MEDICARE SHARED SAVINGS PROGRAM

Brian Machut, FSA
612.716.7988 • brian.machut@wakely.com
Brad Heywood, ASA, MAAA
720.221.9601 • brad.heywood@wakely.com

Proposed Benchmarking Updates to the Medicare Shared Savings Program

In 2012, the Center for Medicare and Medicaid Services (CMS) initiated a new program aimed at reducing medical expenditures, improving quality of care and bettering health for Medicare beneficiaries. This program, known as the Medicare Shared Savings Program (MSSP), was met with 220 Accountable Care Organizations (ACOs) at its start and has now grown into more than 500 ACOs across the nation. Over the 10 years the program has been running, ACOs have generated over $11.2 billion savings ($13.2 billion including the Next Generation Model)[1] to the Medicare program making it the largest and most successful value-based care program ran by CMS and CMMI (Center for Medicare and Medicaid Innovation).

In recent years, CMS has been concerned with potential plateaus in participation within the program due to ACOs generating savings in prior years and not realizing similar gains in subsequent agreement periods. At the same time, CMS has recently set forth a goal that all beneficiaries with Medicare Fee-For-Service coverage will be in a care relationship with accountability for quality and total cost of care by 2030[2]. To encourage additional participation and support ACOs that have seen historical success in their future agreement periods, CMS's release of the 2023 Medicare Physician Fee Schedule (PFS) Proposed rule contains some of the larger proposed updates to the Medicare Shared Savings Program in the history of the program.

Since the announcement of the 2023 Proposed PFS, there have been numerous briefs published providing high-level summaries of these proposed changes to MSSP, ranging from participation changes to quality measurement updates and updated financial methodologies. Within this white paper, we focus specifically on changes to the financial methodology of the program, providing a deeper dive into how the included changes to the benchmark calculations and risk score mechanisms are proposed to be implemented. We then analyze the effects of these updates and what it can mean for your ACO, whether you are a new ACO looking to enter for the first time, or a mature ACO within the program.

Please be aware that the policies discussed herein are not yet final. An updated review will be performed later in the year once policy is final. In addition, each of the policies included in this document are currently proposed to become effective for new agreement periods starting January 1, 2024.

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[1] https://www.naacos.com/highlights-of-the-2020-medicare-aco-program-results

[2] https://innovation.cms.gov/strategic-direction

Benchmark Methodology Updates

Background:

Since the inception of the Shared Savings Program, CMS has continually modified the process to calculate and update benchmarks to address various stakeholder concerns. In this iteration of proposed changes, CMS indicated three core concerns, or dynamics, that were sought to be addressed by the proposed modifications to the benchmarking methodology:

- **The "Ratchet Effect"** – when benchmark years correspond to performance years of an ACO's previous agreement period, how does CMS ensure the rebased benchmarks serve as a fair and accurate baseline, and do not continually require ACOs to "beat" their own prior performance

- **Regional Impact** – when ACOs' own expenditures influence the calculations of the regional adjustment and the regional portion of the trend and benchmark update factors, there can be unintended consequences, particularly for ACOs with a large market share or who participate in a region with significant ACO penetration. This is often referred to as the "Rural Glitch", as these impacts tend to have a larger impact on ACOs operating in rural areas where high ACO market penetration is more likely.

- **Selection Bias** – how to ensure the benchmark methodology encourages program entry and continued participation, particularly for those ACOs serving medically complex, high-cost patient populations.

In the subsequent sections, we'll reference back to these criteria and how the proposed changes address these concerns.

Benchmark Trend Changes:

Current Status: Under current policy, CMS updates an ACO's historical benchmark from Base Year 3 (BY3) to the Performance Year (PY) by applying a blend of national and regional growth rate trends. Importantly, both the national and regional trends used are retrospective trends, meaning they reflect actual growth rates observed from BY3 to the PY. Additionally, the percentage weight applied to each trend component depends on an ACO's market share within their region – ACOs with higher regional market share receive a trend update factor that is more heavily weighted on national trends, and vice versa.

One common complaint under current policy stems from the dynamic in which an ACO that successfully reduces costs for its own beneficiaries will also reduce its average regional costs as a result. Because an ACO's historical benchmark is updated in part based on the retrospective trends in its region, a reduction to the regional FFS trend will result in reduced benchmarks. This has been of particular concern for both ACOs with higher market share within their regional service area, as well as ACOs operating in regional service areas that more generally have high ACO market penetration.

What's changing: The proposed changes would add to the current two-way national-regional blended trend by incorporating a prospective trend factor based on the United States per Capita Cost (USPCC), similar to what is seen in Medicare Advantage and Direct Contracting / ACO REACH. This national prospective trend would be referred to as the Accountable Care Prospective Trend (ACPT) and would be applied when updating the benchmark from Benchmark Year 3 (BY3) to the Performance Year (PY). Note that the proposed methodology specifically states that the ACPT would not be used to trend forward BY1 and BY2 to BY3 – it would only be used to trend BY3 to the performance year.

CMS notes that the ACPT will be set at the beginning of the agreement period and remain for the entirety of the agreement period (5 years). The ACPT will be blended with the national and regional growth rates that currently exist in the MSSP program to create a three-way blended trend used to update an ACO's benchmark. The ACPT trend will receive a weight of one-third, with the remaining two-thirds weight applied to the existing national-regional trend. There will be two separate ACPT trends – one for ESRD enrollment types and one for the other three MSSP enrollment types (Disabled, Aged/Dual Eligible, and Aged/Non-Dual Eligible).

CMS is also proposing the inclusion of a guardrail policy to ensure that the use of the three-way blended trend does not lead to lower savings relative to the current policy. If an ACO incurs losses for a given performance year that exceed its minimum loss rate (MLR), CMS is proposing to recalculate the benchmark under the existing two-way national-regional blend. If the two-way blend results in a smaller amount of losses, then CMS will utilize the two-way blend to determine the resulting savings. However, CMS notes that if the use of the two-way blend puts an ACO into a shared-savings position, they will not be able to report or receive these savings. Finally, the proposal includes a policy whereby CMS would retain discretion to reduce the weight assigned to the ACPT trend on an "ad-hoc basis" in the event that unanticipated circumstances result in actual national per capita FFS expenditures diverging significantly from those predicted by the ACPT. Please reference **Section A** in the attached Appendix for detailed calculations of how the ACPT trend is proposed to be implemented.

How this impacts your ACO:

- First, it is important to note that the proposed guardrail will help protect ACOs from incurring greater losses under the new methodology relative to existing policy. However, there remains the possibility that the proposed approach will result in lower shared savings if an ACO is in a shared savings position and the ACPT-blended trend results in a lower benchmark than the existing national-regional retrospective trend.

- Additionally, a key feature of the ACPT blending mechanism is that CMS intends to implement the ACPT growth factor as a risk-adjusted *flat dollar amount* that is based on per capita expenditures of the national assignable FFS population. As a result, the lower a given ACO's BY3 expenditures are relative to the national assignable population, the more favorable of an "effective" ACPT trend they will receive (see Appendix section A).

- Finally, since the ACPT trend will be prospectively set for the entirety of the agreement period, the trend used to update the benchmark to the performance year will be less influenced by actual national

and regional expenditure trends, thereby partially mitigating some of the concerns associated with the "rural glitch."

If implemented, it will be important for ACOs to review the ACPT in comparison to their own historical expenditure trends, as well as those of their regional service area.

Prior Savings Adjustment:

A notable concern of ACOs involved in MSSP is the deterioration to their benchmark as a result of prior successful performance, also known as the "ratchet" effect. Under currently policy, as ACOs enter renewing agreement periods, their historical benchmark is rebased using years that correspond to performance years of the prior agreement period. Successful ACOs that are able to curb medical expense trends will thus have benchmark expenditures that are deflated due to savings generated. The prior savings lead to lower benchmarks in the following performance periods and as a result, make it more difficult to achieve continued savings. As noted in the background to this whitepaper, CMS is concerned that this deterioration to the benchmark might dissuade ACOs from continuing in the program and is counter intuitive to the overall goals of the program. In order to address these concerns, CMS is proposing to incorporate an additive adjustment for prior savings that would apply to the benchmarks for renewing and re-entering ACOs.

How it will work: At the highest level, CMS will first determine a prior savings per capita value by taking the straight average of the per capita savings or losses generated by the ACO over the three performance years that immediately precede the start of the ACO's current agreement period (i.e. which correspond to the current agreement period's benchmark years).[3] 50% of the prior savings per capita will then be added back to the benchmark, but CMS will constrain any positive adjustments to the higher of either the prior savings adjustment or the ACO's positive regional adjustment (i.e. ACOs don't get both adjustments). If the regional adjustment is negative, ACOs will be able to use prior savings to offset the negative regional adjustment. Refer to **Section B** in the attached Appendix for detailed examples on how the prior savings adjustment has been proposed to operate.

How this affects your ACO: The addition of the prior savings adjustment can only increase benchmarks – no ACOs will receive lower benchmarks as a result of this proposed policy. CMS simulation suggests that about 22 percent of all ACOs would receive a higher benchmark under this proposal, and the average net effect on per capita benchmarks would be approximately a $130 increase. To the extent that your ACO is already receiving positive

The addition of the prior savings adjustment can only increase benchmarks

regional adjustments, this change will likely have a nominal impact on your benchmark. However, ACOs

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[3] Note that additional modifications to the average per capita savings that may apply in the case of renewing ACOs, ACOs that were in non-compliance in one or more years, or ACOs that were not reconciled in one or more of the three years preceding the start of the current agreement period.

that have achieved prior savings and that otherwise would receive a negative regional adjustment will benefit more significantly.

Reducing the Impact of the Negative Regional Adjustment:

Current Status: A main feature of MSSP benchmarking is the blending of the historical expenditures with a regional rate. Currently, an ACO's historical benchmark expenditures are adjusted, at the enrollment type level, by a percentage of the difference between the average expenditures in the ACO's regional service area and the ACO's historical expenditures. The percentage weight applied to regional expenditures in the adjustment is dependent on both the agreement period and whether or not the ACO has higher or lower average cost, on a risk-adjusted basis, compared to their region. The overall goal of the regional adjustment to the benchmark is to allow efficient ACOs to have an upward lift to their benchmark if they perform better than the region. Conversely, inefficient ACOs performing worse than the region will receive a downward adjustment to their benchmark.

Further, current policy dictates a cap be applied to the per capita dollar amount that the regional adjustment can have on an ACO's benchmark. This cap is currently symmetric, at plus or minus 5% of the national per capita Medicare FFS expenditures in BY3 for the assignable population[4]

What's changing: Within the proposed Physician Fee Schedule, CMS is proposing to implement two policy changes to limit the impact of negative regional adjustments on an ACO's benchmark:

1. Reduce the cap on negative regional adjustment from 5% to 1.5%

2. After applying the cap, implement an offset factor to further reduce the negative regional adjustment as an ACO's proportion of Dual members increases, or its average risk score increases

CMS notes that the impetus for these two policy changes was a concern that the existing 5% negative regional adjustment cap was too severe to provide adequate incentive for participation among ACOs treating high cost and medically complex patients, where it is more likely that risk-adjusted regional expenditures do not fully account for the true cost to treat these populations. **Section C** in the attached Appendix contains an illustrative example of how this proposed change would be implemented.

How this affects your ACO: This proposed change can only increase an ACO's benchmark. Given that close to 90% of MSSP ACOs are receiving positive regional adjustments under the current policy, it may seem like this won't impact many groups. However, the proposed offset factor can still boost the regional adjustment for ACOs that are receiving positive regional adjustments in aggregate but have some enrollment types performing worse than the region

ACOs serving medically complex populations may see the greatest benefit

(see Appendix C). CMS's simulation estimates that about 59% of MSSP ACOs would have been

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[4] The assignable population refers to all Medicare FFS beneficiaries who could be assigned to an MSSP ACO based on CMS's criteria

impacted positively by this policy change. That being said, the impact for many ACOs may be nominal, and we would expect that ACOs currently receiving negative regional adjustments, or who serve largely higher-risk populations (which tend to be more likely to receive negative regional adjustments) will benefit the most.

Risk Score Growth and Cap Adjustments:

Current Status: In the MSSP program currently, prospective HCC risk scores are used to update the historical benchmark to each performance year to account for changes in the severity and case mix of assigned beneficiaries. The updates are subject to a positive 3% cap, which represents the maximum increase in risk scores, relative to BY3, that is allowed for any performance year over the entire agreement period. This means that the "risk ratio" (the ratio of performance year risk score to BY3 risk score), applied to historical benchmark expenditures to capture changes in health status between the performance year and BY3 will never be higher than 1.03 over the entire agreement period. In its current state, this 3% cap is applied in each Medicare enrollment type (ESRD, Disabled, Aged/Dual and Aged/Non-Dual).

Issues with the Current Approach: While not an exhaustive list, some of the commonly cited observations and concerns with the current approach are as follows:

1. Beneficiaries in the disabled and aged/dual enrollment types are more likely to experience risk score caps than the aged/non-dual population

2. The rates at which different enrollment types are subject to risk score caps can vary significantly, due to factors such as smaller sample sizes in certain enrollment types and risk score volatility in high-risk patients

3. The current policy caps the ACO's ratio at 1.03, but there is no cap placed on the risk-adjusted regional expenditures that drive part of the benchmark update factor. It is argued that this penalizes ACOs in areas where the region's normalized risk score increases by more than 3%

What's Changing: Under the proposed rule, the MSSP program would make two main changes to address some of the issues cited above (**Section D** of the Appendix provides more detailed examples of these changes):

1. The 3% risk score cap would be applied after accounting for changes in beneficiary demographic risk score changes (similar to the proposed ACO REACH methodology)

2. The 3% cap would be applied in aggregate across all four enrollment types, rather than for each individual enrollment type. This cap would only apply to risk score growth for a particular enrollment type if the aggregate growth in risk scores across all enrollment types, after adjusting for demographic changes, exceeds 3%.

How this impacts your ACO: CMS performed simulation modeling to determine how this proposed change may impact currently participating ACOs. The results of the simulation indicated that 45% of ACOs would have had a higher updated benchmark under the proposed methodology, 5% would have had a lower benchmark, and 50% would be unchanged.

> *There continues to be no cap on regional risk score growth under the proposed changes*

The above results indicate that, while this is likely to benefit many ACOs, it is possible that the change will result in a lower benchmark than the current policy. This will happen to ACOs that have an aggregate demographic risk ratio that is less than 1 and are also subject to the aggregate cap. CMS also notes that this policy will make it much less likely for ESRD, Disabled, and Age/Dual enrollment types to be capped, which may improve incentives for treating these complex and high-cost populations. Finally, it should be noted that the proposed changes do not include any type of floor on risk score deterioration (as is included in ACO REACH), nor do they address the concern that there is currently no risk score growth cap on an ACO's regional service area.

Conclusion

As ACOs are seeking to better understand how these proposed changes might affect their ACO, it is important to note again that as the proposal stands, only ACOs that would renew their agreement after 2024 would be able to access the changes discussed in this white paper. ACOs currently in an agreement period or that start a new agreement period in 2023 would not, as written, have access to these proposed changes until they renew following 2024.

The proposed changes above mark an important step forward towards improving the sustainability and viability of the Shared Savings Program. If you are a group interested in entering the program or want to better understand how your ACO might be impacted, Wakely experts can help you strategically think through the implications and model out projected financial outcomes in wake of these proposed updates.

Please contact Brian Machut at Brian.Machut@wakely.com or Brad Heywood at Brad.Heywood@wakely.com with any questions or to follow up on any of the concepts presented here

OUR STORY

Five decades. Wakely began in 1969 and eventually evolved into several successful divisions. In 1999, the actuarial arm became the current-day Wakely Consulting Group, LLC, which specializes in providing actuarial expertise in the healthcare industry. Today, there are few healthcare topics our actuaries cannot tackle.

Wakely is now a subsidiary of Health Management Associates. HMA is an independent, national research and consulting firm specializing in publicly funded healthcare and human services policy, programs, financing, and evaluation. We serve government, public and private providers, health systems, health plans, community-based organizations, institutional investors, foundations, and associations. Every client matters. Every client gets our best. With more than 20 offices and over 400 multidisciplinary consultants coast to coast, our expertise, our services, and our team are always within client reach.

Broad healthcare knowledge. Wakely is experienced in all facets of the healthcare industry, from carriers to providers to governmental agencies. Our employees excel at providing solutions to parties across the spectrum.

Your advocate. Our actuarial experts and policy analysts continually monitor and analyze potential changes to inform our clients' strategies – and propel their success.

Our Vision: To partner with clients to drive business growth, accelerate success, and propel the health care industry forward.

Our Mission: We empower our unique team to serve as trusted advisors with a foundation of robust data, advanced analytics, and a comprehensive understanding of the health care industry.

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Appendix – Illustrative Examples

A – Benchmark Trend Changes:

How it works: The following section provides a step-by-step guide to how CMS has proposed the implementation of the ACPT trend will impact the development of benchmarks[5]. In the following example, assume we are calculating the updated historical benchmark for the Aged/Non-Dual population of an ACO entering a new agreement period in 2024, and CMS has indicated that the annual, 5-year ACPT trend will be 5%[6]. Further, assume that the truncated national assignable per capita expenditures for the Aged/Non-Dual enrolment type is $13,000.

Step 1: Express the ACPT growth rate as a flat dollar amount: In each performance year, the ACPT flat dollar amount will be equal to truncated national assignable per capita expenditures multiplied by the ACPT:

- PY1 flat dollar amount = $13,000 * (1.05 – 1) = $650

- PY5 flat dollar amount = $13,000 * ($1.05^5$ – 1) = $13,00 * (1.276 – 1) = $3,588

Step 2: Risk Adjust the flat dollar amount: To account for differences in the relative risk of the ACO's population, CMS will adjust the flat dollar amount by the ACO's normalized risk score in BY3. If the ACO's BY3 normalized risk score is 1.025, the PY1 flat dollar amount will be adjusted to $666 ($650 * 1.025) and the PY5 flat dollar amount will equal $3,678 ($3,588 * 1.025).

Step 3: Express the flat dollar amount as a relative factor: In order to combine the flat dollar amount with the existing two-way national-regional trend, CMS will re-express the flat dollar amount as a factor that is relative to the ACO's historical benchmark expenditures. If the historical benchmark expenditures for the ACO's Aged/Non-Dual population are $12,000, the ACPT trend factor in PY1 will be 1.056 ($666 / $12,000 + 1) and the PY5 factor will be 1.306 ($3,678 / $12,000 + 1).

Step 4: Blend the ACPT factor with the two-way national-regional factor: Assume this ACO's assigned beneficiaries represent 20% of the assignable population in the ACO's regional service area. The assumed regional expenditure growth from BY3 to PY1 is 2.5% and the national assignable expenditure growth from BY3 to PY1 is 3.0%. Finally, assume there is no change in the normalized risk score between BY3 and PY1 for the Aged/Non-Dual population for this ACO (i.e. risk ratio is 1.0). Incorporating the ACPT trend with a weight of one-third, the resulting blended 3-way national-regional-ACPT update factor in PY1 would be **1.036,** calculated as follows:

- Two-way national-regional factor = 1.026 [1.025 * 80% + 1.03 * 20%]

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[5] Examples included in this whitepaper are adapted or used directly from examples outlined in the proposed Medicare Physician Fee schedule

[6] CMS may calculate a single, annualized growth trend to apply for all 5 years of the agreement period, or they may release a 5-year schedule of growth rate trends that differ from year-to-year if it is believed that a uniform growth rate across all five years does not fit the expected expenditure growth pattern

- Three-way factor w/ ACPT = 1.036 [1.026 * 2/3 + 1.056 * 1/3]

- The resulting PY1 benchmark for this ACO would be $12,432 [$12,000 * 1.036] which is $120 higher than what it would be under the current policy

B – Prior Savings Adjustment:

Illustrative Examples: The following section covers four different scenarios of how the prior savings adjustment is proposed to be calculated in practice.

Assume that we are calculating prior savings adjustments for a new agreement period starting January 1, 2024. In Table B1, we list the three years immediately preceding the first year of the current agreement period. The "Performance-Year Attributed" column contains the number of beneficiaries assigned to the ACO at the time each of these prior performance years' savings were reconciled. The "Base-Year Attributed" column corresponds to the number of beneficiaries assigned in each of the benchmark base years using the ACO's current provider participant list.

Recall that changes to an ACO's provider participant list will change the number of attributed beneficiaries. To account for potential changes in assignment as a result of updates to an ACO's provider list, CMS calculates a **proration factor** (capped at 1.0) that is applied to the per-capita prior savings. This will ensure that the prior savings adjustment does not exceed the cumulative savings generated by the ACO in the three years preceding the current agreement period. In the example in Table B1, changes to the provider participant list have resulted in a decrease to the number of attributed beneficiaries in 2021 through 2023. As a result, a proration factor of 1.0 will be applied to the prior savings per capita. If the base-year attributed beneficiaries had increased relative to the performance-year assigned beneficiary counts, a proration factor between zero and one would be applied which would reduce the per-capita prior savings adjustment.

Table B1

Year	Performance-Year Attributed	Base-Year Attributed	Uncapped Proration Factor	Capped Proration Factor
2021	8,000	6,000		
2022	7,000	5,500		
2023	9,000	7,000		
Weighted Avg.	8,000	6,167	1.30	1.00

Table B2

Scenario	Prior 3-Year PY Savings Per Capita	Apply Proration (1.00 from Table 1): [A]	Regional Adj: [B]	Is [A] + [B] Positive or Negative?	5% National Per Capita: [C]	50% of Pro-rated Prior Savings: [D]	[E] = Lesser of [C] and [D]	Higher of [B] and [E]	Final Adjustment
A	$725.00	$725.00	-$100.00	Positive	$600.00	$312.50	$312.50	$312.50	$312.50
B	$133.33	$133.33	-$150.00	Negative	n/a	n/a	n/a	n/a	-$16.67
C	$466.67	$466.67	$50.00	Positive	$600.00	$233.33	$233.33	$233.33	$233.33
D	$466.67	$466.67	$250.00	Positive	$600.00	$233.33	$233.33	$250.00	$250.00

Table B2 continues the example from Table B1 by highlighting four different possible scenarios:

Scenario A – Assume the simple average of the per capita savings over the prior three years amount to $725. Further, assume in this scenario that the regional adjustment is calculated to be -$100. Since the

regional adjustment is negative, we are able to use the prior savings adjustment to offset the negative regional adjustment. If the sum of the prorated per-capita prior savings and the regional adjustment ($725 + -$100 = $625) is positive, then the prior savings adjustment is calculated as the lesser of 50 percent of the net pro-rated average savings per capita ($625) and 5 percent of the national per capita FFS expenditures for assignable beneficiaries ($600). The ACO will thus receive a final positive benchmark adjustment of $375 applied to each enrollment type. Note that ACOs only receive this one adjustment to the benchmark – they won't receive both a prior savings and a regional adjustment.

Scenario B – In this scenario, the pro-rated average per capita prior savings are $133.33 and the regional adjustment is -$150. Since the sum of these two is negative, we are able to use the full amount of the prior savings to offset the negative regional adjustment (i.e. prior savings are not adjusted by 50%). This results in a final benchmark adjustment of $-16.67.

Scenario C – Pro-rated average prior savings are $467.67 and the regional adjustment is $50.00. Since both the prior savings and regional adjustments are positive, we take the lesser of 50% of the pro-rated average per capita prior savings and 5% of the national per capita FFS expenditures for assignable beneficiaries [minimum of $467.67 * 50% and $600 is equal to $233.33]. We then compare this result to the regional adjustment and take the higher of the two. Since the prior savings adjustment of $233.33 is higher than the regional adjustment of $50, the final benchmark adjustment will be $233.33.

Scenario D – Finally, scenario D illustrates a similar situation to scenario C, however the regional adjustment in this example exceeds the capped pro-rated average per capita prior savings, resulting in a final benchmark adjustment that is equal to the regional adjustment.

C – Reducing the Impact of the Negative Regional Adjustment:

How it works: The following section provides an illustration of how CMS has proposed to implement a reduction to negative regional adjustments applied to ACO's benchmarks.

Table C1

Enrollment Type	Enrollment Percentage	ACO Region Expenditures Minus ACO Historical Expenditures [A]	Weight [B]	Uncapped Regional Adjustment [A] x [B]
ESRD	2.0%	$29,667	15.0%	$4,450
Disabled	17.0%	-$1,120	15.0%	-$168
Aged/Dual	11.0%	$2,827	15.0%	$424
Aged/Non-Dual	70.0%	-$1,727	15.0%	-$259
Total		-$495		-$74

Table C2

Enrollment Type	5% National Assignable Per Capita Exp.	-1.5% National Assignable Per Capita Exp.	Capped Regional Adjustment (Before Offset)	Offset Factor	1 - Offset Factor	Final Regional Adjustment
ESRD	$4,299	-$1,290	$4,299	N/A	N/A	$4,299
Disabled	$591	-$177	-$168	0.609	0.391	-$66
Aged/Dual	$880	-$264	$424	N/A	N/A	$424
Aged/Non-Dual	$528	-$158	-$158	0.609	0.391	-$62
Total			-$7			$78

The ACO in table C1 above is, in aggregate, performing *higher* than the region by $495 per capita. If we assume the ACO is in its first agreement period, the corresponding weight applied to the regional difference is 15%. Before any caps, this results in a negative regional adjustment of $74. Then, we apply the positive 5% cap and newly updated negative 1.5% cap to the raw regional adjustments. Note that the ESRD population and the Aged/Dual population both have positive regional adjustments, and the ESRD population hits the 5% positive cap. The Disabled and Aged/Non-Dual populations both have negative regional adjustments, with the Disabled population hitting the negative 1.5% cap. As a result of the new 1.5% negative regional cap, the overall regional adjustment, prior to any offset factor adjustment, is -$7 (not pictured, but note the regional adjustment under current policy would be -$77).

Next we calculate any offset factors. If we assume that 22% of this ACO's population is Dual-eligible, and the aggregate BY3 normalized risk score of 1.389, the offset factor would be calculated as follows (subject to a minimum value of zero and a maximum value of 1):

$$\text{Offset Factor} = 0.22 + (1.389 - 1) = 0.609$$

Finally, any enrollment types with negative regional adjustments would be multiplied by one-minus the offset factor (or 0.391). In the end, we end up with a *positive* regional adjustment of $78 under the new proposed rule. Note that offset factors are only applicable for enrollment types that have negative regional adjustments – in this case Disabled and Age/Non-Dual. Additionally, it is not a requirement for the negative regional adjustment to hit the 1.5% cap in order to receive a favorable adjustment from the offset factor.

D - Risk Score Growth and Cap Adjustments:

How it works: Table D1 and D2 below depict two different examples of how the proposed risk score cap calculation would work.

Table D1

Enrollment Type	Dollar Weights	Demographic Risk Change	Aggregate Cap	HCC Risk Ratio (pre-Cap)	HCC Risk Ratio (post-Cap)
ESRD	5.0%	1.035		0.980	0.980
Disabled	7.5%	1.020		1.050	1.050
Aged/Dual	8.0%	0.990		1.089	1.056
Aged/Non-Dual	79.5%	1.030		1.076	1.056
Weighted Average		1.026	1.056	1.070	

Table D2

Enrollment Type	Dollar Weights	Demographic Risk Change	Aggregate Cap	HCC Risk Ratio (pre-Cap)	HCC Risk Ratio (post-Cap)
ESRD	4.1%	1.046		1.051	1.051
Disabled	9.8%	1.027		1.032	1.032
Aged/Dual	13.9%	1.023		1.047	1.047
Aged/Non-Dual	72.2%	0.986		1.002	1.002
Weighted Average		0.998	1.028	1.013	

Table D1 – In this example, we note that the overall demographic risk score increased by 2.6% relative to BY3. Three percent is then added on which results in an overall aggregate cap of 5.6%. This means that if the aggregate risk ratio across all enrollment types exceeds 1.056, we will need to test each enrollment type against the cap. In this case, the aggregate risk ratio is 1.07. As a result, we compare each enrollment type's risk ratio against the aggregate cap of 1.056. Both the Age/Dual and Aged/Non-Dual enrollment types have risk ratios that exceed 1.056, and so they get capped at that amount.

Table D2 – In Table D2, we apply the same methodology as in Table D1's example. However, we note that the HCC risk ratio of 1.013 is *less* than the aggregate cap of 1.028. Because the aggregate risk ratio does not exceed the aggregate cap, we do not need to compare whether each individual enrollment type exceeds a risk ratio of 1.028 and no risk score capping will occur.