Issue Brief

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KEY POINT

- Median estimate of the financial impact of the Shared Savings Program for calendar years 2017 – 2019 would be net federal savings of $120 million greater than what would have been saved if no changes were made.

CMS Proposes Benchmarking Changes to the Shared Savings Program

The Centers for Medicare & Medicaid Services has issued a proposed rule that would update the methodology used to calculate the benchmarks of accountable care organizations that continue their participation in the Medicare Shared Savings Program after an initial three-year agreement period.

A copy of the document is available at: https://www.federalregister.gov/articles/2016/02/03/2016-01748/medicare-program-medicare-shared-savings-program-accountable-care-organizations----revised-benchmark. The proposed 199 page document is scheduled to be published in the Feb. 3rd *Federal Register*. The above link will change upon publication. A 60-day comment period is being provided. Unless otherwise noted, these changes would be effective 60 days after publication of the final rule.

COMMENT

In reading through this proposal, it is apparent that the Medicare program is becoming more and more complex than ever. The adjustments being discussed seem overwhelming. The issue of quality care is no longer apparent or paramount. Rather, the focus is on simply reducing Medicare outlays. This proposal does not even include a table of contents. Previous rulemaking usually included a table of contents even though page numbers were never provided. The lack of page numbers makes it difficult for the reader to easily locate specific issues.

BACKGROUND

According to the proposal, the Medicare Shared Savings Program now includes 434 ACOs serving more than 7.7 million Medicare beneficiaries nationally.

CMS says the proposed rule is designed to improve program function and transparency. To achieve these goals, CMS proposes to make the following modifications to the current program.

- Modifying the methodology for rebasing and updating ACO historical benchmarks when an ACO renews its participation agreement for a second or subsequent agreement period to incorporate regional expenditures, thereby making the ACO's cost target more independent of its historical expenditures and more reflective of FFS spending in its region.
- Modifying the methodology for risk adjustment to account for the health status of the ACO's assigned population in relation to FFS beneficiaries in the ACO's regional service area, and to apply this approach in determining the regional adjustment that is

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applied to the ACO's rebased historical benchmark.

- Revising the methodology for adjusting ACO benchmarks to account for changes in ACO participant composition.
- Adding a participation agreement renewal option to encourage ACOs to enter performance-based risk arrangements earlier in their participation in the Shared Savings Program.
- Defining circumstances under which CMS would reopen payment determinations to make corrections after the financial calculations have been performed and ACO shared savings and shared losses for a performance year have been determined.

SUMMARY OF COSTS AND BENEFITS

The median estimate of the financial impact of the Shared Savings Program for calendar years 2017 through 2019 would be net federal savings of $120 million greater than what would have been saved if no changes were made.

PROVISIONS OF THE PROPOSED REGULATIONS

Integrating Regional Factors When Resetting ACOs' Benchmarks

CMS proposes to determine an ACO's regional service area by the counties of residence of the ACO's assigned beneficiary population.

These calculations will be undertaken separately according to the following populations of beneficiaries (identified by Medicare enrollment type): end stage renal disease, disabled, aged/dual-eligible, aged/non-dual eligible. Further, CMS proposes to determine expenditures for ESRD beneficiaries statewide, and apply these amounts consistently to each county within a state.

Establishing the Beneficiary Population Used to Determine Expenditures for an ACO's Regional Service Area

CMS proposes using all assignable beneficiaries, including ACO-assigned beneficiaries, in determining expenditures for the ACO's regional service area to ensure sufficiently stable regional mean expenditures. CMS proposes to define the ACO's regional service area to include any county where one or more assigned beneficiaries reside. CMS also proposes to include the expenditures for all assignable FFS beneficiaries residing in those counties in calculating county FFS expenditures by enrollment type that will be used in the ACO's regional cost calculations. Further, CMS proposes to weight county-level FFS expenditures by the ACO's proportion of assigned beneficiaries in the county, determined by the number of the ACO's assigned beneficiaries residing in the county in relation to the ACO's total number of assigned beneficiaries.

Determining County FFS Expenditures

CMS is proposing the following approach to calculating county FFS expenditures.

- Determine county FFS expenditures based on the expenditures of the assignable population of beneficiaries in each county, where assignable beneficiaries are identified for the 12-month period corresponding to the applicable calendar year.
- Calculate assignable beneficiary expenditures using the payment amounts included in Part A and B FFS claims with dates of service in the 12-month calendar year for the relevant benchmark or performance year, allowing for a three-month claims run out and applying a completion factor. The completion factor will

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be calculated based on national FFS assignable beneficiary expenditures.

++ These calculations will exclude IME, DSH, and uncompensated care payments.
++ These calculations will take into consideration individually beneficiary identifiable payments made under a demonstration, pilot or time limited program

- Truncate a beneficiary's total annual Parts A and B FFS per capita expenditures at the 99th percentile of national Medicare FFS assignable beneficiary expenditures as determined for the relevant year to minimize variation from catastrophically large claims. CMS would determine truncation thresholds separately for each of the four Medicare enrollment types (ESRD, disabled, aged/dual eligible, aged/non-dual eligible).
- Adjust county FFS expenditures for severity and case mix of assignable beneficiaries in the county using prospective CMS- Hierarchical Condition Category risk. CMS would determine average risk scores separately for each of the four Medicare enrollment types (ESRD, disabled, aged/dual eligible, aged/non-dual eligible).

Proposals for Applying Regional Expenditures to the ACO's Rebased Benchmark

CMS is proposing to calculate the ACO's rebased benchmark using historical expenditures for the beneficiaries assigned to the ACO in the 3 years prior to the start of its current agreement period, applying equal weights to the benchmark years, but not accounting for shared savings generated by the ACO in its prior agreement period. CMS proposes to adjust the ACO's rebased historical benchmark to reflect risk adjusted regional average expenditures, based on county FFS expenditures determined for the ACO's regional service area.
CMS proposes to revise section § 425.602 to limit the scope of the provision to establishing, adjusting, and updating the benchmark for an ACO's first agreement period. CMS proposes to specify in a new regulation at § 425.603 how the benchmark would be reset for a subsequent agreement period, including the proposed methodology for adjusting an ACO's rebased historical benchmark to reflect FFS expenditures in the ACO's regional service area in the ACO's second or subsequent agreement period starting on or after Jan. 1, 2017. Further, CMS proposes to make conforming and clarifying revisions to the provisions of § 425.602, including to: revise the title of the section; remove paragraph (c) from § 425.602 and incorporate this paragraph in the new regulation at § 425.603; and to add a paragraph that describes the adjustments made to the ACO's historical benchmark during an ACO's first agreement period to account for changes in severity and case mix for newly and continuously assigned beneficiaries as presently specified under § 425.604, § 425.606, and § 425.610.

CMS proposes to incorporate the following proposed policies regarding the weight to be applied in determining the regional adjustment in a new regulation at § 425.603.

- Calculate the regional adjustment in the ACO's second agreement period by applying a weight of 35 percent to the difference between regional average expenditures for the ACO's regional service area and the ACO's rebased historical benchmark expenditures.
- In the ACO's third and subsequent agreement periods, the percentage used in this calculation would be set at 70 percent unless the Secretary determines a lower weight should be applied as specified through future rulemaking.

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Proposals for Regional Growth Rate as a Benchmark Trending Factor

CMS is proposing to replace the national trend factors used for trending an ACO's benchmark year 1 and BY 2 expenditures to BY 3 in calculating an ACO's rebased historical benchmark with regional trend factors derived from a weighted average of risk adjusted FFS expenditures in the counties where the ACO's assigned beneficiaries reside.

Proposals for Modifying the Calculation of National FFS Expenditures, Completion Factors and Truncation Thresholds Based on Assignable Beneficiaries

CMS is proposing to use the authority under section 1899(i)(3) of the Act to revise the regulation at § 425.602(b)(1) to specify that the annual update to the benchmark will be based on the projected absolute amount of growth in national per capita expenditures for Parts A and B services under the original Medicare FFS program for assignable beneficiaries. CMS further proposes to specify in this provision of the regulations that it will identify assignable beneficiaries for the purpose of calculating the update based on national FFS expenditures using the 12-month calendar year corresponding to the year for which the update is being calculated.

Proposed Timing of Applicability of Revised Rebasing and Updating Methodology

CMS is proposing to make these changes applicable to ACOs starting a second or subsequent agreement period on or after Jan. 1, 2017.

Summary of the above items

The following CMS table summarizes the proposals discussed in this section of the proposed rule, including the percentage (weight) to be used in calculating the amount of the adjustment for regional FFS expenditures to be applied to the ACO's rebased historical benchmark, using regional (instead of national) trend factors in establishing an ACO's rebased historical benchmark, using regional (instead of national) FFS expenditures to update the ACO's benchmark for each performance year, and the timing of the applicability of the proposed new rebasing methodology.

CHARACTERISTICS OF CURRENT AND PROPOSED BENCHMARKING APPROACHES

Source of Methodology	Agreement Period	Historical Benchmark Trend factors (Trend BY1, BY2 to BY3)	Adjustment to the historical benchmark for regional FFS expenditures (percentage applied in calculating adjustment)	Adjustment to the historical benchmark for savings in prior agreement period?	Adjustment to the historical benchmark for ACO Participant List changes	Adjustment to historical benchmark for health status and demographic factors of performance year assigned beneficiaries	Update to historical benchmark for growth in FFS spending
Current Methodology	First	National	N/A	N/A	Calculated using benchmark year assignment based on the ACO's certified ACO Participant List for the performance year	Newly assigned beneficiaries adjusted using CMS-HCC model; continuously assigned beneficiaries adjusted using demographic factors alone unless CMS-HCC risk scores result in a lower risk score	National
	Second and subsequent	National	N/A	Yes	Same as methodology for first agreement period	Same as methodology for first agreement period	National
Proposed Rebasing Methodology	Second (third for 2012/2013 starters)	Regional	Yes (35 percent)	No	ACO's rebased benchmark adjusted by expenditure ratio*	No change	Regional
	Third and subsequent (fourth and subsequent for 2012/2013 starters)	Regional	Yes (70 percent unless the Secretary determines a lower weight should be applied, as specified through future rulemaking)	No	Same as proposed methodology for second agreement period	No change	Regional

* Proposed adjustment to the historical benchmark for ACO Participant List changes using an expenditure ratio would be a program-wide change applicable to all ACOs including ACOs in their first agreement period. As part of the proposed rebasing methodology, the regional adjustment to the ACO's rebased historical benchmark would be recalculated based on the new ACO Participant List.

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Adjusting Benchmarks for Changes in ACO Participant Composition

CMS proposes to replace the current approach for calculating adjusted historical benchmarks for ACOs that make ACO participant list changes with an approach that adjusts an ACO's historical benchmark using a ratio that is based on expenditures for the ACO's beneficiaries assigned using both the ACO participant list for the new performance year and the ACO participant list for the most recent prior performance year (stayers) and expenditures for the ACO's beneficiaries assigned using only the ACO participant list for the ACO's most recent prior performance year (stayers and leavers) for the same reference year. CMS proposes to define the reference year as benchmark year three of the ACO's current agreement period. This figure would then be combined with reference year expenditures for beneficiaries assigned using only the ACO participant list for the new performance year (joiners) to obtain the overall adjusted benchmark.

Facilitating Transition to Performance-Based Risk

To respond to stakeholder concerns and to provide additional support for ACOs that are willing to accept performance-based risk arrangements, CMS is proposing to add a participation option that would allow eligible Track 1 ACOs to defer by one year their entrance into a performance-based risk model (Track 2 or 3) by extending their first agreement period under Track 1 for a fourth performance year.

Administrative Finality: Reopening Determinations of ACO Savings or Losses to Correct Financial Reconciliation Calculations and a Conforming Change

Under § 425.314(a)(4), if as a result of any inspection, evaluation or audit, it is determined that the amount of shared savings due to the ACO or the amount of shared losses owed by the ACO has been calculated in error, CMS reserves the right to reopen the initial determination and issue a revised initial determination. (See CMS' website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/Reconsideration-Review-Process-Guidance.pdf).

CMS says it is concerned that the current uncertainty regarding the timeframes and other circumstances in which it would reopen a payment determination to correct financial calculations under the Shared Savings Program could introduce financial uncertainty that could seriously limit an ACO's ability to invest in additional improvements to increase quality and efficiency of care.

CMS is proposing that it would have discretion to reopen a payment determination at any time in the case of fraud or "similar fault."

CMS is proposing that it have the discretion to reopen a payment determination, within four years after the date of notification to the ACO of the initial determination of shared savings or shared losses for the relevant performance year, if there is good cause.

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting