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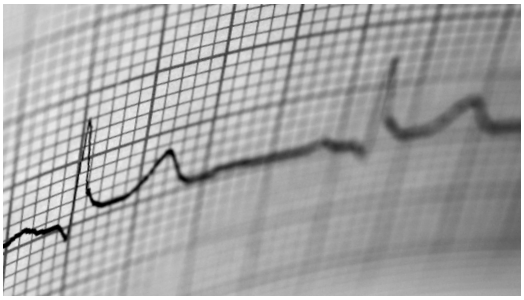

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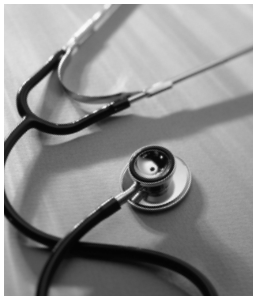

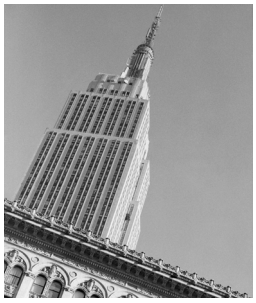

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Performance of New York's Accountable Care Organizations in Year 2 of the Medicare Shared Savings Program

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Executive Summary

The Medicare Shared Savings Program (MSSP) is the largest accountable care program sponsored by the Centers for Medicare and Medicaid Innovation, and one of its highest-visibility initiatives. The program is now four years old. Its ambition is to transform the health care delivery system serving Medicare beneficiaries by encouraging organized provider groups across the nation to develop high-performing, integrated health care delivery systems. With its shared-savings and shared-risk models, the MSSP also figures prominently in Medicare's plan to move from fee-for-service to value-based payment systems.

As the accountable care arrangements continue to spread across New York State, it seemed timely to review New York State's experience and results to date with this delivery system innovation. Twenty-one provider organizations in New York State have been in the MSSP long enough to have generated results, which have been analyzed and reported by CMS. In the first year of the program, New York ACOs' performance in terms of cost savings and quality measures was roughly in line with that of other MSSP participants nationwide. In Year 2, they were comparatively strong on quality measures but less impressive in terms of cost savings: in aggregate, those 21 ACOs generated savings to Medicare of $1.6 million, a savings rate of 0.05 percent of total expenditures.

In this paper, we also sought to identify characteristics apparently associated with success in the MSSP. Using CMS data and focusing on New York participants, we considered whether success in generating savings was associated with experience, size, organizational model, or geography. Some less quantifiable ACO-specific characteristics (e.g., leadership, infrastructure, and professional cohesion) appeared to be as important to an ACO's success—or even more so. Relatedly, some basic design elements of the MSSP program (notably attribution and benchmarking) appear to have had a pronounced effect on ACOs' ability to generate savings. In June 2015, CMS changed some of the problematic aspects of those rules, and in late January 2016 proposed to change others; the impact of these adjustments remains to be seen.

The experience of the state's Medicare ACOs to date offers some insights for providers, payers, and policymakers in New York, as ACOs continue to spread and mature. Under the DSRIP program, New York's Medicaid program is investing in the creation of large integrated delivery systems to serve Medicaid enrollees, postulating that they will be able to evolve into high-performing ACOs. It is also pursuing an aggressive plan to implement value-based payment, in which shared savings programs like the MSSP are considered foundational. Given the difficulty that even well-established provider groups have had in generating and sustaining savings under the MSSP ACO program, some caution may be warranted when considering the expectation that all provider groups will succeed in generating appreciable savings and the time that they will require to do so.

Introduction

Since April 2012, the Centers for Medicare and Medicaid Services (CMS) has selected 434 provider organizations to participate in the Medicare Shared Savings Program (MSSP), serving over 7.7 million beneficiaries nationwide. The MSSP's goals are to improve Medicare beneficiaries' health and health care experience, and to reduce the rate of spending growth while still allowing Medicare recipients free choice in providers.

Enacted as part of the Affordable Care Act, the MSSP is a permanent part of the Medicare program. The MSSP couples delivery system innovation with value-based payment (VBP), encouraging development by organized provider groups (multispecialty group practices, physician networks, hospital systems, or physician-hospital partnerships) to form accountable care organizations (ACOs), which then agree to provide care to a population of fee-for-service (FFS) Medicare beneficiaries attributed to them. If an ACO succeeds in generating savings against a benchmark, it can then share in those savings.

As of January 2016, New York State was home to 29 MSSP ACOs,[1] serving over 300,000 FFS Medicare beneficiaries and involving over 15,000 physicians. Some of the state's ACOs have been in the MSSP since its inception; others have been in the MSSP for one year or less. A full roster of New York ACOs as of January 2016 is shown in Appendix 1.

The MSSP offers provider groups different options for risk-sharing: Track 1 (shared savings only), Track 2 (shared savings / shared risk) and a new Track 3 (a modified shared savings / shared risk arrangement). Most ACOs participating in the MSSP nationwide are in Track 1. Only one ACO in New York State,[2] and few nationally, are in one of the shared risk models.

CMS has issued two reports analyzing the performance of the MSSP ACOs to date,[3] assessing participants' effectiveness in improving quality and reducing costs by measuring against benchmarks. Those publications provide an opportunity to look at the early experience of New York's ACOs for trends that could be useful to providers, payers, and policymakers. In this report, we review and analyze CMS's published results of New York's MSSP ACOs in their first two years, in terms of

[1] This number includes only ACOs participating in the MSSP as of January 2016. This is a net figure; there were 27 in January 2015, and in January 2016 five were added to the program while three—Crystal Run, HealthCare Provider and Rochester General—left it. This total also excludes Montefiore Health System, which participates in CMS's Pioneer ACO Program, which is separate from the MSSP.

[2] On January 1, 2016, Catholic Medical Partners ACO shifted from Track 1 to Track 3.

[3] CMS Reports on MSSP results for Year 1 (covering 2012–13), and Year 2 (covering 2014):

Medicare Shared Savings Program Accountable Care Organizations Performance Year 1 Results, https://data.cms.gov/ACO/Medicare-Shared-Savings-Program-Accountable-Care-O/yuq5-65xt

Medicare Shared Savings Program Accountable Care Organizations Performance Year 2014 Results, https://data.cms.gov/dataset/Medicare-Shared-Savings-Program-Accountable-Care-O/ucce-hhpu

quality and costs. We also test some of the characteristics that might be associated with success in the MSSP, and offer some insights and issues for further consideration as ACOs continue to spread and mature throughout the state.

The CMS MSSP Reports: What's Included and What's Not

In November 2014 and July 2015, CMS published reports that describe the financial and quality results of the MSSP participants across the country. Because of the need for claims run-out, analysis, and calculations by CMS, there is a lag time between the end of the performance year and publication of results. The November 2014 publication reported on the first performance year (called here Year 1), covering ACOs' initial 12- to 20-month term of MSSP participation in 2012–13, depending on the start date. The July 2015 publication reported on the second performance year (Year 2), equivalent to calendar year 2014.

How long a given provider organization has been participating in the MSSP determined whether it was included in one or both of CMS's reports on their performance on costs and quality. Providers selected for the MSSP in 2012 and 2013 are included in both of CMS's reports, while those selected in 2014 are only included in CMS's report for Year 2. The 11 New York ACOs selected in 2015 and 2016 were not included in either.

CMS's Methodology for Calculating Shared Savings and Quality

CMS's methodology for calculating an ACO's financial results is conceptually straightforward. The total actual expenditures generated in a given year in caring for an ACO's attributed Medicare fee-for-service beneficiaries are compared to a provider-specific benchmark; if there are savings, the provider group gets to share them with CMS. However, the actual mechanics involved—particularly how patients are attributed to an ACO, how the benchmarks are calculated, and how a minimum savings rate (MSR) of 2.0–3.9 percent is applied—are quite complex.

CMS's methodology for measuring and rewarding quality is also complex. An ACO's performance is measured against 33 quality metrics and compared to national benchmarks; its ability to share in any savings it generates is modulated by its performance on quality. In their first year of participation, ACOs are required to merely report on quality indicators to be eligible to receive the full portion of any savings they generate. In subsequent years, ACOs' actual performance on quality measures—how well they do against benchmarks, not just whether they submit a report—affects their ability to share in any savings they generate. If an ACO fails to meet or exceed a national benchmark, its ability to receive any savings it generates is

reduced by a certain percentage.[4] (This arrangement is called "pay for performance" rather than the so-called "pay for reporting" required in Year 1.)

Table 1. New York ACOs for Which CMS Has Issued Performance Results

Joined	Organization	Organizational Model
April 2012	Accountable Care Coalition of Mount Kisco	Group Practice
	Crystal Run Healthcare ACO, LLC *	Group Practice
	Chinese Community ACO	Physician Network
	ACO of the North Country	Physician-Hospital Partnership
	Catholic Medical Partners	Physician-Hospital Partnership
July 2012	ProHEALTH Accountable Care Medical Group	Group Practice
	WESTMED Medical Group, PC	Group Practice
	Beacon Health Partners, LLP	Physician Network
	Healthcare Provider ACO, Inc. *	Physician Network
	Mount Sinai Care, LLC	Hospital System
	Asian American Accountable Care Organization	Physician Network
	Balance Accountable Care Network	Physician Network
	Accountable Care Coalition of Syracuse	Group Practice
	Chautauqua Region Medical Partners	Physician-Hospital Partnership
January 2013	NYC HHC ACO, Inc.	Hospital System
January 2014	FamilyHealth ACO	Physician Network
	New York State Elite ACO	Physician Network
	Primary PartnerCare Associates IPA	Physician Network
	Accountable Care Coalition of Greater New York	Physician Network
	Adirondacks ACO	Physician-Hospital Partnership
	Rochester General Health System ACO *	Physician-Hospital Partnership

*Three of these ACOs left the program by January 2016: Crystal Run Healthcare ACO, LLC, Healthcare Provider ACO, Inc., and Rochester General Health System ACO.

[4] In Year 2, 25 of 33 measures are calculated on a pay-for-performance basis. In Year 3, that number increases to 32 of 33 measures.

Overview: New York MSSP Financial Results for Year 2

In 2014, New York State's MSSP ACOs generated $1.7 million in savings against their total spending/expenditures benchmark of over $3 billion, a rather modest aggregate savings rate of 0.05 percent. As shown in Table 2, that overall total is composed of three different groups of MSSP ACOs.

- Four ACOs generated over $35 million in savings to Medicare, for which they received roughly half, a total of $15.7 million in in shared savings.
- Five generated nearly $13 million in savings for Medicare, but not enough to exceed their MSR, so they were not eligible to receive shared savings.
- Twelve ACOs' expenses were above their benchmark, generating "losses" to Medicare (but not to the ACOs, per the shared savings arrangement) of over $46 million beyond their benchmarks.

Table 2. New York ACOs' Financial Performance in Year 2

ACO	Total Assigned Beneficiaries	Benchmark Expenditures	Actual Expenditures	Generated Savings	Savings as % of Benchmark
ProHEALTH	28,825	$275,715,167	$258,561,947	**$17,153,220**	6.2%
WESTMED	12,273	$108,348,393	$101,126,474	**$7,221,919**	6.7%
HHC	13,294	$117,275,057	$110,153,040	**$7,122,016**	6.1%
Chautauqua	6,816	$61,704,178	$57,734,542	**$3,969,635**	6.4%
Subtotal: ACOs that Earned Shared Savings	*61,208*	*$563,042,795*	*$527,576,003*	***$35,466,790***	*6.3%*
Healthcare Provider ACO	27,791	$414,704,079	$404,975,183	**$9,728,896**	2.4%
CCACO	11,219	$106,387,253	$104,891,827	**$1,495,426**	1.4%
Mount Sinai Care	33,825	$383,882,561	$382,994,067	**$888,494**	0.2%
Primary PartnerCare Associates IPA	6,347	$79,296,747	$78,919,174	**$377,572**	0.5%
FamilyHealth ACO	3,618	$32,299,760	$31,949,885	**$349,875**	1.1%
Subtotal: ACOs that Saved vs. Benchmark, but <MSR	*82,800*	*$1,016,570,400*	*$1,003,730,136*	***$12,840,263***	*1.3%*
Asian American ACO	12,997	$111,072,169	$111,609,979	**($537,811)**	-0.5%
ACC of Syracuse	12,729	$93,080,190	$93,682,872	**($602,683)**	-0.7%
New York State Elite ACO	5,620	$103,142,602	$104,173,901	**($1,031,299)**	-1.0%
Accountable Care Coalition of Greater New York	6,353	$48,347,207	$49,705,909	**($1,358,702)**	-2.8%
Catholic Medical Partners	25,614	$197,196,601	$199,387,211	**($2,190,609)**	-1.1%
Adirondacks ACO	27,412	$241,068,567	$243,472,685	**($2,404,118)**	-1.0%
ACO of the North Country	5,061	$40,259,112	$42,945,557	**($2,686,445)**	-6.7%
Crystal Run Healthcare ACO	12,201	$138,881,297	$142,233,699	**($3,352,402)**	-2.4%
Beacon Health Partners	15,474	$150,687,172	$154,784,874	**($4,097,701)**	-2.7%
Rochester Regional ACO	11,844	$101,018,304	$105,719,054	**($4,700,749)**	-4.7%
ACC of Mount Kisco	14,481	$117,547,029	$126,202,612	**($8,655,583)**	-7.4%
Balance ACO	8,165	$146,995,248	$162,017,792	**($15,022,545)**	-10.2%
Subtotal: ACOS that Did Not Save vs. Benchmark	*157,951*	*$1,489,295,498*	*$1,535,936,145*	***($46,640,647)***	*-3.1%*
New York State Total	**301,959**	**$3,068,908,693**	**$3,067,242,284**	**$1,666,406**	**0.05%**

New York MSSP ACOs' Performance Lags National Experience on Cost Savings

Performance results of New York's ACOs in Year 1 was roughly in line with that of other ACOs in the program nationwide. But, as shown in Table 3, the Year 2 results for New York's ACOs compared less favorably to national results. Only 19 percent of all MSSP ACOs in New York qualified to receive shared savings in Year 2, compared to 26 percent nationally; and 57 percent of New York's MSSP ACOs generated no savings at all against their benchmark, compared to a national average of 46 percent.

Table 3. New York ACOs' Year 2 Financial Results vs. National Averages

	Nationally*		New York State	
	#	%	#	%
Experienced ACOs	214	100%	15	100%
Number generating and receiving shared savings	65	30%	4	27%
Number generating savings but *not* receiving shared savings due to failure to successfully report quality or other issue	10	5%	0	0%
Number generating savings, but not beyond MSR	49	23%	3	20%
Number not generating savings vs. benchmark	90	42%	8	53%
Average earned shared savings for those receiving them	$4,205,625		$8,866,698	
Total generated savings (or losses)	*$286,690,945*		*$10,433,827*	
New ACOs	119	100%	6	100%
Number generating and receiving shared savings	23	19%	0	0%
Number generating savings but *not* receiving shared savings due to failure to successfully report quality or other issue	2	2%	0	0%
Number generating savings, but not beyond MSR	34	29%	2	33%
Number not generating savings vs. benchmark	62	52%	4	67%
Average earned shared savings for those receiving them	$3,232,414		N/A	
Total generated savings (or losses)	*$4,786,899*		*($8,767,421)*	
All ACOs	333	100%	21	100%
Number generating and receiving shared savings	88	26%	4	19%
Number generating savings but *not* receiving shared savings due to failure to successfully report quality or other issue	12	4%	0	0%
Number generating savings, but not beyond MSR	83	25%	5	24%
Number not generating savings vs. benchmark	152	46%	12	57%
Average earned shared savings for those receiving them	$3,967,980		$7,874,289	
Total generated savings (or losses)	*$291,477,844*		*$1,666,406*	

* National figures include New York State figures.

New York MSSP ACOs Outperform National Average on Quality Results

New York's MSSP ACOs fared substantially better in terms of their performance on the ACO quality measures. All ACOs, regardless of their performance year, have to successfully report on all 33 quality measures to be eligible to receive shared savings. In addition, the state's original 15 ACOs—those in the second year of their agreement with CMS—were subject to having shared-savings bonuses readjusted based on an aggregate quality score. Some highlights of the comparisons, as shown in Figure 1 and Table 4:

- New York's ACOs achieved an average aggregate score of 86.31 (out of 100), slightly higher than the national average of 83.08 but (see Table 4) lower than scores in neighboring states.

- All but three New York MSSP participants scored higher than the national average.

- Four of New York's ACOs ranked in the top 25 in the nation on the basis of quality: ProHEALTH (1st), Beacon Health Partners (9th), WESTMED Medical Partners (21st), and Chautauqua Region Associated Medical Partners (22nd).

- While the transition from "pay for reporting" to "pay for performance" makes historical comparisons difficult, New York's average score improved on 26 measures, with the state outperforming the national average on 27 measures in in Year 2 compared to 21 measures in Year 1;

- Collectively, New York's ACOs scored highest on the "Preventive Health: Depression Screening" measure and lowest on "Care Coordination/Patient Safety: Percent of PCPs Who Qualified for EHR Incentive Payment."[5]

[5] While different factors seemed to drive the comparatively low scores of the three New York ACOs that performed worst in quality, having received a low score on the EHR Incentive Measure—that is, the percentage of primary care physicians who successfully meet meaningful use requirements—was common to all three. CMS considered this quality measure so important that it doubly weighted the measure in tabulating quality scores. Interestingly, a national analysis of MSSP results found an inverse relationship between this measure and financial performance—ACOs that performed well here were statistically *less* likely to achieve savings. (Sutherland S, B Egan, R Davis, V Rutledge, and A Sinopoli. December 2015. Diving Into the Pool of ACO Quality Measures: MSSP Year 2 Performance Metrics. *Health Affairs Blog*.)

Figure 1. A Profile of New York MSSP ACOs' Year 2 Quality Scores

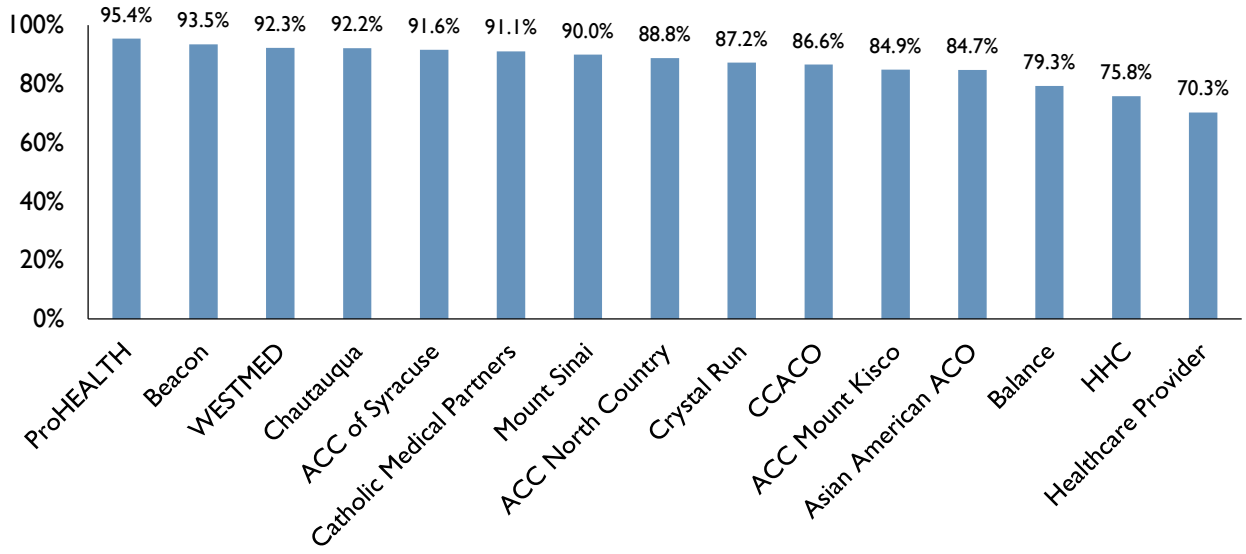


Table 4. Mean Quality Scores of MSSP ACOs in New York and Neighboring States

Vermont	91.00%
Massachusetts	89.68%
Pennsylvania	87.35%
Connecticut	87.01%
New Jersey	86.35%
New York	**86.31%**
National Mean	83.08%

Results on Cost Savings and Quality

For a perspective of New York ACOs' overall performance, we ranked them according to their performance on both cost savings and quality (Table 5).

Table 5. Ranking of New York ACOs' Year 2 Performance on Costs and Quality

	Financial Performance	Quality Performance
ProHEALTH	1	1
WESTMED	2	3
HHC ACO Inc.	3	14
Chautauqua	4	4
Healthcare Provider	5	15
CCACO	6	10
Primary PartnerCare	7	N/A
FamilyHealth	8	N/A
Mount Sinai	9	7
Asian American ACO	10	12
ACC Syracuse	11	5
New York State Elite	12	N/A
ACC Greater New York	13	N/A
Catholic Medical Partners	14	6
Adirondacks ACO	15	N/A
ACC North Country	16	8
Crystal Run	17	9
Beacon	18	2
Rochester	19	N/A
ACC Mt. Kisco	20	11
Balance	21	13

N/A signifies that the ACO was still in the Pay for Reporting phase of MSSP and therefore was not given a quality score by CMS.

Experienced ACOs' Year 2 Results Similar to Year 1; Some Surprises

With CMS's second-year reports, it is possible to examine the performance of New York's MSSP ACOs over time. As is shown in Table 6, some broad trends are apparent, notably the erosion in aggregate savings generated, between Year 1 and Year 2. (See Appendix 2 for more detail.)

Table 6. Summary of Performance of New York MSSP ACOs, Year 1 vs. Year 2

	Year 1	Year 2	Year-Over-Year Difference
Eligible ACOs	15	21	+6
ACOs receiving shared savings	3	4	+1
Savings generated	$57.3 million	$35.5 million	-$22 million
ACOs generating savings, but <MSR	5	5	same
Savings generated vs. benchmark	$20.8 million	$12.8 million	-$8 million
ACOs generating losses vs. benchmark	7	12	+5
Losses vs. benchmark	($49.5 million)	($46.6 million)	+$3 million
Statewide net savings vs. aggregate benchmark	$28.5 million	$1.7 million	-$27 million
Savings as percentage of aggregate benchmark	0.86%	0.05%	-0.81%

Among New York's 21 MSSP ACOs eligible for performance-based rewards in Year 2, 15 experienced ACOs had results reported in both Year 1 as well, allowing some year-to-year comparisons to be made. As is shown in Table 7, some of the ACOs participating in both years saw significant year-over-year changes in their financial performance. Catholic Medical Partners saw the greatest swing in savings, a two-year drop of over $30 million; and ProHEALTH, Beacon and Crystal Run each generated over $4 million less in savings in Year 2 than in Year 1. Conversely, WESTMED, Chautauqua, and Balance each improved their financial performance between Year 1 and Year 2 by more than $4 million.

Table 7 shows the relative position of the 15 "experienced" MSSP ACOs when one aggregates their financial performance of over Year 1 and Year 2.

Table 7. Performance of Experienced ACOs, Year 1 and Year 2

	Year 1	Year 2	Change from Year 1 to 2	Year 1 and 2 Combined
ProHEALTH	$21,913,987	$17,153,220	-$4,760,767	$39,067,207
CMP Buffalo	$27,922,572	-$2,190,609	-$30,113,181	$25,731,963
Healthcare Provider	$11,482,434	$9,728,896	-$1,753,538	$21,211,330
HHC	$7,428,094	$7,122,016	-$306,078	$14,550,110
WESTMED	-$1,547,377	$7,221,919	+$8,769,296	$5,674,542
CCACO	$3,449,181	$1,495,426	-$1,953,755	$4,944,607
AAACO	$1,862,456	-$537,811	-$2,400,267	$1,324,645
Chautauqua	-$2,982,394	$3,969,635	+$6,952,029	$987,241
Mount Sinai	-$1,508,302	$888,494	+$2,396,796	-$619,808
Beacon	$3,009,069	-$4,097,701	-$7,106,770	-$1,088,632
Crystal Run	$956,461	-$3,352,402	-$4,308,863	-$2,395,941
ACC of Syracuse	-$2,467,432	-$602,683	+$1,864,749	-$3,070,115
ACO of the North Country	-$4,748,083	-$2,686,445	+$2,061,638	-$7,434,528
ACC of Mt. Kisco	-$10,779,404	-$8,655,583	+$2,123,821	-$19,434,987
Balance	-$25,472,755	-$15,022,545	+$10,450,210	-$40,495,300
Total	**$28,518,507**	**$10,433,827**	**-$18,084,680**	**$38,952,334**

Note: ACOs are ranked by total savings generated over Year 1 and Year 2.

Seeking Associations Between ACO Characteristics and Performance

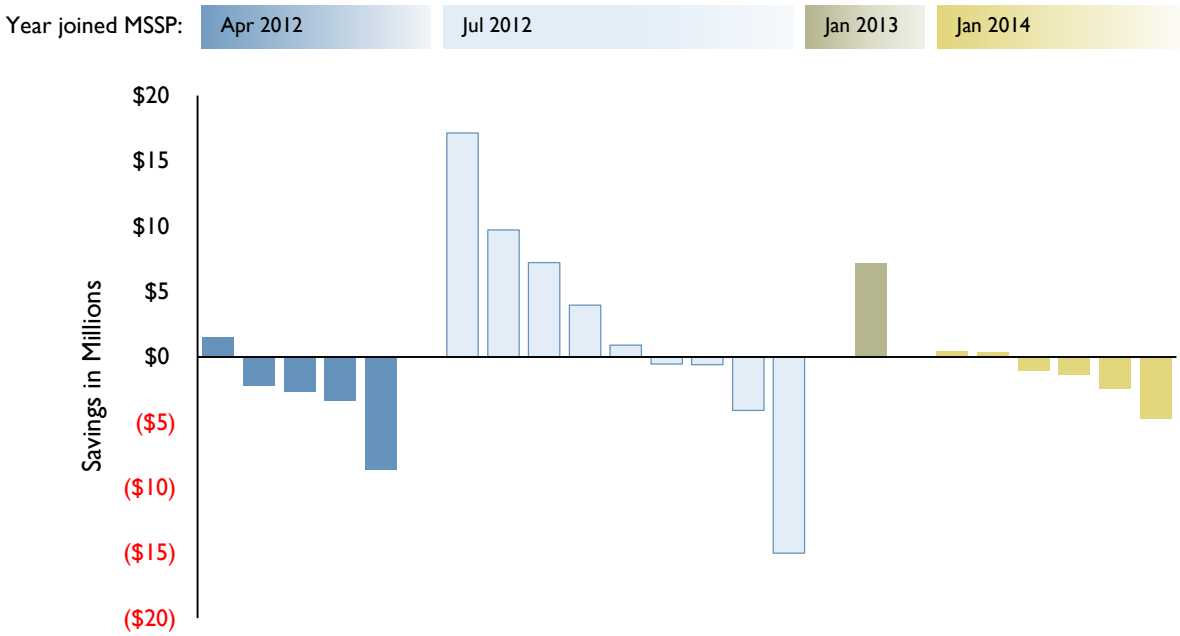
As we reviewed the cost and quality results of the state's MSSP ACOs between 2012 and 2014, we looked for correlations, associations, and explanations for their different performance in generating cost savings, focusing on four characteristics: experience (length of time in the MSSP program), size (number of beneficiaries), type of sponsorship, and location.

Does Experience Matter? Perhaps

In its press release accompanying the release of the Year 2 data, CMS noted that "ACOs with more experience in the program tend to perform better, over time."[6] A national review of MSSP ACOs' performance found that three-quarters of ACOs with savings were in their second or third year of the program.[7]

To see how this trend looked in New York, we arrayed the state's ACOs according to their start dates in the Medicare Shared Savings Program and displayed their Year 2 success in generating savings for Medicare (Figure 2). While there is some indication that the second and third cohorts (those selected in July 2012 and January 2013) outperformed those selected in January 2014, they also outperformed those selected in the first cohort (April 2012).

Figure 2. Length of Time in the MSSP and Financial Performance



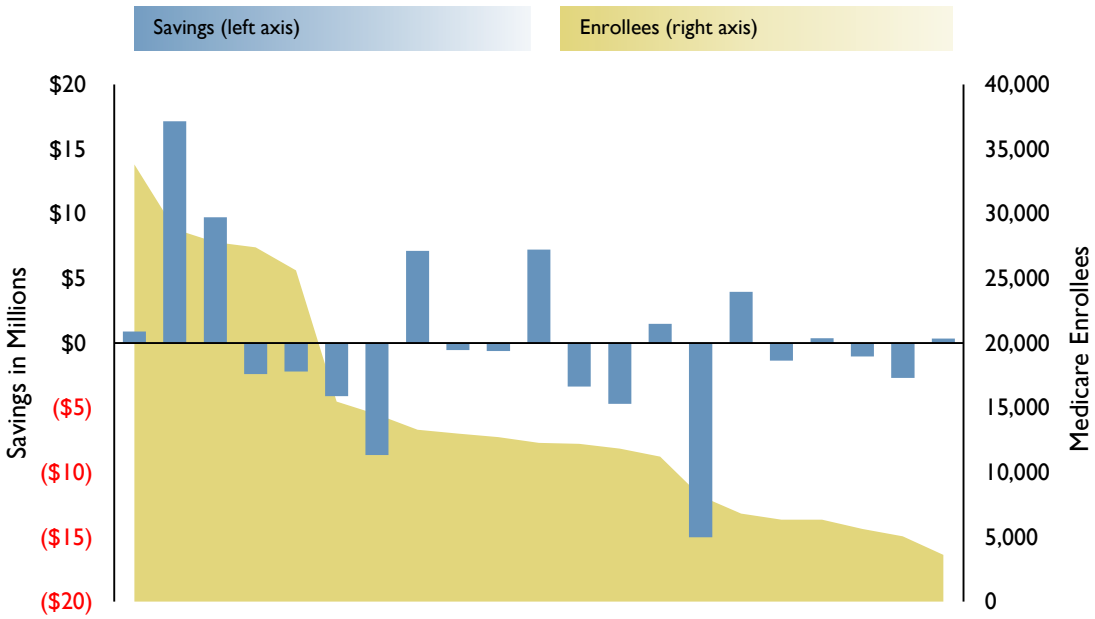
[6] CMS. August 25, 2015. "Medicare ACOs Continue to Improve Quality of Care, Generate Shared Savings" (press release). https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-08-25.html

[7] Sutherland S, B Egan, R Davis, V Rutledge, and A Sinopoli. December 2015. Diving Into the Pool of ACO Quality Measures: MSSP Year 2 Performance Metrics. *Health Affairs Blog*.

Does Size Matter? Not Much

Some analysts[8] have noted that smaller ACOs nationwide may be more effective in generating shared savings than larger ACOs. We looked for a relationship between size and financial performance among New York's MSSP ACOs. Figure 3 arrays ACOs by number of attributed Medicare beneficiaries against their Year 2 results in terms of cost savings. While there is no clear relationship between size and financial performance, it appears that in New York, the larger MSSP ACOs perform slightly better than those with fewer enrolled patients.

Figure 3. ACO Size (by Number of Medicare Enrollees) and Financial Performance, Year 2



[8] http://healthaffairs.org/blog/2015/11/04/medicare-acos-continue-to-show-care-improvements-and-more-savings-are-possible/

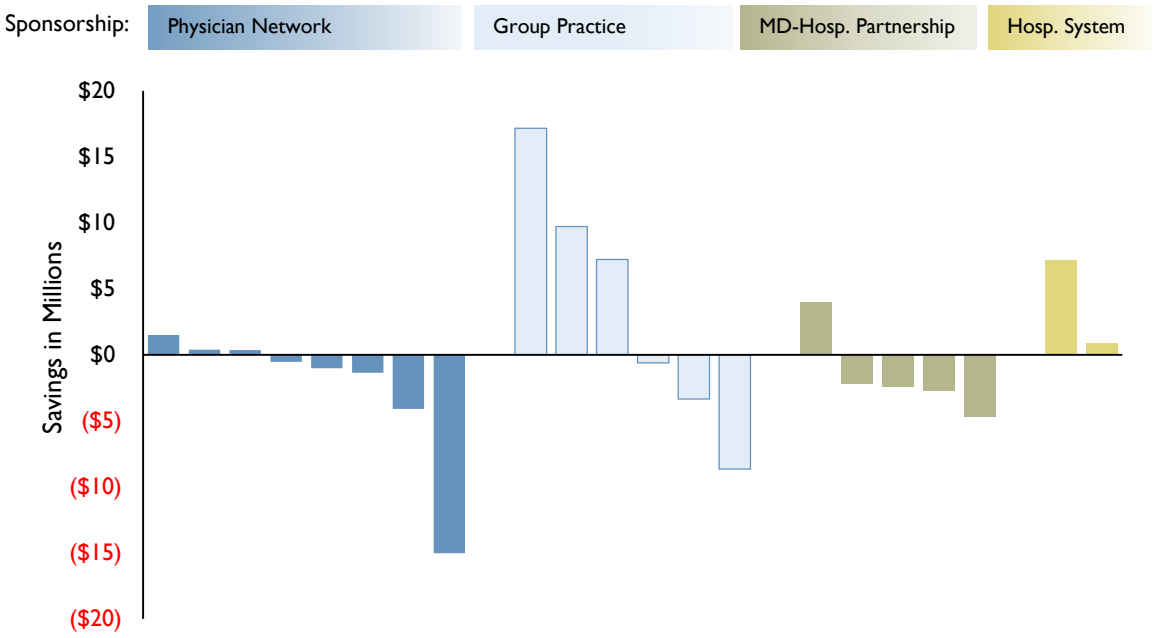
http://healthaffairs.org/blog/2015/09/24/mssp-year-two-medicare-acos-show-muted-success/

http://healthaffairs.org/blog/2015/01/22/early-evidence-on-medicare-acos-and-next-steps-for-the-medicare-aco-program/

Does Sponsorship Matter? Yes

The third issue we probed was whether organizational sponsorship—whether the ACO is physician-led or hospital-led—makes a difference in an MSSP ACO's performance. In this area, analysts have found, nationally, that physician-led ACOs tend to perform better than hospital-led ACOs[9]. New York's experience to date (Figure 4) tends to both challenge and support that national finding. As a broad category, "physician-sponsored" ACOs in New York State are not performing particularly well in generating shared savings. Their performance appears to be bimodal: the less formally organized physician networks continue to face challenges in generating savings, while the more formally organized physician-sponsored ACOs (particularly those sponsored by group practices) appear to be more successful. The same broad trend seems to apply to the hospital-affiliated ACOs: the more loosely organized physician-hospital groups are not performing well in generating savings, while the more tightly organized systems appear to be having more success.[10]

Figure 4. ACO Sponsorship and Financial Performance, Year 2



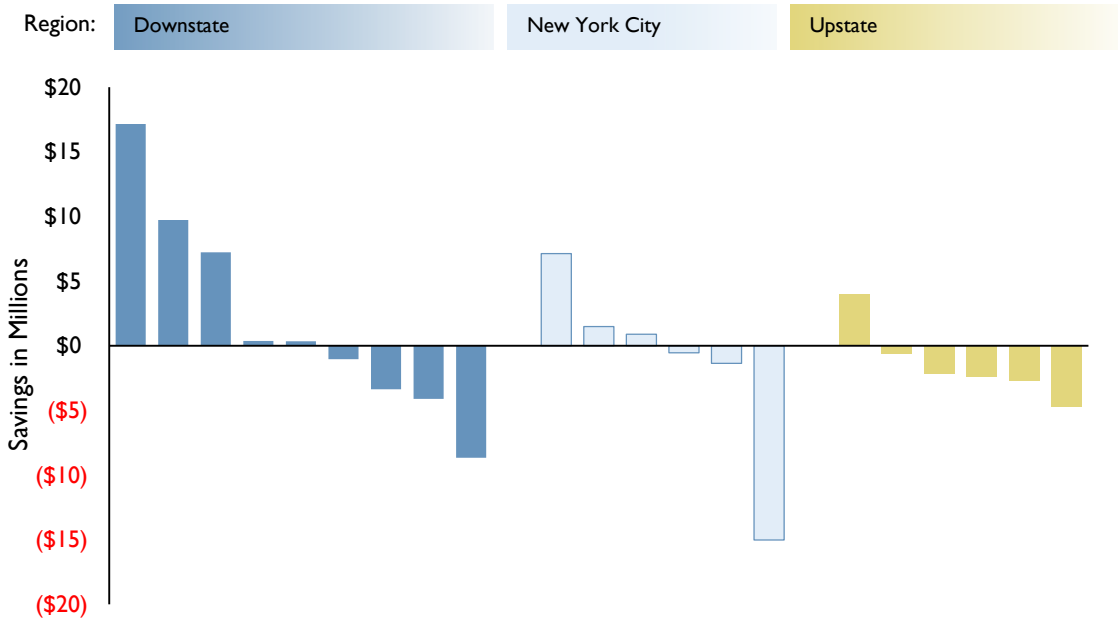
[9] McClellan M, SL Kocot, and R White. January 2015. Early Evidence On Medicare ACOs And Next Steps For The Medicare ACO Program (Updated). *Health Affairs Blog*. http://healthaffairs.org/blog/2015/01/22/early-evidence-on-medicare-acos-and-next-steps-for-the-medicare-aco-program/

[10] Of the physician-led models, group practices tend to be more formally organized, while physician networks tend to be less formally organized. Of the hospital-led models, hospital systems tend to be more tightly organized, while physician-hospital partnerships are more loosely organized. See Burke G and S Brundage. April 2015. *Accountable Care in New York State: Emerging Themes and Issues*. New York: United Hospital Fund. (See particularly Figure 2 on page 5.) https://www.uhfnyc.org/publications/881042

Does Geography Matter? Not Much; Results May Reflect Other Characteristics

There is some evidence[11] that geographical setting—urban, suburban, or rural—is a factor influencing the success of an ACO in generating savings. In order to examine that issue, we arrayed the state's 21 MSSP ACOs and their Year 2 savings according to three broad geographic regions in New York State: downstate (counties in the Hudson Valley and Long Island); New York City; and upstate (the remainder of the state). As is shown in Figure 5, there appears to be some association between being located downstate region—which has a markedly lower penetration of Medicare Advantage[12]—and having success. However, there are ACOs in other regions that have been quite successful in both performance years. Additionally, the successful downstate ACOs also tend to be organized differently (as more closely organized groups), a factor that may contribute to, or in large part account for, their success.

Figure 5. ACO Region and Financial Performance, Year 2



[11] Berger G and D Introcaso. September 2015. MSSP Year Two: Medicare ACOs Show Muted Success. *Health Affairs Blog*. http://healthaffairs.org/blog/2015/09/24/mssp-year-two-medicare-acos-show-muted-success/

[12] Burke G and Brundage S. *New York's Medicare ACOs: Participants and Performance*. United Hospital Fund, 2015

Another Possible Factor in Success: Program Mechanics

Beyond the organizational and geographical issues noted above, analysts continue to point to the MSSP's mechanics—the way attribution is handled, how benchmarks are set, and how the MSR is applied—as contributing to the success of ACOs in that program.

Attribution. The MSSP's use of retrospective (or year-end) attribution for assigning patients and their care costs to ACOs means that many patients initially assigned to an ACO (and actively managed during the year) are not included in its final attribution, and many new patients (whom ACOs have not had time to effectively engage) are assigned to the ACO at the end of their performance year. This is an issue affecting all MSSP ACOs, since they operate under the same rules; but some ACOs may have been more effective in anticipating and responding to this "churn" by developing programs to retain existing patients and quickly integrate newly attributed patients.

Application of the Minimum Savings Rate. A second issue identified by a number of analysts[13] is the way in which the MSR is calculated and applied, and how it reduces the benefit that ACOs can receive from higher performance. Initially proposed by CMS as a way to respond to random variation in utilization and costs, the MSR is a corridor of 2.0 to 3.9 percent above and below the benchmark (for each ACO, the percentage depends on the number of attributed patients), which serves as a threshold an ACO must clear before it is eligible to share in savings it generates.

Providers whose savings have not exceeded the MSR receive no reward for their efforts—even if they have invested in new staff and systems and have generated savings for Medicare. In Year 1, five New York State ACOs generated $20 million in such savings, but did not receive any benefit for their efforts; in Year 2, five ACOs (two of the same ACOs as in Year 1) generated over $13 million in savings but did not exceed their MSRs and thus saw no financial reward from their efforts.

One large ACO (HealthCare Provider ACO) generated a total of $20 million in savings to Medicare in Year 1 and Year 2, but did not qualify to receive shared savings because it did not clear the MSR threshold. The same thing happened to another, much smaller ACO (the Chinese Community ACO, or CCACO), which generated almost $5 million in savings over its first two years.

Benchmarking. There is a growing consensus[14] that the magnitude of an ACO's benchmark—the expenditure "target" against which it is competing—is probably the single greatest factor contributing to an ACO's success in generating savings.

[13] Berger G and D Introcaso. September 2015. MSSP Year Two: Medicare ACOs Show Muted Success. *Health Affairs Blog*. http://healthaffairs.org/blog/2015/09/24/mssp-year-two-medicare-acos-show-muted-success/

[14] Berger G and D Introcaso. September 2015. MSSP Year Two: Medicare ACOs Show Muted Success. *Health Affairs Blog*. http://healthaffairs.org/blog/2015/09/24/mssp-year-two-medicare-acos-show-muted-success/

Benchmarks differ from one ACO to the next, based in large part on historical spending patterns by the ACO's providers, in caring for the population attributed to them.[15] Two issues in particular have been regularly cited in the literature and by leaders of New York's ACOs: how benchmarks are established, and how they are updated.[16]

In theory, it is far easier to reduce costs from a high base (e.g., one that includes comparatively high use of emergency departments and hospitals) than from one which has historically been lower. Tying reimbursement to historical spending patterns thus tends to reward the historically high-cost providers, and punish those with lower historical utilization and costs. While success of New York ACOs in generating savings does appear to be related to their respective benchmarks, there have been some notable exceptions in both directions—ACOs with higher benchmarks generating less savings, and ACOs with lower benchmarks generating more savings.

The way benchmarks are updated can also affect an ACO's results. Under the original methodology, an ACO's benchmark was updated annually to reflect a three-year rolling average of the provider's historical costs and performance, in which the three prior years were weighted differently: the most recent year was weighted at 60 percent, the second year back at 30 percent, and the third year back at 10 percent. The effect of that methodology was to punish providers that had performed very well in any given year, by changing the benchmark for the following year to a new and lower figure.

The impact of this issue can be seen in the surprisingly different Year 1 and Year 2 results for Catholic Medical Partners in Buffalo. After generating one of the highest levels of shared savings in the nation in Year 1, their benchmark target fell in Year 2 from $8,691 to $7,942, a reduction of roughly $750 per patient, per year.

[15] The marked variation among the state's MSSP ACOs in terms of their respective benchmarks reflects a number of factors: the characteristics of the patients for whom they care (e.g., proportion of dual-eligible beneficiaries, tendency to use EDs, case-mix, and severity) and the ACO providers' own historical practice patterns.

[16] McClellan M, SL Kocot, and R White. January 2015. Early Evidence On Medicare ACOs And Next Steps For The Medicare ACO Program (Updated). *Health Affairs Blog*. http://healthaffairs.org/blog/2015/01/22/early-evidence-on-medicare-acos-and-next-steps-for-the-medicare-aco-program/

CMS Is On the Case

The MSSP methodology issues noted above are likely factors in the extent to which New York ACOs' financial performance lagged in Year 2. CMS has acknowledged that issues of methodology have affected the performance of ACOs in their second year of the program. A number of these concerns were addressed in CMS's June 2015 update of the MSSP rules,[17] which changed the way attribution is handled, how the MSR is applied, and how prior years' experience is used to update an ACO's benchmark.[18] Noting its continuing desire to have ACOs move from the shared savings program to a two-sided performance-based risk program (in which ACOs share in both savings and losses), CMS has altered its contracting process to allow ACOs to remain in Track 1 (shared savings only) for an additional one to three years.[19] It also developed two new ACO models, in which some of the MSSP program's more problematic aspects have been addressed.

In a notice of proposed rule-making issued in January 2016,[20] CMS proposed to address a number of other design issues facing MSSP ACOs.[21] A number of important issues remain to be resolved for the current MSSP participants, but CMS is clearly open to adjusting the model to enable high-performing ACOs and the MSSP program as a whole to succeed.

Closing Thoughts

The early experience of ACOs in New York is a fascinating story that is still unfolding. In choosing to participate in the MSSP, provider groups across the state have organized themselves differently and invested their own resources in learning a new system of caring for patients and populations.

In this report, we have focused on the CMS-reported measures of costs and quality for New York ACOs participating in the MSSP program. We have attempted to put

[17] Federal Register, June 9, 2015. https://www.gpo.gov/fdsys/pkg/FR-2015-06-09/pdf/2015-14005.pdf

[18] The June 2015 rule changed the way benchmarks are calculated, moving from 10/30/60 percent to equal weights of 33 percent for each year.

[19] In the original rules, an ACO was required, after its initial three-year contract, to move from Track 1 (shared savings, only) to Track 2 (shared savings / shared risk); under the rules finalized in June, 2015, CMS will permit ACOs to remain in Track 1 for an additional contract period (or in some cases, one additional year), following which they would have to move to one of the risk-sharing models.

[20] CMS. January 28, 2016. Proposed Changes to the Medicare Shared Savings Program Regulations (fact sheet). https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-01-28-2.html

[21] Those proposed rules would change ACOs' benchmarks to reflect regional (rather than national) Medicare FFS expenditures; and change the way CMS adjusts benchmarks to reflect the relative complexity of existing, attributed patients and patients served by new providers joining the ACO's Participant List.

those measures in context, and to assess some of the forces and influences that may be related to their variable success.

We now have two data points for 15 of the state's 29 ACOs, reports on their performance on cost and quality in each of their first two performance years. While two points are all that is necessary to draw a line, we are hesitant to extrapolate from this experience, particularly when so many of the key design elements (particularly attribution and benchmarking) are in flux.

However, over the past three years tracking the evolution of ACOs in New York State, we have learned a few things, chief among them that the MSSP is a complicated and idiosyncratic program, and that it takes time for providers to build up the infrastructure—care management, data analytics, quality improvement programs, and information systems—and experience required to produce results.

We have also learned that the mechanics—the way in which accountable care programs are constructed and administered—seem to have an outsized effect on providers' ability to succeed. These are issues that ACOs and Medicare are both grappling with, and they are issues that any New York payer considering accountable care contracts must consider as well.

Across New York State, provider groups—a variety of physician groups and hospitals—are participating in the ACO program. Each is starting from a different place, with a different history, culture, and infrastructure. Their trajectory in the MSSP seems to indicate that the more loosely the ACO is structured, the greater its difficulty in gaining and maintaining the momentum required to succeed.

These observations are relevant to two major initiatives under way in New York: the State's pursuit of value-based payment with all payers, and the Delivery System Reform Incentive Payment Program (DSRIP), New York's Medicaid redesign program.

As part of DSRIP, providers across the state have organized themselves into 25 performing provider systems (PPSs), regionally based organizations composed of a diverse combination of hospitals, physicians and physician groups, providers of behavioral health services, and an array of community-based social service providers. The stated intent of the program is to provide the investment capital required for these organizations to evolve into ACO-like integrated delivery systems, substantially improving their performance in a series of dimensions, including quality and outcomes, and reducing preventable ED visits and hospital admissions.

Most of New York's Medicare ACOs are built on pre-existing provider organizations with a history of working together. Their variable experience in the MSSP demonstrates the difficulty achieving results in the near term, and may serve as a caution to those expecting rapid results from the state's PPSs—most of which are new organizations, just starting to build a common culture and infrastructure, and trust.

In parallel with the DSRIP program, the state is also focused on increasing the proportion of Medicaid's provider payments that are tied to VBP. In both the Medicare and Medicaid programs' plans, shared savings programs (like the MSSP) represent the "floor" for an aggressive move from fee-for-service payment systems to alternative payment methods and VBP. The state's VBP Roadmap—which includes many of the same priorities as CMS's plan for payment reform in the Medicare program—has an aggressive goal: that within five years, 80 percent of all managed care payments would be tied to *at least* a shared savings model, with the intent to move as rapidly as possible to shared risk contracts.

The number of New York State provider groups entering the Medicare ACO program continues to grow. It is clear that providers are getting that message, and beginning to experiment with shared savings as a first step. What is less clear, based on the results to date, is whether all of those efforts will be successful, or how long it will take for them to deliver consistently positive results: increased quality and reduced costs.

While the mechanical elements of the ACO program appear to have a strong influence on outcomes, most analysts and ACO leaders with whom we have spoken feel that the key drivers of success may in fact be those that are less quantifiable and do not show up as well on spreadsheets and bar charts. In their view, succeeding at accountable care takes strong and legitimate leadership; it takes a substantial investment to build a strong infrastructure to support population health improvement; and, perhaps most important, it requires a shared sense of purpose among a heterogeneous mix of providers historically accustomed to going their own way. The ACOs that have those three things are likely to be the ones that succeed at accountable care.

Acknowledgments

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Appendix 1. Medicare ACOs Based in New York State as of January 2016

Joined	Organization	Organizational Model
April 2012	Accountable Care Coalition of Mount Kisco	Group Practice
	Chinese Community ACO	Physician Network
	ACO of the North Country	Physician-Hospital Partnership
	Catholic Medical Partners	Physician-Hospital Partnership
July 2012	ProHEALTH Accountable Care Medical Group	Group Practice
	WESTMED Medical Group, PC	Group Practice
	Beacon Health Partners, LLP	Physician Network
	Mount Sinai Care, LLC	Hospital System
	Asian American Accountable Care Organization	Physician Network
	Balance Accountable Care Network	Physician Network
	Accountable Care Coalition of Syracuse	Group Practice
	Chautauqua Region Medical Partners	Physician-Hospital Partnership
January 2013	NYC HHC ACO, Inc.	Hospital System
January 2014	FamilyHealth ACO	Physician Network
	New York State Elite ACO	Physician Network
	Primary PartnerCare Associates IPA	Physician Network
	Accountable Care Coalition of Greater New York	Physician Network
	Adirondacks ACO	Physician-Hospital Partnership
January 2015	Aledade Primary Care ACO LLC	Physician Network
	Bassett Accountable Care Partners	Hospital System
	Healthcare Partners of the North Country	Physician-Hospital Partnership
	Innovative Health Alliance of NY	Physician-Hospital Partnership
	New York Quality Care	Physician-Hospital Partnership
	Richmond Quality, Inc.	Physician-Hospital Partnership
January 2016	Cayuga Area Preferred	Physician-Hospital Partnership
	Empire State Health Partners, LLC	Physician Network
	Hudson Accountable Care, LLC	Physician Network
	North Shore-LIJ MSSP ACO, LLC	Physician-Hospital Partnership
	St. Joseph's Health ACO	Physician-Hospital Partnership

Organizations No Longer Participating in the MSSP

Joined	Organization	Organizational Model
April 2012	Crystal Run Healthcare ACO, LLC	Group Practice
July 2012	Healthcare Provider ACO, Inc.	Physician Network
January 2014	Rochester General Health System ACO	Physician-Hospital Partnership

Appendix 2. Results of New York MSSP Participants in Year 1 and Year 2

New York MSSP ACOs, Year 1 (Year 2 is on next page)

ACO	Total Assigned Beneficiaries	Benchmark Expenditures	Actual Expenditures	Generated Savings	Savings as % of Benchmark	Shared Savings
Catholic Medical Partners	33,253	$397,492,202	$369,569,629	**$27,922,572**	7.%	$13,682,060
ProHEALTH	28,651	$358,236,161	$336,322,174	**$21,913,987**	6.1%	$10,737,854
HHC ACO	12,369	$107,675,574	$100,247,480	**$7,428,094**	6.9%	$3,639,766
Subtotal: ACOs that Earned Shared Savings	*74,273*	*$863,403,937*	*$806,139,283*	***$57,264,653***	*6.63%*	*$28,059,680*
Healthcare Provider	29,313	$498,653,673	$487,171,239	**$11,482,434**	2.3%	-
CCACO	13,833	$192,513,845	$189,064,665	**$3,449,181**	1.8%	-
Beacon	16,790	$204,068,192	$201,059,123	**$3,009,069**	1.5%	-
Asian American ACO	14,769	$161,975,470	$160,113,015	**$1,862,456**	1.1%	-
Crystal Run	12,941	$208,622,533	$207,666,072	**$956,461**	.5%	-
Subtotal: ACOs that Saved vs. Benchmark, but <MSR	*87,646*	*$1,265,833,713*	*$1,245,074,114*	***$20,759,601***	*1.64%*	-
Mount Sinai	25,042	$353,393,023	$354,901,324	**($1,508,302)**	-.4%	-
WESTMED	14,082	$160,881,833	$162,429,210	**($1,547,377)**	-1.%	-
ACC - Syracuse	14,057	$133,047,092	$135,514,524	**($2,467,432)**	-1.9%	-
Chautauqua	7,884	$92,247,040	$95,229,434	**($2,982,394)**	-3.2%	-
ACC North Country	5,879	$69,726,454	$74,474,537	**($4,748,083)**	-6.8%	-
ACC Mount Kisco	16,326	$189,431,358	$200,210,762	**($10,779,404)**	-5.7%	-
Balance ACO	10,459	$208,786,843	$234,259,597	**($25,472,755)**	-12.2%	-
Subtotal: ACOS that Did Not Save vs. Benchmark	*93,729*	*$1,207,513,643*	*$1,257,019,388*	***($49,505,747)***	*-4.1%*	-
New York State Total	**255,648**	**$3,336,751,293**	**$3,308,232,785**	**$28,518,507**	**0.85%**	**$28,059,680**

Source: *Medicare Shared Savings Program Accountable Care Organizations Performance Year 1 Results*, https://data.cms.gov/ACO/Medicare-Shared-Savings-Program-Accountable-Care-O/yuq5-65xt

New York MSSP ACOs, Year 2

ACO	Total Assigned Beneficiaries	Benchmark Expenditures	Actual Expenditures	Generated Savings	Savings as % of Benchmark	Shared Savings
ProHEALTH	28,825	$275,715,167	$258,561,947	**$17,153,220**	6.2%	$8,019,532
WESTMED	12,273	$108,348,393	$101,126,474	**$7,221,919**	6.7%	$3,266,226
HHC	13,294	$117,275,057	$110,153,040	**$7,122,016**	6.1%	$2,644,605
Chautauqua	6,816	$61,704,178	$57,734,542	**$3,969,635**	6.4%	$1,794,027
Subtotal: ACOs that Earned Shared Savings	*61,208*	*$563,042,795*	*$527,576,003*	***$35,466,790***	*6.3%*	*$15,724,390*
Healthcare Provider ACO	27,791	$414,704,079	$404,975,183	**$9,728,896**	2.4%	-
CCACO	11,219	$106,387,253	$104,891,827	**$1,495,426**	1.4%	-
Mount Sinai Care	33,825	$383,882,561	$382,994,067	**$888,494**	0.2%	-
Primary PartnerCare Associates IPA	6,347	$79,296,747	$78,919,174	**$377,572**	0.5%	-
FamilyHealth ACO	3,618	$32,299,760	$31,949,885	**$349,875**	1.1%	-
Subtotal: ACOs that Saved vs. Benchmark, but <MSR	*82,800*	*$1,016,570,400*	*$1,003,730,136*	***$12,840,263***	*1.3%*	-
Asian American ACO	12,997	$111,072,169	$111,609,979	**($537,811)**	-0.5%	-
ACC of Syracuse	12,729	$93,080,190	$93,682,872	**($602,683)**	-0.7%	-
New York State Elite ACO	5,620	$103,142,602	$104,173,901	**($1,031,299)**	-1.0%	-
Accountable Care Coalition of Greater New York	6,353	$48,347,207	$49,705,909	**($1,358,702)**	-2.8%	-
Catholic Medical Partners	25,614	$197,196,601	$199,387,211	**($2,190,609)**	-1.1%	-
Adirondacks ACO	27,412	$241,068,567	$243,472,685	**($2,404,118)**	-1.0%	-
ACO of the North Country	5,061	$40,259,112	$42,945,557	**($2,686,445)**	-6.7%	-
Crystal Run Healthcare ACO	12,201	$138,881,297	$142,233,699	**($3,352,402)**	-2.4%	-
Beacon Health Partners	15,474	$150,687,172	$154,784,874	**($4,097,701)**	-2.7%	-
Rochester Regional ACO	11,844	$101,018,304	$105,719,054	**($4,700,749)**	-4.7%	-
ACC of Mount Kisco	14,481	$117,547,029	$126,202,612	**($8,655,583)**	-7.4%	-
Balance ACO	8,165	$146,995,248	$162,017,792	**($15,022,545)**	-10.2%	-
Subtotal: ACOS that Did Not Save vs. Benchmark	*157,951*	*$1,489,295,498*	*$1,535,936,145*	***($46,640,647)***	*-3.1%*	-
New York State Total	**301,959**	**$3,068,908,693**	**$3,067,242,284**	**$1,666,406**	**0.05%**	**$15,724,390**

Source: *Medicare Shared Savings Program Accountable Care Organizations Performance Year 2014 Results,* https://data.cms.gov/dataset/Medicare-Shared-Savings-Program-Accountable-Care-O/ucce-hhpu

Appendix 3. New York MSSP Quality Scores Compared to National Average

Categories for which New York's average was worse than the national average are shaded yellow.

Category / Score Code		National Avg. Score	New York Avg. Score	Difference in Performance
Patient / Caregiver Experience				
ACO 1	Getting timely care, appointments, and information	80.13	79.56	-0.57
ACO 2	How well your doctors communicate	92.39	92.34	-0.04
ACO 4	Access to specialists	83.97	83.05	-0.92
ACO 3	Patients rating of doctor	91.58	91.74	+0.16
ACO 5	Health promotion and education	58.29	59.62	+1.33
ACO 6	Shared decision-making	74.60	74.75	+0.15
ACO 7	Health status/functional status	71.10	71.36	+0.27
Care Coordination / Patient Safety				
ACO 8	Risk standardized, all condition readmissions	15.15	15.59	+0.44
ACO 9	ASC admissions: COPD or asthma in older adults*	1.08	1.13	-0.05
ACO 10	ASC admission: heart failure*	1.19	1.07	+0.11
ACO 11	Percent of PCPs who qualified for EHR incentive payment	76.71	66.71	-10.01
ACO 12	Medication reconciliation	83.55	85.80	+2.25
ACO 13	Falls: screening for fall risk	45.67	50.75	+5.08
Preventive Health				
ACO 14	Influenza immunization	57.74	66.32	+8.58
ACO 15	Pneumococcal immunization	55.22	61.33	+6.11
ACO 16	Adult weight screening and follow up	67.01	71.67	+4.66
ACO 17	Tobacco use assessment and cessation	87.04	88.75	+1.72
ACO 18	Depression screening	39.37	50.89	+11.52
ACO 19	Colorectal cancer screening	56.16	61.75	+5.58
ACO 20	Mammography screening	61.42	63.24	+1.82
ACO 21	Proportion of adults who had blood pressure screened in last two years	60.36	65.74	+5.38
At-Risk Population				
DM Composite	Diabetes: composite score (ACO #22–26)	25.36	29.63	+4.27
ACO 22	Diabetes: hemoglobin A1c control (HbA1c) (<8 percent)	69.33	70.69	+1.36
ACO 23	Diabetes: Low density lipoprotein (LDL) (<100 mg/dL)	56.53	59.92	+3.39
ACO 24	Diabetes: blood pressure (BP) <140/90	69.51	72.28	+2.76
ACO 25	Diabetes: tobacco non-use	75.29	75.51	+0.22
ACO 26	Diabetes: aspirin use	80.42	82.20	+1.79
ACO 27	Diabetes: percent of beneficiaries with diabetes whose HbA1c in poor control (>9 percent)*	20.32	19.40	+0.92
ACO 28	Hypertension: percent of beneficiaries with hypertension whose BP <140/90	67.96	71.12	+3.16
ACO 29	IVD: percent of beneficiaries with IVD with complete lipid profile and LDL	57.29	61.27	+3.98
ACO 30	IVD: Percent of beneficiaries with IVD who use aspirin or other antithrombotic	80.84	82.32	+1.48
ACO 31	HF: beta-blocker therapy for LVSD	84.32	81.78	-2.54
CAD Composite	CAD: composite score (ACO #32–33)	66.90	72.50	+5.60
ACO 32	CAD: drug therapy for lowering LDL cholesterol	74.23	79.14	+4.92
ACO 33	CAD: ACE Inhibitor or ARB therapy for patients with CAD and diabetes and/or LVSD	75.25	76.96	+1.71

*In most of the measures listed, a higher score indicates better performance; the three exceptions are indicated with asterisks.