MEDICARE SHARED SAVINGS PROGRAM

Performance Year 2016 Quality Performance and Financial Reconciliation Results for ACOs with 2012-2016 Start Dates

October 19, 2017

Medicare Shared Savings Program

Agenda

- Introduction
  - Delivery of Annual Financial and Quality Reports
  - Defining the Performance Year (PY) 2016 Time Period
  - Descriptive Statistics on Shared Savings Program Accountable Care Organizations (ACOs)
- PY 2016 Quality Performance Results
- PY 2016 Financial Performance Results
  - Part I: Overview of Results
  - Part II: Benchmarks and Risk Adjustment
  - Part III: Non-Claims Based Payments and Trends in Expenditures, Utilization, and Beneficiary Turnover
- Questions and Answers

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Introduction

- Report Timeline
- Time Periods for ACOs Reconciled in PY 2016
- Payment Characteristics of ACOs Reconciled in PY 2016
- Entity Type of ACOs Reconciled in PY 2016
- ACO Size and Historical Benchmark Level of ACOs Reconciled in PY 2016

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PY 2016 Final Report Timeline

- CMS delivered reports to 432 ACOs on the following dates:
  - On August 2, 2017, CMS delivered embargoed 2016 Quality Performance Reports and 2016 Consumer Assessment of Healthcare Providers & Systems (CAHPS) Performance Reports
    - ACO Quality Report; ACO-11 Detailed Report; CAHPS Report
  - On September 5, 2017, CMS delivered embargoed 2016 Financial Reconciliation Reports and accompanying informational reports to ACOs
    - Settlement Report; Aggregate Expenditure/Utilization Report; Assignment List Report; Assignment Summary Report
  - On October 13, 2017, CMS delivered unembargoed versions of the reports.
    - ACO Quality Report; ACO-11 Detailed Report; CAHPS Report; Settlement Report; Assignment List Report; Assignment Summary Report (Track 3 ACOs only)
- Reports are accessible through your ACO's Managed File Transfer (MFT) mailbox for 30 days from delivery date and through the Shared Savings Program ACO Portal indefinitely.

Time Periods for ACOs Reconciled in PY 2016

- 2016 renewals (2012 and 2013 starters) (147 ACOs)
  - Historical benchmark years: 2013, 2014, 2015
  - 2016 is PY1 of second agreement period
- 2014 starters (100 ACOs)
  - Historical benchmark years: 2011, 2012, 2013
  - 2016 is PY3 of first agreement period
- 2015 starters (85 ACOs)
  - Historical benchmark years: 2012, 2013, 2014
  - 2016 is PY2 of first agreement period
- 2016 starters (100 ACOs)
  - Historical benchmark years: 2013, 2014, 2015
  - 2016 is PY1 of first agreement period

Payment Characteristics of ACOs Reconciled in PY 2016

- Payment characteristics for ACOs
  - 410 in Track 1 (one-sided shared savings model)
  - 6 in Track 2 (two-sided shared savings/losses model)
  - 16 in Track 3 (two-sided shared savings/losses model)
  - 63 participating in Advance Payment (AP) or ACO Investment Model (AIM)

Entity Type of ACOs Reconciled in PY 2016

- ACO entity type (based on Provider Enrollment, Chain, and Ownership System (PECOS) and participant list data)
  - 134 physicians only (group and/or individual practices)
  - 58 with a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC), but no hospital
  - 226 with hospital(s)
  - 8 with a post acute care facility, but no hospital or FQHC/RHC
  - 6 with another facility type, but no hospital, FQHC/RHC, or post acute care facility

ACO Size and Historical Benchmark Level of ACOs Reconciled in PY 2016

- ACO size (# of assigned beneficiaries)
  - 169 with <10,000 assigned beneficiaries
  - 148 with 10,000 - 19,999 assigned beneficiaries
  - 51 with 20,000 - 29,999 assigned beneficiaries
  - 64 with 30,000+ assigned beneficiaries
- Historical benchmark level ($)*
  - 242 with historical benchmarks >= 2016 national fee-for-service (FFS) mean total expenditure ($9,804)
  - 190 with historical benchmarks < 2016 national FFS mean total expenditure ($9,804)

* As a reference, the National FFS mean total expenditures for 2016 is equal to $9,804

PY 2016 Quality Performance Results

- Overview of Quality Measurement Approach
- Overview of Quality Performance Assessment
- Quality Measure Descriptive Statistics, by domain
- Highlights
- Opportunities for Improvement
- Quality Improvement Reward
- Summary of PY 2016 Quality Results

Overview of Quality Measurement Approach

- 34 quality measures serve as the basis for assessing, benchmarking, and paying for ACO quality performance, and are separated into the following four key domains:
  - Patient/Caregiver Experience
  - Care Coordination/Patient Safety
  - Preventive Health
  - At-Risk Population

Overview of Quality Performance Assessment

- ACOs are required to meet the quality performance standard applicable to the performance year in order to be eligible to share in savings.
  - PY1 of first agreement period = Complete and accurate quality data reporting
  - PY2 of first agreement period and all subsequent performance years = Complete and accurate reporting and performance benchmarks are phased

	PY1 (2016 starter)	PY2 (2015 starter)	PY3 and beyond (2014 starters, 2016 renewals)
Pay-for-Performance Measures	0	17	23
Pay-for-Reporting Measures	34	17	11
Total Number of Measures	**34**	**34**	**34**

Overview of Quality Performance Assessment (cont.)

	2012 Reporting Period	2013 Reporting Period	2014 Reporting Period	2015 Reporting Period	2016 Reporting Period
Met Quality Performance Standard	109 (96%)	214 (97%)	322 (97%)	388 (98%)	428 (99%)
Did not Meet Quality Performance Standard	5 (4%)	6 (3%)	11 (3%)	9 (2%)	4 (1%)
Total Number of ACOs	**114**	**220**	**333**	**397**	**432**

Overview of Quality Performance Assessment (cont.)

- ACOs' performance on each Pay-for-Performance measure is compared to a national benchmark based on FFS data
  - ACOs earn points for each Pay-for-Performance measure based on a sliding scale
  - Performance below the minimum attainment level (i.e., below 30 percent or below 30th percentile) would earn zero points for that measure
- Additional quality improvement (QI) points available for each domain for ACOs beyond PY1 of their first agreement period
  - Methodology used to determine QI Reward points mirrors Medicare Advantage's Five Star Rating Program
    - ACOs can earn up to an additional 4.00 points to the number of points earned in each domain, not to exceed the maximum points that are possible in that domain
  - 33 measures were available for the QI Reward (i.e., had two years of available data).

Overview of Quality Performance Assessment (cont.)

- Points assigned on a sliding scale based on domain improvement score:

$$100 * \frac{\left(\begin{array}{c}Number\ of\ measures\ with\ a\ statistically\ significant\ improvement \\ -Number\ of\ measures\ with\ a\ statistically\ signficant\ decline\end{array}\right)}{Number\ of\ Eligible\ Measures}$$

Domain Improvement Score	Quality Improvement Points
90+ percent	4.0 points
80+ percent	3.56 points
70+ percent	3.12 points
60+ percent	2.68 points
50+ percent	2.24 points
40+ percent	1.8 points
30+ percent	1.36 point
20+ percent	0.92 point
10+ percent	0.48 point
<10 percent	No points

- Points earned (capped at the total possible points available in the domain) are divided by the total points available for that domain to produce a domain score.
- Domain scores are averaged to arrive at an overall quality score.

2016 Quality Measure Descriptive Statistics Patient/Caregiver Experience Domain

Quality Measure	Description	Shared Savings Program Median 2015 Performance	Shared Savings Program Median 2016 Performance	Percent Change (Improvement/ Decline)
ACO-1	CAHPS: Getting Timely Care, Appointments, and Information	80.23	80.13	-0.12%
ACO-2	CAHPS: How Well Your Providers Communicate	92.65	92.99	0.37%
ACO-3	CAHPS: Patients' Rating of Provider	92.05	92.16	0.12%
ACO-4	CAHPS: Access to Specialists	83.71	83.71	0.00%
ACO-5	CAHPS: Health Promotion and Education	59.04	60.09	1.78%
ACO-6	CAHPS: Shared Decision Making	74.99	75.35	0.48%
ACO-7	CAHPS: Health Status/Functional Status	72.20	71.95	-0.35%
ACO-34	CAHPS: Stewardship of Patient Resources	27.00	27.58	2.15%

2016 Quality Measure Descriptive Statistics Care Coordination/Patient Safety Domain

Quality Measure	Description	Shared Savings Program Median 2015 Performance	Shared Savings Program Median 2016 Performance	Percent Change (Improvement/ Decline)
ACO-8	Risk Standardized, All Condition Readmissions	14.82	14.65	-1.15%
ACO-35	Skilled Nursing Facility 30-day All-Cause Readmission measure (SNFRM)	18.02	18.08	0.33%
ACO-36	All-Cause Unplanned Admissions for Patients with Diabetes	53.69	51.94	-3.26%
ACO-37	All-Cause Unplanned Admissions for Patients with Heart Failure	75.86	74.11	-2.31%
ACO-38	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	61.82	59.17	-4.29%
ACO-9	Ambulatory Sensitive Condition Admissions: Chronic Obstructive Pulmonary Disease or Asthma Older Adults (AHRQ Prevention Quality Indicator (PQI) #5)	1.08*	1.15*	NA
ACO-10	Ambulatory Sensitive Condition Admissions: Heart Failure (AHRQ Prevention Quality Indicator (PQI) #5)	1.03*	1.04*	NA
ACO-11	Percent of PCPs who Successfully Meet Meaningful Use Requirements	83.03%	89.47%	7.76%
ACO-13	Falls: Screening for Fall Risk	58.70%	65.64%	11.82%
ACO-39	Documentation of Current Medications in the Medical Record	91.00%	93.32%	2.55%

* Expressed as Observed/Expected ratio

2016 Quality Measure Descriptive Statistics Preventive Health Domain

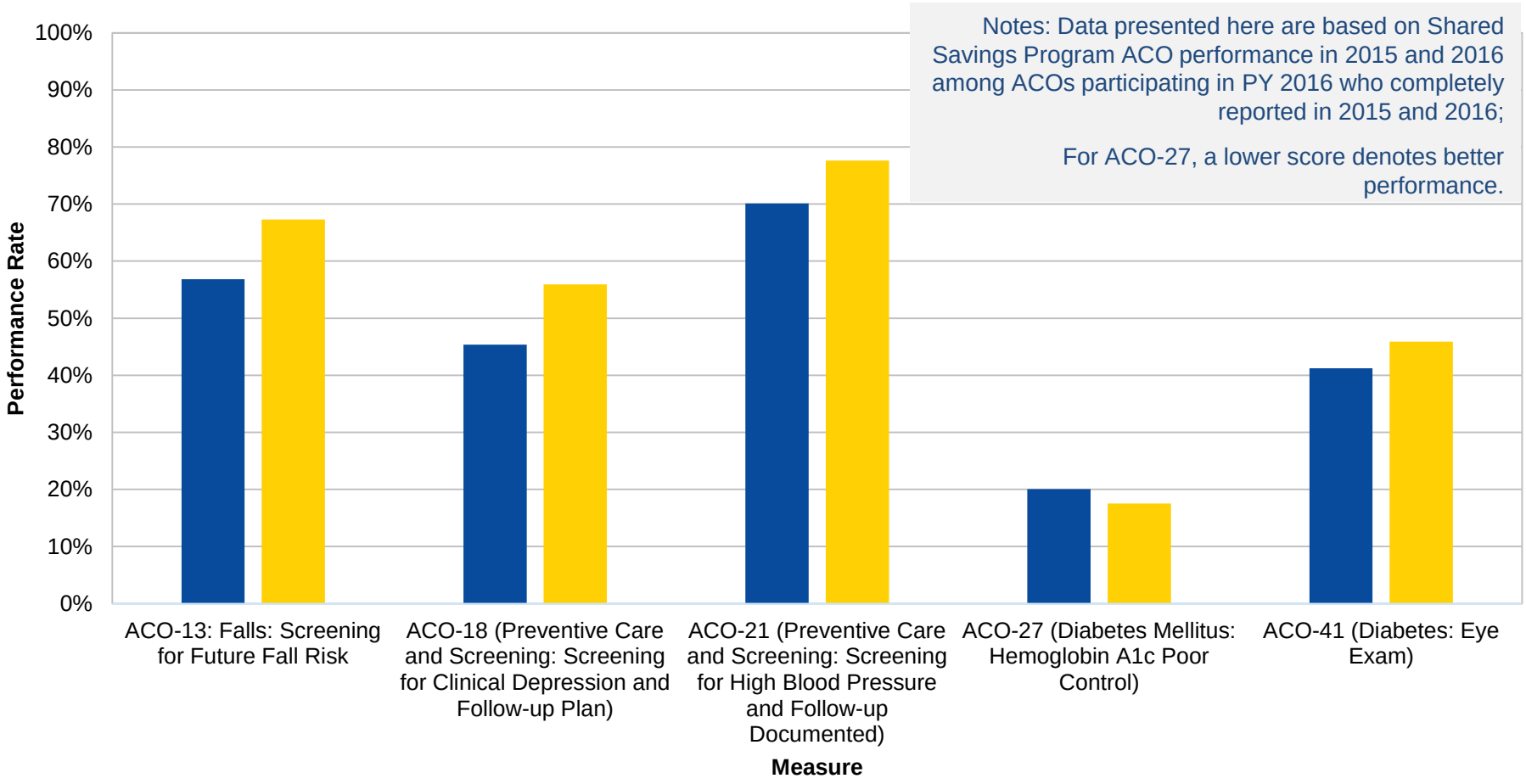
Quality Measure	Description	Shared Savings Program Median 2015 Performance	Shared Savings Program Median 2016 Performance	Percent Change (Improvement/ Decline)
ACO-14	Influenza Immunization	63.18%	69.60%	10.16%
ACO-15	Pneumococcal Vaccination	66.07%	71.98%	8.95%
ACO-16	Adult Weight Screening and Follow-up	71.94%	76.25%	5.99%
ACO-17	Tobacco Use Assessment and Cessation Intervention	92.66%	94.03%	1.48%
ACO-18	Depression Screening	45.28%	53.43%	18.00%
ACO-19	Colorectal Cancer Screening	61.32%	63.24%	3.13%
ACO-20	Mammography Screening	66.22%	68.94%	4.11%
ACO-21	Proportion of Adults who had Blood Pressure Screened in Past 2 Years	74.06%	80.80%	9.10%
ACO-42	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	-	78.78%	-

2016 Quality Measure Descriptive Statistics At-Risk Population Domain

Quality Measure	Description	Shared Savings Program Median 2015 Performance	Shared Savings Program Median 2016 Performance	Percent Change (Improvement/ Decline)
ACO-40	Depression Remission at Twelve Months	0.00%	2.33%	
Diabetes Composite	Diabetes Composite (All or Nothing Scoring)	33.96%	38.59%	13.63%
ACO-27^	Diabetes Mellitus: Hemoglobin A1c Poor Control	17.29%	16.38%	-5.26%
ACO-41^	Diabetes: Eye Exam	40.24%	44.26%	9.99%
ACO-28	Hypertension (HTN): Controlling High Blood Pressure	69.98%	70.68%	1.00%
ACO-30	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	86.36%	87.43%	1.24%
ACO-31	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	90.14%	91.24%	1.22%
ACO-33	Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy - for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVEF<40%)	79.19%	80.52%	1.68%

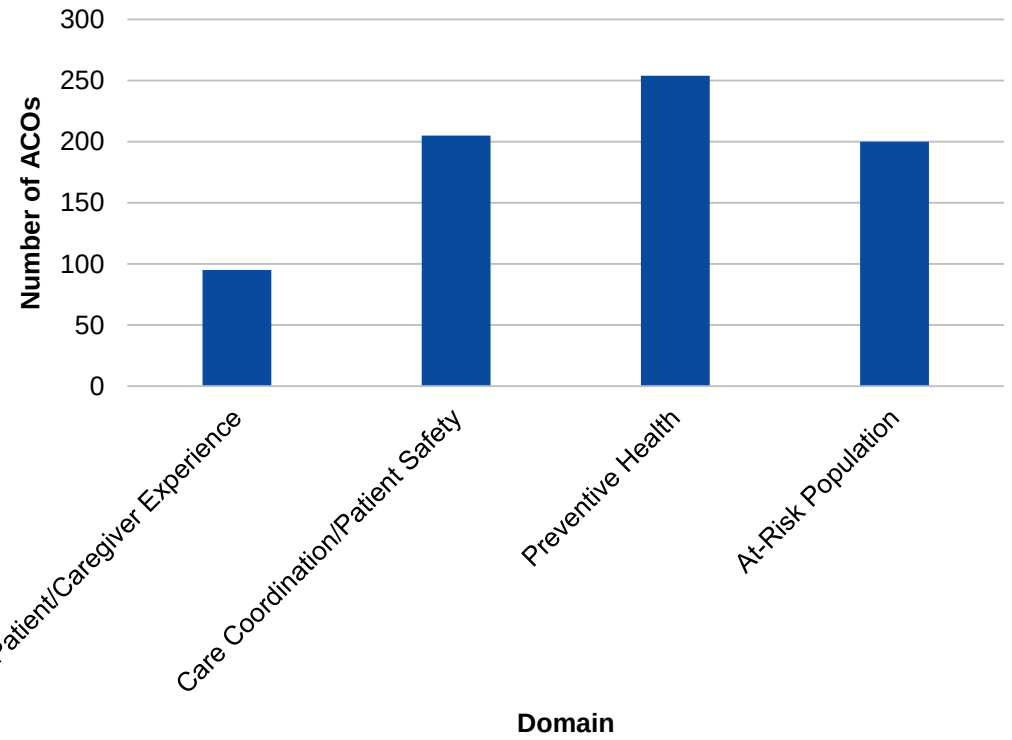
Note: ^Scored as part of Diabetes Composite measure; LVEF = left ventricular ejection fraction

Across all Shared Savings Program ACOs that reported in both 2015 and 2016, average performance improved by over 10 percent on five measures



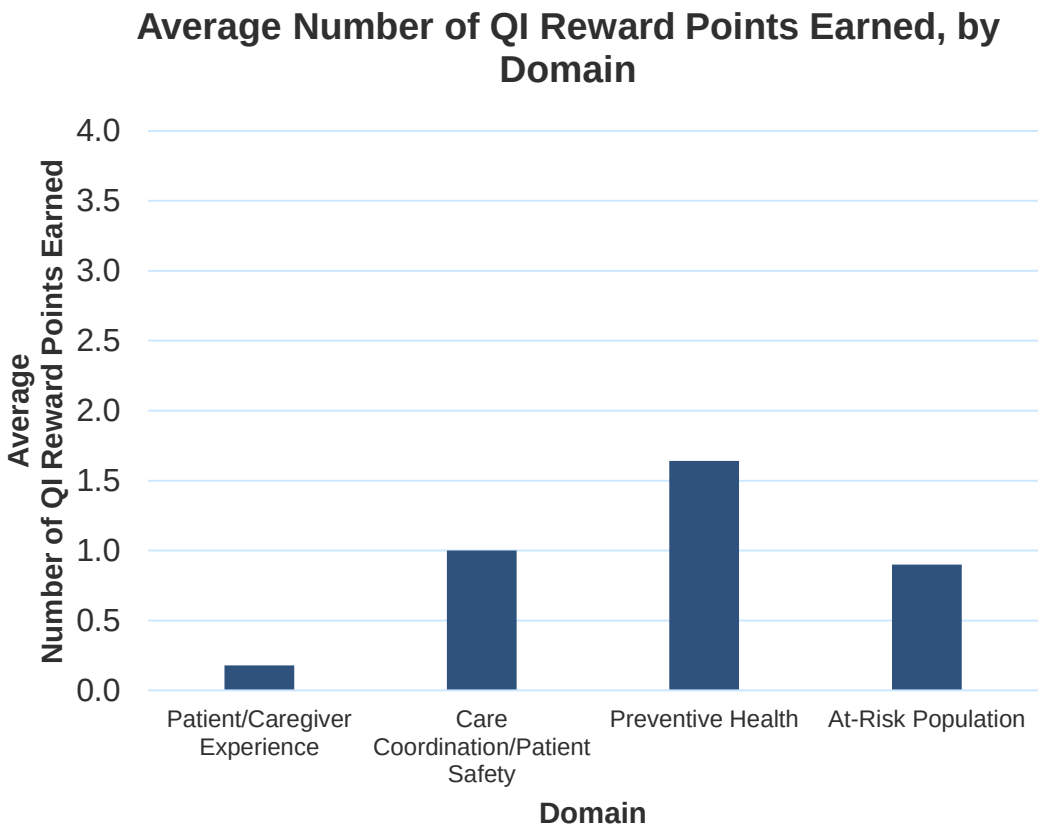
Quality Improvement Reward

- 332 ACOs in PY2 and beyond (of the 432 total ACOs who participated in 2016) were eligible for a QI Reward across 33 measures
- The number of ACOs earning QI points varied by domain
  - 95 ACOs in Patient/Caregiver Experience Domain
  - 205 ACOs in Care Coordination/Patient Safety Domain
  - 254 ACOs in the Preventive Health Domain
  - 200 ACOs in At-Risk Population Domain



Quality Improvement Reward (cont.)

- Among ACOs that were eligible for a QI Reward, the impact was, on average, an addition of nearly 3.24 percentage points on the Overall Quality Score.
- QI Reward Points earned varied (out of 4 possible points in each domain)
  - Average of 0.18 points in the Patient/Caregiver Experience Domain
  - Average of 1.00 points in the Care Coordination/Patient Safety Domain
  - Average of 1.64 points in the Preventive Health Domain
  - Average of 0.90 points in the At-Risk Population Domain



Summary of PY 2016 Quality Results

- In 2016, 99 percent (428 of 432) of ACOs satisfactorily reported required quality measures and will be eligible to share in savings, if earned. Four ACOs did not completely report required quality data.
- 330 of the 428 ACOs subject to pay-for-performance measures earned an average quality score of 94 percent. The remaining 98 ACOs received a quality score of 100 percent since they were in pay-for reporting status.
- 93 percent of eligible ACOs received QI Reward points in at least one domain. The QI Reward increased quality scores by an average of 3.24 percentage points.
- ACOs that participated in the program longer showed greater improvement in quality performance.
  - Across all ACOs that reported in 2013 and 2016, average performance improved by 15 percent across the 25 measures used consecutively across years.

PY 2016 Financial Performance Results
Part I: Overview

- Summary of Performance Categories
- Overview of ACO Financial Performance by Geography
- Overview of ACO Financial Performance by Composition
- Overview of ACO Financial Performance by Previous Performance
- Overview of ACO Financial Performance by Start Date

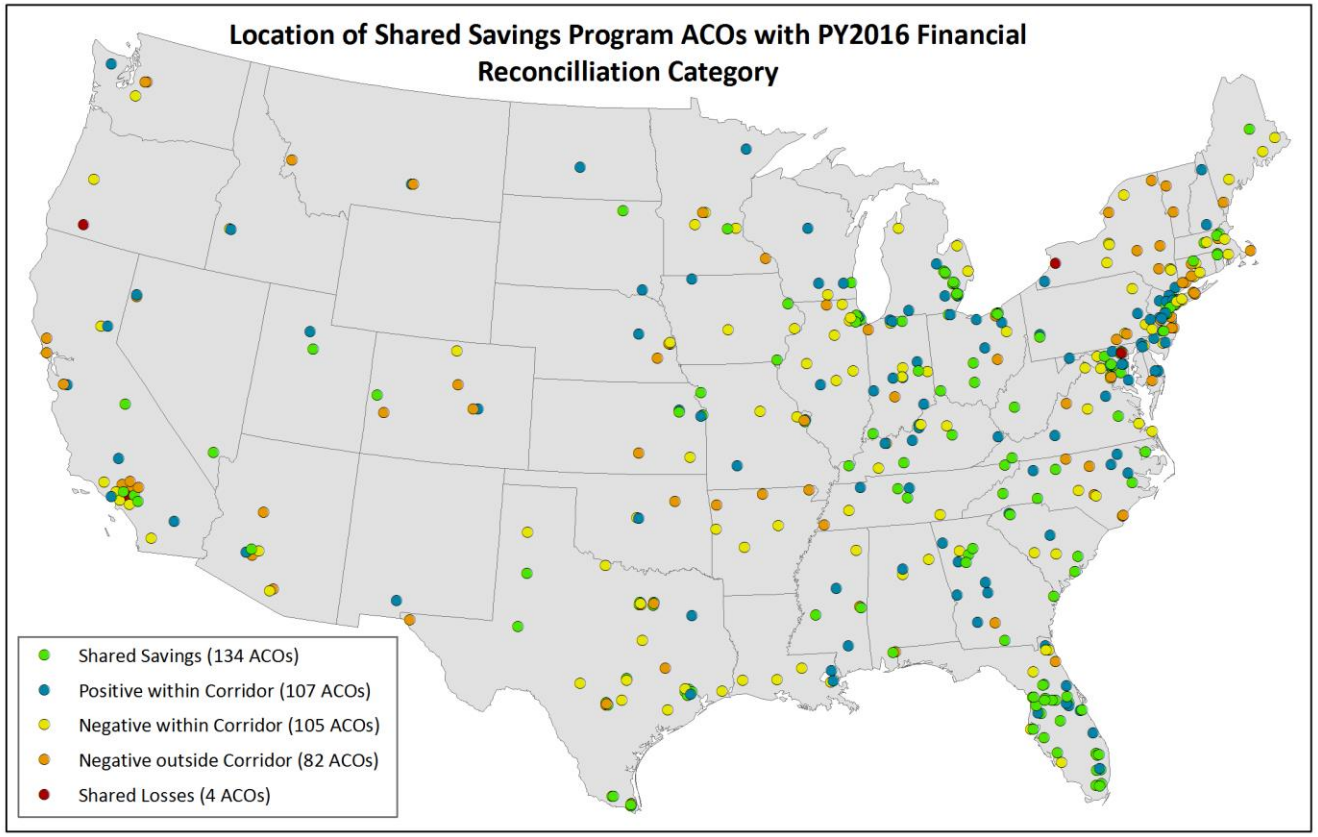
Performance Category Definitions

- Shared savings
  - Benchmark Minus Performance Year Expenditures ≥ minimum savings rate (MSR)
- Positive within corridor
  - Benchmark minus performance year expenditures > 0 and < MSR
- Negative within corridor
  - Benchmark minus performance year expenditures < 0 and > Negative MSR for Track 1 or minimum loss rate (MLR) for Track 2 and Track 3
- Negative outside corridor
  - Benchmark minus performance year expenditures ≤ negative MSR for Track 1 or MLR for Track 2 and Track 3

Summary of Performance Category Totals and Dollars

- 134 out of 432 ACOs (31 percent) generated shared savings.
  - These ACOs earned performance payments totaling more than $700 million.
  - 5 ACOs with shared savings will not receive payments due to AP or AIM recoupment.
- 107 ACOs (25 percent) were positive within corridor.
- 105 ACOs (24 percent) were negative within corridor.
- 82 Track 1 ACOs (20 percent) had assigned beneficiary expenditures that were greater than their updated benchmark and fell outside their negative MSR corridor.
- No Track 2 ACOs shared losses.
- 4 Track 3 ACOs shared losses.

Geographical Distribution of Shared Savings Program ACO Performance



Source: RTI analysis of PY 2016 financial reconciliation data. Note: ACO location based on county with plurality of assigned beneficiaries.

Performance by ACO Entity Type, PY 2016

Entity Type Based PECOS and Participant List Data	All ACOs	Shared Savings	Positive w/in Corridor	Negative w/in Corridor	Negative outside Corridor
All ACOs	432	31%	25%	24%	20%
Physician Only	134	45%	22%	20%	13%
FQHC/RHC	58	31%	28%	21%	21%
Hospital	226	23%	26%	27%	25%
Post Acute Care Facility	8	38%	13%	38%	13%
Other Facility	6	33%	17%	50%	0%

Source: RTI analysis of PY 2016 financial reconciliation data.
Note: Due to rounding, percentages may not sum to 100 percent.

PY 2016 Performance Compared to Earlier Performance Years

Financial Performance	Shared Savings	Positive w/in Corridor	Negative w/in Corridor	Negative outside Corridor
PY 2016 (N=432)	31%	25%	24%	20%
PY2015 (N=392)	31%	21%	22%	26%
PY2014 (N=333)	28%	27%	26%	20%
PY1 (N=220)	26%	27%	27%	20%

Source: RTI analysis of PY1, PY 2014, PY 2015, and PY 2016 financial reconciliation data.
Notes: PY1 final includes the 21-month period (4/1/2012- 12/31/2013) for April 2012 starters, the 18-month period (7/1/2012- 12/31/2013) for July 2012 starters and Calendar Year (CY) 2013 for January 2013 starters. Due to rounding, percentages may not sum to 100 percent.

Financial Performance by Start Date, by Performance Year

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Start Year	Shared Savings in PY1	Shared Savings in PY 2014	Shared Savings in PY 2015	Shared Savings in PY 2016
2012	32%	37%	42%	42%
2013	21%	27%	37%	36%
2014	N/A	19%	22%	36%
2015	N/A	N/A	21%	26%
2016	N/A	N/A	N/A	18%
Total	26%	28%	31%	31%

Source: RTI analysis of PY1, PY 2014, PY 2015, and PY 2016 financial reconciliation data.
Notes: PY1 final includes the 21-month period (4/1/2012- 12/31/2013) for April 2012 starters, the 18-month period (7/1/2012- 12/31/2013) for July 2012 starters and CY 2013 for January 2013 starters. Due to rounding, percentages may not sum to 100 percent.

PY 2016 Performance Compared to PY2015 Performance

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2012 - 2015 Starters

Financial Performance	Shared Savings: PY 2016	Positive w/in Corridor: PY 2016	Negative w/in Corridor: PY 2016	Negative outside Corridor: PY 2016
Shared Savings: PY 2015	71.0%	16.8%	9.3%	2.8%
Negative Outside Corridor: PY 2015	7.3%	17.1%	29.3%	46.3%

Source: RTI analysis of PY1, PY 2014, and PY 2015 financial reconciliation data.
Notes: PY1 final includes the 21-month period (4/1/2012- 12/31/2013) for April 2012 starters, the 18-month period (7/1/2012 - 12/31/2013) for July 2012 starters and CY2013 for January 2013 starters. Due to rounding, percentages may not sum to 100 percent.

Summary of PY 2016 Financial Results Part I: Overview

- 31 percent of ACOs continue to share savings and 25 percent are trending positive in PY 2016, a 4 percentage point increase from the prior performance year.
- Physician-only ACOs continue to outperform compared to ACOs that include a hospital.
  - 41 percent of physician-only ACOs shared savings, compared to 23 percent of ACOs including hospitals.
- ACOs continue to show greater improvement in financial performance as they gain experience in the program.
  - 42 percent of April and July 2012 starters shared savings, compared to 36 percent of 2013 and 2014 starters, 26 percent of 2015 starters, and 18 percent of 2016 starters.

PY 2016 Financial Performance Results
Part II: Benchmarks and Risk Adjustment

- Overview of Benchmarks and Risk Adjustment
- PY 2016 Benchmarks
- Factors that Affect the Updated Benchmark
- Summary of Benchmark Levels and Changes by Performance Category

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Overview of Benchmarks and Risk Adjustment

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- The historical benchmark is based on the three years prior to the start of an ACO's agreement period.
  - An ACO in its first performance year of its first agreement period will receive a historical benchmark based on the three years preceding the start of the agreement period.
  - For an ACO in the first year of a second or subsequent agreement period, the benchmark is called the rebased historical benchmark and is based on the three years preceding the start of the agreement period which are the years in the prior agreement period.
    - For ACOs renewing in 2016, the rebased benchmark includes an adjustment for prior savings.
    - For ACOs renewing in 2017 and subsequent years, the rebased benchmark includes a regional FFS adjustment.
  - The historical benchmark is adjusted for the second or subsequent performance year in an agreement period if the ACO has finalized changes to its participant list or if there are regulatory changes affecting the benchmark calculation.

Overview of Benchmarks and Risk Adjustment (cont.)

- After any necessary adjustment, an ACO's historical benchmark is updated each performance year during financial reconciliation to adjust for changes in beneficiary characteristics and by the projected absolute amount of growth in national per capita expenditures for Parts A and B services under the original fee-for-service program.
- Calculations are made separately for each Medicare enrollment category: end-stage renal disease (ESRD), disabled, aged/dual eligible, and aged/non-dual eligible status.
- Performance year expenditures are compared to the updated benchmark (not the historical benchmark), for determining savings and losses.

PY 2016 Benchmarks

- 2016 starters received historical benchmarks based on benchmark years 2013, 2014, and 2015.
- 2016 renewals received rebased historical benchmarks based on benchmark years 2013, 2014, and 2015 that incorporated adjustments for savings earned in their prior agreement period.
  - 59 percent of renewal ACOs received an adjustment for prior savings, which averaged $197.
- All 2014 and 2015 starters received adjusted benchmarks based on their respective three benchmark years and reflecting:
  - Changes to the assignment methodology
  - Expanded definition of dual eligible status
  - Participant list changes (for 75.1 percent of ACOs)

Factors that Affect the Updated Benchmark

- National expenditure trends from benchmark year (BY) 3 to PY 2016 (by 4 enrollment categories: ESRD, disabled, aged/dual and aged/non-dual)
- Risk ratios, PY 2016/BY 3 (by four enrollment categories)
  - Change in Hierarchical Condition Category (HCC) risk scores of newly assigned
  - Change in HCC or demographic risk scores of continuously assigned
  - Change in proportion of newly vs. continuously assigned
- Changes in assigned beneficiary proportions from BY3 to PY 2016 (by 4 enrollment categories)

Factors that Affect the Updated Benchmark

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Dollar Amount of National FFS Growth Increment (BY3 to PY 2016)

$ Change (BY3 to PY 2016)	2014 Starter (BY3 to PY3)	2015 Starter (BY3 to PY2)	2016 Starter/Renewal (BY3 to PY1)
ESRD	$1,424	$729	$852
Disabled	$767	$510	$180
Aged/dual	$551	$445	$53
Aged/non-dual	$501	$421	$106

Source: CMS Office of the Actuary.
Note: Calculated as PY 2016 value minus BY3 value.

Factors that Affect the Updated Benchmark

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PY 2016 Risk Score by Newly/Continuously Assigned

N = 432 ACOs	Increased	Decreased
Newly Assigned Beneficiary HCC Risk Score	41.1%	58.9%
Continuously Assigned Beneficiary HCC Risk Score	49.2%	50.8%
Proportion Newly Assigned	34.4%	65.6%
Proportion Continuously Assigned	65.6%	34.4%

Source: RTI analysis of PY 2016 financial reconciliation data.
Notes:
1) Newly assigned beneficiaries in a given year = Beneficiaries assigned to the ACO in that year that were not assigned to and did not receive primary care services from the ACO during the assignment window for the prior calendar year.
2) Continuously assigned beneficiaries in a given year = Beneficiaries assigned to the ACO in that year that were assigned to or did receive primary care services from the ACO during the assignment window for the prior calendar year.

Factors that Affect the Updated Benchmark

PY 2016 Overall Risk Ratios by Enrollment Category

N=432 ACOs	ESRD	Disabled	Aged/Dual	Aged/Non-Dual
Count with risk ratio < 1	230	219	222	247
Proportion with risk ratio < 1	53%	51%	51%	57%
Minimum risk ratio	0.857	0.801	0.818	0.929
Median risk ratio	0.998	1.000	0.999	0.998
Maximum risk ratio	1.118	1.118	1.135	1.056

Source: RTI analysis of PY 2016 financial reconciliation data.

Note: Risk ratio is defined as the ACO risk score in the performance year divided by the ACO risk score in BY3.

Factors that Affect the Updated Benchmark

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PY 2016 Changes in Enrollment Proportions

N=432 ACOs	Changes in Enrollment Proportions			
	ESRD	Disabled	Aged/Dual	Aged/Non-Dual
Number of ACOs with Decrease	196	355	273	101
Percent of ACOs with Decrease	45.4%	82.2%	63.2%	23.4%
Median Change in Enrollment Proportion	0.000	-0.007	-0.002	0.009

Source: RTI analysis of PY 2016 financial reconciliation data.
Note: Changes in enrollment proportions calculated as PY 2016 value minus BY3 value.

Summary of Benchmark Levels and Changes by Performance Category

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Benchmark Measure	All ACOs	Shared Savings	Positive w/in Corridor	Negative w/in Corridor	Negative outside Corridor
Number of ACOs	432	134	107	105	86
Average Historical Benchmark ($)	10,698	11,558	10,834	9,862	10,210
Average Updated Benchmark ($)	10,889	11,614	11,042	10,139	10,484
Average Change in Benchmark ($)	191	56	208	277	274
Average Percentage Change in Benchmark	2.1%	0.9%	2.1%	3.0%	3.0%

Half of the ACOs with updated benchmark < historical benchmark, shared savings, compared to one-fourth for the ACOs with updated benchmark > historical benchmark.

Source: RTI analysis of PY 2016 financial reconciliation data.

Summary of PY 2016 Financial Results Part II

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Benchmarks and Risk Adjustment

- National FFS growth increments from BY3 to PY 2016 were positive across all Medicare enrollment types for all starter cohorts.
- On average, updated benchmarks were higher than historical benchmarks across all performance categories; however, ACOs generating shared savings experienced a substantially smaller increase on average than ACOs in other performance categories.

Financial Performance Results
Part III: Non-Claims Based Payments and Trends in Expenditures, Utilization, and Beneficiary Turnover

- Non-Claims Based Payments
- Expenditure Trends, BY3 to PY 2016
- Utilization Trends, BY3 to PY 2016
- Beneficiary Turnover

Non-Claims Based Payments

- Non-Claims Based Payments (NCBP) associated with the following programs are included in PY 2016 total expenditures:
  - Comprehensive Primary Care Initiative (CPCI)
  - Community-Based Care Transitions (CBCT)
  - Bundled Payments for Care Improvement (BPCI)
  - Medicare Health Care Quality Demonstration (MHCQ)
- The PY 2016 annual Aggregate Expenditure/Utilization (EXPU) Report also provides:
  - NCBP person-years: Total person-years among assigned beneficiaries with at least one non-zero NCBP in any program in the expenditure period
  - NCBP per beneficiary with NCBP: Per capita NCBP (all programs) among beneficiaries with at least one non-zero NCBP in any program in the expenditure period
- This presentation presents statistics on the above measures and the above measures calculated by individual program, as well as statistics on NCBP per beneficiary (total).

NCBP Person-Years by Program

PY 2016

NCBP Person-Years	All Programs Combined	CPCI	CBCT	BPCI	MHCQ
Number of ACOs	431	199	336	431	13
Minimum	2.4	0.3	0.4	1.4	0.9
Mean	212.9	7.2	85.4	144.6	75.0
Median	105.3	2.0	4.2	73.5	3.3
Maximum	2,439.4	124.8	1,826.2	1,778.7	805.2

Source: RTI analysis of PY 2016 financial reconciliation data.

NCBP per Beneficiary with NCBP by Program

MEDICARE SHARED SAVINGS PROGRAM

PY 2016

NCBP per Beneficiary with NCBP	All Programs Combined	CPCI	CBCT	BPCI	MHCQ
Number of ACOs	431	199	336	431	13
Minimum	-$ 16,320.94	$ 0.00	$ 144.86	-$ 17,997.33	$ 297.82
Mean	$ 1,146.17	$ 142.35	$ 376.40	$ 1,350.90	$ 867.44
Median	$ 1,158.25	$ 130.84	$ 378.72	$ 1,466.25	$ 893.47
Maximum	$ 8,114.39	$ 364.68	$ 722.69	$ 9,206.71	$ 1,092.01

Source: RTI analysis of PY 2016 financial reconciliation data.

NCBP per Beneficiary (Total) by Program

MEDICARE SHARED SAVINGS PROGRAM

PY 2016

NCBP per Beneficiary (Total)	All Programs Combined	CPCI	CBCT	BPCI	MHCQ
Number of ACOs	431	199	336	431	13
Minimum	-$ 322.80	$ 0.00	$ 0.01	-$ 324.60	$ 0.02
Mean	$ 12.10	$ 0.05	$ 1.82	$ 10.61	$ 1.52
Median	$ 7.85	$ 0.02	$ 0.10	$ 6.54	$ 0.17
Maximum	$ 159.16	$ 0.73	$ 38.66	$ 159.16	$ 11.74

Source: RTI analysis of PY 2016 financial reconciliation data.

NCBP as Percent of Updated Benchmark Expenditures by Program

PY 2016

NCBP per Beneficiary (Total)	All Programs Combined	CPCI	CBCT	BPCI	MHCQ
Number of ACOs	431	199	336	431	13
Minimum	-0.76%	0.00%	0.00%	-0.76%	0.00%
Mean	0.13%	0.00%	0.12%	0.12%	0.01%
Median	0.07%	0.00%	0.06%	0.06%	0.00%
Maximum	1.60%	0.34%	1.60%	1.60%	0.09%

Source: RTI analysis of PY 2016 financial reconciliation data.

Notes to Expenditure and Utilization Trends

- Values in this section are calculated from the annual Aggregate Expenditure/Utilization reports the ACOs received with their PY 2016 financial reconciliation reports and PY 2016 final historical benchmark reports.
- All trends are based on 432 ACOs unless otherwise noted.
- A three-months claims run out is used.
- All beneficiary annualized expenditures are truncated by setting expenditures that are greater than the truncation threshold equal to the truncation threshold.
  - For each Medicare enrollment type, the expenditure truncation threshold is the national unweighted 99th percentile of annualized Part A and Part B expenditures (excluding indirect medical education (IME)/disproportionate share data (DSH), uncompensated claims (UCC), and pass-through payments) for national FFS beneficiaries, calculated by CMS' Office of the Actuary. The component expenditures are truncated using the same truncation thresholds.
- A claims completion factor 1.013 is applied to expenditures.
- Expenditures are not standardized for geographic variations in Medicare prices (i.e., arising from the Area Wage Index or the Geographic Practice Cost Index).
- Risk adjustment is not applied in any of these calculations.
- ACOs vary by the number of years between BY3 and PY 2016 and the analysis for BY3 and PY 2016 expenditure and utilization comparisons did not adjust for this difference.

Trends in Total Expenditures

BY3 to PY 2016

Total Per Capita Expenditures	Shared Savings	Positive w/in Corridor	Negative w/in Corridor	Negative outside Corridor
Number of ACOs	134	107	105	86
Average BY3 Per Capita Expenditures ($)	11,279	10,766	9,896	10,289
Average PY 2016 Per Capita Expenditures ($)	10,791	10,891	10,263	11,132
Average Percentage Change in Per Capita Assigned Beneficiary Expenditures, BY3 to PY 2016	-3.5%	1.4%	3.9%	8.8%

Source: RTI of PY 2016 financial reconciliation data.

Average Percentage Change in Inpatient Expenditures

MEDICARE SHARED SAVINGS PROGRAM

BY3 to PY 2016

Expenditure Category	Shared savings	Positive w/in corridor	Negative w/in corridor	Negative outside corridor
Inpatient Hospital, Total	-5.0%	1.2%	3.0%	8.6%
Short-Term Hospital	-4.4%	1.7%	3.6%	8.8%
Long-Term Hospital	-6.5%	8.2%	10.6%	44.1%
Rehabilitation Hospital or Unit	0.6%	10.2%	3.8%	12.7%
Psychiatric Hospital or Unit	-2.9%	2.9%	7.9%	-0.2%

Source: RTI analysis of PY 2016 financial reconciliation data.
Note: Long-term hospital measure is based on subset of 423 ACOs with long-term hospital claims in both periods.

Average Percentage Change in Part B Expenditures

MEDICARE SHARED SAVINGS PROGRAM

BY3 to PY 2016

Expenditure Category	Shared Savings	Positive w/in Corridor	Negative w/in Corridor	Negative outside Corridor
Part B Physician/Supplier, Total	0.2%	2.5%	3.9%	7.4%
Evaluation & Management	-2.4%	1.1%	2.9%	6.0%
Part B Drugs	12.4%	10.1%	9.1%	16.7%
Procedures	-0.9%	1.4%	1.9%	4.4%
Imaging	-5.2%	-2.0%	-2.4%	-1.1%
Ambulance	-11.1%	-4.1%	0.1%	2.0%
Laboratory & Other Tests	-9.3%	-8.3%	-8.9%	-5.1%

Source: RTI analysis of PY 2016 financial reconciliation data.

Average Percentage Change in Other Component Expenditures

BY3 to PY 2016

Expenditure Category	Shared Savings	Positive w/in Corridor	Negative w/in Corridor	Negative outside Corridor
SNF Expenditures	-18.3%	-6.9%	-3.8%	16.3%
Outpatient Expenditures	3.8%	5.0%	9.2%	12.0%
Home Health Expenditures	-9.7%	-0.2%	2.7%	9.9%
DME Expenditures	-9.2%	-8.1%	-7.7%	-9.8%
Hospice Expenditure	-6.1%	2.1%	8.2%	12.4%

Source: RTI analysis of PY 2016 financial reconciliation data.

Average Percentage Change in Hospital Utilization

MEDICARE SHARED SAVINGS PROGRAM

BY3 to PY 2016

Utilization Category	Shared Savings	Positive w/in Corridor	Negative w/in Corridor	Negative outside Corridor
Hospitalizations, Total	-8.9%	-3.2%	-2.2%	1.0%
Short-Term Hospital	-8.7%	-3.1%	-2.1%	1.1%
Long-Term Hospital	-6.2%	-2.6%	2.7%	13.9%
Rehabilitation Hospital or Unit	-3.9%	4.9%	-2.5%	2.9%
Psychiatric Hospital or Unit	-9.1%	-2.4%	-1.6%	-5.5%

Source: RTI analysis of PY 2016 financial reconciliation data.
Note: Long-term hospital measure is based on subset of 423 ACOs with long-term hospital claims in both periods.

Average Percentage Change in Other Utilization Categories

BY3 to PY 2016

Utilization Category	Shared Savings	Positive w/in Corridor	Negative w/in Corridor	Negative outside Corridor
SNF Discharges	-15.5%	-4.8%	-3.1%	11.2%
SNF Utilization Days	-21.5%	-9.1%	-7.0%	10.3%
ED Visits	-3.8%	0.1%	2.1%	2.2%
ED Visits that led to Hospitalization	-8.8%	-2.4%	-1.9%	2.3%
CT Events	3.6%	5.8%	8.1%	10.9%
MRI Events	2.8%	3.2%	4.1%	7.0%

Source: RTI analysis of PY 2016 financial reconciliation data.
Note: ED = Emergency department; CT = Computed tomography; MRI = Magnetic resonance imaging.

Average Percentage Change in Primary Care Utilization

MEDICARE SHARED SAVINGS PROGRAM

BY3 to PY 2016

Utilization Category	Shared Savings	Positive w/in Corridor	Negative w/in Corridor	Negative outside Corridor
PCS visits with PCP	-1.2%	1.3%	0.8%	0.1%
PCS Visits with Specialist	0.1%	0.2%	1.1%	2.1%
PCS Visits with NP/PA/CNS	20.1%	22.9%	34.4%	39.9%

Source: RTI analysis of PY 2016 financial reconciliation data.
Note: PCS = Primary care service; PCP = Primary care physician; NP = Nurse practitioner; PA = Physician assistant; CNS = Clinical nurse specialist.

ACO Beneficiary Turnover, CY2015 and CY2016

MEDICARE SHARED SAVINGS PROGRAM

- On average, 72 percent of beneficiaries assigned to an ACO in 2015 were assigned to the same ACO in 2016.
- Of those beneficiaries assigned in 2015 but not 2016, 23 percent on average were available and potentially retainable for assignment but were not assigned because:
  - The ACO did not provide the plurality of primary care services to the beneficiary in CY 2016 assignment window (3 percent of beneficiaries on average).
  - They had no primary care service visit with a physician at the ACO (20 percent of beneficiaries on average).
- Of those beneficiaries assigned in 2015 but not 2016, 5 percent on average were not available for assignment because:
  - The beneficiaries were deceased in CY 2015 assignment window (4 percent of beneficiaries on average).
  - The beneficiaries were no longer Shared Savings Program eligible due to not meeting all of the general eligibility requirements (1 percent of beneficiaries on average).

Summary of PY 2016 Financial Results Part III

MEDICARE SHARED SAVINGS PROGRAM

Non-Claims Based Payments and Trends in Expenditures, Utilization, and Beneficiary Turnover

- Per capita assigned beneficiary expenditures declined by 3.5 percent from BY3 to PY 2016 among ACOs that generated shared savings.
- ACOs sharing savings showed improvement across multiple categories of Medicare Part A&B spending and utilization.
  - ACOs sharing savings had a decline in inpatient expenditures and utilization from BY3 to PY 2016 across several facility types.
  - Home health and imaging expenditures from BY3 and PY 2016 declined among ACOs generating shared savings.
  - SNF utilization from BY3 to PY 2016 declined significantly among ACOs generating shared savings.
- For most ACOs, the majority of beneficiaries assigned to an ACO in 2015 were assigned to the same ACO in 2016.
  - On average, 72 percent of beneficiaries assigned to an ACO in 2015 were assigned to the same ACO in 2016.

QUESTION & ANSWER SESSION

Questions & Answers

Contact Information	Type of Inquiry[1]
SharedSavingsProgram@cms.hhs.gov	For questions related to the financial reconciliation report and quality performance report
APOSD@cms.hhs.gov Phone: 1-888-734-6433 (select Option 2); TTY/TDD 1-888-734-6563	For technical assistance using MFT or the Shared Savings Program ACO Portal
QNETSupport@hcqis.org Phone: 1-866-288-8912; TTY 1-877-715-6222 Fax: 1-888-329-7377 Hours: Monday – Friday, 7 a.m. – 7 p.m. Central Time	For quality measures-specific questions

[1] Include the CMS ACO ID number on all correspondence with CMS.

Acronyms Used in this Presentation

- **ACOs**: Accountable Care Organizations
- **AIM**: ACO Investment Model
- **AP**: Advance Payment
- **BPCI:** Bundled Payment for Care Improvement
- **BY**: Benchmark Year
- **CAH:** Critical Access Hospital
- **CAHPS:** Consumer Assessment of Healthcare Providers & Systems
- **CBCT:** Community-Based Care Transitions
- **CMS:** Centers for Medicare & Medicaid Services
- **CPCI**: Comprehensive Primary Care Initiative
- **CY**: calendar year
- **DSH**: disproportionate share hospital
- **ESRD**: end-stage renal disease
- **ETA**: Electing Teaching Amendment
- **EXPU:** Expenditure/Utilization

Acronyms Used in this Presentation

- **FFS**: fee-for-service
- **FQHC:** Federally Qualified Health Center
- **HCC**: Hierarchical Condition Category
- **IME**: indirect medical education
- **MFT**: Managed File Transfer
- **MHCQ**: Medicare Health Care Quality Demonstration
- **MLR**: minimum loss rate
- **MSR**: minimum savings rate
- **NCBP**: Non-Claims Based Payments
- **OACT**: CMS Office of the Actuary
- **PECOS**: Provider Enrollment, Chain, and Ownership System
- **PY:** performance year
- **QI**: Quality Improvement
- **RHC**: Rural Health Clinic