Opportunities for 2022 Improvements to MSSP ACOs in the Physician Fee Schedule

June 2021

Agenda

- The risk score cap is capping ACOs, but letting the regional risk score shoot past the cap directly penalizing ACOs through the lopsided policy
- Rural glitch where an ACO reduces its own annual inflation continues to create disparate payments between ACOs even if they have identical performance
- Quality measurement of all patients and all payers raises significant accuracy concerns that will not be addressed just by giving ACOs more time

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Risk Cap Policy

- CMS has a policy where the risk score for an ACO's eligibility category cannot increase more than 3% from its most recent benchmark year
  - ACO started in 2019 has a risk score in Aged category of 1.00 in 2018
  - Risk score will not increase beyond 1.03 through 2024
  - Purpose was to de-emphasize attention on risk coding while still allowing for some needed fluctuation
- CMS choose to not apply the risk core cap to the region risk score
  - In response to comments in Pathways regulation, CMS expressed a belief that the region would never exceed the risk cap so there was no need to apply it at the regional level
  - COVID brings increased variation and now the region risk exceeds the cap with frequency
- If an ACO's risk score goes up 6% and the region's risk score goes up 6%, the ACO's benchmark is reduced a devastating 3% even though they simply matched their region
  - A savings rate of 5% is considered pretty good for an ACO
  - An ACO in this situation would be reduced to 2% and would likely not get any savings payments at all

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Risk Cap Policy in the 2020

- Aledade has 90,800 (16%) of its assigned beneficiaries in regions and eligibility categories where the regional risk ratio is above 1.03 in 2020
  - Quite a lot for something that CMS stated was unlikely to ever happen
  - This will only get worse as the risk score baseline does not reset for another 3 years
  - Our hardest hit ACO is losing 3.38% of its savings in 2020 to this phenomenon
- Solution
  - Hold the rate of change between the ACO and the region at 3%

	BY3	PY1	PY2
ACO Actual	1.05	1.11	1.13
Region	1.00	1.06	1.08
ACO Cap Solution	N/A	1.146 (1.05*1.03*(1.06/1.00))	1.168 (1.05*1.03*(1.08/1.00))

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Risk Cap Policy Solution Advantages

- Under current policy the example ACO loses 3% of its savings in PY1 and 5% of its savings in PY2 despite matching the regional change in risk score
- Under the solution
  - CMS remains protected from risk coding intensity as the variation from region is still capped
  - Allows for natural variation in risk scores
  - No unintended consequences as the ACO and region move together
- Policy needs to be retroactive
  - The harm that CMS stated was not going to happen happened in 2020 and is occurring right now
  - 2020 and 2021 should not be lost years
- Minimal Alternative
  - One alternative for 2020 and 2021 would be to apply the risk cap to the region and the ACO
  - While it is not as good measure of how any ACO performed in 2020 and 2021 it at least removes the unintended harm caused by the risk cap policy in 2020 and 2021

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What is the Rural Glitch?

- The “Rural Glitch” refers to a flaw in the Medicare Shared Savings Program (MSSP) that **systematically penalizes ACOs with a large market share when they reduce costs**. We coined this the rural glitch because these ACOs tend to be located in rural areas.
- Primary care is the lifeblood of rural medicine and at the center of value-based care. It is crucial that rural areas have the same opportunity as urban areas to be rewarded for delivering better care at lower costs.

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Prior Solutions

- Pathways to Success unsuccessfully attempted to address this flaw in 2019
  - CMS implemented a blend of national and regional inflation
    - Most of the ACO's trend is affected by rural glitch (81% on average)
    - Introduces national inflation variations which are not linked to ACO performance
  - The impact of a blended trend merely depends on whether regional inflation happens to be higher or lower than national inflation. This "correction" does not necessarily benefit ACOs that are actually generating savings.

Rural Glitch Math

- Including the costs of all patients in the regional adjustment - those both in the ACO and out - penalizes an ACO for reducing costs relative to its regional competitors
- This suppression of the savings rates of ACOs varies widely based on market share (the greater the share of the market the more an ACO lowers its regional inflation)
- An ACO with 5,000 beneficiaries that reduces costs 5% in Montgomery County, MD will see its effective share rate in Level E reduced from 50% to 47.5%
- An ACO of identical sized and performance in Garland County, Arkansas (Hot Springs) will see its effective share rate in Level reduced to 37.5%
- We see no policy justification for the same work paying 27% in the DMV than in Arkansas

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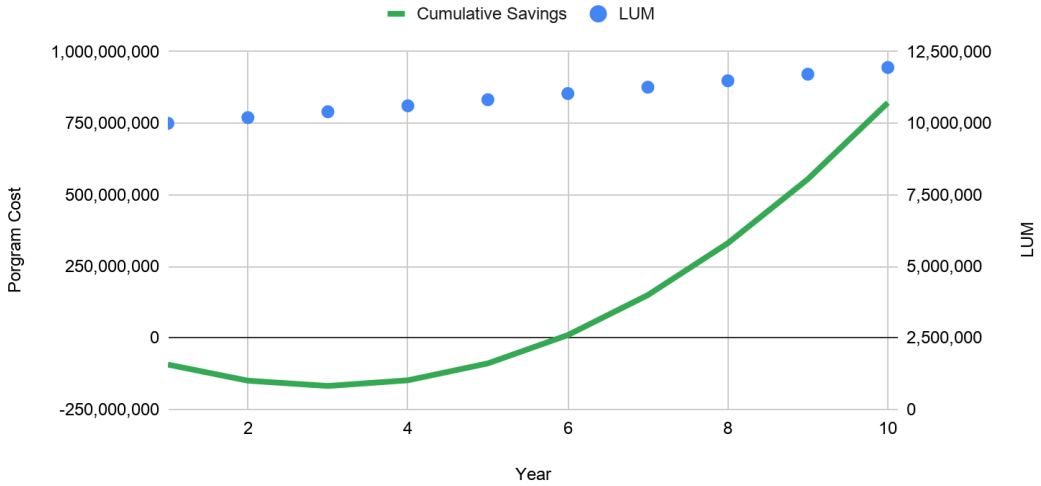
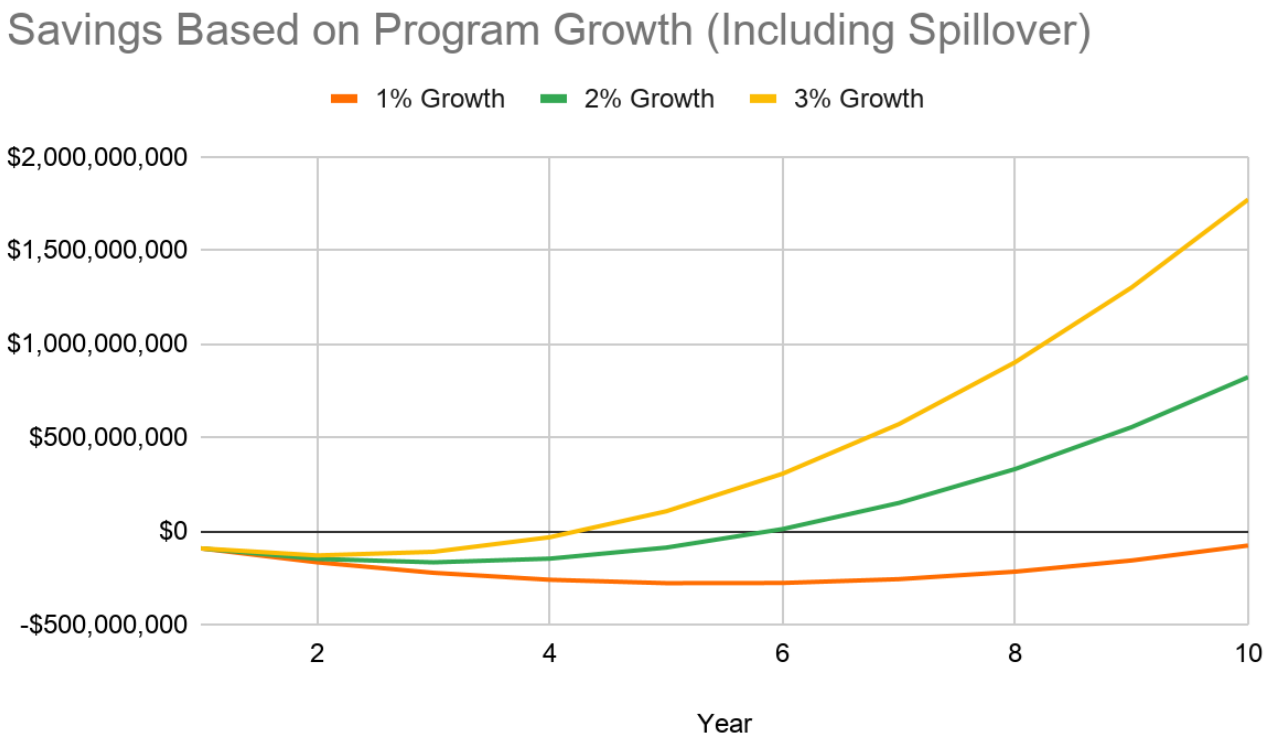
Financial Effects

- Using a conservative spillover amount of $194* per beneficiary, the program saves CMS $821M over 10 years if it leads to an increase of 2% in annual growth
  - Calculations are extrapolated from ACOs that started their first contract in 2017 or later as county level puf data is not available for ACOs with benchmark years prior to 2014
  - $1.841 billion in additional savings of which $1.02 billion is paid to ACOs



* Medicare ACO efforts reduced FFS spending in 2016 by $1.75B after accounting for shared savings payments.

Financial Effects



The more the program grows, the more it saves

Without program growth, the cost of fixing rural glitch is $931M over 10 years

Failure to Fix Program Will Stunt Growth

- In 2017 - 2019 over a million beneficiaries were in ACOs that did not make savings under Pathways (therefore no ROI), but would have made savings if rural glitch was fixed.
    - 2017: 8 ACOs (106k beneficiaries)
        - $20.6 million in savings per year
    - 2018: 9 ACOs (132k beneficiaries)
        - $25.6 million in savings per year
    - 2019: 24 ACOs (794k beneficiaries)
        - $154 million in savings per year

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Fixing the Rural Glitch in the Least Burdensome Way

- Problems
  - Some ACOs have high regional penetration possibly creating small number problems
    - Especially true in higher risk categories in less than 10 ACOs that specialize in high risk
  - Currently, CMS only has to create one county benchmark each year
- Solutions
  - CMS can remove the effects of the ACO on its regional trend and benchmark without creating a unique to every ACO county benchmark and trend
    - Currently CMS already calculates for the year:
    - Regional risk and cost (A)
    - ACO risk and costs (B)
    - ACO penetration for the region (C)
    - (A-B)*C + A = Regional Benchmark/Trend without the ACO's beneficiaries
  - CMS can cap penetration for the region at 50% by eligibility category or expand the region
    - Capping at 50% prevents small numbers while fixing the rural glitch for 98% of the beneficiaries in MSSP
    - Medicare Advantage addresses this same issue today by expanding the reference region
      - Creates a more accurate solution than a 50% cap
      - Concede that it is more administratively burdensome on CMS

Quality Measurement

- CMS proposal to move to counting every patient regardless of health care coverage and regardless of relationship with the practice is problematic in both burden and accuracy
- Burden
  - Aledade works with over 80 different EHRs
  - Not just 80 different reports
    - 80 different designs on where data elements are captured
    - Thousands of different templates (health care providers can customize EHRs)
    - Several variations of the same measure
      - Some payers have their own specifications so EHR may calculate differently for those patients versus Medicare patients
    - Exporting the data is spotty with differing levels of detail
  - Legal hesitancy
    - We think the logic from MIPS transfers to the ACO level, but ACOs are understandably concerned

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The real problem is accuracy

- Currently CMS measures a sampling of Medicare beneficiaries who have established primary care relationships with the ACO participants
- Benefits of Sampling
  - A small ACO will see 100,000 patients in a year, a medium ACO could easily see a million
  - At these sizes sampling is simply more accurate measurement
  - A sample can be researched and differences in workflows, differences in reporting, differences in documentation can be overcome to get a measure of the quality delivered rather than a measure of the documentation of workflow
  - Third parties could create an all patient sample
- Benefits of Focusing on Primary Care Relationships
  - The ACO model is about accountability for people with strong relationships quality should be the same
  - Concerns that all patients will hide disparities and not focus on health equity

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