The Ephemeral Accountable Care Organization—An Unintended Consequence of the Medicare Shared Savings Program

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A fundamental element of health care payment reform under the Affordable Care Act is the development of Accountable Care Organizations (ACOs). The ACO model employs shared-risk contracts to better align the interests of health care providers and payers with the intent of driving efficiency and quality in care. The Medicare Shared Savings Program is the most popular of the Medicare ACO programs, with over 200 health systems across the nation participating at this time. However, a pitfall in the way that the Medicare Shared Savings Program is structured, specifically the benchmarking and rebasing method, could make it difficult for even top-performing ACOs to achieve sustained success, thereby threatening the long-term viability of the program. In this paper, we present this pitfall to the radiology community as well as potential solutions that can be considered by CMS moving forward.

Key Words: Accountable Care Organization, Medicare, shared-risk, rebasing, benchmarking

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INTRODUCTION

The Medicare Shared Savings Program (MSSP) is a cornerstone of the Affordable Care Act and pushes forward the Accountable Care Organization (ACO) model [1]. By realigning economic incentives among providers, ACOs are intended to enhance quality while simultaneously lowering the overall costs of health care. Under the MSSP, an ACO will receive a percentage of their health care savings, ie, a direct bonus from the federal government, if performance and cost criteria are met. These bonuses are intended to encourage medical professionals and health care systems to adopt the ACO model.

Over 200 health systems in the United States are participating in the 3-year renewable MSSP contract, and many others are considering whether or not to join. Breslau, Abramson, and the ACR have written informative papers about the ACO model and its potential impact on radiology, emphasizing the importance of radiologist participation in institutional dialogue about adopting and succeeding in risk-sharing contracts, such as the MSSP [2-4]. In this piece, we highlight a potential pitfall of the proposed method of calculating shared savings under the MSSP, specifically the benchmarking and rebasing method, which could hinder even top-performing ACOs' ability to achieve sustained success and threaten the long-term viability of the ACO model.

THE BENCHMARKING AND REBASING PROBLEM

Under MSSP, savings are calculated by comparing actual expenditures to a benchmark value determined by CMS for each ACO [5]. This benchmark is based upon fiscal precedent, derived from a weighted average of health care costs of the specific patients assigned to that ACO in the 3 years preceding the agreement period, with annual adjustments for beneficiary characteristics and anticipated growth in Medicare fee-for-service expenditures. For an ACO to qualify for the bonus, the ACO's average per capita Medicare expenditures must fall below this benchmark by a given percentage, known as the statutory Minimum Savings Rate, which varies from 2.0% to 3.9%, depending on an organization's size. If the average expenditures exceed the benchmark, the ACO must pay a portion of the excess costs back to Medicare—essentially representing a financial penalty. Although ACOs can elect to avoid this downside risk during their initial MSSP agreement period, all ACOs wishing to continue to participate in the MSSP beyond

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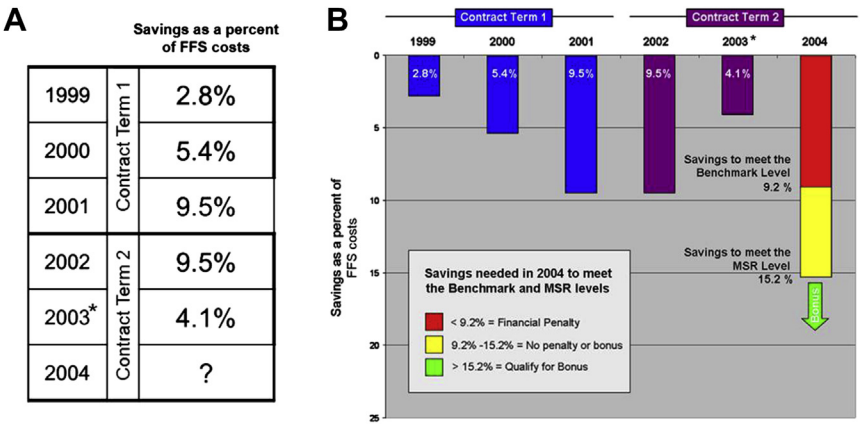

Fig. 1. Illustration of the rebasing problem using actual data from the Kentucky Partnership Program—a prepaid Medicaid managed care program.
(A) Savings data from the Kentucky Partnership Program—a prepaid Medicaid managed care program—are used to illustrate a potential pitfall in the financial incentive structure of the Accountable Care Organization model [5]. Savings data are presented as a percentage of the estimated fee-for-service (FFS) expenditures for patients participating in the traditional FFS system. In this hypothetical example, the first 3-year MSSP contract term is defined as 1999-2001 and the second MSSP contract term as 2002-2004. (B) Savings data from the first term are used to calculate the second term benchmark level using the rebasing methodology described in MSSP. Data from 2002 and 2003 are then used to calculate the percent savings below FFS that would be required in 2004 to meet the benchmark level or the Minimum Savings Rate (MSR) level (defined here as 2% below the benchmark level) for the second contractual term. As the graph demonstrates, qualifying for the federal bonus in the second term is unlikely considering the program's historic savings. (*Represents calendar year, rather than fiscal year.)

the initial term will be forced to participate in a 2-sided contract model that incorporates both risk and reward.

The benchmark is rebased, or recalculated, at the start of each new 3-year contract term, using the method described above. Accordingly, when an ACO signs up for a second 3-year contract term, the new benchmark for that term will be calculated based on the patient health care costs from the preceding 3 years. Because the preceding 3 years represent the prior MSSP contract, the ACO's savings during the first contract term could tighten the new benchmark. Thus, succeeding in the second term essentially means not only sustaining the health care savings of the prior 3 years, but also achieving an additional 2% to 3.9% on top of that. The current rebasing method is clearly intended to encourage ACOs to achieve continual cost improvements across multiple contract terms. However, by placing an ACO in a race against itself, the MSSP rebasing method makes shared savings increasingly difficult to generate. The extent to which any health care institution can safely and effectively generate incremental health care savings term after term is finite.

Because the benchmark of the first contract period is based on a system's historic costs, health care systems that have been committed to optimizing the efficiency of care and reducing unnecessary costs for years, such as the Mayo Clinic, will have fewer savings opportunities left in the system. Thus, such institutions could potentially face difficulty in achieving sufficient incremental savings even in the first contract period. Notably, the Mayo Clinic, touted as a model around which the ACO system was developed, has decided not to participate in MSSP.

In Figure 1, we illustrate the rebasing problem using a hypothetical ACO whose annual reported cost savings are identical to those of a prepaid Medicaid managed care program in Kentucky from 1999 to 2003 [6]. Our example demonstrates that the managed care program would have difficulty qualifying for a federal bonus in a second contract term because, in part, of its success in the first contract term. Moreover, since ACOs participating in a second MSSP term must bear the risk of financial losses, this hypothetical ACO could actually be made to pay a financial penalty despite having sustained cost savings.

What Are the Implications for Institutions Participating in the MSSP?

The rebasing pitfall described herein will only apply to ACOs that achieve savings in their contracts. Yet, the ease of achieving shared savings under MSSP is uncertain. Data from Haywood and Kosel, based on the Medicare Physician Group Practice Demonstration, indicate that the transition to an ACO may require significant infrastructural investments—averaging $1.7 million—with only about one half of the participating organizations receiving *any* shared savings over the initial 3 years to offset those costs [7]. Because participating institutions in the Demonstration Project were principally selected for their *a priori* high level of integration and experience, it is particularly concerning that these institutions did not fare well in the contract (recognizing