

Revisiting the Role of Academic Medical Centers in Medicare Shared Savings Program ACOs



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Since the introduction of accountable care organizations (ACOs), many have questioned the viability of academic medical center (AMC) participation in the Medicare Shared Savings Program (MSSP). According to a 2011 perspective piece in the *New England Journal of Medicine*, “ACOs at academic medical centers will be challenging,” and “several leaders...doubt that ACOs can readily be established at academic medical centers.”¹ Albeit the minority, several notable AMCs have formed or participated in MSSP ACOs since that time. Although not all academic ACOs have yet met with success, the University of Michigan (“Michigan”), Hackensack University Medical Center (“Hackensack”), and Thomas Jefferson University Hospitals (“Jefferson”) earned significant shared savings in the most recent MSSP performance year. As Michigan, Hackensack, and Jefferson exemplify, AMCs should not be afraid of participating in the MSSP and should consider partnering with community hospitals and independent primary care physicians through an ACO.

Challenges for AMCs

The Affordable Care Act created the MSSP “to facilitate coordination and cooperation among providers to improve the quality of care for Medicare fee-for-service (FFS) beneficiaries and reduce unnecessary costs.”² Under the MSSP, CMS assigns a Medicare FFS beneficiary to an ACO if the beneficiary receives a plurality of primary care services from primary care physicians participating in the ACO. Under the 1-sided model—which presents no downside risk—ACOs that meet the MSSP’s quality,

savings, and eligibility requirements will earn a payment of up to half of the savings it achieves for Medicare for its assigned beneficiaries. An ACO must meet or exceed a minimum savings rate to earn a shared savings payment.³

Recognizing the critical role of AMCs in the MSSP, CMS excluded Indirect Medical Education and Disproportionate Share Hospital payments from ACO cost determinations to prevent “incentives for ACOs to avoid appropriate referrals to teaching hospitals in an effort to demonstrate savings.” As CMS explained, “Removing the disincentive for ACOs to refer patients to teaching hospitals will help ensure beneficiaries continue to be referred to the most appropriate place of service for their care.”⁴

Nevertheless, AMCs must overcome a variety of additional obstacles to achieve success in the MSSP: autonomous academic departments that lack true clinical integration, tenure systems based on publication and scholarly reputation more so than quality of care, and incentives that align more closely with research than delivery of clinical services.⁵ Such challenges only magnify the inherent difficulty that all providers face in any value-based reimbursement arrangement: “aligning the incentives of the entire organization when going from a volume-based model to a model that has more to do with the longer-term provision of healthcare to members of a population.”⁶

Despite these difficulties, a number of AMCs have established or participated in MSSP ACOs, including Hackensack (2013), Johns Hopkins (2013), University of Virginia (“Virginia”) (2013), Indiana University Health (“Indiana”) (2013), University of Cal-

ifornia, Los Angeles (“UCLA”) (2013), University of Michigan (2014), Jefferson (2014), and Cleveland Clinic (2015). Each of these academic ACOs elected to participate in the 1-sided MSSP model.

Structure of AMC-Affiliated ACOs (academic ACOs)

Academic ACOs vary dramatically in design, governance, and participation: some consist predominantly of employed and academic physicians, while others include an AMC among a much broader network of independent and community providers.

On one side of the spectrum, UCLA,⁷ Virginia,⁸ and Indiana⁹ participate in ACOs composed primarily of employed physicians or affiliated academic physicians. Similarly, Cleveland Clinic¹⁰ and Johns Hopkins¹¹ participate in ACOs that consist mostly of employed physicians, but also include several independent practices. In contrast, the Physician Organization of Michigan ACO (“POMACO”), Delaware Valley ACO (“DVACO”), and Hackensack Alliance ACO participate in ACOs with significant independent and community provider participation.¹² POMACO includes the Michigan faculty group practice among numerous independent primary care practices across the state.¹² Jefferson’s participation in DVACO provides an example of an AMC that collaborates not only with an expansive network of independent community physicians, but with a number of community hospitals outside of its parent health system.¹³

Results of Academic ACOs in Performance Year 2014

CMS announced ACO results for performance year 2014 on August 25, 2015. According to CMS, 92 MSSP ACOs generated savings for Medicare and earned performance payments. In addition, 89 ACOs generated savings for Medicare, but did not meet the minimum savings rate, disqualifying them from a shared savings payment. CMS noted that ACOs in their first year of MSSP generally had less success than ACOs with more experience.¹⁴ Overall, the academic ACOs we examined had mixed results. On the successful side, Michigan/POMACO generated approximately \$27 million in savings for Medicare and earned a shared savings payment of more than \$12 million. Hackensack University Medical Center’s ACO (Hackensack Alliance) generated nearly \$6.5 million in savings, and earned a shared savings payment of approximately \$2.8 million. Finally, DVACO and Jefferson were successful, generating more than \$13 million in savings and earning a shared savings payment exceeding \$6.5 million in its first year of MSSP.

Several academic ACOs generated savings for Medicare, but did not qualify for a shared savings payment because they did not achieve sufficient savings for Medicare. Notably, the Johns Hopkins ACO saved more than \$5 million for Medicare, but its savings as a percentage of benchmark did not quite meet the

minimum savings rate. Virginia’s ACO had a similar outcome, generating roughly \$1.7 million for Medicare, which did not meet the minimum savings rate.

Finally, several academic ACOs missed their MSSP benchmark significantly. For example, UCLA Faculty Practice Group missed its benchmark by approximately \$14 million and Indiana University Health ACO missed its benchmark by nearly \$3 million. Cleveland Clinic’s ACO entered the MSSP in 2015, and its first year results will not be released until next year.

Conclusions

One cannot draw broad conclusions based on a small sample of ACOs during a single year, so time will tell whether the MSSP ACOs present a financially viable strategy for the bulk of AMCs. However, of the limited ACOs examined, those AMCs that partnered with community providers appeared to have the most success during the 2014 performance year. Further study is warranted to evaluate whether and to what extent ACOs that include both AMCs and community providers tend to outperform those ACOs that include only AMCs and affiliated physicians. One explanation for such a result could be better coordination of services for Medicare FFS beneficiaries across the continuum of care. At a minimum, the early achievement of DVACO/Jefferson, POMACO/Michigan, and Hackensack Alliance demonstrate the feasibility of AMCs succeeding in MSSP through collaboration with community providers.

Author Affiliation: Thomas Jefferson University and Jefferson Health, Philadelphia, PA.

Source of Funding: None.

Author Disclosures: Mr Gerber is vice president of Network & Payment Strategy and associate general counsel at Jefferson Health. Jefferson Health is a 40% owner of Delaware Valley ACO, where Mr Gerber formerly worked.

Authorship Information: Concept and design; acquisition of data; analysis and interpretation of data; drafting of the manuscript; critical revision of the manuscript for important intellectual content.

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