American Hospital Association

Regulatory Advisory

July 14, 2016

CHANGES TO THE MEDICARE SHARED SAVINGS PROGRAM

AT A GLANCE

At Issue:

On June 10, the Centers for Medicare & Medicaid Services (CMS) published a final rule that makes changes to the Medicare Shared Savings Program (MSSP) for accountable care organizations (ACOs). Specifically, the final rule modifies the methodology by which CMS calculates financial benchmarks for MSSP ACOs and establishes a new renewal option for ACOs that move to two-sided risk.

Changes in the rule include:

- Modification of the methodology for rebasing an ACO's financial benchmark when it renews participation for second and subsequent agreement periods. The new methodology will phase-in the use of regional expenditures and reduce reliance on an ACO's historical spending.
- Creation of a new participation option for certain renewing Track 1 ACOs that agree to move to a two-sided risk model. The new option will allow eligible Track 1 ACOs to extend their first agreement period for one year before moving to the selected two-sided risk model.
- Definition of the circumstances under which CMS may reopen determinations of shared savings and shared losses.

Most changes in the rule will be effective in performance year 2017. The changes regarding reopening determinations will be effective Aug. 10.

Our Take:

The AHA is pleased that CMS has created an additional option to extend the glide path for those ACOs that are interested in moving to a two-sided risk model. This proposal recognizes that ACOs start with different experience managing risk and may have different learning curves. However, we remain skeptical that the program as currently structured sufficiently incentivizes ACOs to accept greater risk. In addition, we appreciate that CMS recognized the need to modify its benchmarking methodology to decrease the reliance on historical financial performance so that ACOs that renew their participation are not penalized for their prior achievements.

What You Can Do:

- ✓ Share this advisory with your ACO's leadership or with those executives who are responsible for assessing enrollment in the MSSP.
- ✓ Assess the impact of the changes on whether your facility plans to apply for participation or renewal in the MSSP, including whether your facility may be interested in moving to a two-sided risk track after extending Track 1 participation by one year.

Further Questions:

Contact Melissa Myers, senior associate director for policy, at (202) 626-2356 or mmyers@aha.org.

American Hospital Association

Regulatory Advisory

JULY 14, 2016

CHANGES TO THE MEDICARE SHARED SAVINGS PROGRAM

BACKGROUND

On June 10, the Centers for Medicare & Medicaid Services (CMS) published a final rule that makes changes to the Medicare Shared Savings Program (MSSP) for accountable care organizations (ACOs). The final rule modifies the methodology by which CMS calculates financial benchmarks for MSSP ACOs and establishes a new renewal option for ACOs that move to two-sided risk.

AT ISSUE

Changes to the Benchmark Methodology

CMS finalized its proposal to modify the methodology it uses to calculate ACOs' financial benchmarks when rebasing[1] the benchmark between agreement periods. Specifically, CMS will apply regional expenditures when rebasing an ACO's benchmark in second and subsequent agreement periods. This change does not affect how the agency calculates ACOs' financial benchmarks for their first agreement period under the MSSP. That calculation will continue to be based solely on an ACO's historical expenditures.

Definition of Regional Service Area. CMS finalized its proposal to define an ACO's regional service area to include any county where one or more assigned beneficiaries reside. To determine regional expenditures, CMS will include in its calculation all assignable beneficiaries residing in the counties that make up an ACO's regional service area. An "assignable beneficiary" is a beneficiary who receives at least one primary care service from any Medicare-enrolled physician who is a primary care physician or whose specialty designation is used for purposes of assignment to an ACO.

CMS states that counties tend to be more stable regional units compared to other alternatives considered, such as Metropolitan Statistical Areas and Combined Statistical Areas. Further, CMS asserts that the use of counties, as opposed to a

[1] CMS uses the terms "rebase" and "reset" interchangeably throughout the rule. For simplicity, this advisory uses the term "rebase."

larger unit such as states, better captures regional variations in Medicare expenditures and allows for more customized regional definitions for each ACO.

Applying Regional Expenditures to the Rebased Benchmark. CMS finalized its proposal to calculate an ACO's historical benchmark for its second and subsequent agreement period using its current methodology, with two modifications. First, CMS will eliminate the current adjustment that lessens the extent to which an ACO's savings achieved in the prior performance period result in a lower benchmark. Instead, CMS will calculate and apply a regional fee-for-service (FFS) adjustment to the rebased historical benchmark.

The AHA supports the transition to a benchmarking methodology that reduces the need for an ACO to continually beat its past performance to achieve savings. However, we are disappointed that CMS finalized its proposal to eliminate the adjustment for an ACO's past savings.

In addition, CMS will use regional, rather than national, growth rates to trend expenditures for benchmark year (BY) 1 and 2 to BY3 dollars. Table 1 compares the current and new methodologies for calculating the rebased benchmark.

Table 1 – Current and Proposed Rebasing Methodologies

Current Methodology	New Methodology
Determine historical Parts A and B FFS expenditures for the three years prior to the first performance year of the new agreement period. This calculation excludes indirect medical education (IME) and disproportionate share hospital (DSH) payments but includes beneficiary-identifiable payments made under a demonstration, pilot or time limited program (for example, the Comprehensive Care for Joint Replacement model).	Same as current.
Make separate expenditure calculations for the following types of Medicare enrollment: end-stage renal disease (ESRD); disabled; aged/dual-eligible; and aged/non-dual eligible	Same as current.
Adjust expenditures for changes in severity and case mix using prospective CMS-Hierarchical Condition Category (HCC) risk scores	Same as current.
Truncate an assigned beneficiary's total annual Parts A and B FFS per capita expenditures at the 99th percentile of national Medicare FFS expenditures for each benchmark year. This minimizes variation from catastrophically large claims.	Same as current.
Trend expenditures for BY1 and BY2 to BY3 dollars using a national growth rate based on national Medicare expenditure data. A separate calculation is done for each of the four enrollment categories.	Trend expenditures for BY 1 and BY 2 to BY3 dollars using regional trend factors derived from a weighted average of risk adjusted FFS expenditures in the counties where the ACO's assigned beneficiaries reside. A separate calculation is done for each of the four enrollment categories.

Apply BY3 proportions of ESRD; disabled; aged/dual-eligible; and aged/non-dual eligible beneficiaries to trended and risk-adjusted BY1 and BY2 expenditures	Same as current.
Equally weight each benchmark year. This is different than the calculation of an ACO's original benchmark, in which more recent years receive a higher weight.	Same as current.
Adjust the benchmark to lessen the extent to which savings achieved in the prior performance period result in a lower benchmark.	Apply a regional FFS adjustment. For more details on the regional adjustment methodology, see Appendix A.

Phasing in the regional adjustment. CMS finalized, with modifications, its proposal to phase in the regional adjustment over two agreement periods for ACOs that renew participation in the MSSP. CMS proposed that, in an ACO's first agreement period in which the regional adjustment is applied, CMS would apply a weight of 35 percent to the difference between the ACO's regional average expenditures and its rebased historical benchmark expenditures. In the next and subsequent agreement periods, the weight would increase to 70 percent of the difference between the ACO's regional average expenditures and its rebased historical benchmark expenditures.

CMS modified its plan to phase-in the regional adjustment due to stakeholder concerns that its proposal would too quickly reduce benchmarks for ACOs that are high-cost relative to their regions, potentially driving those ACOs out of the program. As a result, the agency will compare each ACO's rebased historical benchmark to its regional expenditures to determine whether the ACO is high- or low-cost compared to its region, and apply the regional adjustment as follows:

- If an ACO's spending is lower than its region, CMS will phase-in the regional adjustment as originally proposed, by applying a weight of 35 percent in the first agreement period in which the adjustment is applied and 70 percent in the next and subsequent agreement periods.

- If an ACO's spending is higher than its region, CMS will apply a weight of 25 percent in the first agreement period in which the adjustment is applied, 50 percent in the second agreement period and then 70 percent in any subsequent agreement periods.

This modification will result in a more gradual transition to the regional adjustment for ACOs that are high-cost relative to their region. CMS believes this will allow those ACOs more time to plan for the transition and mitigate its impact.

Updating the rebased benchmark during the agreement period. Currently, CMS updates an ACO's historical benchmark annually by adding the flat dollar equivalent of the projected growth in national per capita Parts A and B FFS expenditures. To be consistent with its transition to the use of regional expenditure data in other benchmark calculations, CMS finalized its proposal instead to apply a growth rate that reflects risk-adjusted growth in regional per beneficiary FFS spending for the ACO's regional service area. This update factor

will be calculated and applied for the four types of Medicare enrollment (ESRD, disabled, aged/dual eligible, aged/non-dual eligible). This change will apply only in an ACO's second and subsequent agreement period; CMS will continue to use the national growth rate to update the benchmark in an ACO's first agreement period. In addition, CMS will continue to use the national growth rate to update the benchmark for ACOs that started in the program in 2012 or 2013 and began their second agreement period on Jan. 1, 2016. Those ACOs will transition to the new policy beginning Jan. 1, 2019 if they continue for a third agreement period.

Modifying Calculations to Consider Only ACO-assignable Beneficiaries. CMS currently makes several calculations based on expenditures for all Medicare FFS beneficiaries, regardless of whether they are eligible to be assigned to an ACO. Those calculations include the growth rates used to trend expenditures during the benchmark period; the projected amount of growth in national per capita expenditures for Parts A and B services used to update the benchmark; the completion factors applied to benchmark and performance year expenditures; and the truncation thresholds.

CMS finalized its proposal to consider only ACO-assignable Medicare beneficiaries when calculating the growth rates used to trend forward expenditures during the benchmark period; the projected growth in national per capita FFS expenditures for Parts A and B; and the truncation thresholds for limiting the impact of catastrophically large claims. CMS will continue to calculate completion factors based on expenditures for all FFS beneficiaries. In addition, CMS will consider only ACO-assignable beneficiaries when using county FFS expenditures to rebase, adjust and update an ACO's benchmark for a second or subsequent agreement period. This change will apply for the 2017 and all subsequent performance years. CMS states that it made this change because including all FFS beneficiaries may introduce bias into the calculations, since there may be differences in the health status and health care costs of Medicare beneficiaries who are not assignable to an ACO. Further, the agency notes that the bias may be more pronounced when calculating regional FFS expenditures, which are based on a relatively smaller population than calculations based on the national FFS population.

Timing of Applicability of Revised Methodology. CMS finalized its proposal to adopt the following approach for applying the changes to the benchmarking methodology to MSSP ACOs:

- All ACOs will have the benchmark for their first agreement period set using the current methodology.

- Renewing ACOs that started in 2012 or 2013 and that began a second agreement period on Jan. 1, 2016, will not move to the new rebasing methodology until their third agreement period (beginning in 2019). Those ACOs will still receive two agreement periods (or three, for ACOs that are high-cost relative to their regions) to phase in the regional adjustment.

- Renewing ACOs that started in 2014, 2015 or 2016, and subsequent cohorts (which begin their second agreement period on or after Jan. 1, 2017) will have their benchmarks rebased under the proposed new methodology for adjusting the rebased historical benchmark.

Risk Adjustment. CMS finalized its proposal to adjust for differences in health status between an ACO and its regional service area in a given year when determining the regional adjustment to the ACO's rebased historical benchmark. Specifically, for each category of Medicare enrollment, CMS will calculate a measure of risk-adjusted regional expenditures that would account for the differences in HCC risk scores of the ACO's assigned beneficiaries and the average HCC risk scores in the ACO's regional service area.

Adjusting for Changes in ACO Participants. Currently, CMS adjusts for changes in ACOs' participant lists from year to year by recalculating the three-year benchmarks as if the updated list was the list in place when the original benchmark was calculated. Noting concerns with the significant operational burden associated with this approach, CMS proposed to streamline the process by instead adjusting for changes to ACOs' participant lists by calculating the impact on expenditures from only one reference year, which would be BY3 of the ACO's current agreement period.

CMS did not finalize this proposal, however, citing stakeholder feedback that additional time is needed to analyze it. Instead, the agency states that it will revisit the issue in future rulemaking. For more details on this proposal, see Appendix B.

Facilitating Transition to Performance-based Risk

CMS notes that, despite changes the agency made in its June 2015 final rule to encourage ACOs to take on additional risk, nearly all of the first group of ACOs eligible for renewal chose to remain in Track 1, the one-sided risk model. As a result, CMS finalized its proposal to create an additional renewal option to encourage renewing ACOs to move more quickly to two-sided risk. The option will be available to Track 1 ACOs that are renewing for the first time, and thus eligible to renew for a second agreement period under Track 1. If instead the renewing Track 1 ACO selects a two-sided risk model (Tracks 2 or 3), that ACO would be able to extend its first agreement period under Track 1 to a fourth year and defer movement to Track 2 or 3 by one year. Further, CMS would defer rebasing the ACO's historical benchmark for one year. An ACO choosing this option would be assessed in the fourth performance year on the quality performance standard in place for the third performance year of the ACO's first agreement period.

After the fourth performance year, the ACO would transition to Track 2 or 3 for a three-year agreement period. If, after the fourth performance year, the ACO decides it does not want to move to Track 2 or 3, the current close-out procedures and payment consequences of early termination would apply. Further, if the ACO were approved for the extension of its first agreement period and terminates prior to the start of the second agreement period (in Track 2 or 3), the ACO would be considered to have terminated the second agreement period. This means that the

ACO would have to wait the duration of that agreement period (three years) to reapply to the MSSP.

This option will first be available to ACOs with 2014 start dates that seek to renew their participation agreement in order to enter a second agreement period beginning on Jan. 1, 2017. An ACO electing this option would still be required to undergo the renewal process specified in existing regulations, including the requirement that the ACO demonstrate its capability to repay shared losses as required to enter a two-sided risk model.

Reopening Determinations of ACO Savings or Losses

CMS states that, after its release of first year performance results for MSSP ACOs, the agency discovered an issue with the source data used in the final financial reconciliation. The error resulted in an overstatement of shared savings and an understatement of shared losses. CMS did not recoup any shared savings payments or any shared losses, as it has not specified in regulation or guidance the actions it would take under such circumstances, where it identifies an error in a prior payment determination. However, as a result, the agency proposed – and now finalizes – the circumstances in which it may reopen a payment determination to make corrections after the financial calculations have been performed and ACO shared savings and losses have been determined.

Under this policy, CMS will have discretion to open a repayment determination at any time in the case of fraud or "similar fault" (defined in current regulations at § 405.902). In addition, the agency will have discretion to reopen a payment determination within four years of the date of notification to the ACO of the initial determination of shared savings or shared losses if there is "good cause." Good cause would be established if there is new and material evidence that was not available or known at the time of the payment determination and that may result in a different conclusion, or if the evidence that was considered in making the payment determination clearly shows on its face that an obvious error was made at the time of the payment. The agency notes that this approach to reopening for good cause is the same that applies to reopening Parts A and B claims determinations under § 405.986.

The agency states that new and material evidence or an obvious error could come to CMS's attention through a variety of means, such as program integrity reviews or audits by the Office of Inspector General, Government Accountability Office (GAO) or CMS through its Medicare contractors. It further states that good cause may not be established by changes in substantive law or interpretive policy. CMS will have the sole discretion to determine if good cause exists. It also will have sole discretion to determine if an error was made, whether a correction would be appropriate, and the timing and manner of any correction. The agency will issue subregulatory guidance on potential issues that could constitute good cause.

The AHA is disappointed that CMS did not revise the rule to clarify that "good cause" could include ACOs' identification of their own errors, not just those made and/or identified by CMS or one of its contractors, as we had urged. However, the agency states that, although it retains sole discretion, it

will consider provider-identified errors when it determines whether good cause exists.

In addition, the agency states that it will provide additional information through subregulatory guidance on how it will consider materiality when determining whether to reopen for good cause. For example, CMS may establish a threshold for making financial corrections to address technical errors made by the agency in the determination of shared savings payments or shared loss recoupments. CMS discusses the potential of a threshold set at 3 percent of the net amount of ACO shared savings and shared losses computed for the applicable performance year for all ACOs, which the agency states is consistent with guidance from the GAO for financial audits of federal entities.

FURTHER QUESTIONS

Please contact Melissa Myers, AHA senior associate director of policy, at (202) 626-2356 or mmyers@aha.org with further questions.

APPENDIX A – CALCULATING THE REGIONAL ADJUSTMENT

As a first step to calculating expenditures for an ACO's regional service area, CMS will calculate county FFS expenditures. Separate expenditure calculations will be made for the four categories of Medicare enrollment. Specifically, the agency will:

- Calculate expenditures for assignable beneficiaries within a county using Medicare Parts A and B FFS payments for claims with dates of service in the 12-month calendar year for the relevant benchmark or performance year.

- Allow for a three-month claims run out and apply a completion factor. The calculations would exclude indirect medical education (IME), disproportionate share hospital (DSH) and uncompensated care payments, but would include beneficiary-identifiable payments made under a demonstration, pilot or time-limited program.

- To minimize variation from catastrophically large claims, truncate each beneficiary's total annual Part A and B FFS per capita expenditures at the 99th percentile of national Medicare FFS assignable beneficiary expenditures for the relevant year. A truncation threshold would be determined separately for each of the Medicare enrollment types.

- Risk-adjust county FFS expenditures for severity and case mix of assignable beneficiaries using prospective CMS-HCC risk scores.

Given the small numbers of beneficiaries with ESRD residing in individual counties, CMS proposed to calculate per-capita expenditures and average risk scores for ESRD beneficiaries statewide and apply those amounts to each county within the state. However, in the final rule CMS did not adopt this proposal, but instead will calculate expenditures for ESRD beneficiaries using the same methodology as the other categories of beneficiaries.

To calculate expenditures for the ACO's regional service area, CMS will weight county-level FFS expenditures by the ACO's proportion of assigned beneficiaries in the county. This proportion will be determined by comparing the number of an ACO's assigned beneficiaries residing in a county with the ACO's total number of assigned beneficiaries.

To apply the regional adjustment to the rebased benchmark, CMS will:

- For each Medicare enrollment category:
    - Calculate the difference between the average per-capita amount of the ACO's historical benchmark and the per capita regional average amount. If the historical benchmark is higher than the regional average amount, the difference will be expressed as a negative number.

    - Multiply the resulting difference by a specified percentage (see "phasing in the regional adjustment" above), which yields the amount of the regional adjustments that will be applied to the historical benchmark
    - Add the adjustment to the truncated, trended and risk-adjusted average per capita value of the ACO's rebased historical benchmark for that enrollment type.

- Multiply the adjusted value of the ACO's rebased historical benchmark for each Medicare enrollment type by the proportion of the ACO's assigned beneficiary population for that Medicare enrollment type, based on the ACO's assigned beneficiary population for BY3 of the rebased historical benchmark.

- Sum expenditures across the four Medicare enrollment types to determine the ACO's adjusted rebased historical benchmark.

APPENDIX B – ADJUSTING FOR CHANGES IN ACO PARTICIPANTS

To adjust for changes in ACO participants, CMS proposed to adjust for changes to ACOs' participant lists by calculating the impact on expenditures from only one reference year, which CMS proposes as BY3 of the ACO's current agreement period. Although CMS did not finalize this proposal, citing stakeholder concerns that more time is needed to analyze the potential change, it stated that it will revisit the issue in future rulemaking. Under the proposal, CMS would have identified three categories of beneficiaries:

- Stayers: beneficiaries assigned to an ACO under both the ACO's new participant list and the list for the most recent prior performance year;
- Joiners: beneficiaries who are assigned to the ACO using the new participant list but not the list for the most-recent prior performance period; and
- Leavers: beneficiaries who are not assigned to the ACO using the new participant list, but who were assigned based on the list for the most recent-prior performance period.

To determine the adjustment to an ACO's benchmark, CMS would have:

- Calculated a stayer component by multiplying an ACO's historical benchmark by a ratio of average per capita reference year expenditures for stayers to average per capita reference year expenditures for stayers and leavers combined;
- Calculated a joiner component by determining average per capita reference year expenditures for joiners; and
- Combined the stayer and joiner components to obtain the overall adjusted benchmark. CMS would have taken a weighted average of the stayer and joiner components, with the weight representing the relative share of the total number of assigned beneficiaries identified as stayers or joiners, respectively, based on the new participant list.

This calculation would have been made for each of the four Medicare beneficiary categories. The resulting benchmarks would have been weighted by the proportion of assigned beneficiaries for the corresponding Medicare beneficiary category, and then would have been summed to calculate a single weighted average per capita adjusted historical benchmark.