Affordable Care Act payment reform achieves early gains: study

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Accountable care organizations that joined the Medicare Shared Savings Program (MSSP) when it launched in 2012 achieved modest savings while maintaining or improving performance on measures of quality of patient care in 2013, the first full year of the program, researchers at Harvard Medical School found in the first rigorous examination of this key health care payment reform program. These early adopters lowered spending by 1.4 percent in 2013 relative to a control group of non-ACO providers in the same areas, which represents a $238 million reduction in spending.

These savings provide more evidence of early promising results from accountable care organization initiatives in Medicare, of which the MSSP is the largest. But the results also tell a more complex story about the pattern of savings across different types and cohorts of ACOs. The findings are published today in the *New England Journal of Medicine*.

ACOs are groups of health care providers who agree to provide care to a population of patients under a global budget known as a benchmark. ACOs that hold spending below the benchmark and perform well on measures of quality of care share in the savings. In contrast with other ACO programs such as the Pioneer model, MSSP participants are not required to reimburse Medicare if spending exceeds the benchmark. The first two cohorts of provider groups (220 in total) entered the MSSP in mid-2012 or at the beginning of 2013. Since then, the program has expanded and currently includes over 430 participants.

While the ACOs that joined in 2012 cut spending by $238 million, the next cohort of ACOs that joined in 2013 achieved no savings in their first full year in the program, suggesting that the early success of the first participants may not be replicated by the subsequent waves of ACOs that have joined the MSSP. In addition, because Medicare paid out $244 million in shared-savings bonuses to ACOs in the first two cohorts, the lower spending in the 2012 cohort did not constitute net savings to Medicare.

"These results suggest that ACOs with no downside risk can achieve savings, but that savings to Medicare and society may be slow to develop," said J. Michael McWilliams, the Warren Alpert Associate Professor of Health Care Policy at HMS and lead author of the study. "But the incentives for ACOs to lower spending are currently very weak, so savings may accelerate if the incentives are strengthened."

In particular, the current method for setting an ACO's benchmark diminishes its incentives to save. Specifically, if an ACO lowers spending now, it is penalized with a lower benchmark later. According to the authors, severing the link between an ACO's benchmark and its previous savings could go a long way toward rewarding ACOs adequately for curbing wasteful practices and allowing the returns necessary for ACOs to invest in more efficient systems of care.

The investigators also found that independent primary care groups participating in the MSSP achieved significantly greater savings than hospital-integrated groups.

"Some have presumed that forming a large hospital system that owns a lot of outpatient practices is a prerequisite for ACO success," McWilliams said. "We do not find this to be the case."

One reason for this finding, the authors note, is that independent

physician groups have stronger incentives to prevent hospitalizations than hospital-owned groups, since their shared-savings bonuses from doing so are not offset by foregone organizational profits from the reduction in hospital care.

Finally, the authors found that ACOs in the MSSP with high spending for their region achieved greater savings than ACOs with spending below the regional average. This suggests that ACOs with more opportunities to cut spending had an easier time doing so. Recently, the Centers for Medicare and Medicaid Services proposed transitioning to a system in which an ACO's benchmark would be primarily based on average spending in its region. Because the participation of high-spending ACOs in the voluntary MSSP is particularly valuable for lowering overall spending in Medicare, the authors caution against moving to such regional benchmarks too quickly. Doing so could prompt ACOs with high spending for their region to leave the program, thereby diminishing program-wide savings.

"These early results are encouraging overall," said McWilliams, who is also a practicing general internist and HMS associate professor of medicine at Brigham and Women's Hospital. "But building on the initial success of ACO models in Medicare will require stronger incentives and rigorous evaluations to identify groups of systematically successful ACOs whose organizational models and strategies can be disseminated."

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