New Benchmark Rules - How to Play to Win

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Practice Performance
- MSSP benchmarking methodology
- New benchmarking rules
- Timeline of benchmarking rules
- Insights from ACOs in different models
- Benchmarking rules closing points ~ what’s in your control
- ACOs are here to stay with over 7,700,000 Medicare FFS beneficiaries benefiting from one of 430 ACO across 49 states.
- Sec. 3022 of the Patient Protection and Affordable Care Act (PPACA) amends Title XVIII of the Social Security Act by adding Sec. 1899, the Shared Savings Program defines the Medicare Shared Program rules.
- ACO rules are defined through 2027+; ACOs are the future by law.
- One of the biggest questions was the sustainability of the MSSP Program under the original ‘historic’ benchmark methodology and if both high performing ACOs with low benchmarks can succeed as well as high cost, high benchmarks.

The answer is yes.
All MSSP ACOs in their first performance contract are assigned historic benchmarks where they must ‘beat their own benchmark.’

In October of 2015, CMS finalized the MSSP regulations and introduced ‘rebased’ and ‘regional’ benchmarks and on June 6, 2016 CMS Released ‘Final Medicare Shared Savings Program Rule (CMS-1644-F)’

‘Final rule phases in use of regional factors when resetting ACOs’ benchmarks and facilitates transition to performance-based risk’
Summary of Major Provisions

- Modifying the methodology for rebasing and updating ACO historical benchmarks when an ACO renews its participation agreement for a second or subsequent agreement period to incorporate regional expenditures, thereby making the ACO’s cost target more independent of its historical expenditures and more reflective of FFS spending in its region.

- Applying a methodology for risk adjustment to account for the health status of the ACO’s assigned population in relation to FFS beneficiaries in the ACO’s regional service area in determining the regional adjustment that is applied to the ACO’s rebased historical benchmark.

- Adding a participation agreement renewal option to encourage ACOs to enter performance-based risk arrangements earlier in their participation in the Shared Savings Program.
MSSP Benchmarking includes three types of benchmarks:
- First Agreement Period Historical Benchmark
- Subsequent Period Rebased Benchmark (2016)
- Subsequent Rebased Regional Benchmark (phases in from 2017 - 2023)

By the end of this session, you will learn how the program has evolved, the new rules around Benchmarks and how the MSSP Benchmarking Rules are designed to support the long-term sustainability of the program along side of Medicare Advantage.
First Agreement Benchmarking Methodology

- When the Medicare Shared Savings Program (MSSP) launched in 2012, all ACO benchmarked were calculated using a historical benchmark.
- In the final rule, all ACOs will continue the Program using historical benchmarks:
  - Historic Part A and Part B Fee For Service expenditures are calculated for each type of beneficiary population (ESRD*, disabled, aged/dual eligible and aged/non-dual)
  - Expenditures are risked adjusted using CMS HCC methodology
  - Benchmarks are adjusted for inflation and risk over time
  - Expenditures are truncated at the 99th percentile to limit impact of outliers
  - Claims data is weighted by Benchmark Year (BY)
    - Benchmark Year 1 = 10%
    - Benchmark Year 2 = 30%
    - Benchmark Year 3 = 60%
### Historic Benchmark Calculation

#### Benchmark calculation example

<table>
<thead>
<tr>
<th>Classification</th>
<th>Cost</th>
<th># of Beneficiaries</th>
<th>% of Population</th>
<th>Benchmark ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged</td>
<td>$8,200</td>
<td>8,900</td>
<td>89%</td>
<td>$7,298</td>
</tr>
<tr>
<td>Dual-Eligible</td>
<td>$13,175</td>
<td>300</td>
<td>3%</td>
<td>$395</td>
</tr>
<tr>
<td>Disabled</td>
<td>$9,250</td>
<td>700</td>
<td>7%</td>
<td>$648</td>
</tr>
<tr>
<td>ESRD</td>
<td>$84,850</td>
<td>100</td>
<td>1%</td>
<td>$849</td>
</tr>
</tbody>
</table>

Benchmark = $9,189

The same calculation is run for 3 years and weighted for each Benchmark Year.

At the beginning of each performance year, benchmarks are calculated from the prospectively assigned beneficiaries based on historic costs. At the end of each ACO’s performance year, the actual beneficiaries are attributed and the benchmark recalculated.

**Helpful Tips**

Understanding beneficiary assignment rules are the foundation for understanding your benchmark and a key to success.
First Agreement Period Historical Benchmark

Benchmark 2012 - 2015

- 2009 BM (10%)
- 2010 BM (30%)
- 2011 BM (60%)
- 2012-2015 Benchmark

PMPY
Approx. 191 ACOs – were rebased in 2016
### What does it Look Like

<table>
<thead>
<tr>
<th>Aged/non-dual</th>
<th>4,086</th>
<th>3,870</th>
<th>3,664</th>
<th>11,620</th>
</tr>
</thead>
</table>

- **[H] Assigned Beneficiary Proportions and Expenditures ($)**
  - ESRD: 0.007 | 629
  - Disabled: 0.062 | 833
  - Aged/dual: 0.075 | 1,522
  - Aged/non-dual: 0.856 | 9,946

- **[I] Rebased Historical Benchmark ($)**
  - - | - | - | 12,930 |

### Calculate Adjustment for Savings in Prior Agreement Period

<table>
<thead>
<tr>
<th></th>
<th>PY1(AP1)</th>
<th>PY2(AP1)</th>
<th>PY3(AP1)</th>
<th>3-Year Average</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>[J] Assigned Beneficiary Person-Years</strong></td>
<td>29,884</td>
<td>33,676</td>
<td>59,389</td>
<td></td>
</tr>
<tr>
<td><strong>[K] Total Savings</strong></td>
<td>28,555,723</td>
<td>32,173,449</td>
<td>76,642,477</td>
<td></td>
</tr>
<tr>
<td><strong>[L] Per Capita Savings</strong></td>
<td>956</td>
<td>955</td>
<td>1,291</td>
<td></td>
</tr>
<tr>
<td><strong>[M] Net Savings Generated?</strong></td>
<td>-</td>
<td>-</td>
<td>1,067</td>
<td></td>
</tr>
<tr>
<td><strong>[N] Final Sharing Rate</strong></td>
<td>Yes</td>
<td>-</td>
<td>48.3%</td>
<td></td>
</tr>
<tr>
<td><strong>[O] Average Per Capita Savings Amount (Maximum Adjustment)</strong></td>
<td>50.0%</td>
<td>45.8%</td>
<td>49.0%</td>
<td></td>
</tr>
</tbody>
</table>

### Apply Adjustment for Savings in Prior Agreement Period

<table>
<thead>
<tr>
<th></th>
<th>PY1(AP2)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>[P] Person-Years Threshold</strong></td>
<td>40,983</td>
</tr>
<tr>
<td><strong>[Q] Assigned Beneficiary Person-Years for Second Agreement Period</strong></td>
<td>50,086</td>
</tr>
<tr>
<td><strong>[R] Per Capita Prior Savings Adjustment (Pro-Rated)</strong></td>
<td>422</td>
</tr>
<tr>
<td><strong>[S] Historical Benchmark Adjusted for Prior Savings (Pro-Rated)</strong></td>
<td>13,352</td>
</tr>
</tbody>
</table>

Actual Dollars to CMS are added in subsequent Benchmark.
New Benchmark Rules - How to Play to Win
Subsequent & Regional Benchmarks

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Rebased & Regional Benchmarks

- Use regional instead of national trend factors to trend forward benchmark year expenditures in calculation of rebased historical benchmark (+).
- Replace the adjustment for prior period savings with an adjustment that compares the ACO’s historical spending with that of its regional service area (+/-).
- Use a regional update factor instead of national increment to update the rebased historical benchmark for the performance year (+).

*For End Stage Renal Disease (ESRD) beneficiaries, CMS uses county-level expenditure and risk data*
<table>
<thead>
<tr>
<th>Number of ACOs with spending higher than its regional service area</th>
<th>Number of ACOs with spending lower than its regional spending area</th>
</tr>
</thead>
<tbody>
<tr>
<td>111</td>
<td>222</td>
</tr>
</tbody>
</table>

*2014 ACO performance year used to simulate rebase year 2017

Source: NAACOS
<table>
<thead>
<tr>
<th>Agreement period (for example, 2014 starters renewing for 2017)</th>
<th>ACO’s spending relative to its regional service area</th>
<th>Weight used to calculate regional adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agreement period to which regional adjustment is applied for first time (ex. second agreement period beginning in 2017)</td>
<td>ACO spending is higher than RSA</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>ACO spending is lower than RSA</td>
<td>35%</td>
</tr>
<tr>
<td>Agreement period to which regional adjustment is applied for second time (ex. third agreement period beginning in 2020)</td>
<td>ACO spending is higher than RSA</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>ACO spending is lower than RSA</td>
<td>70%</td>
</tr>
<tr>
<td>Agreement period to which regional adjustment is applied for third time (ex. fourth agreement period beginning in 2023 and subsequent years)</td>
<td>ACO spending is higher than RSA</td>
<td>70%</td>
</tr>
<tr>
<td></td>
<td>ACO spending is lower than RSA</td>
<td>70%</td>
</tr>
</tbody>
</table>

Source: NAACOs
Benchmarking Rules Closing Points

**What Is In Your Control?**
- Maintain your population
- Risk scoring and HCC
- Managing performance against your benchmark

**What Else is Considered?**
- Health Care Inflation
- Quality Counts
Medicare Fact Sheet *Final rule phases in use of regional factors when resetting ACOs’ benchmarks and facilitates transition to performance-based risk*

Next Generation Financial Model

- **Key components:**
  1. **Benchmark**
     - Each ACO’s benchmark calculated prospectively for the ACO’s aligned beneficiaries.
  2. **Risk Arrangement**
     - Each ACO selects one of two risk arrangement options.
  3. **Payment Mechanism**
     - Each ACO selects one of four payment mechanism options.

Source: CMMI
Prospective Benchmark (2016-2018)

The benchmark will be prospectively set prior to the performance year using the following four steps:

1. **Baseline**
   - Determine ACO’s baseline using one-year of historical baseline expenditures.

2. **Trend**
   - Trend the baseline forward using a regional projected trend.

3. **Risk Adjustment**
   - The full HCC risk score will be used. ACO risk score allowed to grow by 3% between the baseline and the given performance year. ACO risk score decrease also capped at 3%.

4. **Discount**
   - Apply discount derived from quality and efficiency adjustments.

Source: CMMI
Trend (2016-2018)

The baseline will be trended forward using a regional projected trend:

- National projected trend similar to that currently used in Medicare Advantage (MA).
- Regional prices applied to the national trend.
- Under limited circumstances, CMS may adjust the trend in response to price changes with substantial expected impact (negatively or positively) on ACO expenditures.
Discount (2016-2018)

- Once the baseline has been calculated, trended, and risk-adjusted, CMS will apply a discount.
- Summing the following components creates each ACO’s discount:
  - **Quality:**
    - Range: **2.0% to 3.0%**
    - Formula: \([2.0 + (1 - \text{quality score})]\)%
  - **Regional Efficiency:**
    - Range: **-1% to 1%**
    - Compares the ACO’s risk-adjusted historical per capita baseline to a risk-adjusted regional FFS per capita baseline.
  - **National Efficiency:**
    - Range: **-0.5% to 0.5%**
    - Compares the risk-adjusted regional FFS baseline to risk-adjusted national FFS per capita spending.
- **Total discount range:** **0.5% to 4.5%**
<table>
<thead>
<tr>
<th>Benchmark Step</th>
<th>Illustrative Amount</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline Spending/Baseline Risk Score</td>
<td>$100/1.00</td>
<td>Run alignment in baseline year to determine ACO’s historic expenditures and baseline risk.</td>
</tr>
<tr>
<td>Trend</td>
<td>2.0%</td>
<td>Add trend to the baseline: $100 + (.02 x $100) = $102</td>
</tr>
<tr>
<td>Risk Adjustment</td>
<td>1.02</td>
<td>Risk adjust the trended baseline using risk score for PY aligned beneficiaries: $102 x 1.02 = $104.04</td>
</tr>
<tr>
<td>Discount</td>
<td>1.0%</td>
<td>Subtract discount: $104.04 – (.01 x $104.04)</td>
</tr>
<tr>
<td>Illustrative Benchmark</td>
<td>$103.36</td>
<td>--</td>
</tr>
</tbody>
</table>
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