## Aledade Background

Aledade ([www.aledade.com](http://www.aledade.com)) partners with more than 1,000 primary care physician practices, Federally Qualified Health Centers (FQHCs), and Rural Health Centers (RHCs) in value-based health care. Organized into 86 Medicare and Commercial accountable care organizations (ACOs) across 37 states, these physician practices are accountable for 1.7 million lives, with 744,000 of those in the Medicare Shared Savings Program (MSSP). More than half of our primary care clinicians are in practices with fewer than 10 clinicians. We are committed to outcome-based payment models to improve the value of health care delivered to Medicare beneficiaries and other Americans.

Aledade partners with practices that disproportionately serve patients in areas with a lower income compared to both Original Medicare and the MSSP. More than 65% of the practices Aledade partnered with in 2021 are in a Primary Care Health Professional Shortage Area (HPSA), and nearly half are in a Medically Underserved Area (MUA). (Interestingly, our analysis shows that the income distribution of MSSP beneficiaries is similar to that of the broader Medicare population, which contrasts with the [assertions](#)<sup>3</sup> of CMS.) But if we want to make these strategies sustainable in the long run and to improve MSSP equity by encouraging more ACOs to develop in these communities, we need to solve this problem and remove MSSP's current strong disincentive for ACOs to grow or locate in HPSAs.

Median County Household Income (2020)	Traditional Medicare (36.9M)	Lives attributed to all MSSP ACOs (10.1M)	Lives attributed to Aledade (406k)
Less than \$46,309	8.3%	7.9%	21.6%
\$46,310 to \$54,505	15.6%	16.0%	25.9%
\$53,506 to \$62,327	23.3%	23.4%	18.5%
Up to \$151,806	52.7%	52.6%	34.0%

## Regionalization Data

Risk-adjusted costs were calculated for each county and eligibility category by dividing costs by risk. Person years were summed across each county and a weighted average across each of the four eligibility categories was calculated to get a single value for each county's risk-adjusted

<sup>3</sup><https://www.cms.gov/newsroom/press-releases/medicare-shared-savings-program-saves-medicare-more-16-billion-2021-and-continues-deliver-high>

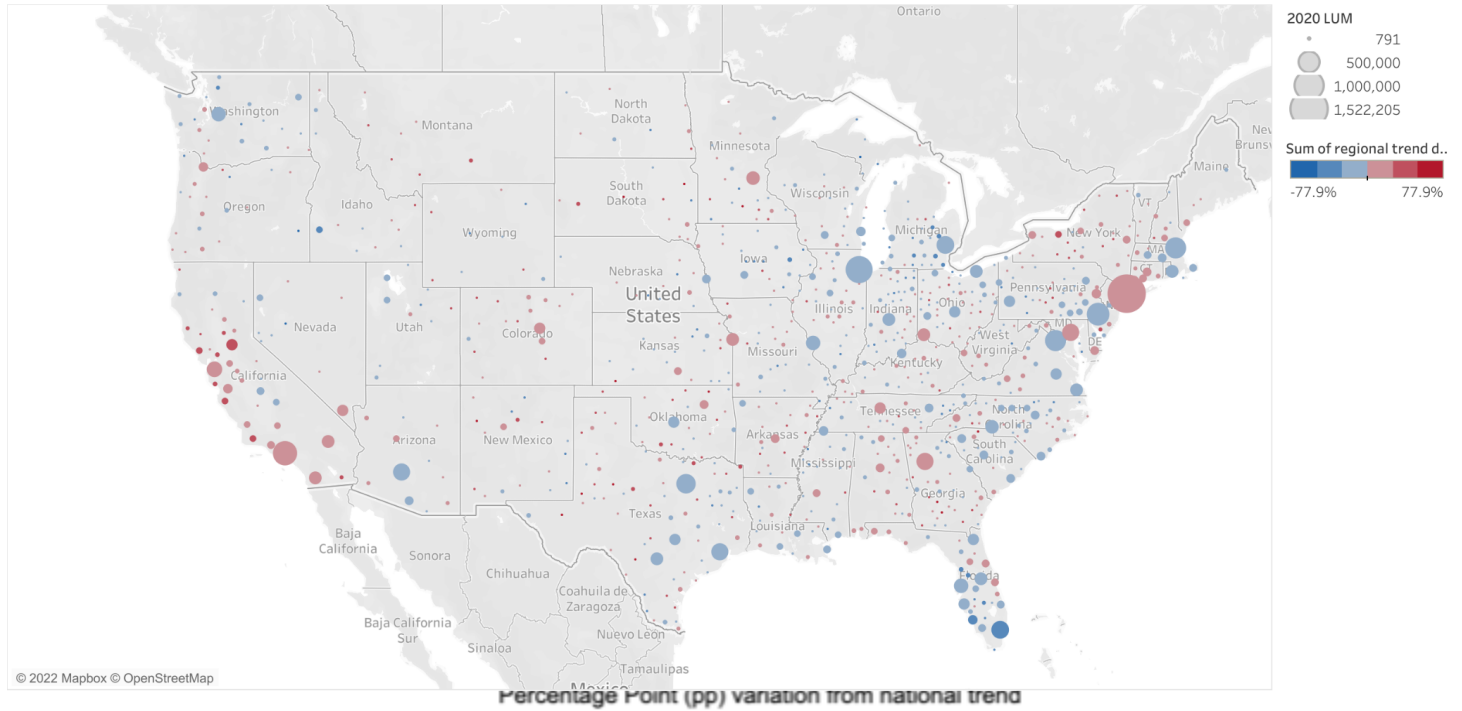
costs. This process was done for each year between 2015 and 2020. National risk-adjusted costs were calculated for each year and the risk-adjusted cost trend was calculated using 2015 as the reference year.

Risk-adjusted cost trends were then calculated for each county using 2015 as the reference year. The difference between each county's trend and the national trend was calculated. A negative value indicated that the county trend was lower than national (right side of graphs). A positive value indicated that the county outpaced national inflation (left side of graphs). Our analysis shows that separating the data by the number of counties or assignable person years does not make a significant difference and the same trend applies. As you get further from the reference year, the number of counties (or the number of person-years) that have a regional trend that is plus or minus two percentage points from the risk-adjusted national trend grows, refuting the point made by others that regional trends tend to follow the national trend and that any outliers will eventually return to the national mean. *Figure 1* illustrates this concept for all person-years while *Figures 2 through 6* illustrate this for counties with more than 3,000 assignable person-years

<b>Figure 1 data</b>					
	<b>15-16 trend</b>	<b>15-17 trend</b>	<b>15-18 trend</b>	<b>15-19 trend</b>	<b>15-20 trend</b>
>10pp above	201,764	265,422	531,413	800,380	1,320,255
8-10pp above	149,928	268,338	478,846	643,263	1,280,315
6-8pp above	468,114	812,301	804,667	2,019,495	1,461,091
4-6pp above	1,301,143	1,845,114	2,299,335	2,058,013	1,644,978
2-4pp above	3,252,461	4,094,928	3,909,919	3,278,035	2,856,422
0-2pp above	8,317,704	6,662,977	6,155,506	4,042,140	3,192,522
0-2pp below	8,988,124	7,494,072	5,329,288	4,938,480	3,604,288
2-4pp below	3,503,956	3,168,932	3,966,815	4,367,791	4,245,392
4-6pp below	1,093,888	1,755,363	2,187,997	2,094,945	2,832,902
6-8pp below	387,926	751,614	958,507	1,504,881	1,613,394
8-10pp below	149,736	361,922	397,736	818,058	793,940
>10pp below	148,508	295,577	421,213	581,357	783,911

The number of lives that reside in a county where the county's inflation trend varies by more than +/- two percentage points from national grows from one third of assignables in the first year (10.66m out of 27.96m) to nearly three fourths (18.83m out of 25.63m)

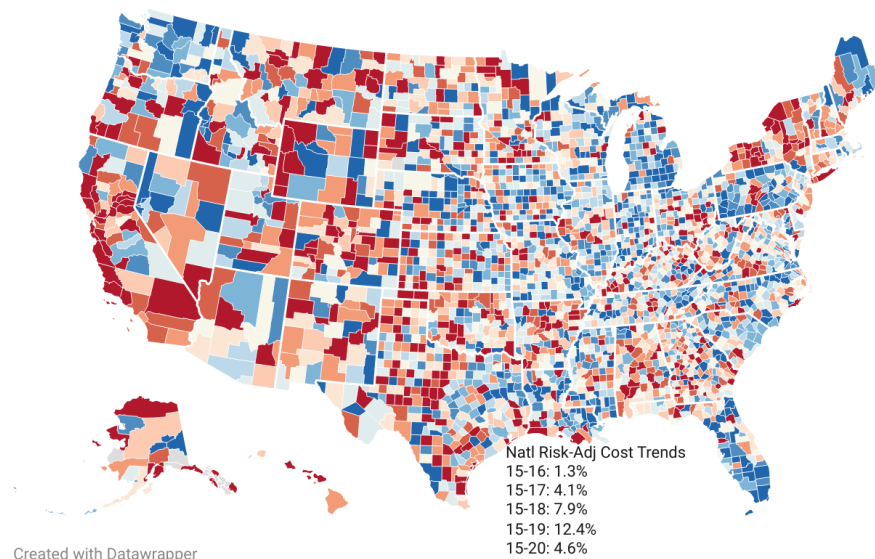
**Figure 1**



## County Trends Compared to National Inflation from 2015 to 2020

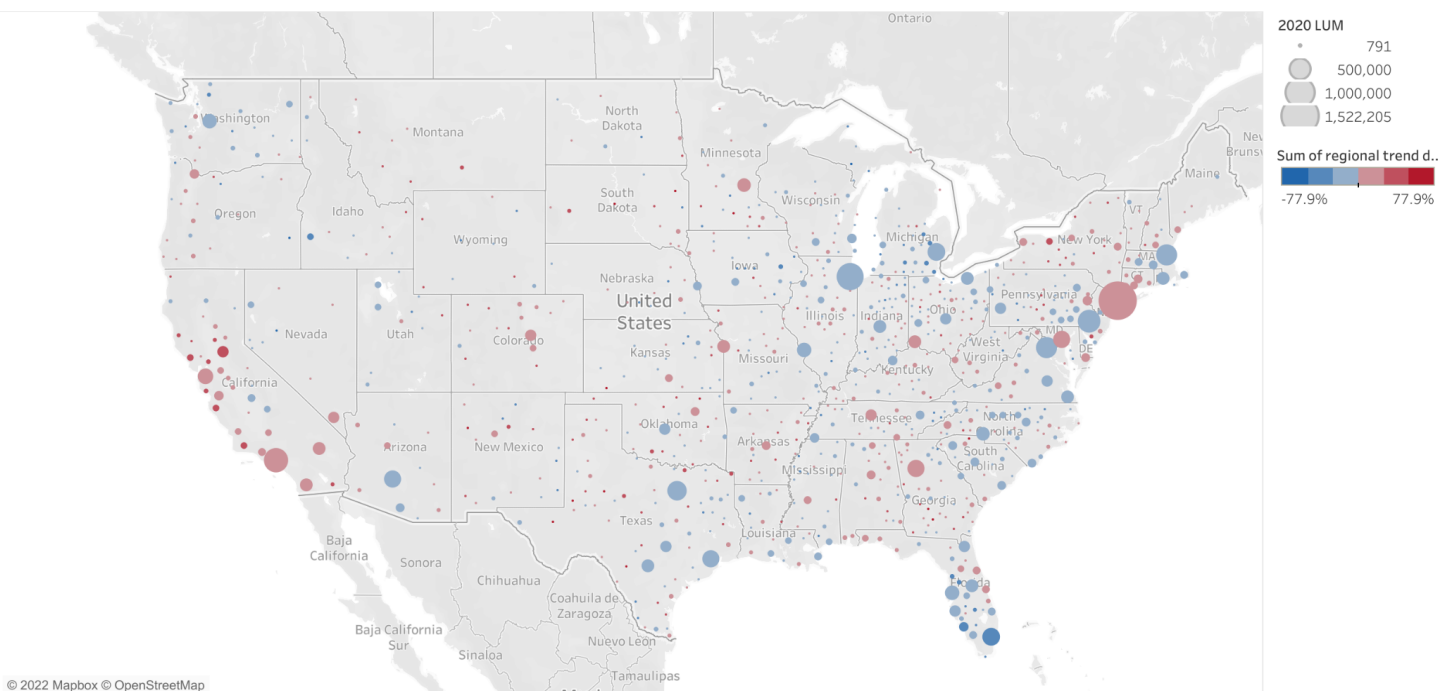
Allows for 1 pp of variation from national trend. If country trend was greater then value of +1. If county trend was lower than national then -1

lower for 5 years higher for 5 years

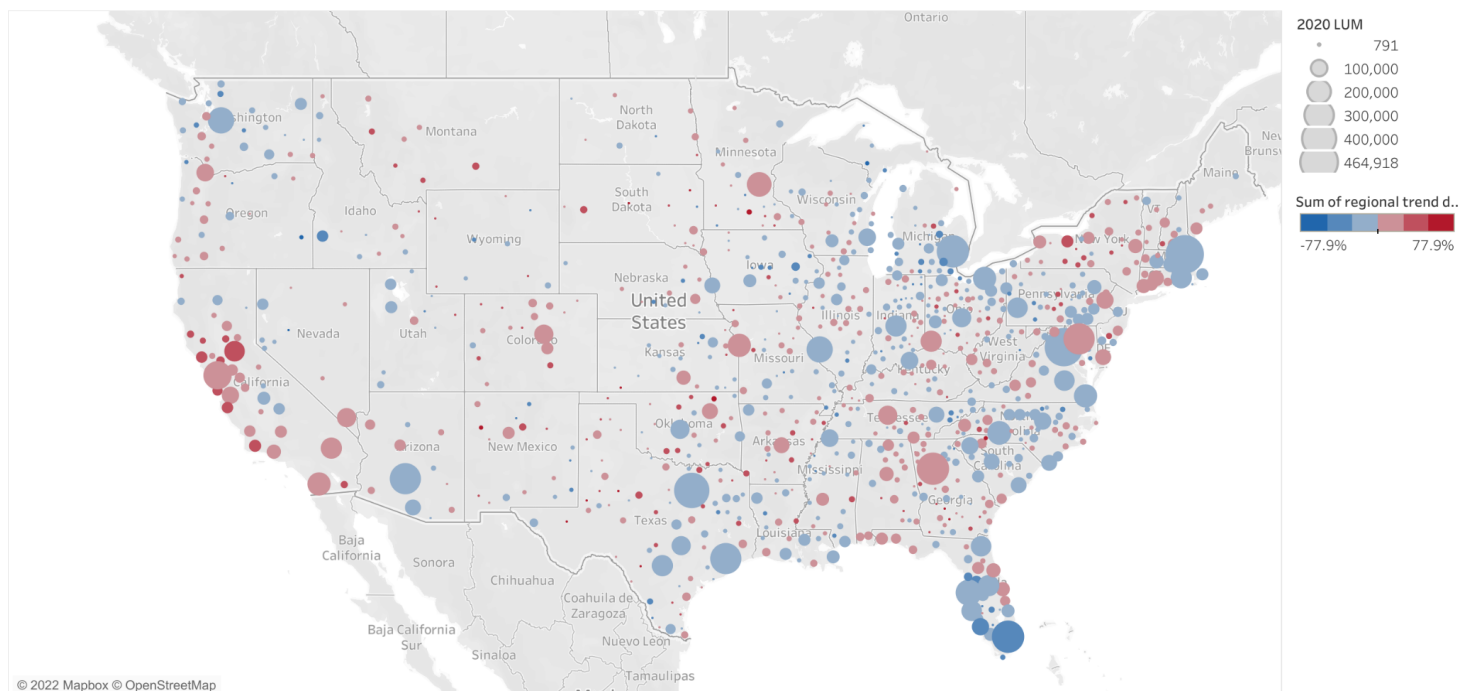


Created with Datawrapper

## Deviation from Natl Trend for all CBSAs



## Deviation from Natl Trend for CBSAs with <500,000 person-years



The ten largest CBSAs, their 2020 assignable person-years, and their 'overall deviation from national trend' scores are as follows:

<b>CBSA</b>	<b>2020 psn_yrs</b>	<b>Deviation from Natl Trend over 5 yrs</b>
New York-Newark-Jersey City	1,522,205	9.1%
Chicago-Naperville-Elgin	756,651	-8.2%
Los Angeles-Long Beach-Anaheim	610,661	15.8%
Philadelphia-Camden-Wilmington	536,634	-8.1%
Boston-Cambridge-Newton	464,918	-2.0%
Washington-Arlington-Alexandria	461,590	-3.6%
Dallas-Fort Worth-Arlington	391,422	-6.8%
Detroit-Warren-Dearborn	330,376	-18.8%
Miami-Fort Lauderdale-West Palm Beach	326,342	-26.0%
Atlanta-Sandy Springs-Roswell	315,300	5.1%

These maps and tables highlight Aledade's argument that moving towards a national trend creates winners and losers solely based on geography. CMS would likely see selective participation in the program with ACOs that have a large population in Michigan, Florida, or Pennsylvania more likely to join the program than ACOs with a large population in California or New York.

If CMS is to be successful in reaching its goal of having 100 percent of Medicare beneficiaries in a value-based relationship by 2030 it can't adopt a policy that would decrease the amount of savings an ACO could make for no reason other than the region it is located in compared to the national population.

## Data on eCQM Accuracy versus Sampling

### Current performance based on automation

Because Aledade handles integrations with hundreds of EHR vendors we have unique insights into the capabilities and readiness of different vendors and independent practices. Our analysis focuses on the top vendors which serve roughly 65% of our partner practices. All vendors examined have significant opportunities to close the performance gap between automated, electronic reporting and sampled, manually abstracted reporting across all three measures.

- High BP Control: **8-40% Gap** between automated only rates and manually adjusted rates (augmented chart abstraction)



- A1c Control: [37-68% Gap](#)
- Depression Screening: [77-87% Gap](#)

Practices with no interface issues								
	Practices	Automated			Sample			Performance Difference
		Denominator	Numerator	Rate	Denominator	Numerator	Rate	
High Blood Pressure Control								
EHR Vendor 1	8	996	361	36.2%	72	55	76.4%	40.1%
EHR Vendor 2	49	35,800	21,760	60.8%	1,032	789	76.5%	15.7%
EHR Vendor 3	111	31,221	20,309	65.0%	1,121	827	73.8%	8.7%
EHR Vendor 4	152	79,326	43,529	54.9%	2,937	2,256	76.8%	21.9%
EHR Vendor 5	42	14,178	9,847	69.5%	559	449	80.3%	10.9%
EHR Vendor 6	8	4,778	2,589	54.2%	611	450	73.6%	19.5%
EHR Vendor 7	11	9,214	6,269	68.0%	369	280	75.9%	7.8%
EHR Vendor 8	36	15,535	9,712	62.5%	755	533	70.6%	8.1%
HbA1c control								
EHR Vendor 1	8	321	69	21.5%	66	59	89.4%	67.9%
EHR Vendor 2	51	11,052	4,975	45.0%	1,044	940	90.0%	45.0%
EHR Vendor 3	113	9,281	4,179	45.0%	1,009	900	89.2%	44.2%
EHR Vendor 4	157	26,470	11,184	42.3%	3,009	2,628	87.3%	45.1%
EHR Vendor 5	44	3,729	1,658	44.5%	554	499	90.1%	45.6%
EHR Vendor 6	8	1,431	379	26.5%	656	534	81.4%	54.9%
EHR Vendor 7	11	3,312	1,890	57.1%	397	372	93.7%	36.6%
EHR Vendor 8	36	5,330	2,051	38.5%	731	613	83.9%	45.4%
Depression Screen								
EHR Vendor 1	8	3,328	69	2.1%	66	59	89.4%	87.3%
EHR Vendor 2	51	61,875	4,975	8.0%	1,044	940	90.0%	82.0%
EHR Vendor 3	113	53,995	4,179	7.7%	1,009	900	89.2%	81.5%
EHR Vendor 4	158	120,792	11,184	9.3%	3,009	2,628	87.3%	78.1%
EHR Vendor 5	44	30,204	1,658	5.5%	554	499	90.1%	84.6%
EHR Vendor 6	8	8,404	379	4.5%	656	534	81.4%	76.9%
EHR Vendor 7	11	19,122	1,890	9.9%	397	372	93.7%	83.8%
EHR Vendor 8	36	29,097	2,051	7.0%	731	613	83.9%	76.8%