



Executive Summary – Proposed MSSP “Benchmarking” Rule

Top Issues Providers Need to Understand from the Proposed MSSP “Benchmark Rebased” Rule

On Jan. 28, 2016, the Centers for Medicare & Medicaid Services (CMS) released the long-awaited rule proposing changes to the Medicare Shared Savings Program (MSSP) benchmark rebasing methodology. The rule also included several other significant changes that impact risk adjustment and could facilitate the transition to risk. HFMA will make a detailed summary available in the coming weeks.

The proposed rule was published in the [February 3, 2016](#), *Federal Register*. Comments on the proposed rule are due to CMS by March 28, 2016.

Proposed Revisions to Benchmark Rebased:

In proposing the following changes, CMS states that it is seeking to reflect an ACO’s performance against providers in the same market rather than just evaluating the ACO against its own past performance. None of the changes below would apply to ACOs in their first agreement period. See Appendix I for a comparison to current methodology and an implementation timeline.

- 1) CMS will incorporate regional adjustments into setting and trending benchmarks forward. To determine regional adjustments, CMS will define an ACO’s regional service area as including any county with at least one attributed beneficiary. It will then calculate the average per capita fee for service (FFS) expenditures of all beneficiaries eligible to be attributed to an ACO in the county. A weighted per capita average spending for the ACO in question will be calculated by multiplying each county’s average expenditure by the proportion of attributed ACO beneficiaries who reside in that county and summing the products.
- 2) After the initial contracting period, CMS would use the ACO’s average regional service area per capita FFS expenditure (as described above) to calculate an adjustment to the ACO’s rebased historical benchmark. The difference between the ACO’s per capita regional average amount and the average per capita amount of the rebased historical benchmark would be multiplied by 35 percent (during the second agreement period)¹ and up to 70 percent at the discretion of the Secretary of Health and Human Services (during the third agreement period) and added to the ACO’s historic benchmark.
- 3) CMS currently uses a national factor to trend an ACO’s benchmark year 1 (BY1) and benchmark year 2 (BY2) to benchmark year 3 (BY3). The proposed rule would replace the national trending factor with a factor based on the ACO’s regional service area to trend an ACO’s BY1 and BY2 to BY3 for calculating the ACO’s *historical rebased benchmark factor*. In a change from the June 2015 final rule, CMS will now propose to remove prior year’s savings from the rebased benchmark.
- 4) Similarly, CMS would replace the national flat dollar equivalent of the projected absolute amount of annual growth in Parts A and B FFS expenditures currently used to update the historical benchmark during performance years during a contracting period. 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

¹ For ACOs that began their second contracting period on 1/1/2016, this phasing in will occur during the third and fourth contracting periods.



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calculated as a growth rate that reflects risk adjusted growth in regional per beneficiary FFS spending for the ACO’s regional service area.

Risk Adjustment and Coding Intensity

The rule proposes the following changes to the risk adjustment mechanism and the process used to update benchmarks to reflect year-to-year changes in the ACO participant list (and therefore attributed beneficiaries).

- 1) CMS will adjust for differences in health status between an ACO and its regional service area in a given year, in determining the regional adjustment to the ACO’s rebased historical benchmark. For example, CMS will compute a measure of risk-adjusted regional expenditures that would account for differences in hierarchical condition category (HCC) risk scores of the ACO’s assigned beneficiaries and the average HCC risk scores in the ACO’s regional service area. CMS believes this approach will account for differences in health status between the ACO’s assigned population and the broader FFS population in the ACO’s regional service area. It would also capture differences in coding intensity efforts applied to the ACO’s assigned population and the FFS population in the ACO’s regional service area.
- 2) Instead of re-running data for each prior year using the new performance year’s ACO participant list to update benchmarks for changes in the physicians who participate in the ACO, CMS is proposing to use a ratio based on expenditures for the ACO’s beneficiaries assigned using both the ACO Participant List for the new performance year and the ACO Participant List for the most recent prior performance year (capturing “stayers” – those who are continuously assigned) and expenditures for the ACO’s beneficiaries assigned using only the ACO Participant List for the ACO’s most recent prior performance year (stayers and leavers – those who are no longer assigned to the ACO) for the same reference year. CMS will define the reference year as BY3 of the ACO’s current agreement period. This figure would then be combined with reference year expenditures for beneficiaries assigned using only the ACO Participant List for the new performance year (joiners – those who are newly assigned to the ACO) to obtain the overall adjusted benchmark. The same process will be used re-determine the regional adjustment as well.

Facilitating Transition to Performance-Based Risk:

CMS continues to encourage ACOs to move from shared savings only (Track 1 MSSPs) to shared savings/loss models (Track 2 or 3 MSSPs). The rule proposes a change that CMS believes will make the transition to risk easier for Track 1 MSSPs.

- 1) The rule adds 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. ACOs eligible to elect this proposed new participation option would be those ACOs eligible to renew for a second agreement period under Track 1 but instead are willing to move to a performance-based risk track two years earlier, after continuing under Track 1 for one additional year. This option would assist ACOs in transitioning to a two-sided risk track when they need only one additional year in Track 1 rather than a full three-year agreement period in order to prepare to accept performance-based risk. ACOs electing this options would still need to meet all of the criteria to



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participate in Track 2 or 3 (e.g., meet repayment requirements) in the application process for the second agreement period.

Circumstances for Reopening Initial and Final Determinations of ACO Shared Savings or Loss

In the proposed rule, CMS attempts to codify the circumstances under which it would re-open an initial or final determination of shared savings or loss for a performance year. The rule proposes the following:

- 1) If there is good cause, CMS will have the discretion to reopen a payment determination within four years after the date of notification to the ACO of the initial determination.
- 2) While CMS states that it would consider a materiality threshold based on the impact to the total population of ACOS, it does not propose a materiality threshold. If CMS finalizes the policy, the proposed rule states that it expects to provide additional information through the sub-regulatory process as to how it will consider the materiality of an error.

Appendix I: CHARACTERISTICS OF CURRENT AND PROPOSED BENCHMARKING APPROACHES

			Adjustments to the Historical Benchmark				
Source of Methodology	Agreement Period	Historical Benchmark Trend Factors (Trend BY1, BY2 to BY3)	For Regional FFS Expenditures (percentage applied in calculating adjustment)	For Savings in Prior Agreement Period?	For ACO Participant List Changes	For Health Status and Demographic Factors of Performance Year Assigned Beneficiaries	Update to Historical Benchmark for Growth in FFS Spending
Current Methodology	First	National	N/A	N/A	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
	Second and subsequent	National	N/A	Yes	Same as methodology for first agreement period	Same as methodology for first agreement period	National
Proposed Rebasing Methodology	Second (Third for 2012/2013 starters)	Regional	Yes (35 percent)	No	ACO's rebased benchmark adjusted by expenditure ratio*	No change	Regional
	Third and subsequent (Fourth and subsequent for 2012/2013 starters)	Regional	Yes (70 percent)**	No	Same as proposed methodology for second agreement period	No change	Regional

* Proposed adjustment to the historical benchmark for ACO Participant List changes using an expenditure ratio would be a program-wide change applicable to all ACOs, including ACOs in their first agreement period. As part of the proposed rebasing methodology, the regional adjustment to the ACO's rebased historical benchmark would be recalculated based on the new ACO Participant List.

**Unless the Secretary determines a lower weight should be applied, as specified through future rulemaking.