Summary of CMS' Benchmarking and ACO NPRM
Prepared by NAACOS on February 3, 2016

Overview

The Centers for Medicare & Medicaid Services (CMS) released a notice of proposed rulemaking (NPRM) and related factsheet, which puts forward proposed changes to the Medicare Shared Savings Program (MSSP) benchmarking methodology, among other MSSP changes. The proposed benchmarking methodology would gradually phase in the use of regional cost data over the course of multiple three-year ACO agreement periods. If finalized, only those ACOs that joined the MSSP in 2014 and begin a new three-year agreement period in 2017 would have their new benchmarks incorporate regional cost data at that time. ACOs with start dates other than 2014 would have regional cost data incorporated into their benchmark when they start their second three-year agreement period. Current MSSP benchmarking methodology is outlined in this CMS resource.

This summary reviews key elements of the NPRM, such as CMS' proposals to:

- Gradually move from nationally to regionally based benchmarks over the course of multiple three-year agreement periods with regional cost data accounting for 35 percent and ultimately 70 percent of the benchmark
- Define regional service areas used to calculate benchmarks based on all counties where one or more beneficiaries assigned to the ACO resides
- Use regional growth rates instead of national growth rates for Medicare expenditures when trending the benchmark years forward
- No longer adjust subsequent benchmarks to account for savings in prior agreement periods
- Use all beneficiaries eligible for ACO assignment ("assignable beneficiaries") instead of all fee-for-service (FFS) beneficiaries as the basis for calculations using regional and national FFS expenditures
- Weight county-level FFS costs by the proportion of the ACO's assigned beneficiaries in the county
- Establish circumstances under which CMS may reopen a decision related to shared savings or losses
- Allow ACOs selected to transition to risk-based ACO models to have an additional fourth year Track 1
- Revise the methodology used to adjust benchmarks at the start of each performance year as a result of changes to ACO participant Taxpayer Identification Number (TIN) composition

Calculating Regional Beneficiary Cost Data

Definition of "Region"

To incorporate benchmark factors based on regional costs, CMS considered a few ways to define "region," such as by state, metropolitan statistical area, or Medicare geographic practice cost indices. However, CMS proposes to use the "regional service area" of each ACO, which the agency is defining as all counties where one or more beneficiaries assigned to the ACO reside. CMS states that using county-level data will allow for more customized regional definitions for each ACO.

Beneficiary Population for Regional Expenditure Data

Within the regional service area, CMS must select which Medicare beneficiaries to include in the population used to calculate the regional cost data. The agency considered a few alternatives when defining the selected population, including all FFS Medicare beneficiaries or only non-ACO beneficiaries. However, CMS proposes to use all "assignable beneficiaries," including ACO-assigned beneficiaries, in determining expenditures for the ACO's regional service area in an effort to ensure sufficiently stable regional mean expenditures. CMS defines an assignable beneficiary as a Medicare FFS beneficiary who receives at least one primary care service during a specified 12-month assignment window from a Medicare-enrolled physician who is a primary care physician or who has one of the specialty designations included in §425.402(c). Therefore, if a FFS beneficiary gets at least one primary care service from any Medicare-enrolled physician who is a primary care physician or who has one of the primary specialty designations used for purposes of MSSP assignment, the beneficiary would be included in the population used to calculate expenditures for the ACO's regional service area.

Weighting the Regional Population by County

Because the regional service area would be defined to include any county where one or more assigned beneficiaries reside, CMS proposes to account for the geographic spread of an ACO's assigned population by weighting an ACO's regional expenditures relative to the proportion of the ACO's assigned beneficiaries in each county. According to CMS assignment data from the first quarter of 2015 for all active MSSP ACOs, these ACOs served beneficiaries residing in between two and 32 counties with a median of eight counties served.

Calculating Regional Average Expenditures

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. To calculate regional average expenditures, CMS would:

- Calculate Hierarchical Condition Category (HCC) risk adjusted regional per capita FFS expenditures using county level Parts A and B expenditures for the ACO's regional service area for each Medicare enrollment type (end stage renal disease [ESRD], disabled, aged/dual eligible, aged/non-dual eligible), weighted based on the proportion of ACO assigned beneficiaries residing in each county for the most recent benchmark year. In calculating ESRD expenditures, CMS would use state-level data (see next section).
- Weight the resulting regional expenditures by the proportion of assigned beneficiaries for the most recent benchmark year for each Medicare enrollment type (ESRD, disabled, aged/dual eligible, aged/non-dual eligible).

CMS would utilize a three-month claims run out with a completion factor, and the calculations would continue to exclude payments related to indirect medical expenses, disproportionate share hospital payments, and uncompensated care. After calculating the regional average expenditures, CMS would apply this adjustment to the ACO's rebased historical benchmark.

End Stage Renal Disease

As part of the process to adjust beneficiary expenditures for severity and case mix using HCC risk scores, CMS proposes to compute state-level per capita expenditures and average risk scores for the ESRD population in each state and apply those state-level values to all counties in a state. CMS believes using state-wide expenditure and risk score data for the ESRD population is appropriate given the small numbers of ESRD beneficiaries in many counties and says using statewide values would be more statistically stable.

Modifying Use of FFS Expenditures for Trending, Updates and Truncation Thresholds

Several elements of the current MSSP financial calculations are based on expenditures for all Medicare FFS beneficiaries regardless of whether they are eligible to be assigned to an ACO, such as data used to trend forward benchmark dollars to account for inflation and data to update benchmarks to account for growth in expenditures not related to inflation. To address CMS' concerns about potential bias from using all FFS beneficiaries when shifting to the use of regional elements in the benchmarking methodology, the agency proposes to reconsider the population used in program calculations for both national and regional FFS populations.

Truncating Expenditures

CMS proposes to use the population of national assignable beneficiaries, rather than all Medicare FFS beneficiaries, when calculating 99 percent truncation thresholds for catastrophically large claims. CMS proposes this change would apply for the 2017 performance year and all subsequent performance years, and it would be applied to new ACOs as well as those in the middle of an agreement period.

Trending Forward Benchmark Expenditures

Under current policy, CMS trends the first two benchmark years' per capita expenditures ahead to the third benchmark year by using the national growth rate for spending on Medicare Part A and B services. For ACOs in initial agreement periods, beginning with performance year 2017, CMS proposes to trend forward the benchmark using national Medicare expenditure data for national assignable, rather than all FFS beneficiaries.

For ACOs entering into subsequent agreements with rebased benchmarks in 2017 and beyond, CMS proposes to replace the national trend factor with regional trend factors derived from a weighted average of risk adjusted FFS expenditures in the counties where the ACO's assigned beneficiaries reside. The agency would calculate and apply the trend factors for each of the following populations of beneficiaries: ESRD, disabled, aged/dual eligible, aged/non-dual eligible.

Update Factor to Account for Expenditure Growth

CMS updates benchmarks by the projected absolute amount of growth in national per capita expenditures for Parts A and B services to account for change in FFS growth that are not the result of inflation (which is accounted for in the trending calculation). For ACOs in initial agreement periods, beginning with the performance year 2017, CMS proposes to use national Medicare expenditure data to determine the national growth rates for assignable beneficiaries, which would be used as the revised update factor.

The agency proposes to calculate the update factor for rebased benchmarks in second and subsequent agreement periods using regional FFS expenditures in an effort to better capture the cost experience in the ACO's region, the health status and socioeconomic dynamics of the regional population, and location-specific Medicare payments. CMS would calculate and apply separate update factors based on risk adjusted regional FFS expenditures for each of the following populations of beneficiaries: ESRD, disabled, aged/dual eligible, and aged/non-dual eligible.

Risk Adjusting in Determining Regional Adjustments to ACO's rebased historical benchmark

To account for differences in health status between an ACO's assigned population and the broader FFS population in the ACO's regional service area, CMS proposes to adjust for differences in health status between an ACO and its regional service area in a given year. This would determine the regional adjustment to the ACO's rebased historical benchmark. CMS would compute for each Medicare enrollment type a

measure of risk-adjusted regional expenditures that would account for differences in HCC risk scores of the ACO's assigned beneficiaries and the average HCC risk score in the regional service area.

No Longer Accounting for Savings in Rebased Benchmarks

Under current policy, CMS accounts for the average per capita amount of savings generated during the ACO's previous agreement period by adding a portion of the savings into the rebased benchmark (only for ACOs that have net per capita savings across the three performance years). CMS proposes to revise this policy and, if finalized, would no longer account for savings in the previous agreement period when calculating the rebased benchmark for a new three-year agreement period. The agency argues that transitioning to a benchmark methodology that incorporates an adjustment for regional FFS expenditures would mitigate the impact of no longer accounting for savings in subsequent agreement periods.

Timeline for Transitioning to Benchmarks with Regional Cost Data

CMS proposes to gradually make an ACO's benchmark more reflective of expenditures in its region and less reflective of the ACO's own historical expenditures by phasing in the use of regional cost data over time. The agency would maintain the current methodology for establishing the benchmark for an ACO's first agreement period based on the historical expenditures for beneficiaries assigned to the ACO with no adjustment for expenditures in the ACO's regional service area. Beginning with the subsequent three-year agreement period, CMS proposes to implement the regional adjustment amount by taking 35 percent of the difference between the ACO's regional service area expenditures and the ACO's rebased historical benchmark expenditures. For ACOs entering their third or subsequent agreement periods, the percentage would increase to 70 percent based on regional FFS expenditures for assignable beneficiaries.

ACOs that began the MSSP in 2014 would be the first group affected by the revised rebasing methodology, and, if finalized, their new benchmarks for the three-year agreement period beginning in 2017 would reflect 35 percent regional expenditure data. These ACOs would also be the first to shift to the 70 percent regional adjustment, beginning with their third agreement period starting in 2020. ACOs that began the MSSP in 2012 and 2013 and began new agreement periods in 2016 would not have regional cost data incorporated until their next agreement period begins in 2019.

Benchmark Changes Resulting from ACO Participant TIN Modifications

ACOs are required to alert CMS of changes in the composition of its ACO participants and ACO providers/suppliers. ACOs may delete participant TINs during the performance year. Annually an ACO may add participant TINs, resulting in a certified ACO participant list that is the basis for beneficiary assignment and operations for the ACO's next performance year. This certified participant list is utilized in a number of ways, such as to recalculate the ACO's historical benchmark based on the three years prior to the start of its agreement period, to determine performance year expenditures, and to determine quality measurement and sampling.

Due to the frequency of changes to participant TINs, CMS proposes to adjust an ACO's historical benchmark for changes in participant TIN composition using an expenditure ratio calculated for a single year that accounts for differences in the ACO's assigned population determined based on its prior and current participant composition. If finalized, this program-wide proposed change would go into effect in 2017 and would replace the current methodology. CMS estimates that the results of this proposed change would be highly correlated with those under the current methodology but this method would be less administratively burdensome for CMS and ACOs.

Extended Track 1 Participation Option

CMS proposes to add a participation option that would allow eligible Track 1 ACOs to defer 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. This option would only be for ACOs that are eligible for a second agreement period under Track 1 but instead apply for, and are accepted to, participate in a performance-based risk track. Only after being accepted in Track 2 or 3, could the eligible ACO elect to continue under Track 1 for an additional year. The terms of the initial three-year agreement would remain in place for the additional fourth year. The new agreement period in Track 2 or 3 would still be three years. If finalized, this option would be available for ACOs that started the MSSP in 2014 or later.

Reopening ACO Shared Savings/Loss Determinations

Currently, the determination of whether an ACO is eligible for shared savings and the amount of such shared savings, as well as the underlying financial calculations, are not appealable and are precluded from administrative and judicial review. In this rule, the agency proposes circumstances under which it would consider reopening a payment determination after financial calculations are performed and shared savings/losses determined. CMS proposes to use its discretion to reopen a payment determination within four years after the notification of the initial determination if there is "good cause," which would exist as a result of new and/or material evidence not available or known at the time of the payment determination. The agency would have sole discretion determining whether good cause exists and does not propose specific examples of what would constitute good cause, but the agency states it would issue further guidance if the proposal is finalized. Further, CMS is considering establishing a materiality threshold for reopening determinations that result from technical errors by the agency, such as CMS computational errors. The agency discusses a materiality threshold of 3 percent of the total amount of net shared savings/losses for all ACOs for a performance year. CMS proposes that it would have discretion to reopen a payment determination at any time in the case of fraud or "similar fault."

New Publicly Available Data

Along with the NPRM, CMS made new data available to the public that allows for analysis of the methodologies proposed in this rule. The following new data files are available through the MSSP website:

- Files containing average county FFS expenditures, CMS-HCC prospective risk scores and person-years for assignable beneficiaries by Medicare enrollment type (ESRD, disabled, aged/dual eligible, aged/non-dual eligible) for 2012, 2013, and 2014.

- Files containing the total number of assigned beneficiaries for each ACO for each county where at least one percent of the ACO's assigned beneficiaries reside for 2012, 2013, and 2014.

CMS anticipates making county-level data used in the MSSP calculations publicly available annually, and this data is in addition to data the agency previously made available in the MSSP ACO Public Use Files, which contain ACO-specific financial and quality performance data.

Comments to CMS

CMS will accept public comments on the proposed rule through March 28, 2016 and those interested in submitting feedback to the agency may do so by going to this webpage.