NAACOS Assessment of High-Low Revenue Designations

Overview

The Centers for Medicare & Medicaid Services (CMS) on December 21, 2018 published a final rule containing significant changes to the Medicare Shared Savings Program (MSSP). The rule can be accessed here, along with a NAACOS analysis of the final rule. One major change is CMS categorizing ACOs as either "high revenue" or "low revenue", a distinction the agency says reflects an ACO's ability to control spending and therefore should correspond to an ACO's ability to assume risk. In a comment letter to CMS, NAACOS opposed creating this distinction, and we continue to advocate for its repeal so as to not create arbitrary divisions among ACOs and push some ACOs into risk too soon. This resource explains the high-low revenue calculations and includes analysis using 2016 data to simulate how many ACOs would be classified under each category and to explore characteristics of the ACOs in each category.

High Revenue and Low Revenue ACO Designations

To make the high-low revenue distinction finalized in the final Pathways to Success rule, CMS evaluates total fee-for-service (FFS) revenue for ACO participants compared to the ACO's benchmark expenditures. This method uses Medicare claims data to make this determination, and the finalized definitions of high revenue and low revenue ACOs are as follows:

- ***High revenue ACO*** means an ACO whose total Medicare Parts A and B FFS revenue of its ACO participants is at least 35 percent of the total Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries.
- ***Low revenue ACO*** means an ACO whose total Medicare Parts A and B FFS revenue of its ACO participants is less than 35 percent of the total Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries.

In other words, the numerator looks at all of an ACO's participants identified by their Tax Identification Numbers (TINs) and finds the total Medicare Parts A and B FFS revenue of those affiliated TINs. This dollar amount includes spending for an ACO's assigned and unassigned beneficiaries. The denominator is essentially an ACO's benchmark, the Parts A and B spending of assigned beneficiaries. These calculations are based on the most recent calendar year for which 12 months of data are available. CMS notes that low revenue ACOs tend to be smaller, physician-led, and rural ACOs, which the agency explains are less likely to have access to capital to assume risk. CMS notes that hospital or health system ACOs will typically be considered high revenue, but hospital- or health system-based ACOs with relatively low ACO participant FFS revenue compared to their benchmark will be low revenue ACOs.

As explained in further detail in the NAACOS analysis, this distinction determines program specifics such as the timing for when an ACO must move to risk. For example, new high revenue ACOs are required to move to the Enhanced Track after one agreement period in the Basic Track while new low revenue ACOs will be permitted two agreement periods in the Basic Track. In the final Pathways to Success rule, CMS explains its

belief that the high-low revenue distinction supports the agency's goal of moving more ACOs to risk while, for the most part, allowing smaller, physician-led ACOs more time in a shared savings only model.

CMS Determination of Revenue Status

The high-low revenue determination will be made during the application cycle prior to the start of each performance year, as this will stipulate the ACO's track/level. To make the determination, CMS will use ACO participant revenue and expenditures for the most recent calendar year for which 12 months of data are available. For example, for the application cycle for performance year 2020, which will occur in calendar year 2019, CMS will use 2018 data. CMS declined suggestions to make high-low revenue determinations before the application is submitted because ACOs can still make changes to participant lists during the application process and determinations could change. However, CMS will tell ACOs if they are high or low revenue before they sign a participation agreement. The agency also vowed to provide "timely feedback" to ACOs throughout an application cycle on its revenue status. CMS also said it will work with ACOs during the participant list change process to determine effects on an ACO's revenue status.

ACOs Changing Revenue Status

CMS will monitor low revenue ACOs experienced with performance-based risk in Basic Level E to see if they become high revenue, which will require them to participate in the higher risk Enhanced Track. Since determinations are made annually, an ACO's revenue status could change from low to high during a participation agreement. This could happen if, for example, the composition of an ACO changes. The ACO will be allowed to finish that year in the Basic track before being ineligible to continue in the Basic track. CMS will allow an ACO to change its participant list to retain its low revenue status.

Overview of Calculating High-Low Revenue Designations

To better understand the potential impact of the distinction, NAACOS and the Institute for Accountable Care used the NAACOS ACO Data Warehouse to simulate high and low revenue designations for all ACOs participating in the MSSP in 2016 (the last full year of data in the warehouse). To replicate the rules, we calculated total Medicare Parts A and B expenditures for all participant providers (TINs; TINs and CMS Certification Numbers; CCNs) associated with a given ACO. This dollar amount includes spending for an ACO's assigned and unassigned beneficiaries, forming the numerator of the high-low revenue ratio. Next, we calculated total Parts A and B FFS expenditures for ACO assigned beneficiaries, regardless of where those expenditures took place. This forms the denominator for the ratio. We then took the ratio of total expenditures to total ACO assigned beneficiary expenditures and applied the finalized threshold of 35 percent. ACOs with ratios equal to or greater than 35 percent were considered high revenue ACOs. Those with ratios below 35 percent were considered low revenue ACOs. As a final step, we merged these results with the 2016 MSSP ACO public use file (PUF) to determine ACO type and earned shared savings.

MSSP-Wide Findings of Revenue Status

Although the new designation largely tracks with existing ACO categorizations, our analysis found there are a number of physician and Federally Qualified Health Center (FQHC)- and Rural Health Clinic (RHC)-affiliated ACOs that would have been designated high revenue based on 2016 data. This can happen for many reasons, such as a situation where the ACO is relatively small part of the overall book of business for the provider group. One physician-directed ACO, for example, had $24 million in ACO-related expenditures and $277 million in non-ACO expenditures.

It's important to note that when CMS makes high-low revenue calculations, the agency will do so using the most recent calendar year of data available and using the ACO's composition, based on specific ACO participants, at the time the ACO applies for the MSSP or during an annual process when the ACO can update its participants for the upcoming year. The table below shows the CMS designation for each MSSP ACO in 2016 and how that ACO would be categorized using the new high-low revenue rules.

The majority of performance year 2016 ACOs were hospital affiliated (N=226) and for the most part these ACOs are designated high revenue. For the physician-affiliated ACOs, on the other hand, about 12 percent (N=16) are designated high revenue. Even more striking is that about 22 percent of RHC/FQHC ACOs are seen as high revenue. It's worth noting, this is historic data and the high-low revenue designation will be reset each year.

Table 1: Distribution of High-Low Revenue Determination by ACO Category, 2016

ACO category*	Low Revenue	High Revenue
Physician affiliated	118	16
Hospital affiliated	8	218
FQHC/RHC	45	13
Post-acute Care (PAC)	7	2
Other	5	0
TOTAL	**183**	**249**

**Note: The ACO category is assigned using hierarchical rules from CMS. If the ACO has a hospital, it is counted in the hospital category regardless of other facilities included in the ACO. If there is no hospital but one or more FQHC/RHC, then the ACO is in the FQHC/RHC category. Post-acute-care providers include skilled nursing facilities, home health or hospice providers. ACOs that have any other facility type go into the "other" category. Finally, an ACO with no institutional affiliates is designated physician affiliated.*

Total Part A and B expenditures at low revenue ACOs is on average 13 percent of total ACO assigned beneficiary Part A and B expenditures. For high revenue ACOs, the picture is quite different with total Part A and B expenditures that are greater than the overall ACO beneficiary expenditures. Shifting to shared savings, we see in Table 2 that 40 percent of low revenue ACOs generated savings compared to 24 percent of high revenue ACOs. These findings are consistent with the high concentration of hospital lead ACOs in the high revenue group.

Table 2: High-Low Revenue Ratio, Components and Performance based on 2016 Designations

	Low Revenue	High Revenue
Number ACOs	183	249
Mean ACO Beneficiaries	12,856	22,214
High/Low Ratio		
Mean	0.13	1.52
Min	.025	0.35
Max	0.34	15.8
Total A&B Expenditures (numerator)	20,937,150	325,920,239
Total A&B Expenditures, ACO assigned (denominator)	158,493,869	259,642,412
Percent that earned Shared Savings	40%	24%

Looking more closely at the high-low revenue ratio by ACO type, we can see the highest ratio in 2016 was a physician-led ACO. In general, the hospital- and physician-led ACOs share many similar characteristics in terms of FFS expenditures and ACO assigned beneficiary expenditures. The FQHC/RHC ACOs appear to be smaller with fewer resources.

Table 3: High-Low Revenue Ratio, Components and Performance based on ACO Type and 2016 Designation

	FQHC/RHC		Hospital		Physician	
	Low	**High**	**Low**	**High**	**Low**	**High**
Number ACOs	45	13	8	218	118	16
Mean ACO Beneficiaries	10,995	11,964	27,962	23,848	12,279	9,507
High-Low Ratio	0.12	1.67	0.21	1.32	0.12	4.20
Total A&B Expenditures (numerator)	$1,499,214	$191,738,738	$68,506,858	$334,865,438	$18,431,710	$342,239,954
Total A&B Expenditures, ACO assigned (denominator)	$131,566,846	$142,949,403	$315,303,308	$279,277,372	$1,543,472,22	$101,432,452
Earned Shared Savings/ Losses (range)	$1,412,705 ($0-$12,479,101)	$1,372,893 ($0-$8,883,074)	$3,420,017 ($0-$22,835,022)	$1,235,654 (-$3,675,911-$28,924,272)	$2,229,556 ($0-$30,540,508)	$1,307,119 ($0-$5,081,852)

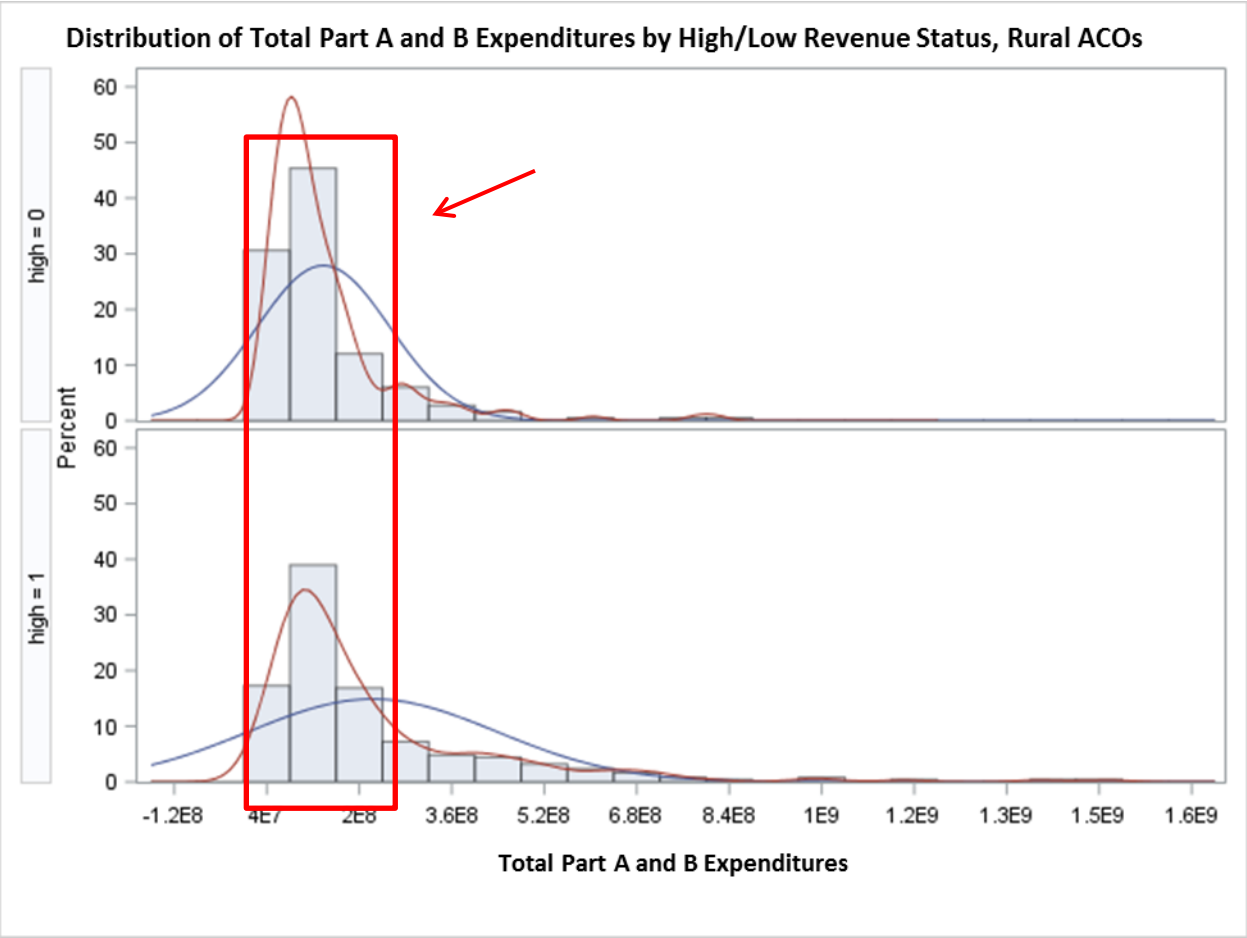
Since the high-low revenue statistic is a measure of the concentration of beneficiary expenditures within any given system, it is possible that dominant, high volume providers in rural areas get labeled a high revenue provider when in fact they are relatively small. To test this, we looked at the distribution of high and low revenue providers by rural-urban status. We find that 17 percent of high revenue providers are rural (N=42) compared to 11 percent (N=20) for low revenue. As expected, the low revenue rural providers are mostly physician affiliated (40%, N=8) or FQHC/RHC affiliated (55%, N=11). More than 80 percent of rural, high revenue providers (N=35) are hospital affiliated with an additional 17 percent (N=7) FQHC/RHC affiliated. This small, FQHC/RHC affiliated group is concerning because they appear to have smaller patient panels and lower revenue than the hospital affiliated high revenue rural ACOs.

Table 4: Distribution of High-Low Revenue Determination, Size and Revenue for Rural ACO by Category, 2016

	Low Revenue			High Revenue		
ACO category*	**Number ACOs**	**Mean Benes (range)**	**Range Total A+B Expenditures**	**Number ACOs**	**Mean Benes (range)**	**Range Total A+B Expenditures**
Physician affiliated	8	12,463 (5,310-29,578)	$56,074,028-$269,171,343	0	---	---
Hospital affiliated	1	---	---	35	14,996 (5,000-64,439)	$53,372,503-$600,779,645)
FQHC/RHC	11	9,448 (4,486-19,909)	$43,901,438-$194,447,570	7	10,763 (6,208-13,540)	$52,214,392-$142,925,956)
TOTAL	**20**			**42**		

**Note: The ACO category is assigned using hierarchical rules from CMS. If the ACO has a hospital, it is counted in the hospital category regardless of other facilities included in the ACO. If there is no hospital but one or more FQHC/RHC, then the ACO is in the FQHC/RHC category. Post-acute-care providers include skilled nursing facilities, home health or hospice providers. ACOs that have any other facility type go into the "other" category. Finally, an ACO with no institutional affiliates is designated physician affiliated.*

Looking more closely at the distribution of total Part A and B expenditures among rural ACO by high-low revenue status, we see considerable overlap for the vast majority of providers. In other words, the high-low revenue designation is not doing a good job of differentiating providers based on size. However, the high revenue group does have a set of high revenue organizations out in the tail.



CMS states in the final Pathways to Success rule that increasing the high-low revenue threshold from the proposed 25 percent to 35 percent results in an increase of low revenue ACOs by 13 percent based on CMS modeling of 2018 performance data. The agency doesn't appear to specify how many ACOs would fall into either category of its final policy. CMS expressed concern in the final rule that the 25 percent threshold would count ACOs with moderate revenue as high revenue ACOs because of, for example, multi-specialty physician practices or safety-net providers such as FQHCs. Based on NAACOS's analysis, the number of physician-affiliated ACOs considered high revenue fell from nearly 20 percent under the proposed rule to about 12 percent under the final rule's threshold. The number of FQHCs and RHCs considered high revenue feel from 35 percent to 22 percent after the adjustment in the final rule.

Appendix 1: Methodology

To determine the high-low revenue status for each ACO, we used the logic provided by CMS in the proposed rule under *5. Determining Participation Options Based on Medicare FFS Revenue and Prior Participation* (pp. 41813-41815 in the Federal Register), restated in the final rule (pp. 67864-67878 in the Federal Register) and finalized under § 425.20. To start, we first calculate the total Medicare Parts A and B payments for all of an ACO's participant providers (TINs and CCNs) in 2016. This calculation includes all FFS beneficiaries, regardless of ACO assignment and all expenditures, including indirect medical education (IME), disproportionate share (DSH), and outlier payments. This forms the numerator for our ratio.

As a second step, we calculate total Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries in 2016. Once again, all FFS expenditures are included. This forms the denominator for our ratio. As a third step, we take ratio of total FFS expenditures for ACO participants divided by FFS expenditures for ACO assigned beneficiaries. If this ratio is less than 35 percent, then ACO is considered low revenue. If the ratio is greater than or equal to 35 percent, then the ACO is considered high revenue.

To validate this analysis, we reproduced the regulatory impact analysis done by CMS to support this section of the rule. Although the regulatory impact analysis uses a different numerator (assigned beneficiaries only) and a threshold (10 percent) for the ratio, we were able to get a close approximation of these results, suggesting we are using comparable total expenditure variables.