Independence at Home Demonstration Shared Savings Methodology

Specifications
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Contents

Executive Summary

The Independence at Home (IAH) Demonstration features a shared savings component whereby practices that show Medicare savings may receive incentive payments in the form of savings sharing with CMS. To determine if a practice has achieved savings, actual expenditures for each practice will be compared to a spending target for the practice. The spending target will estimate the Medicare FFS Part A and B expenditures that would have been incurred by IAH beneficiaries in the absence of the demonstration. In order to receive a shared savings incentive payment, practices must show savings that are greater than a minimum savings requirement and must achieve a minimum level of quality performance.

To determine if a practice achieved savings in each performance year, we will compare actual per beneficiary per month (PBPM) expenditures in the performance year to the practice's spending target for the performance year. Calculation of the incentive payment depends upon the level of savings achieved and quality performance. Performance year 1 for practices beginning the demonstration on June 1, 2012 (Cohort 1) was June 1, 2012 – May 31, 2013 and for practices beginning the demonstration on September 1, 2012 (Cohort 2) was September 1, 2012 – August 31, 2013. Some practices are participating in the demonstration as consortia. Each consortium will each receive a separate calculation, but not each practice within a consortium.

Enrollment and Eligibility

Each practice's eligible population includes the subset of patients enrolled in the IAH Reporting System who also met the claims-based criteria for enrollment in the demonstration during the performance year (hospitalization and post-acute care use in the twelve months prior to enrollment, not enrolled in a Medicare Advantage or PACE plan, enrolled in both Medicare Part A and B, not in hospice, and Medicare is primary payer). The eligible population also includes a small group of beneficiaries who had not been enrolled in the IAH reporting system but who met the claims-based eligibility criteria in the performance year AND who the practice indicated met the chronic condition and functional impairment criteria (these patients are known as "potential eligibles").

We will define a period of eligibility for each patient during each performance year based on the patient's enrollment date, as reconciled between CMS and the practice, and disenrollment information, as either reported by the practice or determined by the Medicare Enrollment Database (EDB). The EDB will be used as the source for the following disenrollment reasons:

- Death
- Enrollment in a Medicare Advantage or PACE plan
- No longer eligible for either Medicare Part A or Part B
- Medicare becoming secondary payer

Patients may be disenrolled during the performance year for other reasons. To disenroll patients for any reason other than the four listed above practices must report the disenrollment date and reason

in the IAH reporting system. These reasons include permanently moving to a nursing facility, moving out of the practice's service area, changing providers within the practice's service area, electing hospice and not maintaining the IAH provider as the hospice physician of record, or other reasons as determined by the practice. Beneficiaries who are disenrolled for any of the reasons listed below will be subject to the "six month rule" and will either be dropped from the performance year population (if enrolled for less than six months before the disenrollment) or have their enrollment extended to the end of the performance year or the date of a mandatory disenrollment reason, whichever comes first (if enrolled for six months or more):

- Patient changed primary care provider within the practice's service area
- Patient or patient's family declined in-home care
- Patient elected hospice and the IAH provider did not remain the physician of record
- Practice was unable to locate the patient
- Practice discharged the patient from its service

Actual Expenditures

Actual expenditures will include the Medicare payments for all Medicare Part A and Part B claims occurring during the performance year beginning with each patient's enrollment date and ending with the last day of the performance year or the day before the disenrollment date, if the patient was disenrolled during the year. Note that expenses incurred on the date of death will be included in the actual expenditure calculation. We will allow six months after the end of the performance year for claims to be reported. This is consistent with the level of runout included in the costs used as the basis for the spending targets (described below). The actual expenditures will be based on annual expenditures per beneficiary that have been truncated at the 99th percentile within the practice.

Spending Targets

We will determine spending targets for each beneficiary in the practice's performance year population. The spending target for the practice will be calculated as the average of these beneficiary-level spending targets, weighted by beneficiary months of enrollment. The beneficiary-level spending targets depend upon a base FFS expenditure amount, a trend factor, and a risk adjustment factor, as shown in the following formula:

Spending Target = Average FFS County Cost * Trend * (Risk Score + Frailty Factor)

The Average FFS County Cost is derived from data that is published by CMS each year. These data represent the average Medicare expenditures for FFS beneficiaries in one calendar year and are reported separately by county, Medicare status (aged, disabled, ESRD), and type of expense (Hospice, Other Part A, Part B). We will also use the dialysis data, which is reported at the state level. Beneficiaries will be assigned an Average FFS County Cost based on their residence at enrollment, as reported by the practice, and their Medicare status. Beneficiaries who are either Aged or Disabled will be assigned a composite Aged-Disabled cost for their county of residence (this is consistent with the development and intended use of the risk scores, which are described below). Beneficiaries with a Medicare status of

ESRD will be assigned an Average FFS County Cost based on whether they were on dialysis or had had a transplant during the performance year. Those on dialysis, or who are in the first, second, or third month after transplant will be assigned the dialysis cost in their state. Those who are in the fourth or later month after transplant will be assigned the composite Aged-Disabled cost for their county of residence. This is consistent with the development and intended use of the ESRD risk scores.

The Average FFS County Costs are based on data that are lagged behind the demonstration performance years. As such, we will trend the costs from the midpoint of the calendar year (July 1) to the midpoint of the performance year (December 1 for Cohort 1 and March 1 for Cohort 2). We will source trends from the most recently available Medicare Trustees Report and will disaggregate by state using other historical geographic data published by CMS. The trends will be applied separately for Part A and Part B.

We will determine risk scores using the CMS-HCC and CMS ESRD risk models, version 2113.87. Risk scores will be based on demographic information and diagnoses incurred in the twelve months prior to each beneficiary's enrollment date. Beneficiaries with a Medicare status of Aged or Disabled will receive a risk score produced by the CMS-HCC model. Beneficiaries with a Medicare status of ESRD will receive one of four risk score types produced by the CMS ESRD model according to the beneficiary's dialysis/transplant status – dialysis, transplant months one through three, transplant months four through nine, and transplant months ten and higher. Regardless of the model used, all beneficiaries will receive the community score; we will not use the institutional or new enrollee scores produced by the models. IAH beneficiaries who do not have twelve months of FFS eligibility in the year prior to enrollment (both Part A and Part B, not enrolled in MA or PACE, no Medicare secondary payer) will be assigned the higher of the following two risk scores:

- The risk score produced by the appropriate model when the beneficiary's partial-year experience is used; or,
- The average risk score for the practice for Aged and Disabled beneficiaries. For ESRD beneficiaries we will use the average ESRD risk score across the entire demonstration due to low prevalence at the practice level.

To reflect functional impairment that is not captured by the CMS-HCC risk model, we will apply frailty factors that have been developed by CMS for use with this model. The frailty factor applied to each beneficiary will depend upon the number of functional impairments reported by the practice in the IAH reporting system and whether or not the beneficiary is also enrolled in Medicaid. Note that frailty factors are only intended to be applied to CMS-HCC risk scores, not CMS ESRD risk scores. As such, we will not apply a frailty adjustment to beneficiaries receiving an ESRD risk score.

Determining Savings and Incentive Payments

To determine if a practice achieved savings during the performance year, we will divide the actual expenditures by the spending target and subtract the result from 1; we call this the savings percentage. If the savings percentage is negative, actual expenditures were greater than the spending target and there were no savings. If the savings percentage is positive, actual expenditures were less than the

spending target and there may have been savings on which to calculate an incentive payment. To determine if the savings qualify a practice for an incentive payment, the savings percentage will be compared to a minimum savings requirement (MSR). The use of an MSR is to ensure that differences between the target and actual spending represent actual savings rather than differences owing to normal variation in Medicare spending. The more beneficiaries there are in the practice population, the lower the MSR.

We will use two levels of MSR; one at a 95% confidence level and one at a 90% confidence level. At these levels, we can be 95% and 90% confident that savings have not occurred due to pure variation. Practices that meet the 95% MSR may receive up to 80% (based on quality performance) of shareable savings; practices that meet the 90% MSR may receive up to 50% (based on quality performance) of shareable savings. Practices whose savings percentages are negative or less than both MSRs do not qualify for an incentive payment. Shareable savings are defined as the savings above the first 5% saved; CMS retains the first 5% saved, which is equal to 5% multiplied by the spending target and total beneficiary months.

The amount of the final incentive payment depends upon quality performance. To qualify for incentive payments, a practice must have met or exceeded performance requirements on at least three of the six quality measures that are tied to payment. Practices that meet fewer than three of the quality measures are not eligible for an incentive payment. Practices that met three, four, five, or six of the quality measures will receive 50%, 67.7%, 83.3%, or 100% of the savings that qualify for sharing, respectively.

Introduction

Section 1866E of the Social Security Act, as added by Section 3024 of the Affordable Care Act (P.L. 111-148), directs the Centers for Medicare & Medicaid Services (CMS) to conduct the Independence at Home (IAH) Demonstration to test home-based primary care for Medicare fee-for-service (FFS) beneficiaries with multiple chronic illnesses and functional limitations. Home-based primary care is designed to provide comprehensive, coordinated, continuous, and accessible care to high-need patients and to coordinate health care across all treatment settings. Home-based primary care allows health care providers to spend more time with their patients, perform assessments in a patient's natural environment, and assume greater accountability for all aspects of the patient's care. This focus on timely and appropriate care is designed to improve overall quality of care and quality of life for patients served, while lowering health care costs by forestalling the need for care in institutional settings.

The IAH demonstration includes a shared savings component, whereby practices that show Medicare savings may receive incentive payments in the form of savings sharing with CMS. To determine if a practice has achieved savings, actual expenditures for each practice will be compared to a spending target for that practice in each performance year. The spending target will estimate the Medicare FFS Part A and B expenditures that would have been incurred by IAH beneficiaries in the absence of the demonstration. There will be an independent shared savings calculation for each of three twelve-month performance years. Some practices began the demonstration on June 1, 2012 (Cohort 1) and others began on September 1, 2012 (Cohort 2); the practices in each cohort will receive a separate calculation. Some practices are participating in the demonstration as consortia. These consortia will each receive a separate calculation, but not each practice within a consortium.

The purpose of this paper is to detail the methodology that will be used to determine IAH shared savings incentive payments. Section 1 covers the characteristics required of patients who qualify for IAH and how their periods of eligibility will be determined. Section 2 covers the calculation of the actual performance year expenditures. Section 3 covers the calculation of the spending target and Section 4 covers the method used to determine if a practice qualifies for a shared savings incentive payment, and if so, how much the payment will be.

Section 1: Population and Eligibility

The first step in the shared savings calculation is defining the population we will use to determine if there have been savings. As described in the sections below, not every patient enrolled by a practice or consortium will be eligible for the demonstration, and not every patient in the final demonstration population will have been enrolled by a practice or consortium. Once the population has been defined, we then must determine each patient's period of eligibility during the performance year. In the sections below we provide the eligibility criteria for the demonstration and the methods we used to apply those criteria, explain the difference between "enrolled" beneficiaries and "potentially eligible" beneficiaries and how they are defined, and provide the methods we will use to determine periods of eligibility within each performance year.

1.1 Population

We will include all "applicable" beneficiaries who are patients of a participating IAH practice or consortium at any point during a performance year. An applicable beneficiary is defined as an individual who on their date of demonstration enrollment:

- Is entitled to Medicare Part A and enrolled in Medicare Part B,
- Is not enrolled in a Medicare Advantage (MA) or PACE plan,
- Had Medicare as the primary payer,
- Is not on hospice,
- Has two or more chronic conditions, as determined by the practice[1],
- Requires human assistance with two or more activities of daily living (ADLs), as determined by the practice[2],
- Has had a hospital admission in the 12 months prior to enrollment (see Appendix A for the hospitalization specifications), and
- Has used post-acute or sub-acute rehabilitation services in the 12 months prior to enrollment (see Appendix A for the post-acute care use specifications)
- Has had a home visit with the enrolling IAH practice in the 12 months prior to enrollment (see Appendix A for the home visit specifications).

There are two types of applicable beneficiaries:

(1) Enrolled Beneficiaries. These are beneficiaries who a practice has entered into the IAH Reporting System, an electronic tool used by the practices to provide information to CMS about the patients they believe are eligible for the demonstration.

(2) Potentially Eligible Beneficiaries. These are beneficiaries who have been identified via a Medicare claims analysis (more details below) as potentially eligible for the demonstration but

[1] Rather than specifying a list of chronic conditions, CMS, for purposes of this demonstration, is defining chronic disease or condition to mean a disease or medical condition that is expected to last for more than 1 year, limits what a person can do, and requires ongoing medical monitoring.
[2] The ADLs are bathing, dressing, toileting, transferring, walking, and eating.

who have NOT been entered into the IAH Reporting System, nor has the practice provided a sufficient explanation for why they did not enroll them (for example, patient did not have two chronic conditions). These patients will be included in the shared savings calculation.

The exception to including ALL applicable beneficiaries in a performance year are those who were voluntarily disenrolled prior to having six months of eligible enrollment in the performance year. These patients will not be included at all in the population on which shared savings will be calculated. Voluntary disenrollment occurs when a patient changes providers within the practice service area, is discharged by the practice, declines home care, or elects hospice and changes provider. More information on the "six month" rule is below in Section 1.2.4.

1.1.1 Enrolled Beneficiaries

Enrolled beneficiaries have been entered by an IAH practice into the IAH Reporting System. Such patients have been informed of the practice's participation in the demonstration and have agreed to have their data used for the demonstration. By enrolling patients in the reporting system, the practice attests that they believe the patient meets all of the eligibility criteria in the list above on the enrollment date entered. When enrolling a patient, the practice reports the patient's name, date of birth, enrollment date, number of ADL limitations, the presence of at least two chronic conditions, and specific ambulatory care sensitive conditions (diabetes, congestive heart failure, or chronic obstructive pulmonary disease). Enrolling a patient in the IAH Reporting System does NOT affect a patient's ordinary Medicare coverage or their choice of providers.

Many practices may not have information on an enrolled patient's medical history, including when a hospitalization occurred, when the patient received post-acute care, or even information on the patient's Medicare eligibility. To assist the practices and to confirm eligibility for inclusion in the shared savings calculation, we will use the Medicare administrative data available to us to confirm each patient's eligibility on the enrollment date reported by the practice. These data include information available in the Medicare EDB and the Medicare claims data. We will confirm the existence of a qualifying hospitalization, post-acute care use, and an in-home visit with the IAH practice, and that the patient is not enrolled in an MA or PACE plan, has both Part A and Part B, has Medicare as primary payer, and is not on hospice. We are unable to confirm the remaining eligibility criteria (chronic illness and ADL limitations) using the data and must rely on the practices' attestation that the patient meets them.

Patients who do not meet all criteria based on these analyses will not be included in the population on which shared savings will be calculated.

1.1.2 Potentially Eligible Beneficiaries

To assist practices in identifying which of their patients had the qualifying hospitalization and post-acute care required for enrollment and to ensure that practices enroll ALL of their patients who meet the criteria for the demonstration, we will use an analysis similar to the one above for confirming eligibility to find any other patients that the practices have not enrolled but who meet the claims-based

criteria for the demonstration. Such patients *may* also meet the ADL and chronic condition requirements, pending information provided by the practices, and are called "potentially eligible."

For each performance year we will provide a list of potentially eligible patients to each practice. All patients on the list meet the claims-based eligibility criteria as of some enrollment date in the performance year (we will provide the earliest enrollment date that applies). Practices will have the opportunity to return the list, indicating that each patient is already enrolled, will be enrolled, does not meet the ADL and/or chronic condition criteria, or cannot be enrolled for some other reason (see Appendix C for the full list of available responses).

This process informs the practices which of their patients meet the claims-based criteria and also identifies other patients who may need to be enrolled. The technical specifications for identifying potentially eligible patients and their enrollment dates are in Appendix B. The responses that a practice may return for each potentially eligible patient are listed in Appendix C.

1.2 Periods of Eligibility

In general, applicable beneficiaries will be included in the shared savings calculation for the entire time between their enrollment and disenrollment (if one exists) dates during the performance year. This means we will include all such patient months the actual expenditures calculation. Exceptions are patients subject to the "six month rule" and special treatment for patients affected by Hurricane Sandy in performance year 1.

1.2.1 Enrollment

The enrollment date is the date that each patient became eligible for the demonstration. As noted above, "enrollment" does not limit the other Medicare providers the patient can see. The enrollment date serves as the beginning date for determining the patient's eligible months in the performance year. By demonstration design, all enrollments begin on the first day of the month.

There are two potential sources for each patient's enrollment date. The first is the enrollment date entered by the practice in the IAH reporting system, called the "reporting system enrollment date." Only enrolled beneficiaries will have such a date. In addition to confirming eligibility on the reporting system enrollment date, as described in Section 1.1.1, we will also use data to determine if an earlier or later enrollment date may be appropriate. This date is called the "claims-based enrollment date." Cases where an enrollment date different than the reporting system enrollment date may apply include:

- The patient does not meet the claims-based eligibility criteria on the reporting system enrollment date, but meets eligibility some time thereafter. In such cases the patient may still be enrolled (rather than being considered ineligible) as of the claims-based enrollment date.

- The patient meets the claims-based eligibility criteria on the reporting system enrollment date, but also appears eligible for enrollment some time before based on the data. We include these cases because practices are required to enroll patients as soon as they become eligible for the demonstration.

Potentially eligible beneficiaries will only have a claims-based enrollment date, as they will not have been enrolled by the practices. For both enrolled beneficiaries and potentially eligible beneficiaries, we generate an array of possible claims-based enrollment dates in the performance year. The claims-based enrollment date is set to the earliest possible enrollment date in the performance year on which all of the criteria listed in Section 1.1 are met, except the chronic condition and ADL criteria (since these cannot be determined by the claims).

For enrolled beneficiaries, practices will have the opportunity to reconcile the reporting system enrollment date with the claims-based enrollment date before the population for each performance year is finalized. Each practice will receive a list of their enrolled patients. The enrolled patient list will provide both the reporting system enrollment date and the claims-based enrollment date, if one was found. Practices must enter one of the responses regarding enrollment status in Appendix D and return the workbook so that a final enrollment date may be chosen.

1.2.2 Disenrollment

Patients will be disenrolled from the demonstration for any of the following reasons, which we will categorize into two groups:

Group A

- Death
- Patient loses Medicare Part A or Part B
- Medicare becomes secondary payer
- Patient enrolls in a MA or PACE plan

Group B

- Patient becomes permanently institutionalized
- Patient moves out of a practice's service area
- Patient goes on hospice and the IAH practice will not continue to follow the patient (is no longer the "physician of record")
- Patient no longer wishes to have the IAH practice provide their primary care (in the home)
- Patient no longer wishes to have their data shared for the purposes of the demonstration
- Practice discharges the patient from service (reasons include unable to contact the patient, patient non-compliance, or patient unable to make copayments for services)
- Other practice reasons

Practices must report disenrollments for any reason (both groups) via the IAH Reporting System. The disenrollment reasons in Group A can all be verified using the Medicare EDB. We will use the EDB to set such disenrollment dates (and not use practice-reported information for these disenrollment reasons). The disenrollment reasons in Group B cannot be easily verified using Medicare data sources. For this group we must rely on the information the practices have reported. If multiple disenrollment reasons/dates exist, we will use the earliest disenrollment date.

1.2.3 Reenrollment

Beneficiaries may be reenrolled in the demonstration after being disenrolled. Beneficiaries who are disenrolled for any reason may be reenrolled within six months without reestablishing eligibility criteria. Beneficiaries may be reenrolled after six months; however, eligibility criteria must be reestablished. Practices may use the reenrollment provision to properly reflect patients who move outside of their service area for part of the year ("snowbirds") or to reenroll patients who temporarily joined an MA plan. Note that the risk score calculated based on the beneficiary's initial enrollment will not be updated.

Reenrolled beneficiaries will have more than one enrollment date and potentially more than one disenrollment date. So that practices do not use the reenrollment provision to disenroll patients during costly episodes, practices must call the IAH Help Desk to reenroll a patient. We will not use Medicare data to determine when a patient may become eligible for reenrollment; it will be the practice's responsibility to reenroll their patients. Upon reenrollment after six months of disenrollment, we will use the data to determine eligibility on the reenrollment date the practice has entered.

1.2.4 Eligibility Exceptions

"Six Month Rule"

We will implement special rules for patients who the practices have reported as voluntarily disenrolling from the demonstration. These rules were directed by OMB, in efforts to prevent practices from prematurely disenrolling patients who they know or believe to be high cost. Patients who leave the demonstration voluntarily after six or more months of enrollment in any performance year, by changing practices within the provider service area, becoming discharged by the practice, declining home care, or electing hospice and changing providers, will be included in the calculations based on the full performance year. However, patients who disenroll voluntarily after fewer than six months of enrollment in any performance year will not be included in the patient population for the entire performance year for purposes of establishing the expenditure target and calculating savings.

For example, a patient who is enrolled for eight months out of a performance year will be counted as being enrolled for the entire year, and any costs associated with utilizations within that year will be used in determining savings calculations—even costs associated with the time when that patient was no longer receiving primary care from the participating practice. Note that if such a patient becomes ineligible for the demonstration after the voluntary disenrollment (such as death or joining an MA plan), he or she will be disenrolled as of that date.

If a patient is enrolled in the demonstration for 5 months out of a performance year, but then decides to change practices, the patient will not be included in the patient population at all for that performance year, nor will the patient's expenditures.

Hurricane Sandy

Two IAH practices have service areas in states that were severely affected by Hurricane Sandy in the fall of 2012. Some of their patients were sent to hospitals or other facilities due to power outages in their homes, destruction of their homes, or mandatory evacuations. These practices believe that these patients would not have incurred these claims had the hurricane not occurred. CMS will allow an adjustment in the performance year 1 shared savings calculation that accounts for the uncontrollable effects of this natural disaster.

CMS requested that the practices send documentation of the affected patients and claims. The practices identified individual patients, the type of claim that occurred, the admission and discharge dates of the claim, and the reason they believe the admission occurred. If the identified patients were eligible for the demonstration during the time they were in these facilities, the associated patient months will be excluded from the shared savings calculation, as will all expenditures during this time period, and any hospitalizations or emergency department utilization will be excluded from quality measure calculations. The length of these "black out" periods varies from three days to two months. Our assumption is that if a facility admission occurred during the storm that would not have occurred otherwise, any physician billings or other services during the facility stay would also not have occurred otherwise. We will exclude claims from the numerator and patient months from the denominator during the black-out period.

Section 2: Calculating Actual Expenditures

Once the performance year population has been defined we will calculate the actual expenditures for each practice and consortium. Actual expenditures will be calculated on a per beneficiary per month (PBPM) basis. We will allow six months after the close of the performance year for all claims to be reported. Note that this translates to a *minimum* of six months of claims runout and that most months will have more than six months. Using performance year 1 for cohort 1 as an example, this means we will wait until the end of November 2013 for claims to be reported to tabulate actual expenditures.

Expenditures will be included for all beneficiaries during the time they were enrolled and/or eligible during the performance year. The methods for defining eligibility and the associated time period were described above in Section 1. We will include expenditures for all claims where the service date is inside the period of eligibility. The service date for most claims is the date the beneficiary received the service (referred to as the "from date" on the claim). For Inpatient and Skilled Nursing Facility (SNF) claims, the service date is the date the beneficiary was admitted to the facility (the admission date on the claim). Note that for qualifying patients, no claims will be included during Hurricane Sandy black-out periods, as described above in Section 1.2.4.

We will include all Medicare Part A and Part B FFS expenditures from the Inpatient, SNF, Outpatient, Physician, Durable Medical Equipment (DME), Home Health Agency (HHA), and Hospice claims files. Indirect Medical Education (IME), Graduate Medical Education (GME), and Disproportionate Share Hospital (DSH) payments will be excluded, though we will include inpatient pass through amounts, which include direct medical education, capital-related costs, and bad debt. Individually identifiable payments made under any other CMS demonstration, pilot, or time-limited program will be included. These provisions will ensure that the actual expenditures are calculated on the same basis as the average FFS county costs, which exclude IME and DSH and include pass through amounts.

We will not apply any completion factors to these expenditures. We will have included six months of claims runout, at a minimum, which will match the amount of runout that is used in the development of the average FFS county costs, on which the spending target is based. Therefore there should be no differences in the comparison that are attributable to differing claims runout periods.

2.1 Outlier Adjustment

Annual expenses per beneficiary will be truncated at the 99th percentile of annual expense for all beneficiaries in each practice/consortium prior to finalizing the actual expenditures that will be measured against the spending target. Truncation is performed to reduce the effect of unexpectedly high-cost patients that a practice may treat in any given year. These high-cost patients could negatively impact the calculation of a practice's savings. Annual expenses above the 99th percentile will be set equal to the 99th percentile.

2.2 Sequestration Adjustment

Beginning April 1, 2013, all Medicare expenditures were reduced by two percent due to sequestration. In the absence of sequestration, Medicare expenditures would be approximately two

percent higher (technically 1/0.98 or 2.041% higher) than the payment that was actually made. Each IAH performance year will have been subject to sequestration for at least part of the year. The average FFS county costs on which the spending targets for the first two performance years will be based (CY 2011 and CY 2012, respectively) were not subject to sequestration; those on which the spending target for performance year 3 will be based (CY 2013) were not subject to sequestration until April 1, 2013. So that we make an appropriate comparison between the actual expenditures and the spending target, we will adjust the actual expenditures at the claim level, based on the date of service, to correspond to the level of sequestration (or lack thereof) in the average FFS county cost data. Otherwise, the 2% sequestration reduction would be misrepresented as savings.

All non-DME claims with a through date of April 1, 2013 or after will be adjusted by dividing the Medicare payment by 0.98. DME claims with a *from date* of April 1, 2013 or after will be adjusted by dividing the Medicare payment by 0.98 (this reflects how sequestration was actually implemented). Dividing by 0.98 will increase the claim payments up to the amount that would have been paid in the absence of sequestration.

2.3 Final Actual Expenditures

PBPM actual expenditures will be calculated by summing the total Medicare FFS payments, after adjusting for outliers and sequestration (and Hurricane Sandy where applicable in the first performance year), for all of the beneficiaries at each practice and consortium and dividing by the associated beneficiary months.

Section 3: Calculating the Spending Target

The spending target will estimate the Medicare FFS Part A and B expenditures that would have been incurred by IAH beneficiaries in the absence of the demonstration. It will be practice-specific in that it is developed for each practice and consortium's applicable beneficiary population. We will calculate a new spending target for each performance year. Spending targets will first be determined for each beneficiary in the performance year population and then will be averaged over the entire practice to obtain the practice-level spending target.

The beneficiary-level spending targets will depend upon a base FFS expenditure amount, a trend factor, and risk adjustment factors, as shown in the following formula:

Spending Target = Average FFS Cost in County of Residence * Trend * (Risk Score + Frailty Factor)

The Average FFS Cost in County of Residence (per beneficiary per month), Trend, and Frailty Adjustment factors are established each year by CMS. The trend will represent the expected average increase in the PBPM Medicare Part A and B costs. The risk scores will be derived using the CMS Hierarchical Chronic Condition (CMS-HCC) model and will be based on demographic factors and diagnoses from the twelve months prior to enrollment in the demonstration. The frailty factor will be added to the risk score to reflect a beneficiary's impairments with ADLs that may increase the costs of care. The frailty factor will be based on the number of ADL impairments reported by the practice and each patient's Medicaid status. All new enrollees of IAH providers will receive a prospective CMS-HCC risk score and frailty factor. The risk score and frailty factor for continuing enrollees will be updated in future performance years only for changes in demographics (age and Medicaid status).

An individual practice or consortium's spending target will equal the average of these PBPM predicted costs, weighted by the number of months of each beneficiary's participation. Below we describe each of the elements of the spending target in more detail.

3.1 Average FFS County Costs

CMS' Office of the Actuary (OACT) publishes average FFS expenditure data each year at the county level by Medicare entitlement category (aged, disabled, ESRD) and at the state level for beneficiaries on dialysis. The data are lagged by about fifteen months. For example, the calendar year 2011 expenditures were published in April 2013. We will use the following FFS expenditure data for each performance year:

Performance Year	FFS Expenditure Data Year
1	CY 2011
2	CY 2012
3	CY 2013

The 2011 expenditures allow six months after the close of the year for claims to be reported. Future years of FFS expenditures may include differing runout periods. If this is the case, we will apply a

completion factor in the development of the actual expenditures, since they will always be compiled six months after the close of the performance year. The FFS data include all Medicare Part A and Part B expenditures.

The FFS data include total Medicare payments and Medicare payments excluding IME, GME, and DSH payments. We will use the latter set of expenditures, those that exclude IME, GME, and DSH. Note that these expenditures include inpatient pass through amounts. Though hospice is a Medicare Part A cost, it is published in a separate file. We will include the hospice expenditures in the total spending target.

The FFS data is reported for each county as a Part A per capita expenditure for all Part A enrollees (including those enrolled in Part A and B as well as those only enrolled in Part A) and a Part B per capita expenditure for all Part B enrollees (including those enrolled in Part A and B as well as those only enrolled in Part B). Because the IAH population is required to be enrolled in both Part A and B, we will apply an adjustment at the state level so that the Part A and Part B per capita expenditures represent the costs for beneficiaries enrolled in both Part A and Part B. We will use the Medicare Limited Datasets, which is based on the Medicare 5% Sample, to determine this adjustment. The adjustment will be applied according to each beneficiary's state of residence as reported by the practice (for enrolled beneficiaries) or as determined by the Medicare EDB (for potentially eligible beneficiaries).

Every patient in each practice and consortium will be assigned an Average FFS County Cost based on their county of residence, as reported by the practice, and their Medicare status. We will assign a county cost for each eligible month to reflect any movement from Aged or Disabled status into ESRD status and to reflect the progression of ESRD patients (dialysis, transplant, post-graft). Beneficiaries who are either Aged or Disabled will be assigned a composite Aged-Disabled cost for their county of residence (this is consistent with the development and intended use of the risk scores, which are described below). Beneficiaries with a Medicare status of ESRD will be assigned an Average FFS County Cost based on whether they were on dialysis or had had a transplant during the performance year. Those on dialysis, or who are in the first, second, or third month after transplant will be assigned the dialysis cost in their state. Those who are in the fourth or later month after transplant will be assigned the composite Aged-Disabled cost for their county of residence. This is consistent with the development and intended use of the ESRD risk scores. The Medicare entitlement and ESRD information will come from the Medicare EDB.

Though residence is also available from the EDB, the source we will use for beneficiary residence will be the zip code reported by the practice in the IAH reporting system. We believe that the practices are the best source for residence information because they visit their patients in the home, whereas zip codes in the EDB represent the SSA mailing address and may not represent a beneficiary's true residence. For potentially eligible beneficiaries we will use the EDB to determine residence since we have no other source. Zip codes will be mapped to SSA county codes for use of the FFS data.

Once an Average FFS county cost has been assigned to each patient-month, we will standardize the non-hospice cost by dividing by the average risk score for all FFS beneficiaries in the county. Each

county's risk score is published in the same file as the expenditures. We standardize the costs to bring them to a "1.0," or, average, basis. This will allow them to serve as an appropriate basis for the risk adjustment used to calculate the spending target; CMS-HCC risk scores represent a population's predicted cost relative to average (for example, a risk score of 2.0 indicates predicted expenses that are twice that of the average). We will not standardize the hospice expenditures because they are not likely to vary by a beneficiary's diagnosis history.[3]

3.2 Trending to the Performance Year

We will trend the Part A and Part B expenditures from the midpoint of the FFS expenditure data year to the midpoint of the performance year. For practices and consortia beginning the demonstration on June 1, 2012, we will apply trend from July 1, 2011 to December 1, 2012 for performance year 1. For consortia beginning the demonstration on September 1, 2012, we will apply trend from July 1, 2011 to March 1, 2011 for performance year 1.

The trend factors will be updated each year and will come from the most recently available Medicare Trustees Report. Because the Trustees Report publishes the percent change in average per beneficiary cost only at the national level, we will use historical years of published FFS data in conjunction with the Trustees Report to develop state-level trends to apply to each practice's spending target. In other words, the trends will be state-specific, but will be calibrated to the national average Part A and B trends published in the Trustees Report. For example, if a state has shown in the past that its Part A trends in FFS expenditures are 3% higher than the national average, we will increase the Trustees Report Part A trend by 3% for that state in the development of the spending target.

For performance year 1 we will use the 2013 Trustees Report, which shows trends of 0.3% for Part A per beneficiary costs and 3.2% for Part B per beneficiary costs for 2011 to 2012. For 2012 to 2013, the estimated trends are -1.8% for Part A and 1.1% for Part B.

3.3 Calculating the Risk Score

Risk scores will be calculated for all applicable beneficiaries using the v2113.87 CMS-HCC and CMS ESRD risk models. They will be based on diagnosis and demographic information from the twelve months prior to each patient's enrollment date. Risk scores will be calculated only upon initial enrollment in the demonstration per OMB requirements. As with the FFS county costs, we will assign a risk score to each new IAH beneficiary for each eligible month in the performance year to reflect any movement between Medicare statuses and to reflect movement within the ESRD status. For each performance year after a beneficiary's first year in IAH, the risk score will be updated only for demographic changes (age, Medicaid status) or for a Medicare status change into ESRD.

CMS uses the CMS-HCC and ESRD models to adjust capitation payments made to Medicare Advantage (MA) and Medicare PACE plans, with the intention of paying health plans appropriately for their expected relative costs. CMS-HCC risk scores measure a person's or a population's health status

[3] Hospice rates were established in 1983 and have been updated since based on inflation and geography. Hospice rates are paid daily for the entire time a patient is enrolled in hospice, regardless of service usage during that period.

relative to the average, as applied to expected medical expenditures. A population with a risk score of 2.0 is expected to incur medical expenditures twice that of the average. It is important to note that the model is accurate at the group level and that actual expenditures for any individual can be higher or lower (sometimes significantly) than those predicted.

The models are prospective, using demographic and diagnosis information from a base year to estimate expenditures in the next year. For example, risk scores for 2012 are based on information from 2011.The demographic characteristics used are age, sex, Medicaid status, and original reason for Medicare entitlement. The diagnosis information used is the set of ICD-9 diagnosis codes reported on Medicare claims in the base year. The models specify that only Hospital Inpatient, Hospital Outpatient, Physician, and some non-Physician claims be used. The source of a particular diagnosis code has no relevance (i.e., diagnoses from an Inpatient hospitalization have equal weight as those from a Physician visit), nor does the frequency with which the diagnosis code has been reported.

For more information on the CMS-HCC risk model, see the following web page: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors-Items/Evaluation2011.html?DLPage=1&DLEntries=10&DLFilter=hcc&DLSort=0&DLSortDir=descending

Both models produce a community, institutional, and new enrollee score for each beneficiary, however we will only assign the community score. We will not use the institutional scores because IAH applicable beneficiaries are not institutionalized, by definition. We will not use the new enrollee score, even if a beneficiary is a new Medicare enrollee, because IAH beneficiaries are significantly different than general Medicare new enrollees and we believe the new enrollee scores would significantly underestimate their risk. See Section 3.3.5 below for the method we will use to assign risk scores to new enrollees and others who did not have a full year of Part A and B enrollment in the year on which the risk score is based.

The sections that follow describe how we will assign and use the CMS-HCC risk scores and the ESRD risk scores and the adjustments we will make to all risk scores.

3.3.1 Scores from the CMS-HCC Model

Beneficiaries with a Medicare status of Aged or Disabled in any eligible month of enrollment will receive a risk score produced by the CMS-HCC risk model. These beneficiaries will also receive the Aged-Disabled composite average FFS county cost for the same month. The CMS-HCC risk score will be multiplied by the county cost that has been assigned. Note that, all else being equal, the CMS-HCC model will produce the same risk score for an aged or disabled beneficiary; this is why we use the Aged-Disabled composite Average FFS county costs.

3.3.2 Scores from the CMS ESRD Model

Beneficiaries with ESRD will receive a risk score produced by the CMS ESRD model. The model produces four types of risk score:

- Dialysis,
- Transplant Months 1-3 (for aged and non-aged),

- Transplant Months 4-9 (for aged and non-aged), and
- Transplant Months 10+ (for aged and non-aged).

For each of these cells the model also produces an institutional and new enrollee score, however we will not use these scores for the same reasons as above. We will use dialysis and transplant information from the Medicare EDB to determine which ESRD risk score to apply in each month of eligibility, and to determine whether to assign the aged or non-aged score.

Scores from the ESRD model have been calibrated to be multiplied by two different "base costs." One would expect that the risk score for a beneficiary on dialysis would be quite high; however the dialysis score will generally be much lower than the CMS-HCC score run for the same person. This is because the dialysis scores have been developed to have a much higher "base cost" than the HCC scores. As such, dialysis scores and Transplant Month 1-3 scores will be multiplied by the average cost for beneficiaries on dialysis in each state. Transplant Month 4-9 and Transplant Month 10+ scores will be multiplied by the Aged-Disabled composite Average FFS County Cost, consistent with how these post-graft scores have been modeled.

3.3.3 Frailty Adjustment

The CMS-HCC model under predicts expenses for the non-institutionalized frail elderly. So that PACE plans, which focus on a frail population, would not be underpaid, CMS developed a frailty adjustment to more accurately pay plans treating such a population. Frailty is measured by functional status and depends upon the number of ADL limitations that a beneficiary has as well as the beneficiary's Medicaid status. The ADLs are bathing, eating, dressing, toileting, transferring, and walking. Frailty adjustments are applied for 0, 1-2, 3-4, and 5-6 ADL limitations. For PACE, ADL limitations are collected by self- or proxy-reported responses to the Health Outcomes Survey-Modified. In IAH ADL limitations are reported by the participating practices.

Because the IAH population is also a frail population and is one that is required to need human assistance with at least two ADLs, we will apply a frailty adjustment to each non-ESRD beneficiary's risk score, using the frailty adjustment factors that have been developed by CMS.[4] These factors are developed using CMS' frailty model, and they are updated whenever the CMS-HCC model is updated. We will use the frailty factors published in the 2013 Call Letter, which are those associated with the model version we are using. CMS publishes the frailty adjustment factors each year in the Final Call Letter to Medicare Advantage and Part D plans announcing the rates and payment policies for the upcoming year. The values we will use are as follows:

Number of ADLs	Non-Medicaid	Medicaid
1-2	0.151	0.000
3-4	0.276	0.147
5-6	0.276	0.380

[4] We will not apply frailty factors to risk scores produced by the CMS ESRD model. The frailty factors are developed using the CMS-HCC model and are not consistent with risk scores produced by the CMS ESRD model.

The frailty adjustment is additive, rather than multiplicative, in that the frailty adjustment factor is added to the CMS-HCC risk score. We will use the same frailty adjustment factors each year, unless we change the model version used to produce CMS-HCC scores for new IAH enrollees; in that case we will update the frailty adjustment factors. The frailty adjustment for each IAH beneficiary will not be updated once it has been initially determined.

Practices must report the ADLs with which each enrolled beneficiary requires human assistance. For potentially eligible beneficiaries, we will assign the minimum number of ADLs (two) required for demonstration eligibility. Recall that we only include potentially eligible patients who the practice has said they have already enrolled or intend to enroll, which suggests that the practice agrees that the patient is eligible for the demonstration and has the minimum required numbers of ADL limitations and chronic conditions.

3.3.4 Normalization

The CMS-HCC and CMS ESRD models are calibrated with each new version to produce an average risk score of 1.0 for the calibration year. When the models are used on years other than the calibration year, predictions for prior years are lower and predictions for subsequent years are higher, due to natural changes in coding and population that occur over time. To account for this, risk scores must be normalized back to 1.0 when using the risk model with years other than the calibration year. The calibration year for the v2113.87 CMS-HCC model is 2011 and for the ESRD model is 2009. The diagnoses we will run through the models for performance year 1 will have occurred between June 2011 and August 2013 (depending on the beneficiary's enrollment date) so we will apply normalization factors appropriate for each of the twelve possible enrollment dates in the performance year. The following normalization factors were published in the 2013 Advance Notice:

Aged/Disabled (CMS-HCC):	1.028 (1.014 annualized)
Dialysis:	1.023 (1.006 annualized)
Post-Transplant:	1.070 (1.017 annualized)

We will use the same normalization factors for each performance year unless we update model versions, at which point we would also update the normalization factors. Normalization factors will be applied from the midpoint of the model's calibration year to the midpoint of each beneficiary's diagnosis year. The number of months of normalization to apply will vary depending upon the beneficiary's enrollment date and the type of risk score. For an Aged or Disabled beneficiary enrolling on June 1, 2012 we will apply 5 months of normalization (1.014 ^ (5/12)). For a beneficiary on dialysis enrolled on May 1, 2013 we will apply 43 months of normalization. To apply normalization, we divide the risk score produced by the risk model by the normalization factor.

3.3.5 "New Enrollee" Scores

The CMS risk models are designed to use for beneficiaries with twelve months of FFS eligibility in the base year, in order that a full year of diagnoses be used in the determination of the risk score. Beneficiaries who are new to Medicare or who were enrolled in an MA plan for part of the year prior to enrollment do not meet this criterion. When determining risk scores for such enrollees in the general

Medicare population, CMS applies the new enrollee risk score produced by the model. However, these new enrollee scores are based on experience in the general Medicare population, which is on average significantly healthier than the IAH population. As such, the new enrollee scores produced by the CMS risk model are not appropriate for the IAH population and a different method must be used.

IAH beneficiaries who do not have twelve months of FFS eligibility in the year prior to enrollment (both Part A and Part B, not enrolled in MA or PACE, no Medicare secondary payer) will be assigned the higher of the following two scores:

- The risk score produced by the model when the beneficiary's partial-year experience is used
- The average risk score for the practice for Aged/Disabled risk scores. For ESRD Dialysis and transplant scores we will assign the average for the entire demonstration due to the low prevalence at the practice level.

This comparison will be made prior to frailty adjustment; beneficiaries will receive frailty adjustment based on the ADL counts reported by the practice.

3.4 Determining the Practice/Consortium Spending Target

As described in the sections above, we will assign a trended average FFS county cost and a risk score for each month that an applicable beneficiary is enrolled in the demonstration. To calculate the spending target for each practice/consortium we will take the following steps:

1. Calculate a spending target for each beneficiary month as the product of the average FFS county cost, trend, and risk score for that month.

2. Calculate a spending target for each beneficiary as the average of that beneficiary's monthly spending targets during the performance year, weighted by the beneficiary's months of eligibility in each month.

3. Calculate the spending target for the practice/consortium as the average of the beneficiary-level spending targets, weighted by each beneficiary's eligible months during the performance year.

It is important to note that this calculation will not produce the same spending target as if the multiplication were implemented at the practice level (practice average FFS county cost multiplied by trend and practice average risk score).

Section 4: Determining Shared Savings Incentive Payments

There will be several steps in determining whether or not a practice/consortium will share in any savings. First, the actual expenditures must be compared with the spending target. Then it must be determined whether the practice/consortium meets the minimum savings requirement (MSR) for its size. Finally, quality performance must be evaluated to determine any final payment amounts.

4.1 Expense Comparison

We will compare actual expenditures to the spending target on a PBPM basis. The actual-to-expected ratio will be PBPM actual expenditures divided by the PBPM spending target. Ratios below 1.0 indicate possible savings. We will calculate the savings percentage as one minus the savings ratio.

4.2 Minimum Savings Requirement

Per the IAH legislation, each participating practice must meet an MSR to be eligible to share in savings. The use of an MSR is to ensure that differences between the target and actual spending represent actual savings rather than differences owing to normal variation in Medicare spending. The size of the MSR is inversely related to the size of the IAH practice (i.e., as practice size increases the MSR decreases). If the savings percentage (as calculated above) is greater than the MSR, then we are confident that the difference between the spending target and actual expenditures represents actual savings. Note that CMS will retain the first five percent saved, consistent with statute.

Practices that meet the MSR at the five percent significance level will receive a maximum of 80 percent of any savings beyond the first five percent retained by CMS. Practices that meet the MSR at the ten percent significance level will receive a maximum of 50 percent of any savings beyond the first five percent retained by CMS.

The MSRs will be determined by a claims analysis using a comparison group of beneficiaries that has been determined by a Medicare data analysis to meet the eligibility criteria for the IAH demonstration, but is not receiving primary care in the home. The comparison beneficiaries will be defined by the evaluation contractor each year and will also be propensity score matched to the group of beneficiaries enrolled in the demonstration. Because the evaluation analysis will be completed after the shared savings analysis each year , the performance year 1 comparison group used for MSR calculation will be that defined by the evaluator for the year prior to the demonstration. The performance year 2 comparison group used for MSR calculation will be that defined by the evaluator for the first year of the demonstration and the performance year 3 comparison group used for MSR calculation will be that defined for the second year of the demonstration. For more information on the comparison group see the evaluation contractor's first annual report.

The MSRs are a function of practice size and the spending targets and actual expenditures of the comparison group beneficiaries. To determine the MSRs, we will calculate actual expenditures and a spending target for each comparison beneficiary using the same methods as described in Section 2 and Section 3. For each IAH practice/consortium, we will simulate 1,000 virtual "practices" equal in size to the number of applicable beneficiaries in the practice by randomly drawing from the full comparison

group.[5] We will calculate a savings percentage for each group. The MSRs for each practice size will be equal to the 90th and 95th percentiles of the saving percentage for all groups in each set of simulations. At these levels, we can be 90% and 95% confident that savings have not occurred due to pure variation. We assume, under non-demonstration circumstances, that the spending targets and actual expenditures will be equal and any differences that appear between these amounts are due to random variation. Should there be small differences between the spending targets and actual expenditures, we will apply an adjustment before determining the MSRs such that the average ratio of spending target to actual expenditures over all simulated practices is 1.0.

4.3 Quality Performance

Practices must meet quality performance thresholds to be eligible for shared savings incentive payments. To qualify for incentive payments, each practice must meet or exceed performance requirements on at least three of the six quality measures that are tied to payment. Practices that meet fewer than three of the quality measures will not be eligible for incentive payments. The quality measures tied to payment and their minimum performance thresholds shown in Table 1. Table 2 shows the percentages of incentive payments a practice will receive if it meets or exceeds the performance requirements of the specified quality measures.

Table 1: Quality Measures Tied to Payment and their Thresholds

Quality Measure	Threshold Value
Number of inpatient admissions for ambulatory-care sensitive conditions	Threshold equal to or less than the average utilization in an unmanaged, clinically similar population with case mix and geographic adjustments
Number of readmissions within 30 days	
Number of ED visits for ambulatory-care sensitive conditions	
Contact with beneficiaries within 48 hours upon admission to the hospital, and discharge from the hospital and/or ED	80% of the time
Medication reconciliation in the home	80% of the time
Patient preferences documented in medical record	80% of the time

[5] Although each IAH practice has its own comparison group, the comparison groups are not always large enough from which to draw a large number of random practices that do not significantly overlap. As such, we draw from the comparison group as a whole.

Table 2: Percentage of Shared Savings Earned Based on Quality

Number of Quality Measures Met (of those tied to payment)	Percentage Received of Savings that Qualify for Sharing
< 3	0%
3	50%
4	66 $^{2}/_{3}$%
5	83 $^{1}/_{3}$%
6	100%

4.4 Determination of Final Shared Savings Incentive Payment

Practices with fewer than 200 applicable beneficiaries in the performance year or for which we calculate a negative savings ratio do not qualify for any shared savings incentive payment. Practices with at least 200 applicable beneficiaries in the performance year and a positive savings ratio are eligible to receive shared savings incentive payments if they meet the MSR at either the 5% or 10% significance level. Only savings after the first five percent saved will be shared between the practice and CMS. Finally, eligible practices will be paid based on the proportion of quality measures met that are tied to payment. A few examples follow, assuming the simulated MSRs in Table 3 below.

Table 3: Example Minimum Savings Requirements

	Minimum Savings Requirement	
Practice Size	5% significance level (if met, 80% shared)	10% significance level (if met, 50% shared)
200	14.1%	11.4%
400	8.0%	6.0%
500	9.3%	7.5%
800	7.4%	5.7%
1000	6.4%	5.0%
2000	4.4%	3.5%

Example 1

Practice A, with 400 applicable beneficiaries and 4,000 eligible months during the performance year, achieves a savings percentage of 12% based on a spending target of $3,409 and actual expenditures of $3,000 PBPM. Practice A meets the MSR at the 5% significance level for a practice of this size (8%) and qualifies to share in 80% of any savings after the first 5%. CMS will retain the first 5% saved ($170.45 PBPM, $681,800 in total). The remaining 7% ($238.63 PBPM, $954,520 in total) may be shared between CMS and the practice.

Quality Measures Met	Amount Available to Share after CMS retains the first 5% saved	Percentage Paid Based on Quality	Amount Earned after Quality
<3	80% * $954,520 = $763,616 (CMS keeps 20% * $954,520 = $190,904)	0%	$0
3		50%	$381,808
4		66 $^{2}/_{3}$%	$509,077
5		83 $^{1}/_{3}$%	$636,347
6		100%	$763,616

Practice A met four of the six measures, to receive a payment of $509,077. There was a total of $1,636,320 saved. CMS retains $1,127,243 (69%) and the practice receives $509,077 (31%).

Example 2

Practice B, also with 400 applicable beneficiaries and 4,000 eligible months during the performance year, achieves a savings percentage of 7% based on a spending target of $2,688 and actual expenditures of $2,500 PBPM. This savings percentage is less that the 8% MSR at the 5% significance level but is greater than the 6% MSR at the 10% significance level. Practice B qualifies to share in 50% of any savings after the first 5%. CMS will retain $537,600 (5% * $3,400 * 4,000). The remaining 2% (or $215,040) may be shared between CMS and the practice. The amount available to share is 50% of $215,040, or $107,520. Practice B meets all six of the quality measures tied to payment and receives the full amount of $107,520. CMS retains a total of $847,000.

Example 3

Practice C, with 2,000 applicable beneficiaries, achieves a savings percentage of 5%, meeting the MSR at the 5% significance level. CMS will retain all savings because there were no savings above the first 5%.

Example 4

Practice D, with 500 applicable beneficiaries, achieves a savings percentage of 5%. This does not meet the MSR to qualify for an incentive payment at either the 5% significance level or the 10% significance level for a practice of this size and, therefore, the practice does not qualify for any incentive payment.

Appendix A: Hospitalization, Post-Acute Care, and Home Visit Specifications

Qualifying Hospitalization

In the 12 months prior to the enrollment date the beneficiary must have had a Medicare-covered hospitalization (one that can be found in the final action claims). A qualifying hospitalization is:

1. An Inpatient claim where the last 4 digits of the provider number are in one of the following ranges:
    a. 0001-0899 (acute care hospitals)
    b. 1300-1399 (critical access hospitals)
    c. 4000-4499 (psychiatric hospitals)
    d. S*** (psych unit of an acute care hospital)
    e. M*** (psych unit of a critical access hospital) OR
2. An Outpatient claim with any revenue center code of 0760 (general classification category) or 0762 (observation room) AND any procedure code of G0378 (hospital observation service, per hour) or G0379 (direct admission of patient for hospital observation care). These are observation stays.

The discharge date on the inpatient claim or the thru date on the outpatient claim must be within the twelve month period prior to enrollment. The date of the qualifying hospitalization is the earliest of:

- The discharge date on the earliest qualifying INP claim;
- The thru date on the earliest qualifying outpatient claim.

Qualifying Post-Acute Care Use

In the 12 months prior to the enrollment date the beneficiary must have had a post-acute care visit. Qualifying post-acute care is:

1. An Inpatient claim with the following provider codes (last 4 digits):
    a. 3025-3099 (inpatient rehab) OR
    b. 2000-2299 (long term care acute)
    c. T*** (rehab unit of an acute care hospital)
    d. R*** (rehab unit of a critical access hospital)
2. Any Home Health Agency claim
3. Any Skilled Nursing Facility claim

The discharge date on a SNF or Inpatient claim must be within the twelve month period prior to enrollment. Either the from date OR thru date on a HHA claim must be within the twelve month period prior to enrollment. The date of the qualifying post-acute care service is the earliest of:

- The discharge date on the earliest SNF claim;
- The discharge date on the earliest qualifying Inpatient claim;

- The “from date” or “thru date” on the earliest HHA claim, whichever falls within the 12 month period prior to enrollment.

Home Visit

A home visit is any Physician claim with a Place of Service Code in (12, 13, 14, 33, 32) AND a procedure code in (99341-99345, 99347-99350, 99324-99328, 99334-99340).

Appendix B: Identification of Potentially Eligible Patients

Below are the steps we take in identifying potentially eligible IAH patients and assigning them enrollment dates. The methodology assumes the use of IAH provider Tax Identification Numbers (TINs), National Provider Identification Numbers (NPIs), and Medicare claims and EDB data.

1. Generate a list of beneficiaries who had at least one home visit to any participating IAH provider (TIN-NPI combination) in the applicable look back period (see next paragraph). A home visit is any Physician claim with a Place of Service Code in (12, 13, 14, 33, 32) AND a procedure code in (99341-99345, 99347-99350, 99324-99328, 99334-99340).

   For potentially applicable beneficiaries who would begin enrollment between June 1, 2012 and May 31, 2013 (Year 1 for June 1 IAH practices), the look back period begins June 1, 2011 and ends April 30, 2013. For potentially applicable beneficiaries who would begin enrollment between September 1, 2012 and August 31, 2013 (Year 1 for September 1 IAH practices), the look back period begins September 1, 2011 and ends July 31, 2013.[6]

   Keep track of the FIRST home visit found, to use later in setting the enrollment date.

2. Remove any beneficiaries that practices have already enrolled in the program (or enrolled and subsequently disenrolled).

3. For the remaining beneficiaries, pull Inpatient, Outpatient, and Home Health claims for the applicable look back period. Determine if each beneficiary had both a qualifying hospitalization and a qualifying post-acute care event, as defined in Appendix A, in any twelve-month period inside the look back period.

4. Generate potential enrollment dates based on whether both a hospitalization and post-acute care use were found in the same twelve month period prior to each potential enrollment date. The enrollment date is set to be the first of the month after the beneficiary's eligibility date. The eligibility date is defined as the date on which the beneficiary:
   a. Has been discharged from a hospitalization in the preceding 12 months,
   b. Has been discharged from PAC in the preceding 12 months OR has received home health services in the preceding 12 months[7], and
   c. Is no longer in a facility where the facility stay relates to either the qualifying hospitalization or PAC. Beneficiaries are considered "in the community" once they have been out of a facility for three days, (including the day of discharge and excluding the day of any readmission). If both qualifying events have occurred, yet there continue to be hospital

[6] The look back period for a given year ends one month before the last possible enrollment date for that year. This is because enrollment in the demonstration begins on the first of the month AFTER the qualifying events have occurred.
[7] A beneficiary may be enrolled even if home health services are continuing.

readmissions or continuing post-acute care facility stays, the beneficiary's enrollment date is postponed until they have been in the community for three days.

NOTE: Once a beneficiary has met the qualifying criteria and is back in the community for at least 3 days, the enrollment date is set to the first day of the next month, even if the beneficiary is admitted to the hospital before that enrollment begins.

5. Check each potential date of enrollment for other program eligibility requirements. On the enrollment date, the beneficiary must:
    a. Be alive
    b. Not be in an MA or PACE plan
    c. Have part A
    d. Have part B
    e. Have Medicare as primary payer (note that the only primary payer codes used to exclude beneficiaries are A and G, working aged and working disabled)
    d. Not be on hospice
    e. Have had a prior home visit with the IAH practice (carried from step 1).

6. If left with multiple potential enrollment dates, assign the earliest enrollment date.

Special Cases

1. Beneficiary has a hospital or rehab stay in the middle of a home health claim.
    a. The home health claim (if it is the first PAC use in the look back period) counts as the qualifying PAC. The hospital discharge date, provided it is followed by three days in the community, is treated as the second qualifying event and the enrollment date is set to the first of the month after the hospital discharge date.

2. Beneficiary has a series of SNF claims that would count as the qualifying PAC, but none of the SNF claims ever shows a discharge date (in this case we assume the person continued the SNF stay but has exhausted the Medicare SNF benefit).
    a. If the beneficiary has a subsequent hospitalization or institutional PAC event, we set the discharge date of the open-ended SNF stay to the admission date of the subsequent event. The enrollment date is then set to the first of the month after the discharge date of the subsequent event.
    b. If no subsequent institutional admission dates exist, then the person is considered NOT in the community and is not counted as eligible.

3. The HHA "from date" occurs before the beginning of the 12 month look back period AND the "thru date" falls between the admission and discharge dates of a chain of consecutive stays or after the admission date of an open ended SNF claim (a claim with no final discharge date).

a. The first day of the look back period is treated as the HHA from date so as not to “miss” the HHA episode as a qualifying event (since it would have been identified by the thru date being inside the look back period).

Appendix C: List of Practice Reconciliation Responses – Potentially Eligible Beneficiaries

The practices are provided a drop-down list of the responses below from which to select a reason that each potentially eligible patient was not enrolled or indicate that the patient will be enrolled. The options are:

- **Patient is enrolled**—This option should be selected for patients who are included on the Potentially Eligible tab and have been enrolled in the Demonstration. This includes patients who were enrolled between the end of this reporting period and now, even if they have since been disenrolled.
- **Patient will be enrolled after they are notified that their physician is participating in the Demonstration**—This should be selected for patients the practice intends to enroll as soon as the patient is notified of the Demonstration. This includes patients who are currently eligible, and were not eligible as of the date given in the workbook.
- **Patient did not agree to participate**—Patients who declined to participate when they were notified of the Demonstration. Their medical record must show that the practitioner had a conversation with the patient regarding the Demonstration and the patient declined.
- **Patient does not have two chronic conditions**—Patients who do not have two chronic conditions at the time of enrollment are not eligible for the Demonstration.
- **Patient does not have two functional dependencies**—Patients who do not have two functional dependencies requiring human assistance at the time of enrollment are not eligible for the Demonstration.
- **Patient does not have two functional dependencies AND does not have two chronic conditions**—Patients who do not have two functional dependencies requiring human assistance and who also do not have at least two chronic conditions at the time of enrollment are not eligible for the Demonstration
- **Patient began receiving hospice care prior to receiving notification letter**—Patients who begin receiving hospice care before being enrolled in the Demonstration are not eligible.
- **Patient permanently moved into a nursing home prior to receiving notification letter**—Patients who moved into a nursing home before being enrolled in the Demonstration are not eligible.
- **Patient is not currently part of our in-home practice**—All patients who have an in-home place of service code for a claim associated with an IAH practice and meet the eligibility criteria for the analysis are included in the list of potentially eligible patients. If a patient is included in this tab, but not a part of your practice (examples: transitional care or your practice only made a few in-home visits, but you are not their primary care provider; patient moved out of your service area; patient does not usually receive care in the home), you should select this option.
- **Patient died prior to receiving notification letter or before their enrollment date**—Patients who died prior to being enrolled in the Demonstration are not eligible because they cannot be notified of the Demonstration.

Appendix D: List of Practice Reconciliation Responses – Enrolled Beneficiaries

The practices are provided a drop-down list of the responses below from which to select to indicate whether the claims-based enrollment date is correct or incorrect, if different from the reporting system enrollment date, and the reason why.

- **Patient's claims-based enrollment date is correct**—This option should be selected when the Reporting System Enrollment Date is incorrect and the Claims-Based Enrollment Date should be used.
- **Patient did not have two chronic conditions as of claims-based enrollment date**—Patients who did not have two chronic conditions at the time of the Claims-Based Enrollment Date, but later developed two chronic conditions, should be enrolled as of the Reporting System Enrollment Date.*
- **Patient did not have two functional dependencies as of claims-based enrollment date**—Patients who did not have two functional dependencies requiring human assistance at the time of the Claims-Based Enrollment Date, but later developed two functional dependencies requiring human assistance, should be enrolled as of the Reporting System Enrollment Date.*
- **Patient did not have two functional dependencies AND did not have two chronic conditions as of claims-based enrollment date**—Patients who did not have two functional dependencies requiring human assistance and who also did not have at least two chronic conditions at the time of the Claims-Based Enrollment Date, but later developed both, should be enrolled as of the Reporting System Enrollment Date.*
- **Patient was not part of our in-home practice as of claims-based enrollment date—**Patients who meet all of the eligibility requirements, but joined your practice after their Claims-Based Enrollment Date, should be enrolled as of their first visit with your in-home practice.

*Note that patients who are ineligible on the reporting system date will not be included in the population on which shared savings will be calculated.