Advising the Congress on Medicare issues

Medicare shared savings program performance

David Glass, Luis Serna, Jeff Stensland

April 4, 2019

MEDPAC

Overview

- 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

- 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?

- 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

- 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.

MEDPAC

Results preliminary; subject to change

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

Beneficiary assignment	Percentage point difference in spending growth relative to the market average 2012- 2016	Number of beneficiaries in category
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

MEDPAC

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

Results preliminary; subject to change

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 **newly** formed in 2016	2.1	183,615
First ACO assignment in 2016, to an **existing** ACO (started prior to 2016)	16.0	281,300

MEDPAC

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

Results preliminary; subject to change

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%
Switchers:					
Joined existing ACO in 2016	13%	8%	4%	3%	22%
Left existing ACO in 2016	14%	9%	9%	6%	28%

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.

Results preliminary; subject to change

Three definitions of treatment and comparison groups

Treatment group	Comparison group
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

Source: MedPAC analysis of ACO assignment from 2012-2016.

Results preliminary; subject to change

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

- 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

- 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)

- 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

- 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

Results preliminary; subject to change

Wellness visits could be used for patient selection

- 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: AWVs 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

- 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

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