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## CMS “CAPPING” ACO POTENTIAL

### The Need for Capped Regional Risk Scores

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Since the inception of the Medicare Shared Savings Program (MSSP) in 2012, CMS has stated its objective to create better care for individuals and better health for populations, while lowering growth in expenditures<sup>1</sup>. To do so, they have challenged Accountable Care Organizations (ACOs) participating in the program to reduce expenditures for their assigned beneficiaries—individuals on Original Medicare that are visiting the ACO’s providers—below a defined “benchmark” specific to that ACO. This benchmark is described further within the appendix of this report and is based on: the ACO’s historic expenditures, regional and national expenditure trends, and changes to the morbidity (i.e.: risk scores) of the ACO and the ACO’s region.

In order to prevent “gaming” or overcoding of risk scores within the program, CMS has limited ACOs to only receive credit for increases to risk score of 3% between their benchmark period and performance period. However, the risk scores within the ACO’s region—to which the ACO is directly compared for the purposes of benchmark development—are not capped or limited in any way. This inconsistency in risk score capping is described within the remainder of this brief and is currently disadvantaging all ACOs in regions with relatively higher risk score growth.

#### Inconsistencies in Risk Ratio Capping

The general benchmark development can be seen within the appendix of this report, using an example ACO with 2021 as its performance year (PY) and 2016 – 2018 as its benchmark years (BY1 – BY3). Our focus for the purposes of this report is on step 3, specifically the development of the regional trend factor.

See table 1 below for an example of an ACO that is seeing increases to risk score greater than 3% between 2019 and 2021 both within its own population and within the region.

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<sup>1</sup> <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram>

**Table 1 – Example: Regional and ACO Expenditures and Risk Score**

Expenditures	2018 (BY3)	2021 (PY)	Change
Regional Expenditures - not risk adjusted (PBPY)	\$10,000	\$10,500	5.0%
ACO Expenditures - not risk adjusted (PBPY)	\$9,000	\$9,400	4.4%
<b>Risk Score</b>			
Regional Normalized Risk Score	1.05	1.12	6.7%
ACO Normalized Risk Score	1.10	1.17	6.4%
ACO Normalized Risk Score - CAPPED	1.10	1.13	3.0%
<b>Risk Adjusted Expenditures</b>			
Regional Expenditures - risk adjusted (PBPY)	\$9,524	\$9,375	-1.6%
ACO Expenditures - risk adjusted (PBPY)	\$8,182	\$8,034	-1.8%
ACO Expenditures - risk adjusted (PBPY) and CAPPED	\$8,182	\$8,297	1.4%

In this example we see:

- An ACO maintaining their expenditure trend at a level lower than the region (4.4% vs 5.0% respectively).
- Both the ACO and its region seeing modest increases to risk score between the benchmark and performance period (6.4% and 6.7% respectively).

However, CMS will be adjusting the ACO’s benchmark *down* 1.6% for the regional trend rate, because of the increase in normalized risk score. Through the benchmark development, specifically the risk ratio and the risk-adjusted regional update factor, **CMS will be comparing the region’s risk adjusted trend experience of -1.6% to the ACO’s risk adjusted and capped trend experience of 1.4%**. This inconsistency in risk score capping is harming any ACO in a region with greater than 3% increase in normalized risk score between the benchmark and performance period.

### Impact on Future ACO Savings

If the intent of the “capping” of ACO risk scores within MSSP is to prevent gaming or overcoding, and 3% is the maximum natural risk score increase a population should expect, it stands to reason that this 3% “cap” should be applied to regional risk scores within the regional risk adjusted trend rate as well. Furthermore, because of the impact that COVID has had on 2020 diagnosis capture and the resulting 2021 risk scores, regional risk score trends are currently varying more than in prior years. Additionally, a decrease in the 2021 normalization factor has made it possible for regions to see significantly increased normalized risk score trends in 2021.

CMS has acknowledged this issue and resulting risk score misalignment within the Medicare Physician Fee Schedule Proposed Rule<sup>2</sup>. The change CMS had considered to address this issue would be to increase the cap on the ACO risk score to a percentage of the amount that the ACO's regional risk score has increased. In the example above, because the ACO's regional risk score increased by more than 3%, their risk ratio cap would also increase.

CMS has stated within the Proposed Rule that they are currently not planning on moving forward with this approach due to the concerns that they could be incentivizing ACOs with significant market share to artificially inflate their region's risk scores. They are however accepting comments surrounding this potential methodology change.

Because there is no downside limit on the amount an ACO's risk score could *decrease*, the change described above would only help ACOs, especially ACOs in regions with significant risk score growth.

The commitment to providing better healthcare for individuals and populations at a lower cost requires ACOs to devote time and resources to improving the efficiency of their practices, and to embrace all of their beneficiaries. Being responsible for higher risk beneficiaries and not being properly compensated for them may lead to ACOs feeling "capped out."

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<sup>2</sup> <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched>

## Appendix: MSSP Benchmark Development

The following appendix is intended to capture and describe the adjustments that are made to take an ACO from their historical benchmark to their final benchmark within the shared savings calculation. All numbers are placeholders used for demonstrative purposes only.

### Step 1: Calculate the 2021 Historical Benchmark

Under the MSSP, ACOs receive a historical benchmark report from CMS containing their assigned beneficiaries and experience for each of three historical benchmark years (BY). The experience that ACOs receive includes per capita expenditures, risk scores, and national-regional trend factors by BY and population, as well as the population distribution<sup>3</sup> in BY3. The first two years of historical expenditures are risk adjusted and trended to put per capita expenditures on a BY3 basis. The three BYs are weighted together, and the population distribution in BY3 is used to create a composite rebased-historical benchmark.

Table 1 below shows an example of how the historical benchmark (before regional adjustment<sup>4</sup>) is calculated. Note that the three columns of BY expenditures have already been trended to BY 3, risk adjusted to BY 3, and weighted based on the ACOs agreement period.

These numbers are all provided to the ACO by CMS at the beginning of each performance period.

**Table A1 – Example: Calculate the 2021 Historical Benchmark**

Trended Historical Benchmark Expenditures	BY1 <sup>5</sup>	BY2	BY3	Benchmark = B1+BY2+BY3	Assigned Beneficiary Proportions	Benchmark Proportion*
ESRD	\$26,059	\$27,866	\$27,025	\$80,950	0.9%	\$729
Disabled	\$3,540	\$3,225	\$3,463	\$10,228	14.5%	\$1,483
Aged/dual	\$5,085	\$5,688	\$5,208	\$15,981	12.3%	\$1,966
Aged/non-dual	\$3,164	\$3,085	\$3,257	\$9,506	72.3%	\$6,873
<i>Historical Benchmark Expenditures Before Regional Adjustment (\$)</i>						<b>\$11,050</b>

### Step 2: Regionally Adjust the 2021 Historical Benchmark

The next step is then to calculate the regional adjustment to apply to this historical benchmark. The purpose of this adjustment is to compare the ACO’s historical expenditures to that of the region. ACOs with lower historical expenditures and that have effectively managed their population in the past will be

<sup>3</sup> Population distribution indicates the proportion of ESRD, Disabled, Aged/Dual, and Aged/Non-dual beneficiaries within the ACO’s population.

<sup>4</sup> The regional adjustment is described below and is intended to capture differences between the ACO’s population and their region.

<sup>5</sup> BY1 = Historical beneficiary expenditures for BY1, trended and risk adjusted to BY3, multiplied by the weight given to BY1.

starting at a lower historical benchmark. Therefore, CMS will increase their benchmark based on how much lower they are than the region.

The comparison made is BY3 risk adjusted expenditures for the ACO and for the ACOs region<sup>6</sup>. For each population, if the difference is positive (i.e., an ACO’s rebased-historical expenditures during the benchmark period are lower than the region), a positive regional adjustment is applied. Similarly, if the difference is negative, a negative regional adjustment is applied.

Table 2 contains an example of how the regionally adjusted historical benchmark is calculated. In this example, the ACO’s expenditures are lower than the region for all four populations, where the “Before Applying Cap (\$)” column reflects a percentage of the difference between regional expenditures and the ACO’s historical benchmark expenditures. Depending on the ACOs agreement period the percentage will either be 35% or 50%.

This adjustment is provided to the ACO by CMS at the beginning of each performance period.

**Table A2 – Example: Regionally Adjust the 2021 Historical Benchmark**

Regional Adjustments	Benchmark	Before Applying Cap (\$)	Adjustment Cap (Abs. Value) (\$)	After Applying Cap (\$)	Adjusted Historical Benchmark Expenditures	Assigned Beneficiary Proportions	Benchmark * Proportion	
ESRD	\$80,950	244	4,500	244	\$81,194	0.9%	\$731	
Disabled	\$10,228	98	750	98	\$10,326	14.5%	\$1,497	
Aged/dual	\$15,981	266	948	266	\$16,247	12.3%	\$1,998	
Aged/non-dual	\$9,506	216	665	216	\$9,722	72.3%	\$7,029	
<i>Regionally-Adjusted Historical Benchmark (\$)</i>								<b>\$11,255</b>

Step 3: Estimate the Updated Benchmark for PY 2021

Finally, the *regionally adjusted historical benchmark* is adjusted to be on the same basis as the PY using estimates of the national per capita trend and update factors by population, the regional per capita trend and update factors, and the ACO’s CMS-HCC risk ratios. These adjustments are not provided by CMS until the final settlement calculation (typically eight months after the end of the performance year) and can be the biggest gap between what an ACO has been comparing to throughout the performance period (the *regionally adjusted historical benchmark*), and what they will be ultimately held to as a benchmark.

The risk ratios are the ratio of the average risk score of the ACO’s assigned PY beneficiaries (by population) to the ACO’s assigned beneficiaries for BY 3, subject to a cap of 1.03 within each population. This risk ratio puts the acuity of the BY population onto a consistent basis with the PY population. The national and regional trend and update factors are weighted together by the proportion of the ACO’s expenditures within its region to calculate the *national-regional blended update factor*. The weight placed on the national trend factor is the percentage of assignable person years in the ACO’s region that are assigned to the ACO in BY 3 (i.e., the ACO’s “market share” within its region); the weights placed on the

<sup>6</sup> Regions are defined based on where the beneficiaries assigned to an ACO reside, at the county level.

regional trend factors are the complements of the national weights. These weights can be found in Table A3 of an ACO’s settlement report. The calculation of updated benchmark by population is then:

$$\text{Updated Benchmark} = (\text{Regionally adjusted historical benchmark}) * (\text{ACO CMS-HCC risk ratio}) * (\text{national-regional blended update factor})$$

Table 3 contains an example of how the updated benchmark is calculated. Note that the assigned beneficiary proportions apply to the PY and not BY 3 as they did in Table 1 and 2.

**Table A3 – Example: Estimate the Updated Benchmark for PY 2021**

Updated Benchmark	Regionally-Adjusted Historical Benchmark	Risk Ratio	National/Regional Blended Trend Factor	Updated Benchmark	Assigned Beneficiary Proportions	Benchmark * Proportion
ESRD	\$80,950	0.989	1.012	\$81,194	0.8%	\$650
Disabled	\$10,228	0.989	1.018	\$10,326	14.6%	\$1,508
Aged/dual	\$15,981	0.989	1.089	\$16,247	12.2%	\$1,982
Aged/non-dual	\$9,506	0.989	0.985	\$9,722	72.4%	\$7,039
<i>Updated Benchmark (\$)</i>						<b>\$11,178</b>

After determining the Updated Benchmark value, the difference between the above value and the ACOs expenditures are used to calculate the gross and shared savings for MSSP. While expenditures also contribute to the savings an ACO receives, understanding the benchmark, how it is calculated, and what drives changes in the benchmark can help ACOs better understand their financial performance and ways that they can improve over time.

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