MILLIMAN ISSUE BRIEF

ACO minimum savings/(loss) rates: Less is more?

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Introduction

While seeking to improve population health, the Centers for Medicare and Medicaid Services (CMS) Innovation Center supports innovative payment and service delivery models that allow participating providers to achieve large savings. In 2011, CMS established the Medicare Shared Savings Program (MSSP) and brought the concept of the accountable care organization (ACO) to a wider audience. A key feature of the MSSP methodology is the minimum savings rate (MSR) and minimum loss rate (MLR). ACOs that participate in the MSSP are familiar with these corridors because they can mean the difference between receiving shared savings and receiving nothing. On the other hand, for ACOs currently taking downside risk, the MLR provides a buffer that neutralizes potential losses.

The MSR and MLR create a savings/(losses) corridor that erases shared savings and losses up to a specified threshold. After an ACO's savings/(losses) exceed the MSR/MLR corridor, the MSR/MLR has no effect and savings/(losses) are calculated on a first-dollar basis. This paper explores the MSR/MLR options available to ACOs and presents the authors' perspective on what ACOs should consider when selecting the MSR/MLR under an MSSP track with downside risk.

Calculating an ACO's shared savings

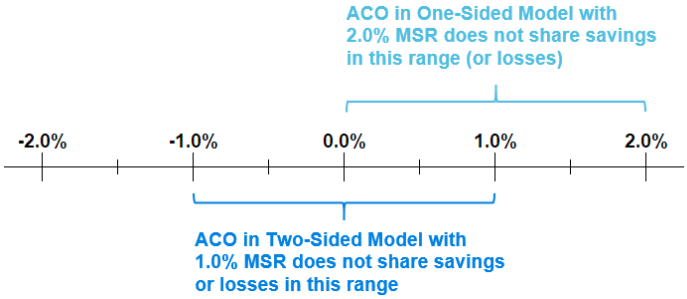
CMS determines each ACO's spending target (called the expenditure benchmark) based on several factors, which include the ACO's historical expenditures as well as expenditures in the ACO's region.[1] The difference between the expenditure benchmark and the actual expenditures incurred is the ACO's raw savings.

Raw Savings = Expenditure Benchmark – Actual Expenditures

To ensure ACOs only share in the savings they generate (rather than savings generated through random variation), CMS requires that the ACO's raw savings as a percentage of the benchmark exceed the MSR. Similarly, under two-sided arrangements, the total savings as a percentage of the benchmark must exceed the MLR before the ACO shares in losses. Figure 1 shows an illustrative example of this for two ACOs:

1. An ACO in a one-sided model with 60,000 or more assigned beneficiaries that has an MSR of 2%.
2. An ACO in a two-sided model that selects a 1% MSR/MLR.

FIGURE 1: ILLUSTRATIVE EXAMPLE OF MSR AND MLR



Shared Savings Program

A shared savings program is a provider payment model that layers over an existing reimbursement arrangement. Typically the provider is reimbursed on a fee-for-service (FFS) basis, and then, if the provider can keep healthcare spending below a defined target, the payer reimburses the provider a portion of the savings. In one-sided (upside-only) models, providers only share in savings, and in two-sided (downside) models, providers share in both savings and losses.

Under the MSSP, ACOs can elect whether to participate as a one-sided model (for a limited period of time) or a two-sided model. Because two-sided models include the provider taking on the risk of sharing losses with CMS, they have higher shared savings potential than one-sided models.

Under Pathways to Success, newer ACOs can start in an upside-only model, but transition over time to taking both upside and downside risk.

[1] For an in-depth discussion of the MSSP benchmark see: http://www.milliman.com/insight/2019/Pathways-to-Success-MSSP-final-rule-Financial-benchmark/.

If the MSR/MLR is met, then the *total* savings/(losses) are multiplied by a shared savings rate (SSR) or shared loss rate (SLR) to arrive at shared savings. It is important to note that the total savings, not the savings in excess of the MSR (or MLR), is multiplied by the SSR (or SLR).

Final Shared Savings/(Losses) = Raw Savings/(Losses) * SSR/(SLR)

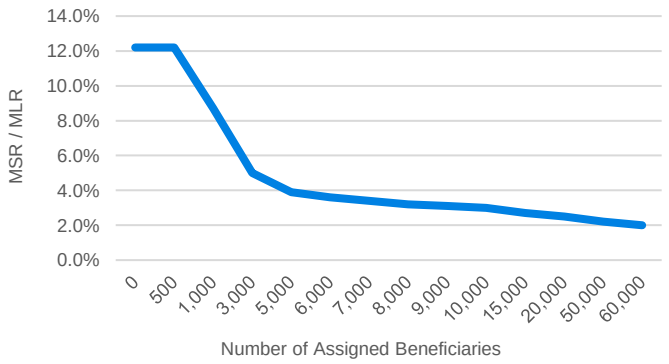
The SSR and SLR take into account the ACO's quality score as well as the amount of risk (as determined by the ACO's current track/level). The shared savings/(losses) are subject to upper limits when determining final shared savings.

There are many moving pieces to the MSSP shared savings calculation besides an ACO's actual health expenditures. Each ACO is confronted with the decision of when to transition to a two-sided model as well as potential changes in trends, demographics and risk scores, and quality scores. ACOs that participate in two-sided models must also select the MSR/MLR at the start of each agreement period.

Selecting an MSR/MLR

There are two main methods of determining an ACO's MSR/MLR. The first method is prescribed by CMS and determines the MSR/MLR based on the number of beneficiaries assigned to the ACO (see Figure 2), which results in MSRs/MLRs between approximately 2% and 12%. This method is an option for ACOs in two-sided models, and is required for ACOs in one-sided models—creating an additional barrier to shared savings for upside-only ACOs through a higher MSR than under the two-sided models.

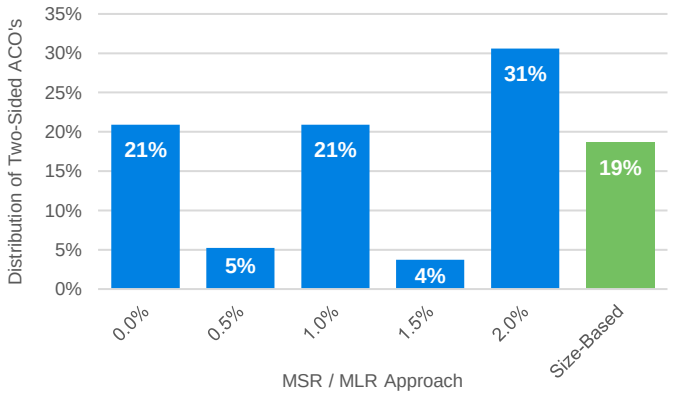
FIGURE 2: MSR/MLR BY NUMBER OF ASSIGNED BENEFICIARIES IN ACO



The second method of determining the MSR/MLR is only available to two-sided ACOs. Under this method the ACO can select an MSR/MLR between 0.0% and 2.0%, at 0.5% intervals (e.g., 0.5%, 1.0%). The MSR/MLR is symmetrical, meaning the threshold for savings and losses are the same percentage.

Figure 3 shows the percentage of two-sided ACOs from 2016 to 2018 that elected the size-based method or each of the 0.0% to 2.0% MSR/MLR thresholds.

FIGURE 3: MSR/MLR APPROACHES IN TWO-SIDED ACO'S (2016-2018)

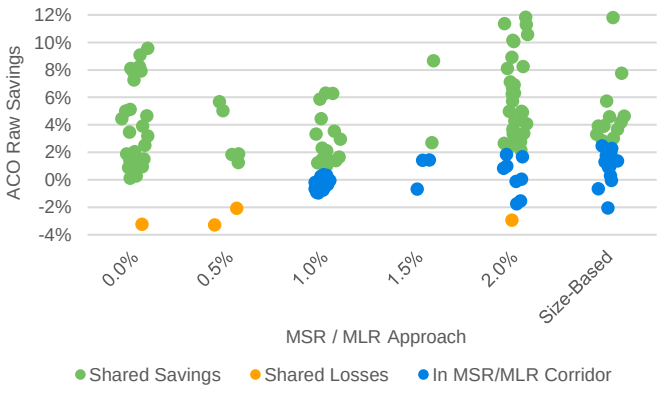


Approximately half (50%) of ACOs chose a 2% or greater (including size-based) MSR/MLR, limiting the chance that these ACOs will share in savings or losses, versus the smaller savings/(loss) threshold of 1.5% or less.

EFFECT OF THE MSR/MLR

As stated above, the MSR/MLR may have a large impact on the shared savings that ACOs ultimately collect from CMS. Figure 4 shows the effect of the MSR/MLR selection on two-sided ACO savings and losses. Each dot represents an ACO that, due to the MSR/MLR selected, either shared savings (green), shared losses (orange), or saw savings/(losses) negated (blue).

FIGURE 4: MSR/MLR EFFECT ON TWO-SIDED ACO RESULTS (2016-2018)



We can see from these results that slightly more ACOs saw savings negated due to MSR/MLR selection than saw losses negated.

IS A 0.0% MSR/MLR THE "RIGHT" CHOICE?

A 0.0% MSR/MLR means an ACO is effectively guaranteed to have a settlement with CMS: either positive or negative. From Figures 3 and 4 above, we see that 21% of ACOs in two-sided models elected an MSR/MLR of 0.0% in 2016 to 2018. Ignoring sensitivity to losses, a 0.0% MSR/MLR generally produces the greatest opportunity for gains because:

- The shared savings rate is generally higher than the shared loss rate (e.g., assuming a quality score of 67% or greater under Track 3 or ENHANCED).
- There is no implicit discount under the MSSP, so ACOs are generally expected to have an equal chance of achieving gains or losses, assuming the benchmark methodology accurately measures expected future costs.

However, electing an MSR/MLR greater than 0.0% protects the ACO from some potential loss sharing. By definition the MSR/MLR does *not* protect ACOs from large losses (e.g., losses outside the MLR). Picking an MSR/MLR greater than 0.0% does reduce the chance of a negative settlement with CMS. ACOs may want to avoid negative settlements because:

- ACOs are generally designed to expand revenue for provider participants rather than reduce revenue. Therefore, a negative settlement (especially early on) may undermine the ACO and potentially lead to provider participants leaving the ACO or termination.
- The MSSP settlement methodology may produce unexpected or counterintuitive results, and the MSR/MLR may be perceived as offering some (albeit limited[2]) protection against the technical risks of the MSSP in addition to random variation.

Ultimately the "right" MSR/MLR is ACO-specific and requires reviewing each ACO's goals and the available information about historical and potential future performance. ACOs may be surprised by the amount of data and information available,[3] and actuaries can help ACOs evaluate their options and make informed decisions.

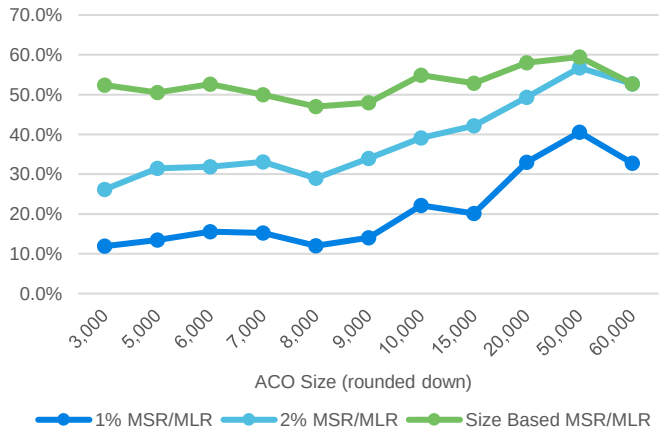
MAKING THE TRANSITION FROM ONE-SIDED MODELS

ACOs in one-sided models can draw on their own historical performance data and experience in the MSSP when transitioning to a two-sided model, allowing the ACO to simulate the available options. (New ACOs can also access historical performance data.)

For ACOs in one-sided models, the MSR is set according to the number of assigned beneficiaries (size-based MSR), as detailed previously in Figure 2. Because these ACOs only share in savings and not in losses, the MSR acts as a barrier to shared savings. For example, an ACO with 8,000 assigned beneficiaries must achieve savings of at least 3.2% (the size-based MSR for the ACO), otherwise the ACO will not share in the savings.

ACOs in two-sided models have the option of setting the MSR/MLR either using the size-based approach or selecting an MSR/MLR between 0.0% and 2.0%. Figure 5 shows the percentage of ACO savings/(losses) that fall within specific MSR/MLR thresholds. Larger ACOs are historically more likely to fall within the MSR/MLR for fixed MSR/MLR values (1% and 2% are shown), while approximately 50% of ACOs fall within the size-based thresholds.

FIGURE 5: PERCENTAGE OF ACOS AFFECTED BY MSR/MLR (2016-2018)



For ACOs entering a track with downside risk, these historical results can provide a rough guide for how often each MSR/MLR option will affect an ACO's MSSP settlement. For example, if the results in Figure 5 are a good indicator of future performance, then keeping the size-based MSR/MLR approach has roughly a 50% chance of negating savings and losses.

[2] Working with an actuary can help ACOs understand the nuances of the MSSP and quantify the technical risks of the program.

[3] For example, detailed clinician-level cost and utilization data is available from CMS for traditional Medicare.

Conclusion

ACOs face many decisions when determining how to maximize savings in the MSSP. One important decision for ACOs in two-sided models is the selection of the MSR/MLR. Selecting a lower MSR/MLR (0.0%) creates more opportunity for savings than a higher MSR/MLR, but also a greater likelihood of losses. Each ACO should evaluate the MSR/MLR options based on the ACO's goals, risk tolerance, and available data and information. ACOs already participating in the MSSP (e.g., in a one-sided model) can inform their decisions by evaluating the effect of the MSR/MLR under a range of scenarios based on historical performance. ACOs new to the MSSP can also access historical clinician-level performance data, and use this information to inform their decision-making process.

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