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Centers for Medicare & Medicaid Services
Medicare Shared Savings Program Listening Session: Proposed Rule on Revised Benchmark Rebasing Methodology
MLN Connects National Provider Call
Moderator: Amanda Barnes
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This transcript was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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Operator: At this time, I would like to welcome everyone to today's MLN Connects® National Provider Call.

All lines will remain in a listen-only mode until the feedback session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time. I will now turn the call over to Amanda Barnes. Thank you, you may begin.

Announcements and Introduction

Amanda Barnes: Thank you, Holley. I'm Amanda Barnes from the Provider Communications Group here at CMS, and I am your moderator today.

I would like you – to welcome you to this MLN Connects listening session on the Medicare Shared Savings Program Proposed Rule on the Revised Benchmark Rebasing Methodology. MLN Connects Calls are part of the Medicare Learning Network®. This listening session is an opportunity for CMS to receive early feedback from stakeholders on proposed policy changes to the Medicare Shared Savings Program.

Before we begin, I have several announcements. We have a presentation that you may view or download, and that URL is cms.gov/npc. Again, that URL is www.cms.gov/npc. At the left side of the webpage, select National Provider Calls and Events, and then select today's event – today's date from the call list.

This call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website, and an announcement will be placed in the MLN Connects Provider eNews when these become available.

And finally, for this listening session, we would like to hear your feedback on two categories which are listed on slide 3 of the presentation. After we present on each topic, we will open the line for callers to enter a queue to provide feedback. Please wait until your topic is announced before getting into the queue to provide your comments.

At this time, I would like to turn the call over to Elizabeth November from the Performance-Based Payment Policy Group here at CMS. Elizabeth?

Presentation

Elizabeth November: Hey. Thank you, Amanda. This is Elizabeth November with the Shared Savings Program staff at CMS.

We are hosting today's listening session to get early feedback on the proposed policy changes included in the latest Shared Savings Program Notice of Proposed Rulemaking, which was published in the *Federal Register* on February 3rd, 2016, and for which the comment period will close on March 28th, 2016.

We are very limited in what we can discuss about the proposed rule during this comment period and in the time leading up to the publication of the final rule. Therefore, today's session is intended to be an opportunity for us to hear your considerations about the proposed policies.

In terms of the format of today's call, we will be providing a brief overview of select proposed policies. We are segmenting today's session as to first receive your feedback on proposed policies for incorporating regional fee-for-service expenditures into the methodology for resetting the ACO's historical benchmark.

After we hear feedback from callers who enter the call queue on this topic, we will review several other proposed changes to the program's policies, including a streamlined approach to adjusting the ACO's historical benchmark for changes in its composition of ACO participants identified by taxpayer identification numbers, referred to as TINs, an additional option to facilitate ACO's transition to performance-based risk, and an administrative finality of financial calculations proposal.

We will then hear feedback from callers on topics related to these proposed changes. We encourage you to review the entire proposed rule available through the *Federal Register*. Feedback received during today's listening session will not be considered formal comments on the rule.

Please see the proposed rule for instructions on submitting formal comments. In order to be assured that your comments receive consideration, you must officially submit your comments in one of the following ways:

- electronically through regulations.gov, or
- by regular mail, or
- by express or overnight mail, or
- by hand or courier.

To be assured consideration, comments must be received no later than 5 p.m. eastern time on March 28th, 2016. When commenting, please refer to file code CMS-1644-P. And as Amanda mentioned, there are slides available for today's presentation through the CMS website. So, periodically, as we go through today's presentation, we'll reference slide numbers in case you're following along.

Segment 1: Proposed Revisions to Benchmark Rebasing Methodology

So, we'll take a – a few minutes at first to summarize the key proposed changes for use of regional fee-for-service expenditures in resetting ACO historical benchmarks and resetting an ACO's benchmark for a second and subsequent agreement period beginning on or after January 1st, 2017.

We propose to make an adjustment when establishing the ACO's rebased historical benchmark to reflect a percentage of the difference between regional fee-for-service

expenditures and the ACO's regional service area and the ACO's historical expenditures. A higher percentage will be used in calculating this adjustment to the ACO's rebased historical benchmark for the ACO's third agreement period and all subsequent agreement periods.

We propose to replace the national trend factor with regional trend factors for establishing the ACO's rebased historical benchmark and to remove the adjustment to explicitly account for savings generated under the ACO's prior agreement period.

Further, we propose to annually update the rebased benchmark to account for changes in regional fee-for-service spending, replacing the current update, which is based solely on the absolute amount of projected growth in national fee-for-service spending. As indicated on slide 6, we propose to define an ACO's regional service area to include any county where one or more assigned beneficiary resides.

We also propose to include the expenditures for all assignable fee-for-service beneficiaries residing in those counties in calculating county fee-for-service expenditures by enrollment type that will be used in the ACO's regional cost calculations. Assignable beneficiaries are all beneficiaries residing in the county who are eligible for assignment, and the four enrollment types are:

- ESRD,
- disabled,
- aged/dual,
- and aged/non-dual beneficiaries.

We propose to weight county-level fee-for-service expenditures by the ACO's proportion of assigned beneficiaries in the county when calculating an ACO's regional service area expenditure amount.

As indicated on slide 7, we are also proposing a program-wide change to use all assignable beneficiaries instead of all fee-for-service beneficiaries as the basis for program calculations using national fee-for-service expenditures, including:

- the claims completion factors and the truncation thresholds for limiting the impact of catastrophically large claims on ACO expenditures,
- the growth rates used for trending benchmark expenditures,
- and the annual benchmark update.

Slide 8 includes a table which provides an overview of the proposed changes to the benchmarking methodology as compared to the current benchmarking approach, and a similar table is included – is included in the proposed rule. I want to turn the call back to Amanda now.

Feedback on Segment 1

Amanda Barnes: Thank you, Elizabeth. Before we begin hearing from you, I would like to remind everyone that this call is being recorded and transcribed. Before providing your feedback, please state your name and the name of your organization, and remember to pick up your handset to assure clarity. Please note your line will remain open during the time you're providing your feedback, so, anything you say or any background noise will be heard.

The first topic is feedback on proposals related to the benchmarking rebasing methodology. Holley, we're ready to hear from our first caller.

Operator: To provide your feedback, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Please hold while we compile the Q&A roster. Again, please hold while we compile the roster.

Again, please continue to hold while we compile the roster.

Your first comment comes from John Vigorita.

John Vigorita: Hi. This is John, and I represent Optimus Healthcare Partners. Up here in Optimus, we are 2012 – April 2012 starters. We actually wholeheartedly support the rebasing methodology. However, we don't believe we should be waiting for the second and third subsequent years. This should begin immediately. If this is the correct thing to do, we believe it should begin immediately.

Amanda Barnes: Thank you very much.

Operator: Our next comment will come from the line of Bonnie Shuck.

Bonnie Shuck: Actually, it was a question. Could you explain in a little more detail the difference between assignable beneficiaries and all fee-for-service beneficiaries?

Elizabeth November: Sure. So, assignable beneficiaries are those who are eligible for assignment to an ACO as opposed to the broader fee-for-service population. So, an example we specify in the proposed rule is that the broader fee-for-service population includes non-utilizers of healthcare services.

Bonnie Shuck: OK. Thank you.

Amanda Barnes: Thank you.

Operator: Our next comment comes from the line of Dr. Bryan Demarie.

Dr. Bryan Demarie: Hello. This is Bryan Demarie, Medical Director for USMD for our SeniorCare program. We have about 20,000 in the MSSP, and we certainly feel that this is a step in the right direction and it's going to help those of us who – we are sitting at – at the second-in-state for cost –for lowest cost. And so, when you're already sitting at the – the higher performing area, it's tougher for us to further improve without some sort of return on investment. And so, we're hoping that we continue to – to move in this direction and – and agree with our first caller that sooner is better to help those of us who have the systems in place to continue to develop these systems and further push the cost of care down in the market and in the state. Thank you.

Amanda Barnes: Thank you.

Operator: Our next comment comes from the line of Allison Irman.

Allison Brendon: Oh, thank you. Allison Brendon, that's OK. My question is, if an ACO dropped out of the MSSP during their first agreement period, and then, if they join the program again, when they begin the program again, would that count as their first agreement period or their second agreement period in terms of whether or not regional cost data is incorporated?

Amanda Barnes: One moment.

Elizabeth November: Hi. Could you please send that detailed question to us by email to the email that's specified in the presentation? It's…

Amanda Barnes: Slide 14.

Elizabeth November: Oh, thank you, Amanda. It's aco@cms.hhs.gov. Thank you.

Allison Brendon: Sure. Thank you.

Operator: Again, to provide your feedback, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key.

Your next comment comes from the line of David Introcaso.

David Introcaso: Yes. This is David Introcaso. I'm with the American Medical Group Association. So, a few comments…risk adjustment is part of this, certainly. So, there's a sentence in the proposed rule. I'm not clear of its meaning; so, maybe I start with clarity.

CMS is – is – is fulfilling the transition in 2016 to a new HCC model that markedly reduces the model's sensitivity to subjectively coded severity levels for key chronic

conditions. And I don't see any further discussion of what this "fully transitioning in 2016" means. So, can you provide some clarity on that?

Thomas Nolan: So, the information on the Part C risk score model that – that is used to produce agency risk scores is published as part of the – the Medicare Advantage Part C information on the CMS website. And that includes the details for how that model was transitioned over the last few years to the fully weighted basis of the new model in 2016. So, that information is available as part of that program's published material.

David Introcaso: OK. Well, that was my second question. So, this is the MA call letter that came out where the discussion concerns going to six enrollee – or six enrollment categories, is that correct?

Amanda Barnes: One – one second.

Thomas Nolan: Yes. I believe so.

Amanda Barnes: One second.

David Introcaso: Sure.

Thomas Nolan: Yes. So, this program's risk, it doesn't follows the final risk model for each program year for the Medicare Advantage program. And so, yes, it would – it would be described for 2016 in the call letter from the – the final letter from spring of 2015 for the 2016 program year.

David Introcaso: Oh, so, it's – it's the '15 letter for '16. It's not the letter that was just out for '17, correct?

Thomas Nolan: Correct. That would describe future potential changes to the model that would apply in future years.

David Introcaso: OK. The reason I ask is because, overall, my comment is—and you've heard this many times before, and MedPAC is also in agreement on this comment—and that is the risk adjustment between the two programs needs to be comparable. It's not. So, if CMS could work towards that goal again, I think it's largely the stakeholder community's view that that would be helpful.

You're probably well aware in that context that for the – how you adjust for the continuing – or the continuously enrolled has been a problem for the ACO stakeholder community. So, I'm sure you'll hear that complaint again.

My next related comment to the benchmarking concerns quality measurement, since I noted MedPAC. MedPAC made this same comment in its February 2 letter to Tavenner

last year, which is – since how – since there again is a dissimilarity between how CMS measures and rewards quality between the ACO program and MA—that meaning one's penalty-only, one's bonus-only, which is MedPAC's phrasing. The – if you don't – if you go to a regional blend and you don't have parity in quality performance and benchmarking between ACOs and MA, then CMS will never figure out, again per MedPAC, which programming is – which programs are working best in which regions. So, you may remember, MedPAC spent a lot of time looking at how these three fee-for-service MA and ACOs compare. But you can't measure comparability, particularly if you go to regional blend in ACOs, if you don't factor in the quality measurement program and, again, the dissimilarity between quality measurement in MA and ACOs.

I do want to echo the comment made by several others, now at least two, about—and this is also per MedPAC—that at some point in time, presumably sooner than later, that all ACOs operate under one fee-for-service benchmarking calculation for establishing, updating, and resetting the benchmarks.

We would be supportive also, to be specific on that, that the 2012/2013 ACOs who signed a second agreement period contract in January where we started, January 1, 2016, that they not be excluded, as proposed in the rule, from benefiting from the proposed change.

I could go on. I'll leave it at that. I don't want to take up everyone else's time. So, thank you very much.

Amanda Barnes: Thank you so much. And to the prior commenter, if you could submit your comment through the *Federal Register* process, we have that on the slide deck 13 and 14. We'll help you out with that.

Holley, we're ready for our next question.

Operator: And to provide feedback, again, press star, then the number 1 on your touchtone telephone. To remove yourself from the queue, press the pound key.

Our next comment comes from the line of Tim Peterson.

Tim Peterson: Afternoon. I'm with the University of Michigan and with the Physician Organization of Michigan Accountable Care Organization. I just wanted to offer a bit of counterpoint to the two callers that had supported the regional benchmark methodology.

We are curious and wonder whether CMS thinks the regional benchmark methodology won't lead to greater variation in pricing and costs across the country as opposed to less variation, which has been one of Medicare's goals – or stated goals over time—to

minimize some of the variation in Medicare expenditures across the country. We think focusing more on a national benchmark would further that goal and are worried that the regional benchmark would be counter to CMS's larger goals. Thank you.

Amanda Barnes: Thank you so much. At this time, we're going to pause a few—oh, Holley, did one come in?

Operator: We do have another comment from the line of John Vigorita.

John Vigorita: Hi. I just want to say that we – for us at least – Optimus Healthcare Partners sits right outside New York City. Regional benchmarking reflects reality, and a national benchmark doesn't – doesn't do that for us. And – and so, yes, a national benchmarking might – might work for some people. It certainly doesn't work for us here in New Jersey.

And I also want to thank David for his comment. Yes, those successful ACOs that started back in 2012 are being penalized by the delay in the revised benchmarking. So, that we've been successful in our first two and looks like third performance year, and we will do nothing but suffer until the – the proposed rebenchmarking takes place.

Keypad Polling

Amanda Barnes: Thank you so much.

Holley, at this time, we're going to pause for a few moments to complete keypad polling. We're ready to start.

Operator: CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9.

Again, if you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9. Please hold while we complete the polling.

Again, please continue to hold while we poll.

Please continue to hold while we complete the polling.

Thank you for your participation. I'd now like to turn the call back over to Amanda Barnes.

Segment 2: Other Proposed Revisions

Amanda Barnes: Thank you, and I will go ahead and turn the call back over to Elizabeth November for Segment 2 of our presentation.

Elizabeth November: Thank you. We're going to spend a few minutes reviewing several other proposed office changes specified in the Notice of Proposed Rulemaking. In case you're following along with the slides, we will reference some slide numbers as we go along.

Slide 10 provides an overview of our proposals for how we adjust an ACO's historical benchmark for changes in its composition of ACO participants identified by taxpayer identification numbers or TINs.

We propose a program-wide application of a streamlined approach to adjusting an ACO's historical benchmark at the start of each performance year for changes in its ACO participant TIN composition finalized before the start of that year. The proposed adjustment would use an expenditure ratio calculated for a single year that accounts for differences in an ACO's assigned population determined based on its prior and current participant composition. This proposed approach replaces the current approach requiring recalculation of an ACO's 3-year average per capita historical benchmark if the ACO changes its ACO participant TIN composition during the prior performance year.

As indicated on slide 11, to facilitate ACOs transition to performance-based risk, we are proposing to provide an additional option for ACOs participating under Track 1, the one-sided model, to apply to renew for a second agreement period under a two-sided model, that is, Track 2 or 3.

Under this option, eligible ACOs would apply for and be approved to renew for a second agreement period under a two-sided model, including meeting requirements for establishing a repayment mechanism. The ACO would remain in their existing Track 1 agreement for an additional year, and we would defer rebasing the ACO's historical benchmark for 1 year.

This proposal does not replace the current option for eligible ACOs to continue participation in Track 1, the two-sided model for a – I'm sorry, the one-sided model, for a second 3-year agreement period.

Slide 12 describes proposals for administrative finality of financial reconciliation calculations. We propose to further define timeframes and other criteria for reopening of a determination of ACO shared savings or shared losses to correct financial reconciliation calculations, including:

- to limit reopenings to not later than 4 years after the date of the notification to the ACO of the initial determination of shared savings or shared losses for the performance year for good cause and
- reserving the right to reopen a payment determination at any time in the case of fraud or similar fault.

So, we would like people to enter the queue to provide feedback on these other proposed changes and, as time allows, following conclusion of that call queue, we will reopen the call to and invite additional feedback on any of the proposed changes, including the first segment on the proposed changes for the rebasing methodology. Thank you.

Feedback on Segment 2

Amanda Barnes: Thank you. Holley, we're ready to hear from our first caller.

Operator: To provide your feedback, please press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, press the pound key. Please hold while we compile the roster. Again, please hold while we compile the roster.

And our first comment comes from David Introcaso.

David Introcaso: Thank you, again. So, this is concerning your facilitating transition performance-based risk. Per the two options you propose—the fourth year under a first agreement or the first year under a second agreement—you know, we're uncertain how this is helpful or beneficial in that, why wouldn't an ACO just choose a second Track 1 agreement. So, we don't know how – we're not confident that this proposal will actually be widely adopted. So, that's my first comment.

What I'd like to suggest, moreover, is, obviously CMS is interested in moving Track 1—so, we still make up 95 percent of the program—more rapidly to a Track 2 or 3 and they will ultimately get there obviously, or CMS will or you will, because, of course, after 6 years, if you want to – can you participate then, you have to be. So, I get that.

But in an effort to transition more rapidly these Track 1's, I was reminded of the related language in the December 8th, 2014, proposed rule, and I could cite you specifically the page, *Federal Register* page 72830, where you talked about splitting ACO TIN lists into different tracks. And then, in that conversation, in that proposed rule, CMS or you outlined seven criteria in how this would be accomplished. I think – we think that's worth reconsideration, among other benefits, you'd allow the Track 1 to accept varying degrees of risk, and that the – the ACO would be simultaneously able to limit their risk exposure while accelerating their movement to risk contracting. And this, you phrase as, "segmented lists." And that the ACOs could change or – or reinvent these segmented lists in – during their agreement period or be able to move their provider suppliers from Track 1 to a two-sided model. This works only, of course, if they go from 1 to 2 because

Track 3 is prospective assignment. But there are other, obviously, aspects to be worked out. But we do think that creates a better more incremental glide path. You've heard that phrase a million times.

So, that's the comment on the – on the administrative finality. What it looks like to us, at least preliminarily, is that, CMS is reserving the right to decide whether or not to reopen or – or reopen unilaterally or remaking its reopening decisions unilaterally and using unknown or, as you say in the text, unspecified criteria. So, our first read of this is that, if this is an accurate assessment, the proposed rule's reopening discussion really doesn't help because it appears ultimately CMS is saying, "This is black box."

I would go further, say, relative to the comment about good cause and materiality and the proposal of a certain percent in sum for the program, at any percent in sum for net shared annual savings, we think that's too high of a barrier burden and there ought to be some opportunity spelled out that would allow an individual ACO, if they believe that they have suffered material financial harm, that they on an individual basis be able to petition for reopening. So, I'll leave it at that. Thank you.

Amanda Barnes: Thank you.

Operator: To provide your feedback, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key.

Our next comment comes from the line of Carol Romano.

Carol Romano: Hi. So, sorry for the delay. Can you hear me?

Amanda Barnes: Yes, we can.

Carol Romano: Great. So, I – I have one comment and one question. So, my comment goes back to the notion of removing the adjustment to the historical benchmark for savings in prior agreement period. We think that the change in the manner in which the historical benchmark will be transformed in this model will not make up for the losses that those of us who have been successful are threatened with by the removal of the adjustment to the historical benchmark for savings that we were able to engender for the previous performance period.

So, we think this is a strong disincentive to the ACOs who are most successful in reducing expenditures. And so, this really doesn't make very much sense to us. For those of us who have been successful in repeatedly and consistently reducing expenditures, we would think that Medicare would be working to do more to promote our continued involvement rather than removing incentives.

And then, I have a question regarding the facilitating transition to performance-based risk. One of our concerns when we submitted our application for our second performance period and we were considering entering into Track 2 or Track 3 is that we didn't know in advance what our financial benchmark would be in that shared risk model. So, in – in this proposal, when might we know what our benchmark is going to be, and will we get that benchmark only after we've made the decision to take on risk or not take on risk?

Elizabeth November: So, under the proposed option, it would be available to use the benchmark – would basically follow the current schedule for when those benchmarks are made available. It wouldn't allow for advance knowledge of what the benchmark value would be prior to the ACO entering a risk model.

Carol Romano: You know, that makes it difficult even for those of us who have confidence in our ability to perform. It just – it just makes us very uneasy, and I'm sure there are a lot of other Track 1 ACOs out there who feel the same. So, thank you. You know, we'll – we'll submit a request that that be reconsidered.

Elizabeth November: Thanks, and just as a – as a good reminder to everyone on the call to please remember to submit formal written comments on the proposed rule. Thanks.

Amanda Barnes: Thank you.

Operator: Our next comment will come from the line of Sherman Lee.

Sherman Lee: Hello. How are you doing? This is Sherman Lee from MetroHealth. I was calling – I have a question with the proposed rule change to utilize regional factor. Will the growth increment calculation utilized for the updated benchmark be modified or will that remain the same going forward?

Elizabeth November: So, the proposals are to use a regional trend factor in establishing the historical benchmark, as well as to use a regional update factor annually during the course of the agreement period.

Sherman Lee: OK. So, it would – it would follow the same calculation rules as the national – as it does now, correct?

Elizabeth November: So, there would be an annual update to the benchmark, but it will be a regional update based on the fee-for-service expenditures for the ACO's regional service area. It'd be – likely be quite different from the national update—the national update is much more uniform throughout ACOs participating in the program—that this would change to a update factor that's based on the ACO's regional service area fee-for-service expenditures.

Sherman Lee: OK. Yes. One of the things that I found is in trying to utilize – in trying to make the switch to the regional trend factor where I found that our historical benchmark went up. However, when using the calculation, our updated benchmark would look like it will be pulled down significantly. So, that was one of the things that I noticed.

Elizabeth November: OK. Thank you for your observation.

Sherman Lee: OK. Thank you.

Operator: Again, to provide feedback, please press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key.

Our next comment will come from Allison Irman.

Allison Irman: Hi. I had a question about the reopening for the ACO determinations and when that 3-percent materiality threshold will be applied or when CMS would use – kind of evaluate things whether good cause exists. Could you explain a little bit more about an instance when CMS would evaluate something based on good cause vs. using that 3-percent threshold?

Amanda Barnes: One moment.

One moment.

John Pilotte: Thank you for the – the question. And we, again, encourage you to submit that through the formal comment process, as well. But just to clarify that we – good cause is an established process to define – to define the area of what – and we provided. And I would encourage you to sort of review those definitions of – of good cause.

It's – we also provide an example of what we would consider good cause in the event of a CMS error, and looked at things such as other materiality thresholds, such as those used by other government oversight entities, and so forth, in determining various factors of what we would constitute a good cause for potentially opening up a – for a CMS error.

So, that information is provided as sort of an example. There are general criteria discussed, and I would encourage you to submit comments on – on that approach, as well as criteria to be taken into an account.

Allison Irman: OK. Thank you. I guess I was just trying to understand a little bit more about, if good cause would be evaluated, for an individual ACO to – might reopen something based on good cause to an individual ACO without considering that 3-percent

materiality threshold. I'm just wondering if those are mutually exclusive or if there's overlap there. Does that make sense?

Elizabeth November: Thank you. And again, it's – it's helpful to hear that it could potentially use some clarification, so…and we really appreciate that feedback. Thanks.

As John mentioned, it would be probably a good thing, if you haven't already, to read through the details that are included in the Notice of Proposed Rulemaking. But we'll certainly consider clarifying what you've indicated. Thank you.

Allison Irman: Thank you.

Operator: At this time, I'll turn the conference back over to Amanda Barnes.

Elizabeth November: OK.

Further Comments

Amanda Barnes: Thank you, Holley. At this time, we can open the floor up for additional comments on the topics presented today.

Operator: To provide your feedback, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, press the pound key. Please hold while we compile the roster.

And we have a comment from the line of David Introcaso.

David Introcaso: Thank you, again. Since I went on about risk adjustment, maybe this is more of a clarity question than a comment. But when you talk about or propose a – a – a comparative risk adjustment, and I'm quoting here, "in relation to fee-for-service beneficiaries in the ACO's regional service area," it appears that – and in concept, we approve that idea such that risk adjustment – your revised method to risk adjust parallels the regional work you're doing in the update historical in reset.

But when you say the revision to the risk adjustment will reflect this comparison to the ACO's regional service area – when you say regional service area, do you mean by the counties proportionally weighted? And the reason I ask is because you went at length to describe and – and explain why you're not using fee-for-service county in your regional blend; you're using assignable Bennies in ACO counties.

So, here, wouldn't it be the same? It wouldn't just be a – a comparison to HCC for fee-for-service in the ACO's region. It would just – it would be a comparison HCC for assignable Bennies in the appropriate ACO counties. Do I – what's – what's the explanation of this? Was I clear?

Amanda Barnes: One moment.

Thomas Nolan: So, what was proposed was to indeed calculate the regional service area expenditures and risk scores to affect those calculations, and that's what was then published for informational purposes for Calendar Year 2014, '13, and '12. Alongside that proposed rule was each county's assignable counts of beneficiaries, their average expenditures, and their average risk scores. So, your understanding appears correct.

Heather Grimsley: We have failed to remind everybody that we did publish two files associated with the NPRM. They are detailed on – in Section G, Publicly Available Data To Facilitate Modeling of the Proposed Changes.

In those files, one file contains the average county fee-for-service expenditures, CMS-HCC prospective risk scores, and person-years for assignable beneficiaries by Medicare enrollment type, which is ESRD, disabled, aged/dual eligible, and aged/non-dual eligible for 2012, 2013, and 2014.

The second file contains the total number of assigned beneficiaries for each ACO for each county where at least 1 percent of the ACO's assigned beneficiaries reside for 2012, 2013, and 2014.

There are also two public-use files that are available for Performance Year 1 and for – or Performance Year 2014. And we are updating the 2013 Performance Year 1 file to include the 2013 risk scores. That should be available within the next 2 weeks.

David Introcaso: Can – this is – this is David again. Can I just confirm what I think I understood that your response says? That when you comparatively risk adjust, that is defined as risk adjustment for all fee-for-service bennies in the appropriate ACO counties, is that correct?

Thomas Nolan: The comparison would be to assignable fee-for-service beneficiaries in the ACO's counties.

David Introcaso: OK. So, you're persisting with—and that's what I'm trying to get clarity on—you're persisting with the comparison to assignable bennies in the county. And again, that's consistent with how you're doing this throughout. So, that's correct.

Thomas Nolan: Correct.

David Introcaso: All right. Thank you.

Amanda Barnes: Thank you.

Operator: Again, to provide feedback, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, press the pound key.

And your next comment will come from the line of Matt Cayman.

Matt Cayman: Hello. Good afternoon. First of all, I wanted to thank you all for publishing all of that data to support the analysis of this proposed rule. My comment pertains to the risk adjustment that is done to determine the regional average amount that is applied to rebased historical benchmark.

Will the risk adjustments be done by normalizing both the ACO historical benchmark and the regional average benchmark to a 1.0 risk score? Or will it be indexed to the ACO's historical risk score, similar to how they do the risk adjustment inserting the performance year currently?

Elizabeth November: Hi. Could you please submit your recommendation as a formal comment on the NPRM, the Notice of Proposed Rulemaking, please?

Matt Cayman: Yes. So, it – the mechanics weren't exactly specified in the rule, is that correct?

Elizabeth November: Right. I mean, we don't go into the how to evolve the calculations in the proposed rule, which is intended to give a broader outline of the proposed policy changes. So, to the extent that you have a suggestion on how to perform the calculations, please include that in your formal comments.

Matt Cayman: Definitely. Thank you.

Amanda Barnes: Thank you.

Operator: And your next comment will come from the line of Allison Irman.

Allison Irman: Hi. You just – I just kind of missed something related to some additional data that you said you were going to be releasing in the next couple of weeks. Could you repeat that, please?

Heather Grimsley: So, we are providing an update to the Performance Year 1 public-use file that is available on the program website. And that update will be to add the Calendar Year 2013 risk scores by enrollment type for the benchmark years and Performance Year 1. That data is currently available in the Performance Year 2014 file. We are adding it to the 2013 file.

Allison Irman: Thank you.

Operator: Thank you. I'd now like to turn the conference back over to Amanda Barnes.

Amanda Barnes: And I'll turn it back over to Elizabeth for closing.

Additional Information

Elizabeth November: Thank you everybody for your very thoughtful feedback today. Just as a reminder, which we have mentioned throughout the call, please submit your formal comments in writing to us by the close of the comment period on March 28, 2016, at 5 p.m. eastern time.

Again, instructions for submitting formal comments are specified in the proposed rule. We also want to point you to the resources slide included in today's presentation which contains links related to the proposed rule and also how to contact us. We look forward to receiving your written comments. Thank you.

Amanda Barnes: Thank you so much. An audio recording and written transcript of today's call will be posted in the MLN Connects Call website, and we will release an announcement in the eNews when these become available.

Again, my name is Amanda Barnes and I would like to thank our subject matter experts. And also, thank you for participating in today's MLN Connects Listening Session on the Shared Savings Program Proposed Rule on Revised Benchmark Rebasing Methodology.

Thank you and have a great day.

Operator: This concludes today's call. Presenters, please hold.

-END-

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