spg SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

Proposed Rule on Medicare Shared Savings Program

OVERVIEW

On January 28th, the Centers for Medicare and Medicaid Services (CMS) released a proposed rule that would refine the methodologies used for resetting benchmarks for accountable care organizations (ACOs) that continue to participate in the Medicare Shared Savings Program (MSSP) after their initial agreement period.

CMS will accept comments until March 28th. This document summarizes several major provisions of the proposed rule. The proposed rule is available here.

BENCHMARKING METHODOLOGY

MSSP ACO performance is currently evaluated by comparing each ACO's expenditures for its assigned participants to the ACO's average per capita historical benchmark. The historical benchmark is based on the Medicare Part A and B fee-for-service (FFS) expenditures of the ACO's assigned beneficiaries and is annually risk adjusted and trended forward according to national growth rates of Part A and B expenditures.

The current methodology makes it difficult for long-term participants in MSSP to continue to achieve savings year over year, since their initial successes in lowering costs become the benchmark against which they are measured in subsequent years. To address this, CMS proposes that ACOs that continue to participate in MSSP after their initial three-year agreement period would have their historical benchmarks adjusted relative to regional growth, rather than solely national growth. This methodology would favor ACOs that become more efficient than their regional peers over the course of their first agreement period. A similar methodology is being piloted in the Next Generation ACO model.

The ACO's regional service area would include any county where at least one assigned beneficiary resides and FFS costs would be weighted according to the proportion of assigned beneficiaries that reside in that county.

CHANGES TO ACO COMPOSITION

A MSSP ACO's historical benchmark is currently set according to its assigned population during its "benchmark years," the three years prior to the ACO's start date. Prior to the start of each performance year, ACOs are required to submit a list of the physicians and providers participating in their ACO. If an ACO reports changes in the composition of its participants, CMS must recalculate the ACO's historical benchmark from each of the three benchmark years based on which patients would have been assigned to the new set of providers.

In an effort to reduce the operational burden of recalculating benchmarks, CMS is proposing to calculate these mid-agreement adjustments using a single reference year: benchmark year three. The historical benchmark would be further adjusted according to changes in the ACO's proportion of beneficiaries by Medicare enrollment type: end stage renal disease, disabled, aged/dual eligible; and aged/non-dual eligible.

TRANSITION TO PERFORMACE-BASED RISK

MSSP ACOs currently enter three-year agreements to participate in one of three tracks. Track 1 is a one-sided shared savings model under which the ACO may share savings, but not loses. Tracks 2 and 3 are two-sided performance-based risk models under which the ACO must share both savings and losses. At the end of their first agreement period, Track 1 ACOs may apply for one additional three-year contract to continue in their current track or apply to Track 2 or 3.

To encourage more MSSP ACOs to take on performance-based risk, CMS is proposing to allow ACOs participating in Track 1 to apply to have their shared savings-only agreement extended for only a fourth performance year rather than a second three-year agreement in Track 1. At the end of the fourth year, the ACO would be required to transition into Track 2 or 3.

RECONSIDERATION OF ACO PAYMENTS

The proposed rule establishes specific criteria under which CMS may reopen an ACO's payment determination of savings or losses. The re-opening of a payment determination due to an error identified during an inspection, evaluation, or audit must occur within four years of the initial determination. There would be no time restriction for CMS to reopen a payment determination in the case of fraud.

DATA SOURCES

CMS has released the following data files to support commenters in modeling the proposed changes to the benchmarking methodology:

- Average per capita county-level FFS spending and risk scores, by Medicare enrollment type; and
- The number of ACO assigned beneficiaries per county, where at least one percent of assigned beneficiaries reside.

The new data sources are available here.