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CMS Revises Medicare Shared Savings Program's Performance Benchmarking Methodology to Encourage Continued Participation by Current Accountable Care Organizations

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On November 1, 2022, the Centers for Medicare & Medicaid Services (CMS) issued the Calendar Year 2023 Physician Fee Schedule (PFS) Final Rule, which includes changes to the Medicare Shared Savings Program (MSSP), the nation's largest Accountable Care Organization (ACO) program, to advance CMS's overall value-based care strategy of growth, alignment, and equity. While many of the changes seek to support new ACO participants, revisions to MSSP's performance benchmarking methodology aim to encourage continued participation by current ACOs. The revisions seek to strengthen financial incentives for long term participation by reducing the impact of ACOs' performance on their benchmarks, addressing the impact of ACO market penetration on regional expenditures used to adjust and update benchmarks, and supporting the business case for ACOs serving high-risk and high dually eligible populations to participate, which should help sustain and potentially increase participation in the MSSP.

Specifically, CMS finalized three proposals: (i) incorporating a prospective, external factor in the growth rates used to update the benchmark; (ii) adjusting rebased benchmarks to account for an ACO's prior savings; and (iii) reducing the impact of negative regional adjustments on ACO benchmarks. When viewed in tandem with other CMS initiatives, such as CMS's promotion of the separate ACO REACH model, the Final Rule reflects a significant step towards CMS's goal of having 100% of Traditional Medicare beneficiaries in an accountable care relationship with their healthcare provider by 2030.

Incorporating a Prospective, External Factor in Growth Rates Used to Update the Historical Benchmark

ACOs and other interested parties expressed concerns regarding the dynamic under which an ACO that reduces costs for its own assigned beneficiaries also reduces its average regional costs. This results in a relatively lower benchmark for the ACO under the blended national-regional growth rates used to trend and update the ACO's historical benchmark.

In response to these concerns, CMS will blend a prospectively projected administrative growth factor, a variant of the United States Per Capita Cost (USPCC) referred to in the Final Rule as the Accountable Care Prospective Trend (ACPT), with national and regional growth rates to update an ACO's historical benchmark for each performance year. Incorporating this prospective trend will insulate a portion of the annual update from any savings occurring as a result of the actions of participating ACOs and address the impact of increasing market penetration by ACOs in a regional service area on the existing blended national-regional growth factor.

Because the ACPT will be prospectively set at the outset of an agreement period, any savings generated by ACOs during the agreement period will not be reflected in the ACPT. Accordingly, incorporation of the ACPT will allow for benchmarks to increase beyond actual spending growth rates as ACOs slow spending growth. By limiting the negative impact that efforts by ACOs to slow spending growth have on their own benchmarks, CMS

believes the use of this three-way blend to update ACOs' benchmarks will incentivize both greater savings by ACOs and greater program participation.

CMS's modeling of the three-way blend indicated that ACO benchmarks increased an average of $19 per capita, with an average of 62 percent of all ACOs across all years modeled receiving a larger benchmark increase compared with the current two-way blend. An average of 65 percent of ACOs operating in a regional service area with higher MSSP market penetration were better off under the three-way blended update factor compared with the current two-way blend.

Adjusting ACO Benchmarks to Account for Prior Savings

CMS also finalized its proposal to adjust benchmarks to account for prior savings, helping to mitigate decrease of an ACO's benchmark over time by returning an amount to its benchmark that reflects its success in lowering growth in expenditures from the previous agreement period. Specifically, the Final Rule will incorporate an adjustment for prior savings that will apply in the establishment of benchmarks for renewing ACOs and re-entering ACOs that were reconciled for one or more of the three performance years immediately preceding the start of their agreement period.

For the second and each subsequent performance year during the term of the ACO's agreement period, CMS will redetermine the proration factor used in calculating the prior savings adjustment to account for any changes in the ACO's assigned beneficiary population. Such redeterminations will take into account the addition and removal of ACO participants or ACO providers/suppliers, a change to the ACO's beneficiary assignment methodology selection, or changes to the beneficiary assignment methodology. If none of these circumstances apply for the second or subsequent performance year, CMS will not redetermine the proration factor.

CMS believes that incorporating an adjustment for prior savings, when the adjustment for prior savings will be more advantageous for ACOs than the regional adjustment, will limit the negative ratchet effects of benchmark rebasing. Under the existing benchmarking methodology, the savings an ACO achieves in one agreement period can reduce its rebased benchmark for the subsequent agreement period either directly, by reducing the historical spending that forms the basis for its rebased benchmark, or indirectly, by reducing regional expenditures in the ACO's regional service area leading to negative (or smaller positive) regional adjustments. Under the provisions of the Final Rule, ACOs that have demonstrated prior savings will receive higher benchmarks under the following scenarios:

- ACOs with a negative regional adjustment would receive either a smaller negative regional adjustment or a positive adjustment for prior savings, depending on the relative size of the negative regional adjustment and their pro-rated average prior savings.

- ACOs with a positive regional adjustment whose pro-rated average prior savings multiplied by 50 percent are higher than their regional adjustment would receive a prior savings adjustment that is larger than their regional adjustment would have been under current policy. In contrast, ACOs whose positive regional adjustment is greater than 50 percent of their prorated average prior savings would not be impacted by the adjustment for prior savings, and would continue to receive the (larger) regional adjustment.

No ACOs will receive a lower benchmark as a result of this policy, and modeling suggests that approximately 22 percent of all ACOs will receive a higher benchmark under the Final Rule. ACOs most likely to benefit from this change are those with prior success in MSSP that are not receiving significant positive regional adjustments to their benchmarks.

Reducing the Impact of the Negative Regional Adjustment

CMS finalized its proposal to reduce the impact of negative regional adjustments on ACO benchmarks by changing the associated cap and gradually decreasing the negative regional adjustment amount as an ACO's weighted-average prospective HCC risk score increases, the proportion of dually eligible Medicare and Medicaid beneficiaries increases, or both. Specifically, CMS is changing the cap on negative regional adjustments from negative 5 percent of national per capita expenditures for Part A and B services in BY3 for assignable beneficiaries to negative 1.5 percent. After the cap is applied to the regional adjustment, CMS will gradually decrease the negative regional adjustment amount as an ACO's proportion of dual eligible Medicare and Medicaid beneficiaries increases or its weighted-average prospective HCC risk score increases.

ACOs most likely to benefit from this Final Rule will be those with significant downward regional adjustments, particularly those focused on higher-risk populations for which the risk-adjusted regional benchmark does not fully account for the populations' expected cost levels.

CMS's changes to the MSSP benchmarking methodology will apply to agreement periods beginning on January 1, 2024. The Final Rule is scheduled to be published in the Federal Register on November 18, 2022.

If you have questions about this topic, please feel free to reach out to Joseph Keillor, Mary Grace Griffin, or the Baker Donelson Health Law team member with whom you typically work.