WHITE PAPER

Medicare Shared Savings Program Performance Analysis

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Program Characteristics

The Medicare Shared Savings Program (MSSP) is the largest Accountable Care Organization (ACO) program sponsored by the Center for Medicare and Medicaid Services (CMS). This program was started in April 2012 and implemented a value based care structure that is intended to reward providers for shifting care delivery from a volume basis to a value basis. Ultimately this program is focused on providing incentives for providers to achieve the Triple Aim of healthcare:

- Improved patient experience
- Improved health of populations
- Reduced per capita cost of care

The MSSP program currently offers ACOs four different tracks (1, 1+, 2, and 3) with varying levels of financial risk, from upside potential only (track 1), to increasing levels of downside risk (tracks 1+, 2, and 3). Along with the varying levels of upside potential and downside risk, member assignment methodology and the availability of benefit enhancement waivers are track differentiators.

Participation in the program involves ACOs agreeing to a three year contract period, with optional renewals for additional three year periods. An exception to this is ACOs that began in either April or July of 2012, which were first eligible for renewal in January 2016, and so started the program with an agreement period greater than three years.

Program Participation

Participation in the program has increased every year, growing from 220 ACOs in 2013, to 561 in 2018. Accompanying the growth has been high persistency within the program, as shown in chart 1. Throughout the lifespan of the program, 92% of ACOs persist in the program from year to year. However, years in which an ACO renews their participation in the program, and the benchmark is reset, produce a lower average persistency of 79%.

> *Longevity within the program is critical to achieving and growing shared savings.*

Increased participation every year, coupled with high persistency in the program demonstrate the overall attractiveness of this program. The high persistency of the program also supports analysis of the results on a longitudinal basis.

Analysis of Results – ACO Perspective

One of the goals of the Triple Aim is reducing the per capita cost of care. ACOs who are able to reduce the per capita cost of care below a set

benchmark are eligible to share in that reduction of costs. The reduction needs to be greater than a set percentage, which is determined by the number of members in the ACO or selected by the ACO, depending on the track.

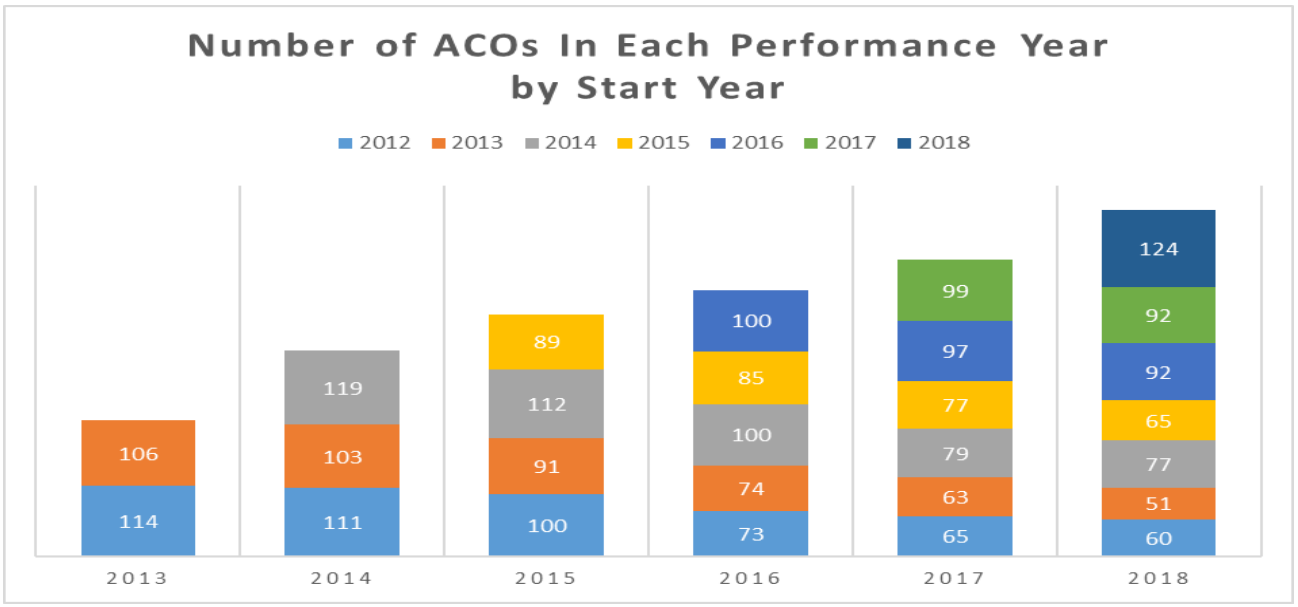
Once the reduction exceeds that minimum, the amount to be shared is modified by a factor related to the quality of care delivered by the ACO providers, resulting in the net shared savings. Maintaining or increasing the quality of care, while reducing the costs of that care can take time. Interventions need to be identified and implemented, and many ACOs will not recognize the financial benefits of those actions immediately.

Chart 2 shows the percentage of ACOs that earn net shared savings in each performance year, segmented by their original starting year within the program. Generally, 20% of ACOs earn net shared savings in the first year of the program. As they persist within the program the percentage earning net shared savings continues to grow, with greater than 40% of ACOs from 2012 – 2014 earning savings in 2017.

For ACOs that earn net shared savings, the amount of those savings have been steadily increasing over time. In aggregate, the amount that ACOs have earned has grown every year, from $316m in 2013 to $799m in 2017. However, when analyzing the per capita results based on start year, chart 3 shows the annualized per capita shared savings earned are increasing from 2013 ($231) to 2016 ($332), with a decrease in 2017 ($283). The decrease in 2017 is impacting all start year cohorts, but is especially impactful for the cohort that renewed in 2017.

The results across all ACOs have shown similar favorable results and trends. Program-wide, ACOs earned $244m in 2013, $341m in 2014, $646m in 2015, $691m in 2016, and $781m in 2017. In many cases, these trends highlight the

Chart 1: ACO Participation by Performance Year and Start Year



fact that longevity within the program is critical to achieving and growing shared savings.

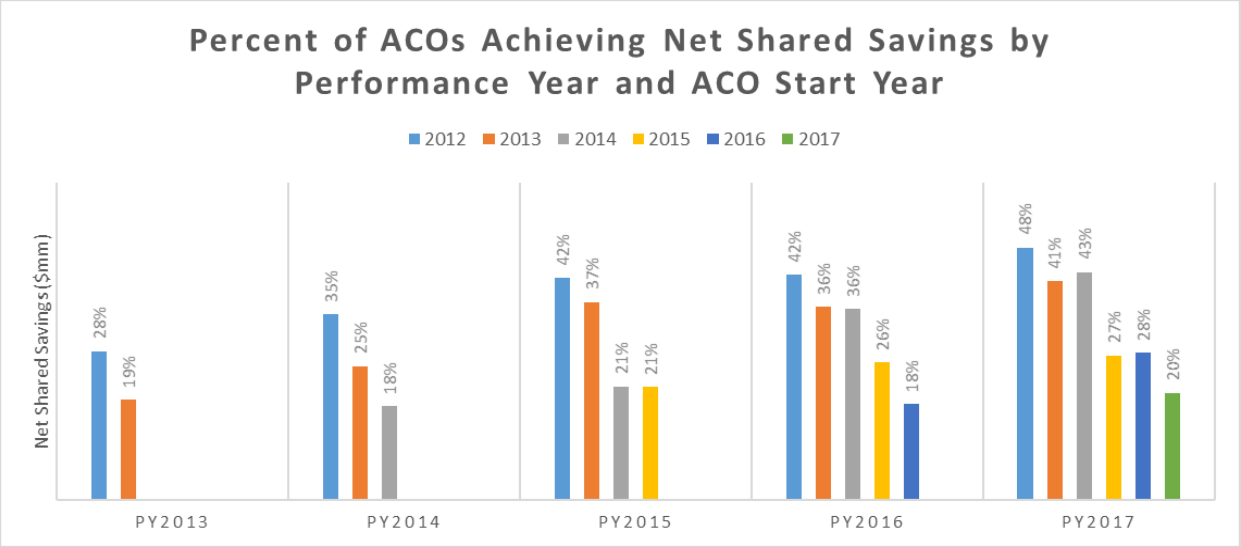
Analysis of Results – CMS Perspective

This program has been net favorable for ACOs, as demonstrated by positive net shared savings every year. But the same can't be said for CMS. CMS sets a benchmark for each ACO every year starting with a weighted average of the three years that precede the start of the ACO's contract period. This benchmark is then updated each year to reflect the expected growth in costs, changing acuity of the population, and shifts in the composition of ACO membership. If the ACO's actual expenditures are lower than this benchmark, the ACO is potentially eligible for net shared savings, and CMS benefits as well with lower than projected costs.

If the opposite is true, and costs exceed the benchmark, then the ACO may be responsible for paying back a portion of losses, if they participate in any track besides 1. Historically and currently, most ACOs participate in track 1, where costs above the benchmark are absorbed by CMS with no penalty to the ACO. This results in a loss for CMS.

For 2013 through 2016, ACOs have produced an aggregate net loss for CMS of $384m. These losses have ranged from a low of $39m in 2016 to a high of $216m in 2015. However, in 2017 those results have reversed, with CMS realizing a gain of $314m. This gain is driven by increasingly favorable results from the longest participating ACOs, along with less unfavorable results for newer ACOs. Chart 4 illustrates this trend.

Chart 2: Percent of ACOs Achieving Net Shared Savings by Performance Year and Start Year



When segmenting these results by those ACOs that take on downside risk and those that don't, it becomes apparent that the potential for losses attracts organizations that manage care more aggressively.

Downside risk bearing ACOs have produced a gain to CMS every year: $8m in 2013, $10m each in 2014 and 2015, $33m in 2016, and $23m in 2017, for an aggregate gain of $84m. These year over year favorable results from the CMS perspective, combined with general

improvement in ACO performance year over year, from all perspectives, has led CMS to propose some significant changes to the program that will likely be implemented in 2019.

Pathways to Success

Early in August of 2018 CMS proposed an overhaul to the MSSP ACO program that would implement their objectives of:

- Moving ACOs from upside potential only to downside risk in a shorter and more thoughtfully planned timeframe;
- Encouraging longevity in the program with 5 year contract periods;
- Providing more flexibility for ACOs in terms of assignment methodology, availability of waivers, and ability to provide incentives directly to beneficiaries;
- Varying the amount of downside risk based on the Fee For Service revenues for ACO participants;
- Improving the benchmark calculations at initiation and renewal, and;
- Revising the currently convoluted risk adjustment to a more straightforward methodology.

These changes in aggregate appear to be favorable to the program. They increase the likelihood of producing gains to CMS through a more aggressive pathway to downside risk, longer contract periods, and less opportunity for ACOs to game the system with untimely exits and re-entries into the program.

At the same time, CMS is increasing the flexibility and attractiveness to ACOs who believe they can be successful under the program parameters that have been proposed. Not every ACO will have the risk tolerance to start or continue participation in this program. Favorability to the ACOs will vary based on the provider composition of the ACO, risk tolerance, and ability to more aggressively manage beneficiaries under Medicare Fee for Service.

Chart 3: Received Net Shared Savings Per Capita by Performance Year and Start Year

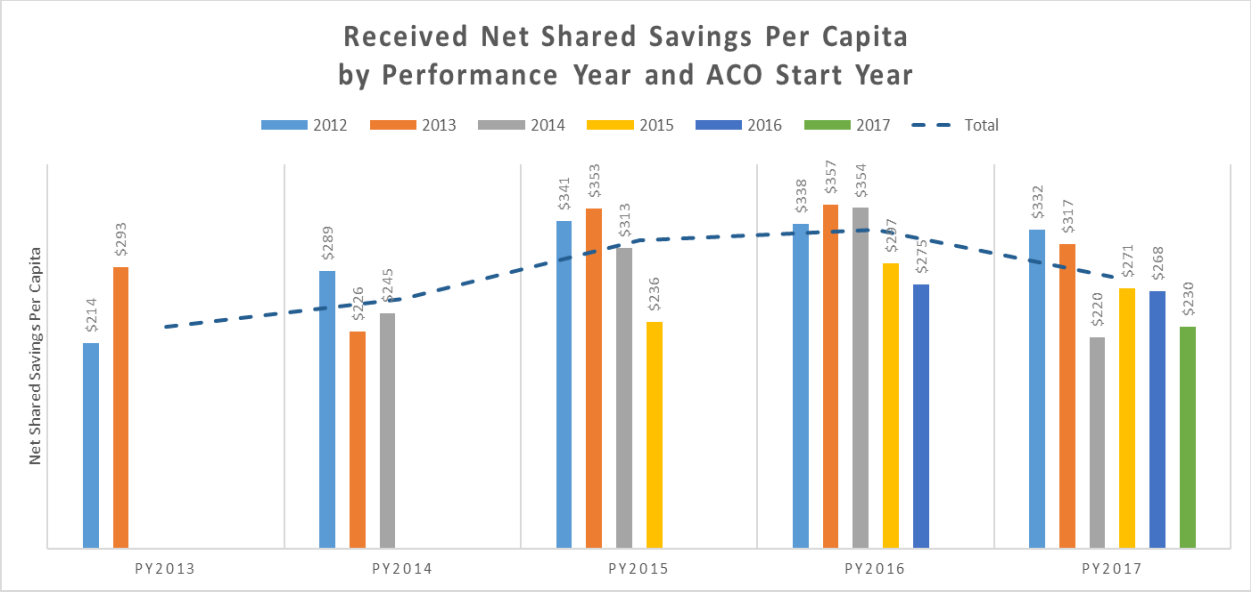
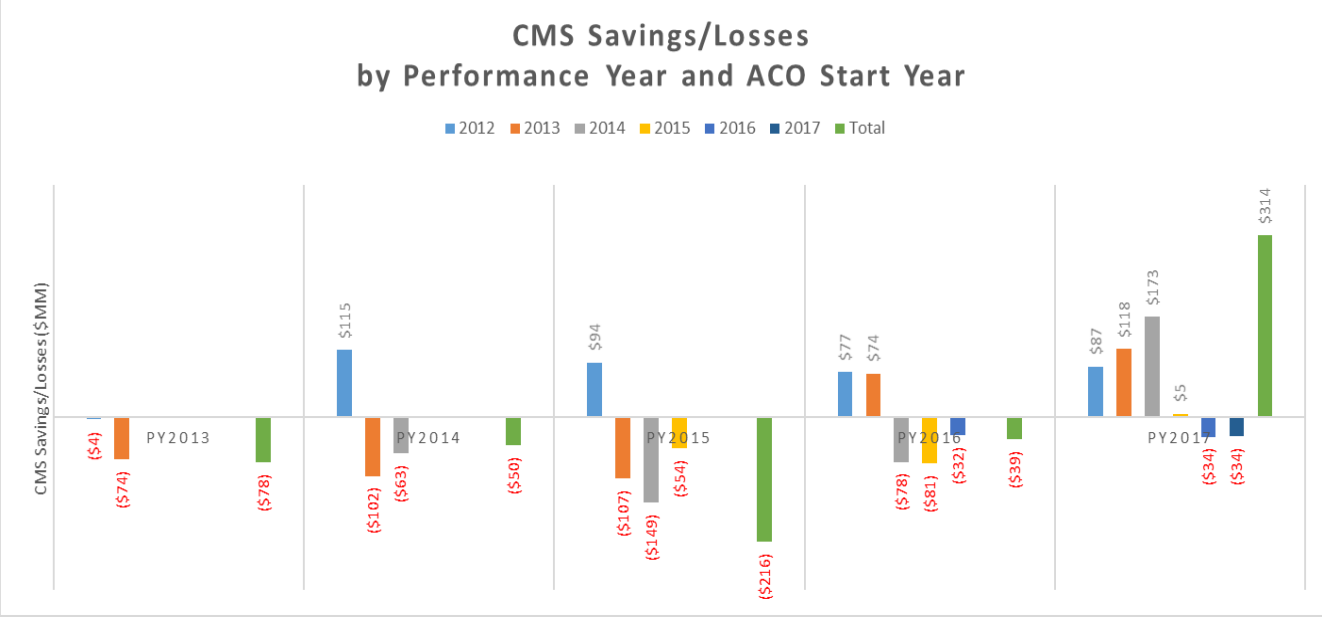


Chart 4: CMS Savings/Losses by Performance Year and Start Year



Conclusion

The Medicare Shared Savings Program has undergone many changes since its inception in 2012. During that time, an increasing number of participating ACOs have seen positive financial results. Most recently, CMS has started to see positive results from the program as a whole and continuing positive results from downside risk bearing ACOs. The recently proposed changes to the program build on the themes of longevity in participation and encouragement of ACOs to invest in the program through taking on downside risk.

Please contact one of the authors directly, or the provider risk group at provider.risk@wakely.com with any questions, or to follow up on any of the concepts presented here.