Healthcare reform is moving full steam ahead, buoyed by early results that include an increase in the number of people insured, a flattening in the rate of growth of healthcare expenditures and Medicare per capita costs, and an increase in the number of participants in Medicare and commercial value-based programs. The growth in the number of Medicare Shared Savings Programs (MSSPs) and Medicare accountable care organizations (ACOs) has continued to increase in 2015. More than 400 MSSPs now provide services to more than 7 million Medicare beneficiaries. The early results show that a minority of MSSPs (24%, starting in 2012 and 2013, 26% in 2014) (Centers for Medicare & Medicaid Services [CMS], 2015b) have produced shared savings, while the majority of MSSPs have yet to achieve shared savings (CMS, 2014).

Other initiatives that have catalyzed the movement to value-based reimbursement and increased the interest in MSSPs include the following:

• Congress has replaced the Sustainable Growth Rate legislation with the Medicare Access and CHIP Reauthorization Act of 2015 by an overwhelming bipartisan vote.
• U.S. Department of Health and Human Services Secretary Burwell has increased both the speed of implementation and the number of available Medicare value-based payment models (CMS, 2015a).
• Commercial payers have set targets similar to the CMS targets to convert provider payment arrangements to value-based payment arrangements.

BUILDING A SUCCESSFUL MEDICARE SHARED SAVINGS PROGRAM
Premier’s population health management team has helped more than 60 organizations apply for and implement MSSP and Pioneer ACO programs. In 2014, 47% of the Premier Population Health Management Collaborative members participating in the MSSP or Pioneer program attained shared savings (versus 26% across the country). I have worked closely with many MSSP organizations and analyzed the key attributes that have led to success, as well as the challenges experienced by ACOs that have not generated shared savings. As a result, Premier developed “The Ten Keys to Building a Successful Medicare ACO (MSSP).” These 10 attributes were found to be common
among the successful MSSPs that have met the 33 metrics CMS has identified in each of the four domains and experienced shared savings (Federal Register, 2014).

1. **Identify and engage beneficiaries:** The first step is to identify the attributed beneficiaries by gathering addresses from multiple sources, such as hospital and physician billing systems, because CMS does not provide beneficiary addresses. The new rules do not require information to be mailed to beneficiaries regarding sharing of claims data, but doing so will be helpful in providing them with educational materials. ACOs should know the preferred communication method for each patient and have the relevant contact information. Maintaining a database of beneficiaries attributed to the ACO or likely to be attributed to the ACO can ease care management and help ensure that annual wellness visits and preventive care services are offered. I also recommend including in the database the affiliated physicians—both primary care and specialty care—for each patient. Although this involves additional analytic work, it can be beneficial in promoting better coordination of services and improved communication for ACO providers and patients. Also critical to engaging Medicare patients is the development of a beneficiary communication plan, including a call center and staff training on key topics, such as the beneficiary release form to allow the ACO to receive Medicare claims data.

2. **Implement a claims analytics tool:** CMS will provide the MSSPs with Parts A, B, and D Medicare claims data for all beneficiaries who have been preliminarily aligned with the ACO or who have received primary care services from an ACO participant during the previous year. The claims analytics tool enables the MSSP staff to analyze and segment the population to identify high-risk and chronically ill patients, as well as to identify outmigration (i.e., services by providers who are not ACO participants) according to the primary care physician and the patient’s clinical condition. Doing so will be critical to building the care management and care coordination programs and retaining care in the system.

3. **Establish a communication plan:** The communication plan should be directed toward both providers and beneficiaries and include multiple avenues (electronic, telephonic, and written) to educate recipients and provide an avenue for questions and concerns to be addressed in a timely manner. MSSPs also should develop and publicize compliance hotlines.

4. **Identify the highest risk population:** In most populations, 5% of the population is responsible for almost 50% of the total costs (Kaiser Family Foundation, 2012). MSSPs can identify this highest-risk group by using the claims analytics tool, reviewing hospital admissions and emergency department visits, and seeking physician input. In most communities, no one has coordinated care to this group because of the lack of alignment and focus; therefore, the potential exists for significant improvements in care coordination and quality, as well as significant cost savings.
5. **Establish a mechanism to capture key metrics**: CMS requires MSSPs to report 33 metrics in four domains, including patient experience (7 measures), care coordination and patient safety (6 measures), preventive health (8 measures), and care for the at-risk population (12 measures). In the first year of the program, MSSPs must report these metrics, which requires use of a patient experience (satisfaction) tool and a Physician Quality Reporting System/Group Practice Reporting Option reporting tool. In the second year, the MSSP must meet targets for 25 of the 33 metrics to receive 100% of the shared savings.

6. **Implement a network management program**: Implementing a plan to manage the delivery network could assist the MSSP in increasing in-network care. MSSP beneficiaries have the option to go to any Medicare provider for care. Managing the network by using claims data to review referral patterns can provide valuable insights that can lead to candid discussions with providers and actions to retain additional care in the network (thereby offsetting revenue loss resulting from lower inpatient hospital admission use rates for the chronically ill).

7. **Implement robust, team-based patient-centered medical homes (PCMHs)**: Numerous studies have demonstrated that when robust team-based PCMHs are deployed that include professional midlevel providers such as nurse practitioners, licensed social workers, nurse care managers, and physician assistants, and the role of the primary care physician expands to include supervision of midlevel professionals and direction of care to fewer but sicker patients, costs can be reduced. A white paper by UnitedHealth Center for Health Reform & Modernization (2014) identified an average per capita reduction of 6.2% in four states in which PCMHs were implemented. A common mistake in the PCMH is to seek certification without first changing the care processes into a robust team-based model.

8. **Build a care management model**: Developing a care management model for the high-risk population and the chronically ill population is critical to coordinating care and managing costs. Many organizations have developed “hybrid care” management programs (a combination of clinical care management and use of lay care coordinators) that are integrated with primary care practices and that focus only on the high-risk population and the chronically ill in six key disease areas. These six chronic diseases frequently include asthma, diabetes, congestive heart failure, chronic obstructive pulmonary disease, hypertension, and chronic depression. The ratio of care managers to the patient population depends on the specific care management model and the mix of patients (such as Medicare and commercial).

9. **Develop a shared savings distribution model**: Another critical factor is the development of a shared savings distribution model that aligns the goals and desired behaviors of participants in the MSSP delivery system. Many MSSPs heavily weight the shared savings distribution toward primary care physicians because they must lead the care redesign process and care management and coordination
efforts. Most MSSPs attempt to keep the incentives aligned with CMS’s 33 metrics and to achieve the Triple Aim goals of improving health, enhancing quality and satisfaction, and bending the cost curve. MSSPs need to identify the key metrics that support these goals and keep the number of metrics manageable.

10. **Develop an approach to non-acute care management:** Non-acute care, including post-acute care, is an area of major cost that has not been well managed in the fee-for-service environment in most communities, primarily because of the lack of focus and aligned economic incentives. For example, the goal of the hospital discharge planner has been to transfer the patient to a post-acute care setting without evaluating the quality metrics and economics of the alternatives. Many successful MSSPs start by using claims data to evaluate and benchmark their non-acute care costs, but they also develop a tool to assess the performance of non-acute care providers and develop criteria to select preferred non-acute care partners.

Many organizations attempt to implement too many objectives at once. For example, a prestigious academic institution that was not attaining shared savings noted it had 70 goals in the first year of the program. Staff members felt overwhelmed by the large number of goals, and they were not able to attain shared savings.

**MEETING THE CHALLENGE**

The development and implementation of an MSSP can be a complex and challenging process that requires new approaches and staging of priorities. Because this is a relatively new area, no road maps to success are available. The foregoing 10 keys can help MSSPs on the road to shared savings.

**ACKNOWLEDGMENT**

The author would like to recognize the following colleagues for their input, editing, and assistance in preparing this article for publication: Seth Edwards, director of Premier’s Population Health Collaborative; Mary Margaret Huizinga, MD, chief clinical office of Premier’s Population Health Collaborative; and Meredith Damore, vice president of Clinovations, Washington, D.C.

**REFERENCES**


For more information about the concepts in this column, contact Mr. Damore at Joe_Damore@PremierInc.com.