

# Medicare shared savings program performance

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# Overview

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- Background on the Medicare shared savings program (MSSP) and prior results
- Our analysis and estimates of savings
- Policy implications for assignment of beneficiaries
- Discussion

# The Medicare shared savings program

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- MSSP established in the Patient Protection and Affordable Care Act of 2010
- First cohort of accountable care organizations (ACOs) mid-2012
- Has grown rapidly—432 ACOs with 7.9 million assigned beneficiaries in 2016
- Almost all ACOs through 2016 in one-sided risk models with retrospective assignment of beneficiaries
- Bonus for an ACO's “shared savings” calculated as “benchmark” minus actual spending

# Did the MSSP save money for the Medicare program or not?

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- Examine changes in spending for beneficiaries who were alive and eligible for assignment from 2012 through 2016
- Define savings as difference between growth in spending for beneficiaries assigned to ACOs compared to what would have been spent on those beneficiaries in the absence of the MSSP—counterfactual analysis
- Calculate difference in spending growth between “treatment” group and “comparison” group
- Past performance is not indicator of future performance

# Review of January findings

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- Beneficiaries switch in and out of ACOs; more precisely, CMS assigns them or removes them from assignment to ACOs
- Beneficiaries who switched tended to have higher growth in spending from 2012-2016 than those who did not
- Change in health status could make beneficiaries switch
  - use different physicians, thus switch assignment
  - increase spending, which is the outcome of interest
- Interaction between assignment change and spending complicates estimates of savings

# Beneficiary assignment is dynamic

ACO entry year	Beneficiaries originally assigned	Remained continually assigned		
		Year 2	Year 3	Year 4
2013	715,241	83%	72%	59%
2014	760,388	82%	66%	
2015	909,940	79%		

Source: MedPAC analysis of ACO assignment for beneficiaries who—from 2012-2016—were alive, in fee-for-service, had an annual E&M visit, and resided in the same county. Analysis only includes beneficiaries assigned to ACOs in MSSP through 2016.

# Beneficiaries with no change in ACO assignment had lower spending growth than market average

<b>Beneficiary assignment</b>	<b>Percentage point difference in spending growth relative to the market average 2012- 2016</b>	<b>Number of beneficiaries in category</b>
Assigned to the same ACO in 2013, 14, 15, 16	-10.0	408,292
Never assigned to an ACO (2013-2016)	-1.3	3,838,089

# Beneficiaries who switch have higher spending growth than the market average

Beneficiary assignment	Percentage point difference in spending growth relative to the market average 2012-2016	Number of beneficiaries in category
Switched ACO during 2013, 2014, 2015	1.2	1,777,369
Same ACO 2013-2015, left in 2016	13.8	149,427
First ACO assignment in 2016, to an ACO that was <b>newly</b> formed in 2016	2.1	183,615
First ACO assignment in 2016, to an <b>existing</b> ACO (started prior to 2016)	16.0	281,300

# Switching can coincide with change in health care use

2015-2016 ACO assignment	Use in 2016 but not 2015				New use of one or more
	Hospital use	Home health use	Specialist assignment	Plurality of E&M visits in SNF	
Continual assignment	11%	7%	2%	1%	16%
<b>Switchers:</b>					
Joined existing ACO in 2016	13%	8%	4%	3%	22%
Left existing ACO in 2016	14%	9%	9%	6%	28%

# Three definitions of treatment and comparison groups

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Treatment group

Comparison group

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Ever in an ACO

Never in an ACO

Assigned to ACO in 2013

Not assigned to ACO in 2013

Assigned to ACO in 2016

Not assigned to ACO in 2016

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# Which group switchers are in affects estimates of savings

Model	Switchers and potential bias	Findings over 2012 to 2016 period
Ever/Never in an ACO 2013 to 2016	All ACO switchers in treatment group	Finds ACO spending growth over 2% higher
Assigned/Not assigned to an ACO in 2013	Switchers in both treatment and comparison groups	Finds ACO spending growth about 1% to 2% lower
Assigned/Not assigned to an ACO in 2016	Comparison group includes beneficiaries assigned to high-cost-growth physicians/ACOs that dropped out of MSSP; “survivor” bias	Finds ACO spending growth about 4% lower

Source: MedPAC analysis of ACO assignment for beneficiaries who—from 2012-2016—were alive, in fee-for-service, had an annual E&M visit, and resided in the same county.

# Estimate of MSSP performance directionally the same regardless of statistical method

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- Three methods:
  - Descriptive statistic
  - Propensity weighting
  - Propensity weighted regression
- Directionally the same, magnitude differs
- For example, for assigned to ACO/not assigned in 2013 model estimates of savings range from 1.3% to 2.0%
- National average: Actual savings will vary by market and by ACO

# Modest savings and assignment switching pose future risk for MSSP

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- MSSP savings have been small
- Assignment switching may result in a favorable or unfavorable selection of patients for an ACO
- The distribution of patients to a specific ACO could result in unwarranted shared savings or losses
- Retrospective assignment may exacerbate MSSP vulnerability to favorable and unfavorable patient selection

# Annual wellness visits (AWVs)

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- Wellness visits could be used for patient assessment and care planning
- ACOs also use AWVs to help ensure that beneficiaries remain assigned to the ACO
  - Could target patients with relatively little health care spending for wellness visits, creating favorable selection
  - No beneficiary copay
  - ACOs can pay beneficiaries to come in for a wellness visit
- Do ACO beneficiaries have more AWVs?

Results preliminary; subject to change

# ACO beneficiaries had more wellness visits

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- ACO beneficiaries more likely to have wellness visit in 2016
  - 33 percent of ACO beneficiaries
  - 18 percent of all other assignable beneficiaries
- ACOs more likely to schedule the AWV in the last quarter of 2016
  - 32 percent of ACO AWVs
  - 25 percent of non-ACO AWVs

# Wellness visits could be used for patient selection

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- Wellness visits in the last quarter of 2015 associated with:
  - 19 percent lower HCC-adjusted spending during 2015
  - higher spending growth from 2015 to 2016 (due to low starting spending in 2015)
  - 8 below average HCC-adjusted spending in 2016 despite higher spending growth
  - Therefore: AWWs had a strong association with past health
- Selection potential is greater with retrospective assignment—easier to predict current year spending than next year's spending

# Conclusion

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- The MSSP generated some modest savings (~1 to 2 percent) by 2016 (before shared savings)
- Any opportunities for ACOs to increase their shared savings payments through favorable selection (e.g., wellness visits) could put net program savings at risk
- Assignment switching could also put ACOs at risk of unfavorable selection and unwarranted shared losses
- Prospective assignment may help mitigate risks of both favorable and unfavorable selection while still encouraging patient assessment and care planning

# Discussion

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- Defining treatment and comparison groups
- Estimates of savings
- Policy option of prospective assignment
- Other issues