

# Healthcare's Next Revolution: Finding Success in the Medicare Shared Savings Program

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Data is the catalyst for healthcare's next revolution. Today's healthcare providers and administrators have an incredible opportunity to participate in what may be the biggest societal shift of a lifetime: the move from a fee-for-service (FFS) payer model to value-based care (VBC). Effectively using data will facilitate that shift.

On December 21, 2018, CMS issued a final rule for the Medicare Shared Savings Program (MSSP), strengthening the financial incentives for ACOs to drive improved outcomes. The health systems that embrace data to achieve financial success will grow while others will struggle to compete. This article explores the high points in history that have led to the current challenges, why financial imperatives drive cultural change in our economic model, ways MSSP can help healthcare organizations achieve financial success, and ideas for how to utilize data to develop better healthcare delivery systems.

## A Series of Revolutions

A series of revolutions has driven the development of the U.S. healthcare system, enabling dramatic improvements in all aspects of healthcare quality and outcomes over the past century. These include the following:

## The Industrial Revolution

In the early 1900s, the industrial revolution led to financial gains and a tax base that allowed the government to create hospitals, medical schools, and educational institutions. As a result, public health began to improve as child mortality rates decreased.

## A Quality Revolution

Between 1900 and 1930, insights such as the Flexner Report, which looked at the quality of care provided and the quality of training physicians received, spurred a quality revolution in healthcare. As a result of the Flexner Report, almost half of all medical schools and hospitals across the country were shuttered, and processes were put in place that granted states the right to license hospitals and medical schools. These changes prompted further reductions in child mortality rates.

## Pasteurization and Sanitation Improvements

In 1948, two developments again moved the needle on child mortality rates, from 20 to 30 percent down to two to four percent: the advent of food pasteurization and the creation of sanitary sewer systems. Neither of these developments are what people typically think of as healthcare, but they drove the largest reduction in child mortality of any other public health efforts. Tax dollars facilitated many of these improvements, spurred by governmental regulations, rather than private individuals or companies.

These revolutions have raised the bar for healthcare quality to where there's no question that the system is far better today than in 1900. But, looking at the Gini coefficient, inequality is growing and there's more work to do. The question is, "What's the next revolution?" Many experts predict that the U.S. healthcare system is headed for a payer model revolution that will help move the needle from a FFS to a VBC model to create scalable, sustainable improvements in patient outcomes. Profitability in a market economy, should be viewed not just as a result of improvement efforts, but also a mechanism to achieve success and drive sustainable outcomes.

## What Is "Value" Based Care?

As pressures mount for healthcare organizations to shift to VBC, it's important to keep in mind that there's a spectrum between a FFS model and a VBC model and that value can have different meanings in different systems. Value can mean the following:

- The ability to reduce cost per unit of quality.
- Sustained improvements in clinical patient outcomes.
- Overall patient happiness with healthcare provided.
- Appropriate utilization of services.

While value can have many meanings, data management is central to any definition of value. What's important is that healthcare systems understand where they are on the spectrum between FFS and VBC and know where they want to be five years from now.

## Is the Shift to VBC Real?

Although healthcare organizations have focused on moving towards VBC for decades, the data shows that the shift is indeed taking place and FFS models are declining. According to the Health Care Payment Learning and Action Network, “The percentage of total healthcare payments linked to a value-based payment model (shared savings, shared risk, bundled payments, population-based payments) reached 34% of total dollars paid to providers in 2017, up 23% from 2015.” Additionally, the data shows that the shift to value is indeed real: the proportion of businesses aligned with FFS models is in decline from 51.7 percent in 2016 to 25.4 percent projected in 2021.

The move to value is working, and healthcare payers are following suit:

- Roughly 40 percent of Aetna claims payments are going to doctors and providers who practice VBC. Aetna has committed to increasing that number to 75 percent by 2020.
- Anthem has more than \$38 billion in spend tied to value-based contracts, representing 30 percent of commercial claims and roughly 40,000 providers.
- UnitedHealthcare has more than 800 VBC arrangements. In 2017, the payer had \$75 billion in payments to care providers, and they expect that number to increase to \$75 billion in 2020.

## Medicare in 2018

Medicare saw a reduction in utilization by over a billion dollars in 2018 and showed additional promising signs, including the following:

- ACOs in the MSSP generated \$314 million in net savings to Medicare after accounting for bonuses paid to participants.
- ACOs received \$800 million in shared savings bonuses.
- 34 percent of ACOs earned some shared savings bonus.

Clif Gaus, president and CEO of the National Association of ACOs, said of these statistics, “These results show that ACOs have turned the corner and this evidence dispels confusion about ACO performance. The hard work of ACOs is paying off for patients, providers, and for the Medicare trust fund.” And, according to CMS, the number of Medicare advantage plan choices will increase 20 percent in 2019 to more than 3,700 options in the marketplace—another sign that value-based models are here to stay.

## Pathways to Success: What Is MSSP?

MSSP is an alternative payment model created following the passage of the Affordable Care Act (ACA) of 2010 and was revised in late 2018. The model rewards providers and hospitals for achieving quality metrics and lowering healthcare expenditures. Revisions to MSSP require ACOs to take on more financial risk earlier, potentially incurring fees if organizations don't realize quality metrics and cost savings and indicating an important cultural shift that will help move the needle from FFS to VBC.

By 2022, CMS estimates that 40 percent of all covered lives in the U.S. healthcare system will be part of either Medicare or Medicaid. With revisions to MSSP, Medicaid programs across the country are following suit and adopting similar payment methodologies, asking hospitals and providers to take on more financial risk, improve the health of populations, and decrease healthcare costs.

## Success in the Medicare Shared Savings Program

Common focuses for the management of VBC delivery include both raising the quality of care and lowering the total costs of care. In raising quality of care, ACOs must achieve the following:

- Identify and close gaps in care across the continuum.
- Efficiently target interventions for high-risk populations.
- Leverage evidence-based care protocols to reduce unnecessary variation in quality of care.

In lowering the cost of care, ACOs must achieve the following:

- Improve risk identification, documentation, and benchmarking.
- Right-size utilization by matching medical necessity with need.
- Identify and reduce unwarranted variation in costs across providers and facilities.

Revisions to Medicare Shared Savings Program (“Pathways to Success”) encourages ACOs to transition to performance-based risk more quickly and to incrementally increase savings. The revisions cover several important highlights:

- Risk score change will be capped at plus or minus three percent over the life of an ACO's five-year agreement period.
- Benchmarking will be regional rather than national in scope.
- ACOs must move into downside risk faster, with no ACO allowed to spend more than 2.5 years in an upside-only risk track.
- Participants will either be “high revenue” or “low revenue” ACOs.

- Providers opting out of MSSP will be subject to a Merit-Based Incentive Payment System (MIPS). Going forward, it will be difficult to perform well in the MIPS program with considerable dual-sided risk in fee schedules.
- Track participation options are detailed below in Figure 1.

## Track Participation Options

	BASIC					ENHANCED
	Level A	Level B	Level C	Level D	Level E	
Agreement Period	5 Years					5 Years
APM Status	MIPS APM	MIPS APM	MIPS APM	MIPS APM	Advanced APM	Advanced APM
Shared Savings Rate	40%	40%	50%	50%	50%	75%
Maximum Savings	10% of Benchmark	10% of Benchmark	10% of Benchmark	10% of Benchmark	10% of Benchmark	20% of Benchmark
Shared Loss Rate	N/A	N/A	30%	30%	30%	40% to 75%
Maximum Losses	N/A	N/A	2% of Revenue capped at 1% of Benchmark	4% of Revenue capped at 2% of Benchmark	8% of Revenue capped at 4% of Benchmark	15% of Benchmark

Figure 1: A summary of new MSSP track options.

## How to Succeed in the New MSSP

With more financial risk at stake, ACOs need to plan for success. To do so, ACOs will need the following strategy:

- Shift routine patient management away from physicians to mid-level providers.
- Track prospective performance around financial, clinical, and patient experience metrics.
- Enhance primary care experience with new delivery models.
- Leverage data to drive predictive analytics for specific populations.
- Scale to more than 100,000 covered lives.
- Embed technology in their care model design.

Simply having the right technology, while a key component to success in a shared savings model, doesn't necessarily drive adoption or success, making it critical that ACOs embed technology within the care model design. Healthcare systems reluctant to move away from a FFS model should keep in mind a few key points:

- If the shared savings rate is greater than the operating margin (plus additional fixed costs incurred) for a given population, there's financial incentive to participate in the program.
- Using technology to highlight physician behavior can lead to improved retention of patients within the system and reduce unnecessary utilization or increased variation in care. If the system can increase patient retention from 50 to 60 percent, that's equal to a 10 percent growth in topline volume, which would offset any lost revenue from a reduction in unnecessary care.
- Health systems also need to remember that because the shared savings payment is not considered revenue, it directly impacts an organization's contribution margin.

## The Next Healthcare Revolution Is Here

The ACA and other regulatory changes have encouraged health systems to digitize healthcare, but these changes have had mixed success. While EMR adoption is high, the push for digitization has also created cynicism among providers who think of technology as a box-checking exercise. EMRs are necessary, transactional tools that do the job they were designed for. As health systems adopt smarter tools that can use data to transform care and affect real change, this cynicism may turn to excitement at the possibility of driving important changes in the healthcare landscape.

Amid both new and evolving regulatory requirements, it's an exciting time at the front lines of care. Changes to MSSP that require more financial risk earlier are the beginning of an important cultural shift. And, because other payers and Medicaid programs are following suit, this could be the financial push needed to move the U.S. healthcare system away from FFS and finally tip the balance to VBC. Providers and administrators that embrace these changes and help usher them forward can make a scalable difference that impacts the lives of countless people. 📢