CMS Ensured That Medicare Shared Savings Program Beneficiaries Were Properly Assigned:

Beneficiaries Were Assigned to Only One Accountable Care Organization and Were Not Assigned to Other Shared Savings Programs

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Contents

Glossary of Terms

- **Accountable Care Organization (ACO) participant:** An eligible provider or supplier (or a group of providers or suppliers) that voluntarily participates in the Medicare Shared Savings Program (MSSP).

- **Agreement period:** An ACO agrees to participate in the MSSP for at least 3 performance years.

- **Performance Year (PY):** A 12-month period beginning on January 1 of each year during an ACO's agreement period in the MSSP. For PY 2013, an ACO's first performance year, the PY could also be for 18 or 21 months and could begin on April 1 or July 1, 2012.

- **Track:** A financial risk model that an ACO can operate under the MSSP. In track 1, an ACO can share only savings. In tracks 2 and 3, an ACO can share in savings or losses.

Disclaimer: The definitions in this glossary are for the purposes of this report only and may not be the same definitions used in Federal regulations and CMS guidance.

Why We Did This Review

- The MSSP was established by the Patient Protection and Affordable Care Act (ACA) to facilitate coordination and cooperation among providers and suppliers to:
  - improve quality of care for Medicare Parts A and B fee-for-service (FFS) beneficiaries and
  - reduce health care costs.
- We reviewed the MSSP as part of OIG's body of work covering the Centers for Medicare & Medicaid Services' (CMS) administration and testing of payment and service delivery models.
- This is one of several OIG reviews examining aspects of ACOs under the MSSP.
- OIG may also examine other aspects of ACOs under other shared savings programs.

Objective

Our objective was to determine whether CMS complied with certain Federal requirements when assigning beneficiaries to ACOs in the MSSP during PYs 2013 through 2015 (first 3 PYs of the program).*

* See slide 15 for these Federal requirements.

Background:
Traditional Medicare Fee-For-Service

- CMS administers Medicare's traditional FFS program.
- Under FFS, Medicare reimburses providers and suppliers for services and specific items they provide.
- Medicare's FFS reimbursement method tends to reward providers and suppliers for the volume of services delivered rather than the quality of those services.
- Delivery of care is often fragmented because of insufficient incentives to coordinate care and improve quality.

Background:
Medicare Accountable Care Organizations

- A Medicare ACO is a type of health care entity formed by one or more ACO participants, such as doctors, hospitals, and other health care providers.
- ACO participants are encouraged to coordinate care for their Medicare beneficiaries and reduce health care costs while improving quality of care.
- A goal of coordinated care is to ensure that beneficiaries, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

Background: Medicare Shared Savings Program

- ACA § 3022 required CMS to establish the MSSP no later than January 1, 2012.
- Eligible providers and suppliers may voluntarily participate in the MSSP by creating or joining an ACO.
- Medicare continues to pay ACO participants under FFS.
- ACOs may be eligible to receive additional payments (i.e., shared savings payments) if they reduce health care costs and meet certain quality performance standards. ACOs may also be responsible for a portion of any shared losses.

Background: Accountable Care Organizations in the Medicare Shared Savings Program

- An ACO submits an application to CMS to participate in the MSSP.
- To be approved to participate, an ACO must:
  - have at least 5,000 beneficiaries;
  - meet all other eligibility and program requirements, including the requirement that an ACO participant providing primary care services belong to only 1 ACO; and
  - agree to participate in the program for an agreement period.

Background: Accountable Care Organizations in the Medicare Shared Savings Program

- The amount of a shared savings payment an ACO receives or a shared loss it owes to CMS depends on the track that it chooses to participate in during its agreement period.*

Track	ACO's Share of Savings (%)	ACO's Share of Losses (%)
1	Up to 50%	Not liable
2	Up to 60%	Up to 60%
3	Up to 75%	Up to 75%

- ACOs had the option to choose only tracks 1 or 2 during the first 3 PYs of the MSSP.**
- In PY 2015, 7.3 million beneficiaries were assigned to 392 ACOs, and 119 ACOs (30 percent) received $646 million in shared savings payments.

* Even though an ACO can share up to 50, 60, or 75 percent of generated savings or losses, CMS limits the shared savings payment (amount paid to the ACO) or loss recoupment amount (amount owed to CMS) based on the PY and track the ACO is in.
** Track 3 was added as an option beginning in PY 2016.

Background: Calculation of Shared Savings Payments

Step 1: CMS determined an ACO's target health care costs at the beginning of each PY using historical Medicare claim data for beneficiaries who would have been assigned to an ACO.*

Step 2: CMS determined an ACO's actual health care costs using Medicare claim data for the assigned beneficiaries during the PY.

Step 3: Generally, if actual health care costs were less than target health care costs, the ACO generated savings. However, if the actual health care costs were greater than target health care costs, the ACO incurred losses.

Step 4: CMS generally calculated the amount of shared savings or losses, if any, by multiplying the generated savings or losses by the ACO's share-of-savings or share-of-losses percentage and its quality score (maximum of 100 percent).**

Step 5: CMS provided shared savings payments to the ACO, which then distributed those payments to ACO participants.

* In CMS's final rule issued on June 6, 2016, CMS revised its methodology for calculating an ACO's target health care costs in later agreement periods beginning in PY 2017.

** An ACO's quality score was calculated based on points earned as a result of reporting and meeting certain quality performance standards.

Background: Beneficiary Assignment

- Each PY, CMS assigns a Medicare beneficiary to an ACO based on where he or she receives a plurality of primary care services as determined by the highest Medicare allowed amount for services when compared with other ACOs, individual providers, or provider organizations.
- For ACOs in tracks 1 or 2, CMS assigned beneficiaries six times each PY, resulting in six different lists of beneficiaries.
- CMS grouped these lists into two types:
  - **Preliminary prospective beneficiary assignment lists:** initial and quarterly lists of beneficiaries an ACO was likely to be accountable for. An ACO could use these lists to improve quality of care and reduce health care costs for its potentially assigned beneficiaries throughout each PY.
  - **Final retrospective beneficiary assignment list:** the final list of actual beneficiaries assigned at the end of the PY. CMS used this list to determine an ACO's shared savings and losses for each PY.

Background: Beneficiary Assignment

- The designated ACO is responsible for the quality and cost of care* of Medicare beneficiaries during a PY.
- Beneficiary assignment is the basis for many key MSSP operations, such as determining an ACO's financial performance and reporting quality measures after each PY.
- To be assigned to an ACO, a beneficiary must meet assignment eligibility criteria, including (1) obtaining at least one primary care service from a physician who is an ACO participant and (2) not being enrolled in managed care (Medicare Part C).

* The cost of care is limited to Medicare Part A and Part B care.

Background: Beneficiary Assignment

- Assigned beneficiaries continue to be free to choose health care providers and are not limited to obtaining services from ACO participants.
- CMS used Medicare claims for primary care services to assign beneficiaries to an ACO based on a two-step beneficiary assignment process:*
  - **Step 1:** CMS assigned a beneficiary to an ACO if he or she received a plurality of primary care services from primary care physicians participating in the ACO, as measured by Medicare Part B allowed charges.
  - **Step 2:** If a beneficiary did not receive any primary care services from a primary care physician, either inside or outside the ACO, CMS assigned the beneficiary to an ACO if he or she received a plurality of primary care services from another ACO participant (e.g., a non-primary-care physician, nurse practitioner, or physician assistant).

* CMS's beneficiary assignment is an operational process, which is not a result of a beneficiary's action or request. CMS revised the two-step beneficiary assignment process in PY 2016.

Background: Beneficiary Assignment

- CMS must ensure that any ACO participant that provides primary care services is a participant in no more than one ACO.
- This ensures that beneficiaries who receive primary care services from that participant are assigned to only a single ACO in the MSSP.*
- CMS may not assign a beneficiary to the MSSP if he or she is assigned to another shared savings program that provides shared savings payments (e.g., Independence at Home Demonstration and Next Generation ACO Model).**

* 42 CFR § 425.306(b) and 76 Fed. Reg. 67802, 67810–11 (Nov. 2, 2011).
** 42 CFR §§ 425.114(a) and 425.401(a)(3).

How We Conducted This Review

- Our review covered approximately 9.7 million beneficiaries whom CMS assigned to ACOs in the MSSP during the first 3 PYs.
- We reviewed data related to beneficiaries on the final retrospective beneficiary assignment list.
- We focused our review on determining whether CMS ensured that (1) beneficiaries were assigned to only one ACO in the MSSP and (2) beneficiaries who were assigned to the MSSP were not assigned to other shared savings programs. (Beneficiaries assigned to more than one ACO or to multiple shared savings programs are referred to as “overlapping beneficiaries.”)

How We Conducted This Review

- To accomplish our objective, we:
  - reviewed CMS's beneficiary assignment data, including which shared savings program a beneficiary was assigned to and the beneficiary's participation dates in the program;
  - reviewed CMS's policies and procedures and interviewed CMS officials and program contractors to obtain an understanding of CMS's overall beneficiary assignment process; and
  - interviewed officials from five ACOs that participated in the first 3 PYs of the MSSP to obtain an understanding of the program from the ACOs' point of view.
- We did not review CMS's two-step beneficiary assignment process to determine whether beneficiaries were assigned to the correct ACO.

How We Conducted This Review

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Results of Our Review

- CMS complied with Federal requirements when assigning beneficiaries to ACOs in the MSSP during PYs 2013 through 2015 by ensuring that MSSP beneficiaries:
  - were assigned to only one ACO and
  - were not assigned to other shared savings programs.
- Accordingly, we are making no recommendations.

Results of Our Review

- CMS's processes for ensuring compliance with the Federal requirements when assigning beneficiaries to ACOs in the MSSP included the following:

  - To ensure that beneficiaries were assigned to only one ACO, CMS determined whether an ACO participant belonged to only one ACO during the application process. If an ACO participant belonged to more than one ACO, CMS requested that the ACO work with the ACO participant to select only one before CMS would approve the ACO's application.

  - To ensure that beneficiaries were not assigned to other shared savings programs, CMS had processes to identify and resolve the beneficiary overlaps.*

* See the Appendix, slides 21 through 23.

Appendix: CMS's Process for Identifying Overlaps in Beneficiary Assignments

- CMS's process for identifying beneficiaries who were assigned to multiple shared savings programs (i.e., overlapping beneficiaries) included reviews by:
  - a CMS contractor to identify and resolve any overlaps between the MSSP and other shared savings programs (more information on slide 22) and
  - CMS to identify and resolve any overlaps among shared savings programs (more information on slide 23).

Appendix:
CMS Contractor's Review of Beneficiary Overlaps

CMS explained the process used by a CMS contractor to identify and resolve any beneficiary overlaps between the MSSP and other shared savings programs:

1. A CMS contractor performs beneficiary assignments and prepares a list of beneficiaries for the MSSP using Medicare claims from the IDR.

2. The contractor then downloads the beneficiary assignment data for other shared savings programs from the MDM.

3. The contractor compares the beneficiary assignment list from the IDR and the beneficiary assignment data from the MDM.

4. The contractor identifies and removes overlapping beneficiaries from the MSSP beneficiary assignment list and uploads the revised MSSP beneficiary assignment list to the MDM.

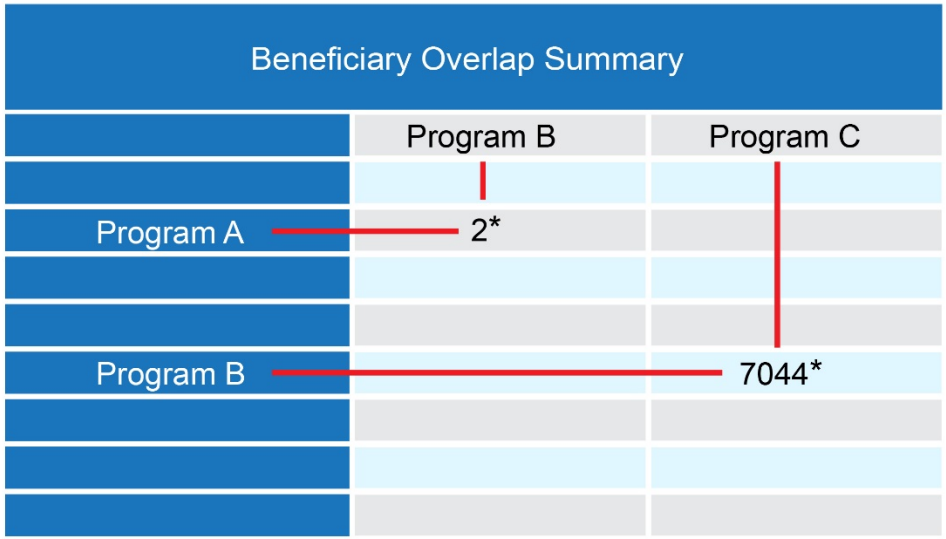
Integrated Data Repository (IDR): A data warehouse that contains CMS beneficiary, claim, and provider data.

Master Data Management System (MDM): A repository system that stores beneficiary assignment data for all shared savings programs.

Appendix:
CMS's Review of Beneficiary Overlaps

CMS explained the process it uses to identify and resolve any beneficiary overlaps among shared savings programs:

1. CMS uses the beneficiary assignment data loaded in the MDM to generate an overlap report.
2. CMS identifies overlapping beneficiaries among shared savings programs.
3. CMS determines which program the beneficiaries will ultimately be assigned to.
4. CMS removes an overlapping beneficiary from one of the shared savings programs by updating the beneficiary's participation dates.



* Number of overlapping beneficiaries between shared savings programs.