Independence at Home Demonstration Revised Actuarial Shared Savings Methodology

Specifications

May 25, 2021

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Contents

Executive Summary

Section 1866E of the Social Security Act, as added by Section 3024 of the Affordable Care Act (P.L. 111-148), directs the Centers for Medicare & Medicaid Services (CMS) to conduct the Independence at Home (IAH) Demonstration to test home-based primary care for Medicare fee-for-service (FFS) beneficiaries with multiple chronic illnesses and functional limitations. The demonstration is intended to improve the quality of care and reduce expenditures for this high-risk group. Participating practices that achieve those goals may receive incentive payments that reflect a share of the saved expenditures. This document describes the revised actuarial methodology CMS designed and which is being used to determine the incentive payments for all IAH practices beginning in the sixth demonstration year (calendar year 2019).

The amount of any incentive payment to participating practices is based on (1) calculation of any significant savings, and (2) achievement of quality performance benchmarks. Calculation of incentive payments is a multi-step process. These steps include the following:

- Determination of the eligible population to be used in the calculation incentive payments. These are the patients for whom the practice was responsible for providing care under IAH.
- Calculation of actual expenditures for each practice's IAH population. These expenditures include Medicare Part A and Part B FFS payments during the performance year for the eligible population.
- Calculation of spending targets. A spending target is calculated for each practice, representing the expected expenditures in the absence of the demonstration. Each practice's spending target is based on the average of the risk-adjusted spending targets for the beneficiaries in the population.
- Determination of statistically significant savings. A one-sided confidence interval is constructed around each practice's actual expenditures, for use in determining whether savings are statistically significant. Spending targets are compared to the upper bound of the confidence intervals (80^{th} and 85^{th}) to determine if any observed savings are likely to be actual, rather than due to random variation. If the spending target is greater than the upper bound of the confidence interval, the savings are considered statistically significant, and the practice may be eligible for an incentive payment.
- Calculation of maximum incentive payment. Practices may receive a maximum of either 80% or 50% (depending upon the confidence level associated with the interval around the expenditures) of the available savings, if the savings are determined to be statistically significant. Available savings are those remaining from the difference between the spending target and the actual expenditures, after the first 5 percent, which is retained by CMS.
- Assessment of quality performance. Practices must meet performance thresholds for a minimum of 3 out of 6 quality measures that are used in the calculation of incentive payments. The amount of incentive payment received increases with the number of quality measure benchmarks that are met. These quality measures assess inpatient admissions for ambulatory care sensitive conditions (ACSC); emergency department (ED) visits for ACSC; hospital readmissions with 30 days; prompt follow-up (48 hour) with beneficiaries upon admission to a hospital, discharge from a hospital, or discharge from an ED; medication

reconciliation within 48 hours of hospital discharge or ED visit; and documentation of patient preferences in the medical record.

- Final incentive payment calculation. The maximum incentive payment depends upon performance on the quality measures. Other adjustments to the incentive payment are made in response to law. Current law affecting calculations include a required 2 percent reduction for sequestration, and payment reductions should the total enrollment in IAH exceed 15,000 in demonstration years 6 and 7, or 20,000 in demonstration years 8–10.

Introduction

Section 1866E of the Social Security Act, as added by Section 3024 of the Affordable Care Act (P.L. 111-148), directs the Centers for Medicare & Medicaid Services (CMS) to conduct the Independence at Home (IAH) Demonstration to test home-based primary care for Medicare fee-for-service (FFS) beneficiaries with multiple chronic illnesses and functional limitations. Home-based primary care is designed to provide comprehensive, coordinated, continuous, and accessible care to high-need patients and to coordinate health care across all treatment settings. Home-based primary care allows health care providers to spend more time with their patients, perform assessments in a patient's natural environment, and assume greater accountability for all aspects of the patient's care. This focus on timely and appropriate care is designed to improve overall quality of care and quality of life for patients served, while lowering health care costs by forestalling the need for care in institutional settings.

The IAH demonstration includes a shared savings component, whereby practices that show Medicare savings may receive incentive payments in the form of savings sharing with CMS. To determine if a practice has achieved savings, actual expenditures for each practice are compared to a spending target for that practice in each performance year. The spending target is an estimate of the Medicare FFS Parts A and B expenditures that would have been incurred by IAH beneficiaries in the absence of the demonstration. There is an independent shared savings calculation for each twelve-month performance year. Some practices began the demonstration on June 1, 2012 (Cohort 1) and others began on September 1, 2012 (Cohort 2); the practices in each cohort received a separate calculation for the first three performance years. For all practices, performance year 4 began October 1, 2015 and ended September 30, 2016 and performance year 5 began October 1, 2016 and ended September 30, 2017. The demonstration was extended for an additional two years, with performance year 6 occurring from January 1–December 31, 2019, and performance year 7 occurring January 1–December 31, 2020. The extension was extended again for performance year 8 occurring January 1–December 31, 2021, performance year 9 occurring January 1–December 31, 2022, and performance year 10 occurring January 1–December 31, 2023. Some practices are participating in the demonstration as a consortium. The consortium receives a separate calculation of the shared savings across its practices; shared savings are not calculated separately for each practice within the consortium.

This paper presents the methodology used to determine IAH shared savings incentive payments under the revised actuarial method that is used for all practices in performance years 6 through 10. Section 1 covers the characteristics required of patients who qualify for IAH and how their periods of eligibility are determined; Section 2 covers the calculation of the actual performance year expenditures; Section 3 covers the calculation of the spending target; and Section 4 covers the method used to determine if a practice qualifies for a shared savings incentive payment, and the method for calculating the amount of any such payment.

Section 1: Population and Eligibility

The first step in the shared savings calculation is defining the population used to determine if there have been savings. As described in the sections below, not every patient enrolled by a practice or consortium will be eligible for the demonstration, and not every patient in the final demonstration population will have been enrolled by a practice or consortium. Once the population is defined, we then determine each patient's period of eligibility during the performance year. In the sections below, we provide the eligibility criteria for the demonstration and the methods we used to apply those criteria; explain the difference between "enrolled" beneficiaries and "potentially eligible" beneficiaries and how they are defined; and provide the methods we use to determine periods of eligibility within each performance year.

1.1 Population

We include in the population all "applicable" beneficiaries who are patients of a participating IAH practice or consortium at any point during a performance year. An applicable beneficiary is defined as an individual who, on their date of demonstration enrollment:

- Is entitled to Medicare Part A and enrolled in Medicare Part B,
- Is not enrolled in a Medicare Advantage (MA) or Programs of All-Inclusive Care for the Elderly (PACE) plan,
- Has Medicare as the primary payer,
- Is not on hospice,
- Has two or more chronic conditions, as determined by the practice,[1]
- Requires human assistance with two or more activities of daily living (ADLs), as determined by the practice[2],
- Has had a hospital admission in the 12 months prior to enrollment (see Appendix A for the hospitalization specifications),
- Has used post-acute or sub-acute rehabilitation services in the 12 months prior to enrollment
- (see Appendix A for the post-acute care use specifications), and
- Has had a home visit with the enrolling IAH practice in the 12 months prior to enrollment (see Appendix A for the home visit specifications).

A final eligibility criterion is that applicable beneficiaries must not be part of another Medicare FFS shared savings initiative for any period of time overlapping with an IAH performance year. If an otherwise eligible beneficiary has already been included in another such initiative for the purposes of a final reconciliation, he/she is excluded from IAH. Once a beneficiary has been included in IAH he/she will continue to be included in IAH until disenrollment.

There are two types of applicable beneficiaries:

[1] Rather than specifying a list of chronic conditions, CMS, for purposes of this demonstration, is defining chronic disease or condition to mean a disease or medical condition that is expected to last for more than 1 year, limits what a person can do, and requires ongoing medical monitoring.
[2] The ADLs are bathing, dressing, toileting, transferring, walking, and eating.

1. Enrolled Beneficiaries. These are beneficiaries who a practice has entered into the IAH Reporting System, an electronic tool used by the practices to provide information to CMS about the patients they believe are eligible for the demonstration.
2. Potentially Eligible Beneficiaries. These are beneficiaries who have been identified via a Medicare claims analysis (more details below) as potentially eligible for the demonstration but who have NOT been entered into the IAH Reporting System by the practice, nor has the practice provided a sufficient explanation for why they did not enroll them (for example, patient did not have two chronic conditions). These patients will be included in the shared savings calculation.

Finally, after the first performance year in which they are included as part of the population, patients who continue to be alive, enrolled in Medicare Parts A and B, not enrolled in Medicare Advantage or PACE, and have Medicare as primary payer on the first day of the current performance year are also included in future performance year's populations. Patients who met all criteria for initial enrollment in a previous performance year are not required to have a hospitalization and post-acute care each year to requalify.

The exception to including ALL applicable beneficiaries in a performance year is those beneficiaries who were voluntarily disenrolled prior to having six months of eligible enrollment in the performance year. These patients are not included at all in the population on which shared savings are calculated. Voluntary disenrollment occurs when a patient changes provider within the practice service area, is discharged by the practice, declines home care, elects hospice and changes provider, or meets other criteria determined by CMS. More information on voluntary disenrollment and the "six-month rule" is below in Section 1.2.4.

1.1.1 Enrolled Beneficiaries

Enrolled beneficiaries have been entered by an IAH practice into the IAH Reporting System. Such patients have been informed of the practice's participation in the demonstration and have agreed to have their data used for the demonstration. By enrolling patients in the reporting system, the practice attests that they believe the patient meets all of the eligibility criteria in the list above on the enrollment date entered. When enrolling a patient, the practice reports the patient's name, date of birth, enrollment date, number of ADL limitations, the presence of at least two chronic conditions, and specific ambulatory care sensitive conditions (diabetes, congestive heart failure, or chronic obstructive pulmonary disease). Enrolling a patient in the IAH Reporting System does NOT affect a patient's ordinary Medicare coverage or their choice of providers.

Practices may not have information on an enrolled patient's medical history, including when a hospitalization occurred, when the patient received post-acute care, or even information on the patient's Medicare eligibility. To assist the practices and to confirm eligibility for inclusion in the shared savings calculation, we use the Medicare administrative data available to us to confirm each patient's eligibility on the enrollment date reported by the practice. These data include information available in the Medicare Enrollment Database (EDB) and the Medicare claims data. We use these data to confirm the existence of a qualifying hospitalization, post-acute care use, and an in-home visit with the IAH practice, and that the patient is not enrolled in an MA or PACE plan, has both Part A and Part B, has Medicare as primary payer, and is not on hospice. We are unable to confirm the remaining eligibility

criteria (chronic illness and ADL limitations) using the Medicare administrative data and must rely on the practices' attestation through data in the IAH Reporting System that the patient meets them.

Patients who do not meet all criteria based on these analyses are not included in the population on which shared savings are calculated.

1.1.2 Potentially Eligible Beneficiaries

To assist practices in identifying which of their patients had the qualifying hospitalization and post-acute care required for enrollment, and to ensure that practices enroll ALL of their patients who meet the criteria for the demonstration, we use an analysis of Medicare administrative data similar to the one described above (Section 1.1.1) for confirming eligibility to find any patients that the practices have not enrolled but who meet the claims-based criteria for the demonstration. Such patients *may* also meet the ADL and chronic condition requirements, pending information provided by the practices. These patients are called "potentially eligible."

For each performance year, we provide a list of potentially eligible patients to each practice. Potentially eligible patients are people who are not enrolled in IAH, but who have received an in-home visit by the practice and who meet the claims-based eligibility criteria. In this list we provide the earliest date on which a person met those enrollment criteria. Practices are responsible for reviewing the list and returning it, indicating whether each patient is already enrolled, will be enrolled, does not meet the ADL and/or chronic condition criteria, or cannot be enrolled for some other reason (see Appendix C for the full list of available responses). Beneficiaries identified as potentially eligible, for whom practices do not indicate any reason that they are not eligible and should not be enrolled, are treated as enrolled and included in the population for which shared savings are calculated.

This process informs the practices which of their patients meet the claims-based criteria for enrollment in IAH and also identifies other patients the practices have seen in the home who may need to be enrolled. The technical specifications for identifying potentially eligible patients and their enrollment dates are in Appendix B. The responses that a practice may return for each potentially eligible patient are listed in Appendix C.

1.2 Periods of Eligibility

In general, applicable beneficiaries are included in the shared savings calculation for the entire time between their enrollment and disenrollment (if one exists) dates during the performance year. This means we include all such patient months in the actual expenditures calculation. Exceptions are patients who voluntarily disenroll from a practice. Eligibility periods for these individuals are determined based on the "six-month rule" (see Section 1.2.4).

1.2.1 Enrollment

The enrollment date is the date in the performance year on which each patient's period of eligibility in that year begins. For patients newly enrolled, the enrollment date is the first day of the month after the date the patient initially became eligible for the demonstration. For patients enrolled in prior years and still eligible for the current year, the enrollment date is the first day of the performance year. By demonstration design, all enrollments begin on the first day of the month.

There are two potential sources for each newly enrolled patient's enrollment date. The first is the enrollment date entered by the practice in the IAH Reporting System, called the "reporting system enrollment date." Only beneficiaries who have been entered into the IAH Reporting System will have

such a date. In addition to confirming eligibility on the reporting system enrollment date, as described in Section 1.1.1, we also use Medicare administrative data to determine if an earlier or later enrollment date may be appropriate. This date is called the "claims-based enrollment date." Cases where a claims-based enrollment date may differ from the reporting system enrollment date include:

- The patient does not meet the claims-based eligibility criteria on the reporting system enrollment date, but meets eligibility some time thereafter. In such cases, the patient may still be enrolled (rather than being considered ineligible) as of the claims-based enrollment date.
- The patient meets the claims-based eligibility criteria on the reporting system enrollment date, but also appears eligible for enrollment some time before based on the data. We include these cases because practices are required to enroll patients as soon as they become eligible for the demonstration.

Potentially eligible beneficiaries will have only a claims-based enrollment date, as they will not have been entered into the IAH Reporting System by the practices. For both enrolled beneficiaries and potentially eligible beneficiaries, we generate an array of possible claims-based enrollment dates in the performance year. The claims-based enrollment date is set to the earliest possible enrollment date in the performance year on which all of the criteria listed in Section 1.1 are met, except the chronic condition and ADL criteria (since these cannot be determined by the claims).

Once a patient has been found to be eligible for IAH and the enrollment date determined, the patient is included in future performance years as of the first day of the performance year, as long as they have not been disenrolled by the practice (see Section 1.2.2) and continue to be alive, enrolled in Medicare Parts A and B, are not enrolled in Medicare Advantage or PACE, and have Medicare as primary payer on the first day of the performance year.

1.2.2 Disenrollment

Patients are disenrolled from the demonstration for any of the following reasons, which we categorize into two groups:

Group A

- Death
- Patient loses Medicare Part A or Part B
- Medicare becomes secondary payer
- Patient enrolls in an MA or PACE plan

Group B

- Patient becomes permanently institutionalized
- Patient moves out of a practice's service area
- Patient elects hospice and the IAH practice will not continue to follow the patient (is no longer the "physician of record")
- Patient no longer wishes to have the IAH practice provide their primary care (in the home)
- Patient no longer wishes to have their data shared for the purposes of the demonstration
- Practice discharges the patient from service (reasons include unable to contact the patient, patient non-compliance, or patient unable to make copayments for services)
- Other reasons provided by the practice

Practices must report disenrollments for any reason (both groups) via the IAH Reporting System. The disenrollment reasons in Group A are all verified using the Medicare EDB. We use the EDB to set such disenrollment dates (and do not use practice-reported information for these disenrollment reasons). The disenrollment reasons in Group B cannot be easily verified using Medicare data sources. For this group we rely on the information the practices report. If multiple disenrollment reasons/dates exist, we use the earliest disenrollment date.

1.2.3 Reenrollment

Beneficiaries may be reenrolled in the demonstration after being disenrolled. Beneficiaries who are disenrolled for any reason may be reenrolled within six months without reestablishing eligibility criteria. Beneficiaries may be reenrolled after six months; however, eligibility criteria must be reestablished. Practices may use the reenrollment provision to properly reflect patients who move outside of their service area for part of the year ("snowbirds") or to reenroll patients who temporarily joined an MA plan, for example. Risk scores (Section 3.3) are calculated based on the beneficiary's initial enrollment and are not updated if they disenroll and later reenroll.

Reenrolled beneficiaries have more than one enrollment date and potentially more than one disenrollment date within the same performance year. So that practices do not use the reenrollment provision to disenroll patients during costly episodes, practices must call the IAH Help Desk to reenroll a patient. We do not use Medicare data to determine when a patient may become eligible for reenrollment; patients who may be eligible for reenrollment are not included in the list of potential eligibles that we provide to the practices. It is the practice's responsibility to reenroll their patients.

For patients who are reenrolled more than six months after being disenrolled, we use the Medicare administrative data to determine whether they newly meet all IAH eligibility criteria (as listed in Section 1.1.1) on the reenrollment date the practice has entered. In other words, such patients must have had a hospitalization, post-acute care, and a home visit from the IAH practice in the 12 months prior to the reenrollment date, in addition to meeting the remaining Medicare FFS enrollment criteria. Patients who are reenrolled six months or less after being disenrolled are not required to fully requalify, but must still be enrolled in Medicare Part A and Part B, not be enrolled in a MA or PACE plan, and have Medicare as primary payer.

1.2.4 Eligibility Exceptions

"Six Month Rule"

The six-month rule is applied to patients who the practices report as voluntarily disenrolling from the demonstration. This rule was determined in clearance for the demonstration, in efforts to prevent practices from prematurely disenrolling patients who they know or believe to be high cost. Patients who are voluntarily disenrolled from the demonstration after six or more months of enrollment in any performance year are included in the calculations based on the full performance year. However, patients who are voluntarily disenrolled after fewer than six months of enrollment in any performance year are not included at all in the patient population for the performance year for purposes of establishing the expenditure target and calculating savings. The six-month rule applies to the following reasons for disenrollment (all of which are considered "voluntary"):

- Patient changed primary care provider within the IAH practice's service area

- Patient or patient's family declined in-home care
- Patient elected hospice and the IAH practice did not remain the physician of record
- The IAH practice was unable to locate the beneficiary
- The IAH practice discharged the patient from its service
- Other reasons reported by the IAH practice, as determined by CMS

For example, a patient who is enrolled for eight months of a performance year and is subsequently disenrolled for changing practices is counted as being enrolled for the entire year, and any costs associated with utilization within that year are used in determining savings calculations—even costs associated with the time when that patient was no longer receiving primary care from the participating practice. Note that if such a patient becomes ineligible for the demonstration after the voluntary disenrollment (such as by death or joining an MA plan), he or she is disenrolled as of that date.

If a patient is enrolled in the demonstration for 5 months of a performance year, but then decides to change practices, the patient and all associated expenditures are excluded from that performance year.

Section 2: Calculating Actual Expenditures

The actual expenditures for each practice and consortium are calculated after the performance year population has been defined. Actual expenditures are calculated on a per beneficiary per month (PBPM) basis. We allow six months after the close of the performance year for all claims to be reported. Note that this translates to a *minimum* of six months of claims runout; most months in which services occur during the performance year will have more than six months of claims runout. Using performance year 6 as an example, this means we will wait until the end of June 2020 for claims to be reported to tabulate actual expenditures.

Expenditures are included for all beneficiaries during the time they were enrolled and/or eligible during the performance year. The methods for defining eligibility and the associated time period were described above in Section 1. We include expenditures for all claims where the service date is inside the beneficiary's period of eligibility. Expenses occurring on the date of death are included in the actual expenditure calculation. The service date for most claims is the date the beneficiary received the service (referred to as the "from date" on the claim). For Inpatient and Skilled Nursing Facility (SNF) claims, the service date is the date the beneficiary was admitted to the facility (the admission date on the claim).

We include all Medicare Part A and Part B FFS expenditures from the Inpatient, SNF, Outpatient, Physician, Durable Medical Equipment (DME), Home Health Agency (HHA), and Hospice claims files. Indirect Medical Education (IME), Graduate Medical Education (GME), and Disproportionate Share Hospital (DSH) payments are excluded, though we include inpatient pass-through amounts, which include direct medical education, capital-related costs, and bad debt. These provisions ensure that the actual expenditures are calculated on the same basis as the average FFS county costs, which exclude IME, GME, and DSH and include pass through amounts. Individually identifiable payments made under any other CMS demonstration, pilot, or time-limited program also are included.

We do not apply any completion factors to these expenditures. The use of six months of claims runout, at a minimum, matches the amount of runout that is used in the development of the average FFS county costs, on which the spending target is based. Therefore, there should be no differences in the comparison that are attributable to differing claims runout periods. If it is ever the case that the FFS data include runout that is more than six months, we will apply a completion factor in the development of the actual expenditures, since they will always be compiled six months after the close of the performance year. If the FFS data should ever include less than six months of runout, we will either apply a completion factor to the FFS expenditures or include less runout in the development of the actual expenditures, whichever is deemed most appropriate at the time by CMS.

2.1 Outlier Adjustment

Annual PBPM expenses per beneficiary are truncated at the 99th percentile of annual expense for all beneficiaries in IAH, prior to finalizing the actual expenditures that are measured against the spending target. Truncation is performed to reduce the effect of unexpectedly high-cost patients that a practice may treat in any given year. These high-cost patients could negatively impact the calculation of a practice's savings. Annual expenses above the 99th percentile are set equal to the 99th percentile.

We determine the truncation thresholds separately for ESRD and non-ESRD beneficiaries and also geographically adjust so that practices in lower-cost areas have a fair chance at receiving the outlier adjustment. To determine the geographic adjustment, we use the relationships between each practice's

average FFS county cost and the demonstration average FFS county cost; these are the same FFS county costs that are used to set the spending targets (see Section 3.1)

2.2 Sequestration Adjustment

Beginning April 1, 2013, all Medicare expenditures were reduced by two percent due to sequestration. In the absence of sequestration, Medicare expenditures would be approximately two percent higher (technically 1/0.98 or 2.041% higher) than the payment that was actually made. Beginning May 1, 2020 and effective through December 31, 2020, sequestration was suspended as part of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). The suspension was extended through March 31, 2021 as part of the Consolidated Appropriations Act of 2021 and has now been extended through December 31, 2021 (H.R. 1868, signed April 14, 2021).

All Medicare claims expenditures in years in which sequestration reductions were implemented will be adjusted to remove the effects of sequestration reductions. All non-DME claims with a through date of April 30, 2020 or earlier will be adjusted by dividing the Medicare payment by 0.98. DME claims with a *from date* of April 30, 2020 or earlier will be adjusted by dividing the Medicare payment by 0.98 (this reflects how sequestration was actually implemented). Dividing by 0.98 will increase the claim payments up to the amount that would have been paid in the absence of sequestration. Claims occurring May 1, 2020 through at least December 31, 2021 (based on the dates and claim types above) will not receive these adjustments. Similar adjustments will be made, as appropriate, given the law in effect at the time.

2.3 Final Actual Expenditures

PBPM actual expenditures are calculated by summing the total Medicare FFS payments, after adjusting for outliers and sequestration, for all of the beneficiaries at each practice and consortium and dividing by the associated number of beneficiary months.

Section 3: Calculating the Spending Target

The spending target estimates the Medicare FFS Parts A and B expenditures that would have been incurred by IAH beneficiaries in the absence of the demonstration. It is practice-specific in that it is developed for each practice and consortium's applicable beneficiary population. We calculate a new spending target for each performance year. Spending targets are first determined for each beneficiary in the performance year population and then are averaged over the entire practice to obtain the practice-level spending target.

The beneficiary-level spending targets depend upon a base FFS expenditure amount, a trend factor, and risk adjustment factors, as shown in the following formula:

Spending Target = Average FFS Cost in County of Residence * Trend * (Risk Score + Frailty Factor + Utilization Factor)

The Average FFS Cost in County of Residence (per beneficiary per month) and Trend Factors are derived from data published each year by CMS. We use the most currently available data at the time of the calculation. The trend represents the expected average increase in the PBPM Medicare Parts A and B costs. The risk scores are derived using the CMS Hierarchical Chronic Condition (CMS-HCC) model and are based on demographic factors and diagnoses from the twelve months prior to initial enrollment in the demonstration. The frailty factor is added to the risk score to reflect a beneficiary's functional impairments that may increase the cost of care and are not reflected by the CMS-HCC model. The frailty factor is based on the number of ADL impairments reported by the practice and each patient's Medicaid status. Finally, the utilization factor is added to the frailty-adjusted risk score to reflect the level of risk that is not captured by the CMS-HCC model for beneficiaries with a hospitalization and post-acute care in the 12 months prior to their enrollment date in the performance year. All new enrollees of IAH providers receive a prospective CMS-HCC risk score, frailty factor, and utilization factor. The risk score and frailty factor for continuing enrollees are updated in future performance years only for changes in demographics (age and Medicaid status). The utilization factor is applied in future performance years only if a continuing enrollee had a hospitalization and post-acute care in the 12 months prior to the performance year.

An individual practice's or consortium's spending target equals the average of these PBPM predicted costs, weighted by the number of months of each beneficiary's participation. Below we describe each of the elements of the spending target in more detail.

3.1 Average FFS County Costs

CMS' Office of the Actuary (OACT) publishes average FFS expenditure data each year at the county level by Medicare entitlement category (Aged, Disabled, ESRD) and at the state level for beneficiaries on dialysis. The data are lagged by about fifteen months. For example, the calendar year (CY) 2018 expenditures were published in April 2020. For performance year 6, we will use CY 2018.

The FFS expenditure data include six months of claims runout after the end of the calendar year. If it is ever the case that the FFS data include runout that is more than six months, we will apply a completion factor in the development of the actual expenditures, since they will always be compiled six months after the close of the performance year. If the FFS data should ever include less than six months of runout, we will either apply a completion factor to the FFS expenditures or include less runout in the

development of the actual expenditures, whichever is deemed most appropriate at the time by CMS. The FFS data include all Medicare Part A and Part B expenditures.

The FFS data include total Medicare payments and Medicare payments excluding IME, GME, and DSH payments. We use the latter set of expenditures, those that exclude IME, GME, and DSH. Note that these expenditures include inpatient pass-through amounts. Though hospice is a Medicare Part A cost, it is published in a separate file. We include the hospice expenditures in the total spending target.

The FFS data is reported for each county as a Part A per capita expenditure for all Part A enrollees (including those enrolled in Parts A and B as well as those only enrolled in Part A) and a Part B per capita expenditure for all Part B enrollees (including those enrolled in Parts A and B as well as those only enrolled in Part B). Because the IAH population is required to be enrolled in both Parts A and B, we apply an adjustment at the state level so that the Part A and Part B per capita expenditures represent the costs for beneficiaries enrolled in both Part A and Part B. We use the Medicare Limited Datasets, which are based on the Medicare 5 percent Sample, to determine this adjustment. The adjustment is applied according to each beneficiary's state of residence as reported by the practice (for enrolled beneficiaries) or as determined by the Medicare EDB (for potentially eligible beneficiaries).

Every patient in each practice and consortium is assigned an Average FFS County Cost based on their county of residence, as reported by the practice, and their Medicare status. We assign a county cost for each eligible month to reflect any movement from Aged or Disabled status into ESRD status and to reflect the progression of ESRD patients (dialysis, transplant, post-graft).

Beneficiaries who are either Aged or Disabled are assigned a composite Aged-Disabled cost for their county of residence. This is consistent with the development and intended use of the risk scores used for IAH, which are described below. Beneficiaries with a Medicare status of ESRD are assigned an Average FFS County Cost based on whether they were on dialysis or had had a transplant during the performance year. Those on dialysis, or who are in the first, second, or third month after transplant are assigned the dialysis cost in their state. Those who are in the fourth or later month after transplant are assigned the composite Aged-Disabled cost for their county of residence. This is consistent with the development and intended use of the ESRD risk scores used for IAH. The Medicare entitlement and ESRD information come from the Medicare EDB.

County of residence is identified by the zip code reported by the practice in the IAH reporting system. Though residence is also available from the EDB, we believe that the practices are the best source for residence information because they visit their patients in the home, whereas zip codes in the EDB represent the SSA mailing address and may not represent a beneficiary's true residence. For potentially eligible beneficiaries, the EDB is used to determine the county of residence, as it is the only source of information. Zip codes are mapped to SSA county codes for use of the FFS data.

Once an Average FFS county cost has been assigned to each beneficiary-month, the non-hospice cost is standardized by dividing it by the average risk score for all FFS beneficiaries in the county. Each county's risk score is published in the same file as the expenditures. We standardize the costs to bring them to a "1.0," or, average, basis. This allows them to serve as an appropriate basis for the risk adjustment used to calculate the spending target; CMS-HCC risk scores represent a population's predicted cost relative to average (for example, a risk score of 2.0 indicates predicted expenses that are

twice that of the average). We do not standardize the hospice expenditures because they are not likely to vary by a beneficiary's diagnosis history.[3]

Finally, we adjust all Average FFS county costs to remove the effect of sequestration on the claims data underlying the files. Mirroring the adjustment, we make to the claims data in the calculation of the actual expenditures (see Section 2.2), we divide by 0.98.

3.2 Trending to the Performance Year

The trend factors are updated each year and come from the most recently available Medicare Trustees Report. Because the Trustees Report publishes the percent change in average per beneficiary cost only at the national level, we use historical years of the average FFS county cost data (aggregated to the state level) in conjunction with the Trustees Report to develop state-level trends to apply to each practice's spending target. In other words, the trends are state-specific, but are calibrated to the national average Parts A and B trends published in the Trustees Report. For example, if a state has shown in the past that its Part A trends in FFS expenditures are 3% higher than the national average, we increase the Trustees Report Part A trend by 3% for that state in the development of the spending target.

For performance year 6 we will use the 2020 Trustees Report, which shows trends of 3.1% for Part A per beneficiary costs and 6.2% for Part B per beneficiary costs for 2018 to 2019. For 2019 to 2020, the estimated trends are 5.2% for Part A and 6.2% for Part B. These trends may change in future Trustees Reports, on which subsequent performance years' calculations will be based.

3.3 Calculating the Risk Score

Risk scores are calculated for all applicable beneficiaries using the v2113.87 CMS-HCC and CMS ESRD risk models. They are based on diagnosis and demographic information from the twelve months prior to each patient's enrollment date. Risk scores are calculated for each beneficiary upon initial enrollment in the demonstration. As with the FFS county costs, we assign a risk score to each new IAH beneficiary for each eligible month in the performance year to reflect any movement between Medicare statuses and to reflect movement within the ESRD status. For each performance year after a beneficiary's first year in IAH, the risk score is updated only for demographic changes (age, Medicaid status) or for a Medicare status change into ESRD; it is not updated for changes in diagnoses.

CMS uses the CMS-HCC and CMS ESRD models to adjust capitation payments made to Medicare Advantage (MA) and Medicare PACE plans, with the intention of paying health plans appropriately for their expected relative costs. CMS-HCC risk scores measure a person's or a population's health status relative to the average, as applied to expected medical expenditures. A population with a risk score of 2.0 is expected to incur medical expenditures twice that of the average. It is important to note that the model is accurate at the group level and that actual expenditures for any individual can be higher or lower (sometimes significantly) than those predicted.

The risk score models are prospective, using demographic and diagnosis information from a base year to estimate expenditures in the next year. For example, risk scores for 2020 are based on

[3] Hospice rates were established in 1983 and have been updated since based on inflation and geography. Hospice rates are paid daily for the entire time a patient is enrolled in hospice, regardless of service usage during that period.

information from 2019. The demographic characteristics used are age, sex, Medicaid status, and original reason for Medicare entitlement. The diagnosis information used is the set of ICD-10 diagnosis codes reported on Medicare claims in the base year. The models specify that only Hospital Inpatient, Hospital Outpatient, Physician, and some non-Physician claims be used. The source of a particular diagnosis code has no relevance (i.e., diagnoses from an Inpatient hospitalization have equal weight as those from a Physician visit), nor does the frequency with which the diagnosis code has been reported.

For more information on the CMS-HCC risk model, see the following web page:

https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors-Items/Evaluation2011.html?DLPage=1&DLEntries=10&DLFilter=hcc&DLSort=0&DLSortDir=descending

Both the CMS-HCC and CMS-ESRD models used for IAH produce a community, institutional, and new enrollee score for each beneficiary, however we use only the community score. We do not use the institutional scores because IAH applicable beneficiaries are not institutionalized, by definition. We do not use the new enrollee score, even if a beneficiary is a new Medicare enrollee, because IAH beneficiaries are significantly different than general Medicare new enrollees and we believe the new enrollee scores would significantly underestimate their risk. See Section 3.3.5 below for the method we use to assign risk scores to new enrollees and others who did not have a full year of Parts A and B enrollment in the year on which the risk score is based.

The sections that follow describe how we assign and use the CMS-HCC risk scores and the CMS ESRD risk scores, and the adjustments we make to all risk scores.

3.3.1 Scores from the CMS-HCC Model

Beneficiaries with a Medicare status of Aged or Disabled in any eligible month of enrollment receive a risk score produced by the CMS-HCC risk model. All else being equal, the CMS-HCC model used for IAH produces the same risk score for an Aged beneficiary as it does for a Disabled beneficiary.[4] Aged and Disabled beneficiaries also receive the Aged-Disabled composite average FFS county cost for the same month. The CMS-HCC risk score will be multiplied by the average FFS county cost that has been assigned to each beneficiary.

3.3.2 Scores from the CMS ESRD Model

Beneficiaries with ESRD receive a risk score produced by the CMS ESRD model. The model produces four types of risk score:

- Dialysis,
- Transplant Months 1–3 (for aged and non-aged),
- Transplant Months 4–9 (for aged and non-aged), and
- Transplant Months 10+ (for aged and non-aged).

For each of these cells, the model also produces an institutional and new enrollee score; however, we do not use those scores for the same reasons as were discussed above. We use dialysis and

[4] Though more current versions of the CMS-HCC model produce different risk scores for aged and disabled beneficiaries, IAH uses an earlier version of the model that does not.

transplant information from the Medicare EDB to determine which ESRD risk score to apply in each month of eligibility, and to determine whether to assign the aged or non-aged score.

Scores from the ESRD model are calibrated to be multiplied by two different "base costs." One would expect that the risk score for a beneficiary on dialysis would be quite high; however, the dialysis score will generally be much lower than the CMS-HCC score for the same person. This is because the dialysis scores have been developed to have a much higher "base cost" than the CMS-HCC scores. As such, dialysis scores and Transplant Month 1–3 scores will be multiplied by the average cost for beneficiaries on dialysis in each state. Transplant Month 4–9 and Transplant Month 10+ scores will be multiplied by the Aged-Disabled composite Average FFS County Cost, consistent with how these post-graft scores are modeled.

3.3.3 Frailty Adjustment

The CMS-HCC model used for IAH under-predicts expenses for the non-institutionalized frail elderly. So that PACE plans, which focus on a frail population, would not be underpaid, CMS developed a frailty adjustment to more accurately pay plans treating such a population. Frailty is measured by functional status and depends upon the number of ADL limitations that a beneficiary has as well as the beneficiary's Medicaid status. The ADLs are bathing, eating, dressing, toileting, transferring, and walking. Frailty adjustments in the PACE program are applied for 0, 1–2, 3–4, and 5–6 ADL limitations. For PACE, ADL limitations are collected by self- or proxy-reported responses to the Health Outcomes Survey-Modified. In IAH, ADL limitations are reported by the participating practices.

Because the IAH population is also a frail population and is one that is required to need human assistance with at least two ADLs, we apply a frailty adjustment to each non-ESRD beneficiary's risk score, using frailty adjustment factors that have calibrated to be used in combination with the IAH utilization factor, described below in Section 3.3.4.[5] In addition, because IAH requires beneficiaries to have at least two functional impairments before qualifying for enrollment, CMS separately developed a frailty factor to apply to the CMS-HCC risk score for beneficiaries with two functional impairments (as opposed to using a grouped frailty factor for 1–2 functional impairments). The recalibrated frailty factors for the revised actuarial-based method are shown in Table 1.

Table 1: IAH Frailty Factors

Number of ADLs	Non-Medicaid	Medicaid
1*	0.123	0.000
2	0.153	0.000
3-4	0.247	0.182
5-6	0.247	0.409

* Shown for illustrative purposes only.

The frailty adjustment is additive, rather than multiplicative, in that the frailty adjustment factor is added to the CMS-HCC risk score. We will use the same frailty adjustment factors each year. The frailty adjustment for each IAH beneficiary is not updated once it has been initially determined.

[5] We will not apply frailty factors to risk scores produced by the CMS ESRD model. The frailty factors are developed using the CMS-HCC model and are not consistent with risk scores produced by the CMS ESRD model.

Practices must report the ADLs with which each enrolled beneficiary requires human assistance. For potentially eligible beneficiaries, we assign the minimum number of ADLs (two) required for demonstration eligibility. Recall that we include potentially eligible patients who the practice has said they have already enrolled or intend to enroll, which suggests that the practice agrees that the patient is eligible for the demonstration and has the minimum required numbers of ADL limitations and chronic conditions. Potentially eligible patients who are included in a performance year because the practice did not provide any response regarding eligibility status for IAH are also assigned two ADLs for the purposes of calculating risk scores.

3.3.4 Utilization Adjustment

CMS also applies a utilization adjustment, in addition to the frailty adjustment, to the CMS-HCC risk score to reflect the level of risk that is not captured by the CMS-HCC model for beneficiaries with a hospitalization and post-acute care in the 12 months prior to their enrollment date in the performance year. This utilization factor helps to better predict the cost of IAH beneficiaries in the absence of the demonstration. The utilization factor for all beneficiaries is 0.245, and will be applied to the CMS-HCC risk score of all beneficiaries newly enrolled in the performance year (who, by default, have had the required utilization prior to initial enrollment) and to the CMS-HCC risk score of all beneficiaries continuing enrollment in the performance year who had a hospitalization and post-acute care in the 12 months prior to the performance year. For continuing enrollees who did not have a hospitalization and post-acute care in the 12 months prior to the performance year, the utilization factor is zero. The utilization factor will apply to only CMS-HCC risk scores, and not to CMS ESRD risk scores.

3.3.5 Normalization

The CMS-HCC and CMS ESRD models are calibrated with each new version to produce an average risk score of 1.0 for the calibration year. When the models are used on years other than the calibration year, predictions for prior years are lower and predictions for subsequent years are higher, due to natural changes in coding and population that occur over time. To account for this, risk scores must be adjusted to produce an average of 1.0 when using the risk model with years other than the calibration year. This adjustment is called normalization.

The calibration year for the v2113.87 CMS-HCC model and for the CMS ESRD model is 2009. As such, normalization factors in IAH will account for average changes in coding and population between 2009 and each beneficiary's initial year of enrollment in IAH. For example, a beneficiary who first enrolled in IAH in performance year 3 will have a normalization factor calculated for year 3 and applied for all subsequent years in which the beneficiary remains eligible. The normalization factor is not updated in any subsequent years in which the beneficiary is enrolled in IAH.

Consistent with the methodology used by the CMS Office of the Actuary for calculating normalization factors, in IAH CMS calculates normalization factors based on the average change in national average "raw" (not normalized) risk scores over a five-year period. These national averages were published annually in the Advance Notice of Methodological Changes for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and Draft Call Letter. The national average risk scores shown in Table 2 for the model versions used by IAH were published through the 2020 Advance Notice. This was the last year for which CMS will publish updated national average risk scores for these models.

Table 2: National Average CMS-HCC and CMS-ESRD Raw Risk Scores

Risk Score Type	2011	2012	2013	2014	2015	2016	2017	2018
CMS-HCC	1.030	1.042	1.042	1.048	1.051	1.079	1.098	1.125
CMS-ESRD	0.956	0.971	0.973	0.980	0.985	1.008	N/A	N/A

To calculate the normalization factor for IAH beneficiaries at the time of their initial enrollment, we first determine the annual average change in the national average risk score based on the five years of risk score data ending in the performance year or in 2018, whichever is earlier. For example, for beneficiaries who were first enrolled in year 3, we calculate an annualized average change in risk scores from 2011 to 2015, and for those first enrolled in year 6, we calculate the annualized average change in risk scores from 2014 to 2018 (as 2019 national average risk score data for these models is unavailable). The annualized change for beneficiaries enrolling in year 6 is 1.0179 (or (1.125/1.048) ^ (1/4)).

Normalization factors are applied from the midpoint of the model's calibration year to the midpoint of each beneficiary's enrollment year. The number of months of normalization to apply will vary depending upon each beneficiary's enrollment date. For example, for an Aged or Disabled beneficiary enrolling on January 1, 2019 and average annual change in risk scores of 1.0179 calculated above, we would apply 10 years (the number of years between 2019 and 2009, the model denominator year) of change (1.0179 ^ 10) and the normalization factor would be 1.194. To apply normalization, we divide the risk score by the normalization factor.

3.3.6 "New Enrollee" Scores

The CMS risk models are designed to use for beneficiaries with twelve months of FFS eligibility in the base year, so that a full year of diagnoses be used in the determination of the risk score. Beneficiaries who are new to Medicare or who were enrolled in an MA plan for part of the year prior to enrollment do not meet this criterion. When determining risk scores for such enrollees in the general Medicare population, CMS applies the new enrollee risk score produced by the model. However, these new enrollee scores are based on experience in the general Medicare population, which is on average significantly healthier than the IAH population. As such, the new enrollee scores produced by the CMS risk model are not appropriate for the IAH population and a different method must be used.

IAH beneficiaries who do not have twelve months of FFS eligibility in the year prior to enrollment (both Part A and Part B, not enrolled in MA or PACE, no Medicare secondary payer) are assigned the higher of the following two scores:

- The risk score produced by the model when the beneficiary's partial-year experience is used; or
- The average risk score for the practice for Aged/Disabled risk scores. For ESRD Dialysis and transplant scores we assign the average for the entire demonstration due to the low prevalence at the practice level.

This comparison is made prior to frailty and utilization adjustments; beneficiaries receive frailty adjustment based on the ADL counts reported by the practice and utilization adjustment based on their experience in the 12 months prior to the performance year.

3.4 Determining the Practice/Consortium Spending Target

As described in the sections above, we assign a trended average FFS county cost and a risk score for each month that an applicable beneficiary is enrolled in the demonstration. To calculate the spending target for each practice/consortium we take the following steps:

1. Calculate a spending target for each beneficiary month as the product of the average FFS county cost, trend, and risk score (including frailty and utilization adjustments) for that month.
2. Calculate a spending target for each beneficiary as the average of that beneficiary's monthly spending targets during the performance year, weighted by the beneficiary's months of eligibility in each month.
3. Calculate the spending target for the practice/consortium as the average of the beneficiary-level spending targets, weighted by each beneficiary's eligible months during the performance year.

Section 4: Determining Shared Savings Incentive Payments

There are several steps in determining whether or not a practice/consortium will share in any savings. First, the actual expenditures must be compared with the spending target. Then it must be determined whether the practice/consortium has generated savings that, with some level of confidence, are not due to random variation. Finally, quality performance must be evaluated to determine any final incentives. Final incentive payments are then reduced by 2% for any year for which sequestration is in effect at the time of payment, as is required by current law, and by an amount that varies each year depending on whether the annual enrolled beneficiary maximum of 15,000 (PY6 and PY7) or 20,000 (PY 8–10) was exceeded in that year.

4.1 Expense Comparison

We compare actual expenditures to the spending target on a PBPM basis. The actual-to-expected ratio is defined as PBPM actual expenditures divided by the PBPM spending target. Ratios below 1.0 indicate possible savings. The savings percentage equals one minus the actual-to-expected ratio.

4.2 Statistically Significant Savings Requirement

Per the IAH legislation, "the spending targets shall include a risk corridor that takes into account normal variation in expenditures for items and services covered under parts A and B…" This provision ensures that differences between the target and actual spending represent actual savings rather than differences owing to normal variation in Medicare spending. To determine if actual savings have occurred, CMS constructs a one-sided confidence interval around each practice's average actual expenditures for the performance year and compares the practice's spending target to the upper bound of the confidence interval. If the spending target exceeds the upper bound of the confidence interval, CMS is confident that the savings were not random, and the practice is eligible for an incentive payment. The more beneficiaries there are in a practice's population and the lower the variation in expenditures among those beneficiaries, the smaller the width of the confidence interval and the more likely that actual savings have occurred.

CMS calculates the one-sided confidence interval using the standard error of each practice's actual expenditures.[6] The lower bound of the confidence interval is the average actual PBPM expenditures. The upper bound is equal to the average actual PBPM expenditures plus a constant multiplied by the standard error. In other words, the upper bound is some number of standard errors above the average actual expenditures. The constants are those consistent with 80% (0.842) and 85% (1.036) confidence. These constants assume a normal distribution of expenditures in each practice. If the spending target is above the upper bound of the confidence interval, CMS is 80% or 85% confident that the savings were "real" and not due to random variation. The upper bound of the 85% confidence interval can be expressed as:

$$\text{Actual Expenditures} + 1.036 * \text{Standard Error}$$

The upper bound of the 80% confidence interval can be expressed as:

$$\text{Actual Expenditures} + 0.842 * \text{Standard Error}$$

[6] The standard error of the mean is equal to the standard deviation divided by the square root of the number of beneficiary months in the practice's or consortium's IAH beneficiary population.

If the practice's spending target exceeds the upper bound of the 85% confidence interval, it may receive up to 80% (based on quality performance) of shareable savings; if the practice's spending target exceeds the upper bound of the 80% confidence interval (but not the upper bound of the 85% confidence interval) it may receive up to 50% (based on quality performance) of shareable savings. Shareable savings are defined as the savings above the first 5 percent saved; CMS retains the first 5 percent saved, which is equal to 5 percent multiplied by the spending target and total beneficiary months. If the practice's spending target does not exceed the upper bound of either confidence interval, it will not qualify for an incentive payment for the performance year. The 50% or 80% of shareable savings is referred to as the savings that qualify for sharing.

4.3 Quality Performance

Practices must meet quality performance thresholds to be eligible for shared savings incentive payments. To qualify for incentive payments, a practice must meet or exceed performance requirements on at least three of the six quality measures that are tied to payment. Practices that meet fewer than three of the quality measures are not eligible for incentive payments. The quality measures tied to payment and their minimum performance thresholds are shown in Table 3. Table 4 shows the percentages of incentive payments a practice will receive if it meets or exceeds the performance requirements of the specified quality measures.

Table 3: Quality Measures Tied to Payment and their Thresholds

Quality Measure	Threshold Value
Number of inpatient admissions for ambulatory-care sensitive conditions	Threshold equal to or less than the average utilization in an unmanaged, clinically similar population with case mix and geographic adjustments
Number of readmissions within 30 days	
Number of ED visits for ambulatory-care sensitive conditions	
Contact with beneficiaries within 48 hours upon admission to the hospital, and discharge from the hospital and/or ED	50% of the time
Medication reconciliation in the home within 48 hours of hospital discharge or ED visit	50% of the time
Patient preferences documented in medical record	80% of the time

Notes: Medication reconciliation and 48-hour follow-up after hospital discharge or ED visits are required to be in the home. This requirement is temporarily waived, beginning January 27, 2020, in response to the Covid-19 pandemic. Follow-up visits conducted via telecommunication qualify for inclusion in the calculation of these two quality measures for Year 7 through the end of the COVID public health emergency.

Table 4: Percentage of Shared Savings Earned Based on Quality

Number of Quality Measures Met (of those tied to payment)	Percentage Received of Savings that Qualify for Sharing
< 3	0%
3	50%
4	66 $^{2}/_{3}$%
5	83 $^{1}/_{3}$%
6	100%

4.4 Sequestration Reduction

All incentive payments include the 2% sequestration reduction for any year that sequestration is in effect at the time of payment. Payments made during a period where sequestration is not in effect will not be reduced by 2%. The reduction will be made after a preliminary incentive payment has been calculated based on quality performance.

4.5 Reduction for Annual Enrollment Maximum

The language in Section 3024 of the Patient Protection and Affordable Care Act originally limited the number of beneficiaries that could participate in the IAH demonstration to 10,000. Under the amendment that extended the demonstration to a sixth and seventh year, that maximum was increased to 15,000. For years 8-10, the maximum was increased to 20,000.

The 15,000 maximum applies to performance years 6 and 7. No limits are imposed on the number of patients that any practice may enroll in IAH. However, the number of beneficiaries on which incentive payments are calculated will be reduced proportionately in each practice or consortium in years in which the total number of applicable beneficiaries has exceeded 15,000. For example, if the total demonstration population reached 16,000 in a performance year, we would reduce the number of beneficiaries included in the incentive payment calculation by 1,000. This is 6.25% of the total. We would reduce the number of beneficiaries in each practice or consortium by 6.25%, rounding to reduce by a whole number of beneficiaries. Assuming a practice with 350 beneficiaries, we would reduce their population by (1,000/16,000) * 350 people, which is 21.9. We would round that number up and reduce by 22 beneficiaries. For years 8–10, a similar calculation will be performed if the total enrollment exceeds 20,000.

The beneficiary population is reduced only for the purposes of incentive payment calculation; for shared savings and quality calculations we use the experience of all applicable beneficiaries. We reduce the beneficiary population after the savings percentages and quality measures have been calculated but BEFORE incentive payments have been calculated such that the total number of applicable beneficiaries on which annual incentive payments are calculated does not exceed 15,000. Including all beneficiaries in the annual calculation of savings and quality results in more robust calculations and narrower confidence intervals.

Consider the example above with 350 applicable beneficiaries initially and assume that there are 2,800 associated beneficiary months. We would calculate savings based on the performance year experience of all of those beneficiaries. If that calculation results in $200 PBPM in savings, the total

dollars saved, from which incentive payments are ultimately determined, is $560,000 (2,800 * $200). To apply the adjustment for reaching the 15,000 maximum, we would reduce the total beneficiary months for this practice by the number of beneficiary months associated with 22 beneficiaries in this practice. If there is an average of 8 months per beneficiary, we would reduce the practice's total beneficiary months by 176 months (22 beneficiaries * 8 months per beneficiary). The resulting beneficiary month total would be 2,624 and the adjusted total dollars saved is $524,800 (2,624 * $200). In this way, the population on which incentive payments are determined has been reduced to a total of 15,000 or fewer and the calculations on which savings and quality are based are as robust as possible.

Any practice whose reduced beneficiary population would fall below 200 will have its reduction adjusted such that the number of beneficiaries on which the final incentive payment is based is 200. This reflects the required minimum practice size.

4.6 Determination of Final Shared Savings Incentive Payment

Practices with fewer than 200 applicable beneficiaries in the performance year or for which the actual expenditures exceed the spending target do not qualify for any shared savings incentive payment. Practices with at least 200 applicable beneficiaries in the performance year and whose actual expenditures are less than their spending targets are eligible to receive shared savings incentive payments if their spending targets exceed the upper bound of the confidence interval around the actual expenditures at either the 80% or 85% confidence level. Only savings after the first five percent saved will be shared between the practice and CMS. Finally, eligible practices will be paid based on the number of quality measures met that are tied to payment. A few examples follow.

Example 1

Practice A, with 400 applicable beneficiaries and 4,000 eligible months during the performance year, achieves a savings percentage of 12% based on a spending target of $3,409 and actual expenditures of $3,000 PBPM. The upper bound of the 85% one-sided confidence interval around Practice A's actual expenditures is $3,350, meaning that Practice A qualifies to share in 80% of any savings after the first 5 percent. CMS will retain the first 5 percent saved ($170.45 PBPM, $681,800 in total). The remaining 7% ($238.63 PBPM, $954,520 in total) may be shared between CMS and the practice, after adjusting for sequestration (if it is in effect) and whether the demonstration annual enrollment maximum of 15,000 beneficiaries was reached.

Table 5: Example Practice A Possible Incentive Payments

Quality Measures Met	Amount Available to Share after CMS retains the first 5 percent saved	Percentage Paid Based on Quality	Amount Earned after Quality
<3	80% * $954,520 = $763,616	0%	$0
3		50%	$381,808
4	(CMS keeps	66 $^{2}/_{3}$%	$509,077
5	20% * $954,520 = $190,904)	83 $^{1}/_{3}$%	$636,347
6		100%	$763,616

Practice A met four of the six measures, to receive a payment of $509,077. There was a total of $1,636,320 saved. CMS retains $1,127,243 (69%) and the practice receives $509,077 (31%).

Example 2

Practice B, also with 400 applicable beneficiaries and 4,000 eligible months during the performance year, achieves a savings percentage of 7% based on a spending target of $2,688 and actual expenditures of $2,500 PBPM. The upper bound of the 85% confidence interval around Practice B's actual expenditures is $2,800 and the upper bound of the 80% confidence interval is $2,600, meaning that Practice B qualifies to share in 50% of any savings after the first 5 percent. CMS will retain $537,600 (5% * $3,400 * 4,000). The remaining 2% (or $215,040) may be shared between CMS and the practice. The amount available to share is 50% of $215,040, or $107,520. Practice B meets all six of the quality measures tied to payment and the amount of $105,370 (or, $107,520 * 0.98, for sequestration if in effect). We assume the total applicable beneficiary population in this example was below 15,000. CMS retains a total of $847,000.

Example 3

Practice C, with 2,000 applicable beneficiaries, achieves a savings percentage of 5 percent, and its spending target exceeds the 85% confidence interval around its actual expenditures. CMS will retain all savings because there were no savings above the first 5 percent.

Example 4

Practice D, with 500 applicable beneficiaries, achieves a savings percentage of 6%, however Practice D's spending target exceeds neither the upper bound of the 85% confidence interval nor the 80% confidence interval around its actual expenditures. Practice D does not qualify for an incentive payment.

Appendix A: Hospitalization, Post-Acute Care, and Home Visit Specifications

Qualifying Hospitalization

In the 12 months prior to the enrollment date the beneficiary must have had a Medicare-covered hospitalization (one that can be found in the final action claims). A qualifying hospitalization is:

1. An Inpatient claim where the last 4 digits of the provider number are in one of the following ranges:
   a. 0001-0899 (acute care hospitals)
   b. 1300-1399 (critical access hospitals)
   c. 4000-4499 (psychiatric hospitals)
   d. S*** (psych unit of an acute care hospital)
   e. M*** (psych unit of a critical access hospital) OR
2. An Outpatient claim with any revenue center code of 0760 (general classification category) or 0762 (observation room) AND any procedure code of G0378 (hospital observation service, per hour) or G0379 (direct admission of patient for hospital observation care). These are observation stays.

The discharge date on the inpatient claim or the thru date on the outpatient claim must be within the twelve-month period prior to enrollment. The date of the qualifying hospitalization is the earliest of:

- The discharge date on the earliest qualifying INP claim;
- The thru date on the earliest qualifying outpatient claim.

Qualifying Post-Acute Care Use

In the 12 months prior to the enrollment date the beneficiary must have had a post-acute care visit. Qualifying post-acute care is:

1. An Inpatient claim with the following provider codes (last 4 digits):
   a. 3025-3099 (inpatient rehab) OR
   b. 2000-2299 (long term care acute)
   c. T*** (rehab unit of an acute care hospital)
   d. R*** (rehab unit of a critical access hospital)
2. Any Home Health Agency claim
3. Any Skilled Nursing Facility claim

The discharge date on a SNF or Inpatient claim must be within the twelve-month period prior to enrollment. Either the from date OR thru date on an HHA claim must be within the twelve-month period prior to enrollment. The date of the qualifying post-acute care service is the earliest of:

- The discharge date on the earliest SNF claim;
- The discharge date on the earliest qualifying Inpatient claim;
- The “from date” or “thru date” on the earliest HHA claim, whichever falls within the 12-month period prior to enrollment.

Home Visit

A home visit is any Physician claim with a Place of Service Code in (02, 12, 13, 14, 33, 32) AND a procedure code in (99341-99345, 99347-99350, 99324-99328, 99334-99340). For visits occurring during the Public Health Emergency (PHE) declared on January 27, 2020 as the result of the 2019 Novel Coronavirus, audio-only Evaluation and Management codes 99441, 99442, and 99443 will also count as home visits, with the same place of service requirements listed above. These codes will be treated as home visits for the duration of the PHE.

Appendix B: Identification of Potentially Eligible Patients

Below are the steps we take in identifying potentially eligible IAH patients and assigning them enrollment dates. The methodology assumes the use of IAH provider Tax Identification Numbers (TINs), National Provider Identifiers (NPIs), and Medicare claims and EDB data.

1. Generate a list of beneficiaries who had at least one home visit by any participating IAH provider (TIN-NPI combination) in the applicable look back period (see next paragraph). A home visit is any Physician claim with a Place of Service Code in (02, 12, 13, 14, 33, 32) AND a procedure code in (99341-99345, 99347-99350, 99324-99328, 99334-99340). For visits occurring during the Public Health Emergency (PHE) declared on January 27, 2020 as the result of the 2019 Novel Coronavirus, audio-only Evaluation and Management codes 99441, 99442, and 99443 will also count as home visits, with the same place of service requirements listed above.

   For beneficiaries who begin enrollment in Year 6 the look back period begins January 1, 2018 and ends November 30, 2018. For those who begin enrollment in Year 7 the look back period begins January 1, 2019 and ends November 30, 2019. The look back period for a given year ends one month before the last possible enrollment date for that year. This is because enrollment in the demonstration begins on the first of the month AFTER the qualifying events have occurred.

   Retain the FIRST home visit found, to use later in setting the enrollment date.

2. Remove any beneficiaries that practices have already entered into the IAH Reporting System). Practices enroll or disenroll beneficiaries by entering the appropriate data in the IAH Reporting System.

3. For the remaining beneficiaries, pull Inpatient, Outpatient, and Home Health claims for the applicable look back period. Determine if each beneficiary had both a qualifying hospitalization and a qualifying post-acute care event, as defined in Appendix A, in any twelve-month period inside the look back period.

4. Generate potential enrollment dates based on whether both a hospitalization and post-acute care use were found in the same twelve-month period prior to each potential enrollment date. The enrollment date is set to be the first of the month after the beneficiary's eligibility date. The eligibility date is defined as the date on which the beneficiary:

   a. Has been discharged from a hospitalization in the preceding 12 months,
   b. Has been discharged from PAC in the preceding 12 months OR has received home health services in the preceding 12 months,[7] and
   c. Is no longer in a facility where the facility stay relates to either the qualifying hospitalization or PAC. Beneficiaries are considered "in the community" once they have been out of a facility for three days, (including the day of discharge and excluding the day of any readmission). If both qualifying events have occurred, yet there continue to be hospital readmissions or continuing post-acute care facility stays, the beneficiary's enrollment date is postponed until they have been in the community for three days.

[7] A beneficiary may be enrolled even if home health services are continuing.

NOTE: Once a beneficiary has met the qualifying criteria and is back in the community for at least 3 days, the enrollment date is set to the first day of the next month, even if the beneficiary is admitted to the hospital before that enrollment begins.

5. Check each potential date of enrollment for other program eligibility requirements. On the enrollment date, the beneficiary must:
   a. Be alive
   b. Not be in an MA or PACE plan
   c. Have part A
   d. Have part B
   e. Have Medicare as primary payer (note that the only primary payer codes used to exclude beneficiaries are A and G, working aged and working disabled)
   f. Not be on hospice
   g. Have had a prior home visit with the IAH practice (carried from step 1)
   h. Not have already been included in the final reconciliation for another Medicare FFS shared savings initiative (because IAH population definition is retrospective).
6. If left with multiple potential enrollment dates, assign the earliest enrollment date.

Special Cases

1. Beneficiary has a hospital or rehab stay in the middle of a home health claim.
   a. The home health claim (if it is the first PAC use in the look back period) counts as the qualifying PAC. The hospital discharge date, provided it is followed by three days in the community, is treated as the second qualifying event and the enrollment date is set to the first of the month after the hospital discharge date.
2. Beneficiary has at least one SNF claim that could count as the qualifying PAC, but there is no discharge date on the claims(s) (in cases like this we assume the person continued the SNF stay but has exhausted the Medicare SNF benefit).
   a. If the beneficiary has a subsequent visit in the home, assisted living facility, group home, or custodial care facility (place of service codes 12, 13, 14, and 33), we set the discharge date of the open-ended SNF stay to the date of the earliest such visit. The enrollment date is then set to the first of the month after the eligible visit.
   b. If no subsequent eligible visits exist, then the person is considered NOT in the community and is not counted as eligible.
3. The HHA “from date” occurs before the beginning of the 12-month look back period AND the “thru date” falls between the admission and discharge dates of a chain of consecutive stays or after the admission date of an open ended SNF claim (a claim with no final discharge date).
   a. The first day of the look back period is treated as the HHA from date so as not to “miss” the HHA episode as a qualifying event (since it would have been identified by the thru date being inside the look back period).

Appendix C: List of Practice Reconciliation Responses – Potentially Eligible Beneficiaries

The practices are provided the list of the responses below from which to select a reason that each potentially eligible patient was not enrolled or indicate that the patient will be enrolled. The options are:

- **Patient is enrolled**—This option should be selected for patients who are included on the Potentially Eligible list and have already been entered into the IAH Reporting System.
- **Patient will be enrolled after they are notified that their physician is participating in the Demonstration**—This should be selected for patients the practice intends to enter into the IAH Reporting System as soon as the patient is notified of the Demonstration. This includes patients who are currently eligible and were not eligible as of the date given in the workbook.
- **Patient did not agree to participate**—Patients who declined to participate when they were notified of the Demonstration. Their medical record must show that the practitioner had a conversation with the patient regarding the Demonstration and the patient declined.
- **Patient does not have two chronic conditions**—Patients who do not have two chronic conditions at the time of enrollment are not eligible for the Demonstration.
- **Patient does not have two functional dependencies**—Patients who do not have two functional dependencies requiring human assistance at the time of enrollment are not eligible for the Demonstration.
- **Patient does not have two functional dependencies AND does not have two chronic conditions**— Patients who do not have two functional dependencies requiring human assistance and who also do not have at least two chronic conditions at the time of enrollment are not eligible for the Demonstration.
- **Patient began receiving hospice care prior to receiving notification letter**—Patients who begin receiving hospice care before being enrolled in the Demonstration are not eligible.
- **Patient permanently moved into a nursing home prior to receiving notification letter**—Patients who moved into a nursing home before being enrolled in the Demonstration are not eligible.
- **Patient is not currently part of our in-home practice**—All patients who have an in-home place of service code for a claim associated with an IAH practice and meet the eligibility criteria for the analysis are included in the list of potentially eligible patients. If a patient is included in the list but is not a part of the practice (examples: transitional care, the practice only made a few in-home visits and is not their primary care provider, the patient moved out of the practice's service area; patient does not usually receive care in the home), this option should be selected.
- **Patient died prior to receiving notification letter or before their enrollment date**—Patients who died prior to being enrolled in the Demonstration are not eligible because they cannot be notified of the Demonstration.