



A Strategy for Medicare Payment Reform

Improving Accountable Care Organizations While Expanding Bundled Payments

By Topher Spiro, Maura Calsyn, and Meghan O'Toole May 2015

Center for American Progress



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Introduction and summary

Medicare currently pays for most health care services on a fee-for-service, or FFS, basis, paying doctors, hospitals, and other health care providers separately for each item and service furnished to a patient. This payment structure rewards quantity over quality. First, it encourages the overuse of health care that is unnecessary or even potentially harmful, especially for high-cost items and services. Second, it does nothing to encourage coordination between different health care providers.

The health care system—including the Medicare program—is slowly adopting new payment models that change these incentives and encourage higher-quality, more coordinated care. The Department of Health and Human Services, or HHS, recently set a timeline to accelerate Medicare’s move away from FFS payments. HHS’ goal is for 50 percent of its Medicare payments to be made through alternative payment models by 2018, with an interim goal of 30 percent by 2016.¹

Medicare’s payment reform efforts have largely focused on two models: accountable care organizations and bundled payments. Accountable care organizations, or ACOs, are groups of health care providers that share responsibility for providing lower-cost, higher-quality care for a group of patients. Bundled payments are fixed amounts paid by payers—including Medicare, Medicaid, states, and private health care plans—to health care providers for all of the care a patient is expected to need during a defined period of time or for a set of services needed to treat a particular injury or illness.

The **fee-for-service payment system** is where health care insurers, including Medicare and Medicaid, pay doctors, hospitals, and other health care providers separately for different items and services furnished to a patient.

An **alternative payment model** is one that holds health care providers accountable for the quality and cost of care furnished to a patient.

Accountable care organizations are groups of health care providers that agree to share responsibility for coordinating lower-cost, higher-quality care for a group of patients.

Bundled payments are fixed amounts paid to health care providers for a bundle of services or for all the care that a patient is expected to need during a period of time.

Within these broad parameters, there are numerous ways to structure ACO and bundled payment reforms. In fact, Medicare alone has a number of different ACO and bundled payment models. This variation allows Medicare to test a wide variety of payment reforms, but it also creates significant confusion about how best to move payment reform forward.

This report outlines a broad strategy for Medicare payment reform based on the Center for American Progress' analysis of the initial results from one of Medicare's most ambitious ACO models, the Pioneer ACO Model. We first calculated overall savings by the Pioneer ACOs, finding that they reduced overall spending by 0.67 percent compared with the target amount of spending in the model's second year. These results are consistent with L&M Policy Research's independent evaluation of the Pioneer program so far. We also reviewed quality results for the program, finding that the Pioneer ACOs are providing quality care but that there is still room for improvement.

Because these overall results were modest, we also took a closer look at Montefiore Health System's successful Pioneer ACO to determine why it was able to realize far greater savings than other participating organizations. (see Appendix A)

It is unclear if other Pioneer ACOs will be able to replicate the same level of success of the few high-performing organizations. Unlike ACOs—whose success appears based at least in part on their geographic location and mix of patients—bundled payments have already been successful in a variety of settings and for a range of health care conditions. For this reason, CAP urges the Centers for Medicare & Medicaid Services, or CMS—the agency within HHS that administers the Medicare program—to focus additional resources on expanding its bundled payment reforms.

ACOs will remain an important part of Medicare's payment reform efforts, and CMS should continue to improve its ACO programs—including the Pioneer ACO Model—to allow more organizations to achieve success over time. But if Medicare is going to achieve its goal of moving away from FFS payments, it must focus greater attention on bundled payment models.

The Pioneer ACO Model

The principles of accountable care organizations—rewarding health care providers for the quality of care instead of the volume of care and sharing savings with high-performing organizations—have been in place for quite some time. The Pioneer ACO Model and other Affordable Care Act ACO programs followed private-sector ACOs and similar shared risk arrangements. And the Medicare program previously tested other coordinated care approaches. For example, the Centers for Medicare & Medicaid Services created the Physician Group Practice Demonstration from 2005 to 2010 to test a shared savings model.² In fact, the Pioneer ACO Model includes only organizations that have previous experience with accountable care arrangements. It launched in 2012 as the first Medicare ACO program and will run for five years, until February 2017. And unlike other parts of the Affordable Care Act, some conservative health care experts have supported similar programs that move the health care system away from fee for service, raising the possibility that these types of payment reforms could gain bipartisan support.³

Like other ACO programs, Pioneer ACOs that hold their health care spending for a group of Medicare beneficiaries under a specified target—while meeting standards on quality measures determined by CMS—will share in a portion of the resulting savings to Medicare. The amount of savings is measured as the difference between actual spending and the ACO’s target spending, as calculated by CMS.⁴ In the Pioneer ACO Model, beneficiaries are considered part of an ACO—known as being attributed or aligned—if they have received the plurality of their primary care with the ACO’s providers over the previous three years.⁵ Medicare attributes beneficiaries to specific ACOs at the beginning of each year of the ACO program. Patients can choose to receive care from any provider, whether inside or outside the ACO.

Medicare designed the Pioneer ACO program to be farther reaching than other Medicare ACOs. First, Pioneer ACOs must enter into similar payment arrangements with other payers, such as private health plans or Medicaid. Second, these ACOs accepted “two-sided” risk, meaning that they are not simply eligible to

share Medicare's savings if they meet spending and quality targets; they also agree to refund Medicare for a portion of any excess spending.⁶ Together, these requirements create a higher level of risk and reward for Pioneer ACOs than their counterparts in other Medicare ACOs.⁷ Third, the Pioneer model transitions to population-based payments for eligible participants in the third through fifth years of the program.⁸ Population-based payments are per-beneficiary payments; they move Medicare even farther away from traditional FFS payments.⁹ Population-based payments give Pioneers ACOs greater flexibility to innovate and to coordinate patients' care by allowing them to invest in infrastructure and provide services not currently paid for by the FFS system.¹⁰

The Pioneer ACO Model began in 2012, with 32 participants chosen from 80 applicants.¹¹ In 2013—the second year of the program—only 23 Pioneer ACOs participated. Today, 19 ACOs representing approximately 625,000 aligned beneficiaries remain for the fourth year.¹² The cumulative attrition means that 41 percent of the Pioneer ACOs that started in the program have since dropped out, with many of them joining another Medicare ACO called the Medicare Shared Savings Program, or MSSP, instead. MSSP ACOs are less risky because they only share in shared savings: Unlike a Pioneer ACO, an MSSP ACO that spends above its benchmark is not responsible for reimbursing Medicare for losses.¹³ The incentives for MSSP ACOs to lower costs are therefore not as strong as in the Pioneer ACO Model.

ACOs—including Pioneer ACOs—also must meet quality standards in order to share in any savings, which helps ensure that savings come from offering higher value and more coordinated care rather than from stinting on care. Each ACO earns a quality score on each of 33 quality measures, along with an overall quality score.¹⁴

Financial and quality results for Pioneer ACOs

CMS measures each ACO's savings or losses by comparing its spending to a benchmark. CMS sets the benchmark based on the previous three years of spending on the beneficiaries for whom the ACO is responsible, which is then inflated by a national growth rate for Medicare spending.

CMS has reported financial data for each Pioneer ACO in the first two years of the program, except for three ACOs that deferred financial reconciliation until after the program's third year. These data consist of each ACO's percentage of savings or losses, amount of savings or losses, and the shared savings payments that the

ACO earned or the losses it owed back to Medicare. Using the reported data, we calculated the net federal savings—the difference between the ACOs’ amounts of savings and losses and the earned shared savings payments to ACOs and the losses repaid from ACOs to Medicare.

We also analyzed how each Pioneer’s savings compared with its spending, using the reported data from CMS to calculate each Pioneer’s benchmark spending target. We used benchmark spending as a proxy for actual spending because CMS has not publicly reported each Pioneer ACO’s actual spending. This analysis differs from, but complements, an independent evaluation by L&M Policy Research that compared actual spending for beneficiaries aligned to Pioneer ACOs with the spending for similar but unaligned beneficiaries in the ACOs’ markets.¹⁵

For the quality results, CMS provided each ACO’s score for each of the 33 quality measures. CMS also reported, for all ACOs combined, the average score for each measure and the average overall quality score across all measures, both out of a possible 100 percent. We used CMS’ guidance on the quality measures to calculate the overall quality score for each ACO.¹⁶

These results are preliminary, and later results may differ significantly. Yet even though these first two years of data should be interpreted with caution, it is important to closely monitor these results because the Pioneer ACO program is the most ambitious current ACO model. Furthermore, evaluating the program as it is currently structured is useful because Pioneers that have shown savings are now eligible to receive partial population-based payments.¹⁷ Lessons learned from successful Pioneer ACOs also can guide further payment reform efforts.

Definitions

Benchmark: The expected Medicare expenditures for beneficiaries aligned to the ACO*

Amount of savings or losses: The amount that each ACO spent below—savings—or above—losses—its benchmark

Percentage of savings or losses: Savings or losses as a percentage of each ACO's benchmark

Net model savings: The sum of all ACOs' amounts of savings or losses

Amount of shared savings payments or losses owed: The reward payment that an ACO earned for spending below its benchmark or the amount that an ACO must return to CMS for spending above its target

Net shared savings: Shared savings payments paid by CMS to ACOs minus the losses repayments from ACOs to CMS

Net federal savings: The difference between net model savings and net shared savings

Percentage of net federal savings: The net federal savings for each ACO as a percentage of its benchmark

* We calculated the benchmark by dividing the amount of savings or losses by the percentage of savings or losses for each ACO. We were unable to calculate the benchmark for two ACOs in Year 1 because they had savings percentages of 0 percent. We also were unable to calculate the benchmark for the three ACOs that deferred reconciliation in Year 2 because their individual financial results are not available.

Financial results

Over the two years for which they are available, the data reveal modest results for the Pioneer ACO Model in terms of generating savings. Tables 1 and 2 below include both the financial data reported by CMS and our calculations based on those data.

Findings

In Year 1, the 32 Pioneer ACOs produced \$92 million in net model savings—an average of \$2.9 million per ACO. CMS paid \$75 million in net shared savings to high-performing ACOs. Therefore, the net federal savings were \$17 million—an average of \$545,000 per ACO. The net federal savings represented 0.23 percent of the total benchmark spending.*

Promisingly, financial savings increased from Year 1 to Year 2 even though fewer ACOs participated in Year 2. The 23 Pioneer ACOs generated \$96 million in net model savings, or an average of \$4.2 million per ACO, while CMS paid \$55 million in net shared savings to the ACOs. Therefore, the net federal savings were \$41 million—an average of \$1.8 million per ACO and 0.67 percent of the total benchmark spending.**

Despite the overall trend toward increased savings, results across individual ACOs were extremely varied in the second year. Savings were concentrated in a small number of ACOs, and many Pioneer ACOs did not meet their spending targets. A closer look at the results reveals that in the second year:

- Almost 40 percent of the Pioneer ACOs—9 out of 23—spent above their spending targets.***
- More ACOs did not qualify for shared savings than did qualify. Twelve ACOs did not qualify for shared savings payments in Year 2, compared with the 11 ACOs that did.
- The three Pioneer ACOs with the highest net savings to Medicare—Montefiore ACO, Steward Healthcare Network, and Michigan Pioneer ACO—were responsible for 70 percent of the net federal savings. Montefiore ACO alone accounted for 27 percent of net federal savings.

* This figure does not include the two Pioneers whose benchmarks we could not calculate, but their addition would only change the current calculation of 0.23 percent minimally, if at all, given that they had such small savings.

** The 0.67 percent figure does not include the data for the three Pioneer ACOs that deferred reconciliation, so the calculation will be slightly different once the data are available.

*** We assume that the three Pioneer ACOs that deferred reconciliation spent above their targets and incurred losses in Year 2.

TABLE 1

Summary of the Pioneer ACOs' financial results

	Year 1	Year 2
Average percentage of total savings	0.88%	1.59%
Net model savings	\$92 million	\$96 million
Net shared savings	\$75 million	\$55 million
Net federal savings	\$17 million	\$41 million
Percentage of net federal savings	0.23%	0.67%

Source: Centers for Medicare & Medicaid Services, "Medicare Pioneer ACO Model Performance Year 1 and Performance Year 2 Financial Results" (2014), available at <http://innovation.cms.gov/Files/x/PioneerACO-FncI-PY1PY2.pdf>. CAP analysis is based on these data.

CMS commissioned an independent evaluation of the Pioneer ACO program to determine how spending for beneficiaries aligned to Pioneer ACOs differed from unaligned beneficiaries. L&M Policy Research's evaluation of the Pioneer ACO Model's first two years found positive but modest results.¹⁸ The evaluation concluded that the Pioneer ACOs saved Medicare approximately \$385 million—\$280 million in Year 1 and \$105 million in Year 2—when their spending was compared with spending for similar beneficiaries before accounting for the shared savings payments that Medicare paid to successful ACOs. Yet only 10 Pioneers achieved statistically significant savings in both years, also without accounting for shared savings earned. However, as CMS noted, "These results are encouraging, given how historically challenging it has been for physicians to achieve spending reductions in Medicare demonstration projects."¹⁹

Both our analysis of financial performance and the independent evaluation of actual spending show that Pioneers' overall savings to date are small, and the results highlight the gap between a few organizations with high savings and the rest of the Pioneer ACOs.

Barriers to greater savings

The Pioneer ACO Model is a tremendous change to the system, even for providers at the forefront of delivery and payment system reform. It will take time for all Pioneers to achieve significant savings given the need to invest in infrastructure, restructure care delivery systems, adapt to changed payment incentives, and become accustomed to the new data that CMS is providing.

Even Montefiore Health System—which had almost 20 years of experience using similar care coordination and payment approaches and whose successful Pioneer ACO is profiled in Appendix A—found this transition challenging.²⁰ Furthermore, successful ACOs may achieve savings over several years—even if they do not realize significant savings each year.²¹ And as discussed below, the benchmarking methodology may mask the success that some Pioneers have had in coordinating care and limiting costs.

In addition to the significant upfront investments in time and resources, ACOs have cited other reasons for their initial, modest results. Many ACOs have had difficulty in making sure that patients receive most of their care from doctors within the ACO—a problem known as leakage—that undermined their efforts to coordinate care. Each Pioneer ACO is responsible for all Medicare hospital and physician spending for their assigned beneficiaries, but beneficiaries are free to choose any provider or service within or outside the Pioneer ACO. When patients seek outside care, it is more difficult for ACOs to coordinate care and eliminate duplicative or unnecessary services. Furthermore, Pioneer ACOs currently do not have any means of incentivizing patients to remain inside their networks, and many aligned beneficiaries do not know that they are part of an ACO.

CMS' benchmark methodology also may have limited the savings that some ACOs could achieve. When ACOs incur losses, those are losses as measured against their benchmark spending target rather than their total spending. Each Pioneer ACO's benchmark takes into account the past three years of spending for their aligned beneficiaries. Therefore, organizations with low spending before they became Pioneer ACOs have lower benchmarks with which their future spending is then compared. This methodology leaves them with less room to decrease their spending, making it harder to sustain savings.

Most ACOs feel that the benchmark is unfair for already low-cost ACOs.²² One ACO that left the program, Sharp HealthCare, cited the benchmark methodology as the reason why it dropped out, saying that it had a favorable performance but still was projected to be at risk for shared losses.²³ Another example is Healthcare Partners of Nevada, which achieved the highest amount of savings out of all the Pioneers in L&M Policy Research's evaluation, yet had a losses percentage of 2.6 percent using CMS' results. This ACO declined to participate in the full second performance year.

TABLE 2

Financial results for the Pioneer ACO Model

In millions of dollars

Pioneer ACO name	Year 1						Year 2					
	Percentage of savings or losses	Amount of savings or losses	Shared savings payments or losses owed	Net federal savings	Benchmark	Percentage of net federal savings	Percentage of savings or losses	Amount of savings or losses	Shared savings payments or losses owed	Net federal savings	Benchmark	Percentage of net federal savings
Allina Health	0.0%	\$0.01	\$-	\$0.01	*	*	1.7%	\$1.87	\$-	\$1.87	\$110.00	1.7%
Atrius Health	-1.0%	-\$2.44	\$-	-\$2.44	\$244.00	-1.0%	1.0%	\$3.15	\$-	\$3.15	\$315.00	1.0%
Banner Health Network	4.0%	\$19.10	\$13.37	\$5.73	\$477.50	1.2%	2.8%	\$15.15	\$9.22	\$5.93	\$541.07	1.1%
Beacon Health	5.0%	\$4.05	\$2.03	\$2.02	\$81.00	2.5%	-5.6%	-\$6.26	-\$2.89	-\$3.37	\$111.79	-3.0%
Bellin-Theda-Care Health-care Partners	4.6%	\$7.62	\$5.34	\$2.28	\$165.65	1.4%	2.1%	\$3.21	\$2.27	\$0.94	\$152.86	0.6%
Beth Israel Deaconess Care Organization	4.2%	\$15.56	\$7.78	\$7.78	\$370.48	2.1%	3.9%	\$17.38	\$10.60	\$6.78	\$445.64	1.5%
Brown & Toland Physicians	6.0%	\$10.69	\$5.34	\$5.35	\$178.17	3.0%	2.4%	\$4.50	\$2.47	\$2.03	\$187.50	1.1%
Dartmouth-Hitchcock ACO	1.0%	\$1.67	\$1.00	\$0.67	\$167.00	0.4%	Deferred	Deferred	Deferred	Deferred	Deferred	Deferred
Fairview Health Services	0.0%	\$0.05	\$-	\$0.05	*	*	Deferred	Deferred	Deferred	Deferred	Deferred	Deferred
Franciscan Alliance	6.0%	\$13.34	\$6.67	\$6.67	\$222.33	3.0%	Deferred	Deferred	Deferred	Deferred	Deferred	Deferred
Genesys PHO	-2.9%	-\$5.10	-\$2.55	-\$2.55	\$175.86	-1.5%	-2.8%	-\$4.86	-\$2.49	-\$2.37	\$173.57	-1.4%
Healthcare Partners of California	-1.3%	-\$4.07	\$-	-\$4.07	\$313.08	-1.3%	NP	NP	NP	NP	NP	NP
Healthcare Partners of Nevada	-2.6%	-\$5.48	\$-	-\$5.48	\$210.77	-2.6%	NP	NP	NP	NP	NP	NP
Heritage California ACO	-0.2%	-\$1.97	\$-	-\$1.97	\$985.00	-0.2%	-0.5%	-\$5.46	\$-	-\$5.46	\$1,092.00	-0.5%
JSA Medical Group, a division of HealthCare Partners	-4.5%	-\$5.12	\$-	-\$5.12	\$113.78	-4.5%	NP	NP	NP	NP	NP	NP
Michigan Pioneer ACO	3.9%	\$8.04	\$4.02	\$4.02	\$206.15	2.0%	4.9%	\$13.86	\$5.95	\$7.91	\$282.86	2.8%
Monarch HealthCare	6.3%	\$12.14	\$6.07	\$6.07	\$192.70	3.2%	5.4%	\$14.61	\$8.59	\$6.02	\$270.56	2.2%

Pioneer ACO name	Year 1						Year 2					
	Percentage of savings or losses	Amount of savings or losses	Shared savings payments or losses owed	Net federal savings	Benchmark	Percentage of net federal savings	Percentage of savings or losses	Amount of savings or losses	Shared savings payments or losses owed	Net federal savings	Benchmark	Percentage of net federal savings
Montefiore ACO	7.1%	\$23.34	\$14.00	\$9.34	\$328.73	2.8%	7.0%	\$24.59	\$13.41	\$11.18	\$351.29	3.2%
Mount Auburn Cambridge Independent Practice Association	3.4%	\$4.06	\$2.03	\$2.03	\$119.41	1.7%	3.3%	\$3.60	\$2.26	\$1.34	\$109.09	1.2%
OSF Healthcare System	1.0%	\$1.86	\$-	\$1.86	\$186.00	1.0%	-0.4%	-\$1.25	\$-	-\$1.25	\$312.50	-0.4%
Park Nicollet Health Services	-0.6%	-\$0.78	\$-	-\$0.78	\$130.00	-0.6%	2.6%	\$3.12	\$2.09	\$1.03	\$120.00	0.9%
Partners HealthCare	2.4%	\$14.39	\$7.20	\$7.19	\$599.58	1.2%	0.5%	\$3.26	\$-	\$3.26	\$652.00	0.5%
Physician Health Partners	-4.1%	-\$9.08	\$-	-\$9.08	\$221.46	-4.1%	NP	NP	NP	NP	NP	NP
Plus!/North Texas ACO	-5.2%	-\$9.31	\$-	-\$9.31	\$179.04	-5.2%	NP	NP	NP	NP	NP	NP
Presbyterian Healthcare Services	-2.2%	-\$2.36	\$-	-\$2.36	\$107.27	-2.2%	NP	NP	NP	NP	NP	NP
PrimeCare Medical Network	-0.6%	-\$0.82	\$-	-\$0.82	\$136.67	-0.6%	NP	NP	NP	NP	NP	NP
Renaissance Health Network	0.1%	\$0.29	\$-	\$0.29	\$290.00	0.1%	-1.2%	-\$3.46	-\$1.61	-\$1.85	\$288.33	-0.6%
Seton Accountable Care Organization Inc.	-2.2%	-\$1.73	\$-	-\$1.73	\$78.64	-2.2%	NP	NP	NP	NP	NP	NP
Sharp Health-Care ACO	-0.3%	-\$0.98	\$-	-\$0.98	\$326.67	-0.3%	-1.3%	-\$4.09	\$-	-\$4.09	\$314.62	-1.3%
Steward Healthcare Network	1.1%	\$4.82	\$2.41	\$2.41	\$438.18	0.6%	3.3%	\$19.22	\$9.72	\$9.50	\$582.42	1.6%
Trinity Pioneer ACO	-0.5%	-\$0.30	\$-	-\$0.30	\$60.00	-0.5%	2.7%	\$2.03	\$1.22	\$0.81	\$75.19	1.1%
University of Michigan	0.3%	\$0.66	\$-	\$0.66	\$220.00	0.3%	NP	NP	NP	NP	NP	NP
Total		\$92	\$75	\$17	\$7,525			\$96 **	\$55 **	\$41 **	\$6,488	

* We could not calculate the estimated benchmark and percentage of net federal savings for two Pioneers in Year 1 because the percentage of savings or losses was 0 percent.

** These figures include the amounts for the three Pioneer ACOs that deferred reconciliation, but those amounts are not publicly available. Therefore, these figures do not equal the sum of the columns.

Note: All dollar amounts are in millions. "NP" stands for "not participating" and means that the Pioneer ACO did not participate in Year 2 of the program.

Source: The data for percentages of savings or losses, amount of savings or losses, and shared savings payments or losses owed come from the Centers for Medicare & Medicaid Services, or CMS, reported data. See Centers for Medicare & Medicaid Services, "Medicare Pioneer ACO Model Performance Year 1 and Performance Year 2 Financial Results" (2014), available at <http://innovation.cms.gov/Files/x/PioneerACO-Fncl-PY1PY2.pdf>. The Center for American Progress calculated the net federal savings, benchmark, and percentage of net federal savings based on these data. The names of the ACOs also are taken directly from these data.

Quality results

The Pioneer model requires ACOs to report and meet quality standards as a condition of receiving shared savings. These quality measures ensure that providers do not try to lower costs by stinting on care or providing a lower quality of care.

A careful look at the data CMS released for Year 1 and Year 2 of the Pioneer ACO program paints a modest but improving picture. The data show that, overall, Pioneer ACOs provided quality care and improved their quality scores from Year 1 to Year 2. As CMS reported, the average score for 28 out of 33 quality measures increased from Year 1 to Year 2, while the average improvement across all quality measures was 14.8 percent.²⁴ Twenty ACOs improved their score from Year 1 to Year 2 on at least 20 quality measures.

In Year 2 of the program, none of the Pioneer ACOs achieved a high quality score—defined as being above the 80th or 90th percentile of the performance benchmark—on five of the quality measures. This represents a slight improvement from Year 1, when none of the ACOs achieved a high quality score on seven of the quality measures. Pioneer ACOs also improved their electronic health record adoption from Year 1 to Year 2. For the electronic health record measure in Year 2, 10 of the 23 Pioneers had high scores, an improvement from the four Pioneer ACOs with high scores on this measure in Year 1. Moreover, all of the ACOs improved on their Year 1 score for this measure.

Another recent study, “Changes in Patients’ Experiences in Medicare Accountable Care Organizations” by J. Michael McWilliams and others, provides a more nuanced picture of the quality of care furnished by ACO-affiliated providers.²⁵ The study’s researchers used the survey data to compare the experiences of patients attributed to all Medicare ACOs with the experiences of Medicare beneficiaries receiving care from non-ACO providers. This assessment of patient-reported experiences is important for two reasons. First, it helps ensure that the ACO model does not lead providers to limit recommended or necessary care. Second, if patients are happy with the ACO model, they are more likely to continue to receive care from ACO providers, which will help care coordination efforts.

The researchers analyzed how patients rated their care in four areas: “Overall ratings” of care and physicians; “Timely access to care”; “Interactions with primary physicians”; and “Care coordination and management.” Importantly, ACO beneficiaries did not report any areas in which care worsened.

Ratings for two categories—overall care and physicians and interactions with primary physicians—were not statistically different between beneficiaries in the ACO group and those in the control group. Researchers posited that the reason could be that results in these categories are closely linked to physicians’ interpersonal skills, which likely remain constant regardless of participation in an ACO. However, patient ratings in the two other categories—timely access to care and care coordination and management measures—were higher for the ACO group. The study’s authors suggest that these qualities are more likely to be found in ACOs that focus resources on care coordination. Additionally, medically complex patients—who are more likely to be targeted by ACOs for care coordination—reported significantly better overall care under the ACO model.

Together, these results suggest that the ACO model can help improve quality by encouraging care coordination and improving the overall patient experience. Yet there is still much room for ACOs to improve their quality of care. The Pioneer ACOs with higher quality-measure scores have yet to realize significant financial savings, while the three Pioneer ACOs with the highest savings percentages all earned below-average quality scores.

This correlation does not necessarily mean that Pioneer ACOs have achieved savings by sacrificing quality, or that these goals are mutually exclusive. For instance, the correlation could have resulted from the Pioneer ACOs’ benchmarking methodology, which may limit savings for previously low-spending ACOs. Or the higher-saving organizations may need to focus even greater resources on these areas of care. These efforts will be important to monitor because if the ACO model is to recruit successfully additional organizations and retain participating providers, it is important that organizations with high quality scores are also ones that are capable of realizing savings.

Recommendations for improving the Pioneer ACO Model

The Pioneer ACO Model’s modest and varied financial and quality results suggest that there is significant room to improve this model of coordinated care. In Appendix A, we consider the factors, including a comprehensive risk stratification system, that may have contributed to the success of one Pioneer ACO—Montefiore ACO in the Bronx, New York. In Appendix B, we highlight the relative success of Pioneer ACOs in Massachusetts to examine the importance of state efforts to support payment reforms. These findings should inform future modifications of the program.

The Pioneer ACO Model—together with Medicare’s other ACO programs—will need to succeed if the Department of Health and Human Services is going to meet its aggressive payment and delivery system reform goals. HHS’ new Next Generation ACO Model, which will launch in 2016, addresses several of the concerns that have been identified during the first two years of Pioneer ACO operations. The new model also tests financial arrangements with higher levels of risk and reward than currently offered in Medicare’s ACO models.²⁶

While the new Next Generation ACO Model has promise, HHS should work simultaneously to improve the Pioneer program. Several of the Next Generation ACO requirements also should be incorporated into the Pioneer ACO program. Additionally, the Office of the Actuary at the Centers for Medicare & Medicaid Services recently certified that the Pioneer ACO program reduces net Medicare spending, making it the first model eligible to be expanded nationwide.²⁷ CMS has said that it plans to scale the Pioneer ACO Model and make it a permanent part of the Medicare program.²⁸ Therefore, these changes also will help keep current participants, encourage greater participation in the future, and improve performance as CMS expands the program.

Improve patient retention

Increasing patient retention within the ACOs’ networks will allow ACOs to better coordinate care, resulting in improved quality and lower costs. Patient retention is, in part, an issue of providing patients with information; the current Pioneer model does not offer many options for ACOs to engage directly with patients and help them understand the benefits of the ACO. For example, Montefiore ACO reported that it initially did not know who its attributed patients were, which limited its ability to use its risk stratification system with all ACO patients in a timely manner. Many, if not most, aligned beneficiaries also do not know that they are part of an ACO. A report that surveyed Pioneers also noted, “Most organizations also desired greater ability to conduct outreach to educate attributed beneficiaries on how to use the system and access care and to help beneficiaries to understand the benefits of care coordination.”²⁹

In addition, the Pioneer model does not allow ACOs to enroll patients who do not meet Medicare’s strict primary-care-centered attribution model. Unaligned beneficiaries are therefore unable to opt in to enrollment in a Pioneer ACO. Montefiore reported that due to the program’s success, it had to turn down unaligned patients who asked whether they could participate in the ACO.³⁰

HHS has begun to address these concerns in the Pioneer ACO Model. First, this year, HHS is allowing five Pioneer ACOs to recruit patients by sending out mailers to see if those efforts will improve patient assignment and retention.³¹ Second, President Barack Obama's fiscal year 2016 budget encourages beneficiaries to receive care from ACO providers and would allow ACOs to pay the cost-sharing amount for their beneficiaries' primary care visits.³²

The Pioneer and Next Generation ACO models take additional steps to improve patient retention.³³ Formerly in the Pioneer ACO Model, if patients were aligned to a Pioneer ACO in one year but did not receive most of their primary care services from within it during that year, they would not be aligned with the ACO the following year—even if they wanted to remain part of the ACO. Now, beneficiaries who are part of either the Pioneer or Next Generation ACO in one year will be able to voluntarily opt in to the ACO for the next year, even if they would not have otherwise qualified due to HHS' attribution model. ACOs would first send letters to all beneficiaries about the benefits and principles of the ACO, and beneficiaries could choose to continue with the program. CMS is also considering whether Medicare beneficiaries who were never aligned to an ACO should also be able to opt in.³⁴ We recommend that CMS allow these motivated beneficiaries to participate voluntarily in an ACO.

Second, patient retention may be driven in part by patient interactions with their doctors. For this reason, the Next Generation ACO Model includes reward payments from CMS to aligned beneficiaries who receive a certain percentage of their health care services from the providers within the Next Generation ACO. This reward amount will be approximately \$50 per person per year for beneficiaries who receive at least 50 percent of their care from providers within their ACO.

However, for the reward payments to succeed in attracting beneficiaries to the program and keeping them within the ACO when they receive health care services, the payments must be larger. Furthermore, beneficiaries must have a clear understanding of the reward payment structure and the benefits of receiving care from providers participating in a single ACO.

Reward payments also should encourage patients to check in regularly with their primary care doctors' offices. Regular contact with patients helps providers coordinate patients' care and, in some cases, may allow doctors to catch new health care issues before they cause more serious problems. For these reasons,

CMS should not only increase the size of the reward payment but also change its structure to encourage ACO beneficiaries to see their primary care providers or primary care coordinators more than once per year.

One option would be to offer a larger bonus of \$250 if a beneficiary receives all of her care from providers in a single ACO. The beneficiary would still qualify for the bonus if she used non-ACO providers for services not offered by any ACO provider. The bonus would be credited to the beneficiaries' Medicare premium for the following year. CMS should also waive cost sharing for beneficiaries' primary care visits during the year.

Adjust the benchmarking methodology

Changes to the benchmarking methodology could address the concerns of current Pioneer ACOs, especially if they were already low spending, that their benchmarks limited their ability to achieve savings. ACOs also worry that planned adjustments to the baselines of successful Pioneer ACOs after the first three performance years—a process known as rebasing—will further limit their future savings. Under the current methodology, ACOs that have achieved savings will face lower future budget targets and will have to find new savings to generate shared savings payments.³⁵

The Next Generation ACO Model attempts to address these benchmarking concerns. In the model, CMS will apply a discount to an ACO's benchmark that takes into account the ACO's relative efficiency. As CMS explained, "ACOs that have already attained cost efficiency compared to their regions will have a more favorable discount." CMS is also considering de-emphasizing historical expenditures in the fourth and fifth performance years of the Next Generation ACO Model—another method to allow historically low-spending ACOs to achieve and sustain savings.³⁶

Targeted changes to the benchmarking methodology should balance the need to encourage ACO participation but also protect savings for Medicare. Although many Pioneer ACOs are worried about the current methodology, altering the approach too much could increase the savings possibility for ACOs at the expense of savings for Medicare. We recommend a blended growth rate that combines both the state growth rate and the national growth rate. This would address regional differences while keeping the target aggressive enough that ACOs would need to continue to make investments in care coordination and quality in order to achieve significant savings.³⁷

Allow specialist attribution

Under the Pioneer model, patients are attributed to an ACO based on primary care providers—including primary care physicians, nurse practitioners, and physician assistants—even if a patient receives most of his or her care from a particular specialist.³⁸ However, many patients do not have ongoing relationships with a primary care physician or have stronger relationships with particular specialists.

CMS should allow patients with specific conditions to be attributed to ACOs based on care provided by the specialists that treat those conditions. For example, Montefiore ACO reported that attributing patients based on their behavioral health providers would improve efficiency, given that 80 percent of its clients with intensive medical issues have a comorbid behavioral health issue.³⁹ For many of these patients, their behavioral health provider, not a primary health provider, is their key, ongoing contact with the health care system.

If CMS were to allow specialist attribution, patients could designate a care coordinator—either their primary care doctor or a specialist—who would be responsible for coordinating their care.

Invest in expanded technical assistance

CMS currently provides technical assistance and information to Pioneer ACOs, including monthly and quarterly data reports, and requires ACOs to engage in shared learning activities.⁴⁰ However, Pioneers report that they continue to rely primarily on internal sources of learning.⁴¹ Therefore, CMS' technical assistance should go further in encouraging and helping implement best practices, such as the risk stratification system that Montefiore has established. For example, only seven Pioneers report using a patient survey or risk assessment to identify patients for care management, but Pioneers who are using these tools have found them to be very helpful.⁴² Because many ACOs would require technical and financial support to set up such a system, CMS should provide grants to set up risk stratification or other, similar systems.

These changes strike a balance that should allow both ACOs and Medicare to achieve savings, while expanding the program to additional seniors who would benefit from greater care. Yet even with these changes, ACOs alone cannot adequately transform the Medicare program.

Bundled payment model

Under bundled payments, providers receive a single payment from a payer that covers the expected costs of all services needed to treat a patient for a given condition or episode of care. For example, a bundled payment would cover all of the costs associated with caring for a patient with a knee or hip replacement during the time a patient usually needs to recover from that course of treatment. For this reason, treatments for common conditions or injuries that have identifiable start and end points are particularly well suited for episode-based bundles.⁴³

If the providers hold costs below the amount of the bundled payment while also meeting quality measures, they keep the difference as savings. If, however, the costs to treat the patient are greater than the bundled payment amount, the providers are responsible for that overspending and do not receive additional funding to cover those extra costs.

In some ways, bundled payments are similar to ACOs; both, for example, encourage care coordination.⁴⁴ However, bundled payments have several advantages in particular situations. Unlike ACOs, bundled payments are not focused on an entire population of patients and all of the services that those patients receive.⁴⁵ Instead, bundled payments are targeted at specific services on a per-person basis, so they can be adopted more widely, offering flexibility for providers and recipients. For instance, ACOs are not always practical in rural areas with smaller numbers of beneficiaries and fewer providers in the same geographic area.

Providers participating in bundled arrangements require less investment in infrastructure than successful ACOs, which must monitor data and care coordination of patients. This makes the implementation of bundles less costly and easier administratively.⁴⁶

Examples and benefits of bundled payments

Medicare already pays for some services with small, bundled payments. For instance, Medicare pays one amount per beneficiary to hospitals for all inpatient hospital services provided to beneficiaries. But the fee-for-service program still pays doctors a separate amount for caring for patients admitted to the hospital. Expanding these bundles to include both hospital and physician services, as well as other services or medications needed to treat patients, encourages providers to coordinate care, eliminate unnecessary services, and lower their input costs. Bundled payments can also address variation in costs and encourage treatment based on evidence-based clinical guidelines. For example, studies have shown that there is wide variation in adherence to evidence-based clinical guidelines in oncology practices.⁴⁷ Episode-based bundles that are defined based on evidence-based clinical guidelines can foster discussion among providers in the same hospital system or physician group about best practices and clinical treatment decisions.

Larger episode-based bundled payments can yield immediate savings by encouraging providers to find innovative ways to lower costs without skimping on care. For example, in the Medicare Acute Care Episode, or ACE, demonstration, CMS paid discounted, fixed payments for various cardiac and orthopedic procedures. The ACE demonstration began in 2009, with five hospitals in four states participating for three years.⁴⁸ The program reduced costs for both Medicare and participating hospitals, while maintaining or improving the quality of care for patients.⁴⁹

An independent evaluation concluded that these bundled payments saved Medicare \$319 per episode.⁵⁰ The amount of hospital savings varied, but generally those savings resulted from efforts that hospitals and physicians made to improve vendor negotiations, which lowered prices on surgical implants, equipment, and other high-cost materials.⁵¹ The program also encouraged providers to streamline order sets and adhere to best practices.⁵²

The Bundled Payments for Care Improvement initiative

Medicare's Bundled Payments for Care Improvement, or BPCI, initiative is testing additional episodic and bundled payment structures.⁵³ Participants in the initiative can choose from 48 defined episodes of care, such as knee or hip surgeries or cardiac care, in four general models. Three of the bundles reconcile costs after

care. Using this model, providers can select bundles for inpatient stay only, inpatient plus post-discharge services, and post-discharge services only.⁵⁴ In the fourth option, providers prospectively choose their payment amounts for a patient's inpatient stay.

In the three retrospective payment models, the hospital or other health care provider agrees to a discounted payment from the typical Medicare payment amount. In the prospective model, the Centers for Medicare & Medicaid Services makes a single payment to a hospital at the beginning of an episode, which covers the cost of all services that the patient will receive for that episode. The hospital then pays all providers that provide services to the patient out of that one bundled payment amount rather than separately billing Medicare for each provider after the patient receives care.

Although the variety in the BPCI initiative may encourage greater participation, it also has made the program's results difficult to assess. A recent independent evaluation of the first year of the BPCI initiative was limited in its ability to assess the results of the program due to small sample sizes.⁵⁵ For three of the models in the BPCI program, only 220 of the 6,691 providers that were approved by CMS and prepared to enter the models actually received offers from CMS to begin participating in bundled payments. Only 14 hospitals are currently participating in the fourth model.⁵⁶

The Oncology Care Model

CMS also has recently launched an Oncology Care Model—a five-year episode-based payment demonstration for cancer care that is scheduled to begin in spring 2016.⁵⁷ This model grew directly out of the work of a CMS organized by the Center for American Progress. In the Oncology Care Model, practices receive episode-based payments for caring for patients who are receiving chemotherapy for almost all types of cancer. Medicare's payments to participating practices are based on the cost of all medical services provided to cancer patients within six months of starting chemotherapy.

Typically, payers make separate payments for each service to each provider that cares for a chemotherapy patient, including separate payments to an oncologist for an office visit and to the doctor's office or hospital for both the costs of the chemotherapy drug and its administration. And if a patient goes to the emergency room

with side effects from the chemotherapy, Medicare then pays the emergency room doctors and the hospital additional amounts. Under the Oncology Care Model, CMS looks holistically at the services that a chemotherapy patient will receive and calculates a target amount of spending that each patient should incur. This system provides incentives for the practice to provide high-quality and coordinated care to ensure that, for example, a patient does not ever go to the emergency room with an avoidable problem.

The Oncology Care Model—like the retrospective BPCI models—is an important step toward prospective bundled payments. Providers still receive FFS payments from CMS under the Oncology Care Model, but there are two types of payments to incentivize practices to lower the total cost of care and improve the quality of care for chemotherapy patients. Importantly, these payments are designed with the entire treatment episode in mind.

First, participating practices receive a per-beneficiary, per-month payment of \$160 for each Medicare beneficiary in the model to help practices coordinate care for these patients for the entire episode of care.⁵⁸ Second, Medicare sets a target total cost of care for the entire episode for each practice—based on the practice’s historical expenditures—and then pays the practices a retrospective performance-based payment that is the difference between actual expenditures and the total cost-of-care target. The performance-based payment also includes a savings discount for CMS, and practices must meet quality measures, including adherence to evidence-based clinical guidelines.

The Oncology Care Model includes almost all cancer types and is a multipayer model, meaning that other participating payers, such as private insurers, are also paying practices with the same or similar payment arrangements. This helps align incentives across payers and apply the new payments to a broader population of patients. Because of this, the Oncology Care Model has the potential to dramatically lower costs and transform cancer care across the country.

Bundled payments in states and among private insurers

A number of private health plans and states are also experimenting with bundled payments.⁵⁹ For example, UnitedHealthcare and The University of Texas MD Anderson Cancer Center recently partnered to test prospective bundled payments for head and neck cancers. Their pilot cancer bundles program was the first col-

laboration using bundled payments in a large cancer system, and it helped inform CMS' Oncology Care Model.⁶⁰ Several private payers and health care systems are starting to use bundles developed by PROMETHEUS Payment Inc., which is a nonprofit bundled payment initiative. The initiative has developed bundles for conditions including depression, diabetes, and joint replacements. One study of the PROMETHEUS bundle for knee replacement surgery and post-discharge care showed per-episode savings of 8 percent to 10 percent.⁶¹

Arkansas' Health Care Payment Improvement Initiative is a multipayer model that involves an episode-based payment model that is similar to bundled payments.⁶² The model pays on an episode basis for a wide variety of health care services, including prenatal care, ADHD, and upper respiratory infections. Medicaid, private insurers, and some self-insured employer plans, including Wal-Mart, are participating in the initiative. Each payer sets its own payment amount for an episode, but the definition of the included services remains constant. When payment incentives and reforms are aligned across insurers, providers have an even greater incentive to adopt best practices and lower their own costs.

These bundled payment initiatives are varied, but a review of specific programs shows that by changing incentives for providers to follow clinical-based practice guidelines, streamline vendor negotiations, and reduce unnecessary costs, episode-based bundles can increase value and improve care.

Recommendations for expanding bundled payments

While ACOs have attracted significant attention among Medicare payment reformers, bundled payment initiatives offer a chance for more immediate savings and quality improvements. As such, CMS should dramatically expand the use of bundled payments in Medicare.

The Affordable Care Act gives the secretary of health and human services the authority to expand successful demonstration programs. The secretary should use this authority to expand the successful Medicare ACE demonstration. Ideally, Medicare would adopt all of the ACE demonstration's bundled payments for orthopedic and cardiac procedures. If Medicare is unwilling to take such a large initial step, it should consider a more targeted expansion. For example, its

orthopedic bundles may be easier to adopt and have fewer variations in costs.⁶³ Regardless of the scope of the expansion, however, Medicare should act quickly to scale up at least part of this successful payment method.

In addition, CMS should modify the BPCI initiative so that its results can be more easily reviewed. Without additional changes, the program will remain fragmented, and it might not be possible to assess whether specific bundles should be expanded to the rest of the Medicare program. CMS has recently indicated that it is considering expanding the BPCI initiative and is seeking input on an expansion.⁶⁴ In order to offer the best chance that its bundles can be expanded in the future, CMS should try to encourage greater participation in a limited number of episodes that can then be reviewed for cost savings and quality improvements.

Additionally, we recommend that CMS move to prospective bundled payments in the Oncology Care Model—rather than the FFS payments that remain embedded in the current retrospective payments—in order to create even greater incentives to lower costs for oncology care.

Conclusion

As the nation's largest insurer, Medicare has the ability to set the course for the health care sector. The Department of Health and Human Services' goals are important for signaling a strong commitment to alternative payment models, which will prompt private insurers and other health care payers to accelerate their efforts to adopt new payment models. In fact, only two days after the announcement of HHS' goals, a coalition of some of the largest insurers and health care systems in the United States declared a similar goal: moving 75 percent of their business to value-based arrangements by 2020.⁶⁵

Successful payment and delivery system reform will not be one size fits all. Instead, Medicare must continue to improve programs—such as the Pioneer ACO Model—where initial results are modest yet suggest promise. At the same time, Medicare must take immediate steps to expand its bundled payment initiatives, which are more scalable and result in more immediate savings.

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Appendix A: Montefiore ACO case study

Montefiore ACO, a Bronx-based health system, had the highest savings percentage at 7 percent, highest savings at \$24.6 million, and highest net federal savings at \$11.2 million of all Pioneer accountable care organizations in the second year.⁶⁵ If every ACO had achieved the same net federal savings as a percentage of the benchmark as Montefiore did, 3.2 percent, federal savings would have equaled more than \$207 million in 2013—at least five times greater than the actual federal savings.

Characteristics of the Montefiore ACO

Before joining the Pioneer ACO program, Montefiore had significant experience with care coordination and accepting risk-based payments, which is commonly cited as a factor in its success in the program.⁶⁶ In the 1990s, Montefiore established the infrastructure necessary to provide integrated care and to administer capitated contracts with insurers.⁶⁷ By the time it joined the Pioneer ACO program, Montefiore was already managing more than 100,000 lives with population-based payments. Montefiore also had previous experience with Medicare care coordination demonstration programs.⁶⁸

Montefiore also has a highly attached patient population, which may have helped it better coordinate care across different providers. ACOs that did not have historically strong relationships with their aligned beneficiaries before entering the Pioneer ACO program have had more difficulties with patients seeking care outside of the ACO.⁶⁹

⁶⁵ L&M Policy Research's analysis did not find statistically significant changes in Montefiore's spending for its beneficiaries compared with similar beneficiaries, despite Montefiore having the largest savings compared with its benchmark. This discrepancy may be explained by the different methods that L&M Policy Research used in its evaluation and some potential spillover from Montefiore to the comparison group of beneficiaries that L&M Policy Research used. The Centers for Medicare & Medicaid Services' benchmarking methodology, which determines ACOs' savings or losses percentages, may also have contributed—underscoring how difficult the benchmarking methodology is.

First, Montefiore has a broad provider network and dominant presence in the Bronx. When Montefiore entered the Pioneer program, it also created new partnerships to further expand its provider network. Montefiore's Pioneer ACO includes about 2,400 physicians—1,600 Montefiore employees at its four hospitals and roughly 100 outpatient offices, as well as 800 doctors in community-based private practice—and 700 nurse practitioners, physician assistants, and psychologists.⁷⁰

In addition, the Bronx is the poorest urban county in the country and has very high rates of chronic illnesses, especially diabetes.⁷¹ Because many of Montefiore's patients are lower income and less healthy, and because it has such a large market share in the Bronx, its patients may have been less likely to travel or seek care outside of the ACO. However, Montefiore reported that patient retention was still an area of concern and that it too had experienced significant leakage of patients seeking outside care.⁷² But these issues may have been an even greater problem for other ACOs, contributing to higher-than-average savings for Montefiore.

Risk stratification system and analytics

Montefiore uses a strong risk stratification infrastructure to identify patients most in need of intensive care management.⁷³ After joining the Pioneer ACO program, Montefiore used the system to target the 20 percent of high-needs patients who drive 80 percent of its expenditures.⁷⁴ In the system, patients meet with staff members who collect data on both the patient's medical history and other life circumstances, such as family and workforce status. Following this initial visit, the patient undergoes two to three hours of medical and psychosocial evaluation. Montefiore then assigns a level of risk to each patient: (1) "well and worried well"; (2) "functional chronically ill"; and (3) "frail ill/high-utilizers." This third group is the 20 percent of high-needs patients that Montefiore cares for using an intensive full care management team, palliative care, and transitional care management.⁷⁵

Complementing the risk stratification system is a comprehensive quality and data analytics infrastructure. Montefiore adopted electronic health records before many other providers and continues to invest significantly in this data infrastructure. Annually, Montefiore dedicates approximately 3,000 staff members and \$52 million to quality and data analytics.⁷⁶

Appendix B: Health care reform and ACOs in Massachusetts

Accountable care organizations do not exist in a void, and those that provide care in areas where there is already a focus on payment and delivery system reform appear to have an advantage compared with those in less reform-focused areas. Therefore, state efforts to encourage new payment models can help reinforce the goals of the Pioneer ACO program.

Reform efforts in Massachusetts

Massachusetts has a strong focus on care coordination and cost containment. For example, the Massachusetts Special Commission on the Health Care Payment System evaluates the state's payment system and recommends reforms to provide patient-centered and cost-effective care.⁷⁷ This commission unanimously voted in 2009 for the state to transition to a global payment system in order to increase care coordination, lower costs, and improve quality of care.⁷⁸ Each year, the Massachusetts Health Policy Commission establishes an annual cost growth benchmark and monitors progress toward the goal.⁷⁹

Additionally, in January 2009, Blue Cross Blue Shield of Massachusetts created the Alternative Quality Contract, or AQC.⁸⁰ The AQC is a global payment model where payments from Blue Cross Blue Shield to providers are a per-member, per-month amount to cover all services for Blue Cross patients.* The model also includes reward payments for quality improvements to avoid any incentives for providers to skimp on care, as well as technical support to provide more data to providers.

* Patients are eligible if they are enrolled in two types of plans—health maintenance organizations, or HMOs, and point-of-service, or POS, plans. These two types of plans require patients to choose a primary care physician, which allows Blue Cross Blue Shield to attribute patients and pay providers. Provider groups are eligible if they include primary care physicians who care for at least 5,000 eligible Blue Cross patients.

The AQC has shown positive results so far. A study that looked at the first four years of the AQC found that enrollees had lower spending growth and greater quality improvements than similar populations in other states.⁸¹ After the early success of the AQC, another large insurer in Massachusetts, the Tufts Health Plan, instituted a similar payment model.

Pioneer ACOs in Massachusetts

All five Pioneer ACOs located in Massachusetts—Atrius Health, Beth Israel Deaconess Care Organization, Mount Auburn Cambridge Independent Practice Association, Partners HealthCare, and Steward Healthcare Network—had positive savings percentages and savings amounts in Year 2. Three of the five also qualified for shared savings. In fact, Steward Healthcare Network, Beth Israel Deaconess Care Organization, and Mount Auburn Cambridge Independent Practice Association were three of the five ACOs with the highest savings percentages.

All five Massachusetts-based Pioneer ACOs also participate in the AQC. Beth Israel Deaconess Care Organization noted that its experience in the AQC helped it be selected for the Pioneer ACO program.⁸² The statewide culture of payment reform, the infrastructure put into place for the AQC, and their experience with a payment model with the same goals as the Pioneer ACO Model may have enabled these organizations to transition more easily into the Pioneer ACO program and consequently achieve higher levels of success. For this reason, broader state-based reforms should be considered a critical part of future payment and delivery system efforts.

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