Issue Brief

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KEY POINTS

- CMS finalized the incorporation of regional FFS expenditures to establish benchmarks for ACOs.
- Regulatory impact analysis is expected to save $110 million in calendar years 2017-2019.

CMS Releases Final ACO Program Rule

The Centers for Medicare and Medicaid Services has issued a final rule to incorporate regional fee for service expenditures into the methodology for establishing, adjusting, and updating the benchmarks of Accountable Care Organizations that continue their participation in the Medicare Shared Savings Program after an initial three-year agreement period. The final rule also adds a participation option to encourage ACOs to transition to performance-based risk arrangements and provides greater administrative finality around the program's financial calculations.

A copy of the 285 page document is available at: https://www.federalregister.gov/articles/2016/06/10/2016-13651/medicare-program-medicare-shared-savings-program-accountable-care-organizations--revised-benchmark.

The rule is scheduled for publication in the *Federal Register* on June 10. The above-cited link will change upon publication.

COMMENT

ACOs receive Medicare FFS payments and its only after retroactive review that any bonuses or repayments become due. The problem here is that CMS cannot establish a simple prospective price. The regulatory impact analysis section consumes 42 pages to basically say that CMS expects the rule to save the program $110 million for CYs 2017-2019 more than what would been saved if no changes were made. CMS says further that a relatively wide range of possible outcomes exist form a cost increase of $240 million to a savings amount of $480 million.

It is apparent that CMS is quite concerned about continued participation in the program, but is also extremely cautious in the updating process and its true goal is to save Medicare outlays. The Office of Management and Budget sat on this rule since April 29. One wonders what took so long to finally approve. Unfortunately, delay seems to be the norm these days.

MODIFICATIONS TO THE BENCHMARKING METHODOLOGY

Background on Establishing, Updating and Resetting the Benchmark

Currently, CMS calculates a benchmark for each ACO using a national risk-adjusted average of per capita Parts A and B expenditures for original Medicare FFS beneficiaries who would have been assigned to the ACO in each of the 3 calendar years prior to the start of the agreement period.

In establishing the benchmark for an ACO's first agreement period, the first benchmark year is weighted 10 percent, the second benchmark year is weighted 30 percent, and the third benchmark year is weighted 60 percent. CMS says this weighting creates a benchmark that more accurately reflects the latest

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expenditures and health status of the ACO's assigned beneficiary population. CMS also adjusts for changes in beneficiary characteristics, and annually updates the benchmark by growth in national per capita Medicare FFS expenditures for populations of beneficiaries in each of the following Medicare enrollment types: ESRD, disabled, aged/dual eligible, aged/non-dual eligible.

Integrating Regional Factors When Resetting ACOs' Benchmarks

CMS is finalizing, with certain modifications, its proposal to determine an ACO's FFS expenditures based on the county FFS expenditures for the ACO's regional service area for populations of beneficiaries according to Medicare enrollment type (ESRD, disabled, aged/dual eligible, aged/non-dual eligible).

CMS say it considers an ACO's region to be synonymous with the service area from which it derives its assigned beneficiaries. Further, CMS says that a fundamental concept underlying consideration of the definition of an ACO's regional service area is that this geographic definition bear a relationship to the area of residence of the ACO's assigned beneficiaries, as a means of accounting for the geographic spread of the ACO's assigned population.

COMMENT

CMS says that "county-level data offers a number of advantages over the other options, including Core Based Statistical Areas (CBSAs), Metropolitan Statistical Area (MSAs), Combined Statistical Area (CSAs), States/territories, and Hospital Referral Regions (HRR)." One must ask why CMS uses CBSAs and the other geographic area definitions for the prospective payment system area wage index values that have proven difficult and complex to say the least.

Establishing the Beneficiary Population Used to Determine Expenditures for an ACO's Regional Service Area

CMS proposed to define the ACO's regional service area to include any county where one or more of the ACO's assigned beneficiaries reside.

Further, CMS proposed to weight an ACO's regional expenditures relative to the proportion of its assigned beneficiaries in each county, determined by the number of the ACO's assigned beneficiaries residing in the county in relation to the ACO's total number of assigned beneficiaries.

CMS is finalizing its proposal to include in the definition of an ACO's regional service area any county where one or more beneficiaries assigned to the ACO reside. CMS says it continues to believe this approach is necessary to accurately reflect the diversity of the ACO's assigned beneficiary population and to provide a complete picture of the ACO's regional service area.

Adjusting the Reset ACO Historical Benchmark to Reflect Regional FFS Expenditures

CMS is finalizing its proposals to revise the methodology used to rebase ACO benchmarks for new agreement periods starting on or after January 1, 2017, to incorporate a regional FFS adjustment to the ACO's rebased historical benchmark. CMS is finalizing the proposed approach to calculating the regional FFS adjustment using average per capita expenditures for benchmark year three for assignable beneficiaries in the ACO's regional service area, and to risk adjust to account for the health status of the ACO's assigned population in relation to the assignable FFS beneficiaries in the ACO's regional service area in

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determining the regional FFS adjustment. CMS is also finalizing its proposal to add new § 425.603 that incorporates its policies for resetting, adjusting and updating the benchmark for a second or subsequent agreement period.

Transitioning to a Higher Weight in Calculating the Adjustment for Regional FFS Expenditures

CMS is finalizing with modifications a phased approach to transitioning to greater weights in calculating the regional adjustment amount, which is expressed as a percentage of the difference between regional average expenditures for the ACO's regional service area and the ACO's rebased historical expenditures. CMS says this approach maintains the current methodology for establishing the benchmark for an ACO's first agreement period in the Shared Savings Program based on the historical expenditures for beneficiaries assigned to the ACO with no adjustment for expenditures in the ACO's regional service area, and the current methodology for resetting the historical benchmark for the second agreement period for ACOs that entered the program in 2012 and 2013 and started a new agreement period on January 1, 2016.

As summarized in table below, the result of this step will determine the percentage weight applied in calculating the regional FFS adjustment.

Percentage Weight Applied in Calculating the Regional FFS Adjustment

Agreement period (for example, 2014 starters renewing for 2017)	ACO's spending relative to its region	Weight used to calculate regional adjustment
Performance year within an agreement period to which regional adjustment is applied for the first time (for example, second agreement period beginning in 2017)	ACO spending is higher than its regional service area	25 percent
	ACO spending is lower than its regional service area	35 percent
Performance year within an agreement period to which regional adjustment is applied for the second time (for example, third agreement period beginning in 2020)	ACO spending is higher than its regional service area	50 percent
	ACO spending is lower than its regional service area	70 percent
Performance year within an agreement period to which regional adjustment is applied for the third time (for example, fourth agreement period beginning in 2023 and subsequent years)	ACO spending is higher than its regional service area	70 percent
	ACO spending is lower than its regional service area	70 percent

Parity Between Establishing and Updating the Rebased Historical Benchmark

Under the authority of section 1899(i)(3) of the Act, CMS is finalizing its proposal that for ACOs in their second or subsequent agreement period whose rebased historical benchmark incorporates an adjustment to reflect regional expenditures, the annual update to the benchmark will be calculated as a growth rate that reflects growth in risk adjusted regional per beneficiary FFS spending for the ACO's regional service area, for each of the following populations of beneficiaries: ESRD, disabled, aged/dual eligible, aged/non-dual eligible. CMS is incorporating this methodology at § 425.603(d). CMS says that this final provision includes some minor revisions to the

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proposed regulatory language in order to ensure that the final methodology for updating the rebased benchmark is described accurately and consistently.

Modifying the Calculation of National FFS Expenditures, Completion Factors and Truncation Thresholds Based on Assignable Beneficiaries

CMS takes into account Parts A and B expenditures for all Medicare FFS beneficiaries, and exclude IME payments and DSH and uncompensated care payments to align with its methodology for calculating benchmark and performance year expenditures.

CMS is finalizing its proposal to use assignable beneficiaries in all national and regional FFS calculations with one modification. CMS is not finalizing its proposal to determine completion factors based on assignable Medicare FFS beneficiaries, and will continue to determine these completion factors based on the timing of submission of claims across the entire Medicare FFS population.

However, as proposed, CMS will limit the Medicare FFS population used in all other program calculations to "assignable" Medicare beneficiaries who meet the following requirements: (1) received at least one primary care service, as defined under § 425.20, with a date of service during the 12-month assignment window; and (2) this primary care service was provided by a primary care physician, as defined under § 425.20, or by a physician with one of the primary specialty designations included in § 425.402(c). The assignable beneficiary population will be identified consistently across program tracks using the assignment window for the 12-month calendar year corresponding to the benchmark or performance year. This revised methodology will apply to all ACOs, including those ACOs with 2015 and 2016 agreement start dates that are in the middle of an agreement period, as well as ACOs that entered the program in 2014 and elect the participation option established with this final rule to defer by one-year entrance into a second agreement period under a two-sided model.

Timing of Applicability of Revised Rebasing and Updating Methodology

CMS is finalizing its proposal to make the new benchmark rebasing policies described in this final rule, including the phase in of the percentage used in calculating the regional adjustment, applicable to ACOs entering into a second or subsequent agreement period in 2017 or subsequent years. With respect to ACOs that started in the program in 2012 and 2013 that have renewed their agreements for a second agreement period beginning in 2016:

- CMS applied the rebasing methodology established with the June 2015 final rule, under which CMS equally weight the benchmark years and account for savings generated during the ACO's prior agreement period, in rebasing their historical benchmark for their second agreement period (beginning in 2016). With the conforming changes made to the regulations text in this final rule, this methodology is incorporated in new § 425.603(b).
- CMS will apply the methodology specified under § 425.602(b) to update the benchmark annually for each year of the second agreement period for these ACOs.
- CMS will apply the new rebasing policies, including the revised phase in of the percentage used in calculating the regional adjustment that it is adopting to these ACOs for the first time in calculating their rebased historical benchmark for their third agreement

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period (beginning in 2019), as if the ACOs were entering their second agreement period. Accordingly, the 2012 and 2013 starters will have the same transition to the use of a higher percentage in calculating the regional adjustment as all other ACOs.

CMS provides the following table identifying characteristics of benchmarking approaches by agreement period.

Source of Methodology	Agreement Period	Historical Benchmark Trend Factors (trend BY1, BY2 to BY3)	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

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As modified by this final rule: Rebasing 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

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ADJUSTING BENCHMARKS FOR CHANGES IN ACO PARTICIPANT COMPOSITION

During the program's initial performance years, CMS says it experienced a high volume of change requests from ACOs, both adding and removing ACO participants. CMS adjusted the historical benchmarks for 162 of 220 ACOs (74 percent) with 2012 and 2013 start dates for the 2014 performance year to reflect changes in ACO participants. For the 2015 performance year, CMS adjusted benchmarks for 245 of 313 ACOs (78 percent) with 2012, 2013 or 2014 start dates to reflect changes in ACO participants.

CMS is not finalizing its proposal to replace the current approach for calculating adjusted historical benchmarks for ACOs that make ACO Participant List changes with a new programwide approach that would adjust an ACO's historical benchmark using an expenditure ratio based on single reference year. Relatedly, CMS is not finalizing the proposed definitions of "stayers," "leavers," and "joiners" in § 425.20 at this time.

FACILITATING TRANSITION TO PERFORMANCE-BASED RISK

Currently, for its initial agreement period, an ACO applies to participate in a particular financial model or track of the program as specified under § 425.600(a). If the ACO's application is accepted, the ACO must remain under that financial model for the duration of its 3-year agreement. ACOs entering the program under the one-sided shared savings model (Track 1) that meet eligibility criteria may continue their participation under this model for a second three-year agreement.

CMS proposed to add a participation option that would allow eligible Track 1 ACOs to defer by one year their entrance into a performance-based risk model (Track 2 or 3) by extending their first agreement period under Track 1 for a fourth performance year.

CMS is finalizing its proposal to provide an additional option for ACOs participating under Track 1 to apply to renew for a second agreement period under a two-sided track (Track 2 or Track 3) under the renewal process specified at § 425.224.

ADMINISTRATIVE FINALITY: REOPENING DETERMINATIONS OF ACO SAVINGS OR LOSSES TO CORRECT FINANCIAL RECONCILIATION CALCULATIONS, AND A CONFORMING CHANGE

The financial reconciliation calculation/methodology and the amount of shared savings an ACO might earn, including all underlying financial calculations, are not appealable.

CMS notes that the PY 1 shared savings payments were overstated for some ACOs and shared losses were understated for some other ACOs. CMS has determined this issue resulted in an estimated 5 percent overstatement of PY 1 shared savings payments to ACOs and an understatement of shared losses.

CMS is finalizing its proposal that if CMS determines that the amount of shared savings due to an ACO or the amount of shared losses owed by an ACO has been calculated in error, CMS may reopen the earlier payment determination and issue a revised initial determination: (1) at any time in the case of fraud or similar fault, as defined in §405.902; or (2) not later than four years after the date of notification to the ACO of the initial determination of shared savings or shared losses for the relevant performance year under § 425.604(f), §425.606(h) or §425.610(h), for good

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cause. Good cause may be established when there is new and material evidence of an error or errors, that was not available or known at the time of the payment determination and may result in a different conclusion, or the evidence that was considered in making the payment determination clearly shows on its face that an obvious error was made at the time of the payment determination. Good cause will not be established by a change of legal interpretation or policy by CMS in a regulation, CMS ruling or CMS general instruction, whether made in response to judicial precedent or otherwise.

CMS will have sole discretion to determine whether good cause exists for reopening a payment determination. Also, good cause will not be established by a reconsideration, appeal, or other administrative or judicial review of any determinations precluded under §425.800.

FINAL COMMENT

This is an interesting development. CMS believes it has overpaid bonus to many ACOs and is now looking to prevent such in the future. Yet, CMS has been notoriously underpaying for many of the prospective payment outlier adjustments and does not even flinch in trying to recognize such errors.

ACOs have been an interesting concept since enactment. But like other bonus/ penalty situations like the hospital-based value purchasing program, tying payment to benchmarks as a means to reward high quality is still ill-defined primarily using costs as the surrogate.

Further, the reward/ penalty amounts are small in the aggregate to individual providers. CMS is too cautious and simply afraid to expand these values. Until more definitive and understandable quality measures are available, these programs may have limited success.