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Medicare Shared Savings Program Proposed Benchmarking Rule Summary

**Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations--
Revised Benchmark Rebasing Methodology, Facilitating Transition to Performance-Based
Risk, and Administrative Finality of Financial Calculations**

[CMS-1644-P]

Summary of Proposed Rule.

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I. Introduction and Background (pages 5824-5826)

On January 28, 2016, the Centers for Medicare and Medicaid Services (CMS) placed on public display a proposed rule that would make important changes to the benchmarking rebasing methodology used in the Medicare Shared Savings Program (MSSP), among other changes. This proposed rule was published in the February 3, 2016 issue of the *Federal Register* (81 FR 5824-5872). Page references given in this summary are to this published document.

Of special note, the proposed rule would:

- Modify the methodology for rebasing and updating ACO historical benchmarks to incorporate regional expenditures when an ACO renews its participation agreement for a second or subsequent agreement period.
- Streamline its methodology for adjusting ACO benchmarks to account for changes in ACO participant composition.
- Add a participation option to encourage ACOs to enter into a performance-based risk arrangement earlier. This would allow an ACO in its initial agreement period under Track 1 to enter a fourth performance year (PY) before transitioning to a three-year performance-based risk track (Track 2 or Track 3).
- Define circumstances under which it would reopen payment determinations to make corrections after the financial calculations have been performed and ACO shared savings and shared losses for a performance year have been determined.

As noted in more detail in section III of this summary, CMS estimates that changes being proposed would result in median estimated federal savings of \$120 million greater than what would have been saved if no changes were made. CMS anticipates improvements in the accuracy of benchmarking calculations are expected to increase overall participation in the program.

The public comment period on the proposed rule will close on March 28, 2016.

CMS states that, unless otherwise noted, changes to the MSSP program would be effective 60 days after publication of the final rule. Table 1 of the proposed rule lists key changes that have an applicability date other than the effective date (see below). CMS notes that by indicating a provision is applicable to a PY or agreement period, activities related to implementation of the policy may precede the start of the PY or agreement period.

Table 1 – Applicability Dates of Select Provisions of the Proposed Rule

Preamble Section	Section Title/Description	Applicability Date
II.A.2, II.A.3.	Integrating regional factors in resetting ACO benchmarks	Second or subsequent agreement period beginning January 1, 2017 and all subsequent years
II.A.2.e.3.	Use of assignable beneficiaries in calculations based on National FFS expenditures	PY 2017 and subsequent performance years
II.B.	Modification to the methodology for adjusting benchmarks for changes in ACO participant composition	PY 2017 and subsequent performance years
II.C.	An additional participation option that would allow eligible Track 1 ACOs to defer by 1 year their entrance into a performance-based risk model (Track 2 or 3) for their second agreement period	Second agreement period beginning January 1, 2017 and all subsequent years
II.D.	Definitions of circumstances for reopening determinations of ACO shared savings or shared losses to correct financial reconciliation calculations	60 days from publication of the final rule

II. Provisions of the Proposed Regulations (pages 5826-5858)

A. Proposals for Regional Definition (pages 5828-5832)

1. Proposals for Defining the ACO's Regional Service Area

CMS proposes to determine an ACO's regional service area by the counties of residence of the ACO's assigned beneficiaries. In other words, counties will serve as the building block for determining ACO's regional service area. CMS notes there is precedent in the Medicare program for using county-level data to set cost targets for value based purchasing initiatives citing the Physician Group Practice (PGP) demonstration and the use of county-level expenditure data used to establish benchmarks for local Medicare Advantage (MA) rates, with the exception of ESRD payments which are determined at the state-level.

Furthermore, CMS proposes to define regional costs using county FFS expenditures. These calculations will be undertaken separately according to the following populations of beneficiaries (identified by Medicare enrollment type): ESRD, disabled, aged/dual-eligible, and aged/non-dual eligible. CMS believes that county-level data offer a number of advantages over other options considered, such as MSAs, citing, among others, that small areas (such as counties) better capture regional variation in Medicare expenditures and allow for more customized regional definitions for each ACO. CMS also cites an additional advantage in that the use of county-level FFS data in calculating expenditures for an ACO's regional service area would permit ACOs to be viewed as being on the spectrum between traditional FFS Medicare and MA, a concept some commenters and stakeholders have urged CMS to articulate.

CMS also proposes to determine expenditures for ESRD beneficiaries statewide, and apply these amounts consistently to each county within a state. This approach is consistent with the approach used in MA. CMS believes the use of state-wide values for the ESRD population is appropriate given the small numbers of ESRD beneficiaries residing in many U.S. counties and would create more statistically stable values.

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

CMS notes that for purposes of calculating regional FFS costs the population must be sufficiently large to produce statistically stable mean expenditure estimates and must be representative of the demographic mix, health status and cost trends of the beneficiary population within the ACO's regional service area. Therefore, CMS considered whether the calculation of regional FFS costs for an ACO's regional service area should include or exclude the costs for the ACO's assigned beneficiary population. CMS defines "assigned beneficiaries" as those beneficiaries that received at least one primary care service from any Medicare-enrolled physician who is a primary care physician or who has one of the primary specialty designations that are used for purposes of assignment under the MSSP. CMS believes that including all FFS beneficiaries in the calculations would introduce bias into the calculations of the ACOs' regional service area expenditures.

CMS also considered how to weight the ACO's regional costs in cases where an ACO's assigned population spans multiple counties. CMS believes it will be important to weight an ACO's regional expenditures relative to the proportion of its assigned beneficiaries in each county. Absent this weighting, CMS believes it could overstate or understate the influence of the expenditures for a county where relatively few or many of an ACO's assigned beneficiaries reside.

Taking these considerations into account, CMS makes the following proposals:

- Proposes using all assignable beneficiaries, including ACO-assigned beneficiaries, in determining expenditures for the ACO's regional service area in order to ensure sufficiently stable regional mean expenditures.
- Proposes to define the ACO's regional service area to include any county where one or more assigned beneficiaries reside.

- Proposes to include the expenditures for all assignable FFS beneficiaries residing in those counties in calculating county FFS expenditures by enrollment type that will be used in the ACO's regional cost calculations
- Propose to weight county-level FFS expenditures by the ACO's proportion of assigned beneficiaries in the 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.

3. Proposals for Determining County FFS Expenditures

CMS proposes the following approach to calculating county FFS expenditures. In brief, CMS will determine county FFS expenditures for the assignable population based on the 12 month calendar year. Expenditures will include payments amounts in Part A and B claims and exclude certain payment adjustments such as IME, DSH, and uncompensated care. In order to minimize variation from catastrophically large claims, CMS proposes to truncate these expenditures at the 99th percentile of national FFS assignable beneficiary expenditures. CMS will also adjust county FFS expenditures for differences in case-mix of assignable beneficiaries using prospective CMS-Hierarchical Condition Category (HCC) risk scores. The table below provides detail of the CMS proposals.

To address potential issues associated with small numbers of ESRD beneficiaries in certain counties and its effect on the stability of its expenditure estimates, CMS proposes to compute state-level per capita expenditures and average risk scores for the ESRD population in each state and to apply those state-level values to all counties in a state.

CMS further notes that it anticipates making county level data used in MSSP calculations publicly available annually. For example, a publicly available data file would indicate for each county: average per capita FFS assignable beneficiary expenditures and average risk scores for all assignable beneficiaries by Medicare enrollment type (ESRD, disabled, aged/dual eligible, aged/non-dual eligible).

B. Proposals for Applying Regional Expenditures to the ACO's Rebased Benchmark (pages 5832-5836)

CMS notes that while it agrees with commenters on the benefits of incorporating regional expenditures in rebased benchmarks, it is interested in moving to an alternative rebasing approach that builds on the program's existing benchmarking methodology established under the authority of section 1899(d)(1)(B)(ii) of the Act. Furthermore, CMS believes that the plain language of this section demonstrates Congress' intent that the benchmark established for a MSSP ACO would reflect the ACO's historical expenditures in the 3 most recent years prior to the start of the ACO's agreement period. At the same time, CMS believes Congress recognizes that this historical benchmark should be adjusted "for beneficiary characteristics and such other factors as the Secretary determines appropriate." Thus, CMS believes this language would give the Secretary authority to adjust the benchmark in the second or subsequent agreement periods for regional FFS expenditures.

1. Proposals for Adjusting the Reset ACO Historical Benchmark to Reflect Regional FFS Expenditures

CMS discusses its proposals to reset an ACO's historical benchmark to reflect regional FFS expenditures. This would apply to the second agreement period for most ACOs, and the third agreement period for those that started in the program in 2012/2013. CMS considers two options to reset the ACO's historical benchmark.

In the first option, CMS would calculate the adjustment based on a regionally-trended version of the ACO's prior historical benchmark. The calculation of the regionally-trended amount would involve the following steps:

1. Use the ACO's historical benchmark from a prior agreement period, adjusted to account for ACO Participant List changes.
2. Risk adjust to reflect changes in health status of the ACO's assigned beneficiaries from the prior agreement period to the most recent year prior to the start of the new agreement period.
3. Trend the historical benchmark to the most recent year prior to the start of the new agreement period based on risk adjusted county FFS expenditures for the ACO's regional service area.
4. Reweight the regionally-trended expenditures by the proportion of the ACO's assigned beneficiaries in each of the four Medicare enrollment types (to reflect changes in the enrollment mix) for benchmark year 3 of the ACO's new agreement period.

In the second option, CMS would use a regional average determined using county FFS expenditures. CMS prefers this option and states that it would be easier from an operational standpoint, easier for ACOs and stakeholders to understand, and more closely align with the MA rate-setting methodology. **Under this preferred approach**, CMS would use the following steps to adjust the ACO's rebased historical benchmark.

1. For each Medicare enrollment type (ESRD, disabled, aged/dual eligible, aged/non-dual eligible), calculate the difference between the per capita regional average amount and the average per capita amount of the ACO's rebased historical benchmark. These values may be positive or negative.
2. Multiply the resulting difference, for each Medicare enrollment type by a percentage determined for the relevant agreement period (35%, 70%, or other number as determined by the Secretary). The value of this percentage is described in detail on page 9 of the summary. The products (one for each Medicare enrollment type) resulting from this step are the amounts of the regional adjustments that will be applied to the ACO's historical benchmark.
3. Add the adjustment to the ACO's rebased historical benchmark, adding the adjustment amount for the Medicare enrollment type to the truncated, trended and risk adjusted average per capita value of ACO's rebased historical benchmark for the same Medicare enrollment type.
4. Multiply the adjusted value of the ACO's rebased historical benchmark for each Medicare enrollment type by the proportion of the ACO's assigned beneficiary population for that Medicare enrollment type, based on the ACO's assigned beneficiary population for

benchmark year 3 of the rebased historical benchmark.

5. Sum expenditures across the four Medicare enrollment types to determine the ACO's adjusted rebased historical benchmark.

CMS notes that under both options, it would equally weight the 3 benchmark years (as finalized in the June 2015 rule). CMS, however, would trend forward benchmark year (BY) 1 and BY2 expenditures to BY3 dollars using regional growth rates for Parts A and B expenditures (as proposed).

In a departure from its policy finalized in the June 2015 rule, CMS states that in calculating the ACO's rebased historical benchmark, it would not apply the current adjustment to account for savings generated by the ACO under its prior agreement period. CMS implies that this adjustment is unnecessary and that an alternative rebasing methodology that accounts for regional FFS expenditures would generally leave a similar or slightly greater share of measured savings in an ACO's rebased benchmark for its ensuing agreement period.

In summary, CMS proposes to calculate the ACO's rebased benchmark using historical expenditures for the beneficiaries assigned to the ACO in the 3 years prior to the start of its current agreement period, applying equal weights to the benchmark years, but not accounting for shared savings generated by the ACO in its prior agreement period. CMS proposes to adjust the ACO's rebased historical benchmark to reflect risk adjusted regional average expenditures, based on county FFS expenditures determined for the ACO's regional service area.

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

CMS proposes a phased approach to moving to a higher weight in calculating the regional adjustment, ultimately reaching 70 percent, subject to assessment by the Secretary. CMS proposes to incorporate the following proposed policies regarding the weight to be applied in determining the regional adjustment in a new regulation at §425.603:

- Calculate the regional adjustment in the ACO's second agreement period by applying a weight of 35 percent to the difference between regional average expenditures for the ACO's regional service area and the ACO's rebased historical benchmark expenditures.
- In the ACO's third and subsequent agreement periods, the percentage used in this calculation would be set at 70 percent unless the Secretary determines a lower weight should be applied as specified through future rulemaking.

C. Proposals for Parity between Establishing and Updating Rebased Historical Benchmarking (pages 5836-5841)

1. Proposals for Regional Growth Rate as a Benchmark Trending Factor

CMS proposes to replace the national trend factors used for trending an ACO's BY1 and BY2 expenditures to BY3 with regional trend factors. The regional trend factors will be derived from a weighted average of risk adjusted FFS expenditures in the counties where the ACO's assigned beneficiaries reside. CMS proposes to calculate and apply these trend factors for each of the following populations of beneficiaries: ESRD, disabled, aged/dual eligible, and aged/non-dual eligible. This would be incorporated in a new proposed regulation at §425.603.

CMS believes that using regional trend factors, instead of national trend factors to trend forward expenditures in the benchmark period, will be advantageous. Specifically, CMS believes that regional trend factors would more accurately reflect the cost experience as well as the health status of the FFS population that comprise the ACO's regional service area. CMS also believes that regional trend factors could better capture location-specific changes in Medicare payments (for example, the area wage index) compared to the use of national trend factors.

CMS recognizes that using regional FFS trend factors would result in higher benchmarks for ACOs that are low growth in relation to their region compared to benchmarks for ACOs that are high growth relative to their region. ACOs with lower growth rates relative to their region would benefit from a relatively higher benchmark as this would increase their opportunity for savings and participation. On the other hand, ACOs with higher growth rates above their regional average may be discouraged from participating as it would be more difficult to achieve savings.

2. Proposals for Updating the Reset Benchmark During the Agreement Period.

CMS notes that an update factor based on the regional FFS expenditures would better align with its proposal to use regional FFS expenditures in developing the trend factors for the rebased historical benchmark (to trend BY1 and BY2 expenditures to BY3) and its proposal to adjust the ACO's rebased historical benchmark to reflect regional FFS expenditures. Consistent with its proposed policy CMS would continue to apply its current methodology in an ACO's first agreement period and for those ACOs that just started their second agreement period on January 1, 2016. As with use of regional trend factors instead of national trend factors, CMS believes calculating the update factor using regional FFS expenditures would better capture the cost experience in the ACO's region, the health status and socioeconomic dynamics of the regional population, and location-specific Medicare payments, when compared to using national FFS expenditures.

CMS proposes to include a provision (in the proposed new regulation at §425.603) to specify 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 risk adjusted growth in regional per beneficiary FFS spending for the ACO's regional service area.

CMS also proposes to calculate and apply separate update factors based on risk adjusted regional FFS expenditures for each of the following populations of beneficiaries: ESRD, disabled, aged/dual eligible, and aged/non-dual eligible.

The sequence for adjustments and the application of the update would be as follows:

- Calculate the ACO's rebased historical benchmark using historical expenditures for the beneficiaries assigned to the ACO in the 3 years prior to the start of its current agreement

period, using trend factors based on regional FFS expenditures to trend the ACO's BY1 and BY2 expenditures to BY3, and applying equal weights to the benchmark years.

- Adjust the ACO's rebased historical benchmark to reflect risk adjusted regional average expenditures based on county FFS expenditures determined for the ACO's regional service area.
- As needed, adjust the ACO's rebased historical benchmark to account for changes in ACO participants for the performance year.
- Adjust the ACO's rebased historical benchmark according to the health status and demographic factors of the ACO's performance year assigned beneficiary population. CMS would continue to apply the current newly and continuously assigned risk adjustment methodology.
- Update the adjusted rebased historical benchmark using the growth rates in risk adjusted FFS expenditures for the ACO's regional service area for each Medicare enrollment type (ESRD, disabled, aged/dual eligible, aged/non-dual eligible).

CMS clarifies that the current methodology for calculating the annual update will continue to apply in updating an ACO's historical benchmark during its first agreement period, as well as in updating the rebased historical benchmark for the second agreement period for ACOs that started in the program in 2012 or 2013, and entered their second agreement period on January 1, 2016. CMS believes the continued application of an update based on national FFS spending is consistent with the methodology used to establish the benchmarks for these ACOs, particularly the use of trend factors based on national FFS spending to trend an ACO's BY1 and BY2 expenditures to BY3.

D. Proposals for Parity between Calculation of ACO, Regional, and National FFS
(pages 5841-5845)

1. Proposals for Calculation of Regional FFS Expenditures

CMS proposes to take the following considerations into account in calculating county FFS expenditures used to determine expenditures for an ACO's regional service area.

- Calculate the payment amounts included in Parts A and B FFS claims using a 3-month claims run out with a completion factor. Exclude IME, DSH, and uncompensated care payments. Include individually beneficiary identifiable payments made under a demonstration, pilot or time-limited program.
- Truncate a beneficiary's total annual Parts A and B FFS per capita expenditures at the 99th percentile of national Medicare FFS expenditures as determined for the relevant benchmark or performance year in order to minimize variation from catastrophically large claims.
- Adjust expenditures for severity and case mix using prospective CMS-HCC risk scores.
- Make separate expenditure calculations for each of the following populations of beneficiaries, stated as beneficiary person years: ESRD, disabled, aged/dual eligible, and aged/non-dual eligible.

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

As way of background, CMS notes that several elements of the existing MSSP financial calculation are based on expenditures for all Medicare FFS beneficiaries regardless of whether they are eligible to be assigned to an ACO. These financial calculations include the growth rates used to trend forward expenditures, the completion factors applied to the benchmark and performance year expenditures, and the truncation thresholds set at the 99th percentile of national Medicare FFS expenditures, among others. Generally, beneficiaries eligible for assignment to Shared Savings ACOs are subsets of the larger population of Medicare FFS beneficiaries. CMS uses a two-step assignment process to determine "assignable beneficiaries": (1) the beneficiary must have received a primary care service (as defined under §425.20) during the 12-month assignment window; and (2) the service must have been furnished 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).

CMS believes it is timely to reconsider the population that should be used in program calculations for both national and regional FFS populations and would prefer a similar logic as used with the two-step assignment process described above. CMS is concerned that using expenditures for all Medicare FFS beneficiaries, as opposed to a narrower population of FFS beneficiaries, in calculating certain program elements may introduce a degree of bias in these calculations, particularly for elements based on regional FFS expenditures.

CMS notes that one factor related to calculating expenditures for assignable beneficiaries is the assignment window used to identify this population. CMS proposes to calculate county FFS expenditures and average risk scores, as well as factors based on national FFS expenditures, using the assignable beneficiary population identified using the assignment window for the 12-month calendar year corresponding to the benchmark or performance year. This is the same assignment window that is currently used to assign beneficiaries under Track 1 and Track 2 (Track 3 uses an offset 12-month period).

CMS also proposes to use assignable Medicare FFS beneficiaries to perform the following calculations: (1) truncation thresholds for limiting the impact of catastrophically large claims on ACO expenditures; and (2) growth rates used to trend forward expenditures during the benchmark period. CMS states it will provide additional information through subregulatory guidance regarding the process for using assignable beneficiaries to perform these calculations, as well as calculation of the claims completion factor applied under. In addition, CMS proposes a new provision of the MSSP regulations that would govern the methodology for resetting, adjusting, and updating an ACO's benchmark for a second or subsequent agreement period.

CMS proposes that regulatory changes regarding use of assignable beneficiaries in calculations based on national FFS expenditures would apply for the 2017 performance year and all subsequent performance years. These provisions would also apply to ACOs that are in the middle of an agreement period. CMS would adjust the benchmarks for these ACOs at the start of the first performance year in which these proposed changes apply so that the benchmark for the ACO reflects the use of the same methodology that would apply in expenditure calculations for the corresponding performance year.

E. Proposed Timing of Applicability of Revised Rebasing and Updating Methodology (pages 5845-5846)

As background, CMS in the June 2015 final rule indicated that the revised rebasing methodology would “apply to ACOs beginning new agreement periods in 2017 or later. ACOs beginning a new agreement period in 2016 would convert to the revised methodology at the start of their third agreement period in 2019” (80 FR 32795). CMS did not differentiate between ACOs that started their first agreement period under the MSSP on January 1, 2016, and ACOs that started in the program in 2012 and 2013 and entered their second agreement period on January 1, 2016. CMS believes that a phased approach to adjusting an ACO's rebased historical benchmark to reflect regional FFS expenditures would give ACOs and other stakeholders greater opportunity to prepare for, understand the effects of, and adjust to the application of benchmarks that incorporate regional expenditures.

CMS proposes making revised rebasing methodology changes applicable to ACOs starting a second or subsequent agreement period on or after January 1, 2017. These changes would initially apply in resetting benchmarks for the second agreement period for all ACOs other than 2012 and 2013 starters (who entered their second agreement period on January 1, 2016).

Under this proposal, the 2012 and 2013 starters would have the same transition to regional adjustments to their rebased historical benchmarks as all other ACOs: the percentage applied to

the difference between the ACO's regional service area expenditures and ACO's rebased historical benchmark expenditures would be set at 35 percent for their third agreement period (in 2019); in its fourth or subsequent agreement period this percentage would be set at 70 percent unless the Secretary determines a lower weight should be applied, as specified through future rulemaking.

Table 2 summarizes the CMS benchmarking proposals, including the percentage (weight) to be used in calculating the amount of the adjustment for regional FFS expenditures to be applied to the ACO's rebased historical benchmark, using regional (instead of national) trend factors in establishing an ACO's rebased historical benchmark, using regional (instead of national) FFS expenditures to update the ACO's benchmark for each performance year, and the timing of the applicability of the proposed new rebasing methodology.

TABLE 2: CHARACTERISTICS OF CURRENT AND PROPOSED BENCHMARKING APPROACHES

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 historical benchmark 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 unless the Secretary determines a lower weight should be applied, as specified through future rulemaking)	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.

F. Risk Adjustment and Coding Intensity Adjustment (pages 5846-5848)

1. Proposals for Risk Adjusting in Determining the Regional Adjustment to the ACO's Rebased Historical Benchmark and Seeking Comment on Approaches for Risk Adjusting Rebased Benchmarks

CMS proposes to 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 would compute for each Medicare enrollment type a measure of risk-adjusted regional expenditures that would account for differences in 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 would account for differences in health status between the ACO's assigned population and the broader FFS population in the ACO's regional service area. CMS also states that it would capture differences in coding intensity efforts applied to the ACO's assigned population and the FFS population in the ACO's regional service area.

CMS recognizes that the proposed approach would serve as a partial coding intensity adjustment, but it may not fully adjust for differential coding intensity by the ACO relative to its region. There are a number of factors CMS believes mitigates the potential impact of coding intensity on ACO financial calculations including its transition in 2016 to a new HCC model.

CMS notes that these proposed changes would not apply in calculating the benchmarks for ACOs in their first agreement period, or in establishing and updating the rebased historical benchmark for the second agreement period for ACOs that started in the program in 2012 and 2013 and started a new agreement period on January 1, 2016. Rather, CMS will continue to use CMS-HCC risk scores for the ACO's assigned beneficiary population in risk adjusting the ACO's historical benchmark at the start of the agreement period.

CMS also lays out two alternatives that it might consider in the future to limit the impacts of intensive coding while still accounting for changes in health status within an ACO's assigned beneficiary population.

- Apply the methodology currently used to adjust the ACO's benchmark annually to account for the health status and demographic factors of the ACO's performance year assigned beneficiaries (according to newly and continuously assigned populations) when rebasing the ACO's historical benchmark. Under this approach, newly assigned beneficiaries would always receive full HCC risk adjustment, whereas continuously assigned beneficiaries would receive either HCC or demographic risk adjustment, depending on whether average HCC risk scores were rising or falling. CMS notes that one advantage of this alternative is that it is already part of the current benchmarking methodology and is familiar to ACOs and stakeholders, and would be relatively easy for CMS to implement.
- Apply a coding intensity adjustment similar to the methodology used in the MA program which relies on an analysis of populations of beneficiaries who remained in MA for two consecutive reference years, and whose diagnoses all came from MA, referred to as

stayers. One advantage CMS cites is that it has several years of experience with the methodology used under the MA program.¹

G. Adjusting Benchmarks for Changes in ACO Participant (TIN) Composition

CMS proposes an alternative approach to streamlining calculations of adjusted historical benchmarks. CMS would make adjustments to the historical 3-year benchmark from the most recent prior performance year, and make adjustments to this benchmark using expenditures from a single reference year. CMS proposes to define the reference year as benchmark year 3 of the ACO's current agreement period for which beneficiary assignment has been performed using both the ACO Participant List for the most recent prior performance year and the new ACO Participant List for the current performance year. This would reduce the number of benchmark years for which assignment would need to be determined.

Calculations for the adjustment would be made in relation to three populations of beneficiaries assigned to the ACO in the reference year:

- Stayers: beneficiaries assigned to an ACO using both the ACO Participant List for the most recent prior performance year and the new ACO Participant List.
- Joiners: beneficiaries who are assigned to the ACO using the new ACO Participant List but not the ACO Participant List for the most recent prior performance year.
- Leavers: beneficiaries who are assigned to the ACO using the ACO Participant List for the most recent prior performance year but not the new ACO Participant List.

Calculation of the adjusted historical benchmark involves a series of calculations for each Medicare enrollment type (ESRD, disabled, aged/dual eligible, and aged/non-dual eligible). These steps can be found in detail on page 5850 of the proposed regulation. The purpose of the calculation is to adjust the benchmark to reflect the revised population mix of beneficiaries and their characteristics as defined by the stayers, joiners, and leavers. CMS believes this revised approach offers the right balance between approximating the accuracy of the current methodology for adjusting historical benchmarks (which requires performing beneficiary assignment for all 3 of an ACO's historical benchmark years with the new ACO Participant List) and operational ease. Initial modeling suggests that benchmarks calculated using this alternative methodology are highly correlated with those calculated using the current methodology.

CMS proposes to apply this new approach program wide as it believes it will address operational inefficiencies in the calculation of adjusted historical benchmarks under the current approach while still providing an accurate adjustment to reflect changes in ACO participants. In addition, CMS proposes to specify that the adjustment would apply to the ACO's rebased historical benchmark in a new provision of the MSSP regulations. CMS also proposes to add definitions for "stayers", "joiners" and "leavers". In the unlikely event that an ACO's new ACO Participant

¹ For a full description of the MA approach see "Advance Notice of Methodological Changes for Calendar Year (CY) 2010 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies," February 20, 2009, available online at <https://www.cms.gov/Medicare/HealthPlans/MedicareAdvtgSpecRateStats/downloads/Advance2010.pdf>.

List results in zero stayers, CMS would continue to apply the current methodology for adjusting the ACO's historical benchmark for ACO Participant List changes.

H. Facilitating Transition to Performance-Based Risk (pages 5848-5851)

CMS proposes to add a participation option that would allow eligible Track 1 ACOs to defer by 1 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 that would be 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 2 years earlier, after continuing under Track 1 for 1 additional year. CMS states that 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 3-year agreement period in order to prepare to accept performance-based risk.

CMS believes that the additional year could allow such ACOs to further develop necessary infrastructure to meet the program's goals, such as further developing their care management services, adopting additional mechanisms for measuring and improving quality performance, finalizing implementation and testing of electronic medical records, and performing data analytics. This option would be available to Track 1 ACOs whose first agreement period is scheduled to end on or after December 31, 2016. Under this proposal, ACOs that elect this new participation option would continue under their first agreement period for a fourth year, deferring benchmark rebasing as well as deferring entrance to a two-sided risk track if they are approved for renewal.

CMS notes that an ACO electing this option would still be required to undergo the renewal process prior to its initial agreement (PY 3) and meet all other renewal requirements, including that it is capable of repaying shared losses, as required to enter a performance-based risk track. With respect to quality performance, the quality performance standard that would apply for performance year 4 would be the same as for the ACO's performance year 3. After completion of the fourth performance year under Track 1, the ACO would transition to the selected performance based risk track (Track 2 or 3) for a second agreement period of 3 performance years.

I. Administrative Finality: Reopening Determinations of ACO Savings or Losses to Correct Financial Reconciliation Calculations, and a Conforming Change (pages 5851-5858)

1. Circumstances for Reopening Determinations

CMS reports that after the release of financial reconciliation results for performance year 1 of the MSSP, it discovered an issue with one of the source input data fields² that resulted in an estimated 5 percent overstatement of that performance year's shared savings payments and an

² Due to a sign error (plus sign instead of minus sign) in some cancellation claims used to calculate ACO benchmarks and performance year results, ACO total expenditures were understated in the final performance year 1 reconciliation.

understatement of shared losses. CMS also states that shared savings payments were not understated nor were shared loss recoupments overstated for that performance year. Under current law and regulation, the determination of an ACO's eligibility for shared savings or liability for shared losses is not appealable, but CMS may, pursuant to an inspection, evaluation or audit, reopen an initial determination if the agency discovers that the amount of shared savings or losses was calculated erroneously. However, CMS has not specified in regulations or guidance the actions it would take when it identifies an error in a prior payment determination. It proposes a finality policy under which it would permit corrections for fraud or for good cause within a defined timeframe after the financial calculations have been made and the shared savings or losses have been determined. ***CMS invites comments on the proposals described below.***

CMS proposes that if it determines that the amount of shared savings due to an ACO or the amount of shared losses owed by the ACO has been calculated in error, CMS may reopen the earlier payment determination and issue a revised initial determination. In the case of fraud or similar fault, CMS proposes to grant itself the discretion to reopen a payment determination at any time. However, with respect to reopening a determination for good cause (described below), CMS proposes to limit its discretion to do so during the 4-year period after the date of notification to the ACO of the initial determination of shared savings or shared losses for the relevant performance year. In developing its proposal for reopenings for good cause, CMS indicates that it is trying to balance between program integrity goals (that payments be accurate and timely) with efforts to minimize unnecessary operational burdens on ACOs and CMS as well as to support an ACO's ability to invest in additional improvements to increase quality and efficiency of care.

CMS proposes that good cause may be established when there is “new and material evidence” of either—

- (1) an error that was not available or known at the time of the payment determination and which may result in a different conclusion, or
- (2) 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.

CMS believes that 4 years is a sufficient period for new and material evidence to come to its attention (such as through program integrity review or audits by CMS, the OIG or the GAO).

CMS proposes that it would have sole discretion to determine (i) whether good cause exists for reopening a payment determination; (ii) whether a correction would be appropriate based on its proposed criteria; and (iii) the timing and manner of any correction.

It also proposes that good cause would not be established by changes in substantive law or interpretive policy (e.g., 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). If CMS does finalize this policy, it would provide subregulatory guidance on issues that would constitute good cause; the preamble to the proposed rule includes a couple examples of what would not constitute good cause: (i) an ACO-identified claims anomaly (e.g., a provider that submitted claims earlier or later than usual) or (ii) a third party payer's error in making a payment determination if CMS processed the claim with the information in its system or records.

Finally CMS proposes that good cause would not be established by a reconsideration, appeal, or other administrative or judicial review of any determinations precluded under §425.800³.

With respect to what constitutes materiality for technical errors the agency makes, CMS does not propose to specify criteria; rather, the agency would provide further information through subregulatory guidance. CMS indicates it might limit reopening for its technical errors to those that have a material effect on the net amount of shared savings and shared losses for all ACOs in a performance year. The agency is considering a 3-percent threshold⁴; in other words, a CMS technical error that affects total net shared savings and shared losses⁵ for all ACOs in a performance year of 3 percent or more would be considered a “material” error. CMS had considered applying this threshold for each ACO but rejected that approach in favor of limiting reopenings for errors at the program level.

CMS includes several examples of what would not constitute “material” under its proposed “new and material evidence” standard described above. It notes that it would not reopen a payment determination to consider additional claims information submitted by the ACO or ACO participants after the 3-month claims run out and the application of the completion factor.

CMS notes that making corrections for good cause might also add to program complexity; therefore, indicates that it would make corrections in a unified reopening to correct errors for a performance year to the extent feasible. If CMS determines that the reopening criteria under its proposal are met, CMS would recompute the financial results for all ACOs affected by the error or errors. If an adjustment to shared savings payments or shared losses recoupment is required for a performance year because of a reopening, it may adjust or recoup for those savings or losses in a subsequent performance year. CMS does note that repayment by an ACO of shared losses for a performance year must continue to be made within 90 days of receipt of notification; an ACO would not be able to delay repayment by notifying CMS of an error.

Finally, CMS clarifies that nothing in this proposal would limit the scope of the current law and regulation limitation on administrative and judicial review, and it proposes to add a revised initial determination to the list of determinations for which administrative or judicial review is precluded under §425.800.

2. Conforming Change

In the June 2015 MSSP final rule, CMS established a new performance-based risk option (referred to as “Track 3”) that includes prospective beneficiary assignment and a higher sharing rate. However, CMS did not amend the list of determinations for which administrative or judicial review is precluded under §425.800 to include a reference to determinations for Track 3. CMS proposes to do so in this rule

³ These include specification of quality or performance standards; assessment of quality of care; assignment of beneficiaries; eligibility for and amount of shared savings; percent of shared savings and limit on total shared savings; and ACO termination for failure to meet quality performance standards.

⁴ CMS notes that the 3-percent threshold is based on a review of GAO guidance for financial audits of federal entities.

⁵ CMS explains that total net shared savings and shared losses is the amount of shared savings after subtracting the amount of shared losses.