

# Next Generation ACO Model



**Review of Alignment /  
Benchmarking  
Methodology**

*April 5, 2016*

*For Discussion Purposes  
Only: Actual methodology is  
specified in methodology  
paper*

# Agenda

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# Agenda, continued

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- **Payment Mechanisms**
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# Overview of cross-sectional approach (1/2)

In each performance year (PY1, PY2, and PY3):

- Alignment is run twice (once for the performance year, once for baseline year), using the provider list for that performance year

- Alignment period
- Baseline expenditures
- Performance-year expenditures

**Performance Year 1, using PY1 provider list**

Panel	2011	2012	2013	2014	2015	2016	2017	2018
PY-aligned								
BY-aligned								

**Performance Year 2, using PY2 provider list**

Panel	2011	2012	2013	2014	2015	2016	2017	2018
PY-aligned								
BY-aligned								

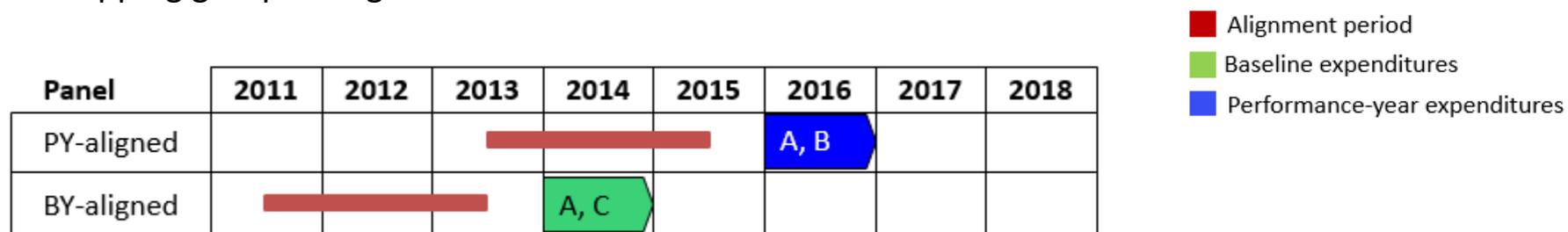
**Performance Year 3, using PY3 provider list**

Panel	2011	2012	2013	2014	2015	2016	2017	2018
PY-aligned								
BY-aligned								

In a given performance year, each panel contains a different but overlapping group of aligned beneficiaries

# Overview of cross-sectional approach (2/2)

How can a beneficiary be aligned to the ACO for the baseline but not the performance year, or vice versa? Put another way, what does it mean to say that each panel contains a different but overlapping group of aligned beneficiaries?



## Example beneficiaries (Performance Year 1)

- **Beneficiary A** – Aligned during baseline year and performance year
- **Beneficiary B** – Not aligned during baseline year but aligned during performance year
- **Beneficiary C** – Aligned during baseline year but not performance year
- This schematic does not represent a prediction of the prevalence of turnover between panels
- Reasons for beneficiary B and C not being aligned in both baseline and performance year could include change in utilization patterns (receiving more or less primary care services from ACO providers between the two alignment periods), exclusion due to lack of alignment eligibility for either the baseline or performance year (e.g., moved in or out of Medicare Advantage, geographic exclusions because of change in residence, etc.)

# Overview of claims-based alignment

## 2-stage alignment algorithm

- **Alignment based on primary care services provided by primary care specialists** if 10% or more of the allowable charges incurred on QEM (qualified evaluation & management) services received by a beneficiary during the 2-year alignment period are obtained from physicians and practitioners with a primary care specialty
- **Alignment based on primary care services provided by selected non-primary care specialties** if less than 10% of the QEM services received by a beneficiary during the 2-year alignment period are provided by primary care providers

Vast majority of beneficiaries fall under this first category

## Determination of NGACO / practice to which beneficiary is aligned (by plurality)

For a hypothetical beneficiary...

- 10%+ of allowable QEM charges for primary care services provided by primary care specialists (thus, alignment will be based on QEM from primary care specialists)
- Use allowable QEM charges for primary care services provided by primary care specialists, weighted by alignment year (most recent year gets 2/3 weight, later year gets 1/3 weight) – figures shown below → **plurality (although not majority) of charges for ACO providers, so aligned to ACO X**

ACO X - \$800  
(across all primary care specialists in ACO X)

TIN A - \$400  
(across all primary care specialists in TIN A not in ACO)

TIN B - \$300  
(across all primary care specialists in TIN B not in ACO)

ACO Y - \$200  
(across all primary care specialists in ACO Y)

# Alignment eligibility exclusions – What are they and when do they occur?

## A.2.1 Alignment-eligible beneficiary

- A beneficiary is alignment-eligible for a base- or performance-year if:
  1. *During the related 2-year alignment period*, the beneficiary had at least one paid claim for a QEM service; and,
  2. *During the base- or performance-year*, the beneficiary:
    - a. Has at least one month of coverage under Part A;
    - b. Has no months of coverage under only Part A;
    - c. Has no months of coverage under only Part B;
    - d. Has no months of coverage under a Medicare Advantage or other Medicare managed care plan;
    - e. Has no months in which Medicare was the secondary payer;
    - f. Was a resident of the United States;

A beneficiary may be alignment-eligible in a base-year but not a performance-year and may be alignment-eligible in a performance-year but not a base-year.

## A.3 Quarterly exclusion of beneficiaries during the performance-year

Alignment-eligibility requirements 2.a through 2.f (see section A.2.1) will be applied to the performance year as part of the quarterly exclusion process. Exclusions will be performed at six points during the year:

1. In January of the performance year, PY-aligned beneficiaries who became ineligible for alignment because they died prior to the start of the performance year will be excluded.
2. In April of the performance year PY-aligned beneficiaries who enrolled in Medicare Advantage plans will be excluded.
3. In July of the performance year, PY-aligned beneficiaries who became ineligible for alignment during the first quarter of the performance-year will be excluded.
4. In October of the performance year, PY-aligned beneficiaries who became ineligible for alignment during the 2<sup>nd</sup> quarter of the performance-year will be excluded.
5. In the January following the end of the performance year, PY-aligned beneficiaries who became ineligible for alignment during the 3<sup>rd</sup> quarter of the performance-year will be excluded.
6. Prior to the preliminary financial settlement in the April following the end of the performance year, PY-aligned beneficiaries who became ineligible for alignment during the 4<sup>th</sup> quarter of the performance-year will be excluded along with beneficiaries not meeting the alignment requirements related to the service area of the NGACO.

A beneficiary who is determined to be not alignment-eligible in one quarter will be continue to be considered ineligible even if subsequent updates to eligibility data indicate that the beneficiary was eligible in a subsequent quarter. Once a beneficiary is excluded, the beneficiary is removed from all financial calculations for that year. All alignment-eligible beneficiaries except those who die during the performance year will, therefore, contribute 12 months of experience to the performance-year expenditure.

# Entitlement categories

**Each month** of beneficiary experience assigned to one of two entitlement categories

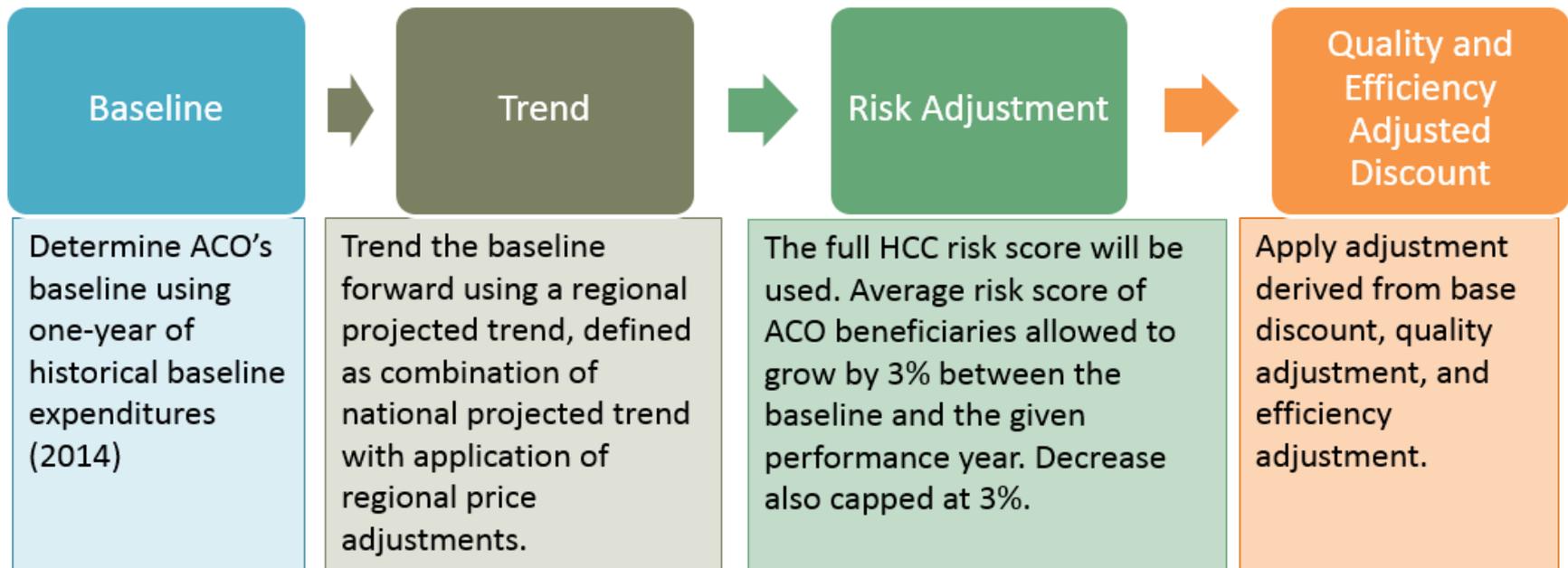
- **Aged and Disabled (A/D) aligned beneficiaries** (aligned beneficiaries eligible for Medicare by age or disability) who do not have End Stage Renal Disease (ESRD).
- **End stage renal disease (ESRD) aligned beneficiaries** (aligned beneficiaries eligible for Medicare by ESRD). (ESRD status in a month is determined based on Medicare enrollment/eligibility files not dialysis claims. A beneficiary's experience accrues to the ESRD entitlement category if, during a month, the beneficiary was receiving maintenance dialysis for kidney failure or was in the 3-month period starting in the month when a kidney transplant was performed.)

Because experience is assigned month-by-month, one beneficiary can contribute some month(s) to one entitlement category and other month(s) to the other category

All elements of benchmark (except for quality adjustment to the standard discount) will be calculated separately for the two entitlement categories

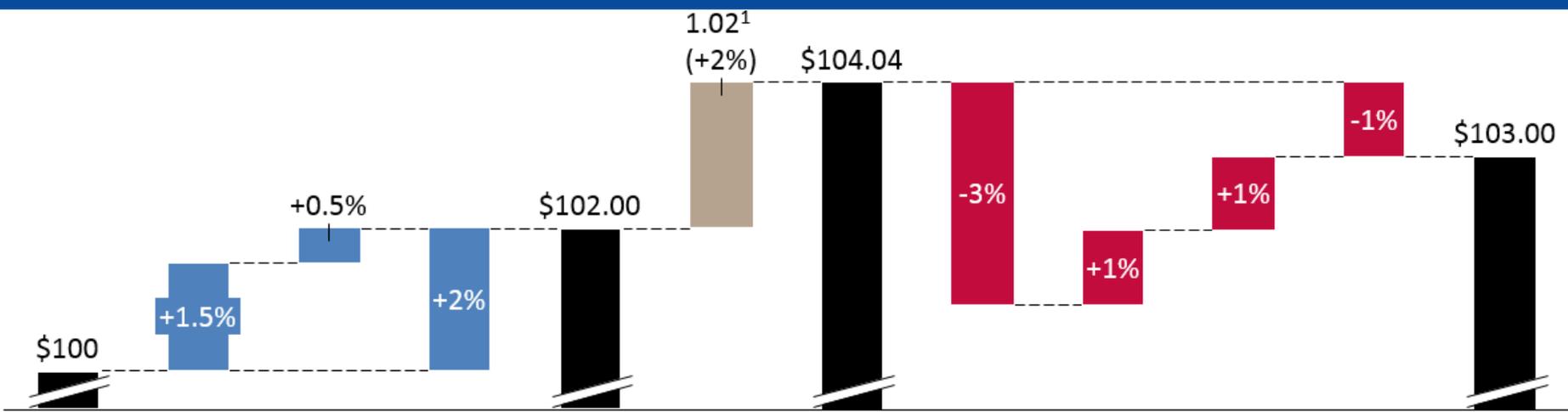
# Overview of benchmark

The benchmark will be **prospectively set prior to the performance year** using the following four steps<sup>1</sup>:



<sup>1</sup> Benchmark will be prospectively set with retrospective adjustments based on final risk adjustment and quality score information

# Building from baseline to benchmark (graph)



<u>Baseline expenditure:</u>	<u>National projected trend:</u>	<u>Regional price adjustment:</u>	<u>Total trend adjustment</u>	<u>Baseline, trended</u>	<u>Risk adjustment:</u>	<u>Baseline, trended and risk adjusted</u>	<u>Base discount</u>	<u>Quality bonus</u>	<u>Efficiency adjustment</u>	<u>Overall Quality and Efficiency Adjustment</u>	<u>Benchmark</u>
Run alignment in baseline year (2014) to determine ACO's historic expenditures	Projected trend from baseline year to performance year	Change in regional price factors (e.g., AWI / GPCIs) relative to the nation			Ratio of performance year to baseline year average risk score		(always 3%)	(always +1% in PY1)	(regional and national components, range of -1.5% to +1.5%)		
<p><b>Trend</b> – set prospectively (i.e. does not change during/after course of performance year)<sup>2</sup></p>				<p><b>Risk adjustment</b> – not set prospectively (i.e. ratio not final until final risk scores known, after performance year)<sup>3</sup></p>		<p><b>Quality and Efficiency Adjusted Discount</b> – efficiency adjustments set prospectively, quality adjustments set mid-year<sup>4</sup></p>					

1 In this example, 1.02 (equivalent to a +2% adjustment) is the ratio of the average re-normalized performance year risk score to the average re-normalized baseline year risk score (for instance, 1.0302 / 1.0100 = 1.02)

2 Exception to not changing during/after course of performance year in cases of unexpected utilization / price changes with a very large impact on ACO expenditures

3 CMS exploring options for providing interim information prior to the final risk scores being available

4 In Performance Year 2 (2017), for example, adjustment based on Performance Year 1 scores, which are not available until mid-2017.

# Building from baseline to benchmark (illustrative example / table)

## Calculation of prospective benchmark for Aged/Disabled beneficiaries

	Baseline (CY2014)	Benchmark
<b>ACO baseline (CY2014) expenditure:</b>	<b>\$876.54</b>	\$876.54
<b>Projected PY1/CY2015 regional trend adjustment:</b>		<b>\$30.36</b>
Projected PY1/CY2015 regional trend:	3.46%	
Projected PY1/CY2015 national trend:	3.00%	
CY2015 GAF trend adjustment	0.45%	
<b>Risk adjustment to the baseline</b>		<b>\$0.00</b>
<b>Trended baseline</b>		<b>\$906.90</b>
<b>Standard discount</b>	-3.00%	<b>-3.00%</b>
<b>National baseline efficiency adjustment to the standard discount</b>	0.04%	0.04%
National efficiency ratio	0.993	
<b>Regional baseline efficiency adjustment to the standard discount</b>	0.13%	0.13%
Regional efficiency ratio	0.987	
<b>Quality benchmark adjustment</b>		1.00%
<b>Quality- and efficiency-adjusted discount</b>		<b>-1.84%</b>
<b>Benchmark</b>		<b>\$890.25</b>

# Baseline

- Next Generation ACO (NGACO) model uses a **one-year baseline** (2014)
- **Pioneer ACO model and Shared Savings Program** use a three-year baseline, trending the first two baseline year expenditures to the third baseline year<sup>1</sup>
- NGACO one-year baseline **significantly reduces complexity** of savings / loss calculation by eliminating multi-year baseline trending

<sup>1</sup> In these models/programs, Baseline Year 1 and Baseline Year 2 are trended to Baseline Year 3 by factors accounting for the change in state expenditures, risk scores, and (for the Pioneer ACO model in Performance Years 4 and 5) regional price adjustments (the Pioneer model sometimes refers to the later as “locality price adjustments”)

# Projected Regional Trend

- **A projected regional trend will be calculated for each entitlement category (Aged/Disabled and ESRD).** It will be the product of:
  - A national projected FFS trend (expenditure percentage growth rate) for the entitlement category similar to that currently used by the Medicare Office of the Actuary (OACT) in its calculation of the Medicare Advantage (MA) county ratebook; and,
  - A regional geographic adjustment factor (GAF) trend-adjustment that accounts for the impact of the performance-year Medicare geographic price factors on baseline expenditure (does not account for regional/local changes in utilization)
- **Trend defined as difference between two points of time:** baseline and performance year
  - In PY1: Difference between 2014 and 2016
  - In PY2: Difference between 2014 and 2017
  - In PY3: Difference between 2014 and 2018
- The projected regional trend will be set prior to the start of the performance year and will be applied to final settlement without retrospective adjustments to account for the difference between projected and actual trend.
- Under limited circumstances, CMS would adjust the projected trend in response to unforeseeable events such as legislative actions that have a substantial impact on Medicare FFS expenditures.

# Projected National FFS Expenditure Trend -- Overview

- The projected national FFS expenditure trend will be determined using a methodology similar to those used by the CMS OACT to calculate the MA county ratebook.<sup>1</sup>
- OACT calculates a projected FFS United States Per Capita Cost (USPCC), which is used in the calculation of the ratebook.<sup>2</sup>
  - OACT calculates the FFS USPCC separately for Aged/Disabled and ESRD beneficiaries.
- The FFS USPCC will be customized for the NGACO Model by applying adjustments that will be made to take into account differences between the FFS population as a whole, and the subset of FFS beneficiaries eligible to be aligned to NGACOs.
  - E.g., FFS beneficiaries eligible to be aligned to NGACOs are required to be users of qualifying evaluation and management services in a certain time period
  - Note however that the beneficiaries eligible for alignment to an NGACO (i.e., the “national reference population”) are the vast majority of FFS beneficiaries.

<sup>1</sup>The methodology used by OACT to project the FFS USPCC can be found at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2015.pdf>. An high level overview of this projection methodology is provided in a later slide.

<sup>2</sup>For example, the 2016 projected FFS USPCC used in the MA benchmark calculation can be found in the 2016 MA Announcement (published April 6, 2015): <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2016.pdf>.

# Projected National FFS Expenditure Trend -- Timing

- For each performance year, the **projected trend will be the projected percentage difference** between the base year (CY2014) and:
  - In PY1: CY2016
  - In PY2: CY2017
  - In PY3: CY2018
- The **prospective projected trend will be set in the quarter prior to the start of the performance-year** using OACT's most recent projection of spending for the performance year.
- **Illustrative example of projected national FFS trend for PY1 (for Aged/Disabled):**
  - In the 2016 MA Announcement (published April 6, 2015) are:
    - Current estimate of 2014 FFS USPCC = \$774.78
    - Current projection of 2016 FFS USPCC = \$800.21
  - Thus projected national FFS trend between 2014 and 2016 = 3.28%

**Please note** that this is an illustrative example and should not be construed as the projected national FFS trend for the NGACO Model's PY1. Specifically, the projected trend for PY1 will be customized for the NGACO reference population, and in addition, if available, will be based on a more recent OACT projection of the 2016 FFS USPCC than was published in the 2016 MA Announcement.

# Projected National FFS Expenditure Trend – Methodology (1/2)

- The methodology used by OACT to project the FFS USPCC for the MA county ratebook is based on the projection methodology used in the Medicare Trustees Report.<sup>1</sup>
- At a high level, this projection methodology has two major parts: 1) projection FFS expenditure base, and 2) projected change in FFS expenditures.

## 1. Projection FFS expenditure base

- To establish a suitable base from which to project future FFS expenditures, the incurred payments for services provided must be constructed for the most recent period for which a reliable determination can be made.
- Accordingly, payments to providers must be attributed to dates of service, rather than to payment dates; in addition, the nonrecurring effects of any changes in regulations, legislation, or administration, and of any items affecting only the timing and flow of payments to providers, must be eliminated.
- The process of allocating the various types of payments made to the proper incurred period—using incomplete data and estimates of the impact of administrative actions—presents difficult problems, and the solutions to these problems can be only approximate.

<sup>1</sup> See, e.g., <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2015.pdf>

# Projected National FFS Expenditure Trend – Methodology (2/2)

## 2. Projected change in FFS Expenditures

- Part A (inpatient hospital, skilled nursing facility, home health agency, hospice)
- Part B (physician, durable medical equipment, hospital outpatient, clinical laboratory, and other)
  
- For example, projected change in FFS expenditures for inpatient hospital services are analyzed in five broad categories:
  - Hospital input price index—the change in prices for goods and services purchased by the hospital.
  - Unit input intensity allowance—an amount added to or subtracted from the input price index (generally called for in legislation) to yield the prospective payment update factor.
  - Volume of services—the change in total output of units of service (as measured by covered hospital admissions).
  - Case mix—the financial effect of changes in the average complexity of hospital admissions.
  - Other sources—a residual category reflecting all other factors affecting hospital expenditure changes (such as enacted legislative changes).
  
- The changes in the input price index (less any intensity allowance specified in the law), units of service, and other sources are compounded to calculate the total change in expenditures for inpatient hospital services.

# Regional Geographic Adjustment Factor (GAF) Trend Adjustment -- Overview

- Medicare FFS payments under most Medicare payment systems are adjusted to reflect the cost-of-doing-business in the local geographic area in which the provider operates.
  - Examples of these Geographic Adjustment Factors (GAFs) are the Medicare area wage index (AWI) and the geographic practice cost index (GPCI). These local geographic price adjustments are updated annually.
- The purpose of the GAF trend adjustment in the NGACO Model is to prevent the benchmark from being unfairly understated (or overstated) because of differences between the GAFs that Medicare used to calculate provider payments in the base-year (CY2014) and the performance-year.
- The GAF trend adjustment factor for a county is an estimate of the impact on base-year provider payments for services provided to reference beneficiaries residing in the county of the difference between the base-year Medicare GAFs and the performance year Medicare GAFs.

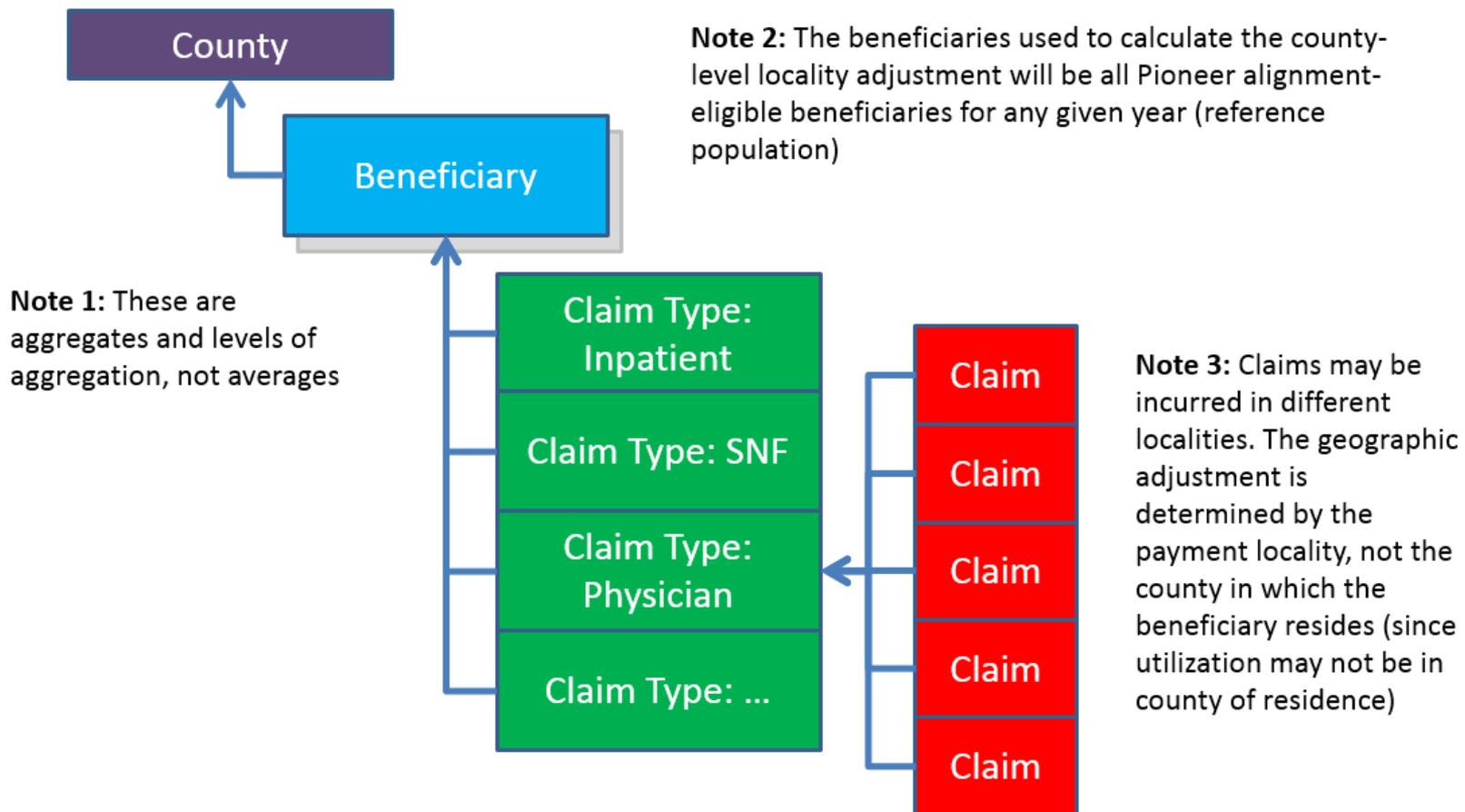
# Calculation of the GAF Trend Adjustment (1/2)

- The GAF trend-adjustment for a county will be the ratio of:
  - The county PBPM expenditure calculated after adjusting base year claims to reflect the impact on provider payments of the geographic pricing factors that Medicare will use in the performance year; to,
  - The actual incurred county PBPM expenditure (reflecting the geographic pricing factors that Medicare used to calculate provider payments in the base year).<sup>1</sup>
- The GAF-trend adjustment factor will be calculated prospectively for alignment-eligible beneficiaries in each county in the base year and will have no impact on the national FFS trend.
- The GAF trend-adjustment for an NGACO will be the person-month weighted average of county GAF-trend adjustment factors, where the weights are the NGACO aligned beneficiary person months residing in each county.
- The GAF trend adjustment requires that baseline claims be adjusted to reflect the estimated impact on baseline expenditures of the GAFs that Medicare will apply when calculating provider payments in the performance year.
- Baseline claims will be adjusted using appropriately weighted performance year geographic pricing factors. For example:
  - The geographic price adjustment under the Inpatient Prospective Payment System (IPPS), the Area Wage Index (AWI), is weighted by the proportion of cost that is attributable to labor.
  - Under the Physician Fee Schedule, the three Geographic Practice Cost Indexes (GPCIs) are weighted by the corresponding relative value units.

<sup>1</sup> See, e.g., <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2015.pdf>

# Calculation of the GAF Trend Adjustment (2/2)

Building up to county-level locality adjustment – uses a method of claims-level re-pricing



# Risk Adjustment

- Key background concept: Next Generation ACO benchmark is **cross-sectional**, which means that:
  - Alignment algorithm applied to baseline year, and **then separately** to performance year<sup>1</sup>
  - **Populations in these two time periods will overlap but be different** – some beneficiaries will be aligned in baseline year but not performance year, while some beneficiaries will be aligned in performance year but not baseline year (e.g., because of changes in utilization patterns, changes in provider/market landscape, etc.)
- Risk adjustment is meant to **adjust for the difference** between the baseline and performance-year populations<sup>2</sup>
- **CMS Hierarchical Condition Category (HCC) model** used to determine average risk score of baseline year population and average risk score of performance-year population<sup>2</sup>
- Similar to the Pioneer ACO model and Shared Savings Program, **average risk scores will be “re-normalized” to the average risk score of the national population** (i.e. for the purposes of financial reconciliation, HCC risk scores are adjusted in any given year such that the average risk score nationally is 1)<sup>3</sup>
- Increase in average risk score **capped** at 3% cap. Decrease in HCC risk score will also be **capped** at 3%
  - PY1: Difference between average risk score of ACO beneficiaries in 2014 and average risk score of ACO beneficiaries in 2016
  - PY2: Difference between average risk score of ACO beneficiaries in 2014 and average risk score of ACO beneficiaries in 2017
  - PY3: Difference between average risk score of ACO beneficiaries in 2014 and average risk score of ACO beneficiaries in 2018
- **Risk adjustment initially set prospectively, but retrospectively adjusted** for final reconciliation when “final risk scores” become available after the performance year<sup>4</sup>

<sup>1</sup> In contrast, a “cohort methodology” aligns beneficiaries once to the performance year and looks at expenditures for this same group of beneficiaries in the baseline year (i.e. this cohort is followed over time). The Pioneer ACO model used a cohort methodology from Performance Years 1 – 3 (2012 – 2014). A cross-sectional methodology is used by the Pioneer ACO model in Performance Years 4 – 5 (2015 – 2016) and the Shared Savings Program.

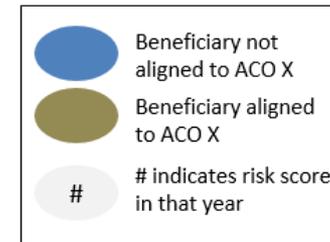
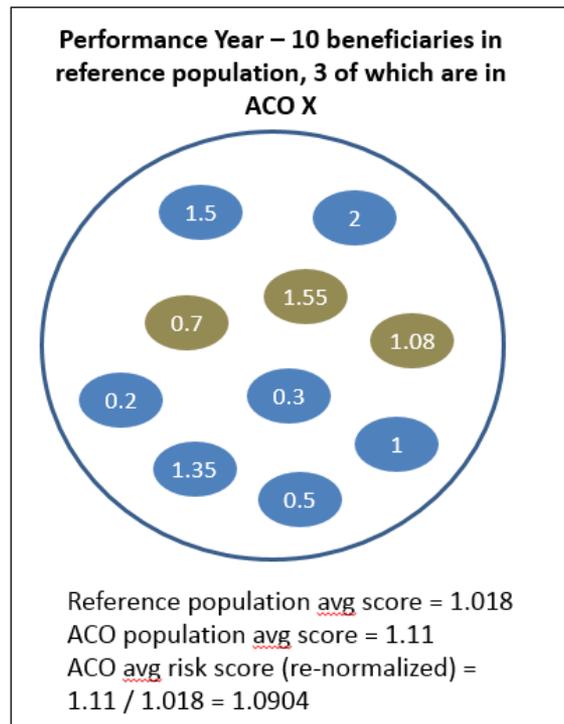
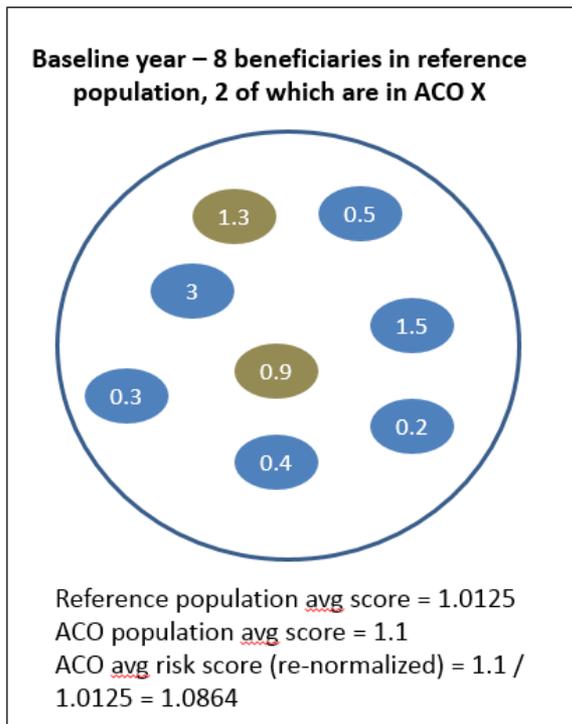
<sup>2</sup> The “baseline year population” and the “performance year population” are also referred to as the “baseline year panel” and the “performance panel” in certain Pioneer / Shared Savings Program documents – a panel here simply refers to a group of beneficiaries which may overlap with other panels

<sup>3</sup> The “national population” here refers to the national population of beneficiaries eligible to be aligned to a Next Generation ACO

<sup>4</sup> Note that HCC scores are based on diagnoses in claims for the year prior to the performance year. As an example, consider Performance Year 2 (2017). Performance year risk scores are based on prior-year claims (i.e. claims incurred in 2016). The HCC methodology does not allow for final calculation of these performance year risk scores until early-to-mid 2018. The benchmark, however, will be prospectively set based on currently available information at the time, and CMS is exploring options for updating benchmark based on interim risk score information available prior to the final scores becoming available.

# Risk Adjustment – Illustrative Example of Risk Ratio

- Note that this is within an entitlement category (aged/disabled) and, for the purposes of simplification / illustration, assumes all beneficiaries in entitlement category for entire year



- **Risk ratio =  $1.0904 / 1.0864 = 1.00364$**
- ACO Baseline year expenditure will be multiplied by 1.00364 to account for change in risk – since increase of 0.364% (within cap of +/- 3% or 0.97 – 1.03), risk ratio not capped

# Quality- and Efficiency-Adjusted Discount

- The NGACO benchmark will be calculated by applying to the trended, risk-adjusted benchmark an efficiency- and quality-adjusted discount. The adjusted discount is the sum of four components:
  - A standard discount of 3.0%.
  - MINUS: A quality adjustment to the standard discount of up to +1.0%
  - MINUS: A regional efficiency adjustment of  $\pm 1.0\%$
  - MINUS: A national efficiency adjustment of  $\pm 0.5\%$
- The quality- and efficiency-adjusted discount for an NGACO thus can vary from 0.5 to 4.5% **(assuming a +1.0% quality adjustment for PY1, range in PY1 is from 0.5 to 3.5%)**
- A separate quality- and efficiency-adjusted discount will be calculated for Aged/Disabled and ESRD beneficiaries.
- The efficiency adjustments will be calculated separately for Aged/Disabled and ESRD beneficiaries and may differ. The same quality adjustment will apply to each entitlement category however.

# Quality adjustment (1/2)

- The quality adjustment to the standard Medicare savings requirement may be up to 1 percentage point. **In other words, the standard discount of 3% may be reduced by as much as 1 percentage point based on the NGACO's quality of care performance.**
- **For each performance year, the ACO's quality score will range from 0 to 100, and the quality adjustment to the standard discount will be the product of the quality score and 1%.**
- For example, if the NGACO's quality score is 90%, then the quality adjustment would be 0.9%. In this case, the quality adjusted standard discount would be 2.1% (3% + 0.9%).
- The following table illustrates the relationship between the quality score and the quality adjustment to the standard discount:

Quality score	Adjustment
100	+1.00%
90	+0.90%
80	+0.80%
70	+0.70%
60	+0.60%
50	+0.50%
40	+0.40%
30	+0.30%
20	+0.00%
10	+0.00%
0	+0.00%

# Quality adjustment (2/2)

- **Use of current year quality score**
  - In PY1, CMS will assume a quality score of 100 for all ACOs when setting the prospective benchmark.
    - In the event an ACO fails to successfully report for PY1, CMS will retrospectively adjust the quality score to zero.
  - In PY2, CMS will initially assume a quality score of 100% as PY1 quality scores will not be available at the time that the benchmark is calculated.
    - CMS will apply the method above in PY1 for ACOs that begin in 2017.
    - CMS will retrospectively adjust the benchmark after the end of PY2 to reflect final PY2 quality scores for 2016 starters.
  - For PY3, the prospectively-set quality score component will be based on the quality score from PY1.
    - CMS will retrospectively adjust the benchmark after the end of PY3 to reflect final PY3 quality scores.
- **Minimum Quality Requirement**
  - Each NGACO must meet certain minimum quality requirements, including the submission of all data required to calculate quality scores.
  - In the event an NGACO does not satisfy the minimum quality requirement, it will not be allowed to share in savings, but will be required to pay losses. The quality score for an NGACO that does not meet the minimum quality requirements will be zero.

# Regional efficiency adjustment (1/2)

- The regional efficiency adjustment adds  $\pm 1.0\%$  to the standard discount
- It is based on the ratio of:
  - The ACO's standardized baseline PBPM; to
  - The ACO's regional standardized baseline PBPM.
- Standardization controls for differences in:
  - The risk of the ACO's and region's beneficiaries
  - The GAFs that Medicare applies in the ACO's region
- The standard discount will be:
  - Decreased if the ACO baseline is lower than the regional baseline
  - Increased if the ACO baseline is higher than the regional baseline

# Regional efficiency adjustment (2/2)

Regional baseline efficiency adjustment	
ACO baseline	\$924.00
GAF baseline adjustment factor	1.100
ACO baseline re-normalized risk score	1.050
Standardized ACO baseline	\$800.00
Standardized regional baseline	\$840.00
Regional efficiency ratio	0.952
Regional Efficiency Adjustment	0.476%
Adjusted discount (=3% less REA)	2.524%

Table 7.2.5. Regional efficiency adjustment for selected regional efficiency ratios

Regional efficiency ratio	Adjustment	Regional efficiency ratio	Adjustment
0.90 or less	+1.00%	1.00	-0.00%
0.91	+0.90%	1.01	-0.10%
0.92	+0.80%	1.02	-0.20%
0.93	+0.70%	1.03	-0.30%
0.94	+0.60%	1.04	-0.40%
0.95	+0.50%	1.05	-0.50%
0.96	+0.40%	1.06	-0.60%
0.97	+0.30%	1.07	-0.70%
0.98	+0.20%	1.08	-0.80%
0.99	+0.10%	1.09	-0.90%
1.00	+0.00%	1.10 or higher	-1.00%

# National efficiency adjustment (1/2)

- The national efficiency adjustment adds  $\pm 1.0\%$  to the standard discount
- It is based on the ratio of:
  - The ACO's standardized baseline PBPM; to
  - The national standardized baseline PBPM.
- Standardization controls for differences in:
  - The risk of the ACO's and all alignment-eligible (national) beneficiaries
  - The GAFs that Medicare applies in the ACO's region
- The standard discount will be:
  - Decreased if the ACO baseline is lower than the national baseline
  - Increased if the ACO baseline is higher than the national baseline

# National efficiency adjustment (2/2)

National baseline efficiency adjustment	
ACO baseline	\$924.00
GAF baseline adjustment factor	1.100
ACO baseline re-normalized risk score	1.050
Standardized ACO baseline	\$800.00
Standardized national baseline	\$880.00
National efficiency ratio	0.909
National Efficiency Adjustment	0.455%
Adjusted discount (=2.524% less NEA)	2.069%

Table 7.3.2. National efficiency adjustment for selected national efficiency ratios

National efficiency ratio	Adjustment	National efficiency ratio	Adjustment
0.90 or less	+0.50%	1.00	-0.00%
0.91	+0.45%	1.01	-0.05%
0.92	+0.40%	1.02	-0.10%
0.93	+0.35%	1.03	-0.15%
0.94	+0.30%	1.04	-0.20%
0.95	+0.25%	1.05	-0.25%
0.96	+0.20%	1.06	-0.30%
0.97	+0.15%	1.07	-0.35%
0.98	+0.10%	1.08	-0.40%
0.99	+0.05%	1.09	-0.45%
1.00	+0.00%	1.10 or higher	-0.50%

# Definition of ACO region

**The ACO's region consists of all counties in which its base-year aligned beneficiaries reside.** The ACO region is used in in two components of the benchmark calculation:

- 1) The calculation of the regional trend; and,
- 2) The calculation of the regional efficiency adjustment to the standard discount.

For these components of the benchmark calculation, a **person-month weighted average** of county-specific values (i.e., the regional trend and the standardized regional baseline expenditure) will be calculated.

# Expenditures – what is and is not included?

- **Exclusion of certain provider payments**
  - Medicare inpatient pass-through payment amounts (estimates) on inpatient claims are excluded from expenditures.
  - Direct Graduate Medical Education, PQRS, eRx, and EHR incentive payments for eligible professionals, and EHR incentive payments to hospitals are excluded from expenditure calculations.
  - Uncompensated Care (UCC) payments are excluded from the baseline and performance-year expenditure of beneficiaries.
- **IME / DSH**
  - Indirect Medical Education (IME) and Disproportionate Share Hospital (DSH) payments are included in calculation of the baseline and performance-year expenditure, but are **excluded from the expenditure used in the calculation of the regional and national efficiency adjustments.**
- **Sequestration** – Financial calculations on payments as if sequestration had not been required
- **Population-based payments** – Expenditures included as if population-based payment reduction not in place

# Capping

When required by a calculation (e.g., for a capped baseline or for the calculation of an efficiency ratio), the capped expenditure incurred by a beneficiary is determined separately by entitlement category based on the expenditure incurred by a beneficiary during months in which the beneficiary contributed experience to an entitlement category.

The capped expenditure for a base- or performance-year that accrues to the entitlement category by the beneficiary is the lesser of:

1. The expenditure accrued to the category by the beneficiary during the year; and,
2. The expenditure cap that applies to that entitlement category for that year.

The expenditure cap is based on the experience accrued by the beneficiary to the entitlement category. It is equal to the product of:

1. The PBPM cap on expenditures for the entitlement category for that year;
2. The number of months that the beneficiary accrued to the entitlement category during the year;

The PBPM cap on expenditures for a given entitlement category is the 99th percentile of the expenditure PBPM incurred by all alignment-eligible beneficiaries who accrue experience to the entitlement category during the year. Expenditure caps will be based on national experience.

# Risk Arrangements

Arrangement A: Increased Shared Risk	Arrangement B: Full Performance Risk
Parts A and B Shared Risk <ul style="list-style-type: none"><li>• 80% sharing rate (PY1-3, 2016-2018)</li><li>• 85% sharing rate (PY4-5, 2019-2020)</li><li>• 15% savings/losses cap</li></ul>	100% Risk for Parts A and B <ul style="list-style-type: none"><li>• 15% savings/losses cap</li></ul>

- Benchmarks calculated the same way for both arrangements
- Different sharing rates affect ACO risk
- Both arrangements cap individual beneficiary expenditures at the 99<sup>th</sup> percentile of expenditures to moderate outlier effects

# Example Savings/Losses Calculation

Shared Savings/Losses Reconciliation	Arrangement A: Increased Shared Risk	Arrangement B: Full Performance Risk
Illustrative Benchmark	\$100,000,000	\$100,000,000
Sharing Rate	80%	100%
Savings/Losses Cap	15%	15%
Maximum Savings/Losses	+/- \$12,000,000 [80% x (15% x \$100,000,000)]	+/- \$15,000,000 [100% x (15% x \$100,000,000)]
Actual PY Expenditures	\$97,000,000	\$97,000,000
Shared Savings Payment	\$2,400,000	\$3,000,000
Actual PY Expenditures	\$103,000,000	\$103,000,000
Shared Losses Owed	\$2,400,000	\$3,000,000

- Savings or losses determined by comparing total Parts A and B spending for PY-aligned beneficiaries to the benchmark
- Risk arrangement determines ACO's share of savings or losses

# Payment Mechanisms

Payment Mechanism 1: Normal FFS	Payment Mechanism 2: Normal FFS + Monthly Infrastructure Payments	Payment Mechanism 3: Population-Based Payments (PBP)	Payment Mechanism 4: All-Inclusive Population-Based Payments (April 2017)
Medicare payment through usual FFS process	Medicare payment through usual FFS process plus additional PBPM payment to ACO	Medicare payment redistributed through reduced FFS and PBPM payment to ACO	Medicare payment redistributed through 100% FFS reduction and PBPM payment to ACO; Next Generation ACO responsible for paying claims for AIPBP-participating Next Generation Participants and Preferred Providers

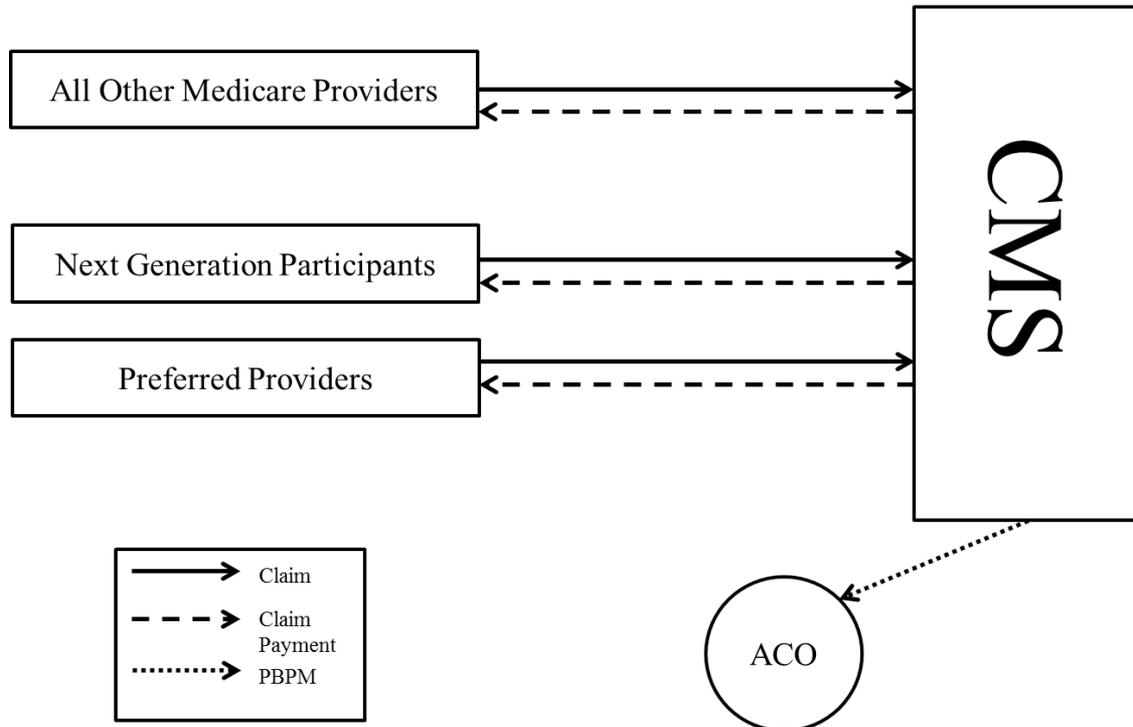
- Alternative payment flows do not affect beneficiary out-of-pocket expenses or net CMS expenditures
- Payments to ACOs will be reconciled and may result in other monies owed

# Infrastructure Payments

- All claims paid through normal FFS payment
- The ACO chooses an additional per-beneficiary per-month (PBPM) payment unrelated to claims
- Maximum payment rate: \$6 PBPM
- All infrastructure payments will be recouped in full from the ACO during reconciliation, regardless of savings or losses.

# Infrastructure Payments Conceptual Diagram

FFS + Infrastructure Payment



All providers/suppliers submit claims to CMS as normal, and CMS pays all claims as normal. Unrelated to claims, CMS makes a monthly per-beneficiary per-month (PBPM) payment to the ACO.

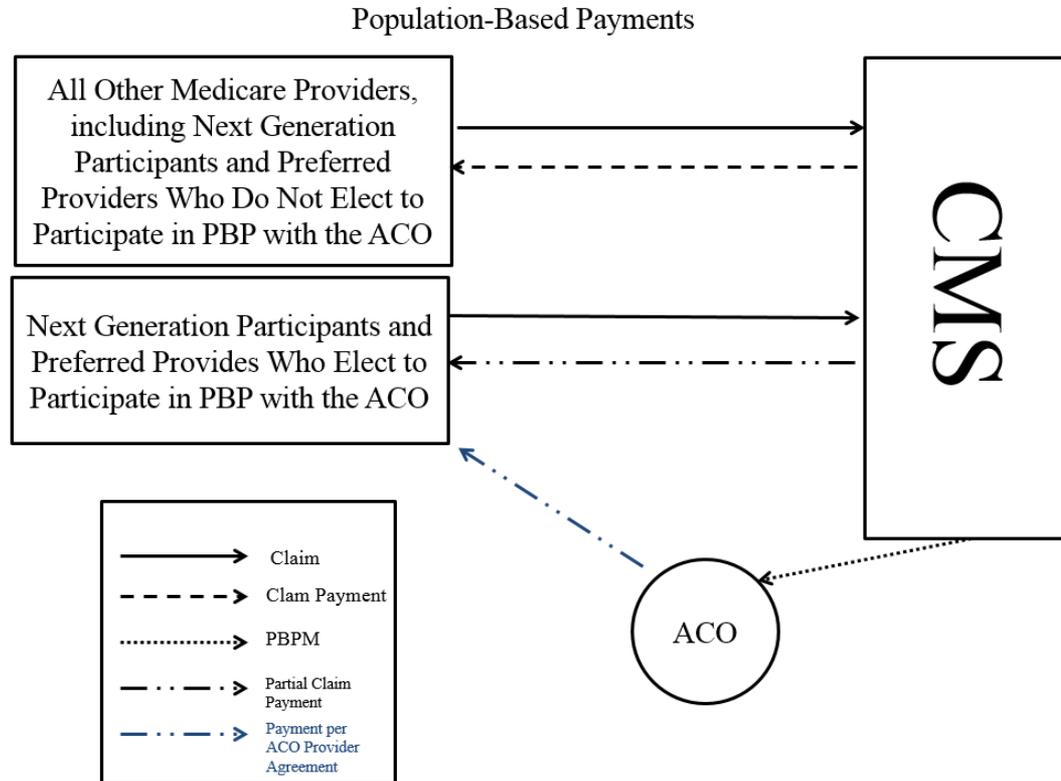
# Population-Based Payments (PBP)

- ACO determines a percentage reduction to the base FFS payments of its Next Generation Participants and Preferred Providers for care supplied to Next Generation PY-aligned beneficiaries.
  - ACO may opt to apply a different percentage reduction to different subsets of its Participants and Preferred Providers
  - PBP-participating Next Generation Participants and Preferred Providers must agree in writing to the percentage reduction.
- CMS will pay the projected total annual amount taken out of the base FFS rates to the ACO in monthly payments.

# PBP Example Calculation

Example ACO	Amount	Description
# of Aligned Beneficiaries	25,000	---
Benchmark (Projected Spending)	\$300,000,000 (\$12,000 PBPY = \$1,000 PBPM)	Benchmark calculated using model benchmark methodology
Projected Spending by PBP-Participating Next Generation Participants and Preferred Providers	75%	Using historic claims, CMS projects spending by providers participating in PBP
FFS % Reduction	10%	Providers agree to reduction off base FFS rates
PBPM to ACO	\$75	10% of 75% x \$1,000 PBPM
Monthly Payment to ACO	\$1,837,500	\$75 PBPM x 25,000 aligned beneficiaries minus 2% sequestration
Annual Amount Paid to ACO	\$22,050,000	\$ monthly payment x 12 months

# Population-Based Payments Conceptual Diagram



All Next Generation Participants and Preferred Providers submit claims to CMS as normal. CMS pays Next Generation Participants and Preferred Providers participating in PBP reduced FFS rates and pays the ACO a PBPM payment, with which the ACO pays the PBP-participating Participants and Preferred Providers, according to written agreements.

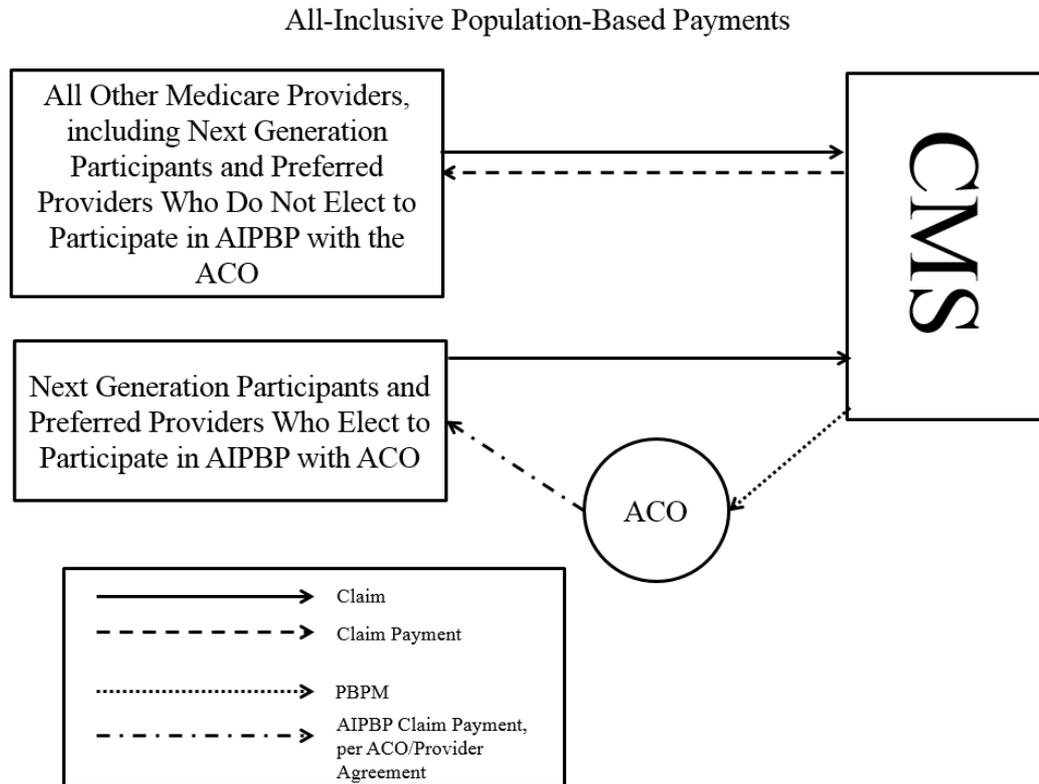
# All-Inclusive Population-Based Payments (available in April 2017)

- ACOs elect to participate in AIPBP and Next Generation Participants and/or Preferred Providers agree to receive 100% FFS reduction
- ACO is responsible for paying claims for Next Generation Participants and/or Preferred Providers receiving 100% reduced FFS
- Claims process:
  - All AIPBP- participating providers/suppliers submit claim to CMS as normal
  - CMS sends ACO claims information for those services
  - ACOs are responsible for making payments
- CMS will continue to pay normal FFS claims for care furnished to Next Generation Beneficiaries by Participants and Preferred Providers not participating in AIPBP (as well as care furnished by all other Medicare providers and suppliers).

# AIPBP Example Calculation (April 2017)

Example ACO	Amount	Description
# of Aligned Beneficiaries	25,000	---
Benchmark (Projected Spending)	\$300,000,000 (\$12,000 PBPY = \$1,000 PBPM)	Benchmark calculated using model benchmark methodology
Projected Spending by Next Generation Participants and Preferred Providers	75%	Using historic claims, CMS project spending by providers participating in AIPBP
AIPBP PBPM	\$750	75% of \$1,000 PBPM
Monthly Payment to ACO	\$18,375,000	\$750 AIPBP PBPM x 25,000 aligned Beneficiaries minus 2% sequestration
Annual Amount Paid to ACO	\$165,375,000	\$ monthly payment x 9 months

# AIPBP Conceptual Diagram (April 2017)



All providers/suppliers submit claims to CMS as normal. CMS will pay the ACO a monthly PBPM AIPBP payment, with which the ACO will be responsible for paying AIPBP-participating providers/suppliers. ACOs will receive claims and payment information from CMS to inform payment to the Next Generation Participants and Preferred Providers participating in AIPBP. CMS will continue to pay claims for all Medicare providers not participating in AIPBP.

# Payment Mechanism Reconciliation

- Separate reconciliation for infrastructure payments, PBP, and AIPBP
- Infrastructure payments fully recouped from savings or in addition to losses.
- PBP and AIPBP reconciled to account for actual spending versus projection, and may result in other monies owed to CMS or ACO.