

ANALYSIS: IS YOUR HEALTH SYSTEM READY FOR TWO-SIDED RISK?

Navigant study indicates many health systems are losing money on MSSP despite earning shared savings

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Through [Obama-era insurance reforms](#), hospitals and health systems were promised increased volume-for-unit rate discounts. This promise of patient and volume growth resulted in the pivot to risk, with many providers implementing a “must-have” population health playbook — investing hundreds of millions of dollars on [physician enterprises](#), [IT \(including electronic health records\)](#), and other population health infrastructure.

Many health systems thoughtfully built accountable care organizations (ACOs) and physician networks, and moved a portion of their managed care contracting intentionally toward risk. For many, entering the Medicare Shared Savings Program (MSSP) Track 1 represented a “toe in the water” step to embrace the new economic and clinical realities of population health. However, new data now indicates many ACOs are still not generating savings and, considering their investments in IT and capabilities such as care management, losing money as an organization. These leaders now face the prospect of whether or not to embrace two-sided risk starting in January of 2019.

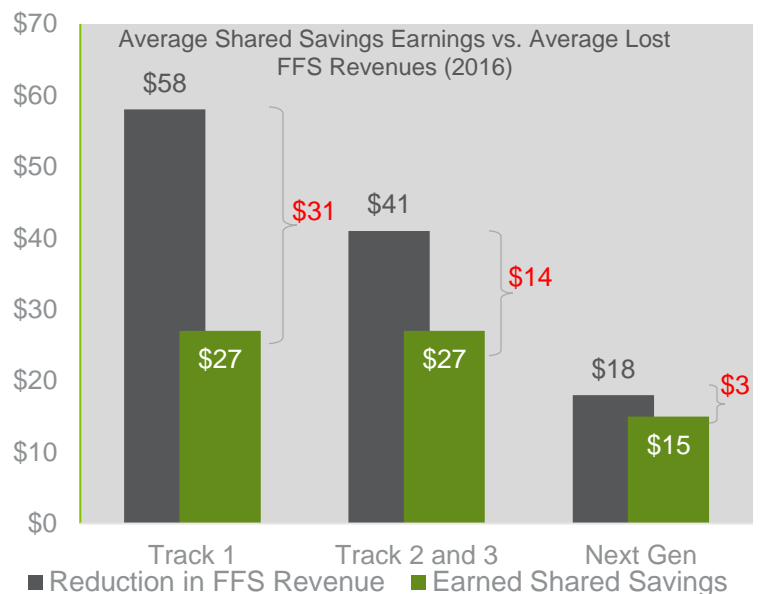
EVEN HIGH PERFORMERS LOSING FINANCIALLY DUE TO UNSUSTAINABLE SHARED SAVINGS MODEL

The failure to generate positive margin impact based on sizable bets in population health programs is illustrated by recent MSSP outcomes.

According to a Navigant analysis of 2016 MSSP results (Figure 1), Track 1 ACOs that earned shared savings still incurred a \$31 per member per month (PMPM) loss on average, equating to \$5.2 million in losses for an average organization.

Track 1 ACOs earning shared savings still incurred an average **\$31 PMPM loss = \$5.2 million in losses** per organization

Figure 1: MSSP PMPM losses among ACOs earning shared savings



*Note: Financial results a weighted average (by beneficiary) of PMPM reductions in expenditures and shared savings earned among MSSP ACOs in each category that earned shared savings payments in 2016

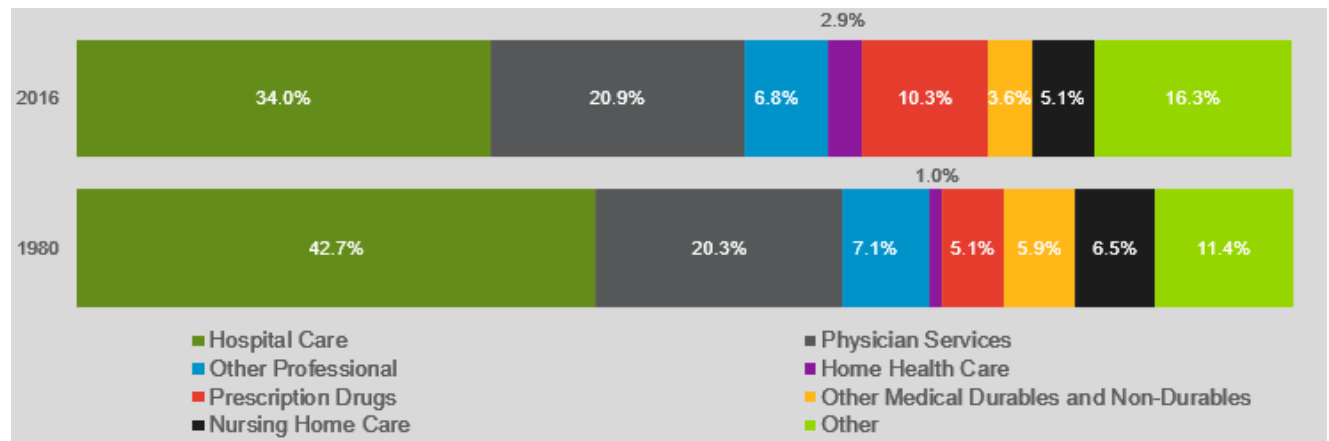
Of those Track 1 ACOs earning shared savings, the average \$27 PMPM savings payment was vastly offset by a \$58 PMPM reduction in Medicare fee-for-service (FFS) revenue.

While Track 2 and 3 ACOs earning shared savings fared better financially, they still lost an average of \$14 PMPM or \$2.9M per organization. Next Gen ACOs earning shared savings lost \$3 PMPM or \$1.2M per organization.

Hundreds of ACOs joined MSSP to test value-based programs and develop the capabilities needed to manage the health of populations. These ACOs have largely selected MSSP Track 1 to avoid downside risk. Yet, there remains an implicit negative financial impact built into the shared savings economic model that may not be obvious to many participating organizations.

A contributor to MSSP’s unsustainable model is a core parameter of Track 1, which dictates that Medicare retains half of every dollar of savings that an ACO generates. This means Track 1 ACOs must significantly reduce fee-for-service (FFS) payments, often impacting their organizations, to be eligible for shared savings. Health system-based Track 1 ACOs earning shared savings are particularly susceptible financially due to changes in avoidable utilization paid under a FFS model. But changes in avoidable care occur in both inpatient and ambulatory settings, with hospital care accounting for just over one-third of national spending on health services and supplies (Figure 2).

Figure 2: National Expenditures for Health Services and Supplies by Category, 1980 and 2016



Source: American Hospital Association, “Trendwatch Chartbook 2018 (page 5, chart 1.5),” July 2018, <https://www.aha.org/system/files/2018-07/2018-aha-chartbook.pdf>

As health systems employ more physicians and own more community-based sites of service, such as ambulatory surgery centers and clinics, decreased FFS revenue has a direct impact on a system’s top and bottom lines.

While these ACO losses may be acceptable as a bridge to the future, how does a health system pivot and use its experience in MSSP Track 1 to develop/hardwire the care delivery improvements and supporting infrastructure that will pay dividends in the next year?

GET READY TO PIVOT: VALUE-BASED CARE ‘BUSINESS AS USUAL’ IS NOT A SUSTAINABLE GROWTH STRATEGY

For providers, a business-as-usual approach — including staying in MSSP Track 1 — is not an option for growth, nor is “doubling down” on costly population health investments. Instead, organizations need to carefully re-evaluate the interaction of the following key issues:

- Is the employer/insurer market I serve ready to move to value-based payment models in the near term, and have they already worked on models that marginalize my services?
- What clinical and operational capabilities are required to be successful in my market?
- How does my organization use its current population health investments and capabilities to drive value in the near and long terms?

RE-EVALUATE YOUR RISK STRATEGY AS A PLATFORM FOR GROWTH

Once it’s understood how these dynamics will impact current and future states, organizations should consider the following strategic options:

1. Risk is not available or sustainable for every market or health system. Consider moving away from investment in risk-based reimbursement models until:
 - Federal ground rules for MSSP or local market conditions become more favorable
 - Your ACO’s care management capabilities become more capable of improved performance
 - You see clear indications that your local commercial market is moving forward in this space
2. Recalibrate risk — Right-size strategy, investments, and contracting approach with market realities while operating in both FFS and value-based environments. Provider executives should consider the following “no regrets strategies” to drive revenue and margin growth in any scenario:
 - Emphasize in-network customer keepage
 - Consider Medicare Advantage and other payer partnerships
 - Engage physicians to drive internal clinical standardization efforts through such programs as a [Hospital Quality and Efficiency Program \(HQEP\)](#)
 - Focus care coordination on populations driving negative margins (Medicaid, regular Medicare, etc.)
 - Reduce total cost of care in targeted areas

Organizations should determine the enterprise-wide impact of their value-based contracts – including MSSP – and use that input to inform the strategic options discussed above. Strategic and operational issues that impact market strategies are complex and should be informed by best practices from other market leaders that have successfully navigated this journey.

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