Analysis of Policy Options to Reduce the Impact of COVID-19 on ACO Benchmarks

Institute for Accountable Care

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Analysis for Discussion Today

1. **Purpose**: NAACOS asked the IAC to analyze the impact of removing 2020 spending from MSSP benchmarks because of concern that health care spending volatility due to COVID-19 (and beyond ACO's control) could lower benchmarks for ACOs entering new 5-year agreement periods beginning in 2022.
2. **Analysis**: Impact of using 2017 – 2019 spending (trended to 2020) to calculate historical MSSP benchmarks compared with using 2018 – 2020 spending. COVID episodes are removed from 2020 spending and from 2019-20 trend rates.
3. **Data**: All analyses are conducted using 100% Medicare claims data files from CMS Virtual Research Data Center following current MSSP program rules.

Note: 142 current MSSP ACOs will start a new agreement period in 2022. No other current MSSP ACOs are affected.

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Conceptual Model of the Impact of Including vs. Dropping 2020 Spending for MSSP Benchmark Calculation

Hypothesis: Depressed 2020 spending could depress 2022 and future MSSP benchmarks

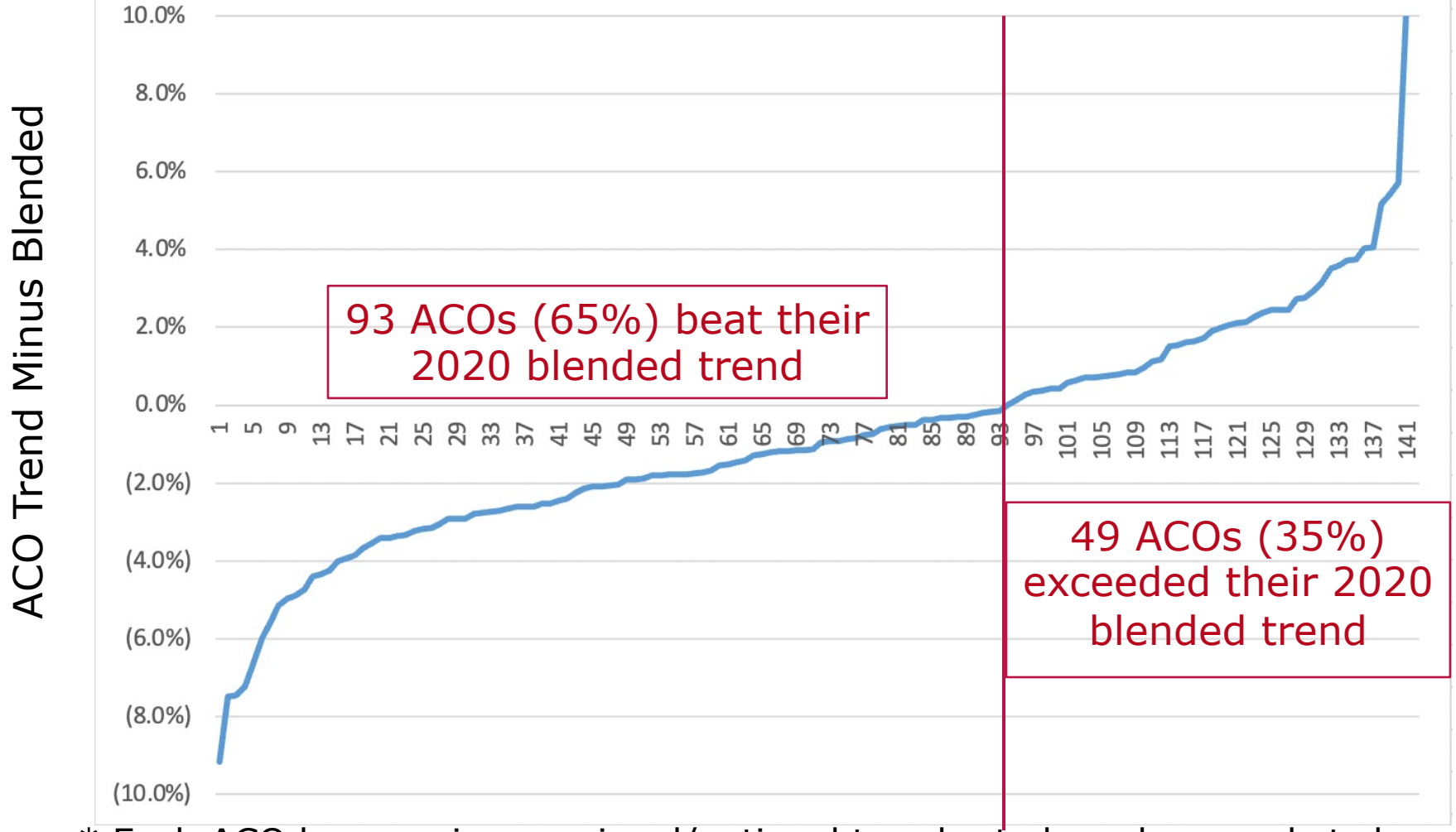
	2017	2018	2019	BY3 Historical Benchmark	Updated to 2020
Benchmark 2017-2019	$10,000	$10,300	$10,609	$10,609	$9,760
	2017	**2018**	**2019**	**2020**	**BY3 Historical Benchmark**
Benchmark 2018-2020		$10,300	$10,609	$9,760	$9,760
	2017	**2018**	**2019**	**2020**	
Regional Blended Trend	3.0%	3.0%	3.0%	-8.0%	

Assumptions: ACO spending grows at regional trend rate, no regional/national blending, risk scores stay constant, benchmark years weighted at 33.3% each.

Conclusion: Theoretically, the annual trend factor could offset the impact of depressed 2020 spending due to COVID-19. This holds when the ACO 2019 – 20 trend equals the regional trend. But ACO benchmarks could rise or fall due to within region spending variation driven by COVID-19

ACOs' 2019 - 2020 Spending Trends Varied Substantially from Their Regional Trend*

Graph Shows Change in ACOs' 2019 -2020 PMPY Spending MINUS Regional/National Trend



* Each ACO has a unique regional/national trend rate based on market share.

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Results

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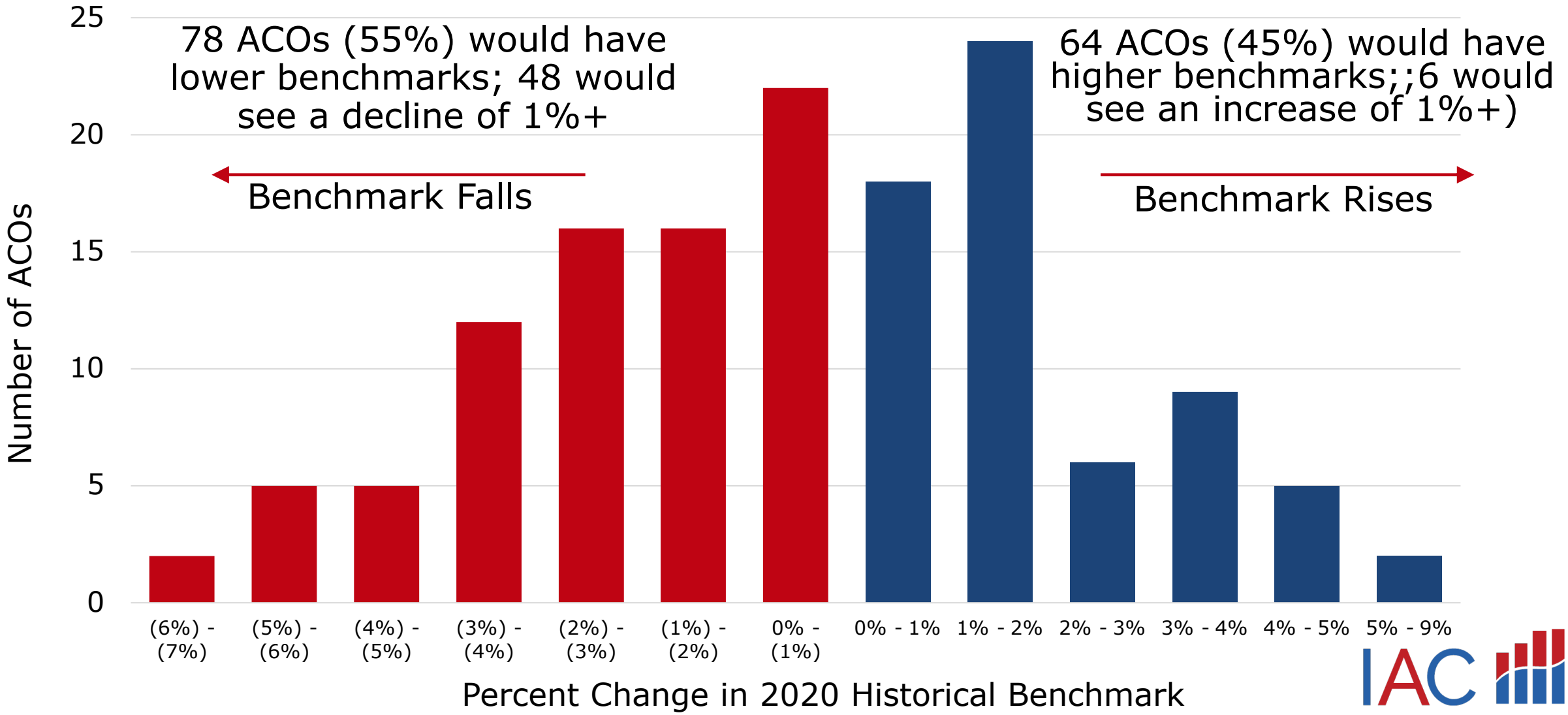
Estimated Impact of Dropping 2020 from ACO Benchmark Calculation[1] (Percent change from using 2017–19 vs. 2018–20 as benchmark years)



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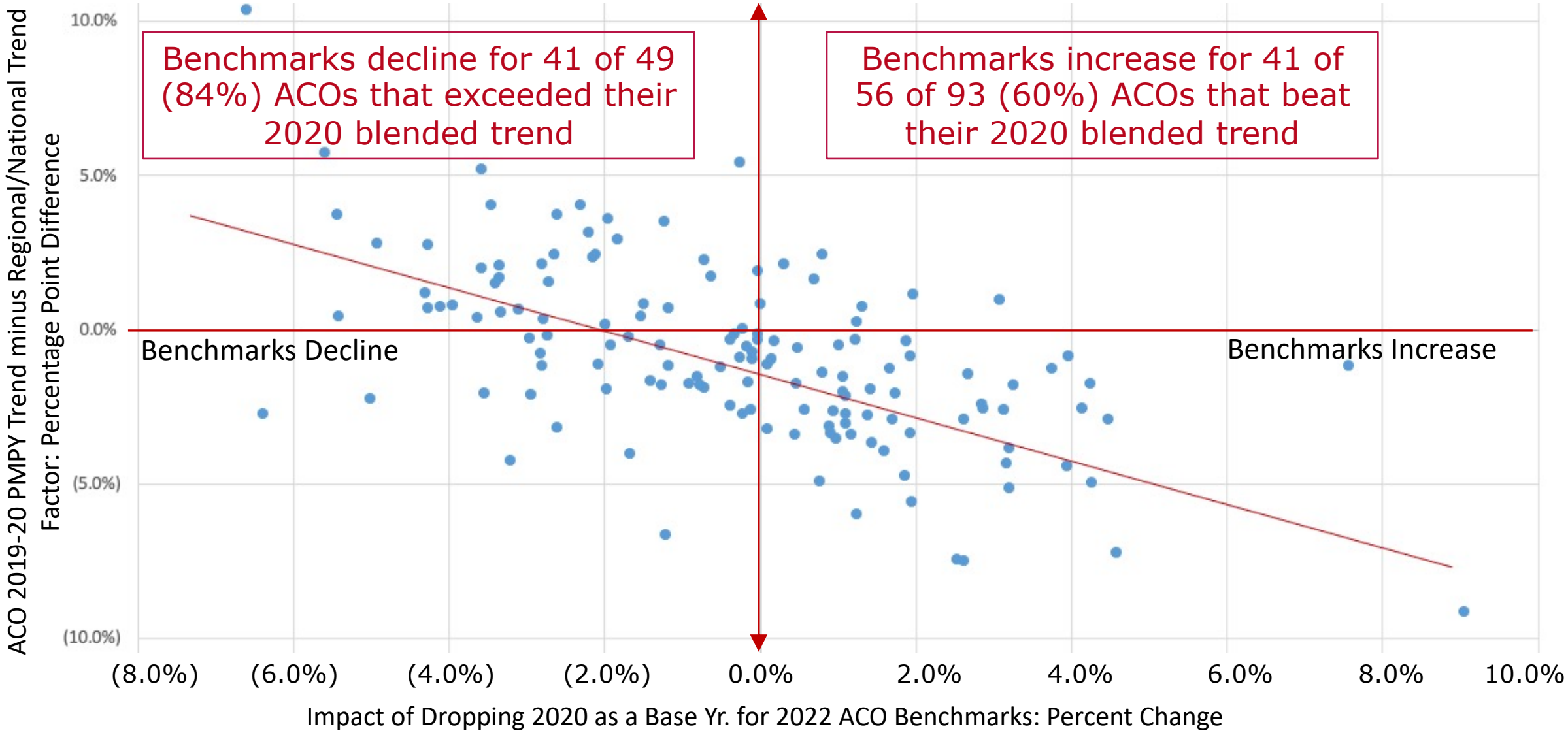
Dropping 2020 as a Base Yr. for 2022 Benchmark Generally Helps ACOs That Beat their Region's 2019-20 Trend Rate and Hurts Those That Exceeded It (N=142*)



Characteristics of ACOs With Benchmarks That Increase versus Decrease When 2020 is Excluded

	Benchmarks Rise if 2020 is Excluded	Benchmarks Fall if 2020 is Excluded
Number of ACOs	64	78
2020 Savings > 2%	63%	49%
Started MSSP in 2012-2016	41%	31%
Two-sided in 2020	17%	15%
Size > Median (12,723 benes)	47%	67%
High Revenue	67%	77%
Percent PCP > Median (39.8%)	45%	24%

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Methods

- Analysis conducted using 100% Medicare claims data in the VDRC.[1]
- Conduct ACO attribution based on preliminary 2021 provider lists for calendar years 2017 – 2020 per MSSP attribution rules.[2,3]
- Calculate monthly beneficiary-level eligibility status and spending for attribution-eligible and attributed benes.[4]
- Calculate PMPY spending by eligibility category for each ACO and each US county; PMPY spending is annualized and truncated per MSSP rules.
- For 2020, remove spending and beneficiary months for COVID-19 episodes as defined by CMS.
- Calculate prospective beneficiary-level risk scores for 2017-20 using HCC groupers from CMS web site.[5]
- For each ACO, calculate county weights by eligibility category.
- For each ACO calculate PMPY spending and average risk score by eligibility category for ACO region.
- Using these files, estimate each ACOs historical benchmark under two scenarios: 1) 2017 – 2019 benchmark years trended forward to 2020; 2) 2018 – 2020 benchmark years.

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Methodology Notes

VRDC Users Lack Full Access to the Information Used by CMS to Calculate Benchmarks

1. We use annual data files for 2017 – 2019 and monthly data files for 2020 with somewhat different runout

2. We use preliminary 2021 provider lists that are not updated to reflect current FQHC and RHC participation

3. We lack data on NGACO prospectively attributed beneficiaries (which are not eligible to be attributed to MSSP ACOs) and rely on estimates created by compiling NPIs from NGACO websites and calculating prospective attribution for these NPIs.

4. Monthly beneficiary eligibility flags in MBSF differ from what CMS uses for benchmark calculation. Most important difference is in ESRD status.

5. The risk scores we calculate differ somewhat from national and county averages published by CMS; we calculate our own renormalization factors so that our risk scores are internally consistent. We cannot calculate risk scores separately for institutionalized beneficiaries because information about institutional status available in the VRDC is outdated.

Recommendation: CMS should make the actual beneficiary-level monthly eligibility status and prospective annual risk scores used for MSSP benchmarks available to researchers

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