Resolving the MSSP's Rural Glitch

A proposed solution to level-set benchmarking methodologies for ACOs

Introduction

In 2016, the Centers for Medicare and Medicaid Services (CMS) changed the benchmarking methodology for accountable care organizations (ACOs) entering their second or third contracts. Most notably, it introduced the concepts of a regional benchmark, which is used to compare the ACO's risk-adjusted costs to that of its neighbors, and of regional trends that update the benchmark annually, based largely on regional changes in Medicare costs. Introducing regional costs and trends was a much needed change to support the Medicare Shared Savings Program's (MSSP) sustainability. By distancing itself from historical-only benchmarks, CMS has made it feasible for experienced providers that have been in multiple ACO agreements to continue participating in the program and provide high-value, low-cost care to beneficiaries.

In creating the regional trends and benchmarks CMS did not remove ACO beneficiaries from regional comparisons. Because the ACO's own population is included in the "neighbor comparison," ACOs end up having to fight against the progress they've made. This created a situation where ACOs can perform the same but receive different shared savings payments. We refer to this phenomenon as the "rural glitch." The rural glitch affects all ACOs, regardless of market penetration, but it harms those with the highest penetration the most. When Aledade first wrote about this, ACOs with a large market share tended to be in more rural areas.

Since then, the MSSP underwent a major transformation with the creation of Pathways to Success. Among the changes, CMS reintroduced national cost trends (national times market share) blended with regional trends (regional times one minus market share). This solution has two major flaws. First, most of the ACO's trend continues to be affected by the rural glitch. For 2019A, the first year of the Pathways program, the average ACO had a market share of 18 percent. Despite CMS's attempted fix, 82 percent of the ACO's benchmark and trend is still being affected by the rural glitch. Second, by using national inflation trends, this introduces variations that are not linked to ACO performance, but rather to whether the ACO is in a region where inflation was higher or lower than the nation.

Let's set aside rural glitch for a bit and focus just on why using a regional-national blended trend not only leaves 82 percent, on average, of the problem unaddressed, but also brings back the misaligned incentives of using national inflation. Santa Fe county in New Mexico had an inflation rate of 1.1096 for their aged non-dual population between 2018 and 2019. On the other hand, Napa county in California had an inflation rate of 1.007. Using only regional trends, an ACO with the exact same population would have an updated benchmark of $11,096 in Santa Fe[1] versus $10,070 in Napa. However, by inserting national inflation into the equation, that benchmark can change drastically for an ACO with a larger market share. If the ACO has a market share of 40 percent, the national-regional blend trend takes the Napa benchmark to $10,214 (+$144) while reducing the Santa Fe ACO's benchmark to $10,830 (-$266). Table 1 below shows how using a blended trend affects the benchmark compared to using only the regional trend, based on the ACO's market share.

	Inflation Trend		Benchmark Under	Effect of Blended Trend based on Market Share Relative to Regional Only Benchmark			
	Regional	National	Regional Only	5%	10%	20%	40%
ACO A	0.98	1.04	$9,800	$30	$60	$120	$240
ACO B	1.00	1.04	$10,000	$20	$40	$80	$160
ACO C	1.02	1.04	$10,200	$10	$20	$40	$80
ACO D	1.04	1.04	$10,400	$0	$0	$0	$0
ACO E	1.06	1.04	$10,600	-$10	-$20	-$40	-$80
ACO F	1.10	1.04	$11,000	-$30	-$60	-$120	-$240

Table 1

[1] *Assuming a historical benchmark of $10,000 and no risk growth.*

Now, back to the rural glitch. An ACO that's successful in slowing down spending growth is penalized for that by having its beneficiaries included in the regional trend. As we mentioned, CMS tried to address this by creating a blended trend that replaces a percentage of the regional trend with the national trend. Setting aside all the demonstrated concerns with national inflation, this blended trend still leaves most of the trend affected by the rural glitch.

At the beginning of a performance period, CMS sets the ACO's historical benchmark, which includes a regional adjustment of 15 to 50 percent based on whether the ACO has costs higher or lower than its region and the agreement period number. For the following example, let's take an ACO with a historic benchmark of $10,000.

At the end of the performance year, the ACO has reduced costs by 1 percent while the region has grown by 3 percent. The trend used to update the ACO's benchmark *should* be *1.03* for an updated benchmark of $10,300. But, because of the rural glitch, the inclusion of the ACO's beneficiaries in the region results in a trend of 1.018. The ACO's updated benchmark is instead $10,180 — $120 lower than it would have been in a non-glitched world. This difference in benchmark results in 3.88 percent versus 2.75 percent of savings created. For an ACO of 10,000 patients that's the difference between earning $2 million in shared savings or making no money at all.[2]

Even though the ACO had expenditures below its benchmark **and** grew costs more slowly than the region, it was not enough to make savings. Table 2 shows how the same ACO's shared savings would be affected at different market shares.

Market Share	Shared Savings Under:		Savings Rate Under:	
	Rural Glitch	Fixed Version	Rural Glitch	Fixed Version
5%	$1,900,000	$2,000,000	3.70%	3.88%
10%	$1,800,000	$2,000,000	3.51%	3.88%
15%	$1,700,000	$2,000,000	3.32%	3.88%
20%	$1,600,000	$2,000,000	3.13%	3.88%
25%	-	$2,000,000	2.94%	3.88%
30%	-	$2,000,000	2.75%	3.88%
35%	-	$2,000,000	2.56%	3.88%
40%	-	$2,000,000	2.37%	3.88%
45%	-	$2,000,000	2.17%	3.88%
50%	-	$2,000,000	1.98%	3.88%

Table 2

The rural glitch works the other way too — it creates a cushion for ACOs that aren't regionally efficient and that don't do a good job of controlling costs. If an ACO (with the same market share in the same hypothetical region) was regionally inefficient and increased costs by 3.5 percent while the region remained flat, the ACO would be protected from having to pay back $1,050,000 in losses.[3]

2 *MSR for a 10,000 beneficiary ACO is 3.0%. Assumes 100% quality and 50% split with CMS for savings.*

3 *Assumes a 30% shared losses split with CMS, which is used in BASIC E.*

Methods

To inform our proposed policy of removing an ACO's beneficiaries when calculating regional trends, we quantified the cost that fixing the rural glitch would have for the government due to increased (but well deserved) higher shared savings.

The model was developed using CMS' different public use files (PUFs). County-level data only goes back to 2014, which poses a limitation for recreating benchmarks since they are based on the three years prior to the ACO's agreement start period. This forced the analysis to be limited to ACOs that started in 2017 or later. For simplicity, it also only looked at ACOs in their first agreement period. This analysis includes 96 ACOs for performance year 2017, 212 for 2018, and 193 for 2019. 2019 uses data from the January to July performance period and is annualized to present numbers for 12 months (i.e., does not account for half year savings).

There are three benchmarks to consider when trying to figure out the government cost of fixing rural glitch. First, the benchmark that CMS used to determine savings against during the actual performance year. This is the benchmark that is found in the PUFs. Second, the benchmark an ACO would have if the rural glitch was fixed. Our definition of a fixed benchmark uses only the regional trend and removes the ACO's beneficiaries, starting in the first contract. Third, the benchmark an ACO would have if the Pathways to Success program had been in place from 2017 to 2019.[4, 5]

We decided it was necessary to create that third benchmark because the program has fundamentally changed since we first raised the rural glitch issue in 2018. In order to estimate the effects of fixing the rural glitch, it was necessary to compare it to the current Pathways program and benchmarking methodology, not to the rules that were used when regional benchmarks were first introduced.

All models allow the ACO's risk score to increase by up to 3 percent from BY3 and use the PY proportions found in the *Number of ACO Assigned Beneficiaries by County PUF* for the three benchmark years.

Findings

Our findings suggest that CMS would have paid an average of $105 per beneficiary per year in shared savings for the cohort of ACOs in our analysis. This is $9 higher than what they would have paid under the Pathways rules ($96 per beneficiary). This is to be expected, as we would expect ACOs to outperform their non-ACO neighbors. Over 10 years, assuming there are 10million beneficiaries in the program with no growth, this would cost $931 million. However, fixing the rural glitch is valuable because it encourages ACOs all across the country and not just in advantaged markets. CMS benefits greatly from higher MSSP participation with direct savings plus spillover effects from ACO-type care coordination being provided to beneficiaries not attributed to an ACO.

[4] *Benchmarks are a best estimate. CMS does not publish full data for counties where there are less than 10 beneficiaries in a Medicare eligibility category, which causes there to be some counties for which an inflation trend cannot be calculated. In these cases we assumed inflation to be equal to 1.*

[5] *CMS does not publish full data for ACO's where they have less than 10 beneficiaries in a given county. This causes the calculated ACO market share to be slightly larger than the actual value and regional trends to differ slightly from actuals.*

In 2018, CMS estimated the combination of direct savings and spillover to be $222 per beneficiary.[6] We used a conservative spillover amount of $194 per beneficiary, which subtracts the difference between the original cost per beneficiary and the cost of fixing the rural glitch from CMS's spillover amount.[7] Assuming 2 percent growth in the program per year, fixing the rural glitch leads to savings of $821 million for CMS over 10 years (Figure 1). However, you only need the program to grow by a mere 1 percent each year to break even on the cost of fixing rural glitch. At three percent growth the program is saving CMS nearly $2 billion. Essentially, the more the program grows, the more Medicare saves.

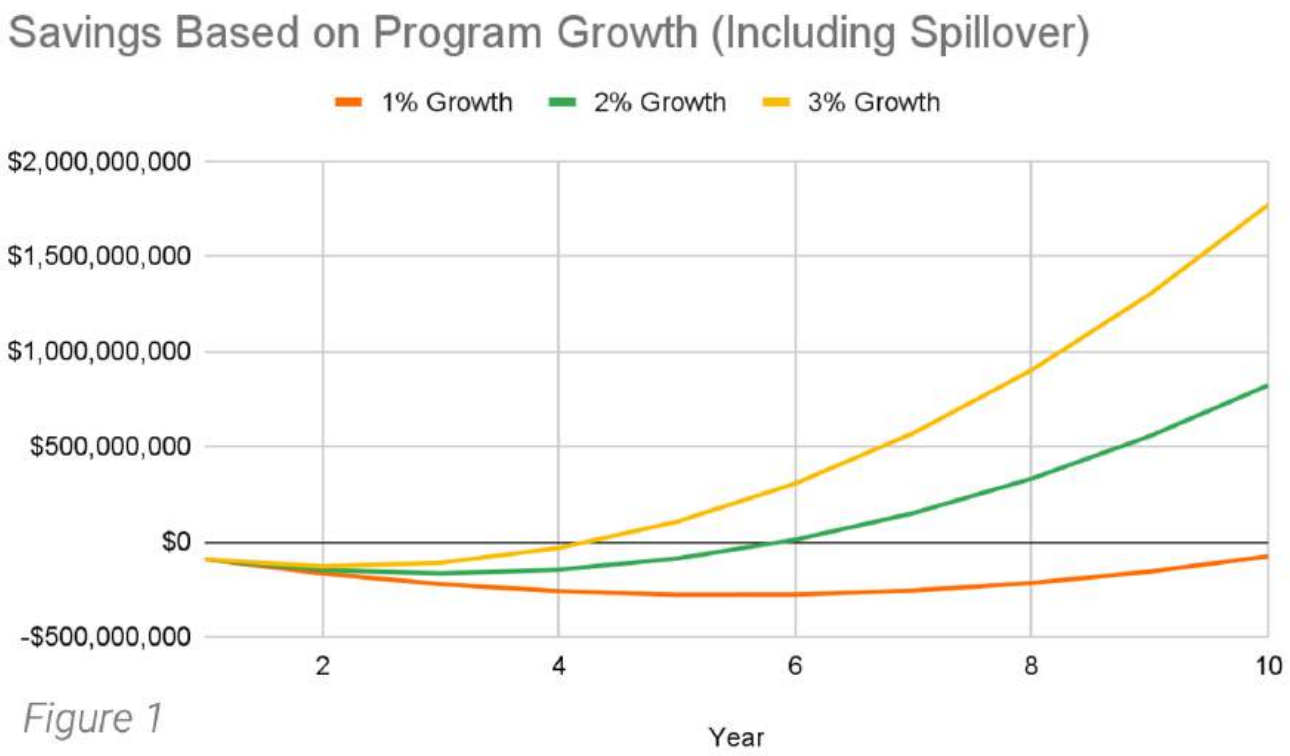

Figure 1

Conclusion

CMS has acknowledged this issue in the 2022 Proposed Physician Fee Schedule and is requesting comments on the best way to ensure benchmarks do not penalize ACOs for the work they are doing. The fix CMS proposes, which was initially suggested by Aledade, is simple to implement and has universal support from a diverse coalition of policy makers. Aledade will be submitting our formal comments in September, but we urge CMS to finalize a rural glitch fix in this rulemaking cycle instead of delaying it yet another year.

6 ACOs were responsible for roughly 0.5% lower FFS spending in 2016 after accounting for shared savings payment. This is about $1.75 billion in FFS spending divided by the 7.88 million beneficiaries attributed to ACOs that year.

7 $222 - ($105 - $77) = $194.