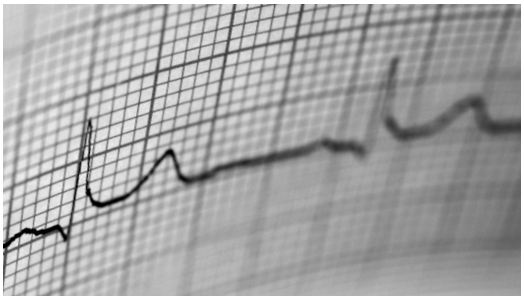
United Hospital Fund

Accountable Care in New York State: Emerging Themes and Issues



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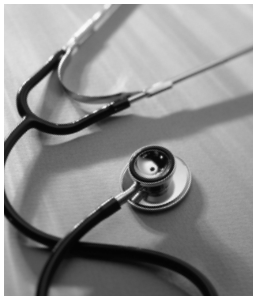

United Hospital Fund

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Accountable Care in New York State: Emerging Themes and Issues

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Contents

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Executive Summary

Provider groups across New York are experimenting with a new approach to organizing and delivering health care services under accountable care arrangements with Medicare and, increasingly, with other payers. This report and a companion piece, *New York's Medicare ACOs: Participants and Performance*, analyze the status and trajectory of Medicare's accountable care programs in New York from quantitative and qualitative perspectives.

This qualitative report is based on interviews with leaders of New York-based Medicare accountable care organizations (ACOs). It reviews their experience to date and identifies some emerging themes and issues for consideration by providers, payers, and policymakers as they consider how to adopt more value-based purchasing methods in New York State.

- Moving from a fee-for-service system to one capable of managing the care of defined populations requires a suite of different interventions: medical homes and improved ambulatory care performance; registries to identify high-risk patients and care management programs to manage their care; managing referrals and care transitions; and network-wide programs of quality and performance improvement.
- Developing a successful ACO requires investing in the infrastructure needed to support health information technology, data analysis, care management, and primary care. Some relevant functions, such as network-wide quality improvement processes and claims data analysis, work better at a larger scale and in more organized systems. Some ACOs are partnering with other organizations to acquire such capacities.
- Providers are using different organizational models to pursue accountable care, including group practices, physician networks, physician-hospital partnerships, and hospital systems. In general, more tightly organized groups that had already invested in the infrastructure required for population health management and quality improvement appear to be better positioned to succeed under accountable care.
- All Medicare ACOs interviewed felt that Medicare's Shared Savings Program—an early exemplar of value-based purchasing—has design elements that hamper their ability to succeed, related to patient attribution and churn, benchmarking and performance targets, and their ability to engage patients in their own care.
- The leaders of the Medicare ACOs we interviewed felt that, given time to develop, accountable care has the potential to improve care and reduce costs. Having made the investments necessary to function as an ACO, a number of the state's Medicare ACOs are actively pursuing accountable care contracts with their commercial payers. Over the next few years, adoption of the accountable care model in New York State seems poised to expand due to a shared sense of its potential.

Overall, the early experience of the Medicare ACOs in New York appears to be positive; the model has shown potential as a way of better organizing, providing, and paying for care. As more providers and payers craft accountable care contracts, and as the number of people covered under value-based contracts increases, providers, payers, and policymakers should take the opportunity to learn from the experience and insights of these early adopter ACOs.

Introduction

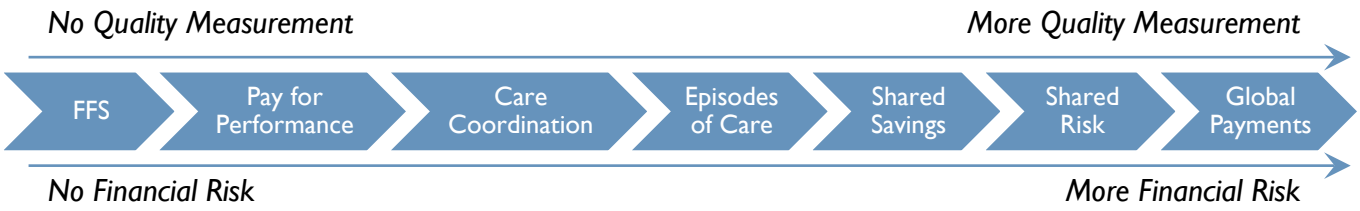
Across New York State, physician groups, hospital systems and physician-hospital partnerships are experimenting with a new approach to organizing, delivering, and being paid for health care services, under accountable care contracts with the Centers for Medicare and Medicaid Services (CMS). Provider groups participating in Medicare's two accountable care organization (ACO) programs—the Pioneer ACO program and the Medicare Shared Savings program (MSSP)—contract with CMS to manage and coordinate care for a defined population of Medicare beneficiaries, and agree to be accountable for the quality and costs of care provided to the members assigned to them. In return, they have the opportunity to share a portion of any savings they generate (stated in terms of their attributed patients' total costs of care), compared with an agreed-upon benchmark.

ACOs are potentially transformational innovations, changing the way health care services are organized and the way they are paid for. They are also the best-known example of shared savings programs, an important approach to value-based purchasing (VBP).

Over the past few years, New York State has embraced VBP as a cornerstone of its approach to health care reform. It is a central theme in the New York State Health Innovation Plan; it is a core strategy in the state's $6.4 billion Medicaid Delivery System Reform Incentive Payment (DSRIP) program; VBP is being adopted in a variety of different forms by private payers; and CMS recently announced its own plan to move aggressively toward VBP in its traditional Medicare fee-for-service program.[1]

Most definitions of VBP postulate a model in which there is a staged evolution in payment methods (see Figure 1) moving from fee-for-service to pay-for-performance, and from there to accountable care payment methods such as shared savings and shared risk.

Figure 1. Evolving Payment Methods for Health Care



Source: New York State Department of Financial Services. July 2014. *New York Health Care Cost and Quality Initiatives.* Available at http://www.dfs.ny.gov/reportpub/payment-reform-report.pdf.

Medicare's shared savings model is considered by many to be an "on-ramp" for more highly evolved forms of VBP, including shared risk and global payments. We focus here on Medicare ACOs because Medicare's model of accountable care is consistently defined, and because it is the longest-standing and most widespread, visible, and transparent. Medicare's ACO model informed New York State's recently proposed ACO regulations; and its shared

[1] HHS. January 26, 2015. "Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value" (press release). Available at http://www.hhs.gov/news/press/2015pres/01/20150126a.html (accessed March 19, 2015).

savings model is often cited, adapted, and used by other payers as the basis for their own accountable care contracts.

Currently, 27 New York-based provider groups are participating in Medicare's ACO programs. Over the past year, the United Hospital Fund has engaged many of those groups in a study of the evolution and progress of this new model. This report explores some of the lessons learned about organizing and delivering services under accountable care; it reviews some of the basic design features of Medicare's ACO programs; and it raises some issues for consideration by the state's providers, payers, and policymakers.

An accompanying report, *New York's Medicare ACOs: Participants and Performance*, presents a quantitative profile of Medicare accountable care organizations in New York. Both reports focus on New York State's Medicare ACOs, in which the defined populations are drawn from New York's fee-for-service (FFS) Medicare beneficiaries and the payer is CMS. Both revisit a 2013 Fund report[2] that documented New York's initial movement toward accountable care, and both examine issues surrounding the adoption and implementation of this VBP model.

As the number of organizations participating in Medicare's ACO programs has increased over the past four years, more providers across New York State are gaining experience with this new model for organizing and paying for care. Medicare's ACO participants have had to make a series of new investments and develop a new set of skills, perspectives, and relationships as they work to reorganize and improve the care they provide to patients across the continuum. They have also had to operate within the rule-set of Medicare's Shared Savings Program, which has posed some additional challenges.

As New York pursues VBP and expands the ACO model beyond Medicare, providers, payers, and policymakers can learn from the experience of the organizations now participating in Medicare's ACO program. What they have learned about managing and improving the care of defined populations should be taken into account in the design and roll-out of these new methods of payment.

Organizational Models

The term Medicare "accountable care organization" is somewhat misleading; it does not actually define a particular organizational type, but refers instead to a variety of differently organized provider groups that have contracted with CMS to accept responsibility for the care, patient experience, and total costs of covered care for a specific, defined population of Medicare FFS beneficiaries.

Accountable care arrangements are often associated with formally organized integrated delivery systems (in which the physicians, hospitals, and potentially other providers operate under a unified governance structure), but in the Medicare ACO program, an ACO does not need to be integrated. In fact, only 4 of the 27 New York provider groups participating in Medicare's ACO programs are organized as integrated delivery systems. One of the key

[2] Burke G. April 2013. *Moving Toward Accountable Care in New York*. New York: United Hospital Fund. Available at http://www.uhfnyc.org/publications/880897 (accessed March 19, 2015).

differences among New York's Medicare ACOs is in their sponsorship. CMS allows four types of provider groups to participate in the Medicare ACO program:[3]

1. ACO professionals in group practice arrangements (also known as multispecialty group practices or MSGPs; in these reports we use the term ***Group Practices***)

2. Networks of individual practices of ACO professionals (also known as independent practice associations or IPAs; we use the term ***Physician Networks***)

3. Partnerships or joint venture arrangements between hospitals and ACO professionals (we here use the term ***Physician-Hospital Partnerships***)

4. Hospitals employing ACO professionals (we here use the term ***Hospital Systems***)

As shown in Figure 2, these four types vary substantially in terms of their formal organization, infrastructure, and management.

Figure 2. Organizational Models for Accountable Care

	Physician-Led	Hospital-Led
More Integrated	**Group Practice** Formally organized physician partnership Unified leadership and aligned physicians Common management, EMRs, and systems Infrastructure for contracting and quality improvement *Number in New York: 5*	**Hospital System** Unified leadership for system Core of system-employed physicians Common EMRs and other services Infrastructure for contracting, data/analytics, and quality improvement *Number in New York: 4*
Less Integrated	**Physician Network** Independently practicing physicians Most formed to contract with payers Variable organization and infrastructure *Number in New York: 10*	**Physician-Hospital Partnership** Hospitals, physicians employed by hospital, and independent (voluntary) physicians Originally formed to contract with payers, now a vehicle for clinical integration Variable organization and infrastructure *Number in New York: 8*

There are two categories of differences between the different setups. Differences in ownership, leadership, governance, and available resources can affect the groups' performance as ACOs. There are also differences in incentives: the economics of the ACO model—in which the main near-term target for savings is by reducing emergency department visits and preventable admissions and readmissions—have different implications for physician-led and hospital-led ACOs. We explore both sets of differences below.

Organizational Capacity

The capacity of the organizations to effect change varies with their degree of formal organization, their ability to undertake network-wide programs of quality improvement, the

[3] Social Security Administration. Compilation of the Social Security Laws: Shared Savings Program. Available at http://www.ssa.gov/OP_Home/ssact/title18/1899.htm (accessed March 19, 2015).

resources available to them, and their ability to put into place some of the key infrastructure required for population health management.

Within the physician-led organizations, group practices—which are composed of physicians and partners employed by the group itself—appear to be more advantageously positioned for accountable care. Group practices generally have a unified leadership, a well-developed infrastructure and common culture, and established mechanisms for peer review of performance.

Physician networks, on the other hand, are generally less formally organized and led. They are often built on the foundation of an IPA. They are composed of independently practicing physicians, generally with less infrastructure to support quality improvement and peer review than group practices have. Within this broad category, however, there is diversity. Some physician networks (e.g., Catholic Medical Partners, the Greater Rochester IPA, and Beacon Health Partners) have developed more robust central services, investing in electronic medical record (EMR) systems, patient-centered medical homes, and clinical and claims data analytics. In so doing they have developed the quality improvement and care management infrastructure that enables them to operate more like a group practice.

Similar distinctions exists within the hospital-affiliated ACOs.

Hospital systems generally have a large number of employed or closely aligned physicians, often using the same EMR system, with unified leadership, substantial resources and established mechanisms for performance and quality management. Physician-hospital partnerships, on the other hand, tend to be less formally organized, and generally involve more voluntary community-based physicians using different EMR systems. The hospital or overarching physician-hospital organization have historically had less oversight and management control over these voluntary partners.

Organizational Models and the Economics of Accountable Care

A key challenge in the Medicare ACO program is for the involved providers to improve their performance and manage the care of their attributed patients in such a way that the Medicare program spends less than a benchmark based on their attributed patients' historical total costs of care. Most ACOs have initially focused on achieving those savings by reducing preventable emergency department visits, hospital admissions, and readmissions, particularly for high-risk patients. Longer-term strategies to lower costs include reducing duplicate or unnecessary testing, and lowering specialty care costs. These goals have different implications for the physician-led and hospital-led models.

For physician-led ACOs, Medicare's shared savings model represents a new revenue source, as the main near-term source of savings is likely to be reduced ED and hospital use, which affects *someone else's* income. For hospital-affiliated ACOs, however, pursuing a goal of reduced hospital admissions is problematic, as hospital admissions generally represent their primary revenue source. Unless they are able to selectively reduce admissions of their attributed patients to competitor hospitals, avoided hospitalizations at their own facilities represent a revenue loss.

Under the Medicare Shared Savings Program, ACOs receive half of the savings they generate as a result of reductions in inpatient care (and revenue) at hospitals. However, hospital-affiliated ACOs have a number of competing uses for those shared savings: they

need to invest in primary care, cover new costs (e.g., data analytics, quality improvement, and care management), and share a portion of whatever remains with their participating physicians.

Payment Arrangements

The MSSP offers participants two payment options: shared savings (Track 1, one-sided risk, upside only) and shared risk (Track 2, involving both upside and downside risk). In New York, all of the organizations participating in the MSSP are in Track 1, the shared savings model.

Under this model, providers continue to be paid via existing payment methods (generally FFS) but have the potential to receive a share of any savings they generate against a target spending amount (after achieving a minimum savings rate [MSR] ranging from 2.0 to 3.9 percent, depending on enrollment) at year-end. This approach allows providers and payers to continue to use existing systems to bill and pay for services as they are provided; CMS then calculates and distributes savings (if any) some time after the end of the performance period.

Most providers serve patients covered by a number of different payers, under a variety of different contractual arrangements; Medicare's ACO contract thus covers only a portion of the participating provider groups' patients. Care for the remainder of their patients is paid for by other payers using other methods—mainly FFS but increasingly involving pay-for-performance arrangements. A number of the Medicare ACO providers reported having contracts with other payers that involve shared savings plans; a few are using capitation payments. Like the Medicare ACO program, however, each of those contracts is payer-specific, applying only to the care of the specific population that is covered by that particular payer in that particular contract.

Medicare ACOs in New York State

From the start of the Medicare ACO program in 2012 through January 2015, CMS selected 27 New York State-based organizations to participate in its Medicare ACO programs. In 2014, those organizations were serving 427,000 Medicare FFS beneficiaries and involved over 19,000 physicians statewide. The organizations participating are listed in Figure 3.

Figure 3. Medicare ACOs Based in New York State as of December 31, 2014

	ACO Start Date	Organization Type	Patients Attributed	Physicians
Montefiore ACO	January 2012	Hospital System	25,000	2,700
Chinese Community ACO	April 2012	Physician Network	13,833	230
Accountable Care Organization of the North Country*	April 2012	Physician Network	5,879	20
Accountable Care Coalition of Mount Kisco	April 2012	Group Practice	16,326	290
Catholic Medical Partners	April 2012	Physician-Hospital Partnership	33,253	900
Crystal Run Healthcare ACO, LLC	April 2012	Group Practice	12,941	275
Asian American Accountable Care Organization	July 2012	Physician Network	14,769	334
Balance Accountable Care Network	July 2012	Physician Network	10,459	1,000
Beacon Health Partners, LLP	July 2012	Physician Network	16,790	280
Healthcare Provider ACO, Inc.	July 2012	Physician Network	29,313	600
Mount Sinai Care, LLC	July 2012	Hospital System	32,000	1,500
ProHEALTH Accountable Care Medical Group	July 2012	Group Practice	28,651	450
Accountable Care Coalition of Syracuse, LLC	July 2012	Group Practice	14,057	65
Chautauqua Region Assoc. Medical Partners	July 2012	Physician-Hospital Partnership	7,884	35
WESTMED Medical Group, PC	July 2012	Group Practice	14,082	281
HHC ACO, Inc.	January 2013	Hospital System	12,369	3,500
Accountable Care Coalition of Greater New York	January 2014	Physician Network	6,500	100
Adirondacks ACO	January 2014	Physician-Hospital Partnership	26,000	318
FamilyHealth ACO	January 2014	Physician Network	7,000	200
New York State Elite ACO	January 2014	Physician Network	5,600	82
Primary PartnerCare Associates IPA, Inc.	January 2014	Physician Network	7,200	32
Rochester General Health System ACO	January 2014	Physician-Hospital Partnership	15,000	950
Bassett Accountable Care Partners	January 2015	Hospital System	15,794	555
Healthcare Partners of the North Country	January 2015	Physician-Hospital Partnership	7,400	125
Innovative Health Alliance of New York	January 2015	Physician-Hospital Partnership	12,000	300
NewYork Quality Care	January 2015	Physician-Hospital Partnership	29,916	4,000
Richmond Quality, LLC	January 2015	Physician-Hospital Partnership	7,200	21
Total			**427,216**	**19,143**

* The Accountable Care Coalition of the North Country operated as an physician network from 2012 to 2014; in January 2015 it changed its sponsorship to a physician-hospital partnership and its name to the Accountable Care Organization of the North Country.

Source: For MSSP participants selected in 2012–13, the number of attributed patients was updated to agree with CMS year-end performance reports, available at https://data.cms.gov/ACO/Medicare-Shared-Savings-Program-Accountable-Care-O/yuq5-65xt (accessed April 8, 2015.) For the Pioneer ACO and for MSSP participants selected in 2014 and 2015, figures are as reported by the ACO leaders.

Emerging Themes: The Challenges of Accountable Care

In the second half of 2014, United Hospital Fund staff conducted semi-structured interviews with leaders of 17 of the state's Medicare ACOs. Questions focused on the ACOs' approach to infrastructure, performance, shared savings contracts with other payers, and issues encountered in the Medicare ACO program. As they reflected on their experience, some consistent themes emerged that are relevant for providers, payers, and policymakers assessing the potential to expand the use of shared savings and other value-based purchasing approaches in New York.

The Imperative: Improve the Performance of the Ambulatory Care System

The ACO leaders we interviewed noted that succeeding under an accountable care contract requires a suite of different interventions across the care continuum. The central challenge, they noted, was the need to improve the performance of the ambulatory care delivery system: improving access and the quality and coordination of care. This, in turn, requires strong, legitimate physician leadership over the primary care and specialty care network; an ACO-wide culture of quality coupled with transparent, peer-led quality improvement processes focused on measuring, reporting, assessing, and improving performance; and system-wide application of evidence-based medicine aimed at reducing practice variation among participating physicians.

Relatedly, they noted that improving primary care and creating medical homes was critical to population health management, as was the creation of new care management structures—registries to identify, stratify and track different patient populations, care management programs for high-risk patients, programs to improve the management of care transitions, and network-wide programs of quality improvement.

They noted that accountable care requires physicians to take on new roles, to think of themselves less as individuals and more as leaders and members of a team. The Medicare ACOs must be prepared to assume responsibility for their patient panels as populations, using registries and predictive analytics to segment their patient panels into low-, medium-, and high-risk cohorts, and to work differently, to address the different needs of those different cohorts. In addition, ACOs and their physicians must be trained to use clinical and claims data to understand the total costs of care and the drivers of those costs; they also need to use both clinical and claims data to inform the way they organize and manage care.

These are substantial challenges. ACOs, they noted, need an ongoing commitment to staff training, and to using clinical and claims data reports as part of an organized program to measure and improve network performance against specific measures of quality and efficiency. They also need time to produce results.

New Investments

Analysts have made widely varying estimates of the size of the initial investment required to set up a single ACO, ranging from CMS's low-end estimates of $ 1-1.8 million[4] to the American Hospital Association's estimate of $11 to $25 million.[5] Although CMS offers MSSP applicants an option (the Advance Payment ACO program) under which it would provide some of the required start-up capital as an advance against future shared savings, none of New York's ACOs have chosen to participate in this program. Each of New York's Medicare ACOs has capitalized its own start-up costs, either by using existing resources, borrowing funds, or partnering with other organizations.

Leaders of New York's Medicare ACOs did not provide specific figures, but all cited the magnitude of the investment required to participate in the MSSP. They noted the need to hire new staff (e.g., care managers, patient educators, and health coaches); to implement new systems; to absorb the costs of staff training and workflow redesign; and in particular, to develop or acquire a series of new capacities—network management, network-wide quality improvement processes, and clinical and claims data analytics and reporting.

Four areas of investment were regularly cited: primary care, care management, health information technology and data/analytics. Details on each follow.

Primary Care

The ACO leaders interviewed all agreed that a high-performing primary care network, one built around the principles of the medical home, is fundamental to effectively managing population health—particularly to managing the care of patients with multiple chronic illnesses, who tend to generate the highest costs.[6] Under the medical home model, physicians and their staffs share responsibility in care teams, moving away from reactive visits toward processes that focus on prevention and wellness. New York's Medicare ACOs are all building those capacities (whether or not they are pursuing formal recognition by the National Committee for Quality Assurance) in their primary care practices.

Care Management

Medicare ACOs leaders noted the imperative to focus on their highest-risk patients and to manage their care using a well-developed care management infrastructure: registries that enable them to stratify their patient population according to medical complexity and risk, identify their high-risk patients, and track their status, over time; and care managers who work with those patients between visits and during care transitions, addressing issues that might result in more serious problems or in a hospital admission.

A number of the group practices, hospital systems, and some of the more advanced physician networks had robust care management staff and systems in place or were

[4] Federal Register. Vol. 76, No. 67. April 7, 2011. Proposed Rules, Medicare Shared Savings Program. See Table 10, page 19634. Available at http://www.gpo.gov/fdsys/pkg/FR-2011-04-07/pdf/2011-7880.pdf (accessed March 19, 2015).

[5] American Hospital Association. May 13, 2011. "New Study Finds the Start Up Costs of Establishing an ACO to be Significant" (press release). Available at http://www.aha.org/presscenter/pressrel/2011/110513-pr-aco.shtml (accessed March 19, 2015).

[6] See Burke G. December 2013. *Advancing Patient-Centered Medical Homes in New York*. New York: United Hospital Fund. Available at http://www.uhfnyc.org/publications/880951 (accessed March 19, 2015).

beginning to develop them before 2012. Smaller physician network ACOs have had to invest in those capacities as part of their start-up.

Most of the ACO leaders we interviewed also agreed that care managers act most effectively when they are embedded in the primary care practices, but they noted that this is a fairly expensive approach that requires scale to succeed. In general, larger primary care practices, are more likely to be able to support an embedded, dedicated care manager.

Many ACOs reported using a mixed model, with care management provided on-site but supported by the network's centralized care management system, which can provide additional skills and capacities (e.g., telephonic support, data analysis, remote telemedicine monitoring, and home visits). In this model, the on-site care managers can be shared across a number of smaller practices.

Health Information Technology

In a few Medicare ACOs, a single EMR platform is used by most of the participating physicians and practices. This arrangement—which enables communication among the involved clinicians, quality measurement, and timely reporting within the ACO—is viewed as ideal. In most ACOs, however, participating physicians use a variety of EMRs, which hampers their ability to exchange clinical information and manage patients effectively.

Medicare ACOs also need timely information from hospitals regarding their members' emergency department visits and inpatient admissions, discharges, and transfers. Such real-time data are critical to the ACOs' ability to reduce preventable admissions and manage care transitions. Hospital-affiliated ACOs can produce and distribute this information rapidly; physician-led organizations have faced more challenges doing so. Some have been able to work with regional clinical data exchanges to generate those reports, but many still rely on phone calls and faxes.

Data and Analytics

Finally, ACOs stressed the challenges entailed in acquiring and managing clinical and claims data, and in using them to evaluate providers' performance in comparison to that of their peers. Such data are critical to assessing and improving network-wide performance. Organizations that had already invested in these capacities in-house were able to use internal staff to manage and analyze claims data received from CMS. Most of the state's ACOs, however, have used a combination of in-house capacities and services contracted from companies (e.g., Universal American, MDLand, Optum, Aledade, and the Advisory Board) with expertise in claims data analytics and population health management.

Building on Medicare's ACO Program: Contracting with Other Payers

The ACO leaders we interviewed noted that while it may be possible to focus on and reorganize care for a specific population of patients covered by a specific payer during a demonstration project, maintaining such a focus over the longer term is likely to be unsustainable for a single payer. They noted that managing population health requires that the involved providers change their operations not just for patients covered by their shared savings contracts, but for all the patients for whom they care.

Having invested in the competencies of accountable care, and having changed their operations to better align their performance with population-based payments, nearly all of the Medicare ACO leaders interviewed expressed an interest in expanding their involvement in accountable care. They seek to convert more of their commercial, Medicare Advantage, and Medicaid managed care contracts to shared savings and risk-based payments, spreading their investments and capabilities over a larger patient base.

A number of the organizations sponsoring Medicare ACOs have already put such contracts in place. Five of the Medicare ACOs (WESTMED, Crystal Run, ProHEALTH, FamilyHealth, and Catholic Medical Partners) are already working under shared savings contracts with their major payers. These contracts cover between 30,000 to 150,000 additional non-Medicare FFS lives. A sixth (Montefiore) is working under full-risk capitation contracts with a number of its payers.

In our interviews, we were not able to gain an in-depth understanding of the nature of the accountable care contracts those providers had or were pursuing with other payers. Those interviewed noted that while many commercial accountable care contracts tend to use the Medicare ACO program as a basic model, those contracts often differ from the MSSP (and from each other) in their details, often using slightly different approaches for patient attribution, benchmarks, risk-adjustment methods, and performance measures. They viewed increasing the proportion of patients who are covered by accountable care contracts as critical, but felt achieving consistency across those contracts was important as well.

Mechanics Matter

In its initial formulation of the ACO program, CMS had to align the program's design and scoring with the requirements of Medicare's existing fee-for-service program. Some of those decisions have created difficulties for MSSP participants in their first years of implementation. One of the recurring themes in our interviews with the leaders of the state's Medicare ACOs was the extent to which some design features compromise their ability to succeed in managing the care of the beneficiaries attributed to them, or to achieve shared savings.

The issues cited here are not new; they have been raised by a variety of ACO experts and organizations involved with ACOs nationwide.[7] [8] [9] CMS recognizes that some adjustments to its initial methodology may be warranted. In December 2014, CMS released a new proposal to strengthen the MSSP, proposing changes responding to several of the areas discussed below. That Notice of Proposed Rulemaking—which requests comments on a series of potential changes, responding to identified problems—is scheduled to be finalized in the spring of 2015.[10] The proposed rule change addressed a number of issues: data sharing, renewals of participation agreements, beneficiary attribution, incentives to move to two-sided risk, and benchmark calculations. However, it did not materially change one key issue for MSSP participants: the retrospective attribution of Medicare beneficiaries to MSSP ACOs, and the use of the year-end roster as the patient cohort to set benchmarks.

Some of the logistical concerns described below are not specific to Medicare ACOs, but are basic features of any shared savings program. They point to issues other payers will need to grapple with, as they move from traditional FFS toward population-based approaches.

ACOs Build on the Medicare FFS Program

The fundamental challenge facing providers participating in Medicare's ACO programs is the fact that the model is overlaid on the existing FFS payment system, rather than replacing it. This means that Medicare ACOs operate under the rules of the Medicare FFS program, which, among other things, guarantee beneficiaries free choice of providers and require specific coinsurance and deductible payments.

Under the Medicare ACO program, physicians, hospitals, and other providers in a Medicare ACO are not actually paid differently. Providers continue to bill Medicare for the services they provide to attributed beneficiaries, and they continue to receive fee-for-service payments through the Medicare FFS program. For providers in (and outside) a Medicare ACO, nothing really changes—they are still paid directly by Medicare, using existing fee schedules, for any billable services they provide.

The prospect of shared savings, on the other hand, is a bit more speculative. Shared savings (if any) are only available to providers participating in an ACO after the end of a given performance period, following a series of complex and largely opaque calculations by CMS. If the ACO is successful in generating shared savings, that aggregate amount is then allocated among the participating providers, using a predetermined formula.

This arrangement provides a comparatively weak incentive for a given provider to change his or her behavior. In fact, it creates a potential conflict for providers, a tradeoff between

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[7] Medicare Payment Advisory Commission. June 16, 2014. Letter to Marilyn Tavenner. Available at http://www.medpac.gov/documents/comment-letters/comment-letter-to-cms-on-accountable-care-organizations-(june-16-2014).pdf?sfvrsn=0 (accessed March 19, 2015).

[8] McClellan M, R White, F Mostashari, and L Kocot. June 2014. *Health Policy Issue Brief: How to Improve the Medicare Accountable Care Organization (ACO) Program*. Brookings Institution. Available at http://www.brookings.edu/research/papers/2014/06/16-medicare-aco-program-changes (accessed March 19, 2015).

[9] Forster A et al. August 2012. *Accountable Care Strategies: Lessons from the Premier Health Care Alliance's Accountable Care Collaborative*. The Commonwealth Fund. Available at http://www.commonwealthfund.org/publications/fund-reports/2012/aug/accountable-care-strategies (accessed March 19, 2015).

[10] CMS. December 8, 2014. Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations. Proposed Rule. Available at https://www.federalregister.gov/articles/2014/12/08/2014-28388/medicare-program-medicare-shared-savings-program-accountable-care-organizations (accessed March 19, 2015).

generating FFS revenues today and reducing today's utilization and income for possible shared savings in the future.

Many of the ACO leaders we interviewed—particularly those in hospital-led ACOs—noted this conflict. Some of the more advanced groups and systems suggested that they would welcome a move toward more robust gain-sharing models—such as capitation, global payments, percent-of-premium arrangements—as this would allow them to uncouple provider payments from the volume-incenting Medicare FFS system, and to better align incentives with the behaviors needed for the ACO to succeed.

ACOs Serving Patients with Unlimited Choice

ACO leaders noted the difficulty serving Medicare FFS beneficiaries, who remain in a program that offers them essentially unlimited access to primary care and specialty providers. This presents a challenge to Medicare ACOs, which are limited networks; they can try to manage and improve the care of their attributed patients to the extent that it is provided in-network, but they have virtually no influence over the care their patients receive from providers outside their network. Under the Medicare ACO program rules, patients are free to seek care outside of the ACO network, and CMS continues to pay those providers at their usual FFS rates. The resulting costs are allocated to the Medicare ACO to which the patient has been attributed.

Most providers have historically been largely unaware of the extent of such out-of-network utilization by their patients. The ACO leaders interviewed all reported their clinicians' surprise, upon first receiving Medicare claims data on their attributed patients, at both the extent of such utilization and the magnitude of such expenditures. New York's ACOs have made efforts to influence their patients' use of outside providers by giving primary care physicians information about their patients' use of outside providers, increasing the availability of in-network specialists, improving appointment access, and simplifying referral processes. However, in a program that offers beneficiaries free choice of providers, and in the absence of any incentives to patients to use in-network services, this pattern has proven difficult to change.

Programs in Medicare Advantage (Medicare's managed care option), to which ACOs are often compared, are much more able to control utilization outside their provider networks by offering different cost-sharing incentives. Commercial ACO arrangements are not necessarily constrained by the same issues; they have more flexibility to design insurance contracts to fit the accountable care providers with whom they are contracting, tailoring provider networks and cost-sharing provisions to align with the ACO's operational needs.

Patient Attribution and Churn

A Medicare ACO's success is measured by its ability to improve health care quality and patient experience, and to reduce the total costs of care, for a defined population. These are the people for whom the ACO has accepted responsibility, whose health and expenditures will be used to measure the ACO's performance. The key to success in Medicare ACOs, all ACO leaders agreed, is their ability to accurately and consistently identify and manage the defined population for whom they are responsible. To do that, they need a consistent roster of attributed patients on whom to focus their care management efforts. This is a fundamental issue in the MSSP program, but will also apply to other programs (e.g., the

state's DSRIP program, and shared savings or shared risk programs sponsored by commercial payers) that rely on patient attribution formulas—rather than patient selection and attestation—to assign patients to particular providers and establish provider accountability.

Medicare ACO leaders stressed the importance of having a fixed and stable roster of participating Medicare beneficiaries at the outset, so they are able to focus during the year on understanding and responding to their health problems and better managing their care.

In most Medicare Advantage programs, patients select a primary care provider who is responsible for managing their care. In Medicare's FFS program, however, people may not have a specific provider who fills that role. Because beneficiaries are free to see any primary care doctor or specialist they wish to in the Medicare FFS system, it can be difficult to determine who is a given patient's primary care (or responsible) provider.

CMS designed and is using an attribution methodology to assign Medicare beneficiaries to an ACO. The basic mechanics of attribution are straightforward: Medicare FFS beneficiaries are attributed to a given ACO based on the care provided to them by primary care physicians. Patients are attributed to physicians who generated the preponderance of "evaluation and management" charges in caring for that beneficiary over the three previous years.[11] If the physician with the majority of such charges is a participant in the ACO, then the beneficiary is attributed to that ACO.

CMS uses a retrospective attribution process in the MSSP in order to compensate for the natural attrition in the number of originally attributed patients (because of too few visits to ACO physicians, visits to non-ACO physicians instead, enrollment in a Medicare Advantage plan, or death), augmenting that patient population to include new patients. At the start of the year, MSSP ACOs receive an initial attribution roster, which is periodically refreshed during the year. At the end of the year, the ACOs receive a final attribution (the population cohort used to calculate ACO performance on quality and cost metrics). Through this process, some previously attributed patients may be lost to the ACO, and some new patients may be added; surprisingly different results may emerge over the course of the year.[12]

CMS's decision to calculate an ACO's cost and quality performance using the year-end attribution (which can include many newly attributed patients) has turned out to be a serious issue for New York's MSSP ACOs. MSSP participants reported changes in their patient rosters between the initial and final attribution rosters (known as attribution "churn") ranging from 20 to 40 percent.

Such changes in the attributed population, and ongoing inclusion of new patients in the measurement cohort, can compromise the ACOs' ability to succeed on measures of both quality and costs. One Medicare ACO leader suggested that it might make sense to

[11] If no primary care physician has submitted charges for the beneficiary, there is a second attribution run, in which visits to specialist physicians are considered.

[12] For example, when CMS reported in early 2014 on the interim financial results of MSSP ACOs, three in New York (Chinese Community ACO, Beacon, and ProHEALTH) were identified as being on track to receive shared savings. Five months later, when CMS ran its final attributions and compared ACO results to the thus-changed benchmarks, only one of the three (ProHEALTH) ended the performance year with shareable savings; and two other ACOs (Catholic Medical Partners and HHC) that had not been cited in the interim report ended the performance year with substantial shared savings. Source: CMS. Performance Year 1 Interim Results for ACOs that started in April and July 2012. Available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/PY1-InterimResultsTable.pdf (accessed March 27, 2015).

maintain the periodic updating, but to include in the measurement cohort only those beneficiaries who had been included in the ACO's attributed population for at least six months or a year.

Benchmarks and Performance Targets

Benchmarks for cost savings—the risk-adjusted, trended spending rate for their attributed patients, measured in terms of total costs of care per member, per year (PMPY)—are the target spending rates against which ACOs' financial performance is judged. The benchmarking process is at the heart of the ACO shared savings methodology, and how those benchmarks are established is therefore critical.

In the MSSP, spending benchmarks are ACO-specific, based on the provider group's *own* historical performance in caring for the population of Medicare FFS beneficiaries attributed to it. In order to correct for random changes in spending, CMS has established a minimum savings rate (MSR) of 2.0 to 3.9 percent below the established benchmark. This means that an ACO must generate savings of at least 2.0 to 3.9 percent beyond its benchmark to be eligible to share in the savings they have generated. Medicare ACO leaders we interviewed had concerns about this approach and the way it has been implemented by CMS.

Their main concern with this method was the fairness of establishing ACO-specific benchmarks based on a provider group's own historical performance. Such an approach tends to punish higher-performing providers whose PMPY expenses are already lower than average. Provider groups with historically low rates of utilization and below-average costs of care must reduce their costs of care below an already low base, and—because benchmarks are recalculated annually to include the most recent year's data[13]—they must continue to reduce those costs every year. Conversely, this method can reward providers whose PMPY expenses have historically been higher than average expenses, as they may have more and easier opportunities for performance improvement.

There is a growing consensus among policy analysts[14] that the current method should be amended. Most of the leading proposals argue for including the regional average per capita cost as a factor in calculating an ACO's expense benchmark, rather than using an ACO's own historical performance as the sole driver.

Patient Engagement

Finally, leaders of New York's Medicare ACOs noted that many of their attributed Medicare beneficiaries do not understand the program or how it works, and because Medicare ACOs are constrained by CMS rules in their communications with beneficiaries, they have difficulty engaging beneficiaries in efforts to improve care and reduce preventable utilization and related costs.

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[13] Under the proposed FY2015 MSSP rules, this will change to a biannual benchmarking system.

[14] McClellan M, R White, F Mostashari, and L Kocot. June 2014. *Health Policy Issue Brief: How to Improve the Medicare Accountable Care Organization (ACO) Program*. Brookings Institution. Available at http://www.brookings.edu/research/papers/2014/06/16-medicare-aco-program-changes. See also Medicare Payment Advisory Commission. June 16, 2014. Letter to Marilyn Tavenner. Available at http://www.medpac.gov/documents/comment-letters/comment-letter-to-cms-on-accountable-care-organizations-(june-16-2014).pdf?sfvrsn=0 (both accessed March 19, 2015).

Under the current model, Medicare beneficiaries do not actively choose an ACO for their care; they are assigned to one based on their historical utilization patterns. They can refuse to allow their health care data to be shared with the ACO, but the costs of their care are still included in calculating the ACO's performance. In addition, Medicare ACOs are prohibited from reducing or eliminating coinsurance or deductibles for specific high-value services.

As MedPAC noted in its comments to CMS on the MSSP program, "there is nothing tangible to attract the beneficiary; from the beneficiary's perspective, the benefits in the ACO are the same as in FFS, and their cost sharing is the same. " [15]

A number of analysts have noted this problem[16] [17] calling for changes in ACOs' ability to communicate with members about the ACO program, and to be able to modify or waive coinsurance for high-value services such as primary care visits. Commercial accountable care arrangements and managed care organizations face fewer challenges on this front, since the use of financial incentives to influence member behavior (e.g., waiving deductibles and coinsurance for high-value services) is an established technique.

The Challenges for Different Stakeholder Groups

The early experience of the Medicare ACOs in New York State (presented in the accompanying quantitative report) appears to be producing some positive results in cost savings and quality. Although some problems have yet to be resolved, the model has significant potential as a way of better organizing and providing care. As the number of people covered under value-based contracts increases, it seems prudent to mine the ACOs' experience for lessons that may be useful.

Many of the challenges ahead are particular to different stakeholder groups. Our analyses of these challenges, organized below by stakeholder group, are informed primarily by our discussions with the leaders of the New York provider groups participating in the MSSP; they may have broader relevance in other areas as well.

What's Ahead for Providers

Ambulatory Care and Quality Improvement

Accountable care focuses on improving the health of specific populations of patients across the care continuum. This requires a shift in perspective from that of providers of discrete services to that of a delivery system. Accountable care uses a specific set of measures to assess performance on quality, and costs. Contracting provider groups must improve their

[15] Medicare Payment Advisory Commission. June 16, 2014. Letter to Marilyn Tavenner. Available at http://www.medpac.gov/documents/comment-letters/comment-letter-to-cms-on-accountable-care-organizations-(june-16-2014).pdf?sfvrsn=0 (accessed March 19, 2015).

[16] McClellan M, R White, F Mostashari, and L Kocot. June 2014. *Health Policy Issue Brief: How to Improve the Medicare Accountable Care Organization (ACO) Program.* Brookings Institution. Available at http://www.brookings.edu/research/papers/2014/06/16-medicare-aco-program-changes (accessed March 19, 2015).

[17] Medicare Payment Advisory Commission. June 16, 2014. Letter to Marilyn Tavenner. Available at http://www.medpac.gov/documents/comment-letters/comment-letter-to-cms-on-accountable-care-organizations-(june-16-2014).pdf?sfvrsn=0 (accessed March 19, 2015).

performance as a group in managing the care of the attributed patient population, and on managing that population's utilization and total costs of care.

A high-performing ambulatory care system is critical to the ACO's success in managing and improving the health of the population for which it is responsible. Patients served by an ACO must have easy access to primary care (ideally, organized as a medical home), and that care must be coordinated with the specialists to whom the primary care provider regularly refers. The ACO must also have a strong, legitimate, peer-led, network-wide quality improvement program to help measure and manage and improve the performance of providers practicing in ambulatory care settings.

The different organizational types are differently positioned to be able to undertake this culture change. Most group practices, advanced physician networks, and hospital systems with employed physicians already have established processes for ongoing quality improvement and the infrastructure to support any necessary staff training. These organizations are reasonably well positioned to improve quality, reduce variation in practice, and control utilization and costs. The more loosely bound physician networks (many of which have historically focused on negotiating payer contracts) and newer hospital-physician partnerships face a steeper path.

The Substantial Benefit of Existing Infrastructure

Building the new infrastructure required to achieve improved outcomes under accountable care takes time and money. Comparatively well-resourced organizations that had already invested in the necessary capabilities—multispecialty groups such as ProHEALTH, Crystal Run, and WESTMED; more advanced physician networks such as Beacon, Catholic Medical Partners, and the Greater Rochester Independent Practice Association (the IPA partner of Rochester General ACO); and hospital systems such as Montefiore, HHC, and Mount Sinai—appeared poised for better outcomes over time.

Juggling Different Financial Systems and Incentives

As provider groups move into accountable care, they will be living for a time in two worlds with quite different financial incentives, finding themselves operating in ways increasingly ill-suited to maximizing revenue under the FFS payment system. They will quickly need to broaden the base of payers whose payment methods are aligned with the accountable care model, and to achieve as much multipayer support as they can. But shared savings and shared risk arrangements are only the start.

As Medicare and other payers move beyond shared savings to other more advanced value-based purchasing models, such as global payments and capitation, the participating provider groups will face a new set of challenges. Accepting and managing risk under capitation or prepayment is an enormous challenge for a provider group, requiring that it build or acquire an entirely new set of skills and capacities that have historically been the sole domain of the payers.

Under capitation, provider groups will need to take on credentialing, network management, customer and provider relations, and system-wide utilization management. More daunting still, ACOs accepting prepayment will take on an entirely new set of financial responsibilities: they will need to be able to accept, manage, and adjudicate provider bills

and claims; they will need to establish and negotiate provider payment rates; and they will need to pay both in-network and unaffiliated providers. Provider organizations interested in pursuing these more advanced payment methods will need to either build these functions themselves or purchase them from payers or third-party administrators.

Different Trajectories for Different Models

There are two basic models for accountable care: physician-led and hospital-led. They have different economics, different centers of power, and different capacities for managing ambulatory care. Numerous and varied factors affect the models' ability to succeed as ACOs in the short term; it is unclear how the two models will fare over the longer term.

In the short term, physician-led models based in group practices and in well-led, well-resourced physician networks appear to be positioned best for success in the MSSP. Hospital systems and physician-hospital partnerships also have the potential to succeed, but to do so they will need to effectively manage and improve the performance of their ambulatory care systems, and to manage the performance of the ACO network as a whole. In the near term, accountable care presents a challenge for hospital-led systems, since it will likely reduce hospital income, their main source of operating income. The leaders of hospital-led Medicare ACOs we interviewed recognize this conflict. However, they see the need to evolve to a clinical and financial model in which they can participate in shared savings (and, eventually, in more robust forms of value-based purchasing), and they are using their involvement in the ACO program to help make that transition.

Smaller group practices and physician networks are the type whose trajectory is the most difficult to predict. The shared savings model should reward them for providing more efficient care; but for the smaller physician networks—particularly those whose primary function has been payer contracting—it will be a substantial challenge to build the infrastructure and sustain the new costs that accountable care requires.

What's Ahead for Purchasers and Payers

Commercial Payers

As part of their move toward value-based purchasing, commercial payers are already beginning to experiment with shared savings contracts and other population-based payment methods with provider groups. Like the MSSP, these appear to be programs built on top of, rather than replacing, their historical FFS payment systems that have shown the potential to drive volume and cost.

Building new contracts while keeping the old ones going. Like providers, payers will be operating for some time in two different worlds. For members covered by more traditional contracts, they must maintain the infrastructure required to provide payer-based credentialing, network management, health education, and care management, as well as receiving and paying claims. Meanwhile, under accountable care contracts, they are beginning to delegate those duties (and costs) to their provider partners. Until a substantial portion of their membership is covered by accountable care, they will need to maintain and support both systems and the related infrastructure for each.

ACO leaders we interviewed also reported that while many commercial payers are using the basic mechanics of Medicare's ACO programs, some have different approaches to attribution, measuring quality, and calculating shared savings. As currently constructed, however, the MSSP has a number of design flaws that commercial payers may want to consider as they craft their own accountable care contracts. Payers need to consider how to design their contracts to address some of the shortcomings of the Medicare ACO program, and—if possible—reduce the differences between each other so they can amplify their effect on the delivery system they all use.

Shifting risk and cutting out the middleman. In the long term, a fundamental question raised by accountable care is where the payer fits in. There are two ways in which accountable care can be implemented, which have different implications for payers and their roles:

- Purchasers can contract with payers to provide health insurance to their members, and the payers can then sub-contract with organized provider groups, using shared savings or a more advanced model of risk-sharing. In this model, the insurance risk resides with the payer, or middleman.
- Purchasers can contract *directly* with organized provider groups. In this model there is no middleman, and the insurance risk resides with the ACO provider system itself.

Across New York, a number of purchasers, payers, and providers are already using the first model, under which provider groups can accept performance risk but not insurance risk, thus avoiding the need to put in place reserves required to operate as insurers. Commercial contracts of this type are already regulated (and subject to prior review) by the New York State Department of Financial Services, under Regulation 164. The payers contract with both purchasers and provider groups, retain specific roles and functions, and maintain reserves to cover the contract's ultimate insurance risk.

Under the second model, purchasers (notably self-insured employers) would contract directly with ACOs to provide and manage the care of their covered populations. This would enable purchasers to substantially reduce or eliminate the role that third-party administrators and payers currently play. However, the involved provider group would need to acquire or build a series of new insurance functions, and establish and maintain reserves adequate to cover their insurance risk.

What's Ahead for Policymakers and Regulators

Under Whose Oversight?

For policymakers and regulators, accountable care is a conundrum. It is clearly an important policy issue for New York State, but it does not fit easily or well into the State's existing policy and regulatory frameworks, which tend to focus either on health care facilities or organizations (e.g., hospitals, hospital-sponsored clinics, diagnostic and treatment centers, and mental health clinics) licensed under Article 28 or Article 31 of the public health law, or on health insurance organizations licensed under Articles 42, 43, and 44. Accountable care organizations can be seen as a hybrid of the two types.

The state's recently finalized ACO regulations represent an effort to include accountable care arrangements in New York's regulatory and oversight systems. They establish a public review and approval process to ensure that ACOs are organized and led appropriately and are accountable to the Department of Health and the public, and they provide ACOs the necessary legal and antitrust protections (a Certificate of Public Advantage) to organize and operate such networks.

One of the key public policy concerns addressed in the current ACO regulations relates to providers entering into shared risk contracts. The regulations require a prior review of the financial viability of the provider organization, in the event they generate a substantial loss under a shared risk arrangement.

The ACO regulations also consider the differences that exist between the two ways in which provider groups can craft accountable care contracts. If the contract involves a sub-capitation of the provider group by an insurer or payer, the insurance risk remains with the insurer. However, if the provider group contracts *directly* with a purchaser (or in the case of Medicaid, with the State), then provider group assumes the insurance risk, and the arrangement becomes subject to insurance regulations. This would require—among other things—that an ACO have substantial capital reserves and be subject to a different type of oversight.

Another regulatory question concerns the applicability of ACO regulations to organizations composed of privately practicing physicians organized as group practices, as IPAs, or as faculty practices (physicians employed by hospitals or medical schools but not employed by Article 28-licensed facilities). These are entities that have not traditionally been regulated by New York State. Regulating ACOs means bringing these organizations and their member physicians into some manner of public oversight and accountability.

Relevance to Medicaid and DSRIP Performing Provider Systems

New York State's experience to date with Medicare ACOs may also be relevant to the implementation of the state's Medicaid waiver, the Delivery System Reform Incentive Payment program (DSRIP). Fundamentally a pay-for-performance program, DSRIP provides incentives to hospital-led performing provider systems (PPSs) to organize systems of care that reduce avoidable hospital use.

Like the MSSP, DSRIP is overlaid on an existing payment system, under which providers continue to be paid by Medicaid managed care plans for services rendered, with the plans generally paying providers using FFS payment methods. This gives mixed messages to the involved provider groups: behaviors and performance encouraged and rewarded by one payment method are discouraged by the other. The sooner Medicaid managed care plans can align their payment methods with the DSRIP program's delivery system reform and population health improvement goals, the more likely they will be to bring about lasting change and performance improvement.

Based on early indicators of performance, it appears that the more organized and better-resourced provider groups are likely to be more successful in Medicare's ACO programs. Many of the ACOs that achieved cost savings in their first performance period were groups with substantial history together, established leadership and trust, and some of the relevant infrastructure already in place.

Many of the PPSs on which DSRIP relies are comparatively new alignments of providers who may not yet have had the opportunity to develop the necessary relationships and shared infrastructure. DSRIP also provides PPSs with upfront capital to invest in those new capacities.

Finally, Medicare ACOs have reported difficulties engaging patients to participate effectively in their own care, at least in part because they have been constrained in their communications with their members, and also because they have not been able to use financial incentives available to commercial plans, such as reductions in coinsurance and deductibles for the use of high value services. These issues may also affect performing PPSs, serving patients covered by Medicaid, in the DSRIP program.

What's Ahead for Patients and Enrollees

For New Yorkers enrolled as patients in these new organizations, accountable care could be a valuable development. The stated goals of Medicare's ACO programs— to provide patients with a medical home, to improve their experience of care, to improve the quality of care they receive, and to reduce their preventable utilization of hospitals and emergency departments and their costs of care—seems to align well with consumer interests. For their part, the programs want patients to participate more actively in their own care, and, as much as possible, to use in-network providers. How programs encourage such behavior will affect their enrollees' experience.

Engagement and Incentives

Accountable care also assumes that there will be a change in patients' relationships with their health care providers: they will have improved access to their primary care providers, receive evidence-based care and have access to care managers to help them coordinate and manage their care. Most ACOs have expanded access; at some ACOs, this expansion includes web portals that patients can use to communicate with their providers, find answers to their questions, take care of routine actions (e.g., refilling prescriptions), and receive messages from their provider team.

An ACO's success will partly depend on the ability and willingness of its patients—particularly those with chronic illnesses, who are at risk for higher health care use and costs—to participate actively in their own care and to use in-network providers rather than shopping for other providers. From a consumer perspective, free choice is a necessary safeguard for Medicare beneficiaries using these new ACOs, which arguably have an incentive to offer less care. A consumer advocate might say it is the ACO's job to build loyalty and to improve the patient experience enough that enrollees will want to stay in network. One suggested change in the process for assigning Medicare beneficiaries to ACOs would involve attestation: beneficiaries identify the provider they consider responsible for coordinating their overall care, and are then attributed to that provider's ACO. Such a process could give beneficiaries a more active choice and potentially increase patient

engagement; it could also help stabilize the ACO beneficiary population.[18] In future models of accountable care, patients' more active choice may be guided by incentives for participating in specific high-value prevention and wellness activities.

Conclusion

New York's Medicare's ACO programs are experiments at scale, testing the effectiveness of a new approach to organizing, delivering, and paying for care. Accountable care is a major change from the status quo, with the potential to transform the health care system in New York, improving quality of care, patient experience of care, and population health, all while controlling its costs.

Over last three years, Medicare ACOs in New York State have expanded substantially, and have begun to show some of the expected results; and they have only just begun. Such arrangements will likely continue to expand, with more enrollment within the Medicare ACO program and expanded enrollment in similar models under commercial insurance and perhaps Medicaid.

Spreading effective ACO models to populations outside Medicare could improve care and reduce costs. However, any change of this magnitude will be hard to accomplish, particularly when established FFS-based behaviors—on the part of both providers and patients—continue to be rewarded by most payers.

As the momentum behind value-based purchasing grows, and as more provider groups and payers craft accountable care contracts using techniques like shared savings and shared risk, it is important that those involved learn from MSSP participants' experience thus far.

Accountable care requires a set of new perspectives and competencies, as well as a credible and trusted hub organization that can mount the necessary infrastructure. It is a long-term project, and the model's incentives and the providers' investments of time and money both need to reflect that. The model is still evolving, and there may be a need to revisit some of its basic design features and to find better multipayer alignment on the model elements and mechanics.

In our interviews, it was abundantly clear that provider groups across the state are intrigued by the ACO model and are embracing it. Not just because it's a way to make money in a new, value-based purchasing system, but because they see in it a way to work together more effectively to provide higher quality and better care, and to improve the health and reduce the costs of care of defined populations.

[18] National Association of ACOs. February 16, 2015. Joint letter to Marilyn Tavenner. Available at https://www.naacos.com/pdf/MSSP-NAACOSJointCommentLetter020615.final.pdf (accessed March 19, 2015).

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