

JUNE 2019

ACO POLICY BRIEF

Transforming Care: Risk Contracts and Performance Management Approaches of Massachusetts ACOs

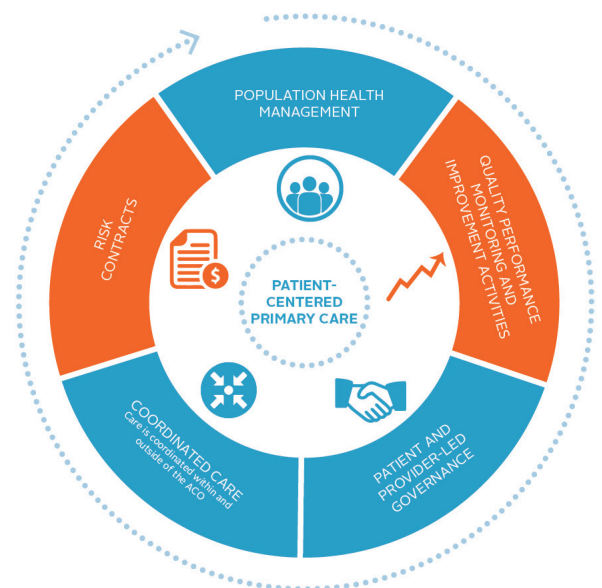
HPC standards require ACOs to demonstrate that their governing body **assesses performance** and **sets strategic performance improvement** goals at least annually; and reviews a performance dashboard that includes **at least one quality measure** in the domains of process, efficiency, outcomes, and patient experience of care

Physicians, hospitals, and other health care providers in Massachusetts are increasingly organizing as accountable care organizations (ACOs) in order to more effectively advance the “triple aim” of better health, better care, and lower costs.¹ A defining feature of ACOs in Massachusetts is that they contract with payers under global budget risk contracts in which the ACO is typically expected to keep annual per member spending within a set budget and may earn financial incentives for meeting agreed-upon quality performance targets. These contracts generally include varying levels of risk exposure; some providing ACOs with an opportunity to share in savings if the ACO spends less than the target budget (typically referred to as “upside risk”), and others holding ACOs responsible for a portion of losses if the ACO spends more than the target budget (“downside risk”). As of 2017, 41% of commercially insured Massachusetts residents were covered under non-fee-for-service contracts, largely in global budget risk contracts.² MassHealth also moved 850,000 lives into these types of contracts in 2018.³

Such risk contracts are designed to give ACOs incentives to monitor their cost and quality performance and implement data-driven strategies to improve the health of their attributed population. However, there is substantial variation in how risk contracts are structured and performance is measured, contributing to administrative complexity and misaligned provider incentives. In 2017, there were more than 100 different quality measures in use in

risk contracts across the Commonwealth, as well as wide variation in the amount of risk borne by ACOs.⁴ A significant percentage of the Massachusetts population is covered by risk contracts, yet little has been reported publicly about the structures of these contracts or about how ACOs manage their cost and quality performance.

Information gathered through the HPC’s ACO Certification program can add to the public’s understanding of risk contracts. The HPC issued statewide standards for certifying Massachusetts ACOs in 2017 and certified 18 ACOs under these standards in 2017 and 2018.ⁱ ACOs seeking certification were required to describe their risk contract experience, demonstrate



i The HPC-certified ACOs are: Atrius Health, Inc.; Baycare Health Partners, Inc.; Beth Israel Deaconess Care Organization; Boston Accountable Care Organization, Inc.; Cambridge Health Alliance; Children’s Medical Center Corporation; Community Care Cooperative, Inc.; Health Collaborative of the Berkshires, LLC; Lahey Health System, Inc.; The Mercy Hospital, Inc.; Merrimack Valley Accountable Care Organization, LLC; Mount Auburn Cambridge Independent Practice Association, Inc.; Partners HealthCare System, Inc.; Reliant Medical Group, Inc.; Signature Healthcare; Southcoast Health System, Inc.; Steward Health Care Network, Inc.; Wellforce, Inc. For more information on the certified ACOs and the ACO Certification program, visit: <https://www.mass.gov/service-details/the-hpc-accountable-care-organization-aco-certification-program>.

leadership engagement in setting performance goals and reviewing results, and report on their approaches to analyzing data and engaging providers in improvement activities and incentives. These standards were developed in part to better understand ACOs' experience with global budget risk contracts and how they are managing their performance for success.

This policy brief, the third in a series,ⁱⁱ describes the HPC's findings regarding variation in risk contract structure and terms across the 18 HPC-certified ACOs, summarizes the certified ACOs' approaches to performance management under those contracts, including how incentives are shared with participating providers, and concludes with a discussion of some policy implications.

HPC ACO Certification Risk Contract and Performance Requirements

The 2017 standards for ACO Certification required that the ACO:

- Participate in at least one substantive, quality-based risk contract. Each ACOs was required to report data on all risk contracts by payer, including the overall risk exposure, number of lives managed, and number of years of participation in each arrangement;
- Demonstrate that its governing body (e.g., Board of Directors) assesses performance and sets strategic performance improvement goals at least annually; and reviews a performance dashboard that includes at least one quality measure in the domains of process, efficiency, outcomes, and patient experience of care;
- Describe how it analyzes performance, including its sources of performance data, the types of quality measures reviewed, and how the ACO develops and shares performance reports with providers; and

ii The HPC is issuing a series of policy briefs and other resources regarding the current landscape of certified ACOs based on the information submitted by applicants for ACO Certification under the 2017 standards, and combined with other publicly available information. For more information and to read the first two briefs in this series, visit: <https://www.mass.gov/service-details/transforming-care-aco-briefs-and-other-resources>

- Describe how it distributes risk contract gains or losses across providers or reinvests in the ACO.

FINDINGS FROM ACO CERTIFICATION: HPC-CERTIFIED ACOs' EXPERIENCE WITH RISK CONTRACTS AND PERFORMANCE MANAGEMENT APPROACHES

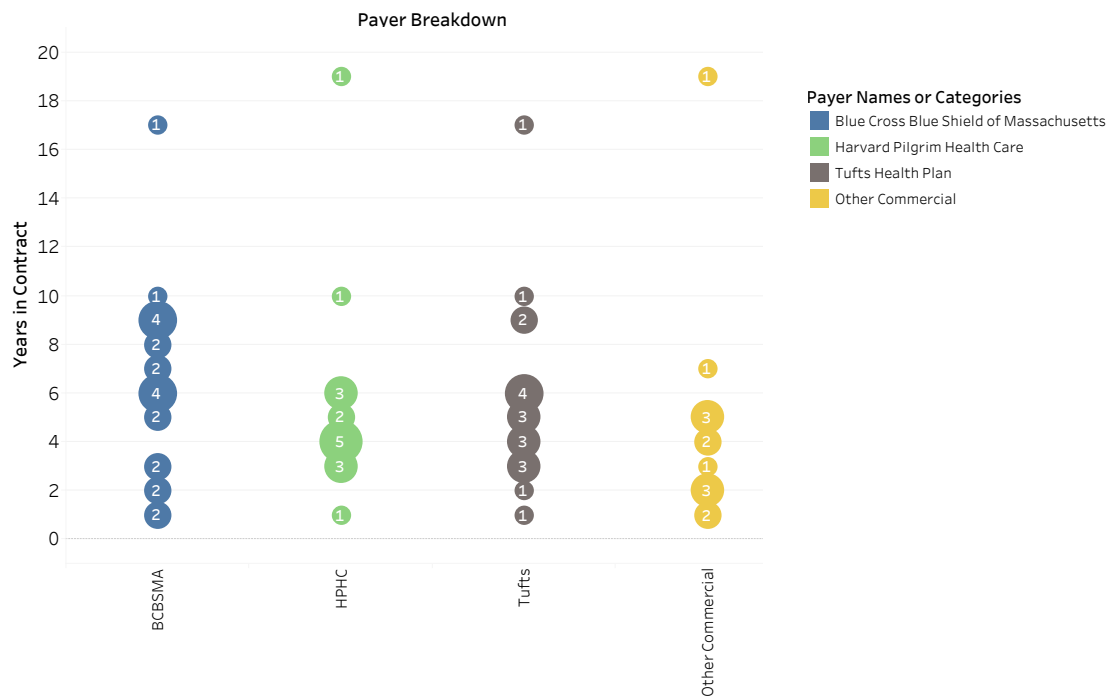
The HPC's analysis of the certification responsesⁱⁱⁱ is presented below in two sections. The first describes the HPC-certified ACOs' experience with risk contracts, including the number of contracts held, amount of risk held, and years of participation in each arrangement. The second reviews ACO approaches to managing performance. To maintain HPC ACO Certification data confidentiality requirements, the data is presented in aggregate and is de-identified at the ACO level. The findings represent the ACOs' experience as reported at the time of certification, and do not include contracts with 2018 start dates, such as the 17 MassHealth ACO program contracts (see Appendix A for additional details on methodology).

Financial Accountability: HPC-certified ACOs' Experience with Risk Contracts

Collectively, HPC-certified ACOs participate in a large number of public payer and commercial risk contracts. One of the earliest commercial risk contracting opportunities in Massachusetts was with Blue Cross Blue Shield of Massachusetts (BCBSMA) through the Alternative Quality Contract,⁵ which was first offered in 2009. Five ACOs participated in another early ACO model, the Medicare Pioneer ACO program, which began in 2012.⁶ The 18 ACOs had varying years of experience in risk contracts at the time of certification, ranging from zero to 19 years; most of the reported risk contracts began between two and six years prior to reporting (see **Figure 1**). The total number of covered lives attributed to each ACO at the time of certification varied

iii In developing this brief, the HPC analyzed the 2017 certification application responses of 17 ACOs, including two that received provisional certification at that time, and the application of one additional ACO that received certification in 2018.

Figure 1: ACO Experience with Commerical Risk Contracts



widely, as did the number of lives covered by individual contracts, with the smallest commercial risk contracts covering less than 1,000 lives and the largest covering over 130,000.

At the time of certification, the ACOs collectively held 70 commercial risk contracts and 15 public payer risk contracts. Of the 70 commercial contracts, 22 were with BCBSMA, 16 with Harvard Pilgrim Health Care, and 19 with Tufts Health Plan; 13 of the contracts were with other commercial payers including Neighborhood Health Plan, Fallon Health, Health New England, Network Health, BMC HealthNet Plan, Unicare, and Cigna. Fifteen commercial contracts across eight ACOs included individuals covered by the Massachusetts Group Insurance Commission (GIC),^{iv} the insurance provider for employees and retirees of the Commonwealth of Massachusetts and their dependents and survivors;⁷ thirteen of these contracts covered GIC lives exclusively, while the remaining two contracts included both GIC and other commercial lives.^v Most of

the commercial risk contracts were for members in health maintenance organization (HMO) products; only eight of the 70 commercial contracts covered members in preferred provider organization (PPO) products.

With respect to public payer contracts, at the time of certification, ten of the ACOs held eleven^{vi} risk contracts with Medicare through the Shared Savings or Next Generation ACO programs; only eight ACOs had no experience with Medicare risk contracts. While the full MassHealth ACO program did not begin until March 2018, by the time of certification in late 2017, four ACOs had gained some experience with risk contracting for the MassHealth population through risk arrangements with a MassHealth managed care organization (MCO).^{vii}

Out of the 85 total commercial and public risk contracts analyzed, 59 contracts included down-

iv Several certified ACOs hold separate GIC contracts with multiple payers.

v In order to promote APM adoption, the GIC required its health plans to move covered lives into Integrated Risk-Bearing Organizations (IRBO) starting in 2013. (See <https://malegislature.gov/Bills/189/SD2695.pdf>.)

vi One of the certified ACOs is composed of several separate legal entities, two of which hold separate risk contracts with Medicare.

vii Five HPC-certified ACOs also participated with MassHealth through the one-year Pilot ACO program in 2017. While those contracts are not formally included in this analysis due to their limited duration and population size, they provided important risk experience for the participating ACOs.

The number of quality measures included in risk contracts ranged from zero to 51, with an average of 21.

side risk and 26 were upside-only arrangements. While a few of the reported contracts put the ACO at full performance risk, most included limits on the amount of upside and/or downside risk assumed by the ACO.

The number of quality measures included in risk contracts in this analysis ranged from zero to 51, with an average of 21. In addition to the variation in the number of measures in their contracts, most ACOs also reported that the measures themselves vary from one contract to another, consistent with previous HPC analyses of the significant quality measure variation that providers experience.⁴

Approaches to Managing Performance across HPC-certified ACOs

Defining a Performance Strategy: ACOs' Approaches to Setting Quality Improvement Priorities and Goals

HPC-certified ACOs are required to have governing bodies that assess performance and set strategic performance improvement goals at least once per year. As depicted in Figure 2, the selection of improvement goals may be informed by the quality measures in an ACO's risk contracts and/or the quality improvement priorities determined internally by ACO leadership. The selection of performance goals may drive an ACO's strategies for analyzing and

reporting performance data and incentivizing providers.

Thirteen HPC-certified ACOs indicated that they select quality measures for performance tracking based on the measures included in their contracts with payers. Eleven ACOs said that they identify additional measures to track in domains in which they wish to improve based on past performance. One ACO indicated that disparities and considerations for special populations play a role in its selection of measures for improvement.

With regard to the process for goal-setting, many ACOs indicated that executive management teams or individuals (e.g., chief medical officer or chief quality officer), or designated committees (e.g., quality or performance committee) are charged with proposing performance improvement goals for review and approval by the governing body. Several ACOs noted that their process also includes input from department managers, and one ACO reported including input from other front-line staff.

Tracking Performance: ACOs' Approaches to Analyzing Performance and Engaging Clinicians

HPC-certified ACOs reported varying approaches to generating performance reports. All 18 ACOs indicated that they both develop their own reports and leverage reports provided by payers. Fourteen ACOs collaborate with

Figure 2: Internal and External ACO Accountability



vendors for performance reports. The data used in performance reports come from many different sources; all HPC-certified ACOs use both claims and clinical data to analyze quality performance; 15 use patient surveys; and nine use patient-reported outcome measures (PROMs), most commonly for depression (see **Figure 3**).

Figure 3: Patient-reported outcome measures



ACOs also vary in the types of measures they analyze. All 18 HPC-certified ACOs reported analyzing measures of efficiency (e.g., readmissions, avoidable admissions), outcomes (e.g., diabetes HbA1c control, blood pressure control), and process (e.g., breast cancer screening, colon cancer screening). Additionally, 12 of the 18 ACOs reported performing analyses related to access (e.g., getting timely appointments).

All but one of the 18 HPC-certified ACOs indicated that they share performance reports with their participating providers in the aggregate and at the practice level. Most ACOs reported disseminating performance reports on a monthly or quarterly basis to participating clinician leadership and/or quality committee members. ACOs described various ways of sharing these reports, with many providing them to individual clinicians through a self-service website or platform; via email or other secure delivery to practice or other provider subgroup leadership; and/or through other internal distribution channels such as newsletters.

Example of an Approach to Disseminating Reports

At one ACO, each primary care practice regularly receives a report that compares its recent performance on efficiency and quality metrics with that of prior years and with aggregate ACO averages. The ACO also provides daily operations reports that include recent emergency department and inpatient admissions. All of these reports are also shared with ACO leadership, providing a common and transparent set of data for all levels of the organization.

Incentivizing Providers: ACOs' Approaches to Sharing Risk-Based Incentives with Participants

Under risk contracts, an ACO may earn incentive payments if it is successful in meeting its financial and quality targets. ACOs reported various approaches in the use of these payments; a few ACOs reported reinvesting shared savings in infrastructure and one ACO mentioned using such funds for reserves. Most ACOs, however, did distribute these payments to participating providers, as discussed further below, with varying implications for individual clinician compensation.

Six ACOs reported that they distribute shared savings based on the performance of a subgroup of the provider organization (e.g., “risk unit” or “pod”); in such cases, the subgroup’s policies and procedures determine whether its individual clinicians are eligible to receive a portion of those shared savings. Another reported approach, which six ACOs employ, is direct distribution of shared savings by the ACO to individual participating clinicians. Only one ACO reported holding individual clinicians at risk of losing a portion of their compensation in the event of a deficit at the ACO level. A small number of ACOs reported that their clinician compensation model includes performance incentives that are not in the form of shared savings or deficits.

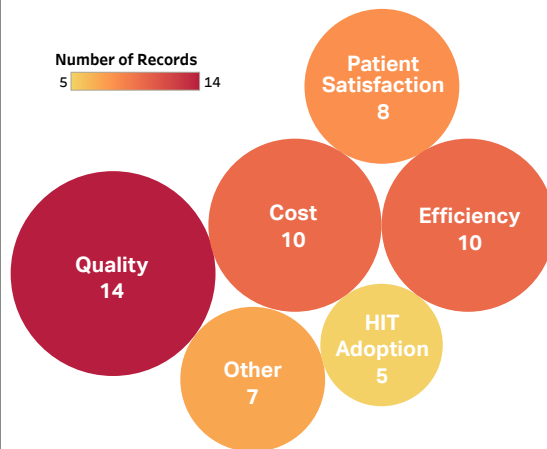
ACOs reported on the types of providers and clinicians that are eligible for shared savings and accountable for deficits through the Massachusetts Registration of Provider Organizations Program (MA-RPO). Some ACOs indicated

Most ACOs consider performance on **quality, efficiency, and cost** when determining how to **distribute shared savings**.

that they distribute shared savings and deficits to both primary care providers and specialists, including behavioral health clinicians. Only one ACO reported sharing savings and deficits with post-acute providers.⁸

The majority of ACOs reported taking into consideration performance on quality, efficiency, and cost when determining how to distribute shared savings, and several ACOs also consider patient satisfaction and adoption of health information technology (HIT) (see **Figure 4**). Other factors that ACOs reported as considerations for distribution of shared savings included: panel size, relative historic revenue, care retention in the preferred network of hospitals and other providers, compliance with ACO standards and processes, citizenship or participation in ACO meetings and activities, and performance on strategic goals such as patient-centered medical home recognition.

Figure 4: Factors used for distributing incentives



CONCLUSIONS AND POLICY IMPLICATIONS

As the Commonwealth moves toward a value-based, accountable health care system, health care providers and payers should accelerate the adoption of risk contracts, particularly with downside risk, for all populations. Such contracts give ACOs incentives to deliver high-quality, efficient care, and ACOs need a data-driven approach to performance management and analytics to incentivize and promote accountability for participating providers. Information collected through the HPC's ACO Certification

program supports the following findings and policy implications.

Expansion of APMs

- While Medicare⁹ and MassHealth¹⁰ have restructured their programs in recent years to feature more risk contracts as well as more aggressive timelines for transitioning to downside risk for ACOs, risk contract adoption and movement to downside risk has been significantly slower in the commercial market, particularly for PPO products.¹¹ Though determining how to attribute patients to the ACO has been noted as a challenge for these products, a consensus methodology has been developed to help overcome this barrier.¹² **As payers and providers gain more experience in risk contracts, they should increasingly expand these contracts to apply to PPO populations in order to align incentives across ACOs' broader patient populations.**

- Upside-only contracts account for about 25 percent of all risk contracts and 100 percent of the self-insured and PPO-based contracts held by HPC-certified ACOs. Some upside-only arrangements may lead to quality and cost improvements for providers, but outstanding questions remain about their effectiveness.¹³ While it may be appropriate for providers to build experience initially in upside-only contracts, **payers and providers should consider more aggressively transitioning contracts, including PPO and self-insured contracts, to include more downside risk** to maximize impact on performance.

Quality Measurement Alignment

- The quality measures included in risk contracts play a significant role in ACO performance management approaches. However, these measures are highly variable, and different contracts may also use slightly different specifications to measure the same underlying aspect of quality performance. This variation makes focused quality improvement more difficult and represents a significant administrative burden for ACOs. **ACOs and payers should adopt the Massachusetts Aligned Quality Measure Set, developed by the Executive Office of Health**

and Human Services’ (EOHHS) Quality Measure Alignment Taskforce, in order to streamline variation in quality measures and focus improvement for patients served by the ACO model. The Aligned Measure Set represents a vision for multi-payer alignment of quality measurement for ACOs that seeks to promote measurement of outcomes and reduce administrative burden for payers and providers.¹⁴

- The fragmented nature of quality performance data reporting from payers to providers represents another opportunity for administrative simplification. Because ACOs receive payer-specific performance reports, they must invest additional resources to develop multi-payer reports for participating providers to assess and improve their quality performance across all of their patient populations. **The creation of a Massachusetts multi-payer clinical data repository, as some other states have done through public/private partnerships,^{viii} could relieve administrative burden and support quality improvement.**

Sharing Incentives with Participating Providers

- ACOs have an opportunity to better engage providers in the goals of value-based care delivery by tying compensation to performance. **ACOs should evaluate how their methods of distributing shared savings, allocating responsibility for any deficits, and generally incentivizing providers through performance-based compensation could be further used to influence provider behavior toward high-value care.** This should include exploring incentives for all provider types that participate in the ACOs, not just primary care (e.g., specialists, including behavioral health clinicians, post-acute care providers). Traditional volume-based approaches to specialist compensation may make establishing risk-based compensation models more challenging; but some ACOs

are already innovating in this area, including for behavioral health, showing that new approaches are possible and deserve broader consideration.

APPENDIX A. METHODS FOR RISK CONTRACT COUNTS

In counting the number of risk contracts held by the 18 ACOs at the time of certification, the HPC excluded certain contracts reported in certification applications that were not considered global budget-based risk contracts, such as Medicare Advantage and Medicare CMS bundles.

In addition, the data included in this policy brief reflects only risk contracts that were active at the time of certification. As such, this brief does not include information on risk contracts with start dates in 2018, including MassHealth ACO contracts, nor contracts that had concluded before 2017 (e.g., Medicare Pioneer ACO contracts).

In their certification applications, several ACOs reported holding risk contracts that cover the Massachusetts Group Insurance Commission (GIC) population, which includes state employees and retirees, and their dependents and survivors. GIC contracts are categorized as commercial risk contracts in this brief and are grouped with other commercial risk contracts by payer (e.g., Tufts Health Plan, Harvard Pilgrim Health Care). Some ACOs’ GIC lives are included within broader commercial contracts that also cover non-GIC lives. Such contracts were counted only once in this brief.

Some ACOs reported having fully-insured and self-insured risk contracts with the same payer. In such cases fully- and self-insured contracts with the same payer were counted as separate and distinct risk contracts.

viii Examples include Maryland’s Chesapeake Regional Information System for our Patients (CRISP), which operates both as a health information exchange and a clinical data repository, and the Clinical Quality Measure Reporting and Repository Service of the Michigan Health Information Network.

ACKNOWLEDGEMENTS:

Jasmine Bland
Vivian Haime
Catherine Harrison
Katie Shea Barrett
Katherine Mills
Lois Johnson

EXECUTIVE DIRECTOR:

David Seltz

HPC BOARD:

Dr. Stuart Altman
Chair
Dr. Donald Berwick
Ms. Barbara Blakeney
Mr. Martin Cohen
Dr. David Cutler
Mr. Timothy Foley
Dr. John Christian Kryder
Mr. Richard Lord
Mr. Ron Mastrogiovanni
Secretary Michael Heffernan
Administration and Finance
Secretary Marylou Sudders
Health and Human Services

ABOUT THE HPC:

The Massachusetts Health Policy Commission, an independent state agency, strives to advance a more transparent, accountable, and innovative health care system through its independent policy leadership and investment programs.

For more information about the HPC, please visit our website www.mass.gov/hpc

ENDNOTES

- 1 Berwick DM, Nolan TW, Whittington J. The Triple Aim: Care, Health and Cost. 2008 May. 27(3). Available from: <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.27.3.759>.
- 2 Annual Report on the Performance of the Massachusetts Health Care System. Boston, MA: Center for Health Information and Analysis; 2018. Available from: <http://www.chiamass.gov/assets/2018-annual-report/2018-Annual-Report.pdf>.
- 3 MassHealth presentation at Health Policy Commission meeting of the Care Delivery Transformation Committee on November 28, 2018. Available from: https://www.mass.gov/files/documents/2018/11/28/11282018_CDT%20Presentation_to%20post.pdf.
- 4 Quality Measurement Misalignment in Massachusetts. HPC Datapoints Series. Boston, MA: Health Policy Commission; 2018. Available from: <https://www.mass.gov/info-details/hpc-datapoint-5-quality-measurement-misalignment-in-massachusetts>.
- 5 Mechanic RE, Santos P, Landon BE, Chernew ME. Medical Group Responses to Global Payment: Early Lessons from the 'Alternative Quality Contract' in Massachusetts. 2011 September. Health Affairs. 30(9). Available from: <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2011.0264>.
- 6 Medicare Pioneer ACO Model. <https://innovation.cms.gov/initiatives/pioneer-aco-model/>.
- 7 Massachusetts Group Insurance Commission. <https://www.mass.gov/orgs/group-insurance-commission>
- 8 Massachusetts Registration of Provider Organizations Data. Boston, MA: Health Policy Commission; 2018. Available from: <https://www.mass.gov/service-details/ma-rpo-data>.
- 9 Verma S. Pathways To Success: A New Start For Medicare's Accountable Care Organizations. Health Affairs Blog. 2018 August. Available from: <https://www.healthaffairs.org/doi/10.1377/hblog20180809.12285/full/>.
- 10 Lloyd J, Heflin K. Massachusetts' Medicaid ACO Makes a Unique Commitment to Addressing Social Determinants of Health. 2016 December. Center for Health Care Strategies, Inc. Available from: <https://www.chcs.org/massachusetts-medicare-aco-makes-unique-commitment-addressing-social-determinants-health/>.
- 11 2017 Annual Health Care Cost Trends Report. Boston, MA: Health Policy Commission; 2018. Available from: <https://www.mass.gov/files/documents/2018/03/28/Cost%20Trends%20Report%202017.pdf>.
- 12 Mariotti, M. Consensus Guidelines for Commercial Non-HMO Patient Attribution Methodology. Atrius Health. 2015 Aug.
- 13 Murray R, Delbanco S. The Evidence on Shared Savings: Do We Know Enough? Health Affairs Blog. 2019 July. Available from: <https://www.healthaffairs.org/doi/10.1377/hblog20180705.615709/full/>
- 14 MA EOHHS Quality Alignment Taskforce. Reports to date are available here: <https://www.mass.gov/how-to/ma-eohhs-quality-alignment-taskforce-report-on-work-through-july-2018>.