Going Deeper on Financial Changes in the Proposed 2023 Physician Fee Schedule

July 28, 2022
2:00 pm ET

Agenda

- Welcome and Introductions
- Context from CMS Leadership
- Deep Dive on All Proposed MSSP Financial Changes
  - Review Proposed Policies
  - Illustrative Examples
  - Analyze empirical results across ACOs
  - Rank proposals based on frequency/severity of ACOs affected
- ACO Perspective
- Audience Q&A

Housekeeping

Webinar is being recorded

The recording and slides will be available on the NAACOS website within 24 hours

You will receive an email when they are available.

We will take questions at the end of the program

At any time, please submit written questions using the **Questions tab** (not chat) on the dashboard to the right of your screen

Speakers

	**Aisha Pittman** Senior Vice President of Government Affairs NAACOS		**Doug Jacobs** Chief Transformation Officer Center for Medicare at CMS
	**Andrew Webster** Co-Founder and Lead Actuary Validate Health		**Travis Broome** Senior Vice President for Policy and Economics Aledade

Context From CMS Leadership

Proposed 2023 MPFS Rule

- CY 2023 MPFS Proposed Rule Released July 7, comments due September 6
  - Submit your comments via regulations.gov, reference CMS-1770-P

- Several wins in proposed rule
  - ✓ Additional time in upside only for new ACOs
  - ✓ Retaining upside-only for existing upside-only ACOs
  - ✓ Benchmark policies that address:
    - ✓ Risk adjustment caps
    - ✓ ACO historical spending and growth trends
    - ✓ Regional adjustments
  - ✓ Improved quality performance Standard
  - ✓ Up-front incentive payments for certain ACOs
  - ✓ Continued focus on increasing program participation

NAACOS Resources:

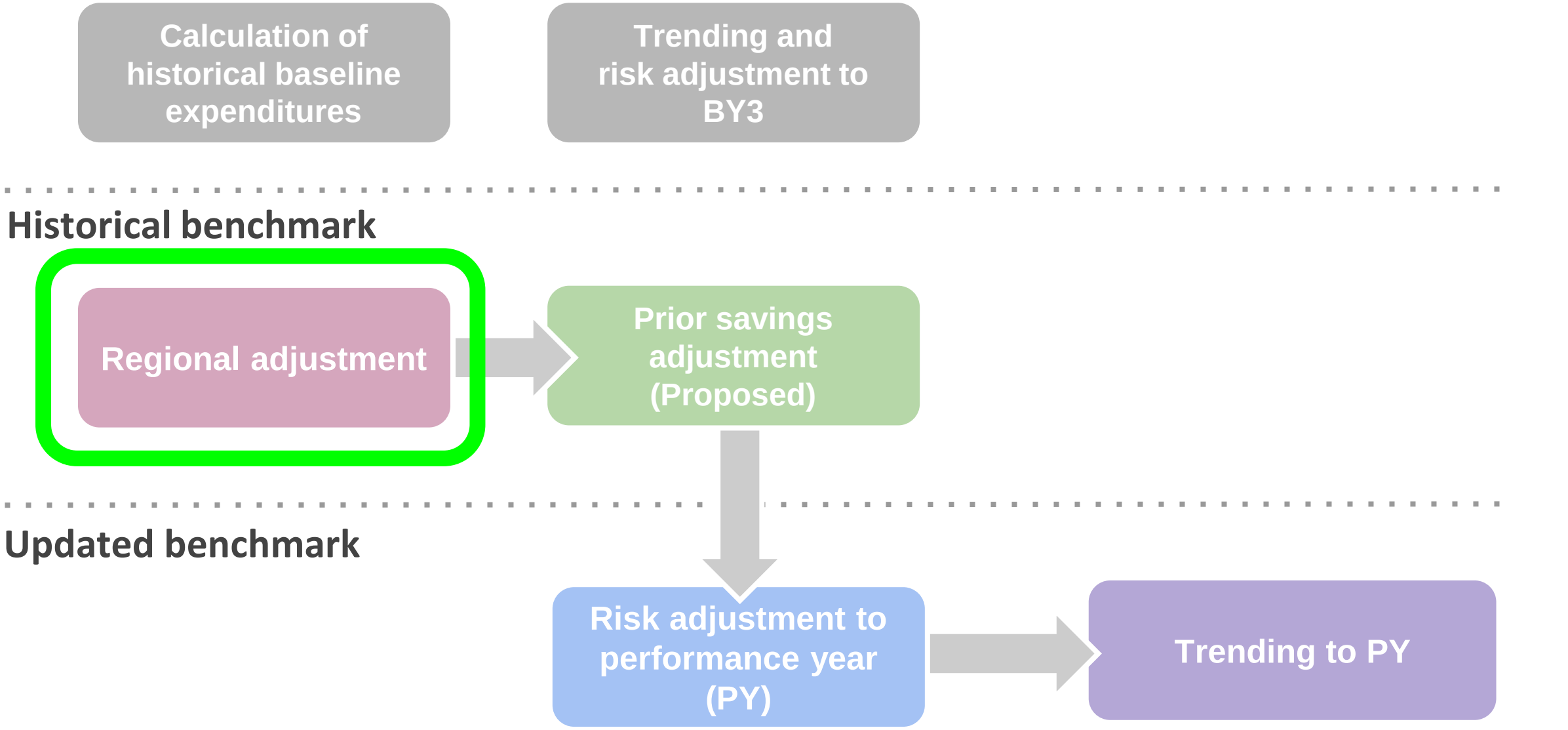
- Press statement
- In-depth analysis coming soon
- Financial methodology webinar on July 28
- Email us your feedback– advocacy@naacos.com
- NAACOS Fall conference Sept. 7-9 in Washington, DC

CMS Resources:

- CMS fact sheet
- CMS fact sheet
- QPP factsheet

Deep Dive on Proposed Changes

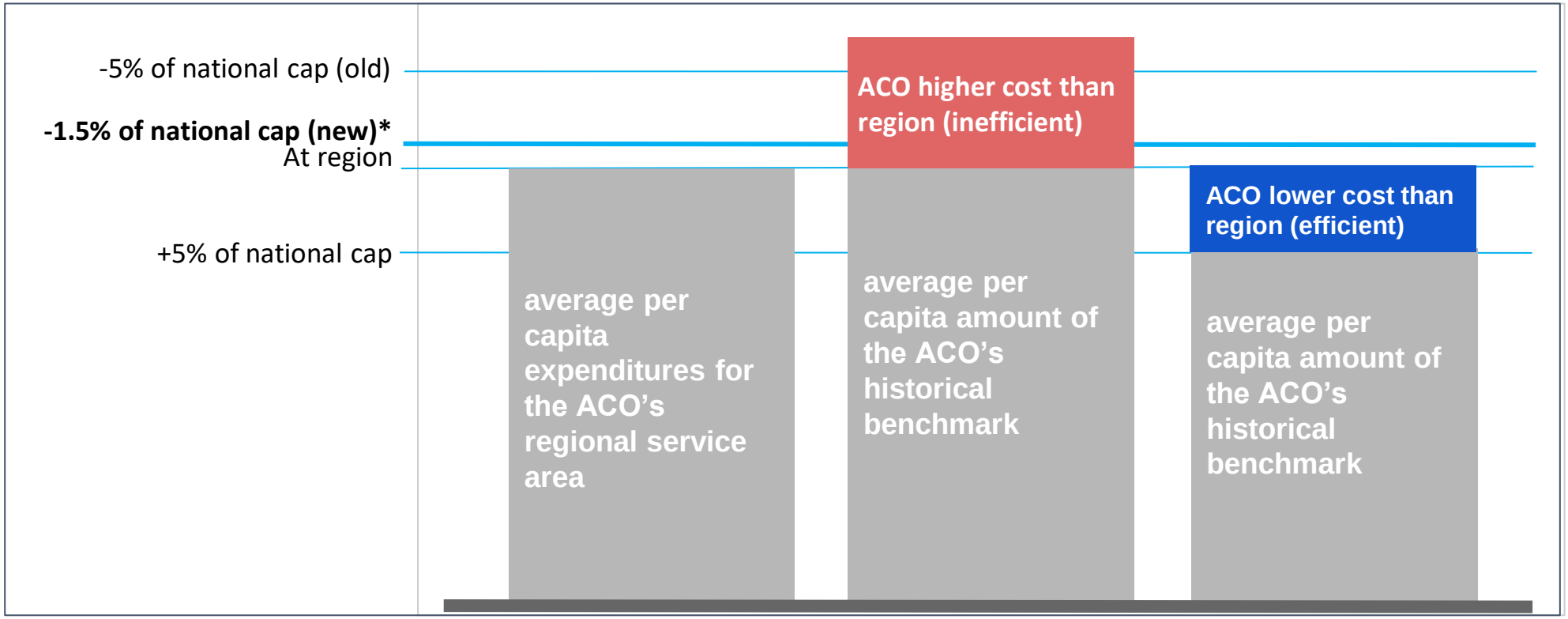
Proposed benchmarking process



Regional adjustment

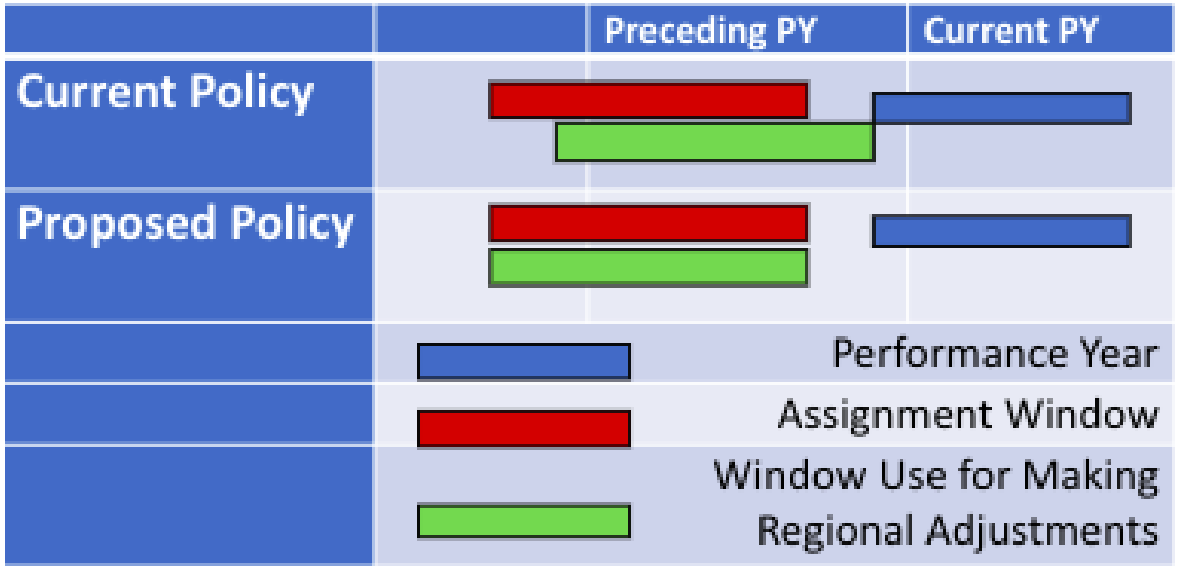
1. Determine risk adjusted difference between region and ACO
2. Apply the regional adjustment weight to the difference
3. Cap the difference at
   a. If positive, +5% of national assignable FFS
   b. If negative, -1.5%* of national assignable FFS
4. Further offset to account for % Medicaid and weighted HCC risk scores

Goal:
Entice ACOs with high spending to enter and remain in MSSP



Calculating the Regional Adjustment for ACOs using Prospective Assignment

- CMS still uses the previous calendar year to base certain financial calculations for all ACOs, regardless of their using prospective or retrospective assignment
- CMS proposes to calculate regional spending using offset assignment window that matches that of ACOs under prospective assignment
  - Not proposing changes to national factors in financial calculations
- CMS estimates that benchmarks were 0.2% to 1.9% higher for ACOs under prospective assignment than they would have been if the regional adjustment had been based on an offset assignment window
- The median estimated bias was 1.0%
- This bias grew under Pathways as more ACOs were under regional adjustment



How will you be impacted by these changes?

- (+) In PY 2020, there were 55 ACOs or 11% with a negative regional adjustment who could benefit from reduced negative regional adjustments

- (+/-) In PY 2022, there are 184 ACOs or 38% under prospective assignment who may experience a lower benchmark under a new agreement in PY 2024 or later

	ACOs under prospective assignment		ACOs under retrospective assignment		All ACOs
Year	Count	%	Count	%	Count
2016	16	4%	417	96%	433
2017	36	8%	444	93%	480
2018	93	17%	468	83%	561
2019	86	18%	401	82%	487
2020	173	33%	344	67%	517
2021	151	32%	326	68%	477
2022	184	38%	299	62%	483

Proposed benchmarking process

Calculation of historical baseline expenditures

Trending and risk adjustment to BY3

Historical benchmark

Regional adjustment

Prior savings adjustment (Proposed)

Updated benchmark

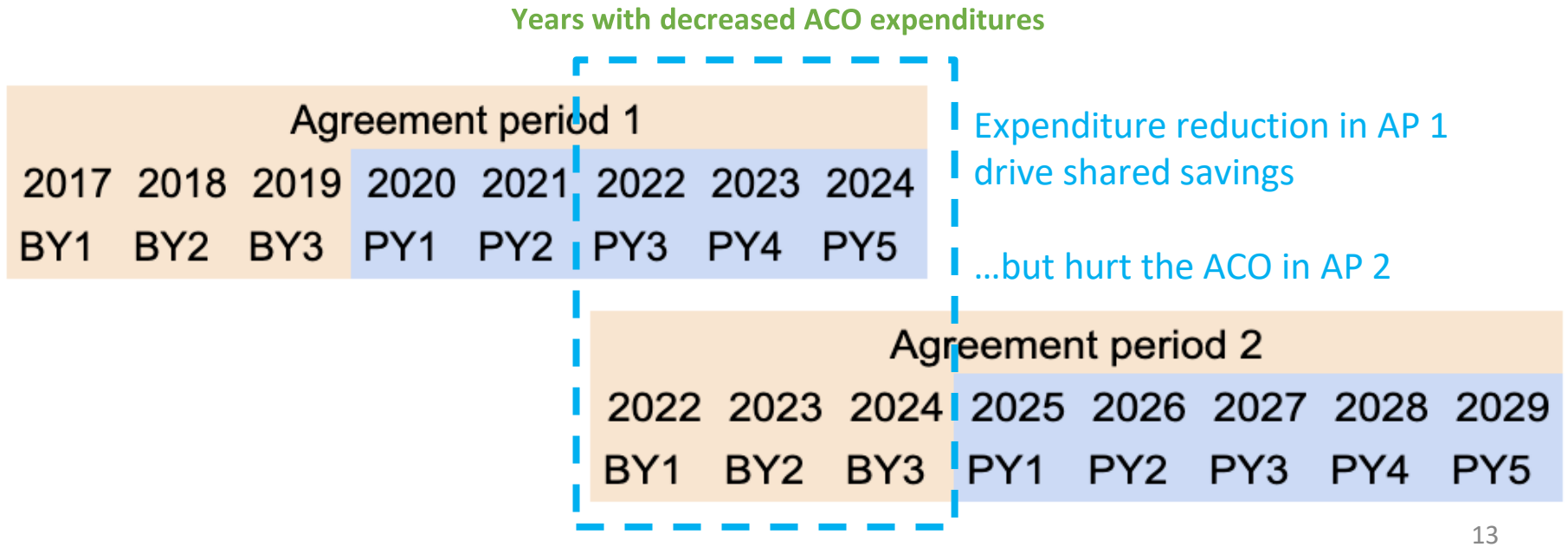
Risk adjustment to performance year (PY)

Trending to PY

Ratcheting effect between agreement periods

- Negative feedback loop: Generating shared savings in the current 5-year agreement period makes it harder to generate savings in the future 5-year agreement period due to benchmark rebasing
- The proposed solution for ratcheting **between** agreement periods is to add a prior savings adjustment to the benchmark

Demonstration of overlap in agreement period years.



Calculation steps

Calculate the average of up to 3-year prior savings for qualifying years *

1. **Use proration factor to account for beneficiary changes between benchmark and performance years**
2. **Apply 50% “scaling factor”to account for “simplified” net****
3. **Apply a prior savings cap *****

* A year qualifies if
  - There was a reconciliation (not a skipped year for re-entering ACOs)
  - Met the quality performance standard
  - Not under corrective action plan

** The minimum savings rate (MSR) is not applied

*** 5% of FFS cap excludes COVID

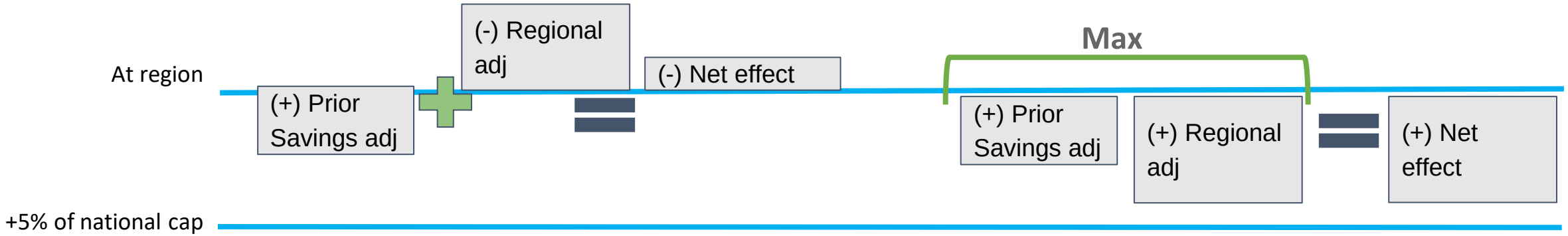
Regionally inefficient vs efficient ACOs

ACO higher cost than region (regionally inefficient)

If neg regional adjustment then **sum** prior savings and regional adjustment

ACO lower cost than region (regionally efficient)

If pos regional adjustment take the **larger** of prior savings and regional adjustment



The prior savings adjustment ensures that the regional adjustment is at least the prior savings amount

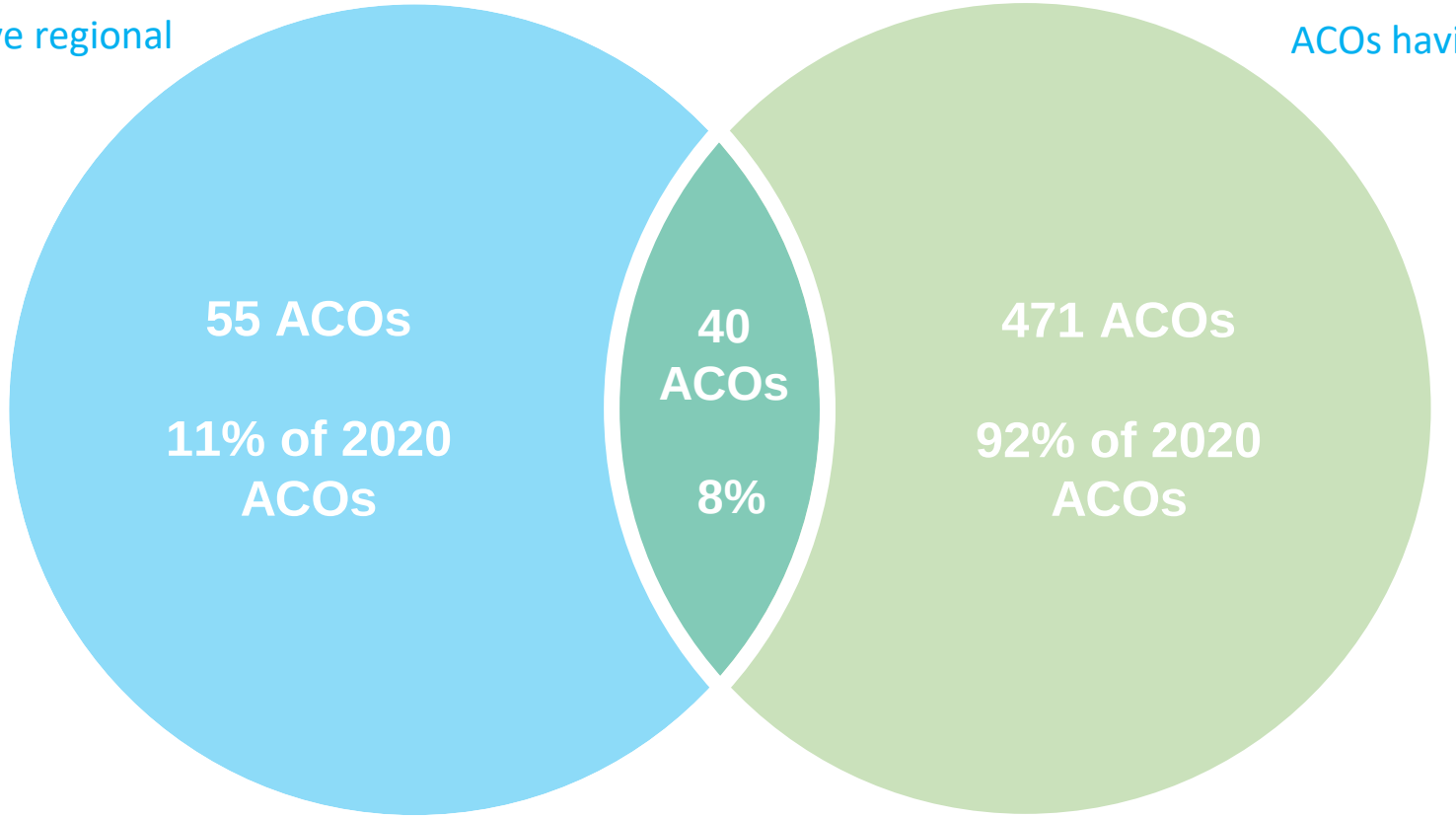
Benefit to the benchmark is **not double counted**

How will you be impacted by these changes?

Correlation between negative regional adjustment and not generating shared savings dilutes this rule's ability to benefit current ACOs

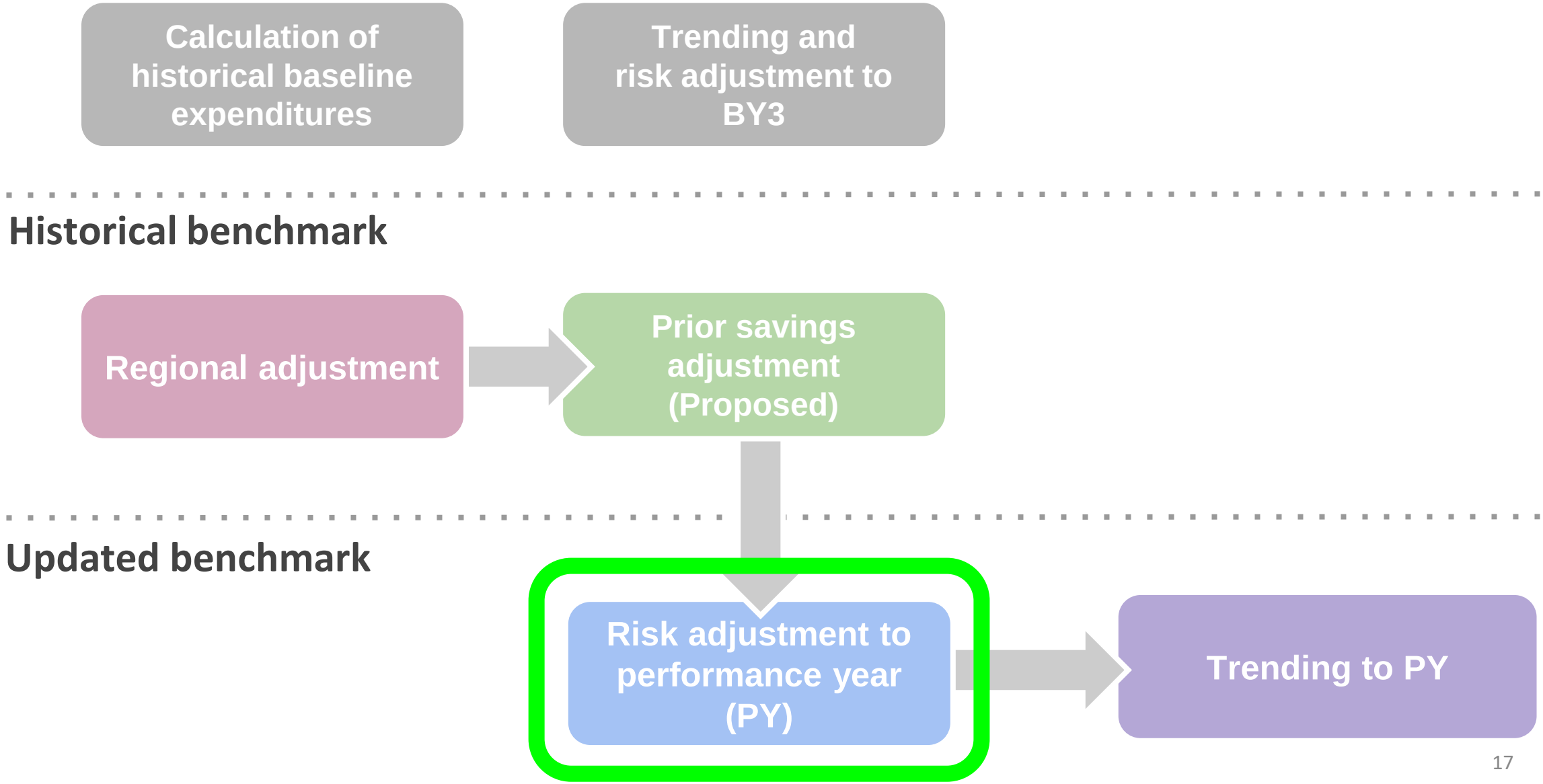
ACOs having a negative regional adjustment in 2020

ACOs having any year of positive shared savings (including 2020)



The negative regional adjustment is based on PY 2020 weighted average regional adjustment. Prior savings is based on all prior settlements for the PY 2020 ACOs

Proposed benchmarking process



Separate capping by enrollment type

- % of MSSP ACOs capped by years from the reference year
- At least one enrollment type is capped more often than not
- Percentage of ACOs capped increases as number of years from the reference year increases
- Enrollment types for ESRD, disabled and aged dual capped more often than aged non-dual leading to a disincentive to care for these populations

Performance Year Number	Total ACO Years	Count of Capped	% w/Risk ratio Capped
Any enrollment type			
1	772	521	67%
2	711	496	70%
3	551	422	77%
4	206	130	63%
Aged Dual			
1	772	264	34%
2	711	270	38%
3	551	231	42%
4	206	79	38%
Aged non-Dual			
1	772	95	12%
2	711	136	19%
3	551	159	29%
4	206	63	31%
Disabled			
1	772	203	26%
2	711	203	29%
3	551	182	33%
4	206	79	38%
ESRD			
1	772	212	27%
2	711	181	25%
3	551	133	24%
4	206	44	21%

Source: VH analysis of risk score capping across ACOs and years

7-step capping process

1. Determine demographic risk score growth for each Medicare enrollment type.

2. Calculate the dollar-weighted average demographic risk ratio across the four enrollment types to obtain a single aggregate dollar-weighted average demographic risk ratio.

3. Calculate the sum of the aggregate dollar-weighted average demographic risk ratio from Step 2 and 0.030. This would represent the aggregate cap.

4. Determine prospective HCC risk score growth for each Medicare enrollment type

5. Calculate the aggregate growth in prospective HCC risk scores by calculating the dollar-weighted average prospective HCC risk ratio across the four enrollment types

6. Determine if the ACO will be subject to the cap

7. Compare the prospective HCC risk ratio for each enrollment type calculated in Step 4 to the aggregate cap determined in Step 3

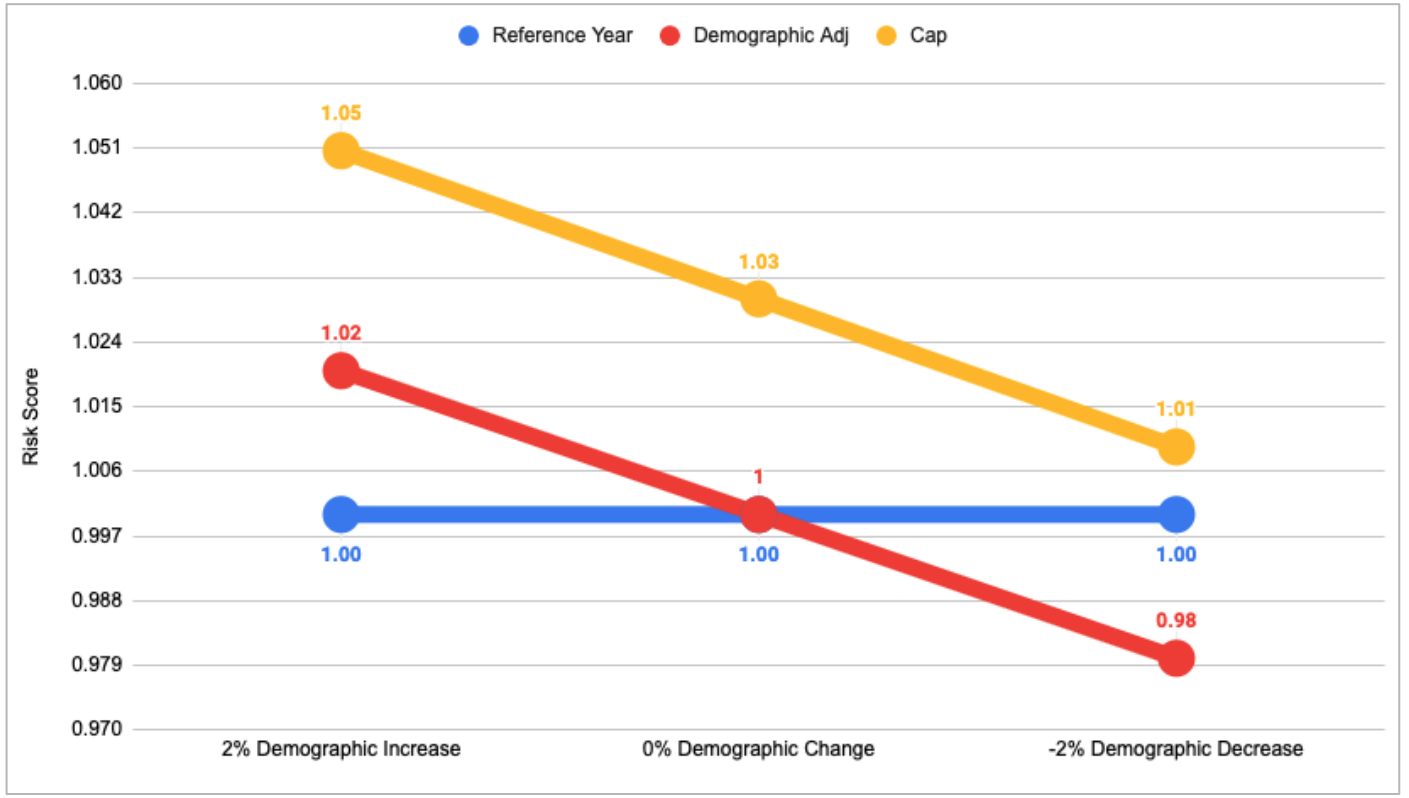
KEY

Enrollment type level

ACO level

Example: Demographic-adjusted cap

- Applies to PY 2024 MSSP and REACH ACOs
- +3% risk ratio cap shifts by change in demographic-only risk score
- Examples
  - Higher mix of age-ins in PY ⇒ Caps shift downward 2% based on age
  - Hired new geriatricians in PY ⇒ Caps shift upward 2% based on age

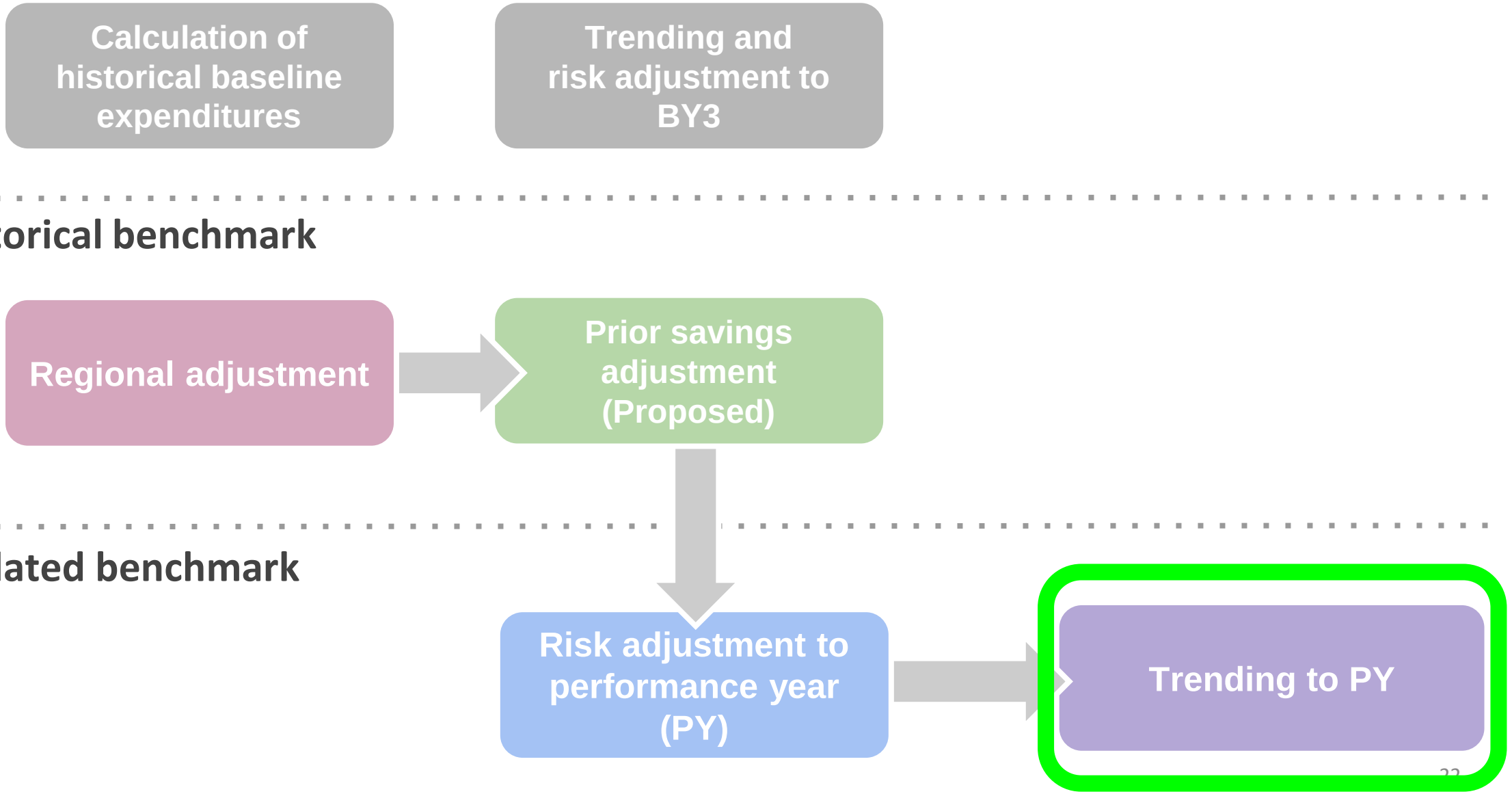


How will you be impacted by these changes?

- CMS simulations shows 45% of ACOs have higher BMs, 5% have lower BMs, 50% unaffected
- We're currently evaluating the magnitude of the national demographic-only risk scores versus aggregate capping

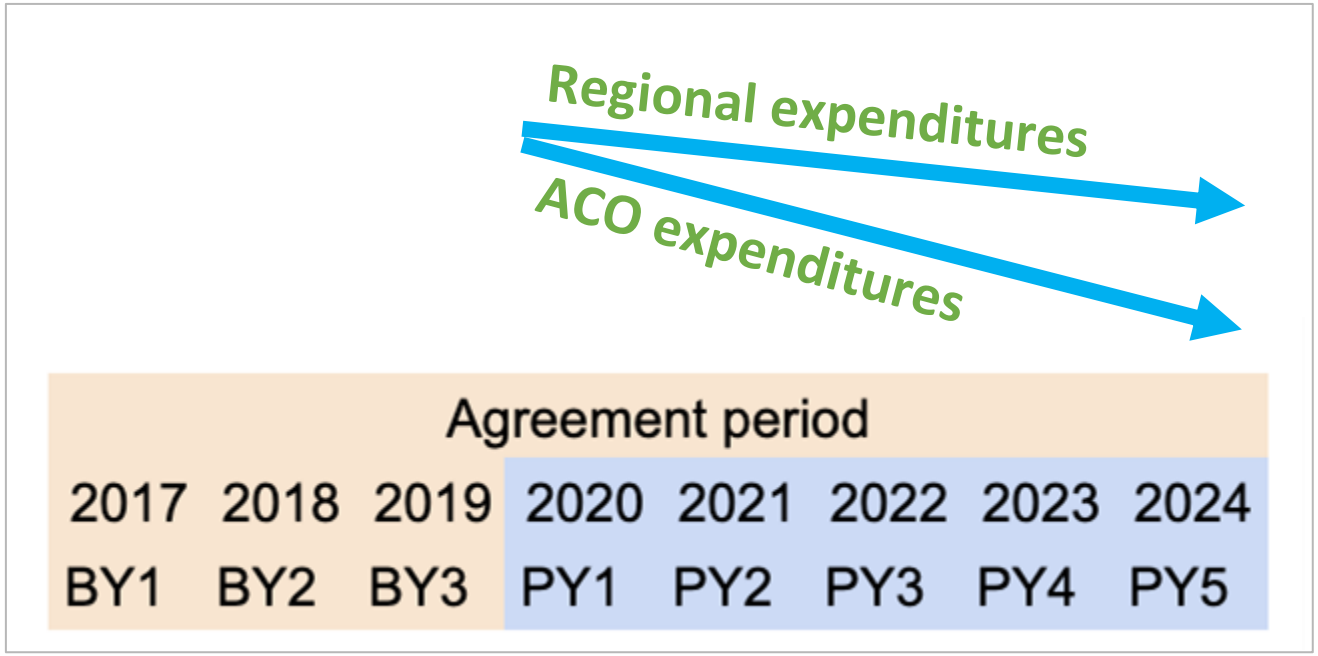
Performance Year Number	Total ACO Years	Count of Capped	% w/Risk Ratio Capped
Any enrollment type			
1	772	521	67%
2	711	496	70%
3	551	422	77%
4	206	130	63%

Proposed benchmarking process



Ratcheting effect within agreement periods

- Negative feedback loop: Generating shared savings within the current 5-year agreement period reduces the regional expenditures and makes it harder to earn shared savings in subsequent performance years within the current 5-year agreement period
- The proposed solution for ratcheting **within** agreement periods is to replace 1/3rd of the benchmark update factor with a prospectively set national trend



Accountable Care Prospective Trend (ACPT)

Definitions

- Goal: The proposed solution for ratcheting **within** agreement periods is to add a prior savings adjustment to the benchmark
- Accountable Care Prospective Trend (ACPT): a three-way blend with national and regional growth rates to update an ACO's historical benchmark for each performance year (PY) in the ACO's agreement period
- United States Per Capita Cost (USPCC)

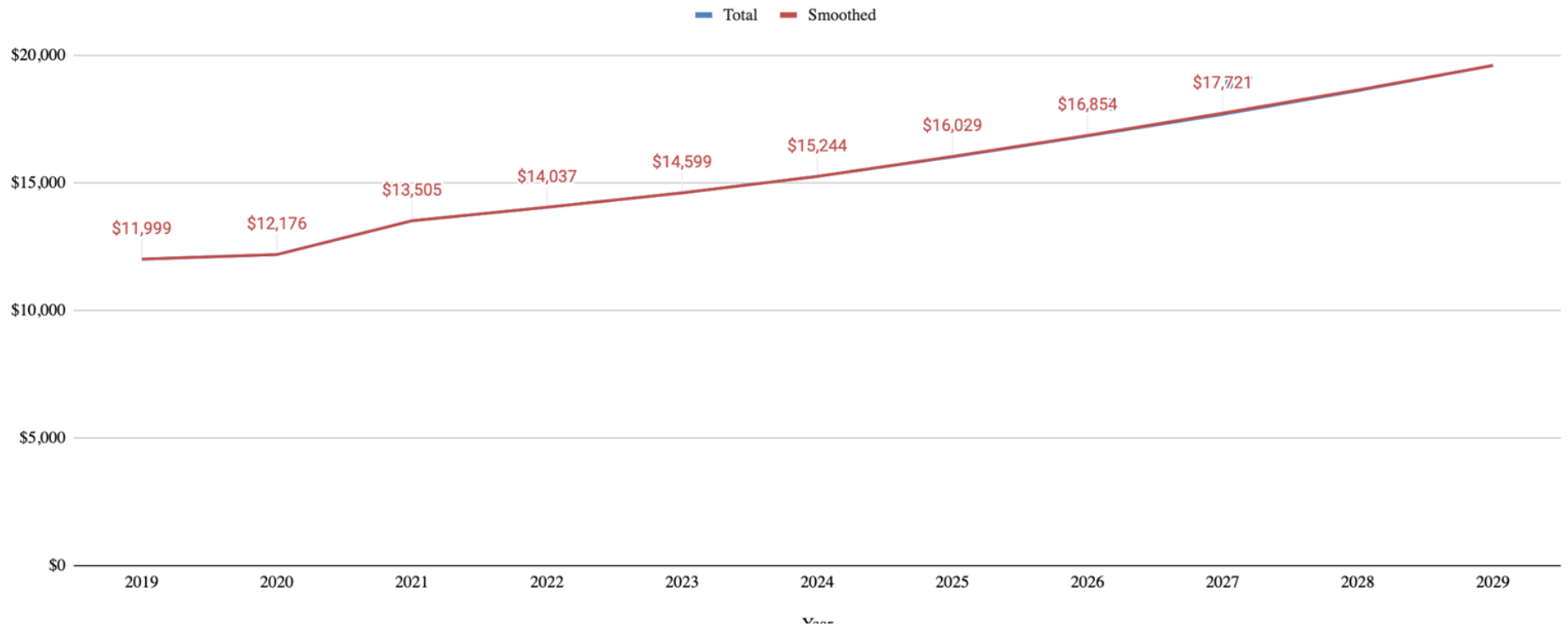
ACPT Methodology

- A three-way blend would be calculated as the weighted average of the ACPT (one-third) and the existing national-regional blend (two-thirds) for use in updating an ACO's historical benchmark between benchmark year (BY) 3 and the PY
- The ACPT would be projected by the CMS Office of the Actuary (OACT)
- The ACPT would be a modification of the existing FFS USPCC growth trend projections used annually for establishing Medicare Advantage rates
  - Excluding
    - Indirect medical education (IME)
    - Disproportionate share hospital (DSH) payments
    - The proposed new supplemental payment for Indian Health Service (IHS)/Tribal Hospitals and hospitals located in Puerto Rico
  - Including payments associated with hospice claims (to be consistent with Shared Savings Program's expenditure calculations)

Accountable Care Prospective Trend (ACPT)

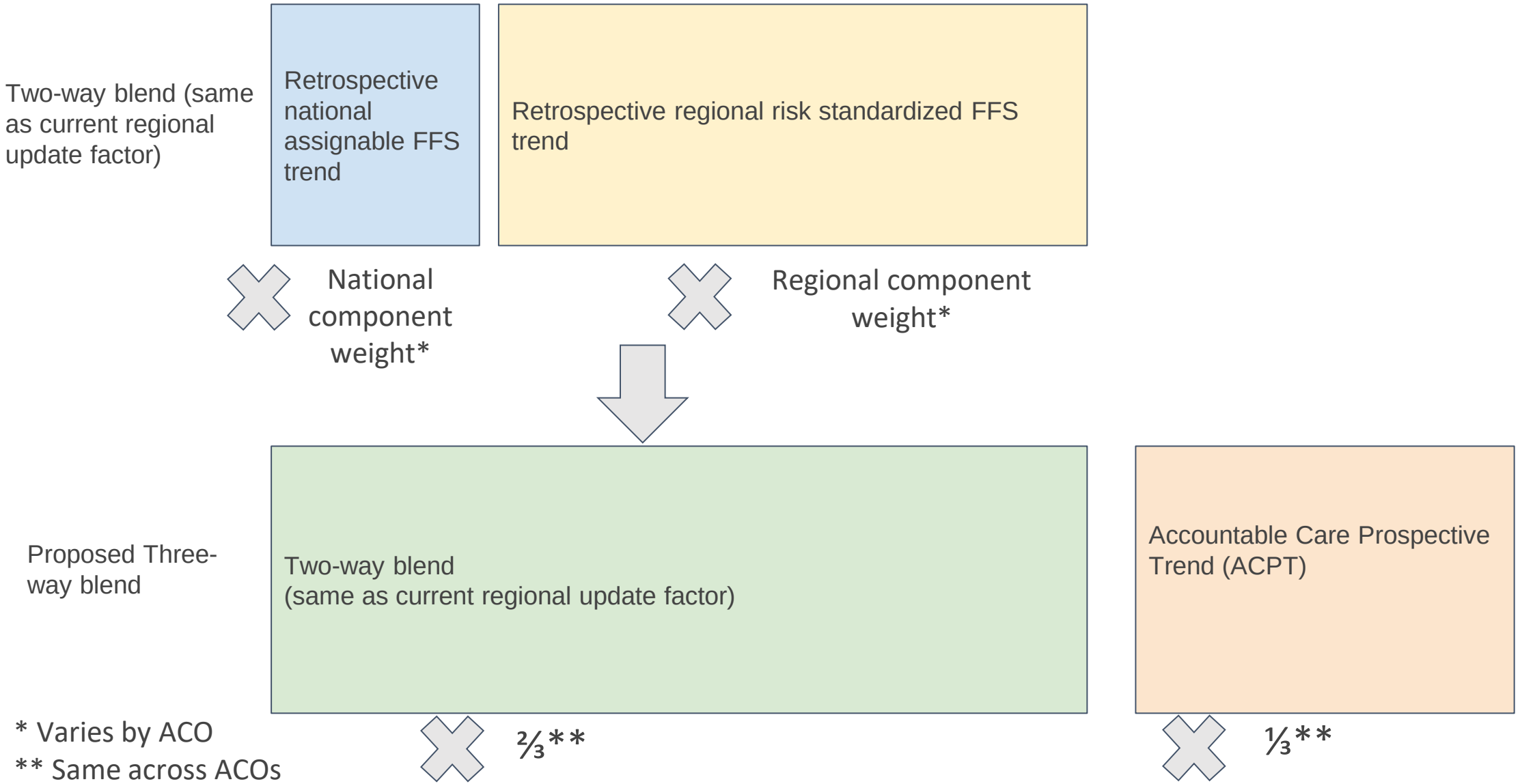
Prospectivity

- ACPT growth factors for the ACO's entire 5-year agreement period will be set near the start of the agreement period
- The ACPT factors would remain unchanged throughout the ACO's agreement period, providing a degree of certainty to ACOs
- growth



Values of USPCC from 2010 to 2030 are from the 2021 Medicare trustees report p213 https://www.cms.gov/files/document/2021-medicare-trustees-report.pdf
Aged/disabled, ESRD combined

Three-way blend

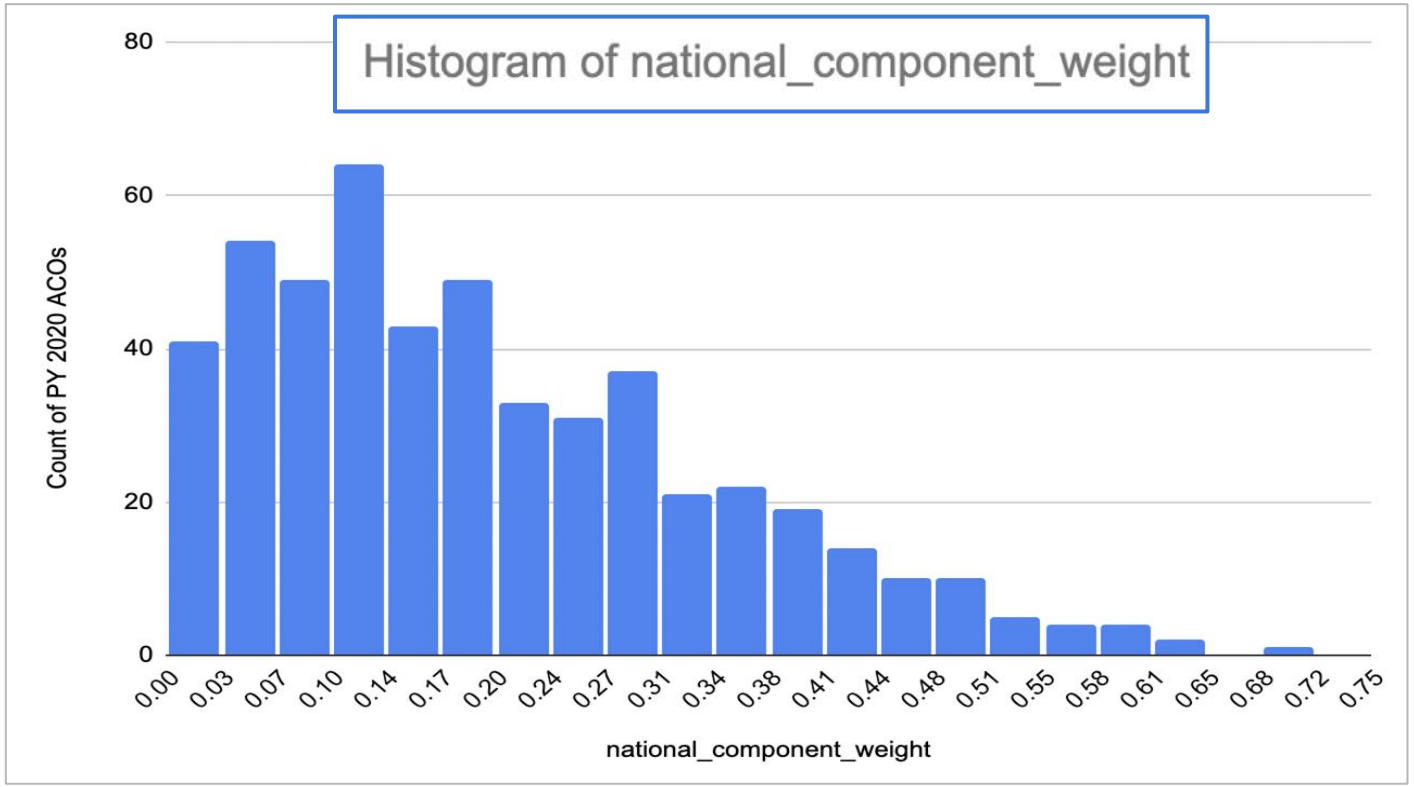


* Varies by ACO
** Same across ACOs

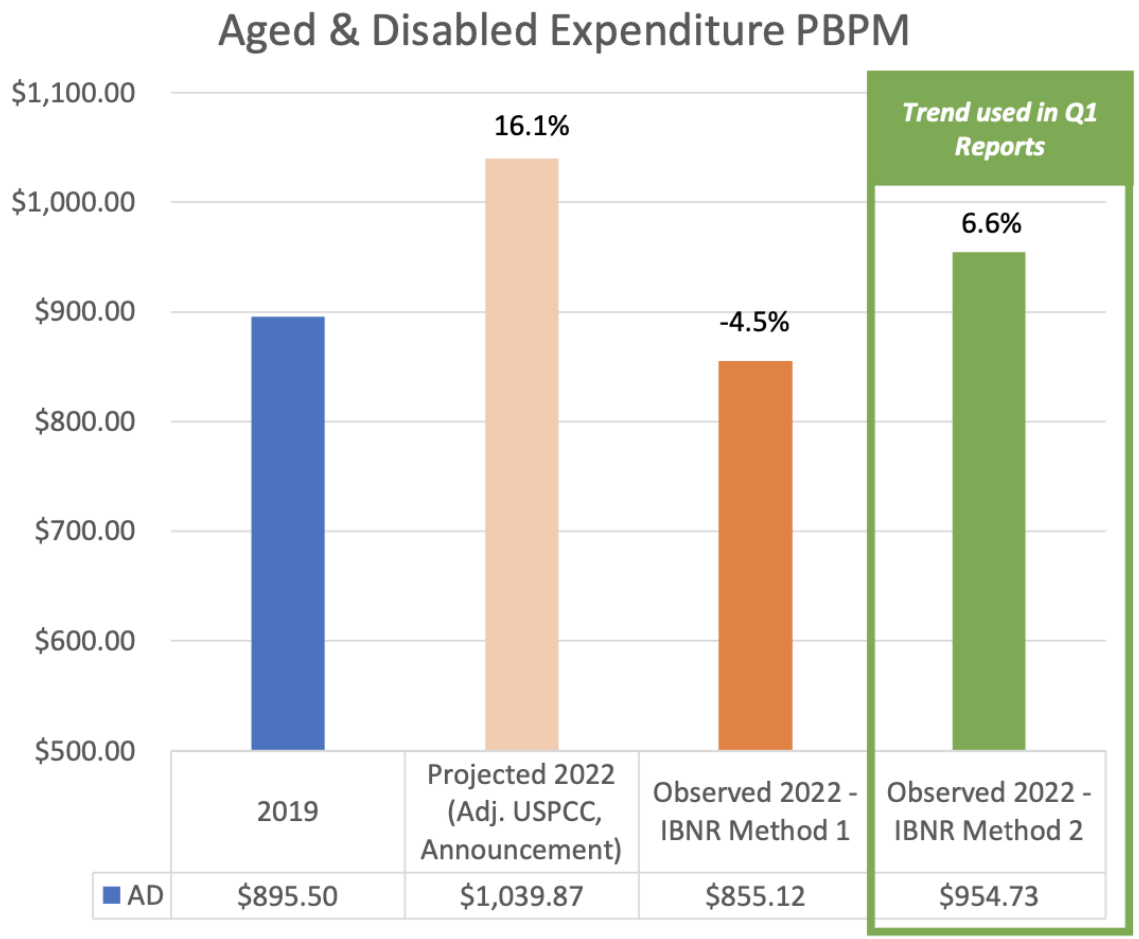
How will you be impacted by these changes?

According to CMS data

- ⊕ 62% of ACOs would see higher benchmarks under this proposed prospective three-way trend factor
- ⊖ 38% would presumably see lower benchmarks
- ⊖ Over 94 or 20% of ACOs in PY 2020 already have a national component weight over ⅓ (aged non-dual only)



5-year USPCC forecasting error

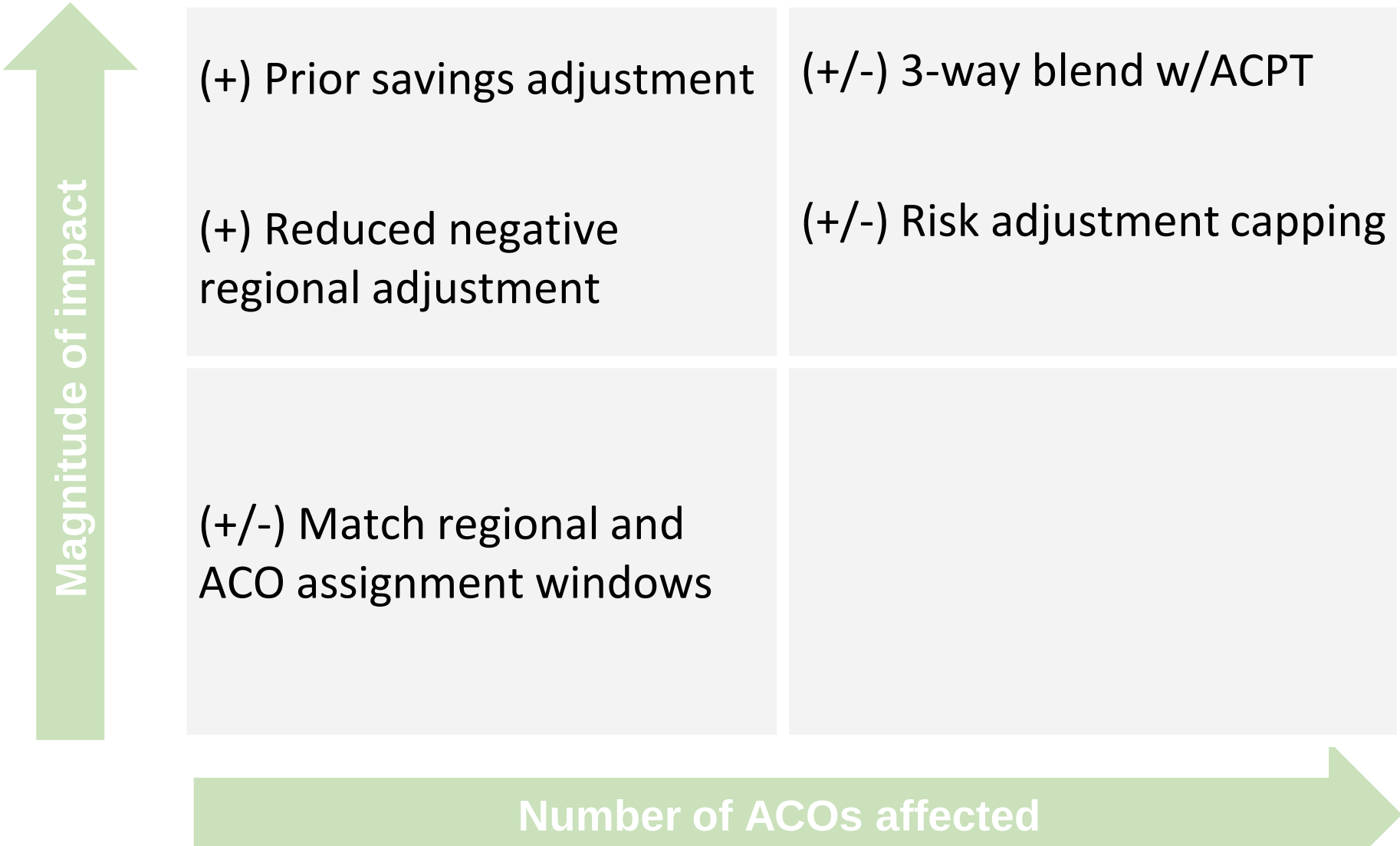


Large correction to USPCC in GPDC in 2022

RFI contains several proposals to minimize the potential for forecasting error

From CMS GPDC PY2022 Q1 QBR Webinar May 2022

Impact of proposed changes on ACOs



PY 2024 decisions

	New & Re-entering ACOs (New agreement)	Renewing ACOs (Within existing agreement)
Start MSSP under existing PY 2023 rules or wait for PY 2024 changes	✓	
Start a new agreement for PY 2024**		✓
Select assignment methodology as related to prospective/retrospective bias to regional adjustment	✓	✓

** Forecasting your shared savings helps you identify if you're being helped by the proposed Prior Savings Adjustment.

Further Resources

- https://www.naacos.com/naacos-analysis-of-the-cy-2023-proposed-medicare-physician-fee-schedule
- https://validatehealth.com/webinar-series-py-2023-decisions-for-acos/

ACO Perspective

Administrative Benchmarking

Projecting the future instead of measuring the present

What do we think cost trends would have been without MSSP and in the Innovation Center?

National vs Local Underserved versus Wellserved

When the base is out of alignment how do you bring it into alignment at the right pace?

Within our control versus outside our control

How do we account for variation from national trends that we cannot control?

Why Administrative Benchmarking

For the Next Major Leap in ACO Participation

Fundamental Problems with Current Benchmarking

1) As ACOs across the country reduce expenditures they ratchet down their savings opportunities
2) Since current benchmarking is competitive at the local level, every practice that engages in an ACO reduces the incentive for the next practice to join an ACO
3) As participation in MA and MSSP grows, the remaining pure fee for service population eventually is no longer a useful comparison group

Potential Problems with Administrative Benchmarking

1) Projections can be wrong
2) Savings rates are extraordinarily sensitive to even slight fluctuations in trends
3) National trends, projected or observed, may not reflect local market trends nor can an individual ACO drive its market trends significantly

Creating the Best Benchmark for the Future

No Ratchet

No ratchet

No rural glitch

No rebased benchmarks

Create a benchmark not dependent on observed fee-for-service experiences, but on projected Medicare spend

Create an environment where every ACO has the opportunity to succeed

Local Guardrails

Ensure that ACO performance matters more to success than differences between national and local observed trends

Do not account for all differences as that brings back the ratchet

Be okay with success

Convergence into Regional rate

ACOs start from different places

Over time different ACOs benchmarks in the same market should converge rewarding high performing ACOs over lower performing ACOs while still creating an environment where all ACOs can achieve savings

Questions?

Thank you!

Please email advocacy@naacos.com with additional comments and questions.

Appendix

Example: Regionally efficient ACO

Calculate Historical Benchmark	BY3	Benchmark
[I] Historical Benchmark Before Regional Adjustment ($)	–	**$10,700**
Determine Regional Adjustment		
[J] Risk-Adjusted Regional Expenditures Before Accounting for ACO Assigned Beneficiary Health Status ($)		
Aged/non-dual	$11,200	–
[C] CMS-HCC Risk Score		
Aged/non-dual	0.98	–
[K] Risk-Adjusted Regional Expenditures After Accounting for ACO Assigned Beneficiary Health Status (ACO Risk-Adjusted Regional Average Expenditure Amount) ($)		
Aged/non-dual	–	$10,976
[L] Difference between ACO Risk-Adjusted Regional Average Expenditure Amount and Historical Benchmark Expenditures ($)		
Aged/non-dual	–	$276
[M] Weighted Average Difference between ACO Risk-Adjusted Regional Average Expenditure Amount and Historical Benchmark Expenditures ($)	–	$165
[N] Regional Adjustment Weight	–	50%
[O] Regional Adjustment Before Applying Cap ($)		
Aged/non-dual	–	$138
[P] Regional Adustment Cap (Absolute Value) ($)		
Aged/non-dual	–	$553
[Q] Regional Adjustment After Applying Cap ($)		
Aged/non-dual	–	$138
[R] Regionally-Adjusted Historical Benchmark Expenditures ($)		
Aged/non-dual	–	$10,838

- Table 1 - Historical Benchmark tab of the Benchmark report
- No change from current rules
- Capping will continue to be done separately per enrollment type

Note: The above is a PY 2022 CMS historical benchmark report modified for proposed rule using de-identified values for a specific ACO

Example: Regionally inefficient ACO

Calculate Historical Benchmark	BY3	Benchmark
[I] Historical Benchmark Before Regional Adjustment ($)	–	**$12,200**
Determine Regional Adjustment		
[J] Risk-Adjusted Regional Expenditures Before Accounting for ACO Assigned Beneficiary Health Status ($)		
Aged/non-dual	$11,200	–
[C] CMS-HCC Risk Score		
Aged/non-dual	0.98	–
[K] Risk-Adjusted Regional Expenditures After Accounting for ACO Assigned Beneficiary Health Status (ACO Risk-Adjusted Regional Average Expenditure Amount) ($)		
Aged/non-dual	–	$10,976
[L] Difference between ACO Risk-Adjusted Regional Average Expenditure Amount and Historical Benchmark Expenditures ($)		
Aged/non-dual	–	-$1,224
[M] Weighted Average Difference between ACO Risk-Adjusted Regional Average Expenditure Amount and Historical Benchmark Expenditures ($)	–	-$326
[N] Regional Adjustment Weight	–	15%
[O] Regional Adjustment Before Applying Cap ($)		
Aged/non-dual	–	-$184
[P] Regional Adustment Cap (Absolute Value) ($)		
Aged/non-dual	–	-$166
[Q] Regional Adjustment After Applying Cap ($)		
Aged/non-dual	–	-$166
[R] Regionally-Adjusted Historical Benchmark Expenditures ($)		
Aged/non-dual	–	$12,034

- Table 1 - Historical Benchmark tab of the Benchmark report
- Regional adjustment is capped under proposed rule
- Offset based on % Medicaid and amount of average risk score over to further reduce the regional adjustment

Note: The above is a PY 2022 CMS historical benchmark report modified for proposed rule using de-identified values for a specific ACO

Example: Regionally efficient ACO

	2021 BY1	2022 BY2	2023 BY3		
Calculate Adjustment for Savings in Prior Agreement Period	**PY1(AP1)**	**PY2(AP1)**	**PY3(AP1)**		**3-Year Average**
[J] Assigned Beneficiary Person Years	10,000	14,000	16,000		–
[K] Total Savings	$5,000,000	$7,000,000	$8,000,000		–
[L] Per Capita Savings	$500	$500	$500		$500
[M] Net Savings Generated?	–	–	–		Yes
[N] Final Sharing Rate	50%	50%	50%		50%
[O] Average Per Capita Savings Amount (Maximum Adjustment)	–	–	–		$250
Apply Adjustment for Savings in Prior Agreement Period					**PY1 (AP2)**
[P] Person Years Threshold	–	–	–		13,333
[Q] Assigned Beneficiary Person Years for Second Agreement	–	–	–		16,000
[R] Per Capita Prior Savings Adjustment (Pro-Rated)	–	–	–		$208
[S] Regional adjustment					$215
[T] Maximum of Regional adjustment and prior savings adjustment (regionally efficient only)					$215
[U] Regional adjustment + prior savings adjustment (regionally inefficient only)					NA
[V] Historical Benchmark					$12,000
[W] Historical Benchmark Adjusted for Prior Savings	–	–	–		**$12,215**

- Table 1 - Historical Benchmark tab of the Benchmark report
- The prior savings adjustment is < the regional adjustment so the new rule doesn't benefit the regionally efficient ACO

Note: The above is a PY 2019 CMS historical benchmark report modified for proposed rule using de-identified values for a specific ACO

Example: Regionally inefficient ACO

	2021 BY1	2022 BY2	2023 BY3		
Calculate Adjustment for Savings in Prior Agreement Period	**PY1(AP1)**	**PY2(AP1)**	**PY3(AP1)**		**3-Year Average**
[J] Assigned Beneficiary Person Years	10,000	14,000	16,000		–
[K] Total Savings	$5,000,000	$7,000,000	$8,000,000		–
[L] Per Capita Savings	$500	$500	$500		$500
[M] Net Savings Generated?	–	–	–		Yes
[N] Final Sharing Rate	50%	50%	50%		50%
[O] Average Per Capita Savings Amount (Maximum Adjustment)	–	–	–		$250
Apply Adjustment for Savings in Prior Agreement Period					**PY1 (AP2)**
[P] Person Years Threshold	–	–	–		13,333
[Q] Assigned Beneficiary Person Years for Second Agreement	–	–	–		16,000
[R] Per Capita Prior Savings Adjustment (Pro-Rated)	–	–	–		$208
[S] Regional adjustment					-$215
[T] Maximum of Regional adjustment and prior savings adjustment (regionally efficient only)					NA
[U] Regional adjustment + prior savings adjustment (regionally inefficient only)					-$7
[V] Historical Benchmark					$12,000
[W] Historical Benchmark Adjusted for Prior Savings	–	–	–		**$11,993**

- Table 1 - Historical Benchmark tab of the Benchmark report
- The prior savings adjustment helps to nearly wipe out the negative regional adjustment but the benchmark is still less than historical experience

Note: The above is a PY 2019 CMS historical benchmark report modified for proposed rule using de-identified values for a specific ACO

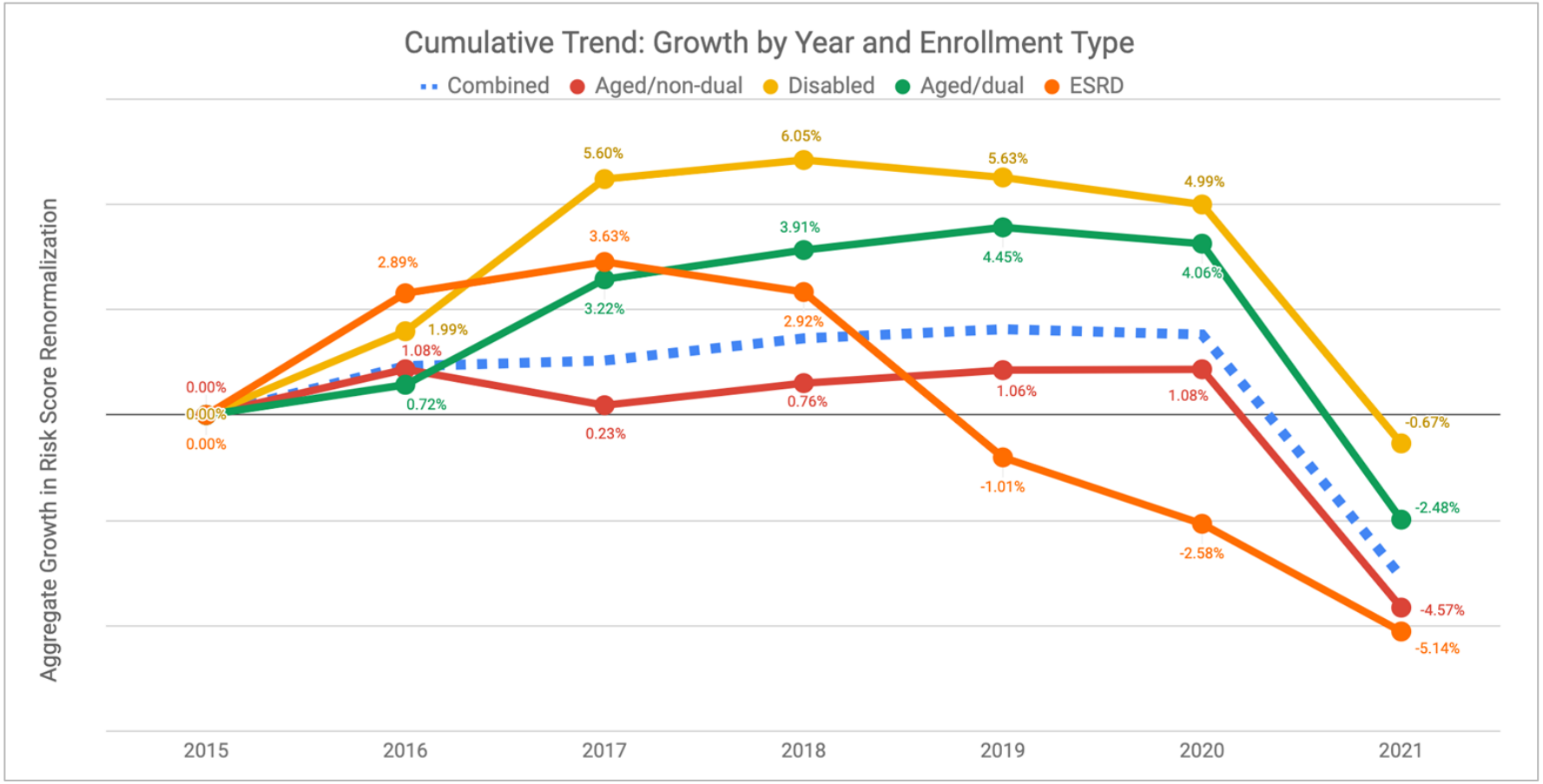
Example: Demographic-only risk score

- Based only on age, gender, Medicaid status, and original reason for entitlement
- Incorporates the average chronic illness burden for the group
- Separately renormalized from coding-based risk scores

Risk marker	Coding-based Risk Score	Demographic-only Risk Score
Female, age 70-74, non-Medicaid, non originally disabled	0.386	0.690
Respiratory Arrest (HCC 83)	0.354	-
Cardio-Respiratory Failure and Shock (HCC 84)	-	-
Total	**0.740**	**0.690**
PY 2021 Renormalization factor for Aged non-dual	1.004	0.912
Renormalized risk score	**0.737**	**0.757**

Separate renormalization for demographic-only risk scores

- Ensures that the national assignable/alignable population risk score is 1.0 in each year
- Generally increasing (except for 2020/2021)
- Continuous coding accuracy improvement is needed to keep pace with national change in risk score



Source: Validate Health study in June 2022

https://validatehealth.com/Implications-of-Plummeting-National-Risk-Scores-for-Your-ACOs-2021-Shared-Savings Settlement/

Example: ACO in slow growing region

	2023 BY3	2024 PY
[A] OACT National Assignable FFS Per Capita		
Aged/non-dual	$12,500	$13,000
[B] National Expenditure Trend and Update Factors		
Aged/non-dual		1.040
[C] Risk-Adjusted Regional Expenditures ($)		
Aged/non-dual	$13,500	$13,700
[D] Regional Expenditure Trend and Update Factors		
Aged/non-dual		1.015
[E] National Component Weight		
Aged/non-dual		10%
[F] Regional Component Weight		
Aged/non-dual		90%
[G] National-Regional Blended Trend Factors and Update Factors (two-way blend)		
Aged/non-dual		1.02
[H] Accountable Care Prospective Trend (ACPT)		
Aged/non-dual		1.051
[I] Accountable Care Prospective Trend (ACPT) Weight		
Aged/non-dual		33%
[J] Two-way blend weight		
Aged/non-dual		67%
[K] Three-way blend		
Aged/non-dual		1.029

- Table A3 - Trend & Update tab of the Settlement report
- ACPT increases the benchmark

Example: ACO in fast growing region

	2023 BY3	2024 PY
[A] OACT National Assignable FFS Per Capita		
Aged/non-dual	$12,500	$13,000
[B] National Expenditure Trend and Update Factors		
Aged/non-dual		1.040
[C] Risk-Adjusted Regional Expenditures ($)		
Aged/non-dual	$12,000	$12,800
[D] Regional Expenditure Trend and Update Factors		
Aged/non-dual		1.067
[E] National Component Weight		
Aged/non-dual		10%
[F] Regional Component Weight		
Aged/non-dual		90%
[G] National-Regional Blended Trend Factors and Update Factors (two-way blend)		
Aged/non-dual		1.064
[H] Accountable Care Prospective Trend (ACPT)		
Aged/non-dual		1.051
[I] Accountable Care Prospective Trend (ACPT) Weight		
Aged/non-dual		33%
[J] Two-way blend weight		
Aged/non-dual		67%
[K] Three-way blend		
Aged/non-dual		1.060

- Table A3 - Trend & Update tab of the Settlement report
- ACPT decreases the benchmark