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Foreword

As New York State enters a new era ushered in by the Patient Protection and Affordable Care Act (ACA), we are faced with an old challenge: the need to simultaneously improve the quality and reduce the costs of our health care system. Across the state, health care providers and payers are rising to this challenge rapidly—and, in many cases, radically. They are implementing innovations to improve the quality and safety of care they deliver, alter the way patients and families experience care, and reduce utilization that adds cost but little value. It is an exciting time of experimentation that calls for close study.

Among the innovations receiving the most attention over the past few years is “accountable care,” a concept featured in the ACA. Under various Medicare initiatives, organized groups of providers in New York State are accepting responsibility and financial risk for improving the quality and reducing the cost of care they deliver to defined populations of Medicare beneficiaries. It is an approach that is also being pursued by a number of commercial insurers.

Accountable care builds on two trends reshaping New York’s health system: the aggregation of providers into larger and more capable organizations and networks, and the movement of payers away from fee-for-service payment systems toward arrangements that reward (and punish) providers for their performance. It also incorporates many of the best ideas being piloted across the state: the patient-centered medical home, active and focused care management, coordination of care across providers, and the routine application of evidence-based medicine in all practice settings.

This report is part of an ongoing effort by the United Hospital Fund to identify, analyze, and disseminate promising innovations in health care delivery and financing in the state. Gregory Burke, the Fund’s Director of Innovation Strategies, describes the current state of evolution of accountable care in New York State, portrays the diversity of those efforts, and discusses some of the challenges accountable care faces. Like many of the health care innovations now being tested in New York, accountable care represents a path into unfamiliar terrain; thoughtful analysis and clear explanation will be valuable guides as we proceed.

JAMES R. TALLON, JR.
President
United Hospital Fund
Acknowledgments

In preparing this report, we consulted with a number of experts across the state, including the leaders of 12 of the organizations participating in the Medicare ACO program, who agreed to provide the profile information included in the report. Those experts and ACO representatives were extraordinarily generous with their time and insights in providing both background context and current detail.

This report was supported in part by the Altman Foundation, TD Bank, EmblemHealth, New York Community Trust, and Excellus BlueCross BlueShield.
Introduction

The accountable care organization (ACO) program was one of the “big ideas” included in the Patient Protection and Affordable Care Act (ACA). Accountable care is a new and potentially transformational approach to organizing, delivering, and paying for health care services. The goal of the Medicare ACO program as built into the ACA is to improve the performance of Medicare’s health care delivery system by giving providers financial incentives to improve the quality of care, to improve the patients’ and families’ experience of care, and to reduce utilization and costs.

Ultimately, the Medicare ACO program is designed to shift some or all of the financial risk (the difference between the actual costs of care and premiums paid) from the Centers for Medicare & Medicaid Services (CMS) to the participating provider groups. The ACO program does this by attributing a defined population of Medicare fee-for-service beneficiaries to an organized group of providers (based on the beneficiaries’ historical patterns of utilization) and holding the group accountable for the quality of care, the patient experience of care, and the total costs of care generated by that population—all covered health care costs generated by the defined population, including out-of-network utilization, home health, nursing home care, pharmacy costs, and medical equipment. If the provider group meets specified benchmarks in quality and patient experience, they will be eligible to share in any savings they generate against target expenditures.

This paper describes the movement toward accountable care in New York State, reviews some of its major moving parts, portrays the diversity of experiments across the state, and discusses some of the challenges involved in this broad change.

Approaches to implementing accountable care differ from one community to another across the state; but, for all the local diversity, many of the issues faced are common. Altering the organization and delivery of health care services in ways that satisfy the demand for transformational—not marginal—change, while still living in a world where most income is driven by fee-for-service payment systems, remains a difficult proposition.

Accountable Care Basics

Despite the considerable mythology that has grown up around ACOs, accountable care is not in fact a magical construct. It is a contract between an organized group of providers and a payer, under which the providers agree to be held accountable for providing the full range of health care services required by a defined cohort of that payer’s members. In return, the payer agrees to allow participating providers to share in any savings they are able to generate as a result of providing high-quality, efficient care to that population.

Accountable care agreements are by definition payer-specific and population-specific. They are contracts between a particular provider group and a particular payer, focusing on improving the quality and cost-effectiveness of the care the group provides to a specific cohort of that payer’s members.

Provider groups selected as Medicare ACOs may also have accountable care agreements with other payers, each covering a portion of the patients they serve. However, they continue to be paid for the remainder—initially, the great majority of their patients—under existing payer contracts and arrangements, including fee-for-service payments and a variety of pay-for-performance schemes.

Medicare’s ACO Programs

CMS is currently sponsoring two different ACO programs, the Pioneer ACO Model and the Medicare Shared Savings Program (MSSP). The two programs have similar requirements for structure and governance (permitting physician groups, hospitals, and health systems to participate as ACOs). Both programs use historical claims-paid data to establish their financial benchmarks, and both use the same 33 quality measures in four categories (patient and caregiver experience, care coordination and patient safety, preventive health, and at-risk
populations) as their quality benchmarks. In the MSSP model, providers must agree to participate for at least three years. In the Pioneer program, providers must commit to three one-year performance periods, although they may be given an extension of two years. The main differences between the two programs are in their status, scale, and payment method.

**Pioneer ACO Model**
The Pioneer ACO Model is a demonstration project launched by the Center for Medicare & Medicaid Innovation (CMMI) in January 2012, to test how particular ACO payment arrangements and alternative program designs can best improve care and generating savings for Medicare (CMS 2013a). It was designed specifically for organizations that had experience with capitation or other population-based payment systems. Pioneer ACOs will operate for their first two years under a “shared savings” model (discussed below) that includes some shared risk. If they meet certain savings and quality criteria, they become eligible in their third year—and for an optional fourth and fifth year—to convert to a global or capitated payment system.

There are 32 organizations now participating in the Pioneer ACO program, one of which (Montefiore Medical Center) is located in New York.

**Medicare Shared Savings Program**
The MSSP is a permanent part of the Medicare program (CMS 2013b). It was designed for organizations that are interested in making the transition from fee-for-service to population-based payments but have had less experience with such payment schemes.

The program was initially defined and authorized in Section 3022 of the ACA, and it was launched in April 2012 with the selection of 27 participating organizations in 18 states. CMS added 89 more participants in July 2012, and another 106 in January 2013. Of the 222 provider groups participating in the program, 16 are in New York.

All of the MSSP participants will be using a shared savings model (with or without shared risk) for the duration of their three-year contracts with CMS. The payment models are described in more detail below, in the section “Risk-Sharing Models.”

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**A Note on Terminology**
The ACA and much of the literature uses the term “accountable care organization” (ACO) to refer to a specific model: the CMS-defined organizational structures, requirements, and payment schemes—including both shared savings and risk-based payments—being implemented by CMS in its Pioneer and Shared Savings programs.

CMS’s approach is by far the best-known model for accountable care, but accountable care is by no means a Medicare-only phenomenon. Increasingly, other payers—commercial payers, self-insured purchasers, and state Medicaid programs—are launching accountable care demonstrations and pilot projects of their own, initiatives designed to test and evaluate the potential of the model. These arrangements may not be called ACOs (Cigna, for example, calls its version “collaborative accountable care”) or precisely follow the CMS definitions, but most borrow heavily from the MSSP mechanics.

There is no one organizational model for an accountable care organization. Even under Medicare’s ACO initiatives, participating providers can use a variety of different organizational structures, often involving new groupings of physicians, hospitals, and other providers.

In this report, we use the term “accountable care organization” and ACO when specifically referring to organizations in the CMS initiatives; elsewhere we use the more general terms “accountable care” and “accountable care network” to reflect the diversity in the field.
The fundamental change that accountable care represents is shifting financial and performance-based risk from payers to health care providers themselves. This is an enormous change, involving two different innovations:

- Changing the structure and function of the delivery system. Integrating providers (physicians and hospital-physician organizations) into high-performing health care systems able to accept responsibility for, and manage the full range of care required by defined populations.
- Changing the payment system. Moving from fee-for-service toward population-based payments, which put the provider group at risk for its performance and give it a strong incentive to provide high-quality, cost-effective care.

Both of these sets of changes are described in detail below.

**Changes in the Delivery System**

The foundation of an accountable care network is a high-performing, integrated delivery system. Putting that delivery system together requires major changes in organization, governance, and performance of providers and provider groups, and a series of new skills and capacities.

**Structure and Governance**

Historically, health care providers—particularly physicians and hospitals—have operated as freestanding professional and economic entities, silos that coexisted but seldom worked together formally or effectively. The first challenge of accountable care is to craft these independent entities into a high-performing, organized provider network.

Accountable care requires a formal organizational structure for the network, including legitimate, representative, and accountable structures and processes for governance and decision-making among a diverse group of participating providers, and a common culture of quality and patient-centeredness. Accountable care networks need to develop a series of new administrative systems to measure and improve quality of care and patient experience across the care continuum, and to measure, track and manage utilization and cost. They also need explicit processes to equitably allocate performance incentives, bonuses, and shared savings among the participating providers. These are all significant challenges, particularly for a new organization.

**The Performance Imperative**

Accountable care demands that the involved providers substantially improve their performance as a system, particularly in areas that contribute to preventable emergency department visits, specialty care utilization and costs, and hospital admissions and readmissions (Higgins et al. 2011). This requires:

- a strong primary care base built on the patient-centered medical home (PCMH) model, with improved access and quality, which can serve as the locus for both care management and relationship management, particularly for the chronically ill;
- systems and staff to help coordinate and manage the care of all of its members across various sites and services, paying particular attention to specialty referrals and care transitions;
- organized, system-wide processes for quality improvement, including the capacity to measure, report on, and analyze quality and patient experience metrics against benchmarks, to identify variations and continually improve performance;
- programs of patient health education and patient engagement, which enable members to participate meaningfully in their own care; and
- systems that measure, report on, analyze, and manage members’ utilization and costs of care, with a focus on potentially preventable emergency department visits, hospital admissions, and specialty referrals, tests, and procedures.
A New Infrastructure

Accountable care requires a number of new skills and a new infrastructure to support them—updated systems and dedicated staff.

Care management is a core competency for accountable care (Dorr 2008; Kolbasovsky et al. 2012). Accountable care networks use designated care managers to help track and manage the care of members who have complex conditions, using electronic medical records (EMRs) and registries to identify and follow these patients, help coordinate their care, provide them with ongoing support, identify gaps in care or potential problems, and intervene before those problems become acute. These systems and dedicated staff can identify, track and manage health care utilization and costs for the populations for whom the network is responsible, particularly those with multiple chronic diseases who tend to be the highest-cost users.

Accountable care also depends on information systems to support the delivery of care, including EMR systems and regional clinical data exchanges that can enable effective communication among providers, and help coordinate patients’ care during referrals and care transitions. Updated information systems can enable providers to use data from EMRs and claims systems to identify and track discrete populations; to measure, analyze, and report on provider performance relative to the population covered by the accountable care contract; and to identify variances from quality, utilization, and cost benchmarks at the provider level and at the system level, in order to focus and support utilization management and quality improvement processes.

Some of the new capacities and staff in accountable care are directed toward encouraging patient engagement: patient education, electronic access to medical records, and other systems to manage member relations and improve self-care.

Lastly, provider groups participating in a shared savings program need systems that enable them to track and assess the performance of individual providers and groups, and to fairly allocate any savings generated as a result of operating more efficiently. Those participating in prepayment or capitation arrangements will need new and robust claims-based financial systems—as opposed to the clinical data systems they use now—to accept and manage risk, process and adjudicate claims, and pay clinicians for the services they provide.

Changes in the Payment System

As illustrated in Figure 1, accountable care is part of a continuum of payment changes, which moves from the historical fee-for-service system to pay-for-performance, bundling, shared savings, and, eventually, global budgets and capitation. These payment methods shift from paying for units of service to global payments covering the total costs of care for a population. Moving from left to right in the chart, the different systems include more services and expose participating providers to increasing levels of performance-based risk (Delbanco 2011).

The capacity of providers to accept and manage those different types of payments correlates with changes in their organization and performance, as they move from solo and independent providers toward groups and integrated delivery systems. (Shih et al. 2008). Essentially any provider can participate in a pay-for-performance arrangement, or receive PCMH or care management payments. However, it requires a substantially higher level of organization to participate in accountable care arrangements, whether using shared savings or a capitated payment system.

Risk-Sharing Models

The Medicare ACO programs (and most commercial plans’ accountable care arrangements) employ three basic models for sharing risk with providers:

- providers can participate under a “one-sided” shared savings model, in which providers share in any savings they are able to generate versus the target expenditure, which is calculated at year-end, subject to various thresholds, with no downside risk for losses (expenditures in excess of the target);
- providers can participate under a “two-sided” shared savings model in which providers can
providers can accept some or all of the financial risk for care provided to that population, using capitation or prepayment. This arrangement allows the ACO to change the way it pays physicians and hospitals for the care they deliver, and to retain and distribute any savings generated; but it also exposes providers to any losses incurred.

**Medicare ACO Payment Models**

The two different ACO programs that CMS is currently operating—Pioneer and MSSP—use different payment approaches.

Participants in the MSSP have the option of participating under either the “one-sided” risk model (in which they share in savings but not losses) or the “two-sided” risk model (in which they share in both savings and losses). Under both models, individual providers continue to be paid through Medicare’s traditional fee-for-service system. If they meet specified quality and patient satisfaction targets, the ACOs can share in any savings they are able to generate against target expenditures, distributing them to their participating providers.

In the first two years of their contract, Pioneer ACOs operate under a “two-sided” risk shared savings payment arrangement similar to the one available to MSSP participants, with higher levels of shared savings and risk than in the MSSP. Starting in year three of the initiative, organizations that have earned savings over the first two years become eligible to move away from fee-for-service payment to population-based payment and full-risk arrangements (e.g., capitation, or a mix of fee-for-service and capitation payments) that can continue through the optional fourth and fifth years of the contract. Pioneer ACOs are also required to develop similar outcomes-based payment arrangements with other payers by the end of the contract.
second year.

The shared savings model offers interested provider groups a low-risk way to gain experience with accountable care, and the ability to share in any savings they are able to generate against their expenditure target. This payment method—which is also being used by most commercial payers in accountable care arrangements—gives providers an incentive to improve quality and restrain preventable utilization and costs, without exposing them to financial risk. Shared savings, however, is generally considered an initial step on the path to two-sided risk-sharing and—ultimately—to global payments and capitation.

The Changing Role of Consumers (Patients No Longer)

Accountable care changes the way providers relate to members, and the way members experience care. Accountable care providers must know all of their members, including those not currently using health care services; and they must assess and track their members’ health status, making sure they receive all recommended care. This requires a strong member services function, a new set of skills for most provider systems.

Increasing patient engagement—including participation in shared decision-making, and self-management of chronic conditions—is associated with better health outcomes and lower costs (Coulter 2008). An accountable care network must invest in educating, involving, and empowering its members, rather than merely providing episodic services to them as patients. These are new skills and perspectives for providers whose historical focus has been on managing acute care episodes, and a considerable change for many members who have been accustomed to a more passive role. Making this change successfully will require new staff—health educators and patient engagement specialists.

Health information technology (HIT) can help improve patient engagement. New communication systems such as web portals can enable providers to communicate with their members, and allow members to communicate with their caregivers; other new technologies (e.g., remote telemonitoring) can help care managers track members’ health status and health problems. New information systems can give patients and their families fuller and faster access to their medical histories, as well as records of their health problems and the care they have received, making it easier to manage appointments, referrals, medications, and self-care.
Accountable Care in New York

Many providers and provider groups across New York State are currently pursuing accountable care contracts with Medicare or one of the state’s commercial payers. This section begins with an overview of some of the legal and regulatory issues involved in accountable care. We then review the current status of such arrangements by payer type, and discuss three of the organizational models being employed for accountable care: multispecialty group practices, independent practice associations, and hospital-physician partnerships. For each of these models, we present several detailed profiles of New York organizations currently implementing accountable care to demonstrate the diversity of innovative approaches around the state.

Legal and Regulatory Issues

The development of accountable care arrangements—contracts between organized groups of providers and payers, whereby providers accept performance-based and financial risk for the care of defined populations, and share in any savings they can generate—may raise a number of legal and regulatory issues. As accountable care arrangements grow, there are potential questions as to how the concept fits with a number of existing legal and regulatory constructs now in place at the state and federal level, laws designed for a competitive marketplace and a different health care system model: antitrust regulations, prohibitions on the corporate practice of medicine, prohibitions on fee-splitting, and regulations governing health care practitioner referrals.

Recognizing these potential conflicts, and interested in fostering the growth of accountable care, the New York State legislature passed legislation in 2011 (New York Public Health Law Article 29-E) that provides specific legal “safe harbors” for providers and payers entering into accountable care contracts. The law was then amended in 2012 to add more specificity, since the ACO concept at the federal level had recently been articulated in detail by CMS. This law gives the New York State Department of Health—in consultation with the State’s Department of Financial Services (DFS), which regulates insurance—the ability to issue Certificates of Authority (COAs) to provider groups meeting specific requirements (e.g., governance, operation, state supervision, and public reporting). The COAs authorize these groups to operate as accountable care organizations. The law has three different features:

- Although Medicare ACOs do not need a state license to operate in New York, the option of obtaining one enables ACOs to obtain state-level flexibility or corporate authority that makes operating a Medicare ACO easier. This statute gives provider groups participating in the Medicare ACO programs (both Pioneer and MSSP) an expedited process for receiving a state COA, as well as the legal protections such certification brings.
- It offers additional legal protection to providers pursuing accountable care contracts with commercial payers. The DFS currently reviews certain arrangements between insurers and providers, under regulations that seek to ensure that providers taking on financial risk have adequate reserves in place to meet their obligations. The ACO statute is not intended to duplicate that existing State regulatory oversight of financial risk transfer between insurers and health care providers.
- The statute also provides a legal framework for the creation of Medicaid ACOs in New York State, but (as discussed below) it is not yet clear how the state will proceed in that regard. An interagency work group is currently considering those options.

The Department of Health is presently drafting regulations that will accompany this statute.

Payer Involvement in Accountable Care

Broadly speaking, health insurance includes three lines of business, which align with different populations: Medicare; Employment-based, Group, or Individual health insurance (collectively referred to as commercial insurance); and Medicaid. Medicare, Medicaid
and commercial insurance cover different populations, have different ultimate purchasers, and interact differently with the various payers, which in turn pay providers using different mechanisms. As discussed below, each of these three populations is positioned differently for accountable care.

- Nationally, three-quarters of Medicare beneficiaries are enrolled in traditional Medicare, which pays providers using a traditional fee-for-service system and is administered through CMS. One-quarter are enrolled in a managed care option, the best known being Medicare Advantage, which can be provided through approved managed care plans, including commercial plans.

- Employment-based, Group, or Individual health insurance is largely provided by commercial health insurance plans (including commercial managed care plans), which can pay providers under any method they choose, ranging from traditional fee-for-service to capitation. Commercial payers also serve managed care patients insured by Medicare (Medicare Advantage) and Medicaid (Medicaid managed care).

- Medicaid in New York has been moving away from a fee-for-service payment model toward one based on care management for all with improved financial incentives. Care management can be delivered in any coverage setting, managed care being the most obvious and prevalent in New York. Currently, three-quarters of all Medicaid beneficiaries are members of managed care plans, which receive capitated premiums from the State Office of Health Insurance Programs to cover all of those beneficiaries’ care. The State plans to move most of the remaining Medicaid beneficiaries—including many of the most costly and complex patients in the Medicaid program—into managed care over the next few years. It is not yet clear to what extent New York Medicaid intends to deploy ACO care management to people remaining in so-called fee-for-service Medicaid, but the tools are there if the Department of Health decides to do so.

**Medicare**

The Medicare ACO program applies only to members in the traditional Medicare program, which currently pays providers using a fee-for-service payment system. The Medicare ACO is by far the best known and understood of the various payers’ approaches to accountable care. Because it is a public program and one of the centerpieces of the ACA, there is a high level of transparency around CMS’s approaches, models, mechanics, and metrics, and around the providers selected to participate in it. The Medicare ACO program includes both beneficiaries whose only coverage is Medicare, as well as dually eligible beneficiaries who are jointly covered by Medicare and Medicaid.

To date, 17 provider groups based in New York State (see Figure 2) have been selected by CMS to participate in its ACO programs. Sixteen were selected for the Medicare Shared Savings Program, and one (Montefiore) was selected for the Pioneer ACO Model.

**Commercial Payers**

Accountable care contracts between commercial payers and provider groups are somewhat less transparent than their Medicare analogs. Unless the participants choose to issue press releases or otherwise publicize them, these arrangements are, like any other contractual relationship between payers and providers, largely opaque.

While it is difficult to quantify the number of such arrangements or to describe their mechanics in detail, Leavitt Partners, a group with a national perspective on the accountable care movement, estimates that accountable care contracts between commercial payers and providers outnumber Medicare ACOs, covering at least as many people (Muhlestein et al. 2012).

Commercial payers are also reported to be crafting their accountable care contracts using many of the same basic approaches and techniques that CMS has used, in such areas as patient attribution, payment methods, shared savings, and performance measures. One important consideration when discussing commercial payers is that they often offer products in all three lines of business—commercial insurance to employers, groups, and individuals, whether as an HMO/managed care...
In addition to the New York-based providers, two groups located in adjacent states (Hackensack University Medical Center in New Jersey and the Geisinger Health System in Pennsylvania) selected by CMS to participate in the Medicare ACO program have proposed to serve populations in New York State.
product, or as fee-for-service; Medicare Advantage; and Medicaid managed care. When a commercial payer chooses to pursue an accountable care contract with a provider group, it can craft and execute accountable care contracts that include any or all of its products and populations.

Figure 3 presents some examples, drawn from publicly available information, of commercial payers’ accountable care arrangements in New York State.

**Medicaid**
Implementing accountable care under New York’s Medicaid program is complicated by the fact that the great majority of Medicaid beneficiaries are already enrolled in Medicaid managed care.

For those beneficiaries, the New York State Office of Health Insurance Programs already pays capitated premiums for three-quarters of its beneficiaries to nonprofit and commercial managed care plans, which are accountable to the State for measures of quality, patient satisfaction, and costs of care. HMOs and prepaid health services plans (PHSPs) participating in the program already bear the insurance risk for those populations, and most have developed a sophisticated infrastructure to support member services, provider relations, utilization management, quality improvement, patient education, and engagement and care management.

It is understandable why providers would wish to contract directly with the State. Such contracts would, in theory, enable them to eliminate a middleman (the managed care plan), and gain direct access to the Medicaid capitation payment. In some cases, however, particularly among provider-sponsored PHSPs (e.g., HealthFirst and MetroPlus), the sponsoring providers are already at some financial risk for

**Figure 3. Examples of Accountable Care Contracting with Commercial Payers**

<table>
<thead>
<tr>
<th>Provider</th>
<th>Payer</th>
<th>Payment Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adirondack PCMH Demonstration</td>
<td>All payers</td>
<td>PCMH care management, shared savings</td>
</tr>
<tr>
<td>Crystal Run Healthcare</td>
<td>Aetna, MVP, Affinity, Empire BlueCross BlueShield, and others</td>
<td>Quality incentives, shared savings</td>
</tr>
<tr>
<td>Kaleida Health</td>
<td>BlueCross BlueShield of Western New York</td>
<td>Quality incentives, shared savings</td>
</tr>
<tr>
<td>North Shore-LIJ</td>
<td>United Healthcare</td>
<td>Quality incentives, shared savings</td>
</tr>
<tr>
<td>Montefiore Medical Center</td>
<td>EmblemHealth, Empire BlueCross BlueShield</td>
<td>Capitation, shared savings</td>
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<td>Mt. Kisco Medical Group</td>
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<td>New York City Health and Hospitals Corporation</td>
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<td>WESTMED Medical Group</td>
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<td>Quality incentives, shared savings, some percentage of premium</td>
</tr>
</tbody>
</table>
their performance. Their management of their members' care, utilization and costs affects the profitability of the plan as a whole; and in some cases the plan passes through to the provider or shareholder some of the savings (or losses) incurred in caring for plan members attributed to their delivery system.

If the State wishes to enable providers to participate more directly in accountable care arrangements, there appear to be two broad options:

- for the State to enable providers to establish new provider-operated accountable care plans, allowing members served by a given delivery system to disenroll from their current managed care plan and shift to that system's new accountable care plan (with the state paying their premium directly to the provider group); or
- for providers to partner with existing managed care plans to develop accountable care arrangements—potentially using a shared savings model, or using partial or full-risk capitation—to delegate to the accountable care provider some or all of the plans' insurance risk.

These models are by no means the only ways in which the state's Medicaid program can move toward accountable care. A number of other special-purpose Medicaid networks are already developing, focused on improving care coordination and the quality of care for specific populations of Medicaid beneficiaries. One example is the managed long-term care (MLTC) program, an area in which a number of provider-sponsored plans already exist (Samis, Detty, and Birnbaum 2012). The MLTC program reorganizes payment and health care delivery for Medicaid beneficiaries who are using institutional and community-based long-term care.

Another example is the Medicaid Health Home program, under which providers across the state are forming new networks (including providers of physical and mental health services, substance use treatment programs, community organizations, and agencies addressing social services and housing) to better manage the care and reduce the expenditures of some the Medicaid program’s most complex, highest-cost beneficiaries. In the Medicaid Health Home program, providers are being paid differently, receiving a risk-adjusted care management payment, to cover the costs of providing enhanced care management; and the Health Homes will have the opportunity to share in the savings (if any) they generate against a target expenditure, for patients for whom they have accepted responsibility (Patchias, Detty, and Birnbaum 2013).

Organizational Models for Accountable Care

The challenge in creating an accountable care network is to aggregate the providers and organize the delivery system differently. Among these various new partnerships and configurations, there are three organizational models that have particular promise as pathways to the creation of an accountable care network: multispecialty group practices, independent practice associations, and integrated delivery systems or networks (Shortell 2010).

Multispecialty Group Practices

The first organizational model for an accountable care network builds on the foundation of a high-functioning multispecialty group practice (MSGP), an organized, self-governing group of physicians that generally has well-developed and legitimate processes for peer review of quality, utilization, and cost, and has the systems required to effectively manage the health and health care of defined patient populations on its panel (Shortell and Schmitlein 2004; Tollen 2008). Many health systems regularly cited as high-performing—for instance, Group Health, Kaiser, the Geisinger Health System, and the Marshfield Clinic—have a well-established multispecialty group practice as their foundation.

In New York, group practices range in scope and capability from small single-specialty groups to large multispecialty groups that have a strong PCMH base, fully capable EMR systems, sophisticated care management utilization management, and effective systems to support quality improvement. The larger and more
capable groups are all potentially well positioned to serve as regional accountable care organizations.

To date, CMS has selected five multispecialty groups based in New York to participate in the Medicare Shared Savings Program:

- the Accountable Care Coalition of Mount Kisco,
- the Accountable Care Coalition of Syracuse (based in FamilyCare Medical Group),
- Crystal Run Healthcare ACO in Middletown,
- ProHealth Accountable Care Medical Group in Nassau County, and
- WESTMED Medical Group in Westchester County.

In addition, a number of MSGPs in New York State have accountable care contracts with private insurers, covering their commercially insured and managed care populations. WESTMED Medical Group has such contracts with Aetna, Cigna, United Healthcare/Oxford, and Empire Blue Cross; the Mount Kisco Medical Group and the Weill-Cornell Physicians Organization (the faculty practice for the Weill-Cornell Medical School) both have collaborative accountable care contracts with Cigna; and Crystal Run Healthcare has accountable care contracts with Aetna, MVP, Affinity, Empire BlueCross BlueShield, and others.

Two of these groups—Crystal Run Healthcare and WESTMED—are profiled below.
Crystal Run Healthcare: A Multispecialty Group in Middletown

In Orange and Sullivan Counties, Crystal Run Healthcare (CRHC), a large multispecialty group practice, is transforming the way it provides health care. CRHC’s senior leadership is committed to moving away from compensation based on fee-for-service and relative value units, leading the move to value-based purchasing and care transformation. The Medicare ACO is part of that transformation. Since the practice is changing its model for all patients (“payer agnostic”) CRHC is pursuing accountable care contracts with other payers as well. CRHC has received National Committee for Quality Assurance (NCQA) recognition as a Level 3 PCMH and as an ACO.

History: Crystal Run Healthcare started in 1996 as a multispecialty group practice; today, the group has over 300 providers in over 40 medical specialties with 15 practice locations across Orange and Sullivan Counties.

Crystal Run has an extensive program base. In addition to its ambulatory practice sites, CRHC has hospitalists at all local hospitals, urgent care centers for after-hours care, nursing home-based physicians to manage CRHC patients in area nursing homes, and a transition manager (an RN) in its primary hospital. Crystal Run has had a fully functional EMR system since 2000, including all providers in its practice sites as well as those in area hospitals, urgent care centers, and nursing homes.

The Medicare ACO: CMS’s MSSP contract is with Crystal Run Healthcare ACO, LLC, a new corporation developed by CRHC

Structure: Multispecialty group practice

Model: Shared savings, one-sided risk, no advance payment

Governance: The board of the ACO has 10 members, essentially all physician leaders or partners in the practice; and a 6-member Medicare Beneficiaries Advisory Council, the chair of which attends meetings of the ACO board in a non-voting advisory capacity

Service Area: Orange and Sullivan Counties, with small populations attributed from New Jersey and Pennsylvania

Physicians: 250 total physicians in Crystal Run and ACO; 40 percent are primary care

Medicare Beneficiaries: CMS has attributed 10,000 Medicare beneficiaries to Crystal Run’s ACO

Role of Hospitals: None of the area hospitals are included as partners under the shared savings program

Infrastructure

PCMH: All of Crystal Run’s primary care practices have been recognized by NCQA as Level 3 PCMHs

HIT/Analytics: Crystal Run has a sophisticated EMR system, with data and analytics capacity in-house. CRHC is working with the Advisory Board’s Crimson Initiative for claims-based data and analytics, and has an ongoing relationship with Milliman for actuarial analyses and utilization management.

Care Coordination: CRHC has had a care management program in place since 2004. CRHC’s nurse care managers received training in Geisinger’s guided care model. CRHC now has on-site care managers at all of its primary care practice sites.

Quality: Crystal Run has a robust quality improvement program that covers all practices and populations. Treatment decisions are based on nationally accepted, evidence-based guidelines. Using standard tools (HEDIS, etc.), CRHC has developed and used performance dashboards focusing on key Medicare metrics of cost, quality, and patient experience, mainly for primary care but expanding now to specialties too.

The practice has received NCQA recognition as a PCMH (Level 3 under 2011 standards) and as an ACO; CRHC is currently the only provider/system in New York State to have achieved NCQA ACO recognition.
WESTMED: A Multispecialty Group in Westchester

WESTMED Medical Group is a large and growing multispecialty group practice in Westchester County that is pursuing accountable care with as many payers as it can. WESTMED’s vision is to be an organization that focuses on value and performance, working under value-based payment arrangements, which will improve quality, reduce costs, be better for the community, and improve the viability of the practice. WESTMED’s leaders consider capitation payment not as a risk, but as a way for physicians to control their own destiny, keeping decision-making in physicians’ hands, allowing them to keep people healthy and manage care more efficiently.

History: The Westchester Medical Group (now WESTMED) started in 1996 with 16 physicians (12 internists and 4 specialists), most of whom retained their office-based practices, sharing lab services and billing. In 1999, the group absorbed the nearby Kaiser facility and 20 Kaiser Permanente physicians, contracting with additional payers under a variety of payment schemes, including capitation. Today, the group has 250 MDs in four large sites in central and southern Westchester. WESTMED continues to grow by roughly 20 percent per year. WESTMED has had an EMR system (GE Centricity) since 2002. It also has hospitalists in all three local hospitals, maintains urgent care centers for after-hours care, and is placing physicians in area nursing homes. WESTMED is changing the delivery system for all of its patients, which requires multipayer support to cover program infrastructure. It is working with a number of commercial payers and Medicare managed care plans (Cigna, Aetna, Oxford, and Empire) to develop similar changes in payment.

The Medicare ACO: CMS’s MSSP contract is with WESTMED Medical Group, PC

Structure: Multispecialty group practice

Model: Shared savings, one-sided risk, no advance payment

Governance: Board and committees are the same as WESTMED’s, but for the ACO program, there is an advisory committee that includes Medicare members

Service Area: Central and southern Westchester; less than 10 percent from southern Fairfield County in Connecticut

Physicians: WESTMED has 250 physicians, roughly half of whom are in primary care

Medicare Beneficiaries: CMS has attributed 11,500 Medicare beneficiaries to WESTMED’s ACO

Role of Hospitals: None of the area hospitals are included as partners under the shared savings program. In the future, WESTMED may make contracts with hospitals that include some sharing of savings and risk

Infrastructure

PCMH: All of WESTMED’s primary care practice sites have been recognized by NCQA as Level 3 PCMHs

HIT/Analytics: WESTMED has sophisticated data and analytics capacity in-house, through EMR and practice management systems. It is contracting with Optum Analytics, a division of United Healthcare, to develop and manage its claims-based data and analytics.

Care Coordination: WESTMED is putting into place a robust care management program with embedded care managers (also supported by Optum Analytics, which is providing technical assistance) at its four large sites

Patient Engagement: WESTMED is using EMMI (a patient engagement consultant with a suite of internet-based interventions) to assist with patient education and engagement. Its initial focus is on diabetes and behavioral health management. WESTMED has also hired two psychiatrists.

Quality: WESTMED is using performance dashboards focusing on key Medicare metrics of cost, quality, and patient experience, using standard tools (HEDIS, etc.). ACO preparation has focused on quality improvement and variation reduction, with workgroups including ambulatory care pathways (symptoms/diagnoses and transitions), palliative care, referrals, care management, and urgent care.
Independent Practice Associations
A second model for an accountable care network is the independent practice association (IPA), a group of independently practicing physicians organized to accomplish together what its members could not accomplish alone. Many IPAs trace their roots back to the 1990s, when they served as vehicles for physicians to negotiate contracts and rates with payers or to enable them to accept and manage risk.

In New York, IPAs are taking on a series of new roles: negotiating pay-for-performance arrangements with payers; organizing the financing for and implementation of network-wide EMR systems; expanding their member physicians’ capacity to exchange clinical information through regional health information organizations; assisting in the capitalization and implementation of PCMHs; and developing and sharing services (e.g., care management and patient education) that their member physicians and practices need to manage population health but could not otherwise afford.

A number of these IPAs have also developed increasingly sophisticated systems to support care management, utilization management, and IPA-wide programs of quality improvement.

These capacities—the ability to manage care across the continuum, and to measure, manage, and report on population-based measures of quality, patient experience, utilization, and cost—position them well to serve as accountable care organizations.

To date, CMS has selected seven New York-based physician-led IPAs to participate in the Medicare ACO Shared Savings Program:

- the Accountable Care Coalition of the North Country (the North Country Physicians Organization) in St. Lawrence and Franklin Counties,
- the Asian American Accountable Care Organization in New York City,
- Balance Accountable Care Organization in New York City,
- Beacon Health Partners in Nassau County,
- Chautauqua Region Associated Medical Partners in Jamestown,
- the Chinese Community Accountable Care Organization in New York City, and
- Healthcare Provider ACO in Nassau County.

Three of these IPA-based accountable care networks are profiled below.
Beacon Health Partners: A Physician-Led IPA Model Based on Long Island

Based in Manhasset, Beacon Health Partners is a grass-roots, physician-owned and -governed organization whose vision is to become a recognized leader in implementing comprehensive care management programs and pay-for-performance reimbursement models tied to quality measures and patient outcomes. With a membership of 280 autonomous, independently practicing physicians, Beacon is committed to becoming a clinically integrated physician network that enhances the viability and sustainability of independent physicians. Participation in the ACO Shared Savings program is one way to achieve that. Beacon is working with a number of commercial payers to expand its involvement in a range of accountable care and shared savings arrangements.

**History:** Beacon Health Partners is an IPA led, owned, and managed by physicians. Beacon started in 2010, expanding over the next two years to include 280 privately practicing physicians practicing on Long Island and in Queens, Brooklyn, and Manhattan. In 2011, Beacon entered into a three-year collaborative agreement with Empire BlueCross BlueShield, to help move toward becoming an ACO. Building on that experience, infrastructure, and practice support, Beacon applied to participate in the MSSP and was selected in 2012.

**The Medicare ACO:** CMS’s MSSP contract is with Beacon Health Partners, LLP

**Structure:** IPA

**Model:** Shared savings, one-sided risk, no advance payment

**Governance:** Beacon has a 15-member board that meets the requirements of the ACO program. The Board has a range of committees, including Quality, Utilization Review, Finance, and Membership, as well as a Medicare Beneficiary Advisory Group.

**Service Area:** Beacon serves Long Island, Queens, and parts of Brooklyn and Manhattan

**Physicians:** Roughly 280 physicians, nearly 100 practices involved in Beacon’s ACO

**Medicare Beneficiaries:** Roughly 13,000 Medicare beneficiaries have been attributed to Beacon’s participating physicians

**Role of Hospitals:** Beacon is partnering with all the local hospitals and health systems on the management of patients requiring hospitalization, but hospitals are not currently involved in either Beacon’s governance or its planned shared savings distribution

**Infrastructure**

**PCMH:** Beacon’s leaders consider the medical home model to be an essential foundation for accountable care, and is pursuing PCMH recognition for about 60 primary care practices within the network. Beacon is providing resources (including staff to work directly with providers on practice transformation) to assist practices in making the changes required to achieve NCQA recognition.

**HIT/Analytics:** Beacon has helped its members to adopt, implement, and use EMRs, and to meet CMS’s “Meaningful Use” criteria. Beacon is evaluating alternative vendors and partners that could provide population health management, claims-based analytics, care coordination tools, and reports based on key performance indicators to support the ACO and similar ventures.

**Care Coordination:** Beacon is building care coordination teams to make an integrated care coordination/care management program available to participating practices. This program is starting as a centralized service, with care coordinators supported and deployed to the practices. Beacon’s longer-term goal is to train and use staff working in the practices as much as possible.

**Quality:** Beacon is putting in place a range of quality measurement, reporting, and improvement processes as part of its preparation for the MSSP, as well as the PCMH and pay-for-performance processes in which its member practices participate.
Chautauqua County AMP: A Rural, Regional ACO in Western New York

In the state’s westernmost county, providers and social service agencies have come together around a common vision for this rural community: to move toward a higher-performing health system, improving the quality and performance of the region’s health system; better managing utilization of specialists and hospital/ED visits by focusing on care coordination, care management, and communication; and improving performance against quality benchmarks to achieve savings. Encouraged by their selection as a Medicare ACO, they are considering the prospects for broader accountable care contracting with other payers in region.

History: Chautauqua County is a rural community with a history of regional planning and cooperation, often led by the Chautauqua County Health Network, a rural health network. The Chautauqua County Regional Association Medical Partners (AMP) grew out of an IPA (the Chautauqua County Integrated Delivery System, or IDS) that was founded in 1997 to contract with payers for Medicare managed care.

The Medicare ACO: CMS’s contract is with the Chautauqua County Regional Association Medical Partners (AMP), a new organization formed to participate in MSSP

Structure: Joint venture between independent community hospitals, long-term care providers, and primary care professionals

Model: Shared savings, one-sided risk, no advance payment

Governance: Board includes PCPs; representatives from hospitals, long-term care providers, IDS, and community-based providers through CCHN; and a Medicare beneficiary

Service Area: Chautauqua County, and the region served by their participating PCPs

Physicians: 35 primary care physicians

Medicare Beneficiaries: 6,996 Medicare members attributed

Role of Hospitals & Other Partners: All local hospitals involved; they have three board seats. The board also includes a seat for long-term care providers and for the region’s rural health network. AMP is working closely with social service providers and the regional Agency on Aging.

Infrastructure

PCMH: CCHN has worked with the region’s primary care physicians to achieve NCQA recognition. Most of the participating practices (86 percent) have NCQA recognition as PCMHs and the remainder will be working toward designation in 2013.

HIT/Analytics: CCHN, IDS, and AMP have partnered with Covisint to develop an intra-county health information exchange, built in complement with the Regional Health Information Exchange. It will provide analytics and a companion secure messaging and referral communications application extending connections to the different affiliates. AMP currently has the capacity to provide clinical decision support and conduct basic analytics on aggregated chronic disease registries using the system.

Care Coordination: RNs certified in the Johns Hopkins Guided Care Model are leading the care management program from the PCMH. With an initial focus on complex ill patients, staff are utilizing a variety of patient engagement tools and coordinating chronic disease care with community-based services. Local hospitals are also participating in CMS Partnership for Patients initiatives, including the HANYS Hospital Engagement Contractor and the regional Community-Based Care Transition Intervention.

Quality: CCIDS has put in place a range of quality measurement, reporting, and improvement processes as part of the PCMH and pay-for-performance processes in which the region’s practices participate. AMP will be building on that foundation, and using the infrastructure already developed for its ACO quality improvement program.
The Chinese Community Accountable Care Organization: Accountable Care for a Special Population

The Chinese Community Accountable Care Organization (CCACO) was organized to serve New York City’s Chinese community, focusing its efforts on providing culturally competent care to its patients while improving their health care and reducing costs. This collaboration of physicians with expertise in caring for this underserved minority population with special considerations is working with its community partners, hospitals, visiting nurse services, home care service agencies, churches, senior centers, and senior social day care centers. It will engage patients and their families, encouraging them to participate in their care plans and disease management.

The CCACO is pursuing the Triple Aim—improving performance in quality, satisfaction, and cost—with a specific focus on improving care for elderly Chinese people, a unique and special population facing barriers in both language and information. The CCACO is also providing care that is culturally sensitive; dealing with issues of transportation, food, and prescription drugs; and addressing care coordination, the management of care transitions, particularly as patients are admitted to and discharged from hospitals.

History: The CCACO was formally organized in February 2011 by a committee of 29 Chinese-American physician leaders practicing in areas of New York City where there are sizeable Chinese communities (Manhattan, Brooklyn, and Queens)

The Medicare ACO: CMS’s MSSP contract is with the Chinese Community Accountable Care Organization
Structure: IPA
Model: Shared savings, one-sided risk, no advance payment
Governance: In February 2011, the organizing committee elected an 11-member board, composed of physicians
Service Areas: In New York City, the CCACO is most involved in communities with large concentrations of Chinese elderly, including lower Manhattan, Flushing in Queens, and Sunset Park in Brooklyn
Physicians: Over 200 physicians are participating in the CCACO. Roughly half are primary care physicians. Most are in small practices, but there are some groups of 5–10 physicians.
Medicare Beneficiaries: Roughly 12,000 Medicare members have been attributed to CCACO providers. Of that total, roughly 40 percent live in Brooklyn, 30 percent live in Queens, and 30 percent live in Manhattan.
Role of Hospitals: The CCACO does not have a hospital represented on its board, but its advisory committee includes hospital leaders from each of its service areas. It has not yet finalized how it would distribute any savings generated. The CCACO also works closely with a range of community nonprofit agencies on housing, transportation, health services, and infrastructure, as well as other services for seniors.

Infrastructure
HIT/Analytics: Most physicians have EMR systems, and the CCACO is encouraging all to get them. It will be working with an outside vendor (not yet selected) on finance and utilization analytics.
Care Coordination: The CCACO is currently working out the logistics of mounting an organized care management and care coordination program. It sees dedicated care managers as essential, and is considering how best to deploy them—possibly through a combination of centralized care managers and as many others as are affordable located in physician practices.
Quality: The quality improvement program, receiving oversight and support from the CCACO, will become a centralized function. Provider and patient education and patient engagement are also key areas for investment.
Hospital-Physician Partnerships and Systems

A third model involves hospital-physician partnerships and integrated systems, in which physicians and hospitals work together to improve clinical integration within their network, to improve the quality of care, and increase the use of evidence-based approaches to care in both hospitals and physician practices. In such partnerships, physicians and hospitals work together to measure, report on, and manage quality, utilization, and cost; and to better manage referrals, care transitions, and coordinated care for all patients, particularly those with chronic conditions.

Hospital-physician partnerships and systems are well positioned to act as accountable care networks and to accept responsibility for the care of populations. In New York State, a number of health systems (including Montefiore Medical Center, the New York City Health and Hospitals Corporation, and Mount Sinai Medical Center in New York City; North Shore-LIJ on Long Island; Bassett Health in central New York; and Kaleida Health and the Catholic Health System in Buffalo) already have in place much of the foundation needed to serve as an accountable care network. They have strong, mutually supportive relationships with their physicians (many employed by the medical center or an affiliated group or IPA); the capacity to provide and manage care across the full care continuum; and strong relationships with payers that could evolve into risk-sharing, accountable care partnerships.

Five of these systems and partnerships have been selected by CMS to participate in Medicare’s ACO program. Montefiore was named by the CMS Innovation Center as one of 32 Medicare Pioneer ACOs in January 2012. Over the next year, four more systems were selected to participate in the Medicare Shared Savings Program:

- Catholic Medical Partners/Catholic Health System in Buffalo,
- Mount Sinai Care in New York City,
- Bon Secours Health System in Orange and Rockland Counties, as part of a multi-state ACO, and
- New York City’s Health and Hospitals Corporation.

At least four hospital-physician partnerships have accountable care arrangements with commercial payers: Kaleida Health in Buffalo recently entered into an accountable care arrangement with BlueCross BlueShield of Western New York; Montefiore has a longstanding relationship with Emblem Health, under which the hospital and its physicians accept full-risk capitation payments covering the total costs of care for its members in the Bronx and southern Westchester counties, and, more recently, an accountable care arrangement with Empire BlueCross BlueShield; the New York City Health and Hospitals Corporation has a longstanding relationship with MetroPlus; and the North Shore-LIJ Health System is developing an accountable care relationship with United Healthcare.

The development of integrated physician-hospital organizations and health systems has the potential to transform the provider landscape in New York, creating increasingly large and capable regional health care delivery systems that could eventually serve as accountable care organizations.

Four health systems participating in the Medicare ACO Program are profiled below.
Catholic Medical Partners: An Integrated Delivery System in Western New York

In western New York, Catholic Medical Partners (a network of more than 900 independent practicing physicians) and Catholic Health Services (CHS, an integrated delivery system that includes three hospitals, two nursing homes, and a home health agency) have partnered to create a Medicare ACO to serve the people of the economically challenged Erie and Niagara counties. Catholic Medical Partners (CMP) and its providers are focused on accelerating clinical redesign and creating the infrastructure to achieve the Triple Aim: to improve the efficiency, safety, quality and coordination of care, to educate and involve patients in their own care and to share information resources, in order to make a difference in patients’ lives.

History: Formed in 1999 as a physician-led IPA that includes practicing physicians in Erie and Niagara Counties, CMP (originally Catholic IPA, or CIPA) is a well-developed and capable IPA. It has developed a series of capacities to serve their constituent physicians, including providing capital and technical assistance to accelerate the adoption and use of electronic health records.

In partnership with Catholic Health System, CMP has led clinical integration initiatives for its members, including acquisition of electronic medical records, participation in the region’s clinical data exchange, clinical registries, and care coordination. CMP supported its primary care physicians in achieving NCQA recognition as Level 3 PCMHs. CHS and CMP have experience with risk-based payment. The two organizations partnered for more than eight years on a variety of risk-based contracts and have developed many capabilities required to manage populations under risk arrangements.

The Medicare ACO: CMS’s MSSP contract is with Catholic Medical Partners Accountable Care (CMPAC), a partnership between CMP and CHS

Structure: IPA / health system

Model: Shared savings, one-sided risk, no advance payment

Governance: CMPAC has a separately incorporated board with 18 physician directors, 6 directors from CHS, and 1 consumer

Service Area: 70 percent of CMP’s ACO members come from Erie County; the remainder come from surrounding counties in western New York

Physicians: 951 physicians in the IPA, including 280 primary care physicians

Medicare Beneficiaries: CMS has attributed 29,500 Medicare beneficiaries to CMP physicians

Role of Hospitals: CHS hospitals are full partners, and have seats on the CMPAC board

Infrastructure

PCMH: Over half of the physicians in the CMP network have been recognized by NCQA as Level 3 PCMH providers

HIT/Analytics: CMP/CHS has developed substantial in-house data analytic capabilities. It uses MedInsight data analytics and the Sorian clinical system.

Care Coordination: CMP/CHS has invested in care management, with 280 nurses trained as care coordinators, all embedded in the practices. Care coordinators are augmented by pharmacists, nutritionists, social workers, and therapists, all of whom are also available to the practices. CMP has an NCQA-accredited disease management program.

Quality: CMP has invested in quality improvement (QI) processes, supported by HIT systems and central staff who track, analyze, and report on over 5,000 data points, developing provider report cards that show performance in prevention and chronic care, patient satisfaction, network utilization patterns, and avoidable hospitalizations and rehospitalizations. This effort has enabled its members to participate in a variety of pay-for-performance initiatives, and it provides the foundation for the ACO’s QI program.
Montefiore Medical Center: New York’s Only Pioneer ACO

The Bronx, the nation’s poorest urban county, may not be a place one would expect to find a well-developed example of accountable care. But that is where and what Montefiore Medical Center (MMC) is. The University Hospital for the Albert Einstein College of Medicine, MMC has developed an extensive and capable integrated delivery system, and—over a period of 15 years—has put in place the organizational structures and processes that enabled it to accept and manage full-risk capitation contracts, first with commercial payers and Medicaid managed care plans, and more recently with CMS as the state’s only Pioneer ACO.

MMC’s goal is to improve the health of the populations it serves in the Bronx and southern Westchester, providing them with a full range of high-quality, cost-effective services, with as much of that care as possible provided under capitation or shared savings arrangements.

History: Over the past 20 years, MMC has built one of the state’s largest, most comprehensive delivery systems, with an extensive community-based primary care network, specialty care in three major “hubs,” four hospitals, a home health agency, and an enterprise-wide electronic medical record system.

In 1996, MMC created two organizations enabling it to participate in managed care: a physician-medical center IPA to serve as a contracting vehicle, and a care management organization (CMO) to provide the infrastructure required for capitated managed care contracts. By 2011, the medical center was serving over 150,000 members under full-risk contracts with a variety of managed care plans, including commercial payers, Medicare Advantage, and Medicaid managed care. This foundation enabled MMC to be selected by CMS as a Pioneer ACO program in December 2011.

The Medicare ACO: CMS is contracting with an affiliate of Montefiore’s IPA

Structure: IPA / health system

Model: Pioneer ACO

Governance: The ACO is affiliated with the Montefiore IPA, but is separately incorporated with its own board (4-5 physicians, 4 medical center representatives, and 2 Medicare beneficiaries)

Service Area: Initial service area is the Bronx and southern Westchester

Physicians: 2,400 physicians in the IPA, including 450 primary care physicians, and 700 NPs, PAs, and psychologists

Medicare Beneficiaries: CMS has attributed 23,250 Medicare beneficiaries to Montefiore physicians

Role of Hospitals & Other Providers: Montefiore hospitals are full partners, represented on the ACO Board. Montefiore has requested that CMS approve an expansion of the ACO to include additional providers, each of which would accept responsibility for its own attributed populations.

Infrastructure

PCMH: Most of MMC’s primary care practices have been recognized by NCQA as Level 3 PCMHs

HIT/Analytics: MMC has an enterprise-wide EMR system, and the CMO has a data/analytics team experienced in both analyzing claims data and using them to support operations, financial management, and utilization management. MMC is also working with Treo, Inc. on data and analytic support.

Care Coordination: One of the CMO’s core competencies is care management, with nearly 300 staff (RN, LPN, SW, and analysts) working with systems that enable them to identify, stratify, track, and manage the care of high-risk patients

Quality: The IPA has well-developed systems to measure, report on, and analyze performance data, and a robust program to support quality improvement around populations for whom the IPA has accepted responsibility
Mount Sinai Care: Accountable Care in an Urban Academic Medical Center

In 2010, Mt. Sinai Medical Center began to pursue accountable care to help prepare the organization for a changing health care environment; to enable them to participate in and benefit from those changes; to improve the quality and cost-effectiveness of the care provided; and to put in place capacities needed for population health management. Through the Medicare ACO, Mt. Sinai is working with its affiliated and employed physicians on population health management and improvement, positioning it for a number of possible futures in which payment will flow differently, including full-risk capitation and other population and performance-based payment systems. In particular, the organization’s leaders feel strongly that expanding and supporting a high-performing primary care base is the right thing to do.

History: This effort began formally two years ago, when Mt. Sinai began an initiative to increase the medical center’s preparedness for health reform by improving the quality and cost-effectiveness of the care provided.

The Medicare ACO: CMS’s MSSP contract is with Mount Sinai Care, LLC, a new corporation formed for the purpose of participating in the MSSP. Mt. Sinai School of Medicine (MSSM) is the sole member of this new corporation.

Structure: Health system, including hospitals and physicians, sponsored by a medical school

Model: Shared savings, one-sided risk, no advance payment

Governance: Mt. Sinai Care’s board of directors includes full-time faculty from the School of Medicine (three-fourths of the board are physicians participating in the ACO as providers), representatives of the hospital and medical center administration, a member of the medical center’s board of trustees, and a Medicare beneficiary

Service Areas: Manhattan, around the medical center on the Upper East Side and East Harlem; western Queens, with physicians who practice around Mt. Sinai Hospital Queens; Yonkers, where Mt. Sinai has seven physicians; and on Long Island’s north shore, where Mt. Sinai has an affiliated group of 70 physicians

Physicians: Roughly 1,500 physicians, 140 of whom are primary care physicians. All of the primary care physicians are Sinai full-time staff.

Medicare Beneficiaries: CMS has attributed roughly 26,000 Medicare beneficiaries to Mount Sinai Care across the service area

Role of Hospitals: Mt. Sinai Care has Mt. Sinai Hospital and its affiliated hospitals in Queens as full partners; and is working with Huntington Hospital (a North Shore-LIJ network member) and St. Catherine’s Hospital on Long Island

Infrastructure

HIT/Analytics: Mt. Sinai uses Epic for ambulatory and inpatient care. It has a variety of tools for population health management, including registries. It is also working with Oracle for data management and reporting on Medicare claims data, with the potential to cross-link to Epic. A group of policy and data analysts at MSSM who are familiar with the use of Medicare claims data for research purposes are part of the team. Mt. Sinai is also evaluating three strategic development partners to develop and produce analytics and report cards on performance.

Care Coordination: Mt. Sinai is using data from Epic to track patients who are at risk, have “gaps in care,” or who need care management. It is also placing care coordinators in primary care practices, using a combination of HIT and care management staff to separate at-risk populations into low-risk (assigned to BA-trained staff for contact and follow-up) and high-risk (assigned to Master’s-level SW or MPH), with a particular focus on hospital-to-home care transitions.

Quality: The Mt. Sinai ACO has a robust quality improvement program, using quality metrics from the Epic EMR system, focusing on analytics and reporting back to physicians. The data system produces quarterly reports quarterly at the physician, practice, and ACO level, focusing on quality metrics and utilization.
The New York City Health and Hospitals Corporation: A Safety Net System Pursuing Accountable Care

The New York City Health and Hospitals Corporation (HHC), the city’s primary safety net provider, is transforming from a system of hospitals to a quality-driven, ambulatory care-centric health care delivery system that focuses on population health. With 11 acute care hospitals in four of the city’s five boroughs, HHC is the nation’s largest public hospital system, each year providing roughly 225,000 admissions, over one million ED visits, and nearly five million clinic visits to a population that is among the city’s most diverse and in need of quality health care, including 475,000 uninsured city residents. HHC has developed an affiliated Medicaid managed care plan, MetroPlus, which has enabled the system to gain experience accepting and managing full-risk capitation. HHC’s recent selection to participate in the Medicare Shared Savings Program builds on that foundation, expanding its managed care efforts to include Medicare beneficiaries.

History: Over the past 15 years, HHC has invested in a number of key capacities that have transformed the organization from a group of safety net hospitals with outpatient departments into a regional health system. HHC is staffed by salaried physicians, and it partners with a growing cadre of community-based physicians and with federally qualified health centers in the communities it serves. HHC has focused on quality improvement, and it has invested in health information technologies, managed care, and care management.

With the growth of its managed care affiliate, MetroPlus, HHC has gained skills and experience managing populations of patients under prepayment; and it has pioneered a number of efforts focused on managing the care of patient populations who are among the health system’s most challenging. These capacities are enabling HHC to reposition itself as a high-quality, fully integrated delivery system that includes ambulatory care, inpatient care, homecare, and an allied payer, and can focus on the Triple Aim.

The Medicare ACO: CMS is contracting with the HHC ACO, Inc., an HHC subsidiary

Structure: Integrated delivery system
Model: Shared savings, one-sided risk, no advance payment
Governance: The HHC ACO is governed by a board of 8 members including HHC leadership, physicians, and a Medicare beneficiary
Service Area: New York City
Physicians: 3,500
Medicare Beneficiaries: CMS’s initial attribution included 15,000 Medicare beneficiaries, a figure that HHC leaders expect to grow
Role of Hospitals: Full partners in the ACO, participating in shared savings

Infrastructure
PCMH: All of HHC’s primary care facilities have been recognized by NCQA as Level 3 PCMHs
HIT/Analytics: Between its existing internal capacities and those resident in MetroPlus, HHC will be handling its own EMR-based and claims-based analytics and reporting
Care Coordination: HHC has already put into place a number of care coordination programs, including social workers and care managers based in its ambulatory care practices and emergency departments. It plans to rationalize those efforts, developing a unified care management program that will be run as a centralized, shared service, with care managers embedded in the practice sites.
Quality: HHC has invested heavily in a system-wide quality improvement program, and it has achieved recognition for the effectiveness of those efforts. It plans to build increasingly sophisticated analytic and reporting capacities as centralized, shared services, and to delegate many quality improvement activities to the local leadership in its regional networks. HHC was the 2008 recipient of the National Quality Forum and The Joint Commission’s John M. Eisenberg Award for Innovation in Patient Safety and Quality.
**Issues and Challenges**

**Accountable Care, Version 1**

Despite considerable enthusiasm for accountable care and efforts by providers and payers across the state to pilot this promising model, it is important to remember that accountable care in New York State is still an experiment in its early stages.

Provider systems are just starting to organize themselves as accountable health systems capable of managing the care and costs of care for populations of patients—and of being held accountable for their performance. Accountable care requires changes in culture and frame of reference, major improvements in performance, and a series of new capacities and new skills for population health management. Not all of the provider groups currently pursuing accountable care may be able to make all of those changes.

Payers, including Medicare, are only beginning to establish accountable care payment systems. All of the MSSP participants in New York State are using what many analysts consider a “starter set”: a shared savings model with no downside financial risk. Under this no-risk model, providers are paid using existing fee-for-service payment methods, and are eligible, at the end of a budget year, to share in any savings they are able to generate compared to an expenditure target.

The challenge inherent in the shared savings model is that it leaves in place the basic features of the fee-for-service payment methodology—particularly the incentive for individual providers to generate high volumes of services, for which they will still be paid on a fee-for-service basis. Some have questioned whether such a design provides sufficient incentives for providers to change behavior—whether the prospect of achieving a bonus tomorrow can counter the fee-for-service reward for providing more reimbursable services today (Berenson 2010).

Accountable care payment models will change in the coming years, shifting toward models with stronger incentives and real risk transfer through two-sided risk and capitation. When that happens, providers who have been able to manage within the essentially risk-free shared savings program will face another set of challenges, questions about where to invest their resources and how to optimize their performance. Assuming and managing financial risk is different from a one-sided shared savings arrangement; not all of the provider groups currently pursuing accountable care may be able to make this transition.

There are several other serious challenges to the spread of accountable care in New York, and questions about its ability to address the linked problems of quality and cost. Some of those challenges are discussed below.

**Changing Culture, Relationships, and Behaviors**

Accepting and managing population-based risk requires that providers fundamentally shift their frame of reference, relationships, and behaviors.

Traditionally, health care providers have functioned as autonomous units, each focusing on its own job (e.g., seeing ambulatory patients, or providing hospital care), caring for patients one at a time, and being paid under the fee-for-service system for the volume of services it provides. Accountable care radically shifts that perspective, to one much more like that of a payer.

- Providers are accountable for the quality of care and patient experience for an entire population—the well, the acutely ill, and the chronically ill. This includes all members participating in the accountable care contract, not just those who use health care services.
- As part of that shift in perspective, they are responsible for addressing the overall health care needs of their members, not just the clinical needs of their patients. This is a fundamentally different perspective, requiring a longitudinal relationship between the provider system and the individual members.
- Under accountable care, providers view health care utilization—visits, admissions, tests and procedures—as costs rather than sources of revenue.
• They are responsible for quality, patient experience, and costs not just as individual providers but as a system.
• They are responsible for managing the population’s total health care costs—all covered health care costs generated by the defined population, not just services delivered by providers who are part of their own network.

In sum, providers must shift their perspective to that of an integrated system caring for a population of members within a fixed premium, improving the quality, coordination, and experience of care those members receive, maintaining and improving their health (not just caring for them when they are acutely ill), and being accountable for their members’ total costs of care across the care continuum. This is a major change in their frame of reference.

Two Competing Models

Broadly speaking, there are two models for accountable care: those based in organized physician groups (MSGPs or IPAs) and those involving hospital-physician partnerships. The main difference between the two is the involvement of the hospital in the network: as a partner sharing in savings, or as a vendor. Two-thirds of the Medicare ACOs named to date in New York State are based in physician groups.

A great strength of a physician-led accountable care network is the group’s clarity of focus. A physician group without a hospital component benefits financially under a shared savings model by keeping patients out of the hospital, so its priority is to build the capacity of the ambulatory care system (which it controls), in order to reduce emergency department visits and hospital admissions and readmissions (Gandhi and Weil 2012; Berenson 2010). Without a hospital partner, they have no need to share those savings with the hospital; they get to keep and distribute among its physician participants any savings they generate. The shortcoming of the physician-only accountable care network is that most have limited capital available to fund, deploy, and operate the ACO’s required infrastructure.

The physician-hospital or system-led model has the advantage of substantially greater resources (access to capital, HIT expertise, and administrative talent) that hospitals can bring to the venture. Its main challenge is that the largest and most achievable source of savings is in reducing hospital admissions, which are the hospitals’ main revenue source. Not only do hospitals stand to lose significant volume and revenue under an effective accountable care arrangement, but any savings generated would need to be shared with the participating physicians.

Organizational Challenges

Organizing a diverse group of stakeholders into a high-performing health system requires leadership and changes in historical relationships among providers, legitimate governance and decision-making processes, and a shared culture focused on quality and performance improvement.

Deciding on the composition of the provider network—determining who is involved as a partner (sharing in the potential savings), who is involved as a vendor, and who is not involved at all—is another challenge. The composition of the network, particularly the presence or absence of hospital partners, the statesmanship involved in deciding who is in and who is out, and the willingness of payers to contract with one or the other model (physician-led or system-led), could affect an accountable care network’s potential impact and degree of divisiveness in a given community.

Accountable for Quality

Under accountable care, a provider network must create new structures and processes to measure, report on, analyze, and improve performance at the provider level, in groups and system-wide. This requires a system-wide quality improvement program focused on improving quality, patient experience and utilization (particularly in reducing preventable utilization and cost), reducing variation, and employing evidence-based medicine.

In both the MSSP and Pioneer ACO Model
(and in most commercial accountable care programs), provider groups must achieve specified performance targets in quality and patient experience of care before they can share in any savings they generate. This is a key component of the accountable care contract, intended to ensure that providers focus on patients and not just on reducing their own utilization and costs.

Both of Medicare’s ACO programs currently use 33 nationally endorsed performance metrics to gauge quality of care and patient satisfaction, measures largely drawn from standard tools (the Healthcare Effectiveness Data and Information Set and the Consumer Assessment of Healthcare Providers and Systems, HEDIS and CAHPS). Some of those measures have recently been criticized by participants in the Pioneer ACO program as needing further refinement, especially in establishing benchmarks, if they are to be used to judge performance on quality. ACOs are currently meeting with CMS officials to discuss their concerns (Kliff 2013).

Some other payers may use the CMS quality measures, or they may have their own set of measures, and the CMS measures are likely to change over time. These difference and shifts, and the increasing stringency of quality measures being used, will be challenges to providers pursuing accountable care arrangements, particularly those working with a number of different payers.

Investing in New and Different Skills

In accountable care, provider groups must put in place a series of new capacities focused on population health, many of which are new functions and will require investments up front.

Transforming traditional, generally under-resourced primary care practices into high-functioning medical homes is widely viewed as a prerequisite for accountable care. This requires potentially significant investments in EMRs and in practice transformation. The new functions required of medical homes may generate added operating costs (Burke 2011).

Accountable care networks must have a robust data analytic capacity. They must be able to acquire, manage, and use clinical and claims data to help track, measure, report on, and manage the care provided to specific populations. They can either build that analytical infrastructure themselves (a substantial commitment of time and resources) or they can contract with a payer or a third-party administrator to provide some or all of those services. These are new costs.

It is increasingly clear that, to succeed in accountable care, provider groups must be able to more fully involve and engage their members in decision-making and in managing their own care. This requires investment in a number of new functions centered on the network’s members:

- member services, to establish and maintain a relationship with all members covered by the accountable care contract;
- care management systems, to enable trained staff to identify, risk-stratify, track, and support patients as needed, particularly those undergoing care transitions and those with multiple chronic illnesses, who are at risk for complications and potentially preventable emergency department visits and admissions; and
- staff and programs focused on patient education and patient engagement, to help patients participate more effectively in their own care and chronic disease self-management.

Establishing this new infrastructure requires a substantial up-front investment, and additional operating costs, for which there may be no source of support or payment in the near term.

Identifying and Engaging Members

Another challenge facing payers and providers is to in fact define the “defined population”—those individuals for whom the provider is accepting responsibility, for whose care and costs they will be accountable. Unlike classic HMO arrangements, in which patients must select a primary care physician, the fee-for-service
Medicare program and most commercial health insurance plans allow members a relatively free choice of providers.

Prevailing methods for patient attribution (prospective and retrospective attribution) are a pragmatic response to a real problem: that many people do not have or regularly use a primary care physician. In order to assign members to a given accountable care provider group, CMS (and most other payers) use a variety of algorithms to attribute members to an accountable care network, using historical claims data, to identify the primary care physician (or in some cases, specialist) from whom a given member received most of their ambulatory or primary care in prior years. If that physician is included in the ACO’s network, the patient is attributed to that network. However, the methods currently used to attribute members to a given provider or network are complex, inexact, and difficult for providers to administer.

Once the population has been defined, provider networks must understand the characteristics of the populations for which they have assumed responsibility, in order to tailor their services to best meet those populations’ needs. At a high level, they must be able to assess the size, composition, and risk factors of major cohorts within that population—the well, the acutely ill, and those with chronic conditions—and respond to their specific needs. The well, for example, need programs focused on prevention and wellness, and maintaining good health; the acutely ill need reliable programs to support patients and caregivers during care transitions; and those with chronic illness need targeted programs of care management and self-management training.

Finally, an accountable care network must be able to effectively engage its members, changing the way they relate to and interact with their providers and with the health care system, and the degree to which they can become partners in the care process, managing their own health.

These are not altogether new ideas or approaches, but they have not generally been recognized or reimbursed under fee-for-service payment systems, and thus have not always been pursued with vigor by providers. Under accountable care, however, they are essential.

The Role of the Payers

As accountable care networks take on more of the perspectives and roles of payers, the question arises, “What role will payers have in such ventures?”

Accountable care is a new product, unfamiliar to most purchasers and plan members; and such networks are not yet available in most areas of the state. It will take time for the accountable care model to replace more familiar health insurance offerings, even if it is priced competitively, with less onerous deductibles and copayments.

In theory, purchasers and self-insured employers (who represent over 40 percent of all employment-based insurance in New York State) could contract directly with accountable care provider groups for the care required by their members and their families, eliminating the need for an insurance plan. However, New York insurance rules require that any organization proposing to accept insurance risk maintain substantial reserves to cover potential shortfalls. Traditionally, providers have not had such reserves.

An alternative would be for providers to contract with payers to receive accountable care payments (ranging from shared savings with or without risk, to partial or full capitation) for specific, defined populations. In such arrangements (which are regulated in New York State by the Department of Financial Services), the payer retains the insurance risk, sharply reducing the need for provider groups to establish large reserves. In the near term, one can expect that payers will continue to play such a role, accepting premium payments from purchasers, and crafting accountable care contracts with provider groups.

The Importance of Risk Adjustment

One of the most important issues in accountable care is establishing appropriate targets against which providers’ performance will be measured.
Not all members are identical in terms of their health status or utilization patterns, and not all providers serve patients with the same risk profile. Some practices serve patients with much higher (or lower) burdens of disease than others. This is a factor that must be considered in setting the performance benchmarks against which they will be evaluated, and the utilization and cost targets on which their shared savings calculations will be based. Risk adjustment is critical in establishing those rates and benchmarks, but the techniques are imperfect, and the methods vary from payer to payer (American Academy of Actuaries 2011; Boyarsky and Parke 2012).

Partnering with Payers: Infrastructure for Population Health Management

Much of the infrastructure that providers need for accountable care—claims and member-based data and analytics; care management, patient education, and patient engagement; and a network-wide quality improvement structure—is new to providers forming accountable care networks. It is not, however, new to payers.

As they approach accountable care, many provider groups are looking to partner with payers who can package these services and capacities and provide them to the networks. Some payers, including Aetna, UnitedHealthcare/Optum, and Collaborative Health Systems (a subsidiary of Universal American), have identified this area as a business opportunity, and are offering services to provider groups interested in pursuing accountable care. As noted in the provider profiles above, a number of the state’s MSSP ACOs are already partnering with payers for specific functions, particularly claims data reporting and analytics. A potential future extension of these partnerships would be to develop and market co-branded insurance plan/delivery system products.

Three of the physician-led Medicare MSSP ACOs in New York State—the Accountable Care Coalition of Syracuse, the Accountable Care Coalition of the North Country, and the Accountable Care Coalition of Mount Kisco—are currently working with Collaborative Health Systems (CHS) as a full partner in the ACO. Under these arrangements, CHS provides the ACOs with investment capital and a series of key capacities (data analytics, care management, and administrative and financial leadership and expertise) in return for a part ownership in the ACO and a share of any savings they are able to generate. These three arrangements are profiled on the following page.

The Need for Multipayer Alignment

In the current, early phase of accountable care, provider groups must craft accountable care contracts with individual payers one at a time, with each paying for the care of its own covered lives in its own way and measuring success using different metrics. In the near term, it is unlikely that any provider system will have the majority of its volume and revenue in accountable care arrangements.

This contract-by-contract approach leaves providers and systems pursuing accountable care with “a foot in two canoes,” trying to move toward behaviors that are adaptive in an accountable care environment, while a substantial portion of their business—perhaps the great majority of it—is still being paid for under a fee-for-service system (Cavanaugh and Burke 2010). As they pursue accountable care, they will be adopting behaviors that run contrary to the incentives found in the prevailing fee-for-service payment system—i.e. reducing revenues to the individual providers and to the system. For the foreseeable future, these provider groups will be faced with the prospect of operating in two different and contradictory modes, depending on the payment incentives—operating in one way for accountable care patients, and another for those covered by fee-for-service.

To resolve this conundrum, providers will need a critical mass of their payers to support the accountable care model, and, if possible, through similar approaches. Accountable care will soon need such multipayer alignment if it is to achieve scale, and move from a series of experiments and pilot projects to a true transformation in health care.
**ACOs Partnering With a Payer for Infrastructure They Need**

Rather than taking on the cost of creating their own infrastructure, three Medicare ACOs in New York are working with a partner that already has such infrastructure: Collaborative Health Systems (CHS), a subsidiary of Universal American, a publicly traded for-profit health insurance company that offers Medicare Advantage plans. The Accountable Care Coalition of the North Country, LLC (ACC-NC); Accountable Care Coalition of Syracuse, LLC (ACC-S); and Accountable Care Coalition of Mount Kisco, LLC (ACC-MK) are organized as partnerships between local health care providers and CHS, which provides them with much of the infrastructure and capacity they need to participate in the Medicare Shared Savings Program.

Their visions are much the same: to bring health care professionals together to coordinate and improve care for the Medicare patients they serve; and dedicating resources to managing patients, lowering resource use. CHS is making a substantial up-front investment in the infrastructure required by these three groups. The company owns a share in the ACOs it develops, and it expects to recoup its investment in the long term from its share of bonus payments its ACOs earn.

**History:** The North Country Physicians Organization (sponsor of ACC-NC) is a multispecialty medical provider that offers medical care to patients at various locations in Potsdam, Canton, Massena, Ogdensburg, Gouverneur, and Malone. The FamilyCare Medical Group (sponsor of ACC-S) in Syracuse is a large multispecialty practice in 30 locations in central New York. Mount Kisco Medical Group (sponsor of ACC-MK) is a large multispecialty medical provider that offers medical care at 25 locations throughout the Mount Kisco area, from White Plains to Poughkeepsie.

**The Medicare ACOs:** CMS's MSSP contracts are with Accountable Care Coalition of the North Country, LLC; Accountable Care Coalition of Syracuse, LLC; and Accountable Care Coalition of Mount Kisco, LLC

**Structure:** NCPO is an IPA; FCMG and MKMG are both multispecialty group practices

**Model:** All three ACOs are shared savings, one-sided risk, no advance payment

**Governance:** Each of the three physician groups partnered with Collaborative Health Systems (CHS) to create a separate organization to serve as the contracting entity for the CMS Shared Savings Program. In each case, the board is 75 percent participating providers, 23 percent CHS, and 2 percent Medicare beneficiaries.

In each of the three ACOs, a management committee serves as the operational arm. Each has four subcommittees: operational oversight, quality improvement, care coordination, and compliance/ethics. The ACO’s medical director (selected from among the IPA’s physicians) chairs the care coordination committee. An executive director/CEO and chief financial officer are both provided by CHS.

**Service Areas:** ACC-NC: St. Lawrence, Franklin; ACC-S: Syracuse, Central New York; ACC-MK: Westchester, Putnam, and Dutchess counties

**Physicians:** ACC-NC: 20 physicians; ACC-S: 65 physicians; ACC-MK: 290 physicians

**Medicare Beneficiaries:** ACC-NC: 5,300 beneficiaries attributed; ACC-S: 12,000; ACC-MK: 12,750

**Role of Hospitals:** None of the groups’ area hospitals are included as partners under the shared savings program

**Infrastructure**

Partnership with CHS enables the groups to use CHS’s expertise, systems, and capabilities in operations, data analysis, finances, and care management

**PCMH:** Many of the primary care practices in these ACOs have been recognized by NCQA as Level 3 PCMHs

**HIT/Analytics:** CHS is providing claims data analytics from its home base, using sophisticated systems built around its Medicare Advantage product

**Care Coordination:** Care management is supported by CHS, which selects, trains, and funds local care coordinators, who work with the practices and conduct home visits. CHS also helps practices identify and stratify patient populations, helping to predict who may require intervention, and generate “work lists” that specify tasks and care gaps to be filled.

**Quality:** Each ACO has a standing QI committee and designated staff who work closely with CHS to collect, analyze (through the CHS central analytics group), and report on all CMS-required elements, using both EMRs and claims data to measure performance and identify QI opportunities
The evolution of accountable care networks has the potential to improve the way the various parts of the health care delivery system work independently and together, improving care quality and experiences of care for whole populations, not just individual patients. And it has the potential to achieve meaningful reductions in both utilization and cost. As accountable care arrangements move from the experimental stage to the mainstream, greater change could ripple through the state’s health care system.

Achieving that potential, however, will not be easy or fast. Accountable care challenges the status quo, and it will require major changes for providers, payers, and consumers.

For providers, accountable care challenges their perspective, which must change from providing discrete services to managing the care of populations under risk-based arrangements within a fixed budget—and coming to view utilization of services as a cost rather than a source of revenue. Providers must shift from a system centered around hospitals, in which physicians are “feeders” to specialty care and admissions, to a system centered around ambulatory care, in which physicians are responsible for managing patient populations. Accountable care also challenges providers’ historical relationships, particularly the relationship between physicians and hospitals. Instead of operating as silos and competitors, they will need to act as partners, working together within an organized and mutually accountable system.

For payers, accountable care challenges their basic business model, which must change from that of an insurer carrying and managing risk, to that of an intermediary transferring risk to provider groups. Many payers already have an infrastructure that includes functions providers are likely to need (e.g., member services, network management, care management, and patient education and engagement) and that they may wish to sell to emerging accountable care networks. And their historical relationships with other health care stakeholders will undergo a great change too, as they shift from payer to partner.

For patients, accountable care raises a series of challenging questions about their new role as “consumers.” The accountable care model assumes that they will be willing and able to identify and select high-value providers and plans; that they will be able to engage their providers in discussions about their care, the alternatives available, and the costs and implications of one course of treatment versus another; and that they will be effectively engaged to participate in their own care, accept responsibility for managing their chronic illnesses, and undertake difficult lifestyle choices involved in maintaining their own health and preventing exacerbations in their illnesses. So far there is little evidence on how these questions will play out, or on the degree to which accountable care’s success will depend on these changes in consumer behavior.

In diverse communities across the state, providers, payers, patients, and community leaders are working together, crafting their own approaches to their own unique sets of health care problems, using the resources at hand. Their needs in these communities are often quite different; and, as is described in the profiles throughout this report, so are the responses by the physicians, hospitals, and payers in those communities.

Creating these new accountable care networks will not be easy or quick, and it will take some time for them to achieve their potential—if, in fact, they are able to do so. Meanwhile, the existing methods of organizing, delivering, and paying for health care services will not disappear overnight. Accountable care is among the most promising models included in the ACA; but in the near term, providers and payers will both be pursuing two very different care and financing models.

Accountable care is indeed a “big idea.” It represents a real change from the status quo, and it points to a different way of doing things that seems, intuitively, to be right. If providers and payers can work together on this effort, it could make a real difference.
References


