



Medicare Shared Savings Program Final Rule Overview

June 2016



Overview of Today's Session

- Background
- Part 1: Modifications to benchmarking methodology
- Part 2: Facilitating transition to performance-based risk
- Part 3: Administrative finality of financial reconciliation calculations
- Resources
- Question & Answer session

Background

- Regulations related to the Shared Savings Program's financial models
 - Established in November 2011, and modified in June 2015
 - Modified by a final rule published June 10, 2016 in the Federal Register (81 FR 37950)
- These latest modifications strengthen incentives under the program after considering comments received on issues specified in the 2016 notice of proposed rulemaking

Part 1: Modifications to benchmarking methodology

- This rulemaking focused on revising the methodology for rebasing (resetting) the ACO's historical benchmark in the ACO's second or subsequent agreement period
- The final rule also includes broader, program-wide changes, to the methodology for determining factors based on national FFS expenditures used in financial calculations
- In response to commenters' suggestions, we did not finalize our proposal to replace the current approach for calculating adjusted historical benchmarks for ACOs that make ACO Participant List changes with a new program-wide approach that would determine this adjustment using an expenditure ratio based on a single reference year

Revised Rebasing Methodology

- Revised rebasing methodology applies to second or subsequent agreement periods beginning in 2017 and subsequent years
- Integrates factors based on regional fee-for-service (FFS) expenditures in resetting benchmarks:
 - Use regional growth rates as trend factors for determining the rebased benchmark
 - Phase-in a regional adjustment to the rebased benchmark, with a longer phase-in for ACOs that have higher spending compared to their region
 - Use regional growth rates to annually update the rebased benchmark
- These changes improve the program's incentives for ACOs by recognizing an ACO's efficiency relative to its region and limiting the link between an ACO's performance and its future benchmarks

Determining Regional Expenditures

- An ACO's regional service area will include all counties where one or more beneficiaries assigned to the ACO reside
- County-level data will be used to determine regional FFS expenditures for the ACO's regional service area
 - County-level data calculated consistently across populations identified by Medicare enrollment type: End Stage Renal Disease (ESRD), disabled, aged/dual eligible, aged/non-dual eligible
 - County expenditures determined using the assignable beneficiary population: a subset of the broader FFS population, identified based on the 12-month period corresponding to the calendar year for which the calculation is being made
 - County expenditures risk adjusted by applying full CMS-HCC risk scores
- Weight county-level FFS expenditures by the proportion of the ACO's assigned beneficiaries in the county, and by Medicare enrollment type

Resetting the Historical Benchmark

- Replace the national trend factors with regional trend factors for establishing the ACO's rebased historical benchmark (restate BY₁ and BY₂ expenditures in terms of BY₃); remove the adjustment to explicitly account for savings generated under the ACO's prior agreement period
- Adjust the ACO's rebased historical benchmark to reflect a percentage of the difference between the regional FFS expenditures in the ACO's regional service area and the ACO's historical expenditures
 - Regional expenditures determined using regional average expenditures for the ACO's regional service area
 - Risk adjustment to account for the health status of the ACO's assigned population in relation to FFS beneficiaries in the ACO's regional service area
 - Phased approach to determining the weight (percentage) used in calculating the adjustment

Phase-in of Regional Adjustment

- Use an increasing weight in calculating the regional adjustment
 - 35 percent (first agreement period in which regional adjustment applied); 70 percent (second or subsequent agreement period in which regional adjustment applied)
 - For ACOs that have higher costs than their region the weight placed on the regional adjustment will be reduced: 25 percent (first agreement period in which regional adjustment applied); 50 percent (second agreement period); 70 percent (third and subsequent agreement period)

Phase-in of Regional Adjustment - continued

- Uses the most advantageous weight in calculating the regional adjustment during the phase-in, according to whether the ACO's historical spending is relatively higher or lower compared to spending in its regional service area
- Provides a longer phase-in for ACOs that have higher spending than their region in order to provide more time for these ACOs to be successful
- To account for changes in the ACO's certified ACO Participant List during the agreement period, we will adjust an ACO's rebased historical benchmark prior to the start of the performance year, including redetermining the regional adjustment

Timing of Applicability - 2016 Renewals

- For ACOs that started in the program in 2012 and 2013, and entered a second agreement period beginning in 2016
 - Revised methodology will apply for the first time in calculating the rebased historical benchmark for their third agreement period (beginning in 2019)
 - For these ACOs' second agreement period (2016 – 2018), we continue to apply the benchmark rebasing methodology established with the June 2015 final rule, including:
 - Equally weighting the ACO's historical benchmark years
 - Applying an adjustment for savings generated under the ACO's first agreement period
- Avoids disruption to agreement periods in progress; gives ACOs time to adapt to changes

Annual Data Files

- CMS plans to release data files each fall
 - Annual data files containing county-level expenditure and risk score data
 - ACO-specific, aggregate data on counties of residence of the ACO's assigned population for each performance year

Assignable Beneficiaries Used to Calculate National FFS Expenditures

- Final rule revises the methodology for calculating factors based on national FFS expenditures, to use assignable Medicare FFS beneficiaries instead of all FFS beneficiaries
 - Assignable beneficiary means a Medicare FFS beneficiary who receives at least one *primary care service* with a date of 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). [*Italics indicates terms defined under § 425.20*]
 - Excludes from calculations beneficiaries who would not meet requirements for being assigned including non-utilizers of primary care services
 - Assures parity with use of the assignable population in regional FFS calculations

National FFS Expenditure Factors Based on Assignable Population

- Use of assignable beneficiaries in national FFS expenditure calculations includes –
 - Trend factors and annual update used in calculating an ACO's benchmark for its first agreement period and rebased benchmarks for ACOs that entered a second agreement period beginning in 2016
 - Truncation thresholds for determining benchmark and performance year expenditures (programwide)
- Timing of applicability
 - For factors used to establish benchmarks: applicable to agreement periods beginning in 2017 and subsequent years
 - For factors used in benchmark and performance year calculations during the agreement period: applicable to performance year 2017 and subsequent years
 - We will adjust benchmarks under current agreement periods for performance year 2017 and subsequent years (2014 starters electing fourth year under first agreement period, 2015 starters, and 2016 starters/renewals) so that benchmarks for these ACOs reflect the methodology used in expenditure calculations for the performance year

Characteristics of Benchmarking Approaches by Agreement Period

Source of Methodology	Agreement Period	Historical Benchmark Trend Factors (trend BY ₁ , BY ₂ to BY ₃)	Adjustment to the Historical Benchmark for Regional FFS Expenditures (percentage applied in calculating adjustment)	Adjustment to the Historical Benchmark for Savings in Prior Agreement Period?	Adjustment to the Historical Benchmark for ACO Participant List Changes	Adjustment to the Historical Benchmark for Health Status and Demographic Factors of Performance Year Assigned Beneficiaries	Update to the Historical Benchmark for Growth in FFS Spending
November 2011 final rule	First	National	No	No	Calculated using benchmark year assignment based on the ACO's certified ACO Participant List for the performance year	Newly assigned beneficiaries adjusted using CMS-HCC model; continuously assigned beneficiaries adjusted using demographic factors alone unless CMS-HCC risk scores result in a lower risk score	National
As modified by June 2015 final rule	Second (beginning 2016)	National	No	Yes	Same as methodology for first agreement period	Same as methodology for first agreement period	National
As modified by this final rule: Rebasement Methodology for second or subsequent agreement periods beginning 2017 and subsequent years	Second (third for 2012/2013 starters)	Regional	Yes (35 percent, or 25 percent if ACO is determined to have higher spending compared to its region)	No	Same as methodology for first agreement period; regional adjustment redetermined based on ACO's certified ACO Participant List for the performance year	No change	Regional
	Third (fourth for 2012/2013 starters)	Regional	Yes (70 percent unless the Secretary determines a lower weight should be applied, as specified through future rulemaking, or 50 percent if ACO is determined to have higher spending compared to its region)	No	Same as methodology for second agreement period beginning 2017 and subsequent years	No change	Regional
	Fourth and subsequent (fifth and subsequent for 2012/2013 starters)	Regional	Yes (70 percent unless the Secretary determines a lower weight should be applied, as specified through future rulemaking)	No	Same as methodology for second agreement period beginning 2017 and subsequent years	No change	Regional

Part 2: Facilitating transition to performance-based risk

- ACO enters a 3-year agreement period for a particular participation track, either under the one-sided shared savings model (Track 1) or a two-sided shared savings / shared losses model (Track 2 or Track 3) and remains under that track for the entire agreement period
- Final rule establishes an additional option for Track 1 ACOs renewing for a second agreement period under a two-sided model
 - Initial participation agreement under Track 1 extended for an additional year
 - ACO defers entering risk model and benchmark rebasing for 1 year
- New option applicable to second agreement periods beginning in 2017 and subsequent years; available beginning with the 2017 renewal cycle (2014 starters)

Part 3: Administrative finality of financial reconciliation calculations

- Final rule defines timeframes and other criteria for reopening of a determination of ACO shared savings or shared losses to correct financial reconciliation calculations, including:
 - Limiting re-openings to not later than four 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.

Resources

- Access the rule through the Federal Register
<https://www.federalregister.gov> (81 FR 37950)
- Shared Savings Program website
<https://www.cms.gov/sharedsavingsprogram>
 - News and Updates webpage contains a Fact Sheet and Press Release on the final rule
 - How to Apply webpage for new applicants/renewals
- For further information contact us by email
 - Active ACOs: SharedSavingsProgram@cms.hhs.gov
 - Applicants: SSPACO_Applications@cms.hhs.gov

Question & Answer Session