Advancing health equity through value-based care

Patients and communities receiving care in value-based arrangements have better access, outcomes

Primary care is at the center of value-based care. Research shows that when structured well, such as through established programs like the Medicare Shared Savings Program (MSSP), value-based arrangements work to reduce unnecessary care and encourage high quality care, leading to improved health outcomes and cost-savings–from fewer emergency room visits, fewer hospital admissions and readmissions, and improved prevention and chronic care management.[1] It is essential that patients and communities have access to value-based primary care to advance health equity and improve health outcomes.

Current policy is preventing primary care practices from entering or expanding ACOs in underserved areas and bringing value-based care to more patients

There is a policy that can be changed through CMS action (sometimes referred to as the "rural glitch") that systematically penalizes certain ACOs in rural areas and other health professional shortage areas, when they are successful at delivering better care at lower costs. It is crucial that ACOs serving underserved communities be supported equitably similar to ACOs in areas awash with specialists.

The MSSP is focused on getting incentives right to encourage participation, and CMS has made improvements to the program through the years to advance that goal. However, when CMS initiated the regional efficiency adjustment in benchmarks, no one foresaw that certain ACOs would be systematically penalized for reducing Medicare expenditures. This happens because an ACO's beneficiary population is included in the regional trend calculation, so they are penalized for making improvements to patient care and achieving savings when CMS determines their benchmark the following year. When an ACO reduces costs, this carries over to also reducing the region's costs and this effect increases the more beneficiaries an ACO has in its region. Unfortunately, many of these ACOs are disproportionately located in areas where there is a shortage of health professionals, such as rural areas and underserved communities, where CMS has stated it wants to see more participation in value-based models.

As these ACOs systematically have diminished incentives, we cannot be surprised that MSSP participation is less in these underserved areas, further contributing to the inequality these communities already face. These beneficiaries will not get better care at lower cost because current policy incentivizes ACOs to avoid them. This runs counter to at least two of the goals in CMS' strategic plan: driving accountable care, and advancing health equity.

A simple solution has broad support

CMS outlined a potential solution to the rural glitch in the 2022 Medicare Physician Fee Schedule that is within the agency's regulatory authority to implement. Many stakeholders in value-based care agree with the proposed solution:

- CMS can remove the effects of an ACO on its regional trend through simple algebra, by calculating the regional benchmark trend without including the ACO's beneficiaries.
- CMS's proposed mathematical solution works well in nearly every case and uses data CMS already produces.

Fixing this policy flaw will address health inequities & drive participation in value-based care

The most encouraging part of CMMI's goal of expanding total cost of care arrangements is the explicit link to achieving equitable outcomes for patients. Focusing on broad health system transformation, in part by expanding total cost of care arrangements, is very much in alignment with advancing equitable outcomes. Fixing this policy flaw will point the arrow in the right direction for increasing participation in accountable care in underserved communities and rural areas.

There is an urgent need to invest in primary care in rural and underserved areas. Aledade's analysis has demonstrated that dozens of counties in these areas are affected by these inequitable policy flaws – and that could jeopardize the viability of independent primary care practices and ACOs in those communities.

A national perspective makes it hard to see the negative impacts, but individual ACOs in underserved areas are greatly harmed

Aledade has many examples of ACOs that are affected by this inequitable policy flaw (or the "rural glitch"). One example, to give a sense, is an ACO in North Carolina that primarily serves African American beneficiaries in rural Craven and Pamlico counties. Their benchmark is currently nearly $300 lower than it would be if its own beneficiaries were not being included. This translates to an additional $3 million in savings that ACO practices and patients are not able to access because of the current policy flaw that other ACOs in more urban areas don't have. That means $3 million less to reinvest into their practices to continue providing quality care to the communities they serve.

We need to send the right signal to the health care community. Current policies reinforce inequality and say "stay clear of health professional shortage areas and underserved communities." We should flip that script so that public policy encourages ACOs to locate and expand in underserved communities, not avoid them.

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[1] https://www.ajmc.com/view/more-than-beating-the-benchmark-5-medicare-acos-2015-2019