MEDICARE SHARED SAVINGS PROGRAM

Historical Benchmark Rebasing Methodology & Reports for Renewal Agreements Beginning in 2017 & Subsequent Years

Audience: ACOs Currently Participating in their Second Agreement Periods

March 29, 2018

Medicare Shared Savings Program

DISCLAIMER

- This presentation 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 this document for your reference.
- This presentation was prepared as a service to the public and is not intended to grant rights or impose obligations. This presentation may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES | MEDICARE SHARED SAVINGS PROGRAM

Agenda

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

Background and Overview of Financial Model

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

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) (§ 4 25.602)
  - 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

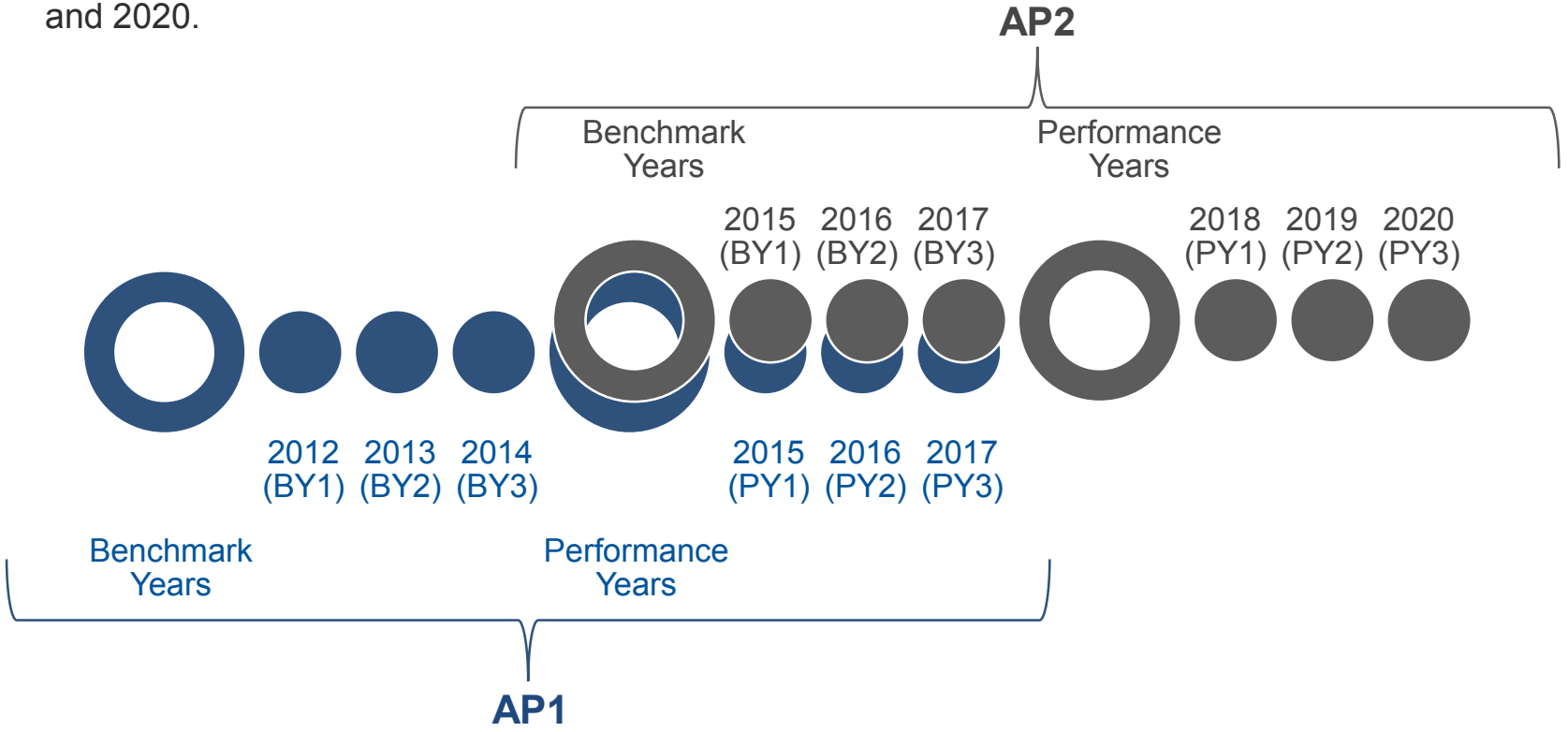
- The Track 1+ Model is a CMS Innovation Center model designed based on feedback from stakeholders for options to facilitate ACOs' transition to performance-based risk.
- The model is based on Track 1, but tests a payment design that incorporates more limited downside risk compared to Tracks 2 and 3, 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 2015. For this ACO in AP1, the three benchmark years (BYs) would be 2012, 2013, and 2014 and the three performance years would be 2015, 2016, and 2017. The same ACO's second AP begins in 2018. For this ACO in AP2, the three benchmark years would be 2015, 2016, and 2017 (the previous AP's performance years) and the s would be 2018, 2019, and 2020.



Overview of Financial Model (cont'd)

Rebased Historical Benchmark

- Determined during the performance year.
- Based only on historical data (BY1 – BY3).
- Two versions:
  - Preliminary
  - Final

Updated Benchmark

- Determined annually at the time of financial reconciliation for each performance year.
- Updates the rebased historical benchmark to capture changes between the benchmark years and the performance year.

Financial Reconciliation

- Performed after the end of each performance year.
- Compares ACO assigned beneficiary performance year expenditures with the updated benchmark to determine savings or losses.

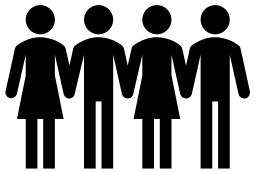
Expenditure Calculations

- ACO Expenditure Calculations
- Regional Expenditure Calculations
- Regional Expenditure Resources

ACO Expenditure Calculations: Overview

MEDICARE SHARED SAVINGS PROGRAM

- 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 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.
  - Incorporate beneficiary-identifiable non-claims based payments (NCBP).

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 one. 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.

Regional Expenditure Calculations

- The rebasing methodology incorporates FFS expenditures for an ACO's regional service area (defined as all counties where one or more beneficiaries assigned to the ACO reside).
- Per capita FFS expenditures are calculated among assignable beneficiaries in each county in an ACO's regional service using methodology consistent with that used to calculate ACO per capita expenditures.
- County-level per capita FFS expenditures are risk-adjusted by dividing by the mean county CMS-Hierarchical Conditions Category (HCC) risk score.
- Risk-adjusted regional expenditures are computed by taking a weighted average across risk-adjusted county expenditures for all counties in the regional service area.
  - Each county is weighted by the proportion of the ACO's assigned beneficiary person-years residing in the county.

Regional Expenditure Calculations: Example

County	County Per Capita Expenditure [1]	County Mean CMS-HCC Risk Score [2]	County Risk-Adjusted Expenditure [3] = [1]/[2]	Proportion ACO Assigned Beneficiary Person-Years [4]	Weighted County Risk-Adjusted Expenditure [5] = [3] x [4]
A	$10,000	1.025	$9,756	0.70	$6,829
B	$11,000	1.028	$10,700	0.20	$2,140
C	$8,000	0.996	$8,032	0.07	$562
D	$18,000	1.030	$17,476	0.03	$524

- Risk-adjusted regional expenditures = Sum of Column [5] across Counties A through D = $10,055
- CMS performs separate calculations for each Medicare enrollment type.
- County per capita expenditures and mean risk scores are based on all assignable beneficiaries in county (including those assigned to ACOs).

Regional Expenditure Resources

- CMS has made available the following Public Use Files (PUFs) to help ACOs understand and estimate regional expenditures:
  - County-level Fee for Service Data for Shared Saving Program Benchmark Rebasing PUF
    - This file includes per capita expenditures, average CMS-HCC risk scores, and person-years by enrollment type for each county in the United States.
    - CMS publishes this file annually in the summer following the calendar year to which it relates.
  - Number of ACO Assigned Beneficiaries by County PUF:
    - This file includes total assigned beneficiaries by ACO for each county where at least one of its assigned beneficiaries resides.
    - CMS publishes this file annually for each performance year with the release of financial reconciliation.

Regional Expenditure Resources (cont'd)

- Other regional expenditure resources available to ACOs include:
  - The Assignment Summary Report (ASR) that ACOs receive on a quarterly and annual basis includes assigned beneficiary person-years by enrollment type (Table 2-5).
    - Static reports include all counties with at least one percent of an ACO's assigned beneficiaries.
    - Dynamic reports available through Cognos on the Shared Savings Program ACO Portal include all counties with at least one ACO assigned beneficiary.
  - The March 23, 2017, webinar on the rebasing methodology (available on the ACO Portal) provides an example of how ACOs can use the PUF and ASR data to estimate risk-adjusted regional expenditures.

Rebased Historical Benchmark

- Overview
- Establishing the Rebased Benchmark
- Regional Adjustment Weight
- Adjusting the Rebased Benchmark for PY2 and PY3
- Rebased Benchmark Report Walkthrough

Rebased Benchmark Overview

- CMS establishes an ACO's rebased historical benchmark near the start of its second or subsequent AP.
- CMS provides an ACO with both a **preliminary** Rebased Historical Benchmark Report and a **final** Rebased Historical Benchmark Report during its PY1.
  - The preliminary rebased 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 three months of claims run-out for BY3
    - Uses BY2 values for BY3 risk scores, county FFS expenditures (used to calculate regional expenditures), and truncation thresholds
  - The final rebased benchmark uses actual BY3 information when it becomes available later in the performance year. It also appears as Table 1 of the Financial Reconciliation Report the ACO receives with performance year financial reconciliation.

Rebased Benchmark Overview (cont'd)

- CMS provides an ACO with an **adjusted** rebased Historical Benchmark Report during its PY2 or PY3 to reflect ACO Participant List changes or other program changes for that performance year.
  - The adjusted rebased benchmark is based on the same calendar benchmark years as the benchmark provided in PY1.
  - The adjusted rebased 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.

Rebased Benchmark Overview (cont'd)

Characteristic	Preliminary	Final	Adjusted
Recipient ACOs	ACOs in their first performance year	ACOs in their first performance year	ACOs in their second or third performance year
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

Rebased Benchmark Overview (cont'd)

- The rebased historical benchmark differs from the historical benchmark for an ACO's first AP in that it:
  - Uses different benchmark years
  - Uses trend factors based on regional rather than national factors
  - Equally weights the three benchmark years
  - Applies a regional FFS adjustment
- CMS also uses regional growth rates (instead of national growth increments) to update the final or adjusted rebased historical benchmark to the performance year, for each performance year in an ACO's second or subsequent AP.

Establishing the Rebased Benchmark

- Determine which beneficiaries would have been assigned to the ACO in each of the three benchmark years 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+ 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-HCC risk scores.
- For each enrollment type, trend forward risk-adjusted BY1 and BY2 expenditures to BY3 using regional expenditure growth rates.

Establishing the Rebased Benchmark (cont'd)

- For each enrollment type, take an average of the risk-adjusted, trended expenditures across the three benchmark years using equal weights for each year to obtain the rebased benchmark amount for that enrollment type.
- Apply a regional FFS adjustment for each Medicare enrollment type. The adjustment is equal to a percentage of the difference between the risk-adjusted average per capita expenditure amount for the ACO's regional service area and the ACO's rebased historical benchmark amount.
- State the regionally-adjusted, rebased historical benchmark as a single per capita amount by taking a weighted average across the four Medicare enrollment types, using the BY3 proportion of ACO assigned beneficiary person-years in each enrollment type as weights.

Regional Adjustment Weight

- To determine the percentage weight used to calculate the regional FFS adjustment, CMS compares an ACO's historical spending to its regional service area as follows:
  - Uses the difference between Regional Expenditure – ACO Historical Expenditure for each enrollment type:
    - Weights the difference for each enrollment type by multiplying by the ACO's BY3 assigned beneficiary person-year proportion for that enrollment type.
    - Sums these weighted differences across the four enrollment types.
  - If this sum is a net positive value, CMS determines the ACO's historical spending is lower than its regional service area.
  - If this sum is a net negative value, CMS determines the ACO's historical spending higher than its regional service area.

Regional Adjustment Weight (cont'd)

Agreement Period (AP) (e.g., 2018 renewals)	ACO Spending Relative to Its Region	Percentage Weight Used to Calculate Regional Adjustment*
Performance year in AP where adjustment is applied for the first time (e.g., second AP beginning in 2018)	Higher	25
	Lower	35
Performance year in AP where adjustment is applied for the second time (e.g., third AP beginning in 2021)	Higher	50
	Lower	70
Performance year in AP where adjustment is applied for the third (or subsequent) time (e.g., fourth AP beginning in 2022)	Higher	70
	Lower	70

*The percentage weight used to calculate the regional adjustments may vary within the agreement period if the rebased benchmark is adjusted due to participant list changes.

Adjusting the Rebased Benchmark for PY2 or PY3

MEDICARE SHARED SAVINGS PROGRAM

- To adjust the rebased historical benchmark for PY2 or PY3 of a second or subsequent 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 Rebased Benchmark for PY2 or PY3 (cont'd)

- Using the new assigned populations for each benchmark year, CMS re-determines the rebased historical benchmark (including the county weights used to calculate risk-adjusted regional expenditures), 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.

Rebased Benchmark Report Walkthrough

MEDICARE SHARED SAVINGS PROGRAM

Review Excel Template of

Rebased Historical Benchmark Report, Tables 1, 2, 3, 4, and 5

Updated Benchmark

- Overview
- Methodology

Updated Benchmark Overview

- CMS updates the rebased 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 rebased historical benchmark.
  - For ACOs in PY2 or PY3, CMS updates the adjusted rebased historical benchmark. If CMS did not calculate an adjusted benchmark for the year, CMS updates the benchmark used for the prior PY.
- CMS uses the updated benchmark, not the rebased 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 regionally-adjusted rebased 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 expenditure based on regional expenditure growth between BY3 and the performance year by multiplying by the regional update factor.
- 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

MEDICARE SHARED SAVINGS PROGRAM

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 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 expenditure 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 >= 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)

MEDICARE SHARED SAVINGS PROGRAM

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 >= 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 (Reflects ACO's Track) [3]	55%
Shared Losses Amount [4] = [1] x [3]	-$2,750,000
Shared Losses Limit (Reflects ACO's Track) [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 ranging from 2.0% to 3.9%, depending on the ACO's total number of assigned beneficiaries in the performance year (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 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 benchmark-based limit.

Risk Adjustment

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 risk 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 rebased 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).
  - CMS also uses CMS-HCC risk scores to adjust for differences in health status between the ACO's assigned beneficiary population and that of assignable beneficiaries in its regional service area.

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.
  - **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 PY 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)

- 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 PY 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 PY, CMS uses CMS-HCC risks 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

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 and 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
Claims and Claims Line Feeds 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 Methodology and Reports for ACOs in their First Agreement Period and ACOs that Renewed their Agreement in 2016	March 27, 2018
Performance Report Walkthrough (PY2017 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