Winning At Risk: A Medicare Shared Savings Playbook
Idea in Brief

Accountable care organizations (ACOs) present a significant opportunity to reduce health care expenditures and ensure quality care. However, successfully managing the transition to accountable care is one of the most difficult challenges facing health organizations today. Their key is to focus on the risk contract and approach population health management in a staged, incremental way. Based on our work with clients who have seen success and shared in savings through the Medicare Shared Savings Program (MSSP), we offer a step-by-step “playbook” for this popular program.

- Make sense of the claims data CMS sends you
- Get a handle on referrals and grow your network
- Monitor quality to ensure shared savings
- Optimize budget and revenue with flawless documentation
- Tackle the low-hanging fruit of cost and utilization
- Take an incremental approach to chronic care management
A Fundamental Shift in Thinking

In January 2015 Department of Health and Human Services (HHS) Secretary Sylvia Burwell threw down the gauntlet. By 2018, Burwell announced, half of all Medicare payments will be tied to value through alternative payment models, the first time in the history of the Medicare program that HHS had set explicit goals for such value-based payments. What “value” means remains open to interpretation, as specifics around the Medicare Incentive Payment System get resolved. But emerging payment mechanisms such as Accountable Care Organizations (ACOs) and bundled payment arrangements are proliferating, and will continue to do so. And the Centers for Medicare and Medicaid Services (CMS) is leading the way in the fundamental shift in how we pay for health care – from volume to value. To put this in perspective: Today, only 20% of Medicare payments are made through alternative payment models, up from almost none in 2011.1

Just two days after Burwell’s announcement, an important coalition of commercial payers, providers, and industry partners, called the Health Care Transformation Task Force, followed suit with a commitment to shift 75% of its business to value-based models by 2020. Members of the group include Partners Health care, the powerful Boston health system that oversees Brigham and Women’s and Massachusetts General hospitals; Ascension, the nation’s largest Catholic and nonprofit health system; Aetna, a national for-profit insurer; and Health Care Service Corporation, which operates five state Blue Cross plans.2 Dr. Richard J. Gilfillan, CEO of Trinity Health and former director of the Center for Medicare & Medicaid Innovation who serves as the coalition’s chairman, said at the time that the group was “committed to rapid, measurable change.”

After years of speculation and false starts, the move from volume to value now has well-defined players, targets and deadlines.

Payment reform has the potential to transform health care for generations to come by improving clinical outcomes, ensuring access to care, and reducing unnecessary costs traditionally associated with fee for service. But shifting the financial incentives of a $3 trillion industry is a herculean task – especially for providers. While payers essentially turn the mandated 15% medical loss ratio into a 15% interest bearing annuity, provider organizations face uncertain survival as they accept the emerging status quo.

At athenahealth, we count more than a dozen successful Pioneer and Medicare Shared Savings Program (MSSP) ACOs among our clients. We’ve learned a lot about what works – and what doesn’t – and counsel our new clients based on that experience.

In this paper, we present our practical guide to winning as an MSSP, drawing on our experience helping clients meet quality targets, maximize revenue and reduce costs in order to realize profit in the program. These principles also can be used to manage contracts under other accountable care programs.

ACOs: Are We There Yet?

The ACO has been one of the most rapidly adopted models for health care organizations participating in value-based care. According to data from Leavitt Partners in a March 2015 Health Affairs article:

- 744 ACOs now exist in all 50 states and cover 23.5 million lives,
- 132 health insurance payers now have at least one accountable care contract, and
- An expected 72 million lives will be under ACO contracts by 2020.3

CMS Models Supporting the Transition to Value-Based Care

- **Bundled payments** expanding the episode of care
- **Shared Savings and ACOs** creating total accountability for cost and outcomes
- **Pay-for-performance programs** linking payments to care
- **Medical homes** sharpening the focus on high-risk patients

Source: Leavitt Partners Center for Accountable Care Intelligence
Leavitt Partners identified six distinct types of ACOs clustered into three groups, depending on whether they are led by hospitals, large integrated delivery systems, or physicians. The way each of these groups attacks risk depends on its market share, the costs and medical inflation in its region, and profit margins across the continuum of care it manages.

The challenges and opportunities are different for each type of ACO. Theoretically, physician-led ACOs have the most to gain. Ideally, doctor-led organizations without hospitals can reduce inpatient utilization and profit handily if they succeed. The challenge often is mindset: Many physician-only organizations are small and think they lack resources to tackle risk. By contrast, large health systems generally have a broader ability to tackle risk, especially if they have the reserves to profit from managed care reductions in inpatient and specialty utilization. Single-hospital ACOs face the most difficulties. With lower reserves than large health systems, and frequently dependent on inpatient revenue for survival, hospital ACOs walk a fine line between reduction of inpatient volume and shared savings. Unless these ACOs can capture market share from competitors, hospital ACOs must figure out how to deal with lower occupancy levels to stay afloat.

Medicare Shared Savings Program

The most popular ACO contract today is the Medicare Shared Savings Program (MSSP). As of April 2015 there were 404 ACOs participating in the MSSP, serving more than seven million beneficiaries. MSSP provides an incentive for physicians to manage the total cost and quality of care for a defined population. Medicare establishes a target cost for beneficiaries who receive the plurality of their primary care from the provider group in question. If the cost of care comes in below target, the health system can keep a share of the savings achieved. Savings are then adjusted based on the provider’s performance on 33 quality, process, and patient satisfaction metrics.

One of the key attributes of the MSSP program is the ability to choose either an upside-risk-only contract (sharing in savings, with no risk for losses) or an upside/downside-risk contract (sharing in savings while being at risk for losses). ACOs opting for both upside and downside risk receive a larger share of any shared savings. Since 2012, only four ACOs – less than one percent – elected to take downside risk and two of those shared in losses.

Medicare Shared Savings Program (MSSP) At A Glance

- A voluntary program open to health systems and physician groups
- Most popular ACO contract in the U.S. with over 404 participating organizations
- Offers two tracks: upside-only with smaller share of savings, or two-sided risk with more favorable sharing rate
- Patients are assigned retrospectively based on primary care billings
- ACOs eligible to share in portion of savings resulting from reduced utilization
- Bonuses are contingent upon meeting quality targets

Mixed But Promising Results

Despite explosive growth and considerable promise, success has proved elusive for the vast majority of ACOs. In the first program year, only a quarter received a bonus, while 11 failed the most basic test of reporting quality scores. Recent results for 2014 show little improvement – less than one-third of ACOs received a payment.

At athenahealth, a number of our ACO clients have outperformed the national average and realized significant savings. In 2013, the second year of the Pioneer ACO program, just two of our clients accounted for more than $36 million in savings – close to 40% of all savings that year. Based on our work with these and other successful clients, we’ve distilled a step-by-step “playbook” for winning at MSSP.
A Medicare Shared Savings Playbook

The MSSP offers ample opportunity for groups to profit while increasing the quality of care. And approved changes in June 2015 to the MSSP could make the program even more attractive to providers: CMS now allows ACOs to remain in the upside-only track for extended second agreement period; a new performance-based version (Track 3) with prospective attribution and more risk was added; it enabled access to more patient data with fewer administrative hurdles; and updated the minimum savings rate in the upside/downside contracts (Track 2) to match the upside-only ones (Track 1).

To succeed with MSSP, we recommend the following:

Make sense of the claims data CMS sends you

Once enrolled in MSSP, CMS sends participants the entire claims history of their established beneficiaries. This is not a perfect representation of your current population. Some patients may be seeing other providers, and invariably new patients will enter your population. Nevertheless, this claims data tells the story of where patients are going, how much care costs, and how good that care is.

Nearly every population health management vendor touts the ability to manage this data as a business intelligence process. Ask your vendor about their experience in this area. How many clients are live? How long does it take? Can data be pushed into the workflow? Can they harmonize data from CMS and commercial ACO programs? Difficulties with this process are significant cause for concern. Don’t pay a dime until you see your data live. Once published, your team should analyze the data for patterns of utilization and cost. Move patients from high-cost providers to low-cost providers of equal quality so everybody wins (except the high-cost, low quality provider).

Get a handle on referrals and grow your network

Invariably, CMS data will reveal patterns of patients receiving care outside the ACO. While tackling network leakage is tricky, it’s obviously best to pay yourself, rather than a competitor, for care you can provide. Your ACO likely cannot provide everything to your beneficiaries, and mandating that patients receive care at a particular provider raises both moral and legal issues. It’s essential, however, for patients to be able to access in-network providers easily. Direct referrals internally whenever possible. This results in better-coordinated care and a higher patient retention rate. There is also a side benefit in streamlining the data-collection process for reporting to CMS.

Under Medicare, patients don’t need referrals for specialist treatment. This makes managing referral patterns more difficult, especially when concerned family and caregivers have their own strong opinions of where the patient should seek care. But simple procedural changes can help: Network-wide scheduling tools allow credentialed providers or their staff to directly schedule all outpatient and most inpatient appointments and tests while the patient is still in the care setting—or after they leave through mobile-ready scheduling solutions. Keep physicians in the loop: By making sure your doctors know all their in-network options and reminding them that other in-network providers share their quality and experience goals, they can better coordinate care and streamline the patient experience.

In situations where you must refer patients to out-of-network services, referring to higher-quality, lower-cost providers is essential. Physician-led ACOs may benefit from reducing inpatient utilization and partnering with a hospital that can give them attractive financial terms. Organizations should consider investing (or partnering) with skilled nursing facilities, nursing homes, homecare, and hospice care—and working with their providers to encourage end-of-life discussions with all patients.

Bringing in patients for routine exams and screenings can help expand your patient panel, lower your actuarial risk and increase the total revenue available to you. In our experience, the Medicare Annual Wellness Visit (MAWV) provides a terrific opportunity to bring patients into your network. The MAWV appointment is free for the patient, and basic patient engagement and outreach tools should be sufficient for recruiting large numbers to come in for their check up. Unfortunately, on available
data, fewer than 12 percent of patients actually come in for their visits; this is a huge missed opportunity to attribute more lives to your contract.

Sometimes, increasing the patient panel doesn’t require recruitment of new patients, but merely ensuring existing patients are properly attributed. CMS provides ACOs with regular reports on their assigned population and financial performance, both at the start of the agreement period and routinely during the course of the performance year. Compare these reports, particularly the Assignment Summary Reports on assigned beneficiaries, against historical lists of attributed lives, and also against lists of patients seen by providers in the past six months who did not make it onto the official CMS roll.

Finally, are there patients in your system who recently aged into Medicare or switched from a commercial plan? Your population health management IT system should be able to identify these patients and launch campaigns and outreach to ensure they are brought in for care—and thus added to the CMS attribution. By accurately tracking what you’re already doing and making sure that it’s included in CMS’s data, you may come closer to reaching the shared savings goals before making the more difficult changes.

Monitor quality to ensure shared savings

MSSP success requires that your organization meet and report on 33 measures across four domains: 1) patient/caregiver experience, 2) care coordination and patient safety, 3) preventive health, and 4) care for at-risk populations. To do that, you must monitor your entire population directly, identify care plans to address those gaps, and then take action to close gaps in care. The first step is to find out where the quality gaps exist—for instance, you might be failing to lower admission rates for conditions that can be managed outside an inpatient setting, either at an ambulatory care center or through remote services such as telemedicine. COPD is a prime example; programs can be put in place to keep the condition under control and managing exacerbations remotely whenever possible.

Once you have identified gaps in care you should put in place a plan to fill them. In our experience, one common area where utilization can be safely reduced is post-acute care—in this case, ensuring you can create seamless transitions should be your focus. How can patients be handed off after an acute episode to ensure they aren’t readmitted? Effective care coordination—and the satisfying patient experience it engenders—requires the removal of all barriers to effective patient care and follow up. Achieving seamless transitions is a strategic challenge for many health systems and hospitals. “All our strategic discussions at the moment are around care relationships and IT and how we’re going to connect people, connect physicians and use data,” a CEO of an Alabama-based health system recently said. That sentiment is shared by many executives interviewed by athenahealth.

Optimize budget and revenue with flawless documentation

In order to optimize revenue (shared savings) from the MSSP contract, you’ll need to ensure that your population’s risk-adjustment factor is appropriately calculated. To do this, providers’ documentation during clinical visits must be flawless and exhaustive. You must have processes to capture each patient’s full complexity during provider encounters so that your organization’s risk-adjustment factor can be appropriately high. If it’s too low, you’re less likely to achieve shared savings, even if your quality scores are high. Proper documentation during patient encounters also ensures that you will have an accurate actuarial understanding when the time comes to deploy care management resources.

Unfortunately, providers often document their patients’ primary concerns without capturing a full list of their conditions. A well-designed EHR system can correct this by automatically prompting physicians to either enter or leave blank common conditions that might otherwise be overlooked. It also can alert physicians to historical coding for each patient that fell off the diagnosis in the most recent encounter—in case the condition was overlooked rather than addressed. How much room for improvement exists in most organizations’ coding hygiene? We recently worked with a large provider organization that reported an annual influenza rate of just four percent—a preposterously small figure. When we instituted best practices for correct coding, the number jumped almost overnight by an enormous margin—not because of a flu outbreak but because they were able to document a more accurate representation of the disease burden in the population.
Tackle the low-hanging fruit of cost and utilization

Care management programs are expensive and difficult to implement. They are also essential to any meaningful population health strategy—and one guided by the MSSP is no exception. By targeting patients with meaningful opportunities for cost reduction first, you’ll get the quickest payback when you scale up care management programs.

Medicare beneficiaries with more than one chronic condition account for 68% of the Medicare population but 93% of costs, and the sickest patients—those with six or more chronic conditions—represent 14% of Medicare beneficiaries but nearly half of all Medicare costs. The cost reductions from chronic care management programs frequently take years to accrue. Properly segmenting your patients will allow you to focus your resources most effectively. For example, diabetics should not be viewed as a single group, but broken into segments based on whether their disease is under control, or whether they are at risk of becoming heavy utilizers of health services or already require a lot of expensive care. Conversely, substantial costly programs aimed at patients in the pre-terminal stages of chronic illness are rarely successful at reducing costs. Many of these patients would be better served by appropriate referral to hospice care.

Next Steps on the Journey to Risk

At athenahealth, we understand how accountable care changes the way you manage patients’ health—and practice medicine. Static analytics and disparate population health tools aren’t enough to achieve savings efficiently in this complex landscape.

**athenaCommunicator® Enterprise** is an end-to-end service that delivers advantages others can’t, including guaranteed results.

As an MSSP ACO, you can confidently navigate the accountable care environment with our population health services, designed to respond to change and deliver results with:

- **Actionable data.** We create a single, actionable source of information for you by aggregating data from our cloud-based network, your inpatient records, payer claims, and other EHRs, harnessing the power of our open platform, which processes more than 1.2 billion transactions a year.

- **Continually updated cloud-based software.** Quality measures are embedded directly into the workflow, at no additional cost.

- **Visibility into gaps in care.** Our service stratifies your population and identifies opportunities for intervention. With our rules engines, we align patient data to the specific quality metrics you’re accountable for.

- **Communication with patients.** We then determine the most effective way to engage different types of patients, and reach out via text, email, or phone, significantly reducing your staff’s administrative burden. Patients can then schedule an appointment via our patient portal.

- **Single workflow for coordinating care.** Data is transformed into a single, consolidated workflow for care managers, giving them a comprehensive dashboard view of your patients, and actionable population health information.

- **Tools for tracking and optimizing.** You get customized analytics to track and manage costs, utilization and outcomes, and to compare providers and facilities against benchmarks. Improving population health outcomes, lowering costs

With complete visibility into your operations, you can eliminate redundant procedures and any unnecessary interventions. Your utilization is optimized and your organization is more efficient.

You’ll have the insight to manage quality at lower costs—and a partner taking on the demanding work associated with effective population health management.
Our MSSP Guarantee

In our continued commitment to providers, athenahealth offers the industry’s only ACO Guarantee: If your organization participates in the ACO Medicare Shared Savings Program (MSSP), we guarantee you’ll receive MSSP shared savings—and we’re staking our own revenue on it. If you use our athenaCommunicator® Enterprise services, we will take on 100% of the risk with you. Your fee is directly aligned with the level of success we help you attain.

Here’s how it works: You don’t pay for athenaCommunicator Enterprise if you don’t receive any MSSP shared savings. If you do, your fee is 10% of any MSSP shared savings you receive.

Achieving high quality scores in the MSSP demands firm, efficient population health management. The athenahealth approach goes far beyond conventional analytics tools, and begins with the patient.

Learn more about our cloud-based population health service at 866.817.5738 or athenahealth.com.
Endnotes


9. Ibid.

10. Ibid.

Notes
A leading provider of cloud-based services for medical groups and health systems. Our mission is to be the most trusted service to health care providers, helping them do well by doing the right thing.