Medicare Shared Savings Program: Accountable Care Organization

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Medicare Shared Savings Proposed Rule

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Makes Changes to benchmarking rebasing methodology used in the MSSP program.

Modifies method for rebasing and updating ACO historical benchmarks to incorporate regional expenditures when an ACO renews participation agreement for second or subsequent agreement period

CMS seeks to reflect an ACO’s performance against providers in same market (instead of measuring based on its past performance)
To analyze impact on your institution, here are the data sources

- Number of ACO Assigned Beneficiaries by County: total assigned beneficiaries by ACO for each county where at least 1 percent of their assigned beneficiaries reside for 2012, 2013, 2014)
  - [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Statutes-Regulations-Guidance.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Statutes-Regulations-Guidance.html)
Medicare Shared Savings Approach

• ACOs are paid under fee for service
• To receive a shared savings payment must meet quality performance standards and generate shareable savings based on CMS payment methodology
• Savings: (1) actual assigned patient population expenditures are below the established benchmark and (2) the performance year expenditures meet or exceed the minimum savings rate (MSR)
MSSP ACO Tracks

**Track I**
Upside only: not accountable for losses
May share in the savings under Medicare; after first agreement ends, renew under Track 2.
- The MSR varies based on the size of the ACO’s population

**Track 2**
2-sided risk
ACOs: Share in the Savings and Losses. Can share a higher percentage of the savings than track one.
MSR is 2% of the benchmark.

**Track 3**
More down-side risk
Beginning 1/1/16, may share 75% of any shared savings earned in exchange for greater assumption of downside risk
Prospective assignment of beneficiaries and a waiver of the Skilled Nursing Facility (“SNF”) three-day qualifying hospital stay rule
Current Benchmarking Method: Measuring ACO Performance

Evaluate ACO’s effectiveness in lowering expenditures for assigned beneficiaries against a benchmark reflective of the ACO’s historical cost.

CMS sets average per capita historical benchmark at beginning of ACO’s first 3 year agreement

Benchmark based on Part A and B Medicare FFS expenditures for beneficiaries who would have been assigned to the ACO in each of 3 years prior to start of ACO agreement

Second agreement period: Adjustments to reflect the average per capita amount of savings generated by the ACO in its prior agreement period
## Current ACO Benchmark Calculation

<table>
<thead>
<tr>
<th>Baseline</th>
<th>Updates</th>
<th>Risk Adjust</th>
</tr>
</thead>
</table>
| • Determined at start of agreement period  
  • Uses 3 years of historical data on expenditures under Part A and B from assigned beneficiaries  
  • For ACO’s in first agreement, benchmark years are weighted (year 1: 10%; year 2: 30%; year 3: 60%)  
  • First 2 benchmark years are trended forward to 3rd benchmark year for growth rates based on national FFS expenditures. | • Annual update of benchmark based on the projected absolute amount of growth in national per capita expenditures for Parts A and B (Adjusted for changes to list of ACO participants identified by TINs) | • Adjusted on an annual basis for beneficiary characteristics  
  • Uses Hierarchal Condition Categories (HCC model) |
Proposed Changes to Benchmark

For second and subsequent agreements only

- Applies to ACOs with second & subsequent agreements beginning 2017 or later
- Use regional trend factor to establish the ACO’s rebased historical benchmark
- Remove adjustment to account for savings generated under ACO’s prior agreement period
- Rebase the historical benchmark to reflect a percentage of the difference between the regional FFS expenditures in ACO’s regional service area and the ACO’s historical expenditures (start with 35%)
- Annually update the rebased benchmark to account for changes in regional FFS spending
Proposal: Regional Service Area

- Determined by counties of residence of ACO’s assigned beneficiaries (1296 counties)
- Would include any county where one or more beneficiaries assigned to that ACO reside
- Would weight county-level FFS costs by the proportion of the ACO’s assigned beneficiaries in the county.
Proposal: Regional Costs

- Use only county FFS expenditures
- Costs determined for 4 categories of enrollees:
  - Disabled
  - Aged/dual-eligible
  - Aged non-dual eligible
  - ESRD (uses statewide data)

Indirect medical education (IME), DSH payments and uncompensated care payments are excluded from calculation.
Beneficiary Population Used to Determine Regional Expenditures

- Use all “assignable beneficiaries,” including ACO-assigned beneficiaries in determining expenditures for the ACO’s regional service area.

- “Assignable Beneficiaries”: received at least 1 primary care visit from any physician who is a Medicare enrolled primary care physician or a physician with primary specialty designation for purposes of ACO assignment in the ACO shared savings program during the 12-month assignment window.
## Characteristics of Current and Proposed Benchmarking Approaches

<table>
<thead>
<tr>
<th>Benchmark Approach</th>
<th>Agreement Period</th>
<th>Historical Benchmark Trend Factors (BY1, 2,3)</th>
<th>Adjustment to Historical Benchmark for Regional FFS expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Methodology</td>
<td>First Agreement</td>
<td>National</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Second Agreement</td>
<td>National</td>
<td>N/A</td>
</tr>
<tr>
<td>Proposed Methodology</td>
<td>Second Agreement</td>
<td>Regional</td>
<td>Yes (35%)</td>
</tr>
<tr>
<td></td>
<td>Third and Subsequent Agreement</td>
<td>Regional</td>
<td>Yes (70%) unless CMS decides to use lower weight</td>
</tr>
</tbody>
</table>
### Current and Proposed Benchmarking Approaches

<table>
<thead>
<tr>
<th>Benchmark Approach</th>
<th>Agreement Period</th>
<th>Adjustment to historical benchmark for savings in prior agreement pd.</th>
<th>Adjustment to Historical Benchmark for ACO Participant List Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Methodology</td>
<td>First Agreement</td>
<td>N/A</td>
<td>Calculated using benchmark year assignment based on ACO’s certified ACO Participant List for Performance yr.</td>
</tr>
<tr>
<td></td>
<td>Second Agreement</td>
<td>Yes</td>
<td>Same as first agreement period methodology</td>
</tr>
<tr>
<td>Proposed Methodology</td>
<td>Second Agreement</td>
<td>No</td>
<td>ACO’s rebased benchmark adjusted by expenditure ratio</td>
</tr>
<tr>
<td></td>
<td>Third and Subsequent Agreement</td>
<td>No</td>
<td>Same as second agreement proposed methodology.</td>
</tr>
</tbody>
</table>
# Current and Proposed Benchmarking Approaches

<table>
<thead>
<tr>
<th>Benchmark Approach</th>
<th>Agreement Period</th>
<th>Adjustment to historical benchmark for health status &amp; demographic factors of performance year beneficiaries</th>
<th>Update to historical benchmark for growth in FFS Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Methodology</td>
<td>First Agreement</td>
<td>Newly Assigned beneficiaries adjusted using HCC; continuously assigned beneficiaries adjusted using demographic factors alone unless HCC risk scores result in lower score</td>
<td>National</td>
</tr>
<tr>
<td></td>
<td>Second Agreement</td>
<td>Same as first agreement method</td>
<td>National</td>
</tr>
<tr>
<td>Proposed Methodology</td>
<td>Second Agreement</td>
<td>No change</td>
<td>Regional</td>
</tr>
</tbody>
</table>
Benchmark Calculation: Step 1

For each of 4 categories of beneficiaries: calculate average rebased historical benchmark

Use new participant TINs, equally weight 3 prior base years, trend baseline using average of risk adjusted FFS for ACO counties, Savings from prior years are not added back
Benchmark Calculation: Steps 2-6

1. Compare rebased historical benchmark per capita to regional average amount per capita (+ or – value)
2. Multiply by 35% for 2nd agreement period (70% for 3rd)
3. Add adjustment to rebased historical benchmark
4. Multiply by weighting for category based on year 3
5. Sum across enrollment categories
### Benchmark Example: Second Agreement

<table>
<thead>
<tr>
<th>Benchmark Step</th>
<th>ACO #1 (Located in Higher Cost Region)</th>
<th>ACO #2 (Located in Lower Cost Region)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Baseline: Rebased historical benchmark (based on 3 prior years)</strong></td>
<td>$9,500</td>
<td>$9,500</td>
</tr>
<tr>
<td><strong>Trend forward baseline expenditures based on regional trends</strong></td>
<td>2% ($9500) x 1.02 = $9690</td>
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</tr>
<tr>
<td><strong>Adjust for regional expenditures to reflect a percentage of the difference between the FFS expenditures in ACO’s regional service area and the ACO’s historical expenditures (start with 35%)</strong></td>
<td>$10,555 (regional FFS expenditures) - $9690.00 (historical benchmark with trend) = $865.00 ($865)(.35) = $302.75</td>
<td>$8,555 (regional FFS expenditures) - $9690.00 (historical benchmark with trend) = -$1,135 (-$1,135)(.35) = -$397.25</td>
</tr>
<tr>
<td><strong>Add Regional Adjustment to historical benchmark</strong></td>
<td>$9,690.00 + $302.75 = $9,992.75</td>
<td>$9,690.00 - $397.25 = $9,292.75</td>
</tr>
</tbody>
</table>
Facilitating Faster Transition to Risk

Intended for Track 1 participants who are ready to accept risk earlier.
Limited to ACOs with first agreement period ending on or after 12/31/16.

Proposed participation option: allow eligible Track 1 ACOs to extend their first agreement period of Track 1 for a fourth year.

Must move to 3 year performance period in Track 2 or 3 following 1 year extension in Track 1.
Proposal Reopening Determinations

• If error in calculation of Shared Savings or Losses, CMS may reopen earlier payment determination and revise.

• 4 year period to reopen after date of initial determination

• 3% threshold:
  • A CMS technical error that affects total net sharings and losses for all ACOs in performance year of 3 percent or more would trigger reopening.
Questions:

How would the new benchmark (using regional FFS expenditures and trending) impact your ACO? Would it result in greater savings or losses?

How would including any county in your region with one ACO assigned beneficiary impact you?

Would you prefer your individual ACO assigned beneficiaries be excluded from the regional fee for service expenditure calculation?

How will you be impacted by the CMS proposal to remove the ACOs savings from the rebased benchmark?
Questions

Do you support a phased in transition to the regional benchmark of 35% in the second agreement and 70% in the third agreement?

If you are considering becoming a new ACO, would you prefer to have your benchmark based on the regional expenditures in your first agreement?

If you are an ACO that just renewed for January 1, 2016 would you like to have the option of transitioning to the regional benchmark method earlier (e.g. 2017)?
Questions

Would you consider remaining an extra fourth year in Track 1 and then transitioning to Track 2?

How would CMS proposal to reopen earlier payment determinations of shared savings impact you?