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Historical Benchmark Methodology and Reports for ACOs in their First Agreement Period and ACOs that Renewed their Agreements in 2016

Audience: ACOs Currently Participating in their First Agreement Period and ACOs that Renewed their Agreements in 2016

March 27, 2018

Medicare Shared Savings Program

DISCLAIMER

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Agenda

- Background and Overview of Financial Model
- ACO Expenditure Calculations
- Historical Benchmark
- Updated Benchmark
- Financial Reconciliation
- Risk Adjustment
- Resources
- Question & Answer Session



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Background and Overview of Financial Model

- Regulatory Background
- Track 1+ Model
- Sequestration Policy
- Overview of Financial Model



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Regulatory Background

- Methodology for establishing the Accountable Care Organization's (ACO's) benchmark and calculating shared savings/losses is outlined in the Medicare Shared Savings Program (Shared Savings Program) final rule (42 CFR part 425).
- Key provisions include:
 - Selection of risk model (Tracks 1, 2, or 3) (§ 425.600)
 - Establishing, adjusting, and updating the benchmark for an ACO's first agreement period (AP) (§ 425.602)
 - Resetting the benchmark for a second or subsequent AP (§ 425.603)
 - Calculation of shared savings under Track 1 (§ 425.604)
 - Calculation of shared savings/losses under Track 2 (§ 425.606)
 - Calculation of shared savings/losses under Track 3 (§ 425.610)

Track 1+ Model

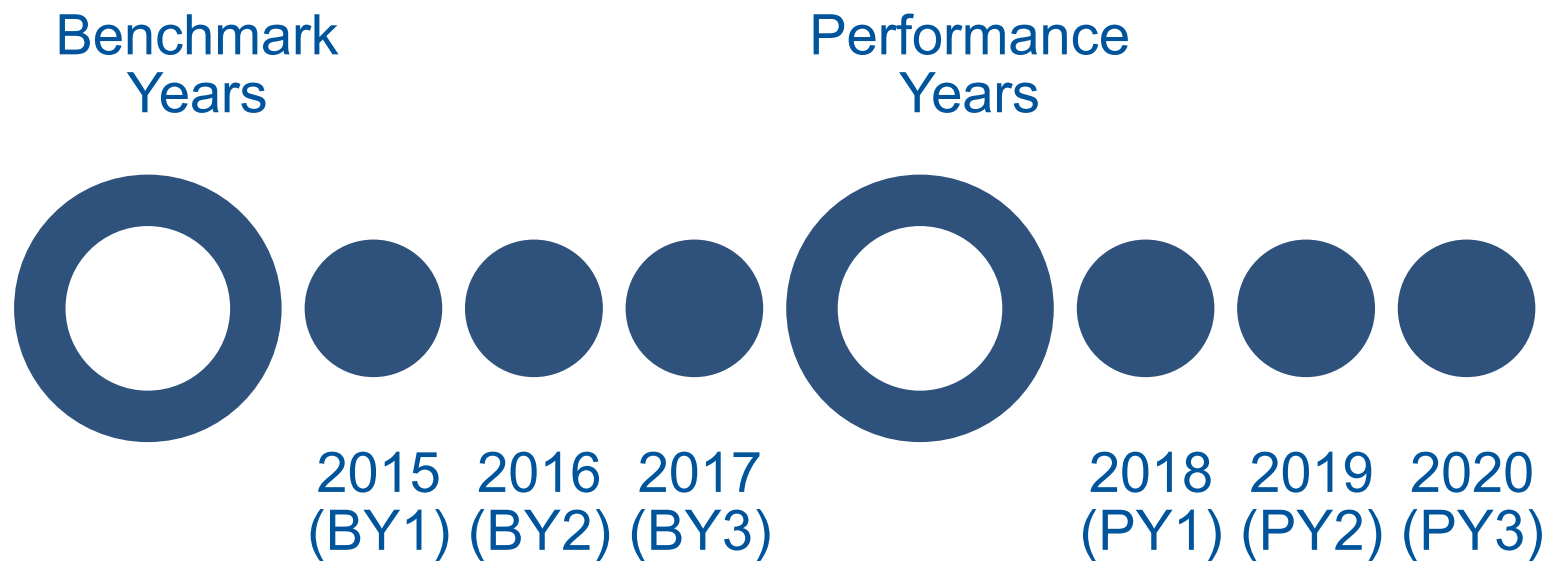
- The Track 1+ Model is a CMS Innovation Center model designed based on feedback from stakeholders for options to facilitate ACOs' transition to performance-based risk.
- The model is based on Track 1, but tests a payment design that incorporates more limited downside risk compared to Tracks 2 and 3, as well as elements of Track 3 to help ACOs coordinate care, such as prospective assignment.
- The model was first available for Performance Year (PY) 2018, with the following ACOs eligible to apply:
 - Track 1 ACOs within their current AP
 - New applicants
 - Track 1 ACOs renewing their participation agreement
- The financial methodology for the model is described in the [July 2017 CMS fact sheet](#).

Sequestration Policy

- Sequestration (Public Law 112-25) reduced Medicare provider payments by two percent for all services provided on or after April 1, 2013.
- Performance payments occurring after April 1, 2013, are subject to the sequestration adjustment and will be reduced by two percent.

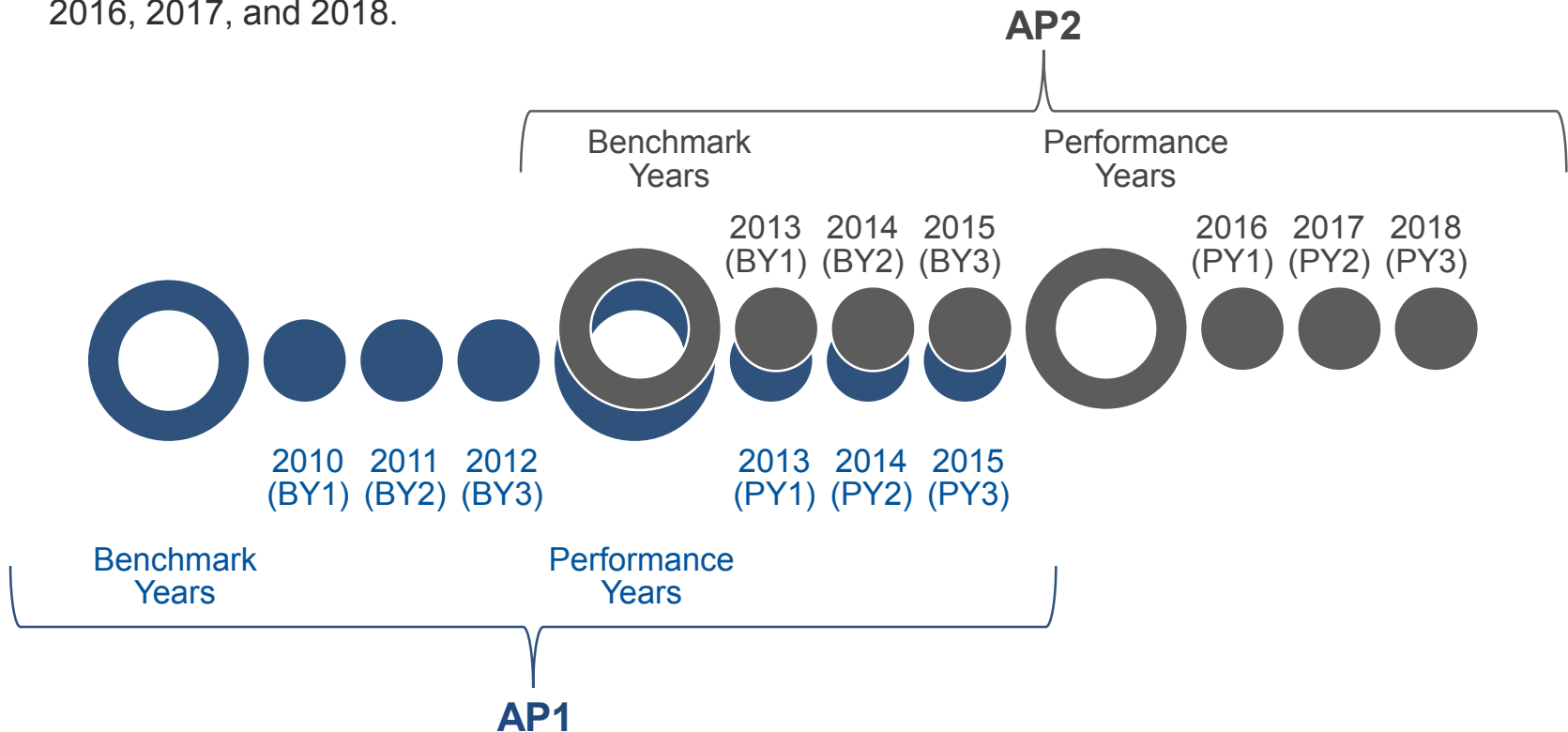
Overview of Financial Model

Example: An ACO's first AP begins in 2018. For this ACO, the three benchmark years (BYs) would be 2015, 2016, and 2017 and the three performance years would be 2018, 2019, and 2020.

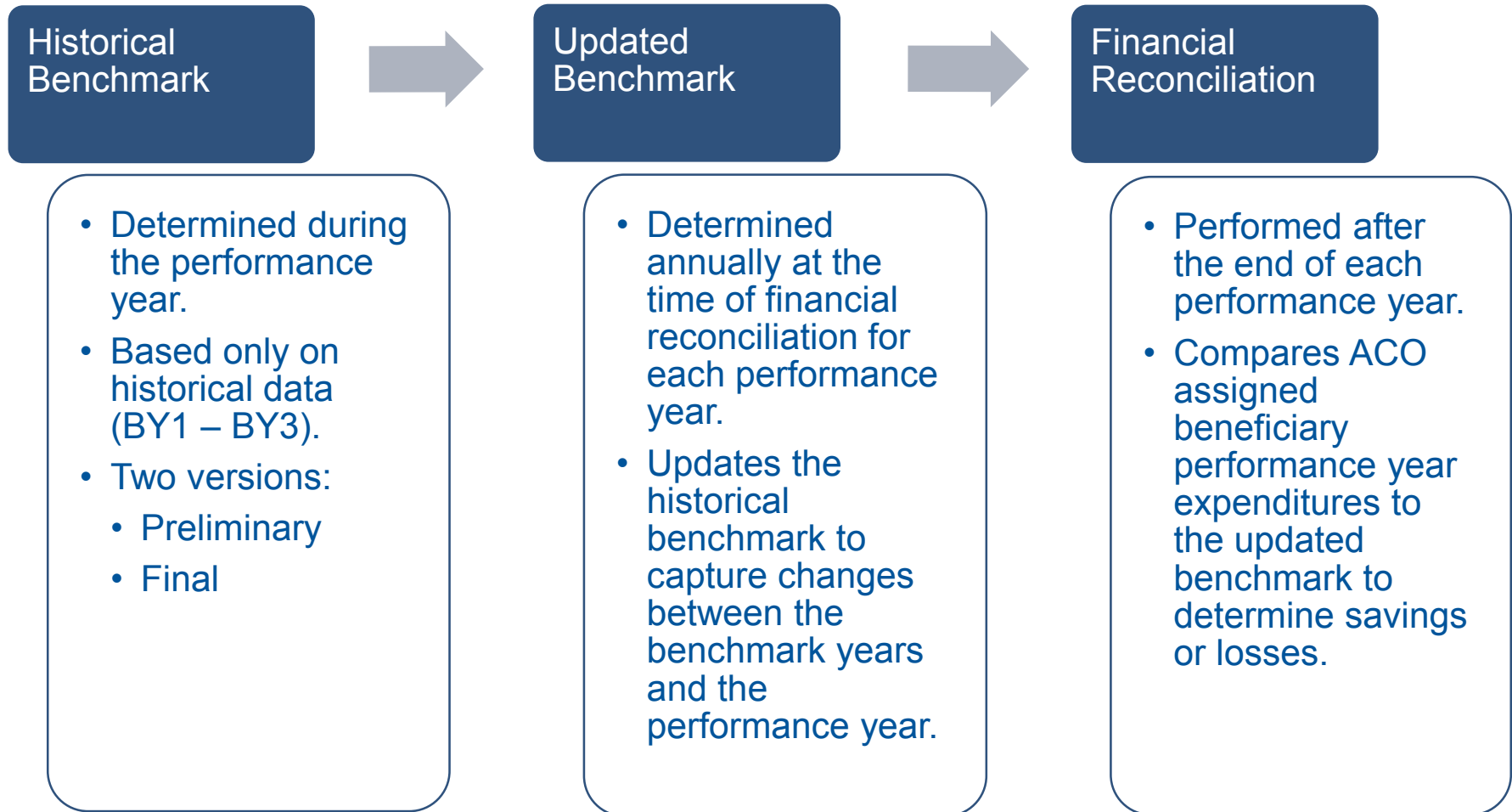


Overview of Financial Model (cont'd)

Example: An ACO's first AP begins in 2013. For this ACO in AP1, the three benchmark years would be 2010, 2011, and 2012 and the three performance years would be 2013, 2014, and 2015. The same ACO's second AP begins in 2016. For this ACO in AP2, the three benchmark years would be 2013, 2014, and 2015 (the previous AP's performance years) and the performance years would be 2016, 2017, and 2018.



Overview of Financial Model (cont'd)



ACO Expenditure Calculations

- Overview
- Methodology

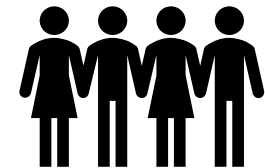


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ACO Expenditure Calculations: Overview



- ACO per capita expenditures are a key element of the program's financial model.
- CMS uses the same methodology to calculate expenditures for benchmark years and performance years.
- CMS calculates average per capita expenditures separately for each of four Medicare enrollment types:
 - End-stage renal disease (ESRD)
 - Disabled
 - Aged/dual eligible
 - Aged/non-dual eligible



ACO Expenditure Calculations: Methodology



- For each assigned beneficiary (by enrollment type) for the benchmark year or performance year, calculate total annual Medicare Parts A and B fee-for-service (FFS) expenditures as follows:
 - Use the Medicare paid claim amount for claims with dates of service during the calendar benchmark year or performance year and processed by the end of a three-month claims run-out period.
 - Exclude indirect medical education (IME), disproportionate share hospital (DSH), uncompensated care (UCC), and pass-through payments.
 - Add back in FFS payment reductions made for:
 - Sequestration (for claims in or after April 2013)
 - Population-based payments (PBPs) associated with CMS Innovation Center models
 - Incorporate beneficiary-identifiable non-claims based payments (NCBPs).

ACO Expenditure Calculations: Methodology (cont'd)



- Annualize the beneficiary's expenditure to convert to a 12-month basis.
 - Example: An eligible beneficiary was only in the program for six months, before passing away. The beneficiary's expenditure from those six months would be multiplied by two to annualize to a 12-month basis.
- Truncate the beneficiary's annualized expenditure so it does not exceed a specified dollar threshold/cap equal to the 99th percentile of annualized expenditures of the national assignable FFS population. This is done to reduce impact of catastrophically high expenditures for some beneficiaries.
 - Example: The aged/non-dual eligible truncation threshold/cap is \$122,128. A beneficiary's annualized expenditures are \$200,000. For purposes of calculating expenditures, assume that this beneficiary's annualized expenditures are \$122,128.

ACO Expenditure Calculations: Methodology (cont'd)

- Take a weighted average of annualized, truncated expenditures across all assigned beneficiaries, weighting by the fraction of the year each beneficiary is eligible (person-years).
 - Example: Expenditures for a beneficiary with six eligible months in the program would receive a weight of $1/2$. This beneficiary's experience represents half of a person-year. Expenditures for another beneficiary with 12 eligible months would receive a weight of 1. This beneficiary's experience represents a full person-year.



- Apply a completion factor to account for claims for services that were provided during the calendar benchmark year or performance year but not processed by the end of the three-month run-out period.

Historical Benchmark

- Overview
- Establishing the Historical Benchmark for the First AP
- Establishing the Historical Benchmark for 2016 Renewals
- Adjusting the Historical Benchmark for PY2 or PY3
- Historical Benchmark Report Walkthrough



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Historical Benchmark Overview

- CMS establishes an ACO's historical benchmark near the start of its first AP.
- CMS provides an ACO with both a **preliminary** Historical Benchmark Report and a **final** Historical Benchmark Report during its PY1.
 - The preliminary benchmark is typically provided in the spring of PY1 and uses preliminary data for BY3.
 - Assignment (for Track 1 and 2 ACOs) and expenditures (for all tracks) based on less than 3 months of claims run-out for BY3
 - Uses BY2 values for BY3 risk scores, national FFS expenditures, and truncation thresholds
 - The final historical benchmark uses actual BY3 information when it becomes available later in the PY. It also appears as Table 1 of the Financial Reconciliation Report the ACO receives with performance year financial reconciliation.

Historical Benchmark Overview (cont'd)

- CMS provides an ACO with an **adjusted** Historical Benchmark Report during its PY2 or PY3 to reflect ACO Participant List changes or other program changes for that performance year.
 - The adjusted historical benchmark is based on the same three benchmark years as the historical benchmarks provided in PY1.
 - The adjusted historical benchmark also appears as Table 1 of the Financial Reconciliation Report the ACO receives with performance year financial reconciliation after PY2 or PY3.
- If an ACO makes no ACO Participant List changes in PY2 or PY3 and there are no program-wide changes, the ACO will not receive an adjusted historical benchmark that year.
 - In this case, the benchmark that appears as Table 1 of the Financial Reconciliation Report will be the same as that from the prior performance year.

Historical Benchmark Overview (cont'd)

Characteristic	Preliminary	Final	Adjusted
Recipient ACOs	ACOs in their <u>first performance year</u>	ACOs in their <u>first performance year</u>	ACOs in their <u>second or third performance year</u>
Typical timing	Spring of PY1	Summer of PY1	Spring of PY2 or PY3
Data included	Uses preliminary BY3 data	Uses final BY3 data	Reflects participant list and other program-wide changes

Establishing the Historical Benchmark for the First AP

- Determine which beneficiaries would have been assigned to the ACO in each of the three BYs using the ACO's certified ACO Participant List for PY1 using:
 - Retrospective assignment for Track 1 and Track 2 ACOs
 - Prospective assignment for Track 3 and Track 1+ Model ACOs
- For each of the four Medicare enrollment types, for each benchmark year, calculate ACO per capita expenditures among assigned beneficiaries.
- For each enrollment type, risk adjust BY1 and BY2 ACO per capita expenditures to BY3 using CMS-Hierarchical Conditions Category (HCC) risk scores.
- For each enrollment type, trend forward risk-adjusted BY1 and BY2 expenditures to BY3 based on growth in national assignable FFS expenditures calculated by CMS Office of the Actuary (OACT).

Establishing the Historical Benchmark for the First AP (cont'd)

- For each enrollment type, take a weighted average of the risk-adjusted, trended expenditures across the three benchmark years to obtain the benchmark expenditure for that enrollment type.
 - BY1: 10% weight.
 - BY2: 30% weight.
 - BY3: 60% weight.
- State the historical benchmark as a single per capita amount by taking a weighted average of benchmark expenditures across the four Medicare enrollment types, using the BY3 proportion of ACO assigned beneficiary person-years in each enrollment type as weights.

Establishing the Historical Benchmark for 2016 Renewals

- Use same methodology as that used for ACOs in a first agreement period except:
 - Equally weight the three benchmark years.
 - Apply a per capita adjustment for ACOs that generated savings, on average, in their first AP.
- The historical benchmark for ACOs that renewed for a second AP in 2016 is referred to as the rebased historical benchmark.

Adjusting the Historical Benchmark for PY2 or PY3

- To adjust the historical benchmark or rebased historical benchmark for PY2 or PY3 of an ACO's AP, CMS re-determines assignment for each of the same three benchmark years using the ACO's certified ACO Participant List for PY2 or PY3.
- The new assigned population for each benchmark year will reflect the following:
 - An ACO's own ACO Participant List changes, if any
 - Changes in competition occurring within the ACO market that are related to other ACOs making participant list changes and/or other ACOs exiting or entering the program
 - Assignment methodology changes, if applicable (none for PY 2018)
 - Change of beneficiary assignment window (for ACOs that moved from Track 1 to the Track 1+ Model in PY2 or PY3)

Adjusting the Historical Benchmark for PY2 or PY3 (cont'd)

- Using the new assigned populations for each benchmark year, CMS re-determines the historical benchmark, making any necessary modifications for program-wide changes.
 - For example, starting PY 2018, program expenditure calculations for the benchmark years and performance years incorporate only final NCBPs that are not subject to further reconciliation.
- CMS will also calculate an adjusted historical benchmark for the fourth year of an ACO's first AP, if applicable, for Track 1 ACOs that have exercised the option to defer renewal to Tracks 2 or 3 by one year.

Historical Benchmark Report Walkthrough



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Review Excel Template of
Historical Benchmark Report, Tables 1, 2, and 3

Updated Benchmark

- Overview
- Methodology



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Updated Benchmark Overview

- CMS updates the historical benchmark at the time of financial reconciliation to reflect changes between BY3 and the performance year.
 - For ACOs in PY1, CMS updates the final historical benchmark.
 - For ACOs in PY2 or PY3, CMS updates the adjusted historical benchmark. If CMS did not calculate an adjusted benchmark for the year, CMS updates the benchmark used for the prior performance year.
- CMS uses the updated benchmark, not the historical benchmark, to determine whether an ACO has earned shared savings or owes losses.
- The updated benchmark determination appears as Table 2 of the Financial Reconciliation Report.

Updated Benchmark Methodology

- Risk adjust the historical benchmark expenditure for each Medicare enrollment type to account for changes in severity and case mix between BY3 and the performance year.
- For each enrollment type, update the risk-adjusted historical benchmark expenditure with the projected absolute amount of growth in per capita expenditures for Parts A and B services for the national assignable FFS population between BY3 and the performance year, as determined by OACT.
- State the updated benchmark as a single per capita amount by taking a weighted average of updated benchmark expenditures across the four enrollment types, using the performance year proportion of ACO assigned beneficiary person-years in each enrollment type as weights.

Financial Reconciliation

- Overview
- Methodology
- Financial Model Summary by Track



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Financial Reconciliation Overview

- CMS compares performance year ACO per capita expenditures to the updated benchmark to determine whether an ACO has generated savings or losses.
- Savings must exceed a minimum savings rate (MSR) for an ACO to be eligible for shared savings.
- For an ACO in a two-sided risk model (Tracks 2 and 3 and the Track 1+ Model) losses must exceed a minimum loss rate (MLR) for the ACO to be accountable for shared losses.
- Better quality performance can increase shared savings payments to an ACO or reduce shared losses owed to CMS.
- The shared savings or losses calculation appears as Table 3 in the Financial Reconciliation Report.

Financial Reconciliation Methodology

- Determine an ACO's assigned beneficiary population for the performance year.
- For each Medicare enrollment type, calculate ACO per capita expenditures for the performance year.
- State the ACO's performance year expenditures as a single per capita amount by taking a weighted average of expenditures across the four enrollment types, using the performance year proportion of ACO assigned beneficiary person-years in each enrollment type as weights.
- Multiply the updated benchmark and the ACO per capita expenditures by total performance year assigned beneficiary person-years to obtain total updated benchmark expenditures and total ACO assigned beneficiary expenditures.
- Subtract total ACO assigned beneficiary expenditures from total updated benchmark expenditures.

Financial Reconciliation

Methodology: Shared Savings

- If the total updated benchmark expenditures minus total assigned beneficiary expenditures > 0 , compare difference to the MSR.
 - If difference \geq MSR and the ACO has met the quality performance standard, the ACO is eligible for shared savings.
 - If difference $<$ MSR, the ACO is not eligible for shared savings.
- If ACO is eligible for shared savings, multiply total savings (i.e., positive difference between total updated benchmark expenditures and total assigned beneficiary expenditures) by the final sharing rate to obtain the shared savings amount.
- Reduce the shared savings amount by two percent for sequestration.
- Compare the sequestration-adjusted shared savings amount to the shared savings limit.
 - An ACO's shared savings payment (i.e., earned performance payment) is equal to the lesser of the sequestration-adjusted shared savings amount or the shared savings limit.

Financial Reconciliation

Methodology: Shared Savings (cont'd)

Shared Savings Example	Values for Hypothetical ACO
Difference Between Total Updated Benchmark and Total Assigned Beneficiary Expenditures [1]	\$5,000,000
MSR (Reflects a % of Total Updated Benchmark Expenditures) [2]	\$4,500,000
Is [1] >= [2] and Did ACO Meet Quality Performance Standard?	Yes
Final Sharing Rate [3]	45%
Shared Savings Amount [4] = [1] x [3]	\$2,250,000
Shared Savings Amount after Sequestration Adjustment [5] = [4] – ([4] x 0.02)	\$2,205,000
Shared Savings Limit [6]	\$9,000,000
Earned Performance Payment [7] = Minimum of [5] and [6]	\$2,205,000

Financial Reconciliation

Methodology: Shared Losses

- For two-sided ACOs only, if the total updated benchmark expenditures minus total assigned beneficiary expenditures < 0 , compare to the MLR.
 - If difference \geq MLR (in absolute value terms), the ACO is liable for shared losses.
 - If difference $<$ MLR (in absolute value terms), the ACO is not liable for shared losses.
- If ACO is liable for shared losses, multiply total losses (i.e., negative difference between total updated benchmark expenditures and total assigned beneficiary expenditures) by the final losses rate to obtain the shared losses amount.
- Determine shared losses owed to CMS by taking the lesser (in absolute value terms) of the shared losses amount and the loss sharing limit.

Financial Reconciliation

Methodology: Shared Losses (cont'd)

Shared Losses Example	Values for Hypothetical ACO
Difference Between Total Updated Benchmark and Total Assigned Beneficiary Expenditures [1]	-\$5,000,000
MLR (Reflects a % of Total Updated Benchmark Expenditures) [2]	-\$4,500,000
Is [1] >= [2] (in absolute value terms)?	Yes
Final Losses Rate [3]	55%
Shared Losses Amount [4] = [1] x [3]	-\$2,750,000
Shared Losses Limit [5]	-\$2,000,000
Losses Owed to CMS [6] = Minimum of [4] and [5] (in absolute value terms)	-\$2,000,000

Financial Model Characteristics by Track: MSR/MLR

- For all Track 1 ACOs:
 - Variable MSR depending on the ACO's total number of assigned beneficiaries in the performance year, for example:
 - 5,000 assigned beneficiaries = 3.9% MSR
 - 60,000 assigned beneficiaries = 2.0% MSR
 - No downside risk or MLR.
- ACOs in a two-sided risk model (Tracks 2 and 3 or Track 1+ Model) may choose one of the following at the start of their AP:
 - MSR/MLR of 0%
 - Symmetrical MSR/MLR of 0.5% to 2.0% (in increments of 0.5 percentage points)
 - Symmetrical MSR/MLR that varies based on the number of beneficiaries assigned to the ACO (determined in same manner as for Track 1)

Financial Model by Track: Savings or Losses Rates

Characteristic	Track 1	Track 2	Track 3	Track 1+ Model
Final Sharing Rate	Maximum of 50%	Maximum of 60%	Maximum of 75%	Maximum of 50%
Final Losses Rate	No Losses	Minimum of 40%, Maximum of 60%	Minimum of 40%, Maximum of 75%	Fixed 30%

- For all tracks, the final sharing rate increases as the ACO's quality score increases, subject to the maximum rate.
- For Tracks 2 and 3, the final losses rate decreases as the ACO's quality score increases, subject to the minimum rate.

Financial Model by Track: Savings or Losses Limits

Characteristic	Track 1	Track 2	Track 3	Track 1+ Model
Shared Savings Limit	10% of Updated Benchmark	15% of Updated Benchmark	20% of Updated Benchmark	10% of Total Updated Benchmark Expenditures
Loss Sharing Limit	No Losses	5% of Updated Benchmark in PY1, 7.5% in PY2, 10% in PY3 and Subsequent Performance Years	15% of Updated Benchmark	8% of ACO Participant Part A and B Revenue OR 4% of Total Updated Benchmark Expenditures

- The maximum level of the ACO's loss sharing limit will be determined by the composition of the ACO.
- The Track 1+ Model revenue-based limit is capped at the benchmark-based limit.

Risk Adjustment



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Risk Adjustment

- Risk adjustment is a method for adjusting expenditures to account for differences in expected health costs of individuals.
- CMS performs risk adjustment at the population level, taking into account demographic information (age, sex, eligibility) and health status (diagnoses).
- Risk adjustment adjusts for changes in severity and case mix over time or for differences between populations at a point in time, and allows CMS to set accurate ACO performance targets for measuring financial performance.
- By performing risk adjustment, CMS is also recognizing ACOs that care for complex patients and attempting to avoid disincentives for ACOs to serve these populations.

Risk Adjustment (cont'd)

- CMS uses prospective CMS-HCC risk scores for program calculations. In using these risks scores, CMS:
 - Does not apply the Medicare Advantage coding intensity adjustment
 - Renormalizes risk scores by Medicare enrollment type to ensure that the mean risk score for the national assignable FFS population is equal to 1.0 each year
- In determining the historical benchmark, CMS uses mean CMS–HCC risk scores for the ACO’s assigned beneficiary population to risk adjust BY1 and BY2 expenditures to BY3 (i.e., full upward and downward adjustment).

Risk Adjustment (cont'd)

- In determining the updated benchmark, CMS uses a risk adjustment methodology that is designed to limit the impact of changes in health status and ACO coding initiatives between the benchmark period and the performance year.
- Under this methodology, CMS considers newly and continuously assigned beneficiaries separately.
- When determining if a beneficiary is newly or continuously assigned, CMS uses the same claims-based assignment eligibility requirements and uses the ACO's Participant List applicable for the performance year.

Risk Adjustment (cont'd)

- Specifically, newly and continuously assigned are:
 - **Newly Assigned:** a beneficiary that is assigned to the ACO in the performance year and who was ineligible for assignment to the ACO in the assignment window for the prior year or who was eligible for assignment but was not assigned to nor received a primary care service from the ACO in that window.
 - **Continuously Assigned:** a beneficiary that is assigned to the ACO in the performance year and who was eligible for assignment to the ACO in the assignment window for the prior year and who was assigned to or received a primary care service from the ACO in that window.

Risk Adjustment (cont'd)

- For newly assigned beneficiaries, CMS uses CMS-HCC risk scores to adjust the benchmark for changes in severity and case mix between BY3 and the performance year (full upward and downward adjustment).
- For continuously assigned beneficiaries:
 - If there is a decline in CMS-HCC risk scores between BY3 and the performance year, CMS uses CMS-HCC risk scores to adjust the benchmark for changes in severity and case mix between BY3 and the performance year for this population.
 - If there is an increase, CMS uses demographic factors to account for changes between BY3 and the performance year.

Resources

- Shared Savings Program Specifications
- Other Shared Savings Program Financial Webinars
- Acronyms



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Shared Savings Program Specifications

- For additional information on the program's financial model, including the risk adjustment methodology, see the Medicare Shared Savings Program Shared Savings or Losses and Assignment Methodology Specifications
 - Version 6, applicable for PY 2018 is forthcoming
 - [Version 5](#), applicable for PY 2017
 - [Version 4](#), applicable for PY 2016

Other Shared Savings Program Financial Webinars

Webinar Title*	Date
Claim and Claim Line Feed User Group	Monthly
Performance Year 2016 Benchmark Calculations, Financial Reconciliation & Reports (including rebasing methodology applied to 2016 renewals)	March 16, 2016 (Track 3) March 17, 2016 (Track 1 & 2)
Performance Year 2017 Benchmark Calculations, Financial Reconciliation & Reports and Rebasing Methodology for Renewal Agreements in 2017 & Subsequent Years	March 15, 2017 (Tracks 1 & 2) March 16, 2017 (Track 3) March 23, 2017 (Rebasing)
Historical Benchmark Rebasing Methodology and Reports for Renewal Agreements Beginning in 2017 & Subsequent Years	March 29, 2018
Performance Report Walkthrough (PY 2017 Financial Reconciliation)	August 2018

*Slides available on the Shared Savings Program ACO Portal calendar

Acronyms

- ACO: Accountable Care Organization
- AP: Agreement period
- BY: Benchmark Year
- DSH: Disproportionate share hospital
- ESRD: End-stage renal disease
- FFS: Fee-for-service
- HCC: Hierarchical Condition Category
- IME: Indirect medical education
- MLR: Minimum loss rate
- MSR: Minimum savings rate
- NCBP: Non-claims based payment
- OACT: CMS Office of the Actuary
- PBP: Population-based payment
- PY: Performance Year
- SSP: Shared Savings Program
- UCC: Uncompensated care cost

QUESTION & ANSWER SESSION



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