

Medicare Shared Savings Program (MSSP)

Summary of June 10, 2016 Final Rule

Soon after the 2013 inception of the Medicare Shared Savings Program, Accountable Care Organizations (ACOs) argued the program was unsustainable because financial benchmarks were established and would be reset based on the ACO's historical spending. This meant ACOs had to meet the unrealistic goal of endlessly improving upon their previous performance. Recognizing this problem, the Centers for Medicare & Medicaid Services in a December 2014 proposed rule requested comment on several alternative benchmarking approaches that would include a regional spending component or some combination of regional spending and the ACO's historical performance. In February 2016, CMS published a proposed rule that would include a regional spending blend in calculating an ACO's reset and updated benchmark. This proposed rule was finalized on June 10, 2016. The following provides an overview of the June final rule.

Including a Regional Blend in Calculating an ACO's Reset Benchmark

For second agreement period ACOs beginning in January 2017, CMS will reset an ACO's benchmark using a 35% regional blend. This means CMS will calculate the difference between the average per capita expenditure amount of the ACO's regional service area and the average per capita amount of the ACO's rebased historical benchmark, or apply a weight of 35% to the difference between regional average expenditures and the ACO's rebased historical benchmark expenditures. The regional blend would increase to 70% if the ACO continues in the program for a third agreement period. To mitigate the effect on those ACOs with historical spending comparatively higher than their region, CMS will apply a 25% regional weight to the reset benchmark (or for the second agreement period), a 50% regional weight to the second reset benchmark (or for the third agreement period), and a 70% weight to the third reset benchmark (or the fourth agreement period).

For first agreement period ACOs beginning in January 2017, CMS will continue to establish and update their financial benchmarks using the original benchmark rules. For 2012 and 2013 ACOs that signed a second agreement period contract beginning in January 2016, CMS also will have their benchmarks updated under the original update rules. If 2012 and 2013 ACOs decide to participate under a third agreement beginning in January 2019, they will have their reset and updated benchmarks calculated using the new regional blend formula.

In the final June 2015 ACO rule, CMS agreed to include any savings in calculating an ACO's reset benchmark. In the 2016 proposed and final rule CMS has decided to exclude these savings.

Defining Regional in Determining Reset Benchmarks

Regional spending will be calculated using benchmark year 3 data, or the most recent year prior to the start of the ACO's second and subsequent agreement periods. More specifically, regional spending will be defined as county fee-for-service (FFS) expenditures for the counties in which one or more of the ACO's assigned beneficiaries reside. CMS will weight county-level FFS costs by the proportion of the ACO's assigned beneficiaries in the county. CMS will risk adjust county FFS expenditures for the ACO's regional area using assigned and assignable beneficiaries. By "assignable" CMS means all beneficiaries that at least one, but not the preponderance of, primary care visit with an ACO primary

care physician in the previous year. CMS will continue to calculate regional and historical risk adjusted spending by four sub-populations: End Stage Renal Disease (ESRD); disabled; aged/dual eligible; and, aged/non-dual eligible.

Regional Update Factor

CMS updates an ACO's benchmark in agreement years two and three to account for year-over-year spending growth. CMS will calculate these annual updates consistent with how the agency resets ACO benchmarks. This means CMS will determine a growth rate that reflects growth in risk adjusted regional per beneficiary FFS spending for the ACO's regional service area. For first agreement period ACOs, CMS will continue to update their benchmarks using the flat dollar equivalent of the projected absolute amount of growth in national per capita expenditures for Parts A and B services.

Facilitating Transition to Risk

CMS is finalizing its proposal to allow a Track 1 ACO that renews for a second agreement period as a Track 2 or 3 to defer for one year its performance as a risk-based ACO. CMS also will defer rebasing the ACOs benchmark for the first year of the second agreement period. At the end of this fourth year the ACO will transition to the selected risk track for a three year agreement period. If the ACO that has been approved for the extension terminates its participation before the start of its second agreement period, or fourth year, the ACO will not be able to participate again in the program until the four years have expired.

Using Assignable Beneficiaries in All Calculations

Changes to the ACO program in this final rule apply to second agreement period ACOs, but there is one provision that CMS will apply uniformly throughout the program. The agency will use assignable beneficiaries in all FFS calculations. This means this revised methodology will apply to all ACOs, including those with 2014 and 2016 agreement start dates. This methodology also is applicable to those 2014 ACOs that agree to a one year deferred entrance into a second agreement period under a two-sided model.

Calculating ESRD Regional Costs

CMS proposed to calculate ESRD regional spending at the state, not county, level and apply the value consistently to each county within the state. In the final rule CMS chose not to take this approach and instead will calculate expenditures for ESRD populations at the county level.

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