MILLIMAN WHITE PAPER

"Pathways to Success" MSSP final rule: Winners and losers

Anders Larson, FSA, MAAA
Cory Gusland, FSA, MAAA

Milliman

On December 21, 2018, the Centers for Medicare and Medicaid Services (CMS) issued a final rule that will significantly change the Medicare Shared Savings Program (MSSP). This rule finalizes many of the "Pathways to Success" provisions detailed in the proposed rule published on August 8, 2018, with some modifications that may have a significant impact on a number of accountable care organizations (ACOs). At its core, the final rule creates a structured timetable for inexperienced ACOs to transition to downside risk, gradually increasing the maximum risk exposure as those ACOs gain more experience with the MSSP. This paper is the eleventh in a series of Milliman white papers on the proposed and final versions of this rule.

The initial MSSP proposed rule was met with a wide range of reactions. Some stakeholders originally suggested that this will be the beginning of the end of the MSSP.[1] Others praised CMS for making changes they believe move the program in the right direction.[2] Although CMS made several revisions to the rule before finalizing, the final rule will affect all MSSP accountable care organizations (ACOs). There will be some winners and some losers, and the impact of the rule change will vary by ACO, depending on their current situations and unique characteristics. Given this variability, we examined the rule from the perspective of different ACO situations to help readers understand how the MSSP rule might affect different ACOs.

Throughout this paper, we will refer to the rule in place until July 1, 2019, as the "prior rule," which is different from the "proposed rule" released on August 8, 2018. We will primarily contrast the final rule with the prior rule, rather than with the proposed rule. For a comparison of key differences between the proposed and final rule, please refer to the Milliman white paper released on January 7, 2019.[3]

Other papers in this series identified the following key characteristics that will determine an ACO's risk-sharing parameters and financial benchmarks under the rule:

- Participant revenue
- Costs relative to its region
- Prior experience within the MSSP[4]

In this paper, we explore these characteristics plus a few others. While this is not an exhaustive compilation of all ACO characteristics that are relevant to the final rule, this report highlights the primary considerations that affect most ACOs. We used these characteristics to identify what might be considered "winners" and "losers." We are defining ACOs as "winners" if the final rule provides some type of benefit to the ACO compared to the prior rule and vice versa for "losers." The winners' benefits could be a more favorable benchmark, lower risk exposure, or additional options that were not previously available. Our categorization of ACOs as winners or losers is meant to be generally applicable—there will certainly be individual ACOs within some of our "winner" cohorts that do not benefit, and vice versa for the "loser" cohorts.

We published a paper exploring this topic on October 3, 2018,[5] based on the proposed rule released on August 8, 2018. This is largely an update to that paper based on the final rule. We believe that in most cases the changes between the proposed and final rule lessened the negative effects for the "losers" identified in our previous paper. As a result, some stakeholders appear to have softened their opinions of the rule.[6]

1 National Associations of ACOs. Proposed rule likely to drive exodus of Medicare accountable care organizations (ACOs). Retrieved September 17, 2018, from https://www.naacos.com/press-release--mssp-nprm.

2 Meltzer, R. (August 13, 2018). CMS's ACO proposal resurfaces discord over pace of risk-based models. FierceHealthcare. Retrieved September 17, 2018, from https://www.fiercehealthcare.com/payer/cms-s-proposed-rule-acos-draws-praise-from-obama-s-national-coordinator.

3 See http://us.milliman.com/insight/2019/Pathways-to-Success-MSSP-final-rule-Key-revisions-to-the-proposed-rule/.

4 The final rule does also consider experience in other CMS and Center for Medicare and Medicaid Innovation (CMMI) programs, such as the Pioneer ACO Model, Next Generation ACO Model, and Comprehensive ESRD Care Model.

5 See http://us.milliman.com/insight/2018/Pathways-to-Success-MSSP-proposed-rule-Winners-and-losers/.

6 National Associations of ACOs. NAACOS statement on CMS's final "Pathways" rule and Next Generation ACO results. News release. Retrieved January 30, 2019, from https://naacos.memberclicks.net/press-release--naacos-statement-on-cms-s-final--pathways--rule-and-next-generation-aco-results.

Winners: Low-revenue ACOs

ACOs that are comprised primarily of physicians (i.e., those without hospital participants) are likely to be classified as "low-revenue" ACOs under the final rule. In general, low-revenue ACOs will have smaller (or similar) amounts of risk exposure as under the prior rule, while gaining more flexibility and choices. Compared to the prior rule, these ACOs will have the ability to maintain relatively low levels of risk for longer periods of time (up to an additional 10½ years) before moving to the ENHANCED Track.[7] Additionally, they will have a lower loss-sharing limit due to the revenue-based loss sharing in Levels C, D, and E of the BASIC Track, relative to the current Track 2 or Track 3.

Figure 1 illustrates the loss-sharing limits for a hypothetical ACO under various levels of the BASIC Track. In levels C, D, and E (the three levels with downside risk), the loss-sharing limits for low-revenue ACOs are based on a percentage of participants' *total Part A and Part B revenue during the year*. On the other hand, under the prior rules the loss-sharing limit was a function of the benchmark. We expect the revenue-based limits to be considerably lower than the benchmark-based limits for low-revenue ACOs.

Level E of the BASIC Track is nearly identical to Track 1+, and therefore low-revenue ACOs with previous experience in Track 1+ will not see any impact to their loss-sharing limits, although they can remain at this level for longer under the final rule. However, low-revenue ACOs that had been planning to move to downside risk soon have the option of more gradual transitions to risk (in Levels C and D) under the final rule than under the prior rule.

7 Under the prior rule, it is possible for an ACO to have a total of nine years at the Track 1 or Track 1+ level. Under the final rule, low-revenue ACOs that are still in Track 1 can have an additional 10½ years before moving to the ENHANCED Track. Therefore, some ACOs that started in 2013 could end up taking a total of 17 years before moving to the ENHANCED Track.

Losers: ACOs with costs much lower than their regional benchmarks

Because some efficient ACOs would be able to generate shared savings without achieving further cost reductions, CMS limited the impact of the regional benchmark adjustment in the final rule in two ways:

1. The weight given to the regional benchmark adjustment will not exceed 50% in any agreement period (the maximum was 70% under the prior rule).
2. The total impact of the regional benchmark adjustment (after blending) in each beneficiary entitlement category cannot exceed 5% of the national fee-for-service (FFS) expenditures (there was no limitation under the prior rule).

As previously mentioned, CMS noted in the final rule that 80% of ACOs that renewed for a second agreement period in 2017 had costs below their risk-adjusted regional benchmarks (and therefore benefited from the regional benchmark adjustment). Many of these ACOs may have anticipated driving further cost reductions, widening the cost difference compared to their regions' costs. This provision may limit the ability of some ACOs to benefit from these significant cost differences.

Winners: ACOs with costs much higher than their regional benchmarks

For many of the same reasons that ACOs with costs much lower than their benchmark are losers, ACOs with costs much higher than their benchmarks are winners. The 5% limits by entitlement category (mentioned above) can be a major mitigating factor for ACOs with unusually high costs for certain populations. Additionally, CMS has reduced the weight given to the regional benchmark adjustment in the first agreement period[8] from 25% to 15%.

8 First agreement period in this case defined as the first agreement period in which an ACO is subject to the regional benchmark adjustment. ACOs starting 2016 or later have not yet been subject to the regional benchmark adjustment.

FIGURE 1: COMPARISON OF LOSS-SHARING LIMITS FOR AN ACO WITH MEDICARE FFS REVENUES OF 15% OF THEIR FINANCIAL BENCHMARKS UNDER THE FINAL RULE AND PRIOR RULE (IN MILLIONS)

METRIC	LEVEL C	LEVEL D	LEVEL E TRACK 1+	MSSP TRACK 2	MSSP TRACK 3*
Total Part A and Part B revenue for ACO participants	$15	$15	$15	$15	$15
Total benchmark expenditures	$100	$100	$100	$100	$100
Loss sharing limit	$0.3	$0.6	$1.2	$5–10**	$15

* Under the prior rules, Track 3 used prospective assignment and Track 2 used retrospective assignment. Therefore, the total benchmark expenditures for a given ACO would not necessarily be the same under Track 2 and Track 3 but we have made this simplifying assumption for the example.

** Loss sharing limits under Track 2 increase in each performance year.

Under the prior rule, these ACOs faced a significant uphill battle after the first agreement period. Although they will still be penalized for having high costs relative to their regions under the final rule, the impact is decidedly less severe.

Winners: ACOs with high market shares

Under the prior rule, ACOs that comprised a large share of their markets (including many rural ACOs) had a very difficult time generating savings after the first agreement period because the regional trends for these ACOs were largely driven by the ACO's own experience.

The final rule addresses this issue by introducing a blended national-regional trend. For ACOs with high market share, the blended national-regional trend will be heavily weighted toward the national trend. This mitigates some, but not all, of the risk of an ACO lowering its own future financial benchmark through significant cost reductions in its current period.

While the final rule addresses a portion of the high market share trend issue, the regional benchmark adjustment will continue to have a limited impact on these ACOs because they make up large portions of the regional benchmarks. This will continue to be a challenge for ACOs with costs lower than their regional benchmarks and will remain a benefit when an ACO's costs are higher than its regional benchmark.

Losers: ACOs beginning Track 1 in 2016, 2017, 2018, or hoping to start Track 1 in 2019

ACOs that entered their first agreement periods under MSSP Track 1 in 2017 or more recently, as well as those planning to enter the MSSP in 2019, will have less time and slightly lower gain-sharing in upside-only risk tracks. Under the prior rule, ACOs could be in Track 1 up to six years and an ACO's participants could be in Track 1 even longer if the participants switch ACOs.[9] Furthermore, the new upside-only risk track will share in 40% of gross savings, rather than 50% under the prior Track 1. Figure 2 illustrates the shared savings from 2019 to 2021 for a new 10,000-life ACO under the prior and final rules. For this illustration, we have assumed the ACO achieved 5% gross savings each year and progressed as slowly as possible through the BASIC Track glide path. Under this illustrative example, total shared savings in these three years would be approximately 33% lower under the final rule (about 20% due to lower gain-sharing rates each year and 13% due to the delay in the 2019 program start date, from January 1 to July 1).

There are some mitigating factors for this cohort. ACOs currently in Track 1 that were already planning to move to downside risk will not see a major negative impact, and ACOs starting an agreement period in 2017 or 2018 can finish their current agreement periods before starting the BASIC or ENHANCED tracks. One change may be beneficial for some ACOs starting in 2019—the regional benchmark adjustment begins in their first agreement period, rather than the second agreement period under the prior rule. As mentioned by CMS in the final rule, 80% of ACOs had positive regional benchmark adjustments in 2017.

Winners: ACOs interested in rebasing "off-cycle" in 2019 (i.e., within their current agreement periods)

Under the final rule, an ACO with an existing agreement period ending in 2020 or 2021 can choose to enter into a new 5½-year agreement period commencing in 2019, at which time the ACO's benchmark would be rebased. This may be beneficial to an ACO if:

- Its financial benchmark under its existing agreement period is inadequate based on current cost and utilization levels within its region.
- The ACO is "efficient" compared to its region and the ACO is in its first agreement period (and thus not subject to the regional benchmark adjustment).

Under the prior rule, an ACO did not have the option to rebase off-cycle in 2019.

9 CMS has effectively closed this loophole in the final rule. An ACO will not be considered "new" if the majority of ACO participants (defined by TIN) have previously participated in the MSSP.

FIGURE 2: COMPARISON OF SAVINGS FOR AN ILLUSTRATIVE ACO JOINING THE MSSP IN 2019

METRIC	2019	2020	2021	2019-2021 TOTAL
Average Assigned Beneficiaries	10,000	10,000	10,000	10,000
Benchmark Expenditures (per beneficiary per year, PBPY)	$12,000	$12,600	$13,230	n/a
Gross Savings Percentage	5%	5%	5%	n/a
Gross Savings (prior rule)	$6,000,000	$6,300,000	$6,615,000	$18,915,000
Gross Savings (final rule)	$3,000,000	$6,300,000	$6,615,000	$15,915,000
Shared Savings (prior rule)	$3,000,000	$3,150,000	$3,307,500	$9,457,500
Shared Savings (final rule)	$1,200,000	$2,520,000	$2,646,000	$6,366,000

Conclusion

Low-revenue ACOs appear to be the most significant winners under the final rule because they will enjoy material reductions in risk exposure for up to 10½ years if they stay in the BASIC Track. CMS made it clear in the final rule discussion that it wants to build on the early successes of physician-led ACOs. It will be interesting to see whether this final rule affects how ACOs structure their participation lists in the future.

Conversely, high-revenue ACOs that were not planning on transitioning to downside risk appear to be the most significant losers because they will be required to take downside risk sooner. These ACOs will need to decide whether they are willing to be at risk for the total cost of care of their beneficiaries. Given that ACOs have been a large catalyst for the movement to value-based care, their decisions may have a significant impact on population health efforts within their communities.

This paper highlights the importance for individual ACOs to consider their unique situations when assessing the impact this final rule will have on their organizations. While some ACOs inevitably will be inclined to leave the program, other ACOs may find a viable path, or even be better positioned, for the future.

FOR MORE ON MILLIMAN'S PERSPECTIVE ON MSSP:
Visit milliman.com/mssp
Visit our blog at healthcaretownhall.com
Follow us at twitter.com/millimanhealth

Milliman

Milliman is among the world's largest providers of actuarial and related products and services. The firm has consulting practices in life insurance and financial services, property & casualty insurance, healthcare, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

milliman.com

CONTACT

Anders Larson
anders.larson@milliman.com

Cory Gusland
cory.gusland@milliman.com

High-level review

The chart below summarizes the high-level impact of the final rule on ACOs based on various characteristics (some of which are not discussed in detail in this paper). Although the list is not exhaustive and many items are interrelated, it highlights some of the key themes of the final rule. The high-level impacts on ACOs are separated into three categories: financial benchmark, upside potential ("shared savings"), and risk exposure ("shared losses").

The impacts shown are relative to the prior rule, not relative to other ACOs. For example, ACOs would always prefer to have lower costs relative to their regions because the regional benchmark adjustment will increase their financial benchmarks. But ACOs might receive less benefit under the final rule than they would have under the prior rule.

In the chart, a green circle with a checkmark indicates a clear favorable impact and a red circle with an X indicates a clear unfavorable impact. When the effect is moderate or uncertain we removed the checkmark or X. For instance, new ACOs might benefit from the immediate application of the regional benchmark adjustment, but it is also possible they will see negative effects from this.

Figure key			
Moderate or uncertain unfavorable impact	●	Moderate or uncertain favorable impact	●
Clear unfavorable impact	✗	Clear favorable impact	✓

Category	ACO characteristic	Impact on financial benchmark	Impact on upside potential	Impact on risk exposure
ACO's revenue participation	Low revenue			✓
	High revenue			
Cost relative to region	Low cost	✗		
	High cost	✓		
Market share within region	Rural/high market share	✓		
	Urban/low market share			
ACOs not planning to take downside risk	New ACO*	●	✗	✗
	2016-2018 starter		●	✗
	2012-2015 starter**		●	●
ACOs planning to take downside risk	New ACO†	●	●	
	Renewing ACO			
ACOs interested in rebasing early	2017-2018 starter	✓		

* Impact on financial benchmark for new ACOs is uncertain or moderately positive because the regional benchmark adjustment will happen immediately, which could be positive or negative. We categorized this as a moderate positive impact because most ACOs received a favorable regional benchmark adjustment in 2017.

** Under the prior rule, these ACOs would have had to take downside risk in 2019 or exit the program. The final rule allows these ACOs to stay in an upside-only risk arrangement longer, but the upside sharing rate is slightly reduced.

† Impact on upside potential for new ACOs planning to take downside risk is moderately negative because the 2019 performance year is shorter by half. Other sharing parameters are similar to options already available (Track 1+ and Track 3).