



Executive Summary – Final MSSP “Benchmarking” Rule

Top Issues Providers Need to Understand from the Final MSSP “Benchmark Rebasings” Rule

On June 6, 2016, the Centers for Medicare & Medicaid Services (CMS) released the long-awaited rule finalizing 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 final rule was published in the [June 10, 2016, Federal Register](#).

Final Revisions to Benchmark Rebasings:

In finalizing the following changes, CMS states that it is seeking to reflect an Accountable Care Organization’s (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 the timeframe in which the final rule will apply to MSSP based on their start date.

- 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 percent¹ (during second agreement periods starting in 2017 and thereafter). In the following agreement periods the blend would be up to 70 percent² at the discretion of the Secretary of Health and Human Services (during the third/fourth agreement period based on start date). The regional amount would be added to the ACO’s historic benchmark which will be proportionally weighted based on the agreement period and the ACOs benchmark relative to the regional average.
- 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 final rule replaces 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*. This change would be in effect for second and subsequent agreement periods starting in 2017 and thereafter. In a change from the June 2015 final rule, CMS will not add back savings from the prior contract period to the rebased benchmark for ACOs moving forward. CMS will not remove the savings from ACOs who just started their second agreement period on January 1, 2016. However, it will not be added back for these ACOs in subsequent agreement periods.

¹ or 25 percent if ACO is determined to have higher spending compared to its region

² or 50 percent if ACO is determined to have higher spending compared to its region



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- 4) 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 between 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 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 finalizes the following changes to the risk adjustment mechanism.

- 1) CMS will adjust for differences in health status between an ACO and its regional service area in a given year when 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.

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 finalizes 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 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 participate in Track 2 or 3 (e.g., meet repayment requirements) in the application process for the second agreement period. If an ACO that elects this option elects not to transition to a two-sided risk track after the additional year in Track 1, it will have to exit the program and wait until the end of its second agreement period (two years) to reapply.

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

In the final 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 finalizes the following:



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- 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 discuss a materiality threshold. The final 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.



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TABLE 3– 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
As modified by this final rule: Rebasing Methodology for second or subsequent	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



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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
agreement periods beginning 2017 and subsequent years	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