Medicare Shared Savings Program
New Method for Capping Hierarchical Condition Category (HCC) Growth

Abstract:

According to CFR Title 42 § 425.605, Medicare Shared Savings Program ACOs renewing or starting contracts January 1, 2024 or later are subject to a new method for capping Hierarchical Condition Category (HCC) growth between their 3rd benchmark year (BY3) and the subsequent performance year (PY). In 2024, 140 ACOs started new contract cycles subject to this rule change. The recent release of the ACO performance results for PY 2024 allows us to assess the impact of this new method on cost growth. Of these 140, seven ACOs were subject to HCC capping under the new rules. If the prior rule had been in effect, 65 ACOs would have had at least 1 entitlement group capped for HCC growth. However, of the 140 ACOs, 69 (49%) had a demographic risk ratio of less than 1, while 90 (64%) had a demographic risk ratio between 0.995 and 1.005, suggesting little variation in the demographic make-up of most ACOs. As such, we found that 5 of the 7 ACOs flagged for HCC growth capping using the updated criteria would still receive a cap without demographic adjustment.

As such, this analysis indicates that while the HCC rule change had a broad impact on how ACOs are evaluated, the practical impact of demographic variability adjustments paired with a universal HCC cost growth benchmark was minor in the time between BY3 and PY 2024. It should be noted that HCC capping dynamics will continue to shift as these contracts move forward, potentially allowing more notable differences to emerge between the previous method for capping HCC growth and the new rules.

Background:

According to CFR Title 42 § 425.605, Medicare Shared Savings Program ACOs renewing or starting contracts January 1, 2024 or later are subject to a new method for capping Hierarchical Condition Category (HCC) growth between their 3rd benchmark year (BY3) and the subsequent performance year (PY).Previously, HCC score growth was capped at 3% across entitlement groups and specified as such on a case-by-case basis.The updated rule caps HCC growth in-aggregate rather than by entitlement group, while also accounting for demographic variability. The recent release of the ACO performance results for PY 2024 allows us to assess the impact of this new method on cost growth.

Findings:

In 2024, 140 ACOs started new contract cycles subject to this rule change.Of these 140, seven ACOs were subject to HCC capping under the new rules. If the prior rule had been in effect, 65 ACOs would have had at least 1 entitlement group capped for HCC growth. Clearly, the new rule impacts a broad set of ACOs.

Findings (cont):

Since the new method incorporates 2 features that impact capping, accounting for demographic changes and aggregation of HCC growth prior to capping, we wanted to assess which feature carried the greatest impact. Of the 140 ACOs, 69 (49%) had a demographic risk ratio of less than 1, while 90 (64%) had a demographic risk ratio between .995 and 1.005. As expected, there was little variation in the demographic make-up of most ACOs. If the cap was applied based on the aggregate HCC growth and did not account for demographic changes then only 5 ACOs would have received a cap. This is because 2 of the 7 that did receive a cap had demographic risk ratios of less than 1 and were very near to an aggregate HCC growth of less than 3%.

While the rule change had a broad impact, comparing the weighted average risk ratio of PY to BY3 for each approach shows that the impact was minimal for most ACOs. Only 3 ACOs had a risk ratio that was lower with the new rules, which was due to a shrinking demographic risk score. Over half (74) had the exact same risk ratio under both rules, leaving 63 that saw a higher risk ratio under the new rules. However, 48 (76%) of those 63 had a improvement of 0.25% or less, and only 5 (8%) had an improvement of 0.5% or greater.

Implications:

This analysis indicates that the new approach to capping HCC scores in the MSSP ACO program did change the regularity that the cap was implemented for many ACOs. However, the ultimate impact of this change remained relatively low. It is very important to recognize that this analysis is based on the first year of the contract in which this rule change was in place. It would be expected that the HCC capping dynamics will shift as these contracts move forward and there is more time between BY3 and the PY.