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Proposed Updates to the Medicare Shared Savings Program's Performance Benchmarking Methodology

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On July 7, 2022, the Centers for Medicare & Medicaid Services (CMS) issued the Calendar Year (CY) 2023 Physician Fee Schedule (PFS) proposed rule that includes changes to the Medicare Shared Savings Program (MSSP) to advance CMS's overall value-based care strategy of growth, alignment, and equity. While many of the proposed changes seek to support new accountable care organization (ACO) participants, proposed revisions to MSSP's performance benchmarking methodology aim to encourage continued participation by current ACOs.

The proposed revisions would 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 will help sustain participation and grow the program. Specifically, CMS is proposing a package of three proposals: (i) incorporating a prospective, external factor in the growth rates used in updating 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.

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

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

In response to these concerns, CMS is proposing to incorporate a prospectively projected administrative growth factor – a variant of the United States Per Capita Cost (USPCC) referred to in the proposed rule as the Accountable Care Prospective Trend (ACPT), into a three-way blend with national and regional growth rates to update an ACO's historical benchmark for each performance year in the ACO's agreement period. Incorporating this prospective trend in the update to the benchmark would insulate a portion of the annual update from any savings occurring as a result of the actions of ACOs participating in the MSSP 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 would be prospectively set at the outset of an agreement period, any savings generated by ACOs during the agreement period would not be reflected in the ACPT. Accordingly, incorporation of the ACPT would allow for benchmarks to increase beyond actual spending growth rates as ACOs slow spending growth. By limiting the negative feedback of efforts by ACOs to slow spending growth on their own benchmarks, CMS believes the use of this three-way blend to update ACOs' benchmarks would be an incentive for both greater savings by ACOs and greater program participation.

CMS's modeling of the proposed three-way blend indicated that during the period examined, 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 is proposing to adjust benchmarks to account for prior savings, helping to mitigate lowering of an ACO's benchmark over time by returning to an ACO's benchmark an amount that reflects its success in lowering growth in expenditures from the previous agreement period. Specifically, the proposed rule would incorporate an adjustment for prior savings that would 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.

CMS believes that incorporating an adjustment for prior savings, when that adjustment would be more advantageous for ACOs than the regional adjustment, would 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 proposal to incorporate an adjustment for prior savings, ACOs that have demonstrated prior savings would 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 adjustments are greater than 50 percent of their prorated average prior savings would not be affected by the proposed adjustment for prior savings, and would continue to receive the (larger) regional adjustment.

While no ACOs would receive a lower benchmark as a result of this policy, numerical modeling of the proposed policy suggests that approximately 22 percent of all ACOs would receive a higher benchmark under this policy. ACOs most likely to benefit from this proposed 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 proposes to reduce the impact of negative regional adjustments on ACO benchmarks by changing the cap on those adjustments and gradually decreasing that adjustment amount as an ACO's weighted-average prospective HCC risk score increases, or the proportion of dually eligible Medicare and Medicaid beneficiaries increases, or both. Specifically, CMS proposes to change the cap on negative regional adjustments from negative 5 percent of national per capita expenditures for Parts A and B services under the original Medicare FFS program in BY3 for assignable beneficiaries to negative 1.5 percent.

After the cap is applied to the regional adjustment, CMS would gradually decrease the negative regional adjustment amount as an ACO's proportion of dual-eligible Medicare and Medicaid beneficiaries or its weighted-average prospective HCC risk score increases.

ACOs most likely to benefit from this proposed 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 proposed changes to the MSSP benchmarking methodology would apply to agreement periods beginning on January 1, 2024. Public comments on the proposed rules may be submitted online and are due no later than 5 p.m. Eastern time on September 6, 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.