Accountable Care Organizations:

Past, Present, and Future

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Executive Summary

THE FORMATION AND IMPLEMENTATION OF ACCOUNTABLE Care Organizations (ACOs) includes the development of both value-based care (VBC) capabilities and new value-based payment (VBP) arrangements.

ACOs are designed with the goal of taking responsibility for the health status, quality of care, patient satisfaction, and costs for a defined population. Many ACOs, through agreements with both governmental and private payers, have been able to demonstrate sizable and meaningful improvement in attaining these goals since the inception and diaspora of the model.

The movement toward VBC and VBP by payers and providers has continued to grow. The drivers of this growth are multi-faceted and include:

- Bipartisan agreement on policy
- Historical success of ACOs and bundled payment programs saving Medicare hundreds of millions of dollars and improving quality metrics
- Implementation of the Medicare Access and CHIP Reauthorization Act (MACRA)/Quality Payment Program (QPP)
- Adoption of these value-based principles by state Medicaid programs
- Desire and strategy of commercial health plans and large employers to shift risk to providers

The approach to these new models has continued to evolve from one-sided or "shared savings" risk arrangements to two-sided risk arrangements with limited downside risk or the downside risk with guard rails. About 15–20 percent of VBP arrangements now include some form of downside risk, although most include a mechanism to cap the exposure to excessive losses. The Centers for Medicare & Medicaid Services (CMS) has led this movement through the implementation of the Pioneer ACO, Medicare Shared Savings Program (MSSP) and the Next Generation ACO (NGACO) models.

A further reason for continued movement to risk-based models is the dynamic that healthcare purchasers, both the government and employers, desire to shift risk to providers as an incentive to manage cost, improve quality and satisfaction, and improve health, as well as to develop a more predictable approach to healthcare expenditures. Specifically, the long-term goal is to shift payments to providers to a per-capita basis, as this model will increase predictability of costs and incentivize providers to purse the Triple Aim™ of improved quality, reduced costs, and improved beneficiary experience.

This white paper provides a background on the ACO model and discusses the experience of Medicare, Medicaid, and commercial payers in implementing the model, lessons learned, expectations for the future of the ACO model, and implications for governing bodies.

Overview of the ACO Model

ACOs are designed to facilitate improvement of healthcare quality, reduce growth in costs, and enhance patients' experience of care, while improving provider satisfaction. CMS defines ACOs as:

> "Groups of doctors, hospitals, and other healthcare providers, who come together voluntarily to give coordinated, high-quality care to their patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors."[1]

This model has been applied across numerous payers/population types, including Medicare, Medicaid, commercial payers, direct-to-employer agreements and with the under-insured and uninsured population. The ACO model is not entirely new and has been tested by various payers and healthcare providers over the past 15 years. Medicare played a leading role in the development and iteration of the model. Payment models for ACOs (described in more detail in the complete white paper) include shared savings under fee-for-service, pay-for-performance, and one-sided and two-sided risk with caps on savings and losses. Providers must adhere to quality and cost thresholds based on a set of metrics established up front.

Lessons Learned over the Past 15 Years

The movement to value-based payment models, particularly ACOs, requires a shift in the delivery of care, as well as a shift in the culture of most healthcare providers. The cultural change of moving from acute episodic care to managing a population every day is challenging and difficult. Since the inception of these models, ACOs have met with varying degrees of success. The following characteristics are common among ACOs that are successful in improving quality, reducing costs, and improving the experience of care for the population they are serving:

- Engaging effective physician leadership
- Utilizing an Advanced Primary Care model (APC)
- Enhancing utilization of population health information technology
- Providing care management
- Managing post-acute utilization

A final lesson learned is the benefit of leveraging an ACO as an integration vehicle to work across the continuum. Some non-traditional partners, and even competitors, are experimenting with using an ACO model to work together to manage populations across a broad geography. Moreover, many ACOs include participation from federally qualified health clinics (FQHCs), critical access hospital (CAHs), and other rural providers to ensure that the ACO has adequate coverage and access options to manage the population in rural and urban areas.

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1 See www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/.

The Future of Accountable Care

As more ACOs are required to move to two-sided risk, there is a potential that CMS will continue to iterate and develop alternative models in an effort to meet providers "where they are" in relation to a readiness to assume two-sided risk. This evolution could include models with more limited risk such as a primary care capitation model, models with greater amounts of risk, or tiered models that assume more or less risk for specific portions of the population that is being served. Regardless of the evolution, ACOs should use the first six years of their agreement in a one-sided model to prepare for risk through development of infrastructure, tools, expertise in key capabilities, and resources. It is clear that there will be continued movement by all payers, not just CMS, to require providers to implement value-based care models and to assume more risk in the future.

Impact on the Role of Governance

Hospitals, health systems, medical groups, and other organizations that have developed ACOs, clinically integrated networks, and other affiliations and partnerships are finding that the role of governance and oversight of these entities is now and will continue to become much more complex. This is especially true in cases where there is some form of joint venture involved with other partners. A key governance question is to whom are the boards of sponsored ACOs ultimately accountable? The governing bodies of sponsoring organizations will need to pay close attention in the future to the reporting relationships and degree of control that should be exercised with the entities. ACO boards require expertise in non-traditional areas such as post-acute care, health plan leadership, Medicare beneficiaries, etc.

Several health systems with which we are familiar have been careful about who they appoint as their representatives to their ACO governing boards. They have taken care to have representatives of their ACO provide at least semi-annual reports to the hospital or health system board regarding the entity's performance relative to the ACO's goals, performance metrics, and results versus the purposes originally identified for creating the ACO. Care is also taken to monitor that the ACO's performance and practices are consistent in areas such as quality and utilization and remain aligned with the health system's mission and values.

Governing bodies of ACOs themselves must take care to reinforce to their directors their roles and responsibilities to the organization itself, and relative to sponsoring organizations. Issues of confidentiality and fiduciary responsibility are paramount. This also includes discerning what information can be appropriately shared with sponsoring organizations, as well as among partners if the ACO is a joint venture with multiple parties. Furthermore, health system boards and their ACO boards should be working together to expand system integration of quality and cost improvements across other areas of the health system beyond the ACO.

Just as hospital and health system boards are generally vigilant to ensure that their board members receive ongoing education, training, and development, so too should ACOs consider to what degree their board members need ongoing board development activities and opportunities. Best practices in governance should be used as standards to assess individual and collective board performance and effectiveness as well as benchmarking the ACOs performance against top performers across the industry.

As ACOs grow in their influence and importance to healthcare providers of every type and at all levels, the role of governance will be an essential component of whether these organizations can be sustainable and successfully achieve their goals and purposes. Good governance practices must be understood, developed, and monitored to ensure appropriate accountability and oversight, especially by those who have ultimate fiduciary responsibilities for the entity.

Discussion Questions for Boards and Executives:

1. Where are we on the journey or transition to value-based care? Are we where we want to be or should we be further along? Where are we compared to our competitors in our market? How does our position relative to our competitors affect our ability to continue the transition to value-based care?
2. What are our goals regarding value-based care and population health? Are these realistic goals? Do they stretch us enough to get us where we want to be, or should we be changing our goals?
3. What capabilities do we need to implement or improve upon in order to move further towards reaching our value goals?
4. Are we ready to take on risk-based payment models? What factors should we be considering in order to determine our readiness to take on risk?
5. Is our governance structure for our ACO or clinically integrated network sufficient? What improvements can we make in regards to the reporting relationship and communication between the ACO board and the health system/owner entity board? Do we have the right skills and expertise on the ACO board?
6. Clinical integration is a key factor in building a successful ACO model. What is our relationship with our physicians? What problems need to be addressed? How strong are our relationships with our employed physicians vs. independent physicians, and how is that affecting physician performance? Do we have the physician leadership necessary to change physician behavior and decision-making?
7. Does our organization have the right culture and mindset to deliver value-based care? If not, what needs to change and how?
8. Who are our partners in delivering value-based care? What partnerships do we need to take on in order to do this better (such as post-acute care, home health, other care provider organizations that require collaboration and coordination across the care continuum)?
9. How can we take the lessons learned and successes from changing care delivery to the ACO patients and disseminate that across all patients served?
10. What is our strategy for increasing our percentage of (and how much to increase) value-based payment contracts over the next five to 10 years?

Introduction

The formation and implementation of Accountable Care Organizations (ACOs) includes the development of both value-based care (VBC) capabilities and new value-based payment (VBP) arrangements. ACOs are designed with the goal of taking responsibility for the health status, quality of care, patient satisfaction, and costs for a defined population.

MANY ACOS, THROUGH AGREEMENTS WITH BOTH GOVERNmental and private payers, have been able to demonstrate sizable and meaningful improvement in attaining these goals since the inception and diaspora of the model.

The movement toward VBC and VBP by payers and providers has continued to grow. The drivers of this growth are multi-faceted and include:

- Bipartisan agreement on policy
- Historical success of ACOs and bundled payment programs saving Medicare hundreds of millions of dollars and improving quality metrics
- Implementation of the Medicare Access and CHIP Reauthorization Act (MACRA)/Quality Payment Program (QPP)
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The approach to these new models has continued to evolve from one-sided or "shared savings" risk arrangements to two-sided risk arrangements with limited downside risk or the downside risk with guard rails. About 15-20 percent of VBP arrangements now include some form of downside risk, although most include a mechanism to cap the exposure to excessive losses. The Centers for Medicare & Medicaid Services (CMS) has led this movement through the implementation of the Pioneer ACO, Medicare Shared Savings Program (MSSP) and the Next Generation ACO (NGACO) models; 17 percent of the Medicare ACOs in 2018 now involve downside risk.

About 20 percent of value-based payment arrangements now include some form of downside risk, and this continues to increase.

Another aspect that will drive an increase in the number of VBP arrangements including two-sided risk is the incentives contained in the QPP Advanced Alterative Payment Model (AAPM) track. The AAPM provides qualified providers with a 5 percent bonus payment based on their Medicare fee-for-service Part B payments.

A further reason for continued movement to risk-based models is the dynamic that healthcare purchasers, both the government and employers, desire to shift risk to providers as an incentive to manage cost, improve quality and satisfaction, and improve health, as well as to develop a more predictable approach to healthcare expenditures. Specifically, the long-term goal is to shift payments to providers to a per-capita basis, as this model will increase predictability of costs and incentivize providers to purse the Triple Aim™ of improved quality, reduced costs, and improved beneficiary experience.

The adoption of VBP arrangements must be coordinated with the development and implementation of VBC capabilities. These new VBP arrangements usually begin with a pay-for-performance model that includes financial rewards for attaining quality and satisfaction metrics. The more advanced models include a one-sided risk arrangement that usually includes a shared savings component with commercial payers, Medicare Advantage plans, or Medicare (Medicare Shared Savings Track 1). The one-sided risk model usually includes a financial target either based on per capita costs, the cost growth trend, or the Medical Loss Ratio and the attainment of quality and satisfaction metrics (such as patient satisfaction, readmission rates, and clinical metrics such as the attainment of a targeted Hemoglobin A1-c for Diabetics). The two-sided risk model for commercial, Medicare Advantage, and Medicare Shared Savings (MSSP Tracks 1+, 2, and 3, and the NGACO model) includes downside risk for the delivery system if it does not meet the targeted expense amount. The MSSP Track 1+ has the most limited amount of downside risk for delivery systems.

As noted, about 15-20 percent of these VBP arrangements are in two-sided risk, but there is steady growth in the movement to two-sided risk arrangements in many areas of the country. This white paper provides a background on the ACO model and discusses the experience of Medicare, Medicaid, and commercial payers in implementing the model, lessons learned, expectations for the future of the ACO model, and implications for governing bodies.

Overview of the ACO Model

ACOS ARE DESIGNED TO FACILITATE IMPROVEMENT OF healthcare quality, reduce growth in costs, and enhance patients' experience of care, while improving provider satisfaction. CMS defines ACOs as:

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This model has been applied across numerous payers/population types, including Medicare, Medicaid, commercial payers, direct-to-employer agreements, and with the under-insured and uninsured population. While the approaches may differ based on payers, Premier Inc.'s Population Health team has identified the following core capabilities that facilitate success under ACO models:

Person-centered foundation: This capability is reflective of the need for designing all aspects of an ACO through a person-centric perspective. The goal is to drive greater understanding, ownership, and accountability for one's own health through greater engagement, activation, and consideration of specific circumstances, as well as greater participation and inclusion of family and caregivers.

Advanced Primary Care Model (APC): Greater utilization and integration with primary care is a critical component for successful ACOs. The APC model includes offering expanded access, same day scheduling, and utilization of a multi-disciplinary care team to provide care coordination and to serve as the medical home for patients.[3]

High-value network: The development and utilization of a network of high-value professionals and providers across the continuum of care who are integrated with the ACO and aligned in the goal of delivering value based on the Triple Aim™ metrics. This includes primary care clinicians, specialists, hospitals, and post-acute providers.

Population health information technology (PHIT): Leveraging vast amounts of claims and other data and creating actionable information is a critical component for ACOs. PHIT includes more than just electronic health records, encompassing the ability for predictive modeling, risk stratification, and alternative approaches for engaging and enabling beneficiaries through patient portals. Moreover, there needs to be a mechanism for interoperability across the continuum to share data and manage beneficiaries.

Leveraging vast amounts of claims and other data and creating actionable information is a critical component. Population health IT includes more than just electronic health records, encompassing the ability for predictive modeling, risk stratification, and alternative approaches for engaging and enabling beneficiaries through patient portals. There needs to be a mechanism for interoperability across the continuum to share data and manage beneficiaries.

Governance and operations: In order to be successful, the ACO should include an effective partnership between administrators and clinicians. Moreover, the transformation to a population health strategy generally necessitates a shift in culture and mindset. Positive support from the leadership of the organization assists with the facilitation of buy-in and ownership by participants of the ACO related to the clinical, administrative, and cultural change required for success. It is critical to have effective physician leadership and engaged physicians to successfully implement the transformation to value-based care.

Payer partnerships: The final capability is the ability to identify and engage payer partners willing to reward providers and the ACO for the attainment of metrics that demonstrated enhanced value, as well as provide the comprehensive and timely claims data and tools to facilitate success. ACOs can implement population health capabilities in seven segments, including: Medicare fee-for-service, Medicare Advantage, Medicaid, commercial, direct-to-employers, employees, and the under- and uninsured.[4]

2 See www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/.

3 Advanced primary care is based on principles of the Patient-Centered Medical Home and builds on the care delivery models employed in other CMS model tests, including the Comprehensive Primary Care Initiative. See https://innovation.cms.gov/initiatives/Advanced-Primary-Care/ for more information.

4 J. Damore and B. Gray, "Six Target Markets for ACO-Type Partnerships," *HFMA Journal,* April 25, 2011.

Overview of CMS ACO Programs and Demonstrations

The ACO model is not entirely new and has been tested by various payers and healthcare providers over the past 15 years. Medicare played a leading role in the development and iteration of the model. The sections below provide an overview of these various demonstration projects and outlines how the model has evolved over time.

Physician Group Practice (PGP) Demonstration and the Physician Group Practice Transitional Demonstration (PGPTD) Projects

Mandated by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, the PGP was designed as the first physician pay-for-performance program under the leadership of President G. W. Bush's Administration. The goal of the program was to better coordinate healthcare through increased investment in administrative structures and processes for more efficient delivery of care. To this end, participants were eligible to receive incentive payments ("shared savings") for improvements in quality and cost efficiency at the physician group practice level. The first iteration of the program started in 2005 and operated for five years. The program was further extended for two additional years through the PGP Transitional Demonstration.

Programmatic Design Elements

In PGP, participants continued to be reimbursed through the FFS system, but received incentive payments for achievements in quality and cost. CMS identified the key design elements of the program as "identifying PGP patients, determining whether there were any changes in the efficiency and quality of care, and assessing whether those changes were due to the incentive payments."[5] This approach has been utilized in all the subsequent ACO models.

Specifically, CMS assigned beneficiaries to a PGP annually, based on if the beneficiary received more evaluation and management (E&M) services from the PGP than from other providers. PGPTD participants were able to select from two assignment methodologies:

- A two-step process that first assigns patients based on certain primary care services (E&M codes) from primary care physicians, and then utilizes visits to specialists for those beneficiaries who did not receive services from primary care physicians, or
- A plurality of office and other outpatient service E&M codes regardless of specialty.[6]

Based on the patient's attribution to a primary care provider, CMS developed a target expenditure, and if the PGP's actual per capita Medicare expenditures were lower and surpassed a 2 percent band/corridor (Minimum Savings Rate), they were eligible to receive an incentive payment of up to 80 percent of the gross savings.

In addition to the financial performance, PGPs were measured on 32 quality metrics. These metrics covered multiple conditions and treatments, including diabetes, congestive heart failure, coronary artery disease, hypertension, and preventive care. The measures were reported through two mechanisms: claims-based (seven quality measures) and medical records-based (25 measures). Performance was measured against threshold and improvement targets.

Program Participation

Ten PGPs participated in the initial phase of the demonstration. Six of the initial PGPs continued with the PGPTD, while three moved to the Pioneer ACO Model (see the section below). Below is a list of participants in this inaugural ACO model:

- Billings Clinic (PGP and PGPTD participant)
- Dartmouth-Hitchcock Clinic (PGP and ACO Pioneer)
- Everett Clinic
- Forsyth Medical Group (PGP and PGPTD participant)
- Geisinger Clinic (PGP and PGPTD participant)
- Marshfield Clinic (PGP and PGPTD participant)
- Middlesex Health System (PGP and PGPTD participant)
- Park Nicollet Health Services (PGP and ACO Pioneer)
- St. John's Health System (PGP and PGPTD participant)
- University of Michigan (PGP and ACO Pioneer)

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5 J. Kautter, Ph.D., et al., *Evaluation of the Medicare Physician Group Practice Demonstration* (Final Report), prepared for CMS and CMMI, September 2012. Available at: https://downloads.cms.gov/files/cmmi/medicare-demonstration/PhysicianGroupPracticeFinalReport.pdf.

6 CMS, "Physician Group Practice Transition Demonstration" (fact sheet), August 2012. Available at: https://innovation.cms.gov/Files/fact-sheet/PGP-TD-Fact-Sheet.pdf.

Program Results

PGP and PGPTD were largely successful demonstration projects. CMS realized a gross savings of $152.8 million over the five years of the PGP, with a net savings of $137.8 million. CMS distributed $107.6 million to PGPs as incentive payments. This equates to an annual gross saving on a per beneficiary basis of $143.18. Over the duration of the program, the number of PGPs earning performance payments increased (see list below). Two PGPs earned payments in all five years of the program. With that said, financial performance varied across the participants, with the extreme of a PGP averaging $818 per person savings, and another saw savings of only $323 per person per year:[7]

- PY1 – 2 PGPs earned over $7.3 million
- PY2 – 4 PGPs earned over $13.8 million
- PY3 – 5 PGPs earned over $25.2 million
- PY4 – 5 PGPs earned over $31.6 million
- PY5 – 4 PGPs earned over $29.4 million

In addition to financial improvement, PGPs displayed consistent improvement on the 32 quality measures. Throughout the program, all PGPs achieved improvements in their scores for most of the measures. To illustrate this point, in PY1, the 10 PGPs achieved an average of 90 percent of possible points, but by PY5, all 10 achieved an average of 99 percent of points. Further, by PY5, seven PGPs met all 32 of the measure targets, and the remaining three met over 90 percent of their targets.[8]

Patient Protection and Affordable Care Act (ACA)

Passed by the 111th U.S. Congress and signed by President Barack Obama on March 23, 2010, the ACA endeavored to further leverage delivery system reform models, such as ACOs, to make healthcare—Medicare specifically—more sustainable and to continue the shift to value-based care and payment models. During the debates in Congress that led to the development of the ACA, there was a broad belief that the ACO model posed significant potential to improve quality, reduce costs, and enhance patient experience. To facilitate greater dispersion of participation in ACO model, the legislation created the Medicare Shared Savings Program (MSSP), which built on the experience of PGP.

In addition, the ACA created the Center for Medicare & Medicaid Innovation (CMMI), which has broad authority to test and scale innovative payment and delivery system models that show promise for maintaining or improving quality of care, while slowing the rate of growth in program expenditures.[9] One of the initial programs tested by CMMI was the Pioneer ACO model, which subsequently led to the Next Generation ACO model. Below we will explore the various ACO programs and demonstration projects tested by CMS and CMMI over the past six years to experiment with and implement strategies to contain cost and improve quality in FFS Medicare.

Pioneer ACO/Medicare Shared Savings Program (MSSP)/Next Generation ACO Model (NGACO)

Beginning in 2012, the Pioneer ACO model was designed as a transition program for PGP participants, as well as for organizations and providers already experienced in managing the health of a population. The goal of the program was to provide a glide path for ACOs to move rapidly from a two-sided risk, shared savings model to population-based payments. The design of the program was similar to many of the elements included in the PGP, as well as the new MSSP model. Moreover, the design incorporated an all-payer component, which worked to align incentives with private payers to improve quality and health outcomes, while achieving cost savings for Medicare, employers, and patients.[10] The program ended on December 31, 2017 and was replaced by the NGACO.

As outlined above, in parallel to the development of the ACO Pioneer program, the ACA required CMS to create the MSSP. This model was designed for organizations with less experience in managing populations and less willingness to immediately assume two-sided risk. The model has evolved to include four tracks from which ACOs can select for participation.

Programmatic Design Elements

As noted above, the ACO Pioneer Model was designed to facilitate a more rapid movement by ACOs from FFS to population-based payments. To this end, the program initially closely resembled PGP in that providers continue to be paid FFS, and potentially receive a shared savings payment for reducing costs below an expected expenditure amount; however, different than PGP, the model also included a potential for ACOs to pay CMS back for overspending the benchmark. Because of the nature of two-sided risk, CMS decided to include a requirement that participants be prospectively aligned with at least 15,000 beneficiaries (5,000 for rural ACOs). Participating ACOs were able to select from five risk sharing options, outlined in **Table 1**.[11]

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7 M. Evans, "Medicare ACOs Can Learn Lessons from Earlier Demo Project," *Modern Healthcare,* August 26, 2014.

8 Kautter, 2012.

9 S. Guterman, K. Davis, K. Stremikis, and H. Drake, "Innovation in Medicare and Medicaid Will Be Central to Health Reform's Success," *Health Affairs,* Vol. 29, No. 6, June 2010.

10 CMS, "Pioneer ACO Model" (Web page), available at https://innovation.cms.gov/initiatives/Pioneer-aco-model/.

11 L&M Policy Research, LLC, *Evaluation of CMMI Accountable Care Organization Initiatives* (Pioneer ACO Final Report), prepared for CMMI, December 2016. Available at https://innovation.cms.gov/Files/reports/pioneeraco-finalevalrpt.pdf.

Table 1. Pioneer ACO Payment Arrangements

PY	Pioneer Core	Core Option A	Core Option B	Pioneer Alt. 1	Pioneer Alt. 2
PY1	60% 2-sided 5-10% sharing/loss cap 1–2% MSR	50% 2-sided 5% sharing/loss cap 1–2% MSR	70% 2-sided 5–15% sharing/ loss cap 1–2% MSR	50% 1-sided 5% sharing cap 2–2.7% MSR (depending on the number of aligned beneficiaries)	60% 2-sided 5–10% sharing/loss cap 1–2% MSR
PY2	70% 2-sided 5–15% sharing/loss cap 1–2% MSR	60% 2-sided 5–10% sharing/loss cap 1–2% MSR	75% 2-sided 5–15% sharing/ loss cap 1–2% MSR	70% 2-sided 5–15% sharing/loss cap 1–2% MSR	70% 2-sided 5–15% sharing/loss cap 1–2% MSR
PY3	Population-based payment=0–50% of ACOs expected part A & B revenue Risk: 70% 2-sided, 5–15% sharing/loss cap, 1–2% MSR	Population-based payment=0–50% of ACOs expected part A & B revenue Risk: 70% 2-sided, 5–15% sharing/loss cap, 1–2% MSR	Population-based payment=0–50% of ACOs expected part A & B revenue Risk: 75% 2-sided, 5–15% sharing/loss cap, 1–2% MSR	Population-based payment=0–100% of ACOs own expected part A & B revenue, less 3% discount Risk: Full risk for all Part B with a discount of 3–6% (depending on quality scores) and shared risk for Part A (70% sharing rate, 5–15% sharing/loss cap.)	Population-based payment=0–100% of ACOs own expected part A & B revenue, less 3% discount Risk: Full risk for all Part B with a discount of 3–6% (depending on quality scores)
PY4	Same as PY3. Rebase using 2011, 2012, 2013	Same as PY3. Rebase using 2011, 2012, 2013	Same as PY3. Rebase using 2011, 2012, 2013	Same as PY3. Rebase using 2011, 2012, 2013	Same as PY3. Rebase using 2011, 2012, 2013
PY5	Same as PY4	Same as PY5	Same as PY6	Same as PY7	Same as PY8

The MSSP provides a lower-risk alternative for ACOs to gain experience with managing a population. As noted above, the program currently offers four tracks: Track 1, Track 1+, Track 2, and Track 3. CMS has stated a goal of using the model to move providers into risk-based models. To that end, there is a limit on two, three-year agreement periods that an ACO can participate in a one-sided model, before being forced to join a two-sided risk track if the ACO wishes to continue in the model. In addition to these models, CMMI is testing the NGACO. The NGACO is a continuation of the Pioneer program and is designed for more experienced ACOs interested in taking on greater amounts of risk. **Table 2** provides an overview of the four tracks.

Table 2. Medicare MSSP ACO Tracks

	MSSP Tracks 1 & 2	MSSP Track 3	Medicare ACO Track 1 Plus	Next Generation ACO
Shared savings/losses	Track 1: up to 50% Track 2: 60% Loss rate: 40% min, 60% max	Up to 75% Loss rate: 40% min, 75% max	Savings – 50% Losses – 30%	80-85% or 100% 2 risk arrangement options
Minimum Savings Rate	Track 1: variable based on size of attributed population Track 2: Choice of no MSR/MLR, 0.5 increments between 0.5 and 2.0 (symmetrical), or variable by size (2-3.9%)	Same as Track 2	Same as MSSP Track 1	Discount based on -3% standard, quality performance, and performance in comparison to national and regional trend
Caps on savings and losses	Track 1: Savings – 10% benchmark Losses – N/A Track 2: Savings – 15% of benchmark Losses - 5% in year 1, 7.5% in year 2, and 10% in year 3	Savings – 20% of benchmark Losses – 15% of benchmark	4% of benchmark	Savings – 15% of benchmark Losses – 15% of benchmark
Benchmark	• Set at the beginning of the ACO performance period • Trended based on per-capita FFS spending growth in four beneficiary categories; adjusted for national growth in per-capita spending • Risk adjustment using CMS-HCC model, cannot increase for continuously aligned beneficiaries, but can increase with addition of newly aligned beneficiaries • **Blend** national trend factor with regional trend factors for second and subsequent agreements		Same as MSSP Track 1	• Prospective (benchmark set at start of performance year) • Regional projected trend • Benchmark includes a discount that incorporates quality and efficiency adjustments and rewards both attainment and improvement • Risk adjustment using the CMS-HCC model with a 3% cap on average increases or decreases

To ensure that Medicare ACOs are pursing the Triple Aim, CMS requires annual reporting of quality and satisfaction metrics. Both the MSSP and NGACO utilize the same quality measures with the exception of one measure, focused on utilization of certified electronic health record technology. Currently, MSSP ACOs are subject to 31 metrics and NGACOs are subject to 30 measures that focus on four categories: patient/caregiver experience, at-risk populations, care coordination/patient safety, and preventive health. An ACO's performance on these measures impacts the amount of shared savings/losses it is able to recognize.

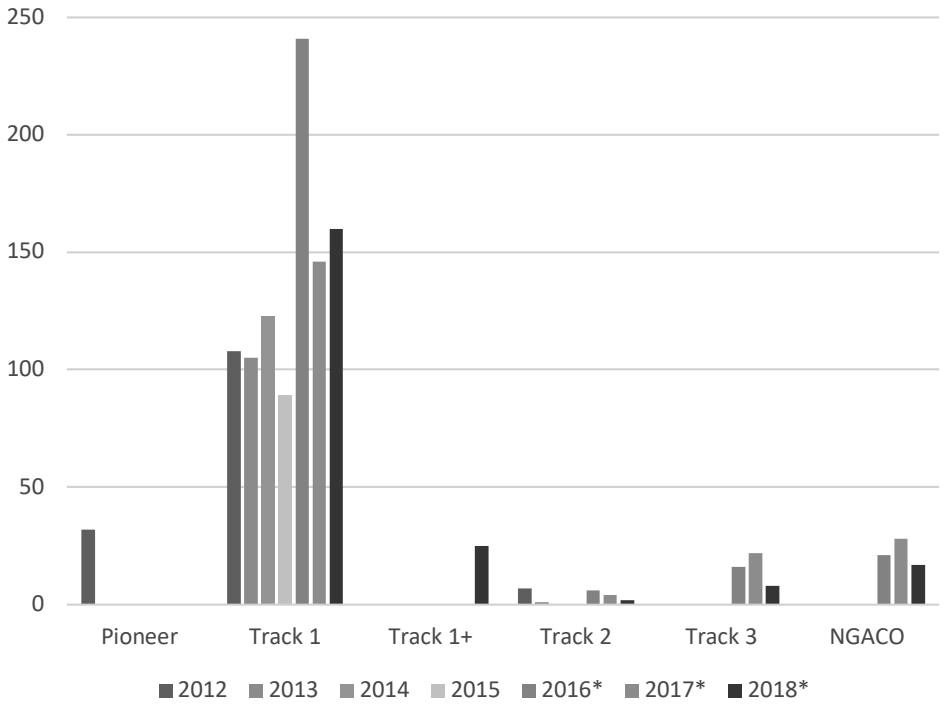
Program Participation

The ACO Pioneer program launched in 2012 with an initial three-year performance period and two optional additional performance years. Given the model was designed for more experienced ACOs, 32 ACOs began in the model in 2012; however, due to some attrition, the program ended on December 31, 2016 with nine ACOs participating. Most of the participants were part of larger health systems.12

Participation in the other Medicare models has continuously increased year-over-year. **Exhibit 1** highlights the new cohort of ACOs that joined the model for each year by track. Beginning in 2016, the exhibit includes both initial applicants and renewing ACOs. As of the 2018 performance year, there are over 560 Medicare ACOs.[13] Participation in the model is largely centered on Track 1, with about 20 percent of ACOs participating in the other models.

12 CMS, "Pioneer ACO Model," (Web page), available at https://innovation.cms.gov/initiatives/Pioneer-aco-model/.
13 As of publication, Medicare has not yet announced the PY18 class of Next Generation ACOs.

Exhibit 1. Medicare ACO Participation (by Year)[14]



Program Results

Overall, Medicare ACOs have recognized improvements in reducing per capita costs, while improving quality of care and beneficiary experience. Some critics of the model believe that the results have not been as great as expected. However, it is evident from the data that savings created through population health models take time, as it not only requires a cultural shift but also the development of new tools and services. Importantly, the results also show that savings delivered through these programs does not come at the expense of the quality of care. Due to this dynamic, in May 2015, the CMS Office of the Actuary certified that the ACO Pioneer Model met the criteria of CMMI programs to potentially become a permanent model by reducing costs, without negatively effecting quality of care. **Table 3** outlines the savings and quality results achieved through each performance year of the program.

ACOs require an effective partnership between administrators and clinicians. The transformation to a population health strategy necessitates a shift in culture and mindset. Positive leadership support assists with the facilitation of buy-in and ownership. It is critical to have effective physician leadership and engaged physicians to successfully implement the transformation to value-based care.

14 CMS, "New ACOs Join the Shared Savings Program," January 18, 2017, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/news.html.

Table 3. Medicare ACO Model Performance on Quality and Cost Per Year

Medicare ACO Program	Performance Year	Total Savings to Medicare	Total Shared Savings	Percent of ACOs with Shared Savings	Average Quality Score
MSSP	2012–2013	$832,689	$315,908,773	23.64%	P4R
	2014	$974,704,175	$341,246,303	25.83%	83.08%
	2015	$1,568,222,249	$645,543,866	30.36%	91.44%
	2016	$1,697,849,782	$700,607,912	31.02%	93.36%
Pioneer	2012	$141,700,253	$77,264,204	40.63%	P4R
	2013	$129,541,908	$66,441,579	47.83%	85.25%
	2014	$143,552,180	$81,554,006	55.00%	87.22%
	2015	$63,432,991	$34,105,679	50.00%	92.26%
	2016	$68,032,685	$37,128,920	75.00%	92.96%
NGACO	2016	$71,684,941	$58,348,176	61.11%	P4R

Note: P4R—Pay for Reporting

It is evident from the data that savings created through population health models take time, as it not only requires a cultural shift but also the development of new tools and services. Importantly, the results also show that savings delivered through these programs does not come at the expense of the quality of care.

Medicaid

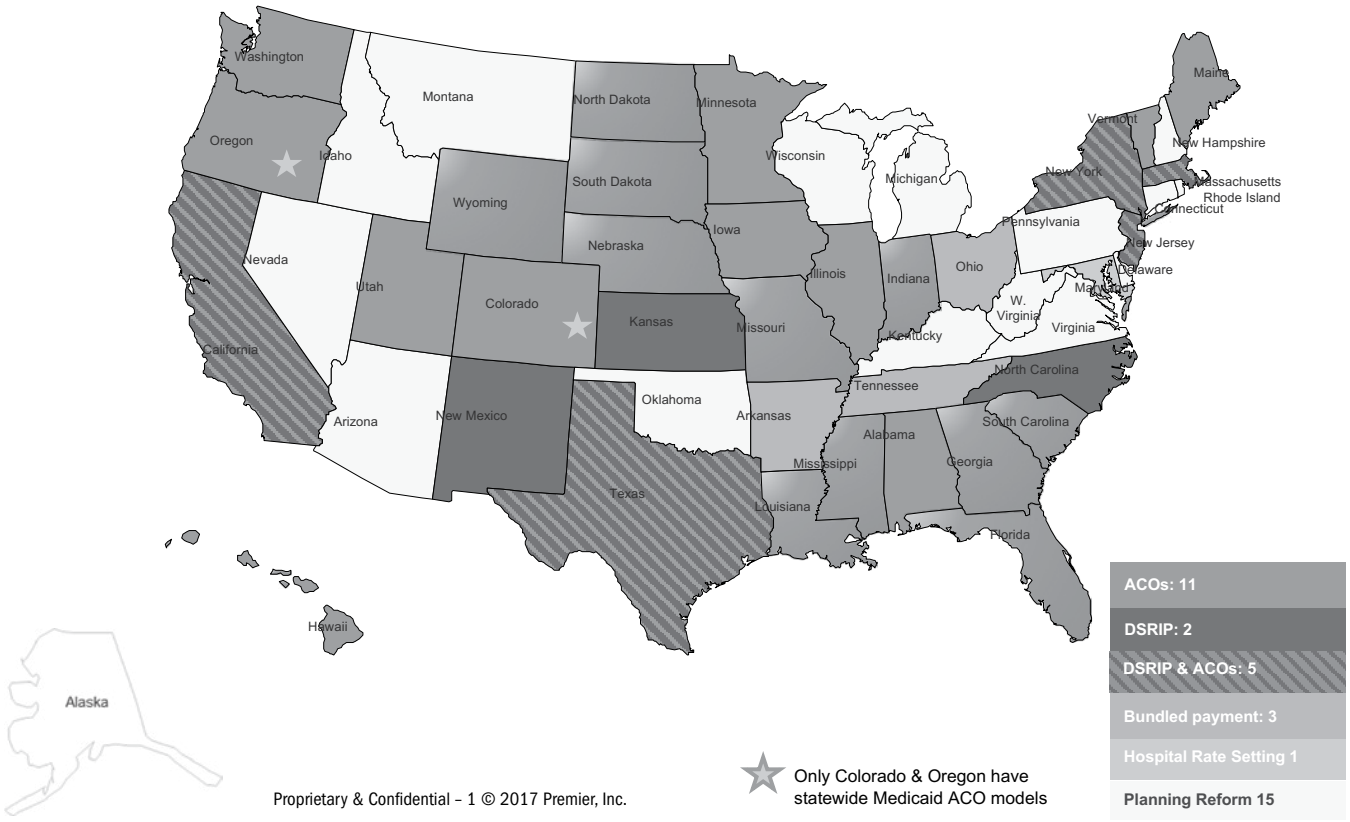
As federal ACO models continue to show progress in reducing costs, improving quality, and enhancing beneficiaries' experience of care, many states are exploring the potential of implementing similar programs through their Medicaid programs. This movement towards alternative payment and delivery structure redesign has largely been driven by the rapid and sizable growth of Medicaid costs in every state budget, coupled with the slowdown in growth of state tax revenue.[15] With many competing priorities for budgetary dollars, identifying opportunities to reduce costs in Medicaid programs is of great interest at the local and federal levels.

Traditionally, Medicaid programs operate on an FFS basis, but many states are exploring alternative approaches. These include the utilization of the 1115 waivers authority, which, in some states have included Delivery System Reform Incentive Payment Programs (DSRIP) as a mechanism to test delivery and payment reforms. The 1115 waiver is designed to allow greater flexibility for states to implement innovative approaches to care redesign and payment delivery. As of 2017, 11 states have implemented an

ACO model, of which two are participating in DSRIP alone, and seven are both participating in DSRIP while implementing an ACO model (see **Exhibit 2**). The utilization of federal waivers allows states to customize the approach and design of the model based on the needs of their patient and provider populations.

15 R. Rudowitz and A. Valentine, "Medicaid Enrollment & Spending Growth: FY 2017 & 2018," Kaiser Family Foundation, October 19, 2017, available at www.kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2017-2018/.

Exhibit 2. Medicaid Delivery System Reform Models



One example of such customization is the current Medicaid ACO model of Oregon's Coordinated Care Program, implemented utilizing an 1115 waiver. Through this model, the state is promoting primary care and preventive services to manage chronic conditions, as well as to coordinate care for beneficiaries throughout the healthcare continuum. Initiated in 2012, the model leverages coordinated care organizations (CCOs), like ACOs, which are groups of "all types of healthcare providers who have agreed to work together…to serve people who receive coverage under the Oregon Health Plan (Medicaid)." There are currently 16 CCOs operating in Oregon.[16] The program is designed to measure performance on 17 CCO incentive metrics, and 16 additional state performance metrics, which monitor quality, access to care and financial performance.[17]

The state performance metrics are required as a part of their 1115 Medicaid waiver, and dependent on achievement level, the state may have to pay financial penalties. The CCOs receive payments based on their performance on process or quality incentive metrics. As a part of the waiver, Oregon has agreed to reduce the rate of Medicare spending per capita from a historical average of 5.4 percent to 3.4 percent within three years. The state has been able to achieve these spending targets in each of the reported performance years.[18]

As another example, Massachusetts embarked on a new Medicaid ACO plan beginning in March 2018. The state has also used an 1115 waiver to implement this new model, which includes a DSRIP program. The state has created a regional, statewide ACO model that allows providers to choose from three different models to participate in the program:

- Model A: integrated partnership of a provider-led ACO with a health plan (made possible through ownership or a joint venture)
- Model B: advanced provider-led entity that contracts directly with MassHealth
- Model C: provider-led ACO that contracts directly with MassHealth managed care organizations

All program models focus on network structures that incentivize care coordination, quality outcomes, and health exchanges that utilize alternative payment methodologies and allow for local

16 Oregon Health Authority, "Coordinated Care: The Oregon Difference" (Web page), available at www.oregon.gov/oha/HPA/Pages/CCOs-Oregon.aspx.

17 Oregon Health Authority, "Oregon's Health System Transformation Coordinated Care Organizations Performance Reports" (Web page), available at www.oregon.gov/oha/HPA/ANALYTICS-MTX/Pages/HST-Reports.aspx.

18 K. J. McConnell, "Oregon's Medicaid Coordinated Care Organizations," *JAMA,* 315(9); 869–870 (2016).

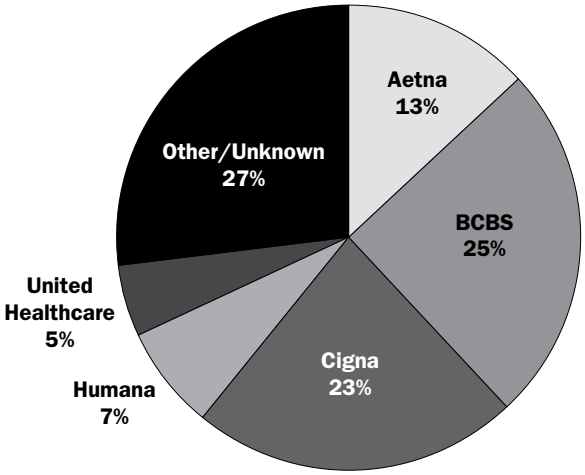
negotiation and network development led by providers and managed care organizations.

Commercial Payer and Direct-to-Employer Arrangements

In addition to governmental payers, commercial payers and large employers are beginning to utilize ACO-like shared savings arrangements with providers. As of April 2016, commercial shared savings arrangements covered approximately 17.2 million lives through over 500 agreements—exceeding the number covered through the Medicare ACO models. Four hundred (400) of these agreements are in place through one of the five major insurers. Blue Cross and Blue Shield have the greatest number of ACO agreements; however, all payers are leveraging the model (see **Exhibit 3**).[19]

Premier's Population Health Management Collaborative holds an annual meeting with the five major national payers to learn about their value-based/ACO contracting strategy. Over the past three years of meetings, we have observed that the commercial payers have shifted from a slower adoption pace to one that is much more aggressive and mirrors the "Better Care. Smarter Spending. Healthier People." initiative from the Department of Health and Human Services and CMS. During the most recent meeting, each of the five payers articulated a strategy to reach 50 percent of their agreements under a shared savings model by 2020, with one wanting to potentially begin testing capitated payment models.

Exhibit 3: Commercial ACOs by Payer (2017)



Source: Definitive Healthcare.

19 Definitive Healthcare, "Commercial Groups Driving Force Behind ACOs Development" (Web page), February 21, 2017, available at www.definitivehc.com/news/commercial-groups-driving-force-behind-aco-development.

Case Examples: What Different ACOs Learned and Accomplished

To provide a picture of how the various ACO structures described above have been implemented, this section profiles three different organizations that each had a different ACO structure: Medicaid, Medicare, and commercial payer. These organizations shared what their priorities were, how they accomplished their goals, and key lessons learned.

Memorial Healthcare System: Medicaid ACO

Broward Health and Memorial Healthcare System, two public hospital safety-net systems covering Broward County and surrounding areas in South Florida, partnered with a safety-net provider services network organization called Community Care Plan (CCP) to administer its Medicaid ACO in July, 2014 (at the time, CCP was known as South Florida Community Care Network). CCP is a provider service network and serves members enrolled in Medicaid, Children's Medical Services Network, and self-insured employee health plans, including Memorial Healthcare System.

Memorial is a safety-net provider and a public health system under the South Broward County Hospital District and one of the largest public healthcare systems in the U.S. Matt Muhart, Executive Vice President & Chief Administrative Officer at Memorial, considers the safety net to extend beyond the uninsured to the Medicaid community, as they are still underserved despite having government insurance coverage, facing continued problems in Medicaid with access and quality. "When the opportunity came up to move from an administrative role managing care for our population under a non-risk basis to actually bidding on and winning full-risk Medicaid business, it made a lot of sense to me," Muhart explained. "Ultimately, managing the totality of the cost of care and the quality of care through a separate organization made a lot of sense from addressing our role as a safety net provider, improving the health of the community, while recognizing that we don't make money on every Medicaid patient that comes in the door. In fact, we lose money. And so, the best strategy for us was to have Community Care Plan manage that population, keep them healthy, and keep them out of hospitals."

The Memorial/Broward Health Medicaid ACO covers 45,000 lives in what is considered a "full-risk Medicaid product" that consists of 90 percent of the Medicaid business in Broward County (North and South districts). The two health systems invested $5 million each over about five years to build the infrastructure and IT to support the ACO and CCP. The two systems each had a different EMR, so the first task was unifying the EMR platform so that data could be shared across the ACO. "The first six months were all about culture and building infrastructure," said John Benz, President & CEO of CCP. "Employees needed to effectively see the purpose for which we were created and understand their goals and objectives." They were "lucky" in the first six months, according to Benz, and made $6 million during that time while they were still trying to put together the pieces.

Once the culture and infrastructure were in place, the next major investment was in building a data warehouse. Called Horizon, it gathers everything possible from internal and external sources to provide a full picture of every ACO members' health status, risk, disease profile, etc. While this was a significant up-front investment, leaders felt it was necessary in order to make decisions based on real-time information, rather than relying solely on historical claims data.

The next piece was physician alignment and incentivizing physicians based on quality metrics. The physicians are under shared savings, pay-for-performance, and fee-for-service contracts (about 75 percent of the ACO patients are in shared savings and pay-for-performance arrangements, and the rest are fee-for-service). Their performance challenge (where reimbursement was at risk) was set at making above the 50th percentile on national standards for NCQA in 37 different quality measures, a rule put in place in the State of Florida for the Medicaid model. Achieving alignment with physicians takes constant monitoring. "In reality, we handhold our providers," said Benz. The pay-for-performance provider program through CCP assesses physician performance against evidence-based care protocols and usage of clinical guideline recommendations. They provide physicians with customized, individual practice data and aim to close gaps in clinical quality measures so that all physicians are performing at or above threshold.

The ACO also includes both social workers and care managers. Each primary care practice with over 400 members has a dedicated care manager to manage high-risk patients as determined by the practice and CCP through a scoring procedure looking at disease or case mix, pharmacy use, physician and ER visits, and hospitalization rates. Support for these patients include closing gaps in access, a member and physician portal, and an annual "care roadmap" for each member. In addition, there is a home visitation program for patients who have presented to the ER more than three times in a calendar year or have not seen a primary care physician in 18 months. The home care team, involving

nurse practitioners and physicians, does a complete physical workup, creates a quality measure scorecard for the patient, and assigns them a primary care physician. They provide education to the patient about dental, visual, and medical benefits; transportation; and any other barriers to receiving care. They follow up to ensure that the patient has seen his or her physician to receive their care roadmap within two months of the home visit. To date, they have seen an 80 percent success rate with this aspect of the model.

The Medicaid ACO is earning four- and five-star ratings from CMS and has the capacity to expand to 200,000 members. Administrative costs have remained low, which has helped their success (CCP spends 91 cents of every Medicaid dollar on direct healthcare services). Net earnings were at about $35 million over 35 months; in 2016, CCP achieved 24 percent above financial projections. How much and how fast to grow in the future are the current strategic considerations.

At the time the Medicaid ACO was created in 2014, Memorial was already well-positioned to take on a population health model due to its primary care service model that had been in place for a few decades. South Broward Hospital District got into population health in the early 1990s, when the district board decided its job was to accept responsibility for the health of the community. Early efforts focused on the uninsured and low-income population. It was hospital-focused, meaning that most interventions were done from the standpoint of trying to avoid uncompensated care. This included the development of a special primary care delivery system specifically for the uninsured and Medicaid population (commercial and Medicare patients were excluded).

Then, in 2000, Florida Governor Jeb Bush created legislation to create six provider service networks (PSNs) for Medicaid managed care via private, for-profit insurers. These PSN programs included shared savings, administrative arrangements, and the provision of care to the Medicaid population for Broward, Miami-Dade, and Monroe Counties. The South Florida Community Care Network was born, the state's first safety-net hospital-owned provider services network, today known as CCP.

With the passing of the ACA in 2010, there were no primary care physicians in the area willing to take part in exchange product networks, because of their participation in the Medicaid managed care plans through CCP. In Broward County, the ACA exchange plans grew quickly to over 200,000 members, and participating private insurers found that they didn't have enough primary care physicians to carry the network through private avenues. So the insurers approached Memorial's primary care centers to see if they would participate in the networks to give the plans a "home" for their members. Memorial agreed, and at that point, the Memorial primary care centers went from 100 percent Medicaid and indigent to 60 percent Medicaid/indigent and 40 percent private payer, virtually overnight.

Today, these primary care centers have evolved into patient-centered medical homes that are part of a comprehensive primary care provider service network that combines Medicaid and commercial lives in both fee-for-service and shared savings, ACO-type arrangements.

Governance and Leadership Structure, and Keys to Success

Benz reports to both Broward and Memorial system boards and their CEOs on a quarterly basis to share financial and quality results of the Medicaid ACO, as well as quarterly reporting to the hospital district board. CCP itself holds monthly board meetings and has a quality improvement committee that handles everything from patient satisfaction to call center statistics.

In addition to the Medicaid ACO, Memorial has a commercial clinically integrated network (CIN) that includes Memorial employees and is also administered by CCP. Memorial and CCP are working on developing a centralized set of services, including technology, to leverage across each ACO administered/managed by CCP. The ultimate goal is to continue to develop synergies across all populations, and leaders are currently creating a document, called Population Health House, to identify how these synergies can further develop over time.

Benz considers this Medicaid ACO product to be something that other public hospital systems across the country can and should attempt. In fact, CCP has told the Governor of Florida that it would be willing to do a block grant for universal coverage in Broward County because the public hospital districts there already have responsibility for the population. "You can't have population health without management," Benz said. "You have to have a legitimate back-office mindset to solve the long-term issues and take the short-term bumps. It's giving back to your community."

For Memorial, the main keys to success were to ensure that the ACO was clinically led and professionally managed, funnel patients through a strong primary care model, and ensure robust data-sharing to drive improvement throughout the ACO.

Hackensack Meridian Health: Hackensack Alliance Medicare ACO

In 2010, Dr. Peter Gross, CMO at Hackensack Health System in New Jersey, approached Dr. Morey Menacker, a primary care physician leader who currently serves as Vice President of Specialty Care and Care Transitions at Hackensack Meridian Health, with the idea of developing an ACO as a demonstration project in the infant stages of looking at value-based care. They were inspired by the Pioneer ACO project under demonstration at the time by CMS. "Dr. Gross was very forward-thinking," said Dr. Menacker. "My only concern was, if we were going to do it, we needed to do it right." The initial step in "doing it right" was focusing on how to eliminate waste, improve outcomes, and then use that information to benefit the entire hospital network.

Dr. Menacker has helped lead Hackensack Meridian Health's population health strategy since joining the organization in 1988. He has served as the President and CEO of HackensackAlliance ACO, Hackensack University Medical Center's MSSP ACO, since its inception in 2012. "We recognized [in 2010] that we were not prepared for the Pioneer ACO program," said Dr. Menacker. "But it gave us a head start to prepare ourselves when the MSSP program became a reality."

The first step to prepare for the MSSP ACO program was to obtain the start-up capital necessary to build the infrastructure. The Hackensack President was willing to think outside the box regarding new types of programs, recognizing that there might not be an ROI with this type of investment, but that if the ACO did generate savings, it would be able to pay back the hospital for the infrastructure loan. So the hospital loaned the ACO the capital to get started, but the ACO was set up under ownership by the Hackensack physician group. "I think that that was a very important step because if this was set up as a hospital-based program, and it was run by the hospital, then the doctors wouldn't feel ownership of really changing the way they practice," said Dr. Menacker. While the ACO gained assurance from the hospital that it wouldn't intervene, a key goal at the outset was to translate ACO successes into standards of practice throughout the organization, so they wouldn't remain "trapped" in the ACO program.

The second step was to limit the program to primary care physicians to manage Medicare patients. "We felt that bringing in specialists would not align incentives because we couldn't guarantee how much savings there would be [due to an inability to control decisions on what and how many procedures]," Dr. Menacker explained. By focusing on primary care doctors who were willing to make changes in their daily practice, they created a PCMH model and sought certification from NCQA. This became the foundation of how the ACO viewed value-based care. They mandated that every practice that joined the ACO become PCMH-certified within one year. Consultants were hired to assist new practices in transforming their processes to make this a reality. The ACO paid for the consultants' fees during this step in the implementation. The practices that participated were not required to have a prior affiliation with Hackensack.

The third step was to research the major issues associated with compliance and outcomes and develop relationships between patients and their medical homes. "When you are dealing with patients over 65 who spend 10 minutes with the doctor discussing a problem, how much of this information does the patient remember by the time they're walking out the door?" Dr. Menacker posited. "That is reported to be somewhere around 50 percent. And how often do people comply with those recommendations before they see the doctor the next time, which may be three months, six months, or a year later? About 25 percent. So we recognized that the biggest hurdle was not that the doctors didn't know what they were doing, or that the patients were not seeing their doctors, but that there was a disconnect once the patients walked out of the office. We had no mechanism to monitor compliance, whether it's compliance with medication, diagnostic tests, or consultative work. So we moved aggressively into a care coordination model."

This was before care coordination was commonplace, so HackensackAlliance created its own playbook. Nurses were trained in care coordination and became certified as outpatient care coordinators through an online program at Duke University or a local program in New Jersey. Care coordinators were embedded into each PCMH, seeing patients in person and then following up via phone. "We were preventing a lot of unnecessary duplication of services, unnecessary emergency room visits, unnecessary hospitalizations, and we were also building a database on these patients at the same time," said Dr. Menacker.

This process did not require significant investments in technology at the outset. ACO leaders realized early on that they would not succeed if they tried to "fix everything" all at once. Instead, they set specific annual goals. The initial goal was minimizing unnecessary diagnostics and ER visits. "These are low-tech interventions," said Dr. Menacker. "We expanded hours in our practices. We changed the message when the practices were closed and created a system so patients can call care coordinators after hours on their cell phones [to determine if their situation required emergency care]." In one example, at 3:30 p.m. on Christmas Eve, a patient's daughter called a care coordinator because her father was slurring his speech. She was concerned that he was having a stroke. The care coordinator took a detailed history and found out the patient was diabetic, but he didn't have any other focal neurologic signs. "The care coordinator talked to the patient's doctor, who was planning on leaving to go home to his family, but was still at the office and was willing to stay," said Dr. Menacker. "The patient was hypoglycemic and they were able to adjust the patient's insulin dose. He was able to spend Christmas Eve and Christmas with his family. We eliminated an unnecessary emergency room visit and an unnecessary hospitalization, just because the patient called the care coordinator." This is one aspect of how the doctor/patient relationship is developed via the PCMHs, and one example of the ACO's initial attempts to create change and demonstrate savings. HackensackAlliance was able to distribute a significant amount of money back to its physicians and also begin to pay off start-up expenses at the end of its first year.

In the second year, the goal was to work on reducing 30-day readmissions. Their research revealed that the main causes of readmissions were medication reconciliation problems and lack of follow-up with primary care in an appropriate amount of time. The ACO mandated follow-up appointments within 72 hours of discharge and patients had the appointment already scheduled for them when they left the hospital. In addition, every patient received a 30-day supply of all medications upon discharge. They were advised to stop taking what they had at home, and to bring everything to their follow-up appointment. If there were duplicates, the physician would have the opportunity to ensure that the patient was taking the right medications and dosages. "We actually inserted Pharm.D's in our hospital who now do all the medication reconciliations for every single patient, after we showed success in decreasing our 30-day readmission rate to less than 10 percent," Dr. Menacker said. This is one example of how the ACO is translating successes to the entire health system.

> "The ACO works as a clinical laboratory. You identify what the problem is. You create a workflow to correct the problem or improve it. And then once you show value, you roll it out to the entire organization."
>
> *—Dr. Morey Menacker, President & CEO, HackensackAlliance*

In another example, they created an app to assist patients with chronic heart failure to remember when to take which medications. The app would generate alarms, and if the alarms were not turned off, the patient's care coordinator would receive a notification. In the initial pilot program with about 25 patients, they decreased average patient hospitalizations from four per year to 0.8.

Recently, the ACO recognized that it needed to address post-acute care issues, as this represented 33 percent of its total cost, but the ACO did not own any post-acute care services. The first question to be answered was whether the patients receiving post-acute care actually needed it, and then develop post-acute practice standards. In order to do this, they developed a checklist to identify patients, upon admission to the hospital, who were at high-risk for requiring post-acute care. It was mandated that a HackensackAlliance physician would monitor all patients who went to sub-acute and post-acute care. In addition, care coordinators would visit post-acute facilities and analyze and work with doctors to minimize lengths of stay. To help with this, the hospital would send physical therapy notes along with the patient to the post-acute facility, demonstrating the patient's status upon discharge and the expected length of stay based on physical therapy.

The HackensackAlliance ACO has regularly been recognized as one of the top Medicare ACOs in the country. In its 2015 performance year, it ranked seventh in the nation for total savings, saving more than $33 million while earning a 95.7 percent overall quality score. Due to its success, the ACO was approached two years ago by commercial insurers interested in partnering. "With commercial carriers, a significant number of these patients are young and healthy," Dr. Menacker explained. "It's difficult to create significant savings out of minimizing waste and improving efficiencies when most of the patient utilization is limited to annual wellness visits. However, there are still a lot of things that can be done. And we've been relatively successful with our commercial payers. But we're moving into a new environment and made a clear decision that the future of healthcare and healthcare financing is going to depend upon an integrated clinical model. So we've made a commitment as an organization that this is our goal."

HackensackAlliance has now contracted with commercial payers and created a clinically integrated network, which currently has over 3,000 doctors, with a goal of increasing to 5,000 doctors by the end of 2018 (via a combination of employed physicians and independent medical staff physicians).

Governance and Leadership Structure, and Keys to Success

As HackensackAlliance is part of the MSSP ACO program, CMS has specific requirements for the governance structure of these ACOs. The board must be made up of 75 percent of ACO-participating physicians. The ACO board also includes members of the community and hospital administration. The ACO board reports progress to the Hackensack Meridian Health board on a regular basis.

"From a leadership standpoint, it's got to be about vision," said Menacker. "You have to have not only the right vision, but to be able to verbalize and demonstrate it. I think that is a vital part of this entire process."

The keys to success at Hackensack include the focus on primary care in the initial stages, the development of a roadmap for steps to success, and the intent at the outset to ensure that benefits to ACO patients could be implemented throughout the health system.

Baystate Health and Baycare®: Commercial ACO

Baystate Health, located in Springfield, Massachusetts, and its physician–hospital organization, Baycare Health Partners (Baycare®), have been committed to a movement to value-based care since the mid-2000s. When founded in 1994, Baycare was primarily focused on arranging fee-for-service managed care contracts. In the early 2000s, they began their clinically integrated journey to improve the quality, safety, and efficiency of care delivered to their patients.

In 2009, Blue Cross Blue Shield of Massachusetts announced the first value-based contract in Massachusetts, the Alternative Quality Contract (AQC), which is a value-based payment model with two-sided risk and quality metrics built on a fee-for-service model. Two things accelerated entering the AQC contract, according to Dr. Stephen Sweet, CEO of Baycare. First, they saw

that the primary care doctors were not happy in the fee-for-service, RVU value-driven system. They were tired and increasingly burned out trying to keep improving productivity every year. Second, a physician from a competing provider organization that was closely aligned with another local medical center was trying to recruit all of the major primary care practices in the area to enter into the Blue Cross AQC through its contract, which posed a competitive threat to Baystate Health and Baycare. In addition, the State of Massachusetts had embarked upon a major effort towards value-based care with its own state-wide insurance program. So Baycare and its board realized that value-based care with provider risk was where the market was headed, and that it needed to become involved in the Blue Cross AQC.

In 2010, Baycare entered into the Blue Cross AQC, a commercial ACO product with 15,000 members with the primary care practices employed by Baystate as well as the other major independent primary care practices—all of whom are members of Baycare. In the beginning, this was a subset of Baycare acting as a pilot with the intent to extend the opportunity to all Baycare providers. Recognizing that it would be difficult to treat only 15,000 patients differently than the rest of the population, Baystate's goal was to expand the ACO model as soon as possible to other commercial payer and Medicare patients. To do this, Baycare expanded its participation in additional VBP agreements over time with other payers including Health New England (Baystate's health plan), UniCare/GIC, Cigna, and Tufts Health Plan. This approach was designed to provide a critical mass of patients under these models to truly gain the attention of clinicians.

During the initial year of the agreements, they began working with eight physician practices that were culturally ready to accept risk and pilot the value-based agreements. Initially, it took several months of education to create the burning platform to convince the practices to begin to transition to a value-based model, as there were concerns related to the financial impact. With that said, they have been extremely successful over the years, and participation has continued to grow. After the first results were released, they received a significant amount of interest from other parties. During the first year of the agreements, Baycare was able to earn over $3.3 million dollars in additional payments. Over the six years of cumulative performance in these models, it has earned over $56 million in additional payments above fee-for-service and maintained strong quality scores.

Since the ACO's inception, Baycare has focused on five key population health strategies to mitigate risk and manage performance. They include better management of the following:

- Post-acute care:
  - » Decreasing inappropriate length of stay
  - » Coordinating emergency room transfers
  - » Reducing rehospitalizations
- Acute care:
  - » Decreasing unnecessary emergency room visits
  - » Decreasing avoidable inpatient admissions and readmissions
- Costly care:
  - » Focusing on appropriate utilization of sites of care
  - » Utilizing less expensive sites of care when appropriate
- Accurate coding:
  - » Ensuring complete and accurate documentation and diagnosis coding to better identify complex patients in need of additional care
- Specialty engagement:
  - » Enhancing collaboration with specialists in areas such as enhanced access, reduced out-of-area utilization, and bundled payment models
- Care management:
  - » Implementation of a team-based model across the continuum

Governance and Leadership Structure, and Keys to Success

The Baycare Health Partners ACO board of 23 members is comprised of seven primary care clinicians, nine specialists, and seven representatives from Baystate Health (including one community advocate independent of the health system). With super majority quorum and voting requirements such that any of these three key stakeholder groups has veto power, they believe that this structure fosters buy-in from all three parties, since there is a need to bring all parties together to reach consensus in implementing value-based care capabilities. Their keys to success included building relationships with primary care practices, a narrow focus on the five population health strategies listed above while allowing the flexibility to rapidly adjust the tactics supporting their execution, strong ACO leadership, an engaged board, and aligned contract terms.

Lessons Learned over the Past 15 Years

The movement to value-based payment models, particularly ACOs, requires a shift in the delivery of care, as well as a shift in the culture of most healthcare providers. The cultural change of moving from acute episodic care to managing a population every day is challenging and difficult.

SINCE THE INCEPTION OF THESE MODELS, ACOS HAVE MET with varying degrees of success. Through Premier's work with over 50 Medicare ACOs, as well as participants in other payer models, we have identified the following characteristics that are common among ACOs that are successful in improving quality, reducing costs, and improving the experience of care for the population they are serving:

- **Engaging effective physician leadership.** It is critical for ACOs to be physician-led and professionally managed. In order to effectuate the clinical care delivery redesign necessary for success under an ACO model, effective physician leadership is needed to be the champions of change. There are many ways that ACOs work to engage with clinicians as a part of the model (see sidebar).
- **Utilizing an Advanced Primary Care model (APC).** A robust, team-based APC model that includes the integration of care management is critical to engaging beneficiaries and navigating throughout the healthcare system.
- **Enhancing utilization of population health information technology.** A key aspect of ACO models is access to large amounts of claims and clinical data across the continuum. Leveraging PHIT is an important tool to transform that data into useful, actionable information. Examples include predictive modeling and risk stratification of patients in areas such as high risk/high utilizers and those with chronic diseases such as diabetes, and congestive heart failure. Leveraging this data to inform providers of their performance in comparison to evidence-based care models and where there are opportunities for improvement is critical.
- **Providing care management.** Care coordination and management across the continuum is critical to successful ACOs. Focusing on the high-risk and rising-risk population—the 5 percent of the population who account for 50 percent of the cost—can provide great value to the ACO, as well as to the beneficiaries. Care managers should act as a part of the care team, be embedded in primary care practices, and utilize care plans across the continuum. Many ACOs have care managers focus on high-cost disease management programs, like diabetes, congestive heart failure, hypertension, chronic depression, and chronic obstructive pulmonary disease.
- **Managing post-acute utilization.** As noted above, the development of a high-value network of providers based upon the use of evidence-based pathways and performance data across the continuum is critical. One area of focus that has led to success is managing post-acute care (PAC). CMS has identified a significant amount of variation in utilization of PAC, particularly the use of skilled nursing facilities.[20] An important strategy for ACOs is to work with these providers to ensure beneficiaries are in the appropriate site of care. Other utilization metrics (such as length of stay) are also important in managing care in the PAC setting.

Engaging Clinicians in ACO Leadership and Governance

The following actions, taken together, ensure effective clinician engagement and leadership in the ACO, and are critical to the overall success of the ACO:

- Include broad representation of participating physicians on the governing body, as well as within the key governing committees.
- Ensure early commitment with clinical leaders in the development of the value-based care model, which facilitates engagement and fosters buy-in and ownership.
- Develop a long-term engagement strategy for physician education regarding quality and cost.
- Provide real-time data and comparative benchmarking to inform clinicians about performance on key metrics.
- Align compensation incentives through a gainsharing methodology.

A final lesson learned is the benefit of leveraging an ACO as an integration vehicle to work across the continuum. Some non-traditional partners, and even competitors, are experimenting with using an ACO model to work together to manage populations across a broad geography. Moreover, many ACOs include participation from federally qualified health clinics (FQHCs), critical access hospital (CAHs), and other rural providers to ensure that the ACO has adequate coverage and access options to manage the population in rural and urban areas.

20 J. Herbold and A. Larson, *Performance of Skilled Nursing Facilities for the Medicare Population* (white paper), Milliman, December 2016, available at http://www.milliman.com/uploadedFiles/insight/2016/2352HDP_Performance_20161212.pdf.

The Future of Accountable Care

As evidenced from the information presented in this white paper, the ACO model is very fluid and has continued to evolve since the PGP began in 2005.

AS CMS AND OTHER PAYERS GAIN GREATER EXPERIENCE IN the model, as ACOs provide insights into what is effective and what is not, and as new tools are developed, it is likely that this evolution will continue. Two areas that will likely impact the growth and design of the models include the MACRA Quality Payment Program (QPP) and the movement to two-sided risk arrangements.

Impact of the Quality Payment Program

The Quality Payment Program (QPP) creates a strong incentive to move to an ACO model. On January 1, 2017, CMS began the implementation of the QPP, which alters the manner in which clinicians are reimbursed for FFS Medicare. Specifically, QPP creates two alternatives for providers: participate in the Merit-based Incentive Payment System (MIPS) or join an Advanced Alternative Payment Model (AAPM):

- **Merit-based Incentive Payment System:** MIPS is a value-based purchasing program in which clinicians are judged on four categories: quality, cost, advancing care information, and improvement activities. Dependent on their performance in comparison to their peers, a clinician's payment is adjusted, upward or downward.
- **Advanced APM:** The alternative is to join an AAPM, which includes some form of actuarial or two-sided risk. This includes many of the Medicare ACO models and rewards participants with a 5 percent bonus on their Part B payments if they have a significant portion of their fee-for-service payments from AAPMs.

Success under MIPS is very similar to what is required for success in an ACO. Moreover, there is a separate, preferential scoring standard for Medicare ACOs that do not qualify as an AAPM (such as MSSP Track 1 programs) and are still participating in MIPS. Because of the potential for a bonus under AAPM, and the preferential scoring, we expect to experience a continued growth in the participation of Medicare ACO models. One hundred twenty-four (124) new Medicare ACOs started in January, 2018. A similar number of new Medicare ACOs may start in January, 2019.

Movement to Risk-Based Models

Under the MSSP program, ACOs are required to move to a risk-based model at the end of their second agreement period. Because of this requirement, CMS has developed multiple options that include downside risk, from Track 1+ with limited risk, to the NGACO model, which allows for full population-based payment.

As more ACOs are required to move to two-sided risk, there is a potential that CMS will continue to iterate and develop alternative models in an effort to meet providers "where they are" in relation to a readiness to assume two-sided risk. This evolution could include models with more limited risk such as a primary care capitation model, models with greater amounts of risk, or tiered models that assume more or less risk for specific portions of the population that is being served. Regardless of the evolution, ACOs should use the first six years of their agreement in a one-sided model to prepare for risk through development of infrastructure, tools, expertise in key capabilities, and resources. It is clear that there will be continued movement by all payers, not just CMS, to require providers to implement value-based care models and to assume more risk in the future.

It is clear that there will be continued movement by all payers, not just CMS, to require providers to implement value-based care models and to assume more risk in the future.

Impact on the Role of Governance

Hospitals, health systems, medical groups, and other organizations that have developed ACOs, clinically integrated networks, and other affiliations and partnerships are finding that the role of governance and oversight of these entities is now and will continue to become much more complex. This is especially true in cases where there is some form of joint venture involved with other partners. A key governance question is to whom are the boards of sponsored ACOs ultimately accountable? The governing bodies of sponsoring organizations will need to pay close attention in the future to the reporting relationships and degree of control that should be exercised with the entities. ACO boards require expertise in non-traditional areas such as post-acute care, health plan leadership, Medicare beneficiaries, etc.

Several health systems with which we are familiar have been careful about who they appoint as their representatives to their ACO governing boards. They have taken care to have representatives of their ACO provide at least semi-annual reports to the hospital or health system board regarding the entity's performance relative to the ACO's goals, performance metrics, and results versus the purposes originally identified for creating the ACO. Care is also taken to monitor that the ACO's performance

and practices are consistent in areas such as quality and utilization and remain aligned with the health system's mission and values.

> A key governance question that remains is to whom are the boards of sponsored ACOs ultimately accountable? The governing bodies of sponsoring organizations will need to pay close attention in the future to the reporting relationships and degree of control that should be exercised with the entities.

Governing bodies of ACOs themselves must take care to reinforce to their directors their roles and responsibilities to the organization itself, and relative to sponsoring organizations. Issues of confidentiality and fiduciary responsibility are paramount. This also includes discerning what information can be appropriately shared with sponsoring organizations, as well as among partners if the ACO is a joint venture with multiple parties. Furthermore, health system boards and their ACO boards should be working together to expand system integration of quality and cost improvements across other areas of the health system beyond the ACO.

Just as hospital and health system boards are generally vigilant to ensure that their board members receive ongoing education, training, and development, so too should ACOs consider to what degree their board members need ongoing board development activities and opportunities. Best practices in governance should be used as standards to assess individual and collective board performance and effectiveness as well as benchmarking the ACOs performance against top performers across the industry.

As ACOs grow in their influence and importance to healthcare providers of every type and at all levels, the role of governance will be an essential component of whether these organizations can be sustainable and successfully achieve their goals and purposes. Good governance practices must be understood, developed, and monitored to ensure appropriate accountability and oversight, especially by those who have ultimate fiduciary responsibilities for the entity.

Conclusion

With the fiscal challenges imperative in the U.S.—the explosive growth of the Medicare population, increasing costs, fewer tax dollars to fund entitlement programs, and the growth of chronic disease—it is clear that the movement to value-based care and payment and ACOs will accelerate.

OUR NATION DOES NOT HAVE AN ALTERNATIVE. WHILE THE models will evolve, payers will continue to create economic incentives and penalties for providers to move out of traditional FFS.

In order to meet providers where they are on the journey to value-based care, CMS and other payers have continued to create, test, and scale new models, largely with the overarching goal of adding value, reducing waste, and placing greater amounts of risk on healthcare providers.

In addition to the push from payers, there are strategic reasons for moving to an ACO model. As competitors enter into these types of arrangement, and markets become saturated with ACOs, the competition for attributed lives will grow and could lead to a growth in narrow networks which could exclude some providers. Understanding the dynamics related to ACOs, pros and cons, and other considerations are critical for success in the future state of healthcare.