

New York's Medicare
Accountable Care Organizations
Improve Performance in Year 5 of the
Medicare Shared Savings Program

Gregory C. Burke

DIRECTOR, INNOVATION STRATEGIES, UNITED HOSPITAL FUND

May 2019

Acknowledgments

Since 2013, UHF has produced a series of reports tracking the growth and performance of organizations in New York State that have participated in the Medicare Shared Savings Program. These reports benefited greatly from the advice, support, and ongoing involvement of those Medicare accountable care organizations. These Medicare ACOs have been pioneers in transforming their own delivery systems, and they have generated many insights into the hard work that innovation requires. Previous reports on the Medicare Shared Savings Program are available on UHF's website, www.uhfnyc.org.

This work has been supported in large part by **The Peter and Carmen Lucia Buck Foundation**. Their generous, ongoing support has enabled us to follow the trajectory of the state's Medicare ACOs over time, to analyze regional trends in the uptake of this care model, and to identify key issues facing providers in adopting and sustaining it.

Copyright 2019 United Hospital Fund

Overview

For six years, the Centers for Medicare and Medicaid Services (CMS) has been promoting accountability for populations of patients through its Medicare Shared Savings Program (MSSP). UHF has been tracking the progress of the organizations participating in the program (Medicare accountable care organizations, or Medicare ACOs) each year; this report focuses on New York ACO performance in 2017, the most recent year for which CMS data are available.

There are currently 32 Medicare ACOs in New York, serving over 500,000 Medicare beneficiaries—roughly 30% of all Medicare fee-for-service beneficiaries in the state. As a group, New York's ACOs generated nearly \$11.5 million in gross savings against their benchmarks in 2017, an improvement of over \$70 million from each of the two prior years. Thirteen ACOs received shared savings incentive payments (receiving nearly \$52 million in shared savings distributions in 2017), up from five in 2016. Those top-line figures did not, however, translate into actual savings to CMS. After accounting for the shared-savings distributions, as well as the fifteen ACOs with losses, New York's MSSP ACOs generated a net loss to CMS of roughly \$40 million, or \$75 per beneficiary.

Strikingly, there was large year-to-year variation in financial performance among the state's ACOs: between 2016 and 2017, six ACOs increased their savings against their benchmarks by \$9 million or more—and two increased their losses by more than \$9 million.

New regulations from CMS mandate the assumption of more financial risk by Medicare ACOs, as such arrangements are thought to be more successful generating savings. As those requirements phase in over the next few years, provider groups currently participating in the “shared savings only” model will need to evaluate whether they wish to continue in the program. As Medicaid and commercial payers move aggressively to adopt value-based payment approaches, New York's experience with Medicare's ACO program offers some relevant lessons. The recent improvement in ACOs' financial performance is encouraging; New York's ACOs appear to be learning how to work more effectively within the mechanics of the MSSP. But the progress has been slow, and the expansion of value-based payment systems similar to those of the MSSP may not quickly solve New York's longstanding problems of cost and quality.

Introduction

The Medicare Shared Savings Program (MSSP) program is now six years old, with five years of reported results that quantify the success of participating provider organizations (Medicare accountable care organizations, or ACOs) in achieving the program's stated goals: reducing the costs of care and improving the quality of care. UHF has been following the growth and performance of Medicare ACOs in New York State since the program's inception, regularly analyzing performance data released by the Centers for Medicare & Medicaid Services (CMS).

Over the past six years, the number of provider groups participating in the MSSP has changed. Each year some new provider groups have entered the program, while others have left it or moved to other CMS programs, such as the Next Generation ACO Model program offered by the CMS Innovation Center. Thirty-two provider organizations in New York State participated in the MSSP in 2017.¹

The most recent CMS data on this program² details the performance of MSSP ACOs in 2017. This report focuses on New York ACOs' 2017 cost and quality results. The sections that follow:

- Briefly review the current mechanics of the MSSP
- Describe the characteristics of the state's Medicare ACOs in terms of ownership, size, location, and penetration of Medicare ACOs among eligible Medicare beneficiaries in communities across New York
- Present the New York ACOs' performance against cost and quality benchmarks in 2017
- Review those results in the context of prior years' performance
- Consider how some ACO characteristics may help explain or correlate with success in generating cost savings
- Discuss some of the impending CMS changes to the ACO program³ and their implications for future Medicare ACO participation

1 Montefiore Medical Center has participated in Medicare's ACO program since its inception but not in the MSSP, and thus is not included in this report. It was in the Pioneer ACO program from 2012 to 2016 (when the program was discontinued). In 2017, it entered the Next Generation ACO program and served over 43,000 Medicare beneficiaries, earning nearly \$12 million in shared savings. <https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/>

2 CMS. 2017 Medicare Shared Savings Program Organizations. <https://data.cms.gov/Special-Programs-Initiatives-Medicare-Shared-Savin/2017-Medicare-Shared-Savings-Program-Organizations/28pq-6hh8>

3 On December 21, 2018, CMS finalized regulations that made some substantial changes to the Medicare ACO program, with the intent of hastening the movement of MSSP ACOs from the MSSP's Track 1 (the one-sided "shared savings only" model) to two-sided, shared-risk arrangements. Those changes are described by CMS on its website: <https://www.cms.gov/newsroom/fact-sheets/final-rule-creates-pathways-success-medicare-shared-savings-program>

New York's ACO experience to date in the MSSP has significance well beyond the Medicare program. Many of the state's Medicaid and commercial payers are moving rapidly into value-based payment (VBP) models in contracting with organized provider groups across the state, often using similar mechanics of shared savings and shared risk. The performance of New York's provider groups in the MSSP offers some cause for both optimism and caution.

Methodology

The core data set used in developing this report was the 2017 Shared Savings Program Accountable Care Organization Public Use File from CMS, released on November 30, 2018.⁴

Deciding which ACOs to include in a report on New York ACOs is complicated by the fact that the MSSP—like Medicare—is a national program, in which state boundaries are not necessarily defining characteristics. Some ACOs based in New York serve residents of adjoining states, and vice versa. After analyzing the CMS data, and with the caveats noted below, we identified 32 provider groups as New York ACOs: those based in New York⁵ or based elsewhere but with a substantial number of providers or Medicare beneficiaries in New York (e.g., Hudson and Matrix).

Caveats. Two additional multistate ACOs (Aledade Primary Care ACO and Trinity Health Integrated Care) included New York in their service areas but were more difficult to characterize. Aledade Primary Care ACO included a small number of providers and attributed Medicare beneficiaries in New York in 2017; it left the MSSP in 2018. Trinity Health was a new entrant to the MSSP in 2017; that year it absorbed the Syracuse-based St. Joseph's Health ACO (which had entered the MSSP in 2016 with roughly 14,000 attributed Medicare beneficiaries) within a much larger, multistate ACO.

In calculating statewide gross savings and losses against benchmarks, this report includes the 32 New York ACOs as defined above, but not Aledade or Trinity.⁶ In

4 CMS. 2017 Shared Savings Program Accountable Care Organizations Public Use File. <https://data.cms.gov/Special-Programs-Initiatives-Medicare-Shared-Savin/2017-Shared-Savings-Program-SSP-Accountable-Care-0/gk7c-vejx/data>

5 CMS. 2017 Medicare Shared Savings Program Organizations. <https://data.cms.gov/Special-Programs-Initiatives-Medicare-Shared-Savin/2017-Medicare-Shared-Savings-Program-Organizations/28pq-6hh8>

6 In 2017, Trinity Health Integrated Care had 54,281 beneficiaries; a benchmark of \$592,288,916; total expenses of \$575,409,158; gross savings of \$16,879,758; and earned savings of \$12,406,622. Aledade Primary Care had 8,784 beneficiaries; a benchmark of \$90,826,205; total expenses of \$91,721,017; gross losses of \$894,812; and no earned savings.

calculating the number of attributed beneficiaries, this report excludes Aledade but does include the 14,000 attributed beneficiaries reported for St. Joseph's Health in 2016, since its providers continued to participate in the MSSP after it was absorbed into Trinity.

How Does the MSSP ACO Program Work?

Conceptually, the MSSP is quite simple: an organized group of providers accepts responsibility for managing the costs and quality of care provided to a defined population of Medicare fee-for-service beneficiaries. An ACO's performance in caring for its attributed population is measured annually against cost and quality benchmarks. ACOs that meet quality standards and generate lower costs than the benchmark for their attributed beneficiaries can share in those savings.

In practice, however, the mechanics of the MSSP are quite complex, largely because the program is bolted onto an existing fee-for-service (FFS) architecture. Medicare beneficiaries retain the freedom to see any provider they choose. Providers continue to be paid under the Medicare program's FFS payment system, with retrospective comparison of their performance to ACO-specific quality and cost benchmarks. That methodology has five major components:

- **Provider Network.** The first step in forming a Medicare ACO is for an organization to submit to CMS a roster of participating providers—physicians, hospitals, and other providers who are in its ACO. Provider groups participating in the MSSP fall into two broad categories: physician-sponsored, and hospital-physician partnerships.
- **Attributed Patients.** In Medicare's FFS program, beneficiaries have free choice of providers. In order to assign Medicare beneficiaries to a given ACO, CMS attributes Medicare beneficiaries to a given ACO based on where most evaluation and management office visits took place. Until recently, ACOs were given a preliminary roster of Medicare beneficiaries at the beginning of a performance year, with quarterly adjustments removing some beneficiaries and adding others. An ACO's performance is measured using the updated roster of Medicare beneficiaries attributed to them at year-end.
- **Quality Benchmarks.** ACOs are required to report quality data using 32 measures spanning four quality domains: Patient/Caregiver Experience, Care Coordination/Patient Safety, Preventive Health, and At-Risk Population. ACOs must meet or exceed a benchmark quality performance standard to be eligible to share in any savings generated.
- **Cost of Care Benchmark.** An ACO's cost benchmark is determined by a mix of different factors, including the historical total costs of care generated by

attributed patients, modified by regional and national average experience and trends. These costs are adjusted to reflect the population's relative risk score (its burden of disease) using CMS's Hierarchical Condition Category risk-adjustment scoring system.

- **Correcting for Random Variation.** CMS has established a minimum savings rate/minimum loss rate (MSR/MLR), a corridor of 2%–4% above and below the benchmark, to correct for random variation. ACOs in the upside-only arrangement (Track 1, described below) must exceed the MSR before they can share in any savings generated. Shared-risk ACOs are required to repay CMS for any losses if their expenses exceed the MLR.

The MSSP ACO Tracks

During 2017, the MSSP had four different tracks: Track 1, Track 1+, Track 2, and Track 3. MSSP participants in Track 1 can receive a portion of any savings they generate, but they are not exposed to any losses from costs that exceed their benchmark. The other three tracks are all shared-risk arrangements, in which participants can share in savings but must repay CMS for a portion of any expenses outside their benchmark.

Nationally, nearly all MSSP participants entered the program in Track 1, and most are still in it. All of New York's Medicare ACOs were in Track 1, in 2017. The one exception was Trinity Health ACO, a multistate ACO, which was in Track 3.

CMS also offers a fifth Medicare ACO program, the Next Generation ACO Model, a shared-risk model with different rules for attribution, benchmarking, and risk sharing. One New York organization, Montefiore Medical Center, participated in this program in 2017; it is not included in this report.

Medicare ACOs in New York State

In 2017, there were 32 MSSP ACOs operating in New York State (see Figure 1). They entered the MSSP in five cohorts, with the first group entering in 2012–13 and new ACOs joining the program each January thereafter. The ACO census has changed over time; five ACOs included in prior UHF reports left the program between 2015 and 2017 (two returned to the program in 2017). New York's 2017 Medicare ACOs were evenly split between physician-led and hospital-led models (17 and 15, respectively).

Figure 1. New York-Based Medicare Shared Savings Program Participants with Quality and Cost Results for 2017

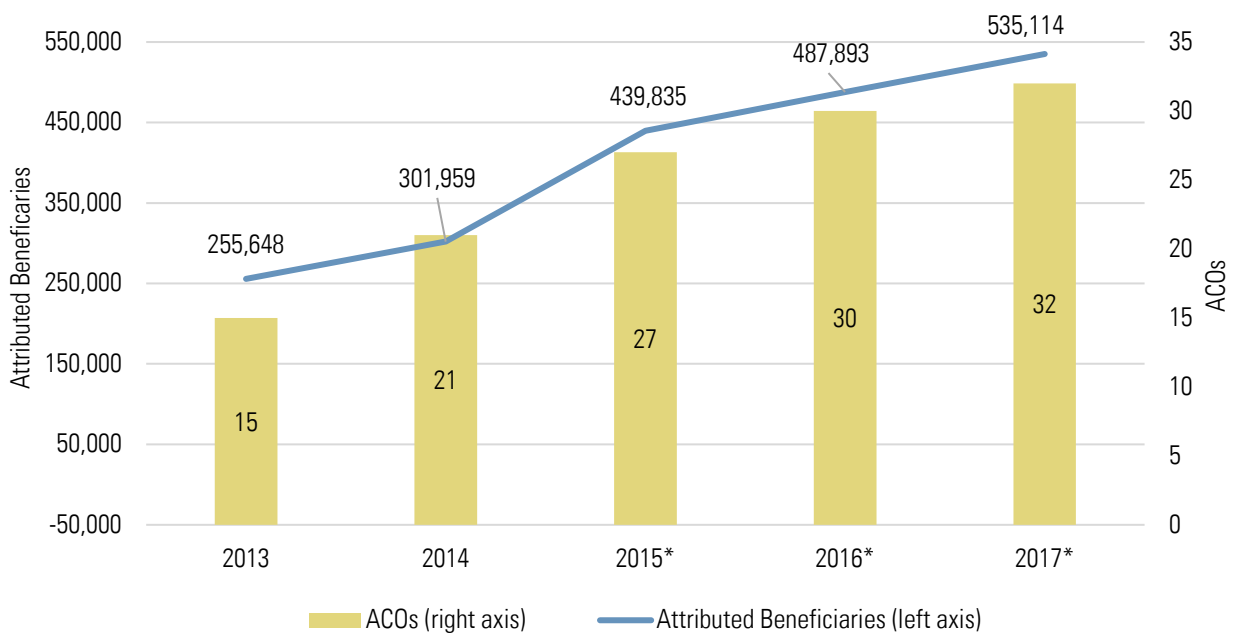
Cohort (Start Date)	ACO Name	In Program in 2017?	Region	Model
Cohort 1 (2012–2013)	CareMount ACO (See Note 1)	✓	Downstate	Physician-led
	ACO of the North Country, LLC (Note 2)	✓	Upstate	Hosp-Physician Partnership
	Catholic Medical Partners (Note 3)	No	Upstate	Hosp-Physician Partnership
	Chinese Community ACO / CCACO	✓	NYC	Physician-led
	Crystal Run Healthcare ACO, LLC (Note 4)	✓	Downstate	Physician-led
	Accountable Care Coalition of Syracuse, LLC	✓	Upstate	Physician-led
	Asian American Accountable Care Organization	✓	NYC	Physician-led
	Balance ACO	✓	NYC	Physician-led
	Beacon Health Partners, LLP	✓	Downstate	Physician-led
	Chautauqua Region Medical Partners, LLC	✓	Upstate	Hosp-Physician Partnership
	Healthcare Provider ACO, Inc. (Note 5)	No	Downstate	Physician-led
	Mount Sinai Care, LLC	✓	NYC	Hosp-Physician Partnership
	ProHEALTH Accountable Care Medical Group	✓	Downstate	Physician-led
	WESTMED Medical Group	✓	Downstate	Physician-led
HHC ACO Inc	✓	NYC	Hosp-Physician Partnership	
Cohort 2 (2014)	Alliance for Integrated Care of NY (Note 7)	✓	NYC	Hosp-Physician Partnership
	Adirondacks ACO, LLC	✓	Upstate	Hosp-Physician Partnership
	FamilyHealth ACO, LLC (Note 8)	✓	Downstate	Physician-led
	New York State Elite ACO (Note 9)	No	NYC	Physician-led
	Primary PartnerCare ACO IPA	✓	Downstate	Physician-led
Rochester Regional Health ACO (Note 10)	✓	Upstate	Hosp-Physician Partnership	
Cohort 3 (2015)	Bassett Accountable Care Partners, LLC	✓	Upstate	Hosp-Physician Partnership
	Healthcare Partners of the North Country	✓	Upstate	Hosp-Physician Partnership
	Innovative Health Alliance of New York, LLC	✓	Upstate	Hosp-Physician Partnership
	NewYork Quality Care	✓	NYC	Hosp-Physician Partnership
	Orange Accountable Care of New York	✓	Downstate	Physician-led
Richmond Quality, LLC	✓	NYC	Hosp-Physician Partnership	
Cohort 4 (2016)	Cayuga Area Preferred, Inc.	✓	Upstate	Hosp-Physician Partnership
	Empire State Health Partners, LLC	✓	NYC	Physician-led
	Hudson Accountable Care, LLC	✓	Downstate	Physician-led
	Matrix ACO LLC	✓	Downstate	Physician-led
	Northwell Health ACO	✓	Downstate	Hosp-Physician Partnership
St. Joseph’s Health ACO (Note 11)	No	Upstate	Hosp-Physician Partnership	
Cohort 5 (2017)	Empire ACO LLC	✓	Downstate	Physician-led
	Healthy Communities ACO (Note 6)	✓	Downstate	Physician-led
	New York Medical Partners ACO, LLC	✓	Downstate	Physician-led

1. Original start April 2012, sponsored by Collaborative Health Systems; reorganized as CareMount ACO in 2016.
2. Original start April 2012, sponsored by Collaborative Health Systems; reorganized as ACO of the North Country in 2016.
3. Original start April 2012; moved to Track 2 in 2016; left MSSP in 2017, has not reentered program.
4. Original start April 2012; left MSSP in 2016; reentered as new start in 2017.
5. Left MSSP in 2016, has not reentered program.
6. Part of multistate Bon Secours Good Help ACO from 2013–16; in 2017, entered as New York-specific Healthy Communities ACO.
7. Original start January 2014, sponsored by Collaborative Health Systems; reorganized in 2015 as Alliance for Integrated Care of NY.
8. FQHC-based ACO; Aledade provides some management services.
9. Left MSSP in 2017, has not reentered program.
10. Original start January 2014; left MSSP in 2016; reentered as new start in 2017.
11. St. Joseph’s Health started as a New York State ACO in 2016; combined with multistate ACO (Trinity Health) in Track 1+ in 2017.

Growth Trajectory

Over the past five years, the number of organizations participating in the MSSP and the number of Medicare beneficiaries served by those ACOs have both continued to grow. As shown in Figure 2, the number of MSSP ACOs has more than doubled, from 15 to 32, and the number of beneficiaries served by those ACOs has grown from roughly 250,000 to over 500,000⁷—despite the fact that between 2015 and 2017 three ACOs (serving over 50,000 Medicare beneficiaries) left the MSSP.

Figure 2. Growth of MSSP ACOs in New York State



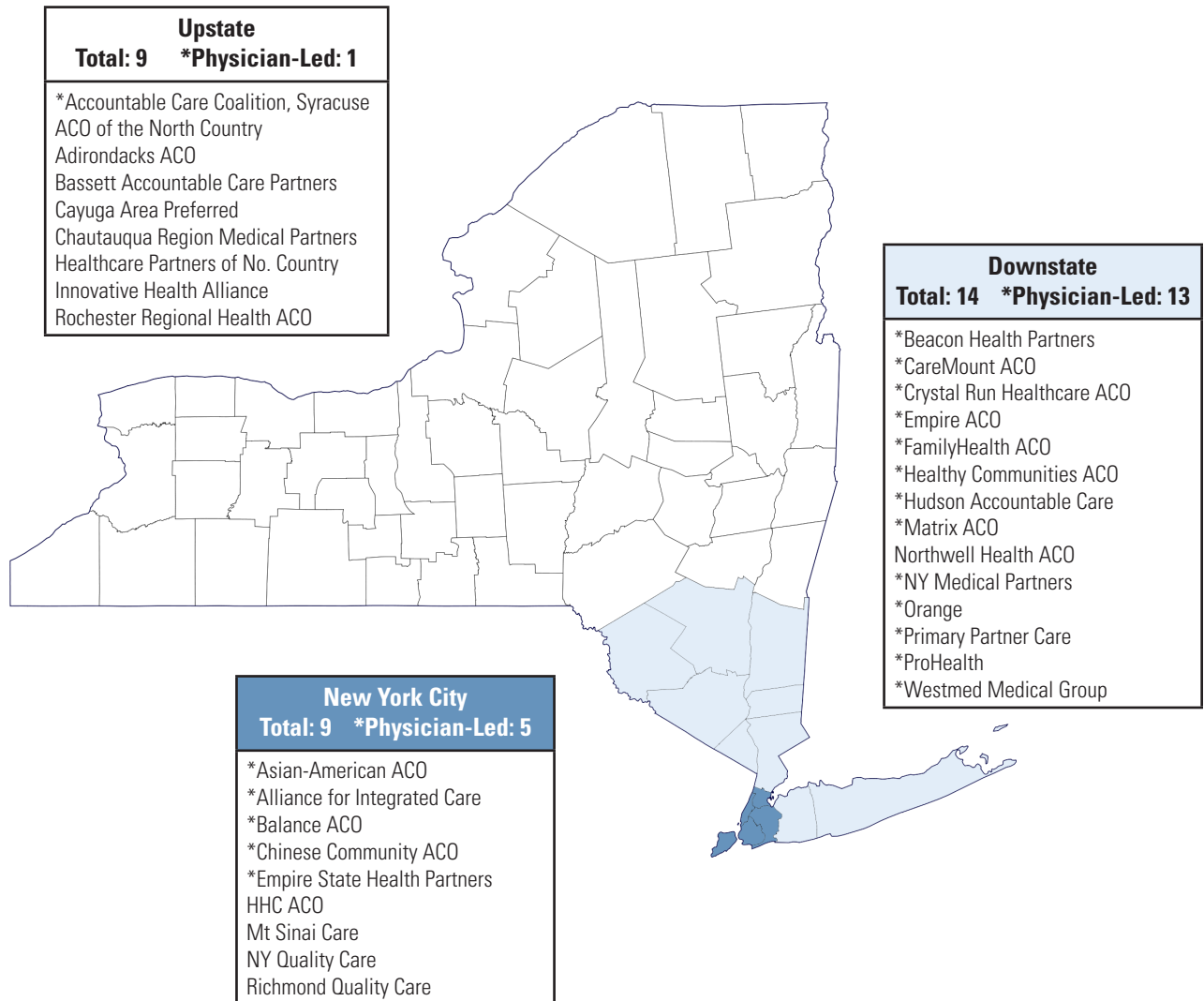
* Does not include Aledade. Substitutes 2016 St. Joseph's Health enrollment for Trinity 2017, and substitutes 2017 Healthy Communities enrollment for Bon Secours 2016.

7 Between 2016 and 2017, two New York-based ACOs changed sponsorship: St. Joseph's Health (previously a Syracuse-based MSSP ACO) was absorbed into Trinity Health ACO, a large, multistate ACO sponsored by Trinity Health; and Healthy Communities ACO, which had been part of the multistate Good Help/Bon Secours ACO, entered the MSSP as a freestanding New York ACO. In order to present a more accurate picture of New York residents served by Medicare ACOs, the Attributed Beneficiaries in Figure 2 were adjusted as follows: 1) Trinity's attributed beneficiaries were adjusted to reflect St. Joseph's Health ACO's 2016 attributed beneficiaries (instead of Trinity's reported figures for 2017); and 2) the Good Help/Bon Secours figures for 2015 and 2016 were adjusted to reflect the 2017 attribution for Healthy Communities ACO.

Location of Medicare ACOs in New York

In 2017, MSSP ACOs were spread across New York State, with nine each based in New York City and upstate, and fourteen in downstate counties (i.e., Long Island and the lower Hudson Valley). There are notable differences among the three regions in terms of their sponsorship: Upstate ACOs tend to be hospital-physician partnerships, downstate ACOs are largely physician-sponsored, and New York City ACOs are more evenly split between the two models (Figure 3).

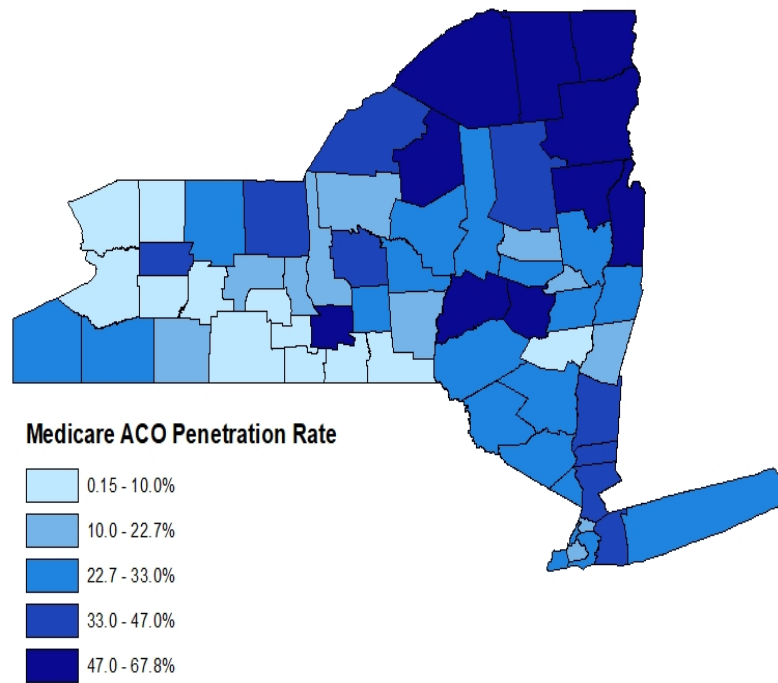
Figure 3. Count of MSSP ACOs in New York, Physician-Led and Total, by Region



MSSP ACO Penetration Across New York

CMS data on the MSSP include county-level data⁸ on the number of beneficiaries attributed to Medicare ACOs. In 2017, over 500,000 Medicare beneficiaries were attributed to Medicare ACOs—roughly 30% of the state’s 1.8 million Medicare FFS beneficiaries. Since CMS’s report focuses on the beneficiaries’ county of residence, it includes residents served by ACOs based in adjoining states, but it does not include residents of other states served by New York ACOs. Figure 4 presents those data at a county level, depicting the ACO penetration rate—the proportion of Medicare FFS beneficiaries who were attributed to an MSSP ACO, by county.

Figure 4. MSSP ACO Enrolled Beneficiaries—Penetration by County, 2017

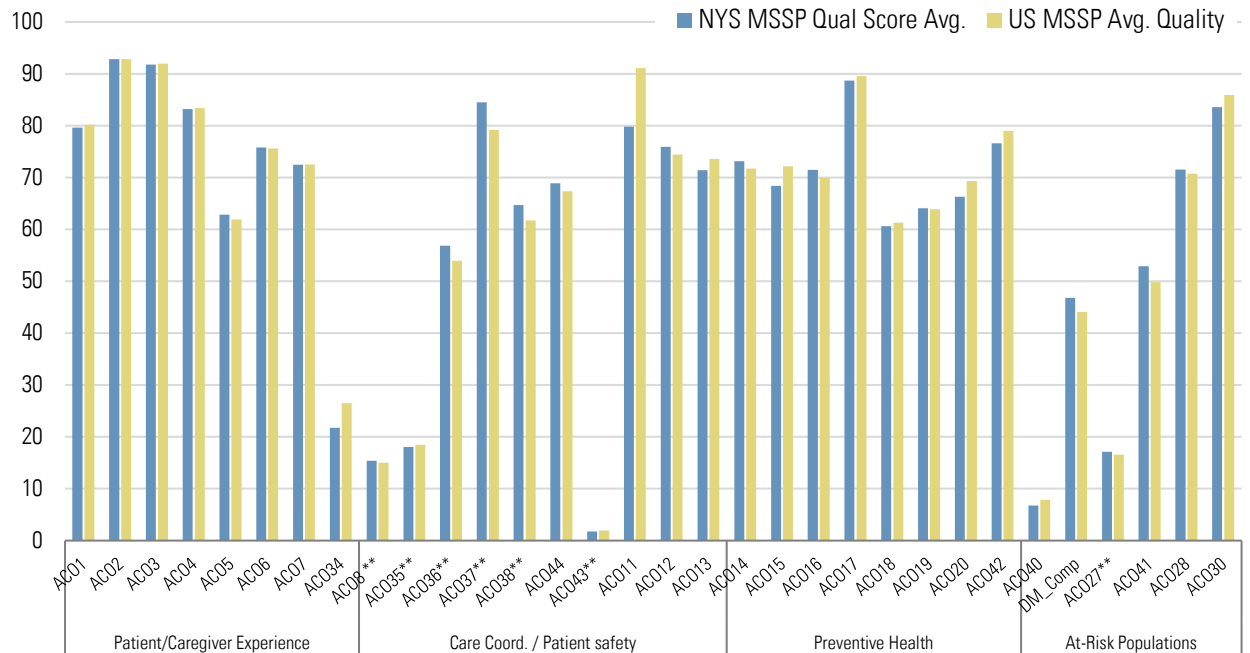


New York State ACO Quality Results

As is shown in Figure 5, New York ACOs’ 2017 quality results were broadly comparable to those from the rest of the country. On 12 measures the New York average was better than the US average, and on 20 measures the reverse was true. The most marked difference was on measure ACO11, “Use of Certified Electronic Health Record Technology,” in which New York’s score was far lower than the US score; this measure is double-weighted in calculating ACO performance scores in order to incentivize EHR adoption. (See the appendix at the end of this report for detail on the differences between the performance of ACOs in New York and in the entire country.)

⁸ Number of ACO Assigned Beneficiaries by County Public Use File (PUF) ; https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/SSPACO/SSP_Benchmark_Rebasing.html

Figure 5. Quality Performance of MSSP ACOs, New York State vs. All United States, 2017



** Measures in which lower scores are better.

2017 Financial Results

In 2017, New York’s MSSP ACOs generated aggregate savings of roughly \$11.5 million against their benchmarks. However, not every ACO saved money. As is shown in Figure 6, there were three different groups of ACOs in terms of financial performance.

- 13 ACOs reduced expenses below their benchmarks and earned shared savings distributions
- 4 ACOs saved money, but less than the MSR, and thus earned no shared savings
- 15 ACOs had total patient care costs for their attributed beneficiaries that exceeded their benchmarks, but because they were in Track 1 they did not have to repay CMS

Comparing financial results to organization type is in some ways surprising. Ten of the thirteen ACOs that achieved sufficient savings to earn shared savings bonuses were physician-led, and mainly smaller organizations; while the four organizations generating the largest losses against benchmarks were affiliated with or sponsored by large hospital systems.

Figure 6. ACO Financial Results for 2017 (Released Aug. 30, 2018), Ranked by Net Savings to CMS

Start Date	ACO Name	Beneficiaries*	Benchmark	Total Expense	Gross Savings vs. Benchmark	Earned Savings	Net Savings to CMS
2012	Balance ACO	5,742	\$128,423,263	\$90,089,518	\$38,333,745	\$12,842,326	\$25,491,419
2015	NewYork Quality Care	38,033	\$492,783,296	\$474,941,306	\$17,841,991	\$7,130,415	\$10,711,576
2012	WESTMED Medical Group	13,473	\$144,750,196	\$132,590,626	\$12,159,570	\$5,384,460	\$6,775,110
2014	Primary PartnerCare ACO IPA	19,427	\$261,137,075	\$249,713,956	\$11,423,119	\$4,979,555	\$6,443,564
2015	Richmond Quality, LLC	7,513	\$93,632,022	\$82,748,135	\$10,883,888	\$4,871,913	\$6,011,975
2015	Orange Accountable Care of New York	8,802	\$116,278,721	\$110,061,318	\$6,217,403	\$2,804,738	\$3,412,665
2017	Healthy Communities ACO, LLC	10,075	\$109,901,142	\$104,249,092	\$5,652,050	\$2,769,505	\$2,882,545
2017	Crystal Run Healthcare ACO, LLC	16,329	\$207,092,391	\$201,499,057	\$5,593,333	\$2,740,733	\$2,852,600
2013	HHC ACO Inc	10,293	\$96,813,284	\$91,536,311	\$5,276,973	\$2,182,360	\$3,094,613
2016	Matrix ACO LLC	4,673	\$64,709,358	\$59,974,729	\$4,734,629	\$1,582,291	\$3,152,338
2012	CCACO	9,193	\$89,871,473	\$85,443,165	\$4,428,308	\$1,939,045	\$2,489,263
2014	FamilyHealth ACO, LLC	8,673	\$105,938,479	\$101,959,610	\$3,978,870	\$1,619,619	\$2,359,251
2014	Alliance for Integrated Care of NY	3,933	\$42,122,241	\$39,742,683	\$2,379,558	\$993,935	\$1,385,623
<i>Subtotal:</i>							
<i>ACOs Generating Shared Savings</i>		<i>156,159</i>	<i>\$1,953,452,941</i>	<i>\$1,824,549,506</i>	<i>\$128,903,437</i>	<i>\$51,840,895</i>	<i>\$77,062,542</i>
2016	Hudson Accountable Care, LLC	11,294	\$114,555,209	\$111,591,310	\$2,963,899	\$0	\$2,963,899
2012	Asian American ACO	11,043	\$108,555,628	\$107,321,320	\$1,234,308	\$0	\$1,234,308
2017	Rochester Regional Health ACO, Inc.	18,994	\$195,559,205	\$194,855,970	\$703,235	\$0	\$703,235
2012	Accountable Care Coalition of Syracuse, LLC	16,404	\$140,868,381	\$140,815,694	\$52,687	\$0	\$52,687
<i>Subtotal: ACOs with Savings < MSR</i>		<i>57,735</i>	<i>\$559,538,423</i>	<i>\$554,584,294</i>	<i>\$4,954,129</i>	<i>\$0</i>	<i>\$4,954,129</i>
2012	Chautauqua Region AMP	4,783	\$43,842,757	\$44,171,409	(\$328,652)	\$0	(\$328,652)
2014	Adirondacks ACO, LLC	26,804	\$269,250,360	\$270,301,455	(\$1,051,096)	\$0	(\$1,051,096)
2012	ProHEALTH	33,575	\$356,866,360	\$357,955,183	(\$1,088,823)	\$0	(\$1,088,823)
2012	ACC of Mount Kisco, LLC	24,287	\$240,618,838	\$241,882,420	(\$1,263,582)	\$0	(\$1,263,582)
2017	New York Medical Partners ACO, LLC	8,534	\$95,711,530	\$97,719,750	(\$2,008,220)	\$0	(\$2,008,220)
2016	Empire State Health Partners, LLC	7,878	\$84,185,395	\$86,288,281	(\$2,102,886)	\$0	(\$2,102,886)
2012	ACO of the North Country, LLC	8,326	\$74,684,051	\$77,234,590	(\$2,550,539)	\$0	(\$2,550,539)
2016	Cayuga Area Preferred, Inc.	6,853	\$52,963,516	\$57,422,150	(\$4,458,634)	\$0	(\$4,458,634)
2015	Innovative Health Alliance of New York, LLC	22,966	\$213,725,069	\$221,676,542	(\$7,951,473)	\$0	(\$7,951,473)
2015	Healthcare Partners of the North Country	10,676	\$100,239,118	\$108,381,599	(\$8,142,480)	\$0	(\$8,142,480)
2017	Empire ACO LLC	5,768	\$99,573,772	\$108,587,632	(\$9,013,860)	\$0	(\$9,013,860)
2015	Bassett Accountable Care Partners, LLC	13,587	\$136,065,311	\$146,018,536	(\$9,953,225)	\$0	(\$9,953,225)
2016	Northwell Health ACO	47,612	\$580,670,288	\$593,041,062	(\$12,370,774)	\$0	(\$12,370,774)
2012	Mount Sinai Care, LLC	44,633	\$544,942,326	\$567,390,471	(\$22,448,145)	\$0	(\$22,448,145)
2012	Beacon Health Partners, LLP	40,407	\$511,536,137	\$549,211,057	(\$37,674,920)	\$0	(\$37,674,920)
<i>Subtotal:</i>							
<i>ACOs with Losses vs. Benchmark</i>		<i>306,689</i>	<i>\$3,404,874,828</i>	<i>\$3,527,282,137</i>	<i>(\$122,407,309)</i>	<i>\$0</i>	<i>(\$122,407,309)</i>
NYS MSSP ACO Total		527,750	\$5,917,866,192	\$5,906,415,937	\$11,450,257	\$51,840,895	(\$40,390,638)

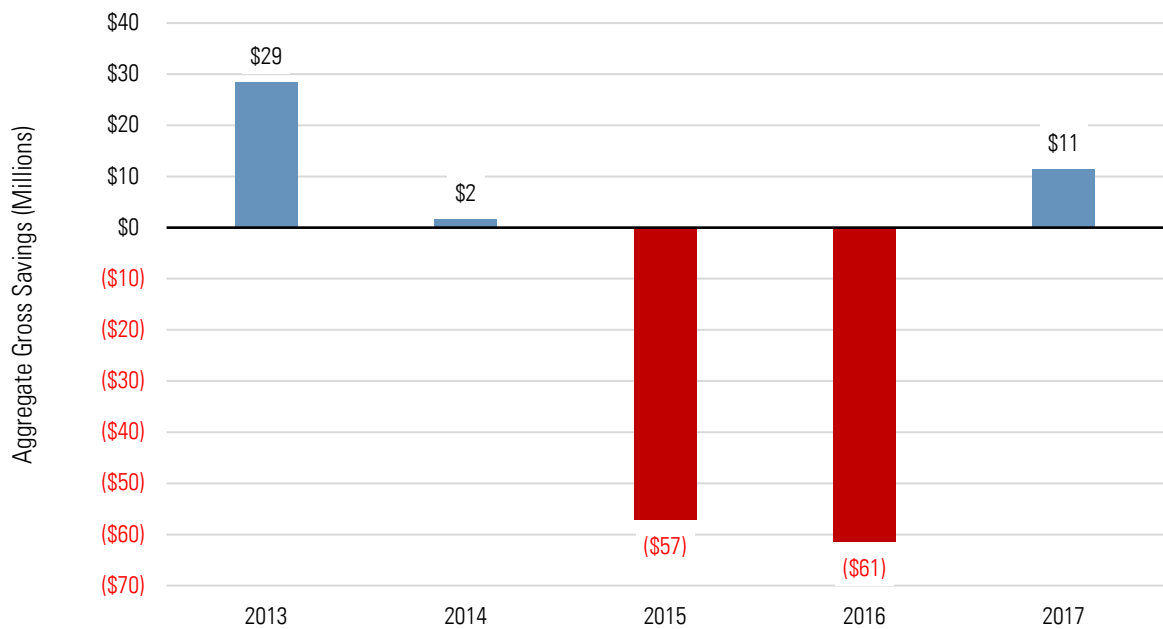
*Note: Does not include financial results for two multistate ACOs, Trinity and Aledade. In 2017, Trinity assumed responsibility for an existing MSSP ACO, St. Joseph's Health ACO, including St. Joseph's in its Track 3 MSSP. St Joseph's 2016 enrollment, 14,531 beneficiaries, is included in the statewide totals.

Source: <https://data.cms.gov/Special-Programs-Initiatives-Medicare-Shared-Savin/2017-Shared-Savings-Program-SSP-Accountable-Care-0/gk7c-vejx/data>

ACO Cost Savings: Five-Year Trajectory, 2013 to 2017

As Figure 7 shows, after a promising start in 2013, the Medicare ACO program roughly broke even in 2014, and then, for the next two years, the state's ACOs generated aggregate losses against benchmarks of roughly \$60 million per year. Only a few ACOs (six in 2015 and five in 2016) earned shared-savings distributions. In 2017, the state's ACOs generated over \$11 million in gross savings against benchmarks, an improvement of over \$70 million from 2016, with 13 ACOs receiving shared savings. To put that accomplishment in context, however, it should be noted that the 2017 results represent a savings of 0.19% against their aggregate benchmark expenditures of \$5.9 billion.

Figure 7. Year-by-Year Aggregate Savings vs. Benchmarks



Net Savings to CMS

As CMS and other analysts have noted,⁹ the real test of the MSSP is whether the program actually saved CMS money, net of the shared-savings distributions. Unlike Medicare ACOs nationally—which generated an aggregate net savings of over \$313

9 Verma S. August 2018. *Pathways To Success: A New Start For Medicare's Accountable Care Organizations*. Health Affairs blog. <https://www.healthaffairs.org/doi/10.1377/hblog20180809.12285/full/> ; Bleser WK, Mulestein D, Saunders RS, and McClellan MB. September 2018. *Half a Decade in, Medicare Accountable Care Organizations Are Generating Net Savings: Part 1*. Health Affairs blog. <https://www.healthaffairs.org/doi/10.1377/hblog20180918.957502/full/> ; Mechanic R and Gaus C. September 2018. *Medicare Shared Savings Program Produces Substantial Savings: New Policies Should Promote ACO Growth*. Health Affairs blog. <https://www.healthaffairs.org/doi/10.1377/hblog20180906.711463/full/>

million to CMS, after including the bonus payments to the organizations generating shared savings¹⁰—New York’s ACOs still cost CMS money, \$40 million in 2017. Figure 8 displays the 2017 results from that perspective.

Figure 8. National and New York State Gross Savings and Net Savings to CMS, 2017

	# of ACOs	Beneficiaries	Benchmark	Total Expenses	Savings/Loss	Shared Savings/Loss	Net Savings to CMS
<i>National MSSP ACOs</i>							
Track 1	433	8,117,612	\$85,423,809,589	\$84,447,610,415	\$976,199,161	\$685,656,874	\$290,542,287
Track 2	6	69,846	\$758,914,854	\$751,410,065	\$7,504,790	\$2,298,913	\$5,205,877
Track 3	33	805,428	\$8,731,767,470	\$8,620,927,076	\$110,840,397	\$92,848,189	\$17,992,208
US Total	472	8,992,886	\$94,914,491,913	\$93,819,947,556	\$1,094,544,348	\$780,803,976	\$313,740,372
<i>New York MSSP ACOs</i>							
NY Total*	32	535,114	\$5,917,866,192	\$5,906,415,937	\$11,450,257	\$51,840,895	(\$40,390,638)

* All New York MSSP ACOs included here are in Track 1.

Outliers and Their Impact

The overall financial results of the state’s ACOs in 2017 were skewed by the performance of four outliers that generated substantially greater savings (Balance and New York Quality Care) or losses (Beacon and Mt. Sinai) than other New York ACOs. The remaining 28 ACOs generated expenses that were more tightly clustered, generating total costs of care for their attributed beneficiaries within \$10–\$12 million of their CMS spending benchmarks.

The two highest-performing ACOs generated aggregate gross savings against benchmark of over \$56 million, and received nearly \$20 million in shared savings, resulting in a net savings to CMS of over \$36 million. The two lowest-performing ACOs generated a loss against benchmark of over \$60 million (an overall loss to CMS of the same amount). The remaining ACOs fell into three broad categories:

- Eleven generated savings of nearly \$73 million, and earned shared savings of \$32 million. As a group, they generated net savings to CMS of nearly \$41 million.
- Four generated savings against their benchmarks but did not exceed their MSR. They generated roughly \$5 million in savings, a net savings to CMS of roughly \$5 million.
- Thirteen generated costs exceeding their benchmarks, a net loss to CMS of \$62 million.

10 CMS. 2017 Shared Savings Program Accountable Care Organizations Public Use File. <https://data.cms.gov/Special-Programs-Initiatives-Medicare-Shared-Savin/2017-Shared-Savings-Program-SSP-Accountable-Care-0/gk7c-vejx/data>

Together, these 28 ACOs generated gross savings against benchmark of over \$16 million and received shared-savings payments of nearly \$32 million, a net loss to CMS of roughly \$16 million.

Figure 9. Impact of Performance Outliers

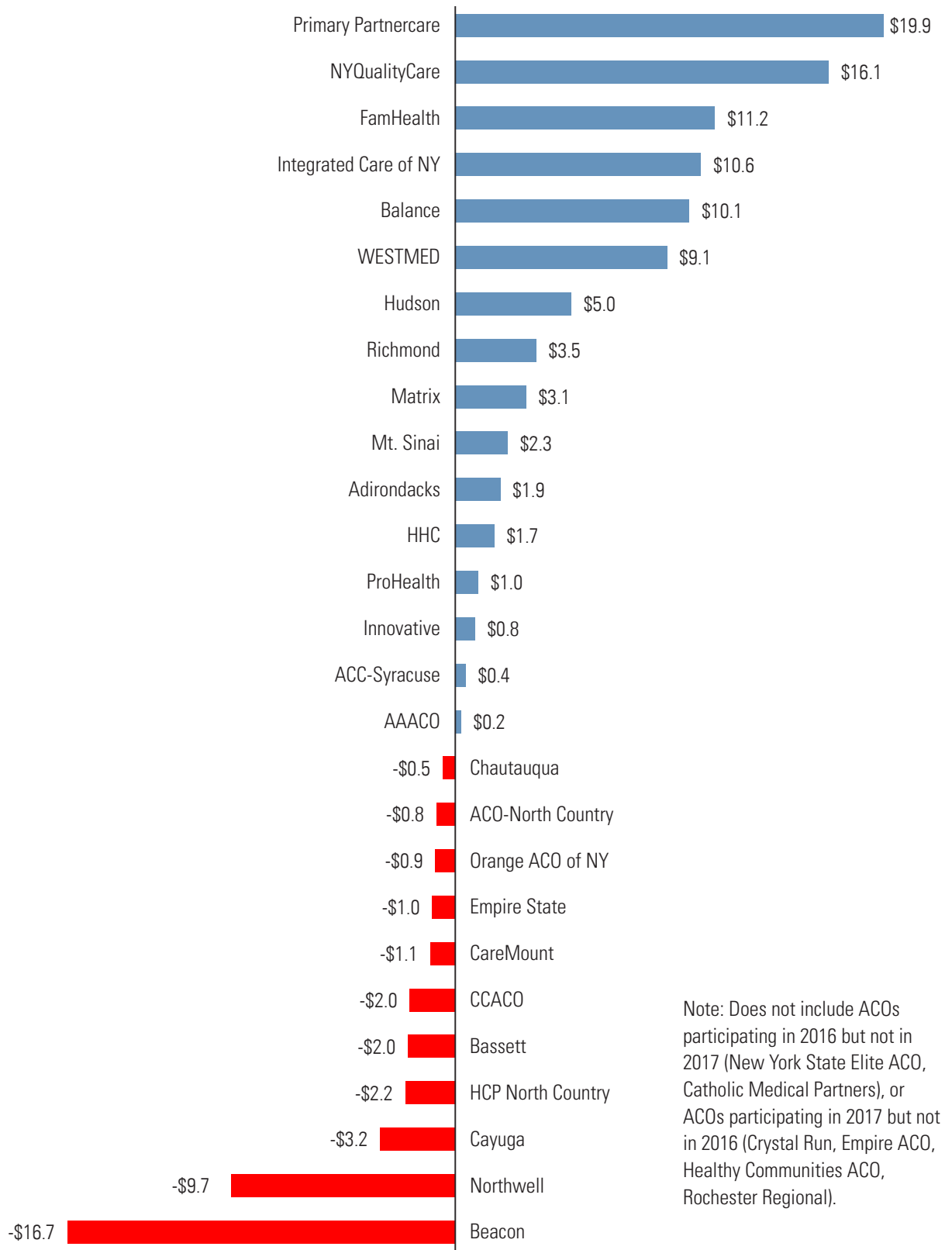
	Beneficiaries*	Benchmark	Total Expense	Gross Savings vs. Benchmark	Earned Savings	Savings as % of Benchmark	Net Savings to CMS
<i>Outliers (N=4)</i>							
Outliers: Savings (N=2)	43,775	\$621,206,559	\$565,030,824	\$56,175,736	\$19,972,741	9.04%	\$36,202,995
Outliers: Losses (N=2)	85,040	\$1,056,478,463	\$1,116,601,528	(\$60,123,065)	\$0	-5.69%	(\$60,123,065)
<i>Remainder (N=28)</i>							
Achieved Shared Savings (N=11)	112,384	\$1,332,246,382	\$1,259,518,682	\$72,727,701	\$31,868,154	5.46%	\$40,859,547
Savings, but < MSR (N=4)	57,735	\$559,538,423	\$554,584,294	\$4,954,129	\$0	0.89%	\$4,954,129
Generated Losses (N=13)	236,180	\$2,348,396,365	\$2,410,680,609	(\$62,284,244)	\$0	-2.65%	(\$62,284,244)
Total New York State (N=32)	535,114	\$5,917,866,192	\$5,906,415,937	\$11,450,257	\$51,840,895	0.19%	(\$40,390,638)

*Note: Does not include financial results for two multistate ACOs, Trinity and Aledade. In 2017, Trinity assumed responsibility for an existing MSSP ACO, St. Joseph's Health ACO, including St. Joseph's in its Track 3 MSSP. St Joseph's 2016 enrollment, 14,531 beneficiaries, is included in the statewide totals.

Changes in ACO Financial Performance, 2016 vs. 2017

Among the 27 ACOs that participated in the MSSP in both 2016 and 2017, 16 improved performance against their benchmarks in 2017, while 11 saw their gross savings against benchmarks deteriorate. As is shown in Figure 10, several ACOs experienced large year-to-year swings in financial performance: six ACOs saw an increase in savings against benchmarks of more than \$9 million, and two saw an increase in their losses against benchmarks of more than \$9 million.

Figure 10. Changes in Gross Savings vs. Benchmarks, 2016-17 (\$ Millions)



Explaining ACO Success

There is a growing literature¹¹ focusing on attributes associated with ACOs' ability to generate savings. The most common explanations of success cite experience (noting the time required to put in place the required infrastructure, and time to learn how to use it); sponsorship (physician-sponsored or hospital-sponsored); and size. UHF has previously¹² found some association between experience and results, and a stronger association with sponsorship (physician-only ACOs appearing to perform better), but no clear predictors of success.

Discussions with ACO leaders and industry experts suggested that some less quantifiable characteristics were at least as important as the structural issues: strong and legitimate leadership; substantial investment to build a strong infrastructure to support population health improvement; and, perhaps most important, a shared sense of common purpose among a heterogeneous mix of providers historically accustomed to going their own way.

In our new analysis, there again appears to be some relationship between sponsorship and savings—physician-only ACOs performing somewhat better than those co-sponsored by hospitals—and no discernible correlation between savings and experience, location, or size.

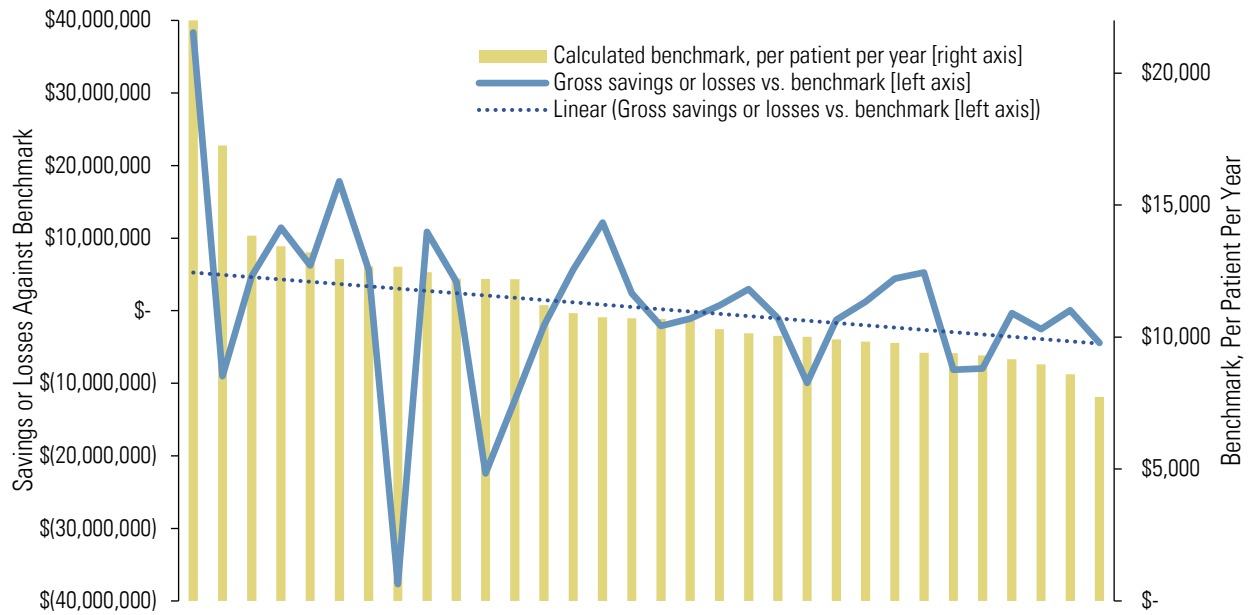
This report also includes a new probe: the relationship between an ACO's average benchmark (dividing the ACOs' total target expenditures by their total attributed beneficiaries, to derive a crude per-member, per-year expense) and an ACOs' success in generating savings. Not surprisingly, there appears to be an association between raw savings achieved and the benchmark (based in large part on historical spending) against which the ACOs were competing.

With the exception of the loss outliers, ACOs with higher benchmarks (those serving a sicker population, or a population with more preventable utilization and costs), seemed to have the highest likelihood of success in the program; those with lower benchmarks (and presumably less preventable utilization and cost) had a harder time generating savings. It is highly unlikely that the MSSP's policy goal was to reward those with historically higher utilization and costs and punish those with lower utilization and costs, but that is one of the program's apparent effects.

11 Bleser WK, Mulestein D, Saunders RS, and McClellan MB. September 2018. *Half a Decade in, Medicare Accountable Care Organizations Are Generating Net Savings: Part 1*. Health Affairs blog. <https://www.healthaffairs.org/doi/10.1377/hblog20180918.957502/full/>; 2017 ACO Results: A Summary of What Mattered Most, <https://carejourney.com/2017-aco-results/>; Avalere. September 2018. *Experienced Medicare Accountable Care Organizations Generate Savings* (press release). <https://avalere.com/press-releases/medicare-accountable-care-organizations-generate-savings-as-experience-grows>

12 Burke GC and Brundage SC. April 2016. Performance of New York's Accountable Care Organizations in Year 2 of the Medicare Shared Savings Program. United Hospital Fund. <https://uhfnyc.org/publications/publication/performance-of-new-yorks-accountable-care-organizations-in-year-2-of-the-medicare-shared-savings-program/>

Figure 11. ACO Savings/Losses Against Starting Benchmarks



Changes on the Way

On December 21, 2018, CMS finalized changes in the regulations¹³ governing the Medicare ACO program, explicitly accelerating the assumption of financial risk by MSSP participants. This move was based on an observation that ACOs in two-sided risk arrangements—in which ACOs are responsible for losses, not just eligible to share in gains—have been more successful than one-sided arrangements in generating savings for CMS.¹⁴

The new rules will eliminate the MSSP’s Track 1 (shared savings only), and replace CMS’s current five ACO tracks (MSSP’s Track 1, 1+, 2, and 3, plus the Next Generation ACO Model) with two tracks, known as “Basic” and “Enhanced.” The length of time an ACO can remain in a one-sided risk arrangement before progressing to increasing levels of financial risk is also being shortened from 6 years to between 1.5 and 3 years.

13 CMS. December 2018. *Final Rule Creates Pathways to Success for the Medicare Shared Savings Program*. <https://www.cms.gov/newsroom/fact-sheets/final-rule-creates-pathways-success-medicare-shared-savings-program>

14 On December 21, 2018, CMS released the 2017 financial results for the 51 organizations participating in its Next Generation ACO Model program, citing an aggregate \$337 million gross savings and a net savings to CMS of over \$165 million. <https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/>

The Basic track mandates an annual progression through five levels (A–E) of increasing financial risk. CMS's stated intent in making these and related changes is to move ACOs as rapidly as possible to a two-sided risk model. These new regulations also change some of the basic mechanics of the Medicare ACO program, which have historically had an outsized and occasionally unpredictable effect on the way ACO financial and quality performance is measured.

The coming changes are summarized below.

- Agreement periods for ACOs are extended from three to five years, providing ACOs with more stability and predictability.
- The number of quality measures (and the reporting burden on providers) is being reduced. Some current measures are being retired, and a new measure focused on adoption and use of certified electronic health record technology is being added.
- Formulas for calculating shared savings are changing, reducing that rate from 50% to 40% for ACOs in the upside-only models (Basic levels A and B), but allowing ACOs in risk-bearing models (Basic levels C, D, and E) to continue to share up to 50% of their gross savings.
- Formulas for calculating shared losses (Basic levels C, D, and E) are set at 30%, with limits ranging from 2% to 4% of an ACO's Medicare total costs of care for its attributed beneficiaries.
- The regulations change the way benchmarks are calculated, adjusting the trend factors and the way risk adjustment is handled.
- Methods of attributing Medicare FFS beneficiaries to ACOs are changing. ACOs will be able to choose between prospective and retrospective attribution, and Medicare beneficiaries will have the opportunity to select a primary care provider—thus having a choice as to which ACO they are attributed to.
- For risk-bearing models, the regulations permit ACOs to provide beneficiaries with incentives for taking advantage of preventive services, and with expanded access to telehealth and skilled nursing facility services.

These new regulations, which are scheduled to go into effect on July 1, 2019, have important implications for New York's Medicare ACOs, essentially all of which are currently participating in the upside-only Track 1. As these changes phase in over the next several years, provider groups will need to decide whether or not to continue participating in the program, as they are forced to assume greater financial risk.

Implications

The performance of New York’s Medicare ACOs in 2017—aggregate savings against benchmarks of roughly \$11 million—represented a significant improvement over the previous two years, in which the state’s ACOs generated losses of about \$60 million each year against benchmarks. However, after accounting for the payments made by CMS to those achieving shared savings, the ACOs in New York generated a net loss of roughly \$40 million to CMS in 2017. As both Medicaid and commercial payers in New York continue to move away from FFS payment methods and adopt VBP approaches (often based on the Medicare ACO’s shared-savings / shared-risk model), the state’s experience with the Medicare ACO program over the past six years is instructive.

On one hand, the recent improvement in financial performance is encouraging. Provider groups across the state appear to be learning how to work together under payment methods that focus on reducing the total costs of care for specific populations. Anecdotally, they have been better managing the care of patients who currently have high costs and high needs—and working to prevent those with particular risks and chronic conditions from becoming the next generation of high-cost patients. These changes have not come easily and have required substantial investments in new infrastructure required to manage attributed patients—particularly in care management, data analytics, and quality improvement. This achievement is particularly impressive given that provider groups have done so in a mixed payment environment, in which most patients are still seen under a fee-for-service payment system.

On the other hand, the slow progress of these providers suggests some caution: a rapid expansion of ACO-like shared-savings and shared-risk payment methods may not be a quick fix for the state’s longstanding cost and quality problems. The provider groups participating in the Medicare ACO program are not a random sample. They include many of the state’s strongest and most advanced physician groups and hospital-led delivery systems. If *these* organizations are having trouble generating savings in the Medicare ACO program, it is not clear how the remainder of the state’s providers will fare under such value-based payment programs.

Finally, there continue to be questions about the mechanics of the Medicare ACO program, and about the basic premise of the shared-savings / shared-risk model as a framework for VBP over the longer term:

- The way shareable savings are generated is mechanically complex, based on a competition against a benchmark that reflects the providers’ own recent performance, as well as on regional trends. As provider groups reduce their

costs, the pool of possible savings continues to shrink, and over time it becomes harder to generate savings.

- Providers in the ACO program have found that the best and quickest way to generate savings is to focus sharply on the highest-risk patients—the 5% of patients who generate roughly 50% of medical costs—whose potentially preventable utilization may be easier to change. As with other cost-reduction measures, there are limits to how much such approaches can yield.
- The main source of savings in most ACOs is reduced or avoided hospital care. This poses a particular challenge for hospital-led ACOs, which have decidedly mixed incentives: they are investing scarce resources in an ACO, whose main purpose and effect is to reduce their own revenues. As ACOs become more effective at reducing hospital visits, they risk destabilizing the finances of the state’s hospital system, particularly its smaller and rural institutions.

On balance, the Medicare ACO experiment does appear, at a national level, to be producing some of the results hoped for at its inception: it has improved quality, at least as measured by the program’s quality measures; and it has reduced costs of care for beneficiaries somewhat. The Medicare ACO program has stimulated providers across the country and across New York State to come together in new organizational forms, to try to achieve the “Triple Aim” of health care—improving population health and the patient experience of care while lowering costs. This migration towards higher-performing, integrated delivery systems should provide lasting value. While New York’s performance in reducing costs has lagged the nation’s, there are signs that the state’s ACOs are moving in the right direction. Whether that trajectory is sustainable, and whether the ACO program’s shared-savings / shared-risk model is a good chassis on which to build value-based payment systems is less clear.

Appendix: Average ACO Quality Scores in the MSSP, New York vs. US

Measure Code	Quality Measure	NYS MSSP Avg. Quality Score	US MSSP Avg. Quality Score	NYS Better/Worse Than US
ACO41	Diabetes: Eye Exam	52.94	49.85	3.09
DM_Comp	Diabetes Composite (All or Nothing Scoring)	46.79	44.09	2.70
ACO16	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	71.48	69.92	1.56
ACO44	Use of Imaging Studies for Low Back Pain	68.87	67.32	1.55
ACO12	Medication Reconciliation Post-Discharge	75.93	74.46	1.47
ACO14	Preventive Care and Screening: Influenza Immunization	73.15	71.72	1.43
ACO5	CAHPS: Health Promotion and Education	62.85	61.93	0.92
ACO28	Controlling High Blood Pressure	71.53	70.76	0.77
ACO35*	Skilled Nursing Facility 30-day All-Cause Readmission Measure	18.05	18.46	0.41
ACO19	Colorectal Cancer Screening	64.08	63.87	0.22
ACO6	CAHPS: Shared Decision-Making	75.83	75.64	0.19
ACO43*	Prevention Quality Indicator (PQI): Ambulatory Sensitive Condition Acute Composite	1.78	1.93	0.16
ACO2	CAHPS: How Well Your Providers Communicate	92.81	92.81	(0.00)
ACO7	CAHPS: Health Status/Functional Status	72.47	72.56	(0.09)
ACO4	CAHPS: Access to Specialists	83.23	83.40	(0.17)
ACO3	CAHPS: Patients' Rating of Provider	91.76	91.99	(0.23)
ACO8*	Risk-Standardized, All-Condition Readmission	15.38	15.01	(0.37)
ACO27*	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	17.11	16.57	(0.53)
ACO1	CAHPS: Getting Timely Care, Appointments, and Information	79.64	80.18	(0.54)
ACO18	Preventive Care and Screening: Screening for Depression and Follow-up Plan	60.60	61.31	(0.71)
ACO17	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	88.67	89.56	(0.89)
ACO40	Depression Remission at 12 Months	6.73	7.87	(1.14)
ACO13	Falls: Screening for Future Fall Risk	71.42	73.57	(2.15)
ACO30	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	83.57	85.92	(2.35)
ACO42	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	76.60	79.02	(2.42)
ACO36*	All-Cause Unplanned Admissions for Patients with Diabetes	56.86	53.95	(2.91)
ACO38*	All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions	64.66	61.75	(2.91)
ACO20	Breast Cancer Screening	66.31	69.30	(2.99)
ACO15	Pneumococcal Vaccination Status for Older Adults	68.41	72.14	(3.73)
ACO34	CAHPS: Stewardship of Patient Resources	21.77	26.49	(4.72)
ACO37*	All-Cause Unplanned Admissions for Patients with Heart Failure	84.53	79.18	(5.35)
ACO11	Use of Certified EHR Technology	79.82	91.13	(11.31)

Arranged by how much better or worse than the US average the New York average was (right-hand column).

* Indicates measures for which a lower score is better.