

Strengthening Incentives and Promoting Sustainability in the Medicare Shared Savings Program

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The Medicare Shared Savings Program is Medicare’s largest Accountable Care Organization (ACO) initiative and is one of the major health care delivery reform models established by the Affordable Care Act. The program’s three-part aim is to achieve better care for individuals, achieve better health for populations, and reduce health care costs.

- Recent changes adopted in the Shared Savings Program through rulemaking by the Centers for Medicare & Medicaid Services (CMS) strengthened incentives for efficiency and effected changes in benchmarking policies aimed at improving program sustainability.
- In the June 2015 final rule, CMS finalized several policies aimed at encouraging more ACOs to accept performance-based risk, including a new two-sided risk option.
- In the June 2015 and June 2016 final rules, CMS finalized policies aimed at improving program sustainability by modifying the way financial benchmarks are calculated for ACOs that have completed their first agreement period. Notably, beginning in 2017, benchmarks for ACOs entering a second or subsequent agreement period will incorporate regional factors.
- Moving forward, it will be important for CMS to monitor the effects of these policy changes—particularly as they pertain to participation and performance of ACOs that have higher spending than their regions—and to make further refinements, as necessary, to help meet the aims of the program.

Accountable Care Organizations (ACOs) are groups of physicians, hospitals, or other health care providers that come together voluntarily to provide coordinated patient care. The Medicare Shared Savings Program (Shared Savings Program) is Medicare’s largest ACO initiative and is one of the major health care delivery reform models established by the Affordable Care Act. The program has a specific three-part aim: to achieve better care for individuals, to achieve better health for populations, and to reduce health care costs by promoting accountability and greater care coordination among providers.

Each ACO participating in the Shared Savings Program comprises a set of providers that is responsible for a specific population of Medicare beneficiaries assigned to that ACO based on primary care services provided to those patients. ACOs that keep spending for their assigned beneficiaries below a financial benchmark and achieve certain quality standards are eligible to share in a portion of the savings generated for the Medicare program. ACOs that choose to accept performance-based risk are also responsible for sharing in losses if spending exceeds the benchmark. Providers participating in a Shared Savings

Program ACO continue to receive traditional Medicare fee-for-service (FFS) payments under Parts A and B for services rendered to assigned beneficiaries.

Since its inception, the Shared Savings Program has evolved based on Centers for Medicare & Medicaid Services (CMS) refinements to the program through rulemaking.¹ This issue brief discusses key developments in the program resulting from final rules issued by CMS in 2015 and 2016.² These developments include policies to encourage ACOs to take on performance-based risk and to modify how benchmarks are calculated for ACOs in a second or subsequent agreement period to improve the sustainability of the program.

Strengthening Incentives by Encouraging Performance-based Risk Sharing

The incentive for controlling spending is believed to be weaker under the one-sided shared-savings-only model compared with two-sided models. One reason for this is that ACOs operating under a one-sided model have limited incentive to reduce the services they provide directly, because doing so would mean forgoing an FFS payment in exchange for an uncertain bonus (in the form of shared savings) down the road. Consequently, two-sided risk models—in which ACOs share in losses as well as in savings—are generally recognized as having the greatest potential for reducing unnecessary spending.³ However, to encourage ACOs to accept performance-based risk, two-sided models generally must offer greater expected rewards.

ACOs entering the Shared Savings Program initially had the option of choosing between a one-sided savings-only risk model (Track 1) and a two-sided risk model (Track 2) for an initial 3-year agreement period. ACOs renewing for a second agreement period would be required to participate in Track 2 to continue in the program.

Although Track 2 offers ACOs a higher share of savings than Track 1 (see Table 1), very few ACOs have selected this option, suggesting that most participants—or would-be participants—have not found the risk-reward tradeoff offered by this option to be attractive.⁴ This may reflect lack of experience on the part of ACOs in accepting and managing even limited financial risk. It may also indicate that the level of risk is too high or reflects an uncertainty that the necessary savings can be achieved.

A New Performance-based Risk Option: Track 3

In the June 2015 final rule, CMS finalized several policies aimed at encouraging ACOs to accept performance-based risk, including a new two-sided risk option known as Track 3. This new track offers greater financial rewards than the program's existing options; for example, up to 75% of generated savings. In exchange, however, organizations must be willing to assume greater risk for losses (see Table 1).

Another distinguishing feature of Track 3 is that ACOs choosing this option receive prospective assignment, meaning that an ACO will receive a list of its assigned beneficiaries prior to the start of a performance year. A Medicare beneficiary will be assigned to a Track 3 ACO if he or she receives more primary care services from that ACO's providers during a defined window prior to the start of the performance year than from other providers. This is in contrast to Track 1 or Track 2 ACOs that receive preliminary prospective assignment with retrospective reconciliation.⁵

By allowing providers to better target and monitor their efforts on a known set of patients, prospective assignment may encourage more ACOs to assume performance-based financial risk.⁶ However, a Track 3 ACO may not actually see all of its prospectively assigned beneficiaries during the

¹ For an overview of the Shared Savings Program based on the November 2011 final rule, see Cole Beebe, M., Pope, G., Kautter, J., et al. *Accountable Care Organizations in Medicare*. Research Triangle Park, NCRTI International. 2015. Available from https://www.rti.org/sites/default/files/accountable_care_organizations_in_medicare.pdf.

² Centers for Medicare & Medicaid Services. *Medicare Shared Savings Program: Accountable Care Organizations; Final Rule* (80 FR 32692, June 9, 2015); and *Medicare Shared Savings Program; Accountable Care Organizations—Revised Benchmark Rebased Methodology, Facilitating Transition to Performance-Based Risk, and Administrative Finality of Financial Calculations; Final Rule* (81 FR 37950, June 10, 2016).

³ McWilliams, J.M., Hatfield, L.A., Chernew, M.E., et al. *Early performance of Accountable Care Organizations in Medicare*. *New Eng J Med*. 374:2357-2366, June 2016. DOI: 10.1056/NEJMsa1600142

⁴ In 2013, five Track 2 ACOs were participating in the Shared Savings Program; by 2015, this number had fallen to three ACOs. See Centers for Medicare & Medicaid Services. *Shared Savings Program Accountable Care Organizations (ACO) public use files for 2013 and 2015*. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/SSPACO/>.

⁵ Using this methodology, an ACO receives preliminary lists of assigned beneficiaries during the performance year but does not receive the final list of beneficiaries for which the ACO is accountable until the time of financial reconciliation at the conclusion of the performance year.

⁶ The June 2015 final rule also modified the algorithm used to assign beneficiaries to ACOs. The new algorithm, which applies to both retrospective and prospective assignment, for example, considers primary care services rendered by nurse practitioners, physician assistants, and certified nurse specialists in the first step of the assignment process and no longer considers primary care services provided by surgeons and certain physician specialties. These changes were expected to better identify the providers managing the care of beneficiaries.

Table 1. Comparison of the Medicare Shared Savings Program Risk Models, Accountable Care Organization Agreement Periods Starting in 2016 or Later

	Track 1	Track 2	Track 3
Shared savings rate	Maximum of 50%	Maximum of 60%	Maximum of 75%
Shared loss rate	Not applicable	Minimum of 40%, Maximum of 60%	Minimum of 40%, Maximum of 75%
Shared savings cap	10% of updated benchmark	15% of updated benchmark	20% of updated benchmark
Shared loss cap	Not applicable	5% of updated benchmark in 1st performance year, 7.5% in 2nd performance year, 10% in 3rd and subsequent performance years	15% of updated benchmark
MSR/MLR	MSR: From 2.0 % to 3.9%, depending on total assigned beneficiaries. MLR: not applicable.	Choice of symmetrical MSR/MLR: 0%, 0.5% to 2.0% (in 0.5% increments), or 2.0% to 3.9% depending on total assigned beneficiaries	Choice of symmetrical MSR/MLR: 0%, 0.5% to 2.0% (in 0.5% increments), or 2.0% to 3.9%, depending on total assigned beneficiaries
Assignment methodology	Preliminary Prospective with Retrospective Reconciliation	Preliminary Prospective with Retrospective Reconciliation	Prospective
Skilled nursing facility waiver	No	No	Yes

Note: MSR/MLR = Minimum savings rate/Minimum loss rate

performance year—for example, because those beneficiaries chose to receive services from other providers—but is still accountable for Parts A and B Medicare spending on those patients. Also, a Track 3 ACO has the opportunity to apply for a programmatic waiver to Medicare’s 3-day skilled nursing facility (SNF) rule that typically requires a 3-day inpatient hospital stay before SNF services will be covered.⁷

Providing Choices: Minimum Savings Rate and Minimum Loss Rate

For a Shared Savings Program ACO to be eligible to receive shared savings, its benchmark expenditures must exceed actual expenditures by a certain threshold known as the minimum savings rate (MSR). This raises the probability that an ACO is rewarded for actual improvements in efficiency rather than random variation. Similarly, for

an ACO in a two-sided risk model, actual expenditures must exceed the benchmark by a threshold known as the minimum loss rate (MLR) for the ACO to be liable for shared losses.

Initially, a flat 2% MSR/MLR was applied to Track 2 ACOs. However, based on the June 2015 final rule, ACOs entering either Track 2 or Track 3 can choose from a menu of MSR/MLR options at the start of their agreement period beginning in 2016 and in subsequent years.⁸ An ACO that selects a higher MSR/MLR will have the protection of a higher threshold before liability for losses, although it will have a higher threshold to meet before being eligible to share in savings. An ACO that selects a lower MSR/MLR will have less protection against liability for losses, although it will benefit from a corresponding lower

⁷ As of January 2016, 16 Shared Savings Program ACOs were participating in Track 3 for the 2016 performance year, 6 were participating in Track 2, and 411 were participating in Track 1. See Centers for Medicare & Medicaid Services. Medicare Shared Savings Program Fast Facts. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/All-Starts-MSSP-ACO.pdf>. Last updated January 2017.

⁸ ACOs participating in Track 2 or Track 3 must choose from one of the following options for the MSR/MLR: (1) 0% MSR/MLR, (2) symmetrical MSR/MLR in a 0.5 percent increment between 0.5% and 2.0%, or (3) symmetrical MSR/MLR that varies, based on the number of beneficiaries assigned to the ACO, as used for Track 1.

threshold for sharing in savings. Providing the flexibility for ACOs to select a threshold in accordance with their risk tolerance has the potential to make two-sided risk models more attractive to a larger number of participants.

Transitioning to Risk

CMS has also created more options for ACOs entering the Shared Savings Program in Track 1 to transition to two-sided risk. Following the June 2015 rule, these ACOs are now allowed to remain in Track 1 for a second 3-year agreement period. While this change may seem to work against the goal of moving more participants to two-sided risk, it could lead to continued participation and ultimately to acceptance of performance-based risk in a third agreement period for ACOs that would otherwise leave the program after the initial 3 years. For Track 1 ACOs that are not ready to transition to a two-sided risk model after the initial agreement period but do not want to wait another 3 years, the June 2016 final rule created a new option under which an ACO can effectively extend its first agreement period for a fourth year before moving to Track 2 or Track 3.

Improving Program Sustainability Through Changes in the Benchmark Methodology

The methodology used to set financial benchmarks plays an integral role in determining whether an ACO achieves savings or incurs losses. Consequently, the chosen approach can have ramifications for an ACO's willingness to participate in the program, its willingness to accept performance-based risk, and its financial success. Ultimately, these factors affect the program's ability to meet its goals of improving patient care and population health while reducing costs.

Establishing an ACO's First Agreement Period Benchmark

For an ACO entering the Shared Savings Program, the benchmark is based on historical expenditures for beneficiaries who would have been assigned to the ACO in the 3 years prior to the start of the ACO's agreement period. Mean per capita expenditures for the first 2 historical years are trended forward to the third year

using national Medicare FFS expenditure trends and are also risk-adjusted. Expenditures for the 3 years are then combined, with the more recent years receiving greater weight.

These calculations are performed separately for each of four Medicare enrollment types, with the results then weighted together based on the proportion of assigned beneficiaries in each type.⁹ The historical benchmark is adjusted each performance year for changes in assigned beneficiary health risk, and updated by the projected absolute amount of growth in national per capita expenditures for Parts A and B services under the original Medicare FFS program and by changes in the proportions of assigned beneficiaries for the four Medicare enrollment types. The updated benchmark is then used to determine savings and losses.¹⁰

Rebasing an ACO's Benchmark in Its Second or Subsequent Agreement Period

Originally, Shared Savings Program regulations did not specify using a different approach for determining the benchmark for an ACO's second or subsequent agreement period (see Table 2). Rather, an ACO continuing in the program would receive a new historical benchmark calculated using the same methodology but based on the 3 years immediately preceding the new agreement period. The process for resetting the benchmark is referred to as "rebasings."

Several concerns surround using an ACO's own historical expenditures to determine its benchmark, particularly as ACOs move beyond their initial agreement period. Many stakeholders have argued that using this rebasing methodology is unfair to ACOs that successfully reduced beneficiary expenditures in the prior period. Using rebased historical expenditures could yield high benchmarks for inefficient ACOs—which may fail to provide sufficient incentive for providers in these organizations to reduce spending in meaningful ways. At the same time, this approach would tend to produce relatively lower benchmarks—which are more difficult to beat—for ACOs that have demonstrated success in reducing expenditures, potentially providing a disincentive for their continued participation. Essentially, this methodology tends to favor continued improvement rather than attainment of savings.

⁹ The four enrollment types are (1) entitled by end-stage renal disease, (2) entitled by disability (under age 65), (3) entitled by age and by receiving Medicaid benefits (dual eligible), and (4) entitled by age and not receiving Medicaid benefits.

¹⁰ Per the 2016 final rule, beginning in 2017 the program's benchmarking methodology is also amended to use assignable beneficiaries who have had at least one primary care service visit with a physician as the basis for all national FFS inputs. Assignable beneficiaries will also be the bases of all regional factors used in rebased benchmark calculations.

Stakeholders have also raised concerns that national trend and update factors used in benchmarking calculations do not adequately capture factors unique to the region the ACO serves, including the health status of the region's population, the geographic composition of the region (such as rural versus urban areas), and socioeconomic differences within the regional population.

The Shared Savings Program's June 2015 and June 2016 final rules addressed these concerns.

Rebasing for Agreement Periods Beginning in 2016: Adjusting for Prior Success

To address the potential of successful ACOs being penalized and to encourage their continued participation in the Shared Savings Program, CMS adopted two changes to the approach for computing rebased benchmarks in the June 2015 final rule, which are summarized in Table 2. Both modifications were used in the calculation of rebased benchmarks for the program's initial entrants that began their second agreement period on January 1, 2016.

First, expenditures for the three benchmark years for an ACO's second agreement period would be weighted equally,

rather than assigning higher weights to the later years. An ACO is likely to have more success in lowering beneficiary expenditures in the second and third years of its initial agreement period because the ACO gains more experience in the program. Also, because these years correspond to the second and third benchmark years of the new agreement period, equal weighting can reduce the decline in benchmarks that a successful ACO may otherwise experience, increasing the incentive to continue in the Shared Savings Program.

Second, the rebasing methodology includes an adjustment for prior period savings, which also benefits successful ACOs. To do this, CMS calculates per capita total savings (total benchmark expenditures minus total assigned beneficiary expenditures) for each of the 3 years of the prior agreement period and then uses the average of these three values. This average per capita savings amount is then multiplied by the ACO's average final sharing rate that takes into account quality performance over those years, resulting in a per capita adjustment amount.¹¹ Any ACO that generates positive savings, on average, is eligible for an adjustment to their rebased benchmark, regardless of whether the savings generated in any particular year

Table 2. Evolution of the Medicare Shared Savings Program Rebasing Methodology

	November 2011 Final Rule	June 2015 Final Rule	June 2016 Final Rule
Factors used for trending earlier benchmark years	Percentage change in national FFS expenditures	Percentage change in national FFS expenditures	Percentage change in regional FFS expenditures
Weighting of benchmark years	10% to 30% to 60%	Equal	Equal
Prior savings adjustment	None	Yes	None
Regional adjustment	None	None	Yes
Benchmark update factor	Dollar amount of projected growth in national FFS expenditures from third benchmark year to performance year	Dollar amount of projected growth in national FFS expenditures from third benchmark year to performance year	Percentage growth in regional FFS expenditures from third benchmark year to performance year
First cohort for which methodology will apply	Not applicable	ACOs starting second agreement period in 2016	ACOs starting second or subsequent agreement period in 2017 and subsequent years

Note: ACOs = Accountable Care Organizations, FFS = Fee for service

¹¹ The June 2015 final rule also places a threshold on the number of assigned beneficiaries to which the adjustment can be applied. If an ACO's assigned beneficiary population increases between agreement periods, the per capita adjustment amount is reduced proportionally.

Table 3: Hypothetical Numerical Example of the Medicare Shared Savings Program Regional Adjustment to Rebased Benchmark for a Given Enrollment Type, First Agreement Period in Which Adjustment Is Applied

	ACO A (Lower Spending Compared with Regional Service Area)	ACO B (Higher Spending Compared with Regional Service Area)
Rebased benchmark expenditure [A]	\$10,000	\$10,000
Regional expenditures [B]	\$12,000	\$8,000
Regional adjustment [C] = [B] – [A]	\$2,000	–\$2,000
Weight applied to adjustment [D]*	35%	25%
Adjusted rebased benchmark [E] = [A] + ([C] × [D])	\$10,700	\$9,500

Note: ACO = Accountable Care Organization

*The determination of the percentage weight [D] within a particular agreement period will be based on whether the weighted average difference between the regional expenditure and the ACO's rebased benchmark expenditures across the four enrollment types is greater than or less than zero.

exceeded the ACO's MSR. Furthermore, an ACO that generates negative savings (i.e., losses), on average, does not receive any adjustment; consequently, its benchmark is not lowered by its past losses.

Rebasing for Agreement Periods Beginning in 2017 and Subsequent Years: Incorporating Factors Based on Regional Fee-for-Service Expenditures

The June 2016 final rule made further modifications to the rebasing methodology, which are summarized in Table 2. For second or subsequent agreement periods beginning in 2017 or later years, CMS will use regional as opposed to national trend factors, a change that will tend to favor ACOs operating in areas with high expenditure growth. Further, the rebased benchmark will no longer be adjusted for savings generated in the prior agreement period. Instead, a regional adjustment is applied to the rebased historical benchmark to account for differences between the regional FFS expenditures in the ACO's regional service area and the ACO's historical expenditures.¹²

The adjustment, which is to be calculated separately for the four Medicare enrollment types, is equal to the difference

between the risk-adjusted regional expenditure amount and the rebased benchmark expenditure, multiplied by a set percentage that will increase over time. For ACOs that have lower spending compared with their regional service area based on a weighted average across the four enrollment types, the percentage is initially set to equal 35% in the first agreement period using the new methodology, increasing to a maximum of 70% in the next agreement period.

ACOs that would be disadvantaged by the regional adjustment—such as ACOs that have higher spending in their regional service area based on a weighted average across the four enrollment types—would receive a slower phase-in. A numerical example of the regional adjustment calculation for two hypothetical ACOs is shown in Table 3, one with lower spending than its regional service area (ACO A) and one with relatively higher spending (ACO B). Under the new regulations, rebased benchmark expenditures for each enrollment type will be updated for the performance year using an update factor equal to percent growth per capita expenditures for the ACO's regional service area, as opposed to the projected absolute amount of growth in national per capita expenditures for the FFS population.

¹² For these calculations, an ACO's region comprises the counties in which at least one assigned beneficiary resides. Regional expenditures are calculated as a weighted average of risk-adjusted county expenditures, with weights based on the proportion of assigned beneficiaries residing in each county.

The expected result of the new rebasing policy is that over time an ACO's benchmark will become less dependent on the ACO's own historical expenditures and more reflective of cost factors outside the ACO's direct control—that is, geographic (area) cost levels and the underlying health status risk of the ACO's assigned beneficiary population. It also aligns the Shared Savings Program more closely with Medicare Advantage, in which payments also account for geographic expenditure variation and beneficiary health status risk. While likely more equitable over the long term, the new approach should have differing impact for ACOs depending on how their spending aligns with that of their region. In particular, ACOs that are inefficient (higher cost) relative to their regions may be deterred from entering or continuing in the program, or at least from accepting two-sided risk.

Next Steps

The recent changes adopted in the Shared Savings Program through rulemaking by CMS strengthen incentives for efficiency and effect changes in benchmarking policies aimed at improving program sustainability. CMS is also

developing Track1+, a new model that will provide ACOs another option for moving to performance-based risk.¹³ Moving forward, it will be important for CMS to monitor the effects of these policy changes—particularly as they pertain to participation and performance of ACOs that have higher spending than their regions—and to make further refinements, as necessary, to help the program meet its three-part aim of achieving better care for individuals, achieving better health for populations, and reducing health care costs.

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¹³Centers for Medicare & Medicaid Services. Advancing Care Coordination through Episode Payment Models (Cardiac and Orthopedic Bundled Payment Models) Final Rule (CMS-5519-F) and Medicare ACO Track 1+ Model. <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-12-20.html>. Last updated December 20, 2016.

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