DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network®
Official CMS Information for Medicare Fee-For-Service Providers

Methodology for Determining Shared Savings and Losses under the Medicare Shared Savings Program

FACT SHEET

Overview

On October 20, 2011, the Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health & Human Services (HHS), finalized new rules under the Affordable Care Act to help doctors, hospitals, and other health care providers better coordinate care for Medicare patients through Accountable Care Organizations (ACOs). ACOs create incentives for health care providers to work together to treat an individual patient across care settings – including doctor's offices, hospitals, and long-term care facilities. The Medicare Shared Savings Program (Shared Savings Program) will reward ACOs that lower their growth in health care costs while meeting performance standards on quality of care and putting patients first. Provider participation in an ACO is purely voluntary.

In developing this final rule, CMS worked closely with agencies across the Federal government to ensure a coordinated and aligned inter- and intra-agency effort to facilitate implementation of the Shared Savings Program.

CMS encourages all interested providers and suppliers to review this final rule and consider participating in the Shared Savings Program.

This fact sheet discusses how CMS will determine whether an ACO is entitled to shared savings or, in some cases, liable for shared losses and the amounts of such shared savings or losses.

Medicare Shared Savings Program Approach

Under the Shared Savings Program, the ACO providers and suppliers will continue to be paid for services rendered to Fee-For-Service Medicare beneficiaries in the same manner as they would otherwise. In addition, the participating ACO will be eligible to receive a shared savings payment if the ACO meets the quality performance standards and has generated shareable savings under the performance-based payment methodology described in the rule.

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ACOs Choose One of Two Available Tracks

CMS is implementing both a one-sided model (sharing of savings only for the term of an ACO's first agreement) and a two-sided model (sharing of savings and losses for the term of an ACO's agreement). This approach combines the one-sided model described under section 1899(d) of the Social Security Act (the Act) with a two-sided model that includes both shared savings and shared losses under the authority granted CMS under section 1899(i) of the Act. CMS believes this approach has the advantage of providing an entry point for organizations with less experience with risk models, such as some physician-driven organizations or smaller ACOs, to gain experience with population management before transitioning to a risk-based model, while also providing an opportunity for more experienced ACOs that are ready to share in losses to enter a sharing arrangement that provides a greater share of savings, but at the risk of repaying Medicare a portion of any losses.

Track 1 – Shared Savings Only for the Initial Agreement: Under Track 1, shared savings will be calculated for each performance year during the term of an ACO's first agreement. ACOs will not be held accountable for losses in this Track. Those ACOs that wish to continue participating in the Shared Savings Program beyond the first agreement period must do so in Track 2; that is, under the two-sided model.

Track 2 – Shared Savings and Shared Losses for All Years of the Agreement: Alternatively, more experienced ACOs that are ready to share in losses in return for the opportunity for a higher share of savings may elect to enter the two-sided model. ACOs that enter the Shared Savings Program under Track 2 will be under the two-sided model for the term of their initial agreement and any subsequent agreement. Under this model, the ACO will be eligible for a higher sharing rate, with a higher performance payment limit, than will be available under the one-sided model.

Determining Shared Savings and Losses

Under the final rule, CMS will take the following steps to determine shared savings and losses:

- **Step 1 – Establish Benchmark and Update for Each Performance Year Within the Agreement Period:** Section 1899(d)(1)(B)(ii) of the Act requires the Secretary to establish the "benchmark for each agreement period for each ACO using the most recent available 3 years of per-beneficiary expenditures for parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO." This section also requires the benchmark to "be adjusted for beneficiary characteristics and such other factors as the Secretary determines appropriate and updated by the projected absolute amount of growth in national per capita expenditures for parts A and B services under the original Medicare

fee-for-service program, as estimated by the Secretary." A new benchmark is to be established, consistent with these requirements, at the beginning of each agreement period.

The benchmark is a surrogate measure of what the Medicare Fee-For-Service Parts A and B expenditures would otherwise have been in the absence of the ACO. The initial benchmark is risk adjusted using the CMS Hierarchical Condition Categories (HCC) risk adjustment model that was originally developed in conjunction with the Medicare managed care (Medicare Advantage) program, also known as Medicare Part C. The HCC risk adjustment model is used to calculate expected expenditures for a population of Medicare beneficiaries. Although costs for an individual beneficiary may be higher or lower than expected, these variations are likely to balance each other across a population of beneficiaries. To minimize variation from catastrophically large claims, CMS will truncate an assigned beneficiary's total annual Parts A and B Fee-For-Service per capita expenditures at the 99th percentile of national Medicare Fee-For-Service expenditures as determined for each benchmark year.

In calculating the benchmark, CMS will trend the benchmark years forward to the third benchmark year by employing the national growth rate in Medicare Parts A and B expenditures for Fee-For-Service beneficiaries. CMS will weight the most recent year of the benchmark, Benchmark Year three (BY3), at 60 percent, BY2 at 30 percent, and BY1 at 10 percent. This weighting allows CMS to establish lower Minimum Savings Rates (MSRs) since the weighting results in a more accurate benchmark.

Each year of the agreement period, CMS will update the ACO's benchmark by the projected absolute amount of growth in national per capita expenditures for Parts A and B services under the original Medicare Fee-For-Service program using data from the CMS Office of the Actuary.

- **Step 2 – Compare Performance to the Benchmark to Determine Shared Savings/Losses:** Section 1899(d)(1)(B)(i) of the Act establishes that an ACO shall be eligible for payment of shared savings "only if the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for parts A and B services, adjusted for beneficiary characteristics, is at least the percent specified by the Secretary below the applicable benchmark." The statute further requires the Secretary to establish that percentage "to account for normal variation in expenditures … based upon the number of Medicare fee-for-service beneficiaries assigned to an ACO."

  To account for normal variation, CMS will establish an MSR. In the one-sided model, the statute requires us to establish an MSR to account for normal variation based upon the number of assigned beneficiaries. The MSR creates a corridor around the benchmark that must be met or exceeded in order for the ACO to be eligible to share in savings. A similar concept is applied in the two-sided model, a Minimum Loss Rate (MLR),

to determine if an ACO is responsible for shared losses. Under the one-sided model, the MSR varies with the size of the ACO's assigned population such that ACOs with smaller populations (that have more variation in expenditures) have a larger MSR and ACOs with larger populations (that have less variation in expenditures) have a smaller MSR. Under the one-sided model, MSRs range from 2 percent to 3.9 percent.

Under the two-sided model, for which there is no requirement for the MSR to be based on the number of assigned beneficiaries, both the MSR and MLR are set at a flat 2 percent for all ACOs. This relatively lower MSR under the two-sided model appropriately balances the risk that an ACO will achieve savings due to normal variation in expenditures, with their guarantee that they will share in losses.

To calculate savings or losses, the ACO's per capita, risk-adjusted Medicare expenditures in each performance year will be compared to its updated benchmark. If actual expenditures are lower than the updated benchmark and savings meet or exceed the MSR, the ACO will be eligible for shared savings.

Under the two-sided model only, if actual expenditures are higher than the benchmark and losses meet or exceed the MLR, a loss is incurred.

CMS will adjust the benchmark and performance year expenditures to account for changes in severity and case mix for beneficiaries. Full prospective CMS-HCC risk scores will be used to adjust each ACO's 3-year historical benchmark. During the performance years, for beneficiaries continuously assigned to the ACO, year to year, CMS will update the risk score using demographic factors only if this subpopulation experiences a decline in risk scores, in which case the risk score will be reset at the lower risk score rate. For beneficiaries that are newly assigned to the ACO during the performance year, full CMS-HCC prospective risk scores will apply to encourage ACOs to continue to accept high risk and complex patients.

- **Step 3 – Determining Sharing Rate and Shared Savings:** If an ACO meets quality standards and achieves savings according to Step 2, the ACO will share in savings. CMS will apply a sharing rate, determined for each ACO based upon its quality performance, to the difference between the updated benchmark and the actual expenditures for the performance year. The ACO will share in savings at this rate, on a first dollar basis up to the performance payment limit.
    - o **One-Sided Model** – The ACO may earn a sharing rate of up to 50 percent based on quality performance. Under the one-sided model, the

performance payment limit will be 10 percent of the applicable year's Part A and Part B updated benchmark.

- **Two-Sided Model** – The ACO may earn a sharing rate of up to 60 percent based on quality performance. Under the two-sided model, the performance payment limit will be 15 percent of the applicable year's Part A and Part B updated benchmark.

Determining Shared Losses under the Two-Sided Model

As noted above, ACOs in the two-sided model will share losses with CMS if the per capita costs for beneficiaries assigned to the ACO in the performance year are above the updated benchmark by an amount equal to or greater than the MLR, which is set at a flat 2 percent under this model. ACOs are liable for up to 60 percent of the entire difference between the updated benchmark and the actual expenditures for the performance year. The actual amount varies based on their quality performance. CMS will calculate a final sharing rate, determined for each ACO based upon its quality performance in the same manner as if the ACO were sharing in savings. The shared loss rate will be determined based on the inverse of the ACO's final sharing rate (that is, 1 minus the final shared savings rate). This approach rewards an ACO with a high quality score by reducing the amount of losses it will owe to CMS. Conversely, an ACO with a low quality score will owe a larger percentage of shared losses to CMS.

Additionally, CMS will implement a loss sharing limit on the total amount owed based on a percent of the ACO's updated benchmark for the applicable performance year. In the ACO's first performance year under the two-sided model, the loss sharing limit will be 5 percent of the Part A and Part B updated benchmark, 7.5 percent in the second performance year, and 10 percent in the third performance year.

Resources

The Shared Savings Program final rule can be downloaded at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Statutes_Regulations_Guidance.html on the CMS website.

It will appear in the November 2, 2011, issue of the "Federal Register." The Shared Savings Program will be established January 1, 2012.

For information about applying to participate in the Shared Savings Program, visit http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram on the CMS website.

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