Understanding PY 2020 MSSP Results

The webinar will begin at 1:00 pm ET. Please make sure you are dialed in to the webinar on your telephone with the audio pin.

Agenda and Housekeeping

1. Speakers will present for around 50 minutes
   - Overview and audience polling
   - Data expert perspective
   - Lessons learned from ACOs
2. Q&A will take the remainder of the time
   - You can submit written questions using the Questions tab (not chat) 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.
3. Webinar is being recorded
   - Slides and recording will be available on the NAACOS website within 24 hours.

Speakers

Allison Brennan
Allison is the Senior Vice President of Government Affairs for the National Association of ACOs in Washington, D.C. where she helps develop and advocate for policies to benefit ACOs. Policy and advocacy are core components of NAACOS's mission, as is member education.

Andrew Webster
Andrew is co-founder, CEO and lead actuary at Validate Health, a 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. Andrew is an actuarial advisor to NAACOS.

Speakers

Stephen Nuckolls

Stephen is the chief executive officer of Coastal Carolina Health Care, PA, and their ACO, Coastal Carolina Quality Care, Inc. His responsibilities include the direct management of the 60 provider multi-specialty physician-owned medical practice and its ACO that was selected by CMS in the initial round in April 2012 and is currently in a 2-sided risk model. Stephen is Treasurer of the NAACOS Board of Directors.

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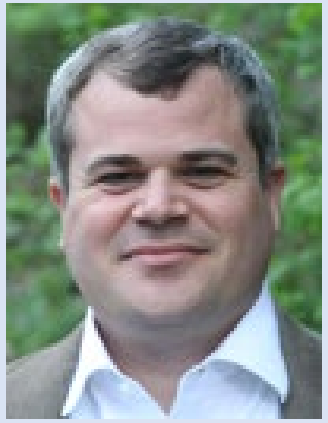


Travis Broome

Travis is the senior vice-president of policy and economics at Aledade, Inc. He guides Aledade and partner physicians through the policy, strategy and economics of value based health care. Joining Aledade shortly after its start, he worked on nearly every aspect from business development, to early analytics, to serving as an ACO executive director. Prior to Aledade, he spent seven years at the Centers for Medicare & Medicaid Services. Travis is a member of the NAACOS Board and serves as Chair of the NAACOS Policy Committee.

Overview

MSSP PY 2020 Results

- CMS delivered embargoed MSSP PY 2020 results to ACOs in early August
- This webinar will discuss key takeaways of the results while adhering to the embargo.
- We are waiting for the public release of results and NAACOS will analyze the results and issue a press release.
- Help educate your communities about ACOs and the positive effects of your ACO's work by contacting local media.
  - Use our ACO media toolkit to get started!

Polling Question

What type of forecasting did your ACO do to predict PY 2020 MSSP performance?

- Used the CMS forecasting tool, doing the evaluation in-house
- Used another methodology, doing the evaluation in-house
- Hired a 3rd party to forecast our ACO's performance
- Did not do any 2020 performance forecasting
- Other

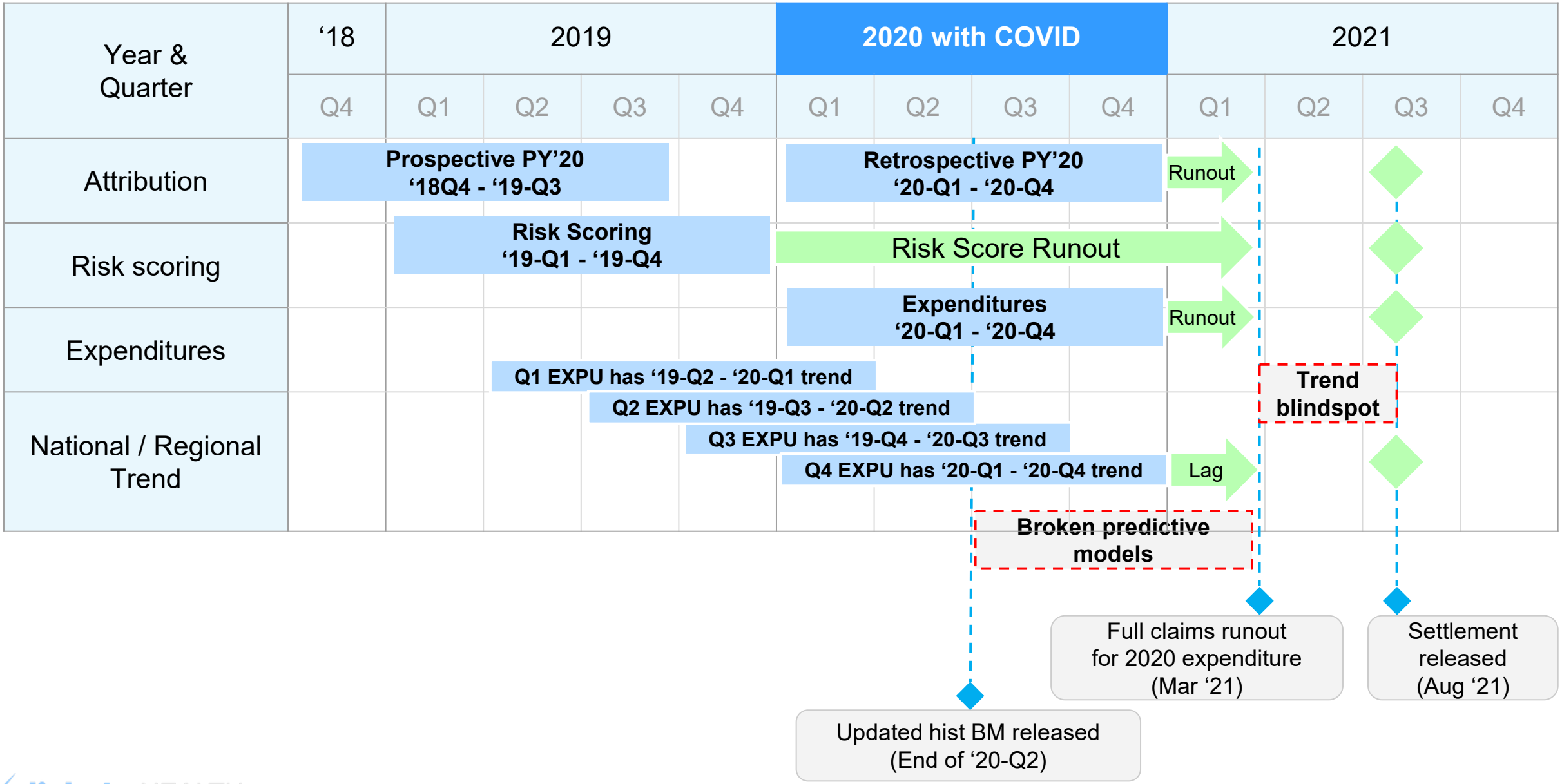
Polling Question

How did your ACO's actual performance results compare to your forecasted results?
Our ACO's actual performance was:

- Much better than our forecasted results
- Somewhat better than our forecasted results
- Equal to/very close to our forecasted results
- Somewhat worse than our forecasted results
- Much worse than our forecasted results

Understanding ACO Results: Data and Actuarial Expert Lessons Learned

Timing of forecast in relation to data availability



Intro to the CMS Updated Benchmark Estimation Calculator

The calculator projects ACO financial performance by estimating
the blended national/regional update to the ACO's historical benchmark.*

Blended national/regional update factor ✖ **Regionally adjusted historical benchmark expenditures** = **Projected updated benchmark expenditures**

Reference Period: Latest quarter vs Benchmark Year 3

Blended national/regional update factor calculation

National expenditure update factor:

Per capita expenditures for the national **assignable** fee-for-service population

✖

National Weight for the latest quarter from QEXPU Report Table 2

✚

Regional expenditure update factor:

Expenditures for the ACO's **regional service area**

✖

Regional Weight for the latest quarter from QEXPU Report Table 2

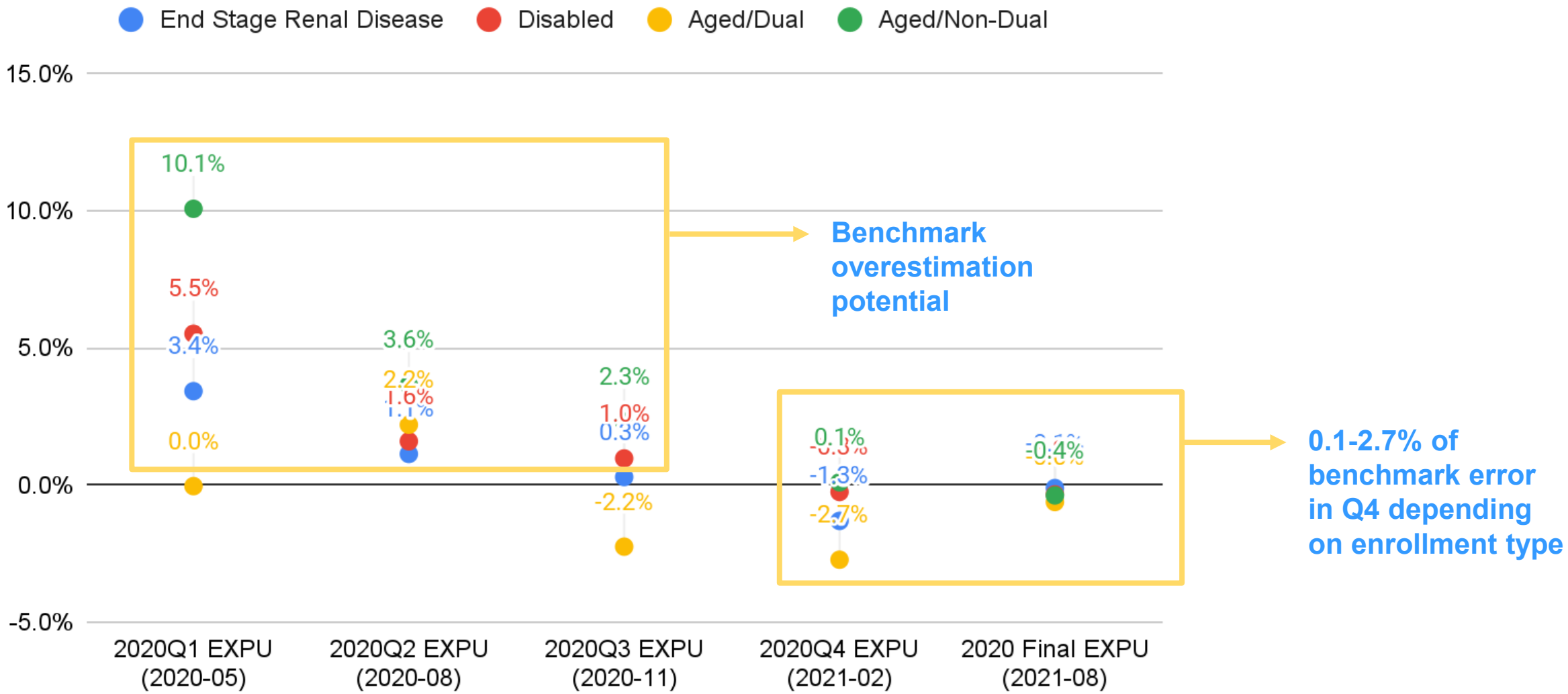
**Applicable to ACOs with an agreement period on/after 07/01/2019*

Source: ACO-MS CalcUsingBlendedUpdateFactorV2.xlsx

Limitations of the CMS Updated Benchmark Estimation Calculator

Limitation	Possible Solution(s)
Benchmark is not risk adjusted	• Calculate for a range of scenarios including flat and +/-3% • Estimate risk scores using CCLF
Based on partial year and/or incomplete claims run out data	• Study prior EXPUs vs settlement to develop factors • Calculate customized completion factors using your CCLF data
Expenditures for ACOs under prospective assignment are measured year-to-date (not rolling 12)	• Use CCLF to a calculate rolling-12 measurement period • Calculate trend using year-to-date EXPU columns
Regional expenditures are not risk adjusted in QEXPU	• Use past experience to develop a range of regional risk score outcomes
Uses the national and regional weights calculated for the ACO for each quarter, not final settlement	• Calculate the sensitivity of trend based on the range of national and regional weights (likely insensitive)

Error in national trend by quarter

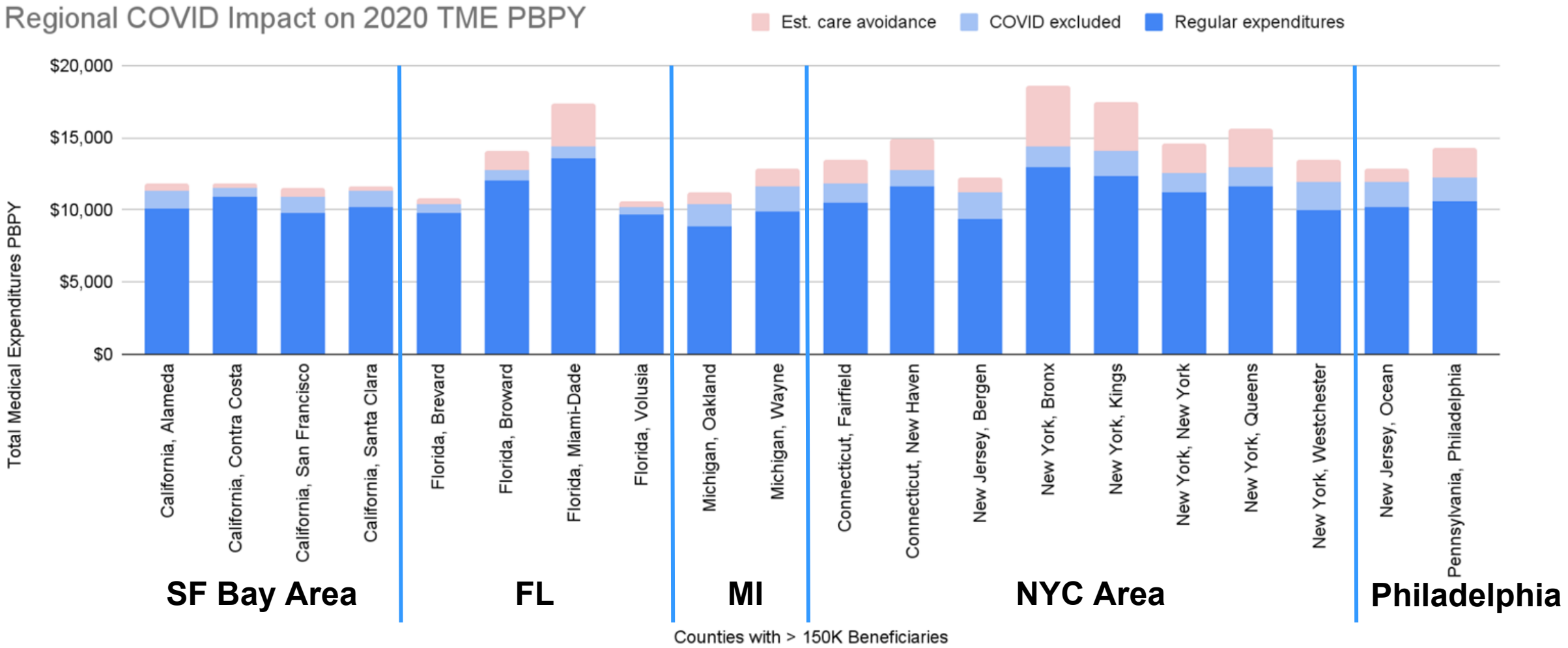


Changes in the 2020 settlement

- Attribution process and codes changed => 5-6% decrease in assignable benes
- Negative national and regional trends
- COVID IP exclusion impact at the ACO, region, national levels removing person years, expenditures, and risk scores (but not attribution eligible visits)
- COVID impact to the truncation threshold (0.1% increase in truncation)
- No net losses
- No sequestration

Regional comparison

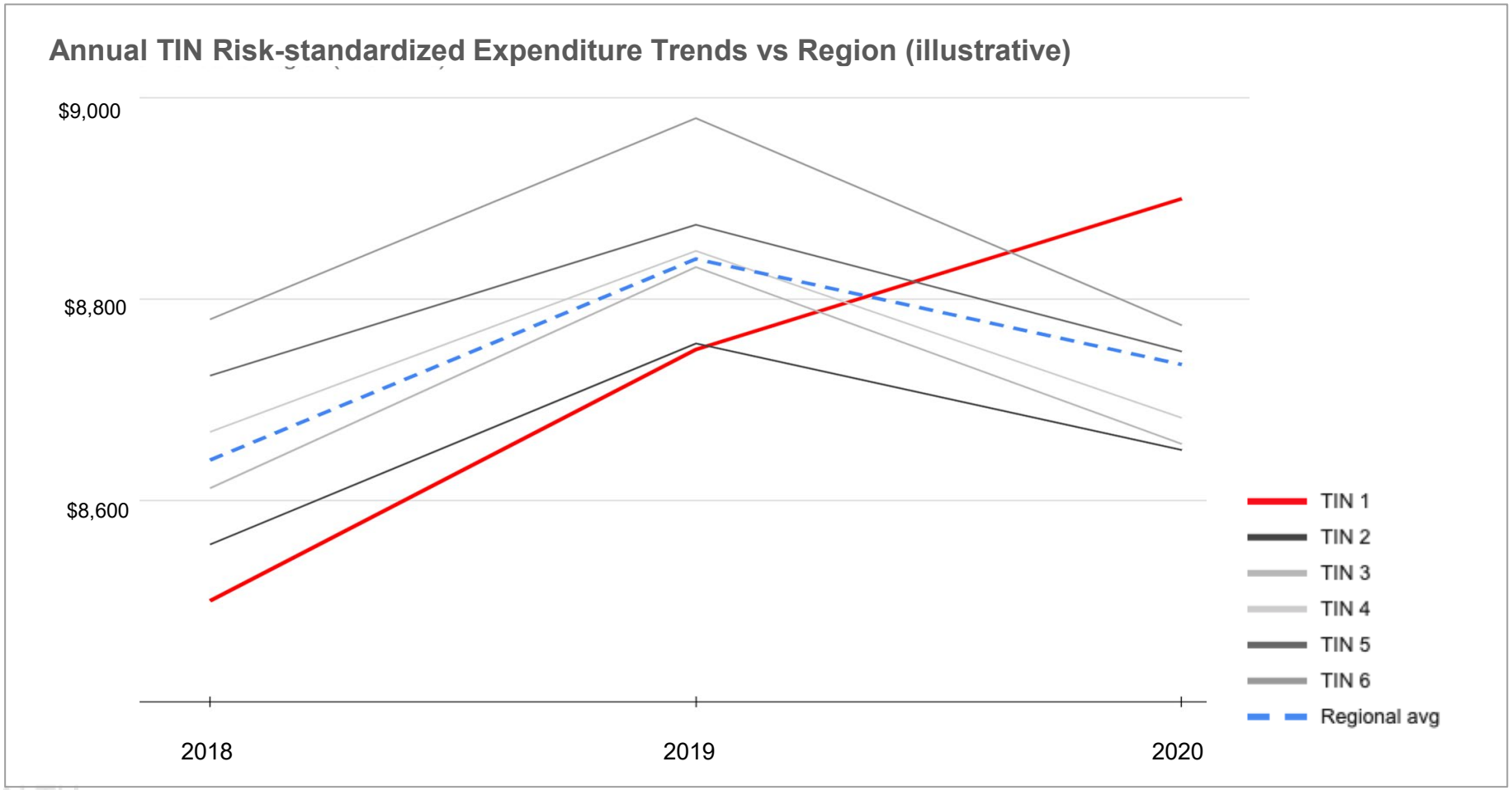
- **COVID care avoidance** decreased many regional trends across the country



From: [Webinar 1 of 3 – How to use your 2020 MSSP settlement to make 2022 decisions by Sept 10 deadline]

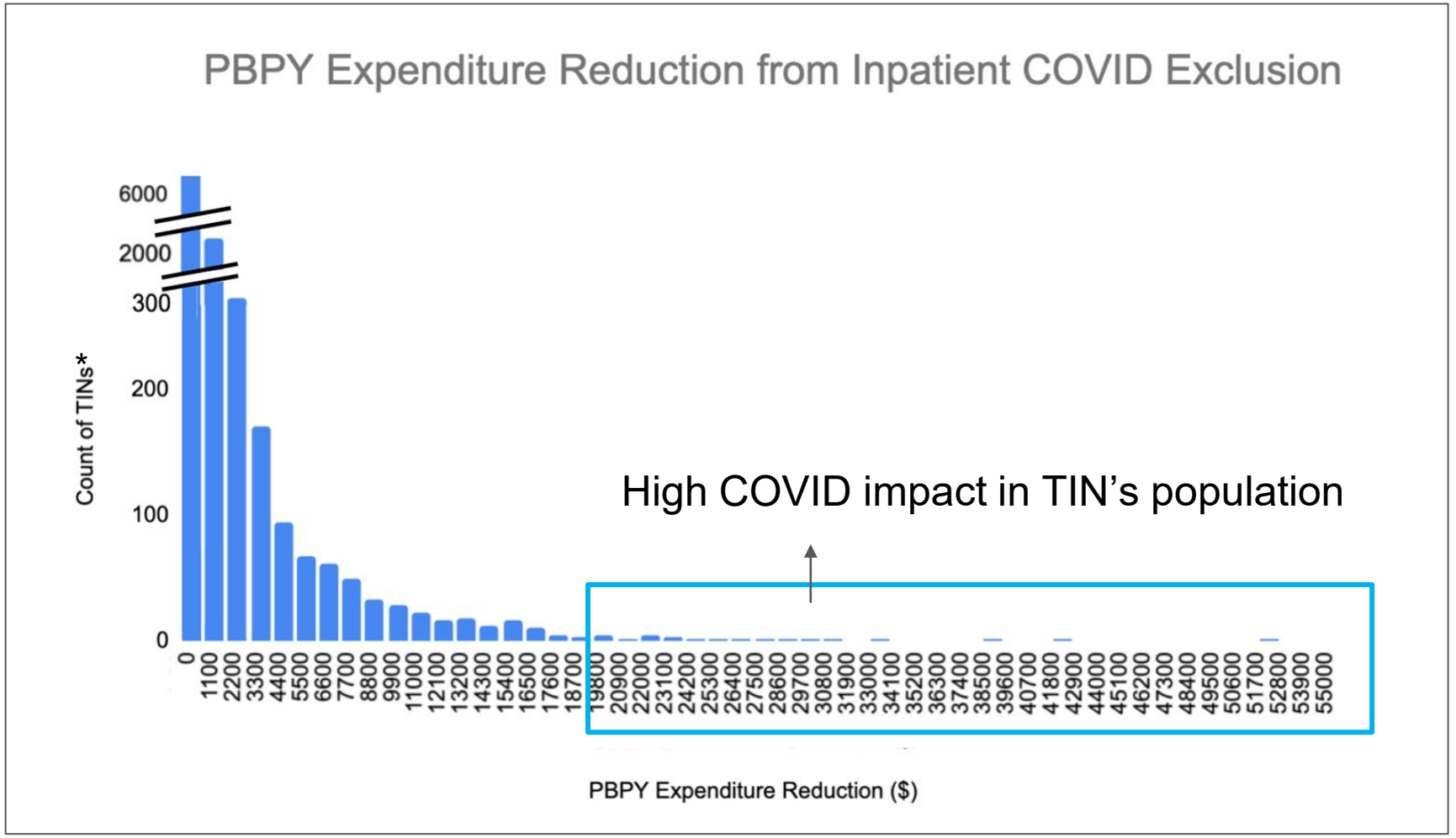
Identifying TINs with inelastic or out of sync trends

- A TIN with **inelastic practice patterns** may be particularly disadvantaged in a MSSP program
- COVID magnified the impact of regional trends on shared savings
- **Double hit** to ACO's shared savings



Highly skewed COVID inpatient exclusion across TINs

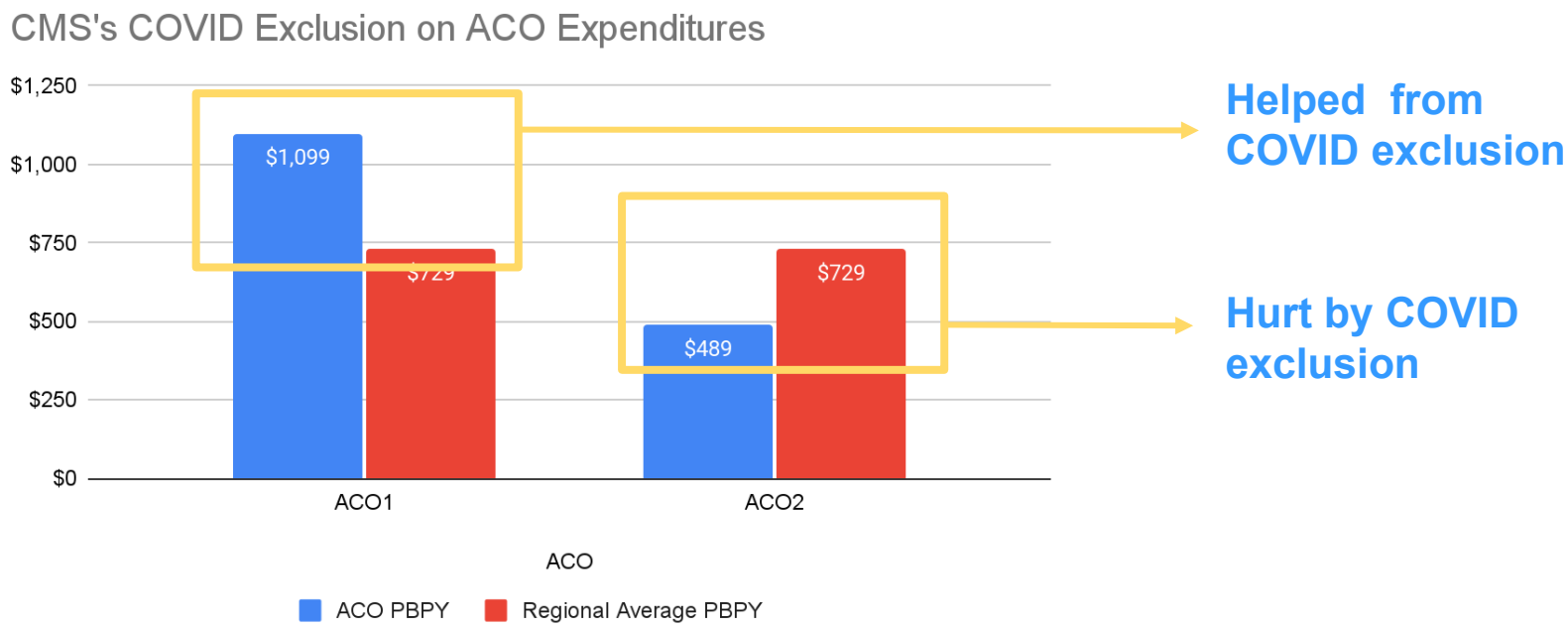
- TINs had average $1.3K PBPY expenditure reduction from COVID
- COVID exclusions in $3K to $52K PBPY range concentrated in only 10% of TINs



From: [Webinar 1 of 3 – How to use your 2020 MSSP settlement to make 2022 decisions by Sept 10 deadline]

Helped or Hurt by CMS's COVID exclusion?

CMS Inpatient COVID exclusion methodology incurs disproportionate impact



Helped from COVID exclusion

Hurt by COVID exclusion

Drastic difference due to utilization patterns

ACO	Hospital Discharges (Per 1000)	Skilled Nursing Facility Discharges (Per 1000)	% Total Assigned with COVID-19 Episode	Pre-adjusted Expenditure ($PBPY)	Adjusted Expenditure ($PBPY)	IP Exclusion Expenditure ($PBPY)
ACO1	291	42	7.9%	$10,221	$9,122	$1,099
ACO2	188	67	3.6%	$9,957	$9,468	$489

Validate Health methodology

Andrew M. Webster, MS, ASA, MAAA
andrew.webster@validatehealth.com

Develop **computer models** to recreate CMS financial calculations for

- MSSP / Pathways
- Next Gen / Direct Contracting
- Medicare Advantage
- Proposed CMS / CMMI programs

Leverage competitive **market data** to identify

- Timely regional trends
- Growth opportunities
- Competitive threats

Financial **decisions** for ACO contracts

- Track selection
- TIN participant selection
- Multi-year risk hedging and planning

Ongoing financial **optimization**

- Allocation of shared savings contribution by provider
- HCC risk adjustment optimization
- Beneficiary attribution
- Performance forecasting

Lessons Learned from ACOs

Understanding your Financial Settlement and Reconciling to Projections
Case Study

Stephen W. Nuckolls, MAC, CEO
Coastal Carolina Health Care, P.A.
Coastal Carolina Quality Care, Inc.

August 24, 2021

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Coastal Carolina Health Care, PA

60+ Providers (60% PCP)

- Internal Medicine
- Family Medicine
- Emergency Medicine
- Cardiology
- Hematology/Oncology
- Gastroenterology
- Neurology
- Pulmonary/CC
- Rheumatology
- Endocrinology
- Podiatry

16 Clinic Locations

- Urgent Care
- Imaging Center
- Sleep Lab
- GI ASC

Single Enterprise-wide EHR

More Concentrated/Rural Market

78% of PCP Patients in Total Coast of Care Contracts

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ACO Overview

- Medical Practice (CCHC) Owns Medicare ACO (CCQC)
- Started Medicare ACO - April 1, 2012
- Enhanced Track Started July 1, 2019
- Prospective Assignment
- >11,000 MSSP Assigned Beneficiaries

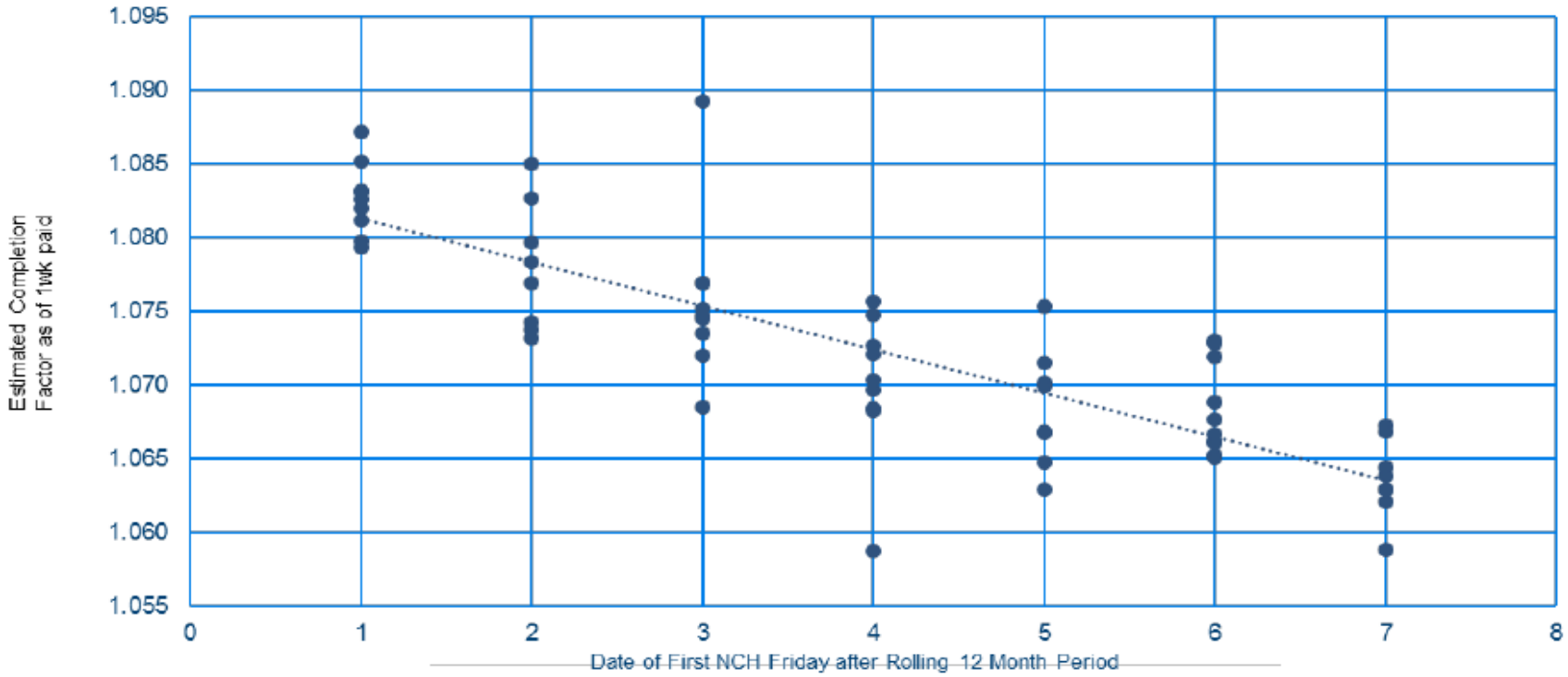
EXPU Parameters

Parameters	
Table of Contents	
Claims-Based Beneficiary Assignment Window	10/01/2018 - 09/30/2019
Shared Savings Program ACO Report Period	01/01/2020 - 12/31/2020
National Assignable FFS Report Period	01/01/2020 - 12/31/2020
National Assignable FFS Year-to-Date Report Period	01/01/2020 - 12/31/2020
Voluntary Alignment End Date	09/30/2019
Claims Processed as of	01/01/2021
Claims Completion Factor	1.072
ACO Track	ENHANCED
ACOs Included in All MSSP ACOs Column	ACOs under prospective assignment
Performance Year Participant List on which Report is Based	2020
Date Produced	01/13/2021

Claims Run-Out and Completion Factors

- Quarter 4 reports (and all Tracks 1&2 quarterly reports) are generally more stable because of the longer incurred claims period relative to the relatively short one week of payment run-out.
- However, error bars are still necessary…

Est. Compl. Factors as Function of the Date of First Friday After Rolling 12M Incurred Period



Claims Run-Out and Completion Factors

Summary of Finding—Influence of NCH Friday Date on Estimated Completion Factor

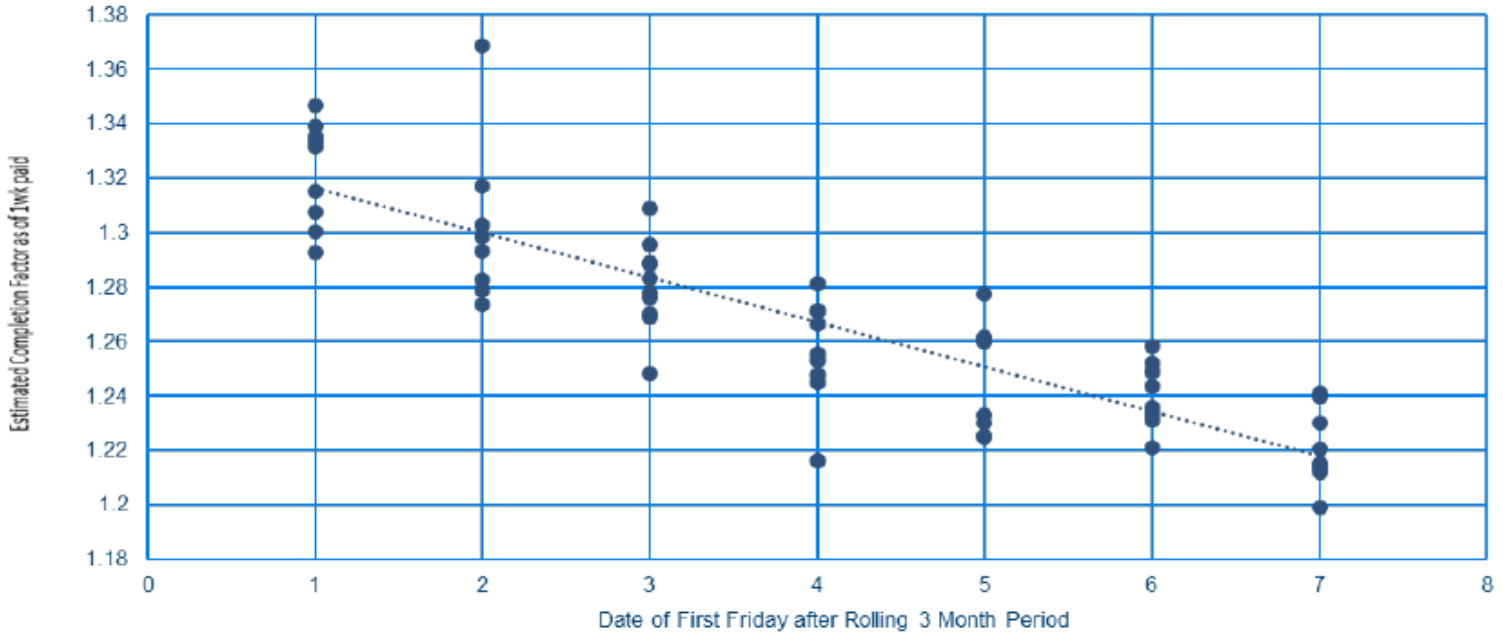
Report's Incurred Claims Period	Existing CMS Estimate	Approximate Empirical Mean by NCH Date		Persisting Standard Error
		Friday 1st	Friday 7th	
3 months (T3 Q1)	1.283	1.330	1.220	0.019
6 months (T3 Q2)	1.139	1.150	1.115	
9 months (T3 Q3)	1.091	1.095	1.070	
12 months (All T1&2, T3 Q4)	1.072	1.080	1.065	0.004

- Persisting standard error indicates the uncertainty that remains even after adjusting for NCH Friday
  - Highest in Track 3 Q1 reports (SE = .019)
  - Uncertainty declines as reporting period expands (SE falls to about .004 for 12m reports)
- Q3 reports will be paid through Friday October 6, implying standard completion factor of 1.091 may again be somewhat conservative for the average Track 3 ACO's Q3 report this year in 2017

Claims Run-Out and Completion Factors

- Quarterly reports for Track 3 ACOs are particularly sensitive to uncertain run-out because the remaining run-out is a larger share of incurred claims in Q1, Q2 or Q3 compared to the 12 months in Q4 and all quarterly reports for Tracks 1&2 ACOs.
- Q1 reports are the most uncertain (and most sensitive to NCH Friday)

Est. Compl. Factors as Function of the Date of First Friday After Rolling 3M Incurred Period



2020 Projected

	Projected Benchmark								Projected Costs		Change		
	Benchmark	Risk	Risk	Growth		Bene			Per		Per		
	(3)	Ratio	Adj.	(2)	Updated	Yrs	Pct	Aggregate	Bene (5)	Total	Bene $	TTL $	%
End Stage Renal Disease	76,939	100.00%	76,939	5,762	82,702	18	0.16%	1,495,519	72,887	(1,318,037)	9,815	177,483	-11.87%
Disabled	11,130	100.00%	11,130	(803)	10,327	691	6.17%	7,135,868	9,569	(6,612,119)	758	523,749	-7.34%
Aged/Dual	15,584	100.00%	15,584	879	16,463	333	2.98%	5,486,269	15,569	(5,188,395)	894	297,874	-5.43%
Aged/Non-Dual	10,021	100.00%	10,021	(342)	9,679	10,151	90.69%	98,256,332	8,785	(89,175,364)	895	9,080,968	-9.24%
Total (1)	10,364	100.00%	10,364	(324)	10,039	11,193	100.00%	112,373,988	9,139	(102,293,914)	901	10,080,074	-8.97%
									Projected Sharing Rate (75%*.95*.98)			69.83%	
									Proj. Shared Savings			7,038,412	

Notes

(1) Per 2020 Final Settlement Report

(2) Calculation of Change in Per Capita Spending

	National Per Capita Costs			Reg. Per Capita Costs (5)			National	Blended Change	
	2018 (4)	2020 Q4 P	Change	2018	2020 Q4	Change	Weight	$	%
End Stage Renal Disease	85,411	84,560	(850)	74,237	80,672	6,435	0.092	5,762	6.75%
Disabled	11,154	10,349	(805)	10,269	9,467	(802)	0.231	(803)	-7.20%
Aged/Dual	17,243	17,275	31	14,974	16,170	1,196	0.273	879	5.10%
Aged/Non-Dual	10,173	9,738	(435)	9,052	8,796	(257)	0.479	(342)	-3.36%
Total	10,565	10,121	(444)	9,409	9,173	(236)	0.457	(324)	-3.33%

(3) Per CMS Benchmark report dated July 2019

(4) Per 2018 Annual EXPU report provided in July 2019

(5) Per 2020 Q4 EXPU - Regional Expense Tab. (Exlcudes RAF Adj.)

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2020 Actual

	Actual Benchmark								Actual Costs		Change		
	Benchmark (3)	Risk Ratio (1)	Risk Adj.	Trend (2)	Updated	Bene Yrs	Pct. (1)	Aggregate	Per Bene (1)	Total	Per Bene $	TTL $	%
End Stage Renal Disease	76,939	101.00%	77,709	1.061	82,424	19	0.17%	1,566,061	70,000	(1,330,000)	12,424	236,061	-15.07%
Disabled	11,130	102.00%	11,352	0.962	10,926	691	6.18%	7,549,981	9,500	(6,564,500)	1,426	985,481	-13.05%
Aged/Dual	15,584	103.00%	16,052	1.086	17,438	334	2.99%	5,825,652	16,000	(5,345,333)	1,438	480,318	-8.24%
Aged/Non-Dual	10,021	101.50%	10,172	0.972	9,885	10,146	90.67%	100,297,131	9,000	(91,314,750)	885	8,982,381	-8.96%
Total (1)	10,370	101.57%	10,535	0.975	10,298	11,190	100.00%	115,238,824	9,343	(104,554,583)	955	10,684,240	-9.27%
									Actual Sharing Rate (75%*99%)			74.25%	
									Actual Shared Savings			**7,933,048**	

	National Per Capita Costs (1)				Reg. Per Capita Costs (1)				National	Blended Change	
	2018	2020	$ Change	% Change	2018	2020	$ Change	% Change	Weight	$	Trend
End Stage Renal Disease	85,979	84,848	(1,130)	0.987	75,370	80,000	4,630	1.061	0.010	4,572	1.061
Disabled	11,823	11,917	94	1.008	10,134	9,600	(534)	0.947	0.250	(377)	0.962
Aged/Dual	17,597	18,739	1,142	1.065	14,605	16,000	1,395	1.096	0.300	1,319	1.086
Aged/Non-Dual	10,557	10,099	(458)	0.957	8,621	8,500	(121)	0.986	0.480	(283)	0.972
Total	10,973	10,596	(378)	0.966	9,007	8,913	(94)	0.990	0.460	(233)	0.975

Costs		**(205)**
Trend		**91**
Risk		**157**
Quality/Sequestrat		**42**
Overall		**86**

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CMS' Benchmark Estimation Tool

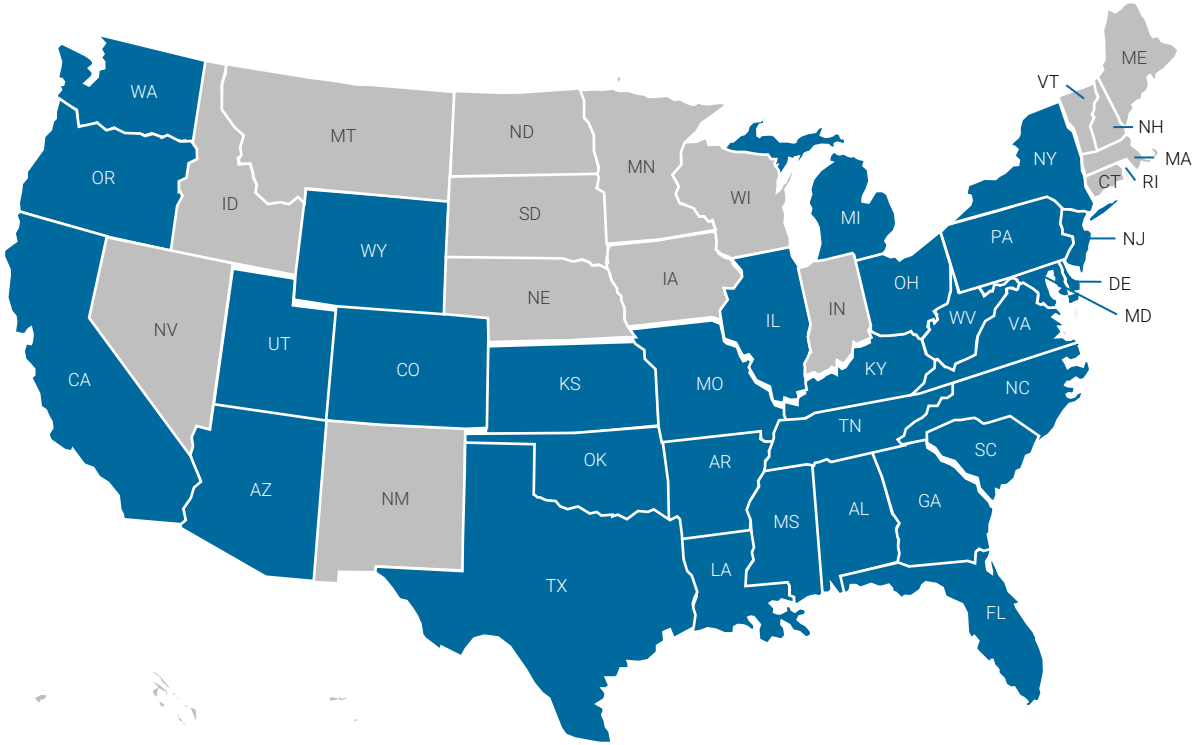
- Details Located in ACO Management System (Search – Benchmark Estimation)
- Updated May 2020
- Videos
- 3 Spreadsheets/Tools
  - National Update/Trend Factor
  - Regional Update/Trend Factor
  - Blended Update/Trend Factor

Aledade

Intersection of Finances and Policy

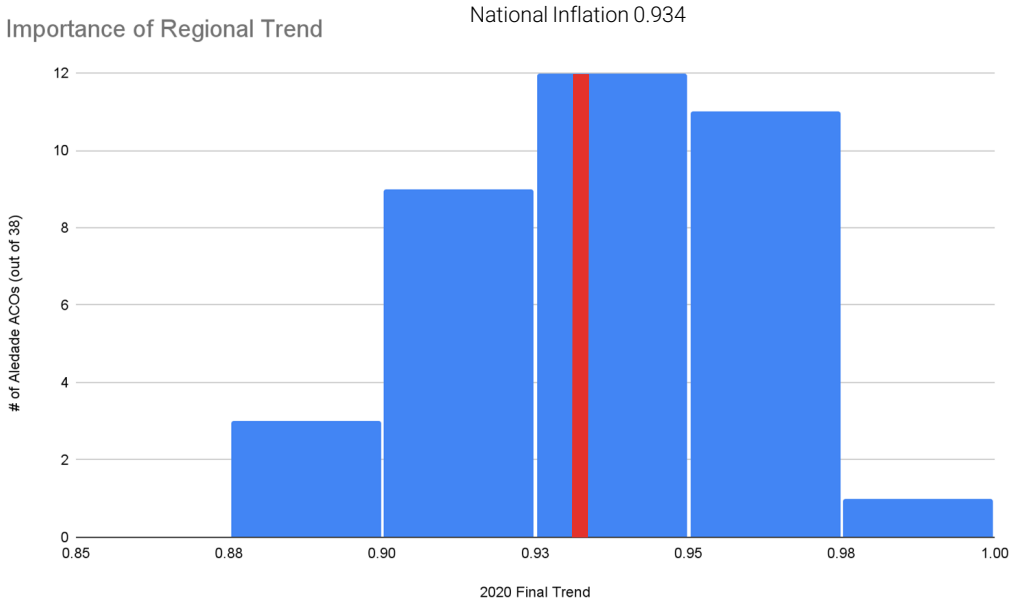
Travis Broome, MPH, MBA
SVP of Policy and Economics

Independent Practices and Community Health Centers



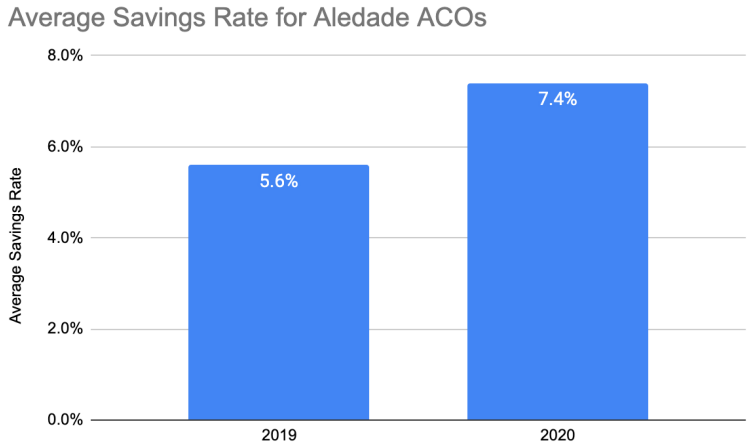
- **31** States
- **35** MSSP ACOs
- **47** Other Value-Based Care Partnerships
- **800+** Independent Practices
- **7,800+** Clinicians
- **1,000,000+** Attributed Patients
- **90+** Electronic Health Records & Practice Management Systems
- **$12+** Billion Under Management

COVID-19: The Ultimate Stress Test



- Individual ACO performance would have been wildly different with national inflation
- Program wide it “averages” out
- Who cares about the average if you are the ACO on the far right of the histogram?

- Benchmarks that best reflect local trends protect savings rates from variation across the country
- A good benchmark methodology means that even when costs go down overall, savings are still possible



80% is not 100%: Making the Benchmark Better - Risk

All ACOs are subject to a cap of 1.03 on the ACO risk ratio

Table A1: Risk Ratios for Annual Adjustment to the Historical Benchmark

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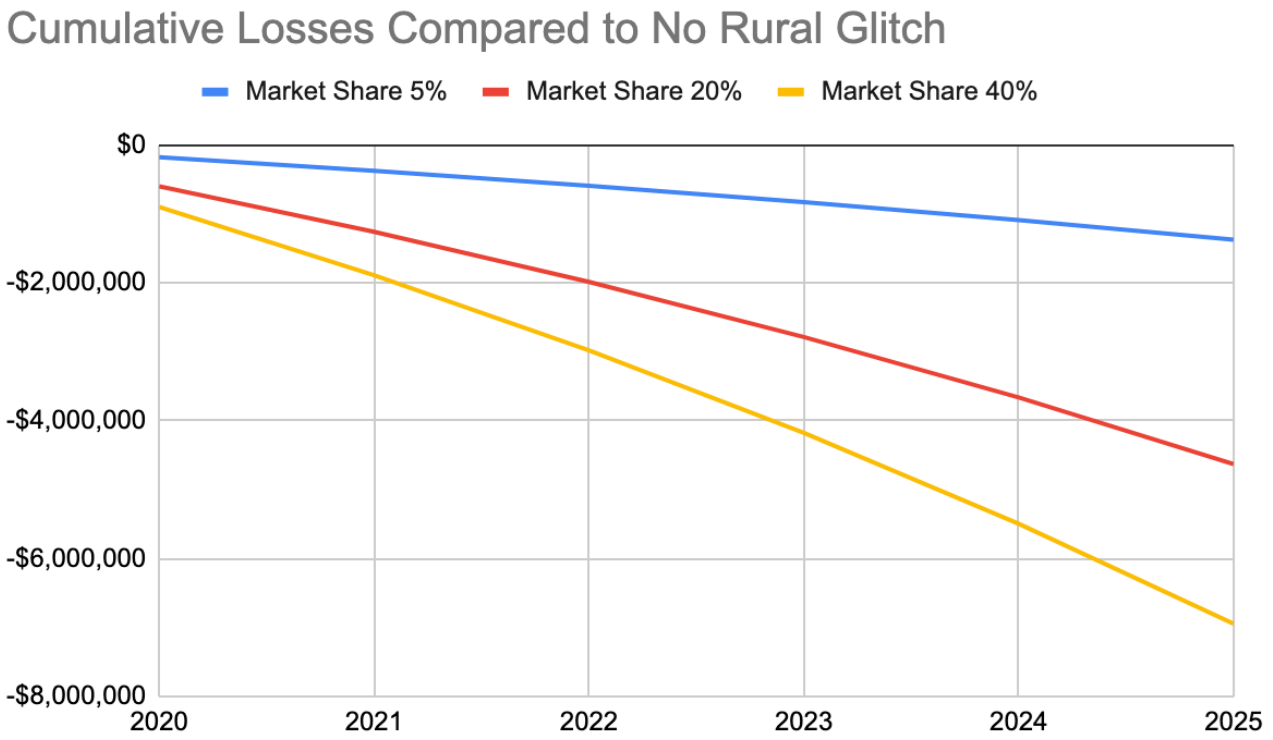
Medicare Enrollment Type	BY3 CMS-HCC Risk Score [A]	PY CMS-HCC Risk Score [B]	CMS-HCC Risk Ratio (Uncapped) [C]	Risk Ratio Cap [D]	Final Risk Ratio (Capped) [E]
ESRD	0.965	0.996	1.033	1.030	1.030
Disabled	0.986	0.937	0.951	1.030	0.951
Aged/dual	0.925	0.972	1.050	1.030	1.030
Aged/non-dual	0.966	0.986	1.021	1.030	1.021

- The region is not subject to the risk cap
- 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
- 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 3.4% of its savings in 2020 to this phenomenon, which amounts to a loss of $2.9 million in the shared savings earned by this ACO
- As of 2021 Q2 **23%** of Disabled, **27%** of Dual, and **18%** of Aged MSSP aligned beneficiaries live in counties w/ risk ratios above 1.03

Making the Benchmark Better - Rural Glitch

- 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%
- *The 80/20 rule still applies where a regional trend with rural glitch is much better reflection of your performance than national trend would be*



NAACOS Advocacy

- NAACOS has repeatedly advocated for MSSP improvements to support ACO success! Advocacy topics relevant to this webinar include recommendations to:
  - Increase the ACO's portion of savings through a higher shared savings rate
  - Remove COVID-19 spending from 2020 expenditures
  - Fix the "rural glitch" benchmarking flaw to remove ACO beneficiaries from the regional reference population
  - Increase risk cap to be no less than 5%; introduce a downward cap of 5% or less
  - Align risk score cap policy for an ACO and its region
  - Use consistent risk adjustment methodology/version for benchmark and performance periods
- **Recent NAACOS letter to CMS detailing these recommendations and many more!**
- **Many of these policy changes are included in the NAACOS-backed Value in Health Care Act of 2021 (H.R. 4587). Learn more about the bill here and tell your lawmaker to support this important legislation using our grassroots take action center!**

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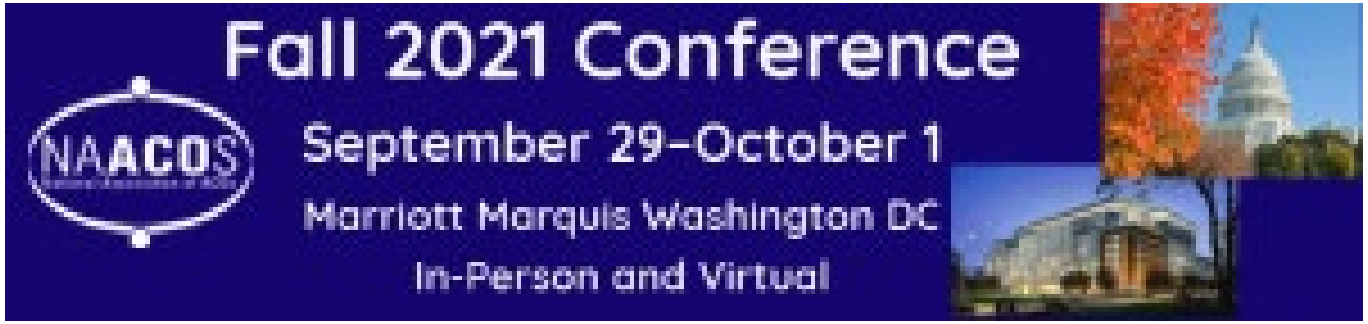
- Complimentary Live and On-Demand Webinars
- Listservs for operational, policy and financial best practices
- Policy, Advocacy and Grass Roots Resources
- Data and Benchmarking reports (ex. “B-CAPA”)

Get 3 extra months of membership free when you contact membership@naacos.com today!



Plenary topics:

Opening Plenary with Jon Blum
Dr. Robbie Pearl on his new book - Uncaring
ACOs and Health Equity: Promise or Peril?
Future of Quality Measurement and Improvement in Value Based Payment
CMS Town Hall

- Register here: https://www.naacos.com/fall-2021-registration

Breakout topics:

What's Ahead for Direct Contracting
Strategies to Improve Care for Beneficiaries with Complex Needs
Hospital at Home 2.0
Critical Policy Updates for ACOs
Leveraging ACO Infrastructure for Entire Organization
Post COVID Lessons Learned
How Medicare Advantage Experience Drives ACO/Direct Contracting Success
Health Equity
Transitioning to eCQM Reporting
The Future of Digital Health for ACOs
Physician Compensation Models that Support Transition to Value
Clinical Integration within your ACO/CIN: Managing the Challenges of Keepage and Leakage

Questions?

Thank you!