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healthcare financial management association

**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-F]**

**Summary of Final Rule**

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**I. Introduction and Background** (pages 37950-37952)

On June 6, 2016, the Centers for Medicare and Medicaid Services (CMS) placed on public display a final rule that would make important changes to the benchmarking rebasing methodology used in the Medicare Shared Savings Program (MSSP), among other changes. Under the MSSP, providers of services and suppliers that participate in an Accountable Care Organization (ACO) continue to receive traditional fee-for-service (FFS) payments under Parts A and B, but the ACO can receive a shared savings payment if it meets specified quality and savings requirements. This final rule is published in the June 10, 2016 issue of the *Federal Register* (81 FR 37950-38017). Page references given in this summary are to this published document. CMS said it received a total of 74 timely comments on the February 3, 2016 proposed rule (81 FR 5824-5872).

Of special note, the final rule modifies 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. CMS finalizes its proposal to use a subset of all Medicare FFS beneficiaries, or “assignable beneficiaries” for existing MSSP financial calculations. Further, CMS adds a participation option to encourage ACOs to enter into a performance-based risk arrangement earlier. CMS also defines 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. CMS did not finalize its proposal to streamline its methodology for adjusting ACO benchmarks to account for changes in ACO participant composition and defers any revisions to the methodology for future rulemaking.

CMS states that, unless otherwise noted, changes to the MSSP program will be effective 60 days after publication of the final rule. Table 1 of the final rule (reproduced below) lists key changes that have an applicability date other than the effective date. 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 Finale Rule**

Preamble Section	Section Title/Description	Applicability Date
II.A.2	Integrating regional factors in resetting ACO benchmarks.	Second or subsequent agreement periods beginning in 2017 and subsequent years.
II.A.2.e.3	For factors based on National FFS expenditures used in establishing the ACO’s historical benchmark: use expenditures for assignable beneficiaries to determine trend factors and truncation thresholds.	Agreement periods beginning in 2017 and subsequent years. For 2014 starters electing the participation option to defer by 1 year entrance into a second agreement period under a two-sided model, 2015 starters, and 2016 starters/renewals, historical benchmarks will be adjusted for the 2017 performance year and any subsequent years in the current agreement period.
II.A.2.e.3	For factors based on National FFS expenditures used in benchmark calculations and performance year expenditure calculations during the agreement period: Use expenditures for assignable beneficiaries to determine the annual benchmark update, and the truncation thresholds for determining performance year expenditures.	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 in 2017 and subsequent years.

CMS also notes that over 400 organizations are now participating in the MSSP, and this includes 147 ACOs with 2012 and 2013 agreement start dates that entered into a new 3-year agreement to

continue their participation in the program and 100 ACOs that entered the program for a first agreement period beginning January 1, 2016.

## **II. Provisions of the Final Regulations and Responses to Public Comments** (pages 37952-38002)

### **A. Regional Definition** (pages 37957-37962 )

#### 1. Defining the ACO's Regional Service Area

CMS finalizes its proposal to determine an ACO's regional service area by the counties of residence of the ACO's assigned beneficiary population. CMS also finalizes its proposal to define regional costs as county FFS expenditures for the counties in which the ACO's assigned beneficiaries reside. These will be used in resetting an ACO's historical benchmark for a second or subsequent agreement period.

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 MA rates.

CMS will also 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 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 in the past have urged CMS to articulate.

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

CMS finalizes its proposal to define the ACO's regional service area to include any county where one or more assigned beneficiaries reside. In addition, CMS finalizes several proposals, among others described elsewhere in its final rule, on the calculation of county FFS expenditures and an ACO's regional FFS expenditures:

- Include expenditures for all assignable FFS beneficiaries (including ACO assigned beneficiaries) residing within the county to calculate the county's FFS expenditures; and
- Weight an ACO's regional expenditures relative to the ACO's proportion of its assigned beneficiaries in each 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. CMS also clarifies the weighting of county-level expenditures by the ACO's proportion of beneficiaries by Medicare enrollment type (ESRD, disabled,

aged/dual eligible, aged/non-dual eligible) in each county for purposes of determining the ACO's regional expenditures.

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 ACO's regional service area expenditures.

CMS also discusses its rationale for weighting 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, in establishing the beneficiary population used to determine expenditures for the ACO's regional service area, will:

- Use 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.
- Define the ACO's regional service area to include any county where one or more assigned beneficiaries reside.
- 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
- Weight county-level FFS expenditures by the ACO's proportion of assigned beneficiaries in the county. CMS clarifies in the final rule that it intends to calculate each county's expenditures by enrollment type (ESRD, disabled, aged/dual eligible, aged/non-dual eligible), and to weight these expenditures by the ACO's proportion of assigned beneficiaries in the county for the applicable enrollment type.

**B. Applying Regional Expenditures to the ACO's Rebased Benchmark** (pages 37962-37974)

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

a. Summary of Proposals Finalized

CMS finalizes its proposals to revise the methodology used to rebase ACO benchmarks for new agreement periods starting on or after January 1, 2017 to incorporate a regional FFS adjustment to the ACO's rebased historical benchmark. CMS finalizes the proposed approach to calculating the regional FFS adjustment using average per capita expenditures for benchmark year 3 for assignable beneficiaries in the ACO's regional service area, and to risk adjust to account for the

health status of the ACO's assigned population in relation to the assignable FFS beneficiaries in the ACO's regional service area in determining the regional FFS adjustment.

In addition, CMS finalizes its proposal to redetermine the regional FFS adjustment, consistent with the current approach to adjusting an ACO's historical benchmark to account for changes in the ACO's certified ACO Participant List during the agreement period. CMS also finalizes conforming and clarifying revisions to address the methodology for establishing, adjusting, and updating the historical benchmark for ACOs that entered a second agreement period in 2016; and describes the adjustments made to the ACO's historical benchmark during an ACO's first agreement period to account for changes in severity and case mix for newly and continuously assigned beneficiaries.

b. Approach to Adjusting the ACO's Rebased Historical Benchmark

In the final rule CMS adopts a benchmarking methodology using a regional average determined using county FFS expenditures. CMS will use the following steps to adjust the ACO's rebased historical benchmark using a regional average determined using country FFS expenditures.

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 (25%, 35%, 70%, or other number as determined by the Secretary). The value of this percentage is described in detail on page 12 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 it will equally weight the 3 benchmark years (as finalized in the June 2015 rule). CMS, however, will 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 will not apply the current adjustment to account for savings generated by the ACO under its prior agreement period. CMS states that this adjustment is unnecessary and that an alternative rebasing methodology that accounts for regional FFS expenditures will generally leave a similar or slightly greater share of measured savings in an ACO's rebased benchmark for its ensuing agreement period.

c. Risk adjustment and coding intensity adjustment

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 for each Medicare enrollment type a measure of risk-adjusted regional expenditures that will 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 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. CMS also states that it will 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 this approach will 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 mitigate the potential impact of coding intensity on ACO financial calculations including its transition in 2016 to a new HCC model, and that ACOs are less susceptible to coding practices, compared to MA, as ACOs can be comprised of entities with little influence over the coding practices at other facilities or settings (comments made by many stakeholders in the December 2014 proposed rule).

CMS notes that these changes will 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.

In summary, CMS will 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 account for shared savings generated by the ACO in its prior agreement period. CMS will 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. Transitioning to a Higher Weight in Calculating the Adjustment for Regional FFS Expenditures

CMS finalizes with modifications a phased approach to transitioning to greater weights in calculating the regional adjustment amount, which is expressed as a percentage of the difference

between regional average expenditures for the ACO’s regional service area and the ACO’s rebased historical expenditures. Instead of applying a uniform weight of 35 percent in the second agreement or third for the 2012/2013 starters, CMS will use a lower weight (25 percent) in calculating the adjustment for ACOs with higher spending compared to their region.

This approach maintains the current methodology for establishing the benchmark for an ACO’s first agreement period in the MSSP based on the historical expenditures for beneficiaries assigned to the ACO with no adjustment for expenditures in the ACO’s regional service area, and the current methodology for resetting the historical benchmark for the second agreement period for ACOs that entered the program in 2012 and 2013 and started a new agreement period on January 1, 2016.

CMS will apply the regional adjustment to the ACO’s rebased historical benchmark for ACOs entering a second or subsequent agreement period in 2017 and subsequent years. CMS will use the following phased-approach to determine the weight used in calculating the adjustment.

**Table 2 – Percentage Weight Applied in Calculating the Regional FFS Adjustment**

<b>Agreement period (for example, 2014 starters renewing for 2017)</b>	<b>ACO’s spending relative to its region</b>	<b>Weight used to calculate regional adjustment</b>
Performance year within an agreement period to which regional adjustment is applied for the first time (for example, second agreement period beginning in 2017)	ACO spending is higher than its regional service area	25 percent
	ACO spending is lower than its regional service area	35 percent
Performance year within an agreement period to which regional adjustment is applied for the second time (for example, third agreement period beginning in 2020)	ACO spending is higher than its regional service area	50 percent
	ACO spending is lower than its regional service area	70 percent
Performance year within an agreement period to which regional adjustment is applied for the third time (for example, fourth agreement period beginning in 2023 and subsequent years)	ACO spending is higher than its regional service area	70 percent
	ACO spending is lower than its regional service area	70 percent

This phased approach will apply to ACOs that entered the program in 2012 and 2013 and started their second agreement period on January 1, 2016, for the first time in calculating their rebased historical benchmark for their third agreement period (beginning in 2019).

In the final rule, CMS deviates from the proposed in response to commenters by using lower weights in calculating the adjustment for ACOs with higher spending compared to their region. For those ACOs where spending is higher than its region, CMS will begin the regional adjustment weight at 25 percent the first time the regional adjustment is applied, 50 percent for the second time, and 70 percent in subsequent periods. In contrast, ACOs where spending is lower than its region will begin the regional adjustment weight at 35 percent and move to 70

percent for the second and subsequent periods. CMS states that it will continue to evaluate whether a lower weight (below 70 percent) should be used in calculating the regional adjustment.

**Parity between Establishing and Updating the Rebased Historical Benchmark** (pages 37974-37981)

1. Regional Growth Rate as a Benchmark Trending Factor

CMS finalizes its proposal to replace the national trend factors used for trending an ACO's BY1 and BY2 expenditures to BY3 with regional trend factors in calculating an ACO's rebased historical benchmark. The regional growth rate is derived from a weighted average of risk adjusted FFS expenditures for the ACO's regional service area, determined by the counties where the ACO's assigned beneficiaries reside. CMS will calculate and apply these trend factors for each of the following populations of beneficiaries: ESRD, disabled, aged/dual eligible, and aged/non-dual eligible. CMS incorporates this methodology at §425.603(c)(5).

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 will 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 will 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 will 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. Updating the Reset Benchmark during the Agreement Period.

Under the authority of section 1899(i)(3) of the Act, CMS finalizes its proposal 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 growth in risk adjusted regional per beneficiary FFS spending for the ACO's regional service area, for each of the following populations of beneficiaries: ESRD, disabled, aged/dual eligible, aged/non-dual eligible.

CMS notes that an update factor based on the regional FFS expenditures would better align with using regional FFS expenditures in developing the trend factors for the rebased historical benchmark (to trend BY1 and BY2 expenditures to BY3) and adjusting the ACO's rebased historical benchmark to reflect regional FFS expenditures. CMS will continue to apply its current

methodology<sup>1</sup> in an ACO's first agreement period and for those ACOs that just started their second agreement period on January 1, 2016. As with the 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 finalizes its proposal as proposed, but states that it shares the concerns raised by commenters about the longer term effects on participation resulting from relatively lower benchmark updates for regions with lower growth rates, reflecting ACOs' success in lowering growth in expenditures in those regions or a more general pattern of lower growth in the region.

### **Parity between Calculation of ACO, Regional, and National FFS Expenditures (pages 37981-37989)**

#### **1. Calculation of County FFS Expenditures**

CMS finalizes its proposed methodology for calculating county FFS expenditures with one modification. CMS finalizes the use of county level data to determine regional FFS expenditures for the assignable beneficiary population in the ACO's regional service area, and to perform these calculations separately according to the following populations of beneficiaries (identified by Medicare enrollment type): ESRD, disabled, aged/dual eligible, and aged/nondual eligible.

However, CMS is not finalizing its proposal to aggregate the expenditures for the ESRD population at the state level and will instead apply this value consistently to each county within the State. CMS also finalizes its proposal to calculate county FFS expenditures in the same way that is currently used to calculate ACO expenditures in order to assure parity with the calculation of ACO benchmark and performance year expenditures as specified under the MSSP regulations.

CMS note the importance of calculating FFS expenditures for an ACO's region in a manner consistent with the methodology used to calculate an ACO's benchmark and performance year expenditures in order to increase predictability and stability. For instance, CMS will continue to use a claims completion factor based on national FFS claims to determine FFS expenditures for an ACO's regional service area, as opposed to calculating a county-level claims completion factor. Likewise, CMS believes that IME and DSH payments should be excluded from program calculations, so as not to create an incentive for ACOs to avoid referrals to hospitals that receive IME and/or DSH payments in an effort to demonstrate savings. Other areas that CMS addresses include how to minimize variation from catastrophically large claims and adjusting expenditures for severity and case mix.

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

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<sup>1</sup> Flat dollar equivalent of the projected absolute amount of growth in national per capita expenditures for Parts A and B services under the original Medicare FFS program.

- 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 99<sup>th</sup> 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. Modifying the Calculation of National FFS Expenditures, Completion Factors, and Truncation Thresholds Based on Assignable Beneficiaries

CMS finalizes its proposal to use assignable beneficiaries in all national and regional FFS calculations with one modification. CMS is not finalizing its proposal to determine completion factors based on assignable Medicare FFS beneficiaries, and will continue to determine these completion factors based on the timing of submission of claims across the entire Medicare FFS population.

Currently, 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 99<sup>th</sup> 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 believed it was timely to reconsider the population that should be used in program calculations for both national and regional FFS populations and preferred a similar logic as used with the two-step assignment process described above. CMS was concerned that using expenditures for all Medicare FFS beneficiaries, as opposed to a narrower population of FFS beneficiaries, in calculating certain program elements would introduce a degree of bias in these calculations, particularly for elements based on regional FFS expenditures.

CMS will 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 specifies that the annual update to the benchmark will be based on the projected absolute amount of growth in national per capita expenditures for Parts A and B services under the original Medicare FFS program for assignable beneficiaries.<sup>2</sup>

CMS will 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. In addition, CMS adds a new provision of the MSSP regulations governs the methodology for resetting, adjusting, and updating an ACO's benchmark for a second or subsequent agreement period.

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

### **C. Timing of Applicability of Revised Rebasing and Updating Methodology** (pages 37989-37994)

CMS finalizes its proposal to make the new benchmark rebasing policies applicable to ACOs entering into a second or subsequent agreement period in 2017 or subsequent years. With respect to ACOs that started in the program in 2012 and 2013 that have renewed their agreements for a second agreement period beginning in 2016, CMS will apply the new rebasing methodology for the first time for their third agreement period that begins in 2019. Specifically, for the 2012 and 2013 starters, CMS will do the following:

- CMS will apply the rebasing methodology established with the June 2015 final rule, under which it equally weights the benchmark years and accounts for savings generated during the ACO's prior agreement period, in rebasing their historical benchmark for their second agreement period (beginning in 2016). CMS will apply the methodology specified under §425.602(b) to update the benchmark annually (flat dollar equivalent approach) for each year of the second agreement period for these ACOs.

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<sup>2</sup> CMS determined that it was necessary to rely on this authority in Section 1899(i)(3) of the Act instead of Section 1899(d)(1)(B)(ii), as the plain language of Section 1899(d)(1)(B)(ii) of the Act demonstrated Congress' intent that the benchmark update be calculated using the national FFS population, as opposed to a subset. Section 1899(i)(3) of the Act authorizes the Secretary to use other payment models in place of the payment model outlined in section 1899(d) of the Act as long as the Secretary determines these other payment models will improve the quality and efficiency of items and services furnished to Medicare beneficiaries, without additional program expenditures.

- CMS will apply the new rebasing policies, including the revised phase in of the percentage used in calculating the regional adjustment that it is adopting in this final rule, to these ACOs for the first time in calculating their rebased historical benchmark for their third agreement period (beginning in 2019), as if the ACOs were entering their second agreement period. Accordingly, the 2012 and 2013 starters will have the same transition to the use of a higher percentage in calculating the regional adjustment as all other ACOs.

Table 4 summarizes the CMS benchmarking policies, 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 new rebasing methodology.

**TABLE 3– CHARACTERISTICS OF BENCHMARKING APPROACHES BY AGREEMENT PERIOD**

<b>Source of Methodology</b>	<b>Agreement Period</b>	<b>Historical Benchmark Trend Factors (trend BY1, BY2 to BY3)</b>	<b>Adjustment to the Historical Benchmark for Regional FFS Expenditures (percentage applied in calculating adjustment)</b>	<b>Adjustment to the Historical Benchmark for Savings in Prior Agreement Period?</b>	<b>Adjustment to the Historical Benchmark for ACO Participant List Changes</b>	<b>Adjustment to the Historical Benchmark for Health Status and Demographic Factors of Performance Year Assigned Beneficiaries</b>	<b>Update to the Historical Benchmark for Growth in FFS Spending</b>
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

<b>Source of Methodology</b>	<b>Agreement Period</b>	<b>Historical Benchmark Trend Factors (trend BY1, BY2 to BY3)</b>	<b>Adjustment to the Historical Benchmark for Regional FFS Expenditures (percentage applied in calculating adjustment)</b>	<b>Adjustment to the Historical Benchmark for Savings in Prior Agreement Period?</b>	<b>Adjustment to the Historical Benchmark for ACO Participant List Changes</b>	<b>Adjustment to the Historical Benchmark for Health Status and Demographic Factors of Performance Year Assigned Beneficiaries</b>	<b>Update to the Historical Benchmark for Growth in FFS Spending</b>
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

**F. Adjusting Benchmarks for Changes in ACO Participant (TIN) Composition** (pages 37991-37994)

After consideration of the public comments received, CMS is not finalizing its proposal to replace the current approach for calculating adjusted historical benchmarks for ACOs that make ACO Participant List changes with a new program-wide approach that would adjust an ACO's historical benchmark using an expenditure ratio based on a single reference year.

CMS is finalizing, as proposed, clarifying revisions to the description of the current approach to calculating adjusted historical benchmarks for ACOs that make ACO Participant List changes to specify that the benchmark is adjusted to take into account the expenditures for beneficiaries who would have been assigned to the ACO in any of the 3 most recent years prior to the agreement period using the most recent certified ACO Participant List for the relevant performance year. In addition, CMS will include a similar provision to provide that the same adjustment for ACO Participant List changes will be made to an ACO's rebased historical benchmark.

**G. Facilitating Transition to Performance-Based Risk** (pages 37994-37997)

CMS finalizes its proposal to provide an additional option for ACOs participating under Track 1 to apply to renew for a second agreement period under a two-sided track (Track 2 or Track 3). If the ACO's renewal request is approved, the ACO may defer entering the new agreement period under the performance-based risk track for 1 year and extend its first agreement period under Track 1 for a fourth performance year. Further, as a result of this deferral and extension, CMS will also defer rebasing the ACO's benchmark for one year. At the end of the fourth performance year under Track 1, the ACO will transition to the selected performance-based risk track for a 3-year agreement period.

In addition, CMS finalizes its proposal that if an ACO that has been approved for an extension of its initial agreement period terminates its participation agreement prior to the start of the first performance year of the second agreement period, then the ACO will be considered to have terminated its participation agreement for the second agreement period. Such an ACO will not be eligible to participate in the MSSP again until after the date on which the term of that second agreement period would have expired if the ACO had not terminated its participation.

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. In addition, 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. 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.

#### **H. Administrative Finality: Reopening Determinations of ACO Savings or Losses to Correct Financial Reconciliation Calculations, and a Conforming Change (pages 37997-38002)**

##### **1. Circumstances for Reopening Determinations (§425.315)**

In the proposed rule, CMS noted that it had not specified in regulations or guidance actions it would take when it identifies an error in a prior payment determination. CMS proposed 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 finalizes its proposals for administrative finality without modification.

If CMS 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 as follows:

- In the case of fraud or similar fault, CMS may reopen a payment determination at any time.
- In the case of reopening a determination for good cause, CMS must do so not later than 4 years after the date of notification to the ACO of the initial determination of shared savings or shared losses for the relevant performance year.

*Good Cause.* Good cause may be established as follows:

- (1) When there is "new and material evidence" that was not available or known at the time of the payment determination and which may result in a different conclusion, or
- (2) When the 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 has sole discretion to determine (i) whether good cause exists for reopening a payment determination; (ii) whether a correction is appropriate; and (iii) the timing and manner of any correction.

CMS will provide guidance through subregulatory mechanisms on issues that will constitute good cause, and it provides examples of those that do not constitute good cause. For example, a change in substantive law or interpretative 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) does not constitute good cause. The following examples also do not constitute good cause: (i) an ACO-identified claims anomaly (e.g., a provider that submitted claims earlier or later than usual), (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, or (iii) a reconsideration, appeal, or other administrative or judicial review of any determinations precluded under §425.800<sup>3</sup>.

*Materiality Standard.* With respect to what constitutes materiality for technical errors the agency makes, CMS does not propose to specify criteria; rather, it will provide further information through subregulatory guidance. Any materiality standard that CMS establishes will apply at the program level (i.e., to all ACOs); CMS will not tailor materiality considerations to particular characteristics or circumstances of individual ACOs.

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. As it did in the proposed rule, CMS is considering a 3-percent threshold; in other words, a CMS technical error that affects total net shared savings and shared losses<sup>4</sup> for all ACOs in a performance year of 3 percent or more would be considered a "material" error. CMS notes that the 3 percent threshold is used by GAO in auditing financial statements of federal entities; while acknowledging that ACOs are not federal entities, CMS nonetheless believes this is an appropriate threshold for the new and material standard it adopts in the final rule.

CMS also notes that it will 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.

*Unified Reopening.* CMS finalizes its proposal to make corrections for good cause in a unified reopening to the extent feasible. If CMS determines that the reopening criteria are met, it will 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 also states 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 adds a revised initial determination to the list of determinations for which administrative or judicial review is precluded under §425.800.

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<sup>3</sup> 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.

<sup>4</sup> CMS explains that total net shared savings and shared losses is the amount of shared savings after subtracting the amount of shared losses.

## Publicly Available Data

CMS made available several data sources to facilitate analysis of the proposed modifications to the MSSP benchmarking methodology.

- Aggregate Expenditure and Risk Score Data on Assignable Beneficiaries by County: average county fee-for-service expenditures, CMS-HCC prospective risk scores and person-years for assignable beneficiaries by Medicare enrollment type (End Stage Renal Disease (ESRD), disabled, aged/dual eligible, aged/non-dual eligible) for 2012, 2013 and 2014.
- Number of ACO Assigned Beneficiaries by County: total assigned beneficiaries by ACO for each county where at least 1 percent of their assigned beneficiaries reside for 2012, 2013 and 2014.

These files can be downloaded at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Statutes-Regulations-Guidance.html>.

Using the publicly available data files released with the 2016 proposed rule, some commenters modeled the proposed benchmarking changes. For example, analysis results from several commenters showed that up to two-thirds of ACOs will have their benchmarks upwardly adjusted as a result of the revised rebasing methodology. In response, CMS notes its appreciation of the informative comments and believes these data were a sufficient tool to allow the public to analyze the general impact of the new method for rebasing. CMS also stated that the analyses by commenters were generally in harmony with CMS' calculations and were helpful with respect to changes made to the regional adjustments.