January 30, 2018

Demetrios Kouzoukas
Principal Deputy Administrator for Medicare and Director
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: CMS error calculating Performance Year 2016 results for ACOs with previous savings

Dear Mr. Kouzoukas:

The National Association of ACOs (NAACOS) writes to inform you of a calculation error affecting the 2016 performance results and payments for certain Medicare Shared Savings Program (MSSP) ACOs. **As a partner to ACOs and the party responsible for executing performance calculations and determining shared savings payments, we are calling your attention to this issue to urge you to take corrective action to accurately reward these ACOs using the correct methodology as dictated by regulation and established program methodologies.**

NAACOS is the largest association of ACOs, representing more than 4 million beneficiary lives through more than 300 Medicare Shared Savings Program (MSSP), Next Generation, and commercial ACOs. NAACOS is an ACO member-led and member-owned non-profit organization that works on behalf of ACOs across the nation to improve the quality of Medicare delivery, population health and outcomes, and health care cost efficiency. Our members, more than many other healthcare organizations, want to see an effective, coordinated patient-centric care process. Our recommendations reflect our expectation and desire to see ACOs achieve the long-term sustainability necessary to enhance care coordination and health outcomes for Medicare beneficiaries, reduce healthcare costs, and improve quality in the Medicare program.

The error in the performance year (PY) 2016 calculation relates to how CMS accounts for prior savings that ACOs achieved during their initial agreement periods beginning in 2012 or 2013. Based on regulations in place for PY 2016, there is an error in the order of operations where the performance payment limit or cap is applied to total savings instead of being applied to the ACO's share of the savings. This is inconsistent with the actual shared savings that ACOs received in all previous performance years. The cap should be applied after multiplying gross savings by the quality percentage and savings rate when calculating the prior savings adjustment. This is consistent with financial reconciliation methodology. We believe this error unfairly affects the following 17 ACOs (identified by their 2016 names):

- Accountable Care Options, LLC

- Allcare Options, LLC*
- CCACO
- Collaborative Health ACO
- Florida Physicians Trust, LLC
- Hackensack Alliance ACO
- HHC ACO Inc
- Integral Healthcare, LLC
- Memorial Hermann Accountable Care Organization
- Methodist Alliance for Patients and Physicians
- Oakwood Accountable Care Organization, LLC
- Paradigm ACO, LLC
- Physicians ACO
- RGV ACO Health Providers, LLC
- Rio Grande Valley Health Alliance, LLC
- Southern Kentucky Health Care Alliance
- The Premier HealthCare Network LLC

**Allcare Options, LLC was the only ACO of the 17 ACOs that did not earn shared savings, but they could be impacted in PY 2017 and PY 2018.*

According to this CMS document, *Medicare Shared Savings Program Shared Savings and Losses and Assignment Methodology Specifications* (April 2017, Version 5), pages 56 and 57 state:

> "CMS will then calculate the shared savings percentage. The maximum quality performance sharing rate percentage is 50 percent under the one-sided model (with the remaining percent going to the Medicare program). CMS will base the quality sharing rate on the ACO's quality performance. The final sharing rate is equal to the product of the ACO's quality score and the maximum sharing rate of 50 percent (if the ACO has met the quality performance standard for the performance year). In an ACO's first performance year, an ACO can earn the maximum 50 percent of shareable savings for quality performance based on complete and accurate reporting of quality measures (known as pay for reporting). Following the first performance year, an ACO must continue to report completely and accurately on all measures; but in addition, its performance will be assessed relative to performance benchmarks for a specified set of measures in each performance year (known as pay for performance). If the ACO does not meet the quality performance standard for the performance year, it will not be eligible for any shared savings (i.e., the final sharing rate will be zero percent).
>
> The final savings rate will apply to an ACO's savings on a first dollar basis. Under the one-sided model, shared savings are subject to a cap equal to 10 percent of total updated

historical benchmark expenditures in each performance year. If an ACO is eligible to receive shared savings, CMS will reduce the shared savings amount paid to the ACO by two percent due to sequestration. This two percent reduction will be applied after all other calculations for shared savings are complete and prior to applying the cap. For those ACOs that are participating in the Advance Payment Model or the ACO Investment Model, sequestration is applied to the gross payment amount and then the advance payment withhold is subtracted" (emphasis added).

Therefore, all adjustments, including the quality and shared savings percentages are to be made before applying the payment cap. The error of prematurely applying the cap of 10 percent of benchmark for Track 1 ACOs and 15 percent of benchmark for Track 2 ACOs results in a missed savings opportunity for these ACOs. The cap should be applied after multiplying gross savings by the quality percentage and savings rate when calculating the prior savings adjustment. This is consistent with financial reconciliation methodology.

Example of calculation error

Suppose a hypothetical ACO has an updated benchmark of $10,000 per beneficiary per year (PBPY) and performance year expenditures of $8,500 PBPY. They have a 95 percent quality score and are in Track 1 which means they have a 50 percent shared savings rate. Applying the cap after other adjustments, as it should be calculated and demonstrated below, leads to a prior savings adjustment that is larger and therefore results in a higher future benchmark.

Correct process applies the cap after other adjustments:

Step 1: Take gross savings of $10,000 PBPY less $8,500 PBPY expenditures, which equates to $1,500 PBPY in gross savings.

Step 2: Apply the quality and savings rate adjustments of 95% x 50% = 47.5%, which results in $1,500 x 47.5% = $712.50 in shared savings

Step 3: Apply the cap of 10% of updated benchmark (10% x $10,000 = $1,000), which results in $712.50 in shared savings since $712.50 is less than the $1,000 cap.

In contrast, applying the cap before other adjustments leads to a prior savings adjustment that is lower, therefore resulting in a lower future benchmark. In this instance, which is incorrect and contrary to CMS policy, step 2 and 3 are reversed.

Incorrect process applies the cap before other adjustments:

Step 1: Take gross savings of $10,000 PBPY less $8,500 PBPY expenditures, which equates to $1,500 PBPY in gross savings.

Step 3: Apply the cap of 10% of updated benchmark (10% x $10,000 = $1,000), which results in $1,000 in shared savings since $1,500 is above the cap.

Step 2: Apply the quality and savings rate adjustments of 95% x 50% = 47.5%. This results in $1,000 x 47.5% = $475.00 in shared savings.

It is important to note that if not corrected this issue will continue to unfairly penalize these ACOs for the 2017 and 2018 performance years as well. We have confirmed this calculation error with an external actuary, and we are aware that other ACOs and actuaries have also identified this error through their own calculations.

Our survey data shows that ACOs invest, on average, $1.6 million annually to operate their ACO. These funds go towards clinical and care management, health IT/population analytics/reporting, and ACO management and administration. Given the significant investments ACOs make both financially and through their commitment to transforming how care is delivered, they rely on CMS to fairly execute program calculations that determine shared savings, which is critical to fund an ACO's continued operations and transformation. We recognize the complexity of program calculations and appreciate the difficult job of properly executing these calculations with 100 percent accuracy. However, it is critical that these calculations are correct and when provided with evidence to the contrary, it is essential that CMS take swift and decisive action to correct errors and adjust earned shared savings appropriately. By doing so, CMS demonstrates its role as a partner to ACOs and a fair arbitrator of its own rules, methodologies and calculations. Not doing so disadvantages ACOs by withholding their rightful shared savings and also sends a message that CMS does not hold itself accountable for its own errors. Furthermore, it undermines the confidence ACOs have in the program and with CMS. Therefore, we urge CMS to thoroughly investigate this issue and provide the missing shared savings payments for ACOs affected by this error. We appreciate the opportunity to call this to your attention and hope you will consider and act upon the feedback included in this letter. Thank you for your careful consideration of this matter. Should you want to further discuss this, please contact me at abrennan@naacos.com.

Sincerely,

Clif Gaus, Sc.D.
President and CEO
National Association of ACOs

Cc: Jeet Guram, Senior Advisor to the Administrator
John Pilotte, Director of the Performance-Based Payment Policy Group