Medicare Shared Savings Program Primer

The Medicare Shared Savings Program (MSSP) was established by the Affordable Care Act (ACA) and is considered a key pillar of delivery-system reform under the Center for Medicare and Medicaid Innovation (CMMI). MSSP is the main authority in the ACA for the creation of accountable care organizations (ACOs) in Medicare. Currently, 404 ACOs participate in the MSSP and provide care for 7.3 million Medicare beneficiaries in 49 states, including Washington, DC and Puerto Rico.

Assuming Shared Savings and Risk: MSSP Tracks 1 & 2

- The vast majority of MSSP ACOs (99%) participate in Track 1 (one-sided risk, shared savings only), but a few have elected to participate in Track 2, where they assume both shared savings and losses.
- Track 1 MSSP ACOs must meet or exceed a Minimum Savings Rate (MSR) and meet the minimum quality performance standards in order to be eligible to share in savings at a rate of 50% of the total achieved.
- According to the 2016 MSSP final rule, track 2 MSSP ACOs able to meet or exceed the Minimum Savings Rates (MSR) will be eligible to share in savings at a rate of up to 60%, based on their quality performance. This change offers a more attractive option for providers by acknowledging both up and downside risks, while providing a mechanism to see the savings they generate.
- The FY 2016 MSSP final rule allows ACOs to extend their Track 1 participation for an additional 3 years without penalty; previously Track 1 participants would be required to assume shared losses after 3 years of participation.

Ongoing Evolution of the MSSP: The Introduction of Track 3

- The MSSP rule creates a new Track 3. It integrates aspects of the Pioneer ACO model into a newly defined two-sided risk option.
- Track 3 provides participating ACOs access to higher rates of shared savings (75%), prospective beneficiary assignment, and the option to use new care coordination technologies.
- These provisions are expected to make a two-sided risk option attractive to potential participants compared to the existing methodology under Track 2.

Focused on Continuing to Improve MSSP Impact on Quality and Care Coordination

- In 2016, MSSP will require ACOs to describe how enabling technologies will be used to increase care coordination. These include, but are not limited to, electronic health records, population health management technologies, and telehealth services.
- The MSSP final rule improves data-sharing capabilities between the Centers for Medicare & Medicaid Services (CMS) and participating ACOs in order to facilitate care coordination and the assessment of quality measures.
- New benchmark setting strategies to align incentives will be proposed by CMS later in 2015 through a separate rule.

Key Takeaway

In performance-year one of the program, MSSP ACOs achieved $383 million in total Medicare Trust Fund savings. In addition, MSSP ACOs had better-than-average quality on 17 of 22 group practice reporting option (GPRO) measures compared to Medicare fee-for-services (FFS) providers. However, fewer than a quarter achieved shared savings, which suggested difficulty in meeting the efficiency goals of the program.

- The mixed results have raised concerns from stakeholders that the model doesn’t adequately and appropriately provide participants with financial reward for meeting the benchmarks.
Key Takeaway on Benchmark

CMS will follow the same benchmarking methodology for ACOs that are new to the program. Under the MSSP final rule, CMS will rebase the benchmark for ACOs entering a second agreement period by equally weighting all three benchmark years (instead of emphasizing year 3). The benchmark will also be based on trends in national health care spending.

What is the Impact: MSSP Estimated Savings

- Based on the estimated $540 million median net savings targeted for CYs 2016-2018, CMS expects the proposed rule to save an additional $240 million.
- The provisions in the rule are expected to translate into $278 million in shared savings for the MSSP participating ACOs.

MSSP: One Lever to Expand Alternative Payment Models (APMs)

- Increased likelihood to gain exposure and experience in APMs, such as ACOs.
- Ongoing collaboration between CMS and private payers, providers, and other health care organizations reflects the commitment to refining these pilots to best meet improved quality, greater care coordination and cost savings goals.
- Clear prioritization of care coordination will impact physician practice and require greater collaboration across different health care professionals.

Comparison of One and Two-Sided Risk Models by Track

<table>
<thead>
<tr>
<th>PARAMETER</th>
<th>TRACK 1: ONE-SIDED RISK MODEL</th>
<th>TRACK 2: TWO-SIDED RISK MODEL</th>
<th>TRACK 3: TWO-SIDED RISK MODEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>TWO-SIDED RISK EXPOSURE</td>
<td>Allowed to continue in one-sided risk for 2 agreement periods (or a total of 6 years)</td>
<td>Two-sided risk model; no flexibility to transition to Track 1</td>
<td>Two-sided risk model; no flexibility to transition to Track 1</td>
</tr>
<tr>
<td>BENEFICIARY ASSIGNMENT</td>
<td>Preliminary prospective assignment for quarterly reports</td>
<td>Preliminary prospective assignment for quarterly reports</td>
<td>Prospective assignment for reports, quality reporting, and financial reconciliation</td>
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<td></td>
<td>Retrospective assignment for financial reconciliation</td>
<td>Retrospective assignment for financial reconciliation</td>
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<tr>
<td>MAXIMUM SHARED SAVINGS &amp; LOSS POTENTIAL</td>
<td>50% max shared savings potential; no shared losses</td>
<td>40-60% max shared savings potential; 40-60% max shared losses based on quality score</td>
<td>40-75% max shared savings potential; 40-75% max shared losses based on quality score</td>
</tr>
<tr>
<td>LOSS SHARING LIMIT</td>
<td>Not applicable</td>
<td>Limit on shared losses phased in:</td>
<td>15%</td>
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<td></td>
<td></td>
<td>• PY1: 5%</td>
<td>• Losses in excess of the annual limit would not be shared</td>
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<tr>
<td></td>
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<td>• PY2: 75%</td>
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<td></td>
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<td>• PY3+ : 10%</td>
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<td>Losses in excess of the annual limit would not be shared</td>
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SGR

The Sustainable Growth Rate (SGR) repeal passed earlier this year provides additional incentives for clinics to transition to APMs, including increased fee updates and access to bonus payments.

HHS

Defined goals by Health & Human Services (HHS) to expand APMs to account for 30% and 50% of Medicare payments by 2016 and 2018 respectfully.

CMMI

CMMI announced in May that the Pioneer ACO model had met the criteria necessary to expand to a larger population of Medicare beneficiaries. The Pioneer ACOs have saved more than $384 million dollars in its first two years or $300 per Medicare beneficiary.

Implications for Providers

- Increased likelihood to gain exposure and experience in APMs, such as ACOs.
- Ongoing collaboration between CMS and private payers, providers, and other health care organizations reflects the commitment to refining these pilots to best meet improved quality, greater care coordination and cost savings goals.
- Clear prioritization of care coordination will impact physician practice and require greater collaboration across different health care professionals.