UNDERSTANDING YOUR ACO'S BENCHMARK

John Ricard
254.931.8515 • john.ricard@wakely.com

Oliver Smidt
720.226.9816 • oliver.smidt@wakely.com

Dani Cronick, FSA, MAAA
720.531.6133 • dani.cronick@wakely.com

Introduction to the Medicare Shared Savings Program

The Medicare Shared Savings Program (MSSP) has been committed to better care for individuals, better health for populations, and lowering the growth of expenditures since its inception in 2012. Accountable Care Organizations (ACOs) target these goals of the MSSP by providing high quality care and creating gross savings that come from the difference between where CMS would have expected an ACO's average beneficiary expenditures to be—based on historical expenditures, regional and national expenditure trends, and changes in population risk over time—and where the actual average expenditures landed for that ACO's population of beneficiaries. ACOs are rewarded for their success in the program by sharing in a portion of the gross savings with CMS. ACOs can increase their gross savings by either increasing their benchmark, decreasing their expenditures, or both. To help ACOs better understand what goes into calculating their benchmark and expenditures, Wakely has prepared this brief to break down the component parts of gross savings.

What is Driving my ACO's Updated Benchmark?

There is a timing and informational gap in the data provided by CMS around the benchmark to which ACOs in the Medicare Shared Savings Program will ultimately be compared. CMS provides ACOs at the beginning of each performance period a *historical benchmark*. However, there are often major changes between this historical benchmark and the *updated benchmark* that will be used in the final settlement calculation, and the updated benchmark is not provided until eight months *after* the performance period has completed.

This gap can leave many ACOs in the dark as to how their actual performance is comparing to their benchmark throughout the year. The goal of this brief is to help ACOs understand what changes and adjustments go into their final updated benchmark, and how they can proactively predict and adapt to these changes throughout the performance year.

The remainder of this paper goes into detail on the development of the updated benchmark, however below we have listed a few key factors for ACOs to consider.

- **Regional and National FFS trends –** historical benchmarks are trended to the performance period using a blend of actual regional and national trends based on all assignable fee-for-service (FFS) beneficiaries. In 2020, because regional and national expenditures were lower, this drove down many ACOs' updated benchmarks.

- **Shifts in beneficiary mix –** CMS will remix an ACO's benchmark if their mix of ESRD, Disabled, Aged/Dual, and Aged/Non-Dual beneficiaries changes between the benchmark and performance periods. Recently we have seen a trend of ACOs increasing in their portion of Aged/Non-Dual beneficiaries (the lowest cost individuals), decreasing their final benchmark.
- **Changes in Normalized Risk Score –** finally, CMS will adjust for any changes to population risk and normalized risk score between the benchmark and performance period. However, this adjustment is currently capped at an increase of 3% total[1].

Benchmark Development

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[2] 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[3]) 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 1 – Example: Calculate the 2021 Historical Benchmark

Trended Historical Benchmark Expenditures	BY1[4]	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%	$6,873
Historical Benchmark Expenditures Before Regional Adjustment ($)						**$11,050**

[1] Note: this is 3% increase between the benchmark period and performance period, this is not an annual number.
[2] Population distribution indicates the proportion of ESRD, Disabled, Aged/Dual, and Aged/Non-dual beneficiaries within the ACO's population.
[3] The regional adjustment is described below and is intended to capture differences between the ACO's population and their region.
[4] BY1 = Historical beneficiary expenditures for BY1, trended and risk adjusted to BY3, multiplied by the weight given to BY1.

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 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[5]. 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 2 – 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%	$7,029
					Regionally-Adjusted Historical Benchmark ($)		**$11,255**

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

[5] Regions are defined based on where the beneficiaries assigned to an ACO reside, at the county level.

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 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:

Updated Benchmark = (Regionally adjusted historical benchmark)*(ACO CMS-HCC risk ratio)*(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 3 – 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%	$7,039
					Updated Benchmark ($)	**$11,178**

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.

Please contact John Ricard at John.Ricard@wakely.com, Oliver Smidt at Oliver.Smidt@wakely.com, or Dani Cronick at Dani.Cronick@wakely.com with any questions or to follow up on any of the concepts presented here.

OUR STORY

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